University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th August 2024 at 9.30 am to 12.35 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

AGENDA

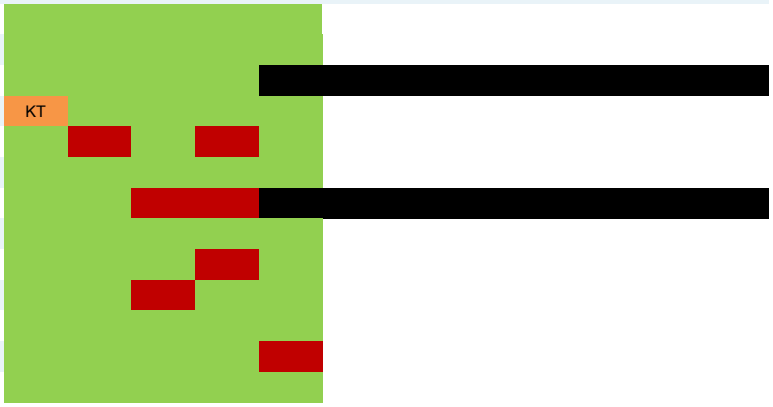
Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 10th July 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 - July 2024	Information	Ms H Ashley	Enclosure	
10:15		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (01-08-24)	Assurance	Prof A Hassell	Enclosure	1
10 mins	**8.**	Quality Strategy Update	Assurance	Mrs J Holmes	Enclosure	1
10 mins	**9.**	Care Quality Commission Action Plan Update	Assurance	Mrs J Holmes	Enclosure	1
10 mins	**10.**	Infection Prevention Board Assurance Framework	Assurance	Mrs J Holmes	Enclosure	1
10:50		**IMPROVING & INNOVATING**				
5 mins	**11.**	Strategy & Transformation Committee Assurance Report (31-07-24)	Assurance	Ms T Bowen	Enclosure	2
10:55 – 11:10 COMFORT BREAK						
11:10		**RESOURCES**				
5 mins	**12.**	Performance and Finance Committee Assurance Report (30-07-24)	Assurance	Prof G Crowe	Enclosure	7 & 8
10 mins	**13.**	Digital Strategy Update	Assurance	Mrs A Freeman	Enclosure	5
11:25		**RESPONSIVE**				
45 mins	**14.**	Integrated Performance Report – Month 3	Assurance	Mrs J Holmes Mr S Evans Mrs J Haire Dr M Lewis Ms H Ashley Mrs A Freeman Mr M Oldham	Enclosure	ALL
12:10	**GOVERNANCE**					
5 mins	**15.**	Audit Committee Assurance Report (01-08-24)	Assurance	Ms A Rodwell	Enclosure	
10 mins	**16.**	Board Assurance Framework – Quarter 1	Assurance	Mrs C Cotton	Enclosure	
5 mins	**17.**	Board Development Programme Update – Schedule of Board Seminars	Assurance	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 9.00 am 5th August to** nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:35	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 9th October 2024, 9.30 am via MS Teams** **NB. The Annual General Meeting will take place on Wednesday 4th September at 12.30 pm, North Staffordshire Medical Institute**				

University Hospitals of North Midlands NHS Trust

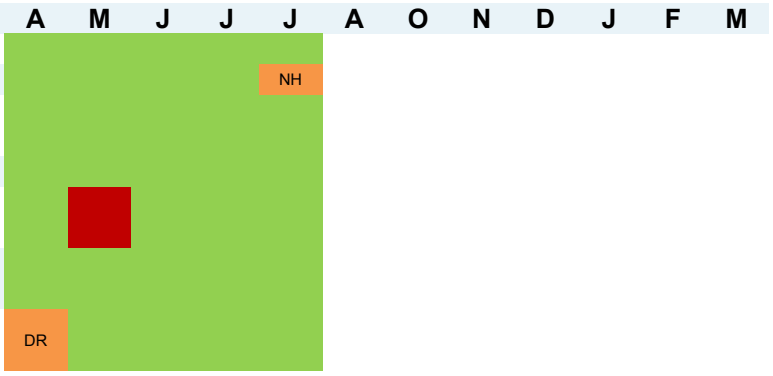
Trust Board (Open)

Meeting held on Monday 10th July 2024 at 9.30 am to 12.15 pm
Via MS Teams

MINUTES OF MEETING



Voting Members:		
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
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
Mrs AM Riley	AR	Chief Nurse
Mrs A Rodwell	AR	Non-Executive Director
Prof S Toor	ST	Non-Executive Director



Non-Voting Members:		
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 L Thomson	LT	Director of Communications
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI

In Attendance:		
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Ms C Lloyd		Patient (item 6)
Mrs R Pilling		Head of Patient Experience (item 6)
Mrs S Reid		Complaints, PALS and Volunteer Manager (item 6)

Members of Staff and Public: 5

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
105/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
2.	**Declarations of Interest**	
106/2024	There were no declarations of interest raised.	
3.	**Minutes of the Meeting held 5th & 24th June 2024**	

107/2024	5th June 2024 Professor Hassell requested an amendment to page 6, and it was agreed to for the sentence to read "… to discuss cases of detriment with Professor Hassell, in his role as the *Non-Executive Director Champion for Freedom to Speak Up*". With the exception of the above amendment, the minutes of the meeting were approved as a true and accurate record. 24th June 2024 The minutes of the meeting held 24th June 2024 were approved as a true and accurate record.	
4.	**Matters Arising via the Post Meeting Action Log**	
108/2024	PTB/600 – Mr Wakefield queried the progress in developing the business case for the ophthalmology audit. Dr Lewis highlighted that the case was under development and further updates in relation to national audits would be provided to the Quality Governance Committee via the Clinical Effectiveness report. PTB/601 – Mrs Riley explained that the coding standards related to primary and secondary diagnosis coding, which was reviewed as part of Data Security and Protection Toolkit.	
5.	**Chief Executive's Report - June 2024**	
109/2024	Ms Ashley highlighted a number of areas from her report. Mrs Riley highlighted that the Trust had 114 inpatients with covid and this number had continued to increase, with two new variants identified. It was noted that the number was above the trigger point, which had resulted in masks being reinstated in clinical areas. Mr Wakefield thanked the teams involved with the Professor Powis and Care Quality Commission (CQC) visits. Dr Lewis highlighted the improved performance in respect of job planning and recognised the work undertaken by the clinical teams and medical staffing in improving this position. Dr Griffin queried the timescale for the productivity plan and Ms Ashley stated that whilst Mrs Riley had been identified as nurse representative for the Midlands region, a timescale to conclude the work had not been confirmed. Ms Bowen congratulated the team on the completion of the network migration and she queried if anything official had been received from the new Government. Mrs Thomson stated that the Trust had already contacted the new local Members of Parliament. **The Trust Board received and noted the report.**	
6.	**Patient Story**	
110/2024	Ms Lloyd highlighted that she had been involved in a road traffic accident and as a result was stuck in a car for over an hour. She explained that she had been taken to Royal Stoke via Air Ambulance, where it was found she had multiple injuries including breaking her spine and a bleed on the brain. She explained that	

	she was admitted to the Intensive Care Unit and had multiple surgeries and particularly paid thanks to her Spinal Surgeon, Mr Rouholamin. She read out a letter to him, thanking him for the surgery undertaken and described the exceptional care she had received, articulating her recovery and adding that she had since started to regularly raise funds for the Welsh Air Ambulance. Professor Maddock queried Ms Lloyd's length of stay, and it was noted that she was an inpatient for 13 days. She also queried her rehabilitation at home and how she was supported with this, to which Ms Lloyd stated that once she was home she felt fully supported. Mrs Riley queried if there was anything which could have been done differently and Ms Lloyd stated that when she was in a side room that helped her to recover as it was a better atmosphere. She reiterated that the care received was exceptional. Dr Griffin queried how she felt now and she stated that she had recovered well and wanted to move on and help to inspire others in similar situation with their recovery. Mrs Haire queried if Ms Lloyd had any advice for patients in a similar situation given her exceptional recovery and outlook and she stated that she would urge people to face things head on, taking one step at a time, while remaining focussed. Mrs Thomson agreed to work with Ms Lloyd and Mrs Pilling to share her story and help others with their recovery. Mr Wakefield noted Ms Lloyd's resilience and determination especially going back to work after four months. He stated that the Trust was not always able to recognise the impact the care provided had on patients' lives and thanked Ms Lloyd for describing the impact so well. **The Trust Board noted the patient story.** Ms Lloyd, Mrs Pilling and Ms Reid left the meeting.	
7.	**Clinical Strategy Update**	
111/2024	Ms Ashley highlighted the following: • The County Hospital plan had been included for information • The activities undertaken during the past year were described in addition to the priorities for 2024/25 • The challenges and opportunities at Royal Stoke to address urgent care pathways were to be explored • Further work was expected to be undertaken once the national Major Conditions Strategy had been launched • From 1st April 2024, there had been a change in commissioning arrangements for specialised services and these were now delegated to Integrated Care Boards Professor Hassell congratulated the team on the clarity of the strategy and the update for County Hospital. He queried the references to partnership working and what that looked like in practice. Ms Ashley stated that an update would be provided to the Board in August to reflect discussions with Shrewsbury and Telford Hospitals and other partners such as Mid Cheshire.	

	Dr Griffin referred to specialised commissioning and queried if an emergent strategy was expected in relation to this. Ms Ashley stated that the specialised commissioning activities were supported by Operational Delivery Networks with separate work programmes, although the geography of the Trust and the need to serve various populations made it more difficult to be incorporated into one network. Ms Bowen referred to the overarching workforce plan for County Hospital and queried progress with this. Mrs Haire stated that the plan had not yet been developed as the work to determine the clinical pathways needed to be undertaken first. Dr Lewis referred to relationships with neighbouring Trusts and the need to build upon existing relationships to better serve the patients from bordering areas. Mr Wakefield referred to progress with implementation of LIMS and Ms Ashley stated that this had been implemented in all but one discipline which was expected to go live in September. Mr Wakefield referred to partnership working and the increase in patients aged over 70 attending the Trust. He referred to the need to articulate how partners were seeking to improve capacity for these patients in the community rather to avoid them coming into hospital and Ms Ashley stated that Mr Evans was Senior Responsible Officer for this workstream. **The Trust Board received and noted the update and approved the County Hospital Strategic Plan.**	
HIGH QUALITY		
8.	**Maternity and Neonatal Quality Governance Committee Assurance Report (05-06-24)**	
112/2024	Professor Toor highlighted the following: • 1 referral had been made to the Maternity and Newborn Safety Investigations Bureau and two further incidents were discussed • A review of the Care Quality Commission (CQC) action plan had highlighted 4 outstanding areas whereby further assurance was required • Further work was being undertaken in relation to obtaining more feedback from patients • The Committee welcomed the strengthening of neonatal governance and the progress made in addressing the workforce challenges, in addition to noting the reduction in neonatal deaths since 2021 Mrs Riley referred to neonatal staffing and recruitment to vacancies, whereby the focus was on Qualified in Specialty nurses which involved the nurses undergoing a 9 month training programme. Mr Wakefield queried the reference to Maternity and Neonatal Voices Partnership (MNVP) and Mrs Riley highlighted that this referred to the type of patients participating with MNVP were not representative of the local population in terms of ethnicity etc. **The Trust Board received and noted the assurance report.**	
9.	**Quality Governance Committee Assurance Report (04-07-24)**	
113/2024	Professor Hassall highlighted the following:	

	• CQUINs were continuing to take place with the aim of improving quality, despite there being no financial benefit • The progress in completing patient safety investigations was noted and the Committee were encouraged by the direction of travel. It was noted that the Risk Management Panel were aiming to strengthen the safety recommendations identified as well as ensuring these were auditable and audited • An update in relation to paediatric audiology was provided following a review in Scotland which identified various failings, with recommendations made to complete a national exercise which included looking back at paediatric audiology tests over past 5 years. It was noted that the Trust had been proactive in addressing this and a further update was to be provided in 4 months • A lot of positive assurances were noted including the update on paediatric sepsis, the Clinical Excellence Framework process, annual mortality report, and increased use of interpreters on wheels • New national guidance regarding sepsis screening had been received and due to technical challenges in implementing this the Quality and Safety Oversight Group had agreed to implement this within the Emergency Department in the first instance Dr Lewis referred to paediatric audiology and the aim to ensure the learning was translated to other departments. He stated that accreditation processes were already in place for larger areas of the Trust and added that he had asked the Chief Healthcare Scientist to review any areas of risk within other specialities as well as paediatric audiology. Mr Wakefield queried the reference to challenging the safety recommendations and Professor Hassell stated that the Committee had queried whether the safety recommendations could be made more robust. **The Trust Board received and noted the assurance report.**	
10.	**Bi-Annual Nurse Staffing Assurance Report**	
114/2024	Mrs Riley highlighted the following: • The Executive had discussed the Royal College of Nursing guidance and the uplift of establishments to 25%, but had agreed to maintain the uplift to 21.5% although this would remain under review • Since the previous review, internal audit had assessed the process used and substantial assurance was provided Mr Wakefield referred to the positive messages within the paper and improvement in metrics which needed to be reflected in other enabling strategies. Professor Crowe welcomed the process used to undertake the reviews and these being done on a regular basis and welcomed the ambition to extend the scope to other areas. **The Trust Board noted the progress made to ensure compliance with national guidance in determining safe nursing and midwifery staffing levels. The Trust Board noted that business cases would be undertaken in line with the recommendations within the paper.**	
PEOPLE		
11.	**People, Culture and Inclusion Committee Assurance Report (03-07-24)**	

115/2024	Professor Crowe highlighted that the Committee took the time to focus on deep dives on the Board Assurance Framework. He thanked Mrs Cotton and the governance team for their facilitation of the sessions, which had been positively received. **The Trust Board received and noted the assurance report.**	
12.	**People Strategy Update**	
116/2024	Mrs Haire highlighted the following: • The report highlighted Year 2 of the delivery plan • Significant progress had been made, utilising the improving together methodology • Work had concentrated on strengthening the associated governance to ensure that the Executive group flowed into the Chief People Officer report and through to the People, Culture and Inclusion Committee (PCI) • There had been a positive change in turnover and vacancy rates as well as statutory and mandatory training • There had been a slight improvement in sickness absence but this had remained largely static • All areas of the plan had been delivered, resulting in the agreement of acceptable assurance • Additional areas of work had been undertaken which were not included within the plan, such as industrial action, ongoing work on sexual safety, visa and immigration and the pay issue between band 2 to band 3 roles • The Trust continued to operate at system level Mr Wakefield referred to productivity and queried what the strategy for improving general productivity was. Mrs Haire highlighted that the improving together tools had been used in terms of creating a sustainable workforce plan and the focused had moved to looking at productivity, capacity and demand. Ms Ashley added that productivity also needed to be woven into other supporting strategies to identify the way in which the strategies contributed to productivity. Mr Wakefield referred to the need to articulate what productivity means for the Trust, by the end of September. Dr Griffin queried if similar establishment reviews for therapies and scientists to track pressure points were undertaken. Dr Lewis stated that from a healthcare scientists perspective, initial work had been focussed on identifying where the relevant roles were with the next phase to consider whether there was the right number of people, in the right posts. Mrs Haire added that the Chief Allied Health Professional was undertaking a detailed review of the workforce strategy as well as continuing to create more visibility of that workforce. Mr Wakefield stated that the overall numbers in the strategy had not moved significantly, and that some areas of sickness absence had not improved. He requested that an update on this be provided to PCI. Mrs Haire stated that sickness absence continued to be monitored, in particular the staff groups which remained high and above average. Professor Crowe welcomed the continued focus on creating a long term workforce plan for hard to fill areas to ensure a sustainable pipeline. **The Trust Board noted the progress on the delivery of the People Strategy for Year 2 and the underpinning programmes of work.**	

RESOURCES		
13.	**Performance and Finance Committee Assurance Report (01-07-24)**	
117/2024	Professor Crowe highlighted the following: • Positive assurance was provided on a number of areas; progress with cancer performance and sustainability and the progress towards net zero, part of which was supported by the work in relation to District Heat Network • The Committee approved the expansion to the skin service • Areas of concern related to financial performance, Emergency Department performance and progress with elective non-cancer performance. However, there were pockets of progress in some areas but there remained challenged services and whilst actions were underway, these had not yet demonstrated sustainable improvements • Work had been commissioned to review the business case review process in terms of considering how the outstanding reviews could be caught up, as well as considering whether these could be reviewed via delegation • Report on productivity was to be provided to the next meeting in terms of the trajectory and how this was to be supported • Going forwards the agenda needed to become more manageable to enable deeper focus on priority areas **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
14.	**Integrated Performance Report – Month 3**	
118/2024	<u>High Quality</u> Mrs Riley highlighted the following: • Good progress had been made in terms of maternity metrics and falls which needed to be sustained, in addition to verbal duty of candour • Hospital acquired infections such as e coli and c-difficile continued to be an area of focus • Sepsis management in the Emergency Department was to reflect the changes in NICE guidance, which was expected to assist with performance although this would mean that two systems would be in place in the interim • Maternity sepsis actions for antibiotics were being considered and the A3 was to be refreshed to determine the further actions required • VTE assessment performance requires improvement although it had been confirmed that harm was not being caused by the poor performance Mr Wakefield referred to the issue of c-difficile and possible overuse of certain antibiotics. Mrs Riley stated that antimicrobial and antibiotic prescribing was being reviewed across the system and Mr Wakefield queried whether it was being prescribed correctly or appropriately in all cases. Mrs Riley stated that this was regularly audited, and the audits had not identified that the Trust was prescribing outside of guidance. Dr Lewis added that patients identified as having a penicillin allergy were being reviewed to identify if they were truly allergic in order to ensure the right antibiotics could be prescribed. Professor Crowe referred to the maternity metrics and use of improving together methodology which had contributed to improvement. Mrs Riley stated that this had been taken forward by the use of A3s and other tools and Professor Crowe suggested that this best practice be disseminated to other areas.	

Professor Crowe referred to sepsis performance which had dipped below 70% and queried the impact of the revised guidance. Mrs Riley stated that the new guidance provided an opportunity to prescribe antibiotics at alternative time interviews, and best reflected the working practices.

Professor Hassell referred to the appropriateness of antimicrobial prescribing which was discussed at Quality Governance Committee (QGC), with assurance provided in terms of how this was being scrutinised.

Responsive

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

- There had been positive movements in 4 hour performance but it was recognised that there remained long wait issues and an impact on ambulance handover
- Workstream 1 was seeing traction as well as County Hospital performance (workstream 4) but a step change was expected in August when the Trust would be able to fully mobilise the Same Day Emergency Care Centre (SDEC)

Professor Hassell referred to the reference to 12 hour trolley waits and growth of inpatient demand which was largely unmet and queried what this meant. Mr Evans stated that this referred to the increasing number of medical admissions within the Emergency Department and increase in overall admissions for medical specialties. He added that the SDEC would create a protected space to see and discharge patients more in a more timely manner and that the system was also looking at alternatives which could be provided to reduce demand over time.

Mr Wakefield referred to the County strategy whereby 80% of patients were aged over 70 but 30% of inpatients in medical beds at Royal Stoke were aged over 80. Mr Evans stated that this was due to the mix between length of stay and volume therefore patients had a longer length of stay if they were frail. Ms Ashley added that activity at County Hospital was skewed because those in the younger age group with different acuity were fast tracked to Royal Stoke.

Mr Evans highlighted the following in relation to elective and cancer performance:

- There had been a continued reduction in the number of patients waiting over 78 weeks, although some patients were waiting more than 104 weeks and whilst the focus continued to be on reducing this to 0 patients, it was highly likely that there would remain patients in both of the categories for July, although this was expected to be in single figures
- In terms of the elective plan, two specialties remained challenged; gastroenterology and respiratory although additional capacity for both services had been agreed which was expected to reduce the waiting list
- The Trust was expecting to deliver the 28 day faster diagnostic standard and in terms of 62 day performance conversations were being held in terms of the possibility of being removed from tier 1 for cancer performance once performance had been sustained
- The Trust had not set a diagnostic performance trajectory in line with the national planning guidance which was in the main due to endoscopy performance

Mr Wakefield referred to the 1700 patients waiting for diagnostics beyond the 6 week timescale and queried how much of this had grown. Mr Evans stated that 50% was due to increased volume.

People

Mrs Haire highlighted the following:

- In terms of staff engagement, the Staff Voice was open for July with actions focussing on increasing the response rate to provide more meaningful feedback
- Wagestream had been launched has part of the Trust's focus on financial wellbeing whereby colleagues on bank shifts could draw down their salary in almost real time
- A deep dive was being undertaken into the main driver of sickness absence; stress, anxiety and depression. The in month sickness absence position had decreased as expected, although this was anticipated to slightly increase due to covid
- Turnover and vacancies continued to perform well with a number of campaigns focussed on retention including the medical staff finishing school
- Appraisal rates had slightly increased and there had been particular success in improving rates within Women's Children's and Support Services by utilising the improving together methodology. It was noted that other Divisions had been asked to learn from this improvement
- There had been a decline in agency costs to 2.6% reflecting the work being completed across all Divisions

Mr Wakefield welcomed the improvements in turnover and vacancy reduction but queried the reason for there being no movement in sickness absence. Mrs Haire stated that the normalised position was 5% even though the aspiration was 3.39% and she stated that this was tracked every month with Divisions. Ms Ashley added that as the Trust increased the number of permanent employees, this should have a positive effect on sickness absence. She stated that there would also be areas which would benefit from targeted actions and these needed to be identified.

<u>Improving and Innovating</u>

Dr Lewis highlighted that participation in clinical trials was satisfactory and that it was being considered as to how clinical academic posts and research active employees could be tracked.

<u>Resources</u>

Mr Evans stated that in terms of non-elective activity:

- another unit had been opened in the last year which was contributing to the increase in activity
- the upwards trend in activity was aligned to the previous conversations and corelated with the importance of demand management
- daycase and elective volumes were positive, reinforcing the strategy to maximise the Elective Recovery Fund (ERF) and reduce the waiting list
- there had not been a sustained growth in outpatient attendances and this was expected to increase, linked with the productivity work and focussed reduction in do not attend (DNA) and number of cancelled appointments
- Outpatient follow-ups were expected to reduce given the focus on systems such as patient initiated follow ups

Professor Crowe referred to non-elective activity and the use of acute care at home and call before convey. He queried if these were run at an optimum level how much it could be expected to improve performance. Mr Evans stated that call before convey would stop patients getting to the Emergency Department and acute care at home focussed on the back of pathway, reducing length of stay

	rather than reducing admission. Professor Crowe queried whether the falls prevention schemes were working well and Mr Evans stated that these schemes were not working at the required level and as such schemes were to be reprioritised to focus on those with a high impact. It was agreed to consider how this could be addressed with partners in terms of the schemes which were not working as well as they could to reduce demand. Mr Oldham highlighted the following in relation to month 2 financial performance: • Some estimates had been used to inform the £4 m deficit position, the primary driver of which was cost improvement programme (CIP) progress and some hotspots in medical staff overspend which was to be the subject of a deep dive • The month 3 position was expected to be a £5 m deficit although there remained opportunities in terms of ERF and CIP. Unmitigated, the year end position was expected to be a £20 m deficit • Capital spend was £6.3 m aligned with the plan, although the Trust remained over committed by £2.5 m but this was expected to be offset by IFRS 16 • There was an overarching risk regarding system capital due to an overcommitment as a result of some leases in other providers which were being reviewed • Cash stood at £79.7m which was slightly lower than plan Mr Wakefield referred to ERF monies and queried what was being assumed in the full year forecast. Mr Oldham stated that this was to be reviewed for Quarter 1 in terms of how much had been transacted against CIP programmes. Mr Wakefield requested clarification of whether the planned investments for the next 9 months had been funded and anything above that would be self-funded to which Mr Oldham confirmed. Ms Ashley stated that whilst the Executive were encouraging business cases for ERF activity, there may be other business cases which could not be self-funded and may be required to address patient safety concerns. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
15.	**Review of Meeting Effectiveness and Review of Business Cycle**	
119/2024	No further comments were made.	
16.	**Questions from the Public**	
120/2024	There were no questions from the public.	
DATE AND TIME OF NEXT MEETING		
17.	**Wednesday 7th August 2024, 9.30 am, Trust Boardroom, Third Floor, Springfield**	

Trust Board (Open)

Post meeting action log as at **01 August 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/601	05/06/2024	Quality Account	To confirm what was meant by the reference to mandatory ratings for clinical coding	Ann-Marie Riley	10/07/2024	10/07/2024	Mrs Riley explained that the coding standards related to primary and secondary diagnosis coding, which was reviewed as part of Data Security and Protection Toolkit.	B
PTB/602	05/06/2024	Integrated Performance Report - M1	To provide further detail in terms of the type of research undertaken to the Strategy and Transformation Committee.	Matthew Lewis	31/07/2024	24/07/2024	Update provided to Prof. Hassell on the types of research undertaken. This will be included within future IPR's. This has also been included in the Research Strategy update presented to Strategy and Transformation Committee on 31/07/24.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

July 2024

Part 1: Contract Awards

2.1 Contract Awards and Approvals

Since 14th June to 14th July 2024, 2 contract awards over £1.5 m were made, as follows:

- **Provision of Office 365 Licences** supplied by CDW Limited, for the period 01/07/2024 to 30/06/2025, at a total cost of £1,621,799.79 incl. VAT, providing savings of £91,982.30 approved on 10/07/2024
- **Vehicle leasing Salary Sacrifice Scheme - Additional Funds** supplied by Tusker Direct, NHS Fleet Solutions, for the period 01/04/2022 to 31/04/2026, at a total cost of £2,728,151.00 incl. VAT, providing savings of £370,235, approved on 10/07/2024

2.2 Consultant Appointments – July 2024

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant in General Medicine with Specialist Interest in Diabetes	Newly created	Yes	TBC
Spinal Surgeon	Newly created	Yes	TBC
Interventional Cardiologist	Vacant post	Yes	TBC
Consultant in Neonatal Transport	Vacant post	Yes	TBC
Consultant PICU	Newly created	Yes	TBC

No medical staff have taken up positions in the Trust during July 2024.

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

Post Title	Closing Date
Consultant Oral & Max Fax	22/07/24

2.3 Internal Medical Management Appointments – July 2024

No medical management interviews have taken place during July 2024.

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

Part 2: Highlight Report

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

System / Regional Focus

1. Digital ReSPECT

The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their healthcare professionals to understand what matters to them and what is realistic in terms of their care and treatment.

Along with our 'early adopter' partners across Staffordshire and Stoke-on-Trent, we went live with 'digital ReSPECT' patient documentation using our local shared care record, One Health and Care. This means that we now have the capability to update patients forms to record their future care preferences at any time.

2. Maternity & Neonatal Services Successes

We were pleased to receive a letter of praise for our maternity and neonatal teams from Staffordshire and Stoke-on-Trent ICB. They commented on the excellent quality improvements made over the last year, which have been recognised locally, regionally and nationally. Maintaining the safety of women and their babies despite the operational pressures the team have faced, the welcome and information received on two previous visits to services and how proud the teams were to work in the organisation, were just a few of the highlights. Congratulations to all involved.

We also received an email from the ICB Chief Medical Officer and Chair of the Local Maternity and Neonatal Programme Partnership Board congratulating our teams on the work done to reduce the numbers of mothers smoking during pregnancy. Last year saw the biggest fall nationally in the proportion of mothers smoking during pregnancy, which campaigners have attributed to the expansion of a 'stop smoking' programme in maternity services. In his email, congratulations were given to our team for their hard work and dedication on the clear progress made within this pathway and for safeguarding the wellbeing of both babies and their mother.

Our hospitals provide a unique environment for people to consider the implications of their health-related behaviours and I have urged all staff to **'make every moment count'** with our patients.

3. Project Search Graduation Celebration – 12th July

A graduation ceremony was held on Friday, 12th July celebrating the success of our 'Class of 2024' students. Students, their parents and key stakeholders including representatives from UHNM, Sodexo and Newfriars College attended the event held at the Quarter by Potbank, Stoke. The Project SEARCH programme gives 18 to 24-year-olds with disabilities and learning difficulties the opportunity to work at Royal Stoke University Hospital and County Hospital to gain vital experience to help with future employment prospects, independence and confidence.

The partnership, which commenced in 2018, has supported 25 young people with special educational needs and disabilities into paid employment, allowing them to be independent adults within the community. Our congratulations and best wishes go to our Class of 2024 and we look forward to continuing to build on the success of the programme.

Organisational Focus

4. Digital Noting in the Emergency Department

We've seen some real success with our Digital Strategy in the Emergency Department and it was great to see the final 'go live' at Royal Stoke during July. Digital noting became a key programme of work four years ago, having started with just a single structured note to reduce the contact with paper during Covid. The scope of the programme grew to include all nursing and clinical documentation, with 30+ new 'structured notes' being created and altered to replace and improve on the paper record keeping process.

New hardware and improved network capacity has been installed throughout the department, and new processes have been established to improve patient flow. The main benefits of this digitalisation programme include:

- More efficient patient care as clinical staff can review patient notes digitally rather than relying on paper
- Time saved in locating paperwork and not having to scan documentation
- All documentation is now legible and audited
- Printing costs reduced and flexibility in editing digital forms when required

My thanks go to everybody involved in making this happen, including our IM&T Directorate and the Emergency Department.

5. Malaysian Ministry of Health Visit to UHNM 22nd July 2024

On Monday, 22nd July, supported by Siemens Healthineers, we hosted a visit by representatives from the Malaysian Ministry of Health. This was a second visit, building on the success of a previous visit held in 2023. The aim being to gain an understanding of our PFI Management Equipment Service (MES), the technology available, the positive benefits it derives for our patients and the opportunities and risks associated with such a scheme. Feedback from the visit was very positive and will be used to inform the Malaysian Ministry of Health's Strategic plans in improving government facilities in this area.

6. Values Week

During the week we celebrated 'Values Week' which generated a great deal of interest amongst our staff. It was a pleasure to see staff getting involved and recognising each other for going above and beyond for our patients and their colleagues. Our Values Recognition Scheme is just one of the ways in which we highlight the positive culture we are building within our organisation.

7. Acute Medical Receiving Area (AMRA)

The physical construction and commissioning of the new AMRA has been completed and handed over to us. The new AMRA facility is due to 'go live' with the full occupation by patients on Friday, 2nd August. The new modular unit will facilitate an increase in general and acute beds in medicine and support us in reducing 12-hour trolley waits and improving our ambulance handover performance.

8. Public Consultation Event Project STAR - 15th July 2024

Since the completion of the new multi-storey car park at Grindley Hill Court, focus is now on the final element of the Project STAR programme and the exciting renewal project designed to provide strategic transformation for the NHS and regeneration of the city of Stoke through the development of the old Infirmary and outpatient sites. Stoke-on-Trent and Staffordshire is a major UK growth hub, and Project STAR fits closely with other regeneration projects currently taking place to 'power up' the region. To ensure local residents have the opportunity to hear about the proposed plans for housing on the old sites, we hosted an

event on Monday, 15th July providing an opportunity for local residents to hear about the proposals and ask questions. Over 170 individuals attended the event and comments received on the day will be considered as part of the planning permission process ahead of the formal planning application being submitted by the Trust in August 2024.

Highlight Report

Quality Governance Committee | 01 August 2024

Matters of Concern / Key Risks to Escalate

For information:

- 5/8 Assurance Rated reports received a Partial Assurance rating
- Partial Assurance noted for **BAF 1: Delivering Positive Patient Outcomes**
- Partial Assurance given for the **Nurse Staffing & Quality Report** as there remains areas of concern; mechanisms are in place and under continuous review to provide more comprehensive assurance. There are 7 wards / portals requiring additional support at Q4.
- There has been an increase in **staff absence** following the recent Covid outbreak
- **Maternity Dashboard** identified some data quality issues which were being worked through
- Partial Assurance given for the **Infection Prevention** quarterly report; 1 MRSA in quarter 1, C Difficile and e-coli are above trajectory; both MRSA and C Difficile are in the lowest quartile as part of the NHS Oversight Framework metrics and there is a regional and national increase in infection rates
- Improvements being seen across a number of metrics within the **Quality Performance Report**
- Partial Assurance rating assigned to the Quality Performance Report, which aligns with the rating assigned to the BAF, given that a number of metrics are yet to achieve the target
- **Management of beds** is currently split across a number of individuals; to be addressed through ongoing discussions
- Partial Assurance for the Quality Strategy Update due to evidence of progress against the ambitions and being on track with delivering objectives for this year and next although there is further progress to be made in delivering the Strategy

Major Actions Commissioned / Work Underway

- Development of a **Digital Dashboard** is under development to provide real time patient harm data correlated with staffing / workforce metrics
- Significant progress is being made with the development of a self-assessment tool against the **CQC's new Single Assessment Framework;** a briefing paper will be circulated and a more detailed discussion at a future meeting
- Oversight of **CQC 'must do'** actions will be provided in more detail to the Quality & Safety Oversight Group
- **Sepsis Management Group** are continuing to explore actions to improve compliance within Maternity
- Consideration to be given to future reports, including the Maternity Dashboard to ensure **greater focus on outcomes and the experience** of others
- Planning for the 2024/25 **staff flu / Covid vaccination** campaign is underway
- Review of partial assurance areas in the In**fection Prevention Assurance Framework** to ensure they are captured on the Risk Register, as well as further development of the framework report
- Discussions are ongoing around corporate / executive leadership for the **management of beds**
- An assurance rating is to be incorporated into the Chief Nurse / Chief Medical Officer summary within the **Quality Performance Report**
- An update on the implementation of '**Martha's Rule'** will be presented September
- **Single Sex Accommodation** incident reporting to be included in Quality Report to ensure that the Committee have oversight

Positive Assurances to Provide

- 3/8 Assurance Rated reports received an Acceptable Assurance rating
- There are net zero band 5 nursing **vacancies and agency** usage is on a zero trajectory, 360 internationally recruited nurses with very low (3.6%) turnover
- Newly recruited **Patient Safety Harm Educators** will be focussed on supporting wards where the need has been identified
- Internal Auditors conclusion of *Reasonable Assurance* into their review of CQC actions, which was overall gave Acceptable Assurance to the Committee
- The CQC are lifting the **County Hospital Section 29a** following a recent inspection
- Acceptable Assurance given for the **Maternity Dashboard** due to sustained improvements in triage and induction of labour and outcome of VTE deep dive
- Acceptable Assurance given to the **Infection Prevention Assurance Framework** overall although there are action plans and monitoring mechanisms in place for areas rated as '*partial compliance*' and they will be cross checked with the Risk Register

Decisions Made

- Approval of the minutes of the previous meeting
- Approval of BAF 1 within the Board Assurance Framework (whilst noting the points identified below)

Comments on the Effectiveness of the Meeting

- Good discussion, flowed well particularly around assurance
- Time for discussion – lighter agenda, well chaired
- Comfortable to ask questions and to probe areas well
- Good quality papers, written well and easy to read
- Constructive challenge on assurance ratings

Cross Committee Considerations

- **People, Culture & Inclusion Committee**: development of a Digital Dashboard which will allow correlation with workforce metrics
- **Audit Committee**: Further development of BAF 1 to review the rationale as it is largely focussed on Clinical Effectiveness, gaps to be addressed to align with some of the areas of concern in quality metrics, review of proposed risk score (taking into account NHSOF metrics and the proposed reduction at Q3 to ensure that it is realistic)

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Nurse Staffing & Quality Report Q4 2023/24	BAF 1 BAF 2	High 12 Ext 16	Partial	Assurance	7.	Quality Performance Report M3 24/25	BAF 1	High 12	Partial	Assurance
2.	CQC Action Plan Update	BAF 1	High 12	Acceptable	Assurance	8.	Quality Strategy Update	BAF 1	High 12	Acceptable	Assurance
3.	Maternity Dashboard: June 2024	BAF 1	High 12	Acceptable	Assurance	9.	Quarter 1 Board Assurance Framework	BAF 1	High 12	Partial	Assurance
4.	Q1 Infection Prevention Report	BAF 1	High 12	Partial	Assurance	10.	Quality & Safety Oversight Group Highlight Report (15th July 2024)	BAF 1	High 12	Not Rated	Assurance
5.	Infection Prevention Board Assurance Framework Q1 24/25	BAF 1	High 12	Acceptable	Assurance	11.					

Attendance Matrix

Members:		M	J	J	A	S	O	N	D	J	F	M
Andrew Hassall	Non-Executive Director (Chair)											
Claire Cotton	Director of Governance	NH	NH	NH								
Matthew Lewis	Chief Medical Officer		AM		AM							
Katie Maddock	Non-Executive Director											
Jamie Maxwell	Head of Quality, Safety & Compliance											
Ann-Marie Riley	Chief Nurse											
Sunita Toor	Non-Executive Director											

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Quality Strategy Update	**Agenda Item:**	8
Author:	Ann Marie Riley, Chief Nurse		
Executive Lead:	*Chief Nurse*		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	*Delivering Positive Patient Outcomes*	*12 (high)*

Executive Summary

UHNM Quality Strategy (2022-2025) puts patients and the communities we serve at the centre of our journey to world-class excellence ensuring that the care we provide is person centred and meets the needs of our population. Our Quality Strategy 2022-2025 sets out to build on the Trust's previous quality strategies and brings into focus four key priorities so that we achieve local, regional and national standards regarding quality of care to ensure regulatory compliance and patient satisfaction.

The Quality Strategy 2022-2025 has been developed with involvement from staff, service users and carers/relatives. A literature review was undertaken to ascertain current best practice in terms of quality in an acute setting. A thematic review of the Trust's harm data and incidents was undertaken in order for us to be confident that our priorities capture the true essence of the challenges identified and that our key initiatives have identified metrics that make it clear what we are aiming for and when we have achieved our goals. Using the tools and principles available to us from Improving Together we have undertaken the 'A3' process on each of the four priorities.

Four clear priorities emerged from the literature and these were reflected during consultation with our staff, patients and relatives/carers:

Priority one: To develop consistently positive practice environments recognising our staff are safety critical
Priority two: To deliver consistently safe and reliable care
Priority three: To prevent avoidable delay in patient assessment, treatment and discharge
Priority four: To ensure that our patients have access to services and/or treatments that meet their needs and delivers positive outcomes and experiences

This paper provides a position statement of progress with the above Priorities against Year 2: 2023 (Milestones). This position statement details the actions taken to date. Improvements will continue to be made against the milestones and appropriate data metrics analysed to measure the impact of the actions taken.

Assurance Assessment		
Significant Assurance	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable Assurance	General confidence in delivery of existing mechanisms / objectives	

Partial Assurance	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	X
No Assurance	No confidence in delivery	

Rationale

Evidence of progress against our ambitions and on track with delivering objectives for this year and next, and Improvements will continue to be made against the milestones and appropriate data metrics analysed to measure the impact of our actions taken.

Key Recommendations

To take assurance that the strategy continues to be delivered and worked to.

NHS
University Hospitals of North Midlands
NHS Trust

Quality Strategy Delivery Plan Annual Report

2023-2024

Delivering Exceptional Care with Exceptional People

Contents

NHS
University Hospitals of North Midlands
NHS Trust

Quality Performance

Key Performance Indicator	Target	2023/24 Performance	2022/23 Performance
Patient Falls (per 1000 bed days)	5.6	5.3	5.9
Patient Falls with harm (per 1000 bed days)	1.5	1.8	1.91
Medication Errors (per 1000 bed days)	6.0	6.7	5.2
Never Events	0	6	4
Duty of Candour (verbal / formal notification)	100%	96.0%	92.9%
Duty of Candour (written within 10 days)	100%	80.2%	55.9%
Pressure Ulcers (category 2 hospital acquired with lapses in care)	96	91	69
Pressure Ulcers (category 3 hospital acquired with lapses in care)	48	12	12
Pressure Ulcers (category 4 hospital acquired with lapses in care)	0	0	0
Friends and Family Test (% A&E recommendeations)	85%	70.2%	62.9%
Friends and Family Test (% inpatient recommendations)	95%	95.5%	97.3%
Friends and Family Test (% maternity recommendations)	95%	91.1%	90.2%
Written Complaints (rate per 10,000 spells)	35	27.82	22.57
Hospital Standardised Mortality Ratio (HSMR) (rolling 12 month)	100	95.03 (01/23 – 12/23)	97.27 (01/22 – 12/22)
Standardised Hospital Mortality Indicator (SHMI) (rolling 12 months)	100	98.50 (01/23 – 12/23)	104 (11/21 – 10/22)
VTE Risk Assessment Compliance	95%	95.2%	99.0%
Reported C-Difficile	96	180	144
Avoidable MRSA Bacteraemia Cases	0	3	1
Inpatient Sepsis Screening Compliance	90%	95.1%	89.7%
Inpatient IV Antibiotics (given within 1 hour)	90%	98.6%	93.4%
Children Sepsis Screening Compliance	90%	89.7%	89.7%
Children IV Antibiotics (given within 1 hour)	90%	100%	66.7%
Emergency Portals Sepsis Screening Compliance	90%	82.3%	81.8%
Emergency Portals IV Antibiotics (given within 1 hour)	90%	75.8%	63.9%
Maternity Sepsis Screening	90%	71.1%	80.6%
Maternity IV Antibiotics (given within 1 hour)	90%	85.5%	83.9%

Priority One: To develop consistently positive practice environments recognising our staff are safety critical

What did we say we would do?	What did we actually do?
To develop our establishment review process	Workforce review of AHPs by our Chief AHP which can start to be incorporated into the establishment review; Non ward based areas currently under review 100% compliance with the business cycle of the establishment review process Establishment review process reviewed by internal audit and received **substantial assurance**
Minimise the number of vacancies across all staff groups	Significant progress has been made to stabilise the workforce resulting in zero vacancies for registered nurses, midwives and a small amount of turnover vacancies for healthcare assistants. We have also seen improvement in RN sickness (down 3%); MW sickness (down 5%); RN/MW and HCA turnover (down 4%) and have maintained 100% of our newly qualified midwives for the second year. Chief AHP appointed, workforce review complete, AHP vacancies have reduced by 50%; we have developed a range of professional opportunities for a broad range of staff and proactively developed supportive programmes to support our international nurses careers journeys from career conversations to navigating the recruitment process
	CeNREE continues to grow and is currently supporting 160 NMAHPs to engage in research & academic development opportunities. Our Chief Nurse Fellowship programme was well evaluated by Cohort 1 and this opportunity has been extended to pharmacy and clinical scientists for cohort 2 (29). Our Chief AHP was appointed in 2023 and since her appointment we have seen 29% increase in student placements. We continue to develop our preceptorship, education and training programmes and were thrilled to be awarded both the National Preceptorship for Nursing Quality Mark, and the NHS Pastoral Care Quality Award.
To roll out Improving Together as our organisational continuous improvement approach	Just short of 5000 colleagues have received some level of Improving Together training; At the beginning of April, the Quality Improvement Academy was accredited by the Lean Competency System Organisation which is affiliated with the University of Cardiff. 2023/24 saw a 15% improvement in adoption of tools when compared to the previous year; Delivery of IT to the majority of County Hospital
	We recognise extraordinary nurses and midwives via our Daisy Award scheme and have introduced a Diamond Award for clinical B2-B4 colleagues
To improve our staff survey results	Improvements reported through People Strategy Annual Report
Develop a culture of inclusion and belonging	Improvements reported through People Strategy Annual Report
What we didn't deliver and why	1. 100% of all budgets aligned with the electronic rosters due to historic funding complexities 2. All theatre and outpatients to be included in the establishment review – Divisions currently conducting reviews in these areas
What is the assurance rating?	Acceptable Assurance: General confidence in delivery of existing mechanisms/objectives

Priority Two: To deliver consistently safe and reliable care

What did we say we would do?	What did we actually do?
Develop suite of harm free care ambitions and deliver year 2 milestones	In Q1 2023, UHNM Activity and Mobility Programme joined with Johns Hopkins Medicine in the United States of America and began work to introduce their activity and mobility programme to UHNM. To ensure if someone has cause to raise a complaint that the process is simple, timely and effective answering the concern raised in a format that all our service users can understand
	Introduced a Diversional Therapist role which has been pivotal in providing an environment for our patients whereby activities are at hand to promote patient independence, enhance their mobility and to encourage and assist their recovery. This initiative has been shortlisted for 2 HSJ Awards
	During 2023/2024, a new standard patient menu was introduced at Royal Stoke, using a new supplier called Apetito, and the menu has received positive patient feedback. An updated Nutrition Bundle and Nutrition Care plan has been introduced into adult inpatient areas
	11% reduction in total patient falls per 1000 bed days and 19% reduction in falls resulting in any harm to patients per 1000 bed days in 2023/24 compared to 2022/23. 12% reduction in number Serious Incidents reported (prior to adoption of PSIRF in December 2023) compared to same period in 2022/23.Rate of reported patient safety incidents with moderate harm or above per 1,000 bed days in 2023/2024 has decreased from 0.9 to 0.66.
	We are working with Parkinsons UK as in late 2023, we pledged to improve the delivery of time critical medications for patients with Parkinsons at our trust, this has seen us develop a plan in line with the Time Critical Medicines Standard Operating Procedure/guidelines for all time critical medication, including those patients who are nil by mouth (NBM) or require a nasogastric (NG) tube. Work continues led by our Parkinsonian Specialist Nurses and our Pharmacy Dept. We have undertaken work led by our Sepsis team at UHNM, to improve the compliance with IVAB given within one hour within our emergency portals.
	We promoted 'But first a drink' back in June 2023, highlighting our hydration campaign led by our Chief Dietician. This seen us encouraging patients and staff to think hydration first. We promoted this via social media stressing the importance of hydration to wellbeing and recovery. Our work with 'Sip to Send' continues meaning that our patients are not kept Nil By Mouth prior to their surgery, this has evolved further to coincide with a NHSE programme of work DrEaMing which we are fully involved in, this concentrates on Drinking, Eating and Mobilising our patients in the hours post-surgery to ensure we do not decondition patients.
	5% decrease in rate of reported pressure ulcers developed whilst under care of UHNM; 22% reduction in unstageable pressure ulcers and 11% reduction in deep tissue injury compared to 2022/2023;
	The total number of complaints opened at Royal Stoke University Hospital during 2023/24 was 440 which is 29% lower than the pre COVID-19 three-year average of 616. The total number of complaints opened at County Hospital was 58 in 2023/24, which is 48% lower than the pre-COVID 3-year average of 112.
	Our UHNM Maintaining Continence Function Ambition 2022-2025, is our ambition which challenges practices that could violate a person's dignity and recognises opportunity for protecting the functional ability of those within our care,. 2023 seen us scope our Continence training package to ensure it was comprehensive and in line with Local and National Excellence/Guidance, 2024 has seen us incorporate this into our mandatory training, and our ambition for next year is get to 95% compliance with this. We have been encouraging the work of our Continence Champions across our ward areas and re-educating staff on the use of HOUDINI skin-care health to avoid prolonged or unnecessary catheterisation.

Priority Two: To deliver consistently safe and reliable care

What did we say we would do?	What did we actually do?
Ensure that safeguarding of our most vulnerable patients is central to all we do.	Focused interventions at County in response to the S29a, including adding an interim HoN post for County Internal audit of MCA framework - reasonable assurance CQC reinspection in relation to S29a at County –positive verbal/written feedback –we await the report Oliver McGowan Safeguarding training
Patient Safety Incident Response Framework (PSIRF)	From Quarter 4, we introduced the Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. The national PSIRF approach is to review incidents based on system reviews and focus learning on improvement and not just focus on incidents based on the level of harm. To support PSIRF we published our Patient Safety Incident Response Plan which outlines our approach and focus for patient safety incidents during 2023/24 and 2024/25
Develop a Centre of Research and Innovation Excellence (CeNREE) which includes a human factors faculty	In their 2nd year, CeNREE have: provided support to over 120 NMAHPs; is hosting two NIHR Senior Research Leaders; supporting four prestigious NIHR PCAF fellowships, one NIHR DCAF fellowship, one Cystic Fibrosis Trust fellowship, one North Staffs Medical Institute grant and one West Midlands Clinical Research Network Personal Development grant which have been awarded since CeNREE's launch; have hosted two successful symposia; have hosted an internship programme for a PhD student; is now a member of CNO England Research Transformation Leaders Network and the CoDH Clinical Academic Roles Implementation Network (CARIN) through the CeNREE Lead providing a voice at a national level; have hosted two NHS England Clinical Leadership Fellows; have supported eight staff to graduate from the first cohort of the Chief Nurse Fellow Programme, two of which have secured promotions and one of which is working on a national project -Cohort 2 of the fellowship programme sees 29 fellows join the programme and the opportunity to become a fellow has been extended to pharmacy technicians, pharmacists, and clinical scientists; have appointed 12 Research Ambassadors to signpost staff to CeNREE support and encourage evidence-based practice
Deliver Clinical Effectiveness Group objectives	A dedicated Clinical Effectiveness (CE) lead is now identified and a CE Strategy has been drafted with an accompanying delivery plan detailing the different steps to be taken to enable UHNM to provide patients with the best possible clinical outcomes for their individual circumstances
Implement a Trust Wide digital audit programme; annual review of questions	Tendable CEA continue monthly and inform CEF accreditation, quality and staffing reports and support triangulation of ward/dept performance ; Nursing Ward to Board dashboard in development; internal audit of County completed and CQC inspection relating to S29a completed 4 July- very positive feedback from the CQC but we await the final report. We await the CQC inspection for maternity
What we didn't deliver and why	1. Work in collaboration with Patient Safety Learning to complete Safety Assessment at UHNM –this has been delayed due to the focus on implementation of PSIRF 2. We are not at target for a number of metrics although performance has improved in most metrics 3. Delay to ePMA rollout 4. 4 CQC s29a notices for maternity and Medicine at County
What is the assurance rating?	Partial Assurance: some confidence in delivery of existing mechanisms/objectives, some areas of concern

Priority Three: To prevent avoidable delay in patient assessment, treatment and discharge

What did we say we would do?	What did we actually do?
	Safeguarding training Children's Safeguarding Training revised their levels of education package, combining packages for Level 2 and 3 to support staff to reduce duplication and ensure our staff are trained to the requirements they need to enable a 'think family first' approach to all interventions and be compliant with the curriculum. This supports early identification in safeguarding concerns which enable the timely assessments and more timelier discharges for our patients. Adult Safeguarding have revised the content of all levels of their training to ensure that they are compliant with the inter-collegiate document, we revised our MCA Dols package to make it more applicable to UHNM providing case scenarios to staff, and we also identified all medical staff to complete MCA dols training too. The team have driven and focused emphasis on the facilitation of The Level 3 Adults Safeguarding package (as previously we hadn't monitored strict compliance) to regulate and assure of ourselves of compliance, (including best interests and capacity scenarios), this supports our staff to undertake more individualised assessments and treat within best interests safely and least restrictively were applicable.
	Oliver McGowan - We are passionate about improving services for our patients with Learning Disabilities and Autism. Our approach to how we incorporate the Oliver McGowan learning was driven by people who really understand the implications of poor patient experience. We recruited a team of experts including a qualified teacher to support us in the development and educational structure required to deliver a course to all patient facing members of UHNM. This course required Patient Experts who identify as having a learning disability and Autism , a Nationally Guided but locally driven programme was developed and started to be rolled out across UHNM. The plan is that this will take us nearly two years to deliver, and our early feedback is excellent.
	Timely obs - For the wards with the lowest compliance it has become a divisional driver to improve on timely completion of observations, these have been monitored through the dashboard and the vital steering group and Divisional PRM. Timely Observations is an area which is monitored in the CEF (Clinical Excellence Framework) programme. We have revised our CEF programme and made it Patient led. We have designed a status exchange and an expectations guide for our wards/areas that are performing at a Bronze level, this is rolled out and being used under the leadership of a patient and the Deputy Chief Nurse.
We will better understand the potential/actual harm caused through not achieving the constitutional standards across non elective and elective pathways	Introduced PSIRF. Patient Safety Incident Response Framework, was introduced across UHNM ,in the autumn/winter of 2023. We appreciated that capturing learning is vital to support all aspects of improving patient care and Patient Safety will always remain our priority. This year to support a new way of thinking about Patient Safety and learning from incidents, and to enable staff to feel able to speak up about any concerns, (and ensure learning takes place), we have merged two teams together and recruited to a Head of Nursing for Quality, Safety and Compliance. The two teams were the Senior Clinical Corporate Nursing Team and the Divisional Quality and Safety Managers. This ensures we can work with new Patient Safety tools to promote continual learning. We can more effectively measure and monitor actions plans from lessons learned and the monitoring of their impact.
To reduce steps and procedures that do not add value to patients and service users outcomes or experience	Reported through workstream two and non-elective improvement board
What we didn't deliver and why	1. Essential to role training not at target 2. Delays continue to assessment and treatment across UEC and elective pathways
What is the assurance rating?	Partial Assurance: some confidence in delivery of existing mechanisms/objectives, some areas of concern

Priority Four: To ensure that our patients have access to services that meets their needs and delivers positive outcomes and experiences

What did we say we would do?	What did we actually do?
Strengthen our patient/public voice and ensure we maximise opportunities for co-production across our improvement portfolio	Patients being at the centre of all we do, has meant that we bring patients in to have influence and impact on our meetings. Our Patient Experts lead programmes of care ensuring the patient voice is captured. This has really had a positive impact on teams, who are held to account by patients wanting to support our improvements. We have employed our own Corporate Patient Safety Expert, this gentleman identifies as having learning difficulties and is a wheelchair user, he is enabling us to ensure we are considerate of our disabled patient's needs. Already in his first few months, he has improved how we deliver some services and has plans to make a significant impact on the experience of service users and staff in the coming months. We have included patients in our interview selection process' for our staff recruitment and in our Quality Reviews. With our new PSIRF tools, we include patients in the capturing of 'when things have not gone to plan' to support us in forming the lessons that are needed to be learned.
To ensure if someone has cause to raise a complaint that the process is simple, timely and effective answering the concern raised in a format that all our service users can understand	We have refreshed the complaints response process and are now utilising digital checks to reduce the reduce response times. The team are now checking with families how best to resolve a concern rather than automatically utilising the formal complaints process-this is resulting in less formal complaints being lodged
What we didn't deliver and why	1. Develop patient partnership type role although this is being discussed to determine the best approach for UHNM 2. Still not meeting complaints response times 3. FFT and complaints suggest we have work to do to improve communication in relation to the discharge process
What is the assurance rating?	Partial Assurance: some confidence in delivery of existing mechanisms/objectives, some areas of concern

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Care Quality Commission Action Plan Update	**Agenda Item:**	9.
Author:	Debra Meehan, Lead Nurse Quality & Safety, Nicola Hassall, Deputy Director of Governance		
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

ID15788	Delivery of RTT Performance	**Ext 20**	ID23842	RTT Outpatient Capacity / Wait Times	**Ext 16**
ID24028	Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	**Ext 16**	ID25682	Unstructured records management	**High 12**
ID9738	Nursing Training - Medicine	**High 12**	ID23361	Number of open adverse incidents and root cause analysis investigations	**High 12**
ID13419	Midwifery safe staffing	**High 9**	ID9782	Reporting of Patient Safety Incidents	**High 8**
ID9783	Incident Investigation	**High 8**	ID15993	Maternity Assessment Unite Triage	**Mod 6**
ID8580	Medical staffing for the Emergency Department	**Mod 6**	ID8543	Lack of facilities for storage of patient records in ED	**Mod 4**

Situation

Following the previous Care Quality Commission (CQC) inspections, actions for improvement were identified. This report provides assurance to the Trust Board on the progress made to date against the must do and should do recommendations.

Background

The CQC inspected UHNM in August 2021, visiting and rating Urgent and Emergency Care (Requires Improvement) and Medicine (Good) at Royal Stoke and Medicine (Requires Improvement) and Surgery (Good) at County Hospital. A Well Led inspection took place in October 2021.

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

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

The CQC have since visited County Hospital on 4th July 2024. Positive feedback was received both verbally and written. An extensive number of data requests were submitted to the CQC by the deadline of 15th July 2024. The Trust has been informed that the CQC are removing the section 29A warning notice and is currently awaiting the final report and outcome of their review of the County Hospital ratings.

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

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

The CQC also conducted a focussed visit to Maternity Services in March 2023 and concerns were raised in two areas; timeliness of maternity triage and management of induction labour. This resulted in the Trust being served with a Section 29A Warning Notice under the Health and Social Care Act 2008.

Immediate mitigating actions were put in place and the Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 30th June 2023, which was submitted and the Trust is currently awaiting a further review of maternity services by the CQC.

The inspection of Maternity Service concluded with the following ratings:

- Overall Rating: Requires Improvement
- Are Services Safe: Inadequate
- Are Services Well Led: Requires Improvement

The Maternity Services CQC action plan is being presented to Maternity QGC in August 2024.

