Board Papers
Part 1 – September 2014

The South Manchester Way
“It’s the way we do things round here.”
**MEETING OF THE BOARD OF DIRECTORS ON THURSDAY 25 SEPTEMBER 2014
COMMENCING AT 9.30 AM IN THE BOARD ROOM, 4TH FLOOR,
TOWER BLOCK, WYTHENSHAWE HOSPITAL**

**PART 1 AGENDA - OPEN TO NOMINATED OBSERVERS**

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<thead>
<tr>
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<th>Subject Matter</th>
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<th>Paper</th>
<th>Time</th>
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<tbody>
<tr>
<td>1.</td>
<td>Apologies</td>
<td>Chairman</td>
<td>-</td>
<td>9.30</td>
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<tr>
<td>2.</td>
<td>Patient story</td>
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<td>3.</td>
<td>Declaration of Board Members’ interests concerning agenda items</td>
<td>Chairman</td>
<td>-</td>
<td>9.40</td>
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<tr>
<td>4.</td>
<td>Minutes of previous Board meeting(s); <strong>For approval</strong> Part 1 Board of Directors meeting 28 August 2014 Matters Arising</td>
<td>Chairman</td>
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**Chairman and CEO Updates**

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<tbody>
<tr>
<td>5.</td>
<td>Chairman’s communications</td>
<td>Chairman</td>
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<tr>
<td>6.</td>
<td>Chief Executive’s Report – <em>For discussion and noting</em></td>
<td>Chief Executive</td>
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**Performance Updates**

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<tbody>
<tr>
<td>7a</td>
<td>INTEGRATED PERFORMANCE REPORT – <em>For discussion and noting</em></td>
<td>JC MB/JW</td>
<td>C1</td>
<td>10.00</td>
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<tr>
<td>7b</td>
<td>Quality, Safety and Performance dashboard – <strong>partially redacted</strong></td>
<td>JO'C</td>
<td></td>
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<tr>
<td>7c</td>
<td>Financial performance – <strong>partially redacted</strong></td>
<td>NAH</td>
<td>C2</td>
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<tr>
<td>7d</td>
<td>EPIP Update</td>
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<td>7e</td>
<td>Financial performance</td>
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<td>7f</td>
<td>Recovery Planning</td>
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**TEA & COFFEE BREAK**

**Operational Updates**

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<td>8.</td>
<td>Strategic Risk Register – <em>for approval</em> - <strong>partially redacted</strong></td>
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<tr>
<td>9.</td>
<td>Health &amp; Safety Strategy – <em>for noting</em>*</td>
<td>UM</td>
<td>E</td>
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<tr>
<td>10.</td>
<td>Dementia Strategy – <em>for approval</em>*</td>
<td>MB</td>
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**Governance Matters**

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<tbody>
<tr>
<td>11.</td>
<td>Amendment to UHSM Scheme of Delegation</td>
<td>NAH</td>
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<td>11.10</td>
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**Other Matters**

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<tr>
<td>12.</td>
<td><em>Any Other Business</em></td>
<td>Chairman</td>
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<td>11.15</td>
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Date, time and place of next meeting:
Thursday 23 October at 9.30am, Boardroom, 4th Floor, Tower Block, Wythenshawe Hospital
**Title of Board paper and link to corporate objectives.**

Minutes of the Part 1 Meeting of the Board of Directors on 28 August 2014; Over-riding objective - maintaining Green for governance

<table>
<thead>
<tr>
<th>Board meeting date</th>
<th>25 September 2014</th>
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<tbody>
<tr>
<td>Purpose</td>
<td>To approve the minutes as a true and accurate record of the proceedings.</td>
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<tr>
<td>Actions Recommended</td>
<td>Discussion / Noting / <strong>Decision</strong></td>
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**Unusual acronyms**

BRU – Biomedical Research Unit  
CIP – cost improvement programme  
COSRR – Continuity of Service Risk Rating  
CQC – Care Quality Commission  
DMD – Divisional Medical Director  
EBITDA – Earnings before interest, tax, depreciation and amortization  
FFT – Friends and Family Test  
HSE – Health and Safety Executive  
HIRS – Hospital Incident Reporting System  
ITFF – Independent Trust Financing Facility  
NICE – National Institute for Clinical Excellence  
PMO – Project Management Office  
RAF – Monitor’s Risk Assessment Framework  
RTT – Referral to treatment target (or 18 Week target)  
RAMI – Risk adjusted mortality index  
SI – Serious Incident  
SHMI – Summary Hospital-level Mortality Indicator

Communications after the meeting

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**Report of**

Head of Corporate Governance

**Paper prepared by**

Head of Corporate Governance
MINUTES OF THE PART 1 MEETING OF THE BOARD OF DIRECTORS HELD ON 28 AUGUST 2014, IN THE BOARDROOM, FOURTH FLOOR, TOWER BLOCK, WYTHENSHAWE HOSPITAL AT 9.30 P.M.
PART 1 – OPEN TO NOMINATED OBSERVERS

DIRECTORS PRESENT
Felicity Goodey, Chairman
Attila Vegh, Chief Executive
Roger Barlow, Non-Executive Director
Lorraine Clinton, Non-Executive Director
Martin Gibson, Non-Executive Director
Mandy Bailey, Chief Nurse
John Crampton, Interim Medical Director
Nora Ann Heery, Finance Director
Jim O’Connell, Interim Chief Operating Officer
Ms Janet Wilkinson, Director of HR and OD

STAFF IN ATTENDANCE
Miss Toli Onon, DMD Unscheduled Care
Dr Sue Beards, DMD Clinical Support Services
Ms Jenny Farley, DDOP Scheduled Care
Susan Rudd, Head of Corporate Governance
Anne-Marie Miller, Director of Communications
Gill Bailey, Assistant FT Secretary

NOMINATED AND OTHER OBSERVERS IN ATTENDANCE
None this time

14/090  AGENDA ITEM 1  APOLOGIES
Apologies were received from Philip Smyth, Non-Executive Director, Professor Graham Boulnois, Non-Executive Director and Dr Richard Levy, DMD Scheduled Care

14/091  AGENDA ITEM 2  PATIENT STORY
The Chief Nurse noted that an electronic tablet pilot of the Friends and Family Test in Outpatients has been taking place. The tablets are used to collect patient feedback which allows for more timely responses and allows actions to be taken on a faster basis.

A comment was recently received by a day patient on an electronic tablet who had attended for a procedure. The care received was excellent however a great deal of anxiety and stress had been suffered trying to find the unit on the morning of the procedure. The day case unit team responded to this feedback within a week and have modified the map sent to patients so that the unit is clearly visible and every letter sent to day unit patients contains the map. A review of signage is also currently underway following feedback from a number of patients and visitors. The electronic tablet enabled more timely feedback and response.

The Board was advised that the national PLACE scores have just been published. Further analysis of the results will take place however the overall score for cleanliness is 97.11%, just below the national average of 97.25%. The score for food at the Wythenshawe site is 80.8% which is below the average of 88.97%. The result is potentially due to the options
available at lunchtime and a more varied menu is being introduced in September. Pleasingly the focus on food at Buccleugh has resulted in an improved score. Privacy and dignity and condition and appearance remain above the national average.

14/092 AGENDA ITEM 3 DECLARATION OF INTERESTS
There were none.

14/093 AGENDA ITEM 4 MINUTES OF PART 1 MEETING HELD ON 24 JULY 2014
The minutes of the Board meeting were approved as a true and accurate record of the proceedings.

14/094 AGENDA ITEM 6 CHIEF EXECUTIVE’S REPORT
The Chief Executive presented his report and welcomed Janet Wilkinson, Director of HR and Organisational Development who has joined the Trust this month.

The Healthier Together public consultation continues with a number of engagement events taking place. Staff were provided with an opportunity to hear directly from the Healthier Together team and ask a number of questions.

Plans for the redevelopment of A&E were revealed to media and staff, the project will cost £12m and is due for completion Autumn 2015.

The Trust has been working with Sodexo and SMHL to improve performance across the services being provided: domestic, catering, laundry, portering and maintenance. An improvement trajectory across all areas has been agreed with an action plan to review progress on a number of initiatives.

A groundbreaking ceremony was held to celebrate the start of the children’s unit courtyard renovation into a sensory garden, thanks to a donation from Key 103s Cash for Kids charity.

Plans are in place to refurbish the Courtyard, with occupation by notable retailers and the relocation of the current WH Smith, subject to planning permission which should be granted in September.

The Board reviewed the Transaction Reporting requirements in line with Monitor’s Risk Assessment Framework and noted the reporting requirements in relation to “material” and “significant” transactions. The Trust is currently in breach of its licence and therefore such transactions may be subject to a more detailed review by Monitor.

The Trust is undertaking a “No Delay for 7 Days” initiative week commencing 22nd September 2014. This will result in seven days of intensive improvement activity in relation to the Emergency Department (ED) and patient flow. There are rapid improvement initiatives focusing on five high impact actions: ED staffing, Specialty Review, Geriatrician 7/7, GP Expected Patients and Home on Time. The week is being supported by Commissioners and social services.

For the duration of the week there will be a commitment from staff for all areas to focus leadership at all levels, cancel non urgent meetings and minimise email traffic. There will be a daily review of progress and we will listen, learn and share our experiences. Sodexo will play a key part in this initiative, working in partnership to support the actions.

The objective of the week is to improve patient experience, safety, quality and flow throughout the Trust, and to improve and accelerate discharge processes. The week will

Part 1 Board of Directors 25 September 2014
also be used to accelerate and embed known good practice.

**14/095 AGENDA ITEM 7 INTEGRATED PERFORMANCE REPORT**

Item 7a: Quality Account

The report is designed to draw the Board’s attention to areas where the Trust is not doing as well as expected. The Chief Executive, as Chair of the Operational Board, introduced the report noting that detailed discussion of the Quality Account and Finance Report has taken place at the Operational Board, which was also attended by a non-executive director.

The Board focused discussion on areas where performance is giving rise to concern.

**Mortality**
The Trust is within the top 30% of trusts for mortality as measured by the Standardised Hospital Mortality Indicator (SHMI), with a national ranking of 40 out of 141 acute hospitals. The Trust’s Risk-adjusted Morality Index (RAMI) is below expected and the Hospital Standardised Mortality Ration (HSMR) for the latest twelve available months is 96.7. The latest SHMI figures for the current month indicate a small rise which will be reviewed and a detailed report provided to the Operational Board.

**Complaints**
The Trust responded to almost 98% of formal complaints within the timeframe agreed, with all divisions meeting the 90% target.

**Serious Incidents**
These are discussed in detail at the Quality and Assurance Committee and learning is shared in a number of ways, including a newsletter to staff. A ‘Speak out Safely’ initiative is being launched in October and further detail will be provided to the next meeting. The Board requested the Quality and Assurance review the number of serious incidents compared to peers.

**Action: Quality & Assurance Committee to review the number of serious incidents compared to peers**

**A&E**
Performance for July was 92.23% against the 95% standard. The Emergency Improvement Programme (EPiP) has been strengthened and is now under the governance of the Recovery Board. A granular plan has been developed with executive sponsors for work streams and daily meetings with operational managers and ED consultants. Support continues to be provided by the Emergency Care Intensive Support Team (ECIST) and the detailed work streams align the five high impact actions discussed earlier.

Performance for August has improved however it will be challenging to achieve compliance in quarter 2.

**Friends and Family Test**
The Trust has set an objective in 2014/15 to be within the top twenty per cent of acute hospital trusts for the Friends and Family test, which is measured using the Net Promoter Score (NPS). The response rate on wards is strong however the response rate in A&E continues to be a challenge and the Trust was outside the top twenty per cent. Increased focus in this area includes a Matron reviewing all individual comments received and discussing with directorates.

It was noted that, nationally, there is a review of the comparison of the data as it is

*Part 1 Board of Directors 25 September 2014*
acknowledged that trusts utilise different methods of data collection, groups of people respond differently to different methods of questioning.

Mandatory Training
The Trust achieved 84.38% compliance against a target of 95%. Actions are being undertaken to improve compliance through a reminder and escalation system. The appropriate systems are being developed and will be in place for the next financial year.

Nutritional Assessment
The Trust achieved 91.7% against a 95% target. It was noted that there has been a change in targets, in line with national CQUIN, that 95% of all adults to be screened, compared to only adults over 60 years previously. The Ward Accreditation process has increased focus in this area and all nutritional documentation has been revised to make it easier to read.

Outpatient Appointments with the outcome ‘did not attend’
The Trust’s overall Did-Not-Attend (DNA) rate reduced from 8.6% to 7.9% in July, above the target of 7.5%. Meetings are being held with individual directorates, and although this is a significant improvement on this time last year, we have set ourselves the challenge to be within the top 5 trusts in the region. The Operational Board requested further detail on the areas where there are the opportunities to make a difference.

Cancelled Operations
The cancellation rate for July was 1.53% with the top four reasons for cancellation being list overrun, clinical administrative error, emergency/trauma took priority and equipment failure/unavailable. The Operational Board are working to understand the reasons for cancellations with detailed collaborative work being undertaken between divisions in each area.

62 day wait from referral to treatment for all cancer patients
All cancer standards were achieved in June 2014, with the exception of the 62-day wait from referral to treatment. Performance of 82.25% was below the 85% threshold, however compliance for quarter one has been achieved.

Nationally, there is the opportunity of planned breach during August and September, and the trust is working to reduce the backlog whilst ensuring long term sustainability.

Staff Attendance
Performance in July was 94.8% against a 96% threshold. Attendance continues to be lower in areas of high vacancies, overtime and turnover. Recruitment plans and strategies continue and managers are supported in taking timely and appropriate action. The trust wide Employee Assistance Programme will be launched on 1st September 2014 with a focus on its counselling services. A high level of focus and review continues at divisional level and at nursing forums to provide additional support.

Item 7b Financial Performance and Cost Improvement/Recovery Plan
The Trust year to date position for the period ending 31st July 2014 is a normalised deficit of £0.3m, which is £0.1m worse than plan. The financial performance generates a continuity of service rating of level 1, which is in line with plan.

The performance is largely attributed to slippage on delivery on CIP, and pay pressures remain a concern. Strong performance on income has offset these pressures. There remains a significant risk in future periods due to a forecast gap in CIP of £3.6m and the underlying pay pressures.

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The Trust is working with Deloitte to strengthen existing plans and generate additional schemes to address the gap. A number of new schemes are being developed and the output of this work will be confirmed in September.

**Action:** Recovery Plan update and discussion of additional schemes to address gap

**14/096 AGENDA ITEM 8 NURSE STAFFING UPDATE**

The Trust is working with Deloitte to strengthen existing plans and generate additional schemes to address the gap. A number of new schemes are being developed and the output of this work will be confirmed in September.

