Tameside and Glossop Integrated Care NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Quality and Governance Committee December 2019 (walk-abouts)
The Committee draws the following matters to the Board's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Walkabout- Outpatients Yellow/ Blue Zones	Members undertook a walkabout in these areas and reported back.	There was positive assurance about the patient experience in this area, although some potential areas of improvement were noted.	Follow-up feedback	February 2020
Walkabout- Children's Unit	Members undertook a walkabout in this area and reported back.	There was positive assurance related to the patient experience, although some specific items that required improvement had been noted.	Follow-on feedback	February 2020.

Assurance gained includes the Committee receiving evidence that:

i. The extent of the issue has been quantified;
ii. The impact is included in all internal and external reporting
iii. There are processes in place to learn from the occurrence, and measures have been put into place to prevent them happening again

Tameside and Glossop Integrated Care NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Quality and Governance Committee January 2020
The Committee draws the following matters to the Board's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Operational situation	The Committee were updated on the current operational pressures being faced by the Trust.	The Committee noted that the Trust was seeing a significant increase in the number of those requiring care, beyond the predictions in national data. There was a particular increase in patients requiring short stays in hospital.		
		There was positive assurance that the Trust continued to be focused on ensuring the quality of care and patient experience provided.		
Quality Dashboard	The Committee received the quality dashboard.	The Committee noted that the dashboard was still developing, and further comments were invited outside of the meeting.		
		The Committee discussed the actions being taken to obtain assurance regarding the position on nutritional reviews	Deep dive to be presented to the Committee	April 2020.
Learning from Deaths	The Committee received the periodic update report	The Committee noted and welcomed the actions being taken to allocate more resource to this area, to address a potential back-log of cases.	Final periodic report to the Board	January 2020.
Influenza vaccination	The Committee were updated on progress	There was positive assurance from the news that over 80% of Trust colleagues had now been vaccinated.		

Assurance gained includes the Committee receiving evidence that:

i. The extent of the issue has been quantified;
ii. The impact is included in all internal and external reporting
iii. There are processes in place to learn from the occurrence, and measures have been put into place to prevent them happening again

Tameside and Glossop Integrated Care NHS Foundation Trust

Meeting date	30th January, 2020	x	Public		Confidential	Agenda item
Title	Financial Report – Month 9					16
Lead Director	Sam Simpson – Director of Finance					
Author	Asif Umarji – Assistant Director of Finance Lindsey Hulme – Assistant Director of Finance					

Recommendations made/ Decisions requested

The Board are asked to discuss the contents of the report, recognise the risk and endorse the actions required.

This paper relates to the following Strategic Objectives-

	1	Deliver safe and caring services
	2	Improve our patients' and carer's experience of our services
	3	Support the health and wellbeing needs of our community and staff
	4	Drive service improvement, innovation and transformation
	5	Develop our workforce to meet future service and user needs
X	6	Use our resources wisely

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
	Well-Led	X	Use of Resources

This paper is related to these BAF risks-	AF 5.8 – Failure to deliver the Trust's 2019/20 control total for Income and Expenditure without a corresponding increase in the delivery of TEP.

Where issues are addressed in the paper-

	Section of paper where covered
Equality and Diversity impacts	N/A
Financial impacts if agreed/ not agreed	All Paper
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The paper provides the Board with an update on the Month 9 Position, regarding Revenue, TEP, Capital and Cash.

Key highlights

1. **Month 9 –** Trust reported a £2.146m deficit (Pre PSF) which is £24k underspent against plan.

2. **The Trust is reporting to NHSI that it still expects to achieve its control total.**
   - The Trust is working with its local commissioners to address the activity and acuity related pressures.
   - The Trust recognises the risk to the delivery of the System control total as the financial position of other organisations deteriorate, work is underway at a GM level to manage this position.

3. **Trust Efficiency Programme –** The Trust target is £11.580m. At month 9 it is forecasting c.£11.701m by the end of the year, this is an improvement in month of c£134k. The Trust continues to drive efficiency savings to help mitigate the overall Trust position, work is also underway to develop ideas and schemes towards the 2020/21 programme.

4. **Agency expenditure -** The Trust has an agency cap of £9.454m, but a plan of £7m. During Month 9 the Trust spent £439k against a plan of £739k, reporting an underspend of £300k, YTD the Trust is reporting spend of £4.119m against a plan £5.669m, underspend of £1.550m.

5. **Cash and Capital -** For Month 9, cash is better than plan; capital is £77k behind plan in month. YTD

   - The Trust is forecasting to spend all of its available capital.

   - As part of the 2020/21 capital planning process which has already commenced, priority schemes have been identified that can be accelerated to 2019/20.

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Board Report – Financial Performance

As at M09 December 2019/20

Sam Simpson – Executive Director of Finance

Financial Overview: Month 9 Position

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Summary of Performance

	Month 9			YTD			Annual
Financial performance metric	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)
Normalised Surplus/(Deficit) before PSF & FRF	(£2,170)	(£2,146)	£24	(£20,056)	(£20,044)	£12	(£25,220)
PSF	£472	£472	£0	£3,072	£3,072	£0	£4,727
FRF	£1,480	£1,480	£0	£9,624	£9,624	£0	£14,807
Surplus/(Deficit) post PSF	(£218)	(£194)	£24	(£7,360)	(£7,348)	£12	(£5,686)
Capital Expenditure	£577	£500	(£77)	£2,958	£1,755	(£1,203)	£3,826
Cash and Equivalents	£1,220	£1,930	£710				£1,220
Trust Efficiency Savings	£1,167	£1,011	(£157)	£8,051	£7,598	(£452)	£11,580
Use of Resources Metric	3	3		3	3		3

Summary

- **Revenue -** The Trust has agreed a control with NHSI of **c.£5.686m** after Financial Recovery Fund (FRF) and Provider Sustainability Funding (PSF)**;** for the financial period to **31st December 2019**, the Trust has reported a net deficit of **£194k** post FRF and PSF, which is **£24k (fav.)** better than plan.
- **Forecast Position –** The Trust is forecasting to achieve its control total. The Trust is working closely with its commissioners to address activity and acuity related pressures.
- **System Control Total (SCT)** - The Trust recognises the risk to the delivery of the SCT as the financial position of other organisations deteriorate, work is underway at a GM level to manage this position. The risk relates to cash and the impact would be in 2020/21 – Full year effect is **£127k**, the risk only relates to Q4.
- **Trust Efficiency Programme (TEP) -** The Trust target is **£11.580m**. At month 9 it is forecasting **c.£11.701m** by the end of the year, this is an improvement in month of **c£134k.** The Trust continues to drive efficiency savings to help mitigate the overall Trust position, work is also underway to develop ideas and schemes towards the 2020/21 programme.
- **Agency cap -** The Trust has an agency cap of **£9.454m**, but a plan of **£7m**. During Month 9 the Trust spent **£439k** against a plan of **£739k**, reporting an underspend of **£300k,** YTD the Trust is reporting spend of **£4.119m** against a plan **£5.669m,** underspend of **£1.550m.**
- **Capital** – Capital expenditure is behind plan by **c.£77k** in month and **c.£1.203m** year to date.
- **Cash –** The cash balance is above plan at Month 9 due to receiving a late Q2 PSF payment.

Financial Overview: Divisional Position

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Summary of Performance

		In Month				Year to Date		
Divisional I&E Position	Annual Plan	Plan (£000)	Actual (£000)	Variance (£000)		Plan (£000)	Actual (£000)	Variance (£000)
Clinical Support Services	£26,350	£2,202	£2,232	**£30**		£19,716	£19,972	**£256**
Community Services	£23,670	£1,949	£1,931	**(£17)**		£17,852	£17,480	**(£372)**
Corporate	£38,641	£2,772	£2,712	**(£60)**		£30,887	£30,726	**(£161)**
Income	(£202,840)	(£16,916)	(£17,010)	**(£93)**		(£152,092)	(£151,758)	**£334**
Medicine	£54,563	£4,507	£4,918	**£411**		£41,051	£43,354	**£2,303**
Reserves	£817	£252	£40	**(£212)**		£1,342	(£346)	**(£1,688)**
Surgery / Women & Childrens	£64,485	£5,454	£5,370	**(£84)**		£48,604	£47,919	**(£685)**
I&E Position	**£5,686**	**£218**	**£194**	**(£24)**		**£7,360**	**£7,348**	**(£12)**

Summary (In Month)

Clinical Support Services £30k overspent
- Outsourcing costs to support with clearance of plain film backlog continues as well as activity related pressures relating to reagents and tests particularly from GP direct access.

Community Services (£17k) underspent
- The underspend is driven mainly by staffing vacancies.

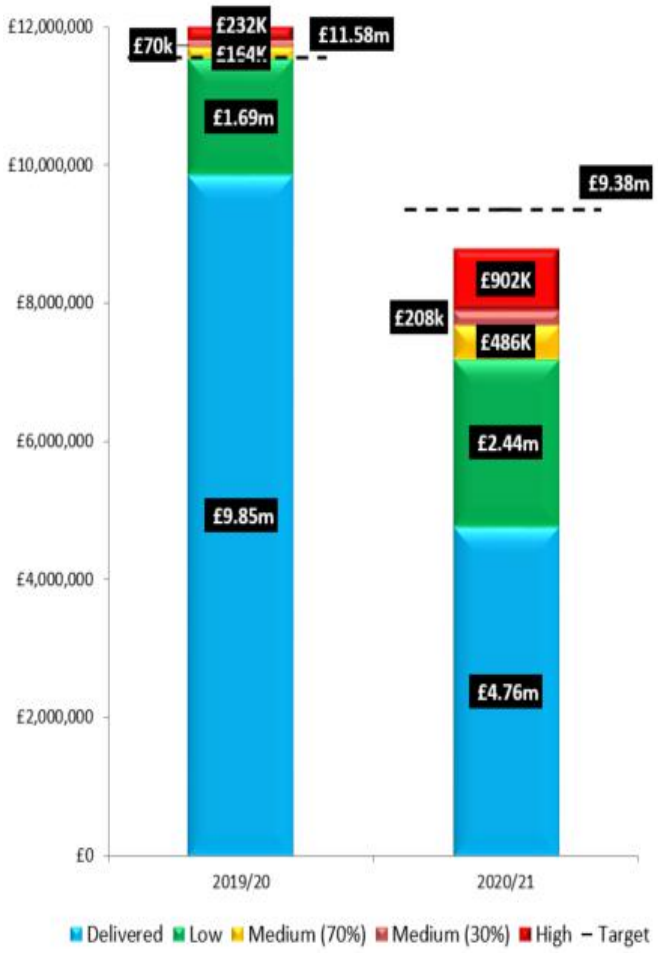
Corporate (£60k) underspent
- The favourable variance is predominantly driven by additional RTA income. This is offset by increases in estate costs (forecasted) such as water rates, telephone rental and IT hardware.

Income (£93k) overachievement
- Mainly due to an over performance with Associate contracts for activity in critical care and Non Elective discharges.

Urgent Care, Medicine and Pharmacy £411k overspent.
- The main drivers of this are overspends on agency premium to backfill vacancies, drug expenditure (which is partially offset by clinical income) and underachievement of TEP.

Surgery, Women & Children's £84k underspent
- The underspend is predominantly driven by nursing underspends across Theatres and Obs & Gynae, but offset against medical staffing backfill pressures (ECP and Agency) across a number of specialities.