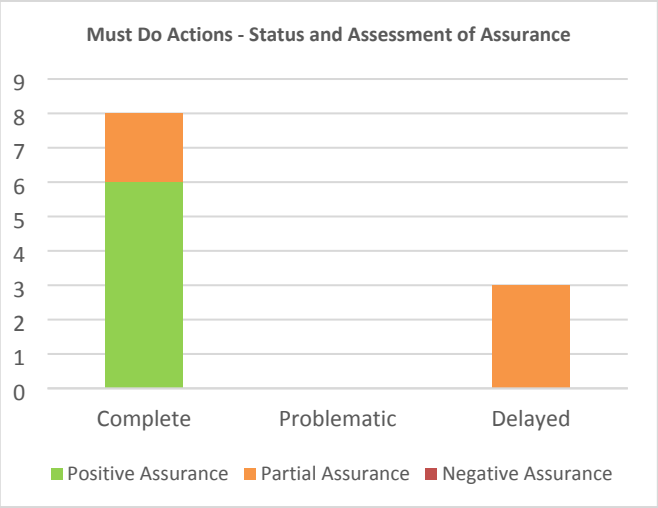
Assessment

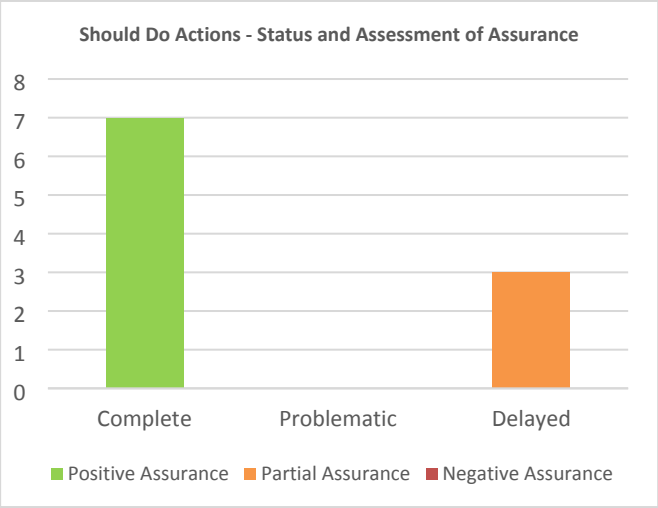
Following feedback from the Quality Governance Committee (QGC) and Internal Audit during early 2023, work was undertaken to review all completed actions and ensure that they addressed the concerns raised by the CQC. As a result, some duplicate actions were removed, and additional columns were added to capture ongoing assurance of sustained improvement against the completed actions including any additional actions required to provide positive assurance.

In August 2023, the QGC also agreed to archive 15 actions, which had either been fully completed, had a clearly defined monitoring process or had been progressed as far as possible. All archived actions have been mapped to a Risk on the Risk Register, where appropriate.

In June 2024, Internal Audit reported reasonable assurance with regards to the CQC action plan. Three management actions were assigned.

Current status of open actions are as follows:





On review of the updated action plan in July 2024, agreement was given by QGC for two additional actions that have no outstanding actions and a clearly defined monitoring process, which is Business as Usual through UHNM governance processes, to be archived. Outstanding risks will be monitored via the Risk Register:

A4: Medicine-Urgent and Emergency The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this.

A5: Medicine-Urgent and Emergency The Trust MUST ensure all risks are appropriately identified, assessed and mitigation put in place where possible. Regulation 17 (1)

Of the remaining open actions, those relating to the following issues have made positive progress since the previous update:

Speech and Language Therapy (SLT) provision at County Hospital
Recruitment to 2.0WTE SLT posts at County Hospital is being progressed.

Section 29A the risk management of patients with mental health needs in medicine at County Hospital
Internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital. A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024. The Trust has been informed that the CQC are removing the section 29A warning notice and is currently awaiting the final report and outcome of their review of the County Hospital ratings.

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	

Rationale

Internal Audit into the CQC Action Outcomes Framework concluded in June 2024 with an opinion of 'reasonable assurance' that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. However, there were some issues identified which need to be addressed in order to ensure that the control framework is effective in managing the identified risks.

Key Recommendations

The Trust Board is asked to note the updated action plan and progress made to date.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	10.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality	x	People		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.	4	6

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	**44**	**10**

The main areas of concern, which all have key actions, relate to:

- Food Safety Training
- 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.

Highlight Report

Strategy & Transformation Committee | 31 July 2024

Matters of Concern / Key Risks to Escalate

For information:

- A **Partial Assurance** rating was accepted for the Research and Innovation update, on the basis that work is to be undertaken to allow for full oversight and monitoring of research activity
- Whilst significant growth has been seen in **research activity through CENREE**; sustainability of that position is of concern
- Internal Audit findings of **Partial Assurance** for IT Service Management and Data Security and Protection and **Minimal Assurance** for the IT Systems Managed by Operational Areas
- **Partial Assurance** given for the **Digital Strategy** update in view of recent Internal Audits; the Committee will oversee implementation of the actions arising from both
- **Partial Assurance** given for the Improving Together Programme Update based on concern specifically around embedding of processes into daily practice

Major Actions Commissioned / Work Underway

- 6 monthly assurance report on **Anchor Institution** to be provided to the Committee
- Work being undertaken to ensure that the **Transformation Programme** is more strategically led; **Partial Assurance** rating was accepted by the Committee in view of the ongoing development
- Approval has been given to progress with the development of a business case for the **Urgent Treatment Centre**
- Further development of the **Research & Innovation Strategy** is underway, and a bid has been submitted to the National Institute of Healthcare Research (NIHR) to become a commercial centre
- Future **Research & Innovation** reports are to better track progress against the strategy, as well as addressing the current gaps in assurance identified through the BAF Deep Dive
- Review of **Research & Innovation governance** structure to ensure it aligns with the corporate structure, at the same time work is being undertaken to broaden the remit of the **Research & Innovation** Group
- Corporate project being undertaken around building **Improving Together** into the lifecycle of our employees (commencing September), work is also being undertaken around leader standard work and visibility / success of the programme at County Hospital and wider
- An Executive Summary to be developed for the **Improving Together** Report focussed upon the key assurances required by the Committee
- New **Cyber Security** Assurance Report is being developed for the Audit Committee, as agreed at the BAF Deep Dive
- BAF to reflect the strategic risks associated with delivery of the **Digital Strategy** as well as continuing to explore opportunities with partners
- A plan is underway to align the **enabling strategies** with the overarching strategy

Positive Assurances to Provide

- **Acceptable Assurance** given for the Anchor Institution activities given it is a new concept and requires cross organisation working and a long journey; however, UHNM is in a strong position
- Progress has now been made with **SDEC** which has decreased the risk escalated via the Executive Strategy & Transformation Group regarding estates, derogations and workforce
- Significant progress has been made in delivering the **Research & Innovation** Strategy, including work through the **CENREE**
- **Digital Strategy** progress report demonstrates significant progress in delivering and maintaining technology to improve our digital position and support elective recovery

Decisions Made

- Approval of the BAF Quarter 1
- Approval of the Executive Group Governance Pack

Comments on the Effectiveness of the Meeting

- Meeting ran very well, each item given the attention required
- Lots of business covered, some housekeeping required in terms of papers and ensuring that they are assurance focussed

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Anchor Institution Update	BAF 3	15	Acceptable	Assurance	7.	Digital Strategy Update	BAF 5	12	Partial	Assurance
2.	UHNM Transformation Programme	Various		Partial	Assurance	8.	Cyber Security Assurance Report Q1 24/25	BAF 5		Partial	Assurance
3.	Executive Strategy & Transformation Group Highlight Report (19-06-24)	BAF 3		n/a	Assurance	9.	Executive Digital and Data Security Protection Group Highlight Report (18-07-24)	BAF 5		n/a	Assurance
4.	Research Strategy Update	BAF 9	ID3098 6	Partial	Assurance	10.	Quarter 1, 2024/25 Board Assurance Framework (BAF)	BAF 1 BAF 2 BAF 3 BAF 4 BAF 5 BAF 6 BAF 7 BAF 8 BAF 9	12 16 15 20 12 12 16 16 12		Approval
5.	Executive Research & Innovation Group Highlight Report (04-07-24)	BAF 9		n/a	Assurance	11.	Internal Audit Reports: • Service Management Process (Information Technology Infrastructure Library) • IT Systems Managed by Operational Areas Data Security and Protection Toolkit	BAF 5	12		Assurance
6.	Improving Together Countermeasure Summary	-		Partial	Assurance	12.	Executive Groups Governance Pack	-			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											
Simon Evans	Chief Operating Officer	?	?									
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	AMM
Ann-Marie Riley	Chief Nurse	
Lisa Thomson	Director of Communications	
Lorraine Whitehead	Director of Estates, Facilities & PFI	

NHS
University Hospitals of North Midlands
NHS Trust

Highlight Report

Performance and Finance Committee to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- Partial Assurance rating given for the Month 3 Finance Report, due to the CIP requirement of £56.6m (At the end of July, the full set of CIP to deliver the target is yet to be identified); the biggest opportunity to improve is to increase productivity levels
- At the end of July, the full set of **CIP** to deliver the target is yet to be identified
- Outstanding **Overseas Visitors** invoices and there are issues which are being seen at a national level. Additional resource has been identified to support the Overseas Visitor Team
- **12-hour A&E** performance remains a challenge although the opening of AMRA is expected to improve this position
- Lost hours due to **ambulance handovers**, although also, expected to improve with AMRA and an internal audit is also being undertaken to review the data and recording practices
- **62-day cancer** pathway performance; however, strong performance was seen during June which was above trajectory and expected to continue to improve
- Additional patients have been added to the **62-day cancer backlog** although this remains below the threshold set and this will continue to be monitored
- Overall Partial Assurance for **Elective**: 78 weeks is being forecast not to achieve the planned 0, Covid has affected planned care patients as well as some patients not being fit to be treated – a small number of patients expected for August; 65-week position is also of concern but remains within trajectory and is now expected to start improving although is not expected to achieve the target and this has been shared with NHSE
- 2-week delay with the additional **endoscopy capacity** although it is expected to recover to plan
- 'Bottlenecks' impacting the ability to effectively progress **theatre productivity**; a rating of Partial Assurance was confirmed and the need for additional oversight recognised
- **Capital** programme for the **automated dispensary** has been negatively impacted by the new requirements of the Building Safety Act and a new timeline has had to be agreed; this has led to a Partial Assurance rating being assigned to Pharmacy performance and procurement overall

Major Actions Commissioned / Work Underway

- An **ICS Recovery Director** has been appointed by the system with a key objective to deliver the savings identified within the financial plan
- Programme of work in place to improve overall **productivity**; a report to provide assurance on progress is planned for the Committee in September and this will include the use of Improving Together where appropriate
- Detailed discussions / challenge on **CIP** delivery with Divisions through the Executive Finance, Activity & Performance Group
- At Month 4 a report on **staffing costs** will give greater oversight of overspend and any associate action required; vacancy and agency controls are in place but may need to be strengthened
- Financial **forecasting** will continue to be refined
- Reporting on **Overseas Visitors** activity is to be each 6 months and consideration is to be given to the best use of digital / data along with appropriate Executive oversight
- Use of the **Improving Together Programme** around ward processes continues to be in place although a review of its impact, in particular weekend working is being undertaken
- Significant opportunity identified for **productivity** improvement within theatres; a programme of work is underway with refreshed governance
- Additional risk/financial implications to be added to the **Contract** Report narrative
- Next **Deep Dive** to focus on financial risks within the BAF including appetite and tolerance
- New process for Business Case Reviews being developed for approval

Positive Assurances to Provide

- A **CIP** workshop has been held with Divisions, with involvement from the Turnaround Director
- An allocation from the ICB has covered the **capital** funding shortfall previously identified
- Acceptable Assurance was given for the North Midlands and Cheshire Pathology Service Budget Setting and Month 3 position as it was delivering and is expected to continue
- Non-elective **4-hour performance** has been very positive, and another month of above plan is anticipated which is the best seen since July 2020
- **SDEC and AMRA** are due to open on Friday 2nd August on track and within budget
- **Faster Diagnosis Standard** remains strong and above trajectory; discussions are ongoing with regional colleagues around being stepped down from Tier 1; overall Acceptable Assurance for Cancer

Decisions Made

Approval of Contracts / Extensions and Expenditure approvals:

- NMCPS Blood Sciences Managed Service Contract (e-REAF 14306)
- Extension of the NMCPS Blood Sciences Managed Service Contract (e-REAF 14376)
- New NMCPS Blood Sciences Managed Service Contract (e-REAF 14323)
- Home Delivered Peritoneal Dialysis (e-REAF 14298)
- New Outsourcing of Radiology Reporting Contract (e-REAF 14169)
- Endoscopy Consumables (e-REAF 14159)
- Subcontract for Endoscopy Diagnostics Services (e-REAF 14131)

- **Plastics and Dermatology Business Cases** previously approved which have rightsized the teams
- All actions have been completed in relation to **Data Quality Internal Audit** and full validation of patients over 52 weeks has been completed
- Both **medicines CQUINS** were delivered during the last financial year and are on track to deliver this year
- Enhanced Primary Care – GP Federation Service Extension (e-REAF 11445)
- Additional Funds for NMCPS Blood Sciences Managed Service Contract (e-REAF 14458)
- Endoscopy Mobile Unit (fully managed service) County Hospital Site (e-REAF 14395)

Comments on the Effectiveness of the Meeting

- All were content with the meeting; the next meeting will include a Deep Dive session.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
1.	Finance Report – Month 3 2024/25 • CIP Progress Report	BAF 7/8	16	Partial	Assurance
2.	NMCPS (North Midlands and Cheshire Pathology Service) Budget Setting and M03 Financial Position	BAF 8	16	Acceptable	Assurance
3.	Overseas Visitor Activity and Income	BAF 8	16	Significant	Assurance
4.	Performance Report – Month 3 2024/25	BAF 4	20	Acceptable Partial	Assurance
5.	Theatre Productivity Progress Update	BAF 4	20	Partial	Assurance
6.	Business Case Review: BC-0434 Building Resilience and Stability within our existing Critical Care bed base to manage surge	-		Not Assessed	Assurance
7.	Business Case Review: BC-0493 Additional CT scanner EDCT2 (CT8)	-		Not Assessed	Assurance
8.	Pharmacy Directorate Medicines Finance, Procurement and Performance Report Q3-23-24 & Update Q1 24-25	BAF 8	ID32550 ID32553 ID32551 ID32552 ID25152 ID25050	Partial	Assurance
9.	Modular SDEC (AMRA) Final Update	-	ID27158		Information
10.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-			Approval
11.	Executive Infrastructure Group Highlight Report	BAF 6			Assurance
12.	Quarter 1, 2024/25 Board Assurance Framework (BAF)	BAF1 BAF2 BAF3 BAF4 BAF5 BAF6 BAF7 BAF8 BAF9	12 16 15 20 12 12 16 16 12		Approval

Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Digital Strategy Update	**Agenda Item:**	13
Author:	Amy Freeman – Chief Digital Information Officer		
Executive Lead:	Amy Freeman – Chief Digital Information Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 5	*Digital Transformation*	*12 (High)*

Executive Summary

Situation

- The report provides an overview of the progress and plans of the Digital Strategy, which aims to use digital and data insights to enable the delivery of exceptional care.

Background

- The report lists 48 new projects and 4 system upgrades that were delivered in 2023/2024, aligned to the Digital Strategy or Trust Strategic Objectives. Some of the projects include Security Operations Centre, One Consultation, Radiology Home Reporting Bundle, PKB Amplify, and Electronic Patient Record Outline Business Case.
- There are 140 projects and 31 requests for new work that are planned for 2024/2025. Some of the projects include Electronic Patient Record Soft Market Testing, PKB Transformation, Community Diagnostics Centre, PACS/CRIS Refresh, and Windows 11 Implementation. Funding is not available for all of these projects and prioritisation will be required.
- The report shows how the Digital Strategy aligns with the Trust's strategic priorities, such as high quality, people, systems and partners, responsive, improving and innovating, and resources.

Assessment

- The report concludes that significant work has been done to deliver and maintain technology to improve the digital position and support elective recovery of the Trust.

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	
Rationale		
Partial assurance has been proposed due to recent Shadow IT and Service Management Internal audit reviews.		

Key Recommendations

To note the Digital Strategy Update.

Digital Strategy Update

July 2024

1. Introduction

This paper details the actions undertaken in 2023/2024 to support the delivery of the Trusts Digital Strategy and strategic objectives. The paper also details the actions planned for 2024/2025.

2. Background

Our vision is to deliver exceptional care with exceptional people and it has never been more important to enable this vision with supportive digital and data insight services. The delivery of digital technology and data driven insights can make a significant impact on patient outcomes through supporting service and pathway redesign, clinical decision support, enabling patient self-management and self-service, and increased productivity.

The Digital Strategy – 2022 - 2025 sets out how UHNM will use digital and data insights to enable the delivery of exceptional care.

During 2023/2024 IM&T have delivered 48 new projects and 4 system upgrades.

3. 2023/2024 Project Delivery

During 2022/2023 IM&T have delivered the following initiatives aligned to the Digital Strategy or Trust Strategic Objectives.

- **Security Operations Centre – Strategic**
  The delivery of a 24x7x365 security operations centre monitoring and responding to cyber threats.

- **Critical Care GE Systems Integration Development – Divisional Priority**
  The integration of the critical care system with the patient administration system to enable accurate demographic information.

- **One Consultation - Strategic**
  A more cost effective video consultation platform powered by Microsoft Teams.

- **Electronic Discharge Letters to One Health and Care - Strategic**
  The provision of discharge letters to the Staffordshire Shared Care Record – One Health and Care

- **Radiology Home Reporting Bundle – Divisional Priority**
  The development and implementation of a radiology specific home reporting computer hardware to enable flexible and effective reporting of images from home.

- **Elective Care NHS England Weight Management Pilot – National Priority**
  The identification of patients eligible for the pilot, inviting them to the pilot, and registering them on the national solution using PKB, interoperability and analytics.

- **Removal of Bitlocker Preboot Screens - Strategic**
  Improve colleague experience through removing unnecessary steps in the log in process. Removing the Bitlocker preboot screen will mean colleagues can log in with a single username and password.

- **Network and Communication Services Business Case and project initiation - Strategic**
  The network and communication business case seeks approval to change the way in which network and communication services are currently delivered and a modernisation of the network to a clinical grade network.

- **Office 365 - Strategic**
  Office 365 is a subscription-based productivity suite by Microsoft that provides a collection of popular applications such as Word, Excel, PowerPoint, and Outlook, along with cloud-based storage and collaboration tools, accessible across multiple devices and platforms.

- **Rubrik - Strategic**
  Rubrik is a data management and cloud data protection platform. It offers a comprehensive solution for backing up, recovering, and managing data across on-premises, cloud, and hybrid environments. Rubrik simplifies data management tasks and ensures data security, scalability, and accessibility.

- **Microsoft Team and Cisco Telephone Integration - Strategic**
  Microsoft Teams and Cisco Telephone integration allows seamless communication and collaboration by connecting Microsoft Teams, with Cisco Telephone systems. This integration enables users to make and receive phone calls directly within the Teams interface, enhancing productivity and streamlining communication workflows.

- **CareFlow appointment letters into PKB – National Priority & Strategic**
  Integrating CareFlow appointment letters into the Patients Know Best patient portal offers several benefits. It provides patients with convenient access to their appointment details, reduces the reliance on physical letters. It improves patient engagement and empowers individuals to manage their healthcare information digitally.

- **Fortinet Internet Monitoring and VPN - Strategic**
  Fortinet is a comprehensive internet monitoring and VPN solution. With advanced technology and robust features, it will enable UHNM to monitor online activities, detect threats, and maintain network security. The VPN ensures secure remote access, protecting sensitive data and maintaining privacy for users connecting to the network from outside locations with the benefit of being able to connect to public WIFI services.

- **ED County Digital Clinical & Nursing Notes - Strategic**
  Digital clinical noting in emergency departments brings numerous benefits. It enhances efficiency by streamlining documentation, improves accuracy through standardized templates, enables real-time collaboration, reduces errors, enhances patient safety, provides easy access to patient information, and facilitates data analysis for improved healthcare delivery and decision-making.

- **Vitals Abbey Pain Dashboard – Divisional Priority**
  The development of dashboard that provides an overview of Abbey Pain scores using information from the Trusts digital observation system – Vitals

- **LIMS BHI/BT Go Live - Strategic**
  A Laboratory Information Management System (LIMS) for Biochemistry, Haematology, Immunology, and Blood Transfusion offers numerous benefits. It improves laboratory workflow, enhances data management and analysis, ensures accuracy and traceability of samples, streamlines quality control, facilitates regulatory compliance, and ultimately enhances patient care in these vital areas of laboratory medicine.

- **Imprivata Kiosk Rollout – Royal Stoke ED - Strategic**
  Implementing Imprivata kiosk mode offers valuable benefits. It enhances user authentication and security by providing a secure self-service login experience, streamlines access to shared workstations, improves efficiency and productivity, reduces administrative burden, and ensures compliance with data privacy regulations in healthcare environments.

- **PKB Amplify – National Priority & Strategic**
  PKB Amplify aims to improve communication with patients through delivering the following capabilities in PKB the Trusts Patient Engagement Platform:-
    - Cystic Fibrosis clinical transformation
    - HAE care plans
    - Alcohol service clinical transformation
    - PALS service transformation
    - NIV service transformation
    - PKB appointments cancellation and signposting

- **Anaesthetics Medical Record System – Divisional Priority**
  The implementation of a clinical record for anaesthetics in theatre.

- **Waiting List 12 Week Validation – National Priority**
  IM&T have developed an automated process for the validation of patients on waiting lists. The solution messages the patient a link to a form which they complete and the results are returned into the data warehouse. A report has been developed which displays changes to the patients circumstances for operational staff to action for example cancel the request.

- **Robotic Process Automation - Strategic**
  RPA solutions were developed to support Lung Screening and Patient Initiated Follow Up (PIFU)

- **Johns Hopkins App – Divisional Priority**
  An app to support the implementation of Johns Hopkins Activity and Mobility Programme. The programme sees the assessment, planning and achieving of mobility goals become part of daily board round to ensure that patients are supported to achieve their goal with staff documenting the highest level of mobility achieved daily.

- **Foundry (Federated Data Platform) – National Priority**
  UHNM were a pilot site for Integrated Elective Care Coordination for Patients Programme (IECCPP) in both Inpatients and Outpatients. IM&T enabled the programme with infrastructure, data transformation and feeds and information governance expertise.

- **Electronic Patient Record – Outline Business Case – Strategic**
  The business case for a Staffordshire wide electronic patient record was developed alongside a detailed specification of requirements, procurement documentation and benefits case.

- **iRefer – GP Referrals – Divisional Priority**
  iRefer system ensures that the most appropriate imaging test is conducted at the right time which can have a major impact on healthcare provision more widely.

- **HL7 Data Feeds – Divisional Priority**
  The following data feeds were developed to support clinical services through system integration:-
  - Ascent
  - SpaceLabs
  - Smoking Cessation

- **ORDR Implementation at Royal Stoke - Strategic**
  ORDR is a cyber security technology that has been in use at County Hospital for some years however was unable to be installed at Royal Stoke due to issues with the network providers. These issues have been worked through and the solution has now been installed at Royal Stoke which enables visibility and security of network connected medical devices.

- **CRIS/PACS Refresh Business Case - Strategic**
  IM&T have been heavily involved in the development of the CRIS/PACS refresh business case with colleagues from Estates and PFI.

- **Site Room Dashboard – Divisional Priority**
  IM&T have developed a Site Room Dashboard which delivers real time (within 15 minutes) visibility of Ambulances, ED, Bed Capacity, Discharges and performance

4. System Upgrades

IM&T have undertaken a number of upgrades in 2023/2024 to ensure that key systems are kept up to date and on supported version. The list of solutions upgraded is detailed below.

System	Function
CareFlow PAS and BI Upgrade	Move to a supported version of the software.
Medisec Trust Upgrade to v1.6 (letters addressed to patients, cc'd GPs)	To support the ability to send letters to patients and copies to General Practice in line with new documentation standards.
IDOX Upgrade - Casenote Tracking	Move to a supported version of the software.
Robotic Process Automation – BluePrism Upgrade to 7.1.2	Move to a supported version of the software.

5. Planned 2024/25 Actions

There are 140 projects planned for 24/25 and 31 requests for new work an example of the some of the projects on the portfolio are listed below:

- **Electronic Patient Record Soft Market Testing**
  Undertake soft market testing of the EPR market to confirm if a solution exists for Primary Care, Community, Mental Health, Acute and Social Care to inform the outline business case for a System wide EPR.

- **PKB Transformation**
  Develop PKB to provide the following additional functionality:-
  - Appointment rescheduling
  - Radiology letters
  - Solus appointments and letters
  - Remcare integration
  - PreAMS and prehabilitation
  - PIFU and waiting list validation

- **Imprivata Kiosk Rollout – County Hospital and Royal Stoke**
  Implementing Imprivata kiosk mode offers valuable benefits. It enhances user authentication and security by providing a secure self-service login experience, streamlines access to shared workstations, improves efficiency and productivity, reduces administrative burden, and ensures compliance with data privacy regulations in healthcare environments.

- **Community Diagnostics Centre (CDC)**
  Implement the network, communication, and clinical systems to the new CDC.

- **ESR Data Warehouse Feed**
  To enable data warehouse dashboards for staff data held in ESR.

- **Access Database Replacement**
  Local department databases written in Microsoft Access need to be replaced with a secure and supported solution.

- **Wireless Location Services**
  The ability to tag devices and identify the location and status of the device in the hospital to support asset management and patient flow.

- **PACS/CRIS Refresh**
  To replace the PACS and CRIS with a supported modern solution for radiology.

- **Programme Management Solution**
  The implementation of a programme management solution to enable greater visibility of projects, risks and actions to support joined up service provision.

- **Windows 11 Implementation**
  Windows 10 becomes end of life in October 2025 and the Trust will need to upgrade 10,000 devices on to Windows 11.

- **Network Service**
  UHNM take ownership of the network service from the 19th June 2024. The current service will terminate and the newly established network service team to operate and improve the service.

- **PIFU Automation**
  A digital solution supporting patients on a patient-initiated follow-up pathway brings significant benefits. It empowers patients to take an active role in their healthcare, improves access to care, enhances communication with healthcare providers, promotes timely interventions, increases patient satisfaction, and optimises healthcare resource allocation.

- **ED Vitals**
  The deployment of the Trusts digital observations system - Vitals in the emergency departments offers numerous benefits. It enables real-time monitoring of patients' vital signs, facilitates early detection of deteriorating conditions, improves patient safety, supports prompt interventions, enhances documentation accuracy, and streamlines communication among healthcare providers for more effective emergency care.

- **Electronic Prescribing and Medication Administration**
  Implementing an Electronic Prescribing and Medication Administration (ePMA) system brings numerous benefits. It enhances medication safety by reducing errors, improves efficiency in prescribing and administration processes, supports real-time access to patient medication records, facilitates decision support, and promotes seamless communication among healthcare providers for better patient care.

- **Clinical Narrative**
  Clinical Narrative is a CareFlow product that will enable prescribing and administration information in ePMA to be automatically added to discharge summaries and is a dependency on the ePMA project.

- **Royal Stoke ED Digital Clinical & Nursing Notes**
  Digital clinical noting in emergency departments brings numerous benefits. It enhances efficiency by streamlining documentation, improves accuracy through standardised templates, enables real-time collaboration, reduces errors, enhances patient safety, provides easy access to patient information, and facilitates data analysis for improved healthcare delivery and decision-making.

- **Medisec Discharge and Medisec Trust Letters in PKB**
  Integrating Medisec discharge letters into the Patients Know Best patient portal offers significant benefits. It enables seamless access to discharge summaries, promotes patient engagement, enhances care coordination, improves communication between patients and healthcare providers, and facilitates comprehensive and patient-centric health information exchange for better post-discharge management.

- **Doc Editor – CareFlow**
  Implementing Doc Editor reduces the dependency on having Microsoft Word installed on Trust clinical computers. This could reduce the Microsoft Licence cost where the only dependency on Microsoft Work being installed is CareFlow.

- **LIMS Cellular Pathology**
  The last pathology discipline to go live enabling the decommissioning of the legacy Lab Centre system.

- **ECDS v4**
  NHS England have published ECDS v4 which is a regulatory obligation for NHS providers who provide emergency care. The key changes in ECDS v4 are:
    - recording of Virtual Care (including virtual consultations)

- recording Same Day Emergency Care (SDEC) activity
- recording of Hot Clinics (Pilot)
- deprecation of EC Service Type 04 – 'NHS walk in centres'
- recording activity relating to prevention of violence and injury / Injury Sharing to Tackle Violence (ISTV)
- introduction of new Assessment Scales
- expansion of clinical data terms (ECDS Max)
- other minor changes (see TOS Change Control for more details)

6. Conclusion

In the past 12 months significant work has been put into delivering and maintaining technology to improve our digital position and support elective recovery.

56% of the project completed were strategic projects vs national or divisional projects.

It is expected that due to financial pressures the planned project list for 24/25 will reduce.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report (IPR)

Month 3 Performance 2024/2025

Delivering Exceptional Care with Exceptional People

Contents

NHS
University Hospitals of North Midlands
NHS Trust

Data Quality & Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

Explaining Each Domain:

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

RAG Rating Key:

	Good level of assurance for the domain
	Reasonable Assurance with an action plan to move into Good
	Limited or No Assurance for the domain with an action plan to move into Good

This report uses Statistical Process Control (SPC) methods to draw two main observations of performance data and the below key, and icons are used to describe what the data is telling us.

Variation	Are we seeing significant improvement, significant decline or no significant change?
Assurance	How assured of consistently meeting the target can we be?

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

Assurance Grid

Failing

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

VARIATION	ASSURANCE: Pass	ASSURANCE: Hit and Miss	ASSURANCE: Fail
Special Cause - Improvement	Sepsis - Adult Inpatient IVAB Turnover Rate	Induction of Labour Patient falls with harm per 1000 bed days Sepsis - Adult Inpatient Screening Cancer 28 Day FDS	Vacancy Rate UEC 4 Hour Performance RTT No. of Patients Waiting >65 Weeks RTT No. of Patients Waiting >104 Weeks RTT No. of Patients Waiting >78 Weeks Appraisal Rate
Common Cause		Maternity Triage Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Medication Incidents per 1000 bed days Medication Incidents % with moderate harm or above Patient Safety Incident Investigation (PSII's) instigated Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Family & Friends Test - Inpatient Family & Friends Test - Maternity Sepsis - ED Portals IVAB Sepsis - Childrens Screening Sepsis - Maternity Screening Increase Clinical Trial Participation Agency Utilisation UEC Cat Handover Average Time Outpatients' 1st Outpatients' Follow Up Subject Access Request Performance Data Security Breaches	Family & Friends Test - ED Employee Engagement Sickness Absence (In Month) Cancer 31 Day Combined Cancer 62 Day Combined Diagnostics DM01 Performance UEC 12 Hour Trolley Wait Daycase / Elective Activity Freedom of Information Performance
Special Cause - Concern	Non-Elective Activity	Sepsis - ED Portals Screening RTT No. of Patients Waiting >52 Weeks Treating patients in a timely manner (Hospital Combined Performance Score)	

Worsening

High Quality | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We continue to see continual improvements across a range of metrics and the progress made to stabilise the NMAHP workforce is being maintained.

We have met the required targets for induction of labour, MW triage, falls, pressure ulcers developed under UHNM and pressure ulcers with lapses in care.

Some metrics, whilst not at target, are seeing continual improvement including falls with moderate harm, e-coli, C-diff and timely observations.

Work is underway following agreement last month that ED can transition to the new NICE Sepsis guidance and key milestones will be reported to the Committee when developed. Maternity have agreed that Maternity Sepsis will become a Directorate Driver metric and progress will be monitored via MNQSOG/QSOG.

We had a CQC inspection in relation to the S29a at County on 4th July and received very positive verbal feedback which was confirmed in writing. We returned the data requests to the CQC on 15th July and are awaiting feedback in relation to the S29a and potential impact to ratings.

There has been a never event relating to wrong site surgery which in currently under investigation.

What is driving this?

Falls with harm reducing overall since peak in April 2022 however in month four patients fell and suffered moderate harm or above

Pressure Ulcers developed under the care of UHNM are reducing overall since peak in April 2022 and lapses in care continue to reduce since peak in Oct 2022

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

VTE assessment performance has dropped in month and this is predominantly due to the date and time not being recorded on the assessment form by the prescribers who carry out the assessment. This is required so we can demonstrate that an assessment has been done within 12 hrs of admission which is the metric we are required to report nationally.

Between December 2023 and March 2024 there were 4 never events -these related to wrong site surgery (lesions) as is the Never Event reported in month

High Quality | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

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

We are continuing to work with all services across the Trust to implement PSIRF methodologies and principles for incident responses and learning. This is planned to improve the identification of system-based learning and recommendations to support our wider learning for improving the quality of care provided

Tissue Viability Team have developed an A3 for improving pressure damage developed under UHNM care with key countermeasures for all areas to adopt

The patient experience team are constantly working with clinical teams to promote and increase completion rates for patients and assessing new approaches to try and increase completion of the FFT questions including efficacy of text messaging in Maternity, improving access to paper questionnaires in Emergency Departments along with greater visibility of QR codes. Surgery have FFT as a Divisional Driver metric and report countermeasures and progress through PRM.

Timely observations continues to be a driver metric discussed at Divisional PRM and Medicine Division continue to have the biggest impact in overall performance although Ward One has now achieved 95% for the month and their whole team approach is being shared for others to learn from.

UHNM are participating in regional work focusing on C-Diff to consider any learning to support reducing regional rates of C-Diff.

The never events are being reviewed thematically utilising PSIRF PSII – learning and actions will be discussed at September RMP

What can we expect in future reports?

There will be continued reporting of these indicators in future reports and progress / outcome to the identified actions will be included in future reports.

Focus on Timely Observations actions to improve compliance with Medicine and Surgery asked to revisit their A3 and related countermeasures

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

UHNM are in the first wave of Trusts implementing Martha's Rule. This is expected to be implemented across adults and Children at RSUH within the next 12 months. By Q3 provider sites are expected to be moving to implementation of parts 1,2 and 3 of Martha's Rule with a data being collated (metrics TBC). We will report progress against the milestones to QSOG and QGC and will report performance against metrics once agreed and available.

High Quality | Dashboard

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Induction of Labour	95.0%	97.9%	96.3%						
Maternity Triage	85.0%	96.0%	93.0%						
Patient Safety Incidents rate per 1000 bed days	50.7	54.6	52.8						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.7	0.7						
Patient falls with harm per 1000 bed days	1.5	1.7	1.8						
Medication Incidents per 1000 bed days	6.0	6.1	5.8						
Medication Incidents % with moderate harm or above	0.5%	0.0%	1.3%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	0.0	1.0						
Never Events per month	0.0	0.0	1.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.4	1.5						
Family & Friends Test - Inpatient	95.0%	95.4%	96.4%						
Family & Friends Test - ED	85.0%	65.3%	65.6%						
Family & Friends Test - Maternity	95.0%	91.6%	85.5%						
Sepsis - Adult Inpatient Screening	90.0%	98.0%	97.9%						
Sepsis - Adult Inpatient IVAB	90.0%	100.0%	100.0%						
Sepsis - ED Portals Screening	90.0%	71.9%							
Sepsis - ED Portals IVAB	90.0%	72.7%	74.1%						
Sepsis - Childrens Screening	90.0%	85.0%	90.2%						
Sepsis - Childrens IVAB	90.0%	66.7%	50.0%						
Sepsis - Maternity Screening	90.0%	70.6%	66.7%						
Sepsis - Maternity IVAB	90.0%	75.0%	88.9%						

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes	High 12	Partial					High 12	Acceptable

High Quality | [Induction of Labour]

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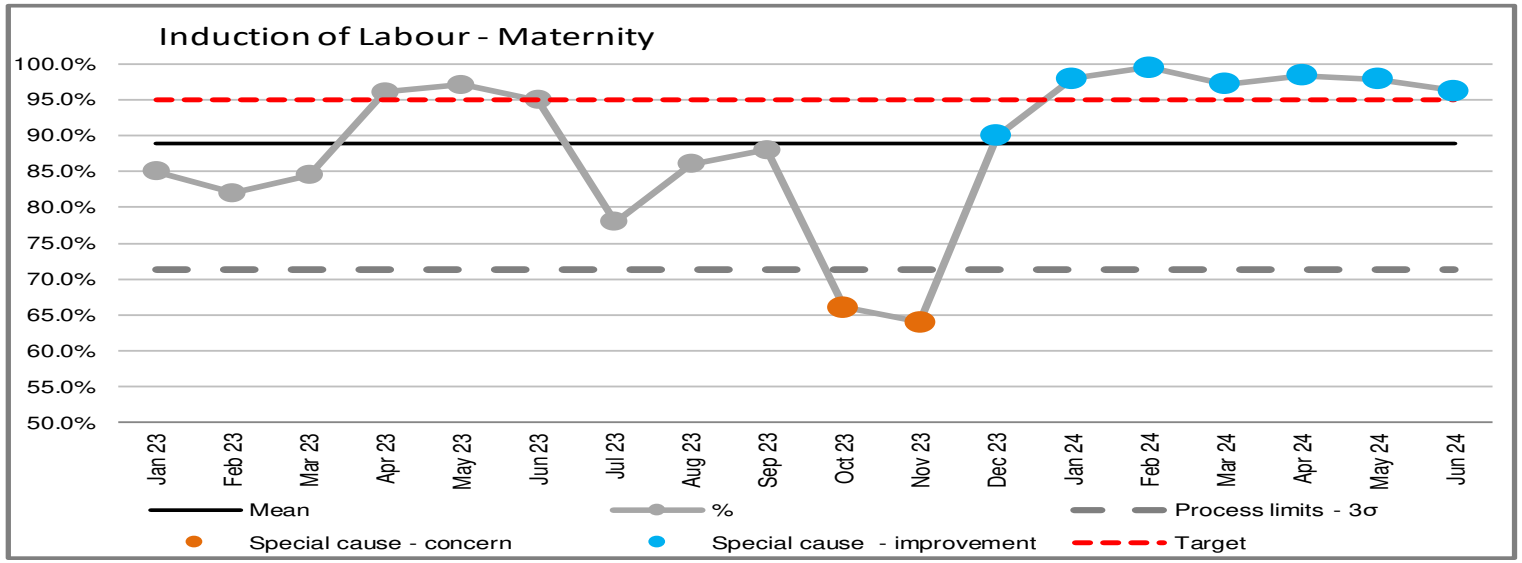
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
95%	98.4%	97.9%	96.3%

Background

Induction of Labour Compliance

What is the data telling us?

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

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

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

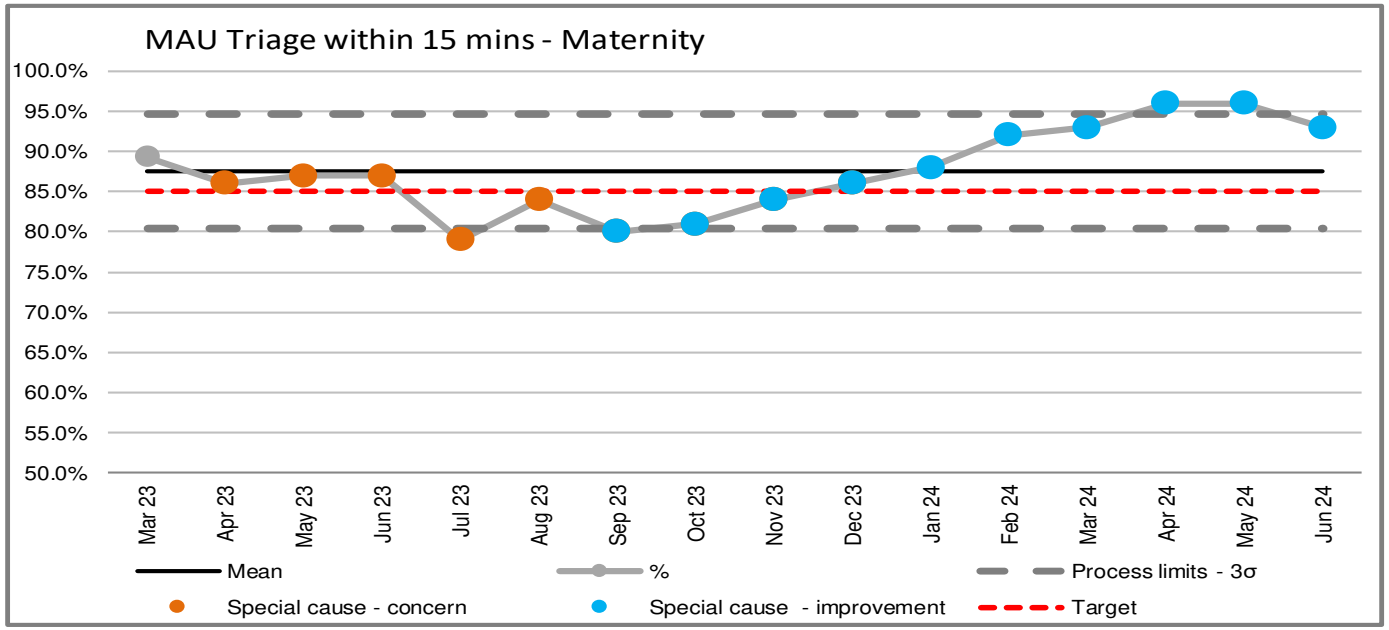
What are we doing about it?

The IOL improvement group continues to meet monthly to review the A3 improvement plan and identify any trends and further actions.
The A3 will be refreshed to focus on sustainability of the current performance.
Any IOL breaches are safety netted and incident reported for full review through the internal governance process.
Any IOL breaches are discussed daily at the patient safety huddle and escalated.
Any IOL breaches will have a well being appointment with a medical review and if necessary admitted for observation.
Prioritisation occurs daily by the on call Consultant Obstetrician for all IOL's booked for that day
All midwifery vacancies now recruited to (all new postholders should be onsite during Q3)

High Quality | [Maternity Triage]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
85%	96.0%	96.0%	93.0%

Background

Maternity patients triaged within 15 minutes.

What is the data telling us?

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

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

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

What are we doing about it?

The MAU improvement group continue to meet monthly to review the A3 improvement plan and identify any trends and further actions.
All MAU timing breaches are incident reported and reviewed in relation to impact and outcome
MAU triage breaches are included in daily patient safety huddle
This metric has met the Improving Together parameters to move from a driver to a watch metric. The A3 will be refreshed to focus on sustainability of current performance. The watch metric will be reviewed at the Executive Performance Review Meeting with the Division.

All midwifery vacancies now recruited to (all new postholders should be onsite during Q3).

High Quality | [PSIs per 1000bed days]

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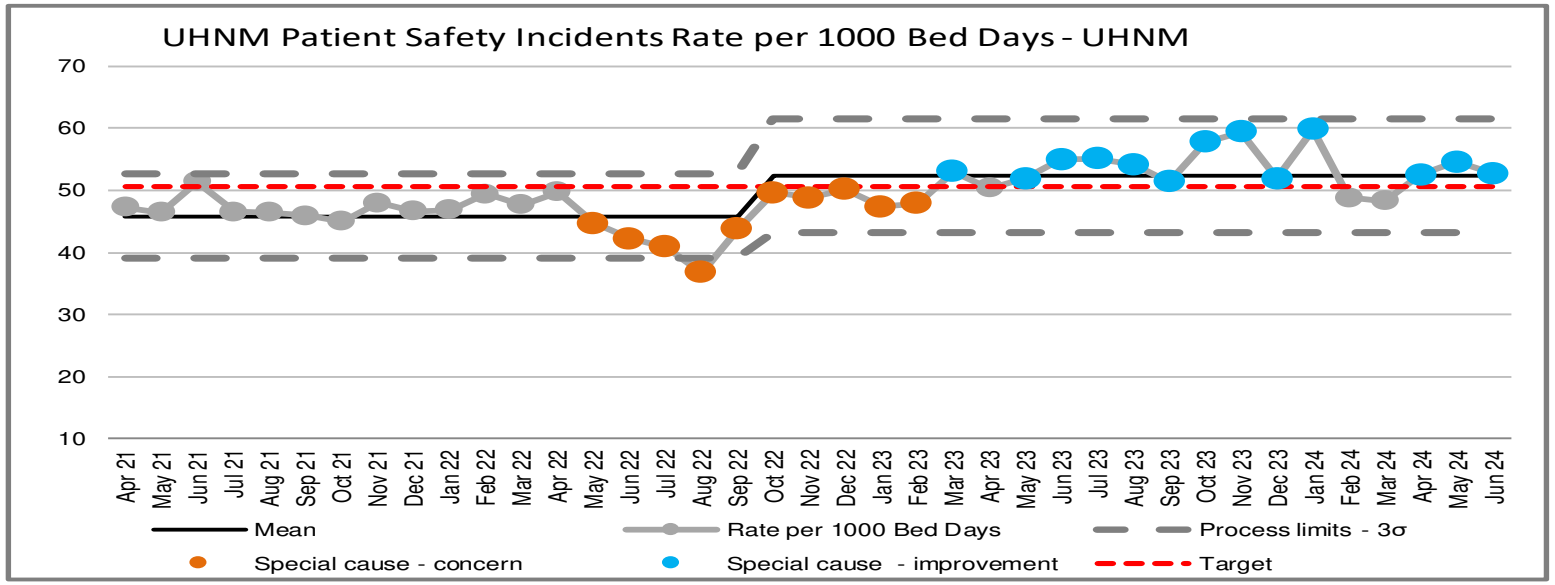
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

NRLS Mean	Apr 24	May 24	Jun 24
50.70	52.55	54.60	52.77

Background

Patient Safety Incidents rate per 1,000 bed days

What is the data telling us?

There is consistent levels of reporting across the Trust and maintaining the improvements and higher mean rate since October 2022. LFPSE reporting and additional NHSE mandated questions introduced in February 2024 and the reporting rate continues to be consistent with the same months during 2023. This indicates that the additional questions are not adversely affecting the reporting of incidents.

There is no significant variation in reporting rates although the rate is consistently above the previously published NRLS average for Acute Trusts (new national LFPSE data publication is awaited)

What are we doing about it?

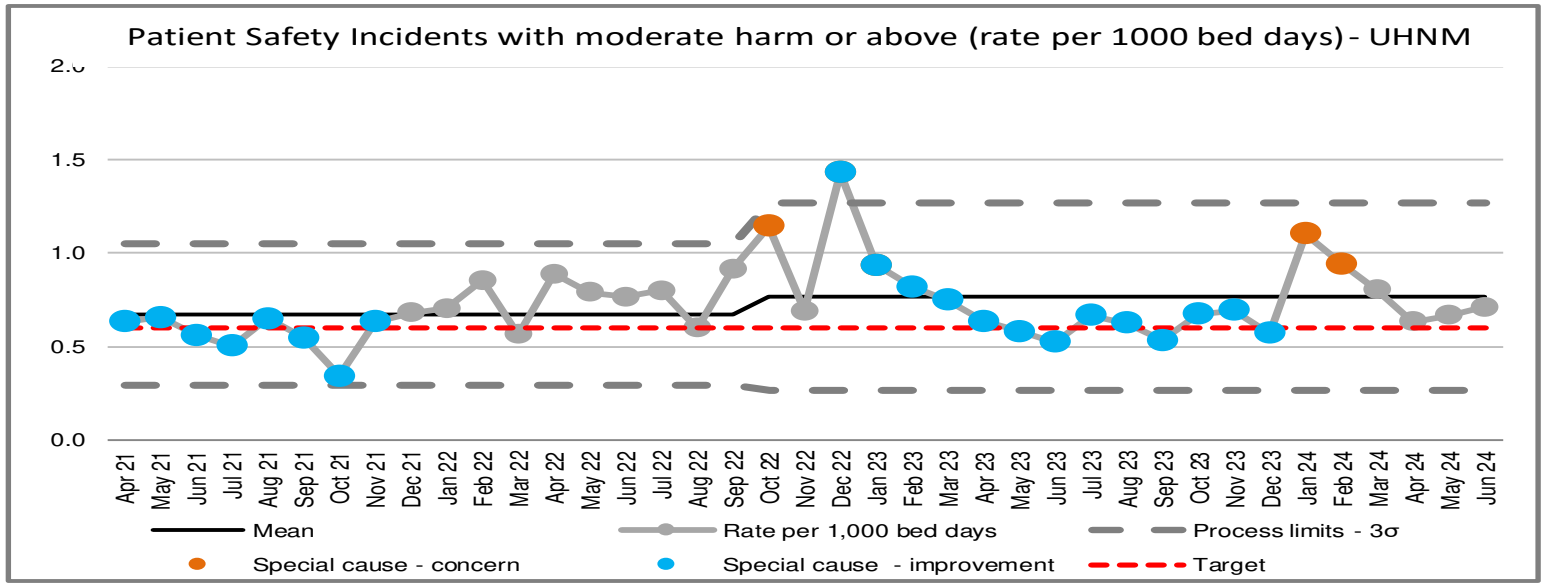
Reviewing incident categories and locations to see if any focus areas and to continue to promote reporting incidents and near misses. Will adopt PSIRF principles re thematic reviews / improvement works to identify potential learning along with ant recommendations. Currently reviewing the near miss and low harm data to identify potential trends for improvement projects.

To utilise LFPSE data published to assess/benchmark our reporting and outcomes as soon as this is available. Will continue to monitor internal reporting rates and totals to focus where there may be reductions.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
0.60	0.63	0.67	0.71

Background

Patient safety incidents reported with moderate harm and above rate per 1,000 bed days

What is the data telling us?

The rate of PSIs reported with moderate harm or above is returning to previous lower levels noted in 2023. The rate in June 2024 has increased but is within normal variation.

As noted in overall PSI rate, January 2024 increase appears to be the anomaly and 1 off exception/increase compared to the longer-term reducing trend during 2023.

What are we doing about it?

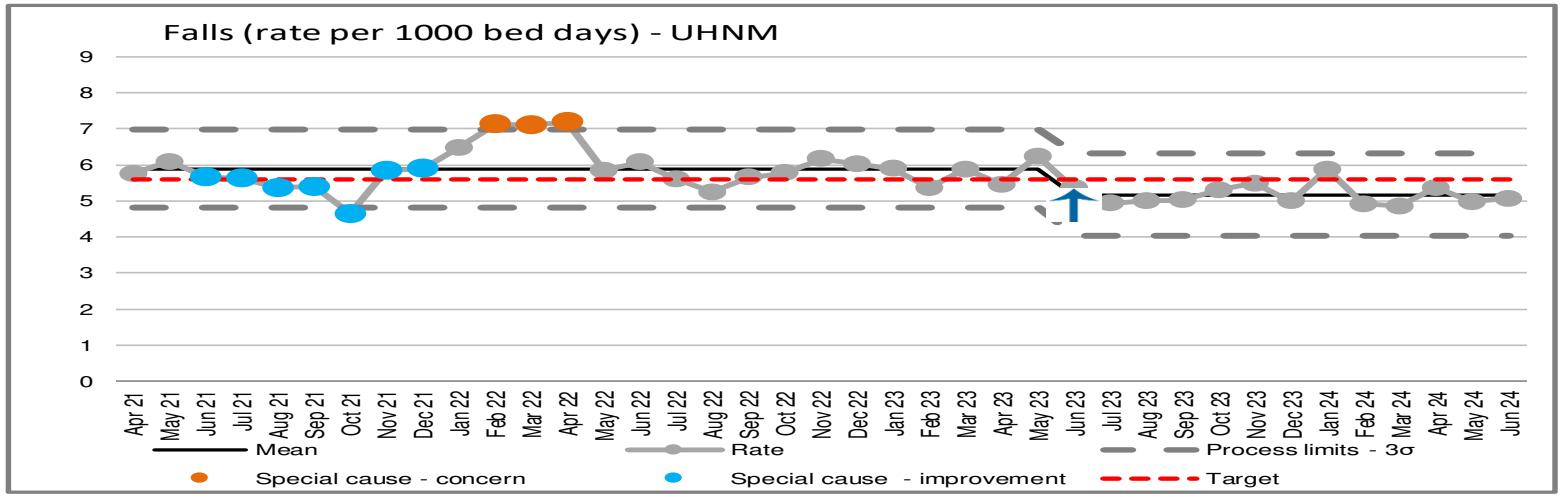
Reviewing harm profile and locations / categories for moderate harm and above incidents.

To support PSIRF principles re learning and proportionate responses to incident reviews. Will work with divisions and specialist services re any safety recommendations and themes identified to improve.

High Quality | [Patient Falls per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
5.6	5.4	5.0	5.1

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 June 2023. The rate for June 2024 is within expected limits.

The areas reporting the highest numbers of falls in June 2024 were:
Royal Stoke ECC – 18 falls, Royal Stoke AMU – 13 falls, Ward 124 – 9 falls

What are we doing about it?

From the 40 falls across the 3 areas there was 1 injury from AMU. The PSIRF toolkit was completed in conjunction with the quality nurse on AMU. This patient had been admitted due to recent cataract surgery, vision had been affected and the patient had become confused.

AMU have had a multiple faller that had fallen 3 times for this month. The patient and the documents were reviewed at the time of these falls.

AMU now have tables for the staff in the bay. We will monitor to see if this improves visibility of the patient to prevent falls.

Electronic documentation is being introduced in ECC. We have worked together to ensure the documentation questions address the falls agenda. Visual inspection of the beds, entrapment risk, trolley rails protocol, bed rail risk assessment, mobility aides and therapeutic observations are amongst some of the changes made.

Changes to provide improvement and clarity to the new risk assessment book regarding falls have been made.

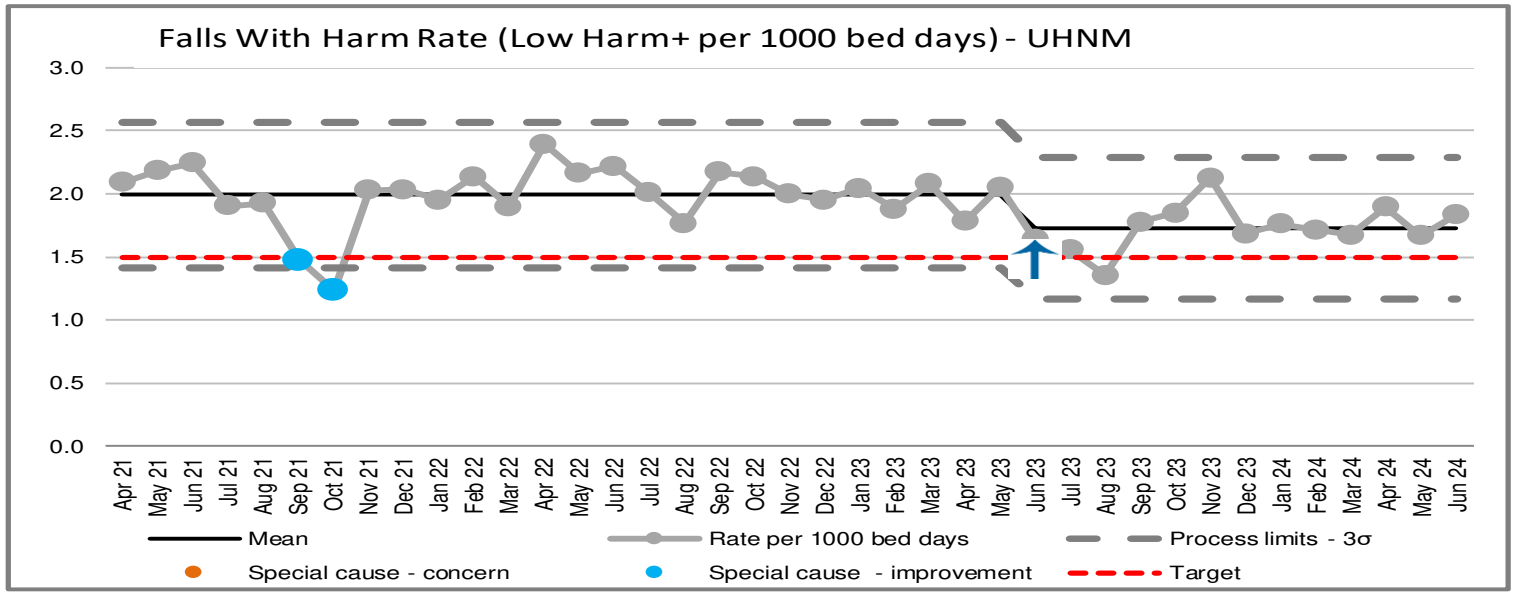
Falls audits have been completed on the top reporting areas

New falls Champion training has been advertised and the next 2 sessions will take place this month.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
1.5	1.9	1.7	1.8

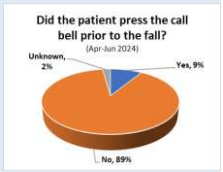
Background

The rate of patient falls reported with low harm or above per 1000 bed days. Excludes collapses and managed falls

What is the data telling us?

