HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

TUESDAY 29 JANUARY 2019
THE BOARDROOM, HULL ROYAL INFIRMARY
9.00AM – 11.30AM

AGENDA: MEETING TO BE HELD IN PUBLIC

	Opening Matters		
1	Apologies	verbal	Chair – Terry Moran
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair – Terry Moran
3	Minutes of the meeting of 13 November 2018	attached	Chair – Terry Moran
4	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker 4.2 Board Reporting Framework 2018/19 4.3 Board Development Framework 2018/19	attached	Director of Corporate Affairs – Carla Ramsay
	4.4 Any other matters arising from the minutes	verbal	Chair – Terry Moran
5	Chairs Opening Remarks	verbal	Chair – Terry Moran
6	Chief Executive's Briefing	attached	Chief Executive Officer – Chris Long
7	Patient Story	verbal	Interim Chief Medical Officer – Makani Purva
8	Board Assurance Framework – Q3 Report	attached	Director of Corporate Affairs – Carla Ramsay
9	**Director Reports**		
	9.1 Quality Report	attached	Chief Nurse – Mike Wright
	9.2 Nurse and Midwifery Staffing Report	attached	Chief Nurse – Mike Wright
	9.3 Fundamental Standards	attached	Chief Nurse – Mike Wright
	9.4 Clinical Negligence Scheme for Trusts – Maternity	attached	Chief Nurse – Mike Wright/Head of Midwifery – Jan Cairns
	9.5 Quality Committee Minutes December 2018	attached	Chair of the Committee – Martin Veysey
	9.6 Performance and Finance Report	attached	Chief Operating Officer – Teresa Cope – Chief Financial Officer- Lee Bond
	9.7 NHS Operational Planning and Contracting Guidance 2019/20	attached	Director of Strategy and Planning – Jacqueline Myers

	9.8 Performance and Finance Minutes December 2018		Chair of the Committee – Stuart Hall
10	**Governance and Assurance**	attached	
	10.1 Health and Safety Report		Chief Nurse – Mike Wright
	10.2 Audit Committee Minutes January 2019	attached	Chair of Committee – Tracey Christmas
	10.3 Charitable Funds Minutes November 2018	verbal	Chair of Committee – Vanessa Walker
	10.4 Board Assurance Framework – Seven Day Hospital Services	attached	Chief Medical Officer – Makani Purva
	10.5 Flu Vaccination Letter	attached	Director of Workforce and OD – Simon Nearney
	10.6 Guardian of Safe Working	attached	Guardian of Safe Working – Dr Muthukumar
11	**Any Other Business**		
	11.1 Contract recommendation paper for the provision of Orthotic and Prosthetic Services including the Supply of Consumables	attached	Deputy Finance Director – Steve Evans
	11.2 Contract recommendation paper for the continued use of The Health Trust Europe Total Workforce Solutions Framework Agreement	attached	Deputy Finance Director – Steve Evans
12	Any questions from members of the public	attached	Chair – Terry Moran
13	**Date and time of the next meeting: Tuesday 26 February 2019 2.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary**	verbal	

Attendance

	2018							2019		
Name	**30/1**	**13/3**	**15/5**	**10/7**	**11/9**	**13/11**	**29/1**	**26/2**	**12/3**	**Total**
T Moran	✓	x	✓	✓	✓	✓				
A Snowden	✓	✓	x	✓	✓	✓				
S Hall	✓	✓	✓	✓	✓	✓				
V Walker	✓	✓	✓	✓	✓	✓				
T Christmas	x	x	✓	✓	✓	✓				
M Gore	✓	✓	✓	✓	✓	✓				
T Sheldon	x	✓	✓	-	-	-				
C Long	✓	x	✓	✓	✓	x				
L Bond	✓	✓	✓	✓	x	✓				
M Wright	✓	✓	✓	✓	✓	✓				
E Ryabov / T Cope	✓	✓	✓	✓	✓	✓				
K Phillips	✓	✓	✓	✓	-	-				
M Purva	-	-	-	-	✓	✓				
M Veysey	x	✓	✓	✓	✓	✓				
In Attendance										
J Jomeen	-	-	x	x	✓	✓				
J Myers	✓	✓	✓	✓	✓	✓				

S Nearney	✓	✓	✓	✓	✓	✓				
C Ramsay	x	✓	✓	*	*	✓				
R Thompson	✓	✓	✓	✓	✓	✓				

*****Carla Ramsay – career break

Hull and East Yorkshire Hospitals NHS Trust
Trust Board
Minutes of the meeting held 13 November 2018

Present:	Mr T Moran CB	Chairman
	Mrs V Walker	Vice Chair
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr A Snowden	Non-Executive Director
	Prof. M Veysey	Non-Executive Director
	Prof J Jomeen	Associate Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr M Wright	Chief Nurse
	Mrs E Ryabov	Chief Operating Officer
	Dr M Purva	Interim Chief Medical Officer
In Attendance:	Ms J Myers	Director of Strategy and Planning
	Mr S Nearney	Director of Workforce and OD
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Corporate Affairs Manager

No **Item** **Action**

1 Apologies:
Apologies were received by Mr Long, Chief Executive Officer and Mrs Cope, Chief Operating Officer

2 Declarations of interests
2.1 Changes to Directors' interests since the last meeting
There were no declarations of interest received.

2.2 To consider any conflicts of interest arising from this agenda
Declarations of interest
There were no declarations received.

3 Minutes of the meeting of 11 September 2018
The following amendments were requested:
4.1 Action Tracker – Mr Wright asked that the sentence be changed to "advised that there was a small error rate with patients receiving their correct medication on discharge."

CEO Briefing – should read "NHS England, Yorkshire and Humber Commissioning Group".

It is the NHS 10 year plan rather than forward plan.

8.1 Board Assurance Framework – paragraph 3 should read the National Staff Survey.

10 Emergency Preparedness – paragraph 3 should read "alternative incident control room".

12 Responsible Officer report – Dr Purva clarified that it was the Revalidation Policy in paragraph 2 being referred to.

14 Energy business case, paragraph 4 should be the maintenance of the existing boilers and not replacements.

~~20 Performance, paragraph 3 – Ellen to confirm wording.~~

4 Matters Arising

Mr Wright advised that there was access to self-checking system in both outpatient departments in Hull Royal Infirmary and Castle Hill Hospital. He added that support staff were on hand to help with patients with learning difficulties.

Mr Wright also reported that the CNST monies would not be received in this financial year, but that the scheme could be extended into next year.

4.1 Action Tracker

The Board reviewed the Action Tracker and discussed the balanced scorecard. Mr Snowden advised that Ms Myers was joining the Non Executive Meeting in November to present the updated version.

4.2 Board Reporting Framework

The Board received the framework. There were no issues raised.

4.3 Board Development Framework

The Board received the framework. There were no issues raised.

5 Chairs Opening Remarks

Mr Moran stated that he was pleased that the Trust was one of only 24 Trusts that had been given Veterans Accreditation in recognition of the commitment the trust had shown to supporting former military personnel. Dr Purva reported additionally that she had been to Germany to a Field Hospital to see a simulation exercise showing how healthcare staff prepare for significant events where a number of learning points arose that may be useful for wider trust interest. Mr Moran suggested having a Development Session with the facilitators from Germany presenting to the Board.

Mr Moran also spoke about the couple who had been married 66 years and were both in the hospital on different wards. Staff arranged for them to spend their anniversary together even though both husband and wife were receiving end of life care. Mr Moran thanked the staff involved for the compassionate care provided to the couple and their family.

Mr Moran reported that it was Mr Snowden's last Board meeting as he was leaving the Trust. He stated that Mr Snowden had been at the Trust for a long time and was a wonderful colleague and a great vice chair and would be very much missed. Mr Snowden thanked Mr Moran and everyone around the Board table. He added that the Trust was working together more than he had ever seen and thanked all the staff he had met over the years.

Mr Moran also reported that it was Mrs Ryabov's last Board meeting and that she was going to work in Scotland as a Chief Operating Officer. Mr Moran thanked Mrs Ryabov and stated that her knowledge and impact on the Trust's operations were second to none. He wished her well and said she would be missed. He added that Mrs Cope would take over the role

full time and welcomed this transition.

Mrs Ryabov thanked the Board and advised that she was sad to leave the Trust but the move would mean she could send more time with her immediate family and therefore reduce her weekly commuting from Scotland. She added that Mrs Cope was a fantastic Chief Operating Officer and it had been a privilege working with her.

Mr Moran also announced that Mr Wright would be retiring at the end of the financial year and the Trust was currently recruiting a successor.

6 Chief Executive's Briefing

Mr Bond presented the report and highlighted winter pressures and the flu vaccination uptake which was currently at 53%. Mr Bond advised that any staff not having the vaccine would be requested to state why. Mr Moran added that he would like Board members to be subject to the same requirement and asked each member to confirm that they had had the vaccination or send a private note to explain why please.

Mr Bond also highlighted new innovations and new nursing roles which were part of the long term development plan.

Mr Bond also drew the Board's attention to the Moments of Magic.

The Board reviewed the balanced scorecard and Mr Gore stated that theatre utilisation was below target. Mrs Ryabov reported that capacity was still an issue.

Mr Bond highlighted the performance regarding paying bills and that non-NHS performance was at 92%. NHS performance was more challenging.

6.1 Establishment Amendment Order

Mr Bond presented the paper which outlined the legal process to bring the change to the trust name into legal effect and advised that there was now a programme in place and would be effective from 1st February 2019. Ms Ramsay had established a working group to review practical issues such as letter headed notepaper, signage and the launch in February. Prof. Veysey stated that once launched it was important to have a forward looking implementation plan in place. Ms Myers advised that there was a plan in place and was embedded in the Trust Strategy.

Resolved:

The Board received and accepted the amendment order.

7 Patient Story

Dr Purva spoke of a patient who had received neurosurgery and needed a plate fitting. The plate was not available for a variety of reasons and the fitting was delayed by several days. Dr Purva advised that there was learning from the incident and better planning was required and had been implemented.

Dr Purva also spoke about a previous healthcare professional that was retired and came to the hospital for care. He was very complimentary about the nurses and the care he was given, even though he had been worried about what to expect.

[this doesn't read right and not sure what you are trying to say?]A patient had been involved in a hit and run accident and when his son visited he was so upset he fainted and fractured his skull. The care that the family received was excellent and both patients were managed appropriately and are recovering well.

Dr Purva also spoke about exemplary care being used for revalidation purposes at the request of a patient's wife. Dr Purva added that it was inspiring to hear of the good work that Trust staff do.

The agenda was taken out of order at this point

8.2 BAF 6 Partnership Working
Ms Myers presented the risk paper relating to partnership working. Ms Myers reported that discussions had begun to form an integrated care partnership. A letter of intent was to be developed for a provider led solution to the system-wide healthcare issues. The Trust links to the University would be further strengthened by the Trust's name change.

Mrs Walker asked if all partners were engaged in the process and Ms Myers advised that the leadership team were sharing functions and risks and there was an optimistic approach being made.

GP partners were reviewing primary care with service focussed groups emerging. A number of workshops had been arranged on the Southbank to look at service developments.

The Board discussed the risk rating level and whether it should be reduced to 12 from 16 due to the progress being made. Prof Veysey stated that the risks had not changed and the goal posts were always moving due to the nature of the programme. Mr Gore added that it was too early to reduce the risk due to a number of issues.

Mr Hall stated that the shared financial risk was still high and would have an impact on the Trust's financial planning and delivery of the Control Total.

Mr Moran suggested that this topic be discussed at a Board Development session in more detail.

Resolved:
The Board received and accepted the report. The Board agreed to keep the risk rating at the current level of 16.

8.3 BAF 7.2 – Infrastructure
Mr Bond presented the risk and highlighted not being able to renew out of date equipment in a timely manner meant that service provision could be effected.

The IT network was also an issue and would impact the IM&T programmes of work. Mr Bond reported that the Trust was spending capital funds as goods and services were required on a risk based approach.

Mr Bond also stated that urgent kit was required in radio pharmacy as the current kit was running at 60% downtime, causing patient experience and efficiency problems.

Mr Bond advised that the risk to the Trust over the next three months was reduced but would be an issue in 2019/20 and beyond.

The Board discussed reducing the risk and Mrs Ryabov stated that due to the critical equipment issues the risk should remain at 20, which was supported by Mr Snowden and Mr Gore.

The Board agreed to leave the risk at 20 and asked Mrs Walker to raise the concerns around capital funding at a future Chair networking event she was attending to understand other Trust pressures.

Mr Bond presented a loan application to cover fire prevention works which was approved by the Board. Mr Gore expressed is disappointment that the funding had not come from PDC monies.

Resolved:
The Board received and accepted the report. The Board agreed:

- to keep the risk rating at 20
- to approve the loan application for fire prevention works

8 Board Assurance Framework

Ms Ramsay presented the report and advised that the Board was actively managing the risks due to the discussions new happening as part of the Board meetings and risks were also being reviewed at Committee level.

The Audit Committee were assured that the current process was working and both External and Internal Auditors were able to scrutinise and challenge any areas of concern.

There was a discussion around the risk from the South Bank and Ms Myres assured the Board that additional referrals were being managed well and not having a major impact on the Trust. Mr Hall reported that such issues were discussed at the Performance and Finance Committee and any changes in demand would be escalated to the Board.

Resolved:
The Board received and accepted the report.

9.1 Quality Report

Mr Wright presented the report and advised that the Never Event presented at the last Board meeting had been de-escalated.

Serious Incidents were being reviewed in line with procedures and investigations were being scrutinised at the Quality Committee.

Mr Wright reported that the Trust was in the top 25% of reporters of incidents according to the National Reporting and Learning System. Mr Moran asked if this meant that the Trust had a lot of incidents or whether other Trusts were not reporting as robustly. Mr Wright advised that the Trust was a good reporter but the levels of harm were low. He added that the regulators were satisfied with the Trust's reporting levels.

Mr Wright reported that there had been a case of MRSA bacteraemia but had been a complex patient, who was now recovering well.

There had been 2 MSSA bacteraemia cases in October and Dr Lily was reviewing the learning from the investigations which was linked to catheter and line care.

The complaint rates into the Trust were steady and the 40 working day turnaround target was being sustained.

The Friends and Family Test results were positive and the Care Quality Commission had held focus groups in the Trust in October and November.

Mr Wright reported that the HSIB would be independently reviewing maternity incidents and carrying out their own investigations. He added that the HSIB were not expecting to share their findings with the Trust.

There was a discussion around pressure ulcer damage and Mr Snowden asked what measures were being taken in the wider health economy. Mr Wright advised that issues have been raised with the Commissioners and the action plan developed would be reviewed at the Quality Committee.

Mr Gore congratulated the teams on the year on year reduction of CDiffile numbers and Mr Wright advised that the measurement for this infection was changing to review the patient journey and expand the length of time investigated.

Resolved:
The Board received and accepted the report.

9.1.1 Mortality Q2 Report
Dr Purva presented the report and advised that structured judgement reviews were being carried out looking at poor and excellent practice to highlight trends, key themes and any learning.

Recognising the deteriorating patient was still a key issue but was being analysed. Dr Purva advised that the Trust was using the Yorkshire Contributing Factors framework and was looking to implement an e-learning package. The Medical Examiner role was being reviewed as every organisation would be expected to have one to look at all deaths.

There was a discussion around how the themes and trends were being captured and the actions plans in place. Dr Purva advised that the deteriorating patient was included on the Quality Improvement Programme and Mr Wright added that e-Observations would also have a major impact on identifying these patients.

Ms Myers reported that the Trust's long term goal is to reduce avoidable deaths and the Trust was currently setting its baseline.

Mrs Walker stated that how patients died was very important and any avoidable deaths should be reviewed taking into account delays in treatment and quality of care. It was agreed that a further discussion

would be held at the Quality Committee.

Mr Moran complimented Dr Purva on the report and asked if an annual report could be received to highlight the trends and themes and the actions put into place following the investigations. Mr Moran also asked for more details around the Medical Examiner implementation work.

Resolved:
The Board received and accepted the report.

9.8 Guardian of Safe Working Report
Dr Muthukumar presented the report and advised that the most common reason for submitting an exception report still appeared to be related to rota gaps and understaffing. This leads to overstaying beyond contracted hours or missed and training opportunities. In a few instances the trainees appear to be staying over in the interest of patient care.

He added that Junior Doctor fill rates were better than last year and closer to 90%. Mr Nearney reported that the boarding process was much better with contractual information being supplied well in advance of commencement in the Trust.

There was a discussion around the Junior Doctor morale and the mess facilities they had. Dr Muthukumar reported that an area had been identified on the 3rd floor but needed work to make it more suitable for down time. Mr Nearney agreed that this areas needed to be updated. Mrs Walker suggested that Charitable Funds may be available the help with this upgrading.

Mr Moran expressed his concern regarding how overtime working was not being captured and Dr Muthukumar advised that it was a software issue. Mr Nearney agreed to review this with Dr Murthukumar.

Resolved:
The Board received and accepted the report.

9.2 Nursing and Midwifery Report
Mr Wright presented the report and highlighted new National requirements recording care time over a period against the number of patients in a ward at midnight. Mr Wright and the nursing teams were currently reviewing this data. This was the new Care Hours Per patient Day metric. A Board Development session was discussed to understand the metric in more detail.

He reported that the Safety Thermometer work was ongoing and the Trust sickness rates had been positive in month and the patient safety briefings were still being held 6 times per day.

Mr Wright reported that 8 new nursing recruits had commenced with the Trust and the trainee nursing associates programme was underway, as was the international nurse recruitment programme.

Mr Moran asked about the HR metrics highlighted in the report and why basic fire training was showing red in a number of cases. Mr Wright advised that releasing nurses from wards was difficult due to the extreme

pressures they faced.

Resolved:
The Board received and accepted the report.

9.3 Quality Minutes September/October 2018
Mr Snowden presented the October 2018 minutes as he chaired the meeting. He reported that Serious Incident reporting had been robustly reviewed by the Committee as well as the 'Getting it Right First Time' update.

Mr Snowden expressed his concern that the meeting did not have time for the other items of business. Ms Ramsay advised that this had only happened on one occasion and did not have cause for concern yet, but would work with Committee members going forward.

Resolved:
The Board received and accepted the minutes.

9.4 Performance and Finance Report
Performance
Mrs Ryabov presented the performance section of the report. She advised that the Trust's key priorities were delivery of the 62 day cancer target of 85% and delivery of the 52 week wait trajectory.

She reported that diagnostic waiting times were improving and this had been helped by York taking back their work, but there were still some issues around colonoscopy diagnostics.

The 52 week waits were now meeting and exceeding trajectory and the Trust was focussing on 36 week waits to get the overall number down.

The 62 day standard performance was adrift and due to a number of issues. Mrs Ryabov advised that the Health Groups would present their issues to the Performance and Finance Committee in November 2018.

Mrs Ryabov advised that the list size was still challenging and breast screening had seen 13 breaches in months with 10 related to histology.

Finance
Mr Bond presented the report and advised that in Month 7 the pressures continued with the addition of the clinical waste issue. This was not covered in the budget and the Trust had no ability to cover the money.

The other significant risk was the change in rules around the SPV.

The Surgery and Family and Womens Health Groups were in line with forecast but Medicine was behind due to medical staffing agency costs and Clinical Support had costs associated to a linear accelerator, cellular pathology and radiology outsourcing.
Mr Gore asked how the Trust was planning to close the CRES gap and Mr Bond advised that it was reliant on technical adjustments and discussions with the Commissioners. Mr Gore asked how confident Mr Bond was that the organisation would hit its Control Total and Mr Bond advised that he could not guarantee it but was striving to do so.

Resolved:
The Board received and accepted the report.

9.4.1 Financial Plan – 2019/20
Mr Bond presented the plan and advised that the paper had been received at the Performance and Finance Committee in October 2018.

He highlighted the brief introduction to the planning framework for NHS England and NHS Improvement and advised that the 2019/20 plan had to be completed by February 2019, followed by a 5 year plan by the end of July 2019. Mr Bond reported that the developments around the Integrated Care System were key to the financial planning process.

Mr Bond reported that changes had been made to some tariffs and he had illustrated different scenarios relating to the Control Total for 2019/20 in his report. He added that the financial planning was complicated further by the STP planning process.

There was also an updated procurement method outlined in the report and he would present a paper to the next Performance and Finance meeting giving more details.

There was a detailed discussion around the planning process, the assumptions being made and the timescales involved. Mr Moran suggested that a Board Development session might be required to give the right amount of attention to the issues.

Mr Bond advised that it was key to understand capacity both in the Trust and in the wider health economy to develop a credible plan.

Resolved:
The Board received and accepted the report.

9.4.2 Winter Plan 2018/19
Ms Myers presented the plan and highlighted that the impact of winter meant a higher demand for beds due to sicker patients and longer stays in hospital.

The Trust had received winter funding and an additional winter ward was being built to accommodate the increase in patients in winter. Ms Myers added that staffing the ward would be a risk for the Trust as staff will have to be taken from other areas, but Mr Wright advised that this would be managed and risk assessed at the safety briefings 6 times per day.

Mr Bond asked for clarity around removing 10 beds from C16 and whether the financial plans had been reviewed accordingly. Ms Myers advised that the plans would be reviewed in December.

Resolved:
The Board received and approved the winter plan.

9.5 Performance and Finance Minutes September/October 2018
Mr Hall presented the minutes and advised that the Performance and

Finance Committee were having an extra meeting with Health Group leads to review RTT and 52ww issues and recovery plans.

He reported that the Committee was reviewing cancer and diagnostic performance, CRES delivery and the impact of winter pressures as the main areas of focus.

Mr Hall also stated that the Health Group overspend of £3.1m was mainly driven by pay expenditure for medical staffing.

Resolved:
The Board received and accepted the minutes.

9.6 National Patient Surveys
Mr Wright presented the report and it was agreed that the Quality Committee would scrutinise the information further. Ms Myers stated that the significant improvements were worth noting formally by the Board.

Resolved:
The Board received the report and noted the improvements made.

9.7 Freedom to Speak Up Report
Ms Ramsay presented the report and highlighted that there were no new risks and that the main issues raised were around poor behaviours.

She advised that focussed work was ongoing to support staff and managers in the areas displaying poor behaviours.

Ms Ramsay added that the Trust was consistent with other Trust's themes and trends.

Resolved:
The Board received and accepted the report.

10.1 Standing Orders Report
Ms Ramsay presented the report to the Board and highlighted an amendment to the Trust's Standing Orders for the operational management of claims documents.

Mr Moran asked for clarity around the use of seal and Ms Ramsay advised that it was a contract for an alarm and detection for babies in cots.

Resolved:
The Board received the report and approved:

- The amendment to the Trust's Standing Orders
- The use of the Trust seal

10.2 Director of Infection Prevention and Control Report
Mrs Johnson presented the report and advised that the Infection Prevention team were working strategically to look at different ways of working and introducing new roles such as clinical scientists.

Mrs Johnson advised that MRSA bacteraemia and C Difficile were being prudently managed and cases were reducing. MSSA was linked to more

complex patients so ongoing route cause analysis investigations were being completed for each case.

There was an early indication from the Southern Hemisphere that there were low levels of flu reported and the flu vaccine was showing good effectiveness. Mrs Johnson stated that this was a good indication of what would happen in the UK.

Mrs Johnson advised that Norovirus was very unpredictable but the Trust had good procedures in place to isolate patients and a new cleaning contract was in place with OCS.

Mr Snowden asked how effective the flu vaccine was proving to be and Mrs Johnson advised that the early indications from the Southern Hemisphere were suggesting that it was effective and most deaths were linked to the 80 plus group of patients.

Resolved:
The Board received and accepted the report.

10.3 Health and Safety Report
The Health and Safety Report was deferred to the January 2019 meeting for further scrutiny.

11/1 1.1 Charitable Funds 29 October 2018/HEY Charity Accounts for information
The Charitable Funds minutes of the meeting held 29 October 2018 and the HEY Charity Accounts were received by the Board.

12 Brexit
Ms Ramsay presented the report and advised that Brexit with a deal posed fewer risks to the organisation than without. A no deal would mean there could be issues around stocks, supplies and staff and how goods would be processed at the ports.

Mr Moran asked if it should be on the Board Assurance Framework as a business risk and Ms Ramsay advised that it would be dealt with as part of business continuity planning. She added that the message from the centre was not to panic.

Resolved:
The Board received the report and agreed to manage the process as part of business continuity planning.

13 Any other business
There was no other business discussed.

14 Any questions from members of the public
There were no questions asked from the members of the public.

15 Date and time of the next meeting:
Tuesday 29 January 2019, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary

Trust Board Annual Cycle of Business 2017 - 2018 - 2019			2017									2018						2019		
Focus	**Item**	**Frequency**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Mar**	**Apr**	**May**	**May Ext.**	**July**	**Sept**	**Nov**	**Jan**	**Mar**
Strategy and Planning	Operating Framework	annual							x											x	
	Operating plan	bi annual									x			x						x	
	Trust Strategy Refresh	annual				x								BD			x				
	Financial plan	annual	x	x								x	x	x	x				x	x	x
	Capital Plan	annual	x										x								x
	Performance against operating plan (IPR)	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Winter plan	annual							x										x		
	IM&T Strategy	new strategy													x						x
	Research and Innovation Strategy	new strategy									x			BD							
	Scan4Safety Charter	new item							x												
	Equality, Diversity and Inclusion Strategy	new strategy											x								
	Digital Exemplar	new item							x												
	People Strategy	Refresh Strategy																	BD		
Strategy Assurance	Trust Strategy Implementation Update	annual		x											x						
	People Strategy inc OD	annual						x										x			x
	Estates Strategy inc. sustainabilty and backlog maintenance	annual								x					BD				BD		
	Research and Innovation Strategy	annual									x							x			
	IM&T Strategy	annual																			x
Quality	Patient story	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Quality Report	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Nurse staffing	monthly	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Fundamental Standards (Nursing)	quarterly		x			x			x			x				x	x		x	
	Quality Accounts	bi-annual		x						x					x				x		
	National Patient survey	annual	x										x								x
	Other patient surveys	annual	x																		
	National Staff survey	annual	x										x								
	Quality Improvement Plan (inc. Quality Accounts and CQC actions)	quaterly			x			x							x					x	
	Safeguarding annual reports	annual							x									x			
Regulatory	Annual accounts	annual		x												x					
	Annual report	annual		x												x					
	DIPC Annual Report	annual						x										x			
	Responsible Officer Report	annual						x	x									x			
	Guardian of Safe Working Report	quarterly	x				x			x			x				x		x		x
	Statement of elimination of mixed sex accommodation	annual		x											x						
	Audit letter	annual		x												x					
	Mortality (quarterly from Q2 17-18)	quarterly							x			x			x				x		x
	Workforce Race Equality Standards	annual						x										x			
	Modern Slavery	annual		x											x						x
	Emergency Preparedness Statement of Assurance	annual							x									x			
	Information Governance Update (new item Jan 18)	bi-annual										x		BD			x				x
Corporate	H&S Annual report	annual					x										x				
	Chairman's report	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Chief Executive's report	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Board Committee reports	each meeting	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Cultural Transformation	bi annual	x					x		x					x		x				x
	Annual Governance Self Declaration	annual		x												x					
	Standing Orders	as required		x	x	x		x	x	x	x	x	x		x		x	x	x	x	x
	Board Reporting Framework	monthly	x	x	x	x	x	x	x	x	x	x	x		x		x	x	x	x	x
	Board Development Framework	monthly			x					x	x	x	x		x		x	x	x	x	x
	Board calendar of meetings	annual						x													
	Board Assurance Framework	quarterly	x			x	x		x		x				x			x	x	x	
	Review of directors' interests	annual	x						x						x						
	Gender Pay Gap	annual											x								x
	Fit and Proper person	annual	x												x						x
	Freedom to Speak up Report	quarterly	x				x				x				x				x		x
	Going concern review	annual		x												x					
	Review of Board & Committee effectiveness	annual			x										x						

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST BOARD DEVELOPMENT PROGRAMME 2017-19

Overarching aims:

• The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does

• To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Board Development Dates 2017-19	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation		
04 July 2017			Area 1: Trust Board - updated Insights profile	Area 2 and BAF 3: Trust Strategy Refresh and appraoch to Quality Improvement				
10 October 2017			Area 1 and BAF 1: Cultural Transformation and organisational values				Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation	
28 November 2017			Area 2 and BAF 2 - Nursing staffing risks and strategic approach to solutions		Area 4 and BAF 4 - Trust position on diagnostic capacity - short-term impact and long-term issues; 62 day cancer			
				Area 1: Risk Appetitie - Trust Board to set the Trust's risk appetite against key risk areas				
05 December 2017				Area 1: High Performing Board and BAF 3 - CQC self-assessment and characteristics of 'outstanding'				
16 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - overview, process to review, key considerations		Area 4 and BAF 2 - People Strategy update		Area 4 and BAF 4 - Tracking Access			
30 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - key considerations and strategy delivery		Area 2 and BAF 2 - People Strategy update					Area 2 and BAF 7.1 - 7.3 - Financial plan and delivery 2017-18 and financial planning 2018-19
20 February 2018	Area 2 and BAF 4, 5, 6 : Key strategies to achieve our vision and goals and vision for the STP							
Extra meeting	Areas 2 and BAF 4 & 5: Strategy refresh -STP deliberations and direction of travel							

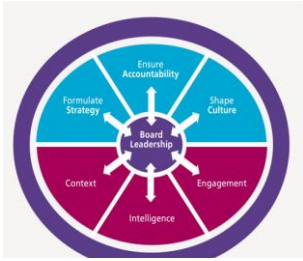
27 March 2018	Areas 2 and BAF 4 & 5: Strategy refresh - key strategic issues (partnerships, infrastructure)							
17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy				
		Area 1 and BAF 1: Draft 2018-19 BAF						
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents						Area 2 and BAF 7.1: Tower Block strategy
		Area 1 and BAF 1: Draft 2018-19 BAF						
18/07/2018 - at EMC	Area 2 and BAF 6 & 7.2: Strategy refresh - clincial strategy							
31 July 2018				Area 4 and BAF 3: Deep Dive - Never Events				Area 1 and BAF 7.1: Financial strategy including STP and ICO
				Area 3 and BAF 3 & 4: Elective Care e-Learning RTT				
25 September 2018		Area 1 and BAF 1: What does the Board spend its time on?		Area 1 and BAF 3: Journey to Outstanding				
27 November 2018			Area 1 and BAF 2: People Strategy Refresh					
29 January 2019	Area 2 and all BAF: Updated Trust Strategy		Area 1 and BAF 2: Trust Board and orgnaisaitonal improvement capacity and capability					
26 March 2019				Area 4 and BAF 4: Performance deep dive				Area 1 and BAF 7.1 and 7.2 - Longer term financial plan
/05/2019 (possibly 11 June)								
30 July 2019								
24 September 2019								
26 November 2019								

Other topics to schedule:

Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
	BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve What could prevent the Trust from achieving this goal? Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence	BAF 2: There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There are recurring risks of under-recruitment and under-availability of staff to key staffing groups There is a risk that the Trust continues to have shortfalls in medical staffing What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence	BAF 3: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years What could prevent the Trust from achieving this goal? Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like	BAF 4: There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements What could prevent the Trust from achieving this goal? For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a	BAF 5: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships What could prevent the Trust from achieving this goal? Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP	BAF 6: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2017-18 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services BAF 7.2: Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment BAF 7.3: Principal risk: There is a reputational risk as a result of the Trust's ability to service creditors on time, with the onward risk that businesses refuse to supply What could prevent the Trust from achieving this goal? Lack of sufficient cashflow

Principles for the Board Development Framework 2017 onwards

Key framework areas for development *(The Healthy NHS Board 2013, NHS Leadership Academy)* looks at both the roles and building blocks for a healthy board.
With the blue segment highlight the core roles and the crimson segments defining the building blocks of high-performing Trust Boards.



Overarching aim:

- The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
- To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?
- Do we use the skills and strengths we bring in service of the Trust's purpose?

- How can we stop any deterioration in our conversations and ensure we continually improve them?
- How can we build further resilience, trust and honesty into our relationships?
- Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect from everyone in order to have a culture that delivers outstanding patient care

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?
- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development

Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?
- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

Providing opportunity for Board development using external visits and external speakers, to provide additional knowledge, openness to challenge and support for the Board's development and trajectory

- Outcome: to provide opportunities for Board knowledge development as well as opportunities for the Board to be constructively challenged and underlying working assumptions to be challenged
- To provide an external focus to the Board not just for development but also to address the inward-facing perception reported by the Board itself as well as by the CQC

Area 4 – Deep Dive and exceptions

Internal exceptions that require Board discussion and knowledge development and ownership of issues, as they relate to the Trust's vision and delivery of the strategic goals

- Outcome: Board to challenge internal exceptions
- Board to confirm its risk appetite against achievement of the strategic goals and the over-arching aim of becoming high-performing Trust Board and 'outstanding' rated organisation by 2021-22

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

29 January 2019

Title:	Chief Executive Report
Responsible Director:	Chief Executive – Chris Long
Author:	Chief Executive – Chris Long

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	£18m investment in emergency care facilities, new services for stroke patients, launch of It's Serious Stuff campaign for winter; name change celebration event	

Recommendation:	That the Board note significant news items for the Trust

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

JANUARY 2018 TRUST BOARD

1. KEY MESSAGES FROM NOVEMBER AND DECEMBER

Hull secures £18m investment in emergency care facilities
Following a major announcement at the start of December our Trust learned that we will receive over £18m to invest in emergency care facilities.

As well as paying for new MRI and CT scanners for the Emergency Department, the funds will enable the children's wards at Hull Royal Infirmary to move into the Women and Children's hospital.

It is the biggest capital investment in facilities at the Trust for a decade and comes just two years after the Emergency Department itself was completely rebuilt. With a dedicated helipad almost complete at the rear of the Hull Royal Site, Hull's status as a major trauma centre will be further enhanced as dedicated scanning facilities are provided on site. This will considerably reduce turnaround times for patients ensuring their journey through our hospitals is more efficient and help us to get patients in the right bed, first time.

Where the paediatric facilities are concerned patients and their families will benefit from having inpatient and outpatient facilities in the same dedicated building. Specialist nursing and medical care will be provided in one place for the first time since the construction of the Women and Children's Hospital in 2002.

The Trust is benefitting from a share of £88.5m capital secured by the Humber, Coast and Vale Health and Care Partnership (STP) which will also see a major upgrade of the Emergency Departments in Grimsby, Scunthorpe and Scarborough.

Hull offers new service to save more stroke patients from brain damage or disability
Patients from North Yorkshire and Northern Lincolnshire are benefitting from a service performed at Hull Royal Infirmary to reduce the risk of brain damage or long-term disability after strokes.

The Comprehensive Stroke Centre at Hull and East Yorkshire Hospitals NHS Trust has launched a Regional Mechanical Thrombectomy Service, known sometimes as a "Lazarus procedure," to help more patients.

Patients taken to district hospitals in York, Scarborough, Grimsby and Scunthorpe will be "blue lighted" by ambulance to the Interventional Radiology Theatres at Hull Royal Infirmary if they are considered suitable for the minimally invasive Mechanical Thrombectomy.

Performed under local anaesthesia or sedation, the procedure involves a wire passed into the patient's brain to retrieve the blood clot, enabling some people to recover mobility, speech and other faculties damaged by an acute ischaemic stroke.

Improvements can be so dramatic, Mechanical Thrombectomy has been called a "Lazarus procedure" because of its ability to reduce the risk of long-term disability or death in some stroke patients.

It's Serious Stuff
The local communications patch (CCGs, CHCP, Humber), led by the HEHYT communications team, launched a full programme of winter messages aimed at encouraging the local population to make sensible choices when accessing healthcare. The campaign

has focused on social media, targeting local postcodes and promoting alternatives to the Emergency Department. Partnering local media, schools, sports teams and pubs has resulted in a significant amount of media overage over the Christmas and New Year period.

The aim of the campaign is to affect a long-term behaviour change in the population we serve with more people choosing to be treated outside of hospital for minor conditions and illnesses.

A locally developed brand 'It's Serious Stuff' is a departure from the national branding and marketing which the Trust has used for the last few years.

Families can play a vital role in keeping loved ones out of hospital
Greta Johnson, lead infection prevention and control nurse at our Trust, issued an appeal before Christmas to families to make sure older people have at least eight drinks a day to reduce their risk of hospital admissions.

Drinking at least 1.5 litres of fluid or around eight cups a day prevents infections such as Urinary Tract Infections (UTIs), which are particularly common in older people.

People over 65 are also at greater risk of dehydration, which can in turn increase the risk of developing an infection.

Keeping hydrated as well as warm and active are all practical steps which can be taken to keep an older person well and reduce the risk of hospital admissions.

Name Change celebration event
In February 2019, our Trust is scheduled to change its name to *Hull University Teaching Hospitals NHS Trust*. I am very pleased that a celebration event of the partnership with the University of Hull and the name change is being held on 1 February 2019, with a showcase of our research and innovation as well as a recruitment fair in the afternoon. Trust and University staff are warmly invited.

Health staff see out the NHS's 70th year in seasonal style
Sixty-five health workers performed at Hull Minster on 19th December this week to celebrate the festive season and give thanks for 70 years of the NHS.

Staff from local health organisations including Hull and East Yorkshire Hospitals NHS Trust, Humber NHS Foundation Trust and City Health Care Partnership led a special Christmas Concert for the congregation.

Midwives, doctors, nurses, mental health workers and administrative staff were among those singing songs linked to the nature of their work, including 'People, Help the People' to mark the 70th anniversary of the National Health Service.

There was also a number of readings from health staff and traditional carols for the congregation to join in with.

New video promoting Hull's hospitals for people seeking career changes
A three-minute video was produced by the Trust in December showcasing the opportunities available to people who decide the new year is the time to land their dream job.

Part of our "Remarkable People, Extraordinary Place" recruitment campaign, the video was also shown at university job fairs all over the north of England.

The video features renowned Paediatric Surgeon Sanya Besarovic along with nurses, physiotherapists and consultants explaining how teamwork helps our teams produce the best possible care for patients.

Haemophilia team get positive peer review
Our Haemophilia service which looks after hundreds of people with bleeding disorders has received a positive peer review for the quality of care given to patients.

Services for 400 patients from Hull, the East Riding and North Lincolnshire underwent the full-day inspection against rigorous national standards as part of the peer review in November.

Now, the service based in the Queen's Centre has become the first moderate-sized treatment centre in the UK to receive a positive peer review as part of a national programme.

Well done to all of our staff who help to provide this service to patients.

Hull pathology team receives global recognition for commitment to quality
Pathology staff at our Trust were celebrating in November after winning Quality Team of the Year in a prestigious international awards ceremony.

The International Quality Awards 2018 recognise excellence within the quality profession and winners are acknowledged for enhancing the reputation of their organisations around the globe.

Judges voted to award the honour to the Hull team after praising the "rigorous quality structures in place across their laboratories." They said: "The team provides a high culture of transparency and a shared drive for continuous improvement."

Many congratulations to everyone involved with the Pathology service.

Patients benefit from £450k theatre upgrade
One of the operating theatres at Castle Hill Hospital underwent a £450,000 upgrade to enable patients to benefit from the latest technical advances in healthcare.

During November new lighting, technology and equipment was installed at Theatre 11 at Castle Hill, the operating theatre where patients with upper gastrointestinal problems undergo surgery.

Surgeons can now use multiple 4k high-definition monitors providing superior image quality during laparoscopic procedures, allowing more precision while the patient is on the operating table. Touch screens can be used by theatre teams while they are scrubbed to adjust settings, meaning more efficient and immediate changes can be made.

Smart lighting using LEDs has been installed which is more environmentally friendly and energy efficient, switching off automatically when everyone has left the theatre.

Hull one of first NHS trusts awarded Veteran Aware accreditation
As the nation marked the 100th anniversary of the end of the First World War, the NHS celebrated the first wave of new Veteran Aware hospitals.

Our Trust became one of the 24 acute hospital trusts accredited by the Veterans Covenant Hospital Alliance (VCHA) to lead the way in improving NHS care for veterans and members of the Armed Forces community.

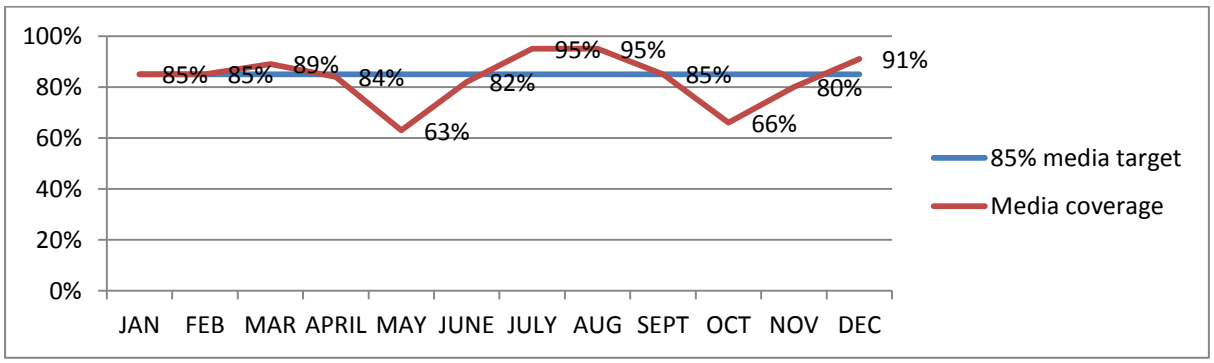
Staff will be trained to be aware of veterans' specific needs and make past and present servicemen and women aware of appropriate charities or NHS services which could help them, such as mental health services or support with financial or benefit claims.

The trust will also ensure that the Armed Forces community is never disadvantaged compared to other patients, in line with the NHS's commitment to the Armed Forces Covenant.

2. MEDIA COVERAGE

The Communications team issued 20 news releases in November and 25 in December.

In December 91% of our media coverage was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been exceeded in all but two months out of the last 12:



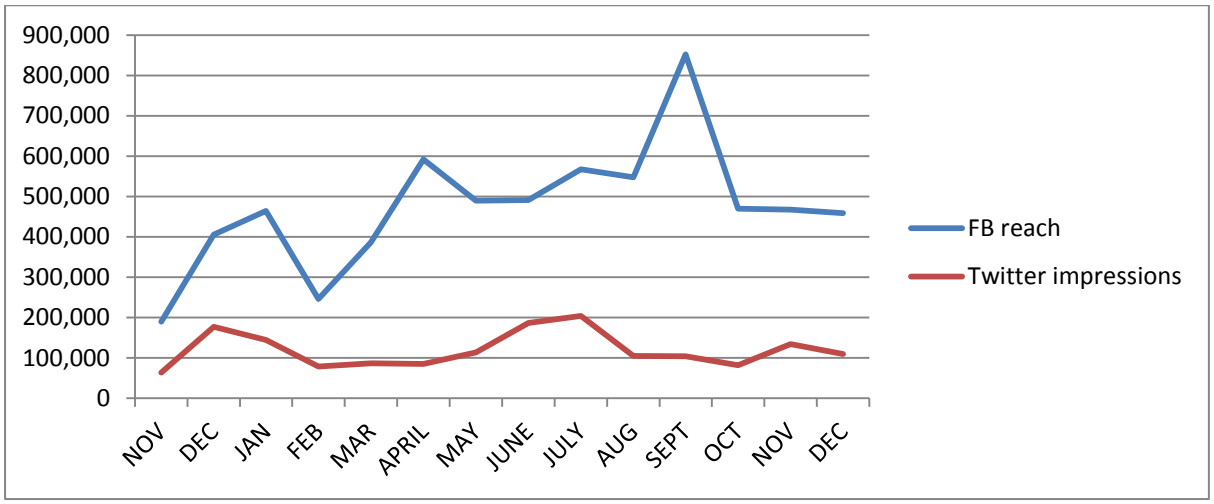
Facebook reach is the number of people that have seen content within a certain period, it can also be called unique impressions.

- In November total "reach" for all posts on trust Facebook pages was 467,305
- In December total "reach" for all posts on trust Facebook pages was 459,008

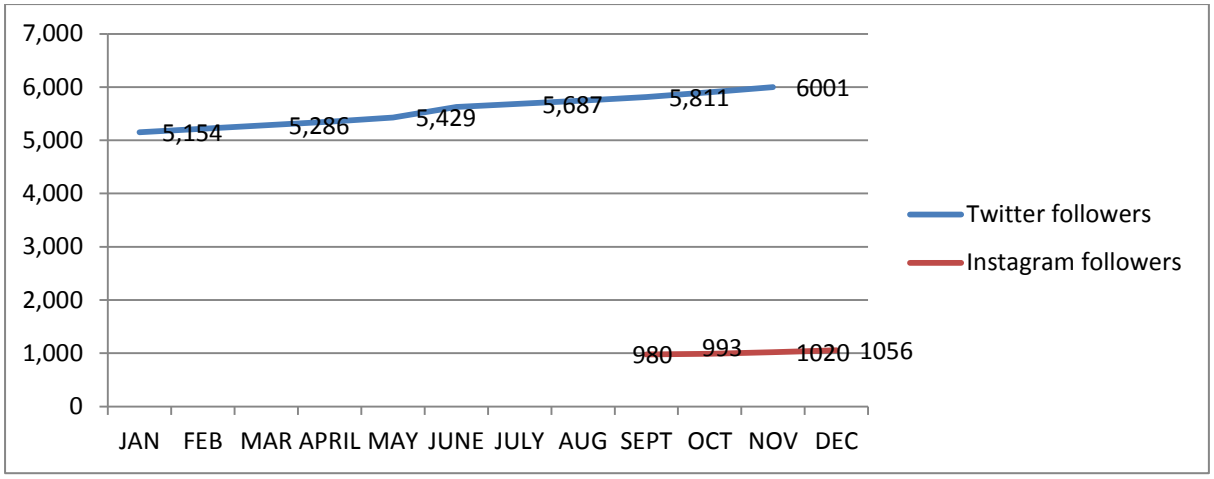
Twitter impressions are a total tally of all the times a Tweet has been seen. This includes not only the times it appears in a followers' timeline but also the times it has appeared in search or as a result of someone liking the Tweet.

- @HEYNHS Twitter account impressions 134,700 (November)
- @HEYNHS Twitter account impressions 110,000 (December)

Social media reach and impressions November-December 2018



The number of people 'following' the Trust on Twitter and Instagram is also increasing:



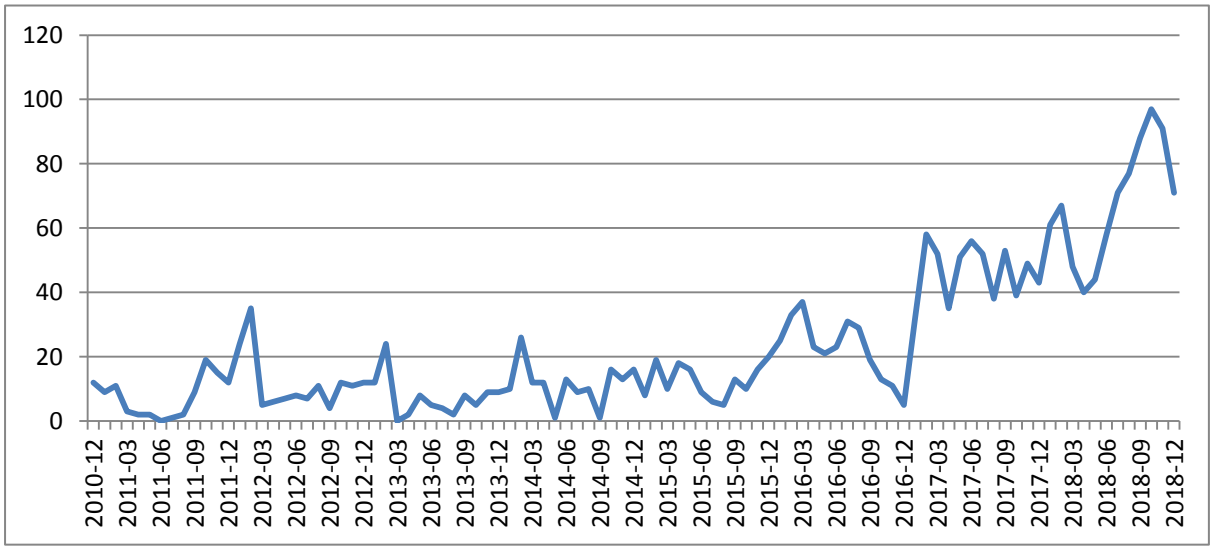
3. MOMENTS OF MAGIC

Moments of Magic nominations enable staff and patients to post examples of great care and compassion as well as the efforts of individuals and teams which go above and beyond the call of duty. They illustrate our values at work and remind us that our workforce is made up from thousands of Remarkable People.

In November and December we received 91 and 71 Moments of Magic nominations, respectively.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2010-2018



HEY LONG TERM GOALS - December 2018 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Never Events	0	0	⇨
R	Complaints (QIP - closed within 40 working days)	90%	85.42%	⇩
G	Healthcare Associated Infections - MRSA	0	0	⇨
G	Healthcare Associated Infections - C.Diff (YTD target)	52	26	-
R	Safety Thermometer - Harm Free Care	95%	91.97%	⇩
R	Venous Thromboembolism (VTE) Risk Assessment (Q2 1819)	95%	92.61%	⇧
G	Mortality - HSMR (September 2018)	<100	95.6	⇧
G	Friends & Family Test - Inpatients (November 18 - Trust v National %)	95.46%	98.61%	⇧
R	Friends & Family Test - Emergency Department (November 18 - Trust v National %)	86.65%	84.55%	⇩

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	3

Workforce

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Staff Retention/Turnover	<9.3%	9.10%	⇩
G	Staff Sickness	<3.9%	3.42%	⇩
R	Staff Vacancies	<5.0%	5.21%	⇩
R	Staff WTE in post (<0.5% from Plan)	7340	7447.1	⇧
R	Staff Appraisals - AFC Staff	85%	82.30%	⇩
G	Staff Appraisals - Consultant and SAS Doctors	90%	92.50%	⇧
G	Statutory/Mandatory Training	85%	91.00%	⇧
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£9.2m	£12.1m	-
G	Staff: Friends & Family Test - Place of Work (Q2 1819 v National)	65%	69%	⇧
G	Staff: Friends & Family Test - Place of Care (Q2 1819 v National)	81%	84%	⇧

Category	No. of Risks Rated 15 and above
Corporate Staffing Risks	3
Corporate Clinical Risks	1

Performance

RAG	Indicator	Target	STF Trajectory	Performance December	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	82.50%	81.99%	⇩
G	52 Week Referral To Treatment Breaches	0	23	4	⇧
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	8.94%	⇧
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	88.7%	76.37%	⇩
R	Cancer: ADJUSTED 62 Days Referral To Treatment (November Data)	85%	81.99%	74.90%	⇧
G	Length of Stay	<5.2	-	5	⇧
R	Clearance Times	12 weeks	-	14.8	⇩
G	Waiting List Size	55,140	55,140	54,220	⇩
G	Available Clinic Slot Utilisation	80%	-	90.10%	⇩
R	Theatre Utilisation	90%	-	80.96%	⇩
R	E-Referrals - GP Engagement	100% by October 2018	-	99.1%	⇩
R	Appointment Slot Issues	35% (TBC)	-	41.10%	⇩

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	3

Finance

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Capital Expenditure	21.2	8.8	⇧
R	Statement of Comprehensive Income Plan - Year to Date	2.043	0.345	-
R	CRES Achievement Against Plan	£11.3m	£9.8m	-
R	Invoices paid within target - Non NHS	95%	91%	⇨
R	Invoices paid within target - NHS	95%	70%	⇧
R	Risk Rating	3	3	⇧

Category	No. of Risks Rated 15 and above
Corporate Non-Clinical Risks	2

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

Tuesday 29 January 2019

Title:	Board Assurance Framework
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	The purpose of this report is to present the 2018-19 Board Assurance Framework, for the Board to highlight any positive assurance or areas requiring further assurance linked to the Board's agenda.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Summary of Key Issues:	The Trust Board has held detailed discussions on all but one BAF risk areas year to date. During this financial year, BAF 2: Staffing was increased following discussion at the July 2018 Board meeting from a rating of 16 to 20. All other risk ratings have remained the same year to date. The Performance and Finance Committee had an in-depth review of waiting lists and cancer waiting times at its December 2018 and was asked to take a view on BAF 4 on performance as to whether this should increase when quarter performance figures are known. The Quality Committee looked at communications as a common issue in incidents but no recommendation to change risk ratings. The process by which the BAF is used by the Trust Board to inform the Board's meeting agenda has changed during 2018-19, and is used more pro-actively to lead discussion areas at public Trust Board meetings.	

Recommendation:	The Board is asked to review the current risk areas on the Board Assurance Framework and determine whether: • There are any particular gaps in assurance requiring further work by the Trust Board • There is positive assurance from the Board's discussions today to add to the BAF • Approve or amend the proposed Q3 ratings for each BAF risk area

Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

1. Purpose of this report

The purpose of this report is to present the 2018-19 Board Assurance Framework, for the Board to highlight any positive assurance or areas requiring further assurance linked to the Board's agenda.

2. Background

The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack, of assurance during the year as to what extent the level of risk is being managed. The Board Assurance Framework (BAF) also determines what an acceptable level of risk would be. The BAF is a key governance mechanism to measure and monitor the level of strategic risk in the organisation.

The Trust has put in place a 'ward to board' process for risk management, for the BAF to include reference to relevant risks form the Corporate Risk Register, which is reviewed and agreed by the Executive Management Committee. This provides the opportunity to link corporate-level risks where they impact on the strategy and achievement of the Trust's over-arching goals.

The Board spent time at its development session in May 2018 on the use of the Board Assurance Framework and determined that Board discussions should be framed more around the Trust's strategic objectives and risks to their achievement. How this is enacted in practice is described below.

Page 1 of the Board Assurance Framework now consists of a visual to group the strategic risks in to 5 domains. This can help as an aide-memoire as to where a discussion 'fits' in terms of strategic discussion. The BAF can be populated through discussions framed around risks and assurance to the strategic objectives.

3. Board Assurance Framework (BAF) 2018-19

At the Trust Board in July 2018, the Board discussed four of the BAF risks with the highest risk ratings in Q1:
BAF 2 – staffing. Q1 risk rating = 15, increased to 20
BAF 4 – performance. Q1 risk rating = 16
BAF 6 – STP and partnership working = 16, review again in 3 months' time
BAF 7.1 – achievement of financial plan = 20

At the Trust Board in September 2018, the Board discussed two further BAF risk areas:
BAF 1 – Staff engagement and organisational culture = 12
BAF 3 – Quality of patient care = 9

At the November 2018 Board meeting, the Trust Board discussed:
BAF 6 – Partnership working = 16 (to remain at 16)
BAF 7.2 – Capital funding 2017-18 = 20 (to remain at 20)

Through these detailed discussions, the Board increased the risk rating of BAF 2 – staffing and agreed to increase the risk rating to 20. The Board recognised the work already in place and ongoing and agreed that this would be reviewed with a view of reducing it providing the Board were assured that actions in place mitigated the risk satisfactorily.

The other risk ratings were unchanged for Q2. In respect of BAF 7.1, the Board agreed to leave the risk rating at 20 but there was concern around the end-of-year loading to achieve

the CRES. The Performance and Finance Committee is to keep monitoring the situation and escalate any emerging issues.

The Performance and Finance Committee at its October 2018 reviewed BAF 7.2 relating to capital funding in 2017-18 and this was on the Board agenda in November 2018 for more detailed discussion. After detailed debate, it was agreed to retain the risk rating at 20; whilst there is a short-term improvement in capital funding availability, the longer-term risks posed by lack of capital funding and the potential impact on the Trust remain the same.

The Board also followed up its discussion on BAF 6 (STP and partnership working) at the November 2018 meeting. There has been some positive progress seen since the last Board update, which was discussed in detail by the Board. This progress has been recent and the Board felt, from a risk management point of view, that a reduction in risk would come should the progress be sustained. The Board agreed that the BAF score remains the same for now.

The Performance and Finance Committee held detailed discussions with Health Groups at its November meeting to look at NHS Constitutional standards. The current risk rating is 16 (4 likelihood and 4 impact). The Committee received detailed understanding of the current situation and the work being undertaken by Health Groups up until year end to maintain, and where possible, improve waiting times. The Committee agreed that there were some mitigating actions in place with good assurance from the Health Groups. BAF 4 is described as: *there is a risk that the Trust does not meet operational planning guidance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 18-19, with an associated risk of distress caused to patients and the ability of the Trust to secure STF monies*. The Trust has missed Q1 STF monies linked with ED performance and whilst there was assurance that the Trust should see improvements in all waiting time areas by year-end, the Trust is not yet on track to meet all requirements.

The Performance and Finance Committee at its December 2018 meeting debated in detail whether to recommend that the risk rating for this BAF area increases on the basis of likelihood, as the ED target was not met in Q1 and was not on track in Q3. It was agreed to review the position at the January 2019 meeting when the Q3 figures were known.

The Quality Committee wa also asked whether for its view on Q3 ratings to feed in to Trust Board discussions. The Quality Committee held detailed discussion at its November 2018 meeting on a general risk around communication linked with serious incidents and whether the risk that the Trust fails to learn from incidents is increasing. Concluding these discussions, It was not felt that this was an increase in risk in the organisation but there should be increased recognition of communications as an underlying issue and specific actions in QIP projects where communication can be a root cause to improve communications and reduce risk of harm or poor patient experience.

All BAF risk areas have been reviewed and positive assurance, gaps in assurance and control measures have been updated, per the version of the BAF attached. The Board has met four times and the Performance and Finance and Quality Committees seven times this financial year. There are no other particular areas of risk or assurance that have been escalated during this time other than the notes above. There are some particular pressure points that will need active monitoring by Board Committees, particularly capital and infrastructure, and making quality improvements and a safety culture, as well as a long-term staffing plan. These will form Board and Committee discussions during the year.

The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 21 risks on the corporate risk register. Of these 21 risks, 20 map to risk areas on the BAF, as follows:

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 6 corporate risks (reduced by 1)
BAF 3 quality of care = 5 corporate risks (two closed and two new risks identified)
BAF 4 performance = 4 corporate risks
BAF 5 specialist services = 0 corporate risks
BAF 6 partnership working = 0 corporate risks
BAF 7.1 financial plan = 0 corporate risks
BAF 7.2 infrastructure = 5 corporate risks

There is a new corporate risk in relation to contingency planning and the unknown affect and risk from Brexit (specifically a No Deal Brexit scenario). This does not map to a specific BAF risk but is a risk across the organisation.

Mapping corporate risks helps to show the link between operational and strategic risk; if the number of corporate risks in a particular BAF area increases, it could indicate that strategic issues are starting to have an operational effect on patients and staff; like, the number of corporate risks in a BAF area suggests that there are already operational effects from a strategic issue and increases can be indicative of a risk escalating.

The number of corporate risks relating to the financial plan achievement has reduced by 2, following a review by the two HG raising risks before on achievement of the financial plan for this financial year (both risks related to achievement of last year's plan). In August 2018, the Executive Management Team agreed a new corporate risk relating to the ReSPECT process (patients expressing their care preferences and do not resuscitate status). This risk has been drawn up for EMC approval and will map to BAF 3.

The number of infrastructure risks (BAF 7.2) has risen from 1 to 5 in the last 12 months.

Staffing has the greatest number of corporate risk and is one of the highest-rated areas on the Board Assurance Framework.

4. Recommendations

The Board is asked to review the current risk areas on the Board Assurance Framework and determine whether:

- There are any particular gaps in assurance requiring further work by the Trust Board
- There is positive assurance from the Board's discussions today to add to the BAF
- Approve or amend the proposed Q3 ratings for each BAF risk area

Carla Ramsay
Director of Corporate Affairs

January 2019

PEOPLE
Honest, caring and accountable culture
Valued, skilled and sufficient staff

Strategic risks:
Staff do not come on the journey of improvement – seen in staff engagement and staff FFT scores

Work on medical engagement and leadership fails to increase staff engagement and satisfaction

Lack of affordable five-year plan for 'sufficient' and 'skilled' staff

FINANCE
Financial sustainability

Strategic risks:
Failure to deliver 2018-19 financial plan and associated increase in regulatory attention

That the Trust is not able to formulate and implement a three-year financial recovery plan to leads to financial sustainability, and that this failure impacts negatively on patient care

PATIENTS
High quality care
Great local services
Great specialist services

Strategic risks:
Failure to continuously improve quality
Failure to embed a safety culture
Failure to address waiting time standards and deliver required trajectories – increased risk of patient harm and poorer patient and staff experience

INFRASTRUCTURE
High quality care
Financial sustainability

Strategic risks:
Growing risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment

Linked to three-year financial recovery plan – risk that capital requirements cannot be met and pose an increased risk to financial recovery

PARTNERS
Partnership and integrated services

Strategic risks:
Risks posed by changes in population base for services
Lack of pace in acute service/pathway reviews and agreement on partnership working
Risk of lack of credible and effective STP plans to improve services in the local area within the resources available, and a lack of influence by the Trust in these plans
STP rated in lowest quartile by regulator

BOARD ASSURANCE FRAMEWORK 2018-19 AS PRESENTED TO THE JANUARY 2019 TRUST BOARD AND BOARD COMMITTEES

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey There is a risk that the Trust fails to embed a safety culture *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues	None	**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Chief Executive cultural briefings in 2018 on management behaviours and 'stop the line' Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores Continuous examples and feed back to staff as to how speaking up makes a difference	**12**	**12**	**12**		**4 x 1 = 4**	**<u>Positive assurance</u>** Positive receipt by clinicians of the Never Event session – to follow up Detailed discussion at September 2018 on staff culture and the People Strategy – positive assurance about continued progress on workforce, including increases in engagement score and workstreams underpinning the People Strategy to continuously improve staff engagement. Board development discussion and workshop on revising the People Strategy in November 2018 and engagement events with Health Groups to be held. **<u>Further assurance required</u>** Recent staff engagement score shows some slowing of progress – whilst the score is on an upward trend, there are concerns about continued progress

		Risk that some staff or putting patient safety first			inspire staff Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the People Strategy						

Risk Appetite

The Trust has been managing and mitigating the level of risk posed by staff culture since 2014, and has been on a journey of improvement on staff engagement. There needs to be a renewed focus on staff culture to bring about a new level of improvement. The appetite for risk is high, insofar as the Trust has worked in a high-risk environment regarding staff culture, which has been mitigated over time as a result of acknowledging the poor staff culture in 2014 and putting a robust plan in place to engage with staff ever since. The Trust wants to mitigate this to a lower-level risk in respect of the impact that poor engagement and poor behaviours have; the Trust is not prepared to take risks with staff culture where this jeopardises patient care or staff welfare.

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* Staff do not come on the journey of improvement – seen in staff engagement and staff FFT scores Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse, OPD vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists	**5 (impact)** **3 (likelihood)** **= 15**	People Strategy 2016-18 in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices (including nursing); Advanced Clinical Practitioners and Physicians Associates being deployed and recruited to cover Junior Doctor and nursing roles, in addition the Trust has introduced new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 18-19; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at	Need clarity as to what 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs	**15**	**20**	20		5 x 2 = 10	**<u>Positive assurance</u>** New roles being put in place and supported by the Trust in 18-19 including Physicians Associates, further ACPs, nursing apprenticeships Progress on recruitment during 18-19 with qualified nursing staff – recruitment from university graduates and international recruitment New programme being put in place with trainee doctors from Pakistan Improved fill rates from September 2018 university recruitment of newly qualified nurses; higher fill rate in junior doctor rotas than previously Recruitment to some specific posts – success seen in Anaesthetics **<u>Further assurance required</u>** Variable pay spend predicted to continue during 18-19; some HGs already under some pressure even with re-set budgets Reviewed in detail at July 2018 Trust Board – risk rating increased, to be reviewed in September 2018 with a view to the risk rating coming back down after mitigating actions – reviewed at September 2018 and not yet to decrease. Nursing fill rates improved with new intake of graduate nurses but still not in better quartile. Difficulties seen in winter planning and staffing – lower fill rates than last year and less ability to flex staff this winter to further increase winter capacity

					monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training Nursing safety brief several times daily to ensure safe staffing numbers on each day Employment of additional junior doctor staff to fill junior doctor gaps Regular reports to the Trust Board from the Guardian of Safe Working					

Risk Appetite

There is a link between patient safety and finances; the Trust draws a 'red line' as compromising quality of care and has part of the overspent position in 2017-18 was to maintain safety of services due to staffing shortfalls. The Trust needs to reduce the risk to its financial sustainability posed by quality and patient safety but without compromising the Trust's position on patient safety. The Trust is putting a plan in place to encompass new clinical training roles and build these in to workforce plans, so is demonstrating a good appetite to adapt and change to further mitigate this risk. The Trust will need to show some agility and willingness to invest as part of this risk appetite.

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like That the Trust does not increase its public, patient and stakeholder	MHG: Hyper Acute Stroke Unit capacity CCSHG: lack of compliance with blood transfusion competency assessments CCSHG: Risk to patient safety involving discharge medicines Corporate: Embedding ReSPECT process Pathology results reviewed by requesting clinicians	**3 (impact)** **3 (likelihood)** **= 9**	Setting expectations on a safety culture in the Trust – Never Event session to be followed up by Chief Executive briefings sessions and the 'Stop The Line' campaign Quality Improvement Plan (QIP) was updated in light of latest CQC report and has been further updated from the new CQC report published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)	**9**	**9**	9		3 x 2 = 6	**Positive assurance** Detailed understanding at Board development on next steps to reach good and outstanding – shared understanding with Board and EMC on the progress that is required; underscores ambition to be outstanding by 2021-22 **Further assurance required** CQC rating of 'requires improvement' – shows a lot of progress since last report but still work to do to progress to 'good' overall Targeting intervention/quality improvement plans for improving communications, as the most common factor in serious incidents

		engagement, detailed in a strategy									

Risk Appetite

The Trust remains focussed on delivery of high quality services for its patients; the Trust does not want to compromise patient care and does not have an appetite to take risks with quality of care. The Trust acknowledges that the risk environment is increasing in relation to the Trust's financial position and ability to invest in services, and that the Trust has an underlying run-rate issue to address.

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet operational planning guidance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 18-19, with an associated risk of distress caused to patients and the ability of the Trust to secure STF monies. *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce its list size compared to the position at 31 March 2018; this will require targeted work by each specialty ED performance did improve following a period of intensive support and improvement focus but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG Capacity of intra-vitreal injection service MHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target	**4 (impact)** **4 (likelihood)** **= 16**	Trajectories set against sustainable waiting lists for each service, to move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Capacity and demand work in cancer pathways	Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	**16**	**16**	**20**		4 x 2 = 8	**Positive assurance** Q2 ED trajectory met Improvement starting to be seen in diagnostic waiting times (Dec 18) Volume of long-waiting cancer patients (104 day waits) decreasing **Further assurance required** Full suite of Performance targets not met in the first half of the year; variable performance month-to-month. Reviewed in detail at July 2018 Trust Board; detailed understanding of current actions and underlying issues. Specific services reviewed at September and October 2018 Performance and Finance Committee meetings in respect of RTT – extraordinary P&F Committee being considered to bring shared understanding and recommendation to the Trust Board on how to progress with RTT. Extra session o P&F Committee November 2018 to understand delivery plans and what is deliverable; year-end position showing that 6 main requirements of the Trust in 18-19 will most likely not be met in full Q1 ED trajectory not met

		backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to make further gains										

Risk Appetite

A range of plans are being put in place to further manage these issues in to 2018-19. This will need further focus in 2018-19, including the completion of the work and investigation relating to the tracking access issue. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. The Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope of the Aligned Incentives Contract where the activity comes under the local commissioners' contracts, and fit within the funding from NHS England for specialised commissioning services. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes.

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk:* There is a risk that reductions in the Trust's patient population for (some) of its specialist services may present sustainability challenges. *What could prevent the Trust from achieving this goal?* Actions relating to this risk may be taken by other organisations than the Trust and the Trust may struggle to influence these decisions, particularly in relation to patient populations beyond the Humber geography.	None	**3 (impact)** **4 (likelihood)** **= 12**	The Trust chairs the HCAV STP Hospital partnership Board The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is a member of the Yorkshire and Humber Oversight Group for Specialised Commissioning	Ongoing discussions and evolution of the STP and also its links to local health economy programmes of work	**12**	**12**	**12**		4 x 2 = 8	**Positive assurance** Engagement work with acute partners in the STP – active participation in 2 x acute services reviews Positive relationship with NHS England as commissioner of specialised services **Further assurance required** Role and pace of change achievable through STP

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**4 (impact)** **4 (likelihood)** **= 16**	The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is playing a key role in the Humber Acute Review (CEO and DOSP) The Trust is playing a key role in the STP workforce workstream (DOWOD) The Trust has a seat on the Hull Place Board (CEO) The Trust is participating in the East Riding Place Based initiatives The Trust has a partnership meeting with CHCP		**16**	**16**	**16**		4 x 2 = 8	**Positive assurance** Some progress seen in last 6 months; Letter of Intent between main provider organisations to work more as an Integrated Care Partnership and more progress towards working as an Integrated Care System at STP level. Scarborough acute service review commenced; progress detailed at November 2018 Trust Board **Further assurance required** Reviewed in detail at July 2018 Trust Board; detailed understanding of current position and actions being taken – gap in assurance on scale and pace of change/partnership development Progress detailed at November 2018 Trust Board – evidence of sustaining progress is required to mitigate and manage this risk level down

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2018-19 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	None	**5 (impact)** **4 (likelihood)** **= 20**	Health Group budgets revisited for 2018-19 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES. Weekly Productivity and Efficiency Board (PEB) in place; outputs monitored by Performance and Finance Committee HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Year 2 of Aligned Incentives Contract with local commissioners; consistent approach to income Investment in staffing shortfalls and recruitment to drive reductions in variable pay Will start discussions with CCG colleagues on system solutions Discussions with NHSI over control total re:	Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position	**20**	**20**	**20**		5 x 3 = 15	**Positive assurance** Financial position to month 7 in line with plan **Further assurance required** Reviewed in detail at July 2018 Trust Board and further review at month 6 identifies issues that require solutions, including gaps in achievement of financial plan through: non-development of SPV this year (£2.9m), CNST premium (£0.5m), Hep C CQUIN (£0.6m) and health group forecasts; November 2018 position shows same gaps. M8 figures from Health Groups did not match forecast – new overspends seen

					SPV					

Risk Appetite

The Trust is willing to review any CRES proposal and has a robust Quality Impact Assessment in place to understand any change posed to quality and safety as a result of a new CRES scheme. The Trust will not put in significant CRES schemes that would compromise patient safety. The aim of any CRES scheme is to maintain or ideally improve quality.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**5 (impact)** **4 (likelihood)** **= 20**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Remedial fire works undertaken in the short-term – also secured £4.9m capital funding for works Applied for £2.6m emergency capital Applied to convert £3.7m bonus PSF received in 2017-18 to capital	Insufficient funds to manage the totality of risk at the current time Programme enables the Trust to run on a day-to-day basis but is not addressing the root causes sufficiently, such as fire safety – the level of risk increases as the Trust manages 'as is'	**20**	**20**	**20**		5 x 2 = 10	**Positive assurance** No major issues so far this financial year – tightly managed capital position and no new issues to overcome Additional capital funding received and loan funding applied for to improve position in-year – discussed in detail at November 2018 Trust Board **Further assurance required** Need response to funding applications Lack of headroom to manage further system problems, e.g. unexpected equipment failure November 2018 Trust Board discussed lack of long-term availability of larger sums of capital funding – risks to Trust on infrastructure and backlog maintenance remain significant

Risk Appetite

The Trust is balancing a number of risks in relation to capital; the amount of capital available to the Trust is very limited compared with the calls on capital that the Trust has quantified –i.e. backlog maintenance, equipment replacement, capital development requirements for safe patient environments, quality of sanitary accommodation; the longer the Trust manages its estates as it is, the increase of non-compliance risks with regulatory requirements

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
29th JANUARY 2018

Title:	QUALITY REPORT JANUARY 2019
Responsible Director:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	Mike Wright, Executive Chief Nurse

Purpose	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to service quality (patient safety, service effectiveness and patient experience)	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues	Information is provided in the report on the following topics: • Patient Safety Matters including Never Events and Serious Incidents • Safety Thermometer • Healthcare Associated Infections (HCAI) • Patient Experience Matters • Care Quality Commission • Learning from Deaths • Safeguarding Annual Reports for 2017/18 Areas of good practice are presented alongside those that require actions and improvement.	

