University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8TH May 2024 at 9.30 am to 12.35 pm
to be held in the Trust Boardroom, Third Floor, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 3rd April 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report - April 2024	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (02-05-24)	Assurance	Ms S Toor	Enclosure	1
5 mins	**8.**	Maternity Dashboard – March 2024	Assurance	Mrs S Jamieson	Enclosure	1
10 mins	**9.**	Infection Prevention Board Assurance Framework	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**10.**	PLACE Inspection Findings and Action Plan	Assurance	Mrs L Whitehead	Enclosure	1, 7
10:45		**RESOURCES**				
5 mins	**11.**	Performance & Finance Committee Assurance Report (30-04-24)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
15 mins	**12.**	Annual Plan 2024/25	Approval	Ms H Ashley	Enclosure	
11:05 – 11:20 COMFORT BREAK						
11:20		**PEOPLE**				
5 mins	**13.**	Strategy & Transformation Committee Assurance Report (01-05-24)	Assurance	Ms T Bowen	Enclosure	2, 3, 4, 6, 9
11:25		**RESPONSIVE**				
40 mins	**14.**	Integrated Performance Report – Month 12	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:05	**GOVERNANCE**					
5 mins	**15.**	Audit Committee Assurance Report (02-05-24)	Assurance	Ms T Bowen	Enclosure	
10 mins	**16.**	Q4 Board Assurance Framework	Assurance	Mrs C Cotton	Enclosure	
10 mins	**17.**	Annual Rules of Procedure and Outcome of Committee Effectiveness	Approval	Mrs C Cotton	Enclosure	
12:30	**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 5.00 pm 6th May to** nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:35	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 5th June 2024, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd April 2024 at 9.30 am to 12:05 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)											
Mrs T Bowen	TBo	Non-Executive Director											
Mrs T Bullock	TB	Chief Executive											
Mr S Evans	SE	Chief Operating Officer	KT										
Prof G Crowe	GC	Non-Executive Director											
Dr L Griffin	LG	Non-Executive Director											
Ms A Gohil	AG	Non-Executive Director											
Mr M Oldham	MO	Chief Finance Officer											
Dr M Lewis	ML	Chief Medical Officer											
Prof K Maddock	KM	Non-Executive Director											
Prof 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	Director of Governance											
Mrs A Freeman	AF	Chief Digital Information Officer											
Mrs J Haire	JH	Chief People Officer											
Prof A Hassell	AH	Associate Non-Executive Director											
Mrs A Rodwell	AR	Associate Non-Executive Director											
Mrs L Thomson	LT	Director of Communications											
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	DR										

In Attendance:

Mr J Dutton	Corporate Governance Support Manager (minutes)
Ms R Pilling	Head of Patient Experience (Item 1)
Mr D Ruscoe	Deputy Director of Estates, Facilities & PFI
Mr S Rushton	Patient (Item 1)
Mrs K Thorpe	Deputy Chief Operating Officer

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
050/2024	Mr Rushton introduced himself to the Board and shared his experience of receiving a hip replacement. This was his second hip replacement and was done as a day case which he described as a quick procedure with a swift recovery. He expressed that the procedure had significantly improved his life and granted him independence.	

	Mr Wakefield asked if he was given the choice of day surgery and Mr Rushton confirmed this and praised the seamless process. Mrs Bullock highlighted that Mr Rushton was the first patient to undergo this procedure as a day case and expressed her appreciation for his contribution to helping the trust in trailblazing new processes. Dr Griffin queried the difference in experience in the first and second surgeries, to which Mr Rushton stated that the day case approach resulted in a better recovery with minimal pain. Mr Wakefield commended Mr Rushton's positive experience and highlighted the importance of recording such success stories to inform and encourage other patients. The Board thanked Mr Rushton for sharing his story, which underscored the benefits of day case procedures. *Mr Rushton and Ms Pilling left the meeting.*	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
051/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield announced the appointment of Dr Simon Constable as the new Chief Executive Officer of UHNM, with the start date yet to be confirmed. Ms Ashley was to be the interim in the period following Mrs Bullock's departure at the end of June.	
3.	**Declarations of Interest**	
052/2024	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 6th March 2024**	
053/2024	The minutes of the meeting held 6th March 2024 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
054/2024	PTB/586: It was noted that an update was to be provided to the next Performance and Finance Committee.	
6.	**Chief Executive's Report – March 2024**	
055/2024	Mrs Bullock highlighted a number of areas from the report. Mr Wakefield queried the extension of the Locum Consultant Neonatologist and the difficulties to recruit to the post and Dr Lewis explained that following successful recruitment to the last vacancy that an additional vacancy had arisen and the Trust would persist in advertising for the role in order to appoint substantively. Dr Lewis advised he was pleased with the success of the previous recruitment at a time of national challenge and noted that he hoped for a similar successful outcome this time.	

	Mr Wakefield inquired about the ongoing corridor care and plans for resolution and Mrs Bullock acknowledged the ongoing need to use the corridor during extremis and highlighted the new build attached to the Emergency Department (ED) which would provide additional beds and the on-going work into right-sizing the hospital to ensure the appropriate number of specialty beds would support in addressing corridor care in the medium and longer term. Mrs Bullock noted that the shortfall in beds was predominantly within Medicine and that plans were in place to provide additional beds within the Trust but this was also part of a system-wide piece of work. Dr Griffin welcomed the achievements related to the Laboratory Information Management System (LIMS) and HSJ award received, as well as commending the support provided to colleagues during Ramadan. Professor Maddock inquired about the planning guidance, specifically regarding the urgent and emergency care target which was proposed to increase from 76% to 78%, noting the challenges in achieving the current target. Mrs Bullock acknowledged the significant challenge but noted the commitment to aspire to meeting this. Mrs Bullock also highlighted that whilst the trust had not hit the 76% target for the end of March, we had improved our performance by 8% and ended March at 70.18%, which met the Trust's commitment to the region of reaching over 70%. Mrs Bowen queried the nature of the joint executive meetings with North Staffordshire Combined Healthcare NHS Trust and Mrs Bullock explained that these were both operational and strategic, along with focus on building relationships and understanding each other's challenges, as well as exploration of opportunities for collaboration and system working. Mr Wakefield referenced a national report from The Times regarding harm caused to patients due to excess waits in A&E and inquired whether this was being considered as part of the Trust's review process. Dr Lewis responded that the Trust always considered the potential harm caused by long waits. However, identifying harm on an individual patient level was challenging as much of the data on excess deaths and mortality was based on population-level statistics. The effects of prolonged waits often manifested after a delayed period of time, making it difficult to attribute harm to specific patients. Nevertheless, the Trust were mindful that patients waiting for extended periods could suffer adverse consequences. Dr Lewis suggested that the best approach was for the department to consider this aspect when presenting their data to the Mortality Review Group. **The Trust Board received and noted the report and approved the e-REAFs 13299 and 13737.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (28-03-24)**	
056/2024	Professor Hassell highlighted the following from the assurance report: • The 2023 national maternity survey highlighted patient choice as a particular area of challenge, although it was hoped that this would improve for the next survey following improvements in staffing levels. • Eight wards were identified as requiring additional support; six of these were as a result of Care Excellence Framework (CEF) visits whereby it was noted that the standards for these had been raised. Active support, including patient representation, was being provided with plans for revisits.	

	• There had been three recent never events, including two wrong-site dermatology incidents, prompting a deep dive investigation which would be provided to the Quality & Safety Oversight Group (QSOG). • A national issue was raised regarding the high-risk patient screening programme for breast screening, whereby a number of women had been identified as requiring an appointment for urgent screening. The Committee was assured of the robust approach being taken, with progress to be reported to QSOG. • Improvements in outpatient letter processes were noted in terms of ensuring letters were addressed to patients and copied to GPs, with emphasis on clarity in any action required by GPs. • Four patient safety partners had been recruited. • Efforts to engage patients and the public from ethnic minority backgrounds were noted, including accurate data collection and initiatives for engagement with pregnant women in minority ethnic and deprived areas, with plans for Ms Gohil to share expertise with colleagues. Ms Gohil noted some concern regarding outpatient letters, including patients who may not have English as their first language and was concerned that some GPs may not be reading these letters. Dr Lewis acknowledged the high workload of GPs and highlighted that the renal team had been noted for their positive approach to GP letters whereby sections clearly outlined the actions required for GPs, aiming to facilitate the implementation of these actions in primary care settings. In terms of language barriers, Mrs Freeman stated that letters created using the Medisec discharge tool were accessible through the Patient Knows Best (PKB) portal, allowing patients to use online translation tools, and colleagues were encouraged to utilise Medisec for this purpose. **The Trust Board received and noted the assurance report.**	
8.	**Maternity Dashboard – February 2024**	
057/2024	Mrs Riley summarised the following from the report: • A training plan for the year was established and remained on track for compliance with the Clinical Negligence Scheme for Trusts (CNST). • Positive improvements were noted in induction of labour and Maternity Assessment Unit (MAU) triage processes. Although NHS England had notified the trust that the triage compliance target for all Midlands trust would be set at 85% which was currently being achieved and noted UHNM had an internal stretch target of 95%. • Efforts to address vacancies continued, with full recruitment anticipated by summer / early autumn. • The report from the inspection by the Care Quality Commission (CQC) regarding the Section 29a was still awaited. • A forthcoming Rapid Quality Review Meeting offered an opportunity to showcase progress. • The team was currently benchmarking against new CNST standards. Professor Hassell noted that the Quality and Governance Committee (QGC) had commended the positive induction of labour and triage performance. Dr Griffin referred to the HSIB referrals and queried what the suspected HIE was in relation to and Mrs Riley agreed to clarify this. Mr Wakefield questioned if there was a risk of over-recruitment, given that 1:1 care had been maintained and the acuity table only showed a shortage of up to two	**AR**

	midwives. Mrs Riley explained that staffing levels were determined by Birth Rate Plus which was a nationally recognised method, and in order to maintain care and a positive experience, staff were being pulled from other areas, hence the ongoing recruitment efforts. Professor Toor noted a recent positive walkabout undertaken as maternity safety champion which was not reflected in the report. **The Trust Board received and noted the report.**	
RESOURCES		
9.	**Performance & Finance Committee Assurance Report (25-03-24)**	
058/2024	Mrs Bowen highlighted the following escalations and positive assurances from the report: • Challenges continued within Endoscopy and a plan was in place to address this. • There were currently three 104 week wait patients, the number of 78 week waits was expected to reduce to single figures by April, and there was positive performance seen in the Faster Diagnostic Standard and addressing of the cancer backlog. • Month 11 financial performance resulted in a £3.3 million deficit, ahead of forecast despite being £4 million behind plan, aiming for a break-even position. 2024/25 Financial outlook discussions focused on mitigating actions for the deficit, and positive Elective Recovery Fund (ERF) income and reduced agency spend were noted. Future risks regarding capital availability and estates backlog were also highlighted. • A risk was highlighted regarding funding for the Community Diagnostic Centre (CDC) and was subject to further discussion. • A procurement update highlighted bottom line savings of £8.17m, and continuing collaboration across the Integrated Care System. • Positive assurances were given regarding colorectal redesign and neonatal nursing business case reviews. **The Trust Board received and noted the assurance report.**	
PEOPLE		
10.	**Transformation & People Committee Assurance Report (27-03-24)**	
059/2024	Professor Crowe highlighted the following escalations and positive assurances from the report: • An improvement in compliance with the disciplinary policy, with an increased number of investigations completed in a timely manner. • Progress in addressing the gender pay gap, with five out of six metrics showing improvement. • Reduction in vacancies and an improved assurance rating for the Chief People Officer report, though work continued on remaining hard-to-fill areas and retention. • Updates from the Guardian of Safe Working highlighted an increased number of unresolved reports within the junior doctor community, but no immediate safety concerns were identified. Further work was planned to triangulate with other sources of information. • The work on the sexual safety campaign led to an increase in the number of allegations raised, as expected.	

	• Assurance was received on agency controls, with only one of four areas found to be non-compliant, though the Trust was not expecting to meet the national agency target of 3.7%. Efforts would be made between the People, Culture & Inclusion and Performance and Finance committees to ensure effective control measures. Dr Griffin queried the implications of not achieving the agency target and Mr Oldham explained that this formed part of the oversight framework and tiering allocation for financial governance and would be taken into account during the evaluation of overall financial performance – though it was noted that agency use had reduced significantly. **The Trust Board received and noted the assurance report.**	
11.	**2023 NHS Staff Survey Report**	
060/2024	Mrs Haire summarised the following points from the Staff Survey Report: • The response rate improved to 45% overall, a significant improvement from the previous year. • The staff engagement and morale scores improved to 6.8 and 5.92 respectively. • There was an improvement in 5 out of 7 people promises, with a focus on 4 key areas for the year ahead: creating a compassionate and inclusive organisation, keeping people safe and healthy, a focus on learning, and supporting flexible working. • While progress had been made in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators, more progress was needed, with plans to identify further areas for enhancement. • A detailed plan of work was presented at the March Transformation and People Committee. Mr Wakefield noted the increased response rate and queried the lessons learned to sustain and enhance this improvement. Mrs Haire stated that a collective organisational effort was made in pushing for increased participation, and emphasised that delivering on commitments encouraged participation, underscoring the importance of continuing such efforts. Professor Hassell enquired about the process for disseminating information to divisions to ensure actions were taken forward and Mrs Haire explained that as part of the Improving Together methodology, there was an employee engagement driver metric in place and countermeasures would be identified to drive progress forward, monitored monthly via performance reviews. Professor Crowe highlighted the culture improvement plan that consolidated various aspects coherently, and he emphasised that the next phase of change needed to be delivered at the middle management level. Additionally, a cultural heatmap continued to be developed to gain a broader understanding of issues and identify specific areas for targeted intervention. **The Trust Board welcomed the progress made and noted the 2023 National Staff Survey report and results along with corporate priorities planned for 2024/25.**	
12.	**Gender Pay Gap Report**	
061/2024	Mrs Haire highlighted the following from the report:	

	• There was an improvement in 5 out of 6 metrics, a 6.6% reduction in the median pay gap and a 2.5% reduction in the mean pay gap. • The main factor in the gender pay gap was a higher proportion of males in higher pay quartile roles despite representing a smaller percentage of the workforce. • 100% of all eligible consultants received an internal clinical excellence award (CEA) regardless of gender. However, there were more men employed in the Medical and Dental professional group compared to women. • Flexible working was an important factor for improving gender equality and career progression. There would be a continued focus on conducting deep dives into staff surveys and promoting a new performance development review framework with an emphasis on talent progression. Mr Wakefield acknowledged positive progress but questioned the use of the mean and median as a crude tool, suggesting consideration of the mode for a different perspective on gender pay gap and Mrs Haire agreed to explore this. Mr Wakefield inquired why all consultants received CEA's and Dr Lewis explained that during COVID-19, the competitive process was suspended nationally, leading to equal distribution of awards. Reforms to this framework were currently under review and being consulted on; it was expected that awards would no longer be administered locally. Ms Gohil queried plans to support the development of women to encourage more applications for senior positions and Mrs Haire responded by mentioning the redesign of performance development reviews (PDR) to focus on talent and growth opportunities, along with ongoing efforts on talent progression. Additionally, there was further work to do to map out talent across different tiers within the organisation. **The Trust Board noted the contents of the report and the recommended actions to improve the Gender Pay Gap at UHNM.**	**JH**
13.	**Leadership Competency Framework**	
062/2024	Mrs Haire presented the update on the actions required to implement the new Leadership Competency Framework (LCF). Mrs Cotton noted that the independent well-led review was currently underway, and survey questions would be aligned with this framework. Professor Crowe welcomed the introduction of domains and links to other activities. He reflected on the practical aspects, noting the significant number of questions in the self-assessment and Mrs Cotton stated that whilst there wasn't much flexibility as this was a national document, the process would be digitised to aid completion. **The Trust Board approved:** • **The incorporation of the competency domains into all future Board Member job descriptions and recruitment processes, as well as being used to help evaluate applications and identify questions to explore skills and behaviours.** • **Incorporating the competency domains as part of Board Member appraisals undertaken in 2024, noting that the Trust templates would be reviewed again once the new Board Member Appraisal Framework had been published.**	

	The Trust Board also noted that the outputs of the appraisal process and implementation of the LCF would be included within existing reports to the Nominations and Remuneration Committee, and that the competency domains were expected to be built into national leadership programmes and support offers for Board Directors and Aspiring Board Directors.	
RESPONSIVE		
14.	**Integrated Performance Report – Month 11**	
063/2024	**Quality & Safety** Mrs Riley highlighted the following in relation to quality and safety performance: • Serious Incident (SI) / Patient Safety Incident Investigation (PSII) charts would be amended going forwards as it no longer provided comparable benchmarks. • A piece of work was underway to better understand themes related to operational pressures in the Friends and Family Test (FFT). • A review of contributing factors to C Diff had been conducted, identifying areas for improvement. • There was a notification of changes in reporting for HAI (Healthcare-Associated Infections) and community-acquired infections, shifting from the date of admission to the decision to admit. This change would likely lead to an increase in HAI incidences and the trajectory would be altered accordingly. Mrs Bowen inquired about the FFT for A&E and if follow-up text message surveys had been considered and Mrs Riley agreed to explore the possibility of this with the team. Mr Wakefield observed that timely observations continued to improve and queried any connections with the 8 wards identified as needing extra support. Mrs Riley responded that the wards mentioned could be chosen for various reasons, not solely based on timely observations. Other factors were considered, and teams were now focusing on leader standard work. Mr Wakefield referred to the national increase in measles cases and inquired about any impact on the Trust and Mrs Riley stated that there had been a small number of cases at UHNM; there was an increase in children presenting with probable symptoms but the majority were not actual cases. Mrs Bowen referred to the actions to ensure that the number of Patient Advice and Liaison Service (PALS) contacts escalated to formal complaints did not rise and sought re-assurance that the team were focusing on what was best for the complainant and Mrs Riley confirmed this, noting that the most effective approach didn't always involve a formal route. Professor Crowe expressed concern about sepsis screening compliance in emergency portals and sought assurance on the plan to address it. Mrs Riley responded that updates on this were provided to QSOG and QGC and the team was working hard to meet the trajectory, though there were difficulties with operational pressures. Professor Hassell noted the discussions at QGC and acknowledgement of the challenges faced by the ED, indicating that addressing these would also support sepsis screening compliance. It was agreed to provide a future update on the impact of the interventions put in. **Operational Performance**	**AR** **AR**

Mrs Thorpe summarised urgent and emergency care performance, noting that the Trust finished March at 70.18% against the 4-hour standard, the highest it had been since July 2021, and there were slight improvements in 12 hour trolley waits and ambulance handovers.

Mr Wakefield queried the planning guidance in terms of 12 hour waits and Mrs Thorpe clarified that the approach covered both internal waits and ambulance handovers waits, from a system perspective.

Dr Griffin welcomed the improvement in the 4-hour standard and queried what had enabled this and Mrs Thorpe responded that the improvement was attributed to various factors, including a focus on workstreams and the introduction of measures such as rapid handover protocols. The key takeaway was to continue working on these initiatives.

Mrs Thorpe highlighted the following in relation to planned care performance:

- Unvalidated data for March indicated that the month ended with three 104 week patients waiting, due to patient choice and complexity, and the number of 78 week patients decreased from 159 to 71 and was expected to reduce to single figures by the end of April.
- The cancer backlog continued to reduce and the Trust's 'fair share' aim had been achieved.
- The Faster Diagnosis Standard was achieved in February.

Mr Wakefield inquired about the status of patients waiting for 65 weeks and Mrs Thorpe stated that there were a significant number of patients in this category and mentioned that planning guidance required a reduction to zero patients by the end of September. Significant work was ongoing to address this and would be discussed further at the Performance and Finance Committee (PAF).

Mr Wakefield queried progress with the plan for endoscopy and Mrs Thorpe responded that this still remained a high-risk area and additional support had been provided to improve the position.

Mr Wakefield raised the topic of productivity which had been a national focus and questioned if progress against this could demonstrated and Mrs Thorpe confirmed that there were various ways to demonstrate productivity. Mr Wakefield suggested further consideration of this at PAF.

Professor Crowe questioned if a review of the winter plan had been undertaken and if the additional capacity remained open. Mr Wakefield noted that an update on the winter plan was expected at the next PAF. In terms of the additional capacity, Mrs Thorpe confirmed that this was still open, with associated costs. Professor Crowe expressed concerns about stretched resources and continued support for these facilities and Mr Oldham agreed this was a pressure but also noted the national view that this was now considered mainstreamed and funded in this year's allocation for urgent and emergency care. However, he also noted that the funding did not cover the costs.

Mrs Bullock conveyed a message from NHS England thanking the Trust for its current position, progress that was being seen and acknowledging the desire for continuous improvement. Specifically, Mrs Thorpe was recognised as instrumental in this regard.

Workforce

Mrs Haire highlighted the following in relation to workforce performance:

- Turnover and vacancy rates continued to show improvement and a stretch target for vacancies was being considered.
- Sickness absence had improved, with reductions in COVID-related absences.
- Stress awareness activities were due to take place throughout April.
- PDR compliance had only slightly improved and efforts continued to drive this at performance reviews.
- Compliance with statutory and mandatory training was just below the trust metric, and consideration was being given to monitoring of essential to role training via performance reviews.
- The monthly staff voice surveys had now moved to quarterly to focus on addressing feedback received.

Professor Maddock expressed concern about the rate of absences due to stress and anxiety and queried the spread of this across different grades and types of staff. Mrs Haire responded that detailed reports were received from the Occupational Health (OH) service, and further information could be provided to the People, Culture, and Inclusion Committee on the work being undertaken to support psychological wellbeing. The working assumption was that the underlying causes were widespread and not always work-related, and she emphasised the availability of support services.

JH

Mr Wakefield enquired if monitoring of agency use was undertaken in areas being recruited to and Mrs Haire confirmed that discussions were held with divisions to identify areas of agency expenditure by staff group and this detailed information was available.

Finance

Mr Oldham summarised that for Month 11 the Trust had delivered a year-to-date deficit of £3.3m against a planned surplus of £0.7m; this adverse variance of £4m was primarily driven by underperformance against the Trust's in year Cost Improvement Programme (CIP) target and unfunded additional winter escalation capacity that remained open through the year. Though the Trust was still forecasting to achieve a break-even position.

Professor Crowe inquired about the current CIP position and the split between recurrent and non-recurrent costs, as well as expectations. Mr Oldham responded that a target of £55m had been set for the year, with approximately £20m being non-recurrent. Mr Oldham noted that £47m of this would be transacted recurrently against the £55 million target, with the gap primarily between divisions and industrial action costs. Further challenges were anticipated next year due to the non-recurrent nature of the CIP programme.

Mr Wakefield highlighted the difference in the cost and amount funded for escalation beds and questioned if this had been recognised centrally and Mr Oldham explained that it could be argued that funds were provided for the urgent and emergency pathway for winter escalation. However, the system's winter schemes exceeded that allocation.

Mr Oldham provided an update in terms of the 2024/25 financial outlook, noting that discussions remained ongoing in respect of the size of the deficit and a final submission was required by 2nd May.

The Trust Board received and noted the report.

GOVERNANCE

CLOSING MATTERS		
15.	**Review of Meeting Effectiveness and Review of Business Cycle**	
064/2024	No further comments were made.	
16.	**Questions from the Public**	
065/2024	Mr Syme asked the following questions: <u>Home Birth Service</u> He noted that UHNM was due to re-commence its Home Birth service and that a significant challenge for UHNM's maternity services was the levels of defined risk, as pregnancies were becoming more complex. He referred to the drop in UHNM's percentage of low risk pregnancies compared to the number referred to by West Midlands Clinical Senate review and expressed concern at this, and questioned how risk would be factored in to the recommencing of the Home Birth service. Mrs Riley explained that all women who requested a home birth would be risk assessed in line with local and national guidance, just as did previously, therefore only those suitable for home birth would be booked for such. This risk assessment process carried on throughout pregnancy and suitability for home birth was continuously re-assessed in terms of any emerging/new risks. Mr Syme queried whether women having their first child could do so as a home birth and Mrs Riley confirmed they could. <u>Midwifery Continuity of Carer at Full Scale</u> Mr Syme referred to the Midwifery Continuity of Carer default model of care, which should be offered to all women. He highlighted that recent Board papers referred to a risk in relation to no Operational Midwifery Continuity of Care Team and given the NHS England directive, he queried the state of readiness in UHNM's Maternity Service being able to provide this default model of care. Mrs Riley noted that the NHSE plans set out in 2017 were superseded by guidance issued by NHSE on 21.09.22 which stated that there would no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services would instead be supported to develop local plans that worked for them. Mrs Riley noted that UHNM did submit their continuity of carer plans, which were signed off and contributed to by the Local Maternity & Neonatal System (LMNS) in June 2022 which set out a clear trajectory for UHNM to aim to begin continuity of carer when the service was fully staffed to minimum safe staffing levels in line with Birthrate Plus.	
DATE AND TIME OF NEXT MEETING		
17.	**Wednesday 8th May 2024, 9.30 am, Trust Boardroom, Springfield, Royal Stoke**	

Trust Board (Open)

Post meeting action log as at 02 May 2024

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Action completed
GA / GB	On Track	A. Action on track – not yet completed *or* B. Action on track – not yet started
A	Problematic	Due date has been moved once. Revised due date provided.
R	Delayed	Due date has been moved twice or more. Revised due date provided.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/586	03/01/2024	Integrated Performance Report – Month 8	To provide an update on admission avoidance schemes at a future Performance and Finance Committee.	Simon Evans	~~27/02/2024~~ ~~26/03/2024~~ 15/05/24		To be covered as part of the surge plan update which is to be provided to the Trust Board Seminar in May.	A
PTB/590	06/03/2024	Chief Executive's Report – February 2024	To share the plans for the Cancer Centre, as a result of the Coates Foundation donation, with members of the Board.	Lisa Thomson	08/05/2024		**Update to be provided**	GA
PTB/591	06/03/2024	Maternity Dashboard - January 2024	To provide an update on the outstanding CQC actions to a future Maternity Quality Governance Committee.	Ann-Marie Riley	22/05/2024		Action not yet due.	GA
PTB/592	06/03/2024	Care Quality Commission Action Plan Update	To provide further assurance to the Quality Governance Committee in respect of the audit data into use of the mental health tool.	Ann-Marie Riley	02/05/2024	02/05/2024	Update provided to QGC May 2024.	B
PTB/593	06/03/2024	Integrated Performance Report - Month 10	To provide an update on endoscopy funding and operational impact at a future Performance and Finance Committee	Simon Evans	30/04/2024	30/04/2024	Update provided on Endoscopy to April's PAF.	B
PTB/594	06/03/2024	Health and Wellbeing Strategy	To provide a supporting delivery plan to a future Strategy and Transformation Committee, in addition to including quantitative targets, both baseline and trajectories, within Appendix 1,	Helen Ashley	01/05/2024	01/05/2024	Outcome Framework presented to Strategy & Transformation Committee on 01/05/24, along with an update on Health Inequalities. It was agreed to bring these together with an update on Anchor Institutions, to the next meeting, to demonstrate how those work programmes align to the Strategy	B
PTB/595	03/04/2024	Maternity Dashboard – February 2024	To confirm with Dr Griffin what the HIE was in relation to with regards to HSIB referrals.	Ann-Marie Riley	08/05/2024		**Update to be provided**	GB
PTB/596	03/04/2024	Gender Pay Gap Report	To consider the mode as opposed to the mean/medium for a different perspective on the gender pay gap.	Jane Haire	05/06/2024		The national reporting for gender pay doesn't provide mode information and this will require a new report to be developed for this. The Workforce Information Team and Inclusion lead are reviewing the criteria for a bespoke report.	GB
PTB/597	03/04/2024	Integrated Performance Report – Month 11	To explore the possibility for follow-up text message surveys for the friends and family test for A&E.	Ann-Marie Riley	05/06/2024		Action not yet due.	GB
PTB/598	03/04/2024	Integrated Performance Report – Month 11	To provide an update to a future meeting on the impact of interventions put in to improved sepsis screening compliance in the Emergency Department.	Ann-Marie Riley	10/07/2024		Action not yet due.	GB
PTB/599	03/04/2024	Integrated Performance Report – Month 11	To provide further information to the People, Culture & Inclusion Committee on sickness absences due to stress and anxiety in terms of the spread across different grades and types of staff.	Jane Haire	03/07/2024		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

April 2024

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th March to 14th April 2024, 2 contract awards over £1.5 m was made, as follows:

- **Day Case Unit at County Hospital** supplied by IHP Integrated Health Projects, capital bid 7025, at a total cost of £5,097,335.40 incl. VAT, approved on 09/04/2024
- **Off-Site Storage for Health Records** supplied by Iron Mountain UK Ltd, for the period 01/04/2024 to 31/03/2029, at a total cost of £2,383,440.00 incl. VAT, with savings of £36123.00 incl.VAT approved on 09/04/2024

In addition, the following eREAFs were approved at the Performance and Finance Committee on 30th April. These require Trust Board approval due to the value:

In Centre Haemodialysis Consumables (e-REAF 13922)

Contract Value £2,126,280.00 incl. VAT
Duration 01.04.24 – 31.03.26
Suppliers Fresenius, TPS, Medical Access, Baxter, Medtronic, Nipro, B Braun

New NMCPS Blood Sciences Managed Service Contract (e-REAF 13917)

Contract Value £28,310,000.00 incl. VAT
Duration 01.10.25 – 30.09.32
Supplier Roche Diagnostics Ltd

Additional Funds for NMCPS Blood Sciences Managed Service Contracts (e-REAF 13838)

Contract Value £2,563,743.23 incl. VAT
Duration 01.10.22 - 30.09.24
Suppliers Beckman Coulter UK Ltd, Siemens Healthineers UK.

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – April 2024

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Orthopaedic Hand and Wrist Surgeon	New	TBC	TBC
Locum Consultant Geriatrician	Vacancy	Yes	TBC
Consultant NeuroInterventional Radiologist	New	Yes	TBC
Consultant Primary Eye Care	New	TBC	TBC
Locum Consultant in Emergency Medicine	Vacancy	TBC	TBC
Acute Medicine Consultant	Vacancy	Yes	TBC
Consultant in Neonatal Medicine	New	Yes	TBC
Consultant Obstetrician & Gynaeoncologist	Vacancy	Yes	TBC
Consultant Gastroenterologist	Vacancy	No	Candidate unsuccessful

The following provides a summary of medical staff who have taken up positions in the Trust during April 2024:

Post Title	Reason for advertising	Start Date
Locum Consultant Cardiothoracic Anaesthetist	Vacancy	22/04/2024
Locum Consultant Neurologist	New	02/04/2024
Consultant Anaesthetist (Specialist interest in Vascular & Max Fax)	New	08/04/2024
Locum Cardiology Consultant	Vacancy	01/04/2024

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

Post Title	Closing Date	Notes
Consultant Clinical Oncologist - Breast and Gynae	18/04/2024	No Applications
Acute Medicine Consultant	18/04/2024	No Applications

2.3 Internal Medical Management Appointments – April 2024

The following provides a summary of medical management interviews which have taken place during April 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead - Endoscopy Medicine	Vacancy	TBC	TBC

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

Part 2: Highlight Report

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

National / Regional

1. Maternity Incentive Scheme Year 5 Results

We received great news this month in relation to our CNST Maternity Incentive Scheme submission. Following an external verification process undertaken by NHS Resolution, we received confirmation that we have achieved all ten safety actions for year five. We will shortly receive the return of our contribution into the incentive fund, together with a share of unallocated funds. This is a fantastic achievement for maternity and neonatal services, well done!

2. 62 Day Urgent Suspected Cancer Backlog Reduction

I was delighted to receive a letter from the NHS Cancer Programme in April, congratulating us on the positive progress our teams have made in reducing our 62 day backlog over the past year and improving Faster Diagnosis Standard (FDS) performance. Since April 2023, our backlog has reduced to 222 patients (an improvement of 35.4%) and our Faster Diagnosis performance improved by 12%.

This progress was highlighted as some of the most positive seen nationally, and significantly contributed to the overall national position. It is great to receive this recognition and I would like to congratulate the cancer team and all the clinical and non-clinical teams who supported this significant achievement and for ensuring our actions are always in the best interests of our patients.

3. Progress Against Elective Targets

NHS England wrote to the Trust in April, thanking all of our teams for their fantastic efforts, in reducing our number of over 78 week waits. The letter recognised that despite having another challenging year, the impact of Industrial Action and continued demand on services, the efforts made in reducing the backlog is of great credit and should be applauded. My thanks go to all involved in helping to deliver this position.

System / Regional Focus

4. Financial Planning 2024/25

Many of my executives joined me at a recent meeting with other local NHS providers, the local authority and Integrated Care Board colleagues to discuss our collective response to the Integrated Care System's financial challenge. Along with every organisation in our healthcare system we are under significant national scrutiny to ensure we are doing everything we can to address the financial gap.

Whilst our priority remains the safe care of our patients, we will be challenging all of our areas to ensure we are being as productive as we can be, as well as continuing to be robust in the controls and actions we are taking to support financial improvements.

5. West Midlands Clinical Senate Visit

Earlier in the month, we had a visit to our maternity services from representatives of the West Midlands Clinical Senate. The visiting team thanked us for a warm welcome and the valuable information the team shared during the visit, which was an essential part of collating evidence for a review into how we deliver maternity services in the future. The Senate team found all staff to be engaging and helpful in demonstrating

how our services are currently configured and were able to visibly see the passion our staff have for caring for women and babies within our system.

Organisational Focus

6. Project STAR

I took pleasure in formally launching the new multi-storey staff car park on 24th April, when we held an official ribbon cutting ceremony. The car park is due to open for staff to use on Tuesday 7 May. The new car park on the former Grindley Hill site for all staff and has 1,600 car park spaces, replacing the parking currently provided on the old Royal Infirmary (RI) and some of the Central Outpatients Department (COPD).

7. A Night Full of Stars

We have recently announced that this year's annual Night Full of Stars Staff Awards will be held on 6 September at the Double Tree Hilton. Nominations are now open and whilst I won't have the pleasure this time, it is always an honour to review award nominations where we highlight and celebrate individuals and teams across our organisation who have been nominated by their colleagues for making a real difference to our patients, their families, and our organisation. Good luck!

8. Chief Executive Officer

The interviews for my replacement were held in early April, and following a rigorous recruitment process, Dr Simon Constable was appointed. Simon is an experienced Chief Executive, currently at Warrington and Halton Teaching Hospitals NHS Foundation Trust, and a Consultant Physician and Clinical Pharmacologist by background. I know he will make a significant contribution to UHNM and is very much looking forward to joining our amazing organisation.

Following my retirement at the end of June, Helen Ashley, Director of Strategy and Deputy CEO will take on the role on an interim basis, and Simon will be joining UHNM later in the summer/early autumn.

9. George Cross Badges

I am pleased to report that our colleagues have now started to receive their George Cross badges, a token of appreciation of our recognition and gratitude for our people's hard work during the Covid-19 Pandemic. My thanks go to Unison and UHNM Charity for coordinating the issue of badges to colleagues.

Highlight Report

Quality Governance Committee 2nd May 2024 to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- 5 hospital acquired MRSA bacteraemia's had been reported within Quarter 4, 2 of which were unavoidable. Issues in relation to lack of screening for MRSA were identified for the other 3 cases and actions were being taken to communicate and remind staff of policy requirements
- The number of clostridium difficile cases remained above the upper limit within Quarter 4 and learning from other Trusts had identified that electronic prescribing was in place at Trusts with better performance. Actions were being taken in respect of implementing additional controls for the prescribing of co-amoxiclav and these were to be considered by the Antimicrobial Steering Group.
- It was noted that in terms of sepsis reporting, recent NICE Guidance had changed the way in which this was due to be reported, although the system in place to record this within the Trust, VitalPack, was not expected be updated until 2025, and this had been escalated nationally
- The Infection Prevention Board Assurance Framework highlighted compliance against key criteria, whereby 11 elements had been identified as partially compliant and particular areas of concern were noted to be the data gap in respect of staff with the MMR vaccine as well as delays with blood cultures at County Hospital. The actions identified to address areas of non-compliance were presented to the Committee
- In terms of midwifery staffing acuity, 40% of shifts were up to two midwives short and this was noted to be in relation to increased annual leave and the learning from this was to be used to plan annual leave for 2024/25
- The medicines optimisation report highlighted risks in relation to a delay in installing an automated dispensing system due to changes in building regulations, and a paper regarding the implication of the regulations had been considered by the Executive Team
- Risks associated with the implementation of sodium valproate were highlighted, whereby an action plan was in place. It was noted that the Trust was behind the implementation date of January 2024 and updates on this were provided on a monthly basis to the system quality group
- Month 12 quality performance report highlighted a further never event and a thematic review was being undertaken, the learning from which would be shared with the Quality Oversight Group. In addition, the delay and pace of improvements with timely observations were challenged and an update on the actions being taken using the Improving Together tools was provided. It was agreed to provide an update on the trajectory for improvement at a future meeting
- Whilst an extreme risk continued to be reported in respect of ineffective clinical effectiveness provision, work was progressing in confirming and aligning resources within the Quality, Safety and Compliance structure. In addition, the Clinical Effectiveness Group continued to engage and make progress with Divisions
- An update was provided in relation to the retrospective clinical harm reviews undertaken for a sample of long wait patients and an electronic prospective solution continued to be worked up. It was noted that of the harm reviews undertaken no serious harm or detrimental impact on patient outcomes had been identified. It was also recognised that the current priority for clinicians was to provide treatment for patients on the waiting list, as opposed to carrying out additional retrospective or prospective reviews.

Major Actions Commissioned / Work Underway

- A paper was to be considered by the Quality and Safety Oversight Group in terms of assessing the impact of the change in NICE Guidance and ability to report sepsis in line with the guidance
- To report the progress on the actions being taken in respect of clostridium difficile at a future meeting
- To amend the IPC BAF Executive Summary in terms of highlighting actions which were close to being completed as well as clarifying any expected delays and the reasons for these. It was agreed to clarify the due dates and identify revised dates where these had been delayed
- An update to be provided within the next Patient Experience report on the actions being taken to improve friends and family test responses
- To address and clarify inconsistencies of data reported in relation to maternity sepsis and infection prevention MRSA reporting
- Improvement plan for Venous Thromboembolism (VTE) to be considered by the Quality and Safety Oversight Group
- Ongoing actions continued to be undertaken in respect of the Thirlwall Inquiry, in terms of how concerns were dealt with as they are raised, how services and were monitored and problems identified, and how harm was assessed. This was being considered with Executives in terms of areas of focus, and actions and monitoring would be undertaken via the Quality and Safety Oversight Group
- An update was provided on the actions taken to increase awareness of mental health requirements, and ongoing audits of compliance. It was noted that the internal audit into Mental Capacity Act was being re-reviewed in terms of its methodology and focus on County Hospital and this was to be further discussed at Audit Committee
- To continue with discussions in respect of streamlining the Committee's agenda with a move forwards reporting by exception

Positive Assurances to Provide

- The maternity dashboard for March demonstrated that training compliance was on target, in addition to improvements with maternity triage and induction of labour. One to one care had also been maintained throughout the month
- The Committee noted that the Trust had been removed from the System Maternity Assurance and Oversight Group due to the improvements made whereby assurance would be provided via business as usual mechanisms
- The Committee welcomed the update on progress with implementation of the Johns Hopkins Programme whereby go live took place on 8 wards in November 2023, and associated research was being undertaken up by the CeNREE team. The programme was also to be publicised via a week long communications event in the summer and system wide communications were being considered
- The medicines optimisation report highlighted positive CQUIN performance and the discharge medicines service had seen improved performance month on month. The Trust had sustained its top position in the region for adverse drug reaction reporting and had been congratulated on range of staff reporting
- Verbal duty of candour reporting had remained at 100% with continued improvements with the internal 10 day written target
- The Committee welcomed the update provided in relation to the communications developed in respect of 'Home Care is Best Care' which had been consulted on with the Hospital User Group
- The Patient Led Assessments of the Care Environment (PLACE) results for 2023 demonstrated scores above the national average across all domains, which placed the Trust in the top 6% of NHS Trusts nationally for cleaning scores
- The outcome of the Committee Effectiveness reviews highlighted mainly positive feedback and a couple of actions identified for further improvement

Decisions Made

- The Committee approved the 2024/25 Annual Clinical Audit Plan
- The Committee approved the Quarter 4 Board Assurance Framework and top 3 risks
- The Committee approved the Committee Annual Report and revised Terms of Reference

Comments on the Effectiveness of the Meeting

- Committee members welcomed the quality of papers provided and the succinct summaries provided by report authors

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Infection Prevention HAI Report Q4 23/24	BAF 1	High 12	🔴	Assurance	9.	Clinical Effectiveness Group Highlight Report	BAF 1		🔴	Assurance
2.	Infection Prevention Board Assurance Framework	BAF 1	High 12	🔴	Assurance						
3.	Maternity Dashboard: March 2024	BAF 1	ID13419	🟢	Assurance	10.	Home Care is Best Care	BAF 1 BAF 5	High 12 Ext 20	🟢	Information
4.	Johns Hopkins Programme	BAF 1	High 12	🟢	Assurance	11.	Mental Health Audits	BAF 1	High 12	-	Assurance
5.	Medicines Optimisation and Safety Report Q3 & 4 2023/24	BAF 1	ID31771 ID28910 ID29312 ID28382 ID21719 ID21481 ID23506 ID23500	🔴 🟢	Information	12.	Patient Waiting List Backlog	BAF 1	High 12	🔴	Assurance
6.	Quality Performance Report – Month 12 23/24	BAF 1	High 12	🔴 🟢	Assurance	13.	UHNM PLACE Results 2023	BAF 7	High 12	🟢	Assurance
7.	Thirlwall Update	BAF 1	High 12	-	Assurance	14.	Quarter 4, 2023/24 Board Assurance Framework (BAF)	ALL		-	Approval
8.	2024 / 2025 Annual Clinical Audit Plan	BAF 1	ID26887 ID8877 ID8500	-	Approval	15.	Committee Effectiveness 2023/24: • Quality Governance • Maternity & Neonatal Quality Governance			-	Approval
9.	Quality Safety & Compliance Overview Update	BAF 1	ID26887	🔴	Information	16.	Quality & Safety Oversight Group Highlight Report	BAF 1	High 12	-	Assurance

Attendance Matrix

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director (Chair)												
Mrs C Cotton	CC	Director of Governance	NH											
Dr M Lewis	ML	Medical Director												
Prof K Maddock	KM	Non-Executive Director												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Mrs A Riley	AR	Chief Nurse												
Prof S Toor	ST	Non-Executive Director												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
Report Title:	Maternity Dashboard: March 2024	**Agenda Item:**	8.
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery – Workforce & Gynaecology		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	Title	Risk level
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019)	9
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	6
11518	No current operational Midwifery Continuity of Care team	6
15993	Maternity Assessment Unit Triage	6

Executive Summary

Situation

The Maternity Dashboard report provides an overview of the Maternity performance for March 2024.

Background

The Maternity incentive scheme - year 5 requires evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board using a minimum data set. The measures within the dataset are included and additional information provided.
Based on the CQC report released 23.6.23, UHNM Maternity is rated “requires improvement”.

Though not part of the maternity support programme, UHNM is part of SMOAG (System Maternity Oversight Assurance Group) which provides additional support and guidance. The final meeting of this group was held and the feedback was extremely positive.

Assessment

- Compliance with training is good, focus required for anaesthetic training over coming months.
- Improvements with midwifery triage within 15 minutes and induction of labour within guidance continue.
- Acuity and staffing levels on the delivery suite and wards continue to be monitored.
- One to one care in labour maintained throughout the month.
- The delivery Suite coordinator has remained supernumerary throughout March

Key Recommendations

The Trust Board is asked to receive this report.

University Hospitals of North Midlands NHS Trust

Maternity Monthly Dashboard

12th March 20242024 (March report)

1. Introduction

The Maternity incentivisation scheme - year 5 requires the Trust to:

- Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues. (safety action 9)
- Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set (figure 1).
- Demonstrate an effective system of midwifery planning to the required standard. (safety action 5)

Figure 1: Minimum Data Set

- **Findings of review of all perinatal deaths using real time data monitoring tool**

Report on:

- The number of incidents logged, graded as moderate or above and what actions are being taken.
- Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.
- Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover, versus actual prospectively
- Findings of review of all cases eligible for referral to HSIB
- Service User Voice feedback
- Staff feedback from frontline champions and walkabouts
- HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust
- Coroner Reg 28 made directly to the Trust
- Progress in achievement of CNST 10

2. Assessment

1.Incidents logged and graded as moderate or above and the actions taken.

In February there were no PSII (patient safety incident investigations)

2.Training compliance for all maternity staff groups.

Training continues in line with CNST requirements and compliance is good across all specialities.

Staff Training Figures FETAL WELLBEING Training

APRIL 2023 – MARCH 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff	55	16	39	335	390
Staff trained (inc PROMPT Trainers)	49	15	34	310	359
*Current compliance	89%	93%	87%	92%	92%

Staff Training Figures PROMPT Training

(APRIL 2023 – MARCH 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL THEATRE NOT INC	Theatre	HDU NURSES
*Total number staff	65	17	48	68	27	41	335	106	574	7	4
Staff trained (inc PROMPT Trainers)	61	15	46	52	21	31	294	91	498	6	0
*Current compliance	93%	88%	95%	76%	77%	75%	87%	85%	86%	85%	

The HDU nurses are new in post and training has been booked.

Training of the anaesthetists is ongoing.

Training has continued through March.

3.Findings of review of all cases eligible for referral to HSIB.

There was 1 HSIB referral in March.

- This was a baby who was cooled.

4.Service User Voice feedback.

"Thank you so much for looking after me on the blossom suite and finally delivering my baby. You made me feel safe and reassured me every step of the way. My experience was made easier because of you. Thank you."

5.Staff feedback from frontline champions and walkabouts.

The safety champion walkabout in March were very positive. A full report of findings will be provided in the quarterly report.

6.HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust.

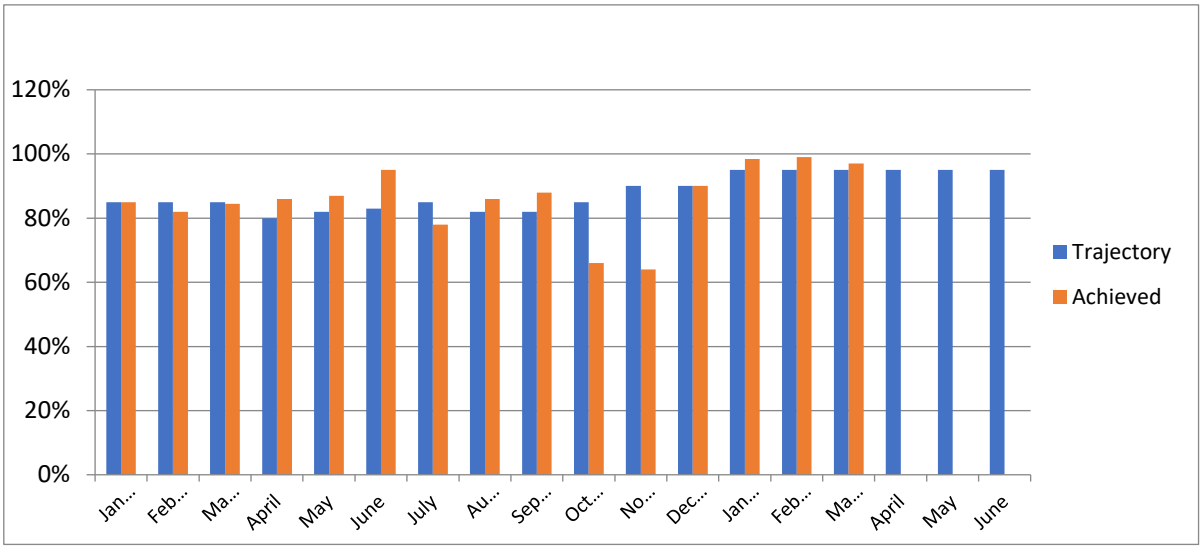
Following a CQC regulatory visit in March 2023, a section 29a safety warning was issued. This was in relation to MAU safety and the Induction of Labour process.

6.1 As part of the actions for this Maternity Assessment Unit Midwifery triage times are audited and monitored daily.
6.2 To provide assurance regarding the induction of labour process, breaches against maternity guidance are monitored each month.

6.3 Induction of labour.

We continue to monitor the birthing people booked for induction of labour and the percentage that breach current guidance. There has been a steady improvement in the percentage of people commencing induction of labour in line with guidance and in March it was above the trajectory. 97% of service users were induced in line with guidance.
On analysis of the data, the cases that were delayed were because of neonatal unit acuity.
No harm was caused as a result of this delay.

Figure 4 - The percentage of people who commence their IOL within the specific guideline for their pregnancy pathway.



6.4 Midwifery triage within 15 minutes.

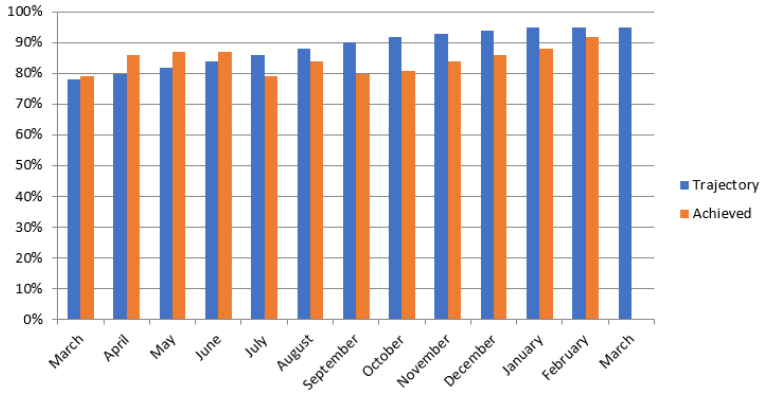
The monitoring of midwifery triage times continues. 93% of service users were seen by a midwife within 15 minutes.

1621 people attended MAU in March, of which 120 breached the 15-minute midwifery triage target time.

90% of the breaches were seen within 15 to 30 minutes, this is an improvement on February when 77% were within that time frame.

62% of the total breaches were seen within 16-20 minutes.

Figure 5 - Percentage of birthing people who present at MAU who are triaged within 15 minutes.



Improvement work continues the MAU midwifery triage times. UHNM have set a stretch target of 95% compliance, it is recognised that, nationally there is no agreed level of compliance and many units are working to an 85% target.

Because we believe that we should always aim to provide the best care possible for the people who use our service, 95% will continue to be our target.

7. Coroner Reg 28 made directly to the Trust.

No Coroner regulation 28 were made to the trust in January.

8. Progress in achievement of CNST 10 year 5.

Figure 6**.**

Perinatal review tool	
Maternity service data set	
Transitional care service	
Clinical workforce	
Midwifery workforce	

Saving babies lives V2.0	
Maternity services partnership	
Training	
Trust Safety Champions	
HSIB	

All elements of CNST10 have been achieved and agreed by the ICB and Trust Board.

9. Demonstrate a systematic, evidence-based process to calculate midwifery staffing establishment is completed.

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

A full birthrate plus review was undertaken at UHMN in 2022, the recommendations were approved and implemented following that report.

10. Minimum staffing in maternity services.

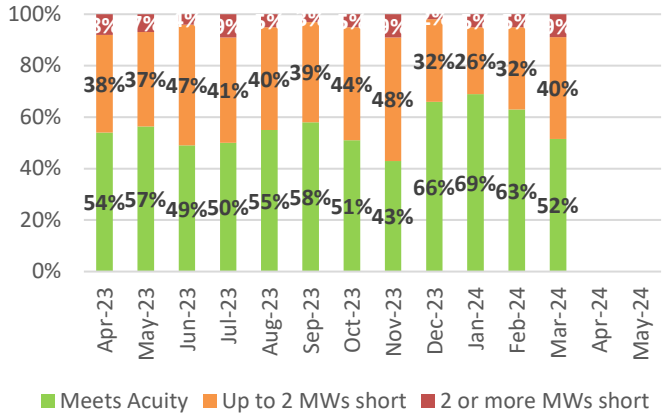
Based on 25.99% uplift the minimum staffing in maternity services for UHNM is 271.88 whole time equivalent midwives and 29.91 non-clinical/specialist midwife roles.

11. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

The current midwifery vacancy is 25.03 WTE (9.2%)
Maternity will be attending the divisional recruitment event on 17th April.
Current third year student midwives have been approached and band 5 midwifery positions offered.
The trajectory is that full establishment is achieved by October 2024.

Midwifery staffing acuity.

The chart below shows acuity on the delivery suite.



It is also important to consider the acuity in the inpatient ward areas, particularly the post-natal areas (Ockendon 2022, IEA12.4)

In 2021 Birthrate plus for ward acuity was withdrawn and has recently been relaunched, we are now able to monitor and improve staffing on wards 205 and 206. The team are undergoing training and support and the data this provides will support staffing levels moving forward.
Initial analysis of data for March showed 71% compliance with data entry.86% of entries indicated that there was a shortage of midwives based on the acuity at the time.

The ward-based acuity tool does not differentiate between a small number of midwives needed and a significant number of midwives needed, (as does the delivery suite tool). The colours are simply red or green. It does, however, support the manager in planning her roster and allocation of staff.
Though midwifery numbers have increased on the wards, they are not yet fully established to birthrate plus numbers. There are also some training issues for data input which are being addressed by the ward manager. In its current format the tool does not give detailed reports of acuity and staffing, this is being discussed with the birthrate plus team.
The acuity on all wards is discussed at the daily safety huddle and reviewed two hourly by the flow coordinator.

The escalation policy was used in times of negative acuity. This involves moving midwives from other areas and escalating to community teams where necessary.

12. The midwife to birth ratio.

The recommended overall ratio for University Hospitals of North Midlands NHS Trust of 24.8 births to 1wte (Birthrate Plus 2022). January's average birth to midwife ratio was 25.1 births to 1wte. This is expected to fall as recruitment continues with the aim that ratios will be in line with Birthrate Plus recommendations when we are fully established.

13.The percentage of specialist midwives employed.

The 2022 Birthrate plus report recommended the appropriate levels of specialist midwives based on the activity within the unit:

Total Clinical WTE	271.88
Non-Clinical	29.91
Clinical, Specialist	301.79

Currently there are 28.43 WTE specialist/ Management positions in Maternity.

14.The Trust can report compliance with this standard if this is a one-off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time.

The Birthrate Plus data for March confirms that all women received one to one care in labour.
The delivery suite coordinator remained supernumerary at all times.

15. Medical staffing.

Medical staffing cover on the delivery suite has been maintained, 7 days a week with a Senior Registrar, Junior Registrar and SHO/F2. Consultant presence is in place Monday to Friday between 8.30 am and 10.00 pm with consultant presence on Saturdays and Sunday between 8.30 am and 5.00 pm. In addition, a consultant non-resident is on-call who takes over from the end of the shifts.

16. PMRT, Stillbirths and Neonatal Deaths.

In March 8 PMRT were completed. 5 of these have been published and graded.

Case 1	B+B
Case 2	B+A
Case 3	B+B
Case 4	B+A
Case 5 twin 2	B+B+A

Categories used to grade the different aspects of care for each death.
A. No issues with care identified.
B. Care issues that would have made no difference to the outcome.
C. Care issues which may have made a difference to the outcome.

D. Care issues which were likely to have made a difference to the outcome.

In March one case was jointly reviewed with Warwick, this is not yet published as waiting for Warwick to complete their action plan.
2 further neonatal deaths have been reviewed, not yet published as waiting for input from other teams.

All cases will be reviewed using the PMRT tool.

17. Complaints.
2 complaints regarding maternity services were received in March.
Both cases are being reviewed.

18. Sepsis management.

The data shows an improvement in screening and antibiotics given within an hour. There are still improvements to be made with screening, particularly in our emergency portals.

January 2024				February 2024				March 2024		
Areas	Screening	IVAB within hour		Areas	Screening	IVAB within hour		Areas	Screening	IVAB within hour
Emergency portals	79%	50%		Emergency portals	↑89%	N/A		Emergency portals	76%	100%
Inpatients	22%	0%		Inpatients	↑70%	↑100%		Inpatients	90%	100%

The ward managers and sepsis champions in both areas are reviewing the process of screening and action plans are being formulated.

19. Venous Thrombosis Embolism (VTE) management

Thrombosis and thromboembolism were the leading cause of maternal death in 2020-22 (MBRRACE- Jan 24)

VTE assessment is assessed within 24 hours of admission on both wards 205 and 206 remain at 100%.
The Blossum suite has dropped slightly to 92.9% as has the delivery suite to 90.5% at 12 hours post admission however are100% at 24 hours.
Reminders have been sent to all staff regarding the need to complete VTE assessment on admission.

Summary and discussion

The elements required for compliance with The Maternity incentivisation scheme - year 5 are included in this report.

Improvement work in line with the CQC actions are ongoing, the progress is good but we recognise that there is always more work to do. Midwifery staffing and acuity will continue to be monitored; we will be focusing on the acuity tool in the ward areas to ensure that it is a reliable effective tool.

The Maternity incentivisation scheme- year 6 has now been released. This will form the basis for the monthly dashboard moving forward.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	9.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	*Patient Outcomes and Experience*	*High 12*

Executive Summary

Situation

The IP BAF was refreshed in September 2023 and aligned with the refreshed Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Infection Prevention and Control Manual (NIPCM). The Board Assurance Framework is ordered by the ten criteria of the Act and compliance is RAG rated as follows, not applicable, non-compliant, partially compliant and compliant.

Whilst use of the framework is not compulsory, it should be used by organisations to ensure compliance with infection prevention (IP) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

Background

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

Assessment

Whilst the Trust has no areas of non-compliance, partial compliance is declared in relation to the following sub-sections of the 10 key criteria, and work in these areas remains in progress.

Criteria	No. of Areas Compliant	No. of Areas Partially Compliant
1. Systems to manage and monitor the prevention and control of infections. These systems use risk assessment and consider the susceptibility of service users and any risks their environment and other users may post to them.	7	0
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	3	7

3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.	6	0
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.	5	0
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.	5	0
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	4	2
7. Provide or secure adequate isolation precautions and facilities.	4	0
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate.	6	1
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	1	0
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	2	1
Total	**43**	**11**

The main areas of concern relate to:

- Data gap for staff MMR
- Blood culture delay from County Hospital

The action plan for criteria rated as partial complaint has been provided to the Quality Governance Committee and will continue to be monitored by the Committee.

Key Recommendations

The Trust Board is asked to note the document for information and to note the on-going work to monitor the action plan going forwards.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
Report Title:	UHNM Patient Led Assessment of the Care Environment (PLACE) Results 2023	**Agenda Item:**	10.
Author:	Nan Sharp, Head of Governance & Compliance, EFP Division/ Teresa Platt, Deputy Head of Governance & 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

BAF 7	*Infrastructure to Deliver Compliant Estate Services*	*High 12*

Executive Summary

Situation

- This report provides a summary of findings from the PLACE inspections that took place at UHNM in October and November 2023 and follows the national publication of the results in February 2024.

Background

- PLACE is the system for assessing the quality of the patient environment in both the NHS and private/independent sectors.
- Our patient assessors were welcomed back to our County and Royal Stoke sites over a series of inspection dates during October and November 2023 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.

Assessment

- UHNM have achieved excellent scores that are above the national average across all 8 domains assessed and are in the top 6% of NHS Trusts nationally for cleaning scores.
- 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 colleagues 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.

Key Recommendations

- Trust Board is asked to receive and note the contents of this report and its findings following PLACE inspections undertaken during October and November 2023. It should be noted that the associated action plan has been considered by the Quality Governance Committee

University Hospitals of North Midlands NHS Trust

UHNM PLACE RESULTS 2023

May 2024

1. Introduction

Patient Led Assessments of the Care Environment (PLACE) is the system for assessing the quality of the patient environment. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but others are also encouraged and helped to participate in the programme.

Good environments matter and every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be drawn to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The assessments involve local people who use the services or have had experiences of it (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care. The assess such things as privacy and dignity, food, cleanliness, and general building maintenance and more recently, the extent to which the environment can support the care of those with dementia, or with a disability.

The assessments take place annually and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. Note that PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision, or how well staff are doing their job.

This report provides a description of the process and summarises the scores achieved for the full UHNM PLACE inspection undertaken in 2023.

2. PLACE Process

PLACE assessments are a voluntary annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 2 patient assessors, making up at least 50% of the group. In 2022, the criteria for staff to patient assessor ratio was enforced and assessments not meeting this standard, are excluded from the national results.

PLACE assessments provide a framework for assessing quality against common guidelines and standards. The assessment quantifies the facilities cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or a disability. Assessments are scored against 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 these are attached in Appendix 1. 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 2023 that the dates for the 2023 collection was planned to run for 12 weeks from Monday 4th September to Friday 24th November 2023. Inspection dates were coordinated with the availability of patient assessors, relevant Trust staff with representatives from Estates, Facilities and PFI in line with guidance. The inspections were supported by External Verifiers from other NHS Trusts which included an EFM Matron from Manchester and Manager from Tameside and Glossop.

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 extended to 15th December in response to some organisations experiencing issues with ward closures due to covid and UHNM successfully submitted its data on 14th December.

3. PLACE Scores and Patient Assessor Comments

PLACE scores were published nationally on 22nd February 2024 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 1,106 of assessments were undertaken in 2023 compared to 1,046 in 2022. There were 37 assessments that were excluded due to patient assessor numbers or ratio to staff assessors not meeting the minimum criteria. The findings were based on the 1,069 remaining assessments and results are not comparable with previous years.

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 2023.

UHNM achieved above the national average for all domains.

An action plan has been developed which outlines areas identified during the inspections to be actioned that will be addressed to support improvement in this area.

PLACE Scores 2023:

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	99.98%	95.34%	93.40%	95.86%	91.47%	99.89%	89.52%	92.72%
THE COUNTY HOSPITAL	100%	95.97%	94.10%	97.22%	93.24%	99.56%	92.15%	92.35%
UHNM TRUST SCORE	99.98%	95.43%	93.50%	96.04%	91.71%	99.85%	89.88%	92.67%
NATIONAL AVERAGE	98.10%	90.86%	N/A	N/A	87.49%	95.91%	82.54%	84.25%

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. Below is a summary of some of the comments received for each site: -

County Hospital:

"I was really impressed with the overall standard of cleanliness within the hospital."

"Staff were generally very helpful and friendly. This was particularly so on Renal Unit and Elective Orthopaedic."

"Compassion, enthusiasm of the staff really stood out in the majority of areas, very clean hospital, well done."

Royal Stoke Hospital:

"The general cleanliness was of a high level throughout new and old building estate."

"Overall, the standards of cleanliness, care, maintenance of the environment were very good."

"No improvements needed. Exceeded my expectations. Older building are well maintained, signage was excellent."

"All in all, aspects of the environment lend themselves to excellent patient experience."

"All staff were extremely friendly and took pride in their area with a willingness to accompany the assessment team."

An action plan is in place to address comments which were made that require attention.

4. Conclusion

The PLACE scores achieved in 2023 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. 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 is in place which provides more detail on the comments received and areas where action is necessary to make further improvements. It should be noted that a regular non-conformance that was noted and actioned by areas inspected during the 2022 inspection was regarding the day, date and time not being visible in all patient areas, this can be achieved by the introduction of a dementia friendly clock being in place across all patient areas. 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

Trust Board is asked to receive and note the contents of this report and its findings following PLACE inspections undertaken during October and November 2023.

Appendix 1 – Inspection Schedule 2023

UHNM PLACE Inspection – Royal Stoke Wards/Outpatients

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

PFI Wards	Lyme Building Wards	Outpatient Departments	Maternity Wards
216	100	Outpatients 1	205
217	109 & food tasted	Outpatients 2	
218 & food tasted	ITU Pod 6	Outpatients 3	West Building Wards
225		Discharge Lounge	76b
227	Trent Building	Poswillo	78
230 & food tasted	124	Children's Outpatients Clinic	79 & food tasted
CCU	127 & food tasted	Cardiac Clinic	
		Neurophysiology Clinic	
Compulsory Areas		Heart and Lung Clinic	
External Area ED		Shine Clinic	
Emergency Dept		Breast Clinic	
		Hearing and Balance	
		Chemotherapy Suite	
		Fracture Clinic	

Team 1 – 2 PFI Wards including public Areas, 3 Outpatient Areas, 1 Meal service	**Team 2 –** 2 PFI wards including public areas, 3 Outpatient areas
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 2023 - County 18th October 2023	Essential Area	In Patient area	Outpatient area	Communal Area	External Area	Comment
Ground Floor						
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				**CLOSED**
Ward 1		x				
AMU		x				
Breast Care Unit			x			
Elective Orthopaedic Unit		x				
Chapel				x		
STS (NEW)				x		
Nightingales				x		
2nd Floor						
Ward 12		x				
Ward 14		x				
Ward 15		x				
Neurological Unit/Shine			x			
Women's Health			x			
External Buildings						
Hand Centre			x			OFF LIMITS
Totals						

Highlight Report

Performance and Finance Committee to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- Challenges in respect of identification of cost improvement savings for 2024/25 were highlighted, considering the amount of non-recurrent savings made for 2023/24 and impact of these on the underlying position
- In terms of operational performance standards, in light of the national planning guidance, the Trust had assessed itself as non-compliant in relation to diagnostics
- The financial overview for 2024/25 highlighted a planned break-even position although there was £25 m of unmitigated risk associated with the plan
- The workforce plan highlighted the ongoing work to reduce bank and agency usage and the Committee noted potential risk in relation to this not taking account of any future business cases
- Month 12 Emergency Department 4 hour performance had improved to 70.3% and ambulance handover times had also improved slightly, although both targets remained below desired performance levels
- Planned care performance had been impacted by Industrial Action in particular the ability to reduce long wait patients and it was noted that there would remain a number of 78 week patients waiting to be treated, until the end of May 2024
- Diagnostics performance continued to be challenged in respect of endoscopy and a deep dive was presented to the Committee which highlighted that a business case was being prepared to address the mismatch between demand and capacity
- BAF 5 – responsive care remained the highest risk for 2023/24 at Extreme 20

Major Actions Commissioned / Work Underway

- Budget setting paper to be considered at May's meeting
- To update the two business cases for Junior Doctors to clarify the intended benefits of investment including projected agency savings as well as confirming what elements were for retrospective approval
- The Committee received the Trusts response to the NHS national planning guidance whereby the revised trajectories would be incorporated into the revised Integrated Performance Report
- Best, worst, most likely financial scenarios to be considered at the next meeting
- BAF 8 to be updated for Quarter 1 regarding the risk in relation to financial sustainability and in year financial balance

Positive Assurances to Provide

- As forecast, a small surplus £0.2 m was delivered at year end compared to the planned breakeven position and there was a small underspend in relation to capital expenditure
- The Trust had considered the planning guidance for operational performance, and identified compliance for Urgent Emergency Care, Elective Care and Cancer
- The Trust had been congratulated by the national team in terms of improving cancer performance for backlog reduction and delivering the Faster Diagnostics Standard. The Committee thanked the teams involved for the improved performance
- BAF 8 – financial sustainability had reduced to its target for 2023/24 given the year end position
- The Committee received the output of the Committee Effectiveness review, and noted that two actions for improvement had been identified with 88% of responsive being positive

Decisions Made

- The Committee approved Business Case BC0532: Junior Doctors Workforce Cardiac and Trauma and Neurosciences, subject to receipt of updated benefits realisation at June's meeting
- The Committee approved Business Case BC0556 NMCPS Blood Sciences Managed Service Contract Award
- The Committee approved the following eREAFs; 13838, 13917, 13822, 13922, 13943, 13709 and 13739)
- The Committee noted the BAF for Quarter 4 and approved the top 3 risks for the Annual Governance Statement; sustainable workforce, financial sustainability and delivering quality responsive care
- The Committee approved the revised Terms of Reference and change in membership

Comments on the Effectiveness of the Meeting

No further comments were made

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
1.	Finance Report – Month 12 2023/24	BAF 8	Low 3	●●	Assurance
2.	Business Case: Junior Doctors Workforce (BC-0532) • Cardiac • Trauma and Neurosciences	BAF 3	ID11677 ID10868 ID8596	-	Approval
3.	2024/25 Operational Plan & 2024/25 System Plan	BAF 3 BAF 5 BAF 8	High 12 Ext 20 Low 3	●●	Assurance
4.	Performance Report – Month 12 2023/24 & NHS England Letter: 62 Day Urgent Suspected Cancer Backlog Reduction	BAF 5	Ext 20	●●	Assurance
5.	Endoscopy Performance Report Including High Level Demand and Capacity and Planning Narrative	BAF5	Ext 20 ID15697	●	Assurance
6.	Business Case: BC-0556 NMCPS Blood Sciences Managed Service Contract Award		ID24123 ID22641	-	Approval
7.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure			-	Approval
8.	Quarter 4, 2023/24 Board Assurance Framework (BAF)	ALL		●●	Approval
9.	Committee Effectiveness 2023/24			●	Approval
10.	Operational Impact of Key Capital Schemes			-	Information

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.	Ms H Ashley	Director of Strategy												
3.	Ms T Bowen	Non-Executive Director												
4.	Mrs T Bullock	Chief Executive												
5.	Mr S Evans	Chief Operating Officer												
6.	Mrs C Cotton	Director of Governance	NH											
7.	Mr M Oldham	Chief Finance Officer												
8.	Mrs S Preston	Strategic Director of Finance												
9.	Mrs A Rodwell	Associate Non-Executive Director												
10.	Mr J Tringham	Director of Operational Finance												
11.	Ms A Gohil	Non-Executive Director												

Attended | Apologies & Deputy Sent | Apologies

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
Report Title:	Annual Plan 24-25	**Agenda Item:**	12.
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**	✓

Executive Summary

As part of both the Annual Planning process as well as the Improving Together Programme, the Executive have taken time to review the Trusts Strategic Priorities, Strategic Initiatives and Annual / Breakthrough objectives 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 and the new draft Trust Strategy due to be published later this year, 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 24/25 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 previously been shared with Board Members 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 24/25

Annual Plan 2024/2025

Contents

Introduction

This **Annual Plan 2024/25** sets out our intentions and priorities for the coming year.