The rate of patient falls with harm has also been significantly lower since June 2023. The rate was within expected range in June 2024.

Wards with falls reported as resulting in serious injuries in June (7 incidents):
Stoke AMU, FEAU, Ward 221, Ward 127, Ward 225, Discharge Lounge, Specialised Decisions Unit



What are we doing about it?

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

Discharge Lounge are caring for patients outside of the SOP criteria. Documentation is not adequate for the patients that are in the unit for longer. Discussions have taken place with Matron of the area.

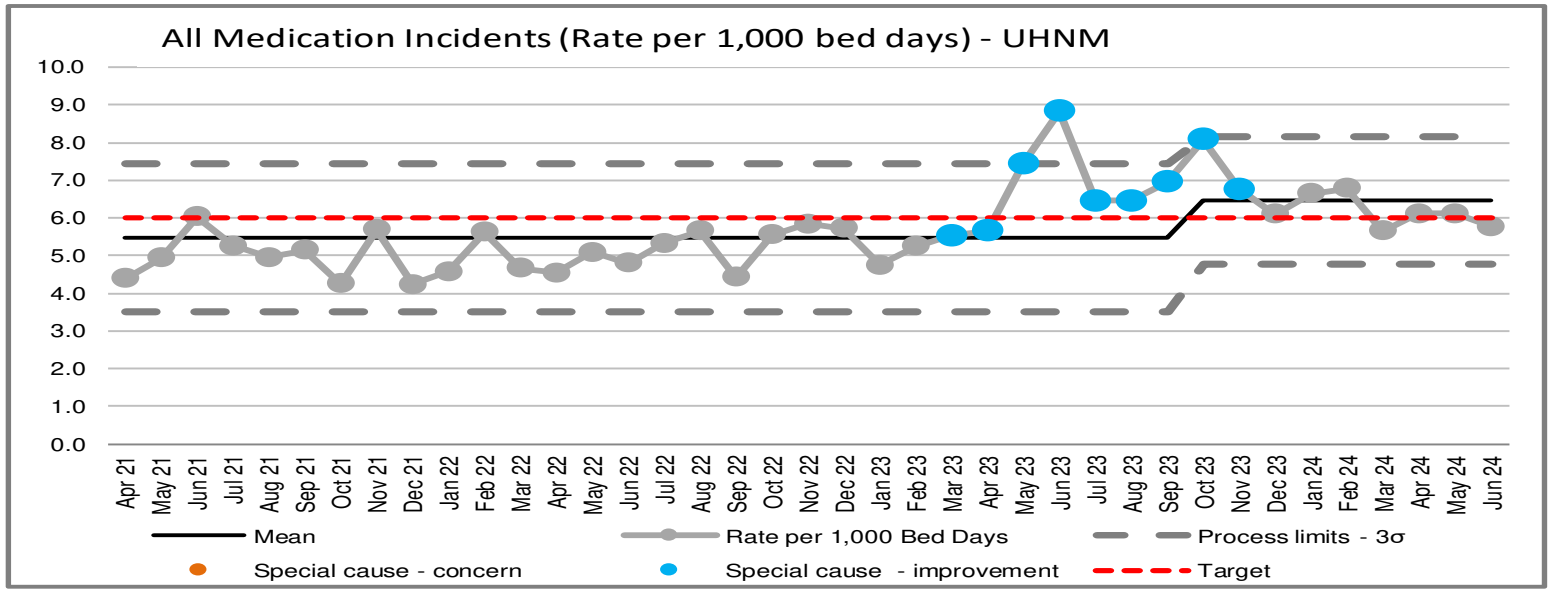
Data remains to show that only 9% of those patients that have fallen have pressed the call bell prior to the fall. A global e-mail has been delivered to the wards to request that they disseminate this information to the wards to encourage the patients to use the call bell. Documentation asks the questions if the patient has the call bell, can they use the call bell and if they are unable to what are the alternative measures put in place and have the staff explained to the patient why it is important that they ask for assistance. Every opportunity is taken to discuss this point with staff.

The team continue to work with all areas, this includes audits, spot checks, 1:1 discussion with staff on walkabouts, multiple fallers, training, PSIRFS and action plans.

High Quality | [Medication Incidents per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

NRLS Mean	Apr 24	May 24	Jun 24
6.0	6.1	6.1	5.8

Background

Reported Medication incidents rate per 1,000 bed days

What is the data telling us?

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

What are we doing about it?

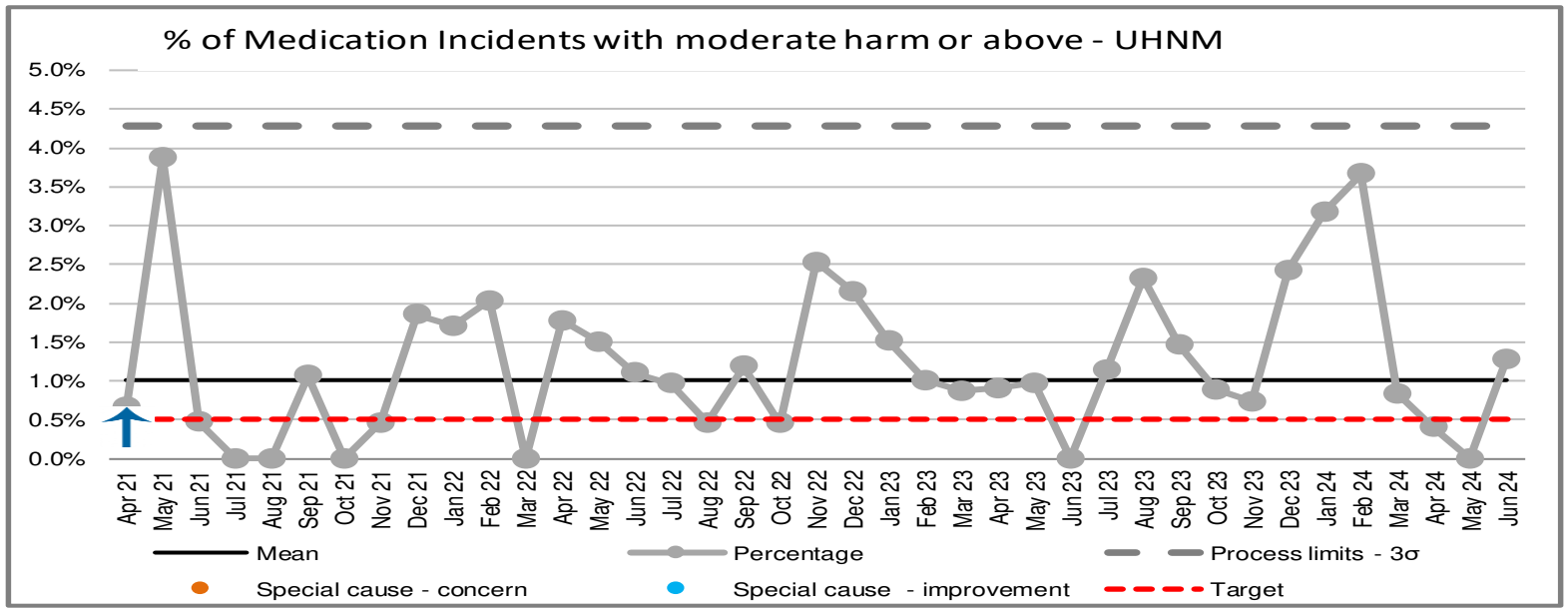
Pharmacy Team reviewed all incidents relating to missed doses and identified that the top categories for missed doses were anticoagulants, antimicrobials, insulins and anti-epileptic medicines. In order to support wards and departments in addressing the missed doses the Pharmacy Team developed key actions for the wards.

The Pharmacy Safe Medications Team have circulated QR code questionnaire to staff via Quality Nurses for feedback on reasons why there has been reduction in reporting in recent months.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
0.5%	0.40%	0.00%	1.27%

Background

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

What is the data telling us?

The number of medication incidents reported with moderate harm or above has been reducing recently following increase during January 2024 (as per overall PSIs). The overall trend for medication incidents with moderate harm or above has been around the long term mean even when there were noted increases in overall medication related incidents reported.

This demonstrates that there are lower numbers of patients suffering harm as result of the reported errors and actions being taken to prevent serious harm.

What are we doing about it?

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

High Quality | [Never Events per month]

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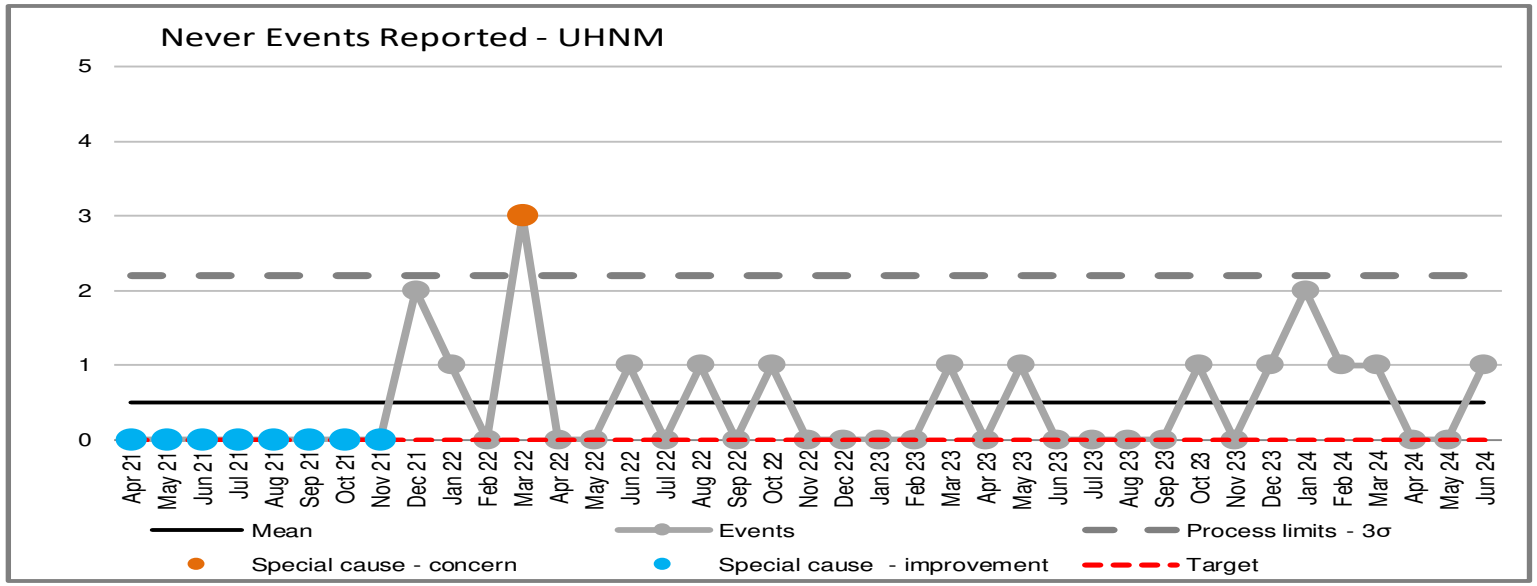

Variation	Assurance

Target	Apr 24	May 24	Jun 24
0	0	0	1

Background

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

What is the data telling us?

There has been 1 new reported Never Events during June 2024. Under SPC rules normal variation following previously logged incidents during 2023/2024.

What are we doing about it?

The latest Never Events reported during 2024 which relate to Wrong site surgery (incorrect lesions removed or biopsy) are under review within specialised Surgery services utilising PSIRF Patient Safety Incident Investigation along with thematic review of these new incidents and previously reported wrong site surgery / incorrect lesion removed from previous years to assess the actions and system solutions to mitigate these type of incidents.

High Quality | [Duty of Candour – verbal/formal notification]

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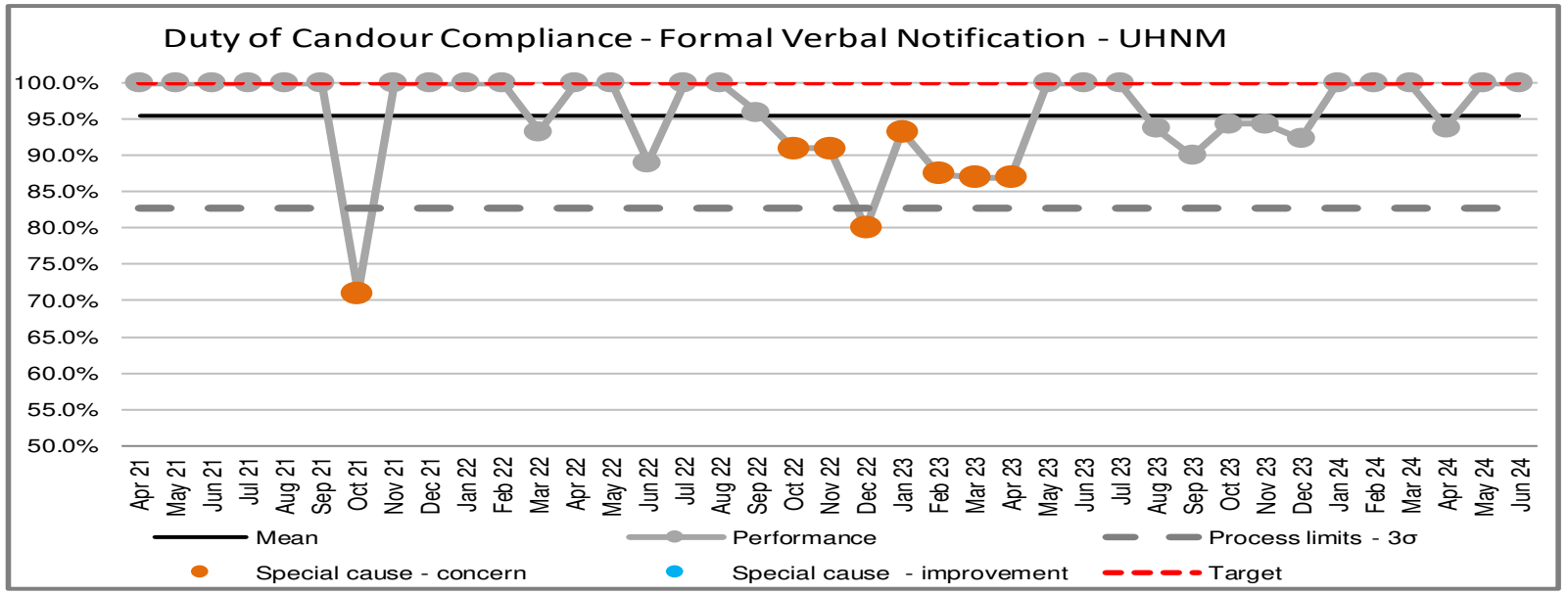

Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
100%	93.8%	100.0%	100.0%

Background

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

What is the data telling us?

The achievement of verbal duty of Candour has been inconsistent with the recording of the completion of this in Datix. During June 2024 we have noted all cases had verbal Duty of Candour completed out of 22 total cases.

What are we doing about it?

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

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

High Quality | [Duty of Candour – written notification]

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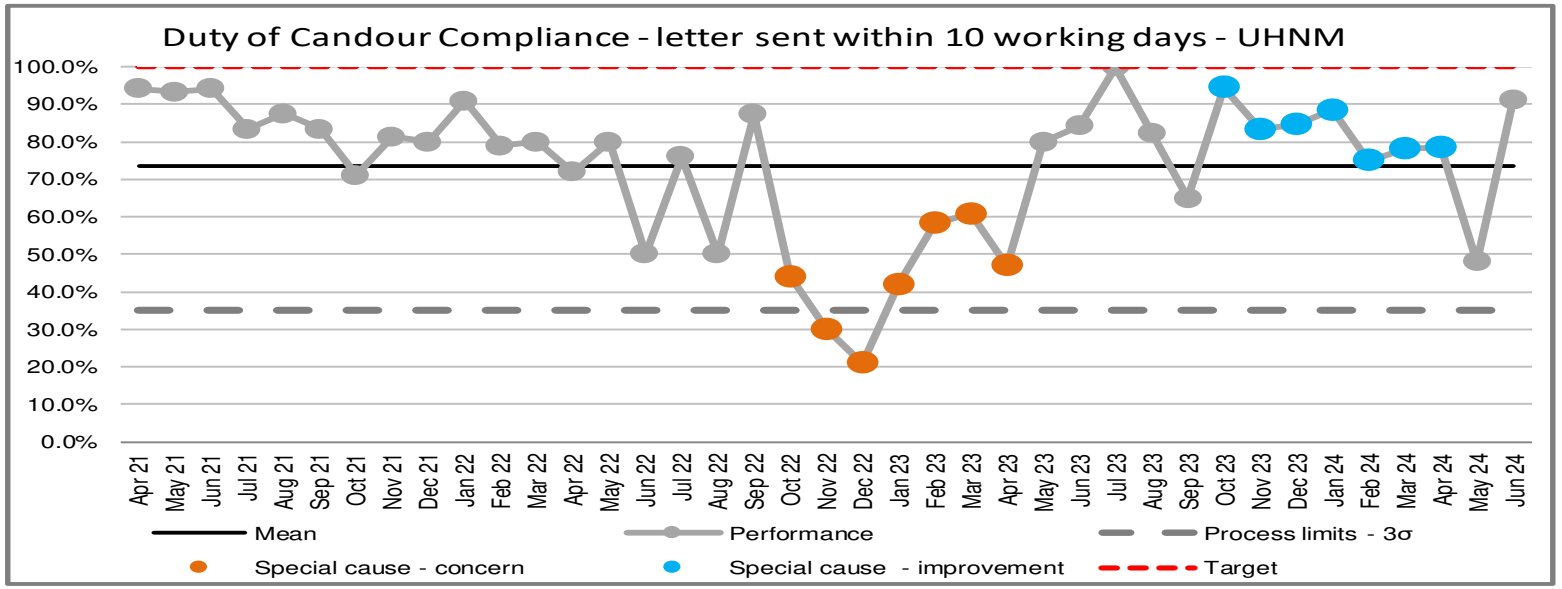

Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
100%	78.6%	48.0%	91.0%

Background

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

What is the data telling us?

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

Following fall in compliance during May, June has seen an improvement with 20 cases out of the 22 meeting the internal 10 day target at 91%.

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

What are we doing about it?

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

Divisions have instigated new escalation processes to try and support teams further in completing these letters within the timeframes

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

Provide safe, effective and caring services

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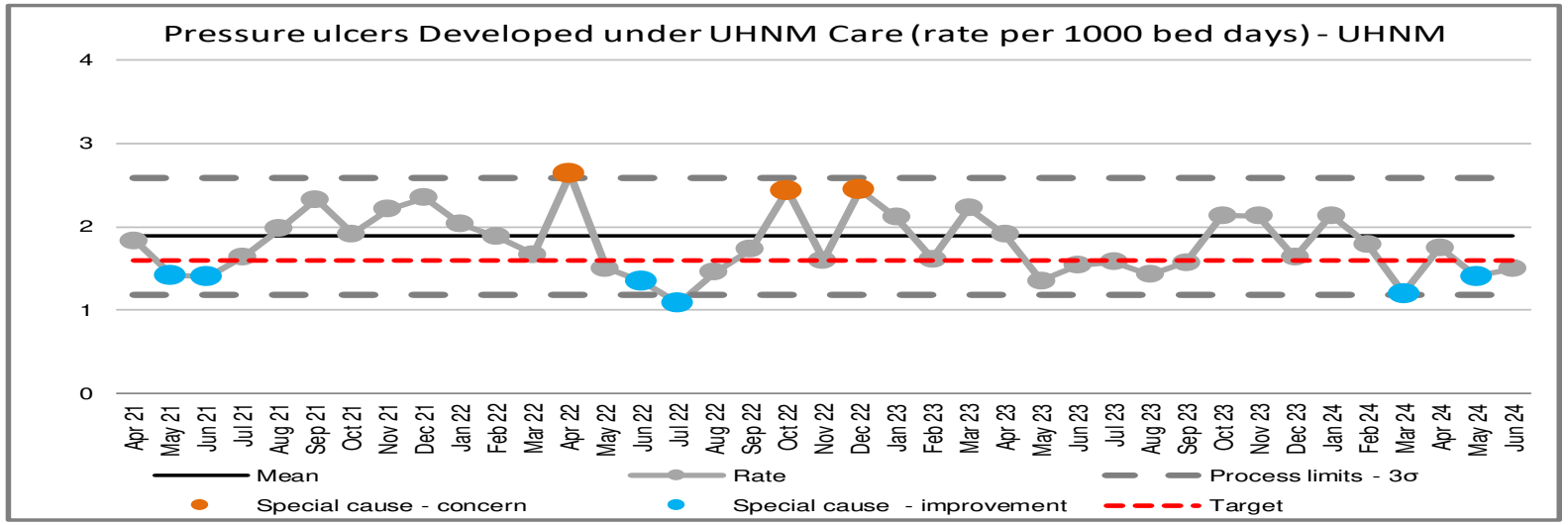


Variation	Assurance

Target	Apr 24	May 24	Jun 24
1.6	1.75	1.40	1.49

Background

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

What is the data telling us?

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in June.

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

As well as pressure ulcers, 11 urethral splits were reported in June, 4 with lapses identified (4 TBC).

What are we doing about it?

Education available for pressure prevention, continence, wound assessment, and lower limb.

Aim for ESR package to be completed and presented at steering group at end of July

Involvement of therapy teams to support completion of documentation for pressure prevention.

To commence a focus of the month to share Trust wide.

The Corporate team have completed an A3 for pressure damage developing under UHNM care, a draft has been sent to QSOG. A report will now go to QGC.

Further chairs to be purchased, costings are with procurement.

Peer review for the pressure prevention audit on Tendable agreed to be completed by medicine.

The skin health booklet is being is currently with Harlow being formatted. Education will be rolled out prior to release of the booklet.

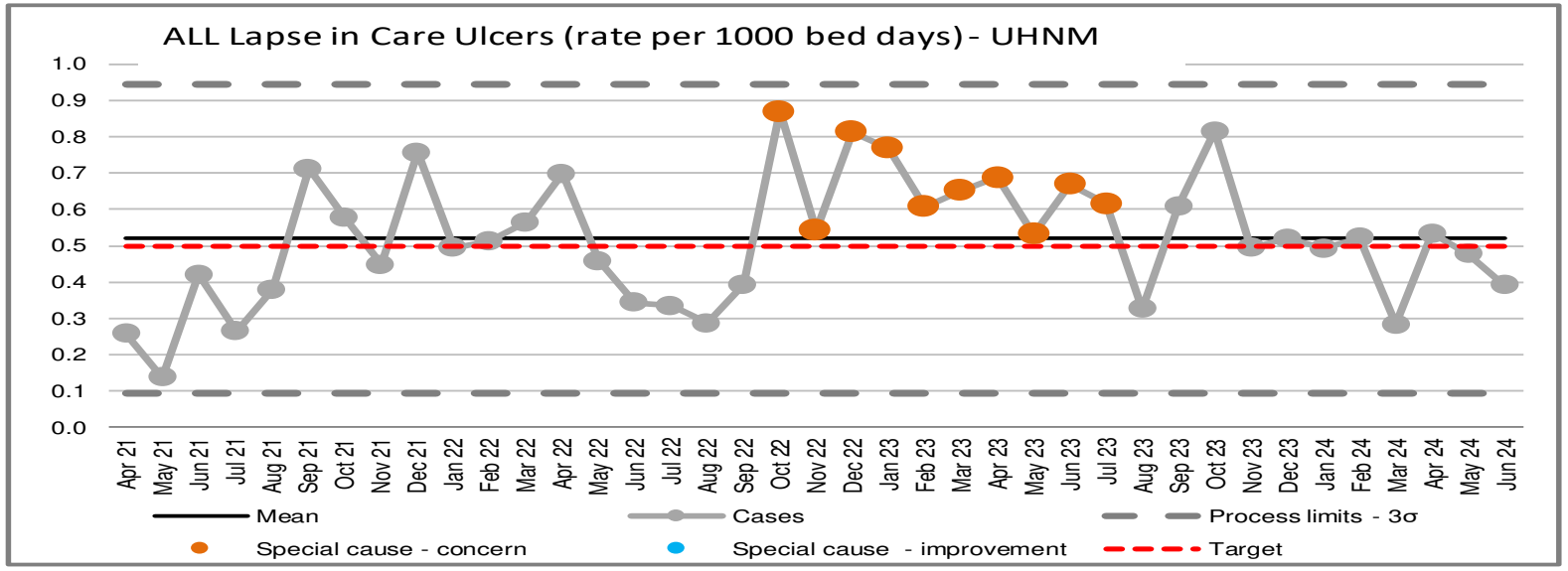
Critical care has commenced an evaluation by using Cavilon as preventative measure.

ED has commenced a mattress evaluation following no longer using the Repose Companion

High Quality | [Pressure ulcers with lapses in care per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
0.5	0.53	0.48	0.39

Background

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

Root Cause(s) of damage - Lapses - Apr 2024	Total
Management of repositioning	10
Management of device	6
Management of heel offloading	3

What is the data telling us?

The rate of pressure ulcers with lapses in care identified was within expected range in June. The most common lapses in care identified are shown in the table above right.

Wards with more than case with a one lapse in care identified to date for June are: Stoke ED (3) and Ward 15 (1 patient with both heel and buttock damage reported 6 days apart)

34% of Pressures Ulcers developed under UHNM Care were identified with lapses in care to date in May. (This figure is not quoted for the latest month, June, because a number of cases remained to be checked for lapses on the 3rd of the month when the data snapshot was taken).

What are we doing about it?

PSIRF toolkits are completed when lapses in care identified and actions to be implemented.
Multiple reporting areas are invited to an assurance panel to present learning and assurances from incidents. Weekly visits from Quality and safety team to support improvements,.
Multiple reporting areas for June were ED Stoke, 201, 120, 121, 12, 108 and AMU Stoke.
Category 4 incidents all been booked for MDT meetings for learning to be identified and shared.
Purpose T to be implemented to support with holistic assessments being completed.
Protocol for HA cat 2's for Matrons and senior nurses currently being evaluated on ward 128 for the management of category 2's at ward level. Ward 225 have commenced the education.
Promoting involvement of therapy teams with completing documentation.
Consultant connects to potentially be evaluated in ED and AMU. Currently looking at devices and generic email accounts.

High Quality | [Reported C Diff cases per month]

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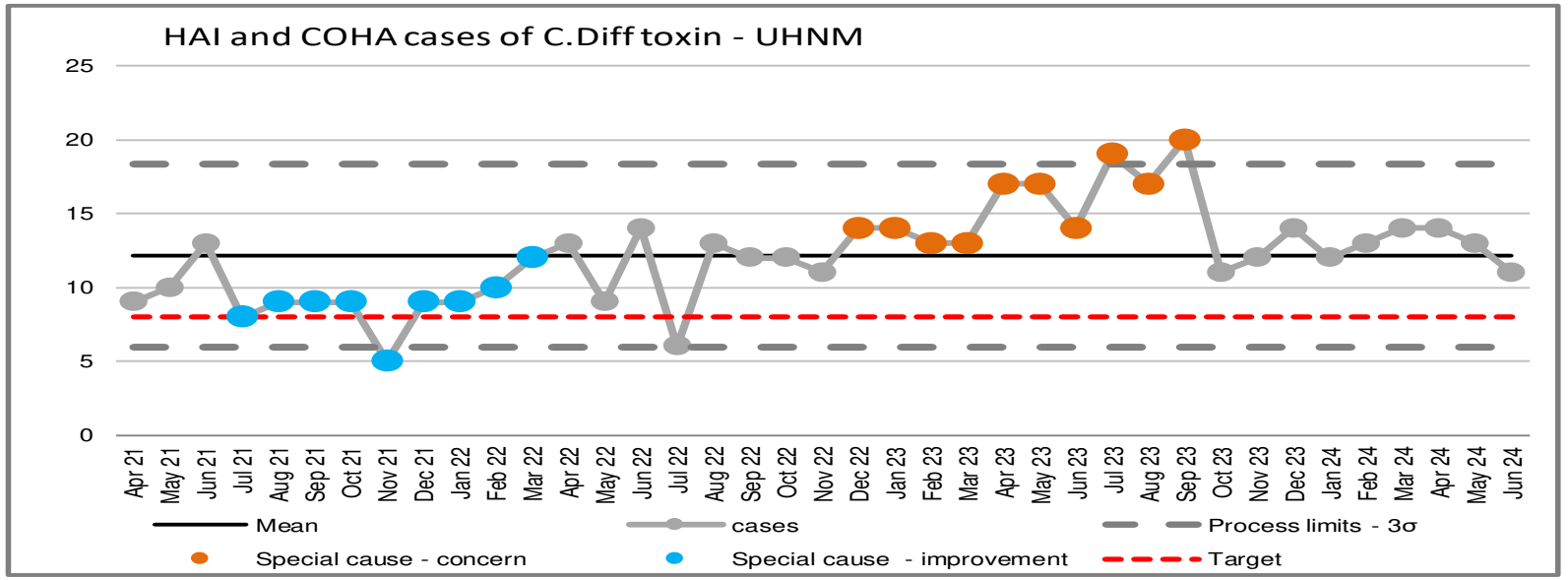

Variation	Assurance

Target	Apr 24	May 24	Jun 24
8	14	13	11

Background

Number of HAI + COHA cases reported by month

What is the data telling us?

Number of Cdiff cases despite reducing are still above trajectory and remain a concern
There have been 11 reported C diff cases in June 2024. 5 x HAI and 6 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 June . Where ribotypes are different person to person transmission is unlikely.

- Ward 15 x 3 HAI (May x 1, June x 2) different ribotypes
- Ward 14 x 2 HAI (May x 1, June x 1) different ribotypes
- FEAU 1 x HAI 1 x COHA – unable to ribotype

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Task and Finish Group for West Building is in place
- CURB -95 score added to CAP antimicrobial Microguide .
- CURB - 95 Score and UTI work discussed at the Weekly Clinical Group
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Relaunch of the pooh help line and timely sending of stool samples
- Big bed clean

High Quality | [Friends & Family Test - Inpatients]

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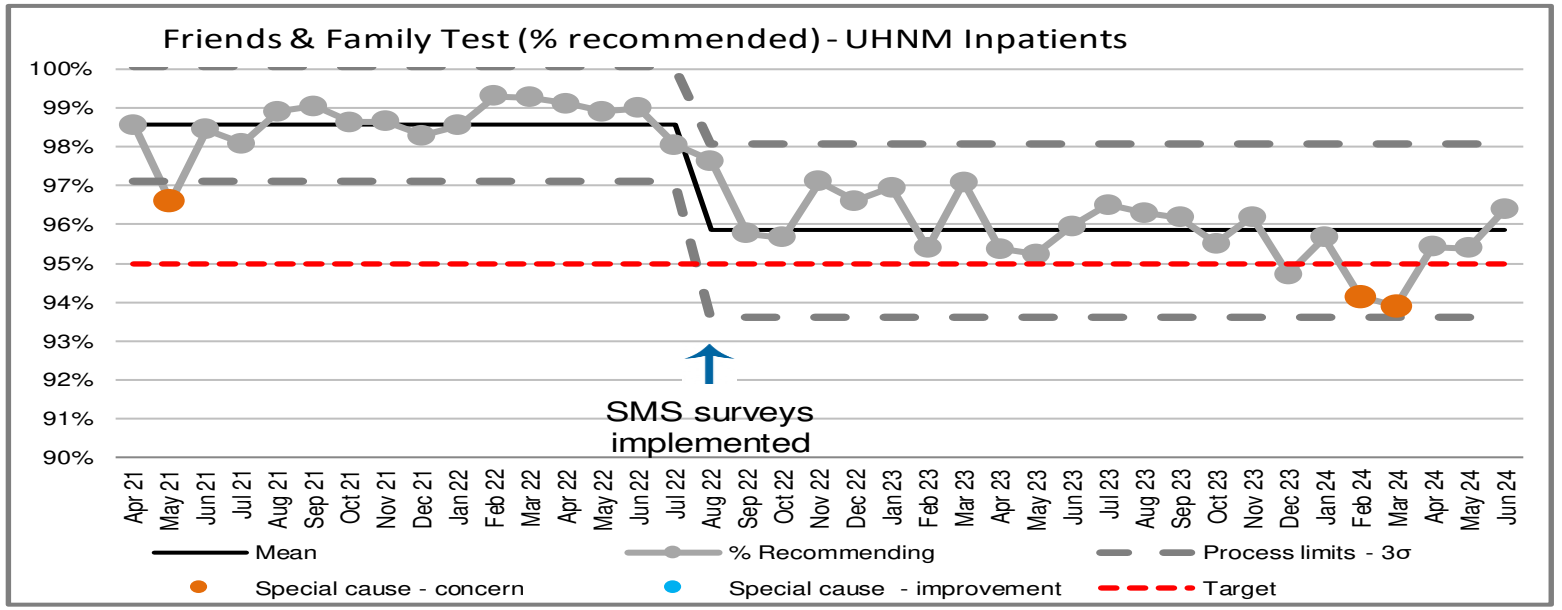

Variation	Assurance

Target	Apr 24	May 24	Jun 24
95%	95.4%	95.4%	96.4%

Background

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

What is the data telling us?

The monthly satisfaction rate for inpatient areas was within expected limits in June 2024. The average rate remains above the national average of 94% (April 2024 NHS England).

In June 2024, a total of 2488 responses were collected from 67 inpatient and day case areas (11284 discharges) equating to a 22% return rate which is slightly lower than last month and lower than the internal target of 30%. UHNM have the 16th highest response rate for all reporting Trusts in the country (152) and are 81st for percentage positive responses (NHS England April 24 latest data)

What are we doing about it?

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- a new task & finish group is being set up to include Patient Rep and PSP
Pain management
Involvement in care and decision making
Improving the experience of our oncology patients

High Quality | [Friends & Family Test - ED]

Provide safe, effective and caring services

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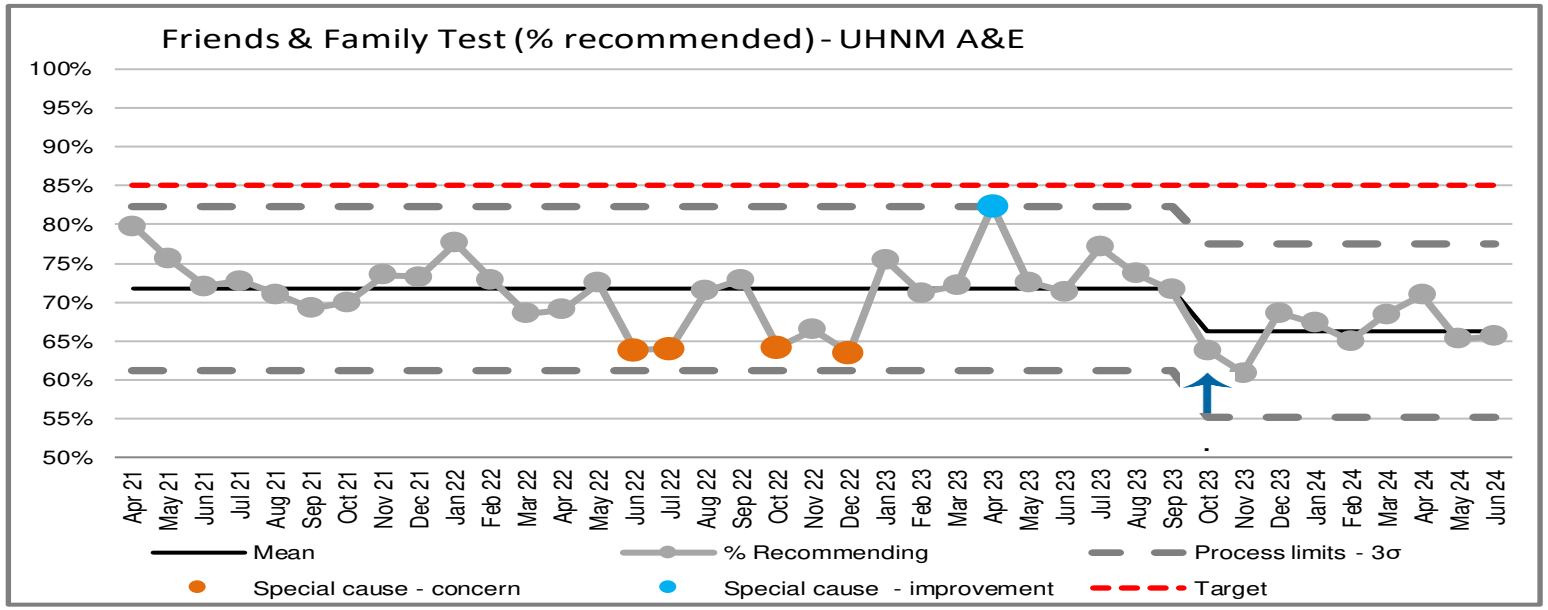

Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
85%	70.9%	65.3%	65.6%

Background

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

What is the data telling us?

The overall satisfaction rate for our EDs was within expected limits in June 2024, but has been significantly lower on average since October 2023.
The Trust received 1253 responses which was 8% and remains the same as the previous month. The Trust's overall satisfaction rate is on parr with the national average of 79% (NHS England April 24- latest figures) .UHNM is 39th out of 124 Trusts for the number of responses in ED (NHS England April 24), and 87th out of 124 Trusts for the percentage positive results.

Feedback from patient experience of using 111First and the kiosks continues to be monitored with 21% of respondents in June 2024 reported to have used 111First prior to attending ED, which is a decrease on the previous few months. Key themes from June 2024 continue to be communication, staff attitude, long waits – all across both sites.

What are we doing about it?

QR code made visible throughout the department.
Consideration to alternative methods of sharing QR code such as "business cards" available on reception and throughout the department.

'You said we did' board in waiting room.

High Quality | [Friends & Family Test - Maternity]

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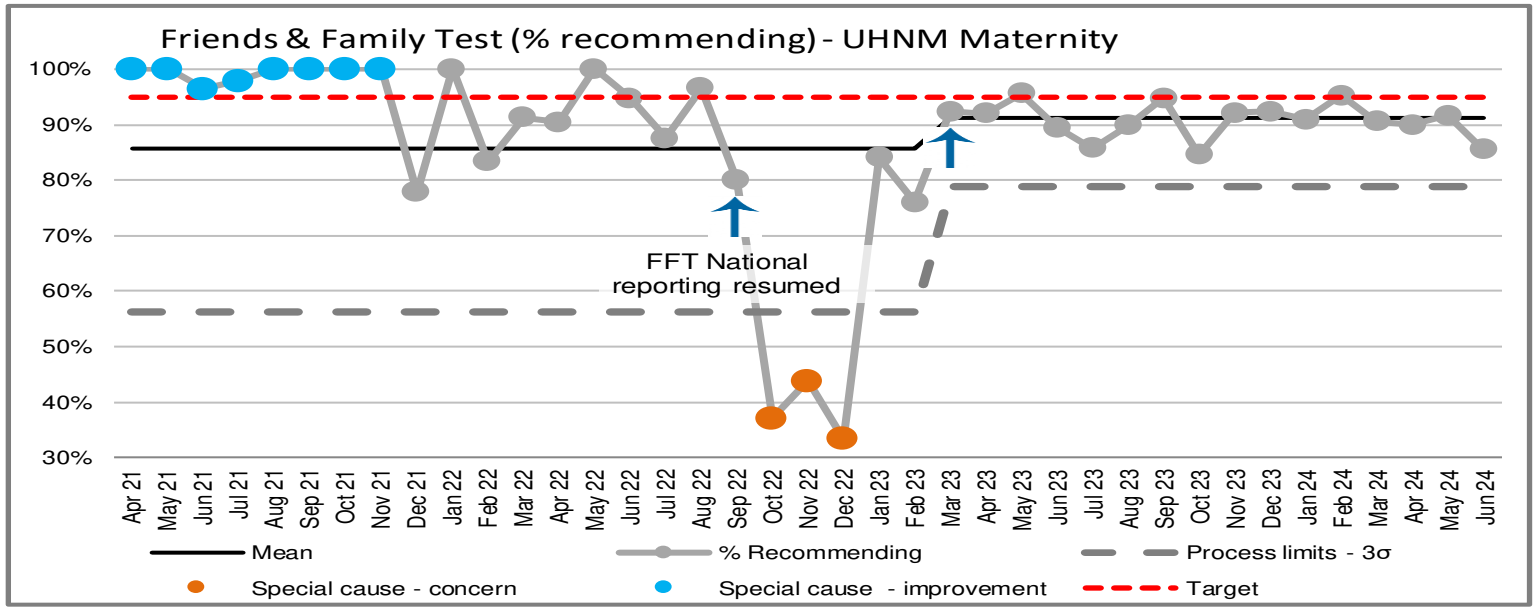

Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
95%	90.0%	91.6%	85.5%

Background

FFT Maternity % patients Recommending Service

What is the data telling us?

The average % recommending has been stable since 2023, a little below the 95% target.
There were a total of 145 surveys were received in June 2024 across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 71 of these being collected for the "Birth" touch-point, providing a 14% response rate (based on number of live births) an 80% satisfaction score which is an increase on the previous month's figures.
The Antenatal touch point scored 88% recommendation (24 surveys) which is decrease on the previous month (93%). The post-natal ward touch point scored 90% satisfaction rate (40 surveys) which an increase in satisfaction percentage (88%).
Compared to the latest national data available (April 24) out of 112 reporting Trusts, UHNM were 64th for number of responses for antenatal & 79th for percentage positive; 54th for number of responses for birth & 83rd for percentage positive, 50th for post-natal ward & 48th for percentage positive; and 36th for post-natal community & 33rd for percentage positive.

What are we doing about it?

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

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

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

High Quality | [VTE Risk Assessment Completion]

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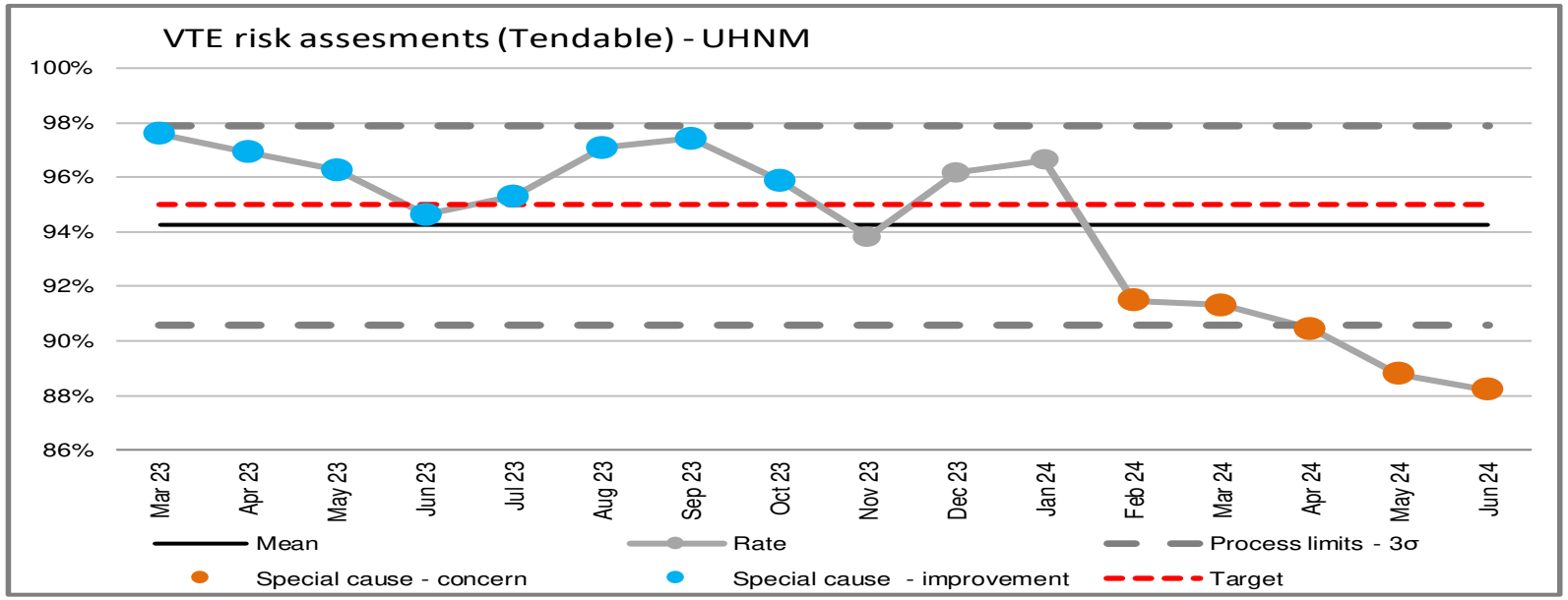

Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
95%	90.4%	88.8%	88.2%

Background

The percentage of patients assessed for risk of VTE within 12 hours of admission to hospital (Source: Tendable)

What is the data telling us?

The NICE standard is for initial VTE risk assessment to be carried out within 12 hours of admission and the national target is 95%.

Wards are asked to audit the VTE assessment in 10 sets of patient notes per month, using Tendable and this provides assurance. The question asked on Tendable is "Has the VTE risk assessment been completed within 12 hours of admission?"

At least 350 patient records a month have been audited since June 2023. Reported compliance has been significantly lower since February 2024 which may be due to work with Quality Nurses to encourage rigorous audit standards.

What are we doing about it?

A recent audit conducted of all inpatient areas highlighted that 91% of patients had at least a partial VTE risk assessment completed on admission (within 12 hours), compliance is poor due to the recording of a date and time on the risk assessment to determine when it was completed. From the data collected there were only 2 patients that had their assessment completed outside of the 12-hour window that had a recorded date and time.
ePMA once introduced will provide accurate assurance of VTE risk assessment completion.
Communications have been sent via all Clinical leads and Ward managers, within the UHNM Bulletin, Current news and the Quality & Safety Newsletter to raise awareness of the importance of recording an accurate a date and time, areas with the lowest compliance are also being visited by SSR Quality & Safety .

Notification has been received that national data collection is resuming in April 2024 having been suspended since 2020, and data from Tendable is to be submitted..

High Quality | [Hospital Associated Thrombosis rate]

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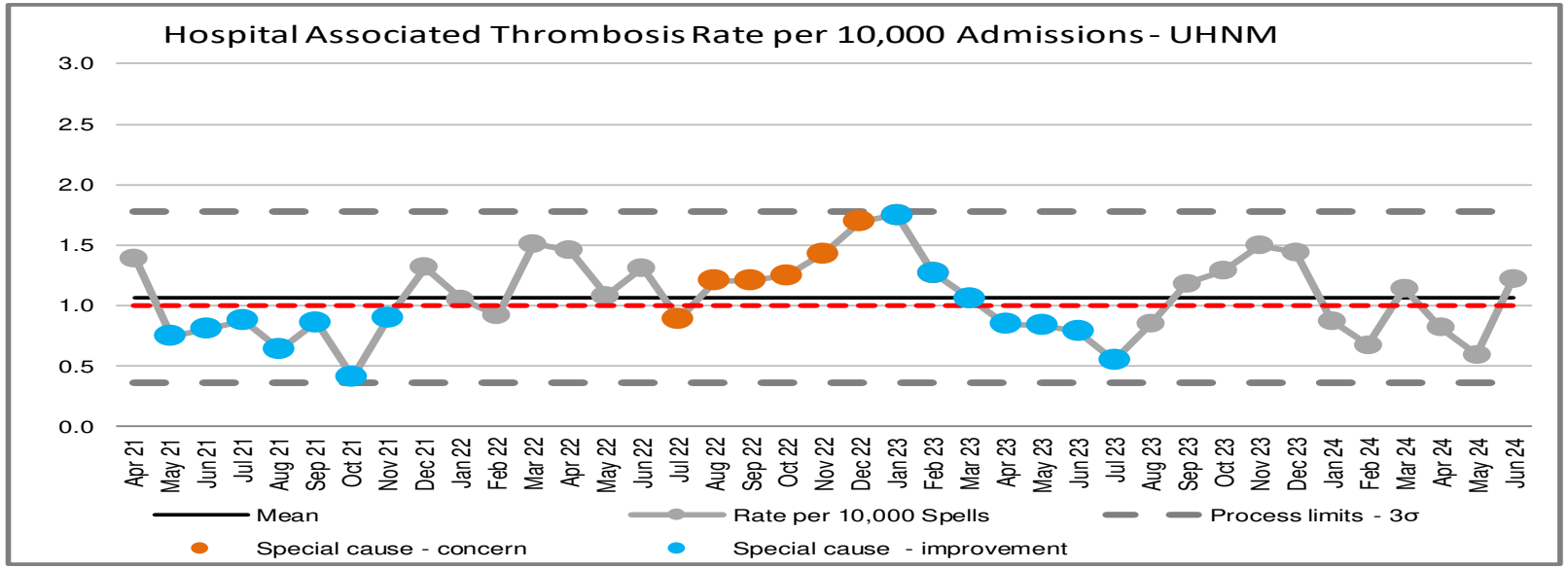

Variation	Assurance

Target	Apr 24	May 24	Jun 24
1	0.82	0.60	1.23

Background

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

What is the data telling us?

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

What are we doing about it?

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

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

Recent Preventable HAT's will be reviewed as part of a thematic review being undertaken by the VTE steering Group

High Quality | [Sepsis – Adult Inpatient]

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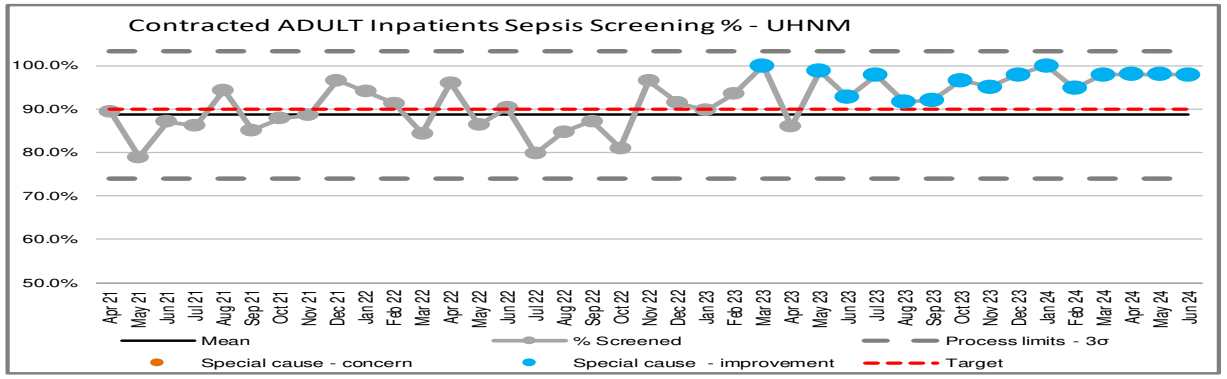
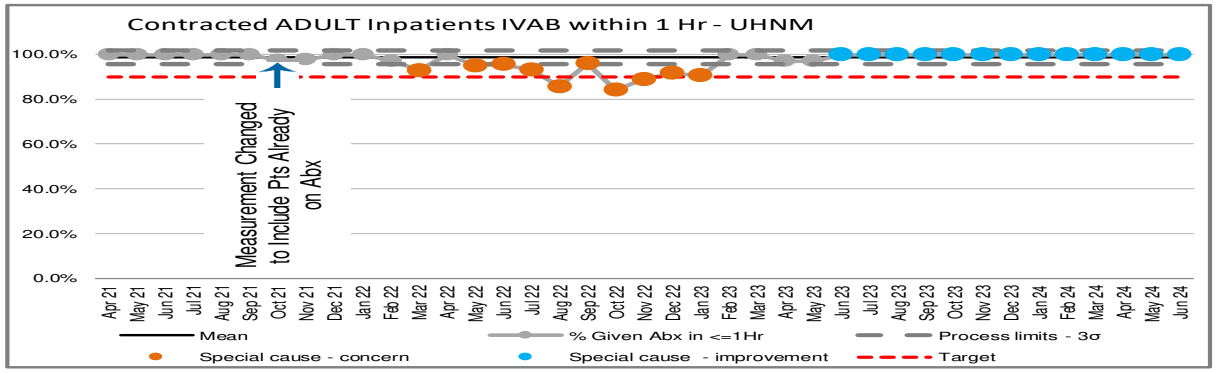


Variation	Assurance
H	?

Target	Apr 24	May 24	Jun 24
90%	98.0%	98.0%	97.9%

Background

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



Variation	Assurance
H	P

Target	Apr 24	May 24	Jun 24
90%	100.0%	100.0%	100.0%

Background

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

What is the data telling us?

Inpatient areas achieved the screening and IVAB within the 1 hour target for June 2024.

There were 96 cases audited with 2 missed screening. Out of 96 cases audited 64 were identified as red flag sepsis with 36 having alternative diagnosis. 28 patients were already on IVAB treatment.

All true red flag sepsis patients received IVAB within 1 hour.

What are we doing about it?

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

The sepsis team continue to raise awareness of the importance of sepsis screening and IVAB compliance by being involved in HCA induction and qualified nurses preceptorship programmes.

High Quality | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

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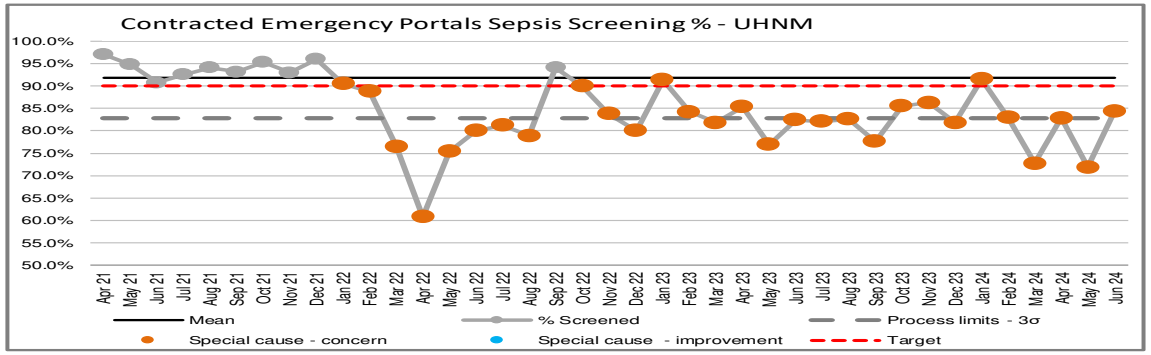
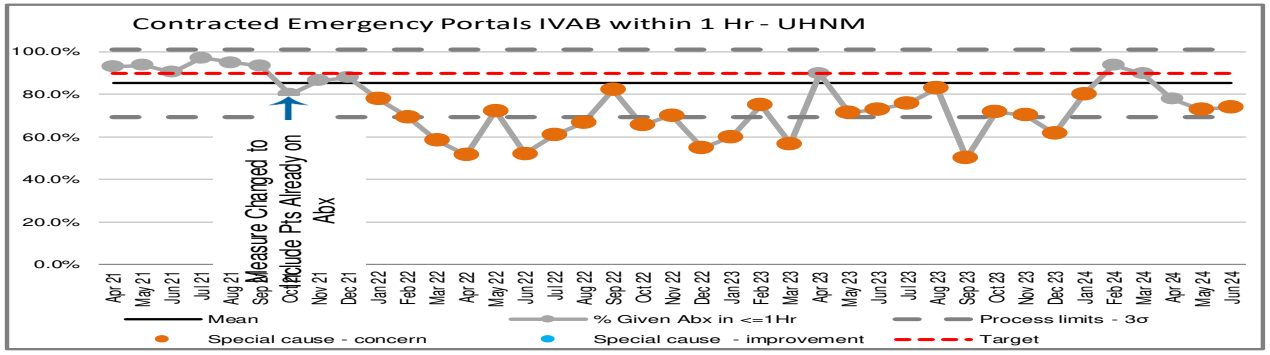


Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
90%	83%	72%	84%

Background

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



Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
90%	78%	73%	74%

Background

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

What is the data telling us?

Adult Emergency portals screening did not meet the target for June 2024. Contributed to ED at both sites and AMU County. There were 102 cases audited with 16 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 74.1 %

Out of 102 cases there were 86 red flag sepsis in which 22 patients were already on IVAB. 28 patients had an alternative diagnosis leaving 36 newly identified sepsis 15 patients received IVAB outside the target 1 hour window with 4 patients greater than a 2 hours delay.

