Board of Directors

Public Board to be held at 10:00 on Thursday 03 September 2020
Via video conferencing in line with social distancing measures

Item No.	Title	Purpose	Type and Page No.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest i) Any new interests to declare ii) Any interests to declare in relation to open items on the agenda	Receive	Verbal	Chair
1.3	Minutes of the public meeting held on 2 July 2020	Approve	Pg 3	Chair
1.4	Matters Arising/ Action Log	Approve	No open actions	Chair
2. Chairman and Chief Executive Reports				
2.1	Chair's Report	Discuss	Verbal	Chair
2.2	Chief Executive's Report	Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive / discuss	Presentation	Director of Patient Care & Chief Nurse
3.2	Nursing staffing update	Discuss	Pg 10	Director of Patient Care and Chief Nurse
4. Strategy				
4.1	BLMK recovery return and expected outcomes	Discuss	Pg 18	Director of Operations
4.2	Estates update	Discuss	Verbal	Deputy CEO
4.3	Digital Programme update	Discuss	Verbal	Deputy CEO
5. Performance				
5.1 5.2 5.3	Performance Report Month 4 Finance Month 4 Workforce Report Month 4	Receive / Discuss	Pg 31 Pg 36 Pg 45	Deputy CEO/ Director of Operations Director of Finance Director of Workforce
6. Finance				
6.1	Capital programme governance	Discuss	Verbal	Director of Finance
7. Assurance and Statutory Items				
7.1	Freedom To Speak Up Guardian Annual Report	Discuss	Pg 50	Director Patient Care and Chief Nurse
8. Governance				

Item No.	Title	Purpose	Type and Page No.	Lead
8.1	Changes to the Constitution and Terms of Reference of Corporate Management Board and Divisional Management Board	Approve	Pg 56	Director of Corporate Affairs
8.2	Summary reports Finance & Investment Committee – 29 June 2020 Workforce & Development Assurance Committee – 15 July 2020	Note	 Pg 74 Pg 76	Committee Chairs
9. Closing Administration				
9.1	Any Other Business	Discuss/ Note/ Approve	Verbal	Chair
9.2	Questions from Members of the Public While under normal circumstances the public can attend part of provider board meetings, current Government social isolation requirements constitute 'special reasons' precluding face to face gatherings as permitted by legislation	Note	Verbal	Chair
9.3	Motion to Close the Meeting	Receive	Verbal	Chair
9.4	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted"	Approve		Chair

BOARD OF DIRECTORS MEETING

Draft Minutes of the Board of Directors meeting held in PUBLIC on May 7, 2020 remotely via Teams due to pandemic

Present:	
Simon Lloyd	Chairman
Joe Harrison	Chief Executive
Ian Reckless	Medical Director
Danielle Petch	Director of Workforce
Mike Keech	Director of Finance
Ian Reckless	Medical Director
Sam Donohue	Depute Chief Nurse
Heidi Travis	Non-Executive Director (Chair of the Finance & Investment Committee
Helen Smart	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Andrew Blakeman	Non-Executive Director (Chair of the Audit Committee)
Nicky McLeod	Non-Executive Director (Chair of the Workforce Development & Assurance Committee)
Haider Husain	Non-Executive Director
John Lisle	Non-Executive Director
Luke James	Associate Non-Executive Director
In attendance:	
Alison Marlow	Trust Secretary

1	**Welcome**
	The Chairman welcomed all present to the meeting.
1.1	**Apologies**
	Apologies were received from Nicky Burns-Muir (Sam Donohue present on her behalf)
1.2	**Declarations of interest**
	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
1.3	**Minutes of the meeting held on May 7, 2020**
	The minutes of the public Board meeting held on May 7, 2020 were accepted as an accurate record.
1.4	**Matters Arising/ Action Log**
	There were no matters arising.
2	**Chairman and Chief Executive's Reports**
2.1	**Chairman's Report** • Simon Lloyd reported that he was still involved as much as possible with the hospital, and in regular contact via telephone and teams/teleconferencing meetings. He attended (virtually) a meeting of Eastern region chairs earlier in the week and the consensus was that the region has coped well with the effects of the pandemic.

2.2	• The ICS has a new Chair - Rima Makarem, who has a scientific background and has been on the Board of UCLH. Simon Lloyd will be attending a BLMK partnership Board meeting on July 3. • A Covid memorial was being unveiled in Campbell Park on Sunday – Jill Wilkinson would be attending on behalf of the Trust **Resolved**: The Board **noted** the Chairman's' Report **Chief Executive's Report** **Covid-19 update** Joe Harrison said that the organisation is focused on restarting activity. Emma Livesley said that on Tuesday of this week there had been 266 attendances in ED, which was near to pre-Covid levels and performance in the department was high. There were two Covid patients in the hospital and ICU activity had returned to normal levels. The expectation for the coming weekend was that there would be an increase in ED activity of 10% due to some lockdown restrictions being lifted. She said stocks of PPE were good. Emma Livesley said that the recovery phase was slowly taking place. There had been a big cancel and reset project in outpatients, medicine and surgery too, ensuring that patients were rebooked in chronological order. The Trust had also been undertaking and maintaining virtual clinics, with appointment by phone or video so that patients didn't have to come in unnecessarily. She said patient uptake was a concern and there was a piece of work to be done around how we improve public perception and confidence. Cancer services had been maintained throughout. Diagnostics were up and running and activity levels in endoscopy had been somewhat reduced but had now moved to Phase 3 of the endoscopy recovery plan. In summary, the Trust was performing well and ED still has red/green zones which would be maintained for the timebeing. To put the situation into perspective Joe Harrison said it was important to recognise that other hospitals weren't yet starting up, for example West Herts hadn't opened diagnostics and Bedford was experiencing a significant number of Covid patients. Nicky McLeod asked if there were targets set for virtual outpatients. Emma Livesley said no national or regional targets had been set and the Trust had set its own target at 30% of capacity for each clinic, alternating face to face appointments with virtual ones. Luke James asked if there was a patient satisfaction survey over virtual clinics. Emma Livesley said no, but the ad hoc feedback was positive and patients enjoyed the flexibility. She said patients seemed to prefer phone contact to video and that the Trust would be looking at activity from a patient experience perspective. Ian Reckless added that the assumption that video would have been preferred seemed not to be the case. **Elective Activity** Using the speciality of trauma and orthopaedics as an example, Emma Livesley said it was difficult to predict recovery of the service. In March 19/20 there had been 368 referrals to the service but in April/May/June the Trust had only received 2% of the normal level of referrals. She said the waiting list wasn't expected to rise dramatically and in fact had reduced

somewhat due to there being no throughput from GPs, however this was likely to change in the future. She reminded the Board that a clean ward for T&O had been trialled in Ward 12 last winter and that now Ward 21 was being reconfigured to become a clean ward, allowing the Trust to operate more efficiently. This would be online late September.

There had been reduced efficiency of theatre lists due to extra PPE/IPC requirements. She said one of the major constraints was the patient uptake to have the operations they had been waiting for. A mailshot of 2,500 elective patients had gone out last month asking if patients still wanted their operation and over 350 didn't wish to proceed at this juncture.

She stressed the variables across specialities were immense and Joe Harrison agreed that more detail would be available at the September Board meeting.

Partnership Working

Ian Reckless said that the Provider Alliance work in MK had slowed down but that there were four clear areas of focus:

1. GPs were being incentivised to do more work in care homes and CNWL was buddying with hospital geriatricians, with GPs also involved in MDT meetings.
2. Pharmacy provision was split between community pharmacies and the hospital and work was progressing with the CCG to bring the two functions closer together for improved patient safety and to make transfers of care more seamless. This required the CCG to work closely with MKUH on this.
3. Outpatients. The Trust wants to revisit the notion of joint working with our consultants and GPs, especially in clinics such as dermatology and rheumatology, to help to reduce the significant backlog of patients.
4. Community Bed Base. There were around 100 beds outside the hospital in MK. Ian Reckless said they were keen to develop the use of these bed-based facilities to improve effectiveness and the patient experience of stroke/fractured neck of femur patients in a therapeutic setting. He said funding was required to make these changes happen.

John Lisle asked if the community beds had a discharge to assess model. Ian Reckless said no, that active rehabilitation was the primary aim of usage. He did stress that the Trust had made good progress regarding length of stay (LoS) and delayed transfers of care. He also commented that the situation concerning out-of-area patients was challenging and that discussions were ongoing in this regard.

Workforce Wellbeing

Danielle Petch reminded the Board of a number of initiatives introduced to support staff during the pandemic, including the Staff Hub, wellbeing calls to staff self-isolating or shielding, mental health support, P2P (Peer to Peer) support. Most recently staff had been able to be swabbed and also have antibody tests.

Risk assessments had been carried out as staff returned to work and a series of briefings was planned to prepare to get people back into the workplace over the next month.

	The Trust was required to risk assess all staff in at risk groups and this had been completed, with over 1000 carried out so far. In addition she wrote to all staff in payslips to explain the process and invite them to apply for assessments if in an affected group. Staff had been also asked to have conversations with their managers so that they were aware of the situation in their particular area and 98% of staff had done this. BAME (black and minority ethnic) staff: risk assessments for this group were in line with expectation – 33-4% of staff are BAME and 32% of at risk assessments had been carried out for BAME colleagues. This information was published on the Trust intranet for all staff to access. Helen Smart commented on the introduction of so many positive things to support staff and asked what the uptake had been for psychological support bearing in mind high levels of anxiety. Danielle Petch said that the Surgery and ICU (Intensive Care Unit) teams had received specialist support and that was being rolled out to other areas. She said the Trust had been in the process of changing Employee Assistance Programmes (EAP) and that in the light of Covid, both suppliers had been kept on to allow for anticipated uptake in demand. Local support was also available through the Trust's own P2P volunteers, and two local counsellors had offered their services free of charge to Trust staff. Joe Harrison added that the Trust was adhering to requirements in administration areas and through site risk assessments, endeavoured to have Covid-secure areas to reduce the need for mask wearing in an office environment. **Ad hoc** Joe Harrison said that the Trust had moved from the pilot phase of sending letters electronically and had now stopped sending paper letters to people on MyCare who opted for paperless Resolved: The Board **noted** the Chief Executive's Report
3	**Quality**
3.1	**Patient Story** Sam Donohue shared Covid patient Nick's moving story. His messages were to thank every single person involved in his care, and also to warn people that Covid could happen to anyone. He wanted the Trust to convey to patients the length of recovery and also the impact on mental health. Simon Lloyd said the story was highly relevant. Ian Reckless said follow up clinics did include psychological support. He said some of the long term effects seemed to be persistent tachycardia and fatigue. Helen Smart asked if there were any family support mechanisms, but Sam Donohue said she didn't know of any formal programmes. Luke James and Haider Husain thanked her for sharing the story and asked about wider publicity. Kate Jarman said a lot of media work had been done and other stories were being recorded for learning and QI. **Resolved:** The Board thanked SD for her presentation.
3.2	**Nursing Staffing Update**

	Sam Donohue said there had been increased interest in nurses applying for Band 5 roles, some of who were nurses who had previously been working in London. The student nurses reported a positive experience – the Trust had been paying them at Band 4 rates and was recruiting them into Band 5 roles. Several students who have been working at the Trust wish to transfer to a closer university so they can continue their placements here. There were high vacancy rate son Ward 8 and Wards 15/16 and a new recruitment campaign was being created, to reflect preceptorship and specialist courses that were being made available. Helen Smart wanted to record the positive student experience. Sam Donohue said the B4 nursing associate role had been successful and the Trust was looking at more B6 leadership roles to suit the patients both today and in the future
3.3	**Mortality Report**
	IR discussed the Mortality Report and for the benefit of new members explained the two different quantitive methods used. He explained some of the apparent discrepancies were due to different time frames and added that since the introduction of eCare, the Trust's ability to accurately code has fallen somewhat. Haider Husain asked if other Trusts using Cerner had similar issues. Ian Reckless said one issue was around the depth of coding and the 'slice' indicating who was the consultant in charge of an episode or series of episodes. There was also an issue regarding outpatient depths being treated as if inpatient, but coming changes to eCare should reduce this happening.
3.4	**Serious Incident Report**
	This included data for Q1,a time when the Trust changed a lot of processes very quickly due to Covid. Ian Reckless said the report highlighted some unintended consequences around care in ED when staff were so Covid-focused they didn't factor in other checks. He said there were three particular incidents to learn from and continue to learn from. Referring to the suicide on Ward 25, Joe Harrison stressed that actions had already been carried out with regard to the physical estate and patient pathway.
4	**Strategy**
4.1	**Use of Day Surgery Unit for ICU** Emma Livesley explained that Day Surgery Unit was being used as ICU while the current department (Ward 6) was undergoing modifications and would be returning to usage in September. Ian Reckless emphasised that Day Surgery had already been trialled as an ICU as part of the expansion of services during the peak of the Covid outbreak.
4.2	**Objectives** Joe Harrison said the executive team had gone through the objectives. Due to the situation, he asked for support to pause a number of objectives with the view to bringing them back for discussion at the next Board seminar in October. Simon Lloyd commented that Covid had clearly led to improved system working. Andrew Blakeman wished to note that the people objectives had still been met in full.
4.3	**Health infrastructure Programme (HIP2 update)** John Blakesley gave a presentation and update on proposals and stressed that unlike most hospital redevelopment plans, the Trust's was being done

	due to growth, not decay. With 2,900 new homes being built in MK, the population would be an estimated 500,000 in 2030. In patient growth has risen by 30% since 2011. The Trust's maternity unit was already at capacity; and with seven new schools opened in MK the number of children in the town had increased by a third in seven years. Surgery had been criticised at various GIRFT reviews as not having good enough facilities. Joe Harrison had reminded about the use of private hospitals and the CCG was keen for the Trust to repatriate that business. In planning: pathway unit, imaging centre, women's and children's hospital, surgical block, radiotherapy services, a third multi-storey care park, office accommodation and primary care hubs as part of MKPlace facilities. A full strategic outline would be brought to November Board and a project team was close to being appointed (funded through the £1.1m seed funding).A development board, headed by Joe Harrison, would be formed as a big project it required its own governance structure (reporting into Finance & Investment and up to Board). Andrew Blakeman commented that it was an impressive plan and he hoped the funding would be provided. With regard to a radiotherapy unit, Ian Reckless said there had been a seven-year conversation with Oxford. Realistically, the Trust couldn't provide it directly, so the aim was to get all parties in Oxford and MK to agree the goal was to have a facility in MK, with the Trust to build it and Oxford to rent it. The situation was encouraging. Joe Harrison asked for Board support to work up the plans to develop the estate. **Outcome: the Board gave its support to the development of new estate plans.**
5	**Performance**
5.1	**Performance Report M12** John Blakesley confirmed that during April, May and June, bed occupancy had been low, with low numbers of stranded and super-stranded patients. There had been excellent ED performance and attendances in the department were growing day by day. Cancer – there had not been so many diagnostics as the Trust aspired to but compared to the region the Trust was performing well. The Trust had been using independent and private healthcare providers for elective operations and that would continue to ensure patients were supported. Due to additional requirements re PPE, cleaning and distancing, the Trust was performing fewer procedures, for example 50 orthopaedic cases in June, around half of normal capacity. Helen Smart asked about the increase in readmission rates and asked if there was any correlation to Covid-19. JH provided assurance that all readmissions had been reviewed and confirmed that there was no indication of any discharge issues. **The performance report was received and noted.**
5.2	**Finance Report M2** Mike Keech presented the M2 report. He stressed that Covid had had a big impact on the performance of the organisation and of pay/non-pay costs. He said the national team would provide a top-up to break even position. He said the Trust was starting to get some indication of what August might look like in terms of finance. He said he was expecting costs to change in the coming months and the Trust would do revised financial modelling with