**Action:** Recovery Plan update and discussion of additional schemes to address gap

**14/096 AGENDA ITEM 8 NURSE STAFFING UPDATE**

The Chief Nurse presented the report noting that all nurse staffing levels must be published on NHS Choices each month, as requested by NHS England.

The report highlights a number of areas that have not achieved 85% of their staffing establishment, both during the day and at night. It was noted that the information details the planned and actual staffing at the beginning of a shift and does not take into account where actions have been taken to support any deficits e.g. staff being moved to another ward mid shift. Actions that are taken include escalation via the Nurse Staffing escalation process, ward manager or shift coordinator steps into the absence; staffing huddle identifies staff that can be moved from across the divisions, review of bed occupancy and acuity and dependency of the ward.

NICE have recently released guidance on safe staffing for nursing in adult inpatient wards in acute hospitals. These make recommendations and the senior team are currently working through the detail of an implementation plan for recommendations.

Recruitment activity continues, with 29 WTE band 5 nurses due to commence in post in the coming months and a further 156 posts under offer. There is also a continued drive to recruit band five nurses both nationally and internationally.

There has been an average of 4.8% in sickness amongst nurses and 8.96% amongst HCAs over the last 12 months and are amongst the highest levels seen. In order to establish the level of sickness experienced on night shifts data will be gathered for the entire organisation in September 2014 and reported to the Board in the October update.

Nursing staffing is a risk entered into the Risk Register with the mitigating actions noted, including noting that the move to long days will enhance the shift fill rate.

The Board noted its concern regarding the shift fill and requested analysis of the UHSM fill rate in comparison to other trusts.

The Board noted the report and approved its publication.

**14/097 AGENDA ITEM 9 REVALIDATION AND APPRAISAL ANNUAL REPORT**

Dr Crampton presented the report of progress on the implementation of doctors’ Revalidation and Appraisal.

UHSM uses an electronic appraisal database (PReP) across the organisation. As at 31st March 2014 the total number of doctors with an in date appraisal was 228, and there are a total of 392 doctors with a prescribed connection to UHSM. It was noted that there are some doctors who will have had a ‘paper’ appraisal rather than electronic, and therefore not recorded on the system.

The revalidation team are working to develop an alert system which would warn doctors that they are out of their annual appraisal window and which requires them to complete their appraisal as soon as possible. Once a robust alert system is in place, appraisal will
be classed as mandatory in the time frame. The team are also working to identify the reasons behind a delayed appraisal and to review and develop the structure of appraisers and appraisal leads in the Trust. Refresher training for appraisers and appraisal leads is also planned, for their continual development. Appraiser leads are also to be introduced in each division.

An audit of appraisal quality is underway which will examine the standard of input and output forms and Personal Development Plan (PDPs). This will help to address any training issues.

The Board noted the report and supported the actions being taken to increase compliance.

14/098 AGENDA ITEM 10 STRATEGIC RISK REGISTER AND BOARD ASSURANCE FRAMEWORK
Dr Crampton presented the report noting that it is an update of all significant risks on the strategic risk register. The Board discussed the following risks for addition to the significant risk register:

i) Not realising the potential of the Cardiac Joint Venture

ii) UHSM not being designated a specialist site following the Healthier Together consultation.

The Board agreed their addition to the register with residual risk scores of 12 and 15 respectively.

Following implementation of an action plan, the risk of breach of equality and diversity legislation has reduced and it was agreed to reduce the residual risk score of this risk.

The Board then discussed notable updates to the register, highlighting the risk relating to missed cancers and fractures. The Quality & Assurance Committee had raised concerns about progress against completing historical clinical reviews of unviewed histopathology results on the system. A number of reviews are still carried out using paper based methods. A programmed plan to remove paper histopathology results from the Trust will be implemented, and will include training for relevant Consultants on the ICE system.

The Board approved the Significant Risk Register and Board Assurance Framework.

14/099 AGENDA ITEM 11 CQC INTELLIGENT MONITORING REPORT
Following publication of the Care Quality Commission Intelligent Monitoring Report in June 2014, UHSM was assigned to band 2, a higher risk position than the previous report in March 2014. There are some new ‘elevated’ and ‘risk’ areas within the report and the Board has previously discussed areas where the data used is historical and improvements need to be made.

An analysis of each risk, together with any action required, has been undertaken. Progress of actions will be monitored through the Quality and Assurance Committee. Emergency readmissions with an overnight stay following elective admission has been identified as a risk area. Information from Dr Foster shows that UHSM was worse than expected. The Trust is already undertaking an audit of re-admissions, supported by a third party; however this will cover largely non-elective patients. An audit of re-admissions of elective patients will therefore be undertaken to ascertain the latest position.

The Board also noted the work being undertaken in preparation for an inspection under Part 1 Board of Directors 25 September 2014
the new CQC framework with a steering group being set up to look at how best to communicate with clinical staff, learn from other organisations and identify gaps and requirements to strengthen existing governance and monitoring arrangements.

14/100 AGENDA ITEM 12 STAFF FRIENDS AND FAMILY TEST
The Director of HR and Organisational Development introduced the report providing an update on the NHS Staff Survey undertaken in May 2014, the introduction of the quarterly Staff Friends and Family Test, and the Quarterly Staff Pulse Survey for 2014/15 with the feedback from Quarter 1.

Four themes for improvement were identified from the NHS Staff Survey in 2014 i) appraisals and performance management ii) employee health and wellbeing iii) errors and incidents and iv) equality and diversity training. To support the improvement plan a quarterly ‘pulse survey’ to explore each of these areas in depth was developed and rolled out in June 2014.

Two mandatory NHS Staff Friends and Family Test questions were incorporated into the quarterly pulse survey and issued to 25% of UHSM employees. The response rate for the quarter one the survey was 16%.

The question ‘Would you recommend the Trust as a place to receive treatment’ received a net promoter score of 23; the question ‘Would you recommend the Trust as a place to work’ received a net promoter score of -32.

Further analysis will be developed with suggested actions being taken forward, and divisional scorecards are under development.

Appraisals remain a key area and an action plan will be discussed and implemented through the Executive Team.

The Board noted the report and approved the next steps to be taken.

14/101 AGENDA ITEM 13 ABSENCE MANAGER SERVICE PILOT
The Board received the update on the Trust’s Absence Manager project and the changes to the scope of the project and governance arrangements.

The Absence Manager system will be rolled out to all directorates within the Trust with the revised proposal of a new ‘targeted implementation strategy’ to ensure the highest areas with absence problems are targeted first. This approach will provide support in driving down absenteeism and also support line managers to embed the new process into their areas.

The project is an enabler in support of the Recovery Programme and an Electronic Staff Record (ESR) data validation exercise has been instigated, due to complete in October 2014.

The new Director of HR and Organisational Development, Janet Wilkinson, is the new Executive Sponsor, a new project manager has been appointed and the project will report to the Workforce and Education sub committee.

The Board noted that the launch of a new Employee Assistance Programme, with a focus on stress management counselling, is being launched in September and that Managers are also being supported through Absence Management workshops.

Part 1 Board of Directors 25 September 2014
Following discussion the Board noted and approved the project and revised governance arrangements.

14/102 AGENDA ITEM 14 GOVERNANCE MANUAL
The Head of Corporate Governance presented an update Governance Manual, V 3.0, which represents part of the UHSM system of internal control.

The Board noted the changes to the Standing Financial Instructions (SFIs), Standards of Business Conduct and the Tender Policy, and that they were approved by the Audit Committee in July 2014.

The Board reviewed and approved the Terms of Reference for the new Quality and Assurance Committee, the Operational Board and the Strategic Development Committee and ratified V3.0 of the Governance Manual.

14/103 AGENDA ITEM 15 GOVERNOR ELECTIONS
UHSM’s Council of Governors currently has a number of vacancies for elected seats and a by-election is being held during autumn to fill these seats. UK Engage have been appointed as the Returning Officer for the election.

The Board noted the communications programme, information sessions and timetable. The term of office for successful candidates will commence on 1st November for a period of three years.

14/104 AGENDA ITEM 15 AUDIT COMMITTEE ANNUAL REPORT
Roger Barlow, Chair of Audit Committee, presented the Annual Report of the Audit Committee to the Board for the financial year 2013/14, inviting comment and note of the work of the Committee.

The Board noted the comprehensive work that has been undertaken during the financial year.

14/105 AGENDA ITEM 15 ANY OTHER BUSINESS
There being no further business the meeting was declared closed.

Signed by the Chairman, Felicity Goodey
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<th>Chief Executive’s report</th>
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<tr>
<td>Board meeting date</td>
<td>25 September 2014</td>
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<tr>
<td>Purpose</td>
<td>To brief the Board on current matters of Trust-wide importance.</td>
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<td>Any communications actions after the meeting.</td>
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<tr>
<td>Report of</td>
<td>Chief Executive</td>
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<tr>
<td>Paper prepared by</td>
<td>Director of Communications and Engagement</td>
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Quality Diamond Updates

Patient Safety and Clinical Outcomes

Healthier Together
The Healthier Together public consultation will finish on Tuesday 30 September 2014. All staff and the public have had a number of ways to provide their views on proposed changes. We firmly believe that Wythenshawe Hospital should be designated as a ‘Specialist Hospital’. We will formally respond to the consultation. I would like to thank all staff, stakeholders and the public for their support during the consultation period.

Speak Out Safely
The Trust is launching a campaign to support staff to raise concerns and give feedback to management. There are already a number of ways that staff can do this e.g. via discussing and escalating things with management, incident reporting, and using the Trust’s whistleblowing procedures. These mechanisms will be reinforced with staff as part of the campaign. In addition the Trust is currently assessing whether an external company called Safeline is commissioned so that staff can report externally also. This has worked well in other organisations locally and gives staff an opportunity to raise serious concerns anonymously. The campaign will be launched in October and communication to staff will be undertaken in a number of ways; team brief, screen saver, posters, team meetings, newsletters, intranet site. This will be an ongoing campaign to ensure staff feel that they can report concerns, that they will be listened to and actions will be fed back to them.

Patient Experience

No delays for 7 days
From Monday 22nd September until Monday 29th September 2014 the Trust will be focusing on seven days of intensive improvement activity that will involve all our staff and external health and social care partners. Our aim is to solve the problems that cause our patients delays in emergency assessment areas such as the Emergency Department or on wards when they are waiting to be discharged. There’s been great support from both clinical, and non-clinical staff, and ‘No delays for 7 days’ will demonstrate the very best of UHSM, working as One Team to deliver the best patient care.

Car Parking
UHSM has a Car Park Management Policy for staff and visitors which applies to Wythenshawe and Withington Hospital sites. The policy is cognisant of the guidance issued by the Department of Health ‘NHS patient, visitor and staff car parking principles’ published 23rd August 2014. In particular:

- Existing patient and visitor concessions have been extended to include an enhanced concession for frequent visitors of long stay patients and patients regularly attending for Out-Patient treatment. Registered disabled drivers, renal patients and cystic fibrosis patients retain their free parking.
- A new ‘pay on foot’ system has been installed to visitor car parks at the: Acute, Nightingale, Nightingale Extension, Cystics, Outpatients, North West Heart Centre and Maternity. This is supported by new barrier equipment and pay stations. They are new generation pay stations which dispense change, provide receipts, have a large screen to inform visitors of the tariff required and will also have the ability to pay by credit or debit cards. Intercom connections with security are available at all pay stations and exit.
barriers. Car parking capacities are relayed to visitors via SPACES/FULL signs at the entrances.

- Existing staff tariffs and salary sacrifice concessions remain unchanged. Staff concessions include free parking for a range of volunteers and visiting consultants, designated spaces for staff with specific medical conditions that require parking close to the building and facilities for staff who have elected to subscribe to the Trust’s Restricted Staff Scheme with designated areas for more convenient parking.
- Visitor barrier access cards are issued to staff to permit their access onto specified visitor car parking areas during evenings and weekends.
- Data on car park usage including peak use/cost of ticket used/concession tickets used etc. is also available from the system. This data will enable the Trust to maximise the efficiency of its parking areas.

PLACE Results
PLACE (Patient-led Assessments of the Care Environment) results were published in August 2014, the scores presented are for four separate domains: cleanliness; food; privacy, dignity and wellbeing; and condition and appearance. Due to the changes in the scoring mechanism for food (which is now weighted) and the assessment criteria for privacy, dignity and wellbeing; the scores for these domains are not directly comparable with the scores for 2013. Compared to neighbouring trusts, UHSM was placed in the following order:

- Sixth for cleanliness, which is a mid range score
- Lowest for food and nutrition, however Dermot Murphy gained a positive score
- Third for privacy and dignity
- Fourth for condition, appearance and maintenance

The Trust’s PLACE results, along with the results from neighbouring trusts, is reported in the table below:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Cleanliness</th>
<th>Food</th>
<th>P&amp;D</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wythenshawe Acute</td>
<td>97.01%</td>
<td>80.51%</td>
<td>92.41%</td>
<td>94.56%</td>
</tr>
<tr>
<td>Buccleuch Lodge</td>
<td>100%</td>
<td>89.05%</td>
<td>76.25%</td>
<td>87.69%</td>
</tr>
<tr>
<td>Dermott Murphy</td>
<td>99.57%</td>
<td>92.68%</td>
<td>88.10%</td>
<td>91.53%</td>
</tr>
<tr>
<td>Tameside Hospital</td>
<td>91.90%</td>
<td>88.87%</td>
<td>82.78%</td>
<td>86.96%</td>
</tr>
<tr>
<td>Salford Royal Trust</td>
<td>99.46%</td>
<td>93.12%</td>
<td>94.20%</td>
<td>98.12%</td>
</tr>
<tr>
<td>Central Manchester Trust</td>
<td>97.48%</td>
<td>89.08%</td>
<td>90.35%</td>
<td>94.83%</td>
</tr>
<tr>
<td>Trafford General</td>
<td>97.02%</td>
<td>84.87%</td>
<td>83.09%</td>
<td>92.31%</td>
</tr>
<tr>
<td>Stockport Trust (Stepping Hill)</td>
<td>96.84%</td>
<td>90.55%</td>
<td>86.03%</td>
<td>91.75%</td>
</tr>
<tr>
<td>Christie</td>
<td>98.69%</td>
<td>95.31%</td>
<td>93.92%</td>
<td>95.99%</td>
</tr>
</tbody>
</table>

(PLACE 2014 Results, HSCIC)

No Smoking Policy
We have reviewed our No Smoking Policy following the recent incident involving e-cigarettes and comments from colleagues. As part of this review we looked at how other organisations approach no smoking on NHS grounds in Greater Manchester; we specifically asked about their approach to smoking shelters. The executive team, however, have reviewed how we monitor and enforce our policy and have agreed to support the enforcement of the policy. The Estates team and Sodexo have agreed with the Executive team the following:-
• Staff, patients and visitors – communication exercise to raise awareness of Trust policy to staff in general (e.g. smoking cessation) and to support ward/department staff in the management of patients who wish to smoke. We will also promote the no smoking environment to visitors through the use of posters and signage in appropriate locations e.g. main entrances and other localised smoking locations.
• Entrances – review the siting of bins and seating to ensure they are appropriately placed e.g. away from office/clinic windows. Additional bins could be funded from PLACE revenue. CSIFM to investigate the option of the use of a mechanised sweeper to improve litter picking and efficiency.
• General – utilise (and publicise) the support of Security should situations arise where visitors are smoking outside offices, etc. and are being confrontational when approached by UHSM staff. We will review the current approach by Security to Smoking Patrols.