What are we doing about it?

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

High Quality | [Sepsis – Children]

Provide safe, effective and caring services

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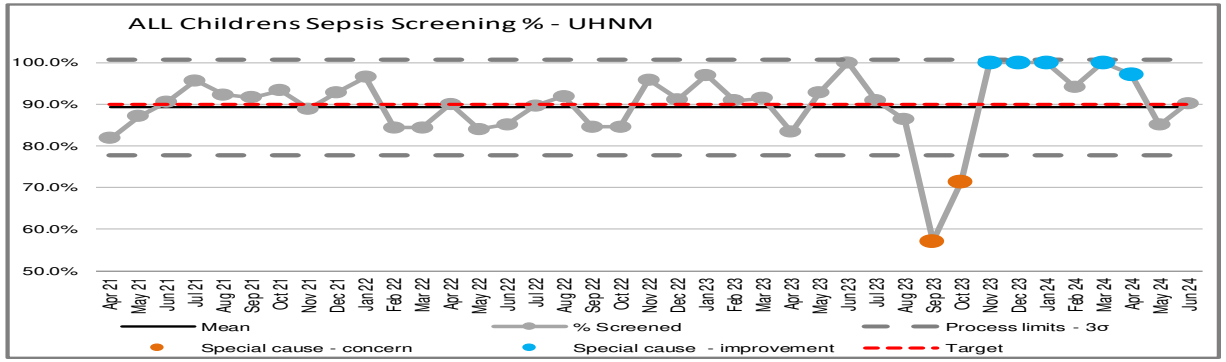
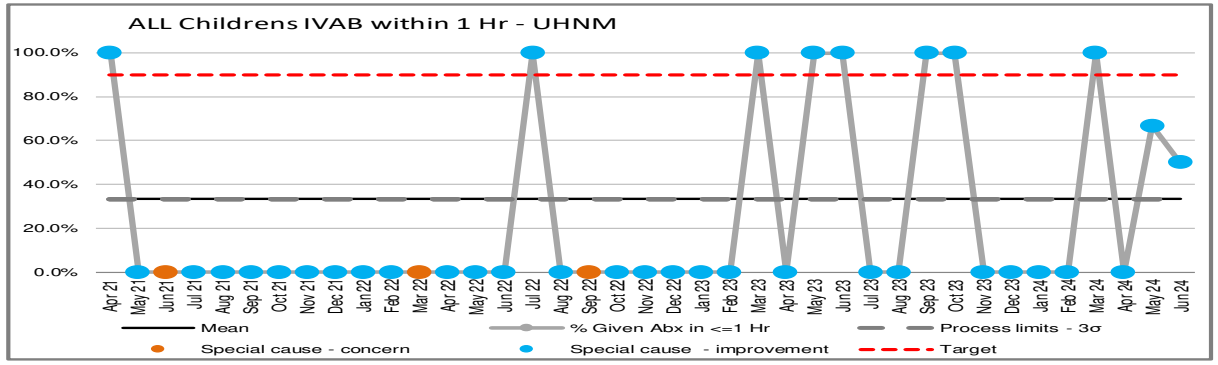


Variation	Assurance
	?

Target	Apr 24	May 24	Jun 24
90%	97.1%	85.0%	90.2%

Background

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



Variation	Assurance
H	F

Target	Apr 24	May 24	Jun 24
90%	n/a	66.7%	50.0%

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?

We are still seeing a small number of children trigger with PEWS >5 and above inpatient areas. Most inpatient paediatrics are already on oral or IV antibiotics prior to trigger of PEWS >5

There were 43 cases audited for emergency portals with 1 missed screening.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

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

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

High Quality | [Sepsis – Maternity]

Provide safe, effective and caring services

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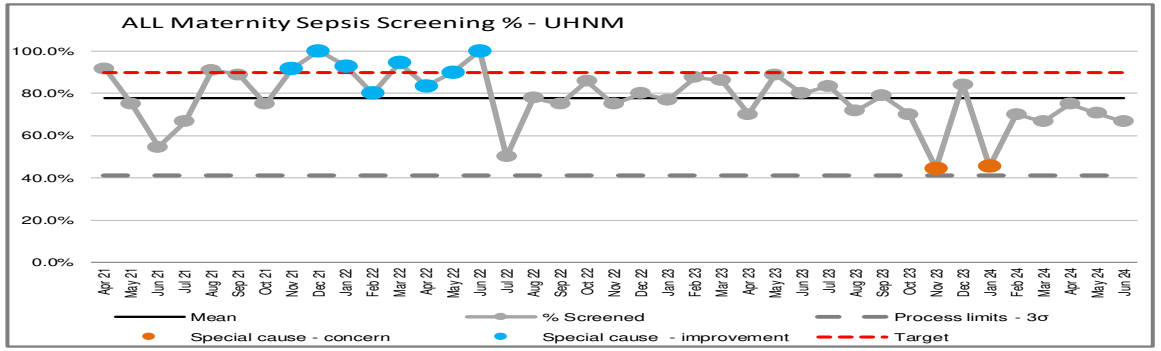
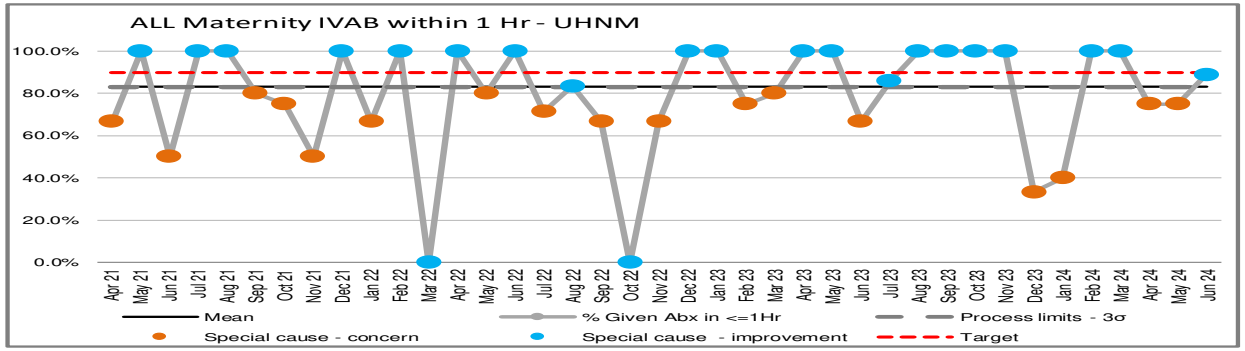


Variation	Assurance

Target	Apr 24	May 24	Jun 24
90%	75.0%	70.6%	66.7%

Background

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



Variation	Assurance

Target	Apr 24	May 24	Jun 24
90%	75%	75%	89%

Background

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

What is the data telling us?

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

There were 22 cases audited from emergency portal MAU with 7 missed screenings. Inpatient had 5 cases audited with 2 missed screenings. (has been escalated but no documentation in the screening tool)

What are we doing about it?

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

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

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

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

The 4-hr performance standard is 76% climbing to 78% in March 2025. June validated position is 71% which is 0.5% below the May outturn but is 0.7% above the agreed and submitted improvement trajectory. This is the fourth consecutive month in a row where we have achieved over 70% and this has not been achieved since 2021. During the month of June, we achieved above the 78% standard once in June (79.4% on 27 June) for overall compliance on combined type 1-3. Our relative performance was largely within 3rd quartile of Trusts, however in 2024/25 several Trusts previously not reporting as part of the Clinical Standards Trial have now restarted which means despite seeing some of our best performance since 2021, we are still ranked in the third quartile for ED performance and 12hr waits.

Below is the submitted 4hr standard improvement target which forecasts our anticipated improvements. The largest contributions to this trajectory are a step change in September based on the expected impact of the Same Day Emergency Care new unit; a recognised deterioration from November to January from winter pressures and then a step up in February and March were the combined improvement plans for Urgent and Emergency Care will mature.

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
69.2%	69.8%	70.3%	70.2%	70.7%	72.1%	72.0%	70.6%	69.2%	66.6%	72.4%	78.0%

June has seen an increase in the number of 12-hour trolley waits and aggregated time of arrival greater than 12-hours. Whilst this is still an overall improving picture comparison with previous years seasonal variation indicates the level of improvement is not as great as in the last two years. This suggests that growth of inpatient demand continues to be largely unmet.

Ambulance handover and response time data released is a month in arrears. The Category 2 response time for ambulance services mean recorded for , based on a 4-week average was 27 minutes and 56 seconds. This was an improvement of 66 seconds from previous month. The System based trajectory submitted Cat 2 mean time improvement which assumes a 15% improvement June to August and reduction of 20% from September to March. In addition, the system is developing a recovery plan to address the extreme delays in ambulance offload to support the Cat 2 mean response.

Elective

We met the cancer 28-day diagnostic performance standard for the first time in February, and this was maintained in March. Maintaining the improvements was more challenging during April as predicted, however we overachieved against trajectory in May and June, achieving 75.4% in June.

Cancer 62-day standards had shown four consecutive months of improvement, however as predicted, May position deteriorated slightly due to April's 28 day FDS position, this did however still remain in trajectory. The June position continues to be validated and currently performance is under trajectory at 60.5%. Whilst there has been improvement in several tumour sites; Breast and Skin notably, others remain challenged due in the main to diagnostic delays in pathways, this is expected to improve as endoscopy capacity increases. The focus continues to be on improving the position to produce improvement against the standard.

As predicted, there has been a reduction in 6week diagnostic performance related in the main to Endoscopy. This has occurred due to the prioritisation of patients on a >65/78w pathway whilst also continuing to protect 2ww capacity. Non-obstetric ultrasound performance has also reduced and without additional capacity the position is likely to deteriorate further. A plan to address this is being developed.

The number of patients waiting 78 weeks or more post validation ended at 12 for June, 26 less than in May. 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. The 0 trajectory is now planned for July.

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

We remain within our expected trajectory for Emergency Department attendances - June activity out turned 23,869 attendances verses 25,548 in May which equates to a 6.58% decrease. Flow for our patients in our Emergency Departments requiring inpatient treatment has improved but is still below the daily requirement to hit the end of year standard. The non-admitted pathway, during June, has been strong in core hours but deteriorates out of hours and overnight.

The number of 12-hour waits increased in June (871pts in June compared to 701pts in May). The availability of medical inpatient beds and timeliness of accessing is primary issue. The expectation and standard associated with Clinically Ready to Proceed is within 60 minutes of final intervention by the emergency department and is set at 95%. June achieved 49.23% of our patients accessed their onward pathway in that time which is a slight improvement of 2.23%

Both the capacity of Emergency Departments (overcrowding) and the profile of ambulance arrivals (variation can be 0 to 22 ambulances/hours) has impacted on the ability to offload in a timely manner. In addition to this UHNM and WMAS information systems continue to not align and have at times significant discrepancies in time waited by patients. This is being reviewed by Trust Auditors to examine whether this is an issue driving delays reported or in real time.

Elective

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 Q1 2024 and this will be required throughout 2024/25 with business cases being developed to right size the service permanently. Additional capacity is still due to come on-line from the 1st week of August with a mobile endoscopy unit.

Cancer treatment backlog reduction (62 day) continues at expected 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.

Our longest waiting patients over 78 weeks continue at a reducing trend, however there are challenges in patients waiting in the 65-week cohort; with particular focus on Gastro, Respiratory and ENT. These specialties all had successful Elective Recovery Fund (ERF) bids approved in June with additional capacity coming online through a combination of in-sourcing and TIs from July. There continues to be risks relating to data quality risk both internally and between independent sector partners. A plan to validate the WL using the Trust validation team and additional external validators is in development and a business case is expected to be developed to support a larger scale validation exercise using AI.

Jn Dr IA in June led to a cancellation of 221 patients (190 OP/23 DC and 8 Elective) Patients on a cancer pathway and our longest waiting patients were protected as much as possible, with all patients rebooked in July (excluding where patients chose otherwise).

Responsive | Overview

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University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

Work continues within workstreams 1, 2, 3 and 4 to improve our non-elective flow and responsiveness to meet demand, improve patient experience and safety. Resource for Workstream 2 (ward standard work – process improvement) is of risk and additional measures are being reviewed ahead of winter planning.

Having developed our internal Rapid ambulance handover protocol our longest offload times are reducing however at this stage we are not reducing the average handover time. There have been many more days of handover performance without significant delays and several days have now recorded no 60 minute delays at all. The ICB has confirmed funding to support the implementation of an hospital and ambulance liaison function and to improve timely handovers (and recording of those handovers.) This will be developed WMAS leadership teams.

Work progresses with the new Same Day Emergency Care Unit at Royal Stoke hospital site and is confirmed to become operational on 2 August 2024 and will be fully functional by the end of August.

Elective

Whilst Jnr doctor IA in June led to cancellation of 221 patients, we were able to protect our cancer and longest waiting patients in the main and all 221 patients were rebooked in July.

Endoscopy services continue their three-part improvement plan for the resolution of demand versus capacity. Following a procurement process, a supplier for the mobile unit was agreed in July and the unit is expected to be operational from the first week in August 2024. 727 patients will have their scope through the unit each month - this will reduce our surveillance/planned backlog and support diagnostic recovery in line with trajectory. In addition to this we will continue to insource additional capacity this has been supported by cancer alliance and ERF funding for Q1 24/25 with a further ERF bid for Q2-4 being agreed in June.
The 3rd element of the business cases for endoscopy recurrent staffing is currently in progress through governance structures and will be completed by September.

Phase 1 ERF cases for extra elective capacity through insourcing & WLIs to support the ongoing reduction in our longest waiting patients were approved and were mobilised albeit later than hoped due to the financial planning round. Phase 2 ERF cases were approved in June to commence in July for some of our most pressured 65-week specialties namely, Respiratory, ENT and Gastro, with trajectories amended to reflect this. We continue to micromanage the pathways of our longest waiting patients.

There is a focus on utilisation and productivity in theatres and outpatients; the exec led Divisional level finance, activity and performance meetings continue to support the divisional improvement work.

Data quality and failsafe reporting alongside validation have detailed workplans, and whilst there is a shortfall in our current validation capacity, we are contacting patients while they wait. Validation resource has been targeted at Respiratory, Gastro and ENT pathways. RTT and planned care administrative training is available, along with intermediate level, and a clinical RTT training module has been added. Improved links between RTT training and DQ outputs are being explored.

Cancer performance and the protection of capacity for cancer recovery will remain a focus for our elective capacity. This will include the ring fencing of funding for cancer improvement which if mobilised should deliver performance in line with our trajectories.

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

We expect our performance to follow our trajectory which considers the pressures over the summer months with incremental improvement as part of our Non-Elective Improvement Programme. We expect August/September to be the first step change in performance because of the new SDEC modular build.

Alongside improvements in 4-hour performance we expect 12 hour and ambulance handover delays to improve at this point. We have seen the correlation between improvements in flow and these indicators. Recognising this we must also put in place any actions accepted from the Audit on timely recording of ambulance handover times.

Elective

We have a continued focus on diagnostics and planned care, and the planning submission has reflected the challenged position for these areas. We have submitted a plan which has a trajectory of zero 78-weeks by July, and zero 65 weeks by September, however the 65 week position deteriorates before improvement is seen and achieving 78weeks has proven to be a significant challenge, albeit the number of patients affected are reducing and are expected to reduce in July. The diagnostics waiting time plan does not see us meeting the 6 week DM01 standard this year with the modalities of greatest concern being endoscopy for which there are a number of plans and Non-Obstetric Ultrasound, which still requires additional capacity to be signedd off and mobilised. Planned Care Improvement Group will continue its focus on data quality, both increasing pace of delivery and the expansion of validation capacity to improve the quality of patient pathway data.

Cancer services have the greatest protection of services (including cancer diagnostic services), and recovery trajectories are set to continue in 24/25.

The new Endoscopy capacity being delivered from August is expected to deliver a marked change in waiting times that will impact across surveillance, planned care and will bolster cancer pathways.

Responsive | Dashboard

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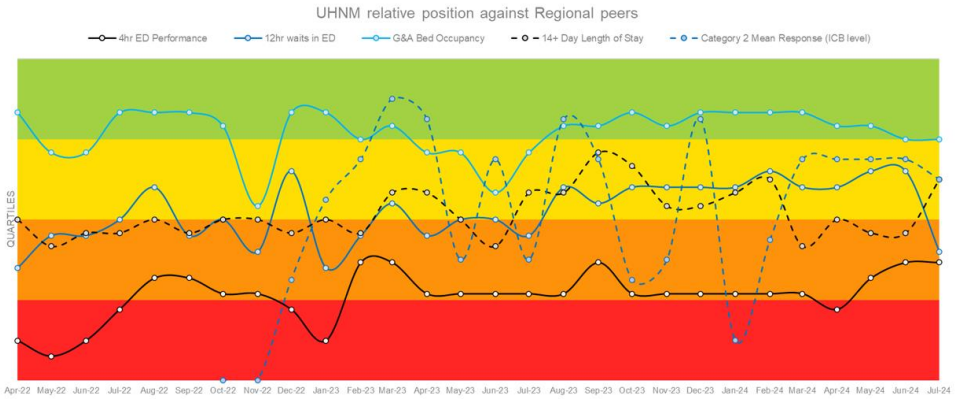
University Hospitals of North Midlands NHS Trust

Responsive

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
UEC 4 Hour Target	76%	71.5%	70.9%						
UEC 12 Hour Trolley Wait	0%	4.7%	6.2%						
UEC Cat 2 Handover Average Time	00:18:00	00:28:22	00:27:56						
Cancer 28 Day FDS	75%	75.8%	75.4%						
Cancer 31 Day Combined	96%	90.5%	86.0%						
Cancer 62 Day Combined	85%	67.9%	60.5%						
Diagnostics DM01 Performance	99%	68.6%	64.1%						
RTT No. of Patients Waiting >52 Weeks	0	5,156	5,169						
RTT No. of Patients Waiting >65 Weeks	0	1,137	1,429						
RTT No. of Patients Waiting >78 Weeks	0	34	16						
RTT No. of Patients Waiting >104 Weeks	0	7	7						
Treating patients in a timely manner (Hospital Combined Performance Score)	7,000	4,010	4,008						

Relative position against Midlands Trusts

For 4hr ED Performance, 12hr waiting in ED, G&A Bed Occupancy, 14+ day Length of Stay and WMAS Category 2 Mean Response*



*Monthly Category 2 Mean Response is a comparison between the 11 ICBs served by WMAS & EMAS and is extrapolated from weekly data which is only available from October 2022

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

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

Responsive | UEC 4 hour Target

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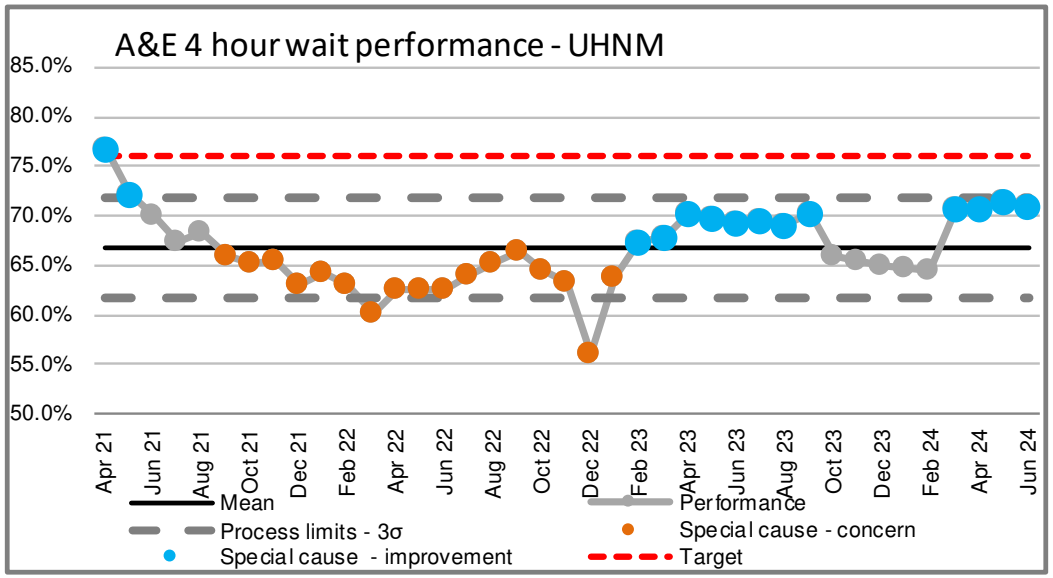
University Hospitals of North Midlands NHS Trust

Responsive

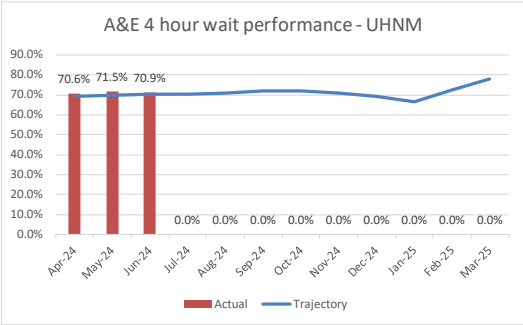


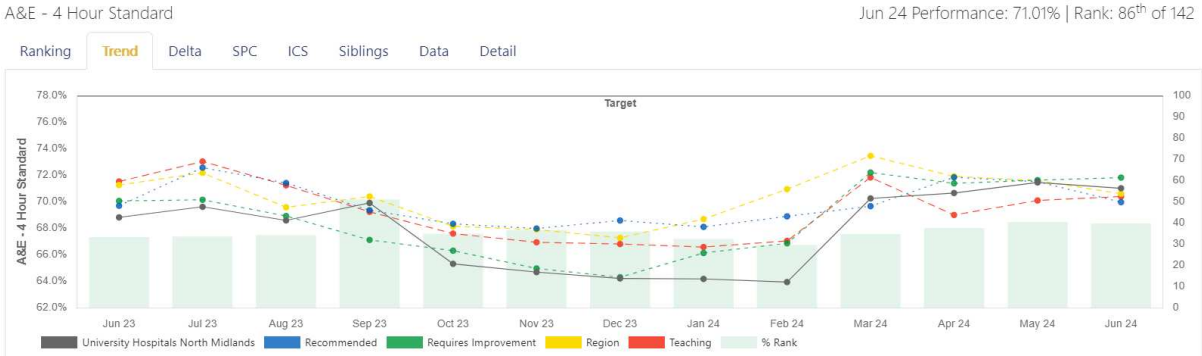
Variation	Assurance
H	F

Target	Apr 24	May 24	Jun 24
76%	70.6%	71.5%	70.9%

Background

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





What is the data telling us?

Validated Performance is 70.9% for June which has decreased by 0.5% from last month, however the average over the last 3 months has been 71%.
The teams continue work to improve this performance metric is evidenced in the incremental improvements since March, albeit a slight dip in performance from last month.
Type 1 4hr performance for Royal Stoke was 46.1% which is 0.7% higher than last month at 45.4%.
Type 1 4hr performance for County was 65.7% which is 2.4% lower than last month at 68.1 %, however over the last 3 months performance has averaged 65.7% and since March seen an overall improvement of 5.3%
The submitted improvement trajectory against the 4hr standard set for June has been met (71% vs 70.3%) but is 6% adverse to the national target of 77% until February 2025 and then 78% for March 2025 onward.
The only day in June that we achieved greater than 78% was 27th June when it recorded total 4hr compliance of 79.4%
We are ranked 86th of 142 Acute Trusts against the chosen parameters of comparison in June verses 85th in May.

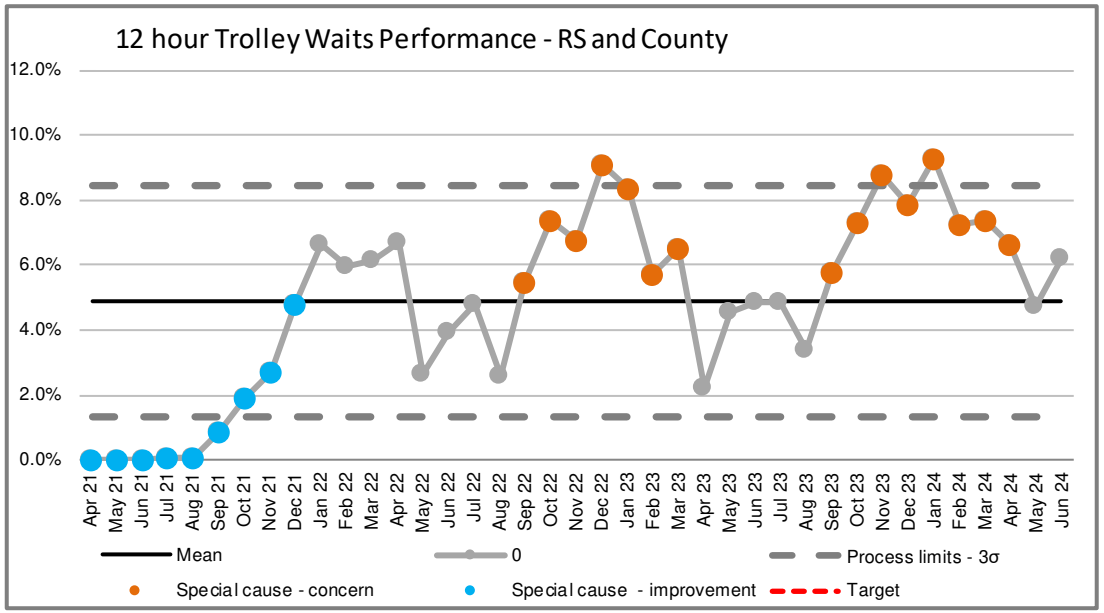
What are we doing about it?

- Ambulatory standard work continues across Royal Stoke and County sites.
- Operational huddles implemented in Ambulatory area reviewing safety including patient prioritisation, staffing and flow.
- CDU utilisation reviews on Royal Stoke to identify further opportunities.
- EhPC pathways review following a missed opportunities audit.
- Management of surges to support triage at County site including room conversion and staffing on a mid-shift to flex to demand.
- SDEC expansion in AEC, including new AMRA unit to open in August which will provide increased capacity and a review of the escalation policy in the Acute Medicine areas is being undertaken as part of the AMRA unit opening.
- A focus on 4hr performance overnight continues and medical staffing aligned to support late evening surges.

Responsive | UEC 12-hour Target

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

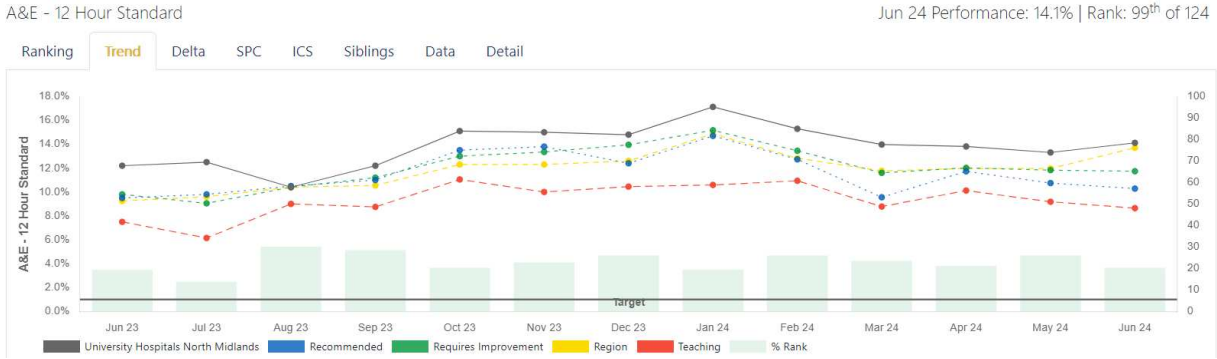


Variation	Assurance
	F

Target	Apr 24	May 24	Jun 24
0%	6.6%	4.7%	6.2%

Background

Percentage of Attendences that breach the 12 hour trolley wait time, divided by the total ED attendances at RS and County.



What is the data telling us?

June has seen an increase in the number of 12-hour trolley waits (6.2%) compared to last month 4.7%), however over the last 3 months the average is 5.8% over the last 3 months.

June saw an increase of 170 patients waiting greater than 12-hour post decision to admit. This demonstrated a negative shift from 4.7% to 6.2%. Our overall ranking deteriorated 92nd out of 124 Acute Trusts in May to 99th out of 124 in June.
However, what this chart does not describe the associated decrease in total aggregated time of arrival (TOA) to clinically ready to proceed in the Emergency Department which was 13.51% of all Type 1 attendances on the admitted pathway.

Mean time in the emergency department varies in and out of hours.

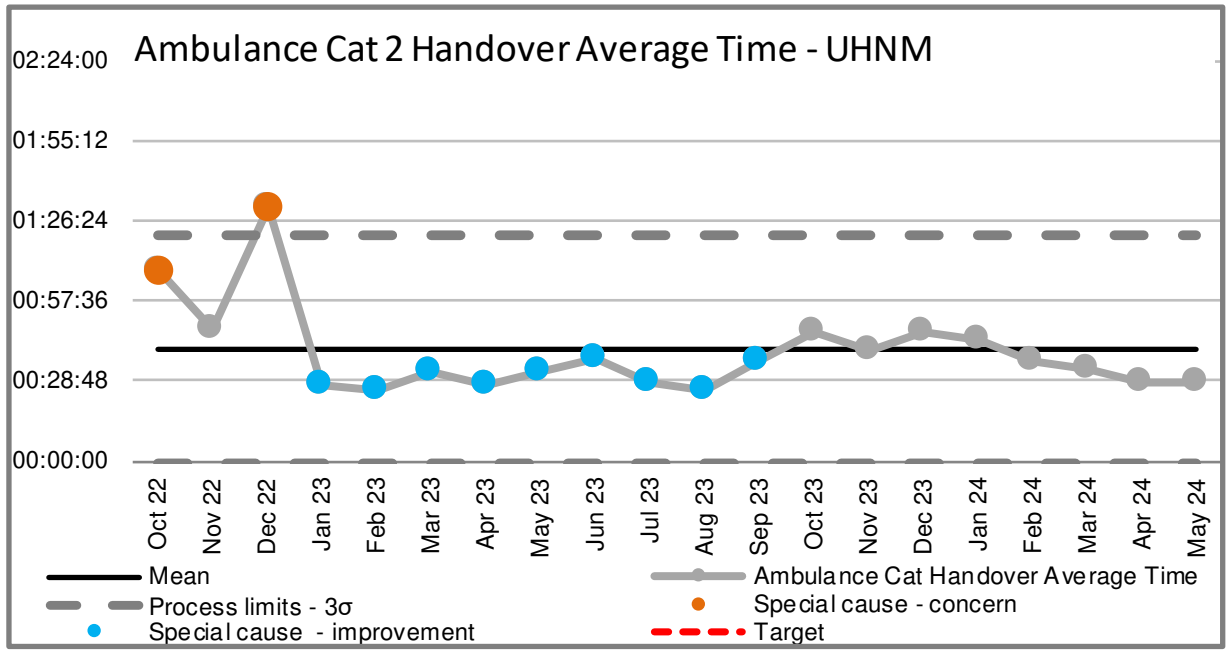
What are we doing about it?

- Rollout of standard work continues across Medicine wards to support timely discharges; this is being expanded into Network Division.
- Task and finish groups continue to work through the root cause analysis to identify actions to address issues identified including TTO's, Transport, Diagnostic Delays and Discharge processes to support earlier in the day discharges.
- Frailty >75, single document for CGA & admissions agreed and is currently being made electronic. Test of change continues for IDH in-reach to ED and support to FEAU.
- Frailty >75, End of life pathway – undertaking peer review to support earlier decision making.
- Work continues to prep for the move of the AMRA unit which will create additional capacity in AMRAU & SSU.
- Effective implementation of 'Your Next Patient (YNP)' and resolution.
  Command and Control principles adopted in Medicine and Emergency Care to respond to increased demand and pressures.

Responsive | UEC Cat 2 Handover Average

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

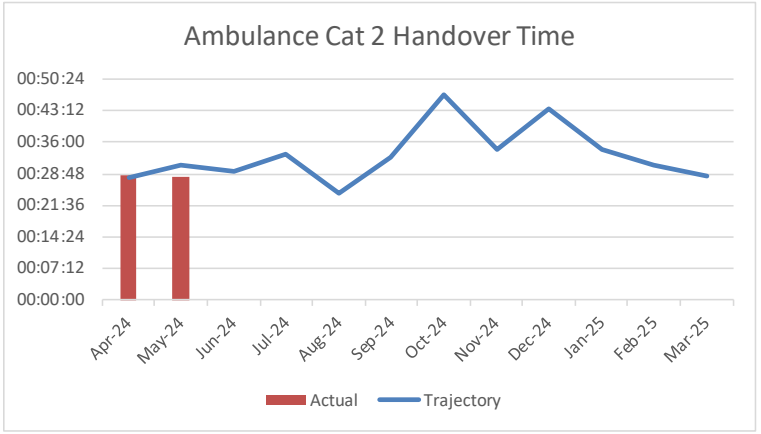


Variation	Assurance

Target	Mar 24	Apr 24	May 24
00:00:00	00:33:01	00:28:22	00:27:56

Background

The average time taken for patients to be handed over from Ambulances arriving at UHNM.



What is the data telling us?

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears.
Ambulance Cat 2 mean time has continued to reduce since January 2024, January saw an average Cat 2 mean of 43.34 minutes compared to 33.01 minutes in March 2024, 28.22 minutes in April and now 27.56 minutes in May
Handover within 15minutes of arrival in May demonstrated a 24.7% compliance. June demonstrated 25.14%. An improvement of 0.44%

What are we doing about it?

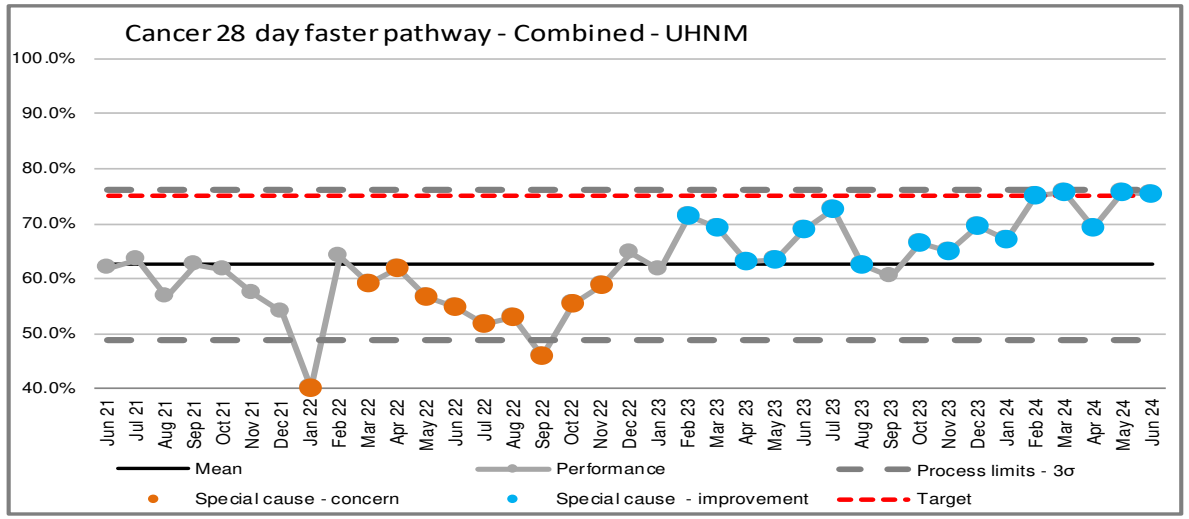
We have instigated an internal rapid handover process, which when triggered and enacted, drives the off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed. The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances.
'Your Next Patient' protocol is enacted to decompress the emergency department to further support flow and off load capability.
Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release.

Responsive | Cancer 28 Day FDS

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

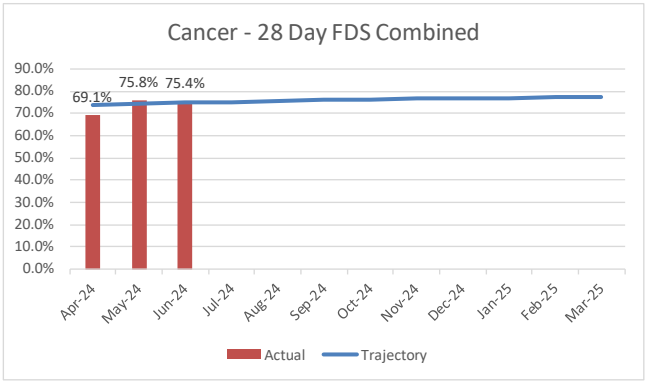


Variation	Assurance
	

Target	Apr 24	May 24	Jun 24
75%	69.1%	75.8%	75.4%

Background

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



What is the data telling us?

The combined faster diagnosis standard performance has demonstrated a special cause improvement over the past year. UHNM achieved the national standard for the first time in February 24 and again in March 24. Although April missed the standard UHNM achieved again in May and continues to be back on trajectory as June is also predicted to achieve.
When broken down at tumour site level, some pathways perform better than others; Upper GI, Skin and Breast being consistent and high achievers.
Pathways that require a higher number of investigations such as Gynaecology and Urology perform lower than the standard.

What are we doing about it?

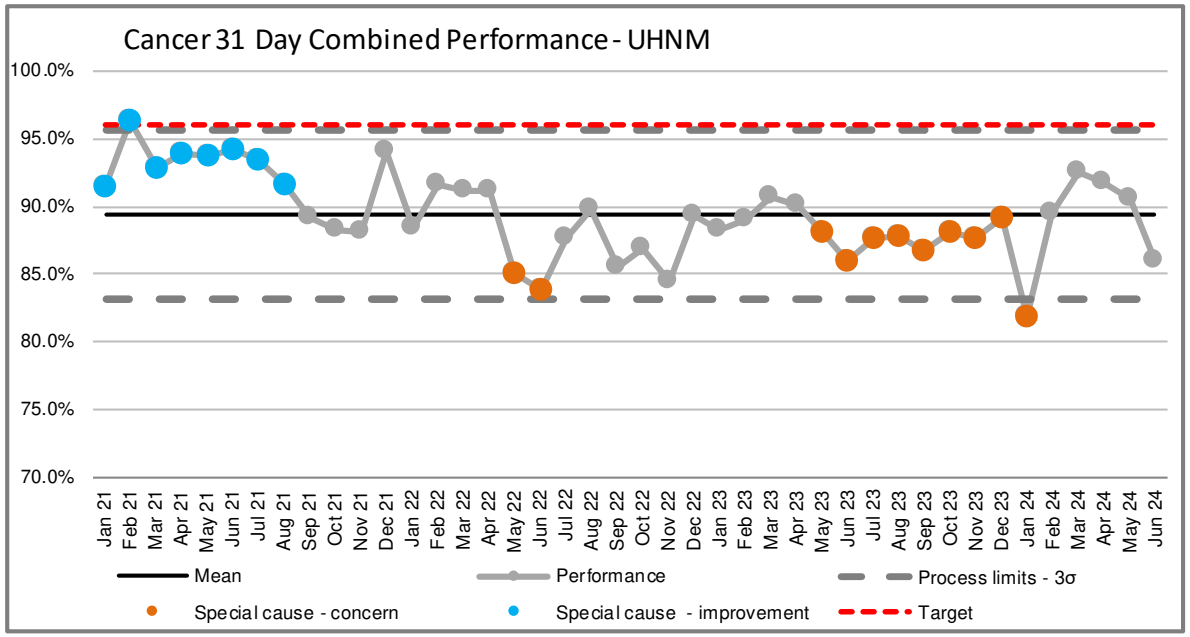
Improvement plans for lower performing pathways are in place; Gynae and Urology. Best practice from better performing providers is being sought for Haematology pathways. Teams have implemented national priorities such as Cancer Navigators who expedite patient pathways. Referral optimisation plans will support faster timelines for patients receiving diagnosis or all clear for cancer.

Responsive | Cancer 31 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive



Variation	Assurance

Target	Apr 24	May 24	Jun 24
96%	91.8%	90.5%	86.0%

Background

% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer

What is the data telling us?

The 31-day combined cancer treatment standard achieved 91% in April 24, 90% in May and is predicted to achieve 86% in June 24. There is varying performance when broken down by tumour site. Consistent and high achievers are Breast, Skin and Upper GI. However, the most challenged tumour sites are Urology and Colorectal. Urology reported the longest waits due to access to surgical capacity. This was mainly for Kidney patients waiting for a Partial Nephrectomy.
The longer waits on the Colorectal pathway were either due to access to surgery or therapeutic endoscopy procedures.

What are we doing about it?

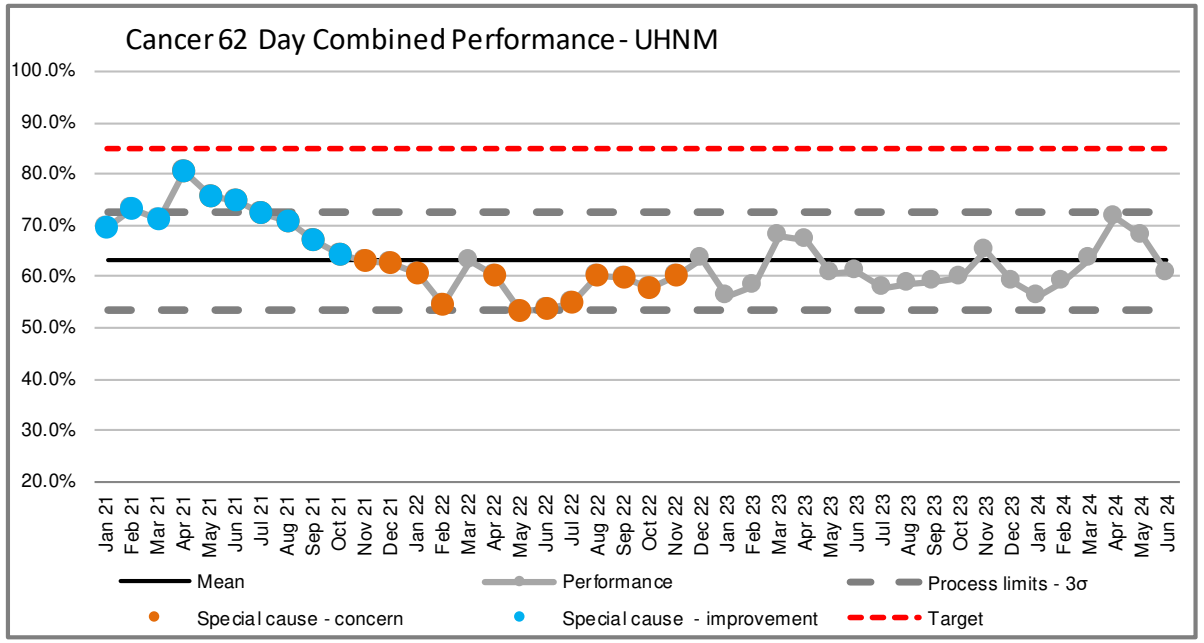
Access to robotic procedures are prioritised through the oversight group.
The endoscopy improvement plan is underway and a business case which considers required capacity to meet demand and clear backlogs is progressing through the sign off process.
Partial Nephrectomy capacity has been escalated through the Tier 1 route with a request for mutual aid. 31 day treatment capacity is inherent to 62 day improvement plans.

Responsive | Cancer 62 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

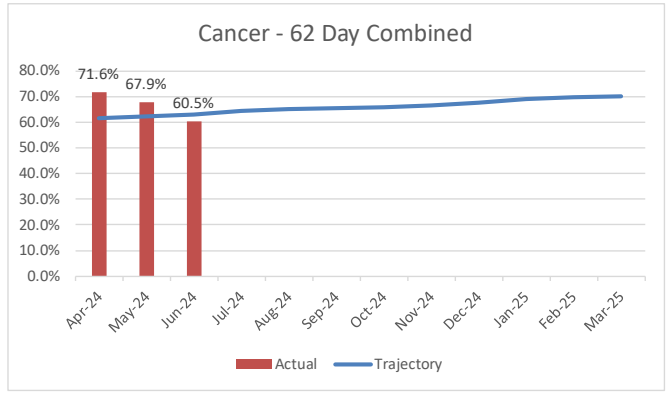


Variation	Assurance
	F

Target	Apr 24	May 24	Jun 24
85%	71.6%	67.9%	60.5%

Background

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



Cancer 62 Day All Routes

May 24 Performance: 67.87% | Rank: 69th of 139

What is the data telling us?

The combined 62-day performance was reported at 71.6% for April 24, an improvement for the third consecutive month and higher than trajectory. May 24 was finalised at 67.9% again higher than trajectory. June is still being collected and validated for upload.

When broken down by tumour site, there are no consistent achievers however pathways with better performance than most include Breast and Skin.

Pathways with the most challenged performance are Gynae, H&N, Lung and Colorectal.

Contributing factors include delay to diagnostics including Hysteroscopy and pathology reporting which impacts significantly for Gynae and Lung, and timely access to Colonoscopy for Colorectal patients. Oncology capacity also impacts timely treatment.

What are we doing about it?

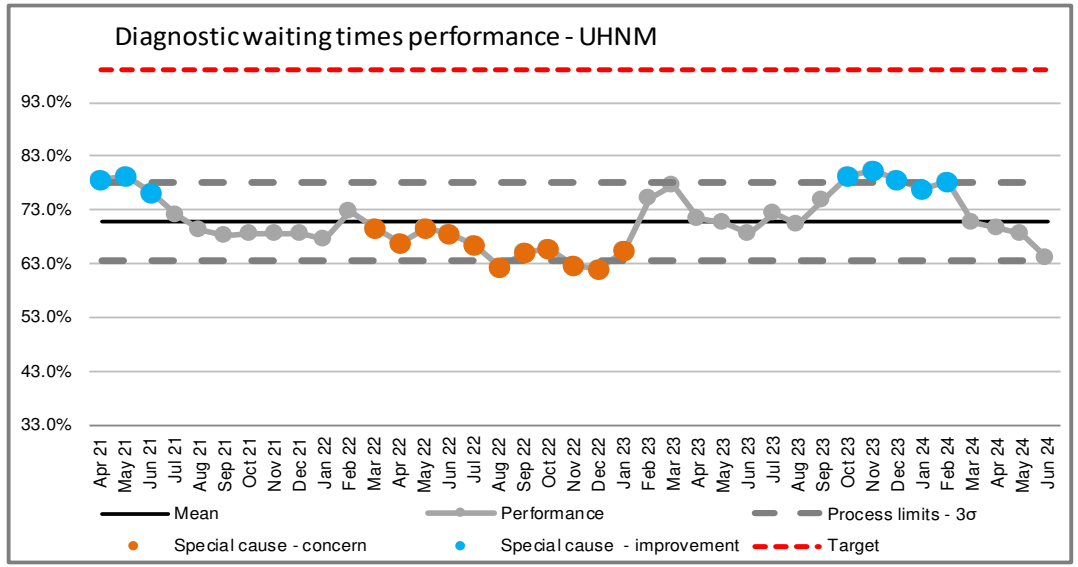
62 day treatment improvement plans have been worked up to include most challenged treatment modalities; surgery and oncology. Longest breaching pathways are being analysed with clinical input. A new 104+ breach analysis governance process has been enacted to ensure oversight of long waiters. The annual peer review process commenced early June and ensures tumour site treatment challenges are visible and escalated through the trust.

Responsive | Diagnostics DM01 Performance

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

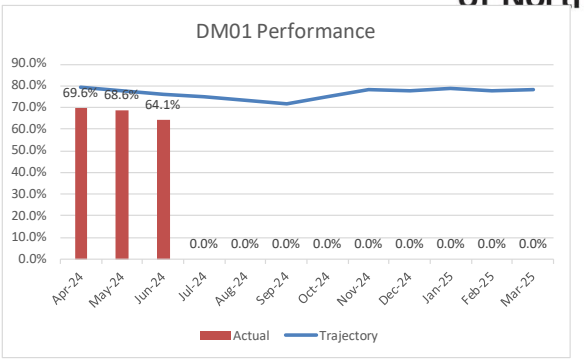


Variation	Assurance

Target	Apr 24	May 24	Jun 24
99%	69.6%	68.6%	64.1%

Background

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



What is the data telling us?

June data is unvalidated.
DM01 performance overall has shown no cause for change within process limits. There are several contributing factors:
- Endoscopy diagnostics waits are still challenged with 1282 diagnostic patients waiting >6weeks. However, to note, the waiting list continues to reduce, and this position is against a waiting list plan of 2271 for the month of June. Breach % for Endoscopy now showing at 56.45%. All measures continue on a downwards trajectory.
- Echocardiograms are still challenged with the waiting list continuing to increase. Performance has deteriorated to 55.6% in June from 63.33% in May.
- MRI performance deteriorated whilst the 2 Valley scanners were being replaced, this is now completed, and performance is improving.
- Non – obstetric ultrasound performance is a focus for improvement but there are some fundamental issues relating to staffing levels and training.

What are we doing about it?

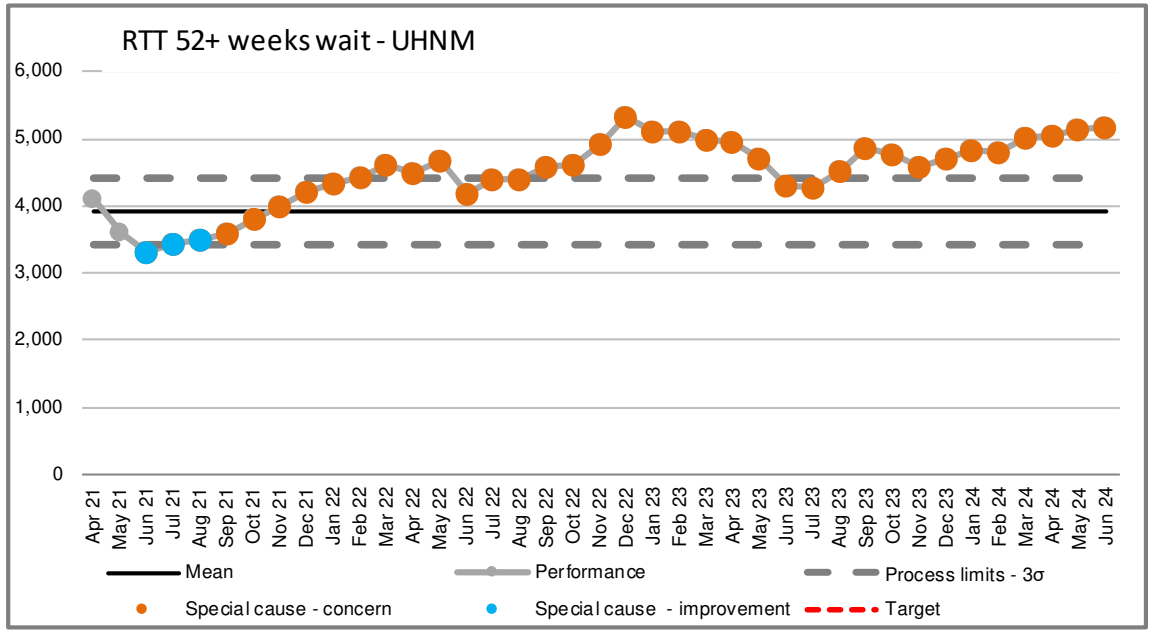
Q2-4 ERF funding has been approved , this will enable the service to continue to insource to increase capacity. All vacant in week sessions are being covered by insourcing service, Trust TI session or locum consultants / Dr's. To note endoscopy was overdelivering against ERF for Q1.
A mobile unit is due to be operational from 1st August 2024, which will clear surveillance backlog and support diagnostic recovery in line with trajectory.
The 3rd element of the business cases for endoscopy recurrent staffing is currently in progress through governance structures.
Endoscopy are also validating both through administration and Clinical pathways all patients waiting beyond 52wks. This is alongside a focused piece to improve DNA and cancelation rates.

Our Echo capacity is being supported through ongoing use of an external provider and for Neurophysiology the use of Elective Services to continue to deliver testing into 2024_25 has been approved.
Non- obstetric Ultrasound – a review of the root causes is being undertaken, this includes staffing, training and the reasons why demand in increasing in specific areas – a remedial action plan will be developed.
Interim support has been requested by the Directorate in the for of an in-sourcing solution and the Directorate is currently awaiting an outcome of this request.

Responsive | RTT No. of Patients Waiting Over 52 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

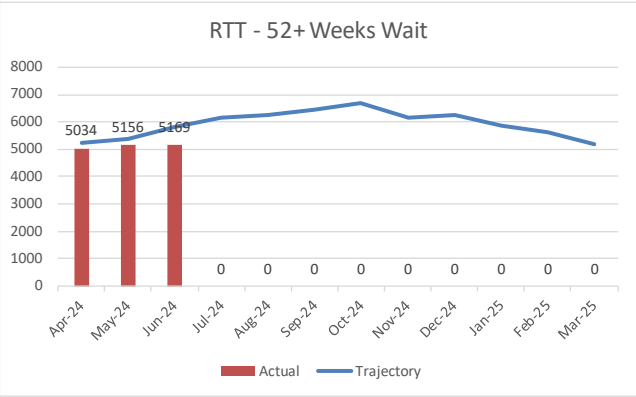


Variation	Assurance
H	F

Target	Apr 24	May 24	Jun 24
0	5034	5156	5169

Background

The number of patients on a RTT pathway who have waited longer than 52 weeks for treatment.



What is the data telling us?

52-week waits have continued to grow from October 2023 and are at their highest point since January 2023. Although this growth was in plan, we have 648 fewer patients waiting over 52 weeks than expected.

There has been a reduction in the total PTL size by 1500 patients (down 1.8%).

The proportion of patients waiting 52+ weeks who have reached a decision to admit is currently 27%. We are now ranked the same in May as April at 145th.

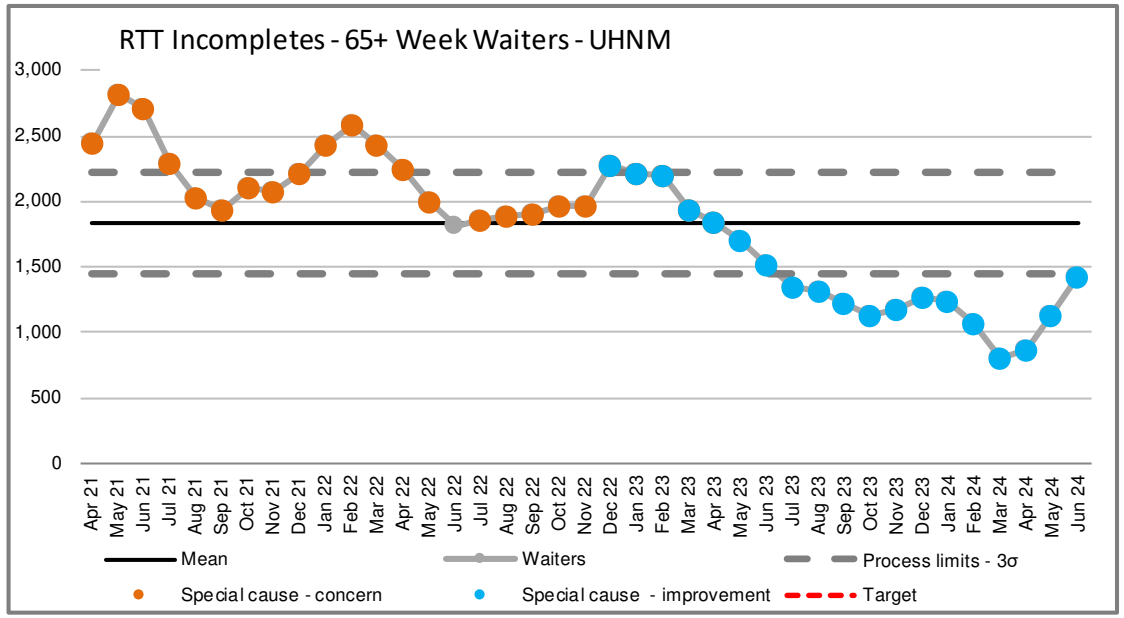
What are we doing about it?

