Trust Board (Open)

May 2020

Trust Board (Open)

Meeting held on Wednesday 6th May 2020 at 9.30 am to 11.15 am via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
09:30	**PROCEDURAL ITEMS**				
5 mins	1.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal
	2.	Declarations of Interest	Information	Mr D Wakefield	Verbal
	3.	Minutes of the Meeting held 8th April 2020	Approval	Mr D Wakefield	Enclosure
5 mins	4.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure
20 mins	5.	Chief Executive's Report – April 2020 • Covid-19	Information	Mrs T Bullock	Enclosure
10:00	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**				
5 mins	6.	Quality Governance Committee Assurance Report (22-04-20)	Assurance	Ms S Belfield	Enclosure
10:05	**ENSURE EFFICIENT USE OF RESOURCES**				
5 mins	7.	Performance & Finance Committee Assurance Report (21-04-20)	Assurance	Mr P Akid	Enclosure
10 mins	8.	Financial Performance Report – Month 12	Assurance	Mr M Oldham	Enclosure
10:20	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**				
5 mins	9.	Transformation and People Committee Assurance Report (23-04-20)	Assurance	Prof G Crowe	Enclosure
10:25	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**				
20 mins	10.	Integrated Performance Report – Month 12	Assurance	Mr P Bytheway Mrs M Rhodes Mrs R Vaughan Mr M Oldham	Enclosure
10:45	**GOVERNANCE**				
5 mins	11.	Audit Committee Assurance Report (30-04-20)	Assurance	Prof G Crowe	Enclosure
10 mins	12.	Raising Concerns Report – Quarter 4	Assurance	Mrs R Vaughan	Enclosure
5 mins	13.	Rules of Procedure	Approval	Miss C Rylands	Enclosure
11:05	**CLOSING MATTERS**				
5 mins	14.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure
5 mins	15.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 4th May 2020 to claire.rylands@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal
11:15	**DATE AND TIME OF NEXT MEETING**				
	16.	**Wednesday 10th June 2020, 9.30 am, via videoconference**			

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Trust Board (Open)

Meeting held on 8th April 2020 at 9.30 am to 11:05 am
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)											
Mr P Akid	PA	Non-Executive Director											
Ms S Belfield	SB	Non-Executive Director											
Mr P Bytheway	PB	Chief Operating Officer											
Mrs T Bullock	TB	Chief Executive											
Prof G Crowe	GC	Non-Executive Director											
Dr L Griffin	LG	Non-Executive Director											
Prof A Hassell	AH	Non-Executive Director											
Mr M Oldham	MO	Chief Financial Officer											
Dr J Oxtoby	JO	Medical Director											
Mrs M Rhodes	MR	Chief Nurse											
Mr I Smith	IS	Non-Executive Director											
Mrs R Vaughan	RV	Director of Human Resources											

Non-Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation											
Mr M Bostock	MB	Director of IM&T											
Mrs J Dickson	JD	Interim Director of Communications											
Miss C Rylands	CR	Associate Director of Corporate Governance											
Mrs F Taylor	FT	NeXT Non-Executive Director											
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI											

In Attendance:

Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
052/2020	Mr Wakefield welcomed members of the Board to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield provided his thanks to staff on behalf of the Board, to all those involved at the present time, in addition to sending his sympathies to those who had become ill and those who had lost their lives, to their friends and families. He stated that the Board meeting was utilising new technology therefore it was unclear at this stage how to make the meeting public, although he was aware that members of the public were keen to continue observing the meeting and he remained keen to facilitate this going forwards and noted that the feasibility and practicality of this was being looked into. He highlighted that the Trust was following the same process as the vast majority of Trust Boards across the Country and noted the papers had been published on the website and the minutes	

	would also published. In addition, members of the public continued to have the opportunity to ask questions in relation to items on the agenda, in the usual way. Mr Wakefield stated that in terms of governance, the agenda had been driven by needing to do things differently, in line with other Trust's in the UK, and was to focus on various important issues although Covid-19 had overtaken things. Mrs Bullock referred to the meeting being the first virtual meeting for the Board, and that the items on the agenda had been included because the papers were ready, she stated that going forwards the agenda may need to be reduced to essential business and issues in relation to Covid. Mr Wakefield recognised that a generous donation had been received from the Coates Foundation and stated that this would be covered later in the meeting.	
2.	**Declarations of Interest**	
053/2020	The standing declarations were noted.	
3.	**Minutes of the Meeting Held 11th March 2020**	
054/2020	The minutes of the meeting held on 11th March 2020 were approved as a true and accurate record.	
4.	**Matters Arising via the Post Meeting Action Log**	
055/2020	PTB/422 – Mr Wakefield stated that the action in relation to reviewing future meetings in light of Covid-19 had taken place and changes had been made. PTB/427 – Mr Wakefield confirmed that Chair's action had been taken regarding the Microsoft Windows 10 Business Case and this had been approved. PTB/426 - Dr Griffin queried the progress made in removing the Section 31 notices and questioned whether the Care Quality Commission (CQC) had clarified the requirements during the Covid-19 pandemic, in terms of whether weekly reports continued to be required. Mrs Rhodes stated that she had spoken to the CQC and it had been agreed to provide updates every two weeks during Covid-19. In addition, Mrs Bullock and Mrs Rhodes had been involved with teleconferences with the CQC. Mrs Rhodes stated that in respect of the Section 31 notices, a letter had been prepared which was due to be issued last week although she was unsure if this had been sent and agreed to confirm. Mrs Rhodes added that a number of her actions had since been completed and agreed to provide an update to Miss Rylands. PTB/403 – Mrs Rhodes stated that she had met with the Trauma ward and a process had been set up for the team to meet with the family and explain what actions were being taken. She stated that a meeting was due to take place to discuss the issues surrounding meals although this had been delayed due to the current situation. She added that the team were pleased to receive the feedback and practice had been changed in trauma and Intensive Care following the story.	 **MR** **MR**

5.	**Chief Executive's Report**	
056/2020	Mrs Bullock highlighted the following: • She welcomed Mrs Dickson to the Board meeting in her capacity as Interim Director of Communications. She explained that Lisa Thompson was expected to join the Trust in the substantive role in July 2020. • In respect of Covid-19, arrangements had been put in place to keep the Non-Executive's updated. This included providing a daily dashboard of metrics, information on the daily executive huddle's and gold meeting, and a weekly virtual meeting between the Non-Executive Directors, herself and Miss Rylands. It was agreed that Miss Rylands acting as a single point of access was working well. Dr Griffin raised a question regarding whether cancer services and surgery was continuing. Ms Ashley stated that the guidance was clear that cancer surgery should continue to operate as much as possible. As such, the Trust had safeguarded some capacity internally in order to treat complex cancer patients and had dedicated 4 theatres for urgent, emergency surgery and cancer surgery to take place. She stated that less complex patients had been moved to the independent sector, including Breast cancer patients and other specialties being moved to The Nuffield and Rowley Hall. The Trust was continuing to maintain oversight of patient waits and two week waits and Mr Bytheway added that the 4 theatres being used were operating 24/7, with the anaesthetists and surgeons working shifts to allow operating 24/7 for both emergency and elective work. Mrs Taylor queried whether chemotherapy and radiotherapy were continuing to take place and Mr Bytheway confirmed that daycase chemotherapy continued to be provided at UHNM in addition to radiotherapy. It was noted that the haematology and oncology ward was moving to the independent sector. • Mrs Bullock noted that in terms of the decisions being made, a log of these was being kept, a summary of which had been provided, although Non-Executive Directors continued to be informed via the channels outlined above. Mr Smith queried how well the Emergency Department was working with Covid-19 and non-Covid-19 patients and Mr Bytheway stated that a pragmatic approach had been taken, in order to split the Department two weeks ago with Personal Protective Equipment (PPE) split between the areas and doors put into the 'red' area to completely isolate single bays. He added that the 'green' area was working with Vocare in order to treat ambulatory patients and minor injuries had been moved to the Haywood and other Minor Injury Units. • Mrs Bullock referred to the summary of key risks, and highlighted the mechanisms in place to identify and respond to risks at a divisional and corporate level. Mr Wakefield queried how staff were bearing up given the current circumstances and queried how the Trust were communicating any changes to services, with members of the public. Mrs Bullock stated that there had been a lot of camaraderie between staff and they were supporting each other, doing things to keep morale up, but there were staff who were anxious and concerned, and they were raising this with their teams	

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which was positive. She stated that the Executive team were going out to ward areas as much as possible to alleviate any concerns from staff.

Mrs Vaughan referred to the actions being taken to address staff wellbeing and referred to the work with system partners to provide support to staff for their physical, emotional and psychological wellbeing. This included a number of tools and advice made being available, in addition to facilities for accommodation. Work continued to be taken with the national team and with local authorities and a helpline had also been put in place for staff to access individually. In addition clinical psychological support was being provided as required, and requirements were continually being reviewed. It was noted that in line with national guidance, the Trust was providing free car parking, and also free snack boxes to support staff in addition to keeping normal lines of communications open, such as the Freedom to Speak Up route.

Mrs Dickson referred to the communications with stakeholders and stated that a dedicated space had been utilised on the website, which outlined the changes made as part of the response to Covid-19 i.e. cancellation of non-urgent appointments and changes to minor injuries. In addition social media was being utilised as well as directly contacting patients and working with colleagues across the system to share communications on all channels. She added that weekly stakeholder updates were being provided to outline any changes, and this was also being sent to local Members of Parliament.

Ms Ashley stated that GP referrals continued to be sent to the Trust, and work was being undertaken with primary care and CCG colleagues to review the routine referrals and forward any urgent referrals to the Trust, this was the same for cancer referrals.

- Mrs Bullock referred to the Nightingale Hospital in Birmingham which the Trust would not be sending patients to unless all local system capacity was full, which she felt was the right decision for the local population. She stated that alternative arrangements were being put in place between the Stoke on Trent and Staffordshire system and the Shropshire system to enable management of the local populations for the duration of the outbreak. Discussions had taken place with Shrewsbury and Telford NHS Trust (SaTH) and colleagues from UHNM had visited SaTH to consider the support required for both organisations. Next steps included getting to a position of establishing the collective capacity available in hospital, out of hospital capacity, modelling and timings of when additional capacity may be required.

Professor Crowe requested assurance that the leadership team was not overstretching itself in supporting SaTH and Mrs Bullock stated that the same level of input would be required if the Trust was working with the Nightingale option. She stated that leadership support was being maintained at the present time, but the team were solely focussing on Covid related issues.

- The Trust was in the process of mobilising out of hospital beds for patients who were Covid positive. The locations for this care would utilise bed capacity at Haywood, Harplands, Bradwell, Cheadle and Leek. A number of these facilities were expected to be ready by the end of the week, although staffing was required for Bradwell, Cheadle and Leek, for which Mrs Vaughan was linking in with Midlands Partnership NHS Foundation Trust (MPFT). It was noted that capacity would only be opened as required and the main piece of work related to identifying what type of patients the facilities would be used for

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	and then determining the appropriate staffing model. Mr Wakefield summarised that he felt the arrangements would stretch the workforce and management capacity and queried whether this could be managed. Mrs Bullock stated that it would be a challenge but the staffing required would not just be that from UHNM but also that of system partners and the volunteers and retired staff returning to support the NHS. Mrs Rhodes described the workforce model put in place and the development of 'team around the patient', given that the Trust was expecting to have more patients and less staff, resulting in the recommended staff ratios being not able to be maintained. She stated that this had been highlighted by Ruth May, Chief Nurse of NHS England, the Nursing and Midwifery Council and the CQC, who have recognised that things would need to be done differently, utilising different staff and had written to staff in this regard. It was noted that the team of staff around each patient would comprise of trained nursing staff, other registered nurses, healthcare support workers and volunteers and this would be the case in both critical care and on the wards. Mrs Rhodes stated that she was pleased to see the camaraderie regarding this and the ways in which staff were working to keep patients and staff as safe as possible. **The Trust Board received and noted the report and approved the following E-REAF:** • **Pharmacy Dispensing Service for Ambulatory Patients - Drug Costs (REAF 3435) – Extension**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
6.	**Quality Governance Committee Assurance Report**	
057/2020	It was noted that papers in relation to the Quality Governance Committee had been circulated to members of the Committee for assurance and information, in the absence of an actual meeting taking place. **The Trust Board received and noted the assurance report.**	
ENSURE EFFICIENT USE OF RESOURCES		
7.	**Performance and Finance Committee Assurance Report**	
058/2020	Mr Akid highlighted the following: • The Trust had reached a strong position for the end of the year • Cost improvements were slightly behind plan • Good progress had been made on the IM&T strategy although it was recognised that there may be some delays due to Covid-19 • Good progress had been made on the PFI contract • The Committee approved two business cases **The Trust Board received and noted the assurance report.**	
8.	**Financial Performance Report – Month 11**	
059/2020	Mr Oldham highlighted the following: • For the month 11 position, good performance had been made for February, with the position being £8.5 m better than planned, and a surplus of £4.9 m	

	year to date. • The run rates for pay and non-pay had continued in line with previous periods and Health Education England had unexpectedly provided £1 m to the Trust, which was related to the tariff for services provided to students on site. • The Trust continued to forecast £5 m surplus at the end of the year and a meeting was due to take place to finalise the year end position • Capital was challenging and slightly behind, but this was to be reviewed and it was anticipated that the Trust would achieve the Capital Resource Limit (CRL) by the end of the year. • In terms of cash, the Trust was in a strong position, with £8 m better than planned. All TSA monies had been received from the Department of Health and CCG in addition to the Financial Recovery Fund (FRF). Mr Wakefield requested an update in terms of the impact on the Trust of the national buy out of loans. Mr Oldham stated that the national guidance had been received and all working capital and temporary loans would be converted to Public Dividend Capital (PDC) by 30th September, the net impact of which was £0.3 m of additional costs which would be covered by adjustments to the reimbursement of Covid-19 costs or the 2020/21 FRF payment, resulting in nil impact on the accounts for 2020/21. It was noted that the dividend rate for PDC was less than that of some of the interest rates on the loans. • Mr Oldham referred to the costs incurred due to Covid-19 and the regular guidance being received. He stated that one submission had been made in relation to £1 m of revenue costs incurred for 2019/20 including elements in relation to more IT equipment being required to facilitate home working and additional PPE, cleaning. He referred to the processes in place to capture and escalate costs and stated that the impact on contract income where activity had been reduced would not be funded centrally as this would be offset by savings in CCG's and therefore for local systems to resolve. Professor Crowe queried whether the year end audit would be delayed and Mr Oldham stated that the auditors were reviewing the scope and the adaptations to be made. He stated people coming in to do stock takes had been stopped and communicated with the auditors and the timetable for the annual accounts had been put back slightly and that audit committee dates had been altered to accommodate. Mr Wakefield summarised that for the period, the Trust finished as it had anticipated, a process was in place to collect and recover Covid-19 costs, and the audit process was in hand. • Mr Oldham referred to the impact on the 2020/21 planning and that up to the end of July the Trust would be provided with a block contract value based on month 9 2019/20, topped up to the actual run rate over winter, in addition to capturing additional Covid-19 costs. The impact of this was that the contract should equal the costs incurred for the first period. It was noted that two payments had been made in April therefore challenges to cash flow were not expected and ongoing discussions and guidance was expected. **The Trust Board received and noted the report.**	
9.	**IM&T Strategy Progress Report**	

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060/2020	The report was taken as read as this had been presented to the Performance and Finance Committee, with questions received and responded to. Mr Wakefield queried how Covid-19 may impact on any projects scheduled for quarter 1. It was noted that the majority of funding in regards to the delivery plan was central funding and discussions were ongoing as to whether this would be extended. It was agreed that any issues as a result of this would be provided to the Performance and Finance Committee. Professor Hassell queried if the progress with the e-prescribing system had been impacted and Mr Bostock stated that as the Trust was following the global digital exemplar, assurance received by NHS England was that the £2 m would not be time limited and the contract with the supplier would not be impacted. Mr Wakefield welcomed the comprehensiveness of the report and the work being undertaken by the IM&T Team. **The Trust Board received and noted the report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
10.	**Transformation and People (TAP) Committee Assurance Report**	
061/2020	Professor Crowe highlighted that in the absence of an actual meeting, key papers were circulated for assurance and comments. He stated that the Committee were assured of the Month 11 position and acknowledged the work undertaken to understand the impact of Covid-19 and what was being put on hold. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
11.	**Integrated Performance Report - Month 11**	
062/2020	<u>Operational Performance</u> Mr Bytheway highlighted the following in relation to urgent care performance: • There had been positive changes between January and February in terms of 4 hour performance and cancer performance, although performance from March had become more challenged due to the impact of taking swabs, restrictions on moving patients etc. While performance continued to be monitored, cancer had become the main area of focus to ensure clinically urgent patients continued to be seen and operated on. • It was highlighted that there had been 30, 12 hour breaches in March which was mainly due to the changes in processing patients and guidance; it was believed these were not ongoing issues. Mr Wakefield queried how the Emergency Department had been impacted by Covid-19 and queried how patients were being kept safe. Mr Bytheway stated that pragmatic action had been taken early on to segregate the Department which ensured the safety of patients. He stated that further changes continued to be made and the ‘red’ areas had been made into cubicles, with doors etc so that patients could be separated. He added that there had been a reduction in attendances to the Department, to approximately 300 attendances a day.	

Mr Wakefield queried the processes in place to continue with elective work and Mr Bytheway stated that waiting lists were being reviewed and routes of escalation were being identified.

Mr Bytheway continued:

- He referred to the critical care capacity which had been enhanced and changes split into 4 phases. It was noted that the Trust was in phase 2, which was the process to increase equipment and PPE/Ventilators, via liaison with the Incident Control Centre (ICC), Regional ICC and National ICC.
- It was noted that critical care capacity was presently in a good position, and critical care capacity and oxygenating care capacity was being modelled twice a week, which was being triangulated with other models in order to establish the anticipated trajectory.
- It was noted that there were presently 8 empty wards across both sites and planning had been undertaken to create more side rooms, with more space being available to move patients through the system.
- In terms of mortuary space, there were over 200 spaces and work was being undertaken with the system to consider additional space if required and all emergency portals had been split into 'red' and 'green' areas.
- The work undertaken by the pathology team in testing swabs on site whereby numbers were increasing week by week, was particularly positive.
- In terms of oxygen supply, a lot of work had been undertaken to deliver a clear line of sight for this, and all Covid beds could provide high flow oxygen in various forms. Mrs Whitehead stated that the Trust had one of the biggest oxygen tanks in the country and no issues had been identified. There had been some national shortages of cylinders but the Trust was not relying upon these, with the plan to provide piped oxygen for wards. She added that telemetry was being read by the hour and levels were being topped to 80%.
- The number of medically fit for discharge (MFFD) patients had been reduced across the organisation; at Royal Stoke there were 34 in hospital and 9 at County Hospital, which had reduced by 100, when compared to the previous month. In addition work was being undertaken to ensure that patients were discharged on the day they had been declared MFFD and this needed to continue once the outbreak had finished.

Mr Smith queried if the Trust was nearing capacity for its mortuary provision and Mrs Rhodes stated that this was not the case and capacity was being managed through the usual processes. She added that there was capability for pop up spaces if required.

Mrs Rhodes referred to care of the dying, and that Covid-19 positive patients for palliative care were being treated as any other patients, although the biggest difference was that nurses and doctors were being the family member as well as the carer which brought its own challenges.

<u>Caring and Safety</u>

Professor Crowe requested clarification of the new c difficile reporting and Mrs Rhodes stated that the Trust was 23 above trajectory for the end of February and by the end of the year she expected the Trust to be above the trajectory. She explained that there had been a change in the definitions earlier in the year to include the numbers of patients who had been discharged and got c difficile in the following 28 days and this was the main contributor.

Mrs Rhodes highlighted that she expected an increase in mixed sex breaches to be reported going forwards; this was due to older couples who were both Covid-

	19 positive, being admitted to hospital at the same time and a decision being made to allow the couples to remain in a bay together rather than separating them. Mrs Bullock stated that nationally it was expected that there would be some breaches due to this. Financial Rating Mr Oldham referred to the £10 m grant received by the Coates Foundation and stated that the donation would be provided to the UHNM Charity; the Foundation had already been given an outline of the things the Trust were considering as appropriate. The Trust was required to issue formal proposals to the Foundation outlining the purpose of the spend, benefits and costs which would be taken to their grants committee. Following this the Trust would receive an acceptance letter outlining some of the conditions and once signed the cash would be released. Mr Oldham stated that it was imperative that the governance was correct in terms of spending the monies and approval was required to be obtained from the Charity Committee before taking proposals to the Foundation. He highlighted that two bids were to be progressed quickly which included a bid for some IT equipment and software and another bid for a Vocera communications system in the Emergency Department and Critical Care, to enable staff to respond more quickly and obtain help where required. Mr Oldham stated that he would share this with Dr Griffin, as Chair of the Charity Committee in anticipation of obtaining Chairs action. The Trust Board agreed with this approach. Mr Oldham explained that discussions were also required as to how the donation would be utilised for strategic projects which was welcomed by the Board. Organisational Health No questions were raised. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
12.	**Review of Meeting Effectiveness / Business Cycle Forward Look**	
063/2020	It was noted that going forwards items on the business cycle may need to be deferred due to the current circumstances and the reasons for this would be noted and tracked on a monthly basis.	
13.	**Questions from the Public**	
064/2020	Mr Syme provided the following questions by email prior to the meeting: UHNM Services Mr Syme queried how UHNM along with the whole care economy ensured that the message that UHNM as an acute unit and a Major Tertiary Hospital, was still open to provide acute services for a whole range of conditions as well as having to deal with the increasing clinical care demands of the very dangerous virulent Covid-19 illness. It was noted that capacity had been safeguarded to continue with urgent, emergency and cancer surgery. This involved utilising the independent sector and	

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operating 4 theatres on a 24/7 basis. It was noted that regular communications were made to stakeholders and on social media in respect of continuing with business as usual, particularly any changes to appointments, the cancellation of non-urgent appointments and changes to minor injuries.

In addition, Mr Syme queried how UHNM was ensuring that it would maintain its standards of quality and safe delivery to the entirety of its patients?

Dr Oxtoby stated that governance mechanisms continued to be in place with regards to quality and safety, which had and been bolstered by additional processes during Covid, including ways in which clinicians could raise any concerns.

Infection Control: Staff and Patient Safety

Mr Syme queried whether UHNM had obtained specified standards PPE in such quantities that all those who have or likely to have contact with Covid-19 have sufficient PPE to help safeguard themselves and inhibit cross infection to others who are not Covid-19 infected? He queried whether PPE had been fully distributed to the above staff and queried if UHNM had the necessary volume/numbers of goggles of specified standards to ensure that employees could 'safely' deliver care to those infected by Covid-19.

Mrs Rhodes stated that the Trust had all the PPE it needed for the time being, although as the number of patients increased, it may become more difficult to ensure stock levels were maintained. She stated that in terms of goggles and face visors, supplies were in place and more had been ordered. In addition UHNM's prosthetics department acted innovatively to produce visors internally via 3D printing.

Mr Syme queried if it was policy to swab test the entirety of UHNM staff and queried what the situation was regarding those employed by Sodexo and others on UHNM sites regarding testing as they do come into contact with patients and staff?

Mrs Bullock stated that it was not appropriate to test all staff but noted that the Trust had sufficient capacity in place to test staff who were either symptomatic or index cases and this included Sodexo staff. Mr Bullock also added that UHNM were able to offer capacity to organisations within the system and potentially to neighbouring Trusts.

Cross Infection

Mr Syme stated that as Covid-19 spreads there would be concentrations of the illness in acute hospital settings. He added that there were numerous instances nationally attested to by senior clinicians of non Covid-19 inpatients acquiring Covid-19 in hospitals and sadly dying. He questioned what extra infection prevention and control strategies and actions UHNM was taking to minimise this and negate the cross infection from Covid-19 patients to both inpatients and other staff at UHNM.

Mrs Bullock stated that additional procedures were in place which followed national guidance for PPE requirements. Mrs Rhodes stated that there were a number of wards where known Covid-19 positive patients were, and extra precautions had been taken by the Trust in following the guidance on PPE. She added that the Trusts position was to assume all patients were Covid-19 positive, therefore ensuring maximum safety precautions and noted the PPE worn by staff reflected that.

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	Mr Wakefield reiterated his thanks to all the staff for their work and dedication at the present time and that the Board was very grateful.	
DATE AND TIME OF NEXT MEETING		
14.	Wednesday 6th May 2020, 9.30 am – 12.30 pm	

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Trust Board (Open)

Post meeting action log as at 29 April 2020

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/382	14/08/2019	Patient Story	To take the revised dementia strategy to the Quality Assurance Committee.	Michelle Rhodes	31/05/2020		Action not yet due.	GA
PTB/403	11/12/2019	Patient Story	To look at the ways in which communication could be improved with critical care patients, in addition to promoting the different meal choices available as well as listening to the family and patient in terms of their wishes and assessment of their capability.	Michelle Rhodes	31/05/2020	31/03/2020	Complete. Update provided at April's Board.	B
PTB/410	11/12/2019	Information Management and Technology Strategy Progress Report	To identify any problem areas with Wi-Fi, before considering what solutions were available.	Mark Bostock Lorraine Whitehead	31/05/2020		Action not yet due. Target date moved due to impact from Covid-19. Wifi Audit completed. Report/summary currently being produced.	GA
PTB/415	08/01/2020	Update on Influenza	To establish a research project into the numbers of staff with flu and whether they received the flu vaccine, linking in with Public Health England.	John Oxtoby	31/05/2020		Delayed due to Covid-19.	GA
PTB/417	05/02/2020	Patient Story	To confirm how the Trust had shared the story with staff in order to learn from the experiences described, and to reinvigorate the 'It's OK to Ask' campaign.	Michelle Rhodes	31/05/2020	29/04/2020	This has been discussed with Sisters, matrons & ACNs. Relaunch will not happen until visiting resumes in some format	B
PTB/418	05/02/2020	Quality Governance Committee Assurance Report	To provide assurance of the processes in place for medics and other professionals, in terms of the management of concerns about individuals practice to the TAP and management of concerns of quality/safety to QGC.	John Oxtoby	31/05/2020	22/04/2020	Complete - taken to Quality Governance Committee.	B
PTB/420	11/03/2020	Patient Story	To share the patient story with the Ward Sisters meeting so that this could be shared further.	Michelle Rhodes	31/05/2020	31/03/2020	This was completed in March 2020	B
PTB/421	11/03/2020	Patient Story	To discuss with SAU, the ways in which staff determine the needs of the patient in terms of assessing whether they shoudl be waiting on a chair or bed.	Michelle Rhodes	31/05/2020	31/03/2020	This was completed in March 2020, all staff reminded to look at appropriate seating for patients. Sister on SAU asked to look at purchasing appropriate seating as required.	B
PTB/423	11/03/2020	Staffing Establishment Reviews	To discuss the issues associated with midwifery staffing and neonatal staffing further at the Quality Governance Committee (QGC).	Michelle Rhodes	30/04/2020	22/04/2020	Paper taken to April QGC.	B
PTB/424	11/03/2020	Staffing Establishment Reviews	To articulate the timeline of the business cases and when they were to be expected to be undertaken and present this to Performance and Finance Committee.	Michelle Rhodes	31/05/2020		Delayed due to Covid-19.	GB
PTB/425	11/03/2020	Staffing Establishment Reviews	To provide an update on the recruitment campaigns and implementation plan to the Transformation and People Committee.	Michelle Rhodes Ro Vaughan	31/05/2020		Delayed due to Covid-19.	GB
PTB/426	11/03/2020	Care Quality Commission Report	To take the letter to the QGC in respect of requesting to remove the Section 31 notices, and keep them appraised of the discussions.	Michelle Rhodes	30/04/2020	29/04/2020	Update provided at April's meeting. This has now been sent to the CCQ, letter and template will be submitted to May QGC.	B
PTB/428	11/03/2020	Transformation and People (TAP) Committee Assurance Report (27-02-20)	To discuss key linkages between the QGC and TAP with Ms Belfield.	Gary Crowe	31/05/2020		Action not yet due.	GB
PTB/429	11/03/2020	Review of Meeting Effectiveness / Business Cycle Forward Look	To review the business cycle for 2020/21 in terms of avoiding duplication.	Claire Rylands	30/04/2020	08/04/2020	Complete. Revised business cycle prepared and provided to April's meeting.	B
PTB/430	11/03/2020	Questions from the Public	To consider the ways the Trust could make it clearer of the routes available to patients when they have a concern or a complaint.	Michelle Rhodes	30/06/2020		This will be relaunched along with Its Ok to ask.	GB
PTB/431	11/03/2020	Questions from the Public	To consider articulating a risk in respect of Covid-19 in addition to articulating any risks arising from the nursing establishment review.	Claire Rylands	30/04/2020	27/04/2020	Covid related risks included within CEO report.	B

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on Wednesday 29th April. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the purpose was to provide an opportunity for:

- The Chief Executive to thank our Divisional Management Team for their work to date and flexibility to do what is required to support our preparations for Covid-19
- Update Divisions on the national position, local position and next steps in relation to Recovery and Restoration
- Divisions to provide updates in terms of their latest position, next steps, staff wellbeing and any concerns / risks

Key points highlighted by the Executive Team were as follows:

- Thanks and appreciation to all staff for what had been achieved during such unprecedented and challenging times and the on-going support available to ensure their wellbeing.
- Four phases of recovery and restoration work which cover 1) effective management of Covid-19 patients, 2) on-going management and phased approach to the reinstatement of 'business as usual' activity, 3) Recovery and Restoration up to March 2021 and 4) the 'new NHS'.
- Arrangements being put into place at a Trust, system and multi-agency level for Restoration and Recovery.
- Planning guidance being worked on at a national level for April next year, which will include the management of backlogs.
- Development of speciality, directorate, divisional and Trust wide plans going forward, which are predicated on keeping patients and staff safe.
- Focus on transformation; ensuring that old practices are not reverted to and that innovation, i.e. digital consultations are a key feature of the 'new NHS'.
- Arrangements in place for testing of both staff and patients, which included more recently the testing of all patients coming in as a 'non-elective' and all patients being discharged into care homes.
- Ensuring that the estate is developed and organised in a way which will meet the needs of our service users going forward, covid-19 and non-covid-19.
- Acknowledgement of the contribution of key corporate services which had enabled organisation wide change, i.e. IT, Human Resources, Communications and Charities and Estates and Facilities.

Key points highlighted by Divisions were in relation to:

- Further thanks and recognition of all staff who had worked so hard, flexibly and professionally.
- The development of divisional plans and key areas of priority, i.e. Cancer Pathways, Urgent Care Improvement Plan, Pharmacy.
- Staff morale, which in the main was very positive despite the challenges being faced each day.
- Ensuring that staff engagement remained a top priority given the positive impact of sustained clinical engagement and leadership.
- The need to capitalise on recruitment opportunities in collaboration with Human Resources.
- An increase being seen within Trauma and emergency operating lists which had led to some strain upon services.
- Recognition of the way in which Divisions had come together and worked collaboratively and the importance of sustaining that.

Any Board member seeking to obtain further information regarding the items considered by the Trust Executive Committee should contact Claire Rylands, AssociateDirector of Corporate Governance.

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. During March, 5 contract awards, which met this criteria were made, as follows:

- **Pharmacy Dispensing Service for Ambulatory Patients - Drug Costs (REAF 3435)** supplied by Lloyds Pharmacy at a total cost of £6,500,000.00 for the period 01/04/19 - 30/09/20, approved on 03/03/2020
- **Energy Management & Procurement Services (REAF 3425)** supplied by BiU at a total cost of £36,000,000.00 for the period 01/04/20 – 31/03/25, approved on 18/02/2020
- **Sakura Fintek Histology Laboratory Automation into Roche MES (REAF 3403)** supplied by Roche at a total cost of £2,409,662.00 for the period 01/04/20 – 31/03/30, providing savings of £40,161.00 and approved on 18/02/2020
- **Microbiology Total Laboratory Automation into Biomerieux MES (REAF 3393)** supplied by Biomerieux at a total cost of £5,978,801.00 for the period 01/04/20 – 31/03/30, providing savings of £99,647.00 and approved on 18/02/2020
- **Roche Pathology Managed Equipment Service contract (REAF 3383)** supplied by Roche at a total cost of £24,000,000.00 for the period 01/04/20 – 31/03/30, providing savings of £252,000.00 and approved on 13/02/2020

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during April 2020:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
None to report			

The following table provides a summary of medical staff who have joined the Trust during April 2020:

Post Title	Reason for advertising	Start Date
Medical Examiner x 2	New	01/04/2020
MOD Consultant in Emergency Medicine	Vacancy	01/04/2020
Consultant Vascular Surgeon	Vacancy	01/04/2020
Consultant Cardiothoracic Anaesthetist	Vacancy	01/04/2020
Clinical Director - Directorate of General Medicine	Vacancy	01/04/2020
Consultant in Acute Medicine	Vacancy	01/04/2020
Locum Consultant Foot and Ankle Surgeon	Vacancy	02/04/2020
Consultant Orthopaedic surgeon pelvis and soft tissue knee	Retire and Return	13/04/2020
Consultant Gynaecological Oncologist	Retire and Return	13/04/2020
Locum Consultant Orthopaedic Surgeon specialising in Fragility Fractures	New	20/04/2020

The following table provides a summary of medical vacancies which closed without applications / candidates during April 2020:

Post Title	Closing Date	Note
Consultant in Acute Medicine	05/04/2020	No Applications
Consultant Clinical Oncologist with specialist interest in Breast and Skin malignancy	08/04/2020	No Applications

3. Covid-19

Arrangements are in place to provide Non-Executive members of the Board with regular updates on Covid-19. This includes:

- Daily update via email covering numbers of cases, staff sickness levels, new guidance and key issues being managed by the Executive Team
- Weekly Microsoft Teams meeting with Chief Executive and Associate Director of Corporate Governance

Given the arrangements outlined above and the pace at which matters are developing with regard to Covid-19, a verbal update will be provided to the Board in order to ensure the most up to date information is being shared.

4. Governance

In addition to the informal arrangements outlined above to maintain communication with Non-Executive members of the Board during Covid-19, Committees of the Board have continued to take place virtually, in line with the Interim Terms of Reference previously agreed. Highlight reports from those Committees are included within the papers as usual.

In addition to the existing Business Cycles, time will be allocated at the beginning of each Committee to provide opportunity for Executive Directors to provide more 'real time' updates on any matters which require timely escalation.

Governance arrangements will remain under review and a Board Seminar has been scheduled for Thursday 7th May to provide opportunity for the Board to reflect upon the interim arrangements and to agree the next steps as we move into the Recovery and Restoration phase.

5. Summary of Key Decisions Made

As Chief Executive, during this national Level 4 Major Incident I have exercised my authority to make a number of decisions which have been necessary to assist with our management and response to the Covid-19 Pandemic. Since my last Chief Executive briefing to Board, the following key decisions have been made as summarised below:

- Transfer of cancer services to the Independent Sector on an interim basis
- Suspension of the Divisional Performance Management Review process

In addition, the following decisions have also been made:

- Approval of bids submitted for utilisation of monies donated by the Denise Coates Foundation
- Approval via Chairs action for funding by the Charity for the television system, Hospedia, at the County Hospital

6. Board Assurance Framework

As outlined within my previous report, it has been necessary to take a more dynamic approach to risk management to that set out within our Risk Management Policy. However, there are a number of key strategic risks associated with Covid-19 which have been identified and are being managed through the Executive Team. These were summarised in my previous report, however, further work has been undertaken to outline the Board Assurance Framework associated with these risks and can be found at appendix 1 and will continue to be reviewed and updated. This will be further considered by Committees of the Board in May.

7. Remembrance Service

On Tuesday 28th April we joined the rest of the NHS in remembering staff and colleagues who have died in service as a result of Covid-19, with a minutes silence.

Whilst numbers were limited to ensure social distancing rules were adhered to, prayers were led by our Chaplaincy Team and a round of applause was given.

In addition, we have made the decision to include a rainbow, a poignant feature throughout Covid-19, in the designs for our Contemplation Gardens, which are now well underway.

8. Gifts and Appreciation

The support and appreciation shown for the NHS during this pandemic has been a real boost for us all. We are particularly grateful at UHNM for the many donations received via our Charity, to all of our staff during these difficult times.

Whilst the majority of donations have been provided via the Charity, we do have policies and procedures in place for the receipt of Gifts and Hospitality. Our staff have been reminded of these policies and procedures, and we have maintained our arrangements for reporting gifts to the Audit Committee (including specific reporting on gifts received directly to departments and not via the Charity).

9. Letter from the Stoke-on-Trent Coroner / Clap for Carers

It was a pleasure to receive a thank you letter from the Stoke-on-Trent coroner who has praised staff for being 'unfailingly calm, professional and helpful' which is reflective of the public opinion witnessed each Thursday during the Clap for Carers. It is humbling that so many people want to step out of their homes and give applause to say thank you and it has been very moving to see the supportive attendance of our partners from the fire and police services.

10. Student Nurses

Michelle Rhodes and I took time to welcome a team of student nurses from Staffordshire University who have chosen to come and work for UHMM. We personally thanked them for putting themselves forward to start early and work at such a time.

A further team, this time from Keele University, will start this week and we are grateful for their passion and commitment to help our patients.

11. Zero Tolerance to Abuse of Staff

The safety of our staff is paramount and as a Trust we will not tolerate the abuse of our staff. I was recently informed of two convictions of members of the public who had abused staff on our Royal Stoke Site. Working with our police colleagues we will continue to pursue zero tolerance of bad behaviour or abuse towards our staff and these convictions clearly demonstrate that we will take necessary and appropriate action when require to do so.