An update on the progress against this is to occur in October.

IN THE NEWS

Starlight Secret Garden Opens
Key 103 presenter Darren Proctor officially opened the new sensory garden at UHSM’s Starlight Children’s Outpatients Department on Tuesday 9 September. Thanks to the generosity of Key 103’s listeners, who helped to raise more than £100,000 for the Cash for Kids’ Operation Outpatients appeal, the old courtyard has been transformed into a fantastic, family friendly space, full of life and colour.

Open Day
UHSM is opening its doors to the public for its annual Open Day on Sunday 28th September to celebrate heart, lung and transplant services. The event will be opened by our 1,000th transplant recipient and is open to all the family. The Annual Members’ Meeting begins at 3.00pm and is open to all Foundation Trust members.

GOVERNANCE

CQC Regulations
New regulations setting out fundamental standards of care (CQC) will come into force for all care providers on 1 April 2015. There is currently a consultation ongoing in relation to this – which the Trust will respond to. However, two of the new requirements - the fit and proper person requirements for directors and the duty of candour will come into force for NHS providers on 1st October 2014.

The new fit and proper requirement will apply to all directors and “equivalents”. This will include executive and non-executive directors of NHS trusts and foundation trusts. It will be the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all directors meet the fitness test and do not meet any of the ‘unfit’ criteria. A declaration in writing is required that they are fit and proper individuals for that role. In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors’ disqualification order) and significantly, excluding from office people who: “have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider”.

For organisations already registered with the CQC, the test will be used when a new director is appointed; the fitness of existing directors and a declaration of such may be required where concerns are raised in relation to whether the Trust is deemed to be well led or have serious governance concerns. Monitor/TDA and the CQC will be working in partnership in relation to this.
The Duty of Candour requirements require all NHS trusts by law to ensure that patients/families are informed if they have been involved in a safety incident within the hospital deemed to be moderate or above. Proven breach of this law will result in prosecution. The Trust already has in place duty of candour arrangements following an incident, and breach of this is monitored on a monthly basis by the Board of Directors.
TITLE OF BOARD PAPER

Title of Board paper and link to specific corporate objective

Integrated Performance Report: August 2014
Corporate Objective 2014/15
1. to provide a safe & high-quality clinical service for our patients;
2. to achieve financial stability through delivery of a financial recovery programme;
3. to enhance patient experience and quality of care by ensuring we have the right people, in the right place, at the right time; and
4. to work collectively with our strategic partners.

Board meeting date

25th September 2014

Purpose

The Board is asked to review current performance

Actions Recommended

Discussion / Noting / Decision

Publication

This paper will be published under the UHSM publication scheme

Unusual acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>COSRR</td>
<td>Continuity of Services Risk Rating</td>
</tr>
<tr>
<td>DCIS</td>
<td>Ductal Carcinoma In Situ</td>
</tr>
<tr>
<td>DNA</td>
<td>Did-not-Attend</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends &amp; Family Test</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>GMCCN</td>
<td>Greater Manchester and Cheshire Cancer Network</td>
</tr>
<tr>
<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio</td>
</tr>
<tr>
<td>HSW</td>
<td>Health Support Worker</td>
</tr>
<tr>
<td>HWB</td>
<td>Health and Wellbeing</td>
</tr>
<tr>
<td>ICE</td>
<td>Integrated Clinical Environment</td>
</tr>
<tr>
<td>MRSA</td>
<td>Meticillin-resistant staphylococcus aureus</td>
</tr>
<tr>
<td>MSSA</td>
<td>Meticillin-sensitive Staphylococcus aureus</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
</tr>
<tr>
<td>NPS</td>
<td>Net Promoter Score</td>
</tr>
<tr>
<td>PIR</td>
<td>Post Infection Review</td>
</tr>
<tr>
<td>RAMI</td>
<td>Risk-adjusted Mortality Index</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SHMI</td>
<td>Summary Hospital-level Mortality Indicator</td>
</tr>
<tr>
<td>SI</td>
<td>Serious Incident</td>
</tr>
<tr>
<td>StEIS</td>
<td>Strategic Executive Information System</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
</tr>
</tbody>
</table>

Any communications actions after meeting

None

Report of

John Crampton, Interim Executive Medical Director
Mandy Bailey, Chief Nurse
Jim O’Connell, Interim Chief Operating Officer
Janet Wilkinson, Director of HR & Organisational Development
Nora Ann Heery, Director of Finance

Paper prepared by

Peter Nuttall, Director of Performance & Information
Alan Bromley, Head of Performance
Board of Directors’ Meeting: 25<sup>th</sup> September 2014
Integrated Performance Report 2014/15

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APPENDIX ONE
Staffing levels (Monday to Sunday) by ward for August 2014 20
PATIENT EXPERIENCE OVERVIEW

<table>
<thead>
<tr>
<th>Category</th>
<th>Target</th>
<th>Trust</th>
<th>SCH</th>
<th>UNS</th>
<th>CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints response time</td>
<td>90%</td>
<td>95.1%</td>
<td>92.3%</td>
<td>100.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Dissatisfied complaints (YTD)</td>
<td>N/A</td>
<td>23%</td>
<td>7</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>FFT Net Promoter Score - Inpatients</td>
<td>69</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFT response rate - Inpatients</td>
<td>25%</td>
<td>47.3%</td>
<td>44.3%</td>
<td>52.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>FFT Net Promoter Score - A&amp;E</td>
<td>69</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFT response rate - A&amp;E</td>
<td>15%</td>
<td>13.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*includes a dissatisfied complaint in the Corporate Division

Friends & Family Test: The overall response rate of 47.3% for inpatient surveys, in August 2014, exceeds the Q4 CQUIN target of 40%. At 13.4%, the A&E response rate was below the Q1 CQUIN target of 15%. Inpatient areas continue to perform strongly with an overall NPS of 82 (84 - Scheduled Care and 80 - Unscheduled Care). Wards and departments with low response rates and/or NPS continue to be targeted, linking with other patient-experience measures. The A&E NPS of 58 recorded in August represents an improvement on July’s performance (NPS of 50). The use of different collection methods in A&E is known to affect NPS (modal effect).

Complaints: The Trust responded to 95.1% of formal complaints within the timeframe agreed with complainants; all Divisions except Clinical Support (88.9%) met the 90% target.
PERFORMANCE REPORT: September 2014 Board (August 2014 performance)

### PATIENT SAFETY & CLINICAL OUTCOMES

<table>
<thead>
<tr>
<th>Incident category</th>
<th>No.</th>
<th>Clinical Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Incidents (SI) reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls</td>
<td>1</td>
<td>CH&amp;SC*</td>
</tr>
<tr>
<td>Tissue viability</td>
<td>1</td>
<td>CH&amp;SC*</td>
</tr>
<tr>
<td>Unexpected complication/ outcome of treatment</td>
<td>1</td>
<td>Surgery</td>
</tr>
<tr>
<td>Tissue viability</td>
<td>1</td>
<td>Urgent Care</td>
</tr>
</tbody>
</table>

N/A

*CH&SC - Complex Health & Social Care

#### Slips, trips and falls (Complex Health & Social Care)

A patient was discovered on the floor of Ward F4. A CT scan of the head was normal, however, a fractured right neck-of-femur was identified and care was referred to the Orthopaedic Team. The patient has since died.

#### Tissue viability (Complex Health & Social Care)

A patient with reduced mobility had a newly-acquired category two pressure ulcer identified; the ulcer deteriorated to an unstageable necrotic sacral sore. Gaps have been identified in the patient's pressure-area care.

#### Unexpected complication/ outcome of treatment (Surgery)

A patient with breast cancer had a mastectomy with reconstruction at the Trust in 2011. In August 2014, the patient presented with Ductal Carcinoma In Situ (DCIS) in the reconstructed left breast. A review of the previous surgery has been undertaken.

#### Tissue viability (Urgent Care)

Newly-acquired category two and three pressure sores were identified, which were likely to have existed on admission to hospital; there was no documentation or assurance, however, to confirm this.

Signed off by John Crampton
PERFORMANCE EXCEPTION REPORTS: INTERIM EXECUTIVE MEDICAL DIRECTOR (2 of 3)

Redacted
PERFORMANCE REPORT: September 2014 Board (August 2014 performance)

STAFF ENGAGEMENT (Attract, retain and develop talent)

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>4-month trend</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Induction, rolling 12 months</td>
<td>≥95%</td>
<td>91.22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% mandatory training compliance</td>
<td>≥95%</td>
<td>85.13%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ISSUE - Trust Induction
91.2% of staff who were required to do so completed Trust Induction over the last twelve months to August 2014, which is below the 95% threshold set locally. Performance is expected to return to around 95% next month.

ISSUE - Mandatory Training
Mandatory-training compliance in August 2014 was 85.13%, which is significantly below the 2013/14 target of 95%, but meets the revised 85% target.

PROPOSED ACTIONS
A significant number of changes are being made to mandatory training, which include the way that compliance is reported and disseminated:

- A revised target of 85% has been approved with reporting mechanisms being developed to deliver this by the end of September 2014;
- the Mandatory Training Competency Checker allows staff to check their mandatory training compliance;
- a detailed action plan is in place to address other issues and provide a timeline for changes to mandatory training content; and
- a number of new mandatory topics have been introduced and these will be monitored from September.

ASSESSING IMPROVEMENT
The monthly exception reports to the Board demonstrate whether the action plan is improving compliance rates across the Trust.

Expected date to meet target: September 2014
Signed off by: John Crampton
PERFORMANCE EXCEPTION REPORTS: CHIEF NURSE (1 of 3)

PATIENT SAFETY & CLINICAL OUTCOMES (Reduce avoidable harm)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Trajectory (Cumulative)</th>
<th>4-month trend</th>
<th>Performance (Cumulative)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA - actual cases YTD</td>
<td>0</td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**ISSUE**

The Trust reported a pre-48 hour MRSA bacteraemia in August 2014. Following a multi-disciplinary Post-Infection Review (PIR), involving the provisional assigned organisation (NHS South Manchester CCG) and the assisting organisations (Public Health Manchester and Pennine Care FT - Trafford Division) the blood culture was defined as a contaminant. The blood-culture specimen was positive for MRSA due to contamination of the sample during collection and did not represent a true infection; contaminants are assigned to the organisation where the specimen sample was taken. The Trust last reported a post-48 hour case of MRSA bacteraemia in February 2014.

**PROPOSED ACTIONS**

- Post-Infection Review (PIR) has been completed;
- local action plan developed for UHSM and Pennine Care FT following learning points identified for both organisations;
- action plan disseminated to responsible parties within the Trust; and
- follow-up meeting with Manchester Public Health and Pennine Care FT proposed to sign off completed actions.

**ASSESSING IMPROVEMENT**

- Action plan to be on October’s agenda of the Infection Prevention Sub-committee.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>0</td>
</tr>
<tr>
<td>May-14</td>
<td>0</td>
</tr>
<tr>
<td>Jun-14</td>
<td>0</td>
</tr>
<tr>
<td>Jul-14</td>
<td>0</td>
</tr>
<tr>
<td>Aug-14</td>
<td>1</td>
</tr>
<tr>
<td>Year-to-date</td>
<td>1</td>
</tr>
</tbody>
</table>

Expected date to meet target: September 2014

Signed off by: Mandy Bailey
PERFORMANCE EXCEPTION REPORTS: CHIEF NURSE (2 of 3)

PATIENT SAFETY & CLINICAL OUTCOMES (Reduce avoidable harm)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Target</th>
<th>Trend (last 4 points)</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of inpatients who undergo a nutritional assessment within 24 hours of admission</td>
<td>≥95%</td>
<td>82.86%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ISSUE**

95% of inpatients are expected to be nutritionally assessed using the Malnutrition Universal Screening Tool (MUST) within 24 hours of admission. In August 2014, twenty-nine patients (82.9%) received a nutritional risk assessment within 24 hours of admission. Of the seven wards audited, four were found to be fully compliant, whilst two of the wards recorded low scores; these were ward A5 (50%) and ward F14 (60%). Both wards have previously received extra support and ward-based training. Ward A5 is looking at using redesigned paperwork, similar to that used on Ward A3, which achieved 100% compliance when audited.

**PROPOSED ACTIONS**

- nutritional screening assessments have been incorporated into the monthly Safety Thermometer, which is completed at ward level giving wards increased ownership of nutritional screening;
- continue spot check audits to ensure importance of nutrition screening is emphasised;
- communication material to support use of the improved screening tool and accompanying care plan will be printed shortly;
- continued provision of training as part of nursing induction and on any ward where requested;
- nutrition screening is part of the Ward Accreditation Programme;
- results are sent out to ward matrons and managers quarterly; and
- extra training and support agreed with new staff on wards F14 and A5.

**ASSESSING IMPROVEMENT**

Training and support at ward level continues. Safety Thermometer data is evaluated each month to identify trends and target intervention.

---

Expected date to be on trajectory: September 2014
Signed off by: Mandy Bailey

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PERFORMANCE REPORT: September 2014 Board (August 2014 performance)
PERFORMANCE EXCEPTION REPORTS: CHIEF NURSE (3 of 3)

PATIENT EXPERIENCE (Positive experience of care)

Friends & Family Test Net Promoter Score (NPS) - A&E

<table>
<thead>
<tr>
<th>Target</th>
<th>Trend (last 4 points)</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>top 20%</td>
<td><strong>58</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ISSUE
The Trust has set an objective in 2014/15 to be within the top twenty percent of acute hospital trusts for the Friends and Family Test, which is measured using the Net Promoter Score (NPS). In August 2014, the NPS for responses recorded in A&E (NPS of 58) was outside the top twenty percent of acute trusts* (NPS of 69). The response rate of 13.4% for the Friends and Family Test in A&E was below the Quarter 1 CQUIN target of 15%. It is second consecutive month that this target has not been met. A response rate of at least 20% is required for A&E at the end of Quarter 4.

*measured using Quarter 1 (2014/15) performance for acute hospital trusts in England

PROPOSED ACTIONS
- the patient-experience lead for the Friends and Family Test has discussed possible solutions with A&E leads to urgently address the low response rate;
- the Matron for A&E will ensure that paper questionnaires are handed to every patient on discharge from the Department;
- additional frontline volunteers will support staff with the paper questionnaires;
- completed questionnaires will be reviewed by the Patient Experience Team on a daily basis; and
- an option to switch from SMS messaging to a ‘home call’ option, which has been shown to increase response rates, will be considered at the end of October 2014.