- Validation of all patients >52weeks will be undertaken in July by Trust Validation Team with plans to validate to >45weeks in August
- Revamped RTT & Planned Care training offering now available, including Intermediate Training. RTT training performance wil be monitored through Planned Care Board from August
- Clinician training now available combined with Clinic Outcome Form training
- Exploring utilisation of digital tools (Palantir's CCS) to focus validation to pathways with DQ issues and/or missing pathway milestones
- Further Patient Validation Texts have been sent, with 68% response rate and 2,214 patients wishing to be removed from the waiting list.
- Divisions supported with tracking and admin process improvements where resource allows.
- Route to 52 Week Meetings being diarised for August and September to identify specialties at risk and further mitigations

Responsive | RTT No. of Patients Waiting Over 65 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

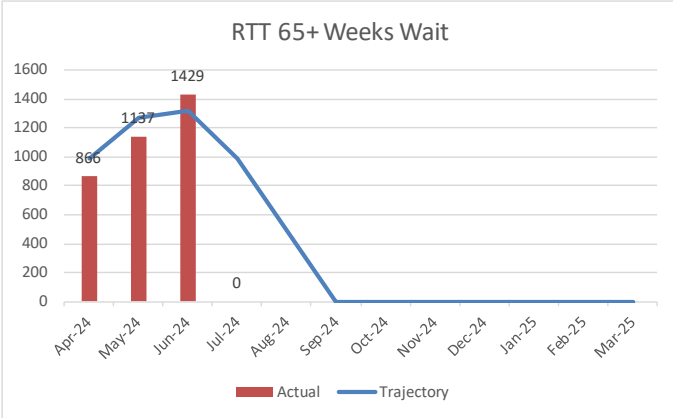


Variation	Assurance
L	F

Target	Apr 24	May 24	Jun 24
0	866	1,137	1,429

Background

The number of patients on a RTT pathway who have waited longer than 65 weeks for treatment.



What is the data telling us?

The 65-week reduction had been following special cause for improvement from December 22, since April 24 the volume of patients waiting 65+ weeks has seen growth. Although this was in plan, the volume of patients in June is 112 higher than expected.

May ranking was 151st verses 146th in April.

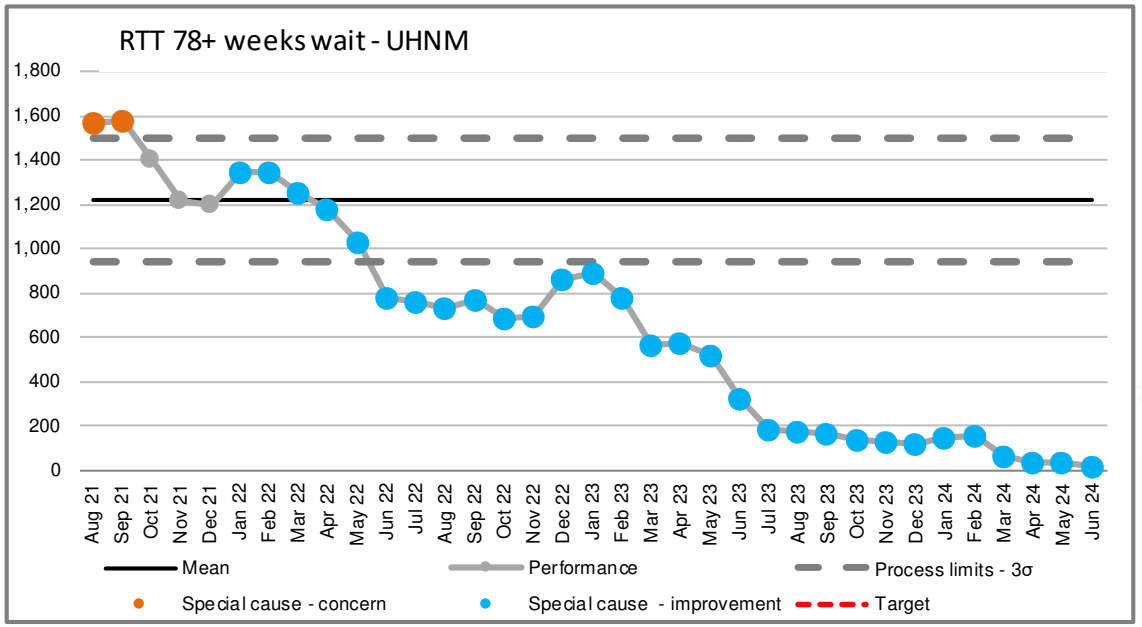
What are we doing about it?

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

Responsive | RTT No. of Patients Waiting Over 78 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

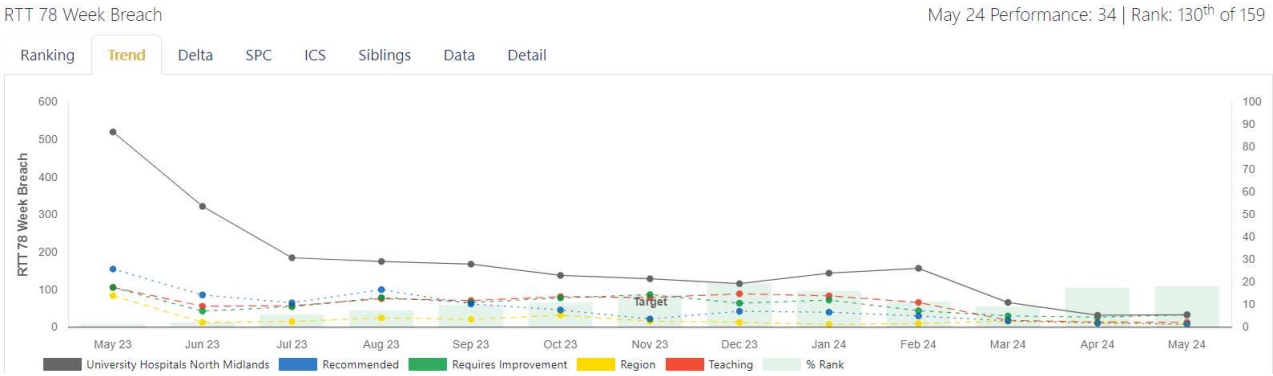


Variation	Assurance
L	F

Target	Apr 24	May 24	Jun 24
0	33	34	16

Background

The number of patients on a RTT pathway who have waited longer than 78 weeks for treatment.



What is the data telling us?

78-week waits have continued to see a reduction with June 24 expecting to be less than half of May 24 (June figures are provisional).

What are we doing about it?

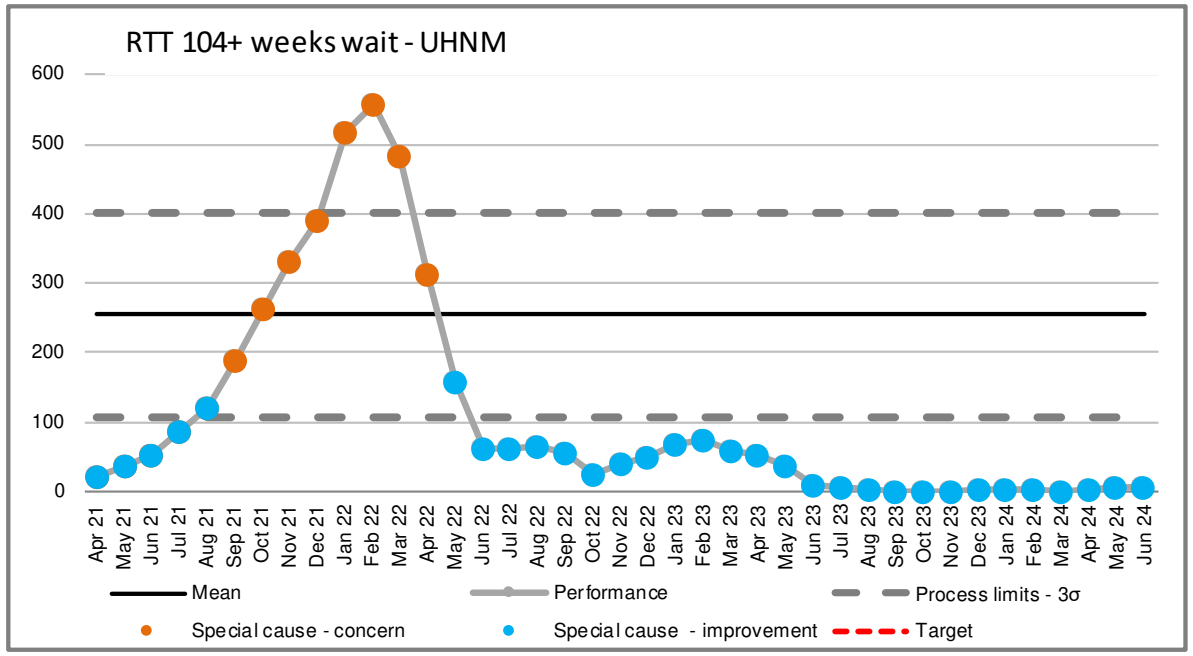
Actions as per those patients over 65 weeks along with continuing tracking and micromanaging of long waiting patients, with regular PTL meetings with each relevant directorate, and support functions.

Responsive | RTT No. of Patients Waiting Over 104 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

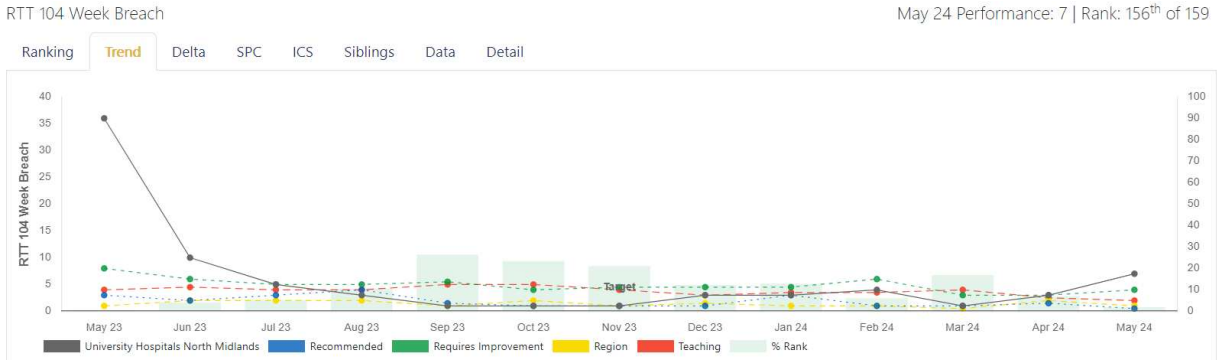


Variation	Assurance
L	F

Target	Apr 24	May 24	Jun 24
0	3	7	7

Background

The number of patients on a RTT pathway who have waited longer than 104 weeks for treatment.



What is the data telling us?

The Trust reported seven 104-week breaches for May, June figure is provisional, but is anticipated to reduce to 5.

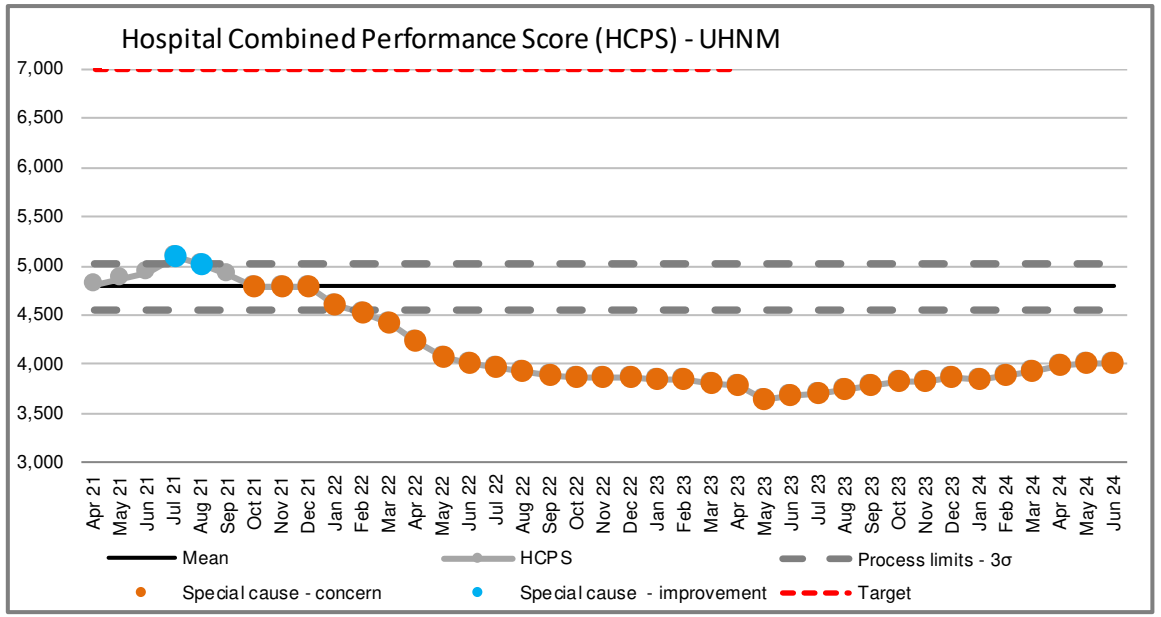
What are we doing about it?

A whole scale review of validation, RTT training and DQ will be underway in July. A DQ Task Force is being established and will be chaired by the COO. A plan for internal trust validators along with a proposal to bring in external capacity is currently being developed. The Trust will continue to carry a degree of risk until the NHSE 2023 validation guidance is introduced (an additional 200k pathways require validating up to end of March if we are to achieve NHE DQ standards.

Responsive | Treating Patients in a Timely Manner (HCPS)

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Apr 24	May 24	Jun 24
7000	3983	4010	4008

What is the data telling us?

Hospital Combined Performance Score. A combined score of metrics across 10 indicators, developed and sourced from Public View.

What is the data telling us?

The Hospital Combined Performance Score has seen improvement since May 2023, June 2024 took a slight dip when comparing to May 2024.
Since January 2024 improvement to this score has been as a result of increased performance in the 4-hour standard, a reduction in the DTA to admission over 4 hours, Cancer 62-day standard and the RTT 18-week standard. Sickness Absence Rate and SHMI rates improved in June 2024.

What are we doing about it?

We are focused on improvements in the indicators which feed the combined hospital score, and these are included in the A3 improvement programmes for both the elective and non-elective programmes.

People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our *Staff Engagement* score was 6.42 for April 2024, down from 6.61 for March 2024, against a target of 7.2. The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until July 2024. A total of 273 bank staff have signed up for the Wagestream solution, (115 in May-24) with a further 19 enrolling. There has been a total of 536 streams, totalling £66,000 since Wagestream's launch.

Sickness absence remains above our expected standard of 3.39%. In month we have seen a 0.31% increase to 5.18%, while the 12-month cumulative rate remains at 5.3% for the second consecutive month. The main driver of this continues to be stress and anxiety, followed by other musculoskeletal problems and gastrointestinal problems as the second and third most common reasons. The in-month increases were mainly driven by the increased reporting of Covid-19 related absences.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in June 2024 increased slightly to 7.9% but remains consistently below our 11% target, for the last 21 months. Vacancies increased to 8.88% (8.45% in May 2024). The main drivers of this were a slight reduction in staff in post and a slight increase in the total budgeted establishment.

Agency costs decreased by 0.1%, in June 2024, from 2.6% in May 2024. In real-terms, overall agency usage increased by 13.4 WTE, to 152.6 WTE in June 2024 (139.2 WTE in May 2024).

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. There has been a recent increase in reported Covid-19 cases.

Reductions in agency expenditure are expected to continue, resulting from increased system level controls, which were implemented, using our electronic rostering system's in-built controls, from 20th May onwards. However, a certain proportion of our agency expenditure is being driven by the continued need for escalation capacity, activity relating to the elective recovery programme and the additional staffing which is required to reduce the emergency department's ambulance waiting times.

People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Overview from the Chief People Officer

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

The staff survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'.

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress. Facemask wearing has been re-introduced to control Covid-19's spread.

Agency Expenditure remains subject to continued scrutiny through the Divisional Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls.

System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. It is anticipated that this will show as a reduction in overall agency WTE, and a commensurate reduction in agency expenditure/cost (£) over the coming months. This control was implemented from 20th May 2024, with an expected 8 week lead in time, before any reductions are seen.

What can we expect in future reports?

We may see a further incremental increase in sickness absence, resulting from the recent increase in Covid-19 cases, which are being driven by the recent 17% increase in cases being reported across England.

Further updates regarding the uptake of the Wagestream solution, which has started its three months trial, before a decision is made to rollout this solution out to our substantive workforce as well, as part of our employee benefits package.

We expect the agency spend to remain below the 3.2% threshold, resulting from the additional system level controls which have been implemented.

People | Dashboard

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Employee Engagement	7.2	6.4	6.4						
Sickness Absence (In Month)	3.40%	4.87%	5.18%						
Vacancy Rate	8.00%	8.45%	8.88%						
Turnover Rate	11.00%	7.74%	7.85%						
Appraisal Rate	95.00%	86.56%	86.82%						
Agency Utilisation	3.20%	2.56%	2.52%						

Related Strategy and Board Assurance Framework (BAF)

People Strategy

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

People | Employee Engagement

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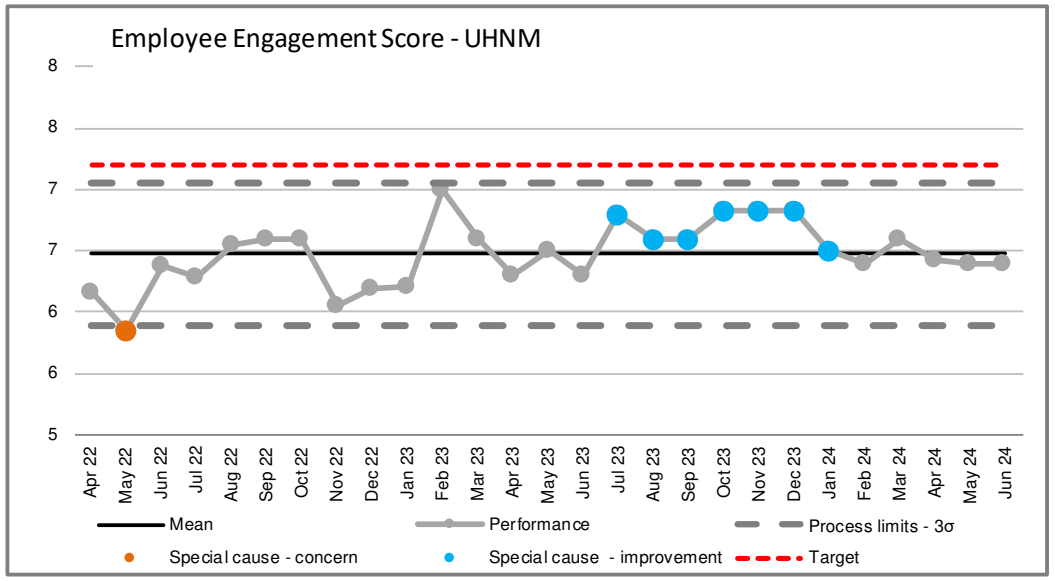
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Apr 24	May 24	Jun 24
7.2	6.4	6.4	6.4

Background

What is the data telling us?

Our Staff Engagement score was 6.42, for April 2024, down from 6.61 for March 2024, against a target of 7.2.

The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until July 2024. Therefore, the most recent score is used in the intervening months.

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'. The next reportable period is July 2024.

Sustained operational pressures continue to impact on overall employee engagement.

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

People | Sickness Absence in Month

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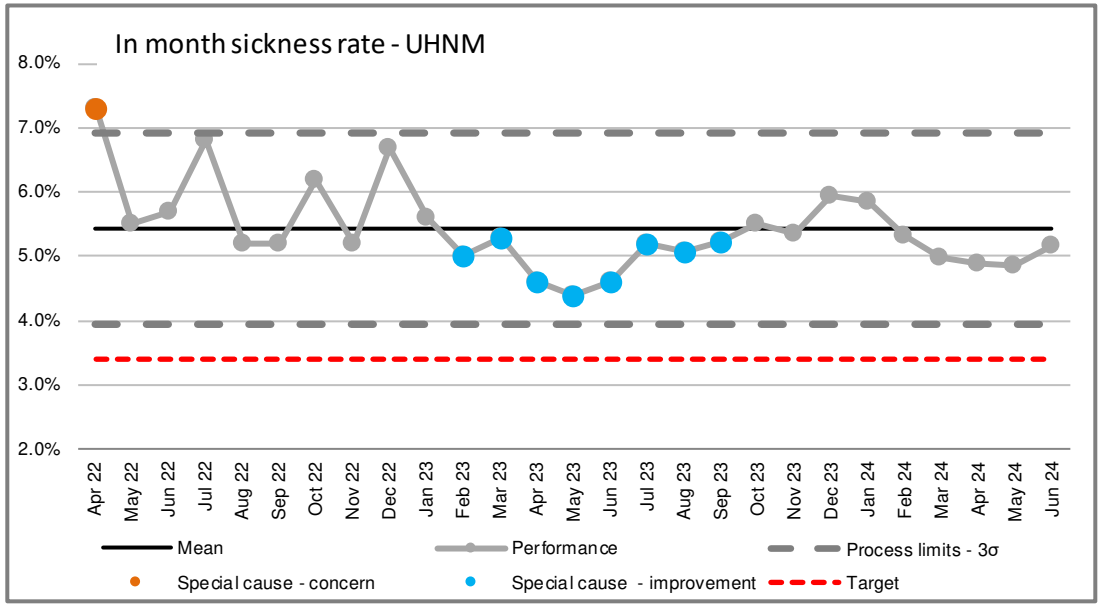
University Hospitals of North Midlands NHS Trust

People



Variation	Assurance
	F

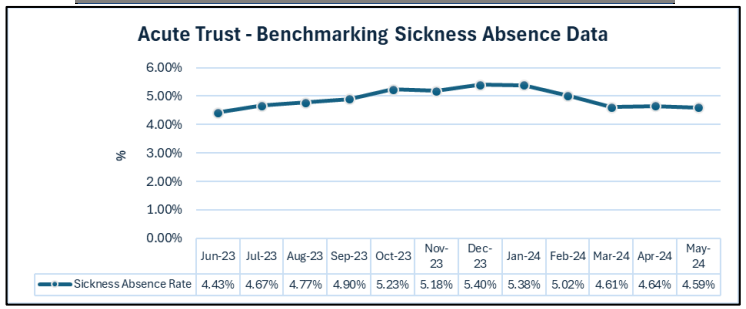
Target	Apr 24	May 24	Jun 24
3.4%	4.9%	4.9%	5.2%

Background

Percentage of days lost to staff sickness

Our sickness absence rates are comparable to other Acute Trust's when examining the available benchmarking data.

(Benchmarking data effective May 2024)



What is the data telling us?

The rolling 12-month average sickness absence rate increased slightly to 5.29% (5.26% in May 2024) against the target of 3.4%.

The in-month sickness absence increased to 5.18% in June (4.87% in May-24) with chest and respiratory problems seeing the biggest increase, most likely from the 130 Covid-19 cases which were reported on ESR, compared to 76 cases in May 2024.

In rank order (highest first), the top 3 reasons for absences during June were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, and (3) Gastrointestinal problems.

What are we doing about it?

Medicine Division - sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases.

Surgery Division – assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

Network Division - commenced sickness assurance meetings.

Women's Children's and Clinical Division - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

People | Vacancy Rate

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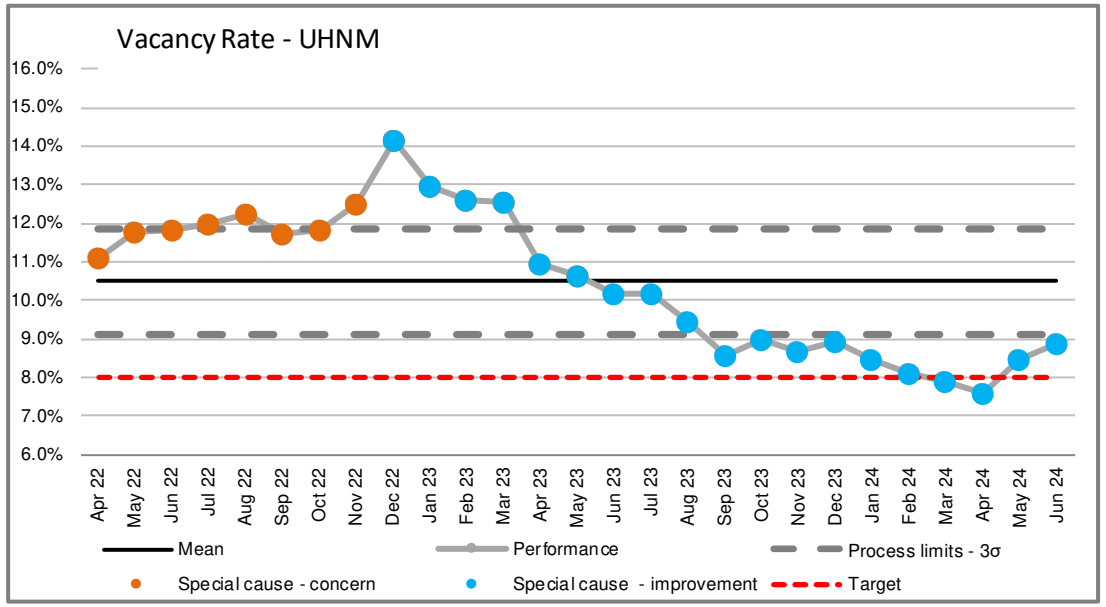
University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
8%	7.6%	8.5%	8.9%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 30-06-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,643.47	1,480.96	162.51	9.89%	9.47%
Registered Nursing	3741.85	3384.36	357.49	9.55%	9.51%
All other Staff Groups	6882.51	6312.67	569.84	8.28%	7.63%
Total	12,267.83	11,177.99	1,089.84	8.88%	8.45%

What is the data telling us?

The summary of vacancies, by staff groupings, highlights a 0.43% increase in the overall vacancy rate. The reasons for this are explained below.

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

Colleagues in post decreased in June 2024 by 19.08 fte, budgeted establishment increased by 36.88 fte, which increased the vacancy fte by 55.96 FTE overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/06/24]

What are we doing about it?

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

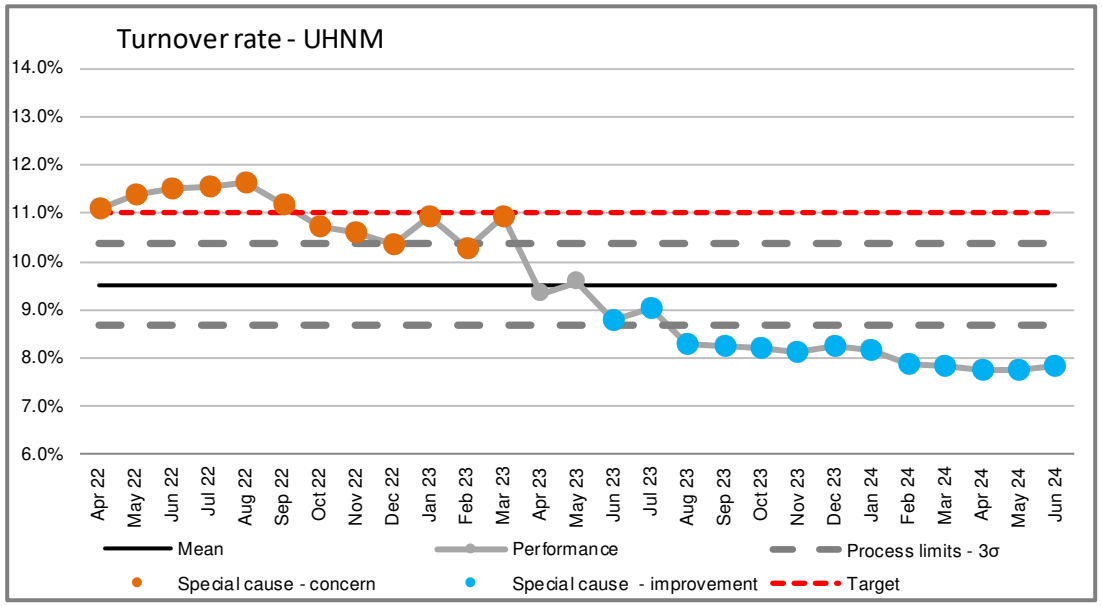
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

People | Turnover Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

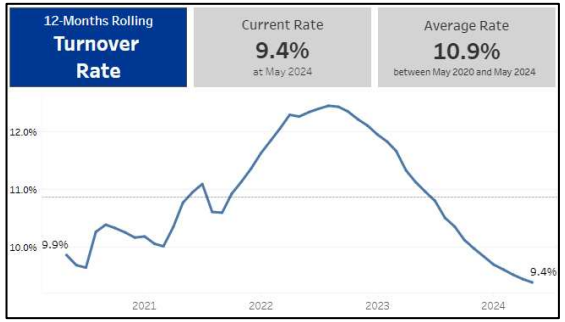
Target	Apr 24	May 24	Jun 24
11.0%	7.8%	7.7%	7.9%

Background

Turnover rate.

Based on the most recent benchmarking data, comparing ourselves against other Acute Trusts, our overall turnover is much lower.

(Benchmarking data effective May 2024)



What is the data telling us?

The turnover rate in June 2024 remains low, at 7.9% (7.7% in May 2024), which is consistently below the Trust's 11% target, for the last 21 months.

What are we doing about it?

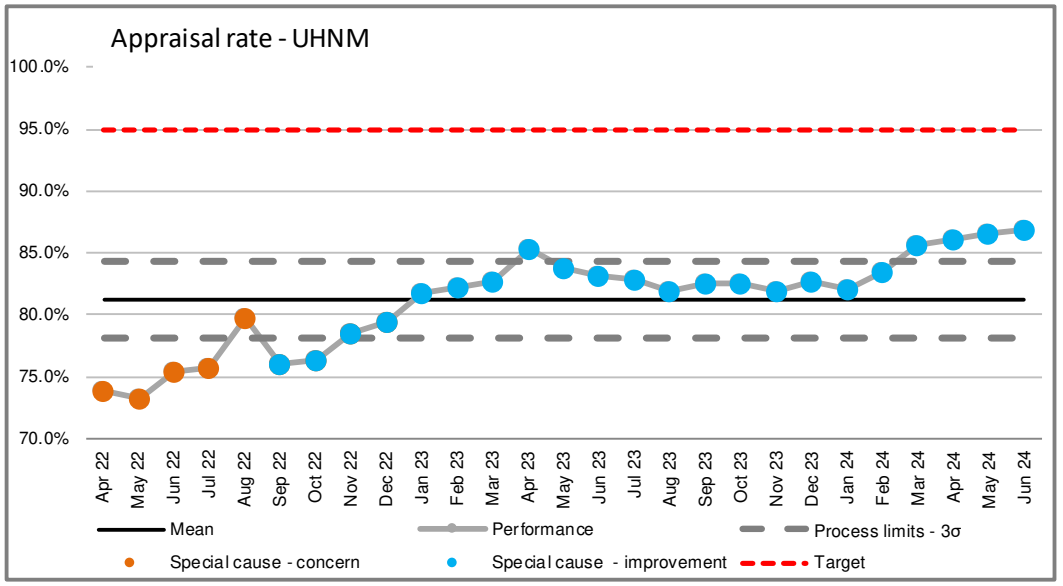
Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who started in a fixed term post.
- Implementation of the Wagestream solution, for bank staff, including our people who work both substantively and on the bank.
- Monthly targeted campaigns aligned to our four People Promise areas of focus (Apr-Oct 2024). For example, People Promise 1 'We are compassionate and inclusive': We had PRIDE month in June, where we raised internal awareness and attended Stoke Pride with System colleagues.

People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Apr 24	May 24	Jun 24
95%	86.2%	86.6%	86.8%

Background

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

What is the data telling us?

Performance Development Reviews (PDR's) continue to perform below our 95% target.

Over the last five months we have seen consecutive improvements in our appraisal rates, which have gradually increased from 83.5% in February 2024 to 86.8% in June 2024, which is the highest rate seen, since July 2019.

The divisions' weekly monitoring, review and assurance meetings appear to be having the desired effect on driving improvements in compliance.

What are we doing about it?

NMCPS - All out of date PDR's are scheduled with line managers.

Network Division - Weekly PDR compliance hotspot and assurance meetings.

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

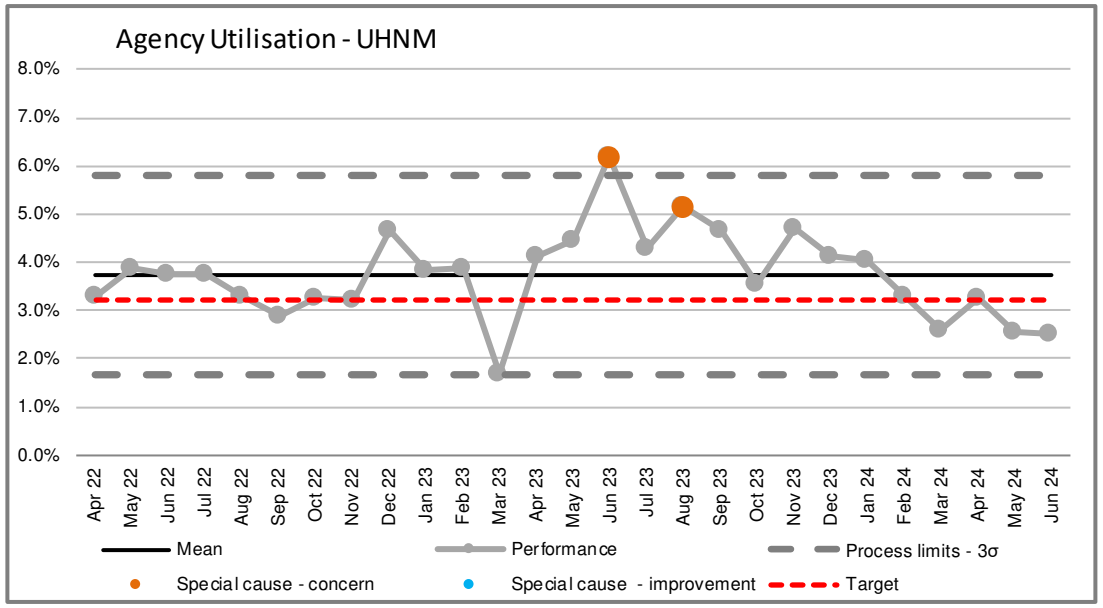
Medicine Division – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

WCCSS – Weekly performance reports and assurance meetings.

People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
3.2%	3.3%	2.6%	2.5%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which reduced by 0.1%, in June 2024, down from 2.6% in May 2024.

In real-terms, overall agency usage increased to 152.6 WTE in June from 139.2 WTE in May 2024. Medical Staffing remained static, while all other staff groups saw reductions in agency usage, apart from in registered nursing & midwifery where increased agency usage occurred in A&E due to the increased use of Band 4 EMT's and to cover sickness absence.

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional meetings. This includes reviewing long-term agency use.
- All current in-sourcing contracts are reviewed monthly, to ensure that they do not breach rules regarding off-framework agency use.
- All off-framework agency arrangements have been reviewed and all off-framework use ceased at the end of June 2024.
- System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. It is anticipated that this will show as a reduction in overall agency WTE, and a commensurate reduction in agency expenditure/cost (£), from July 2024's data, onwards, due to an 8 week lead in time.

Improving & Innovating | Overview

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Overview from the Chief Medical Officer and Chief Nurse

How are we doing against our trajectories and expected standards?

Metric 1: Increasing clinical trial participants: 16th July 2024 saw the second collaborative A3 meeting with cross stake-holder participation to develop the A3 for this metric. The outcome from the meeting is that the problem statement is to be agreed, and we are now moving on to understanding the 'current situation'. This collaborative process will begin to uncover route causes at UHNM regarding research participation numbers.
Research Participants 23/24 Q1 = 323, Research Participants 24/25 Q1 = 385

Metric 2: Increasing clinical academic/joint/honorary contracts: The A3 and scorecard remain under development. The A3 has shown that we do not know how many of these appointments are held in UHNM. The data provided indicates what we know only from those staff who have made this known to CeNREE or the R&I department. This has not increased from last report.

Metric 3: Increasing research active staff: The A3 and scorecard remain under development. The A3 has shown that we do not know what is meant by 'research active' nor how many research active staff we have in UHNM. The data provided indicates what we know only from those staff who have contacted CeNREE or the R&I department for research support or who are current CIs/PIs. This estimated number is probably increasing in part due to newly active staff but also due to gaining awareness of existing research active staff.

What is driving this?

Metric 1: To achieve the increased number of research participants, requires a balanced portfolio of contracted target recruitment numbers. Q1 24/25 is almost 20% higher than recruitment numbers during Q1 23/24.

Metric 2: The A3 has shown that we do not collect this data in a systematic way. This number therefore remains unchanged.

Metric 3: The A3 has shown that we do not collect this data in a systematic way and that we do not have an agreed definition of 'research active'. The estimates number has increased from 370 to 378 since the last report.

Improving & Innovating | Overview

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Overview from the Chief Medical Officer and Chief Nurse

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

Metric 1: We are monitoring recruitment against recruitment targets monthly through lead practitioner meetings. We have a high target questionnaire study reliant on school participation. We will be allocating resource to this once new school term begins.

Metric 2: We have a countermeasure to conduct a quarterly census via Divisional Leads.

Metric 3: We have two countermeasures in place: 1) we will agree a definition of 'research active' with stakeholders in the Research and Innovation Strategy Oversight Group and Executive Research and innovation Group, and 2) we will conduct a quarterly census via Divisional Leads.

What can we expect in future reports?

Metric 1: We will begin to look at the distribution of targets over the number of studies being set up, we are working towards proportionality in the offer of research activities to our patients

Metric 2: Data will become more accurate as census data is analysed. More detailed SPC charts will become available, and trends will be apparent.

Metric 3: Data will become more accurate as census data is analysed. More detailed SPC charts will become available, and trends will be apparent.

Improving & Innovating | Dashboard

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increase Clinical Trial Participation	208.0	103.0	113.0						
Increase Clinical Academic Posts/Honorary Contracts	-	8.0	8.0						
Increase Research Active Employees	-	370.0	378.0						

Improving & Innovating

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

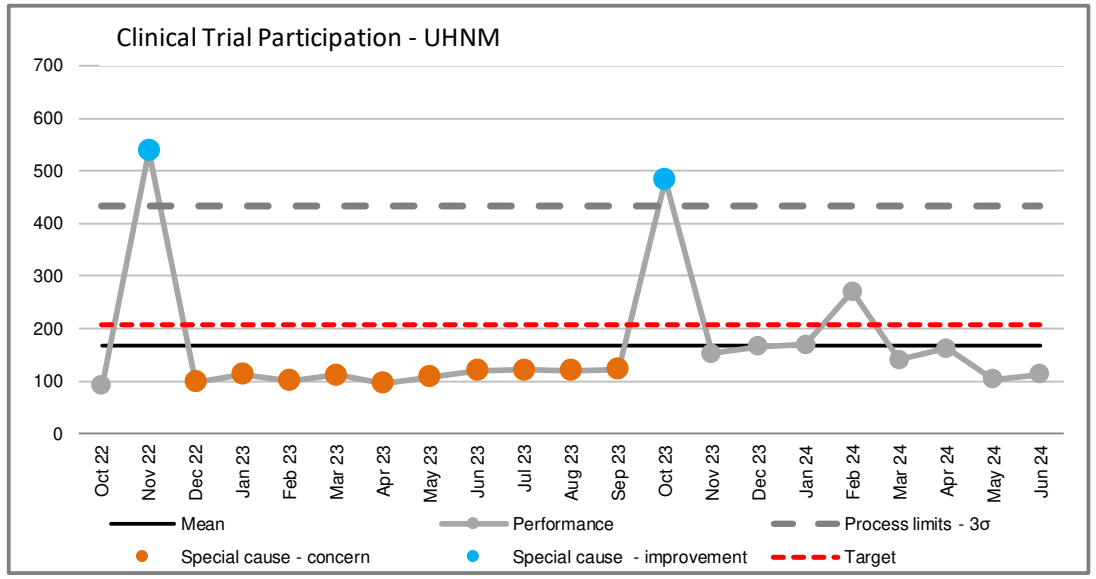
Research Strategy

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

Improving & Innovating | Clinical Trial Participation

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
208	162	103	113

Background

The number of patients starting Clinical Trials each month.

What is the data telling us?

To increase numbers is to also increase the variety of studies we offer, the spikes show our quick turnaround studies, these studies are important and help with increasing our numbers, which in turn will increase our reputation regionally.

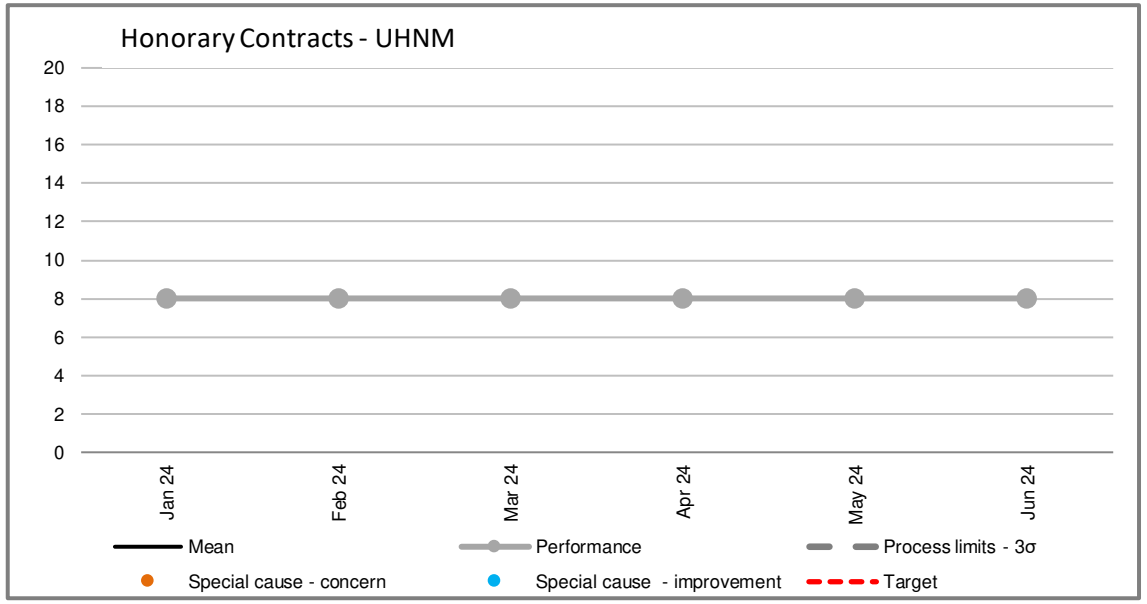
What are we doing about it?

The directorate are mindful that a balanced portfolio is required, from research participation of questionnaire studies, through to full clinical trial, it will take time to balance the portfolio, and ensuring we are aware of studies that are in set up and their potential to support this direction.

Improving & Innovating | Clinical Academic Posts/Honorary Contracts

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
N/A	8	8	8

Background

The number of UHNM staff with clinical academic or honorary appointments.

What is the data telling us?

We do not currently have a process for collecting this data, so this number remains smaller than anticipated.

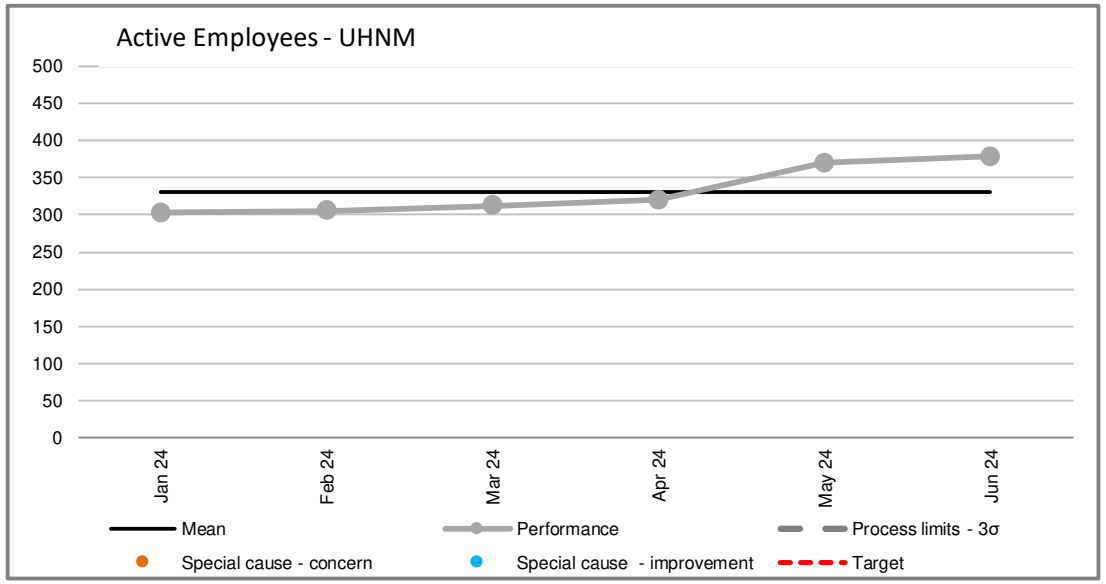
What are we doing about it?

We will conduct a quarterly census via Divisional leads to obtain more accurate data. This will indicate where we need to prioritise our negotiations with Higher Education Institutions (HEIs).

Improving & Innovating | Research Active Employees

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
N/A	320	370	378

Background

The number of research active employees in UHNM.

What is the data telling us?

We do not have a confirmed definition of 'research-active' or a process for collecting this data, so this number remains smaller than anticipated.

The data shows us that this number is increasing; however, this claim is made with caution as in reality this means that we are finding out about research activity, but this may not be new activity.

What are we doing about it?

We will agree a definition with stakeholders and then conduct a census via Divisional Leads. This will highlight the areas where there is a shortfall in research activity where we can focus our attentions for development and support.

Only metric 1 (participation in clinical trials) was discussed at the stakeholder meeting held on 10th June (Research and Innovation Strategy Oversight Group). Metrics 2 and 3 are on the next meeting agenda.

System & Partners | Overview

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Overview from the Director of Strategy & Transformation

How are we doing against our trajectories and expected standards?

This Domain is in development

What is driving this?

System & Partners

System & Partners | Overview

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Overview from the Director of Strategy & Transformation

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

What can we expect in future reports?

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System & Partners

System & Partners | Dashboard

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

In Development

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increased Partnership Working	0.0	0.0	0.0						
Improve the health of our population	0.0	0.0	0.0						

System & Partners

Related Strategy and Board Assurance Framework (BAF)

Health & Wellbeing Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 3: Improving the Health of our Population	Ext 15	Partial					Ext 15	Partial

Resources | Overview

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

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer and Chief Digital Information Officer

How are we doing against our trajectories and expected standards?

Non – elective
Non-elective activity continues at high levels although below plan. This continues the general growth over the last 12 months. Plans for this year incorporate a rebase position incorporating growth in the use of Clinical Decision Unit. These were patients who otherwise would wait for excessive periods of time in ED.

Elective
Against plan June delivered: Demonstrating a positive performance and early signs of extending our elective recovery and accessing the Elective Recovery Fund required this year.
Day case 101%
Elective 91%
First OP Proc 107%
First Outpatient 99%
Follow up 98%
Follow up PROC 92%

Freedom of information requests are not being completed against the nationally mandated standard. It is expected that this will improve when the new information management system is introduced. Subject Access Requests are on target for June 2024. Five projects have been completed in month including ED Digital Noting.

What is driving this?

Non – elective
Although demand management schemes were in place over winter and past the Easter period this was not necessarily seen through a reduction in admissions.
An important note on admissions is the use of the Clinical Decisions Unit which was, for a period, closed. This resulted in a number of patients waiting in ED for 24hours+ receiving treatment in an inappropriate environment. Those patients are now accessing the CDU and that will have contributed to the increased admissions shown from October 2023.

Elective
Elective and day case combined are slightly under delivering against plan predominantly in T and O DC underperformance is offset with significant overperformance in Endoscopy. OP activity is slightly below plan due to underperformance predominantly in oral surgery and orthodontics

The manual management of Freedom and Information Requests make it a challenge to monitor the high volume of complex requests especially where one request is required to be completed my multiple departments.

Resources | Overview

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

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer and Chief Digital Information Officer

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

Non – elective
The System Demand Management Collaborative is tasked with identifying schemes to reduce demand. This programme commenced in April and is likely to have its greatest impact in October 2024.
The Trust, System Partners and the ICB are currently reviewing all services, schemes and initiatives that will influence this.

Elective
There are now monthly executive led FAP meetings with all divisions to review their activity outputs. This sits alongside Outpatient and Theatre improvement workstreams to support improvements in utilisation.
The County strategic programme also is looking at the utilisation and development of work across County theatres and its STS facilities.

For both FOI and SARs the introduction of a new information management system to help manage the workflow and approvals from the summer.

What can we expect in future reports?

Non – elective
Further detail will be made available regarding the schemes being targeted to reduced non-elective admissions.
The newly agreed improvement and recovery trajectories set against the 4hr standard and Cat2 mean will be featured more prominently.

Elective
We will continue to focus on delivering activity to the plan with workstreams through the Planned Care Group that support improving utilisation.
As the Executive Finance, Activity and Performance Groups with the divisions embed there will be specific feedback where escalation is required.

An increase in FOI performance is expected from August 2024 onwards.

Resources | Overview

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

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Daycase / Elective Activity	variable	10,102	9,281						
Non-Elective Activity	variable	9,346	8,785						
Outpatients' 1st	27,430	30,014	27,819						
Outpatients' Follow Up	41,048	44,880	41,599						
Freedom of Information Performance	90.0%	60.0%	61.0%						
Subject Access Request Performance	100.0%	100.0%	100.0%						
Data Security Breaches	0.0	1.0	0.0						

Related Strategy and Board Assurance Framework (BAF)

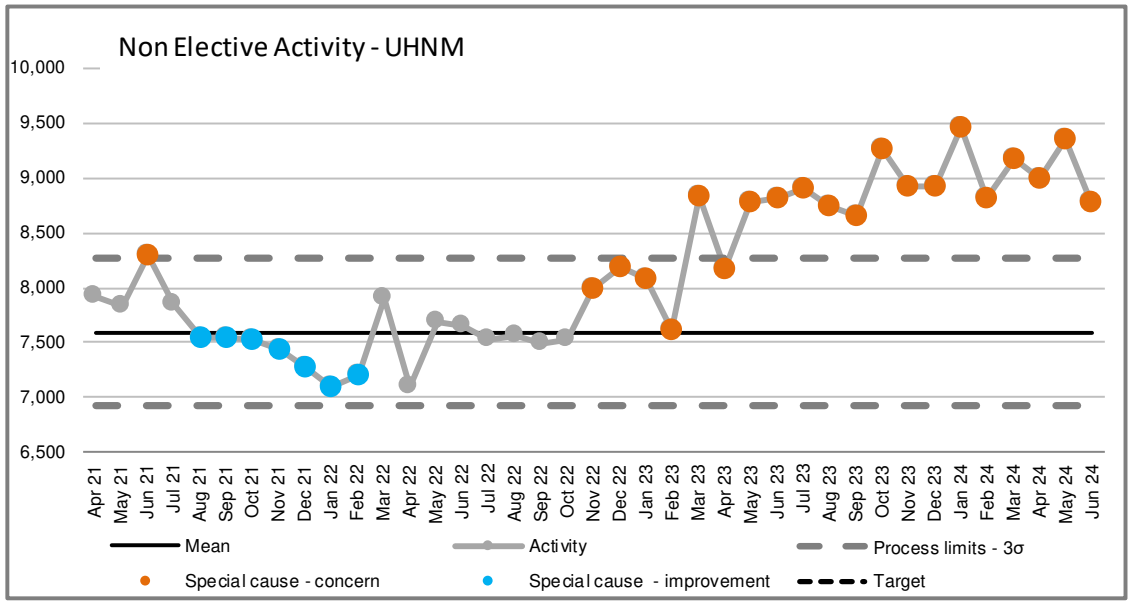
Digital Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 8: Financial Sustainability	Ext 16	Partial					Low 3	Partial
BAF 5: Digital Transformation	High 12	Partial					High 9	Acceptable

Resources | Non elective Activity

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

University Hospitals of North Midlands NHS Trust



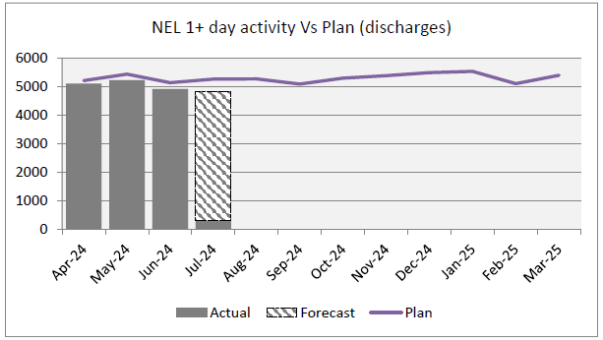
Variation	Assurance
H	P

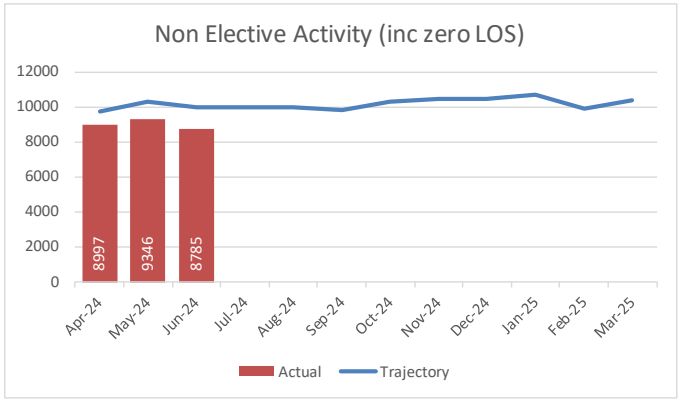
Target	Apr 24	May 24	Jun 24
variable	8,997	9,346	8,785

Background

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

NEL Discharges





What is the data telling us?

We continue to experience a high demand in respect of our non-elective activity. June saw a decrease in the activity profile to that experience in May. 8,785 in June compared to 9,332 in May. A reduction of 5.87%

The associated discharge profile for non-elective achieved 95.8% against plan. Plan 9972 verses an actual of 8791, which is 1181 below expectation. The plan and actual now includes both NEL zero-day LoS and NEL + 1-day LoS.

What the data does not tell us is any variation in average length of stay by pathway and the expected daily discharges by pathway.

What are we doing about it?

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

Renewed focus through Acute Care at Home (ACaH), should positively impact on the utilisation of 'virtual ward' capacity.

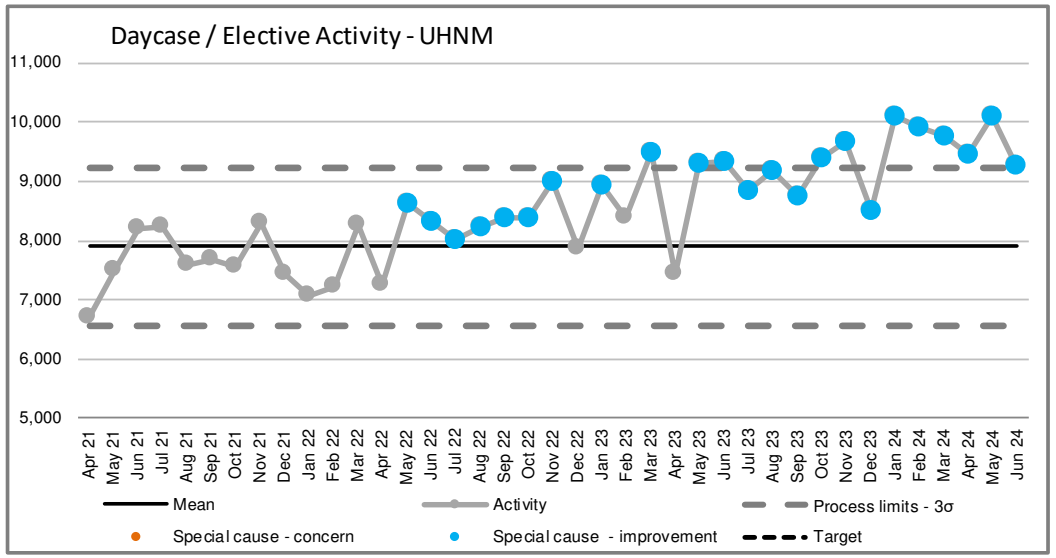
'Call before Convey' does not yet yield the benefit anticipated. Through collaboration with key system partners, this agreed process should prevent attend and admission and work is in train to explore how we maximise this process and fully exploit access to all alternative nonhospital pathways.

In periods of extremis, the ACaH Team are present on site to in reach. Discussions are now beginning to explore how this becomes business as usual (BAU).