Appendix 1 – Summary Board Assurance Framework (BAF)

Risk Theme	Key Controls	Key Assurances	Executive Lead	Committee Governance	Risk Level
Workforce – Inability to ensure Safe Staffing Levels	• Workforce Bureau in place 7 days a week • Nursing Bureau in place • TRAC system for recruitment • Processes for on-boarding and deploying staff, ensuring ward based training for non-clinical staff • Rota and Bank Management Systems ensuring the deployment of staff as needed • Empactis System enabling live reporting of sickness absence • System wide redeployment processes in place • National Webinars • Workforce modelling • Daily Exec Huddle and tactical group for concerns / risks to be raised • Staff testing • Site meetings continue to get real time staffing information and escalation as required • Night Staffing Plan in place • Weekend planning in place which covers staffing • Twice daily divisional meetings with escalation to Workforce Bureau if necessary	• Covid-19 Dashboard • Twice Daily Absence SitReps • Loggist Record – Workforce Group • Escalations to Gold Command • Workforce Mobilisation (Demand and Supply requests) are monitored • Recruitment activity reports • Turnover and stability rates are reported on • Twice daily tactical meetings chaired by the Chief Operating Officer with appropriate escalation to Gold if risk identified that cannot be mitigated • Freedom to Speak Up Guardian oversight	Director of Human Resources	Transformation and People Committee	Likelihood (3) x Impact (4) = **High 12**
Inability to Ensure Staff Wellbeing and Welfare	• Wellbeing Toolkit including counselling / psychological support • Empactis System enabling live reporting of Sickness Absence • Occupational Health – with processes for Staff Testing in place including text notification to speed up results process for staff • Staff Risk Assessment tools including support for BAME groups • Staff Testing • Risk Assessment tools	• Twice daily staff testing lists sent to Occupational Health • OH reports on testing results • Sickness absence rates and reasons are reported on • Reports on usage of staff counselling service; feedback on staff issues from Exec visits; Freedom to Speak up Guardian reports.	Director of Human Resources	Transformation and People Committee	Likelihood (4) x Impact (4) = **Extreme 16**

	• Home Working • Return to work processes • Workforce Group • National Webinars • Friday Face Book Live • Revised Risk Assessment for BAME & support letter • System wide therapies and psychological support • Regular Executive Walkabouts and feedback				
Inability to Maintain Quality and Patient Safety	• Incident Reporting process • Clinical Group • Infection Prevention Group • Mortality Review process • QIA process • Twice daily tactical meeting • ICC infrastructure • Clinical forum hosted by the Medical Director • Weekly senior nurse meetings hosted by the Chief Nurse	• Weekly Incident Report to Chief Nurse • Emergency Department / Ward Safety Assurance Visits • Virtual RCA Panels for Falls and Pressure Ulcers • Section 31 Weekly Update Reports • Quarterly Infection Prevention Reports • IPC policy on the intranet – IP01a and IP01b • Planned Care Cell tracking long waits and oversight for clinicians to escalate	Chief Nurse / Medical Director	Quality Governance Committee	Likelihood (2) x Impact (3) = **Moderate 6**
Inability to Provide Capacity and Equipment	• Pandemic / Continuity Plans • Incident Control Centre (ICC) • Tactical Group • Central Supplies and Procurement Team • Use of Independent Sector • Community Hospitals Plan • Recovery and Restoration Programme	• Daily overview of PPE through tactical group • Twice daily overview of bed position and available Covid and Non-Covid beds • Mitigation and management through Tactical Group • Incident structure in place reviewing all parts or Trust delivery, i.e. Pharmacy, Procurement • Clearly developed plans with appropriate trigger points, i.e. critical care plan for equipment	Chief Operating Officer / Chief Nurse / Medical Director	Performance and Finance Committee	Likelihood (3) x Impact (4) = **High 12**

Inability to Deliver High Risk Service Plans and Pathways	• Planned Care Group • QIA process • Use of Independent Sector • Recovery and Restoration Programme	• Specific delivery plans for high risk patients monitored through Tactical Group • Assurance sought in relation to specific Covid plans from Divisions • Where changes in pathways are needed, then a Quality Impact Assessment is considered by the Tactical Group	Chief Operating Officer / Chief Nurse / Medical Director	Performance and Finance Committee	Likelihood (3) x Impact (4) = **High 12**
Inability to Maintain Patient Flow	• Pandemic Plan • Incident Control Centre (ICC) • Tactical Group • IPC process • Patient Testing • Red / Green areas • Recovery and Restoration Programme	• All beds have been designated Covid or non-Covid with oversight of flow for all Covid through the Medical Division • Modelling in place twice weekly to ensure that we are tracking demand and availability in real time and at least one week in advance • Enhanced site meetings to ensure availability of side rooms to support timely movement from ED • On site testing of Covid to provide a more timely response for allocation of beds	Chief Operating Officer	Performance and Finance Committee	Likelihood (2) x Impact (3) = **Moderate 6**
Inability to Maintain Planned / Cancer Care	• Planned Care Group • Use of Independent Sector • Clinical prioritisation of cases • Recovery and Restoration Programme	• Planned Care Group reports into Tactical group for decisions • Cancer Hub now established with weekly sitreps (accountable to WMCA) • Daily SitReps completed for use of Independent Sector	Director of Strategy and Transformation	Performance and Finance Committee	Likelihood (2) x Impact (4) = **High 8**
Inability to Ensure Effective Communications	• Daily staff briefings • National Webinars • Face Book Live • Monday Messages • Key messages to MPs • Regular updates to local media • OSC updates	• Staff feedback to the Executive Team • Feedback via Trust Executive Committee from Divisions	Acting Director of Communications	Transformation and People Committee	Likelihood (2) x Impact (3) = **Moderate 6**
Inability to Maintain Financial Governance	• SFI's and system of internal control remain in place • Collection and reimbursement processes for additional COVID costs established • Notional budget in place • Cash flow monitoring	• Finance Report • SFI breaches report to Audit Committee • COVID reimbursement returns	Chief Finance Officer	Performance and Finance	Likelihood (3) x Impact (3) = **High 9**

Quality and Governance Committee Chair's Highlight Report to Board

April 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Review of Clinical Incidents in the Neonatal Unit • Review of Covid-19 related matters requested, including Personal Protective Equipment, Mortality / End of Life Care	• Mortality review associated with Covid underway; briefing paper circulated • Implementation of the MHRA action plan remains underway with just two areas relating to development of procedures which are to be completed although these are not relevant to the studies currently underway • Initial review of Covid-19 related mortality has demonstrated that that figures are demonstrating broadly similar outcomes when compared with peers; however further analysis of this data will be undertaken and reported back to the Committee
Positive Assurances to Provide	**Decisions Made**
• Covid-19 research related studies have been prioritised • 91% compliance achieved with training for Data Security and Protection although noted that statutory and mandatory training would be a challenge going forward given the national pause as a result of Covid-19 (deferral of around 3 months at present) • Clinical Ethics Committee has had a series of ad hoc meetings in response -to the Covid-19 situation. It has developed decision-making frameworks on triage for ITU admission and management, communication with families and other aspects of decision-making around COV ID. Fortunately the levels of demand for beds and critical care have been manageable without necessitating instigating the above decision-making framework.	• Approval of Terms of Reference and Membership of the Committee • Approval of Annual Report of the Committee 2019/20

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Infection Prevention Quarterly HAI Report (Q4)	Assurance	6.	Data Security and Protection Training Update	Assurance
2.	Mortality Report	Assurance	7.	Clinical Ethics Forum Highlight Report	Assurance
3.	Trust Processes for Identifying and Managing Concerns about the Performance of Medical Staff	Assurance	8.	Executive Health & Safety Group Highlight Report	Assurance
4.	Review of Clinical Incidents in the Neonatal Unit	Assurance	9.	Quality & Safety Oversight Group Highlight Report	Assurance
5.	Research and Innovation Quality Update	Assurance	10.	Committee Effectiveness 2019/20 including Terms of Reference	Assurance

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Ms S Belfield	SB	Non-Executive Director (Chair)												
Mr P Bytheway	PB	Chief Operating Officer												
Professor A Hassell	AH	Non-Executive Director												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Dr J Oxtoby	JO	Medical Director												
Mrs M Rhodes	MR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mr I Smith	IS	Non-Executive Director												
Mrs F Taylor	FT	Associate Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources												

Performance and Finance Committee Chair's Highlight Report to Board

April 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• A&E performance has dropped to 77%, in the main related to the changes within the department which occurred during March • 34 12 hour breaches in March • Some challenges with RTT waiting list, performance has dropped from 81% to 76% • 7 52 week breaches were reported although they were Covid related • £1m expenditure relating to Covid-19 was reported in Month 12, which is being recovered as part of the national arrangements	• 'Recovery and Restoration' plans now development, including a trajectory as to what RTT will look like over the coming months; Tracy Bullock to lead the system wide Group with Paul Bytheway leading the acute recovery plans • Completion of the Annual Report and Accounts and associated year end audit • Due diligence exercise undertaken associated with the PFI Network and Communications Service and a network refresh is arranged for 2020
Positive Assurances to Provide	**Decisions Made**
• Message being communicated to the public that we are 'open for business' in order to encourage attendance where needed; ED has not seen the level of pressure that we had envisaged • There have been no cancelled clinically urgent or cancer procedures during the Covid-19 period and we are seeing the same numbers • The number of 2 week wait referrals have reduced although the recovery plans need to take account of these increasing; Surgeons have reported that the referrals they are seeing are all appropriate • As part of the Planned Care Covid-19 response, the CCG has set up a Referral Assessment Service (RAS) where GP's triage on a daily basis with urgent referrals identified against 'essential criteria' • Independent Sector capacity is being used for some aspects of Cancer work • Year to date end of year performance was £5.2m surplus although this was a draft position subject to completion of the year end process • A procurement target of £3m had been set for 2020/21 with £2.2m of that achieved to date	• Approval of Annual Report and Revised Terms of Reference and Membership • Approval of contract for Windows 10 Replacement • Approval of contract for Maintenance for Flexible Endoscopes

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1	Month 12 Operational Performance	Assurance	4.	Authorisation of New Contract Awards and Contract Extensions	Approval
2.	Planned Care Covid-19 Response	Assurance	5.	PFI Network and Communication Services Refresh 2020	Information
3.	Month 12 Finance Report / Covid-19 Spend	Assurance	6.	Committee Effectiveness 2019 / 20 including Revised Committee Governance Pack	Approval

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Mr P Akid (Chair)	**PA**	Non-Executive Director												
Ms H Ashley	**HA**	Director of Strategy & Performance												
Mrs T Bullock	**TB**	Chief Executive												
Mr P Bytheway	**PB**	Chief Operating Officer												
Dr L Griffin	**LG**	Non-Executive Director												
Mr M Oldham	**MO**	Chief Finance Officer												
Mrs S Preston	**SP**	Strategic Director of Finance												
Mrs M Ridout	**MR**	Director of PMO												
Miss C Rylands	**CR**	Associate Director of Corporate Governance												
Mr J Tringham	**JT**	Director of Operational Finance												

Executive Summary

Meeting:	Trust Board (Open)	Date:	6 May 2020
Report Title:	Month 12 Finance Report – 2019/20	Agenda Item:	8.
Author:	Author: Jonathan Tringham, Director of Operational Finance Sarah Preston, Strategic Director of Finance		
Executive Lead:	Mark Oldham, Chief Finance Officer		

Purpose of Report:

Assurance	✓	Approval		Information	

Impact on Strategic Objectives (positive or negative):

	Objective	Positive	Negative
SO1	Provide safe, effective, caring and responsive services		
SO2	Achieve NHS constitutional patient access standards		
SO3	Achieve excellence in employment, education, development and research		
SO4	Lead strategic change within Staffordshire and beyond		
SO5	Ensure efficient use of resources	✓	

Executive Summary:

This report presents the financial performance of the Trust for March (Month 12); key elements of the financial performance for the year to date are:

- The actual year to date performance of a £5.2m surplus is £5.2m better than the Trust's to breakeven for the year and £0.2m better than its forecast at Month 6 for a surplus of £5.0m. This position is draft and may change as a result of the yearend process; the reported surplus is not expected to change significantly as a result of this process.
- The position in March includes Provisions for the impact of the East of England Ambulance Service Court of Appeal case and the Trust's exposure under the STP Mental Health risk share; these have contributed to an actual surplus in Month 12 of £0.3m against a planned surplus of £3.6m
- Total Commissioning income is £5.4m ahead of plan for the year to date; within this Electives and Critical Care are under recovered by £2.5m and £2.0m respectively offset by Tariff excluded Drugs income which is £7.3m above plan for the year to date.
- The Trust incurred £1.0m of expenditure relating to Coronavirus in Month 12; as part of a National process the Trust has submitted a claim for funding to fully cover these costs. We will receive confirmation on 14 April of the amount of funding to be received and an adjustment will be made if this is not 100% (we are not expecting to receive less than 100%)
- The Trust has delivered £36.0m CIP for the year which is £4.0m behind plan; in month the Trust has delivered £5.4m CIP which is £0.3m behind the profile of the final plan submitted to NHSI in April.
- Capital expenditure for the year to date stands at £22.0m and is in line with the plan for the year.
- The month end cash balance is £26.5m which is £19.0m higher than plan.
- The Trust has met the requirements to receive FRF and PSF with a total of £27.8m assumed for the year.

Key Recommendations:

The Board is asked to consider and review this report.

Month 12 Finance Report 2019/20

1. Introduction

The Trust achieved a surplus of £0.3m in Month 12 against a planned surplus of £3.6m.

The table below provides a summary Income and Expenditure position for Month 12 and for the year ended 31 March 2020

I&E Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	637.1	55.3	60.1	4.9	637.1	635.3	(1.8)
Tariff Excluded Drugs Income	53.6	4.6	5.7	1.1	53.6	60.8	7.3
Total Commissioning Income	690.7	59.9	65.8	5.9	690.7	696.1	5.4
Private Patients / ICR	4.1	0.3	0.4	0.0	4.1	4.9	0.8
Other Non Clinical Income	81.6	6.4	7.7	1.3	81.6	86.9	5.3
Total Income	776.4	66.6	73.9	7.3	776.4	787.9	11.5
Medical	(145.8)	(12.3)	(12.7)	(0.5)	(145.8)	(148.4)	(2.6)
Registered Nursing	(148.3)	(12.7)	(13.4)	(0.7)	(148.3)	(144.8)	3.5
Scientific Therapeutic & Technical	(54.9)	(4.7)	(5.0)	(0.4)	(54.9)	(54.8)	0.0
Support to Clinical	(63.7)	(5.5)	(5.7)	(0.2)	(63.7)	(63.2)	0.5
Nhs Infrastructure Support	(75.0)	(5.9)	(7.1)	(1.3)	(75.0)	(73.1)	1.9
Total Pay	(487.6)	(41.0)	(44.0)	(3.0)	(487.6)	(484.3)	3.3
Tariff Excluded Drugs Expenditure	(53.0)	(4.6)	(5.5)	(1.0)	(53.0)	(61.2)	(8.2)
Other Drugs	(21.8)	(1.8)	(2.3)	(0.5)	(21.8)	(21.8)	(0.0)
Supplies & Services - Clinical	(69.9)	(5.8)	(7.8)	(2.0)	(69.9)	(72.3)	(2.3)
Supplies & Services - General	(8.0)	(1.1)	(1.2)	(0.1)	(8.0)	(8.0)	0.0
Purchase of Healthcare from other Bodies	(12.0)	(1.0)	(1.2)	(0.2)	(12.0)	(13.0)	(1.0)
Consultancy Costs	(3.5)	(0.3)	(0.2)	0.1	(3.5)	(3.4)	0.2
Clinical Negligence	(20.6)	(1.2)	(1.1)	0.0	(20.6)	(20.6)	0.0
Premises	(29.9)	(3.9)	(5.8)	(2.0)	(29.9)	(31.7)	(1.8)
Depreciation	(27.8)	(2.5)	(2.7)	(0.2)	(27.8)	(27.6)	0.2
Other	(49.4)	(1.5)	(3.3)	(1.7)	(49.4)	(47.2)	2.3
Total Non Pay	(296.0)	(23.6)	(31.2)	(7.6)	(296.0)	(306.7)	(10.7)
Total Operating Costs	(783.6)	(64.6)	(75.2)	(10.6)	(783.6)	(791.0)	(7.4)
Surplus / Deficit from Operations	(7.2)	2.1	(1.2)	(3.3)	(7.2)	(3.1)	4.1
Finance Costs, Interest, PDC, etc.	(25.5)	(2.1)	(2.0)	0.1	(25.5)	(23.8)	1.7
Total Non Operating Costs	(25.5)	(2.1)	(2.0)	0.1	(25.5)	(23.8)	1.7
Total Costs	(809.1)	(66.7)	(77.2)	(10.5)	(809.1)	(814.8)	(5.7)
Net Surplus / Deficit	(32.8)	(0.1)	(3.2)	(3.2)	(32.8)	(26.9)	5.8
Donated Asset / Impairment Adjustment	(0.8)	(0.1)	0.0	0.1	(0.8)	(0.2)	0.6
Operational Net Surplus / Deficit	(32.0)	(0.0)	(3.2)	(3.2)	(32.0)	(26.8)	5.2
Mariginal Rate Emergency Tariff	4.2	0.4	0.4	0.0	4.2	4.2	0.0
Provider Sustainability fund	15.9	1.8	1.8	0.0	15.9	15.9	0.0
Financial recovery fund	11.9	1.4	1.4	0.0	11.9	11.9	0.0
	0.0	3.6	0.3	(3.2)	0.0	5.2	5.2

2. Income

Total Commissioning income was over recovered by £5.9m in Month 12 against a plan of £59.9m and stands at £696.1m for the year which is £5.4m better than plan.

The table below shows the Trust's Commissioning Income and activity position by point of delivery (POD)

Income from patient Activity to Month 12 2019/20	Annual Plan		Income In Month			Activity Year to date			Income Year to date		
	Activity	£m	Budget £m	Actual £m	Variance £m	Budget	Actual	Variance	Budget £m	Actual £m	Variance £m
Elective Inpatient Spells	15,409	65.7	5.7	5.3	(0.4)	15,409	13,762	(1,647)	65.7	63.2	(2.5)
Day case Spells	83,696	58.4	5.1	4.6	(0.5)	83,696	78,895	(4,801)	58.4	57.3	(1.1)
Non Elective Emergency Inpatient Spells	85,671	186.9	15.8	15.9	0.1	85,671	83,263	(2,408)	186.9	185.8	(1.1)
Non Elective Non Emergency Inpatient Spells	23,572	30.1	2.5	2.5	(0.0)	23,572	24,150	578	30.1	29.9	(0.2)
Outpatient Attendances & Procedures	719,001	88.1	7.7	7.3	(0.4)	719,001	695,828	(23,173)	88.1	88.2	0.2
Accident & Emergency Attendances	181,191	26.1	2.2	2.2	(0.0)	181,191	173,091	(8,100)	26.1	26.1	0.0
Critical care	31,796	39.2	3.3	2.8	(0.5)	31,796	30,883	(913)	39.2	37.2	(2.0)
Direct Access		13.2	1.1	1.1	(0.0)				13.2	13.2	(0.0)
Other		123.6	11.3	18.0	6.7				123.6	129.4	5.9
PBR Excluded & Chemotherapy Drugs (Pass through)		53.6	4.6	5.7	1.0				53.6	60.8	7.3
Pass through devices		10.1	0.8	0.7	(0.0)				10.1	9.4	(0.6)
Fines & Penalties		-	-	(0.0)	(0.0)				-	(0.3)	(0.3)
Emergency Threshold		(4.2)	(0.4)	(0.4)	(0.0)				(4.2)	(4.2)	0.0
Total		690.7	59.9	65.8	5.9				690.7	696.1	5.4

The year to date position is heavily influenced by an over recovery against plan of £7.3m for PbR excluded drugs and Chemotherapy Drugs (Pass through)

Other income from patient activity over recovered by £6.7m in month. Month 12 is often a strange month with the impact of a slightly different process to normal and organisations finalising income streams for the financial year. There were three significant transactions that fell into this category relating to funding for Coronavirus related costs, additional non recurrent Education & Training monies and the impact of agreeing a yearend settlement with Specialised Commissioners which contributed towards the over recovery.

Income from Electives and Daycases was £0.4m and £0.5m respectively behind plan in month which was as expected with reductions in planned care activity due to Coronavirus. Emergency activity was very low in March with total spells averaging 239 per calendar day with the average for the year being 293.

The Trust was protected from any significant patient care income losses during the month as it has a fixed payment under the IFPM and agreed a yearend settlement with Specialised Commissioners that secured M8 forecast levels of income for the year (i.e. before the impact of Coronavirus)

The following table provides a draft summary of Total Commissioning Income by Commissioner; further detail is included in Appendix 1 and 2.

Patient Income Position at Month 12 19/20	External Plan / Contract	Income (£m)				
		Finance (£m)	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS	416.8	416.6	416.6	416.9	0.3	0%
NHS ENGLAND	223.2	218.4	218.4	218.7	0.4	0%
OTHER CCG ASSOCIATES	29.1	30.8	30.8	32.7	2.0	6%
OTHER NON NHS CONTRACTS	6.5	7.5	7.5	8.4	0.9	12%
NON CONTRACT ACTIVITY	4.2	4.2	4.2	3.9	(0.3)	-8%
OTHER	14.8	14.8	14.8	17.0	2.2	15%
	694.7	692.2	692.2	697.6	5.4	1%
Less Other Non Patient Income	(1.5)	(1.5)	(1.5)	(1.5)	-	0%
	693.2	690.7	690.7	696.1	5.4	1%

Income from Staffordshire CCGs is based on the Intelligent Fixed Payment Mechanism (IFPM) and is fixed for the year. Several additional contracts have been negotiated with the commissioners, repatriating activity previously carried out by GPs or independent providers, to UHNM. These additional contracts relate to Diagnostics in the form of plain film x-rays and non obstetric ultrasound and phlebotomy services at Leek. In addition the VirginCare Contract has now returned to East Staffs CCG responsibility and has been varied into the IFPM.

The income plan for NHS England is £4.8m lower than the contract value; this relates to Specialised Services. This is as a result of differing growth assumptions and pass though devices that have moved to a zero cost model during the year as opposed to pass through cost for which we have requested a contact variation.

Associate CCGs – the total income plan for these CCGs is £30.8m with the over recovery at Month 12 being £2.0m (6%). The most significant variance is against Shropshire CCG which is showing an over recovery of £0.8m (17% higher than plan for the year to date). The internal income plan is higher than the contract reflecting the increase in activity seen during the year which was transacted as part of the budget reset at Quarter 1.

Within the reported position for Total Commissioning income the Trust has made provision for £0.3m of fines; these relate to contracts with Associate CCGs and NHSE as under the IFPM fines are automatically reinvested. The table below provides details of the contractual fines for 2019/20.

Contractual Fines 2019/20	Operational Standards	Consequence of breach	Staffordshire		Other		Total	
			Total	Value £000	Total	Value £000	Total	Value £000
52 Week waits	Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	0	0.0	0	0.0	0	0.0
C Difficile incidences	Minimise rates of Clostridium difficile	£10,000 for each breach above target	11	110.0	1	10.0	12	120.0
Cancelled Ops	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	132	247.9	90	246.4	222	494.3
MRSA Incidences	Zero tolerance methicillin-resistant Staphylococcus aureus	£10,000 in respect of each incidence in the relevant month	0	0.0	0	0.0	0	0.0
MSA Breaches	Zero tolerance against Mixed Sex Accomodation	£250 per day per patient	0	0.0	0	0.0	0	0.0
Urgent Ops	No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	0	0.0	6	30.0	6	30.0
Total			143	357.9	97	286.4	240	644.3

As part of a National process to understand the full financial impact of Coronavirus the Trust has submitted a return quantifying the loss of non-patient income. The total loss reported by the Trust is £160,751 with the 2 main items being car parking income and R&D income. At this stage no commitment has been made to recompense Trust for these losses and no funding has been assumed by the Trust.

3. Expenditure

The position in Month 12 was influenced by the following transactions:

1. Provision for the impact of the East of England Ambulance Service Court of Appeal case; this impacts all expenditure lines with the exception of Medical.
2. Coronavirus related costs totalling £0.955m were incurred in March with funding to cover all of these costs being claimed as part of a National process. Following validation the Trust will be notified on 16 April how much funding it is to include in its yearend accounts for 2019/20; the Trust is assuming that it will receive the full £0.955m.

   The £0.955m is for Pay and Non pay expenditure; the following table summarises the costs incurred:

Type of Expenditure	£
Decontamination	59,327
PPE	97,901
Sickness/isloation cover	161,304
Diagnostic Sampling	105,085
Laptops to enable homeworking	311,753
Assisted respiratory support capacity	190,830
Other	29,056
Total	**955,256**

3. A review of the Trust's provisions with the two most significant transactions being
   - Update of the redundancy provision including the potential impact of the Pathology reconfiguration.
   - Update of the provision for dilapidations to reflect latest advice from the Estates & Facilities department.
4. A review of the provision made for prior year's good's received notes (GRNs). Where the Trust has a GRN that has not been matched to an invoice it has included a charge in its accounts; the Trust reviews this provision on a monthly basis to ensure that it is appropriate.

Pay expenditure was £44.0m in Month 12 generating an overspend of £3.0m with year to date pay expenditure now standing at £484.3m resulting in an underspend of £3.3m.

Additional costs planned for winter were £4.1m for the year with the actual costs being £3.2m; this underspend was mainly as a result of additional capacity within Critical Care and SAU not being needed and fewer escalation beds being open than planned.

Registered nursing costs overspent by £0.7m in March although after taking into account the impact of the 4 transactions above it broke even for the month.

Medical pay overspent by £0.5m in March with the year to date overspend now standing at £2.6m. As in previous months this is predominantly within Emergency Medicine which is £0.2m overspent for the month and now stands at £2.7m overspent for the year to date. This is mainly driven by high levels of consultant vacancies across the ED and AMU as well as gaps in junior doctor rotas.

For the financial year the Trust's expenditure on agency staff is £0.4m higher than the ceiling set by NHSI of £18.0m. This is mainly as a result of Medical agency costs being £0.1m higher per month on average than for 2018/19.

Non-pay expenditure is overspent by £7.6m in February and now stands at £10.7m overspent for the year within this pass through drugs are £8.2m overspend. A lot of the 4 transactions described above impact on non-pay lines in the account generating significant variances. If these items are adjusted for there the only significant variance relates to Premises costs where final energy bills for the year have been lower than expected.

The expenditure figures do not include the £17.1m impairment adjustment referred to in Section 7. A final adjustment will be made to expenditure to reflect this; this charge is reversed out when reporting the Trust's financial performance for the year

4. CIP

The total original CIP plan for the year is £40.0m.

The table below summarises the performance against the CIP for the year; this performance is built into the Trust's position for the year. The planned performance is as per the final plan submitted to NHSI in April.

CIP 2019/20	Annual	In month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m
Income	6.9	0.7	3.8	3.1	6.9	23.6	16.7
Pay	17.5	2.1	0.7	(1.4)	17.5	7.3	(10.2)
Non Pay	15.6	2.9	0.9	(2.0)	15.6	5.1	(10.5)
Total	40.0	5.7	5.4	(0.3)	40.0	36.0	(4.0)

The CIP delivery in Month 12 is £0.3m behind plan and £4.0m behind plan for the year to date. The CIP report contains further detail including a forecast for the year.

5. Capital

The Trust capital expenditure plan for 2019/20 is £26.1m and includes the changes reported to Performance and Finance Committee along with additional capital funding confirmed by NHSE/I. The Trust has spent £7.1m in Month 12 and £22.0m year to date against a planned spend of £22.0m which is in line with plan; details of the significant items are included below.

Capital Expenditure as at Month 12 2019/20 £m	Revised	In Month			Year to Date		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
ICT Infrastructure	(4.9)	(0.3)	(0.7)	(0.4)	(4.9)	(4.9)	0.0
Estates Infrastructure	(4.2)	(1.9)	(1.8)	0.2	(4.2)	(4.4)	(0.2)
Medical Equipment	(3.6)	(1.7)	(1.2)	0.5	(3.6)	(3.5)	0.1
PFI lifecycle & equipment	(3.2)	(0.7)	(1.0)	(0.3)	(3.2)	(3.2)	0.0
PFI enabling	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.1)	-
Pathology tracker - Finance Lease	(0.5)	-	(0.4)	(0.4)	(0.5)	(0.5)	(0.0)
Health & Safety Compliance	(0.2)	-	(0.0)	(0.0)	(0.2)	(0.2)	0.0
Other Central schemes	(0.7)	-	(0.3)	(0.3)	(0.7)	(0.6)	0.1
LIMS	(1.5)	-	(0.3)	(0.3)	(1.5)	(1.8)	(0.3)
PDC award for HSLI	(1.3)	(0.2)	(0.1)	0.1	(1.3)	(1.3)	(0.0)
Project STAR	(0.5)	(0.5)	-	0.5	(0.5)	(0.2)	0.2
NHSI imaging funding	(1.2)	(1.2)	(1.2)	0.0	(1.2)	(1.2)	0.0
PDC for COVID19	(0.1)	(0.1)	(0.1)	-	(0.1)	(0.1)	-
Total capital expenditure	(22.0)	(6.6)	(7.1)	(0.5)	(22.0)	(22.0)	0.0
PFI equipment pre-payment	(4.1)	-	-	-	(4.1)	(4.1)	-
Total CDEL	(26.1)	(6.6)	(7.1)	(0.5)	(26.1)	(26.1)	0.0

ICT Infrastructure
Expenditure has been achieved in line with plan.

Estates Infrastructure (and other Central Estates schemes)
Due to the COVID19 outbreak there have been significant challenges in completing works due to contractors not being able to come to site. These variances have been managed across schemes in order to meet the overall capital plan wherever possible.

Medical Equipment
Expenditure is in line with forecast and the fast track bid requirements identified towards the end of the year have been achieved.

LIMS
The in-year over spend on the LIMS programme relates to a provision made for VAT in the event that it is not recoverable. This is currently undergoing a detailed review by our VAT advisers and will be adjusted in 2020/21 if the outcome is favourable.

Project Star
Slippage on Project Star expenditure is mainly due to the delay in receiving planning permission from the Local Authority (LA) for the hoarding. LA planning approval was received on 26th March, orders for the hoarding have now been raised but manufacturers are closed due to COVID19. A revised commencement date is currently being identified.

COVID19 Capital Requirements
Expenditure of £0.1m has been incurred on COVID19 capital requirements in March 2020. Based on NHSI capital guidance relating to COVID19 the Trust expects to receive PDC funding to cover these costs.

6. Cash

The Trust holds cash of £26.5m at the year end which is £19.0m higher than plan.

Cash Summary at Month 12 2019/20		In Month			Year to date		
	Budget £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Opening balance	8.4	8.0	16.0	8.0	8.4	8.4	-
Contract Income 2019/20	682.2	56.9	57.4	0.4	682.2	682.1	(0.2)
Contract income 2018/19	3.2	-	-	-	3.2	12.1	8.9
Other Income	98.9	8.5	8.8	0.3	98.9	98.7	(0.2)
Uncommitted Revenue support facility 2019/20	-	(7.3)	(6.4)	0.9	-	7.9	7.9
PSF, FRF and MRET funding	32.0	9.7	4.8	(4.9)	32.0	22.3	(9.7)
Department of Health and NHS England Deficit support	24.8	6.2	24.8	18.6	24.8	24.8	-
Capital funding (PDC capital)	1.3	-	1.5	1.5	1.3	4.0	2.7
Total Receipts	842.4	74.0	90.8	16.8	842.4	851.9	9.4
Payroll (excluding agency)	(455.6)	(38.3)	(38.8)	(0.6)	(455.6)	(454.7)	0.9
Accounts payable	(362.3)	(30.1)	(36.1)	(6.0)	(362.3)	(357.3)	5.0
PDC Dividend	(1.5)	-	1.0	1.0	(1.5)	0.6	2.1
Capital	(24.0)	(6.2)	(6.4)	(0.2)	(24.0)	(22.4)	1.6
Total Payments	(843.4)	(74.6)	(80.3)	(5.8)	(843.4)	(833.8)	9.6
Closing Balance	7.5	7.5	26.5	19.0	7.5	26.5	19.0

Overall cash is £19m higher than plan at the year end. This reflects a number of variances from plan, higher than plan cash relating to 2018/19 and lower than planned payments to reflect the overall revenue position. Cash not received in 19/20 relating to Q4 PSF/FRF is offset by lower than planned repayment of cash support and is due to the timing of receipt of cash relating to 2019/20 deficit support in March 20.

Contract income and other income relating to 2019/20 is in line with plan at the year end.

The cash received for 2018/19 contract income is £8.9m ahead of plan year to date mainly due to cash relating to the outcome of the 2018/19 expert determination being received from commissioners in early September. A number of credit notes (£1.5m) relating to the prior year have not yet been taken by commissioners, this is being escalated as part of the Agreement of Balances exercise.

At the year end the Trust had net cash support borrowing of £8m against a plan position of no increase in borrowing. The cash plan assumed that cash would be received in year in relation to the Q4 PSF/FRF funding where this is due to be received early in 2020/21. The Trust did receive all of the £24.8m deficit support cash in March 2020 however confirmation that this cash would be received was too late to include in the Trusts March cash flow submission to NHSI/DHSC which informs the repayment of borrowing each month. As a result the impact of the items above was that the Trust holds a higher cash balance at the year end.

General accounts payable and capital payments are £5m and £1.6m behind plan mainly as a result of reported underspends on non-pay and the timing of capital payments. The Trust has received a rebate of public dividend capital at the year end which reflects the year end balance sheet position and the higher than plan daily cash balance through the year which is included in the calculation of the PDC charge in the revenue account.

In March/April 2020 changes were announced to the funding arrangements for Trusts early in 2020/21 and to the NHS debt regime. The impact of the changes is being reflected in the Trusts cash flow forecasts from April 2020.

The table below shows the actual cash position for 2019/20. The cash support received to date relating to deficit support and PSF/FRF funding and the repayment in year is also detailed.

Cash and borrowing position 2019/20	Actual 30/04/19 £m	Actual 31/05/19 £m	Actual 30/06/19 £m	Actual 31/07/19 £m	Actual 31/08/19 £m	Actual 30/09/19 £m	Actual 31/10/19 £m	Actual 30/11/19 £m	Actual 31/12/19 £m	Actual 31/01/20 £m	Actual 29/02/20 £m	Actual 31/03/20 £m	Total
Month end cash balance per NHSI plan	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	7.5	7.5
Month end cash balance actual/forecast	4.7	5.1	20.9	15.0	16.6	25.5	15.4	22.1	19.4	21.2	16.0	26.5	26.5
Deficit/Working capital cash support received	4.4	4.3	7.9	-	-	-	-	-	-	(0.9)	-	-	15.7
Deficit/Working capital cash repayment	-	-	-	-	-	-	(4.2)	-	-	-	-	(3.6)	(7.7)
Planned PSF/FRF cash received	-	-	-	-	-	4.2	-	2.4	3.2	-	3.6	4.8	18.0
PSF/FRF cash support received/repayment	1.4	1.4	-	1.9	1.9	-	-	-	-	0.9	(4.6)	(2.8)	(0.0)
DHSC & NHS England deficit support cash	-	-	-	-	-	-	-	-	-	-	-	24.8	24.8

The plan was that at the year end the net cash support borrowing for the year will be nil. As the Trust had not received confirmation as to when either the Q3 PSF cash or the £9.9m deficit support from DHSC would be received by the deadline to submit the March cashflow to NHSI/DHSC, net borrowing for the year was £8m. The Trust was able to repay £6.3m of cash support in March which took the total of loan repayments at 6% interest rate to £15.2m. The Quarter 4 PSF/FRF cash of £9.7m will be received in 2020/21.

In March 20 the funding arrangements for the early part of 2020/21 were changed as part of the NHS response to COVID-19, as a result the Trust will be paid by block contract and top up in the early part of the financial year. In April 2020 changes to the NHS debt regime were also announced which will result in the Trusts historic debt being converted to public dividend capital.

7. Balance Sheet

The Month 12 Statement of Financial Position (Balance Sheet) is shown below.

Balance Sheet as at 31st March 2020	31/03/2019	31/03/2020			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	504.0	499.7	483.8	(15.9)	Note 1
Intangible Assets	22.1	22.1	23.7	1.6	Note 1
Total Non Current Assets	526.1	521.8	507.5	(14.3)	
Inventories	12.8	12.4	13.3	0.9	
Trade and other Receivables	40.9	48.6	39.7	(8.9)	Note 2
Cash and Cash Equivalents	8.4	7.5	26.5	19.0	Note 3
Total Current Assets	62.1	68.5	79.5	11.0	
Trade and other payables	(59.1)	(75.6)	(66.1)	9.5	Note 4
Borrowings	(23.4)	(23.8)	(24.1)	(0.3)	
Provisions	(3.3)	(3.3)	(6.6)	(3.3)	Note 5
Total Current Liabilities	(85.8)	(102.7)	(96.8)	5.9	
Borrowings	(462.0)	(449.8)	(459.0)	(9.1)	Note 6
Provisions	(0.9)	(0.9)	(0.9)	-	
Total Non Current Liabilities	(462.9)	(450.7)	(459.9)	(9.1)	
Total Assets Employed	39.6	36.9	30.3	(6.6)	
Financed By:				-	
Public Dividend Capital	407.1	408.4	409.7	1.2	Note 7
Retained Earnings	(466.4)	(470.4)	(476.2)	(5.8)	Note 8
Revaluation Reserve	98.9	98.9	96.9	(2.0)	Note 1
Total Taxpayers Equity	39.6	36.9	30.3	(6.6)	

The Month 12 Statement of Financial Position (Balance Sheet) is broadly in line with plan with the main variances explained below:

Note 1: Property Plant & Equipment and Intangibles are £14.3m lower than plan. This is mainly due to the valuation of land and buildings at 31 March 2020 which is not built in to the plan figures at budget setting as the valuation could result in an upward or downward valuation. The net impact of the valuation is a reduction in carrying value of £17.1m due to changes in building price indexation, the location factor and a small number of floor area re-measurements. This reduction is partly offset by higher than planned capital expenditure as a result of additional funding for imaging equipment and Project STAR. The intangibles asset value is higher than plan due to the LIMS capital scheme being included in the PPE plan figure rather than Intangibles.

Note 2: Trade and other receivables are £8.9m lower than plan. This is mainly due to invoices relating to the deficit support raised with the Department of Health and Social Care and also Stafford and Surrounds CCG (relating to NHSE deficit support) both being paid in March 2020 and credit notes of £11.7m being raised in March 20 of which £9.7m related to the year end position on the Specialised Services contract. This is partly offset by the accrual for Q4 PSF and FRF funding which will not be received until 2020/21.

Note 3: Cash is £19m higher than plan at the year end. Cash received is higher than plan as the Trust received all £24.8m deficit support funding and the remaining Q3 PSF funding in March 2020. All 2019/20 cash support drawn down in relation to PSF/FRF and deficit support was repaid. The higher cash plan was held to reflect the credit notes raised on the Specialised Services contracts and also the changes to funding regimes and NHS debt in 2020/21.

Note 4: Trade and other payables are £9.5m lower than plan. This reflects the year end revenue position which is better than plan and also the Trust complying with Treasury guidance to make payments to suppliers earlier than the normal 30 day payment terms.

Note 5: Provisions are £3.3m higher than plan and reflect provisions made in Month 12 in relation to the potential impact of the East of England Ambulance overtime holiday pay case and to reflect up to date information on dilapidations on a number of property leases.

Note 6: Borrowings are £9.1m higher than plan. The variance is partly due to the £4m working cash support requested earlier in the financial year relating to the increased 2018/19 deficit. In addition as cash was only received in March 20 for Q3 PSF and 2019/20 deficit support this was too late to impact the repayment of borrowing in March 20 within the DHSC timeframe. A repayment of borrowing £6.4m was made in Month 12. The higher than plan cash balance also reflects the higher than plan borrowing position. Borrowing is also £1.5m higher than plan due to the capital loan taken out in relation to Project STAR.

Note 7: PDC is £1.2m higher than plan due to the Trust receiving PDC relating to imaging equipment of £1.2m.

Note 8: Retained earnings show a £5.8m variance from plan at Month 12. This reflects £4m final adjustment to the prior year closing balance to reflect the outcome of the expert determination, the impact of the valuation of land and buildings charged to the revenue account (£15m) and the better than plan revenue position of £5.2m (excluding impairments due to the asset valuation).

7.1 Trade & other receivables

Total Trade and other receivables stood at £39.7m at 31st March 2020, £8.9m lower than plan. The main variances are explained below:

Trade / Other Receivables & Current assets Actuals	Actual 31/03/19 £m	Plan 31/3/20 £m	Actual 31/3/20 £m	Variance 31/3/20 £m	
Trade Receivables	42.3	21.5	3.4	(18.1)	Note 1
Deficit support invoice not yet due	-	-	-	-	
Prepayments	8.8	4.5	5.0	0.5	
Accrued Income	19.2	25.9	31.4	5.5	Note 2
Bad Debt Provision	(2.7)	(2.8)	(2.6)	0.1	
VAT Receivable	1.6	1.6	1.7	0.1	
Credit Note accrual	(30.0)	(3.9)	(0.8)	3.1	
Other Receivable	1.8	1.8	1.6	(0.2)	
Total	40.9	48.6	39.7	(8.9)	

Note 1: Trade receivables are £18.1m lower than plan. This reflects that in Month 12 the invoices for £24.8m relating to 19/20 deficit support were settled and credit notes raised of £11.7m to reflect the year end SLA position, of these £9.7m relate to Specialised Services.

Note 2: Accrued income is £5.5m higher than plan mainly due to the accrual for Q4 PSF/FRF funding which will not be received until 2020/21. This is partly offset by lower accruals as a year end position was agreed for the Specialised Services contract and other main Commissioners as part of the Integrated Fixed Payments System.

Trade receivables: The table below shows the ageing of the outstanding NHS and Non-NHS trade receivable debt and highlights the larger outstanding balances.

NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 29/2/20 £m	Actual 31/3/20 £m	
Less than 30 Days	24.3	3.3	(3.0)	Credit notes of £11.689 including NHSE £9.7m relating to the specialised contract. Invoices outstanding £1.7m Betsi Cadwaladr, NHS England £1.3m. Health Commission Wales £0.4m, Vale Royal CCG £0.4m
31 to 60 Days	1.6	1.5	2.2	NHS England £1.7m, Mid Cheshire £0.1m
61 to 90 Days	0.5	0.7	1.1	NHS England £0.6m, Stafford and Surrounds £0.1m,
91+ Days	12.3	25.8	0.7	Royal Wolverhampton £0.1m, Mid Cheshire £0.2m, NHS England £0.1m
Total	38.7	31.3	0.9	

Non NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 29/2/20 £m	Actual 31/3/20 £m	
Less than 30 Days	1.4	0.8	1.1	Alliance Medical £0.1m, Keele University £0.235m, EMRT £0.1m
31 to 60 Days	0.5	0.5	0.5	Alliance Medical £0.1m, Vocare £0.1m
61 to 90 Days	0.2	0.1	0.1	
91+ Days	1.5	0.9	0.8	£0.57m overseas visitors, £0.2m salary overpayments
Total	3.6	2.3	2.5	

The overall NHS aged debtor balance is significantly lower than in previous months and reflects that the Trust received payment for the £24.8m deficit support funding for 2019/20 in March 20. NHS debt outstanding for less than 30 days is negative and this reflects credit notes of £11.7m raised in March 20 relating to the year end contracting position, of this £9.7m related to the Specialised Service contract year end position.

There are a number of outstanding invoices and credit notes with NHS bodies. The financial accounts team is reviewing the 2019/20 agreement of balances exercise and is continuing to liaise with NHS England and other NHS bodies where significant balances are outstanding for an update on when the Trust can expect the invoices and credit notes to be settled.

Older Non-NHS debt is proactively managed by the credit control department. This includes credit control, monthly conference calls with the Trust as well as increased referrals to a third party debt recovery service.

Outstanding debt was reviewed in year and a write-off of Non-NHS debt was reported to Audit Committee in January 2020. As a result there has been a reduction in longer term non-NHS debt compared to earlier in the financial year.