ASSESSING IMPROVEMENT
Paper questionnaire response rates and NPS will be monitored on a daily basis. Staff awareness of the Friends and Family Test has improved as results and comments are now displayed in the Department.

Expected date to be on trajectory | Q3 2014/15 | Signed off by | Mandy Bailey

PERFORMANCE REPORT: September 2014 Board (August 2014 performance)
# PERFORMANCE EXCEPTION REPORTS: INTERIM CHIEF OPERATING OFFICER (1 of 5)

## VALUE FOR MONEY (Outpatient & theatre productivity)

<table>
<thead>
<tr>
<th>% outpatient appointments with the outcome ‘did-not-attend’</th>
<th>Target</th>
<th>4-month trend</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✽≤7.5%</td>
<td></td>
<td>8.25%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ISSUE

The Trust's overall Did-Not-Attend (DNA) rate increased from 7.9% to 8.25% in August 2014, which is above the target of 7.5%. The DNA rate for both new and follow-up appointments was 8.25%. This is a significant improvement on the position at the same time last year (new DNA rate of 9.4% and follow-up DNA rate of 9.8%).

### PROPOSED ACTIONS

- carry out a review of specialties with high DNA rates, particularly in Unscheduled Care, to target specific outpatient clinics;
- contact patients who did not turn up for their appointment to understand the reasons for their non-attendance. Develop an action plan to further reduce DNAs based on patient feedback;
- work with our local commissioning groups on choice for first outpatient appointment and develop closer working relationships with schedulers and referral management services in primary care.

### ASSESSING IMPROVEMENT

Outpatient DNA rates are monitored via the monthly divisional Performance Review Panels and through the outpatient work stream, which is part of the Financial Recovery Programme.

---

**Expected date to meet target**: December 2014  
**Signed off by**: Jim O'Connell

---

**7.0%**  
**7.5%**  
**8.0%**  
**8.5%**  
**9.0%**  
**9.5%**  
**10.0%**

% did-not-attend

<table>
<thead>
<tr>
<th>trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-13</td>
</tr>
<tr>
<td>May-13</td>
</tr>
<tr>
<td>Jun-13</td>
</tr>
<tr>
<td>Jul-13</td>
</tr>
<tr>
<td>Aug-13</td>
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<tr>
<td>Sep-13</td>
</tr>
<tr>
<td>Oct-13</td>
</tr>
<tr>
<td>Nov-13</td>
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<tr>
<td>Dec-13</td>
</tr>
<tr>
<td>Jan-14</td>
</tr>
<tr>
<td>Feb-14</td>
</tr>
<tr>
<td>Mar-14</td>
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<tr>
<td>Apr-14</td>
</tr>
<tr>
<td>May-14</td>
</tr>
<tr>
<td>Jun-14</td>
</tr>
<tr>
<td>Jul-14</td>
</tr>
<tr>
<td>Aug-14</td>
</tr>
</tbody>
</table>
VALUE FOR MONEY (Outpatient & theatre productivity)

% of elective patients cancelled for non-clinical reasons at the last minute

<table>
<thead>
<tr>
<th>Target</th>
<th>4-month trend</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤0.8%</td>
<td>1.54%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ISSUE
Fifty-five operations were cancelled at the last minute, for non-clinical reasons in August 2014, which equates to a cancellation rate of 1.54%. This is an improvement on the previous month when the cancellation rate was 2.04%. The top-five cancellation reasons in August were list overrun, emergency/trauma took priority, no ICU/HDU bed available, clinical administrative error and administrative error.

PROPOSED ACTIONS
The following actions have been put in place to ensure all non-clinical cancellations are kept to a minimum:

- an escalation process is in place to ensure appropriate action is taken to address late starts, unavailable ward beds, and equipment issues leading to list overruns;
- a root-cause analysis is carried out for each administrative (clinical and otherwise) with a remedial action plan put in place;
- anaesthetic-led pre-op clinics have commenced, which ensure the optimal work-up of high-risk patients prior to admission;
- a booking and scheduling tool will be introduced in October 2014 to optimise scheduling of lists and to reduce the number of cancellations due to list overruns;
- an escalation process is in place when ICU/HDU bed capacity is an issue; and
- a requirement for additional trauma/emergency theatre capacity is being assessed as part of the Theatre work stream of the Recovery Programme.

ASSESSING IMPROVEMENT
Reducing clinical and non-clinical cancellations is a key project within the Theatre work stream of the Recovery Programme. Progress will be managed by the Theatre Work stream Group and reported to the Recovery Board.

Expected date to meet target: November 2014
Signed off by: Jim O'Connell

Performance Exception Reports: Interim Chief Operating Officer (2 of 5)

Cancellation reasons (top-5), Aug-14 & 14-15 YTD

<table>
<thead>
<tr>
<th>Cancellation reason</th>
<th>Aug-14</th>
<th>14-15 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>List overrun</td>
<td>14</td>
<td>59</td>
</tr>
<tr>
<td>Emergency took priority</td>
<td>10</td>
<td>62</td>
</tr>
<tr>
<td>No ICU/HDU bed</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Clinical admin error</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>Administrative error</td>
<td>6</td>
<td>22</td>
</tr>
</tbody>
</table>

Cancellations by specialty (top-5), Aug-14 & 14-15 YTD

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Aug-14</th>
<th>14-15 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>23</td>
<td>68</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>6</td>
<td>72</td>
</tr>
<tr>
<td>Urology</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4</td>
<td>23</td>
</tr>
</tbody>
</table>
PERFORMANCE EXCEPTION REPORTS: INTERIM CHIEF OPERATING OFFICER (3 of 5)

PATIENT EXPERIENCE (Deliver all access targets)

<table>
<thead>
<tr>
<th>% of patients waiting less than six weeks from referral for a diagnostic test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>Trend (last 4 points)</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>≤1%</td>
</tr>
<tr>
<td>Forecast</td>
</tr>
<tr>
<td>Performance (Aug-14)</td>
</tr>
<tr>
<td>≤1%</td>
</tr>
<tr>
<td>Forecast</td>
</tr>
<tr>
<td>Performance (Sep-14)</td>
</tr>
<tr>
<td>≤1%</td>
</tr>
</tbody>
</table>

**ISSUE**

There is a national standard, supported by a financial penalty, for waiting times for diagnostic procedures. In August 2014, 3.42% of UHSM’s patients waited longer than six weeks for a diagnostic procedure against the 1% threshold. The failure was the result of 72 breaches of neurophysiology tests (a service conducted at UHSM by clinicians employed by Salford Royal) and 29 Colonoscopy tests. Colonoscopy is on track to recover by the end of October 2014.

**PROPOSED ACTIONS**

- as the Peripheral Neurophysiology service is provided under a Service Level Agreement (SLA) with Salford Royal, the service manager has been asked to provide additional neurophysiology consultant sessions;
- an increase from four to six consultant sessions per week was negotiated in May 2014, however, Salford has unilaterally reduced the number of sessions to five per week, following job planning. The SLA will be reviewed with the new service manager at Salford Royal;
- Salford clinicians have been asked to undertake waiting-list initiatives as a short-term measure;
- recruitment is underway for a Neurophysiology Booking Manager to manage capacity and demand within the service using an electronic booking system (bookings are currently kept in paper diaries);
- the endoscopy service has negotiated the return of endoscopy booking to the Endoscopy Unit, where it will be managed locally under the leadership of the nurse lead. This should increase the scrutiny of bookings and maximise slot utilisation as specialist knowledge is applied to the booking process;
- The endoscopy service is recruiting a Booking and Capacity Manager to increase slot utilisation and the use of lists that are cancelled due to leave; and
- the Medical Specialties Directorate is exploring the purchase of a bespoke endoscopy booking system.

**Diagnostic test**

- Peripheral Neurophysiology: 72
- Colonoscopy: 29
- Gastroscopy: 10
- CT: 8
- Other: 19
- **Total**: 138

**Expected date to be on trajectory**: November 2014

**Signed off by**: Jim O’Connell
PERFORMANCE EXCEPTION REPORTS: INTERIM CHIEF OPERATING OFFICER (4 of 5)

PATIENT EXPERIENCE (Deliver all access targets)

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Trend (last 4 points)</th>
<th>Performance (Jul-14)</th>
<th>Forecast (Aug-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-day wait for second or subsequent treatment comprising surgery</td>
<td>≥94%</td>
<td>93.33%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ISSUE

UHSM achieved all national cancer standards in July 2014 with the exception of the 31-day wait for second or subsequent treatment (surgery) and the 62-day wait from referral-to-treatment and the. Performance of 93.33% (30 treatments and 2 breaches) for the 31-day standard (surgery) was marginally below the 94% threshold. Capacity constraints of the required surgeon impacted on the two breaches of second and subsequent treatment (surgery) target in August - one in Lung and one in Head & Neck.

The number of treatments has reduced from an average of 53.6 in 2013/14 to 34.8 in the four months to July 2014. The Trust expects to achieve this cancer standard in August 2014 and Quarter 2.

PROPOSED ACTIONS

- the Interim Divisional Director for Scheduled Care has revised the escalation process and chairs a weekly performance meeting where booked breaches are discussed if the escalation process has not resulted in action; and
- a review of second and subsequent treatment numbers will be carried out to understand why (and where) the treatment numbers have reduced.

ASSESSING IMPROVEMENT

Performance is monitored at the weekly PTL meetings, led by Cancer Services, and at the fortnightly access meetings, which are chaired by the Director of Performance & Information.

Expected date to be on trajectory: August 2014

Signed off by: Jim O’Connell

Cancer std. compliance

31-day second/ subsequent (surgery) performance

<table>
<thead>
<tr>
<th></th>
<th>Treatments</th>
<th>Breaches</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>49</td>
<td>1</td>
<td>97.9%</td>
</tr>
<tr>
<td>May-14</td>
<td>36</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>24</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Jul-14</td>
<td>30</td>
<td>2</td>
<td>93.33%</td>
</tr>
</tbody>
</table>
PERFORMANCE EXCEPTION REPORTS: INTERIM CHIEF OPERATING OFFICER (5 of 5)

PATIENT EXPERIENCE (Deliver all access targets)

<table>
<thead>
<tr>
<th>62-day wait from referral for treatment for all cancer patients (GMCCN reallocation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
</tr>
<tr>
<td>Performance (Jul-14)</td>
</tr>
<tr>
<td>Forecast (Aug-14)</td>
</tr>
<tr>
<td>≥85%</td>
</tr>
<tr>
<td>82.31%</td>
</tr>
</tbody>
</table>

ISSUE

UHSM achieved all national cancer standards in July 2014 with the exception of the 62-day wait from referral-to-treatment and the 31-day wait for second or subsequent treatment (surgery). Performance of 81.76% (74 treatments and 13.5 breaches) for the 62-day standard, which is calculated using the GMCCN breach re-allocation rules, was below the 85% threshold. The Trust expects to achieve the 62-day cancer standard in August 2014. For the second month running, the Trust has seen a high number of patient choice and clinically complex breaches. The thirteen-and-a-half breaches were spread over seven tumour groups.

<table>
<thead>
<tr>
<th>Tumour group</th>
<th>Breaches</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>1</td>
<td>Patient with a pleural effusion, which prevented treatment in date</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1</td>
<td>Breach due to surgical capacity</td>
</tr>
<tr>
<td>Skin</td>
<td>1</td>
<td>Patient choice (no adjustment allowed)</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>Patient choice (no adjustment allowed)</td>
</tr>
<tr>
<td>Lower &amp; Upper GI</td>
<td>4</td>
<td>Combination of patient choice, delays in diagnostics, endoscopy capacity delays, co-morbidities, repeat diagnostics and parallel management with The Christie</td>
</tr>
<tr>
<td>Lung</td>
<td>3</td>
<td>Clinical complexity such as pleural effusion, warfarin, change of treatment plan based on diagnostic results and patient choice delays in the diagnostic phase</td>
</tr>
<tr>
<td>Haematology</td>
<td>2</td>
<td>Multiple teams involved in patient management and multiple diagnostics required to reach a diagnosis and treatment plan</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROPOSED ACTIONS

The Interim Divisional Director for Scheduled Care has established a weekly performance meeting to review cancer escalation, expedite responses and facilitate communication between cancer services and directorate teams.

62-day wait from referral to treatment for all cancer patients (GMCCN reallocation)

<table>
<thead>
<tr>
<th>Tumour group</th>
<th>Breaches</th>
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<td>Urology</td>
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</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROPOSED ACTIONS

The Interim Divisional Director for Scheduled Care has established a weekly performance meeting to review cancer escalation, expedite responses and facilitate communication between cancer services and directorate teams.
Breach pathways will continue to be reviewed between the directorate and Cancer Services Team to improve tracking, escalation and capacity planning.

**ASSESSING IMPROVEMENT**

Performance is monitored at the weekly PTL meetings, led by Cancer Services, and at the fortnightly access meetings, which are chaired by the Director of Performance & Information.

<table>
<thead>
<tr>
<th>Expected date to be on trajectory</th>
<th>August 2014</th>
<th>Signed off by</th>
<th>Jim O'Connell</th>
</tr>
</thead>
</table>
PERFORMANCE REPORT: September 2014 Board (August 2014 performance)

STAFF ENGAGEMENT (attract, retain & develop talent)

<table>
<thead>
<tr>
<th>Time to hire from advert to conditional offer (days)</th>
<th>Target</th>
<th>Trend (last 4 points)</th>
<th>Performance (Aug-14)</th>
<th>Forecast (Sep-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>32.8 days</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

ISSUE
The Trust has set an objective, in 2014/15, to reduce the time to hire (1) from advert to conditional offer (30 days) and (2) from conditional offer to unconditional offer (25 days). In August 2014, the time to hire from advert to conditional offer of 32.8 days was above the 30-day threshold. Several factors contributed to this position:

- extended scheduling of interviews during the summer to accommodate interview panellists’ and candidates’ annual leave;
- recruiting managers seeking to appoint above the approved FTE requiring further approval (and causing delays);
- high volume of activity for doctors’ rotation and foundation doctors; and
- supporting the two-day nurse recruitment event in Dublin.

In addition, the Recruitment Team, which is currently without a senior manager, experienced absence during August due to sickness with colleagues providing cross-cover within the Team.

PROPOSED ACTIONS
- recruitment to the Recruitment Manager post - expected start date 6th October;
- recruitment of additional Recruitment Co-ordinator - commenced in post on 3rd September;
- a plan is in place to further mitigate against expected sickness absence within the Recruitment Team during September; and
- review of recruitment process/workflow planned in October, to better accommodate future fluctuations in demand.

