AGENDA

NHS University Hospitals Plymouth NHS Trust

Trust Board (Public)

Date	Friday 24 April 2020
Time	9.00 am – 10.30 am
Location	Virtual via Microsoft Teams

Standing items				
1	**Welcome, apologies and declarations of interest**	-	Chairman	Verbal
2	**Questions to the Board pertinent to the agenda**	-	Chairman	Verbal
3	**Previous minutes, matters arising and review of actions**	Approval	Chairman	Paper
4	**Chief Executive's Report**	Review	Ann James	Verbal
Quality: Delivering safe, high quality services				
5	**Operational Performance against NHS Constitution standards**	Review	Kevin Baber	Pres
6	**Maintaining cancer treatment during COVID-19 response**	Review	Kevin Baber	Paper
7	**Learning from the Paterson Inquiry and other national reports**	Review	Lee Budge	Paper
Workforce: Valuing our people				
8	**Education & Training Report**	Review	Steven Keith	Paper
9	**Freedom to Speak Up Guardian Report**	Review	Pippa Jephcott	Paper
Governance				
10	**Ratification of Utilities Procurement decision**	Ratification	Nick Thomas	Paper
Closing items				
11	**Any other business**	-	Chairman	Verbal
12	**Key actions for Committees and Executives**	-	Chairman	Verbal
13	**Next meeting: Friday 22 May 2020**	-	Chairman	Verbal

Supplementary papers	
	None this month

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Members of University Hospitals Plymouth NHS Trust Board of Directors have declared the following interests:

Name	Position	Declared Interest
Richard Crompton	Chairman	• Independent Chairman of the Safeguarding Panel for Dimensions UK, a national provider of a range of services for the learning disabled and autistic. • Independent Chairman, Wiltshire Safeguarding Adults Board.
Kevin Baber	Chief Operating Officer	• Member of the Cornwall and Isles of Scilly Health & Care Partnership Transformation Board. • Employer Member of the SW Sub-Committee of the Advisory Committee on Clinical Excellence Awards. • Partner is Associate Director, Medicines Optimisation, at Devon Partnership Trust.
Jo Beer	Director of Integrated Care & Partnerships	None.

Bill Boa	Associate Non-Executive Director	• Founder and Director, Boa & Associates Consultancy Ltd, a limited company providing financial and organisational consultancy services to the NHS. My spouse is also a Director of the company. Current clients include:
		  • Barts Health NHS Trust – acting as Financial Improvement Director of the Trust.
		  • Rushcliffe Clinical Commissioning Group (CCG) – providing 'expert witness' NHS financial support to the CCG.
		  • Supply Chain Co-ordination Ltd – providing expert finance and organisational advice to this organisation, the co-ordinating body for NHS supply chain services in England.
		• Trustee and Treasurer of Arts & Health South West, a registered and incorporated charity: a learning, advocacy, networking and development organisation promoting the value of arts and creativity for the benefit of health and wellbeing.
		• Founding Trustee, National Centre for Creative Health, expected to be established as a charitable incorporated organisation over the next few months.
		• Chair of Audit and Risk Committee, Health Data Research UK, an independent non-profit organisation supported by Government and charitable funding that brings together Universities, NHS organisations, industry partners, patient groups and research institutes across the UK to unite the UK's health data assets to make health data research and innovation happen at scale and to enable discoveries that improve people's lives.

Sarah Brampton	Director of Finance	• Governor at Exeter College and chair of their Audit Committee.
Lee Budge	Director of Corporate Business	• Trustee of Plymouth Access to Housing. • Member of a band which fundraises on behalf of St Luke's Hospice, Plymouth.
Lenny Byrne	Chief Nurse & Director of Clinical Professions	None.
Jacky Hayden	Non-Executive Director	• President of the Academy of Medical Educators. • Member of the Council of the Faculty of Medical Leadership and Management. • Member of the Medical Practitioner Tribunal Service Committee. • Professor of Postgraduate Medical Education University of Manchester. • Visiting Professor Lancaster University. • Associate, General Medical Council. • Suitable Person for the Medical Practitioner Tribunal Service.
Philip Hughes	Medical Director	None.
Ann James	Chief Executive	• Chair, South West Leadership Academy. • Chair, Southwest Talent Board. • Member, One Plymouth. • Chair, National Institute for Health Research Peninsula Partnership Group. • Member, Plymouth Growth Board. • Vice Chair, Board of Governors, Devonport High School for Girls.
Elizabeth Kay	Non-Executive Director	• Director and Trustee of Oral Health Foundation Charity (President Elect 2017). • Chair of management board of research funding committee of the British Dental Association. • Advisory Board BUPA Oasis Healthcare. • Chair of NICE Guideline Committee on Epilepsies • British Dental Association Health and Sciences Committee member. • Trustee and Vice Chair, British Medical and Dental Student Trust. • Director and Trustee of the College of General Dental Practice.
Hisham Khalil	Non-Executive Director	• Head of Peninsula Medical School, Faculty of Health: Medicine, Dentistry and Human Sciences, University of Plymouth. • Consultant Surgeon, University Hospitals Plymouth NHS Trust. • Consultant Surgeon, Nuffield Health Hospital, Plymouth. • Non-Executive Director, Royal Devon & Exeter NHS Foundation Trust. • Director, ENT Plymouth Ltd.
Steven Keith	Director of People	• Member of Plymouth Employment and Skills Board as a representative of the Health sector.
Graham Raikes	Non-Executive	• Chair of Governors, Plymouth Marjon University.

	Director	
Helen Teague	Non-Executive Director	• As a self-employed executive coach and OD specialist I am not currently working with the NHS although this could potentially change in the future. I mentor a member of staff in a charitable organisation closely associated with University Hospitals NHS Trust. • I am an associate consultant with the following consultancies: The Invisible Grail, which focuses predominantly on higher education sector work, and Skylite, an affiliate of Lee Hecht Harrison Penna, which works across all sectors, including the NHS nationally. I am not currently engaged in any work with the NHS locally or nationally but will declare this should the situation change.
Nick Thomas	Deputy Chief Executive, Director of Site Services & Planning	• Non-Executive Director, Plymouth Science Park Ltd. • Member of GS1 UK Healthcare Advisory Board.
Henry Warren	Associate Non-Executive Director	• Chairman and Director of Fluvial Innovations Ltd. • Chair of Peninsula Dentistry Social Enterprise.

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University Hospitals Plymouth NHS Trust

Minutes of the Trust Board meeting
9.00 am Friday 27 March 2020
Virtual Meeting

Present:
Richard Crompton, Chairman
Kevin Baber, Chief Operating Officer
Bill Boa, Associate Non-Executive Director
Sarah Brampton, Director of Finance
Phil Hughes, Medical Director
Elizabeth Kay, Non-Executive Director
Jacky Hayden, Non-Executive Director
Hisham Khalil, Non-Executive Director
Ann James, Chief Executive
Graham Raikes, Non-Executive Director
Helen Teague, Non-Executive Director
Henry Warren, Associate Non-Executive Director

In Attendance:
Jo Beer, Director of Integrated Care & Partnerships
David Brown, Director of Urgent and Emergency Care
Gill Hunt, Board Secretary
Steven Keith, Director of People
Nick Thomas, Deputy Chief Executive

Apologies:
Lenny Byrne, Chief Nurse and Director of Integrated Clinical Professions
Lee Budge, Director of Corporate Business

This meeting of the Board took place via Microsoft Teams, meetings in public having been suspended in accordance with public health advice on social distancing during the COVID-19 pandemic.

Action

31/20 Welcome and Chairman's opening remarks

The Chairman welcomed colleagues to this virtual meeting. He particularly welcomed Bill Boa, recently appointed to the Board as an Associate Non-Executive Director. Mr Boa's extensive NHS experience, and his NHS finance background, would be an asset to the Board. His induction would begin when more normal patterns of interaction were permitted after the current national emergency.

In acknowledging the circumstances in which this meeting would proceed, the Chairman asked colleagues to focus their challenge. It was vital that good governance and effective scrutiny continued. Colleagues were encouraged to test assumptions whilst also maintaining a deep appreciation of the circumstances under which the Executive team were currently working. The Board must also look to the future; it would

want to emerge from the current circumstances stronger and more effective. Colleagues would learn much about themselves during the coming weeks and months and they deserved the Board's support when making difficult decisions. The Board must never tire of saying thank you to colleagues who stepped forward to meet the monumental challenge that lay ahead. The Chairman stated that he struggled to describe his respect and admiration for what NHS staff, individually and collectively, were doing. The public's support shown on national television the previous evening demonstrated their love and respect which he hoped this display would sustain clinical colleagues. He had never felt more proud to be a Chairman of this Trust.

32/20 Declarations of interest, minutes of the previous meeting, matters arising and review of actions

The Chairman requested declarations of interest relevant to the matters listed on the agenda. No declarations were made.

The minutes of the previous meeting, held on 28 February 2020, were agreed as a true and accurate record. There were no matters arising.

Review of Actions
Actions 1824 and 1858 regarding fractured neck of femur
Dr Hughes and Mr Baber stated that the relevant data was not yet available.

Actions 1859 and 1860 52Week Waits
Mr Baber stated that a meeting was scheduled for 30 March 2020 to consider the Trust's harm review process. Data for orthopaedic patients was now to hand and Mr Baber would, as agreed, report it to the next Finance & Investment Committee meeting.

Outstanding actions would be reviewed outside the meeting to revise, if appropriate, timescales for completion. **GH**

33/20 Chief Executive's Report

Ms James' report included an update on the COVID-19 situation which reflected the position as of 19 March 2020. Much had now changed, locally and nationally. In terms of this Trust, the response of staff in respect to the ambitious plan to re-purpose the hospital to cope with COVID-19 patients had been incredible.

Chief Executive briefings to Non-Executive Directors had been established twice weekly. There were daily Executive briefings, with the Executive team now split into three to facilitate a seven day presence on site. Ms James assured the Board that staff were working incredibly hard to increase the intensive care support provision for

patients and efforts would be accelerated further over the coming weekend.

Efforts to continue to support staff were detailed for the Board. The Trust continued to prepare staff for what the nation was about to face and Ms James gave a summary of actions in hand to support staff communications and clarity of information. City stakeholders had been fantastic in their support; however, the Trust would be asking the public to cease donating perishable goods due to the logistical problems associated with distribution.

Current efforts were focused on three main issues:

- Conflicting guidance about Personal Protective Equipment, as reported in national media. Clarity of national guidance was expected imminently.

- Staff testing for COVID-19. There was not yet a national policy on staff testing, leaving individual organisations to make the most pragmatic arrangements based on kit availability. This position was become increasingly untenable. Again, national guidance was expected.

- Operational matters associated with mobilisation in response to COVID-19; standing down routine activity whilst still ensuring that patients were appropriately cared for and, where possible, continuing with business as usual.

Ms James wished to express her appreciation for the support of the Trust's military colleagues, who had been very generous with their support, advice and skills sharing.

The Board noted the Chief Executive's Report.

34/20 Financial Governance (including Scheme of Delegation)

For all NHS organisations, the governing body was accountable for its functions. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities despite the COVID-19 emergency. Guidance from NHS England confirmed that additional funding to cover extra costs associated with responding to the emergency would be made available. The guidance also confirmed that the maintenance of financial controls and stewardship of public money would remain critical during the NHS response to COVID-19.

The Healthcare Financial Management Association had recently issued a briefing on some of the early actions and decisions needed to enable the speeding up of financial transactions while maintaining appropriate

controls and governance during the COVID-19 pandemic, including guidance on Schemes of Delegation and Standing Financial Instructions.

An additional paper, not on the meeting agenda but circulated to the Board on 26 March 2020, set out proposed changes to the Trust's financial governance arrangements in response to the COVID-19 emergency. It detailed governance and practical arrangements for the management of COVID-19 related expenditure to ensure decisions to commit resources could be taken quickly and to ensure robust governance. The changes were in accordance with NHS England guidance. The Trust's existing Scheme of Delegation would continue to apply to all other expenditure.

The Board was asked to review the approach detailed and to approve the changes to the Scheme of Delegation in respect of expenditure controls for COVID-19 response.

Colleagues agreed that the paper was clear. No questions were raised.

The Board approved revisions to the Scheme of Delegation in respect of expenditure controls for COVID-19 response.

35/20 Board Assurance Framework (BAF) and Committee Chairs Reports

The Chairman invited Committee Chairs to brief the Board on key points of assurance arising from the February 2020 round of Committee meetings.

Safety & Quality Committee
Professor Hayden detailed the matters set out in her Chair's summary of the February meeting record at Agenda item C.

It had been the intention, post-February meeting, that Professor Hayden would meet with Mr Byrne and Mr Budge to review and, if necessary, re-cast, the Quality risks on the BAF but this yet to take place. Professor Hayden would discuss with Mr Byrne and Dr Hughes arrangements for the next scheduled Committee meeting in April.

Professor Khalil stated that due to the COVID-19 emergency, the move away from face to face outpatient appointments towards other forms of consultations presented a different aspect of risk; indeed, national bodies were aware of this change. This risk, Professor Khalil suggested, should be identified on the BAF. Dr Hughes agreed. The Trust would continue to ensure patients were risk assessed and appropriately managed. Professor Hayden welcomed this.

People & Culture Committee
Ms Teague stated that it was likely that the next meeting in April 2020

would be deferred and that the time would be used to continue to focus on the actions arising from the February meeting.