Trust Efficiency Programme



	Plan	Delivered	Forecast	Variance	Amber Risk (30%)	High Risk	Variance	Black
In Year (£000's)	£11,580	£9,849	£1,853	(£122)	£70	£232	(£424)	£121
In Year % of plan		85%	16%	-1%	1%	2%	-4%	1%
Recurrent (£000's)	£9,380	£4,765	£2,928	£1,687	£208	£902	£577	£518
Recurrent % of plan		51%	31%	18%	2%	10%	6%	0%

Summary

In Month

Delivered **c£1.01m** of savings against a plan of c£1.17m - **£157k (13.5%) behind plan**

Year to Date

Delivered **c£7.6m** of savings against a plan of c£8.05m. - **£452k (5.6%) behind plan**

Year End

Delivered **c£9.85m** of savings and forecasting a further **c.£1.85m** of savings against a plan of **£11.580m** - **£122k (1.1%) ahead of plan**

*The in year forecast delivery of **£11.701m equates to 4.5%.** The Trust has delivered c.£7.570m additional to the 1.6% efficiency target*

Recurrent

Delivered c£4.765m of savings and forecasting a further c.£2.928m of savings against a plan of £9.380m. – £1.687m (18%) behind plan

*The recurrent forecast delivery of **£7.692m equates to 2.98%.** The Trust has delivered c.£3.56m additional to the 1.6% efficiency target*

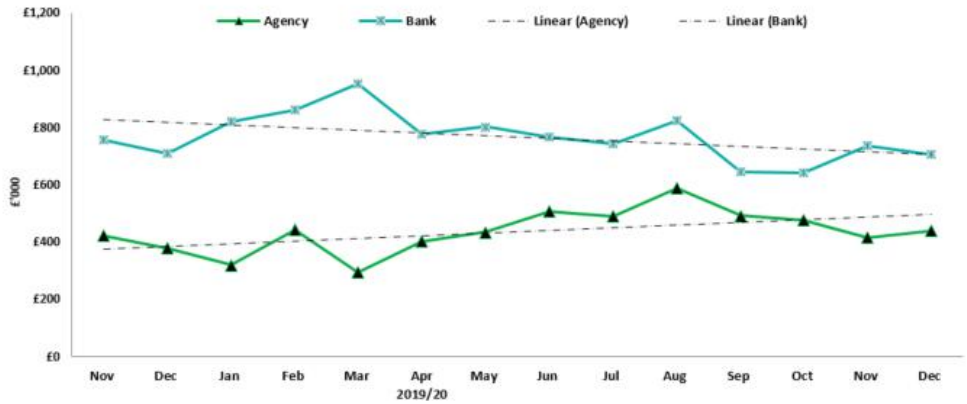
Agency & Bank Analysis

Tameside and Glossop Integrated Care NHS Foundation Trust

Trends of Agency and Bank expenditure and performance against the cap

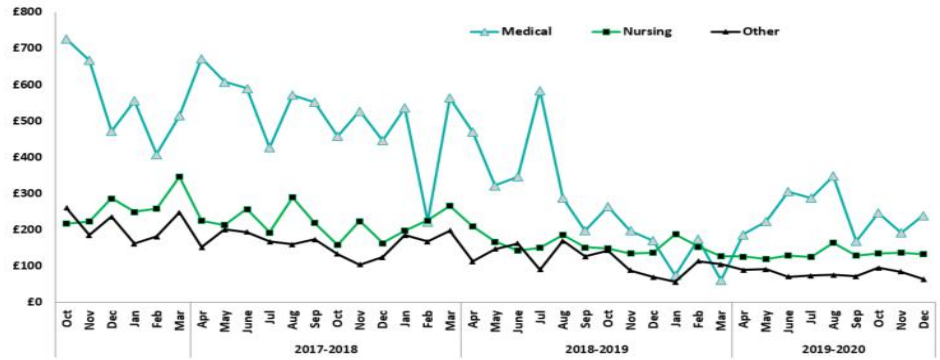
12 Month Trend

Bank and Agency spend £000



36 Month Trend by Staff Group

Agency spend £000



Key messages

- **Agency Cap –** the Trust has been set an agency cap of **c.£9.454m** for 2019/20 but the Trust has set an internal plan of **c.£7m**
- **Trend –** in 2018/19, the average monthly expenditure on agency was c. **£536k** and in 2019/20 the Trust has spent on average **£467k** each month.
- **Performance –** against plan, the Trust has underspent by **c.128k** in month and is now underspent by **c.£1.249m** year to date. Compared to the NHSI cap, the Trust is below plan in month and year to date.
- **Forecast** – The Trust is forecast to spend **c.£5.357m,** which is **c.£1.5m** below plan and **£3.961m** below the NHSI cap.

Agency Cap

		Month 9			YTD		
Staff group	Annual Plan	Plan	Actual	Var	Plan	Actual	Var
				£'000			
Medical	£4,281	£368	£240	(£128)	£3,281	£2,195	(£1,086)
Nursing	£1,416	£150	£134	(£16)	£1,183	£1,202	£19
Other	£1,302	£221	£65	(£156)	£1,205	£722	(£483)
Trust Plan	7,000	739	439	(300)	5,669	4,119	(1,550)

Capital

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Summary

- The Trust's plan for 2019/20 is **£3.832m**. The Trust has submitted bids for additional digital funding totalling £388k, early indication is this is highly likely.

- At Month 9, capital expenditure reported c.£77k underspent in month and c.£1.203m year to date. The in month underspend primarily relates to a small number of capital schemes listed below:-
  - Estates & Facilities 106k – Costs later than anticipated
  - IM&T Schemes £72k – Costs later than anticipated.
  - Medical Equipment (£215k) – Costs earlier than anticipated.
  - Externally Funded (£40k) – this is due to profiling and a delay in the funding being approved.

- The Trust is forecasting to spend all of its available capital.

- As part of the 2020/21 capital planning process which has already commenced, priority schemes have been identified that have been accelerated to 2019/20. The 2020/21 capital plan will be considered by EMT at the end of January 2020.

Capital Programme Breakdown

		Plan			In Month			YTD			Forecast		
Scheme Description		Initial Budget	Revised Budget	Var	Budget	Actual	Var	Budget	Actual	Var	Budget	Forecast	Var
Estates / Facilities		£1,877	£2,322	£445	£199	£305	£106	£1,759	£1,326	(£433)	£2,322	£2,162	(£160)
IM&T Schemes		£411	£660	£249	£0	£72	£72	£417	£235	(£182)	£660	£662	£2
Medical Equipment Schemes		£516	£586	£70	£316	£101	(£215)	£516	£172	(£344)	£586	£493	(£93)
Capitalised Staff Costs		£0	£58	£58	£0	£0	£0	£0	£0	£0	£58	£58	£0
Externally Funded	PDC	£1,493	£423	(£1,070)	£62	£22	(£40)	£266	£22	(£244)	£423	£423	£0
Unallocated		£310	£0	(£310)	£0	£0	£0	£0	£0	£0	£0	£0	£0
Forecast underspend reserve		£80	(£217)	(£297)	£0	£0	£0	£0	£0	£0	(£217)	£0	£217
Total Capital Expenditure		£4,687	£3,832	(£855)	£577	£500	(£77)	£2,958	£1,755	(£1,203)	£3,832	£3,798	(£34)

Capital Plan **£3.832m**

Internally generated **£3.403m**

Digital funding **£0.423m**

Cash Management

Tameside and Glossop Integrated Care NHS Foundation Trust

Key messages

Cash – The month end cash balance for December was £1.930m against a plan of £1.220m, this is due to receiving PSF with late notification.

Loans - The Trust's loan liability will increase by £8.256m in year, this is higher than the proposed control total, primarily due to the expectation that the Trust will receive an element of the 2019/20 PSF and FRF in 2020/21, and consequently have to borrow prior to the cash being received. When the cash for PSF/FRF is received, the Trust will pay off a small proportion of the loan.

The Trust's financial plan forecast a loan balance at March 2020 of £108.686m but due to the receipt of additional PSF relating to 2018/19, the Trust has been able to reduce its borrowing requirement and now expects the balance to be £105.384m, £3.302m less than planned.

The Trust is to increase its multiple uncommitted Single Currency Interim Revenue Support loans from HM Department of Health and Social Care by **£6m** up to a total of **£17m**. This is due to the timing in receipt of FRF & PSF , consequently the Trust will draw down as required and repay as soon as the cash is received.

Month 9 Cash Variance

£1.220m	£1.930m
Cash Plan	**Cash Actual**

Trust Loan Position

£97.128m	£105.384m
Opening Loans 2019/20	**Closing Loans 2019/20**

Statement of Financial Position

NHS
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NHS Foundation Trust

	30th Nov 2019 £'000s	31st Dec 2019 £'000s
Total Non Current Assets	**134,250**	**134,399**
Current Assets and (Liabilities)		
Inventories	1,449	1,348
Trade Receivables and accrued income	16,339	14,012
Cash	1,209	1,930
Current Liabilities	(33,638)	(31,140)
Obligations under PFI	(1,448)	(1,448)
Provisions	(154)	(144)
Total Assets Less Current Liabilities	**118,008**	**118,958**
Non Current (Liabilities)		
Obligations under PFI > 1yr	(49,789)	(49,666)
Interim Revenue Support Loan - DOH	(96,598)	(97,867)
Provisions	(606)	(616)
TOTAL ASSETS EMPLOYED	**(28,984)**	**(29,192)**
Financed By Taxpayers Equity		
Public Dividend Captial	54,884	54,884
Revaluation Reserve	41,818	41,818
Income & Expenditure Reserve	(118,630)	(118,630)
I&E reserve 2019/20	(7,057)	(7,264)
TOTAL TAXPAYERS EQUITY	**(28,984)**	**(29,192)**

Appendix 1

2019/20 Trust Efficiency Programme – In Year

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

2019/20 Trust Efficiency Programme – Theme Breakdown & Forecast

	In Month £000			YTD £000				Forecast				
Theme	Plan	Actual	Var	Plan	Actual	Var	Plan	Delivered	Planned Forecast	Delivered & Forecast	Var	Status
Anaesthetics	£39	£18	(£20)	£243	£204	(£39)	£359	£240	£61	£301	(£58)	↓
Cardiology	£13	£9	(£4)	£59	£43	(£16)	£100	£56	£17	£73	(£27)	↓
Community CYP	£76	£32	(£44)	£330	£240	(£90)	£558	£281	£48	£329	(£229)	↓
Community ITS	£104	£134	£30	£979	£1,094	£115	£1,291	£1,149	£243	£1,392	£101	↑
Corporate	£80	£129	£49	£759	£786	£27	£1,000	£914	£104	£1,018	£18	↑
Diagnostics	£25	£7	(£18)	£174	£64	(£110)	£250	£85	£2	£87	(£163)	↓
Emergency Medicine	£45	£1	(£44)	£321	£38	(£283)	£458	£42	£124	£166	(£292)	↓
Estates	£31	£19	(£12)	£206	£141	(£66)	£300	£168	£128	£296	(£4)	↓
Finance Improvement Team	£118	£96	(£22)	£706	£698	(£8)	£1,060	£908	£35	£943	(£117)	↓
Gastro	£12	£3	(£8)	£64	£28	(£36)	£100	£28	£18	£46	(£54)	↓
Obs & Gynae	£11	£159	£148	£231	£403	£172	£264	£418	£15	£433	£169	↑
Other Medicine Specialties	£13	£5	(£8)	£60	£45	(£14)	£100	£61	(£0)	£61	(£39)	↓
Other SWC Specialties	£34	£19	(£15)	£147	£35	(£112)	£250	£66	£43	£109	(£141)	↓
Performance & Information	£42	£5	(£37)	£168	£207	£39	£294	£239	£104	£343	£49	↑
Pharmacy	£41	£27	(£14)	£202	£331	£130	£325	£393	£127	£520	£195	↑
Procurement	£110	£31	(£79)	£809	£396	(£412)	£1,156	£490	£387	£877	(£279)	↓
Technical	£27	£14	(£13)	£134	£74	(£60)	£216	£115	£58	£173	(£43)	↓
Transformation	£143	£0	(£143)	£571	£0	(£571)	£999	£999	£0	£999	£0	↑
Trauma & Orthopaedics	£156	£142	(£14)	£1,332	£1,275	(£57)	£1,800	£1,700	£0	£1,700	(£100)	↓
Unidentified GAP	(£2)	£0	£2	£5	£0	(£5)	£0	£0	£0	£0	£0	↑
Vacancy Factor - Medicine	£19	£109	£90	£226	£958	£732	£284	£958	£187	£1,145	£861	↑
Vacancy Factor - Surgery	£30	£52	£22	£325	£538	£213	£416	£538	£153	£691	£275	↑
TOTAL ICFT - TEP	£1,167	£1,011	(£157)	£8,051	£7,598	(£452)	£11,580	£9,848	£1,853	£11,701	£121	↑

2019/20 Trust Efficiency Programme – Recurrent

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2019/20 Trust Efficiency Programme – Theme Breakdown & Forecast

Theme	Plan	Delivered	Forecast	Total	Var	Status
Anaesthetics	£211	£42	£63	£105	(£106)	↓
Cardiology	£100	£55	£46	£101	£1	↑
Community CYP	£160	£163	£0	£163	£3	↑
Community ITS	£451	£285	£84	£370	(£81)	↓
Corporate	£350	£19	£0	£19	(£331)	↓
Diagnostics	£250	£85	£0	£85	(£165)	↓
Emergency Medicine	£458	£0	£408	£408	(£50)	↓
Estates	£300	£95	£211	£306	£6	↑
Finance Improvement Team	£960	£673	£341	£1,014	£54	↑
Gastro	£100	£0	£69	£69	(£31)	↓
Obs & Gynae	£264	£60	£5	£65	(£198)	↓
Other Medicine Specialties	£150	£67	£0	£67	(£83)	↓
Other SWC Specialties	£250	£92	£85	£177	(£73)	↓
Performance & Information	£394	£79	£217	£296	(£98)	↓
Pharmacy	£325	£531	£122	£653	£328	↑
Procurement	£1,223	£175	£1,030	£1,205	(£18)	↓
Technical	£216	£168	£236	£403	£187	↑
Transformation	£449	£449	£0	£449	£0	↑
Trauma & Orthopaedics	£1,700	£1,700	£0	£1,700	£0	↑
Unidentified GAP	£669	£0	£0	£0	(£669)	↓
Vacancy Factor - Medicine	£200	£0	£0	£0	(£200)	↓
Vacancy Factor - Surgery	£200	£27	£11	£38	(£162)	↓
TOTAL ICFT - TEP	£9,380	£4,765	£2,928	£7,692	(£1,687)	↓

Tameside and Glossop Integrated Care NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Finance Committee December 2019
The Committee draws the following matters to the Board's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Single Operating Framework	The Committee received an update on performance in November 2019	There was positive assurance around the continued achievement of the national targets for cancer waiting times and 18-week referral to treatment.		
		A&E performance continued to be challenging. The Committee noted that there had been significant increases in attendance, particularly related to paediatric cases.		
		The improvement in staff sickness and absence metrics was welcomed.		
Finance Report, M8 (November 2019)	The Committee were updated on financial performance to the end of November 2019	Whilst the financial position was challenging, there was confidence that the close relationships between system partners would enable the Trust to meet the agreed control total.		