Recommendation	The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required

QUALITY REPORT
JANUARY 2019

EXECUTIVE SUMMARY

Information is provided in the report on the following topics:

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission
- Learning from Deaths
- Safeguarding Annual Reports for 2017/18

Areas of good practice are presented alongside those that require actions and improvement.

QUALITY REPORT
JANUARY 2019

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the current position in relation to:

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission
- Learning from Deaths
- Safeguarding Annual Reports for 2017/18

Areas of good practice are presented alongside those that require actions and improvement.

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

This report covers the reporting period November 2018 and December 2018, where possible. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE)

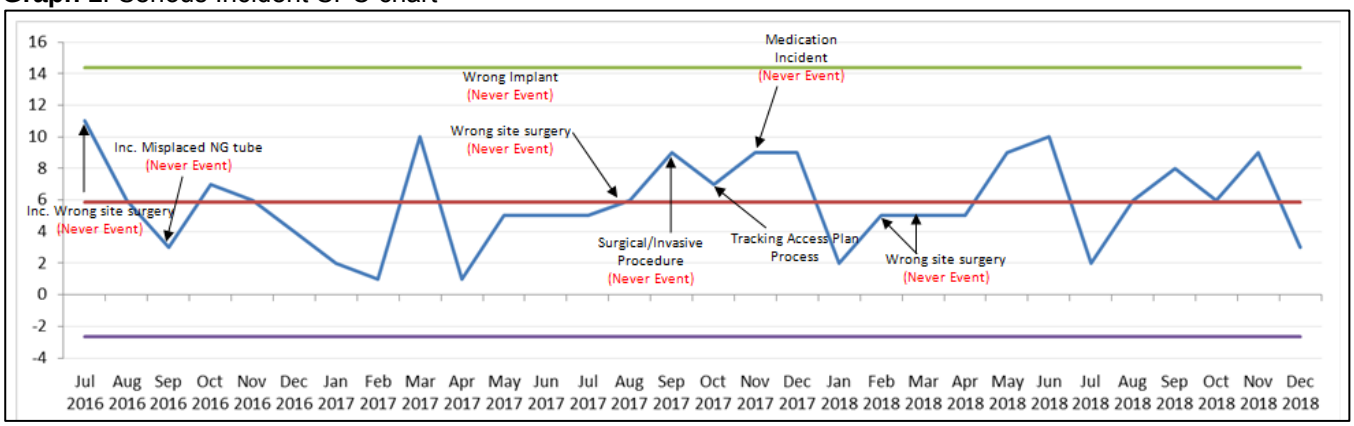
No Never Events were reported during November and December 2018, with the last once reported in March 2018.

Work continues on the actions arising from the Never Events declared in 2017/18, and the December 2018 Operational Quality Committee ratified the 'Stop the Line' policy. The development of this policy was in response to the Never Events declared during 2017/18. This is now being implemented across the organisation.

2.2 Serious Incidents reporting rates

As at the end of December 2018/19, the Trust had declared 55 Serious Incidents so far in-year. The following graph shows the Serious Incident reporting rate, with Never Events highlighted specifically, and the Tracking Access Plan SI noted, also.

Graph 1: Serious Incident SPC chart



2.4 Serious Incidents declared in November and December 2018

The outcomes of all Serious Incident investigations are reported to the Trust Board's Quality Committee where more detailed discussions about each of them takes place. At this meeting, there is open debate and challenge to each investigation's findings and actions as a means of seeking assurance that the Trust is identifying and acting upon and any areas that require attention and improvement. Overall, it is reported that Quality Committee members get positive assurance from this process.

The Trust meets with commissioners each month to present completed SI investigation reports in a similar manner. Commissioners continue to advise the Trust that they receive positive assurance from this process, also.

A summary of the incidents declared during November and December 2018 is contained in the following tables and each of these is now under investigation. Anything of significance from them will be reported to the Quality Committee in due course and anything of undue concern will be escalated to the Trust Board, as required.

The Trust declared 9 Serious Incidents in November 2018.

Table 1: Serious Incidents declared November 2018

Ref Number	Type of SI	Health Group
26428	Treatment Delay – patient did not receive timely treatment for cerebral palsy	Family & Women's
26435	Treatment Delay due to delay in processing bowel sample	Clinical Support
26784	Maternity/Obstetric Incident – intrauterine death	Family & Women's
26880	Treatment Delay – delayed follow up for cancer	Family & Women's
27523	Delayed Diagnosis of hip fracture	Medicine
27530	Delayed Diagnosis – patient was not followed up for cancer	Surgery
27728	Maternity/Obstetric Incident – unexpected admission to Neonatal Unit	Family & Women's
27777	Sub-Optimal Care of the Deteriorating Patient – delays in respiratory review and insertion of chest drain	Medicine
28617	Medication Incident – error in relation to chemotherapy treatment	Clinical Support

The Trust declared 3 Serious Incidents in December 2018.

Table 2: Serious Incidents declared December 2018

Ref Number	Type of SI	Health Group
28666	Delayed Diagnosis of cancer due to non-repeat of a CT scan	Medicine
29224	Maternity/Obstetric Incident – growth scan results not monitored	Family & Women's
29670	Delayed Diagnosis – patient did not receive timely diagnosis despite clinic follow ups	Family & Women's

3. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer (ST) is a series of point prevalence audits that were established to measure the four most commonly reported harms to patients in hospital. Each month, all inpatients are assessed for the existence of any of the four harms that have occurred either before they came into hospital or whilst in hospital. Each month, all inpatients on that day are assessed for the existence of any of the four harms.

The NHS Safety Thermometer point prevalence audit results for December 2018 are attached as **Appendix One**. October and November's data is available if required.

From the 872 in-patients surveyed on Friday 14th December 2018, the results are as follows:

- **92%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2% [n=18]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 885 patients, 49 did not require a VTE risk assessment. Of the remainder, 734/823 had a VTE risk assessment undertaken. This is **89%** compliance on the day. VTE incidence on the day of audit was **6** patients; **4** of which were with a pulmonary embolism and **2** were a deep vein thrombosis.
- There were **5** new pressure ulcers on the census day. However, 47 patients had pre-hospital admission pressure ulcers (40 at Grade 2, 4 at Grade 3 and 3 at Grade 4). These have been fed back to commissioners to manage but this problem seems to be increasing. The chief nurse will discuss this with commissioners at the next Quality Contract meeting with them.
- There were **17** patient falls recorded within three days of the audit day. Of these, 6 resulted in no harm to the patient and 3 with low harm. There is no data for the remaining seven patients so this will be checked and corrected for the next report. However, falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection were low in n umber at **9/186** patients with a catheter **(4.8%)**. Of the **9** patients with infections, **5** of these were infections that occurred whilst the patient was in hospital.

Overall, performance with the Safety Thermometer remains positive, but continues to be reviewed monthly. Each ward receives its individual feedback and results.

Each ward receives its own results and feedback and ward sisters/charge nurses develop actions to address these.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2018/19 as at 31st December 2018

The Trust is required to report monthly on performance in relation to six key HCAI's. These are summarised in the following table.

Organism	2018/19 Threshold	2018/19 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	52 (locally agreed CCG stretch target of 45)	25 (48% of threshold)
MRSA bacteraemia infections (post 48 hours)	Zero	1 case reported October 5th 2018 1 case reported November 22nd 2018 (over threshold)
MSSA bacteraemia	44	40 (91% of threshold)
Gram Negative Bacteraemia		
E.coli bacteraemia	73	58 (79% of threshold)
Klebsiella	4	Baseline monitoring period
Pseudomonas aeruginosa	1	Baseline monitoring period

The current performance against the upper threshold for each are reported in more detail, by organism:

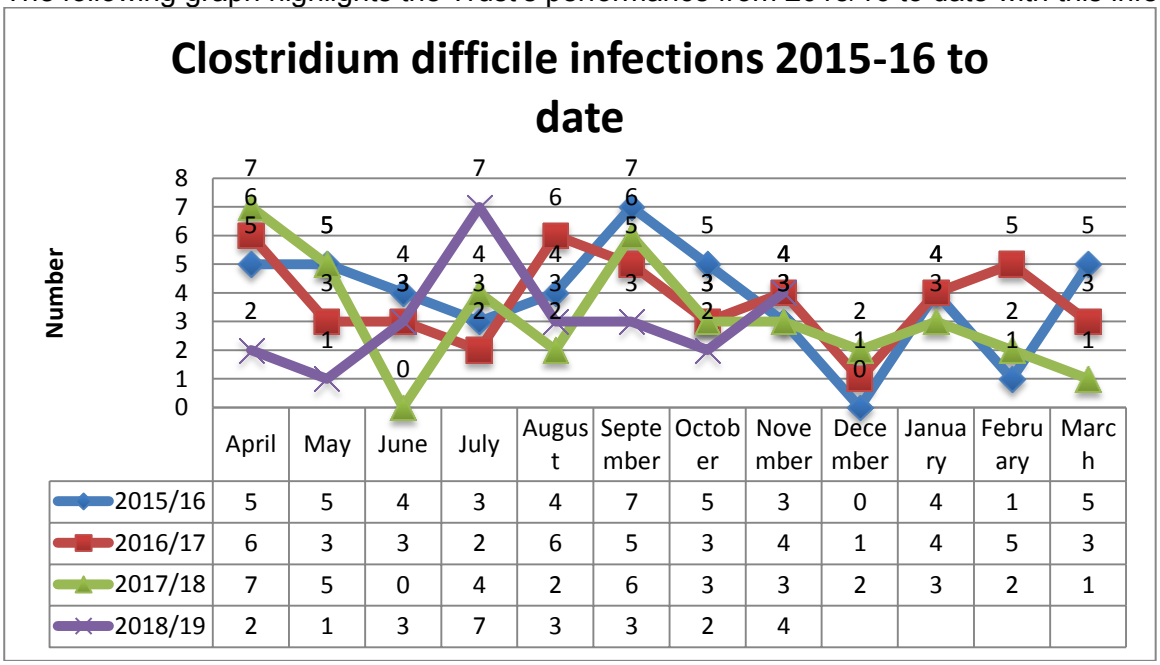
4.1.1. *Clostridium difficile*

Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and painful abdominal cramps. In extreme cases, *C. difficile* infections can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (termed toxic megacolon). In certain cases they can cause or contribute to the death of a patient. Root cause analysis investigations are conducted for each infection and outcomes of RCA investigations for all Trust onset cases shared collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the reporting requirements for 2018/19. A threshold for Trust apportioned cases has been set by NHS Improvement at 52 but a stretch target of 45 has been locally agreed with Commissioners.

At month eight the Trust reported 25 infections against an upper threshold of 52 (48% of threshold). Two Trust onset *C. difficile* cases were reported during October 2018 and a further four during November 2018. From the 1st April 2018, a total of thirteen cases are apportioned to the Medical Health Group, seven to the Surgical Health Group, four to Clinical Support and the remaining one in the Families & Women's Health Group. Four Trust reported cases are patients who have been previously detected with *C.difficile* since 1st April 2018 but with repeated samples, authorised by the Department of Infection.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	53 (45)	25 (48% of threshold)	All twenty five cases have been subject to RCA investigation. Of the twenty five cases, fifteen have been reviewed by Commissioners with fourteen deemed no lapses in practice. One case deemed a lapse in practice due to suboptimal antimicrobial prescribing. Five cases awaiting consideration by the commissioners. The remaining six cases are awaiting final RCA meetings with consultants responsible for their care.

The following graph highlights the Trust's performance from 2015/16 to date with this infection:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	5	5	4	3	4	7	5	3	0	4	1	5
2016/17	6	3	3	2	6	5	3	4	1	4	5	3
2017/18	7	5	0	4	2	6	3	3	2	3	2	1
2018/19	2	1	3	7	3	3	2	4				

During November 2018, a period of increased incidence of *C.difficile* was identified on Ward H100. Two toxin positive cases were detected in addition to *C.difficile* carriers; all 4 cases were apportioned to H100 and sent for ribotyping. The two *C.difficile* carrier cases were differing ribotypes whereas the toxin positive cases were identified as the same ribotype, 078 suggesting onward transmission on the ward. Enhanced ward audits were completed, in addition to RCAs of the toxin positive cases. One case was determined as unavoidable and the other as avoidable – agreed by commissioners. The enhanced ward audits and RCA's identified concerns associated with antimicrobial prescribing, IPC compliance and environmental issues. No further cases detected on H100 since November 2018. This ward will continue to be monitored closely.

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

Staphylococcus aureus (also known as staph) is a common type of bacteria. It is often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and abscesses. If the bacteria enter the body through a break in the skin, they can cause life-threatening infections, such as blood poisoning (bacteraemia). MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of PIR Investigation / Final assignment
MRSA bacteraemia	Zero tolerance	**2 cases - one reported in October and a further case in November 2018, both in the Surgery Health Group** **Over threshold**	October 2018 case – deemed unavoidable by Public Health England (PHE) following investigation however practice issues identified with associated learning for the HG. November 2018 case – complex cardiothoracic case with significant post-operative complications which remains under investigation by the Department of Infection/ Surgery Health Group and to be subsequently reported

The Trust reported one case of MRSA Bacteraemia on 5th October 2018. The infection related to a patient with complex health needs following major colorectal surgery with no previous MRSA history prior to the bacteraemia. However, the patient became unwell on the ward post-operatively and started to show signs of acute infection/sepsis. MRSA was discovered in the patient's blood cultures, nose, wound and central line (venous catheter). It has not been possible to identify the source of this infection.

The patient responded well to antibiotic treatment and resulted in repeated negative blood cultures and MRSA screens. The patient was discharged home on the 3rd December 2018. As a precaution, all other patients on the ward were screened for MRSA and no further cases or evidence of cross infection were identified.

A Post Infection Review investigation, in collaboration with the nursing and surgical teams was completed and reviewed by the commissioners with the bacteraemia deemed unavoidable by Public Health England; however some lapses in practice were identified during the course of the investigation. These have been addressed with the teams concerned and relate to prudent wound and line care.

The Trust reported a second case of MRSA bacteraemia in a patient on the 22nd November 2018. The infection relates to a patient with complex health needs following major cardiothoracic surgery resulting in a prolonged stay on the intensive care unit (ICU) and significant post-operative complications for the patient. The patient is currently nursed on the rehabilitation ward, C29. The Post Infection Review is under way to try to determine how this infection occurred and the findings from this will be reported in due course.

4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

Meticillin-Sensitive *Staphylococcus aureus* is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

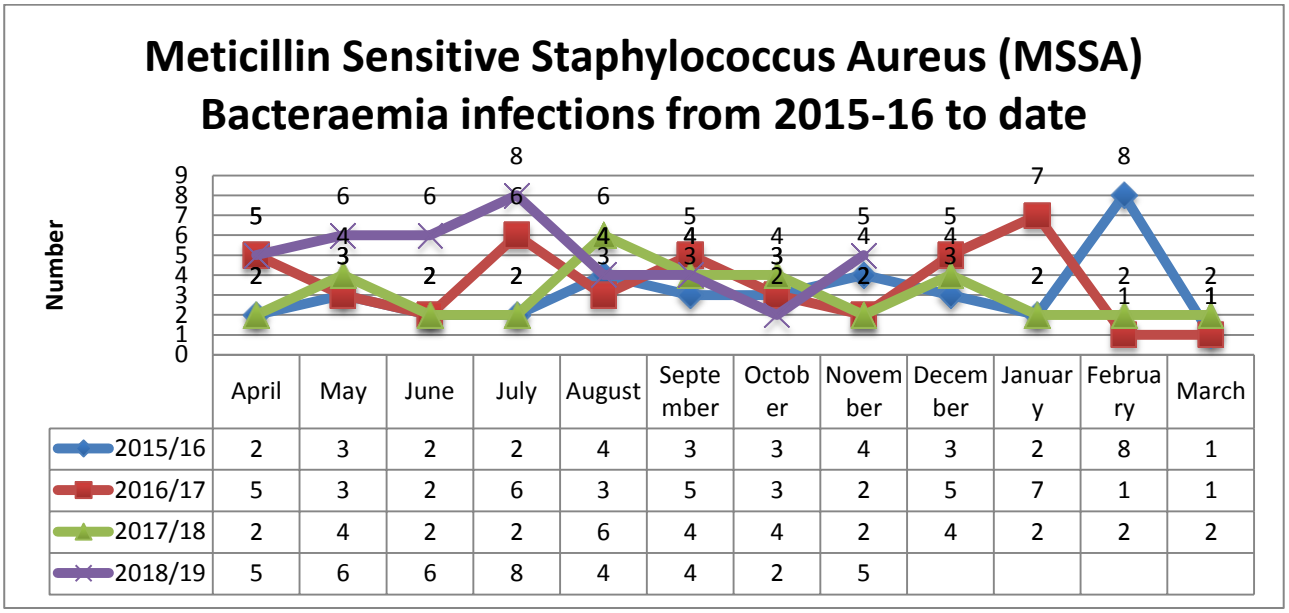
However, MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds. MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream. However unlike MRSA, MSSA is more sensitive to antibiotics and therefore easier to treat, usually. As can be seen from the following table, at month 8, the Trust is already at 91% of its upper threshold for this infection. This is of concern at this stage in the year.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	44	**40 (91% of threshold)**	RCA investigations have been completed on 29 of the 40 reported cases. With the remaining eleven undergoing continued RCA investigation. Outcomes of the RCA's have concluded that most are preventable, linked to hospital acquired pneumonia, complex high risk surgery and IV device management. There are at least 3 hospital onset cases linked to deep seated infections associated with patients who inject recreational drugs. Actions to mitigate risks include cohesive line insertion and management with a review of previous 'Matching Michigan' principles which is ongoing.

MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection again for 2018/19 but the need for continued and sustained improvements regarding this infection remains a priority.

MSSA bacteraemia cases remain relatively static month on month but a deeper dive into prospective MSSA bacteraemia cases is underway by the Infection Prevention and Control Team, in collaboration with Infectious Diseases physicians, medical and surgical teams from the 1st September 2018. In addition, a working party is being formed to focus on device insertion, reason for use and ongoing management. A number or these infections have occurred in patients that inject recreational drugs and present with abscesses and deep infections. This appears to be increasing.

The following graph highlights the Trust's performance from 2015-16 to date:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	2	3	2	2	4	3	3	4	3	2	8	1
2016/17	5	3	2	6	3	5	3	2	5	7	1	1
2017/18	2	4	2	2	6	4	4	2	4	2	2	2
2018/19	5	6	6	8	4	4	2	5				

4.1.4 *Escherichia-coli* Bacteraemia

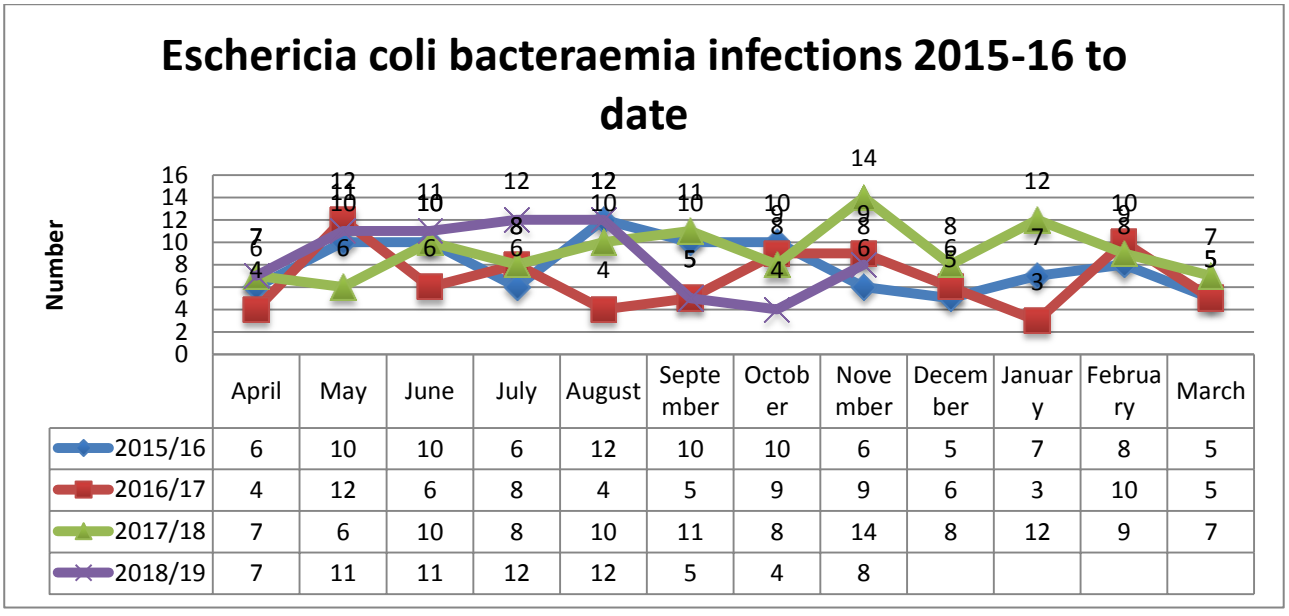
There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals. However, when strains of *E. coli* are outside their normal habitat of the gut, they can cause serious infections, several of which can be fatal. Potentially dangerous *E. coli* can exist temporarily and harmlessly on the skin, predominantly between the waist and knees (mainly around the groin and genitalia), but also on other parts of the body, i.e. a person's hands after using the toilet.

E. coli is now the commonest cause of bacteraemia reported to Public Health England.
E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

During 2018/19, Trusts will still be required by NHS Improvement to achieve a 10% reduction in E. *coli* bacteraemia cases. Achievement of reductions will be collaborative with joint working with commissioners, underpinned by joint action plans as required by NHS Improvement. The focus of attention is on the reduction of urinary tract infections which are responsible for the largest burden of *E.coli* infections. The Trust, along with system partners, is part of an NHS Improvement collaborative to try and reduce the burden of these infections with this project continue across Hull and East Riding.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	No. of cases investigated clinically	Outcome of Clinical Investigation (avoidable/ unavoidable)
E. coli bacteraemia	73 (after 10% reduction)	70 (over threshold)	70	Seventy Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 35 cases detected in the Surgical HG, 21 cases in the Medical HG, 3 cases detected in Families & Women's HG and the remaining 11 cases in Clinical Support HG. Review of cases suggests ongoing causes related to complex abdominal and urological surgery, biliary and urinary sepsis. Ongoing review of cases continues by the IPCT with those deemed possibly preventable or preventable requiring a RCA by the HG. The cases requiring a RCA relate to urinary tract infections and device management – areas the Trust is already taken action on e.g. UTI collaborative and the device task, challenge and finish group.

The following graph highlights the Trust's performance from 2015/16 to date:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	6	10	10	6	12	10	10	6	5	7	8	5
2016/17	4	12	6	8	4	5	9	9	6	3	10	5
2017/18	7	6	10	8	10	11	8	14	8	12	9	7
2018/19	7	11	11	12	12	5	4	8				

The main points here are the concerns over the high resistance rates to commonly-used antibiotics and, also, the learning around the care of patients with urinary catheters and indwelling vascular

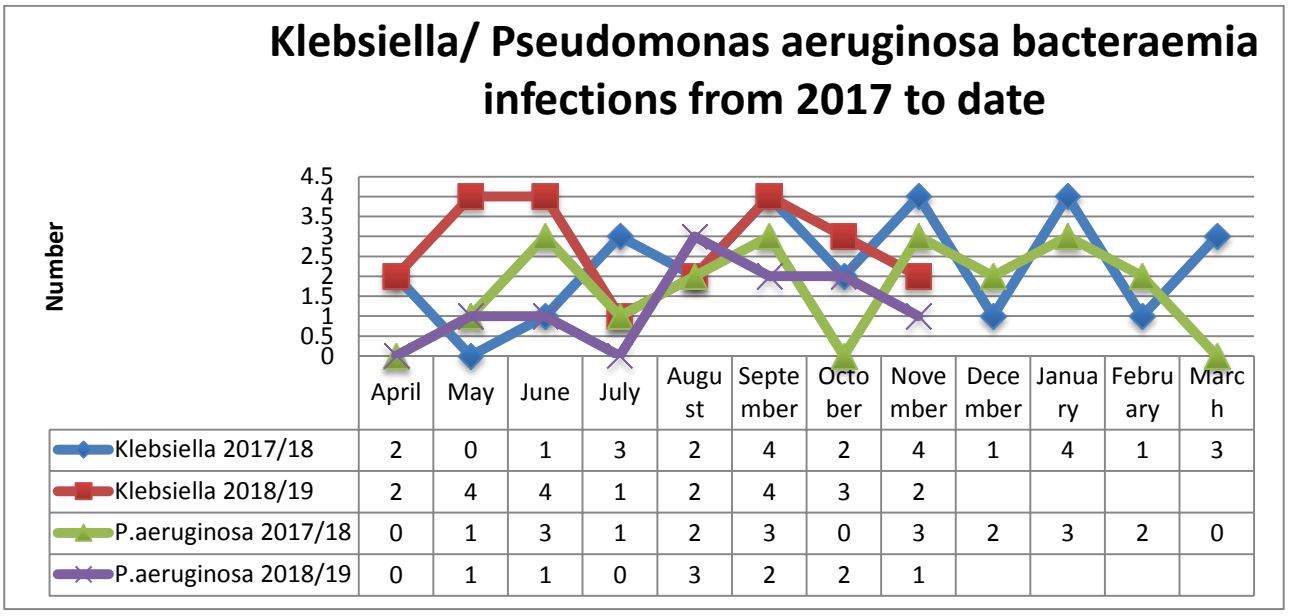
devices both in hospital and the community. All of these are areas of increased focus and actions in the coming months. Trends associated with E.*coli* are reflected in the graph above, including those associated with weather variations especially in the summer months when the increase in dehydration occurs as does the burden of *E.coli* infection, particularly in patients with indwelling urinary catheters.

4.1.5 Gram negative bacteraemia – reporting for 2018/19

If gram-negative bacteria enter the circulatory system, this can cause a toxic reaction to the patient. This results in fever, an increased respiratory rate, and low blood pressure. This may lead to life-threatening condition of septic shock.

NHS England and Public Health England (PHE) introduced a requirement across the health economy to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021. This includes the ongoing reporting of two additional organisms. Surveillance of *E. coli* bacteraemia alongside Klebsiella and Pseudomonas continues during 2018/19 although no thresholds have been published for the latter two GNBSI's.

Review of cases to date suggests similar risk factors as those found with *E.coli* bacteraemia, with Klebsiella related to respiratory infections. Subsequent trends and learning associated with these infections will be reported in future editions of this report, in spite of low numbers reported.



	April	May	June	July	August	September	October	November	December	January	February	March
Klebsiella 2017/18	2	0	1	3	2	4	2	4	1	4	1	3
Klebsiella 2018/19	2	4	4	1	2	4	3	2				
P.aeruginosa 2017/18	0	1	3	1	2	3	0	3	2	3	2	0
P.aeruginosa 2018/19	0	1	1	0	3	2	2	1				

During December 2018, once case of hospital onset Klebsiella pneumoniae was detected and found subsequently to be resistant to antibiotics. The sample was sent for typing and was confirmed as a Carbapenemase Producing Enterobacteriaceae (CPE) positive case. Further microbiological investigation is underway to determine where and why the patient acquired the infection as no source has been found to date.

4.2 Infection Outbreaks

An outbreak is defined by two or more patients with the same infection in the same ward/area.

During October 2018, only Ward H8 had a bay closed on the 28th October 2018 due to patients with diarrhoea. Affected patients were isolated and the bay was cleaned and reopened on the 29th October 2018. No causative organism has been able to be detected.

During November 2018, there were a number of bay closures affecting medical wards at HRI. One bay closed on H8 on the 1st November 2018, H9 on the 10th November 2018, and H5 on the 29th November 2018 with patients vomiting. Symptoms resolved within 48hrs and the bays were cleaned

and reopened accordingly; no causative organism was detected in respect to these bay closures. On the 29th November 2018, 2 bays were initially closed on H70 with patients experiencing diarrhoea and vomiting. Norovirus was confirmed and the ward was closed subsequently on the same day when additional symptomatic patients were identified.

4.2.1 Infection incident

During October and November 2018, screening for Pseudomonas aeruginosa has continued on NICU, on admission for new patients and on a weekly basis for existing inpatients. Colonised cases continue to be detected in extremely small numbers but no bacteraemia cases have been identified since August 2018. To date no cases detected have been microbiologically linked.

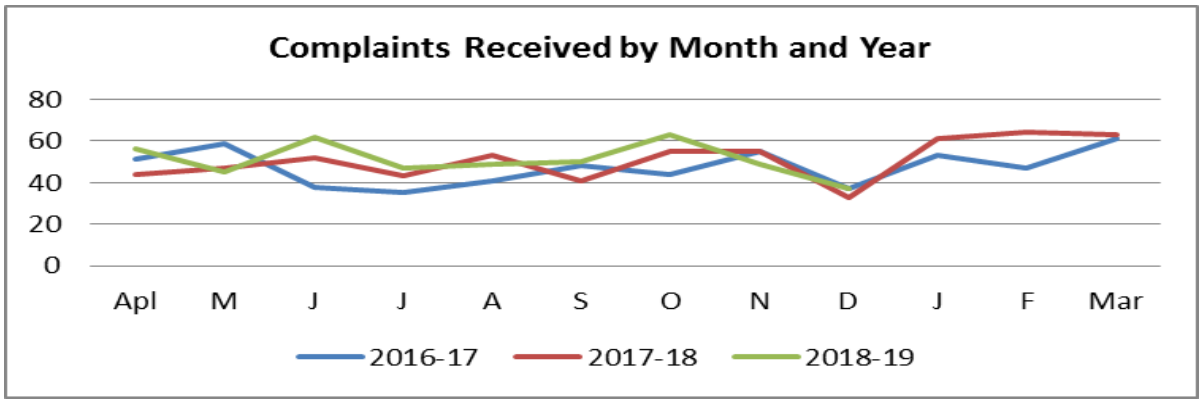
4.2.2 Influenza trends

The influenza vaccination campaign for 2018/19 commenced on the 1st October 2018 and by the 30th November 2018 76% of the Trust's healthcare workforce had taken up the influenza vaccine which is a significant achievement.

On the 27th November 2018 a patient was detected with Influenza A on C7, treated and managed appropriately. A steady increase in Influenza A cases occurred during December 2018 with a noticeable increase around Christmas and New Year. Patients with respiratory symptoms inclusive of a high temperature are being swabbed for Influenza as standard.

5. PATIENT EXPERIENCE

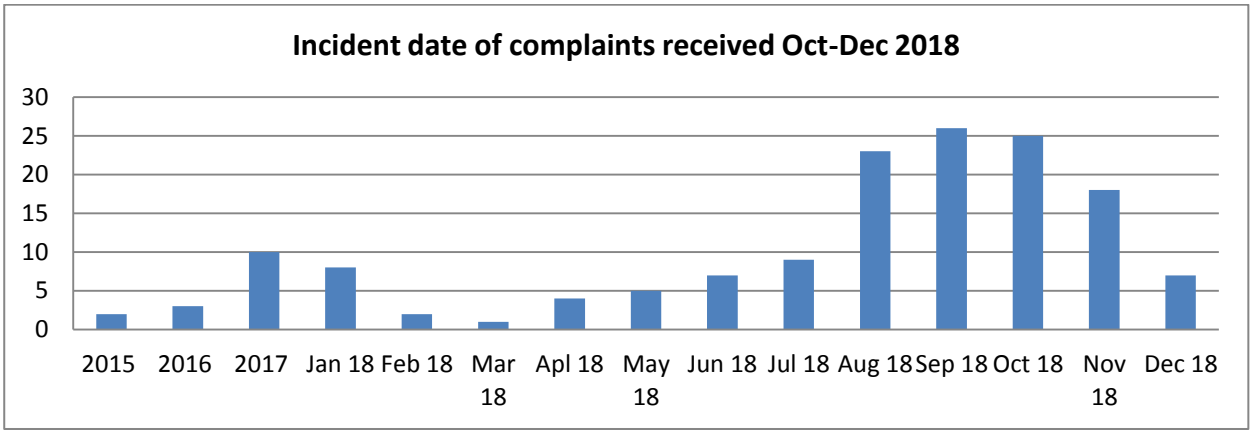
The following graph sets out comparative complaints data from 2016 to date. There were 63 new complaints recorded in October 2018, 49 in November 2018 and 37 in December 2018. October saw the highest number of complaints received since February 2018 (64). The complaints received in October relate mainly to events that took place between August and October (41). There are no specific themes as to the complaints received. However, 23 were for the Medicine HG and 26 for the Surgery HG.



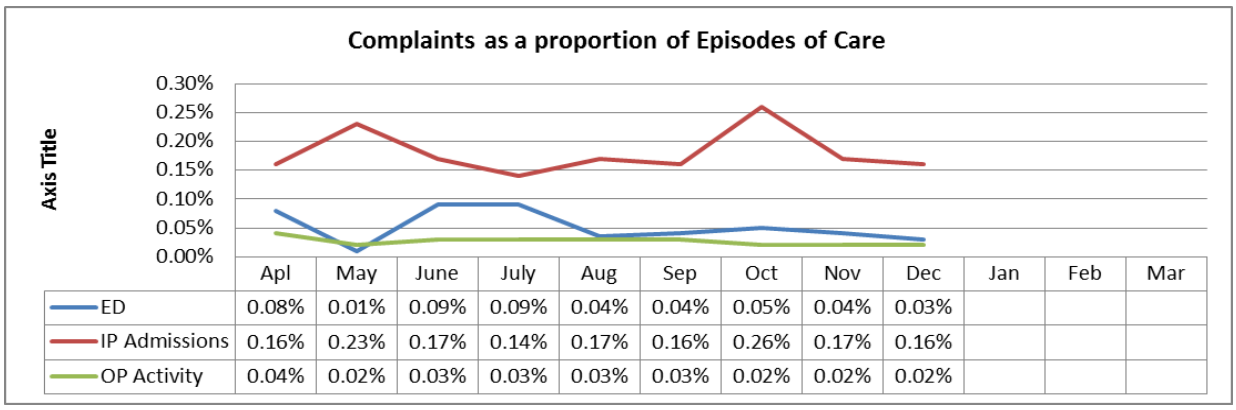
Complaints are graded on closure by a senior member of the Health Group using a rating of 1-4. 1 is low, 2 medium, 3 high and 4 a serious incident. Of the 154 complaints closed between October - December 2018, 15 were level 1 and 135 were level 2; there were no complaints at level 3 and there were 4 level 4's. During this period, 3 complaints were not investigated as one was de-escalated to a PALS, one did not relative to this Trust and one has requested a meeting and is not yet in a position to take it forward. The latter has been referred to the Independent Complaints Advocacy Service (ICA) for support.

Broadly speaking, complaints reflect activity in the previous three months. With regards to the complaints that were received during October and December 2018, the following table indicates the period of time that they relate to as opposed to the time the complaint was lodged with the Trust. The NHS complaints guidance suggests that Trusts should only consider complaints within a 12-month time frame before being 'out of time'. However, the need to complain may not be apparent until some time after the actual event. As such, the Trust takes a pragmatic approach to these.

Incident date relating to complaints



The following table shows the number of complaints received in relation to patient activity at the Trust since April 2018. As can be seen, these remain relatively low.



	Apl	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.08%	0.01%	0.09%	0.09%	0.04%	0.04%	0.05%	0.04%	0.03%			
IP Admissions	0.16%	0.23%	0.17%	0.14%	0.17%	0.16%	0.26%	0.17%	0.16%			
OP Activity	0.04%	0.02%	0.03%	0.03%	0.03%	0.03%	0.02%	0.02%	0.02%			

The following table indicates the number of complaints by subject area that were received for each Health Group during the months of October - December 2018.

Complaints Received by Health Group and Subject – October-December 2018

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0	0	**0**
Clinical Support	0	1	1	1	1	1	0	10	15
Family and Women's	3	0	0	2	0	3	0	14	22
Medicine	3	2	3	6	5	2	1	26	48
Surgery	4	3	6	2	2	1	0	46	64
Totals:	10	6	10	11	8	7	1	96	149

Complaints regarding 'treatment' remain the highest recorded category. The Patient Experience Team continues to work with all Health Groups to highlight themes and trends and to ensure a timely response to complainants.

5.1.1 Examples of outcomes from complaints closed during October - December 2018:

- The family of a patient had difficulties contacting the ward for an update on the patient's progress. They did not live locally and found this to be distressing. When they arrived at the hospital, the patient was in surgery and they felt they should have been made aware of this and that they should have been updated following the procedure. The patient was also transferred across to CHH without the family being informed.
  Outcome: Sincere apologies were made to the family for the poor level of communication. The complaint will be discussed at the next ward nurse team meeting for reflective learning purposes.

- The daughter of a patient that died had questions regarding the nursing care of her mother and the failure to notify the family of her mother's deterioration, which resulted in the family not having the opportunity to be with her when she died.
  Outcome: The Nurse Director has raised at the Governance Meeting the importance of completing medical records accurately and requested a medical records audit to ensure compliance. The Senior Matron will reiterate to staff involved in patient care, the importance of clear and accurate communication to family members in relation to treatment decisions and care plans. The Senior Matron and Consultant will also remind staff involved in caring for patients at end of life, the importance of alerting families as soon as possible of their loved ones likely demise, in order that they can attend the hospital to be with them, if they so wish.

- A family was unhappy with the care their mother received whilst in hospital and felt that her dementia was not acknowledged.
  Outlook: The Senior Matron will review the training figures for the ward in relation to dementia training and will discuss with the Lead Dementia Nurse any further training that is required, including bespoke training for the ward. The complaint will be discussed at the next Senior Nurse Meeting within the Department for the Elderly for learning and discussion, as well as at the next ward meeting to ensure lessons are learned.

5.1.2 Performance against the 40-working day complaint response standard

The standard is for 85% of complaints to be closed within 40 working days. The standard was not achieved in October. However, it was achieved in November and December. This was partly due to staff returning from leave, complaints being opened longer due to delays in obtaining statements and, also, due to staff and not being available for meetings with complainants.

Complaints closed within 40 working days 2018/19 (whole Trust):

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
80%	83%	82%	90%	88%	87%	81%	91%	85%			

The following tables indicate performance by Health Group and the outcome of the complaint for the months of October, November and December 2018.

October 2018	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	1	100%	0	1	0	0	0
Clinical Support	7	100%	2	4	1	0	2
Family and Women's	3	90%	2	1	0	0	3
Medicine	28	75%	3	23	2	1	2
Surgery	10	90%	1	9	0	0	0
Totals:	49	81.25%	8	38	3	1	10

November 2018	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	100%	0	0	0	0	0
Clinical Support	5	80%	0	4	1	0	2
Family and Women's	14	93%	2	9	3	0	2
Medicine	18	88%	2	15	0	1	6
Surgery	20	95%	5	14	0	1	1
Totals:	57	91%	9	42	4	2	12

December 2018	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	100%	0	0	0	0	0
Clinical Support	3	100%	0	3	0	0	2
Family and Women's	7	100%	1	5	0	1	0
Medicine	15	78.6%	3	11	0	1	4
Surgery	23	83.3%	5	18	0	0	4
Totals:	48	85.4%	9	37	0	2	11

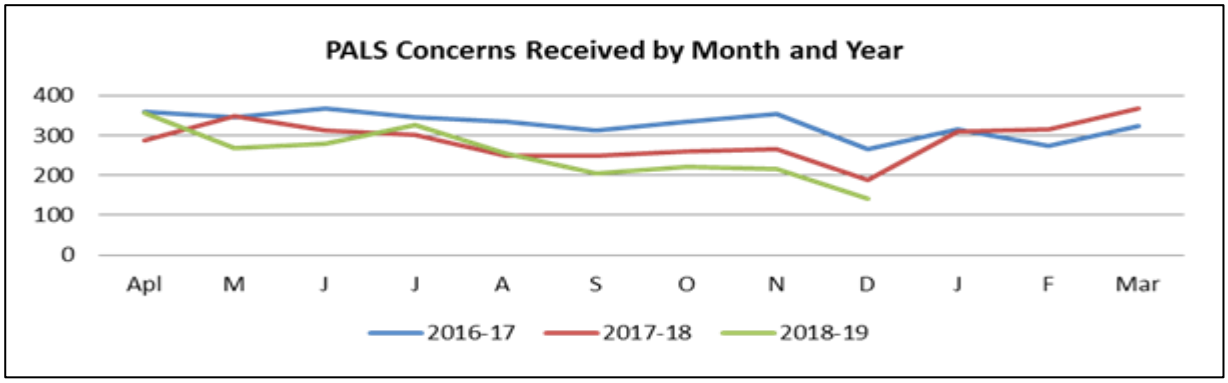
As can be seen from the previous tables, performance is variable across the Health Groups, with Family and Women's Health Group achieving above the standard of 85% each month. Surgery Health Group closed 53 complaints during the three months, 6 of which were closed over 40 days. Medicine Health Group closed 61 complaints during the three month period, 12 of which were outside of the 40 day timescale. Clinical Support closed 15 complaints, with 1 being open over 40 days (complex case). This will continue to be managed through the monthly performance and accountability meetings with Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

The table below details the number of contacts received by PALS during the months of October, November and December 2018. As with complaints received, October also saw a high number of contacts with the PALS team and a reduced number during December.
This information has been shared with the Health Groups in order that they can review and consider any actions that are necessary.

PALS by Type	October 2018	November 2018	December 2018
Comments and Suggestions	0	2	0
Compliments	13	8	6
Concerns	196	178	125
General Advice	12	27	11
Mortality	1	0	0
Totals	**222**	**215**	**142**

The following graph illustrates that the number of concerns received by PALS has reduced steadily over the last four months. This will be partly due to a change in the way PALS have recorded general advice issues since the decision mid-August to no longer log signposting. An example of this would be a request for the CCG contact details to raise concerns regarding a GP, or advice on directions to the hospital etc. This enables the PALS team to concentrate and follow through on concerns that require a more urgent response.



The following table indicates that Delays, Waiting times and Cancellations continues to be the highest subject received by PALS, with Family and Women's and Surgery Health Groups receiving 70 and 71 concerns respectively within the three months of October, November and December 2018.

PALS by Health Group and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	14	1	0	2	3	0	2	7	0	1	0	**30**
Clinical Support	3	4	1	6	22	3	0	0	0	2	8	**49**
Family and Women's	9	6	2	12	70	3	3	0	2	1	12	**120**
Medicine	14	13	3	27	52	10	1	0	0	0	25	**145**
Surgery	20	16	1	18	71	2	0	0	0	0	26	**154**
Totals:	**60**	**40**	**7**	**65**	**218**	**18**	**6**	**7**	**2**	**4**	**71**	**498**

5.2.1 Examples of outcomes from PALS contacts:

- The parents of a very young child asked the Trust if a jpeg tube could be made available so that they could attach it to a teddy to help their son accept his condition and treatment. The child had very limited communication abilities.
  Outcome – The Patient Experience team contacted the Paediatric department who supplied the jpeg tube, which was then forwarded to the family to support the child in coming to terms with his treatment. The family was very grateful.

- Mother of an adult daughter was concerned that she did not have sufficient information on the treatment plan and that her daughter had also fallen whilst on the ward. Her daughter had limited communication due to her condition.
  Outcome – The PALS team contacted the Senior Matron who, with the Ward Sister, met with the mother on the ward the same afternoon, discussed the fall and some nursing issues. One to one supervision was put in place to prevent further falls. A Junior Doctor also met with the family and explained the results of an MRI and lumber puncture investigation.

- Patient was unhappy with her experience when she attended the Endoscopy department. She became distressed as she felt rushed and was unable to go ahead with the procedure. An appointment to discuss the way forward with the consultant was to be arranged, however this had not yet materialised.
  Outcome – The Endoscopy Sister contacted the patient and discussed her concerns, apologising for her poor experience. The staff involved with her care were made aware of the impact on the patient for reflective learning purposes; this will also be discussed with the wider team. An appointment was arranged for the patient to be seen in clinic by the Consultant.

5.2.2 Compliments

- The grandmother of a young child wanted to pass on her thanks to all the staff in the Paediatric Emergency department. She said 'they do a great job and everyone was amazing, attentive and wonderful'.

- Patient emailed PALS to compliment the staff that treated him after a recent head injury. A clinician in Ireland stated 'it was the best stitching she has ever seen!' The compliment was forwarded to the Emergency department to share with the team.

- A family wrote several letters to the Trust in which they expressed their appreciation for the care provided to their father before his death. 'We have been so impressed with the service Dad received before he died. The last twelve months have been difficult. Three weeks before he died we encountered staff in The Queen's Centre and also A&E at HRI. Dad was treated with care and dignity and this made a difference to him and us. After he died, we also encountered Mrs Kaye and her staff within Bereavement Services who were also kind and helpful.'

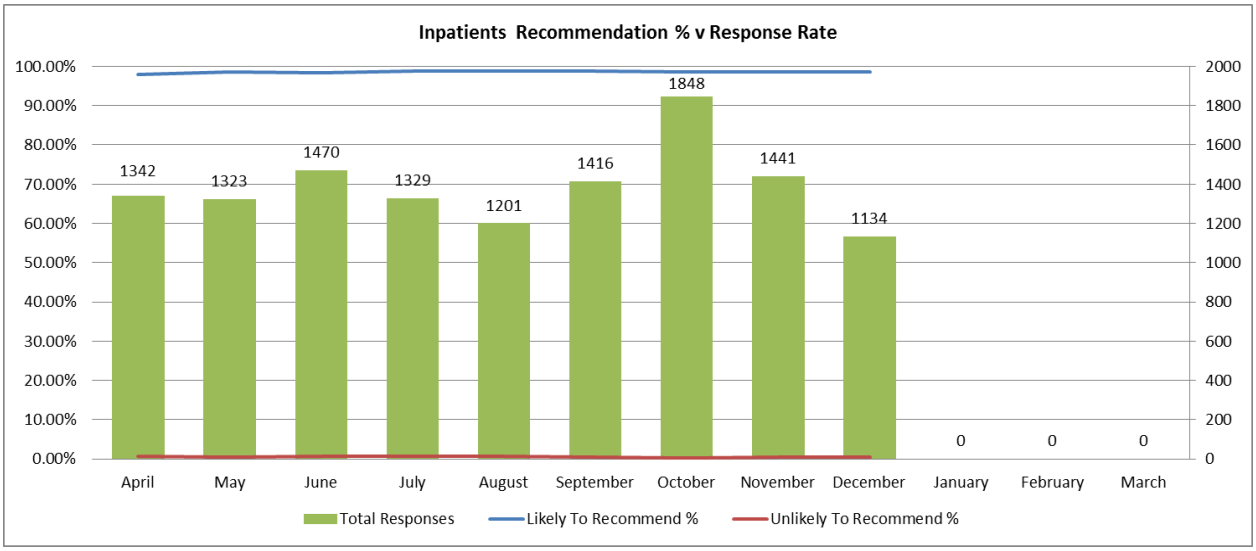
- Patient who had been concerned that a recent inpatient stay had not met her expectations was worried about coming into hospital to have her baby. However, she wrote to advise: 'Not only were staff diligent and professional but they truly cared for me in a way that recognised me as a human being with feelings too. For example, midwives came back to see me after the doctors had carried out their rounds in order to make sure I understood what the doctor had said and to see if I had any questions. They offered me a side room at points when one was available so I could get a good night sleep; they let me know when the day's observations were over so I could leave the ward for some fresh air, and so on. These are just a few small examples but I could carry on.'

- Patient advised that on attending the Emergency department, she was in a position where she was distressed regarding the wait for treatment / admission and had decided that she wanted to return home. She says that Sam recognised that she was not well enough to go home and should remain for further investigation and treatment in the hospital (she was admitted to H60 in the end). Sam persuaded her to stay in ED and assured her that she would return after seeing another patient elsewhere. The patient reported that she did this and made sure that she felt properly valued and cared for.

5.3 Friends and Family Test (FFT)

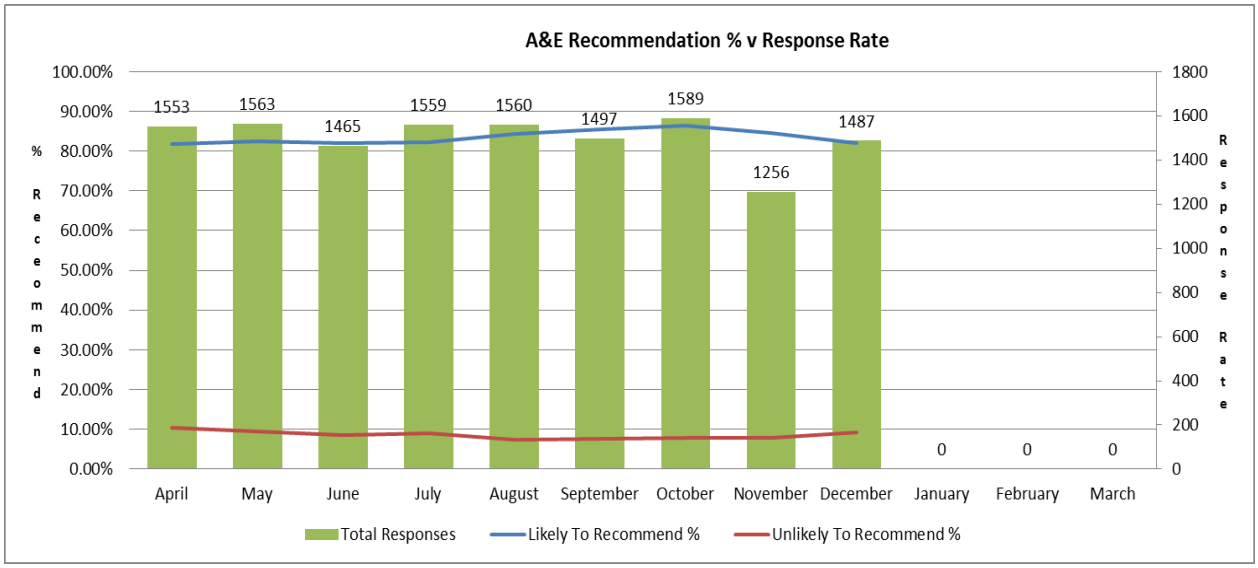
The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for December with 4,337, compared to October 2018 when 5,954 were received. The December 2018 inpatient results indicate that **98.68%** were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set-target of **95%**. This is really positive news for the Trust and its staff. The Patient Experience Team is working with wards to collect patient feedback on a daily basis

5.3.1 Inpatient Summary – all areas



5.3.2 Friends and Family Emergency Department (ED)

1,589 patients who attended the Emergency Department in October 2018 responded to the Friends and Family Test with **86.47%** of patients giving positive feedback and **7.87%** negative feedback. 1,487 patients that attended the Emergency Department in December 2018 responded to the Friends and Family Test with **81.98%** of patients giving positive feedback and **9.21%** negative feedback. The remainder were neither positive nor negative.



5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 9 cases with the PHSO currently. During the months of October, November and December, 6 new investigations were opened and 5 cases were closed; 3 were not upheld and 2 were partly upheld.

5.5 Adult Volunteers

Volunteer applications continue to be received on a regular basis. Work is currently being undertaken to recruit volunteers. Applicants from volunteers in the last recruitment phase were of a

very high standard, with some retired NHS staff and community care professionals wishing to use their experience to support the Trust. These volunteers have been allocated to the hospitality team and will work to enhance services throughout both hospital sites.
Several reliable and committed volunteers have been placed to support the HEY Baby Project to assist midwifery staff in parent education, carousels and providing admin support.

As a means of thanking volunteers for their hard work and commitment, several events were arranged in December including a Christmas meal, free raffle and entertainment. The uptake of these events was high and the feedback was extremely positive.

A link with Humberside Fire and Rescue Service was established and they visited various paediatric hospital departments before Christmas to give out gifts to the children. The Fire Fighters Charity and Humberside Fire and Rescue Service were particularly generous and enjoyed spending time interacting with patients and staff and would like to develop this further in future years.

6. OTHER QUALITY UPDATES

6.1 Care Quality Commission (CQC)

The CQC continues to interact with the Trust on a regular basis. General information requests continue to be received on, for example, completed Serious Incidents. At the present time, the CQC have not informed the Trust of any further focus groups or planned inspections.

The CQC has been informed of the Trust's pending name change and the Statement of Purpose has been updated.

6.2 Learning from Deaths

During November and December 2018, there were a total of 435 deaths within the Trust. Of these deaths, 20 received a full Structured Judgement Review (4.4%).

The Trust follows the 'Learning from Deaths' criteria and one of the KPIs is to review all deaths where an elective procedure was planned. In order to meet this KPI, further developments are planned to ensure that learning can be captured. At present as well as using the SJR methodology, some deaths in this category are reviewed at speciality morbidity and mortality governance meetings. Current activity includes developing methods to capture learning, when deaths are not reviewed using SJR.

The Medical Examiner role will be implemented nationally in 2 stages. Stage 1 – the non-statutory phase from April 1st 2019. During stage 1, the Medical Examiner role will be funded by redirecting funds from cremation forms, although a further directive from the Department of Health is awaited on this point. It is not yet confirmed when stage 2 – the statutory phase, will be commenced but it is believed that it will be in two years.

An Associate CMO reporting to the CMO has been appointed to oversee the implementation of this process in this Trust.

6.2.1 Mortality – Learning from Deaths

This report summarises the key themes arising from an analysis of in-hospital deaths in the organisation in 2018 (January 1st 2018 to December 31st 2018).

6.2.2 Summary of Trust Mortality in 2018

The following table provides a breakdown of patient deaths that occurred within the Trust during 2018:

Total number of In-hospital deaths	Number of elective admissions / Day case deaths	Non-elective admissions
2398	101	2297

6.2.3 Causes of Death

The following table illustrates the 3 most common causes of death during 2018:

1. Pneumonia
2. Acute Cerebrovascular Disease
3. Congestive Heart Failure – non hypertensive

6.2.4 Minimal Criteria for Structured Judgement Review

The National Quality Board set minimal criteria for undertaking structured judgement case note reviews. These are illustrated below, along with the Trusts compliance against these criteria during 2018.

Criteria	Number of cases receiving full SJR (out of total amount of deaths)
Deaths where a concern was raised about the quality of care provision	13 / 13
LeDeR Reviews (internal HEY patients)	2 / 2
Elective procedures	77 / 101
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	0 / 0 (no alerts)

In addition to the Structured Judgement Review, cases receive other reviews outside of the SJR methodology.

The Trust has signed up to the LeDeR program and has trained reviewers who undertake reviews on patients who die both within the Trust and outside of the Trust.

6.2.5 Structured Judgment Review Statistics

During 2018, a total of 325 Structured Judgement Reviews were undertaken. This is 13.5% of all in-hospital deaths. The following table provides a breakdown of review types:

Total Number of SJR undertaken	Cases escalated to Tier 2	Cases requiring Triumvirate decision	SJR cases declared as a Serious Incident
325	43	13	2

Structured Judgement Reviews were also undertaken on specific patient cohorts to help direct further learning, and to allow for themes to be identified, as illustrated by the following table:

Patients receiving SJR with Pneumonia	Patients receiving SJR with Sepsis
56	76

A further review of patients who died from Pneumonia is currently underway, undertaken by Dr Kate Adams, Associate CMO for mortality. A report of findings will be made available in the near future. This will help identify any possible contributory factors towards the winter spike in Pneumonia mortality.

6.2.6 Key Findings

6.2.6.1Sub-optimal Care of the deteriorating patient

During 2018 there were a significant number of Structured Judgement reviews that specifically stated that there were issues relating to the identification and prompt treatment of the deteriorating patient. In addition to findings from Structured Judgement Review there were also a number of serious patient safety incidents, where the root cause was related to the sub-optimal care of the deteriorating patient.

The following actions have been implemented to promote quality improvement in this area:

- Introduction and rollout of NEWS2
- Inclusion of an Outreach nurse on the SI review panel
- Phased implementation of electronic observations (E-Obs).
- Development of QIP for the deteriorating patient
- Dedicated deteriorating patient policy

6.2.6.2 Poor documentation of Death Certificates

Another recurrent theme nationally is in relation to the quality of documentation on the death certificate. It has been recognised that the cause of death is in many cases is incorrectly stated on the death certificate and therefore has the potential to lead to a number of issues, including an increase in patient family complaints and inaccurate mortality statistics. This has been noted nationally as an important issue. The introduction of the Medical Examiner should have a positive impact on this problem, as the role will allow for proper scrutiny to be applied to every in-hospital death.

6.2.6.3 End of Life Planning

During 2018, case note reviews were undertaken by the Trust, in collaboration with the Hull CCG and CHCP, focussing on patients who were admitted from a nursing home to the Trust and died within 48 hours. It was noted that further work needs to be undertaken around end of life planning. To help improve quality around end of life planning, the following actions have been taken:

- Full implementation of the ReSPECT form – further case note reviews planned to determine impact of ReSPECT form.
- Collaborative approach with CCG's, including focus groups to determine how to improve advanced care planning.
- Palliative care Consultants invited to attend the Trust Mortality Committee as core members.

6.2.7 Conclusion

Learning from deaths is vital to improving patient care. In addition to mortality, the mortality committee (henceforth known as mortality and morbidity committee) hopes to broaden its focus and investigate morbidity and near misses to identify learning and embed better system improvements. It is hoped that this will result in less harm and better patient care.

6.3 Safeguarding Adults and Safeguarding Children and Young People Annual Reports 2017/18

Safeguarding Adults and Safeguarding Children and Young People – Annual Reports 2017/18
The Safeguarding Annual Reports for 2017/18 were presented to the Trust's Quality Committee on Monday 17th December 2018. The annual reports are presented in two separate formats; one for Safeguarding Adults and the second for Children and Young People. They are presented separately due to the distinct differences in the management and governance of the subject areas.

The Children and Young Peoples annual report also includes reference to the Child Sexual Assault Assessment Service, which is a service commissioned by NHS England for the Humberside region.

The Trust has statutory responsibilities to safeguard adults, children and young people that access its services and premises. The challenges facing vulnerable adults, children and young people, in particular, remain significant in this health economy.

Referral levels to all the safeguarding services provided by the Trust continue to increase year on year along with an increased scope of issues that the services are responsible for. Nonetheless, these continue to be managed to a high standard.

The Trust continues to meet its statutory obligations in terms of having the required Safeguarding Leads and Named Professionals in post. In addition, the Trust participates actively as a member of both Local Safeguarding Adults and Children Boards for Hull and the East Riding.

Activity data and the profile of the work undertaken in this area are provided in the report alongside areas for priority attention during this current year. The Safeguarding Team delivered on all its key priorities that had been outlined in the previous year's (2016/17) annual reports.

There have been no compliance or regulatory concerns raised in relation to Safeguarding during 2017/18. The team continues to work on a number of key priorities for health including: Mental Capacity, Best Interests, Threshold of Need, Training, Exploitation and Deprivation of Liberty Safeguards. In addition to this and in partnership with Safeguarding Board agencies, the team is focusing on emerging themes from central government under the remit of Safeguarding, including: Domestic Abuse, Mental Health, Learning Disabilities and Autism. These key areas are included in the annual report and work is progressing well on all key priorities for 2018/19.

Key achievements include; delivery of the Prevent training compliance, continued training compliance across all safeguarding domains of over 80% throughout the year, positive assurance from the Trust's Commissioners regarding the delivery of Key Performance Indicators, the delivery of the Safeguarding Quality Improvement Plan and positive feedback from Safeguarding Boards regarding leadership and partnership working in relation to Safeguarding.

Key areas of concern and priorities for Safeguarding include; recruitment to the Named Doctor post (interim cover provided by Designated Doctor for Hull and East Riding), implementation of an Enhanced Care Team, implementation of the Safeguarding Adult Intercollegiate Training Standards (DoH 2018), and a review of safeguarding resources and capacity.

The Quality Committee received the reports with positive feedback and assurance on the Trust's Safeguarding arrangements for 2017/18. The Quality Committee commended the reports with regards to the detail of safeguarding information presented as well as the high standard of service that the safeguarding team provide to patient and service users on behalf of the Trust.

Copies of these full reports are available to all Trust Board members, if required.

7. RECOMMENDATION
The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Mike Wright
Chief Nurse

Makani Purva
Chief Medical Officer

November 2018

Appendix One: Safety Thermometer – December 2018

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

Pressure ulcers + Falls + Urinary infections (in patients with catheters) + VTE = Harmfreecare

SAFETY THERMOMETER NEWSLETTER December 2018

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 14th December on both hospital sites. 872 patients were surveyed

92% of our patients received HARM FREE CARE

Harm Free Care is defined as the number/percentage of patients who have not suffered any of the four harms measured by the safety thermometer before or since admission to hospital.

2% (18) of our patients suffered a New Harm

New Harm is defined as the number/ percentage of patients who have suffered or have started treatment for one of the four harms measured by the safety thermometer since admission to hospital

98% Of our Patients received NO NEW HARM

No New Harm is defined as the number/ percentage of patients who have not suffered any of the four harms measured by the safety thermometer since admission to hospital.

HARM FREE CARE %: How is HEY performing July 18 – November 18

	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Harm Free Care %	95%	93.5%	94.2%	94.8%	93.5%	92%
Sample: Number of patients	844	878	833	898	845	872
Total Number of New Harm	22	14	23	18	20	18
NEW HARM FREE CARE %	97.39%	98.4%	97.24%	98%	97.6%	98%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	6	0.69%	4	2	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	49	5.6%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	734	84.2%	89%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	89	10.2%	11%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	52	5.96%	45	4	3
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	47	5.39%	40	4	3
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	5	0.57%	5	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	17	1.95%
Severity **No Harm**: fall occurred but with no harm to the patient	6	1.61%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	3	0.34%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	**186**	**21.33%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**9**	**1.03%**	**4.8%**
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu **An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital**	**4**	**0.46%**	**2.1%**
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu **An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital**	**5**	**0.57%**	**2.7%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 11th January 2019

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
JANUARY 2019

Title:	NURSING AND MIDWIFERY (SAFE) STAFFING REPORT – JANUARY 2019
Responsible Director:	Mike Wright - EXECUTIVE CHIEF NURSE
Author:	Mike Wright, Executive Chief Nurse

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to nursing and midwifery (safe) staffing levels	
BAF Risk:	BAF Risk 2: There is a risk that a lack of skilled and sufficient staff could compromise the quality and safety of clinical services BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals:	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	
	Financial sustainability	Y
Key Summary of Issues:	The structure of this report has been revised and information is provided in the report on the following topics: • Compliance with the national reporting requirements on this topic • Nursing and Midwifery Staffing Levels for inpatient areas • The use of the new Care Hours Per Patient Day (CHPPD) Metric • An overall 'professional staffing safety risk assessment' to help contextualise and summarise this information to make it more meaningful	

Recommendation:	The Trust Board is requested to: • Receive this report • Decide if any further actions and/or information are required.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations)[1,2], NHS Improvement[3] and the Care Quality Commission.

This report now follows the required new format for reporting safer staffing metrics and uses the Care Hours Per Patient Day (CHPPD) methodology.

2. BACKGROUND

In July 2016, the National Quality Board updated its guidance for provider Trusts, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels. Trust Boards are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

The last report on this topic was presented to the Trust Board in November 2018 (September - October 2018 position).

In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England[5]. In this report, Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as being due to the absence of a single means of consistently recording, reporting and monitoring staff deployment. This led to the development of benchmarks and indicators to enable comparison across peer trusts as well as wards and the introduction of the Care Hours per Patient Day (CHPPD) measure is in line with the second of Lord Carter's recommendations. CHPPD has since become the principal measure of nursing, midwifery and healthcare support staff deployment on inpatient wards. This replaces the 'planned versus actual' methodology used previously.

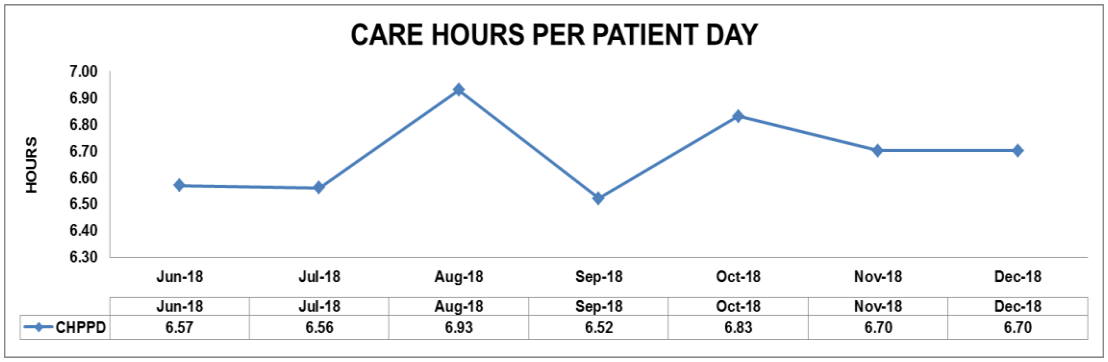
This report presents the 'safer staffing' positions for November and December 2018 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

[1] National Quality Board (2012) 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*
[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing
[3] NHS Improvement (June 2018) Care hours Per patient Day (CHPPD) Guidance for acute and acute specialist trusts
[4] An independent report for the Department of Health by Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

3. CARE HOURS PER PATIENT DAY

Appendix Four provides the description of Care Hours Per Patient Day and its calculation/methodology.

NHS Improvement's Model Hospital Website provides comparison information pertaining to CHPPD and other associated quality metrics. However, trusts are not yet permitted to use these data or publish them until they are confirmed as being reliable. Therefore, for the time being, the Trust's trend analysis for reported CHPPD since the July 2018 publication date (HEY also reported early in June 2018) is provided in the following table.



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
CHPPD	6.57	6.56	6.93	6.52	6.83	6.70	6.70

CHPPD provides just a number that needs to be considered alongside other qualitative and quantitative information, which is described in the next section. It is important not to reach conclusions by considering this number and its trends in isolation. However, as can be seen from the above graph, it remains relatively stable with a slight increase across Oct-Dec as the new registered nurses settle in.

It is also important to add that further work is needed in the Trust to ensure that all appropriate and available staff are included in its CHPPD calculation. As an example, these data can include all care giving staff that work under the direction of a registered nurse or midwife for the totality of their shift on that ward. For this Trust, this means that it will be able to include staff such as patient discharge assistants, ward hygienists and nutritional apprentices. All of these will help to increase the CHPPD metric. This has proved more challenging to achieve than first expected. However, it is hoped that this will be concluded soon.

4. PROFESSIONAL STAFFING SAFETY RISK ASSESSMENTS

As the Trust Board has been advised in previous editions of this report, there are many things to consider in determining whether a ward has safe staffing or not. These include, but not exclusively, the following factors:

- Establishment levels
- Vacancy rates, sickness and absence levels
- Patient acuity
- Skill mix (level of experience of the nursing/midwifery staff)
- Mitigation (other roles, additional support, other professionals, variable pay)
- Level of bed occupancy
- Care hours per patient day (CHPPD)
- Leadership – quality and consistency
- Team dynamics
- Ward systems and processes

It is important that all of these are considered in context alongside an over-arching professional judgement. Also, whilst patient harms such as avoidable hospital acquired pressure ulcers, falls etc. are of serious concern, for the purposes of safe staffing analysis, an assessment needs to be undertaken to establish whether any of these harms are linked to staffing levels, either as a direct/related consequence or not.

In order to try and simplify this and set it all into context, the Chief Nurse, Deputy Chief Nurse and Nurse Directors have developed an overall 'Professional Staffing Safety Risk Assessment (after mitigation)'. The idea behind this is to identify any areas where patient care may be compromised or potentially compromised as a consequence of staffing levels. For example, a ward may have good staffing levels and yet still be seeing high levels of patient harm. Conversely, another ward may be carrying a lot of vacancies and have a high use of temporary staff but with no care quality concerns. As such, it is important not to make assumptions either way without considering the fuller picture for each ward.

Appendix One provides the Nursing Staffing Key metrics for November 2018.
Appendix Two is the same information for December 2018.
Appendix Three provides the Nurse Staffing Quality Indicators – December 2018

The following tables take all of these metrics into consideration and show the current positon of each inpatient area in relation safe staffing as determined and summarised by the Chief Nurse, Deputy Chief Nurse and Nurse Directors.