Ms Teague had not been present at the February meeting and invited Professor Kay, who had attended and chaired, to update the Board. Professor Kay referred colleagues to her Chair's summary of the February meeting record at agenda item B. There had been no changes to the BAF. In the post-COVID-19 environment, staffing, both at a strategic and operational level, would look very different. Mr Keith agreed; the NHS People Plan had been delayed for the foreseeable future. He then gave a brief update on how staffing within corporate functions was being deployed in the current emergency.

Finance & Investment Committee (FIC)
Mr Warren stated that FIC's most recent meeting, via a teleconference on 25 March 2020, had focused on the interim budget for 2020/21 and also on the longer term in preparing for the post-COVID-19 environment. The BAF risks had been covered but no changes had resulted. Mrs Brampton and Mr Raikes, fellow members of FIC, did not wish to add to Mr Warren's summary.

Audit Committee
Mr Raikes gave an updated in line with his Chair's summary in the meeting minutes at agenda item A. He drew the Board' attention to the narrative concerning two matters; additional payments and business continuity. The Audit Committee had been pleased to note that an assurance mapping exercise had been commenced by Mr Budge; completing this exercise and responding to the findings would be an important step forward in terms of improving Board assurance on a wide range of issues.

Mr Raikes would discuss with Mr Budge and Mrs Hunt changes to the internal audit plan, the accounts review timetable following the national changes to reporting and filings deadlines, and the arrangements for the April Audit Committee meeting, all with a view to ensuring statutory compliance.

The Chairman thanked Committee Chairs for their updates.

The Board made no changes to the Board Assurance Framework and no actions were identified to improve assurance.

The Board :

- **Agreed the actions to improve Board assurance to be taken forward by Mr Budge and the Committee Chairs as specified in Annex 1 to the BAF Report.**

- **Agreed that a COVID-19 related BAF would be commenced.** **LJB**

36/20 Care Quality Commission (CQC) Action Plan

Ms James presented this paper on behalf of Mr Byrne. Mr Byrne's report provided an update on the delivery of the 2019 CQC Action Plan. Progress against all 'must do' and 'should do' actions was detailed. Ms James stated that the Trust was discussing with the regulator how it should progress the Action Plan during the current situation. Whilst this was being agreed, work at Service Line and Care Group level continued to be documented for reference.

There were no questions on the report.

The Board noted the CQC Action Plan update.

37/20 Operational Performance update

The Integrated Performance Report for February 2020 was included with the meeting papers.

Mr Baber briefed the Board on the current position in the context of the Trust's response to COVID-19 operational pressures:

Responsive Care

- Ongoing arrangements to provide additional, COVID-19-safe capacity in the Emergency Department.

- ED attendances: now reduced to less than 200 per day over the last ten days. MIU attendances had also dropped.

- Bed occupancy: currently 54%, which would aid ward and patient relocations.

- All elective and non-planned surgery had ceased. Outpatient face to face appointments were switching to telephone.

- Early actions to allow time for staff training, particularly of anaesthetists and theatre staff, in relation to the current emergency had proved beneficial.

- A 27% reduction in GP referrals, including a 35% reduction in two week wait referrals where cancer was suspected. Commissioners had requested GPs to not routinely refer patients, so a further reduction was expected.

- 96 patients were currently waiting >52 weeks, 28 by choice. The forecast for year end was 133 patients.

- Cancer: an improving position in respect of >62 day waits. It was the Trust's intention to continue to operate on all patients whose surgery was urgently required.

- Diagnostic Imaging: the percentage of patients waiting >6 weeks was 8.5% against and an NHS Improvement trajectory of 6.4%. The current forecast for year end was 13.2%, 883 patients, although this could deteriorate further.

The Board agreed the overarching imperatives were to:

- Learn from enforced innovations.
- Work to prepare for the future.
- Maintain oversight of risk as a result of the operational changes made and to clearly document this.

Mr Boa asked whether there was concern that the reduction in two week wait referrals suggested that potential cancers were being missed. Mr Baber and Dr Hughes stated that there was no evidence yet that this might be the case. However, experience suggested that there would be a risk and this would be reviewed when normality resumed.

Mr Boa noted the issue of a mortality outlier alert, on 5 February 2020, for chronic obstructive pulmonary disease and bronchiectasis. Dr Hughes stated that this concerned c67 patients, many of whom would have presented with other medical problems. The case notes were being analysed using a structured judgement tool and the results would be reported to the Board.

Mr Warren referred to the three key improvement priorities set out on page 4 of the IPR. It was not clear to him how these were progressing and he had no assurance that the priorities were having the desired effect. The Chairman agreed; whilst he did not expect the Executive team to respond to this challenge immediately, the Board must return to this important issue.

Safe and Effective Care
Never Events
Dr Hughes stated that since the February 2020 Trust Board meeting, two Never Events had occurred, both in theatres. Details were set out on page 24 of the IPR. The patient had not suffered harm in either case and the incidents had been appropriately reported.

Mortality
Dr Hughes took the Board through the detail of the mortality data set out on pages 8 and 9 of the IPR. Whilst the detail reflected a broadly improving position, mortality was a complex issue and Ms James invited Board colleagues to consider what other sources of evidence there might be that would support the detail of the mortality reviews so that the Board might take comfort from the triangulation of assurance sources.

The Chairman stressed the importance of continuing to foster and to demonstrate a positive reporting culture, particularly in the context of the COVID-19 emergency. The Board would appreciate a short briefing from the Medical Director outside the meeting on actions and communications to support this. **PH**

Workforce
Mr Keith briefed the Board on the impact of the COVID-19 pandemic:

- Overseas staff recruitment had been interrupted.
- Routine staff recruitment continued via virtual interviews.
- Numbers of former clinical staff responding to the national retire/return appeal were positive.
- Support was being given to the Trust's Occupational Health provision in an attempt to shorten lead-in times.
- Additional physio support capacity was being provided to staff.
- Apprentices who would have been about to take up their positions were being given the opportunity to work for the Trust in different.
- A planned report to the Board on mandatory training had been deferred. The issue to which this report related was referred to in the People & Culture Committee minutes at agenda item B.

The Chairman sought assurance that appropriate support was being offered to overseas staff during the current period of international uncertainty. Mr Keith confirmed that it was.

Finance
Mrs Brampton stated that the February 2020 was set out in the IPR. Recent national guidance to NHS provider organisations was being worked through and she would provide further detail in the subsequent private meeting. The Trust continued with its recovery planning work

and it was likely that a Cost Improvement Plan of £20m would be achieved for 2019/20, a significant achievement given the difficult operational context. There were no questions for Mrs Brampton.

It was agreed that Mrs Brampton, Mr Boa and Mr Warren would discuss the Trust's capital position outside the meeting. **SB/BB/ HW**

This concluded the Board's review of the Integrated Performance Report.

38/20 Annual Safeguarding Report

Mr Byrne's report set out to provide assurance to the Board that processes were in place to adequately safeguard those people at risk of abuse, neglect or exploitation. However, in the absence of Mr Byrne, Executive Safeguarding Lead, and, due to the virtual nature of the meeting, the absence of the Trust's Safeguarding Lead, Alison O'Neil, there was no opportunity to raise questions on this report.

It was noted that:

1. The actions set out in this year's Annual Report and that for the previous year appeared similar.

2. The actions did not employ a 'SMART' format (i.e. specific, measurable, attainable, realistic and timely) to aid implementation, measure progress and inform challenge.

3. There was no evidence of the report's governance route to the Board.

It was agreed that:

- The Board would benefit from a quarterly progress report on Safeguarding, particularly on those areas where improvement was required, and a mechanism for this must be identified. **LB**

- The Trust must work with its partners on the profile of safeguarding across the city in the context of the current COVID-19 emergency. Ms James would pick this up urgently. **AJ**

Under the circumstances, the Board noted the report and invited its re-presentation when the three matters identified above had been resolved. **LB**

38/20 Gender Pay Gap 2019

Mr Keith's report set out the Trust's position on its Gender Pay Gap,

which had been due for national publication on 31 March 2020. However, due to the COVID-19 emergency, national publication had been suspended.

Analysis of data confirmed that the Trust's median gender pay gap had marginally worsened from 17.86% in 2018 to 18.25% in 2019. The deterioration resulted from medical staff bonus pay. In the period under review there were more male medical staff who were eligible to apply for Clinical Excellence Awards and the number of successful female applicants had decreased. The Trust's consultant workforce gender split was 72% male, 28% female; the national average gender split was 65% male, 35% female.

Mr Keith had been asked prior to the meeting whether the Trust conducted unconscious bias training. He stated that this was built into recruitment training and covered in the Manager's Passport training but it was not offered as a discrete session as the longevity of the impact was doubtful.

Disappointed that actions to close the gender pay gap had not been successful, Mr Warren stated that the Board should not accept the position and suggested a Board resolution to seek further action. The Chairman agreed. The Board would return to prioritising this issue when a return to normal business permitted.

39/20 Guardian of Safe Working Hours Report

The focus of the Guardian's report was junior doctor staffing in response to the COVID-19 emergency. It set out the position as of 19 March 2020 and was noted by the Board.

Mr Keith stated that he met regularly with the Guardian, Dr Steve Boumphrey, and it had been the intention of the People & Culture Committee at its April meeting to undertake an in-depth review of junior doctor staffing in the Medicine and Surgery Care Groups. Given the COVID-19 context, how this work would be undertaken was subject to review. Dr Hughes stated that Dr Pomphrey's report set out sound principles for future working and he appreciated the Guardian's work in this regard.

Ms James suggested a return to the provision of an Executive response to Guardian reports and the issues raised within. The Board agreed. **SK**

Professor Khalil stated that consideration would be given as to how junior doctor training would be delivered in the future and he referenced guidance from Health Education England and the General Medical Council.

40/20 Any Other Business

Freedom to Speak Up
The Board noted the importance of the Freedom to Speak Up Guardians' role during the current COVID-19 emergency. Mr Keith stated that the Guardians were receiving support in their role. As the current emergency negatively impacted on the ability of staff to raise concerns face to face, other avenues of contact were being promoted. There had also been some progress with strengthening the Guardian team. Mr Keith advised the Board that there were no particular themes of concern emerging currently.

Staff Sickness Absence
Mr Warren expressed his concern that recently joining staff may not have equitable access to sick pay. Mr Keith stated that many new staff would have accrued transferable benefits. Staff joining under TUPE arrangements would have access to Statutory Sick Pay; there were currently no concerns that any member of staff would not be covered. Ms James stated that the Trust was working on the general principle that it would not add to any financial hardship for staff arising from sickness absence.

Review and Learning
The Chairman would welcome colleagues' feedback on the new meeting arrangements outside the meeting.

41/10 Key Actions for Committees and Executives

Not discussed but as identified in these minutes.

42/20 Items for information

The Board received the following papers for information:

- Audit Committee draft minutes, February 2020.
- People & Culture Committee draft minutes, February 2020.
- Safety & Quality Committee draft minutes, February 2020.

No questions arose from these minutes.

There was no other business and the meeting closed at 11.55 am.

43/20 Date of next meeting

Friday 24 April 2020.

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Executive Actions Register (EAR)

16 April 2020

Ref.	Date	Source	Theme	Action	Lead	Date Due	✓	Status	Comments by action hold
1824	31-Jan-20	Trust Board (Public)	Integrated Performance Report	Under #NoF performance, including percentage of patients who were not fit for surgery within 36 hours of admission. (Minute 10/20, page 14)	*Phil Hughes*	13-Mar-20		Overdue	*At March 2020 Board PH advised data not yet available.*
1825	31-Jan-20	Trust Board (Public)	Control of Smoking	Review and amend Control of Smoking Policy in the light of proposed changes agreed at the January public Board and present to the Board for approval. (Minute 11/20 page 16)	*Nick Thomas*	31-Dec-20		Not Yet Due	
1826	31-Jan-20	Trust Board (Public)	Mortality Review/Learning from Deaths	Agreed as future subject for 'deep dive' at a future new-style public Board meeting. (Minute 12/10, page 17)	*Phil Hughes*	13-Mar-20	✓	Complete	*Included in March IPR. Entry made by GH.*
1855	28-Feb-20	Trust Board (public)	Learning from Maternity Services Annual Review and national reports,i.e. East Kent	S&QC Chair and Lenny Byrne to consider whether S&QC should pursue this and, if so, how.	*Jacky Hayden Lenny Byrne*	31-Mar-20		Overdue	
1856	28-Feb-20	Trust Board (public)	Learning from recent high profile national reports, i.e. Paterson Inquiry Report	Briefing on lessons/issues for Trust Boards to consider.	*Lee Budge*	15-Apr-20	✓	Complete	*Report produced and being presented to the Trust Board for consideration on 24th April 2020.*
1858	28-Feb-20	Trust Board (public)	Performance for #neck of femur	Assess Trust performance against relevant comparators (i.e. MTCs) and identify/extract learning. Report to March Board.	*Kevin Baber*	30-May-20		Not Yet Due	*Original deadline 31.03.20. At March public Board data not yet available and deadline extended. Entry made by GH.*
1860	28-Feb-20	Trust Board (public)	52WW	Identify and report reasons for every orthopaedic patient waiting >52 and report to Finance & Investment Committee.	*Kevin Baber*	17-Mar-20		Overdue	*March Board advised by KB that data available and to be presented to next FIC.*
1861	28-Feb-20	Trust Board (public)	Patient Story at January 20 Board	Consider inviting JT back to Board in, say, six months to demonstrate what the Board did in response to her story.	*Lenny Bryne*	01-Sep-20		Not Yet Due	
1878	27-Mar-20	Trust Board (public)	Action lists	Review and extend dates where appropriate in view of COVID-19 emergency.	*Gill Hunt*	31-Mar-20	✓	Complete	
1879	27-Mar-20	Trust Board (public)	BAF dedicated to COVID-19 risks	Establish a BAF related to the current emergency.	*Lee Budge*	15-Apr-20	✓	Complete	*Assurance Framework produced and being presented to the Trust Board for consideration on 24th April 2020.*
1880	27-Mar-20	Trust Board (public)	Maintaining a positive reporting culture during COVID-19 emergency	Prepare a short briefing note for the Board on actions and communications to support the continuation of a positive safety reporting culture.	*Phil Hughes*	15-Apr-20		Overdue	
1881	27-Mar-20	Trust Board (public)	2019/20 Capital position	Sarah Brampton, Bill Boa and Henry Warren to liaise outside Board to consider this.	*Sarah Brampton*	15-Apr-20		Overdue	