7.2 Trade & other payables

Trade and other payables stood at £66.1m at 31st March 2020, which is £9.6m lower than plan. A breakdown of this figure and the reasons for the variance against plan are shown below:

Trade and Other Payables Actuals	Actual 31/03/19 £m	Plan 31/3/20 £m	Actual 31/3/20 £m	Variance 31/3/20 £m	
Trade Payables	(15.6)	(20.5)	(15.6)	4.9	Note 1
Manual Accruals	(12.0)	(18.8)	(15.5)	3.3	Note 2
Deferred Income	(5.0)	(6.5)	(5.6)	0.9	
GRN Accruals	(8.5)	(11.0)	(10.4)	0.6	
Tax/NI Payables	(9.8)	(10.5)	(10.5)	(0.0)	
Pension Payables	(5.9)	(6.2)	(6.4)	(0.2)	
Other Payables	(2.2)	(2.1)	(2.0)	0.1	
Total	(59.0)	(75.7)	(66.1)	9.6	

Note 1: Trade payables are £4.9m lower than plan and reflects the Trusts compliance with Treasury guidance to make prompt payment to suppliers in the current situation rather than making payments in line with normal payment terms.

Note 2: Manual accruals are £3.3m lower than plan and reflects the revenue outturn position.

7.3 Better payment practice code

The Better Payment Practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later, with a target of 95% compliance. The performance to Month 12 can be seen in the table below.

Better Payment Practice Code	Actual 31/3/19	Actual 29/2/20	Actual 31/3/20
NHS £m			
Total Paid	31.6	28.2	47.0
Paid in terms	21.1	23.0	36.4
Percentage paid in terms	67%	82%	78%
NHS volume			
Total Paid	3,703	3,337	4,762
Paid in terms	2,962	2,755	3,805
Percentage paid in terms	80%	83%	80%
Non NHS £m			
Total Paid	458.9	386.2	539.9
Paid in terms	431.4	362.2	501.7
Percentage paid in terms	94%	94%	93%
Non NHS volume			
Total Paid	131,200	118,417	167,860
Paid in terms	122,292	111,379	158,101
Percentage paid in terms	93%	94%	94%

8 Conclusions

The Trust has delivered a yearend surplus of £5.2m against a plan to breakeven; this performance is in line with its revised forecast at Month 6. Over the last quarter of the year the Trust has received a number of unexpected non recurrent income items; this coupled with a yearend settlement that protected the Trust against activity reductions in its Specialised Services portfolios has enabled the Trust to end the year without increasing financial risk in 2020/21.

Appendix 1 – Patient income POD summary

Patient Income Position at Month 12	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
Daycase / Elective Inpatients	82,890	74.7	82,890	78,103	(4,787)	-6%	74.7	69.4	(5.3)	-7%
Non-Elective Emergency Inpatients	73,164	137.5	73,164	71,248	(1,916)	-3%	137.5	150.6	13.1	10%
Non-Elective Non Emergency Inpatients	21,442	21.4	21,442	22,081	639	3%	21.4	20.6	(0.8)	-4%
Critical Care	13,254	14.4	13,254	13,180	(74)	-1%	14.4	14.3	(0.0)	0%
Excluded Drugs / Devices	12,638	13.3	12,638	10,941	(1,698)	-13%	13.3	12.8	(0.5)	-3%
Other	5,729,735	80.6	5,729,735	5,745,380	15,645	0%	80.6	80.1	(0.5)	-1%
Outpatients	550,732	59.1	550,732	508,159	(42,573)	-8%	59.1	57.8	(1.3)	-2%
IFPS Adjustment		14.2					14.2	9.8	(4.4)	
	6,483,856	415.0	6,483,856	6,449,092	(34,764)	-1%	415.1	415.4	0.3	0%
Other Non Patient Income		1.5					1.5	1.5	-	0%
	6,483,856	416.5	6,483,856	6,449,092	(34,764)	-1%	416.6	416.9	0.3	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
Daycase / Elective Inpatients	23,576	39.9	23,576	24,070	494	2%	39.9	37.3	(2.5)	-6%
Non-Elective Emergency Inpatients	7,823	36.3	7,823	7,125	(698)	-9%	36.3	34.4	(2.0)	-5%
Non-Elective Non Emergency Inpatients	914	5.8	914	866	(48)	-5%	5.8	5.3	(0.5)	-8%
Critical Care	15,893	21.9	15,893	14,180	(1,714)	-11%	21.9	18.8	(3.0)	-14%
Excluded Drugs / Devices	741	42.2	741	1,782	1,041	140%	42.2	47.2	5.0	12%
Other	212,654	48.6	212,654	215,028	2,374	1%	48.6	52.7	4.1	8%
Outpatients	188,542	23.7	188,542	177,564	(10,978)	-6%	23.7	23.1	(0.6)	-3%
	450,143	218.4	450,143	440,614	(9,528)	-2%	218.4	218.7	0.4	0%
OTHER CCG ASSOCIATES										
Daycase / Elective Inpatients	5,579	7.5	5,579	5,390	(189)	-3%	7.5	6.6	(0.8)	-11%
Non-Elective Emergency Inpatients	3,106	8.8	3,106	3,355	249	8%	8.8	9.1	0.3	4%
Non-Elective Non Emergency Inpatients	922	2.2	922	978	56	6%	2.2	2.5	0.3	16%
Critical Care	1,249	1.3	1,249	1,886	637	51%	1.3	2.0	0.7	53%
Excluded Drugs / Devices	2,572	3.2	2,572	2,363	(209)	-8%	3.2	3.4	0.1	5%
Other	16,492	3.3	16,492	19,045	2,552	15%	3.3	3.8	0.5	14%
Outpatients	34,377	4.5	34,377	40,147	5,770	17%	4.5	5.4	0.8	19%
	64,297	30.8	64,297	73,164	8,866	14%	30.8	32.7	2.0	6%
OTHER NON NHS CONTRACTS										
Daycase / Elective Inpatients	181	0.8	181	224	43	23%	0.8	0.9	0.0	4%
Non-Elective Emergency Inpatients	455	2.7	455	534	79	17%	2.7	3.4	0.7	26%
Non-Elective Non Emergency Inpatients	109	0.5	109	95	(14)	-13%	0.5	0.5	(0.0)	-1%
Critical Care	1,235	1.6	1,235	1,340	105	8%	1.6	1.8	0.2	13%
Excluded Drugs / Devices	54	0.5	54	69	15	28%	0.5	0.6	0.1	25%
Other	3,456	1.1	3,456	1,638	(1,818)	-53%	1.1	0.9	(0.2)	-16%
Outpatients	1,964	0.3	1,964	2,085	121	6%	0.3	0.3	0.0	8%
	7,455	7.5	7,455	5,985	(1,470)	-20%	7.5	8.4	0.9	12%
NON CONTRACT ACTIVITY										
Daycase / Elective Inpatients	498	1.3	498	475	(23)	-5%	1.3	1.0	(0.3)	-20%
Non-Elective Emergency Inpatients	1,004	1.4	1,004	939	(65)	-6%	1.4	1.3	(0.0)	-2%
Non-Elective Non Emergency Inpatients	141	0.2	141	107	(34)	-24%	0.2	0.1	(0.1)	-31%
Critical Care	129	0.1	129	216	86	67%	0.1	0.3	0.1	83%
Excluded Drugs / Devices	86	0.1	86	103	17	20%	0.1	0.1	0.0	22%
Other	4,000	0.6	4,000	3,887	(113)	-3%	0.6	0.5	(0.1)	-14%
Outpatients	3,855	0.5	3,855	3,627	(228)	-6%	0.5	0.4	(0.0)	-11%
	9,713	4.2	9,713	9,354	(360)	-4%	4.2	3.9	(0.3)	-8%
OTHER										
Daycase / Elective Inpatients	278	-	278	247	(31)	-11%	-	0.0	0.0	
Non-Elective Emergency Inpatients	128	0.1	128	69	(59)	-46%	0.1	0.0	(0.1)	-96%
Non-Elective Non Emergency Inpatients	44	0.0	44	23	(21)	-47%	0.0	-	(0.0)	-100%
Critical Care	35	-	35	81	46	134%	-	-	-	
Excluded Drugs / Devices	2	4.4	2	17	15	750%	4.4	5.7	1.3	30%
Other	400	10.3	400	318	(82)	-20%	10.3	11.3	1.0	10%
Outpatients	1,046	0.0	1,046	1,132	86	8%	0.0	0.0	(0.0)	-97%
	1,932	14.8	1,932	1,887	(45)	-2%	14.8	17.0	2.2	15%
	7,017,396	692.2	7,017,396	6,980,096	(37,301)	-15%	692.2	697.6	5.4	1%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.5)	(1.5)	-	0%
TOTAL PATIENT INCOME	7,017,396	690.7	7,017,396	6,980,096	(37,301)	-1%	690.7	696.1	5.4	1%

Appendix 2 – Patient income Commissioner summary

Patient Income Position at Month 12	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
NHS CANNOCK CHASE CCG	370,305	21.9	370,305	372,150	1,846	0%	21.9	21.9	0.1	0%
NHS EAST STAFFORDSHIRE CCG	7,493	3.2	7,493	7,927	433	6%	3.2	3.8	0.6	19%
NHS NORTH STAFFORDSHIRE CCG	1,957,541	121.3	1,957,541	2,010,135	52,594	3%	121.3	124.4	3.0	2%
NHS SOUTH EAST STAFFS AND SEISDON PENINSULAR CCG	4,351	2.0	4,351	4,360	8	0%	2.0	1.9	(0.1)	-4%
NHS STAFFORD AND SURROUNDS CCG	1,335,622	72.8	1,335,622	1,310,299	(25,323)	-2%	72.8	74.3	1.6	2%
NHS STOKE ON TRENT CCG	2,808,544	179.7	2,808,544	2,744,222	(64,322)	-2%	179.7	179.3	(0.4)	0%
IPFS ADJUSTMENT	-	14.2	-	-	-		14.2	9.8	(4.4)	-31%
	6,483,856	415.1	6,483,856	6,449,092	(34,764)	-1%	415.1	415.4	0.3	0%
Other Non Patient Income		1.5					1.5	1.5	-	0%
	6,483,856	416.6	6,483,856	6,449,092	(34,764)	-1%	416.6	416.9	0.3	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
CHESHIRE AND MERSEYSIDE AT DENTAL	1,431	0.3	1,431	1,400	(31)	-2%	0.3	0.3	0.0	6%
CHESHIRE AND MERSEYSIDE AT SCREENING	4,614	0.5	4,614	4,033	(581)	-13%	0.5	0.3	(0.2)	-40%
NHS ENGLAND - ARMED FORCES	1,151	0.4	1,151	-	(1,151)	-100%	0.4	-	(0.4)	-100%
NORTH MIDLANDS AT DENTAL	37,692	7.9	37,692	35,326	(2,367)	-6%	7.9	7.9	(0.1)	-1%
NORTH MIDLANDS AT SCREENING	14,977	6.0	14,977	13,006	(1,971)	-13%	6.0	5.8	(0.2)	-3%
SPECIALISED COMMISSIONING TEAM	390,278	203.3	390,278	386,850	(3,428)	-1%	203.3	204.5	1.1	1%
	450,143	218.4	450,143	440,614	(9,528)	-2%	218.4	218.7	0.4	0%
OTHER CCG ASSOCIATES										
NHS BIRMINGHAM AND SOLIHULL CCG	1,159	0.7	1,159	1,463	305	26%	0.7	0.9	0.3	44%
NHS DERBY AND DERBYSHIRE CCG	1,957	1.0	1,957	2,055	98	5%	1.0	1.0	(0.0)	-2%
NHS DUDLEY CCG	514	0.3	514	552	38	7%	0.3	0.3	(0.0)	0%
NHS EASTERN CHESHIRE CCG	5,151	2.4	5,151	5,525	374	7%	2.4	2.5	0.2	8%
NHS REDDITCH AND BROMSGROVE CCG	179	0.2	179	211	32	18%	0.2	0.2	0.0	23%
NHS SANDWELL AND WEST BIRMINGHAM CCG	976	0.8	976	759	(217)	-22%	0.8	0.4	(0.3)	-41%
NHS SHROPSHIRE CCG	10,564	4.7	10,564	12,159	1,596	15%	4.7	5.5	0.8	17%
NHS SOUTH CHESHIRE CCG	28,337	12.6	28,337	32,289	3,952	14%	12.6	13.3	0.8	6%
NHS SOUTH WORCESTERSHIRE CCG	285	0.2	285	245	(40)	-14%	0.2	0.1	(0.0)	-27%
NHS TELFORD AND WREKIN CCG	6,413	3.1	6,413	6,732	320	5%	3.1	2.5	(0.6)	-19%
NHS VALE ROYAL CCG	5,018	3.2	5,018	6,939	1,921	38%	3.2	3.6	0.3	11%
NHS WALSALL CCG	1,189	0.5	1,189	1,499	310	26%	0.5	0.7	0.2	36%
NHS WEST CHESHIRE CCG	708	0.5	708	823	115	16%	0.5	0.6	0.1	30%
NHS WIRRAL CCG	199	0.1	199	217	18	9%	0.1	0.2	0.1	70%
NHS WOLVERHAMPTON CCG	1,432	0.6	1,432	1,511	79	6%	0.6	0.7	0.1	25%
NHS WYRE FOREST CCG	218	0.2	218	182	(36)	-16%	0.2	0.1	(0.0)	-7%
	64,297	30.8	64,297	73,164	8,866	14%	30.8	32.7	2.0	6%
OTHER NON NHS CONTRACTS										
BETSI CADWALADR UHB	2,220	4.3	2,220	3,403	1,183	53%	4.3	5.3	1.0	24%
WALES	4,481	2.9	4,481	1,791	(2,690)	-60%	2.9	2.7	(0.1)	-4%
VIRGIN HEALTHCARE	754	0.3	754	791	37	5%	0.3	0.3	(0.0)	0%
	7,455	7.5	7,455	5,985	(1,470)	-20%	7.5	8.4	0.9	12%
NON CONTRACT ACTIVITY										
NON CONTRACT ACTIVITY	9,713	4.2	9,713	9,354	(360)	-4%	4.2	3.9	(0.3)	-8%
	9,713	4.2	9,713	9,354	(360)	-4%	4.2	3.9	(0.3)	-8%
OTHER										
CANCER DRUGS FUND	-	3.7	-	-	-		3.7	5.3	1.6	42%
NHS ENGLAND DRUGS - NON CONTRACT	-	0.6	-	-	-		0.6	0.8	0.1	17%
OTHER	505	10.5	505	461	(44)	-9%	10.5	11.0	0.5	5%
OVERSEAS VISITORS	658	0.0	658	451	(207)	-31%	0.0	-	(0.0)	-100%
PRIVATE PATIENTS	768	-	768	975	207	27%	-	-	-	
	1,932	14.8	1,932	1,887	(45)	-2%	14.8	17.0	2.2	15%
	7,017,396	692.2	7,017,396	6,980,096	(37,301)	-15%	692.2	697.6	5.4	1%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.5)	(1.5)	-	0%
TOTAL PATIENT INCOME	7,017,396	690.7	7,017,396	6,980,096	(37,301)	-1%	690.7	696.1	5.4	1%

Transformation and People Committee Chair's Highlight Report to Board

April 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• It was acknowledged that the Committee agenda had been reduced given the current situation and that work on progressing the strategy had been paused. • In terms of Transformation, the Committee acknowledged the importance of capturing the new ways of working which had been introduced since Covid and identifying what could continue post Covid. • The Committee queried the effectiveness of the speaking up framework during the Covid pandemic, and it was noted that concerns continued to be raised and information was being obtained from Employee Support Advisors, which would be included in future reports. • There had been some reduction in workforce performance since the start of the Covid pandemic and nationally it had been agreed to pause reporting on statutory and mandatory training and appraisal rate completion.	• The length of time required to recover statutory and mandatory training compliance was noted and despite the expectation of there being a dip in performance, staff working from home were being encouraged to complete as much possible. • It was noted that the Freedom to Speak Up Summit had been delayed and this would be the main area of focus to resume, in terms of triangulating information from incidents, workforce etc with concerns. • The date for the launch of the Staff Charter was to be confirmed and it was agreed that this should be signed by relevant stakeholders prior to the launch. • To amend the Committee Annual Report based on the comments provided. • Future meetings to include a focus on recovery and restoration and the activities to be undertaken.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted the level of support being provided to staff to support their health and wellbeing, which included free car parking, working with nurseries/schools for care provision, free snack boxes and distributing various donations. In addition psychological support was being provided to staff. • Protocols had been had been written in conjunction with Infection Prevention to identify staff who required testing. One of the benefits of the Empactis reporting system was the ease in which staff could be identified and a Testing App had been developed to enable staff members to receive their results via their mobile phone. Since the introduction of staff testing, there had been a positive reduction in the number of staff off work due to Covid. • All but one indicator in relation to speaking up from the Staff Survey results had seen a positive improvement and actions had been identified to make further improvements. Benchmarking had been undertaken to understand the level of reporting compared to peers which demonstrated that the Trust was not underreporting. • It was noted that normal postgraduate activities had ceased and Junior Doctors	• The Terms of Reference were approved. The Annual Report was agreed with a number of amendments.

were to be deployed to meet the needs of the Trust. Communications with the Junior Doctors throughout this period were being maintained. In addition, approximately 38 FY1 doctors were to commence in post week commencing 27th April 2020.

- It was noted that medical school teaching was suspended and improvements in relation to Datix reporting had been made.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	M12 Workforce Performance Report	Assurance	**2.**	Speaking Up Report – Quarter 4 and Annual Report 2019-20	Assurance
3.	Postgraduate Medical and Dental Education Report	Assurance	**4.**	Undergraduate Medical School Report	Assurance
5.	Committee Effectiveness 2019/20 including Revised Committee Governance Pack	Approval			

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)												
Ms H Ashley	HA	Director of Strategy and Transformation												
Ms S Belfield	SB	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Mrs M Rhodes	MR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance	NH											
Mrs R Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	Date:	6th May 2020
Report Title:	Integrated Performance Report	Agenda Item:	10
Author:	Performance Team		
Executive Lead:	Helen Ashley: Director of Strategy and Transformation /Deputy Chief Executive		

Purpose of Report:

Assurance	✓	Approval		Information	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards		✓
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond	✓	
SO5		Ensure efficient use of resources	✓	

Executive Summary:

Background

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Finance and use of resources
2. Operational Performance
3. Organisational Health
4. Quality of Care - safety, caring and Effectiveness

This report shows performance against the five National Constitutional Standards:
1. A&E
2. Diagnostic six week waits
3. RTT 18-weeks
4. All cancer 62 day waits
5. 62 day waits from screening service referral

Assessment

In March 2020, the Trust achieved against the NHS Improvement Single Oversight Framework performance indicator Cancer 31 day subsequent surgery (94.74%) and for 31 day anti-cancer drug therapy (100%). The Trust underperformed against the 4 hour standard, 77.6%. RTT delivery is 76.03%. Cancer performance for 2ww is 76.85%; 31 day 95.47% and 62 day 77.84%.and Diagnostics at 91.84%.

EMERGENCY ACCESS

Whilst we started to see the fruits of our improvement programme in January and February, COVID-19 preparations have superseded our urgent care improvement programme. In response to COVID-19, our focus has been on maintaining 4 hour performance under the circumstances and above all patient and staff safety. However, the requirements to manage suspected/positive COVID-19 patients differently in ED and our urgent care portals have required a different plan/response. Our response to COVID-19 has focused primarily on:

- Creating different "zones" in our Emergency Departments to manage suspected COVID-19 and non-COVID-19 patients, which has also required an adjusted workforce model. This also includes

our urgent care portals, Inc. AMRAU, AMU and AEC.
- Minors at Royal Stoke has transferred to Haywood Walk-in Centre and at County minor patients are now flowing to the Fracture Clinic;
- Significant capacity has been freed up to manage coronavirus patients: nearly 600 empty beds (Inc. 8 empty wards) and a significant reduction in MFFD (lowest levels recorded). Additionally, a comprehensive critical care plan to effectively quadruple capacity has been developed.
- Implementation of new medical rotas; including comprehensive 7 day coverage, a Consultant Physician overnight, twice as many Registrars overnight, and a significant increase in the number of junior doctors in and out of hours, particularly in COVID-19 wards.
- The development of a dedicated 'operational hub' in the West Building to provide significant scrutiny, oversight and support to ensure the timely management and discharge of patients; very low levels of MFFD patients in the Trust.

Next steps:
COVID-19 plans in place, with two primary changes to be implemented in April 2020 to manage the growth in COVID-19 cases:
- A new ("one-team") model for the Site Operational and Divisional Flow Teams to manage flow and discharges across the organisation, including the robust management of COVID-19 wards and side rooms.
- 24/7 Consultant on site cover on the Royal Stoke site.

REFERRAL TO TREATMENT
The RTT Incomplete Pathway standard in March achieved 76.04% against an Internal trajectory of 86.46% and a NHSI operational plan of 85.0%.The number of Incomplete pathways has reduced from 48743 in February to 47459.
There were 7 over 52 week patients.

Next Steps
Enhanced governance grip through a revised Accountability Framework; Weekly COO led COVID Planned care cell with Senior Managers from the Divisions. Programmes of work are being developed:
- To provide assurance that we are capturing and maintaining PTLs in accordance with central guidance and our local Standard Operating Procedures and prioritising cancer and 'urgent' patient pathways for 'no delays' treatments.
- To develop a programmes of systematic tactical validation for outpatient, diagnostic and inpatient waiting lists.
- Divisions submitted their prioritisation and tactical validation plans and these will be collated and discussed at the PCC meetings
- Divisional Teams have been asked to scope the opportunity for treatment of patients within all modalities available, including continuance of virtual clinics and extending these where appropriate, considering use of the IS sites for 'clean' surgical activity and the Beacon Park Diagnostics Centre for a range of independently staffed diagnostics modalities to support activity recovery.
- The Corporate Teams are mobilising staff who have the relevant skills but who are either self-isolating or can work from home to support work on the tactical validation plans presented at PCC.

CANCER
The trust is currently achieving 31 Day Subsequent Anti-Cancer drugs and 31 Day subsequent surgery for March 20. Following receipt of specific Covid-19 guidance for delivery of diagnosis and treatments for cancer patients during the pandemic plans are in place to provide services as close to business as usual as possible, whilst ensuring safety of patients and staff. These plans include development of an automated cancer diagnostic and cancer surveillance PTL and continuation of the cancer deep dive validation exercises to support improvement of CWT position across all measures. These plans will intensify throughout April based on the existing Cancer Plan to secure in month improvements in cancer performance for March whilst preparation throughout May is planned for a data revision exercise to improve Q3/4 data which will be submitted to CWT via NHS Digital on 02nd June 2020.

Next Steps
- **Cancer Services Recovery Plan:** to continue to build on the Covid -19 response work in terms of new ways of working and to draft capacity plans to enable tactical management of patients once a

date for return to business as usual is agreed. This will comprise of a **Phase 1 proposal** covering recovery actions together with a Phase 2 sustainability plan.

- **Phase 1: Recovery Plan.** This is a detailed operational recovery plan that will enable UHNM to resolve our challenges and support delivery of short, medium and long term sustainable capacity solutions and improvements in our Cancer Performance Post Covid-19.
- **Phase 2 Sustainability plan:** This plan will involve assurance of clinical pathway management against best practice, ensuring we do not lose traction on the new ways of working, building on our DQ tactical management and validation and use of near real time cancer dashboards to support visibility of information and to monitor and track progress.

DIAGNOSTICS

Diagnostics waiting times for February is currently at 91.48% against a 99% threshold directly due to the restrictions applied from the national mandate to suspend all routine activity.

CARING AND SAFETY

The Trust achieved in March 2020:
• Zero mixed sex accommodation breaches
• Written Complaints (27.57 Vs. a target of 35 per 10,000 spells)
• C-Diff cases were 8 for the month against the plan of 8
• Zero MRSA Bacteraemia Infections
• Achieved the target reduction for all categories of Hospital Acquired, Trust Apportioned, Pressure Ulcers
• The number of patient falls resulting in low harm or above (50 vs. 60, internal target)
• Zero never events

The Trust failed the set standards for:
• VTE, 94.11% against an operational standard of 95%

The Family & Friends have not been collected due to the restrictions currently in place (COVID-19).

FINANCE

The financial position for the Trust at Month 12 is a £5.2m surplus, which is £5.2m positive variance against the breakeven plan.
Operating income at month 12 of the financial year is £787.0m; this is £10.6m above plan.
Pay expenditure is £484.3m at Month 12, £3.3m positive variance to plan. Non Pay spend is £278.9m at Month 12 which is an overspend of £10.7m.
The CIP Target within the plan is £40.0m. At month 12 the Trust has achieved £36.0m of savings, which is £4.0m below plan.
The Trust's Planned Capital Expenditure for the year is £26.1m. The Trust has spent £26.1m to Month 12.
The Trust's current liabilities exceed its current assets by £17.3m.

WORKFORCE

The in-month sickness rate was 5.38% at 31/03/20 (M12) compared to 5.10% at 29/02/20.
The 12 month cumulative rate increased slightly (from 4.61% to 4.69%). This is based on available days and FTE lost over the rolling 12m period.
Of absences reported during March 2020, March 2020, 993 out of a total 1272 absences were reported as covid-related. (78%) Of the total 1550 absences reported between1st and 22nd of April, 1001 were reported as covid-related (65%). A process for staff testing for covid-19 has been established and has recently been extended to all staff groups. Staff Wellbeing and Engagement work has necessarily been focussed on the actions to address the workforce elements of the Trust's emergency response to Covid-19.
PDRs and Statutory and Mandatory Training
• Overall, 75.94% of Non-Medical PDRs were recorded in ESR as at 31st March 2020 – deterioration on the 79.75% at 29th February. The performance rate was adversely impacted by a reduction in assignment numbers eligible for a PDR in March, with 100 leavers in month, and an increase in the number of PDRs expiring at 31st March.
The Statutory and Mandatory training rate at 31st March 2020 was 90.73% (90.86% at 29th February

2020). The Statutory & Mandatory training rate shows compliance against the following seven (Core for All) 3 yearly competency requirements and 84.27% of staff have completed all 7 modules (84.59% at 29/02/20) Actions are focussed on addressing the workforce elements of the Trust's emergency response to Covid-19 and therefore it necessary to suspend, for the time being, the action plan to improve PDR compliance and the Statutory and Mandatory training rate.

Key Recommendations:

To note performance

PROUD TO CARE

University Hospitals of North Midlands NHS Trust

PROUD TO CARE

Author: Karan Allman: Deputy Head of Performance
Executive Lead: Helen Ashley: Director of Strategy & Performance

Month 12 2019/20 Integrated Performance Report

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Context & NHS I Single Oversight Framework

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Finance and use of resources
2. Operational performance
3. Organisational health
4. Quality of Care - safety, caring and Effectiveness

Changes to oversight is categorised by several key principles: NHSE & NHSi speaking with a single voice; a greater emphasis on system performance, working with and through system leaders, matching accountability for results; greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The metrics identified in the framework are used as triggers by the regional teams to identify potential concerns and support levels required. There are four levels of support, ranging from 1. maximum provider autonomy to 4. special measures. As a consequence of the application of financial special measures the Trust has been placed in 4.

The following sections of this performance report provide detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHSI single oversight framework indicators.

Performance against National Constitutional Standards
The NHSI single oversight framework includes five constitutional standards:
1. A&E
2. Diagnostic six week waits
3. RTT 18-weeks
4. All cancer 62 day waits
5. 62 day waits from screening service referral

NHS Improvement Single Oversight Framework
The following report is designed to present performance, by exception, against the NHS Improvement Single Oversight Framework. In addition the Trust is developing other domains against which to view performance; however additional domains will be constructed over time. Spotlight reports are also included where performance against indicators that sit outside current domains have been flagged as exceptions, or where specific areas require highlighting.

Operational Performance:

The following performance standards were achieved in March 2020:
- Cancer, 2ww Symptomatic Breast (96.63%) – national standard 93%
- Cancer, Subsequent Anti-Cancer Drug (100%) - national standard 98%
- Cancer, Subsequent Radiotherapy (93.02%) - national standard 94%

The following standards were not achieved in March 2020:
- Cancer, 2ww Suspected Cancer (74.25%) - national standard 93%
- Cancer, 31 Day First Treatment (95.27%) - national standard 96%
- Cancer, Subsequent Surgery (86.37%) - national standard 94%
- Cancer, 62 day (70.72%) – national standard is 85%
- Cancer, 62 day screening (74.07%) – national standard 90%
- 4 hour emergency access standard (77.56%) – national standard 95%
- 34 - 12 hour trolley waits
- 18 week referral to treatment (RTT) standard (76.04%) – national standard 92%
- 7 > 52 weeks RTT waits
- 6 week Diagnostic wait (8.51%) - national standard of 1%

*cancer performance for March remains provisional at 21.04.2020. Final submission is due 6th May 2020

Caring and Safety:
The Trust achieved in March 2020:
- Zero mixed sex accommodation breaches
- Written Complaints (27.57 Vs. a target of 35 per 10,000 spells)
- C-Diff cases were 8 for the month against the plan of 8
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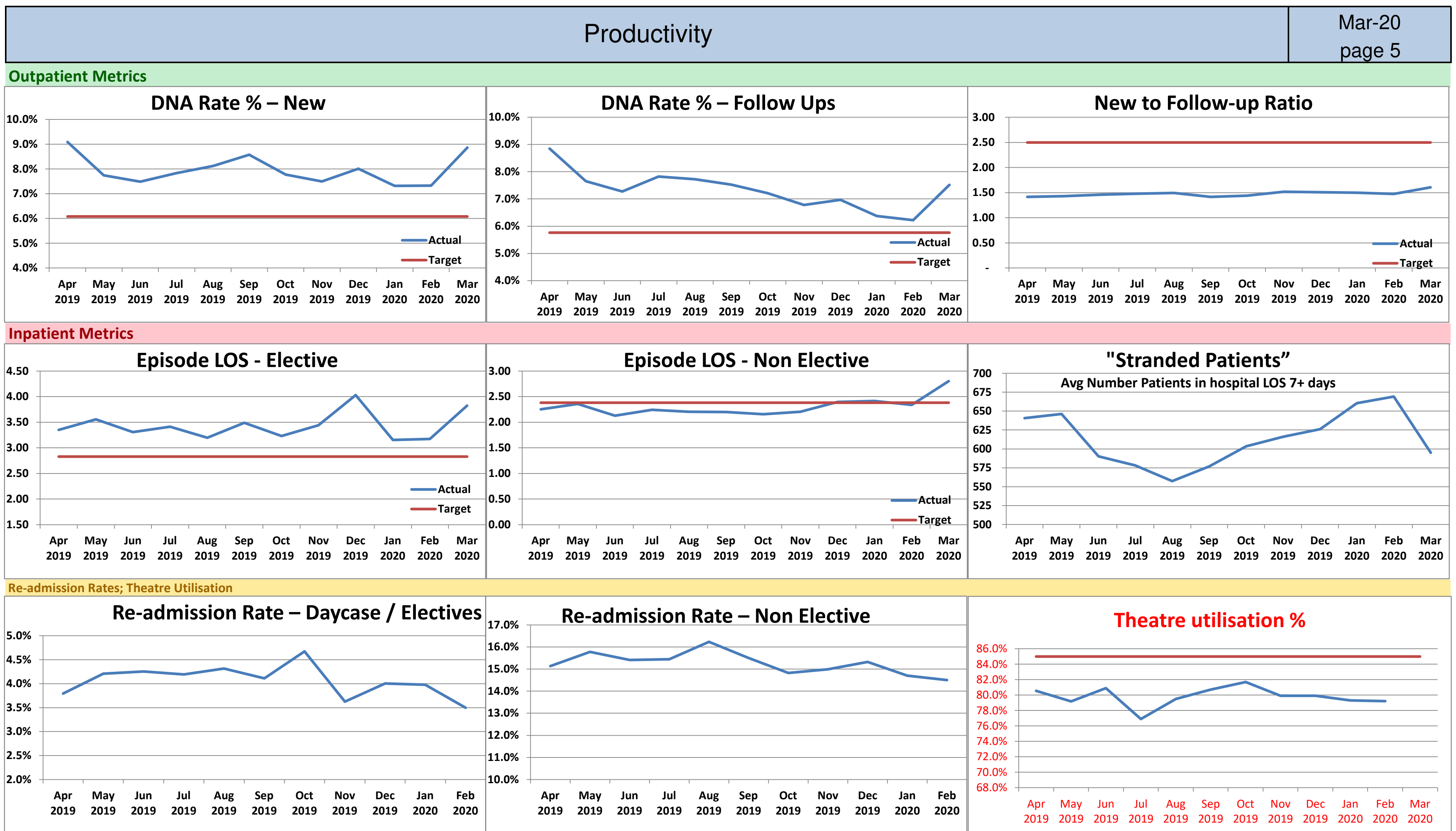
The CIP Target within the plan is £40.0m. At month 12 the Trust has achieved £36.0m of savings, which is £4.0m below plan.
The Trust’s Planned Capital Expenditure for the year is £26.1m. The Trust has spent £26.1m to Month 12.
The Trust's current liabilities exceed it's current assets by £17.3m.

Workforce:
In February the in-month sickness rate reduced to 5.10% (5.36% in January). The 12m Cumulative Rate increased slightly to 4.61% as this is based on available days and FTE lost over the rolling 12 month period. The sickness rate is in line with previous year trends over the winter period and the increase in reported absence was expected with the implementation of Empactis.
The PDR rate was 80.19% (79.28% previously). This is now reported from ESR for all Divisions
The Statutory and Mandatory training rate at 29th February 2020 was 90.86% (90.03% at 31st January 2020). The Statutory & Mandatory training rate shows compliance against the seven (Core for All) 3 yearly competency requirements and 84.59% of staff have completed all 7 modules (83.29% at 31/01/20)

Context

12 month rolling		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Variance of current vs. pervious month (no adjustments for Nos. of days in the month)
A&E	A&E Attendances - RSUH, County, Emerg Eye Clinic, WIC & MIU	21008	21165	21355	20872	22366	21483	21163	21697	21697	21099	20665	18923	15065	**-3858**
	Urgent Care Centre only - Vocare	1821	1897	1879	1624	1735	1541	1557	1637	1757	2325	1857	1352	1011	**-341**
	Total A&E Attendances	22829	23062	23234	22496	24101	23024	22720	23334	23454	23424	22522	20275	16076	**-4199**
	Daily average for total attendances	736.4	768.7	749.5	749.9	777.5	742.7	757.3	752.7	781.8	755.6	726.5	699.1	518.6	**-180.6**
Inpatients	Elective - overnight	1253	1141	1201	1180	1210	1196	1221	1326	1235	1067	1053	1108	953	**-155**
	Elective - day cases	8481	7825	8111	7537	8238	7797	7854	8273	7999	7327	8194	7339	6249	**-1090**
	Non-Elective discharges	10797	10720	11288	10459	10741	10685	10416	11137	10942	10532	10622	9843	8430	**-1413**
	Other - regular day/ night	353	389	386	353	402	367	357	405	370	361	423	357	321	**-36**
Outpatient	First new	30027	28186	27861	25402	27366	24489	26833	29839	26093	24970	27144	24724	22530	**-2194**
	Subsequent	41620	39811	43611	40055	43912	39530	40751	45515	42264	36594	43971	39232	36201	**-3031**

Summary:
All activity was down this month compared to last month and compared againts the same time last year. The daily average for total ED attendances was 518.6 and for Type 1 Royal Stoke only the daily average was 274 (down from 360 per day in February). However in the first half of the month the daily average at Royal Stoke was 336 and it was only in the latter half of the month that attendances reduced. At the end of the month and into April attendances have been below 200.



re-admission rates are reported for previous month

NHS Improvement Framework

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		Rolling Qtr. 18/19/20				2019 -20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Financial Rating	Capital service capacity	4	4	4	4	4	4	4	4	G
	Liquidity (days)	4	3	3	3	3	3	3	3	G
	I&E margin	4	4	4	4	4	4	4	4	G
	Distance from financial plan*	3	1	1	1	1	1	1	1	G
	Agency spend	1	1	1	1	1	1	2	1	G
Operational Performance	A&E- 95% of patients admitted, transferred or discharged within 4-hours	80.76%	80.81%	79.38%	74.99%	76.35%	79.02%	77.56%	77.60%	R
	Diagnostic 6-week wait performance 99% target	98.59%	97.89%	98.61%	99.47%	99.40%	99.44%	91.49%	96.72%	G
	RTT 18-weeks incomplete pathways - 92%	80.02%	79.98%	79.81%	81.81%	80.15%	80.16%	76.04%	80.10%	R
	All Cancer 62 day wait for first treatment:									
	from urgent GP referrals - 85%	76.38%	71.43%	71.78%	69.07%	64.25%	70.72%		66.85%	R
	from a screening service - 90%	82.28%	79.33%	87.43%	89.41%	73.17%	74.07%		73.68%	R

NHS Improvement Framework

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		Rolling Qtr. 18/19/20				2019-20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Organisational health	Staff Sickness (12m cumulative rate as at end of each quarter)	-	4.52%	4%	4.51%	4.55%	4.61%	4.69%	4.58%	R
	Staff turnover (Leavers in previous 12 months as % of Average Headcount)	-	0.0961	10%	9.05%	9.05%	8.75%	8.57%	8.90%	G
	Statutory and Mandatory Training Rate - for seven 3 yearly competencies	-	92.53%	92%	90.20%	90.03%	90.86%	90.73%	90.45%	R
	Proportion of Temporary staff (as a % of budgeted establishment) In month figure only	-	6.24%	6%	6.27%	6.35%	6.31%	6.75%	6.33%	
	Appraisal rates (12 month rolling average) - Trust (excl Consultant Medical Staff)	-	91.54%	85%	83.44%	79.28%	80.19%	75.94%	79.74%	R
	Staff Friends & Family Test % Recommended- Care, Quarterly (HR)	80.4%	n/a		n/a	73.9%	n/a	82.17%	73.9%	G
	Agency costs as a % of total pay cost	-	3.56%	4%	4.05%	3.91%	3.93%	4.09%	3.92%	
Caring	Written Complaints- rate (per 10,000 spells)	30.67	32.89	30.2	30.44	31.29	27.24	27.57	28.84	G
	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	G
	Inpatient Scores from Friends & Family Test- % positive	97.90%	98.20%	98.40%	98.3%	98.4%	98.6%	n/a	98.5%	
	A&E Scores from Friends & Family Test- % positive	69.70%	68.40%	67.00%	65.1%	95.6%	68.3%	n/a	68.9%	
	Maternity Scores from Friends & Family Test- % positive	100.00%	100.00%	100.00%	99.1%	100.0%	88.9%	n/a	96.6%	

F&F tests not available due to current restrictions (COVID-19)

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019-20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Safe	Never Events	2	3	0	2	0	1	0	1	G
	Emergency C-section Rate (as a % of total births)	15.03%	14.93%	13.01%	14.24%	15.26%	14.82%	17.53%	15.07%	
	VTE Risk Assessment	94.67%	93.79%	93.99%	93.29%	92.48%	94.21%	94.11%	93.54%	R
	Clostridium Difficile- variance from plan	-9	-1	1	13	5	5	0	10	G
	Clostridium Difficile- numbers	11	23	25	35	12	13	8	33	G
	MRSA bacteraemia	0	0	0	0	0	0	0	0	G
	Potential under-reporting of patient safety incidents	-	-	-	-	-	-	-	-	
Effective	Hospital Standardised Mortality Ratio (HED)*	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	G
	Hospital Standardised Mortality Ratio- Weekend admission (HED)*	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	G
	Summary Hospital Mortality Indicator*	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	G
	Emergency re-admission within 30 days following an elective or emergency spell at the Provider - 1 month behind	3378	3732	3692	3194	1084	943	not yet available	-	G

Domain Scorecard

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Conti. Limit	Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD
Financial Planning	F1	Capital service capacity	4			Mar-20	4	4	4	4
	F2	Liquidity (days)	4			Mar-20	4	3	3	3
	F3	I&E margin	4			Mar-20	4	4	4	4
Financial Control	F4	Distance from finance plan	1			Mar-20	1	1	1	1
	F5	Agency spend	1			Mar-20	1	1	2	2

Finance KPI Ratings Key

			Ratings: 1	Ratings: 2	Ratings: 3	Ratings: 4
Financial Sustainability	**F1**	Capital service capacity (times)	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x
	F2	Liquidity (days)	>0	(7) - 0	(14) - (7)	<(14)
Financial Efficiency	**F3**	I&E margin (%)	>1%	1-0%	0 - (1)%	< - (1)%
Financial Controls	**F4**	Distance from financial plan (%)	> = 0%	(1) - 0%	(2) - (1)%	< = (2)%
	F5	Agency spend above ceiling (%)	< = 0%	0% - 25%	25 - 50%	>50%

Key to RAG Status
Colour Indicates YTD status of variance / working capital position(green is favourable, red is adverse) Arrow indicates change in the metric since last month(up is improving, down is deteriorating)

	£millions	2019/20 Year To Date	RAG Year To Date	Trend	Commentary
Trust Deficit	Budget	0.0	G	Up	The financial position for the Trust at Month 12 is a £5.2m surplus which is £5.2m positive variance against the breakeven plan
	Actual	5.2			
	Variance	5.2			
Trust Income	Budget	776.4	G	Up	Operating income at month 12 of the financial year is £787.0m; this is £10.6m above plan.
	Actual	787.0			
	Variance	10.6			
Operating Expenditure	Budget	-755.8	G	Up	Pay expenditure is £484.3m at Month 12, £3.3m positive variance to plan. Non Pay spend is £278.9m at Month 12 which is an overspend of £10.7m.
	Actual	-763.2			
	Variance	-7.4			
Cost Improvement	Budget	40.0	R	Down	The CIP Target within the plan is £40.0m At month 12 the Trust has achieved £36.0m of savings, which is £4.0m below plan.
	Actual	36.0			
	Variance	-4.0			
Capital Spend	Budget	26.1	G	Up	The Trust's Planned Capital Expenditure for the year is £26.1m. The Trust has spent £26.1m to Month 12.
	Actual	26.1			
	Variance	0.0			
Working Capital	Current Assets	79.5	A	Down	The Trust's current liabilities exceed it's current assets by £17.3m
	Current Liabilities	-96.8			
	Total	-17.3			

	Ref	Indicator	Exception Triggers			Period	This Period Target	Performance			Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit			Last Period	This Period	YTD	RSUH ED only	County ED only	UHNM total	
Waiting Times	R1	A&E 4 Hours Waiting Time	R			Mar-20	85%	79.02%	77.56%	78.20%	62.68%	85.12%	77.56%	√
	R7	Cancer 62 days from Urgent GP Referral	R			Mar-20	85%	70.72%						√
	R13	Cancer 62 Days from Screening Programme	R			Mar-20	90%	74.07%						√
	R6	Diagnostic Waits Under 6 Weeks	G			Mar-20	>99%	99.44%	91.49%	98.18%			91.49%	√
RTT- 18 Weeks	OP34	RTT Incomplete	R			Mar-20	92%	80.16%	76.04%	80.10%			76.04%	√
Service User Support	R30	Duty of Candour	G			Mar-20	100.0%	100.0%	100.0%	100.0%				

The 4 Hour Access Standard in February achieved 79.02% (76.35% in January)

Summary:

Whilst we started to see the fruits of our improvement programme in January and February, COVID-19 preparations has superseded our urgent care improvement programme. In response to COVID-19, our focus has been on maintaining 4 hour performance under the circumstances and above all patient and staff safety. However, the requirements to manage suspected/positive COVID-19 patients differently in ED and our urgent care portals has required a different plan/response. Our response to COVID-19 has focused primarily on:

- Creating different "zones" in our Emergency Departments to manage suspected COVID-19 and non-COVID-19 patients, which has also required an adjusted workforce model. This also includes our urgent care portals, inc. AMRAU, AMU and AEC.
- Minors at Royal Stoke has transferred to Haywood Walk-in Centre and at County minor patients are now flowing to the Fracture Clinic;
- Significant capacity has been freed up to manage coronavirus patients: nearly 600 empty beds (inc. 8 empty wards) and a significant reduction in MFFD (lowest levels recorded). Additionally, a comprehensive critical care plan to effectively quadruple capacity has been developed.
- Implementation of new medical rotas; including comprehensive 7 day coverage, a Consultant Physician overnight, twice as many Registrars overnight, and a significant increase in the number of junior doctors in and out of hours, particularly in COVID-19 wards.
- The development of a dedicated 'operational hub' in the West Building to provide significant scrutiny, oversight and support to ensure the timely management and discharge of patients; very low levels of MFFD patients in the Trust.