Assurance gained includes the Committee receiving evidence that:

i. The extent of the issue has been quantified;
ii. The impact is included in all internal and external reporting
iii. There are processes in place to learn from the occurrence, and measures have been put into place to prevent them happening again

Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside and Glossop Integrated Care NHS Foundation Trust

Meeting date	30 January 2020	x	Public		Confidential	Agenda item
Title	Freedom to Speak Up Report					18
Lead Director	Amanda Bromley, Director of Human Resources					
Author	Phil Gordon: Freedom to Speak Up Guardian					

Recommendations made/ Decisions requested

The Board of Directors is recommended to:

a. Note the positive assurance on the implementation, approach and activities of the FTSU agenda and the FTSUG role.

This paper relates to the following Strategic Objectives-

X	1	Deliver safe and caring services
X	2	Improve our patients' and carer's experience of our services
X	3	Support the health and wellbeing needs of our community and staff
	4	Drive service improvement, innovation and transformation
	5	Develop our workforce to meet future service and user needs
	6	Use our resources wisely

The paper relates to the following CQC domains-

X	Safe		Effective
X	Caring		Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks-	None

Where issues are addressed in the paper-

	Section of paper where covered
Equality and Diversity impacts	8
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	2
Sustainability (including environmental impacts)	N/A

Executive Summary

This report details:

- The Trust position on the Freedom to Speak Up agenda with reference to promotion, training, governance, culture and casework.
- Assurance on the activities of the Freedom to Speak Up Guardian.

1. INTRODUCTION

1.1 The purpose of this report is to provide the Board with:

- An independent perspective on the Trust position in relation to the Freedom to Speak Up (FTSU) agenda.
- Assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG).

2. NATIONAL DEVELOPMENTS / BOARD RESPONSIBILITIES

2.1 The National Guardian Office (NGO) is creating training resources in order to support their guidelines for FTSU training provision for all staff. This is expected to be completed by March 2020.

2.2 The Executive Lead, Non-Executive Lead and FTSUG met on 15/01/20 to mutually agree the Trust position and approach for Board-led responsibilities, summarised below:

Board responsibility	Position	Plan
Board self-review tool	NGO published new version of tool in July 2019. Initial completion by FTSUG and Non-Executive Lead.	Executive Lead and Non-Executive Lead to take forwards.
Vision / strategy	Reviewed, agreed all actions are in place.	Monitoring of progress covered in Board self-review tool.
Gap analysis of NGO recommendations	Gap analysis completed. Action log in place (Appendix 1).	FTSUG to review regularly with Executive Lead / Non-Executive Lead oversight.

3. ADDITIONAL FTSUG ACTIVITIES

3.1 In November 2019, the FTSUG was supported by the Trust to give two lectures to the first year cohort of nursing students at Salford University.

3.2 The FTSUG is scheduled to deliver a presentation on measuring impact and effectiveness at a NGO-led Regional Integration and Development Event on 31 March 2020.

3.3 The Whistleblowers' support scheme offers tailored support to help participants remain in or get back into employment. Applicant suitability is determined by a panel: the FTSUG joined the pool of panellists in the pilot phase, and the Trust has supported the FTSUG to continue to participate in the scheme.

4. FTSUG PROMOTION

4.1 October was Freedom to Speak Up month. Communications and promotion activities included:

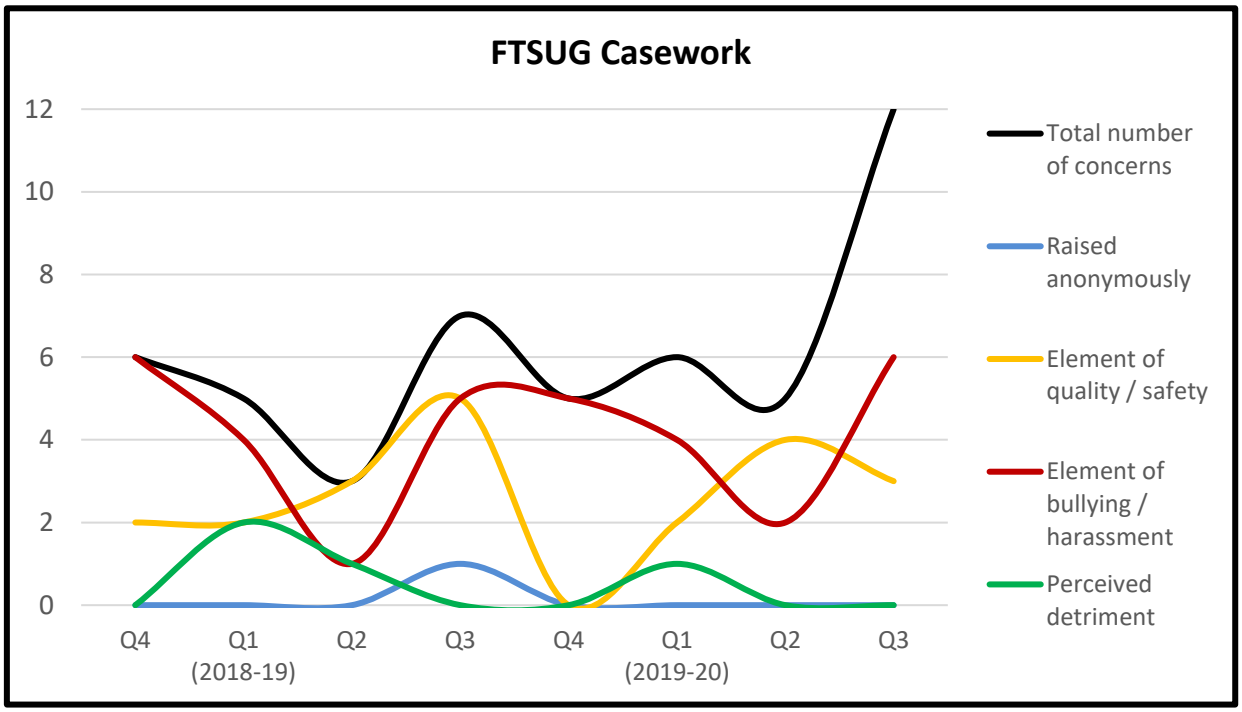
- Weekly updates in Catch Up With Karen.
- Market stalls in Selbourne House and outside Hartshead Restaurant, joined by the Equality, Diversity and Inclusion Lead.
- Raising a "Freedom to Speak Up" flag outside Hartshead South, promoted by the Trust via Twitter.

4.2 The following awareness-raising activities are planned:

- Walkabouts (the FTSUG completed two walkabouts in December / January).
- Updates in person at team meetings on community sites.
- On-site presence at Crickets Lane Clinic.

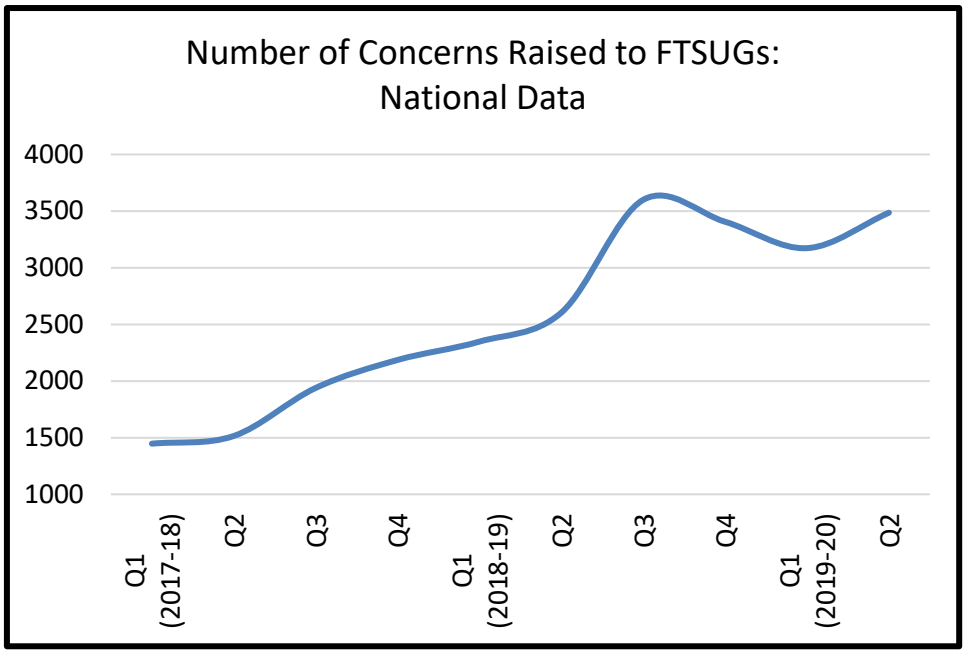
5. FTSUG CASEWORK

5.1 The graph below shows the number of concerns raised per quarter for the last two years, and how many within those contain different elements that are reported to the NGO:

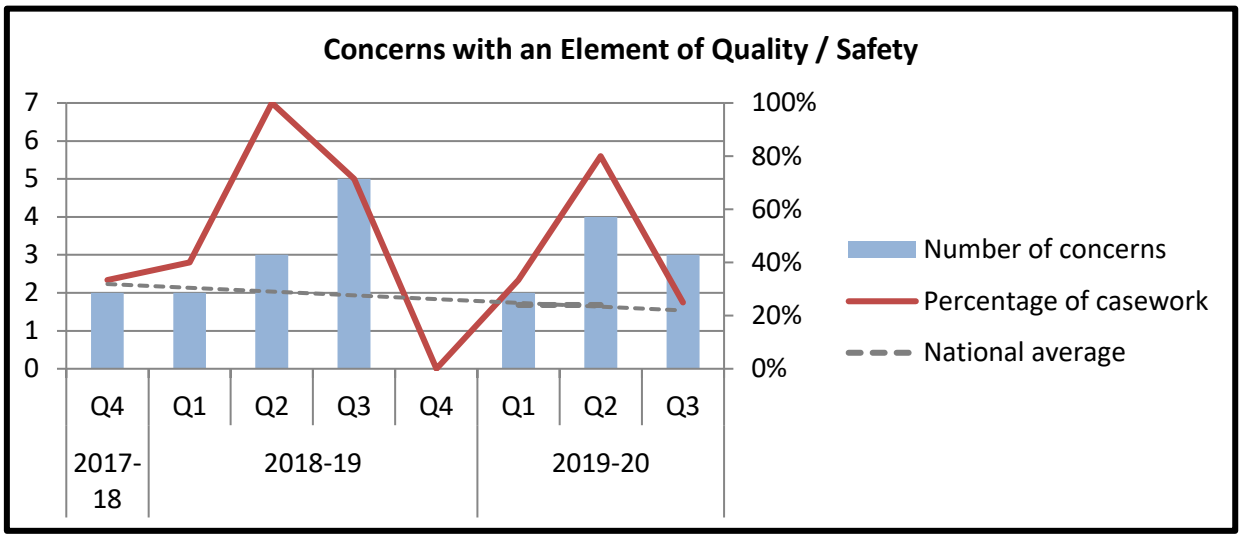


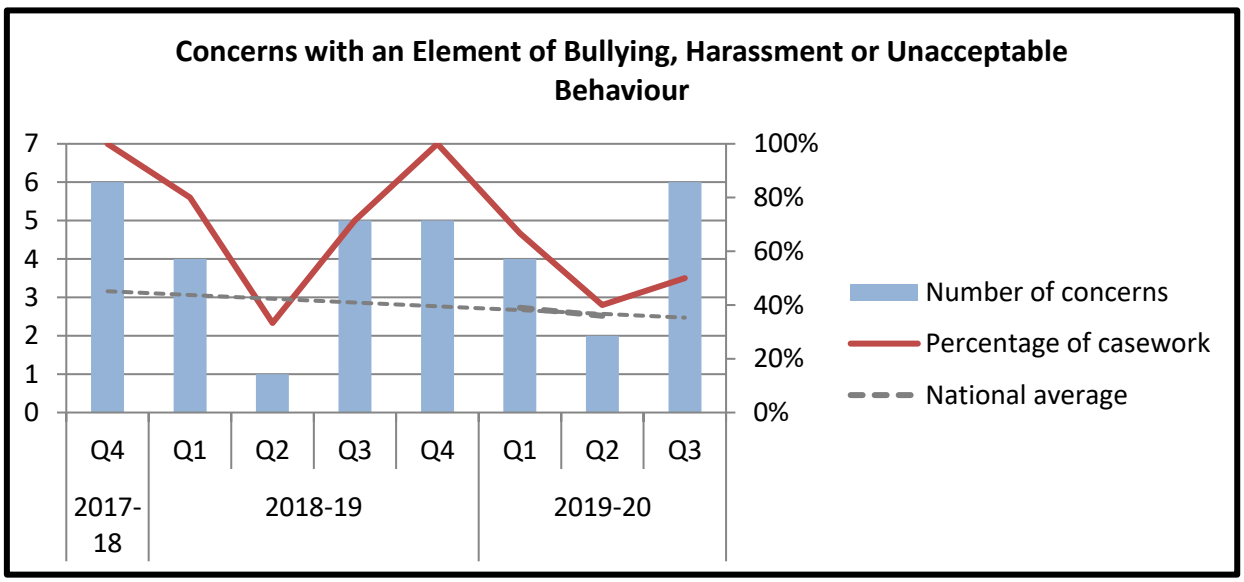
5.2 Six concerns were raised in November 2019 following the FTSUG promotional activities, and the increase was sustained in early January. However this was anticipated due to an increased awareness of the role.