Resources | Daycase/Elective Activity

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

University Hospitals of North Midlands NHS Trust

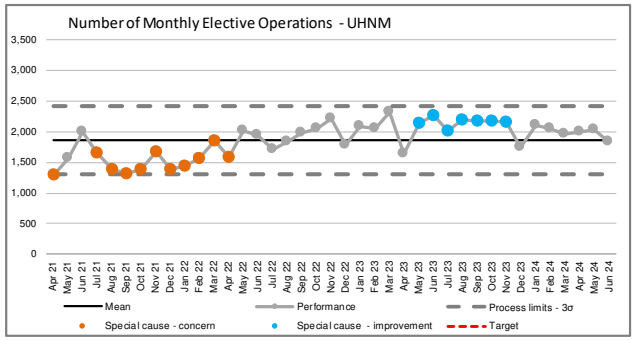


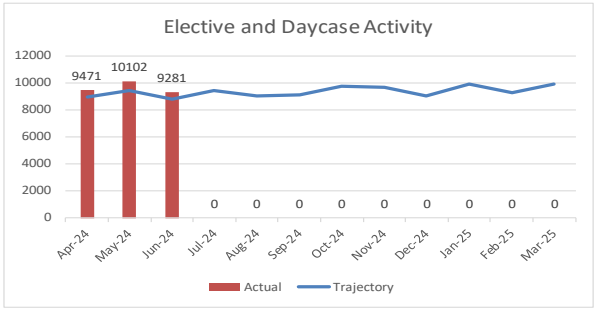
Variation	Assurance
H	F

Target	Apr 24	May 24	Jun 24
variable	9,471	10,102	9,281

Background

Daycase and overnight elective activity provided by the Trust each month





What is the data telling us?

There has been a special cause improvement since April 22 across day case and elective activity. Data above relates to Trust wide Daycase & Elective activity, Further work required and discussed to drill down on aggregated total.

Theatres:
Capped utilisation for theatres has increased to 77.59%
Theatres as a subset is to the right showing an decrease to 1844 cases in June 2024.
Cancelled ops remains below 24mnth mean, increasing to 9.5% in May 2024 but above plan.
Activity numbers were down in month as a result of reduced working days (June 20 v's May 23) plus impact of 2 days Industrial Action.
OTD Cancellations of 194 was consistent with May 24 numbers ad continue to be an area of focus. whilst

What are we doing about it?

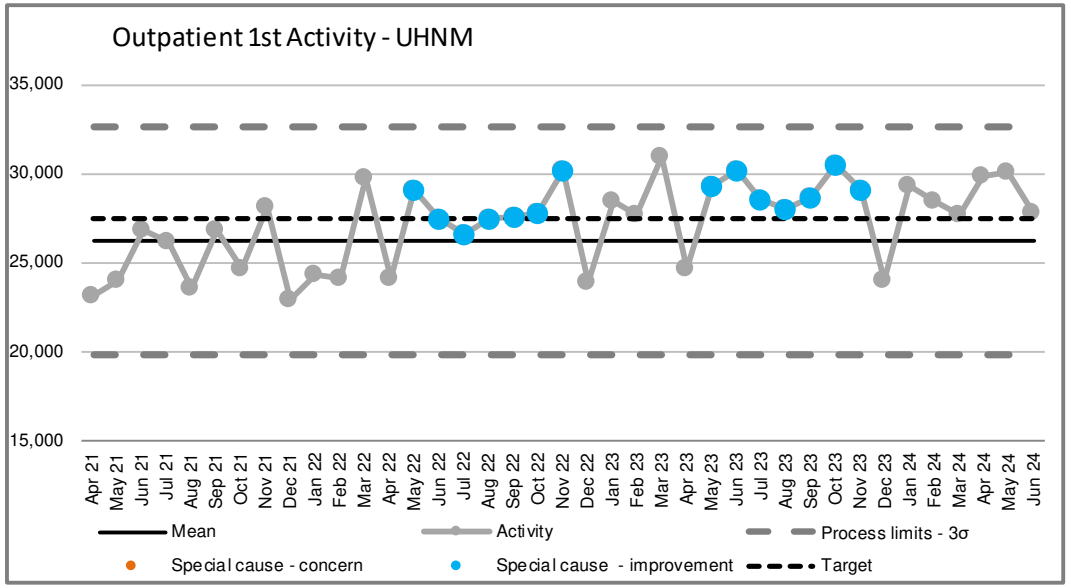
- Full Briefing Paper submitted for PaF 29th July
- Model Health Data discrepancies have been corrected. - June data showing UHNM above national median capped utilisation and County Elective Hub > 80% Capped (national 79.2%)
- Perioperative Medicine Pathway Transformation continues, interviews for Programme manager 17th July. Focus on finalising digital screening tool and planning trial with Gen Surg in August.
- Urology successfully used Standby Pt to backfill on the day cancelation – pathway being rolled out to other specialities
- Golden Patient Process to be rolled out across specialities to improve start times and flow
- Portering Service assessment generated Statement of need to increase resource
- County Elective Hub – post BC approval -Operationalisation of timetables, recruitment, instrumentation commencing
- New TPG meeting format - started and showing encouraging signs of engagement and oversight

Resources

Resources | Outpatient First Appt

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

University Hospitals of North Midlands NHS Trust

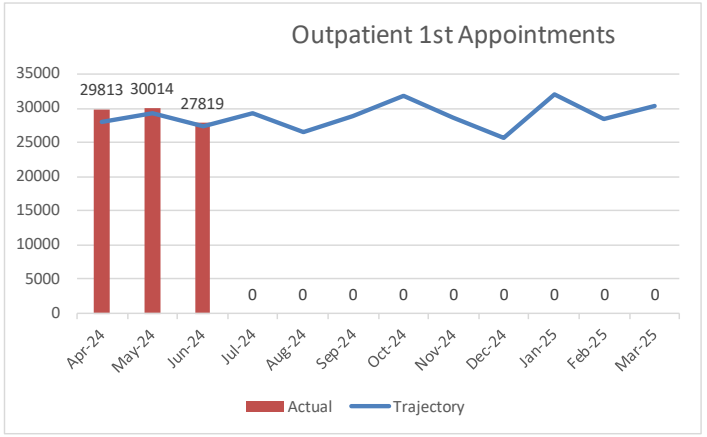


Variation	Assurance

Target	Apr 24	May 24	Jun 24
variable	29,813	30,014	27,819

Background

The number of 1st Outpatient appointments at the Trust each month



What is the data telling us?

Activity saw a sustained increase vs 3 year mean from May to November 2023, mean may need recalculating from April 2023 onwards.

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

OP Cell 2024/25:
In order to "increase proportion of news / follow ups with a procedure", effectively making 'best use of available capacity', the countermeasures will aim to address one or more of the following:
Increase 1st appointments
Reduce follow ups without a procedure
Any capacity released should therefore be used for additional new patients, or to address the long waits / backlog.

What are we doing about it?

Countermeasure	Update / Next Steps
Advice & Guidance (A&G)	Advice & refer (triage by default) –scoping external support at System A&G Group –Birmingham & Solihull to present at Group in July. Final draft of proposed A&G standards circulated widely for comments.
Patient initiated Follow Ups (PIFU)	Increase Move to PIFU in Ophthalmology, RPA went live in July to support this. RPA at Review date live in July for lymphoedema. Next specialties for RPA Gynae & Spinal Surgery. Clinical & Mgt meeting held with ENT based on NHSE benchmarking (July), further actions identified. SMP haematology pathway live in June.
Missed Appointments: - 2 Way messaging - Health Inequalities Audits	• 2 Way Messaging; active technical discussions between Netcall & IM&T, go live August • Health Inequalities Audits – benchmarking & initial analysis complete, dashboard developed, proposal for pilot specialty shared, aligning with wider health inequalities approach, closely linking with public health consultant. **Positive engagement, pilot to start in July.**
Clinic Utilisation	See Missed Appointments. Also, Clinic Process Flow in shared OP Area, findings to be go to OP Cell July 2024
Results Waiting List review	Detailed analysis complete. Audit of neuro surgery and child health completed with 4 categories of outcomes, targeted validation ongoing. Improving Together event 19/06, current process mapped. Good engagement, various teams, next session 24th July.
Outcomes process review	Scoping approach; targeting those outstanding from previous months initially. Improving Together approach to follow RWL focus.

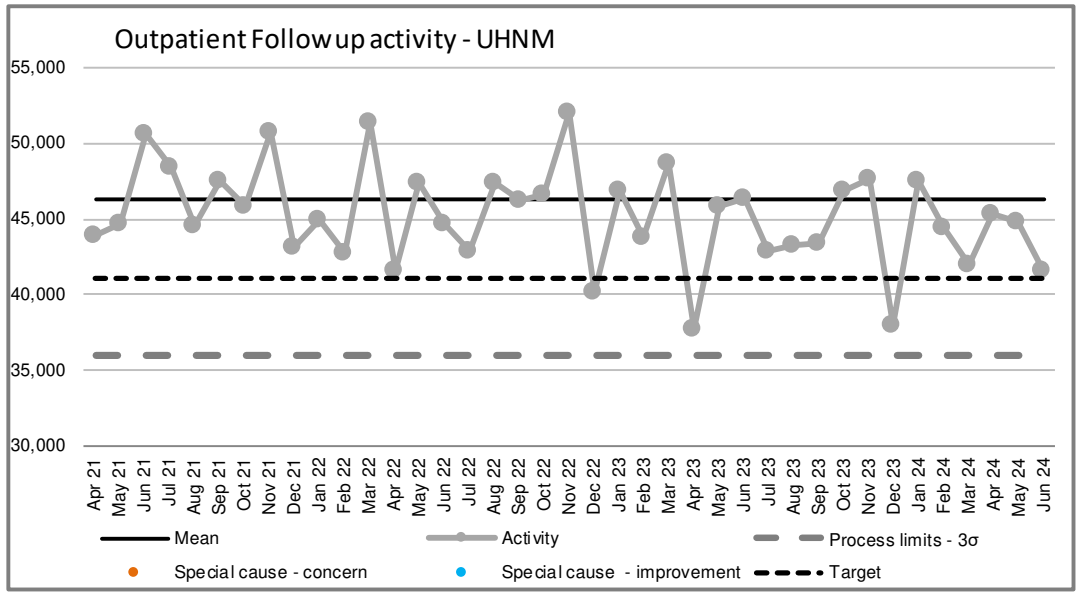
Resources

Delivering Exceptional Care with Exceptional People

Resources | Outpatient Follow Up Appts

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

University Hospitals of North Midlands NHS Trust

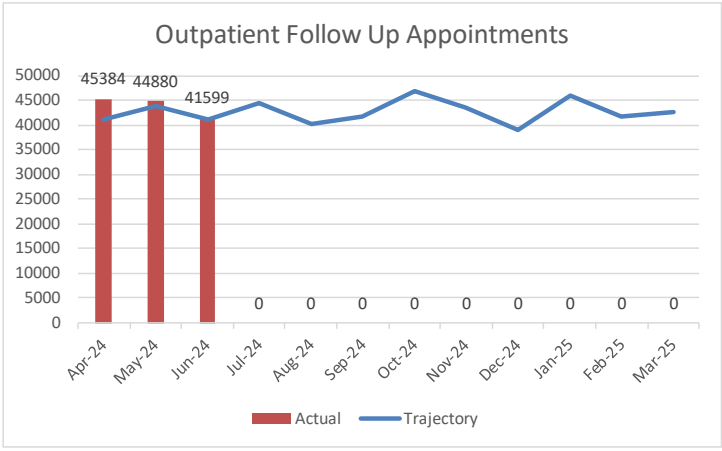


Variation	Assurance

Target	Apr 24	May 24	Jun 24
variable	45,384	44,880	41,599

Background

The number of follow up outpatient appointments at the Trust each month



What is the data telling us?

No significant change at this level; 5 points in a row below mean.

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

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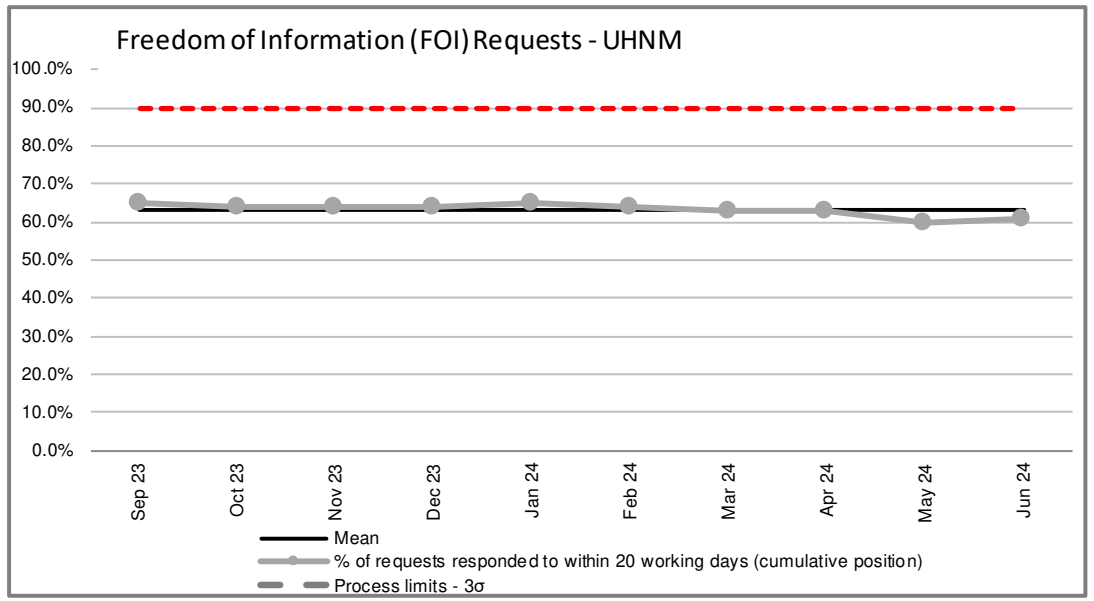
Resources | Freedom of Information Performance

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

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
90%	63%	60%	61%

Background

Freedom of Information Act requires 90% of requests to be responded within 20 working days

What is the data telling us?

The turnaround time is set at 20 working days as per the FOI Act.

The turnaround times for responding to Freedom of Information (FOI) requests is below the 90% target.

The data shows a slight improvement for June but the data is still averaging at 62% (mean)

What are we doing about it?

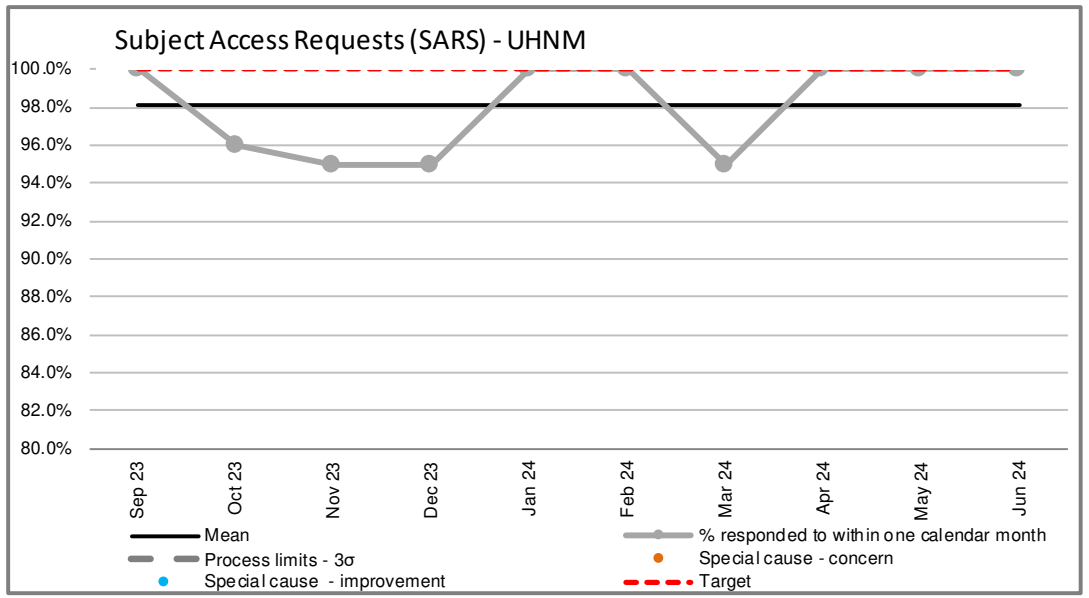
A task and finish group has been established to review the process and identify areas for improvement:

- A digital system has been procured following consultation with key stakeholders. Work is ongoing to ensure processes are in place:
  - To support the FOI team to transition to a new digital solution,
  - To ensure processes are in place to support the user with any issues using the digital solution,
  - Training material/ guides and communications are available for the user prior to Go Live.
- The disclosure log work stream is underway. The proposed approach will make the disclosure log more intuitive for the requestor
- A further meeting has been scheduled for July to confirm a go live date.

Resources | Subject Access Request Performance

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

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
100.0%	100.0%	100.0%	100.0%

Background

Data Protection Act requires subject access requests (SARs) to be responded within one calendar month. The figure includes Health Records/ CCTV/ Staff records plus information contained within emails

What is the data telling us?

The Data Protection Act states all SARs must be responded to within one calendar month unless an extension is agreed with the requestor (for more complex requests).

We have achieved the target for the past 3 months however it must be noted the number of subject access requests continues to increase. The People Directorate, who co-ordinate staff subject access requests continue to receive complex cases, which is impacting on resources.

What are we doing about it?

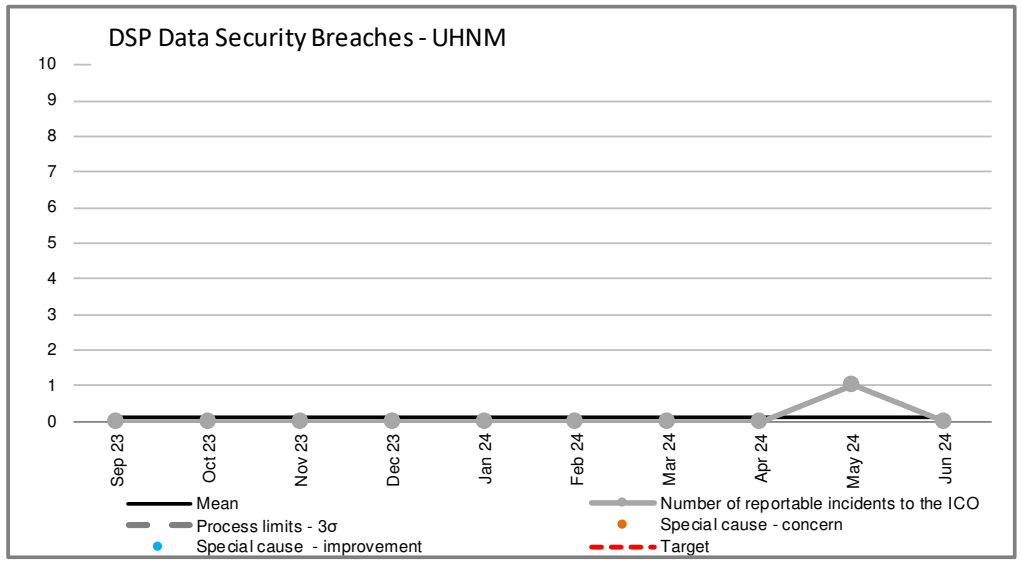
The Data, Security & Protection team are implementing a digital system for Freedom of Information Requests. This will also support the management of SARs. The People Directorate have agreed to move to the digital solution. This will facilitate a review of practice across DSP/Health Records and People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

A project plan is being developed (as per the detail outlined on the FOI slide). The SAR module will be rolled out once the FOI module has been embedded across the Trust.

Resources | Data Security Breaches

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

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 24	May 24	Jun 24
0	0	1	0

Background

What is the data telling us?

A data security breach must be reported to the Supervisory Authority; the Information Commissioner's Office (ICO), if it meets the ICO criteria threshold.

We have reported one serious security breach to date.

What are we doing about it?

A governance and assurance programme is in place to support staff in understanding Data, Security & Protection (DSP) and hence minimise a data security breach:

- Policies and Standard Operating Procedures are reviewed in line with latest/best practice.
- Statutory and Mandatory training is undertaken on a yearly basis
- DSP manual to support staff in their day-to-day duties.
- Training awareness survey to identify staffs understanding of DSP.
- Dedicated training material, for example Information Asset Owners, responsible for the management of digital systems.
- Data Protection Officer (DPO) review of DSP incidents to assess if they meet the threshold for reporting.
- A meeting is scheduled with the ICO to discuss the incident reported in May.

Resources | Digital Project Delivery Lifecycle

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

University Hospitals of North Midlands NHS Trust

	Progress Status					
Project Priority	COMPLETE	IN PROGRESS	MOVED TO BAU	NOT STARTED	ON HOLD	Grand Total
Essential	2	20	1	8	1	**31**
Essential – Proof of Concept (PoC)		1	1	3		**5**
Mandated	2	19	1	21	11	**54**
Other - High Priority		5		6		**11**
Other - Medium Priority		1		4		**5**
Other - Low Priority	1	2	1	12		**16**
Parked				1		**1**
PoC				1		**1**
TBC		2		3		**5**
Grand Total	**5**	**50**	**4**	**58**	**12**	**129**

Variation		Assurance	
Target	Apr 24	May 24	Jun 24
N/A	125	121	120

Background

There is no specific overarching target for the Digital Project Delivery Lifecycle however the count provided above identifies the number of projects presently on the IM&T project pipeline with a status of In Progress, Not Started or On Hold. The adjacent table and associated narrative describes the status and priority of all IM&T projects for 2024_25.

What is the data telling us?

There are currently 50 IM&T projects that are in progress (a decrease of 1 from last month). 5 projects have been completed during June 2024. 70 projects have either not started or are currently on hold (no change from last month). The data shows that IM&T have more projects in flight at this time than during April although, 1 less than in May. As noted in the last report, there continues to be a large volume of IM&T projects slated for delivery during 2024_25.

What are we doing about it?

To ensure that projects are prioritised correctly, IM&T will periodically undertake a review of priorities utilising a defined scoring mechanism based on criteria such as alignment to national/local strategy, benefits and risk reduction. IM&T have also introduced a new project request process and are also developing a new Project Management tool to provide a centralised view and oversight of IM&T projects in addition to associated standardised project management processes.

Resources | Financial Summary

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

University Hospitals of North Midlands NHS Trust

This report presents the financial performance of the Trust for June 2024 (Month 3).

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

- For Month 3 the Trust has delivered a year-to-date deficit of £5.8m against a planned deficit of £0.8m; this adverse variance of £5.0m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and medical staffing pay.
- There is a difference between the budget profile of the Trust's financial plan and the final plan submitted to NHSE; the Trust will continue to monitor performance against its financial plan and inform the committee of the position reported externally. It should be noted that this issue only effects the budget profile not the actual position and is neutral across the year.
- The Trust has a CIP target of £56.6m in 2024/25. The Trust has validated £10.2m of CIP savings to Month 3 against a plan of £12.8m. Of the £10.2m saving delivered £8.7m are non-recurrent against a plan of £7.9m.
- The full year forecast at Month 3 indicates that the most likely position is for a £22m deficit; the Trust will continue to identify mitigations to deliver the best possible outturn for the year with a focus on identifying and delivering recurrent CIPs.
- There has been £14.2m of Capital expenditure to Month 3. This is £0.4m below planned expenditure to Month 3.
- The cash balance at Month 3 is £86.6m which is £11.6m higher than plan mainly due to the profile of cash payments from the ICB; the forecast for the year is for a reduction of £20m due to non-cash elements, a requirement of £7.7m of Trust cash to be used for the 2024/25 capital programme and the payment in 2024/25 of capital payables at 31 March 2024.

Resources | Income and Expenditure

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

University Hospitals of North Midlands NHS Trust

The Trust has delivered a £5.8m deficit at Month 3 which is £5.0m away from the planned deficit of £0.8m. The table below summarises the I&E position at Month 3.

Income & Expenditure Summary Month 03 2024/25	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,064.7	88.6	87.3	(1.3)	266.2	267.6	1.4
Other Operating Income	87.6	7.1	7.2	0.1	21.3	21.2	(0.1)
Total Income	1,152.3	95.7	94.5	(1.2)	287.5	288.9	1.3
Pay Expenditure	(696.3)	(57.5)	(59.1)	(1.6)	(172.6)	(175.8)	(3.2)
Non Pay Expenditure	(422.8)	(35.9)	(34.3)	1.6	(107.5)	(111.2)	(3.7)
Total Operational Costs	(1,119.0)	(93.4)	(93.4)	(0.1)	(280.1)	(287.0)	(6.9)
EBITDA	33.3	2.3	1.0	(1.2)	7.5	1.8	(5.6)
Interest Receivable	3.9	0.3	0.6	0.2	1.0	1.7	0.7
PDC	(2.0)	(0.2)	(0.2)	(0.0)	(0.5)	(0.5)	(0.0)
Finance Cost	(35.2)	(2.9)	(2.9)	(0.0)	(8.8)	(8.8)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	0.0	(0.5)	(1.5)	(1.0)	(0.8)	(5.8)	(5.0)
Plan phasing adjustment	0.0	1.0		(1.0)	1.5		(1.5)
Surplus / (Deficit) reported to NHSE	0.0	0.5	(1.5)	(2.0)	0.7	(5.8)	(6.5)

The year-to-date adverse variance of £5.0m is mainly driven by an under achievement of CIP (£2.6m), the impact of industrial action (£1.2m) and medical staffing pay (£2.1m). Income is over recovered by £1.3m mainly due to additional excluded drugs and devices income.

Resources | CIP

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

University Hospitals of North Midlands NHS Trust

The Trust has a £56.6m CIP target for 2024/25. To Month 3 the Trust is reporting £10.2m savings in year, of which £8.7m relates to non-recurrent schemes. The in month over delivery of £2.3m is supported by the transaction of non-recurrent CIPs in month above the planned level.

CIP Savings Month 3 2024/25	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
Divisional position							
Medicine & Urgent care	3.9	0.3	0.1	(0.2)	1.0	0.1	(0.9)
Surgery, Theatres & Critical Care	3.6	0.3	0.0	(0.3)	0.9	0.1	(0.8)
Network services	2.8	0.2	0.0	(0.2)	0.7	0.1	(0.6)
Womens, Childrens & Clinical Support Services	2.6	0.2	0.1	(0.1)	0.7	0.1	(0.5)
Central functions	1.6	0.1	0.1	(0.1)	0.4	0.1	(0.3)
Estates, Facilities & PFI	1.0	0.1	0.0	(0.1)	0.3	0.1	(0.2)
North Midlands & Cheshire Pathology Services	1.2	0.1	0.0	(0.1)	0.3	0.0	(0.3)
Divisional CIP	16.7	1.4	0.4	(1.0)	4.2	0.6	(3.5)
Pay Underspend	6.0	0.5	1.5	1.0	1.5	1.5	-
Bank interest	2.0	0.2	0.4	0.2	0.5	1.2	0.7
Energy savings	3.2	0.3	0.3	-	0.8	0.8	-
Investment slippage	5.0	0.6	0.6	-	2.5	2.5	-
Other non recurrent	7.3	0.6	1.6	1.0	1.8	2.0	0.2
Additional CIP to 4% of cost base	6.3	0.5	1.6	1.1	1.6	1.6	-
Additional CIP to achieve breakeven	10.2		-	-			-
Total CIP	56.6	4.0	6.3	2.3	12.8	10.2	(2.7)

The table below summarises the recurrent and non-recurrent CIP delivery.

2024/25 CIP target	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
Recurrent	25.0	1.7	0.6	(1.0)	5.0	1.4	(3.5)
Non Recurrent	31.7	2.4	5.7	3.3	7.9	8.7	0.9
Total CIP target	56.6	4.0	6.3	2.3	12.8	10.2	(2.7)

Resources | Capital

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

University Hospitals of North Midlands NHS Trust

UHNM Capital Plan	2024/25 Updated Plan July 2024 £000	YTD Plan M3 £000	YTD Actual M3 £000	Variance M3 £000
Capital funding				
PFI & Loan Commitments	31.5	7.1	7.1	-
Base STP allocation	22.1	5.5	5.5	-
ICB fair share reduction	(0.5)	(0.1)	(0.1)	-
ICB brokerage	(3.1)	(0.8)	(0.8)	-
ICB IFRS16 CDC lease funding	5.0	-	-	-
ICB IFRS16 incremental increase allocation	-	-	-	-
Public Dividend Capital funding	40.9	3.6	3.6	-
Donated, granted other capital funding	7.4	0.8	0.8	-
Internal funding source (including capital receipts)	1.8	-	-	-
Total Capital funding	105.2	16.1	16.1	-
Capital expenditure				
PFI & Loan Commitments	(31.5)	(7.1)	(7.1)	-
Pre-committed investment items (ICB allocation)				
PFI enabling costs	(0.2)	(0.1)	(0.1)	-
Network & Comms BC525	(1.3)	(1.3)	(1.2)	0.1
IM&T computer hardware refresh programme	(5.2)	-	-	-
LED lighting BC546	(0.2)	-	-	-
Pharmacy Robot BC487 -	(0.0)	-	-	-
Investment funding	(0.5)	-	-	-
Central Contingency & risk	(0.3)	-	-	-
Project Star - car park completion/RI remedial	(0.2)	(0.2)	(0.1)	0.0
Emergency Department (restatement costs)	(0.2)	-	-	-
Air heat boiler replacement Trust Contribution	(0.8)	-	-	-
EPMA (Electronic Prescribing) BC	(0.4)	(0.1)	(0.1)	(0.0)
Patient Portal roll out costs (BC 462)	(0.1)	(0.0)	(0.0)	0.0
ED ambulance off - enabling ward moves	(0.3)	(0.1)	(0.1)	-
Endoscopy works 7th room - PDC ICB allocation	(0.4)	-	-	-
County theatre holding bay	(0.3)	-	-	-
Omnicell Cabinet for AMU	(0.3)	-	-	-
Car park barriers BC550	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.1)	(0.1)	(0.1)	(0.0)
Approved minor investments	(0.3)	-	(0.0)	(0.0)
Funding to be (allocated)/shortfall	2.4	-	-	-
Total Pre committed Investment items	(9.4)	(1.8)	(1.7)	0.0
IMT Sub Group Funding	(3.5)	(0.3)	(0.2)	0.1
IM&T lap top replacement top-slice	1.3	-	-	-
Medical Devices Sub Group Total Funding	(3.6)	(0.9)	(0.6)	0.3
Estates Sub Group Total Funding	(4.3)	(0.2)	(0.1)	0.0
Health & Safety compliance	(0.2)	-	-	-
Net zero carbon (sustainability) initiatives	(0.1)	-	-	-
Total Sub Groups	(10.3)	(1.3)	(0.9)	0.4
Total IFRS16 leases	(5.9)	-	-	-
Total Internal Capital Expenditure programme	(57.0)	(10.2)	(9.8)	0.4
Additional CRL / Externally Funded PDC				
CDC phase 2 endoscopy - 24/25 PDC	(6.2)	-	-	-
CDC phase 2 endoscopy - 24/25 IM&T	(0.5)	-	-	-
CDC phase 1 estates enabling - 24/25	(11.3)	-	-	-
CDC phase 1 estates enabling rephase to 2025/26	3.1	-	-	-
CDC phase 2 endoscopy - 23/24 PDC	(2.7)	-	-	-
CDC phase 1 23/24	(0.5)	(0.5)	(0.5)	-
TIF 2 PDC (Breast care unit)	(7.5)	(0.2)	(0.2)	-
TIF 2 PDC (Day Case Unit) -	(8.7)	(1.3)	(1.3)	-
PDC - UEC modular build (AMRA) 23/24 PDC	(2.9)	(1.5)	(1.5)	-
Digital - EPR 2023/24 PDC	(2.1)	(0.1)	(0.1)	-
Digital - EPR 2024/25 PDC	(1.4)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.5)	-	-	-
Equipment - endoscopy CDEL	(1.0)	-	-	-
Charitable funded expenditure	(3.9)	(0.8)	(0.8)	-
Total Additional CRL / PDC Funded expenditure	(48.2)	(4.4)	(4.4)	-
Total Capital Expenditure	(105.2)	(14.6)	(14.2)	0.4
Planned under/(over) spend	(0.0)	1.5	2.0	0.4

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

The capital plan at this stage shows expenditure in excess of income totalling £2.4m. It is expected that this can be mitigated by
- the availability of IFRS 16 funding from NHSE when allocated. In 2023/24 we have received £2.8m of funding and similar levels may be available for 2024/25.
- there is the potential for further VAT credits relating to previous years expenditure becoming available as realised.
- there may be some capital resource funding available from the net book value of asset disposals.
- there may be further slippage on some of the bigger PDC funded schemes, delaying expenditure to future years.

At Month 3 capital funding is in line with plan and capital expenditure is £0.4m lower than plan. Of the £14.2m expenditure, £7.1m relates to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure.

For capital expenditure the main variance from plan is on the medical devices sub-group where expenditure is £0.3m behind plan. This is due to the replacement of equipment at County X-Ray being re-phased to Month 9 due to the delay of the site visit and selection of the preferred model of equipment.

The planned underspend of £1.5m at Month 3 relates to the difference between capital funding through depreciation and planned expenditure. The depreciation charge is generally phased equally over the course of the financial year however capital expenditure is phased largely in the second half of the financial year.

Resources | Balance Sheet

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

University Hospitals of North Midlands NHS Trust

Balance sheet as at Month 3	31/03/2024	30/06/2024			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	686.3	686.9	686.8	(0.1)	
Right of Use Assets	18.1	17.2	17.0	(0.2)	
Intangible Assets	16.3	15.0	14.8	(0.3)	
Trade and other Receivables	1.1	1.1	1.1	0.0	
Total Non Current Assets	721.7	720.3	719.7	(0.6)	
Inventories	17.7	17.7	17.9	0.2	
Trade and other Receivables	44.4	47.4	52.7	5.4	Note 1
Cash and Cash Equivalents	82.0	75.0	86.6	11.6	Note 2
Total Current Assets	144.1	140.1	157.2	17.2	
Trade and other payables	(125.6)	(119.0)	(142.6)	(23.7)	Note 3
Borrowings	(25.7)	(24.7)	(24.9)	(0.3)	
Provisions	(5.7)	(5.7)	(5.5)	0.2	
Total Current Liabilities	(156.9)	(149.3)	(173.1)	(23.8)	
Borrowings	(477.1)	(477.1)	(476.6)	0.5	
Provisions	(2.3)	(2.3)	(2.3)	0.0	
Total Non Current Liabilities	(479.4)	(479.3)	(478.9)	0.5	
Total Assets Employed	229.5	231.7	225.0	(6.7)	
Financed By:				-	
Public Dividend Capital	693.9	693.9	693.9	-	
Retained Earnings	(669.1)	(666.9)	(673.6)	(6.7)	Note 4
Revaluation Reserve	204.7	204.7	204.7	-	
Total Taxpayers Equity	229.5	231.7	225.0	(6.7)	

The balance sheet plan reflects the forecast included within the 2024/25 Financial Plan submitted to NHSE. Variances to the plan at Month 3 are explained below:

Note 1. Trade and other receivables are £5.4m higher than plan. This is mainly due to prepayments of £9.4m being higher than expected, the prepayments mainly relate to managed service contracts and annual licences which are paid for the 12 month period. NHS accrued income is also higher than plan due to income accrued with the ICB of £3.4m.

Note 2. The cash position at Month 3 reflects the higher than planned level of deferred income where cash has been received in advance for the entire financial year from the ICB in a number of areas, particularly ERF. This is partly offset by higher-than-expected capital payments, revenue pre-payments, and the I&E deficit position at Month 3.

Note 3. Trade and other payables are £23.7m higher than plan. This is mainly due to deferred income of £46.5m at Month 3 being significantly higher than plan. Of this balance £30.5m relates to Staffordshire and Stoke ICB due to the upfront payments of ERF funding £15.6m, 2024/25 block contract £4.4m, West Midlands Cancer Alliance funding £2.6m and CDC MRI funding £1.3m. Deferred income relating to high cost devices was £6m at Month 3.

The overall increase in deferred income is partly offset by the reduction in capital payables compared to the year end due to the payment of invoices and reduced level of capital spend in the early months of the financial year.

Note 4. Retained earnings are showing a £6.7m variance from plan which reflects the Month 3 financial performance deficit of £5.8m and adjustments relating to.
- donated income and donated depreciation £0.4m.
- adjust PFI revenue costs to a UK GAAP basis £0.9m.

Resources | Conclusion

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

University Hospitals of North Midlands NHS Trust

The Trust has recorded an actual year to date deficit of £5.8m at Month 3 against a planned surplus of £0.8m, resulting in an adverse variance year to date of £5.0m. This is primarily driven by the non-delivery of CIP, the impact of industrial action and medical pay. A forecast for the year based on Q1 run rates indicates a most likely deficit of £22.0m for the year.

Highlight Report

Audit Committee | 01 August 2024

Matters of Concern / Key Risks to Escalate

For information:

- 3/6 assurance rated reports received a Partial Assurance rating
- Partial Assurance rating issued for the **Ambulance Handover Data** Internal Audit Review; 2 high priority and 1 medium priority action will be monitored via the Performance & Finance Committee; the main theme of the findings was around data quality
- Partial Assurance rating agreed for the **Corporate Governance Report**, as there remain outstanding declarations of interest (escalation action agreed)
- **Total losses and special payments** made during the period April to June 2024 were £230, 386 and 616 debtor balances totalling £1.4m were identified for write-off, a high level of which were associated with Pharmacy stock and overseas visitor debt
- £196k **salary overpayments** and will be addressing this with divisions through the performance review process
- Partial Assurance for SFI Breaches related to Late Termination Change Forms as whilst salary overpayments are being managed at source as and when they occur, in an appropriate and timely manner to ensure repayment work reduce the occurrence is needed

Major Actions Commissioned / Work Underway

- Counter Fraud to contact the individuals who remain non-compliant with their **Declaration of Interest** as a further point of escalation
- Joint work in collaboration with the Ambulance Service to review and improve the 'ambulance journey' data, as recommended in the review of **Ambulance Handover Data**
- Further consideration of the Internal Audit action associated with **job planning** sign off to be given, due to the scale of work involved and lack of timeframe for implementation
- Timescales for requesting of **declarations of interest** will be moved to a fixed annual timescale to support oversight and monitoring
- Delayed **policy reviews** will be added to the Risk Register so that a quantified risk level can be provided to the Committee; consideration will also be given to the frequency of reviews in terms of whether the delay is compliance or capacity related
- A **Cyber Security Report** is being put together for the Audit Committee to consider on a 6 monthly basis as agreed through the Deep Dive process
- NHSE are undertaking a review of our **Regulatory Undertakings** with Subject Matter Experts, and it is hopeful that some may be lifted if sufficient assurance can be provided
- Consideration to be given to the scoring of avoidability of **Pharmacy stock write** off
- Consideration is being given to increasing the resource within the **Overseas Visitor Team** although this will need to be balanced in terms of cost / benefit,
- Counter Fraud review of **Overseas Visitors** identified a number of actions to be taken
- Some additional management actions were presented as part of the External Audit which will be added to the tracker

Positive Assurances to Provide

- 3/6 Assurance Rated reports received an Acceptable Assurance rating
- Acceptable Assurance given to the Losses and Special Payments Update due to there being processes in place, provisions made for the write offs identified (although some improvements were identified in the timeliness of agreeing write off)
- Acceptable Assurance given to the SFI Breaches and Single Tender Waivers (STW) due to there being robust processes and procedures in place to govern all third-party expenditure (there was 1 STW in Q1 and 113 SFI breaches, all rated 'green' as unlikely to have led to lost commercial value)
- Overall 'green' rating for the **Counter Fraud Functional Standard Return** which assures full compliance with requirements
- 24/29 requirements for **Conflicts of Interest** were confirmed as being complete, some improvements were identified and being actioned
- Acceptable Assurance rating agreed for the **Internal Audit Recommendations** Tracker as a significant number of actions have been closed, although there remain several problematic actions that have been delayed and will be overseen by the responsible Committee

Decisions Made

- Approval of minutes of the previous meeting
- Approval of Standing Financial Instructions (SFI) Policy (minor amendments)
- Debt write-off proposed, which will be escalated to the Board

Comments on the Effectiveness of the Meeting

- Members commented that the agenda was managed well given the volume of business covered
- Consideration is to be given to the use of assurance ratings in terms of process or outcome

Cross Committee Considerations

- **Performance & Finance Committee:** Oversight of actions arising from the review of Ambulance Handover Data
- **Strategy & Transformation Committee:** Audit Committee will take over responsibility for Cyber Security Assurance
- **Quality Governance Committee:** will be overseeing a number of improvements to BAF 1 (which were notified to the Audit Committee)

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: Ambulance Handover Data	1 / 4	Ext 20	Partial	Assurance	8.		Losses and Special Payments Update Q1 24/25	7/8	Ext 16	Acceptable	Assurance
2.	-	Internal Audit Action Tracker	-		Acceptable	Assurance	9.		SFI Breaches and Single Tender Waivers Q1 24/25	7/8	Ext 16	Acceptable	Assurance
3.	-	Corporate Governance Report	-		Partial	Assurance	10.		SFI Breaches related to Late Termination and Change Forms Q1 24/24	7/8	Ext 16	Partial	Assurance
4.	-	Quarter 1 Board Assurance Framework, Deep Dives & Summary	1 – 9	As per BAF	*Substantial (IA finding)*	Assurance	11.		Counter Fraud Progress Report	-	-	*Not Rated*	Assurance
5.	-	Regulatory Undertakings	-		Not Rated	Assurance	12.		Final Counter Fraud Annual Report	-	-	*Not Rated*	Assurance
6.		F01 Standing Financial Instructions Policy	7/8	Ext 16	Not Rated	Approval	13.		Final External Audit Findings Report	-	-	*Not Rated*	Assurance
7.	-	Issues for Escalation from Committees			Not Rated								

Attendance Matrix

Members:		May	June	August	October	January
Alison Rodwell	Non-Executive Director (Chair)					
Tanya Bowen	Non-Executive Director					
Gary Crowe	Non-Executive Director					
Leigh Griffin	Non-Executive Director					
Andrew Hassell	Non-Executive Director					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Q1 Board Assurance Framework	**Agenda Item:**	16
Author:	Claire Cotton, Director of Governance and Nicola Hassall, Deputy 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 Q1 2024/25 and is enclosed, along with an accompanying 'Summary BAF'.

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. BAF Deep Dives were held in January 2024, the outputs of which have been fed into planning the risks for 2024/25, in addition the Deep Dives held in May/June will be taken into account when refreshing the BAF for Quarter 2.

Assessment

	The most threatened of our Strategic Priorities is 'Quality', with all nine Strategic Risks posing a threat to its achievement. This is followed by 'Responsive' and 'People', each with eight Strategic Risks posing a threat.
	The most significant Strategic Risk is 'Delivering Responsive Patient Care', which has the highest risk score of Extreme 20, which is above tolerance of 8-12.
	Digital Transformation and Fit for Purpose Estate are in line with their risk tolerance score. However, these are due to be reviewed following the Deep Dives undertaken during the quarter.
	All action plans are currently on track.

Key Recommendations

The Trust Board is asked to approve or amend the BAF and to consider whether risk scores and assurance assessments are an accurate reflection of the position

University Hospitals of North Midlands NHS Trust

Board Assurance Framework

Quarter 1, 2024/25

1 Introduction and Overview

Situation

The Board Assurance Framework (BAF) is a dynamic document, updated on a quarterly basis, which provides a structure and process focussed on the key risks that might compromise the achievement of our objectives (Strategic Priorities). It maps out the key controls that should be in place to manage our objectives and confirms the assurance mechanisms about the adequacy of those controls. Before being presented to the Board, it is scrutinised by the Performance and Finance Committee, People, Culture and Inclusion Committee and Quality Governance Committee, which have responsibility for specific strategic risks and assurance. The Audit Committee has responsibility for oversight of the BAF process.

> An assurance framework is a structured means of identifying and mapping the main sources of assurance and co-ordinating them to best effect.
>
> HM Treasury Guidance on Assurance Frameworks (2012)

Background

A review of the key risks which form the basis of the BAF is undertaken by the Board on an annual basis. During 2023/24, the process was strengthened further, through the introduction of Deep Dives. The Deep Dives have provided committees with a structured, detailed approach to scrutinising the BAF, using a core set of 'Key Lines of Enquiry', which resulted in the identification of opportunities for improvement. Taking these into account, the Board agreed the changes to the BAF for 2024/25 at their Board Seminar in March 2024, which are reflected in this document.

Assessment

Internal Audit

Our Internal Auditors undertake a review of the BAF each year as part of their annual audit programme. Their review of the BAF for 2023/24 was reported to the Audit Committee in May 2024, which concluded with 'Substantial Assurance'. This means that for 7 consecutive years the BAF has received a very positive audit conclusion, which supports the Head of Internal Audit Opinion and the Annual Governance Statement. The 2023/24 review concluded with just one medium priority action which has been completed through the Quarter 1 review and Deep Dive:

✓	Ensure that BAF risk entries accurately capture the controls in place to mitigate risks and where risk scores have remained constant for consecutive quarters, evaluate the effectiveness of existing controls and / or revisit the risk appetite / tolerance for the risk impacted by the effectiveness review.

Deep Dives

During May and July, Committees undertook Deep Dives into the following areas:

- BAF 1: Patient Outcomes and Experience (Quality Governance Committee)
- BAF 2: Improving our Workforce Sustainability (People, Culture & Inclusion Committee)
- BAF 4: (new BAF No.) Responsive Patient Care (Performance & Finance Committee)
- BAF 5: (new BAF No.) Digital Transformation (Strategy & Transformation Committee)
- BAF 6: (new BAF No.) Fit for Purpose Estate Infrastructure (Performance & Finance Committee)

The Deep Dives followed our agreed Key Lines of Enquiry which facilitated a healthy debate, with a number of outcomes agreed for the Quarter 2 update. The outcomes agreed will be reported to the Audit Committee

In addition, it was agreed to develop individual Assurance Maps for each of the Enabling Strategies, to provide a greater depth of assurances in place including those at an operational level. This work will be led by the Director of Governance along with each of the Strategy Executive Leads and consideration is being given to these being included within the refreshed Strategies will are expected to take place throughout 2024/25 aligned with the launch of the overarching strategy.

Key Observations for the Quarter 1 Update

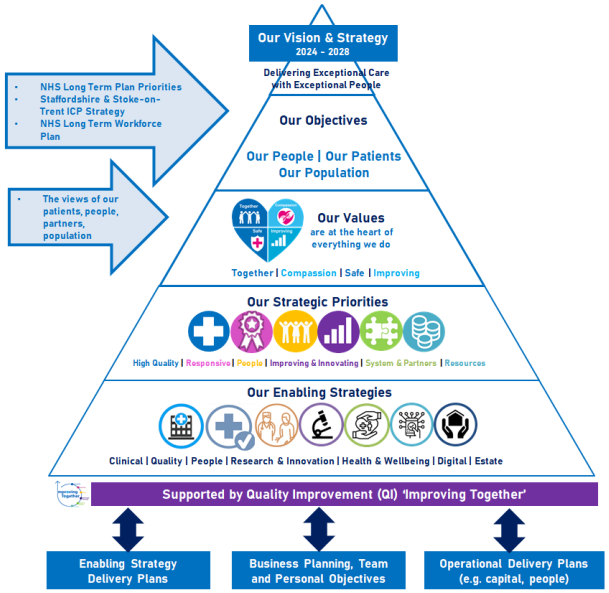
🔍	The 'most threatened' of our Strategic Priorities is 'Quality', with all 9 Strategic Risks posing a threat to its achievement. This is followed by 'Responsive' and 'People', each with 8 Strategic Risks posing a threat.
🔍	The most significant Strategic Risk is 'Delivering Responsive Patient Care', which has the highest risk score of Extreme 20, which is above tolerance of 8 - 12.

	Digital Transformation and Fit for Purpose Estate are in line with their risk tolerance score. However, these are due to be reviewed following the Deep Dive process.
	All action plans are currently on track.

Recommendations

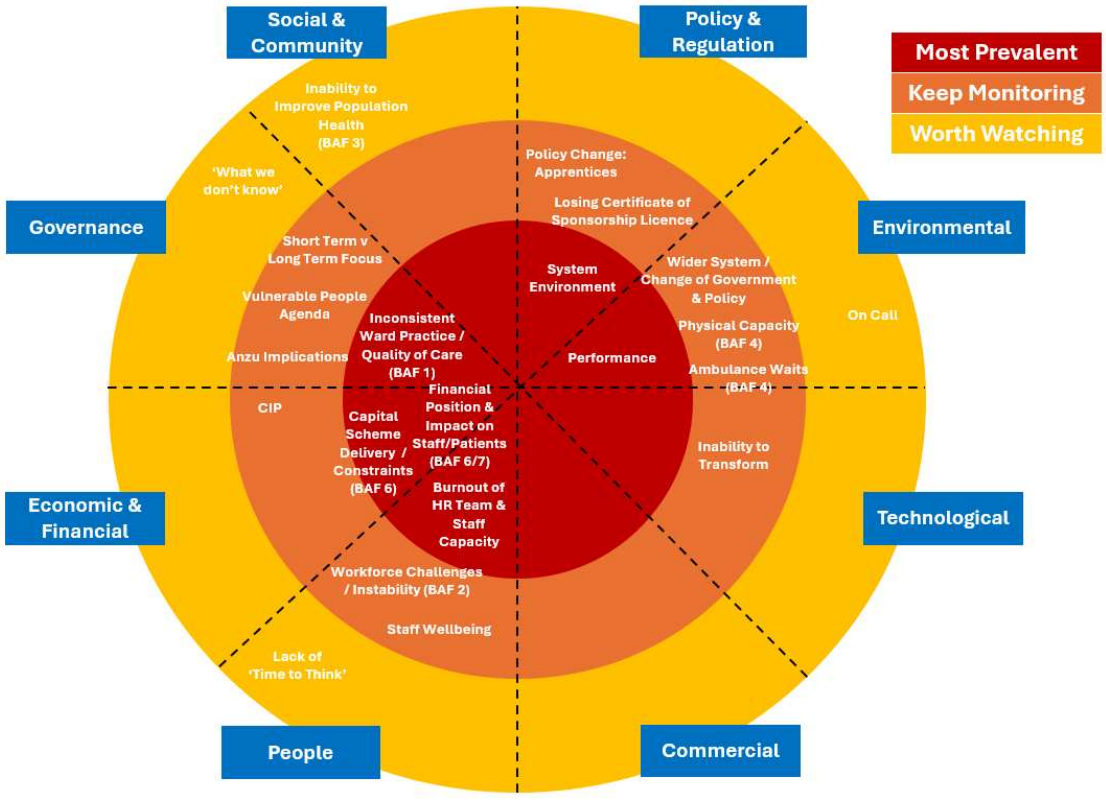
- To note the positive audit conclusion from Internal Audit
- To approve the BAF as an accurate reflection of our position at Quarter 1 2024/25 (whilst noting the proposed changes to be incorporated into Q2)

2 Strategic Framework and Threat to Strategic Priorities



3 Risk Radar

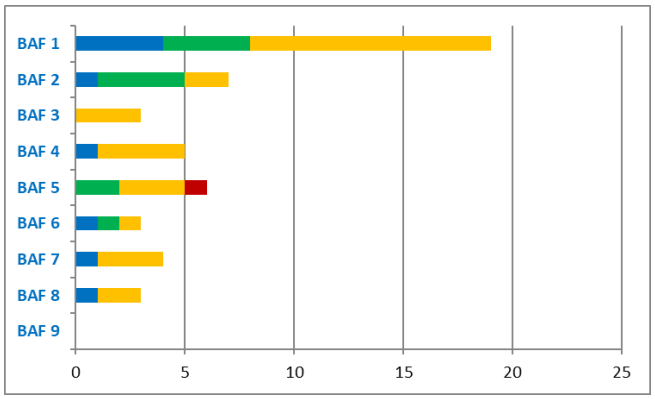
At the Board Seminar in March 2024, a Risk Radar exercise was undertaken to scope out our most prevalent risks and those which will need to be monitored. A number of these already form part of the Board Assurance Framework and have been mapped accordingly. Other risk form part of the operational risk register. The Risk Radar is illustrated below and will continue to be developed.



4 Summary Board Assurance Framework

Assurance Committee	BAF No.	BAF Risk Title	Risk Score and Assurance Q1	Q2	Q3	Q4	Target	Appetite / Tolerance	Linked Risks	Longer Term Risk Actual v	Action BRAG	Strategic Priorities
Quality Governance Committee	BAF 1	Delivering Positive Patient Outcomes	High 12	High 12	High 8	High 8	Mod 6	Minimal	147			
							31/03/26	Above Tolerance (4 - 6)			11	
People, Culture & Inclusion Committee	BAF 2	Improving Workforce Sustainability & Culture	Ext 16	Ext 16	High 12	High 9	High 9	Open	120			
							31/03/25	Above Tolerance (8-12)			15	
Strategy & Transformation Committee	BAF 3	Improving the Health of our Population	Ext 15	Ext 15	Ext 15	High 10	High 10	Open	0			
							31/03/25	Above Tolerance (8-12)	Graph not available as no linked risks identified		2	
	BAF 5	Digital Transformation	High 12	High 12	High 12	High 8	High 8	Open	72			
							31/03/25	At Tolerance (8-12)			3	
	BAF 9	Research & Innovation	High 12	High 12	High 12	High 12	High 8	Cautious	2			
							30/09/25	Above Tolerance (4 - 6)			4	
Performance & Finance Committee	BAF 4	Delivering Responsive Patient Care	Ext 20	Ext 15	Ext 15	Ext 20	High 10	Open	51			
							30/09/25	Above Tolerance (8-12)			2 / 6	
	BAF 6	Fit for Purpose Estate	High 12	High 12	High 12	High 12	High 12	Open	69			
							31/03/29	At Tolerance (8-12)			7	
	BAF 7	Financial In Year Delivery	Ext 16	Ext 16	High 12	High 12	High 12	Open	27			
							31/03/25	Above Tolerance (8-12)			3	
	BAF 8	Financial Sustainability	Ext 16	Ext 16	High 12	High 12	High 12	Cautious	1			
							31/03/25	Above Tolerance (4-6)			2	

5 Strategic Risk Heat Map and 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.

6 Board Assurance Framework

BAF 1: Delivering Positive Patient Outcomes

Quality Governance Committee | Chief Nurse & Chief Medical Officer

Internally Driven ●

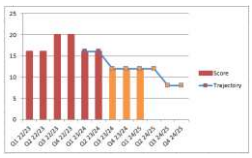
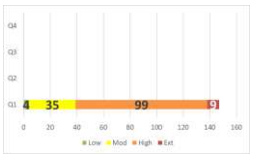
Externally Driven

Risk Description and Impact on Strategic Priorities

Cause	If we do not consistently maintain evidence based, safe and effective care,
Event	then we may see an increased incidence of avoidable harm, poor patient experience and suboptimal patient outcomes,
Effect	resulting in unnecessary reductions in the quality of treatment, failure to deliver statutory and regulatory compliance, increased complaints and litigation, reputational damage and poor staff morale.