	the aim of completing by the end of July. He said planned capital spend had been reduced by £6m (via ICS) but that the pathway unit and HIP2 was outside this lCS limit. **The month 12 finance report was received, discussed and noted**
5.3	**Workforce** Danielle Petch gave an overview of the M2 report. All KPIs were being met apart from sickness and the Trust was awaiting coding from the national team to monitor sickness more clearly and delineate over whether staff were Covid-affected or shielding. She said that BAME reports were available on the staff intranet for all staff to read. Nicky McLeod said it was good that appraisal levels were being maintained and asked about supervision. Danielle Petch said that the chief nurse was keen to develop coaching and also the Band 6 leadership role. She stressed that a lot of staff had been redeployed but now supervision/preceptorship was coming back online. Simon Lloyd said that BAME and diversity were a Board issue and should be noted as such. Joe Harrison said there was a desire to set up a shadow Board arrangement to understand how decisions are made so that BAME/protected characteristics staff could better understand the process. **The Workforce report was received, discussed and noted.** **It was agreed that Danielle Petch should bring plans re a Shadow Board to the next meeting in September.**
6	**Assurance and Statutory Items**
6.1	**IPC (infection Prevention & Control) Board Assurance Framework** There is a new IPC BAF which provides evidence on 10 standards set by NHSE/I. Kate Jarman said it was worth noting that none of the standards was a surprise, with all activity on each standard ongoing. She said the Trust was required to present the IPC BAF to the Board, and that more messages were coming through from the Centre that needed to go on to this BAF including work connected to BAME. Simon Lloyd aid the CQC were interested in the IPC BAF from a governance point of view and it was important to emphasise this
7	**Governance**
7.1	**Use of the Trust Seal** This was noted by the Board.
7.2	**Summary Reports** These were noted by the Board. Helen Smart said that at QCRC the committee extended its thanks to all staff including the executive team who have led and managed the situation through this difficult time
8 **8.1**	**Closing Administration** There was a question from the Press asking what assurance the Trust could give members of the public who were anxious about attending appointments at the hospital. Joe Harrison said the Trust was doing everything possible to minimise infection and to keep patients and staff safe. Ian Reckless also urged the public to take responsibility for their own health in the light of some lockdown restrictions being lifted and the expectation that ED might be busier at the weekend as a result. There was no further business and the meeting was closed at 12.20

Meeting title	Board of Directors	**Date:** September 2020
Report title:	Nursing Staffing Report	**Agenda item: 3.2**
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse
FoI status:		

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	That the Board receive the Nursing Staffing Report.						

Strategic objectives links	Objective 1 - Improve patient safety. Objective 2 - Improve patient care.
Board Assurance Framework links	Inadequate staffing are contributory issues for BAF risks 1.1 and 1.4.
CQC outcome/ regulation links	Outcome 13 staffing.
Identified risks and risk management actions	
Resource implications	Unfilled posts have to be covered by Bank or agency staff, with agency staff having a resource implication.
Legal implications including equality and diversity assessment	None as a result of this report.

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for June and July 2020

1. Purpose

To provide Board with: -

- An overview of Nursing and Midwifery staffing levels.
- An overview of the Nursing and Midwifery vacancies and recruitment activity.
- Update the Board on controls on nursing spend.

Are we safe ?

2. Planned versus actual staffing and CHPPD (Care Hours per Patient Day)

We continue to report monthly staffing data to 'UNIFY' and to update the Trust Board on the monthly staffing position.

CHPPD is calculated by taking the actual hours worked divided by the number of patients on the Ward at midnight.

CHPPD = hours of care delivered by Nurses and HCSW
Numbers of patients on the Ward at midnight

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
June	8923	6.2	3.8	10.1
July	10515	5.6	3.4	9.0

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
June	81.3%	89.4%	94.1%	102.4%
July	72.6%	79.2%	85.9%	89.3%

- *June/July and 2020 data are included in Appendix 1.*

Areas with notable fill rates

All areas had an increased CHPPD due to the low number of patients during May. The CHPPD was particularly high on Wards 24, 21 and 5 as they had very few admissions.

Ward 24 staff were allocated to cover both Ward 10 gynaecological beds and the Trust drive through test swab station for elective patients. Ward 21 opened in July as the clean orthopaedic unit and is currently at 50% capacity until building work is completed in late September to then accommodate clean elective patients. Paediatric admissions have remained consistently low throughout June and July.

Vacancies and Recruitment

Following a recruitment drive led by the Workforce Matron we have the lowest band 5 vacancies reported in over year at a residual of 82.39 WTE which is 11.3 %. All the senior nursing teams have worked closely with the Workforce Matron developing bespoke recruitment campaigns for each clinical service. This has enabled each clinical service to review their profiles, set educational opportunities and plans for new starters and create individualised recruitment plans. This in combination with the Trust's external raised profile with supporting staff with Health and Wellbeing incentives has increased the number of applications.

Maternity/Children's

Following robust recruitment there continues to be minimal vacancies within the maternity department.

In July we recruited 6.2 WTE Band 5 midwives who are now in pre-employment checks. Alongside this we have recruited 0.8 WTE Practice Development Midwife and 1.6 WTE labour Ward Coordinators and 3 WTE ward clerks.

Midwifery/Paediatric Vacancies June 2020						
Band	B7	B6	B5	B4	B3	B2
Total	2.35 WTE	1.0 WTE	7.04 WTE	0.2 WTE	1.86 WTE	4.47 WTE

Maternity have 4% Qualified and 6% Unqualified vacancy rate.

Surgery

Surgery have significantly reduced their vacancies following a successful recruitment campaign in June and July appointing 17.4 WTE band 5 staff nurses. The division is currently advertising for the Intensive Care Unit as they have 3.8 WTE vacancies.

Surgery Vacancies June 2020								
Band	B7	B6	B5	B4	B3	B2	Ward Clerks	Housekeeper
Total	0 WTE	7.8 WTE	14.5 WTE	1.2 WTE	1.4 WTE	19.1 WTE	0 WTE	0 WTE

Surgery have a 7.6% Qualified and 15% Unqualified vacancy rate.

Medicine

Medicine continue to have a number of vacancies after recruiting 26.28 WTE Band 5 staff nurses in June. They have a high number of vacancies in the Emergency Department and Ward 15. The Workforce Matron is currently supporting these areas in further recruitment campaigns. Medicine has just closed an advert and had 120 applications in total. To note, 107 of them without Nursing and Midwifery Council (NMC) registration and the majority were applications from overseas. In future this will require further scrutiny and work on how we can support these candidates in gaining their NMC registration by offering them support with their Objective Structured Clinical Examination practice.

Medicine Vacancies June 2020								
Band	B7	B6	B5	B4	B3	B2	Ward Clerks	Housekeeper
Total	0 WTE	1.8 WTE	53.05 WTE	0 WTE	0 WTE	27.5 WTE	0 WTE	0 WTE

Medicine have a 12% Qualified and 13.7% Unqualified vacancy rate

10 Nursing Associates due to qualify later in the year have been successful in gaining posts in the following areas: Wards 1, 2, 20, Emergency Department and Endoscopy.

Are we efficient?

3. "SafeCare" tool update

Trusts have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality.

The Nursing and Midwifery Council (NMC) sets out nursing responsibilities in relation to safe staffing levels, and demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation. This is also incorporated within NICE guidelines, 'Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals' (2014), NHS England guidance 'A Guide to Care Contact Hours' (2014)'; which additionally recommends inclusion of contact time by registered nursing staff in establishment reviews.

It is essential to provide assurance both internally to the Trust and externally to stakeholders that ward establishments are safe, and staff can provide appropriate levels of care to patients that reflect the Trust values and the National Nursing Strategy (2016), as well as the Director of Patient Care and Chief Nurse.

This is particularly important in the light of key recommendations made by the Francis Report (2013), the Berwick Report (2013) and the National Quality Board publication (2013) 'How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability' in terms of safe ward staffing levels and 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations' (Carter Report 2016).

The Trust is currently piloting the "SafeCare'' toolkit from Allocate within 4 clinical areas with a full role out programme planned. SafeCare dynamically brings information on the actual staff levels together with the numbers and needs of patients. It provides a real-time shift-by-shift view of required versus actual staffing across the organisation making it easier to be responsive to changes in demand or staff availability.

It is accessible on desktop computers, tablets and smart phones allowing clinical and operational teams to quickly:

- Record a census of patient numbers, acuity and dependency – typically three times a day
- See the staffing status of all wards, services, and locations in a single view
- View staffing status across many dimensions including hours short/excess, missing skills, missing patient census
- See all staff rostered on a shift, including their skills
- Track attendance and sickness of those staff
- Redeploy staff safely with full visibility of skills and impact elsewhere, helping to avoid unnecessary agency use
- Request bank or agency cover if needed
- Quickly track 'Red Flags' as they occur as required by the first safe staffing NICE guidelines

Further updates will form part of the ongoing Trust staffing reports.

4. Maternity Update

Maternity Staffing

Our midwifery staffing is planned in line with the national recommendation for safe staffing, which is one midwife to every 28 births. The service is currently funded to provide this level of staff and we use them effectively to follow women throughout their pregnancy to birth and the postnatal period. We prioritise women who are giving birth by providing one to one care in labour and to those who have additional clinical needs within the hospital.

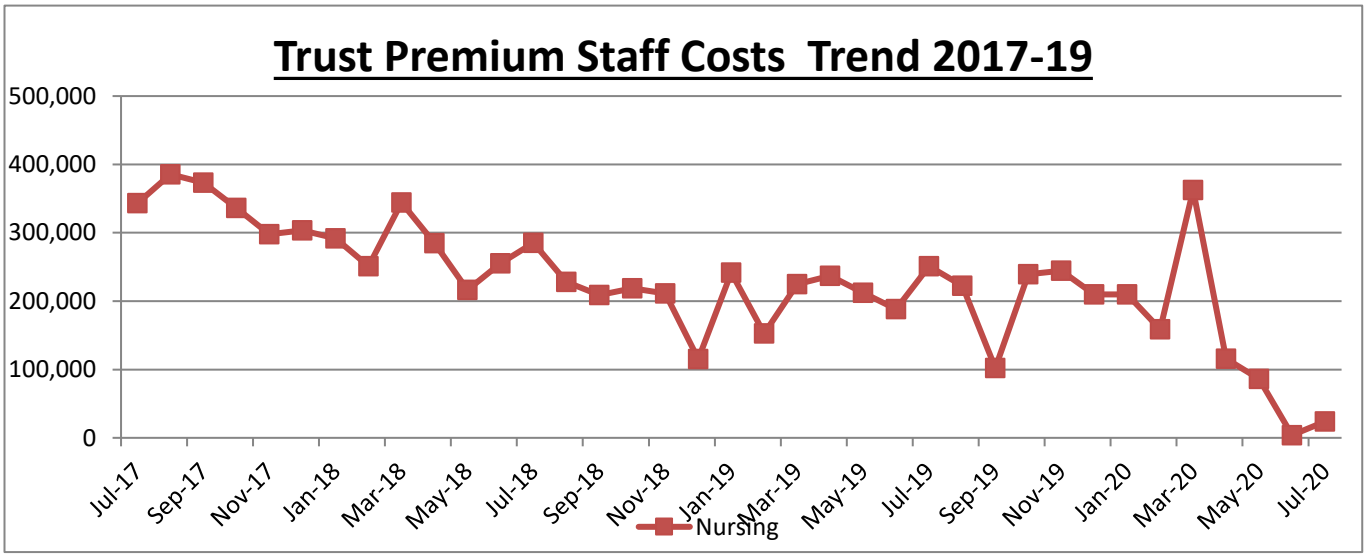
The Midwife to Birth Ratio is stated on the obstetric dashboard monthly and reported at Management Board, Women's CSU meetings and Clinical Quality Board bi-monthly. In July 2020, the Midwife to Birth Ratio was 1:31. This was due to a rise in month of 58 births from 280 in June to 338 births with 344 babies born (6 sets of twins) in July.

Continuity of Carer Teams

The maternity unit continues to work to the national maternity agenda to deliver Continuity of Carer to 51% of women by March 2021.The implementation of geographical caseload teams within maternity services is now becoming embedded into practice. Three continuity teams are already in place as well as a home birth team and two additional continuity teams are confirmed to start from September 2020. This signifies that the maternity unit is on track to meet the national target. Feedback from staff in these teams indicates that working in a caseload team is an extremely positive way of working and provides both enhanced staff and patient experience.

Are we effective?