5.3 There are no established themes in terms of the nature of the concern, or the location or professional group where the concerns are raised. The increase in casework, alongside peaks during Quarter 3, is consistent with the national picture:

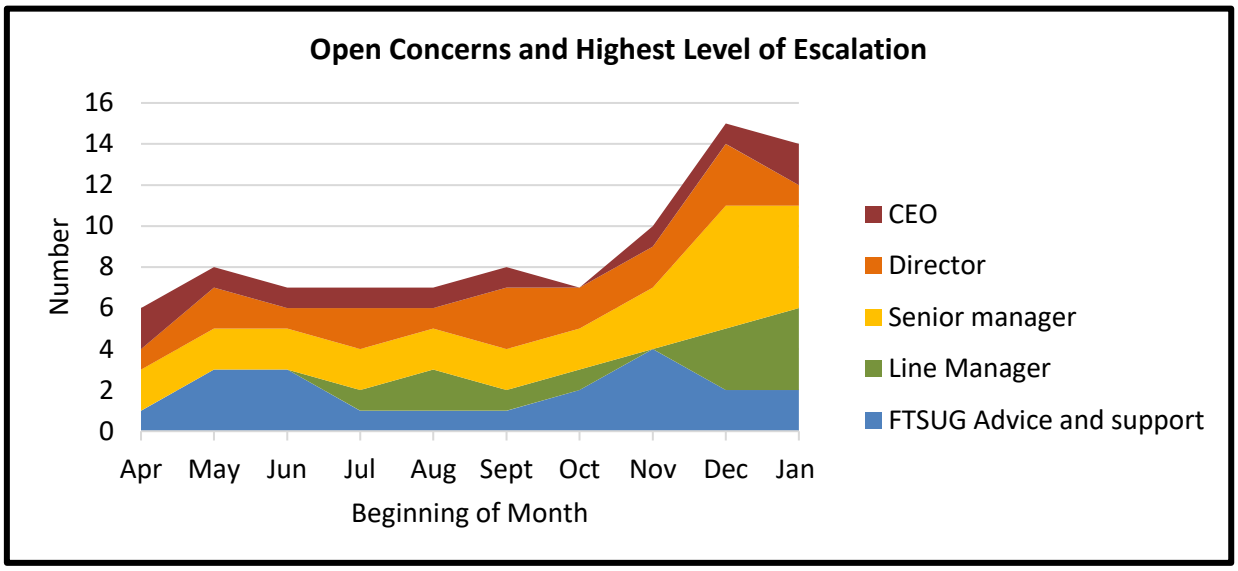


5.4 The two graphs below show the percentage of casework containing the most common elements, benchmarked against the national average:





5.5 The graph below shows the amount of concerns where the FTSUG has involvement each month, and the highest level the concern has been escalated to:



5.6 The FTSUG has not been required to escalate any concerns to the Chief Executive during the timescale indicated by the graph. One concern had been escalated before April 2019, with the FTSUG providing ongoing support to the individual. The most recent concern relates to an individual who met with the Chief Executive prior to contacting the FTSUG.

6. THEMES AND TRENDS

6.1 In December 2019 the FTSUG was aware of three concerns that had been raised via different routes at Crickets Lane Clinic. The FTSUG met with the appropriate senior manager and HR representative. The concerns came from separate teams across two divisions, and there were no further trends in the nature of concerns raised. All were assured that each concern was being appropriately handled and that no overarching trend needed to be identified. However, it was agreed that measures would be put in place to have a more regular visible senior management presence on the site.

7. LESSONS LEARNED

7.1 The Trust and individual managers have a responsibility to proactively take all reasonable steps to protect those who have spoken up from repercussions: in some circumstances this is a legal obligation. This applies whether or not the concern is dealt with using the Raising Concerns process.

7.2 The FTSUG and the Executive Lead for Speaking Up have identified several cases that included an element of speaking up, but were resolved via a process other than the Raising Concerns process. However, adherence to the other process can result in a missed opportunity to follow best practice principles for responding to concerns. For example, a straightforward grievance process may require an individual to provide evidence to support their position, and for their identity to be known. However, if the worker also raises a concern, they cannot be compelled to provide evidence, and may wish to raise some elements of their concern in confidence in order to feel safe to speak up.

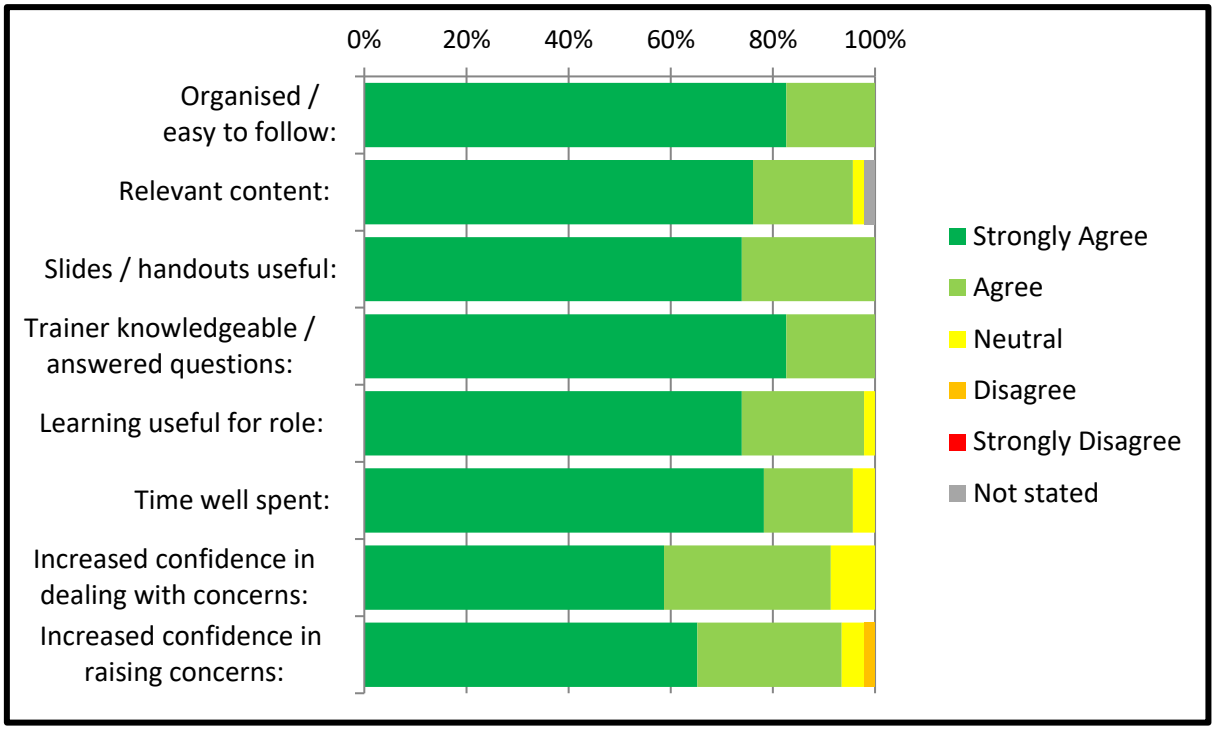
7.3 The FTSUG has agreed with the Assistant Director of HR (Employee Relations) to begin providing updates on trends and lessons learned at departmental meetings.

8. EQUALITY, DIVERSITY AND INCLUSION

There is no trend of unfavourable treatment based on any protected characteristics.

9. FTSUG TRAINING AND DEVELOPMENT

The FTSUG provided training sessions to 29 line managers and 17 preceptees with the following aggregated feedback:



10. FORWARD VIEW

The FTSUG continues to focus on casework and awareness raising activities, while providing both support and challenge for Executive-Led responsibilities.

11. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the positive assurance on the implementation, approach and activities of the FTSU agenda and the FTSUG role.

APPENDIX 1: NGO RECOMMENDATIONS - ACTIONS COMPLETED / IN PROGRESS

NGO Recommendations: Actions Identified and Completed		
Document	**Recommendation**	**Completed**
Case Review 1: Sept 2017	Within six months the trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	10/2018
	Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.	09/2018
Case Review 2: Sept 2017	Within 6 months the trust board should articulate a vision of how it intends to support its workers to speak up, which encompasses a strategy containing deliverable objectives within fixed timescales and under appropriate executive oversight, and to effectively communicate this to trust workers.	03/2019
	Within 6 months a communications and engagement strategy should be developed to promote the Freedom to Speak Up Guardian and Associate Guardian's role, and to evaluate the impact it is having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.	10/2018
	Within 3 months the trust should ensure that all HR policies and procedures meet the needs of workers who speak up, including letters to suspended workers that accurately state their ability to access their Guardian or Associate Guardian.	05/2019
	…"ensure that its bullying and harassment policy and procedure is consistent with the standards set out in the bullying and harassment guidance issued by NHS Employers"…	01/01/2020
	Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.	09/2018
Guidance for FTSUGs on Recording Data	Number of cases raised: anonymously / with an element of patient safety / quality / bullying or harassment / detriment/ professional background/ feedback / learning.	31/07/2018

NGO Recommendations: Action Log				
No.	**Summary of Recommendation**	**Ref.**	**Position / Actions**	**Lead**
1	…"consider developing a local network of ambassadors / champions"…	Survey (3)	26/11/19 proposal drafted by Equality, Diversity and Inclusion Lead, in collaboration with Health and Wellbeing Lead, Head of Patient Experience and FTSUG.	Equality, Diversity and Inclusion Lead
3	…"provide all workers, including all managers, with regular, updated and mandatory training on speaking up"…	Case Review 1 (10)	Held pending expected publication of updated NGO guidance and training resources (estimated 31/03/20).	
8	..."ensure that all investigations into the alleged conduct of workers who have previously spoken up also seek to identify whether any such allegations are motivated by a desire to cause detriment because that worker spoke up and, where such evidence is found, take appropriate action. This should include amending the trust disciplinary policy to require such action."	Case Review 2 (10)	Associate Director of HR drafting new disciplinary policy.	Associate Director of HR
11	..."the trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act."	Case Review 3 (7)	Policy reviewed by FTSUG and taken to Staff Partnership Forum October 2019. Being scheduled for final approval.	FTSUG
13	Within 12 months the trust should revise its speaking up policy, to ensure it is in line with the amendments required by NHS Improvement quoted in this report.	Case Review 6 (3)		

Freedom to Speak Up Self Review Action Log January 2020

The feedback and evidence for this self review has been reviewed by the Exec Lead, (A Bromley), Non Executive Lead (M A Taylor) and the Guardian (P Gordon) and the following actions have been raised where it was felt that we could make some improvements the FTSU role.

There were two Amber areas where it was felt more evidence/action was needed:-

- **Have a strategy to improve your FTSU culture**

  - Whilst we have a robust strategy, which has been communicated across the Trust, with regards to the sub question: ***"Is the strategy is linked to or embedded within other relevant strategies"*** there were no examples to evidence this.

    The Exec Lead in conjunction with the Guardian, are going to review this.

    Action Lead: AB

- **Be Open and Transparent**

  - Again whilst it was felt that there was strong evidence that the Trust has been open and transparent in relation to concerns raised by its workers it was felt that we could do more to ***demonstrate learning's and what changes have been made as a result of this.*** It was agreed that we should look to enhance communications, where approp, of concerns raised and actions taken as a result of a concern being raised.

    The Guardian is to liaise with the Communication Team to consider the options.