The Risk Ratings have been agreed as follows:

Risk Rating	Description
LOW	No staffing related quality concerns
MEDIUM	This could mean: • Although not triggering on quality issues, nursing staff vacancies are thought to be affecting/possibly affecting the quality of care being provided. • Ward is under review/watchful observation by the nurse director and senior matron. • Potential risks as a result of high bank/agency usage
HIGH	Serious quality concerns where there are evident links to staffing levels

4.1 Nursing and Midwifery Staffing Risk Assessments – December 2018
4.1.1 Medicine Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk assessment	Comments/Mitigation
AMU	**LOW**	No staffing related quality concerns.	Staff support from H1 on rotation, support from nurse bank.
EAU	**MEDIUM**	Although not triggering on quality issues, nursing staff vacancies are thought to be affecting continuity of care. Under review.	Agency nurse supporting for 3 months. 1 x trainee NA qualifying in May.
H1	**LOW**	No staffing related quality concerns	Relocating to H36 in Jan 2019 and will have a rota review on merging with the discharge lounge
H5/RHoB	**LOW**	No staffing related quality concerns	
H50	**LOW**	No staffing related quality concerns	
H500	**LOW**	No staffing related quality concerns	This ward has been downgraded to low risk since the last review due to improvements in recent Fundamental Standard Audits. Staff continue to be flexed across the fifth floor as required following reviews by Senior Matron
H70	**MEDIUM**	This ward requires a high presence from the Senior Matron to support the ward focus on quality concerns. Under surveillance	Utilising some agency and bank. B6 and B7 staff providing weekend cover and Senior Matron support. Additional band 6 approved to ensure senior presence on ward for both early and late shifts
H8	**LOW**	No staffing related quality concerns	Additional non-registered staff in post.
H9	**MEDIUM**	1 red fundamental standards score although not thought to be related to staffing levels. Under surveillance.	Senior Matron supporting the ward. Additional Band 6 RN support the ward therefore increasing senior nurse cover.
PDU H80	**LOW**	No staffing related quality concerns	
H90	**LOW**	No staffing related quality concerns	Additional non – registered nurses in post.
H11	**MEDIUM**	No evidence of harm but the ward needs a lot of senior support. Under review	Bank and agency utilised. Flexing staff across the floor to maintain safety
H110	**LOW**	Not able to open additional HASU beds due to staffing levels.	
CDU	**LOW**	No staffing related quality concerns	
C26	**LOW**	No staffing related quality concerns	
C28/CMU	**LOW**	No staffing related quality concerns	

4.1.2 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
H4	**LOW**	No staffing related quality concerns	
H40	**MEDIUM**	No staffing related quality concerns, however increasing demand for major trauma capacity	Maternity Leave 5.4% Vacancy 3.04 wte. Using Bank and Agency to support. Plan to recruit 2 international RN.
H6	**LOW**	No staffing related quality concerns	Using bank and agency plus mutual support with H6.
H60	**LOW**	No staffing related quality concerns	
H7	**MEDIUM**	No staffing related quality concerns	3.48 Vacancy RN recruitment ongoing. Long-term sickness, requiring use of agency and bank
H100	**LOW**	No staffing related quality concerns	
H12	**LOW**	No staffing related quality concerns	
H120	**LOW**	No staffing related quality concerns	
HICU	**LOW**	No staffing related quality concerns	7.50 wte RN vacancies, some use of over cap agency to support activity.
C9	**LOW**	No staffing related quality concerns	
C10	**LOW**	No staffing related quality concerns	
C11	**LOW**	No staffing related quality concerns	
C14	**LOW**	No staffing related quality concerns	
C15	**MEDIUM**	No staffing related quality concerns	4 wte maternity leave, Increasing service demands high staff turnover, R/N support provided from ambulatory care unit.
C27	**LOW**	No staffing related quality concerns	
CICU	**MEDIUM**	Not triggering any quality concerns but under review	Limited support from HRI due to vacancies, 3.99 wte risk of elective cancellation, using high cost agency.

4.1.3 Family and Women's Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
C16	**LOW**	No staffing related quality concerns	9 beds currently closed to release registered nursing staff to support winter pressures. Some use of Bank and Agency.
H130	**LOW**	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours to cover across the 13th Floor and Acorn ward.
Cedar H30	**LOW**	No staffing related quality concerns	Utilising bank and agency on occasion.
Maple H31	**LOW**	No staffing related quality concerns	
Rowan H33	**LOW**	No staffing related quality concerns	
Acorn H34	**LOW**	No staffing related quality concerns	
H35	**LOW**	No staffing related quality concerns	Utilising bank and agency when required.
NICU	**LOW**	No staffing related quality concerns	Vacancies covered with Bank and overtime and flexing paediatric staff resources.
PAU	**LOW**	No staffing related quality concerns	
PHDU	**LOW**	No staffing related quality concerns	
Labour	**LOW**	No staffing related quality concerns	Midwife to birth ratio 1:32. Birth rate plus completed with an action plan to implement the recommendations in place.

4.1 4 Clinical Support Health Group

Ward	Professional Risk Assessment	Rationale for risk rating	Actions
C7	**LOW**	Not triggering any quality indicators and no staffing issues so deemed to be safely staffed	
C29	**LOW**	Not triggering any quality indicators and although supporting DME with a RN, deemed to be safely staffed	
C30	**LOW**	Despite 1.96 wte RN vacancies (14% of registered workforce), not triggering any quality indicators therefore deemed to be safely staffed	
C31	**MEDIUM**	This ward has 3.41 wte RN vacancies (20% of registered workforce) & 5.8% ML. Actions taken have mitigated the risk & no quality indicators are triggering currently; this continues to be closely monitored	Utilising bank and agency, support from other inpatient wards, 5 beds currently closed.
C32	**MEDIUM**	This ward has 1.81 wte RN vacancies (13% of registered workforce) & 4.8% ML; no quality indicators are triggering	Utilising bank and agency, support from other inpatient wards
C33	**MEDIUM**	This ward has 0.6 wte RN vacancies but high ML at 21% of registered workforce; the actions taken are supporting the ward and no quality indicators are triggering; this continues to be closely monitored	Utilising bank and agency, support from other inpatient wards and have over recruited to non-registered posts to support.

5. RECRUITMENT AND RETENTION

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns and rotational programmes.

112 newly registered nurses commenced in post from the University of Hull in September 2018. These nurses have undertaken their induction and have now commenced their preceptorship on the wards and departments.

The first 17 Registered Nursing Associates qualify in May 2019; unfortunately three Trainees have left the course due to various issues. However, it is anticipated that the remaining 17 will complete their programmes.

In addition to the Fifteen Trainee Nursing Associates that commenced their two-year programme in September 2018, the Trust has been working in collaboration with Health Education England to support an additional cohort of 20 Trainee Nursing Associates. Following a successful recruitment campaign, these places have been appointed to and they commenced their programme on the 14th January 2019.

With regards to international recruitment, 43 nurses from the Philippines have now been deployed into the Trust. 33 of the nurses have successfully completed the

Objective Structured Clinical Examination (OSCE), which means they now have their NMC PIN. A further 10 nurses are currently undertaking their OSCE training and are expected to take their exams in February 2019. To date, the Trust has a 100% OSCE pass rate and the Test Centre has commended the preparedness of the Trust's nurses.

The Trust has agreed to recruit further cohorts of nurses from the Philippines for the Medicine and the Surgery Health Groups and it is expected that a further cohort of 10 to arrive in mid-February 2019.

6. ENSURING SAFE STAFFING

The safety brief reviews continue and are completed six times each day. Given the staffing challenges faced during the winter period, the safety briefs are led currently by a Health Group Nurse Director or the Deputy Chief Nurse, with input from the Senior Matrons, (or Site Matron at nights and weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved but is extremely challenging on some occasions. The Trust has a minimum standard whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. Staffing levels are assessed directly from the live e-roster and SafeCare software and this system is working well.

Other factors that are taken into consideration before determining if a ward is safe or not, include:

- The numbers, skill mix, capability and levels of experience of the staff on duty
- Harm rates (falls, pressure ulcers, etc.) and activity levels
- The self-declaration by the shift leader on each ward as to their professional view on the safety and staffing levels that day
- The physical layout of the ward
- The availability of other staff – e.g. bank/pool, matron, specialist nurses, speciality co-ordinators and allied health professionals.
- The balance of risk across the organisation.

7. RED FLAGS AS IDENTIFIED BY NICE (2014)

7.2 Incorporated into the nursing staffing safety briefs collected through SafeCare are a number of `Nursing Red Flags` as determined by the National Institute for Health and Clinical Excellence (NICE 2014).

Essentially, 'Red Flags' are intended to record a delay/omission in care, a 25% shortfall in Registered Nurse Hours or fewer than 2 x RN`s present on a ward during any shift. They are designed to support the nurse in charge of the shift to assess systematically that the available nursing staff for each shift, or at least each 24-hour period, is adequate to meet the actual nursing needs of patients on that ward.

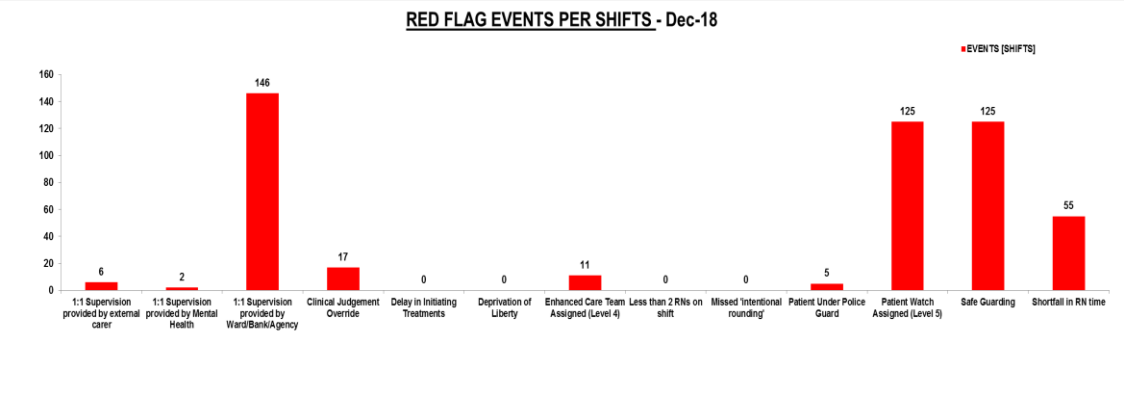
When a 'Red Flag' event occurs, it requires an immediate escalation response by the Registered Nurse in charge of the ward. The event is recorded in SafeCare and all appropriate actions to address them are recorded in SafeCare, which provides an audit trail. Actions may include the allocation or redeployment of additional nursing staff to the ward. These issues are addressed at each safety brief.

In addition, it is important to keep records of the on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

The ‘red flags’ suggested by NICE, are:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
- Pain: asking patients to describe their level of pain level using the local pain assessment tool.
- Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
- Placement: making sure that the items a patient needs are within easy reach.
- Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

The following graph illustrates the number of ‘Red Flags’ identified during December 2018. The Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time.



Dec-18	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	6	1.2%
	1:1 Supervision provided by Mental Health	2	0.4%
	1:1 Supervision provided by Ward/Bank/Agency	146	29.7%
	Clinical Judgement Override	17	3.5%
	Delay in Initiating Treatments	0	0.0%
	Deprivation of Liberty	0	0.0%
	Enhanced Care Team Assigned (Level 4)	11	2.2%
	Less than 2 RNs on shift	0	0.0%
	Missed 'intentional rounding'	0	0.0%
	Patient Under Police Guard	5	1.0%
	Patient Watch Assigned (Level 5)	125	25.4%
	Safe Guarding	125	25.4%
	Shortfall in RN time	55	11.2%
	TOTAL:	492	100%

As illustrated earlier, the most frequently reported red flag that requires extra nursing time is related to the requirement for 1:1 supervision of some sort for patients. As indicated in the previous Board Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which is in the process of being established substantively following a successful trial.

8. ESTABLISHMENT LEVELS

The nursing and midwifery establishments are set and funded to good standards and are reviewed twice a year in line with national guidance. These were last reviewed in May 2018 and are next due to report at the March 2019 Trust Board meeting in public.

9. RISK ASSESSMENT

The inability to recruit sufficient numbers of registered nurses in order to meet full establishment levels remains a concern to the Chief Nurse and senior nurses. Currently, this is a recorded risk at 16 (Likely 4 x Severity 4) until staffing levels stabilise more. Managing the safer staffing risks is a daily occurrence for the senior nursing teams, particularly with additional capacity open to support the Trust through the winter period. Ensuring safe staffing levels on a daily basis remains a constant challenge for the organisation.

10. SUMMARY

It is too early to determine if the use of CHPPD will have any significant impact on helping to determine whether staffing levels are safe or not, especially as there are so many other variables that need to be considered before reaching a conclusion. CHPPD is only a number and must be set into context alongside a lot of other data before it can be meaningful. This will be analysed over time as trends are determined and when comparisons can be made.

Also, NHS Improvement has issued revised guidance on how trusts are to publish workforce data from the next financial year onwards. 'Developing Workforce Safeguards[6]' sets out the future requirements for reporting staffing levels across a broader range of professional groups. Work is under way to determine what this will look like.

11. RECOMMENDATION

The Trust Board is requested to:

- Receive this report
- Decide if any if any further actions and/or information are required.

Mike Wright
Executive Chief Nurse
January 2019

Appendix 1: Nurse Staffing Key Metrics – November 2018
Appendix 2: Nurse Staffing Key Metrics – December 2018
Appendix 3: Nurse Staffing Quality Indicators – December 2018
Appendix 4: CHPPD Description, Methodology, Benefits and Limitations

APPENDIX FOUR - CHPPD Description, Methodology, Benefits and Limitations

What is Care Hours Per Patient Day (CHPPD)?

CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level.

CHPPD is most useful at ward level where service leaders and managers can consider the workforce deployment over time, with comparable wards within a trust or at other trusts as part of a review of staff deployment and overall productivity. This measure should be used alongside clinical quality and safety outcomes measures to reduce unwarranted variation and support the delivery of high quality, efficient patient care.

How is CHPPD calculated?

The Trust is required to submit monthly returns for safe staffing as it has previously. However, these data are now submitted in a different format using the monthly aggregated average CHPPD for each ward.

CHPPD is calculated, as follows:

The total number of hours worked by both registered nurses/midwives and non-registered support staff over a 24 hour period (midnight to 23:59 hours) divided by the number of patients in beds at 23:59 hours each day.

This is then calculated and averaged across the month in question.

The guidance advises that the 23:59 census is not entirely representative of the total and fluctuating daily care activity, patient turnover or the peak bed occupancy on a given ward. However, it advises that what this does do is provide a reliable and consistent information collection point and a common basis on which productive comparisons can be made to measure, review and reduce variation at ward level within organisations and also within similar specialities across different trusts. As such, there are limitations to its use.

Which staff are included?

In addition to registered nurses, midwives and non-registered care staff, other clinical staff that provide patient care on a full shift basis under the supervision and direction of a registered nurse/midwife can now be included in the CHPPD numbers. This includes allied health professional staff providing they work the full shift on that ward, e.g. a physiotherapist working a shift on a stroke unit.

Further anticipated benefits of using CHPPD

The guidance advises further that using CHPPD provides:

- A single comparable figure that can simultaneously represent both staffing levels and patient requirements, unlike actual hours or patient requirements alone.
- Facilitates comparisons between wards within a trust and nationally, also
- As CHPPD is divided by the number of patients, the value does not increase due to the size of a ward and facilitates comparisons between wards of different sizes.
- It differentiates registered nurses and midwives from healthcare support workers to ensure skill mix is well described and that nurse to patient ratio is encompassed within staff deployment considerations.

- An opportunity to compare planned CHPPD from the roster compared to what staff are actually on duty on each given day.

The limitations of using CHPPD
There are a number of limitations/caveats with using CHPPD. These include:

- The overarching principle is that CHPPD needs to be taken into context alongside the fuller workforce and quality metrics and professional risk assessments in order to be meaningful. This is in order to be able to reach an informed conclusion as to whether nursing and care staffing levels present a quality risk or not.
- It does not account for the skill mix or experience levels of the staff on that ward. For example, a ward might not have the full number of staff it was expecting or requires but the skills and experience of the staff on duty might be able to compensate for that, at least in part.
- As the guidance itself states, 23:59 hrs is not fully representative of the patient activity that may have happened on a given ward during the day. This is particularly so in some elective wards.
- For this Trust, CHPPD does not yet include the additional roles that have been introduced on the wards from nursing establishment monies, e.g. the patient discharge assistants, ward hygienists and enhanced care team members. The aggregated hours for these staff are provided in **Appendices One and Two** at **Column H** so that they are at least declared at this stage. The Trust is making changes to the e-roster so that these staff will be included automatically in the CHPPD calculation in the future. The aim will be to try and achieve this for the next version of this report.

HEY NURSE STAFFING KEY METRICS DASHBOARD

Nov-18

KEY METRICS ROTA: 29th Oct - 25th Nov 2018

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	PROFESSIONAL RISK ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST									NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M8]						TEMPORARY STAFFING [9th Jul - 5th Aug-18]				UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE							ROTA APPROVALS [42 DAYS]		ADDITIONAL DUTIES			UNFILLED ROSTER [<20%]	HOURS BALANCES [4 WEEKS] [NET + /- 2%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]		
					Other care staff not currently included in CHPPD HPW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN- Est. [WTE]	TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [< 1%]	STUDY DAY [<2.3%]	WORKING DAY [1%]	MAT LEAVE [<2.5%]	FULL [DAYS]	PARTIAL [DAYS]	TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [%]	HOURS BALANCE [%]	NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.00	5.4%	1.59	7.2%	6.59	115.34	9.4%	6.2%	3.2%	89.0%	29.7%	5.5%	12.4%	0.0%	8.8%	0.1%	2.9%	41.0	41.0	0.8	0.1	0.7	13.8%	1.7%	121.0	121.0	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1211	5085.3	2625.6	6.4	7.55	-1.18	7.31	-0.94	16.79	38.0%	-0.18	-0.8%	16.61	67.57	10.1%	8.9%	1.2%	70.2%	26.1%	10.5%	10.3%	0.2%	4.7%	0.4%	0.0%	36.0	33.0	1.1	0.7	0.4	8.3%	0.1%	120.7	153.7	33.0
	H1	GENERAL MEDICINE	22	LOW	399.0	615	1631.2	1156.0	4.5	7.55	-3.02	7.31	-2.78	0.88	6.0%	0.50	6.3%	1.38	22.51	14.2%	13.4%	0.8%	58.0%	30.6%	8.3%	12.0%	0.0%	1.6%	0.0%	8.7%	35.0	27.0	0.0	0.0	0.0	11.5%	-1.9%	169.3	200.3	31.0
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	618	2095.0	1873.0	6.4	6.94	-0.52	7.74	-1.32	3.78	19.8%	-0.32	-2.4%	3.46	32.27	6.6%	5.9%	0.7%	74.4%	18.3%	0.3%	11.5%	3.3%	2.2%	1.0%	0.0%	55.0	55.0	0.2	0.0	0.2	19.4%	0.3%	-7.0	6.5	13.5
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	724	2934.5	1746.2	6.5	6.74	-0.27	6.38	0.09	2.12	8.6%	1.44	10.9%	3.56	37.84	5.6%	5.6%	0.0%	41.5%	21.2%	5.8%	10.5%	0.0%	4.6%	0.3%	0.0%	31.0	12.0	0.3	0.3	0.0	14.8%	-0.8%	38.0	98.0	60.0
	H50	NEPHROLOGY	19	LOW	283.5	563	1897.3	1201.5	5.5	7.23	-1.73	7.00	-1.50	-2.17	-14.4%	0.23	2.7%	-1.94	23.54	1.6%	1.6%	0.0%	62.5%	30.3%	1.5%	16.1%	0.0%	5.3%	2.2%	5.2%	52.0	47.0	0.3	0.1	0.2	14.0%	-6.1%	-17.5	14.0	31.5
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	704	1538.0	1715.8	4.6	6.74	-2.12	6.38	-1.76	7.36	43.4%	0.25	2.1%	7.61	29.10	14.1%	13.4%	0.7%	60.2%	22.3%	6.4%	13.3%	0.0%	2.4%	0.2%	0.0%	34.0	12.0	0.5	0.4	0.1	14.9%	0.2%	129.3	156.3	27.0
	H70	GENERAL MEDICINE	30	MEDIUM	441.0	894	2072.4	2316.3	4.9	7.55	-2.64	7.31	-2.40	7.54	37.6%	-2.72	-22.4%	4.82	32.22	13.4%	11.2%	2.2%	55.2%	21.1%	1.4%	11.2%	0.3%	1.7%	1.8%	4.7%	53.0	53.0	0.0	0.0	0.0	13.6%	-0.1%	360.5	396.5	36.0
	H8	GERIATRIC MEDICINE	27	LOW	220.5	797	1693.9	1939.3	4.6	6.94	-2.38	6.74	-2.18	2.45	14.7%	0.49	3.7%	2.94	29.78	10.7%	10.4%	0.3%	65.8%	27.1%	6.8%	14.2%	0.0%	1.6%	0.3%	4.2%	53.0	53.0	1.0	0.6	0.4	19.2%	-3.7%	150.8	155.8	5.0
	PDU H80	GERIATRIC MEDICINE	27	LOW	913.5	695	1779.8	2246.5	5.8	6.94	-1.15	6.74	-0.95	7.26	43.7%	-4.23	-32.1%	3.03	29.78	5.3%	3.9%	1.4%	32.1%	25.9%	6.5%	10.7%	0.0%	0.9%	3.8%	4.0%	54.0	54.0	0.1	0.0	0.1	16.7%	0.9%	50.5	56.5	6.0
	H9	GERIATRIC MEDICINE	30	MEDIUM	220.5	726	1499.0	2180.0	5.1	6.94	-1.87	6.74	-1.67	4.09	24.6%	-4.15	-31.5%	-0.06	29.78	16.3%	14.8%	1.5%	90.7%	29.0%	3.3%	13.2%	4.6%	2.4%	3.0%	2.5%	18.0	17.0	0.0	0.0	0.0	5.9%	0.9%	92.0	92.0	0.0
	H90	GERIATRIC MEDICINE	29	LOW	252.0	863	1749.7	1997.6	4.3	6.94	-2.60	6.74	-2.40	4.11	24.7%	-2.83	-21.5%	1.28	29.78	3.5%	3.5%	0.0%	68.0%	26.0%	12.1%	13.0%	0.2%	0.5%	0.2%	0.0%	59.0	53.0	0.0	0.0	0.0	14.1%	0.7%	40.2	66.2	26.0
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	823	1879.0	1912.8	4.6	7.55	-2.94	7.41	-2.80	5.09	22.6%	-2.33	-21.9%	2.76	33.16	8.7%	8.7%	0.0%	49.8%	29.8%	6.6%	12.2%	0.2%	1.7%	2.2%	6.9%	23.0	23.0	0.0	0.0	0.0	10.1%	0.9%	15.0	46.0	31.0
	H110	STROKE / NEUROLOGY	24	LOW	252.0	616	2659.8	2047.5	7.6	7.55	0.09	7.41	0.23	3.78	16.8%	-3.16	-28.4%	0.62	33.64	26.5%	26.5%	0.0%	52.3%	33.6%	7.2%	11.7%	0.1%	4.9%	5.0%	4.7%	23.0	23.0	0.2	0.1	0.1	23.3%	0.2%	-9.8	1729.0	1738.8
	CDU	CARDIOLOGY	9	LOW	0.0	138	1254.8	348.5	11.6	7.93	3.69	7.73	3.89	1.8	14.0%	0.15	5.1%	1.95	15.74	6.9%	6.9%	0.0%	53.2%	35.9%	13.1%	7.1%	1.3%	1.3%	4.3%	8.8%	39.0	26.0	0.0	0.0	0.0	30.7%	-0.4%	0.0	0.0	0.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	953	2620.5	1208.2	4.0	8.46	-4.44	9.93	-5.91	4	15.5%	-0.75	-9.5%	3.25	33.73	4.8%	3.6%	1.2%	93.3%	25.4%	3.2%	14.9%	0.0%	0.7%	0.7%	5.9%	27.0	26.0	0.5	0.4	0.1	17.6%	5.7%	117.0	117.0	0.0
	C28 /CMU	CARDIOLOGY	27	LOW	277.2	718	4355.4	1079.8	7.6	7.44	0.13	7.87	-0.30	2.35	6.2%	1.95	20.3%	4.30	47.78	10.9%	10.9%	0.0%	88.6%	30.9%	4.2%	17.5%	0.1%	3.0%	3.9%	2.2%	45.0	38.0	0.6	0.6	0.0	12.3%	-0.4%	-43.6	111.0	154.6
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	795	2240.5	1450.5	4.6	8.39	-3.75	8.71	-4.07	2.08	9.5%	1.25	12.0%	3.33	32.28	13.5%	12.4%	1.1%	54.3%	28.2%	3.4%	11.7%	0.0%	3.5%	2.3%	7.3%	25.0	25.0	0.2	0.1	0.1	20.1%	-2.5%	70.5	81.5	11.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	385	2540.0	1408.5	10.3	8.39	1.87	8.71	1.55	2.86	13.7%	-1.02	-9.2%	1.84	31.95	6.3%	4.0%	2.3%	55.9%	25.5%	4.1%	13.0%	0.3%	1.6%	1.3%	5.2%	38.0	34.0	0.2	0.0	0.2	7.5%	3.3%	24.0	24.0	0.0
	H6	GENERAL SURGERY	28	LOW	283.5	705	2430.4	1576.3	5.7	6.99	-1.31	7.26	-1.58	1.91	10.0%	1.13	10.6%	3.04	29.74	13.4%	11.8%	1.6%	76.7%	19.4%	1.9%	11.8%	0.0%	1.1%	0.9%	3.7%	61.0	54.0	0.1	0.1	0.0	6.0%	-1.1%	146.0	167.0	21.0
	H60	GENERAL SURGERY	28	LOW	126.0	730	2240.5	1746.0	5.5	6.99	-1.53	7.26	-1.80	0.2	1.1%	2.97	27.9%	3.17	29.74	11.7%	10.1%	1.6%	70.6%	27.7%	3.5%	12.9%	0.5%	2.2%	2.1%	6.5%	61.0	54.0	0.1	0.1	0.0	6.4%	-3.9%	-20.3	23.8	44.0
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	837	2453.5	1887.5	5.2	6.99	-1.80	7.26	-2.07	3.48	16.0%	0.09	0.7%	3.57	34.89	13.4%	11.2%	2.2%	55.2%	21.1%	1.4%	11.2%	0.3%	1.7%	1.8%	4.7%	53.0	53.0	0.0	0.0	0.0	13.6%	-0.1%	-40.0	13.5	53.5
	H100	GASTROENTEROLOGY	27	LOW	239.4	792	2146.3	1786.0	5.0	6.63	-1.66	6.29	-1.32	0.52	2.7%	1.35	11.2%	1.87	31.23	3.4%	3.2%	0.2%	64.5%	25.6%	6.5%	12.1%	0.1%	1.0%	3.5%	2.4%	51.0	51.0	0.0	0.0	0.0	10.1%	1.1%	27.3	51.0	23.8
	H12	ORTHOPAEDIC	28	LOW	252.0	749	2342.0	1850.5	5.6	7.13	-1.53	7.25	-1.65	1.52	7.0%	-0.76	-5.8%	0.76	35.00	10.0%	7.5%	2.5%	60.5%	36.2%	10.6%	14.2%	1.9%	3.0%	5.4%	1.1%	28.0	25.0	0.0	0.0	0.0	12.5%	0.7%	4.0	19.5	15.5
	H120	ORTHO / MAXFAX	22	LOW	283.5	573	2102.8	1616.0	6.5	7.13	-0.64	7.25	-0.76	1.5	9.0%	0.15	1.3%	1.65	28.42	10.0%	10.0%	0.0%	76.6%	26.9%	6.1%	16.9%	0.2%	1.7%	2.0%	0.0%	31.0	25.0	0.0	0.0	0.0	6.4%	0.5%	21.0	25.0	4.0
	HICU	CRITICAL CARE	22	LOW	252.0	467	11645.6	1093.0	27.3	27.13	0.15	26.60	0.68	7.5	7.2%	-0.36	-4.9%	7.14	112.20	0.8%	0.0%	0.8%	38.5%	32.5%	6.9%	13.4%	0.3%	1.2%	6.3%	4.4%	59.0	58.0	0.0	0.0	0.0	18.6%	0.5%	-152.0	70.8	222.8
	C9	ORTHOPAEDIC	35	LOW	252.0	774	2461.6	1585.7	5.2	7.13	-1.90	7.25	-2.02	2.37	10.9%	1.47	12.7%	3.84	33.39	5.0%	4.7%	0.3%	29.3%	26.2%	7.4%	11.4%	0.0%	4.2%	0.6%	2.6%	60.0	55.0	0.0	0.0	0.0	15.8%	-0.7%	-15.3	29.0	44.3
	C10	GENERAL SURGERY	21	LOW	252.0	596	2265.2	1087.0	5.6	6.99	-1.37	7.26	-1.64	1.54	8.4%	1.03	13.2%	2.57	26.08	19.2%	18.3%	0.9%	73.2%	30.1%	7.4%	14.6%	0.4%	1.4%	3.7%	2.6%	46.0	41.0	1.6	1.6	0.0	9.8%	-1.6%	13.8	69.0	55.3
	C11	GENERAL SURGERY	22	LOW	252.0	510	2163.4	1021.5	6.2	6.99	-0.75	7.26	-1.02	1.14	6.3%	1.79	22.9%	2.93	26.08	9.1%	8.8%	0.3%	42.3%	25.5%	7.2%	15.6%	0.0%	1.2%	1.5%	0.0%	56.0	38.0	0.0	0.0	0.0	15.0%	0.3%	-30.5	83.8	114.3
	C14	GENERAL SURGERY	27	LOW	252.0	753	2539.0	1110.3	4.9	6.99	-2.14	7.26	-2.41	2.59	12.7%	-0.01	-0.1%	2.58	29.38	7.1%	5.8%	1.3%	82.6%	20.6%	7.5%	9.5%	0.0%	3.3%	0.3%	0.0%	52.0	41.0	0.6	0.4	0.2	9.5%	2.7%	104.8	114.3	9.5
	C15	UROLOGY	26	MEDIUM	283.5	614	2250.4	1346.0	5.9	6.47	-0.61	6.67	-0.81	0.94	4.6%	0.41	3.4%	1.35	32.71	13.1%	10.7%	2.4%	59.6%	33.8%	7.1%	11.8%	1.7%	1.7%	1.5%	10.0%	46.0	12.0	0.3	0.2	0.1	16.0%	2.1%	81.8	94.3	12.5
	C27	CARDIOTHORACIC	26	LOW	283.2	730	2732.5	1006.0	5.1	8.46	-3.34	9.93	-4.81	3	12.7%	-2.86	-33.2%	0.14	32.22	1.1%	1.1%	0.0%	78.2%	26.5%	2.7%	14.0%	0.1%	1.2%	8.5%	0.0%	56.0	54.0	0.2	0.2	0.0	13.5%	1.4%	3.8	34.0	30.3
	CICU	CRITICAL CARE	22	MEDIUM	157.5	497	11039.6	653.8	23.5	27.13	-3.60	26.60	-3.07	5.99	6.5%	1.17	15.5%	7.16	100.50	4.9%	2.7%	2.2%	67.5%	28.5%	2.5%	12.6%	1.7%	2.6%	4.9%	4.2%	61.0	58.0	0.0	0.0	0.0	11.9%	1.5%	69.8	152.5	82.8
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	474	1896.8	1216.8	6.6	6.58	-0.01	9.03	-2.46	2.87	15.5%	1.35	12.1%	4.22	29.65	4.2%	4.2%	0.0%	40.8%	20.4%	0.9%	10.3%	0.0%	1.3%	2.1%	5.8%	39.0	38.0	0.2	0.1	0.1	27.1%	-0.9%	-85.5	6.0	91.5
	H130	PAEDIATRICS	20	LOW	205.8	506	2491.0	858.5	6.6	11.44	-4.82	12.20	-5.58	-0.23	-1.1%	-0.41	-7.9%	-0.64	26.59	0.1%	0.1%	0.0%	133.3%	22.6%	3.0%	13.5%	0.0%	2.0%	1.7%	2.4%	60.0	59.0	0.0	0.0	0.0	12.4%	-0.1%	9.0	9.0	0.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	173	1559.3	521.5	12.0	8.02	4.01	7.70	4.33	0.37	5.0%	0.12	3.1%	0.49	11.33	9.6%	9.0%	0.6%	48.1%	31.9%	9.3%	14.8%	2.7%	1.3%	1.9%	1.9%	38.0	38.0	0.3	0.3	0.0	23.2%	-0.4%	0.0	0.0	0.0
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	321	2022.2	1341.0	10.5	10.11	0.37	15.48	-5.00	-0.42	-0.91%	1.11	4.10%	0.69	73.34	0.9%	0.9%	0.0%	83.3%	30.5%	8.6%	14.4%	0.0%	2.6%	1.8%	3.1%	54.0	33.0	0.0	0.0	0.0	13.7%	-1.2%	-12.0	0.0	12.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1096	2986.8	1572.5	4.2	10.11	-5.95	15.48	-11.32							0.2%	0.2%	0.0%	33.3%	22.6%	0.4%	12.3%	0.4%	4.8%	0.7%	4.0%	54.0	33.0	0.0	0.0	0.0	7.0%	-1.6%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	265	2140.5	534.0	10.1	9.11	0.98	11.01	-0.92	3.78	18.2%	0.3	5.8%	4.08	26.00	3.2%	3.2%	0.0%	87.3%	23.2%	5.5%	14.8%	0.0%	2.7%	0.2%	0.0%	33.0	19.0	0.1	0.0	0.1	17.4%	-5.1%	0.0	0.0	0.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	281	1526.8	278.0	6.4	11.20	-4.78	10.70	-4.28	1.18	43.5%	0.74	27.3%	1.92	13.84	2.0%	2.0%	0.0%	54.3%	20.1%	2.3%	17.0%	0.0%	0.5%	0.3%	0.0%	55.0	38.0	0.1	0.1	0.0	20.4%	-0.1%	-153.0	18.5	171.5
	LABOUR	MATERNITY	16	LOW	369.5	308	5780.4	1274.0	22.9	10.11	12.79	15.48	7.42	-7.2	-52.6%	-2.11	-15.4%	-9.31	63.84	2.4%	2.4%	0.0%	101.7%	27.2%	6.9%	14.6%	0.2%	2.3%	1.5%	1.7%	33.0	33.0	0.4	0.3	0.1	4.9%	-9.3%	5.5	30.5	25.0
	NEONATES	NEONATOLOGY	26	LOW	157.5	588	7723.9	281.5	13.6	13.26	0.35	12.98	0.63	9.3	123.3%	-0.6	-8.0%	8.70	74.51	4.1%	4.1%	0.0%	82.5%	27.6%	5.1%	16.9%	0.6%	2.4%	1.3%	1.3%	53.0	39.0	0.0	0.0	0.0	10.8%	-0.5%	0.0	0.0	0.0
	PAU	PAEDIATRICS	10	LOW	0.0	121	1363.0	0.0	11.3	11.44	-0.18	12.20	-0.94	0.24	2.3%	0	0.0%	0.24	10.44	2.8%	2.8%	0.0%	86.6%	17.7%	0.7%	12.5%	0.0%	4.5%	0.0%	0.0%	60.0	59.0	0.0	0.0	0.0	2.0%	-0.3%	0.0	0.0	0.0
	PHDU	PAEDIATRICS	4	LOW	0.0	86	1382.5	122.3	17.5	11.44	6.06	12.20	5.30	0.53	4.6%	0	0.0%	0.53	11.66	1.5%	1.5%	0.0%	88.5%	26.5%	0.0%	14.7%	0.0%	3.9%	0.0%	7.9%	60.0	59.0	0.0	0.0	0.0	1.0%	-2.7%	0.0	0.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	314	1396.5	945.8	7.5	7.76	-0.30	7.91	-0.45	-0.07	-0.9%	0.22	2.7%	0.15	20.22	8.1%	7.6%	0.5%	86.9%	17.7%	4.5%	11.1%	0.0%	2.0%	0.1%	0.0%	56.0	42.0	0.0	0.0	0.0	4.1%	-7.7%	-14.5	45.0	59.5
	C29	REHABILITATION	15	LOW	147.0	440	1550.5	1689.7	7.4	7.69	-0.33	6.66	0.70	-1.12	-7.1%	1.59	10.1%	0.47	28.89	1.3%	0.7%	0.6%	66.9%	23.6%	3.1%	14.2%	0.0%	3.7%	1.9%	0.7%	35.0	34.0	0.3	0.2	0.1	2.3%	1.6%	65.0	103.5	38.5
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	634	1740.3	1236.5	4.7	7.92	-3.22	7.14	-2.44	2.42	30.3%	1.19	14.9%	3.61	21.97	14.1%	10.5%	3.6%	72.6%	30.7%	8.5%	12.6%	0.0%	6.3%	3.0%	0.3%	51.0	49.0	0.4	0.3	0.1	4.7%	-4.4%	31.0	94.0	63.0
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	671	1879.8	1175.5	4.6	7.92	-3.37	7.14	-2.59	2.83	24.1%	0.13	1.1%	2.96	25.74	10.4%	7.7%	2.7%	74.9%	26.0%	3.0%	11.7%	0.0%	6.2%	0.5%	4.6%	47.0	45.0	0.4	0.2	0.2	6.4%	-5.0%	-14.5	50.0	64.5
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	634	1752.0	1136.5	4.6	7.92	-3.36	7.14	-2.58	1.04	10.8%	-0.04	-0.4%	1.00	23.57	4.2%	2.6%	1.6%	51.7%	21.0%	0.7%	13.2%	0.0%	3.8%	0.1%	3.2%	54.0	54.0	0.3	0.2	0.1	5.1%	-2.2%	2.0	48.0	46.0
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	689	2783.1	1221.4	5.8	8.21	-2.40	7.23	-1.42	0.6	7.5%	-2.03	-25.4%	-1.43	35.44	3.3%	2.3%	1.0%	26.6%	34.3%	2.5%	11.9%	0.2%	4.0%	1.3%	14.4%	45.0	45.0	0.0	0.0	0.0	23.7%	1.2%	-41.0	0.0	41.0
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR			TOTALS:	10473.6	29766	134314.1	65224.1	6.70	8.84	-51.02	9.25	-71.10	131.49	12.3%	12.68	2.5%	158.06	1786.40	7.7%	6.8%	0.9%	66.2%	26.4%	5.1%	13.0%	0.4%	2.7%	1.9%	3.3%	45.8	39.8	11.4	7.7	3.7	12.8%	-0.7%	1426.7	4976.8	3550.1

HEY NURSE STAFFING KEY METRICS DASHBOARD

Dec-18

KEY METRICS ROTA: 26th Nov - 23rd Dec 2018

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	PROFESSIONAL RISK ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST									NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M9]						TEMPORARY STAFFING [9th Jul - 5th Aug-18]				UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE							ROTA APPROVALS [42 DAYS]		ADDITIONAL DUTIES			UNFILLED ROSTER [<20%]	HOURS BALANCES [4 WEEKS] [NET + / - 2%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]		
					Other care staff not currently included in CHPPD HPW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]	TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [< 1%]	STUDY DAY [<2.3%]	WORKING DAY [1%]	MAT LEAVE [<2.5%]	FULL [DAYS]	PARTIAL [DAYS]	TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [%]	HOURS BALANCE [%]	NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.75	5.1%	2.59	11.8%	7.34	115.34	6.9%	5.6%	1.3%	88.8%	26.8%	6.1%	15.3%	0.0%	1.6%	1.0%	2.8%	56.0	54.0	0.4	0.1	0.3	1.5%	1.5%	134.0	134.0	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1242	5230.8	2532.1	6.3	7.55	-1.30	7.31	-1.06	12.19	27.6%	5.06	21.6%	17.25	67.57	10.4%	9.6%	0.8%	67.7%	36.6%	14.6%	15.0%	0.6%	1.4%	3.8%	1.2%	40.0	37.0	0.3	0.1	0.2	-0.5%	-0.5%	325.5	379.0	53.5
	H1	GENERAL MEDICINE	22	LOW	399.0	630	1729.3	1082.7	4.5	7.55	-3.09	7.31	-2.85	0.88	6.0%	1.14	14.4%	2.02	22.51	11.6%	10.8%	0.8%	48.1%	31.9%	11.6%	18.2%	0.0%	0.2%	0.0%	1.9%	37.0	27.0	0.0	0.0	0.0	-2.8%	-2.8%	10.8	68.5	57.8
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	628	2216.5	1799.5	6.4	6.94	-0.55	7.74	-1.35	3.66	19.2%	-0.32	-2.4%	3.34	32.27	6.6%	5.9%	0.7%	74.4%	18.3%	0.3%	11.5%	3.3%	2.2%	1.0%	0.0%	55.0	55.0	0.0	0.0	0.0	0.3%	0.3%	-51.5	5.5	57.0
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	780	3016.3	1672.8	6.0	6.74	-0.73	6.38	-0.37	2.12	8.6%	2.24	17.0%	4.36	37.84	10.6%	9.2%	1.4%	35.5%	34.4%	6.1%	14.9%	0.0%	4.6%	8.8%	0.0%	-4.0	-5.0	0.5	0.3	0.2	-1.5%	-1.5%	0.3	76.8	76.5
	H50	NEPHROLOGY	19	LOW	283.5	579	1952.5	1258.0	5.5	7.23	-1.69	7.00	-1.46	-1.17	-7.7%	0.23	2.7%	-0.94	23.54	0.4%	0.4%	0.0%	60.0%	21.7%	1.0%	14.0%	0.0%	2.8%	1.3%	2.6%	41.0	40.0	0.0	0.0	0.0	-6.2%	-6.2%	5.7	36.5	30.8
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	730	1703.5	1748.9	4.7	6.74	-2.01	6.38	-1.65	7.36	43.4%	1.25	10.3%	8.61	29.10	20.7%	20.4%	0.3%	80.7%	28.4%	8.9%	13.6%	0.0%	2.3%	3.6%	0.0%	40.0	-7.0	1.4	0.5	0.9	3.4%	3.4%	174.0	199.0	25.0
	H70	GENERAL MEDICINE	30	MEDIUM	441.0	822	2001.0	1770.3	4.6	7.55	-2.96	7.31	-2.72	9.54	47.6%	0.56	4.6%	10.10	32.22	19.0%	17.0%	2.0%	52.4%	31.9%	7.5%	13.4%	2.0%	2.7%	2.6%	3.7%	48.0	48.0	0.0	0.0	0.0	18.7%	18.7%	310.5	310.5	0.0
	H8	GERIATRIC MEDICINE	27	LOW	220.5	831	1923.0	1850.5	4.5	6.94	-2.40	6.74	-2.20	2.45	14.7%	1.65	12.5%	4.10	29.78	5.0%	4.8%	0.2%	55.0%	24.6%	3.4%	16.3%	0.0%	2.3%	0.2%	2.4%	40.0	39.0	0.3	0.3	0.0	-5.6%	-5.6%	101.0	114.5	13.5
	PDU H80	GERIATRIC MEDICINE	27	LOW	913.5	845	1690.1	2159.0	4.6	6.94	-2.38	6.74	-2.18	7.26	43.7%	-0.95	-7.2%	6.31	29.78	14.0%	9.7%	4.3%	40.5%	39.9%	11.0%	12.9%	1.1%	1.5%	7.6%	5.8%	48.0	21.0	0.6	0.4	0.2	0.2%	0.2%	-24.0	57.0	81.0
	H9	GERIATRIC MEDICINE	30	MEDIUM	220.5	822	1546.5	2034.8	4.4	6.94	-2.58	6.74	-2.38	8.26	49.7%	-3.59	-27.3%	4.67	29.78	18.6%	9.8%	8.8%	72.7%	39.5%	7.2%	15.8%	4.8%	1.8%	7.4%	2.5%	27.0	27.0	0.3	0.2	0.1	1.2%	1.2%	211.8	237.8	26.0
	H90	GERIATRIC MEDICINE	29	LOW	252.0	828	1784.0	1962.5	4.5	6.94	-2.42	6.74	-2.22	2.11	12.7%	0.31	2.4%	2.42	29.78	5.1%	4.5%	0.6%	61.7%	31.2%	10.1%	16.3%	1.6%	1.0%	2.2%	0.0%	55.0	45.0	0.0	0.0	0.0	1.0%	1.0%	-16.0	77.5	93.5
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	836	1947.0	1865.3	4.6	7.55	-2.99	7.41	-2.85	4.89	21.7%	-2.80	-26.3%	2.09	33.16	6.5%	6.2%	0.3%	38.4%	29.4%	4.9%	13.0%	2.1%	1.3%	3.7%	4.4%	44.0	39.0	0.0	0.0	0.0	0.6%	0.6%	26.3	74.3	48.0
	H110	STROKE / NEUROLOGY	24	LOW	252.0	594	1546.5	2034.8	6.0	7.55	-1.52	7.41	-1.38	1.78	7.9%	0.15	1.4%	1.93	33.64	25.9%	25.1%	0.8%	36.6%	30.3%	4.2%	10.0%	0.2%	2.9%	8.6%	4.4%	48.0	33.0	0.1	0.1	0.0	0.1%	0.1%	-119.1	1311.8	1430.8
	CDU	CARDIOLOGY	9	LOW	0.0	102	1015.4	223.5	12.2	7.93	4.22	7.73	4.42	2.09	16.3%	0.25	8.6%	2.34	15.74	15.3%	12.5%	2.8%	52.9%	27.2%	3.4%	20.6%	0.4%	1.1%	1.7%	0.0%	32.0	28.0	0.0	0.0	0.0	-1.2%	-1.2%	7.5	7.5	0.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	898	2691.5	1039.0	4.2	8.46	-4.31	9.93	-5.78	3.00	11.6%	1.57	19.8%	4.57	33.73	4.2%	2.9%	1.3%	47.1%	28.6%	6.5%	13.6%	0.0%	1.9%	2.4%	4.2%	55.0	54.0	0.3	0.3	0.0	5.0%	5.0%	156.0	168.0	12.0
	C28 /CMU	CARDIOLOGY	27	LOW	277.2	686	4327.1	803.0	7.5	7.44	0.04	7.87	-0.39	3.35	8.8%	1.73	18.0%	5.08	47.78	6.6%	6.0%	0.6%	38.8%	25.9%	3.1%	15.8%	0.0%	2.3%	2.5%	2.2%	48.0	23.0	0.0	0.0	0.0	0.0%	0.1%	50.1	95.5	45.4
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	738	2547.9	1353.2	5.3	8.39	-3.10	8.71	-3.42	3.08	14.1%	1.73	16.6%	4.81	32.28	11.8%	11.0%	0.8%	55.4%	30.8%	4.2%	12.7%	0.0%	4.2%	5.2%	4.5%	34.0	31.0	0.3	0.2	0.1	-2.9%	-2.9%	25.5	55.0	29.5
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	399	2594.8	1390.8	10.0	8.39	1.60	8.71	1.28	2.86	13.7%	-1.02	-9.2%	1.84	31.95	8.7%	5.1%	3.6%	57.8%	32.0%	7.6%	10.7%	1.2%	2.9%	4.2%	5.4%	21.0	20.0	0.4	0.4	0.0	1.6%	1.6%	108.8	142.8	34.0
	H6	GENERAL SURGERY	28	LOW	283.5	717	2362.0	1556.5	5.5	6.99	-1.52	7.26	-1.79	1.91	10.0%	1.13	10.6%	3.04	29.74	12.9%	11.7%	1.2%	67.6%	31.8%	5.4%	16.3%	0.8%	1.7%	4.2%	3.4%	59.0	55.0	0.0	0.0	0.0	-1.2%	-1.2%	36.0	58.5	22.5
	H60	GENERAL SURGERY	28	LOW	126.0	749	2339.0	1641.0	5.3	6.99	-1.68	7.26	-1.95	0.36	1.9%	1.97	18.5%	2.33	34.89	12.0%	11.4%	0.6%	63.8%	31.2%	5.8%	13.7%	0.7%	1.0%	3.3%	6.7%	54.0	54.0	0.0	0.0	0.0	-3.3%	-3.3%	-80.0	11.0	91.0
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	826	2568.8	1720.0	5.2	6.99	-1.80	7.26	-2.07	3.48	16.0%	0.09	0.7%	3.57	29.74	7.8%	7.0%	0.8%	38.8%	26.5%	2.3%	15.8%	0.0%	1.3%	0.8%	6.3%	55.0	55.0	0.1	0.0	0.1	-0.3%	-0.3%	-48.8	20.8	69.5
	H100	GASTROENTEROLOGY	27	LOW	239.4	809	2159.5	1838.2	4.9	6.63	-1.69	6.29	-1.35	0.52	2.7%	1.35	11.2%	1.87	31.23	11.3%	9.8%	1.5%	53.4%	30.3%	6.2%	16.9%	0.2%	1.4%	3.1%	2.5%	47.0	47.0	0.0	0.0	0.0	2.7%	2.7%	48.8	80.8	32.0
	H12	ORTHOPAEDIC	28	LOW	252.0	758	2455.3	1693.5	5.5	7.13	-1.66	7.25	-1.78	1.77	8.1%	-0.76	-5.8%	1.01	35.00	6.1%	5.8%	0.3%	41.5%	33.5%	4.3%	18.8%	2.7%	2.1%	2.1%	3.5%	35.0	30.0	0.1	0.1	0.0	-0.1%	-0.1%	-26.5	22.0	48.5
	H120	ORTHO / MAXFAX	22	LOW	283.5	596	2177.8	1772.5	6.6	7.13	-0.50	7.25	-0.62	1.50	9.0%	0.15	1.3%	1.65	28.42	15.9%	15.0%	0.9%	79.3%	30.5%	4.1%	18.3%	0.3%	2.5%	5.3%	0.0%	52.0	30.0	0.0	0.0	0.0	1.9%	1.9%	61.5	67.0	5.5
	HICU	CRITICAL CARE	22	LOW	252.0	485	11683.4	874.8	25.9	27.13	-1.24	26.60	-0.71	7.50	7.2%	-0.36	-4.9%	7.14	112.20	0.6%	0.0%	0.6%	22.5%	33.1%	8.5%	17.4%	0.1%	0.9%	1.8%	4.4%	59.0	59.0	0.2	0.2	0.0	-1.4%	-1.4%	-138.3	158.8	297.0
	C9	ORTHOPAEDIC	35	LOW	252.0	595	2265.5	1382.0	6.1	7.13	-1.00	7.25	-1.12	3.37	15.4%	1.47	12.7%	4.84	33.39	5.1%	5.1%	0.0%	33.5%	25.8%	10.3%	11.3%	0.0%	1.2%	0.4%	2.6%	53.0	52.0	0.1	0.1	0.0	0.3%	0.3%	-12.0	28.0	40.0
	C10	GENERAL SURGERY	21	LOW	252.0	552	2214.8	908.4	5.7	6.99	-1.33	7.26	-1.60	1.54	8.4%	1.03	13.2%	2.57	26.08	14.2%	12.8%	1.4%	60.3%	29.5%	3.8%	16.6%	1.7%	3.1%	3.7%	0.6%	39.0	39.0	0.2	0.2	0.0	-1.5%	-1.5%	38.0	43.0	5.0
	C11	GENERAL SURGERY	22	LOW	252.0	552	2223.0	990.0	5.8	6.99	-1.17	7.26	-1.44	1.56	8.6%	1.79	22.9%	3.35	26.08	6.3%	6.3%	0.0%	43.5%	23.1%	6.3%	14.1%	0.0%	1.5%	1.2%	0.0%	55.0	52.0	0.4	0.4	0.0	1.2%	1.2%	8.0	55.5	47.5
	C14	GENERAL SURGERY	27	LOW	252.0	611	2164.0	1031.5	5.2	6.99	-1.76	7.26	-2.03	2.59	12.7%	0.95	10.5%	3.54	29.38	11.1%	7.5%	3.6%	61.1%	29.3%	6.8%	19.2%	0.0%	2.1%	1.2%	0.0%	34.0	34.0	0.4	0.4	0.0	2.3%	2.3%	66.0	88.0	22.0
	C15	UROLOGY	26	MEDIUM	283.5	631	2345.4	1271.5	5.7	6.47	-0.74	6.67	-0.94	0.94	4.6%	0.41	3.4%	1.35	32.71	16.7%	11.7%	5.0%	64.9%	35.2%	7.6%	14.2%	0.0%	0.8%	2.4%	10.2%	30.0	30.0	0.5	0.5	0.0	2.3%	2.3%	50.8	102.3	51.5
	C27	CARDIOTHORACIC	26	LOW	283.2	725	2937.0	1026.5	5.5	8.46	-2.99	9.93	-4.46	0.00	0.0%	-0.86	-10.0%	-0.86	32.22	1.4%	1.4%	0.0%	36.6%	25.6%	0.9%	18.8%	0.9%	1.8%	3.2%	0.0%	52.0	52.0	0.1	0.0	0.1	1.3%	1.3%	-2.0	5.5	7.5
	CICU	CRITICAL CARE	22	MEDIUM	157.5	448	10334.3	514.0	24.2	27.13	-2.92	26.60	-2.39	3.99	4.3%	1.17	15.5%	5.16	100.50	4.0%	1.3%	2.7%	57.5%	34.0%	6.2%	17.4%	1.2%	0.6%	4.4%	4.2%	60.0	59.0	0.1	0.1	0.0	0.0%	0.0%	121.5	280.0	158.5
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	387	1773.8	1074.5	7.4	6.58	0.78	9.03	-1.67	5.35	28.9%	1.35	12.1%	6.70	29.65	5.6%	5.6%	0.0%	62.5%	19.3%	1.0%	12.0%	0.0%	1.1%	0.7%	4.5%	18.0	11.0	0.2	0.2	0.0	-1.6%	-1.6%	-68.5	0.0	68.5
	H130	PAEDIATRICS	20	LOW	205.8	461	2407.5	820.0	7.0	11.44	-4.44	12.20	-5.20	-0.17	-0.8%	0.19	3.6%	0.02	26.59	0.6%	0.6%	0.0%	100.0%	27.4%	3.9%	17.0%	0.0%	1.7%	2.4%	2.4%	47.0	47.0	0.1	0.0	0.1	0.7%	0.7%	5.0	5.0	0.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	232	1611.3	654.5	9.8	8.02	1.75	7.70	2.07	0.58	7.8%	0.12	3.1%	0.70	11.33	15.3%	12.5%	2.8%	52.9%	27.2%	3.4%	20.6%	0.4%	1.1%	1.7%	0.0%	32.0	28.0	1.2	0.9	0.3	-1.2%	-1.2%	9.8	65.5	55.8
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	320	2112.6	1350.5	10.8	10.11	0.71	15.48	-4.66	0.18	0.39%	2.11	7.79%	2.29	73.34	0.7%	0.7%	0.0%	80.0%	32.1%	13.6%	12.7%	0.0%	1.9%	1.8%	2.1%	53.0	52.0	0.0	0.0	0.0	-1.1%	-1.1%	0.0	0.0	0.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1001	2949.5	1593.5	4.5	10.11	-5.57	15.48	-10.94							1.5%	1.5%	0.0%	85.3%	27.4%	5.2%	15.0%	0.5%	2.0%	0.5%	4.2%	53.0	53.0	0.0	0.0	0.0	-2.1%	-2.1%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	284	2228.8	556.0	9.8	9.11	0.70	11.01	-1.20	2.78	13.4%	-0.5	-9.6%	2.28	26.00	3.2%	3.2%	0.0%	69.9%	29.9%	4.2%	17.6%	0.0%	3.8%	4.3%	0.0%	41.0	38.0	0.0	0.0	0.0	-3.9%	-3.9%	0.0	0.0	0.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	269	1517.5	320.5	6.8	11.20	-4.37	10.70	-3.87	1.18	43.5%	0.74	27.3%	1.92	13.84	5.7%	5.7%	0.0%	81.5%	27.1%	8.8%	15.3%	0.0%	1.6%	1.4%	0.0%	67.0	38.0	0.3	0.1	0.2	-0.8%	-0.8%	-134.0	44.0	178.0
	LABOUR	MATERNITY	16	LOW	369.5	290	5734.3	1286.0	24.2	10.11	14.10	15.48	8.73	-6.2	-45.3%	-2.11	-15.4%	-8.31	63.84	2.3%	2.3%	0.0%	102.9%	26.7%	7.1%	15.5%	0.3%	0.6%	1.4%	1.8%	38.0	38.0	0.2	0.1	0.1	-4.1%	-4.1%	0.0	7.5	7.5
	NEONATES	NEONATOLOGY	26	LOW	157.5	608	7681.8	327.0	13.2	13.26	-0.09	12.98	0.19	9.79	129.8%	1.4	18.6%	11.19	74.51	2.5%	2.5%	0.0%	80.3%	28.8%	5.5%	17.4%	0.5%	2.1%	1.4%	1.9%	39.0	38.0	0.0	0.0	0.0	0.0%	0.0%	0.0	0.0	0.0
	PAU	PAEDIATRICS	10	LOW	0.0	105	1411.0	0.0	13.4	11.44	2.00	12.20	1.24	0.24	2.3%	0	0.0%	0.24	10.44	3.5%	3.5%	0.0%	79.5%	18.6%	0.8%	14.9%	0.0%	1.5%	1.4%	0.0%	57.0	47.0	0.0	0.0	0.0	1.4%	1.4%	0.0	0.0	0.0
	PHDU	PAEDIATRICS	4	LOW	0.0	92	1435.5	113.5	16.8	11.44	5.40	12.20	4.64	0.53	4.6%	0	0.0%	0.53	11.66	2.9%	2.9%	0.0%	93.8%	27.4%	0.0%	16.1%	0.0%	3.4%	0.0%	7.9%	57.0	47.0	0.0	0.0	0.0	-7.3%	-7.3%	0.0	0.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	314	1462.3	732.3	7.0	7.76	-0.77	7.91	-0.92	-0.07	-0.9%	0.22	2.7%	0.15	20.22	6.7%	4.6%	2.1%	54.0%	31.5%	5.8%	22.5%	0.0%	1.4%	1.8%	0.0%	38.0	38.0	0.2	0.2	0.0	-5.1%	-5.1%	-121.0	32.0	153.0
	C29	REHABILITATION	15	LOW	147.0	457	1600.0	1899.0	7.7	7.69	-0.03	6.66	1.00	-0.16	-1.0%	1.59	10.1%	1.43	28.89	4.3%	4.3%	0.0%	58.1%	24.8%	6.0%	15.0%	0.0%	3.3%	0.5%	0.0%	46.0	46.0	0.7	0.6	0.1	2.3%	2.3%	50.5	67.5	17.0
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	609	1716.3	1225.8	4.8	7.92	-3.09	7.14	-2.31	1.42	17.8%	1.19	14.9%	2.61	21.97	12.4%	9.7%	2.7%	63.1%	24.8%	7.3%	13.3%	0.0%	1.5%	2.7%	0.0%	52.0	46.0	0.7	0.5	0.2	-4.1%	-4.1%	114.5	151.0	36.5
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	654	1758.1	1215.8	4.6	7.92	-3.37	7.14	-2.59	3.44	29.3%	2.13	18.1%	5.57	25.74	7.6%	6.4%	1.2%	38.8%	23.1%	1.8%	14.7%	0.0%	1.5%	1.6%	3.5%	40.0	37.0	0.1	0.1	0.0	-4.5%	-4.5%	-95.3	54.8	150.0
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	632	1703.0	1118.0	4.5	7.92	-3.46	7.14	-2.68	1.04	10.8%	-0.04	-0.4%	1.00	23.57	8.1%	5.9%	2.2%	49.4%	28.4%	5.9%	16.9%	0.0%	1.4%	0.9%	3.3%	46.0	37.0	0.3	0.3	0.0	-1.9%	-1.9%	29.0	52.5	23.5
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	630	2521.1	1279.8	6.0	8.21	-2.18	7.23	-1.20	1.36	17.0%	-2.03	-25.4%	-0.67	35.44	2.4%	1.7%	0.7%	24.5%	38.5%	4.0%	12.6%	0.0%	1.9%	0.6%	19.4%	41.0	37.0	0.2	0.2	0.0	-0.9%	-0.9%	42.0	87.0	45.0
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR		TOTALS:	10473.6	29389	133317.6	62367.5	6.70	8.84	-52.10	9.25	-72.18	132.78	12.3%	12.68	2.5%	158.06	1786.40	8.4%	7.1%	1.2%	59.3%	29.0%	5.7%	15.4%	0.6%	1.9%	2.6%	2.9%	44.3	38.7	11.3	8.1	3.2	-0.3%	-0.3%	1391.9	5139.0	3747.1

HEY NURSE STAFFING QUALITY INDICATORS

Dec-18

HR METRICS

IN PATIENT FALLS WITH HARM

ADMITTED WITH & HOSPITAL ACQUIRED PRESSURE ULCERS [AVOIDABLE AND UNAVOIDABLE]

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	STAFF APPRAISAL [85%]	STAFF RETENTION [90.7%]	OVERALL MAND. TRAINING [85%]	I.G. TRAINING [95%]	BLOOD TRANS. [85%]	FIRE TRAINING [85%]	RESUS TRAINING [85%]	TISSUE VIABILITY TRAINING [85%]	MODERATE		SEVERE / DEATH		TOTALS		MASD				GRADE 2				GRADE 3				GRADE 4				DEEP TISSUE INJURY				UNSTAGEABLE				DEVICE RELATED [TOTAL]		TOTALS						
																		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED				ADMITTED WITH		HOSPITAL ACQUIRED		AVOIDABLE / REQUIRE RCA		
				MONTH	YTD	MONTH	YTD	MONTH	YDT																																						
MEDICINE	ED	ACUTE MEDICINE	NA	87.9%	86.9%	90.0%	92.0%	93.0%	90.0%	79.0%	87.0%					0	0					87	738			6	82			2	24			30	202	1	1	18	182			1	1	143	1228	1	1			1
	AMU	ACUTE MEDICINE	45	86.4%	89.6%	92.0%	94.0%	92.0%	90.0%	76.0%	95.0%		1			0	1					5	58				5			1	2			8	23		1	2	17					16	105	0	1			
	H1	ACUTE MEDICINE	22	91.7%	97.2%	91.0%	100.0%	96.0%	88.0%	58.0%	83.0%					0	0						8																1					0	9	0	0			
	EAU	ELDERLY MEDICINE	21	96.8%	91.3%	97.0%	97.0%	94.0%	88.0%	85.0%	88.0%	2	3		5	2	8					14	78			0	3			0	2			3	24			2	20					19	127	0	0			
	H5 / RHOB	RESPIRATORY	26	87.5%	94.1%	94.0%	97.0%	100.0%	82.0%	82.0%	84.0%					0	0					1	7	1	8	0	1							0	2		2			2		4	1	10	1	12			
	H50	RENAL MEDICINE	19	85.7%	89.8%	90.0%	100.0%	95.0%	86.0%	86.0%	81.0%		1			0	1					0	8		1					0	1			2	3		1	0	1		2			2	13	0	2			
	H500	RESPIRATORY	24	70.4%	79.0%	92.0%	88.0%	100.0%	92.0%	83.0%	79.0%					0	0					1	8	1	2									6	10			2	6					9	24	1	2			
	H70	ENDOCRINOLOGY	30	64.3%	91.1%	86.0%	81.0%	65.0%	65.0%	73.0%	96.0%					0	0					0	10		2									0	1			0	1		2			0	12	0	4		1	1
	H8	ELDERLY MEDICINE	27	96.9%	88.1%	78.0%	87.0%	87.0%	67.0%	80.0%	83.0%		1			0	1								5									0	3		2				1			0	3	0	8			
	H80	ELDERLY MEDICINE	27	93.8%	94.9%	93.0%	88.0%	100.0%	88.0%	88.0%	97.0%	1	2		2	1	4					0	2		3												3			1	3		2	0	2	1	9	1	1		
	H9	PDU	30									1	4		1	1	5					1	4	1	1																			1	4	1	1			
	H90	ELDERLY MEDICINE	29	96.4%	94.7%	95.0%	94.0%	91.0%	88.0%	72.0%	88.0%		1		2	0	3					0	6		2					0	2			0	2		1							0	10	0	3			
	H11	STROKE / NEURO	28	90.0%	90.8%	89.0%	89.0%	82.0%	71.0%	75.0%	64.0%		3			0	3	1	2						4												1					1		1	2	0	5		1	
	H110	STROKE / NEURO	24	87.1%	86.2%	86.0%	79.0%	76.0%	79.0%	65.0%	82.0%		1			0	1					0	9	2	2	0	3		1					0	1	1	3			1		1		0	13	3	7			
	CDU	CARDIOLOGY	9	66.7%	74.4%	79.0%	93.0%	87.0%	60.0%	60.0%	80.0%					0	0						2																					0	2	0	0			
	C26	CARDIOLOGY	26	61.1%	92.5%	86.0%	91.0%	97.0%	85.0%	70.0%	67.0%		1		1	0	2						1	2	3									1		1				1		1	0	2	2	5	1	1		
	C28 /CMU	CARDIOLOGY	27	67.4%	85.1%	94.0%	89.0%	96.0%	94.0%	83.0%	64.0%					0	0					1	4	3	6														1			1	5	3	6			1
SURGERY	H4	NEURO SURGERY	28	79.3%	88.9%	80.0%	77.0%	87.0%	80.0%	70.0%	60.0%		1			0	1					1	7	1	2	0	1												1		1	1	1	1	9	1	3		1	
	H40	NEURO / TRAUMA	15	83.3%	90.3%	89.0%	88.0%	79.0%	85.0%	76.0%	82.0%					0	0					0	2		3														1	1	3	1	5	0	3	1	6			
	H6	ACUTE SURGERY	28	81.3%	94.4%	87.0%	79.0%	83.0%	72.0%	79.0%	79.0%		1			0	1					0	1	1	1									0	2									0	3	1	1			
	H60	ACUTE SURGERY	28	96.9%	94.9%	80.0%	81.0%	96.0%	77.0%	73.0%	77.0%					0	0					0	3							0	1													0	4	0	0			
	H7	VASCULAR SURGERY	30	85.7%	94.0%	87.0%	100.0%	81.0%	75.0%	53.0%	92.0%					0	0					4	29		3	0	1							0	1		4	3	15		1		4	7	46	0	8			
	H100	GASTRO	24	56.3%	95.4%	85.0%	88.0%	82.0%	85.0%	82.0%	67.0%					0	0					1	3		8												2				2	1	3	0	10			
	H12	ORTHOPAEDIC	28	94.4%	95.1%	94.0%	95.0%	100.0%	93.0%	90.0%	90.0%					0	0					1	4		3			1		0	4		1				2					1	8	0	5			
	H120	ORTHO / MAXFAX	22	86.2%	94.7%	95.0%	100.0%	97.0%	93.0%	90.0%	93.0%					0	0					2	4		5							1	2			1	1	2	1	4	3	5	1	9	1	1		
	HICU	CRITICAL CARE	22	83.8%	93.1%	90.0%	90.0%	94.0%	80.0%	81.0%	94.0%					0	0								2					0	3	2	7	0	2		1			6	0	5	2	10			
	C9	ORTHOPAEDIC	35	92.1%	94.0%	92.0%	83.0%	93.0%	78.0%	75.0%	83.0%					0	0					0	3	2	4									0	1							0	4	2	4			1
	C10	COLORECTAL	21	70.8%	84.6%	80.0%	84.0%	88.0%	60.0%	72.0%	56.0%					0	0							1	1												2							0	0	1	3			
	C11	COLORECTAL	22	95.8%	90.6%	90.0%	96.0%	96.0%	63.0%	96.0%	81.0%					0	0					0	1			0	2			0	1							0	1					0	5	0	0			
	C14	UPPER GI	27	88.6%	96.7%	84.0%	87.0%	94.0%	52.0%	81.0%	81.0%					0	0								2												1				1		0	0	0	3			
	C15	UROLOGY	26	70.4%	84.8%	78.0%	77.0%	71.0%	71.0%	68.0%	77.0%		1			0	1					1	8	3	3	1	2			1	2			1	2		2	1	4	2	2			5	17	5	7			3
	C27	CARDIOTHORACIC	26	95.0%	94.9%	91.0%	86.0%	86.0%	81.0%	75.0%	75.0%					0	0					1	1		1					0	1			1	1							2	3	0	1			
	CICU	CRITICAL CARE	22	80.2%	88.8%	91.0%	90.0%	94.0%	85.0%	82.0%	89.0%					0	0					0	1	1	2					1	1		4				1	1	3			1	2	1	7			
FAMILY & WOMEN'S	C16	ENT / BREAST	30	96.7%	88.0%	95.0%	97.0%	77.0%	93.0%	83.0%	100.0%					0	0																											0	0	0	0			
	H130	PAEDS	20	90.6%	85.7%	92.0%	91.0%	83.0%	94.0%	75.0%	62.0%					0	0																											0	0	0	0			
	H30 CEDAR	GYNAECOLOGY	9	77.8%	100.0%	95.0%	95.0%	100.0%	95.0%	91.0%	100.0%					0	0																											0	0	0	0			
	H31 MAPLE	MATERNITY	20	88.6%	94.7%	95.0%	97.0%	83.0%	87.0%	94.0%	91.0%					0	0																											0	0	0	0			
	H33 ROWAN	MATERNITY	38																																									0	0	0	0			
	H34 ACORN	PAEDS SURGERY	20	86.7%	80.2%	99.0%	96.0%	100.0%	96.0%	100.0%	88.0%					0	0																											0	0	0	0			
	H35	OPHTHALMOLOGY	12	94.4%	100.0%	95.0%	95.0%	95.0%	85.0%	80.0%	100.0%					0	0					0	6		2					0	1													0	7	0	2			
	LABOUR	MATERNITY	16	73.3%	98.3%	89.0%	92.0%	93.0%	84.0%	91.0%	79.0%					0	0																											0	0	0	0			
	NEONATES	CRITICAL CARE	26	91.1%	87.0%	94.0%	92.0%	86.0%	91.0%	88.0%	96.0%					0	0								1																		1	0	0	0	1			
	PAU	PAEDS	10	100.0%	96.0%	96.0%	100.0%	92.0%	100.0%	77.0%	85.0%					0	0																											0	0	0	0			
	PHDU	CRITICAL CARE	4	85.7%	88.4%	95.0%	100.0%	100.0%	77.0%	92.0%	100.0%					0	0																											0	0	0	0			
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	19	81.0%	100.0%	95.0%	100.0%	90.0%	100.0%	86.0%	90.0%		1			0	1								2	0	2																	0	2	0	2			
	C29	REHABILITATION	15	75.9%	94.4%	93.0%	89.0%	82.0%	86.0%	86.0%	71.0%		1			0	1							1	3														1		1	1	1	0	0	1	4			
	C30	ONCOLOGY	22	94.1%	73.2%	87.0%	77.0%	100.0%	91.0%	86.0%	95.0%					0	0					2	24		4									1	5		1	0	7		1		1	3	36	0	6		1	
	C31	ONCOLOGY	27	83.3%	90.4%	80.0%	76.0%	100.0%	68.0%	60.0%	96.0%					0	0					3	18	1	1					0	2			1	11		4	3	15					7	46	1	5			1
	C32	ONCOLOGY	22	70.4%	95.8%	86.0%	82.0%	100.0%	86.0%	73.0%	95.0%	2	2			2	2					4	28			1	1			0	1			1	1		2			1	1			6	31	1	3			
	C33	HAEMATOLOGY	28	77.1%	95.4%	89.0%	81.0%	100.0%	81.0%	76.0%	78.0%					0	0					1	13	1	3									0	4		1	0	5		1			1	22	1	5		1	
TOTALS :				84.1%	91.0%	89.6%	90.0%	90.7%	82.4%	79.1%	83.8%	6	25	0	11	6	36	1	2	0	0	131	1099	22	95	8	103	0	2	4	38	0	0	54	308	5	49	33	282	5	25	5	41	231	1832	32	171	3	8	8

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

29 JANUARY 2019

Title:	**NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS**
Responsible Director:	Mike Wright - Chief Nurse
Authors:	Mike Wright - Chief Nurse, Jo Ledger - Deputy Chief Nurse Caroline Grantham - Practice Development Matron

Purpose:	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits	
BAF Risk:	BAF Risk 3 – High Quality Care	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	Good progress continues to be made overall. Although elimination of all Red-rated fundamental standards has not been achieved fully, significant improvements have been made. The number of fundamental standards rated as Blue and Green have both increased to approximately 78% of the total (up from 76% in September 2018). Areas with red-rated standards are receiving help and support to help them improve.	