5. Agency graph



During the period of June and July the premium staff cost dramatically reduced. This was due to the redeployment of staff and staff returning from isolation. The Agency spend was its lowest in three years with a spend of £3,991 in July.

for Nursing, Midwifery and Care Staff June 2020 (Appendix 1)

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	81.4%	104.1%	100.8%	110.1%	434	8.3	3.8	12.1
MAU 2	74.6%	80.1%	100.1%	105.0%	374	7.5	4.7	12.2
Phoenix Unit	-	-	-	-	0	-	-	-
Ward 15	83.0%	92.0%	96.8%	106.7%	344	8.5	5.6	14.1
Ward 16	81.4%	91.3%	100.9%	114.8%	530	5.5	3.7	9.2
Ward 17	81.2%	102.5%	100.0%	131.7%	607	5.2	3.0	8.1
Ward 18	71.0%	97.3%	102.2%	103.2%	616	3.9	4.5	8.3
Ward 19	77.2%	80.9%	101.1%	106.7%	758	3.3	3.3	6.6
Ward 20	91.5%	90.0%	102.4%	105.6%	653	4.7	2.8	7.5
Ward 21	-	-	-	-	0	-	-	-
Ward 22	105.5%	78.2%	97.8%	74.4%	471	6.2	4.6	10.8
Ward 23	86.5%	102.4%	104.2%	110.7%	932	4.3	4.4	8.7
Ward 24	71.1%	87.1%	79.1%	83.5%	157	11.9	4.2	16.2
Ward 3	74.4%	76.8%	86.7%	87.8%	538	4.2	4.2	8.4
Ward 5	67.9%	45.2%	85.7%	42.8%	155	19.3	2.3	21.6
Ward 7	81.4%	87.1%	100.0%	103.5%	432	5.9	6.0	11.9
Ward 8	78.1%	95.7%	102.2%	123.3%	661	3.8	3.2	7.0
ICU	88.5%	85.3%	73.9%	-	130	35.1	3.3	38.4
Labour Ward								
Ward 9	87.5%	110.7%	94.5%	89.1%	600	5.8	3.9	9.6
Ward 10	78.8%	90.9%	95.1%	-	101	10.7	3.0	13.7
NNU	79.0%	57.8%	91.1%	113.3%	430	9.5	1.5	11.1

for Nursing, Midwifery and Care Staff July 2020 (Appendix 1)

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	80.5%	104.4%	100.2%	108.3%	482	7.7	3.5	11.2
MAU 2	71.9%	69.1%	101.6%	103.7%	277	10.1	6.1	16.2
Phoenix Unit	-	-	-	-	0	-	-	-
Ward 15	83.5%	94.8%	98.4%	119.4%	446	6.7	4.8	11.5
Ward 16	80.5%	95.9%	98.9%	127.9%	547	5.5	4.0	9.5
Ward 17	76.7%	99.9%	96.8%	122.0%	698	4.4	2.5	7.0
Ward 18	73.1%	99.6%	98.1%	111.7%	734	3.3	4.1	7.4
Ward 19	75.2%	72.9%	100.0%	83.0%	810	3.2	2.7	6.0
Ward 20	91.7%	88.3%	101.2%	100.0%	705	4.4	2.6	7.0
Ward 21	25.0%	9.0%	24.4%	4.8%	19	41.2	6.2	47.3
Ward 22	84.8%	64.6%	100.0%	73.1%	538	5.5	4.2	9.7
Ward 23	82.9%	91.6%	82.9%	91.6%	978	5.3	4.4	9.7
Ward 24	73.3%	77.0%	73.3%	77.0%	299	8.2	3.1	11.3
Ward 3	83.7%	81.3%	98.9%	100.0%	828	3.4	3.1	6.5
Ward 5	67.4%	60.3%	97.5%	57.9%	281	12.0	1.7	13.7
Ward 7	78.9%	100.1%	102.2%	126.1%	482	5.4	6.5	11.9
Ward 8	80.3%	88.0%	101.1%	111.3%	685	3.8	2.9	6.7
ICU	46.4%	25.3%	54.6%	0.0%	165	27.9	2.9	30.9
Labour Ward	-	-	-	-				
Ward 9	80.8%	94.6%	88.9%	87.1%	1156	2.9	1.9	4.7
Ward 10	80.1%	90.5%	85.1%	-	103	10.8	3.1	10.9
NNU	75.3%	77.1%	86.7%	114.6%	385	10.5	2.1	12.7

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30 January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed

actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and

regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

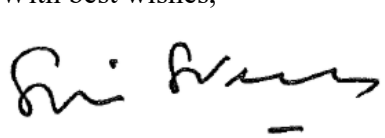
- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems – to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,



Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

Trust Performance Summary: M04 (July 2020)

1.0 Summary

This report summarises performance at the end of July 2020 for key performance indicators and provides a brief update on actions to deliver recovery both on Trust and system-wide performance since COVID-19 pandemic. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

Target ID	Target Description	Target
4.1	ED 4 hour target (includes WIC)	**95%**
4.2	RTT- Incomplete pathways < 18 weeks	**92%**
4.7	RTT- Patients waiting over 52 weeks	**0**
4.8	Diagnostic Waits < 6weeks	**99%**
4.9	All 2 week wait all cancers %	**93%**
4.10	Diagnosis to 1st Treatment (all cancers) - 31 days %	**96%**
4.11	Referral to Treatment (Standard) 62 day %	**85%**

The impact of COVID-19 on the performance of key NHS targets for July 2020 continues to impact negatively but is showing a gradual month on month improvement as more clinical services are being restored, and activity levels are increasing . To ensure this is reflected, the monthly trajectory of these targets have been amended to ensure the revised trajectory is reasonable and reflect a level of recovery for the Trust to achieve and sustain the target set out in the NHS Constitution over the next 12 months.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

July 2020 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	98.0%	97.6%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		79.0%	63.0%		42.0%	x	▼		
4.9	62 day standard (Quarterly)		85.5%	85.5%		74.4%	x	▼		

In July 2020, ED performance of 97.6% was above the 95% national standard and the 90.0% NHS Improvement trajectory.

Although there was a drop in the ED performance in July 2020 when compared to the ED performance in May 2020 (99.1%) and June 2020 (98.8%), this is the fourth consecutive month that the Trust has met the 95% national target.

The performance of this indicator is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19. Activity levels remain at circa two thirds of the levels seen at this time last year. The department continues to operate two distinct pathways / zones (RED and GREEN) for the assessment and treatment of COVID and non-COVID patients respectively.

When comparing the Trust's ED performance in July 2020, MKUH was better than the national overall performance of 92.1%. (see Appendix for details). MKUH compared favourably across the Peer Group comparator, outperforming its peers in July 2020.

The Trust's RTT Incomplete Pathways <18 weeks at the end of July 2020 stood at 42.0% against a national target of 92%. The National performance in June was 52% having dropped 10% points from the previous month. The performance of this key performance indicator is certain to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19, which resulted in the cancellation of non-urgent activity and treatment for patients on an incomplete RTT pathways for several months. Recovery plans are now in place for all services and many have resumed to pre-COVID operational levels of activity. The Independent sector has been used throughout this period for a number of services and continues. Latest Infection Prevention and Control guidance has seen a step change in the ability to deliver services safely and the Trust is expecting to be on track with recovery against the latest guidance.

Cancer waiting times are reported quarterly, six weeks after the end of a calendar quarter. They are initially published as provisional data and later finalised in line with the NHSE revisions policy.

For Q1 2020/21, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 74.4% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 94.7% against a national target of 96%. The percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 86.4% against a national target of 93%.

Cancer services have continued to operate and deliver most treatments for patients throughout the COVID-19 pandemic. Referrals dropped by approximately two thirds and are now returning to normal levels. Haematology and oncology outpatients have continued and where appropriate converted to telephone clinics. Chemotherapy has followed national guidelines. Alternative diagnostic pathways have been adopted as per protocols. Full focus and management is being given to long waiters.

3.0 Urgent and Emergency Care

In July 2020 two out of six measured key performance indicators showed an improvement in their performance in urgent and emergency care:

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.1%	0.0%	✓		✓	
3.2	Ward Discharges by Midday		27%	27%	21.4%	20.6%	✗		✗	
3.4	30 day readmissions				9.1%	10.0%				
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		30	✓			
3.9	Ambulance Handovers >30 mins (%)		5%	5%	2.4%	3.4%	✓		✓	
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	98.0%	97.6%	✓		✓	

Cancelled Operations on the Day

In July 2020, the number of operations cancelled on the day for non-clinical reasons was zero. Little activity has taken place during this reporting period.

Readmissions

The Trust's 30-day emergency readmission rate was 10.0% in July 2020 (the readmission rate in July 2020 may include patients that were readmitted with Covid-19). This was an improvement on the June 2020 readmission rate of 11.6%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of July 2020 was eight, seven patients in Medicine and one patient in Surgery. This was an increase compared to June 2020. Close monitoring of this activity continues with health and social care partners across the system as all services are recovering their activity and some of the dedicated support that was put into the front line services and responsiveness during the height of COVID will be reduced moving forward.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 30, this was an increase compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19. The hospital and partners continue to review each week the long stay patients and ensure the appropriate care plans and discharge arrangements are in in place and actioned appropriately .

Ambulance Handovers

In July 2020, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 3.4%. This was a deterioration in performance when compared to previous months in the financial year 2020/21 and is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19 whereby the department has been divided and running both COVID and non COVD pathways in fairly constrained spaces.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	64.1%	75.0%	✓	▼	✓	
3.5	Follow Up Ratio		1.50	1.50	1.97	1.78	x	▼	x	
4.2	RTT Incomplete Pathways <18 weeks		79.0%	63.0%		42.0%	x	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 75% in July 2020. This was an increase compared to June 2020 overnight bed occupancy of 67.3% and is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Follow up Ratio

The Trust follow up ratio in July 2020 was 1.78. This was a deterioration in performance when compared to the previous months of financial year 2020/21 and is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of July 2020 was 42.0% which was lower than the June 2020 value of 46.7%. At the end of July 2020, the number of patients waiting more than 52 weeks without being treated was 175. These patients were in Surgery (173 patients) and Women and Children (two patients). Recovery plans for all services is focussed on the treatment of

long waiters. Both main theatre and day case surgical capacity will take a step increase by the end of September and be close to pre COVID levels of delivery.

Diagnostic Waits <6 weeks

The Trust did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of July 2020, with a performance of 83.3%. This was however an improvement on the previous month and the volume of diagnostic tests undertaken had increased substantially. The National position for June 2020 was 52.2% against a target of 99%. Diagnostic capacity remains the biggest challenge to the Trust in recovery, which is in line with the national picture. A number of schemes are being looked into to provide additional capacity and the Trust remains fully engaged in all the NHSE/I regionally lead work streams which are sharing best practise from national programmes to expedite recovery.

5.0 Patient Safety

Infection Control

In July 2020 there were two cases of E. coli reported in Medicine (Ward 17 and Ward 19), one case of MSSA reported in Medicine (Ward 17) and one case of Clostridium difficile (C. diff) reported in Medicine (Ward 17). There were no reported cases of MRSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH for the purpose of Dr Foster:

- Barnsley Hospital NHS Foundation Trust
- Bedford Hospital NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Northampton General Hospital NHS Trust
- Oxford University Hospitals NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust

Burton Hospitals NHS Foundation Trust was part of the peer group, but since its merger with Derby Hospitals NHS Foundation Trust, Burton Hospitals NHS Foundation Trust has ceased to exist. Note: In May 2019, fourteen trusts began field testing new A&E performance standards and have not been required to report the number of attendances over 4hrs since then. Two of those are part of the MKUH peer group (Kettering General Hospital NHS Foundation Trust and Luton and Dunstable University Hospital NHS Foundation Trust) and therefore data is not available on the NHS England statistics web site (https://www.england.nhs.uk/statistics/).

May to July 2020 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	May-20	Jun-20	Jul-20
Milton Keynes University Hospital NHS Foundation Trust	99.1%	98.8%	97.6%
Homerton University Hospital NHS Foundation Trust	94.9%	95.6%	94.8%
Northampton General Hospital NHS Trust	92.0%	87.8%	93.8%
Southport And Ormskirk Hospital NHS Trust	95.8%	95.8%	93.3%
The Hillingdon Hospitals NHS Foundation Trust	86.7%	90.1%	92.7%
Mid Cheshire Hospitals NHS Foundation Trust	95.9%	95.8%	92.6%
North Middlesex University Hospital NHS Trust	92.3%	92.0%	91.7%
Oxford University Hospitals NHS Foundation Trust	92.6%	93.2%	91.2%
Barnsley Hospital NHS Foundation Trust	94.3%	91.4%	88.7%
The Princess Alexandra Hospital NHS Trust	92.9%	90.7%	88.3%
Buckinghamshire Healthcare NHS Trust	89.4%	89.3%	85.0%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	94.0%	95.3%	84.6%
Bedford Hospital NHS Trust	n/a	n/a	n/a
Kettering General Hospital NHS Foundation Trust	n/a	n/a	n/a
Luton And Dunstable University Hospital NHS Foundation Trust	n/a	n/a	n/a

*MKUH performance excludes the pending requirement to incorporate NHS 111 appointments at UCS.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date: September 2020**
Report title:	**Finance Paper Month 4 2020-21**	**Agenda item: 5.2**
Lead director **Report authors**	Mike Keech Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Public document	

Report summary	**An update on the financial position of the Trust at Month 4 (July 2020)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board to note the contents of the paper.			

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Outcome 26: Financial position
Identified risks and risk management actions	See Risk Register section of report
Resource implications	See paper for details
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st July 2020

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

   - Present an update on the Trust's latest financial position covering income and expenditure; cash, capital and liquidity; NHSI financial risk rating; and cost savings; and
   - Provide assurance to the Trust Board that actions are in place to address any areas where the Trust's financial performance is adversely behind plan at this stage of the financial year.

EXECUTIVE SUMMARY

2. Due to COVID-19 (covid) the Trust's previously submitted budget has been suspended and the Trust is being funded by a national block payment from April to July. The block payment is made up of three components; a fixed amount based on run rate from last year (£18.6m per month), a top up amount to address a deficit from the block (£3.1m per month) and a covid top up by return for additional covid related costs (allowing the Trust to report a breakeven position).

3. *Income and expenditure* –The Trust has reported a breakeven position for July 2020 against the revised block funding arrangement. Within this position the Trust has claimed an additional £1m (£3.5m YTD) of income over and above the £3.1m (£12.4m YTD) top-up in order to deliver a breakeven position as required by national rules (against which the Trust is able to evidence an additional £4.5m of costs relating to covid).

   After the revised block funding arrangement, the Trust has Overperformed against its original planned deficit for month 4 (after FRF) by 0.3m (£1.3m overperformed YTD).

4. Cash and capital position – the cash balance as at the end of July 2020 was £46.8m, which was £45.8m above plan due to the block payment for August paid on account in July and receipt of £9m PSF/FRF funding for 2019/20.

   The Trust has spent £2.7m on capital up to month 4 which relates to £0.4m pathway unit, £0.05m HIP 2 and £2.25m patient safety and clinically urgent capital expenditure.

5. *NHSI rating – the Use of Resources rating (UOR) score is '3', which* is in line with Plan, with '4' being the lowest scoring.

6. *Cost savings* – Due to covid work on tracking and delivering CIPs has been temporary suspended with the focus instead on recovery planning.

INCOME AND EXPENDITURE

7. In its reporting to NHSI, the Trust is required to report against the income and costs included within the national modelling for the Trust (based on historical actuals uplifted for inflation but with no adjustments for growth). However, in order for the Trust to get a better understanding of the Trust's cost base and how this has been impact by covid, the Trust is also monitoring performance against a planned position that would meet the original financial control total (excluding the regional 0.5% additional efficiency requirement). The tables below summarises performance against the national modelling and the Trust's original plan. For the purposes of the report, the narrative discusses performance against the Trust's original plan.