Ref.	Date	Source	Theme	Action	Lead	Date Due	✓	Status	Comments by action hold
1882	27-Mar-20	Trust Board (public)	Safeguarding	Re-present Annual Safeguarding Report with SMART objectives and detail the assurance route prior to Board review, then instigate quarterly reporting to the Board. Aim for June 2020 to re-present Annual Report and then quarterly reports thereafter.	*Lenny Byrne*	15-Jul-20		Not Yet Due	*Post meeitng Lenny Byrne advised May 2020. Entry made by GH.*
1883	27-Mar-20	Trust Board (public)	Safeguarding in COVID-19 context	Work with city partners - Ann to progress as part of emergency response	*Ann James*	15-Apr-20		Overdue	

SUMMARY REPORT

University Hospitals Plymouth NHS Trust

Trust Board (Public)

April 2020

Subject	**Maintaining cancer treatment during COVID-19 response**
Prepared by	Gill Nicholson, Cancer Services Strategy and Support Manager Lee Budge, Director of Corporate Business
Approved by	Kevin Baber, Chief Operating Officer
Presented by	Kevin Baber, Chief Operating Officer

Purpose

The purpose of this report is to provide the Board with information and assurance on how the Trust is meeting national guidance on maintaining cancer treatment during the response to COVID-19.

Decision	
Approval	
Information	●
Assurance	●

Corporate Objectives

Improve Quality	Develop our Workforce	Improve Financial Position	Create Sustainable Future
●			

Executive Summary

The NHS has issued national guidance that cancer treatment should continue to be prioritised during the response to COVID-19 pandemic. The Trust's assessment of its position against the requirements set out in this guidance is set out in this report.

The Trust is committed to continuing to provide urgent and essential cancer treatments and has a plan in place to achieve this. Notwithstanding this, we will continue to review the effectiveness of our arrangements and respond to any new guidance that may be published.

Quality Impact Assessment

There are significant quality implications associated with this report.

Financial Impact Assessment

There are no direct financial implications associated with this report.

Regulatory Impact Assessment

The report includes a number of references to regulatory requirements.

Equality and Diversity Impact Assessment

There are no direct equality and diversity issues associated with this report.

Environment & Sustainability Impact Assessment

There are no direct environmental or sustainability issues associated with this report.

Key Recommendations

The Board is invited to seek clarification on the arrangements established to maintain cancer treatment during the COVID-19 response and is asked to satisfy itself that the Trust is meeting national advice and guidance in this regard.

Next Steps

The Chief Operating Officer will continue to oversee compliance with national guidance in maintaining cancer treatment. Any issues or concerns will be escalated if required.

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DETAILED REPORT

University Hospitals Plymouth NHS Trust

Trust Board

April 2020

Subject	**Maintaining cancer treatment during COVID-19 response**
Prepared by	Gill Nicholson, Cancer Services Strategy and Support Manager Lee Budge, Director of Corporate Business
Approved by	Kevin Baber, Chief Operating Officer
Presented by	Kevin Baber, Chief Operating Officer

1. Background

1.1 The NHS has issued national guidance that cancer treatment should continue to be prioritised during the response to COVID-19 pandemic. A summary of the guidance received to date is set out below.

Date Issued	Summary of Guidance
23 Mar 2020	The NHSE issued national guidance to support clinicians on treatment decision-making and prioritisation, and to inform conversations with patients on treatment plans.
30 Mar 2020	National guidance recommended that urgent consideration should be given to consolidating cancer surgery in a COVID-free hub, with centralised triage to prioritise patients based on clinical need.
7 Apr 2020	NHS issued clinical guide for the management of essential cancer surgery for adults during the coronavirus pandemic.
8 Apr 2020	Draft documentation received from the cancer alliance in regards to the Peninsula Cancer Hub, with provider level expectation against the proposed model.

2. National requirements

2.1 The key requirements set out in the above guidance may be summarised as follows:

- Risk stratification and clinical prioritisation of patients against national guidance.
- Essential and urgent cancer treatments must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.
- Where referrals or treatment plans depart from normal practice, safety netting must be in place so that patients can be followed up.
- Consolidation of cancer surgery in a COVID free hub, with centralised triage to prioritise patients based on clinical need

2.2 The Trust's assessment of its position against each of these requirements is set out in the remainder of this report.

3. Risk stratification and clinical prioritisation

3.1 Service Lines management teams and Lead Cancer Clinicians have communicated their risk stratifications by specialty level and these have been compiled into templates in line with national guidance, utilising the national guidance of risk stratification criteria Annex A.

3.2 Service lines have been requested to code patients in line with risk stratification documents on IPM with see by date or planned review date in reflection of their priority level 1-6. This information will be collated within a high level report detailing speciality, and the number of patients under each priority level.

3.3 As patients are diagnosed with new cancer they are discussed at the cancer MDT's against MDT standards of care, and risk stratification guidelines. These meetings are supported by reduced attendance in the MDT rooms and virtual conferencing to allow clinicians and our regional partner to link via the trust network and a secure link.

4. Continuation of essential and urgent cancer treatments

4.1 There is a plan to continue to provide urgent and essential cancer treatments. As at 9th April 2020, the Trust had provided 86% of surgical cancer activity.

4.2 There has been a reduction in overall cancer activity. On 9th April 2020, 2 week wait attendances were down 53%, surgery was down by 14% and chemotherapy was down by 33%. However, as part of the risk stratification process, patients have been reviewed and outcomes are recorded on the Patient Treatment List (PTL).

4.3 Patients are informed via telephone appointments and information is followed up with a letter to the GP and patient. The cancer administration team are recording the outcome of patients on hold by using prefixes to identify the different categories. These are detailed in Annex B and summarised in the table below.

Prefix Code	**Description**	**No. at 9th April 2020**
COVID HOLD SH	On hold due to shielding	31
COVID ISO	On hold due to self-isolation	36
COVID SERV	On hold as service stood down	154
Active	Remains on active pathway	913
-	TOTAL	1,134

4.4 The Board may wish to note that a process for monitoring any harm for each of the above patient groups is in the process of being compiled. This will be completed by 22nd April 2020.

5. Establishing safety netting for patient follow-up

5.1 Where treatment plans are departing from normal practice in line with risk stratifications an AHP contact is being created on SCR. This will allow us to understand in more detail the number of patients with a treatment planned change, and implement a harm review process as we move forward in the coming months more work to be undertaken in this area.

6. Consolidation of cancer surgery in a COVID-free hub

Overall arrangements

6.1 The Trust has ring fenced 'clean' theatre facilities for a proportion of cancer surgery, which will provide surgery for Cancer and Urgent procedures. Independent facilities are being utilised for orthopaedic and plastic trauma, breast cancer, urology cancer and urgent time critical procedures.

6.2 The decision not to provide a cancer specific site is based on the following:

- Various specialities are undertaken within the Trust. If we pooled our Surgeons, Anaesthetists and Theatre Team into cancer and non-cancer surgical sites we would not be able to effectively and safely run the emergency provision where priority level 1a/b surgical procedures are normally performed via a 24hour service.

- The level of post op provision and speciality knowledge undertaken within the different theatres cannot be replicated at an independent site within Plymouth.

6.3 The Surgery Care Group has supported this model by adopting the following approach:

- All patients are tested 24 hours prior to surgery utilising the surgery swab pod. Patients who test positive are cancelled and rearranged by clinical teams when the patient is fit for surgery, supporting clean facilities to be maintained. This is being extended to 48 hours for HPB major cancer cases, at the request of the Service Line Director, as should a patient be positive there is sufficient time to replace this patient with another all day long operating case.

- Maximisation of assets continues within the active theatre capacity and will be monitored by the surgical care by ensuring that productivity is at the required level. This is also monitored through the Corporate Recovery Unit. The Surgical Care Group is currently increasing theatre capacity from an average of 12 lists per day to 15+. The priority of the increased capacity will be linked to surgical waiting lists.

- Staffing for clean facilities supporting a designated pool of anaesthetic and surgical team, at a trust level is felt to be detrimental. Consultants have been pooled to cover a consultant led anaesthetic service, supporting our Intensive Care capacity, as well as elective operating lists at UHP. To split the team into cancer and urgent teams would not support the surgical current plan, reducing the number of consultant available to cover elective theatre lists, as on call is the priority for cover.

- PPE applied in line with COVID-19 infection control guidelines: Amber PPE for negative patients and Red for positive patients, AGP procedures and during intubation and extubation of positive or unknown patients. The lead for COVID-19 within the anaesthetic team is Dr Tom Lawson, Consultant Anaesthetist.

Cancer Surgery Prioritisation Team

6.4 In addition, a Cancer Prioritisation Team (CSPT) 2020 has been established comprising of Kevin Baber (Chief Operating Officer) Amy Roy (Director of Cancer Services), Grant Sanders (Surgery Care Group Director), Jemma Edge (Surgery Care Group Manager), Sian Dennison (Lead Cancer Specialist Nurse) and (Gill Nicholson Cancer Strategy & Performance Manager).

6.5 The expectation is that the team will prioritise patients for surgery on the basis of clinical need, and the level of risk to both patient and service related. Linking in with appropriate surgical specialisms and capacity within provider. The team will be responsible for completing risk assessment for patients who do not proceed to operation or whose surgery is rescheduled.

6.6 The CSP team will meet weekly and will be responsible for discussing potential cases that would require referral to the UHP for surgery who require critical care support. The most common surgery's that require critical care support are: Brain, Pancreatic, Lung, and UPGI which is currently only provided by the Trust.

Contributing to the Alliance Surgery Hub

6.7 We are supporting providers in the Alliance with mutual support, either by providing clinicians to work at other sites, or taking referrals of patients. We are contributing clinicians to the Hub to provide clinical prioritisation with references to the information from the referring MDT.

Surgery requiring critical care

6.8 A request has been made for the Trust to continue to provide surgery with critical care support on behalf of the peninsula. An informal agreement has been made with the Cancer Alliance to support this on a case by case basis.

6.9 The Trust currently has 16 bed spaces in Torrington which is a Green Zone for cardiac, neurosurgery and general admissions, there are plans in place to extend this capacity to 20 beds. We will also monitor the wider critical care capacity and expansion plans in conjunction with the pandemic.

Risk Stratification Criteria Annex A

Surgical patients

Categorisation of patients

Priority level 1a
Emergency-operation needed within 24 hours to save life

Priority level 1b
Urgent - operation needed with 72 hours
Based on Urgent / emergency surgery for life threatening conditions such as obstruction, bleeding and regional and / or localised infection permanent injury / clinical harm from progression of conditions such as spinal cord compression

Priority level 2
Elective surgery with the expectation of cure, prioritised according to:
within 4 weeks to save life/progression of disease beyond operability based on

- urgency of symptoms
- complications such as local compressive symptoms
- biological priority (expected growth rate) of individual cancers

Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology

Priority level 3
Elective surgery can be delayed for10-12 weeks will have no predicted negative outcome

Categorisation of patients

This will differ according to tumour type, but it is suggested that clinicians begin to categorise patients into priority groups 1-6. If services are disrupted, patients can be prioritised for treatment accordingly.

Priority level 1

- Curative therapy with a high (>50%) chance of success.

- Adjuvant (or neo) therapy which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Priority level 2

- Curative therapy with an intermediate (20- 50%) chance of success.

- Adjuvant (or neo) therapy which adds 20 – 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Priority level 3

- Curative therapy of a low chance (10 – 20%) of success

- Adjuvant (or neo) therapy which adds 10 – 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse

- Non-curative therapy with a high (>50%) chance of >1 year of life extension.

Priority level 4

- Curative therapy with a very low (0-10%) chance of success.

- Adjuvant (or neo) therapy which adds a less than 10 chance of cure to surgery or radiotherapy alone or treatment given at relapse

- Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension.

Priority level 5

- Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year life extension.

Priority level 6

- Non-curative therapy with an intermediate (15-50%) chance of palliation or temporary tumour control and < 1 year life extension.