As with the previous year, the Annual 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. Work has been undertaken during the last 12 months 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 to the strategic priorities.

Until that time the **strategy deployment framework** will continue to provide the focuses 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 **Delivery of Exceptional Care with Exceptional People**

Whilst the Trust continues to develop its 2024-2029 Strategy (due for publication in the coming months) Our current strategy, **'2025 Vision'** was developed to set a clear direction for us to become a world class centre of clinical and academic achievement and care. Whilst this remains our ambition, in the 10 years since the 2025 Vision was developed the NHS landscape has changed.

These changes have given us opportunity to reconsider our strategic direction and the future for our workforce, our patients and the services we provide. As part of developing our strategy, we have listened to the views of partners and local people, using these to shape our future plans.

Our refreshed strategic framework is based upon our vision and our values, underpinned by our 6 Strategic Priorities, which set out how we will achieve the transformation needed to deliver outstanding care for generations to come.

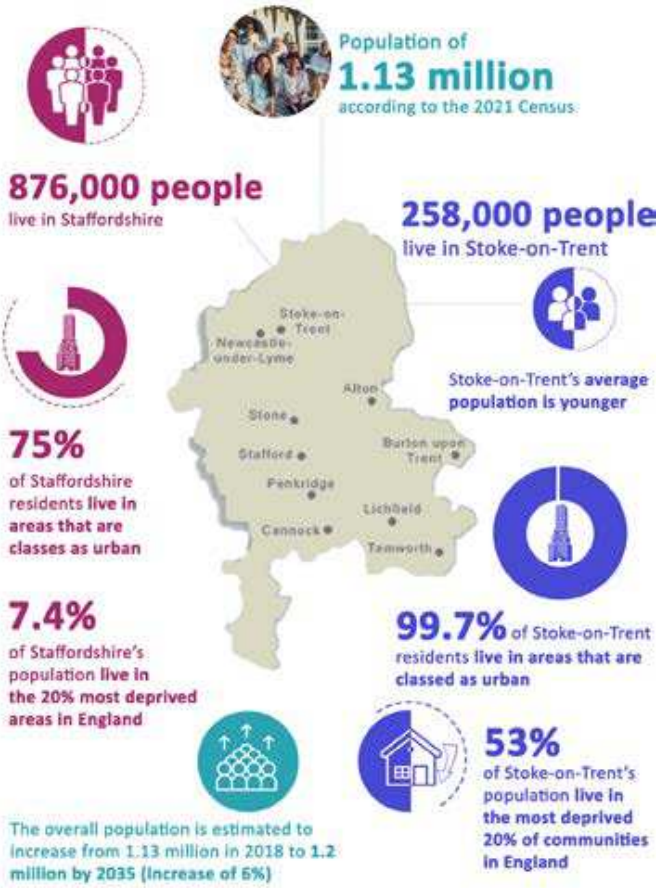
We will now work together with our teams, partners and the system to embed this strategy and use it to help us shape our services and the way we work.

Context

UHNM is one of the largest University Teaching Trusts in the UK, with an international reputation for the innovative treatments provided and the clinical pioneering work through world-class research, education and university partnerships.

We provide our services across two main sites County Hospital in Stafford and Royal Stoke University Hospital in Stoke-on-Trent. Also based on the Royal Stoke site is the Staffordshire Childrens Hospital.

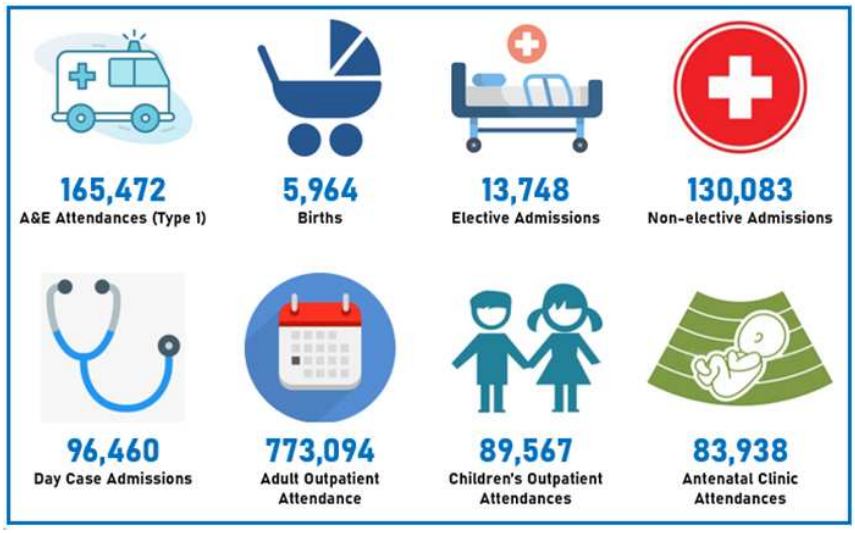
We are a large, modern Trust in Staffordshire, **providing care in state-of-the-art facilities**. We provide a full range of general hospital services for approximately 1.13 million people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide 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.

We see a huge number of patients each and every year through our urgent and emergency pathway, our non-emergency pathway, our outpatient clinics and our maternity services.
It is our goal to ensure that every patient we see receives the right care, in the right place, at the right time. However, the demand for our services is increasing and we are not always able to see and treat our patients as quickly as we want to. Whilst we have made lots of progress with reducing our long waits – we recognise that we have much more to do and we will continue to work hard to achieve this.

2023 – 2024 Patient Activity



As a University Hospital, we partner with **Keele University and Staffordshire University** to deliver world leading scientific research and pioneering teaching and technologies, providing our clinicians and our leaders with the skills and experiences they need to work in our increasingly complex health and social care environment. We have onsite teaching facilities, and we are proud that our **Medical School** is one of the best in the country. **Our research profile** enables us to attract and retain high quality staff.

We play a leadership role, hosting and contributing to multiple regional and national clinical networks to deliver and improve **specialist clinical services.**

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 work closely with health, social care and voluntary sector partners across Stoke-on-Trent and Staffordshire to deliver joined up and integrated care for our populations, and 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. 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 2024/25**, 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 our partners
Resources	Ensuring we get the most from the resources we have, including staff, assets and money

Summary Board Assurance Framework 2024/25		
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's (SSOT) Integrated Care Strategy, 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.

Future integration of health and care will be informed by our collective understanding of our population's health and care needs. It will need to take into account how we work in partnership to address the four elements to improve health and wellbeing. The Kings Fund population health model below details the health and care needs of the population and the factors that influence our population's health and wellbeing.

The SSOT ICS health and wellbeing strategies are also based around this model, which is embedded as the strategic approach across the system. A commitment to ensuring that shared strategies and plans across the ICS consider each of the four elements and where they interact, effectively addressing the things that affect the health and wellbeing of local people.

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** Our 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.

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

	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

National NHS Priorities

The overall priority in 2024/25 remains the recovery of our core services and productivity following the COVID-19 pandemic.

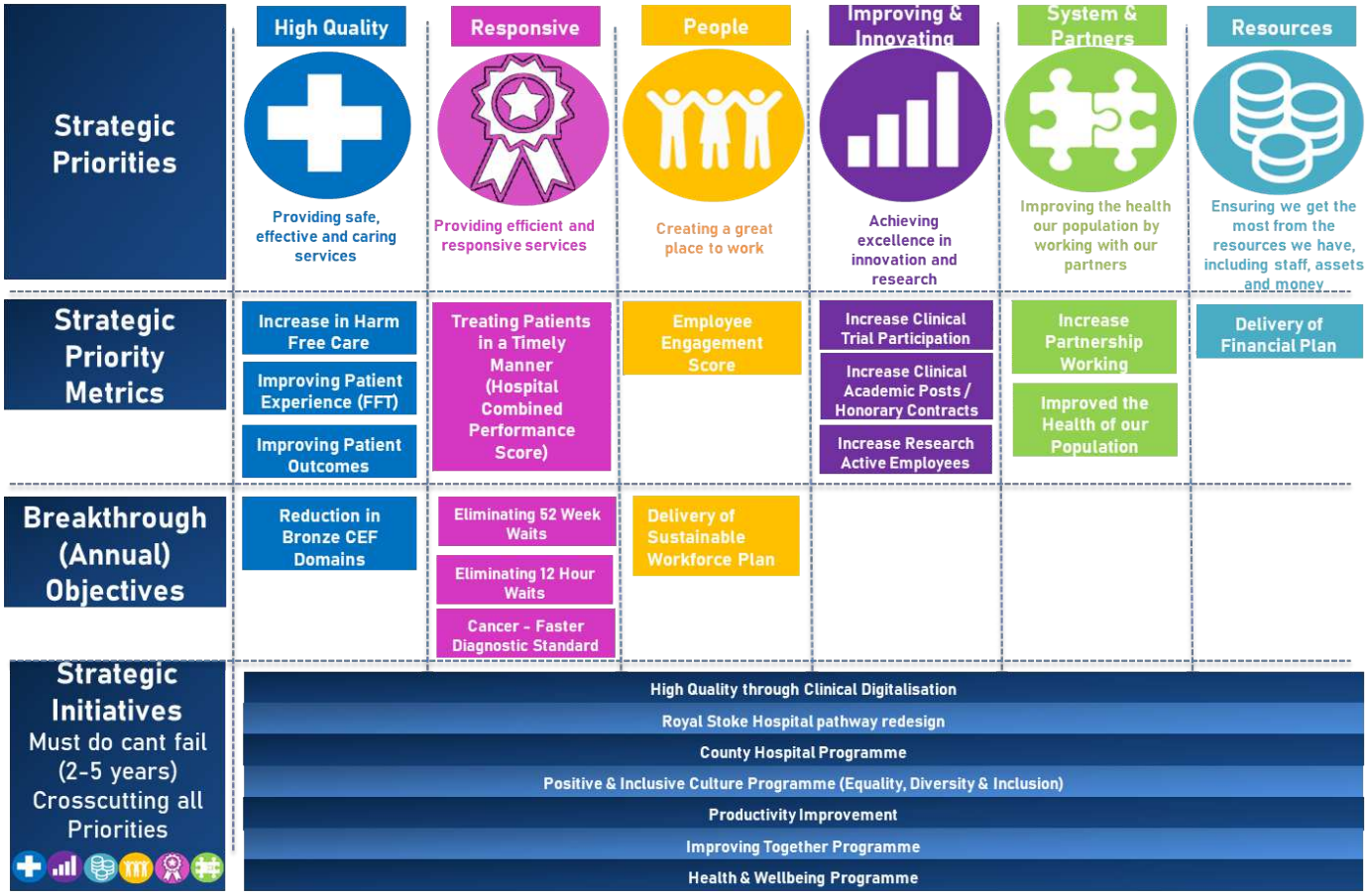
We have taken the national **NHS priorities** into account when developing our Strategic Priorities and have summarised below, those most pertinent to the Trust:

NHS Priorities and Mapping to our Strategic Priority Domains		
NHS	Improve ambulance response and A&E waiting times	
NHS	Reduce elective long waits and improve performance against the core cancer and diagnostic standards	
NHS	Make it easier for people to access community and primary care services, particularly general practice and dentistry	
NHS	Improve staff experience, retention and attendance	
NHS	Maintain our core collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach	
NHS	Improve access to mental health services so that more people of all ages receive the treatment they need	

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

2024/25 Priorities

Developed through the processes outlined above, and taking into account the context in which we work, this section sets out our **priorities for 2024/25**. 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.

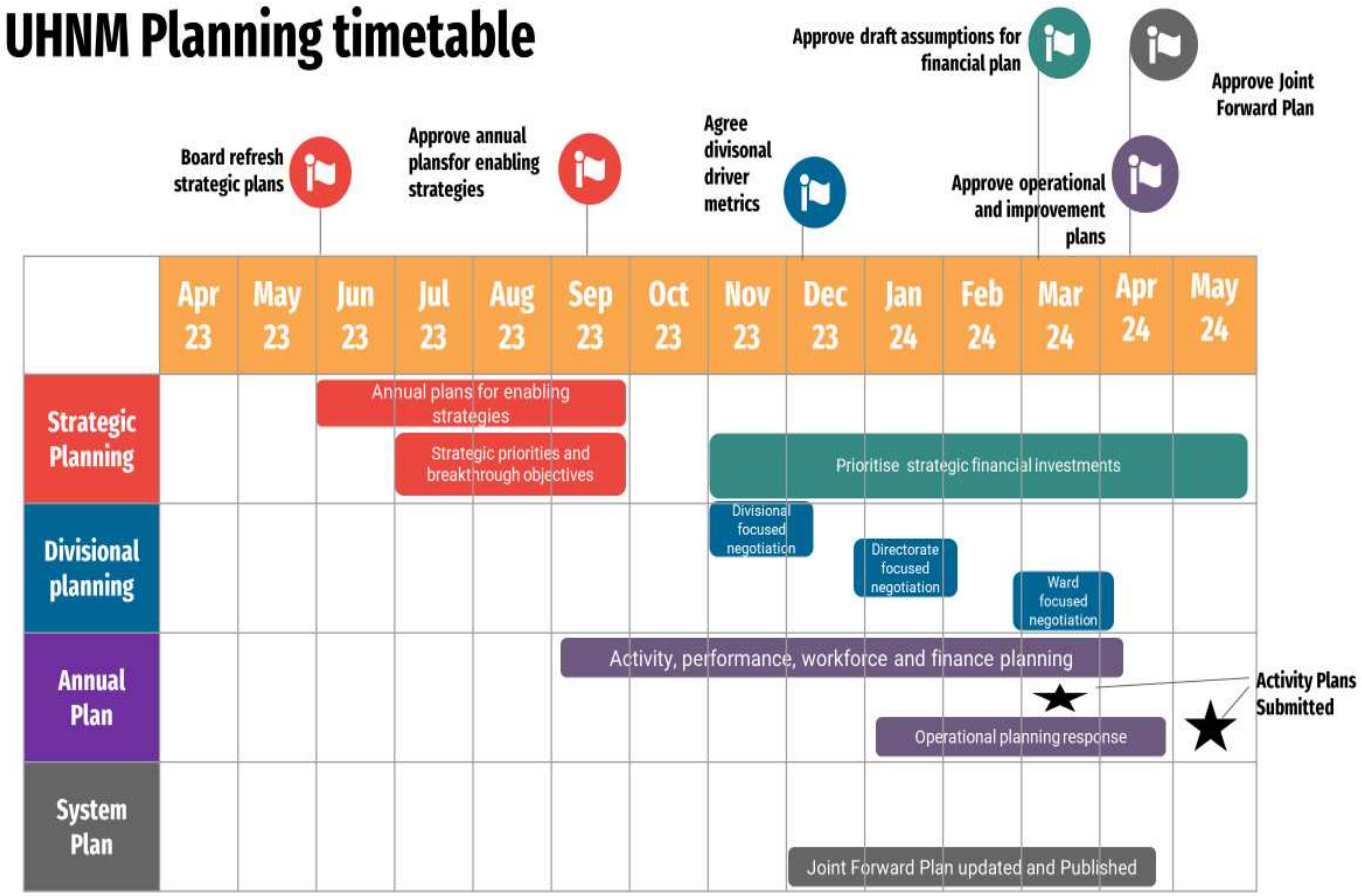


Divisional Priorities - 2024/25 Watch Metrics

Through a process of 'focussed negotiation', each clinical division has agreed their priority metrics, these priorities were discussed and developed towards the end of 2023/24. 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:

	Key Priority Domains					
	High Quality	**Responsive**	**Improving and Innovating**	**System and Partners**	**People**	**Resources**
WCCS	• Induction of Labour • MAU triage within 15 minutes • Maternity Incentive Scheme	• Imaging – TATs • Pharmacy TAT			• Employee Engagement	• Performance to budget
SURGERY	• Patient Experience - F&F test	• 28 day FDS • Eliminating >52 weeks		• Discharge Summaries	• Employee Engagement	• Theatre Productivity • Performance Budget
MEDICINE	• Overall Sepsis Compliance • Hospital acquired pressure ulcers	• Non Admitted 4hr Performance • Endoscopy • Incomplete RTT pathways <52weeks		• Discharge Process / Length of Stay	• Employee Engagement	• Performance to budget
NETWORK	• Timely responsiveness to clinical observations • Complaints response time	• CRTP+1 • Follow-up backlog >52 weeks • Eliminating >52 weeks	• Number of patients recruited to clinical trials		• Employee Engagement	• Performance to budget

Appendix 1 – UHNM Planning Timeline 2024/25



Appendix 2 – Supporting Strategy Priorities for 2024/25

Quality Strategy

Chief Nurse & Chief Medical Officer | Quality Governance Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- RN/RM/HCA vacancy reductions, 4% reduction in turnover, reduction in RN sickness; recruitment workshops for international nurses; Stella Underwood represented UHNM's IEN's along with Staff Nurse Hashim Assad at the King's birthday celebrations at Buckingham Palace in Nov; PNA development and impact
- Awarded NHS Pastoral Care Quality Award for International Nurses and Midwives, awarded National Preceptorship for Nursing Quality Mark
- Daisy and Diamond Awards; Staff professional development B2- B8; new trainee HCA role; first clinical B-4 patient safety conference
- Improving Together Delivery against plan; introduction of leadership council
- Harm free care ambitions; John Hopkins patient mobility collaboration; Tendable roll out and CEF refresh (HSJ Patient Safety shortlist)
- CeNREE going from strength to strength (AC shortlisted for NT Leader of the Year);AHP research engagement event on 23 Oct; inaugural Catalyst event took place on 22nd November 23; CeNREE/NHSE/ICB fellowships
- Review of complaints process; co-production of patient priorities; pt rep at bronze CEF improvement meetings; Carers Strategy launched
- Development and introduction of Chief AHP role and CNIO/associate deputy chief nurse role
- Development of FIT testing team aligned to IP team; big bed blitz;
- Audit of outpatient letters showed 84% now addressed to patient or guardian (31% in 2022)
- Home Care is Best Care initiative launched to improve shared decision making with patients and families.

Risks and Challenges

- Inconsistent delivery of quality metrics
- Operational delivery challenges impact to patient and staff experience and patient outcomes
- Rates of hospital acquired infection
- Clinical Effectiveness risk has remained at 16 for over a year; internal mapping exercise continues with the aim of understanding existing structures, reporting routes and relevant roles within the divisions and directorates; review of best practice in high performing trusts requested.

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Staff development, reward and recognition; and other retention activities to support staff retention	Positive impact on quality / sustainability of services				■
Reduce the number of BRONZE CEF areas	Support ongoing improvement against a range of quality metrics				■
Meet s29a requirements for County and Maternity; Maternity rating in SAFE domain improvement	Positive impact on quality and experience			■	
Achieve Baby Friendly Accreditation	Positive impact on quality	■			
Deliver Year 2 of the Quality Strategy	Positive impact on quality and experience				■
Strengthen clinical effectiveness within Divisions	Positive impact on quality and experience				■

System / Partnership Working

- Chief Nurse -Joint SRO Midlands Research Group
- Chief Nurse -Chair ICB Education, Training and Development Group
- Chief Nurse -Member Nursing and Midwifery Excellence Group (National)
- Chief Nurse -Member of National Retention Advisory Board

People Strategy

Chief People Officer | People, Culture & Inclusion Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- Successful recruitment and attraction campaigns
- Improved Staff Survey Results
- Launch of new PDR paperwork
- Launch of sexual safety campaign
- Being Kind Programme
- Successful inclusion campaigns
- Launch of flexible working campaign
- Successful leadership offerings (Enable, Connects, Clinical Leaders)
- Supporting industrial action
- Extensive university, college and school engagement programme
- Establishment of Women's network, chaired by Deputy CMO
- Chief Registrar post created and out to advert

Risks and Challenges

- Financial pressures which could impact on workforce sustainability and experience
- Industrial action and ongoing operational pressures
- Staff Survey results not improving sufficiently for colleagues from "other ethnic groups" and disabled workers"
- Changing Immigration Rules and compliance issues

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Improving employee engagement (using 2023 NETS/GMC/NSS/Staff Voice insights)	Positive impact on employee experience			■	■
Year 3 Culture improvement programme	Improved culture as reflected in the staff survey		■	■	
Employee Wellbeing, tackling V&A and burnout	Increase in flexible working and Improvement in People Promise - We are flexible			■	■
Flexible Working	Increase in flexible working and Improvement in People Promise - We are flexible			■	
Focus on learning and growth in including apprenticeships (Breakthrough Objective)	Increase in apprenticeships, PDR's, People Promise - We are always learning				■

System / Partnership Working

- Occupational Health Contract at System Level, Successful working with system Chief People Officers, UHNM CPO system SRO for Staff H&WB

Clinical Strategy

Director of Strategy & Transformation | Strategy & Transformation Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- Continue to deliver the NHS Long Term Plan to transform services and improve outcomes across strategic clinical areas (e.g. maternity, unplanned care, cancer, planned care, critical care diagnostics, tertiary, children's and women's)
- Involving patients in their own care through shared decision-making (e.g. NHS app, letters)
- Approval to expand capacity in key areas (Acute Beds, Community Diagnostic Centre, Surgical hub at County Hospital)
- Progress made within admissions avoidance though acute care at home pathways and technology
- Use of technology (e.g. Roll out of new Pathology LIMS, robotic surgery)
- Development of our clinical networks (e.g. Gynaecology, children's and spinal networks).
- Creation of UHNM forum with PCN and LMC leads to drive better work at interface between primary and secondary care

Risks and Challenges

- Continuing to deliver the NHS' delivery plan for tackling the COVID-19 backlog of elective care.
- Continued disruption through long standing industrial action.
- Continued capacity constraints at the Royal Stoke site and impact or patients.
- Process for reviewing elective long waits is evolving.

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Rightsizing bed capacity at RSUH (inc. Critical care)	Positive impact on quality / sustainability of services	■			
County Hospital Strategic Delivery	Improved utilisation and promote patient experience	■	■	■	■
Stoke Community Diagnostic Centre	Increase capacity and reduce disparities in healthcare				■
Urgent Treatment Centre	Standardise urgent care for our population				■
Clinical Support priorities (Pharmacy Robot and completion of LIMS)	Improved quality, safety and efficiency			■	

System / Partnership Working

- Continue to demonstrate strategic alignment with system / partnership working and collaboration by exploring opportunities to work in partnership with other acute providers (MCHFT, SATH, UHDB), at system level through the ICB, regional and national clinical networks.

Research & Innovation Strategy

Chief Medical Officer | Strategy & Transformation Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- Research participation target for the year was reached in month 10
- Creation of stable senior leadership team in R+I Directorate
- 4 consultants conferred honorary titles by Keele in last year
- Established programme of audits to assure research governance in place
- Continued success of CeNREE in building research skills and awareness among nursing, midwifery and AHP people

Risks and Challenges

- High level strategic risks and challenges
- Focus of strategy needs to be broader to include wider trust activities
- Nature of 'research' and 'innovation' require careful definition to include all relevant activities in the trust
- Responding to concerns raised through Staff Voice and establishing common standards and expectations in the research team

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Formation of Research Steering Group to define full scope of UHNM activity	Clarity around the scope of research activity	■			
Assessment of opportunities for UHNM to develop package of innovation	Understand the range of innovation activities at UHNM			■	
Promotion of research active appointments and investigators in the trust	Increase the profile and capacity of MDT investigators	■			
Determine approach to 'pump-priming' research activity in departments	Create a mechanism to initiate research, prior to funding		■		
Increase percentage of commercial trials in research portfolio	Increase potential for research income generation				■

System / Partnership Working

- Meetings arranged with NSC to scope potential areas of collaboration and a shared understanding of system-working in the field of research
- Continued participation at SSHERPa (SSOT and STW systems R+I group)

Digital Strategy

Chief Digital Information Officer | Strategy & Transformation Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- LIMS Go Live for all services with the exception of Cell Path.
- Office 365 for all staff.
- Recruitment to the new Network services team ready for the new network and telecommunications in June.
- EPMA readiness ready for the go live in October.
- Security Operations Centre Service now live with system partners.
- EPR outline business case developed.

Risks and Challenges

- Cyber Fraud
- Loss of Read/ Write Access to Legacy System (LabCentre)
- Pathology IT System Expertise
- Data Centre Air Conditioning EOL - Unfit for Purpose
- Delay in EPMA roll out
- EPMA and/or Clinical Narrative System not fit for purpose
- Pathology LIMS replacement

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
EPR soft market testing and secure funding.	Validate ambition, clarify funding requirements and return on investment		■		
EPMA deployment	Improve medication safety, reduce medication costs				■
Network and telephony services migration	Improve service availability and enable location based asset management				■
Shadow IT governance and assurance	Improved cyber security position, compliance with national standards and opportunity to standardise processes			■	

System / Partnership Working

System wide EPR procurement system
System wide security operations service
System data centre consolidation

Estate Strategy

Director of Estates, Facilities & PFI | Performance & Finance Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- Above national average PLACE scores.
- Capital scheme delivery of 136 projects c£50M+.
- Joint Energy Procurement (SoTCC) c£7M savings against forecast.
- Siemens Variation £432K recurrent benefit, alongside non-financial benefits.
- PSDS £5.4M bid award and Solar Scheme proposals.
- Cleaning & Food Standards implementation, 24/7 Deli, Sodexo Value Proposal Delivery, SSRM Programme Delivery, Project Search, Arts Projects.
- Good progress against EFP People Plan/Workforce Plan actions.
- Mitigation of impact of national resilience issues waste/linen/meal services.
- Delivery of flexible, agile services to respond to Trust's changing demands.

Risks and Challenges

- Increasing estate backlog & medical devices replacement risks, against limited capital available. External monies tight timelines for bids/delivery.
- Estate Strategy refresh reliant on concluding of *'right sizing'* exercise and worked up strategic plan for Royal Stoke site.
- Capital programme delivery challenges CDC/Day Case & Breast Care, Supply Chain issues and Building Safety Act implications.
- EFM Workforce/People Plan refresh and progression of actions.
- Financial pressures/CIP and impact on service delivery.
- NZC delivery of targets and extreme weather impact.
- PFI latent defect/statutory maintenance & access to clinical areas to complete remediation works without impacting on activity.

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Capital Schemes delivery and SSRM, PFI VFM, BedA3 and Space Optimisation.	Optimise estate/positive impact quality/experience	■	■	■	■
Estate Strategy refresh and production of Development Control Plan	Positive impact on quality & sustainability of services	■	■	■	■
Agree process for prioritising funding medical devices. Agree ring-fencing of revenue to support prioritised estate feasibility studies.	Risk reduction & better able to respond to bid requests.	■	■		
EFM Workforce/People Plan refresh to respond to Staff Survey findings.	Positive impact employee experience/more apprentices	■	■		
District Heat Network and production of Business Case	Net Zero Carbon target delivery/reduced heating costs	■	■	■	

System / Partnership Working

- Leading on System Estates Workstreams (Lease and Land) to optimise use of system estate and influence System Infrastructure Strategy.
- Leading on System Sustainability Workstreams and implementation of District Heat Network and Solar Strategy that will deliver system benefits.
- Exploring opportunities for shared resourcing with system partners where mutual benefit can be delivered.
- Optimising benefits brought about as a result of successful strategic partnership.

Health and Wellbeing Strategy

Director of Strategy & Transformation | Strategy & Transformation Committee

NHS University Hospitals of North Midlands NHS Trust

2023 / 2024 Developments and Successes

- Embedded prevention services within alcohol care and tobacco dependency
- Led a system programme to develop tier 3 service for obesity
- Presented a regional conference on our work to reduce inequality within our cancer screening programmes (bucking the national trend)
- Promoted charity led projects to combat loneliness and improve children's oral health
- Working across system to reduce in

Risks and Challenges

- Around 80% of people's health is determined by their environment, social networks, culture, employment, income, and factors which influence behaviours and choices relating to health. This means that working in partnership are largely outside of an acute hospital.
- Our population has long-standing social and health inequality. This has a stark impact in Stoke-on-Trent where 53% of the local population lives in the 20% of the most deprived communities in England.
- The ability to link data across our system remains challenging but is being progressed by our ICB.
- Government investment within prevention services is not consistent

2024 / 2025 Priorities for Implementation	Impact / Outcome of Priority	Q1	Q2	Q3	Q4
Promote opportunities to reduce infant mortality	Reduced risk of mortality				
Reduce health inequalities associated with the CORE20PLUS5 framework	Improve access and equality in care				
Develop a sustainable alcohol care and tobacco dependency service	Reduce premature mortality				
Progress towards NHS net zero	Sustainability of services				
Develop programmes to improve employment opportunities within target populations as part of our role as an Anchor organisation	Reduction in local unemployment				

System / Partnership Working

- We need to work in partnership to address the needs of our local population. We are committed to playing our part as a member of the Integrated Care System (ICS) and will work to strengthen and develop our partnership approach with health and care organisations, as well as our local communities.

Appendix 3 – National NHS objectives for 2024/25

Area	Objective
Quality and patient safety	• Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
	• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	• Improve community services waiting times, with a focus on reducing long waits
	• Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	• Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
	• Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
	• Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
	• Improve patients' experience of choice at point of referral
Cancer	• Improve performance against the headline 62-day standard to 70% by March 2025
	• Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
	• 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%
Maternity, neonatal and women's health	• Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
	• Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	• Improve patient flow and work towards eliminating inappropriate out of area placements
	• Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
	• Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
	• Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
	• Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	• Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
	• Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	• Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
	• Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
	• Increase vaccination uptake for children and young people year on year towards WHO recommended levels
	• Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	• Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
	• Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
	• Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	• Deliver a balanced net system financial position for 2024/25
	• Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Highlight Report

Strategy & Transformation Committee 1st May 2024

Matters of Concern / Key Risks to Escalate

For information:

- **Funding** for the development of services in line with the Clinical Strategy / County Hospital Strategic Plan; elective funds had been made available although this was expected to be more challenged. Discussions remain ongoing around the financial pressures and mitigations
- Three areas of risk had been highlighted in relation to compliance with **Private Healthcare legislation** which were reported to the Executive Strategy & Transformation Group; although one issue had been resolved in relation to data quality and plans were in place which related to patient feedback
- The **Data Security and Protection Toolkit** has identified a concern in relation to training compliance, dedicated sessions have been offered to improve the position
- Concerns were also noted around allocation of national **digital funding** which could present challenges with the Digital Strategy; teams are considering how to mitigate this
- **Top 3 risks** for 2023/24 and moving into the year ahead for the Annual Governance Statement were agreed as being around Financial Sustainability, Workforce and quality / responsive patient care

Major Actions Commissioned / Work Underway

- An **outcomes framework** to underpin the Population Health and Wellbeing Strategy has been developed although it was acknowledged that this requires further development with system leads to establish data capture, analysis and reporting
- Consideration is being given as to which **population health** related metrics will form part of the Integrated Performance Report (IPR); further work will also be undertaken to determine the top 3 key priorities, how their impact will be measured and how the strategy will be communicated
- A **Health Inequalities Stocktake** was undertaken which describes services / activities undertaken to reduce health inequalities; it was recognised that Patient Knows Best (PKB) could be further utilised given the success with the alcohol programme
- A similar stocktake had been undertaken for **Anchor Institution** which will also be shared with the Committee
- **System Transformation** and service change programmes continue to progress including existing and future sites for Urgent Treatment Centres, a case for change for the Freestanding Midwifery Birthing Unit and the Community Diagnostics Centre
- **A progress report** against the Annual Plan will be developed to ensure consistency of approach for the enabling strategies (this was highlighted as part of the Board discussions on Effectiveness)
- The refresh of the **Trust Strategy** continues to be underway and is subject to consultation; it was agreed extend the engagement to optimise inclusivity, provide opportunity for the incoming Chief Executive to input and ensure that quality improvement forms part of 'our brand'. A further draft will be presented to the Committee at the next meeting before being brought to the Board for approval
- Progress on delivery of the **Clinical Strategy** continues with key areas of focus being around bed capacity at Royal Stoke, the County Hospital Strategic Plan, Community Diagnostics Centre, Urgent Treatment Centre, Clinical Support Services and system / partnership working; an overview of progress to date was considered
- The **Estate Strategy** is currently being refreshed and will be based upon the Clinical Strategy
- An accountability framework has been developed for **Shadow IT** systems
- Plans are in place to improve compliance with **NHS Impact** standards over the next 12 months and a quarterly review will be undertaken against the 5 principles. Two key areas of focus are development of leadership behaviours and building improvement into day-to-day work. In addition, the impact of training will be assessed against the Kirkpatrick Model.
- It was noted that the **Effectiveness Review and Annual Report** for the Executive Strategy & Transformation Group will be presented to the next meeting

Positive Assurances to Provide

- The **Population Health and Wellbeing Outcomes Framework** was recognised by the Committee as an excellent piece of work, which had been aligned with the national framework
- The **Health Inequalities Stocktake** was commended as best practice and the team were encouraged to share this at a national level
- Positive assurance was provided in relation to delivery of the **County Hospital Delivery Plan**
- Two key performance indicators for **Cyber Security** have achieved their target, 77% penetration test recommendations have been implemented and the Internal Audit Review of the Data Security and Protection Toolkit was concluded as substantial assurance

Decisions Made

- Approval of the **Population Health and Wellbeing Outcomes Framework**
- Approval of the **Annual Plan 2024/25** which will progress to Board
- Approval of the **Transformation and People Committee Annual Report**
- Approval of **Terms of Reference for Strategy & Transformation Committee**

Comments on the Effectiveness of the Meeting

- Worked very well and provided opportunity to have dedicated time and a comprehensive agenda
- An excellent start for a new Committee and highly effective meeting which flowed very well
- Meeting was very well chaired and the papers were well presented; it was agreed to be open and flexible to ensure that a difference can be made

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
1.	Population Health and Wellbeing Strategy: Outcomes Framework	BAF 4	Ext 15	🟢	Approval
2.	Health Inequalities - Stocktake	BAF 4	Ext 15	🟢	Assurance
3.	ICS Transformation Update	BAF 4	Ext 15	-	Assurance
4.	Annual Plan	-		-	Approval
5.	Clinical Strategy Progress Report 2024/25	BAF 7	High 12	🔴🟢	Assurance
6.	Executive Strategy & Transformation Group Highlight Report	BAF 4	Ext 15	🔴	Assurance
7.	Cyber Security Assurance Report	BAF 6	High 9	🟢	Assurance
8.	Data Security & Protection (DSP) Toolkit Position	BAF 6	ID21784	🔴	Assurance
9.	Executive Digital and Data Security Protection Group Highlight Report (14-03-24 & 18-04-24)	BAF 6	High 9	🔴	Assurance
10.	Improving Together Countermeasure Summary	-		-	Assurance
11.	Quarter 4, 2023/24 Board Assurance Framework (BAF)	ALL		🔴	Approval
12.	Committee Effectiveness 2023/24	-		-	Approval

Attendance Matrix

Members:		M	J	J	A	S	O	N	D	J	F	M
Elaine Andrews	Deputy Director of Strategy											
Tanya Bowen	Non-Executive Director (Chair)											
Gary Crowe	Non-Executive Director (Vice-Chair)											
Zia Din	Deputy Medical Director											
Amy Freeman	Chief Digital Information Officer											
Arvinda Gohil	Non-Executive Director											
Sunita Toor	Non-Executive Director											
Helen Ashley	Director of Strategy											
Claire Cotton	Director of Governance											
Matthew Lewis	Chief Medical Officer											
Ann-Marie Riley	Chief Nurse											
Lisa Thomson	Director of Communications											
Lorraine Whitehead	Director of Estates, Facilities & PFI											

Executive Summary

Meeting:	Trust Board	**Date:**	8th May 2024
Report Title:	Integrated Performance Report, Month 12 2023/24	**Agenda Item:**	14.
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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

The report provides latest (March 2024) update on the different Quality Indicators. The report includes, where possible, peer benchmarking against various quality indicators. These indicators, where applicable, utilise SPC charts and to allow for comparisons allowing for activity and benchmarking, the rate per 1000 bed days. The use of rates per 1000 bed days allows comparison between organisation and national targets/benchmarking by allowing for different activity levels and not just the comparison of raw total numbers. The charts/indicators with only raw total numbers are used to provide internal analysis of the indicators so can also compare different months to set target totals i.e. C Diff Cases, E Coli cases, MRSA which have set target per month already calculated and set nationally for the organisation.

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

All the indicators have now included benchmark for assurance purposes. These benchmarks are either agreed targets set nationally or locally utilising agreed target/benchmark.

The report also includes the Assurance Matrix to allow for summarised version of the different indicators and level of assurance provided by the current results.

Assessment
The number of reported patient safety incidents has decreased for second month along with the rate per 1000 bed days. However, the total number of incidents is still showing significantly higher variation within normal variation limits. As previously noted an increase in reported incidents and near misses should not be seen as negative hence positive rating for variation indicator but can reflect a positive reporting culture. The breakdown of incidents by harm reflects this and that there have been increases in reported incidents with no harm and near misses.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have also shown a further in month reduction in March 2024 and is now back to around the current longer term mean.

The largest categories for reported PSIs excluding Non-Hospital Acquired Pressure Ulcers continue to be Patient Falls, Treatment related and Communication related incidents. Patient Falls incidents remain the largest category after Tissue Viability in March 2024 and there were no significant changes in these categories compared to previous months, although there was a reduction in Medication incidents with moderate or above harm.

Patient falls rate has continued to show longer term positive trend, and March 2024 decreased to below the 5.5 rate with 4.8 and falls with harm rate remained the same at 1.7 during March and remains lower than same period in 2023.

Medication related incidents have decreased this month but continue to show longer term increases as part of the ongoing drive to improve reporting of medication errors/incidents. There has been a decrease in March (at time of the report) in the percentage of these incidents that have been reported as resulted in moderate harm or above. These incidents will be reviewed at Medicines Optimisation & safety Group to assess the impact on patients and also identify and share learning.

As noted previously, since December 2023 we are no longer reported incidents via the Serious Incident Framework following the introduction of the new national Patient safety Incident Review Framework (PSIRF). However, we have logged and notified the ICB of 1 incident during March 2024 on STEIS but under the PSII response. This case relates to a new Never Event.

This incident related to wrong site surgery (incorrect lesion). This new incident will not only have a PSII completed but will also form part of a thematic review of the previously reported and investigated incorrect lesion removals. This thematic review will review and compare any differences or similarities between the incidents and make recommendations on how systems and processes could potentially be improved to reduce the risk of future incidents. The outcome of the thematic review will be formally reported to QSOG and QGC.

Duty of Candour compliance during March for verbal notification at has remained at 100% but there was also been an improvement in compliance with the internally set 10-day target with 78% compared to previous month's 75%. There were 23 cases recorded as formally triggering duty of candour. 18 of the 23 cases have recorded written follow up being provided within the 10-day target but 5 other not complying with the timeframe. There is currently only 1 case awaiting confirmation that the written follow up has been completed and the Trust is compliant with the statutory duty of candour regulations.

The current position for received patient Safety Alerts shows that there are 2 overdue Patient Safety Alert (at time of report). There were no new alerts received during March. The 1 overdue alert, relating to new regulatory measures for oversight of Sodium Valproate is being coordinated by the ICB on behalf of the wider ICS. UHNM have already actioned all the requirements identified in the full alert and a full Trust action plan and response to the alert has been developed. The action plan and monitoring of implementation is being overseen by the Trust's Medicines Optimisation & Safety Group and then reporting through to the ICB. Neurosciences have also already raised and recorded on the risk register.

Pressure Ulcer developed under our care have decreased again as well as the pressure ulcers with lapses in care during March 2024 and remains below the long-term mean. Category 2 pressure ulcer with lapses in care continue to be the largest category with Category 3 and Unstageable showing reductions during March 2024 and Deep Tissue Injuries remaining at 1 for the month. These all remain in normal variation and below the long term mean. The new PSIRF Tissue Viability toolkit is in use and allows more involvement in clinical areas for developing responses and

embedding of learning and sustained improvement.

In addition, Category 2 pressure damage will have an action plan completed for improvements and a thematic review will take place quarterly. The PSIRF toolkits are to be completed for DTI's, Cat 3's, and unstageable damage. The completion of action plans will be checked by Quality and Safety and Governance teams prior to the closure of incidents with multiple reporting wards being invited to assurance meetings and support with improvements.

Friends & Family Test for A&E remains below the 85% target of patients recommending the service and has improved in March with 68.4% with response rate of 9% which is a reduction from 10% previously reported. We are 35th out of 125 (previous month noted we were 40th) Trusts nationally for response rate. However, we are 87th for the percentage pf positive results. To promote and increase the response rate the FFT questionnaires are continuing to be handed out to all patients on arrival to ED and the QR codes have been made more visible throughout the department. In addition, a 'You said, we did' board has been put up in the Waiting Area to demonstrate changes to patient/relatives' comments in a bid to further promote and increase the responses received. Key themes from March 2024 continue to be reported around poor communication, staff attitude, long waits, pain relief especially related to Royal Stoke.

Inpatient FFT results remain below the 95% target with 93.9%. The response rate has however improved in March with 21% compared to 20% in February. We have the 21st highest response rate out of the 154 acute trusts reporting FFT for inpatient areas and 97th for positive responses based on NHSE February 2024 data. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns focussing on timely medications, pain management, involvement in decision making and improving the experience of our oncology patients.

Maternity FFT has dropped below the 95% target at 90.5%. March 2024 saw 95 (127 in February, 110 in January , 104 in December, 85 in November and 97 in October) completed surveys returned with 21 (21 in February, 40 in January, 37 in December, 25 in November and 21 in October) completed from the Birth touchpoint. Our antenatal touchpoint scored 82% recommendation and post natal 90% recommendation. Compared to the latest national data available (February 2024) out of 112 Trusts, we were 52nd for number of responses for antenatal, 72nd for number of responses for birth, 26th for post-natal ward and 23rd for post-natal community which shows improvement in all areas. FFT Task & Finish Group for post-natal care established and work is ongoing with the Maternity Voices for improving feedback.

Our complaints rate remains below the target/benchmark rate of 35 and within normal variation. The Complaints Team are continuing to review the complaints triage process to ensure that it is effective and that the number of PALS escalated to formal complaints does not rise. This is included in the quarterly Patient Experience Reports along with detailed reviews of trends and themes from received complaints. The average monthly response times for March 2024 recording median response time of 57 working days (against target of 40 working days) and shows improvement from the average of 64 days for complaints closed in February 2024.

Our Mortality indices remain within expected ranges and compare well with our peers and other acute trusts. SHMI is showing significant improvement with 9 consecutive months of reductions. HSMR has also reduced for third month in succession.

VTE Risk assessment compliance has declined during March and is below the 95% target at 91.3%. Audits for risk assessment completion and compliance have been carried out following the introduction of the new assessment document. Initially 17 different Medical wards have been audited during February/March 2024. 10 prescription charts in each ward were reviewed. 89% of prescription charts reviewed had at least a partially completed VTE risk assessment, but only 59% had evidence of the assessment being done within 12hours of admission, date and time recorded and a signature.

Hospital Associated Thrombosis rate remains within normal variation but has increased in March 2024 and key themes identified from the reviewed cases related to Missed doses of Prophylactic Dalteparin with no clear rationale recorded and inconsistent daily recording of mechanical thromboprophylaxis.

Timely Observations are continuing to improve across the Trust with current performance at 74.9%. There was 1 wards with less than 50% of patients having timely observations recorded on VitalPack. As previously noted, Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance.

C Diff numbers have increased during March and is same as March 2023 with 14 cases confirmed. There have been number of key actions taken during the past month including the addition of the CUR-95 score has now been added to the CAP antimicrobial Microguide to support clinicians in treatment decisions.

Sepsis screening and IV Antibiotics continue to be below targets within Royal Stoke Emergency Department. Other emergency portals are continuing to achieve these targets. Sepsis Team continue to work with RSUH ED Teams to try and improve compliance and staff are following correct sepsis guidance. Specific targeted actions in ED include having a Deteriorating Patient Reviewer (DPR) in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high-risk sepsis.

The audited missed screening cases in Children and Maternity did not result in any harm and related to lack of or incomplete documentation.

All data used in this report is as recorded on 9th April 2024 and figures may change following further review/investigation/update

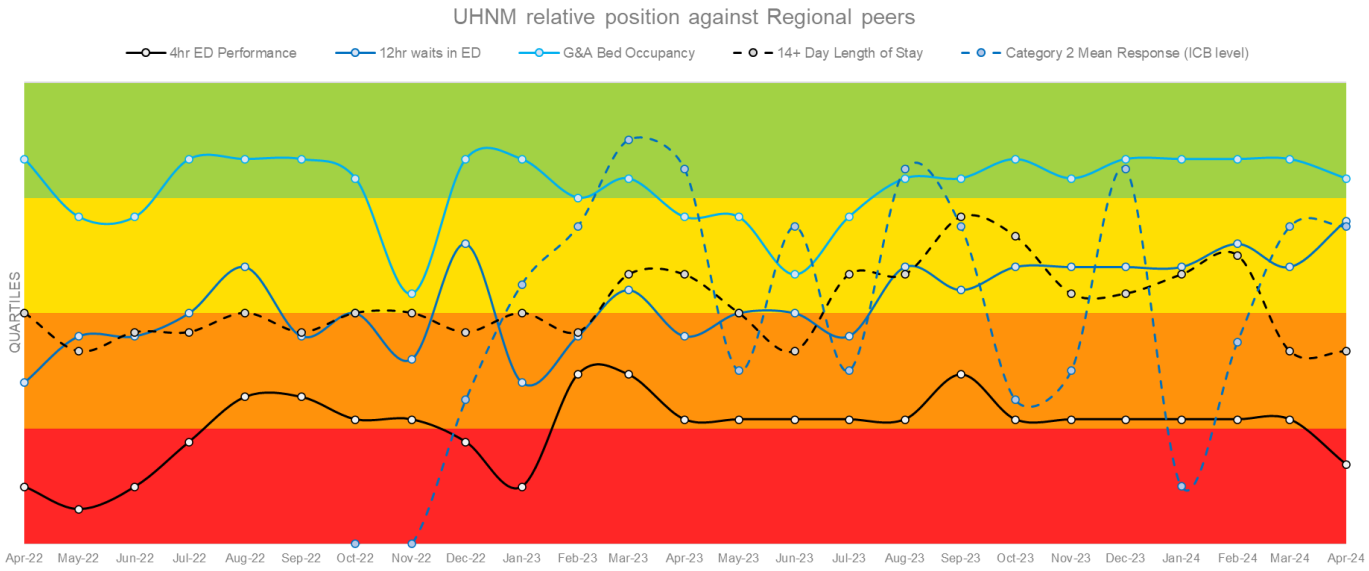
Operational Performance

This executive summary highlights key operational challenges in two groups. Urgent and Emergency Care performance (non-elective care) will be described initially and then Planned care, Cancer and Diagnostics services (elective care) will be grouped into a second summary. UHNM has been assessed as NHS Oversight Framework (NOF) Segmentation 3 and as such, a series of 'Exit Criteria' have been agreed which are aimed at making and sustaining the improvements needed across a range of themes / metrics. Two separate improvement plans have been developed to respond to these using this same split between Emergency Care and Planned Care, Cancer and Diagnostics.

Section 1: Urgent and Emergency Care Performance (Non-Elective Care)

How are we doing against our trajectories and expected standards?

12 Hour trolley wait delays in the Emergency Departments deteriorated in March from 943 in February to 1033 in March equating to an 8.72% increase. Greater than 12 hours aggregated from time of arrival in the Emergency Department increased from 1983 in February to 1987 in March, an increase of 2.22%. The 4-hour standard improved with a March outturn of 70.3% verse 63.9% in February. This demonstrated a 6.3% improvement on the February outturn and is the highest 4-hr performance since May 2021. The Ambulance handover within 60 min indicator also improved in March by 1.5%, although all of these are below the target range desired. During the month of March the 76% 4-hour standard was increasing in its priority having been deprioritised in order to focus on ambulance handover and safety measures.



In relative performance when compared to regional peers the 14+Day length of stay indicator showed deterioration in March however Category 2 mean time for ambulance response saw an improvement again for the second month almost climbing to top quartile. Actual and relative 4 hour performance for March improved although relative performance for 12hour waits in ED dropped. Whilst this relative use of benchmarking data does not show a SPC it is clear to see that we remain consistently within the Q1-3 zones for performance. (*Please note April is incomplete data*)

What is driving this?

Attendances were in line with the predictor for March and together with the full delivery of winter capacity, and in some cases over and above many more days capacity exceeded demand. Throughout March we continued to deliver our Workstream 2 (ward processes) building on the work completed by Medicine supported by KMPG.

In addition, there was constant enactment of your next patient to increase the timeliness of moving patients out of the emergency departments. Preparation and planning for the Easter weekend ensured flow yielded improved discharges through the 'Hop Home for Easter Campaign' although this programme did not show the reduction in bed occupancy experienced by campaigns over winter.

Regionally and nationally performance across the month improved and it is likely that March demand and casemix (and associated indicators of the complexity of patients in our hospitals) was lower than in previous months. Given this, there were still periods of peaks in demand and ambulance arrivals that presented challenges to providing access to the level expected. Patients waiting for beds in ED did reduce during this time however they were not eradicated and thus occupancy in Emergency Departments still exceeded optimum numbers to deliver the access required.

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

Throughout March additional measures were put in place to protect non-admitted pathways and build resilience in admitted pathways to support the achievement of the 4-hour standard. This was managed whilst balancing the demands on inpatient care and ambulance handovers. These activities will continue into April however post bank holiday we will see progressively more winter surge capacity reduce.

The Non-Elective Improvement plan has continued as part of its response to NOF3 and Undertakings. This plan articulates 4 workstreams described in more detail in the performance report. These workstreams articulate focus of improvement efforts now reduced from the 5 previous workstreams. The 4 workstreams have been reviewed and all are being re-focused and re-energised.

Specific areas of feedback:

Admission Avoidance and Length of Stay reduction through Acute Care at Home

- The service still operates with a large vacancy rate and recruitment continues alongside elements of mutual aid to maximise capacity.
- Development of the Call Before Convey services continues with reenforced communication strategies; recent evaluation has been shown to be one of the most successful/well used call before convey services available to benchmark.
- Agreement on the next stage of Call Before Convey to include Category 2 Ambulance Calls has been established and work is commencing on protocol and resourcing to intervene in this important cohort of patients conveyed to hospital.

Non-Admitted Performance

- County Hospital increased demand with diverts and increased intelligent conveyance will be used less in order to support RSUH site. In contrast to previous months this will reduce demand on the County Hospital and thus reduce the number of times departments are over capacity.

Winter Preparation

- Winter/surge plan actions continued through March and are expected to be in place until mid-April before any services reduce to pre-winter levels. Bed bases will not reduce until April when works on the Stafford County Site will require the closure of a ward.
- The review of actions taken and winter measures took place in February and were reviewed again in March and have been used to form the Easter holiday plan alongside mainstreaming of elements of the seasonal plan.

Workstream Priority – Workstream 2 Standard Work (RSUH)

- Improvement in ward discharges on Simple and Timely discharges has a potential to free upwards of 70 beds
- Use of the SAFER Care bundle Red to Green and Reason to Reside tools will reduce constraints to discharge and reduce unwarranted variation in discharge behaviours.
- KPMG support continued until the end of March 2024. This uses intensive improvement cycles whilst aligning to the Trusts Improving Together Methodology. Daily status exchanges and driver meetings are in place to continue to move this forward.

What can we expect in future reports?

The mitigation and improvement actions undertaken in Q4 have ensured a reactive and positive response in March, although not the maximum benefit desired. There is still ambition to achieve sizable improvement in ambulance handover delays, trolley waits within ED and against the 4-hour standard.

Previous planning on the urgent delivery of a discharge lounge has made way for a refocus of effort on ward discharge practice. Early March success of Workstream 2 has resulted in the additional allocation of resources to help expand this in both increasing scope and pace.

In previous months reports there was reference to a contingency action in the event of the emergency pathway continuing to operate over capacity. This was the cancellation of elective surgery for all patients that require inpatient admission and do not have suspected cancer or have very long waits would enable an increase in capacity for medical specialties. This has not taken place in any material way and cancer and elective pathways were protected.

In April a number of services will reduce in size and the level of support to the emergency pathway will reduce. County Ward 7 will close, portering and cleaning services will reduce, as well as additional capacity in the Emergency department in ambulatory areas. These planned reductions are the step down of surge capacity and put a greater dependency on the improvement workstreams to have an impact as well as system wide strategy to reduce demand.

In April WMAS will cease to provide the Hospital Ambulance Liaison Officer post as they utilise personnel in those posts to support additional ambulance response capacity. This important role provides important interface between hospital and ambulance services as well as supporting the coordination of peaks of demand ambulance handovers and delays. UHNM have been requested to replace this service with ICB support and funding however it does pose a substantial risk to ambulance handover performance.

Section 2: Planned Care, Cancer and Diagnostics (Elective Care)

How are we doing against our trajectories and expected standards?

Diagnostic performance in March was above 19/20 levels, and DM01 performance dipped in comparison with February. The largest contribution to this coming from Endoscopy delays, however ultrasound performance also dipped.

The number of patients waiting 78 weeks or more post validation ended at 70, this reduced from 159 in February. As a Tier 1 trust NHSE region and national and regional teams have weekly oversight of improvement trajectories. Trajectories originally had factored in a reduction of capacity in January with the ambition of 0 patients waiting by March. As further Industrial Action occurred in February this trajectory has been updated to reflect a reduction down to 0 patients waiting by April 2024. There remained 1 patient waiting over 104 weeks for treatment at the end of March with an expectation that this reduces back to 0 by the end of April 2024.

Cancer treatment backlog numbers have continued to reduce below trajectory and latest performance at the close of March have numbers better than trajectory. This performance reflects an improvement in several tumour sites however the most notable and with greatest impact is lower GI (Colorectal) which has seen an improvement to better than trajectory performance. The focus now is on maintaining the position to begin to support overall cancer performance % against the standard. There is a significant amount of cancer alliance funding supporting this position which remains in discussion for Q1 24/25, although support to endoscopy has already been approved.

Cancer diagnostic performance met 75.1% in February, and this is predicted to be maintained for March. SPC charts show a sustained improvement from August and further improvement is still required in specific tumour sites.

The National Cancer Team have written to UHNM congratulating us on the 35.4% reduction in the backlog and the 12% improvement in Faster Diagnosis performance. It was noted our improvements are some of the most positive progress seen anywhere nationally, and that UHNM have been a significant contributor to the overall national position to reduce the backlog to pre-pandemic levels.

What is driving this?

As previously reported Endoscopy performance is contributing to both planned care and cancer standards. Backlogs in cancer are now reducing and the service is increasing its capacity however the recovery period will be staged initially recovering cancer 28 day faster diagnostics standard and then planned care 6 weeks standard. Additional capacity has been secured in Q4 2024 and this will be required throughout 2024/25 with business cases being developed to right size the service permanently.

Industrial Action reduced capacity during December, January, and February, and this came back to normal patterns in March although some patients did choose to wait until after the Easter break for treatment. While we had planned to be at 0 patients waiting by March; actions are in place to support a 0, or single figure number of patients waiting over 78 weeks by the end of April.

Cancer treatment backlog reduction (62 day) continue at high levels and capacity has been protected above all other areas of elective care. Increases in capacity supported by West Midlands Cancer Alliance (Lower GI Surgery in particular) have seen a significantly positive impact.

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

Endoscopy services continue their three part improvement plan for the resolution of demand versus capacity. Having completed a recent high level of demand and capacity review it is possible to quantify some of the impact of these schemes.
In Q4 the additional funding to support additional capacity has been fully deployed using support from independent sector insourcing. This is approximately 50% increase in overall capacity moving from 54 funded lists to 72+. This is being used to expand capacity and is the final funding position available to us this financial year. The second part of the plan uses external support brought into endoscopy to help improve utilisation and productivity. It is anticipated this improvement could lead to 15% more capacity although requires several months to fully deliver. This will also include work with the leadership teams to fully mobilise the digital system now implemented and to improve processes and booking practice. This final element will ensure that the service is sustainable into 2025 and will be the longer term recruitment and workforce strategy to deliver a permanent service that responds to patients needs across SSOT. It is expected that the number of lists to address demand and to clear backlog of patients down within the next 12 months is approximately 104 lists per week. That would represent an increase in endoscopist capacity of approximately 95%, although currently theatre physical and nursing capacity appear to be able to accommodate that increase.

Productivity in elective services, and especially outpatient services are part of the wider planned care improvement plan. Utilising the GiRFT methodologies the Trust will focus on specialties that have particularly long waiting lists and work with the national GiRFT *Further Faster* programme. This clinically developed set of improvement tools has been used in a number of areas nationally and will support the focussed recovery of those specialties with gaps in demand and capacity and that have long waiting lists.

Cancer performance and the protection of capacity for cancer recover will remain a focus during the winter and industrial actions. It is expected that despite the increased winter pressure and impact from emergency overflow, cancer services will remain protected. This will include the ring fencing of funding for cancer improvement which if mobilised should deliver performance in line with our trajectories.

What can we expect in future reports?

As discussed in previous months IPR narrative diagnostics and planned care will not be met by March 2024. The full impact of this is still being analysed however the timing of the action is such that it is unlikely any suitable alternatives for the lost capacity will be available when required and Q1 will be the earliest these targets will be met.

Cancer services have the greatest protection of services (including cancer diagnostic services), and recovery trajectories are set to continue in 24/25, although there is a reliance in the cancer alliance funding of which we await confirmation. Referral numbers have remained high during March, and we are working with partners in SSOT to support efficient pathways for our patients at first presentation. Ongoing discussions are taking place with regulators on both undertakings and NOF3 exit criteria which now must be considered in relation to the Industrial Action.

Workforce

How are we doing against our trajectories and expected standards?

- **Turnover** and **vacancy** metrics continue to perform well against our expected standards. The turnover rate in March 2024 has shown a further small improvement to 7.8% and this remains consistently below the Trust's 11% target, for the last 18 months. The vacancy metric has also improved to 7.91% which also remains within our expected standard of 10%. The main driver of the vacancy % is due to an increase in the total FTE for actual people in post.
- **Sickness absence** continues to be above our expected standard of 3.39%. In month we have seen a 0.34% decrease to 4.99%. The 12-month cumulative rate has also fractionally decreased to 5.21% from 5.24%. The

main driver of this continues to be stress and anxiety, although this has seen a 1.4% decrease, when compared to February's position. Gastrointestinal Problems replaced Chest & Respiratory as the second most common reason, at 11.6%, followed by Other Musculoskeletal problems, at 8.0% which pushed Cold, Cough & Flu down to 7.5% in Mar-24. This corresponds to an overall decrease in the total number of reported Covid-19 cases, associated with the usual seasonal changes we expect to see.

- **Performance Development Reviews (PDR's)** continue to be below the Trust target of 95%. In month we have seen a 2.2% improvement from 83.5% to 85.7%. This reflects the Divisions recent focus on improving their performance regarding the timely completion of PDR's. This Will continue to be an area of focus at the Divisional performance reviews.
- **Statutory and Mandatory Training** (core for all subjects) remains just below the Trust target of 95% and has remained at 93.7% for both February and March 2024.

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

- Divisional and Directorate Management Teams continue to manage sickness absence in line with the Trust Policy.
- The refreshed PDR paperwork was released, as planned, in January 2024, supported by electronic training materials, including instructional videos, which have been made available on the Intranet. Divisions are also undertaking weekly PDR compliance reviews, which have helped to drive the recent improvements towards achieving this metric.
- We are continuing to watch the statutory and mandatory training performance to ensure that we maintain the strong position on this metric.

What can we expect in future reports?

- The local Staff Voice Survey achieved an engagement score of 6.61, for March 2024, with 464 responses, which is 14 less responses than February's results.
- Key lines of enquiry continue, within the Divisions, following the publication of the National Staff Survey's results, with improvements being celebrated, while understanding where improvements can be made ahead of this year's survey.
- We should anticipate that sickness absence in month may continue to incrementally improve, now that we are heading into Spring, with less Covid-19 related cases experienced.

Finance

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

- For the financial year 2023/24 the Trust has delivered a year end surplus of £0.2m against a planned breakeven position; this is a positive variance of £0.2m.
- The Trust has received an additional £2.6m funding towards the cost of industrial actions. This takes the total funding for industrial actions and cost pressures to £13.1m for the year.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £46.1m of CIP savings to Month 12 against a plan of £55.0m. The Trust has recognised £4.9m of CIP due to a reduction in the annual leave accrual.
- There has been £95.2m of Capital expenditure which is in line with forecast
- The cash balance at Month 12 is £82m which is £21m higher than plan.

Key Recommendations

The Committee is requested to note the performance against previously agreed trajectories.
The committee is requested to approve narrative within the IPR as an appropriate highlight report; satisfying the requirements of the Trusts undertakings from November 2023 onwards.

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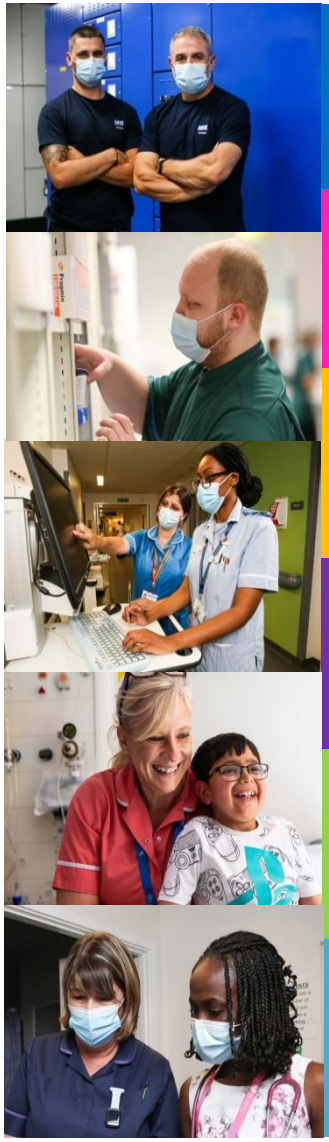


Integrated Performance Report

Month 12 2023/24

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

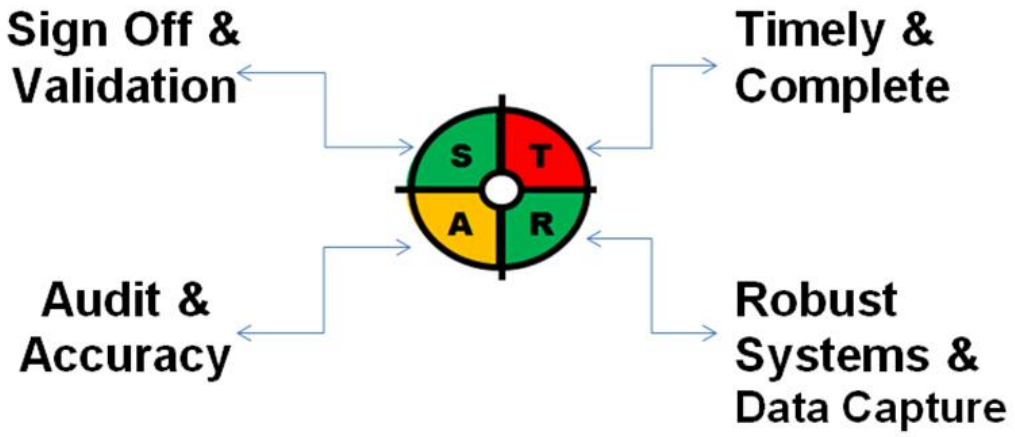
Assurance - how assured of consistently meeting the target can we be?

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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NHS Trust

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

The Trust achieved the following standards in March 2024:

- Falls rate was 4.8 per 1000 bed days for March 2024 and below benchmark rate.
- Hospital Associated Thrombosis has continued to remain below the mean rate and is within normal variation and cases are under review.
- 100% verbal Duty of Candour compliance recorded in Datix.
- Trust rolling 12-month HSMR continues to be within expected range at 94.15
- Trust rolling 12-month SHMI 99.43 and is Band 2 – as expected. There has been continued improvement in SHMI
- Zero avoidable MRSA Bacteraemia cases reported.
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care continues to reduce and is now 0.24 and below the target rate 0.5
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 97.9% and 100% respectively and meeting the 90% target rate
- Children's Sepsis Screening compliance achieved the 90% target with 100% during March.
- Maternity IVAB compliance maintained 100% and above the 90% target for audited patients for second consecutive month
- The rate of complaints per 10,000 spells is 28.06 and remains below the target of 35 and long term mean rate but within normal variation.