Delivery of the Standard - Performance against the 4 Hour Standard in March 2020 achieved 77.6%, which was a 1.5% deterioration based on February 2020. In addition the Trust reported 34 - 12 hour trolley waits.

Attendances at both Royal Stoke and County Hospital were down 18.9% & 20.7% respectively from February, an average of 116 less attendances per day across both sites. When comparing to March 2019 attendances were down for Type 1 (Royal Stoke & County) by 39.6% with performance 6.6% lower than March-19 (74.6% vs. 68%).

Overall LHE attendances at the end of February and beginning of March crudely averaged 2483 per day, whereas towards the end of March this reduced to 1400 (↓ 48.6%).

The first confirmed case of COVID was 9th March and in total there were 141 confirmed COVID-19 patients, of these 38 were discharged. The Trust sadly reported 26 deaths.

The 34 – 12 hr. trolley waits mainly occurred towards the latter half of the month. Key reasons for this was the delays that occurred waiting for a clean side room for those patients who were tested for COVID-19 and awaiting results.

Type 1 ambulance attendances to RSUH and County fell in March by 12.5% & 12% respectively and significantly the ambulance corridor occupancy fell from X in February to 708 in March (48.5%). The aggregate delay in minutes increased from 329 to 332 minutes;

The stranded and super stranded patients also fell . The stranded were on average 64 patients less each week and the super stranded an average 26 patients;

The Medical occupied beds at midnight fell from a daily average of 507 in February to 442 in March;

The number of ambulance handovers >60 minutes increased by 5 to 35 for March.

Next steps:

COVID-19 plans in place, with two primary changes to be implemented in April 2020 to manage the growth in COVID-19 cases:

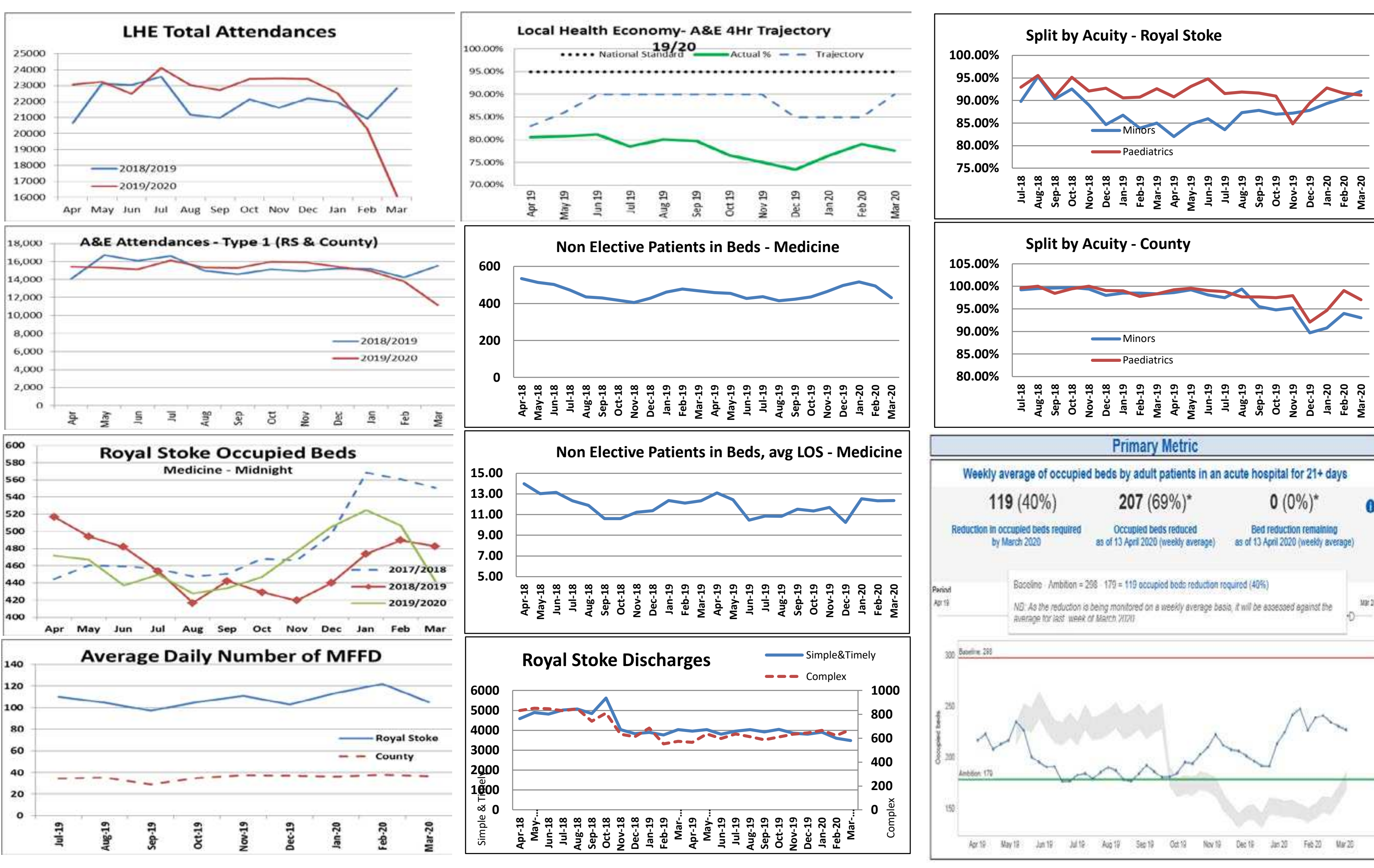
A new ("one-team") model for the Site Operational and Divisional Flow Teams to manage flow and discharges across the organisation, including the robust management of COVID-19 wards and side rooms.

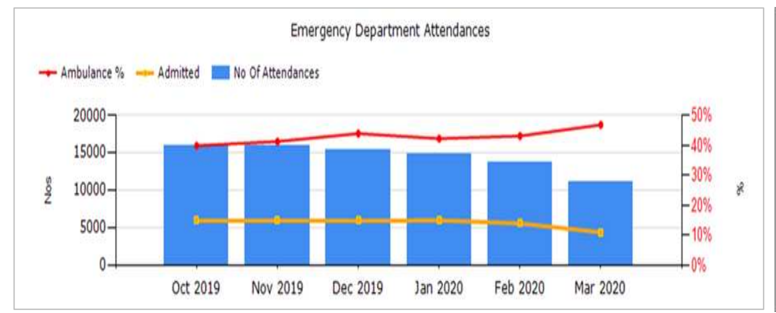
24/7 Consultant on site cover on the Royal Stoke site.

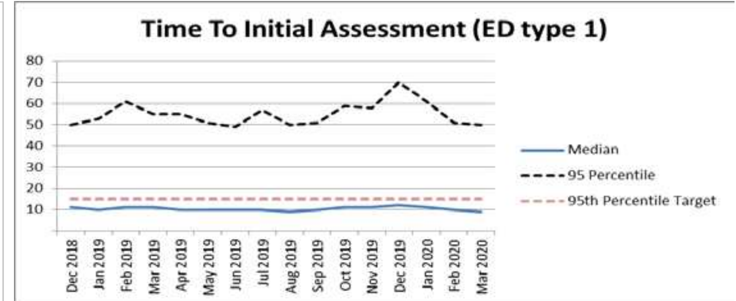
Risks

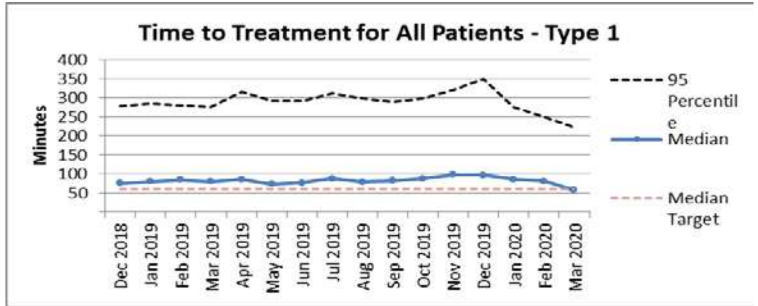
The progression of COVID-19 and increases in demand will impact on performance delivery.

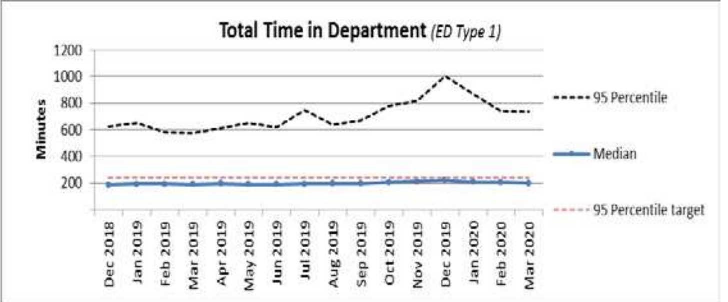
R1: A&E 4 Hours Waiting Time- Key Drivers











Summary

Initial Assessment

The initial assessment is when a patient is assessed by an emergency care doctor or nurse to allow them to determine a priority for treatment (sometimes called triage). The assessment would normally include a brief history of the patient's condition, pain score and vital signs (blood pressure, temperature, pulse).

The median Time to initial Assessment for Type 1 attendances (Royal Stoke & County) was 9 minutes (february 10 mins) and the average for the year was 10 minutes against the standard of 15 minutes. The 95th percentile was 50 minutes versus the 51 minutes in February (with an average of 55 over the year).

Target: A 95th Percentile time to assessment at or below 15 minutes

Treatment time

The treatment time is the time when a patient is seen by a doctor who can diagnose the problem, decide the management plan for the patient and arrange or start treatment if required.

Time to treatment (95th percentile) reduced again in February to 223 minutes (February was 249 mins). For the same period last year the 95th percentile was 276minutes. The average for the year was 293 minutes.

Target: A median wait at or below 60 minutes.

Total time in department

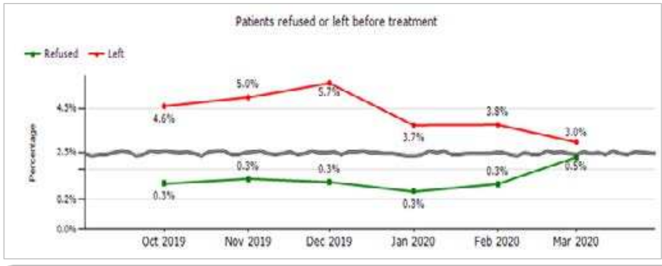
The time a patient spends in the A&E department under the care of hospital staff.

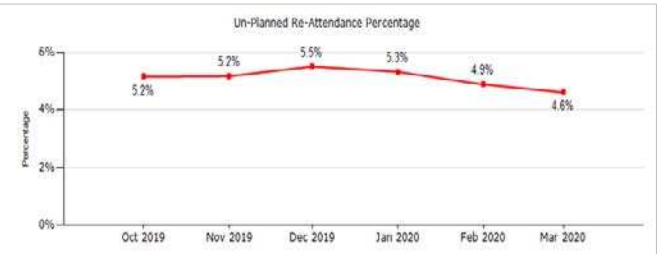
The 95th percentile in February was 736 minutes (February was 743 mins).

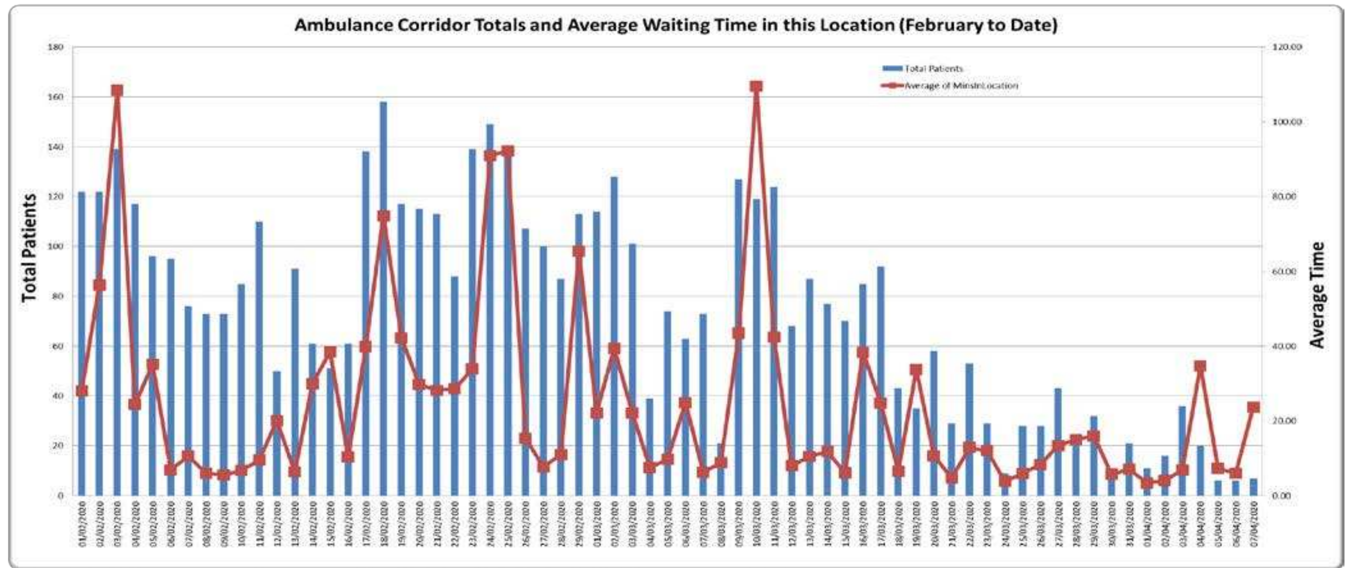
Target: A 95th percentile wait at and below 4 hours.

This is based on a total number of attendances for Royal Stoke & County, Type 1 of 11,132

R1: A&E Clinical Quality Indicators (2)



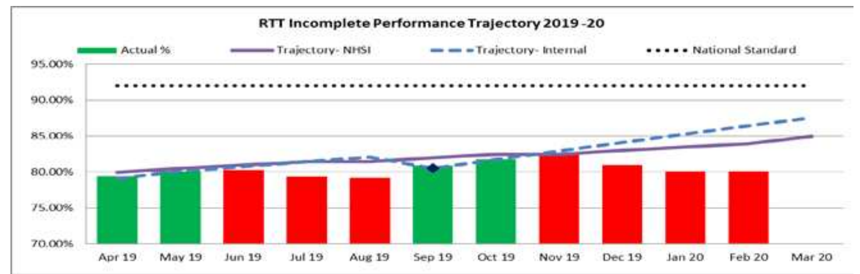




Summary
Left without being seen
A patient who leaves without being seen is one who registered with the receptionist in the ED but then left the department before they saw a doctor.
Patients leaving before being seen for Type 1 attendances (Royal Stoke and County) was 3.0%, down from 3.8% in February. For those patients who refused the performance was 0.5%
Target: A rate at or below 5%.

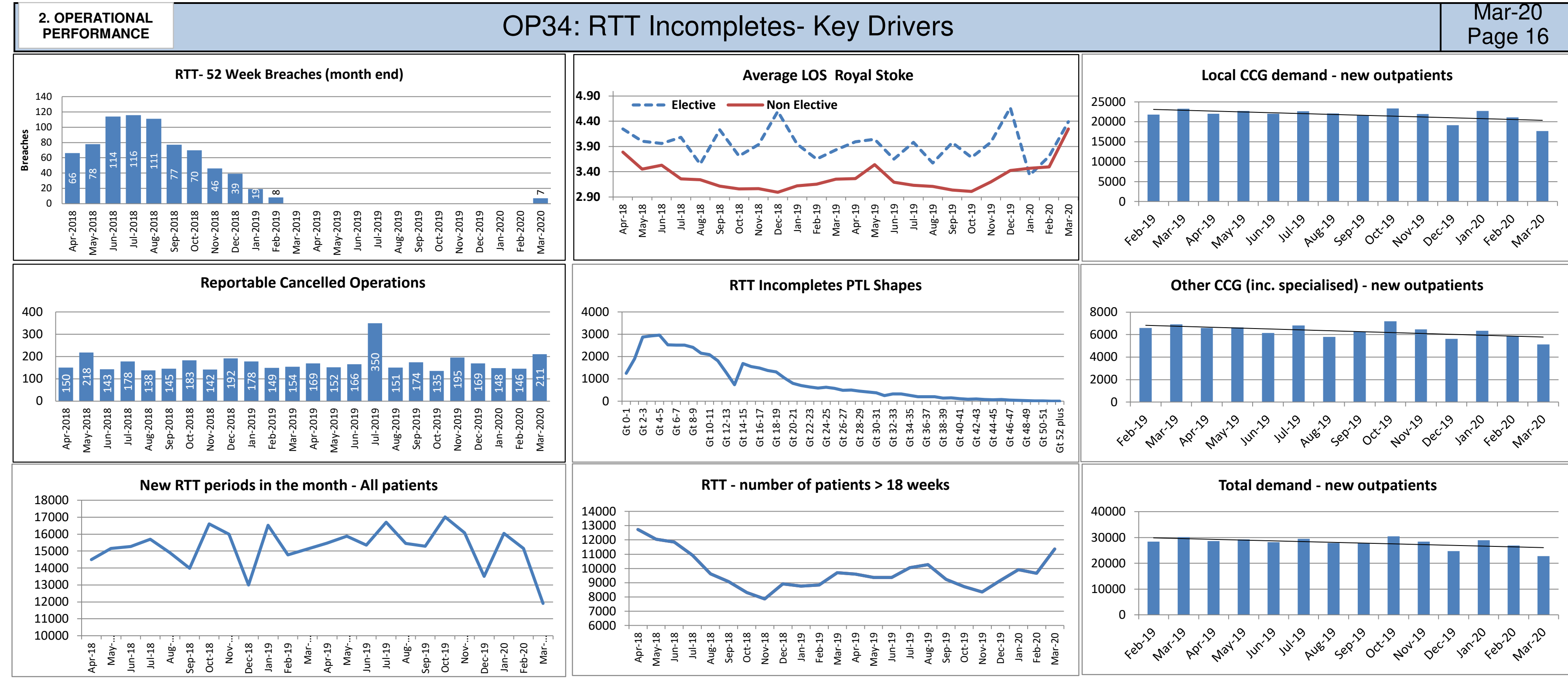
Unplanned re-attendance
An unplanned re-attendance is where a patient returns to an ED within 7 days of a previous ED attendance. This may be for the same condition or a different one.
For Type 1 (Royal Stoke and County), Re-attendances in March are at 4.6% - below the threshold of 5%.
Target: A rate at or below 5%.

Ambulance Corridor
Ambulance corridor occupancy fell in March with the average number of minutes reducing (numbers fell from 1377 patients in Februaryr to 332 in March).



Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Delivery of the standard The RTT Incomplete Pathway standard in February achieved 80.16% against an Internal trajectory of 86.46% and a NHSI operational plan of 84.0%.The number of Incomplete pathways has risen to 48743 (from 48357). Focussed validation work across both corporate and speciality teams is being enacted during March to further improve the February position (cut off 13/3) and drive down the waiting list volume to a figure that will land under the revised operational planning trajectory for 2020 for April 2020. **PTL Growth Drivers:** Growth in Incomplete pathways is seen mainly in Colorectal, Upper GI, Urology, ENT, Gastroenterology, Respiratory Medicine ENT is affected by the long waiting times in Respiratory service. Patients referred for sleep study tend to wait a long time for the appointment and cannot be validated off the PTL until a decision on management option is made. Gastroenterology & Respiratory: no distinction between Straight to Test(RTT) and Direct Access(non RTT) referrals so all registered as RTT pathways on Medway which requires D/Q attention. The Respiratory new referrals demand impacts until treatment capacity in business case is fully deployed. Urology: Multiple pathways created for same patient e.g. CNS Nurse clinic, Consultant clinic, Cystoscopy clinic all having different pathways for same patient. Pathways are being restarted on telephone f/up appointments. D/Q and targeting of staff for training/monitoring commenced. Trauma: impact of 14 bed loss with reduction in high volume, day cases has affected waiting list size. **Positive Assurance:** The Trust continues to report zero patient waiting over 52 weeks, through proactive monitoring and escalation via the corporate validation team. Decommissioning of winter escalation capacity has seen handover of 14 beds back to specialised division to ramp up electives for March. Colorectal have improved performance in February by 3% with test of change pilots seeing and treating or clock stops for patients earlier in the pathway. Colorectal follow up overdue appointments significantly reduced (73% since April-19) due to focussed Divisional clinical validation. Ophthalmology Follow up overdue appointments also reduced since Oct-19 by 59%. ENT and Vascular Surgery have maintained performance but new team in vascular are to focus on pulling forward treatments and validation to improve this position for March. Gastroenterology and Respiratory Medicine have held performance even with growing demand based on validation and additional capacity. Paediatrics has improved performance for the second month following a challenging November and December with a high number of emergency admissions were seen for RSV (regional outlier) where elective capacity was compromised for non elective paeds. **Risks to Delivery and Mitigation:** Pressures in Emergency department and increase in surgical non elective demand for flu/Corona virus – adverse impact on elective operations due to extended NCEPOD lists. With continued IR 35 impact.	Enhanced governance grip through a revised Accountability Framework; Weekly Divisional Access meetings. Weekly COO led Divisional check and challenge performance meetings with ADs. The Trust is working to improve the position of the long waiters currently on the PTL by conducting targeted validation within our most challenged specialties.40 week plans have been developed and the required capacity to improve the position is being sourced. Improvements are also being made to operational grip and performance assurance processes in this area. T&O Elective beds used for escalation capacity to be returned to Ward 110 in February. Re organisation of the theatre performance group now to be chaired by the AD. RTT Recovery Plans are currently been populated by the operational teams this to be monitored via the COO led Access & performance meetings. Working with CCG to manage demand ,external providers assisting in activity clearance (SHS),incentivised internal lists ,increase in length of theatre lists	A
	Next Steps: Divisional performance improvement trajectories reset to end of March to ensure 52 ww compliance and tracking of RTT standard. Weekly monitoring 40/52 wk position with expedited escalation and mapping of specialty service changes. AD-led Theatre Performance Group meetings re-established.	A
	Not Initiated → Scoping → In Progress → Complete	

OP34: RTT Incompletes- Key Drivers



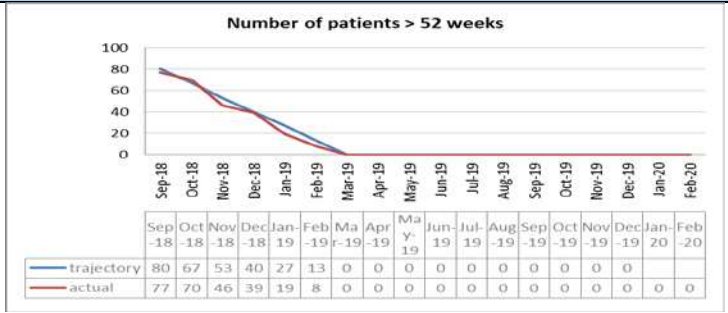
Summary
The graphs above present the key drivers for the Trust RTT performance against the national standard.

Key drivers to note for January:
There were zero > 52 week waiters reported.

There was a total of 146 operations cancelled at the last minute. No significant variance was noted against previous months. Theatre touch time Utilisation in February was 79.2% (January was 79.3%).

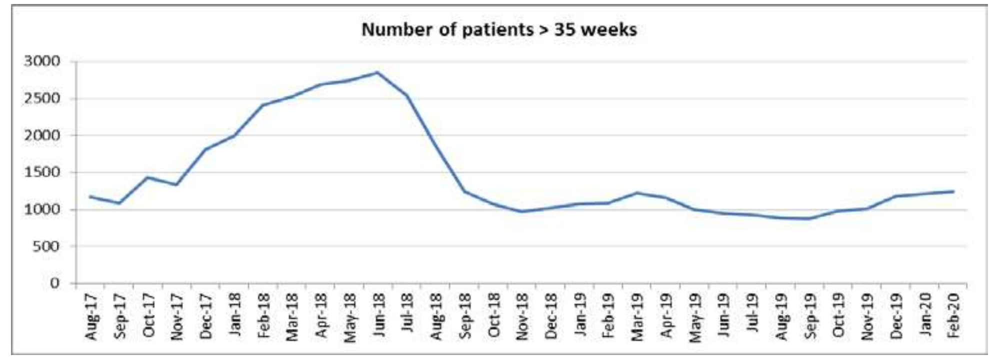
The remaining top 4 reasons for cancellations:
1. No Consultant available
2. Consultant - Cancelled for an emergency - this increased
3. No Suitable Beds Available
4. No theatre time available

DEMAND: The three demand graphs represent - Total demand and demand split by local CCG's and other CCG's (which includes specialised commissioning). Overall demand is decreasing.
For Total demand - there has been an 6.7% fall compared to the same time last year (February 19).
For local demand there was a decrease of 4.7%.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
trajectory	80	67	53	40	27	13	0	0	0	0	0	0	0	0	0	0		
actual	77	70	46	39	19	8	0	0	0	0	0	0	0	0	0	0	0	0

Number of patients > 40 weeks



Over 40 week patients - key treatment functions

Key Treatment Functions	Total
100 General Surgery	16
101 Urology	102
104 Colorectal	44
106 Upper Gastrointestinal Surgery	30
107 Vascular Surgery	6
108 SPINAL Surgery	40
110 Trauma & Orthopaedics	15
120 ENT	8
130 Ophthalmology	3
140 Oral Surgery	7
144 Maxillo-Facial	10
160 Plastics	5
301 Gastroenterology	49
320 Cardiology	12
340 Respiratory Medicine	151
400 Neurology	20
502 Gynaecology	6

OUTPATIENTS

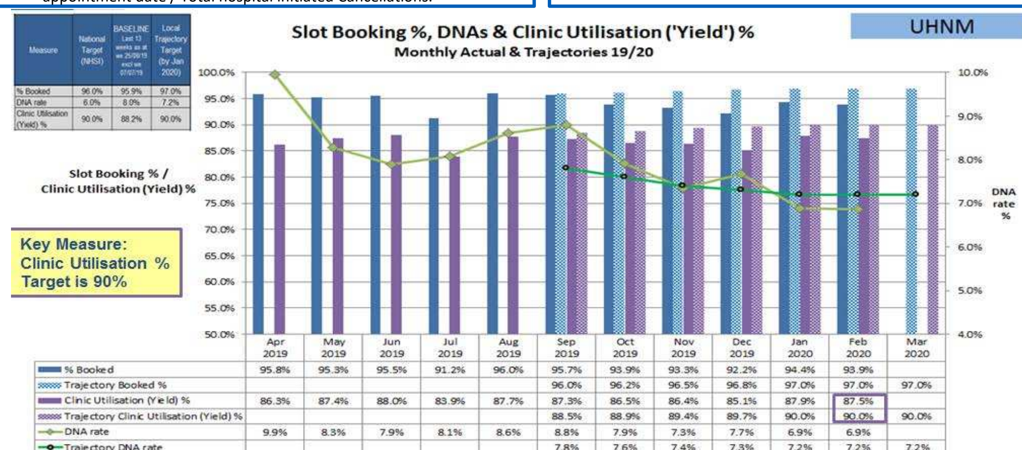
All graphs/information derived from the OP Session Slot Utilisation DNA and Hosp Cancellations Report, and OP Appts Hospital / Patient Cancellation Grid (01/03/20), for clinics flagged as 'yield'.

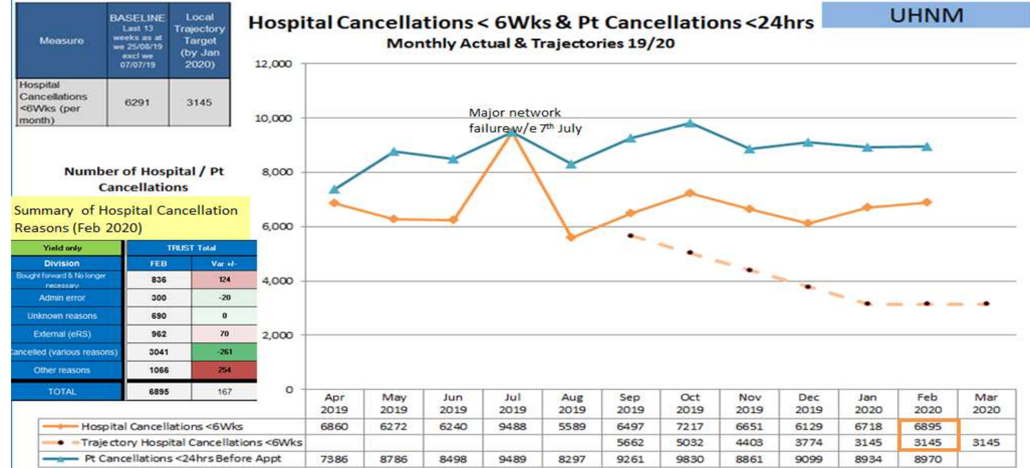
KPI Descriptions:

- Clinic Utilisation ('Yield') = Slot booking % x (1-DNA rate)
- Slot Booking % = Patients Booked Total / Capacity Total
- DNA (Did not attend) = Patients who didn't attend / Total Booked
- Hospital initiated Cancellations (HICs) <6 weeks = Booked appointments cancelled by the trust less than 6 weeks before the appointment date / Total hospital initiated Cancellations.

KPI Targets:

- Clinic Utilisation ('Yield') = 90%
- Slot Booking % = 97%
- DNA (Did not attend) = 7.2%
- HICs < 6 Weeks = Half baseline of 6291 per month: 3145





Clinic Utilisation % (Key composite target) 90% **87.5%** vs **90%**

Booking % (93.9% vs target 97.0%) – % bookings have decreased slightly vs last month; fortnightly specialty meetings include the identification of outlier clinics (prospectively & retrospectively). Specific Specialties requiring further intervention have been identified.

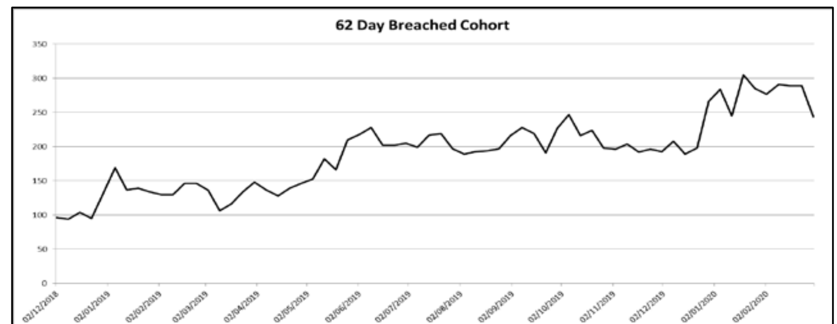
DNA% (6.9% vs target 7.2%) – The DNA rate has continued to reduce and is now below 7%. From discussions with BI, the Netcall load is no longer dependent on the timing of the data warehouse load so this risk has now been successfully mitigated (whilst reminders may be not be based on the most recent changes if a load is delayed). Divisions are being challenged to identify specialty-specific actions to improve on their performance, and a rollout plan for movement to partial booking is being confirmed. SOP for clinicians for viewing DNAs in iPortal has been shared in clinics to help apply DNA policies, with a supporting letter sent via Deputy Medical Director.

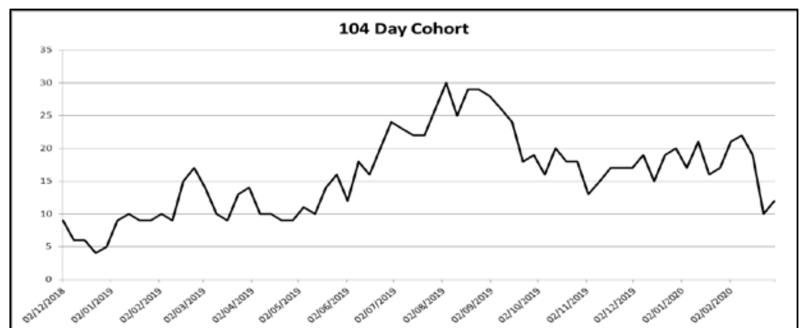
Hospital cancellations (6895 vs target 3145) – Still significantly above target. Reasons for cancellations now being provided; although there are over 40 drop down options. All divisions have been asked to investigate drivers for hospital cancellations, and opportunities to address these, with a plan to reduce. Electronic CAF progressing.

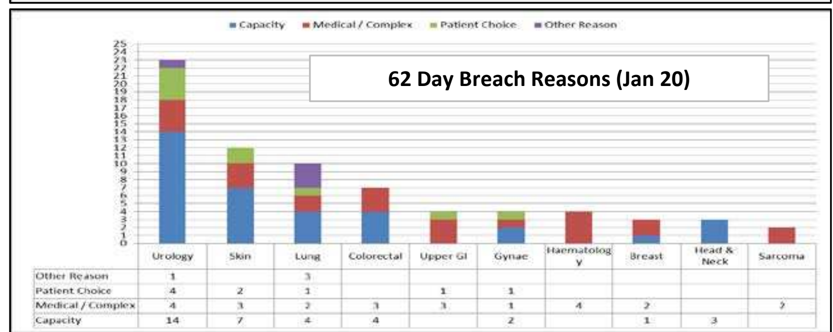
OP KPIs Summary Update

Level	KPI	Jan 2020 Target	Feb 2020 Current Performance	Feb 2020 RAG	Feb 2020 vs last month
UHNM	Clinic Utilisation %	90.0%	**87.5%**	A	-0.4%
	Bookings %	97.0%	**93.9%**	A	-0.4%
	DNAs %	7.2%	**6.9%**	G	0.0%
	Hospital Cancellations	3145	**6895**	R	177
CWD	Clinic Utilisation %	90.0%	**88.8%**	A	-1.6%
	Bookings %	96.3%	**94.7%**	A	-1.7%
	DNAs %	6.6%	**6.3%**	G	0.1%
	Hospital Cancellations	579	**1417**	R	209
Medical	Clinic Utilisation %	85.9%	**82.1%**	A	0.2%
	Bookings %	96.0%	**91.2%**	R	0.2%
	DNAs %	10.5%	**10.0%**	G	0.0%
	Hospital Cancellations	329	**762**	R	96
Specialised	Clinic Utilisation %	89.1%	**85.3%**	A	0.5%
	Bookings %	96.5%	**91.9%**	R	0.1%
	DNAs %	7.7%	**7.2%**	G	-0.4%
	Hospital Cancellations	762	**1571**	R	-142
Surgical	Clinic Utilisation %	92.3%	**89.7%**	A	-0.7%
	Bookings %	98.7%	**95.6%**	A	-0.5%
	DNAs %	6.5%	**6.2%**	G	0.2%
	Hospital Cancellations	1476	**3145**	R	14

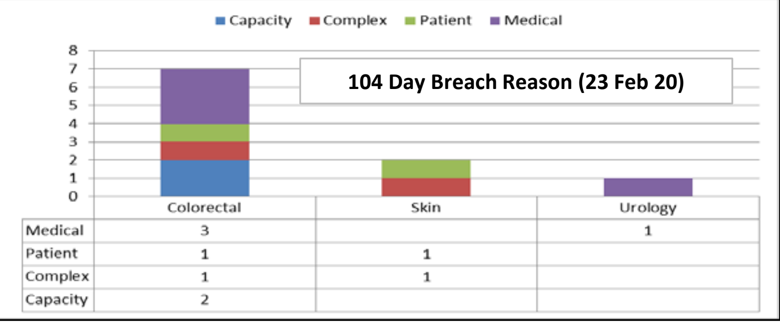
R7: Cancer 62 Days- Key Drivers



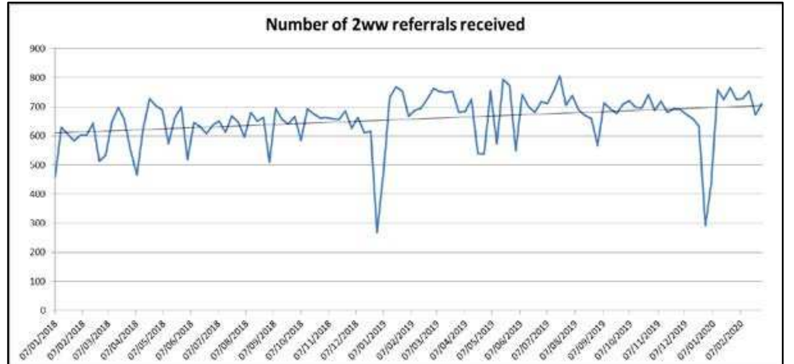




	Urology	Skin	Lung	Colorectal	Upper GI	Gynae	Haematology	Breast	Head & Neck	Sarcoma
Other Reason	1		3							
Patient Choice	4	2	1		1	1				
Medical / Complex	4	3	2	3	3	1	4	2		2
Capacity	14	7	4	4		2		1	3	



	Colorectal	Skin	Urology
Medical	3		1
Patient	1	1	
Complex	1	1	
Capacity	2		



The graphs above present the key drivers for the Trust 62 day Cancer performance against the national standard (85% of patients treated within 62 days from referral). The NHS Single Oversight Framework requires Trust's to achieve the national 85% standard as a measure of operational performance, however failure to deliver the this is used as a trigger in relation to NHSI considering appropriate levels of support for providers. The provisional Trust level performance for 62 day Urgent GP referrals in February is 70.72% (as at 27.03.20).