ASSESSING IMPROVEMENT
Improved capacity and reduced demand following doctors’ rotation has already seen an improvement; 31.2 days for the period 1st to 16th September. However extended interview scheduling during the holiday season has continued into September. Performance in relation to the ‘Time-to-Hire’ will be monitored fortnightly.

Expected date to be on trajectory: October 2014
Signed off by: Janet Wilkinson
PERFORMANCE REPORT: September 2014 Board (August 2014 performance)

VALUE FOR MONEY (Achieve financial stability)

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Performance (Aug-14)</th>
<th>Forecast (year-end)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Cost Improvement Plan (% of plan)</td>
<td>£25.8m</td>
<td>91%</td>
<td>87%</td>
</tr>
</tbody>
</table>

ISSUE
The Trust’s CIP Programme for the five months to August 2014 is behind plan by £0.81m due, primarily, to slippage in the Medical Workforce Scheme. The job-planning process is still underway with final savings due to be confirmed at the end of this process, in October 2014.

PROPOSED ACTIONS
The Trust is iterating a number of schemes with Deloitte, which are being reported at Recovery Board. The output of this work will be confirmed in October 2014 and reported to the Board for approval.

Year-end position: £22.4m (87%)
Signed off by: Nora Ann Heery
# APPENDIX ONE: Staff Levels (Monday to Sunday) by Ward for August 2014

The table below details all ward staffing at UHSM for August 2014. The areas highlighted in red indicate a staffing fill rate of <85%. Details of actions implemented by the Heads of Nursing are also provided. Staffing deficits continue to be identified on a daily basis through the agreed escalation process and staffing huddles. Risk assessments are performed accordingly. 21% of wards across the organisation describe the <85% staffing measurement. The following shifts indicated in red as <85% are; 33% early shift, 33.9% late shift, 25.6% night shift. Areas demonstrating an overall % total fill rate of <85 are; A1, A2, A7, C2, CDU, CCU, F2/ F5, F2 lung and POU.

| Ward                      | Planned Early | Planned Mid | Planned Late | Actual Early | Actual Mid | Actual Late | % Fill Rate Early | % Fill Rate Mid | % Fill Rate Late | Planned Midnight | Actual Midnight | % Fill Rate Midnight | Planned Night | Actual Night | % Fill Rate Night | Planned Total | Actual Total | % Fill Rate Total | Actions                                                                 |
|---------------------------|---------------|-------------|--------------|--------------|------------|-------------|-------------------|-----------------|-----------------|------------------|----------------|----------------|----------------------------|---------------|--------------|----------------|-------------------------------------------------------------------------|
| A1                        | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | 98%            | 96%          | 97%                        | Submitted claims, reduced call outs, revised care plans                  |
| A2                        | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| A7                        | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| C2                        | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| CDU                       | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| CCU                       | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| F2/LUNG                   | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| POU                       | 118           | 103         | 100          | 116           | 101         | 100          | 97.6%             | 94.5%           | 94.5%           | 93.3%           | 94.9%         | 95.0%                      | 98.5%         | 96.8%        | 97.0%                      | Submitted claims, reduced call outs, revised care plans                  |
| **Total**                 | **955**       | **801**     | **801**      | **955**       | **801**     | **801**      | **95.5%**         | **94.4%**       | **94.4%**       | **93.3%**       | **94.9%**     | **95.0%**                   | **98.5%**     | **96.8%**   | **97.0%**                   | Submitted claims, reduced call outs, revised care plans                  |

Performance indicators: 
- 21% of wards across the organisation describe the <85% staffing measurement. 
- 33% early shift, 33.9% late shift, 25.6% night shift. 
- Areas demonstrating an overall % total fill rate of <85 are: A1, A2, A7, C2, CDU, CCU, F2/ F5, F2 lung and POU.

**Actions:** 
- Submitted claims, reduced call outs, revised care plans.
<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
</table>
| Title of Board paper and link to specific corporate objective. | Director of Finance Report – Month 5 (August 2014)  
To achieve a continuity of service risk rating of 2 and deliver the savings required in the financial recovery plan. |
| Board meeting date                               | 25th September 2014                                                     |
| Purpose                                          | To update the Board on the Month 4 financial position of the Foundation Trust as at 31st August 2014 |
| Actions Recommended                              | Discussion / Noting / Decision                                           |
| Publication                                      | This paper will not be published in full under the UHSM publication scheme due to exemptions under S43 (2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust. A redacted summary report will be published on the UHSM website within 3 weeks of the meeting. |
| Unusual acronyms                                 | CCG – Clinical Commissioning Group  
CIP – Cost Improvement Programme  
COSRR – Continuity Of Services Risk Rating  
EBITDA – Earnings Before Interest, Tax, Depreciation and Amortisation  
HEE – Health Education England  
HIV – Human Immunodeficiency Virus  
NAC – National Aspergillosis Centre  
PbR – Payment by Results  
PDC – Public Dividend Capital  
PMO – Project Management Office  
RTA - Road Traffic Accident  
RTT – Referral to Treatment Time |
| Any communications actions after the meeting.    |                                                                         |
| Report of Paper prepared by                      | Nora Ann Heery, Director of Finance  
Finance Team |
Finance Performance Report
Month 05
For the YTD Period ending
31st August 2014
1.0 Executive Summary (for publication)

Summary of Performance
The Trust year to date position for the period ending 31st August 2014 is a normalised deficit of £0.3m after adjusting for exceptional items, which is £0.2m worse than plan. This financial performance generates a Continuity of Service Risk Rating (COSRR) of level 1 which is in line with plan for the 5 month period. This performance represents an in month deterioration of £0.1m largely attributed to slippage on delivery of CIP. Pay pressures continue to be a concern, albeit, these have been partially offset ytd by strong performance on income. There remains a significant risk in future periods due to a forecast gap in CIP of £3.5m and underlying pay pressures. The Trust continues to work on contingency plans to address this gap but there remains a risk to the delivery of the plan in full in year.

Key I&E issues:
• Pay overspend linked to bank & agency.
• CIP slippage re: Medical Productivity and Corporate Schemes
• Higher than plan costs associated with the Recovery Plan implementation costs
• Partially off-set by strong clinical income performance in Outpatients, Critical Care and A&E.

Forecast Outturn
• Given the forecast CIP shortfall of £3.5m and the current level of pay overspend achievement of plan at year end remains a key risk.

Key Risks and Remedial Action
• Full year CIP delivery – the development of contingent schemes with Deloitte is on-going to mitigate this risk but this has not been satisfactorily resolved. This work will conclude by the end of October.
• Control over bank & agency expenditure – this continues to be managed through the recently establishment of weekly bank and agency usage reporting and tighter controls on usage. There has been an improvement in the run rate as of Month 5 however further efforts will be required to continue this trend.

Key Balance Sheet Issues:
• Cash is above plan due to cash held on behalf of hosted services.
• Year to date capital expenditure is £0.4m below plan due to slippage on equipment replacement and LTVS schemes.

<table>
<thead>
<tr>
<th>Summary Income &amp; Cash Flow Vs Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£M</strong></td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Expenditure</td>
</tr>
<tr>
<td>EBITDA</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
</tr>
<tr>
<td>Exceptional Items</td>
</tr>
<tr>
<td>Normalised Surplus/(Deficit)</td>
</tr>
<tr>
<td>EBITDA %</td>
</tr>
<tr>
<td>CapEx</td>
</tr>
<tr>
<td>Cash &amp; Equiv</td>
</tr>
<tr>
<td>CIP % OpEX Less PFI</td>
</tr>
<tr>
<td>COSRR</td>
</tr>
</tbody>
</table>
## PART 1 AGENDA ITEM 8 PAPER D

| Title of Board paper and link to corporate objective | Significant Strategic Risk Register
Links to all corporate objectives |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Board meeting date</td>
<td>25th September 2014</td>
</tr>
<tr>
<td>Purpose</td>
<td>To appraise the Board of Directors of the Trust significant risks and updates.</td>
</tr>
<tr>
<td>Actions Recommended</td>
<td>Discussion and approval</td>
</tr>
<tr>
<td>Publication</td>
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<tr>
<td>Report of</td>
<td>Director of Risk &amp; Governance 0161 291 5762</td>
</tr>
<tr>
<td>Paper prepared by</td>
<td>Director of Risk &amp; Governance</td>
</tr>
</tbody>
</table>
1. SUMMARY NARRATIVE

This is an update of all significant risks on the Board strategic risk register. As per the revised risk management processes, the Board will receive a monthly update on all red risks (i.e. those scored >15) and any changes that have been made to the strategic risk register. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis. This paper has been written following discussion at Executive Directors and Quality & Assurance Committee.

1.1 NEW/EMERGING SIGNIFICANT RISK

There are no new significant strategic risks to report to the Board.

A risk currently being assessed as to whether it warrants inclusion on the strategic risk register, which has been flagged to Quality & Assurance Committee and Board, is the risk in relation to Carbapenemase Producing Enterobacteriaceae (CPE). This will be reviewed with the Chief Nurse and reported to Quality & Assurance Committee in October 2014, with any updates to the next Board meeting.

1.2 CHANGES TO RISKS ON THE STRATEGIC RISK REGISTER

1.2.1 Reduction of residual risk score

**Risk:** A failure to establish an effective Southern Sector Partnership (including Tameside NHS FT), caused by insufficient engagement and/or commitment of partners, disagreement between parties or insufficient models of care, resulting in benefits of Southern Sector Partnership not being realised.

**Executive Lead:** Chief Executive

**Current Residual Risk Rating:** 15 (Impact- 5, Likelihood-3)  
**Current Target Risk Rating:** 10 (Impact- 5, Likelihood-2)

**Recommended Residual Risk Rating:** 12 (Impact- 4, Likelihood-3)  
**Recommended Target Risk Rating:** 8 (Impact- 4, Likelihood-2)

**Rationale for reduction in residual risk score:** Given the consultations ongoing regarding Healthier Together and some of the progress being made in relation to workstreams e.g. procurement of IT, Pathology etc., the impact of this is recommended to be reduced.

**Risk:** Reduced complement of substantive executives and operational managers in place and newly appointed interims may result in lack of strategic and operational focus, inconsistency in leadership and lack of corporate/Trust knowledge, resulting in focusing on short term solutions

**Executive Lead:** Chief Executive

**Current Residual Risk Rating:** 16 (Impact- 4, Likelihood-4)  
**Current Target Risk Rating:** 4 (Impact- 4, Likelihood-1)

**Recommended Residual Risk Rating:** 1 (Impact- 4, Likelihood-3)  
**Recommended Target Risk Rating:** 4 (Impact- 4, Likelihood-1)

**Rationale for reduction in residual risk score:** The Trust has recruited a Chief Operating Officer and appointed two Divisional Directors of Operations. Full substantive executive team will be in place following the substantive recruitment of the Trust Medical Director. This risk will be continuously reviewed.
1.2.2 Recommendation for archiving/filing of risks

**Risk:** The FT may not act, and respond to, complaints appropriately and in a timely manner in accordance with the NHS (Complaints) Regulation 2004, resulting in breach of regulatory requirements and reduced experience for patients and/or their families/carers.

**Executive Lead:** Chief Nurse  
**Residual Risk Rating:** 12 (Impact- 4, Likelihood-3)  
**Target Risk Rating:** 8 (Impact- 4, Likelihood-2)

**Rationale for archiving/filing of risk:** The Trust performance shows that the response targets for complaints have been met for two consecutive months and processes are in place at the divisional governance level. This risk will be reviewed on a weekly basis at Executive Team Meeting, where response rates are reviewed as a Quality Key Performance Indicator and if performance goes off track, the risk will be escalated.

1.2.3 Changes to wording of risks

**Risk:** Not realising potential of Cardiac JV, caused by lack of mutually agreed vision between interested parties, resulting in patients not having access to enhanced care pathways and the Trust not fulfilling clinical priorities, as outlined within the 5 year plan.

**Revised wording of risk:** Not realising the potential of the proposed changes to complex cardiac services in Greater Manchester, caused by lack of mutually agreed vision between interested parties, resulting in patients not having access to enhanced care pathways and the Trust not fulfilling clinical priorities, as outlined within the 5 year plan.

**Executive Lead:** Chief Executive  
**Residual Risk Rating:** 12 (Impact- 4, Likelihood-3)  
**Target Risk Rating:** 8 (Impact- 4, Likelihood-2)

**Rationale for changing wording of risk:** Changed wording of risk from ‘Not realising potential of Cardiac JV’ to ‘Not realising the potential of the proposed changes to complex cardiac services in Greater Manchester’ due to the fact that the JV is not yet the agreed vehicle for taking this review of services forward.

2. **NOTABLE UPDATES TO SIGNIFICANT RISKS**

The following gives notable updates since the significant risks were last presented to the Board of Directors. To note in addition as at the time of writing this report: all actions against significant strategic risks on the Board risk register are on track for delivery.

| RISK: Failure to achieve the financial recovery plan, as outlined within the Trust's 5-Year Plan, which may result in a potential breach of the Trust's license. |
| UPDATE: Deloitte are undertaking a review of the Trust’s recovery plans. Whilst this has identified a £16m gap across the 2 years, Deloitte have recognised there is likely to be sufficient contingency to bridge the gap in 14/15 in the first instance. The Board will receive a separate recovery report at the meeting. |

| RISK: The Trust does not meet a range of access targets, including A&E target, caused by increased demand and/or failure to discharge patients to manage demand, resulting in decreased patient experience and potential for the Trust being in significant breach of its terms of authorisation. |
| UPDATE: The Emergency Improvement Plan is in place and being monitored at Operational Board and Executive Directors. An update of this plan will be given to October Operational Board. The Trust is launching ‘No Delays for 7 Days’ w/c 22nd September and this will enable clinical and .... |
management leads to assess where some of the potential inefficiencies are within the system to look at sustainable service improvement.

In addition the Executive Team have been closely monitoring performance in relation to Referral to Treatment long waits and cancer targets. Data has shown that the Trust failed the 62 day (reallocation) and subsequent 31 day (surgery) cancers targets in July. Scrutiny of performance and improvement plans continue on a weekly basis to ensure that the Trust does not fail the quarter in relation to these targets.

**RISK**
Failure to provide adequate nursing staffing levels in some wards caused by wards not having required establishments and inability to fill vacancies which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.

**UPDATE:**
Benchmarking data for safe staffing (available on NHS Choices) shows the Trust to be an outlier in Greater Manchester for registered nursing fill rates versus planned staffing. A nurse staffing update will be given to the Board at this meeting.

**RISK**
The potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, associated with measures required to reduce UHSM’s cost base.

**UPDATE:**
The Trust has commenced pulse surveys with staff on a regular basis and when Q2 results are analysed, an action plan will be put in place. In addition staff engagement strategy is being developed by the newly appointed Director of HR and the newly appointed Organisational Development team.

**RISK**
UHSM not being designated specialist site, caused by impact of Healthier Together consultation, resulting in potential unintentional consequences impacting on local care delivery.