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target (Tolerance)		Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	3	3	2	2	2	31/03/26	Minimal Appetite		
Consequence	4	4	4	4	3		Risk score is expected to be above agreed tolerance (Mod 4 – 6) until March 2026		
Risk Level	12	12	8	8	6				

Rationale for Risk Score and Progress in the Quarter:

- All ward / department Registered Nurses / Midwives and Healthcare Assistant vacancies now recruited to, with pool of Registered Nurses in talent pool
- Martha's Rule work is now underway, introductory NHS England (NHSE) meeting has taken place
- We have delivered an intensive support programme for a ward that received double Bronze Care Excellence Framework (CEF); this is being evaluated before being rolled out further
- Following a NHSE rapid quality review, we are no longer required to attend System Maternity Oversight and Assurance Group (SMOAG)
- Root and branch review of contributing factors to C Difficile incidences completed
- Developed a reduction of Hospital Acquired Infections (HAI) A3 and Prevention of Pressure Damage A3
- Reallocation of resources has allowed the Clinical Effectiveness Review to commence
- Clinical Effectiveness Group in place and divisional plans now being pulled together although these require further development and embedding into divisional governance
- A3 Clinical Effectiveness under development although progressing slowly
- Governance structure sitting beneath Clinical Effectiveness being developed as well as divisional governance arrangements
- Assurance Report for Clinical Effectiveness being developed for Quality Governance Committee

Key Controls Framework

Divisional	• Mortality rates monitored through the Mortality Review Group • Scrutiny of circumstances surrounding deaths from Medical Examiner +/- Structured Judgement Review • Monthly Directorate Mortality and Morbidity meetings are held to review deaths and discuss cases • Clinical service structures, accountability and quality governance arrangements at Trust, division and service levels • Clinical policies, procedures, guidelines, pathways, supporting documentation and IT systems • Clinical audit function • Clinical staff recruitment, induction, mandatory training, registration and revalidation • Defined safe medical, nursing, midwifery and Allied Health Professional (AHP) staffing levels for all areas • Ward assurance / metrics and accreditation programme
Corporate	• 6 monthly nurse staffing establishment reviews to ensure established numbers match acuity • Birth Rate Plus staffing assessment for midwifery services • Care Excellence Framework refreshed Bronze review meetings • Quality, safety and effectiveness reporting pathways • High Quality identified as a Key Priority Domain for our Improving Together Programme • Divisional Clinical Effectiveness Plans / Dashboard reviewed at Clinical Effectiveness Group • Junior Doctors Workforce Business Case
System	• Registered and regulated by Care Quality Commission (CQC) • Integrated Care Board (ICB) quality, safety and compliance meetings • Healthwatch visits • External regulation / accreditation assessments • Internal Audit Programme • National reports and surveys • Screening Quality Assurance Services (SQAS) assessments and reports

Assurance Map

	Sources of Committee Assurance for 2024/25	Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance	Executive Clinical Effectiveness Group Assurance Report	NR	●	●	●
	Executive Maternity Quality and Safety Oversight Group Assurance Report	NR	●	●	●
	Executive Quality and Safety Oversight Group Assurance Report	NR	●	●	●
2nd Line Assurance	Care Excellence Framework (CEF) Summary	■	●	●	●
	Care Quality Commission Action Plan	⊗	●	●	●
	Clinical Effectiveness Update	■			
	Infection Prevention Board Assurance Framework	■	●	●	●
	Infection Prevention Report	■	●	●	●
	Legal Services Litigation and Inquest Report			●	
	Maternity Dashboard	■	●	●	●
	Maternity and Neonatal Workforce Report	■	●	●	●
	Maternity and Neonatal Medical Workforce Report	■	●	●	●
	Maternity Serious Incident Report	■	●	●	●
	Medical Examiner Update		●		●
	Medicines Optimisation	■	●	●	●
	Mortality Report	■	●	●	●
	Nursing and Midwifery Staffing and Quality Report	⊗	●	●	●
	Patient Experience Report	■	●	●	●
	Patient Safety Incident Investigation & Serious Incident Report	■	●	●	●
	Patient Waiting List Backlog	■	●		
	Perinatal Mortality Report	■	●	●	●
	Quality Account	NR			
	Quality Performance Report	■	●	●	●
	Readmissions Analysis	⊗	●	●	●
	Resuscitation Annual Report			●	
	Safeguarding Adults Annual Report		●		
	Safeguarding Children Annual Report		●		
	Vulnerable Patients Annual Report		●		
3rd Line Assurance	Clinical Effectiveness Framework Internal Audit				●
	Patient Safety Incident Response Framework (PSIRF) Internal Audit	■			
	Care Quality Commission Action Plan Outcomes Framework	■			
	Maternity and Neonatal Action Plan Internal Audit				●
	Mental Capacity Assessment Framework Internal Audit	■			
	Nurse E-Rostering Internal Audit			●	
	Safe Staffing Internal Audit	■			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control

- Development of mature annual Clinical Effectiveness plans at Divisional level, to be approved and tracked through Clinical Effectiveness Group
- Introduction of ePMA system
- Introduce ward to board dashboard utilising real-time data
- Maintain future workforce requirements and pipelines
- Embedding and sustaining Quality Improvement methodology at all levels of the organisation

Gaps in Assurance

- Meet Section 29a requirements
- Robust system is required for evaluating harm in patients waiting for elective procedures
- Reduce / eliminate Bronze overall CEF ratings
- Operation Anzu conclusion and associated learning

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Support the COO with delivery of the non-elective improvement programme.	Reduce Likelihood	CNO COO CMO	31/03/25	Test of Change and Standard work process continues. Additional educator role approved full time to support this programme of work.	
2	Harm Review process to be integrated and enhanced.	Provide Assurance	CMO	31/12/24	Existing processes are currently being reviewed and enhancements under consideration.	
3	Reduce / eliminate number of areas who are rated CEF Bronze.	Provide Assurance	CNO	31/03/25	Bronze CEF meetings continue; 2 areas received second Bronze rating. In response we have delivered an intensive support programme on Ward 230 which is currently being evaluated before rolling out to other areas.	
4	Continue to drive improvements and collate evidence to support us meeting the requirement of the s29a notices.	Reduce Likelihood and Provide Assurance	CNO	30/09/24	Maternity taken off System Maternity Oversight and Assurance Group following a Rapid Quality Review led by NHSE. Evidence sent to the CQC regarding Mental Capacity / Mental Health. Internal Audit of MCA / DOLS – received reasonable assurance. Continue to collate evidence and forward this to the CQC. Reinspection for County Hospital undertaken, awaiting formal feedback.	
5	Embed Clinical Effectiveness processes within divisional teams to provide oversight of patient outcome and quality data.	Provide Assurance	CMO	31/12/24	Processes currently under review.	
6	Continue rollout of Improving Together and embed sustainability.	Reduce Likelihood	CNO	Ongoing Review Q1 2026	Continue to deliver roll out plan in line with the trajectory. Developing Improving Together Strategic Implementation A3. Improving Together Team have self-assessed our IT Programme against the national NHS Impact assessment. Currently at 46% adoption of methodology.	
7	Understand root cause of increased HAI rates and put in appropriate countermeasures to support delivery of improvements.	Reduce Likelihood	CNO	31/03/25	Root and branch review of C-Diff and required countermeasures; Go, Look, Learn's arranged to organisations with lower rates of C-Diff. MRSA review of all cases to understand any key themes and learning. New corporate prevention of HAI A3 developed. Any learning from outbreak meetings shared by IP team Refreshed IP BAF. Health economy focus on reducing incidences of e-coli.	
8	Develop delivery plan for Oliver McGowan (full day) training.	Reduce Likelihood	CNO	31/05/25	Training plan approved by ICB and being shared as good practice. Concern re impact of additional full day training; especially with regards to agreed job plans.	
9	Visiting guidance to be updated in view of legislation changes in April.	Reduce Likelihood	CNO	30/09/24	Engagement across Divisions completed, awaiting comms for public and staff to be published.	
10	Implement Martha's Rule.	Reduce Likelihood	CNO	31/03/25	The first NHSE meeting and welcome event took place on 20 May 2024. Meeting being set up with UHNM and Patient Safety Collaborative. Project meetings now set up for the year chaired by the Chief Nurse.	
11	Delivery ePMA programme.	Reduce Likelihood	CDIO	Q3 2025	Showstopper concerns discussed and awaiting solution from System C. Training plan in development but delivery at risk due to showstopper position. Aim was to start roll out across County in Sept 2024 however this is now at risk.	

BAF 2: Improving our Workforce Sustainability and Organisational Culture

People, Culture & Inclusion Committee | Chief People Officer

Internally Driven ●

Externally Driven ●

Risk Description and Impact on Strategic Priorities

Cause	If we are unable to achieve workforce sustainability through an effective long term workforce plan which is underpinned by a positive organisational culture,
Event	then we may face significant challenges in ensuring that we have colleagues with the right skills in the right place at the right time,
Effect	resulting in an adverse impact on colleague wellbeing, recruitment and retention, the potential to compromise quality of care for our patients, inability to deliver operational targets and increased premium costs negatively affecting the financial position.

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

Risk Scoring

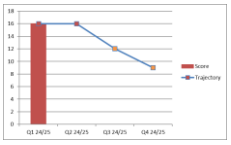
Quarter / Score (Actual & Plan)	Q1	Q2	Q3	Q4	Target	
Likelihood	4	4	3	3	3	31/03/25
Consequence	4	4	4	3	3	
Risk Level	16	16	12	9	9	

Risk Appetite

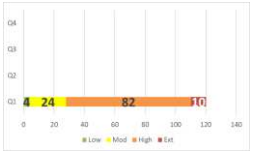
Open

Risk score is expected to be above agreed tolerance (High 8 – 12) until Q3 2024/25

Risk Movement



Linked Risks on Risk Register



Rationale for Risk Score and Progress in the Quarter:

At the end of 2023/24 our BAF risk score for 'Sustainable Workforce' was 16 and the risk score for 'Organisational Culture' was 12. We have now amalgamated the two BAF's into one for 2024/25 and this financial year have significant financial pressures which may have a detrimental impact on aspects of this risk.

- Good progress has been made during Q1 2024/25 and People, Culture & Inclusion Committee agreed to a positive assurance rating in May 2024.
- Completed annual review of 2023/24 People Strategy Delivery Plan and took stock of the goals and aspiration of our plan for 2024/25.
- Our People Plan for 2024/25 is aligned to our Trust Strategic Priorities, the Integrated Care System (ICS) People Priorities and Workstreams, and 2024/25 NHSE national objectives where workforce is an enabler.
- The four domains of our People Strategy Delivery plan continue to be: 1) We will look after our People by… 2) We will create a sense of belonging where… 3) We will grow and develop our workforce for the future by… 4) We will develop our people practices and systems by…
- Using our Improving Together approach our Driver Metrics for months 1 and 2 for Q1 (M3 not yet available) are:
  - Staff Engagement Score: 6.42 against the target of 7.2 (The data source is from the quarterly Staff Voice survey).
  - Culture Indicator (%): 68.6% against target of 100%. However, this target % is under review.
  - Apprenticeships: A3 launched from 01 April 2024 initially as a breakthrough objective but after review this is now being managed as a corporate objective. The metrics are in development and as at the end of M2 (a) there have been ten apprenticeships started against a year-end target of 250, and (b) the apprenticeship levy achieved YTD is £75.6K against a total available levy of £2,654K for the full year.
- Our watch metrics to date in Q1 are as follows:
  - Sickness Absence (R12M): April 5.2% and May 5.3% (static against a historical target of 3.4%)
  - Vacancy Rate %: April 7.6% and May 8.5% (better than target of 10%); aspirational target for this FY is 8%.
  - Staff Turnover %: April 7.6% and May 7.7% (better than target of 10%)
  - Statutory & Mandatory Training (compliance %): April 94.1 and May 94.2 (static against target of 95%)
  - Essential to Role training (compliance %): April 80.0% and May 86.2% (M2 is similar to last FY & below target of 90%)
  - Appraisal (PDR): April 86.2% and May 86.6% (below target of 95% but continued improvement on last FY
  - Pay – Agency YTD actual (%): April 3.3% and May 2.9% (Improvement on last FY and M2 is first time better than Target of 3.2%)
- Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest and respiratory problems. Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in person resources, to improve their personal resiliency when coping with work related stress.
- Reductions in agency expenditure are expected to continue, resulting from increased system level controls, which were implemented using our electronic rostering systems built in controls, from 20th May onwards. However, a certain proportion of our agency expenditure is being driven by the continued need for escalation capacity, activity relating to the elective recovery programme and the additional staffing which is required to reduce the emergency departments ambulance waiting times. We expect to see a gradual reduction in agency spend, resulting from the additional system level controls which have been implemented.

- System level controls have been implemented in our Electronic Rostering solution, for all nursing and midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and / or agency. It is anticipated that this will show as a reduction in overall agency WTE and a commensurate reduction in agency expenditure / cost (3) over the coming months. This control was implemented from 20th May 2024.

Key Controls Framework

Divisional	• Workforce plans in place and budgets transacted accordingly, including Cost Improvement Plans (CIP) delivery against targets • Directorate and divisional management teams monitor staffing levels. Divisional vacancy controls in place. Internal deployment and redeployment of staff to support safer staffing levels. • Experienced medical rota coordinators aligned to Divisions to support operational planning • Divisional targets for Apprenticeships. Monitor uptake and levy against plan. • Insourcing contracts in place in key areas to support the operational recovery plan. • Work on initiatives focussing on the retention of our workforce; including our participation in the NHS People Promise Exemplar programme. • Divisional staff engagement driver metrics reviewed at Divisional Performance Review Meetings. Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Culture improvement programme and plans in place for identified 'hot spot' areas. • Divisional operational escalation plans; including for periods of Industrial Action. • Divisional Workforce Assurance Groups in place
Corporate	• People Strategy for 2022-2025 highlights key strategic areas of workforce activity and planning underway to develop the Strategy and Plan for April 2025 – March 2029 (with stakeholder involvement) • People Strategy Delivery Plan 2024/25. Includes our People driver and watch metrics, highlight and assurance reporting, plus deep dive sessions. • 2024/25 Workforce Plan in place • Pipeline of approved business cases in key areas profiled into the workforce establishment to enable tracking of vacancies and workforce supply. • General recruitment drives are on-going and there is an element of head hunting via informal networks • Work-flow recruitment management system to track and optimise on-boarding processes • Oversight and scrutiny of vacancy controls in place; including bank and agency usage. • Nurse Establishment Reviews reported twice yearly • People (HR) policies and procedures in place and reviewed in accordance with policy review governance • Established Banks (workforce) are in place – including Nursing, Medics, Admin & Clerical, and other staff groups. • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • Continuing work with education leads and teams and providers across the System to enhance opportunities for learning and the education experience for our trainees. • Daily tracking (through the Empactis system) of unplanned absences to support local planning • Operational Escalation / Winter Planning Group stood up at the appropriate time in the year • Junior Doctors Workforce Business Case
System	• ICS People, Culture and Inclusion governance (portfolio assurance, governance, risks, and decision making) • NHSE Regional and national oversight; including review meetings. NHS Employers support to workforce leaders • National target for agency reduction with associated national and system controls for non-clinical agency expenditure

Assurance Map

Sources of Committee Assurance for 2024/25		Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance	Executive Workforce Assurance Group Highlight Report	NR	●	●	●
2nd Line Assurance	Chief People Officer Report		●	●	●
	Equality, Diversity & Inclusion Annual Report		●		
	Formal Case Activity Report		●		●
	Guardian of Safe Working Report		●		●
	Health and Wellbeing Review				●
	Learning, Education and Widening Participation / Apprenticeship Report		●		
	Medical School Quality Report			●	
	Nursing Establishment Review			●	
	People Delivery Plan				
	Positive and Inclusive Culture Programme - Updated Plan 2025/26	NR	●	●	●

	Postgraduate Medical Education Report			●	
	Speaking Up Report			●	
	Strategic Workforce Plan				
	Talent and Succession Planning Update		●		●
	Workforce Disability Equality Standard		●		
	Workforce Race Equality Standard		●		
3rd Line Assurance	Gender Pay Gap Report			●	
	Medical Staff Rostering Internal Audit			●	
	Staff Survey Report				●

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control

- Divisional capacity to effectively manage and drive their People Plans
- Legislative changes (UKVI effective from April 2024)
- Corporate risk in respect of the programme for up banding of Healthcare Support Workers from Agenda for Change Band 2 to 3
- Demand for the People Directorates services outstrip the available resource

Gaps in Assurance

- Potential impact of financial pressures (Trust and System), including CIP targets on the workforce

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	We will strengthen flexible working opportunities through focused campaigns and change initiatives at departmental level.	Reduce likelihood	CPO	31/03/2025	Flexible Working Steering Group continue to provide oversight and decision making for programme delivery. Work is underway on recording flexible working arrangements in ESR which will enable reporting.	
2	We will focus on providing a safe and healthy work environment.	Reduce likelihood	CPO	31/03/2025	People Promise Exemplar programme in progress. Sexual safety programme of activity continues, with workstream leadership through the steering group.	
3	We will continue to support the wellbeing of our staff through our comprehensive wellbeing plan	Reduce likelihood	CPO	31/03/2025	Went live with WageStream at the end of May 24, for our 3-month pilot for Bank Employees who are on e-roster system. April - promoted Stress Awareness Month, shared messages of support, launched Suicide Prevention Toolkit, communicated Wellbeing services.	
4	We will widen career pathways for disadvantaged groups using interventions including reciprocal mentoring	Reduce likelihood	CPO	31/03/2025	Plans are being developed for this in partnership with ICS colleagues.	
5	We will strengthen mechanisms to demonstrate tangible recognition and appreciation so building a sense of value, pride and belonging in our teams	Reduce likelihood	CPO	31/03/2025	Circa 11,800 George Cross badges were issued to bank and substantive staff (as applicable) Nominations received and shortlisted for 2024 Annual Staff Awards.	

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
6	We will increase our employee knowledge and confidence in raising concerns	Reduce likelihood	CPO	31/03/2025	Staff Voice – April 24 we moved to quarterly frequency. This allows more time for divisions to respond to feedback 'you said, we will'.	
7	We will continue to deliver on our retention plan	Reduce likelihood	CPO	31/03/2025	Our People Promise (Retention) Manager started in the fixed-term post In April. Working on People Promise high impact plan.	
8	We will develop and launch a succession planning framework linked to our talent management programme	Reduce likelihood	CPO	31/03/2025	Plans being further developed. Initial focus in respect to our leadership tiers 1 to 3.	
9	We will scale up new roles to tackle key staff shortages	Reduce likelihood	CPO	31/03/2025	Activity progressed in line with our Learning & Education delivery plan. With focus on: • Physician Associates • Anaesthetics Associates • Advanced Clinical Practitioner • Advanced Critical Care Practitioner • Surgical Care Practitioner • Nursing Associate	
10	We will increase the pipeline for local school and college leavers to access healthcare careers maximising the apprenticeship levy	Reduce likelihood	CPO	31/03/2025	Effective co-ordination and support of T level placement students. Virtual work experience. Student simulations sessions run. Partnership careers events. A3 re People Driver metric for Apprenticeships in place from 1 Apr 2024.	
11	We will embed further remote working opportunities through digital transformation	Reduce likelihood	CPO	31/03/2025	The new VPN solution has now been fully deployed and will allow staff to work from public WIFI services.	
12	We will review, adapt and amend our processes in line with national ESR guidance	Reduce likelihood	CPO	31/03/2025	Continued development and ingest of the ESR General Data Warehouse data. This is being supported with the BI Team.	
13	We will continue to develop our people systems in order to streamline our processes	Reduce likelihood	CPO	31/03/2025		
14	We will continue to help improve digital skills through our digital advocate network.	Reduce likelihood	CDIO	31/03/2025	No change, the take up on the skills assessment has been low at just over 200 users. Funding not available to expand the IM&T training service.	
15	We will continue to provide teams with the time, tools and skills for service improvements through our Quality Improvement Academy	Reduce likelihood	CPO	31/03/2025	UHNM continuous quality improvement roll out continues on plan with 75% of County based teams trained in the approach and focus now turning to Medicine Division and their key supporting services from September 2024. A priority at this point is to increase co-production of improvement work, including broader groups of colleagues in specific projects and wherever possible our service users. This will ensure that whilst in-depth training is only delivered to a cohort of colleagues the opportunity to participate in improvement is available widely across the Trust and seen as the way we work.	

BAF 3: Improving the Health of our Population

Strategy & Transformation Committee | Director of Strategy & Transformation

Internally Driven ●

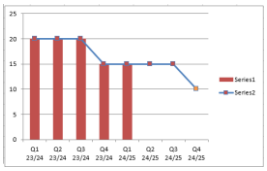
Externally Driven ●

Risk Description and Impact on Strategic Priorities

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

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

Risk Scoring

Quarter / Score (Actual & Plan)	Q1	Q2	Q3	Q4	Target		Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	3	3	3	2	2	31/03/25	Open		Graph not available as no linked risks identified
Consequence	5	5	5	5	5		Risk score is expected to be above agreed tolerance (High 8 - 12) until Q4 2024/25		
Risk Level	15	15	15	10	10				

Rationale for Risk Score and Progress in the Quarter:

Risk likelihood reduced in March 2024 on the basis that we approved or Population Health Strategy. Work is underway to embed action plans. At the point where there is demonstrated delivery against our outcome's framework, the risk rating will be reassessed during 2024/25.

- Population Health enabling strategy approved by Trust Board, with 'easy read' version developed to support communications.
- Stocktake completed to review health inequalities and anchor institution actions, with working group set up. First level outcomes framework developed in Q1 24/25 which identifies infant mortality, cardiovascular disease, respiratory and early cancer diagnosis.
- Analysis for inclusive elective recovery completed for both the system and UHNM and extended to include outpatient and diagnostics in Q1 24/25
- Continued use of charitable funds to help pilot initiatives – i.e. loneliness, Keep Stoke Smiling
- Developing links with local authority, voluntary sector and primary care
- 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

Divisional	• Health inequality, MECC and anchor leads identified across trust services. Use of HEAT tool and A3. • Estates and Sustainability Programme, Workforce, Community Engagement, Elective Recovery an • Patient Engagement leads identified as part of the Health Inequalities and Prevention Group
Corporate	• 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 • A3 for Health & Wellbeing in place • Population Health and Wellbeing Strategy
System	• 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 • National CORE20PLUS5 priorities

Assurance Map

Sources of Committee Assurance for 2024/25		Assurance Ratings Q1	Q2	Q3	Q4
1st Line Assurance	Executive Strategy and Transformation Group Assurance Report		●	●	●
2nd Line Assurance	Health Inequalities – Stocktake				
	Population Health and Wellbeing Strategy Update		●		●

3rd Line Assurance					

Assurance Assessment	
Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• None identified	• Demonstrate delivery of the strategic action plans which will be delivered during 2024/25 to provide sufficient assurance of the ability to reduce the risk to the target level

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Development of metrics to provide a means of measuring progress and delivery of the strategy.	Provide assurance	DST	21/03/25	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	Reduce likelihood	DST	21/03/25	Action plans are described within the strategy – to be incorporated and reported in A3 format from 24/25	

BAF 4: Delivering Responsive Patient Care

Performance & Finance Committee | Chief Operating Officer

Internally Driven ●

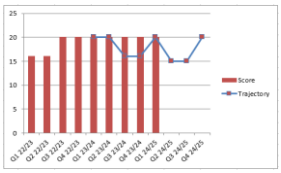
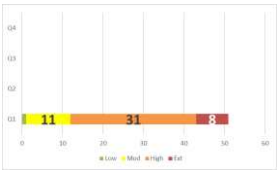
Externally Driven ●

Risk Description and Impact on Strategic Priorities

Cause	If we are unable to create sufficient capacity to deal with service demand,
Event	then we may be unable to treat patients in a timely manner,
Effect	resulting in poor patient outcomes, potential patient harm, impact on staff wellbeing, continued regulatory control and negative impact on the financial position.

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target	Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	4	3	3	4	2	Open		
Consequence	5	5	5	5	5			
Risk Level	20	15	15	20	10	Risk score is expected to be above agreed tolerance (High 8 - 10) until September 2025		

30/9/25

Rationale for Risk Score and Progress in the Quarter:

- Ahead of UHNM trajectory for 4-hour performance, although this is below the national target. There has been continued pressure at RSUH and County and discharges are below the daily requirement. Emergency Department continues to be overwhelmed on a daily basis, and corridor care is continuing to be used. The new variant of covid is impacting on inpatient capacity in addition to causing an increase in staff absence.
- In terms of planned care, on trajectory for cancer recovery but off trajectory for elective care recovery, with significant numbers of patients in respiratory and gastro and long waiting patients still being found due to historic data quality issues, although these are small in number.
- Have continued to be above our submitted trajectory for 4-hour performance (above 70% for March, April and May). Effective use of SDEC (AMRA, CDU). For the 4 workstreams associated with urgent care, we are seeing improvement in the different elements of these programmes.
- Have achieved Faster Diagnosis Standards (FDS) and on trajectory for 62-day targets for cancer services. Elective care continues to see reducing numbers, however not at the pace expected, according to trajectories.

Key Controls Framework

Divisional	• 4 x daily capacity calls with Head of Nursing, Operations with either the Deputy Chief, Operations, Deputy Chief Operating Officer – Delivery and/or the Chief Operating Officer in attendance • Various improvement meetings tracking the actions / milestones across the NEL improvement work streams supported by the Deputy COO - Delivery 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 • Daily strategic lead rota now in place. This is supported by the Deputy COO and interim Deputy Chief Nurse - Operations • Weekly tumour site cancer patient tracking list (PTL) meetings • Weekly divisional referral to treatment (RTT) meetings taking place • Fortnightly validation meetings • Monthly RTT training improvement meeting • Monthly data quality 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
Corporate	• 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 • Community Diagnostic Centre Business Case approved

	• Same Day Emergency Centre modular build business case approved • Dermatology & Plastic Surgery Business case approved • County Hospital Surgical elective hub business case approved • Comprehensive capacity, demand, organisational and system bed model completed to ensure data driven approach to improvement • Undertakings Elective & Non-Elective Plans
System	• 2 x daily calls with System Partners re UEC position and actions required. • 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 workstream 1 of 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. • Monthly tiering meetings with NHSE re: urgent care performance • 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

Sources of Committee Assurance for 2024/25		Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance					
2nd Line Assurance	Endoscopy Performance Report				
	Operational Performance Report		●	●	●
	Productivity Update	NR	●	●	●
	Theatre Productivity Plan	⊗		●	
	Winter Plan		●		
3rd Line Assurance	Data Quality: Ambulance Handover Data Internal Audit		●		
	NHS England Letter: 62 Day Urgent Suspected Cancer Backlog Reduction				
	Planned Care Internal Audit				
	Productivity Reporting Internal Audit				

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• Strengthen internal rapid handover agreed policy to ensure consistently used against the triggers • Schemes to be identified to create additional capacity for challenged specialties	• Improvement in discharge profile to ensure we can do 'today's work today'

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Reduce Likelihood	DST	31/03/25		
2	Ensure full exploration and development of opportunities to utilise data and technology to support the delivery of clinical services	Reduce Likelihood	COO	31/03/25	The process has begun to explore the procurement and implementation of a HIMSS Level 7 system wide EPR system.	
3	Deliver objectives as described in non-elective improvement programme	Reduce Likelihood	COO	31/03/25	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.	
4	Deliver objectives as described in elective improvement programme	Reduce Likelihood	COO	30/09/24	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.	
5	Two phased rightsizing piece of work which firstly looks at the capacity currently available and makes best use, and then a rightsizing piece cross organisation as part of a long-term plan.	Reduce Likelihood	COO	31/10/24	Phase one of the work is underway and the long term	
6	Harm review process for patients waiting for elective care under review	Reduce Likelihood and Consequence	CMO	31/07/24		
7	Introduction of Finance, activity and productivity meeting with each division	Reduce Likelihood	COO	01/05/24	Complete	
8	Consideration for expanded capacity through ERF schemes for challenged directorates	Reduce Likelihood	COO	30/07/24	Complete	

BAF 5: Digital Transformation

Strategy & Transformation Committee | Chief Digital Information Officer

Internally Driven ●

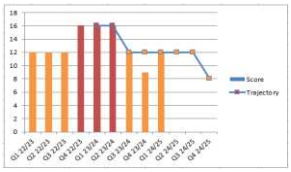
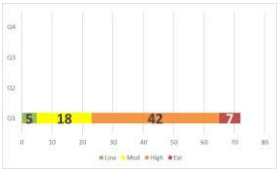
Externally Driven ●

Risk Description and Impact on Strategic Priorities

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

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target	Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	3	3	3	2	2	Open		
Consequence	4	4	4	4	4	Risk score is in line with agreed tolerance (High 8 – 12)		
Risk Level	12	12	12	8	8	31/03/25		

Rationale for Risk Score and Progress in the Quarter:

A number of targeted cyber security attacks have taken place on other NHS Trusts during May and June. Multifactor Authentication is not in place for all externally facing systems which is a mandate from NHS England. iPortal and WIS is operating on deprecated code. Shadow IT still a risk area. Volume of applications to manage from a cyber security perspective is high.

Network and Communication Services has transferred to IM&T (19th June 2024) and the core switches have not been security patched since they were installed. Wireless network coverage is inadequate in clinical areas. System C advised that version 5 of Digital Observations will not have an offline capability, so the network needs to offer good coverage in ward areas.

- The Network and Communication Service has transferred to IM&T on the 19 June 2024.
- Staffordshire Wide EPR Soft Market testing has commenced with 9 interested suppliers.
- The new VPN service has been deployed across the Trust allowing staff the ability to log in to public WIFI services and then use the Trust VPN.
- Video Cameras in Royal Stoke have been fully commissioned to support cyber security.
- Our application for DCB1596 Security Email Standard has been submitted and we await approval from NHS England.
- Pathology users have been migrated to Office 365 and work has started to decommission our on-premises servers.
- Shadow IT Internal Audit is complete and due to go to the Audit Committee this month.
- ITIL Service Management Internal Audit is complete, and actions being progressed.

Key Controls Framework

Divisional	• 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. • RE02 Photography and Video Policy and standard operating procedure has been approved • Laboratory Information Management System (LIMS) BHI migration to Winpath Enterprise is complete.
Corporate	• Suite of key IM&T policies • Executive Digital and Data Security Protection Group monitors active management of IM&T risks via monthly Risk Register Reports • Chief Clinical Information Officer and Chief Nurse Information Officer in post to work with front line clinical staff • Freedom of Information improvement plan developed • Regional Cyber Security Operations Centre live with over 450 servers reporting to the Security Information and Event Management System (SIEM)
System	• Data protection toolkit completed, and improvement plan agreed with NHS England • NHS England Frontline Digitalisation Investment Business Case

Assurance Map

Sources of Committee Assurance for 2024/25		Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance	Executive Digital and Data Security Protection Group Assurance Report		●	●	●
2nd Line Assurance	Cyber Security Assurance Report		●	●	●
	Data Security and Protection Toolkit Submission			●	
	Digital Strategy Progress Report		●		●
3rd Line Assurance	Data Protection and Security Toolkit Internal Audit				
	IT Systems Managed by Operational Areas Internal Audit				
	Service Management Process (ITIL) Internal Audit				

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• Complete LIMS for Cell Path • Upgrade VPN Technology • Complete EPR soft market testing and revised outline business case	• Funding of replacement EPR

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	LIMS Go Live	Reduce likelihood	CDIO	31/10/24	Cell Path to go live in October	
2	EPR Outline Business Case	Reduce likelihood	CDIO	30/09/24	Outline Business Case completed. Soft market testing due to be complete in September.	
3	EPMA Pilot	Reduce likelihood	CDIO	31/10/24	Pilot of EPMA to go live.	

BAF 6: Fit for Purpose Estate

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

Internally Driven ●

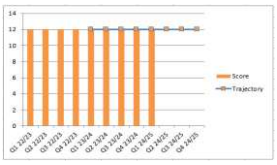
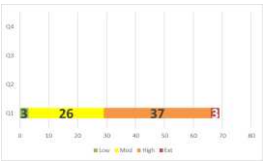
Externally Driven

Risk Description and Impact on Strategic Priorities

Cause	If we are unable to obtain sufficient investment to develop our estate infrastructure and workforce,
Event	then we may be unable to deliver high quality, responsive services in a safe, compliant and sustainable environment,
Effect	resulting in the inability to achieve national standards, manage backlog maintenance, achieve Value for Money (VFM/Model Health targets) and deliver strong performance against Estates, Facilities and PFI Divisional objectives / KPI's.

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target		Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	3	3	3	3	3	31/03/29	Open		
Consequence	4	4	4	4	4		Risk score is in line with agreed tolerance (High 8 – 12)		
Risk Level	12	12	12	12	12				

Rationale for Risk Score and Progress in the Quarter:

- Insufficient capital allocation in 2024/25 to address identified backlog risks inhibiting ability to adhere to statutory compliance and rectify identified backlog
- Supply chain issues and external market influences are resulting in a small number of suppliers within the market to deliver large capital schemes, impacting on price and programme certainty
- The purchase of energy from the global market creates exposure to risk associated with security of supply and therefore escalating costs. Mitigated through Stoke on Trent City Council (SOTCC) joint procurement in 2023/24
- Lack of worked up clinical / demand management plans that underpin System / Trust Strategies impacts on ability to produce a meaningful Estate Strategy with Development and Control Plan (DCP)
- Capital funding constraints impacts on our ability to decarbonise our estate and achieve targets as set out within the NHS Standard Contract
- Aging workforce profile and failure to recruit to key estates craftsmen roles and secure competent technically qualified individuals to replace retirees
- PFI partners / lenders issues associated with agreeing formal variations to respond to Trusts changing requirements and where there is conflict with the PFI Project Agreement / associated schedules / design requirements

Funding Allocation

- Capital allocation for 24/25 for backlog maintenance agreed and prioritised against those areas of most need based on independent review of backlog risks.
- UHNM backlog figures reported nationally through National ERIC return and locally through System Infrastructure Strategy, to inform national investment strategies.
- Mitigation of risks associated with statutory compliance and unplanned outages through robust estates management, monitoring, maintenance and use of Authorising Engineer's (AE's) in specialist areas and independent advice.
- BAF Confirm and Challenge Session held to discuss strategic risks including future funding challenges.

Estate Strategy (Development Control Plan)

- Archus, healthcare infrastructure specialists commissioned to refresh Estate Strategy and support Rightsizing work to inform future Development Control Plan for Royal Stoke site.
- Right Sizing work to conclude and inform Estate Strategy.
- Space Utilisation Panel/Agile Working Policy/Flexible Working all in place and supporting work to optimise the use of existing estate.
- ICB Strategic Estates Group Member and influencing Strategic Estates agenda across a number of workstreams. Supporting the production of System infrastructure Strategy which will inform prioritisation of capital across the system.

Supply Chain Partners / Projects

P23 procurement route for Trust capital projects and small number of suppliers operating across many hospital Trusts impacting on supplier resilience and flexibility. Robust management of suppliers through internal and external overview and scrutiny to ensure agreed programme and finance delivered in accordance with Business Case. Key schemes being AMRAU, CDC, Elective Hub.

PFI Partners/Lender Issues

- Work with Project Co/Lenders representatives on finding mutually acceptable solutions to variations, protecting key principles on which the PFI contract is based i.e. risk transfer. AMRAU variation concluded, and network and communications contract variation being worked through, alongside the impact of the Building Safety Act. Good progress continues to be made on progression of any remedial works to respond to PFI Latent Defect issues. Legal advice sought, along with advice from Department of Health Private Finance Unit and NHSE, as appropriate.
- Robust management of the PFI contract through performance management meetings and contract data, to ensure high levels of performance are sustained and any deviations from performance levels and Project Agreement requirements are actioned accordingly.

Energy Procurement/Decarbonisation

Joint procurement through SOTCC delivered significant savings against energy forecast. First stage of longer-term potential procurement strategy using District Heat Network (DHN). Change to scheme imposed by SOTCC and SEE, subsequently assessed and paper produced for consideration of Execs/PAF. Agreement reached to proceed to Business Case.
Capital allocation for decarbonisation prioritised against those schemes that will have maximum impact.

Workforce Profile/Recruitment Challenges

- Continued to explore innovative ways in which can attract future recruits through collaboration with UHNM Recruitment Team, Colleges and Universities.
- Reviewed and prioritised funding towards Apprentice roles and reviewed structure in place to support high quality apprenticeship.
- Readvertised posts following review.

Key Controls Framework

Divisional	• Robust governance – Business Case, Committee approvals • Estate condition: Planned Preventative Maintenance programme; competent Estates staff / Authorised persons; KPI's monitored through CEF / Environmental Audits, Maintenance Operational Board; Operational Policies, Service Specifications PFI, 6 Facet Survey • Fire Safety / Security Policies; Protocols, Guidelines; patrolling, CCTV, Risk Assessments in place • Sustainability / Net Zero Carbon (NZC): Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Performance & Finance Committee (PAF) (biannual), Public Sector Decarbonisation Scheme (PSDS) Stakeholder meetings established (monthly, to meet grant T&C's), NZC Trust Board Lead (Director EFP), (new) Clinical NZC lead and attendance at ICS and Midlands Green Groups
Corporate	• Estate Condition - Capital bids against prioritised list of Estate 6 Facet Findings with subsequent approval via CIG. • Estate Strategy – Clinical & System Strategy and independent review used to inform content. • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections. • Head of Fire Safety and Security close working with local Police and visibility on site. • Sustainability / NZC: Work with external partners regarding zero-capital solutions and grant funding applications. • Capital team / Capital programme external Audit / internal procedure audit annually
System	• Statutory maintenance programme – Maintenance Operational Board. • Regulatory inspection/validation programmes including: CQC, Patient Led Assessment of the Care Environment (PLACE), Premises Assurance Model (PAM) and Estates Returns Information Collection (ERIC). • External audits on fire by Staffordshire Fire & Rescue and Authorising Engineer and on the security of radioactive sources & pathogens by the Counter Terrorism Security Advisers (CTSA). • Authorising Engineers Audits of building services and associated maintenance regimes. • Participation in National Programme Strategic Supplier Relationship Management (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. • Collaborative working with system partners on Estate Infrastructure and Sustainability agenda, members of key working groups to drive transformation and efficiency in these areas. • Close liaison NHSE and Department of Health PFU on PFI material issues.

Assurance Map

Sources of Committee Assurance for 2024/25		Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance	Executive Health and Safety Group Assurance Report	NR	●	●	●
	Executive Infrastructure Group Assurance Report	NR	●	●	●
	Estate Strategy Progress Report	⊗			

2nd Line Assurance	Capital Income and Expenditure Plan	NR			●
	District Heat Network Update	NR			
	Fire Annual Report				
	Operational Impact of Key Capital Schemes	NR			
	Security Management Annual Report		●		
	Sustainability Bi-Annual Report				●
3rd Line Assurance	PLACE Inspection Findings and Action Plan				
	Transformation and Capital Project Management Internal Audit				●

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control

- Maintenance backlog programme underfunded; this will see a continued rise in backlog figures over next 5 year plan
- Gap in confirmed clinical strategies, and lack of completed feasibilities to deliver agreed clinical plans and Royal Institute of British Architects (RIBA) stage 2 designs and budget costs to match emergency funding as this becomes available to bid for.
- No further expansion space for modulars at Royal Stoke, rightsizing to drive development and refurbishment in the right place to ensure sustainable development control plan (DCP), with a phase delivery approach, 5-10 year DCP.
- Targeted capital refurbishment where appropriate to address significant risk backlog.
- Limited number of national NHS framework supplies bidding for large amounts of NHS funded work, national procurement means one supplier can win multiple schemes and therefore drive resource issues, which can impact programme and cost.
- Limited number of worked up sustainability feasibilities to enable quick utilisation of available capital when becomes available.
- Existing NHS estate is designed to current NHS and Chartered Institute of Building Services Engineers (CIBSE) guidance which currently does not account for the constantly increasing summer hotter prolonged periods, and colder winter snaps. Real risk to operational availability.
- Lack of capital & revenue funding to deliver identified schemes to reduce carbon generation to meet national targets.
- Challenges with pay and the ability to recruit and retain our skilled workforce with private sector pay comparison to agenda for change (AFC)
- Ageing workforce with a risk of losing site knowledge onto future apprentices which can only be funded via current establishment budget.
- Lack of ability to over recruit in areas of high turnover, resulting in bank and overtime whilst we recruit replacement substantive posts.
- Lack of training budget within current funding to upskill workforce for evolving and more digital and technical infrastructure. Becoming more reliant of external contractors at premium costs.
- Jointly agreed interpretation of Building Safety Act between Trust and PFI partners.
- Concluding of remedial works for PFI Latent Defects.
- Concluding of rightsizing work to inform Estate Strategy and Development Control Plan.

Gaps in Assurance

- None identified

Further Actions						
No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Funding allocation	Reduce likelihood	Director EF&P	28/06/24	Work with finance team to understanding funding opportunities for future capital programmes. Reviewing backlog position to inform 5-year plan.	
2	Strategy preparation for future Bids	Reduce likelihood	Director EF&P	31/03/25	Work with strategy and business planning to develop rightsizing piece, and ensure high level design and costing are provided to feed feasibility business cases to deliver clinical strategic objectives.	
3	Supply Chain Partners	Reduce likelihood	Director EF&P	31/03/25	Estates capital team liaising nationally regarding P23 contracts. Facilities teams continue to monitor limited suppliers performance and associated service and price risks.	
4	Adapting to a changing climate	Reduce likelihood and consequence	Director EF&P	31/03/25	New and major refurbishment acute healthcare facilities must adhere to the NZC Building standard. Work is required to ensure this becomes embedded and business as usual through the Capital Development supply chain. The design of building services must ensure resilience to maintain functionality during extreme weather events. Design parameters during capital scheme development to be reviewed and question the need for enhanced specifications in critical areas. The EPRR team are leading on the ICS Adaptation Plan to ensure full integration with other operational plans.	
5	Sustainability / NZC	Reduce likelihood and consequence	Director EF&P	31/03/25	Continue to develop key sustainability strategic projects with system partners. Continue to review national funding opportunities to support. Progress District Heat Network to Business case stage.	
6	Workforce	Reduce likelihood	Director EF&P	27/12/24	Continue to review Building & engineering AFC pay rates Vs that of the private sector. Continue to support Estates R&R business case annually. Work with recruitment to ensure shortest timeline for recruitment. Develop apprenticeship opportunities within current establishment to provide succession planning in technical areas.	
7	PFI Partners/Lender Issues	Reduce likelihood	Director EF&P	30/08/24 30/08/24 31/03/25	Reach agreement on interpretation of Building Safety Act requirements Conclude Supplemental Agreement for N&C Variation Conclude remedial works to respond to PFI latent defects	

BAF 7: Financial In Year Delivery

Performance & Finance Committee | Chief Finance Officer

Internally Driven ●

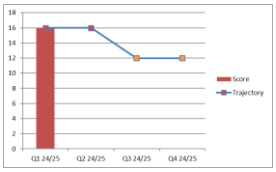
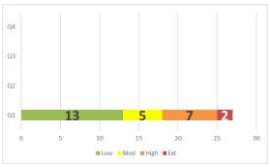
Externally Driven ●

Risk Description and Impact on Strategic Priorities

Cause	If we, or system partners, are unable to manage within the assumptions made in the financial plan for 2024/25
Event	then we will be unable to meet our financial plan for 2024/25,
Effect	resulting in an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust.

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target		Risk Appetite	Risk Movement	Linked Risks on Risk Register
Likelihood	4	4	3	3	3	31/03/25	Open		
Consequence	4	4	4	4	4		Risk Score is expected to be above tolerance (High 8 – 12) until Q3 2024/25		
Risk Level	16	16	12	12	12				

Rationale for Risk Score and Progress in the Quarter:

- The financial plan has been signed off by the Board and PAF have received a detailed paper outlining the key assumptions and risks for the year
- Divisions have submitted their high-level cost improvement (CIP) plans for the year which are currently being assessed with a CIP summit being held in July
- Activity levels were above plan in April, the impact of this on our Elective Recovery Fund (ERF) income is being assessed and will be included in the Q1 financial outturn.

Key Controls Framework

Divisional	• 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 • Monthly Exec led meetings with Divisions include a focus on CIP delivery.
Corporate	• 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. • 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
System	• 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

Sources of Committee Assurance for 2024/25		Assurance Ratings Q1	Q2	Q3	Q4
1st Line Assurance	Executive Infrastructure Group Assurance Report	NR	●	●	●
	Medicines Expenditure Report	⊗		●	
	Supplies & Procurement Report		●		●
2nd Line Assurance	Annual Operational Plan 2024/25 & System Plan				
	Annual Accounts and Financial Statements	NR			
	Capital Income and Expenditure Plan	NR			●
	Financial Outlook			●	●
	Finance Report		●	●	●

	Going Concern				●
	Losses and Special Payments	NR	●	●	●
	Operational Impact of Key Capital Schemes	NR			
	Overseas Patients Activity	⊗		●	
	Overseas Visitors Policy Compliance Audit			●	
	Productivity Update	⊗	●	●	●
	Revenue Plan 2024/25	NR			●
	Single Tender Waiver / Standing Financial Instruction (SFI) Breaches	NR	●	●	●
	Valuation of Land and Buildings				●
3rd Line Assurance	External Audit Progress Report		●	●	●
	Grip and Control: Medical Staff Agency Controls				●
	Key Financial Controls Internal Audit				●
	Productivity Reporting Internal Audit				
	Transformation and Capital Project Management Internal Audit				●

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• Fully signed off CIP Plan • Recurrent CIP versus non-recurrent • Risks around Band 2 – 3 (no mitigation) • Business Cases final sign off for Winter Beds and AMRAU	• No gaps in assurance

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Identification and delivery of in-year CIP target.	Reduce likelihood	DST	31/07/25	Monthly Finance and Productivity meetings with Division in place include a focus on CIP identification. The PMO has established regular meetings with Divisions to support the identification of CIP. Weekly CIP tracker being issued and CIP summit scheduled for July	
2	Ensure the delivery of elective activity targets	Reduce likelihood	COO	31/03/25	Monthly Finance and Productivity meetings with Division in place include a focus on CIP activity delivery. Activity is above plan for M1; additional investment proposals have been presented by Divisions to tackler those areas with long waiters (inc Endoscopy, ENT and, Respiratory and Gastro) - these cases deliver a contribution under the ERF scheme.	
3	Identification of non-recurrent mitigations to support the 2024/25 financial position	Reduce likelihood	CFO	31/12/25	A review of the final outturn for 23/24 has identified some non-recurrent financial upsides that have been factored into the Q1 financial position.	

BAF 8: Financial Sustainability

Performance & Finance Committee | Chief Finance Officer

Internally Driven ●

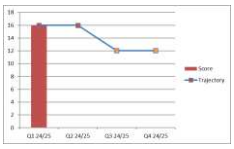
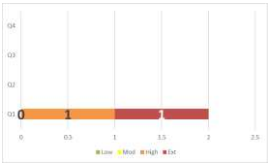
Externally Driven ●

Risk Description and Impact on Strategic Priorities

Cause	If we, or system partners, are unable to manage within the assumptions made within the financial plan for 2024/25,
Event	then our underlying financial position will deteriorate further,
Effect	resulting in less funding being available for investments and an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust.

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target		Risk Appetite	Risk Movement	Linked Risks on Risk Register
Likelihood	4	4	3	3	3	31/03/25	Open		
Consequence	4	4	4	4	4		Risk Score is expected to be above tolerance (High 8 – 12) until Q3 2024/25		
Risk Level	16	16	12	12	12				

Rationale for Risk Score and Progress in the Quarter:

We set a financial plan for 2024/25 with an underlying deficit of £58m; at month 2 we are not delivering against our recurrent CIP target and therefore this position is likely to worsen.

- The financial plan has been signed off by the Board and PAF have received a detailed paper outlining the key assumptions and risks for the year
- Divisions have submitted their high-level CIP plans for the year which are currently being assessed with a CIP summit being held in July
- Elective activity was above plan at month 1; Divisions have been asked to review activity levels to identify whether this is sustainable and if so, quantify any potential recurrent benefit

Key Controls Framework

Divisional	• Performance Management meetings in place with Divisions with financial performance included as a driver metric. • SFIs and scheme of delegation • Exec Team approval of additional investment up to £250k • Monthly Exec led meetings with Divisions include a focus on CIP delivery.
Corporate	• 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. • 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
System	• Consideration of Internal audit programme to reflect changing risks in financial plan • External audit programme in place • System Recovery Programme

Assurance Map

	Sources of Committee Assurance for 2024/25	Assurance Ratings Q1	Q2	Q3	Q4
1st Line Assurance	Executive Infrastructure Group Assurance Report	NR	●	●	●
	Medicines Expenditure Report	⊗		●	
	Supplies & Procurement Report		●		●
2nd Line Assurance	Annual Plan 2025/26				●
	Annual Accounts and Financial Statements				●
	Capital Income and Expenditure Plan				●
	Financial Outlook			●	●
	Finance Report		●	●	●

	Going Concern				●
	Losses and Special Payments	NR	●	●	●
	Operational Impact of Key Capital Schemes	NR			
	Overseas Patients Activity	⊗		●	
	Overseas Visitors Policy Compliance Audit			●	
	Productivity Update	⊗	●	●	●
	Revenue Plan 2024/25	NR			●
	Single Tender Waiver / Standing Financial Instruction (SFI) Breaches	NR	●	●	●
	Valuation of Land and Buildings				●
3rd Line Assurance	External Audit Progress Report		●	●	●
	Grip and Control: Medical Staff Agency Controls				●
	Key Financial Controls Internal Audit				●
	Productivity Reporting Internal Audit				
	Transformation and Capital Project Management Internal Audit				●

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• Fully signed off CIP Plan • Recurrent CIP versus non-recurrent • Risks around Band 2 – 3 (no mitigation) • Business Cases final sign off for Winter Beds and AMRAU	• No gaps in assurance

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Identification and delivery of in-year CIP target.	Reduce likelihood	DST	31/07/25	Monthly Finance and Productivity meetings with Division in place include a focus on CIP identification. The PMO has established regular meetings with Divisions to support the identification of CIP. Weekly CIP tracker being issued and CIP summit scheduled for July	
2	Review the opportunity to recurrently increase Elective activity targets	Reduce likelihood	COO	30/09/25	Activity is above plan for M1; Divisions are reviewing recurrent activity levels to assess the opportunity for increasing recurrent activity targets; any increases will only be transacted once there is sufficient data and assurance to support the increases.	