Cancer site analysis

Annex B

Cancer Site	Referral Type	HOLD SH	ISO	SERV	Active	Total
Brain	2WW				5	5
	31 Day Only				3	3
	31 Day No DTTD				19	19
	Total				**27**	**27**
Breast	2WW				50	50
	Screening				12	12
	Symptomatic				1	1
	31 Day Only				1	1
	31 Day No DTTD				2	2
	Total				**66**	**66**
Colorectal	2WW	5	5	75	107	192
	Tertiary 2WW				3	3
	Consultant Upgrade			2		2
	Screening	1			7	24
	31 Day Only				2	2
	31 Day No DTTD		2	3	11	16
	Total	**6**	**7**	**80**	**130**	**239**
Gynaecology	2WW	3			58	61
	31 Day No DTTD				14	14
	31 Day Only				2	2
	Consultant Upgrade				6	6
	Total	**3**			**80**	**83**
Haematology	2WW				17	17
	Consultant Upgrade				1	1
	31 Day Only				1	1
	31 Day No DTTD				26	26
	Total				**45**	**45**
Head & Neck	2WW	1	4	8	46	59
	Consultant Upgrade		1		2	3
	31 Day Only			2	3	5
	31 Day No DTTD			5	7	12
	Total	**1**	**5**	**15**	**58**	**79**
Lung	2WW	2			44	46
	Tertiary 2WW				1	1
	Consultant Upgrade	1			11	12
	31 Day Only				3	3
	31 Day No DTTD				20	20
	Total	**3**			**79**	**82**
Paediatric	2WW				1	1
	31 Day No DTTD				1	1
	Total				**2**	**2**
Sarcoma	2WW	2			3	5
	31 Day Only	1	1			2

Cancer Site	Referral Type	HOLD SH	ISO	SERV	Active	Total
	31 Day No DTTD	1	1		12	14
	Total	**4**	**2**		**15**	**21**
Skin	2WW	1	3		138	142
	Consultant Upgrade		1		1	2
	31 Day Only				5	5
	31 Day No DTTD				13	13
	Total	**1**	**4**		**157**	**162**
Upper GI	2WW	6	6	31	44	87
	Tertiary 2WW				4	4
	Consultant Upgrade	2	1	2	5	10
	31 Day Only				4	4
	31 Day No DTTD		2		34	36
	Total	**8**	**9**	**33**	**91**	**141**
Urology	2WW	4	7	24	107	142
	Consultant Upgrade		1	2	15	18
	31 Day Only	1			2	3
	31 Day No DTTD		1		39	40
	Total	**5**	**9**	**26**	**163**	**203**
TOTAL		**31**	**36**	**154**	**913**	**1134**

SUMMARY REPORT

University Hospitals Plymouth NHS Trust

Trust Board

April 2020

Subject	**Learning from the Paterson Inquiry and other national reports**
Prepared by	Lee Budge, Director of Corporate Business
Approved by	Lee Budge, Director of Corporate Business
Presented by	Lee Budge, Director of Corporate Business

Purpose

The purpose of this report is to provide the Board with a briefing on the key issues arising from the recently issued Paterson Inquiry Report together with an opportunity to agree how we will oversee our response to this, and other significant national reports.

Decision	
Approval	●
Information	
Assurance	

Corporate Objectives

Improve Quality	Develop our Workforce	Improve Financial Position	Create Sustainable Future
●	●	●	●

Executive Summary

Background

In February 2020, the Trust Board noted that there was learning for all boards arising from the recently issued Paterson Inquiry Report and it was agreed that the Board would be presented with a briefing on relevant issues arising from this and other high profile national reports.

Paterson Inquiry Report

In April 2017, Ian Paterson, a surgeon in the West Midlands, was convicted of wounding with intent, and imprisoned. He had harmed patients in his care. The scale of his malpractice shocked the country. There was outrage too that the healthcare system had not prevented this and kept patients safe. At the time of his trial, Paterson was described as having breached his patients' trust and abused his power.

In December 2017, the Government commissioned an independent Inquiry to investigate Paterson's malpractice and to make recommendations to improve patient safety. This report was published in February 2020. The comprehensive 238-page report presents the Inquiry's methodology, findings and recommendations. It highlights the following key points of learning:

- The boards of Heart of England NHS Foundation Trust (HEFT) and Spire Healthcare were remote from front-line healthcare professionals and patients when Paterson was practising, and for some years afterwards whilst clinical leadership at board level is lacking in listed companies operating in the independent sector.
- Paterson could have been stopped from practising in 2003, and should have been stopped in 2007 rather than 2011.
- There is inequity in the treatment of patients at Spire Parkway and surviving mastectomy patients treated at HEFT. Patients treated at HEFT have had a review of their case, had this communicated to them and have been provided with ongoing care, if necessary. This has not been the case for patients treated at Spire Parkway.
- Paterson exploited patients' fear of waiting for treatment and their fear of having cancer. There was little information available to patients to help them understand the reality of how long they would need to wait for NHS treatment.
- Paterson behaved in ways that were not acceptable or were inappropriate. This behaviour appears to have been tolerated and not challenged by those who should have done so.

- There was a lack of curiosity about Paterson from his colleagues and those in charge of HEFT and Spire for a sustained period of time. This had devastating consequences for patients.

The report notes that there were many regulations and much guidance in place during Paterson's years of practice and that it is significant that a lot of these were disregarded or ignored by Paterson and others. It concludes that is no single legislative or regulatory fix which would ensure safety for all patients in the future but makes a series of recommendations for improving patient safety. The report's overall conclusions and recommendations are set out at Annex A.

Many of these recommendations require a national response and the Government is expected to do this in the next three to four months. Notwithstanding this, there is an opportunity for the Board to give early consideration to the key issues before a further report is presented to the Board once the Government's response has been published.

Our approach to reviewing national reports

Major national reports are currently reported to the Board through the Chief Executive's report. Going forwards, significant reports such as the Paterson Inquiry will continue to be reported in this way but with the following more standardised approach to oversight:

- Risks associated with our response to issues emerging from significant national reports will be recorded on the Board Assurance Framework.
- The Board will consider whether to oversee the Trust's response directly or commission the relevant Committee to do this on its behalf.
- The Board will agree to the removal of the risk from the BAF once it is satisfied that it has received sufficient assurance that all key issues have been adequately addressed.

Quality Impact Assessment

There are a number of potentially significant quality implications associated with this report.

Financial Impact Assessment

There are no direct financial implications associated with this report.

Regulatory Impact Assessment

There are no direct regulatory implications associated with this report although demonstrating a clear response to national reviews may help in evidencing our approach to being well-led.

Equality and Diversity Impact Assessment

There are no direct equality and diversity issues associated with this report.

Environment & Sustainability Impact Assessment

There are no direct environmental or sustainability issues associated with this report.

Key Recommendations

The Board is asked to:

- Note the key learning and recommendations from the Paterson Inquiry Report.
- Note that a further report will be presented to the Board once the Government's response has been published.
- Support the approach for overseeing any future significant national reports.

Next Steps

The issues highlighted in the report will be taken forward as appropriate by the Chief Executive, Executive Directors and the Trust Management Executive (TME).

Paterson Inquiry Report Annex A

Summary and recommendations

Information to patients

We heard from patients that much of the information they received about Paterson was unreliable, and the result of hearsay and an inflated local reputation. Patients had no means of independently testing or verifying the information they received. We heard that patients would welcome a single source of information relating to each consultant's practice. This was endorsed by a significant number of witnesses, including those who had a managerial or clinical responsibility for consultants.

We recommend that there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector.

Patients told us that Paterson had given information about them in the letters he sent to GPs which was different from what he had said at their consultation, but they had not seen these letters at the time. Such letters are routinely sent to GPs after consultation or treatment but are not always written in a way which is easy to understand.

We recommend that it should be standard practice that consultants in both the NHS and the independent sector should write to patients, outlining their condition and treatment, in simple language, and copy this letter to the patient's GP, rather than writing to the GP and sending a copy to the patient.

There are differences in how the NHS and the independent sector are organised. In the independent sector, consultants are not usually employed by the private hospitals, and have to make their own arrangements for clinical indemnity. In addition, most private hospitals do not have intensive care units on site. Patients who require intensive care, or have need for emergency treatment, are usually transferred to an NHS hospital. These differences were not apparent to patients who spoke to the Inquiry at the time they chose to be treated privately by Paterson.

We recommend that the differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised, is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care.

Consent

We heard that patients often felt under pressure to decide to go ahead with surgery. Their options for treatment, including the risks associated with any procedure, were not explained clearly to them before they gave consent for surgery. This was out of line with existing guidance, which sets out that patient consent must be voluntary, informed, and that the patient must have the mental capacity to understand what they are consenting to. Even in the case of patients who need surgery quickly, the Inquiry's clinical panel advised us that patients need a short period of time to reflect on their diagnosis and treatment options to ensure they are giving informed consent for their treatment. We understand that the GMC is also considering this issue.

We recommend that there should be a short period introduced into the process of patients giving consent for surgical procedures, to allow them time to reflect on their diagnosis and treatment options. We recommend that the GMC monitors this as part of 'Good Medical Practice'.

Multidisciplinary team (MDT)

Every patient with breast cancer should have their case discussed at an MDT meeting, in line with up-to-date national guidance. CQC considers this as part of the "safe" and "effective" domains of its inspection framework for independent hospitals providing acute service. We heard that while Paterson was practising at Spire, decisions about patients' treatment were not discussed at properly constituted MDT meetings. Independent sector providers have told us of changes they have made to improve compliance with guidance in this area. We also heard that patients who are treated in the independent sector may have their treatment discussed at MDT meetings in the NHS, but that the quality of those discussions varied.

We recommend that CQC, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance in this area.

Complaints

Patients we saw who were treated in the NHS were not satisfied with HEFT's response to their complaints, and did not appear to know about the role of the Parliamentary and Health Service Ombudsman (PHSO). Private patients treated in the independent sector have no recourse to the PHSO and are directed to the Independent Sector Complaints Adjudication Service (ISCAS), if their hospital subscribes to the service. Private patients did not appear to know of this option. If the hospital does not subscribe to ISCAS, the patient will not have access to independent investigation or adjudication of their complaint.

We recommend that information about the means to escalate a complaint to an independent body is communicated more effectively in both the NHS and independent sector. We recommend that all private patients should have the right to mandatory independent resolution of their complaint.

Patient recall and ongoing care

We recognise that when Paterson was operating, Solihull Hospital was run by Heart of England NHS Foundation Trust (HEFT). However, the following recommendation is about the current and ongoing care of patients treated by Paterson, so it is addressed to University Hospitals Birmingham NHS Foundation Trust and Spire (UHB). Although there have been assurances from both the Trust and Spire that they have recalled all patients who needed to be, we heard from almost a third of patients who gave evidence to the Inquiry that they have never received communication about recall or attended an appointment. We heard from relatives of deceased patients who had not been given information about the appropriateness of their care.
We note that the Trust reviewed, in 2015, all surviving patients of Paterson who had a mastectomy at HEFT. The aim of the Trust's review was to provide advice for each individual patient on the adequacy of their care, and to recommend appropriate follow-up. Patients who had a mastectomy at HEFT have a care plan, where necessary, funded by the NHS. To date, we heard from patients that there has not been an ongoing treatment plan appropriate to their health needs at Spire, although Spire do not accept this.

We recommend that the University Hospitals Birmingham NHS Foundation Trust board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen.

We recommend that Spire should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen, and that they should check that they have been given an ongoing treatment plan in the same way that has been provided for patients in the NHS.

Improving recall procedures

We heard from patients recalled by both HEFT and Spire that their experience of recall was generally inadequate, not patient-focused, and lacked transparency. Patients were often treated as a problem to be solved during the recalls. We also heard that there were no national guidelines to follow at the time, and we understand that this is still the case today.

We recommend that a national framework or protocol, with guidance, is developed about how recall of patients should be managed and communicated. This framework or protocol should specify that the process is centred around the patient's needs, provide advice on how recall decisions are made, and advise what resource is required and how this might be provided. This should apply to both the independent sector and the NHS.

Clinical indemnity

Medical defence organisations cover the costs of claims and damages awarded to patients. However, they are not subject to financial conduct regulation, and the indemnity cover they provide is discretionary. The Medical Defence Union used its discretion to withdraw cover since Paterson's activity was criminal. This left patients without cover. In the event of the medical defence organisation and the hospital failing to provide cover, some witnesses thought there was a need to provide an industry-wide "safety net" so that patients are not left uncompensated. Other witnesses noted that the current system of indemnity cover for consultants working in the independent sector is unregulated, and told us that it should be regulated.

We recommend that the Government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals, in light of the serious shortcomings identified by the Inquiry, and introduce a nationwide safety net to ensure patients are not disadvantaged.

Regulatory system

In 2018/19, the Care Quality Commission, the General Medical Council and the Nursing and Midwifery Council, had a total annual budget of over £435m per year, and between them employed over 5,200 people. In addition to this, the Professional Standards Authority for Health and Social Care employed a further 40 people with an annual budget of £4m, raised by fees paid by the regulatory bodies it oversees. Despite the scale of the regulatory system, it does not come together effectively to keep patients safe. We also heard that it is not accessible or understood by patients. We do not believe that the creation of additional regulatory bodies is the answer to this.

We recommend that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.

Investigating healthcare professionals' practice and behaviour

We heard from senior managers and healthcare professionals in both the NHS and the independent sector that Paterson could and should have been suspended by HEFT earlier than he was, given that concerns first began to be raised in the early 2000s. HEFT used the HR process to investigate him, even though the concerns relating to Paterson from 2003 related to his clinical practice. Goldman told us that he was following legal advice and existing guidance in investigating the concerns, using an HR process. We also heard that some of the healthcare professionals who had raised concerns at HEFT in 2007, and who worked alongside Paterson at Spire, did not tell Spire about the concerns until Paterson was suspended in 2011. Goldman told us that he felt he acted appropriately in response to the concerns raised.