**UPDATE:**
The Trust are compiling the formal response to the consultation to be submitted by the end Sept 14.

**RISK:**

**UPDATE:**

...
**RISK:**
Reduction in quality of service provided as a result of the Trust's recovery plan, which may result in patient harm, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners.

**UPDATE:**
Quality & Assurance Committee will receive a report with updated quality key performance indicators and a quality monitoring dashboard to October’s meeting.

3. CONSIDERATION

Members of the Board of Directors are invited to:

- Approved the Changes to the Strategic Risk Register since the previous review
- Note the significant risks and any updates.

APPENDIX 1- STRATEGIC SIGNIFICANT RISK REGISTER
<table>
<thead>
<tr>
<th>Risk</th>
<th>Residual Risk Rating</th>
<th>Target Risk</th>
<th>Risk Change from last review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to achieve the financial recovery plan, as outlined within the Trust's 5-Year Plan, which may result in a potential breach of the Trust's licence.</td>
<td>20</td>
<td>10</td>
<td>Risk Score Unchanged</td>
</tr>
<tr>
<td>The Trust does not meet a range of access targets, including A&amp;E target, caused by increased demand and/ or failure to discharge patients to manage demand, resulting in decreased patient experience and potential for the Trust being in significant breach of its terms of authorisation.</td>
<td>20</td>
<td>12</td>
<td>Risk Score Unchanged</td>
</tr>
<tr>
<td>Failure to provide adequate nursing staffing levels in some wards caused by wards not having required establishments and inability to fill vacancies which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.</td>
<td>16</td>
<td>12</td>
<td>Risk Score Unchanged</td>
</tr>
<tr>
<td>The potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, associated with measures required to reduce UHSM’s cost base.</td>
<td>16</td>
<td>8</td>
<td>Risk Score Unchanged</td>
</tr>
<tr>
<td>UHSM’s IT infrastructure is insufficient to meet the needs of the Trust, its commissioners or major stakeholders such as GPs  potentially leading to patient safety issues, inefficient clinical and working practices,  loss of reputation and/or market share.</td>
<td>15</td>
<td>10</td>
<td>Risk Score Unchanged</td>
</tr>
<tr>
<td>UHSM not being designated specialist site, caused by impact of Healthier Together consultation, resulting in potential unintentional consequences impacting on local care delivery.</td>
<td>15</td>
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<td>Reduction in quality of service provided as a result of the Trust's recovery plan, which may result in patient harm, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners.</td>
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</table>

<table>
<thead>
<tr>
<th>Title of Board paper and link to corporate objective</th>
<th>UHSM Health and Safety Strategy: Aug 2014-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>To provide a safe and high quality clinical service for our patients</td>
</tr>
<tr>
<td></td>
<td>People and Processes - to enhance patient experience and Quality of Care by ensuring we have the right people, in the right place, at the right time, with the right skills and attitude</td>
</tr>
<tr>
<td>Board meeting date</td>
<td><strong>25th</strong> September 2014</td>
</tr>
<tr>
<td>Purpose</td>
<td>To appraise the Board of Directors of the Trust’s Health and Safety Strategy for the next two years, and the minor changes made since its approval by QAC in August 2014.</td>
</tr>
<tr>
<td>Actions Recommended</td>
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<td>Head of Risk, Compliance and Assurance</td>
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</table>
1. The new two-year Health and Safety strategy was approved by the QAC in August 2014. This identified a number of objectives in four main work-streams:
   - Achieve an open, responsive, inclusive and proactive safety culture.
   - Ensure that an effective schedule of safety inspections is in place, and that findings are managed and reported appropriately.
   - Ensure that appropriate and proportionate investigation of H&S accidents is undertaken, and that findings are reported and actioned.
   - Have positive assurance in relation to UHSM’s H&S policies, and from PFI partners in relation to H&S training and incident management.

2. In the light of outcomes of some early actions, some of the objectives and timescales have been adjusted to ensure the strategy is practicable. This was in consultation with the substantive Health and Safety manager on her return from maternity leave. These adjustments are as follows:

2.1 **KPI – participation of SSRs in 20% of Safety Inspections from Aug to Dec 2014.**

   Review identified that UHSM has only four SSRs, and that a number of unions are not represented. As another KPI was for the H&S team to increase the number of inspections during this period, it was not going to be possible to achieve 20% participation rate. The focus for the period to December will now be to recruit additional SSRs, and then work to achieve participation in safety inspections during 2015.

   Accordingly, the related KPIs for the period Jan to Aug 2015, and Aug 2015-16, have been amended to 25%, and 50% respectively (from 50% and 80%).

2.2 **KPI – to have a plan for development of additional H&S training packages.**

   This deadline for this has been amended from Oct to Nov 2014, due to other priorities and the H&S manager returning on part-time hours.

2.3 **Action – identify staff to participate in inspections and any training needs.**

   This deadline has been amended from Oct to Dec 2014, reasons as above.

2.4 **KPI – All RCA investigations completed as schedule**

   The target date has been moved from Nov to Dec 2014, as review showed that there are currently 14 investigations outstanding.

2.5 **KPI – All expired policies reviewed by the stated period as evidenced on the policy database**

   The target date has been moved from Mar to Jul 2015, in accordance with the target date for all Trust policies, as approved by the Executive Team.

3. The Revised Health and Safety Strategy is presented for Board approval.
UHSM HEALTH and SAFETY STRATEGY

To enable all those who use, visit or work in UHSM, including patients, visitors, staff, volunteers, and contractors, to benefit from active health & safety management, and an effective health & safety culture that helps ensure we have the right people, in the right place, at the right time, with the right skills and attitude.

Prepared by:
Ursula Martin; Director of Governance & Risk, and
Katharine Thorley; Head of Risk, Compliance & Assurance
August 2014
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<th>CONTENTS</th>
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<td>3 Our Vision for Effective H&amp;S Management</td>
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<td>4 Our Goals</td>
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<td>5 Our Work-streams</td>
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<td>5.1 Safety culture</td>
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<td>5.2 H&amp;S inspections</td>
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<tr>
<td>5.3 H&amp;S incident investigation</td>
<td>9</td>
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<td>5.4 Controls &amp; Assurance</td>
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<td>6 Key Performance indicators</td>
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<td>6.1 Year 1</td>
<td>11</td>
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<td>6.2 Year 2</td>
<td>12</td>
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<tr>
<td>7 Appendix – Action plan</td>
<td>13</td>
</tr>
</tbody>
</table>
1. Foreword

The Board of Directors and Senior Management at UHSM recognise that a healthy workforce and safe environment is vital to us achieving our vision.

We are determined to transform health & safety culture and practices by developing and embedding a leading health and safety management system. We will develop our culture and safety management system to be capable of driving continuous improvement in health and safety throughout UHSM, but also capable of adaptation to remain fit for purpose as circumstances, legislation or operating priorities change. We have therefore set ambitious and challenging objectives over the next two years to deliver our goals.

We aspire to achieve an outstanding and continuously improving safety record: to rank amongst the safest healthcare providers and employers in England and beyond in recognition of everyone’s commitment to make UHSM a safer place.

UHSM is a great place to receive treatment and to work. With your leadership, dedication, and shared passion for safety we can make it safer and more efficient. We can reduce and, in some cases, eliminate harm from preventable accidents at work.

I am delighted to introduce our Health & Safety Strategy, and I am looking forward to engaging with all colleagues, partners and stakeholders to see the benefits of providing a safer working environment realised for patients, colleagues, and all those who use or visit our services.

Attila Vegh; Chief Executive Officer.
We operate in a highly diverse and expanding healthcare market, providing care to patients in a variety of settings, and offering a wide range of services and treatments. We can improve UHSM's performance and productivity by maintaining a safe environment where people work or receive treatment. This requires commitment from all staff to managing their own safety, and the safety of others, effectively, and by UHSM promoting healthier lifestyles and managing employee health, safety and wellbeing needs. Providing a safe and healthy workplace and workforce for all those who use our services is our primary concern.

Research has shown that a safe and healthy workplace and workforce is beneficial to organisations in the following ways:

- improving patient safety, by reducing staff absence from work \(^4,5\)
- improving the quality and efficiency of our services, by providing a safe working environment, and reducing harm to our colleagues \(^1,4,5\)
- enhancing employee relations, by involving our colleagues in safety issues \(^2,5\)
- improving employees’ morale and attendance \(^2,5\) \(^3,5\)
- improving reputation and relationships with external stakeholders, commissioners and regulators \(^5\)
- saving money, by reducing work activity related incidents resulting in absence from work, and reduce injury compensation claims \(^3,4,5\)
3. Our Vision for Effective Health & Safety Management

We will be unstinting in our determination to deliver this vision.

To realise the benefits for our patients, colleagues and others working at UHSM, we will focus our efforts in particular on four core work-streams:

- **Safety Culture**
- **Health and Safety Surveillance**
- **Learning from Accident Investigation**
- **Controls and Assurance on Safe Processes**

UHSM believes in a reasonable and proportional approach to practising health and safety; an approach which enables managers, colleagues, partners and contractors to deliver outstanding service for patients.

To deliver our vision, we will adopt shared values, beliefs, attitudes and practices to implement a range of achievable objectives relating to the four core work-streams: safety culture; health & safety inspections; accident investigations; and controls & assurance.
4. Our Goals

Our goals are to:

1. Achieve an open, responsive, inclusive and proactive safety culture, where potential Health and Safety issues are recognised; people are empowered to make them safe; and everyone is open to reporting, feedback, learning and challenge.

2. Ensure that an effective schedule of health and safety surveillance inspections is in place, and that findings are risk-assessed, managed and reported appropriately.

3. Ensure that appropriate and proportionate investigation of H&S accidents is undertaken, that the investigation findings are reported, and that appropriate actions are implemented in respect of lessons learned.

4. Have positive assurance in relation to UHSM’s H&S policies, and from PFI partners in relation to H&S training and incident management

We recognise that everyone has a part to play as ‘one talented team’ to improve safety performance and help UHSM to realise its potential.

We will be unrelenting in our efforts to reduce or where possible eliminate harm: we do not accept that harm is inevitable.

We have set objectives to be delivered over the next two years to achieve our goals, and enable the benefits to be realised.

The main objectives in each of the four work-streams to achieve these goals are set out below. The detailed action plan is attached at the appendix.
5. Our Work-streams

Achieve an open, responsive, inclusive and proactive safety culture, where potential H&S issues are recognised; people are empowered to make them safe; and everyone is open to reporting, feedback, learning and challenge.

The main objectives in this work-stream are to:

- Increase staff-side representative (SSR) involvement in H&S
- Increase safety champion representative involvement in H&S
- Review Safety Culture survey, and undertake new survey to ascertain latest position
- Improve staff H&S training and awareness of current issues in UHSM

These will be achieved by ensuring that:

- SSR are able to participate in local health and safety inspections
- There are regular meetings of SSRs, attended by all reps at the frequency agreed, with reporting of minutes to HSW committee.
- A system is in place to ensure SSRs are up to date with training.
- There are effective safety champions (SC) in place across UHSM, active in supporting H&S agenda.
- A SC forum is established, with meeting schedule and format agreed, and an active work-plan.
- Key points of SC meetings are reported to HSWC to ensure effective reporting of issues and integration of work-plan.
- Results of staff survey are analysed and reported to relevant committees and staff members.
- Improvement actions are identified from the results, and implemented.
- Regular short briefings are provided for to staff on current H&S issues within UHSM
- A series of longer campaigns, focusing on high-risk areas and hazards Trust-wide, will be in place
- A suite of training packages related to key areas of H&S, as identified by a training needs analysis, is in place.
- Mandatory training requirements for H&S are agreed.
Ensure that an effective schedule of **safety inspections** is in place, and that findings are managed and reported appropriately.

**The main objectives in this work-stream are to:**

- Have an electronic template for H&S inspections in place.
- Ensure all areas of the Trust have a H&S inspection each year.
- Have a process in place to ensure that actions arising from inspections are followed up.
- Improve reporting of findings from safety inspections

**These will be achieved by ensuring that:**

- The Health and Safety inspection template is reviewed, and available electronically to facilitate review and analysis of data.
- Inspections are carried out in accordance with the agreed rolling programme of inspection, to ensure that all areas of the Trust are inspected each year.
- Actions are identified, appropriately risk-rated, and sent to relevant managers.
- Where necessary, risk assessments are re-opened from file, and reviewed while actions are progressing.
- Actions not reported as completed are followed up and escalated when necessary.
- A summary of inspection findings and actions are reported routinely to the HSWC.
Ensure that appropriate and proportionate investigation of H&S accidents is undertaken, and that findings are reported and actioned.

The main objectives in this work-stream are to:

- Improve completion of H&S RCA investigation
- Improve reporting of RCA investigation findings and provide information for shared learning.
- Improve the quality and extent of H&S incident investigations

These will be achieved by ensuring that:

- All RCA investigations into cat C incidents or above will be completed within the required timeframe.
- Information on RCA findings will reported to HSWC
- Key issues to be incorporated into staff safety culture briefings
- All HIRS investigations are completed and closed within the required time-frame
- ‘Prompt’ questionnaires for other common categories of accident, will be in place to assist managers in investigations
Have **positive assurance** in relation to UHSM’s H&S policies, and from PFI partners in relation to H&S training and incident management.

The main objectives in this work-stream are:

- To ensure UHSM has all the H&S policies that are required, and these are up to date.

- To ensure UHSM has assurance from Sodexo that their staff H&S training complies with Trust standards.

- To ensure UHSM has assurance from Sodexo that their incident reporting, investigation and feedback of findings complies with Trust standards.

These will be achieved by ensuring that:

- All existing H&S policies and working procedures are in-date, and up to date, reflecting current work processes and legislation

- All required H&S policies that are currently not in place, will be written.

- Sodexo’s reports to UHSM give assurance re the quality and completion of mandatory H&S training of Sodexo’s employees.

- Sodexo’s reports to UHSM give assurance re the rigour of incident reporting, investigation and feedback of findings.