National modelling:

All Figures in £'000	Month 4 Plan	Month 4 Actual	Month 4 Var	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var
Clinical Revenue	18,585	18,224	(361)	37,170	72,811	35,641
Other Revenue	1,393	1,850	457	2,786	8,622	5,836
Total Income	19,978	20,074	96	39,956	81,433	41,477
Pay	(14,988)	(15,694)	(706)	(29,976)	(62,942)	(32,966)
Non Pay	(7,064)	(6,584)	480	(14,128)	(25,834)	(11,706)
Total Operational Expend	(22,052)	(22,277)	(225)	(44,104)	(88,775)	(44,671)
EBITDA	(2,074)	(2,203)	(129)	(4,148)	(7,342)	(3,194)
Financing & Non-Op. Costs	(981)	(1,882)	(901)	(1,962)	(5,375)	(3,413)
Control Total Deficit (excl. top up)	**(3,055)**	**(4,085)**	**(1,030)**	**(6,110)**	**(12,717)**	**(6,607)**
Adjustments excl. from control total:						
FRF	0	0	0	0	0	0
MRET	0	0	0	0	0	0
National Block	0	0	0	0	0	0
National Top up	3,055	3,055	0	6,110	9,165	3,055
COVID Top up	0	1,030	1,030	0	3,552	3,552
Control Total Deficit (incl. top up)	**0**	**(0)**	**(0)**	**0**	**0**	**0**
Donated income	0	0	0	0	0	0
Donated asset depreciation	0	(68)	(68)	0	(272)	(272)
Impairments & Rounding	0	0	0	0	0	0
Reported deficit/surplus	**0**	**(68)**	**(68)**	**0**	**(272)**	**(272)**

Performance against original internal plan:

All Figures in £'000	Month 4 Plan	Month 4 Actual	Month 4 Var	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	20,846	16,359	(4,487)	78,759	53,156	(25,603)	233,455	233,455	0
Other Revenue	1,621	1,850	229	6,524	5,567	(957)	19,295	19,295	0
Total Income	22,467	18,209	(4,258)	85,283	58,723	(26,560)	252,749	252,749	0
Pay	(14,986)	(15,694)	(708)	(60,303)	(62,942)	(2,639)	(180,692)	(180,692)	0
Non Pay	(6,904)	(6,584)	320	(27,527)	(25,834)	1,693	(82,026)	(82,026)	0
Total Operational Expend	(21,890)	(22,277)	(387)	(87,829)	(88,775)	(946)	(262,718)	(262,718)	0
EBITDA	578	(4,068)	(4,646)	(2,546)	(30,052)	(27,506)	(9,969)	(9,969)	0
Financing & Non-Op. Costs	(1,191)	(1,882)	(691)	(4,765)	(5,375)	(611)	(14,299)	(14,299)	0
Control Total Deficit (excl. PSF)	**(613)**	**(5,950)**	**(5,337)**	**(7,310)**	**(35,427)**	**(28,117)**	**(24,268)**	**(24,268)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	5,754	0	(5,754)	19,788	19,788	0
MRET	269	0	(269)	269	0	(269)	3,238	3,238	0
National Block	0	1,865	1,865	0	19,655	19,655	0	0	0
National Top up	0	3,055	3,055	0	12,220	12,220	0	0	0
COVID Top up	0	1,030	1,030	0	3,552	3,552	0	0	0
Control Total Deficit (incl. PSF)	**(344)**	**(0)**	**344**	**(1,287)**	**0**	**1,287**	**(1,242)**	**(1,242)**	**0**
Donated income	0	0	0	0	0	0	1,000	1,000	0
Donated asset depreciation	(68)	(68)	0	(272)	(272)	0	(816)	(816)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(412)**	**(68)**	**344**	**(1,559)**	**(272)**	**1,287**	**(1,058)**	**(1,058)**	**0**

Monthly and year to date review

8. The **deficit excluding central funding (top up) and donated income** in month 4 is £5,950k which is £5,337k adverse to the Trust's original plan; this is due to a combination of:
    - The national block contract income being lower than clinical income assumed in the internal plan (and agreed as part of the heads of terms with Milton Keynes CCG;
    - Lower non-clinical income streams due to lower activity volumes (e.g. parking income);
    - The impact of covid on the Trust's cost base.

    However, after the block payment and top up income the Trust has reported a breakeven position for the month. Included within this position is £4,560k YTD of direct covid costs (excluding loss of non-clinical income which is outside the scope of provider claims) against which the Trust expects to receive an additional £1,030k (£3,552k YTD) top-up (lower than the actual costs of covid as all providers are being advised to report a breakeven position).

9. **On a payment by results basis, income (excluding block, top up and donations effect)** is £4,487k adverse to plan in July and £26,650k YTD with significant reductions in non-elective activity and low levels of activity following suspension of non-urgent elective activityearlier in the year (clinical income is £4,487k adverse to plan in month and £25,603k YTD).

   However, the shortfall on clinical income is offset by the top-up payments which act as both a) a replacement of the financial recovery fund that would otherwise have been in place; and b) additional payments to cover shortfalls on clinical income as a result of the impact of covid.

10. **Operational costs** in July are adverse to plan by £387k in month and £946k YTD

11. **Pay costs** are £708k adverse to budget in Month 4 and £2,639k YTD. High costs against substantive and bank include direct covid related costs due to changes in rotas, additional hours and cover of sickness/self-isolation.

12. **Non-pay** costs were £320k favourable to plan in month and £1,693k favourable YTD. Positive variances can be seen across most non-pay categories with reduction expenditure due to lower than normal activity levels.

13. **Non-operational costs** are £691k adverse in month, this is a result of increase in PDC costs offset by additional income

    Further analysis of the costs can be found in the following appendix 1

COST SAVINGS

14. Due to covid, focus on capture and recording of CIPs has been temporary suspended and instead resources have been directed to recovery planning; however the Trust will be expected to deliver a CIP programme post the current funding arrangement to July.

15. In month 4 budgets have been reduced by £917k (3,668k YTD) as part of the original planned £11m CIP target

CASH AND CAPITAL

16. The cash balance at the end of July 2020 was £46.8m, which was £45.8m above plan due to the block payment for August paid on account in July and receipt of £9m PSF/FRF funding for 2019/20.

17. On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital loans (totalling £131.1m as at 31 March 2020) will be written off during the financial year 20/21 and replaced with Public Dividend Capital for which there is no repayment obligation.

18. The **statement of financial position** is set out in Appendix 3. The main movements and variance to plan can be summarised as follows:

    - Non-Current Assets are below plan by £33.8m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and 2019/20.

- Current assets are above plan by £51.2m, this is due to cash £45.8m, inventories £0.2m and receivables £5.2m above plan.

- Current liabilities are above plan by £167.9m. This is being driven by borrowings £129.3m which were not expected to be repaid, (driven by revenue and capital DHSC borrowings becoming due and transferred from non-current assets. There were already £1.9m of loans in the plan for repayment. These are due to be converted to PDC in 2020/21), deferred income £25.7m and Trade and Other Creditors £12.9m above plan.

- Non-Current Liabilities are below plan by £24.7m. This is being driven by borrowings £25.5 (driven by the inclusion of capital DHSC borrowings becoming due and transferred from non-current assets) offset by provisions £0.8m above plan.

The Trust has spent £2.7m on capital up to month 4 which relates to £0.4m pathway unit, £0.05m HIP 2 and £2.25m patient safety and clinically urgent capital expenditure.

The key performance indicators have been met with the exception of, creditor and debtor days.

RISK REGISTER

19. The following items represent the finance risks on the Board Assurance Framework and a brief update of their current position:

a) There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.

The Trust has a significant capital plan in place for 2020/21 which will lead to significant improvements in the hospital estate, infrastructure, reductions in backlog maintenance and support the Trust's Covid-19 response. The Trust is working closely with regulators to ensure capital funds are made available in order to deliver the capital programme.

b) As a result of Covid-19, the trust incurs additional costs and/or has a reduction in income that leads to its financial position becoming unsustainable.

PBR contracts have been replaced with block contracts (set nationally until July) and top-up payments available where covid-19 leads to costs over block amounts. Trust is in constant dialogue with NHSI/E regarding funding post July.

c) There is a risk that the Trust has insufficient resources (financial or otherwise) or has insuffieicnt physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.

The Trust has developed its recovery plans and is working closely with regulators to ensure sufficient resources are made available to ensure successful delivery.

RECOMMENDATIONS TO BOARD

20. The Trust Board is asked to note the financial position of the Trust as at 31st July 2020 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st July 2020

	July 2020			Year to Date			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	4,788	3,310	(1,478)	17,539	9,479	(8,061)	51,328
Elective admissions	2,671	1,375	(1,296)	9,755	3,333	(6,422)	29,148
Emergency admissions	6,300	5,136	(1,164)	24,795	17,708	(7,087)	73,776
Emergency adm's marginal rate (MRET)	(277)	(247)	29	(1,088)	(1,059)	29	(3,238)
Readmissions Penalty	0	0	0	0	0	0	0
A&E	1,402	1,134	(268)	5,323	3,760	(1,563)	15,489
Other Admissions	266	173	(93)	1,047	628	(418)	3,114
Maternity	1,862	1,939	77	7,108	6,994	(114)	21,186
Critical Care & Neonatal	561	520	(41)	2,209	2,284	75	6,572
Excess bed days	0	0	0	0	0	0	0
Imaging	531	444	(87)	1,941	1,049	(891)	5,799
Direct access Pathology	457	335	(122)	1,669	972	(697)	4,987
Non Tariff Drugs (high cost/individual drugs)	1,773	1,759	(14)	6,475	6,042	(433)	19,348
Other	511	483	(29)	1,988	1,967	(343)	5,946
National Block Top Up	0	1,864	1,864	0	19,655	19,655	0
Clinical Income	**20,846**	**18,224**	**(2,622)**	**78,759**	**72,811**	**(5,948)**	**233,455**
Non-Patient Income	**1,890**	**5,935**	**4,045**	**12,547**	**21,339**	**8,792**	**43,321**
TOTAL INCOME	**22,736**	**24,159**	**1,423**	**91,306**	**94,150**	**2,844**	**276,775**
EXPENDITURE							
Total Pay	**(14,986)**	**(15,694)**	**(708)**	**(60,303)**	**(62,942)**	**(2,639)**	**(180,692)**
Non Pay	(5,131)	(4,825)	306	(21,052)	(19,791)	1,260	(62,678)
Non Tariff Drugs (high cost/individual drugs)	(1,773)	(1,759)	14	(6,475)	(6,042)	433	(19,348)
Non Pay	**(6,904)**	**(6,584)**	**320**	**(27,527)**	**(25,834)**	**1,693**	**(82,026)**
TOTAL EXPENDITURE	**(21,890)**	**(22,277)**	**(387)**	**(87,829)**	**(88,775)**	**(946)**	**(262,718)**
EBITDA*	**847**	**1,882**	**1,035**	**3,477**	**5,375**	**1,898**	**14,057**
Depreciation and non-operating costs	(999)	(974)	26	(3,997)	(3,890)	106	(11,995)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(152)**	**908**	**1,061**	**(519)**	**1,484**	**2,004**	**2,063**
Public Dividends Payable	(260)	(977)	(717)	(1,040)	(1,757)	(717)	(3,120)
OPERATING DEFICIT AFTER DIVIDENDS	**(412)**	**(68)**	**344**	**(1,559)**	**(272)**	**1,288**	**(1,058)**
Adjustments to reach control total							
Donated Income	0	0	0	0	0	0	(1,000)
Donated Assets Depreciation	68	68	0	272	272	0	816
Control Total Rounding	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
PSF/FRF/MRET	(269)	0	269	(6,023)	0	6,023	(23,026)
CONTROL TOTAL DEFICIT	**(613)**	**(0)**	**613**	**(7,310)**	**0**	**7,311**	**(24,268)**

* EBITDA = Earnings before Interest, Taxation, Depreciation and Amortisation

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st July 2020

	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	1,575	642	933
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**1,575**	**642**	**933**
Non-cash income and expense:			
Depreciation and amortisation	3,801	2,850	951
Impairments	0	0	0
(Increase)/Decrease in Trade and Other Receivables	2,421	(1,551)	3,972
(Increase)/Decrease in Inventories	(4)	(4)	0
Increase/(Decrease) in Trade and Other Payables	368	5,990	(5,622)
Increase/(Decrease) in Other Liabilities	25,031	24,210	821
Increase/(Decrease) in Provisions	(145)	(134)	(11)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	0	0	0
Other movements in operating cash flows	(4)	(3)	(1)
NET CASH GENERATED FROM OPERATIONS	**33,043**	**32,000**	**1,043**
Cash flows from investing activities			
Interest received	4	4	0
Purchase of financial assets	0	0	0
Purchase of intangible assets	(3,687)	(3,645)	(42)
Purchase of Property, Plant and Equipment, Intangibles	(148)	344	(492)
Sales of Property, Plant and Equipment			
Net cash generated (used in) investing activities	**(3,831)**	**(3,297)**	**(534)**
Cash flows from financing activities			
Public dividend capital received	1447	0	1,447
Loans received from Department of Health	0	0	0
Loans repaid to Department of Health	0	0	0
Capital element of finance lease rental payments	(74)	(69)	(5)
Interest paid	0	0	0
Interest element of finance lease	(94)	(70)	(24)
PDC Dividend paid	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0
Net cash generated from/(used in) financing activities	**1,279**	**(139)**	**1,418**
Increase/(decrease) in cash and cash equivalents	**30,491**	**28,564**	1,927
Opening Cash and Cash equivalents	**16,286**	**16,286**	
Closing Cash and Cash equivalents	**46,777**	**44,850**	**1,927**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st July 2020

	Audited Mar-20	Jul-20 YTD Plan	Jul-20 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	143.2	179.1	142.6	(36.5)	(0.6)	(0.4%)
Intangible Assets	16.1	13.1	15.5	2.4	(0.6)	(3.7%)
Other Assets	0.9	0.6	0.9	0.3	0.0	0.0%
Total Non Current Assets	**160.2**	**192.8**	**159.0**	**(33.8)**	**(1.2)**	**(0.7%)**
Assets Current						
Inventory	3.4	3.2	3.4	0.2	0.0	0.0%
NHS Receivables	18.7	15.3	10.7	(4.6)	(8.0)	(42.8%)
Other Receivables	6.9	2.6	12.4	9.8	5.5	79.7%
Cash	16.3	1.0	46.8	45.8	30.5	187.1%
Total Current Assets	**45.3**	**22.1**	**73.3**	**51.2**	**28.0**	**61.8%**
Liabilities Current						
Interest -bearing borrowings	(131.3)	(2.0)	(131.3)	(129.3)	0.0	0.0%
Deferred Income	(2.3)	(1.6)	(27.3)	(25.7)	(25.0)	1087.0%
Provisions	(1.5)	(1.3)	(1.3)	0.0	0.2	-13.3%
Trade & other Creditors (incl NHS)	(38.9)	(26.9)	(39.8)	(12.9)	(0.9)	2.3%
Total Current Liabilities	**(174.0)**	**(31.8)**	**(199.7)**	**(167.9)**	**(25.7)**	14.8%
Net current assets	**(128.7)**	**(9.7)**	**(126.4)**	**(116.7)**	**2.3**	**(1.8%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(5.8)	(31.3)	(5.8)	25.5	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(0.8)	(1.6)	(0.8)	0.0	0.0%
Total non-current liabilities	**(7.4)**	**(32.1)**	**(7.4)**	**24.7**	**0.0**	0.0%
Total Assets Employed	**24.1**	**151.0**	**25.2**	**(126.0)**	**1.1**	**4.7%**
Taxpayers Equity						
Public Dividend Capital (PDC)	105.3	222.7	106.7	(116.0)	1.4	1.3%
Revaluation Reserve	48.4	57.7	48.4	(9.3)	0.0	0.0%
I&E Reserve	(129.6)	(129.4)	(129.9)	(0.5)	(0.3)	0.2%
Total Taxpayers Equity	**24.1**	**151.0**	**25.2**	**(125.8)**	**1.1**	**4.6%**

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 3 September 2020**
Report title:	**Workforce Information Report**	**Agenda item: 5.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:	**Public**	

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 July 2020 (Month 4) and relevant Workforce and Organisational Development updates to Trust Board.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note and receive the Workforce Report for Month 4.			