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

Corporate accountability

We heard that many patients treated at HEFT, and many treated at Spire, did not feel that the hospitals took responsibility for what had happened. In the NHS, consultants are employees and the NHS hospital is responsible for their management, and accepts liability when things go wrong. The situation is very different in the independent sector where most consultants are self-employed. Their engagement through practising privileges is an arrangement recognised by CQC. However, this recognition does not appear to have resolved questions of hospitals' or providers' legal liability for the actions of consultants.

We recommend that the Government addresses, as a matter of urgency, this gap in responsibility and liability.

We also heard that patients felt that they did not receive any meaningful apology from the hospitals. We understand that apologising was conflated with admitting legal liability. Despite the historical guidance on being open and saying sorry and, more recently, the statutory Duty of Candour, we were provided with no evidence to show how boards accept and implement accountability for apologising.

We recommend that when things go wrong, boards should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences in relation to their liability.

Adoption of the Inquiry's recommendations in the independent sector

We heard from witnesses that, while the independent sector shares a regulatory system with the NHS, it has a different governance model. Therefore, it is not possible for the Government to require the independent sector to implement all the recommendations it accepts. Where good practice is implemented in the NHS, it is often voluntary in the independent sector. Where the independent sector does adopt best practice, it is often slow and decisions to adopt such practice focus on innovation and flexibility, rather than keeping patients safe.

We recommend that, if the Government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (i.e. private, insured and NHS-funded) if independent sector providers are to be able to qualify for NHS contracted work.

SUMMARY REPORT

NHS University Hospitals Plymouth NHS Trust

24th April 2020

Trust Board

Subject	**Education and Training Report**
Prepared by	Assistant Director of People and Professional Education leads
Approved by	Director of People
Presented by	Director of People

Purpose

The purpose of this report is to provide the Trust Board with an overview of training and education activity in the organisation to ensure the Board has an understanding of the agenda and sight of the key risks.

Decision	●
Approval	●
Information	●
Assurance	●

Corporate Objectives

Improve Quality	Develop our Workforce	Improve Financial Position	Create Sustainable Future
●	●	●	●

Executive Summary

This paper draws together key areas of focus for the Trust Board in relation to multi professional education and training in the organisation, identifying potential risks and opportunities.

Headline messages:

- Urgent delivery has taken place to respond to the training needs in relation to Covid-19;
- Apprenticeship Employer Provider status is currently in a notice period of 12 months due to a failure to be accepted on the register of apprentices (RoATP) – paper contains understanding of the issues and plan to mitigate;
- Apprenticeship levy activity for UHP is rated good; 71% usage versus 31% for the Devon system as a whole;
- Mandatory training compliance remains a concern as noted by the CQC and the paper proposes both actions to address compliance and propose changes to approach to enhance streamlining between organisations;
- Considerable risks remain around space and facilities, training capacity, mentoring support in the learning environment and the funding required for training posts;
- The Learning and Education Strategy is being refreshed and the paper contains a brief update on work to date.

Quality Impact Assessment

The quality of training provision has a direct impact on the quality of patient care.

Financial Impact Assessment

The education and training agenda requires investment but also has the potential to be an area for efficiency and income generation.

Regulatory Impact Assessment

All training, education and learner placements must meet the relevant standards required of the following professional bodies - NMC, HCPC, and GMC and regulatory bodies such as Ofsted and Health Education England.

Equality and Diversity Impact Assessment

Fair access to education and development is a key enabler of the Trust's approach to equality and diversity.

Environment & Sustainability Impact Assessment

None

Key Recommendations

The Trust Board are asked to:

- Note the current position of education and training
- Note the risks raised in relation to training and education around facilities and capacity.
- Support the recommendation that UHP changes its compliance target to 90% for Mandatory training.
- Support the recommendation that UHP changes its compliance target to 90% for Appraisals.
- Support the move to the more comprehensive streamlining approaches set out in 7.3.2

Next Steps

- Implement the change to the compliance targets (if agreed)
- Develop a plan for implementing enhanced streamlining processes

DETAILED REPORT

University Hospitals Plymouth NHS Trust

Trust Board 24th April 2020

Subject	**Education and Training Report**
Prepared by	Assistant Director of People and Professional Training Leads
Approved by	Director of People
Presented by	Director of People

1. Purpose

1.1. The purpose of this report is to provide the Trust Board with insight into the current position of education and training in the organisation, future plans and to raise any associated risks.

2. Background

2.1. The NHS Interim People Plan sets out the vision for people who work in the NHS to help them deliver the 10 Year Plan. The Interim plan places importance on training and education as a key deliverable stating:

"*Our people will need the skills, education and training to realise the potential of these exciting new roles; to extend their practice in current roles; and to work in multidisciplinary teams that facilitate more integrated, person-centred care".*

2.2. In November 2018, the Trust Board agreed a Learning and Development Framework which set out the key areas of focus for UHP in relation to Training and Education. This framework is being reviewed in relation to the Interim People Plan and will inform the revised People Strategy. A first working draft will be brought to the People and Culture Committee in April 2020.

2.3. This paper will set out the key issues and risks for the Board's information and requires a decision in relation to the proposals around Mandatory training and appraisal.

3. Current position

3.1. **Covid-19**

There are a number of serious implications for training in relation to Covid-19. A full plan is being developed and in action by Education leads to respond to the developing circumstances. The principles are:

- Providing remote / lowest contact possible training solutions for essential training / induction only;
- Plans for returning retired staff training;
- Plans for ways to train staff who move to support other areas and have a skills gap;
- Mobilising clinical educators and other training staff to support.
- Up to 100 third year students will be working as paid Band 4 volunteers starting from Monday 20th April to support our ward workforce during Covid-19. Many of these will move seamlessly into their qualified posts on qualifying at the end of July.

3.2. The National Staff survey for 2019 gives the view of over 4000 staff in relation to Training learning and Education. Nationally questions relating to training have been removed from the survey, but UHP have kept them as local questions. The data for 2019 shows improvements across all the questions relating to training have improved:

Questions	2019	2018
My training, learning or development has helped me to do my job more effectively (Strongly Agree, Agree)	71.9%	69.9%
My training, learning or development has helped me to stay up-to-date with professional requirements (Strongly Agree, Agree)	72.8%	71.7%
My training, learning or development has helped me to deliver a better patient/service user experience (Strongly Agree, Agree)	70.2%	69.0%
Opportunities in my team are fair and equitable when applying for... - ...training/development (Strongly Agree, Agree)	66.0%	65.1%

3.3. Relationships with HEI and FE partners continue to develop, particularly in relation to City College Plymouth and work is increasing with focus on the educational pathways to clinical roles.

3.4. In order to meet the aspirations of the National Interim People Plan, it is necessary to continue to focus on creating a supportive learning environment that supports the conditions for growth and development at all levels.

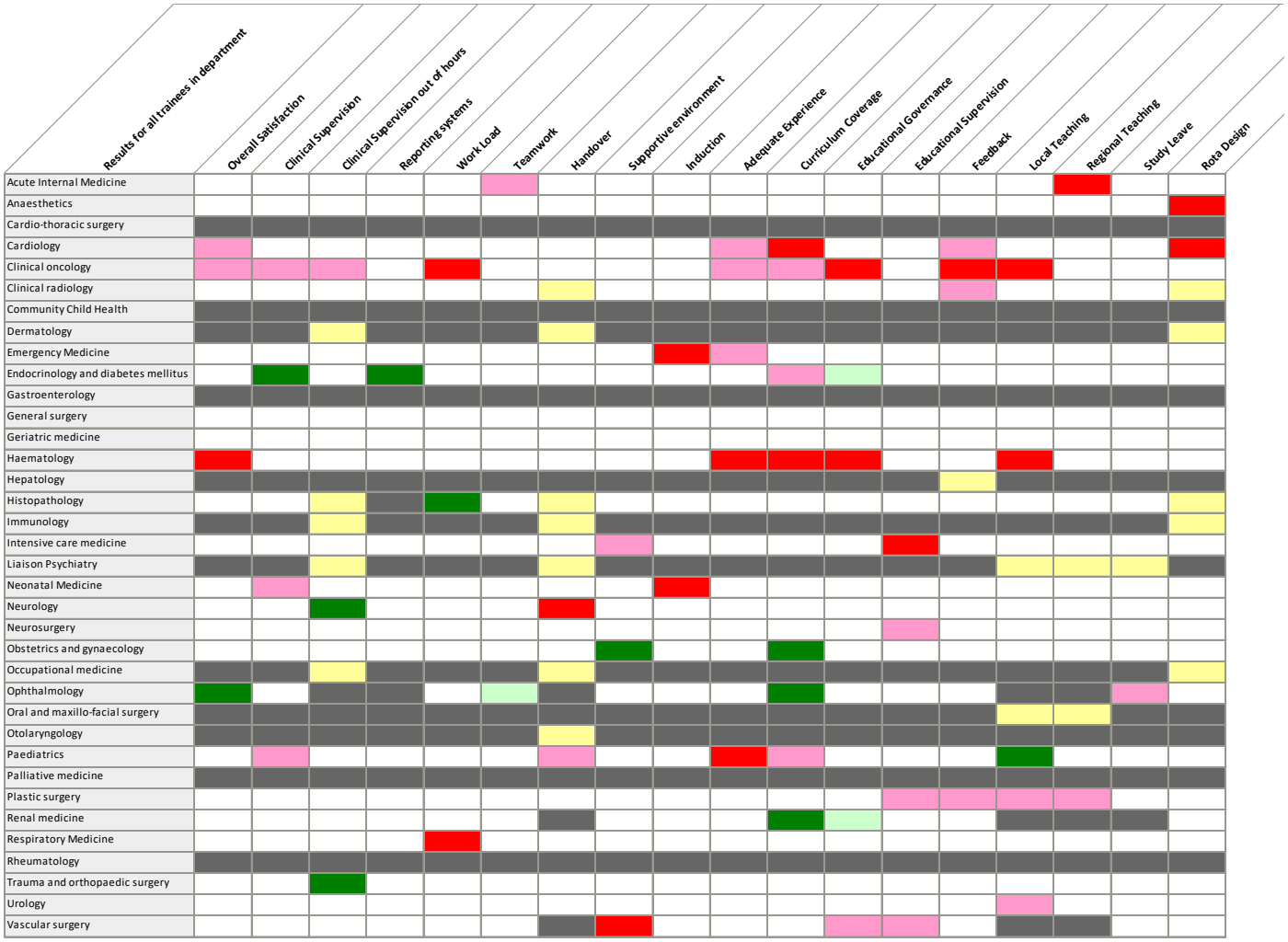
3.5. There remain significant challenges in relation to clarity of funding streams for education and the physical facilities.

4. Medical Education

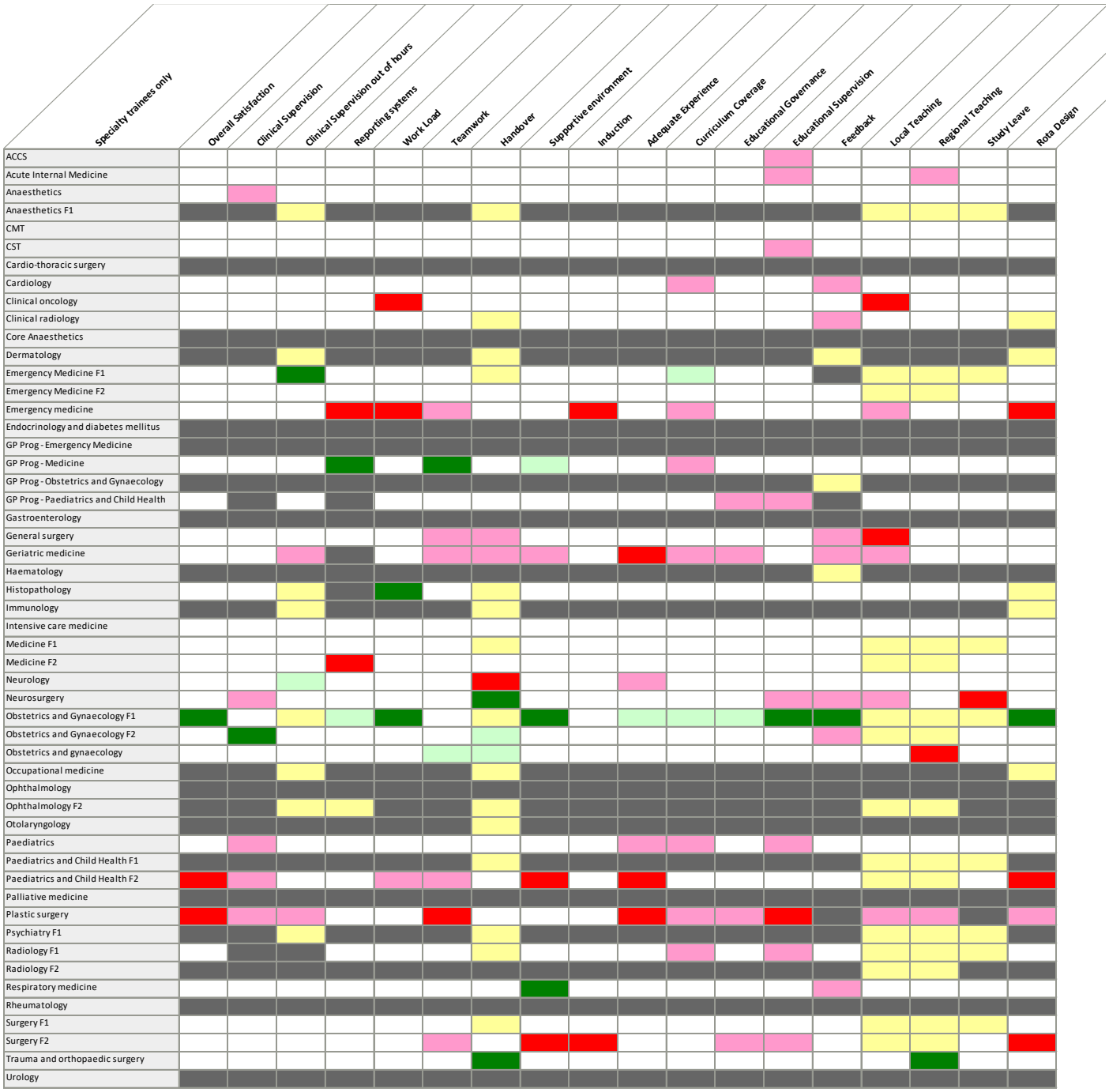
4.1. In relation to medical staff, the 2019 GMC survey update was presented as part of the last Board update in July 2019. The following gives some frames of reference from the GMC National Training Survey 2019 for the departmental updates previously presented, plus assessments of progress.