Recommendation:	The Trust Board is requested to receive this report and: • Determine if this report provides sufficient information and assurance • Determine if any further actions are required

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
GREAT STAFF, GREAT CARE, GREAT WARD:
NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits were introduced in 2015 and have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in September 2018. Good progress is being made and this report presents the position as at the end of December 2018.

Areas of achievement are summarised alongside the next areas for focused attention. Good progress is being made overall.

Audit results are publicised in wards and departments as part of ongoing transparency and accountability to patients and the public for the care provided.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
GREAT STAFF, GREAT CARE, GREAT WARD:
NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our nursing and midwifery teams. The last report on this topic was presented to the Trust Board in September 2018. This provides a progress report up to the end of December 2018.

As indicated in table 1 below, the review process for inpatient areas is set around nine fundamental standards, with the emphasis on delivering safe, effective and high quality patient care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care. This ensures consistency of what is looked at and creates a credible, comparable rating. The aim is to celebrate areas of excellent practice, identify areas where further improvements/support are required and with a clear time frame for the improvement to be delivered within.

Table to illustrate the Nine Fundamental Standards – Inpatient Areas

1. STAFF EXPERIENCE
2. PATIENT ENVIRONMENT
3. INFECTION CONTROL
4. SAFEGUARDING
5. MEDICINES MANAGEMENT
6. TISSUE VIABILITY
7. PATIENT CENTRED CARE
8. NUTRITION & HYDRATION
9. PATIENT EXPERIENCE

Table 1

The following fundamental standards have been agreed for the Outpatient Departments (Table 2). Work has commenced on assessing every Outpatient Department against these seven fundamental standards. Although good progress is being made in implementing the fundamental standard process within these areas, there are still a number of reviews not yet completed. Therefore, in order to provide the Trust Board with a comprehensive review of each fundamental standard, in relation to each outpatient area, the results will be reported in Quarter Four`s Trust Board report.

Table to illustrate the Seven Fundamental Standards – Outpatient Areas

1. STAFF EXPERIENCE
2. PATIENT ENVIRONMENT
3. INFECTION CONTROL
4. SAFEGUARDING
5. MEDICINES MANAGEMENT
6. PATIENT CENTRED CARE
7. PATIENT EXPERIENCE

Table 2

2. ASSESSMENT PROCESS

A fundamental concept of the process is that it is objective; therefore, a number of the standards are conducted by speciality teams. For example, assessment of the Nutrition core standard is completed by the Dietetic Team and the Infection Control core standard by the Infection Prevention and Control Team. In addition, the methodology used during the assessment process is varied and includes:

- Observations of care given and patients' documentation
- Discussion with patients and staff members
- Discussion with the Ward/Department's Senior Sister/Charge Nurse

Following the assessment process, a rating is given (as illustrated below) for each fundamental standard depending on the percentage scored from the visit. Each of these carries a specific re-audit time period and this is incentive based; the higher the score, the less frequent the requirement to re-audit.

Score	Less than 80%	80% to 88%	89 to 94.9%	Above 95%
Frequency of Review	3 month review	6 month review	9 month review	12 month review

In order to ensure the process is both robust and reflects clearly the standard of care being delivered within a clinical setting, performance and outcome data are also used and triangulated with the information obtained during the assessment process.

This is of particular relevance when reviewed in relation to both the Infection Control and Tissue Viability Core Standards. The final ratings for these two standards are capped at 80% in the clinical area if either of the following two conditions applies:

- Scores Amber or above on the ward inspection (above 80%) but has had a hospital acquired harm in the previous six months, i.e. Hospital Acquired Clostridium difficile infection, MRSA Bacteraemia or an avoidable Hospital Acquired Pressure Ulcer
- Scores Red on the ward inspection but has not had hospital acquired harm in that category in the previous six months.

Following the review, the Ward Sister/Charge Nurse is required to formulate an action plan, within a two week time period. A copy of each review and action plan is then sent to the Senior Matron and Nurse Director responsible for that area to approve and endorse. Performance against each action plan is monitored through the Health Group's Governance Structures. In addition, it is a requirement that each action plan is discussed and progress reported and documented at monthly ward/unit meetings.

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in the **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard then the Ward Sister/Charge Nurse will have a discussion with their Senior Matron, with clear objectives set. If the ward gets a second consecutive 'Red' rating then the Senior Sister/Charge Nurse will have a discussion with the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse in order to determine what additional help/support and/or performance action may be required.

In an endeavour to strengthen further the `Ward to Board` concept, the Chief Nurse has introduced an additional panel, chaired by the Deputy Chief Nurse that reviews the performance of each ward against all of the Fundamental Standards in conjunction with each ward/department Senior Charge Nurse/Sister every six months. This purpose of this is threefold, essentially:

1. To ensure that good practice is disseminated and areas of concern are reviewed and addressed from a corporate perspective.
2. Identification of themes across the clinical services which require an organisational approach to resolve, for example issues relating to the nursing documentation.
3. Provide the Chief Nurse with independent assurance in relation to the level of delivery, understanding, consistency and ownership of each of the fundamental standards at ward/department level.

Transparency is deemed fundamental to improving standards of care. In an endeavour to embrace this concept, each of the ward/departments displays their individual results on a "How are we doing?" board (as illustrated below in Figure 1), for patients and relatives to view and as part of our drive to be more transparent and accountable to them for the standards on that ward. Each fundamental standard result is colour-coded according to the rating achieved and states "What we are doing well" and "Areas for improvement".

Ward 60's "How are we doing?" board

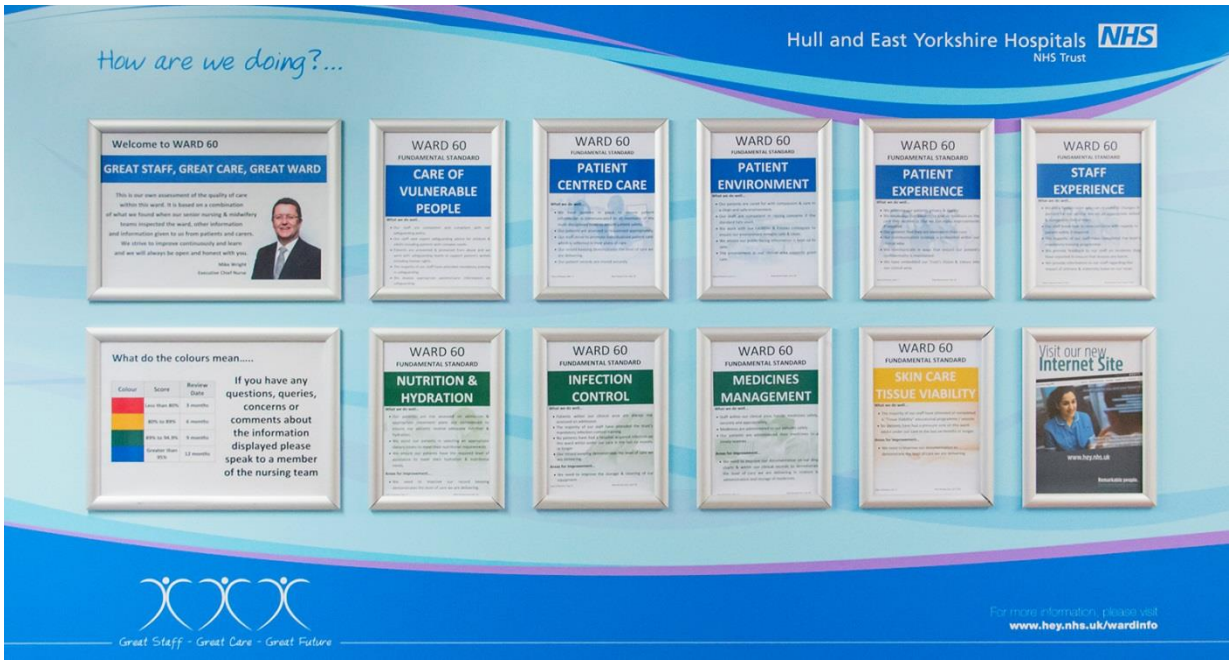


Figure 1

3. CURRENT POSITION

The results are shown for fifty two clinical areas. Firstly, Table 2 below illustrates the overall Trust position in relation to all of the ward fundamental standards as at the 31th December 2018 and the number of wards that are performing at each level.

Appendix One provides an overview of individual ratings by clinical area, where applicable. Please note that a number of the fundamental standards are not applicable within all clinical areas, for example, the nutritional fundamental standard is not completed on the Labour ward; this relates to the duration of time the women spend within this clinical setting.

Current Trust Position for all Ward Fundamental Standards: December 2018								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
30 wards	30 wards	9 wards	48 wards	19 Wards	15 wards	12 wards	14 Wards	42 wards
20 wards	17 wards	16 wards	4 wards	30 Wards	11 wards	23 wards	11 Wards	9 wards
2 wards	5 wards	26 wards	0 wards	3 Wards	20 wards	14 wards	14 Wards	1 wards
0 wards	0 wards	1 wards	0 wards	0 Wards	3 wards	2 wards	7 Wards	0 wards

Table 3

The following tables illustrate progress made in relation to each fundamental standard from June 2018 to December 2018, across the four Health Groups. In some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of the fundamental standard assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken currently and, as a priority, to address those fundamental standards rated Red.

3. STAFF EXPERIENCE

This standard focuses predominantly on the leadership capability within the area. It requires the Charge Nurse/Sister to demonstrate that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of the patients, being cared for in the clinical area. It requires the leader to demonstrate that they are promoting a `Learning Environment` where staff improve continually the care they provide by learning from patient and carer feedback, incidents, adverse events, errors, and near misses.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
4	2	2	3	5	4	3	**7**	9	9	5	**11**	5	5	5	**9**
2	2	3	2	5	6	7	**3**	7	5	11	**6**	12	12	12	**9**
0	2	1	1	0	0	0	**0**	1	3	1	**0**	2	2	2	**1**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Progress since June: 29 reviews have been completed during this period. There is one outstanding review but no Red-rated areas for this standard. The predominant rating for this standard has increased to Blue with 30 areas overall rated as Blue.

4. PATIENT ENVIRONMENT – this standard assesses whether clinical environments are clean and safe for our patients and that patients are cared for with dignity & respect.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
0	0	1	3	4	7	8	9	6	8	10	9	8	8	11	9
5	5	4	3	5	2	2	1	9	8	6	6	9	9	4	7
1	1	1	0	0	0	0	0	2	1	1	2	2	2	4	3
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since June: 28 reviews have been completed during this period. There are no areas rated Red. There has been an increase in Blue rated areas within Clinical Support and Family & Women's Health Groups. There is a slight increase in Amber rated areas in Surgery, which relate to failure to complete the required nurse cleaning at a weekend. Plans to address this issue are discussed under the infection control standard.

5. INFECTION CONTROL – this standard assesses the adherence of the clinical area to the Trust's Infection and Control policies.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
0	0	0	0	0	0	0	0	2	2	5	5	2	2	4	4
3	2	3	4	8	2	3	3	4	4	5	4	4	4	7	5
3	4	3	2	2	8	7	7	11	11	7	8	12	13	8	9
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1

Progress since June: 23 reviews have been completed during this period with 12 outstanding reviews for this standard this quarter. The Infection Prevention and Control Team has committed to completing these by the end of Quarter 4. There is one area rated Red within Medicine; its main area of non-compliance relates to members of the multi-disciplinary team (Doctors & Allied Health Professionals) not adhering to the "Five Moments of Hand Hygiene". Across all the Health Groups, the predominant rating remains Amber, although the numbers at this rating have reduced as the number of Green and Blue rated areas have increased. The main issue remains the failure to clean equipment consistently at weekends, although some areas have addressed this issue by pooling their ward hygienists so that wards have some cover over a weekend. The introduction of the new cleaning

contract has allowed work to commence on identifying how the hygienist's role can be realigned to provide greater cover over the week and weekend.

6. **SAFEGUARDING –** this standard assesses compliance of the clinical area with the local safeguarding policy to ensure that patients are protected from abuse, or the risk of abuse and their human rights are respected and upheld.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
6	6	6	6	8	10	10	10	18	17	16	16	13	17	15	16
0	0	0	0	2	0	0	0	1	0	1	1	5	2	4	3
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since June: 2 reviews have been completed during this review. There are 18 outstanding reviews for this standard. Therefore the majority of ward areas remain rated as Blue for this fundamental standard. There are no Red rated areas for this standard. The 4 Green rated areas within Surgery and Medicine relate to the ward areas not displaying the relevant patient information leaflets. The safeguarding team have put a plan in place to ensure all outstanding reviews are completed by the end of Quarter 4.

7. **MEDICINES MANAGEMENT –** this standard assesses whether staff within the clinical area handle medicines safely, securely and appropriately in accordance with the Trust's Policy and Procedures and that medicines are prescribed and administered to patients safely.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
0	0	2	3	7	7	5	7	6	3	4	4	5	5	5	5
4	5	3	3	2	3	5	3	6	10	13	12	8	5	8	12
2	1	1	0	1	0	0	0	5	4	0	1	6	9	6	2
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since June: 23 audits have been completed during this period. There is one outstanding review for this standard. There has been an increase in the number of Blue-rated ward areas within Clinical Support and Family & Women's Health Groups. There are no clinical areas rated Red for this standard. The improvements are related to sustained compliance in 24 hour monitoring of medication fridges and controlled drugs checks.

8. **TISSUE VIABILITY –** this standard assesses clinical staffs, knowledge and delivery of safe and effective pressure ulcer prevention.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
0	0	0	0	5	5	6	8	1	1	3	4	3	4	2	3
0	1	2	3	2	2	1	1	5	4	4	4	0	1	2	3
6	5	4	3	3	3	3	1	10	12	10	9	12	11	11	7
0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	3

Progress since June: 16 reviews have been completed during this period, with 17 outstanding reviews for this standard. There has been an increase in the number of Blue and Green-rated clinical areas within all the Health Groups. There are three Red-rated areas for this standard within Medicine. Given the current number of category 3 and 4 pressure ulcers being declared over the last quarter, the Chief Nurse commissioned a robust review of the fundamental standard related to tissue viability to ensure it incorporates all themes identified following the recent SI's investigations. The standard was reviewed by the Tissue

Viability Team and ratified at the Wound Management Committee in November 2018. The revised standard has been used since December 2018.

9. **PATIENT CENTRED CARE** – this standard assesses whether patients' clinical records are accurate, fit for purpose, held securely and remain confidential in accordance with the Trust`s policies and procedures.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
0	0	0	1	5	4	4	4	4	5	4	6	2	3	2	1
4	4	6	3	4	5	4	4	7	8	9	8	9	11	10	8
2	2	0	2	0	0	1	1	6	4	4	3	8	5	6	8
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2

Progress since June: 20 reviews have been completed during this period. There are 16 outstanding reviews. There has been a slight decrease in Green-rated scores within Clinical Support, Surgery & Medicine. There is one Red rated area for this standard within Medicine, which relates to a poor standard of assessment. In general there are no major concerns with this standard. Please note that this standard does not assess the documentation associated with, Nutrition, Infection Control and Tissue Viability as these are covered separately. Going forward, these audits will be undertaken by the Practice Development Team in order to ensure continuity, objectivity and the ability to further identify themes across the organisation relating to this fundamental standard.

NUTRITION – this standard assesses compliance with the Trust`s Nutrition and Hydration policy. It requires staff to demonstrate how they reduce the risk of poor patient nutrition and dehydration through comprehensive assessments, individualised care planning and implementation of care to ensure that patients are receiving adequate nutrition and hydration.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
1	1	2	5	2	3	4	3	5	3	3	4	1	3	2	2
2	4	4	1	2	2	1	2	7	8	5	4	8	7	4	4
3	1	0	0	2	2	1	1	5	5	7	6	4	3	6	7
0	0	0	0	1	0	1	1	0	1	2	3	4	3	4	3

Progress since June: 29 reviews completed during this period. There has been an increase in Blue-rated scores within Clinical Support & Surgery Health Groups. Overall, there has been a slight decrease in this standard over the last six months and it is the most challenging standard to achieve consistently high scores in. There has been a slight increase in the number of clinical areas rated as Red for this fundamental standard – 7 areas in total, which is regrettable. These areas need to improve their compliance in relation to the completion of the Food and Hydration charts.

To address the above issues, the Chief Nurse has commissioned a piece of work to review the current roles and responsibilities of both the nursing and catering teams, in relation to completion of the Food and Hydration chart. A task and finish group comprising representation from the Practice Development, Dietetic and Catering Teams are currently working with the ward catering and nursing teams on an educational package, which will allow the ward caterers to complete the food and hydration charts. Currently, the charts are completed consistently for the three meal services by the nursing staff, but two of the beverage and snacks rounds are performed by ward caterers. The plan is to educate the caterers in the importance of snacks in the hospitalised patient and how to complete the food and hydration form. This process will then be piloted on a number of clinical areas across the organisation; if successful, the process will be rolled out Trust-wide. In addition, the Chief Nurse requested for the Quality Improvement Plan (QIP) standard for nutrition to be

revised to ensure that the correct things are being measured and audited. This has now been attended to.

The Deputy Chief Nurse is meeting with the Charge Nurses and Senior Matrons of these areas to address the issues raised within their audits to ensure future compliance with this fundamental standard. In addition, the Dietetic Team has devised a robust educational package, which they are disseminating to all ward areas.

10. PATIENT EXPERIENCE – this standard assesses whether the clinical area has an active process of obtaining feedback from patients. That there is demonstrable evidence that practice is reviewed and changed where appropriate on the basis of patient feedback.

Clinical Support				Family & Women's				Surgery				Medicine			
Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18	Sep 17	Feb 18	Jun 18	Dec 18
3	2	2	6	5	7	6	8	7	11	9	14	6	7	9	14
3	3	3	0	5	3	4	2	10	5	5	3	9	6	5	4
0	1	1	0	0	0	0	0	0	1	3	0	3	6	5	1
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0

Progress since June: 26 reviews completed during this period. There are no Red-rated areas for this standard. There has been an increase in Blue-rated clinical areas for this standard across all the Health Groups and a reduction in Amber and Green-rated standards. There are no major concerns with this standard.

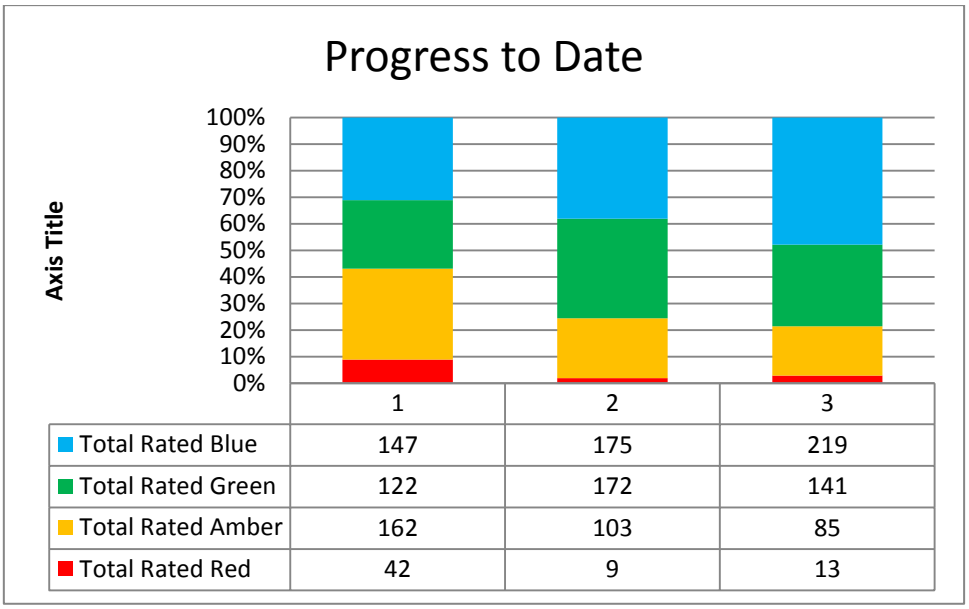
11. OVERALL POSITION:
42 of the 52 clinical areas reviewed have no Red Standards. Figures 2 illustrates the progress that has been made from a Trust perspective over the last six months in the increase in standards rated Blue and Green.

There are 13 standards rated as red, currently:

- 7 - Nutrition
- 2 - Patient centred Care
- 3 - Tissue Viability
- 1 – Infection Control

The breakdown of these is, as follows:

No. of Red Standards	Clinical Areas
One	Cedar, H7, H12, HICU, H200 (EAU), H80 (PDU), H11 & H70
Two	AMU
Three	H9



	1	2	3
Total Rated Blue	147	175	219
Total Rated Green	122	172	141
Total Rated Amber	162	103	85
Total Rated Red	42	9	13

Column 1: July 2016 / Column 2: June 2018 / Column 3: December 2018

Figure 2

The reduction in the total number of standards audited between 2016 and 2018, relates to the reconfiguration of a number of services, namely elective Orthopaedics and Critical Care.

12. AREAS FOR IMPROVEMENT

The Chief Nurse and his senior team continue to aim to eradicate red rated audit scores in the first instance and this will continue to be the objective. However, the standards have been devised to be intentionally robust and challenging to meet and sustain, with the ultimate objective of achieving outstanding patient care for each patient.

One key achievement that has arisen from this process is that the Ward Sisters/Charge Nurses, Senior Matrons and Nurse Directors take their accountability for the standards on their wards and departments extremely seriously.

Although elimination of all Red-rated fundamental standards has not been achieved fully, significant improvements have been made, as demonstrated in the charts above. The number of fundamental standards rated as Blue and Green have both increased to approximately 78% of the total (up from 76% in September 2018).

13. SUMMARY

Currently, there are four core fundamental standards with any Red ratings. These are: Nutrition, Tissue Viability, Infection Control and Patient Centred Care. A concentrated effort on improving this position remains a key priority of the Senior Nursing Teams.

14. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

- Receive this report
- Decide if any if any further actions and/or information are required.

Mike Wright
Executive Chief Nurse
January 2019

Appendix One – Overview Fundamental Standards December 2018

Appendix One: FUNDAMENTAL STANDARDS December 2018

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C7	99%	Jan 20	96%	Sept 19	87%	Jan 19	100%	Mar 19	89%	Mar 19	90%	Sept 19	89%	Feb 19	97%	Dec 19	97%	Dec 19
C29	97%	Jan 20	95%	Oct 19	91%	Jan 19	100%	Feb 19	93%	Sept 19	**89%**	Oct 19	**95%**	Sept 19	97%	June 19	95%	Oct 19
C30	95%	April 19	97%	May 19	**89%**	Dec 18	100%	Feb 19	96%	May 19	89%	Jan 19	93%	Jan 19	**93%**	Sept 19	97%	Aug 19
C31	83%	June 19	93%	Feb 19	80%*	May 19	100%	Mar 19	93%	Sept 19	83%	June 19	81%	Jan 19	95%	Sept 19	96%	Aug 19
C32	93%	Oct 19	91%	Feb 19	92%	June 19	100%	Mar 19	100%	May 19	88%	June19	**86%**	July 19	97%	June 19	97%	Dec 19
C33	94%	April 19	93%	July 19	**80%***	Mar 19	97%	Sept 18	96%	Dec 19	80%	Jan 19	92%	Jan 19	96%	Nov 19	98%	Dec 19

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	95%	Dec 19	95%	Sept 19	94%	Mar 19	97%	Nov 18	97%	Mar 19	98%	Jan 19	90%	Oct 18	95%	June 19	96%	Jan 20
Cedar H30	94%	Feb 19	95%	Sept 19	86%	Mar 19	97%	Oct 18	96%	Dec 19	97%	Jan 20	82%	Aug 19	60%	Feb 19	94%	Feb 19
H31Maple	90%	Feb 19	96%	Jan 19	**80%***	Mar 19	100%	Oct 18	93%	Oct 19	100%	Feb 19	100%	Jan 19	NA	NA	96%	Jan 19
H33Rowan	95%	Nov 19	91%	July 19	83%	Nov 18	100%	Nov 18	96%	Feb 19	100%	May 18	100%	Jan 19	NA	NA	100%	Jan 19
ACORN	96%	Mar 19	100%	Jan 19	80%	Nov 18	100%	Mar 19	92%	Oct 19	92%	April 19	90%	Oct 19	**90%**	June 19	97%	Mar 19
H35	98%	Nov 19	95%	Sept 19	80%*	Dec 18	96%	Feb 19	98%	Dec 19	96%	Jan 20	89%	Oct 18	88%	Jan 19	99%	Nov 19
H130	98%	Nov 19	97%	Nov 19	**85%**	Nov 18	100%	Mar 19	93%	Feb 19	97%	Jan 20	92%	Oct 19	**92%**	Sept 19	91%	Mar 19
Labour	91%	Aug 19	95%	May 19	**86%**	**Nov 18**	100%	Jan 19	96%	Nov 18	100%	Mar 19	100%	Jan 19	NA		98%	Jan 19
NICU	**95%**	Oct 19	95%	Sept 19	**94%**	Jan 19	100%	Mar 19	100%	Mar 19	96%	July 19			100%	June 19	97%	Mar 19
PHDU	97%	Mar 19	100%	Jan 19	**93%**	Dec 18	100%	Dec 18	100%	Jan 19	84%	Jan 19	97%	July 19	**97%**	Mar 19	97%	Dec 19

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C9	97%	Dec 19	97%	April 19	**80%***	Mar 19	91%	Dec 18	90%	July 19	**80%***	Oct 18	94%	Nov 18	**97%**	June 19	99%	Dec 19
C10	95%	Oct 19	97%	April 19	80%*	Mar 19	100%	Nov 18	94%	Mar 19	**86%**	Sept 18	86%	Oct 18	90%	Sept 19	100%	Oct 19
C11	98%	Oct 19	95%	Oct 19	85%	April 19	100%	Feb 19	94%	Mar 19	**96%**	Mar 19	83%	Sept 18	95%	Dec 19	94%	July 19
C14	97%	Oct 19	100%	April 19	80%*	Mar 19	96%	July 18	87%	April 19	**81%**	Oct 18	90%	Dec 18	94%	Mar 19	98%	Aug 19
C15	89%	April 19	93%	Feb 19	80%*	Nov 18	97%	July 19	94%	Jan 19	**80%***	Aug 18	96%	Jan 20	84%	Mar 19	94%	Oct 19
C27	97%	Feb 19	93%	Feb 19	94%	Jan 19	100%	Mar 19	93%	Mar 19	**80%***	Sept 18	94%	Sept 19	**92%**	Mar 19	97%	Oct 19
CICU1	96%	May 19	100%	Sept 19	95%	May 19	100%	May 19	100%	June 19	94%	Jan 19	96%	June 19	96%	May 19	100%	Feb 19
CICU2	98%	April 19	100%	Sept 19	93%	July 19	100%	May 19	100%	June 19	**92.3%**	Feb 19	98%	April 19	100%	May 19	95%	Aug 19

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	93%	Feb 19	83%	Jan 19	**97%**	Sept 19	97%	Dec 18	96%	Mar 19	**85%**	Oct 18	88%	Aug 18	**83%**	**May 19**	97%	Oct 19
H40	91%	Mar 19	93%	Feb 19	97%	April 19	95%	Dec 18	90%	Mar 19	**96%**	Jun 19	89%	Jan 19	**87%**	Mar 19	96%	July 19
H6	90%	Feb 19	93%	July 19	**80%***	Jan 19	97%	July 19	94%	Sept 19	**96%**	Mar 19	96%	Dec 18	**87%**	Feb 19	96%	Jan 19

H60	96%	Dec 19	96%	May 19	**94%**	Jan 19	100%	Mar 19	93%	Mar 19	**91%**	Jan 19	97%	Mar 19	**89%**	April 19	98%	Dec 19
H7	93%	Mar 19	93%	April 19	**90%**	Jan 19	100%	Mar 19	91%	Jan 19	**80%***	Sept 18	**94%**	Jan 19	**71%**	Mar 19	91%	April 19
H12	98%	Dec 19	95%	May 19	100%	April 19	97%	Dec 18	89%	Jan 19	95%	Jan 20	95%	Nov 19	**78%**	Jan 19	95%	Sept 19
H120	95%	Mar 19	93%	Feb 19	**95%**	April 19	100%	Feb 19	92%	Jan 19	**80%***	Sept 18	91%	Oct 19	**85%**	April 19	95%	Sept 19
H100	92%	April 19	87%	Jan 19	**80%***	Feb 19	100%	Jan 19	90%	Mar 19	**86%**	April 19	94%	Nov 18	87%	June 19	97%	Jan 20
HICU1 & 2	95%	Aug 19	100%	Nov 19	87%	July 19	97%	April 19	98%	Feb 19	92%	Feb 19	94%	Nov 18	**71%**	Jan 19	95%	Aug 19

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	97%	Oct 19	**93%**	July 19	88%	Nov 18	100%	July 19	94%	Sept 19	92%	June 19	**84%**	July 19	95%	Dec 19	97%	Oct 19
C26	94%	Sept 19	93%	Feb 19	89%	June 18	100%	Mar 19	95%	Dec 19	96%	Sept 19	90%	June 19	92%	Mar 19	90%	May 19
C5DU	91%	May 19	97%	Feb 19	80%*	Mar 19	97%	June 19	96%	Feb 19	100%	Sept 19	88%	Jan 19	100%	Mar 19	95%	Feb 19

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H200/EAU	95%	May 19	91%	July 19	**97%**	Mar 19	100%	Jan 19	93%	Sept 19	**94%**	Sept 18	56%	Mar 19	**82%**	Jan 19	96%	July 19
H5	95%	Oct 19	95%	Nov 19	**82%**	Oct 18	96%	Feb 19	92%	Sept 19	80%*	Oct 18	**91%**	Oct 18	**91%**	May 19	97%	Nov 19
H50	93%	April 19	87%	Feb 19	**95%**	Mar 19	93%	Dec 18	91%	Sept 19	**98%**	Feb 19	**94%**	Oct 18	**88%**	June 19	95%	July 19
H500	97%	Jan 19	82%	Feb 19	**80%***	Mar 19	100%	Dec 18	89%	Sept 19	**80%***	Oct 18	92%	Oct 18	**91%**	Jan 19	97%	Oct 19
H70	89%	Dec 18	96%	May 19	**81%**	July 19	100%	Nov 18	93%	Sept 19	**62%**	April 19	**92%**	Oct 18	**86%**	Jan 19	**93%**	May 19
H8	94%	June 19	95%	Oct 19	92%	Mar 19	**100%**	Feb 19	89%	Mar 19	80%*	Mar 19	84%	Jan 19	82%	Jan 19	95%	Sept 19
PDU/H80	98%	June 19	88%	April 19	**61%**	Dec 18	100%	June 19	89%	Oct 19	86%	Jan 19	87%	Aug 18	83%	Feb 19	91%	Feb 19
H9	93%	Oct 19	94%	July 19	80%*	Mar 19	90%	Feb 19	84%	June 19	72%	Dec 18	56%	Oct 18	**71%**	Jan 19	89%	Dec 19
H90	91%	Mar 19	97%	May 19	83%	Jan 19	90%	Nov 18	89%	Sept 19	**93%**	April 19	92%	Sept 18	88%	Feb 19	88%	Mar 19
H11	88%	Jan 19	**93%**	May 19	94%	Nov 18	97%	May 19	89%	Sept 19	**82%**	July 19	**80.1%**	July 19	**69%**	Mar 19	93%	July 19
H110	94%	une 19	**90%**	May 19	97%	Feb 19	100%	Jan 19	89%	Mar 19	**80%***	April 19	95%	July 19	87%	Feb 19	98%	Nov 19

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due			Rating	Next due			Rating	Next due
Majors ED	95%	Nov 19	**97%**	May 19	80%	Mar 19	100%	Dec 18	96%	Oct 19			85%	Mar 19			97%	Jan 19
Paeds ED	97%	June 19	**97%**	May 19	97%	Sept 19	100%	Mar 19	100%	Mar 19			90%	June 19			97%	Jan 19
Emergency Care	91%	April 19	**100%**	Nov 19	93%	June 19	97%	July 19	96%	May 19			88%	May 19			100%	Jan 20
AMU	96%	April 19	93%	Aug 19	80%*	July 18	97%	Feb 19	86%	April 19	**71%**	Nov 18	**84%**	April 19	**62%**	Mar 19	96%	Sept 19
H1	96%	July 19	95%	May 19	**91%**	Jan 19	97%	Oct 18	92%	Sept 19	80%*	Nov 18	**92%**	Jan 19	**92%**	July 19	97%	Sept 19

Scoring System	Above 95% 12 Month Review	89%- 94.9% 9 Month Review	80% - 88% 6 Month Review	Below 80% 3 Month Review	*Denotes capped

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
29th JANUARY 2019

Title:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS – MATERNITY INCENTIVE SCHEME – YEAR TWO**
Responsible Director:	Mike Wright - Executive Chief Nurse
Author:	Mike Wright, Executive Chief Nurse Janet Cairns, Head of Midwifery

Purpose	The purpose of this report is to provide information in relation to three aspects of maternity services, namely: • The standards required for year two of the CNST Maternity Incentive Scheme and the Trust's current and anticipated position in relation to complying with these standards • An update on Perinatal Mortality Reviews • Progress with meeting the four Saving Babies Lives Standards	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	• The new CNST incentive standards are likely to be more challenging to meet than last year • Good progress is being made towards achieving them but risks remain.	

Recommendation	The Trust Board is requested to: • Receive the update regarding the new CNST scheme and the proposal for future updates • Receive the review of perinatal deaths and the 'Saving Babies Lives update • Decide if any further information and/or assurance are required at this time.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD JANUARY 2019

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
MATERNITY INCENTIVE SCHEME – YEAR TWO

1. PURPOSE OF THE REPORT

The purpose of this report is to inform the Trust Board about the Trust's readiness to apply for a 10% reduction in its Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2019/20. This is the second year that NHS Resolution has run this initiative. An initial self-assessment has been undertaken by the Trust against the ten standards and this report provides the current position and future anticipated position alongside some risks to achieving this.

In order to meet these standards, NHS Resolution requires progress reports to be presented to the Trust Board. This is required in order to provide assurance and evidence of compliance.

At the point of final submission, the Trust Board will be required to approve a declaration form and this is required to be submitted by 12 noon on Thursday 15th August 2019.

This report is presents the following:

- Background
- The standards required for year two of the CNST Maternity Incentive Scheme and the Trust's current position in relation to complying with these standards
- Progress in relation to reviewing perinatal mortality in the Trust
- Progress with meeting the four Saving Babies Lives Standards
- Summary and Next Steps

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST). This is administered by NHS Resolution (formerly the NHS Litigation Authority). Due to the 'high-risk' nature of maternity services by definition, specific premia are calculated for these services.

The Trust Board is aware of the scheme that was introduced by NHS Resolution in 2018/19 whereby trusts were invited to apply for a 10% reduction in their CNST Maternity insurance premiums for that year (this would have been circa. £568k for this Trust in 18/19). In order to be successful, this required full compliance with all ten of the required standards. This Trust submitted compliance with eight out of the ten standards, with actions to address the outstanding two within a matter of months. The understanding at that time was that, trusts demonstrating only partial compliance would be allocated a proportional reduction dependent upon their level of compliance. This never really manifested, other than a £16k investment to support MDT training costs to meet one of the standards. It is understood that this process does not appear to have been applied consistently across all trusts and an appeal was lodged with both NHS Resolution and NHS Improvement to this effect. It is regrettable that these have not yet yielded any benefit to the Trust and it is now most unlikely that they will do so.

NHS Resolution has now launched Stage 2 of this scheme for this current financial year and the application process starts afresh. The Maternity CNST premium for the

Trust for 2019/20 is £4.71m. Therefore, the possible benefit to the Trust if all ten standards are met is £471k.

The standards have been augmented and now require much more detailed and very specific evidence in order to assure compliance. In addition, the Trust Board is required by NHS Resolution to be cited on the details of this and the Trust Board is required also to 'permit' the Chief Executive to sign the submission declaration on its behalf in August 2019. All of this will then be subject to external verification by the Care Quality Commission, NHS Digital, the National Neonatal Research Database and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths). Trust will then be notified if they have been successful.

4. THE MATERNITY INCENTIVE SCHEME – THE TRUST'S CURRENT POSITION

The ten standards, termed safety actions, are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the Avoiding Term Admissions Into Neonatal units Programme?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle (SBL)?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification (NHSEN) scheme?

The standards have not changed since the last submission. However, as mentioned previously, the evidence required and how this evidence is shared with the Trust Board is significantly different and is outlined in the following table. The Trust's maternity team has put in place a CNST action planning group, which meets weekly to review evidence and escalate issues or concerns.

Based on the evidence available currently, the Trust can demonstrate full compliance with only four out of the ten maternity safety actions at this point in time. This initial self-assessment has been validated by the Head of Midwifery, Clinical Lead for Maternity Services, Divisional General Manager, the Medical and Nurse Directors of the Family and Women's Services Health Group and the Chief Nurse as the Executive Maternity Safety Champion. The areas of non-compliance have actions in place to try and meet the required standards by noon on 15 August 2019, although risks to some of these still remain.

Safety Action	Requirements	Comments & Issues for Escalation	Time Frame & Board Request
1	4 elements to this standard **COMPLIANT**	Compliant with all required elements.	**December 2018 – August 2019** Quarterly reports to be received by the Trust Board that include details of deaths reviewed and action plans.
2	3 mandatory data fields to be completed and 14/22 optional data fields to be submitted **NOT COMPLIANT** Low Risk	The first publication of the Maternity Services Data Set indicates the Trust is Currently not compliant any of the mandatory elements. Compliant with 14/19 of the optional categories. Information services confident when the data is submitted for the assessment all mandatory elements will be compliant and at least 15/19 of the optional elements will be compliant	**31 March 2019** for data submission
3	4 elements to this standard **NOT COMPLIANT** Low Risk	Compliant with 2 out of 4 of the required elements. Requires and agreed action plan to address to address findings from Avoiding Term admissions to Neonatal Units (ATAIN) reviews	**10 March 2019** Action plan agreed at Board level and with Local Maternity System (LMS) and Operational Delivery Network (ODN) **19 May 2019** Progress with agreed action plans to be shared with the Board, LMS and ODN
4	2 elements to this standard **NOT COMPLIANT** High Risk	Proportion of trainees who lose training opportunities due to gaps in the rota as described in the General Medical Council National Training Survey. An action plan is required to address lost educational opportunities, which has to be agreed at Trust Board and submitted to the RCOG Board minutes to formally record the proportion of Anaesthesia Clinical Services Accreditation (ACSA) standards that have been met	**30 June 2019** Review of the GMC National Training Survey – 20 March 2018 – 9 May 2018 Proportion of trainees formally recorded in Board minutes. Approval of action plan to address lost opportunities <u>ACSA standards</u> 6 month period between January 2019 – June 2019. Board minutes to formally record the proportion of Approval of action plan to meet the ACSA standards
5	4 elements to this standard **NOT COMPLIANT** Low Risk	Birth Rate Plus has been undertaken Acquirement of BR+ acuity tool will monitor 2 elements Requirement for specific maternity issues to be included in the Board report	Bi Annual report to Trust Board outlining: Birthrate Plus® outcomes Planned versus actual staffing levels Midwife : Birth ratio Compliance with supernumerary status Red flag incidents
6	2 elements to this standard **COMPLIANT**	Saving babies Lives Care Bundle Compliance with all elements Carbon monoxide monitoring Management of reduced fetal movements Cardiotocograph Training	**July 2019** Report to the Trust Board demonstrating delivery of each element of the SBL care bundle
7	1 element to this standard **COMPLIANT**	Demonstration of user involvement to develop/improve maternity services	**August 15 2019** Board Declaration of assurance
8	1 element to this standard **NOT COMPLIANT** Low Risk	90% of each staff group to attend multi-professional in house training. Training year from August 18 August 19. Anaesthetic and ODP attendance to be monitored to ensure 90%	**August 15 2019** Board Declaration of assurance

9	3 elements to this standard NOT COMPLIANT Low Risk	Work around the Maternity and Neonatal Safety Collaborative will commence in April 2019. Safety Culture survey to be undertaken in February Opportunities to be given for staff to raise safety concerns	**August 15 2019** Board Declaration of assurance
10	1 element to this standard COMPLIANT	All cases reported to NHS Resolution Early Resolution Scheme	**1April 2018 – 31 March 2019** Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Early Resolution

5. FINANCIAL IMPLICATIONS

If the Trust is successful in its application, this will result in a circa £471k saving against its CNST contributions for 2019/20.

6. RISKS

As can be seen, the Trust is not compliant fully with 6 of the safety standards. These are being monitored on a weekly basis and progress will be escalated via the Health Group Business meeting. The majority of standards have been assessed as low risk for non-achievement. The risk for not achieving compliance is high in the following safety standard.

Safety Standard 4 – Medical Staffing

The risk is specifically in relation to non-compliance with the Anaesthesia Clinical Services Accreditation (ACSA) standards. The required standard is described as follows:

"1.2.4.6 – Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff. An elective caesarean section list is defined as a scheduled list, resourced separately from the general workload of the delivery unit, which requires a full theatre team and should include a consultant obstetrician and a consultant anaesthetist."

This element of the ACSA standards is not met as a consultant obstetrician is not available for each caesarean section list and junior doctors cover them mostly. In order to achieve this standard fully, this will involve investment to increase either the Programmed Activities (PA's) of the existing consultants in their job plans and/or investment in new Consultant posts. There is a consultant anaesthetist available at each caesarean list, unless on planned leave when this is then covered by junior doctors. This issue is being considered more carefully by the service before the final assessment can be made. However, it is possible that the Trust will meet this particular safety action by the August 2019 submission deadline.

7. ASSURANCE IN MEETING THE CNST MATERNITY SAFETY ACTIONS

This section of the report (7.1 ad 7.2) comprises information that the Trust Board is required to see in order to be able to comply with the evidential requirements of the Safety Actions.

7.1. Perinatal Mortality Review Tool (PMRT)

One of the pieces of evidence required for assurance of compliance is that the Trust Board is requested to have sight of a quarterly report, which includes details of perinatal deaths reviews and the consequent action plans. A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement Partnership to develop and establish a national standardised tool for this purpose. The PMRT has

been designed with user and parent involvement to support high quality standardized perinatal reviews. A multidisciplinary review group was established in 2018 to undertake perinatal reviews using the PMRT.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

At the conclusion of the multidisciplinary review, the team agrees the grading of care; the categories of which are, as follows:

Prior to the confirmation of the baby's death:

A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.

Following the conformation of the baby's death:

A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

7.1.1 Overview of Deaths Q3 2018/19

Perinatal Mortality Review Tool October – November 2018							
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	50576	Neonatal Death 23 weeks	24/10/18	10/01/18	To be completed	To be agreed	Delivered in Scarborough - Joint review with Scarborough
2	50316	Stillbirth 24 weeks	06/11/18	09/01/18	Yes	To be confirmed	For discussion at PMRT meeting 25/01/19
3	50655	Stillbirth 33 weeks	23/11/18	09/01/18	Yes	To be confirmed	For discussion at PMRT meeting 25/01/19
4	50653	Stillbirth 37 weeks*	25/11/18	09/01/18	Yes	**A/A**	For discussion at PMRT meeting 25/01/19
5	60492	Neonatal Death 24 weeks	15/12/18	10/01/18	Yes	Initial **C/B**	72-hour briefing report completed following initial PMRT review
6	50993	Stillbirth 27 weeks	23/12/18	09/01/18	Yes	To be confirmed	For discussion at PMRT meeting 25/01/19

In Q3 2018/19, there have been two neonatal deaths and four stillbirths. The PMRT has been commenced for all six cases and five families were informed by the Bereavement Midwife that a multidisciplinary review of their baby's care would take place. All parents were given the opportunity to provide information or raise concerns with regard to their care. One of the cases was a woman who gave birth at a neighbouring Trust (case one); the woman is being supported by their maternity services.

The multidisciplinary team reviewed case five as a matter of urgency; the team agreed the grading of care at C/B, and a briefing report is being prepared for the Chief Nurse and Chief Medical Officer for further consideration for escalation as a Serious Incident.

Perinatal mortality review has been undertaken for 100% of cases from 1 October 2018 to 31 December 2018. Action plans agreed from Q3 will be included in the Q4 report. Further monthly meetings have been planned for 2019 with capacity for urgent reviews if required.

7.2 Assurance – Saving Babies Lives Care Bundle

The Saving Babies Lives care bundle is aimed at reducing stillbirths in England through four intervention areas. Performance of trusts against these four interventions is monitored both at a regional and national level. The intervention areas are, as follows:

7.2.1 Reduce smoking in pregnancy

Every woman accessing maternity services should have a carbon monoxide (CO) reading recorded at booking and at 36 weeks (non-smokers) and at opportunistic contacts for smokers. This is undertaken by both midwives and midwifery assistants, who have received training. Currently, the senior midwives undertake record keeping spot checks 10 records per week.

Smoking rates are still over 20% at booking; only reducing to 18% at delivery. The Healthy Lifestyle Midwife works collaboratively with the smoke-free team to support women with smoking cessation. Women having serial scans due to smoking are booked on certain days. The smoke free team are in the scan department on that day to offer CO testing and support.

7.2.2 Growth Assessment Protocol (GAP)

In 2016 when GAP was implemented, all midwives received training. However, findings from the reviews of perinatal deaths identified a requirement for midwives and medical staff to undertake GAP refresher training and fundal height measurement peer assessments. There is currently **62.5%** compliance with this requirement. The trajectory is for 90% compliance by 31 March 2019. The Trust received funding from Health Education England for two midwives to undertake a 3rd trimester scanning programme, also. This will increase the capacity for required scans and ensure more timely reviews are undertaken.

7.3.3 Fetal Movements.

The service is fully compliant with the recommendations for reduced fetal movements and a recent audit that was undertaken in September 2018 indicated **81.7%** compliance with management of reduced fetal movements.

7.4.4 Effective fetal monitoring in labour

The service has an evidence based guideline for fetal monitoring in labour for midwives and obstetricians undertaking intermittent auscultation or electronic fetal monitoring in labour to ensure that the method of fetal assessment is appropriate to the overall clinical picture.

The training sources available are:

- Funding from HEE enabled 70 members of staff (midwives and doctors) to attend advanced CTG master class training facilitated by Baby Lifeline
- K2
- Royal College Obstetricians & Gynaecologists (RCOG) eLfH, online training
- Midwives Mandatory Training Day 2
- Any Perinatal Mortality / CTG teaching session in house
- Any external CTG study sessions

January 2019 CTG training for midwifery staff compliance is **87%**
January 2019 CTG training for medical staff is **85%**

There is a spot check of 10 sets of CTG' on a weekly basis assessing compliance with CTG standards. This is monitored weekly and issues addressed as they are identified.

Since the implementation of the Stillbirth Care Bundle, the maternity services have seen a reduction in stillbirths.

- April 2016 – March 2017 - total stillbirths = 25 11 over 37 Weeks
- April 2017 – March 2018 - total stillbirths = 17 10 over 37 Weeks
- April 2018 to date - total stillbirths = 14 8 over 37 weeks

8. SUMMARY

In summary, the Trust is aiming to achieve as many of the required Safety Standards as possible by the required deadline. The biggest risk to achieving these is in relation to Standard 4 and having a consultant obstetrician present at every elective caesarean section operating list. Further discussion will take place between the Executive Directors and the Health Group to identify whether it will be possible for the Trust to meet this standard. However, as it stands currently, it looks as if it might not be possible to achieve this within the required timeframes.

The new standards require Board oversight, assurance and endorsement on all of the evidence required before being able to submit the Trust's application. As such, it will be necessary to report further evidence to each Trust Board in Public between now and the July 2019 Trust Board meeting.

9. RECOMMENDATIONS

The Trust Board is requested to:

- Acknowledge the update regarding the new CNST scheme and the proposal for future updates
- Receive the review of perinatal deaths and the 'Saving Babies Lives update
- Decide if any further information and/or assurance are required at this time.

Mike Wright
Executive Chief Nurse

Janet Cairns
Head of Midwifery

January 2019

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	17 December 2018	**Chair:**	Prof M Veysey	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Serious Incidents – Maternity Serious Incident process was discussed
- Quality Improvement Programme – VTE, Deteriorating patient and nutrition were highlighted
- Integrated Performance Report – C Section rates, VTE, MRSA and Cancer performance was discussed
- Operational Quality Committee – Serious Incident learning from Health Groups to the wards was highlighted
- Quality Impact of CRES – An update position was received
- Workforce and People Strategy update was received
- The Annual Reports for Safeguarding Adults and Children and Young People were received
- Committee Effectiveness report – this was circulated for discussion at the January 2019 meeting
- Board Assurance Report – Quarter 3 position was presented

Decisions made by the Committee:

None required

Key Information Points to the Board:

There are some amber rated projects in the Quality Improvement Programme including VTE. This has been raised through the Operational Quality Committee for improvements to be made.

The Annual Reports for Safeguarding Adults and Children and Young People were received and provided positive assurance on the Trust's position and progress with safeguarding services during the year

Matters escalated to the Board for action:

None

Hull and East Yorkshire Hospitals NHS Trust
Minutes of the Quality Committee
Held on 17 December 2018

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Mrs J Ledger	Assistant Chief Nurse
	Ms K Rudston	Assistant Chief Nurse
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Ms C Ramsay	Director of Corporate Affairs
	Mrs M Stern	Patient Council Chair
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr M Wright, Chief Nurse, Dr M Purva, Interim Chief Medical Officer, Mrs A Green, Lead Clinical Research Therapist, Mr D Corral, Chief Pharmacist and Mr S Hall, Non-Executive Director	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting of 26 November 2018** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Prof Veysey and Ms Ramsay to meet to discuss the Quality Committee items for 2019/20. Mrs Walker requested that she also be included to help develop a programme for visitors attending the committee in the new year. She suggested this programme should centre around the patient journey. Patient and staff experiences to be captured without duplicating the work of the Patient Council.	
	3.2 Action Tracking List Mrs Bates had met with Mr Hall regarding the Quality Improvement Programme assurance and ratings. This to be removed from the tracker.	
	3.3 Any Other Matters Arising There was no other matters arising.	
	3.4 Workplan The Workplan was presented to the Committee. The 'Safety First' item to be replaced by 'Stop the Line' on the workplan.	**CR**
	4.1 Serious Incidents Mrs Bates presented the report and highlighted that there had been 55 serious incidents reported which meant that the Trust's figures were higher than last year.	

Mrs Bates reported that the new maternity Serious Incident process had commenced. HSIB went live on 3 December 2018 but as yet no incidents had been reported.

There had been no reported Never Events reported in the current financial year and 7 Serious incidents had been closed in November 2018.

Prof Jomeen asked if there was still concern around the new maternity review process and Mrs Bates advised that the teams would meet at the Commissioners meeting in January 2019 to discuss the reporting tool and timescales.

Mrs Walker asked about the emerging theme of deteriorating patients and a specific case involving a patient with learning difficulties. Ms Rudston advised that the incident took place out of hours and the pathway was being reviewed to ensure a quicker response, support and guidance was received.

Mrs Walker was also keen to learn more about the ongoing issues relating to the Service Level Agreement with Humber FT and Ms Rudston suggested that her and Mrs Walker meet separately to discuss such matters in more detail.

The Committee discussed improvements to be made and a system wide approach was required. Ms Rudston stated that work with the CCGS and the GPs was key.

Resolved:
The Committee received and accepted the report.

4.2 Quality Improvement Programme
Mrs Bates presented the report and spoke about reviewing the nutrition QIP and how it was being measured. Mrs Ledger added that the milestones would be updated with more relevant measures put into place.

There was a discussion around the deteriorating patient and how this would be reviewed in line with NEWS 2 being established by the end of March 2019. NEWS 2 was designed to capture from the baseline and flag up serious changes. Mrs Ledger added that escalation and management plans would also be reviewed.

VTE was showing improvements and would be compliant by March 2019.

Resolved:
The Committee received and accepted the report.

5.1 Integrated Performance Report
The Committee discussed the report and highlighted VTE as an improving picture and that had been a reported MRSA bacteraemia.

Mr Snowden asked about the upward trend of C Sections. Mrs Bates advised that the threshold was low for the Trust at 12.1% against the national average of 18%. She added that a key driver of the upward trend was patient choice.

Mrs Bates spoke about the pressured cancer service and the lack of haematologists, but added that diagnostic waits were improving. All issues were being escalated through the risk registers and to the Cancer Alliance.

Resolved:
The Committee received and accepted the report.

5.2 Operational Quality Committee Report
Ms Ramsay reported that there had been detailed discussions regarding Serious Incidents and how the Health Groups manage them and share learning.

Mrs Ledger added that each Health Group was receiving nutrition feedback to ensure the key messages were shared with all staff.

Work was ongoing regarding Outpatients and Mrs Henderson had presented a report to the Performance and Finance Committee to provide governance arrangement and assurance.

Resolved:
The Committee received and accepted the report.

5.3 Clinical Assurance of CRES
Mrs Ledger presented the item and reported that one scheme relating to Band 6 nurses in ward areas was currently being Quality Impact Assessed.

The process was ongoing to review any schemes that might impact on quality. There were no current schemes to highlight.

Resolved:
The Committee received and accepted the update.

5.4 Workforce/People Strategy update, (new roles, recruitment, areas of concern)
Ms Ramsay presented the report which had been written by the Director of Workforce and OD. She highlighted the new roles to fill vacancies and the positive progress in recruitment.

There was a discussion around who staff see as their manager and their understanding of the communication chain. Mrs Ledger stated that work was ongoing with staff to understand engagement, how staff who are working above and beyond are feeling and staff morale in general.

Mrs Stern added that in her experience, if a nurse was well cared for they would provide better care. It was important for all staff to be looked after and offered support where necessary. Mr Snowden added that the Junior Doctors on call accommodation was also being reviewed by the Charitable Funds Committee.

Mr Snowden stated that a Staff Safety Thermometer could be developed to help with ensuring staff were well cared for and felt valued.

Mrs Walker asked that the biggest risks or the items with the most impact be highlighted more clearly in the next report.

Resolved:
The Committee received and accepted the report.

5.5 Safeguarding Annual Reports
Ms Rudston presented the Safeguarding Adults report and highlighted that it did not include information regarding the new Mental Health Quality Improvement Plan and that Vanessa Walker was the Non- Executive lead. These items would be added into the report before final approval.

Ms Rudston advised that lots of work had been carried out to achieve key objectives and that the PREVENT training compliance was now over 80%.

There had been a number of regulatory visits and interviews and actions had been delivered. NHS Improvement would be issuing Learning Difficulties guidance which would ensure robust statements and training for staff.

Ms Rudston advised that the Trust held information on activity which allowed the practitioners to give support and guidance. Trends were being tracked and the quality of referrals monitored to allow for intelligence testing.

Ms Rudston highlighted the summary of work planned for 2018/19 and key areas such as domestic abuse and learning difficulties and the work ongoing with the local authorities. Mrs Walker agreed to discuss referral responses with the local authorities and enhance partnership working.

The Trust was participating in a Differently Enabled event at the Bonus Arena in February 2019 which would be a multi partner conference.

There was a discussion around domestic abuse and the support staff are given. Ms Rudston advised that work was ongoing with Occupational Health to ensure staff knew that support was available, as well as awareness campaigns being highlighted.

Mr Snowden expressed his concern regarding the neglect figure highlighted in the report and Ms Rudston advised that this was being reviewed.

Prof Jomeen commended the teams on the amount of work they had achieved and their future goals.

Safeguarding Children and Young People
Ms Rudston also presented the Children and Young People report and highlighted the difficulties faced when recruiting to a named safeguarding doctor. The role was challenging and unique but work was ongoing to recruit to the post.

Work was ongoing to provide a nurse lead and forensic nurse roles and referrals to social care was showing positive results.

Ms Rudston also advised that the Anlaby Suite had been successfully moved and she would be having an open afternoon in January 2019 for staff to see the new facility.

Mr Snowden requested a wording change in item 10.1.

Prof Veysey congratulated Ms Rudston on the quality improvements and

stated how impressed the Committee were. Ms Rudston agreed to pass on the messages to the teams.

Copies of the final reports would be available for the Committee members.

Resolved:
The Committee received and accepted the report.

5.6 Committee Effectiveness Review
The report was circulated for discussion at the January 2019 meeting. **CR**

6 Board Assurance Framework
Ms Ramsay presented the report and reported that the quarter 3 update position had been captured and would be presented at the January Board meeting.

Ms Ramsay added that the Performance and Finance Committee were also discussing quality of care linked to the waiting list, 62 day and RTT.

Resolved:
The Committee received and accepted the report.

7 Any Other Business
There was no other business discussed.

8 Chairman Summary of the Board
Prof Veysey would summarise the meeting at the January 2019 Trust Board.

9 Date and time of the next meeting:
Monday 28 January 2019, 9am – 11am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2018/19

January 2019

December data

The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined in the NHS Improvement – Single Oversight Framework. This has been updated in August 2017. The draft proposal location is https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/

RESPONSIVE

Description	Aggregate Position	Trend	Variation

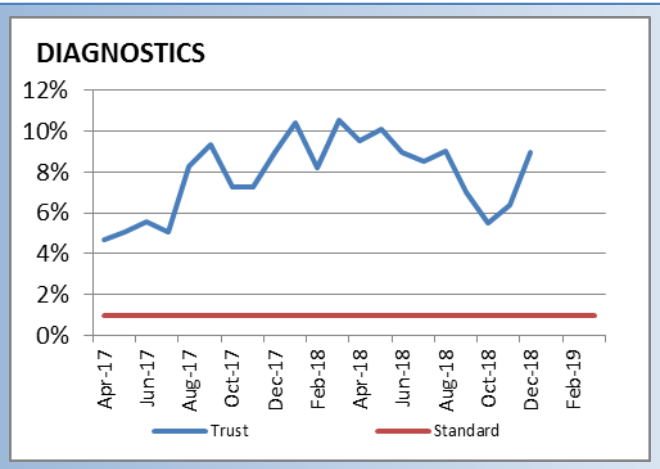
Diagnostic Waiting Times: 6 Weeks

All diagnostic tests need to be carried out within 6 weeks of the request for the test being made

The target is less than 1% over 6 weeks

The latest performance available is December 2018

Diagnostic waiting times has failed to achieve target during December with performance of 8.94%



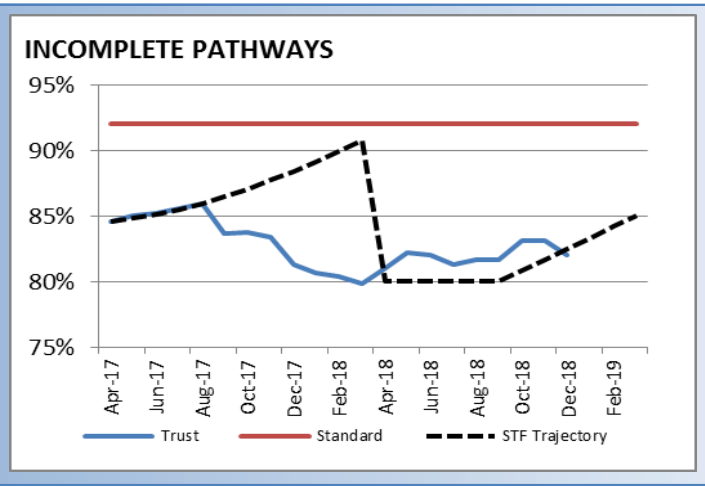
Referral to Treatment Incomplete pathway

Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%

The latest performance available is December 2018

The Trust failed to achieve the December improvement trajectory of 82.5%

December performance was 81.99%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 8 specialties that failed to meet the STF trajectory

RESPONSIVE

Description	Aggregate Position	Trend	Variation

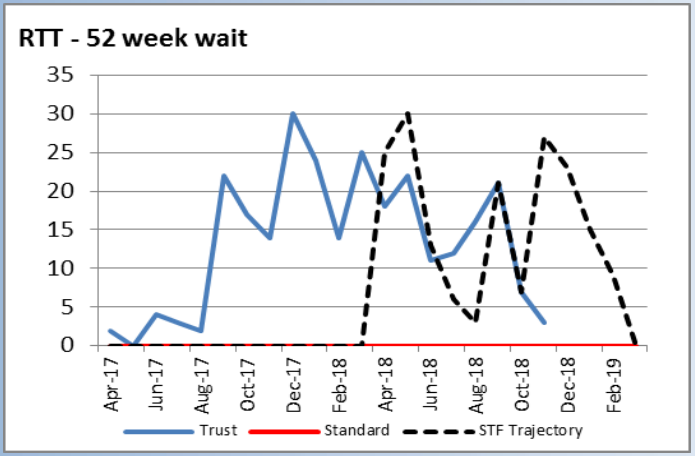
Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The 52 weerk wait STF Improvement trajectory was revised 21st November 2018.

Performance achieved the December improvement trajectory of 23 breaches with 4 breaches during December

The Trust failed to achieve the national standard of zero breaches.

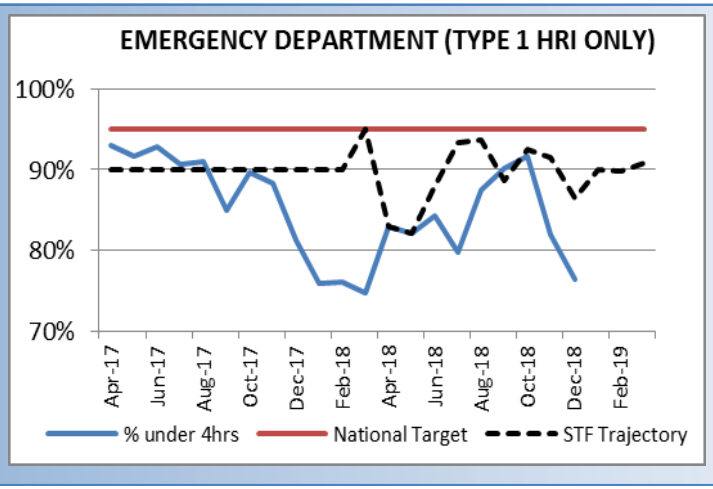


ED Waiting Times (HRI only)

Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

The ED STF Improvement trajectory was revised 20th July 2018. Performance failed to achieve the revised trajectory of 86.5% with performance of 76.4% for December.

This has failed to achieve the national 95% threshold.



Performance has decreased 5.5% during December from the November position.

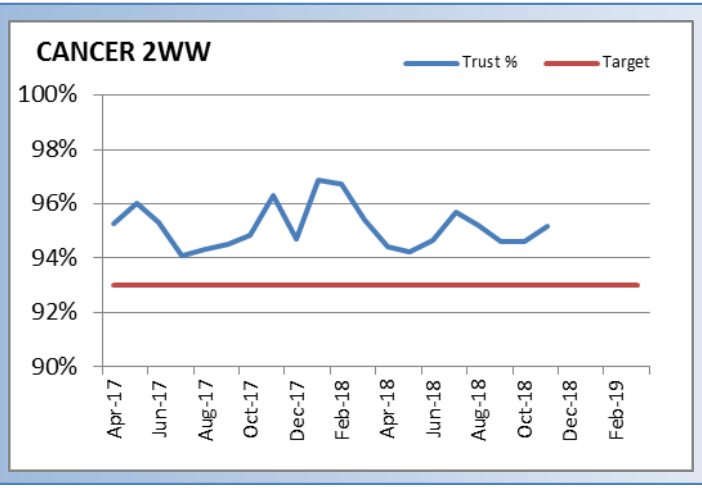
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: Two Week Wait Standard

All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.

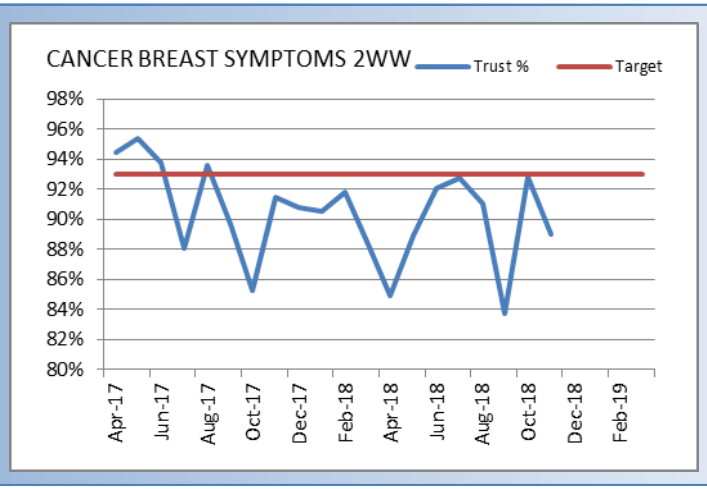
November performance achieved the 93% standard at 95.2%



Cancer: Breast Symptom Two Week Wait Standard

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

November performance failed to achieve the 93% standard at 89.0%



Integrated Performance Report - January 2019

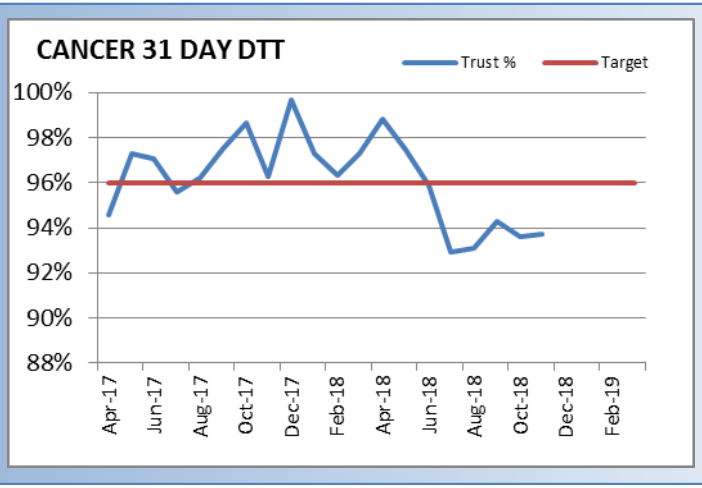
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Standard

All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.

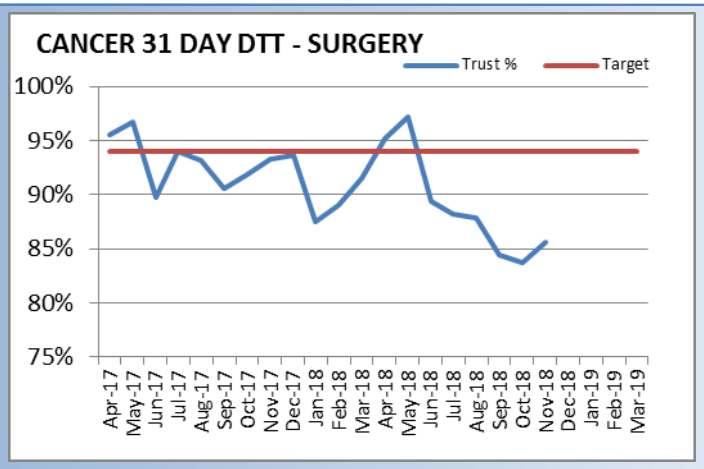
November performance failed to achieve the 96% standard at 93.7%



Cancer: 31 Day Subsequent Surgery Standard

All patients to receive first treatment for cancer subsequent radiotherapy within 31 days of decision to treat. Threshold of 94%.

November performance failed to achieve the 94% standard at 85.6%



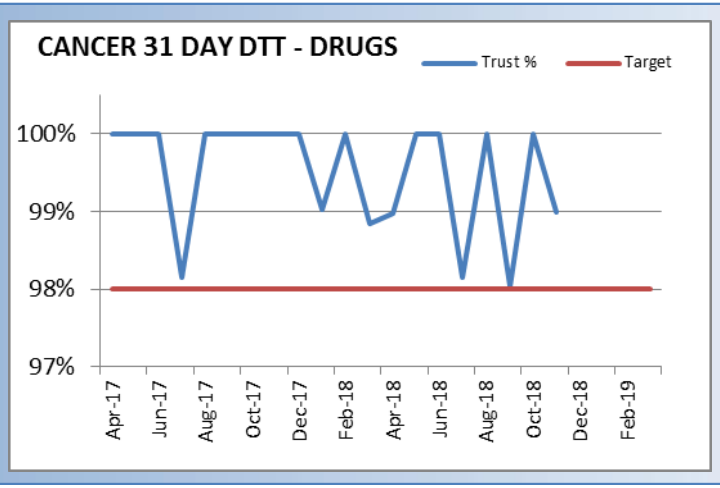
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Drug Standard

All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days of decision to treat. Threshold of 98%.