    Action Lead: PG

AB/MAT/PG

15/1/20

Freedom to Speak Up review tool for NHS trusts and foundation trusts

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5			Executive are visible with staff having opportunity to have informal discussions in addition to more structured discussion. This acts as a feedback mechanism and enables issues to be picked up. It forms part of a temperature test. Informal conversations with staff from all areas are had when out and about in the hospital and issues they raise acted upon or feedback given. Being approachable in manner when engaging with staff. Open door policy to Executives and example developing various workshops which has led to broad discussions about culture across the organisation. Direct staff complaints and concerns have been sent to Chair and CEO, evidence of staff being confident to raise issues to a senior level. Significant informal engagement with staff to display approp behaviours and encourage /demonstrate strong culture of constructive challenge to Board members when the right behaviours are not displayed. Being seen as an Executive not to accept sub-optimal standards whilst being able to deliver that message in a constructive	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				manner. The manner in which more formal meetings are chaired by Executives across a range of forums can demonstrate compassionate and open leadership. Feedback is given by peers, external regulators, and clinical supervision. Reports such as CQC, staff survey are acted upon. Good to Outstanding focus session enable staff to feedback. Cultural barometer used in some areas. Third party assessments may be used to support triangulation. Completion of Lumina sparks assisted in understanding personal strengths and areas for development. Deloitte review interviewed direct reports into Executive team	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up	p6 Section 1 Section 2 Section 3			Designated Executive / Non-Executive Leads We have identified clear processes for staff to raise issues/concerns which were part of a communication plan on this	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				topic. If in doubt speak out campaign. Strong culture and promoting openness and honesty at Board discussions. Staff have been to Board, we have staff presentations and patient videos. Staff present specific agenda items. Board invites FTSU guardian to share learning with them every four months. FTSU strategy has been completed. Clinical teams are invited to attend Committees to provide insight and updates on issues occurring in the organisation. FTSU guardian attends Board New programme of work for the New Year as further improvements can be made. Talent management Plan in place. Recently 2 seminars undertaken led by CEO. The Trust accesses the leadership development programmes. Executive on NHS Leadership Board. CEO chairs the GM Workforce Group which includes leadership discussions. Strong and multi channelled comms Reports provided by the FTSU give illustrative examples. His role is advertised widely across the organisation	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				and included in the induction process. Cases raised via the Guardian are monitored for detrimental treatment Human Resources working with Guardian to create audit and learning tool for concerns raised internally Guardian 1:1s, Board reports, meetings with key leaders	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4			Strategy agreed by Board in November 2018 and monitored via Board. The strategy was shared in the Trust wide communications and is on the Trust Intranet Site (TIS).	I think we do do all this, but we need more commentary / evidence to support this. It is not clear if FTSU strategy linked to other strategies, a review of other appropriate strategies to be undertaken and updated/cross referenced as appropriate. Whilst the Strategy action log is to be shared/reviewed at the Jan 2020 Boar, as part of the regular update, this is not standard agenda item. This is to be reviewed and an appropriate timeframe for Board updates to be agreed? The Strategy action log and progress is reviewed at the regular 1:1 meetings,

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
					consideration to be given to what that actual qualitative and quantitative measures do we use and for this to be documented.
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to	p7 Section 1 Section 2 Section 5			FTSU guardian meets regularly with members of the Exec team. He is regularly based with the Exec team to facilitate conversations in a timely manner. FTSU time has been evaluated and assessed by the guardian as being adequate. At 2 days per week we are in the top 30% of Trusts for time given to the role. Plus it is a dedicated role. Support is provided to the guardian both through support from Execs and NEDs but has also been provided with access to relevant training such as resilience. He also attends national and regional support networks. The Guardian attends SQOOG Committee were information on a range of metrics is shared. He meets regularly with Execs regards specific areas in which info is shared. Guardian shares timesheets, task lists and redacted casework with Executive Lead in 1:1s as standard.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				Guardian has received training in Mental Health First Aid, Resilience and Human Factors, and is a trainer for new Guardians in the North-West. Wellbeing of Guardian discussed in 1:1s as standard. Open channels to all key executives and Guardian provides regular assurance when there are no pressing issues. Casework in Board reports demonstrates escalation of concerns to Board members. Guardian is given access as required to relevant reports: triangulation in annual report. Whilst the Guardian does not routinely access to data, but when trends are picked up the Guardian is able to speak to HR/Senior Management openly and without resistance, including relevant data as appropriate. Guardian is trainer for new North-West FTSUGs, attends regional meetings and conferences, and chaired the North-West Guardian network for one year. Guardian has also met new Guardians outside secondary care e.g. Greater Manchester Health and Social Care Partnership / Parliamentary and Health Service Ombudsman	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy			Policy up to date and regularly being reviewed by Guardian Reviews completed with feedback from Staff Side representatives, and alongside the gap analysis against recommendations from the National Guardian	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances	P8 Section 6			As members of a unitary board information relating to a range of metrics which allow triangulation across the organisation are shared and discussed. Assurance is mapped and explored more fully through the Governance & Assurance Structure. Significant improvement plans have been implemented and monitored in recent years within the organisation.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.					
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7			Guardian reports to the Board of Directors in person every four months. Plus open door policy for Guardian to meet Chair of he wishes to. Strong and effective links with Guardian and Lead NED in place.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD			Post was externally advertised and recruited to. Guardian appointed via external recruitment process; JD currently under review to align with the example JD	
The board can evidence they receive gap analysis in relation to guidance and reports	Section 7			Gap analysis document accessible to Guardian and Director / Deputy Director of Workforce, and shared with Non-	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
from the National Guardian.				Executive Lead. This is also then shared with the Board on a regular basis	
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9			The Trust can demonstrate openness and transparency through the documents noted in this standard. Regular engagement meetings with regulators with examples shared and discussed.	Can we do more here to demonstrate learning's and what we have changed? Can we make link with F&F, staff survey etc to pull out and act and be seen to be acting on key themes?
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have	Section 1			Will be included in individual objectives going forward and part of appraisal.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
considered how they meet the various responsibilities associated with their role as part of their appraisal.					

Tameside and Glossop Integrated Care NHS Foundation Trust

Meeting date	December 2019	**Public** ~~Confidential~~	Agenda item
Title	Learning from Deaths Report		19
Lead Director	Brendan Ryan – Medical Director		
Author	Viv Buckett – Head of Clinical Effectiveness & Audit		

Recommendations made/ Decisions requested

Members are requested to receive and note the report and summary of learning that has been identified.

This paper relates to the following Strategic Objectives-

X	1	Deliver safe and caring services
X	2	Improve our patients' and carer's experience of our services.
	3	Support the health and wellbeing needs of our community and staff
X	4	Drive service improvement, innovation and transformation
	5	Develop our workforce to meet the future service and user needs
	6	Use our resources wisely

The paper relates to the following CQC domains-

X	Safe	X	Effective
X	Caring	X	Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks-	**AF1.3** If the Trust does not have an effective framework in place to address areas of outlying performance in relation to mortality (HSMR & SHMI) and ensure implementation of the National Guidance on Learning from Deaths then the Trust will not deliver against the National programme on Learning from Deaths and optimise care and reduce patient harm as a result of the programme.

Where issues are addressed in the paper-

	Section of paper where covered
Equality and Diversity impacts	N/A
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	Page 3
Sustainability (including environmental impacts)	N/A

Executive Summary

The learning from Deaths Guidance published in March 2017 by the National Quality Board for NHS Trusts and Commissioners in England identified the requirement for Trusts to report on the numbers and outcomes of deaths in hospital.

This report provides the Quarterly report in accordance with these requirements and sets out how the Trust systematically reviews and learns from deaths and provides a dashboard report for awareness and scrutiny in line with National Guidance and the required National Reporting Criteria.

The report also provides an update for oversight and scrutiny by the board of the:

1. Update & Feedback to the Trusts Mortality Improvement Work Action Plan

Background
Mortality – Learning from Deaths Report

The Learning from Deaths Guidance published in March 2017 by the National Quality Board for NHS Trusts and Commissioners in England identified the requirement for Trusts to report on the numbers and outcomes of deaths. To support Trusts the National Quality Board generated a Mortality Reporting Dashboard as a suggested tool to aid the systematic recording of deaths and learning. The Learning from Deaths Dashboard Report has been adapted in line with this National Guidance and incorporates the required National Reporting Criteria.

The Trust Mortality Review Process was established in 2014 with an aim to review all in-hospital deaths within 14 working days of death. Our mortality review is completed in greater detail when compared to the National Mortality Review process (Structured Judgement Review Tool - SJR), using a standardised mortality review proforma which incorporates the PRISM 2 methodology.

The Learning from Deaths Guidance minimum criteria to be incorporated into the Reporting Dashboard:

National Requirement	Trust Position
Total number in scope for mortality review- as a minimum all adult in patient deaths	Trust reviews all in hospital deaths Selected 30 Day Mortality Reviews
Total Number of deaths considered to have more than a 50% chance of having been avoidable. Suggested tool - Royal College of Physicians – Structured Judgement Review Tool (SJR) or alternative based on recognised methodology	Trusts established Mortality Review Process (Appendix 2) is based on the PRISM 2 Study and incorporates the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) (Appendix 1) to grade the outcome and assess the avoidable aspects of the mortality review process
Mortality review to be completed for all in patient deaths of patients identified with a Learning Disability – using the Learning Disabilities Mortality Review (LeDeR) Programme	All learning disability deaths are reviewed using the Trusts Mortality Review Process. A secondary review is completed by the Trusts Mortality Review Team and the Learning Disability Team. Reporting to the local LeDeR team in accordance with guidance.

The Mortality Reporting Dashboard will provide a summary of:

- The numbers of in Hospital Adult and Learning Disabilities deaths
- Number of completed mortality reviews
- The outcome of the mortality reviews graded using the CESDI grading methodology
- Numbers of avoidable/amenable deaths
- Stillbirths
- Maternal Deaths
- Paediatric
- ED Deaths

Deaths identified as requiring investigation will be generated from Mortality Reviews (CESDI graded as 2 or 3), Incident Reports, Complaints, Safeguarding issues and Coronial Inquests.

Reporting Year April 2019 to March 2020
Year to date Quarter Three

	ADULT DEATHS (NOT INCLUDING LEARNING DISABILITY)							LEARNING DISABILITY DEATHS									
			Mortaliity Review Outcome							Mortaliity Review Outcome							
2019/20	Total Deaths	Mortality Review Completed	Grade 0	Grade 1	Grade 2	Grade 3	Possible Avoidable Deaths	Total Deaths	Trust Mortality Review Completed	Grade 0	Grade 1	Grade 2	Grade 3	Possible Avoidable Deaths	LeDeR Mortaltity Review Completed	LeDeR Mortaltity Review in progress
Q1	233	233	206	25	1	0	0	3	3	3	0	0	0	0	2	1
Q2	219	210	186	21	2	0	0	3	3	0	3	0	0	0	1	2
Q3 (TD)	261	17	15	1	2	0	0	0	0	0	0	0	0	0	0	0
YTD	713	460 64%	407 89%	47 10%	5 1%	0	0	6	6	3	3	0	0	0	3	3

	ED Adult Deaths							Paediatric Deaths								Stillbirths	
			Mortaliity Review Outcome							Mortaliity Review Outcome							
2019/20 Quarter	Total Deaths	Mortality Review Completed	Grade 0	Grade 1	Grade 2	Grade 3	Possible Avoidable Deaths	2019/20 Quarter	Total Deaths	Reported to CEDOP	Grade 0	Grade 1	Grade 2	Grade 3	Possible Avoidable Deaths	2019/20 Quarter	Total	Uploaded MBRACE
Q1	28	28	26	1	1	0	0	Q1	3 (2 ED 1 ITU)	3	0	0	0	0	0	Q1	2	0
Q2	25	25	22	3	0	0	0	Q2	0	0	0	0	0	0	0	Q2	5	0
Q3 (TD)	33	29	26	2	1	0	0	Q3 (TD)	2 (ED)	2	0	0	0	0	0	Q3 (TD)	3	0
YTD	86	82 95%	74 90%	5 6%	2 2%	0	0		5	5	0	0	0	0	0	YTD	10	0

To Note: The numbers reported complete vary each month. This is dependent on the numbers of completed Mortality Reviews and the progress and outcomes of the investigation process. All CESDI Grade 2 & 3 deaths will be reported in the Serious Incident & Duty of Candour Report

Investigation outcomes will be incorporated into subsequent reports on completion - (Level 2 Investigations 60 Working days – Level 3 – External Review Investigations within 6 Months). For those deaths subject to a Coronial Inquest the investigation will not be concluded until after the Inquest date to incorporate any recommendations.

September report incorporates the outcomes of an investigation of a 2018/19 Learning Disability Death, the investigation and subsequent Executive Scrutiny Panel found this to be a CESDI Grade 3 - Probable Avoidable Death. This will be included in the Trusts 2019/20 Quality Account in accordance with the National Learning from Deaths Guidance.

2 Trust Mortality Outlier Status HSMR/SHMI – Trust Mortality Improvement Work

Oversight and scrutiny by the Trust Board

Trust Actions

		Completed Actions
NHSI Alerted to Trusts reported position & Support requested	• Trust engagement with NHSI sub-regional team • Meeting held with GM & Lancashire NHSI 20th December 2018	Trust engagement with Medical Director – Dudley Group for shared learning – relating to reduction of mortality indices for the deteriorating patient.
Trust Interrogation of HSMR/SHMI	Review of: • Patient Records • Patient Safety Incidents • Complaints • Patient Safety Measures • Clinical Coding Practices	No significant patient safety issues identified to date NHSI Director of Intelligence & Insight is to review is to review with the NHSI National team the query raised by the Trust in relation to National adherence to Septicaemia Coding Standards and how variation may impact on mortality indices.
NHSI Feedback Letter received February 2019 – shared with Board		
Actions ongoing		
Proactive review of Mortality & Patient Safety	Request to NHSI for support with external review and assurance of current Mortality Review Process & review outcomes	Contact made with NHSI recommended contact: Dr Caroline Allum Medical Director North East London Foundation Trust. Consultant Radiologist
Feedback received from NHSI recommended contact Dr Caroline Allum – Medical Director North East London Foundation Trust		Completed Review – Dr Allum Assurance of good mortality processes at the Trust

Tameside and Glossop Integrated Care NHS Foundation Trust

Minutes of a meeting of the Finance Committee of the Board of Directors, held on Tuesday, 26th November 2019 at 9.30am in the Board Room, Silver Springs House, Tameside General Hospital.

Present	Sallie Bridgen	SB	In the Chair
	Anne Dray	AD	
	Karen James	KJ	
	Sam Simpson	SS	
In attendance	Denise Stone	DS	Divisional Director, Surgery, Women's and Children's For item 130/2019
	Jackie McShane	JMcS	Director of Operations From item 128/2019
	Amy Matson	AM	Finance Business Partner- Surgery, Women's and Children's For item 130/2019
	Peter Nuttall	PNu	Director of Performance and Infomatics
	Steve Parsons	SIP	Trust Secretary
	David Warhurst	DW	Deputy Director of Finance

123/2019 Welcome and apologies

The Chair welcomed colleagues to the meeting.