4.2. Green and pale green results are in the top 25% of scores nationally, with green being significantly so.
White is in the inter-quartile range.
Red and pink are in the bottom 25%, with red being significantly so.
Grey and yellow are less than 3 responses from individual trainees, so no result shown.

4.3. The following table shows the results for all trainees (from F1 to senior specialist registrar) in each department.



4.4. The following table shows the results for specialty trainees only (other than where specified). It is a subset of the previous table, excluding Foundation and Core trainees except where stated.



4.5. The GMC Survey highlighted some Service Lines where there was excellent delivery of postgraduate medical training and others where there was clear room for improvement. The following summarises the actions that have been put in place since the 2019 survey:

Healthcare of the Elderly:

- There were major gaps in outpatient opportunities for trainees, but subsequent to recruitment of senior staff the trainees now have access to a variety of outpatient clinics including: general; falls and syncope; tilts; community; Parkinson's; TIA; frailty; bone health.

Haematology:

- At the time leading up to the GMC survey there were significant workforce challenges with several trainees either less than full time or on maternity leave; the consultants were doing a lot of acting down to cover the service. This period has now passed, resulting in far more time for supervision and training than at the time of the survey.

Intensive Care Unit:

- The department has updated and improved its Induction and also its arrangements for trainee supervision.

Oncology:

- The Acute Oncology Service consultant now attends the board round every day.
- One of the ward junior doctors attends the AOS ward round.
- The cross-cover arrangements for when consultants are on leave has been clarified and formalised.

Paediatrics:

- Increased consultant presence on our children's assessment unit until 9:30pm.
- An additional consultant on the ward until 1pm at weekends.
- The department repeated the survey informally with their new F2 trainees, with much improved results.

Plastic Surgery:

- A number of consultants were away for a significant proportion of the year at the time of the GMC survey but as of September 2019 they are back up to full complement.
- Registrars now able to access regular regional FRCS level teaching for two hours each week with agreement from the consultant body that they will release trainees from other commitments.
- Continue to try to incorporate joint SHO/Registrar teaching into CME sessions, including a journal club.
- Reorganised the delivery of departmental Induction to split the Plastics/ENT components into different days in order to reduce information overload. Also review the current structure of the Induction to see what could be done differently.
- The department has been short of Educational Supervisor provision but at least three consultants are now signed up to do the necessary Deanery training module in Feb/May, the earliest opportunities that courses are available.

4.6. **Assessment of progress:**

Most specialties are assessed in November/December by a Peninsula-wide 'Quality Panel', which is trainee led. We have not yet received reports from many of these Quality Panels; we have received reports from 3 of the 6 specialties above. The final grade can be Inadequate, Requires improvement, Good or Excellent. The following grades have been awarded:

- Healthcare of the Elderly: Requires improvement
- Oncology: Requires improvement
- Paediatrics: Good

4.7. All specialties will be assessed again in the 2020 GMC survey which will take place next month and should report in July 2020.

5. Clinical Education

5.1. The Trust has recruited 91 international nurses since September, of these 47 have passed their OSCEs (formal exams) and area practising as registered nurses.

5.2. We are recruiting a further 54 by June. All of these nurses receive 2 formal days OSCE training every week for 6 to 8 weeks before sitting OSCEs. The Department of Professional Healthcare Education has developed the programme and is delivering this training within existing trust wide resources.

5.3. This has placed some challenge on the team's capacity to deliver all of their services; the feedback on the standard of training has been very positive and the pass rate is 100% to date.

5.4. We are exploring feasible and affordable training and educational pathway options going forward to support the theatre non-medical workforce gaps.

5.5. There are resource capacity risks within the Department of Professional Healthcare Education teams in particular resuscitation services, preceptorship and student placement team in addition to OSCE training for the international nurses.

5.6. These resource risks have been escalated by the DCNO and are currently being reviewed in line with the mandatory training proposals described in this paper. Work is underway to secure additional funding streams e.g. HEE. Considerable risks remain around space and facilities, training capacity, mentoring support in the learning environment and the funding required for training posts.

6. The Learning and Education Strategy review

6.1. The Trust Board agreed a Learning and Development Strategy in November 2018. It set out a framework for UHP's ambitions around learning and education for a 2-year period. The strategy is being reviewed in light of the revised Trust Strategy, the National People Plan, and the refresh of the UHP People Strategy.

6.2. Conversation and engagement has begun in the Learning and Education Steering Group (LEG), which brings together all those with formal roles that influence the education agenda and two further engagement sessions have taken place with LEG members to review the vision and key ambitions of the strategy.

6.3. Further engagement is planned with staff (including underrepresented groups) during the period March to May 2020. Feedback from the LEG group has indicated the predominant need to raise the profile of Learning & Education and to elevate the importance of educational activities to prevent them becoming secondary to operational pressures.

6.4. The group has explored simpler more impactful vision statements to engage further with staff. Options so far are:

- Changing health through excellence in education
- We're here to deliver educational excellence to you
- What we can do for you as a learner
- Individualising your learning for individual care
- Everyone's development is our business

6.5. The group have also scoped draft objectives for the strategy:

- A personalised learning experience
- Develop a reputation for delivery of education differently
- Levering our talent
- Opening health careers to all
- Having a great learning environment (behaviour & building)
- Health & Wellbeing / Inclusivity

- Forming strategic alliances
- Experts & expertise in education
- Visible education activity
- Networks (External & Internal)

6.6. A draft will be brought back to the People and Culture in April 2020.

7. Statutory and Mandatory training

7.1. All staff are required to complete annual Trust Update training in line with the UK Skills for Health Common Core Framework. This is delivered by a combination of e-learning and face-to-face sessions. Compliance is monitored by Care Groups with data provided by the Workforce team.

7.2. Compliance

7.2.1. Between June 2019 and February 2020, compliance for Trust Update has risen from 88.22% to 88.88%, with an average 88.68% over the nine-month period.

7.2.2. For the same period, Basic Life support (Resuscitation) at 81.10% and has risen to 84.10% with an average of 82.21%, and Manual Handling has risen from 88.59% to 89.54% with an average of 87.81%.

7.2.3. Safeguarding Level 1 has remained consistently high with an average of 99.14% and Safeguarding Level 2 has risen from 90.75% to 92.11% with an average 91.30%. Child Protection has risen from 76.7% to 85.48% with an average of 80.74%.

7.2.4. With the exception of Safeguarding Level 2 (which has been consistently high), all areas show and increase since June 2019 and therefore the trends show an upward trajectory.

7.2.5. Whilst the work to raise compliance has seen an improved trend as evidenced above, achieving the 95% mandatory training compliance target set by the Trust Board continues to be a challenge. CQC reports have highlighted the continued failure to meet the target set.

7.2.6. Looking at the practice of organisations rated excellent by the CQC and assessing their compliance targets for mandatory training, there is a range from 75% to 95%. **Appendix 1** contains the data. The Trust currently has a target compliance rate of 95%.

7.2.7. Assessing this data, **the recommendation is that UHP changes its compliance target to 90%.** This still provides stretch given that the average compliance is 88%. The Trust Board is asked to support a change to the target for compliance.

7.2.8. The change in target will not decrease focus from working to reach compliance and the work in place in Care Groups supported by the HR Business Partners will continue.

7.3. Other Mandatory training developments

7.3.1. There are a number of other factors proposed as changes in relation to Mandatory training to improve quality and compliance and are set out in summary below:

7.3.2. The Trust will commit to more comprehensive passporting using the Inter Authority Transfer (IAT) process. This will mean in date staff from other organisations will not be retrained in Manual Handling, and Basic Life Support, if they are in date from their previous organisation. There are some concerns from the specialists which are being risk assessed, however the need for seamless transfer of staff is a key priority and has been approved by the Chief Nursing Officer and Director of People. The Trust Board are asked to note and support this principle, given appropriate clinical support to manage the transition and risks.

7.3.3. The reduction in the requirement to train staff already in date will reduce demand on the internal mandatory training providers. To give some scope, between July 2019 and December 2019 344 staff provided an IAT of mandatory training and these will have gone on to be retrained at UHP.

7.3.4. Reviewing delivery timings and venues as well as DNA information is key to maximise capacity. There is over pressure on the delivery teams, therefore demand needs careful management, including being certain that staff need the identified training.

7.3.5. The Learning and Organisational Development team currently create most of the individualised UHP e-learning packages for all types of training; a local strategy decision has been taken to use national packages where possible to remove duplication of effort and to ensure consistency, both regionally and nationally.

8. Appraisal

8.1. Between June 2019 and February 2020 compliance for appraisal has risen from 83.86% to 86.90%, with an average 86.26% over the nine-month period.

8.2. The National Staff survey in 2019 data shows a declining picture in relation to training needs being identified and then the training being received:

Questions	2019	2018
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	90.2%	92.5%
(As part of your appraisal) Were any training, learning, or development needs identified?	66.7%	67.9%
(As part of your appraisal) My manager supported me to receive this training, learning or development.	53.5%	54.5%

8.3. As with mandatory training, there is a consistent challenge with reaching 95% compliance. **In line with mandatory training it is proposed to change the compliance target to 90% and the Trust Board are asked to support this change.** The current target is 95%.

9. Apprenticeships

9.1. The Trust is set a target that 2.3% of the workforce should be on apprenticeship programmes and the Trust is currently exceeding this considerably, running at 4.3%. Apprenticeship levy activity for UHP is rated good; 71% usage versus 31% for the Devon system as a whole.

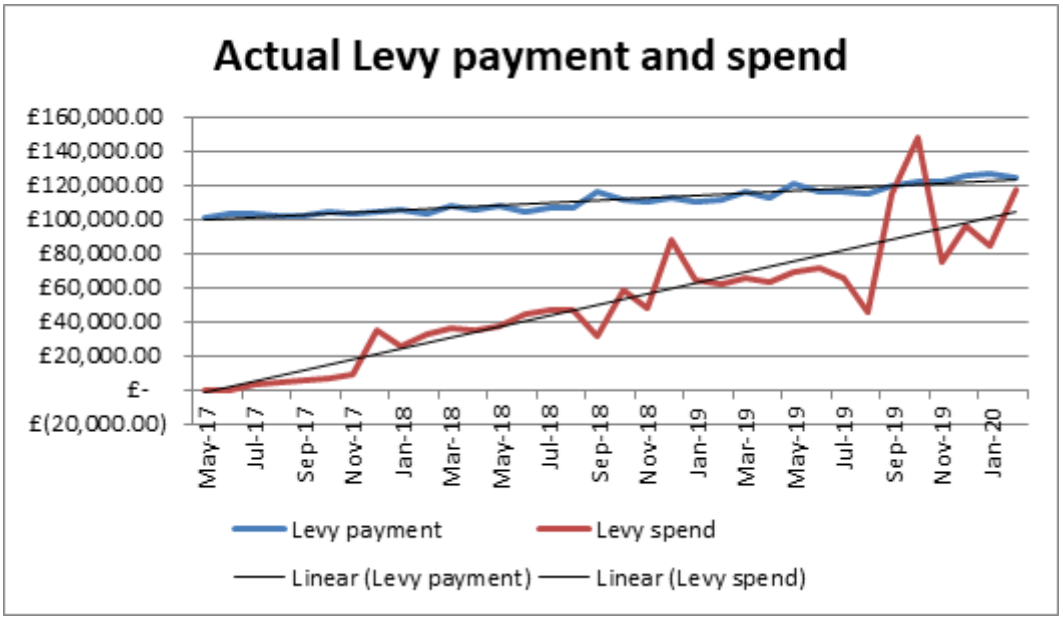
9.2. The Trust position with the apprenticeship levy is positive with no funds lost. The position year on year is below:

Year	Levy	Spend	Percentage
17/18	£1,137,900	£158,355	14%
18/19	£1,317,982	£626,882	48%
19/20	£1,319,620	£857,326	65%

9.3. The amount of spend per month fluctuates, due to, for example, additional payments received as apprentices complete their programmes but average monthly figures are:

Year	Levy	Spend	Percentage
17/18	£103,445	£14,395	14%
18/19	£109,773	£52,240	48%
19/20	£119,932	£86,246	72%

9.4. This graph shows the decreasing gap between levy available and that spent:



9.5. Currently, if UHP continues with no increase in activity, the predicted date of when funds will start to expire is March 2021. The predicted activity currently shows that monthly apprenticeship spend will outstrip the monthly levy in the latter half of this year. The Apprenticeship levy continues to provide funding for over 300 apprentices in the organisation and has capacity to support further activity. Current usage is at 71% with no loss of funds.