The Trust did not achieve the set standards for:

- Rate of falls reported that have resulted in harm to patients currently at 1.7 per 1000 bed days and continues to be within the control limits and normal variation.
- 78% 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
- There were 10 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 1 Never Event – incorrect lesion removed
- 2 overdue Patient Safety Alerts which is awaiting final approval and sign off (as at end of March 202) and 1 alert is continuing to be led by the ICB
- Timely Observations remain below the 90% target but has seen further improvement with 74.9%.
- VTE Risk Assessment completed during admission below 95% target with 91.3% recorded in March (via Tendable)
- C Diff YTD figures remain above trajectory with 14 against a target of 8.
- E. Coli Bacteraemia cases above trajectory with 20 in March compared to target of 16.
- Friend & Family (Inpatients) 93.9% and remains below 95% target.
- Friend & Family (A&E) remains below 85% target at 68.4% which is slight improvement from February 2024.
- Friend & Family (Maternity) 90.5% and below 95% target.
- Sepsis Screening compliance in Emergency Portals declined to 78% and below the target 90%.
- Emergency Portals Sepsis IVAB improved to 89.8% but remains below the 90% target for audited patients.
- Maternity Sepsis Screening compliance 66.7% in March 2024 but remain below 90%

During March 2024, the following quality highlights are to be noted:

- Total number and rate of Patient Safety Incidents decreased in month but continues to show increased reporting over longer term trend
- Total incidents with moderate harm or above and the rate of these incidents within normal variation levels during March and noted further decrease in month (incidents are currently under review)
- Medication related incidents rate per 1000 bed days is 5.1 which below the target and the long term mean rate as is patient related at 5.7. The monthly variation is within the normal expected variation and above the NRLS national rates. The % of medication incidents reported with moderate harm or above has decreased below the mean percentage for March 2024 and incidents remains under review.
- PSIRF adopted and therefore no Serious Incidents reported. 1 new PSII reported in March 2024 and under review using Patient Safety Incident Investigation (PSII) process
- Largest reason / category of complaints in March 2024 continue to relate to clinical treatment with 36% of complaints received relating to issues with clinical treatment.

University Hospitals of North Midlands NHS Trust

Quality Performance Report (QPR) | Assurance Grid

Failing NHS

Aiming Here

Strategic Priority Domain Metrics Key

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

Assurance / Variation Key

Assurance

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

Variation

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

Worsening

Variance

March 2024	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause - Improvement	Inpatient IVAB within 1 hour VTE Risk Assessment Rolling 12 month HSMR	Falls rate per 1000 bed days. Patient Medication Incidents per 1000 bed Serious Incidents & Rate of SIs Contracted Adult Inpatient Sepsis Screening Hospital acquired Thrombosis Rate Inpatient Sepsis Screening Approval Lead Time Sickness	Rolling 12-month SHMI Timely Observations Avoidable MRSA All Children's IVAB in 1 hour All Maternity IVAB in 1 hour
Common Cause		Patient Safety Incidents PSI rate per 1000 bed days Medication incident % moderate harm + PSI's per 1000 bed days no harm PSI rate Moderate Harm and above PSI's per 1000 bed days near miss Medication Incidents per 1000 bed days PU's rate per 1000 bed days Lapses in care PU per 1000 bed days Cat 2 PU with Lapses in care Cat 3 PU with lapses in care Deep Tissue injuries lapses in care. Unstageable PU lapses in care DoC compliance formal verbal & written. HAI and COHA cases of C Diff toxin Friends and Family Inpatient & Maternity Complaints Rate All children sepsis screening All Emergency Portals IV Abx in 1 hourAll Maternity sepsis screening PSIs per 1000 bed days low harm Pat Medication incident % moderate harm Never Events reported	Family and Friends ED RS ED IV Abx in 1 hour Other Emergency Portals IV Abx in 1 hour
Special Cause - Concern		HAI E Coli Bacteraemias All ED portals Screening RS ED Dept Sepsis Screening Childrens Sepsis Screening Net Hours Agency Usage Bank Usage Temporary Staffing	

Patients will receive a variable experience

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	2000	1934	1860		
Patient Safety Incidents per 1000 bed days	50.70	48.02	43.79		
Patient Safety Incidents per 1000 bed days with no harm	34	32.80	28.77		
Patient Safety Incidents per 1000 bed days with low harm	13	12.69	13.23		
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	1.61	1.06		
Patient Safety Incidents with moderate harm +	20	34	16		
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	0.84	0.73		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	4.9	4.8		
Patient Falls with harm per 1000 bed days	1.5	1.7	1.7		
Medication Incidents per 1000 bed days	6	6.5	5.1		
Medication Incidents % with moderate harm or above	0.50%	2.66%	0.92%		
Patient Medication Incidents per 1000 bed days	6	5.4	4.5		
Patient Medication Incidents % with moderate harm or above	0.50%	3.21%	1.04%		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents / PSIIs reported per month	0	1	1		
Serious Incidents / PSIIs Rate per 1000 bed days	0	0.02	0.02		
Never Events reported per month	0	1	1		
Duty of Candour - Verbal/Formal Notification	100%	100.0%	100.0%		
Duty of Candour - Written	100%	75%	78.0%		
All Pressure ulcers developed under UHNM Care	60	73	63		
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	1.81	1.48		
All Pressure ulcers developed under UHNM Care lapses in care	12	21	10		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.52	0.24		
Category 2 Pressure Ulcers with lapses in Care	0	8	4		
Category 3 Pressure Ulcers with lapse in care	N/A	1	2		
Deep Tissue Injury with lapses in care	0	10	5		
Unstageable Pressure Ulcers with lapses in care	0	2	0		

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

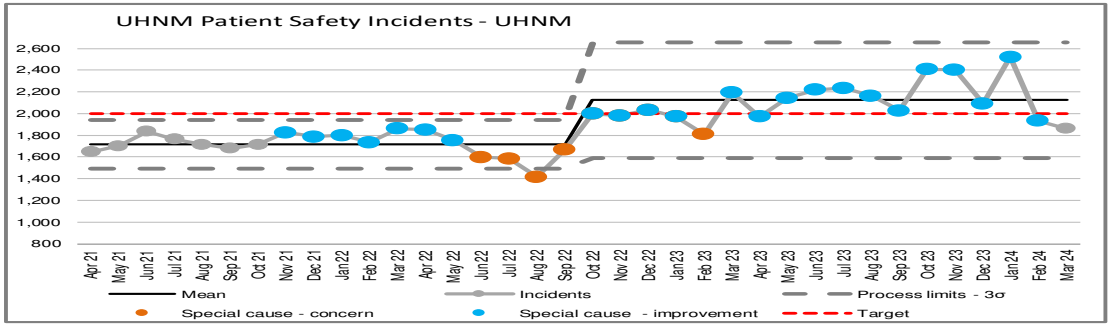
Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	65.0%	68.4%		
Friends & Family Test - Inpatient	95%	94.1%	93.9%		
Friends & Family Test - Maternity	95%	95%	90.5%		
Written Complaints per 10,000 spells	35	28.44	28.06		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	95.74	94.15		
Rolling 12 Month SHMI (4 month time lag)	100	100.35	99.43		
VTE Risk Assessment Compliance	95%	91.5%	91.3%		
Hospital Associated Thrombosis Rate per 10,000 Admission	N/A	0.67	1.14		
Timely Observations	90%	71.0%	74.9%		
Reported C Diff Cases per month	8	13	14		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	16	20		

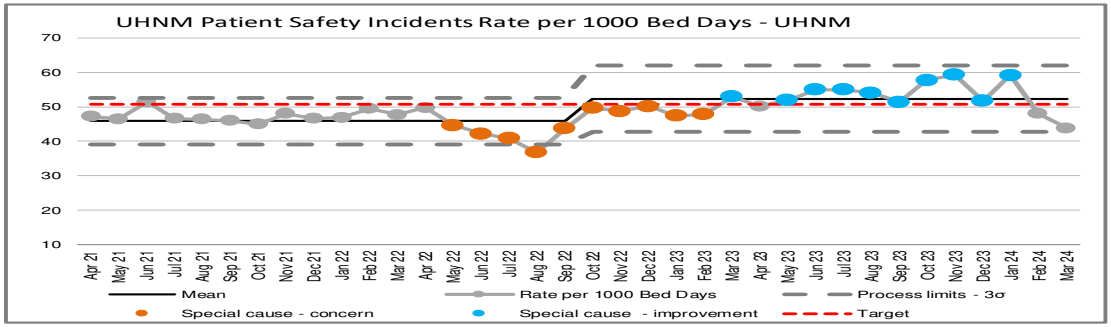
Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracte	90%	94.8%	97.9%		
Inpatient IVAB within 1hr (Contracted)	90%	100%	100.0%		
Children Sepsis Screening Compliance (All)	90%	94%	100.0%		
Children IVAB within 1hr (All)	90%	n/a	100.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	83.0%	78.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	93.62%	89.7%		
Maternity Sepsis Screening (All)	90%	70%	66.7%		
Maternity IVAB within 1 hr (All)	90%	100%	100.0%		

Delivering Exceptional Care with Exceptional People

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
2000	2521	1934	1860

Background

Total Reported patient safety incidents

Variation	Assurance

NRLS Mean	Jan 24	Feb 24	Mar 24
50.70	59.16	48.02	43.79

What is the data telling us:

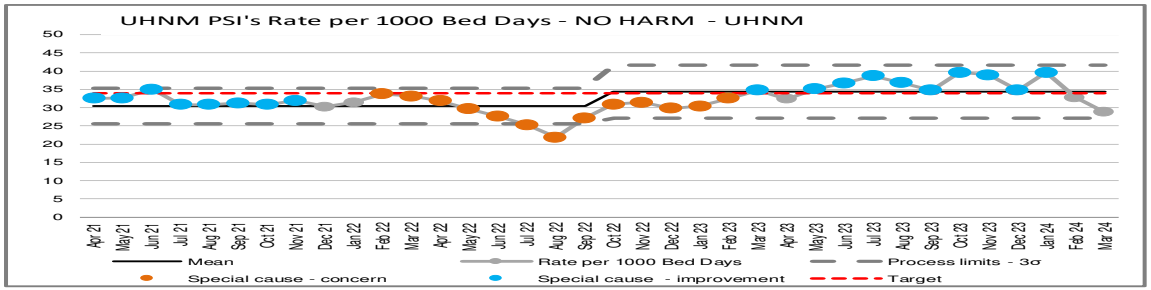
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The March 2024 total is below the mean total and lower than same period in 2023. However, this lower total may also be result of Easter period during March 2024. The rate per 1000 bed days has also decreased and below the NRLS mean rate and the same period in 2023.

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, Treatment related and Clinical assessment incidents. Falls related incidents are the largest category after Tissue Viability in March 2024.

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

NHS University Hospitals of North Midlands NHS Trust

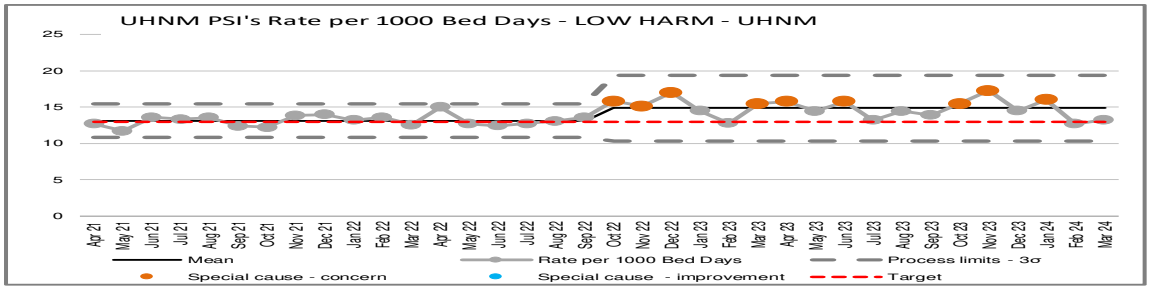


Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
34	39.66	32.80	28.77

Background

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

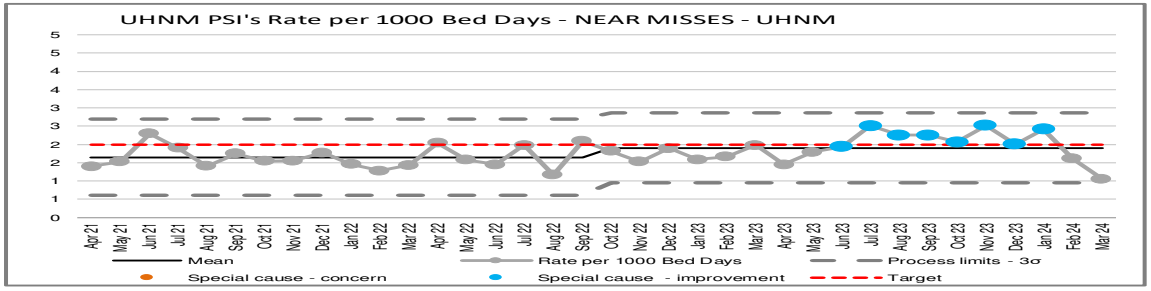


Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
13	16.00	12.69	13.23

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 24	Feb 24	Mar 24
2.0	2.42	1.61	1.06

Background

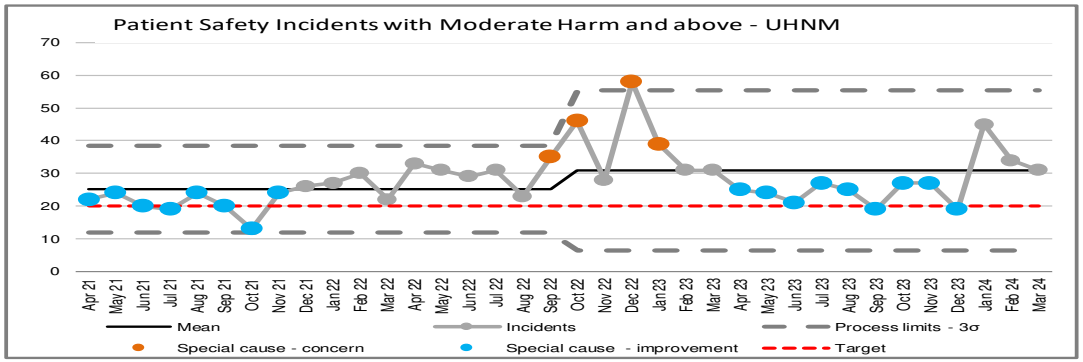
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm, low harm and near misses have rates below the long term mean and target rates during March 2024. The reporting of all incidents and near misses should continue to be encouraged so that mitigating actions and learning can be identified via these incidents to further improve the quality of care and services provided and reduce risk of serious harm.

Reported Patient Safety Incidents with Moderate Harm or above

NHS University Hospitals of North Midlands NHS Trust

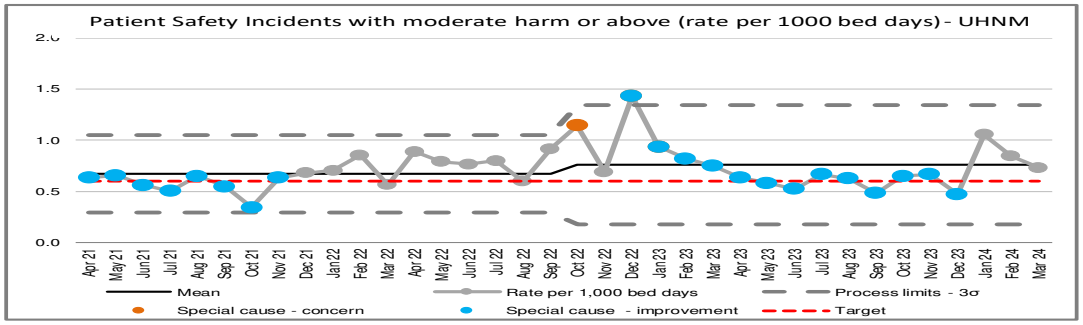


Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
20	45	34	31

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
0.60	1.06	0.84	0.73

What is the data telling us:

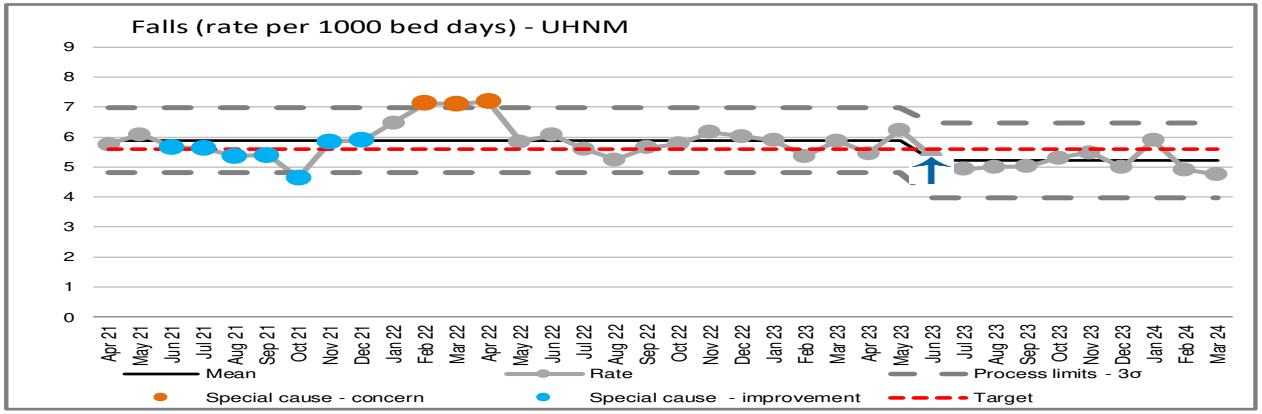
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal control limits but has shown decrease total numbers and rate for March 2024 in line with overall numbers and rates. These remain under review and may alter following completion of the reviews. The last 14 months had seen reducing trends and below the mean rate which was recalculated in October 2022.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Falls (7), Treatment/Procedure related (4) and Communication/Consent (3).

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

Patient Falls Rate per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
5.6	5.9	4.9	4.8

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

The average rate of reported patient falls per 1000 bed days has been significantly lower since Jun-23. The rate for March 2024 is within expected limits.

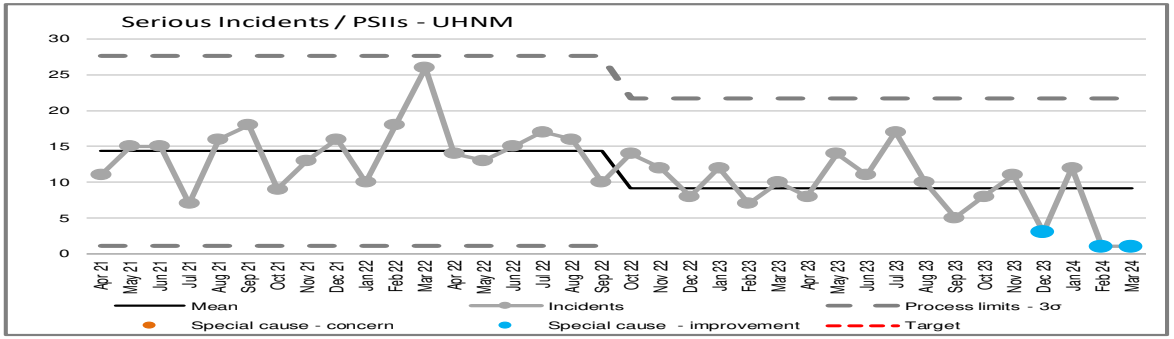
The areas reporting the highest numbers of falls in March 2024 were:
Royal Stoke AMU – 14 falls, Royal Stoke ECC – 13 falls, Ward 110 – 11 falls , Ward 228 – 10 falls

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

- From the 48 falls across the 4 areas there were 2 injury's which were from ECC and Ward 228. PSIRF toolkits were completed in conjunction with the areas and improvements and actions were discussed.
- Wards 110 and 228 have had multiple fallers in March. Due to the nature of patients that are nursed on both wards, there will be a mobility concern.
- New falls Champion training has been advertised and a session has taken place this week.
- Education continues to be provided on a 1:1 basis in ECC to ensure documentation and mitigation for risks are in place.
- Discussions have taken place with both the falls links in ECC and AMU to discuss areas of improvement.
- Q&S have been invited to the Quality Improvement meetings that take place on AMU, Falls is one of the drivers.
- Falls audits have been completed on the above wards and areas of good practice were noted. Areas of improvements were fedback and discussed.
- New N/A induction training has taken place.

Serious Incidents / PSIIs per month

University Hospitals of North Midlands NHS Trust

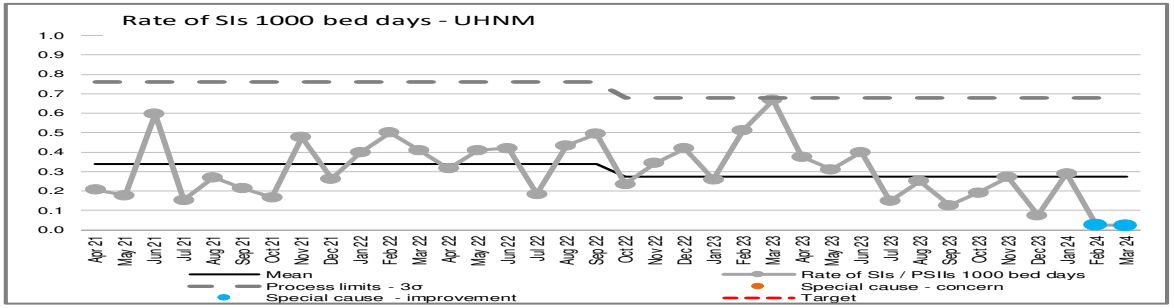


Variation	Assurance

Threshold	Jan 24	Feb 24	Mar 24
0	12	1	1

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
0	0.29	0.02	0.02

Background

The rate of Serious Incidents / PSIIs Reported per 1000 bed days

What is the data telling us:

In December 2023, UHNM stopped reporting incidents under the Serious Incidents Framework and adopted the new Patient Safety Incident response Framework (PSIRF). Whilst UHNM moves towards LFPSE implementation, the interim arrangement is to report on STEIS incidents that previously noted as SIs. During February 2024, UHNM reported 1 incident that is being reviewed using the new Patient Safety Incident Investigation (PSII) methodology

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. March 2024* saw 1 incident reported:

- 1 wrong site surgery related (Dermatology)

The rate of SIs / PSIIs per 1000 bed days has varied consistently within confidence limits but have shown significant improvement with rate below the previous long term mean of 0.4. The confidence limits have been recalculated from October 2022 to reflect the significant changes. The current rate is 0.02.

Maternity related Serious Incidents / PSIIs Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

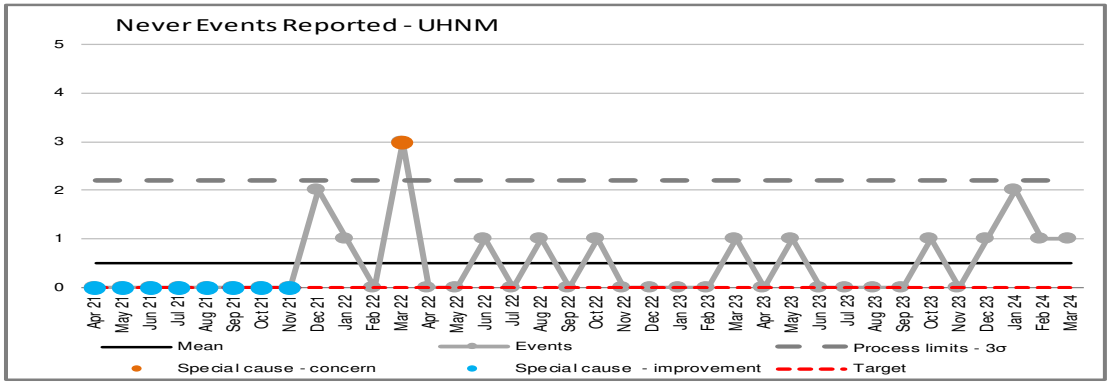
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during December 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There were 0 Maternity related PSIIs reported during March 2024

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:

Never Events



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
0	2	1	1

Background

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

There have been 1 new Never Event reported in March 2024. The target is to have 0 Never Events.

Whilst these are Never Event Category it is now reported via the PSIRF approach and will have a PSII undertaken.

Log No.	Never Event Category	Description
329159	Wong site surgery (incorrect lesion)	The patient attended a clinic appointment on 19/02/2024 following a 2WW referral for a lesion on his scalp that was made via order comms when he was an inpatient. When the patient attended the clinic on 19/02/2024 the doctor reviewed a referral from 2021 instead of the order comms referral. The referral from 2021 was for a lesion on the neck. The lesion on the neck, which was treated in 2021, was subsequently photographed and the patient was consented for a punch biopsy. The patient attended the dermatology theatre on 07/03/2024 and had a punch biopsy on his neck. On 08/03/2024 the patient's daughter contacted the department to raise concerns that the incorrect lesion was operated on. Appointment made for 25/03/2024 for review with Dr.

The latest Never Event is related to incorrect lesion and is second in recent months. These incidents will have PSIIs completed and also review previous actions and complete thematic review to assess / compare differences and similarities between the incidents and share the wider learning.

Duty of Candour Compliance

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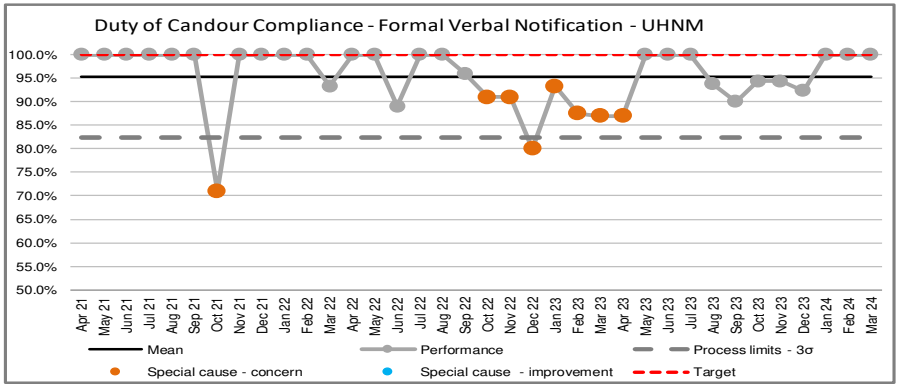

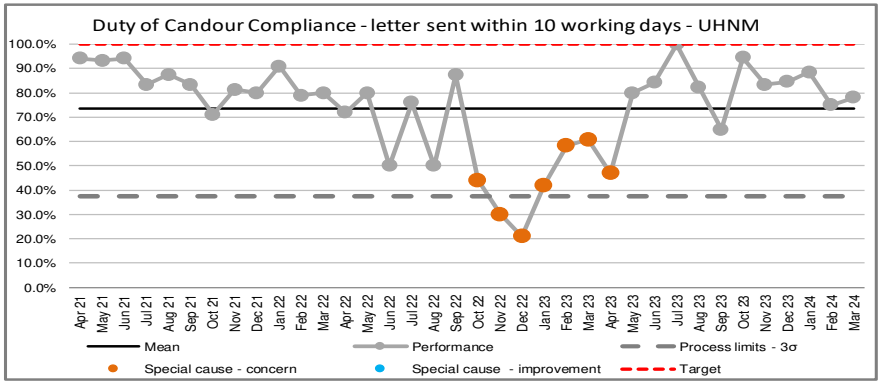

Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
100%	88.5%	75.0%	78.0%

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. 100% (23out of 23) have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance* (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during March 2024 is 78.3% as of 9th April 2024 including those letters that are completed within timescale and not yet exceeded the timeframe. 5 cases were outside the 10-day timeframe have had the letter forwarded and completed..

100% of the identified cases have had Duty of Candour completed.

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

Actions taken:

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

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

Head of QSC has been undertaking additional sessions at Directorate & Specialty Meetings to discuss Duty of Candour and staff responsibilities.

Patient Safety Alerts

NHS
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NHS Trust

New Patient Safety Alerts received:

During March 2024 there have been no new alert received through the Central Alert System (CAS) – national web based cascading system for issuing patient safety alerts and other safety critical information and guidance to the NHS. Alerts available on the CAS website include NHS England and NHS Improvement Patient Safety Alerts (PSA) and Estates Alerts, MHRA Dear Doctor letters, Medical Device Alerts (MDA) and Drug Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

Alert Type	CAS Status	Alert Reference Number	Alert Title	Date Issued	Date Completed	Deadline Date

Currently there are 5 open alerts on the CAS system for UHNM

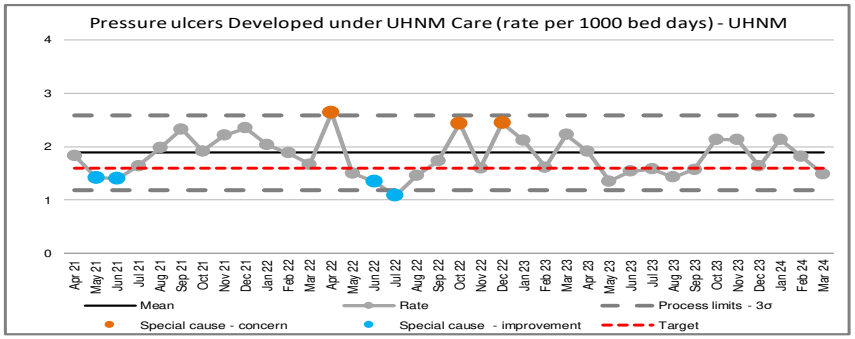
Alert Type	CAS Status	Alert Reference Number	Executive Lead	Alert Title	Date Issued	Deadline Date
NHS PSA	**Open**	Nat/PSA/2023/010/MHRA	Chief Nurse	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	31/08/2023	01/03/2024
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	ICB Lead	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	28/11/2023	31/01/2024
NHS PSA	**Open**	Nat/PSA/2023/014/MHRA	Chief Nurse	Identified safety risks with the Euroking maternity information system.	07/12/2023	07/06/2024
NHS PSA	**Open**	Nat/PSA 2024 002 NHSPS	Medical Director / Deputy MD	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.	31/01/2024	31/01/2025

Overdue Patient Safety Alerts: There is currently 2 overdue alerts.

Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Deadline Date	Comments
NHSPSA	Open	Nat/PSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	01/03/2024	Awaiting Final sign off of actions at QSOG
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	31/01/2024	Feedback/responses being collated at ICB level, going through Meds Safety Group once completed by the ICB lead, awaiting feedback as deadline date has now passed.

Delivering Exceptional Care with Exceptional People

Pressure Ulcers developed under care of UHNM per 1000 bed days

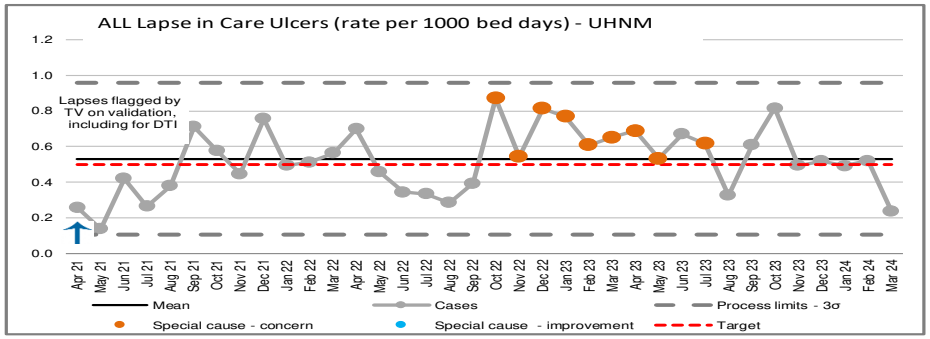


Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
1.6	2.14	1.81	1.48

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 24	Feb 24	Mar 24
0.5	0.49	0.52	0.24

Background

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

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in March. The rate of cases with lapses in care identified was also within expected range in March.

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

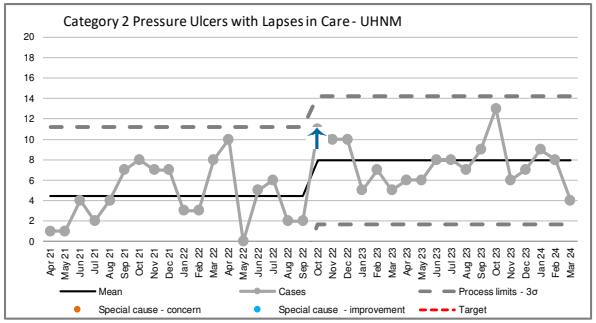
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Actions

- Training delivered for NA induction, Preceptorship days, and ED new starters and have now been delivered to student paramedics.
- Education available for pressure prevention, continence, wound assessment, and lower limb.
- Spring conference has taken place to focus on pathways available, wound assessments, and a mock coroner's court focusing on documentation.
- Chair and mattress audit to go live on Tendable to improve compliance in audit submissions. Video's have been developed to support auditing equipment.
- Peer review for Tendable audit ongoing with an assurance plan to include Matrons, HOH, and DOD's.
- To meet with Harlow for the first draft of the skin health booklet which will include all updated pathways.
- Review of alternative images to be completed in line with governance protocols.
- Tissue Viability team currently on risk registered due to staffing and increased caseload.

Pressure Ulcers with lapses in care

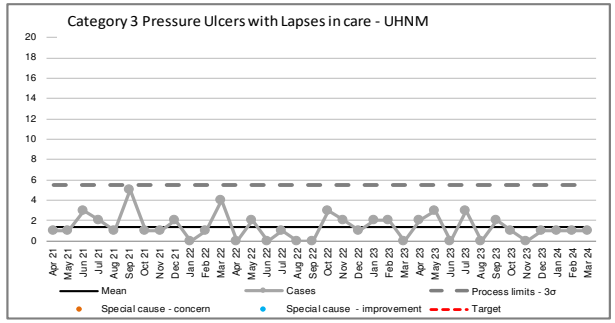
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
N/A	9	8	4

Background

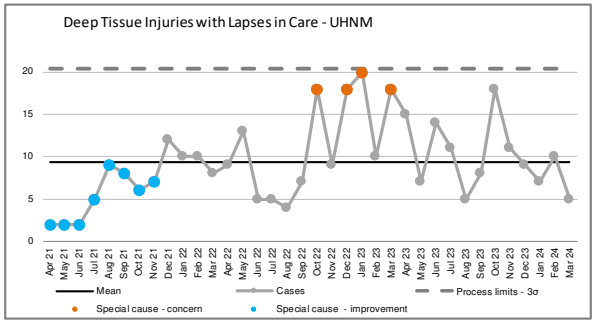


Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
N/A	1	1	1

Background

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

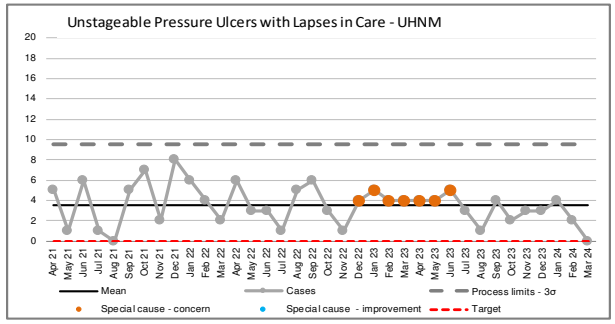


Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
0	7	10	5

Background

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



Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
0	4	2	0

Background

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

What is the data telling us:

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

Locations with more than 1 lapse in March 2024 were: **ECC (2), Ward 103 (2)**

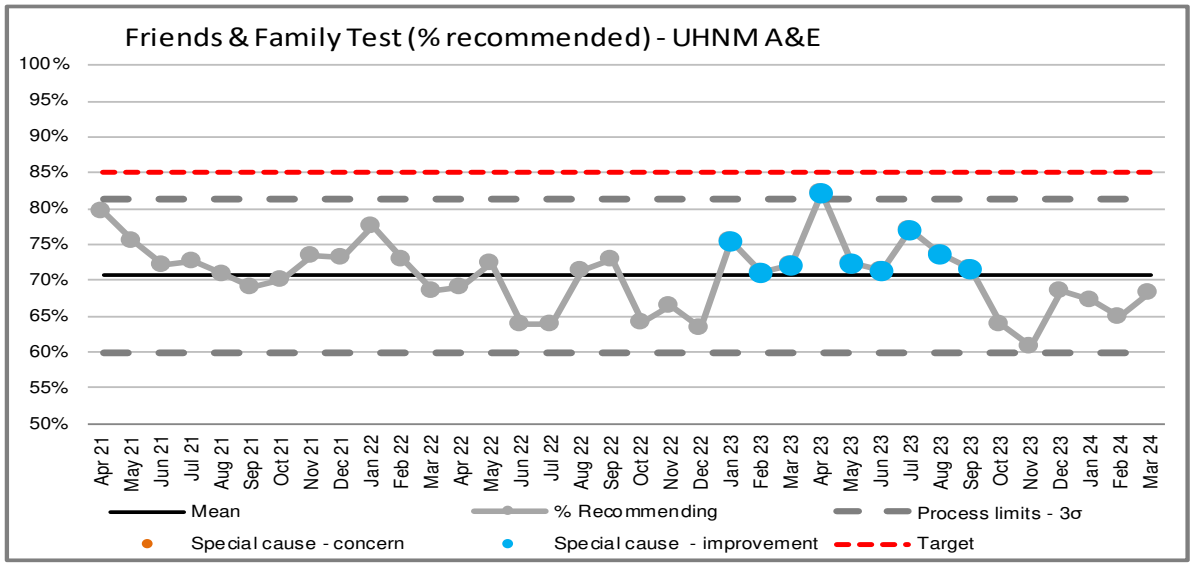
Root Cause(s) of damage - Lapses - Mar 2024	Total
Management of repositioning	6
Management of heel offloading	3

Actions:

- Cat 2 damage will have an action plan completed for improvements and a thematic review will take place quarterly. Protocol for Matrons and senior nurses will be trailed and education to be arranged.
- PSIRF toolkits are to be completed for DTI's, Cat 3's, and unstageable damage. Completion of action plans will be checked by Quality and Safety and Governance teams prior to the closure of incidents.
- Multiple reporting wards are invited to assurance meetings and to be offered support with improvements.
- Matron's to be involved in coroner's request.

Friends & Family Test (FFT) – A&E

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
85%	67.4%	65.0%	68.4%

Background

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

- The overall satisfaction rate for our EDs was within expected limits in March 2024.
- The Trust received 1353 responses which is a decrease on the previous month and the response rate percentage 9% overall. The Trust's overall satisfaction rate is lower than the national average of 77% (NHS England Feb 24- latest figures) at 68%, however this is a 3% increase on previous months. UHNM is 35th out of 125 Trusts for the number of responses in ED (NHS England Feb 24), and 87th out of 125 Trusts for the percentage positive results.
- Feedback from patient experience of using 111First and the kiosks continues to be monitored. A consistent 21% of respondents in March 2024 reported to have used 111First prior to attending ED, which is equal to the previous few months. Key themes from March 2024 continue are around poor communication, staff attitude, long waits, pain relief especially related to Royal Stoke.

Actions :

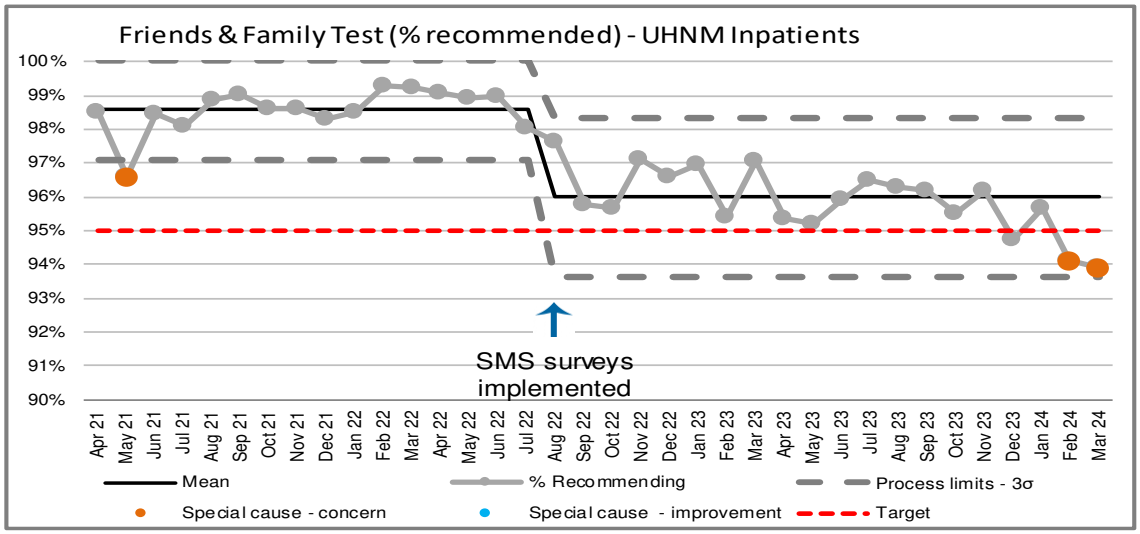
Need to revisit process for handing out FFT paper survey as minimum submission of FFT via this modality.

QR code made visible throughout the department.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
95%	95.7%	94.1%	93.9%

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 was significantly below average in February & March though it was only just below the national average of 94% (December 2023 NHS England).
- In March 2024 a total of 2450 responses were collected from 68 inpatient and day case areas (11684 discharges) equating to a 21% return rate which is higher than last month but lower than the internal target of 30%. UHNM have the 21st highest response rate for all reporting Trusts in the country (153) and are 97th for percentage positive responses (NHS England February 24 latest data)

Actions:

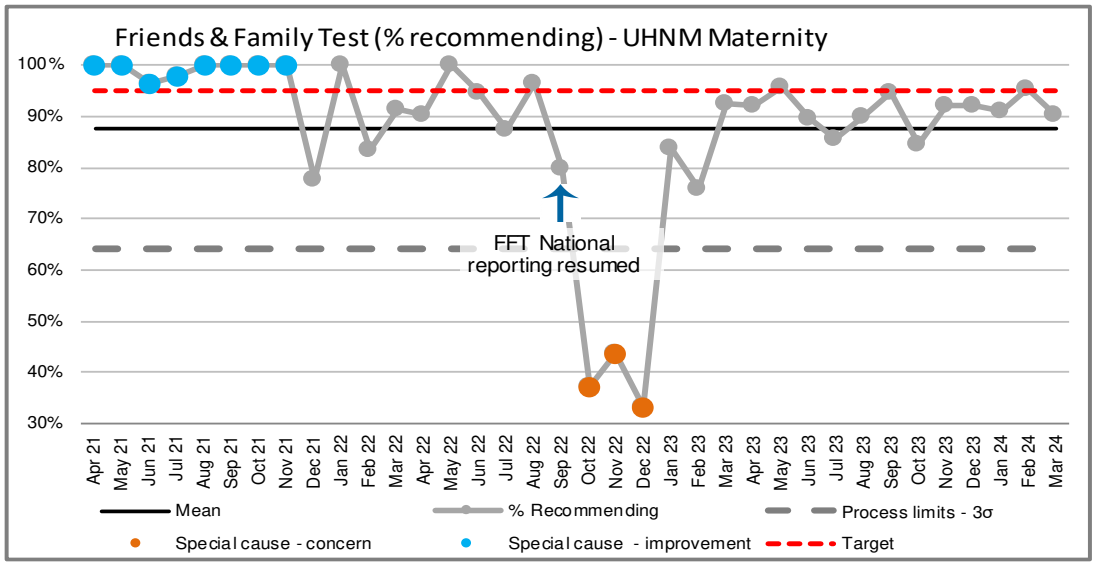
- All areas are now using the most up to date version of the FFT survey
- Continue to focus on Medicine and Surgery to increase response rate.

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

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

Friends & Family Test (FFT) - Maternity

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
95%	90.9%	95.3%	90.5%

Background

FFT Maternity % patients Recommending Service

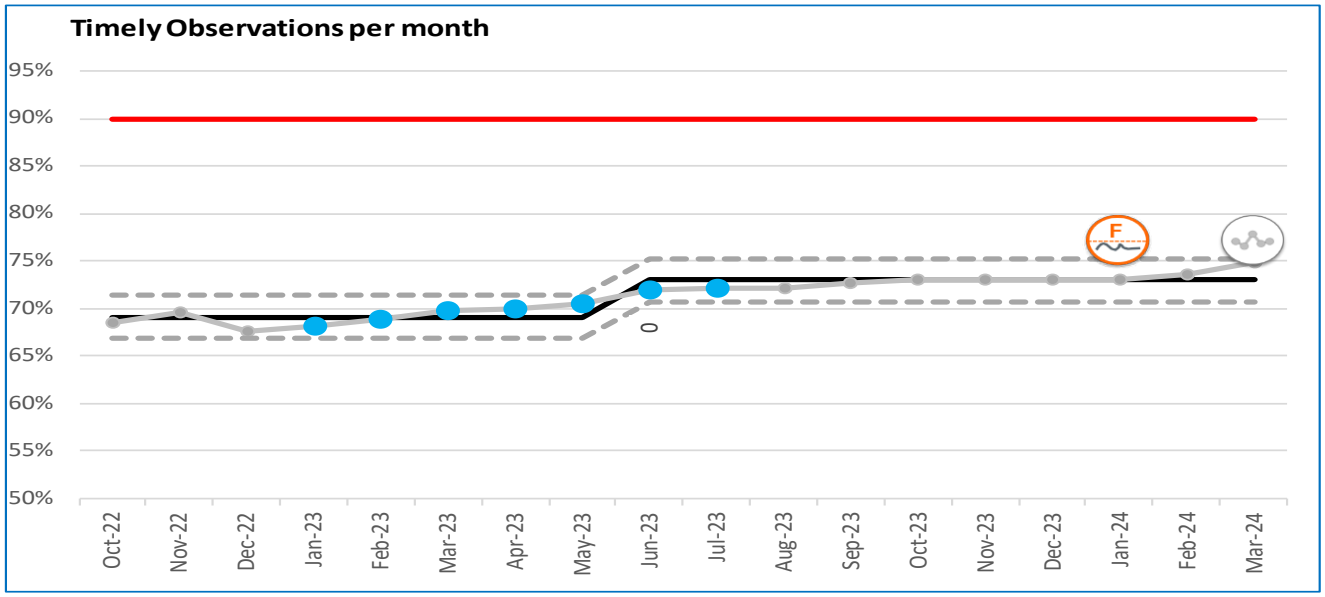
What do these results tell us?

- There were a total of 95 surveys were received in March 2024 across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 21 of these being collected for the "Birth" touch-point, providing an 4% response rate (based on number of live births) and 95% satisfaction score which is a decrease on the previous month's figures.
- The Antenatal touch point scored 82% recommendation (17 surveys) which is a decrease on the previous month (83%). The post-natal ward touch point scored 90% satisfaction rate (51 surveys) which a decrease in both response rate and satisfaction percentage from the previous month.
- Compared to the latest national data available (Feb 24) out of 112 reporting Trusts, UHNM were 52nd for number of responses for antenatal & 75% for percentage positive; 72nd for number of responses for birth & 26th for percentage positive, 34th for post-natal ward & 50th for percentage positive; and 23rd for post-natal community & 6th for percentage positive.

Actions:

- Continue to monitor the efficacy of collecting feedback via text message
- Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.
- Discuss with management team with regards to increasing survey completion for post-natal community.

Timely Observations



What do these results tell us?

Compliance remains well below the 90% target in March 2024. A small improvement has been seen since mid 2023, though progress has been slow. Compliance for March 2024 was 74.9%.

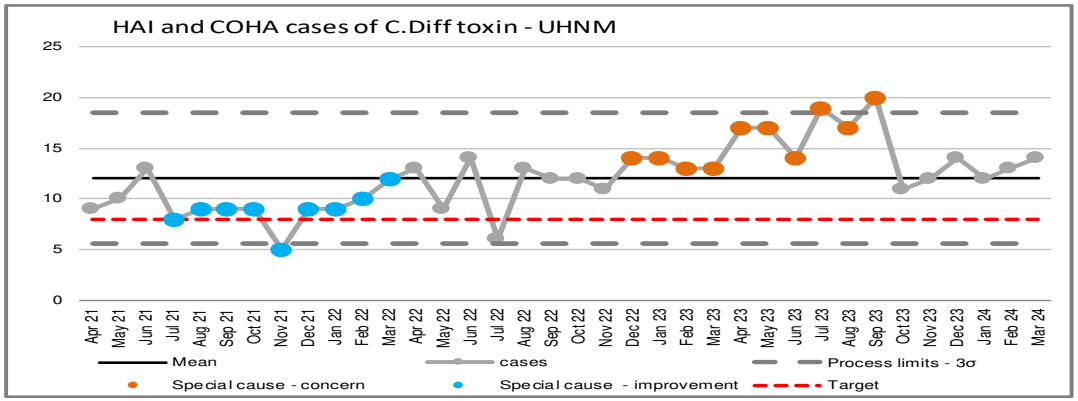
Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance.

Medicine, Surgery and Network Divisions have timely observations as a Driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance. This is being led by the Deputy Chief Nurse and CNIO.

Only Ward 113 had compliance below 50%, at 49.7% in March.

4 wards had compliance between 50 – 60%: Ward 128, Ward 78, Ward 76B, Ward 230.

Reported C Diff Cases per month



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
8	12	13	14

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Number of C Diff cases are outside SPC limits and normal variation

There have been 14 reported C diff cases in February 2024. 13 x HAI and 1 x COHA

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)

COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

There has been three clinical areas with more than one Clostridium *difficile* case within in a 28 day period which triggered in February . Where ribotypes are different person to person transmission is unlikely.

Ward 79 2 x HAI both ribotype 014

Ward 78 3 x HAI awaiting ribotypes

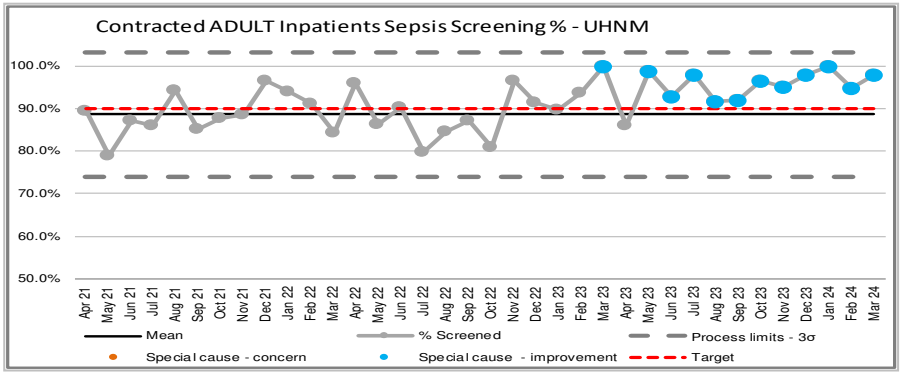
Ward 80 2 x HAI awaiting ribotypes

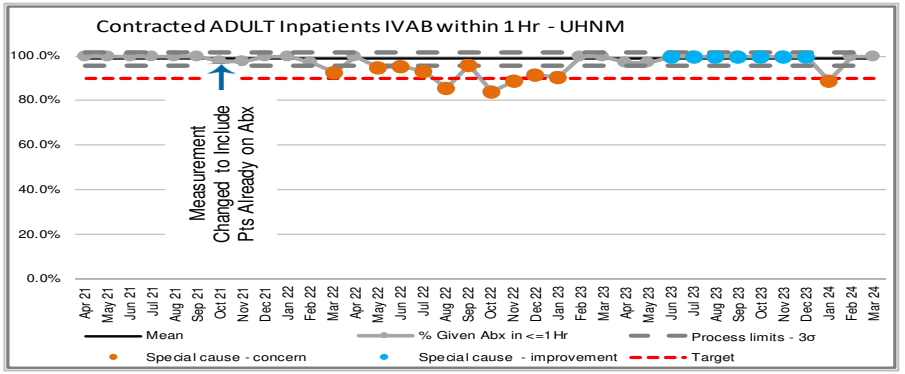
Actions:

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Task and Finish Group for West Building in place
- CURB -95 score added to CAP antimicrobial Microguide
- Campaign commenced in West Buildings to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- AMU and FEAU also targeted as antibiotics are generally started in the admission portals
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Consultant Microbiologist presented to ED and Elderly Care Doctors on Cdiff and antibiotic guidelines
- Consultant Microbiologist continues rounds on the Elderly care wards in West Building
- IP review of emergency portal environment
- CDI bench marking to comparative Trusts to commence in March

Sepsis Screening Compliance (Inpatients)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Jan 24	Feb 24	Mar 24
90%	100.0%	94.8%	97.9%

Background

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

Variation	Assurance
	P

Target	Jan 24	Feb 24	Mar 24
90%	88.9%	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:

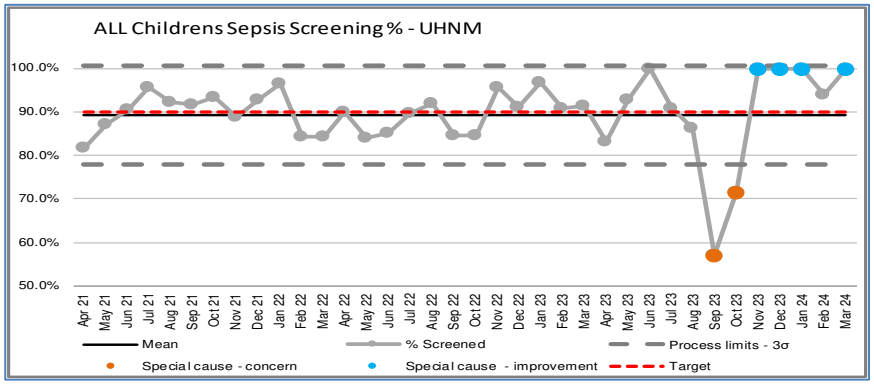
Inpatient areas achieved the screening and the IVAB within 1 hour target for March 2024. There were 96 cases audited with 2 missed screenings. Out of 96 cases audited, 71 cases were identified as red flags sepsis with 47 cases having alternative diagnosis and 24 were already on IVAB treatment.

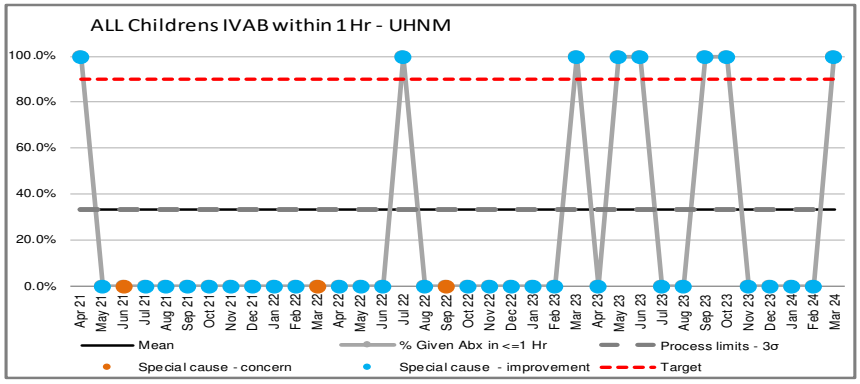
Actions:

- Sepsis sessions/ kiosks continue to all levels of staff in the clinical areas that required immediate support: 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 continue to promote sepsis awareness and best practice in both sites

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Jan 24	Feb 24	Mar 24
90%	100.0%	94.1%	100.0%

Background

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

Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
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:

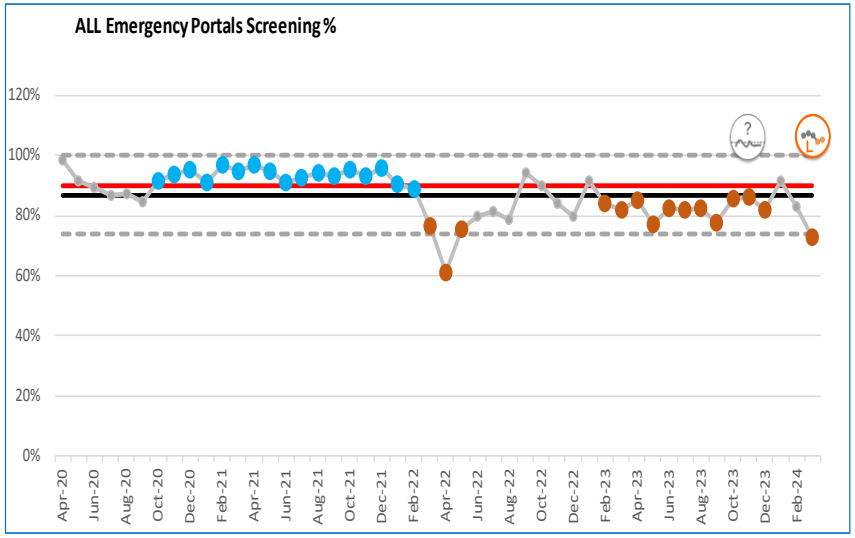
Children's Services target rate of > 90% was achieved for March 2024. We are still seeing a small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 18 cases audited for emergency portals with 0 missed screening. No true red flag sepsis was identified from the randomised audits in inpatients and emergency portals.

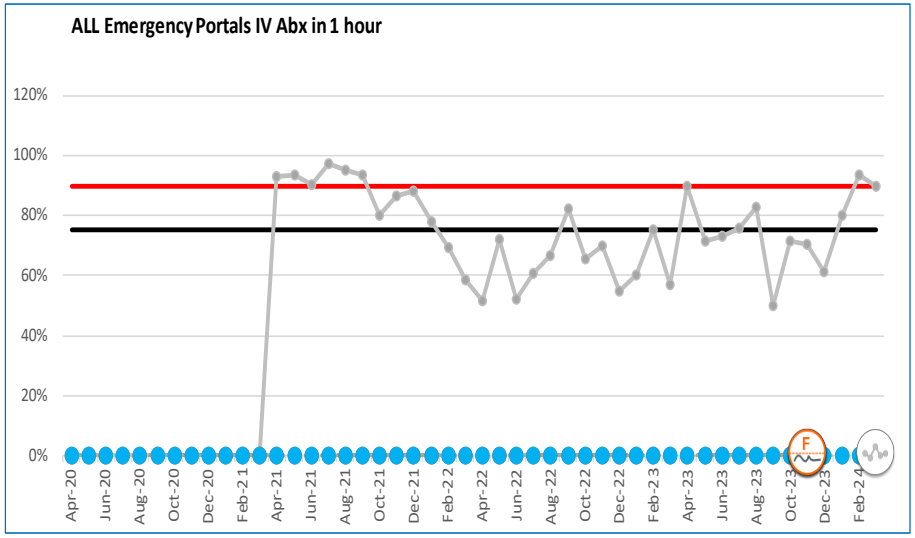
Actions:

- Children emergency portal sepsis screening and documentation is now available electronically
- 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 Induction training when required: on-going
- The children department is aiming to implement the new National PEWS chart and sepsis screening tool guidelines in the coming weeks/months which will be supported by the sepsis team.

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 rate for March 2024. There were 66 cases audited with 18 missed screening (patients are escalated but no documentation available in the screening tool) in total from the emergency portals. The performance for IVAB within 1 hour achieved 89.7 %, which is a very good improvement from previous months. Out of 66 cases, there were 55 red flags sepsis in which the 16 cases already on IVAB, 13 cases were newly identified sepsis, and 26 cases have alternative diagnosis. There were 2 delayed IVAB by ED Royal Stoke. Missed screening contributed by ED & AMU Royal Stoke 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.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff will continue
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- Sepsis Champion Day training is organised for both ED sites with good attendance from Jan 2024 and this will carry on monthly or bi-monthly as planned
- Good emphasis of Deteriorating Patient Reviewer (DPR) Vocera in ED, enable the assigned clinician to review and provide timely assessment, treatment and escalation of patients whose condition meeting the NEWS2 medium to high-risk sepsis triggers.
- Working towards implementation of electronic screening
- There is an on-going plan implementation of the new Sepsis NICE & AoRMC guidelines once the update is available in the sepsis vitalpacs (digital system)

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

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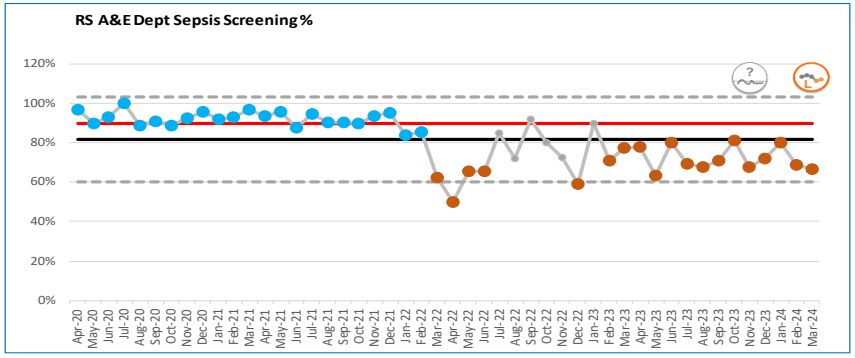
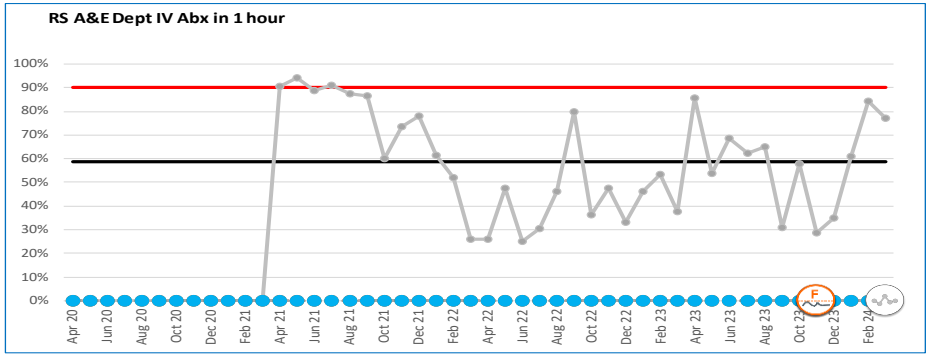
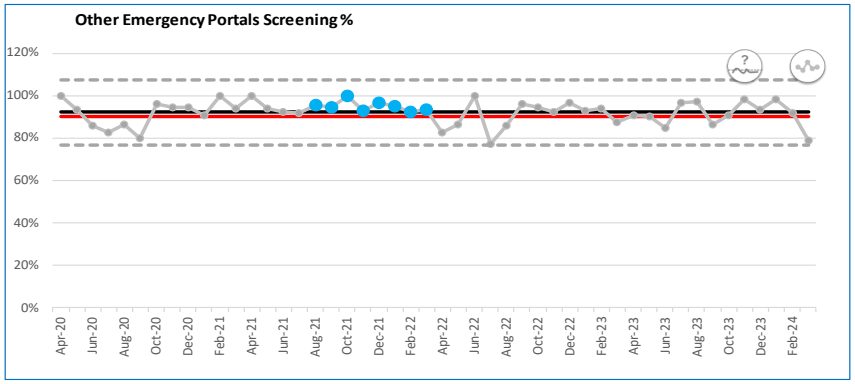
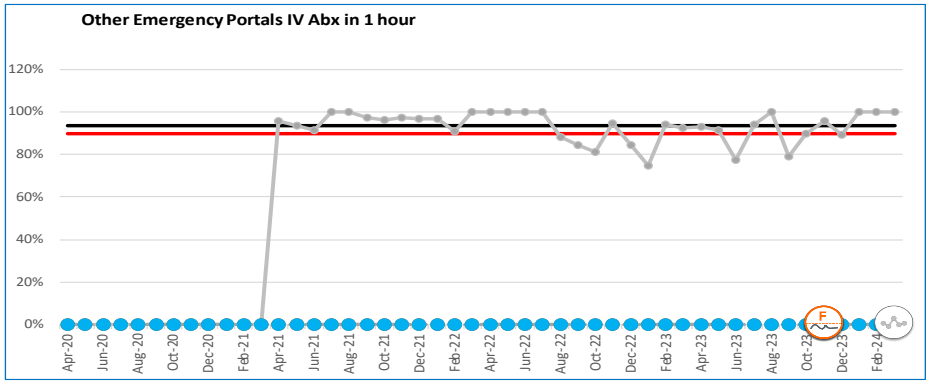
University Hospitals of North Midlands
NHS Trust









What is the data telling us:

Both Emergency Departments remain below target rate for screening for March 2024. Also reduced performance for other ED portals in screening., to include AMU at County and SAU. ED at Royal Stoke remain below target for the delivery of IVAB.

Actions:

- To provide short sessions in ED staff during the winter months focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers: on-going
- Deteriorating Patient Reviewer (DPR) is currently in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high-risk sepsis.
- Colleagues from the ICB visited ED on 30th November 2023 to review practice in terms of sepsis screening and verbal feedback has been positive and the written report is available.

Sepsis Screening Compliance ALL Maternity

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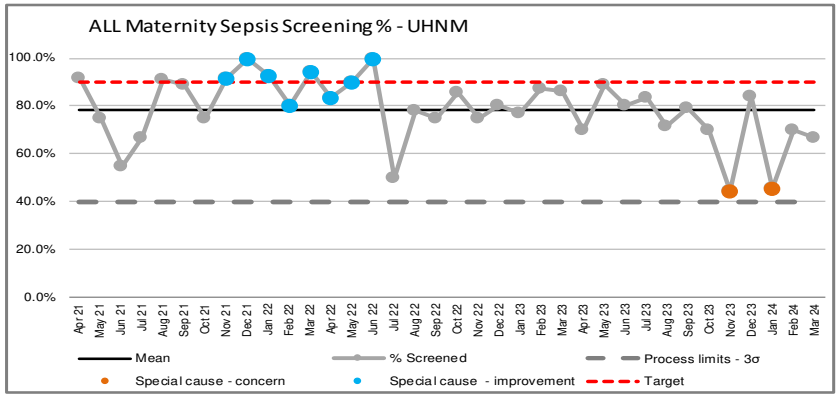
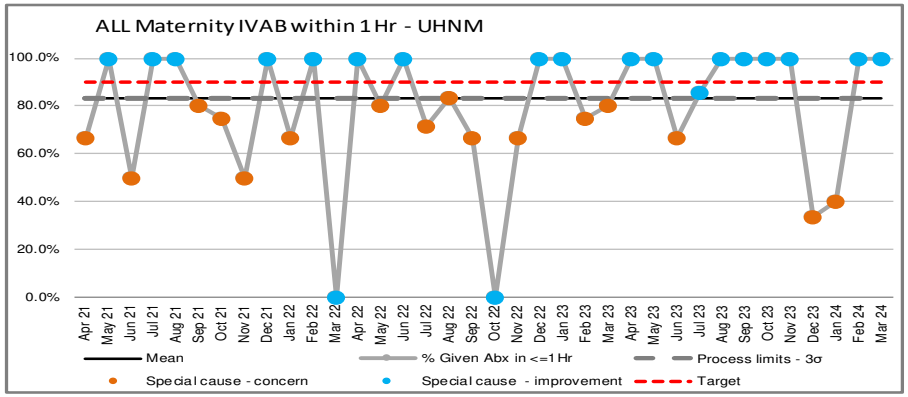
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
	?

Target	Jan 24	Feb 24	Mar 24
90%	45.5%	70.0%	66.7%

Background

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

Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
90%	40%	100%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below target this month for emergency portals. Inpatient areas are also well below target for screening. The compliance was above target for IVAB within 1 hour. This compliance score is based on a very small number (cases).

There were 9 cases audited from emergency portal (MAU) and 6 cases from inpatients with total of 5 missed screening (has been escalated but no documentation in the screening tool).