Strategic objectives links	Objective 8: Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC outcome/ regulation links	Well Led Outcome 13: Staffing
Identified risks and risk management actions	1606 - We may be unable to recruit sufficient qualified nurses for safe staffing in wards and departments 1613 - IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover LEADING TO clinical risk.
Resource implications	
Legal implications including equality and diversity assessment	
Report history	Trust Board, July 2020 (Month 3)
Next steps	
Appendices	

Workforce report – Month 4, 2020/21

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 July 2020 (Month 4), covering the preceding 13 months.

2. Summary of Key Performance Indicators (KPIs) and Compliance

Indicator	Measure	Target	07/2019	08/2019	09/2019	10/2019	11/2019	12/2019	01/2020	02/2020	03/2020	04/2020	05/2020	06/2020	07/2020
Staff in post (as at report date)	WTE		3079.1	3058.5	3084.3	3121.3	3124.6	3115.0	3138.9	3152.5	3177.3	3177.0	3238.8	3266.8	**3276.7**
	Headcount		3563	3538	3566	3602	3609	3595	3620	3636	3666	3656	3723	3761	**3766**
Establishment (as at report date - as per	WTE		3486.9	3493.6	3493.6	3462.3	3462.1	3462.0	3448.3	3452.3	3456.3	3690.8	3698.6	3693.9	**3694.0**
	%, Vacancy Rate	10%	11.7%	12.5%	11.7%	9.8%	9.7%	10.0%	9.0%	9.1%	8.1%	13.9%	12.4%	11.6%	**11.3%**
Staff Costs (12 months)	%, Temp Staff Cost		14.4%	14.3%	14.3%	14.3%	14.2%	14.0%	14.0%	13.9%	13.8%	13.8%	13.3%	12.9%	**12.5%**
	%, Temp Staff Usage		14.5%	14.5%	14.4%	14.4%	14.5%	14.4%	14.3%	14.3%	14.2%	14.1%	13.6%	13.2%	**12.8%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.0%	3.9%	3.9%	4.0%	4.0%	3.9%	3.9%	3.9%	4.1%	4.4%	4.5%	4.5%	**4.5%**
	- %, 12 month Absence Rate - Long Term		*2.3%*	*2.2%*	*2.2%*	*2.3%*	*2.3%*	*2.2%*	*2.2%*	*2.2%*	*2.2%*	*2.3%*	*2.4%*	*2.4%*	***2.4%***
	- %, 12 month Absence Rate - Short Term		*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.9%*	*2.1%*	*2.1%*	*2.1%*	***2.1%***
	%,In month Absence Rate - Total		3.5%	3.4%	3.6%	4.3%	4.2%	4.2%	4.2%	4.2%	6.5%	7.6%	4.7%	3.4%	**3.4%**
	- %, In month Absence Rate - Long Term		*2.0%*	*2.1%*	*2.0%*	*2.3%*	*2.3%*	*2.4%*	*2.2%*	*2.3%*	*2.5%*	*3.3%*	*3.0%*	*2.1%*	***2.3%***
	- %, In month Absence Rate - Short Term		*1.6%*	*1.3%*	*1.6%*	*2.1%*	*1.9%*	*1.8%*	*1.9%*	*1.9%*	*4.0%*	*4.3%*	*1.7%*	*1.4%*	***1.1%***
	- %, In month Absence Rate - COVID-19 Sickness Absence										1.4%	3.8%	1.3%	0.5%	**0.2%**
Starters, Leavers and T/O rate (12 months)	WTE, Starters		373.2	367.4	364.5	368.1	367.7	360.8	340.2	339.3	362.1	369.4	363.3	355.1	**355.9**
	Headcount, Starters		417	412	410	414	416	410	390	388	414	424	415	406	**408**
	WTE, Leavers		274.7	263.7	268.7	270.2	258.0	258.0	255.1	245.9	268.3	270.4	259.9	249.5	**251.7**
	Headcount, Leavers		318	303	310	312	299	298	297	289	315	318	306	295	**298**
	%, Leaver Turnover Rate	10%	10.1%	9.2%	9.4%	9.5%	9.1%	9.0%	9.0%	8.7%	9.4%	9.6%	9.2%	8.8%	**8.8%**
	%, Stability Index		84.8%	85.5%	85.3%	85.4%	85.5%	85.4%	85.4%	85.1%	85.7%	84.4%	85.6%	86.3%	**86.4%**
Statutory/Mandatory Training	%, Compliance	90%	92%	93%	93%	92%	92%	92%	95%	94%	94%	94%	93%	94%	**94%**
Appraisals	%, Compliance	90%	90%	91%	91%	91%	94%	93%	97%	96%	94%	90%	90%	92%	**93%**
Time to Hire (days)	General Recruitment	35	47	46	53	54	58	49	59	54	48	66	58	60	**49**
	Medical Recruitment (excl Deanery)	35	58	83	97	92	105	72	93	26	30	36	59	54	**40**
Employee relations	Number of open disciplinary cases			18			18			14				26	**26**

2.1. The Trust's **vacancy rate** has reduced for the third consecutive month, July's rate being recorded at 11.3%. As recruitment and outreach activity increases, further reductions are anticipated as the year moves into Q4.

2.2. The new **Resourcing Control Panel** continues, however some changes to the format have been agreed. One key theme will be discussed in detail, enabling a far more granular review of data. The data provided by Workforce is proving to be helpful allowing Divisions to review their establishment data and work in collaboration with HR and Finance to make changes to ESR, which are, in-turn reflected in HealthRoster. Such changes result in a significant improvement in data quality and help to surface staffing and rostering practice issues.

Key themes for review include:

1. Action log
2. Long line agency usage monthly review
3. Roster review and month check and challenge feedback
4. Time to Hire and recruitment review

2.3. The impact of the Covid-19 pandemic on **staff absence** is reducing (3.4%); in month, short-term absence (1.1%) has decreased slightly while long-term absence (2.3%) has increased marginally. Overall, the Trust sickness absence levels have now returned to pre-Covid-19 levels. As expected Covid-19 specific sickness continues to reduce and dropped further to 0.2% in July.

2.4. **The Stability Index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period).* Our stability index figure has increased this month by 0.1% to 86.4%. Stability within the organisation is crucial during turbulent times and is helpful to understand the longer-term impact of our various interventions and staff support programmes.

2.5. **Time to hire** has reduced for general recruitment by 11 days; primarily due to greater focus on timely shortlisting. Contact is also routinely being made with candidates under employment offer, but who have not responded to requests for employment checks. Divisional recruitment has increased resulting in a positive impact on the time to hire. Medical staffing activity has also increased but time to hire has been impacted by delays in issuing visas. UK Border Agency (Visas and Immigration) centres are now open but quarantine restrictions remain in place for incoming new entrants in line with national guidance from the Foreign and Commonwealth Office.

2.6. **Employee Relations cases** – the net number of open disciplinary cases has remained the same as the M3 position. A number of these were placed on hold, pending further investigation during the pandemic following guidance from NHS Employers. These cases have now started to increase following the re-commencement of normal procedures and hearings.

2.7. The Trust has updated its disciplinary policy which now places emphasis on preliminary investigations. This helps all involved due to the negative effect that formal

investigations can have. Positive progress has been seen over the course of the year, as the team has reduced timelines and improved our outcomes (reported in detail to JCNC, Workforce Board and Workforce and Development Assurance Committee).

3. Continuous Improvement, Transformation and Innovation

3.1. **Manager self-service,** as previously reported all divisions are now live. As managers begin to use the technology and expand the number and complexity of transactions, further training and support has been required. Drop-in sessions have been held to support the roll out and ensure a smooth transition. Support has also been given to staff with setting up the MyESR app on devices and helping them to view their payslips.

3.2. **Safecare pilot**. Wards 20, 17, 8 will now be joined by Ward 3. Labour Ward has been replaced as a pilot area due to the development a new continuity of care model which requires implementation and embedding before any system configuration can take place. Facilitated by Allocate the initial process mapping for Safecare has been completed, along with basic training for the HR Systems team.

3.3. **Paper payslips** have been switched off, staff are now encouraged to visit the Employee self-service portal to view current and historic payslips. The HR Service and Systems teams are at hand to help anyone experiencing issues accessing their payslip. Implementation has been positive, with a high volume of colleagues from Estates, and Hotel services attending sessions. For all workforce initiatives, help guides are available on the Workspace staff intranet, colleagues are encouraged to access these.

3.4. **eLearning** – during the Covid-19 pandemic the remainder of the outstanding statutory and mandatory training courses have been converted to eLearning accessible modules via the HEE eLearning for Healthcare programme. The Trust has enabled access via its Electronic Staff Record system which has been well received resulting in sustained compliance levels throughout the Covid-19 peak.

4. Culture and Staff Engagement

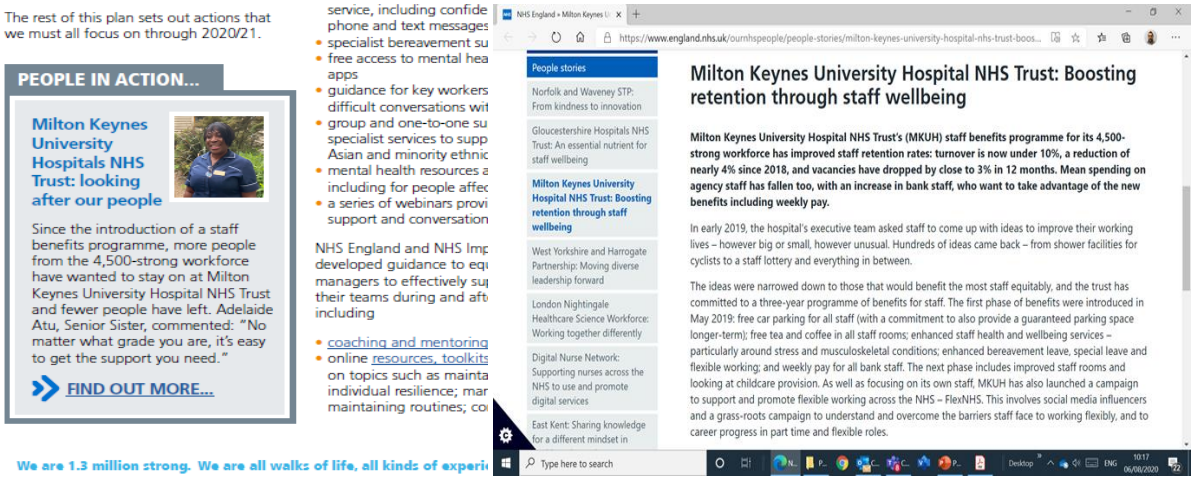
4.1. An **agile working strategy** has been developed which encompasses home/remote and flexible working as the Trust seeks to increase its staff support package further to the recently developed Virtual Care Circles. This will provide the framework to support the changing employment environment of the Trust.

4.2. Planning has commenced for the **National NHS Staff Survey 2020** and the **seasonal Flu campaign**. A targeted 3 week 'Protect and Reflect' campaign will run from 5 to 23 October 2020 to ensure that colleagues are booked into protected time slots to undertake their Staff Survey, get their flu vaccinations and learn more about the Trust's health and wellbeing developments. Rota co-ordinators and Ward Managers have been involved in the planning phases with many booking slots already allocated alongside off-duty commitments.

5. Current Affairs & Hot Topics

5.1. **NHS People Plan** – the full People Plan builds on Interim People Plan (June 2019) and the developing post-Covid-19 world – how best to deliver aspirations in the context of a renewed national support for NHS. The Plan outlines actions to support transformation across the whole NHS; how we must continue to look after each other, foster a culture of inclusion and belonging, grow our workforce, train our people, and work together differently to deliver patient care.

5.2. #TeamMKUH features early in the People Plan in respect of retention and the impact of our benefits programme, and most notably its key role in @FlexNHS, as lead by Kate Jarman, our Director of Corporate Affairs.



5.3. The Trust has a comprehensive Workforce Strategy (2018-21) in place which has delivered many of its actions as outlined by the People Plan, however, a detailed action plan is in development by the senior Workforce team to ensure complete delivery.

5.4. Monitoring and support will be through Integrated Care Systems, Regional People Boards and the Single Oversight Framework with further metrics anticipated in September 2020.

5.5. The **Covid-19** staff health call lines and welfare calls remain in place and the Trust continues to support testing (swabbing) of symptomatic colleagues and non-symptomatic family or household members where required. Antibody testing drop-in clinics are also continuing for colleagues and the Trust is planning to support further research studies in this regard.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 4.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 3 September 2020**
Report title:	**Freedom to Speak Up Annual Report 2019/20**	**Agenda item: 7.1**
Lead director **Report author** **Sponsor(s)**	**Name: Danielle Petch** **Name: Philip Ball** **Name: Joe Harrison**	**Title: Director of Workforce** **Title: Lead Nurse Palliative and End of Life Care** **Title: Chief Executive**
FoI status:		

Report summary	The role of the Freedom to Speak Up Guardian was created as a recommendation from Sir Robert Francis' report that was published in 2015 following his investigation into what went wrong at Mid-Staffordshire NHS Foundation Trust. All Trusts are required to have a Guardian in place to support members of staff who wish to raise concerns, but may feel unable to do so. Guardians are required to report to the Board at least annually on their activities. Philip Ball is currently MKUH's only Guardian and this is his third annual report.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	That the Board notes the contents of this Annual Report and questions the Guardian and the executive lead about Freedom to Speak Up within MKUH			

Strategic objectives links	Objective 7 Become well governed and financially viable
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	This is an annual report
Next steps	
Appendices	

Freedom to Speak Up Guardian Annual Report 2019-20

Executive Summary

This is the third annual report to the Trust Board on Freedom to Speak Up in the Trust for the 12 months from April 2019 to March 2020. The Freedom to Speak Up Guardian is a developing role across the NHS and was created as one of the main recommendations of the Freedom to Speak Up Review carried out by Sir Robert Francis and published in 2015 subsequent to his main report about what went wrong at Mid-Staffordshire NHS Foundation Trust.

The role of Freedom to Speak Up Guardian was created at MKUH in April 2017. Its purpose is to provide independent and confidential support to staff who wish to raise concerns and promote a culture in which staff feel safe to raise those concerns. In the 12 months under consideration, one member of staff contacted the Guardians with their concern. This was resolved through mediation. The lack of speaking up during this time is of concern though no obvious reasons for this have been identified.

There have been changes in the people acting as Guardians during this period as Nicky Burns-Muir changed role and Adewale Kadiri left the Trust in November 2019.