Apologies for absence were received from Trish Cavanagh.

124/2019 Declarations of Interest

No conflicts of interest were declared in any of the business expected to be considered at the meeting.

125/2019 Minutes of the previous meeting

The minutes of the Committee's meeting on 29th October, 2019 were approved as an accurate record.

126/2019 Matters Arising from the minutes

The Committee noted that there had been no need for further action regarding any discrepancy between the plans for the Trust and the CCG, as these had been below the *de minimis* level for GM.

The following updates from the Action Log were noted-

116/2019	Both actions completed
119/2019	Both actions completed

1272019 *Single Operating Framework* monthly update

The Committee discussed the following key points from the circulated update-

a. A number of the red indicators would be considered by other Committees, as usual, and would also be the subject of exception reporting to the Board
b. For October 2019, performance against the 4-hour standard for Accident and Emergency was 86.4%. Whilst this was disappointing, the Trust remained the best in GM, and rated 24th out of 118 Trusts nationally.
c. In October the Trust continued to meet the 18-week referral-to-treatment standard and the 62-day cancer standard, together with the 6-week diagnostic standard. The Trust continued to expect to meet these into the future.
d. The Committee noted that national changes to the reported metrics, including changes to the data sets, were being worked through and were likely to be used in the figures reported for December 2019 (in January 2020).
e. SS- noted that the EMT had reviewed the financial and non-financial benefits from the changes to sickness absence policies, as part of the preparation for the next Use of Resources assessment. These had shown very considerable progress.

[JMcS joined the meeting.]

128/2019 Finance report, Month 7 (October 2019)

SS and DW presented the report, and drew attention to the following points;

a. The Trust had been £130k worse than plan for the month, and was marginally better than plan for the year to date. Internal forecasts were now indicating a real risk of finishing the year having not achieved the plan; however, given the mitigations available, the Trust continued to forecast achievement of the Control Total to NHS Improvement.
b. Key drivers related to both the amount of activity and the acuity of the patients being cared for. As previously reported, there were continuing discussions being held with the CCG regarding these issues and the financial impacts, supported by the detailed data available to demonstrate the change in position.
c. The efficiency programmes continued to deliver effectively, and were likely to mostly meet the plan. However, those gains were being off-set by the unexpected extra costs incurred by the increases in activity and acuity being experienced. The Committee noted a number of specific areas of unexpected and unpredictable increases in cost.
d. It was good news that more of the local population was being treated by the Trust, in terms of the wider issues for quality of care and integration of services. However, it was having a financial impact.
e. The ‘deep dive’ days with specific departments were continuing, and were having a very positive impact and reception. Colleagues were appreciative of the supportive and fast approach to developing ideas into efficiency schemes, which supported both financial performance and improvements in patient care and experience.
f. Agency spend continued to be well within both the ‘cap’ and the lower level agreed in the plan. The Workforce Committee had recently had a detailed review of the position, which was positive in terms of better recruitment to substantive positions.
g. Capital funding for the Digital schemes had now been confirmed. Given this and other challenges, it would be more difficult to spend the full amount of

capital within the year; but there was confidence that this would be achieved. Work had also started on developing capital schemes, within the 2020-2021 planning process.

h. The cash position and forecast was noted, and the Committee reminded that the delay in drawing down loans had reduced the amount of interest required to be paid. The Committee also noted that some of the Financial Recovery Fund payments would not be received and accounted for until the 2020-2021 year.

The following points were discussed by the Committee-

a. The Committee recognised that the adverse position had been affected by increases in demand, and by individual cost factors. It was requested that further consideration was given to how these pressures were presented, to support the Committee in understanding the underlying causes.
b. Whilst welcoming the general presentation of information in the report, the Committee suggested that receiving information on trends in activity and acuity, on an on-going basis, might assist in a fuller understanding whilst there were key issues affecting performance.
c. It was positive that the Trust was able to access detailed and accurate data showing the changes in market share.
d. It was noted that the agency trend information was sensitive to single-individual changes, owing to the relatively high costs of medical agency staff when required. It was positive that the spend on bank was reducing, largely due to the success in appointing to substantive positions.

The Committee then-

a. Noted the financial performance in October 2019, and for the period then ended;
b. Welcomed the good progress with the efficiency programmes, and the very positive engagement being seen with staff in the divisions.

ACTION-

a. SS and DW to review how cost pressures related to group issues are presented to the Committee.

129/2019 Contracts and Performance report

DW drew attention to the following points from the report-

a. The information in the report was being used to work with the CCG in demonstrating the additional activity/ acuity being managed by the Trust: and the related costs that have to be met. Demand for critical care was outlined in detail, as an example, together with the projection of additional beds and clinics required if the trends continued. The Committee noted that, if they eventuated, these would have a significant financial impact.
b. Demand in some specialities, notably dermatology, were inhibiting plans to reduce agency use and thereby reduce costs. A number of options were under consideration to reduce these pressures.

The Committee discussed the following matters relevant to the report-

a. The Committee noted that growth had previously been addressed through transformation funding. However, this was no longer sufficient to address the continuing growth in activity and acuity.
b. Assurance was sought as to the accuracy of estimates of capacity and demand in the planning process. It was noted that ageing of the population, and acuity of need, were included in the detailed work undertaken to plan; however, they were inevitably estimates and not fully reliable. It was noted that the current forward planning work indicated that the increased future demand expected would pose real challenges in being met.
c. It was suggested that it would be useful for the Committee to understand the background and the challenges faced, in assessing the position.

The Committee then-

a. Noted the report;
b. Welcomed the work being undertaken, and the positive engagement with partners within the locality;
c. Suggested that further consideration was given to the format of the report, to enable greater transparency for the position.

ACTION-

a. SS and PNu to give consideration to how the format of the Contracts and Performance report could be adjusted to give greater transparency.

[DS and AM joined the meeting.]

130/2019 'Deep Dive'- Surgery, Women's and Children's' Division

DS ran through the circulated presentation, and the following points were discussed-

a. This was a big division, with an efficiency target for the year of £2 million; of which £1.1 million was to be recurrent savings. At the end of October 2019, £1.6 million had been delivered (£0.4m recurrently). The forecast was delivery of £2.4 million for the year, with £1 million being recurrent.
b. There were a number of schemes being developed within the Division to mitigate risks to achievement of the efficiency targets; and these were being developed with the input of the Finance Improvement Team. Work was also underway, with the Team, to develop schemes for 2020-2021.
c. Support tools such as the Model Hospital and 'Get It Right First Time' were being used to support change. These allowed the identification of both potential quick wins and more challenging options for the future.
d. The age profile of the workforce within the Division gave opportunities in respect of transformational change, which the Directorate sought to seize. The changes also gave opportunities to promote positive cultural changes, including working across teams to support new staff, and increasing involvement in the efficiency process.
e. The move to phone follow-ups was welcomed. Similar developments in the future would be considered, particularly to support the delivery of the *NHS 10-year Plan* ambition to reduce face-to-face consultations for out-patient appointments.

The Committee then-

a. Welcomed the presentation, which gave positive assurance regarding the processes and commitment within the Division;
b. Welcomed the move to phone follow-up appointments, and looked forward to further similar developments, having in mind the direction of travel set out in the *10-year Plan*.

[DS and AM left the meeting.]

131/2019 BAF Risks review

The Committee considered the circulated paper and discussed the following points-

a. Following previous discussions, the wording and risk scores for all risks had been reviewed and updated; changes were drawn to the attention of the Committee.
b. The detail that lay behind the summary sheet had also been updated, and was subject to being finalised.
c. The BAF as a whole would be reviewed in the early part of 2020, in light of the work towards reviewing the corporate objectives for the following year; and the revised risk descriptions would be taken into that work.

The Committee agreed that the revised risk descriptions and ratings were appropriate from the Committee's perspective.

ACTION-

a. Revised risk descriptions to be referred to the Risk Management Committee and then to the Board.

132/2019 Future Workplan

The Committee agreed the following changes-

a. Given the trend of shorter meetings, the time allowed in diaries would be reduced to 2½ hours, with the intention that most meetings would complete in 2 hours. The start time would not be changed at present.
b. The programme of deep dives would be extended beyond once every two months, to ensure that all areas of the Trust were covered on an annual cycle. It was noted that those appearing towards the start of the financial year might have less available assurance as a result, but would be able to set out plans and previous delivery.
c. The Quality Impact Assessments for the various assurance schemes should be reported in summary to the Committee as part of the planning process, in addition to reporting to the Quality and Governance Committee.
d. An update on the intended self-assessment process would be provided to the Committee in December 2019.

ACTIONS-

a. SIP to update the workplan accordingly.
b. SS to change the timings for meetings in diaries.
c. SIP to advise Medical Director/ Director of Nursing and Integrated Governance of need for summary QIA's to this Committee as part of planning process

d. SIP to provide paper outlining proposed self-assessment process to Committee in December 2019.

133/2019 Matters to be reported to the Board of Directors

The following matters would be drawn to the particular attention of the Board-

a. The key metrics from the *Single Operating Framework* update
b. The financial position at the end of October 2019
c. The positive assurance from the 'deep dive'
d. The key points from the Contracts and Performance report discussion

SIP would prepare the report in the usual way.

Tameside and Glossop Integrated Care NHS Foundation Trust

Minutes of a meeting of the Workforce Committee of the Board of Directors, held on Wednesday 20th November 2019 at 10am in the Board Room, Silver Springs House, Tameside General Hospital.

Present	Peter Noble	PN	In the Chair
	Sallie Bridgen	SB	
	Brendan Ryan	BR	
	Peter Weller	PW	From item 68/2019
In attendance	Amanda Bromley	AB	Director of Human Resources
	Lucy Harmer	LH	Assistant Director of HR (Learning and Operational Development
	Steve Parsons	SIP	Trust Secretary
	Taira Shafffi	TS	Assistant Director of HR (Inclusion and Engagement) From item 70/2019
	Mark White	MW	Deputy Director of Human Resources

64/2019 Welcome and apologies

The Chair welcomed colleagues to the meeting, and drew attention to the revision to the structure of the agenda. This was intended to enable the Committee to have discussions in a more structured way, with regard to the key parts of the CQC framework. The forward workplan would also be re-structured to reflect this approach in the future.

Apologies for absence were received from Trish Cavanagh, Eleanor Devlin and Dr Alison Lea.

The Committee noted that PW had been delayed in dealing with an operational issue, and would be joining the meeting shortly.

65/2019 Declarations of Interest

No potential conflicts of interest were declared in the business expected to be considered at the meeting.

66/2019 Minutes of the meeting held on 12th September, 2019

The minutes of the Committee's meeting held on 12th September, 2019 were approved as an accurate record.

67/2019 Matters Arising from the minutes

In response to a query, AB noted that the Workforce Strategy was continuing to be developed. AB noted that she would like to share the Strategy with members of the HR team and the Staff Partnership Forum, before bringing the final version to the Committee by the end of the financial year. The aim was for the Strategy to come to Committee at the January 2020 meeting.

PN noted that the Audit Committee was instituting a process of oversight of the other Board Committees in respect of BAF risk review, in order to ensure that appropriate controls were in place. He enquired how this would work in practice. SIP noted that the Audit Committee had agreed that dates for the Chairs of other Committees to report back should be set; more detailed discussions on the way the process would work were not yet concluded.

The Committee noted the following updates from the Action Log-

49/2019	It was confirmed that the public sector's obligation to have 2.3% of the workforce as apprentices was currently continuing indefinitely. Completed.
32/2019	The draft specification for a GM-wide occupational health specification had been published, and formal procurement was expected to start shortly. Completed.
61/2019	Completed
60/2019	AB noted that cross-referencing the staff survey results to other surveys would not be possible, owing to the different focuses and the timing differences between them. The Committee would receive a report linking the actions and referencing the outcomes of the various surveys. It was noted that the Trust sought to be pro-active in learning from the feedback, rather than having mechanical action plans as a result. Action to be re-stated as accords.

[PW joined the meeting.]

68/2019 Future Workplan

The Committee noted the circulated workplan, and the following changes were agreed-

a. An annual report from the Guardian of Safe Working Hours would be added for January 2020 and subsequent years.
b. An update on the work to review disciplinary processes, in light of the letter from NHS Improvement/ England related to support for those within the process, would be scheduled for January 2020.
c. Updates on progress in implementing the Equality, Diversity and Inclusion strategy would be scheduled for the Committee on a quarterly basis (adjusted for the Committee's meeting pattern).
d. Future editions of the GMC Junior Doctor Survey results would be added to the workplan and an update brought to the January 2020 meeting.

ACTION-

a. AB to update the Workplan to reflect the additional items agreed.

[TS joined the meeting.]