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; still awaiting finalisation
- Monthly Maternity sepsis skills drill is now replaced with ad hoc sepsis sessions in each clinical areas; on-going
- Sepsis sessions will focus and highlight the importance of screening documentation
- The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team

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NHS Trust

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Urgent and Emergency Care Performance (Non-Elective Care)

- Context
  - 12 Hour Trolley Waits increased from 943 in February to 1033 in March, equating to an increase of 8.72%
  - Type 1 A&E Attendances increased from 13019 in February to 14057 in March, equating to an increase in attendances by 7.84% .
- Driver Metrics
  - Four Hour Performance improved from 63.9% in February to 70.2% in March. This was an improvement of 6.3%. This the first time since 2012 >70% has been achieved.
  - 12+ Hours In ED increased from 1943 in February to 1987 in March, equating to an increase of 2.22%
  - Ambulance Handovers <60 Minutes improved from 72.8% in February to 71.3% in March. This demonstrated an improvement of 1.5%.

Planned Care, Cancer and Diagnostic Performance (Elective Care)

Diagnostics Summary

- DM01 activity in March was below 19/20 levels, however data is unvalidated.
- DM01 performance was 68% overall in March, a drop of 8.8% from February (76.8%).
- Endoscopy performance is the main contributor to this performance being below the national target of 99%, however in month reduction of ultrasound should be noted with recovery plans in place.

Endoscopy:

- Insourced weekend service continued alongside an additional locum in the service, following external funding from WMCA. Confirmation that this funding has been supported to continue into Q1 24/25 from WMCA.
- Routine, urgent, surveillance and planned patients continue to wait longer than expected. Maximising in week sessions and use of CNS TI's, additional support from surgeons and 18 Weeks Insourcing to support these cohorts
- Long term trajectory and resource requirement submitted but funding not currently available to further drive non-cancer cohorts
- Request to Proceed drafted to request funding for recovery and BAU activity and ERF papers submitted.
- Management team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including admin and clinical validation). Demand and Capacity model reworked.
- Sustained improved booking performance for lower cancer PTL patients – now 3-4wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions
- Four Eyes Insight on to Week 3 of the 2nd phase of the Improving Efficiency Programme within the Endoscopy service. Awaiting Executive sign off to extend Phase 2 to a 24-week FEI led programme.

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Referral to treatment (RTT Planned Care and Elective Recovery)

- 104ww - one patient was waiting in March – identified as a pop-up returned from an ISP due to admin error. He has now been treated.
- 78ww March was 70 as the final validated position
- 78ww March April is 11 for UHNM. The overall Referral To Treatment (RTT) Waiting has increased again this month to 81,258 (unvalidated), from 226 in February.
- Day case as a % of all elective work is currently 87.5%.

Cancer

- Cancer Waiting Times standards have been amalgamated in to three simplified metrics; 28 Day Faster Diagnosis set at 75%, 31 Day Decision to Treat to Treatment set at a 96%, and 62 Day Referral to Treatment set at 85%.
- Combined 62 Day Standard achieved 59.1% in February. The current provisional position for March is 61.4%.
- The combined 31 Day Standard achieved 89.5% in February. It is predicted to land at 91.9% in March.
- The combined Faster Diagnosis Standard achieved 75.1% in February. It is predicted to land at around 75% in March.
- The total GP referred suspected cancer PTL sits around 3300 in total currently; reflecting higher than usual demand.
- UHNM has achieved the 62 day backlog recovery trajectory to return the number of patients waiting over 62 days to pre-pandemic levels by March 24. The 'fair share' aim was to have a backlog of no more than 273, the backlog at the yeah end was 222, achieving a much better position than the fair shares allocation.
- UHNM continues to receive and see a high volume of GP suspected cancer referrals, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received. Referral optimisation support is being sought from the ICB.

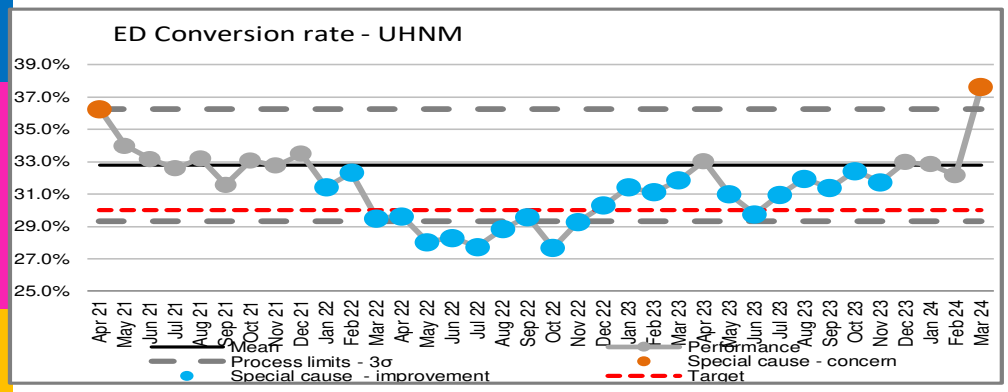
The National Cancer Team have written to UHNM congratulating us on the 35.4% reduction in the backlog and the 12% improvement in Faster Diagnosis performance. It was noted our improvements are some of the most positive progress seen anywhere nationally, and that UHNM have been a significant contributor to the overall national position to reduce the backlog to pre-pandemic levels.

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

NHS University Hospitals of North Midlands NHS Trust

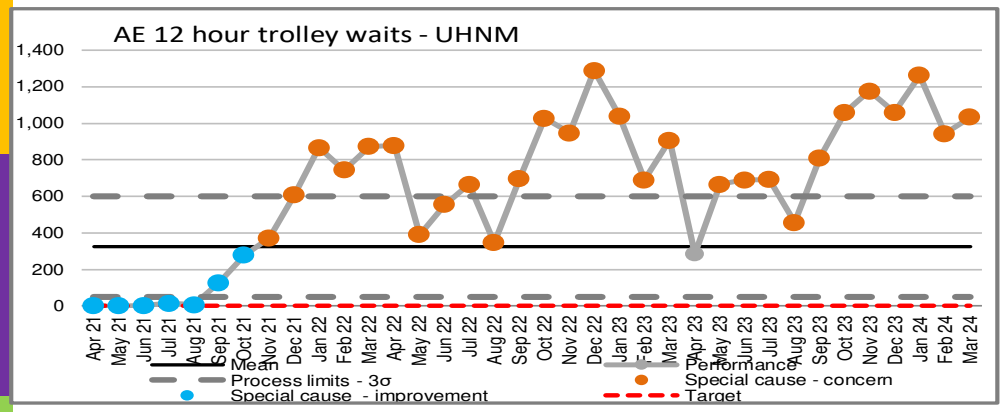


Variation	Assurance
H	?

Target	Jan 24	Feb 24	Mar 24
30%	32.8%	32.2%	37.6%

Background

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

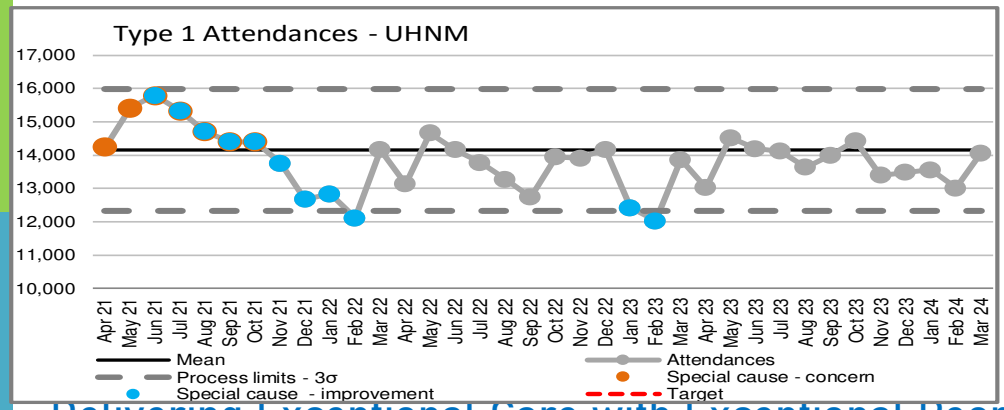


Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
0	1263	943	1033

Background

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



Variation	Assurance

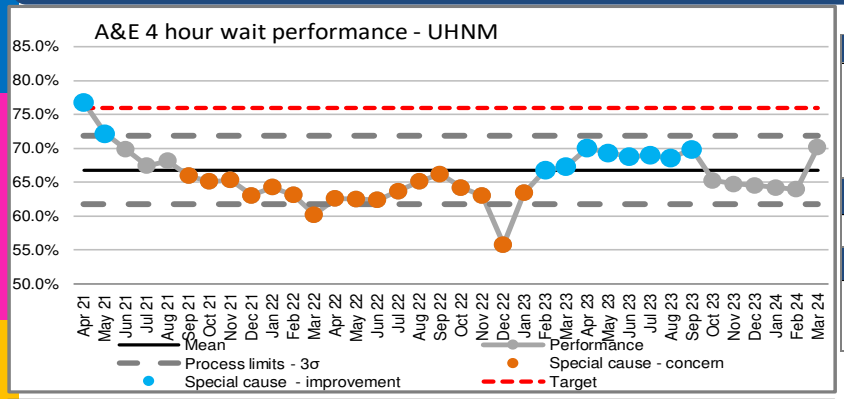
Target	Jan 24	Feb 24	Mar 24
N/A	13560	13019	14057

Background

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

Non-Elective Care – Headline Metrics

NHS University Hospitals of North Midlands NHS Trust



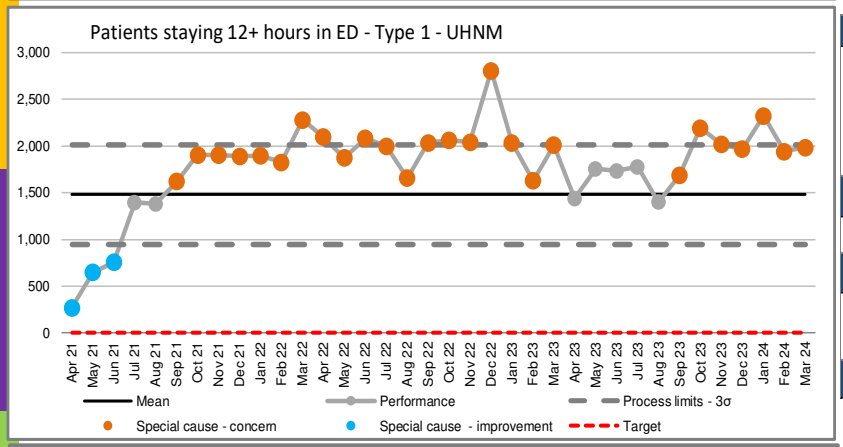
Variation	Assurance
	F

Target	Jan 24	Feb 24	Mar 24
76%	64.2%	63.9%	70.2%

Background

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

4 hour performance improved significantly in March 24, reaching 70%, the highest performance since September 23.



Variation	Assurance
H	F

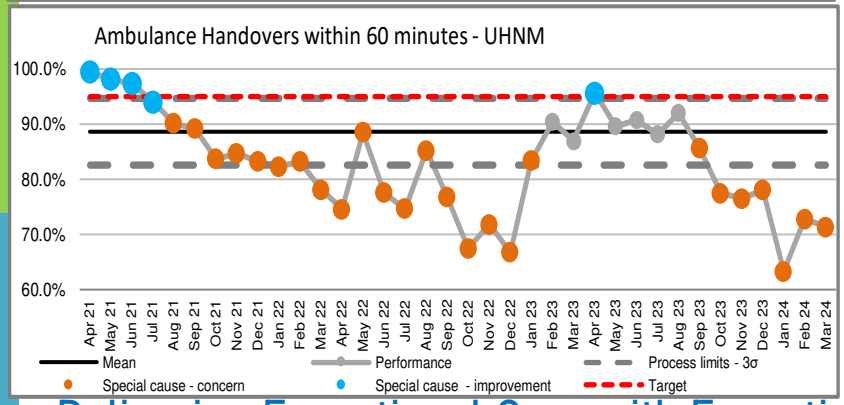
Target	Jan 24	Feb 24	Mar 24
0	2325	1943	1987

Background

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

What is the data telling us?

Patients waiting over 12 hours in ED remained consistent to February 24.



Variation	Assurance
L	F

Target	Jan 24	Feb 24	Mar 24
95.0%	63.3%	72.8%	71.3%

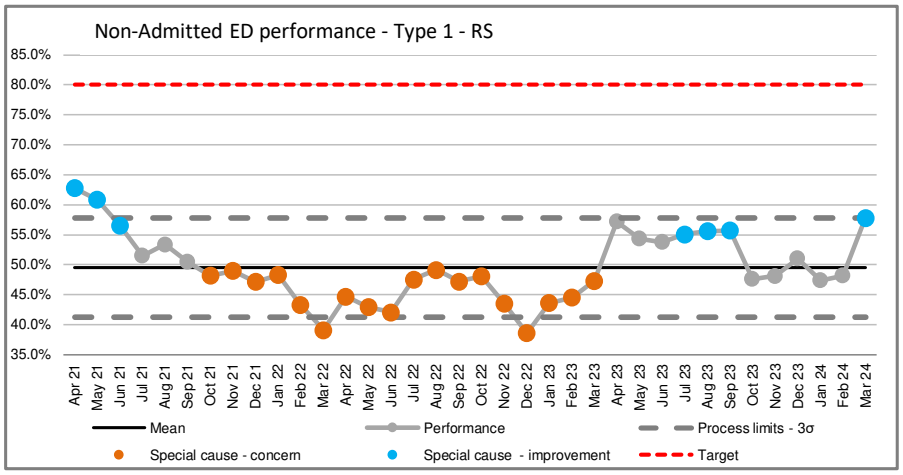
Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes remained relatively consistent to February and considerably lower than the same period last year.

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
80%	47.4%	48.2%	57.8%

Summary

Workstream 1 driver metric 4-hour non-admitted performance was 57.6% for March which demonstrated an increase in performance by 9.4%, discussions are being undertaken within the workstream to ensure that they build on this increase in performance. The workstream identified immediate actions to support achieving the combined performance of 76% including increase in medical staffing dedicated to the ambulatory stream, test of change to reduce DTA's held in Ambulatory and protected staffing in Ambulatory CDU to ensure consistent utilisation which has supported the increase in performance.

Actions

Additional Senior Decision maker allocated in the ambulatory stream which has indicated a slight and consistent improvement in performance continues to be monitored daily using the new dashboard.

Children's ED subgroup focusing on reviewing patients earlier in the journey. EhPC utilisation, particularly in the morning to create flow, senior leadership reviewing rotas, navigation, creation of a navigation shift focusing on standard work.

CDU has been consistently open since the 20th February and staffing is in place to ensure this can continue to be utilised. A review has been completed to understand missed opportunities and an action to review the acceptance criteria is currently being undertaken.

Ambulatory standard work, reviewing and enhancing previous work undertaken. Data review of DTA's in ambulatory (over the last 12 months) to determine potential gains to support 4-hour performance. In the meantime, proactive management of DTA's through the ED Huddles.

Data review of deflections from the ED to support increase in SDEC utilisation.

Standard work for the navigator to have a view of EhPC and ED numbers to ensure proactive management of demand is undertaken.

Workstream 2; Standard Work
Pre-Noon Discharges

NHS
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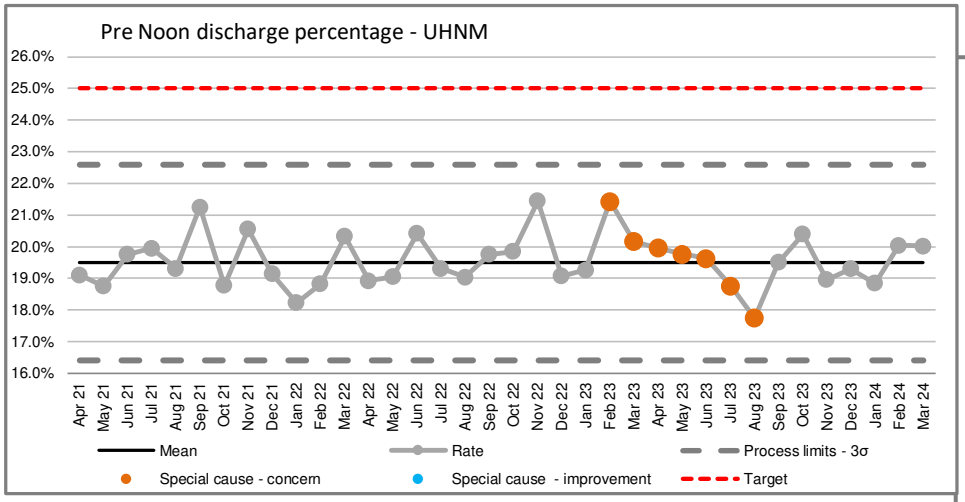
NHS Trust



Variation	Assurance
	F

Target	Jan 24	Feb 24	Mar 24
25%	18.8%	20.0%	20.0%

Background

The percentage of discharges complete before 12 noon.

Summary

The overall Trust performance against pre-noon discharges for non-elective wards only for March was 15.5%, for Royal 16.4% (increase from 15.8% in February) and County 9.4% (reduced from 11.4% in February). The Test of Change (ToC) has completed, and the wards are continuing with the rollout which is being monitored through this workstream.

Actions

Additional wards have now been identified, Ward 122 and Ward 78. Baseline observations have been undertaken and are due to start the standard work, the driver meetings continue regularly through the week to support progress.

The other 4 countermeasures identified through the root cause both within the workstream sessions undertaken and through the ToC and will support earlier in the day discharges. The top contributors identified are forming the below subgroups:

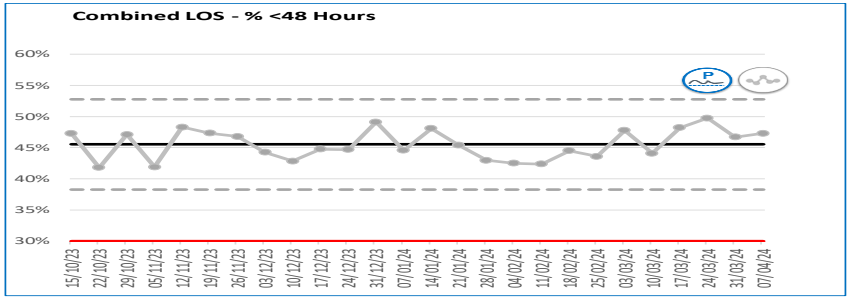
1) TTO Subgroup
2.Transport Subgroup
3.Treatment & Diagnostics Subgroup
4.Discharge Process Subgroup

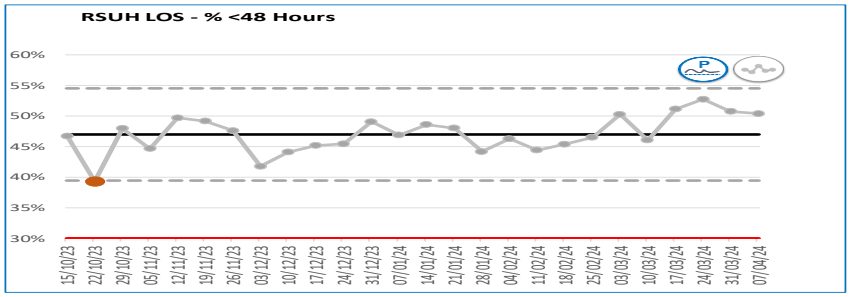
These are in the development stages and a root cause analysis to be undertaken.

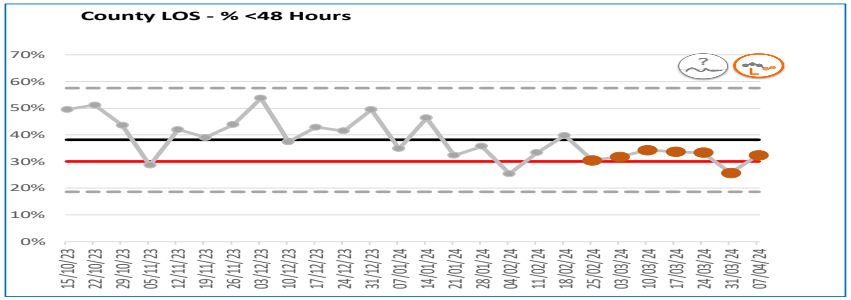
ToC Update

The ToC summary for the 4 identified wards (76b, 120, 128 and 230) stated that over the week there was a reduction in patients waiting over 12 hours by 5.8% on average. This was facilitated by increase in discharges across the medicine division by 20.3% with an average of 2.2 per day length of stay reduction across the 4 wards. The ToC continues to focus on developing a product Standard work detailing how to adhere to SAFER principles, which will be iterated and spread to different wards. **Continuation of this work is an identified countermeasure for workstream 2.**

Workstream 3; Frailty
75+ Patients with LOS <48 Hours







Summary

March combined performance against the driver metric of 75% frail patients with a LoS < 48 hours was 46.9% (increase of 1.3% from last month). The goals have been agreed for each countermeasure of 5% improvement by October increasing to 10% by end March 2025. A review of the data is being completed to identify a phased target which will be agreed at the next workstream meeting.

Actions

The leads for each of the goals are prioritising the below actions:

Actions to achieve Goal 1

- Develop the pathways in the Acute Care at Home team to support the deflection from ED.
- Home Care is Best Care Programme – Incorporating a risk and benefit assessment against potential admission.
- Evaluation of the ambulance service conveyancing review.
- Education piece to WMAS on safeguarding v safety.
- Test of Change (4 weeks) in ED at County for extended day therapy service.
- Test of Change IDH in-reach to ED to explore opportunities.
- Alignment of front of house service across both sites.

Actions to achieve Goal 2

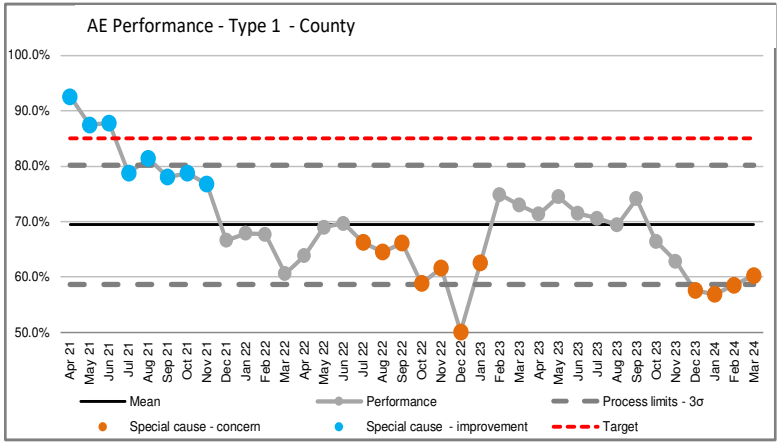
- Single pathway document incorporating CGA and admission document together with a plan to roll out across both sites. CGA workshop planned.
- Ensure RESPECT documentation is mandatory for all appropriate frail patients, with a focus on quality documentation.
- Deconditioning strategy.
- Increasing utilisation of virtual ward for frail complex patients.

Achieve Goal 3

- Education - discharge pathways and understanding of community pathways.
- Transforming the discharge facilitation model to reduce the length of stay for patients (against the discharge ready date) for complex frail patients (IDH).
- End of life pathway – to reduce the length of stay and improve discharge pathway.
- Early supported discharge for patients with therapy needs.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Jan 24	Feb 24	Mar 24
85%	56.9%	58.6%	60.2%

Summary

Workstream 4 driver metric of 4-hour performance for County site achieved 60.2% in March (2.4% higher than last month). During March Patrick Wilkinson took over as lead for this workstream and ongoing monitoring was undertaken to support increasing performance and discussions within the workstream to build on the improved performance.

Actions

Workforce: Workforce modelling in ED being undertaken to determine senior medical support requirements against demand profile.

Ambulatory: Ambulatory standard work and review of the MRU (SDEC) model to explore further opportunities and ensuring alignment with future model.

Review of radiology and pathology support to prevent delays and support performance.

Triage: Continue with staffing review for triage, however this may require a business case if uplift is identified.
To support surges in attendances, a potential area for an additional triage room as been identified, a feasibility study with IP support is being undertaken.

AMU standard work: Aligning to ToC objectives currently being undertaken at the Royal site (refer to WS2 detail).
TTO's: avoiding delays due to errors – education piece being undertaken for junior doctors.

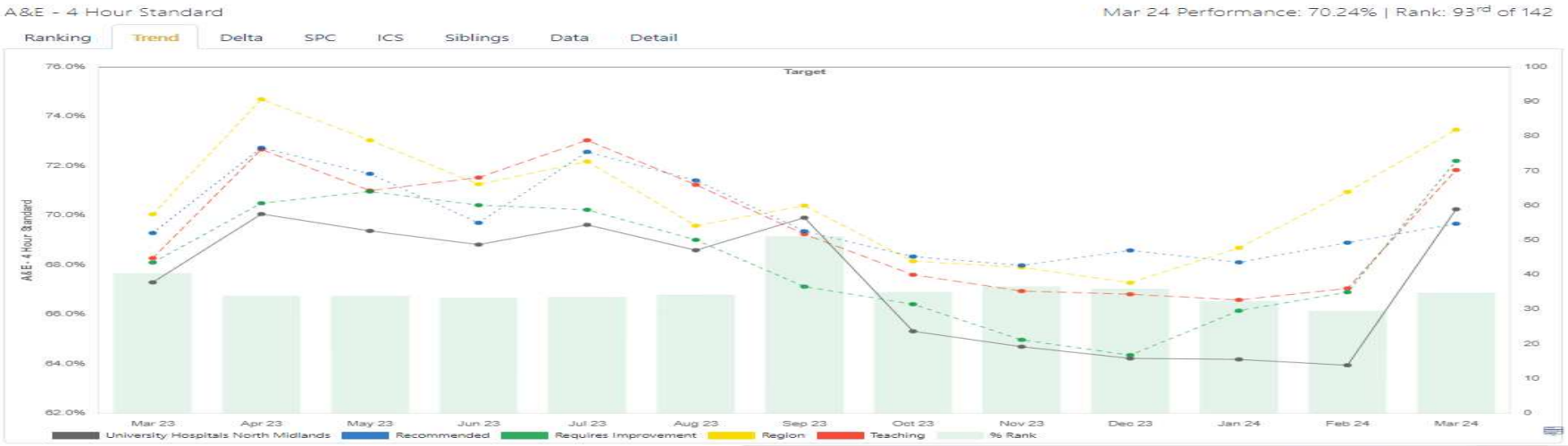
Length of stay reviews continue for long waiters and a score card has been developed to monitor progress.

AMU medical staffing review: Consultant vacancies out of advert, medical staffing demand profile review against rotas to support earlier discharges, ACP resource review across both sites to align resources to demand (new lead ACP will be leading on this review).

The County Frailty group is working closely with WS3 to ensure alignment of services across both sites. A single pathway document is in development incorporating CGA and admission document together with a plan to roll out across both sites. CGA workshop planned.

Urgent Care - 4 hour standard

NHS
University Hospitals of North Midlands
NHS Trust



Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Mar 24	1.0%	14.0%	
A&E - 4 Hour Standard	Mar 24	76.00%	70.2%	
A&E - 4 Hour Standard (Type 1)	Mar 24	76.0%	51.2%	
A&E - 4 Hour Standard (Type 2 or 3)	Mar 24	95.0%	99.2%	
A&E - Conversion Rate	Mar 24	25.0%	25.8%	
A&E - DTA to Admission >12 Hours	Mar 24	0.0%	17.2%	
A&E - DTA to Admission >12 Hours#	Mar 24	0.0	1,037.0	
A&E - DTA to Admission >4 Hours	Mar 24	10.00%	30.3%	
A&E - Left Without Being Seen	Feb 24	5.00%	7.0%	
A&E - Reattendance Rate	Feb 24	5.0%	9.1%	
A&E - Time to Initial Assessment	Feb 24	15.0	-	
A&E - Time to Treatment	Feb 24	60.0	91.0	
A&E - Total Time in A&E	Feb 24	160.0	195.0	
A&E - Total Time in A&E (Admitted)	Feb 24	180.0	415.0	
A&E - Total Time in A&E (Non-Admitted)	Feb 24	140.0	174.0	

- 4 hour performance in March improved across all peer groups including UHNM.
- UHNM saw the biggest improvement in March 2024 since May 2021.
- UHNM are now within range of other peer groups.
- UHNM remain in the third quartile.

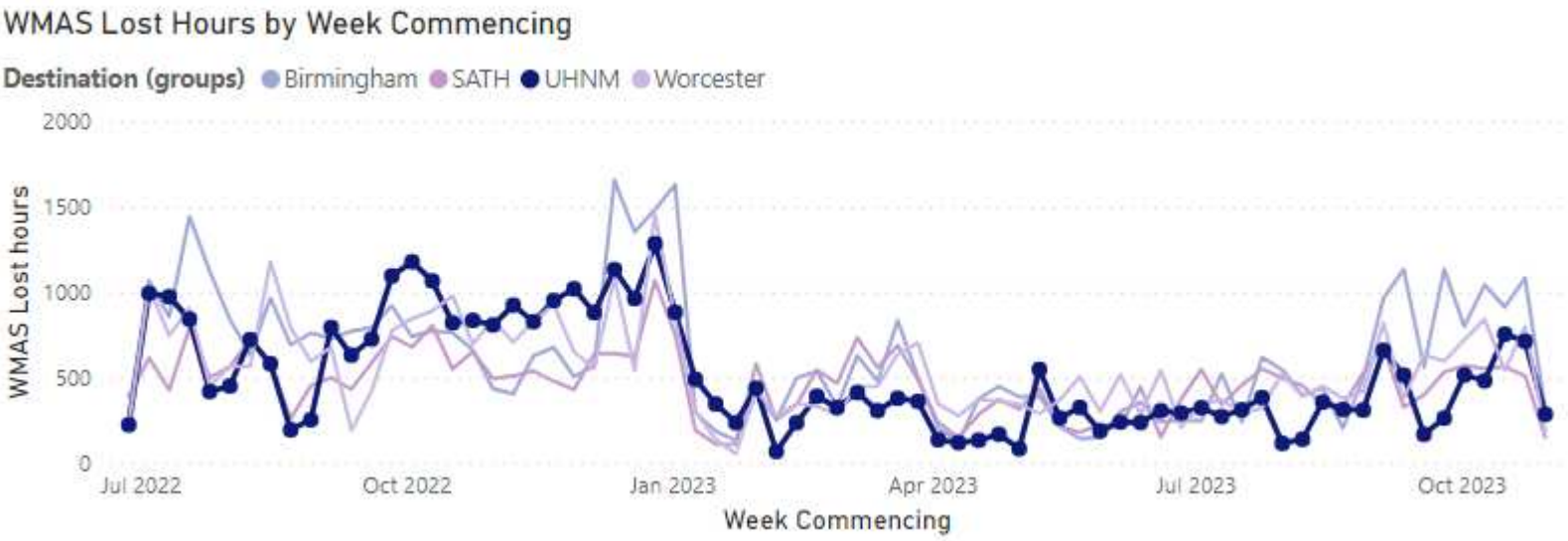
Urgent Care - 12 hour standard

NHS
University Hospitals of North Midlands
NHS Trust

- All peer groups have followed a similar trend since February.
- UHNM continue to have the highest percentage of 12 hour breaches compared to peer groups.
- UHNM remain in the lowest quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Mar 24	1.0%	14.0%	
A&E - 4 Hour Standard	Mar 24	76.00%	70.2%	
A&E - 4 Hour Standard (Type 1)	Mar 24	76.0%	51.2%	
A&E - 4 Hour Standard (Type 2 or 3)	Mar 24	95.0%	99.2%	
A&E - Conversion Rate	Mar 24	25.0%	25.8%	
A&E - DTA to Admission >12 Hours	Mar 24	0.0%	17.2%	
A&E - DTA to Admission >12 Hours#	Mar 24	0.0	1,037.0	
A&E - DTA to Admission >4 Hours	Mar 24	10.00%	30.3%	
A&E - Left Without Being Seen	Feb 24	5.00%	7.0%	
A&E - Reattendance Rate	Feb 24	5.0%	9.1%	
A&E - Time to Initial Assessment	Feb 24	15.0	-	
A&E - Time to Treatment	Feb 24	60.0	91.0	
A&E - Total Time in A&E	Feb 24	160.0	195.0	
A&E - Total Time in A&E (Admitted)	Feb 24	180.0	415.0	
A&E - Total Time in A&E (Non-Admitted)	Feb 24	140.0	174.0	

Urgent Care – Ambulance Handover Delays



- WMAS Ambulance handover delays over 60 minutes apportioned to four Trusts.
- During October UHNM have seen a worsening trend, but remain below/within peer trusts.

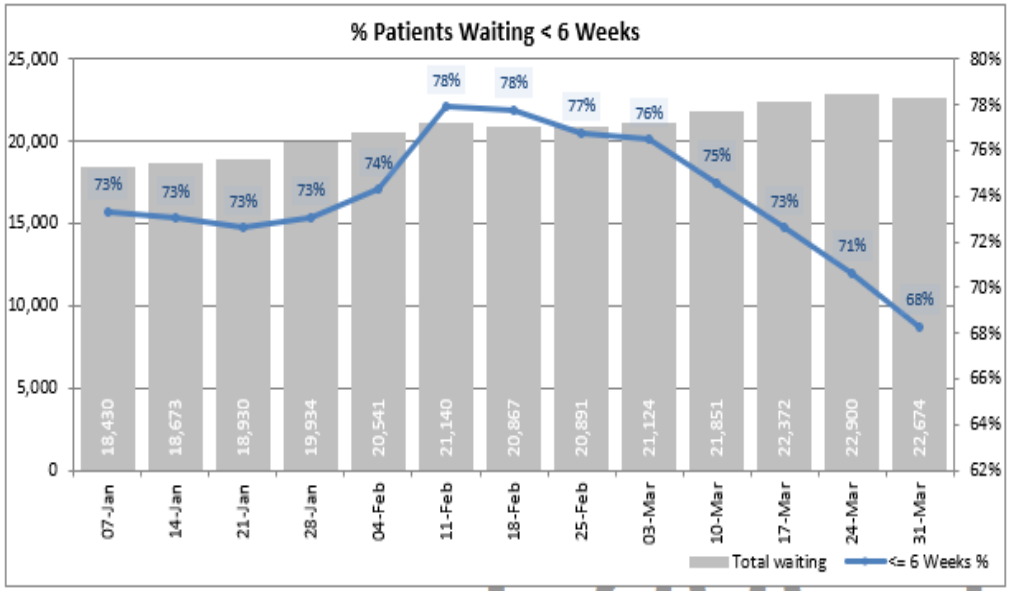
NB. Data not updated due to a data feed issue from WMAS which is being investigated.

Data source: WMAS 09/11/23

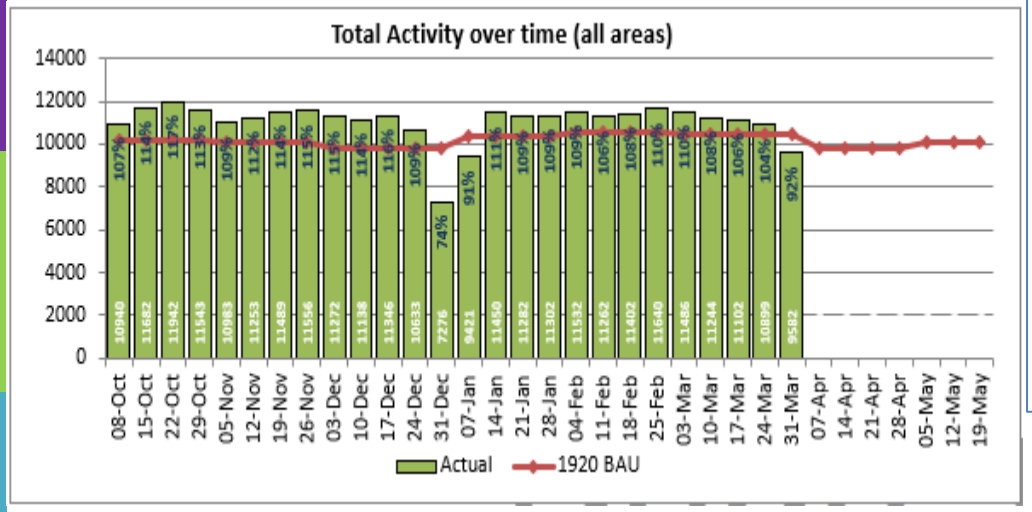
Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*

University Hospitals of North Midlands NHS Trust



Test	<=6	6-9	10-12	13+ Wks	Total	% <6Wks
Magnetic Resonance Imaging	3,289	565	10	1	3,865	85.1%
Computed Tomography	3,563	31	2	5	3,601	98.9%
Non-obstetric Ultrasound	5,166	2,696	403	6	8,271	62.5%
DEXA Scan	0	0	0	0	0	
Cardiology - Echocardiography	1,480	620	68	63	2,231	66.3%
Cardiology - Electrophysiology	0	0	0	0	0	
Colonoscopy	300	129	67	901	1,397	21.5%
Flexible sigmoidoscopy	214	102	59	699	1,074	19.9%
Cystoscopy	121	27	14	57	219	55.3%
Gastroscopy	444	130	74	238	886	50.1%
Neurophysiology	471	111	0	0	582	80.9%
Respiratory physiology	434	59	16	39	548	79.2%
Urodynamics	0	0	0	0	0	
Total	**15,482**	**4,470**	**713**	**2,009**	**22,674**	**68%**



Pathology*:*

The following represents performance as at 25th March 2024;

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 16 (No Change), with 80% of cases reported by Day 9 (Previously Day 10)
- Accelerated (include all Cancer Resections): 95% reported at Day 25 (no change) with 80% of cases reported by Day 17 (Previously Day 16)
- Routine (all Specimens not in above categories): 95% Day reported at 24 (No change) 80% of cases reported by Day 17 (No Change)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 65.5% against the Royal College of Pathologists' target of 80% within 7 days (previously 55%)

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

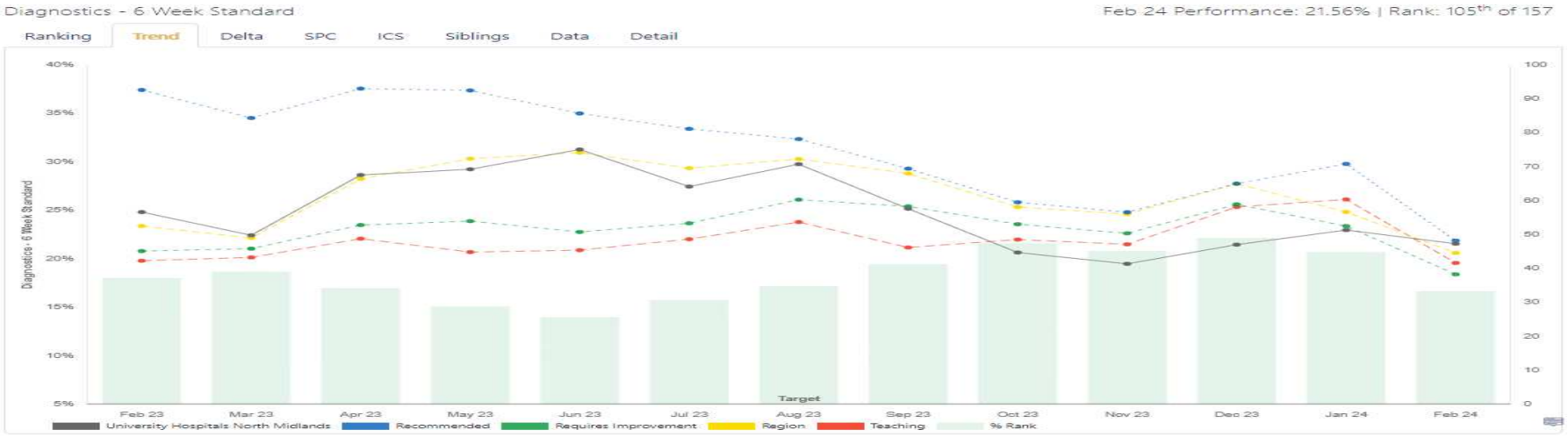
- DM01 activity in March was below 19/20 levels, however data is unvalidated.
- DM01 performance was 68% overall in March, a drop of 8.8% from February (76.8%). Endoscopy performance is the main contributor to this performance being below the national target of 99%. Ultrasound and MRI have also shown a dip in performance.

- In pathology 7 day reporting turnaround time (TAT) for Urgent cases is at 65.5% against the Royal College of Pathologists' target of 80% within 7 days (previously 55%)

Endoscopy remains the highest impact on diagnostic pathways. The specialty has now been taken into internal special measures with a turnaround lead being allocated and a number of actions in place:

- Insourced weekend service continues into quarter 1 of 24/25 following additional external funding from WMCA. This resource is specifically to support reducing cancer wait time but will support 78ww position.
- Concerns raised by surgical/gastro pathways that delays are hindering their ability to deliver 65wks by end of September although these patients have now all had their endo appointment confirmed and the team continue to track on a daily basis.
- Routine, urgent, surveillance and planned patients continue to have wait more than their target date. Maximising in week sessions and use of CNS TI's, additional support from surgeons and 18 Weeks to support these cohorts.
- Capacity and Demand model now reworked, showing a significant gap between funded capacity and sessions available through current estate.
- Request to Proceed and ERF Papers drafted to request funding for recovery and BAU activity.
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including admin and clinical validation).
- Sustained improved booking performance for lower cancer PTL patients .
- Improvement plan ongoing and workstream leads progressing actions.
- Four Eyes Insight on to Week 3 of the 2nd phase of the Improving Efficiency Programme within the Endoscopy service. Awaiting Executive sign off to extend Phase 2 to a 24-week FEI led programme.

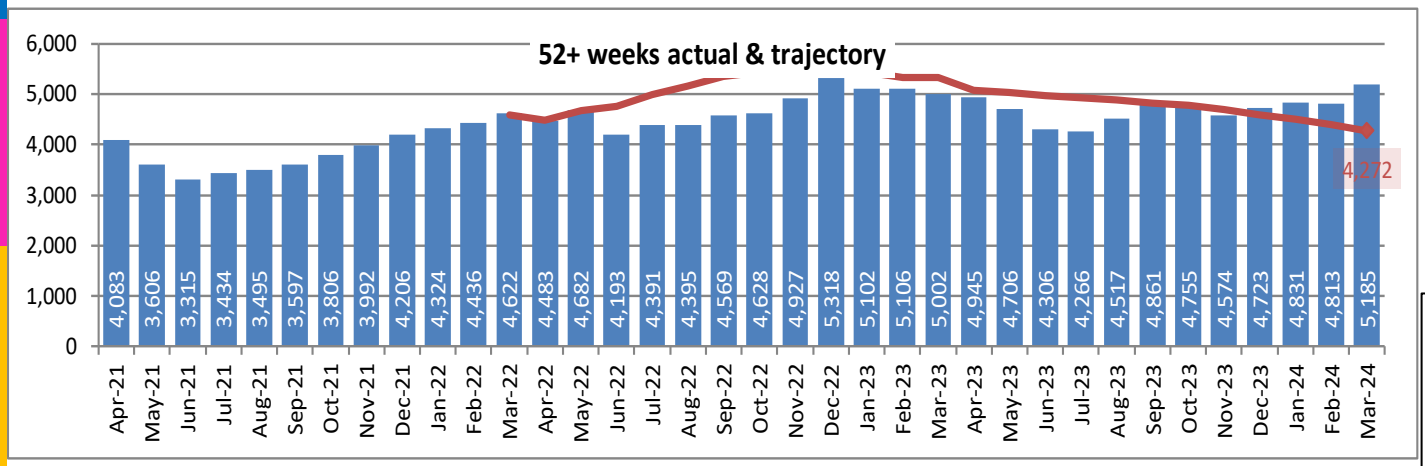
Diagnostics

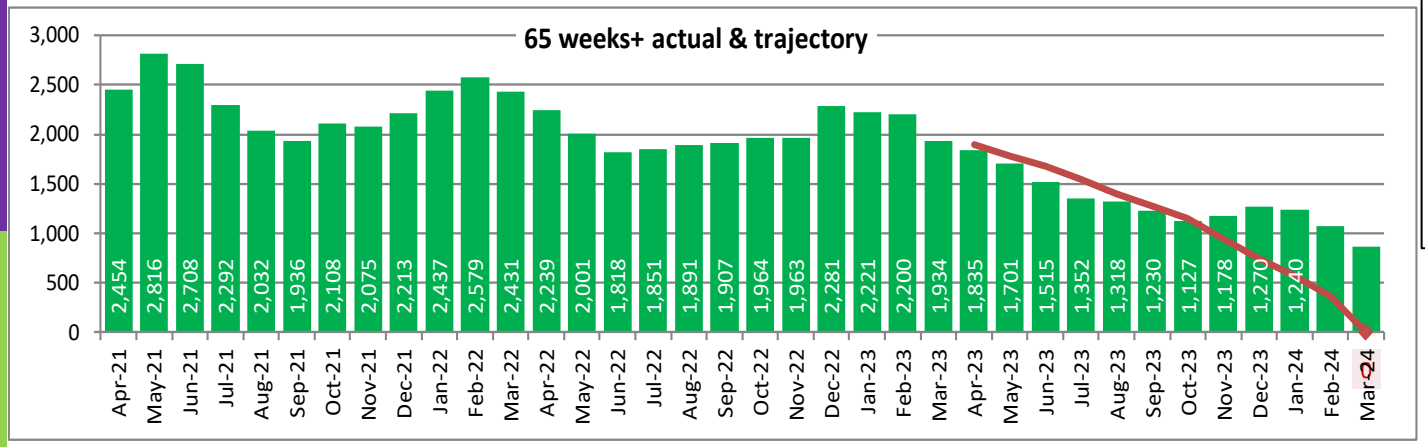


Key Performance Indicator	Period	Target		SPC
Audiology	Feb 24	5.00%	6.5%	
Colonoscopy	Feb 24	5.00%	70.8%	
Computed Tomography	Feb 24	5.00%	1.0%	
Cystoscopy	Feb 24	5.00%	9.3%	
DM01 Waiting <13 Weeks	Feb 24	100.00%	91.8%	
Diagnostics - 6 Week Standard	Feb 24	5.00%	21.6%	
Diagnostics - 6 Week Standard Reversed	Feb 24	95.00%	78.4%	
Echocardiography	Feb 24	5.00%	25.5%	
Electrophysiology	Feb 24	5.00%	-	
Flexi Sigmoidoscopy	Feb 24	5.00%	73.5%	
Gastroscopy	Feb 24	5.00%	46.6%	
Magnetic Resonance Imaging	Feb 24	5.00%	5.4%	
Neurophysiology	Feb 24	5.00%	13.6%	
Non-obstetric Ultrasound	Feb 24	5.00%	20.8%	
Sleep Studies	Feb 24	5.00%	8.5%	
Urodynamics	Feb 24	5.00%	-	

- All peer groups are performing at a similar level.
- Although all peer groups including UHNM have seen improvement in February, other peer groups have seen this at a greater level.
- All groups including UHNM remain significantly above the 1% national target.
- Non Obstetric Ultrasound saw the biggest deterioration in performance in February.
- UHNM remain in the 3rd Quartile.

Planned Care – *RTT*

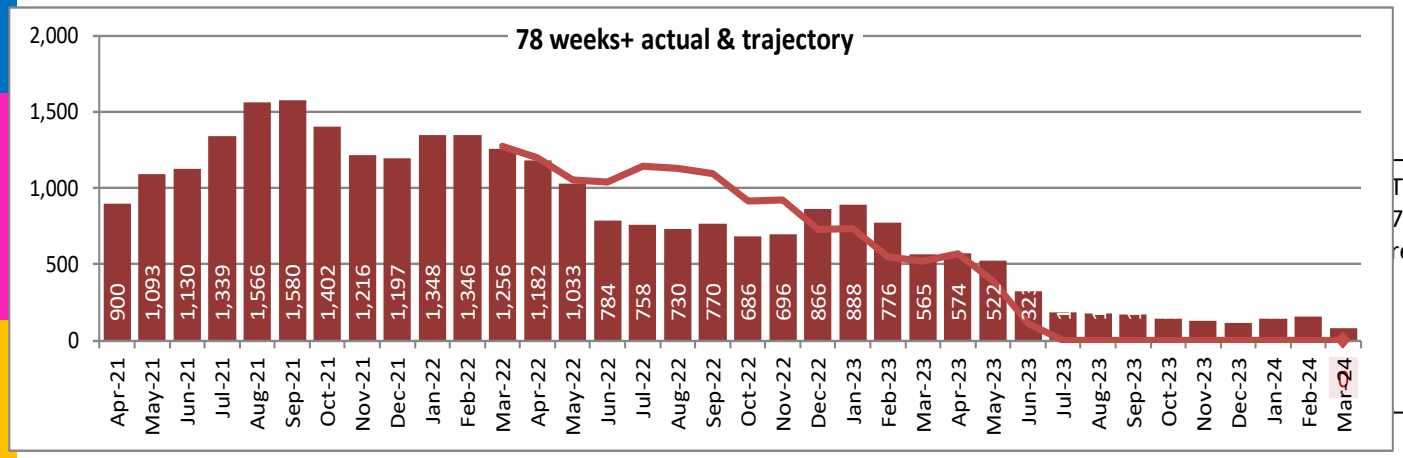




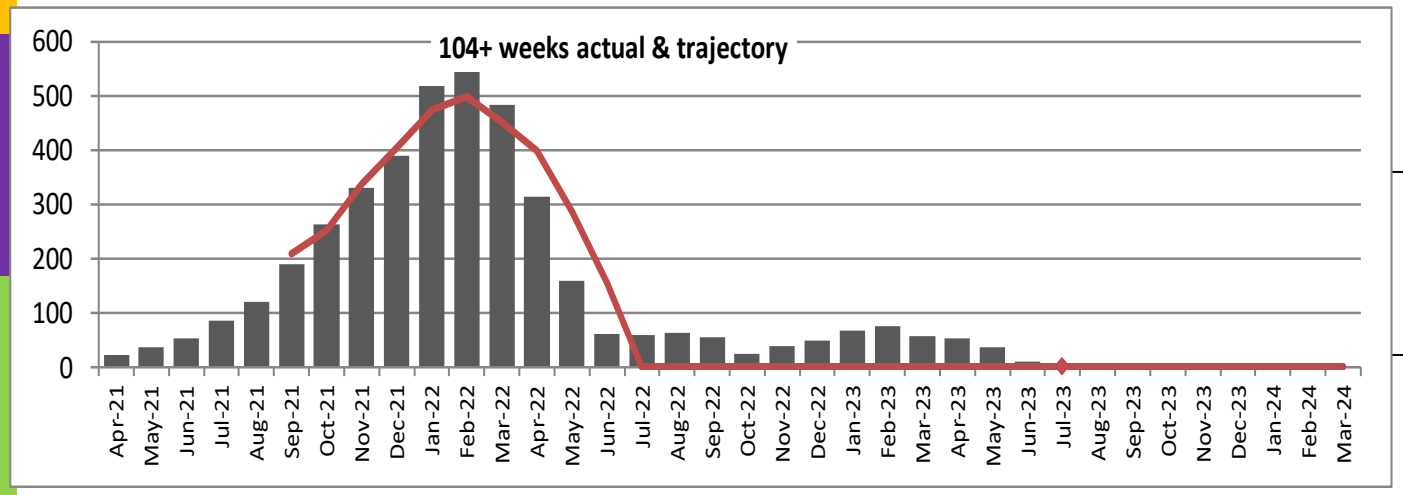
Patients waiting 52+ weeks has seen growth each month since November 2023. March volumes increased by 8%.

65+ week waiters reduced by 19% in March to 867.

Planned Care – *RTT Long Waiters*



The number of patients waiting over 78 weeks in March was 70, a reduction of 89 since February.



There is one patient who has been waiting 104+ weeks in March, who has now been treated.

Planned care - *RTT*

NHS
University Hospitals of North Midlands
NHS Trust

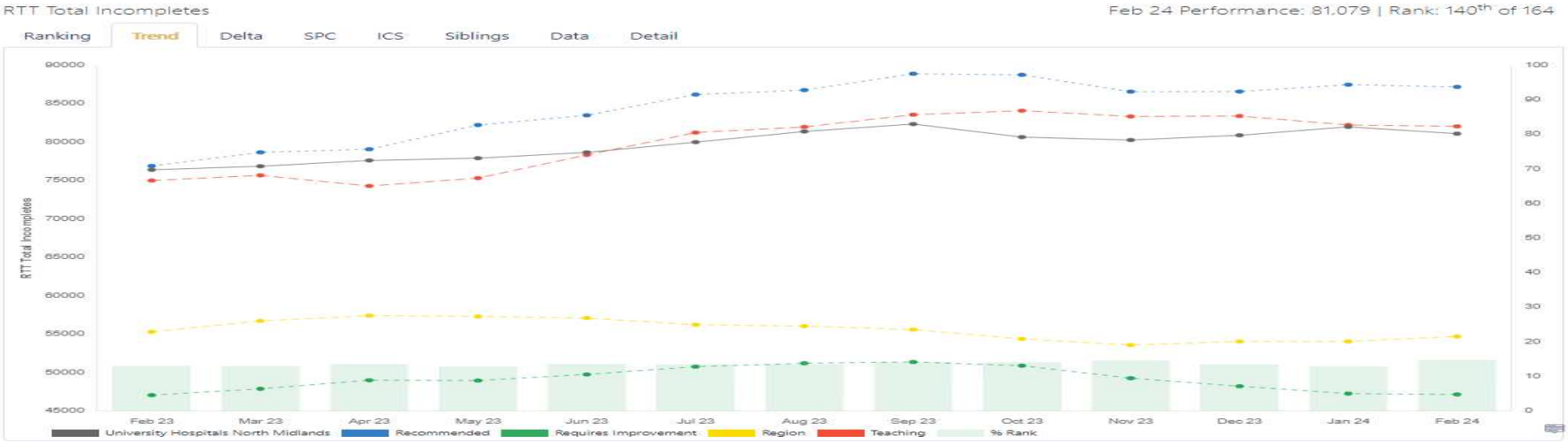
Summary

- 52+ week patients increased during February to 5,185 (unvalidated).
- 78+ patients have been gradually reducing, however, due to winter pressures and IA the number had increased to 159 for February (validated). The position for March is a considerable improvement, reducing to 70.
- The overall Referral To Treatment (RTT) Waiting list now sits 81,258 end of February (unvalidated).
- The focus continues on 78w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 65 week+ patients with the introduction of a weekly elective management oversight group.
- At the end of March the number of > 104 weeks was 1.
- The IS have taken over 1000 patients from Orthopaedics & Spinal (out of over 1000 considered), with a further 60 patients being worked through to contact & transfer each month.

RTT

- Validation has increased with some additional resource in the short term. Temporary validation resource has now ceased, decreasing Corporate Validation capacity by 60%.
- RTT Performance sits at 49.6%, a slight decrease from 49.8% in February.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 59% of all pathways over 52 weeks having been validated within the last 12 weeks. This is a reduction from last month's 69%
- 31,068 eligible patients waiting 12+ weeks were sent a validation form in October 2023, with 1,532 patients confirming they no longer wish to continue their pathway. 2,990 patients said their condition had changed since their referral. These are still being worked through by the clinical divisions. A further validation form invitation is planned to be sent during April.
- Trust wide revamp of validation & training underway, the IST are supporting the Trust with events in September – December to train all admin staff working with RTT. Training programme complete – 525 people attended training.
- Work underway to develop new training courses and add on to Intranet, with courses bookable on ESR. Planned Care Intranet page to be re-launched in April, with updated training materials.
- 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 at 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.
- Roll-out of Palantir's Foundry platform underway, validation of NON-RTT outpatient referrals commenced 21st November.

RTT



	Key Performance Indicator	Period	Target		SPC
150	RTT 104 Week Breach	Feb 24	0	4	
38	RTT 52 Week Breach	Feb 24	0	4,807	
1212	RTT 65 Week Breach	Feb 24	-	1,071	
949	RTT 78 Week Breach	Feb 24	0	158	
142	RTT 95th Percentile Admitted Waiting Time	Feb 24	18.0	70.6	
144	RTT 95th Percentile Non-Admitted Waiting Time	Feb 24	18.0	62.7	
135	RTT Admitted Treatment Within 18 Weeks	Feb 24	90.0%	52.8%	
141	RTT Average (Median) Admitted Waiting Time	Feb 24	9.0	15.3	
143	RTT Average (Median) Non-Admitted Waiting Time	Feb 24	5.0	9.8	
85	RTT Average Wait for Incomplete	Feb 24	7.00	17.6	
133	RTT Incomplete 92nd Percentile	Feb 24	-	49.0	
134	RTT Incomplete Pathways With a DTA	Feb 24	25.0%	15.1%	
136	RTT Non-Admitted Treatment Within 18 Weeks	Feb 24	95.0%	63.4%	
138	RTT Total Clock Starts	Feb 24	-	16,481	
137	RTT Total Clock Stops	Feb 24	-	15,086	
132	RTT Total Incompletes	Feb 24	-	81,079	

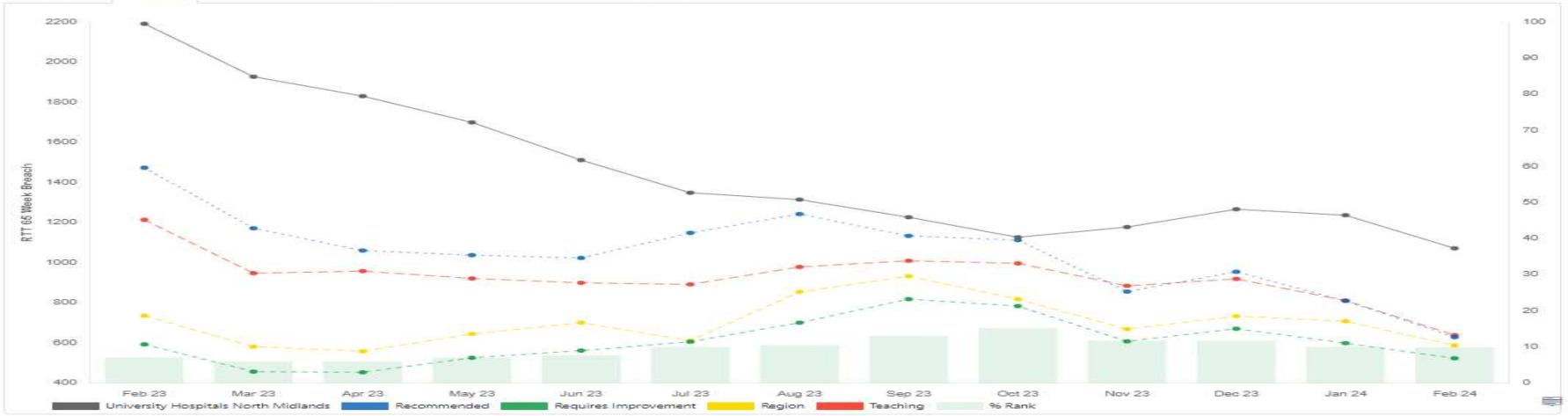
- Volumes of Total RTT Incomplete pathways has plateaued since September 2024.
- UHNM remain in the 4th quartile.

RTT

RTT 65 Week Breach

Feb 24 Performance: 1,071 | Rank: 148th of 164

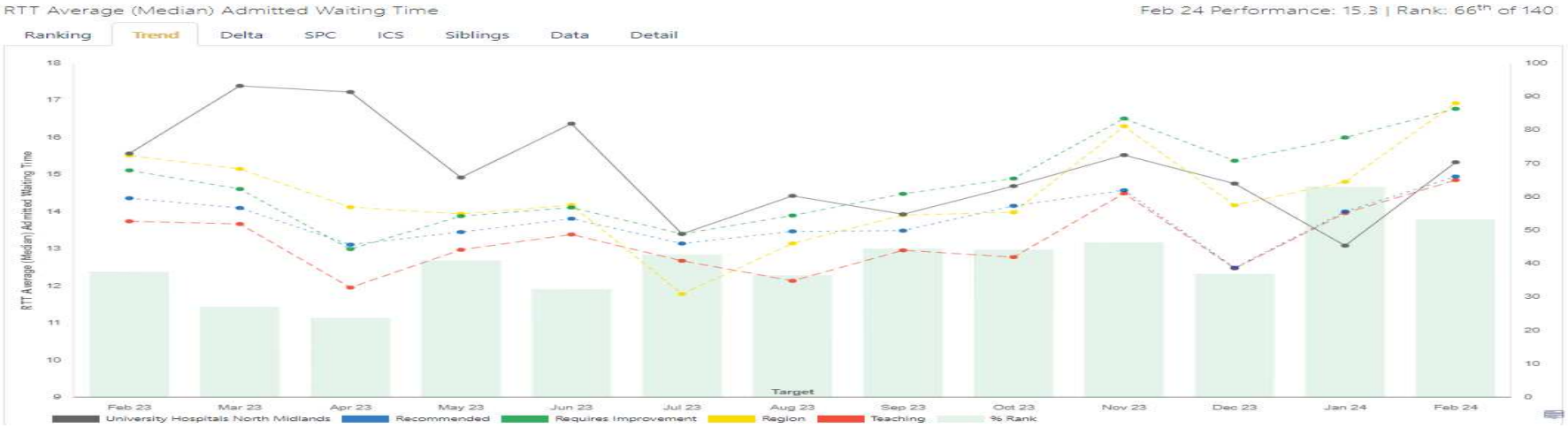
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

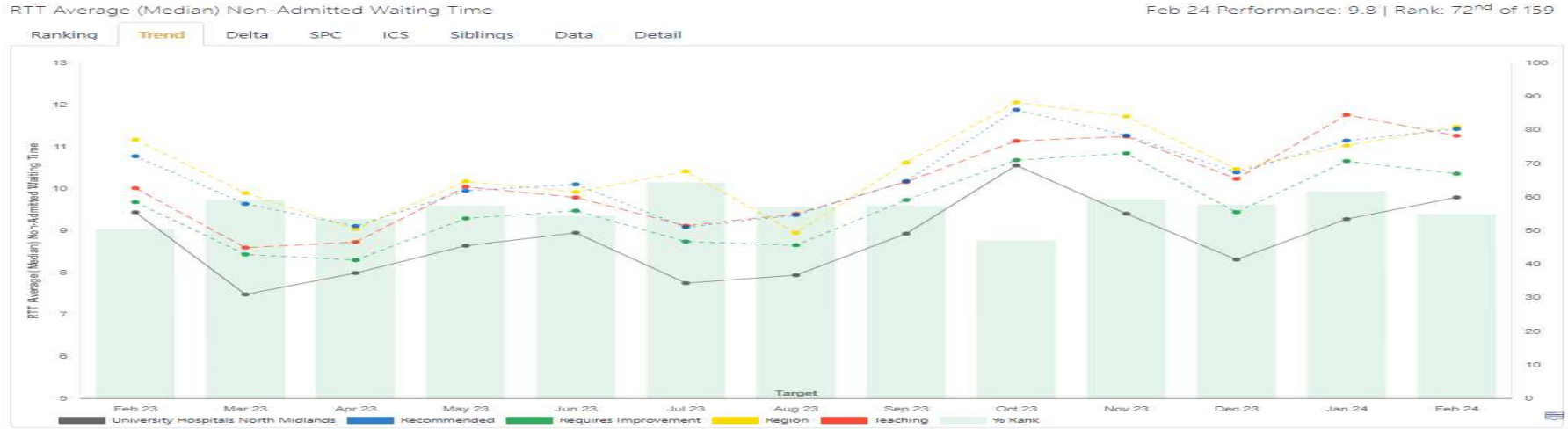


Key Performance Indicator	Period	Target		SPC
RTT 104 Week Breach	Feb 24	0	**4**	
RTT 52 Week Breach	Feb 24	0	**4,807**	
RTT 65 Week Breach	Feb 24	-	1,071	
RTT 78 Week Breach	Feb 24	0	**158**	
RTT 95th Percentile Admitted Waiting Time	Feb 24	18.0	**70.6**	
RTT 95th Percentile Non-Admitted Waiting Time	Feb 24	18.0	**62.7**	
RTT Admitted Treatment Within 18 Weeks	Feb 24	90.0%	**52.8%**	
RTT Average (Median) Admitted Waiting Time	Feb 24	9.0	**15.3**	
RTT Average (Median) Non-Admitted Waiting Time	Feb 24	5.0	**9.8**	
RTT Average Wait for Incomplete	Feb 24	7.00	**17.6**	
RTT Incomplete 92nd Percentile	Feb 24	-	49.0	
RTT Incomplete Pathways With a DTA	Feb 24	25.0%	15.1%	
RTT Non-Admitted Treatment Within 18 Weeks	Feb 24	95.0%	**63.4%**	
RTT Total Clock Starts	Feb 24	-	16,481	
RTT Total Clock Stops	Feb 24	-	15,086	
RTT Total Incompletes	Feb 24	-	81,079	

- All peer groups have followed a similar trend over recent months and all saw further reduction in February 2024.
- UHNM remain above all peer groups and haven't seen the same level of reduction as the Recommended or Teaching peers.
- UHNM remain in the bottom quartile.

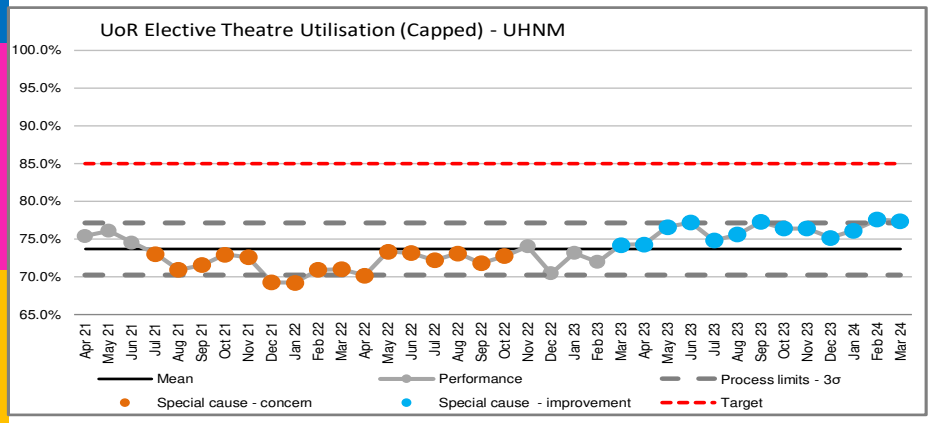
RTT





- The average wait (median), for patients at UHNM on an RTT admitted pathway, has seen a downward trend over the last 12 months, where other peer groups are seeing an upward trend over the same period.
- All peer groups including UHNM for those patients on a non admitted RTT pathway have seen an upward trend over the last 12 months.

Planned Care – *Theatres*

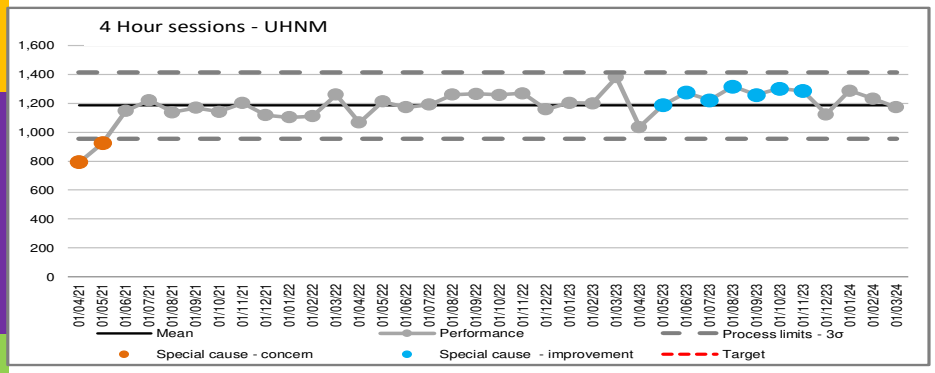


Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
85%	76.1%	77.6%	77.4%

Background

The percentage of theatre time used (capped).