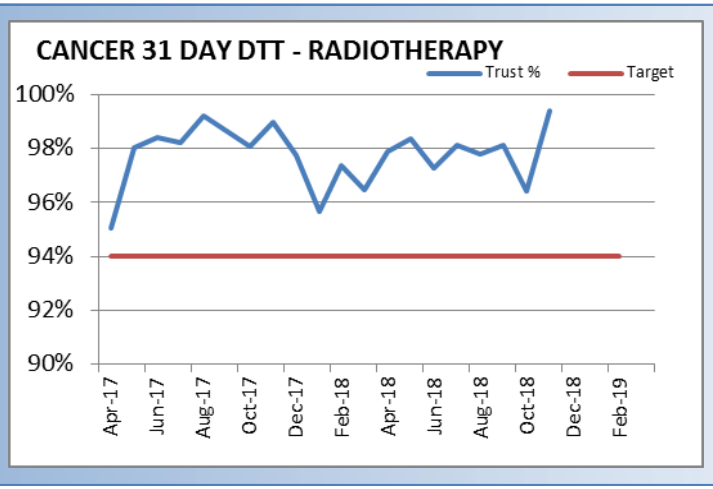
November performance achieved the 98% standard at 99.0%



Cancer: 31 Day Subsequent Radiotherapy Standard

All patients to receive first treatment for cancer subsequent radiotherapy within 31 days of decision to treat. Threshold of 94%.

November performance achieved the 94% standard at 99.4%



RESPONSIVE

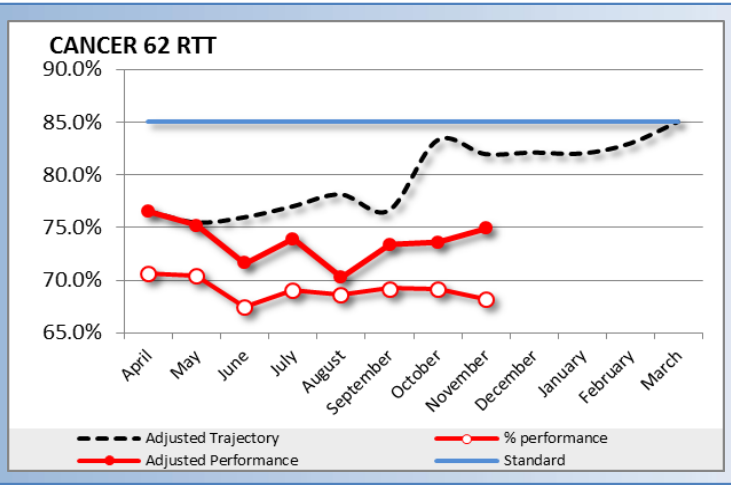
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%

The adjusted position allows for reallocation of shared breaches

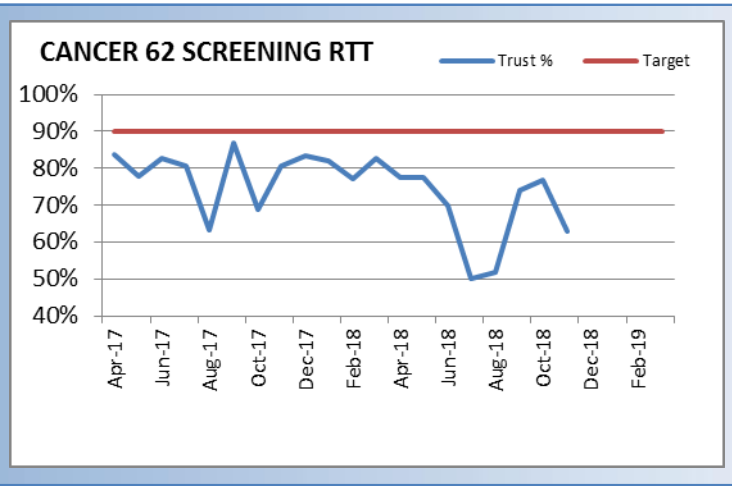
November adjusted performance failed to achieve the STF trajectory of 82.0% with performance of 74.9%



Cancer: 62 Day Screenjng Standard

All patients need to receive first treatment for cancer within 62 days of urgent screening referral. Threshold of 90%

November performance failed to achieve the 90% standard at 62.9%



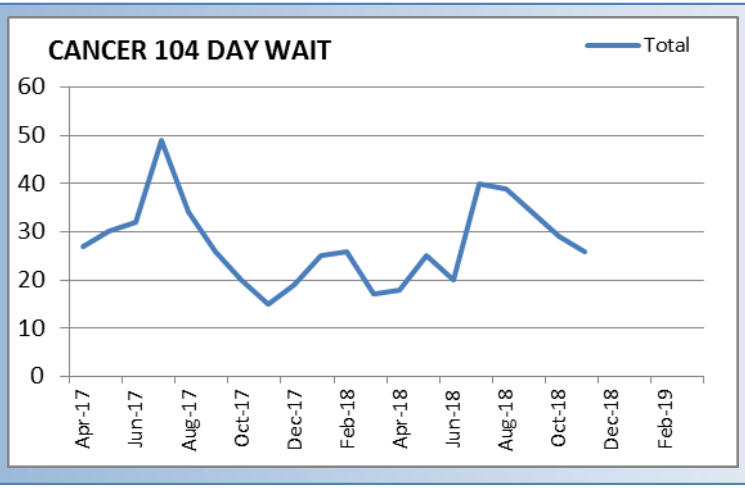
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 26 patients waiting 104 days or over at the end of November



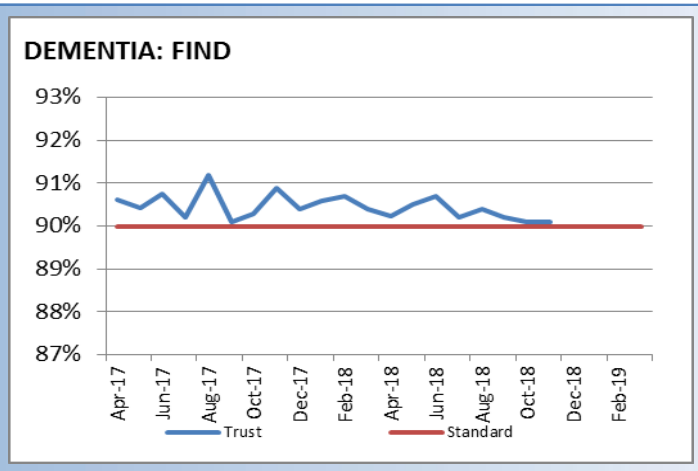
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of all patients asked the dementia case finding question within 72 hours of admission, or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question cannot be completed for clinical reasons.

The latest performance available is November 2018.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 90.10%



RESPONSIVE

Description	Aggregate Position	Trend	Variation

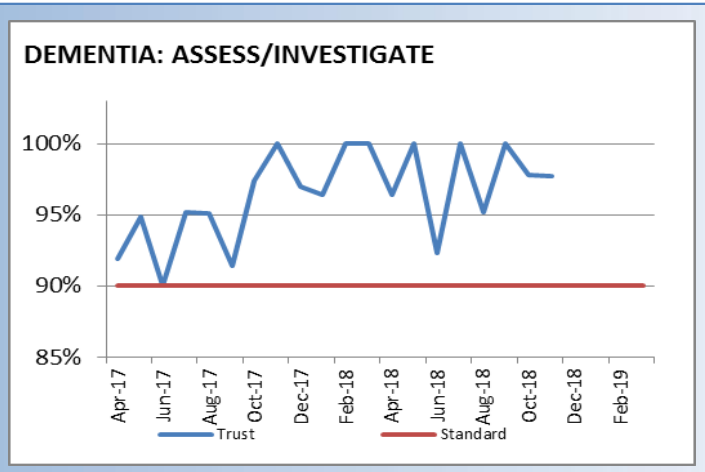
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of patients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations.

The latest performance available is November 2018

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 97.7%



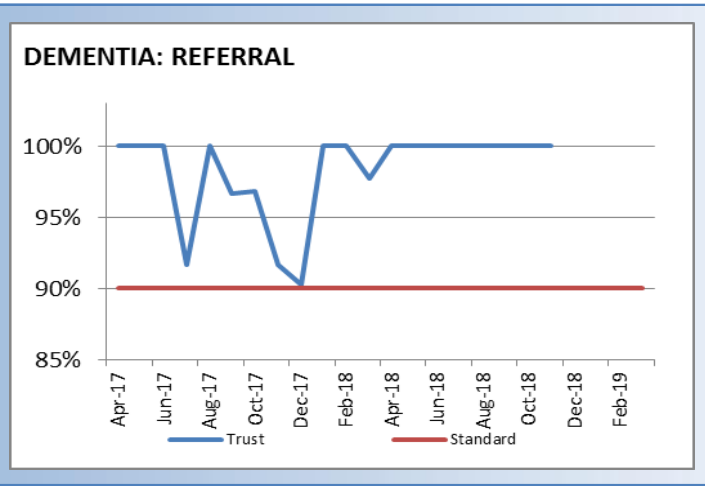
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of patients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.

The latest performance available is November 2018.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 100%



SAFE

Description	Aggregate Position	Trend	Variation

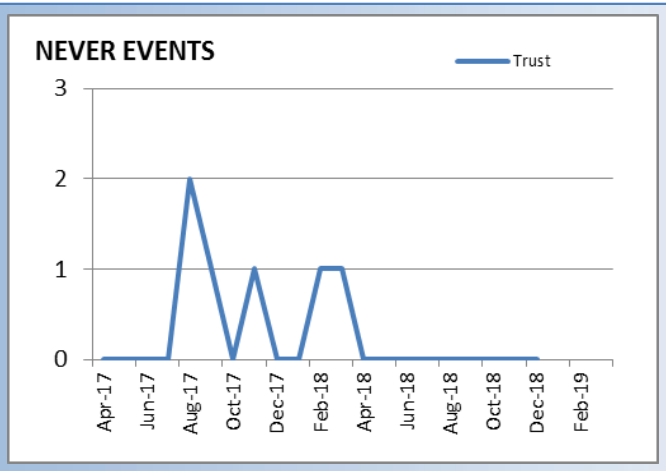
Occurrence of any Never Event

Occurrence of any Never Events

The latest available performance is December 2018

The Trust reported 6 Never Events in 2017-18

There were no cases reported during December 2018.



Further information is included in the Board Quality report

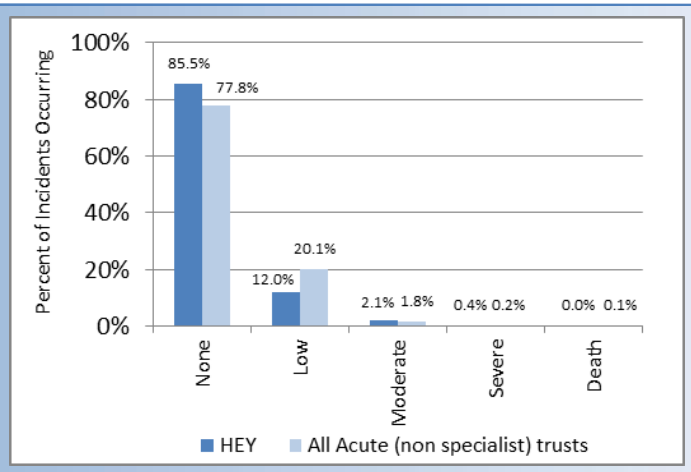
Potential under-reporting of patient safety incidents

Number of incidents reported per 1000 bed days

The latest data available for this indicator is October 2017 to March 2018 as reported by the National Reporting and Learning System (NRLS).

The Trust reported 8,691 incidents (rate of 51.29) during this period. This rates the Trust in the highest 25% of reporters

April to September position will be available in March 2019



SAFE

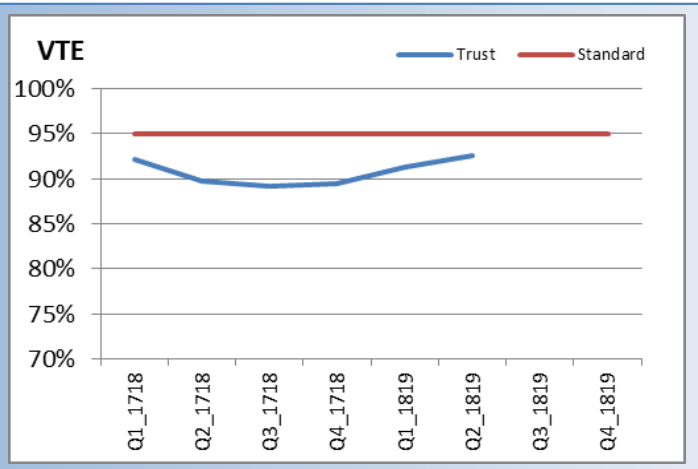
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 92.61% for Q2 2018/19.

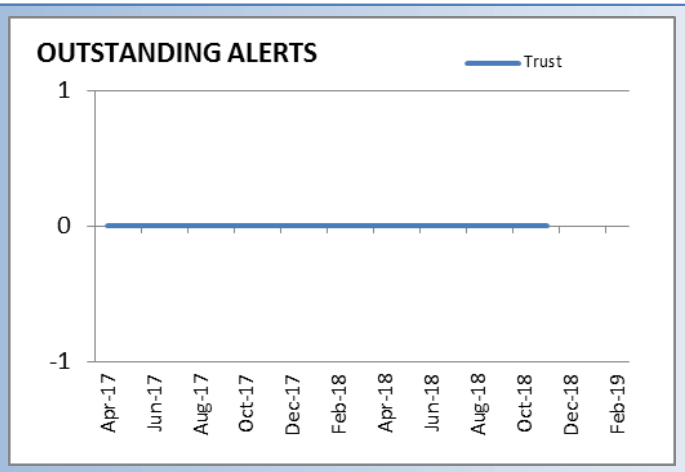


Patient Safety Alerts Outstanding

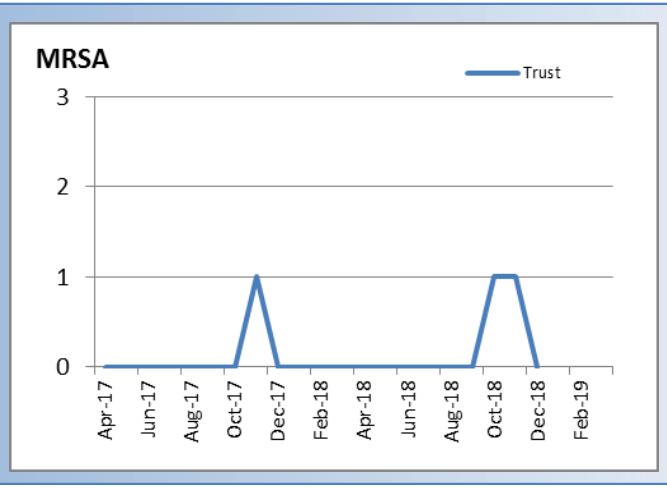
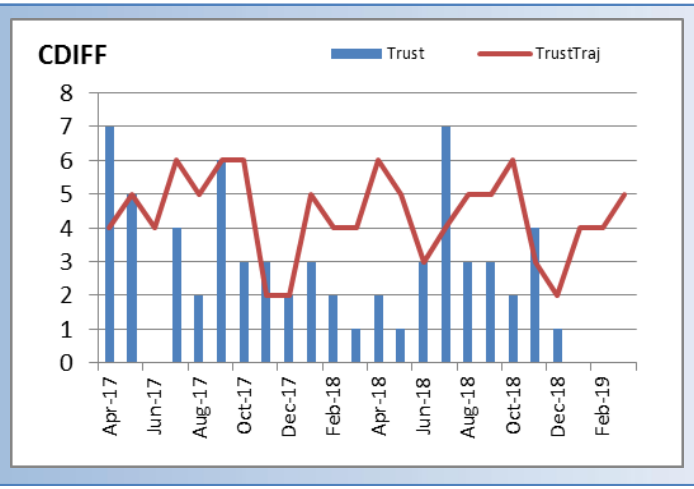
Number of alerts that are outstanding at the end of the month

There have been zero outstanding alerts reported at month end for December 2018.

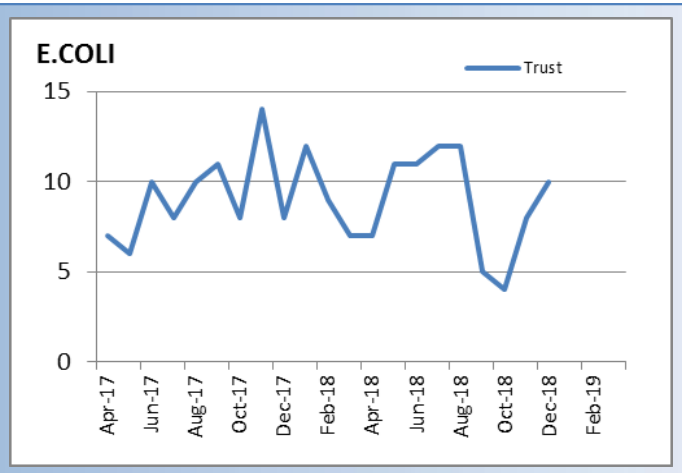
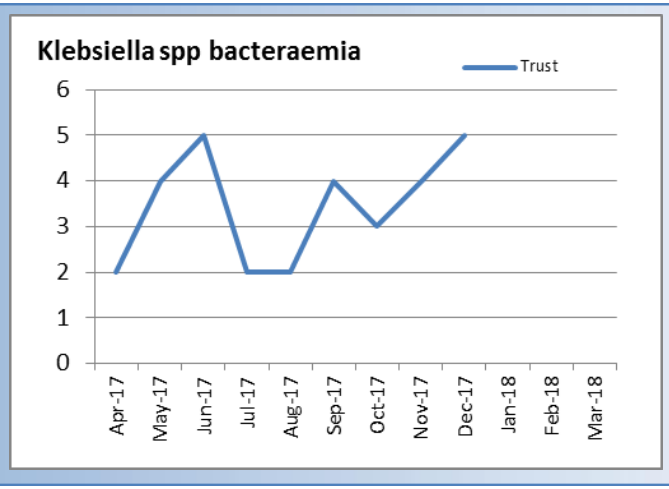
There have been no outstanding alerts year to date.



SAFE

	Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust reported 1 case of acute acquired MRSA bacteraemia during 2017/18. There were no cases reported during December 2018. There have been 2 cases reported year to date.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2018/19 is no more than 52 cases	There were 38 cases during 2017/18 There was 1 incident reported during December which achieved the monthly trajectory of no more than 2 cases		Further information is included in the Board Quality report

SAFE

Description	Aggregate Position	Trend	Variation
Escherichia Coli	Number of incidence of E.coli bloodstream infections	There were 110 cases during 2017/18 There were 10 incidents reported during December 2018.	
Klebsiella spp bacteraemia	Number of incidence of Klebsiella spp bacteraemia	There have been 31 incidents reported year to date.	

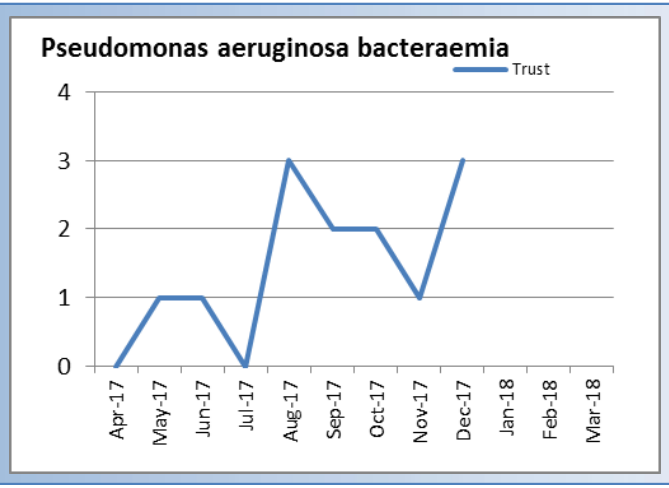
SAFE

Description	Aggregate Position	Trend	Variation

Pseudomonas aeruginosa

Number of incidence of Pseudomonas aeruginosa bacteraemia

There have been 3 incidences reported during December 2018.

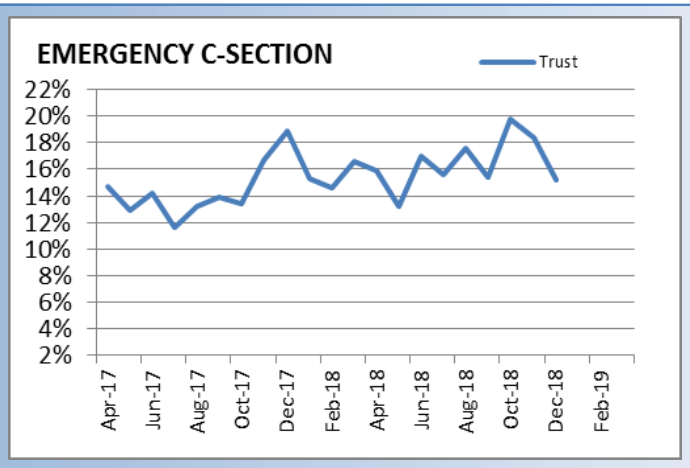


Emergency C-section rate

Maternity: Emergency C-section rate per month

The Trust aims to have less than 12.1% of emergency C-sections

Performance for December failed to achieve this standard at 15.2%



Further information is included in the Board Quality report

EFFECTIVE

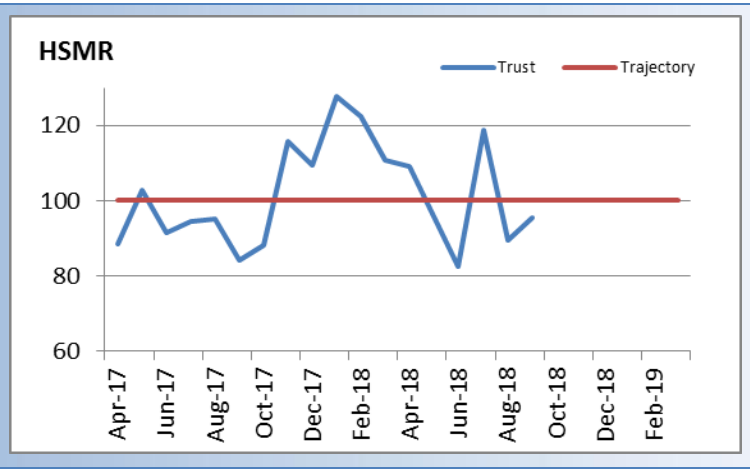
Description	Aggregate Position	Trend	Variation

HSMR

HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups

September 2018 is the latest available performance

The standard for HSMR is to achieve less than 100 and September 2018 achieved this at 95.6

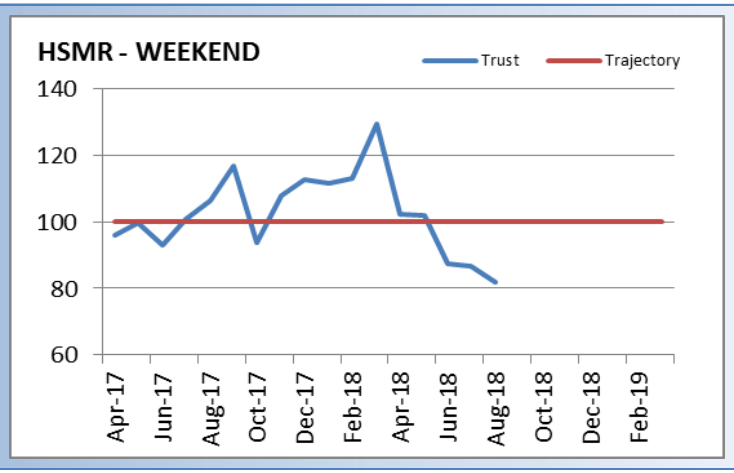


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

September 2018 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and September 2018 achieved this at 82.4



EFFECTIVE

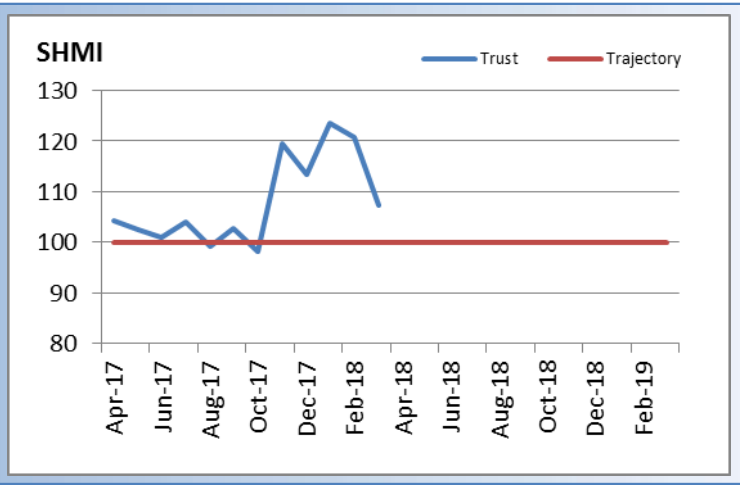
Description	Aggregate Position	Trend	Variation

SHMI

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

March 2018 is the latest published performance

The standard for SHMI is to achieve less than 100 and March 2018 failed to achieve this at 107.4

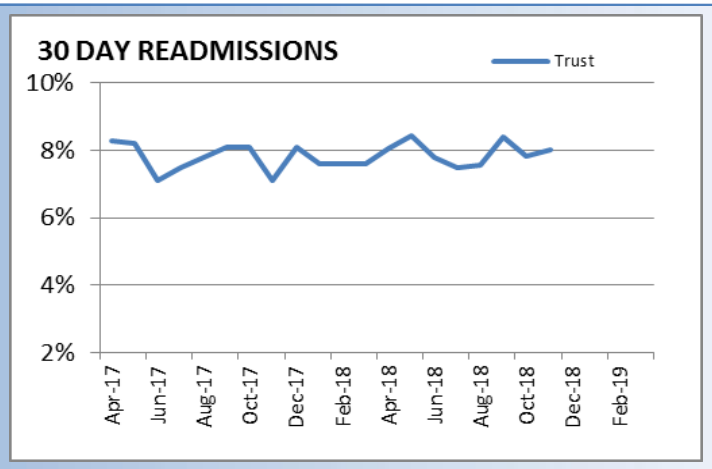


30 DAY READMISSIONS

Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is November 2018

The Trust should aim to achieve less than or equal to 2017/18 performance of 7.8%. The Trust failed to achieve this measure with performance of 8.03%.



Integrated Performance Report - January 2019

CARING

Description	Aggregate Position	Trend	Variation

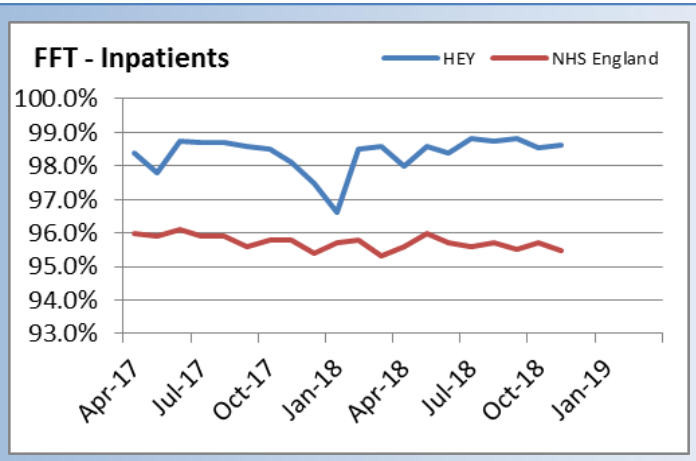
Inpatient Scores from Friends and Family Test - % positive

Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for November was 98.61%

The latest published data for NHS England is November 2018.

December performance will be published on 7th February 2019.



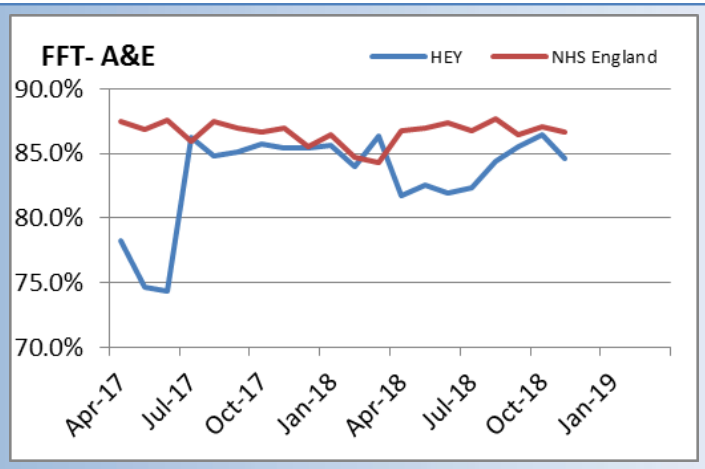
A&E Scores from Friends and Family Test - % positive

Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for November was 84.55%

The latest published data for NHS England is November 2018.

December performance will be published on 7th February 2019.



Integrated Performance Report - January 2019

CARING

Description	Aggregate Position	Trend	Variation

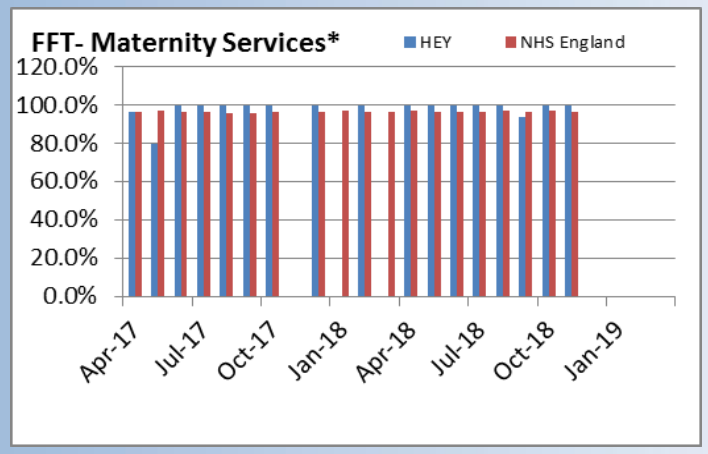
Maternity Scores from Friends and Family Test - % Positive

Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for November was 100%

The latest published data for NHS England is November 2018.

December performance will be published on 7th February 2019.

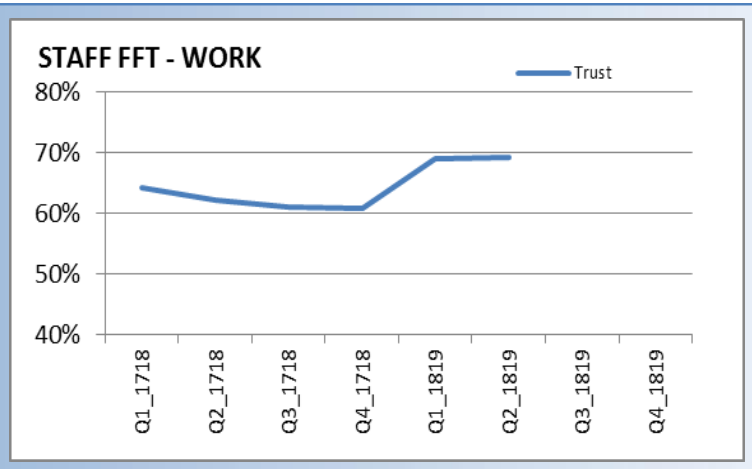


* Question relates to Birth Settings

Relative Position in Staff Surveys

Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?

Performance for Q2 shows 69.1% of surveyed staff would recommend the Trust as a place to work, this has improved slightly from the Q1 position of 68.9%.



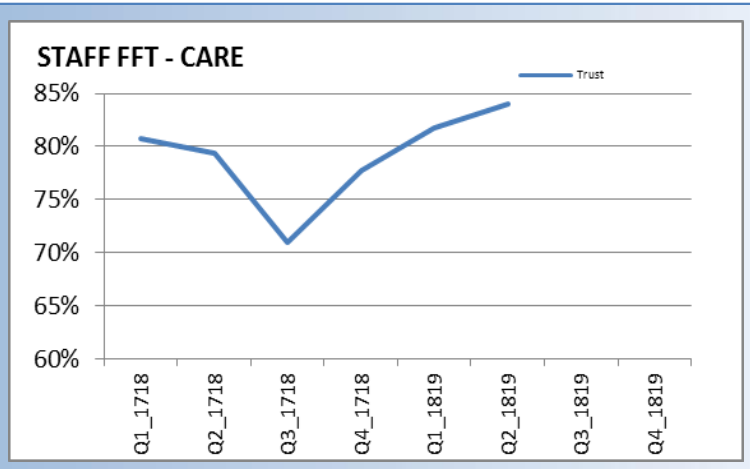
CARING

Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?

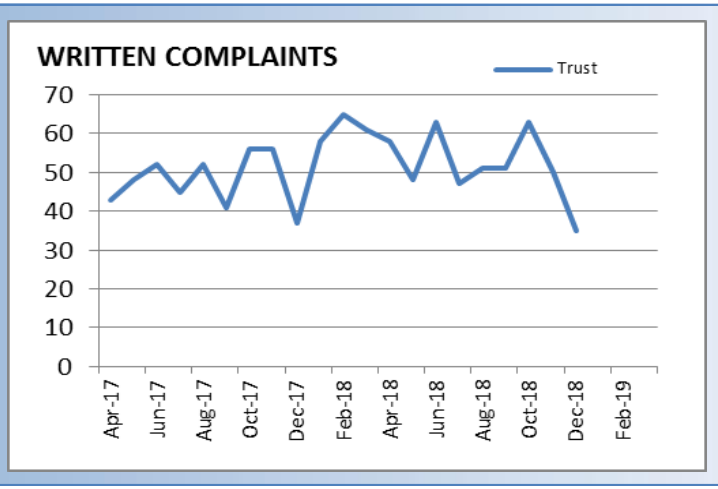
Performance for Q2 shows 84.0% % of surveyed staff would recommend the Trust as a place to receive care/treatment, this has increased from the Q1 position of 81.8%.



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 35 complaints during December, this has decreased from the November position of 50 complaints



There have been 466 complaints year to date

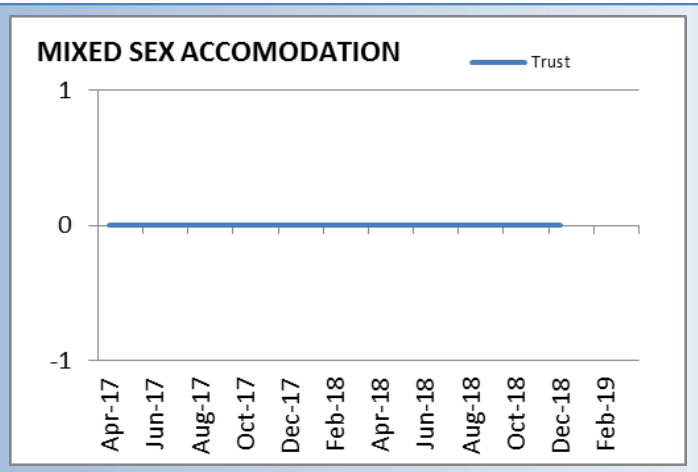
CARING

Description	Aggregate Position	Trend	Variation

Mixed Sex Accommodation Breaches

Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.

There were no occurrences of mixed sex accommodation breaches throughout December 2018.

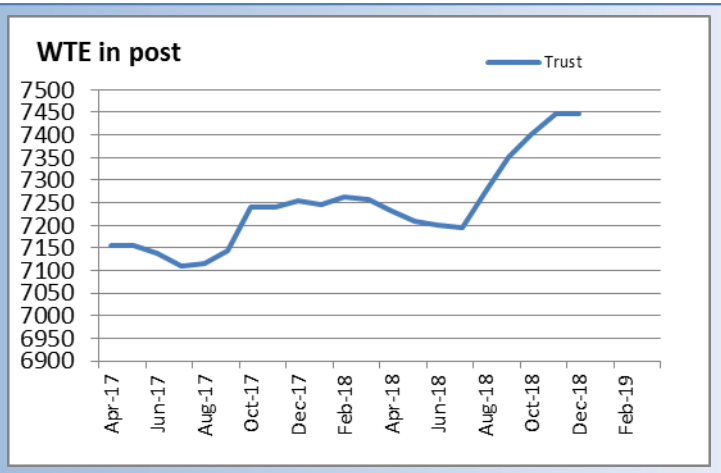


Description	Aggregate Position	Trend	Variation

WTEs in post

Contracted WTE directly employed staff as at the last day of the month

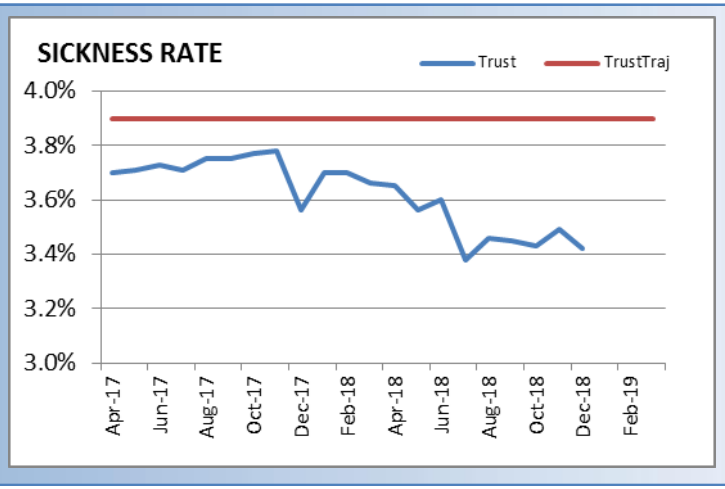
Trust level WTE position as at the end of December was 7447



Sickness Absence Rates

Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.

Performance for December achieved the standard of less than 3.9% with performance of 3.42%



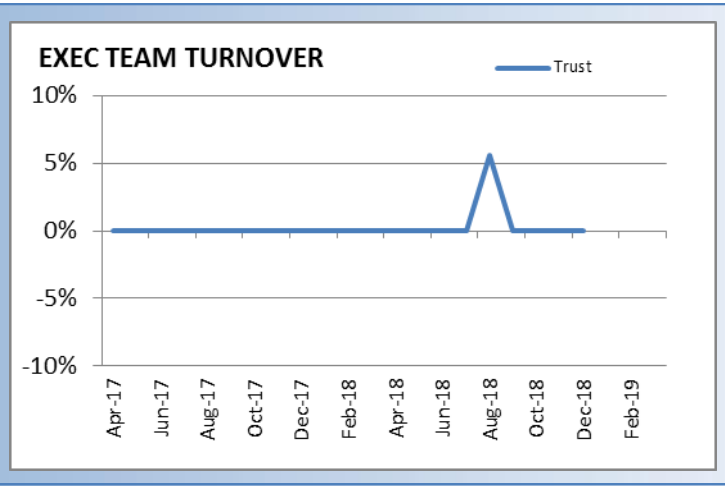
Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

During August Kevin Phillips resigned as Chief Medical Officer, Kevin continues to undertake Clinical work.

Turnover has been 0% for the Executive team during December.

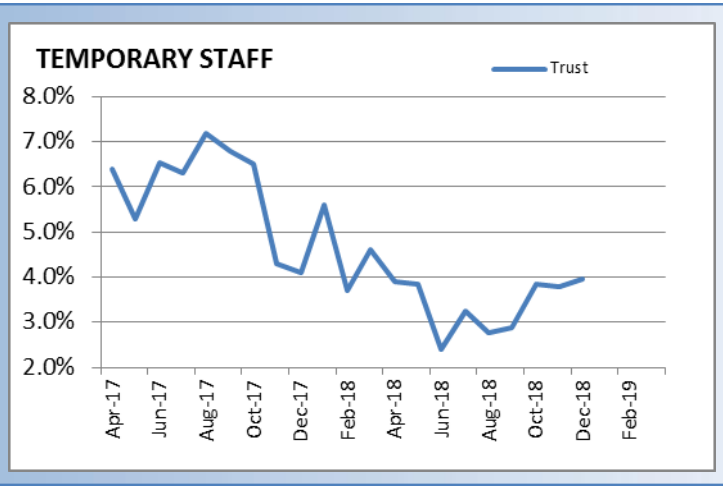


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

Performance is measured on a year to date basis as at the month end

December performance was 3.96%



FINANCIAL SUMMARY: 8 MONTHS TO 31st DECEMBER 2018

1. At the end of December, the Trust is reporting a SOCI surplus of £0.4m which is a shortfall of £1.7m against plan. The shortfall relates to the non delivery of the ED target for quarter 1 and 3 therefore non receipt of Provider Sustainability Funding (PSF). In month the overall position deteriorated significantly with a £1.8m deterioration across clinical health groups & corporate directorates. It has only been possible to maintain the position by phasing in all reserves which now means all reserves are phased into the position.

2. In month the Trust has over performed against contract on its clinical activity by circa £0.9m. The main areas of overtrade were in non electives, Outpatients and pass through drugs. Overall elective activity was on plan . Wet AMD was again below plan for month 9 and is now £1.1m below plan year to date although the health group expect this to partially recover in the last quarter to £0.6m below plan. The Trust is now above the indicative AIC plan by £0.9m.

3. The Trust is £1.4m below plan for CRES delivery at month 9 with £9.8m delivery against a target of £11.2m (87% delivery) with a £0.3m deterioration in month. This is offset by the phasing in of £0.4m of the CRES contingency reserve in month. The year end CRES forecast is now £2.5m below plan excluding the non delivery of the SPV, which would be covered by the contingency.

4. HG run rate positions are £4,3m overspent at month 9, an increase of £1.3m in month. The main movement was in the Surgery Health Group which deteriorated by £0.4m in the month with the majority being in medical and nurse staffing. Pass through drug costs under AIC also increased in month by £0.3m despite the CRES delivery on Adalimumab. CSS deteriorated by £0.3m due to medical staffing pressures and increased outsourcing. There were also pressures on pay and non pay spend in Emergency Medicine. The Trust will not be able to report a balanced position at month 10 if expenditure continues at current levels.

5. Health Groups and Corporate budgets are forecasting that they will be £7.5m overspent at year end, an increase of £0.9m in month. The main shortfall is CRES delivery at £2.5m (covered by CRES Contingency), and £1.8m cost of drugs not reimbursed under the AIC contract. The other main pressures are medical and nurse staffing, .

6. The Trust is expecting to receive the agenda for change funding relating to staff employed by OCS who previously worked for the Trust.

7. Agency spend to the end of December is £8.4m which is above planned level of £6.3m by £2.1m, a deterioration of £0.4m in month. The variance is driven completely by agency medical staffing with the main variance relating to junior medical staff (£1.0m) and Consultant cover at £0.0m.

8. The Trust can currently offset the forecast overspend relating to the CRES (excluding SPV) by releasing the £2.5m CRES contingency reserve. However the shortfall relating to the SPV assumption of £2.9m still requires actions to be confirmed, along with actions for an additional £2.0m of pressures (including clinical waste and contract challenges from NHSE). The Trust is in discussion with local commissioners to identify if there may be additional funding and is also looking at a Revenue to Capital benefit. However other actions of £1.8m will need to be identified including health groups ensuring they do not deteriorate further and looking to improve from current forecasts.

9. The reported capital position at month 9 shows gross capital expenditure of £8.8m which is £3.7m below planned levels and mainly due to the slippage of loan funded schemes and the late approval of the use of STF bonus (£3.7m). There have also been delays in the PDC funded Linear Accelerator scheme (£1.7m) and the MRI scheme (£1.5m). These will now occur in Q4. The £3.7m from bonus funds has been fully committed and orders have been placed and plans are progressing with this expenditure. The gross forecast remains at £21.6m which includes assumptions on receiving capital loan funding of £5.4m. This includes Fire (£4.9m) which has been agreed, and Equipment (£0.5m). The Trust is expecting PDC funding totalling £4.2m in relation to the purchase of a Linear Accelerator £1.7m; Patient Wi-Fi £0.2m (received); Digital Slides scanners £0.2m and Winter Ward £2m (received). The Trust is still awaiting approval of the use of unspent depreciation from 17/18 (£0.4m) and at this stage has been removed from the forecast at month 9.

10. The Trusts liquidity position has been relatively stable so far this year but this will become more difficult given the loss of the Q3 PSF funding of £1.1m and the deteriorating financial position.

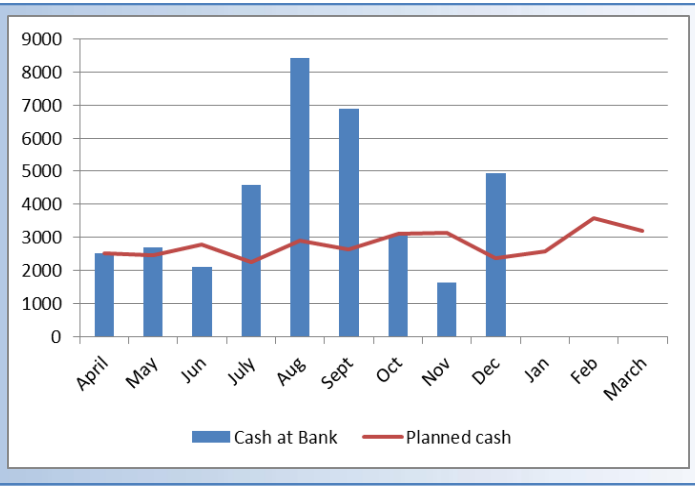
11. The Trusts current underlying run rate stands at £24.1m

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of December we had postive cash position of £4.95m, comprising of monies in the bank of £4.931m and £0.019m of petty cash floats. The cash position is stable and the availability of cash is reflected in our BPPC performance, which although lower than the required standard is good and improving. We continue to focus on debt and securing payment but this is challenging, particularly in respect of NHS organisations. During the last quarter of the financial year we expect PDC of £1.972m and a capital loan of £2.9m and are planning to meet our external financing limit of £0.463m.

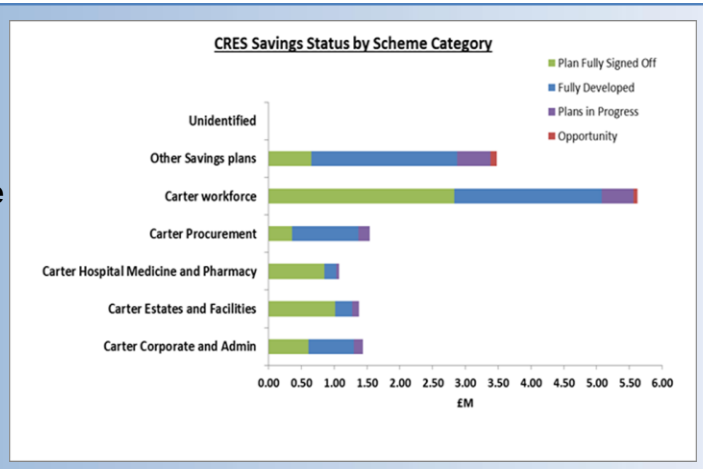


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 9 the Trust's planned level of savings is £11.2m, the actual savings to date is £9.8m thereby creating a £1.4m adverse variance from the plan.

The chart shows an analysis of year to date CRES schemes that are being delivered in terms of fairly broad categories.



The target for the year is to save £19.9m, the Trust is expecting to deliver this target

Description	Aggregate Position	Trend	Variation

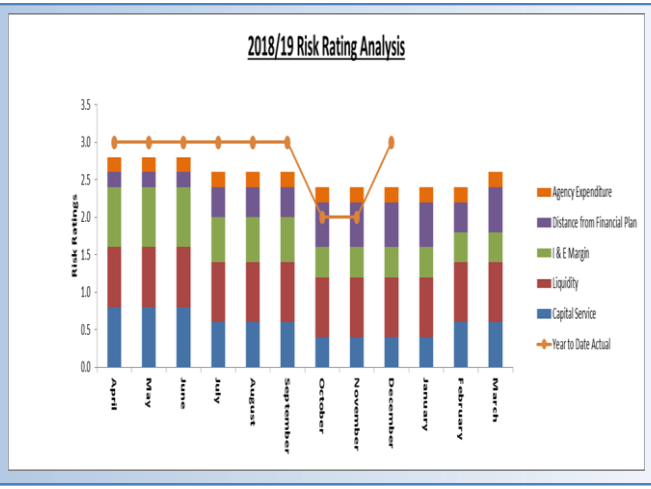
Risk Rating

Financial Sustainability Risk Rating

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess risk.

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess risk. Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst

As at month 9 the Trust is reporting a YTD surplus of £0.4m against a planned position of £2.04m surplus. This has resulted in liquidity being rated as 4, capital servicing as a 3, the I&E margin & the distance from plan being rated as 2 and the agency metric being rated as , giving an overall risk rating of 3.

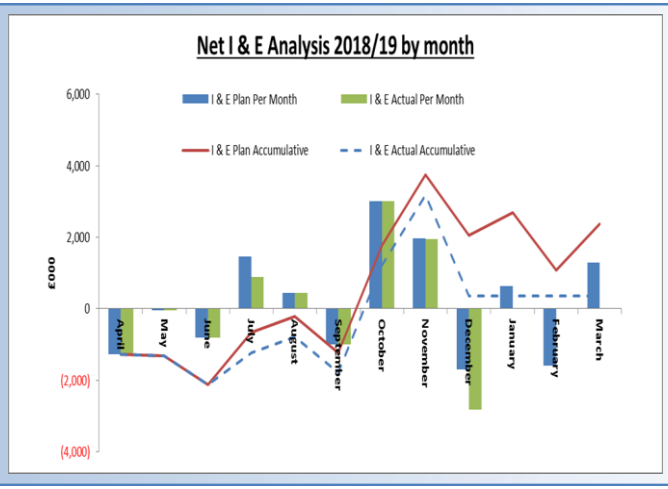


Income & Expenditure

Net income and Expenditure

The Net I & E analysis shows how the Trust has performed in each month in terms of the overall performance surplus plan. The bars showing each month's performance and plan in isolation and the lines showing the cumulative position of plan and actual.

As at month 9 the Trust has delivered a surplus of £0.4m against a planned surplus of £2.04m



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

28 JANUARY 2019

Title:	NHS Operational Planning and Contracting Guidance 2019/20
Responsible Directors:	Lee Bond, Chief Financial Officer Jacqueline Myers, Director of Strategy and Planning
Authors:	Jackie Railton, Head of Strategic Planning Alison Drury, Deputy Director of Finance (Contracts and Planning)

Purpose:	The purpose of this paper is to present to the Performance and Finance Committee a summary of the NHS operational planning and contracting requirements for 2019/20, with particular reference to expectations in relation to finance and service deliverables in the coming year and the timescales for the production and submission of the Trust's Operational Plan 2019/20.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Summary Key of Issues:	It is the Government's intention to bring the NHS, including providers, back into balance by reducing unwarranted variation in performance across the country and improving population health outcomes. 2019/20 will be the first year of a re-set of the financial framework for NHS providers. It is intended that the reforms will encourage system working and build towards the removal of financial control totals from 2020/21. This paper details the financial planning requirements for 2019/20 and the service deliverables.	

Recommendation:	The Performance and Finance Committee are asked to note the content of this paper and the arrangements for the development of the Trust's Operational Plan 2019/20,

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

NHS OPERATIONAL PLANNING AND CONTRACTING GUIDANCE 2019/20

1. PURPOSE OF PAPER

The purpose of this paper is to present to the Performance and Finance Committee a summary of the NHS operational planning and contracting requirements for 2019/20, with particular reference to expectations in relation to finance and service deliverables in the coming year and the timescales for the production and submission of the Trust's Operational Plan 2019/20.

2. BACKGROUND

The Government announced a five year funding settlement for the NHS in June 2018 which provided for an additional £20.5bn per year in real terms by 2023/24. In response, the NHS has developed the NHS Long Term Plan[1] with 2019/20 as the foundation year which sees significant changes proposed to the architecture of the NHS, laying the groundwork for implementation of the Long Term Plan. A brief summary of the Long Term Plan is attached at Appendix 3.

The new financial framework for the NHS is designed to give local organisations and systems the space and support to shape their operational and financial plans to their circumstances, whilst reducing deficits year-by-year. For 2019/20, Trusts and Clinical Commissioning Groups will need to agree organisation-level operational plans which combine to form a coherent system-level operational plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans covering the period to 2023/24.

The NHS Operational Planning and Contracting Guidance 2019/20[2] published in its final form in January 2019 accompanies five-year indicative CCG allocations and sets out the financial regime for Providers in 2019/20, alongside the service deliverables, including those arising from Year One of the Long Term Plan.

3. OPERATIONAL PLANNING AND CONTRACTING REQUIREMENTS

3.1 System Planning

Systems are expected to agree realistic shared capacity and activity assumptions to provide a single, system-wide framework for the organisational activity plans. The organisations within each STP/ICS are expected to take collective responsibility for the delivery of their system operational plan, working together to ensure best use of their collective resources.

System control totals will be set for each STP/ICS which will be the sum of individual organisation control totals.

3.2 Financial Planning

It is the Government's intention to bring the NHS, including providers, back into balance by reducing unwarranted variation in performance across the country and improving population health outcomes. 2019/20 will be the first year of a re-set of the financial framework for NHS

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[2] https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/

providers. It is intended that the reforms will encourage system working and build towards the removal of financial control totals from 2020/21.

Control Total 2019/20

In 2019/20 all Trusts will continue to receive their allocation of the PSF linked to acceptance and delivery of their control totals. The control totals for providers in deficit will reflect a further 0.5% efficiency requirement on top of the 1.1% efficiency factor included in the tariff.

HEYHT received its control total on 16th January, which is summarised at Appendix 1. The control total is to deliver a surplus of £10.4m after receipt of £8.97m non-recurring PSF (Provider Sustainability Fund) and assumes gains from the new tariff/financial architecture of £12m and an efficiency saving of at least 1.6% (circa £8.4m for HEYHT). Work is now underway to model the implications of the new tariff and understand the commissioner allocations to track the funding flows that are assumed in the control total calculation.

The following table summarises each line of the control total calculations for HEYHT and provides a current risk assessment of the assumptions.

	£m	Risk Assessment
Baseline	-13.092	High risk given the underlying position is 24.1m
PSF transferred into prices	9.764	Crude calculations compared with commissioner allocations suggest this is v high risk
CNST	-1.523	Low risk based on notification of charges for 2019/20
Other changes	1.603	High risk as not transparent what this relates to - work ongoing to assess.
Additional 0.5% efficiency	2.626	High risk as additional efficiency required to address underlying position of £24.1m
MRET funding	2.077	Low risk as central funding allocation for this
Sub-total before non-rec PSF	**1.455**	**SURPLUS**
Non-recurring PSF	8.973	Allocation dependent on control total acceptance and delivery
CONTROL TOTAL	**10.428**	**SURPLUS**

CCG allocations include growth of 5.19% and 5.18% for NHS Hull and East Riding CCG, respectively. In addition to the tariff changes included above, these allocations are also expected to include the agenda for change pay award impact for 2018/19 and 2019/20 as the Trust received funding direct from the Department of Health in 2018/19 on a non-recurring basis. There should also be an activity growth element reflected in allocations in order for Systems to improve on the waiting list position in 2019/20 and a requirement for CCGs to invest proportionately more growth in Mental Health service provision. At this stage therefore when reviewing the CCG allocations alongside the Trust's control total, the additional income expected to flow through to help deliver the control total will be a challenge

At this stage, given that the Trust's underlying financial position and the potential mismatch of control total calculations, which assumes income gains passed through from commissioners, this control total is felt to be a challenging target and requires further joint working with commissioners to understand and agree a baseline before discussing any activity growth.

Tariff & Financial Flows 2019/20

Subject to consultation, the uplift of the national tariff will be set at 3.8% for 2019/20. The cost uplifts include the costs of Agenda for Change pay awards that were paid directly to relevant providers in 2018/19. It excludes the anticipated increase in employer pension contributions to 20.6%. Clinical Negligence Scheme for Trust contributions for 2019/20 has been updated for the relevant national and local prices. In addition to the 3.8% cost uplift, the other adjustment to prices include the transfer of a proportion of the Provider Sustainability Fund (PSF) and the transfer into national and local prices of 1.25% from

CQUIN (Commissioning for Quality and Innovation). The CQUIN change has not impacted on our control total as this does not change our overall level of income. The tariff efficiency factor for 2019/20 is 1.1% plus there will be a reduction to prices of 0.36% to cover the costs of the new centralised procurement arrangements. There should be a compensatory reduction in non-pay prices to offset the centralised procurement adjustment although indications are that this may not fully offset this loss and result in a residual cost pressure.

The marginal rate emergency tariff (MRET) and the 30-day readmission rule will be abolished as national rules for 2019/20 on a financially neutral basis between providers and commissioners. The MRET adjustment for HEYHT is just over £2m which has been reflected as a gain in the calculation of the Trust's control total and will be funded separately in 2019/20.

There is an updated Market Forces Factor (MFF) for 2019/20 which will mean a significant change in income for some providers. For HEYHT, the current MFF is 1.0155 for 2018/19 and the revised MFF is to be 1.0150 which is being introduced over 4 years. The MFF for 2019/20 is 1.0154 which is a minimal change for HEYHT and accounts for circa £33k movement and is reflected in control total calculations.

A Financial Recovery Fund (FRF) is to be established (total £1.05bn, including £200m transferred from PSF) to support efforts to secure the financial sustainability of essential NHS services, with Trusts able to cover current day-to-day running costs whilst they tackle unwarranted variation. The FRF will be allocated on a non-recurring basis. In 2019/20 the FRF will only be accessed by Trusts in deficit who sign up to their control totals. After application of FRF funding, it is expected that the number of Trusts reporting a deficit in 2019/20 will be reduced by more than half, and by 2023/24 no Trust will be reporting a deficit. HEYHT will not be eligible for FRF as it is in surplus after the tariff and financial adjustments reflected above, before the allocation of the non-recurring PSF.

Productivity, Efficiency and Transformation

All systems are required to work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20

Providers, working with their systems, are required to develop robust efficiency plans taking account of the opportunities identified in the Model Hospital and outlined in published Getting It Right First Time (GIRFT) reports and Lord Carter's reviews of operational productivity and performance. Key areas of focus include:

- Transformation of outpatient services by introducing digitally-enabled operating models to substantially reduce the number of patient visits in line with the goal of reducing the number of outpatient visits by a third over the next five years.
- Improve the quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff.
- Improve the availability and deployment of the clinical workforce to improve productivity, including a significant increase in effective implementation of e-rostering and e-job planning standards.
- Accelerate the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS's collective purchasing powers.
- Make best use of the estate, including improvements to energy efficiency, clinical space utilisation in hospitals and implementations of modern operating models for community services.

- Improve corporate services, including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services.
- Support and accelerate roll out of Pathology and imaging networks.
- Secure value from medicines and pharmacy, including implementation of electronic prescribing, removal of low value prescribing and greater use of biosimilars.

Providers are also required to look at opportunities to grow their external (non-NHS) income. For HEYHT, there is a view that there is an opportunity to increase income from Overseas Patients. Our current processes and historic activity levels are under review to assess this position.

3.3 Operational Plan Requirements

The Long Term Plan highlights a number of key priorities that are fundamental to achieving further progress in transforming the provision of urgent and elective care, eg: delivery of Same Day Emergency Care (ie increasing the proportion of acute admissions discharged on the day of attendance from a fifth to a third), the transformation of outpatient services and the testing and implementation of the recommendations of the NHS Clinical Standards Review.

A summary of the 2019/20 key service deliverables are outlined in Appendix 2 along with the Trust's current performance.

Health Groups have been asked to model what would be a sustainable waiting list size for each specialty, as defined by NHSI and the requirements to address all follow-up outpatient backlogs. This includes undertaking an assessment of the capacity that would be available in 2019/20. The Trust is currently reviewing the latest specialty capacity assumptions for 2019/20 as part of the internal confirm and challenge process, along with any assumptions on productivity or new ways of working given the drive to reduce the requirement for traditional outpatient models. These assumptions will then be shared with commissioners and System partners for wider agreement on the ambition with regard to improvements in waiting times and waiting list size. As referenced in Appendix 2, the ask in relation to waiting times is to improve on the March 2018 list size, eliminate 52+ week waiters and offer choice of faster treatment at an alternative provider where patients have been waiting six months or longer.

The operational planning guidance also identifies a number of areas relating to long-term transformation which will require consideration and preparation during 2019/20. These include:

- Every area of the country will be part of an ICS by April 2021.
- Implementation of a continuity of carer model within maternity services
- 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
- Roll out of the Saving Babies Lives Care Bundle during 2019.
- Maternity digital care records roll out
- All maternity services delivering an accredited, evidence-based infant feeding programme
- Roll out of the new Rapid Diagnostic Centres.

4. KEY MILESTONES FOR PLANNING AND CONTRACTING 2019/20

System and organisational plans must be developed in line with the national timetable (see below) and through partnership working across STPs/ICSs, with clear triangulation between

commissioner and provider plans to ensure alignment in activity, workforce and income/expenditure assumptions, evidenced through agreed contracts.

Milestone	Date
2019/20 Initial plan submissions – activity focused	14 January 2019
Draft 2019/20 Organisation Operational Plan submission	12 February 2019
Aggregated system operational plan submission	19 February 2019
2019/20 STP/ICS led contract/plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
2019/20 STP/ICS led contract/plan alignment submission	5 March 2019
2019/20 National Tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board/Governing Body approval of 2019/20 budgets	By 29 March 2019
Final 2019/20 Organisation Operational Plan submission	4 April 2019
Aggregated system operational plan submission	11 April 2019
2019/20 STP/ICS led contract/plan alignment submission	11 April 2019
Capital funding announcements	Spending Review 2019
Systems submit 5-year plans signed off by all organisations	Autumn 2019

The Trust submitted its initial high level activity plans on 14th January in line with the above, which assumed 2% growth in ED attendances and 0.5% growth in non-elective admissions based on historic trends over the last 3 years. In terms of elective activity, including outpatient appointments, the base assumption was 2018/19 forecast outturn, with adjustments for expected growth in Wet AMD injections and Bowel Scope activity. Further work is ongoing, in conjunction with the specialty capacity assessments to review and consider the expected improvements in waiting list size and waiting times, along with commissioner QIPP /demand management assumptions.

Note that the next submissions are to be made on 12th February, along with a contract alignment return the week after on 19th February. An additional Board Meeting is being arranged to review progress at the end of February.

5. NEXT STEPS

The corporate teams (Finance, Contracting, Planning and Workforce) are working with Health Groups and Directorates, together with commissioners and provider partners, to develop the Trust's Operational Plan 2019/20 in accordance with national guidance and timescales.

Both the draft and final operational plan submissions will include:

- a finance return
- an activity and performance trajectory return
- a workforce return
- a triangulation return
- an operational plan narrative outlining the Trust's approach to activity, quality, workforce and financial planning for 2019/20
- assurance statements.

The Performance and Finance Committee will receive an update on progress with the development of the Operational Plan in February 2019, with a request for formal endorsement of the plan in March 2019.

6. RECOMMENDATION

The Performance and Finance Committee are asked to note the content of this paper and the arrangements for the development of the Trust's Operational Plan 2019/20,

Lee Bond
Chief Financial Officer

Jacqueline Myers
Director of Strategy and Planning

21 January 2019

Appendix 1

Financial control total and PSF, FRF and MRET funding for 2019/20

Financial control total	**£ million**
Rebased baseline position excluding PSF	**-13.092 Deficit**
£1bn PSF transferred into urgent and emergency care prices	9.764
CNST net change in tariff income and contribution (1)	-1.523
Other changes (2)	1.603
Subtotal before efficiency	**-3.248 Deficit**
Additional efficiency requirement up to 0.5%	2.626
2019/20 control total (excluding PSF, FRF and MRET funding)	**-0.622 Deficit**
MRET central funding	2.077
Subtotal before PSF and FRF allocations	**1.455 Surplus**
Non recurring PSF allocation	8.973
Subtotal before FRF allocation	**10.428 Surplus**
Non recurring FRF allocation	**0.000**
2019/20 control total (including PSF, FRF and MRET funding)	**10.428 Surplus**

(1) CNST net change in tariff income and contribution
- changes to tariff income as set out in '2019/20 planning prices: an explanatory note' and to changes in CNST contribution levels between 2018/19 and 2019/20

(2) Other changes include the impact of:
- Pricing changes in the national tariff - including changes to MFF, top ups and other price relativities
- Distributional impact of Agenda for Change cost increases relative to tariff income increase
- Impact of changes to MFF for Health Education England (HEE) tariffs
- Other changes include increases in overseas patient income, commercial income and inflationary impacts.

Appendix 2

KEY SERVICE DELIVERABLES 2019/20

	TARGET	CURRENT	
Waiting Times			
RTT LIST SIZE BETTER THAN MARCH 2018	< 54642	54,220	Dec-18
	specific no tbc		
RTT INCOMPLETES OVER 6 MONTHS		4,036	Dec-18
52 WEEK BREACHES	0	114	To end Dec-18
NO MORE THAN 1% OF PATIENTS WAITING ABOVE 6 WEEKS FOR A DIAGNOSTIC TEST.	< 1%	8.94%	Dec-18
Cancer			
CANCER 2 WEEK WAIT	93%	95.30%	Dec-18
BREAST SYMPTOMACTIC 2WW	93%	87.60%	Dec-18
CANCER 31 DAYS	96%	93.70%	Nov-18
CANCER 31 DAYS SUBSEQUENT SURGERY	94%	85.60%	Nov-18
CANCER 31 DAYS SUBSEQUENT DRUG TREATMENT	98%	99.00%	Nov-18
CANCER 31 DAYS SUBSEQUENT RADIOTHERAPY	94%	99.40%	Nov-18
CANCER 62 DAYS	85%	68.10%	Nov-18
CANCER 62 DAYS SCREENING	90%	62.90%	Nov-18
Ambulance Turnaround Times			
NO WAITS OVER 30 MINUTES FROM ARRIVAL TO HOSPITAL HANDOVER	0	2172	Nov-18
Long Stay Patients (21+ Days)			
REDUCE BED OCCUPANCY OF LONG STAY PATIENTS BY 25% V 2017-18 (129 BASELINE 17/18)	97	111	3 Mth rolling avg (Dec 18)
REDUCE BED OCCPANCY BY A FURTHER 15% V 2017-18 (40% REDUCTION IN TOTAL FROM 129)	77	111	3 Mth rolling avg (Dec 18)

Appendix 3

NHS LONG TERM PLAN 2019

SUMMARY

1. INTRODUCTION

The funding settlement announced in June 2018 provided the NHS with an average 3.4% a year real terms increase in funding over the next five years. This long term funding commitment aimed to provide the NHS with the financial security to develop its Long Term Plan to secure a National Health Service that is fit for the future.

During the NHS 70th anniversary year, a national debate centred on three truths:

i. Pride in the enduring success of the NHS and the shared social commitment it represents;
ii. Concern in relation to current and future funding, staffing, increasing inequalities and pressures from a growing and ageing population; and
iii. Optimism about the possibilities for continuing medical advance and better outcomes of care.

The NHS Long Term Plan takes all three of these realities into account and aims to:

- Deliver the agreed performance standards
- Transform cancer care so that patient outcomes move towards the very best in Europe
- Provide better access to mental health services, to help achieve the Government's commitment to parity of esteem between mental and physical health
- Achieve better integration of health and social care
- Focus on the prevention of ill-health, so people live longer, healthier lives.

2. NHS LONG TERM PLAN

The NHS Long Term Plan 2019 sets out five significant changes to the NHS service model:

- Boosting out-of-hospital care and finally dissolving the historic divide between primary and community health services.
- Expanding and reforming urgent and emergency care services.
- Enabling people to have greater control over their own health and have more personalised care when they need it.
- Digitally enabled primary and outpatient care, providing more convenient ways for patients to access advice and care
- Local NHS organisations increasingly focussing on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) across England.

The specific actions within the Long Term Plan include:

- The potential impact on A&E attendances that the increase in primary and community care provision may have, including the expansion of Urgent Care Centres. Where possible, the Long Term Plan aims to ensure locally accessible and convenient alternatives to A&E for patients who do not need to attend hospital.

- Reforms to hospital emergency care, in particular the delivery of Same Day Emergency Care (SDEC). It is intended that every acute hospital with a Type 1 A&E Department will provide a comprehensive model of SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20, and provide an acute frailty service for at least 70 hours a week, working to achieve clinical frailty assessment within 30 minutes of arrival.

- Testing and implementing the new emergency and urgent care standards arising from the Clinical Standards Review by October 2019 which aim to improve the patient pathway for people who arrive in A&E following a stroke, heart attack, major trauma, severe asthma attack or with sepsis.

- Partnership working between the NHS and social care to improve performance in getting people home without unnecessary delay when they are ready to leave hospital.

- Moving away from the traditional model of outpatients by redesigning services so that over the next five years the number of face-to-face outpatient appointments is reduced by up to a third.

- Development of Integrated Care Systems with the aim that all health and social care providers will be part of an ICS by April 2021. Every ICS will have streamlined commissioning arrangements in place to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area.

- Greater focus on prevention and health inequalities.

- Better care for those with major health conditions, including earlier diagnosis and treatment for those with cancer and cardiovascular disease.

- Renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years.

- Increase the amount of planned surgery year-on-year to cut long waits and reduce the waiting list.

- Using research and innovation to drive future outcomes improvement.

- Addressing workforce challenges and supporting existing staff through:
    - Development of a workforce implementation plan (to be published in 2019 after the Health Education England budget has been set by the Government)
    - Expanding the number of nurses, midwives, Allied Health Professionals and other staff
    - Growing the medical workforce
    - International recruitment
    - Improving education and development and opportunities for career progression
    - Enabling productive working
    - Leadership and talent management
    - Use of volunteers.

- Development of a wide-ranging and funded programme to upgrade technology and provide digitally enabled care across the NHS.

Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

Meeting Date:	17 December 2018	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Board Assurance Framework – Performance standard position at year end was discussed
- Planning Application for land at East Riding – approval of Jason Mowat as the Trust representative was sought
- Tower block risk issues – encapsulation defects and the next steps were discussed
- Winter Plan Update – the winter ward position was clarified
- Performance Report – ED, 52 week wait, 62 day Cancer and tracking access were highlighted as the key topics
- Finance Report – Current Trust and Health Group positions
- CRES – 80% delivery at month 8
- Patient Level Costing – an update was received. Scan4Safety is complementing the reporting
- Variable Pay report – overspend in Surgery and Medicine, principally in medical staffing
- Workforce/People Strategy Update – 3 year overview was received – the refresh to be presented at the January 2019 Board meeting
- Capital Resource Allocation Committee – fire improvement works update and the STP capital grant business case were discussed

Decisions made by the Committee:

The following contract was approved:

- Contract Extension for the Supply of neuro Interventional Radiology Products

- The Committee approved the appointment of Johnson Mowat to act on behalf of the Trust regarding the land at East Riding

Key Information Points to the Board:

Matters escalated to the Board for action:

Hull and East Yorkshire Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 17 December 2018

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce and OD
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mr D Taylor	Director of Estates and Facilities
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** There were no apologies received.	
2	**Declarations of Interest** There were no declarations received.	
3	**Minutes of the meeting held on 26 November 2018** Mr Evans to be removed from the present list. Following this change the minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** It was agreed that the report written by June Leitch (Improvement Director) would be shared with the Committee. A summary sheet showing assurances and any extraordinary items would be presented.	**TC**
	A report to be added to the action tracker to be received in March 2019 regarding Care Hours per Patient Day. This is to include senior team reporting requirements.	**MW**
	The potential use of Avastin to be discussed at the next PAF pre-meet.	**SH/LB**
5	**Action Tracking List** The action tracking list was reviewed by the Committee.	
6	**Workplan** The Workplan was received by the Committee. There were no issues to raise. Ms Ramsay and Mrs Thompson would review and produce the 2019/20 items in Quarter 4.	**CR/RT**
7	**Board Assurance Framework** Ms Ramsay presented the report and highlighted BAF risk 4 regarding performance on constitutional standards and what the year-end position might be. The Committee discussed increasing the risk rating due to the likelihood of	

missing the targets and not receiving PSF monies. Mrs Cope argued that compared to quarter 1 the Trust was in a much stronger position with more credible plans. Ms Ramsay added that the waiting lists were being better managed and the impact on patients was lower.

Mr Gore expressed his concern around missing 2 control totals in a row due to unsustainable ED performance. Mr Bond suggested waiting until the quarter 3 figures were published and having a more detailed discussion at the Board meeting in January 2019.

Resolved:
The Committee received and accepted the report.

8 8.1 Planning Application for land at East Riding

Mr Taylor updated the Committee regarding the remaining land at Castle Hill Hospital. He spoke of the already built housing estate (600 houses) and the opportunity to sell the remaining land (1500 houses) providing planning permission was granted.

The timetable for the Local Plan Review was set out in the report with adoption (should everything else be granted) in 2022.

Mr Taylor sought the Committee's approval to appoint Johnson Mowat as the Trust's representative to pursue the Outline Planning Application and had attached the associated fees. Mrs Christmas asked if the fees were built into the financial plan and Mr Bond advised that they were.

Resolved:
The Committee received the report and approved the appointment of Johnson Mowat to act on behalf of the Trust.

8.2 Tower Block risk issues

Mr Taylor presented the report and highlighted the issues in respect of the Tower Block encapsulation defects.

He reported that a number of contractual issues had been raised with the supplier one of which was with the glass panels shattering when they heated up and then cooled down. He also reported that there were issues with the paint quality on the columns.

Mr Gore asked about the fire risk situation in the Tower Block and Mr Taylor advised that the Fire Service had cancelled the enforcement notice and have no further issues. He also reported that the ex-Chief Fire Officer now worked at the Trust, and he also believed the risk to be low.

Mr Taylor advised that legal advice was being sought regarding the encapsulation defects and a further update report would be provided to the Committee. **DT**

Resolved:
The Committee received and accepted the report.

8.3 Winter Plan update

A winter plan update had been received in the Non-Executive meeting earlier that day. The winter ward was now open and rota implications were being

monitored.

Resolved:
The Committee received and accepted the update.

9 9.1 Exception Report

There was a discussion around the exception report and which areas to focus the Committee's attention. Mr Hall was keen to explore what were the key issues and gain assurance that they were being addressed. He had reviewed other Trust's data. Mrs Cope agreed to prepare an assurance document with dashboard trend analysis for discussion at the next meeting. **TC**

Mrs Cope presented the performance report and advised that ED performance had deteriorated in November 2018 to 81.9% and December was also proving to be challenging. The Executive Team were meeting to discuss support to achieve the standards and NHS Improvement and NHS England were also involved in the recovery plan.

Mrs Cope also reported on stranded and super stranded patients and late transfers of care. She also mentioned the deterioration in the Trust's length of stay and work was ongoing with social care to reduce this.

RTT was an improving position and Mrs Cope advised that validation work was ongoing.

There had been a meeting to discuss a revised trajectory for 52 week waits and the Trust Access Policy had also been changed.

Mrs Cope reported that the 2 week wait performance was improving.

62 day cancer performance had plateaued and there was a lot of pressure with the tumour sites. There had been issues around PET activity which had impacted on the pathway. This was being addressed. Diagnostic performance was improving with MRI and CT being under pressure. The Trust had received additional cancer funding to help with this.

Mrs Cope advised that the Tracking Access issue was now closed and all patients had been seen. The Clinical Harm Group were carrying out the final reviews but the MBI action plan had been closed down. The final report would be received at the Committee. Mr Hall asked when the internal auditors would be carrying out an audit to ensure the actions had been implemented and Mrs Christmas advised that it was on the Audit Plan. **TC**

Resolved:
The Committee received and accepted the report.

10 10.1 Monthly Finance Report

Mr Bond presented the report and highlighted that the Trust was reporting a surplus of £3.2m which is a shortfall of £0.6m against plan. The shortfall relates to the non-delivery of the ED target in quarter 1 and therefore the Trust did not received the Provider Sustainability Funding.

The Trust had over performed against contract on its clinical activity by £1.7m.

Mr Bond highlighted the Health Group positions and advised that Clinical Support and Family and Women's were on track, but Medicine had missed their forecast by £150k due to medical staffing issues and Surgery were over spent by £1.1m in month. A review of the Health Group forecasts was taking place.

Mr Bond advised that some of the activity to clear 52 week waiters was not paid for by the contract so this was impacting the financial position.

Liquidity was discussed and the Trust's largest debtor was North Lincolnshire and Goole Hospitals NHS Trust. Mr Bond clarified that discussion were ongoing with NLAG regarding the clearance of this debt.

Resolved:
The Committee received and accepted the report.

10.2 CRES Delivery 2018/19
Mr Bond presented the CRES report which showed an expected delivery of £16m at year end (80%).

Mr Bond expressed his concern regarding next year's CRES. Mr Evans added that the CNST premium discount would be potentially available next year 2019/20 which would save the Trust £0.5m.

Resolved:
The Committee received and accepted the report.

10.3 Patient Level Costing
Mr Evans presented the item and advised that the quality of the reporting was getting better along with clinician engagement. Variation between the Health Groups was also reducing.

Mr Evans highlighted 3 key areas for focus: Cardio and thoracic, upper GI and Trauma and Orthopaedics. He added that the Scan4Safety initiative was helping patient level costing and engaging clinicians.

Resolved:
The Committee received and accepted the report.

11 11.1 Variable Pay Report
Mr Nearney presented the report and highlighted the over spend in Surgery and Medicine Health Groups.

Mrs Christmas asked about the extra sessions being worked and Mr Nearney advised that this was to reduce patient waiting although it was costing the Trust more to do this as no income over and above the block contract was received. Mr Gore added that the Trust was £1.5m over budget in month due to extra sessions.

Mr Nearney advised that work was ongoing to balance the position.

Resolved:
The Committee received and accepted the report.

11.2 Workforce/People Strategy update, (new roles, recruitment, areas of concern)
Mr Nearney presented the report which summarised the achievements of the Trust over the last 3 years. He advised that the re-draft work had begun and would be presented to the Board in January 2019.

There was a discussion around the appraisal rate reducing and short term sickness figures. Mr Nearney advised that these were being addressed, but the results were disappointing.

Mr Hall asked about ED Consultant vacancies and Mr Nearney advised that the rota required 20 wte and that the Trust had 15 consultants in post. There were 3 registrars graduating in August 2019 and his team were trying to recruit them.

Resolved:
The Committee received and accepted the report.

12 **12.1 Contract Extension for the Supply of neuro Interventional Radiology Products**
The Committee approved the contract extension.

12.2 Capital Resource Allocation Committee minutes
The minutes were received by the Committee. It was noted that work had begun on the fire improvement works.

The Committee discussed the capital announcement that had been received for the STP. Mr Evans advised that a full business case covering the whole STP would be developed. Mr Hall asked that this be presented to the Committee when available.

Resolved:
The Committee received the minutes and requested that the business case be received for review by the Committee in due course. **LB**

13 **13.1 Committee Effectiveness Report**
Ms Ramsay presented the item and stated that all responses were at the high end of the scale and that members found the Committee to be well performing. Mr Hall stated that he wanted the Committee to be an exemplar and members should feel free to raise any issues with him.

Mr Gore stated that he felt that the level of debate was better and more candid with relevant topics being raised. He praised Mr Hall on the difficult role of chairing the meetings.

Mr Hall asked if the issue around the Committee lacking influence had been addressed and Ms Ramsay stated that it had developed over the last 12 months with the tracking access issue being especially powerful and effective. Invitations for Health Group members to attend the meeting when specific assurance was sought, was also seen to be effective.

Resolved:
The Committee received and accepted the report.

14 Items delegated by the Board
There were no items delegated by the Board

15 Any Other Business
There was no other business discussed.

16 Date and time of the next meeting:
Monday 28 January 2019 – 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
29 JANUARY 2019

Title:	Safety Annual Report 2017/18
Responsible Director:	Mike Wright, Chief Nurse
Author:	David Bovill, Trust Safety Manager

Purpose	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to the management of Safety within the Trust.	
BAF Risk	N/A	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	Information is provided in the report on the following topics: • Safety Department KPI's • General RIDDOR Reportable Incidents • RIDDOR: Occupational Health • Annual incidents by Health Group • Non-reportable slip trip falls • Timeliness of Reporting of incidents to the HSE • Inspections • Staff incidents reported by severity • EL / PL (Employee Liability / Public Liability) Claims • Manual Handling • Objectives for 2018/19	

Recommendation	The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required

SAFETY ANNUAL REPORT 2017-18
29 JANUARY 2019

EXECUTIVE SUMMARY

The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to the management of Safety within the Trust.

Information is provided in the report on the following topics:

- Safety Department KPI's
- General RIDDOR Reportable Incidents
- RIDDOR: Occupational Health
- Annual incidents by Health Group
- Non-reportable slip trip falls
- Timeliness of Reporting of incidents to the HSE
- Inspections
- Staff incidents reported by severity
- EL / PL (Employee Liability / Public Liability) Claims
- Manual Handling
- Objectives for 2018/19

Many positive improvements are being made, which suggests the Trust is improving its culture, behaviour and performance in relation to Health and Safety Matters.

SAFETY ANNUAL REPORT 2017-18
29 JANUARY 2019

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to the management of Safety within the Trust.

The fuller Safety Annual Report is attached for information, if required. This contains information on the following topics:

- Safety Department KPI's
- General RIDDOR Reportable Incidents
- RIDDOR: Occupational Health
- Annual incidents by Health Group
- Non-reportable slip trip falls
- Timeliness of Reporting of incidents to the HSE
- Inspections
- Staff incidents reported by severity
- EL / PL (Employee Liability / Public Liability) Claims
- Manual Handling
- Objectives for 2018/19

The key Safety achievements in-year and priorities/challenges for the current year are now described.

2. KEY ACHIEVEMENTS IN 2017-18

The main body of the report is set out in accordance with the requirements of the national Health and Safety Executive. Key achievements in 2017-18 were:

- **Communication with the HSE:** 2017/18 saw no communicated areas of escalation from the regulator – the Health and Safety Executive (HSE), regarding any safety issues.
- **Reportable Incidents**: The Trust's Safety Team reported 18 incidents to the HSE under the requirements of the RIDDOR regulations in 2017/18 (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). This compares with 32 reported the previous year (2016/17) indicating a positive downward trajectory. The commonest causes were slips, trips and falls (STF), and moving and handling (MH) related injuries. Both of these categories showed a reduction in year, (STF's down 50%, M/H down 11%). The Trust's Occupational Health Team reported 14 incidents to HSE; seven needle-stick injuries and seven cases of other exposure to blood borne viruses. This is also a reduction across both categories from the previous year (13%).
- **Claims:** The number of new staff claims against the Trust totalled 19 in 2017/18. Whilst this is a rise of five from the previous year, the overall pattern of a significant reduction since the 36 new staff claims made in 2014/15, is being maintained.
- **Link Staff:** An increase in the availability of training for new departmental Safety Link Staff and Moving and Handling Link Trainers has equated to an increased number of Link Trainers by 55 and 43 respectively. These staff volunteer to be the 'eyes and ears' for safety in their work areas, and are therefore are given extra training to fulfil this important role.

3. PRIORITIES / CHALLENGES FOR 2018/19

The following are key areas for development in 2018-19:

- **Elimination of slip / trip hazards across sites:** whilst these hazards are identified by the Safety Team / Estates on the periodic, planned area audits, rectification requires time and money. Therefore, a focus will be place on the elimination of this hazards;
- **Risk assessments:** 90% of all wards and departments having all 6 key risk assessments in place;
- **Working at height**: working with Estates, the review, assessment and risk reduction for work on all flat roofs throughout the Trust;
- **Moving and handling training**: Review and delivery of acceptable levels of practical training / competency assessment for all clinical staff.

4. RECOMMENDATION

Many positive improvements are being made, which suggests the Trust is improving its culture, behaviour and performance in relation to Health and Safety Matters.

Attached for information is the full Annual Report 2017-18. The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Dave Bovill
Trust Safety Manager

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
SAFETY DEPARTMENT ANNUAL REPORT - 2017 / 2018

1. KPI'S / EXECUTIVE SUMMARY

1.1 Key Performance Indicators (KPI's)

The following key performance indicators are recorded and monitored quarterly, and cover the following topics:

GENERAL SAFETY KPI'S:

- **Number (and rate = No. / 7,175 employees x 100) of RIDDOR reportable incidents.** This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported than more minor incidents and near-misses. The target for RIDDOR reportable incidents should always be as few as possible, though an organisation as large and complex as HEYT would certainly alert the regulator (HSE) if no such incidents were reported.

- **Total staff slips, trips and falls incident rate (not just RIDDOR).** The justification for this choice of KPI is that it is the single biggest cause of staff injury. The target improvement here would be a steady decrease in reported incidents.

- **Employer's Liability (EL) / Public Liability (PL) Claims –** new employees/public liability claims received

- **Numbers of hazards identified by site quarterly inspections** by the Safety Team; a pro-active measure. The Trust would want to see a reduction in the number of hazards identified in any given area upon subsequent inspections if the corrective actions have been taken. This will clearly take some time to give a more meaningful picture.

- **Staff accidents reported by severity**. Numbers of those classed as either severe or catastrophic. A good reporting culture in the organisation would have staff recording high numbers of near misses, no harm or minor harm incidents. For this reason, an increase in overall staff incidents should not necessarily be seen as a negative outcome. However, the Trust would want to see low numbers of those incidents classed as major or catastrophic, as such incidents are unlikely to go unreported.

1.2 Executive Summary

1.2.1 General RIDDOR Reportable Incidents:

- RIDDOR reportable incidents reported by the Safety Team have shown a decrease, with 18 (0.25 per 100 staff) incidents reported to the Health and Safety Executive for this year compared with 32 (0.44) incidents reported for the previous year. The year prior to that (2015/16) had 33.
- The commonest causes of RIDDOR incidents were for Moving handling and STF's.

1.2.2 Annual RIDDOR incidents by Health Group:

- Shows that Medicine was the Health Group with the most reported incidents for the past 12 months with a total of 5 (giving a rate of 0.42). This was a decrease of (6) when compared to the previous year (11).Clinical support had the lowest rate of RIDDORs, with (2) 0.12 per 100 staff

1.2.3 RIDDOR Reportable slip trip falls:

- Slip trip falls has shown a decrease of 50% (5) when compared to the previous year (10) with slips (3) trip (1) fall (1).

1.2.4 Staff non – RIDDOR reportable slip, trips and falls:

- The past twelve months has witnessed an increase from the previous year from 96 incidents to 102 incidents with Corporate (32) Surgery (24) and Family Women's Health (20).

1.2.5 Occupational Health RIDDOR reportable Incidents (Needle-sticks and blood borne virus exposures):

- When compared to the previous 12 months we have witnessed a slight a decrease of 2 (14 against 16). we have also witnessed no reported cases of Dermatitis for the second consecutive year.

1.2.6 Moving and Handling RIDDORs:

- When compared to the previous year (9), we have seen a slight decrease (8).

1.2.7 Employer's Liability Claims:

- The number of new *staff* claims against the Trust was 19 in 2017/18. Whilst this is a rise of five from the previous year, the overall pattern of a significant reduction since the 36 new staff claims made in 2014/15, is being maintained.

1.2.8 Timeliness of Reporting of incidents to the HSE:

- The reporting of incidents in accordance the RIDDOR Regulations 2013 is **within 15 days.** When compared to the previous year, we have seen an improvement in the timeliness of reporting of incidents to the HSE from (7) to (5) ,however, the overall number of reportable incidents is significantly lower for the past twelve months (18 against 32): (NB**:** This information does not include Occupational Health reportable incidents).

1.2.9 Quarterly Site Inspections:

- During 2016/17 there were seven quarterly inspections carried out across HRI and CHH with 3 at HRI and 4 at CHH. These inspections identified 38 defects at HRI and 41 defects at CHH. At the time of writing, we have witnessed the remedial action of 20 defects being acted upon at HRI and 38 at CHH. We anticipate that we will see further reductions in the number of defects found due to the ongoing remedial work.

1.2.10 Safety Focal Persons / M/H Link Trainers:

- As a result of the infrequency of available training for new Safety Focal Persons (SFP's) the Safety Department took charge of providing the training, since then we have witnessed an increase in the number of new SFP's (55) with further training dates for the upcoming 12 months. We have also trained a further 43 departmental moving and handling Link Trainers.

2. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013

General RIDDOR Reportable Incidents: totals and rates (per headcount x 100):

Table 1: Quarter 4

	FTE 7175				
	Quarter 3			Quarter 4	
Incident Category	Total	Rate		Total	Rate
Slip, trip or fall	1	0.01		1	0.01
Moving and handling	4	0.05		-	-
Struck by or against something	1	0.01		1	0.01
Contact with hot/cold object/liquid, machinery or electricity	-	-		-	-
Contact with sharp material or object, non-medical	-	-		-	-
Other Personal Accident	1	0.01		-	-
Contact with other medical sharps	-	-		-	-
Exposure to harmful agent e.g. radiation, substance, bio agent	1	0.01		-	-
Total	8 ▲			2 ▼	

We have witnessed a decrease of **6** incidents during quarter 4 when compared to quarter 3.

Table 2: Annual

RIDDOR Apr 2017 - Mar 2018	FTE 7175													
	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Rate
Slip- trip fall	2	-	-	1	-	-	-	-	1	1	-	-	5	0.06
Manual handling	3	-	1	-	-	-	3	1	-	-	-	-	8	0.11
Struck by or against something	-	-	-	-	-	-	-	1	-	-	1	-	2	0.02
Contact with hot/cold, object/liquid, electric or machinery	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Contact with sharp material or object non medical	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other personal accident	-	-	1	-	-	-	-	1	-	-	-	-	1	0.01
Contact other medical sharps	-	-	-	-	-	-	-	-	-	-	-	-	1	0.01
Exposure to harmful agent e.g. radiation, substance, bio agent,	-	-	-	-	-	-	1	-	-	-	-	-	1	0.01
Total	5	-	2	1	-	-	4	3	1	1	1	-	18	
	7			1			8			2				

The annual total for reportable incidents shows a considerable decrease: **18** from the previous year (**32)**.

Table 3: Three Year Comparison

	2015 - 2016			2016 - 2017			2017 - 2018		
Incident Category	Total	Rate		Total	Rate		Total	Rate	
Slip, trip or fall	10	0.12	▼	10	0.12	-	5	0.06	▼
Moving and handling	5	0.06	▼	9	0.1	▲	8	0.11	▼
Struck by or against something	5	0.06	-	4	0.04	▼	2	0.02	▼
Contact with hot/cold object/liquid, machinery or electricity	-	-	-	1	0.01	▲	-	-	▼
Contact with sharp material or object, non-medical	1	0.01	-	1	0.01	-	-	-	▼
Other Personal Accident	6	0.07	▼	6	0.07	-	1	0.01	▼
Contact with other medical sharps	2	0.02	▼	-	-	▼	1	0.01	▲
Exposure to harmful agent e.g. radiation, substance, bio agent	4	0.04	▼	1	0.01	▼	1	0.01	-
Total	**33**		▼	**32**		▼	**18**		▼

We have witnessed a significant decrease of **14** incidents when compared to the previous year. The overall pattern over the last three years is showing a downturn in reportable incidents with this year being the most noticeable.

Table 4: Incidents by category:

	2015 - 2016	2016 - 2017	2017 -2018	Total
Slip- trip fall	10	10	5	**25**
Manual handling	5	9	8	**22**
Struck by or against something	5	4	2	**11**
Contact with hot/cold, object/liquid, electric or machinery	-	1	-	**1**
Contact with sharp material or object non medical	1	1	-	**2**
Other personal accident	6	6	1	**13**
Contact other medical sharps	2	-	1	**3**
Exposure to harmful agent e.g. radiation, substance, bio agent,	4	1	1	**6**
Total	**33**	**32**	**18**	**83**

Although we have witnessed a significant decrease with Slip trip falls this category remains to be the highest incident category with **25** over the past three years with Moving handling coming in second with **22.**

3. Annual RIDDOR incidents by Health Group:

RIDDOR incidents by HG

Table 5: Quarter 4

Health Group		FTE	Quarter 3	Rate		Quarter 4	Rate
	Clinical Support	1646	1	0.06	▽	-	-
	Family and Women's Health	1087	1	0.09	▽	-	-
	Surgery	1807	1	0.05	-	1	0.05
	Corporate Directorates	1450	2	0.13	-	1	0.06
	Medicine	1185	3	0.25	▽	-	-
Total:		**7175**	**8**		▽	**2**	

During quarter 4 we witnessed a decrease of (**6**) incidents when compared to quarter 3.

Table 6**:** Annual

Health Group		FTE	Q1	Rate		Q 2	Rate		Q 3	Rate		Q4	Rate	
	Clinical Support	1646	1	0.05	▽	-	-	▲	1	0.06	▽	-	-	▽
	Family and Women's Health	1087	1	0.07	-	1	0.07	-	1	0.09	▽	-	-	▽
	Surgery	1807	2	0.09	▽	-	-		1	0.05	-	1	0.05	-
	Corporate Directorates	1450	1	0.06	▽	-	-	▲	2	0.13	-	1	0.06	▽
	Medicine	1185	2	0.14	▽	-	-	▲	3	0.25	▽	-	-	▽
Total:		**7175**	**7**		▽	**1**		▲	**8**		▽	**2**		▽

Surgery (**4**) and Corporate (**4**) had the most reportable incidents for the year.

Table 7: Three Year Comparison

Health Group		FTE	2015 - 2016 Total	2015 - 2016 Rate		2016 - 2017 Total	2016 - 2017 Rate		2017 - 2018 Total	2017 - 2018 Rate	
	Clinical Support	1646	5	0.3	▲	2	0.12	▽	2	0.12	-
	Family and Women's Health	1087	3	0.27	▽	4	0.36	▲	3	0.27	-
	Surgery	1807	10	0.55	▽	6	0.33	▽	4	0.22	▽
	Corporate Directorates	1450	7	0.48	▽	9	0.62	▲	4	0.27	▽
	Medicine	1185	8	0.67	▽	11	0.92	▲	5	0.42	▽
Total:		**7175**	**33**		▽	**32**		▽	**18**		▽

Medicine (5) and Corporate (3) both show a significant decrease when compared to the previous two years.

4. RIDDOR Reportable slip trip falls:

RIDDOR Reportable slip trip falls:

Table 8: Quarter 4

FTE 7175	Quarter 3		Quarter 4
Incidents	1	▽	1
Rate	0.01		0.01

There was no change during quarter 4 when compared to quarter 3.

Table 9: Annual

FTE 7175	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Incidents	2	▽	1	▽	1	▲	1	▽
Rate	0.02		0.01		0.01		0.02	

Over the year we have witnessed a decrease in slip trip falls.

Table 10: Three Year Comparison

Date	2015 - 2016		2016 - 2017		2017 - 2018	
Incidents	10	▽	10	-	5	▽
Rate	0.13		0.13		0.6	

When compared to the previous 12 months there has been a significant decrease of (**5**) which equates to a **50%** decrease.

5. Non-RIDDOR reportable slip trip falls:

Non-reportable staff slips trip falls by HG:

Table 11: Quarter 4

Health Group	FTE 7175 Quarter 3	Rate	Quarter 4	Rate
Clinical Support	2 ▲	0.12	- ▼	-
Family and Women's Health	6 ▲	0.55	- ▼	-
Surgery	5 ▼	0.27	1 ▼	0.05
Corporate Directorates	11 ▲	0.75	1 ▼	0.06
Medicine	3 ▼	0.25	- ▼	-
Total:	**27** ▼		**2** ▼	

We have witnessed a significant decrease during quarter 4 (**2**) when compared to quarter 3 (**27**).

Table 12: Annual

Health Group	FTE	Q1		Rate	Q2		Rate	Q3		Rate	Q4		Rate
Clinical Support	1646	3	-	0.18	1	▼	0.06	2	▲	0.12	-	▼	-
Family and Women's Health	1087	6	▲	0.55	5	▼	0.45	6	▲	0.55	-	▼	-
Surgery	1807	2	-	0.11	9	▲	0.49	5	▼	0.27	1	▼	0.05
Corporate Directorates	1450	4	▼	0.27	8	▲	0.55	11	▲	0.75	1	▼	0.06
Medicine	1185	4	▼	0.33	5	▲	0.42	3	▼	0.25	-	▼	-
Total:	**7175**	**19**	**-**		**28**	▲		**27**	▼		**2**	▼	

Corporate shows as having the highest score of (**24**) incidents over the past twelve months

Table 13: Two Year Comparison

FTE 7175 Health Group	FTE	2016 - 2017 Total	Rate	2017 - 2018 Total		Rate
Clinical Support	1646	12	0.72	10 ▼		0.6
Family and Women's Health	1087	20	1.83	20	-	1.83
Surgery	1807	17	0.94	24 ▲		1.32
Corporate Directorates	1450	32	2.2	32	-	2.2
Medicine	1185	15	1.26	16 ▲		1.35
Total:	**7175**	**96**		**102** ▲		

We have witnessed a slight increase (**102**) over the past 12 months when compared to the previous year (**96**) with Corporate Directorate showing the overall highest group with (**32**).

As this is a newly added KPI, a three year comparison could not be made. This will be undertaken in future annual reports.

6. RIDDOR – reported by the Occupational Health Department:

RIDDOR – reported by Occupational Health – by category:
Table 14: Quarter 4

Incident by Category	FTE	Quarter 3		Rate	Quarter 4		Rate
Needle Stick Injuries	7175	4	▲	0.05	3	▼	0.04
Exposure To Blood Born Viruses		-	-	-	6	▲	0.08
Work Related Dermatitis		-	-	-	-	-	-
Total		**4**	▲		**9**	▲	

During quarter 4 we witnessed an increase of **5** incidents when compared to quarter 3.
Table 15: Annual

Incident by Category	FTE	Q1	Rate	Q2	Rate	Q3	Rate	Q4	Rate
Needle Stick Injuries	7175	-	-	-	-	4	0.05	3	0.04
Exposure To Blood Born Viruses		1	0.01	-	-	-	-	6	0.08
Work Related Dermatitis		-	-	-	-	-	-	-	-
Total		**1**		**0**		**4**		**9**	

We witnessed the most reportable incidents during quarter 4 **(9)** with a sharp increase with exposure to blood born viruses **(6)** and Needle sticks **(3)**.
Table 16: Three Year Comparison

Incident by Category	2015 - 2016		Rate	2016 - 2017		Rate	2017 - 2018		Rate
Needle Stick Injuries	5	▼	0.06	9	▲	0.12	7	▼	0.09
Exposure To Blood Born Viruses	6	▼	0.08	7	▼	0.09	7	▼	0.08
Work Related Dermatitis	2	▲	0.02	-	▼	-	-	-	
Total	**13**	▼		**16**	▲		**14**	▼	

When compared to the previous 12 months we have witnessed a slight decrease **(2)** as well as witnessing for the second consecutive year of no reportable cases of Dermatitis.

7. Timeliness of Reporting of incidents to the HSE:

The reporting of incidents in accordance to regulation 4.2 of the RIDDOR Regulations 2013 - **within 15 days** (**NB:** The following information does *not* include Occupational Health reportable incidents)

Timeliness of Reporting of incidents to the HSE during 2017 – 2018:

Table 17: Quarter 4 - FTE 7175

Reported	Reported on time	Reported late	Total
Quarter 4	2	-	**2**
Rate	0.02	-	

Quarter 4 shows that there were no late reporting of incidents to the HSE

Table 18: Annual

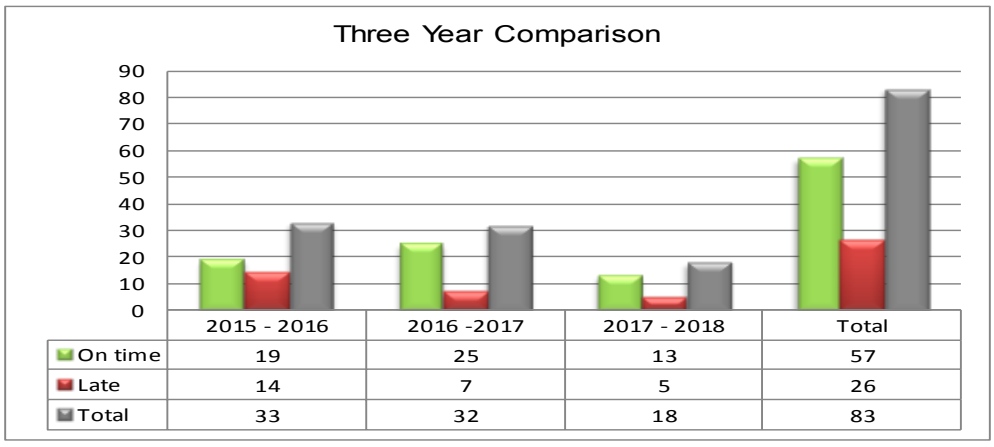
Reported	Reported on time	Reported late	Total
Quarter 1	4	3	**7**
Rate	0.04	0.03	
Quarter 2	1	-	**1**
Rate	0.01	-	
Quarter 3	6	2	**8**
Rate	0.08	0.02	
Quarter 4	2	-	**2**
Rate	0.02	-	
Total	**13**	**5**	**18**

On balance we have seen a decrease over the past twelve months for the late reporting of incidents.

Table 19: Three Year Comparison

Reported	Reported on time	Reported late	Total
20115 - 2016	19	14	**33**
2016 - 2017	25	7	**32**
2017 - 2018	13	5	**18**
Total	**57**	**26**	**83**

When compared to the previous year, we have seen an improvement in the timeliness of reporting of incidents to the HSE: the proportion of those reported late has reduced for the second consecutive year.



8. Quarterly Site Inspections:

Hull Royal Infirmary:

Table 21: Area inspected on a quarterly basis:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
2016 -2017	16	22	15	7	**60**
Area Inspected	Area 3	Area 1	Area 2	Area 3	
2017 -2018	7	26	5	-	**38**

When compared to the previous year (**60**) we have seen a decrease in the total number of defects found (**38**).

Table 22: Defects found at the HRI Estate, by quarter and severity

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	6	26	4	-	**36**
Low	1	-	1	-	**2**
Very low	-	-	-	-	**-**
Overal total	**7**	**26**	**5**	**-**	**38**

Table 23:

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	-	12	-	-	**12**
Low	-	-	-	-	**-**
Very low	-	-	-	-	**-**
Overal total	**-**	**12**	**-**	**-**	**12**

When compared to the previous year, we have seen a decrease of defects identified at HRI (**38** from **60**) with **12** of the **38** defects being acted upon leaving a deficit of **26** defects

Castle Hill Hospital:

Table 24: Area inspected on a quarterly basis:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
2016 -2017	7	9	6	15	**37**
Area Inspected	Area 3	Area 1	Area 2	Area 3	
2017 -2018	15	10	2	14	**41**

When compared to the previous year (**37**), we have seen a slight increase (**41**) in the number of defects found.

Table 25: Defects found at the CHH Estate, by quarter and severity

Defects found					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	14	10	1	13	**38**
Low	1	-	1	1	**3**
Very low	-	-	-	-	**-**
Overal total	**15**	**10**	**2**	**14**	**41**

Table 26:

Defects acted upon					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	12	9	-	13	**34**
Low	1	-	1	1	**3**
Very low	-	-	-	-	**-**
Overal total	**13**	**9**	**1**	**14**	**37**

When compared to the previous year, we have seen a slight increase (**41** against **37**) however, **37** of these defects have already been acted upon leaving a deficit of just **4.**

9. Staff incidents reported by severity:

Table 27: Staff incident severity

Risk Rating	2016 - 2017		2017 - 2018		Total
No harm	224	-	127	▽	**351**
Minor	378	-	348	▽	**726**
Moderate	21	-	19	▽	**40**
Major	-	-	-	-	**-**
Catastrophic	-	-	-	-	**-**
Total:	**623**	-	**494**	▽	**1117**

As this is a newly added KPI, a three year comparison could not be made. This will be undertaken in future annual reports

10. Safety Focal Persons:

The Safety department identified a gap in the training of new Safety Focal Persons (SFP) and as a result have taken charge of providing the necessary training needed for staff to become an SFP.

The new revised training course has been reduce from its original 3 days to just 1 day thus reducing the time staff spend away from the workplace while still managing to maintain and keep all of the key elements and cores skills needed for a staff member to become an SFP.

Since advertising the new revised course there has been a keen interest from staff across the Trust with **55** staff who has since undertook the training course, delivered by the Safety Manager and Deputy Safety Manager, with excellent feedback received by the delegates.

11. Employers/Public Liability Claims – Analysis of Activity 2017/18

Summary of Activity 2017/18

In 2017/18 there were:

- 19 New EL claims and 5 new PL claims;
- 24 new potential non-clinical claims received, compared with 36 in the previous year, of which 18 had been reported as an incident previously;
- The most frequently occurring incident leading to claims continues to be slips/trips with 6 new potential claims received in year;
- 37 claims were closed in the year of which 19 were settled. The highest damages settlement related to a visitor who fell over concrete in the car park outside the tower block due to poor lighting sustaining fractures to both wrists (Damages £26,000, Total £26,158);
- Damages payments for claims closed in the year totalled £82,000 with costs in the sum of £205k;
- One claim defended at trial relating to a burn as a result of contact with the metal cover of a heat lamp whilst removing an empty food receptacle. It was held that injuries sustained as a result of obvious everyday risks that we all face in life will not be compensated.

Fig 1: Trend in Non Clinical Claims

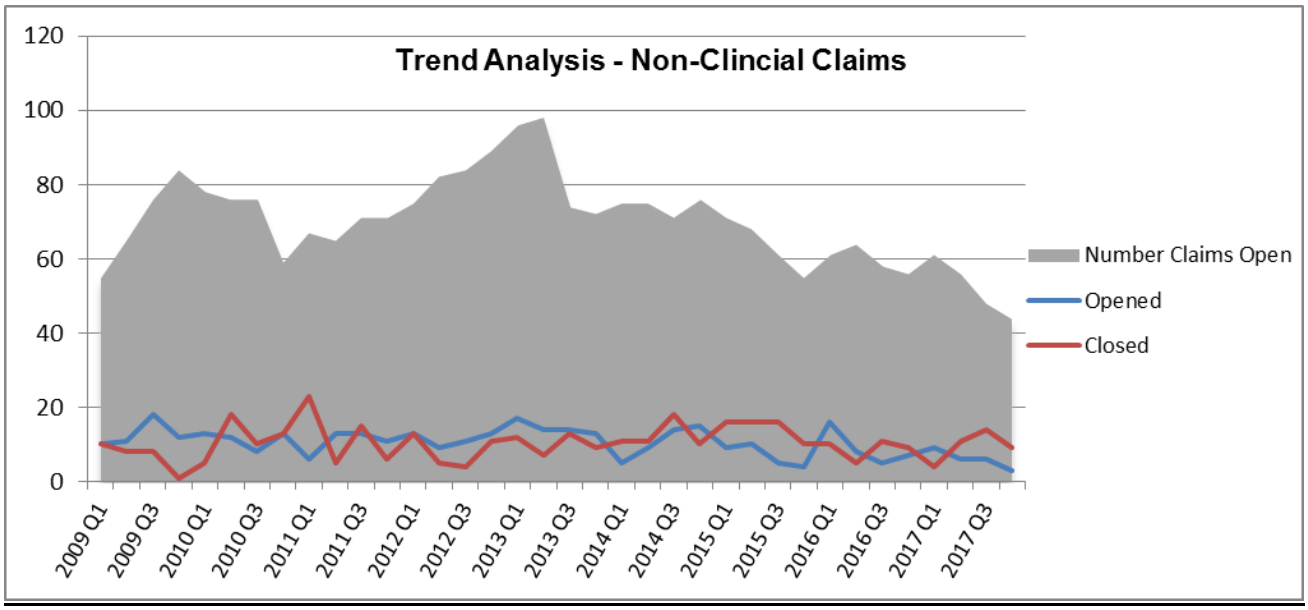


Table 1: Number of new claims by Type and HG

Type of Incident	Employers liability	Public liability	Total
Corporate Functions	8	1	9
Clinical Support - Health Group	1	0	1
Family and Women's Health - Health Group	2	2	4
Medicine - Health Group	5	1	6
Surgery - Health Group	3	1	4
Totals:	19	5	24

Table 2: Number of new claims by type of incident

Type of Incident	Employers Liability	Public Liability	Total
Employee - assault to	2	0	2
Employee - lifting; loading; unloading	4	0	4
Employee - occupational illness or disease	3	0	3
Employee - misuse of personal information	2	0	2
Employee - entrapment of hand	1	0	1
Employee - sharps injury	1	0	1
Employee - slip or trip	6	0	6
Public - defective tools or equipment	0	3	3
Public - infection; inhalation; irritation	0	1	1
Public - breach of confidentiality	0	1	1
Totals:	19	5	24

Table 3: Outcome of claims closed in 2017/18

Outcome	Employers liability	Public liability	Total
Closed as a result of notification from NHS Resolution	10	6	16
Settled	14	5	19
Claim withdrawn by Claimant	0	2	2
Totals:	24	13	37

Table 4: Number of outstanding non clinical claims as at 31 March 2018

Type of Incident	Employers Liability	Public Liability	Total
Employee - slip or trip	10	0	10
Employee - use of tools, machinery or equipment	4	0	4
Employee - lifting; loading; unloading	3	0	3
Employee - occupational illness or disease	3	0	3
Employee - assault to	2	0	2
Employee - misuse of personal information	2	0	2
Employee - injury during horse-play	1	0	1
Employee - scald	1	0	1
Employee - sharps injury	1	0	1
Employee - entrapment of hand	1	0	1
Public - disposal of fetal remains	0	8	8
Public - slip or trip	0	4	4
Public - defective tools or equipment	0	2	2
Public - infection; inhalation; irritation	0	1	1
Public - breach of confidentiality	0	1	1
Totals:	28	16	44

At 31 March 2018 there were 44 active non clinical claims open within the DATIX system. This is the lowest number of open claims for over 10 years.

Table 5: Summary of Claims closed as settled in 2017/18

Type	Specialty	Description	Damages	Total payments
Employers liability	Cardiothoracic Surgery	Fall as a result of slip on water leaking from faulty cooling system which had been reported causing back and neck pain.	£2,800	£11,925
Employers liability	Orthopaedics (Elective)	Exacerbated pre-existing injury to neck requiring pain injections when moved heavy trolley containing equipment. Root cause: inadequate risk assessment and reliance on Claimant to manage the risk.	£3,750	£11,969
Employers liability	Estates Operations (inc grounds and gardens)	Slipped on loose gravel in argyle street car park sustaining soft tissue injury to left knee.	£4,000	£13,011
Employers liability	Theatres	Sustained subluxation of left shoulder when transferring patient using patslide. Root cause: attempted to remove patslide from under patient when timing of team failed resulting in jarring motion and injury. No evidence of risk assessment or manual handling of individuals involved.	£7,500	£14,698
Employers liability	A and E	Sustained back injury causing pain in lower back and leg as a result of transporting patient via trolley down a slope between triage and majors. Root cause: absence of working brakes and/or locking wheels for steer mode when manoeuvring trolleys down slope.	£2,000	£8,421
Employers liability	Orthopaedics (Elective)	Needlestick injury to right ring finger from needle discarded on top of a dressings trolley.	£1,500	£6,251
Employers liability	Catering	Scald to left arm when food splashed on to arm when cellophane film removed from food container.	£1,250	£9,066
Employers liability	Catering	Claimant slipped on wet floor which had recently been cleaned by catering staff causing soft tissue injury to left ankle, leg and hand.	£1,750	£8,477
Employers liability	Estates Operations (inc grounds and gardens)	Slipped on loose gravel in car park sustaining contusion to head, grazes and soft tissue injuries to shoulder and hip. Root cause: loose chippings following repair of pot holes in car park.	£4,982	£13,031
Employers liability	Cardiology	Moving boxes of case notes with a colleague when box slipped out of hand and struck the back of her calf and caused soft tissue injury to arm and hand. Root cause: over-filling of boxes	£5,000	£15,614
Employers liability	Obstetrics	Table lowered in emergency theatre on to a bucket that was expelled from under the able causing the table to lowered further trapping the Claimants foot and causing soft tissue injury.	£2,500	£4,165
Employers liability	Theatres	Slipped on wet floor in the reception area sustaining fracture to 5th metatarsal and sprain to left foot and knee. Floor wet from access/egress in inclement weather.	£5,592	£7,502
Employers liability	Estates Operations (inc grounds and gardens)	Catering assistant tripped in pot hole in argyle street car park falling to the ground and sustaining fractures to ribs.	£1,000	£2,572
Employers liability	Acute Medicine	Fall to floor due to slip on plastic wallet resulting in jarring of hip and soft tissue injuries to knee and arm	£3,910	£5,578
Public liability	Diabetes and Endocrinology	Visitor fell in car park sustaining soft tissue injuries to knees, shoulder and exacerbation of a pre-existing injury to hip.	£4,500	£29,849
Public liability	Car Parking	Visitor fell over concrete in the car park outside the tower block due to poor lighting sustaining fractures to both wrists	£20,000	£26,158
Public liability	Estates Operations (inc grounds and gardens)	Patient slipped on an oil based substance in the day room, falling on to knee and sustaining soft tissue injury. The door was inspected as part of PPM Estates and identified as a potential cause.	£3,000	£5,428
Public liability	Estates Operations (inc grounds and gardens)	Trip over pole left in poorly lit area sustaining back injury.	£4,075	£7,140
Public liability	Urology	Patient sustained soft tissue injuries to right ribs and shoulder when chair gave way causing a fall to the ground	£2,920	£4,542

1. Moving and Handling

Key Activity – Annual Summary

The Moving and Handling Lead regularly liaises with the Critical Care and Surgery Clinical Nurse Educators, PDN's from various divisions, Specialist Nursing staff and with the University of Hull by attending meetings, leading and supporting training and attending moving and handling training sessions to assist and share knowledge. This has also ensured parity between theoretical and practical sessions, despite delivery by different teams.

Attending meetings with the Yorkshire Back Exchange has been problematic during the last 12 months due to prioritising work-load and the fact that dates of meetings are usually published with only a few weeks' notice, when other commitments have already been made by the moving and handling lead. The Moving and Handling lead was unable to attend the National Back Exchange Conference in Leicester due to cost implications.

The Moving and Handling Lead has spent much time rationalising lists of current link training staff. Historically (with no one in post for a considerable time,) the link trainer register had not been updated, leading to confusion as to areas covered. Existing link trainers also stated that they felt somewhat isolated and unsupported. A definitive list of all link trainers (currently 105 trust-wide) has been finalised and distributed, so that they are able to liaise with and support each other. This has forged tighter bonds and has been instrumental in standardising training and clinical practice. The link trainers are now more engaged in the training of staff and the risk assessment process within their areas (see appendix 1.)

Equipment Activity

The equipment procurement plan is to be discussed in July 2018. Historically, a budget of £50k has been used annually to replace moving and handling equipment deemed beyond repair or not fit for purpose. Due to financial restraint, it is currently unknown whether monies will be available for the period 18/19. This will be decided in finance meetings in June.

The moving and handling lead has visited all wards and departments to assess the need for new/replacement equipment. A request was also published on PATTIE asking ward or department who needed hoists, to contact the moving and handling lead. To date, no communication has been received from any ward or department. The assessment for new moving and handling equipment takes into account:

- Age of existing equipment
- Condition of current equipment
- Storage facilities
- Staff engagement in moving and handling training
- Patient acuity

During the past 12 months, the Moving and Handling Lead has also delivered equipment to several areas which previously had none. In most cases this has been for the following reasons:

1. Awareness of new equipment following equipment training
2. Changes to patient acuity
3. More elderly patients
4. Higher dependency of patients
5. Heavier patients

During this financial year, a business case was prepared by the moving and handling lead detailing the cost savings of swapping from Arjo-Huntleigh to Oxford Joerns hoists. Trials were undertaken in 2 areas of the trust with the Oxford Joerns hoist and it was generally well-received. Unfortunately, this was unable to be discussed further due to the need for the £50k budget to be spent. The Trust therefore continues to use Arjo-Huntleigh equipment. Unfortunately, the deal offered by Oxford Joerns has expired and discussion would need to be initiated again should a move to Oxford Joerns be considered.

Current budgetary arrangements prove difficult to manage as the £50k sum needs to be used when it is received. This results in there being no contingency budget available for areas that require new equipment due to change in patient acuity or extension of specialities into other areas. There is also no provision for equipment which breaks down and becomes uneconomic to repair. At the present time, should this occur, wards and departments are asked to wait up to 12 months for replacement equipment via the centralised budget.

The need to buy equipment as a one-off act also creates problems with the delivery of the new stock and collection of the old, to obtain a discount with Arjo Huntleigh. During this financial year, the delivery of new hoists was extremely problematic; due to the lack of available space, there was nowhere to deliver them to and nowhere to store the collectible items (which all need to be decontaminated and remain clean.)

A date was planned whereby the moving and handling lead would accompany the Arjo Huntleigh delivery personnel to deliver and pick up these items. The date was ignored by Arjo and 2 shipments of hoists were delivered to stores at HRI with no notification or communication. The moving and handling lead was then tasked with organising unpacking, removal from pallets (done by the moving and handling lead) and delivery to areas. The products to be collected are still on the wards and creating problems for staff. The problems due to the lack of available space will recur annually unless contingencies can be put in place to manage this. The ability to order and accept equipment as singular items *throughout* the year would remove this risk.

Training

Three Moving and Handling Link Trainer courses were held this year; despite 2017/18 being a very challenging year in terms of provision of resources and equipment. The three day course is held quarterly and is generally well-attended. In order to compensate for the loss of one course in the period 17/18, an extra course has been added to the 18/19 time-table and uptake has been very encouraging.

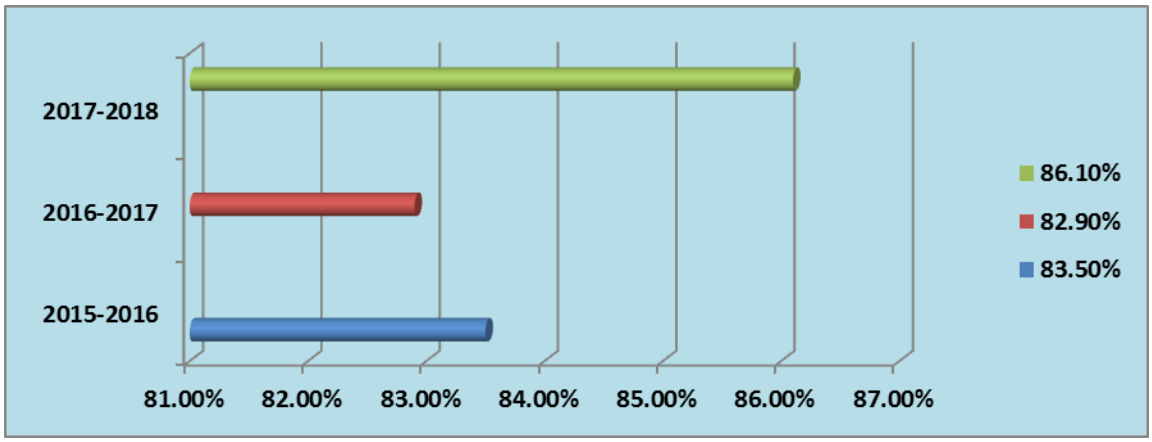
The final HRI Moving and Handling Link Trainer (3-day) course occurred at the Haughton Building April 25th-28th 2017 with 23 candidates. There was then a hiatus of 8 months, due to the closure of the Haughton Building. All essential moving and handling equipment was placed in storage and no alternative training venue was available. There was then a further delay as it was deemed unacceptable for the Trust moving and handling equipment to be stored in the new education and development training facility due to lack of space. The equipment was moved and stored 5 times within this period. At the time of writing this report, a metal container is being fitted out for equipment storage. The equipment is currently split between 2 areas, with the majority now being within the new Education and Development suite and some at another location. It is also worth noting that there has been a loss of some training equipment during this time for reasons unknown.

Due to the smaller training area within the new suite, class sizes have had to be reduced from 25-30 (Haughton) to 8-10 for safety. This however, is less than ideal and provision of space continues to be problematic. The lack of venue at HRI has also been difficult, as clinical staff need to be released from HRI to travel to CHH for training and this is rarely achievable.

Forward Planning:
The three KPI's identified for reporting against in 2015-2016 continue to be significant for the period 2017 - 18. It is recognised that the KPI's detailed below will provide an indication on which areas to build future business plans, asset procurement and training needs.

Training Analysis:

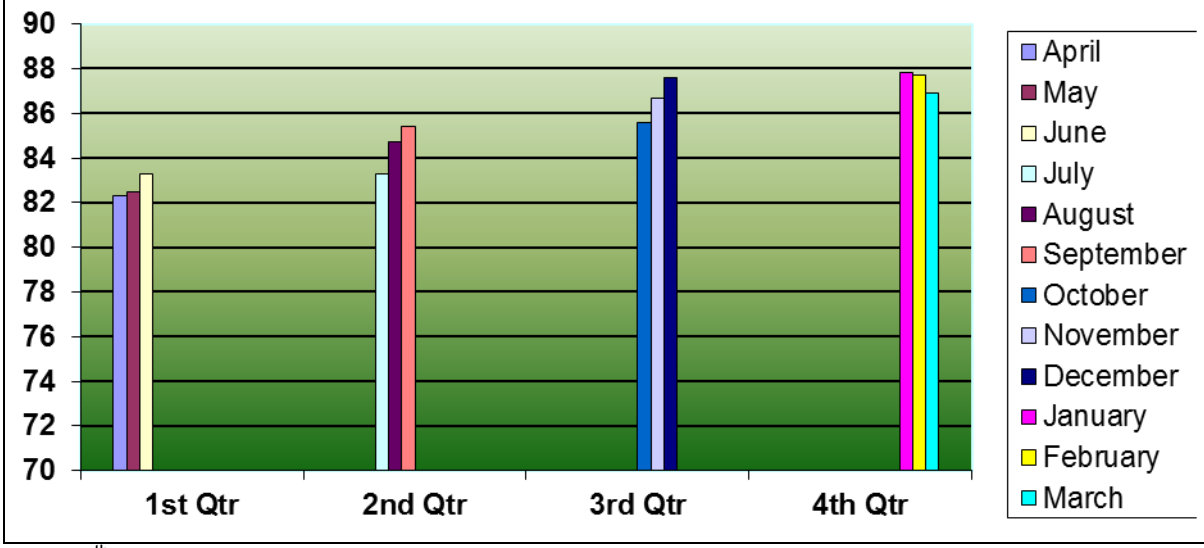
Figure 1. 2017-18 Annual Manual Handling Training Compliance (%) over 3 years. **



Training Compliance has risen overall by 3.2% throughout this year and now complies with the Trust target of 85%. This is thought to be for several reasons:

I. Rise in number of Link Trainers due to recommencing 3-day training session
II. Reduction of winter pressures leading to more training opportunities
III. Robust monitoring by Moving and Handling Lead

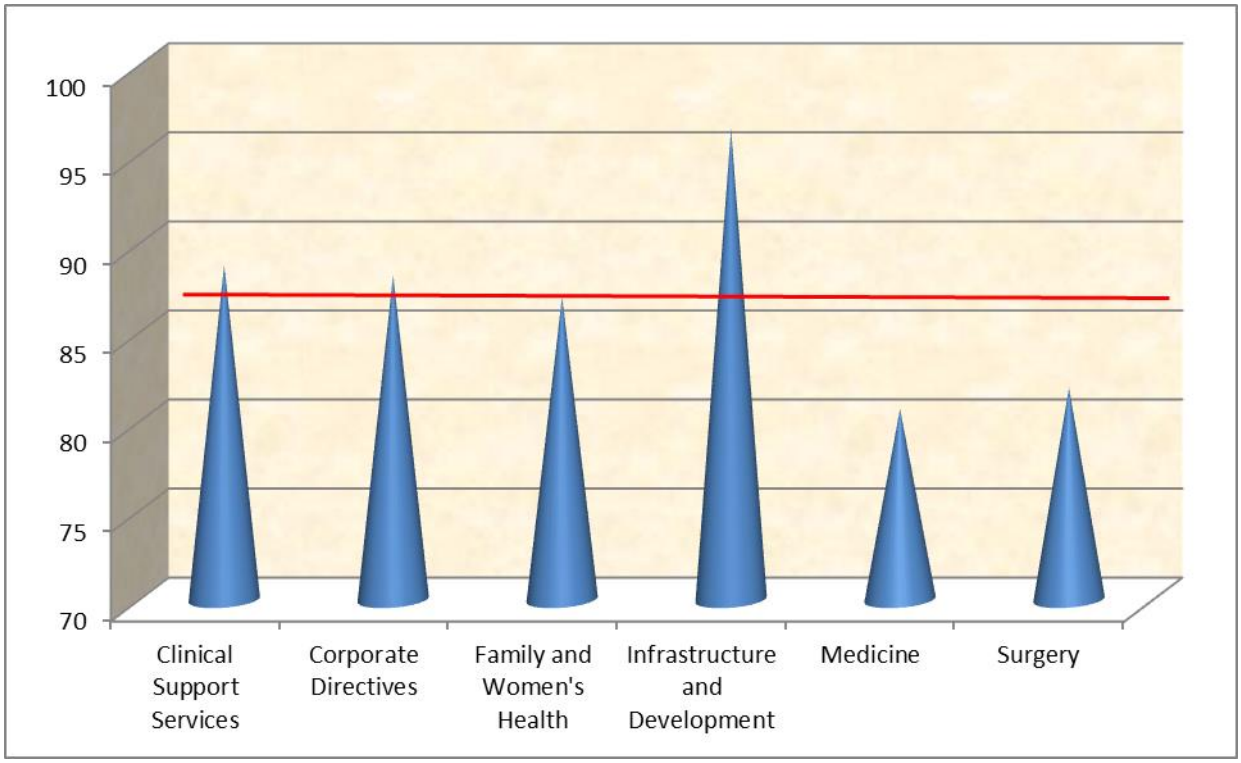
Figure 2. 2017-2018 Manual Handling Training Compliance (Percentage) by Quarter **



The 4th Quarter is seen to have the largest increase in compliance.

Figure 3. 2017-2018 Yearly Manual Handling Training Compliance[1] by Individual Health Group (Trust Compliance)**

[1] The Trust compliance target is 85%.

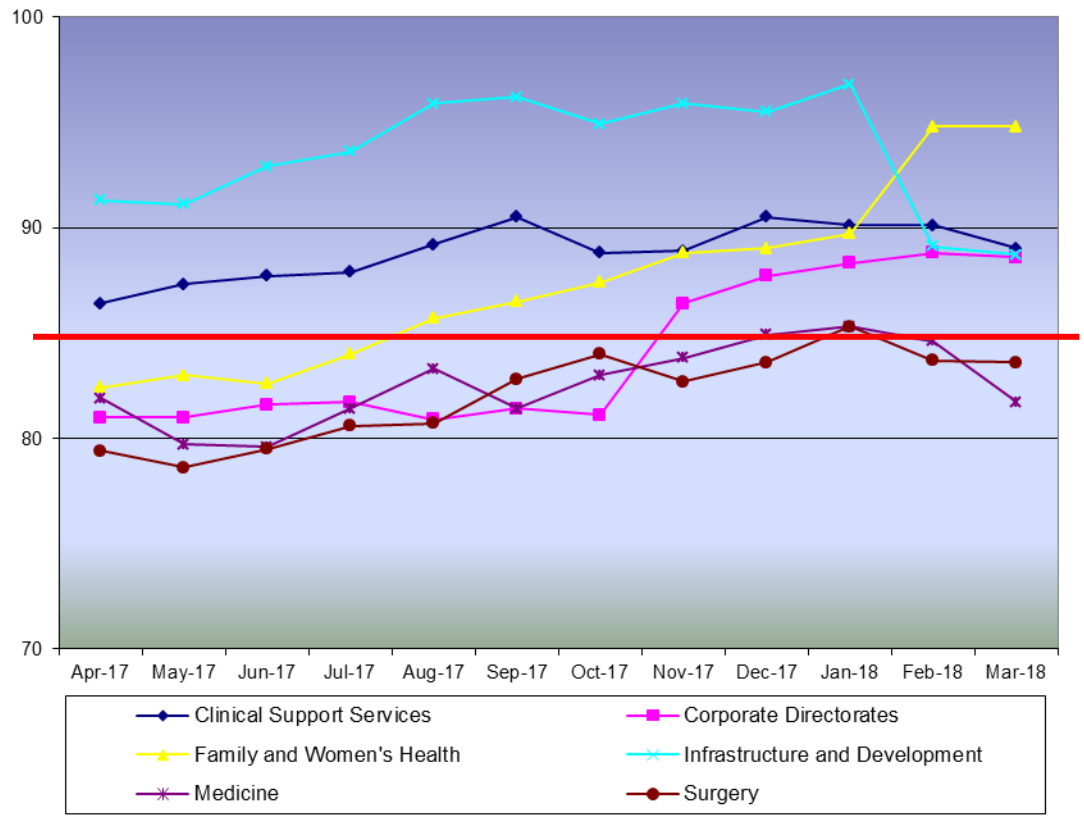


Of concern here, is that the three health groups with the lowest scores are patient-facing. The moving and handling lead provided training updates for staff at Suite 22 CHH but these were poorly attended. Feedback on reasons why training compliance is below the Trust compliance rate of 85% was received from staff with direct patient contact. Reasons given were:

- Poor staffing levels leaving no time for training
- Training needs 4 staff members and an empty bed – wards unable to provide this regularly
- Confusion as to what training was needed
- No Link Trainer available to deliver training
- Difficulty in commuting between sites (bus takes too long and finding a parking space is difficult)

(*Bus times from HRI to CHH are from 35 to 50 minutes. This means that a member of staff undergoing 1hr training will be commuting for 70-100 minutes. This needs to be factored into ward/dept shift and means that one hr training session would need nearly 3hrs allowing for this and is something that Dept Managers are unable to do.

Figure 4. 2017-2018 Yearly Manual Handling Training Compliance: (Trend) by Individual Health Group (—Trust Compliance)**



Failure in compliance is most evident across the Surgery and Medicine Health Groups and these two health groups have managed to achieve compliance only once in the last financial year. Also noticeable, is the fact that both of these health groups saw further reduction in compliance during the fourth quarter. This is possibly symptomatic of an increase in patient activity during this time.

*** Caution should be taken in relation to the data captured in figures 1, 2, 3 and 4 when analysing the percentage on trained staff on each ward, as it is evident that many staff members maintain compliance by retaking on-line moving and handling training (E-Learning) and never attend face-to-face practical training (see Table 1 below as example.) This evidence was born out of the moving and handling lead obtaining teaching lists of individual areas and studying compliance of individual staff members. The moving and handling lead attended the Professional Education Committee meeting to alert them of this. In an effort to find ways to deter staff from doing this, the moving and handling lead met with the data analysts for Education and Development. From this time hence, a new system exists which (whilst not being a definitive solution to this problem,) might improve staff compliance: prior to taking any e-learning module in moving and handling, the candidate will be asked whether they have also completed a practical course AND the Clinical Safety Day in the last 3 years. They will be reminded to tick all 3 training boxes and it is hoped that this might act as an aide-memoir to enable candidates to become and remain compliant.*

The HEY 24/7 recording system previously had no surveillance mechanism in place alerting staff of their mandatory requirements. Unfortunately, this system can be ignored by staff who

may choose to repeat e-learning rather than engage with face-to-face training but it is hoped that it will give staff a greater understanding of their mandatory training obligations. **

The moving and handling lead also attended the Professional Education Committee meeting to discuss provision of Moving and Handling training for new starters. The moving and handling lead has raised concerns about the provision of training within the Trust; at present, new starters on to the nurse bank are given 3 hours of training. The majority of the inductees are university students – all of which have received the training very recently in university and are therefore simply repeating the session again which is inappropriate. New inductees to the Trust from elsewhere however, receive no practical training and are reliant on ward staff for this, irrespective of whether the existing ward staff are compliant. The HSE states:

'You should establish a planned training programme to make sure all staff identified as requiring it receive basic training, as well as updates when necessary. This should also cover new starters to ensure training takes place either before or as close to starting a new job as possible.'[2]

The Matron for Practice Development is in discussion with members of the directorate concerning this. No decision has been made at this present time.

[2] The Manual Handling Operations Regulation 1992; HSE. Pg 66, Guidance 4(3)(c) Section 70.

Incident Analysis:

Table 2. Manual Handling Incidents (all) – Annual Comparison

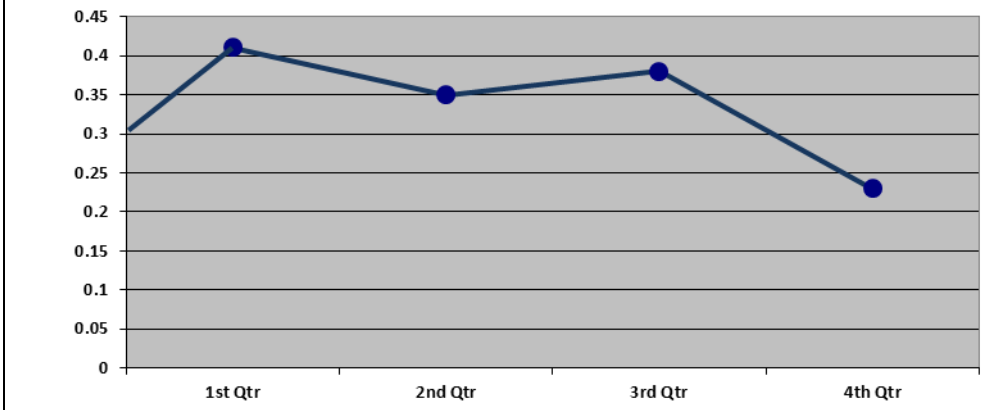
All Incidents by HG & Div Quarterly	2015/16	2016/17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Total	Fin Yr Var	Qtr Var
Clinical Support - Health Group	**21**	**13**	**5**	**7**	**7**	**5**	**0**	**19**	**46.2%**	**-100.0%**
Imaging Division			1	2	1	3	0	6		**-100.0%**
Pathology Division			1	2	3	1	0	6		**-100.0%**
Specialist Service Division			1	1	2	0	0	3		
Therapy and Therapeutics Division			2	2	1	1	0	4		**-100.0%**
Corporate Functions	**22**	**15**	**5**	**3**	**6**	**9**	**5**	**23**	**53.3%**	**-44.4%**
Estates, Facilities and Development			**5**	**3**	**5**	**7**	**5**	**20**		**-28.6%**
Finance and Business (inc. Patient Admin)			0	0	1	0	0	1		
Operations Directorate			0	0	0	1	0	1		**-100.0%**
Quality Governance & Assurance Directorate			0	0	0	1	0	1		**-100.0%**
Family and Women's Health - Health Group	**11**	**13**	**4**	**2**	**2**	**6**	**1**	**11**	**-15.4%**	**-83.3%**
Children, Ophthalmology and Dermatology Division			0	0	0	0	0	0		
Division 2 - Women and Children's Division			3	1	1	3	1	6		**-66.7%**
F&WHG Division 1			1	0	0	3	0	3		**-100.0%**
Women's Services Division			0	1	1	0	0	2		
Medicine - Health Group	**40**	**30**	**11**	**9**	**7**	**7**	**3**	**26**	**-13.3%**	**-57.1%**
Elderly Medicine			1	3	2	0	0	5		
Emergency Medicine Division			3	3	0	5	2	10		**-60.0%**
General Medicine Division			4	0	2	2	0	4		**-100.0%**
Specialist Medicine Division			3	3	3	0	1	7		
Surgery - Health Group	**50**	**28**	**7**	**15**	**8**	**6**	**11**	**40**	**42.9%**	**83.3%**
Cardiovascular and Critical Care			0	0	0	0	0	0		
Digestive Diseases			2	3	2	3	2	10		**-33.3%**
Specialist Surgery			0	0	0	0	0	0		
Specialties Division			2	1	3	0	2	6		
Theatres			2	1	3	2	6	12		**200.0%**
Trauma			1	4	0	1	1	6		**0.0%**
Grand Total	**144**	**99**	**32**	**36**	**30**	**33**	**20**	**119**	**20.2%**	**-39.4%**

There has been an increase of moving and handling reported incidents in all health groups except ‘Family and Women’s Health’ and ‘Medicine.’

Table 3. Manual Handling Incidents (all) – Quarterly Rates shown as percentage of Staffing Figures

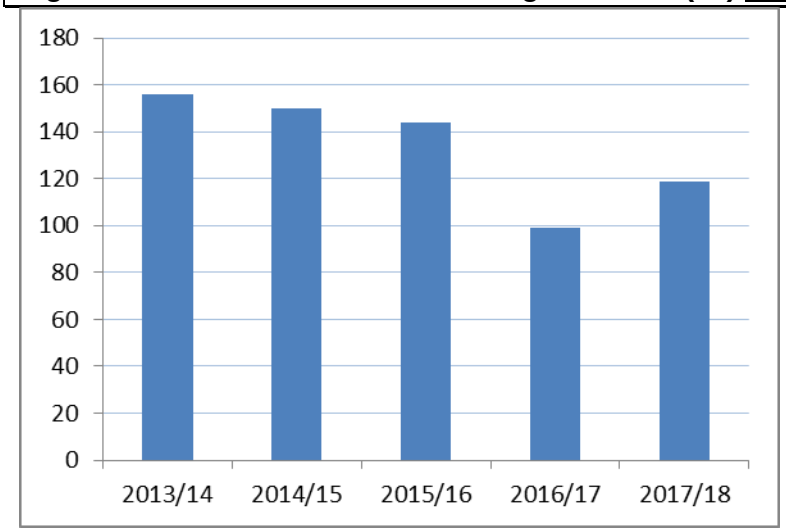
	No of incidents	Head Count	Incident Percentage Rate
Q1 17/18	36	8597	0.41
Q2 17/18	30	8560	0.35
Q3 17/18	33	8604	0.38
Q4 17/18	20	8660	0.23

Figure 5. Manual Handling Incidents (all) – Quarterly Percentage Rates shown as Trend



Overall, despite an increase in staff employed, the percentage rate of ALL manual handling incidents has reduced considerably over the last financial year.

Figure 6. Number of Manual Handling Incidents (all) annually - (Last 5 years)

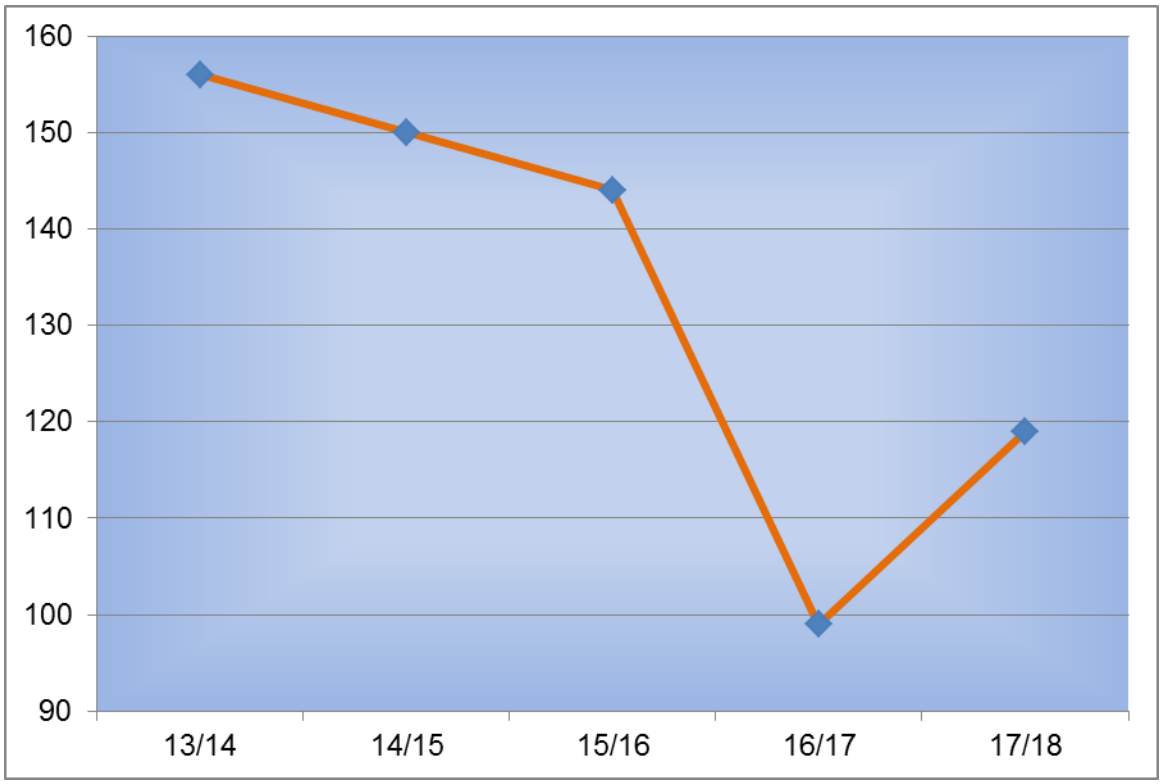


	No of Incidents	Variance
2013/14	156	N/A
2014/15	150	-3.8%
2015/16	144	-4.0%
2016/17	99	-31.3%
2017/18	119	20.2%
Grand Total	**668**	

There has been a 20.2% increase in the number of moving and handling incidents reported over the last 12 months in comparison to the previous year. The moving and handling lead has asked link trainers to encourage ALL staff to input every moving and handling incident and this, coupled with the 49 new link trainers now working within the Trust this financial year, is likely to have had an influence on figures.