References:
# 6. Key Performance Indicators

## Year 1

<table>
<thead>
<tr>
<th>Safety culture</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up-to-date list of SSRs in place, with role description completed.</td>
<td>End Aug ’14</td>
</tr>
<tr>
<td>Participation of SSR in 25% of all safety inspections Jan to Aug ’15.</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>SSR meetings established, and attendance monitored</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>Minutes of SSR meetings received at all HSW Committee</td>
<td>End Jan’15</td>
</tr>
<tr>
<td>SSRs to have attended 50% of meetings to Aug ’15.</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>System is in place to ensure SSR are up to date with training.</td>
<td>End Dec ’14</td>
</tr>
<tr>
<td>Up-to-date list of safety champions in place, with role description completed.</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>SC meetings established, and attendance monitored.</td>
<td>End Mar’15</td>
</tr>
<tr>
<td>SCs to have attended 50% of meetings, Apr to Aug 2015</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>Feedback from SC meetings provided to HSW committee as agreed</td>
<td>End Apr ’15</td>
</tr>
<tr>
<td>Revised safety culture survey documentation completed.</td>
<td>End Dec ’14</td>
</tr>
<tr>
<td>Survey available to staff on UHSM intranet</td>
<td>Jan ’15</td>
</tr>
<tr>
<td>Safety culture survey report completed and action plan developed.</td>
<td>End Mar ’15</td>
</tr>
<tr>
<td>Safety culture action plan (2015) in progress and on track to Aug’15</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>Monthly communication dedicated to health and safety (Feb to Aug ’15)</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>Plan for Safety campaigns completed</td>
<td>End Jan ’15</td>
</tr>
<tr>
<td>Campaign publications run as schedule, Apr to Aug ’15</td>
<td>End Aug ’15</td>
</tr>
<tr>
<td>Plan for developing training packages, with timescales is completed</td>
<td>End Nov ’14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety inspections</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>New safety inspection template is in place</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>Revised safety inspection programme (Aug to Oct 2014) is completed</td>
<td>8 Aug ’14</td>
</tr>
<tr>
<td>H&amp;S manager / interim H&amp;S advisor have each undertaken two inspections per week Aug to Oct 2014</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>Programme Nov ’14-Oct’15 is agreed</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>H&amp;S Inspection report format, spreadsheet and process for monitoring actions is in place</td>
<td>End Oct ’14</td>
</tr>
<tr>
<td>All actions past their due-by date are identified and escalated in accordance with process</td>
<td>End Nov ’14</td>
</tr>
<tr>
<td>Reports submitted to each HSW Committee summarise inspection findings.</td>
<td>End Apr’15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIRS investigation</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Database of all RCA investigation shows completion of all within the required time frame.</td>
<td>End Dec ’14</td>
</tr>
<tr>
<td>RCA feedback report to each HSW committee, or as agreed.</td>
<td>End Jan ’15</td>
</tr>
<tr>
<td>Prompt sheets developed, incorporated into the safeguard system if possible</td>
<td>End Jan ’15</td>
</tr>
<tr>
<td>Prompt sheets used in 50% of HIRS investigations Apr to Aug ’15</td>
<td>End Aug ’15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controls &amp; Assurance</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule for review of H&amp;S policies completed</td>
<td>End Aug ’14</td>
</tr>
<tr>
<td>All expired policies reviewed by the stated period as evidenced on policy database</td>
<td>End Jul ’15</td>
</tr>
<tr>
<td>PFI Report template and content agreed</td>
<td>End Dec ’14</td>
</tr>
<tr>
<td>PFI report to HSWC includes staff training compliance data, and detailed incident investigation findings</td>
<td>End Jan ’15</td>
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### Year 2

<table>
<thead>
<tr>
<th>Success measure</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety Culture</strong></td>
<td></td>
</tr>
<tr>
<td>Participation of SSR in 50% of all safety inspections from Aug 2015.</td>
<td>Aug ’16</td>
</tr>
<tr>
<td>SSRs to have attended 80% of SSR meetings from Aug ’15.</td>
<td>Aug ’16</td>
</tr>
<tr>
<td>SCs to have attended 80% of meetings, from Aug 2015</td>
<td>Aug ’16</td>
</tr>
<tr>
<td>Safety culture action plan (2015) implemented and completed.</td>
<td>End Dec ‘15</td>
</tr>
<tr>
<td>Monthly communication dedicated to health and safety continued from Aug ’15</td>
<td>Aug ’16</td>
</tr>
<tr>
<td>Campaign publications run as schedule, continued from Aug ’15</td>
<td>Aug ’16</td>
</tr>
<tr>
<td>Suite of H&amp;S elearning packages, as agreed, available on Trust training website</td>
<td>End Dec ‘15</td>
</tr>
<tr>
<td><strong>Inspec</strong></td>
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<tr>
<td>All areas within the Trust have had H&amp;S inspection Nov 2014-Oct 2015</td>
<td>End Oct ’15</td>
</tr>
<tr>
<td><strong>HIRS</strong></td>
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<tr>
<td>Prompt sheets used in 80% of HIRS investigations from Aug ’15</td>
<td>Aug ’16</td>
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</tbody>
</table>

*Date of Review: March 2016*
### 7. Appendix – Action plan


<table>
<thead>
<tr>
<th>Objective</th>
<th>Current Status</th>
<th>Target status</th>
<th>Actions required</th>
<th>Resp/y of Target</th>
<th>Target date</th>
<th>Success measurement</th>
<th>Result / date</th>
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</thead>
<tbody>
<tr>
<td><strong>Safety Culture</strong></td>
<td>Increase staff side rep involvement in H&amp;S</td>
<td>Insufficient SSR involvement in Health and Safety inspection due to not being released.</td>
<td>Staff reps are able to participate in local health and safety inspections. Clarify who the staff side reps are, that they wish to continue, and clarify role description. Seek agreement from HR regarding reasonable time to be spent on staff side rep duties Liaise with line managers of staff reps to ensure that SSR are released to carry out their responsibilities as expected</td>
<td>Interim H&amp;S advisor</td>
<td>End Aug 2014</td>
<td>Up-to-date list of SSRs in place, with role description completed.</td>
<td>End Aug 2014</td>
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<td></td>
<td>There is no delegated person to lead staff side reps, and no regular meetings are taking place.</td>
<td>Regular meetings of SSR, attended by all reps at the frequency agreed, with reporting of minutes to HSW committee.</td>
<td>Appoint a lead person to chair SSR meetings. Set up schedule of meetings at a frequency agreed by the SSR and HSW committee, with attendance monitored</td>
<td>Interim H&amp;S advisor</td>
<td>End Oct 2014</td>
<td>Participation of SSR in 25% of all safety inspections Jan to Aug 2015.</td>
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<td>Participation of SSR in 50% of all safety inspections from Aug 2015.</td>
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<td>SSRs to have attended 50% of meetings to Aug 2015.</td>
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<td>SSRs to have attended 80% of meetings from Aug 2015.</td>
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<td>Date of Review: March 2016</td>
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<tr>
<td><strong>Safety Culture</strong></td>
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<tr>
<td>Increase safety champion involvement in H&amp;S</td>
<td>There are no checks to ensure SSR complete their required training</td>
<td>System is in place to ensure SSR are up to date with training.</td>
<td>Identify SSR, and establish system</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
<td>System is in place to ensure SSR are up to date with training.</td>
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<td></td>
<td>Safety champions nominated but currently many inactive due to lack of leadership and focus.</td>
<td>Effective safety champions in place across UHSM, active in supporting H&amp;S agenda.</td>
<td>Clarify who the safety champions are, that they wish to continue, and clarify role description.</td>
<td>Interim H&amp;S advisor</td>
<td>End Oct 2014</td>
<td>Up-to-date list of safety champions in place, with role description completed.</td>
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<td></td>
<td>There is currently no forum to meet with SC and discuss any major issues of concern</td>
<td>SC forum is established with meeting schedule and format agreed, and active workplan. Key points of SC meetings reported to HSWC to ensure effective reporting of issues and integration of workplan.</td>
<td>Agree on meeting schedule and format, and on attendance rates</td>
<td>Health and Safety Advisor</td>
<td>End Mar 2015</td>
<td>SC meetings established, and attendance monitored.</td>
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<td>Ensure meetings take place according to schedule, with appropriate agenda/discussion, and SCs actively encouraged to attend</td>
<td>Health and Safety Advisor</td>
<td>End Dec 2015</td>
<td>SCs to have attended 50% of meetings to Aug 2015</td>
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<td>Agree the feedback required by and with HSW committee, and establish system to ensure this is provided.</td>
<td>Health and Safety Advisor</td>
<td>End Mar 2015</td>
<td>SCs to have attended 80% of meetings from Aug 2015</td>
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<td>Feedback from SC meetings provided to HSW committee as agreed. Apr to Dec 2015</td>
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<td></td>
<td>Review Safety Culture survey, and undertake new survey to ascertain latest position</td>
<td>There is an annual safety culture survey in the Trust but results are not reported to relevant committees or staff members. Appropriate improvement actions are identified, and implemented.</td>
<td>Results of survey are analysed and reported to relevant committees and staff members. Appropriate improvement actions are identified, and implemented.</td>
<td>Review and revise existing survey content and parameters</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
<td>Revised safety culture survey documentation completed.</td>
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<td>Roll out survey for a period of one month, supported by appropriate communications.</td>
<td>Health and Safety Manager</td>
<td>Jan 2015</td>
<td>Survey available to staff on UHSM intranet</td>
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<td>Review and analyse data, and report back to relevant committees and to staff.</td>
<td>Health and Safety Manager</td>
<td>End Mar 2015</td>
<td>Safety culture survey report completed.</td>
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<td>Develop appropriate action plan in response to survey findings.</td>
<td>Health and Safety Manager</td>
<td>End Mar 2015</td>
<td>Action plan developed.</td>
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<tr>
<td>Safety Culture</td>
<td>Ensure action plan is monitored and implemented</td>
<td>Health and Safety Manager</td>
<td>End Dec 2015</td>
<td>Safety culture action plan completed. Apr to Dec 2015</td>
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<tr>
<td>Improve staff H&amp;S training and awareness of current issues in UHSM</td>
<td>Ensure action plan is monitored and implemented</td>
<td>H&amp;S Manager, Comms manager</td>
<td>End Jan 2015 and on-going</td>
<td>Monthly communication dedicated to health and safety Feb ’15 to Aug ’16</td>
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<tr>
<td>There is little focus on H&amp;S issues using UHSM’s communication strategies,</td>
<td>Regular short briefings to staff on current H&amp;S issues within UHSM</td>
<td>Agree format and schedule for monthly H&amp;S information bulletin to staff</td>
<td>End Jan 2015</td>
<td>Safety culture action plan completed. Apr to Dec 2015</td>
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<tr>
<td>Series of longer campaigns focusing on high-risk areas and hazards Trust-wide</td>
<td>Plan campaigns prioritised as indicated by HIRS and staff accident data</td>
<td>H&amp;S Manager, Comms manager</td>
<td>End Jan 2015</td>
<td>Safety culture action plan completed. Apr to Dec 2015</td>
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<tr>
<td>Begin campaigns as plan (first is provisionally “clean as you go” focusing on prevention of STF - depending on review of HIRS)</td>
<td>H&amp;S Manager, Comms manager</td>
<td>End Jan 2015</td>
<td>Safety culture action plan completed. Apr to Dec 2015</td>
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<tr>
<td>There is good H&amp;S induction included in the corporate induction day, and an overarching elearning training, but insufficient subject-specific H&amp;S training packages</td>
<td>Suite of training packages related to key areas of H&amp;S, as identified by a training needs analysis, is in place. Mandatory training requirements for H&amp;S are agreed.</td>
<td>Identify the training requirements for employees to decide which individual packages need to be developed, and the order of priority</td>
<td>End Nov 2014</td>
<td>Safety culture action plan completed. Apr to Dec 2015</td>
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<tr>
<td>An electronic template for H&amp;S inspections is in place.</td>
<td>The Health and Safety inspection template has been reviewed but is in paper format.</td>
<td>Review H&amp;S inspection template incorporating all the health and safety hazards, and liaise with Head of Clinical Effectiveness to create electronic version. This will incorporate appropriate ‘RAYG’ rating of actions.</td>
<td>Health and Safety Manager,</td>
<td>Suite of H&amp;S elearning packages, as agreed, available on Trust training website</td>
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<tr>
<td>The Health and Safety inspection template has been reviewed but is in paper format.</td>
<td>Health and Safety inspection template to be electronic to facilitate review and analysis of data</td>
<td>Develop individual training packages as indicated above, in association with specialist advisors</td>
<td>Health and Safety Manager,</td>
<td>Suite of H&amp;S elearning packages, as agreed, available on Trust training website</td>
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<tr>
<td>Safety Inspections</td>
<td>Safety Inspections</td>
<td>Safety Inspections</td>
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</table>