9.6. Since 2017, the Trust has been an Employer Provider and delivered the Level 2 Health Care Support Worker programme. To do this, the Trust had to apply to the register of apprenticeships (RoTAP).

9.7. All organsations were required to re-register and UHP submitted an application in November 2019. We were told in January 2020, that the application was unsuccessful on the following grounds :

- Governance processes for delivery; eg. evaluation, identifying and making improvements,
- Aspects of the off the job training,
- Maintaining and updating expertise of delivery team,
- Support for apprentices.

9.8. The implication of this is that UHP are unable to take on any new starters to the apprenticeship prograame; exisitng apprentices on programme we can continue to support until the 12 month notice period expires.

9.9. In order to keep training Health care supoprt workers , a contract has been entered into with South Devon College to train the Level 2 apprenticeship. This will be in place until the Trust is able to successfully re-register.

9.10. The Apprenticeship team have support from both the RD and E and City College Plymouth to assist with the resubmission which will be made in May 2020. There are risks around income, which has been in the range of £220k since the start of the programme in 2017 if we fail to meet the requirements after resubmission.

9.11. There is a Critical Care Assistant Practitioner Pilot to test out the role of the Assistant Practitioners within Critical Care; 9 have been appointed and the pilot was due to start at the end of March; due to Covid-19 we have deferred this for at least 3 months and will start this as soon as we can. We have commissioned a new 15-month shortened programme with South Devon College for this and the full apprenticeships including EPA being completed within the 18 months. If successful, this pilot will improve the operational capacity of Critical care

9.12. A second cohort of 7 Nurse Degree Apprentices started in December, the first cohort will qualify late spring. We need to secure funding to proceed with a third cohort if confirmed as part of our nursing workforce recruitment strategy (September 2020). HEE funding was awarded to support these apprentices and survey evaluation work that will be undertaken on these two cohorts to underpin wider workforce redesign.

9.13. A fifth cohort of Trainee Nursing Associates commenced in March 2020; we have also deferred this programme in light of Covid-19 until September when we will start a larger cohort. We were successful in securing a significant amount of HEE funding for a system wide review of Nursing Associates to include pilots, workforce redesign and a future sustainable strategy - Nicola Brockie, a UHP matron, has been appointed to the Programme Lead post. UHP also chairs the Devon wide NA programme board.

9.14. Antony Moffat, Nurse Consultant and Trust ACP lead is leading the HEE funded STP wide review of advanced clinical practice for 5 months which will also support wider workforce redesign and transformation

10 . Recommendations

The Trust Board are asked to:

- Note the current position of education and training
- Note the RoTAP application risks
- Note the risks raised in relation to training and education around facilities, capacity and income in relation to the apprenticeship agenda.
- Support the recommendation is that UHP changes its compliance target to 90% for Mandatory training.
- Support the recommendation is that UHP changes its compliance target to 90% for Appraisal.
- Support the move to the more comprehensive streamlining approaches set out in 7.3.2.

Appendix 1 – Compliance Rates for Mandatory training in organisations rated outstanding.

Trust	Compliance they have set themselves %	Actual Compliance % - other info
University Hospitals Bristol NHS Foundation Trust	90% (except Info Governance which NHS set at 95%)	Currently running at 90% for the CSTF 11 Framework / 94% for remainder, they have an essential 30 subjects
St Helens and Knowsley Teaching Hospitals NHS Trust	85%	Would not say
Guy's and St Thomas' NHS Foundation trust	95%	Currently at 89%
The Royal Wolverhampton NHS Trust	85% externally	We have 2 target compliance report, internally 95%, externally 85%. We have a large number of topics which are reported to our board, over 30. We reach the 85% for quite a few topics but we do struggle to the higher rate.
Northumbria Healthcare NHS Foundation Trust	Was 95% now 85% after re-evaluation (info governance still at 95%) enhanced safeguarding 66%	Currently running at 88.6% December 2019 Sept 83% 2019
Sandwell and West Birmingham Hospitals NHS Trust	95%	
Western Sussex Hospitals NHS Foundation Trust	90% for yearly CSTF	They Export Data from ESR into Excel with a RAG status , this shows they have a 7% non-attendance through annual leave and sickness, so they would not set a target of anything over 93% as it is not achievable. For the yearly CSTF they are running at 89 to 90%. For the 3 yearly training (safeguarding) they are running at 94%. Bank staff cannot work if not in compliant with Mandatory Training

SUMMARY REPORT

NHS University Hospitals Plymouth NHS Trust

Trust Board 24th April 2020

Subject	**Freedom to Speak Up Progress Report**
Prepared by	Freedom to Speak Up Guardians
Approved by	Freedom to Speak Up Guardians
Presented by	Freedom to Speak Up Guardian

Purpose

To provide the Trust Board with a progress report in respect of Freedom to Speak Up (F2SU) activity since the last update in January 2020.

Decision
Approval
Information ●
Assurance ●

Corporate Objectives

Quality Care	Inspired People	Healthy Organisation	Innovate & Collaborate
	●		

Executive Summary

- Decreasing trend in raising concerns prior to Covid-19
- Improved Guardian response times
- Flexible and well supported response to Freedom to Speak Up service provision
- Key Covid-19 related themes include PPE, staff safety and well-being, consistent empathetic communication and inclusion of all staff groups
- A national focus on detriment reporting will require Trust Board to develop a strategy for understanding, reporting and mitigating.

Quality Impact Assessment

The ability of staff to speak out and raise concerns underpins the Trusts ability to ensure the delivery of high quality and safe care to all of our patients.

Financial Impact Assessment

There are no direct financial implications associated with this report. However the support of an open and transparent and supportive culture has clear links to improved staff retention and lower absence rates.

Regulatory Impact Assessment

Meeting the requirements of the CQC Well-Led Framework, specifically KLOE 3.5.

Equality and Diversity Impact Assessment

The ability of staff to raise concerns is vital across all sections of the workforce, and will support the Trust in understanding and taking action where any sections of the workforce are impacted upon less favourably than others.

Environment & Sustainability Impact Assessment

None directly associated with this paper.

Key Recommendations

Develop an organisational understanding of detriment and a collaborative approach to recording, monitoring and mitigating it.

Closely monitor and respond to the experiences of BME colleagues and Hotel Services staff during our Covid-19 response, to ensure equality of experience and inclusivity as an organisational approach.

DETAILED REPORT

Trust Board	24th April 2020
Subject	**Freedom to Speak Up Progress Report**
Prepared by	Freedom to Speak Up Guardians
Approved by	Freedom to Speak Up Guardians
Presented by	Freedom to Speak Up Guardian

1. Purpose

The purpose of this paper is to provide the Trust Board with an overview of the Freedom to Speak Up (F2SU) Guardians work following our last update in January 2020. This report will also discuss F2SU work in the context of the Trust's response to Covid-19.

2. Update on Progress

Executive Support:

We continue to regularly meet with the Chief Executive, Head of Organisational Development, Director of People and other Executive Directors as the need has arisen. These relationships and the preservation of transparent communication and shared good intent have been particularly important during the recent Covid-19 response. Guardians have continued to receive open access for challenging conversation, and generally excellent responsiveness to enable prompt feedback to staff concerns.

Freedom to Speak Steering Group:

The Steering Group is now established and meets quarterly. We have a rotating chair, between the Guardians, HR & OD, Quality & Safety and the Unions, to allow for the triangulation of information and assurance that we are aligned in the work we are doing. The final draft of the updated Terms of Reference for this group will be reviewed

Accessibility:

Performance against our key access measures is detailed below:

Measure	Standard	Standard Achieved	Comments
From initial contact to Guardian acknowledgement	48 hours	Within 24 hours	This is an improved position. 93.5% received a response the same day in Q4 19/20.

From identifying a meeting is required to the meeting date taking place	To be agreed	4 Days	Decreased from the last quarter (5 days). It is important to note that this is based on the availability of both the person raising the concern and the Guardians.

In response to Covid-19 we have tried to improve our accessibility through a number of measures. Both Guardians have redeployed additional hours from their other roles to offer more Guardian support to staff during this time. There is also additional capacity being directed at acknowledging and responding to contacts during evenings and weekends where possible. Whilst face to face follow ups are being minimised, the Guardian team is available to staff through MS Teams virtual meeting software, but is also able to meet at an appropriate social distance in the Guardian office if necessary.

Guardian Team:

The Guardian Team at present comprises Catherine Lemsalu and Pippa Jephcott, each of whom undertake Guardian duties for one day a week. Administrative support is provided by Meghan Fields, and line management by Claire Underdown. The Executive Lead for speaking up continues to be Steven Keith, and the team is pleased to welcome Professor Liz Kaye as their Non Executive Lead.

Dr Jamie Read and Louise Shalders have become Ambassadors for the Freedom to Speak Up Service, and retain close links with the team in order to triangulate information, signpost staff as necessary and provide support and advice as required in a continued mentoring role to the current Guardians. It is important to ensure continuity, experience and preservation of organisational intelligence and context within the Freedom to Speak Up service.

Guardian recruitment is an ongoing challenge. Additional capacity would undoubtedly be welcomed to enable not only more flexibility within the Guardian team, but also to facilitate some of the ancillary tasks taking place on a more regular basis (e.g. data analysis, case review and learning, off-site awareness visits, drop-in clinics, contributions to UHP, regional and national events).

The ‘Staff Advocate’ role is in development, and aims to identify staff members able to act as points of contact for specific groups of staff who may find it difficult to access our support services or be under-represented as part of the workforce. As part of their remit, advocates will have Freedom to Speak Up awareness training and act as champions for the service.

Case Review Gap Analysis and Board Self-Assessment:

Key actions arising from the Case Review Gap Analysis and have been captured in the updated single plan, allowing robust oversight of delivery. The plan will be risk rated following completion of the audit during Q4. AN updated Board Self-Assessment will be brought to Board for overview in July 2020

Healthy Culture:

The Guardian team are supporting the Trust's Healthy Culture approach through the triangulation of data and specific support as required. Key areas requiring support have been identified and were scheduled for 'Round Table' events where key stakeholders are able to share information, data and concerns openly and discuss opportunities for collaborative improvement. Due to the face to face nature of these events, they have been postponed and will be revisited when it is considered safe to do so.

Audit:

An audit survey was distributed to over 100 staff members who raised concerns prior to end of December 2019, the content of which can be found here https://www.surveymonkey.co.uk/r/5DBGBCP. Of 47 respondents, the majority said they felt confident approaching Guardians, and were made to feel safe when raising their concerns. An approximately even split of respondents took their concern further following Guardian contact, but 11 of the 47 said they would not feel confident to raise a concern again and 12 reported being dissatisfied with the overall experience. 6 respondents reported that raising a concern had resulted in a detrimental effect upon their working life.

Training:

There is a requirement to provide all staff with a basic level of Freedom to Speak Up training; the Guardian team are responsible for oversight and understanding the volume of staff who are compliant. Raising Concerns training has now been included in the Equality, Diversity and Inclusion section of mandatory training, following input and review by the Guardian team in early March.

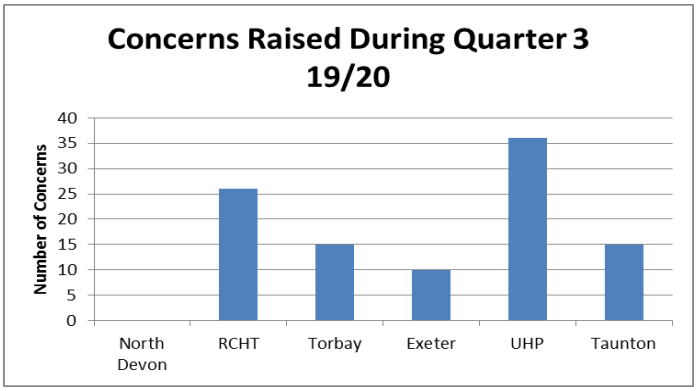
The National team are currently developing a 3 tier e-learning training package which we will adopt, when available, and may form part of the Manager's Passport qualification to encourage appropriate uptake and dissemination.

An induction and experiential training checklist is in development and will be presented at the F2SU Steering Group for approval, to facilitate and make consistent the on-boarding process of new Guardians as they are recruited.

3. Concerns Raised

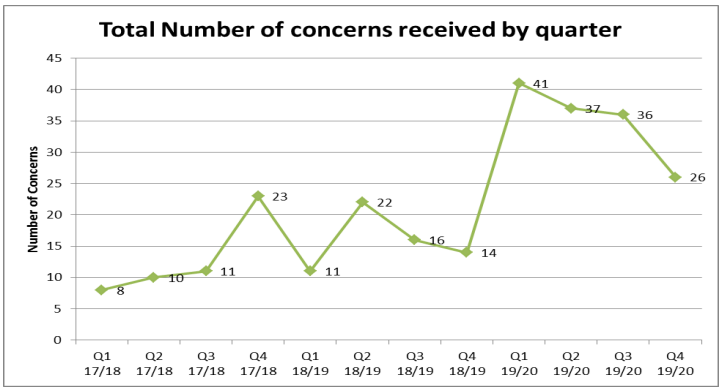
Regional:

In terms of the Region we remain one of the more active Trusts for F2SU issues, In Quarter 3 we saw a higher number of concerns raised. The data below shows the number of cases each Trust reported in Quarter 3 19/20.