70/2019 Update on progress from Staff Survey 2019

TS presented the circulated paper, and drew attention to the following points-

a. The Trust had considered the staff survey results together with other mechanisms of feedback and data sources, and developed a holistic response. The Divisional teams were focused on developing action plans from the survey, with the HR team providing support to assist the Divisions in making the plans effective.
b. Work was being undertaken with system leaders for inclusivity across the locality. The intention long-term was to align health & wellbeing programmes within the locality, and a substantial programme of support was available for colleagues. There was also an aim to encourage flexibility and agility.
c. Turning to the latest survey, which was open for staff to complete and where the results were expected to be published in Spring 2020, there had been challenges in encouraging staff to complete the survey. There was a need to change the approach next year: 33.9% of staff had completed the survey to date, compared to 40% last year. Areas with particularly low rates of return were being supported.
d. The Committee's attention was drawn to the work being undertaken nationally to look at the impacts of (in)civility: these could impact on clinical, financial and patient care. Part of a video from Dr Chris Turner was played, and the Committee noted the link to patient safety and 'just culture'; together with the potential positive and negative impacts beyond processes. The link to the video would be circulated to the Committee.

The Committee discussed the following matters from the report-

a. The Committee queried whether the Trust was clear enough about what 'Outstanding' looked like, and whether progress towards it was being adequately tracked. It was noted that the current discussions with staff were exploratory; and assurance would need to be taken holistically at the Board level..
b. Positive change was unlikely to be seen as a result of the work being undertaken in the results of the staff survey currently open. The time-lags, both in the survey process and owing to the need to have cultural change, meant that the positive outcomes would not be seen immediately.
c. The Committee would welcome work to increase the level of responses for future years, as it considered that the rate of response that had been seen over recent years needed to increase to give a better view to the Board of staff views. It was noted that consideration was being given to a number of ways of increasing responses, including non- e-mail contact and providing the surveys personally recognising that this would have resourcing implications.
d. A leadership programme was being developed to look at leadership within the Trust, aimed at those providing leadership in front-line situations; and recognising the balance between processes and the environment/ context in which leadership was provided.
e. The Committee considered whether the key issues were civility, or whether there was understanding and competency. The Committee noted the academic evidence that incivility in the workplace actively produced a negative impact on productivity, cognitive ability and patient care; and the work being undertaken to include a programme to address in 2020.

The Committee then-

a. Noted the update on the work being undertaken from the results of the staff survey;

b. Requested that each meeting of the Committee was started with a 'staff story', in a similar manner to the patient story considered at the start of each Board and Quality & Governance Committee meeting.

ACTIONS-

a. AB to schedule staff stories for all meetings of the Committee, starting in January 2020.

71/2019 Workforce Dashboard

MW drew attention to the following key points-

a. Rolling 12-month sickness rates were at 5.6%, which was below the annual target although above the monthly one.
b. The time taken to recruit to posts was an average of 62.4 days, against the agreed target of 55 days. The target was challenging, and as a comparator the Trust was broadly a median performer against Trusts in England. There was also an impact on the timing of recruiting nurses in training, who would not come into post whilst they completed their training and registration. 180 people had commenced in post during August and September.
c. At the close of the window, 90.1% of colleagues had completed an appraisal process. This was above the base target agreed by the Board, but had not met the stretch target of 95%.

The following matters were discussed by the Committee-

a. The Committee welcomed the improvement in performance related to sickness, and thanked colleagues across the Trust for their efforts.
b. The Committee discussed the target for staff 'Friends and Family' positive response rates, and noted that the median response rate nationally was about 66% positive, compared to a Trust target of 80% positive. AB noted that the internal target had been set based on previous staff FFT and staff survey results and past performance.
c. It was noted that performance reporting on progress from the Equality, Diversity and Inclusion strategy would be better on a quarterly basis than included in the dashboard, given the longer-term nature of the changes sought.
d. Consideration would be given to how trend analysis might be shown within the report for key metrics.

The Committee then noted the dashboard for the period.

72/2019 Sickness absence- update on policy implementation

MW presented the paper, which updated the Committee on the progress and impact of implementing the new sickness absence policies. He drew attention to the following matters-

a. In the previous winter, there had been substantial issues, including 2 days where 274 colleagues had been absent sick on each. As the Committee knew, a new policy approach had been introduced earlier in this year.
b. Whilst there had been a Business Case prepared for a sickness absence management team, the improvements seen through the policy change had made this less attractive and it was not being pursued at this time.

c. A number of improvements had been put in place to support staff experiencing ill-health, including an on-site mental health consultant one day a month, and a Rapid Access to Treatment scheme for physiotherapy and similar treatments
d. Overall, sickness rates within the NHS were being seen to increase, and it was important that the Committee saw the Trust's improvement against that backdrop. There was a very positive movement of long-term sickness down to about 2.5%, and the latest data in Model Hospital (August 2019) also showed the Trust on a positive track.

The following key matters were discussed by the Committee on the report-

a. The figures within the Model Hospital might not be directly comparable, given that the Trust's figures included community services that were generally not provided by other acute providers.
b. The Committee welcomed the positive progress seen, and the positive impact from the introduction of the new policy approach.
c. The Committee noted that the short-term absence figures were showing a seasonal 'spike', and enquired as to reasons. It was noted that family emergencies in the period were a key factor, and this period had also been affected by recognising some repeated short-term absence as long-term. For reasons led by public health considerations, the North-West consistently had the highest rates of staff sickness absence in England.
d. It was noted that local management could significantly impact on the effective management of both short- and long-term sickness. It was considered that the merging of approach to both types of absence would assist, in terms of focusing on patterns of absence and reviews of how colleagues could be supported to return.

The Committee then-

a. Noted the update report;
b. Welcomed the very positive progress that had been achieved;
c. Noted that this was a very positive message, and requested that it was actively communicated to all staff noting the reduction in pressure on all colleagues by better attendance.

ACTION-

a. MW to arrange communication of positive message on sickness absence to all staff.

73/2019 Spend on agency staff

The Committee noted the report, and discussed the following points-

a. There was a continuing transformational effect; although fluctuating, spend on agency support continued to be below the 'cap' and the agreed budget position (which was substantially below the cap).
b. There had been significant substantive recruitment to medical specialities: and good recruitment for nurses, both student and qualified.
c. The Committee noted that NHS Improvement/ England had introduced new requirements in September 2019, which prevented the use of agency for administrative or estates posts except in emergency and with some limited exceptions in areas such as IT.

d. The Committee noted the introductory support that was being provided to new starters, and suggested that these should be reviewed to identify any risks related to retention of staff. It was noted that discussions were being undertaken.
e. Overall, the first aim was to increase the number of substantive posts being filled; then to utilise bank arrangements rather than agency to meet any short-term gaps.

The Committee then-

a. Noted the update report;
b. Welcomed the very positive progress being seen in this area;
c. Noted the potential for further improvement through lower sickness absence and greater recruitment to substantive positions.

74/2019 Matters to be reported to the Board of Directors

The Committee noted that the following would be drawn to the particular attention of the Board-

- The discussion on the update from the Staff Survey
- The progress on sickness absence

The usual report would be prepared by SIP.

75/2019 Items for note only

The Committee noted the following-

a. Minutes of the Educational Governance Group, 24th September 2019
b. Minutes of the Staff Partnership Forum, 3rd September and 1st October 2019.

76/2019 Apprenticeships

The Committee returned to the topic of apprenticeships within the Trust, and noted the following points-

a. The Trust continued to have good retention of apprentices, both those who joined as apprentices and other staff who took up apprentice qualifications whilst in substantive roles.
b. There were some substantial financial impacts with regards to apprenticeships for nursing roles, as the levy funding would not cover the full costs incurred; and the requirement to 'back-fill' had a particular financial impact. It was also noted that the requirement for the public sector to have 2.3% of its workforce in apprenticeships was higher than implied for the economy generally.
c. The Committee discussed the opportunities for clinical staff, particularly nurses, to progress through apprenticeship routes. It was noted that briefing on the various career routes might usefully be provided to Non-Executive colleagues prior to the Committee resuming the discussion.

Tameside and Glossop Integrated Care NHS Foundation Trust

Minutes of a meeting of the Quality and Governance Committee of the Board of Directors, held on Thursday, 7th November 2019 at 9.30 am in the Board Room, Silver Springs House, Tameside General Hospital.

Present	Martyn Taylor	MT	In the Chair
	Sallie Bridgen	SB	
	Trish Cavanagh	TC	
	Peter Noble	PN	
	Brendan Ryan	BR	
In attendance	Anita Fleming	AF	
	Karen James	KJ	Chief Executive
	Tom Jinks	TJ	Associate Director of Integrated Governance
	Zoe Mayer	ZM	
	Jane McCall	JMc	Trust Chair
	Jackie McShane	JMcS	Director of Operations
	Fiona New	FN	Associate Medical Director
	Kerry Reid-Field	KRF	Head of Midwifery
	Steve Parsons	SIP	Trust Secretary
	Denise Stones	DS	

151/2019 Welcome and apologies

The Chair welcomed colleagues to the meeting, and colleagues introduced themselves to DS and ZM.

Apologies for absence were received from Peter Weller, Amanda Bromley, Amanda Dooley, Paul Featherstone and Sam Simpson.

152/2019 Declarations of Interest

No conflicts of interest were declared in respect of the business expected to be considered at the meeting.

153/2019 Patient Story

DS and MZ presented the patient story, noting the following key points-

a. The patient had been diagnosed with a twisted bowel, and had then been subject to a range of further tests and procedures as their condition deteriorated. Eventually a perforated bowel had been identified.
b. A number of system issues had been identified in the review of this case.
c. Whilst there had been an ultimate decision that surgery was not in the interest of the patient, who was elderly, poor communication with the family and a reluctance to give difficult news had led the family to have an unrealistic set of expectations, which then led to difficulties when the final position was

discussed.

d. A specific difficulty had been identified with the on-call arrangements in surgery, as the individual on-call at the time was difficult to contact owing to personal circumstances.
e. A number of changes had been introduced as a result, including a 'buddy' to back up the on-call clinician. There was also work being undertaken to support colleagues having difficult conversations with families earlier, to prevent unrealistic expectations accruing.

The Committee discussed the following key matters arising from the presentation-

a. The culture for deciding what work is appropriate for frail individuals; it was noted that some teams chose to 'try everything' rather than have a difficult conversation, which could lead to families anticipating a happy outcome that wasn't deliverable. There would be grey areas for judgement, but colleagues needed confidence to positively hold back from action in appropriate circumstances.
b. There was an agreed metric across GM for frailty, which GP's were expectedto be using: this enabled development of advanced care plans. However, GP completion was relatively low, and monitoring/ support were being developed. There could also be some issues about recognising the prior assessments at the 'front door', which were being worked on. This could also be a positive support for public health work as well, enabling early interventions.
c. A query was raised about training and support to change the cultural approach, and preparing patients/ family for the decease of a loved one. The Committee noted that work was being undertaken, with a clear leader; and that this needed to be handled sensitively. The cultural change sought was to attend to what's realistic rather than 'doing everything'.
d. It was noted that some related work under the seven-day services stream had identified pro-active work in respect of frail patients related to pre-operative stays in hospital.
e. The Committee noted the desirability of developing systems that were better at being pro-active in changing prior to issues being identified through failings in patient experience.

The Committee then-

a. Noted and welcomed the patient story
b. Welcomed the open and transparent reporting of a matter where the process had not worked appropriately, and the strong assurance regarding actions taken to improve.

[DS and ZM left the meeting.]

154/2019 Minutes of the meeting held on 3rd October, 2019

The minutes of the Committee's meeting held on 3rd October, 2019 were approved as an accurate record.

155/2019 Matters Arising from the Minutes

The Committee noted the following updates from the Action Log-

137/2019	Completed (two actions)

143/2019	This was on the agenda for the Audit Committee in November 2019. Completed.
149/2019	Arrangements were in place to report assurance to the November meeting of the Board. Action discharged.

156/2019 7-day services- six-monthly update

FN and JMcS presented the circulated report, drawing attention to the following points-

a. The Committee were reminded of the national standards, and the requirement to be compliant with each of them by a given date.
b. There were no significant changes to report in this update.
c. There had been some concern about compliance with Standard 10 (clinical audit); FN had now been appointed to lead the Trust's clinical audit processes, and was taken active steps to ensure that all national audits were complied with in the given time-scales. The Committee were reminded that the national programme had expanded markedly in recent years, and required a significant investment of time and effort from colleagues. There were also challenges with the move nationally to continual data submission, rather than submission at discreet times, which required more commitment from clinical colleagues.
d. Some data issues were noted, particularly regarding documentation standards which would affect compliance with Standards 2 and 8. The national team were aware of the Trust's situation and were not concerned; and a multi-disciplinary group had been formed which was enthusiastically addressing the issues.
e. The Committee needed to note that additional resourcing would be required to achieve Standards 2 and 8, as additional staffing would be required. This was the subject of continuing discussions with the CCG. There would also be a need to reform the way that rotas worked, and to identify possible weekend discharges in advance where possible.

The Committee discussed the following matters-

a. There was concern regarding the resourcing position, if the Trust required additional resources to meet these national standards. It was noted that, as the position had developed, the required funding had dropped from £8 million to £2 million, but the CCG was not in a position to commit to that funding and discussions were continuing as to the way forward. The CCG's position and the possible ways forward in discussions were considered.
b. A greater awareness of the impact of the requirement for Consultant reviews of each patient within 14 hours, and the potential resourcing/ staffing implications, was desirable. This would need to be combined with a greater awareness of the ability to identify patients (such as those pending discharge) as not requiring Consultant review and therefore outside of the standard.
c. A key part of this work would be to lead cultural change and 'mind-sets' to embrace delivery of the standards. However, this would also require commissioners to commit to the necessary funding as well.
d. There was a welcome for the positive work being undertaken to improve the quality of documentation, which had been a concern for the Committee. It was also welcomed that good documentation was acknowledged back to the individual as a positive.