**Date of Review: March 2016**

15/19
<table>
<thead>
<tr>
<th>Safety Inspections</th>
<th>All areas of the Trust have a H&amp;S inspection each year.</th>
<th>Inspections are being undertaken, but insufficient in number, and not all areas are inspected each year. There is a significant backlog on current plan</th>
<th>All areas of the Trust have a H&amp;S inspection each year.</th>
<th>Processes are in place to ensure that actions arising from inspections are followed up.</th>
<th>Actions from inspections are not followed up adequately to ensure completion</th>
<th>Actions are identified, appropriately risk-rated, and sent to relevant managers</th>
<th>Actions are identified, appropriately risk-rated, and sent to relevant managers</th>
<th>Review current programme of H&amp;S inspections and draw up plan for Aug to Oct, prioritising on high-risk areas.</th>
<th>Review current programme of H&amp;S inspections and draw up plan for Aug to Oct, prioritising on high-risk areas.</th>
<th>H&amp;S manager / interim H&amp;S advisor</th>
<th>Aug to Oct 2014</th>
<th>Revised programme (Aug to Oct 2014) is completed</th>
<th>8 Aug 2014</th>
<th>H&amp;S manager / interim H&amp;S advisor have each undertaken two inspections per week Aug to Oct 2014 8 Aug 2014'14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inspections are carried out in accordance with the agreed rolling programme of inspection, to ensure that all areas of the Trust are inspected each year.</td>
<td>Inspections are carried out in accordance with the agreed rolling programme of inspection, to ensure that all areas of the Trust are inspected each year.</td>
<td>Inspections are carried out in accordance with the agreed rolling programme of inspection, to ensure that all areas of the Trust are inspected each year.</td>
<td>Undertake priority inspections as agreed plan.</td>
<td>Undertake priority inspections as agreed plan.</td>
<td>Undertake priority inspections as agreed plan.</td>
<td>Undertake priority inspections as agreed plan.</td>
<td>Draw up programme of inspections for year Nov 2014-Aug 2015</td>
<td>Draw up programme of inspections for year Nov 2014-Aug 2015</td>
<td>Health and Safety Manager</td>
<td>End Oct 2014</td>
<td>Programme Nov 2014-Aug 2015 is agreed</td>
<td>8 Aug 2014</td>
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<tr>
<td></td>
<td>Identify appropriate staff to participate in inspections within the Trust, and circulate programme to them.</td>
<td>Identify appropriate staff to participate in inspections within the Trust, and circulate programme to them.</td>
<td>Identify appropriate staff to participate in inspections within the Trust, and circulate programme to them.</td>
<td>Identify any training needs for staff participating in inspections and ensure this is delivered.</td>
<td>Identify any training needs for staff participating in inspections and ensure this is delivered.</td>
<td>Identify any training needs for staff participating in inspections and ensure this is delivered.</td>
<td>Identify any training needs for staff participating in inspections and ensure this is delivered.</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
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<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Lead inspections as agreed plan</td>
<td>Inspection report format to be agreed and issued as part of the inspection visit</td>
<td>Inspection report format to be agreed and issued as part of the inspection visit</td>
<td>Health and Safety Manager</td>
<td>End Oct 2014</td>
<td>Inspection report format is in place</td>
<td>8 Aug 2014</td>
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<td></td>
<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
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<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
<td>Create spreadsheet on H&amp;S shared drive to monitor progress of actions</td>
<td>Establish process to identify actions past their due-by date</td>
<td>Establish process to identify actions past their due-by date</td>
<td>Health and Safety Manager</td>
<td>End Oct 2014</td>
<td>Spreadsheet is in place</td>
<td>8 Aug 2014</td>
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<td>Establish process to identify actions past their due-by date</td>
<td>Establish process to identify actions past their due-by date</td>
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<td>Establish process to identify actions past their due-by date</td>
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<td>Establish process to identify actions past their due-by date</td>
<td>Establish process to identify actions past their due-by date</td>
<td>Health and Safety Manager</td>
<td>End Oct 2014</td>
<td>Process is in place</td>
<td>8 Aug 2014</td>
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<tr>
<td>Action</td>
<td>Description</td>
<td>Progress</td>
<td>Responsible</td>
<td>Due Date</td>
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<tr>
<td>Safety Inspections</td>
<td>Improve reporting of findings from safety inspections</td>
<td>No information is provided to committee summarising inspection findings / confirming completion of actions</td>
<td>A summary of inspection findings and actions are reported routinely to the HSWC</td>
<td>Design format of report, and agree input required from others including specialist advisors and estates staff. To include assurance re completion of actions.</td>
<td>Health and Safety Manager</td>
<td>End Mar 2015</td>
<td>Reports submitted to each HSW Committee summarise inspection findings. Apr 2015 and ongoing</td>
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<tr>
<td>Investigation of H&amp;S accidents</td>
<td>Improve completion of H&amp;S RCA investigation</td>
<td>There is no systematic process in place to check the progress of RCA investigations into staff accidents, and a number remain uncompleted.</td>
<td>All RCA investigations into cat C incidents or above will be completed within the required timeframe.</td>
<td>Establish process to ensure that RCAs falling behind time-frame are identified and managers are reminded as appropriate. Assist line managers where and when necessary</td>
<td>Health and Safety Advisor</td>
<td>End Dec 2014 and ongoing</td>
<td>Database of all RCA investigation shows completion of all within the required time frame.</td>
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<tr>
<td>Investigation of H&amp;S accidents</td>
<td>Improve reporting of RCA investigation findings and provide information for shared learning.</td>
<td>No information is reported to the HSWC or to Trust staff on findings and learning after an RCA has been completed.</td>
<td>Information on RCA findings will reported to HSWC</td>
<td>Information on RCA findings will reported to HSWC</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
<td>RCA feedback report to each HSW committee, or as agreed. Jan 2015 and ongoing</td>
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<tr>
<td>Investigation of H&amp;S accidents</td>
<td>Controls and Assurance</td>
<td>Date of Review: March 2016</td>
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<tr>
<td>Improve quality and extent of H&amp;S HIRS investigations</td>
<td>UHSM has all the H&amp;S policies that are required, and these are up to date.</td>
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<td>Local HIRS investigations (resulting in lost time of less than 7 days) are not closely monitored, and some are not closed.</td>
<td>A number of H&amp;S related policies have expired and need updating.</td>
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<td>Some policies that are required are not in place and need development</td>
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<td>All existing H&amp;S policies and working procedures are in-date, and up to date, reflecting current work processes and legislation.</td>
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<td>All required H&amp;S policies that are currently not in place, will be written.</td>
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<td>All HIRS investigations will be completed and closed within the required time-frame. ‘Prompt’ sheets for other common categories of accident, will be in place to assist managers in investigations.</td>
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<td>completion of mandatory H&amp;S training of Sodexo’s employees.</td>
<td>Liaise with Sodexo managers to agree report template to ensure that mandatory training compliance figures are included in Sodexo’s report to HSWC.</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
<td>Report template and content agreed</td>
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<td>staff H&amp;S training complies with Trust standards</td>
<td>Currently UHSM has no assurance re the rigour of incident reporting, investigation and feedback of findings: reports from Sodexo (soft and hard FM) are not sufficiently detailed.</td>
<td>Sodexo’s reports to UHSM give assurance re the rigour of incident reporting, investigation and feedback of findings.</td>
<td>Liaise with Sodexo managers to agree report template to ensure that investigation findings – themes, trends and actions taken – are included in Sodexo’s report to HSWC.</td>
<td>Health and Safety Manager</td>
<td>End Dec 2014</td>
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<td>Dementia Strategy 2014-2017</td>
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<td>Purpose</td>
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<td>Report of</td>
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<td>Paper prepared by</td>
<td>Kimberley Salmon-Jamieson – Deputy Chief Nurse</td>
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Introduction

UHSM’s guiding principle is to deliver high quality, person-centred care to people identified or assessed as having known or suspected dementia.

‘Living well with dementia: The National Dementia Strategy’ (2009) outlined key actions to improve the quality of life for people with dementia and their carers. ‘Quality outcomes for people with dementia: building on the work of the National Dementia Strategy’ (2010) described four priority areas:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication.

These four priorities need to be bolstered by improvements in community support services to support early intervention, prevent premature admission to care homes and reduce inappropriate hospital admission and length of stay.

From this national lead, UHSM has identified 6 strategic aims:

1. Deliver patient-centred care that supports people with known, or suspected, dementia and their carers
2. Become a “Dementia Friendly” organisation
3. Develop a highly skilled dementia aware workforce
4. Champion improvements in dementia care at all levels of the organisation
5. Work in collaboration with partner organisations
6. Actively participate in research and audit to maintain and improve standards

This strategy is based upon best practice and national guidance including NICE Clinical Guideline 42 and Quality Statements 1 and 30. The Trust aspires to be fully compliant with this guidance.
We understand that dementia does not only affect the person with the condition but also the people around them. It is important that we do our utmost to identify and support carers, establishing relationships with other agencies like Admiral Nurses and the Carers Trust, so that we can signpost families and carers to support networks. All wards will have a Dementia Champion and a leaflet has been produced that is available in all wards and departments to signpost to other organisations. We actively seek feedback from patients about their experiences of being in hospital and from carers about having a loved one in hospital. We currently send two surveys after discharge, to all patients known to have dementia. One survey for them to complete and one for their carers to complete. The results of the survey help to identify areas where improvements could be made, as well as highlighting examples of good practice which should be shared. Some feedback has also been received through the relationships we are building with other organisations like the Admiral Nurses.

By 2014, all people living with dementia in England should be able to say:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get treatment and support which are best for my dementia, and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I’m inspired to give something back
- I am confident my end of life wishes will be respected. I can expect a good death
- I get treatment and support which are best for my dementia, and my life

We believe that it is vital to include people in planning their care while in hospital and to support them in making plans for their future care. We are committed to assisting people with known, or suspected, dementia to achieve the outcome statements outlined in “Quality outcomes for people with dementia: building on the work of the National Dementia Strategy” (2010).
What we need to do:

- Ensure all people over 75, admitted as an emergency to the hospital, are asked about their memory
- Prompt referral to memory services for investigation of symptoms of dementia
- Ensure those concerned about dementia will know where to go for help
- Promote the concept that a person can live well with dementia
- Ensure information and support is available to everyone affected by dementia in a format, and at a time, that best suits them
- Use individual biography, including religious beliefs and spiritual and cultural identity, to provide individual patient-centred care
- Integrate health and social care planning for appropriate, timely, supported discharge.

How we plan to do it:

- Ensure every ward/department has a Dementia Champion
- Ensure systems are in place to prompt staff to ask people about their memory
- Facilitate the liaison psychiatry service
- Introduce and develop initiatives that improve the quality of patient care like the Dining Companions, individualised care plans, Forget-Me-Not cards
- Ensure all carers receive the “Information Leaflet For Carers”
- Signpost people and carers to community organisations that may also provide support like the Admiral Nurses
- Use feedback, through our surveys, from people with dementia and their carers, about their experience of hospital admissions to inform improvement action plans.

How we will measure success:

- Audit of quality initiatives
- Feedback from people with dementia and their carers.
As a member of the Dementia Action Alliance we are striving to become a dementia friendly organisation, one that understands the needs of people with dementia and strives to meet them effectively and compassionately. Dementia is a significant part of the Ward Accreditation Scheme that is being rolled out across the hospital. A successful bid to The King’s Fund Enhancing the Healing Environment project has ensured several wards have been transformed into Dementia Friendly Areas and work continues to improve the environment across the hospital and promote meaningful activity.

What we need to do:

- Progress the ‘Enhancing the Healing Environment’ work
- Ensure dementia has a significant presence and assessment in the Ward Accreditation Scheme.

How we plan to do it:

- Regularly audit individual areas
- Use compliments and feedback from surveys to drive improvements.

How we will measure success:

- Independent evaluation of the ‘Enhancing the Healing Environment’ work
- 100% of wards to achieve ‘gold’ in the Dementia Standards in the Ward Accreditation Scheme
- Analysis of feedback from people with dementia and their carers will show sustained improvements.
Develop a highly skilled dementia-aware workforce

We have devised a range of training programmes to provide appropriate training to all staff and volunteers. The hospital is committed to raising awareness and training all staff, clinical, non-clinical and volunteers, recognising that dementia is not exclusive to a hospital environment and is common in all aspects of life.

What we need to do:

- Promote the ethos that a person can live well with dementia
- Ensure people with dementia receive individualised care
- Provide good quality training and education to staff that is relevant and easy to access.

How we plan to do it:

- Dementia information sessions will be an integral part of our induction program
- Dementia awareness will become part of UHSM’s Mandatory Training Programme
- Training will be tailored to staff and volunteer groups
- Ensure staff are aware of support available to people with dementia and their carers so that they are able to effectively signpost
- Develop a data capture tool for training to monitor compliance targets.

How we will measure success:

- 100% of staff and volunteers will have attended a dementia information session
- All clinical staff will have completed a more in-depth training session
- Staff who have regular responsibilities for providing care for people with known, or suspected, dementia will have enhanced knowledge and skills in dementia care.
Champion improvements in dementia care at all levels of the organisation

We have designated executive, clinical and operational management leads who are committed to championing the Dementia agenda. The Dementia Operational Group steers the Trust strategy ensuring that all aims are progressed.

What we need to do:

- Disseminate and embed this Dementia Strategy
- Establish dementia as a priority at all levels of the UHSM.

How we plan to do it:

- Identify executive, clinical and operational management leads
- Identify Dementia Champions in all wards and departments
- Develop specialist / skilled practitioner rolls to embed this work.

How we will measure success:

- Monitor via the Dementia Operational Group.
Work in collaboration with partner organisations

Develop seamless pathways of care, working with GPs, community and care homes, between the community and hospital, for people with dementia and their carers.

What we need to do:

- Develop links with local communities and services to support dementia patients and their carers at every step during their patient journey through to discharge
- Ensure effective communication and handover to the right services for the right patient (and carer) at the right time.

How we plan to do it:

Active participation and continuing membership of the Dementia Action Alliance (DAA); delivering UHSM’s DAA action plan to achieve the outcomes of the National Dementia Declaration

- Work with local commissioners to push forwards the integration agenda with its focus on the frail elderly patient and the patient with dementia and their carers.

How we will measure success:

- Collection and analysis of data around hospital admissions and readmissions of those with dementia
- Qualitative analysis of feedback from patients and their carers regarding their experience of access to local services and effectiveness of handover and communication.
Actively participate in research and audit to maintain and improve standards

We are registered with DeNDRoN (Dementias and Neurodegenerative Diseases Research Network) and anticipate the opportunity to participate in multicentre trials. We have actively participated in previous rounds of the National Audit Office Dementia Audit and will continue to do so. Action plans arising out of audits have fed into UHSM’s objectives around dementia care.

What we need to do:

- Identify research projects relevant to people with dementia, and their carers, in the South Manchester area
- Participate in future and upcoming rounds of the National Audit of Dementia (NAD).

How we plan to do it:

- Continued participation in the NAD and reporting of audit findings through UHSM’s governance framework
- Actively seek opportunities to collaborate with national centres of dementia research through the DENDRON network.

How we will measure success:

- Publication of research trial results
- Results of national audits and demonstration of improvement year on year.

To find out more contact:

www.uhsm.nhs.uk/safeguard/pages/dementia.aspx

Telephone: 0161 291 4362

Dementia Team:
Dr Joyce Yeo
Nuala Keaskin (nurse)
Eleanor Ford (physio)
<table>
<thead>
<tr>
<th>Title of Board paper and link to corporate objective</th>
<th>Governance Manual V3.1: amendment to Scheme of Delegation Linked to over-riding corporate objectives.</th>
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<td>Board meeting date</td>
<td>25 September 2014</td>
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<tr>
<td>Purpose</td>
<td>For the Board to approve the additional wording in the Scheme of Delegation and ratify the UHSM Governance Manual V3.1</td>
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<td>Actions Recommended</td>
<td>Discussion / Noting / Decision</td>
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<td>Publication</td>
<td>This paper will be published in line with the UHSM Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting: <a href="http://www.uhsm.nhs.uk/AboutUs/Pages/ExecDirectors.aspx">http://www.uhsm.nhs.uk/AboutUs/Pages/ExecDirectors.aspx</a></td>
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<td>Dissemination of the Governance Manual within UHSM intranet and management teams.</td>
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<td>Report of</td>
<td>Head of Corporate Governance</td>
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<td>Head of Corporate Governance</td>
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INTRODUCTION

Following the ratification of the UHSM Governance Manual V3.0 by Board on 28 August 2014, the Board is asked to approve additional wording to the Scheme of Delegation to provide clarity within the Governance Manual and ratify V3.1 of the same.

The additional wording is as follows:

As part of its underlying core business the Trust enters a number of other contractual arrangements on an annual basis for goods and services which are fundamental to the Trust’s ongoing delivery of healthcare. Such contracts include energy and utilities, clinical negligence insurance, rates, University of Manchester medical staff, Public Health England and intermediate care beds. Where these exceed the limits above the Board delegates powers that such contracts may be authorised jointly by the Chief Executive and Director of Finance and where the requisitioner can demonstrate that the contracts are:

- within in the budget agreed by the Board when approving the annual plan
- In accordance with the Trust’s procurement and tendering instructions set out in the UHSM Governance Manual.

Should the Trust enter into any new business ventures or alternative models of service provision in excess £1m these will need to be authorised by the Board.

Governance Manual V3.1: section 4

RECOMMENDATION

The Board is invited to approve the additional wording to the Scheme of Delegation and ratify V3.1 of the Governance Manual.

Head of Corporate Governance