Philip Ball, Lead Nurse Palliative and End of Life Care, agreed to become Guardian and began formally in July 2019 following training via the National Guardian's Office (NGO). Further efforts to expand the number of Guardians and Champions have been impacted by COVID-19, a situation leaving only one official Guardian trained by the NGO. Protected time for Guardians is an ongoing issue. The NGO is telling the CQC that lack of protected time should impact negatively on a Well led inspection result.

This is an annual report. This report has not been presented to any committees or groups in the Trust.

Background to Freedom to Speak Up

In 2016-17 it became a contractual requirement for all NHS provider trusts to have a Freedom to Speak Up Guardian. By the end of that financial year, all trusts in England had made appointments. Trusts were also expected to adopt a model NHS whistleblowing/raising concerns policy.

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead cultural change in the NHS so that speaking up becomes part of 'business as usual'. The office is not a regulator, but is sponsored by the CQC, and NHS England/Improvement.

The NGO supports the National Guardian for the NHS Dr Henrietta Hughes, in providing leadership, training and advice for Freedom to Speak Up Guardians based in all NHS Trusts. The Office also provides challenge, learning and support to the healthcare system by reviewing trusts' speaking up culture and the handling of concerns where they have not followed good practice. The NGO has a very small team that limits its capacity to support Guardians. Philip Ball has contacted the East of England Regional Guardians group and recently begun a WhatsApp support group where issues can be safely discussed.

The Role of the Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised. The Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. There are two key elements to the role:

- To give independent, safe, and confidential advice and support to members of staff who wish to raise concerns that could have an impact on patient safety and experience.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, and a telephone extension is available (ext. 86296) as another way of contacting the Guardians, particularly for staff who do not normally use email. This has a drawback in that the caller can be anonymous making feedback and changes difficult.

The NGO has encouraged the development of the FTSU Ambassador/Champion role – mainly as a way of signposting staff either to the Guardians, or to other support systems within the organisation, where their concerns may be more appropriately addressed. This has been particularly helpful in MKUH where the only Guardian already has a full-time role. As such during 2019 expressions of interest were invited from any colleagues who wished to take up this opportunity. Several people put themselves forward and 5 others willing to be Guardians and 7 potential Champions were identified. This willingness to become engaged in FTSU activity is a testament to the openness of the Trust, though further training has been stymied by COVID-19 and having only one Guardian. Despite offering internal training to these volunteering staff members the NGO has made it clear they cannot be regarded as Guardians and Champions until trained by the NGO. The restart of NGO training, whether face to face or on-line is awaited.

Freedom to Speak Up activities in the Trust

The FTSU information submitted for MKUH during 2019/20 was limited to one case. The data submitted to the NGO will show a low rate of speaking up, and this remains a cause for concern although further cases have come forward recently.

Philip Ball has been contacting East of England Guardians and attending web-based events put on the NGO. He was able to attend a London and East of England regional event in central London shortly before COVID-19 lockdown was imposed that helped further networking.

During that meeting it became clear that protected time for Guardians, where no paid post is in place, should be allowed for. The NGO has been telling the CQC that lack of protected time for Guardians should be regarded negatively in terms of being a Well Led organisation.

During October 2019, Speaking Up month, efforts were made to recruit further interest in being a Guardian or Champion that helped bolster interest though it did not impact on actual incidents of speaking up.

Changing the Culture

As noted earlier in this paper, one of the aims of Sir Robert Francis' recommendation was to help establish a culture of openness within the NHS. The MKUH Guardian, supported by the Director of Workforce as executive lead, is helping to achieve this in several ways including:

Raising awareness: All new staff are given information about Freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. Philip Ball has recorded a video introduction that is with the Learning and Development team for final editing.

An improved intranet page is in place and fresh posters with names of Guardians and with reminders of ways to speak up has been prepared. Making sure that communications about staff support include references to FTSU, as this has been lacking on occasion.

The Guardian still needs time to set up a programme whereby Guardians and or Champions attend team meetings to deliver short presentations to promote FTSU. The Guardians may also be invited to attend meetings of the newly formed staff networks.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend most time in direct contact with patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up, and also to prepare managers to receive feedback from their staff when they have concerns.

Influencing cultural change: There needs to be continued collaborative working with HR to develop a campaign to raise awareness about bullying and harassment and how to address and combat this behaviour.

National and Regional Developments

MKUH previously sat within both the East Midlands and Thames Valley Wessex regional guardians' networks. Following a recent national reorganisation to align FTSU with the NHSI/E regional structure, MKUH has now been placed in the East of England region, and the Guardian has to build relationships with colleagues across the area.

In August 2019, the NGO issued a document entitled "National guidelines on Freedom to speak Up training in the health sector in England", providing some suggestions on the content of training on FTSU for all levels of staff including middle and senior managers. The Guardian will again work with the executive lead to see how these requirements can best be met. The detailed training packages from the NGO have been impacted by COVID-19 and are still awaited.

Plans for 2020-21

- With the appointment of Philip Ball as a new Guardian, and the appointment of new Guardians and Ambassadors, it is intended that the whole MKUH approach to FTSU be re-launched during October 2020, as it is the 'Speak Up' month.
- The addition of questions on the leaver's questionnaire about awareness of the FTSU Guardians and whether they had used the service.
- To participate in the development of the role of the Freedom to Speak Up Guardian and become active in the new East of England regional group.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust through use of feedback to the Guardian about how well use of the service has worked.
- Become regular contributors to team, departmental and divisional meetings; engage with networks such as the Disability and BAME that are developing at MKUH.

Recommendation

The Trust Board is asked to note the contents of the annual report by the Freedom to Speak Up Guardian.

Philip Ball, FTSU Guardian

24th August 2020

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date: 3 September 2020
Report title:	Changes to the Constitution and Terms of Reference of Corporate Management Board and Divisional Management Board	Agenda item: 8.1
Lead director Report author Sponsor(s)	Kate Jarman	Director of Corporate Affairs
FoI status:	Disclosable	

Report summary	The Executive Directors are proposing a change to the terms of reference and constitution of the Corporate and Divisional Management Board to better reflect the decision-making apparatus of the Trust and to align reporting and decision making with Gold and Silver Command structures in use during any major incident.			
Purpose *(tick one box only)*	Information ☐	Approval x	Discussion ☐	Decision ☐
Recommendation	That the Board approves these changes			

Strategic objectives links	Objective 7, well governed
Board Assurance Framework links	BAF
CQC regulations	Regulation 17:Good governance
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	TORs regularly reviewed
Next steps	Board of Directors decision
Appendices	Papers follow

Changes to the Constitution and Terms of Reference of Corporate Management Board and Divisional Management Board

The Executive Directors are proposing a change to the terms of reference and constitution of the Corporate and Divisional Management Board to better reflect the decision-making apparatus of the Trust and to align reporting and decision making with Gold and Silver Command structures in use during any major incident.

These changes would dissolve Corporate Management Board and replace it with the Trust Executive Group.

The Trust Executive Group comprises the Executive Directors, who meet informally twice weekly. Each month the Trust Executive Group meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads (as specified in the terms of reference).

The Trust Executive Group meetings are chaired by the Chief Executive. The formal monthly business meeting provides scrutiny and oversight across clinical quality, operational and financial performance; as well as compliance and governance reporting; approval of business cases, investment plans and etc (in accordance with the terms of reference).

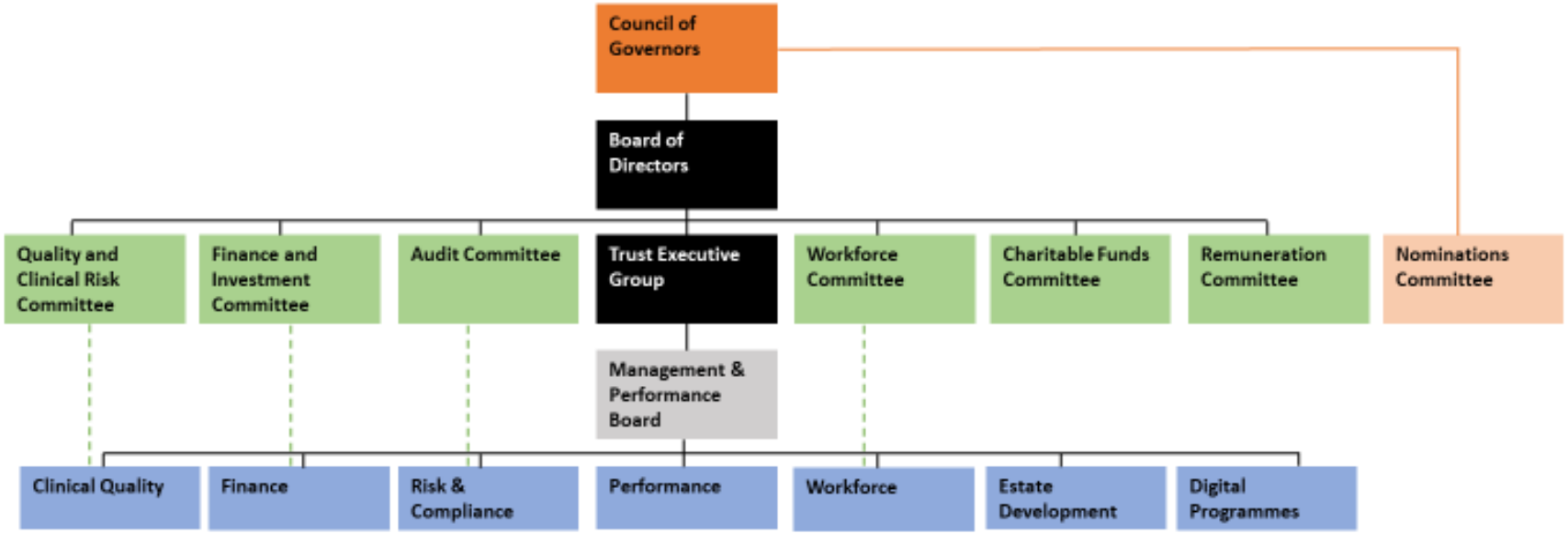
During major incidents, the Trust Executive Group may meet more frequently as Gold Command (as determined by the nature and duration of the incident).

These changes would dissolve Divisional Management Board and replace it with the Management and Performance Board.

The Management and Performance Board comprises the Executive Directors and divisional management. The Management and Performance Board meets monthly, and is chaired by the Deputy Chief Executive. The purpose of the meeting is to hold divisional management to account for the clinical, operational and financial performance of their clinical service units and division overall.

The meeting receives formal reports from each division, and each division attends separately to present their integrated performance reports for detailed scrutiny and discussion.

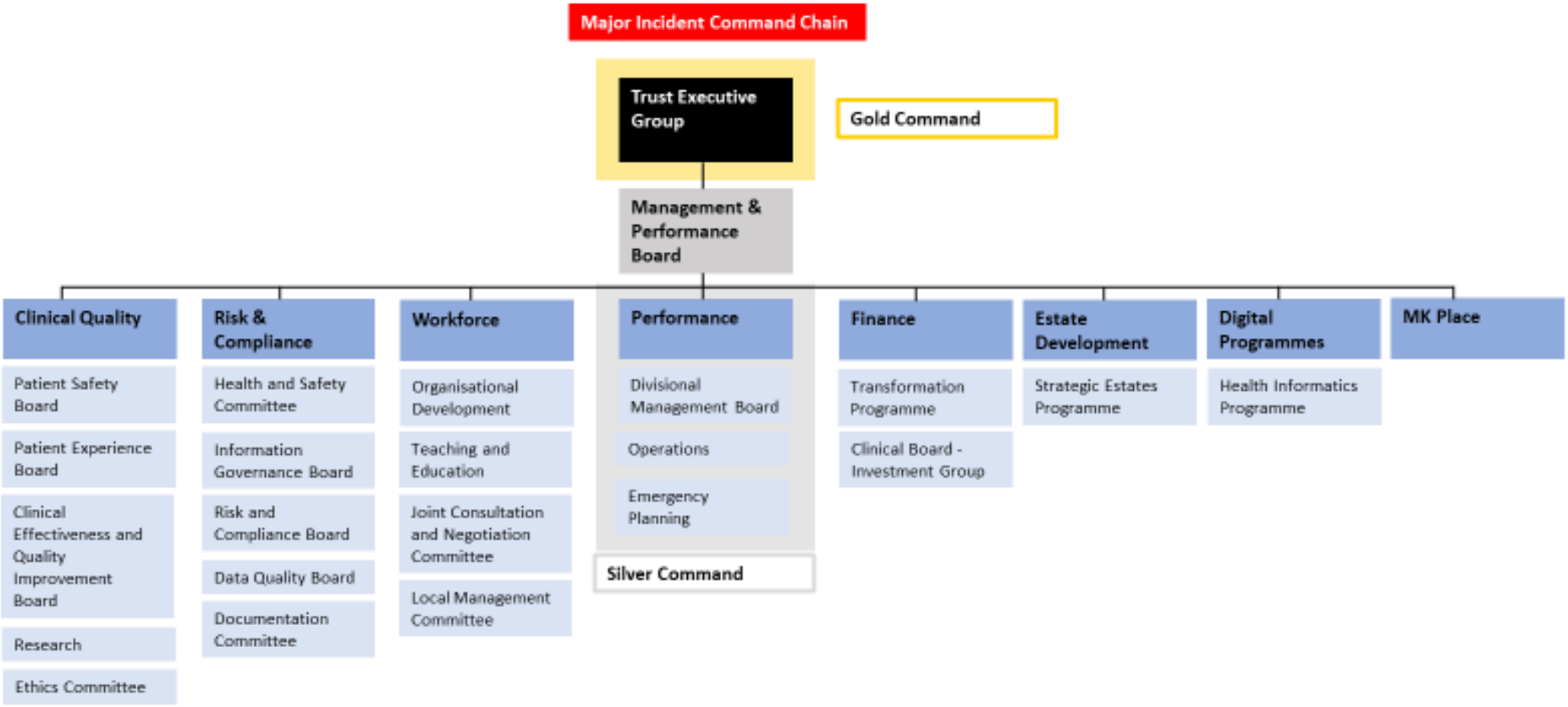
The revised structures are set out below and the terms of reference are attached for comment and approval.



This is the Trust's **corporate governance structure** at **Trust Board (Board of Directors)** level.
The role of the Trust Board is to:

- Set the strategy for the hospital
- Ensure accountability (hold the organisation to account for delivering the strategy and seek assurance that the systems of control are robust and reliable
- Shape the culture of the organisation

In an NHS Foundation Trust the Trust Board is held to account by an elected Council of Governors. The Council is made up of elected staff and public members, representing constituencies. Nominated stakeholders also sit on the Council of Governors. This increases public scrutiny, oversight and accountability.



This is the Trust's **corporate governance structure** at Trust Executive Group
You can see the main reporting lines and groups to the **Trust Executive Group**, which retains oversight and management of the hospital and its operational, financial and clinical quality performance.