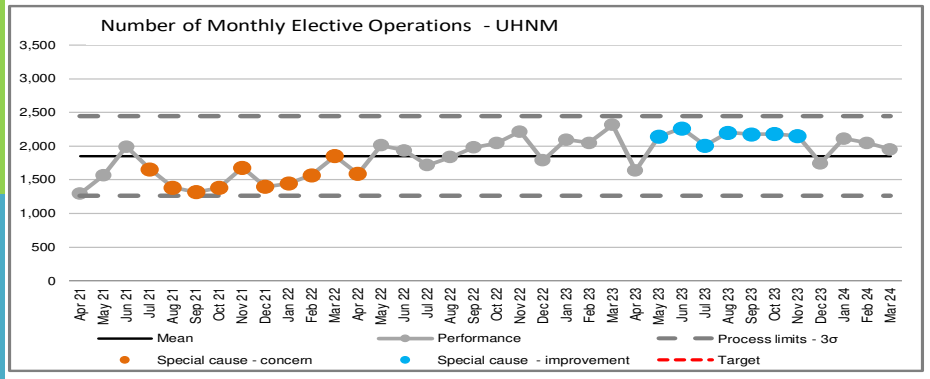


Variation	Assurance

Target	01/01/24	01/02/24	01/03/24
N/A	1287	1233	1173

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/01/24	01/02/24	01/03/24
N/A	2112	2048	1954

Background

The total number of elective operations during the month.

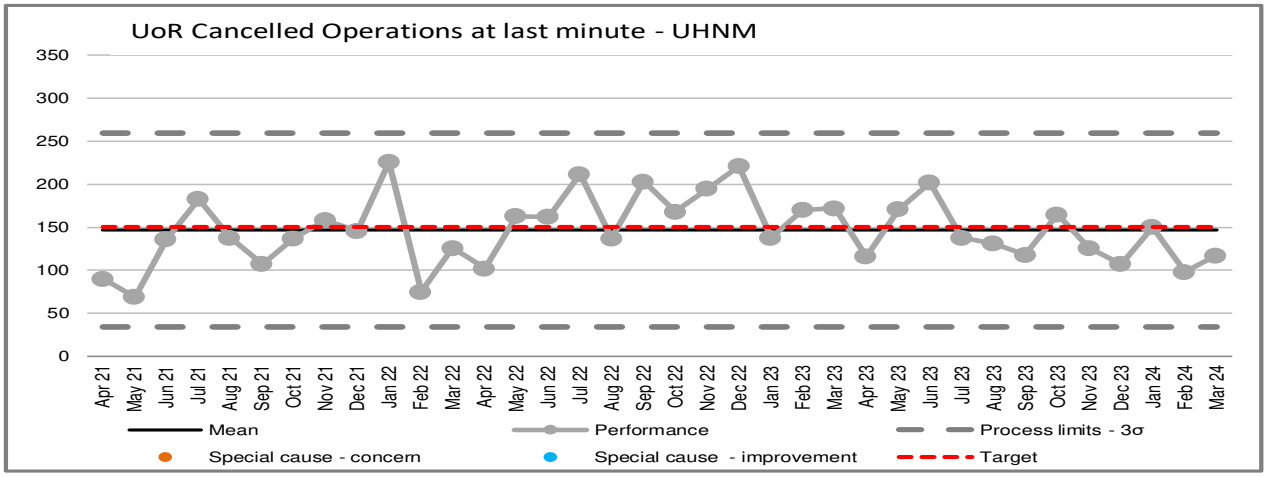
Capped Utilisation performance has improved further and has remained above the upper control limit in March.

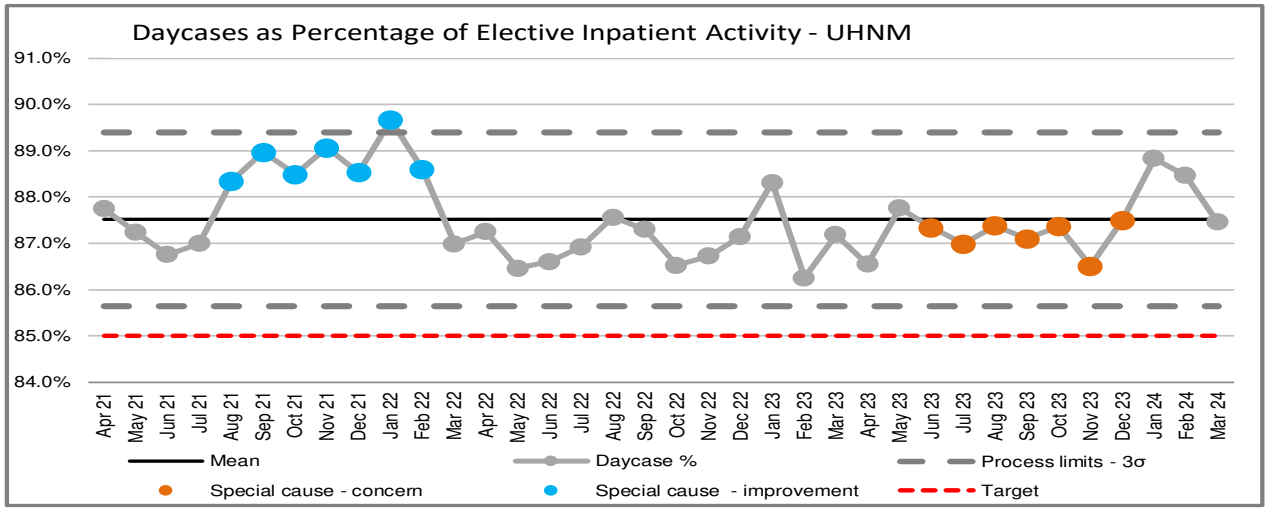
The number of 4 hour sessions continues to see normal variation.

Following a dip in December, Elective Operations are back to normal levels, accounting for reduced working days in March.

Delivering Exceptional Care with Exceptional People

Planned Care – *Theatres*





March saw a slight increases in the number of Cancelled Operations, but remains within normal variation.

Following an increase in the proportion of Daycase activity since November 2023, March saw a marginal reduction to mean

Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

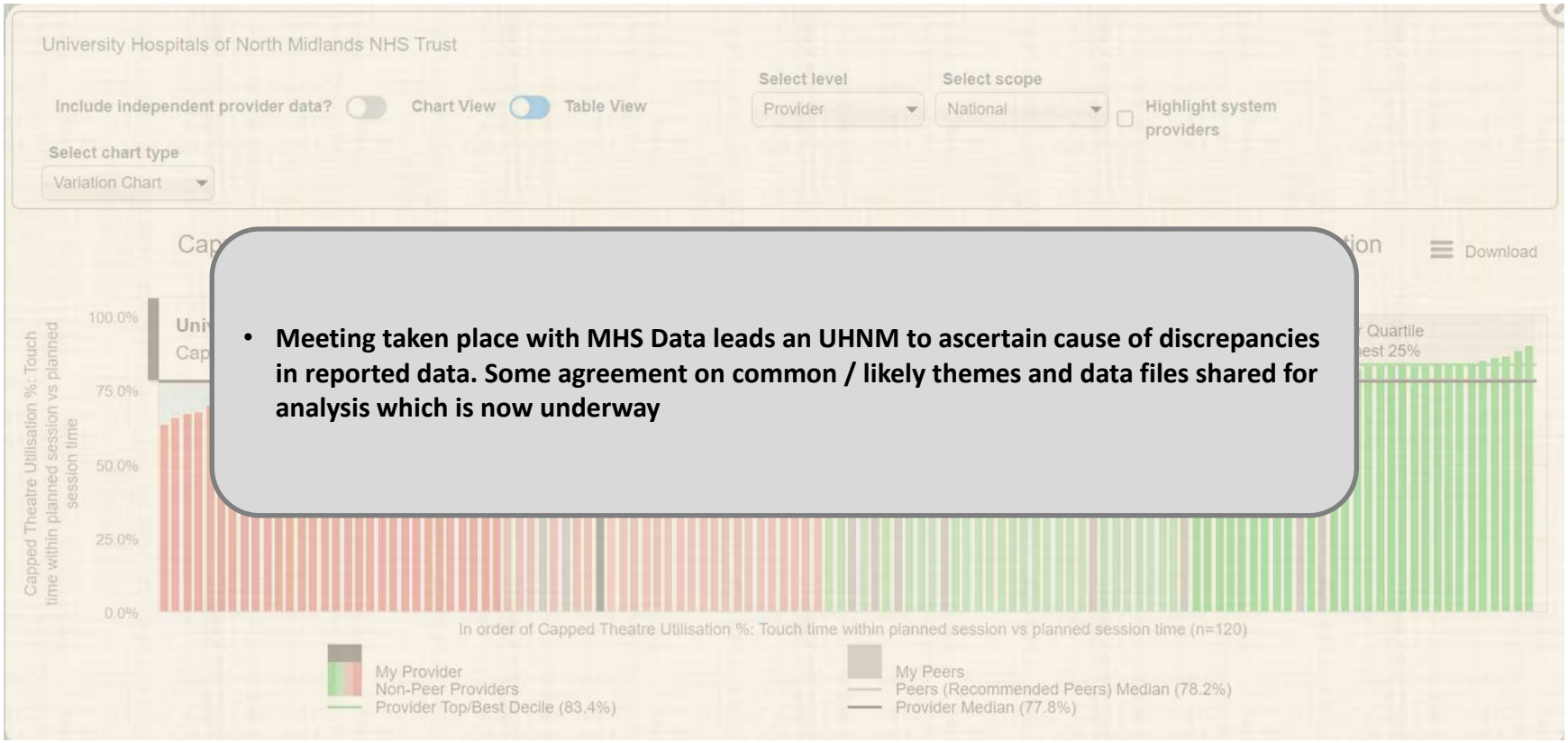
Elective inpatients Summary

- Capped utilisation remains above the upper control limit at 77.4%.
- Cancelled operations increased to 10%, RSUH being the highest at 12%, emerging theme of lack of pt optimization & late diagnostics
- 2nd Perioperative Care Working Group meeting in April and delivery groups continue to meet. Future State pathway mapped with focus on digital transformation. The required temporary increase in Pre-Ams workforce has been outlined Capacity submitted ERF proposal.
- Cardiac Theatre Business Continuity Incident as result of Aspergillus Niger closed and normal service resolved

Actions

- NHSE - APOM review follow up meeting confirmed for 25th April
- CYP-Pre-Ams Business case presented at Pre-Execs for a second time, not supported due to investment and lack of contribution, further consideration to be given as to how to next steps.
- Meeting took place with MHS Data leads and UHNM to ascertain cause of discrepancies with reported data – MHS shared data output files in order for UHNM to analyse in coming weeks.
- Theatres & ACCU directorate developing A3 to focus on "Timely discharge of PACU and CCU" with vision to improve flow and therefore productivity and bed use.

Theatres - Benchmarked

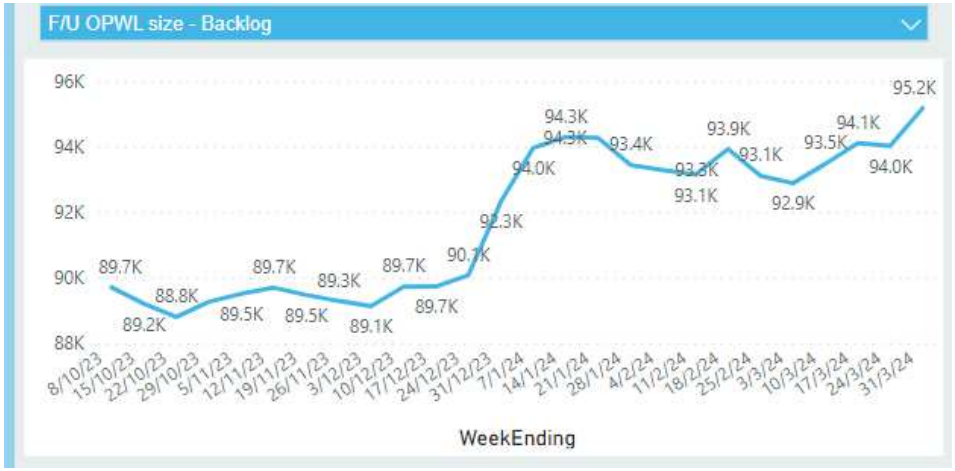


- **Meeting taken place with MHS Data leads an UHNM to ascertain cause of discrepancies in reported data. Some agreement on common / likely themes and data files shared for analysis which is now underway**

Planned Care – *Outpatients*

New Outpatient Performance to Plan

Follow Up Outpatient Performance to Plan



New Outpatient activity performance was 95% of plan in February and 96% YTD.
Outpatient Follow Up performance was 101% in February with YTD at 104%.

The Follow Up Backlog was on a downward trend throughout February, despite the spike during w/e 18th Feb.

Planned care – *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

OP Cell Programme Structure – Current OP Cell framed on reducing follow ups without a procedure by 25%, reflecting the 23/24 Elective Recovery Guidance ambition (and incorporating key actions from the Elective Care Review).

2024/25 National Planning Guidance - Elective Care Objective 3: Increase the proportion of all outpatient attendances that are for first appointments or follow up appointments attracting a procedure tariff to 46% (local 49%). OP Cell needs reframing (albeit likely similar workstreams)

Risks: - 23/24 Business plans included increase in follow ups, in part to clear follow up backlog, 24/25 Business Plans in progress

- Clinically Led challenge required to facilitate clinical conversations and encourage engagement
- Lack of pace on schemes linked to System Partners, previously escalated at Planned Care Improvement Board
- PKB functionality to support waiting list validation & 2way SMS: timeline risk, (revisiting 2 way SMS targeting DNAs)
- Impact of further Industrial Action (IA) on cancelled OP sessions / attendances, impact on improvement work
- CIP impact on admin vacancies process – admin resource remains critical for transformation & sustained performance

- **Referral Management / Variation**

  Advice & Guidance - Advice & refer 'triage by default': scoping internal /external support. Presentation shared at OP Cell and Planned Care, then shared with System Advice & Guidance Group early April, for feedback at next Group. Specialties provisionally identified for pilot pending System support.

  E-referral worklist reports - Reports revised to reflect workflow, with filters to support oversight of urgent & 2ww triage position.

- **Activity Management / Variation**

  PIFU - Position Mar 2024: 5.4% Benchmarking vs national median Feb – UHNM: 32nd of 142 providers (4.7% vs 3.0%).

  'PIFU by Default' initiative – with NHSE support; clinical workshop Nov 7th with Medical Director & Clinical Leads, well attended, updated UHNM comms. **Presented at Midlands OP Board in February.** Linking in with 4 initial priority specialties (with NHSE clinical support); ophthalmology live for 'move to' PIFU from clinics, gynae to pilot RPA for PIFU Discharge letters to encourage uptake. Additional specialty to be targeted from benchmarking.

  Outcomes – Following iportal directive, new report views to target actions effectively (eg where iportal outcome captured and/or letter completed). Review of reporting and associated operational processes underway with DQ and specialty input.

  RPA OP Outcomes - Scoping specialty pilot with UHNM BI, agreement in principle for pilot in a specialty using available robot capacity.

  OP Productivity; Utilisation – Feb 2024 (provisional): Clinic Utilisation: 90.4% vs 90.0% (plan); Booking rate: 96.6% (vs 96.3%) DNA rate: 6.5% (vs 6.5%), review of bookings by TFC to understand under-utilised slots. **Missed Appointments -** overbooking to compensate, **2-way messaging –** paper approved in principle at IM&T SMT, meeting held with supplier, funding identified, potential go live May/June. **Health inequalities Audits -** HED DNA benchmarking specialties vs national position identifies outliers. Linking with NHSE & Public Health consultant around approaches. Initial analysis complete, scoping meetings with specialty ahead of pilot. Proposal to be drafted.

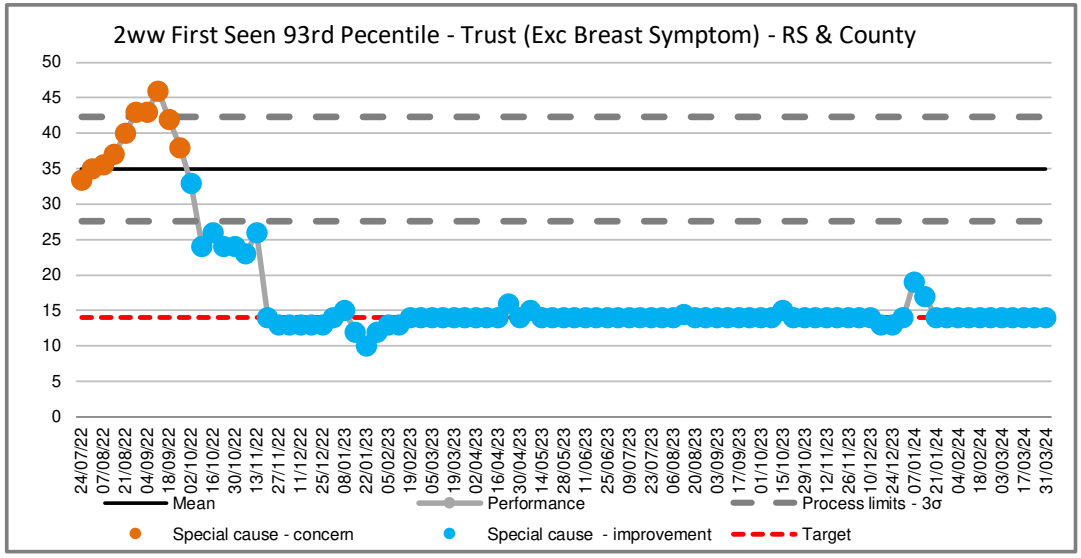
- **Key Enablers**

  GIRFT Further, Faster – key programme, UHNM a cohort 2 Trust. Handbooks shared; monitoring onboarding (16/17) & follow on meetings with clinical & mgt specialty teams. Many outpatient actions similar to OP GIRFT Guidance. Specialty Checklists being reviewed with clinicians (72.9% updated). February Midlands Monthly OP Transformation Network dedicated to Further Faster.

  PIFU RPA – Discharge Letters (at Review Date),with UHNM BI; Urology & paeds live, rolling out vs plan for other specialties. Lymphoedema & gynae next.

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

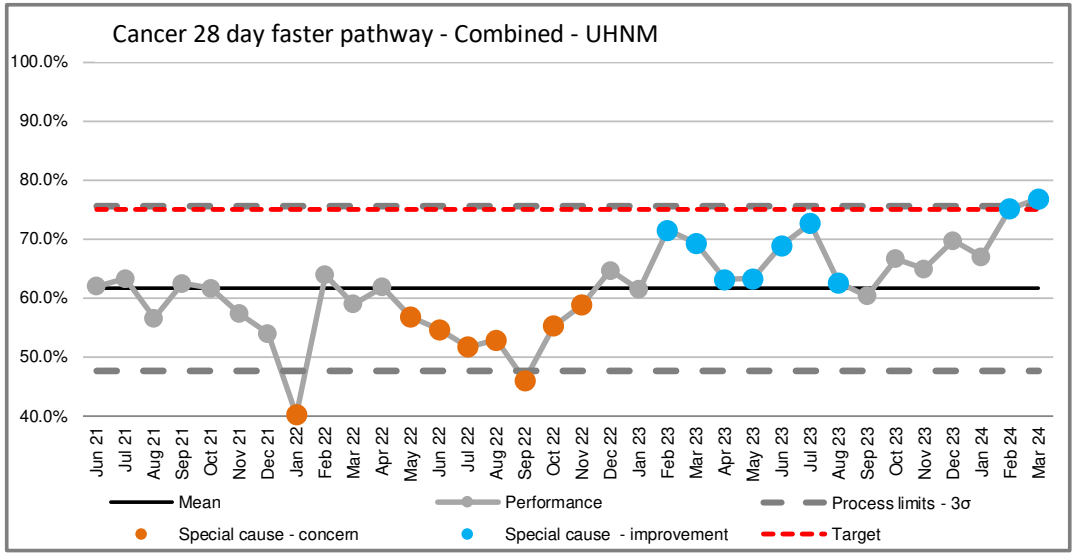
Target	17/03/2024	24/03/2024	31/03/2024
14	14	14	14

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



Variation	Assurance
H	?

Target	Jan 24	Feb 24	Mar 24
75%	67.0%	75.1%	76.8%

Background

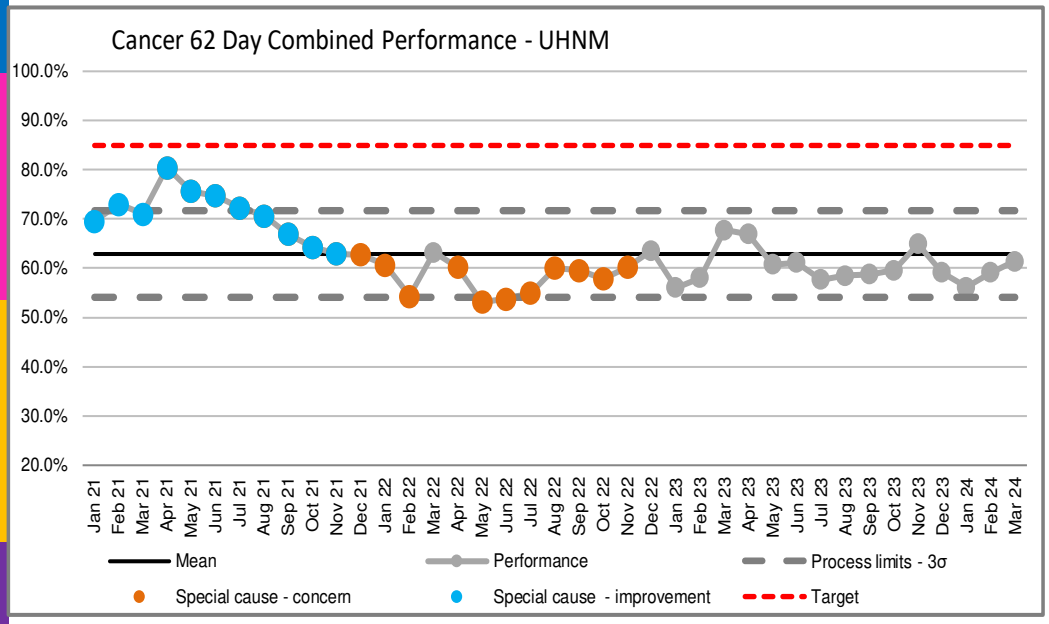
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

Over the past year performance has significantly improved to the point of achieving the standard for the first time in Feb. March is also predicted to achieve the standard however this is still provisional.

Cancer – Headline metrics

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

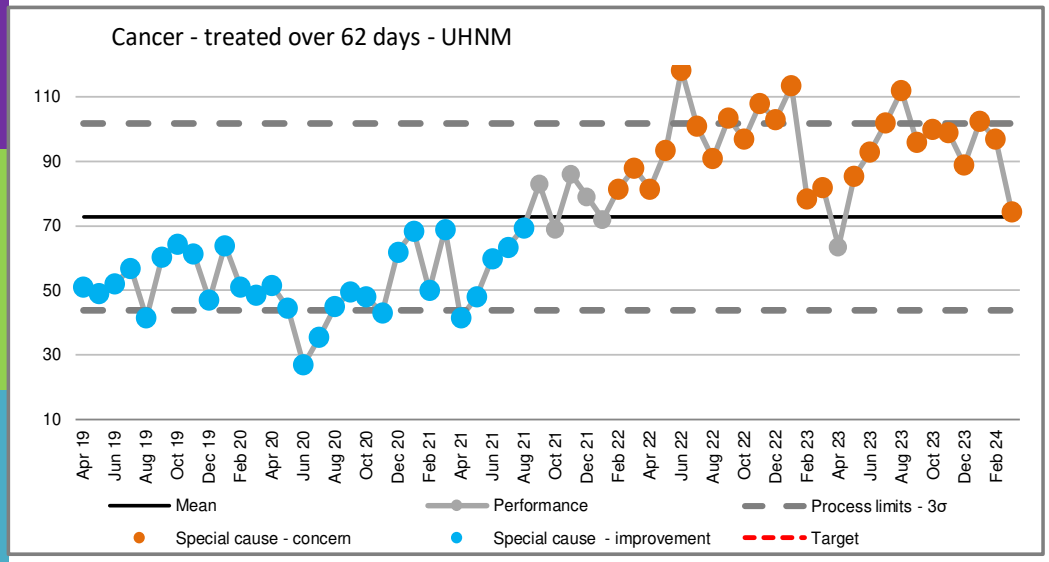
Target	Jan 24	Feb 24	Mar 24
85%	56.1%	59.1%	61.4%

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 2 years. Performance remains between 50 – 60% for Jan & Feb. The March 24 position is incomplete and still being validated.



Variation	Assurance
H	

Target	Jan 24	Feb 24	Mar 24
N/A	102.5	97.0	74.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of GP referred patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 2 years.

Delivering Exceptional Care with Exceptional People

Cancer Actions

NHS University Hospitals of North Midlands NHS Trust

- The Faster Diagnosis Standard has improved over the past few months for most challenged tumour sites Gynae, Urol, LGI and Skin.
- The 62 day and 104 day backlogs have reduced ahead of trajectory for the past 4 months, with Colorectal and Skin ahead of trajectory. UHNM has achieved the 'fair shares' aim to return the backlog to pre-pandemic levels, ahead of the March 24 target. This has been recognised and commended by the national cancer team.
- 25% of referrals received on the lower GI suspected cancer pathway are FIT negative however are within the exclusion criteria agreed with commissioners (IDA, Rectal Bleeding), demonstrating appropriate use of the pathway and endoscopy capacity.
- During a regional audit of 3 months worth of data, UHNM completed colonoscopies for just 0.3% of FIT negative patients who were on a suspected cancer LGI pathway – this is the lowest in the region when benchmarked against providers within the West Midlands.

LGI:

- Surgical capacity has been released through additional activity delivered by SHS supporting recovery of the LGI cancer pathway backlog of patients waiting for diagnosis and treatment. This is enabled by using a mixture of OPAs and, Day Case capacity and has resulted in an improvement of the 62+ backlog position in LGI. In addition, the LGI FDS performance has improved over the past 3 months and is expected to continue to recover.

Skin:

- Extra minor ops and OPA capacity is being provided through weekend activity. TIs are also supporting the position including insourcing.
  The 62+ day backlog position is ahead of trajectory and the FDS has achieved for the past 2 months and is predicted to achieve again in March.

UROL:

- An escalation for support has been submitted to the system, to explore expansion of referral optimisation hub to include all suspected cancer referrals. This is expected to improve FDS performance due to improved quality of referrals. Timescales for the completed review of the Choice and Referral centre which began last year is Sept24. The UROL Expert Advisory Group of the west midlands is focusing on targeted case finding in primary care.

Pathology:

- Pathologists are prioritising reporting into Urgent and Accelerated streams, particularly for high volume pathways such as Skin and Colorectal. One locum consultant, 2 fixed term Band 4's and one locum BMS were recruited using recovery funds in November 23. TATs for Urgent (Diagnostic Cancer) specimens: 95% are reported at Day 16 – an improvement of 2 days since last month.

Endoscopy:

- Recovery plans are being enacted to increase internal capacity using a combination of clinical Endoscopists, consultants/middle grades to improve utilisation. Locums are supporting diagnostic and surveillance waits. Insourced management support has been commissioned. Turn around times from request to test for Colonoscopy patients on a GP referred LGI cancer pathway have reduced in March to an average of 24 days.

Radiology:

- For increased Radiology reporting capacity to support cancer pathways, TIs are being offered, in addition recruitment is underway for an additional fellow, plus a review of outstanding reports and allocation / escalation is continuous.

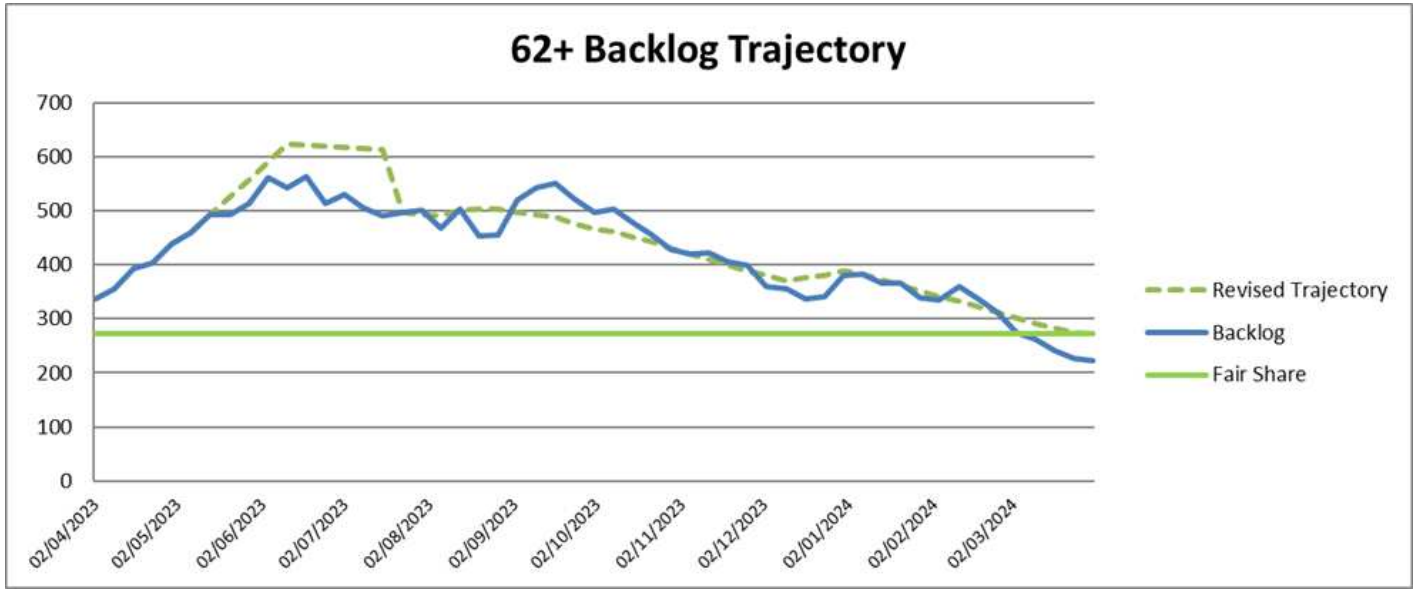
Oncology:

- The 62 day treatment standard will be a focus in 24/25, UHNM has submitted the trajectory to achieve the 70% performance ambition set out by NHSE by the end of the new year. Improvement discussions have already taken place with priorities to be agreed such as capacity and demand modelling and acute to community shift to release capacity where possible.

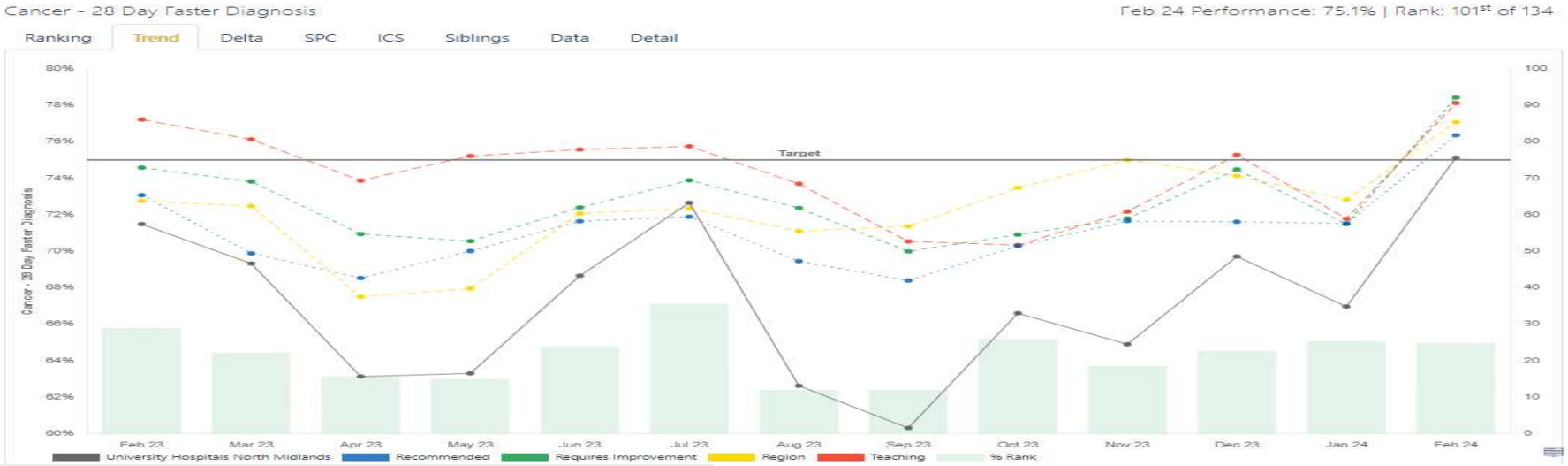
Cancer Trajectories

NHS
University Hospitals of North Midlands
NHS Trust

- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. This was based on a fair share total allocated to Trusts, with UHNM target being 273. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 24, taking into account the unpredicted workforce challenges in Endoscopy. For the week ending 31.03.24 UHNM achieved this aim reporting a backlog of 222. The national cancer team have commended UHNM for this achievement.
- The actual total of patients waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending 31.03.24
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced by 46 patients since last month to a year end position of 222.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced to within target of 14 days.
    - The total PTL has reduced to a current position of around 3300.
    - The number of patients waiting over 104+ was at 79 at the end of March 24.
    - The combined Faster Diagnosis Standard for February achieved the standard.
    - The combined Faster Diagnosis Standard for March is predicted to achieve the standard.



Cancer



	Key Performance Indicator	Period	Target		SPC
403	Cancer - 28 Day Faster Diagnosis	Feb 24	75.0%	75.1%	
406	FDS Acute Leukaemia	Feb 24	75.0%	-	
407	FDS Brain Tumours	Feb 24	75.0%	100%	
408	FDS Breast Cancer	Feb 24	75.0%	92.8%	
404	FDS Breast Symptoms	Feb 24	75.0%	95.6%	
409	FDS Children's Cancer	Feb 24	75.0%	94.4%	
410	FDS Gynaecological Cancer	Feb 24	75.0%	**49.5%**	
411	FDS Haematological Malignancies	Feb 24	75.0%	**45.8%**	
412	FDS Head & Neck Cancer	Feb 24	75.0%	76.3%	
413	FDS Lower Gastrointestinal Cancer	Feb 24	75.0%	**57.0%**	
414	FDS Lung Cancer	Feb 24	75.0%	82.6%	
405	FDS Missing or Invalid	Feb 24	75.0%	-	
415	FDS Other Cancer	Feb 24	75.0%	100%	
416	FDS Sarcoma	Feb 24	75.0%	**66.7%**	
417	FDS Skin Cancer	Feb 24	75.0%	85.6%	
418	FDS Testicular Cancer	Feb 24	75.0%	**72.0%**	
419	FDS Upper Gastrointestinal Cancer	Feb 24	75.0%	91.9%	
420	FDS Urological Malignancies	Feb 24	75.0%	**55.4%**	

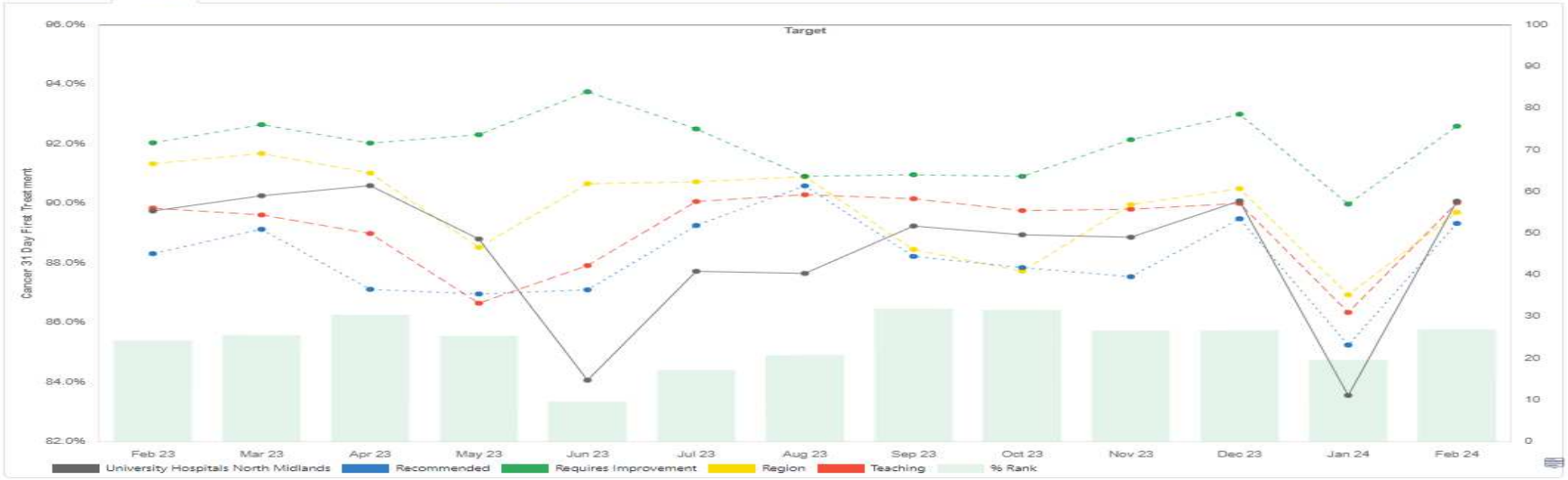
- All peer groups including UHNM exceeded target in February 2024.
- Lowe GI have seen the greatest improvement since September.
- UHNM remain in the third quartile.

Cancer

Cancer 31 Day First Treatment

Feb 24 Performance: 90.07% | Rank: 99th of 135

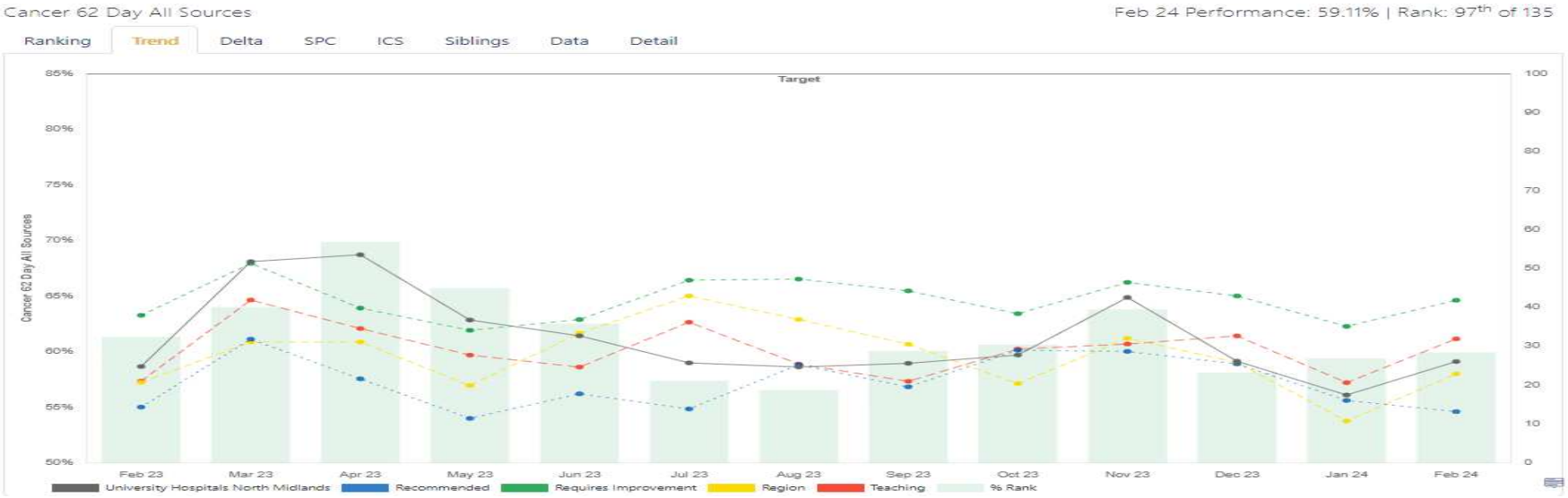
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail



- All peer groups have followed a similar trend since September 2023.
- UHNM improved the most in February compared to peer groups.
- UHNM have moved into the third quartile from the bottom quartile last month.

Key Performance Indicator	Period	Target		SPC
Cancer 2 Week Wait	Feb 24	93.00%	95.0%	
Cancer 2 Week Wait Breast Symptomatic	Feb 24	93.0%	91.7%	
Cancer 31 Day First Treatment	Feb 24	96.00%	90.1%	
Cancer 31 Day Subsequent Treatment	Feb 24	96.0%	88.9%	
Cancer 62 Day All Sources	Feb 24	85.00%	59.1%	
Cancer 62 Day Consultant Upgrade	Feb 24	85.0%	72.6%	
Cancer 62 Day Screening	Feb 24	90.0%	37.0%	
Cancer Sub Treat Drugs	Feb 24	96.0%	98.0%	
Cancer Sub Treat Radiotherapy	Feb 24	96.0%	98.4%	

Cancer



- All peer groups are currently performing at similar levels.
- UHNM are at the midpoint between all peer groups.
- UHNM remain in the third quartile.

Key Performance Indicator	Period	Target		SPC
Cancer 2 Week Wait	Feb 24	93.00%	95.0%	
Cancer 2 Week Wait Breast Symptomatic	Feb 24	93.0%	91.7%	
Cancer 31 Day First Treatment	Feb 24	96.00%	90.1%	
Cancer 31 Day Subsequent Treatment	Feb 24	96.0%	88.9%	
Cancer 62 Day All Sources	Feb 24	85.00%	59.1%	
Cancer 62 Day Consultant Upgrade	Feb 24	85.0%	72.6%	
Cancer 62 Day Screening	Feb 24	90.0%	37.0%	
Cancer Sub Treat Drugs	Feb 24	96.0%	98.0%	
Cancer Sub Treat Radiotherapy	Feb 24	96.0%	98.4%	

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	11.19%	9.80%	8.95%	7.95%	7.80%	11.04%	11.77%	10.48%	13.17%	7.30%	0.55%
Weeks Waited- 78-104	12.33%	10.56%	10.93%	10.04%	7.46%	12.63%	9.45%	10.19%	10.12%	4.80%	1.48%
Weeks Waited- 52-77	14.01%	11.84%	10.35%	9.03%	7.77%	10.69%	9.67%	9.26%	11.40%	4.85%	1.12%
Weeks Waited- Under 52	13.64%	11.25%	10.03%	9.28%	7.45%	10.69%	10.87%	8.95%	10.95%	5.43%	1.47%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.75%	9.95%	9.25%	8.85%	7.76%	11.04%	11.42%	10.37%	12.92%	6.57%	1.11%
Weeks Waited- 78-104	11.21%	10.44%	9.83%	8.66%	7.73%	11.07%	10.94%	9.91%	12.33%	6.55%	1.35%
Weeks Waited- 52-77	13.08%	11.17%	10.02%	9.47%	7.18%	10.66%	10.46%	9.04%	11.26%	6.29%	1.35%
Weeks Waited- Under 52	13.44%	11.43%	10.08%	8.80%	7.58%	10.50%	10.46%	9.09%	11.22%	5.88%	1.52%

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 British	White Irish	Not Specified	Not Stated	Unknown	
Weeks Waited- >104	0.16%	0.47%	0.08%	0.42%	0.40%	0.66%	0.03%	0.11%	0.26%	0.42%	0.42%	0.16%	0.03%	93.05%	0.37%	0.87%	1.66%	0.42%	
Weeks Waited- 78-104	0.44%	0.44%	0.30%	0.81%	0.30%	1.40%		0.15%	0.07%	0.44%	1.11%	0.37%		89.00%	0.37%	2.07%	1.40%	1.11%	
Weeks Waited- 52-77	0.54%	0.61%	0.24%	1.09%	0.58%	1.26%	0.20%	0.07%	0.14%	0.54%	1.26%	0.41%	0.27%	85.31%	0.54%	2.21%	2.04%		
Weeks Waited- Under 52	0.44%	0.73%	0.26%	0.67%	0.53%	1.68%	0.13%	0.18%	0.15%	0.55%	1.57%	0.30%	0.21%	83.87%	0.35%	2.64%	2.21%	3.28%	

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	0.33%	0.38%	0.23%	0.43%	0.48%	0.88%	0.08%	0.15%	0.19%	0.55%	1.44%	0.33%	0.16%	0.23%	87.89%	0.34%	2.53%	1.89%	1.47%
Weeks Waited- 78-104	0.40%	0.76%	0.19%	0.64%	0.62%	1.04%	0.16%	0.13%	0.16%	0.69%	1.43%	0.33%	0.08%	0.22%	84.36%	0.32%	3.09%	2.63%	2.75%
Weeks Waited- 52-77	0.33%	0.75%	0.26%	0.61%	0.56%	1.28%	0.16%	0.21%	0.14%	0.61%	1.58%	0.29%	0.15%	0.21%	83.60%	0.30%	3.14%	2.37%	
Weeks Waited- Under 52	0.79%	0.74%	0.23%	0.66%	0.61%	1.33%	0.18%	0.16%	0.16%	0.78%	1.93%	0.35%	0.19%	0.23%	82.04%	0.30%	3.14%	2.50%	

APPENDIX 1

Operational Performance

Constitutional standards

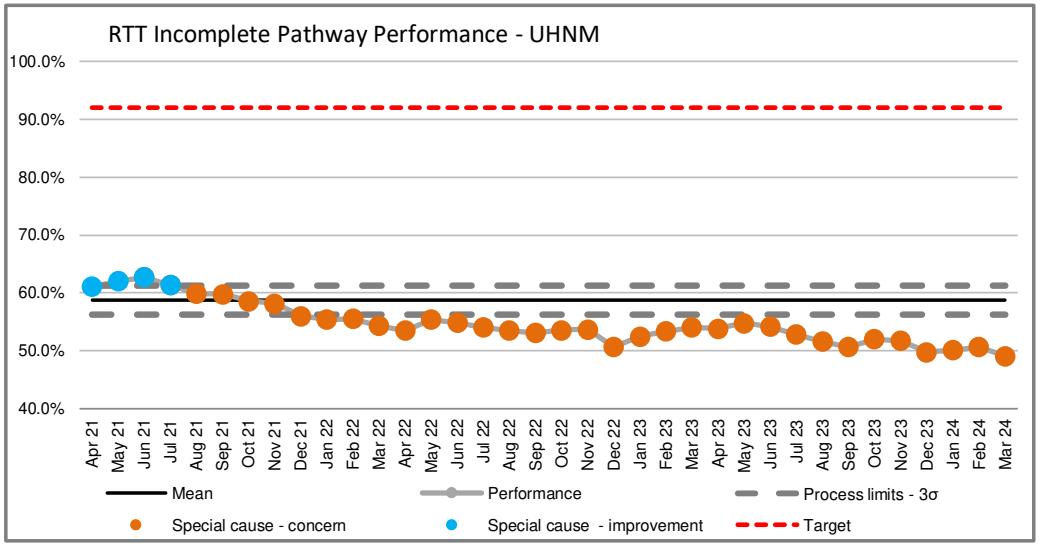
NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	23.50%	L		
	Ambulance handovers greater than 60 minutes	1	1	L	F	
	Time to Initial Assessment - percentage within 15 minutes	85%	58.68%		F	
	Average (mean) time in Department - non-admitted patients	180	274		F	
	Average (mean) time in Department - admitted patients	180	411	H	F	
	Clinically Ready to Proceed	90	561	H	F	
	12 Hour Trolley Waits	0	1033	H	F	
	Patients spending more than 12 hours in A&E	0	1987	H	F	
	Median Wait to be seen - Type 1	60	102		F	
	Bed Occupancy	92%	86.97%			
Cancer Care	Cancer 28 day faster pathway	75%	76.83%	H	?	
	Cancer 31 Day Combined	96%	92.01%		F	
	Cancer 62 Day Combined	85%	61.42%		F	
	2WW First Seen (exc Breast Symptom)	93%	94.97%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.6%	L	?	
	Cancelled Ops	150	117		?	
	Theatre Utilisation	85%	81.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	40%	H	?	
	Super Stranded	183	222	H	?	
	MFFD	100	93	L	?	
	Discharges before Midday	25%	20.0%		F	
	Emergency Readmission rate	8%	12.8%		F	
Elective waits	RTT incomplete performance	92%	49.13%	L	F	
	RTT 52+ week waits	0	5185	H	F	
	Diagnostics	99%	69.17%		F	

Referral To Treatment

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

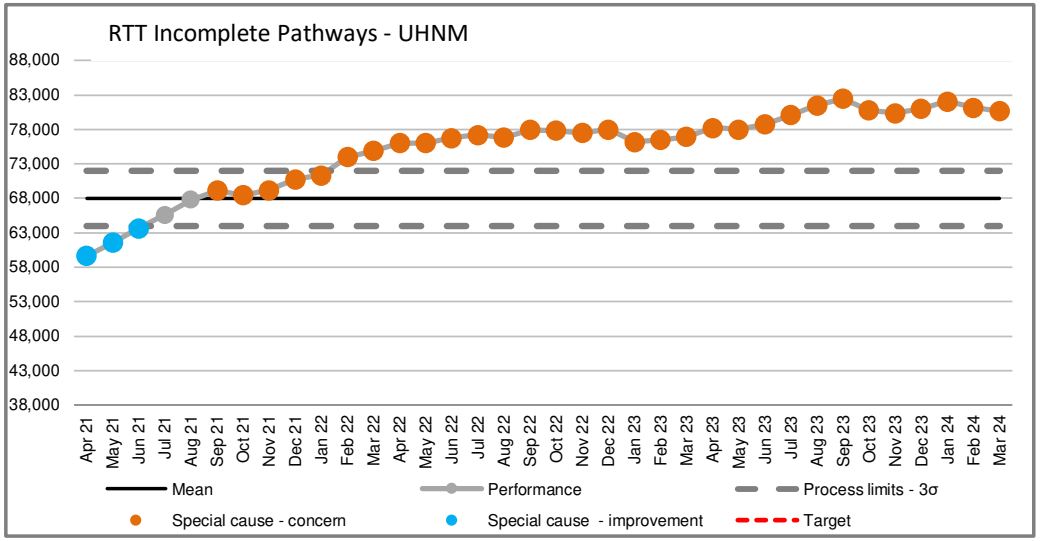
Target	Jan 24	Feb 24	Mar 24
92%	50.2%	50.7%	49.1%

Background

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

What is the data telling us?

RTT performance deteriorated further in March and continues to see a declining trend.



Variation	Assurance
	

Target	Jan 24	Feb 24	Mar 24
N/A	82078	81192	80681

Background

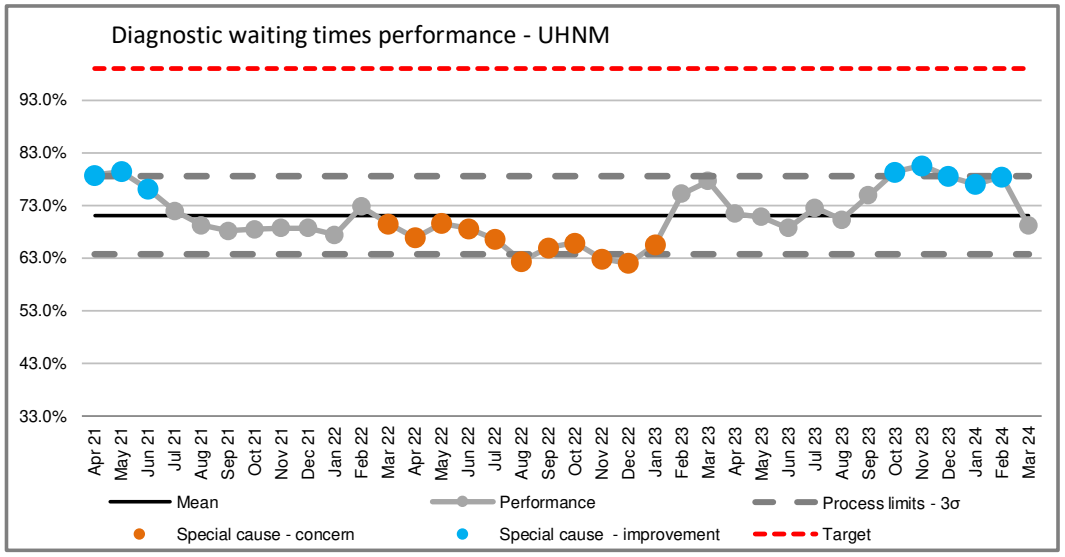
The number of patients waiting over 18 weeks for treatment since their referral.

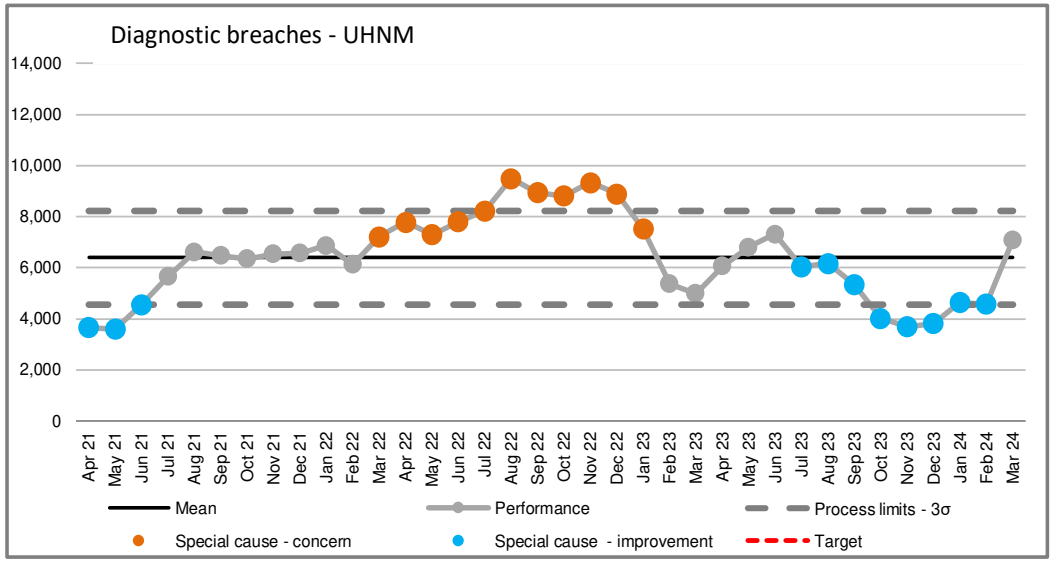
What is the data telling us?

Total number of RTT pathways reduced marginally in March, despite performance against the 18 week target deteriorating.

Delivering Exceptional Care with Exceptional People

Diagnostic Standards





Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
99%	77.0%	78.4%	69.2%

Background

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

What is the data telling us?

Waiting time performance saw a deterioration in March, at 69% against the 99% target.

Although the overall waiting list has increased marginally through March, the volume of diagnostic breaches has increased at a higher rate, reaching over 7000.

Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

- The 12m Turnover rate in March 2024 slightly improved to 7.8% (7.9% in February 2024) which remains consistently below our 11% target, for the last 18 months.
- March's vacancies improved to 7.91% (8.10% in February), influenced by a total increase of 36.87 FTE in post, across all staff groups, offset by a 15.10 FTE increase in the budgeted establishment, reducing the vacancy FTE by 21.77 FTE overall.
- March 2024's in-month sickness rate improved by 0.51% to 4.99% (5.33% in February 2024). The 12-month cumulative rate also decreased fractionally to 5.21% (5.24% in February 2024).
- Stress and Anxiety continues to be the top reason for sickness in March which reduced by 1.4% to 26.1% in Mar-24 (27.5% in Feb-24). Gastrointestinal Problems replaced Chest & Respiratory as the second most common reason, at 11.6%, followed by Other Musculoskeletal problems, at 8.0% which pushed Cold, Cough & Flu down to 7.5% in March 2024, (8.5% in Feb-24), which reflects March's lower reported numbers of Covid-19 cases.
- Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, in the absence of a formal lateral flow test, following the cessation of symptomatic covid testing, since May 2023. During March 2024, the overall number of employees who reported Covid-19 symptoms decreased significantly to 72 episodes, on Empactis, from 161 cases in February 2024. This is reflected in managers only reporting 46 covid-related cases on ESR, for March 2024, which is a decrease from the 84 episodes reporting in February 2024.
- February 2024's PDR Rate improved to 83.5% (82.1% in January 2024). The refreshed PDR paperwork, to support colleagues in achieving their potential, was published in January 2024 and managers were supported in its rollout through drop-in sessions which took place during January 2024, with a renewed focus in the Divisions, on increasing compliance.
- The Statutory and Mandatory training rate on 31st March 2024 remains static at 93.7% (93.7% on 29th February 2024). This compliance rate is for the 7 'Core for All' subjects only.

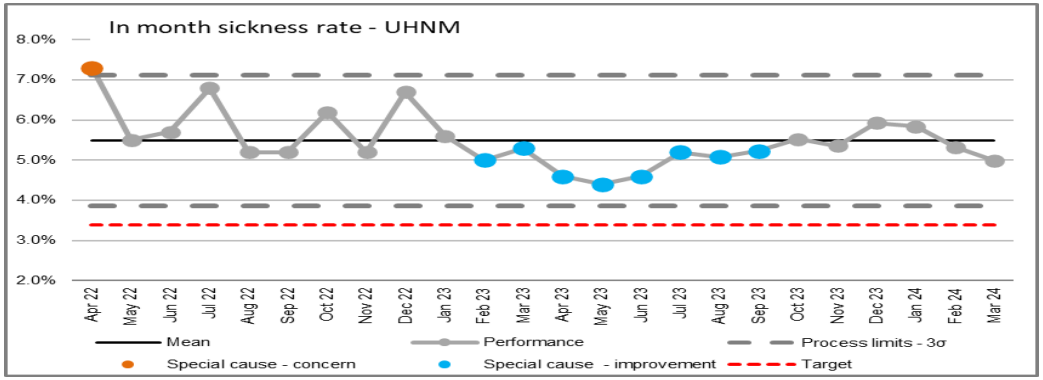
Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.99%		F
Staff Turnover	11%	7.84%	L	P
Statutory and Mandatory Training rate	95%	93.71%		F
Appraisal rate	95%	85.70%	H	F
Agency Cost	N/A	2.58%		P

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jan 24	Feb 24	Mar 24
3.4%	5.8%	5.3%	5.0%

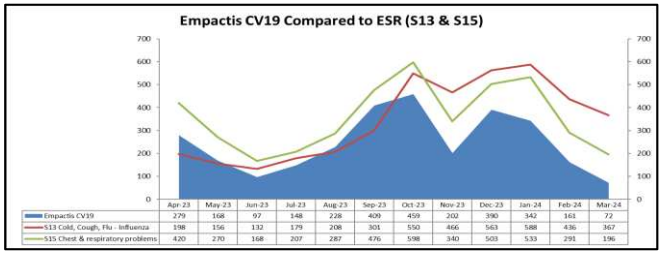
Background

Percentage of days lost to staff sickness

Summary

Org L2	Divisional Trajectory - March 2024	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	2023 / 12	2024 / 01	2024 / 02	2024 / 03	Trajectory
205 Central Functions	3.39%	2.80%	2.37%	2.81%	3.54%	3.46%	3.44%	3.82%	3.78%	3.95%	4.33%	3.96%	3.44%	↓
205 Division of Network Services	5.25%	3.91%	3.80%	4.00%	4.35%	4.83%	4.51%	5.32%	5.10%	5.52%	5.55%	5.39%	4.97%	↓
205 Division of Surgery, Theatres and Critical Care	5.25%	5.47%	4.90%	5.24%	6.62%	6.15%	6.12%	6.15%	6.12%	6.82%	7.34%	5.99%	5.76%	↓
205 Estates, Facilities and PFI Division	5.25%	6.00%	5.32%	5.09%	4.69%	5.11%	4.87%	6.13%	5.19%	4.35%	4.01%	3.62%	4.16%	↑
205 Medicine and Urgent Care	5.25%	5.11%	4.88%	4.78%	5.67%	5.35%	6.12%	6.26%	5.79%	6.45%	5.97%	5.34%	5.36%	↑
205 North Midlands & Cheshire Pathology Service (NMCPS)	4.50%	4.71%	4.68%	5.38%	4.71%	4.43%	4.82%	5.65%	5.00%	5.01%	5.53%	4.65%	4.35%	↓
205 Women's, Children's & Clinical Support Services	5.25%	4.63%	4.62%	5.09%	5.08%	5.01%	4.91%	4.94%	5.20%	5.94%	5.68%	5.59%	4.81%	↓

- For M12, the in-month sickness rate improved to 5.00% (5.33% in Feb-24).
- The 12-month cumulative rate improved to 5.21% (5.24% in Mar-24).
- Stress and Anxiety remains the top sickness reason in March which reduced by 1.4% to 26.1% in Mar-24 (27.5% in Feb-24). Gastrointestinal Problems replaced Chest & Respiratory as the second most common reason, at 11.6%, followed by Other Musculoskeletal problems, at 8.0% which pushed Cold, Cough & Flu down to 7.5% in Mar-24, (8.5% in Feb-24).
- Covid 19 cases reported on Empactis, by the employee, may be recorded as either chest & respiratory, or cold and flu, on ESR, by the manager, in the absence of a formal lateral flow.
- Both ESR reasons have seen a marked decrease, consistent with Empactis.



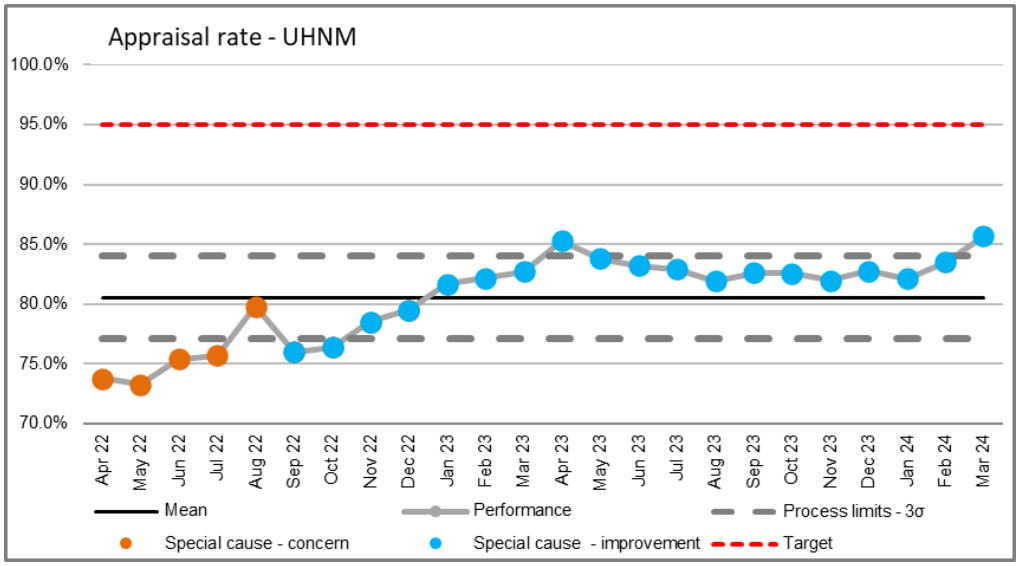
Sickness rate is consistently above the target of 3.4%.

Actions

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

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jan 24	Feb 24	Mar 24
95%	82.1%	83.5%	85.7%

Background

Percentage of people 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%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

- On 31st March 2024, the PDR Rate improved by 2.2% to 85.7%, compared to 83.5% for February 2024.
- This figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target. The improvements which have been made over the last three months are the result of the weekly divisional meetings, focussing on PDR performance.
- The new PDR documentation was published in January 2024, and electronic training materials are available on the Intranet.

Actions

The focus on ensuring completion of PDRs is continuing with:

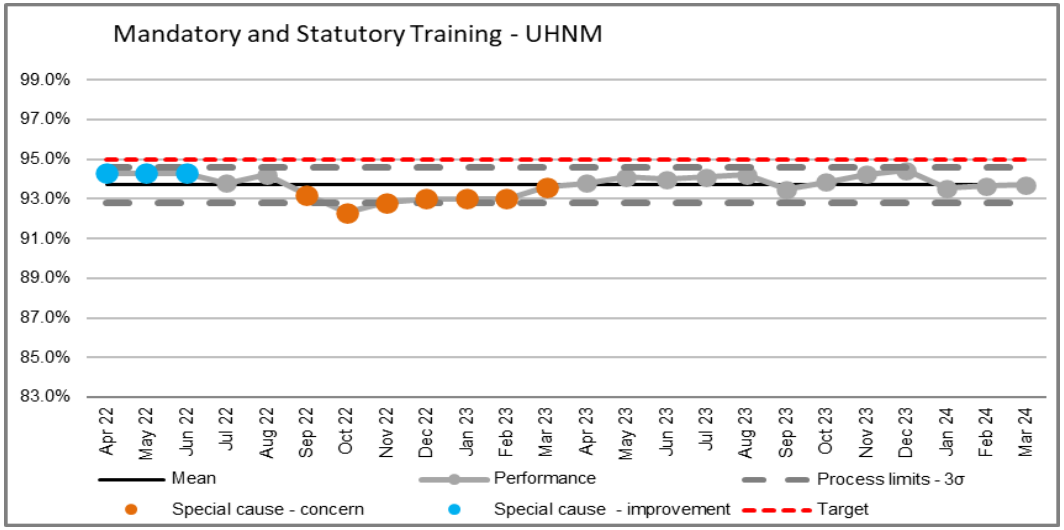
NMCPS - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

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

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

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

Statutory and Mandatory Training



Variation	Assurance
	F

Target	Jan 24	Feb 24	Mar 24
95%	93.5%	93.7%	93.7%

Background

Training compliance.

What is the data telling us?

At 93.7%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 31st March 2024 remains unchanged at 93.7%. This compliance rate is for the 7 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11861	11861	11163	94.12%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years	11861	11861	11259	94.92%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11861	11861	11216	94.56%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Y	11861	11861	11272	95.03%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11861	11861	11308	95.34%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Y	11861	11861	11168	94.16%
NHS|MAND|The Oliver McGowan Mandatory Training on	11861	11861	10419	87.84%

Compliance rates for the Annual competence requirements were as follows:

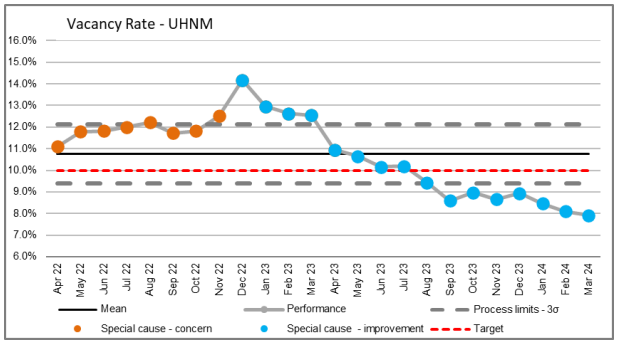
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11861	11861	8713	73.46%
NHS|CSTF|Information Governance and Data Security - 1	11861	11861	10449	88.10%

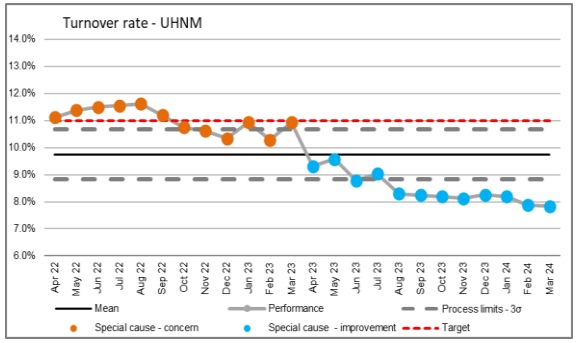
Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind and Oliver McGowan Training are now reported as part of 'Core for All' subjects.