The Committee then approved the 7-day services return for submission.

[FN and JMcS left the meeting.]

157/2019 Quality Dashboard

TJ introduced the dashboard, noting that it was evolving and had been changed, particularly following the review of the work of the Service Quality and Organisational Governance Group (SQOGG). He drew attention to the indicator for mortality reviews within 14 days; remedial action had been taken, and the initial data for October showed improvement.

The Committee discussed the following points from the dashboard-

a. Suggestions for further changes, either as development or as focus changed, would be welcomed and should be made to MT, PW and TJ.
b. There was evidence of positive improvement in the position on pressure ulcers.
c. The exception reports had several references to reminders, which some members felt was passive and that the response should be more pro-active to drive change in culture. It was confirmed that these items would have been escalated to senior staff for resolution; the wording in the report would be reviewed.
d. It was noted that the nutritional risk assessment metric had been added and full data was not currently available; this was being addressed, and the Committee would be receiving a full presentation in January 2020.
e. The Committee particularly welcomed that the dashboard would be changed as priorities and focus changed, to reflect current issues.

The Committee then noted the Quality Dashboard.

ACTIONS-

a. Review exception report wording re reminders/ escalations

158/2019 Service Quality and Organisational Governance Group- minutes

The Committee noted the minutes of SQOGG's meetings in September and October 2019. The following matters were discussed-

a. The Committee confirmed that they wished to see the minutes, as well as the summary report, at this stage.
b. The Committee noted the discussion at SQOGG regarding themes in Radiology, which had noted that there had been missed opportunities to diagnose cancers. Whilst these had been within tolerances, the themes had been identified through SI reviews and the Radiology Committee would be using them to promote learning. It was not thought necessary by SQOGG to draw them specifically to Q&G's attention at this stage.
c. A query was raised regarding the actions being taken to improve responses to patient surveys, particularly the childrens' and young persons's survey. It was noted that this was being included in the developing Patient Experience strategy, and could be discussed in context when the Committee considered the January 2020 update report.
d. The Committee noted the recent 'away-day' for SQOGG, which had served to re-set the focus of the group and agreed future plans. In response to a query,

it was confirmed that the away-day had considered whether some of SQOGG's functions could be shared to other groups, but it was felt that would not be as effective.

ACTIONS-

a. Patient Experience update in January 2020 to include steps to improve response rates to patient surveys.

159/2019 Risk Management Group- Minutes

The Committee noted the minutes of the Risk Management Group's meeting in July 2019, and the summary report from the October 2019 meeting. The following points were discussed-

a. A query was raised regarding potential risk from clinicians receiving pension-related tax charges. It was noted that, at present, this Trust was not seeing any significant impact from this issue, and the risk rating was considered appropriate at present. It was also noted that any individual colleagues would need to take their own advice, to reflect their particular circumstances.
b. There was a suggestion that the shifts in risk could be set out more graphically on a single page; this would be reviewed further outside of the meeting.
c. The cancer risk concern had been further reviewed, which had shown the potential issue was not occurring in practice. Similarly the issue on high-rated risks at a Division level had been further discussed, and resolved, at the October meeting of the group.

ACTIONS-

a. PN to outline format proposals re shifts in risk to TJ for discussion.

[AF and KRF joined the meeting.]

160/2019 Maternity Transformation Update

AF and KRF noted the following key points from the update-

a. There continued to be good progress against the national standards; it was particularly pleasing that the Trust had been recognised at GM for its improvement in smoking cessation during pregnancy.
b. Work was in place to meet the national requirement to offer three options for birth, with the midwifery-led unit expected to open before the end of 2019. The Trust would then comply with that standard.
c. In common with other providers, meeting the national expectations regarding continuity of care was challenging. The Trust had an aim of about 20% compliance, and was currently seeing about 17%.
d. NHS Resolution had confirmed that the Trust had met all of the CNST Midwifery standards; confirmation was awaited of the amount of 'rebate' payable as a result. It was understood the new standards for 2020 would be published shortly.

The Committee discussed the following points-

a. It was noted that the red rating related to community hubs and working across boundaries related to enabling staff to be physically based in the community.

There had been challenges about obtaining appropriate locations, which were being actively and innovatively addressed.

b. In respect of continuing midwifery care, it was noted that the standard required continuity over all three phases of care. Whilst information was available for the antenatal and birth periods, it was not currently available post-natally. The team were working to prioritise patients rather than the counting process; it was also noted that GM was undertaking work in this area. The Committee noted that the national expectations in this area were very challenging and did not necessarily reflect how care was provided on the ground.

The Committee then noted the update, and welcomed the positive progress that could be shown in this area.

[AF and KRF left the meeting.]

161/2019 Deep Dive- CQC risk

TJ presented the 'deep dive', noting that the risk had been reviewed by the Director of Nursing and Integrated Governance, and reported to the Board. Following consideration of the key factors, the judgement was that the risk could be rated at 10. Attention was drawn to the controls in place, which together with the agreed actions were regularly reviewed and updated.

The Committee discussed the following points-

a. The Committee noted the continuing work to ensure that the Trust was well-placed for the next inspection by the CQC, which was likely to arise in the medium-term.
b. A query was raised as to whether the risk should focus on maintaining 'Good', or moving to 'Outstanding'. It was noted that the aim was to both maintain 'Good' and work towards 'Outstanding'; and that some areas, such as Well-Led, might have achieved that if the Trust's financial position was different. JMc noted that November's Board meeting would include relevant discussions on both achievement of corporate objectives and cultural matters.
c. The Committee noted that there was positive work being undertaken to engage staff in the move towards 'Outstanding', which was being well-received and getting good representation from across the Trust in meetings.

The Committee then noted the 'deep dive', and confirmed that it gave positive assurance in respect of this risk.

162/2019 Significant Risk Report

TJ presented the report, noting that no quality-specific risks were being drawn to the Committee's attention. The following points were noted-

a. A query was raised as to why the low rate of response for surveys was not considered a greater risk, given their importance in inspection; attention was also drawn to the comparator with Higher Education, where institutions paid close attention to both comments and response rates. The Committee noted the comparator and the challenge, but considered that the rating currently was appropriate given the potential strategic risk.

The Committee then noted the Strategic Risk Report.

163/2019 CLIC Report

TJ presented the report, noting that it had previously been reviewed by SQOGG to provide appropriate assurance to the Committee. It was noted that there were no significant matters in either of patient incident trends or staffing incidents.

The Committee discussed the following points-

a. The Committee noted that it was important to distinguish bullying and harassment from violence and aggression. Particularly where the latter was from patients suffering from dementia. It was suggested that some colleagues were eliding the two, which could be giving an unbalanced impression in the figures.
b. The positive position being shown on reported incidents against reported harm, and the efforts put into this area by the Divisions to move the Trust into the top 25% nationally, were welcomed.
c. The Committee noted that the targets for CQUIN's had been agreed with a view towards enablement, and there were improvements in performance showing in the second quarter.
d. A query was raised regarding the reporting of clinical audit data in September; it was noted, as discussed earlier in the meeting, that particular circumstances had contributed to this and active steps to resolve were now in place.

The Committee then noted the CLIC report.

164/2019 Other Business- Medical Examiners

An update on progress towards implementing the new system was requested. BR advised that-

a. The Trust was continuing to prepare, and the Trust lead had completed the required training as a Medical Examiner, which was a substantial qualification in its own right. The Trust was some way ahead of the majority of Trusts in practical preparations.
b. There remained uncertainty about how the financial side of the system would work, which would not be resolved until after the pre-election sensitivity period and decisions by any new government. There were currently some different messages being received about the implementation and time-scales for the change.
c. GM had a working group looking at how the system might be implemented, in discussion with HM Coroners for the region. Internally, a small non-exclusive team was being looked at; as were options for some shared service arrangements.

Tameside and Glossop Integrated Care NHS Foundation Trust

Notes of a walk-about by the members of the Quality and Governance Committee of the Board of Directors, held on Thursday 5th December 2019 at 9.30am starting and concluding in the Board Room, Silver Springs House, Tameside General Hospital.

Present	Martyn Taylor	MT	In the Chair
	Jane McCall	JMc	For Sallie Bridgen
	Brendan Ryan	BR	
	Peter Weller	PW	
In attendance	Amanda Bromley	AB	Director of Human Resources
	Amanda Dooley	AD	Head of Assurance and Governance
	Paul Featherstone	PF	Director of Estates and Facilities
	Tom Jinks	TJ	Associate Director of Integrated Governance
	Steve Parsons	SIP	Trust Secretary

165/2019 Welcome and apologies

The Chair welcomed colleagues to the proceedings, noting that the Committee would be undertaking walk-arounds in two areas and then re-convening to review findings and agree any actions required for assurance.

Apologies for absence were received from Sallie Bridgen, Trish Cavanagh, Peter Noble, Karen James and Sam Simpson.

166/2019 Minutes of the meeting on 7th November, 2019

The minutes of the Committee's proceedings on 7th November, 2019 were approved as an accurate record.

167/2019 Matters Arising from the minutes

The Committee noted the following updates to the Action Log-

142/2019	BR advised that the possible safer staffing metric for medical staff was expected to be reported to the January 2020 meeting. Re-dated accordingly.
144/2019	The Committee noted progress with setting up for an external review of Theatres, and agreed to re-date the progress report to April 2020.
157/2019	Completed.
159/2019	TJ had not yet heard from Peter Noble regarding presenting trends/ shifs in risk in the reports. PW noted that there was a wider piece of work being undertaken to review the approach to risk strategy and reporting, into which this could feed. Action discharged.

168/2019 Walkabouts

TJ outlined the key metrics and statistics for the two areas to be visited-

a. Children's Unit
b. Outpatients (Yellow Zone and Blue Zone)

The Committee then rose at 9.44am to do walkabouts, and re-convened at 11am.

<u>Outpatients</u> (Yellow and Blue Zones)

TJ and PF gave feedback on their visits (Yellow and Blue outpatients), and the following points were noted or discussed-

a. Staffing numbers had been positive
b. There had been some feedback regarding having old and unreliable IT equipment. There had also been particular feedback about annual licence renewals for a key piece of software, where the renewals had not been seamless.
c. There had been a very positive balance of compliments to complaints; any complaints received were being handled appropriately and supporting team development and learning.
d. The unit displayed excellent cleanliness; but some issues were reported in maintaining standards when the regular housekeeper was absent.
e. Colleagues described how they were very pleased with the outcome of the recent refurbishment of the unit.
f. There were relatively high Did-Not-Attend (DNA) rates in Maxio-facial, despite use of text reminders and similar; and relatively low in Orthodontics. PW noted that there was some external evidence that high DNA in Maxio-facial could potentially correlate to safeguarding issues; this would be reviewed further for the department.
g. Patients had given very good feedback on staff, and positive feedback on waiting lengths. One specific patient had concerns from previous treatment, but was positive about their current care.
h. Staff had queried whether the clinics operated at the weekends were appropriately utilised, as they had a perception of light usage with full staffing. The senior staff had not reported the same perception when asked. It was noted that usage could be checked, and that having fewer clinics active at weekends might mean that, although each clinic was operating appropriately, the impression might be of less activity.
i. The Committee also noted that there was a wider debate about what required the service of a Registered Nurse and what could be provided by other colleagues; and that some medical colleagues asked for a greater level of registered nurse support. These were complex discussions, being undertaken both within the Trust and nationally.
j. The team ethos in both areas was very strong, and this was something to remain aware of when considering changes in the future. Staff were happy to challenge on issues such as "bare below the elbow".
k. There wasn't an awareness of the *Freedom to Speak Up* Guardian, although staff could articulate how they would speak out. The Committee noted the intention to review how the Guardian could more actively engage with teams directly.

Children's Unit

AB and JMc gave feedback from the walk-around in the Children's Unit, and the Committee noted or discussed the following points-

a. There was appropriate staffing seen for the dependencies present in the department, and this had been appropriately planned.
b. The initial impression was that the Children's Unit was a a busy but calm environment; at the time of the visit, there were 2 unoccupied beds of the 16 available.
c. Staff had been pleasant, and there was a good working relationship between the junior doctors and nurses.
d. Patient feedback on the quality of care had been positive, and they had been pleased with the care received. One specific issue had been noted for later investigation.
e. There was mostly good information displayed, although some was slightly out of date. Similarly, there were some minor signage and leaflet issues identified.
f. The Observation and Assessment (O&A) log-book was being manually maintained, which could be an area ffor consideration of an alternative digital solution. However, there were also some cultural issues evidenced in terms of moving to digital that would have to be addressed also.
g. The 'Sanctuary Room' was not currently being appropriately used, and there were also some issues with the room that could be quickly addressed with the Estates Department. The Children's Department needed to decide what was required in order to provide the correct environment to support children and families who might benefit from that room.
h. There had been some feedback on the staffing arrangements for allergies and food challenged-patients, which would be looked into with local teams.
i. There had been a perception that use of Registered Nurse Associates would take away from the work of Registered Nurses; which chimed with the feedback from the Outpatients walk-about. It was noted that there was a need to better understand the challenges in this area.

Any Other Business

There was no additional business discussed by the Committee.

Date and Time of Next Meeting 9th January 2020 at 13.00hr Silver Springs Boardroom