Figure 9 (below) represents the trend of the overall reporting numbers for ALL incidents reported on Datix for the same period. This overall increase in M&H incidents will be monitored.

Figure 7. All reported incidents on Datix (Last 5 Years):



As can be seen, the increase in reporting between 16/17 and 17/18 whilst significant, in no way duplicates previous figures.

Table 4. Incident Reporting: ALL Moving and Handling - Related Incidents Recorded on Datix:

Year	No of Incidents	Change from previous year
2014/15	150	-3.8%
2015/16	144	-4.0%
2016/17	99	-31.3%
2017/18	119	+20.2%

Table 5. Incident Reporting: STAFF Moving and Handling - Related Incidents Recorded on Datix:

Year	**No of Incidents**	**Change from previous year**
2014/15	**122**	**Nil**
2015/16	**96**	**-14.3%**
2016/17	**77**	**-19.8%**
2017/18	**86**	**+11.6%**

Figure 11 shows an 11.6% rise in reported staff incidents. This could be attributed to raised awareness in staff, of the need to report ALL incidents.

Table 6. Incident Reporting: PUBLIC & PATIENT Moving and Handling - Related Incidents Recorded on Datix:

Year	No of Incidents	Percentage Change from previous year
2015/16	48	Unknown
2016/17	21	-43.75%

2017/18	35	+66.6%

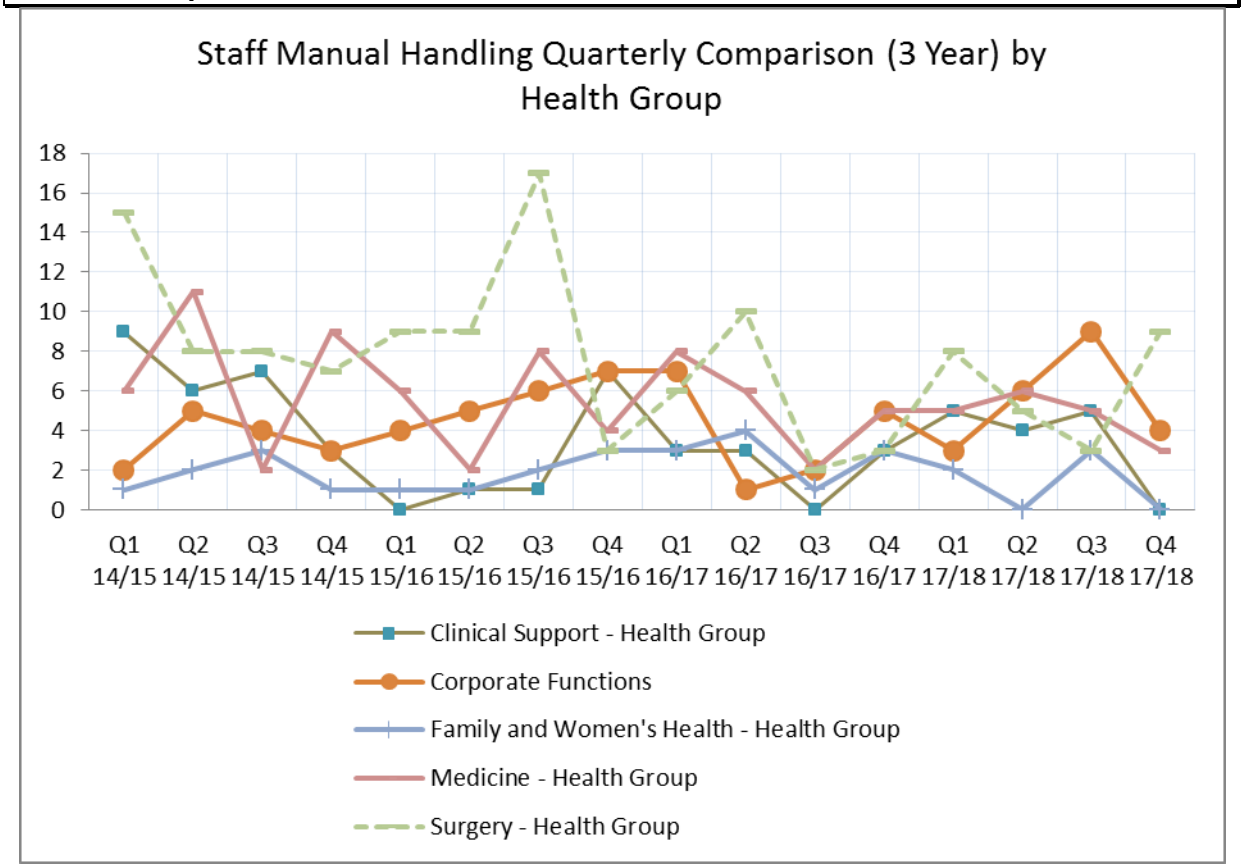
Table 6 shows a 66.6% increase in patient and public moving and handling related incidents.

Table 7. Moving and Handling Incidents Expressed as a Percentage of ALL reported incidents on Datix:

Year	Datix Numbers	Moving and handling reportable incidents as a percentage of all DATIX
2015/16	20034	0.23%
2016/17	19491	0.10%
2017/18	19609	0.17%

Overall, there appears to have been a significant increase in all moving and handling incidents reported throughout the Trust in 2017/18, compared to the previous year, but there is correlation between this and the number of ALL reported incidents. The higher number of incidents for the period 2015/16 is also duplicated in the higher number of moving and handling incidents for this period. Likewise, the lower number of DATIX reports in 2016/17 is reflected in reduced moving and handling figures for that period.

Figure 8. Four-Yearly Rates of Manual Handling Reporting for STAFF incidents by Health Group



This four-year comparison of moving and handling handling reporting, illustrates that health groups act independently of each other and that symmetry across all of these groups is rare. Significant though, is that all health groups (except surgery) experienced a reduction in reporting during the third/fourth quarter (17/18) when patient acuity and activity was at a high

level. This is in direct contrast to the third/fourth quarter of the 16/17 period, when reporting rates increased across all health groups.

Moving and Handling KPI's

- MANUAL HANDLING RIDDOR REPORTABLE INCIDENTS. This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses

- MANUAL HANDLING LINK TRAINERS

- PATIENT HANDLING ASSESSMENTS (Patient handling assessments are seen to be a key proactive control measure for the reduction of both the likelihood and severity of harm arising from clinical moving and handling. They are also used as a planning tool to identify whether the necessary equipment is available and provided during the patient's stay. A random sample of 50 ward based inpatient notes are audited each quarter to identify if patient handling assessments have been completed satisfactorily).

Progress against Moving and Handling KPI's:

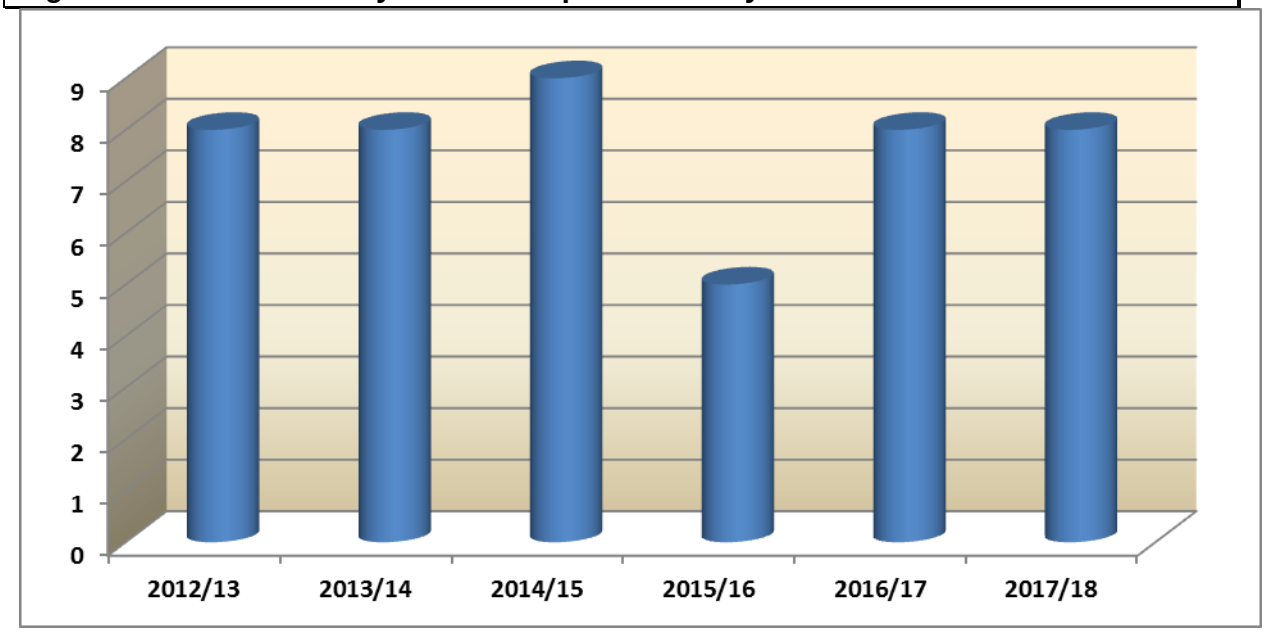
KPI 1 – Manual Handling RIDDOR Reportable Incidents.

Target – 0

Actual - 8

RIDDOR reports are usually associated with incidents of a more serious nature, which impact directly on the health and well-being of the individual. However, these reports are quantifiable and comprehensive. They provide necessary material for detailed investigation and reflective practice. Despite the fact that RIDDOR reportable incidents are *reactive* (rather than proactive), these incidents are more likely to be reported; as such, they are a more reliable measure and indicator of risk and performance across all Health Groups, wards, departments and individual staff members.

Figure 9. Number of Yearly RIDDOR Reports Made by Trust in Last Six Years



Despite an increase in reporting of incidents related to Moving and Handling, the period 2017-2018 has seen no increase in Moving and Handling RIDDOR reportable incidents which remains at 8. The mean average for the last 5 years remains at 7.6. It is hoped that an increase in the number of Link Trainers will eventually help to reduce this rate. However, several factors may influence this:

- Increasingly ageing workforce (many NHS workers are now required to work up to the age of 67 before reaching pensionable age and the NHS Employers website states that one in three workers will be experiencing chronic ill-health by 2020[3].)

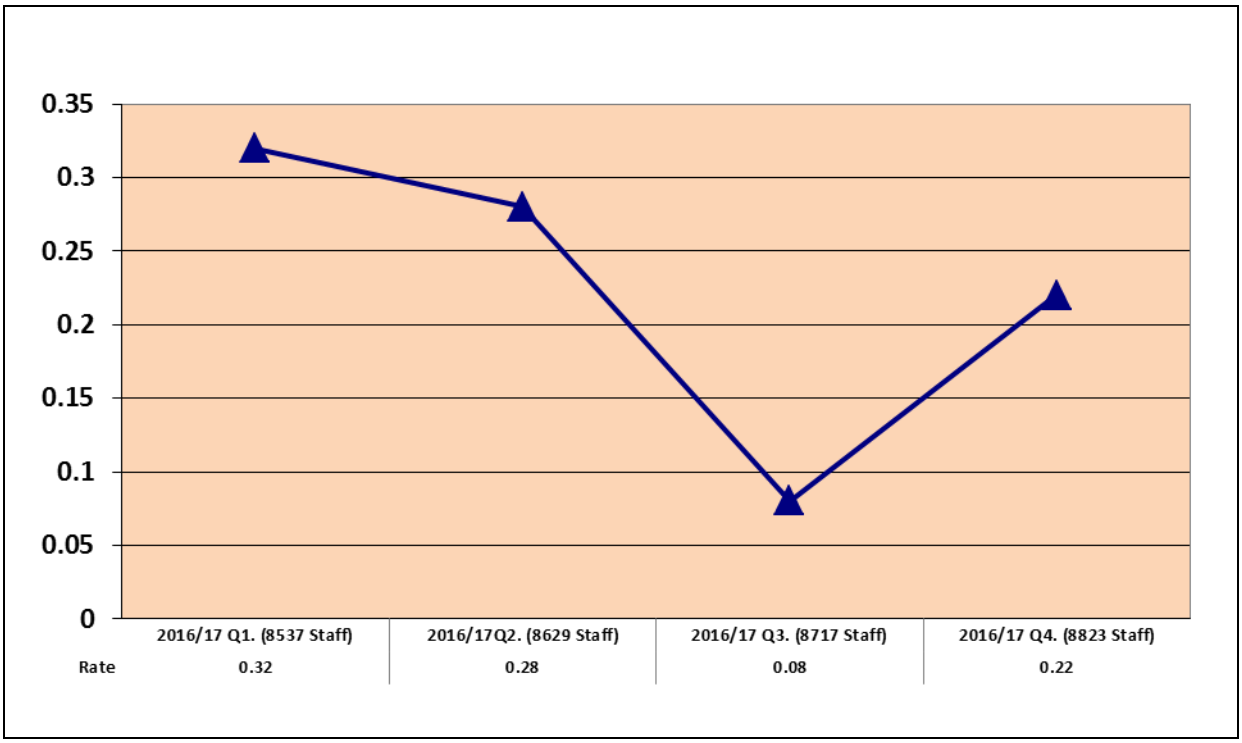
- Increasingly ageing population (with higher dependency and increasing comorbidity). The King's Fund states that from 2012 to 2032 the populations of 65-84 year olds and the over 85s are set to increase by 39 and 106 per cent respectively.[4]

- Higher hospital admission rates (16.5 million Finished Admission Episodes (FAEs) were recorded in 2016-17. This is an increase of 1.8 per cent from the previous year and an increase of 27.5 per cent from 2006-07.)[5]

- Increase in obese /bariatric patients. 25% of British adults are now classed as clinically obese (Royal College of Physicians, 2013) and this number is growing. Wang *et al* estimate that by 2020, 37 per cent of men and 34 per cent of women (aged 16+) will be obese. By 2035 they predict this will rise to 46 per cent of men and 40 per cent of women[6]

- Budgetary constraints on equipment purchase (consumables and non-consumables)

Figure 10. Rate of RIDDOR Reportable Incidents per 100 staff:



[3] http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/working-longer-group-tools-and-resources/the-ageing-workforce-a-resource-for-managers/managing-an-ageing-workforce-the-key-issues
[4] https://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[5] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/hospital-admitted-patient-care-activity-2016-17
[6] Wang YC, McPherson K, Marsh T, Gortmaker SL, Brown M (2011). Research paper. 'Health and economic burden of the projected obesity trends in the USA and the UK'. *Lancet*, vol 378: pp 815-25

KPI 2 – Manual Handling Link Trainers
Target – 100% coverage in Key Areas
The moving and handling lead formulated a survey which was sent to the Link Trainers via the 'SurveyMonkey' website. The survey asked 10 questions about their role in the hope that more insight could be obtained concerning their individual experience. The anonymous results were gathered and processed in April 2018 but due to the low response, the confidence level would be skewed and figures would be of no use. Responses given to questions were beneficial however, and these will be acted upon in due course. Provision for bariatric patients and safety of staff during moving and handling has however, been a recurrent theme and this will be a priority for the moving and handling lead for 18/19. Despite there being 104 Link Trainers in 73 different areas and specialities, there is an evident lack of moving and handling link trainers within the medical and surgical health groups; most noticeably within the wards and departments of HRI tower block, where acuity is perhaps highest (see Table 7.) The moving and handling lead has attempted to rectify this by repeatedly asking C/N's and ward managers to nominate link trainers to access the three-day training; uptake however has been poor.

Due to the high number of link nurses and trainers needed in numerous other specialities (infection control, safety, diabetes, tissue viability, pain, etc) department managers have stated that they find it very difficult to cover all link staff requirements. The three-day training is also seen as onerous by ward/dept managers. Training was reduced from 5 days to 3 days (the minimum duration suggested by the National Back Exchange) and is difficult to complete within the time frame allowed.

Table 8: showing coverage of areas which have a Nominated Moving and Handling Link Trainer

Area which currently has no moving and handling link trainer
Area which currently has a link trainer

HRI			
A&E	AAU	X-Ray	DSU
AMU	MRI	Ward 35	Ward 35
Ward 1	Ward 500	Recovery	Ward 34 Acorn
Endoscopy	Physiotherapy	Ward 12	Ward 30 Cedar
ICU	GHDU	General Theatres	Ward 31 Maple
Recovery	Ward 4	Ward 40	Ward 32
Ward 5	Ward 50	Ward 6	Ward 33 Rowan
Ward 60	Ward 7	Ward 70	Gynae Theatres
Ward 8	Ward 80	Ward 9	Gynae Recovery
Ward 90	AMU	Ward 100	Labour/Delivery
Ward 11	Ward 110	OT	Ward 130E
Ward 130W	# Clinic	Estates	Porters
Cath Lab	Combined	CT Dept	Radiology
Cardiac Physiology	Mortuary Services	Neurophysiology	Nuclear Medicine
Ultrasound	General X Ray	Community	Gynae OPD
IVF & W&C OPD	ANC & ADU W&C	L&D W&C	Ophthalmic Pre-
Ophthalmic	Ophthalmic OPD	Paediatric OPD	Ward 200
EPAU/EGU Clinic	Medical OPD	Elderly OPD	SSMU
Ward 12	Ward 120	Transfusion	PAU/HDU
Histopathology			
CHH			
ENT/Breast	ENT/Breast	Plastics OPD	Endoscopy
Ward 16	Ward 8	Ward 9	Ward 10
Ward 11	Ward 32	Ward 14	Ward 15
Gen/Ortho theatres	Gen/Ortho	ICU 2	GU Recovery
ICU 1	Ward 26	Ward 27	Ward 28

Cardio theatres	Cardio recovery	G/U Theatres	Ward 16
Nuclear Med	Ward 20	Cardiac Cath Lab	GI Physiology
Ward 33	Ward 29	Ward 30	Ward 31
Ward 12	Cardiac Day Ward	Diabetes Centre	Cardiology OPD
Breast care Unit	Dermatology	Interventional	BWH/ERCH
DSU	Teacher Trainer	Pain Management	ECG
Oncology/Haem	Bowel Screening	Radiology	General OPD
SALS	MaxFax		

All clinical areas are expected to have access to a manual handling link trainer in order to provide on-going advice and support to staff and provide practical training updates. Some areas however, have had no link trainer for a significant period of time. The Clinical Nurse Educators and PDN's have proven to be invaluable in fulfilling this role but are not able to cover every area Although there are numerous sub-divided areas across the Trust, Table 8 shows the key areas that have been identified as requiring a manual handling link trainer and is the list that will be measured against. The assessment criteria will be broken down to show the following information:

a) A named link trainer is working within the department or one has been identified from a related area to provide support and training.
b) The nominated link trainer has attended the internal training course to give them the skills and knowledge to fulfil the role.
c) The nominated link trainer has attended an update within the last 12 months.
d) The nominated link trainer is active in their role and has provided support and training within the department as identified in the department TNA.

KPI 3 – Patient Handling Assessments
Target - 100% / Actual 100%
Trust policy states that all in-patients should be assessed for moving and handling need upon admission. Random samples of 50 ward-based in-patient notes are audited each quarter. This will identify whether patient handling assessments have been completed satisfactorily. 10 wards were visited in the past financial year, and 200 patients were randomly selected (50 per quarter).

Table 9: Areas of Audit

HRI			
A&E	AAU	Ward 12	Antenatal Day Unit
AMU	MRI	Day Surgery	Ward 500
Ward 1	MOPD	Ortho OPD	Acorn Ward
Endoscopy	Ultrasound	Ward 31	Ward 30 Cedar
GHDU	Ward 4	Ward 40	Ward 32
Ward 5	Ward 50	Ward 6	Ward 33
Ward 60	Ward 7	Ward 70	ICU
Ward 8	Ward 80	Ward 9	Ward 11
Ward 90	AMU	Ward 100	Ward 110
Labour/Delivery	Ward 130E	Ward 130W	Ward 34
Ward 35	Ophthalmic Day	Ophthalmic OPD	Ward 120
CHH			
Ward 32	Recovery	ICU 2	Ward 6/7
Ward 16	Ward 8	Ward 9	Ward 10
Ward 11	Endoscopy	Ward 14	Ward 15
Ward 16	Ward 33	Ward 31	Ward 30
ICU 1	Ward 26	Ward 27	Ward 28
Ward 29			

It was decided to reduce the areas suitable for audits by removing the areas with transitory patients (such as XRay, Theatres, etc.) There is a risk that a single patient could be audited twice; both on wards and in departments they are visiting temporarily for procedures.

General rates were as follows (non-ward specific)

Figure 11. Percentage of Patients Who Were Not Assessed for Mobility as Per Policy

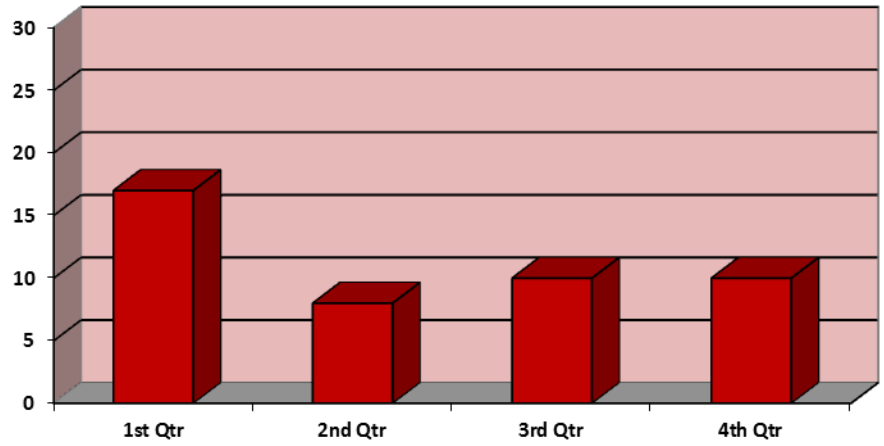
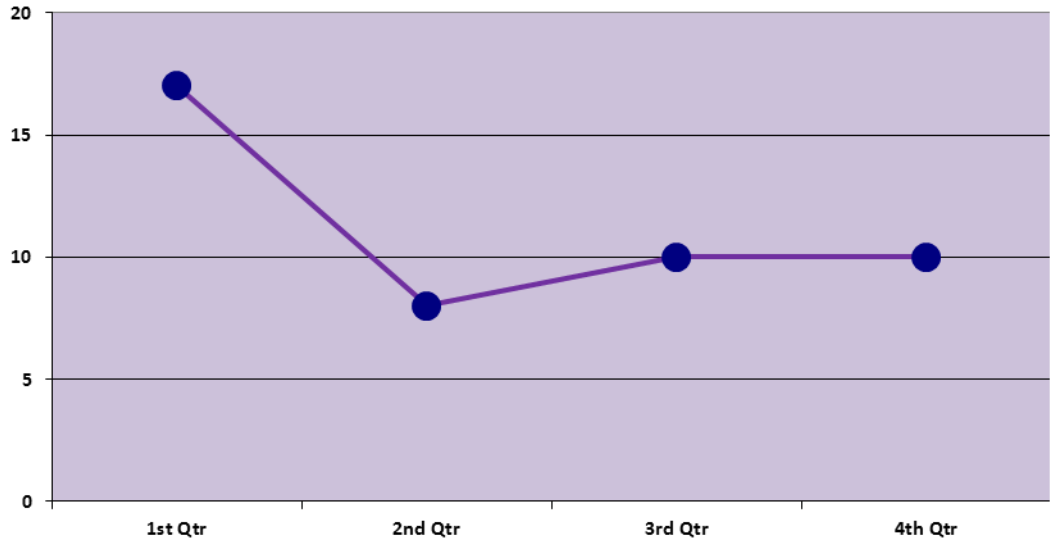


Figure 12. Percentage of In-Patients Not Assessed for Mobility as Per Policy (Expressed as Trend Line)



There is a visible increase in rates between 3rd and 4th Quarter. This could be as a result of increased admission rates. It was also noted that some patients do not undergo assessment during the weekend, when physiotherapists are at reduced numbers.

Figure 13. Percentage of Dependent Patients without Moving and Handling Action Plan Performed on Admission

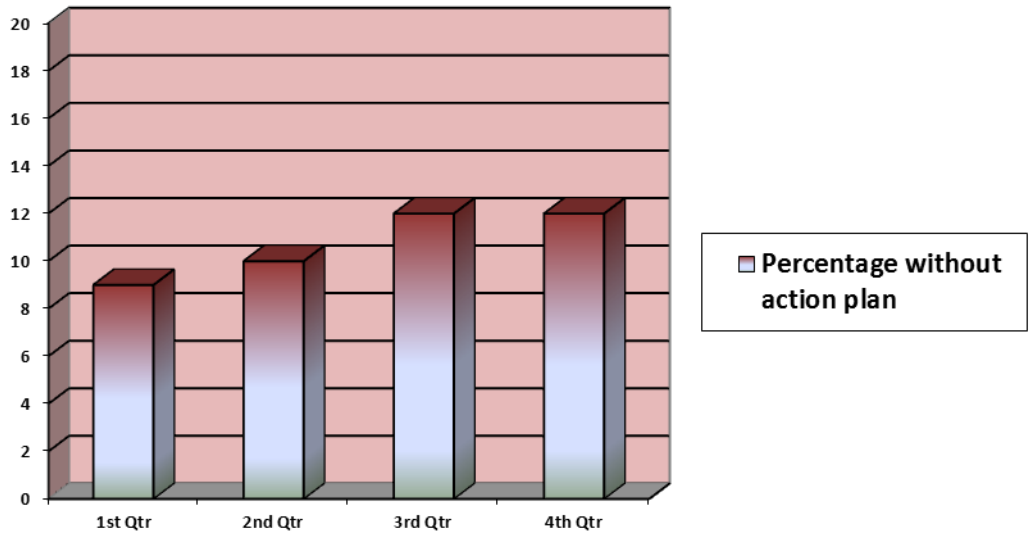


Figure 14. Percentage of Dependent Patients without Moving and Handling Action Plan Performed on Admission Expressed as a Trend

Despite a rise in initial assessment, there was no change in the third and fourth quarter

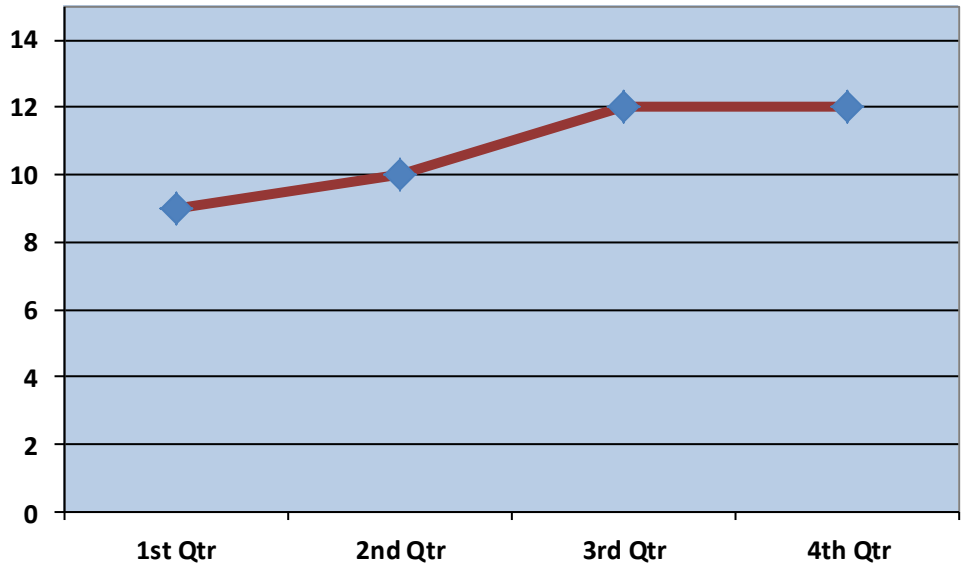


Figure 15. Percentage of Patients not Undergoing DAILY Moving and Handling Action Plans

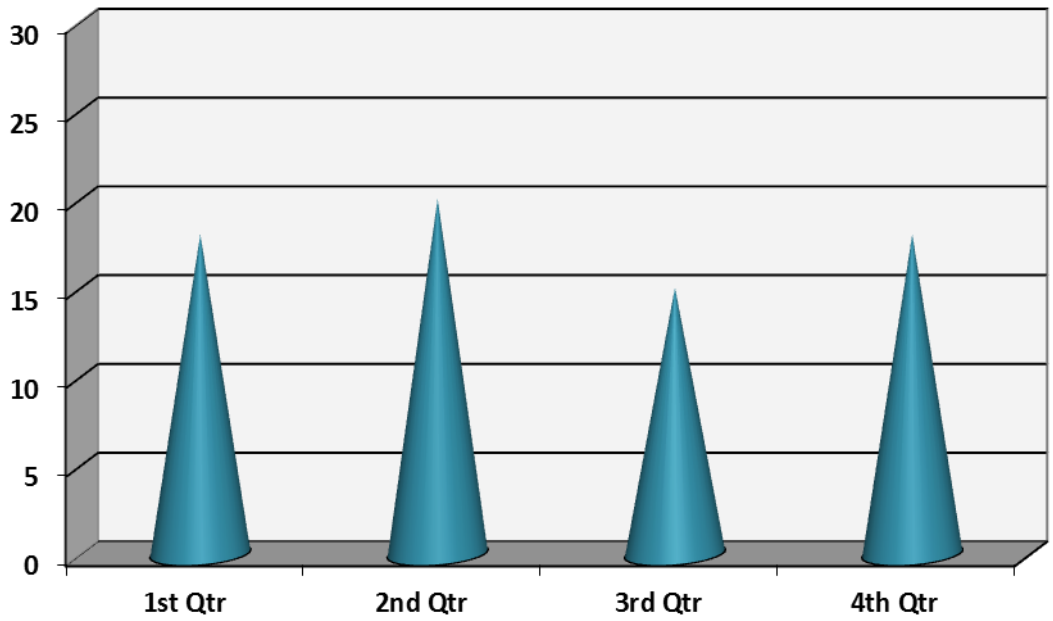
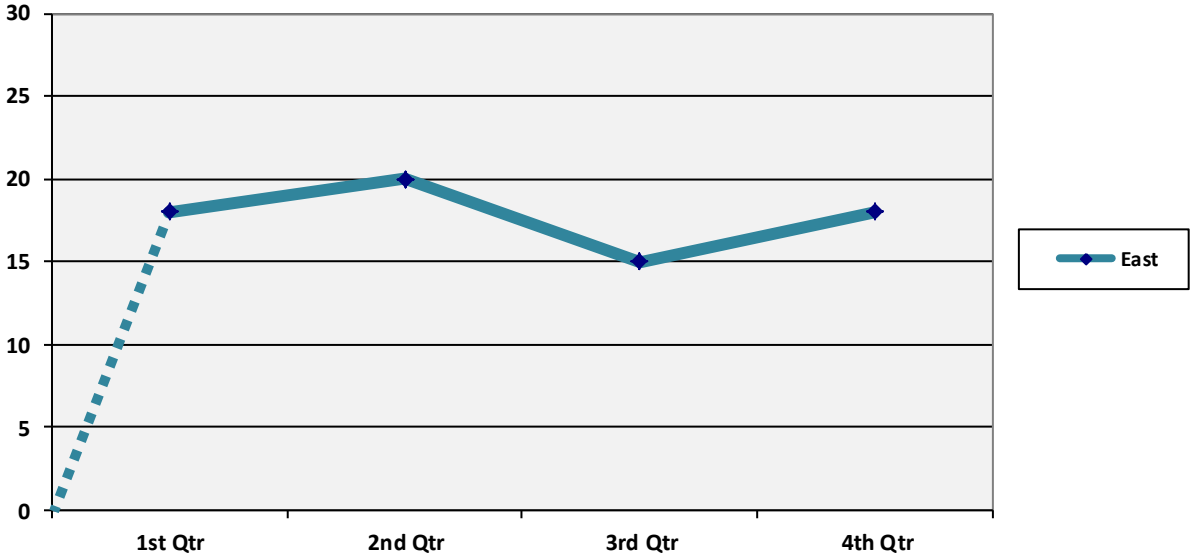


Figure 16. Percentage of Patients not Undergoing DAILY Moving and Handling Action Plans Expressed as Trend



There was a definite decrease in the number of daily mobility assessments completed in Nursing Care-plans between second and third quarter. However, this appears to be reversing, as more assessments are now being carried out. The Moving and Handling Lead is to ask all Link Trainers to monitor this during their 'time-out' and to reiterate the importance of completing these daily. Staff however, are finding this difficult to achieve due to work-load and need to prioritise clinical duties.

Despite informing the Link Trainers of the need to replace damaged or ineffective lateral transfer boards, the audits carried out throughout the year have highlighted that many departments and wards are *still* using substandard lateral transfer boards. One audit revealed that staff are using furniture polish on their board in an effort to restore the glide coating.

Ward audits have also once again highlighted a lack of commitment in using slide-sheets by several wards and departments. The preferred supplier has stated that the original predicted figures of use continue to fall very short of actual use. Reasons for this are mostly financial but staff admit that time is also an issue. The Trust historically orders 100x100cm slide-sheets from Banana/GB UK. Two sheets should be used per patient but in some areas where slide sheets are available, only one is used. The moving and handling lead has been asked to source single full-length slide sheets in an effort to make insertion and removal easier. The emergency department has also raised concern about the use of slide sheets due to the number of patients who are admitted into the department, as there is no budgetary increase to absorb this. Most patients therefore, are still transferred using sheet and board which is less than ideal.

13. Objectives / Priorities for 2017/18

- Increase the number of properly trained Safety Focal Persons and Moving and Handling Link Trainers within the organisation.
- Reduce the likelihood and / or severity of 'major' incidents which could have the potential to cause multiple casualties and damage to the Trust. This will involve working with colleagues from related teams to audit current arrangements and (a) seek assurance where it exists and (b) suggest preventive measures where assurance is inadequate.
- Build upon the successes seen in the reduction of Employer's Liability Claims made against the Trust: this can be achieved by (a) preventive, pro-active measures generally, and (b) investigations that enable realistic defence for the Trust along with lesson learning to reduce the likelihood and quantum of future claims.
- Increase activity in the prevention of slip hazards, including close working with cleaning services, (Safety are already involved in the steering group for the cleaning services tender).
- Review the adequacy of the Trust's management arrangements in the area of work-related stress: this hazard is a stated priority for the HSE in the coming year.
- Ensure adequate or improved quality of training for M&H Link Trainers through the utilization of training facilities and equipment. Following the closure of the training facilities at the Haughton Building and the opening of the new facility at CHH, we need to ensure that hands-on training with equipment is maintained. This will hopefully include using facilities at HRI (possibly 'winter' wards / Clinical Skills).
- Continued efforts to maintain and improve performance towards the KPI targets described at the beginning of this report.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	29 October 2018	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- Project Director Report
- Financial report for the year to date as at 31 August 2018 was received
- Fund balances and spending plans
- Legacies update
- Update on investments; Brown Shipley investments disinvested and transferred to COIF
- Internal Audit report – 5 recommendations made which have been actioned
- Received the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)

Decisions made by the Committee:

- Agreed funding requests for general charitable funds
- Formally approved the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)

Key Information Points to the Board:

- Internal audit report provided significant assurance in respect of procedures in place to effectively manage charitable funds
- External Auditors anticipated issuing an unqualified audit opinion
- Legacies received after 1 October 2018 are now directed to WISHH Charity

Matters escalated to the Board for action:

Nothing to escalate, key issues discussed captured above

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

HELD ON MONDAY 29 OCTOBER 2018

THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr A Snowden (Chair), Vice Chair, Non Executive Director Mrs V Walker, Non Executive Director Mr D Haire, Project Director, Fundraising Mr L Bond, Chief Financial Officer
IN ATTENDANCE:	Mrs D Roberts, Deputy Director of Finance Ms C Ramsay, Director of Corporate Affairs Mrs L Roberts, Personal Assistant (Minutes) Mr P Sethi, Grant Thornton

1 APOLOGIES FOR ABSENCE

No apologies were received.

2 DECLARATIONS OF INTEREST

Mr Bond and Mr Haire declared that they are Trustees of the WISHH charity.

3 MINUTES OF THE MEETING 7 JUNE 2018

The minutes of the meeting held on 7 June 2018 were approved as an accurate record.

MINUTES OF THE EXTRAORDINARY MEETING 27 SEPTEMBER 2018

The minutes of the extraordinary meeting held on 27 September 2018 were approved as an accurate record.

4 MATTERS ARISING

Terms of Reference

Ms Ramsay advised that the refreshed Committee Terms of Reference were presented at the July 2018 Trust Board meeting and approved.

It was noted that the Committee effectiveness review was being supported by Mrs D Roberts and Ms Ramsay. The review would be discussed at a future meeting.

Resolved:

The Committee agreed to discuss the Committee effectiveness review at a future meeting. **ALL**

5 ACTION TRACKER

Mr Snowden advised that the WISHH charity proposal papers had been presented at the July 2018 Trust Board meeting. The action could be removed from the tracker.

6 WORKPLAN 2018/19

The Committee received the 2018/19 workplan and the following changes were to be made:

Grant Thornton and Brown Shipley should be removed from the workplan.

- WISHH should be relabelled as WISHH Progress Report and should be submitted to the Committee every 6 months.

Resolved:
The Committee:

- Agreed to receive the draft 2019/20 workplan at the next meeting. **CR/LR**
- Suggested changes to the 2018/19 and for the proposed 2019/20 workplan. **LR**

7 PROJECT DIRECTOR'S REPORT

The paper was presented to the Committee by Mr Haire who gave an overview of the fundraising activities.

WISHH Charity

Work was on going to ensure the smooth transition of the management of charitable funds by the WISHH charity.

This included the management of financial activities, through systems such as ELFS. The recruitment to the posts of Charity Manager/Fundraiser and the Administrative Officer were discussed. The development of related PR material was being undertaking, including a launch event for the charity. Meetings with the Health Groups would take place to advise them on the transition process.

Replacement of the Brocklehurst Building to enhance research capacity

The Committee was informed that the proposed scope and costs for the replacement of the Brocklehurst Building were still subject to on-going discussion. It was noted that a final decision involving discussions with the benefactor was imminent.

Creating a Dementia Friendly Environment – Wards 8 and 80

A review of the key objectives was undertaken and the project brief had been revised, once fully agreed the brief would be presented to the Committee.

Mrs Walker informed that Committee that a local person, Wendy Mitchell had written a book on Dementia and suggested that the Trust purchases some copies for the Medical Elderly wards. Mr Haire agreed to look into purchasing some on behalf of the Trust.

Da Vinchi Robotic Surgical System – Performance Information

Mr Haire and Mr Bond had met with the Surgery Health Group to discuss the usage of the current Da Vinchi Robotic Surgical System and the proposal for the second robotic system within the Trust.

The Committee would be kept informed of the progress in relation to this project.

Integrated Cyclotron and Radiopharmacy Development

A review meeting had taken place with G.E Healthcare, Design Team and Hobson & Porter, the main contractor .The key dates had been agreed with the facility being fully operational in January 2020. It was noted that that Radiopharmacy element of the development could be functioning shortly after August 2019.

A report detailing the revised finances in relation to the Cyclotron and Radiopharmacy would be presented to the Capital Resource Allocation Committee in due course.

Outpatient facilities for children with complex disabilities

The Health Group was progressing with the proposal in relation to outpatient facilities for children with complex disabilities; however it had been identified that the requirements were greater than originally envisaged.

Paediatric Services – 13th Floor

Work was developing in relation to the 13th floor Paediatric wards, which included environmental improvements to the physical environment and the provision of equipment. It had been estimated that the costs for the requirements would be circa

£200k. It was advised that Mr Bond and Mr Haire would meet to discuss the funding options available.

Retinal Camera
The Committee was informed by Mr Haire that to date the family had raised approximately £65,000 rather than £75,000 quoted for the retinal camera appeal.

Mr Bond advised the Committee that he had received an email from the Chief Executive, which had come from a member of staff. This staff member, from the Trust's Eye Hospital, stated that so far, circa £75k had been raised towards to appeal and that the Trust was being asked to contribute the final £20,000 in support of the project.

The Committee was reminded of earlier discussions, which centred on the Help for Health pledge which proposed a £4 contribution from charitable funds for every £1 donated by the Help for Health Charity. Whilst this particular approach had not been well received in subsequent discussion the Committee had indicated a willingness to consider a request for funding support as the Appeal got closer to its overall target of circa £100,000. No commitment had, however, been given, although the Committee would be receptive to a proposal in due course. The transitional arrangements for the management of the Trust's charitable funds to the WISHH charity could well necessitate the WISHH charity also needing to consider any such request.

As there was a lack of clarity on the make-up of the £75,000 and Mr Haire was meeting with Mr Thompson shortly the overall position would be clarified, including the level of funds received to date.

Hospital Arts Strategy
Plans were being put into place to progress with the individual projects detailed within the Hospital Arts Strategy, with the 3 year development plan being proposed in the Strategy by the end of January 2019. Mr Haire agreed to report back to the Committee on the development at the February 2019 meeting.

There were three particular projects that the Charitable Funds Committee was being asked to support, which were:-

- **CHH Main Corridor & Ward 15**
  As part of improvements to the appearance of the main hospital corridors and ward 15, the instillation of artwork had been requested at a cost of circa £5k. Mr Haire would be attending the Health Group's Board meetings to discuss art in the hospital further.

  The Committee supported this proposal and request.

- **Reading Rooms Project – James Reckitt Library Trust**
  An opportunity to participate in a one year reading/poetry project had been offered by the James Reckitt Library Trust who would support the £25k costs. The Trust however would be required to provide and additional £4.8k for management support and liaison.

  This project would benefit patients in a number of areas such as oncology, medical elderly, paediatrics and renal.

  The Committee supported this proposal and request.

- **Song for Hull Project**
  A proposal to support the Song for Hull event in October 2019 was received at the cost of up to £5k. It was agreed that Mrs Walker would discuss this further with Mr Gore, who would also be invited to the February 2019 meeting.

Health Groups – Amalgamation of Charitable Funds
Discussions had concluded between Mr Haire with the Medicine Health Group and Surgery Health Group regarding the amalgamation of their Charitable Funds. It was noted that the funds had been reduced from 61 to 29 funds for the Medicine Health Group and reduced from 68 to 20 for the Surgery Health Group.

It was noted that a meeting with the ELFS team, to discuss the above was to take place.

Resolved
The Committee:
- Received the report and accepted the contents
- Agreed to receive an update on the Hospital Arts Strategy at the next meeting. **DH**
- Mr Gore to be invited to the February 2019 meeting regarding Song for Hull. **VW/LR**

8 FINANCIAL REPORT AS AT 31 AUGUST 2018
Mrs Roberts presented the Financial Report to the Committee and advised on the financial position of the charitable funds as at 31 August 2018.

Total income received as at 31 August 2018 was £342k, which was significantly lower than plan. It was noted that in previous financial years that this would usually improve during quarter 3 and quarter 4.Total expenditure for the period was £226k which was less than estimated.

The investment portfolio and cash reserves were valued at £2.198m.

It was noted that some of the monies allocated from fund F17095 for the Lazaat transaction would be reallocated back to the fund.

A paper was tabled detailing the charitable funds that had been approved by Trustees since the last meeting.

9 INVESTMENT UPDATE
It was advised by Mrs D Roberts that the investment portfolio with Brown Shipley had been closed. It was estimated that circa £1.2m in funds would be paid to the Trust charitable fund account. The amount would be clarified once a statement was issued by Brown Shipley.

The Committee agreed that circa £850k - £1m of the funds should be transferred into COIF.

Further information on the outcome would be given to the Committee at the next meeting.

Resolved
The Committee agreed to receive an update on investments at the next meeting. **DR**

10 FUND BALANCES AND BIDS FOR GENERAL FUNDS
Mr Haire presented the Fund Balances and Spending Plans paper to the Committee and gave an overview of the current position.

It was advised that as at 31 August 2018 the charity had £2,021m available to spend.

There were 23 funds with a balance in excess of £20k, the balance of these funds combined equated to £1.22m.

Work was on-going with Health Groups to review and identify whether long standing commitments were still required.

Ten requests for funding were received:

Pride and NHS 70th Anniversary Celebrations
Provision of Flags
This was to confirm the approval for expenditure of £696 to purchase flags for staff participating in the Pride celebration in July 2018.

The funding approval was confirmed.

Pride Celebrations
A request for £528 to cover the costs already incurred for the design and application of artwork to two Trust vans was received.

The funding request was not approved.

Anlaby Suite - provision of vinyl wall prints
A request had been made to fund the provision of vinyl wall prints and associated mounting costs for the newly relocated Anlaby Suite. This would create a more informal and relaxing environment for patients using the facilities. The cost of circa £2k was requested.

The funding request was approved.

Day Surgery Unit / Ward 4 Building CHH – Replacement furniture
A request of £5,547.36 was made to purchase 11 replacement chairs for the Day Surgery Unit at CHH. The current chairs were acquired from when the Unit was previous a ward and were in poor condition.

The funding request was approved.

Paediatric: Plastics Trauma Outpatients – Environmental Improvements
A funding request of £1,200 was received to enable the addition of 2 ipads and artwork in the Paediatric Plastics Trauma Outpatients department.

The funding request was approved.

Differently Disabled Conference
The Trust has been asked to contribute £2k towards the total cost £25k for a Differently Disabled Conference in February 2019. The conference aims to bring together local services together to address health inequalities for people with learning disabilities and increase staff confidence to support these patients.

The funding request was approved.

Paediatric Wards – 13th Floor Provision of Equipment and Environmental Improvements
A request was made to support the purchase of 2 automatic BP machine for Neonates, 6 diagnostic wall stations and improvements to the appearance of the playroom, treatment rooms and corridor in the paediatric wards. This was a total cost of £7,281.

The funding request was approved.

James Reckitt Library Trust
A request for up to £4,800 to support a proposed Reading Project to the James Reckitt Library Trust was made.

The funding request was approved.

European Pressure Ulcer Advisory Panel (EPUAP)
This a confirmation of approval already provided by trustees to meet travel costs for some staff who had been awarded the EPUAP Quality Improvement

Whilst the initial sum approved was £1,600 the actual cost was £1,653.53 and this is recommended as a charge against the funds.

The funding approval was confirmed.

Da Vinci Robotic System – Endoscope and Attachments
Funding of £19,241.50 was requested to cover the cost of robotic endoscope and associated items that were ordered for extra weekend theatre sessions. The order was completed to avoid patient operations cancellations.

The funding request was approved.

Resolved
The Committee:
- Received and accepted the report
- Approved the bids for general charitable funds as noted above

11 LEGACY REPORT
Mr Haire presented the Legacy Update report to the Committee.

The paper included the legacies that had been received by the Trust since the last report in June 2018, along with the notification of legacies that would be received at a future date.

An update regarding the two on-going legacy issues which were being pursued by the Trust was given. The Trust had accepted an offer of £14.696.13 from the relative of the deceased for one of the legacies. There were on-going legal issues in respect of the second legacy, although the Trust was expected to receive full payment of circa £26k.

Resolved
The Committee received the report and accepted the contents.

12 REVIEW OF POLICIES AND PROCEDURES
Mrs D Roberts presented the paper and gave the Committee an overview of the changes made to the Charitable Funds Policies.

The Trust's policies had been reviewed and updated to reflect the transfer and closer working with the WISHH Charity and the change in investment policy.

The Fundraising guide would be reviewed at a later date and in conjunction with WISHH.

Resolved
The Committee received the report and approved the changes to the policies.

13 INTERNAL AUDIT REPORT
The Internal Audit of Charitable Funds 2017/18 report was presented to the Committee by Mrs D Roberts.

An audit was undertaken by Mersey Internal Audit Agency during March 2018 as part of the NHS Trust's internal audit programme, with five recommendations for improvement been made.

Resolved
The Committee noted the content of the audit report and the actions taken to implement the recommendations.

14 YEAR END ACCOUNTS AND EXTERNAL AUDITORS REPORT

The external auditors, Grant Thornton had completed their audit of Charitable Funds and issued the Annual Governance Report (ISA 260).

Mrs Roberts presented the Annual Report and Accounts, Letter of Representation and Annual Governance Report (ISA 260) to the Committee for formal approval.

It was noted some recommendations for improvement were suggested which have been accepted by the Trust and have been actioned.

There were some narrative changes to text to be made in the accounts which Mrs Roberts agreed to amend prior to Grant Thornton formally signing off the Annual Report and Accounts.

Resolved
The Committee:

- Received the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)
- Formally approved the Annual Report and Accounts.

15 CHAIRS SUMMARY OF THE MEETING

Mr Snowden summarised the meeting.

16 ANY OTHER BUSINESS

There was no other business discussed.

17 DATE AND TIME OF THE NEXT MEETING

Monday 25 February 2019 at 11:30am,
The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

JANUARY 2019

Title:	Board Assurance Framework for Seven Day Hospital Services
Responsible Director:	Dr Makani Purva, Interim Chief Medical Officer
Author:	Jackie Railton, Head of Strategic Planning

Purpose:	The purpose of this paper is to present to the Trust Board the Board Assurance Framework for Seven Day Hospital Services published by NHS England and NHS Improvement in November 2018, together with the results of the Trust's 2018 self-assessment in relation to seven day service delivery.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	• In November 2018 NHS England and NHS Improvement published guidance for the providers of acute services on the new *'Board Assurance Framework for Seven Day Hospital Services'* • All acute service providers are required to complete a self-assessment of 7DS delivery and gain Board assurance of the self-assessment. Implementation will be on a phased basis, with Phase 1 being a 'trial run' (by February 2019) and Phase 2 being full implementation (by June 2019), with reporting on a bi-annual basis thereafter. • The Board assured templates will be submitted to regional and national 7DS teams so that they can analyse progress against the national ambitions. • Data from the trial run will not be made public, but results from the subsequent full implementation will be published to demonstrate progress.	

Recommendation:	The Trust Board is asked to note the content of this paper and the current position in relation to the delivery of the 7DS standards, and to endorse the actions identified to address gaps in 7DS provision.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK FOR SEVEN DAY HOSPITAL SERVICES

1. Purpose of Paper

The purpose of this paper is to present to the Trust Board the Board Assurance Framework for Seven Day Hospital Services published by NHS England and NHS Improvement in November 2018, together with the results of the Trust's 2018 self-assessment in relation to seven day service delivery.

2. Background

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013 (see Appendix 1), with a particular emphasis on four priority standards identified in 2015, ie:

- **Standard 2 - First consultant review**
  All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within **14 hours** from the time of admission to hospital.

- **Standard 5 – Timely access to diagnostics**
  Hospital inpatients must have scheduled **7 day access** to diagnostic services, typically ultrasound, CT, MRI, echocardiography, endoscopy and microbiology.

  Consultant-directed diagnostic tests and completed reporting will be available **7 days a week**:

  - Within 1 hour for critical patients
  - Within 12 hours for urgent patients
  - Within 24 hours for non-urgent patients.

- **Standard 6 – Access to consultant directed interventions**
  Hospital inpatients must have timely **24 hour access, seven days a week**, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

  - Critical care
  - Interventional radiology
  - Interventional endoscopy
  - Emergency general surgery
  - Emergency renal replacement therapy
  - Urgent radiotherapy
  - Stroke thrombolysis
  - Percutaneous Coronary Intervention
  - Cardiac pacing (either temporary via internal wire or permanent).

- **Standard 8 – Ongoing review**
  All patients with high dependency needs should be seen and reviewed by a consultant **twice daily** (including all acutely ill patients directly transferred and others who deteriorate).

  Once a clear pathway of care has been established, patients should be reviewed by a consultant at least **once every 24 hours**, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

Since 2016 providers have undertaken bi-annual audits of patient case note data to measure achievement of Standards 2 and 8, alongside an assessment of the availability of key diagnostics for Standard 5 and interventions for Standard 6. The audit data was uploaded to a national online tool. However, changes to patient pathways and service improvements were not always reflected in the survey results due to the quality of source data and validation issues. In addition, it was felt that the survey placed a significant administrative burden on Trusts as it involved reviewing a significant number of patient case notes.

NHS England therefore established a clinical reference group of senior provider clinicians to develop a robust board assurance process and self-assessment template to replace the existing survey and online tool.

3. The 7DS Board Assurance Framework

The 7DS Board Assurance Framework[1] for Trust self-assessment of 7DS performance follows a set of principles that ensure it is:

- Consistent, both in terms of the product (a single template for all providers of acute services) and its content (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory);
- Robust and accurate, with assessments based on information directly related to 7DS, allowing for board-level scrutiny and external assurance if necessary;
- Completed bi-annually, with sign off by the Trust Board before submission;
- Compatible with national-level measurement and reporting against the 7DS ambitions within the NHS Mandate and national planning guidance.

The self-assessment template (Appendix 2) enables providers to record their assessment of 7DS delivery in each of the four priority standards for both weekdays and weekends, as well as recording progress against the remaining six standards (the 7DS Clinical Standards for Continuous Improvement) and the four priority 7DS clinical standards in five urgent network specialised services (where applicable).

Implementation of the 7DS Board Assurance Framework is being undertaken on a phased basis:

- Phase 1 – Acute service providers were not required to undertake the Autumn 2018 7DS Survey. Instead, they are required to undertake a trial run of the Board assurance process between November 2018 and February 2019.

  All providers are required to complete the template and gain Board assurance of the self-assessment. No new audits are required to support these self-assessments, but providers can use the previous 7DS survey as evidence.

[1] https://improvement.nhs.uk/resources/board-assurance-framework-seven-day-hospital-services/

- Phase 2 – Full implementation of the 7DS Board Assurance Framework is required between March and June 2019, with completion of the measurement template and subsequent Board assurance of the self-assessment. The self-assessment is to be based on local data, such as consultant job plans, local clinical audits and wider performance and experience measures (eg weekday and weekend ratio data in mortality, length of stay, readmissions).

The self-assessments and assurance process will be undertaken bi-annually with the Board assured templates being submitted to regional and national 7DS teams so that they can analyse progress against the national ambitions. Data from the trial run will not be made public, but results from the subsequent full implementation will be published to demonstrate progress.

The Technical Guidance for NHS Planning 2019/20 requires providers to demonstrate that they have a plan for achieving the four priority standards and the NHS Standard Contract has been updated to reflect the requirement to undertake the bi-annual 7DS Board assurance process.

The Care Quality Commission inspection regime assesses 7DS performance as part of its judgement on a Trust's effectiveness and will use a provider's self-assessment of 7DS delivery as supporting evidence.

4. Findings of the 2018 Self-Assessment Process

The Trust has undertaken its initial self-assessment of progress against delivery of the 7DS clinical standards using its April 2018 7DS Survey (as per national guidance), as well as information gathered from the Health Groups. The 2018 results are shown at Appendix 2 and are summarised below:

4.1 Four Priority Clinical Standards

Clinical Standard	Standard Met/Not Met	Comment
Standard 2 - First Consultant Review	**Not Met**	Weekday performance 78% and weekend performance 68% in April 2018 audit. Lack of contemporaneous recording was noted to be a factor in the under-achievement against this standard.
Standard 5 - Timely access to diagnostics	**Met**	
Standard 6 - Access to consultant directed interventions	**Met**	
Standard 8 - Ongoing review	**Not Met**	The April 2018 audit demonstrated compliance with the once daily review standard on a weekday (99%) but not on a weekend (76%). Whilst the April 2018 audit showed that the twice daily review standard was met, the assessment by Health Groups is that there is variation out of hours and at weekends. Whilst twice daily review is achieved for those patients in critical care beds, it is felt that twice daily reviews are not always achieved for patients on the acute wards.

4.2 7DS Clinical Standards for Continuous Improvement

Clinical Standard	Standard Met/Not Met	Comment
Standard 1 - Patient Experience (patients must be actively involved in shared decision making and supported by clear information to make fully informed choices.	**Met**	FFT results for inpatient wards Inpatient survey 2017: • Overall experience (8.2, from 8.1 in 2016) • Q34 decision-making (7.4, from 6.9 in 2016) • Q36 information given (8.6) • Q45 Answer questions (9.0, from 8.5 in 2016)
Standard 3 - MDT Review (emergency inpatients must be assessed for complex or ongoing needs within 14 hours by a multi-professional team. An integrated management plan with estimated discharge date, physiological and functional criteria for discharge in place within 24 hours)	**Partially Compliant**	7 day MDT assessment undertaken by appropriate staff and in accordance with clinical need, but not all modalities will be present. Speech and Language Therapy, Occupational Therapy and Dietetic Services are mainly 5 day services (though some Saturday services in dietetics). Pharmacy support to majority of ward or board rounds not available at weekends, but is available on call or for dispensing.
Standard 4 – Shift Handovers (led by a competent senior decision maker and held at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts)	**Partially Compliant**	Twice daily shift handovers held at designated times for nursing and junior medical staff. Clinical data recorded electronically on CAYDER. Inclusion of wider multi-professional team – not compliant.
Standard 7 – Mental Health (where a mental health need identified following an acute admission, the patient must be assessed by psychiatric liaison within the appropriate timescales 24/7	**Partially Compliant**	There is a Mental Health Hospital Liaison Team available 24/7. Response times vary according to clinical need and capacity and are not recorded on Trust systems.
Standard 9 – Transfer to Community, Primary and Social Care (support services, both in the hospital and in primary, community and mental health settings, must be available 7 days a week)	**Partially Compliant**	There is no integrated care record shared between primary and secondary services. Advice may be sought from specialties via the on call rota 24/7. System wide work is ongoing to share care plans between providers. OOH access to external services (eg Social services) only available in emergency situations. Transport is available 7 days. Oncology/Haematology Services have employed 2 discharge co-ordinators to ensure, where possible, all unnecessary prolonged stays are avoided over a weekend.
Standard 10 – Quality Improvement (all those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement)	**Met**	Nurse staffing ratios do not differ for weekday or weekend provision, but may be flexed according to capacity, demand and exceptional circumstances (eg large local events). Services participate in Peer Reviews, mortality reviews, grand rounds, national audit (SSNAP), GIRFT, benchmarking exercises, governance meetings, business meetings, DATIX and SI reviews and investigations. The Trust is accredited via the Deanery as a training provider, which is also subject to quality assurance processes.

4.3 7DS and Urgent Network Clinical Services

Clinical Standard	Hyper Acute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centre	Emergency Vascular Services
Standard 2	**Met**	N/A	**Met**	**Met**	**Met**
Standard 5	**Met**	N/A	**Met**	**Met**	**Met**
Standard 6	**Met**	N/A	**Met**	**Met**	**Met**
Standard 8	**Not Met**	N/A	**Met**	**Met**	**Met**

Hyper Acute Stroke is not compliant with Standard 8 (ongoing review) for 90% or more of patients across weekdays and weekends due to the lack of consultant presence out of hours. The on call consultant may review patients but this is not embedded.

5. Next Steps

A Task and Finish Group has been established to review the requirements of the Board Assurance Framework and the outcome of the trial run self-assessment. Key actions identified include:

- Conduct an audit of emergency admissions in March 2019 similar to that undertaken in April 2018 to determine whether the Trust has improved in delivery of Standards 2 and 8 against the 2018 baseline.
- From the results of the March 2019 audit, determine which specialties continue to under-perform against the standards and undertake specific work with each specialty to address shortfalls in delivery against Standards 2 and 8.
- Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo.
- Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity.
- Review systems and processes for determining ongoing review requirements (Standard 8) and ensure that these are robust in all acute specialties.
- Develop a series of metrics to support the reporting of progress against the 7DS standards (eg: mortality, average length of stay, emergency readmissions rate).
- Encourage specialties to take account of 7DS standards compliance requirements when developing individual consultant job plans and service level operational plans.

6. Recommendations

The Trust Board is asked to note the content of this paper and the current position in relation to the delivery of the 7DS standards, and to endorse the actions identified to address gaps in 7DS provision.

Dr Makani Purva
Interim Chief Medical Officer

15 January 2019

No.	Standard	Adapted from source
	Patient Experience	
1	**Standard:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week. **Supporting information:** • Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times. • The format of information provided must be appropriate to the patient's needs and include acute conditions. • With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publicly in ward areas.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*
	Time to first consultant review	
2	**Standard:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital. **Supporting information:** • All patients to have a National Early Warning Score (NEWS) established	NCEPOD (2007): *Emergency Admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* RCP (2012): *Delivering a 12-hour, 7-day*

No.	Standard	Adapted from source
	at the time of admission. • Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within one hour. • All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly, and seen and assessed by a consultant within six hours. • Standards are not sequential; clinical assessment may require the results of diagnostic investigation. • A 'suitable' consultant is one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan. • The standard applies to emergency admissions via any route, not just the Emergency Department. • For emergency care settings without consultant leadership, review is undertaken by appropriate senior clinician e.g. GP-led inpatient units.	*consultant presence on the acute medical unit*
	Multi-disciplinary Team (MDT) review	
3	**Standard:** All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* NICE (2007): *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*

No.	Standard	Adapted from source
	Supporting information: • The MDT will vary by specialty but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients, Occupational Therapy. • Other professionals that may be required include but are not limited to: dieticians, podiatrists, speech and language therapy and psychologists and consultants in other specialist areas such as geriatrics. • Reviews should be informed by patients existing primary and community care records. • Appropriate staff must be available for the treatment/management plan to be carried out.	
	Shift handovers	
4	**Standard:** Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week. **Supporting information:** • Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit. • Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number.	RCP (2011): *Acute care toolkit 1: Handover* RCP (2013): *Future Hospital Commission*
	Diagnostics	
5	**Standard:**	RCP (2007): *Acute medical care: The right*

No.	Standard	Adapted from source
	Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients **Supporting information:** • It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology • Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom the test will alter their management but not necessarily that day. • Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2. • Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker. • Where a service is not available on-site (e.g. interventional radiology/endoscopy or MRI), clear patient pathways must be in place between providers. • Seven-day consultant presence in the radiology department is envisaged. • Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction.	*person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCR (2009): *Standards for providing a 24-hour radiology diagnostic service* NICE (2008): *Metastatic spinal cord compression*
	Intervention / key services	
6	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines,	NCEPOD (1997): *Who operates when?* NCEPOD (2007): *Emergency admissions: A journey in the right direction?*

No.	Standard	Adapted from source
	either on-site or through formally agreed networked arrangements with clear protocols, such as: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery **Supporting information:** • Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2. • Other interventions may also be required. For example, this may include: o Renal replacement therapy o Urgent radiotherapy o Thrombolysis o PCI o Cardiac pacing	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* British Society of Gastroenterology AoMRC (2008): *Managing urgent mental health needs in the acute trust*
	Mental health	
7	**Standard:** Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs	RCPsych PLAN (2011): *Quality Standards for Liaison Psychiatry Services*

No.	Standard	Adapted from source
	Supporting information: • Unless the liaison team provides 24 hour cover, there must be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call staff, etc.) * An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others. ** A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.	
	On-going review	
8	**Standard:** All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. **Supporting information:** • Patients, and where appropriate carers and families, must be made aware of reviews. Where a review results in a change to the patient's management plan, they should be made aware of the outcome and provided with relevant verbal, and where appropriate written,	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCP (2013): *Future Hospital Commission*

No.	Standard	Adapted from source
	information. • Inpatient specialist referral should be made on the same day as the decision to refer and patients should be seen by the specialist within 24 hours or one hour for high risk patients (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected). • Consultants 'multiple day blocks' should be between two and four continuous days. • Ward rounds are defined as a face-to-face review of all patients and include members of the nursing team to ensure proactive management and transfer of information. • Once admitted to hospital, patients should not be transferred between wards unless their clinical needs demand it. • The number of handovers between teams should be kept to a minimum to maximise patient continuity of care. • Where patients are required to transfer between wards or teams, this is prioritised by staff and supported by an electronic record of the patient's clinical and care needs. • Inpatients not in high dependency areas must still have daily review by a competent decision-maker. This can be delegated by consultants on a named patient basis. The responsible consultant should be made aware of any decision and available for support if required.	
	Transfer to community, primary and social care	
9	**Standard:** Support services, both in the hospital and in primary ,community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led	AOMRC (2012): *Seven day consultant present care*

No.	Standard	Adapted from source
	review, can be taken. **Supporting information:** • Primary and community care services should have access to appropriate senior clinical expertise (e.g. via phone call), and where available, an integrated care record, to mitigate the risk of emergency readmission. • Services include pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing and timely and effective communication of on-going care plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and social care teams.	
	Quality improvement	
10	**Standard:** All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week. **Supporting information:** • The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness. • Attention should be paid to ensure the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how	GMC (2010): Generic standards for specialty including GP training

No.	Standard	Adapted from source
	to assess, treat and care for patients in emergency as well as elective settings. • All clinicians should be involved in the review of outcomes to facilitate learning and drive quality improvements.	

Hull and East Yorkshire Hospitals NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance In the audit carried out in April 2018, the casenotes of 260 patients were reviewed to assess compliance with standard 2 during the week of 11/04/2018-17/04/2018. Of the 260 casenotes reviewed, 184 patients were admitted on a weekday while 76 patients were admitted during the weekend. Of the patients admitted Monday - Friday, 78% (143 out of 184) were seen by a Consultant within 14 hours, while 68% (52 out of 76) of patients admitted during the weekend received a Consultant review within 14 hours Actions for improvement include: • Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. • Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. * Undertake specific work with each specialty to address shortfalls in delivery.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Ultrasound	Yes available on site	Yes available on site	
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Emergency Renal Replacement Therapy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance During the week of the audit (11/04/2018-17/04/2018), there were a total of 744 reviews required for patients that required one review per day . Of these reviews 547 were required on a weekday, with 541 of them being carried out (99%). Of the 203 patient reviews that were required on a weekend, 155 reviews were carried out (76%). During the audit week, there were a total of 9 patients that required twice daily reviews. 100 % of patients met this standard, both during the week and on a weekend. N.B. These figures also include reviews that were delegated by the Consultant to another competent member of the multidisciplinary team, as per the advice given by NHS England. Surgery Health Group - The standard is met for those patients within critical care beds. However, not all acutely ill patients in beds on wards will receive the twice daily standard on a weekend. They will be reviewed through on-call should care be affected and deviate from the agreed care pathway. HASU - Reviewed daily by ward-based consultant. On call consultant may review patients out of hours but this is not embedded. Patients will be reviewed further at any time if required. Cardiology - Reviewed daily. Patients will be reviewed further at any time if required.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards, highlighting areas where progress has been made since 2015 Standard 1: Patient Experience - Compliant - Information given to patients does not differ at weekends or weekdays. Standard 3: MDT Review - Partially Compliant - Pharmacy support to majority of ward or board rounds not available at weekends, but is available on call or for dispensing. 7 day MDT assessment will be undertaken by appropriate staff and in accordance with clinical need, but not all modalities will be present. Speech and Language Therapy, Occcupational Therapy and Dietetic Services are mainly 5 day services (though some Saturday services in dietetics). Standard 4: Shift Handovers - Partially Compliant - Within Medicine Health Group there are twice daily shift handovers at designated times. Clinical data recorded electronically on CAYDER. Oncology, Haematology and Rehabilitation Medicine are fully compliant. Standard 7: Mental Health - Partially Compliant - There is a Mental Health Hospital Liaison Team available 24/7. Response times vary according to clinical need and capacity and are not recorded on Trust systems. Standard 9: Transfer to Community, Primary and Social Care - Partially Compliant - There is no integrated care record shared between primary and secondary services. Advice may be sought from specialties via the on call rota 24/7. System wide work is ongoing to share care plans between providers. OOH access to external services (eg Social services) only available in emergency situations. Transport is available 7 days. Oncology/Haematology Services have employed 2 discharge co-ordinators to ensure, where possible, all unnecessary prolonged stays are avoided over a weekend. Standard 10: Quality Improvement - Compliant - Nurse staffing ratios do not differ for weekday or weekend provision, but may be flexed according to capacity, demand and exceptional circumstances (eg large local events). Services participate in Peer Reviews, mortality reviews, grand rounds, national audit (SSNAP), GIRFT, benchmarking exercises, governance meetings, business meetings, DATIX and SI reviews and investigations. The Trust is accredited via the Deanery as a training provider, which is also subject to quality assurance processes.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met. Hyperacute Stroke - non-compliant with 90% reviewed twice daily. On call consultant may review patients out of hours but this is not embedded. Patients will be reviewed further at any time if required.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

NHS England
NHS Improvement

Board assurance framework for Seven Day Hospital Services: an introduction for providers of acute services

November 2018

The Seven Day Hospital Services Programme aims to deliver improvements for patients by supporting high quality care seven days a week

The Seven Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

This work is built on 10 clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013. With the support of the Academy of Medical Royal Colleges, four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week.

Priority 7DS clinical standards

- Standard 2: **Time to initial consultant review**
- Standard 5: **Access to diagnostics**
- Standard 6: **Access to consultant-led interventions**
- Standard 8: **Ongoing daily consultant-directed review**

We are changing the way we measure the improvements trusts make

- Providers of acute services have previously completed a bi-annual self-assessment survey.
- This measured progress against the four priority standards through a combination of case note reviews and self-assessment.
- Though useful in supporting implementation, this survey placed a significant administrative burden on trusts as it involved reviewing many patient case notes.
- To reduce this burden and to allow trust boards to provide direct oversight of 7DS progress, 7DS will be measured through a board assurance framework.
- This process consists of a standard template to assess progress in delivering 7DS, which is then assured by the trust board before submitting results to regional and national 7DS teams.

The new 7DS board assurance framework is based on principles that ensure continuity and robust, accurate assessment

The 7DS board assurance framework for trust self-assessment of 7DS performance follows a set of principles that ensure it is:

- consistent, both in terms of the product (a single template for all providers of acute services) and its contents (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory)
- robust and accurate, with assessments based on information directly related to 7DS, allowing for board-level scrutiny and external assurance if necessary
- less of an administrative burden than the 7DS survey
- completed bi-annually, with sign-off by the trust board before submission
- compatible with national-level measurement and reporting against the mandate and planning guidance 7DS ambitions.