Workforce Vacancies and Turnover

University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	P

Target	Jan 24	Feb 24	Mar 24
11.0%	8.2%	7.9%	7.8%

Background

Turnover rate.

What is the data telling us?

The turnover rate for March 2024 remains below the trust target of 11%.

Turnover rate when measured against total staff in post improved slightly to 7.8% from 7.9% last month.

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

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 2024 improved to 7.8% (7.9% in February 2024) which remains below our 11% target.
- The summary of vacancies by staff groupings highlights a 0.19% improvement in the vacancy rate over the previous month.
- March's vacancies improved to 7.91% (8.10% in February). Colleagues in post increased in March 2024 by 36.87 fte, budgeted establishment increased by 15.10 fte, which reduced the vacancy fte by 21.77 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/03/24]

Vacancies at 31-03-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,694.34	1,470.57	223.77	13.21%	13.54%
Registered Nursing	3689.27	3355.59	333.68	9.04%	9.43%
All other Staff Groups	6743.87	6341.47	402.40	5.97%	6.01%
Total	12,127.48	11,167.63	959.85	7.91%	8.10%

Actions

- Significant amount of recruitment events targeting specific roles across multiple divisions.
- Continued targeted social media campaign.
- Targeted spotlight on UHNM colleagues continue and supplement the recruitment campaigns

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

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

- For the financial year 2023/24 the Trust has delivered a year end surplus of £0.2m against a planned breakeven position; this is a positive variance of £0.2m.
- The Trust has received an additional £2.6m funding towards the cost of industrial actions. This takes the total funding for industrial actions and cost pressures to £13.1m for the year.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £46.1m of CIP savings to Month 12 against a plan of £55.0m. The Trust has recognised £4.9m of CIP due to a reduction in the annual leave accrual.
- There has been £95.2m of Capital expenditure which is in line with forecast
- The cash balance at Month 12 is £82m which is £21m higher than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	123.1		
	Expenditure - Pay	variable	84.0	H	F
	Expenditure - Non Pay	variable	30.6	H	F
Activity	Daycase/Elective Activity	variable	9,726	H	?
	Non Elective Activity	variable	11,173	H	P
	Outpatients 1st	variable	26,405		?
	Outpatients Follow Up	variable	39,529		?

Income & Expenditure

Income & Expenditure Summary Month 12 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,042.0	110.9	115.6	4.7	1,042.0	1,055.6	13.5
Other Operating Income	89.3	8.5	7.5	(1.0)	89.3	89.6	0.3
Total Income	1,131.3	119.4	123.1	3.6	1,131.3	1,145.1	13.9
Pay Expenditure	(701.5)	(84.7)	(84.0)	0.6	(701.5)	(692.9)	8.6
Non Pay Expenditure	(403.5)	(33.3)	(30.6)	2.7	(403.5)	(425.7)	(22.2)
Total Operational Costs	(1,104.9)	(118.0)	(114.6)	3.3	(1,104.9)	(1,118.6)	(13.7)
EBITDA	26.3	1.5	8.4	7.0	26.3	26.5	0.2
Interest Receivable	2.9	0.2	0.5	0.2	2.9	5.8	2.9
PDC	(10.3)	(0.9)	(8.1)	(7.3)	(10.3)	(10.6)	(0.4)
Finance Cost	(19.0)	(1.6)	(4.0)	(2.5)	(19.0)	(21.4)	(2.4)
Other Gains or Losses	0.0	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)
Surplus / (Deficit)	0.0	(0.7)	(3.4)	(2.7)	0.0	0.2	0.2

The major variance at Month 12 are.

- an under delivery of CIP by £8.9m. The main CIP schemes behind plan at Month 12 are the ICB non-recurrent stretch of £5.3m and the divisional target of £7.5m.
- additional capacity costs of £5.0m have been incurred to Month 7; additional funding of £2.1m has been agreed with the Staffordshire and Stoke on Trent ICB and this has been reflected in the Month 7 position. Additional winter and escalation costs from Month 8 are funded as part of the Trust winter plan.
- The additional £13.1m funding received to cover the costs of Industrial Action and other pressures has been allocated to cover the additional pay costs incurred due to industrial action of £5.9m with the remaining £7.2m allocated against non-pay pressures.

Capital Spend

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Capital Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M12 £000	YTD Actual M12 £000	Variance M12 £000
Capital funding						
PFI & Loan Commitments	19.6	-	19.6	19.6	30.4	10.8
Base STP allocation	22.1	-	22.1	22.1	22.1	-
Share of ICB 2022/23 surplus re-distribution	0.7	5.9	6.6	6.6	5.9	(0.7)
Share of ICB IFRS16 allocation	-	2.8	2.8	2.8	2.8	-
Public Dividend Capital funding	19.3	8.8	28.1	28.1	28.9	0.7
Donated, granted other capital funding	5.0	-	5.0	5.0	4.6	(0.4)
Internal funding source (including capital receipts)	2.7	(1.4)	1.3	1.3	1.0	(0.3)
Total Capital funding	69.5	16.1	85.6	85.6	95.7	10.1
Capital expenditure						
PFI & Loan Commitments	(19.6)	-	(19.6)	(19.6)	(30.4)	(10.8)
Pre-committed investment items (ICB allocation)						
PFI enabling costs	(0.2)	-	(0.2)	(0.2)	(0.2)	(0.0)
Project Star	(20.7)	-	(20.7)	(20.7)	(21.2)	(0.5)
Emergency Department (restatement costs)	(0.2)	-	(0.2)	(0.2)	(0.1)	0.1
Air heat boiler replacement Trust Contribution	(0.7)	-	(0.7)	(0.7)	(0.7)	0.0
Wave 4b Funding - Lower Trent Wards	(0.2)	0.2	-	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	-	(0.7)	(0.7)	(0.6)	0.2
Pathology LIMS BC (Trust funded)	(0.6)	0.6	-	-	-	-
Pathology MSC Siemens refresh	(0.1)	-	(0.1)	(0.1)	-	0.1
Patient Portal roll out costs (BC 462)	(0.4)	0.1	(0.3)	(0.3)	(0.1)	0.2
Bi plane enabling (BC 425)	(0.2)	-	(0.2)	(0.2)	(0.2)	(0.0)
CT8 enabling works	(0.6)	-	(0.6)	(0.6)	(0.4)	0.2
Network and Communications (BC 510)	(1.2)	-	(1.2)	(1.2)	(1.2)	0.0
Pharmacy Robot BC487 - equipment	(0.5)	0.5	-	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	0.8	(0.0)	(0.0)	(0.0)	-
Electronic Patients records BC/specification	(0.8)	0.1	(0.7)	(0.7)	(0.7)	0.0
ED ambulance drop-off - enabling ward moves	(0.7)	-	(0.7)	(0.7)	(0.4)	0.3
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	-	(0.4)	(0.4)	(0.0)	0.4
Remaining 2022/23 commitments	(0.3)	0.0	(0.3)	(0.3)	(0.3)	0.0
County CTS equipment (TIF) remaining equipment	(0.2)	-	(0.2)	(0.2)	(0.1)	0.0
County Modular remaining equipment	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.0)
Investment funding - minor cases	(0.4)	(0.6)	(1.0)	(1.0)	(1.3)	(0.3)
Total Pre committed Investment items	(30.0)	1.8	(28.2)	(28.2)	(27.6)	0.6
IMT Sub Group Total Funding	(2.3)	-	(2.3)	(2.3)	(2.4)	(0.0)
Medical Devices Sub Group Total Funding	(2.4)	-	(2.4)	(2.4)	(3.7)	(1.4)
Estates Sub Group Total Funding	(3.6)	-	(3.6)	(3.6)	(3.8)	(0.1)
Sub-group brought forward from 2024/25	-	(1.5)	(1.5)	(1.5)	-	1.5
Health & Safety compliance	(0.2)	-	(0.2)	(0.2)	(0.1)	0.0
Net zero carbon initiatives	(0.1)	-	(0.1)	(0.1)	(0.1)	-
Central funding beds, mattresses, hoists	(0.1)	-	(0.1)	(0.1)	(0.1)	-
Total Sub Groups	(8.7)	(1.5)	(10.2)	(10.2)	(10.2)	(0.0)
New IFRS16 leases (previously classified as operating leases and charged to revenue)						
Lease liability re-measurement	(0.2)	(0.1)	(0.4)	(0.4)	(0.4)	(0.0)
IFRS 16 leases	(0.9)	(1.5)	(2.4)	(2.4)	(2.7)	(0.3)
Community Diagnostic Centre lease	-	-	-	-	-	-
Total Internal Capital Expenditure programme	(59.3)	(1.4)	(60.7)	(60.7)	(71.3)	(10.6)
Additional CRL / Externally Funded PDC						
Wave 4b Funding - Lower Trent Wards	(1.6)	0.3	(1.3)	(1.3)	(1.0)	0.3
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	-	(0.4)	(0.4)	(0.4)	-
TIF 2 PDC (Day Case Unit)	(2.7)	1.2	(1.5)	(1.5)	(1.3)	0.2
TIF 2 PDC (Breast Unit)	(1.2)	0.6	(0.7)	(0.7)	(0.9)	(0.2)
PDC - additional General & Acute beds	(13.4)	2.0	(11.4)	(11.4)	(11.3)	0.1
PDC - Community diagnostic centre phase 1	-	(1.1)	(1.1)	(1.1)	(0.8)	0.3
PDC - Pathology LIMS	-	(1.3)	(1.3)	(1.3)	(1.4)	(0.1)
PDC endoscopy	-	(0.5)	(0.5)	(0.5)	(0.4)	0.0
PDC - cyber & A&E imaging	-	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
PDC - Frontline digitalisation EPR	-	(1.5)	(1.5)	(1.5)	(1.5)	(0.0)
Required NHSE plan re-phasing adjustment	7.2	(7.2)	-	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(2.9)	(2.9)	(2.2)	0.7
Charitable funded expenditure	(2.1)	-	(2.1)	(2.1)	(2.4)	(0.3)
Total Additional CRL / PDC Funded expenditure	(17.1)	(7.8)	(24.9)	(24.9)	(23.9)	1.0
Total Capital Expenditure	(76.4)	(9.2)	(85.6)	(85.6)	(95.2)	(9.6)
Planned under/(over) spend	(7.0)	7.0	(0.0)	(0.0)	0.5	0.5

The main variances at the yearend are:

- Project Star is £0.5m ahead of plan as part of changes to the estates capital plan in year by bringing forward expenditure from 2024/25.
- ED ambulance drop-off enabling ward moves and Endoscopy enabling works are £0.3m and £0.4m behind plan due to delays in finalising costs and the scope of work within the available funding. As part of the changes to the capital plan both schemes will be completed in 2024/25.
- Investment funding of minor cases is £0.3m higher than plan due to Statements of Need approved at CIG to use available capital funding in year.
- Medical devices sub-group expenditure is £1.4m higher than plan due to allocation of funds to bring forward expenditure from 2024/25 to help the overall phasing of the capital plan.
- PDC funded lower Trent ward showed an underspend of £0.3m due to actual costs for the approved scheme being lower than anticipated.
- CDC phase 1 expenditure was lower than plan due to delays and uncertainties around the scheme prior to the end of the year.
- Air Heat boiler replacement external funding was £0.7m below plan due to delays in a number of the schemes however this is offset by a reduction in external funding.

Balance sheet

Balance sheet as at Month 12	31/03/2023	31/03/2024			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	659.2	686.3	27.0	Note 1
Right of Use Assets	18.8	17.2	18.1	1.0	
Intangible Assets	18.4	16.9	16.3	(0.7)	
Trade and other Receivables	1.4	1.4	1.1	(0.3)	
Total Non Current Assets	666.1	694.7	721.7	27.1	
Inventories	16.8	18.0	17.7	(0.3)	
Trade and other Receivables **	57.9	45.1	44.4	(0.7)	
Cash and Cash Equivalents **	84.0	61.0	82.0	21.0	Note 2
Total Current Assets	158.7	124.1	144.1	20.0	
Trade and other payables **	(134.0)	(118.1)	(125.6)	(7.4)	Note 3
Borrowings ***	(14.0)	(25.0)	(25.6)	(0.7)	
Provisions	(5.6)	(5.6)	(5.7)	(0.1)	
Total Current Liabilities	(153.5)	(148.7)	(156.9)	(8.2)	
Borrowings***	(448.2)	(422.6)	(477.1)	(54.5)	Note 4
Provisions	(2.7)	(2.7)	(2.3)	0.3	
Total Non Current Liabilities	(450.9)	(425.2)	(479.4)	(54.2)	
Total Assets Employed	220.3	244.8	229.5	(15.3)	
Financed By:				-	
Public Dividend Capital	665.0	683.2	693.9	10.7	Note 5
Retained Earnings */***	(618.9)	(612.7)	(669.1)	(56.4)	Note 6
Revaluation Reserve *	174.2	174.2	204.7	30.5	Note 1
Total Taxpayers Equity	220.3	244.8	229.5	(15.3)	

Note 5. Retained earnings are showing a £56.4m variance from plan which reflects the year end surplus of £0.2m and adjustments relating to;

- donated income and donated depreciation £2.3m;
- the impact of DHSC consumables £0.3m;
- impairments charged to I&E from the land and building asset valuation £7m.

The most significant movement is to remove the impact of accounting for the PFI liability under IFRS16 and for financial performance measurements returning this to the impact under IAS17, this includes the impact on the PDC dividend. The net impact of the adjustments is £46.2m.

Variances to the plan at the year end are explained below:

Note 1. The increase is mainly due to the impact of the valuation of land and building assets which has increased the net book value by £23m. This is made up of a £30m increase in the revaluation reserve and impairments to retained earnings (a reduction of £7m). The impairments are mainly due to the revaluation of the land for the new multi-storey car park and capital expenditure relating to the donated air heat boiler scheme not resulting in an increase to the asset value.

Note 2. At the year end our cash balance was £82m, which is £21m higher than the plan of £61m. Cash received is £35.5m higher than plan overall, of which £16.4m relates to the ICB block mandate. Included within this is £12.6m cash received from Stoke and Staffordshire ICB to cover the additional cost of industrial action. The remaining balance includes £1.1m winter funding and CDC funding of £1.6m.

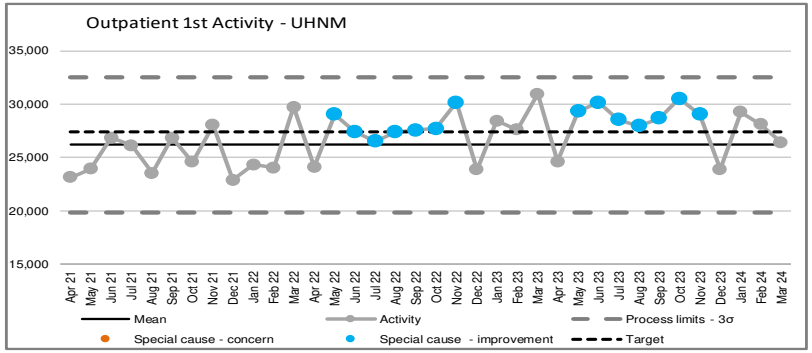
Note 3. Trade and other payables are £7.4m higher than plan, this is mainly due to higher than plan balances of deferred income at the year end. The deferred income balance includes £5.2m relating to high cost devices with NHSE. Other significant deferred income balances include £7.1m with Staffordshire and Stoke ICB in relation to a number of areas including CDC/MRI and West Midlands Cancer alliance funding. A further £2m of deferred income relates to education and training funding and digital pathology funding to match future expenditure.

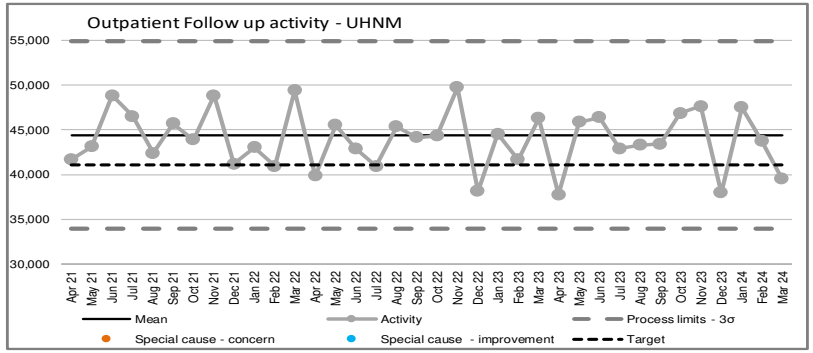
Note 4. Borrowing is £54.5m higher than plan and reflects the impact of the application of IFRS16 to the PFI liability from April 2023. In year the impact of applying the RPI within the Unitary Payment to the opening liability resulted in a £61.8m increase in liability. Repayments of the liability were £8m higher than plan (due to contingent rent not being charged to I&E) and therefore the net impact on the liability in year was an increase of £54m.

Activity

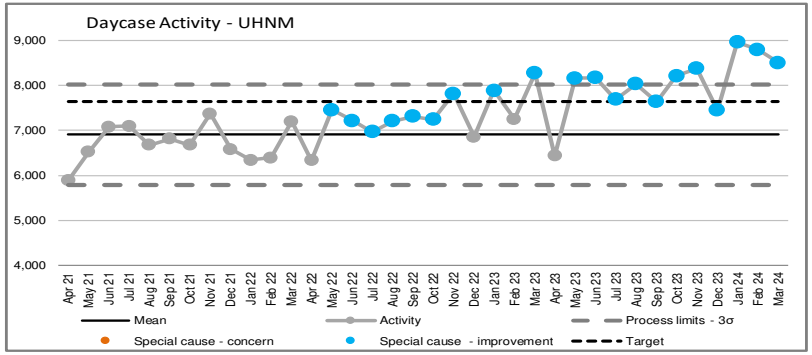
NHS
University Hospitals of North Midlands
NHS Trust

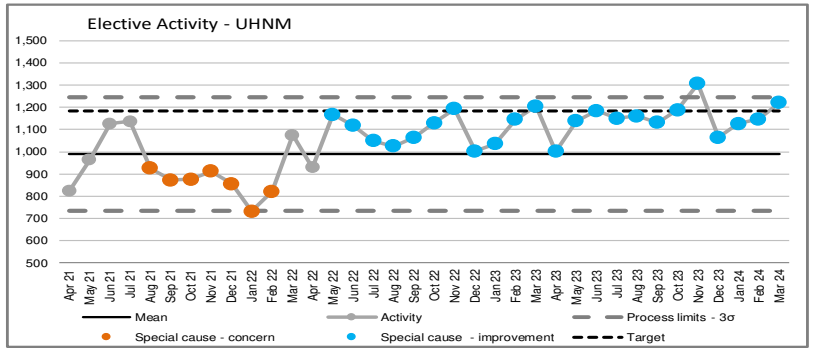
Planned care Outpatient



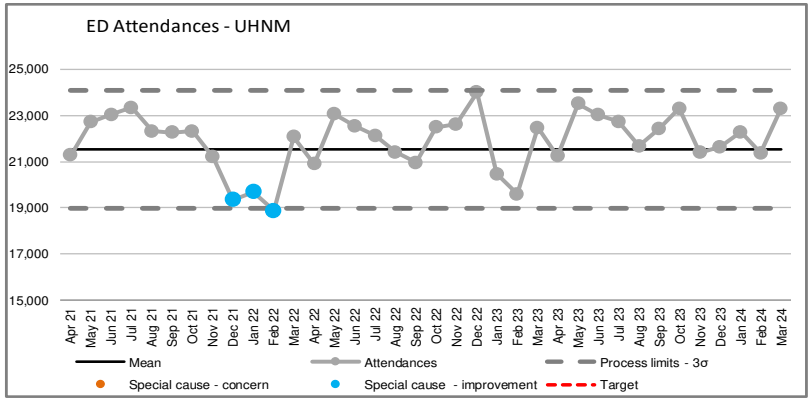


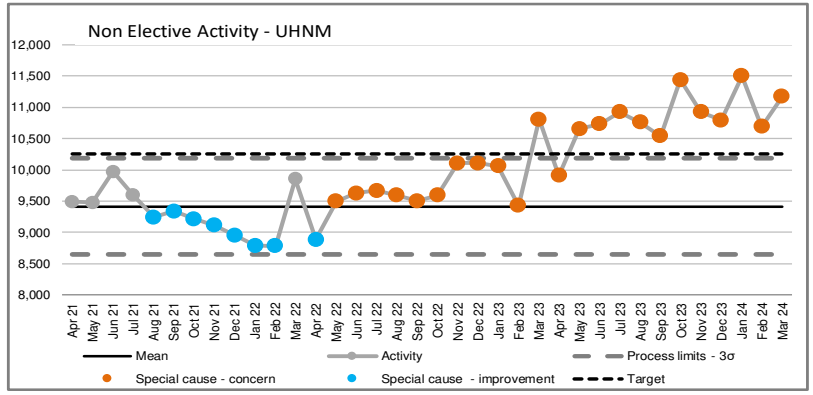
Planned care Inpatient





Urgent Care





Highlight Report

Audit Committee 2nd May 2024 to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- There is a delay with a revised Quality Impact Assessment process / policy as work is being undertaken with system partners to develop a system wide approach
- Agreement of the top 3 risks for the Annual Governance Statement in terms of Sustainable Workforce, Sustainable Finances and Responsive / Quality Care
- Land and Building Valuation and management of override controls were identified as significant risks through the External Audit (which are no different to previous years)

Major Actions Commissioned / Work Underway

- The Internal Audit Review of Mental Capacity was being updated and it was likely that the opinion would be improved although this would be confirmed through the final report
- Internal Audits underway the Committee in June will be IT Systems, Planned Care Waiting List Management, CQC Outcomes Framework and Data Quality Annual Leave Indicators
- A number of procedures were being documented in relation to Speaking Up as a result of the Internal Audit review
- The Annual Goverannce Statement will be updated to reflect the Internal Audit conclusions and the inclusion of key findings
- Policies requiring review are now being discussed at the relevant Executive Group to ensure plans for review are agreed and monitored
- Consideration will be given to how policies due for review will be highlighted going forward
- Development of BAF for the 2024/25 BAF taking into account the discussion at Deep Dive and through the new Committee arrangements
- Consideration to be given to the management of private practice lists
- 3 actions arose from the Effectiveness Review around oversight of Internal Audit Recommendations, meeting attendance and an induction programme for new Committee members
- Consideration of benchmarking, trend and trajectory to enhance to losses and special payments report including provision of Pharmacy data which had previously been presented
- Draft accounts had been produced and submitted to the auditors
- 69% Declarations of Interest have been returned to date and these will continue to be followed up via the online system

Positive Assurances to Provide

- All 5 Internal Audit reports finalised and presented to the Committee received positive Internal Audit opinions including Productivity Reporting, Safe Staffing, Freedom to Speak Up, Board Assurance Framework and Clinical Risk Management
- Actions relating to the fields included within the Speaking Up Tracker have been completed
- A positive Internal Audit Opinion has been concluded ‘an adequate and effective framework for risk management, governance and internal control’
- Committee Deep Dives into the BAF have proven very helpful in further developing the Boad Assurance Framework
- Committee Effectiveness Evaluation concluded that the Committee is functioning effectively
- Positive feedback was provided in relation to the introduction of the Strategy and Transformation Committee
- A full positive rating was given for the annual Fraud Assessment
- The annual Clinical Audit Programme was received for information
- A positive review of the Internal Audit and Counter Fraud function was undertaken

Decisions Made

- Approval of the Internal Audit Plan for 2024/25
- Approval of Standards of Business Conduct Policy
- Approval of Anti-Fraud and Bribery Policy
- Confirmation of the External Audit Risk Assessment

Comments on the Effectiveness of the Meeting

- Good discussion around internal audit, commitment to look at challenged areas, positive review of the plan for Mental Capacity Review, able to approve a number of policies
- Key actions identified for oversight of losses and special payments

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: • Productivity Reporting • Board Assurance Framework • Freedom to Speak Up • Safe Staffing • Clinical Risk Management - Patient Safety Incident Response Framework (PSIRF)	BAF 8 BAF 3 BAF 2 BAF 1		🟢	Assurance	9.	Issues of Escalation from Committees			-	Assurance
2.	Draft Annual Internal Audit Report 23/24			🟢	Assurance	10.	Losses and Special Payments Q4 2023/24	BAF 8	Low 3	-	Assurance
3.	Internal Audit Plan 2024/25			-	Approval	11.	SFI Breaches and Single Tender Waivers Q4 2023/24	BAF 8	Low 3	-	Assurance
4.	Internal Audit Action Tracker			-	Assurance	12.	Overview of 2023/24 Draft Financial Statements	BAF 8	Low 3	-	Assurance
5.	Corporate Governance Report	BAF 8	Low 3	🔴	Assurance	13.	External Audit Plan	BAF 8	Low 3	🔴	Approval
6.	Board Assurance Framework Q4 23/24	ALL		🔴🟢	Approval	14.	Informing the Audit Risk Assessment			-	Approval
7.	Policies for Approval: • G16 Standards of Business Conduct • G18 Anti-Bribery & Anti-Fraud Policy	BAF 8	Low 3	-	Approval	15.	Counter Fraud Annual Report 2023/24	BAF 8	Low 3	🟢	Assurance
8.	Committee Effectiveness 2023/24			🟢	Approval	16.	2024 / 2025 Annual Clinical Audit Plan		ID26887 ID8877 ID8500	🟢	Information

Attendance Matrix

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
Report Title:	Q4 Board Assurance Framework	**Agenda Item:**	16
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance & Claire Cotton, Director of Governance		
Executive Lead:	Claire Cotton, Director of Governance		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Please refer to full BAF and appendices for comprehensive list of all linked risks

Executive Summary

Situation

The Board Assurance Framework (BAF) has been updated by Executive Leads for Q4 2023/24 and is enclosed, along with a refreshed 'Summary BAF' which was introduced in Q2. In accordance with their Terms of Reference, the Audit Committee has responsibility for oversight of the BAF process.

Background

The 2022/23 Internal Audit Review of the BAF and Risk Management recommended the introduction of Deep Dives by Committees as part of the oversight and scrutiny arrangements. Following the BAF Deep Dives in January 2024, the output of the sessions will be fed into planning the risks for 2024/25. These have already been considered by the Executive Team and Trust Board and will be reported to Committees in July 2024.

Assessment

	3 risks have seen a reduction in risk level this quarter; BAF 4 Improving Population Health, BAF 6 Digital Transformation and BAF 8 Financial Sustainability
	The risks score trajectory for BAF 2 was planned to reduce to High 12 during Quarter 4 although due to a number of pressures the risk has remained at Ext 16
	7 / 9 risks have achieved the planned trajectory for Quarter 4; BAF 6 has reduced below the planned trajectory to High 9 and BAF 8 has achieved its target risk score. BAF 2 and BAF 5 remain the only risks above the planned trajectory as at Quarter 4
	The number of linked risks has increased during the quarter for 1 / 9 strategic risks (BAF 5) and has reduced for 2 / 9 risks (BAF 1 and BAF 6)
	13 actions have moved to 'complete / BAU' during Quarter 4, across 6 strategic risks.
	There are a number of areas where sources of assurance have not been seen in line with plan and where possible, these are or have been rescheduled.

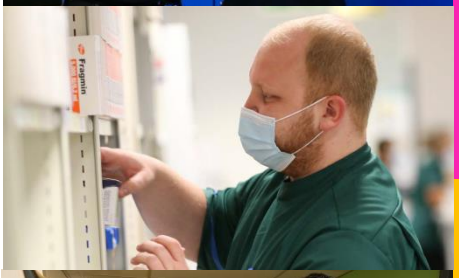
It should be noted that for the 2023/24 Annual Governance Statement, the Trust is required to confirm its top 3 risks for the year. As per 2022/23, our top 3 risks continue to be sustainable workforce, financial sustainability and delivering quality responsive care. Whilst improving the health of our population has been one of our most extreme scoring BAF risks throughout the year, its impact is directly linked to quality and responsiveness.

Key Recommendations

- To approve or amend the BAF and to consider whether risk scores and assurance assessments are an accurate reflection of the position

To agree the top 3 risks for 2023/24.

NHS
University Hospitals of North Midlands
NHS Trust



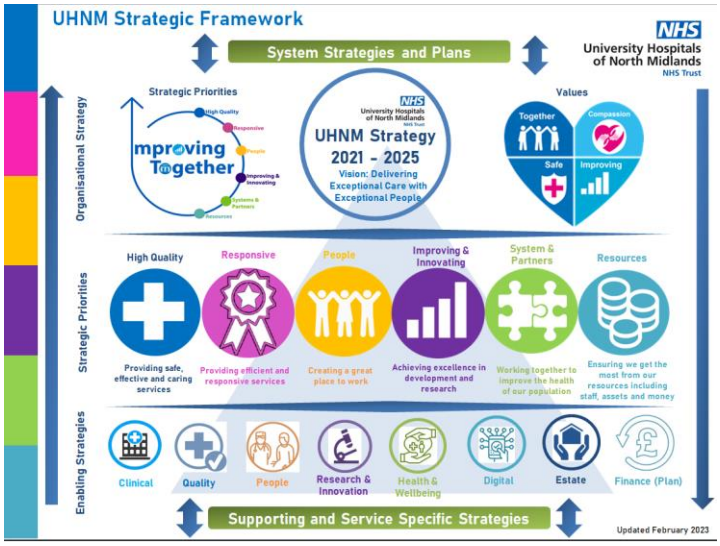
Board Assurance Framework (BAF)

Quarter 4 2023/24

Delivering Exceptional Care with Exceptional People

1. Introduction

Situation



The Board Assurance Framework (BAF) provides a structure and process to focus the Board on the key risks which might compromise the achievement of our Strategic Priorities (see illustration).

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

Background

The strategic risks contained within the 2023/24 BAF were refreshed by the Executive Team and agreed by the Board in March 2023 in line with our annual review process. The format and function of the BAF has been subject to ongoing review. Following the BAF Deep Dives in January 2024, the output of the sessions will be fed into the risks for 2024/25. These have already been considered by the Executive Team and Trust Board and will be reported to Committees in July 2024.

Assessment

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

	3 risks have seen a reduction in risk level this quarter; BAF 4 Improving Population Health, BAF 6 Digital Transformation and BAF 8 Financial Sustainability
	The risks score trajectory for BAF 2 was planned to reduce to High 12 during Quarter 4 although due to a number of pressures the risk has remained at Ext 16
	7 / 9 risks have achieved the planned trajectory for Quarter 4; BAF 6 has reduced below the planned trajectory to High 9 and BAF 8 has achieved its target risk score. BAF 2 and BAF 5 remain the only risks above the planned trajectory as at Quarter 4
	The number of linked risks has increased during the quarter for 1 / 9 strategic risks (BAF 5) and has reduced for 2 / 9 risks (BAF 1 and BAF 6)
	13 actions have moved to 'complete / BAU' during Quarter 4, across 6 strategic risks.
	There are a number of areas where sources of assurance have not been seen in line with plan and where possible, these are or have been rescheduled.

Recommendations

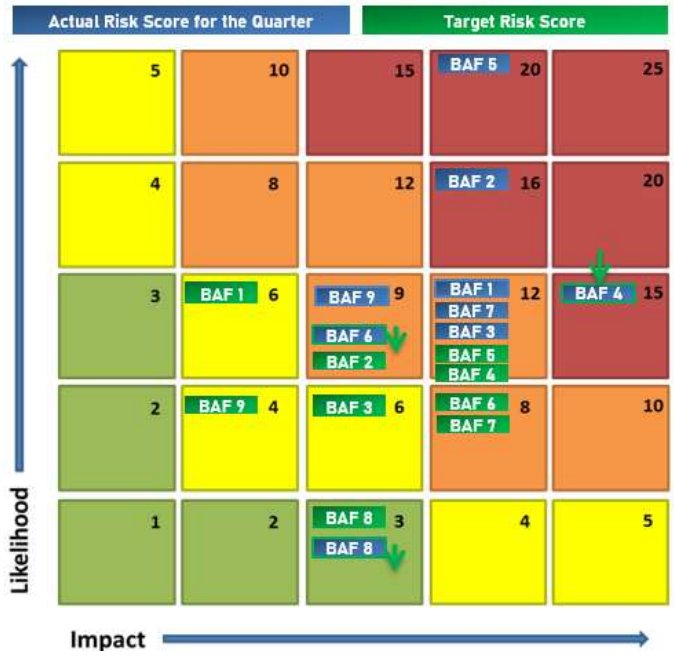
- Consider whether the risk scores and assurance assessments are an accurate reflection of the position
- Consider whether the actions identified are sufficient to either reduce the risk score or to provide additional assurance

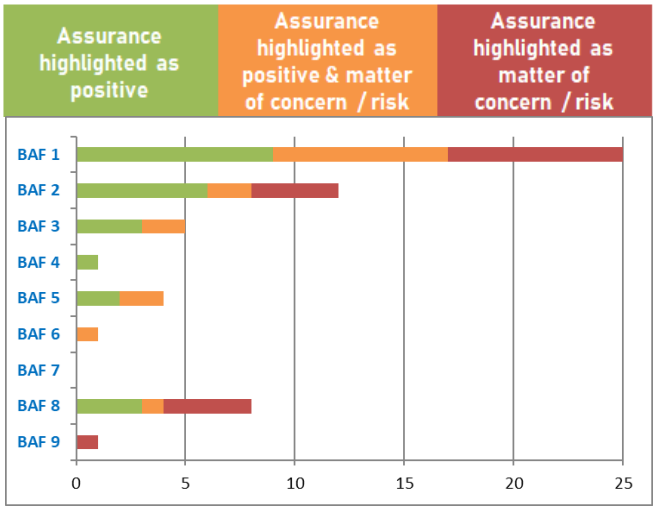
BAF Action Plans – Key to Progress Ratings	
On Track	Improvement on trajectory, either: GA – 'On track – not yet completed' or GB 'On track – not yet started'
Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
Delayed	Off track /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

2. Summary Board Assurance Framework

	BAF Risk Title	Risk Scores & Assurance Assessment Q1	Q2	Q3	Q4	No. Linked Risks	High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources	Actual v Trajectory	Target Risk Score
BAF 1	Patient Outcomes & Experience	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	165 ↓ (Q3 176)	✚	✚	✚	✚				Mod 6
BAF 2	Sustainable Workforce	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	118 → (Q3 118)	✚		✚			✚		High 9
BAF 3	Leadership, Culture & Values	High 12 / Partial Assurance	High 12 / Partial Assurance	High 12 / Partial Assurance	High 12 / Partial Assurance	10 → (Q3 10)	✚	✚	✚					Mod 6
BAF 4	Improving Population Health	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 15 / Partial Assurance	2 → (Q3 2)	✚				✚	✚		High 12
BAF 5	Responsive Patient Care	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	63 ↑ (Q3 62)	✚	✚	✚	✚	✚	✚		High 12
BAF 6	Digital Transformation	Ext 16 / Partial Assurance	Ext 16 / Partial Assurance	High 12 / Acceptable Assurance	High 9 / Acceptable Assurance	73 ↓ (Q3 75)	✚	✚		✚	✚	✚		High 8
BAF 7	Fit for Purpose Estate	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	78 → (Q3 78)	✚	✚	✚	✚	✚	✚		High 8
BAF 8	Financial Sustainability	High 9 / Partial Assurance	High 12 / Partial Assurance	High 9 / Partial Assurance	Low 3 / Partial Assurance	33 → (Q3 33)	✚	✚	✚	✚	✚	✚		Low 3
BAF 9	Research & Innovation	High 12 / Partial Assurance	High 12 / Partial Assurance	High 9 / Partial Assurance	High 9 / Partial Assurance	3 → (Q3 3)	✚		✚	✚	✚	✚		Mod 4

3. Risk Heat Map & Assurance Outcomes





The Assurance Outcomes chart represents the total number of assurances considered by Committees during the quarter and the outcome which was recorded in the Committee Highlight Report to the Trust Board. In terms of BAF 7, the assurances provided were not rated.

4. Board Assurance Framework 2023/24

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

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	3	Likelihood:	3	31/03/2025	Low 1 - 3	5 ↓	Mod 4 - 6	43 ↑
Consequence:	4	4	4	4	Consequence:	2		High 8 - 12	105 ↓	Ext > 15	12 ↓
Risk Level:	Ext 16	Ext 16	High 12	High 12	Risk Level:	Mod 6		Total No. Linked Risks:			165 ↓
Rationale for Risk Level:	Clinical effectiveness delivery remains a concern and Section 29a notices remain in place with a CQC rating of Requires Improvement. Not all quality metrics are meeting required targets										

Position Statement

What progress has been made during the last quarter?

- Received very positive feedback from the Chair of System Maternity Oversight and Assurance Group (SMOAG) following an onsite visit to maternity on 15 March 2024
- Internal audit of UHNM establishment review process concluded with significant assurance on 25 March 2024
- Confirmation received that 84% of out-patients are receiving letters addressed to patient (cc GP)
- Vacancies reduced to zero (with a reserve list) for registered nurses and HCA's following successful recruitment events and retention improved by 4%.

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 • 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 • Specific governance arrangements in place for Maternity Services • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases
2nd Line	• A review of Quality, Safety and Compliance and Clinical Effectiveness was presented to the Quality Governance Committee (QGC), which identified areas where there was a lack of assurance and outlined some immediate mitigation; further updates will be presented through QGC in March 2024. • 6 monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity • Birth rate plus staffing assessment for midwifery services and recruitment completed • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within Divisions; Patient Safety Incident Response Framework (PSIRF) training commenced • RCA Scrutiny Panels in place for Serious Incidents, Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Care Excellence Framework and review meeting with Chief Nurse/Deputy Chief Nurse for any area rated Bronze overall, or with any Bronze domain • Leadership Council for all areas trained in Quality Improvement methodology

	• Clinical Effectiveness Group in place to guide the development and oversight of divisional quality improvement plans, based on analysis of data relating to performance, patient experience, outcomes, audit, national guidelines, risks, litigation and incidents • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and QGC remains in place. Separate QSOG and QGC structure in place for Maternity and Neonates • 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; site wide audit process introduced • Standard Operating Processes approved and implemented for Corridor Care and Your Next Patient • Review of Complaints Process • Overseas nursing business case approved • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Infection Prevention Team co-ordinate Improvement Programmes for infections • Patient Experience team in place • Crude Mortality rates monitored through Mortality Assurance Group • Scrutiny of circumstances surrounding deaths from Medical Examiner +/- Structured Judgement Review • Risk assessments undertaken at ward level for Your Next Patient and Corridor Care in ED (shared with the CQC) • Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners • Integrated Discharge Function in place • Delivery of Workstream 2 actions focusing on length of stay, occupancy and simple and timely discharge • BC-0538 Additional Recurrent Investment in the Medical, ANNP and AHP Workforce in Neonatal Services • BC-0545 Pharmacy Workforce Resource Requirement to Support the Current Medicine Division In-patient Bed Base and Activity • BC-0539 Recurrent Investment in the Medical, Sonographer and Robotic Assistant Workforce for Obstetrics and Gynaecology Services • Focused support in place for international nurses to guide them through recruitment and interview process • Nursing recruitment completed in line with Emergency Department Business Case
3rd Line	• Process in place with ICB to undertake Clinical Quality Review Meetings (CQRM) • ICB Quality and Safety Committee • Key UHNM representatives undertaking PSIRF development programme by ICS as part of national NHS Patient Safety Strategy • NHS Oversight Framework (NOF) Review Meeting • Quality and Safety Oversight Framework • Local Maternity and Neonatal System (LMNS) Board • Meetings held between UHNM and primary care occur monthly to improve care for patients at interface • System Maternity Oversight and Assurance Group • Chief Nurse joint SRO with Chief People Officer on NHS England (NHSE) Flexible Working; and SRO for NHSE retention programme

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Highlight Report from Quality & Safety Oversight Group	●	●	●	●
	Highlight Report from Clinical Effectiveness Group	●	●	●	●
	Highlight Report from Maternity & Neonatal Quality & Safety Oversight Group	●	●	●	●
	Quality Impact Assessment Report	●	●	●	●
	Thirlwall Inquiry Update				●
2nd Line	Monthly Quality and Safety Report	●	●	●	●
	Quality Strategy Year 2 Progress Report			●	
	County Quality Report		●	●	●
	Nurse Staffing Establishment Review	●		●	
	Nursing & Midwifery Staffing Quality Report	●	●	●	●
	Serious Incident Report	●	●	●	●
	Infection Prevention Report	●	●	●	●
	Infection Prevention, Vaccination & Sepsis Team Annual Report		●		
	Paediatric Sepsis Screening Update		●		●
	Sepsis Management – Emergency Department Royal Stoke		●		
	Mortality Report	●	●	●	●
	Medical Examiner Update	●		●	
	Readmissions Update	●	●	●	
	Resuscitation Annual Report			●	
	Care Excellence Framework (CEF) Summary	●	●	●	●

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
	Quality Safety and Compliance Overview				
	Annual Clinical Audit Plan				
	Medicines Optimisation Report				
	Organ Donation and Transplantation				
	CQUIN Report				
	7 Day Services Board Assurance Report				
	End of Life Annual Report				
	Patient Experience Report				
	Vulnerable Patients (Mental Health, Dementia / Learning Disabilities and Autism) Annual Report 2022-2023				
	Safeguarding Children Annual Report				
	Safeguarding Adults Annual Report				
	Infection Prevention Board Assurance Framework				
	Resuscitation Update				
	Patient Safety Incident Response Plan (PSIFP)				
	Maternity Dashboard				
	Maternity Serious Incident Report				
	Maternity Family Experience Report				
	Ockenden Report Update				
	Saving Babies Lives Care Bundle				
	Perinatal Mortality Report				
	NHS Resolution Maternity Incentive Scheme				
	Update on the Suspension of the Home Birth Service				
	ATAIN (Avoiding Term Admissions into the Neonatal Unit)				
	Patient Waiting List Backlog				
	Business Case Review: Overseas Nurses				
	Neonatal Workforce Paper				
	Midwifery Workforce Report				
	Re-audit of Consultant Presence on Ward Rounds & Re-Audit of Consultant Attendance at Clinical Situations				
	Pressure Ulcer Update				
	Deep Dive into Hospital Associate Thrombosis				
	Saving Lives, Improving Mothers' Care				
3rd Line	Get it Right First Time (GIRFT) Update				
	Maternity Voices Partnership Update				
	CQC Inspection Update				
	Litigation and Inquest Report				
	Quality Account (including stakeholder feedback)				
	Maternity CQC Report				
	Cardiothoracic Surgery Review Update				
	Neonatal Unit Assurance Update				
	Internal Audit Review of Care Quality Commission Actions				
	Internal Audit Review of Clinical Risk Management – Patient Safety Incident Response Framework (PSIRF)				
	Internal Audit Review of Safe Staffing				
	Internal Audit Review of CQC Actions Outcomes Framework				
	Internal Audit Review of Mental Capacity Assessment Framework				
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators				
	Maternity Rapid Quality Review				
	NHS Maternity Services Survey and Improvement Plan				
	ICB Quality Visit – County Hospital				
	System Maternity Oversight and Assurance Group Minutes				
	Breast Imaging Response to NHS England Very High Risk Screening Programme				

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

Gaps in Control or Assurance

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

- Awaiting CQC inspection in relation to both Section 29a notices
- Awaiting approval of vacancy to support delivery of clinical effectiveness agenda
- Delivery against related quality and harm free care A3 countermeasures

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.	Continued focus on recruitment and retention strategies	Control to reduce likelihood	Chief Nurse	31/03/25	• Vacancies reduced to zero (with a reserve list) for registered nurses and HCA's following successful recruitment events. • Retention improved by 4%. • Successful B4 patient safety conference; Nursing Associate Forum now in place; inaugural clinical B4 and 5 nursing development day took place 8 March • B6 fellowship programme in development to support leadership capability and develop B7 talent pipeline • Matron Role review completed and B7 ward/dept leader role review to now take place; • CeNREE celebration event to take place in May • CN/DoM/CeNREE fellows successfully completed their fellowship programme. We have received 24 applications for this year's programme (3 AHP; 3 CNIO; 2 MW; 5 Pharmacy and pharmacy technicians; and 11 RNs)	
2.	Delivery of CQC required actions	Control to reduce likelihood	Chief Nurse	31/03/25	• CQC action plan refreshed and presented to Trust Board – problematic actions (e.g. compliance with Statutory & Mandatory Training targets) included on risk register. • Evidence collated and submitted to CQC re section 29A maternity • Evidence sent to CQC re section 29A County Hospital. • SMOAG chair and LMNS visited Maternity on 15 March and positive feedback received. • UHNM will be subject to a NHSE Quality Review process on 5 April 2024 to showcase progress made to date	
3.	External Review of Paediatric Audiology to be undertaken	Control to reduce likelihood	Chief Medical Officer	30/06/24	Outcome to be provided to QGC May/June 2024	

BAF 2: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	4	4	Likelihood:	3	31/3/2025	Low 1 - 3	4 →	Mod 4 - 6	26 ↑
Consequence:	4	4	4	4	Consequence:	3		High 8 - 12	77 ↓	Ext > 15	11 ↑
Risk Level:	Ext 16	Ext 16	Ext 16	Ext 16	Risk Level:	High 9		Total No. Linked Risks:			118 →
Rationale for Risk Level:	Although good progress has been maintained in Q4, as anticipated we have experienced increased challenges during Q4, including System financial pressures, winter pressures and the impact of continued industrial action, therefore the plan to achieve a score of High 12 by Q4 has not been met.										

Position Statement

What progress has been made during the last quarter?

- There has been continued good progress with the delivery of the People Plan during Q4. Our overall workforce plan remains on largely track.
- Driver Metric for the Staff Vacancy Rate (R12M): was 8.5% for Jan 24 and 7.8% for Feb 24 against the target of 10%. The rate has continued to be better than target throughout 2023/24 and will be a watch metric for 2024/25.
- Linked to vacancies, the watch metric for Staff Turnover (R12M) was 8.2% for Jan 24 and 7.9% for Feb 24 against the target of 10%. This has continued to be better than target throughout 2023/24 and will continue to be a watch metric for 2024/25.
- PwC undertook "fieldwork" review on our controls which demonstrated good vacancy controls
- Excellent engagement seen from the '5 reasons why join UHNM' campaign during January through social media. Greatly increased the number of applications.
- Successful Nursing and Newly Qualified Nursing Events have taken place during February bringing us to almost zero ward Nursing and zero Nursing Assistant vacancies. Over 100 individuals from Keele and Stafford Universities being offered/allocated Newly Qualified Nursing positions. (Also see reference to this under BAF 1)
- Successful recruitment at the end of March to our Chief Executive vacancy; start date tbc.
- Deep dive EWAG session in March 2024 on effective recruitment and an update on the UK Visa and Immigration rules.
- Work continues with the Finance Team to understand the relationship between the substantive vacancy position and the budgeted establishment.
- Watch Metric for Agency Costs (as % of pay) have continued to slightly improve during Q4 (4.6% in Jan and 4.4% in Feb 24) but are still above target of 3.7%
- Successful National Apprenticeship Week held in Feb 24, promoting our apprentices and our roles.
- The apprentice uptake against the apprenticeship levy will be a breakthrough objective for 2024/25. Driver metric for Apprentices commences from April 2024; aim is to achieve our Trust target collectively of 250 apprentices 2024/25 and 300 apprentices 2025/26.

Key Controls Framework – 3 Lines of Defence

1st Line

- Directorate and divisional management teams monitor staffing levels
- Divisional vacancy control panels/processes
- Work on initiatives focussing on the retention of our workforce
- Work-flow recruitment management system to track and optimise on-boarding processes. Monthly contract performance management meetings take place between the Head of Resourcing, Recruitment Manager and the recruitment system supplier.
- Experienced medical rota coordinators aligned to Divisions to support operational planning

2nd Line	• People Strategy for 2022-2025 highlights key strategic areas of workforce activity • 2023/24 Workforce Plan reported to Transformation & People Committee (TAP) • Vacancy levels is a key driver metric for the Trust and is reviewed monthly through TAP. In addition, watch metrics for staff sickness rates, staff turnover rates and agency pay costs are reviewed monthly. • Continued work (involving various teams across Central Functions) to improve workforce information data quality, security and protection. • Digital Staff Passport in place to hold staff verified employment and training credentials. • Established Banks are in place – including Nursing, Medics and other staff groups • Nurse Establishment Reviews reported twice yearly to the Trust Board and relevant Committees • Pipeline of approved business cases in key areas from 2022/23 profiled into the workforce establishment to enable tracking of vacancies and workforce supply. • New Business Cases which include additional workforce are required to go through the Trust's approval processes. • Workforce Workstream are in place if/as required to support key transformation programmes. • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • General recruitment drives are on-going and there is an element of head hunting via informal networks • National target to agency reduction set is a key metric reviewed monthly through TAP • Insourcing contracts in place in key areas to support the recovery plan • Continuing work with education teams and providers across the system to enhance opportunities for learning and the education experience for our trainees • Daily tracking of unplanned absences to support local planning • Internal redeployment of staff to support safer staffing levels • Winter planning group stood up at the appropriate time in the year • Overseas nursing business case approved July 2023 • Staff Benefits Portal (Rewards and Recognition, Vivup) • Why Work at UHNM Campaign • New Recruitment Landing page for applicants promoting the benefits of working at UHNM • BC-0538 Additional Recurrent Investment in the Medical, ANNP and AHP Workforce in Neonatal Services • BC-0545 Pharmacy Workforce Resource Requirement to Support the Current Medicine Division In-patient Bed Base and Activity • BC-0539 Recurrent Investment in the Medical, Sonographer and Robotic Assistant Workforce for Obstetrics and Gynaecology Services • Centralised Nursing Assistant recruitment process implemented • Performance & Development Review [PDR] documentation updated to reflect the managers role in undertaking career conversations • Engagement and Retention Manager (People Promise Manager) in place funded by NHS England
3rd Line	• Retention planning at System and Regional level • Member of monthly ICS Workforce Information & Planning Group • Monthly meetings with recruitment leads across the ICS • National and system controls for non-clinical agency expenditure • ICS audit on grip and control (PwC) • System and organisational spending controls • System wide Memorandum of Understanding Signed for T Level Placements setting out our collaboration expectations • Working relationships in place with Job Centre Plus and DWP regarding recruitment into entry level roles • Working with School and Colleges as part of Careers weeks to introduce UHNM to a younger generation • Partner with Staffordshire University on delivering simulation sessions • Partnership with Princes Trust and Chamber of Commerce

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Workforce Assurance Group Highlight Report	●	●	●	●
2nd Line	Chief People Officer Report	●	●	●	●
	Workforce Performance Report	●			
	International Recruitment (Maternity) - Competency Assessments and Failure Rate	●			
	People Strategy Update	●			
	Talent & Succession Planning Update		●		●
	Nursing & Midwifery Staffing and Quality Report	●	●	●	●
	Staff Survey Action Plan	●			
	Nursing Establishment Review	●		●	
	Guardian of Safe Working Report	●	●	●	●
	NHS Long Term Workforce Plan		●		
	Strategic Workforce Plan		●		
	Nursing Headroom and Relationship with Vacancies		●		
	Business Case Review: Overseas Nurses		●		

	Agency Report / Controls				
	Neonatal Workforce Paper				
	Medical Workforce Highlight Report				
	Midwifery Workforce Paper				
	Business Case Review: Neonatal Nursing Workforce				
	Business Case Review: International Recruitment of Nurses				
	Health and Wellbeing Review				
3rd Line	Staff Survey Report				
	Gender Pay Gap Report				
	Internal Audit Review of Bank and Agency				
	Internal Audit Review of Data Quality: Annual Leave Indicators				
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators				

Assurance Assessment

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

Gaps in Control or Assurance

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

- Increasing financial controls are required in respect to vacancy controls. In Q1 2024/25 there will be competing priorities of reducing financial risks to the organisation versus the risk of creating a higher staff vacancy rate, which in turn may have a detrimental effect on service performance and delivery, staff well-being, staff satisfaction, sickness absence rates and staff turnover rates.
- The staff group with the greatest vacancy factor during Q4 has been Medical and Dental staff (13.6% in Jan and 13.3% in Feb 24).
- Agency Expenditure remains above the target and is subject to continued scrutiny through the Divisional Performance Reviews and the Medical Workforce Assurance Group. There is also increased and regular focus at ICB level on workforce numbers, agency spend and controls. Work continues on identifying off-framework agency usage, and moving it to a framework contract, reducing the premium spend. NHS England has stated that all off-framework agency usage must cease by July 2024.
- Key challenges for our Learning, Education and Widening Participation Team has been the high number of requests to support careers events, partnership meetings, supporting on work based programmes, and although we have tapped into our breadth of Education Leads and ambassadors many are clinical and have competing priorities; the demand from schools, colleges and Universities is greater than our capacity. Therefore, strategic decisions are made in respect to which events are prioritised and how to maximise use of technology (e.g. delivering simulation work experience days and programmes etc).

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.	Work with TRAC Supplier to identify application redesign opportunities	Control to Reduce Likelihood	Chief People Officer	~~31/12/23~~ 31/03/24	In Q3, TRAC were developing a 2nd shorter application form (nationally) for Nursing Assistant (aka Healthcare Assistant) roles. TRAC have been piloting it during Q4 (nationally) but this has not concluded yet. UHNM Recruitment Manager is awaiting outcome of the pilot, and it will be implemented at UHNM as soon as it is ready to go-live in 2024/25. (NB. A version of this action will be carried forward to 24/25 BAF with a revised target date).	
2.	Review all placements currently offered by the Trust and where appropriate create a new career pathway through guaranteed interview and job schemes, mirroring the current Newly Qualified Nurse pathway.	Control to Reduce Likelihood	Chief People Officer	31/03/24	Implementation of a new career pathway that mirrors the Newly Qualified Nurses but for Nursing Assistants who have completed their Level 2 or 3 in Health and social Care is in place. This started in Jan 2024 and five local sixth forms and colleges have signed up. (Further action to be considered for 24/25 BAF with a revised target date, re: full roll-out in May 24 roll out across the organisation for every education course	

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
					that we offer placements to. The next one in progress is the Bio-Medical Scientists [BMS] pathway)	
3.	Develop, promote, and deliver retention plan	Control to Reduce Likelihood	Chief People Officer	~~30/11/23~~ 31/03/24	Complete. Following review and discussions in Q3, retention will not be a stand-alone Driver metric for the People Directorate; but this will remain embedded into other drivers and plans. Retention made up of other elements of work which includes Flexible working, Exit/ Stay Interviews, and Talent and Succession Planning. Retention work presented to the Trust Executive Team via EWAG in Jan 24 & plans developed for 2024/25. This will be a key priority for 24/25 as per Staff Survey results. Some work delayed due to assigned retention resources at system level.	
4.	To launch the new/revised welcome booklet for new starters	Control to Reduce Likelihood	Chief People Officer	30/06/24	Work commenced in Q4 in readiness for the launch in Q1	
5.	Task and Finish Group to be established to review and improve onboarding processes for new starters	Control to Reduce Likelihood	Chief People Officer	30/06/24		
6.	To hold further recruitment events for WCSS Division, Nursing Assistants, and Domestic Assistants	Control to Reduce Likelihood	Chief People Officer	30/04/24		
7.	To present the Workforce Plan to Board and Committees	Control to Reduce Likelihood	Chief People Officer	10/05/24	After four iterations, the first submission of the annual operational workforce plan has been presented to the ICS. The workforce plan reflects the workforce growth which is expected in relation to Neonates, Obstetrics and Gynaecology and Same Day Emergency Care business cases which had been approved at the time of the workforce plan's first submission.	
8.	To continue to build the tools which are required to transfer ESR data into our internal data warehouse, on a daily basis	Control to Provide Assurance	Chief People Officer	30/06/24	The ESR (Electronic Staff Record) general data warehouse interface has been turned on and in collaboration with the Business Intelligence Team, work is commencing in April. This will allow work to then commence, over the coming months, on building/designing workforce-related dashboards, where key data is updated on a daily basis, which will become the sole source of truth.	

BAF 3: Leadership, Culture and Values

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	3	3	3	Likelihood:	2	31/3/2025	Low 1 - 3	1 ↓	Mod 4 - 6	2 ↓
Consequence:	4	4	4	4	Consequence:	3		High 8 - 12	7 ↑	Ext > 15	0 →
Risk Level:	High 12	High 12	High 12	High 12	Risk Level:	Mod 6		Total No. Linked Risks:			10 →

Rationale for Risk Level:	Good progress has been made during 2023/24 and TAP agreed to a positive assurance rating in March 2024 compared to 'partial assurance' rating in previous months. However, some initiatives have been delayed while recruitment to key vacancies has taken place, and further analysis of National Staff Survey Results will better inform review of this risk scoring.

Position Statement

What progress has been made during the last quarter?

- There has been continued good progress with the delivery of the People Plan during Q4. Our overall workforce plan remains on largely track.
- Driver Metric for our Staff Engagement score: 6.45 in Jan and 6.40 in Feb 24 which is still below the target of 7.20. Staff Voice restarted in January (following the pause during Staff Survey) and continues to measure employee experience. Our Executive Team agreed for the survey to move from monthly to quarterly for 2024/25 to avoid survey fatigue and to allow divisions time respond to feedback 'you said, we did / we will'.
- Driver Metric for our Culture Indicator score: - 65.7% in Jan and 66.7% in Feb 24 which is still below the target of 100%. Several dashboard iterations have improved the culture heat map dashboard's overall accuracy and data reliability.
- Watch metrics:
  - Sickness Absence (R12M) has remained static in Jan & Feb 24 at 5.2% in Q4 against the target of 3.4%
  - Statutory & Mandatory Training has remained steady at 93.5% in Jan and 93.7% in Feb'24 against the target of 95%
  - Essential to Role training has also been static at 86.4% in Jan and 86.3% in Feb 24 against the target of 90.0%. This is now a watch metrics for 24/25 to maintain focus.
  - Appraisal [PDR] rates have seen a slight improvement of 82.1% in Jan and 83.5% in Feb'24 against target of 95%. New PDR documentation implemented in Q4, and this also included a specific section for 'My Wellbeing'.
- NHS National Staff Survey 2023 – Results:
  - UHNM achieved a 45% response rate; a 12% increase on 2022 with increased participation from all staff groups.
  - Our staff engagement score is 6.8 (out of a possible 10), this has seen a gradual increase from 6.6 in 2022 and sits just below the national average of comparable Acute trusts (average 6.9). Focused work is needed to move beyond the average benchmark.
  - 14 scores are ahead of the sector benchmark including recommending the organisation as a place to receive care
  - A statistically significant improvement across 73/107 questions and improvements within all the People Promises.
  - Key areas of focus in 2024/25 will be on the following four of the seven People Promises: We are compassionate and inclusive / we are safe and healthy / We are always learning / We work flexibly.
- Race Equality Week and National LGBTQ+ Month campaigns held in February
- BAME network held Iftar (Breakfast of Fast) gathering in March to celebrate the holy month of Ramadan Mubarak
- UHNM Women's Network meeting held in March to celebrate International Women's Day, focusing on the Gender Pay Gap with guest speaker Dr Fizzah Ali.
- UHNM Workforce Disability Inclusion conference has been planned and organised for 15th May 2024.

- Enable leadership development participation rates remain good. Reviewed our approach to delivery to be more agile and for 24/25 the training will be delivered as five modules, a mix of virtual and face to face (instead of two-day face to face course).
- Roll out of 'new' (updated) Performance Development Review [PDR] documents and supporting training.

Key Controls Framework – 3 Lines of Defence

1st Line	• Each Division has staff engagement as a key driver metric with monthly scrutiny through Divisional Performance Meetings • Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improvement Plans in place for each hot spot areas • Divisional Workforce Groups in place • Issues managed as/when needed under the Resolution Policy and procedures. Employee Relations activity tracked in respect to these cases at formal stage.

2nd Line	• Executive Routines monthly review of our people driver metrics.
	• Culture Improvement Programme amended with refreshed objectives for 23/24
	• Freedom to Speak Up - oversight
	• Monthly forums with trade union representatives e.g., TJNCC and LNC
	• Three driver metrics of specific focus agreed by the Transformation and People (TAP) Committee and tracked monthly for scrutiny, accountability, and assurance on these critical areas of work – (1) Staff Engagement, (2) Culture and (3) Vacancies.
	• People Strategy 2022-25.
	• People Plan (year 2 of the People Strategy) with monthly reporting on high level progress at TAP; this includes actions under four domains:
	  ○ Looking after our People
	  ○ Creating a Sense of Belonging
	  ○ Growing the Workforce
	  ○ Developing our Practices and Systems
	• Employment Engagement Campaign for 2023/24 in line with 3 Staff Survey priorities set out above
	• Resolution Policy which sets out the new approach to resolving disputes at work
	• Being Kind Behavioural Framework and toolkit
	• Mandatory Being Kind training for all employees including Being Kind Large Scale sessions
	• Team effectiveness toolkit
	• RACE Equality Code action plan and self-assessment
	• The Trust wellbeing plan and wellbeing offer is refreshed and communicated monthly
	• Staff Networks to help shape our people practices and support culture improvement programme
	• Leadership Development Framework including Enable Leadership Course, Silver, Gold and Platinum Connects Programme, High Potential Programme, Master Classes, Insights Programmes
	• Well established cohort of Professional Nurse Advocates
	• Well established Staff Experience Champions network
	• Twice yearly training programme for Clinical Leads and Clinical Directors on Fundamentals of Medical Leadership
	• Sexual Safety Charter task and finish group in place to develop and deliver the action plan
	• Micro aggressions screen savers campaign
	• Engagement and Retention Lead (People Promise Manager) appointed

3rd Line	• Member of ICS groups for (a) Staff Engagement and Well-being, (b) Leadership and Talent Management, and (c) Equality, Diversity and Inclusion. • NHS Workforce Disability Equality Standard (WDES) • NHS Workforce Race Equality Standard (WRES)

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Workforce Assurance Group Highlight Report	●	●	●	●
	Maternity Leadership & Culture Update				●
2nd Line	Chief People Officer Report	●	●	●	●
	Workforce Performance Report	●			
	People Strategy Update	●			
	Education / Apprenticeship Report			●	
	Formal Disciplinary Activity Report	●	●	●	●
	Annual Equality & Inclusion Report		●		
	Quarterly Speaking Up Report	●	●	●	●
	Postgraduate Medical and Dental Education Report			●	
	Medical School Quality Report			●	
	Revalidation / Appraisal Report		●		
	Staff Survey Action Plan	●			

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
	Postgraduate Education and Governance Structure	●			
	Statutory and Mandatory Training – Essential to Role update	●			
	Positive and Inclusive Culture Programme Update 2024/25				●
3rd Line	Staff Survey Report				●
	Gender Pay Gap Report				●
	Workforce Race Equality Standard (WRES)			●	
	Internal Audit Review of Freedom to Speak Up				●
	Workforce Disability Equality Standard (WDES)		●		
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●		

Assurance Assessment

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

Gaps in Control or Assurance

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

- Sustained operational pressures continue to impact on overall employee engagement.
- Essential to Role training compliance is still below the target of 90%.
- Rollout of the Wagestream solution continues to be delayed; awaiting IT approval.
- High level of Employee Relations [ER] cases experienced in Q4; particularly cases being managed under the Resolution Policy (as was also experienced in Q3). Operational ER case load peaked at 94 cases (at formal stages) in Q4. Case work demand on managers (as Investigating Officers and Case Managers), Staff Side and the People Directorate is far greater than capacity and this is a key challenge for us going into 2024/25. In Q1 of 2024/25 our People Operations team will further review caseloads and processes and will ensure support is in place for all ER cases and escalate for system support if/where needed. Resolving employee relations cases is a delicate, time-consuming, and vital aspect of fostering a productive and harmonious work environment.
- All departments in the People Directorate are experiencing very high demand on our services and there are challenges with our capacity and the well-being of our teams. This is under regular review with our service leads and team members to focus on any themes, managing expectations and priorities.

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.	Employee Engagement Plan and Supporting Activities for 2023/24	Control to Reduce Likelihood	Chief People Officer	31/03/24	Complete. Campaign well developed and rolled out. Social Media campaigns, Network events, and divisions aligning to the corporate campaigns. Campaigns for Q4 are referred to in the narrative above.	
2.	Improve employee experience specifically through the work of our Equality, Diversity, and Inclusion Delivery Plan 2023-24. Including delivery of the RACE Equality Code Action Plan; • Reporting • Action • Composition • Education	Control to Reduce Likelihood	Chief People Officer	31/03/24	Complete. Network events and EDI newsletters (UHNM, ICS, regional and national). Leaders Network events. (Examples are included in the narrative above). Work ongoing on WRES and the RACE Equality Code action plan; with focus on anti-racist behaviour, managing conflict/show racism the red card Campaign and reinforce through targeted interventions. EDI matters are now BAU agenda items for EWAG	
3.	Improve leadership effectiveness at all levels in the organisation	Control to Reduce Likelihood	Chief People Officer	31/03/24	Complete. Focused work with divisions to target attendance to increase participation rate from those the training is most designed for i.e. supervisors / line managers. Ongoing review of	

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
					supervisors / non-supervisor who are attending to ensure that supervisors are targeted. Various other leadership programmes are on track, e.g. the Connects Leadership programme (Silver, Gold, and Platinum levels). More specific actions in respect to continuing to improve leadership effectiveness will be in the People Delivery Plan for FY24/25.	
4.	Equality, Inclusion and Human Rights week to take	Control to Reduce Likelihood	Chief People Officer	17/05/24	Planning underway	
5.	Plan on a page in respect of abusive behaviours towards staff from patients and members of the public to be included in joined up comms campaign	Control to Reduce Likelihood	Chief People Officer	30/06/24		
6.	Focus on Talent & Succession Planning and how best to do this at times of heightened financial controls	Control to Reduce Likelihood	Chief People Officer	30/06/24		

BAF 4: Improving the Health of our Population

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	4	3	Likelihood:	3	31/03/2025	Low 1 - 3	1 →	Mod 4 - 6	0 →
Consequence:	5	5	5	5	Consequence:	4		High 8 - 12	1 →	Ext > 15	0 →
Risk Level:	Ext 20	Ext 20	Ext 20	Ext 15	Risk Level:	High 12		Total No. Linked Risks:			2 →

Rationale for Risk Level: Risk likelihood has reduced as per plan for Q4, on the basis that the Trust Board has approved the Population Health strategy. There is further work underway to embed action plans, which will be approved as part of annual planning. At the point where there is demonstrated delivery, the risk rating will be re-assessed during 24/25.

Position Statement

What progress has been made during the last quarter?

- Population Health enabling strategy approved by Trust Board
- Stocktake completed to review health inequalities and anchor institution actions, with working group set up.
- Analysis for inclusive elective recovery completed for both the system and UHNM.
- Continued use of charitable funds to help pilot initiatives – i.e. loneliness, Keep Stoke Smiling
- Developing links with local authority and voluntary sector
- Reconfiguration of our approach to Making Every Contact Count (MECC) to draw together prevention related work on tobacco dependency treatment, alcohol care and obesity, using the improving together methodology to support.