Due to the increase in colorectal GP 2ww referrals the Trust has not achieved the 2ww standard in February (74.25% as at 27.03.20), as predicted.

104 Day improvement actions in place since September 2019. Plan is for the directorate teams to closely monitor this cohort of patients and to reduce capacity delays down to minimum so we can baseline the expected number of pt. choice/complex tertiary pathway delays we would expect given our cancer centre status and volumes of referrals for discussion with NHSE/I.

R7: Cancer 62 Days of Urgent GP Referral

62 Day Standard (GP 2ww Referrals) 85.0% National Standard (treated within 62 days)

University Hospitals of North Midlands NHS

Provisional Data *Last Updated 13/03/2020*

Confirmed Diagnosis:

Cancer Site	Location	Feb-20 Actual Patients <62 days	>62 days	Total	Accountable Patients <62 days	>62 days	Total	%<62
Brain/CNS (Specialised)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Breast (Surgery)	UHNM Combined	26	3	29	26.0	3.0	29.0	89.66%
Breast Symptom (Surgery)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Colorectal (Surgery)	UHNM Combined	0	9	9	0.0	9.0	9.0	0.00%
Gynae (CSS/W&C)	UHNM Combined	5	2	7	5.0	1.5	6.5	76.92%
Haematology (Medicine)	UHNM Combined	4	3	7	4.0	2.5	6.5	61.54%
Head & Neck (Surgery)	UHNM Combined	3	3	6	3.0	3.0	6.0	50.00%
Lung (Medicine)	UHNM Combined	3	11	14	2.5	10.5	13.0	19.23%
Other	UHNM Combined	0	0	0	0.0	0.0	0.0	
Paediatrics (CSS/W&C)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Sarcoma (Specialised)	UHNM Combined	1	0	1	1.0	0.0	1.0	100.00%
Skin (Surgery)	UHNM Combined	18	1	19	18.0	1.0	19.0	94.74%
Upper GI (Medicine)	UHNM Combined	10	7	17	10.0	6.5	16.5	60.61%
Urology (Surgery)	UHNM Combined	43	15	58	43.0	13.0	56.0	76.79%
Trust Exc Breast Symptom	UHNM Combined	113	54	167	112.5	50.0	162.5	69.23%
Trust Inc Breast Symptom	UHNM Combined	113	54	167	112.5	50.0	162.5	69.23%

	Jan-20	Feb-20	Feb-20 Trajectory NHSi	Fan-20 Trajectory Internal	Standard
Two week wait	74.26%	74.25%	95.61%		93%
2ww Breast symptomatic	100.00%	96.63%	97.30%		93%
31 Day First Treatment	94.46%	95.27%	97.39%		96%
31 Day Subsequent Surgery	77.19%	88.37%	94.92%		94%
31 Day Subsequent Anti-Cancer	96.20%	100.00%	100.00%		98%
31 Day Subsequent Radiotherapy	90.91%	95.60%	98.18%		94%
62 Day (2ww) First Treatment	64.07%	70.72%	85.53%	74.00%	85%
62 Day Screening First Treatment	73.17%	74.07%	91.30%		90%

Data last updated 27/03/20. Cancer performance is still provisional until fuinal position reported 07/04/20

Root cause analysis/ Key lines of enquiry

Positive Assurance:

2WW Forensic analysis of PTLs, daily demand and capacity reviews, escalation /assurance provided by Senior Divisional Teams and risks identified early and mitigated where possible, all resulting in a steady improvement.

104 Days: Significant reduction in the number of patients of 104 days – down from 25 to 12 through specialties commencing weekly clinical validation.

62 days – an improved assurance cycle together with a strengthened escalation policy for each patient pathway, early warning systems in place and opportunity to bring forward treatments. Validation of backlog 63 day + together with retrospective validation of breaches and has also improved performance. February performance as at 27/03/20 is 70.72%.

WMCA has offered 93K to West Midlands Trusts UHNM has identified £57k for schemes to support improvement in cancer performance before year end: PTL deep dive validation to support opportunities for improved performance due to strict application of best practice guidance. (Outcomes to be subject to clinical and corporate governance approval prior to final sign off and CWT upload); development of intuitive Cancer dashboard; production of patient business card.

A deep dive of the Gynaecology specialty is underway to accelerate recovery to improve overall Trust performance whilst sustainability plans are developed and strengthened. This is to be followed with UGI, Urology, Breast and Skin.

The recently introduced Governance & Performance framework is beginning to work well with attendance monitored, focus given to ensuring effective plans are in place to manage patients through their pathway within target, escalating blockages and ensuing that assurance and risk are clearly documented. These meetings feed directly into the Corporate Cancer / COO meeting and the new cancer weekly report.

IST critical friend visit on 24th and 27th February 2020 to support our cancer recovery programme progressed – verbal debrief very positive. Report awaited.

Colorectal recovery plan commenced with PTL referrals reduced to circa 200 (40% reduction since January) with the new Triage to Test model.

Delivery of the 2ww and 62 day standards:

The Cancer 62 day performance for February is 70.72% against an internal trajectory of 74.0% (as of 27.03.2020).

Total cancer 62 day treatments for February '20 to date are 175.5. However, there are additional treatments (8 skin) with no confirmed diagnosis many of which are waiting histology results, this may yield more treatments and improve the month end.

2WW appointments in February 20 were slightly less at 2555 (not including breast symptomatic) against January 2552.

Focus on 2ww and 104 day performance improvement.

Risks to Delivery and Mitigation

Colorectal & Urology– diagnostics capacity available to keep apace with demand on TTT & 28 day pathway.

Commissioner support for new patient choice model and validation framework

Fall in Outpatient attendances due to Coronovirus scare

External Pressures / Increased Referral Rates

- UHNM receives 63.1% of all Staffordshire and S-O-T 2ww referrals. This has increased from 60.7% in the last 3 years. More cancer activity is referred to UHNM as a proportion, than other planned care activity and this percentage is growing, confirmed by NSHE.
- UHNM receives 68.8% of all Staffordshire and S-O-T lower GI 2ww referrals.
- Lower GI activity from Staffordshire and S-O-T CCGs to UHNM has grown 48% in the last 3 years (growth from SOT CCG is less [42%])
- Lower GI activity from NS CCGs to UHNM has grown 54 % in the last 3 years. If we disregard East Cheshire reductions this equates to 48% growth to UHNM not offset by reductions elsewhere so the East Cheshire reduction does explain some of why NS growth is higher. It doesn't fully explain the differences in growth between NS and SOT.
- Of further concern for Lower GI is the conversion rate to a diagnosis which has fallen over the past four years against the increased demand. In 15/16 the demand was 4538 with a conversion rate of 4.4% whereas in 18/19 the demand was 6731 (48% increase) with aconversion rate of 2.9%. This is a targeted area for improvements.

Action Plan

Next Steps:

Actions for March within the Cancer Improvement Plan to be implemented and performance improvement tracked.

Development of new Cancer Performance Dashboard with configuration requirements completed and first draft delivered by 31st March 2020.

28 Day FDS PTL validation and clearance to ensure clean pathways from commencement of formal 28 day standard reporting April 2020.

Triage to Test (TTT) colorectal pilot to continue with weekly monitoring of outputs. NOTE: 62 day standard for colorectal will be impacted as a consequence of the clearance plan and this will be documented within the performance trajectory.

Urology cancer PTL clear down to commence which will involve booking backlog patients to right size demand. NOTE: 62 DAY standard impact as same as Colorectal.

New Cancer Booking Script to be introduced to ensure optimised slot utilisation of 2ww appointments with daily huddle with Cancer Bureau to ensure all pts booked < 8 days or escalations completed.

Scoping commenced to support key workforce constraints for template biopsies with alternative model deployed in other cancer centres and continued population

Cancer eLearning packages have been undertaken by the COO and Deputy COO and have been forwarded on to Associate Directors to support with training.

Cancer Alliance:

IST review of Cancer Services PTL and Governance meetings; to commence 24th Feb 2020

A cancer Alliance-led external review of Colorectal demand, pathway delivery and recovery plans, to commence March-20

The Cancer Alliance to support an external review of the quality of the 2ww Colorectal referrals, commenced early February-20

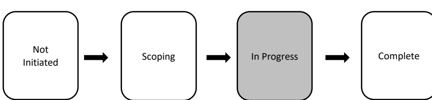
The Alliance transformation monies is supporting the implementation of best practice pathways in Colorectal, UGI, Lung; and Urology prostate – timelines agreed and UGI has already commenced the pilot

Cancer alliance are supporting UHNM in the delivery of the Lung Health check programme which commenced April 2019. Further finding has been secured for year 2 (20/21). This will allow more patients to be assessed through the screening programme.

Funding from the Cancer Alliance has supported a daily mini Lung MDT, this has streamlined the front end of the pathway.

RAG: A

Progress



R13: Cancer 62 Day screening

62 Day Standard (Screening Referrals) 90.0% National Standard (treated within 62 days)

University Hospitals of North Midlands NHS Trust

Provisional Data *Last Updated 11/03/2020*

Confirmed Diagnosis:

Cancer Site	Location	Feb-20 Actual Patients <62 days	Actual Patients >62 days	Actual Patients Total	Accountable Patients <62 days	Accountable Patients >62 days	Accountable Patients Total	%<62
Breast (Surgery)	UHNM Combined	18	3	21	18.0	3.0	21.0	85.71%
Colorectal (Surgery)	UHNM Combined	1	4	5	1.0	4.0	5.0	20.00%
Gynae (CSS\W&C)	UHNM Combined	1	0	1	1.0	0.0	1.0	100.00%
Trust	UHNM Combined	20	7	27	20.0	7.0	27.0	74.07%

Cancer 62 Day screening

Site	Feb-19	Feb-20	Variance
UHNM	87.5%	74.1%	-13.4%

Month	Within	Outside	Total	%
Jul-19	26	5	31	83.87%
Aug-19	23	3.5	26.5	86.79%
Sep-19	24	2	26	92.31%
Oct-19	38	1.5	39.5	96.20%
Nov-19	16	2	18	88.89%
Dec-19	22	5.5	27.5	80.00%
Jan-20	15	5.5	20.5	73.17%
Feb-20	20	7	27	74.07%

Root cause analysis/ Key lines of enquiry

The patients on the 62 day cancer screening pathway are patients referred from the national screening programme. The operational standard is 90%.

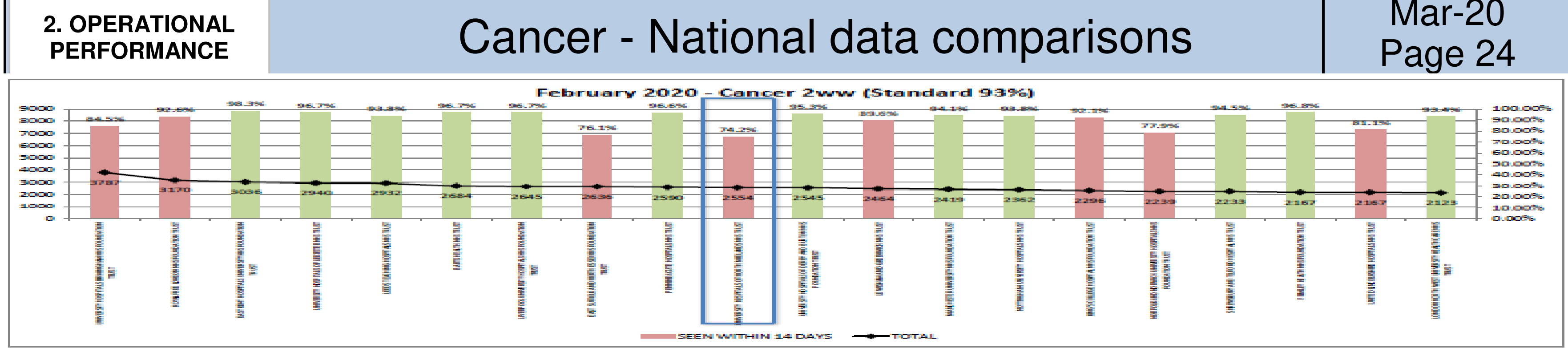
The number of patients in this category are low and as a general rule any more than 1 or 2 breaches will result in under achievement of the standard.

There were 7 breaches in February, 3 breast (2 complex, 1 capacity) & 4 colorectal (1 outpatient capacity, 1 delay to diagnostic test, 1 patient choice, 1 complex), data remains provisional at the moment.

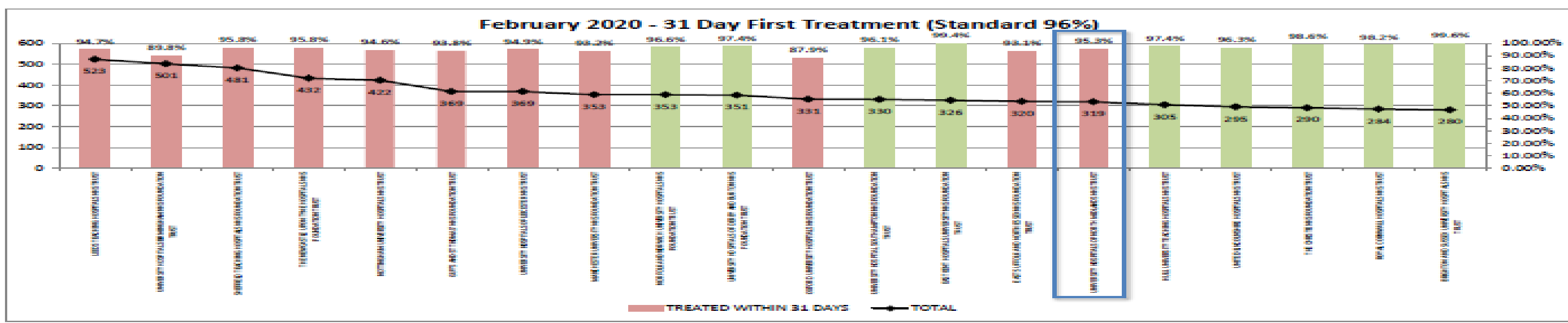
Action Plan	RAG
• Breast screening pathway representatives from screening and generally surgery attend cancer forecast meetings	G
• The weekly cancer PTL meetings continue, each individual patient's pathway is discussed to identify updates and actions to mitigate delays in the pathway.	G

Progress

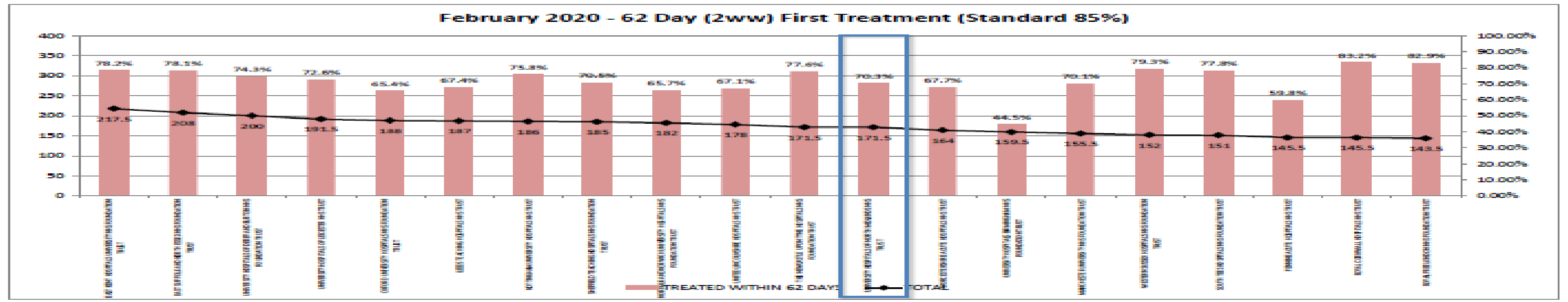
Not Initiated ➡ Scoping ➡ In Progress ➡ Complete



The 2ww comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts.



The 31 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts.



The 62 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts.

Cancer - Regional data comparisons

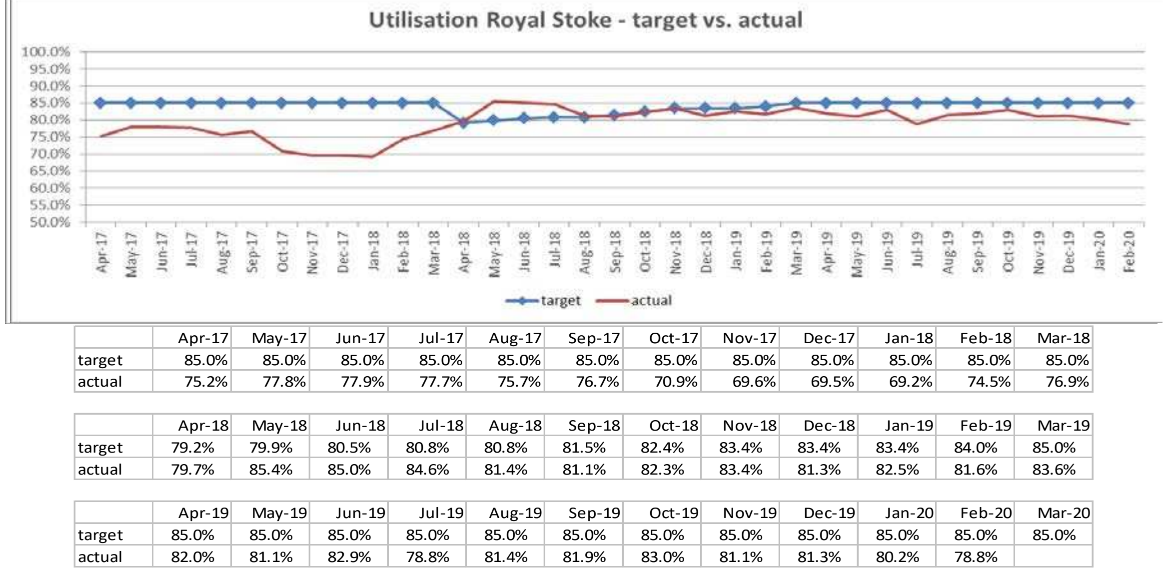
February 2020 - Regional Cancer 2ww (Standard 93%)

February 2020 - Regional 31 Day First Treatment (Standard 96%)

February 2020 - Regional 62 Day (2ww) First Treatment (Standard 85%)

Compared to the Region, UHNM has the 2nd highest number of 2ww referrals. For 31 day, 3rd highest in treatments. For 62 day treatments 2nd highest in treatments.

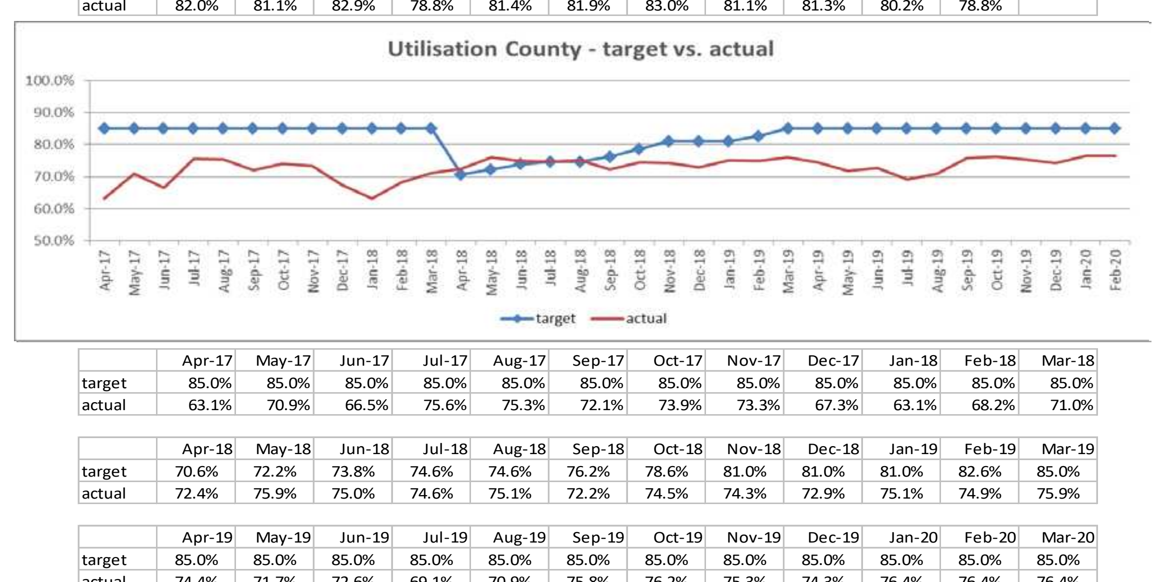
Theatre Utilisation



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	75.2%	77.8%	77.9%	77.7%	75.7%	76.7%	70.9%	69.6%	69.5%	69.2%	74.5%	76.9%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	79.2%	79.9%	80.5%	80.8%	80.8%	81.5%	82.4%	83.4%	83.4%	83.4%	84.0%	85.0%
actual	79.7%	85.4%	85.0%	84.6%	81.4%	81.1%	82.3%	83.4%	81.3%	82.5%	81.6%	83.6%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	82.0%	81.1%	82.9%	78.8%	81.4%	81.9%	83.0%	81.1%	81.3%	80.2%	78.8%	



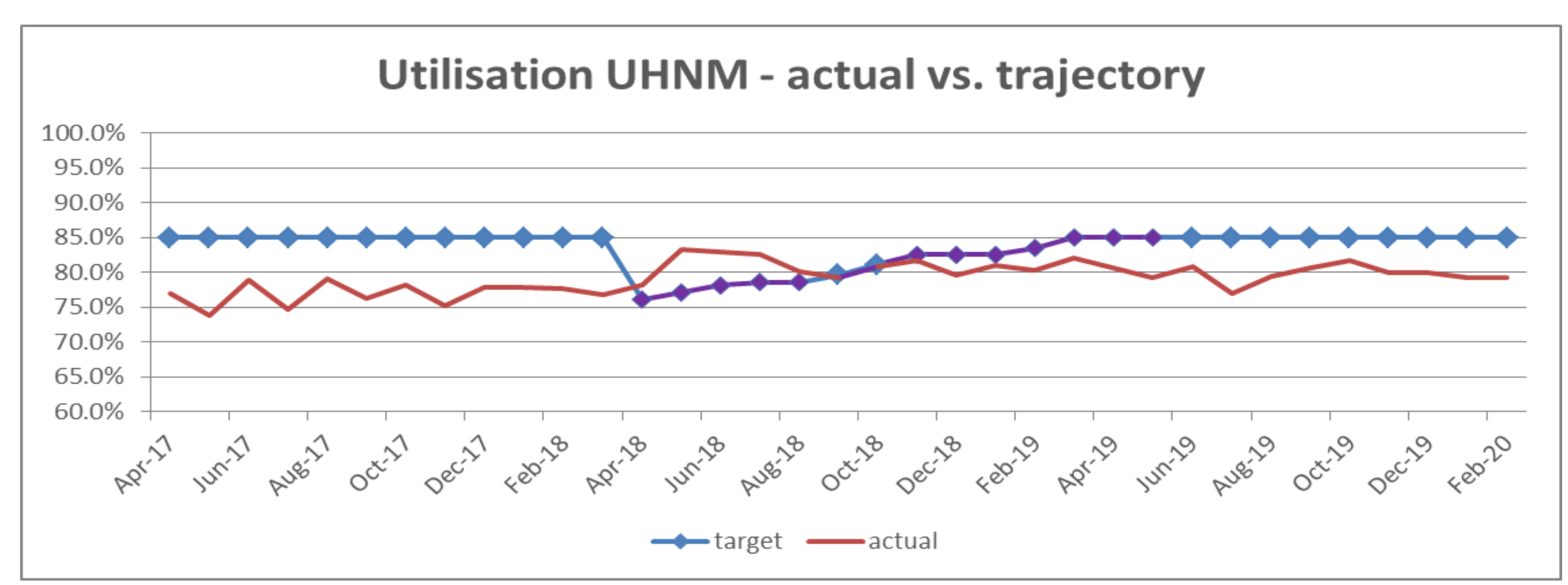
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	63.1%	70.9%	66.5%	75.6%	75.3%	72.1%	73.9%	73.3%	67.3%	63.1%	68.2%	71.0%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	70.6%	72.2%	73.8%	74.6%	74.6%	76.2%	78.6%	81.0%	81.0%	81.0%	82.6%	85.0%
actual	72.4%	75.9%	75.0%	74.6%	75.1%	72.2%	74.5%	74.3%	72.9%	75.1%	74.9%	75.9%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	74.4%	71.7%	72.6%	69.1%	70.9%	75.8%	76.2%	75.3%	74.3%	76.4%	76.4%	76.4%

February theatre utilisation subject to validation

Theatre Utilisation



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	76.9%	73.8%	78.8%	74.6%	79.1%	76.2%	78.2%	75.2%	77.9%	77.9%	77.7%	76.8%

trajectory	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
actual	76.1%	77.1%	78.1%	78.6%	78.6%	79.6%	81.1%	82.5%	82.5%	82.5%	83.5%	85.0%
	78.2%	83.3%	83.0%	82.6%	80.2%	79.2%	80.8%	81.6%	79.5%	81.0%	80.3%	82.0%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	80.6%	79.2%	80.9%	76.9%	79.5%	80.7%	81.7%	79.9%	79.9%	79.3%	79.2%	

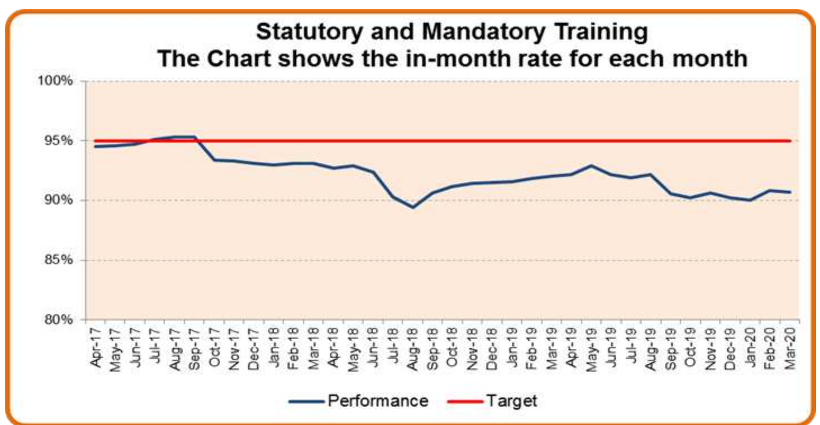
February theatre utilisation subect to validation

Domain Scorecard

	Ref	Indicator	*Exception Triggers* Month Target	Step Change	Conti. Limit	Period	This Period Target	*Performance* Last Period	This Period	YTD	*Site Breakdown* RSUH	County	UHNM	Except.
Workforce	OH5	Executive Team Turnover	G			Mar-20	3.00%	0.00%	0.00%	30.8%				
Workforce	W19	Turnover Rate	G			Mar-20	<11%	8.75%	8.57%					
Workforce	OH7	Proportion of temporary staff (snapshot)				Mar-20		6.31%	6.75%					
Workforce	W20	Sickness Absence Rate **12m Cumulative Rate**	R			Mar-20	<3.39%	4.61%	4.69%					√
Workforce	W22	Appraisal Rate	R			Mar-20	>95%	80.19%	75.94%					√
Workforce	W23	Agency Costs as a % of Total Pay Costs				Mar-20		3.93%	4.09%					
Patient Feedback	OH4	CQC Inpatient Survey (annual)					-							
Staff Feedback	OH6	NHS Staff Survey (annually) Staff Engagement Rate												
Compliance	W50	Mandatory and Statutory Training	R			Mar-20	>95%	90.86%	90.73%					√

site breakdown not available

W50: Statutory and Mandatory Training



The Statutory and Mandatory training rate at 31st March 2020 was 90.73% (90.86% at 29th February 2020). The Statutory & Mandatory training rate shows compliance against the following seven (Core for All) 3 yearly competency requirements and 84.27% of staff have completed all 7 modules (84.59% at 29/02/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Duty of Candour - 3 Years|	9829	9829	8957	91.13%
205|MAND|Security Awareness - 3 Years|	9829	9829	8932	90.87%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	9829	9829	8974	91.30%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	9829	9829	8889	90.44%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	9829	9829	8864	90.18%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	9829	9829	8877	90.31%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	9829	9829	8933	90.88%

Compliance with the annual elements of the Statutory and Mandatory Training requirements are as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	9829	9829	8010	81.49%
NHS|CSTF|Information Governance and Data Security - 1 Year|	9829	9829	9041	91.98%

Root cause analysis/ Key lines of enquiry

There is an agreed pause on compliance for at least 12 weeks and, whilst we expect those working from home and those in self isolation but with no symptoms, to access their statutory and mandatory training this will inevitably lead to a dip in performance for some staff groups

Actions are focussed on addressing the workforce elements of the Trust's emergency response to Covid-19 and that is it necessary therefore to suspend, for the time being, the action plan to improve the Statutory and Mandatory training rate

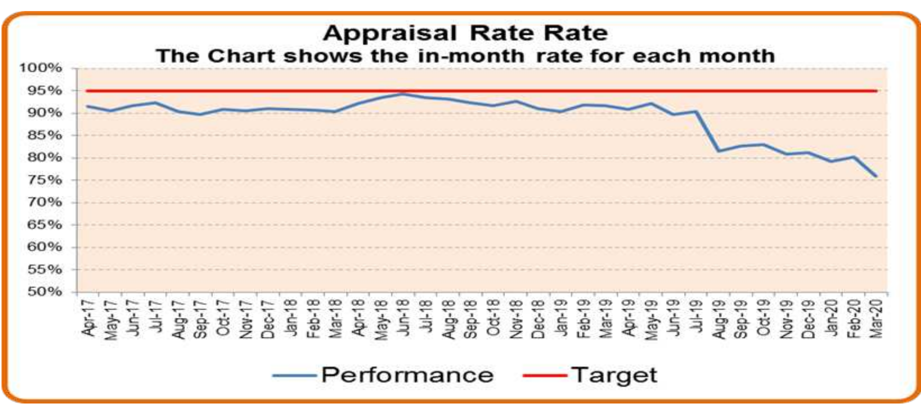
Action Plan

Action	Status
Monthly data quality check. Use ESR to identify any records that remain "confirmed" and follow up with the trainer. Additional training to be provided if required.	G

Progress

Not ➡ Scoping ➡ In Progress ➡ Complete

W22: Appraisal Rates (PDR's)



Overall, 75.94% of Non-Medical PDRs were recorded in ESR as at 31st March 2020 – a deterioration on the 79.75% at 29th February.

Staff Group	Assignment Count	Reviews Completed	Reviews Completed %	Reviews required to reach 95%
Add Prof Scientific and Technic	375	305	81.33	51
Additional Clinical Services	2,087	1,557	74.60	426
Administrative and Clerical	1,768	1,347	76.19	333
Allied Health Professionals	464	291	62.72	150
Estates and Ancillary	527	465	88.24	36
Healthcare Scientists	291	214	73.54	62
Nursing and Midwifery Registered	2,860	2,179	76.19	538
Grand Total	**8,372**	**6,358**	**75.94**	**1544**

The Consultant Revalidation Rate at 29th February was 95.37%

Root cause analysis/ Key lines of enquiry

The performance rate was adversely impacted by a reduction in assignment numbers eligible for a PDR in March, with 100 leavers in month (40 retirements; 55 voluntary resignations and 5 other reasons), and an increase in the number of PDRs expiring at 31st March.

Additionally, due to covid-19, there is an agreed pause on compliance for at least 12 weeks which will lead to a dip in compliance rates

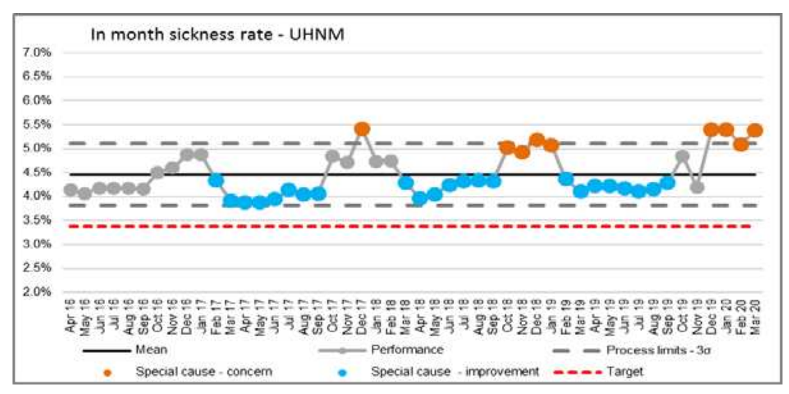
Actions are focussed on addressing the workforce elements of the Trust's emergency response to Covid-19 and that is it necessary therefore to suspend, for the time being, the action plan to improve PDR compliance.

Action Plan	RAG
Support with data uploads continues to be provided.	G
Support for Divisions to produce their own monitoring reports is in place	G

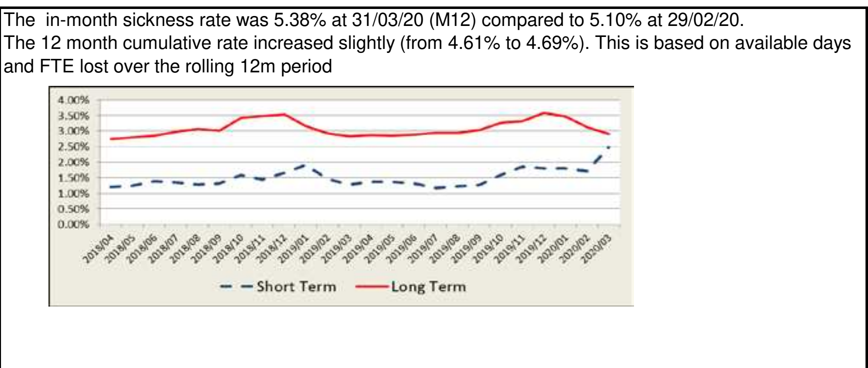
Progress

Not Initi ➡ Scoping ➡ In Progress ➡ Complete

W20: Sickness Absence Rate



The in-month sickness rate was 5.38% at 31/03/20 (M12) compared to 5.10% at 29/02/20.
The 12 month cumulative rate increased slightly (from 4.61% to 4.69%). This is based on available days and FTE lost over the rolling 12m period



Root cause analysis/ Key lines of enquiry

In March 2020, the top reasons for sickness absence were:

Absence Reason	Headcount	Abs Occurrer	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	189	192	3,429	18.3
S99 Unknown causes / Not specified	308	311	2,636	14.1
S15 Chest & respiratory problems	223	225	1,992	10.7
S12 Other musculoskeletal problems	106	110	1,955	10.5
S25 Gastrointestinal problems	214	218	1,294	6.9

Communications have been issued to:
a) remind managers to close absences in Empactis and to continue to complete return to work interviews
b) advise staff how to report covid-related absences in Empactis

Of absences reported during March 2020, March 2020, 993 out of a total 1272 absences were reported as covid-relted. (78%) Of the total 1550 absences reported between1st and 22nd of April, 1001 were reported as covid-related (65%).

A process for staff testing for covid-19 has been established and has recently been extended to all staff groups

Staff Wellbeing and Engagement work has necessarily been focussed on the actions to address the workforce elements of the Trust's emergency response to Covid-19.

Action Plan	RAG
Escalate / fast-track a change request with supplier to automate the absence type and reason based on the callers response to the trigger questions.	G
Open absences where the expected date of return has lapsed have been cross checked against Allocate and closed where applicable.	G
Managers have been identified for further training and employees reminded to close absences in Empactis	G

Progress

Not Initiated ➡ Scoping ➡ **In Progress** ➡ Complete

Domain Scorecard

	Ref	Indicator	Exception Triggers			Period	This Period Target	Performance			Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit			Last Period	This Period	YTD	RSUH	County	UHNM	
Patient Feedback	C12	Mixed Sex accommodation breaches	G			Mar-20	0	0	0	0	0	0	0	
	C7	Written Complaints Rate (per 10,000 spells)	G			Mar-20	35.00	27.24	27.57	30.64	31.19	10.65	27.57	
	C1	FFT Recommended %- Inpatients				Mar-20	95.0%	98.6%	n/a	98.3%				
	C2	FFT Recommended %- A&E				Mar-20	85.0%	68.3%	n/a	67.5%				
	C3	FFT Recommended %- Maternity				Mar-20	95.0%	88.9%	n/a	99.3%				
Staff Feedback	C6	Staff FFT Percentage Recommended- Care - Qtr.				Qtr4	70.0%	n/a	82.2%					

F&F tests unavailabkle due to current restrictions (COVID-19)

5. Safe

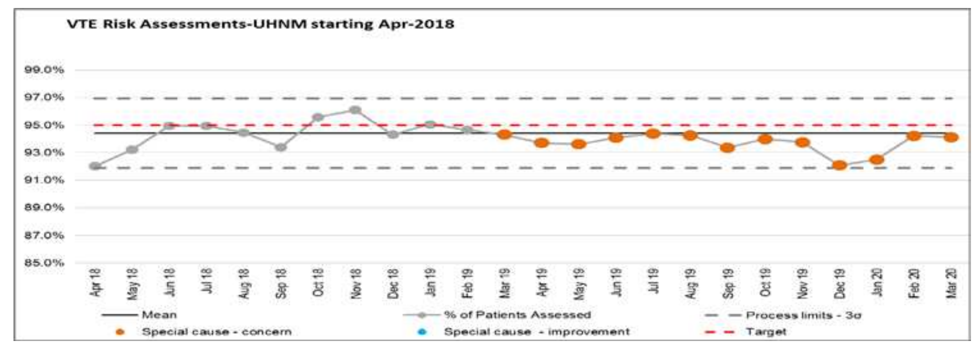
Domain Scorecard

Mar-20
Page 34

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Conti. Limit	Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Breakdown: RSUH	Site Breakdown: County	Site Breakdown: UHNM	Except.
Infection Control	S10	Clostridium Difficile- Infection number	G			Mar-20	8	13	8	116	7	1	8	
	S11	Clostridium Difficile- Variation from Plan	G			Mar-20	8	5	0	23	0	0	0	
	S2	Avoidable MRSA cases	G			Mar-20	0	0	0	0	0	0	0	
Incidents	S3	Never Events	G			Mar-20	0	1	0	6	0	0	0	
	S19	Falls Resulting in Harm (Including Low - Excluding Collapses and Managed Falls)	G			Mar-20	60	60	50	629	44	6	50	
	S25	Medication Errors: Rate per 10,000 bed days				Mar-20	-	46.2	29.1	43.2	28.1	35.7	29.1	
Harm Free Care	S38	Pressure Ulcers- Hospital Acquired Category 2 Lapse in Care	G			* Feb-20	8	1	3	51	3	0	3	
	S38	Pressure Ulcers Hospital Acquired Category 3 Lapse in care	G			* Feb-20	4	2	0	31	0	0	0	
	S29	Pressure Ulcers Hospital Acquired Category 4 Lapse in Care	G			* Feb-20	0	0	0	1	0	0	0	
	S17	Emergency C-Section Rate as % of total births				Mar-20	-	14.82%	17.53%	14.47%			17.53%	
Screening	S36	VTE risk assessments	R			Mar-20	95.0%	94.21%	94.11%	93.7%	93.5%	97.7%	94.1%	√

*reported for previous month

5. Safe	S36 - VTE risk assessments	Mar-20 Page 35



Mar-20	
Target	95%
Mar-19	94.30%
Mar-20	94.11%

Root cause analysis/ Key lines of enquiry

VTE assessments on admission are reported quarterly to Unify. The definition of the Indicator is the number of inpatients aged 16 and over reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool divided by the number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions).

For March 2020 94.11% of VTE risk assessments were completed within 24 hours of patient admissions (all inpatient admissions during March 2020 captured on the WIS), which falls short of the National 95% target. However, results from the monthly point prevalence Safety Express audit shows that for the last six months, over 99.0% of VTE risk assessments have been completed (ward based audit of every inpatient on one specified day of the month).

This suggests that VTE Risk Assessments completed on admission but not uploaded accurately onto the WIS Board. This is supported by the internal audit of UHNM Quality Account 2018/2019, which concluded that UHNM was under-reporting compliance with VTE risk assessments.

The four admission areas with the poorest compliance that would have the biggest impact on the Trusts overall performance are AMU (RSUH), FEAU, Ward 127 (short stay) and Ward 220. Recent spot checks of the VTE risk assessments within prescription charts, within these areas, conclude VTE assessments are being completed but not inputted onto the WIS system. These spot checks will be on-going and fed back to the Ward Managers, Matrons and Divisional Leads.

A work stream is underway to improve VTE risk assessment for patients aged 16-18 years . Monthly email/ indicator results are sent to paediatric medical governance lead to improve compliance for children aged 16yrs and 17yrs as these are currently low and are now included within the trusts Quarterly reports to unify.