BAF 9: Research and Innovation

Strategy & Transformation Committee | Chief Medical Officer & Chief Nurse

Internally Driven ●

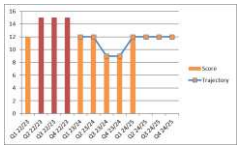
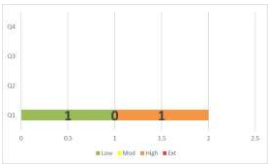
Externally Driven

Risk Description and Impact on Strategic Priorities

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

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

Risk Scoring

Quarter / Score	Q1	Q2	Q3	Q4	Target		Risk Appetite	Longer Term Risk Movement	Linked Risks on Risk Register
Likelihood	3	3	3	3	2	30/09/2025	Cautious		m 
Consequence	4	4	4	4	4		Risk Score is expected to be above tolerance (Mod 4 – 6)		
Risk Level	12	12	12	12	8				

Rationale for Risk Score and Progress in the Quarter:

- Risk score increased following conversation at deep dive, whereby the risk consequence is unlikely to reduce, therefore actions going forwards are focussed on reducing likelihood
- Research participation by patients achieved target for 2023/24 and remains on track for 2024/25
- Approximately 6 consultants have been awarded honorary chairs by Keele University since January 2023
- CeNREE continues to equip nurses, midwives and AHPs with skills necessary to lead research programmes
- Recent Research and Innovation Deep Dive identified the need to define 'research' and 'innovation' more adequately; this will take place through the new Research Steering Group
- Research output is below comparator trusts (e.g. University Hospitals of Coventry and Warwick)
- The first meeting of the Research Steering Group was scheduled for June 2024
- Improving Together methodology is being used to determine the best metrics to monitor number of staff with links to High Education Institutes, and the numbers of staff that are research active
- CeNREE's UHNM 3rd Annual Showcase took place on 7th June 2024

Key Controls Framework

Divisional	• Research Operations and Leadership Meeting is established to coordinate and support operational activities. • Review of research and innovation structure undertaken • 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 Allied Health Professional 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.
Corporate	• 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.
System	• 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

Sources of Committee Assurance for 2024/25		Assurance Ratings			
		Q1	Q2	Q3	Q4
1st Line Assurance	Executive Research and Innovation Group Assurance Report	✕	●	●	●
2nd Line Assurance	Research Quality Assurance Update			●	
	Research Strategy Update		●		●
3rd Line Assurance					

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Gaps to be Addressed

Gaps in Control	Gaps in Assurance
• Further clarification being sought on criteria for joint appointments and research active staff, and the narrative for the strategic risk. Once clear a plan can be considered to meet the risk	• None identified

Further Actions

No.	Action Required	Outcome	Exec Lead	Due Date	Quarterly Progress Report	BRAG
1	Research to form part of Divisional Performance Management Reviews / watch metrics.	Additional Assurance	CMO	30/09/24	R&I Strategic Oversight Forum to be established 24/25. Terms of Reference currently with Exec R&I group for approval	
2	Research to form part of Divisional Board agendas.	Additional Assurance	CMO	30/09/24	Communication to feed into Strategy development committee through divisional membership and R&I board.	
3	Commissioning an external specialist to review QMS prior to the MHRA inspection.	Additional Assurance	CMO	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	
4	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	Reduce likelihood	CMO	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	

7 Linked Risks (risks scoring 12 or above)

ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
31987	UK Visas and Immigration rules (legal migration rules)	20				12	Central Functions	2
15697	Attainment of the Cancer 28 day target for Lower GI	20				4	Medical	4
25353	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	20				6	Central Functions	7
21697	Recurrent CIP requirements for 23/24 and beyond not met	20				8	Central Functions	8
32399	Low diagnostic Neuro Radiologist workforce	20				9	Children's, Women's and Clinical Support Services	1, 2
25980	Your Next Patient Process	16				4	Central Functions	1
26887	Ineffective Clinical Effectiveness Provision	16				6	Central Functions	1
32464	Incorrect use of bedrails	16				6	Central Functions	1
28838	NMCPS Governance, Quality, Training and Health & Safety capacity	16				8	North Midlands and Cheshire Pathology Service	2
32544	UHNM negotiations re: AfC B2 Healthcare Support Workers who have been delivering work at B3	16				12	Central Functions	2
32545	Demand on our People Operations services is greater than our resource capacity	16				9	Central Functions	2
23842	(CQC) Delivery of RTT - Outpatient capacity/wait times	16				4	Medical	4
24028	(CQC) Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	16				6	Medical	4
25469	Delivery of constitutional cancer quality standards	16				4	Surgical	4
25471	Follow Up Delays	16				4	Surgical	4
25628	Ophthalmology Service Delivery	16				4	Surgical	4
25454	EPMA and/or Clinical Narrative System not fit for purpose	16				4	Central Functions	5
25893	Delay in EPMA roll out	16				4	Central Functions	5
26427	Use of Q-pulse as electronic management system	16				6	North Midlands and Cheshire Pathology Service	5
31185	DataCentre Air Conditioning EOL - Unfit for Purpose	16				4	Central Functions	6
32237	Fire Risk on Corridors	16				4	Surgical	6
15664	Liver Mortality - CQC actions	16				4	Medical	1, 2
21157	Haematology Service at MCHT Leighton	16				6	Network Services	1, 2

ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
25120	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	16				8	North Midlands and Cheshire Pathology Service	1, 2
23880	Shortage of Delivery Suite 24 hour theatre Scrub cover	15				4	Children's, Women's and Clinical Support Services	1
30752	Temporary Staffing Checks	15				6	Central Functions	2
20739	Endoscopy planned patients waiting list	15				6	Medical	4
26554	Looked after children - IHA compliance	15				6	Children's, Women's and Clinical Support Services	4
9036	Vulnerability to Cyber Attack	15				12	Central Functions	5
28451	Network outage affecting accessibility of clinical systems	15				6	Central Functions	5
31028	Availability of LIMS Project Funding from April 2024	15				5	North Midlands and Cheshire Pathology Service	5
31673	V scan Air Wireless Ultrasound (DPA) not linked to PACS	15				3	Medical	5
23331	MCHT Ceiling RAAC planks	15				4	North Midlands and Cheshire Pathology Service	6
30476	NHS Financial position and procurement of System Wide EPR	15				5	Central Functions	7
26997	Radiology Reporting Backlog - Neuro Radiology	15				4	Children's, Women's and Clinical Support Services	1, 2
8877	Hospital Acquired Infections	12				8	Central Functions	1
8901	Ensure correct blood sample management	12				6	Central Functions	1
9738	(CQC) Nursing training (both sites)	12				6	Medical	1
11417	End of Life - care pathway	12				9	Central Functions	1
23500	Inadequate Pharmacy support to emergency portals to meet national benchmarking for 7 days	12				3	Children's, Women's and Clinical Support Services	1
28461	Non-compliance of basic life support (BLS) training in Radiology SPR's	12				4	Children's, Women's and Clinical Support Services	1
28868	Neonatal Emergency Transfer Team Training Shortage	12				2	Children's, Women's and Clinical Support Services	1
29167	Lack of Dietetics Service in the Neonatal Unit	12				1	Children's, Women's and Clinical Support Services	1
29312	Inadequate pharmacy service to escalation wards (80/81/120/123)	12				4	Children's, Women's and Clinical Support Services	1
31807	No nursing Clinical Educator in post in Renal	12				2	Medical	1

ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
32652	Clinical Harm Review Process	12				6	Central Functions	1
16652	Staff Wellbeing and Welfare	12				2	Medical	2
19397	Maintaining the Quality Management System in Immunology	12				6	North Midlands and Cheshire Pathology Service	2
26110	Renal clinic letters for Cheshire (Leighton) Patients	12				6	Medical	2
27153	QI Academy Staffing under-resourced to deliver sustainable change	12				12	Central Functions	2
28365	Overall Management Resource Capacity deficit - Imaging	12				9	Children's, Women's and Clinical Support Services	2
28382	Lack of administration support for Governance & Medicine Safety objectives	12				2	Children's, Women's and Clinical Support Services	2
28945	Cheshire Haematology Management cover (MCHT/ECT)	12				8	North Midlands and Cheshire Pathology Service	2
29286	Project and Planned Maintenance Slippage due to ongoing Industrial Action	12				6	Central Functions	2
30650	Improving culture and stability within the Neonatal Consultant Team at UHNM	12				6	Children's, Women's and Clinical Support Services	2
32500	TI Rates	12				4	Central Functions	2
8660	Follow up back log	12				6	Medical	4
12699	High acuity emergency patients - County	12				4	Medical	4
17805	Lung Nodule Management	12				8	Medical	4
18066	Cardiology follow up backlog	12				4	Network Services	4
18664	Gynaecology 52 Week Wait Patient Numbers	12				9	Children's, Women's and Clinical Support Services	4
20435	Paediatric Follow up Backlog	12				6	Children's, Women's and Clinical Support Services	4
20448	Patient LOS above 24 hrs on AMU - against Internal Standards	12				4	Medical	4
21887	Changes to AED Formulary across South & North Staffordshire	12				4	Network Services	4
21947	Insufficient resource for the paediatric dietetic services	12				4	Children's, Women's and Clinical Support Services	4
25470	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12				4	Surgical	4
25790	Diagnostic Sleep Service	12				6	Children's, Women's and Clinical Support Services	4

ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
26808	Holding Ambulance Patients on the ED Corridor	12				4	Medical	4
8849	Staff using unsecured and unlicenced personal phones for work email	12				4	Central Functions	5
10356	Bowel prep prescription pre-assessment capacity	12				3	Medical	5
21332	NMCPS Management of Incidents across all network sites	12				4	North Midlands and Cheshire Pathology Service	5
21784	Confidentiality, Integrity and Availability of Trust Information	12				4	Central Functions	5
23753	Network failure due to multiple service providers	12				4	Central Functions	5
23759	Inappropriate clinical decisions due to large number of digital systems in place	12				4	Central Functions	5
25457	Lack of regular audit of IT assets	12				4	Central Functions	5
25668	Risk of Patient Information changing between Pathology LIMS and ICE	12				6	North Midlands and Cheshire Pathology Service	5
25682	(CQC) Unstructured records Management	12				4	Central Functions	5
26487	Lack of a digital solution to maintain confidentiality of patient information with the GP	12				3	Central Functions	5
27146	Lack of compatibility between iportal and other systems	12				4	Surgical	5
28354	Blood Analyser Lantronix UDS box	12				4	North Midlands and Cheshire Pathology Service	5
28573	End of support for SQL Server 2012 and Windows Server 2012/2012 R2	12				2	Central Functions	5
28595	COIN Network	12				4	Central Functions	5
29217	E-grow digital plotting for height and weight	12				2	Children's, Women's and Clinical Support Services	5
30129	Inpatient E-notification initial report not enabled	12				2	Children's, Women's and Clinical Support Services	5
30246	PathmanDB - Oracle servers High impact exploit/Vulnerability	12				4	North Midlands and Cheshire Pathology Service	5
30477	Lack of records retention in line with Code of Practice	12				4	Central Functions	5
30906	Loss of Read/ Write Access to Legacy System (LabCentre)	12				4	North Midlands and Cheshire Pathology Service	5
31378	XMSGH Domain - Cyber Risk	12				4	Surgical	5
20315	Delay in Interventional Radiology Procedures - Room 5	12				6	Children's, Women's and Clinical Support Services	6
25917	Suitability of Cohort (ambulance holding) Area	12				2	Medical	6

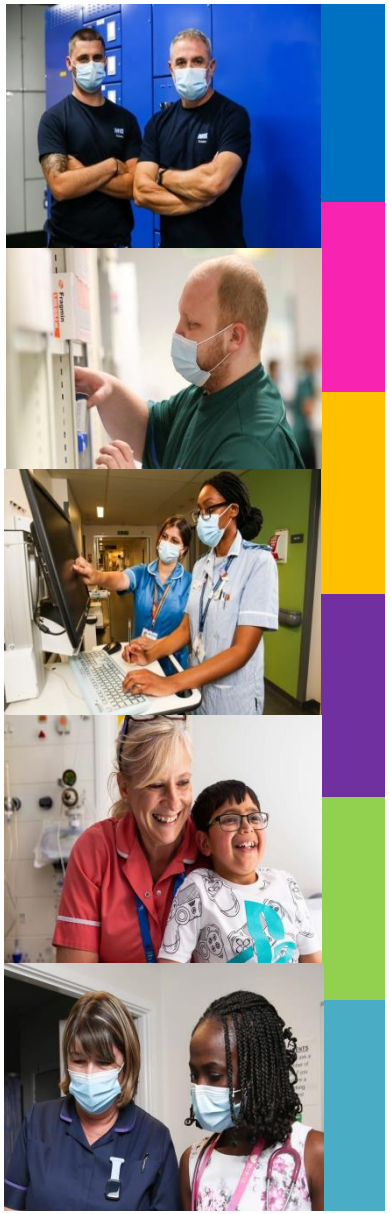
ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
27410	Fire escape in Transitional Discharge Lounge (TDL)	12				9	Medical	6
28684	Lack of Clean Utility Room - Children's High Dependency	12				6	Children's, Women's and Clinical Support Services	6
30237	PFI latent defects	12				4	Estates, Facilities and PFI	6
30963	Endoscopy equipment transferred from Salford to County	12				3	Medical	7
10381	Medical Staffing - Haematology	12				6	Network Services	1, 2
11294	NMCPS Pathology Histology Medical Capacity - dissection & reporting (achieving TAT)	12				6	North Midlands and Cheshire Pathology Service	1, 2
13725	CH Haematology shift service provision (Haematology)	12				4	North Midlands and Cheshire Pathology Service	1, 2
13744	ANP Succession Planning	12				4	Children's, Women's and Clinical Support Services	1, 2
17710	Pharmacy staffing for Inpatient gastroenterology	12				6	Medical	1, 2
18842	Gaps within the Junior Medical Rota	12				6	Children's, Women's and Clinical Support Services	1, 2
20616	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield Hospital	12				4	North Midlands and Cheshire Pathology Service	1, 2
20626	Low staffing levels for Phlebotomy at Cheshire Sites	12				6	North Midlands and Cheshire Pathology Service	1, 2
22514	Nurse Staffing in the Emergency Department both Sites	12				6	Medical	1, 2
23506	Gastroenterology patients insufficient Pharmacy support for highly complex medication regimes	12				3	Children's, Women's and Clinical Support Services	1, 2
24818	RSUH/CH Biochemistry Staffing and Shift Cover	12				6	North Midlands and Cheshire Pathology Service	1, 2
24837	Cystic Fibrosis workforce/service delivery	12				4	Medical	1, 2
25229	Nurse Staffing CAU	12				4	Children's, Women's and Clinical Support Services	1, 2
25247	Nurse Staffing Ward 217	12				4	Children's, Women's and Clinical Support Services	1, 2
25467	Funding for HD capacity and workforce	12				8	Medical	1, 2
25795	Vacant Consultant Neurology On-Call Gaps	12				4	Network Services	1, 2
25857	AMU COUNTY-Lack of pharmacy staff to meet demand due to increased bed base	12				2	Medical	1, 2
26529	Leighton Hospital Hyper-Acute Stroke Pathway	12				4	Network Services	1, 2

ID	Title	Risk Score as at Q1	Risk Score as at Q2	Risk Score as at Q3	Risk Score as at Q4	Rating (Target)	Division	BAF Link
26815	Resuscitation Training	12				6	Central Functions	1, 2
26995	Radiology Reporting Backlog - Body Radiology	12				4	Children's, Women's and Clinical Support Services	1, 2
27472	Inadequate Nurse Staffing in Children's ED Compromising Ability to Provide Basic CQC Nursing Requirements	12				4	Medical	1, 2
28944	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses	12				4	Children's, Women's and Clinical Support Services	1, 2
29508	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12				9	Medical	1, 2
29712	Scientist Shortages in Neurophysiology	12				4	Network Services	1, 2
29767	Backlog for radical prostatectomy	12				4	Surgical	1, 2
29776	Type A - Aortic Dissection rota	12				4	Network Services	1, 2
30482	Nurse Staffing Vacancy within CICU	12				4	Children's, Women's and Clinical Support Services	1, 2
30500	SCP- Inadequate Establishment & Staff Shortages	12				6	Network Services	1, 2
31429	Audiology Staffing	12				4	Surgical	1, 2
31448	Substantive Medical workforce on winter and escalation wards (both sites)	12				4	Medical	1, 2
32025	Consultant Vacancies in Renal Department	12				4	Medical	1, 2
27754	Non compliance of DM01 performance for NOUS	12				3	Children's, Women's and Clinical Support Services	1, 2, 4
26168	Pathology IT System Expertise	12				8	North Midlands and Cheshire Pathology Service	2, 5

NHS
University Hospitals of North Midlands
NHS Trust

Summary Board Assurance Framework

Quarter 1 2024/2025



Delivering Exceptional Care with Exceptional People

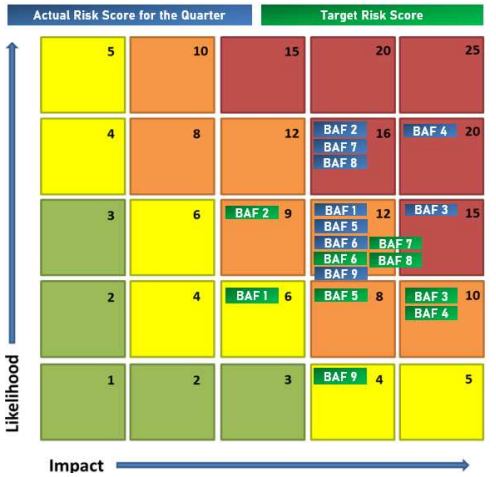
High Level Overview

NHS University Hospitals of North Midlands NHS Trust

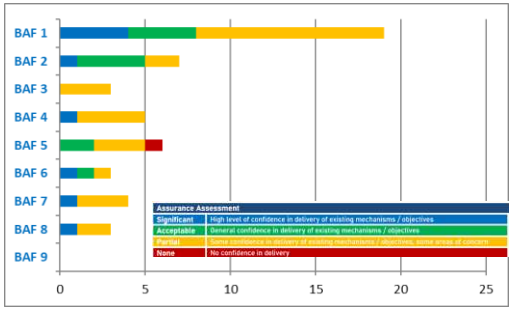
Strategic Risk Summary

Assurance Committee	BAF No.	BAF Risk Title	Risk Score and Assurance Q1	Target	Appetite	Linked Risks	Longer Term Risk Actual v	Action BRAG	Strategic Priorities
Quality Governance Committee	BAF 1	Delivering Positive Patient Outcomes	High 12	Mod 6	Minimal	147		11	
				31/03/26	Above Tolerance (4 - 6)				
People, Culture & Inclusion Committee	BAF 2	Improving Workforce Sustainability & Culture	Ext 16	High 9	Open	120		15	
				31/03/25	Above Tolerance (8-12)				
Strategy & Transformation Committee	BAF 3	Improving the Health of our Population	Ext 15	High 10	Open	0		2	
				31/03/25	Above Tolerance (8-12)	Graph not available as no linked risks identified			
	BAF 5	Digital Transformation	High 12	High 8	Open	72		3	
				31/03/25	At Tolerance (8-12)				
	BAF 9	Research & Innovation	High 12	High 8	Cautious	2		4	
				30/09/25	Above Tolerance (4 - 6)				
Performance & Finance Committee	BAF 4	Delivering Responsive Patient Care	Ext 20	High 10	Open	51		6	
				30/09/25	Above Tolerance (8-12)				
	BAF 6	Fit for Purpose Estate	High 12	High 12	Open	69		7	
				31/03/29	At Tolerance (8-12)				
	BAF 7	Financial In Year Delivery	Ext 16	High 12	Open	27		3	
				31/03/25	Above Tolerance (8-12)				
	BAF 8	Financial Sustainability	Ext 16	High 12	Cautious	1		2	
				31/03/25	Above Tolerance (4-6)				

Strategic Risk Heat Map



Assurance Outcomes Overview



Positive Assurances to Note

- 2 / 9 risks identified as providing acceptable assurance
- 86% of assurances were seen compared to the plan during the quarter
- 18% assurances were rated as significant assurance and 22% as acceptable assurance
- 4% of actions have been completed with the remaining 96% on track

Matters of Concern

- 7 / 9 risks identified as providing partial assurance
- 14% of assurance were not seen during Q1
- 58% assurances were rated as partial assurance and 2% identified as having no assurance
- 7 / 9 target risk scores are above the tolerance

BAF 1: Delivering Positive Patient Outcomes

Chief Nurse & Chief Medical Officer | Quality Governance Committee | Threat to:

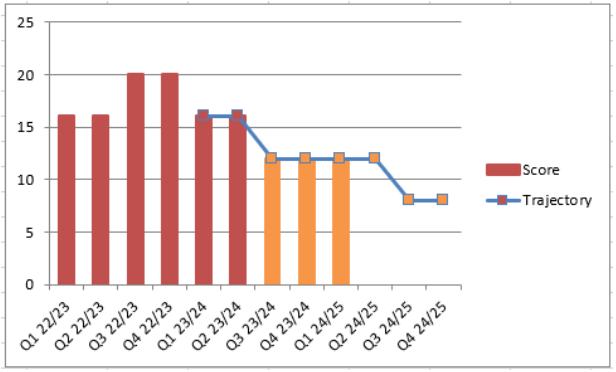
University Hospitals of North Midlands NHS Trust

If we do not consistently maintain evidence based, safe and effective care, then we may see an increased incidence of avoidable harm, poor patient experience and suboptimal patient outcomes, resulting in unnecessary reductions in the quality of treatment, failure to deliver statutory and regulatory compliance, increased complaints and litigation, reputational damage and poor staff morale

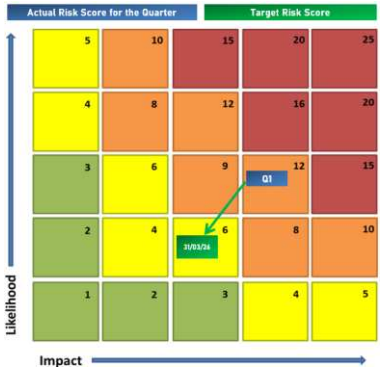
Assurance, Risk Ratings & Target

Partial Assurance	High 12	Q2	Q3	Q4	Mod 6 31/3/26

Risk Movement and Risk Reduction Trajectory



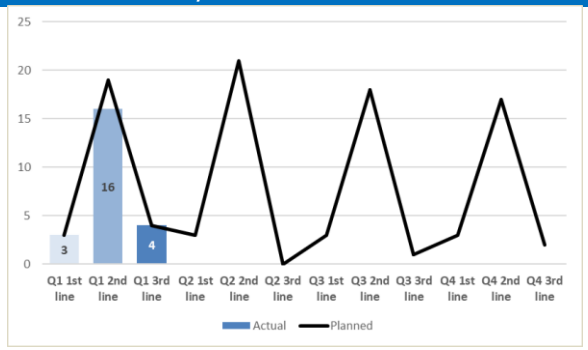
Heat Map Risk Matrix



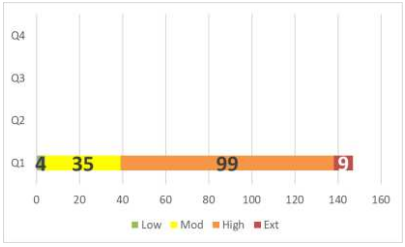
Rationale for Risk Level

The risk score has stayed the same as Q4, although the risk description, current controls and assurances have been reviewed. Main gaps in control relate to clinical effectiveness delivery and introduction of ePMA with further assurance required in terms of Section 29a notices and the need for a robust system to be identified to evaluate harm associated with long waits.

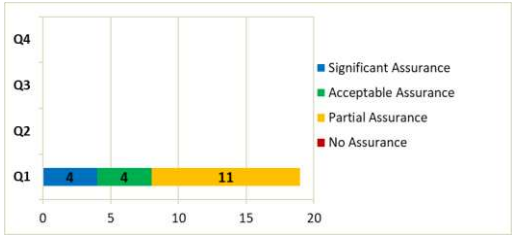
2024 / 2025 Assurance Plan



Linked Risks on Register



Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Support delivery of Non-Elective Improvement Prog	31/03/2025				
2	Enhance harm review process	31/12/2024				
3	Reduce / eliminate CEF bronze rated areas	31/03/2025				
4	Continue improvements in meeting S29a Notices	30/09/2024				
5	Embed clinical effectiveness processes	31/12/2024				
6	Continue rollout of Improving Together	31/03/2025				
7	Understand root cause of increased HAI rates	31/03/2025				
8	Develop delivery plan for Oliver McGowan full day training	31/05/2025				
9	Review visiting guidance in view of changes in legislation	30/09/2024				
10	Implement Martha's Rule	31/03/2025				
11	Deliver ePMA programme	31/12/2025				

Overview

- Risk score reviewed and the same as Q4 in line with planned trajectory
- Risk score expected to be above agreed tolerance until 2026
- Continues to have the highest number of 'linked risks' on the risk register, although this has reduced to 147 at Q1 from 165 at Q4, with 9 linked risks rated as Extreme
- 11 / 19 assurances for the quarter were rated as having partial assurance; 4 sources of assurance were not rated
- 23 / 26 assurances were seen as planned during the quarter

BAF 2: Sustainable Workforce

Chief People Officer | People, Culture & Inclusion Committee | Threat to:

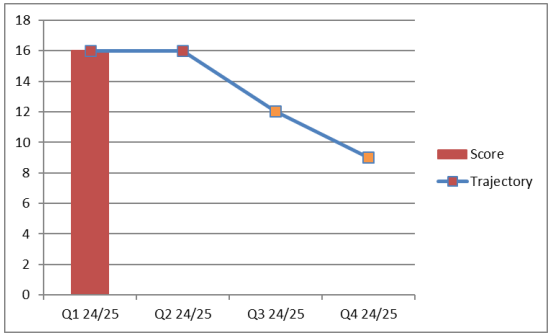
NHS University Hospitals of North Midlands NHS Trust

If we are unable to achieve workforce sustainability through an effective long term workforce plan which is underpinned by a positive organisational culture, then we may face significant challenges in ensuring that we have colleagues with the right skills in the right place at the right time, resulting in an adverse impact on colleague wellbeing, recruitment and retention, the potential to compromise quality of care for our patients, inability to deliver operational targets and increased premium costs negatively affecting the financial position.

Assurance, Risk Ratings & Target

Acceptable Assurance	Ext 16	Q2	Q3	Q4	High 9 31/3/25

Risk Movement and Risk Reduction Trajectory

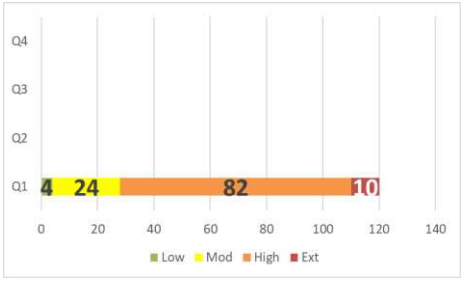


Heat Map Risk Matrix

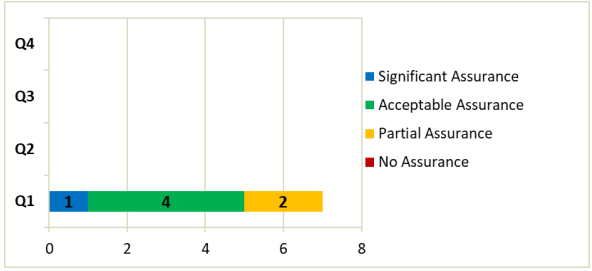
Rationale for Risk Level

- Good progress has been maintained in Q1,including completing the review of the 2023/24People Strategy Delivery Plan, setting the People Plan for 2024/25 and utilisation of Improving Together for our driver and watch metrics
- Vacancy rates and staff turnover continue to be below target, and agency costs for May better than target
- Potential impact of financial pressures not yet known

Linked Risks on Register



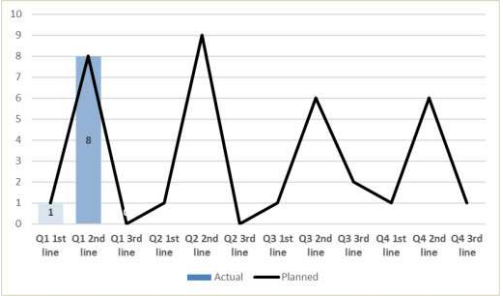
Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Strengthen flexible working opportunities	31/03/2025				
2	Focus on providing a safe and healthy work environment	31/03/2025				
3	Continue to support wellbeing of our staff	31/03/2025				
4	Widen career pathways for disadvantaged groups	31/03/2025				
5	Strengthen mechanisms to demonstrate tangible recognition and appreciation	31/03/2025				
6	Increase employee knowledge in raising concerns	31/03/2025				
7	Continue to deliver on our retention plan	31/03/2025				
8	Develop and launch succession planning framework	31/03/2025				
9	Scale up new roles to tackle key staff shortages	31/03/2025				
10	Increase pipeline for local school and college leavers	31/03/2025				
11	Embed further remote working opportunities	31/03/2025				
12	Review, adapt and amend our processes for ESR	31/03/2025				
13	Continue to develop people systems and streamline processes	31/03/2025				
14	Continue to help improve digital skills of our staff	31/03/2025				
15	Continue to provide teams with time, tools and skills for service improvements	31/03/2025				

2024 / 2025 Assurance Plan



Overview

- Risk score in line with trajectory but expected to be above agreed tolerance until 2024/25
- Second highest number of 'linked risks' on the risk register at 120 at Q1, compared to 118 at Q4
- 2 / 7 assurances for the quarter were rated as having partial assurance; 2 sources of assurance were not rated
- All 9 assurances were seen as planned during the quarter

BAF 3: Improving the Health of our Population

Director of Strategy & Transformation | Strategy & Transformation Committee | Threat to:

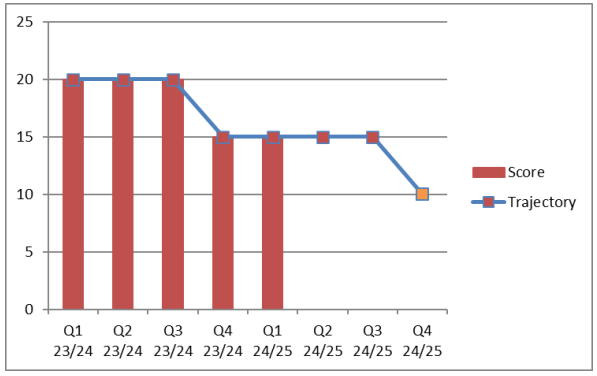
University Hospitals of North Midlands NHS Trust

If we are unable to work together with system partners across organisation and sector boundaries, then we will have minimal impact on the long-term elements of improving population health, 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 and potentially increased pressure on health care services.

Assurance, Risk Ratings & Target

Partial Assurance	Ext 15	Q2	Q3	Q4	High 10 31/3/25

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix

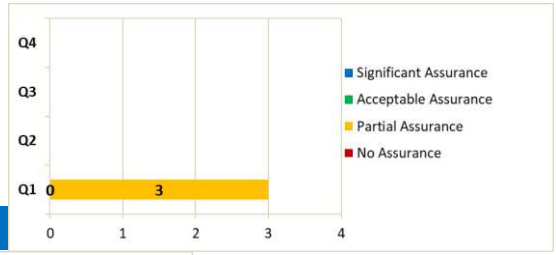
Rationale for Risk Level

- Risk likelihood reduced in March 2024 on the basis that we approved or Population Health Strategy. Work is underway to embed action plans. At the point where there is demonstrated delivery against our outcome's framework, the risk rating will be reassessed during 2024/25.
- Main gaps in assurance relate to sight of the strategic action plans which will be delivered during 2024/25

Linked Risks on Register

Graph not available as no linked risks identified

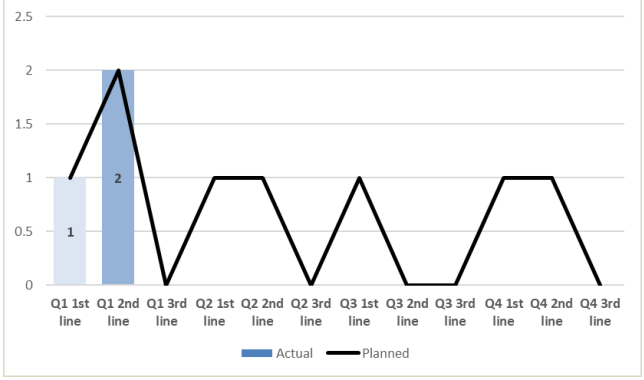
Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Development of metrics to measure progress and delivery	21/03/2025				
2	Develop detailed action plans to support delivery of the strategy	21/03/2025				

2024 / 2025 Assurance Plan



Overview

- Risk score is in line with trajectory although expected to be above agreed tolerance until end of 2024/25
- No linked risks identified on the risk register
- Limited sources of assurance identified, all 3 assurances seen as planned and rated as partial assurance during Q1
- No third line assurances identified

BAF 4: Delivering Responsive Patient Care

Chief Operating Officer | Performance & Finance Committee | Threat to:

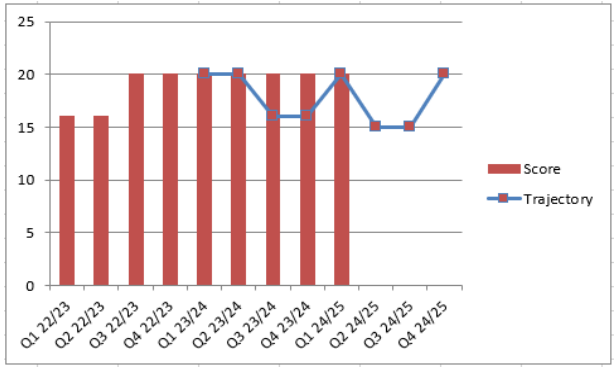
NHS University Hospitals of North Midlands NHS Trust

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 poor patient outcomes, potential patient harm, impact on staff wellbeing, continued regulatory control and negative impact on the financial position

Assurance, Risk Ratings & Target

Partial Assurance	Ext 20	Q2	Q3	Q4	High 10 30/9/25

Risk Movement and Risk Reduction Trajectory



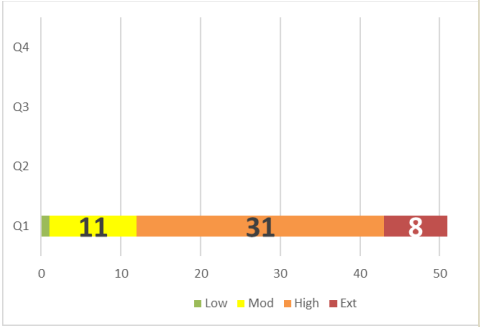
Heat Map Risk Matrix

Rationale for Risk Level

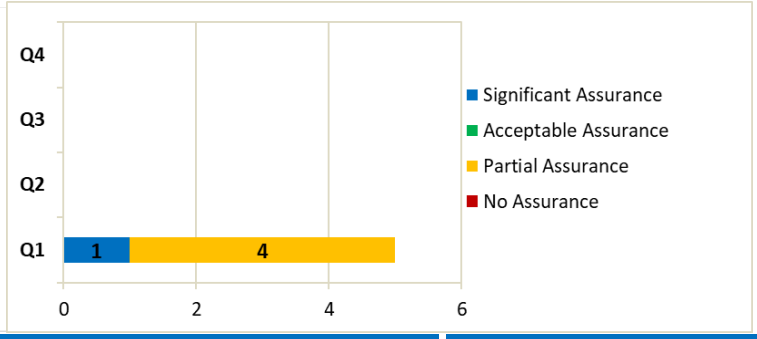
Despite some improvements in performance, there remain areas of risk, and performance has not been consistently delivered.

Main gaps in control relate to internal rapid handover and the schemes to be identified to create additional capacity. In addition, there is a focus required on improving the discharge profile.

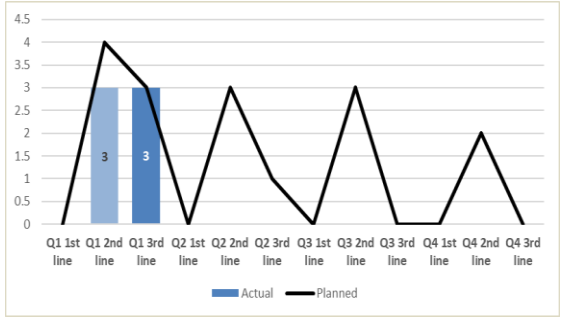
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Increase capacity - County Hospital Elective Care Centre	31/03/2025				
2	Explore/develop data and technology to support services	31/03/2025				
3	Deliver objectives in non-elective improvement programme	31/03/2025				
4	Deliver objectives in elective improvement programme	30/09/2024				
5	Two phased rightsizing work looking at best use of capacity	31/10/2024				
6	Harm review process for patients waiting for elective care	31/07/2024				
7	Introduction of finance, activity and productivity meeting	01/05/2024				
8	Consideration of expanded capacity through ERF	30/07/20204				

Overview

- Highest scoring strategic risk, in line with trajectory but expected to be above tolerance until September 2025
- 51 linked risks on the Risk Register, a decrease from 63 at Q4
- 6 / 7 assurances seen as planned, 4 of which rated as partial assurance; 1 source of assurance not rated

BAF 5: Digital Transformation

Chief Digital Information Officer | Strategy & Transformation Committee | Threat to:

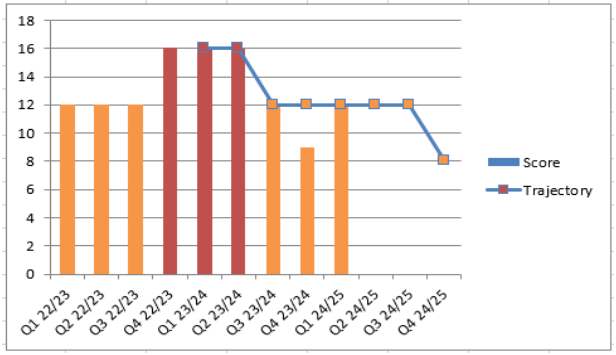
University Hospitals of North Midlands NHS Trust

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.

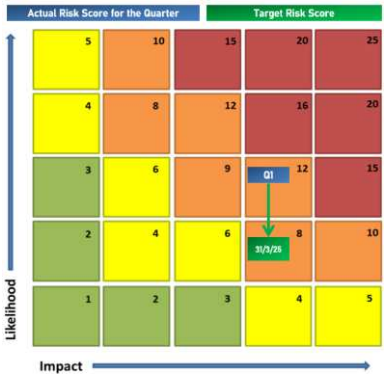
Assurance, Risk Ratings & Target

Acceptable Assurance	High 12	Q2	Q3	Q4	High 8 31/3/25

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix

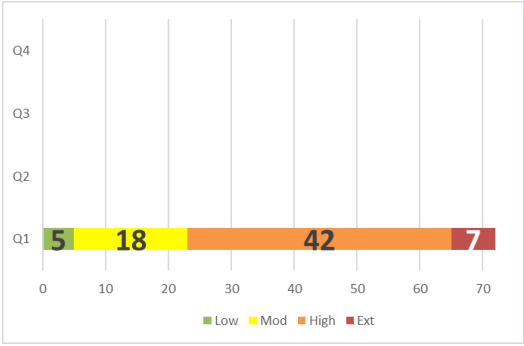


Rationale for Risk Level

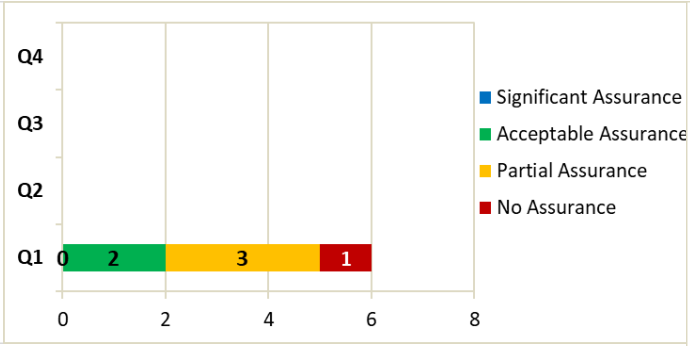
A number of targeted cyber security attacks have taken place at other NHS Trusts and multifactor authentication is not in place for all externally facing systems. Shadow IT still an area of risk and volume of applications to manage from a cyber security perspective is high.

Main gaps in control relate to completion of LIMS, upgrading of VPN technology and completion of the EPR business case.

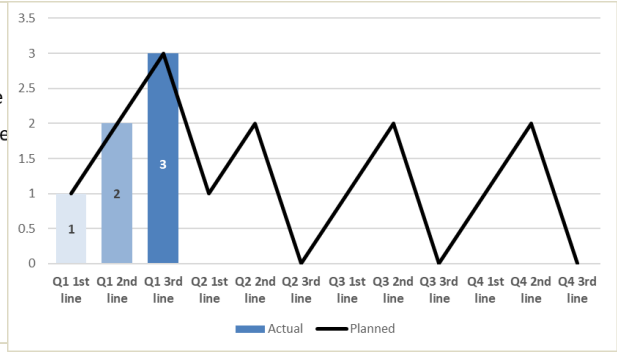
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	LIMS Go Live	31/10/2024				
2	EPR Outline Business Case	30/09/2024				
3	eMPA pilot	31/10/2024				

Overview

- Risk score in line with trajectory and within risk score tolerance
- Number of linked risks on the Risk Register slightly decreased to 72 from 73 at Q4
- All 6 assurances seen as planned during the quarter, with one receiving a rating of no assurance

BAF 6: Fit for Purpose Estate

Director of Estates, Facilities & PFI | Performance & Finance Committee | Threat to:

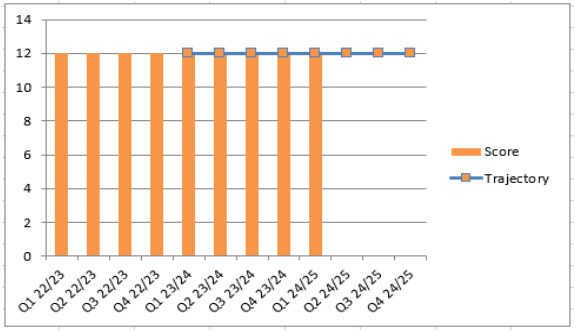
NHS University Hospitals of North Midlands NHS Trust

If we are unable to obtain sufficient investment to develop our estate infrastructure and workforce, then we may be unable to deliver high quality, responsive services in a safe, compliant and sustainable environment, resulting in the inability to achieve national standards, manage backlog maintenance, achieve Value for Money and deliver strong performance against Estates Divisional objectives

Assurance, Risk Ratings & Target

Acceptable Assurance	High 12	Q2	Q3	Q4	High 12 31/3/29

Risk Movement and Risk Reduction Trajectory

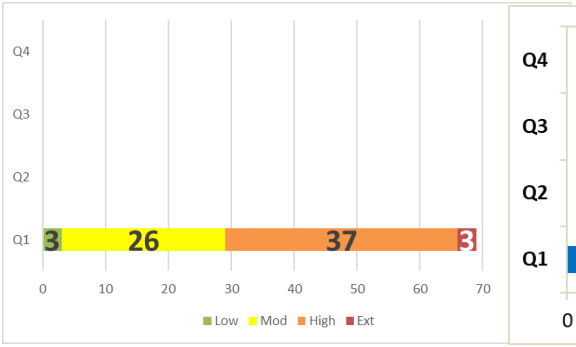


Heat Map Risk Matrix

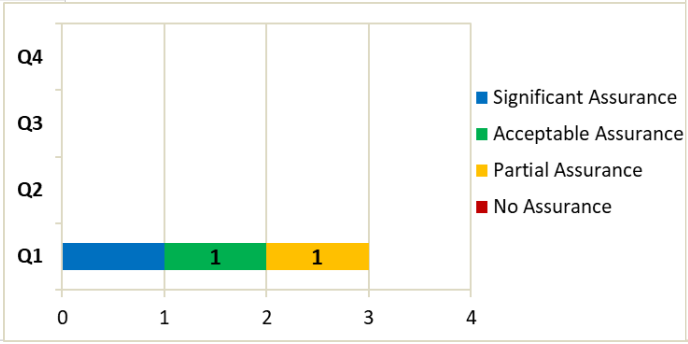
Rationale for Risk Level

- Insufficient capital allocation for 2024/25 and funding constraints
- Supply chain issues and external market influence on number of suppliers available to deliver large capital schemes
- Lack of worked up clinical / demand management plans
- Aging workforce profile and failure to recruit to key estates craftsmen roles
- PFI partners / lenders issues with agreeing formal variations to the Trust's changing requirements

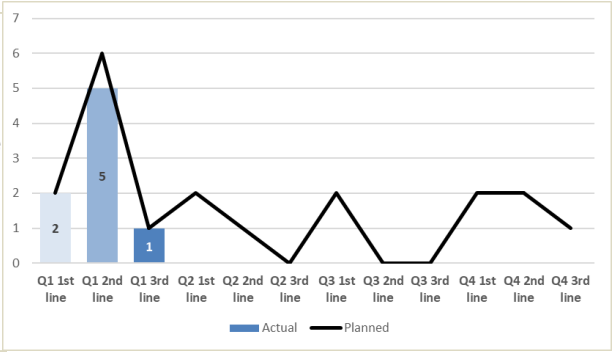
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Funding allocation	28/06/2024				
2	Strategy preparation for future bids	31/03/2025				
3	Supply chain partners	31/03/2025				
4	Adapting to a changing climate	31/03/2025				
5	Sustainability/net zero carbon	31/03/2025				
6	Workforce	27/12/2024				
7	PFI partners / lender issues	31/03/2025				

Overview

- Risk score remains in line with trajectory and in line with tolerance
- Number of linked risks on the Risk Register has reduced to 69 from 78 at Q4
- 8 / 9 assurances seen as planned; 5 sources of assurance not rated

BAF 7: Financial In Year Delivery

Chief Finance Officer | Performance & Finance Committee | Threat to:

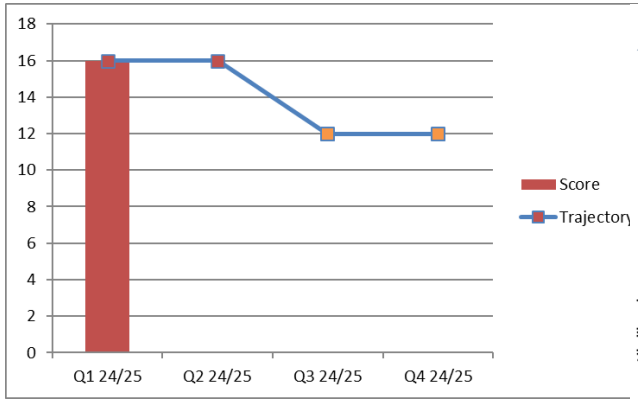
NHS University Hospitals of North Midlands NHS Trust

If we, or system partners, are unable to manage within the assumptions made in the financial plan for 2024/25, then we will be unable to meet our financial plan for 2024/25, resulting in an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust

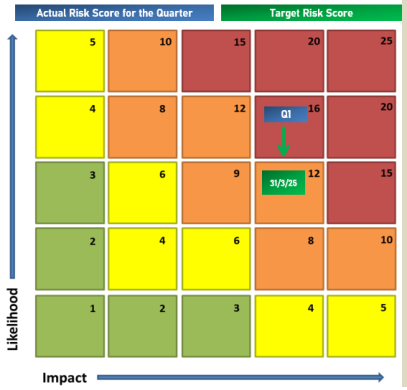
Assurance, Risk Ratings & Target

Partial Assurance	Ext 16	Q2	Q3	Q4	High 12 31/3/25

Risk Movement and Risk Reduction Trajectory



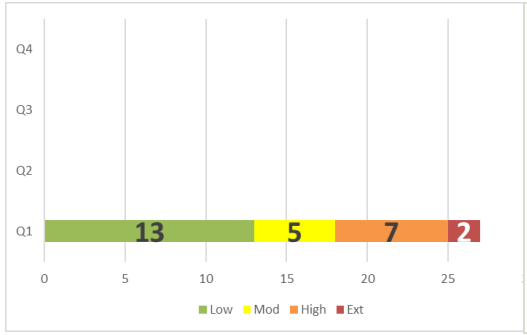
Heat Map Risk Matrix



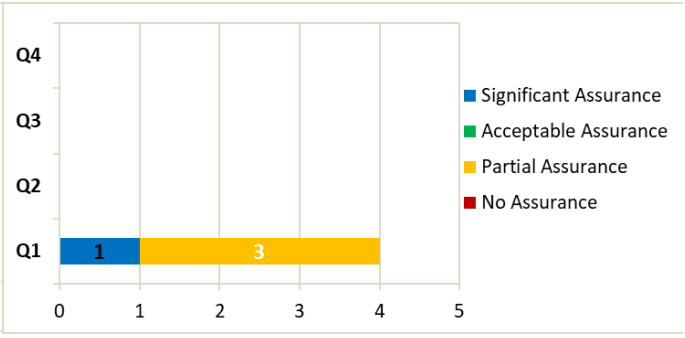
Rationale for Risk Level

- Financial plan has been signed off by the Board and a paper outlining key assumptions and risks has been provided
- Divisions have submitted their high-level cost improvement plans with a CIP summit being held in July
- Activity levels above plan in April, and the impact of ERF income will be included in Q1 financial outturn
- Main gaps in control relate to a fully signed off CIP plan and the amount of recurrent versus non-recurrent savings in addition to the risk around Band 2 to 3 funding and business case for winter

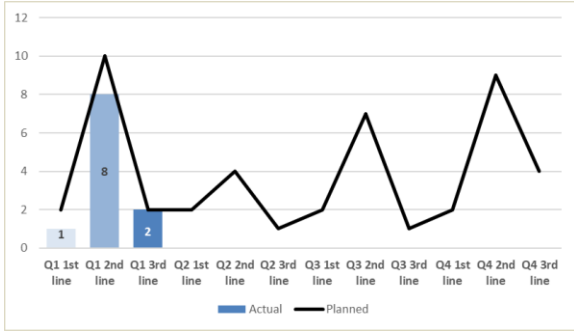
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Identification of recurrent CIP	31/07/2025				
2	Ensure delivery of elective targets	31/03/2025				
3	Identification of non-recurrent mitigations to support the 2024/25 financial position	31/12/2025				

Overview

- Risk score in line with trajectory and expected to be above tolerance until Q3 2024/25
- Linked risks on the Risk Register has reduced to 27 from 33 at Q4
- 11 / 14 assurances seen as planned; 7 assurances not rated

BAF 8: Financial Sustainability

Chief Finance Officer | Performance & Finance Committee | Threat to:

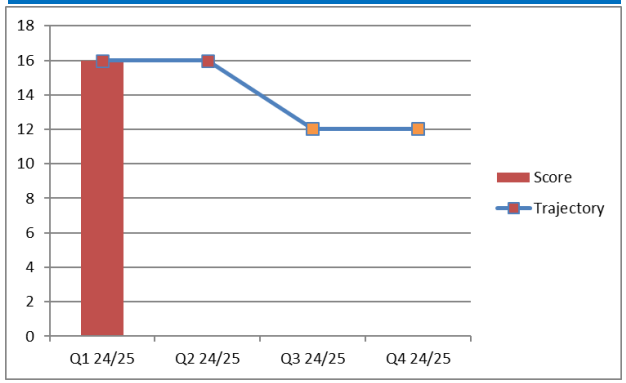
NHS University Hospitals of North Midlands NHS Trust

If we, or system partners, are unable to manage within the assumptions made within the financial plan for 2024/25, then our underlying financial position will deteriorate further, resulting in less funding being available for investments and an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust

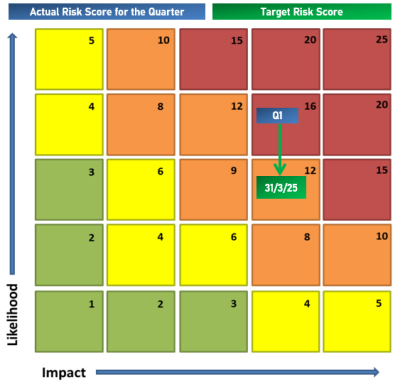
Assurance, Risk Ratings & Target

Partial Assurance	Ext 16	Q2	Q3	Q4	High 12 31/3/25

Risk Movement and Risk Reduction Trajectory



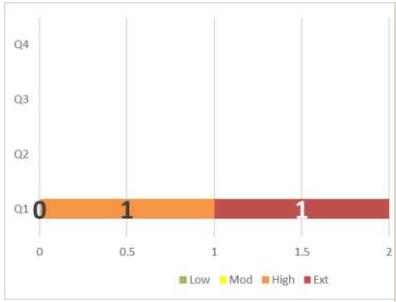
Heat Map Risk Matrix



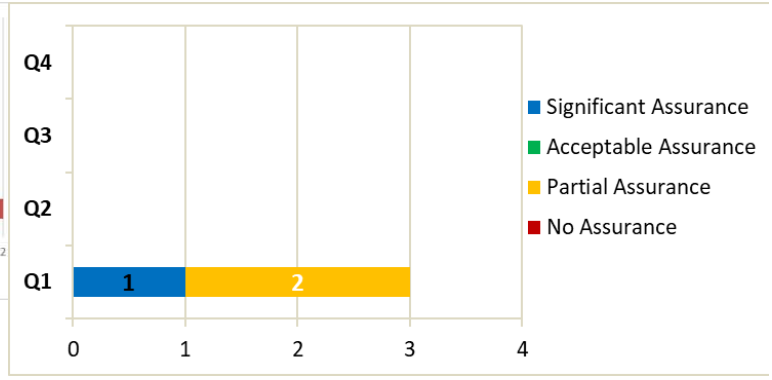
Rationale for Risk Level

- Financial plan for 2024/25 set with an underlying deficit of £58 m, at month 2 we are not delivering against our recurrent CIP target and therefore this position is likely to worsen
- Main gaps in control relate to a fully signed off CIP plan and the amount of recurrent versus non-recurrent savings in addition to the risk around Band 2 to 3 funding and business case for winter

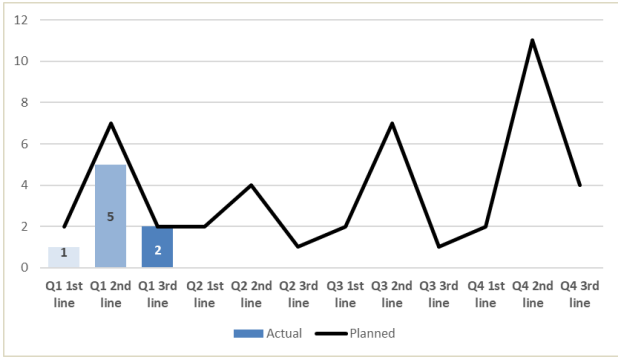
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Identification and delivery of in-year CIP target	31/07/2025				
2	Review the opportunity to recurrently increase elective activity targets	30/09/2025				

Overview

- Risk score in line with trajectory and expected to be above tolerance until Q3 2024/25
- Second lowest number of linked risks on the Risk Register (1)
- 8 / 11 assurances seen as planned; 5 assurances not rated

BAF 9: Research and Innovation

Chief Medical Officer | Strategy & Transformation Committee | Threat to:

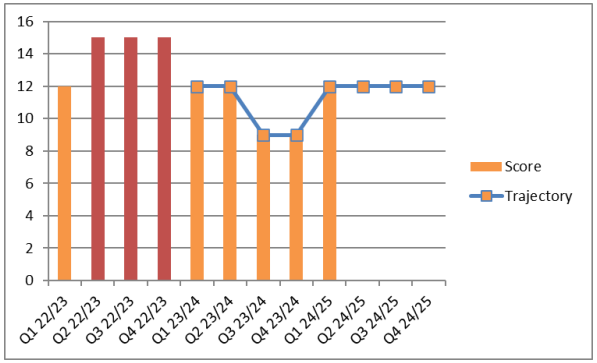
University Hospitals of North Midlands NHS Trust

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, provide high quality innovative care, and attract and retain highly skilled staff, due to our research profile

Assurance, Risk Ratings & Target

Partial Assurance	High 12	Q2	Q3	Q4	High 8 30/9/25

Risk Movement and Risk Reduction Trajectory

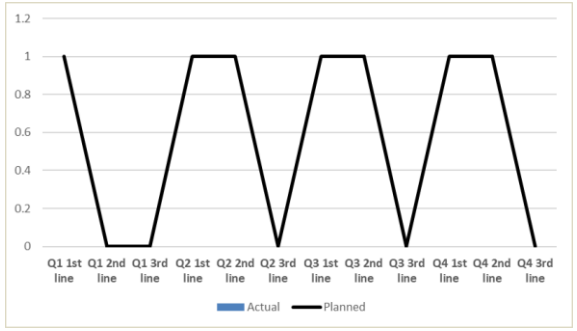


Heat Map Risk Matrix

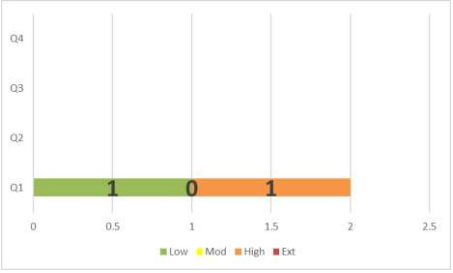
Rationale for Risk Level

- Risk score increased following conversation at deep dive, actions focussed on reducing likelihood as opposed to consequence
- Research participation remains on track for 2024/25
- Research output below comparator Trusts
- Main gaps in control relate to determining the criteria for assessing joint appointments and research active staff

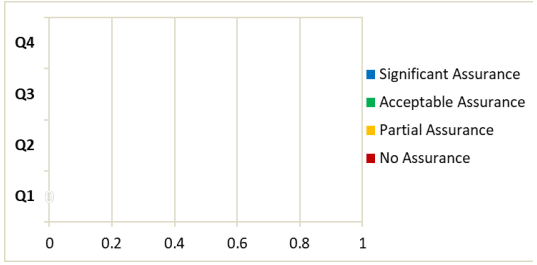
2024 / 2025 Assurance Plan



Linked Risks on Register



Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Research to form part of Divisional Performance Reviews	30/09/2024				
2	Research to form part of Divisional Board Agendas	30/09/2024				
3	Commissioning an external specialist to review QMS prior to MHRA inspection	30/09/2024				
4	research strategy	31/03/2025				

Overview

- Risk score remains in line with trajectory but expected to be above tolerance
- Third lowest number of linked risks
- No assurances seen in quarter and very few items of assurance identified within the assurance map

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th August 2024
Report Title:	Board Development Programme 2024/25 – Schedule of Seminars	**Agenda Item:**	17
Author:	Nicola Hassall, Deputy 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**	✓			

Executive Summary

Situation

This paper is to provide the Board with an overview on progress against the topics identified to be delivered within the 2024/25 Board Seminar Programme.

Background

The outputs of the Board Effectiveness Review were presented to the Trust Board at the Seminar in April 20224. This identified a number of areas of development which subsequently informed the topics within the Board Development Programme for 2024/25. This includes a variety of business and developmental topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

Assessment

A review of the Board Seminar Programme has been undertaken and the attached demonstrates the topics which have been covered as planned, including those which are scheduled for forthcoming Seminars and sessions whilst in Closed Board.

The programme demonstrates that all topics to date have been covered as planned.

Key Recommendations

The Trust Board is asked to consider the progress made with the planned activities within the Board Seminar Programme and to note the timing and activities to be covered for the remaining sessions. In addition, the Board is asked to highlight any further areas of development which they would like to feature within the programme.

Board Development Programme 2024 - 2025

NHS University Hospitals of North Midlands NHS Trust

Topic	Session Lead	Development / Business	Purpose / Outcome	3rd April Closed Bd	12th April Seminar	15th May Seminar	5th June Closed Bd	17th July Seminar	7th Aug Closed Bd	11th Sept Seminar	9th Oct Closed Bd	18th Nov Time Out	4th Dec Closed Bd	15th Jan Seminar	5th Feb Closed Bd	19th March Seminar	Strategic Priorities
Board Development	Director of Governance	Board Development	To consider the findings of our Board Effectiveness Evaluation and agree Board Development for 2024/25														● ● ● ● ● ●
Well Led Self-Assessment	Director of Governance	Strategic	To agree the output of the Board's Self-Assessment														● ● ● ● ● ●
Risk Appetite	Director of Governance	Strategic	To review and agree the Trust's Risk Appetite Statement														● ● ● ● ● ●
Update on Responsiveness, Finance, Workforce & Productivity	Chief Operating Officer / Chief Finance Officer / Chief People Officer / Director of Strategy	Operational / Business Issues	Update in respect of annual planning, associated risks and issues and links to Well Led														● ● ● ● ●
Independent Well-Led Assessment	Director of Governance	Operational / Business Issues	To consider the findings of our External Developmental Review against the Well Led Framework and agree our Development Plan.														● ● ● ● ● ●
Levers of Effectiveness / GIRFT	Chief Medical Officer Chief Operating Officer	Operational / Business Issues	To provide an update in respect of progressing the Clinical Effectiveness divisional programmes of work														● ● ● ●
Innovation	Director of Strategy, Chief Nurse, Chief Digital Information Officer	Operational / Business Issues	To provide an update in respect of progressing the work in relation to innovation														● ●
Counter Fraud Annual Training	Chief Finance Officer	Board Development	RSM to lead the session														●
Enabling Strategies Half Year Update	Director of Strategy plus Executive Leads	Strategic	A review of progress against delivery of our Enabling Strategies.														● ● ● ● ● ●
Board Insights / Personalities	Chief People Officer	Board Development	Understanding personalities														●
Cyber Security	Chief Digital Information Officer	Operational / Business Issues	Annual training and development on Cyber Security / Risk.														●
Sustainability	Director of Estates, Facilities and PFI	Operational / Business Issues	An update on delivery of the Green Plan and key priorities.														● ●
Research and CeNREE	Chief Nurse & Medical Director	Operational / Business Issues	An update on progress with CeNREE and Research.														● ● ●
Strategic Risks - Board Assurance Framework	Director of Governance	Strategic	To agree the Strategic Risks for 2024/25 Board Assurance Framework.														● ● ● ● ● ●
Annual Plan and Focus Confirmation (local priorities)	Director of Strategy and Transformation	Strategic	To agree the Annual Plan, Annual Delivery Plans for Enabling Strategies and to confirm priorities agreed through focussed negotiation.														● ● ● ● ● ●

Trust Board

2024/25 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		3	8	5	10	7	4	9	6	4	8	5	12	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff			Staff			Staff			Staff		
Quality Governance Committee Assurance Report	Director of Governance			NA										
Quality Strategy Update	Chief Nurse / Medical Director													
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse													
RESPONSIVE														
Integrated Performance Report	Various													
Clinical Strategy Update	Director of Strategy													Deferred due to purdah and General Election period
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Director of Governance			PCI	PCI	S&T								
People Strategy Update														
Gender Pay Gap Report	Chief People Officer													
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Director of Governance													Report provided to EWAG and to be considered by the Board once it has been received at PCI Committee
Bi-Annual Establishment Review (Other Professions)	Chief People Officer													
IMPROVING AND INNOVATING														
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy													Update being provided to Strategy & Transformation Committee in July and Exec R&I Group in October - feedback to be incorporated for version to Board.
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
Population Health and Wellbeing Strategy	Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Director of Governance			N/A										
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													Exec decision to defer the strategy to November's Trust Board Time Out, to be presented with other enabling strategies
Digital Strategy Update	Chief Digital Information Officer													
Going Concern	Chief Finance Officer													
Annual Plan	Director of Strategy													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		3	8	5	10	7	4	9	6	4	8	5	12	
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
Scheme of Reservation and Delegation of Powers	Chief Finance Officer													Next due for review February 2026
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Director of Governance													
Fit and Proper Persons Annual Assurance Report	Director of Governance													
Audit Committee Assurance Report	Director of Governance													
Trust Strategy	Director of Strategy													TBC
Board Assurance Framework	Director of Governance													
Annual Evaluation of the Board and its Committees	Director of Governance													
Annual Review of the Rules of Procedure	Director of Governance													
Board Development Programme	Director of Governance													
Well-Led Self Assessment	Director of Governance													To be considered at July's Trust Board Seminar
Risk Management Policy	Director of Governance													Next due for review February 2027
Complaints Policy	Chief Nurse													