Key Controls Framework – 3 Lines of Defence

1st Line	• Health inequality, MECC and anchor leads identified across trust services • Estates and Sustainability Programme, Workforce, Community Engagement, Elective Recovery and Patient Engagement leads identified as part of the Health Inequalities and Prevention Group
2nd Line	• Health Inequalities and Prevention Group in place to drive development of the Health and Wellbeing Strategy, with supporting working groups for HI, anchor and prevention. • Deputy Director of Strategy and Transformation given specific responsibilities for Health and Wellbeing / Reducing Health Inequalities • CDC Business Case approved • A3 for Health & Wellbeing in place • Population Health and Wellbeing Strategy
3rd Line	• ICP Strategy approved with a focus on '5P's' across the life course which all centre on reducing health inequalities across Staffordshire and Stoke-on-Trent • Public Health consultant appointed jointly with the ICB • Health protection links in place to support national/regional/system public health needs, i.e. measles. • Health Inequalities Programme established at ICB level with representation from UHNM • Infant mortality programme established by ICB • Stakeholder session completed with Local Authorities, NHS Providers to seek support / input to Trust priorities, e.g levelling up links becoming established. • National CORE20PLUS5 priorities

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Strategy and Transformation Group Highlight Report	●	●	●	●
2nd Line	Improving Population Health A3 Strategic Priority Update		●		
	Sustainability and Net Zero Carbon Bi-Annual Report		●		
	Community Diagnostic Centre – Stoke-on-Trent	●			●
3rd Line	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●		
	ICS Transformation Update	●	●	●	●

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

Gaps in Control or Assurance

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

- There is a need to demonstrate delivery of the strategic action plans, which will be achieved in 2024/25 to provide sufficient assurance of the ability to reduce the risk to the target level

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 metrics to provide a means of measuring progress and delivery of the strategy.	To provide assurance	Director of Strategy & Transformation	~~31/12/23~~ 2024/25	The outcome framework/metrics are now described within the strategy and will form part of reporting in 2024/25.	
2.	Develop detailed action plans to support the delivery of the strategy	Control to reduce likelihood	Director of Strategy & Transformation	~~31/03/24~~ 2024/25	Action plans are described within the strategy – to be incorporated and reported in A3 format from 24/25	

BAF 5: Delivering Responsive Patient Care

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	5	5	5	5	Likelihood:	3	31/03/2024	Low 1 - 3	0 →	Mod 4 - 6	12 ↑
Consequence:	4	4	4	4	Consequence:	4		High 8 - 12	38↓	Ext > 15	13 ↑
Risk Level:	Ext 20	Ext 20	Ext 20	Ext 20	Risk Level:	High 12		Total No. Linked Risks:			63↑

Rationale for Risk Level:	Despite improvements in performance, there remain areas of risk and performance has not been consistently delivered. In addition, performance has not delivered the specific required parameters. The planned risk score for Q4 has not been achieved in addition to not achieving the target risk score and this risk is to be reconsidered as part of the 2024/25 BAF process.

Position Statement

What progress has been made during the last quarter?

4 hour performance has improved to 70.3%, which is the most improved position since July 2021. We are below our fair shares for cancer 62 day backlog and have also met the 28 Faster Diagnostic Standard (FDS) for the past 2 months. In addition, we have continued to see month on month reductions of long waiters.

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 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 officer's rota' d on a daily basis to provide a visible and accessible point of contact for operational management and risk mitigation
- Weekly tumour site cancer PTL meetings
- Weekly divisional RTT meetings taking place
- Fortnightly validation meetings
- Monthly RTT training improvement meeting
- Monthly DQ meeting
- Monthly Performance and reporting elective meeting
- Action plans are in place for any diagnostic work stream not meeting DM01 standards, any diagnostic work stream impacting on cancer waits, skin, colorectal, oncology, urology and any specially with a cohort of patients waiting over 104 weeks
- Weekly elective oversight management group supported by Deputy COO and CEO

2nd Line

- Monthly internal performance review meetings between Executive and Divisional Leadership Teams to ensure appropriate improvements, management of risk and accountability
- Executive led Non-Elective and Planned Care Improvement Groups to ensure ongoing performance improvement
- Standing up of executive led daily tactical response meetings when significant risks are identified and require corporate support
- Monthly elective improvement group
- CDC Business Case approved
- SDEC modular build business case approved
- Colorectal and general surgery capacity business case approved
- Comprehensive capacity, demand, organisational and system bed model completed to ensure data driven approach to improvement
- Undertakings Elective & Non-Elective Plans

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

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Non-Elective Improvement Group Highlight Report	●	●	●	●
	Planned Care Improvement Group Highlight Report	●	●	●	●
2nd Line	Operational Performance Report	●	●	●	●
	Business Case Review: Colorectal Cancer Pathway Redesign	●			●
	Business Case Review: Urology Nephrectomy Demand	●			
	Business Case Review: UHNM/SATH Urology Alliance and Expansion of Robotic Operating		●		
	Business Case Review – BC-0511 Purchase of Modular Building to provide Enhanced Primary Care at UHNM			●	
	Theatre Productivity Plan 2023-2025 Progress Update			●	
	Waiting List Review Update			●	
	Community Diagnostic Centre – Stoke-on-Trent	●			●
	Elective Care 2023/24 Priorities		●		
3rd Line	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●		
	Independent Review of Waiting List Management, Data & Reporting	●	●		
	NHS England Endoscopy Visit Feedback			●	
	Internal Audit Review of Data Quality ICB Metrics				●
	Internal Audit Review of Data Quality (Urgent Care Standards)			●	
	Internal Audit Review of Planned Care Waiting List Management			●	
	Internal Audit Review of Productivity Reporting				●

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

Gaps in Control or Assurance

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

- Go live for new modular build scheduled for 1st July 2024 which will help to mitigate the overburdened ED, providing further space and revised processes.
- Right sizing hospital work being undertaken
- Work on County Daycase to commence in April - estimated to come online in October 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.	Deliver objectives as described in non-elective improvement programme	Control to reduce Likelihood	Chief Operating Officer	~~31/02/23~~ ~~30/09/23~~ 31/03/24	Objectives and actions for the programme are continually identified via the A3 process and continue to be monitored via the non-elective improvement group. There has been a change in SRO for workstream 1 and original action plans are being reviewed. The lead for workstream 2 has also changed and additional test of change and driver meetings put in place, which is being rolled out across Medicine. Action to be carried forward to 2024/25 BAF with revised target date.	
2.	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Control to reduce Likelihood	Director of Strategy & Transformation	31/03/25	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.	
3.	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	31/03/24	The process has begun to explore the procurement and implementation of a HIMSS Level 7 system wide EPR system. Action to be carried forward to 2024/25 BAF with revised target date.	
4.	The Strategy UEC Delivery and Strategy Groups to deliver the objectives aligned to the System 7 UEC priorities	Control to reduce Likelihood	Chief Operating Officer	31/03/24	Action in progress within the system, linking with the Trust's non-elective improvement programme. Action to be carried forward to 2024/25 BAF with revised target date.	
5.	Deliver objectives as described in elective improvement programme	Control to reduce Likelihood	Chief Operating Officer	31/03/24	Objectives and actions for the programme are now continually identified via the A3 process. These will continue to be monitored via the elective improvement group. Action to be carried forward to 2024/25 BAF with revised target date.	

BAF 6: Digital Transformation

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	3	Likelihood:	2	31/03/2025	Low 1 - 3	6↓	Mod 4 - 6	20→
Consequence:	4	4	4	3	Consequence:	4		High 8 - 12	40↓	Ext > 15	7↑
Risk Level:	Ext 16	Ext 16	High 12	High 9	Risk Level:	High 8		Total No. Linked Risks:			73↓

Rationale for Risk Level: A number of projects have been delivered as planned (Office 365 and LIMS) and soft market testing for Electronic Patient Record has commenced. In addition, we have sustained a positive cyber score and legacy security technology has been decommissioned (web filtering proxy servers), therefore the actual score for Q4 is less than planned.

Position Statement

What progress has been made during the last quarter?

- Selection and purchase of a system to manage Freedom of Information and Subject Access Requests has been completed.
- Documentation and the process for the Staffordshire Wide Electronic Patient Record soft market testing has been completed and agreed by parties ready for the soft market testing launch on the 5th April.
- Laboratory Information System implementation for Biochemistry, Haematology and Immunology and mortuary has been deployed across the North Midlands Pathology Network.
- Pilot of new VPN technology commenced allowing access from public WIFI services that requires the user to sign in to the WIFI service such as hotels, cafes and trains.
- Key roles for the Network and Communications service team have been recruited to and the staff have started. This enables us to be ready for the cut over in June 24.
- Cyber Security Bitsight score of 760 was maintained which compares well to other benchmarked organisations.
- Of the 64 legacy Microsoft Access Databases, 19 have been either replaced or decommissioned, 21 are in progress of being replaced and 24 are outstanding.
- Video cameras have been installed in the Trusts data centres to improve security and will be commissioned in April 24.
- A bid has been drafted to secure national funding for improving network capacity and speed.
- Work on the DCB1596 secure email standard is underway. The secure email standard for health and care organisations is to assure their email service to enable safe email communications with NHS organisations. It will allow the Trust to replace NHSmail email accounts.
- Artificial Intelligence policy has been drafted and is going through ratification.
- Digital Nurse Fellowships will be launched in April with 5 to 6 recruits which will provide much needed digital skills and nurse leadership.

Key Controls Framework – 3 Lines of Defence

1st Line

- Rubrik Office 365 backups in place.
- Office 365 end user migrations complete.
- IM&T governance meetings in place including IT Service Delivery Group, IT Programme Operational Group, Cyber Security Operational Group, Data Security and Protection Operational Group, Record Service Operational Group, Clinical Systems Operational Group and Digital Clinical Office Operational Group.
- Change freeze in place the day before to protect the Trust during Industrial Action.
- RE02 Photography and Video Policy and standard operating procedure has been approved.
- CCTV Checklist approval for the Multistorey Car Park and Trust Data Centres
- LIMS BHI migration to Winpath Enterprise is complete.

2nd Line	• IM&T policies • Risk management report to the Executive Digital and Data Security Protection Group which evidences active management of IM&T risks. • Chief Nurse Information Officer in post to work with nurses, AHPs and Midwifery. • Freedom of Information improvement plan developed • Network and Communication Business Case approved
3rd Line	• Data protection toolkit has been completed and improvement plan agreed with NHSE. • Independent cyber security penetration test of iPortal was completed with no Critical or High issues, • NHS England Frontline Digitalisation Investment Business Case

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Infrastructure Group Highlight Report	●	●	●	●
	Executive Digital and Data and Security Protection Group Highlight Report	●	●	●	●
2nd Line	Freedom of Information (FOI) Improvement Report	●			
	Digital Strategy Progress Report / Project Update	●		●	
	Data Security & Protection Toolkit Submission	●		●	
	Supplier Assurance Report			●	
	Cyber Security Assurance Report	●	●	●	●
	Staffordshire and Stoke on Trent Integrated EPR Programme				●
3rd Line	Internal Audit Review of Digital Strategy Development	●			
	Internal Audit Review of Data Security and Protection (DSP) Toolkit		●		
	Internal Audit Review of IT Systems Managed by Operational Areas				●
	Internal Audit Review of Service Management Process (ITIL)				●

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

Gaps in Control or Assurance

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

- Complete LIMS for Cell Path
- Upgrade VPN technology
- Complete EPR soft market testing
- Network migration in June 24

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

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	SOC Service Go Live	Control to reduce likelihood	Chief Digital Information Officer	01/11/23	Complete. Technical go live completed but operational process still to be agreed	
2.	LIMS Go Live	Control to reduce likelihood	Chief Digital Information Officer	~~31/03/24~~ 30/05/24	BT, BHI and Mortuary live. Cell Path to go live in May	
3.	EPR Outline Business Case	Control to reduce likelihood	Chief Digital Information Officer	~~31/03/24~~ 31/08/24	Outline Business Case completed Soft market testing due to be complete in August.	
4.	EPMA Pilot	Control to reduce likelihood	Chief Digital Information Officer	31/10/24	Pilot of EPMA to go live.	

BAF 7: Fit for Purpose Estate

Internally Driven	✓
Externally Driven	

Risk Description

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

Lead Director / s:	Director of Estates, Facilities & PFI	Supported by:	n/a
Lead Committee/s:	Performance and Finance Committee	Executive Group:	Executive Infrastructure Group

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	3	3	3	Likelihood:	2	31/03/25	Low 1 - 3	4↑	Mod 4 - 6	28↓
Consequence:	4	4	4	4	Consequence:	4		High 8 - 12	46↑	Ext > 15	2↑
Risk Level:	High 12	High 12	High 12	High 12	Risk Level:	High 8		Total No. Linked Risks:			78↑

Rationale for Risk Level:

- Estates condition and backlog maintenance risks remain due to limited identified funding available to address the significant and moderate elements identified via the Estate 2 Facet Survey. With reduced levels of funding against the increased level of backlog, it's unlikely we will reduce the risk score.
- Estates capital programme delivery presenting real challenges given size, scope, scale and timelines imposed for nationally funded schemes - £48.39m value across 130 projects.
- Some estates workforce challenges but an improving position following R&R Business Case approval.
- Sustainability / Net Zero Carbon (NZC) - Ever growing national, mandatory requirements giving rise to the need for both further financial investment and workforce capacity.
- Accredited Specialists commissioned by Project Co to complete intrusive surveys of PFI building fabric ahead of latent defect period end. Survey findings to be used to inform any remediation works
- Estates Strategy Refresh underway and informed by PWC Bed Review and Clinical Strategy refresh.
- Maintain improved cleaning standards within West Building due to condition of estate and lack of investment in infrastructure and building.
- PFI market testing and VFM reviews concluded and focus now on delivery of value added benefits.
- Delivery of the N&C transition plan of services to support successful handover to IM&T in June 2024, following approval of the N&C Business Case.
- Gap in immunisations identified for Sodexo staff in comparison to Trust staff. TFG established with Trust H&S and IPCC reps advising on compliance with legislation and H&S at Work Regulations for employers.

Position Statement

What progress has been made during the last quarter?

Estate Condition

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

Capital Programme

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

Estates Workforce Recruitment/Retention Issues

- Estates Workforce Business Case approved and focus now on implementation, recruitment progressing against vacant posts and improving position seen, but still pockets of challenge on some posts.

Net Zero Carbon (NZC) / Sustainability

- UHNM Green Plan (2022-25) is fully aligned to the national Greener NHS Programme and NZC agenda. Progress against delivery of the UHNM Green Plan and Net Zero trajectory is provided biannually to PAF (next presentation April 2024)
- All currently known decarbonisation schemes that require capital investment have now been collated as part of the Sustainability and NZC capital investment subgroup (total value of schemes is £15 million which are prioritised against the available £100k allocation).

- Delivery of the Public Sector Decarbonisation Scheme (PSDS) to expend the £5.4m grant award continues and is delivering to time and budget.
- The innovative energy procurement strategy in partnership with SoT City Council will commence from 1st April 2024. This has produced significant cost avoidance with a future potential to connect to zero and low carbon energy supplies, including the local district heat network.

Estate Strategy / Clinical Strategy

- Independent reviews of estate at County and Royal concluded and opportunities identified information shared through County steering group. Estate Strategy refresh underway aligned to Clinical Strategy refreshed and PWC Bed Model Review.
- County Hospital Programme (TIF2) – Good progress being made on delivering Phase 2 STS. Programme and progression of detailed design for new Day Case facility and new Breast Care Unit relocation.

PFI Latent Defect Period

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

West Building

- Identified physical estates works completed to improve compliance, alongside refresh of service standards and monitoring arrangements to ensure cleaning standards improved and sustained. Ward 80/81 requires an extensive upgrade and allocation of capital should it continue to be used beyond winter 2023/24. A joint environmental risk assessment of continued use of the building is being completed by estates/nursing colleagues.

Implementation of new facilities National Standards of Healthcare Cleanliness is now complete.

- Business Case produced, approved at PAF in December 22 and the focus has been on the roll out of the new facilities cleanliness standards from the 1st of June 2023. Post 6 months roll out review of the Business Case is underway.

PFI Market Testing Opportunities

- Sodexo Business Case approval secured and contracts signed, now on to delivery of value added benefits.
- Siemens PACS/MES - Business Case approved, Lender approval secured, and formal variation concluded, now on to delivery of value added benefits.
- Network and Communications Service – Business Case approved and transition plans for June 2024 underway. In final stages of concluding formal PFI contract variation documentation.

Immunisations Gap – Sodexo Staff

- A gap in the immunisations that Sodexo staff receive has been identified, in comparison to Trust staff. A T&FG has been established to resolve. The gap associated with new starters has been resolved and work continues on determining availability of screening and immunisation timescales for existing staff. Risk has been added to EFP risk register and actions are being monitored fortnightly at the T&FG.

Key Controls Framework – 3 Lines of Defence	
1st Line	• 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), PSDS stakeholder meetings (monthly, to meet grant T&Cs), Nitrous Review meetings, NZC Trust Board Lead (Director EFP), (new) Clinical NZC lead and attendance at ICS and Midlands Green Groups.
2nd Line	• Project STAR – Business Case approved and construction underway. • Estate Condition - Capital bids against prioritised list of Estate 7 Facet Findings with subsequent approval via CIG. • Estate Strategy – Clinical Strategy and independent review used to inform content. • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections. • Head of Fire Safety and Security close working with local Police and visibility on site. • Sustainability / NZC: Work with SSoT system partners and other external partners regarding zero-capital solutions. • Capital team / Capital programme external Audit / internal procedure audit annually – RSM UK LLP. • Investigate manufacture of Modified Textured foods within County Catering cross sites. • Energy Procurement Options Paper • Roll out of Cleaning Collaborative / new National Standards of Healthcare Cleanliness. Embedding of the new cleaning standards and 6-month review of the business case underway.
3rd Line	• Statutory maintenance programme – Maintenance Operational Board. • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC. • External audits on fire by Staffordshire Fire & Rescue and Authorising Engineer and on the security of radioactive sources & pathogens by the CTSA. • Authorising Engineers Audits of building services and associated maintenance regimes. • Participation in National Programme (SSRM) hosted by Cabinet Office & HM Treasury. • Sustainability / NZC National Audits – Quarterly (national) Greener NHS Data Collections, Annual Fleet Data Collection; National Waste and Food Data Collections. • Accredited Specialist review of building infrastructure.

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Infrastructure Group Highlight Report	●	●	●	●
	Executive Health & Safety Group Highlight Report	●	●	●	●
2nd Line	Financial and Capital Plan Update 2023/24	●			●
	Estates Strategy Progress Report			●	
	Fire Annual Report	●			
	Business Case Review – BC-0511 Purchase of Modular Building to provide Enhanced Primary Care at UHNM			●	
	Sustainability and Net Zero Carbon Bi-Annual Report		●		
	Sustainability Bi-Annual Report	●	●		
3rd Line	PLACE Inspection Findings and Action Plan	●			

Assurance Assessment

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

Gaps in Control or Assurance

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

- Capital Programme – continued focus on mitigating risks of delay on schemes working closely with finance colleagues and bringing in external project management support to supplement existing team given size, scope and scale.
- PFI latent defect – to understand the findings from the intrusive surveys and respond to any remediation works required.
- Sustainability / NZC – directorate workforce/structure review in 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 & right sizing work.
- Contract variations for Sodexo new and existing staff to be issued to implement changes associated with Immunisations Gap for Sodexo staff.

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.	RI Site demolition	Control to reduce Likelihood and Consequence	Director EF&P	~~31/03/23~~ 31/03/25	Phases 1-5 completed, Final building demolition reliant on a decant solution to RSUH.	
2.	Car parking solution	Control to reduce Likelihood and Consequence	Director EF&P	~~31/03/23~~ 29/04/24	Construction of new multi-story car park at Grindley Hill has commenced and will be delivered ahead of programme	
3.	RI/COPD - Release land for land sale	Control to reduce Likelihood and Consequence	Director EF&P	2025/2026	Work to continue on firming up disposal strategy and programme for Infirmary and Outpatients sites. Externally appointed consultant to provide specialist advice.	
4.	Lower Trent Business Case	Control to reduce Likelihood and Consequence	Director EF&P	~~26/01/23~~ 31/03/24	Complete. New ward opened January 2023. The final part of the build was completed end of March	
5.	PFI Market Testing Opportunities	Control to reduce Likelihood and Consequence	Director EF&P	~~31/01/24~~ 29/02/24	Complete. Secured Lender approval Sodexo Business Case, formalise N&C Variation. Agreement was signed during the quarter	
6.	Estate condition	Control to reduce Likelihood and Consequence	Director EF&P	31/03/25	Deliver statutory maintenance & capital schemes mitigating risks as far as possible. West Building Ward 80/81 requires significant upgrade and capital	

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
					investment if a decision is made to continue to use beyond winter 2023/24.	
7.	Capital Programme Delivery	Control to reduce Likelihood and Consequence	Director EF&P	31/03/24	Continue to look at ways of expediting programmes on nationally funded schemes with timescale delivery being key condition of funding. Action ongoing	
8.	Immunisations Gap – Sodexo Staff	Control to reduce Likelihood and Consequence	Director EF&P	~~31/03/24~~ 31/10/24	T&FG established to expedite addressing this gap identified. All parties agreed to progress closing the gap asap with Optima Health and the costs associated with delivery to be agreed separately to avoid causing delay. Formal communications via proforma log and both parties seeking legal advice.	

BAF 8: Financial Sustainability

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	4	3	1	Likelihood:	1	31/03/24	Low 1 - 3	9↓	Mod 4 - 6	8↑
Consequence:	3	3	3	3	Consequence:	3		High 8 - 12	12↓	Ext > 15	4↑
Risk Level:	High 9	High 12	High 9	Low 3	Risk Level:	Low 3		Total No. Linked Risks:			33→
Rationale for Risk Level:	The Trust has met its financial duties for 2023/24, therefore the target risk score has been achieved. However, this has been reliant on non-recurrent mitigations which have contributed to a system wide underlying deficit, therefore the impact of this and the associated risk for 2024/25 is to be considered and articulated as part of the Q1 BAF.										

Position Statement

What progress has been made during the last quarter?

- As above, the financial plan has been delivered for 2023/24 as planned, although reliant on non-recurrent mitigation, contributing to an underlying deficit.

Key Controls Framework – 3 Lines of Defence

1st Line	• Performance Management meetings in place with Divisions with financial performance included as a driver metric. • SFIs and scheme of delegation • Executive Team approving and monitoring spend against ERF • Exec Team approval of additional investment up to £250k • Exec led meetings with Divisions to review planning assumptions for 2024/25 and focus on CIP delivery.
2nd Line	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery. • ICS CFO meeting to review system position • The level of non-recurrent mitigations currently being assessed and quantified • Future investments guidance issued to Divisions in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Reset of the bed model and final allocation of system capacity funding undertaken
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 • System Recovery Programme

Assurance Map

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

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

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

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

Gaps in Control or Assurance

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

- Mitigation and actions required in terms of identifying recurrent savings in order to improve the underlying financial position

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	Director of Strategy	~~30/09/23~~ 31/03/24	The PMO has established regular meetings with Divisions to support the identification of CIP. Weekly CIP tracker being issued and action to be carried forward to 24/25.	
2.	Ensure the delivery of elective activity targets	Control to reduce the likelihood	Chief Operating Officer	~~30/09/23~~ 31/03/24	Objectives and actions for the non-elective programme are continually identified via the A3 process. These will continue to be monitored via the non-elective improvement group. Action to be carried forward to 24/25.	
3.	To consider impact of national guidance on IA funding mechanisms when communicated	Control to reduce likelihood	Chief Finance Officer	30/01/24	Complete. Funding now received for April to October and national steer to expect future costs to be recognised.	

BAF 9: Research & Innovation

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	3	Likelihood:	2	30/09/24	Low 1 - 3	1↑	Mod 4 - 6	1→
Consequence:	3	3	3	3	Consequence:	2		High 8 - 12	1↓	Ext > 15	0→
Risk Level:	High 12	High 12	High 9	High 9	Risk Level:	Mod 4		Total No. Linked Risks:			3→

Rationale for Risk Level:

- UHNM strategic priority of increasing number of recruits to clinical trials has been met, still awaiting the final numbers for March 2024, it is anticipated recruitment will have increased by over 25% on 22/23
- The current Research Governance manager left their position in November 2023 and the R&I Directorate have taken the opportunity to align with other NHS Trusts and increase the seniority of this post. Recruitment was successful, awaiting official start date
- The financial plan for 24/25 is yet to be negotiated and signed off due to absences within UHNM Finance team who support R&I, this uncertainty around the plan will impact on future roles to be advertised in Q1 24/25
- Band 7 Research Administration and Data Manager begins a 12 month secondment to maternity from 1st February. This post was advertised twice with no suitable candidates shortlisted.
- R&I Directorate are part way through their improving together training, A3's and directorate scorecards are being established for 24/25

Position Statement

What progress has been made during the last quarter?

- The Trust achieved its target for recruitment to clinical trials by month 10 of the year 2024/25
- Risk in relation to adhering to MHRA Regulatory Requirements for Research & Development - Research Governance Manager appointment made and Research Auditor in post
- Risk in relation to Covid-19 Affecting Core Research Functions - research activity is going forward at pre-Covid levels, from both delivery and development.
- Risk in relation to insufficient income from commercial clinical trials to support substantive pharmacy staff currently in post - Research participants onto commercial trials has seen a 36% increase from 22/23 to 23/24. Currently 126 participants, up from 93 the previous year. Pharmacy research activity to be supported by new R&I Strategy Oversight Forum to allow for greater awareness of current research pressures.
- Risk in relation to Centre for Research and Education Excellence (CeNREE) sustainability added to the risk register due to unsustainable workload with current fixed term staffing.
- Full year recruitment figures 1920 (to be validated), an increase of 402
- ToR for Research & Innovation Strategy Oversight Forum prepared
- New R&I Directorate Organisation structure complete. Aligning activity with staffing roles
- 12 month Fixed Term Innovation Manager to be advertised to undertake scoping activities to begin building the Innovation portfolio and creating the sustainability model for continuation of role.

Key Controls Framework – 3 Lines of Defence

1st Line	• Research Operations and Leadership Meeting is established to coordinate and support operational activities. • Recruitment monitoring and forecasting are being utilised to align with growth-oriented strategic objectives, with forecasts contributing to feasibility assessments. • Meeting structures in place to actively support and communicate Strategy, Operational, and Governance activities. • Academic Development Officer for CeNREE appointed • Individual departments are jointly appointing additional resources to integrate research into their services through externally funded opportunities. A new Senior Research Practitioner for Neurology started in October 2023. • Chief AHP in post aimed at empowering and promoting research. • Research Governance Manager appointed • Improving Together training in place, cascading the information and daily improvement huddles have begun.
2nd Line	• R&I Strategic Oversight Forum to oversee, Strategic, Operational & Governance (including financial governance) Activity of all UHNM divisions. • Widening out the staff recruitment for delivery beyond nursing to include AHP's and other research active professions an example of this is the recent appointment of Band 7 lead research practitioner is a Physician Associate. • Increasing investment in Patient and Public Involvement and Engagement (PPIE), with plans to establish a PPIE lead position.
3rd Line	• UHNM is a part of SSHERPA, contributing to the ICS research agenda. • A member of the West Midlands R&D Research Forum. Both formal & Informal partnership. • Active participation in the Communities of Practice for the National Contract Value Review • National strategies from the Chief Nurse Office for England, the Chief Midwifery Office for England and the Chief Allied Health Professional Office for England too which we use to support implementation of CeNREE priorities.

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

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line	Executive Research and Innovation Group Assurance Report	●	●	●	●
	Research Quality Governance Update	●		●	
2nd Line	Research and Innovation Strategy		●	●	●
3rd Line	n/a				

Assurance Assessment

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

Gaps in Control or Assurance

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

- Development the R&I strategy tracker to monitor evidence that the objectives are being met
- Continued focus on recruitment and retention, through a sustainable financial plan.
- Continued focus on supporting staff members on fixed term or secondment roles
- Await MHRA Inspection and Outcome
- Resurrect the Research and Innovation Strategic Oversight Forum and Quality Assurance Steering group
- UHNM R&I reports require greater input from stakeholders outside of the R&I directorate, through increased scheduled meetings and structured reporting to aid in the sharing of information (this will be aided by the refreshed Strategic Oversight Forum)
- Further work on utilising improving together methodology, templates, A3's and scorecards

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

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Desktop review of R&I structure being undertaken.	Control to reduce Likelihood	Chief Medical Officer	~~30/09/22~~ 25/11/23	Complete -R&I Manager in post, with a revised structure.	
2.	Develop a report which provides assurance against key performance metrics set out within the Research Strategy.	Additional Assurance	Chief Medical Officer	~~30/09/22~~ 31/12/23	Complete - Strategy Tracker reviewed and approved by Exec R&I, senior team meeting with Quality Improvement to align metrics with Improving Together methodology.	

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.	Substantive recruitment to vacant posts.	Additional Control	Chief Medical Officer	~~30/09/22~~ 31/12/23	Complete. Historical vacancies for the R&I Directorate have been filled.	
4.	R&I Manager, once in post to develop and deliver plan arising from the desktop review.	Additional Control	Chief Medical Officer	~~30/06/23~~ 31/12/23	Complete. New R&I Manager started June 2023 and New R&I Directorate Structure complete	
5.	Review of the Research Governance structure beneath the Executive Group to ensure that there is a forum with appropriate representation from divisions and support services to ensure oversight and scrutiny.	Additional Control	Chief Medical Officer	~~31/03/23~~ 31/03/24	Complete.	
6.	Research to form part of Divisional Performance Management Reviews / watch metrics.	Additional Control and Assurance	Chief Medical Officer	~~30/06/23~~ ~~31/12/23~~ 30/09/24	R&I Strategic Oversight Forum to be established 24/25. ToR currently with Exec R&I group for approval	
7.	Research to form part of Divisional Board agendas.	Additional Assurance	Chief Medical Officer	~~30/06/23~~ ~~31/12/23~~ 30/09/24	Communication to feed into Strategy development committee through divisional membership and R&I board.	
8.	Commissioning an external specialist to review QMS prior to the MHRA inspection.	Additional Assurance	Chief Medical Officer	~~31/12/23~~ 30/09/24	Working with providers of pre-inspection consultants to commission an external review. Will be a priority for the new Research Governance Manager	
9.	Increasing PPIE investment and developing a strategy, involving all R&I, CeNREE, support services, and Divisional representation Ensuring patient voice is at the heart of Research development	Additional Control and Assurance	Chief Medical Officer	~~31/03/24~~ 31/03/25	Once R&I Oversight Forum is up and running, a Strategic Development Forum will begin to co-create the next R&I Strategy	

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 /	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 (risks scoring 12 and above)

ID	Title	Risk Score at End Q1	Risk Score at End Q2	Risk Score at End Q3	Risk Score at End Q4	Target Risk Score	Division	BAF Risk
30752	Temporary Staffing Checks			20	20	6	Central Functions	2
30906	Loss of Read/ Write Access to Legacy System (LabCentre)				20	5	Central Functions	6
21697	Recurrent CIP requirements for 23/24 and beyond not met in Trust due to lack of focus on CIP planning	12	12	20	20	8	Central Functions	8
25353	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	20	20	20	20	6	Central Functions	8
15697	Attainment of the Cancer 28 day target for Lower GI	8	20	20	20	4	Medical	5
26168	Pathology IT System Expertise	20	20	20	20	8	NMCPS	6
25454	EPMA and/or Clinical Narrative System not fit for purpose	16	16	16	16	4	Central Functions	1
26887	Ineffective Clinical Effectiveness Provision	16	16	16	16	6	Central Functions	1
26238	Industrial Action 22/23	16	16	16	16	9	Central Functions	2
25893	Delay in EPMA roll out	16	16	16	16	4	Central Functions	6
31185	DataCentre Air Conditioning EOL - Unfit for Purpose				16	4	Central Functions	7
25980	Your Next Patient Process	16	16	16	16	4	Central Functions	1, 5
27696	Consultant Obstetricians workforce	16	16	16	16	4	CWCSS	1, 2
23842	Delivery of RTT - Outpatient capacity/wait times	16	16	16	16	4	Medicine	5
15664	Liver Mortality - CQC actions	12	12	16	16	4	Medicine	1, 2
21157	Haematology Service at MCHT Leighton	16	16	16	16	6	Network Services	2
25839	Long Wait Patients in the Trauma Directorate	16	16	16	16	12	Network Services	5
24323	Junior Doctor Staffing	12	12	12	16	6	CWCSS	1, 2
20616	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	16	16	16	16	4	NMCPS	2
28838	NMCPS Governance, Quality, Training and Health & Safety capacity	12	12	12	16	8	NMCPS	2
25120	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	16	16	16	16	8	NMCPS	1, 2
25469	Delivery of constitutional cancer quality standards	16	16	16	16	4	Surgery	5
25471	Follow Up Delays	16	16	16	16	4	Surgery	5
25628	Ophthalmology Service Delivery	12	16	16	16	4	Surgery	5
28325	Endoscopy delays - cancer and long waits	16	16	16	16	4	Surgery	5
30149	AAA Time to Surgery		16	16	16	4	Surgery	1, 5
27411	ReSPECT	15	15	15	15	5	Central Functions	1
9036	Vulnerability to Cyber Attack	15	15	15	15	12	Central Functions	6
28451	Network outage affecting accessibility of clinical systems	20	20	20	15	6	Central Functions	6
31027	Lack of Labcentre hardware cover from 01.04.2024				15	5	Central Functions	6
31028	Availability of LIMS Project Funding from April 2024				15	5	Central Functions	6
30476	NHS Financial position and procurement of System Wide EPR			15	15	5	Central Functions	8
21644	Reduced staffing levels and increase in referrals	9	9	9	15	6	Central Functions	1, 2

ID	Title	Risk Score at End Q1	Risk Score at End Q2	Risk Score at End Q3	Risk Score at End Q4	Target Risk Score	Division	BAF Risk
29977	Patients with no recorded outcome from last outpatient attendance			15	15	6	CWCSS	5
20739	Endoscopy planned patients waiting list	12	12	15	15	6	Medicine	5
27158	IM&T Contract Management	12	12	12	15	4	Central Functions	8
26832	Holding Ambulance Patients on the ED Corridor	12	12	12	15	4	Medicine	1, 5
28798	Sodium Valproate Prescribing	9	9	15	15	4	Network Services	1
23331	MCHT Ceiling RAAC planks	15	15	15	15	4	NMCPS	7
31259	Management of County post operative patients requiring return to theatres and/or transfer to RSUH				15	5	Surgery	2
29861	Lack of Paediatric PreAms Service			15	15	4	Surgery	5
8877	Hospital Acquired Infections	12	12	12	12	8	Central Functions	1
8901	Ensure correct blood sample management	12	12	12	12	6	Central Functions	1
11417	End of Life - care pathway	9	12	12	12	9	Central Functions	1
26815	Resuscitation Training	12	12	12	12	6	Central Functions	1
27153	QI Academy Staffing under-resourced to deliver sustainable change	12	12	8	12	12	Central Functions	3
8849	Staff using unsecured and unlicenced personal phones for work email	12	12	12	12	4	Central Functions	6
21784	Confidentiality, Integrity and Availability of Trust Information	12	12	12	12	4	Central Functions	6
23753	Network failure due to multiple service providers	12	12	12	12	4	Central Functions	6
23755	System failure due to lack of Information Technology Infrastructure Library (ITIL)	12	12	12	12	4	Central Functions	6
23759	Inappropriate clinical decisions due to large number of digital systems in place	12	12	12	12	4	Central Functions	6
25870	Network and communication services provision for UHNM	16	16	12	12	6	Central Functions	6
26487	Lack of a digital solution to maintain confidentiality of patient information with the GP	12	12	12	12	3	Central Functions	6
28573	End of support for SQL Server 2012 and Windows Server 2012/2012 R2	12	12	12	12	2	Central Functions	6
28595	COIN Network	12	12	12	12	4	Central Functions	6
29191	Management of Cookies		12	12	12	4	Central Functions	6
29286	Project and Planned Maintenance Slippage due to ongoing Industrial Action		12	12	12	6	Central Functions	6
30246	Image Storage for the V-Scan Wireless Ultrasound Scanner		12	12	12	1	Medicine	6
22949	PFI latent defects	12	12	12	12	4	Estates, Facilities and PFI	7
17952	Dispensing errors at County Hospital	12	12	12	12	4	CWCSS	1
23500	Inadequate Pharmacy support to emergency portals to meet national benchmarking for 7 days	12	12	12	12	3	CWCSS	1
26790	Non-compliance with IR(ME)R - due to not being able to confirm referrer entitlement	12	12	12	12	2	CWCSS	1

ID	Title	Risk Score at End Q1	Risk Score at End Q2	Risk Score at End Q3	Risk Score at End Q4	Target Risk Score	Division	BAF Risk
28461	non compliance of basic life support (BLS) training in Radiology SPR's	12	12	12	12	4	CWCSS	1
28868	Neonatal Emergency Transfer Team Training Shortage	12	12	12	12	2	CWCSS	1
29167	Lack of Dietetics Service in the Neonatal Unit	12	12	12	12	1	CWCSS	1
30129	Inpatient E-notification initial report not enabled			12	12	2	CWCSS	1
21987	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	12	12	12	12	4	CWCSS	1, 2
23506	Gastroenterology patients insufficient Pharmacy support for highly complex medication regimes	12	12	12	12	3	CWCSS	2
28382	Lack of administration support for Governance & Medicine Safety objectives	12	12	12	12	2	CWCSS	2
29547	Increased Sickness levels within the Neonatal Consultant Workforce		12	12	12	12	CWCSS	2
30650	Improving culture and stability within the Neonatal Consultant Team at UHNM				12	6	CWCSS	3
30652	Culture Stability within the whole Neonatal Team at UHNM				12	6	CWCSS	3
18664	Gynaecology 52 Week Wait Patient Numbers	12	12	12	12	9	CWCSS	5
20435	Paediatric Follow up Backlog	12	12	12	12	6	CWCSS	5
25790	Diagnostic Sleep Service	12	12	12	12	6	CWCSS	5
26554	LAC - IHA compliance	12	12	12	12	2	CWCSS	5
26921	Radiology Reporting Backlog - MSK	12	15	15	12	4	CWCSS	5
28365	Overall Management Resource Capacity deficit - Imaging	15	12	12	12	9	CWCSS	5
20315	PathmanDB - Oracle servers High impact exploit/Vulnerability	12	12	12	12	4	Central Functions	6
28802	Insufficient hub space and clinical room capacity for community midwifery teams	12	12	12	12	4	CWCSS	7
13744	Midwifery safe staffing	6	12	12	12	4	CWCSS	1, 2
18842	Pharmacy staffing for Inpatient gastroenterology	12	12	12	12	6	Medicine	1, 2
21481	Gaps within the Junior Medical Rota	12	12	12	12	6	CWCSS	1, 2
24272	Breach of Induction of Labour Guidance	12	12	12	12	4	CWCSS	1, 2
25229	Nurse Staffing CED	12	12	12	12	4	Medicine	1, 2
25247	Nurse Staffing CAU	12	12	12	12	4	CWCSS	1, 2
26995	Radiology Reporting Backlog - Body Radiology	12	12	15	12	4	CWCSS	1, 2
28944	Cessation of external funding at March 2024 for NMCPS posts		12	12	12	4	NMCPS	1, 2
29312	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.		12	12	12	4	CWCSS	1, 2
30482	Type A - Aortic Dissection rota			12	12	12	Network Services	1, 2
27754	Lack of provision for patients requiring DIEP surgery	12	12	12	12	4	Surgery	1, 2, 5
28684	Suitability of Cohort (ambulance holding) Area -	12	12	12	12	2	Medicine	1, 7
29812	Replacement Medical Devices - Capital and Revenue Funding Risk		12	12	12	2	Estates, Facilities and PFI	1

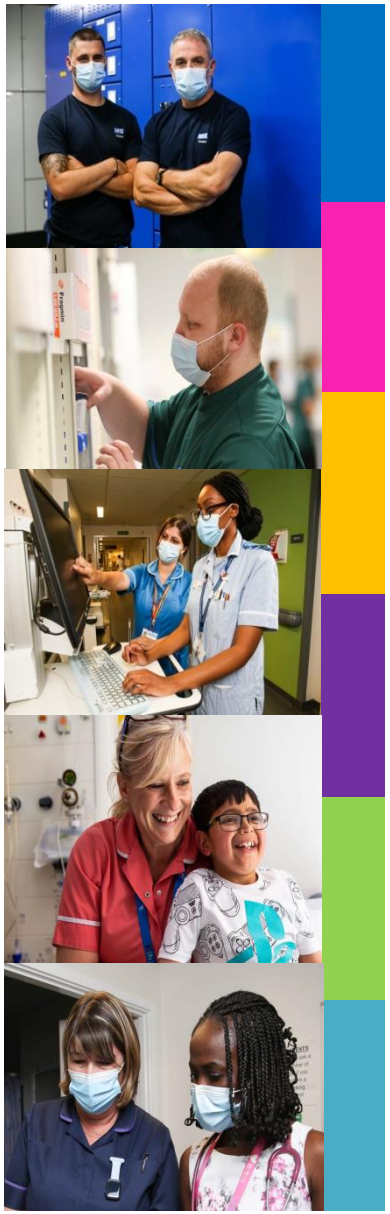
ID	Title	Risk Score at End Q1	Risk Score at End Q2	Risk Score at End Q3	Risk Score at End Q4	Target Risk Score	Division	BAF Risk
30237	ECT Cooper Building roof leaks		12	12	12	4	NMCPS	7
12699	High acuity emergency patients - County	12	12	12	12	4	Medicine	1
20180	Controlled drugs management	12	12	12	12	6	Medicine	1
24837	Cystic Fibrosis workforce/service delivery	12	12	12	12	4	Medicine	2
26110	Renal clinic letters for Cheshire (Leighton) Patients	12	12	12	12	6	Medicine	2
16652	Staff Wellbeing and Welfare	16	12	12	12	2	Medicine	3
8660	Follow up back log	12	12	12	12	6	Medicine	5
10356	Bowel prep prescription pre-assessment capacity	6	12	12	12	3	Medicine	5
17805	Lung Nodule Management	12	12	12	12	8	Medicine	5
20448	Patient LOS above 24 hrs on AMU - against Internal Standards	12	12	12	12	4	Medicine	5
24028	Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	12	12	12	12	6	Medicine	5
29899	Project and Planned Maintenance Slippage due to ongoing Industrial Action		12	12	12	6	Central Functions	6
25890	Urgent care standard referrals (ED)	12	12	12	12	4	Surgery	7
27410	Theatre doors not compliant with fire safety regulations	12	12	12	12	4	Surgery	7
9738	AMRA not funded for staying open overnight	12	12	12	12	6	Medicine	8
17710	ANP Succession Planning	12	12	12	12	4	CWCSS	1, 2
22514	Wards 227 RN Workforce availability	16	12	12	12	3	Network Services	1, 2
23570	Nurse Staffing in the Emergency Department both Sites	12	12	12	12	6	Medicine	1, 2
25228	Neurosciences SHO Rota	12	12	12	12	6	Network Services	1, 2
25467	Nurse Staffing Ward 217	16	12	12	12	4	CWCSS	1, 2
25857	Vacant Consultant Neurology On-Call Gaps	12	12	12	12	4	Network Services	1, 2
26920	AMU COUNTY-Lack of pharmacy staff to meet demand due to increased bed base	15	12	12	12	2	Medicine	1, 2
27472	Inability to always provide extra observational staff for patients who require it which could lead to patient harm	12	12	12	12	5	Medicine	1, 2
26808	Medical Cover Cardiothoracic ICU	12	12	12	12	3	Network Services	1, 3
29704	Your Next Patient (Corridor Queues) Acute Medicine		12	12	12	4	Medicine	1, 5
25917	Use of TDL for medical patients awaiting therapies assessment		12	12	12	3	Medicine	1, 5
31206	Lack of therapy provision Ward 225 - Deconditioning of patients				12	4	Network Services	1
30500	SCP- Inadequate Establishment & Staff Shortages			16	12	6	Network Services	2
18066	Cardiology follow up backlog	12	12	12	12	4	Network Services	5
21887	Changes to AED Formulary across South & North Staffordshire	8	8	12	12	4	Network Services	5
26529	Leighton Hospital Hyper-Acute Stroke Pathway	12	12	12	12	4	Network Services	5
24835	Delay in Interventional Radiology Procedures - Room 5	12	12	12	12	6	CWCSS	7
31163	Replacement of Radiotherapy Dose Calculation System				12	4	Network Services	7
25795	HD capacity and workforce	12	12	12	12	8	Medicine	1, 2
29712	Scientist Shortages in Neurophysiology		12	9	12	4	Network Services	1, 2

ID	Title	Risk Score at End Q1	Risk Score at End Q2	Risk Score at End Q3	Risk Score at End Q4	Target Risk Score	Division	BAF Risk
29776	Inadequate pharmacy service to escalation wards (80/81/120/123)		12	12	12	4	CWCSS	1, 2
11294	NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	12	16	16	12	6	NMCPS	2
20626	Low staffing levels for Phlebotomy at Cheshire Sites	6	6	12	12	6	NMCPS	2
11306	Pathology LIMS replacement	16	16	16	12	3	NMCPS	6
25668	Risk of Patient Information changing between Pathology LIMS and ICE	12	12	12	12	6	NMCPS	6
26427	Use of Q-pulse as electronic management system	9	9	12	12	6	NMCPS	6
28354	Blood Analyser Lantronix UDS box	12	12	12	12	4	NMCPS	6
30787	Histology Consultant Office Accommodation				12	4	NMCPS	7
28714	Inadequate Nurse Staffing in Children's ED Compromising Ability to Provide Basic CQC Nursing Requirements	12	12	12	12	4	Medicine	1, 2
27156	EMR/ESD Service - Lack of Operational Policy	9	12	12	12	4	Surgery	1
30750	Theatre Trolley availability for Ward 104/105			12	12	4	Surgery	1
31429	Audiology Staffing				12	4	Surgery	2
25470	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12	12	12	12	4	Surgery	5
30749	CL/LVA Service Delivery			16	12	4	Surgery	5
27146	Lack of compatibility between iportal and other systems	12	12	12	12	4	Surgery	6
31378	XMSGH Domain - Cyber Risk				12	4	Surgery	6
27953	Nurse Staffing Vacancy within CICU	15	12	12	12	4	CWCSS	1, 2
29767	Backlog for radical prostatectomy		16	16	12	4	Surgery	1, 5

NHS
University Hospitals of North Midlands
NHS Trust

Summary Board Assurance Framework

Quarter 4 2023/2024



Delivering Exceptional Care with Exceptional People

High Level Overview

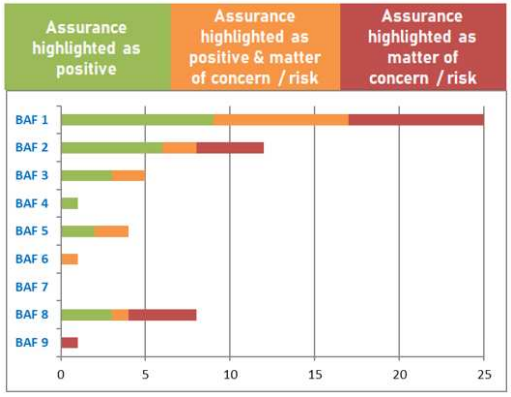
NHS University Hospitals of North Midlands NHS Trust

Strategic Risk Summary

	BAF Risk Title	Risk Scores & Assurance Assessment Q1	Q2	Q3	Q4	No. Linked Risks	High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources	Actual v Trajectory	Target Risk Score
BAF 1	Patient Outcomes & Experience	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	165 ↓ (Q3 176)	✓	✓	✓	✓				Mod 6
BAF 2	Sustainable Workforce	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	Ext 16 / Acceptable Assurance	118 → (Q3 118)	✓		✓			✓		High 9
BAF 3	Leadership, Culture & Values	High 12 / Partial Assurance	High 12 / Partial Assurance	High 12 / Partial Assurance	High 12 / Partial Assurance	10 → (Q3 10)	✓	✓	✓					Mod 6
BAF 4	Improving Population Health	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 15 / Partial Assurance	2 → (Q3 2)	✓				✓	✓		High 12
BAF 5	Responsive Patient Care	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	Ext 20 / Partial Assurance	63 ↑ (Q3 62)	✓	✓	✓	✓	✓	✓		High 12
BAF 6	Digital Transformation	Ext 16 / Partial Assurance	Ext 16 / Partial Assurance	High 12 / Acceptable Assurance	High 9 / Acceptable Assurance	73 ↓ (Q3 75)	✓	✓		✓	✓	✓		High 8
BAF 7	Fit for Purpose Estate	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	High 12 / Acceptable Assurance	78 → (Q3 78)	✓	✓	✓	✓	✓	✓		High 8
BAF 8	Financial Sustainability	High 9 / Partial Assurance	High 12 / Partial Assurance	High 9 / Partial Assurance	Low 3 / Partial Assurance	33 → (Q3 33)	✓	✓	✓	✓	✓	✓		Low 3
BAF 9	Research & Innovation	High 12 / Partial Assurance	High 12 / Partial Assurance	High 9 / Partial Assurance	High 9 / Partial Assurance	3 → (Q3 3)	✓		✓	✓	✓	✓		Mod 4

Strategic Risk Heat Map

Assurance Outcomes Overview



Positive Assurances to Note

- 7/9 risk scores are in line with their trajectory at Q4; including BAF 6 being below trajectory and BAF 8 achieving its target risk score
- 89% of assurances were seen compared to the plan during the quarter
- 44% assurances highlighted positive assurance with a further 25% highlighting both a matter of concern and a positive assurance
- 51% of actions have been completed during the year, with the majority of actions having been completed for BAF 1 and BAF 3

Matters of Concern

- 23 sources of assurance were not seen during Q4
- 31% assurances highlighted a matter of concern for escalation
- BAF 2 and BAF 5 have both exceeded their trajectory for Q4 and BAF 5 has not achieved the planned target score (target date 31/03/2024)
- 15% of actions are either delayed or problematic

BAF 1: Delivering Positive Patient Outcomes

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

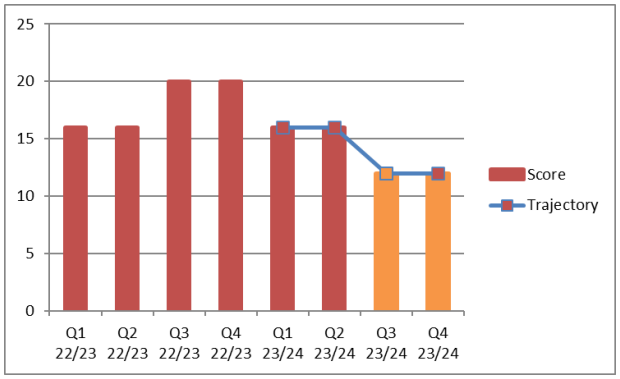
NHS University Hospitals of North Midlands NHS Trust

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 care resulting in patients receiving adverse outcomes and poor experience.

Assurance, Risk Ratings & Target

Acceptable Assurance	Ext 16	Ext 16	High 12	High 12	Mod 6 31/3/25

Risk Movement and Risk Reduction Trajectory



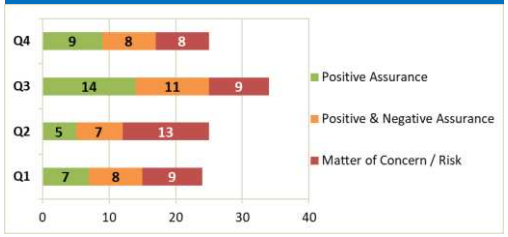
Heat Map Risk Matrix

Rationale for Risk Level

The risk score has remained the same as Q3, due to clinical effectiveness delivery remaining a concern and Section 29a notices remaining in place with a CQC rating of Requires Improvement. In addition, not all quality metrics are meeting required targets.

Linked Risks on Register

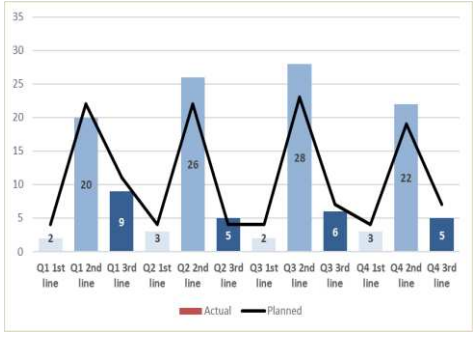
Committee Assassurance Outcomes



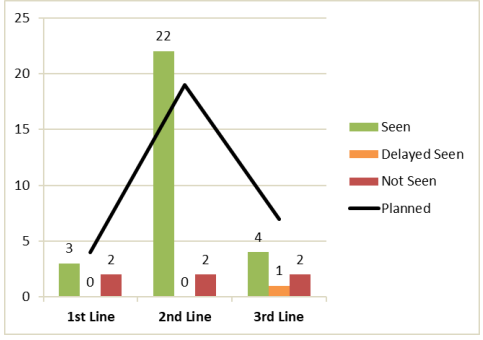
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Implement Tendable audit system	31/12/2023			
2	Develop PSIRP framework	30/09/2023			
3	Recruit midwives to Birth Rate Plus	31/12/2023			
4	Recruit to ED Business Case	31/12/2023			
5	Integrated Discharge Function	30/06/2023			
6	Delivery Workstream 2, LOS, occupancy, discharge	30/09/2023			
7	Continue recruitment / retention	31/03/2025			
8	Delivery of CQC actions	31/03/2025			
9	External review of Paediatric Audiology	30/06/2024			

2023 / 2024 Assurance Plan



Quarter 4 Assurance against Plan



Overview

- Risk remained the same as Q3 in line with planned trajectory
- Continues to have the highest number of 'linked risks' on the risk register, although this has reduced to 165 at Q4 from 176 at Q3, with 12 linked risks rated as Extreme
- 32% of assurance reports for the quarter identified a risk / concern for escalation, compared to 36% receiving positive assurance
- 83% of assurances were seen during the quarter
- Key gaps related to waiting for the CQC inspection in relation to both Section 29a notices, waiting for approval of vacancies to support delivery of clinical effectiveness agenda and sustained delivery against related quality and harm free care A3 countermeasures

BAF 2: Sustainable Workforce

Chief People Officer | Transformation & People Committee | Threat to:

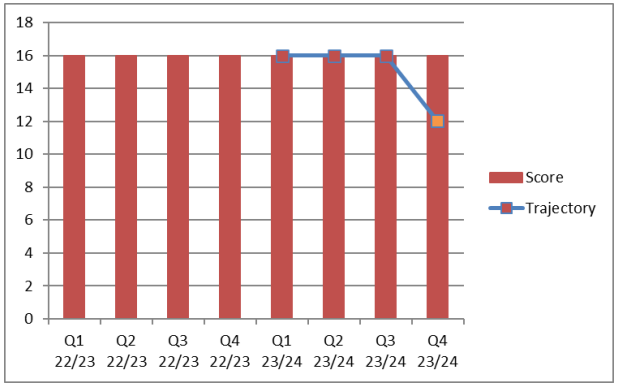
University Hospitals of North Midlands NHS Trust

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

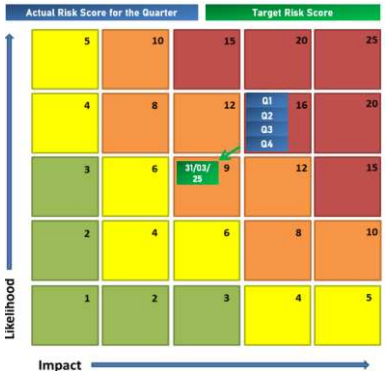
Assurance, Risk Ratings & Target

Acceptable Assurance	Ext 16	Ext 16	Ext 16	Ext 16	High 9 31/3/25

Risk Movement and Risk Reduction Trajectory



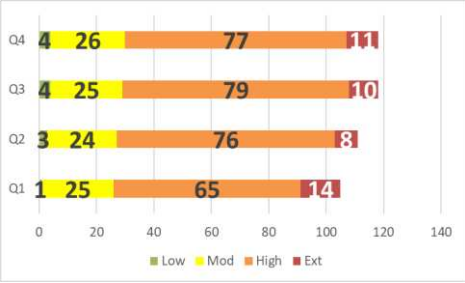
Heat Map Risk Matrix



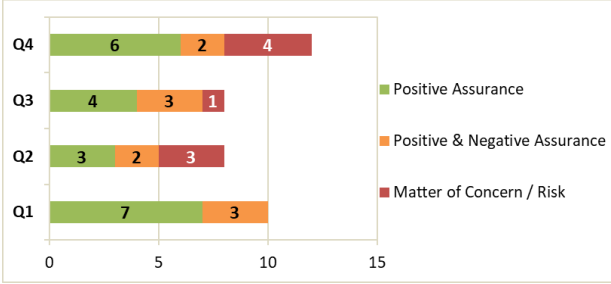
Rationale for Risk Level

- Although good progress has been maintained in Q4, as anticipated we have experienced increased challenges during Q4, including system financial pressures, winter pressures and the impact of continued industrial action, therefore the plan to achieve a score of High 12 by Q4 has not been met.
- Good progress with People Plan being seen; vacancy rates and staff turnover continue to be below target, recruitment campaigns seeing success and successful national apprenticeship week
- Agency costs continue to be above the target, although slightly improved
- Apprenticeship levy to become breakthrough objective for 24/25

Linked Risks on Register



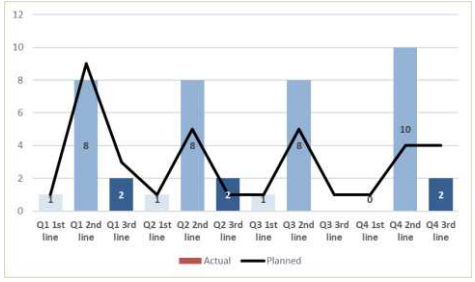
Committee Assurance Outcomes



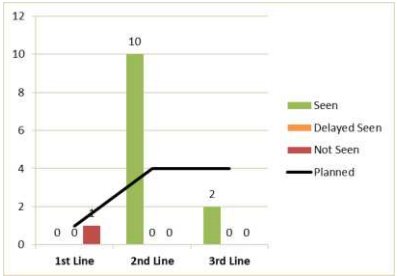
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Support / share skills with local organisation events	31/10/2023			
2	Define and protmote the benefits package on offer	30/09/2023			
3	Increase social media presence as Great Place to Work	31/10/2023			
4	Work with TRAC to identify application redesign	31/03/2024			
5	Review all placements and create new career pathway through guaranteed interview, job schemes, mirroring newly qualified nurse pathway	31/03/2024			
6	Develop, promote and deliver retention plan	30/11/2023			
7	Launch new welcome booklet for new starters	30/06/2024			
8	Task and Finish Group to be established re: onboarding	30/06/2024			
9	Recruitment events to be held	30/04/2024			
10	Workforce Plan to be submitted to Board/Committees	10/05/2024			
11	To build tools to transfer ESR data into data warehouse	30/06/2024			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score above trajectory for Q4
- 2nd highest number of 'linked risks' on the risk register which has remained at 118 at Q4, 11 risks are extreme
- 33% of assurance reports for the quarter identified a risk / concern for escalation, compared to 50% receiving positive assurance
- 92% of assurances were seen during the quarter
- Gaps to address are predominantly around vacancy controls, agency expenditure and capacity within learning, education and widening participation team

BAF 3: Leadership, Culture and Values

Chief People Officer | Transformation & People Committee | Threat to:

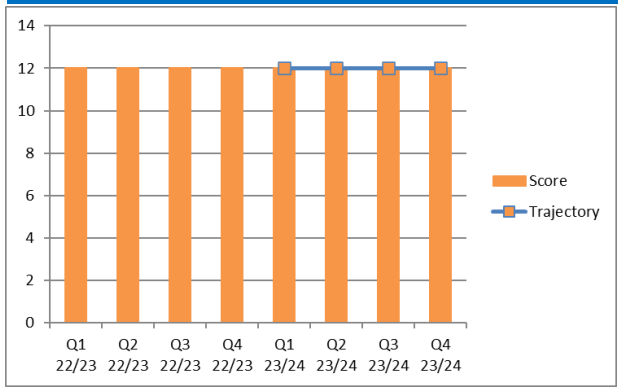
University Hospitals of North Midlands NHS Trust

If we are unable to live our values and improve the culture of the organisation to make UHNM a great 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, retention and performance, ultimately reducing the quality of care experienced by patients.

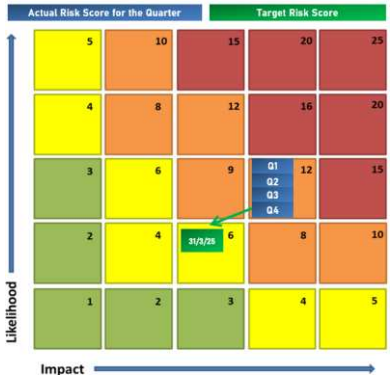
Assurance, Risk Ratings & Target

Partial Assurance	High 12	High 12	High 12	High 12	Mod 6 31/3/25

Risk Movement and Risk Reduction Trajectory



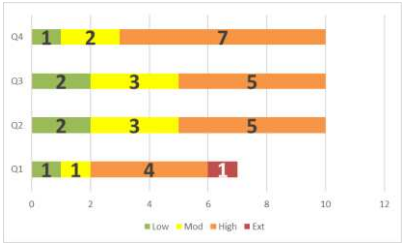
Heat Map Risk Matrix



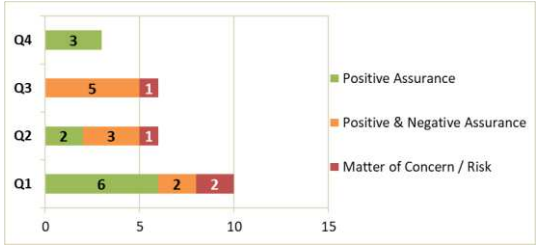
Rationale for Risk Level

- Good progress has been made during 2023/24 and TAP agreed to a positive assurance rating in March 2024 compared to 'partial assurance' rating in previous months. However, some initiatives have been delayed while recruitment to key vacancies has taken place, and further analysis of National Staff Survey Results will better inform review of this risk scoring.

Linked Risks on Register



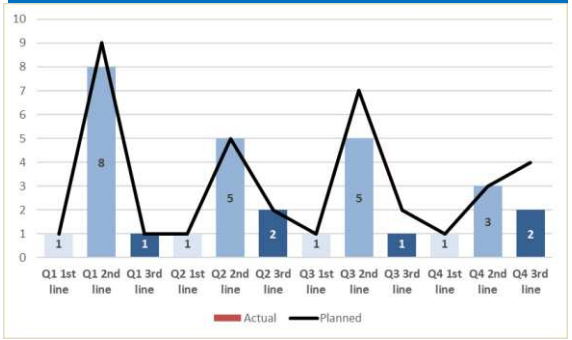
Committee Assurance Outcomes



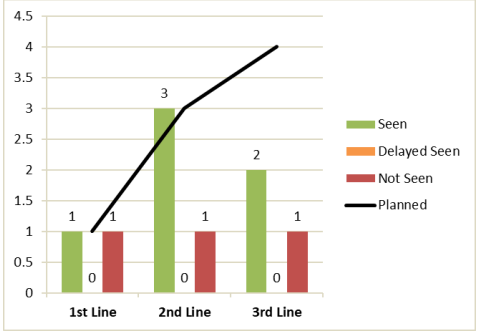
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Enhanced Staff Survey campaign	30/11/2023			
2	Employee Engagement Plan & Supporting Activities	31/03/2024			
3	Improve/increase awareness of Being Kind culture and impact	30/09/2023			
4	Improve employee experience specifically via EDI plan	31/03/2024			
5	Improve leadership effectiveness at all levels	31/03/2024			
6	Culture review / team effectiveness framework / tools	31/12/2023			
7	Equality, Inclusion and Human Rights week	17/05/2024			
8	Plan on Page re: Abusive Behaviours	30/06/2024			
9	Talent and Succession Planning	30/06/2024			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score in line with trajectory for all quarters
- 3rd lowest number of linked risks on Risk Register (10) with no change in total number since Q2 although higher number of high risks in Q4
- All 3 assurance reports for Q4 received positive assurance
- 67% of assurances were seen during the quarter
- Gaps to address are around operational pressures impacting on employee engagement, essential to role training compliance, high levels of employee relations cases and capacity of the People Directorate

BAF 4: Improving the Health of our Population

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

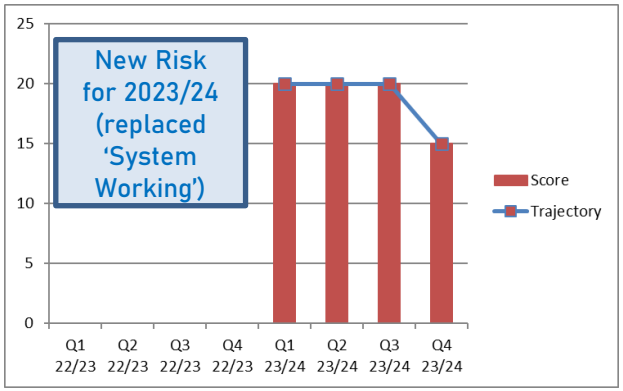
University Hospitals of North Midlands NHS Trust

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

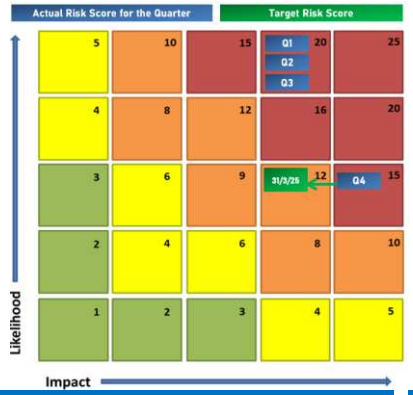
Assurance, Risk Ratings & Target

Partial Assurance	Ext 20	Ext 20	Ext 20	Ext 15	High 12 31/3/25

Risk Movement and Risk Reduction Trajectory



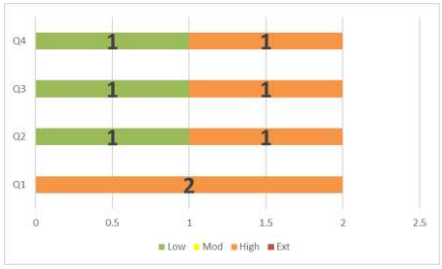
Heat Map Risk Matrix



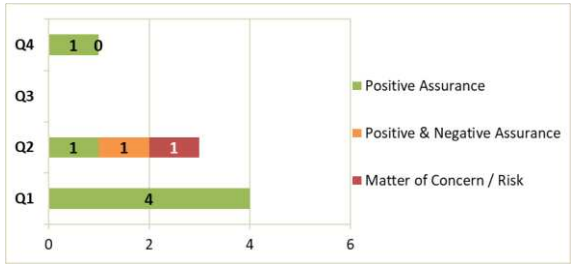
Rationale for Risk Level

- Risk likelihood has reduced as per plan for Q4, on the basis that the Trust Board has approved the Population Health strategy. There is further work underway to embed action plans, which will be approved as part of annual planning. At the point where there is demonstrated delivery, the risk rating will be re-assessed during 24/25.