Corporate Governance and Major Incident Command Chain

Trust Executive Group

Gold Command

The Trust Executive Group comprises the Executive Directors, who meet informally twice weekly. Each month the Trust Executive Group meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads (as specified in the terms of reference). The Trust Executive Group meetings are chaired by the Chief Executive. The formal monthly business meeting provides scrutiny and oversight across clinical quality, operational and financial performance; as well as compliance and governance reporting; approval of business cases, investment plans and etc (in accordance with the terms of reference).

During major incidents, the Trust Executive Group may meet more frequently as Gold Command (as determined by the nature and duration of the incident).

Management & Performance Board

Divisional Management Board

Operations

Emergency Planning

Silver Command

The Management and Performance Board comprises the Executive Directors and divisional management. The Management and Performance Board meets monthly, and is chaired by the Deputy Chief Executive. The purpose of the meeting is to hold divisional management to account for the clinical, operational and financial performance of their clinical service units and division overall.

The meeting receives formal reports from each division, and each division attends separately to present their integrated performance reports for detailed scrutiny and discussion.

During major incidents, a Silver Command will be established, comprising divisional management and senior clinical and professional heads of service. Silver Command will meet as frequently as the nature and duration of the major incident determines.

Each month the **Trust Executive Group** meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads (as specified in the terms of reference). The Trust Executive Group meetings are chaired by the Chief Executive. The formal monthly business meeting provides scrutiny and oversight across clinical quality, operational and financial performance; as well as compliance and governance reporting; approval of business cases, investment plans and etc (in accordance with the terms of reference).

Trust Executive Group

Management & Performance Board

Management and Performance Board
The Divisional Director (a doctor); Divisional General Manager; and Divisional Head of Nursing present the performance (quality, finance, operational performance, compliance and governance). They are held to account for divisional performance and escalate any risks and issues to the wider Board.

Divisional Management Meetings

Divisional Management Meetings are chaired by Divisional Director and meet monhtly. Clinical Service Unit leads all attend, trends and assurance, strategy, performance, finance, clinical governance and quality). Covers the quality, performance and finance agenda at divisional level.

Clinical Service Unit meetings are chaired by CSU Lead, meet approximately 10 times a year for two-way information flow (reporting, escalation and cascade). Covers the quality, performance and finance agenda at CSU level.

Clinical Service Unit Management Meetings

Clinical Improvement Group Meetings

Clinical Improvement Groups (CIGs) meet monthly in every CSU (and also in specialties in larger CSUs are CIGs).
CIGs meet to discuss clinical governance and quality, including incidents, complaints, risks, audit, compliance, etc), mortality & morbidity (and etc).

The structure shown on this page shows the divisional governance structure.

You should be familiar with the meetings described here and will attend many of them, depending on your role. If you are unsure about the governance and reporting structure for your division, please speak to your manager in the first instance.

Milton Keynes University Hospital NHS Foundation Trust

Trust Executive Group

Terms of Reference

Summary

The Trust Executive Group comprises the Executive Directors, who meet informally twice weekly. Each month the Trust Executive Group meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads (as specified in the terms of reference). The Trust Executive Group meetings are chaired by the Chief Executive.

The formal monthly business meeting provides scrutiny and oversight across clinical quality, operational and financial performance; as well as compliance and governance reporting; approval of business cases, investment plans and etc (in accordance with the terms of reference).

During major incidents, the Trust Executive Group may meet more frequently as Gold Command (as determined by the nature and duration of the incident).

Meetings and Conduct of Business

The Board hereby resolves to establish an Executive Committee of the Board to be known as the **Trust Executive Group (TEG)**. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

The TEG is responsible for overseeing the effective operational management of the Trust including the fulfilment of statutory and regulatory requirements; the monitoring of clinical standards and targets; the delivery of high-quality patient centred care; the monitoring of financial performance; and the monitoring of corporate/ business data and information pursuant to the effective running of the organisation.

The TEG is the designated senior operational leadership and decision-making body of the Trust and is chaired by the Chief Executive.

The TEG is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Board.

The TEG is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

Purpose

The TEG is the primary executive decision-making body of the Trust with responsibility for:

- Providing effective operational leadership of the Trust
- Ensuring the Trust delivers safe, high quality and cost-effective services,
- Ensuring the objectives and key performance indicators in annual and operational plans are delivered
- Ensuring statutory and regulatory compliance is met

Membership

Core Membership

- Chief Executive (Chair)
- The Executive Directors
- The Divisional Triumvirate (Divisional Director, Divisional General Manager and Head of Nursing or Head of Midwifery or Lead Allied Health Professional)

Attendance for Agenda-Specific Items

Senior management staff will be expected to attend TEG for agenda-specific items. The Company Secretary, in planning the meeting agenda with the CEO, will inform staff of the requirement to attend.

Members of the TEG are expected to attend all meetings in person. If they are on annual or sick leave, members may send nominated deputies. The meeting secretary should be notified of the attendance of deputies at least 24 hours in advance of the meeting.

The Chief Executive will nominate a member of the TEG to Chair the meeting in his/her absence.

Frequency and Type of Meeting

The TEG comprises the Executive Directors, who meet informally twice weekly.

Once a month the Trust Executive Group meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads as required.

The meeting will focus on corporate/ Trust-wide reporting and accountability. This requires corporate groups to present upward reports on the exercising of their delegated accountabilities. The meeting will also receive an upward report and items of escalation or for approval from the Management and Performance Board.

The reporting structure is available on the intranet.

Quorum

The meeting is quorate when at least three Executive Directors and (at the monthly formal TEG) two Divisional Directors are present.

Principles

The following principles will underpin the work of the TEG:

The TEG will:

- Lead by example by embodying the Trust's values in its work
- Act as an inclusive team, exploiting each other's strengths, demonstrating strong corporate commitment and trust
- Work to transparent and clear priorities
- Have a bias to action
- Have strong and effective communications
- Share information from TEG meetings with the wider organisation as appropriate, respecting the need to maintain confidentiality when required. This includes communicating upwards and downwards in the organisation and consulting colleagues prior to meetings as appropriate.
- Provide papers and presentations for the meeting in accordance with the agreed deadlines and in the required format

Duties

- To ensure the Trust provides safe, high quality care and use resources efficiently and effectively.

- To promote and protect the safety of patients and the quality of their experience.

- To value staff and promote and safeguard their welfare enabling the Trust to secure maximum value from its staff resources.

- To ensure the Trust has strong relationships within the local health economy and with local stakeholders and is recognised as a trusted and valued part of the local health community. Including:

- Listen to and learn from feedback from patients and stakeholders and agreeing action as appropriate

- To ensure appropriate engagement with stakeholders and report on the outcome of engagement activity

- To provide direct input to issues and decisions to be presented to the Trust Board for approval, as appropriate.

- To contribute to the Trust's strategic and annual business plans for approval by the Board.

- To consider and approve business cases and proposals for the appropriate deployment of the Trust's capital and revenue resources in accordance with the Standing Financial Instructions

- To review corporate and operational performance against the business plan objectives and key performance indicators and agree actions to improve delivery and performance as appropriate.

- To ensure the Trust operates in a cost effective manner, working within agreed budgets and to review performance against the Trust's budget including: delivery against Cost Improvement and Transformation Programme Plans; expenditure against forecast

- To support the Chief Executive in exercising their lead management responsibility for risk management, the internal control environment and the implementation of the Trust's quality governance assurance framework, risk management strategy and policy.

- In conjunction with delegated clinical governance groups, to review any lessons learned from patient feedback, external reviews and Major and Serious Incidents, to recommend amendments to the Trust's policies, procedures and practices as a result of this learning and to close the loop ensuring that these recommendations are implemented throughout the Trust.

- To exercise effective oversight of the Trust's arrangements for ensuring compliance with its statutory and regulatory obligations, including performance targets under the NHS Constitution

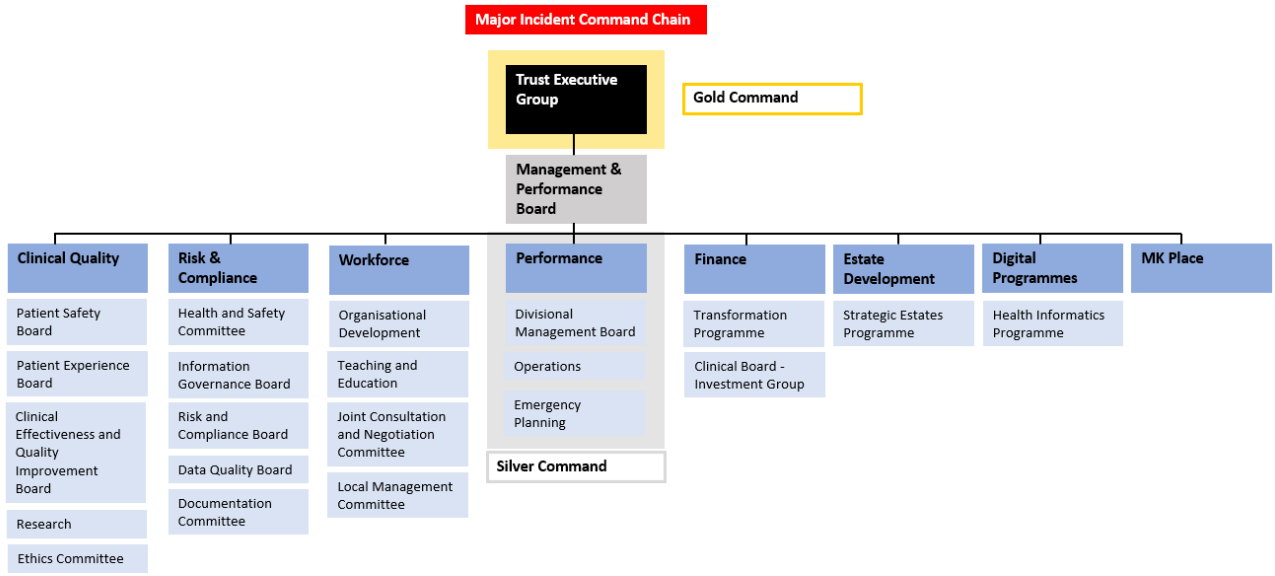
- To enable the Trust to operate with an awareness of relevant national and international guidance and best practice.

- To approve Trust policies and strategies in accordance with agreed procedures.

Sub-Groups

The TEG will be responsible for ensuring that adequate management arrangements are in place to ensure that the Trust provides safe and high-quality services to its patients.

The groups reporting to TEG are contained within the corporate governance structure, available on the Trust intranet. These include all main operational committees and boards.



Upward Reporting

The TEG will provide a monthly summary report to the Trust Board or appropriate Board Committee.

Communication from TEG

The Company Secretary will liaise with the Communications Team regarding communications for staff following TEG meetings as appropriate.

Administration of TEG

The Company Secretary will be responsible for providing support for TEG meetings, including:

- Issuing agendas and papers
- Producing minutes & maintaining the action log
- Providing a report template
- Producing a work-plan for the year

The minutes of the TEG will be reported to the next TEG meeting for approval and it will be maintained and updated by the meeting secretary. Actions for people not present at the meeting will be communicated directly to them within a maximum of one week from the meeting.

Version control

Version	Date	Author	Comments	Status
1.0	28.04.10	Maria Wogan	First draft endorsed by Board	Endorsed

		Trust Secretary		
1.1	26.01.11	Maria Wogan Trust Secretary	Revised draft endorsed by Board of Directors	Endorsed
2.0	Sept 2011	Geoff Stokes	Annual review by the Board taking into account comments from internal audit report	Approved
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4.0	Oct 2017	Ade Kadiri	Revised Terms of Reference approved	Approved
4.1	March 2018	Kate Jarman	Terms of Reference reviewed to reflect move to two meetings a month	Approved
4.2	February 2020	Kate Jarman	Terms of Reference reviewed to reflect move to splitting CMB and Divisional Management Board – making DMB a sub-group of CMB	Approved
4.3	June 2020	Kate Jarman	Terms of Reference reviewed to reflect creation of TEG (replacing Corporate Management Board)	Draft

Milton Keynes University Hospital NHS Foundation Trust

Management and Performance Board

Terms of Reference

Summary

The Management and Performance Board comprises the Executive Directors and divisional management. The Management and Performance Board meets monthly, and is chaired by the Deputy Chief Executive. The purpose of the meeting is to hold divisional management to account for the clinical, operational and financial performance of their clinical service units and division overall.

The meeting receives formal reports from each division, and each division attends separately to present their integrated performance reports for detailed scrutiny and discussion.

Meetings and Conduct of Business

The Trust Executive Group (Executive sub-Committee of the Board of Directors) hereby resolves to establish a vehicle to manage performance and accountability of the four clinical Divisions - the **Management and Performance Board (MPB)**. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

The MPB is responsible for overseeing the effective operational management of the Trust's four clinical divisions, including the fulfilment of statutory and regulatory requirements; the monitoring of clinical standards and targets; the delivery of high-quality patient centred care; the monitoring of financial performance; and the monitoring of corporate/ business data and information pursuant to the effective running of the organisation.

The MPB is the designated performance and accountability Board for the clinical divisions and is chaired by the Director of Operations.

Purpose

The MPB is the designated performance and accountability Board for the four clinical divisions, with responsibility for:

- Providing effective operational leadership of the Divisions
- Ensuring the divisions deliver safe, high quality and cost-effective services,
- Ensuring the objectives and key performance indicators in annual and operational plans are delivered

- Ensuring statutory, constitutional and regulatory compliance is met

Membership

Core Membership

- The Director of Operations (Chair)
- The Executive Directors
- The Divisional Triumvirate (Divisional Director, Divisional General Manager and Head of Nursing or Head of Midwifery or Lead Allied Health Professional)
  The Associate Director of Performance
- The Business Partners (HR and Finance) for the Divisions

Attendance for Agenda-Specific Items

Staff will be expected to attend MPB for agenda-specific items. The Company Secretary, in planning the meeting agenda, will inform staff of the requirement to attend.

Members of the MPB are expected to attend all meetings in person. If they are on annual or sick leave, members may send nominated deputies. The meeting secretary should be notified of the attendance of deputies at least 24 hours in advance of the meeting.

The Chair will nominate a member of the TEG to Chair the meeting in his/her absence.

Frequency and Type of Meeting

The MPB will meet once a month.

The meeting will be split into four segments – each focussing on one clinical Division. Each Division will present information relating to their performance in every aspect (operational, quality, financial, governance). Divisions will attend separately. At the end of MPB all Divisions will attend briefly together to hear key messages, any themes or wider issues, and provide any feedback to the Executive.

Quorum

The meeting is quorate when at least three Executive Directors and two Divisional representatives are there for each Divisional meeting.

Principles

The following principles will underpin the work of the Management Board:
The MPB will:

- Lead by example by embodying the Trust’s values in its work

- Act as an inclusive team, exploiting each other's strengths, demonstrating strong corporate commitment and trust
- Work to transparent and clear priorities
- Have a bias to action
- Have strong and effective communications
- Share information from DMB meetings with the wider organisation as appropriate, respecting the need to maintain confidentiality when required. This includes communicating upwards and downwards in the organisation and consulting colleagues prior to meetings as appropriate.
- Provide papers and presentations for the meeting in accordance with the agreed deadlines and in the required format

Duties

- To ensure the Trust provides safe, high quality care and use resources efficiently and effectively.