Continued focused work is on-going to improve compliance with timely inputting of VTE risk assessments onto WIS. The VTE Steering Group are also liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.

Action Plan	RAG
Development of an E-Learning package to instruct users how to accurately upload VTE risk assessment times on the Ward Information System (WIS) and how to avoid loss of data has been available on ESR Since end of January 2020. Reminder cards have been attached to all WIS boards within the clinical area. Uptake of training will be monitored by the Corporate Quality & Safety Team.	G
The Corporate Quality & Safety Team are providing focused support to admission portals to improve compliance with VTE risk assessment completion and data capture, as required.	A
Areas of non-compliance are escalated to the relevant matron by the Corporate Quality & Safety Team, on a monthly basis.	G
The VTE Steering Group are liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.	A
A work stream is underway to improve compliance with NICE Guidance on VTE risk assessment for patients aged 16-18 years.	G

Progress

Not Initiated ➡ Scoping ➡ In Progress ➡ Complete

Audit Committee Chair's Highlight Report to Board

30th April 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • Partial Assurance with Improvement Required concluded for the review of Data Security and Protection Toolkit; however within an increasingly complex area – UHNM is pushing to be in the upper quartile when compared to peers. The main areas for improvement were in relation to training figures and 'pen testing'. • Discussion regarding inclusion for material uncertainty disclosure in the statement for going concern given the national position with Covid-19 • Increased exposure to fraud related risk associated with Covid-19 • Quarter 4 Board Assurance Framework not completed. A paper to Trust Board is scheduled. The Quarter 1 BAF will be presented to the Committee in July.	• Review of Interim Governance arrangements and associated next steps to be the focus of a Board Seminar at the beginning of May • Covid related Board Assurance Framework produced and being taken to the Trust Board in May which will be followed by a further refresh of the BAF for 2020/21 in light of Covid-19 • Pen test scheduled to take place in May 2020 with NHS Digital which will address one of the recommendations within the Data Security and Protection Toolkit • Development and completion of the Annual Report and Accounts and associated External Audit, in line with the revised national timescales and guidance (which no longer includes an audit of the Quality Account)
Positive Assurances to Provide	**Decisions Made**
• Significant Assurance Ratings concluded for Internal Audit Reviews of Board Assurance Framework and Risk Management and Financial Controls • Head of Internal Audit Annual Opinion of Significant Assurance with Minor Improvements Required • STAR metrics which will be included within the Integrated Performance Report; these have been tested with a positive conclusion • Delivered against all statutory financial obligations as set out within the Analytical Review of the Accounts, excluding payment to terms where performance was comparatively strong. • Positive feedback on interim audit and progress to date with regard to the External Audit of the statutory accounts	• Approval of Committee Annual Report, Revised Terms of Reference and Committee Effectiveness Report • Approval of Internal Audit Plan for 2020/21, noting that flexibility has been included within to provide for utilisation as necessary (i.e. Covid-19 related) • Approval of Local Counter Fraud 2020/21 Plan; fraud associated with Covid-19 will be a key focus during 2021 • Approval of preparation of the Annual Accounts on a Going Concern basis

Comments on the Effectiveness of the Meeting
• Meeting went well and it was agreed that sufficient time was given to cover the business.
• Effective & strong working relationships with Internal and External Auditors being sustained.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Corporate Governance Report	Assurance	7.	Local Counter Fraud 2020/21 Plan	Assurance
2.	Committee Effectiveness Review 2019/20 including Revised Committee Governance Pack	Approval	8.	Counter Fraud Annual Report / Self Review Toolkit against NHS Counter Fraud Authority Standards	Assurance
3.	Internal Audit Progress Report	Assurance	9.	Analytical Review and Draft Accounts	
4.	Head of Internal Audit Opinion 2019/20	Assurance	10.	Going Concern Statement for 2019/20	Assurance
5.	Internal Audit Plan 2020/21	Approval	11.	Actions and Items for Escalation to the Trust Board	Information
6.	External Audit Progress Report / External Audit Plan Addendum – Covid19	Assurance	12.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information

3. 2019 / 20 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

Members:			Apr	June	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)	Attended				
Mr P Akid	PA	Non-Executive Director	Attended				
Ms S Belfield	SB	Non-Executive Director	Apologies				

Attendees:			Apr	June	Jul	Oct	Jan
Mr A Bostock	AB	Internal Audit	Attended				
Mr R Chidlow	RC	Internal Audit	Attended				
Ms N Combes	EM/NC	External Audit	Attended				
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance	Attended				
Mr M Oldham	MO	Chief Finance Officer	Attended				
Mr R Percival	RP	External Audit	Attended				
Mrs S Preston	SP	Strategic Director of Finance	Attended				
Miss C Rylands	CR	Associate Director of Corporate Governance	Attended				
Mr S Stanyer	SS	LCFS					

Executive Summary

Meeting:	Trust Board (Open)	Date:	6th May 2020
Report Title:	Speaking Up Report – Quarter 4 and Annual Report 2019-20	Agenda Item:	12
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

Assurance	✓	Approval		Information	

Impact on Strategic Objectives (positive or negative):

		Positive	Negative
SO1	Provide safe, effective, caring and responsive services	✓	
SO2	Achieve NHS constitutional patient access standards	✓	
SO3	Achieve excellence in employment, education, development and research	✓	
SO4	Lead strategic change within Staffordshire and beyond	✓	
SO5	Ensure efficient use of resources	✓	

Executive Summary:

When things go wrong we need to make sure that lessons are learnt and improvements are made. If we think something might go wrong, it's important we feel able to speak up so that potential harm is avoided. Even when things are going well, but could be made even better we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement. Speaking Up is about all of these things.

This quarterly Speaking Up Report provides an update on progress in relation to developing our speaking up culture together with a summary of concerns raised for the Quarter 4 period of January - March 2020 and an analysis of speaking up data for the year 2019-20. This report has been presented and accepted by the April Meeting of the Transformation & People Committee.

During the quarter 22 concerns were recorded on the speaking up tracker. One of the concerns was raised anonymously. Concerns recorded include issues raised with the Freedom to Speak Up Guardians and those raised to the Executive Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker.

Progress against our FTSU Index action plan is included as an Appendix, which has been updated with the 2019 Staff Survey results and shows positive improvement in three of the four indicators. Also attached as an Appendix is the proposed UHNM Speaking Up Charter, to demonstrate to our staff how they can expect to be supported when raising issues or concerns.

Key areas that are being worked upon are the core speaking up training for all staff and specific training for managers, based on national guidelines from the National Guardians Office and plans for Speaking Up Summits to proactively identify trends and themes by triangulating staff experience and patient safety data which will further embed our Speaking Up Plan and Speaking Up Culture across the organisation.

Key Recommendations:

Trust Board is asked to consider the speaking up data and themes raised during Quarter 4 and the year 2019-20 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up

Quarter 4 and Annual Report

April 2020

1. Introduction

The UHNM Freedom to Speak Up Guardian has logged concerns raised since 1st April 2016. At the time of this report, 192 concerns have been raised either directly to a FTSU Guardian, or the Guardian has been notified of concerns raised with a Designated Officer within the Trust or reported within a department or via another route, such as the Chief Executive office or CQC.

This Quarter 22 concerns have been reported on the speaking up tracker. Regrettably due to the current Covid-19 situation we are unable to report on the number of contacts made during quarter 4 to our Employee Support Advisors.

The National Guardians Office (NGO) has extended the Quarter 4 data submission deadline due to the current Covid-19 situation and the fact that many Freedom to Speak Up Guardians and champions are clinically based. Whilst our speaking up tracker has been maintained during Quarter 4, many of our Employee Support Advisors are front line clinical staff and therefore we are not able to accurately report on ESA contacts until our ESA's are in a position to report this. ESA contact data will be reported as soon as is practicable and an update provided in the next Speaking Up Report.

2. Freedom to Speak Up Index Report

In October 2019 the NGO with NHS England & NHS Improvement published the first Freedom to Speak Up Index report, designed for Trust Boards to use as a measure of the speaking up culture within their organisation. In November 2019 a Gap Analysis against the Index was presented to the Quality Assurance Committee meeting. The Action Plan created to close the gap between UHNM performance and the acute trust average scores is attached as Appendix 3 and includes updated staff survey indicators taken from the 2019 Staff Survey data published in March 2020.

The 2019 Staff Survey has demonstrated improvement in three out of the four the indicators related to speaking up measured by the Index Report. The indicator that has deteriorated slightly relates to staff awareness of how to report unsafe clinical practice. Further work will be undertaken to raise awareness of the routes to raise concerns.

Question	Average for Acute Trusts	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
My organisation treats staff who are involved in an error, near miss or incident fairly	59.6%	57.4%	55.9%	52.3%
My organisation encourages us to report errors, near misses or incidents	88.2%	84.5%	82.4%	83.4%
If you were concerned about unsafe clinical practice, would you know how to report it?	94.2%	92.7%	93.4%	93.3%
I would feel secure raising concerns about unsafe clinical practice	70.4%	67.8%	65.6%	65.9%

Encouragingly, UHNM has seen improvements in the other safety culture indicators in the Staff Survey not included in the Speaking Up Index, including:

Question	Average for Acute Trusts	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
I am confident that my organisation would address my concern	57.7%	56.2%	52.7%	52.8%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	70.2%	70.0%	67.6%	68.3%
We are given feedback about changes made in response to reported errors, near misses and incidents	60.1%	58.9%	57.7%	54.0%

3. Supporting a Speaking Up Culture

UHNM Speaking Up Charter

We have developed a Speaking Up Charter (Appendix 1) to demonstrate our commitment to supporting staff to raise concerns. The Charter, which has been approved by Staff Side outlines what can be expected by someone raising concerns, and also how someone whom concerns have been raised against will be supported. It was agreed at the Transformation & People Committee that the Speaking Up Charter should be signed by our Chief Executive and Side Side Chair and then be promoted across the organisation when the focus of the Trust returns to business as usual.

Benchmarking Information

At the January Transformation and People Committee meeting, a request was made to benchmark our speaking up data to gain an understanding of whether as an organisation we are under/over reporting concerns.

The summary in Appendix 2 outlines speaking up data available on the National Guardians website from NHS Trusts in our Model Hospital Group for the first three quarters of this financial year. This information indicates that the number of issues raised through freedom to speak up routes can vary significantly between organisations, and between quarters, it also demonstrates that UHNM is not under reporting compared to our Model Hospital Group. There are many factors that influence the data, including size of the organisation; whether a FTSU Guardian is well established, and is supported with a network of champions; prevalence of other routes to raise issues, such as an incident reporting system and of course the organisational culture which may result in less or more concerns raised through FTSU routes.

Ian Paterson Independent Inquiry

The report from the Independent Inquiry into breast surgeon Ian Paterson was published in February 2020. The report made several references to speaking up. It stated that whilst healthcare professionals have a duty, as part of their code of conduct to raise concerns where they believe that patient safety or care is at risk that this did not happen in a way that was thorough or adequate in the case of Paterson. There were differences in the way that concerns were raised by professionals in the NHS and in the independent sector. However the response when concerns were raised was inadequate in both sectors and opportunities to stop Paterson practicing as a result of concerns raised by healthcare professionals in the NHS were missed on a number of occasions.

This inquiry identified that Paterson had been investigated using HR processes, and that this meant that he was guaranteed a duty of confidentiality which stood in the way of patient safety. The inquiry believes that this approach was a mistake given that patient safety should have been the paramount consideration, and that where concerns about a doctors practice arise they can be managed by placing restrictions on what that doctor can or cannot do, or excluding them from practising altogether, pending the outcome of any

investigation. In that way, "transparency" with patients would not be an issue since the option of treatment, or a particular treatment by the doctor in question would not arise.

The inquiry also found that concerns seem to have been responded to as if they were individual isolated incidents and hence connections were not made and this was to the detriment of patient safety, and that those coming in to management positions were not being fully briefed that concerns had been raised. This lack of information about the sustained concerns about Paterson may have affected their ability to act appropriately to keep patients safe.

The inquiry also heard that there was a personal cost to the healthcare professionals who raised concerns about Paterson, with many saying they experienced bullying or aggression as a result, and they were not supported in raising concerns. Many of the healthcare professionals who had raised concerns about Paterson were genuinely fearful of the consequences of doing so and had a negative experience of raising concerns. Furthermore around a dozen healthcare professionals told the inquiry they knew at the time that others had raised concerns or complained about him, which appeared to have caused some of them to feel they did not need to act on their own misgivings as others had already done so. The theme of people thinking that it's someone else's responsibility to take action surfaced repeatedly in many areas of evidence to the inquiry.

In summary, the inquiry learned that opportunities to stop Paterson practicing in response to concerns raised by healthcare professionals in the NHS were missed on a number of occasions and for a sustained period of time. Connections were not made between individual incidents to the detriment of patient safety.

It noted that there is a strength of feeling amongst healthcare professions that raising concerns will come at a personal cost to them. This perception continues, despite recent measures to empower and protect healthcare professionals and other staff who raise concerns.

The inquiry recommended that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.

In response to the Inquiry, our Trust Board requested assurance that UHNM has systems and processes in place to enable concerns about doctors to be raised, and that these processes enable both suspension from clinical practice and also to notify other providers of concerns. Our Executive Lead for speaking up and Director of HR provided this report to the March Transformation and People Committee meeting.

Speaking Up Summit

Draft terms of reference have been developed as a starting point for discussion with key stakeholders regarding the introduction of a summit process which will review speak up information and triangulate data from staff experience and patient safety looking for trends, themes and any areas that may be hot spots in order than any action can be proactively identified and swiftly taken, An update will be provided in the next quarterly report.

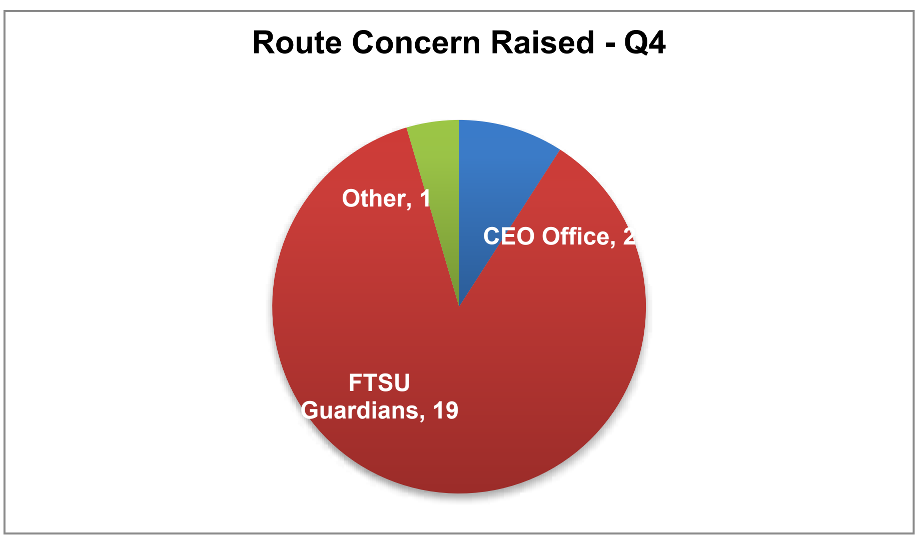
4. Quarterly Speaking Up Cases – Quarter 4 – January – March 2020

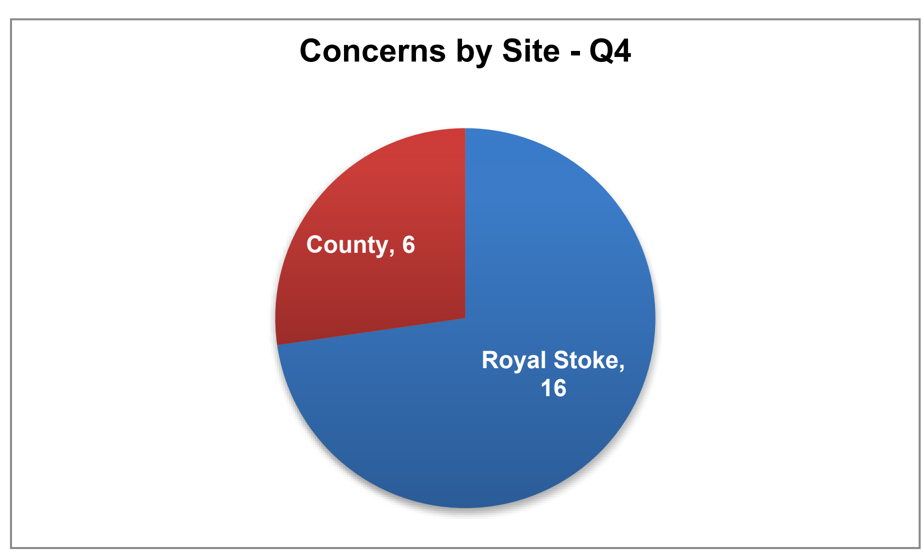
The following information reflects concerns that have been recorded on the Speaking Up tracker. Concerns are recorded in accordance with guidance from the National Guardians Office. Concerns are themed in line with categories issued to NHS Trusts by the NGO. The following information is presented so that patterns emerge over time, whilst being mindful about the need for confidentiality. The data is intended to draw attention to particular issues, patterns of activity or themes:

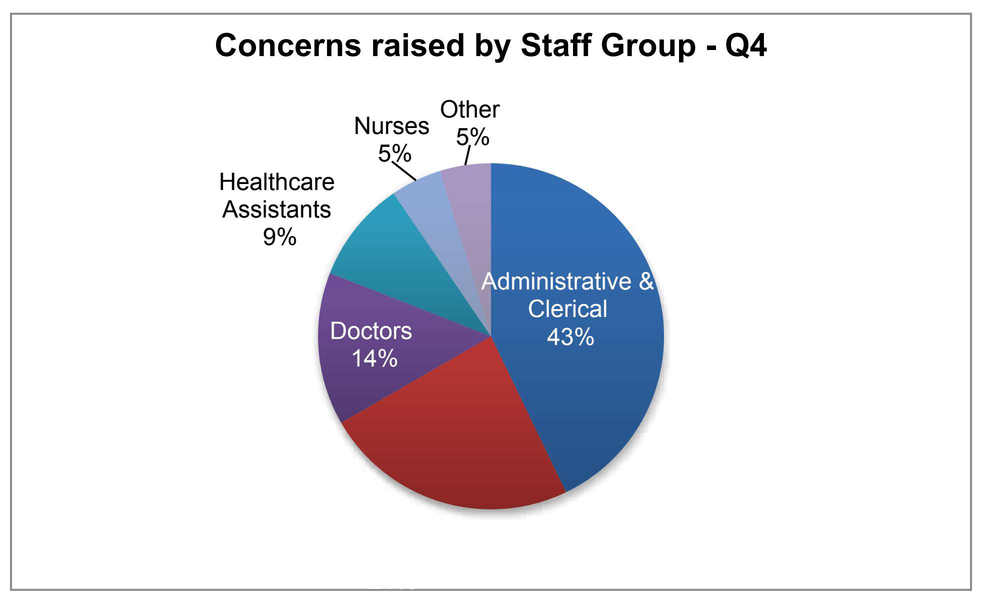
Month	No. of concerns raised in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
January	11	1	9	0
February	4	0	2	0
March	7	0	5	0
Total	**22**	**1**	**16**	**0**

Positively, only one concern was reported anonymously. A signal of a health speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	13
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	2
Quality and safety	3
Patient experience	0
Performance capability	0
Service Changes	4
Other	0
Total	**22**







Summary of speaking up contacts during Quarter 4 January – March 2020

No.	Theme	Summary	Status
1.	Policies, processes and procedures	Concerns raised relating to the response to and treatment following concerns being raised.	Meeting arranged and held with Non-Executive Lead for Speaking Up. Way forward agreed – independent external investigating officer to undertake investigation.
2.	Attitudes and behaviours	Staff member contacted FTSU Guardian about inappropriate behaviour within team and management of disability.	Advice and support given to individual and a meeting arranged with line manager - issue resolved. Closed.
3.	Service changes	Concerns about impact of service change raised with FTSU Guardian.	Escalated to Service lead. Actions agreed and assurances provided to individuals satisfaction. Closed.
4.	Service changes	As above.	As above.
5.	Service changes	As above.	As above.
6.	Service changes	As above.	As above.
7.	Attitudes and behaviours	Concerns received regarding staff experience relating to communication, engagement and inappropriate behaviours in a team.	Concerns were additional to similar concerns raised in Quarter 3. Associate Director responded with comprehensive action plan to address issues. Closed.
8.	Attitudes and behaviours	As above.	As above.
9.	Attitudes and behaviours	As above.	As above.
10.	Attitudes and behaviours	Anonymous letter received in CEO office about inappropriate behaviours on a ward area.	Associate Chief Nurse provided response outlining that a management of change had occurred on the area which may have been a factor in the concerns. No other negative HR indicators. Open Door session to be held with staff to encourage issues to be discussed openly. Closed.

11.	Attitudes and behaviours	Concerns raised via investigating officer of continued concerns of inappropriate behaviours and failure to address these.	Independent fact finding investigation commenced.
12.	Attitudes and behaviours	Concerns raised to FTSU Guardian about inappropriate behaviours in a team.	Advice and guidance provided on dignity at work routes. No further action required.
13.	Attitudes and behaviours	Concerns raised by ex-employee about lack of support, inappropriate behaviours and management action.	Worker submitted concerns to CEO office. Response provided. Listening events to be held in work area, HR and other indicators reviewed.
14.	Attitudes and behaviours	Contact made to FTSU Guardian about poor treatment of colleague.	Advice and guidance provided.
15.	Policies, processes and procedures	Ex-employee raised concerns with FTSU guardian about process for issuing references.	Head of Recruitment provided response to clarify process. Learning for individual manager involved. Closed.
16.	Quality and safety	Clinical worker raised concerns about their underlying health conditions and returning from leave to work with potential Covid 19 positive patients.	Explanation of risk assessment process provided, employee satisfied with response and will discuss with manager on return to work. Closed.
17.	Quality and safety	Concerns raised with FTSU Guardian about multiple staff concerns about social distancing and routine work arrangements continuing during Covid 19 situation.	Escalated to Chief Nurse, arrangements reviewed and response provided. Closed.
18.	Attitudes and behaviours	FTSU Guardian contacted about concerns from employee of inappropriate behaviours.	Meeting being arranged.
19.	Attitudes and behaviours	Concerns raised about attitudes and behaviours of line manager.	Comprehensive action plan in place. Associate Chief Nurse, HR manager and FTSU Guardian supporting implementation. Employee satisfied with action being taken. Closed.
20.	Quality and safety	Concerns raised to Chief Nurse and FTSU Guardian by a clinician about arrangements and availability of personal protective equipment for staff treating Covid-19 patients.	Response provided by Chief Nurse, followed by trust wide communications, which have been regular and updated to reflect WHO guidance on PPE. PPE poster distributed across the organisation.
21.	Attitudes and behaviours	Concerns raised to FTSU Guardian from ex-employee about attitudes and behaviours of management.	Concerns fed into HR and Organisational Development plan for the area. Individual satisfied with action taken.
22.	Attitudes and behaviours	Concerns raised to FTSU Guardian about attitudes and behaviours during Covid-19 situation.	Advice and guidance given about taking personal action and routes to raise formally in due course.

Issues raised with our Employee Support Advisors

Normally we would include the contacts made during the quarter to our Employee Support Advisors. Due to the current situation with Covid-19 an accurate number of contacts to our ESA's cannot be given, as many of our ESA's are front line clinical staff who are presently focusing entirely on clinical duties. An update on ESA activity during Quarter 4 will be reported in the next quarterly speaking up report.

ESA activity is included in speaking up contacts reported to the National Guardians Office. The NGO has extended the national deadline for reporting this data accordingly.

5. Learning from cases

During the quarter our Chief Nurse met with a member of staff who raised concerns around patient care and patient and staff experience. The individual did not feel able to raise issues with line management. The individual talked about poor experiences of staff which they felt were related to staff numbers, training and behaviours which were impacting directly on patient safety and staff retention. The Chief Nurse has taken some immediate action as a result of the meeting to address the patient safety issue, but is also arranging a session with this particular group of staff so that she can hear from them what their experiences are, what development they need and any concerns they have.

The member of staff felt that they had been listened to, and that their concerns had been taken seriously.

6. Recommendations

The focus going forward over the next quarter will be:

- Continue to implement the actions from the Freedom to Speak Up Index Action Plan in particular speaking up training
- Freedom to Speak Up Guardian team to review and update the UHNM Freedom to Speak Up Self Review
- Promote the UHNM Speaking Up Charter
- Further communicate the routes for raising concerns and how to contact the Freedom to Speak Up Guardians
- Agree the terms of reference for the Speaking Up Summit

7. Annual Report 2019-20

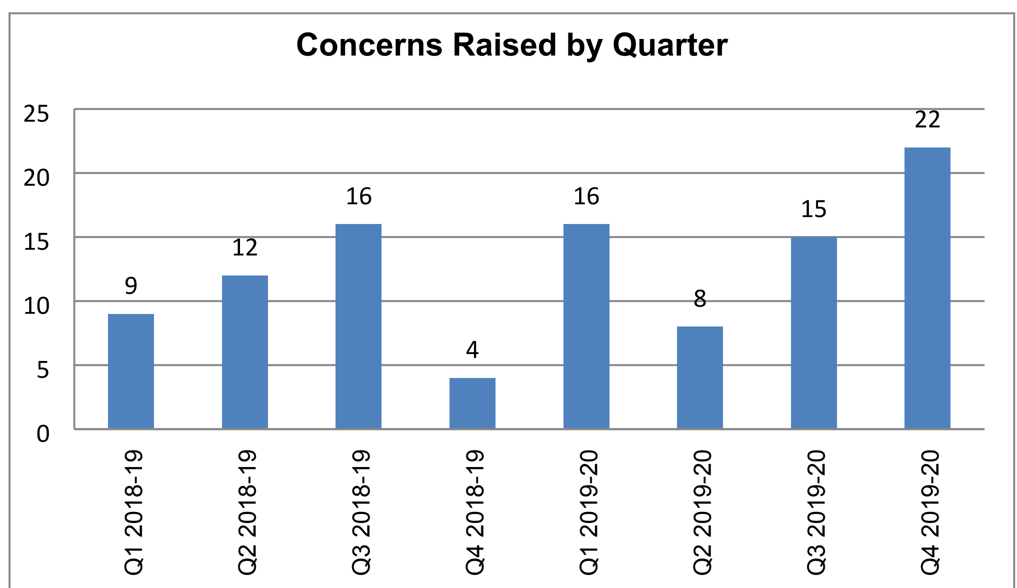
During 2019-20 our focus has been to continue to foster a culture where staff feel empowered and supported to raise issues or concerns. We have:

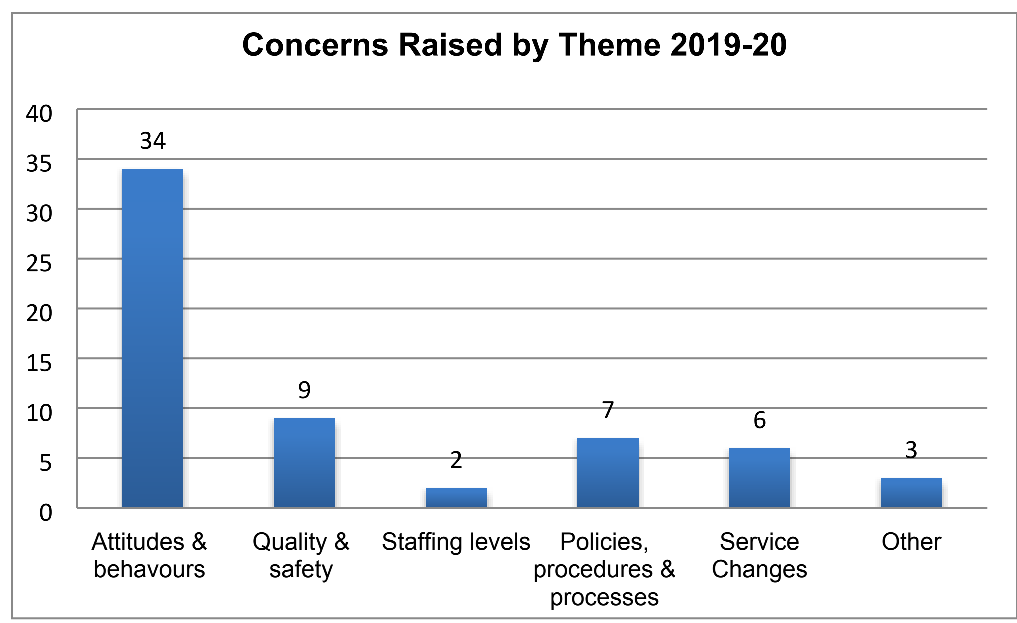
- Reviewed our Speaking Up Policy (previously Raising Concerns at Work (Whistleblowing) Policy in line with best practice and included our commitment to a Just and Learning Culture
- Presented the updated NHS Improvement Guidance for Boards to the Trust Board in September 2019 which summarised the expectations of Executive Directors in relation to freedom to speak up, and the roles and responsibilities of individual Trust Board members
- Held a Freedom to Speak Up board development session on 14th January 2020, led by NHS England & Improvement
- Reviewed and updated the Speaking Up intranet page with frequently asked questions and helpful resources and links
- Launched the Cut it Out anti bullying campaign
- Developed the UHNM Speaking Up Index Action Plan, which is monitored at the Transformation & People Committee
- Increased the number of Associate Freedom to Speak Up Guardian roles, which have been increased to three during this year. The FTSU Guardians are supported by a network of Employee Support Advisors

- A pilot of the anonymous reporting system Work in Confidence has been launched for doctors in training
- The Trust Disciplinary Policy to been updated to include the Just and Learning incident decision tool to support the consistent, constructive and fair evaluation of the actions of workers involved in an incident
- Continue to learn from NGO case reviews and ensure our policies and processes are in accordance with national recommendations and best practice

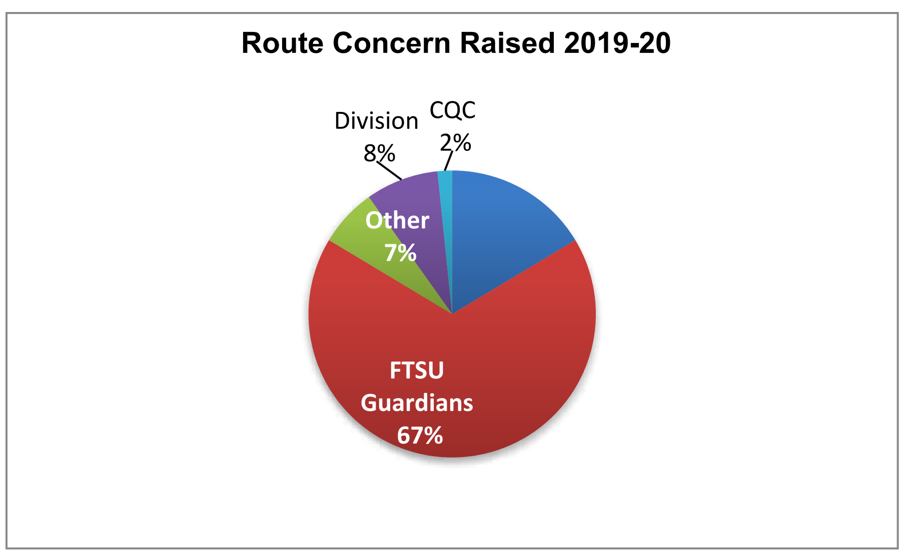
Speaking Up Data 2019-20

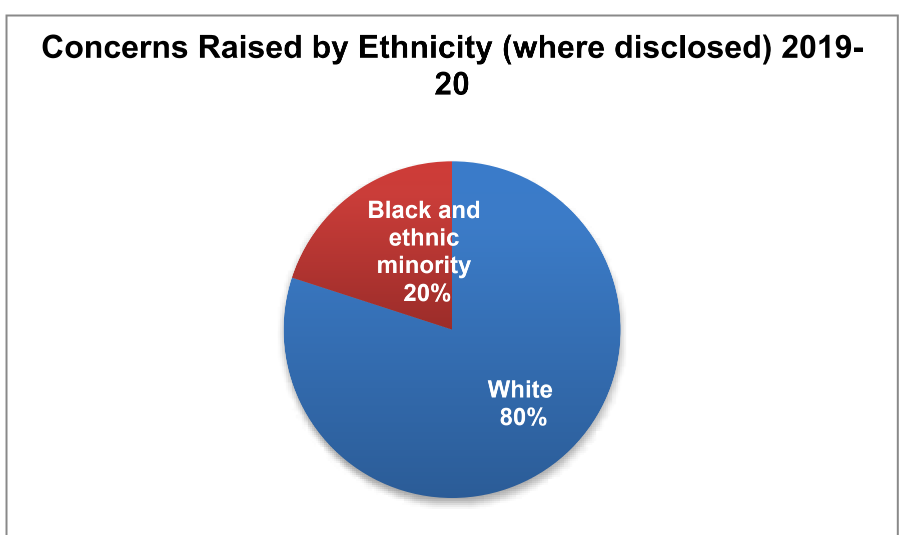
During 2019-20, 61 concerns have been recorded on the speaking up tracker. In accordance with NGO guidelines, concerns are recorded individually even if multiple individuals are raising the same issue or concern (where the number of individuals is known).



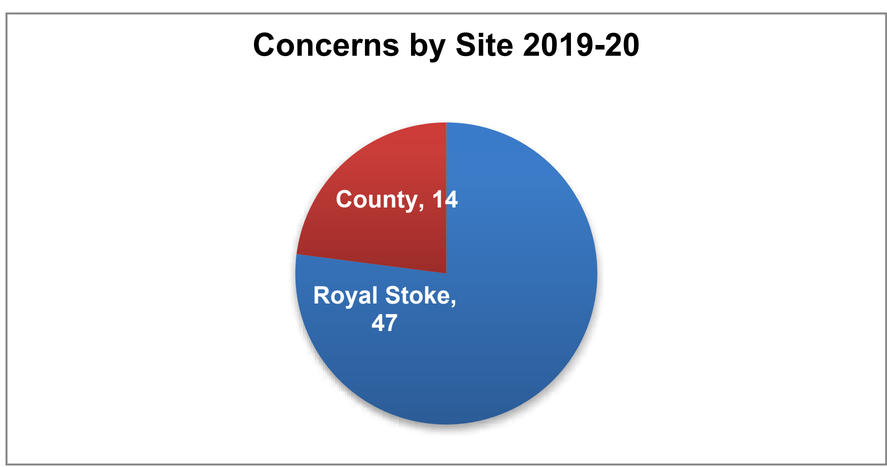


Attitudes and behaviours continue to be the most reported theme of concerns raised, as it was for the previous financial year. This is consistent with other organisations within our Model Hospital Group, and the national data reported by Freedom to Speak Up Guardians. We know that evidence shows that where there is incivility that people are less likely to raise issues, which impacts of patient and staff safety.

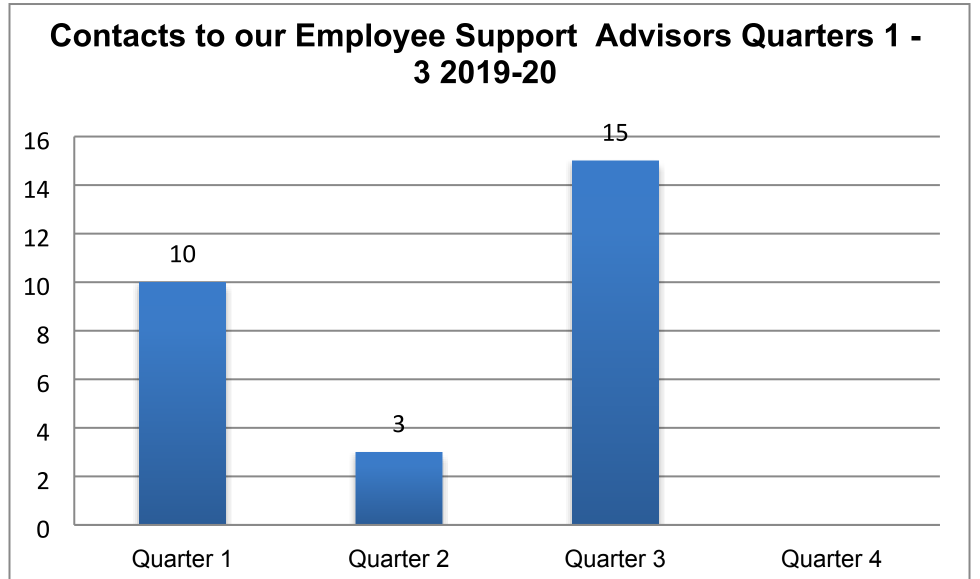




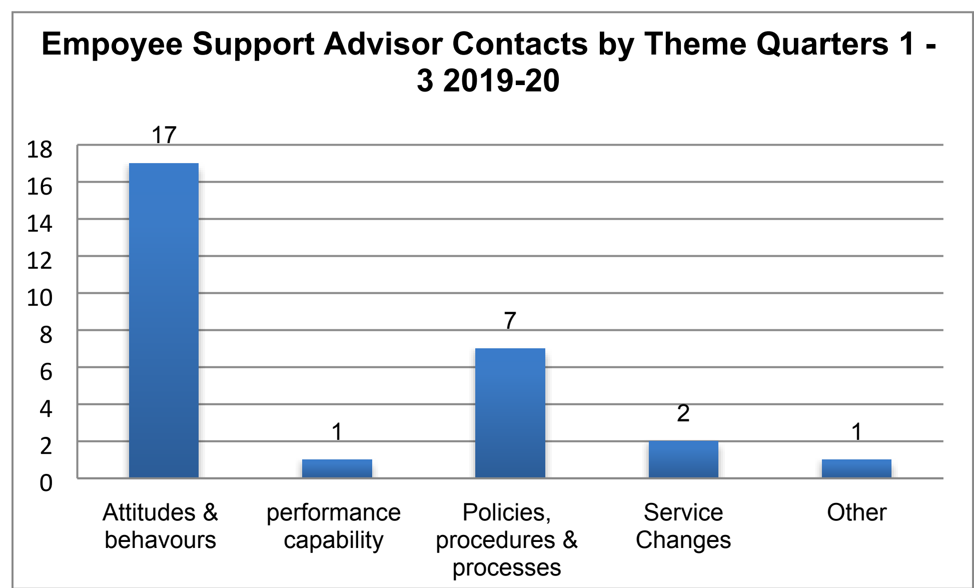
This data tells us that concerns recorded on the Speaking Up Tracker are reflective of our workforce in terms of ethnicity. One of our Associate Freedom to Speak Up Guardians is the Chair of our BAME Staff Network Group, which is also safe place for issues to be raised.



The Royal Stoke Hospital, as the larger site has received 77% of concerns recorded on the Speaking Up Tracker, with County receiving 23% of concerns.



We are not currently able to report on ESA contacts during Quarter 4. Employee Support Advisors provide an important role to confidentially support and assist UHNM workers who feel they are being bullied or harassed in the workplace in addition to signposting staff and supporting them through speaking up processes.



Similarly to concerns recorded on the Case Tracker, our ESA's are contacted in the main with issues related to workplace attitudes and behaviours.

Appendix 1: Speaking Up Charter

UHNM Speaking Up Charter

We promote a healthy speaking up culture where our workers are empowered and encouraged to speak up about concerns and issues related to patient quality and safety and staff experience. But what can I expect if I do speak up?

- I will be thanked for speaking up
- My colleagues and managers are approachable and receptive to receiving concerns, feedback and suggestions for improvement
- My concerns will be taken seriously and a prompt fact finding process will follow to determine what actions need to be taken
- I will be involved in decisions about the process and I will be kept informed although I understand that for reasons of confidentiality, the detail may not be shared
- If a formal investigation is needed, this will be given the necessary resource and scope with a clear terms of reference and timescale
- I know that the focus of any investigation will be on learning and improving and not who is responsible or to blame
- I will have access to support from a Freedom to Speak Up Guardian or Employee Support Advisor who will be available to provide support by listening, signposting and facilitating good communication
- I know that I will not be bullied, victimised or suffer any detriment as a result of speaking up
- I will co-operate fully with fact finding and any subsequent investigation and treat all colleagues with respect
- I will at all times protect confidentiality during an investigation
- Following closure I will continue at all times to observe and adhere to the Trusts values and behaviours

A concern has been raised about me, what can I expect?