Linked Risks on Register



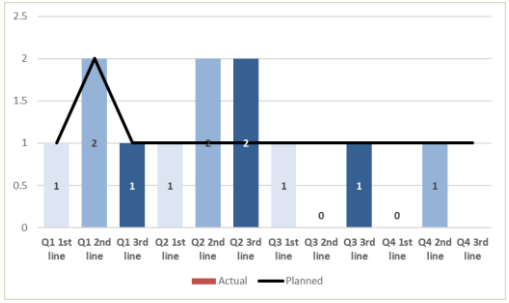
Committee Assurance Outcomes



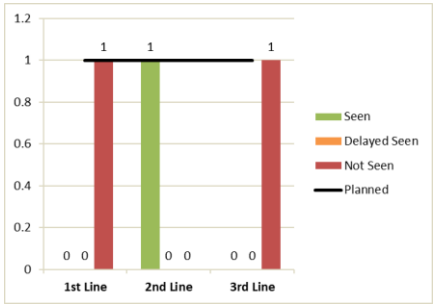
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Approval of Health & Wellbeing Strategy	31/12/2023			
2	Development of programme structure	31/12/2023			
3	Development of metrics to measure progress	2024/25			
4	Undertake stocktake of health inequalities activity and opportunities	30/09/2023			
5	Develop plan to support delivery of strategy	2024/25			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score has been in line with trajectory for all quarters and reduced as planned in Q4
- Lowest risk profile with only 2 linked risks on the risk register throughout the year
- Very limited sources of assurance provided throughout the year
- Gaps to address focus on the need to demonstrate delivery of the strategic action plans, which will be achieved in 2024/25 to provide sufficient assurance of the ability to reduce the risk to the target level

BAF 5: Delivering Responsive Patient Care

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

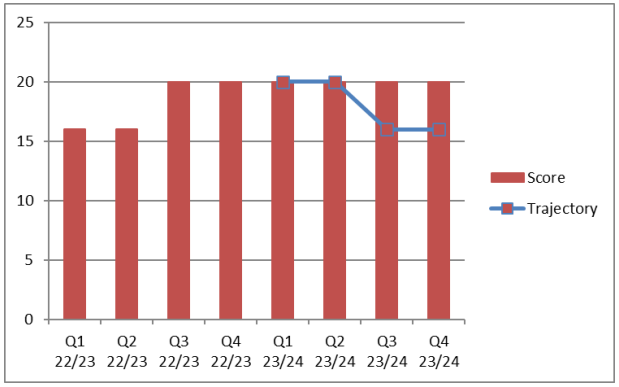
NHS University Hospitals of North Midlands NHS Trust

If we are unable to create sufficient capacity to deal with service demand then we may be unable to treat patients in a timely manner resulting in delays to patient care, poor outcomes and potential patient harm.

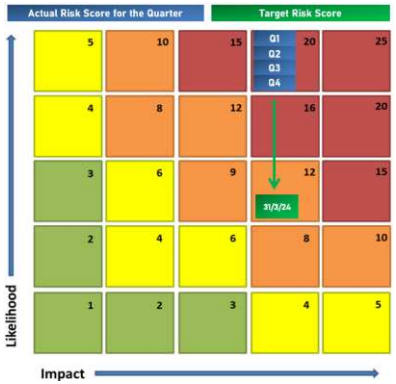
Assurance, Risk Ratings & Target

Partial Assurance	Ext 20	Ext 20	Ext 20	Ext 20	High 12 31/3/24

Risk Movement and Risk Reduction Trajectory



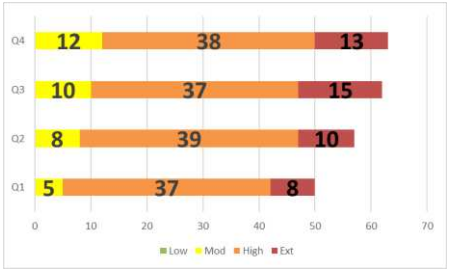
Heat Map Risk Matrix



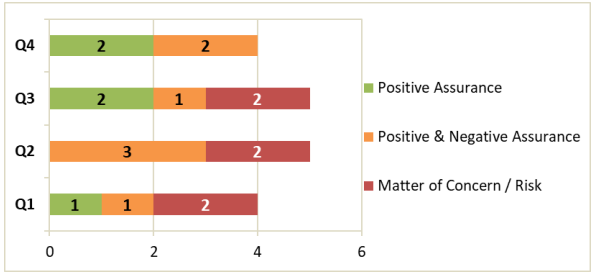
Rationale for Risk Level

Despite improvements in performance, there remain areas of risk, and performance has not been consistently delivered. In addition, performance has not delivered the specific required parameters. The planned risk score for Q4 has not been achieved in addition to not achieving the target risk score and this risk is to be reconsidered as part of the 2024/25 BAF process.

Linked Risks on Register



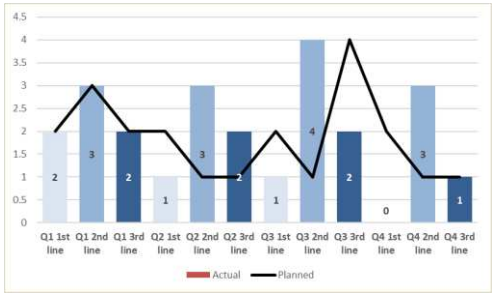
Committee Assurance Outcomes



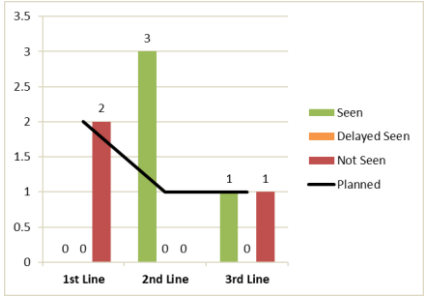
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Execute business cases to support NEL/elective work	31/03/2023			
2	Deliver NEL improvement programme objectives	31/03/2024			
3	Increase capacity - County Hospital Elective Care	31/03/2025			
4	Explore/develop data and technology to support service	31/03/2024			
5	Collaborate with ICS on alternative pathways to UHNM	30/09/2023			
6	Independent review of waiting list management	31/05/2023			
7	Deliver objectives aligned to System 7 UEC priorities	31/03/2024			
8	Deliver objectives in elective improvement programme	31/03/2024			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Highest scoring strategic risk remaining outside of trajectory and target risk score
- 63 Linked risks on the Risk Register increased from 62 at Q3, although slightly lower number of extreme risks
- 4 assurance reports provided for Q4 evenly split between positive assurance and both positive and negative assurance
- Gaps to address are around occupancy and right sizing the hospital in addition to continued work on County Daycase and new modular build

BAF 6: Digital Transformation

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

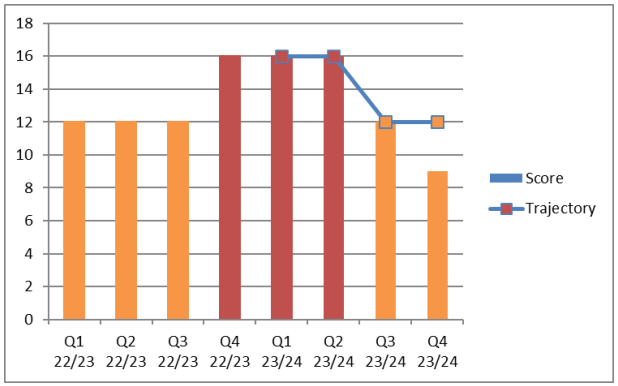
University Hospitals of North Midlands NHS Trust

If our infrastructure and clinical systems are not sufficient or adequately governed or protected then this could compromise connectivity and access to key critical patient information services such as clinical decision support resulting in compromised patient care, staff inefficiencies and breaches of confidentiality, reputational damage and potential fines.

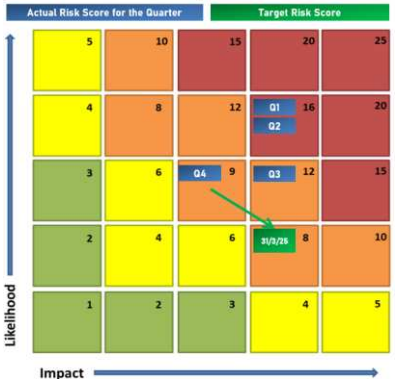
Assurance, Risk Ratings & Target

Acceptable Assurance	Ext 16	Ext 16	High 12	High 9	High 8 31/3/25

Risk Movement and Risk Reduction Trajectory



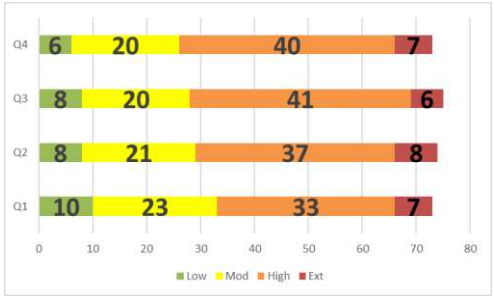
Heat Map Risk Matrix



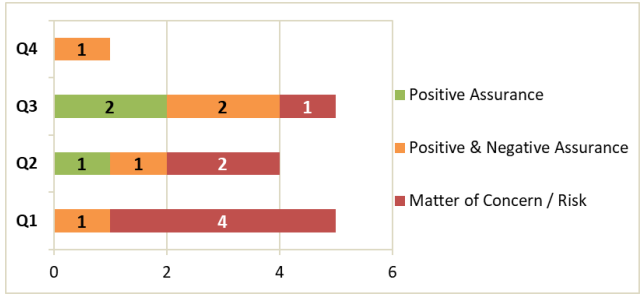
Rationale for Risk Level

A number of projects have been delivered as planned (Office 365 and LIMS) and soft market testing for Electronic Patient Record has commenced. In addition, we have sustained a positive cyber score and legacy security technology has been decommissioned (web filtering proxy servers), therefore the actual score for Q4 is less than planned.

Linked Risks on Register



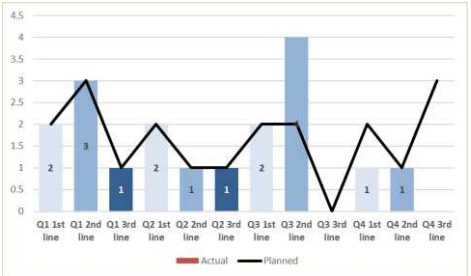
Committee Assurance Outcomes



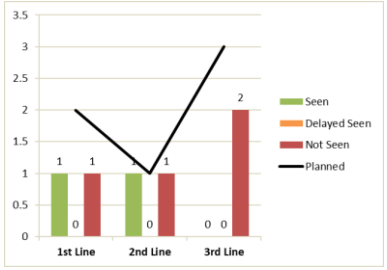
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Office 365 implementation	01/11/2023			
2	Network and Communication business case approval	01/08/2023			
3	SOC service Go Live	01/11/2023			
4	LIMS Go Live	30/05/2024			
5	EPR Outline Business Case	31/08/2024			
6	EPR Pilot	31/10/2024			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score reduced lower than trajectory in Q4
- Linked risks on the Risk Register slightly decreased to 73
- 4 planned assurances were not seen during the quarter
- Gaps to address are around completing LIMS for Cell Path, upgrading VPN technology, completing the EPR soft market testing and network migration

BAF 7: Fit for Purpose Estate

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

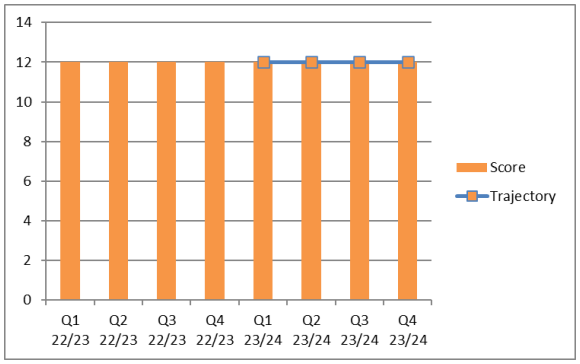
University Hospitals of North Midlands NHS Trust

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.

Assurance, Risk Ratings & Target

Acceptable Assurance	High 12	High 12	High 12	High 12	High 8 31/3/25

Risk Movement and Risk Reduction Trajectory

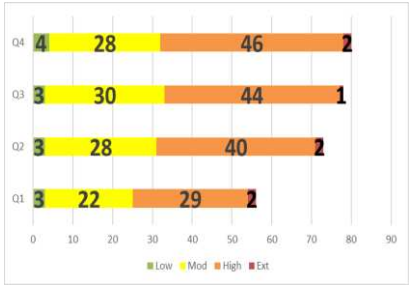


Heat Map Risk Matrix

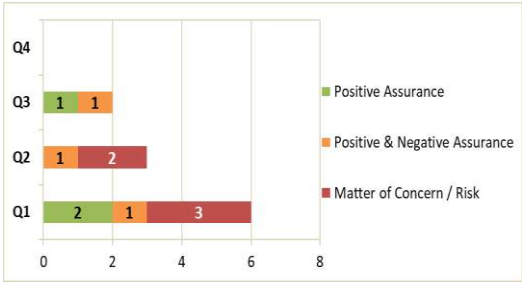
Rationale for Risk Level

- Estate condition and backlog risks remain due to funding constraints
- Challenges with Estate capital programme delivery given size / scope / scale and timeliness required
- Workforce challenges within Estates but improved position
- Sustainability / Net Zero Carbon requirements ever increasing
- Surveys underway relating to PFI building fabric / latent defect
- Estates strategy being refreshed informed by bed review and clinical strategy
- PFI market testing concluded, focus now on formalising with lenders
- Immunisation for Sodexo staff being worked through
- Challenges in maintaining improved cleaning standards within West Building

Linked Risks on Register



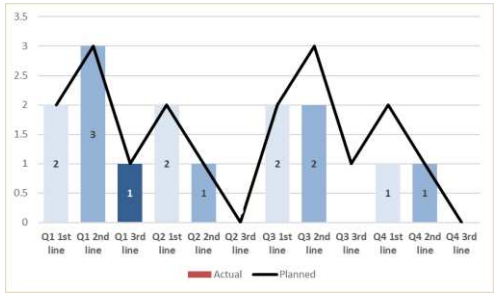
Committee Assurance Outcomes



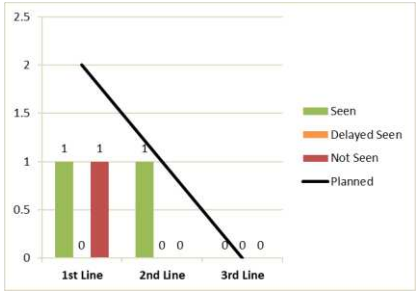
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Energy Procurement Paper	31/07/2023			
2	RI Site demolition	31/03/2025			
3	Car parking solution	29/04/2024			
4	RI/COPD release land for sale	2025/2026			
5	Lower Trent Business Case	31/03/2024			
6	PFI market testing opportunities	29/02/2024			
7	Estate condition	31/03/2025			
8	Cleaning collaborative / cleaning standards	30/06/2023			
9	Capital delivery programme	31/03/2024			
10	Immunisation gap - Sodexo	31/10/2024			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score has remained in line with trajectory for all quarters
- Number of linked risks on the Risk Register has remained the same as Q3 at 78 although slightly higher number of high risks
- Two planned assurances were seen during the quarter although these were not rated
- Gaps to address are around capital programme, PFI latent defect, sustainability, Estate Strategy and contract variations for Sodexo staff

BAF 8: Financial Sustainability

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

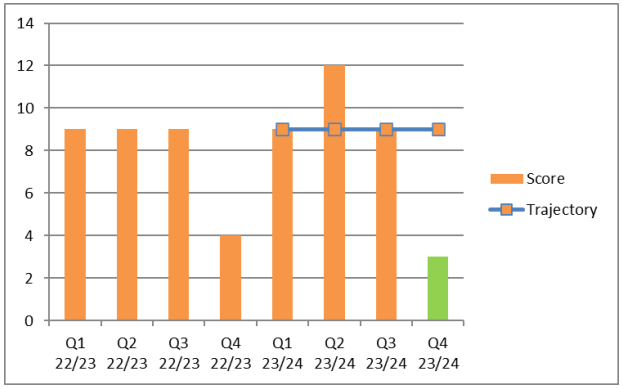
NHS University Hospitals of North Midlands NHS Trust

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

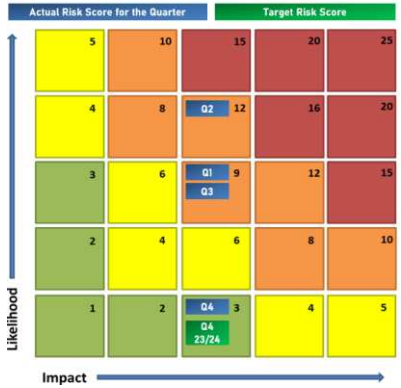
Assurance, Risk Ratings & Target

Partial Assurance	High 9	High 12	High 9	Low 3	Low 3 31/3/24

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix

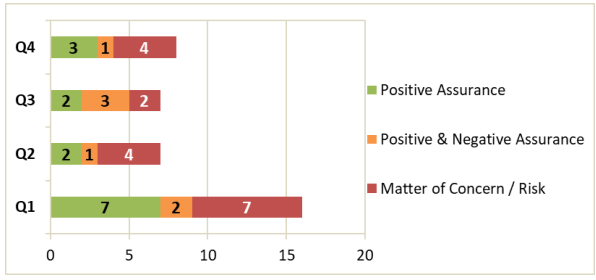


Rationale for Risk Level

- The Trust has met its financial duties for 2023/24, therefore the target risk score has been achieved. However, this has been reliant on non-recurrent mitigations which have contributed to a system wide underlying deficit, therefore the impact of this and the associated risk for 2024/25 is to be considered and articulated as part of the Q1 BAF.

Linked Risks on Register

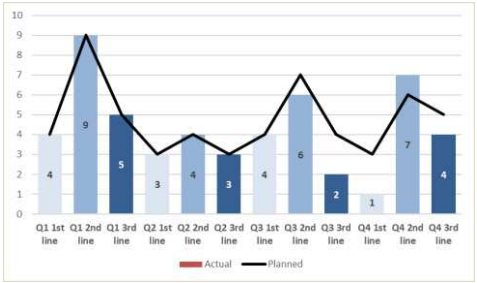
Committee Assassurance Outcomes



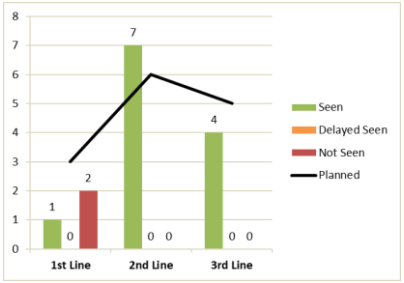
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Identification of recurrent CIP	31/03/2024			
2	Reduce level of recurrent investment to mitigate CIP	30/09/2023			
3	Ensure delivery of elective targets	31/03/2024			
4	Reset bed model and final allocation of system capacity funding	31/07/2023			
5	Consider impact of national guidance on Industrial Action funding mechanisms when communicated	31/12/2023			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score has achieved its target
- Linked risks on the Risk Register has remained at 33 although slight movement between high / extreme risks
- Majority of planned assurances provided within Q4 with main matters of concern relating to business case reviews, agency spend and losses and special payments / stock write offs
- Gaps to address are around mitigation and actions required in terms of identifying recurrent savings in order to improve the underlying financial position for 2024/25

BAF 9: Research and Innovation

Medical Director | Transformation & People Committee | Threat to:

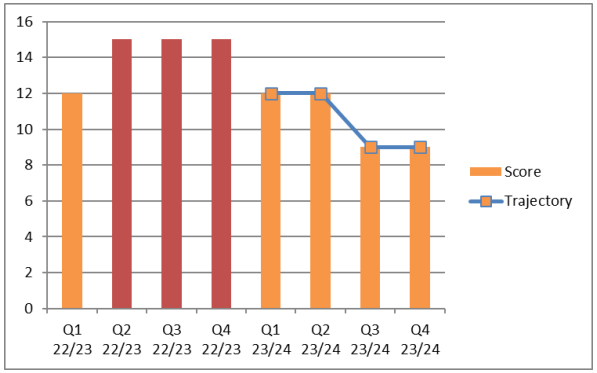
University Hospitals of North Midlands NHS Trust

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

Assurance, Risk Ratings & Target

Partial Assurance	High 12	High 12	High 9	High 9	Mod 4 30/9/24

Risk Movement and Risk Reduction Trajectory

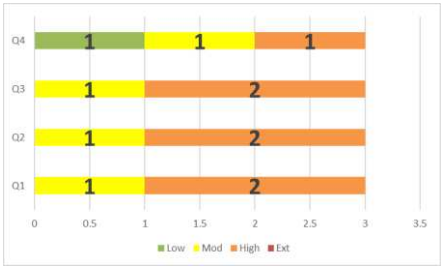


Heat Map Risk Matrix

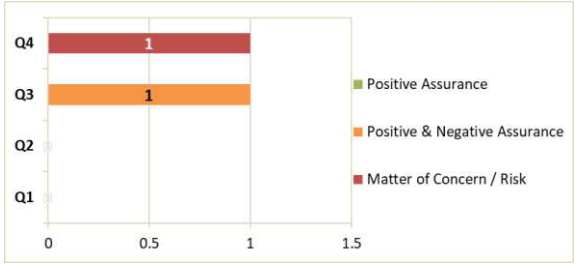
Rationale for Risk Level

- UHNM strategic priority of increasing number of recruits to clinical trials has been met, it is anticipated recruitment will have increased by over 25% on 22/23
- The financial plan for 24/25 is yet to be negotiated and signed off, this uncertainty around the plan will impact on future roles to be advertised in Q1 24/25
- R&I Directorate are part way through their improving together training, A3's and directorate scorecards are being established for 24/25

Linked Risks on Register



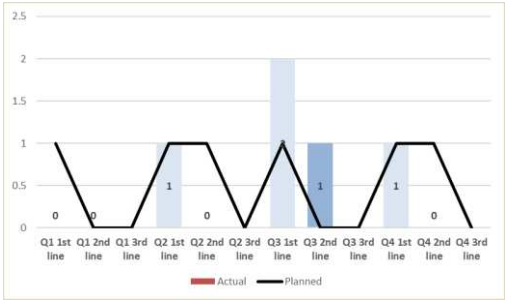
Committee Assurance Outcomes



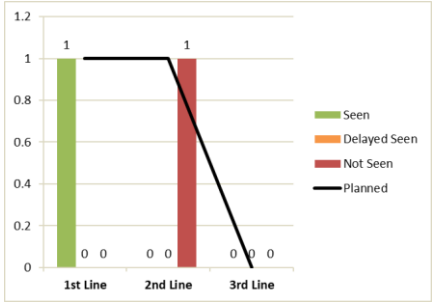
Summary Action Plan

No	Summary Action	Due	Q2	Q3	Q4
1	Desktop review of structure being undertaken	25/11/2023			
2	Develop report which provides assurance against strategy	31/12/2023			
3	Substantive recruitment to vacancies	31/12/2023			
4	Develop and deliver plan arising from desktop review	31/12/2023			
5	Review research governance structure including divisions	31/03/2024			
6	Research to form part of divisional performance metrics	30/09/2024			
7	Research to form part of Divisional Board agendas	30/09/2024			
8	Commission external specialist to review quality system pre-inspection	30/09/2024			
9	increase investment and develop strategy covering R&I, CeNREE and divisions	31/03/2025			

2023 / 2024 Assurance Plan



Q4 Assurance against Plan



Overview

- Risk score remains in line with trajectory
- Second lowest number of linked risks and slight reduction in high risks
- Very weak assurance plan and one item delayed during the quarter with the one item of assurance provided highlighting matter of concern
- Gaps to address are around strategy development, governance and infrastructure to support regulatory preparation

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th May 2024
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 presented for approval, including revised Terms of Reference for each Committee, which have been updated taking into account the comments 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 2023/24. 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 14 actions to be taken forward to further enhance effectiveness and these will be monitored by respective Committees.

Revised Rules of Procedure 2024/25

Following the review of Committee Governance Packs and their approval by respective Committees, the Rules of Procedure for 2024/25 has been revised. Separate terms of reference have been included in respect of the People, Culture and Inclusion Committee and Strategy and Transformation Committee, with minor additional changes having been made to the Terms of Reference, mainly in relation to the business cycles and membership.

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 2024/25

The Trust Board is asked to approve the revised Rules of Procedure for 2024/25, incorporating the Trust Board Business Cycle and Committee Governance Packs.

University Hospitals of North Midlands NHS Trust

Review of Committee Effectiveness 2023/24

April 2024

1. Introduction

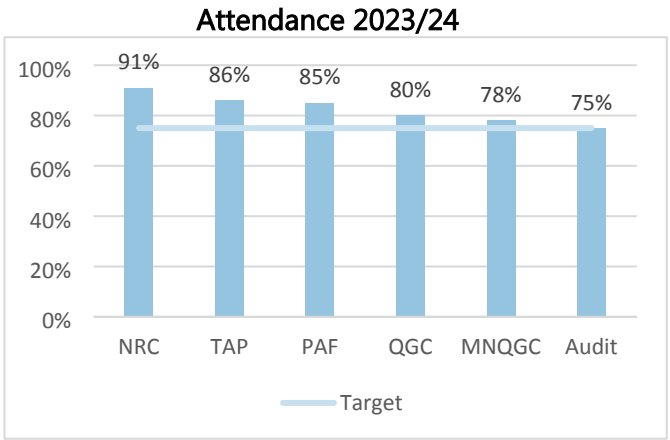
As part of the Trust's governance arrangements, and as set out within the Trust's Rules of Procedure, members and regular attendees of Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2023/24. The questionnaires were based on good practice guidance and a Committee Processes questionnaire was completed by the Deputy Associate Director of Corporate Governance on behalf of the Chair of the Committee.

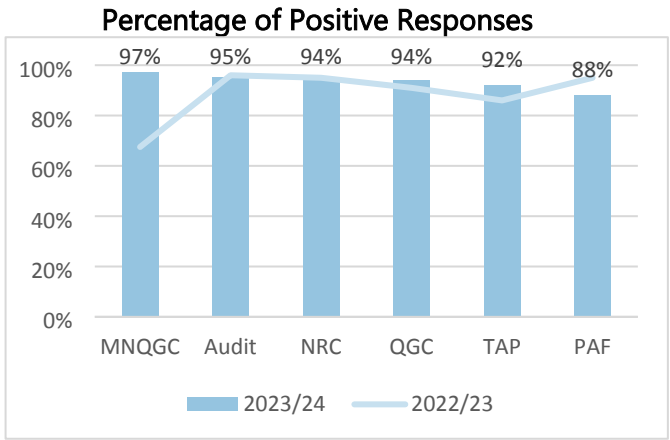
In addition, an annual report for each Committee was prepared which summarised the purpose of the Committee, membership and attendance, key items of business which were covered during the year and actions taken.

The outcomes of these reports have been considered by each Committee, whereby actions for improvement were identified based on the responses provided. In addition, each Committee has approved its revised Committee Governance Pack, which was also amended taking into account the responses from the Committee effectiveness process.

2. Comparison of Attendance and Responses to Committee Effectiveness Questions for all Committees

The charts below demonstrate that attendance for all Committees was above the expected 75% attendance rate. In addition, the percentage of positive responses for the majority of Committees was better or in line with the 2022/23 reviews, with the exception of the responses for Performance and Finance Committee.





3. Outcome of Individual Committee Annual Reports and Effectiveness Reviews

3.1 Performance and Finance Committee

The Performance and Finance Committee oversees all aspects of the Trust's financial, workforce and performance management arrangements, and provides 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.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	71.0%	95%	83%	85%	82%	83%	87%	91%	85%
Percentage of Positive Responses to Effectiveness Questions	84%	N/A	86%	82%	96%	99%	94%	95%	88%

In 2022/23 the following 4 actions were identified and have been completed during 2023/24:

- 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

Following review of the comments made in the 2023/24 review, an additional 2 actions have been identified:

- Membership of the Committee has been revised, to take into account Non-Executive Director skills and experience. In addition, future recruitment campaigns for Non-Executive Directors will focus on addressing the 'financial gap'
- Order of agendas to rotate between focus on finance versus focus on performance

3.2 Quality Governance Committee

The Quality Governance Committee assures the Trust Board of the organisation's performance against quality objectives. 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 governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	82.5%	86%	85%	79%	84%	83%	80%	85%	80%

Percentage of Positive Responses to Effectiveness Questions	96%	98%	92%	91%	93%	98%	92.5%	91%	94%

Following receipt of responses to the Committee effectiveness questionnaire, the following three actions have been identified:

- 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

3.3 Maternity and Neonatal Quality Governance Committee

The purpose of the Maternity and Neonatal Quality Governance Committee is to assure the Trust Board of the organisation's performance against quality and safety in relation to maternity and neonatal services. This includes:

- Receiving assurance that external reports on patient safety which have an impact on maternity and neonates have been reviewed, considered and any learning adopted.
- Reviewing 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
- Reviewing 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.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	79%	78%
Percentage of Positive Responses to Effectiveness Questions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	67.5%	97%

No actions were identified following the 2022/23 review and following the 2023/24 review, the following actions have been considered:

- Alongside the actions identified for QGC, to consider whether the MNQGC could reintegrate with QGC
- To review the items included on the business cycle and to identify what the reports seek to provide assurance on, in addition to considering how the Committee could be assured by the information already considered by Maternity and Neonatal Quality Safety Oversight Group, to avoid duplication

3.4 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.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	80%	83%	93%	77%	83%	87%	90%	68%	75%
Percentage of Positive Responses to Effectiveness Questions	77%	85%	94%	88%	86%	98%	96%	96%	95%

No actions for improvement were identified for 2022/23. In respect of 2023/24 the following actions have been identified:

- Internal Audit Recommendations to continue to be monitored by the relevant Committee, in addition, Executive Directors are to be reminded of the importance of setting realistic timescales
- Executive Directors to continue to hold the time in the diary for Audit Committee meetings; required attendance will be confirmed as part of setting the agenda
- To consider a suitable induction programme for any new members of the Audit Committee

3.5 Nominations and Remuneration Committee

The Committee advises the Trust Board about appropriate remuneration and terms of service for the Executive Directors including the Chief Executive and posts assigned to the Very Senior Manager framework. In addition, it monitors and evaluates the performance of individual Directors (with the advice of the Chief Executive) and oversees appropriate contractual arrangements.

The Committee also ensures there are processes in place to review the role and performance of Non-Executive Directors and the Chairman and is responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	76%	83%	89%	87%	73%	71%	85%	87%	91%
Percentage of Positive Responses to Effectiveness Questions	75%	97%	92%	92%	Not undertaken	99%	98%	95%	94%

The following action was completed during 2023/24:

- 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.

Following receipt of responses to the Committee effectiveness questionnaire, the following two actions have been identified to address the two areas of disagreement:

- Non-Executive Director Membership to be clarified within the revised terms of reference
- Summary of meetings to be provided to the next available Closed Trust Board Meeting

3.6 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.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Average Attendance of Members (%)	N/A	N/A	N/A	N/A	94%	82%	80.5%	84%	86%
Percentage of Positive Responses to Effectiveness Questions	N/A	N/A	N/A	N/A	90%	100%	98%	86%	92%

Following the 2022/23 review the following actions were identified and completed:

- Continuing to develop TAP aligned with the principles of Improving Together, including focus of meetings, structure and content of reporting and roles / behaviours.
- Continuing 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
- Continuing to monitor progress against delivery of previously agreed actions in addition to monitoring any delays with items on the business cycle
- Report authors have been invited to attend Effective Report Writing session

Following the 2023/24 review, additional actions have been identified as follows:

- It is recognised that whilst a number of comments made were in relation to the size of the agenda, it is anticipated that this will be addressed by splitting the Committee into separate areas of focus. The effectiveness of this split will be reviewed after 6 months.
- BAF Deep Dives will continue to be developed and evaluated throughout 2024/25

4. Conclusion

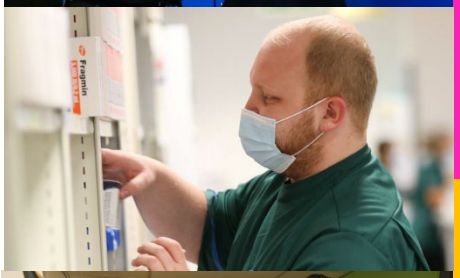
The output of the Committee effectiveness reviews and Committee annual reports have been considered by Committees, and actions for improvement have been agreed. Terms of Reference have also been updated and take into consideration any changes required for 2024/25 and these are included within the revised Rules of Procedure.

5. 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 2024/25

NHS
University Hospitals of North Midlands
NHS Trust



Rules of Procedure

April 2024

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 12,500 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.

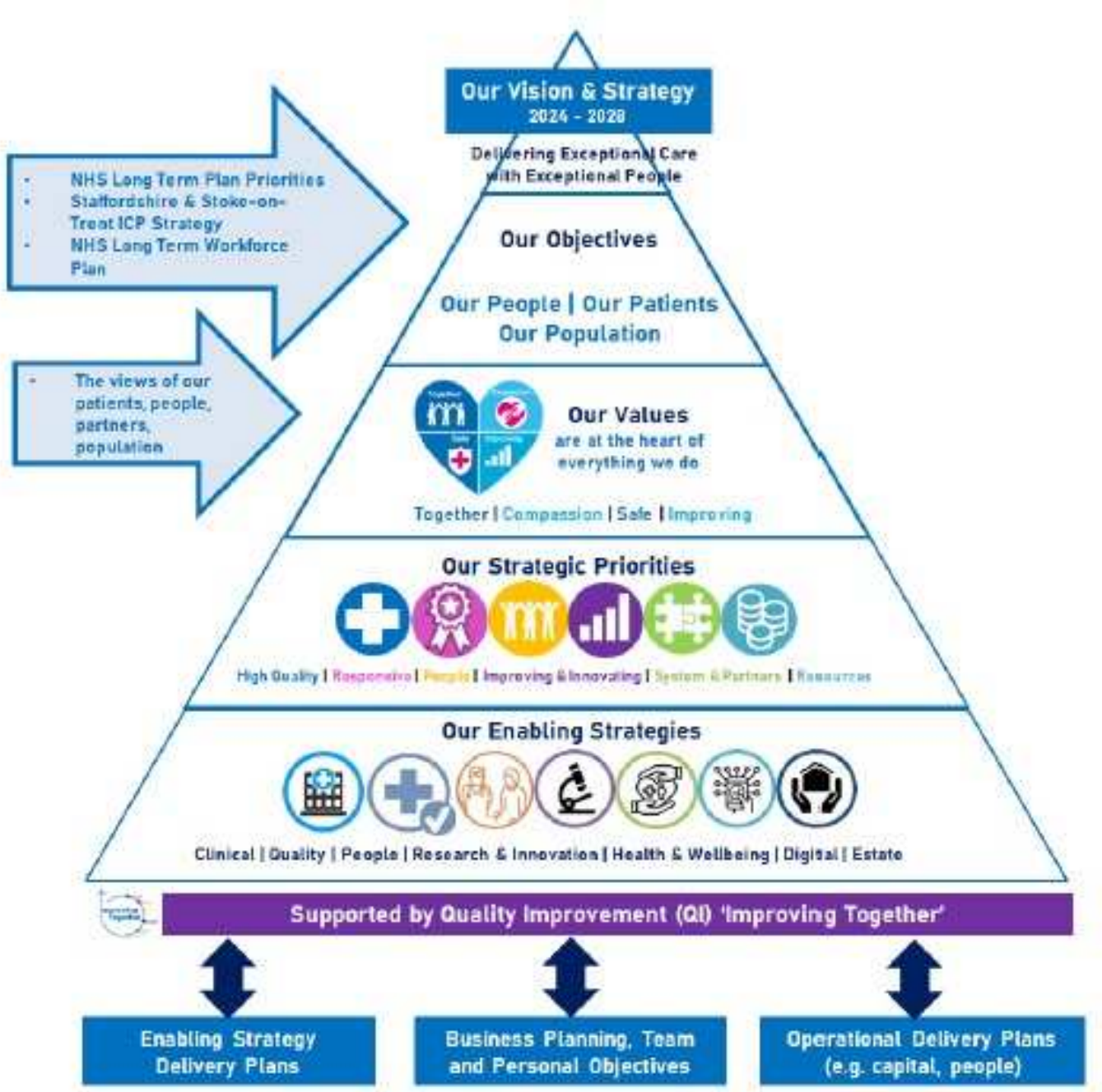
We look to involve our service users in everything we do, from providing feedback about the services we provide, to helping to share our priorities. This work is co-ordinated by our dedicated Patient Experience Team.

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 2024/25, we have already commenced a review of our UHNM Strategy which is currently going through engagement and consultation with our key stakeholders.



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 and 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 ('the NHS Act 2006') and the Health and Social Care Act 2012 ('the 2012 Act'), as amended by the new Health and Care Act 2022 ('the 2022 Act'),
- 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.
- Trusts should also adopt Standing Orders for the regulation of its proceedings and business as well as Standing Financial Instructions (SFIs), as an integral part of Standing Orders setting out the responsibilities of individuals. These documents are set out separately to the Rules of Procedure.
- 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 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 NHS England, 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 Board.
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 it 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 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 Director of 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.
The 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 Board members and the 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 no less than 8 Board meetings 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, 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 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 public, or press representatives, to record or transmit video 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 papers identified as private and confidential, as such, 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 be 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 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 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 request 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; 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 within the papers for the next scheduled meeting.

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), 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 must be formally approved by the Board.

6.13 Personal Conflicts of Interest

If a member of the Board or a Committee member, knowingly has an existing or possible interest which is material and relevant (direct or indirect, pecuniary or not), that in the opinion of a fair minded and informed observer would suggest a real possibility of bias, in any matter 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 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 and Business Cycles can be found at appendices 9 – 15.

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
- 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 risks / escalations, actions and any recommendations to the Board.

Each Committee, led by the Deputy Associate Director of Corporate Governance (on behalf of the Chair), will undertake an annual effectiveness evaluation against their Terms of Reference and Membership and 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

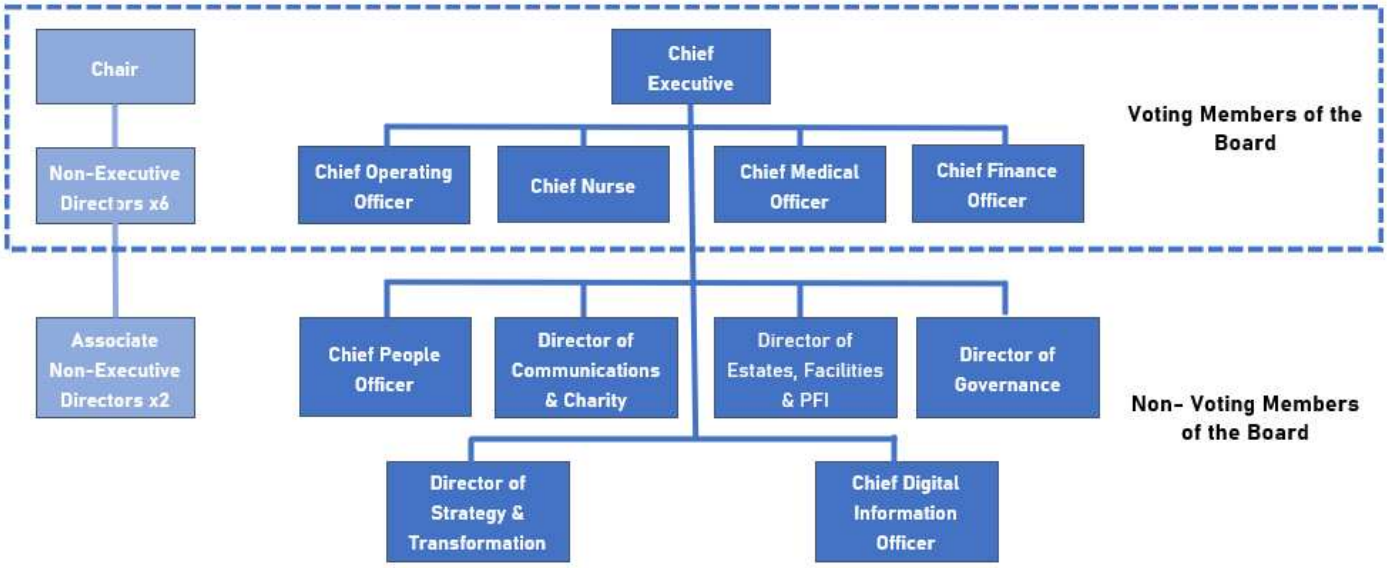
A Committee shall not delegate its functions to any other group established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

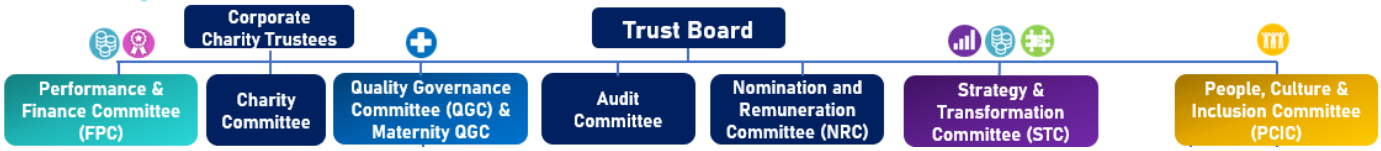
The following documents should be read in conjunction with the Rules of Procedure:

- 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 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

- It is the aim to provide papers 5 days in advance of the meeting, late papers will only be allowed following discussion with the Chief Executive/Chair.
- Upon receipt of the Board papers, 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 (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 existing conflicts of interest with regard to any matter on the agenda.
- 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 an urgent call is expected and permission of the Chair to keep the electronic device on must be sought.
- Refrain from holding 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 Director of Governance 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 after 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 the 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 which 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 which support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the 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	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the Board for whistle blowers	Actively supports and promotes a positive culture for the 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 • Clinicians and staff • Key institutional stakeholders • Regulators	Plays a key leadership role effective communication and building strong partnerships with: • Patients and public • 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

- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2019
- CHRE: Standards for members of Boards and governing bodies in England 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 2024/25

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3	8	5	10	7	4	9	6	4	8	5	12
HIGH QUALITY												
Chief Executives Report												
Patient Story		Staff			Staff			Staff			Staff	
Quality Governance Committee Assurance Report												
Quality Strategy Update												
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												
RESPONSIVE												
Integrated Performance Report												
Clinical Strategy Update												
Emergency Preparedness Annual Assurance Statement and Annual Report												
PEOPLE												
Transformation and People Committee Assurance Report												
People Strategy Update												
Gender Pay Gap Report												
Revalidation												
Workforce Disability Equality Report												
Workforce Race Equality Standards Report												
Staff Survey Report												
Raising Concerns Report												
IMPROVING AND INNOVATING												
Research Strategy Update												
SYSTEM AND PARTNERS												
System Working Update												
Population Health and Wellbeing Strategy												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3	8	5	10	7	4	9	6	4	8	5	12
RESOURCES												
Performance and Finance Committee Assurance Report												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above												
Estates Strategy Update												
Digital Strategy Update												
Going Concern												
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												
Trust Strategy												
Board Assurance Framework												
Annual Evaluation of the Board and its Committees												
Annual Review of the Rules of Procedure												
Board Development Programme												
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 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 Board including items for escalation
- The 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 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

NHS
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.					

Appendix 8 – Minutes Template

NHS
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	

Performance & Finance Committee
Committee Governance Pack
April 2024

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

- Gary Crowe, Non-Executive Director (Chair)
- Tanya Bowen, Non-Executive Director (Vice-Chair)
- Leigh Griffin, Non-Executive Director
- Arvinda Gohil, Non-Executive Director
- Alison Rodwell, Associate Non-Executive Director
- Mark Oldham, Chief Finance Officer
- Simon Evans, Chief Operating Officer
- Helen Ashley, Director of Strategy and Transformation
- Jonathan Tringham, Operational Director of Finance
- Sarah Preston, Strategic Director of Finance
- Claire Cotton, Director of Governance

Attendance at Meetings

Other Executive 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.

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 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

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 identify any risks which may prevent the achievement of the Annual Business Cycle 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 Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

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 People, Culture, and Inclusion 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:

- Workforce performance, issues and developments

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
30th April 2024	9.00 am – 12.00 pm	MS Teams	23rd April 2024
28th May 2024 (Deep Dive)	9.00 am – 12.00 pm	Trust Boardroom	21st May 2024
2nd July 2024	9.00 am – 12.00 pm	MS Teams	25th June 2024
30th July 2024	9.00 am – 12.00 pm	MS Teams	23rd July 2024
27th August 2024 (Deep Dive)	9.00 am – 12.00 pm	Trust Boardroom	20th August 2024
1st October 2024	9.00 am – 12.00 pm	MS Teams	24th September 2024
29th October 2024	9.00 am – 12.00 pm	MS Teams	22nd October 2024
26th November 2024 (Deep Dive)	9.00 am – 12.00 pm	Trust Boardroom	19th November 2024
18th December 2024	9.00 am – 12.00 pm	MS Teams	11th December 2024
28th January 2025	9.00 am – 12.00 pm	MS Teams	21st January 2025
4th March 2025 (Deep Dive)	9.00 am – 12.00 pm	Trust Boardroom	25th February 2025
1st April 2025	9.00 am – 12.00 pm	MS Teams	25th March 2025

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Strategic Priority
	30	28 (DD)	02-Jul	30	27 (DD)	01-Oct	29	26 (DD)	18	28	4 Mar (DD)	01-Apr	
RESOURCES													
Finance Report (including CIP)		Email			Email			Email			Email		
Budget Setting Framework 2025/26													
Approval of Investments for Annual Delivery Plans													
Annual Plan 2025/26													
Draft Financial Outlook													
Capital Plan													
Estate Strategy Progress Report													
Sustainability Bi-Annual Report													
Business Cases between £500,001 to £1,000,000													
Supplies and Procurement Report													
Medicines Expenditure Report													
Overseas Patients Activity													
Annual Audit into Overseas Visitors Policy Compliance													
Assurance Report from Executive Infrastructure Group		Email						Email					
Assurance Report from Executive Business Intelligence Group		Email						Email					
RESPONSIVE													
Operational Performance Report	M12	Email	M2	M3	Email	M5	M6	Email	M8	M9	Email	M11	
Winter Plan													
Theatre Productivity Plan													
Emergency Preparedness Annual Assurance Statement and Annual Report													
GOVERNANCE													
Authorisation of Contract Awards		Email			Email			Email			Email		
Board Assurance Framework	Q4			Q1			Q2			Q3			
Committee Effectiveness													
Accountability Framework													
Executive Groups Governance Pack													
Internal Audit Reports (as required)													
BUSINESS CASE REVIEWS													
Business Case Review Schedule													

Quality Governance Committee
Committee Governance Pack
April 2024

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

- Andrew Hassell, Associate Non-Executive Director (Chair)
- Sunita Toor, Non-Executive Director (Vice-Chair)
- Katie Maddock, Non-Executive Director
- Matthew Lewis, Chief Medical Officer
- Ann-Marie Riley, Chief Nurse
- Jamie Maxwell, Head of Quality Safety & Compliance
- Claire Cotton, Director of Governance

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

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.

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.

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 objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality 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 governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

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.

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 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.

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 identify any risks which may prevent the achievement of the Annual Business Cycle 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 Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle 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 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:

- People, Culture and Inclusion Committee
- Maternity and Neonatal Quality Governance 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
2nd May 2024	09.00 am – 12.00 pm	MS Teams	25th April 2024
30th May 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	23rd May 2024
4th July 2024	09.00 am – 12.00 pm	MS Teams	27th June 2024
1st August 2024	09.00 am – 12.00 pm	MS Teams	25th July 2024
29th August 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	22nd August 2024
3rd October 2024	09.00 am – 12.00 pm	MS Teams	26th September 2024
31st October 2024	09.00 am – 12.00 pm	MS Teams	24th October 2024
28th November 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	21st November 2024
20th December 2024	09.00 am – 12.00 pm	MS Teams	13th December 2024
30th January 2025	09.00 am – 12.00 pm	MS Teams	23rd January 2025
6th March 2025 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	27th February 2025
3rd April 2025	09.00 am – 12.00 pm	MS Teams	27th March 2025

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Strategic Priority
	02-May	30 (DD)	04-Jul	01-Aug	29 (DD)	03-Oct	31	28 (DD)	20	30	6 Mar (DD)	03-Apr	
PRIORITY 1: TO DEVELOP CONSISTENTLY POSITIVE PRACTICE ENVIRONMENTS RECOGNISING OUR STAFF ARE SAFETY CRITICAL													
Nursing and Midwifery Staffing and Quality Report													
PRIORITY 2: TO DELIVER CONSISTENTLY SAFE AND RELIABLE CARE													
Quality & Safety Report	M12	Email	M2	M3	Email	M5	M6	Email	M8	M9	Email	M11	
County Quality Report													
Medicines Optimisation													
Infection Prevention Report	Q4			Q1			Q2			Q3			
Infection Prevention, Vaccination & Sepsis Team Annual Report					Email								
Infection Prevention Board Assurance Framework	Q4			Q1			Q2			Q3			
Care Excellence Framework (CEF) Summary													
Vulnerable Patients Annual Report													
Safeguarding Children Annual Report													
Safeguarding Adults Annual Report													
Paediatric Sepsis Update													
Serious / Adverse Incident Report	Q4			Q1			Q2			Q3			
Annual Clinical Audit Plan													
Clinical Effectiveness Update													
Assurance Report from Clinical Effectiveness Group					Email						Email		
Mortality Report													
Resuscitation Annual Report													
Neonatal Service – Overview and Action Plan Update													
Thirlwall Update													
Cardiothoracic Surgery Review Update													
PRIORITY 3: TO PREVENT AVOIDABLE DELAY IN PATIENT ASSESSMENT, TREATMENT AND DISCHARGE													
Readmissions Analysis													
Patient Waiting List Backlog													
PRIORITY 4: TO ENSURE THAT OUR PATIENTS HAVE ACCESS TO SERVICES AND/OR TREATMENTS THAT MEET THEIR NEEDS AND DELIVERS POSITIVE OUTCOMES AND EXPERIENCES													
Patient Experience Report													
End of Life Annual Report													
Medical Examiner Update													
Organ Donation and Transplantation Bi-Annual Report													
PLACE Inspection Findings and Action Plan													
7 Day Services Board Assurance Report													
Quality Impact Assessment Report													
GOVERNANCE													
Quality Strategy													
Quality Account		Email											
Assurance Report from Quality and Safety Oversight Group													
Care Quality Commission Inspection Update													
CQUIN Report		Email											
Legal Services Annual Litigation & Inquest Report													
Board Assurance Framework	Q4			Q1			Q2			Q3			
Maternity Dashboard													
Committee Effectiveness													
Executive Groups Effectiveness Reviews / Terms of Reference													
Internal Audit Reports (As required)													

Maternity Quality Governance Committee

Committee Governance Pack

April 2024

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 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

- Sunita Toor, Non-Executive Director (Chair)
- Andrew Hassell, Associate Non-Executive Director (Vice-Chair)
- Katie Maddock, Non-Executive Director
- Matthew Lewis, Chief Medical Officer
- Ann-Marie Riley, Chief Nurse
- Head of Quality Safety & Compliance
- Director of Governance

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 3 out of 4 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.

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.

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 identify any risks which may prevent the achievement of the Annual Business Cycle 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 Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality Governance Committee

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
22nd May 2024	9.00 am – 11.30 am	MS Teams	15th May 2024
21st August 2024	9.00 am – 11.30 am	MS Teams	14th August 2024
20th November 2024	9.00 am – 11.30 am	MS Teams	13th November 2024
26th February 2025	9.00 am – 11.30 am	MS Teams	19th February 2025

C. Annual Business Cycle

Title of Paper	Executive Lead	May 22	Aug 21	Nov 20	Feb 26	Strategic Priority
Staff Story	Chief Nurse					
Maternity Dashboard	Chief Nurse					
Maternity Serious Incident Report	Chief Nurse	Q4	Q1	Q2	Q3	
Saving Babies Lives Care Bundle	Chief Nurse	Q4	Q1	Q2	Q3	
Perinatal Mortality Report	Chief Nurse	Q4	Q1	Q2	Q3	
Neonatal Mortality						
NHS Resolution Maternity Incentive Scheme	Chief Nurse					
Midwifery Workforce Report	Chief Nurse					
Midwifery Continuity of Care Update and Action Plan	Chief Nurse					
Neonatal Unit Assurance Update	Chief Nurse					
ATAIN Audit	Chief Nurse					
Consultant Attendance Audit	Chief Nurse					
Medical Workforce Highlight Report	Medical Director					
System Maternity Oversight & Assurance Group (SMOAG) Minutes	Chief Nurse					
Maternity and Neonatal Voices Partnership Feedback Report	Chief Nurse					
Maternity Quality & Safety Oversight Group Assurance Report	Chief Nurse					
Committee Effectiveness	Director of Governance					

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 the following:

- Mrs Alison Rodwell, Associate Non-Executive Director (Chair)
- Professor Gary Crowe, Non-Executive Director (Vice Chair)
- Ms Tanya Bowen, Non-Executive Director
- Professor Andrew Hassell, Associate Non-Executive Director

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

Members are required to attend at least 4 out of 5 meetings per year. Regular attenders are expected to maintain a good standard of attendance.

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 will be invited to attend and discuss, annually with the Committee, the process of assurance that supports the Annual Governance Statement. They will also attend when the Committee considers the draft annual report and accounts. All other Executive Directors will 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.

Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee will hold five meetings per annum. 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 Committee's annual report will also 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.

An annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board.

The Committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

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:

Governance, Risk Management and Internal Control

The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (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 submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's 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 any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

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 over-arching systems of 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 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 (for example, the Quality Governance Committee) so that it understands processes and linkages. However, these other Committees must not usurp the Committee's role.

Internal Audit

The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, Chief Executive and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving 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
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resource
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the 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:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring 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, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the Local Counter Fraud Specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its 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 the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, 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

Management

The Committee shall request and review reports, evidence 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, compliance reviews or accreditation reports).

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 People Culture and Inclusion Committee.
- Reporting on compliance with the fit and proper persons test will be considered by the Nominations and Remuneration Committee.

Governance Regulatory Compliance

The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, and NHS code of governance as required.

The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
2nd May 2024	12.45 pm – 3.00 pm	Via MS Teams	25th April 2024
21st June 2024	12.45 pm – 3.00 pm	Via MS Teams	14th June 2024
1st August 2024	12.45 pm – 3.00 pm	Via MS Teams	25th July 2024
31st October 2024	12.45 pm – 3.00 pm	Via MS Teams	24th October 2024
30th January 2025	12.45 pm – 3.00 pm	Via MS Teams	23rd January 2025

C. Annual Business Cycle

Title of Paper	Apr 02-May	Jun 21	Jul 01-Aug	Oct 31	Jan 30	Strategic Priority	BAF Link	CQC KLOE
GOVERNANCE								
Private Internal and External Audit Discussions								
Board Assurance Framework	Q4		Q1	Q2	Q3			1.2, 4.1, 5.1, 5.4, 5.5
Annual Report and Annual Governance Statement								
Issues for Escalation from PAF, PCI, S&T, QGC								
Internal Audit Recommendation Tracker								4.1, 4.3
Corporate Governance Report								4.1, 4.3
Committee Effectiveness								
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 Breaches								
Accounting Policies Update								
Annual Accounts Timetable								
Valuation of Land and Buildings 2023/24								
INTERNAL AUDIT								
Internal Audit Progress Reports								4.1, 4.2, 4.4, 5.3
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								
Informing the Audit Risk Assessment								
Effectiveness of External Audit								
COUNTER FRAUD								
Counter Fraud Annual Plan								
LCFS Annual Report								
Counter Fraud Progress Report								
Review of Effectiveness of LCFS								
CLINICAL AUDIT								
Annual Clinical Audit Programme								
INTERNAL AUDIT PLAN								
Productivity Reporting								
IT Systems Managed by Operational Areas								
Service Management Process (Information Technology Infrastructure Library (ITIL))								
Board Assurance Framework								
Data Security and Protection (DSP) Toolkit								
Data Quality: Ambulance Handover Data								
Nurse E-Rostering								
Medical Staff Rostering								
Grip and Control: Medical Staff Agency Controls								
Maternity and Neonatal Action Plans								
Planned Care								
Clinical Effectiveness Framework								
Transformation and Capital Project Management								
Key Financial Controls								

Nominations and Remuneration Committee

Committee Governance Pack

April 2024

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 within 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)
- Professor Andrew Hassell, Associate Non-Executive Director (Vice-Chair)
- Dr Leigh Griffin, Non-Executive Director
- Mrs Alison Rodwell, Associate Non-Executive Director

In addition, all other Non-Executive Directors are invited to attend the meeting should they wish. 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 and 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 Executive. The Chief Executive will be excluded from meetings when their own remuneration is being considered.
- Chief People Officer. The Chief People Officer will be excluded from meetings when their own remuneration is being considered.
- Director of Governance. The Director of 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 Closed 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 Director of 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
- 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 Chief People Officer 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
Wednesday 22nd May 24	10.00 am – 11.30 am	MS Teams	15th May 2024
Wednesday 24th July 24	10.00 am – 11.30 am	MS Teams	17th July 2024
Wednesday 25th September 24	10.00 am – 11.30 am	MS Teams	18th September 2024
Wednesday 20th November 24	10.00 am – 11.30 am	MS Teams	13th November 2024
Wednesday 22nd January 24	10.00 am – 11.30 am	MS Teams	15th January 2025
Wednesday 26th March 24	10.00 am – 11.30 am	MS Teams	19th March 2025

C. Annual Business Cycle

Title of Paper	Lead	May 22	Jul 24	Sept 25	Nov 20	Jan 22	Mar 26	Strategic Priority
REMUNERATION								
Redundancy Payments / Tribunal Settlements £10,000 and above	Chief People Officer							
Remuneration and terms of service for Executive Directors and Chief Executive	Chief People Officer							
Remuneration Section of Annual Report	Chief People Officer							
Off-payroll and Interim Board payments	Chief People Officer							
Pension Restructuring Payment Scheme Review	Chief People Officer							
NOMINATIONS								
Changes to the Composition of the Trust Board	Chairman							
Executive / Non-Executive Appointments	Chief Executive / Chairman							
Non-Executive Director Performance Reviews	Chairman							
Review of Time Required for Non-Executive Directors	Chairman							
Annual Non-Executive Director Skills Analysis & 2024/25 Committee Membership	Director of Governance							
Executive Director Portfolios	Chief Executive							
Executive Director Performance Reviews	Chief Executive							
Non-Executive Director Succession Planning	Chairman							
Succession Planning	Chief Executive							
GOVERNANCE								
Fit and Proper Persons Declarations	Director of Governance							
Committee Effectiveness	Director of Governance							

Strategy and Transformation Committee

Committee Governance Pack

April 2024

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Strategy and Transformation Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is fully appraised of the strategic impact of the Transformation Programmes and delivery of the Trust's Strategic Priorities.

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

- Tanya Bowen, Non-Executive Director (Chair)
- Gary Crowe, Non-Executive Director (Vice-Chair)
- Arvinda Gohil, Non-Executive Director
- Sunita Toor, Non-Executive Director
- Helen Ashley, Director of Strategy
- Claire Cotton, Director of Governance
- Matthew Lewis, Chief Medical Officer
- Ann-Marie Riley, Chief Nurse

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 4 out of 6 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 six times a year, including relevant Board Assurance Framework deep-dive sessions.

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 matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

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

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.

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 identify any risks which may prevent the achievement of the Annual Business Cycle 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 Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle 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:

- People, Culture and Inclusion Committee
- Quality Governance 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
1st May 2024	09.00 am – 12.00 pm	MS Teams	24th April 2024
31st July 2024	09.00 am – 12.00 pm	MS Teams	23rd July 2024
28th August 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	21st August 2024
30th October 2024	09.00 am – 12.00 pm	MS Teams	22nd October 2024
29th January 2025	09.00 am – 12.00 pm	MS Teams	22nd January 2025
5th March 2025 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	26th February 2025

C. Annual Business Cycle

Title of Paper	Apr 01-May	Jul 31	Aug 28 (DD)	Oct 30	Jan 29	Feb 5 Mar (DD	Strategic Priority
STRATEGY							
Annual Plan							
Clinical Strategy Update							
Population Health and Wellbeing Strategy Update							
Trust Strategy							
TRANSFORMATION							
Assurance Report from Executive Strategy and Transformation Group			Email			Email	
Transformation Programme Update including ICS Transformation	Q4	Q1		Q2	Q3		
IMPROVING AND INNOVATING							
Improving Together Highlight Report	Q4	Q1		Q2	Q3		
Assurance Report from Executive Research and Innovation Group							
Research Quality Assurance Update							
Research Strategy Update							
RESOURCES							
Assurance Report from Digital and Data Security and Protection Group			Email			Email	
Cyber Security Assurance Report	Q4	Q1		Q2	Q3		
DSP Toolkit Submission							
Digital Strategy Update							
GOVERNANCE							
Board Assurance Framework	Q4	Q1		Q2	Q3		
Committee Effectiveness							
Executive Groups Terms of Reference							
Internal Audit Reports (as required)							

People, Culture and Inclusion Committee

Committee Governance Pack

April 2024

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the People, Culture and Inclusion 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 People and Organisational Development Strategy on the delivery of the Trust's Strategic Priorities.

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

- Gary Crowe, Non-Executive Director (Chair)
- Sunita Toor, Non-Executive Director (Vice-Chair)
- Arvinda Gohil, Non-Executive Director
- Katie Maddock, Non-Executive Director
- Claire Cotton, Director of Governance
- Jane Haire, Chief People Officer
- Ann-Marie Riley, Chief Nurse
- Lisa Thomson, Director of Communications

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 4 out of 6 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 six times a year, including relevant Board Assurance Framework deep-dive sessions.

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 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

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 identify any risks which may prevent the achievement of the Annual Business Cycle 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 Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle 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:

- Strategy and Transformation Committee
- 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
29th May 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	22nd May 2024
3rd July 2024	09.00 am – 12.00 pm	MS Teams	26th June 2024
2nd October 2024	09.00 am – 12.00 pm	MS Teams	25th September 2024
27th November 2024 (Deep Dive)	09.00 am – 12.00 pm	Trust Boardroom	20th November 2024
18th December 2024	09.00 am – 12.00 pm	MS Teams	11th December 2024
2nd April 2025	09.00 am – 12.00 pm	Trust Boardroom	26th March 2025

C. Annual Business Cycle

Title of Paper	Executive Lead	May 29 (DD)	Jun 03-Jul	Sep 02-Oct	Nov 27 (DD)	Dec 18	Mar 02-Apr	Strategic
PEOPLE								
Chief People Officer Report	Chief People Officer							
Annual People Delivery Plan	Chief People Officer							
Annual Strategic Workforce Plan	Chief People Officer							
Postgraduate Medical Education Report	Chief Medical Officer							
Medical School Quality Report	Chief Medical Officer							
Appraisal and Revalidation Annual Report	Chief Medical Officer							
Nursing Establishment Review	Chief Nurse							
Talent and Succession Planning Update	Chief People Officer							
Education / Apprenticeship Report	Chief People Officer							
Annual Learning and Education Annual Report	Chief People Officer							
Assurance Report from Health and Safety Group	Director of Governance	Email			Email			
Health and Safety Report	Director of Governance		Q4	Q1			Q2	
Fire Annual Report	Director of Estates, Facilities & PFI							
Security Management Annual Report	Director of Governance							
Violence Prevention and Reduction Update	Director of Governance							
CULTURE								
Results of Annual Staff Survey Report	Chief People Officer							
Health and Wellbeing Review	Chief People Officer							
Guardian of Safe Working Report	Chief Medical Officer		Q4	Q1			Q2	
Formal Case Activity Report (formerly Disciplinary Report)	Chief People Officer							
Speaking Up Report	Director of Governance							
Positive and Inclusive Culture Programme - Updated Plan 2025/26	Chief People Officer							
INCLUSION								
Workforce Race Equality Standard	Chief People Officer							
Workforce Disability Equality Standard	Chief People Officer							
Equality, Diversity & Inclusion Annual Report	Chief People Officer							
Gender Pay Gap Report	Chief People Officer							
GOVERNANCE								
Assurance Report from Workforce Assurance Group	Chief People Officer							
Committee Effectiveness	Director of Governance							
Executive Groups Terms of Reference	Director of Governance							
Internal Audit Reports (as required)								

Trust Board

2024/25 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Strategic Priority	BAF Link	CQC KLOE	Notes
		3	8	5	10	7	4	9	6	4	8	5	12				
HIGH QUALITY																	
Chief Executives Report	Chief Executive																
Patient Story	Chief Nurse		Staff			Staff			Staff			Staff					
Quality Governance Committee Assurance Report	Director of Governance																
Quality Strategy Update	Chief Nurse / Medical Director																
Care Quality Commission Action Plan	Chief Nurse																
Bi Annual Nurse Staffing Assurance Report	Chief Nurse																
Quality Account	Chief Nurse																
NHS Resolution Maternity Incentive Scheme	Chief Nurse																
Maternity Serious Incident Report	Chief Nurse																
Winter Plan	Chief Operating Officer																
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI																
Infection Prevention Board Assurance Framework	Chief Nurse																
RESPONSIVE																	
Integrated Performance Report	Various																
Clinical Strategy Update	Director of Strategy																Deferred due to purdah
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer																
PEOPLE																	
Transformation and People Committee Assurance Report	Director of Governance																
People Strategy Update																	
Gender Pay Gap Report	Chief People Officer																
Revalidation	Medical Director																
Workforce Disability Equality Report	Chief People Officer																
Workforce Race Equality Standards Report	Chief People Officer																
Staff Survey Report	Chief People Officer																
Raising Concerns Report	Director of Governance																Report provided to EWAG and to be considered by the Board once it has been received at PCI Committee
IMPROVING AND INNOVATING																	
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy																
SYSTEM AND PARTNERS																	
System Working Update	Chief Executive / Director of Strategy																
Population Health and Wellbeing Strategy	Director of Strategy																
RESOURCES																	
Performance and Finance Committee Assurance Report	Director of Governance																
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	NA															
Estates Strategy Update	Director of Estates, Facilities & PFI																
Digital Strategy Update	Chief Digital Information Officer																TBC
Going Concern	Chief Finance Officer																
Annual Plan	Director of Strategy																
Board Approval of Financial Plan	Chief Finance Officer																
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer																
Activity and Narrative Plans	Director of Strategy																
Capital Programme 2022/23	Chief Finance Officer																
Standing Financial Instructions	Chief Finance Officer																Next due for review February 2026

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Strategic Priority	BAF Link	CQC KLOE	Notes
		3	8	5	10	7	4	9	6	4	8	5	12				
Scheme of Reservation and Delegation of Powers	Chief Finance Officer																Next due for review February 2026
GOVERNANCE																	
Nomination and Remuneration Committee Assurance Report	Director of Governance																
Audit Committee Assurance Report	Director of Governance																
Trust Strategy	Director of Strategy																TBC
Board Assurance Framework	Director of Governance																
Annual Evaluation of the Board and its Committees	Director of Governance																
Annual Review of the Rules of Procedure	Director of Governance																
Board Development Programme	Director of Governance																
Well-Led Self Assessment	Director of Governance																To be considered at July's Trust Board Seminar
Risk Management Policy	Director of Governance																Next due for review February 2027
Complaints Policy	Chief Nurse																