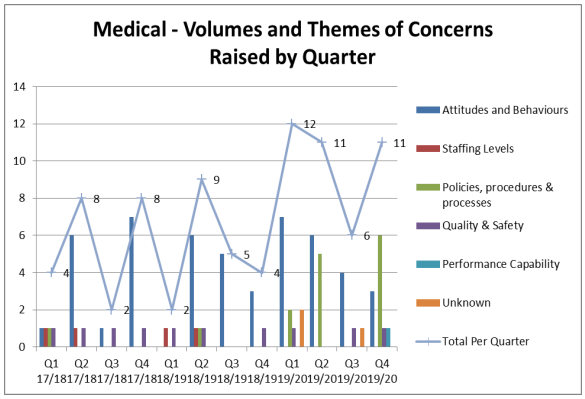
Local:

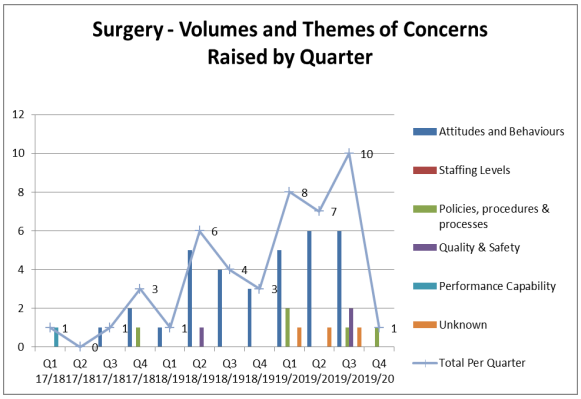
The number of concerns raised to the Guardians in Q4 19/20 has decreased from a significantly busier period at the start of the 19/20 year. This may be due to increased visibility of Guardians at the start of the year due to a number of 'high profile' concerns. New faces within the Guardian team may also have led to the need for a renewed focus on awareness, visibility and building new relationships and communication links.

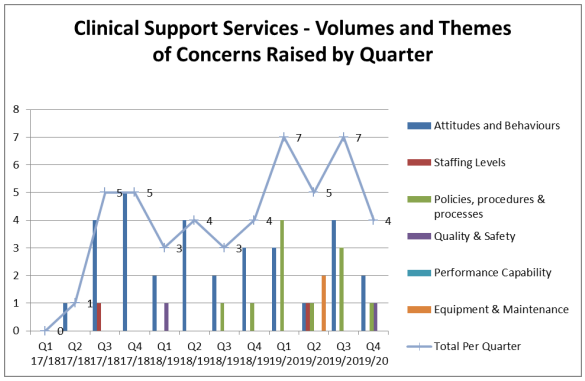


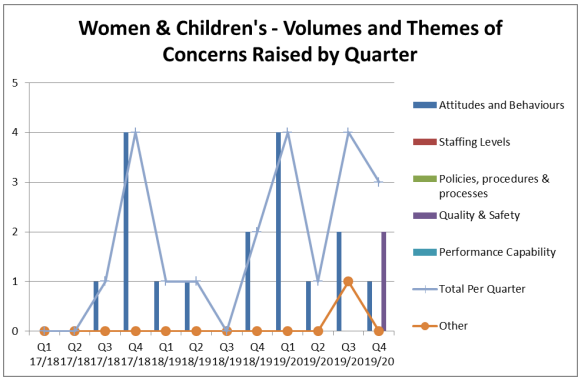
Care Group Data:

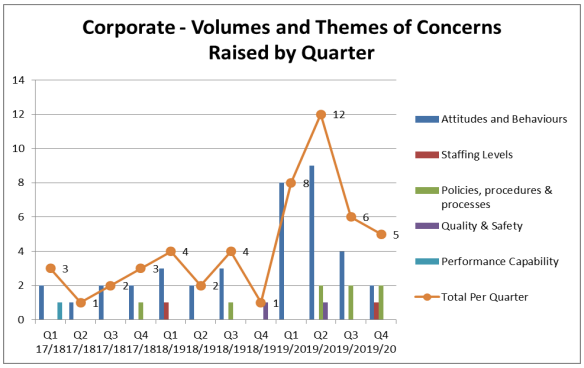
We've detailed below the volume of concerns and themes across our Care Groups. The Guardians team is due to meet with Care Group Managers and the Chief Operations Officer to discuss the most useful and effective way of sharing information at this level, so that managers are well informed and can take effective action to address concerns and provide timely feedback.









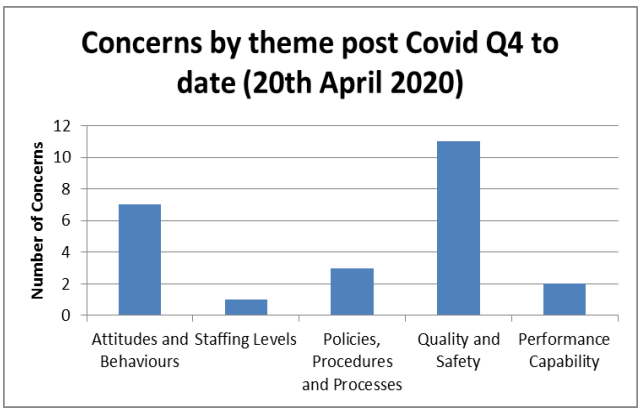


4. Covid-19

The UHP Guardian Team has taken a number of adaptive steps to meet the Covid-19 challenge:

- Both Guardians offering additional hours to F2SU work
- Increased communications reminding staff of the service
- Increased availability, including a commitment to acknowledge or respond to concerns during evenings and weekends
- Offering virtual meetings, physically distanced face to face meetings or resolution by email if possible
- Off-site visits to services that have been relocated undertaken or planned in the coming weeks (Maternity Services at Green Ark and Nomony Children's Centres and Home Park have had a Guardian visit, and plans are being made to visit staff at the Nuffield hospital)

We have seen an increase in concerns being raised to Guardians in Q1 20/21, primarily regarding Covid-19 issues around the following themes:



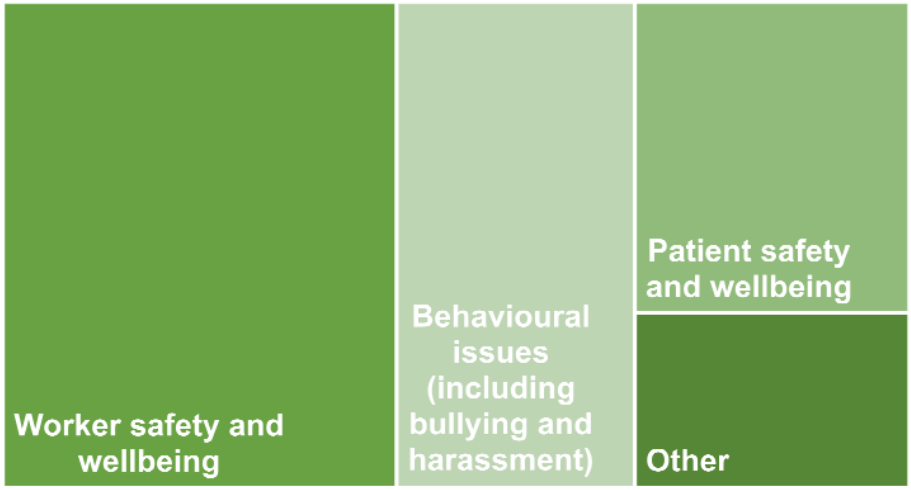
Common themes arising are:

- Personal Protective Equipment (guidance, use, availability, tolerance for personal choice)
- Communication with and inclusion of Hotel Services staff
- Providing staff with the opportunity to work from home, or to work at appropriate physical distance in the hospital
- Consistent communication and access to information in a rapidly changing environment

The National Guardian Office have been actively seeking Trust input at this time to better understand the Freedom to Speak Up response to Covid-19. A Pulse servey was undertaken, a full copy of which can be found https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/covid-19_pulse_survey_0420.pdf .

Interestingly UHP is in the minority 21% as reporting an increase in concerns being raised at this time, with 40% reporting a decrease and 39% reporting no change. 62% of Guardians reported they had seen no change in the support recceived from their senior team, compared to 10% who reported increased support and 28% reporting decreased support. Our experience of the themes of concern being raised are broadly reflected by the national picture (see below).

What themes are being brought to Guardians?



The National Guardian, Henrietta Hughes, has written personally to all Trust Chairs and healthcare leaders, encouraging them to consider their Freedom to Speak Up guardian arrangements in this challenging time and highlighting the importance that staff are encouraged and supported to raise concerns.

It has been noted nationally and covered in mainstream media that Covid-19 may be disproportionately affecting BME colleagues, or identifying inequalities in organisational support and inclusion. This is something the Guardian team will be asking the organisation to consider, so that our BME colleagues do not experience any form of direct or indirect discrimination at this time.

Detriment

Detriment is described in the National Guardian's Information on 'Recording Cases and Reporting Data' as:

"…any treatment which is disadvantageous and/or demeaning and may include being ostracised, given unfavourable shifts, being overlooked for promotion, moved from a team, etc."

There has been a national focus on detriment as experienced by staff who raise concerns following the number of staff reporting experiencing detriment nationally remaining static at 5% compared between 2017/18 and 2018/29. The National Guardian expressed disappointment at the 'general and vague' responses received from Trusts when asked about detriment, and has asked that Trusts focus upon recognising, reporting and addressing detriment where it occurs. This will form part of future CQC well-led assessments.

UHP Guardians have started to record detriment as experienced by staff at the time of raising their concern, and 3 and 6 months following raising concerns. Currently the Guardians have recorded only 2 instances of staff reporting detriment, however, responses to our staff survey indicate there may be a disparity of approach dependent on whether the concern is raised through the Guardian channels or directly through line management.

Staff Survey Q17a - "My organisation treats staff who are involved in an error, near miss or incident fairly" has been indicated as particularly key to monitoring detriment as experienced by staff within organisations. UHP staff currently reply agree/strongly agree to this question 63.2% of the time, compared with a national average of 59.6%.

5. Next Steps

The following are the key actions the Guardian team will be taking over the next few months:

1. Renewed focus on off-site visiting and staff awareness
2. Development of the Staff Advocate role and Freedom to Speak Up training for those staff
3. Continued flexible and adaptive support to staff during the Covid-19 response
4. Collaboration with Trust leadership to develop an effective strategy with respect to detriment
5. Focus at the next steering group to identify moving on from Covid-19 and beginning to widen our focus again

Recommendations

The Trust Board is asked to note the content of this report and acknowledge and support the recommendations made below.

The Trust Board focus on the experiences of BME staff and our Hotel Services staff during this time, in the hope that we ensure our organisation delivers on its values of ‘Respecting Others’ and ‘Listening, Learning and Improving’.

Develop an organisational perspective on detriment, our understanding of how it is experienced and reported by our staff, together with a plan to mitigate and proactively defend against this.

SUMMARY REPORT	NHS University Hospitals Plymouth NHS Trust
Trust Public Board	24 April 2020

Subject	**Utilities Procurement**
Prepared by	John Stephens, Head of Site Services
Approved by	Stuart Windsor, Director of Estates & Facilities
Presented by	Nick Thomas, Director of Planning and Site Services & Deputy Chief Executive

Purpose

To ratify the decision under Standing Order 5.2, that the Trust's Utility supply Contract for gas and electricity was extended by one year from 1 October 2020.

Decision	
Approval	●
Information	
Assurance	●

Corporate Objectives

Quality Care	Inspired People	Healthy Organisation	Innovate & Collaborate
		●	

Executive Summary

The Trust's existing energy Contract was due to expire on 30 September 2020, and therefore the Trust had embarked on a soft market test to establish the most economically advantageous future supply Contract. Due to the focus on responding to the Coronavirus pandemic, and the fact that utility commodities are currently trading at twelve year record low levels, it was recommended that the Trust take advantage of a one year "Purchase in Advance" Contract with the existing supplier, the LASER Energy Buying Group.

To secure the best pricing from 1 October 2020, it was necessary to enter into a Contract extension with LASER as quickly as possible, rather than wait for the full Trust Board to consider the proposal. Standing Order 5.2 allows for emergency decisions to be taken by the Chair and Chief Executive, having consulted at least two Non-Executive Directors, subject to the decision being reported to the next scheduled public Board meeting for ratification.

A report was circulated to the full Board on 2 April 2020 detailing available options and recommending a one year Contract extension with LASER. Positive responses were received from the Chair, Chief Executive, and six Non-Executive Directors. Due to the commercial in confidence nature of the subject matter, the full detailed report will be considered by Private Board following this Public Board.

Quality Impact Assessment

There are no direct quality impacts associated with this Contract extension.

Financial Impact Assessment

It is anticipated that due to the current low market commodity price of Utilities, that this Contract award will result in a decrease in the unit price of both gas and electricity compared to 2019/20 levels.

Regulatory Impact Assessment

There are no regulatory or compliance impacts associated with this Contract extension.

Equality and Diversity Impact Assessment

There are no equality and diversity impacts associated with this Contract extension.

Environment & Sustainability Impact Assessment

There are no environment and sustainability impacts as a result of this Contract extension, since this relates to commodity pricing rather than the consumption of energy by the Trust.

Key Recommendations

It is recommended that the Trust Board ratify the decision to extend the existing Energy supply Contract with LASER by one year under a Purchase In Advance arrangement.

Next Steps

1. Review the Trust's energy requirements and undertake full market test, to be completed by 1 April 2021.