- I will be supported by my managers and Human Resources to establish the facts in a prompt and timely manner
- I will be supported to access staff support services and focus on my wellbeing
- I can be confident that any recommendations made will be based on facts and in accordance with our commitment to a Just and Learning Culture
- I will be supported to access personal and leadership development where appropriate

- I will feel confident that patient and staff safety are the priority and that my team remains a supportive place to work
- I will encourage my staff to speak up when they think that something might be wrong or could be improved and that I welcome feedback
- I will ensure that any colleague in my team who has spoken out suffers no detriment as a result
- I will continue to apply Trust policies and procedures in a fair and appropriate manner
- I will at all times protect confidentiality during an investigation
- Following closure I will continue at all times to observe and adhere to the Trusts values and behaviours

Visit the **Speaking Up** Intranet page at myuhnm/my-staff-experience/speaking-up/ for more information, guidance and where to get independent and confidential advice about a speaking up issue

Appendix 2 – Model Hospital Benchmarking Data

Freedom to Speak Up - National Guardian Reporting Data 2019-2020

	UHNM	Derby Teaching Hospitals	Gateshead Health	Nottingham University Hospitals	Royal Wolverhampton	Sheffield Teaching Hospitals	University Hospitals Southampton	University Hospitals Birmingham	University Hospitals Coventry and Warwickshire	Average quarterly
Total Concerns Reported										
Q1	27	20	7	12	14	3	8	7	12	12.2
Q2	11	59	6	8	28	9	14	16	11	18
Q3	30	61	5	no data	22	9	no data	14	no data	23.5
Number raised anonymously										
Q1	3	3	1	2	0	0	0	0	6	1.6
Q2	2	5	3	1	0	2	0	0	9	2.4
Q3	1	17	0	no data	2	0	no data	0	no data	3.3
Element of patient safety										
Q1	5	2	5	3	2	0	1	3	1	2.4
Q2	2	20	2	3	4	6	2	5	2	5.1
Q3	8	16	2	no data	3	2	no data	5	no data	6
Element of bullying and harassment										
Q1	17	12	5	2	11	2	7	6	4	7.3
Q2	3	27	1	5	25	3	11	8	4	9.6
Q3	20	19	3	no data	17	5	no data	12	no data	12.6
Reporting detriment										
Q1	0	0	0	1	1	0	0	1	0	0.3
Q2	0	0	1	0	11	2	1	4	0	2.1
Q3	0	3	0	no data	8	0	no data	3	no data	2.3
FTSU Index Score (2019)	74%	78%	83%	80%	77%	79%	81%	75%	80%	

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Appendix 3: FTSU Index Gap Analysis and Action Plan (updated March 2020, with 2019 Staff Survey Results)

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	2018: 55.9% 2019: 57.4%	58.3% 59.6%	2.4% 2.2%	• Ongoing communications promoting Speaking Up Policy, which is based on NGO best practice and enables concerns to be raised anonymously or confidentially and that the policy clearly states that the harassment or victimisation of workers that raise issues will not be tolerated, nor any attempt to bully a worker into not raising a concern.	Ongoing	GA
				• Ongoing promotion of the Just and Learning Culture framework. The Just and Learning Culture Framework Decision Tree is used to support the consistent, constructive and fair evaluation of the actions of workers involved in an incident.	Ongoing	GA
				• Introduce Speaking Up training as part of the statutory and mandatory provision for all workers in accordance with NGO national guidelines on Freedom to Speak Up training in the health sector in England (August 2019). To include the Just and Learning framework.	May 2020	GA
				• Ratify and communicate the updated Disciplinary Policy (including Just and Learning approach) across the organisation.	December 2019	B
				• Update all Speaking Up Policy supporting materials to ensure these include the Just and Learning approach and maintain focus on learning not blaming.	December 2019	B
				• Continue to promote our Speaking Up Plan as part of a regular communications strategy.	Ongoing	GA
				• Include information on detriment in FTSU quarterly reports.	January 2020	B

				• Widely promote Policy HR22 – Supporting Staff involved in an Incident, Complaint or Claim (the revised policy was approved at November 2019 TJNCC meeting).	January 2020	**B**
% of staff “agreeing” or “strongly agreeing” that their organisation encourages them to report errors, near misses or incidents	2018: 82.4%	87.9%	5.5%	• Speaking Up training to be introduced for all workers as part of statutory and mandatory training with an emphasis on importance of speaking up and the routes available to do so.	May 2020	**GA**
	2019: 84.5%	88.2%	3.7%	• Continue to invest in compassionate leadership development, and update the Speaking Up training for line and middle management in line with the July 2019 NGO training guidance - Creating the right environment to encourage workers to speak up - Supporting speaking up and listening well - Conflicts - Induction and exit - Feedback	May 2020	**GA**
				• Further Board development session planned on FTSU to include NGO training for senior leaders to cover: - Regulation of speaking up - The benefits of speaking up - The role of senior leaders - Demonstrating leadership - Supporting FTSU Guardians - Measures - Protection - Communication - Learning - Continuous improvement	14.01.2020	**B**

				• On-going messaging encouraging a culture of speaking up from Board members, FTSU Guardian, HR and governance teams via electronic communications and face to face listening events such as ward and department visits, Care Excellence Visits CEO Time to Talk sessions and conferences and leadership events, such as Leaders Network.	Ongoing	GA
% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice they would know how to report it	2018: 93.4%	94.3%	0.9%	• Review FTSU messaging at Induction. – Reviewed.	December 2019	B
	2019: 92.7%	94.2%	1.5%	• Update and promote Speaking Up Page and Staff Experience section of new intranet.	December 2019	B
				• Launch revised 'all workers' FTSU training and revise training delivered through Gateway to Management and Connects to reflect NGO requirements for line and middle managers. To include the routes available and how to raise issues.	May 2020	GA
				• Review communications strategy to ensure a programme of regular messaging that reinforces the message that speaking up is welcomed and how to raise issues. This needs to take into account ways in which more inaccessible workers can be reached.	December 2019	B
% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice	2018: 65.6%	69.3%	3.7%	• Trust wide communications and divisional championing of the Just and Learning Culture Framework.	In place and ongoing	B
	2019: 67.8%	70.4%	2.6%	• Promote zero tolerance approach to victimisation of workers who raise concerns.	December 2019	GA
				• Introduce newsletters and updates with a creative and engaging communication strategy to tell positive stories about speaking up	Quarterly	GB
				• Have a sustained and on-going focus on the reduction of bullying, harassment and incivility, which in November 2019 will include the launch of the 'Cut it Out' campaign.	November 2019 and ongoing	B

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

Executive Summary

Meeting:	Trust Board (Open)	Date:	6th May 2020
Report Title:	Rules of Procedure	Agenda Item:	13.
Author:	Deputy Associate Director of Corporate Governance		
Executive Lead:	Chief Executive		

Purpose of Report:					
Assurance		Approval	✓	Information	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards	✓	
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond	✓	
SO5		Ensure efficient use of resources	✓	

Executive Summary:

Situation
In line with best practice, each Committee of the Trust Board annually reflects on their own performance and effectiveness. The usual review comprises of three parts; committee effectiveness comprising feedback from the Chair and Committee members, an annual summary of the key areas of work and achievements against the Terms of Reference and business cycle and revision of the Committee Governance Pack, taking into account any issues raised by the effectiveness review and annual report.

Background
Whilst Committee Annual Reports have been prepared and presented to respective Committees, along with revised Terms of Reference, the review of effectiveness has not been undertaken for all Committees, due to the impact of Covid-19.

Assessment
Committee effectiveness reviews will take place later in the year for the Performance and Finance Committee, Quality Governance Committee and Transformation and People Committee; although each of these Committees has received and approved its Annual Report and Terms of Reference. The Nominations and Remuneration Committee and Audit Committee have received and considered all three parts of the review.

With regards to the Charitable Funds Committee, the Terms of Reference from 2019/20 have been included within the Rules of Procedure. It is proposed that a governance review is undertaken later in the year in terms of the role and responsibilities of the Corporate Trustee versus the Charitable Funds Committee. This will be undertaken once the substantive Director of Communications commences in post.

No major changes have been made to the Rules of Procedure and only minor changes have been made to the Terms of Reference, mainly due to the change to the names of the Committees and the introduction of the role of the Transformation and People Committee.

Aligned to the revised Governance Structure approved by the Board towards the end of 2019/20 and in response to the Well Led Supportive Developmental Review undertaken by NHSI, the Professional Standards and Conduct Committee is no longer a Committee reporting directly to the Board and has therefore its governance arrangements have been removed from the Rules of Procedure. The group will remain in place and discussions are underway between the Director of Human Resources, Medical Director and Associate Director of Corporate Governance around its revised Terms of Reference / role and function.

In addition, the role and function of the Trust Executive Committee has been revised during 2019/20 and this again is reflected in the revised Governance Structure. The Committee is purely an executive function and its purpose is for information sharing and communication between senior divisional leaders and the Executive Team. Therefore, Terms of Reference have not been included within the Rules of Procedure.

Key Recommendations:

The Trust Board is asked to note:

- that annual reports for each Committee have been considered by the respective Committees.
- that revised Committee Governance Packs have been approved by each Committee, and incorporated within the Rules of Procedure for 2020/21
- that outstanding Committee Effectiveness Reviews will be undertaken later the in the year and changes will be made to the Terms of Reference accordingly.

The Trust Board is asked to approve the revised Rules of Procedure for 2020/21, incorporating the Trust Board Business Cycle and Committee Governance Packs.

Rules of Procedure

April 2020

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About University Hospitals of North Midlands NHS Trust

What we do….

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital.

We are a large, modern Trust in Staffordshire, providing services in state of the art facilities. We provide a full range of general hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of three million, including neighbouring countries and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest Emergency Departments in the Country, with an average of nearly 15,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre Status, as we are the specialist centre for the North Midlands and North Wales.

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

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

Our 2025Vision

Our 2025 Vision was developed to set a clear direction for the organisation, to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care and the place in which the best people want to work.

To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and as operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organisation for inspiration. Our involvement in the Sustainability and Transformation Partnership (STP) is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services.

Our Strategic Objectives

The 2025Vision is underpinned by five Strategic Objectives:

SO1		Provide safe, effective, caring and responsive services
SO2		Achieve NHS constitutional patient access standards
SO3		Achieve excellence in employment, education, development and research
SO4		Lead strategic change within Staffordshire and beyond
SO5		Ensure efficient use of resources

Our Values

We continue to encourage a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff.

- **Together:** We are a team. We are appreciative. We are inclusive.
- **Compassion:** We are supportive. We are respectful. We are friendly.
- **Safe:** We communicate well. We are organised. We speak up.
- **Improving:** We listen. We learn. We take responsibility.

1. Introduction

The University Hospitals of North Midlands NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The North Staffordshire Hospital NHS Trust (Establishment) Order 1992 No 2559 (the Establishment Order). On the 1st April 2003, via order No 792, the name of the hospital was changed to the University Hospital of North Staffordshire NHS Trust. On 1st November 2014, the name of the hospital was changed to the University Hospitals of North Midlands NHS Trust.

- NHS Trusts are governed by statute, mainly the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 (the 2006 Act) and the National Health Service Act 1977 (the 1977 Act and together with the 2006 Act, the NHS Acts).
- The functions of the Trust are conferred by this legislation.
- The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

All generalised reference within these Rules of Procedure to the male gender should read as equally applicable to the female gender and vice versa.

2. Definitions

Accountable Officer	The NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
Associate Member	A person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
Board	The Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.
Budget	Resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, wherever possible, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Chair of the Trust	Is the person appointed by the Secretary of State for Health and Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'the Chair of the Trust' shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The chief accountable officer of the Trust.
Commissioning	The process for determining the need for and for obtaining the supply

	of healthcare and related services by the Trust within available resources.
Committee	Means a committee or sub-committee created and appointed by the Trust.
Committee members	Means persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Employee (Officer)	Employee of the Trust or any other person holding a paid appointment or office with the Trust.
Executive Director (Officer Member)	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Funds held on trust	Those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable.
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Member	Executive Director or non-Executive Director of the Board as the context permits.
Membership, Procedure and Administration Arrangements Regulations	NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
Non-Executive Director (Non-Officer Member)	A member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures.
SID Senior Independent Director	A non-executive director available to raise concerns whereby contact through the normal channels of Chair, Chief Executive, Executive Director or Associate Director of Corporate Governance has failed to resolve.
SO's	Standing Orders.
Standing Financial Instructions (SFIs)	Document detailing the financial responsibilities, policies and procedures adopted by the Trust.
Trust	University Hospitals of North Midlands NHS Trust.
Vice Chair	The Non-executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

3. Governance

The role of the Board is to set strategy, lead the organisation, oversee operations and to be accountable to stakeholders in an open and effective manner. Good governance provides the key to effective leadership, meaningful challenge, accountability and responsibility. Corporate governance is the system by which companies and other Board led organisations are directed and controlled. The Board is separate from the day to day operational management, which is the responsibility of the Executive Directors and the management structure they lead.

As described in NHS Improvement's Well-led Framework, NHS Trusts are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to longstanding sustainability problems, workforce shortages and the slowing growth in the NHS budget. Trust Boards need to ensure that their oversight of care, quality, operations and finance is robust in the face of uncertain future income, potential new models of care and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

NHS Trusts should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that they are providing high quality sustainable care. NHS Trust Boards are responsible for all aspects of performance and governance of the organisation.

4. Statutory Framework

The University Hospitals of North Midlands (UHNM) Board consists of:

- The Chair of the Trust appointed by NHS Improvement (NHSI) on behalf of the Secretary of State
- Up to 6 Non-Executive Directors
- Up to 6 Executive Directors (but not exceeding the number of Non-Executive Directors) including the Chief Executive and the Chief Finance Officer

The Trust Board shall have not more than 13 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

The principal place of business of the Trust is the Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. The Trust also provides services at the County Hospital, Weston Road, Stafford, ST16 3SA.

An organisational chart of the Trust Board members and the Trust Boards Committee Structure can be found at appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

The Board shares responsibility for:

- Ensuring that high standards of corporate governance are observed and encouraging high standards of propriety
- Establishing the strategic direction and priorities of UHNM
- The effective and efficient delivery of UHNM's plans and functions
- Promoting quality in UHNM's activities and services
- Monitoring performance against agreed objectives and targets
- Ensuring that Board members personally and corporately observe the seven principles of public life set out by the Committee on Standards in Public Life.

The Board has collective responsibility for the decisions made by it. Members of the Board shall be subject to the Code of Conduct set out in appendix 3.

Any member of the Board who significantly or persistently fails to adhere to these Rules of Procedure may be judged as failing to carry out the duties of their office and will be managed in accordance with current Trust Policy.

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine and as set out within the annual Calendar of Business.
- The Board may invite any person to attend all or part of a Board meeting.
- Meetings will normally be held in the Trust Boardroom at the Royal Stoke University Hospital or the Postgraduate Medical Centre at the County Hospital (or any other convenient location).
- Members of the Board are expected to attend not less than 8 Board meetings (whether formal meetings or seminars) in any 12 month period.

6.2 Admission of the Public and Press

- The Board will operate in an open and transparent fashion, except where confidentiality requirements are concerned.
- The chair will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, subject to the provisions of the Public Bodies (Admission to Meetings) Act 1960, such as to ensure that the Board's business may be conducted without interruption or disruption. The Board may resolve to exclude the public and conduct its business in private, whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business being transacted or for other special reasons stated in the resolution.
- Members of the public and press are not admitted to meetings of committees or sub-committees except by specific invitation.

Business proposed to be transacted when the press and public have been excluded from a meeting
Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board.

Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Use of mechanical or electrical equipment for recording or transmission of meetings
The Trust does not permit the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board. Such permission shall be granted only upon resolution of the Chair and Chief Executive, in advance of the meeting.

6.3 Board Meeting Agenda and Papers

In normal circumstances, the agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. For meetings held in public, the agenda and supporting papers shall be published via the Trust website www.uhnm.nhs.uk at least three working days before the meeting.

The order of business at Board meetings shall follow the agenda issued for that meeting unless otherwise directed by the Chair, at whose discretion, or at the request of another member of the Board, the order may be altered at any stage. The agenda will be primarily based upon the Business Cycle approved by the Board (appendix 4).

Papers may only be tabled at a meeting of the Board with the permission of the Chair.

No other business other than that on the agenda will be taken except where the Chair considers the item should be discussed.

Members of the Board should treat those papers identified as private and confidential and not discuss them with persons other than Board members or employees unless this is agreed with the Chair. If so discussed, members of the Board should ensure that those with whom they have consulted are made aware of, and respect, the need for confidentiality.

Members must take care not to leave Board papers identified as private unattended or where others may obtain access to them.

6.4 Extraordinary Meetings of the Board

In the event of urgency the Chair may determine to hold a meeting to be known as an extraordinary meeting at such time as he/she may determine.

6.5 Power to Call Meetings of the Board

Where, in the opinion of the Chair, an urgent matter has arisen, the Chair may call a meeting of the Board at any time.

Where two or more members of the Board submit a signed request for a meeting to the chair, the chair shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

6.6 Chairing of Meetings

The procedure at meetings shall be determined by the Chair presiding at the meeting. The Chair shall, if present, preside at all meetings of the Board. In the absence of the Chair, the Vice-Chair will preside.

In the absence of both the Chair and the Vice-Chair, a Non-Executive Director chosen by the other members will preside.

6.7 Procedure at Meetings of the Board

The Chair or person presiding over the meeting of the Board will:

- Preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion
- Determine all matters of order, competency and relevancy
- Determine in which order those present should speak
- Determine whether or not a vote is required and how it is carried out

Written comments on agenda items submitted by any member of the Board who is not present when a particular agenda item is discussed may be circulated to those members of the Board who are present at the meeting and read out at the appropriate point in the meeting.

Decisions of the Board will normally by made by consensus rather than by formal vote. Failing consensus, decisions will be reached by means of a vote when:

- the person presiding over the meeting feels that there is a body of opinion among members of the board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or
- when a member of the Board who is present requests a vote to be taken; or
- any other circumstances in which the person presiding at the meeting considers that a vote should be taken.

Voting will take place as follows:

- Where a decision of the Board requires a vote it shall be determined by a majority of the votes of the members of the Board present and voting on the question. The person presiding at the meeting shall declare whether or not a resolution has been carried or otherwise. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting shall have a second, and casting vote).

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- At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.
- A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. The status of Executive Directors when attending a meeting shall be recorded in the minutes.

No resolution of the Board will be passed if it is unanimously opposed by all of the Executive Directors present or by all of the Non-Executive Directors present.

The minutes of the meeting will record only the numerical results of a vote showing the numbers for and against the proposal and noting any abstentions. The minutes shall be conclusive evidence of the outcome. Votes will not normally be attributed to any individual member of the Board but any member may require that their particular vote be recorded, provided that he/she asks the secretary immediately after the item has concluded.

The Board may agree to defer a decision on an agenda item so that it can be provided with additional information or for any other reason. The decision to defer together with the reasons for doing so will be recorded in the minutes of the meeting together with the proposed time for returning the matter to the Board for its consideration.

The Board may decide to delegate decisions on agenda items to the Chair. Any decision to do so shall be recorded in the minutes of the meeting.

Where in the opinion of the Chair, and considering advice from the Chief Executive, or any other Executive Director, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the members of the Board with the Chair having the power to cast a second casting vote.

Only exceptionally, where the process to reach a decision would not benefit from discussion in a meeting at which members views would inform debate or, if the issue is time critical will a Board decision be reached without a formal meeting.

6.8 Quorum of the Board

No business shall be transacted at a meeting unless at least six Directors with voting rights (including at least two Executive Directors and three Non-Executive Directors). Attendance of the Chair, shall count as one of the Non-Executive Directors.

An individual in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Participation will usually be in person, but in exceptional circumstances members of the Board may participate by telephone or video-conferencing facility and be deemed to be present and constitute part of the board for that meeting.

When a Board meeting:
- Is not quorate within half an hour from the time appointed for the meeting or;
- Becomes inquorate during the course of the meeting;

the meeting shall either be adjourned to such time, place and date as may be determined by the members present or shall continue as an informal meeting at which no decisions may be taken.

6.9 Minutes of the Board

The minutes of the proceedings of a meeting along with a Post Meeting Action Log shall be drawn up and submitted for agreement at the next ensuing meeting where their approval will be recorded.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate (for example matters arising).

The record of the minutes shall include:
- The names of:
  - Every member of the Board present at the meeting
  - Any other person present
  - Any apologies tendered by an absent member of the Board
- The withdrawal from a meeting of any member on account of a conflict of interest and;
- Any declaration of interest

Minutes of any meeting of the Board will record key points of discussion. Where personnel, finance or other restricted matters are discussed, the minutes will describe the substance of the discussion in general terms.

Once agreed, the minutes will be published via the Trust website www.uhnm.nhs.uk.

6.10 Emergency Powers

The functions exercised by the Board may, in an emergency, be exercised by the Chair after having consulted the Chief Executive.

The exercise of such powers by the Chair must be reported to the next formal meeting of the Board in public session for ratification. The reasons for why an emergency decision was required must be clearly stated.

6.11 Delegation of Powers

The Board remains accountable for all of UHNM's functions, even those delegated to Committees, the Chair, Chief Executive, Executive Directors or employees, and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

The list of matters reserved for decision by the Board does not however preclude other matters being referred to the Board for decision. All powers delegated by the Board can be reassumed should the need arise and the Board reserves the right to deal with any matters previously delegated. The Board may also revoke or vary such delegation.

The Board delegates to each Committee the discharge of those functions that fall within their respective terms of reference other than any matters reserved to the Board.

The Chief Executive shall prepare a scheme of delegation (Trust Policy F02 Scheme of Delegation and appendix 6 of this document), identifying which functions he/she shall perform personally and which functions have been delegated to Committees and individual employees.

All powers delegated by the Chief Executive can be reassumed by them should the need arise.

Powers are delegated to the Committees and individual employees on the understanding that they will not exercise delegated powers in a matter which in their understanding is likely to be cause for public concern or which might have an effect on the reputation of the Trust.

The exercise of all delegated powers is on the basis that appropriate expert advice will be sought as necessary and that any costs involved can be met within the authorised budget.

The Corporate Governance Team shall keep a record of the powers, authorities and discretions delegated by the Board.

In the absence of an employee to whom powers have been delegated, those powers shall be exercised by the relevant Executive Director unless alternative arrangements have been approved by the Board. If the Chair is absent the powers delegated to him may be exercised by the Vice Chair in relation to the Board and the Chief Executive after taking advice as appropriate from the Board and Executive Directors.

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive acts as the Accountable Officer. As Accountable Officer, she/he is responsible for ensuring that the public funds for which she/he is personally responsible are properly safeguarded and that functions are used effectively, efficiently and economically.

The standing financial instructions, (Trust Policy F01 Standing Financial Instructions), detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

All proposed expenditure above £1 million must be formally approved by the Trust Board.

6.13 Personal Conflicts of Interest

If a member of the Board or a Committee member knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that in the opinion of a fair minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the Board or any Committee, he/she shall disclose the nature of the interest or duty at the meeting. The declaration of interest or duty may be made at the meeting or at the start of the discussion of the item to which it relates or in advance in writing to the Corporate Governance Team. If an interest or duty has been declared in advance of the meeting, this will be made known by the Chair of the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare an interest as soon as he/she becomes aware of it.

If a member of the Board or a Committee has acted in accordance with the provisions above and has fully explained the nature of their interest or duty, the members of the Board or Committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue and this will be recorded in the minutes and the extent to which the person concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the Chair may first allow them to make a statement on the item under discussion.

Where the chair of the meeting has a relevant interest then he/she must advise the Board or the Committee accordingly, and with their agreement and subject to the extent decided, participate in the discussion and the determination of the issue. This will be recorded in the minutes and the extent to which he/she had access to any written papers on the matter. If it is decided that the Chair should leave the meeting because of a conflict of interest, another member will be asked to chair the discussion of the relevant agenda item in accordance with the procedure set out above.

Employees who are not members of the Board or Committee, but who are in attendance at a meeting of the Board or a Committee should declare interests in accordance with the same procedures as for those who are members. Where the chair of a meeting rules that a potential conflict of interest exists, any employee so concerned should take no part in the discussion of the matter and may be asked to leave by the meeting chair.

A member of the Board, Committee or employee shall be subject to the arrangements for dealing with conflicts of interests as set out in the Trust Policy G16 Standards of Business Conduct.

6.14 Allowances for Non-Executive Members of the Board

Non-Executive members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of duties in accordance with Trust Policy.

7. Meetings and Proceedings of Committees

Where no specific provisions are specified for Committees, these are the same as the principles and provisions for the Board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the Terms of Reference for any Committee, the latter shall prevail.

Committee Governance Packs for each of the Committees, which include Terms of Reference and Membership, Business Cycles, Agenda and Reporting Templates and Self-Assessment Tools can be found at appendices 7 – 13.

7.1 Appointment of Committees

- The Board may establish a Committee for any purpose within its functions and shall determine the powers and functions of any such Committee.
- The Board shall appoint members of the Committees.
- The Board shall appoint, for every Committee, a Chair who shall be a member of the Board, unless there is a specific requirement that the Chief Executive, as Accounting Officer, should be chair.
- The Board shall keep under review, the structure and scope of activities of each Committee.
- The Board shall set out the Terms of Reference for each Committee (see appendices 7 – 13).
- The Board may at any time amend the Terms of Reference of any Committee.

7.2 Meetings of a Committee

A Committee shall hold meetings at such regular intervals as may be determined by the members of the Committee. The Committee shall determine the time and place of the meetings to be held.

7.3 Extraordinary Meetings of a Committee

In the event of urgency, the Committee chair may determine to hold an extraordinary meeting at such time and place as he/she may determine.

7.4 Attendance at Committee Meetings

A member of the Board may attend and speak with the permission of the chair of the Committee at any meeting of a Committee.

A member of the Board who is not a member of the Committee shall not vote on any matter before the Committee.

7.5 Chairing of Committee Meetings

The procedure at meetings shall be determined by the Committee chair presiding at the meeting.

The Committee chair shall, if present, preside at all meetings. In the absence of the Committee chair, a non-executive Board member, who is also a member of the Committee, or a Board member nominated by the Committee chair shall preside.

7.6 Quorum of Committees

The quorum for a Committee meeting shall generally consist of one half of the total membership of the Committee of which at least one non-executive member of the Board is present, unless stated otherwise within their Terms of Reference.

7.7 Minutes of Committees

A member of the Executive Suite shall act as Secretary to Committees or nominate a deputy. The Secretary shall record the minutes of every meeting of the Committee or nominate a deputy. The record of minutes shall be submitted to the Committee at its next meeting for agreement, confirmation or otherwise.

Minutes of all Committee meetings will be accessible to all Board members via the Corporate Governance Team.

7.8 Committee Reporting to the Board

The Corporate Governance Team will prepare a report following each Committee meeting, on behalf of the Committee chair, for presentation to the next Board meeting. This will include a section highlighting key points, and referral of items as appropriate as well as any recommendations to the Board.

Each Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. An evaluation template for each Committee can be found within their respective 'Governance Pack'. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

7.9 Prohibition on Delegation of a Committee's Function

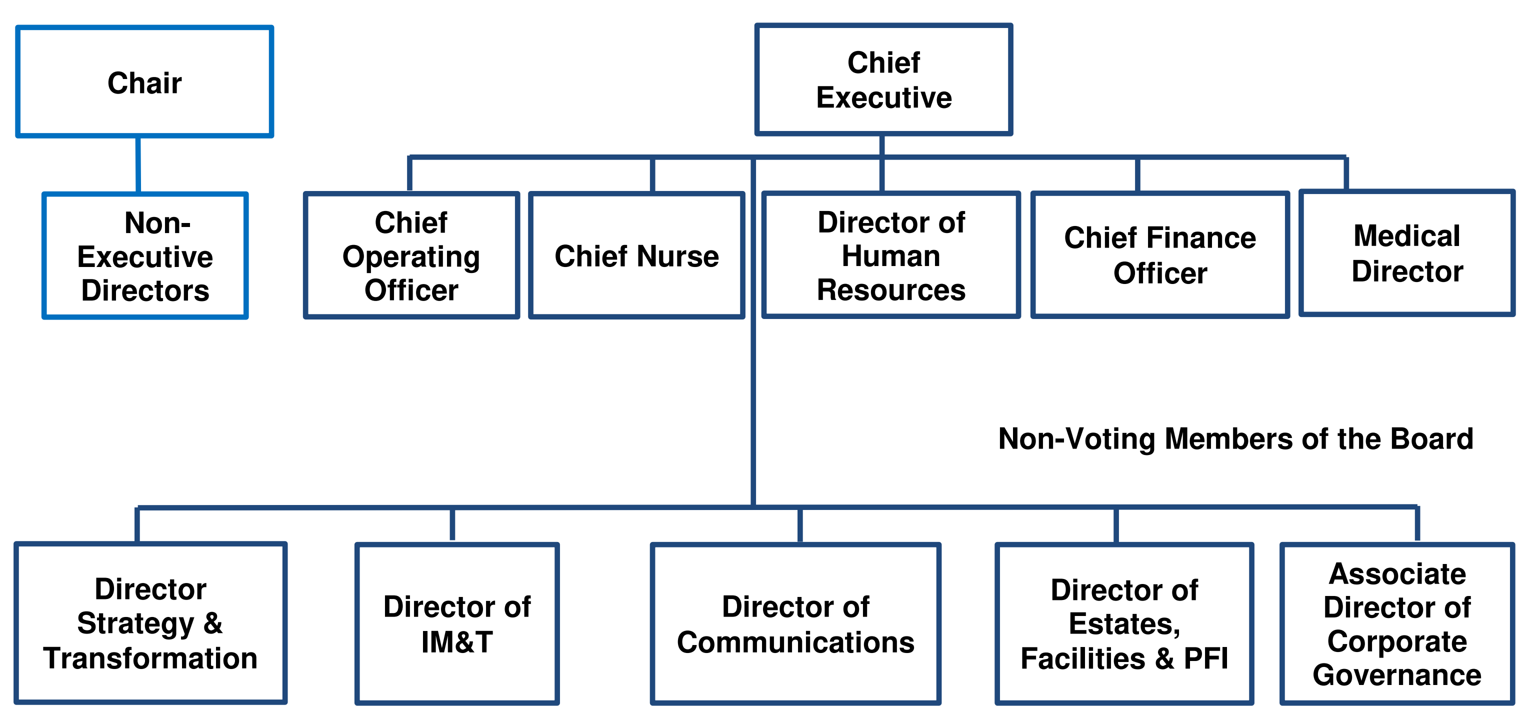
A Committee shall not delegate its functions to any other group established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

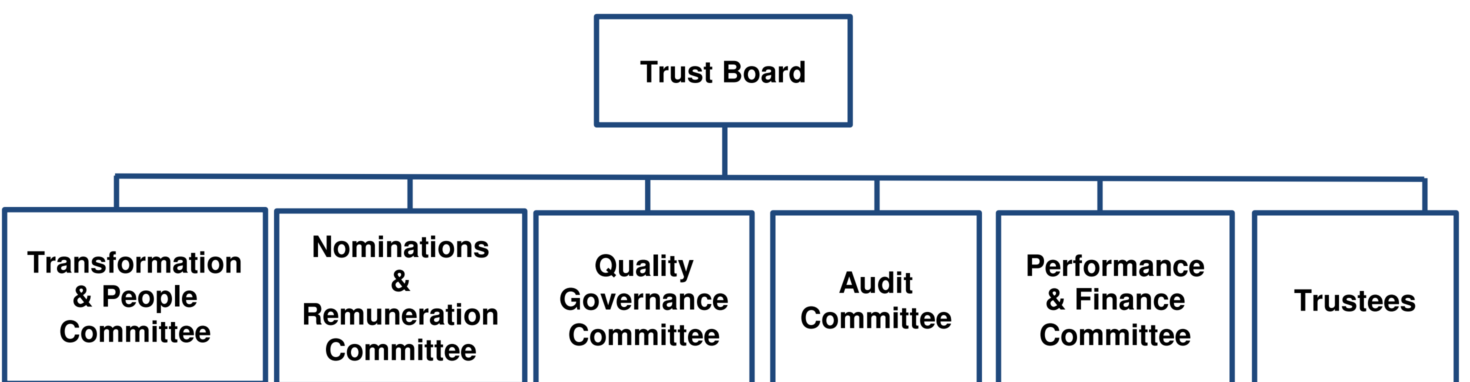
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Trust Board and Committee Organisation Chart



Appendix 3 - Code of Conduct for Board Members

UHNM Trust Board: Code of Conduct

To justify the trust placed in me by patients, service users and the public, I will abide by these standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and wellbeing of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in my dealings.

1. Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards and should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out within this Code are consistent with the Nolan Principles on Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, the Code of Conduct should be read alongside the Trusts Values, Behaviours and Standards Framework.

2. Purpose

Senior leadership roles can frequently require individuals to address dilemmas in difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers.

- Part 1 of this Code of Conduct is designed to provide a framework to guide judgment in these circumstances, through a consistent application of values and principles.
- Part 2 sets out a modern etiquette for Board members, including behavioural expectations, to help ensure that Board meetings are effective and focused.
- Part 3 provides an outline of the individual and collective roles and responsibilities of Board members.

3. Part 1: Standards For Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

In the treatment of patients and service users, their families and their carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible, Board members must commit to:

- The values of the **NHS Constitution** in the treatment of staff, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible.
- Promoting **equality and diversity** in the treatment of staff, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible.
- Promoting **human rights** in the treatment of staff, patients, their families and carers, and the community, and in the design of services for which they are responsible.
- The **duty of candour** to ensure that ‘patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences’. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death.
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test**.

Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the staff and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
Respect	I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
Leadership	I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- To make sound decisions individually and collectively
- Excellence in the safety and quality of care, patient experience and the accessibility of services
- Long term financial stability and best value for the benefit of patients, service users and the community.

This will be done through:

- Always putting the safety of patients and service users, the quality of care and patient experience first, enabling colleagues to do the same.
- Demonstrating the skills, competencies and judgment necessary to fulfil their role and by engaging in training, learning and continuing professional development.
- Having a clear understanding of the business and financial aspects of the organisations work and of the business, financial and legal contexts in which it operates
- Making best use of expertise and that of colleagues while working within the limits of their own competence and knowledge.
- Understanding their role and powers, the legal, regulatory and accountability frameworks and guidance within which they operate and the boundaries between the executive and non-executive.
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively.
- Publicly upholding all decisions taken by the Board under due process for as long as they are a member of the Board.
- Thinking strategically and developmentally.
- Seeking and using evidence as the basis for decisions and actions.
- Understanding the health needs of the population served.
- Reflecting on personal, Board and organisational performance and how their behaviour affects those around them; and supporting colleagues to do the same.
- Looking for the impact of decisions on the services provided, on the people who use them and on staff.
- Listening to patients and service users, their families and carers, the community, colleagues and staff and making sure people are involved in decisions that affect them.
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues and staff, ensuring that messages have been understood.
- Respecting patients' rights to consent, privacy and confidentiality and access to information, as enshrined in data protection and freedom of information law and guidance.

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- To ensure the organisation is fit to service its patients and service users, and the community.
- To be fair, transparent, measured and thorough in decision making and in the management of public money.
- To be ready to be held publicly to account for the organisations decisions and for its use of public money.

This will be done through:

- Declaring any personal, professional or financial interests and ensure that they do not interfere with actions, transactions, communications, behaviours or decision making, removing themselves from decision making when they might be perceived to do so.
- Taking responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns identified.
- Ensuring that effective complaints and whistleblowing procedures are in place and in use.
- Condemning any practices that could inhibit the reporting of concerns by members of the public, staff or Board members about standards of care or conduct.
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation.
- Seeking assurance that the organisations financial, operational and risk management frameworks are sound, effective and properly used and that the values in these standards are put into action in the design and delivery of services.
- Ensuring that the organisations contractual and commercial relationships are honest, legal, regularly monitored and compliant with best practice in the management of public money.
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care.
- Ensuring that the organisations dealings are made public, unless there is a justifiable and properly documented reason for doing so.

4. Part 2: Board Meetings - Etiquette

The Trust Board is the predominant mechanism by which strategy is agreed, performance monitored and executive actions held to account on behalf of stakeholders. It is therefore essential that the Board conducts meetings with a view to optimising the use of the time and intellectual capital of members.

As such, the Board needs to focus on the purpose of the meeting, and all the elements that can contribute to an effective discussion, including the way members interact and work together to ensure sound decision-making.

An effective Board develops and promotes its collective vision of the Trust's purpose, culture, values and the behaviours it wishes to promote in conducting its business. In particular it:

- Provides direction for management;
- Demonstrates ethical leadership, displaying and promoting behaviours consistent with the culture and values it has defined for the organisation;
- Makes well-informed and high-quality decisions based on a clear line of sight into the business.

Ensuring robust and appropriate challenge depends on a number of factors being in place: the right information in the right format in advance of the meeting; an appropriate setting; length of the meeting; good Chairmanship; appropriate Boardroom behaviours and the encouragement of a culture where challenge is accepted.

If Board members are not fully engaged throughout the duration of a Board meeting, and behaviours are poor, decision-making will be impaired. It may be possible that Board papers are failing to engage members, consequently not stimulating directors to ask questions and challenge assumptions behind recommendations.

4.1 Before the Meeting

- Provide papers 5 days in advance of the meeting, to allow these to be circulated to members; late papers will only be allowed following discussion with the Chief Executive/Chair.
- Having received the Board papers before the meeting, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems.
- Be clear on the decision that is being asked for.
- Request further information ahead of the meeting or seek clarification from the Trust Secretary or report author (including highlighting typographical and other errors not of material consequence), where appropriate.
- Submit apologies, and where appropriate arrange for a deputy to attend (ensuring they are well-briefed).
- Arrive for the meeting on time, stay for its duration, and ensure regular attendance at all meetings.
- If you have to leave before the end of the meeting, inform the Chair beforehand. However, this should be avoided whenever possible.

4.2 During the Meeting

- Declare any potential or real conflicts of interest with regard to any matter on the agenda.
- If using an electronic device to make notes during the meeting of discussions and decisions made, it is advisable to inform fellow Board members of your intention and gain the permission of the Chair.
- Unless there are specific reasons for doing so, no part of the meeting should be visually or audio recorded. If such recording is agreed the Chair must inform the meeting beforehand.

4.3 Focussing on the Agenda

- Stay focused on agenda items.
- Dedicate attention to the purpose of the meeting and refrain from performing other duties at the same time.

- Turn off mobile phones/electronic communications device. When an electronic device must be kept on, turn to silent/vibrate. Should individuals need to answer an urgent call; attendees should be forewarned that and urgent call is expected and permission of the Chair to keep the electronic device on must be sought.
- Refrain from private conversations with others at the meeting (whether spoken or written), and the passing of notes.

4.4 Contributing to the Discussion

- If appropriate, attract the Chair's attention when wishing to contribute to the discussion, and wait until the Chair indicates that you may speak so as to avoid interrupting a fellow Board member. Direct comments and discussion through the chair.
- When invited to speak by the Chair, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms.
- Throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made.
- Be constructive and professional in imparting an opinion or information.
- Listen attentively and respectfully to others, making notes of any points to raise when an opportunity to respond arises; do not interrupt when others are speaking.
- Ensure body language demonstrates participation and engagement in the meeting.
- Challenge inappropriate behaviour/language from other Board members at the time via the chair or after the meeting if more convenient.
- Treat attendees fairly and consistently, even if there is disagreement with another's point of view.
- Challenge and provide critique constructively, and ensure that any challenges are proportionate and based on fact. Challenge the issue being discussed, not the personality of other individuals taking part in the discussion.
- Seek clarification or amplification when necessary.

4.5 Unitary Board

- Board members should know and understand their role at the meeting and the need for the Board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body).
- Board members should not act territorially/personally, and should remember the need to contribute to the corporate nature of the Board.
- Regard and welcome challenge as a test of the robustness of papers and arguments presented.
- Do not cause offence or take offence, accept the diversity of opinions and views presented.

4.6 Accountability

- Seek professional guidance/clarification from the Chair during the meeting (or Associate Director of Corporate Affairs outside the meeting) wherever there may be any concern about a particular course of action.
- Keep confidential matters confidential.

4.7 After the meeting

- Participate and contribute to any post-meeting review with a view to making future meetings more effective
- A summary of actions agreed will be produced and circulated by the Corporate Governance Team within 1 day of the meeting. Board members must read the action summary and complete any relevant tasks and report back appropriately on their completion in a timely manner. A central log of all actions agreed by the Board will be maintained by the Corporate Governance Team.
- Draft minutes will be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the Corporate Governance Team at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next Board meeting.
- Observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers, both electronic and paper copies are stored safely.

- Remember that decisions were taken collectively by the Board and therefore that responsibility remains collective too.

Where there is evidence that the Board etiquette policy has been breached, the chair, with guidance from the Corporate Governance Team, will recommend the necessary action to be taken.

Any meeting to discuss breaches of Board etiquette will take place with the presence of the member accused of inappropriate behaviour, in accordance with the Board's code of conduct, where applicable.

Board behaviour and performance, collectively and individually, should be reviewed as part of an annual Board evaluation process.