- To promote and protect the safety of patients and the quality of their experience.

- To value staff and promote and safeguard their welfare enabling the Trust to secure maximum value from its staff resources.

- To ensure the Trust has strong relationships within the local health economy and with local stakeholders and is recognised as a trusted and valued part of the local health community. Including:

- Listen to and learn from feedback from patients and stakeholders and agreeing action as appropriate

- To ensure appropriate engagement with stakeholders and report on the outcome of engagement activity

- To provide direct input to issues and decisions to be presented to the Trust Board for approval, as appropriate.

- To contribute to the Trust's strategic and annual business plans for approval by the Board.

- To consider and approve business cases and proposals for the appropriate deployment of the Trust's capital and revenue resources in accordance with the Standing Financial Instructions

- To review corporate and operational performance against the business plan objectives and key performance indicators and agree actions to improve delivery and performance as appropriate.

- To ensure the Trust operates in a cost effective manner, working within agreed budgets and to review performance against the Trust's budget

including: delivery against Cost Improvement and Transformation Programme Plans; expenditure against forecast

- To ensure effective arrangements are in place for risk management, the internal control environment and the implementation of the Trust's quality governance assurance framework, risk management strategy and policy.

- In conjunction with delegated clinical governance groups, to review any lessons learned from patient feedback, external reviews and Major and Serious Incidents, to recommend amendments to the Trust's policies, procedures and practices as a result of this learning and to close the loop ensuring that these recommendations are implemented throughout the Trust.

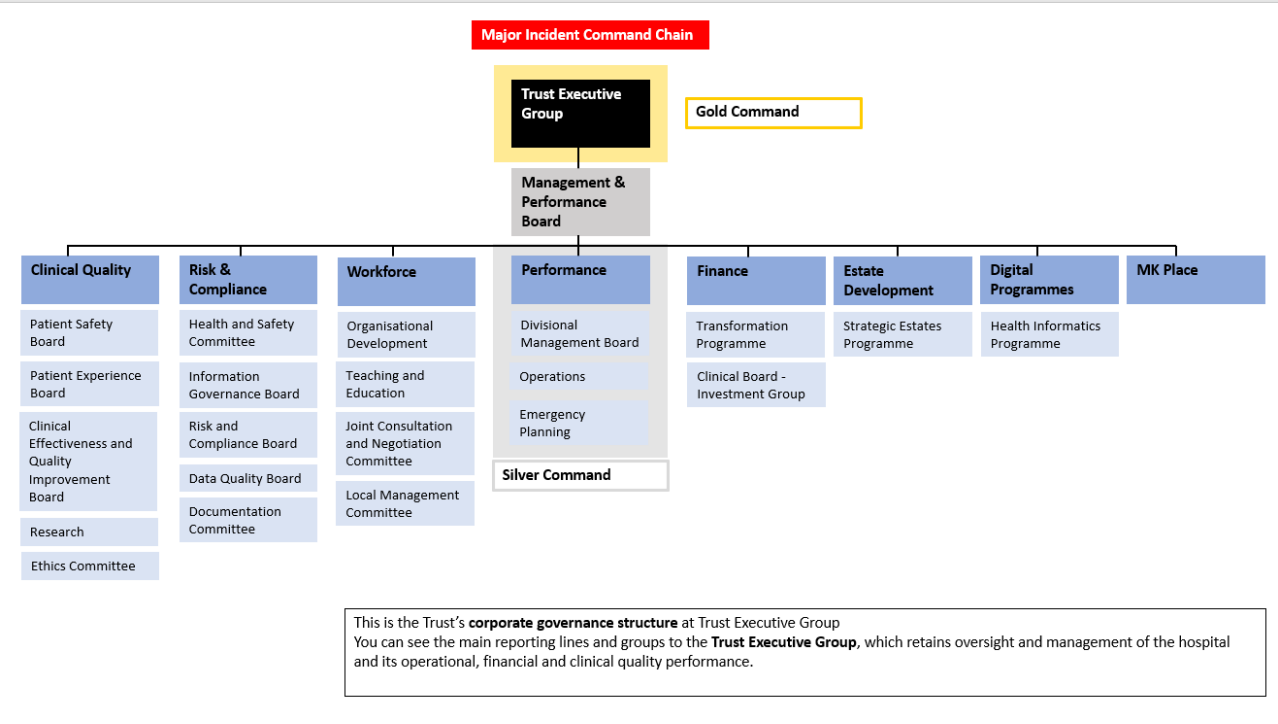
- To exercise effective oversight of the Trust's arrangements for ensuring compliance with its statutory and regulatory obligations, including performance targets under the NHS Constitution

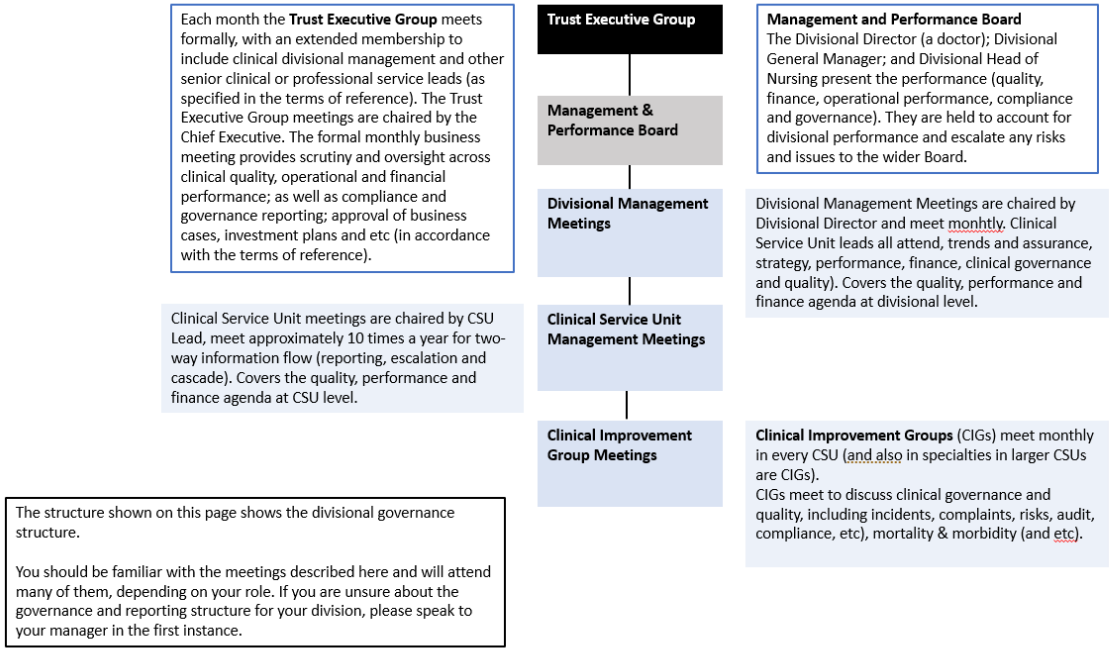
- To enable the Trust to operate with an awareness of relevant national and international guidance and best practice.

- To approve Trust policies and strategies in accordance with agreed procedures.

Sub-Groups

The MPB will be responsible for ensuring that adequate management arrangements are in place to ensure that the Trust provides safe and high-quality services to its patients.





Upward Reporting

The MPB will provide a monthly summary report to the Trust Executive Group or appropriate Board Committee.

Communication from MPB

The Company Secretary will liaise with the Communications Team regarding communications for staff following MPB meetings as appropriate.

Administration of MPB

The Company Secretary will be responsible for providing support for MPB meetings, including:

- Issuing agendas and papers
- Providing a report template
- Producing a work-plan for the year

Minutes for MPB will be taken by the PA to the relevant Divisional Triumvirate.

The minutes of the MPB will be reported to the next MPB meeting for approval and it will be maintained and updated by the meeting secretary. Actions for people not present at the meeting will be communicated directly to them within a maximum of one week from the meeting.

Version control

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Agenda item 8.2
Public Board 03/09/20

Meeting of the Finance and Investment Committee held on 29 June 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved by the Committee.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meeting:

1. Performance dashboard month one

The Committee discussed the operational performance of the Trust in month two, and the challenges of reducing the waiting list and elective backlogs were discussed. It was agreed this would be discussed at Board but the responsibility for addressing these issues lies with those who fund the organisation.

2. Board Assurance Framework

The Committee discussed the BAF, and further amendments were requested where deemed necessary in light of the changing covid environment.

3. Finance Report M2

The Director of Finance reported a similar position to M1 but with a slightly lower Covid top up sum. It was noted that covid costs may remain the same as other costs increase and will require monitoring. It was further noted that, due to the covid environment, three KPIs are rated red.

4. Overseas Visitors Briefing

The Committee noted the process for recovering overseas visitors income.

5. Agency update

It was noted that agency spend remains similar to previous months and additional steps have been put in place to monitor this given the relatively low levels of activity.

6. Update on £20m funding request to region for activity backlog

The Committee noted the overview of capital investments planed for 2020/21 following changes to the capital financing regime. While it was acknowledged that recovery plans will

help bring the organisation back to pre-covid activity levels, completion within the six month timeframe sought by the region will be stretching.

7. Acquisition of Zesty Ltd

The Committee noted the positive aspects of this acquisition

Agenda item 8.2
Public Board 03/09/20

Meeting of the Workforce and Development Assurance held on 15 July 2020
REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

The Workforce Report template for Board was approved by the Committee.

Matters referred to the Board for final approval:

There were no matters referred to the Board for final approval.

Summary of matters considered at the meeting:

Staff story

The Head of Equality, Diversity and Inclusion attended the meeting. She had recently joined the Trust three weeks before lockdown and when she was called upon to man staff helplines during the pandemic she found that her background in both nursing and human resources proved very useful. This also gave her some insight into how her role could support the organisation in delivering the equality, diversity and inclusion agenda. She is keen to bring greater cohesion to this agenda with a more collaborative approach and she gave the example of her attendance at the Nursing, Midwifery and Therapies Board where she encouraged exploration of a more holistic and inclusive approach to all service users. Her involvement as a non-executive director with Cambridgeshire Community Services has given her good insight into bringing governance to life through clinical work.

Equality, Diversity and Inclusion update

The Head of Equality, Diversity and Inclusion presented the report and felt that better communication both internally and externally on progress with this agenda would raise the profile and provide greater visibility for staff and the public. She requested the Board's support in delivering key messaging.

The Trust has successfully applied to participate in the Inclusion and Diversity Partners Programme run by NHS Employers which starts in June 2021. The Trust has also been accepted to participate in the WRES Experts Programme.

A proposal for the Leadership Inclusion Council accompanied the report and was noted by the committee. This will provide additional levels of assurance for the employee voice and engagement. The Leadership Inclusion Council can be used as a development tool. It will be chaired by the Trust Chairman and the first meeting is expected to take place in September. This will not be a decision-making group but will provide feedback to the relevant boards on agenda items and reports.

More emphasis on the patient element within the report was requested which should align with the Patient Experience Strategy. The Committee acknowledged the work undertaken to date and the requirement for better promotion. It was felt that the profile of equality, diversity and inclusion could be raised through the narrative of the Trust's vision and values. Ongoing engagement work such as the Event in the Tent and Ask Joe was highlighted.

Objectives update

The objectives are on track for delivery and those rated green are on track to be achieved by March 2021.

Workforce strategy and plan update

Work will continue to incorporate more of the inclusion work within the strategy. Further work is also required with regard to time to hire and staff benefits. The excellent collaboration internally and externally throughout the pandemic continues, with closer relationships being forged with partners in the community. It had become apparent that the Staff Health & Wellbeing Department requires greater resource in the long-term.

Funding for a new system, SafeCare which allows for acuity-based rostering, has been received and the system will be rolled out after e-rostering has been fully implemented across the Trust by the end of the financial year.

HR Systems and Compliance Report

The portal for self-service is being trialled through Medicine and is expected to improve accuracy, allowing for real-time changes.

Technology has been put to good effect in the onboarding processes for the large number of doctors arriving in August to avoid face-to-face contacts.

Staff who have been given the opportunity of working different areas during the pandemic are now being encouraged to consider internal transfers as part of talent management to enable them to progress.

A new Head of Resourcing has been appointed and it is anticipated that this will have a positive impact on reducing time to hire.

Workforce information quarterly report

The KPI data for the full year to 30 June was presented although it was noted that some of the data extended only as far as 31 May.

The comparison was made between the high incidence of violence and aggression towards staff and the high level of absence under the two categories of Anxiety/ stress/depression/other psychiatric illness and Unknown/Not Declared. This is being monitored and it was further clarified that the data for Unknown/Not Declared is available but is not always picked up through the ESR system.

The consequences of non-compliance with appraisal and statutory mandatory training are that staff will not receive their pay increments. Letters are sent out to staff to remind them when their training and appraisal become due.

Staff Health & Wellbeing (SHWB) Report

The Covid focus throughout the report was noted. The number of calls to the staff helpline have reduced and welfare calls are continuing with support offered.

The organisation has participated in national studies for staff swab and antibody testing and the SHWB have collaborated well with ward staff to coordinate efforts. SHWB have also supported the risk assessment of staff. The Committee was advised that overall staff confidence in returning to work is building. Of the 180 staff who tested positive for Covid-19, three were reported to HSE as RIDDORs. All three members of staff have since returned to work.

The first flu planning meeting has taken place and the national target has increased from 80% to 90% and given previous years' successes in achieving this, it is believed to be achievable but will take a concerted effort.

Staff Survey

The highest response rate was received last year at 55% and the survey for this autumn is under construction. The Committee was informed that listening events are held on the back of the survey results and departments work through resulting action plans with support from HR business partners.

Organisational Development and Talent Management

Organisational development activities were paused during the pandemic and staff focused on statutory mandatory training and appraisal. There is a cultural shift of focus to using appreciative inquiry to drive improvement across the Trust, linked to the equality, diversity and inclusion agenda.

Education update

Feedback on work experience received from a student was highlighted. Greater community engagement is being sought.

The Director of Medical Education is pleased with the outcome from the necessary adjustments for the current climate that have been made to the induction programme for medical students.

Potential impacts from Brexit and Covid on the medical school and its future undergraduates are being considered and monitored through the Medical School Steering Group.

The Apprenticeship Strategy will be presented at the next meeting. It was clarified that underspend from the Apprenticeship Levy cannot be used for backfill and this has been a limiting factor. However, new clinical courses are being structured in ways that make this easier to manage.

Workforce Board Assurance Framework risks

The BAF was not reviewed as it was awaiting updates following the full review undertaken at Board in Seminar.

Workforce Risk Register

Three risks were highlighted as having been updated.

Workforce Board Review

A new template for the Workforce Report for Board was presented and approved.

Any Other Business

The Committee recognised the difficulties the Workforce Team have endured in recent months and all the additional work they have undertaken to support staff. They Committee asked that their thanks are conveyed to them for this.