All Board members share corporate responsibility for:
- formulating strategy
- ensuring accountability
- shaping culture
- ensuring the Board operates as effectively as possible

5.1 Chair and Chief Executive

The Chair and Chief Executive have complimentary roles in Board leadership. These are defined in more detail within the 'Memorandum of Understanding between the Chair and Chief Executive'. In essence, these two roles are:
- The **Chair** leads the Board and ensures the effectiveness of the Board (and Council of Governors once Foundation Trust status is achieved)
- The **Chief Executive** leads the executive and the organisation

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures Board develops vision and clear objectives to deliver organisational purpose	Leads vision, strategy development process	Brings independence, external skills and perspectives and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for delivery of strategy Ensures that Board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of the strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the Boards behaviour and decision making	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour

	Chair	Chief Executive	Non-Executive Director	Executive Director
	Board culture: Leads and supports a constructive dynamic within the Board, enabling contributions from all directors		Board for whistle blowers	
Context	Ensures all Board members are well briefed on external context	Ensures all Board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely and clear information to Board / directors are clear to executive	Ensures provision of accurate, timely and clear information to Board / directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Plays a key leadership role effective communication and building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Ensures Board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns	Leads on engagement with specific internal or external stakeholder groups

6. Monitoring Compliance with the Code of Conduct

Overall Board behaviour and performance, collectively and individually, will be reviewed as part of an annual Board evaluation process.

Individual performance against this Code of Conduct will be assessed as part of the appraisal discussion with the Chief Executive Officer / Chair as appropriate.

7. References

- ICSA: Specimen Board Meeting Etiquette, February 2012
- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2011
- CHRE: Standards for members of Boards and governing bodies in England, (draft for consultation), January 2012
- Professional Standards Authority: Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England
- National Leadership Council: The Healthy NHS Board, Principles for Good Governance, February 2010

Appendix 4 – Trust Board Business Cycle 2020/21

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		8	6	10	8	5	16	7	4	9	6	3	10
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES													
Chief Executives Report	Chief Executive												
Patient Story	Chief Nurse												
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance												
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer												
Care Quality Commission Action Plan	Chief Nurse												
Bi Annual Nurse Staffing Assurance Report	Chief Nurse												
Quality Account	Chief Nurse												
7 Day Services Board Assurance Report	Medical Director												
NHS Resolution Maternity Incentive Scheme	Chief Nurse												
Winter Plan	Chief Operating Officer												
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI												
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS													
Integrated Performance Report	Various												
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH													
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance												
Gender Pay Gap Report	Director of Human Resources												
People Strategy Progress Report	Director of Human Resources												
Revalidation	Medical Director												
Workforce Disability Equality Report	Director of Human Resources												
Workforce Race Equality Standards Report	Director of Human Resources												
Staff Survey Report	Director of Human Resources												
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND													
System Working Update	Chief Executive / Director of												

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		8	6	10	8	5	16	7	4	9	6	3	10
	Strategy												
ENSURE EFFICIENT USE OF RESOURCES													
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy												
IM&T Strategy Progress Report	Director of IM&T												
Going Concern	Chief Finance Officer												
Estates Strategy Progress Report	Director of Estates, Facilities & PFI												
Annual Plan 2020/21	Director of Strategy												
Financial Plan 2021/22	Chief Finance Officer												
Capital Programme 2021/22	Chief Finance Officer												
GOVERNANCE													
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance												
Audit Committee Assurance Report	Associate Director of Corporate Governance												
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3	
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3	
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance												
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance												
G6 Self-Certification	Chief Executive												
FT4 Self-Certification	Chief Executive												
Board Development Programme	Associate Director of Corporate Governance												

Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Team if required, and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, establishment and duties			
Does the Committee have written terms of reference and have they been approved by the Trust Board?			
Are the terms of reference reviewed annually?			
Are committee members independent of the management team?			
Are the outcomes of each meeting reported to the Corporate Trustee?			
Does the committee prepare an annual report on its work and performance?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Compliance with the law and regulations governing the NHS			
Does the committee review assurance and regulatory compliance reporting processes?			

Committee Effectiveness

To be completed by each member of the Group for to submission to the Chair.

Statement	Please tick (✓) one box for each question					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ action
Theme 1 – Committee Focus						
The committee has set itself a series of objectives for the year						
The committee has made a conscious decision about the information it would like to receive						
Committee members contribute regularly to the issues discussed						
The committee is aware of the key sources of assurance and who provides them						
Theme 2 – Committee Team Working						
The committee has the right balance of experience, knowledge and skills to fulfil its role						

Statement	Please tick (✓) one box for each question					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ action
The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives						
The committee is fully briefed on key risks and any gaps in control						
The committee environment enables people to express their views, doubts and opinions						
Members hold their assurance providers to account for late or missing assurances						
Decisions and actions are implemented in line with the timescale set down						
Theme 3 – Committee Effectiveness						
The quality of committee papers received allows committee members to perform their roles effectively						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance						
The committee challenges management and other assurance providers to gain a clear understanding of their findings						
Debate is allowed to flow, and conclusions reached without being cut short or stifled						
Each agenda item is ‘closed off’ appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored						
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well						
The committee provides a written summary report of its meetings to the Trust Board including items for escalation						
The Trust Board challenges and understands the reporting from the Committee						
Theme 4 – Committee Engagement						
Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference						
Theme 5 – Committee Leadership						
The committee chair has a positive impact on the performance of the committee						
Committee meetings are chaired effectively						
The committee chair is visible within the Trust and is considered approachable						
The committee chair allows debate to flow freely and does not assert his/her own views too strongly						
The committee chair provides clear and concise information to the Trust Board on committee activities and gaps in control						

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under Board delegation with approved terms of reference that reflects best practice available nationally. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities. An outcome summary of each meeting of the Committee is formally reported to the Public Trust Board via the Committee Chair. The report has highlighted key points of discussion, challenge, decisions made, referral of items as appropriate and recommendations to the Board.

During the year, the Committee comprised of the following membership:
- xx

Other individuals such as the xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year the Committee has monitored the progress made in delivering the business cycle, as can be seen below:

Compliance with the key responsibilities is evidenced by the actions identified in the following sections:

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has been active during the year in discharging its responsibilities and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Objectives for xxx

- xxx

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

	Attended		Apologies Given – Deputy sent		Apologies Given		Not in Post

Members:		A	M	J	J	A	S	O	N	D	J	F	M

The average attendance of members (or deputies) at the Committee was xx%.

Conclusion

The Committee is of the opinion that this annual report is reflects the work of Committee during xx and that the Committee has reviewed xxx. In addition there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Title of Committee

Meeting held on xx 2019 at xx am to xx pm
Trust Boardroom, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
	PROCEDURAL ITEMS				
	1.	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx xx 2020	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	xx				
	5.				
	6.				
	7.				
	xx				
	8.				
	9.				
	10.				
	xx				
	11.				
	12.				
	13.				
	GOVERNANCE				
	14.				
	15.				
	16.				
	CLOSING MATTERS				
	17.	Review of Meeting Effectiveness and Business Cycle Forward Look			
	18.	Agreement of Items for Highlight Report including Items for Escalation to Trust Board			
	DATE AND TIME OF NEXT MEETING				

Title of Committee

Meeting held on xx 2019 at xx to xx
Trust Boardroom, Springfield, Royal Stoke

MINUTES OF MEETING

Members:	A	M	J	J	A	S	O	N	D	J	F	M
xxx												
xxx												
xxx												
xxx												
xxx												
xxx												

In Attendance:		
xxx	xx	Personal Assistant (minutes)
xxx	xx	xxx
xxx	xx	xxx

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
2.	**Title**	
	xx	
3.	**Title**	
	xx	
4.	**Title**	
	xx	
5.	**Date and Time of Next Meeting**	
	Date / Date / Time / Venue	

Appendix 9 – Audit Committee Governance Pack

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members will be appointed as Chair of the Committee by the Board and the Chair of the organisation shall not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. At least once a year, the Committee should meet privately with the external and internal auditors.

The local counter fraud specialist will attend a minimum of two committee meetings a year.

The Chief Executive should be invited to attend and should discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft annual report and accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Corporate Governance team shall provide appropriate support to the Chair and Committee members.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting year and audit cycle is proposed. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Committee.

Together Compassion Safe Improving PROUD TO CARE

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements
- The robustness of the processes behind the quality accounts.

The annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Integrated Governance, Risk Management and Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality Governance Committee, Performance and Finance Committee and Transformation and People Committee) so that it understands processes and linkages.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consideration of the major findings of internal audit work (and managements response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal annual and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health's arms-length bodies or regulators / inspectors (for example, the Care Quality Commission, NHS Improvement etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality Assurance Committee and Finance and Efficiency Committee in terms of risk management.

Relationship with other Committees:
As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality Governance Committee
- The effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the Transformation and People Committee.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

Management
The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Qualitative aspects of financial reporting.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Thursday 23rd April 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	16th April 2020
Friday 22nd May 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	15th May 2020
Thursday 23rd July 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	16th July 2020
Thursday 22nd October 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	15th October 2020
Thursday 21st January 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	14th January 2020

C. Annual Business Cycle

Title of Paper	Executive Lead	Apr 23	May 22	Jul 23	Oct 22	Jan 21
GOVERNANCE						
Private Internal and External Audit Discussions	Audit Committee					
Annual Governance Statement	Associate Director of Corporate Governance					
Annual Report	Associate Director of Corporate Governance					
Board Assurance Framework	Associate Director of Corporate Governance	Q4		Q1	Q2	Q3
Internal Audit Recommendation Tracker	Associate Director of Corporate Governance					
Committee Effectiveness (including that of other Committees)	Associate Director of Corporate Governance					
Quality Account	Chief Nurse					
Review of the Risk Management System	Internal Audit					
Report from Transformation and People Committee	Associate Director of Corporate Governance					
Report from Performance and Finance Committee	Associate Director of Corporate Governance					
Report from Quality Governance Committee	Associate Director of Corporate Governance					
FINANCE						
Analytical Review and Draft Accounts	Chief Finance Officer					
Going Concern	Chief Finance Officer					
Losses and Special Payments and Stock Write Offs	Chief Finance Officer					
Single Tender Waiver / SFI	Chief Finance Officer					
Audited Accounts and Financial Statements	Chief Finance Officer					
Annual Accounts Timetable	Chief Finance Officer					
Assurance from Third Party Providers i.e. ELFS and RWT	Chief Finance Officer			TBC		
INTERNAL AUDIT						
Approval of Internal Audit Plan	Internal Audit					
Effectiveness of Internal Audit	Audit Committee					
Internal Audit Progress Reports	Internal Audit					
Internal Audit Annual Report and Opinion	Internal Audit					
EXTERNAL AUDIT						
External Audit Plan	External Audit					
External Audit Progress Report	External Audit					
Audit Findings Report and Letter of Representation	External Audit					
Effectiveness of External Audit	Audit Committee					
Annual Audit Letter	External Audit					
Quality Account External Audit Report	External Audit					
Informing the Audit Risk Assessment	External Audit					

Title of Paper	Executive Lead	Apr 23	May 22	Jul 23	Oct 22	Jan 21
COUNTER FRAUD						
Counter Fraud Annual Plan	Counter Fraud					
Trust's Assessment against NHS Protect's Standards	Counter Fraud					
Effectiveness of LCFS	Audit Committee					
Counter Fraud Annual Report	Counter Fraud					
Counter Fraud Progress Report	Counter Fraud					

D. Annual Reporting Template

Introduction

The Audit Committee is established under Board delegation with approved terms of reference which are aligned to the Audit Committee Handbook 2014, published by the HFMA and Department of Health. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisations business. A report following each Committee meeting was presented to the Open Board and summarised the decisions made as well as highlighting any items for escalation. In addition the Trust Board also received a copy of the Committee minutes.

During the year, the Committee comprised of the following membership:
- x

Other individuals such as xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key areas of work and achievements against the Committee Terms of Reference

This section is divided into five sub headings reflecting the five key duties of the Committee as set out in the Terms of Reference.

Integrated Governance, Risk Management and Internal Control
- The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances and considered that the AGS is consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supported the Board's approval of the AGS.
- The Committee has reviewed the Assurance Framework. It believes that the Framework used during the year was fit for purpose and has reviewed evidence to support this. The Framework is in line with Department of Health expectations and has been reviewed by internal audit and external audit to give additional assurance that this opinion is well founded.
- The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded in the organisation. The Committee believes that while adequate systems for risk management are in place, more work is required to ensure that these are embedded throughout the whole organisation. The Committee's opinion is that this issue requires continuing executive management focus and ownership.
- Reviewed and considered the Trust's Annual Report xx.
- Reviewed and considered the Trust's Quality Account xx as well as considering the External Auditors opinion
- Considered regular updates from supplies and procurement

Internal Audit
Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has also:
- Reviewed and approved the internal audit strategy and operational plan.
- Considered the major findings of internal audits and were assured that management have responded in an appropriate manner and that the Head of Internal Audit Opinion and Annual Governance Statement reflected any major control weaknesses.

External Audit
- Reviewed and agreed external audit's annual plan and fees.
- Considered the reports prepared by external audit.
- Reviewed the effectiveness of external audit.
- Considered the external auditors annual audit letter

Counter Fraud
- Reviewed and approved the annual counter fraud plan
- Reviewed the outcomes of the work of Counter Fraud.
- Received the annual report on Counter Fraud

Management
The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling Directors to account when considered necessary to obtain assurance. Examples of such reports being considered at the Committee include; xx.

Financial Reporting

- Reviewed the annual financial statements and considered them to be accurate.
- Regularly reviewed losses and special payments
- Regularly received updates regarding Single Tender Waivers and SFI breaches

Emerging Issues and Objectives for 2021/22

Review of the effectiveness and impact of the Audit Committee

The Committee has been active during the year in carrying out its duty in providing the Board with assurance that effective internal control arrangements are in place. Specifically the Committee has undertaken a self-assessment. Actions arising from this self-assessment include:

Other Matters Worthy of Note

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

Name	Job Title	Apr 19	May 19	Jul 19	Oct 19	Jan 20
MEMBERS						
Prof G Crowe	NED (Chair)					
Mr P Akid	NED					
Ms S Belfield	NED					
EXTERNAL AUDIT ATTENDEES						
Mr R Percival	External Audit					
Ms N Coombe	External Audit					
INTERNAL AUDIT ATTENDEES						
Mr A Bostock	Internal Audit					
Mr R Chidlow	Internal Audit					
Mr S Stanyer	Local Counter Fraud Specialist					
ATTENDEES						
Mr M Oldham	Chief Financial Officer					
Mrs S Preston	Strategic Director of Finance					
Miss C Rylands	Associate Director of Corporate Governance					

The average attendance of members for the Committee was %.

Conclusion

The Committee is of the opinion that this annual report is consistent with the draft Annual Governance Statement, Head of Internal Audit Opinion and the external audit review and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

E. Self-Assessment Checklist

Committee Processes

To be completed by the Chair with the assistance of the Deputy Associate Director of Corporate Governance and presented to the Committee.

Area / Question	Yes	No	Comments
Composition, establishment and duties			
Does the Committee have written terms of reference and have they been approved by the Trust Board?			
Are the terms of reference reviewed annually?			
Has the Committee formally considered how it integrates with other Committees that are reviewing risk?			
Are committee members independent of the management team?			
Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?			
Does the committee prepare an annual report on its work and performance for consideration by the Board?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?			
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements – e.g. CQC			
Has the committee review the accuracy of the draft annual governance statement?			
Has the committee reviewed key data against the data quality dimensions?			
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?			
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting policies due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?			
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
Internal Audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
Does the committee review and approve the internal audit plan, and any changes to the plan?			
Is the committee confident that the audit plan is derived from a clear risk assessment process?			
Does the committee receive periodic progress reports from the head of internal audit?			
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
Does the head of internal audit have a right of access to the committee and its chair at any time?			
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			

Area / Question	Yes	No	Comments
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards?*			
Does the committee receive and review the head of internal audit's annual opinion?			
External Audit			
Do the external auditors present their audit plan to the committee for agreement and approval?			
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
Does the committee review the external auditor's value for money conclusion?			
Does the committee review the external auditor's opinion on the quality account when necessary?			
Does the committee hold periodic private discussions with the external auditors?			
Does the committee assess the performance of external audit?			
Does the committee require assurance from external audit about its policies for ensuring independence?			
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
Clinical Audit			
If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
Counter Fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?			
Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
Does the audit committee receive periodic reports about counter fraud activity?			
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
Does the committee receive and review an annual report on counter fraud activity?			
Does the committee receive and discuss reports arising from quality inspections by NHS Counter Fraud Authority?			

Committee Effectiveness

To be completed by each member of the Committee to submission to the Chair.

Statement	Please tick (✓) one box for each question					Comments/ action
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	
Theme 1 – Committee Focus						
The committee has set itself a series of objectives for the year						
The committee has made a conscious decision about the information it would like to receive						
Committee members contribute regularly to the issues discussed						
The committee is aware of the key sources of assurance and who provides them						
The committee receives assurances from third parties who deliver key functions to the organisation – for example, Shared Business Services / Private Contractors						
Theme 2 – Committee Team Working						
The committee has the right balance of experience, knowledge and skills to fulfil its role						
The committee has structured its agenda to cover quality, data quality, performance targets and financial control						
The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives						
The committee is fully briefed on key risks and any gaps in control						
Other committees provide timely and clear information in support of the committee						
The committee environment enables people to express their views, doubts and opinions						
Committee members understand the messages being given by external audit, internal audit and counter fraud specialists						
Internal audit contributes to the debate across the range of the agenda						
Members hold their assurance providers to account for late or missing assurances						
Decisions and actions are implemented in line with the timescale set down						
Theme 3 – Committee Effectiveness						
The quality of committee papers received allows committee members to perform their roles effectively						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance						
Debate is allowed to flow, and conclusions reached without being cut short or stifled						
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored						
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well						
The committee provides a written summary report of its meetings to the Trust Board including items for escalation						
The Trust Board challenges and understands the reporting from the Committee						
Theme 4 – Committee Engagement						
The committee challenges management and other assurance providers to gain a clear understanding of their findings						
Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference						
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management						
The committee receives clear and timely reports from other Trust Board committees which set out the assurances they have received and their impact (either positive or not) on the assurance framework						
I can provide two examples of where we as a committee have focussed on improvements to the system of internal control as a result of assurance gaps identified						
Theme 5 – Committee Leadership						
The committee chair has a positive impact on the performance of the committee						
Committee meetings are chaired effectively						
The committee chair is visible within the Trust and is considered approachable						
The committee chair allows debate to flow freely and does not assert his/her own views too strongly						
The committee chair provides clear and concise information to the Trust Board on committee activities and gaps in control						

Appendix 10 – Nominations and Remuneration Committee Governance Pack

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities with in its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference

Membership

The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. The Chair of the Trust Board may also serve on the Committee.

- Mr David Wakefield, Chairman (Chair)
- Mr Peter Akid, Non-Executive Director
- Ms Sonia Belfield, Non-Executive Director
- Professor Gary Crowe, Non-Executive Director
- Professor Andrew Hassell, Non-Executive Director
- Dr Leigh Griffin, Non-Executive Director
- Mr Ian Smith, Non-Executive Director

Appointments to the Committee are made by the Trust Board and shall be for a period of up to three years, which may be extended for further periods of up to three years. At such time when the Committee is required to consider matters in relation to the Chair i.e. consideration of successor, the Senior Independent Director will be invited to Chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals, such as the Chief Executive and other advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members of staff will regularly attend Committee meetings in an advisory capacity:
- Director of Human Resources. The Director of Human Resources will be excluded from meetings when their own remuneration is being considered.
- Associate Director of Corporate Governance. The Associate Director of Corporate Governance will provide administrative support to the Committee and advise on points of governance.

Quorum

The quorum necessary for the transaction of business shall be two members.

Frequency of Meetings

The Committee shall meet at least four times a year, and otherwise as required.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Associate Director of Corporate Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Maintaining records of members' appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- As appropriate, the Audit Committee will provide a Value for Money (VfM) view on severance packages as per the agreed thresholds set by NHS Improvement.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

*** Severance Packages approval levels**

Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS Improvement (NHSI).

Redundancy Payments
The Committee must consider/approve any redundancy payments which are £10,000 or above. Any payments below these thresholds can be agreed by the Chief Executive / Director of Finance / Director of Human Resources outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements
The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this

threshold can be agreed by the Chief Executive, Director of Human Resources and Director of Finance outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chairman. Again this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chairman. This process will be supported by NHS Improvement. The Chairman shall assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board, and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Director of Human Resources with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chairman and Non-Executive Directors.
- To consider the person specification when Non-Executive vacancies arise.
- Prior to the appointment of a Non-Executive Director, the proposed appointee should be required to disclose any other interests that may result in a conflict of interest and be required to report any further interests that could result in a conflict of interest.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- To review the results of the Board performance evaluation process that relate to the composition of the Board.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Wednesday 13th May 2020	1.30 pm – 3.00 pm	Trust Boardroom	6th May 2020
Wednesday 15th July 2020	1.30 pm – 3.00 pm	Trust Boardroom	8th July 2020
Wednesday 14th October 2020	1.30 pm – 3.00 pm	Trust Boardroom	7th October 2020
Wednesday 13th January 2021	1.30 pm – 3.00 pm	Trust Boardroom	6th January 2021
Wednesday 17th March 2021	1.30 pm – 3.00 pm	Trust Boardroom	10th March 2021

C. Annual Business Cycle

Title of Paper	May	Jul	Oct	Jan	Mar
REMUNERATION					
Redundancy Payments £10,000 and above					
Remuneration and terms of service for Executive Directors and Chief Executive					
Remuneration Section of Annual Report					
Off-payroll and interim Board payments					
NOMINATIONS					
Changes to the Composition of the Trust Board					
Non-Executive Director Performance Reviews					
Non-Executive Director Succession Planning					
Review of Time Required for Non-Executive Directors					
Executive / Non-Executive Appointments					
Executive Director Performance Reviews					
Succession Planning					
GOVERNANCE					
Fit and Proper Persons Declarations					
Committee Effectiveness					

Appendix 11 – Quality Governance Committee Governance Pack

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Governance Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Delegation. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Director of Human Resources
- Head of Quality Safety & Compliance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals such as, but not restricted to, representatives of clinical governance, audit and risk, internal and external audit may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 10 out of 12 meetings per year.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust

Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

The primary duties of the Committee are as follows:
- To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

Responsibility for Risk Management
The Committee shall consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
- Current and target risk scores
- Impact that the risk has on strategic objectives
- Potential consequences of the risk
- Impact that the risk has on achieving Care Quality Commission standards
- Impact of operational risks on the risk
- Potential or actual origins that have led to the risk
- How the risk is controlled and reported
- The assurance mechanisms for the risk
- Gaps in controls or negative assurances for the risk
- The actions and timescales for mitigating the risk

The relevant Executive Director responsible for managing each respective strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Safe
- Using the assurance framework, the Committee will review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.

- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS Improvement; and professional bodies with the responsibility for the performance of staff, (Royal Colleges, accreditation bodies etc)
- Review the risks and adequacy of assurance that statutory and mandatory training requirements are being met.

Effective (Patient Outcomes)
- Review the risks and adequacy of assurance of compliance with the CQC relevant Outcomes
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.
- Review the risks and adequacy of assurance of staff engagement in annual objectives improving patient safety, clinical best practice and patient experience.

Caring
- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Research Governance
- Review the risks and adequacy of assurance that research activity across the Trust is delivered within the national regulatory requirements and that research and innovation activity is driving improvement.

Other Assurance Functions
- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and research governance.
- `Review details of the number and concerns raised on a quarterly basis
- To maintain oversight of the potential impact on quality arising from financial pressures, the Committee will review quarterly QIA reports

Management
- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Wednesday 22nd April 2020	09:00 am – 11:30 am	Trust Boardroom	14th April 20
Wednesday 20th May 2020	09:00 am – 11:30 am	Trust Boardroom	12th May 20
Wednesday 24th June 2020	09:00 am – 11:30 am	Trust Boardroom	16th June 20
Wednesday 22nd July 2020	09:00 am – 11:30 am	Trust Boardroom	14th July 20
Wednesday 26th August 2020	09:00 am – 11:30 am	Trust Boardroom	18th August 20
Wednesday 23rd September 2020	09:00 am – 11:30 am	Trust Boardroom	15th September 20
Wednesday 21st October 2020	09:00 am – 11:30 am	Trust Boardroom	13th October 20
Wednesday 25th November 2020	09:00 am – 11:30 am	Trust Boardroom	17th November 20

Date	Time	Venue	Deadline for Papers
Wednesday 16th December 2020	09:00 am – 11:30 am	Trust Boardroom	8th December 20
Wednesday 20th January 2021	09:00 am – 11:30 am	Trust Boardroom	12th January 21
Wednesday 24th February 2021	09:00 am – 11:30 am	Trust Boardroom	16th February 21
Wednesday 24th March 2021	09:00 am – 11:30 am	Trust Boardroom	16th March 21

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Safe												
Nurse Safe Staffing Report												
Patient Safety Report		**Q4**			**Q1**			**Q2**			**Q3**	
County Quality & Safety Report												
Serious & Adverse Incidents Report		**Q4**			**Q1**			**Q2**			**Q3**	
Infection Prevention Report												
Mortality Report												
Health and Safety Report												
Readmissions Update												
NHS Resolution Maternity Incentive Scheme												
Fire Report												
Annual Security Report												
Maternity Dashboard												
Perinatal Mortality Review Tool												
Effective												
Compliance and Effectiveness Report		**Q4**			**Q1**			**Q2**			**Q3**	
Care Quality Commission Action Plan												
Research and Development Quality Update												
Get It Right First Time report												
CQUIN Achievement Forecast												
Clinical Audit Progress Report												
Annual Clinical Audit Plan												
Medicines Optimisation												
PLACE Inspection Findings and Action Plan												
EPRR Core Standards Submission												
Caring												
Patient Experience Report		**Q4**			**Q1**			**Q2**			**Q3**	
Safeguarding Children & Adults Annual Reports												
Well Led												
Quality Account	**TBC**											
Litigation Report												
Governance												
Board Assurance Framework	**Q4**			**Q1**			**Q2**			**Q3**		
Quality Impact Assessment												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Report												
Committee Effectiveness												
Assurance Report from Quality and Safety Oversight Group												
Assurance Report from Health and Safety Group												

Appendix 12 – Performance and Finance Committee Governance Pack

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Performance and Finance Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Board in its Scheme of Delegation. The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

Membership

- Non-Executive Directors x2
- Chief Executive
- Chief Financial Officer
- Chief Operating Officer
- Director of Strategy and Transformation
- Operational and Strategic Directors of Finance
- Director of PMO
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals may be invited to attend all or part of any meeting as and when appropriate and necessary.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

On behalf of Trust Board, the prime purpose of the Committee is to oversee progress in the delivery of financial and operational performance, receiving assurance from Executive Directors.

The Committee will also:

- Consider financial and operational strategies, prior to submission to Trust Board for approval
- Approve business cases in accordance with delegated authority from Trust Board, in accordance with the Scheme of Delegation
- Review progress against the delivery of business plans
- Oversee financial and operational related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis
- Escalation of matters to Trust Board as agreed by the Committee.

The duties of the Committee are as follows:

Financial and Operational Performance

- To consider and monitor progress against delivery of the Trust's Financial Plan
- To monitor delivery of the Trust's cost improvement programme
- To oversee and evaluate the development of the Trust's financial and operational performance to deliver the objectives as set out in the Annual Plan and to ensure delivery of the statutory financial and NHS Constitutional targets
- To ensure that the Trust has in place a comprehensive financial and operational performance management control framework
- To review the proposed annual financial plans for revenue and capital, working capital and cash management

Approval of Business Cases and Business Development

- To agree the Trust's Capital Programme for submission to the Trust Board
- To oversee, scrutinise and approve within delegated limits as specified by the Scheme of Delegation the investment appraisal of capital and revenue business cases

Contract and Income Monitoring

- To scrutinise the development of the Trust's contractual regime including contract portfolios and contracting processes
- To identify and scrutinise the systems to provide early warnings of potential risks and opportunities in the implementation of the contractual framework of the Trust
- To identify, monitor, prioritise and mitigate risks to in relation to the implementation of the model contract and the relationship between activity, income and costs

- To ensure the Trust Board is advised of any significant variation in activity and its impact on income and costs
- To review the systems in place to ensure compliance with the contract terms

Treasury Management
- To monitor cash, liquidity and working capital
- To approve relevant benchmarks for monitoring investment performance
- To review and monitor investment performance

Relationship with the Audit Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- Audit – External and Internal
- Approval of Annual Report and Accounts
- Approval of Standing Financial Instructions and Scheme of Delegation
- Local Counter Fraud Specialist work
- Local Security Management Specialist work

Relationship with the Transformation and People Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with other Committees. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- To oversee and evaluate the development of the Trust's workforce performance to deliver the objectives as set out in the Annual Plan
- To ensure that the Trust has in place a comprehensive workforce performance management control framework
- To ensure that any workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Responsibility for Risk Management
The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
21st April 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	14th April 2020
19th May 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	12th May 2020
23rd June 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	16th June 2020
21st July 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	14th July 2020
25th August 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	18th August 2020

PROUD TO CARE

Date	Time	Venue	Deadline for Papers
22nd September 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	15th September 2020
20th October 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	13th October 2020
24th November 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	17th November 2020
15th December 2020	9.00 am – 12.00 pm	Trust Boardroom, RSUH	8th December 2020
19th January 2021	9.00 am – 12.00 pm	Trust Boardroom, RSUH	12th January 2021
23rd February 2021	9.00 am – 12.00 pm	Trust Boardroom, RSUH	16th February 2021
23rd March 2021	9.00 am – 12.00 pm	Trust Boardroom, RSUH	16th March 2021

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FINANCE												
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
CIP Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Budget Setting												
Financial Plan 2021/22												
Capital Programme 2021/22												
Annual Plan 2021/22												
PERFORMANCE												
Operational Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
IM&T Strategy Progress Report												
Data Security and Protection Update												
GOVERNANCE												
Business Cases between £250,000 to £1,000,000												
Business Case reviews												
Authorisation of Contract Awards												
Supplies and Procurement Report												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
PFI Governance and Contract Performance Management												
Annual Audit into Overseas Visitors Policy Compliance												
Assurance Report from Executive Infrastructure Group												
Assurance Report from Executive Business Intelligence Group												
Assurance Report from Data Security and Protection Group												

Appendix 13 – Transformation and People Committee Governance Pack

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Transformation and People Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x 3 (one designated chair and one designated deputy chair)
- Director of Human Resources
- Chief Operating Officer
- Chief Nurse
- Director of Strategy and Transformation
- Financial Support (as delegated by the Chief Finance Officer)
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Regular Attendees

Other individuals such as, but not restricted to the following may be invited to attend all or part of any meeting as and when appropriate and necessary:

- Deputy Director of Human Resources
- Assistant Director of Organisational Development
- Assistant Director of Human Resources Governance
- Director of PMO and Transformation
- Assistant Director of Learning and Education
- Medical Director
- Associate Director for Medical Education
- Guardian of Safe Working
- Freedom to Speak Up Guardian

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

The Trust's Chairman shall not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee is responsible for ensuring that strategic transformation and people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To ensure direction and priorities for the development of workforce strategies, including approval of the People and Organisational Development Strategy, Learning and Education Strategy and Workforce plan.
- To monitor the progress and effectiveness of workforce strategies against corporate strategy, organisational values and workforce experience, as measured by key workforce performance indicators.

- To approve new Workforce / OD projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce.
- To receive assurance that workforce policies are regularly reviewed and updated as required and in line with current legislation.
- To monitor progress associated with Workforce recommendations arising from audits and the Audit Committee.
- To approve the development, implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.
- To review and analyse the experiences of our staff and how we involve and engage with them to support successful and sustainable organisation and cultural change;
- To take an overview of the equality, diversity and inclusion policy and achievement of goals.
- To receive and consider the Quarterly Guardian of Safe Working Hours report on behalf of the Board.
- To receive and consider the Quarterly Speaking Up Report on behalf of the Board
- To consider clinical workforce transformation issues.
- To review and approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports.
- To provide assurance to the Board that the Trust is compliant with relevant HR legislation and best practice.
- To ensure that the workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Transformation

- To ensure direction and priorities for internal and external system wide transformation, including partnership working, aligns with both the Trust's overall strategy and future developments and with the developing Integrated Care System Strategy.
- To scrutinise strategic transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report to highlight good practice and outline areas for improvement on an exception basis.
- To ensure transformation interdependencies and risks are properly accounted for as part of the Trust's overall transformation programme of work and to remove obstacles to successful delivery.
- To ensure key enablers are properly considered as part of the implementation of transformation programmes (e.g. Information Management & Technology and Organisational Development).
- To monitor progress associated with Transformation recommendations arising from audits and the audit committee.
- To receive assurance delivery reports of transformation schemes (inclusive of progress and delivery).
- To scrutinise, challenge and develop workforce and transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report as required.
- Horizon scanning for new developments and benchmarking to ensure practice is always in line with national / regional development
- Ensuring that ensuring new technologies / advances in digitalisation are embraced and considered along with service developments
- Ensuring alignment of research and education to service developments

General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To ensure that the work of the committee liaises and consults with the divisions of the Trust in achieving the objectives of the Annual Work Plan and/or Strategy

- To identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Work Plan or Strategy to the Board.
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality Governance Committee
- Performance and Finance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Thursday 23rd April 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	15th April 2020
Thursday 21st May 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	13th May 2020
Friday 26th June 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	18th June 2020
Thursday 23rd July 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	15th July 2020
Friday 28th August 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	20th August 2020
Thursday 24th September 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	16th September 2020
Thursday 22nd October 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	14th October 2020
Friday 27th November 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	19th November 2020
Thursday 17th December 2020	09:00 am – 11:30 am	Trust Boardroom, Springfield	9th December 2020
Thursday 21st January 2021	09:00 am – 11:30 am	Trust Boardroom, Springfield	13th January 2021
Friday 26th February 2021	09:00 am – 11:30 am	Trust Boardroom, Springfield	18th February 2021
Thursday 25th March 2021	09:00 am – 11:30 am	Trust Boardroom, Springfield	17th March 2021

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PEOPLE												
Guardian of Safe Staffing Report												
NETS Survey Results												
Postgraduate Medical and Dental Education Report												
Undergraduate Medical School												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Report												
7 Day Working Progress Report	**TBC**											
Learning, Education and Widening Participation Progress Report												
Workforce Disability Equality Report												
Staff Survey Report												
Apprenticeship Levy Progress Report												
Workforce Race Equality Report												
Revalidation Report		**Q4**			**Q1**			**Q2**			**Q3**	
Equality and Inclusion Report												
GMC National Training Survey & Action Plan												
Employment Cases	**Q4**			**Q1**			**Q2**			**Q3**		
National Student Survey & Action Plan												
Speaking Up Report	**Q4**			**Q1**			**Q2**			**Q3**		
Workforce Performance Report	**M12**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**
Gender Pay Gap Report												
Annual Plan												
TRANSFORMATION												
Transformation Programme Update	**Q4**			**Q1**			**Q2**			**Q3**		
Research and Innovation Update	**Q4**			**Q1**			**Q2**			**Q3**		
GOVERNANCE												
Board Assurance Framework	**Q4**			**Q1**			**Q2**			**Q3**		
Committee Effectiveness												
Assurance Report from Executive Research and Innovation Group												
Assurance Report from Workforce Assurance Group												
Assurance Report from Executive Strategy and Transformation Group	**TBC**											

Appendix 14 – Charitable Funds Committee Governance Pack

A. Terms of Reference

Constitution and Authority

By resolution of the Trust Board, acting in its capacity as Corporate Trustee, a Committee of the Trust is established, to be known as the Charitable Funds Committee ("the Committee").

The Committee has no executive powers other than those specified in these Terms of Reference. The Committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain independent professional advice as it considers necessary in accordance with these Terms of Reference.

Membership

- Non-Executive Directors x3
- Chief Executive
- Chief Nurse
- Medical Director
- Chief Operating Officer
- Director of Human Resources
- Chief Finance Officer

Only members of the Committee are entitled to be present at its meetings. The Committee may however invite non-members, including external advisors, to attend part or all of its meetings as it considers necessary and appropriate. If not a member of the Committee, the Chairman of the Trust shall have the right of attendance at meetings of the Committee.

Attendance at Meetings

- Director of Communications
- UHNM Charity Manager
- Associate Director/Deputy AD of Corporate Governance
- Representative – CCLA
- Representative of External Audit
- Representative of Internal Audit

Members and attendees are expected to attend 3 out of the 4 meetings unless they can be represented by a nominated deputy.

Quorum

The quorum will be 2 Non-Executive Directors and 2 Executive Directors.

Frequency of Meetings

The Committee will meet at least 4 times a year. The Committee will also decide when to hold the Charitable Funds Annual General Meeting (AGM).

Reporting

The Committee shall report to the Corporate Trustee on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be circulated to the Corporate Trustee.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Corporate Trustee in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Corporate Trustee
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee shall:

- Be responsible for all aspects of the management of the investment of funds held in trust (i.e. Charitable Funds) and for the effective utilisation of those funds.
- Ensure Charities Commission requirements are fulfilled.
- Provide assurance to the Corporate Trustee that systems have been established to manage the funds ensuring that the identification, assessment and management of risk is linked to the achievement of the charity's operational objectives.

The Committee will:

- Formulate an Investment Policy within the powers of the body under statute and within the governing instruments to meet its requirements with regard to income generation and enhancement of capital value.
- Appoint advisors, investment brokers and where appropriate fund managers, authorise the terms for such appointments.
- Ensure compliance with the requirements and regulations of the Charities Act 1993, Trustee Act 2000 and current legislation through self-assessment.
- Ensure that the use of the Trust's assets are appropriately authorised in writing and charges raised within policy guidelines.
- Review the performance of brokers and fund managers.
- Review the performance of investments held and where necessary advise the Corporate Trustee of recommendations regarding future investments and policy guidelines (specifically in relation to investment in tobacco or smoking related industries).
- Review donations and bequests and seek assurance that they are recognised and recorded appropriately, review sources of donations and sponsorships and advise the board on issues concerning the receiving, renewing of legacies and donations. If necessary consider the appropriateness of sources.
- Receive assurance that the Trust policies for the proactive use of funds to ensure that monies are spent effectively and appropriately.

- Ensure that any sponsorship or advertising in relation to fund raising is in accordance with trust policies and procedures and in the best interest of the charitable funds. To advise the Corporate Trustee on matters relating to commercial sponsorship of charitable activities.
- Monitor the overall fund balances and identify variances in fund balances requiring explanation.
- Identify and monitor compliance with limits of expenditure in individual funds (within the Scheme of Delegation).
- Ratify a strategy for the effective utilisation of funds, seek to encourage the use of funds in line with the individual purposes of the funds. The authorisation for utilisation of bequests and donations will be in accordance with the limits specified in the Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers
- Review fundraising proposals, review pro-active approaches to raising funds.
- Review and approve year end accounts and the annual report.
- Approve the letter of representation in respect of audited accounts.
- Review risks in relation to charitable funds/investments and consider their impact on the day to day management of the funds.
- Receive any internal and external audit reports relating to Charitable Funds/Investments and track recommendations.
- Review the effectiveness of the committee by providing an annual report of achievements above the main duties of these Terms of Reference.
- Review the Terms of Reference annually before ratification by the Corporate Trustee.
- To monitor and receive reports on compliance with external accreditation / inspection bodies (as listed below) and ensure that the trust acts on any recommendations and that action plans are implemented in accordance with Appendix 2 of Policy on External Accreditation and Inspection: Charities Commission

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
21st May 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	14th May 2020
27th August 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	20th August 2020
26th November 2020	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	19th November 2020
25th February 2021	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	18th February 2021

C. Annual Business Cycle

Title of Paper	Executive Lead	May 21	Aug 27	Nov 26	Feb 25
CHARITABLE EXPENDITURE (GRANT MAKING) AND FUND ADMINISTRATION					
Grant Applications of £25,000 or above	Director of Communications				
Charitable Expenditure & Fund Administration	Director of Communications				
FUNDRAISING AND MARKETING					
Fundraising Performance Report	Director of Communications				
Legacy Performance Report	Director of Communications				
Communications Report	Director of Communications				
GOVERNANCE					
Charitable Funds Risk Register	Associate Director of Corporate Governance				
Charity Annual Report and Accounts	Director of Communications				
External Audit Charitable Funds Opinion	External Audit				
FINANCE					
Investment Report	CCLA				

Title of Paper	Executive Lead	May 21	Aug 27	Nov 26	Feb 25
Financial Update & Cash Flow Forecast	Chief Finance Officer				
Charity Budget	Director of Communications				
Management Charge to the Charity	Director of Communications				
STRATEGY					
Charity Strategy	Director of Communications				

Trust Board

2020/21 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 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													Public Trust Board meeting did not take place in April due to social distancing
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Deferred due to Covid-19
Annual Plan 2020/21	Director of Strategy													Deferred due to Covid-19
Financial Plan 2021/22	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		Covid Assurance Framework included in CEO Report May 20
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Deferred due to Covid-19
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													Awaiting information from
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred due to Covid-19