The process for 7DS board assurance is consistent for all providers of acute services

- The new measurement system consists of a standard template that all trusts will complete with self-assessments of their performance against the 7DS clinical standards, supported by local evidence.

- This self-assessment will then be formally assured by the trust board. Boards can decide appropriate processes and details to include, based on local systems, governance structures and timetables.

NHS XX NHS TRUST : 7 Day Hospital Services Self-Assessment - Autumn 2018

this disappears when you write over it

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Historical Compliance: Oct 2016: 63%, April 2017: 92% Oct 2017: 90% April: 91%. Whilst the data suggests sustained compliance across the Trust as a whole this masks inconsistent performance across directorates. For those admitted through the medical wards (60% of our total emergency admission) compliance is as high as 96%. Patients admitted through Paediatrics, Orthopaedics, Obs and Gynae, Head and Neck and Surgery have not consistently complied with achievement with results ranging from 78% compliance for Surgery to 43% compliance in Head and Neck. More latterly the evidence has shown that the results do not differ across the days of the week.		Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All diagnostics available across 7 days. CT Heads read by ED Consultants	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes, mix of on-site and off-site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Interventional Radiology available at weekends via shared arrangement with local Trusts. Other interventions available for urgent cases in Trust.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	No, the intervention is only available on or off-site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Historical Compliance: Oct 2016: 73%, April 2017: 95% April: 86%. Compliance shows an historically mixed compliance rates across the Trust as a whole and an inconsistent performance across directorates. Acute Medicine performs highly. The evidence has shown that compliance is consistent across all days of the week.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

Board assurance implementation

The 7DS board assurance framework will be implemented gradually, with a trial run followed by full implementation

Trial run – Nov 2018 to Feb 2019

- In place of the proposed autumn 2018 7DS self-assessment survey, providers of acute services will undertake a trial run of the board assurance process.
- This trial run will take place from November 2018 to February 2019. All providers of acute services will complete the template and gain board assurance of the self-assessment.
- As this is a trial, providers of acute services are not required to complete any new audits to support these self-assessments. Data from the previous 7DS survey can be used as evidence.

Full implementation – Mar to Jun 2019

- Full implementation of the 7DS board assessment framework will take place in March to June 2019.
- This will follow the same process of completing the measurement template and subsequent board assurance of the self-assessment.
- This self-assessment will be based on local data, such as consultant job plans and local clinical audits, as outlined in the full 7DS board assurance framework guidance.

The four priority clinical standards are unchanged and remain the main focus of 7DS measurement

Clinical Standard 2 – First consultant review within 14 hours

- Assessment based on a triangulation of consultant job plans to deliver 7DS, local audits to provide evidence and reference to wider metrics.

Clinical Standard 5 – Access to consultant-directed diagnostics

- As previously, assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by a formal arrangement with another provider.

Clinical Standard 6 – Access to consultant-led interventions

- As previously, assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, either on site or by a formal arrangement with another provider.

Clinical Standard 8 – Ongoing consultant-directed review

- Assessment based on consultant job plans to deliver 7DS, robust MDT and escalation protocols, local audits and reference to wider metrics.

Full details of the measurement criteria for these standards can be found in the 7DS board assurance framework guidance.

The measurement template also captures detail on 7DS in urgent network specialist services and all of the 7DS clinical standards

7DS in urgent network specialist services

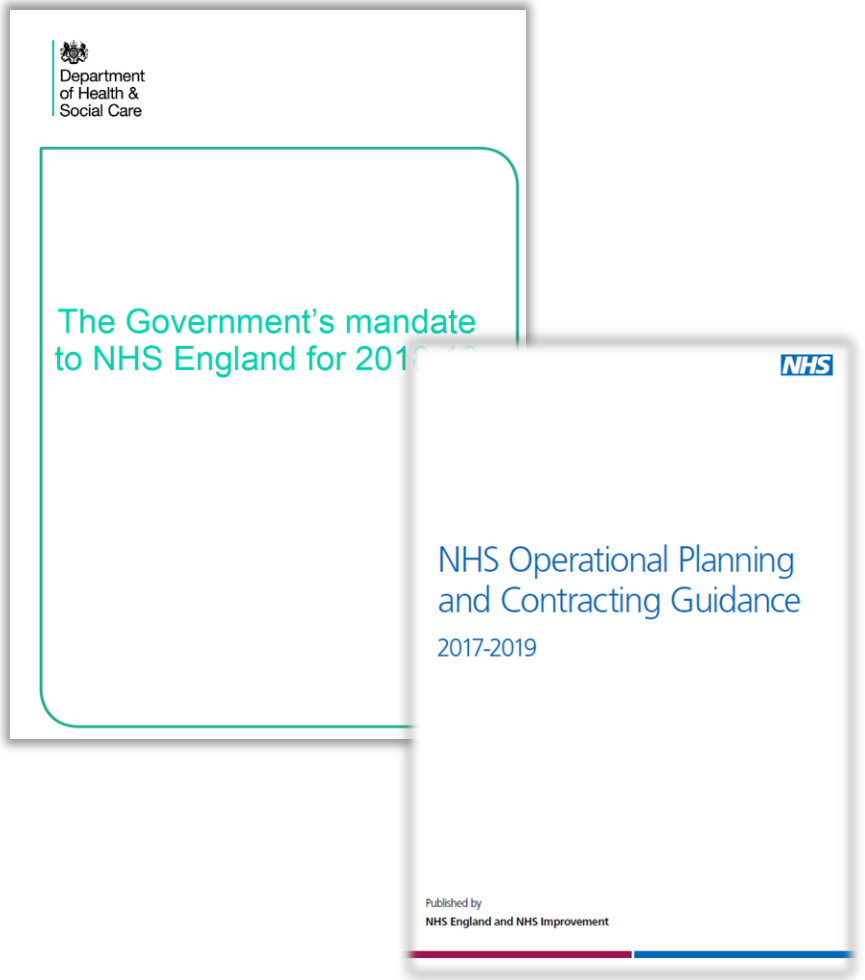
- Alongside the 7DS clinical standards for all patients admitted to hospital in an emergency, providers have been delivering the four priority clinical standards in five urgent network clinical services, namely:
  - hyperacute stroke
  - paediatric intensive care
  - STEMI heart attacks
  - major trauma
  - emergency vascular services.
- The measurement template asks providers of acute services for an updated assessment of progress against the four priority standards in the relevant specialist services on a seven day basis.

7DS standards for continuous improvement

- Delivering all 10 7DS clinical standards is vital to maintaining high quality care seven days a week.
- As well as measuring progress against the four priority 7DS standards, the measurement template asks providers of acute services to summarise progress against the six standards collectively known as the 7DS standards for continuous improvement.
- This summary is not a formal assessment of progress. Full details are in the 7DS board assurance framework guidance.

The board assured assessments of 7DS performance will be analysed to provide measurement against 7DS ambitions

- The government's mandate to NHS England and its remit letter to NHS Improvement set ambitions for delivering 7DS, which are reflected in the shared planning guidance.
- The 7DS board assurance framework will provide the data to support measurement against these ambitions.
- The board-assured measurement templates will be submitted to regional and national 7DS teams so they can analyse progress against the national ambitions.
- Data from the trial run will not be made public, but results from the subsequent full implementation will be published to demonstrate progress.



The board-assured assessments of 7DS delivery will feed into local and national accountability frameworks

The NHS Standard Contract will require providers to undertake the 7DS board assurance process bi-annually. The results from this will form a 7DS metric in the clinical commissioning group improvement and assessment framework to allow CCGs to assess local delivery of 7DS.

The CQC inspection regime assesses 7DS performance as part of its judgement on a trust's effectiveness. CQC will use providers' self-assessments of 7DS delivery as supporting evidence in its inspection processes covering 7DS.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

29th JANUARY 2019

Title:	Flu Vaccination Campaign 2018/19
Responsible Director:	Simon Nearney Director of Workforce and OD
Author:	Carole Hunter Head of Occupational Health

Purpose:	The purpose of the report is to provide information relating to the Trust's 2018/19 staff seasonal flu vaccination campaign and the plans for the 2019/20 vaccination programme.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Key Summary of Issues:	Every NHS Trust is required to vaccinate 75% of frontline healthcare staff that provide direct patient care before the end of February, 2019. The Trust's Occupational Health Department developed and implemented a proactive and innovative vaccination programme for all staff across the Trust. The Trust met the target of 75% by mid-November, 2018. HEY has vaccinated 83% of frontline healthcare staff as at 21st January, 2019. A total of 6,500 staff from all occupational groups have received the flu vaccine. In January 2019 the NHS Employers website showed the Trust was one of the top 10 Trusts in England for the number of frontline staff that have received the flu vaccination.	

Recommendation:	The Committee is requested to note the content of the report.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

TUESDAY 29th JANUARY 2019

FLU VACCINATION CAMPAIGN 2018/19

1.0 Introduction

The purpose of this report is to provide information relating to the Trust's 2018/19 staff seasonal flu vaccination campaign and the plans for the 2019/20 vaccination campaign.

2.0 Background

The Trust's seasonal flu vaccination programme is planned and co-ordinated by the Occupational Health Department (OH) and runs from the beginning of October until the end of February each year.

All NHS Trusts are required to offer flu vaccine to staff involved in the provision of direct patient care. The Trust has made the vaccine freely available to its entire staff and volunteers for several years.

Sickness absence due to colds and influenza led to **5,575** Full Time Equivalent working days being lost in the Trust during 2018. Recently published evidence suggests a **10%** increase in vaccination may be associated with as much as a **10%** fall in sickness absence and guidelines from NICE highlight a correlation between lower rates of staff vaccination and increased patient deaths.

In 2017 the NHS introduced a Commissioning for Quality and Innovation (CQUIN) to incentivise Trusts to increase vaccine uptake rates amongst healthcare workers. The CQUIN for 2108/19 is that **75%** of staff involved in providing direct patient care should receive the vaccine before the end of February to receive 100% of the CQUIN incentive available for meeting the final indicator value.

In preparation for the 2018/19 season NHS Improvement and NHS England carried out a review of evidence and agreed a package of measures with the aim of increasing uptake amongst health care workers involved in providing direct care to patients.

In response to the review a letter was sent to Chief Executives that set out the following expectations for Trusts:

- NHS staff under 65 get the quadrivalent vaccine which gives additional protection
- Setting an aspiration for 100% of front line HCW's to be vaccinated
- Introducing an 'opt out' process
- Identify 'higher- risk' clinical environments in the Trust where patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful
- consider redeploying staff who work in high risk areas and refuse the vaccine
- report on progress publicly to the Trust Board by the end of February

3.0 The 2018/19 vaccination campaign

In line with advice from the Joint Committee on Vaccination and Immunisation 7,000 doses of Quadrivalent vaccine were ordered in January 2018 for the 2019/20 campaign for staff aged 65 and under and 100 doses of Trivalent vaccine for staff aged over 65.

The Communication Plan commenced in August and regular information about the vaccine, myth busters, details of volunteer vaccinators and clinic times were included in the daily and weekly bulletins, as a screensaver on all PC's, as a banner on the intranet and the Chief Executives monthly Team Brief.

It is acknowledged that one of the keys to a successful campaign is to make vaccination readily accessible to staff. Wards and departments are asked each year to identify volunteer vaccinators who will be available to vaccinate their colleagues/peers in their places of work. This year the OH nurses provided theoretical and practical training for **114** volunteers.

Vaccination of staff commenced on the day that the vaccine was delivered to the Trust.

Arrangements for staff to access the vaccine included:

- Members of the Trust Board were vaccinated in October during one of their Time-Out sessions.
- weekly morning and lunchtime drop-in clinics in the Dining Rooms throughout October and November which are very popular
- booked and drop-in clinics in OH
- vaccine offered to staff who attend OH for other reasons
- OH nurses attended the monthly Induction to vaccinate new starters
- OH nurses offered vaccination at training events including Grand Rounds and the Chief Nurse Conference
- staff who have the vaccine administered elsewhere such as their GP's are asked to get a confirmation slip signed to say who administered the vaccine
- The OH nurses provide a service to offer undertake vaccination for staff employed by Dove House Hospice and The Spire Hospital

In response to the expectations detailed in letter issued by NHS England, the following wards and departments within the Trust were identified as 'high risk':

- Oncology
- NICU
- Paediatrics
- Respiratory
- Renal

Nurse Directors were asked to ensure that these areas had sufficient resources in place to vaccinate staff, ask staff to confirm to the ward/department manager whether or not they have been vaccinated and consider the redeployment of staff that decline vaccination if compatible with maintaining patient safety.

Members of the Trust Board were vaccinated in October during one of their Time-Out sessions.

Nurse Directors and HR Business Partners were provided with details of uptake rates on a monthly basis and this was discussed at their monthly Performance Reviews.

4.0 Incentives

As an incentive to encourage staff to have the vaccine the Trust offers an additional annual leave day (pro rata) if they have the vaccine before the end of November and an additional days leave as part of the Staff Incentive Scheme if they have the vaccine, 100 per cent attendance, an in date appraisal, completed all statutory and mandatory training and no outstanding disciplinary actions.

5.0 Data collection

The Trust must provide vaccination uptake rates for staff involved in the provision of direct patient care to Public Health England (PHE) via ImmForm (a mandatory survey for Trusts to complete) on a monthly basis commencing at the beginning of November until the beginning of March each year. In addition, this year Trusts are required to declare how many staff in this category have refused to have the vaccine.

As part of its 'monitoring' function, CQC will be including the indicator 'staff vaccination rates' in intelligence reporting under the 'well led' key question.

In September a mandatory read 'e' mail was sent to all staff that asked them to complete a questionnaire if they opted out of having the vaccine and give their reasons. The aim of the survey was to provide non-identifiable statistical information to identify whether any additional measures that would improve uptake should be included in next year's campaign. Some staff expressed concerns about the questionnaire including feeling they would be targeted by managers for not having the vaccine, it infringed their human rights and asking why they should complete the questionnaire as they had already had the vaccine.

330 staff completed the questionnaire with **162** of those being involved in providing direct patient care and the main reasons given by staff for not having the vaccine are:

- Fear of needles
- Don't Think I'll Get Flu
- No evidence that the vaccine works
- Concerned about possible side effects
- Don't know where to get vaccinated
- Inconvenient place
- Inconvenient times

The information has been included in the monthly returns to PHE. In response to the comments from staff the following actions will be incorporated into the 2019/20 vaccination campaign plan:

- Every ward/department will be required to ensure they have sufficient volunteer vaccinators to ensure staff can be vaccinated in their areas of work at all times during the working week
- A poster showing details of individual volunteer vaccinators will be devised and displayed in clinical areas

- Ensure volunteer vaccinators are provided with up to date material and have the knowledge and feel confident to discuss with and advise colleagues on all aspects of the flu vaccine including efficacy, benefits, side effects and myths.
- Increase communication regarding clinic times and locations
- Review the mandatory read questionnaire

6.0 Outcomes

- The CQUIN target for 75% of staff involved in providing direct patient care to be vaccinated by the end of February was achieved by the middle of November which was the fastest time that this has been achieved
- At the beginning of January 2019 the NHS Employers website showed the Trust was one of top 10 Trusts in England for the number of staff in this category that had received the vaccine
- **83%** of staff involved in providing direct patient care were vaccinated by 21st January 2019.
- **6,500** staff from all occupational groups received the vaccine

The vaccination campaign will continue until the end of February 2019.

7.0 Recommendation

The Trust Board is requested to note the excellent performance of the Trust.

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

29 January 2019

Title:	Quarterly Report on Safe Working Hours: Junior Doctors in Training - for quarter 3 - 1 October 2018 to 31 December 2018
Responsible Director:	Makani Purva, Interim Chief Medical Officer
Author:	Nagarajan Muthukumar, Guardian of Safe Working Hours

Purpose:	**PURPOSE OF THIS REPORT** The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate	
BAF Risk:	BAF Risk 2	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	Exception Report key areas: Oncology, Colorectal Surgery, Elderly Medicine and Respiratory Medicine.	

Recommendation:	The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance Decide if any further information and/or actions are required

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING 1 October – 31 December 2018

EXECUTIVE SUMMARY

The Guardian Report for this Trust Board Meeting covers the quarter from October 2018 to December 2018.

Exception Reporting patterns and responses

The most common reason for submitting an exception report still appears to be related to staff shortages, volume of work and practices such as late ward rounds which lead to trainees staying beyond the contracted hours or missed educational and training opportunities. In a few instances the trainees appear to be staying over in the interest of patient care

In this quarter the following were the number of episodes of exceptions reported trainees by Health Group

Clinical Support - 76
Family and Women – 2
Medicine – 36
Surgery - 16
GP placement – 0

Exception Report trends:

Oncology: This department alone accounted for 73 out of the 130 episodes reported by trainees in the Trust. There have been discussion with senior clinicians in the department to try and look into the issues raised by the trainees which is mainly to do with the fact that the work pattern that the trainees are expected to work are not in line with the work schedule that they have been given. A work schedule review has been requested by the Guardian. This is currently awaiting a meeting between Medical Staffing and the concerned HR business partner.

Colorectal Surgery: There have been 9 reports from trainees based at CHH on this rota. The issues raised are staff shortage, lack of support and late ward rounds all of which lead to trainees staying beyond their scheduled finish time. At the time of writing this report none of these reports have been reviewed by the supervisors.

Elderly Medicine: There were 11 reports (16 episodes) from this department. These related mainly to volume of work and staff shortage leading to trainees staying beyond contracted hours.

Respiratory Medicine: There were 15 reports from this specialty which were mainly to do with staying beyond scheduled hours to deliver clinical care caused mainly by the volume of work.

Junior Doctor Forum

Junior Doctors Mess: The Junior Doctor Forum and the Guardian were delighted to hear that there has been progress in creating a space for the junior doctors in the Tower block. They would like to express their appreciation to the Trust Board and all concerned who have helped moving forward this request from the Junior doctors with an aim to complete the required refurbishment of the identified area by this calendar year.

Summary

Exception reporting seems to be a good early-warning system to indicate where there may be issues. The main issues raised and areas of concern for this quarter have been highlighted in this report. At the current time there still is no system in place to robustly capture all instances were trainees have breached the safe working hours as required by the Junior Doctor Contract 2016. It is therefore not possible for the Guardian to provide assurance to the Trust Board that this aspect of the Junior Doctor Contract is fulfilled by the Trust.

Questions for consideration

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

N.Muthukumar

Consultant Trauma & Orthopaedic Surgeon

Guardian of Safe Working Hours

Hull and East Yorkshire Hospitals NHS Trust

Encl:

Appendix 1 Board Report GSW 1 October 2018 – December 2018

Hull and East Yorkshire Hospitals NHS Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING 1 October – 31 December 2018

1. PURPOSE OF THIS REPORT

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from October to December 2018 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. HIGH LEVEL DATA

Number of doctors / dentists in training (total):	555 (establishment) 478.1 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	478.1
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between HGs)

All trainees in the Trust are now on the 2016 terms and conditions of service (TCS) and have received their work schedules. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hour's adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.

The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

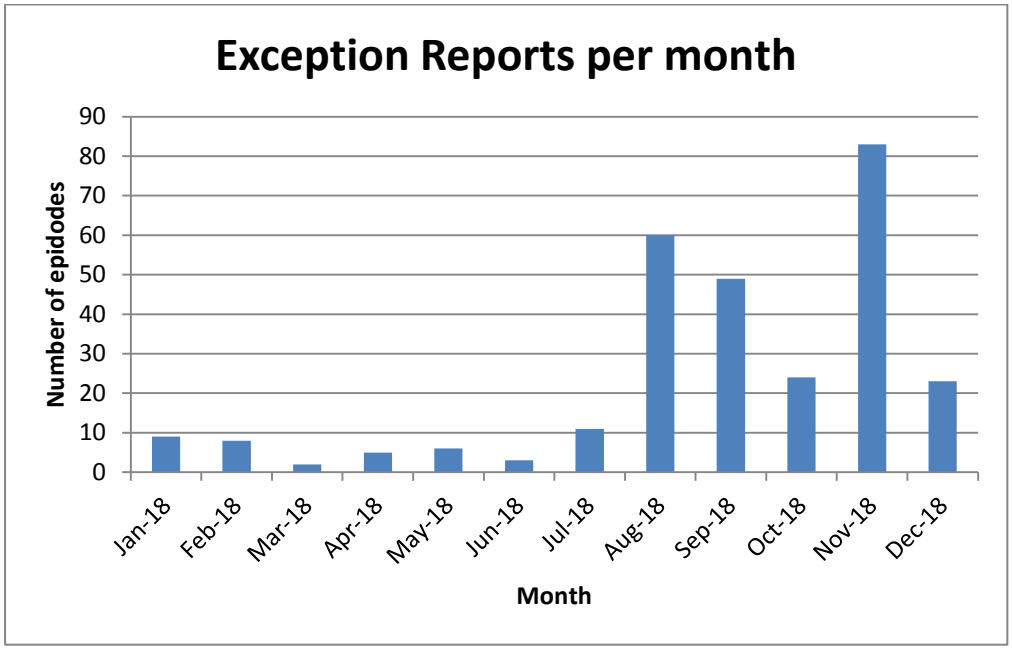
3. JUNIOR DOCTOR WORKING HOURS

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.

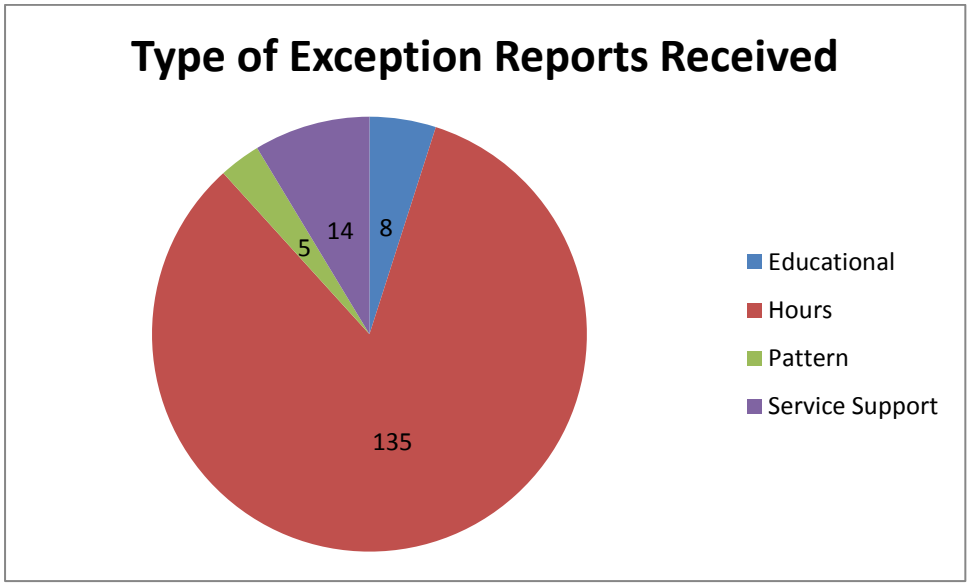
In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern.

There were 130 exception report episodes submitted between 1 October and 31 December 2018 and 32 carried forwards from the previous quarter.

Exception reports over time



Types of exception reports received 1 July – 30 September 2018



Exception reports (episodes) by specialty 1 October – 31 December 2018

Specialty (Where exception ccurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
Acute Surgery HRI	1			1
Breast Surgery		1		1
Colorectal Surgery		10		10
Elderly Medicine		16	14	2
Emergency Medicine		3	1	2
Endocrinology	5	2	6	1
Gastroenterology	4			4
General Surgery	1	1	2	
General Surgery / Vascular	3			3
Haematology		42	42	
Infectious Diseases		3		3
Medical Oncology		7		7
Medicine Nights	1			1
Oncology	4	24	18	10
Orthopaedic Surgery	2		2	
Paediatrics	1	1	2	
Respiratory		15	4	11
Rheumatology	3			3
Surgery Nights CHH	3			3
Trauma & Orthpaedics		1		1
Upper GI Surgery	2	2	4	
Vascular		2		2
Vascular Surgery	2		2	

Exception reports (episodes) by grade 1 October – 31 December 2018

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	21	114	94	41
F2	7	9	9	7
GPS T1		2		2
ST3	2			2
ST4	1			1
CT1	1	4	1	4
CT2		1		1

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades, as time goes on and as they get used to the contract and the exception reporting mechanism. Numbers are small, however, and it is not possible to draw conclusions from these reports yet.

Exception reports (episodes) by rota 1 October – 31 December 2018

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
23 - Vascular Surgery F1 (inc. ENT/Uro)	4	2	2	4
Rota 1 - A&E F2		2		2
Rota 124b General Surgery (Uro/ENT) SHO	3			3
Rota 134 - Orthopaedics F2	2		2	
Rota 135 - Orthopaedic & Plastic Surgery CT	1			1
Rota 15 - Medicine SHO (blp 450)		3		3
Rota 18 - Medicine F1	9	41	29	21
Rota 18B - Medicine F1		42	42	
Rota 25 - Acute-Elective Surgery F1	5	13	5	13
Rota 4 - Medicine F1	4	15	14	5
Rota 5 - Medcine SHO (blp 215)	1			1
Rota 6 - RMO	3			3
Rota 60 - Paediatric F1	1	1	2	
Rota 8 - Onocology/Haematology SHO		5	3	2
Rota 9 - Medicine SHO blp 575		4	4	
Rota 2B - A&E SHO (non PEM)	1		1	

Exception reports (episodes) - response time 1 October - 31 September 2018

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	21	114	94	41
F2	7	9	9	7
GPS T1		2		2
ST3	2			2
ST4	1			1
CT1	1	4	1	4
CT2		1		1

The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

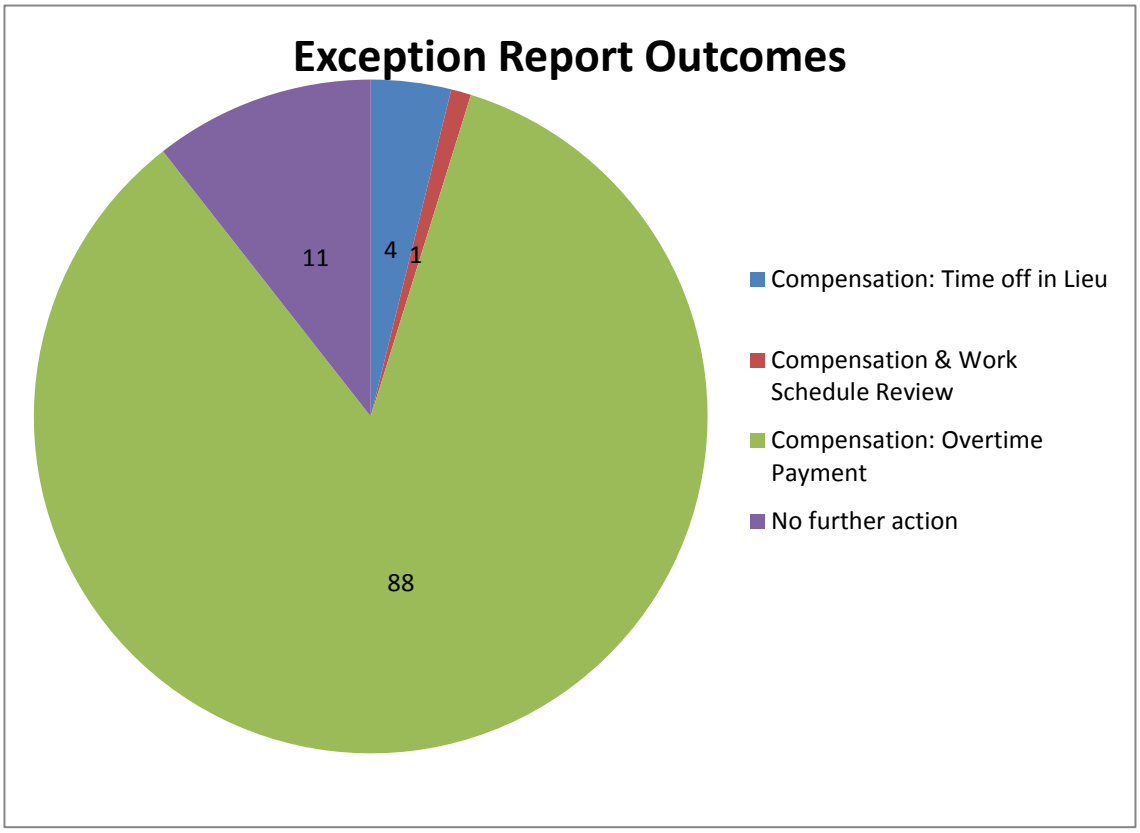
Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.`

This is shown in the table below:

Department (base dept)	No of reports (episodes)	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open
Acute Surgery HRI	2		2			
Clinical Oncology	3	2				1
Colorectal Surgery	1					1
Elderly Medicine	8	1		5		2
Emergency Medicine	3	1				2
Endocrinology & Diabetes	7			6		1
ENT	3					3
Gastroenterology	4					4
General Oncology	2					2
General	11	1	1	1		8

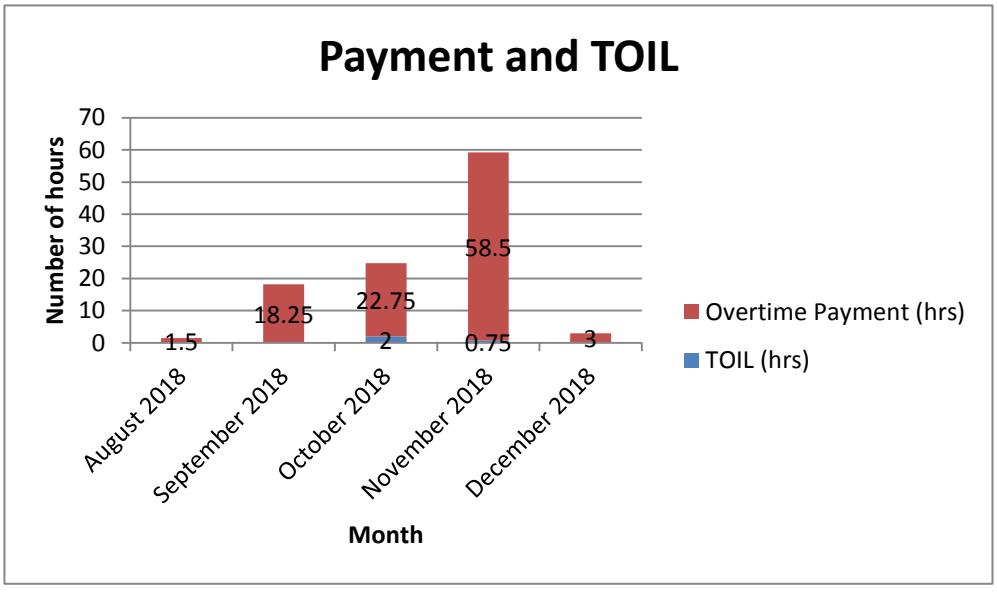
Surgery						
General Surgery / Breast	1					1
General Surgery/ Upper	1		1			
General Surgery / Vascular	7			2	5	
General Surgery / Lower	2					2
Geriatric Medicine	8	4	3	1		
Haematology	42			42		
Infectious Diseases	3					3
Medical Oncology	28	12	4	10		2
Neurology / Stroke Medicine	1					1
Oncology	2					2
Orthopaedic Surgery	2			2		
Paediatrics	2	1		1		
Respiratory	12		11			1
Respiratory Medicine	3	2				1
Rheumatology	3					3
Trauma & Orthopaedics	1					1

Outcomes of completed exception reports 1 October – 31 December 2018



This shows broadly similar proportions of time versus payment compared to the last quarter. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Work schedule reviews

A work schedule review has been requested by the Guardian following a spate of exception reports by trainees from Oncology department.

a) Locum bookings October to December 2018

i) Bank October to December 2018

The Trust currently has an informal medical bank in place which strives to fill as many shifts internally as it can. With the successful creation of a Nurse and Clerical Bank the Trust is looking at creation of a formal Medical Bank in line with the 2016 TCS. We are currently exploring a number of options internally and externally on the best way to support this work. The work on this project will be fed through to the Guardian by the Medical Staffing Operations Group.

The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade				
Grade	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
F1*	56	0	497.90	0.00
F2	352	68	2633.02	610.00
CT/ST-2/GPSTR	1524	40	15074.95	551.50
ST3+	864	30	8814.68	325.00
TOTAL	**2796**	**138**	**27020.55**	**1486.5**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

Locum Bookings (bank) by department				
Speciality	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
Acute Medicine	200	2	1755.40	25.00
Acute Surgery	3	0	39.00	0.00
Anaesthetics	33	0	240.00	0.00
Breast Surgery	33	0	356.00	0.00
Cardiology	60	0	534.84	0.00
Chest Medicine	25	0	236.25	0.00
Colorectal	141	28	1389.85	238.00

CT Surgery	113	2	954.70	36.50
Elderly Medicine	61	0	474.25	0.00
Endocrinology	7	1	51.25	3.50
ENT	122	2	1064.00	12.50
Gastroenterology	21	0	141.80	0.00
General Medicine	160	0	1235.26	0.00
General Surgery	135	0	1429.50	0.00
Haematology	7	0	160.00	0.00
Infectious Diseases	1	0	4.25	0.00
Neonatal Medicine	91	0	1093.00	0.00
Neurology	154	30	1186.75	220.50
Neurosurgery	272	12	2986.50	127.00
Obstetrics & Gynaecology	2	0	15.50	0.00
OMFS	61	21	808.50	336.50
Oncology	21	0	235.50	0.00
Ophthalmology	47	0	331.00	0.00
Orthopaedics	712	30	6994.03	335.00
Paediatric Surgery	44	3	453.67	55.00
Paediatrics	63	0	540.50	0.00
Plastics Surgery	5	2	70.00	48.00
Renal Medicine	6	0	72.25	0.00
Rheumatology	6	0	63.00	0.00
Upper GI	85	0	1078.00	0.00
Urology	75	5	642.00	49.00
Vascular	27	0	358.00	0.00
Winter Pressures	3	0	26.00	0.00
TOTAL	**2796**	**138**	**27020.55**	**1486.50**

Locum bookings (bank) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	16	0	180	0.00
Compassionate/Special Leave	12	0	146.5	0.00
Extra Cover	126	0	1231.56	0.00
Maternity/Paternity Leave	13	0	152.25	0.00
Sickness	87	1	867.65	3.50
Study Leave	8	2	100	25.00
Vacancy	2534	135	24342.59	1458.00
TOTAL	**2796**	**138**	**27020.55**	**1486.50**

ii) Agency October to December 2018

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	56	10	497.90	118.00
F2	352	0	2633.02	0.00
CT/ GPSTR/ST-2	1524	1375	15074.95	13565.45
ST3+	864	600	8814.68	6008.88
Total	**2796**	**1985**	**27020.55**	**19692.33**

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	200	58	1755.4	663.00
Acute Surgery	3	0	39	0.00
Anaesthetics	33	0	240	0.00
Breast Surgery	33	30	356	318.50
Cardiology	60	34	534.84	300.84
Chest Medicine	25	8	236.25	97.25

Colorectal	141	60	1389.85	739.85
CT Surgery	113	48	954.7	401.10
Elderly Medicine	61	4	474.25	48.00
Endocrinology	7	0	51.25	0.00
ENT	122	96	1064	887.50
Gastroenterology	21	2	141.8	16.00
General Medicine	160	160	1235.26	1235.26
General Surgery	135	135	1429.5	1429.50
Haematology	7	0	160	0.00
Infectious Diseases	1	0	4.25	0.00
Neonatal Medicine	91	91	1093	1093.00
Neurology	154	113	1186.75	895.50
Neurosurgery	272	249	2986.5	2725.50
Obstetrics & Gynaecology	2	0	15.5	0.00
OMFS	61	0	808.5	0.00
Oncology	21	9	235.5	107.50
Ophthalmology	47	47	331	331.00
Orthopaedics	712	603	6994.03	5915.53
Paediatric Surgery	44	27	453.67	273.00
Paediatrics	63	63	540.5	540.50
Plastics Surgery	5	0	70	0.00
Renal Medicine	6	4	72.25	47.75
Rheumatology	6	5	63	58.75
Upper GI	85	67	1078	835.50
Urology	75	58	642	512.00
Vascular	27	14	358	220
Winter Pressures	3	0	26	0.00
TOTAL	**2796**	**1985**	**27020.55**	**19692.33**

Locum bookings (agency) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	16	13	180	142.50
Compassionate/Special Leave	12	7	146.5	84.00
Extra Cover	126	96	1231.56	920.56
Maternity/Paternity Leave	13	10	152.25	124.00
Sickness	87	60	867.65	701.50
Study Leave	8	6	100	75.00
Vacancy	2534	1793	24342.59	17644.77
Total	**2796**	**1985**	**27020.55**	**19692.33**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they have to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover; for example sickness is not mentioned as a reason for seeking cover. This has probably been included in the catch-all term 'vacancy' but will need to be teased out in future.

iii) Emergency Department

The Emergency Department books its own bank doctors directly; these figures are currently reported slightly differently.

Locum Bookings (bank) by 1.10.2018 to 31.12.2018 1AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	521	459	521	4960.083	4468.083
Total					

Locum Bookings (bank) by 1.10.2018 to 31.12.2018 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	1215	621	1215	10108.6	4825.5

b) Locum work carried out by trainees October to December 2018

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Base Speciality	**Grade**	**Number of hours worked**	**Number of hours rostered per week**	**Opted out of EWTD**
Obstetrics & Gynaecology	F2	84.00	45:45	Yes
Trauma & Orthopaedics	CT2	73.00	47:00	Yes
Emergency Medicine	F2	69.50	44:00	Yes
Intensive Care	CT2	66.00	46:30	Yes
Hematology	ST3	64.00	44:00	No
Emergency Medicine	GPST1	59.00	47:15	Yes
Emergency Medicine	F2	54.00	44:00	Yes
Trauma & Orthopaedics	F2	50.50	46:30	Yes
Trauma & Orthopaedics	CT2	49.50	47:00	Yes
Hematology	ST3	48:00	30:00	No

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Especially at F2 level, doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis. The appointment of rota co-ordinators is in progress across the Trust as part of the roll-out of e-roster for medical staff, and entry of this data will be a key part of their role.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has EWTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of these rules however Medical Staffing are not responsible for overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required.

Vacancies – table showing vacancies among medical training grades and by rota on 10th January 2019. Detailed below is a table indicating the rota establishment and WTE in post as of 10th January 2019 and Doctor in Training establishment as of 10th January 2019.

Hull East Yorkshire Hospitals NHS Trust - Junior Doctor Rota Establishment Effective 10/01/2019

	Trainee Establishment						Rota Establishment						In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Posts Filled 07.09.20**	**% Posts Filled 10.01.2018**
Academic	0	5	0	0	0	5	0	5	0	0	0	5	0	5	0	0	0	5	100.00%	100.00%
Acute Medicine	3	6	9	0	6	24	3	6	9	0	6	24	3	5	8	0	4	20	85.42%	83.33%
Anaesthetics	4	4	15	0	28	51	4	7	16	0	32	59	4	4	16	0	23	47	77.97%	79.66%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	2	0	0	0	1	3	80.00%	60.00%
Cardiology	2	1	4	1	9	17	2	1	4	1	12	20	2	0	7	4	16	29	165.00%	145.00%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	2	0	0	7	9	75.00%	75.00%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	1	1	50.00%	50.00%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	0	1	0	2	100.00%	100.00%
Elderly Medicine	5	3	6	6	6	26	5	3	6	7	6	27	5	3	6	6	5	25	92.59%	92.59%
Emergency Medicine	0	12	7	5	14	38	0	12	7	5	8	32	0	11	7	5	9	32	100.00%	100.00%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	3	0	2	0	2	7	77.78%	77.78%
ENT	1	1	2	1	4	9	1	1	3	1	6	12	0	1	2	1	6	10	91.67%	83.33%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	2	0	4.6	9.6	96.00%	96.00%
General Practice	0	18	0	39	0	57	0	18	0	39	0	57	0	18	0	34	0	52	89.47%	91.23%
General Surgery	0	1	0	0	0	1	0	1	2	0	0	3	0	0	1	0	0	1	66.67%	33.33%
Haematology	1	0	2	0	4	7	1	0	2	0	7	10	1	0	2	0	5.6	8.6	86.00%	86.00%
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	0	0	0.00%	0.00%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	5	9	2	0	2	0	2	6	66.67%	66.67%
Lower GI Surgery	7	0	2	0	3	12	7	0	2	0	3	12	7	0	2	0	3	12	100.00%	100.00%
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	2	4	0	6	14	100.00%	100.00%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1	1	4	0	10.8	16.8	77.89%	88.42%
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	7	4	11	24	0	2	7	4	10	23	95.83%	95.83%
Oncology	3	1	3	4	5	16	3	1	8	4	12	28	3	1	7	4	12	27	96.43%	96.43%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	8	10	1	1	0	0	8	10	100.00%	100.00%
Oral & Maxillofacial Surgery	0	2	10	0	2	14	0	2	10	0	6	18	0	2	6	0	6	14	77.78%	77.78%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	0	6	0	0	6	0	0	6	100.00%	100.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	7	0	7	14	0	0	3.6	0	6.5	10.1	72.14%	72.14%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	4	6	0	0	2	0	1	3	50.00%	50.00%
Paediatrics	3	4	3	2	8	20	4	4	3	2	8	21	3	4	2	2	8	19	90.48%	90.48%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	0	2	0	2	100.00%	100.00%
Plastic Surgery	0	0	3	0	5	8	0	0	4	0	7	11	0	0	4	0	4.8	8.8	80.00%	80.00%
Psychiatry	5	5	0	4	0	14	5	5	0	4	0	14	5	4	0	3	0	12	92.86%	85.71%
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Radiology	0	0	0	0	24	24	0	0	0	0	24	24	0	0	0	0	20.8	20.8	86.67%	86.67%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	2	1	2	0	4	9	90.00%	90.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	2	2	2	8	20	100.00%	100.00%
Rheumatology	0	0	1	2	3	6	0	0	1	2	3	6	0	0	1	2	3	6	100.00%	100.00%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0.00%
Trauma & Orthopaedics	0	4	3	1	9	17	0	11	4	1	15	31	0	8	4	0	14	26	70.00%	83.87%
Upper GI Surgery	7	0	2	0	4	13	7	0	4	0	4	15	7	0	4	0	3.6	14.6	96.92%	97.33%
Urology	1	3	2	0	3	9	1	3	2	0	5	11	1	3	2	0	5	11	90.91%	100.00%
Vascular Surgery	5	0	1	0	3	9	5	0	6	0	6	17	5	0	1	0	4.8	10.8	63.53%	63.53%
TOTAL	70	84	114	74	213	555	**71**	**94**	**136**	**75**	**261**	**637**	**69**	**82**	**118.6**	**70**	**225.5**	**565.1**	**88.74%**	**88.71%**

Increased vacanices since last report	
Decreased vacancies since last report	
No change in vacancies since last report	

Hull East Yorkshire Hospitals NHS Trust - Junior Doctor Trainee Establishment effective 10/01/2019

	Trainee Establishment						Trainee In Post						
Department	F1	F2	CT/ST1-	GPSTR	ST	Total	F1	F2	CT/ST1-	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	100.0%
Acute Medicine	3	6	9	0	6	24	3	5	6	0	2	16	66.7%
Anaesthetics	4	4	15	0	28	51	4	4	15	0	22	45	88.2%
Breast Surgery	2	0	1	0	2	5	2	0	0	0	1	3	60.0%
Cardiology	2	1	4	1	9	17	2	0	3	1	9	15	88.2%
Cardiothroacic Surgery	0	3	0	0	3	6	0	2	0	0	3	5	83.3%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	100.0%
Elderly Medicine	5	3	6	6	6	26	5	3	6	6	5	25	96.2%
Emergency Medicine	0	12	7	5	14	38	0	11		5	13	29	76.3%
Endocrinology	3	0	2	0	4	9	3	0	2	0	2	7	77.8%
ENT	1	1	2	1	4	9	0	1	2	1	4	8	88.9%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	4.6	9.6	96.0%
General Practice	0	18	0	39	0	57	0	18	0	34	0	52	91.2%
General Surgery	0	1	0	0	0	1	0	0	0	0	0	0	0.0%
Haematology	1	0	2	0	4	7	1	0	2	0	3.6	6.6	94.3%
Histopathology	0	0	0	0	4	4	0	0	0	0	0	0	0.0%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	2	6	66.7%
Lower GI Surgery	7	0	2	0	3	12	7	0	0	0	3	10	83.3%
Neurology	2	2	4	0	5	13	2	2	3	0	5	12	92.3%
Neurosurgery	1	1	2	0	4	8	1	1	1	0	3.8	6.8	85.0%
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	7	4	10	23	95.8%
Oncology	3	1	3	4	5	16	3	1	3	4	5	16	100.0%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	6	8	100.0%
Oral & Maxillofacial Surgery	0	2	10	0	2	14	0	2	5	0	1	8	57.1%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	0	6	85.7%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	3.6	0	6.5	10.1	72.1%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	0	2	100.0%
Paediatrics	3	4	3	2	8	20	3	4	2	2	8	19	95.0%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	100.0%
Plastic Surgery	0	0	3	0	5	8	0	0	3	0	4.8	7.8	97.5%
Psychiatry	5	5	0	4	0	14	5	4	0	3	0	12	85.7%
Public Health Medicine	0	1	0	0	0	1	0	0	0	0	0	0	0.0%
Radiology	0	0	0	0	24	24	0	0	0	0	20.8	20.8	86.7%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	4	9	90.0%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	1	7	18	90.0%
Rheumatology	0	0	1	2	3	6	0	0	1	1	3	5	83.3%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0.0%
Trauma & Orthopaedics	0	4	3	1	9	17	0	4	3	1	8	16	94.1%
Upper GI Surgery	7	0	2	0	4	13	7	0	2	0	3.6	12.6	96.9%
Urology	1	3	2	0	3	9	1	3	2	0	3	9	100.0%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	2.8	8.8	97.8%
TOTAL	**70**	**84**	**114**	**74**	**213**	**555**	**69**	**77**	**88.6**	**66**	**177.5**	**478.1**	**86.1%**

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

The gaps in rota that was an area of concern particularly in some specialties have improved since last August. This is probably due in part to the relaxation in visa rules.

Hull and East Yorkshire Hospitals NHS Trust

Trust Board Meeting

Date: Tuesday 29th January 2019

Title:	Contract recommendation paper for the provision of Orthotic and Prosthetic Services including the Supply of Consumables
Responsible Director:	Jonathan Wood, Director of Operations
Author:	Paul Seabourne, Clinical Manager Lisa Moon, Finance Manager Carl Slater, Senior Contracts Manager

Purpose:	The purpose of this paper is to seek approval of the Chief Executive/Chief Finance Officer and Trust Board to award a contract for the provision of Orthotic and Prosthetic Services including the Supply of Consumables, to Hugh Steeper Ltd.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Summary Key of Issues:	This is a new contract for the provision of Orthotic and Prosthetic Services including the Supply of Consumables. This contract for the Trust replaces both the historical and current combined Orthotic and Prosthetic Service and Consumables Agreement.	

Recommendation:	The Chief Executive/Chief Finance Officer and Trust Board are requested to approve the awarding of this contract to Hugh Steeper Ltd.

CONTRACT RECOMMENDATION PAPER FOR THE PROVISION OF ORTHOTIC AND PROSTHETIC SERVICES INCLUDING THE SUPPLY OF CONSUMABLES

COMPLIANT CONTRACT RECOMMENDATION

Trust Reference:	**HEY/16/172**
Type:	**New Contract Renewal**
Form:	**Services/Consumables**
Period:	**60 Months**
Extension Option:	**Up to 24 Months**
Anticipated Contract Start Date:	**01/03/2019**
Health Group:	**Clinical Support**
Division:	**Pharmacy and Therapies**
Department:	**Orthotic Service & Prosthetic Service**
Procurement Process Used:	**Mini-Competition**
Total Contract Value (Ex. VAT):	**£2,772,816.42 Fixed**
Cost Centre:	**125041 Prosthetic Service Sykes St** **125042 Orthotic Service HRI CHH**
Terms and Conditions which apply:	**NHS Terms and Conditions for the Supply of Goods and the Provision of Services (Contract Version) (January 2018)**
G.D.P.R. Applicable:	**Yes**
Procedure compliant with Trust SFI's:	**Yes**

1. PURPOSE

The purpose of this paper is to seek approval of the Chief Executive/Chief Finance officer and Trust Board to award a contract for the provision of orthotic and prosthetic services including the supply of consumables to Hugh Steeper Ltd.

2. BACKGROUND

2.1 This is the renewal of a contract for the provision of orthotic and prosthetic services including the supply of consumables which has been running for a large number of years since 2003 (Orthotics Service) and 2004 (Prosthetic Service) both contracts with Hugh Steeper Ltd.

2.2 The Procurement Department explored the options of procuring via a relevant framework agreement provider, specifically NHS Shared Business Services (SBS).

2.3 The Procurement Department recommended that the best route to procure these services and goods was via the NHS Shared Business Services Orthotics Products and Services (including Prosthetics) Framework Agreement – Contract Reference: SBS/16/RC/GKB/9027 for the follow reason(s):

- The framework agreement included all of the following lots:

Lot No	Lot Title
Orthotics Products and Services	
Lot 1	**Upper Body including; Neuro, Limbs, Cervical, Spinal. Standard stock and Superior stock Products, Adults only.**
Lot 2	**Lower body including: Lower extremity, Knee, Hip, Limbs, Ankle, Footwear. Standard stock and Superior stock Products, Adults Only.**
Lot 3	**Upper Body including: Limbs, Cervical, Spinal. Bespoke Products only.**
Lot 4	**Lower body including: Knee, Hip, Limbs, Ankle, Footwear. Bespoke Products Only.**
Lot 5	**Paediatric including: Head, Cervical, Hip, Spinal, Knee, Upper and Lower Limbs, Footwear. Standard stock and Superior stock Products.**
Lot 6	**Paediatric including: Head, Cervical, Hip, Spinal, Knee, Upper and Lower Limbs, Footwear. Bespoke Products only.**
Lot 7	**Postiche (Wigs) and associated accessories.**
Lot 8	**Prosthetics including: Feet, Knees, Modular Components, Valves, Endo and Exoskeletal Components, Adult and Paediatric. Standard stock and Superior stock products.**
Lot 9	**Managed Service (to Include Managing Supply, delivery and collection and cleaning. Will include decontamination, where products are not identified as single use.) To provide a partial or fully managed service to the Participating Authority and Customer.**

- The framework agreement was originally £4,000 to access however the access fee was waived on this occasion
- All of the key suppliers including the incumbent supplier (Hugh Steeper Ltd) was listed as being awarded onto the Framework Agreement
- All of the above lots fulfilled the Trust's requirements to complete a mini competition under the above Framework Agreement
- Key draft specifications, invitation to quote and relevant commercial offer schedule templates were available via the Framework Agreement which were utilised
- The Framework Agreement gives freedom and flexibility for all participating Authorities to choose the suppliers they wish within the remit of the Agreement
- A detailed procurement exercise has taken place to ensure that suppliers selected are appropriate in terms of meeting all legislative requirements and quality standards
- Direct delivery option to all participating Authorities
- Option for direct award or mini competition where required
- EU legislation Compliant route of purchase
- Cash saving opportunities
- A centralised agreement for direct purchase of Orthotics and Prosthetics products with contract management and supplier communication provided
- Session fees offered independently of any product commitment

3. PROCUREMENT PROCESS

3.1 The Procurement Department invited bids under the above SBS Framework Agreement by running a mini competition:

- As part of the process the Trust instructed bidders that we may wish to implement the Managed Service option (Lot 9) part way through the initial period of the new contract for example during Year 2 of 5
- 15 companies were invited to submit a bid for the following lots

Lot No	Lot Title
Orthotics Products and Services	
Lot 1	**Upper Body including; Neuro, Limbs, Cervical, Spinal. Standard stock and Superior stock Products, Adults only.**
Lot 2	**Lower body including: Lower extremity, Knee, Hip, Limbs, Ankle, Footwear. Standard stock and Superior stock Products, Adults Only.**
Lot 3	**Upper Body including: Limbs, Cervical, Spinal. Bespoke Products only.**
Lot 4	**Lower body including: Knee, Hip, Limbs, Ankle, Footwear. Bespoke Products Only.**
Lot 5	**Paediatric including: Head, Cervical, Hip, Spinal, Knee, Upper and Lower Limbs, Footwear. Standard stock and Superior stock Products.**
Lot 6	**Paediatric including: Head, Cervical, Hip, Spinal, Knee, Upper and Lower Limbs, Footwear. Bespoke Products only.**
Lot 8	**Prosthetics including: Feet, Knees, Modular Components, Valves, Endo and Exoskeletal Components, Adult and Paediatric. Standard stock and Superior stock products.**
Lot 9	**Managed Service (to Include Managing Supply, delivery and collection and cleaning. Will include decontamination, where products are not identified as single use.) To provide a partial or fully managed service to the Participating Authority and Customer.**

- 3 bids were received

The scoring element of each bid was in sections and weighted as follows as follows:

Lot	Weighting
Account Management (All Lots)	**5%**
Assurance of Supply (All Lots)	**13.5%**
Clinical Evidence (All Lots)	**3.5%**
Contract Management (All Lots)	**3%**
Innovation (All Lots)	**5%**
Risk Management (All Lots)	**3%**
Training (All Lots)	**5%**
Section C - Lot Specific Questions **Lot 1 & 2, Lots 3 & 4, Lots 5 & 6, Lot 8** **Lot 9**	 **22%** **29.5%**
Price **Lot 1 & 2, Lots 3 & 4, Lots 5 & 6, Lot 8** **Lot 9**	 **40%** **20%**

3.2 Following a clinical, technical, commercial and financial evaluation it was agreed to recommend a sole award to Hugh Steeper Ltd as summarised below and attached:

- Appendix One – Scores
- The general consensus received from the evaluation group was to score globally across all of the lots for the orthotics components. The Trust has reasonable activity figures for footwear and orthotic devices with comparable prices from two of the bidders (Hugh Steeper Ltd and CA Blatchford & Sons Ltd) and the activity figures cannot be split into individual lots hence the global comparison for Lots 1 to 6
- Due to the complexity of this contract the evaluation group was unable to attach a score to the financials for the managed service component as neither supplier have provided sufficient information for comparison purposes.
- Each bidder (Hugh Steeper Ltd and CA Blatchford & Sons Ltd) has indicated that they can provide a managed service but further discussion is necessary to determine the service requirements and how this will be potentially implemented from Year 2 onwards

3.3 A sole award option was recommended for the following reasons:

- Hugh Steeper Ltd offered a full and comprehensive bid including all of the Trust's requirements with the exception of further discussion and clarification is required with regards to potentially implementing a managed device for both the orthotic and prosthetic service from Year 2 onwards

3.4 The successful bid from Hugh Steeper Ltd for Lots 1 to 6 and Lot 8 was recommended for the following reasons:

Successful bidder 1 – Hugh Steeper Ltd

- Scored the highest % for Lots 1 to 6 of 97.75%
- Lowest cost bid of £207,749.12 for Lots 1 to 6
- Scored the highest % for Lot 8 of 97.75%
- Lowest cost bid of £346,814.16 for Lot 8

3.5 The unsuccessful bids were rejected for the following reasons:

Unsuccessful bidder 1 - Ossur UK Ltd

- The bidder only offered for the supply of consumables for Lot 1, 2 and 5 and did not offer any of the necessary (orthotic) services required
- Therefore the supplier's bid failed due to not offering orthotic services as requested in the mini competition documents

Unsuccessful bidder 2 - CA Blatchford & Sons Ltd

- Scored the lowest % for Lots 1 to 6 of 84.50%
- Highest cost bid of £225,366.00 (8.48% higher)
- Scored the lowest % for Lot 8 of 57.88%
- Highest cost bid of £490,902.79 (41.55% higher)

4. FINANCIAL IMPLICATIONS

4.1 CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum:	**£712,517**
Current cost inclusive of VAT per annum:	**£855,020.40**
Current contract end date:	**28/02/2019**
Comments	

4.2 NEW COSTS

Proposed cost exclusive of VAT per annum:	**£554,563.28**
Proposed cost inclusive of VAT per annum:	**£665,475.94**
Proposed contract start date:	**01/03/2019**
Duration of contract:	**60 Months**
Value of total contract including VAT:	**£3,327,379.71**

4.3 FINANCIAL IMPACT

SAVINGS

Savings per annum including VAT:	**£189,544.46**
Start Date of savings:	**01/03/2019**

4.4 FUNDING DETAILS

Source of Funding:	**Revenue**
Cost Centre/s:	**125042/125041**
Expense Code:	**711000/702900**
Financial Implications approved by:	**Lisa Moon, Finance Manager**

5. EVALUATION TEAM

5.1 The following colleagues comprised the membership of the evaluation team and are responsible for this recommendation:

- Paul Seabourne, Clinical Manager
- Lisa Moon, Finance Manager
- Vicki Russell, Centre Manager, Artificial Limb Unit
- Paul Capes, Rehabilitation Engineer, Medical Physics, Castle Hill Hospital

6. RECOMMENDATION

6.1 The Chief Executive/Chief Finance Officer and Trust Board are requested to approve the awarding of this contract to Hugh Steeper Ltd.

Jonathan Wood
Director of Operations

Procurement Department comments

This recommendation is compliant with Trust Standing Orders, Standing Financial instructions and EU Regulations.

Procurement Department additional comments: None

Please indicate approval or rejection of this paper by signing in the appropriate box below.

Scheme of Delegation as per Section D Point 9.12 of Corporate Policy 105 – Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions (February 2017)

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Orthotic and Prosthetic Services including the Supply of Consumables

Contract ref: HEY/16/172

The above recommendation **is** accepted.

Signed:…… Date:……

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed:…… Date:……

Trust Board

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Orthotic and Prosthetic Services including the Supply of Consumables

Contract ref: HEY/16/172

The above recommendation **is not** accepted.

Signed:…… Date:……

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed:…… Date:……

Trust Board

Reasons for rejection of recommendation:

Contracts Ref:	HEY/16/172	**Supplier Ref:**	N/A
Contracts Contact:	CS	**Date submitted for approved:**	22/01/2019

Section B		Section Weighting					Hugh Steeper					C. A. Blatchford & Sons				
Sub-Section	Ref.	Lots 1 and 2	Lots 3 and 4	Lots 5 and 6	Lot 8	Lot 9	Lots 1 and 2	Lots 3 and 4	Lots 5 and 6	Lot 8	Lot 9	Lots 1 and 2	Lots 3 and 4	Lots 5 and 6	Lot 8	Lot 9
Account Management	B1	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	**1.25%**	1.25%	1.25%	1.25%	1.25%
Account Management	B2	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Assurance of Supply	B3	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Assurance of Supply	B4	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	**1.50%**	1.50%	1.50%	1.50%	1.50%
Assurance of Supply	B5	5.50%	5.50%	5.50%	5.50%	5.50%	4.13%	4.13%	4.13%	4.13%	4.13%	**5.50%**	5.50%	5.50%	5.50%	5.50%
Clinical Evidence	B6	3.50%	3.50%	3.50%	3.50%	3.50%	2.63%	2.63%	2.63%	2.63%	2.63%	**3.50%**	3.50%	3.50%	3.50%	3.50%
Contract Management	B7	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	**2.25%**	2.25%	2.25%	2.25%	2.25%
Innovation	B8	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	**3.75%**	3.75%	3.75%	3.75%	3.75%
Risk Management	B9	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	**2.25%**	2.25%	2.25%	2.25%	2.25%
Training	B10	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
		38.00%	38.00%	38.00%	38.00%	38.00%	35.75%	35.75%	35.75%	35.75%	35.75%	32.50%	32.50%	32.50%	32.50%	32.50%
Section C																
Lots 1 and 2	L1-01	8.50%					8.50%					8.50%				
Lots 1 and 2	L1-02	6.50%					6.50%					6.50%				
Lots 1 and 2	L1-03	7.00%					7.00%					7.00%				
Lots 3 and 4	L3-01		13.25%					13.25%					13.25%			
Lots 3 and 4	L3-02		8.75%					8.75%					8.75%			
Lots 5 and 6	L5-01			22.00%					22.00%					22.00%		
Lot 8	L8-02				13.25%					6.63%					6.63%	
Lot 8	L8-03				8.75%					8.75%					8.75%	
Lot 9	L9-02					42.00%					42.00%					42.00%
		22.00%	22.00%	22.00%	22.00%	42.00%	22.00%	22.00%	22.00%	15.38%	42.00%	22.00%	22.00%	22.00%	15.38%	42.00%
Section D	Pricing	40.00%	40.00%	40.00%	40.00%	20.00%	40.00%	40.00%	40.00%	40.00%	Note 1	30.00%	30.00%	30.00%	10.00%	Note 1
	Total	100.00%	100.00%	100.00%	100.00%	100.00%	97.75%	97.75%	97.75%	91.13%	77.75%	84.50%	84.50%	84.50%	57.88%	74.50%
							£207,749.12	£207,749.12	£207,749.12	£346,814.16		£225,366.00	£225,366.00	£225,366.00	£490,902.79	
										£207,749.12					£225,366.00	
									Total	£554,563.28					£716,268.79	
									5 Years	£2,772,816.42					£3,581,343.95	

Prices (From Activity Data):

	Prosthetics			Orthotic Footwear	Orthotic Devices	Orthotic (Total)				
Hugh Steeper	£346,814.16	£490,902.79		£205,912.84	£1,836.29	£207,749.12	£225,366	£3,327,379.71	£554,563.28	VAT
										£4,297,612.74
										77.42%
C.A. Blatchford & Sons	£490,902.79	**41.55%**	**Higher**	£221,911.00	£3,455.00	£225,366.00	**8.48%**	**Higher**	£716,268.79	VAT
				92.79%	53.15%					22.58%

Note 1:
Unable to attach a score to the financials for the managed service component as neither supplier have provided sufficient information for comparison purposes.
Each supplier has indicated that they can proivde a managed service but further discussion is necessary to determine the service requirements and how this will be implemented.

Hull and East Yorkshire Hospitals NHS Trust

Meeting

Date

Title:	Continued Access to the Total Workforce Solutions Framework Agreement
Responsible Director:	Simon Nearny
Author:	Sue Richards Tracy Harley Marcus Raw

Purpose:	The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	
	Financial sustainability	✓
Summary Key of Issues:	The Trust has previously signed up to this NHSI mandated framework agreement – provided by HealthTrust Europe – to provide temporary staffing for allied health, scientific, and medical staff groups. This framework provides staff at nationally agreed pay rates. This framework has recently been extended, and this paper seeks to gain approval to continue to source temporary staffing for these staff group via this agreement.	

Recommendation:	The Chief Executive / Chief Finance Officer and Trust Board are requested to approve the extension of access to the HealthTrust Europe's Total Workforce Solutions Framework Agreement.

CONTRACT EXTENSION RECOMMENDATION PAPER FOR THE CONTINUED USE OF THE HEALTHTRUST EUROPE TOTAL WORKFORCE SOLUTIONS FRAMEWORK AGREEMENT

COMPLIANT CONTRACT RECOMMENDATION

Status:	**Official Contract Extension**
Trust Reference:	**HEY/16/255/A – LOT 3A Medical Locums (Temporary)** **HEY/16/255/B – LOT 3B Nursing (Temporary)** **HEY/16/255/C – LOT 3C Allied Health (Temporary)** **HEY/16/255/D – LOT 4 Non-clinical (Temporary)**
Type:	**Contract Extension**
Original Contract Term:	**36 months with an option to extend for up to 24 months**
Original Period of Contract:	**(01/12/2016 - 31/10/2018)**
Period of official extension taken:	**0 Months**
Periods of official extension period remaining:	**24 Months**
Period and dates of this official compliant extension period being recommended:	**12 Months (01/11/2018 - 31/10/2019)**
Health Group:	**Corporate**
Division:	**Workforce and O.D.**
Department:	**Human Resources**
Original Procurement Process Used:	**HealthTrust Europe Total Workforce Solutions Framework (Direct Award)**
Total Contract Extension Value (Ex. VAT):	**£4,779,444.02 Variable**
Cost Centre:	**All Trust clinical departments can use this framework.**
Terms and Conditions which apply:	**NHS Framework Agreement for the Provision of Services.**
G.D.P.R. Applicable:	**Yes**
Procedure Compliant with Trust SFI's:	**Yes**

1. PURPOSE

1.1 The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement for a period of 12 months from 1st November 2018 to 31st October 2019.

2. BACKGROUND

2.1 In December 2016 the Trust signed up to three NHSI mandated framework agreements established to provide NHS Trusts with access to temporary staffing providers:

- The North of England Commercial Procurement Collaborative's (NOECPC) National Clinical Staffing Framework Agreement: For nursing temporary staffing.

- HealthTrust Europe's Total Workforce Solutions Framework Agreement: For allied health, scientific, and medical temporary staffing.

- Crown Commercial Service's Non Clinical Non Medical Framework Agreement: For non-clinical and non-medical temporary staffing.

These frameworks provide a compliant route to engage temporary staff at nationally agreed pay rates. The terms of the sign-up enables the Trust to access the framework for the entirety of the framework period.

3. EXTENSION RECOMMENDATION

3.1 This extension recommendation concerns the HealthTrust Europe framework agreement – which is being utilised to engage temporary allied health, scientific and medical staffing.

3.2 In January 2019 the HealthTrust Europe advised that the framework term had been extended until 31/10/19.

3.3 This recommendation is being made to request continued use of this framework in line with this extension.

4. FINANCIAL IMPLICATIONS

4.1 CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum:	**£4,779,444.02**
Current cost inclusive of VAT per annum:	**£5,735,332.80**
Current contract end date:	**31/10/18**
Comments *Full Trust agency staffing spend for 2017/18 can be found in Appendix One*	

4.2 PROPOSED EXTENSION COSTS

Proposed cost exclusive of VAT per annum:	**£4,779,444.02**
Proposed cost inclusive of VAT per annum:	**£5,735,332.80**
Proposed contract extension start date:	**01/11/18**
Duration of extension:	**12 months**
Value of total contract extension including VAT:	**£5,735,332.80**
Comments: *The costs listed above refer to spend on allied health, scientific, and medical agency staffing only.*	

4.3 FUNDING DETAILS

Source of Funding:	**Revenue**
Cost Centre:	All Trust clinical departments can use this framework.
Financial Implications approved by:	**Tracy Harley**

5. HEALTH GROUP EXTENSION RECOMMENDATION

5.1 The following colleagues from the Corporate Health Group were directly involved in the recommendation of this extension:

- Sue Richards - Head of Workforce Transformation & Service Delivery
- Tracy Harley - Head of Finance Corporate

6. RECOMMENDATION

6.1 The Chief Executive / Chief Finance Officer and Trust Board are requested to approve the extension of access to the HealthTrust Europe's Total Workforce Solutions Framework Agreement for a further 12 months from 1st November 2018 to 31st October 2019.

Simon Nearney
Director of Workforce and O.D.

Procurement Department comments

This recommendation **is** compliant with Trust Standing Orders, Standing Financial instructions and EU Regulations.

Procurement Department additional comments: None

Please indicate approval or rejection of this paper by signing in the appropriate box below.

Scheme of Delegation as per Section D Point 9.12 of Corporate Policy 105 – Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions (February 2017)

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Total Workforce Solutions Framework Agreement

Contract ref: HEY/16/255

The above recommendation **is** accepted.

Signed: …… Date: ……..

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed: …… Date: ……..

Trust Board

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Total Workforce Solutions Framework Agreement

Contract ref: HEY/16/255

The above recommendation **is not** accepted.

Signed: …… Date: ……

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed: …… Date: ……

Trust Board

Reasons for rejection of recommendation:

Contracts Ref:	HEY/16/255	**Supplier Ref:**	-
Contracts Contact:	MR	**Date submitted for approved:**	16/01/19

11.2.2 - Appendix One - Trust Agency Spend 2017- 18

NURSING		
Subjective Name	**4CCN - Level 4 Cost Centre Name**	**Total**
Agency Nursing Qualified	Clinical Support Services	£78,040.25
	Corporate Directorates	£1,326.34
	Family + Womens Health	£71,946.38
	Medicine	£303,498.26
	Other Operating Expenditure	£334.38
	Reserves	£0.00
	Surgery	£952,622.48
Agency Nursing Qualified Total		***£1,407,768.09***
Agency Nursing Unqualified	Medicine	£0.00
Agency Nursing Unqualified Total		***£0.00***
Nursing Total		***£1,407,768.09***
MEDICAL LOCUMS		
Subjective Name	**4CCN - Level 4 Cost Centre Name**	**Total**
Agency Sho'S And Ho'S	Clinical Support Services	£222,362.52
	Corporate Directorates	£0.00
	Family + Womens Health	£171,837.66
	Medicine	£1,113,844.04
	Other Operating Expenditure	£0.00
	Reserves	£0.00
	Surgery	£667,402.77
Agency Sho'S And Ho'S Total		***£2,175,446.99***
Agency Specialist Registrars	Clinical Support Services	£965.74
	Family + Womens Health	£75,072.64
	Medicine	£458,118.78
	Other Operating Expenditure	£0.00
	Reserves	£0.00
	Surgery	£315,184.60
Agency Specialist Registrars Total		***£849,341.76***
Medical Locums Total		***£3,024,788.75***
ALLIED HEALTH		
Subjective Name	**4CCN - Level 4 Cost Centre Name**	**Total**
Agency Ahps	Clinical Support Services	£1,196,733.41
	Corporate Directorates	£0.00
	Family + Womens Health	£21,886.07
	Medicine	£48,387.35
	Other Operating Expenditure	£258.81
	Reserves	£0.00
	Surgery	£6,029.59
Agency Ahps Total		***£1,273,295.23***
	Clinical Support Services	£0.00

11.2.2 - Appendix One - Trust Agency Spend 2017- 18

Agency Hcas And Support Staff	Corporate Directorates	£0.00
	Medicine	£0.00
	Other Operating Expenditure	£0.00
	Surgery	£0.00
Agency Hcas And Support		***£0.00***
Agency Oda	Surgery	£0.00
Agency Oda Total		***£0.00***
Agency Other Medical	Clinical Support Services	£716.54
	Family + Womens Health	£11,682.00
	Medicine	£0.00
	Surgery	£0.00
Agency Other Medical Total		***£12,398.54***
Agency Prof And Tech	Clinical Support Services	£51,238.99
	Corporate Directorates	-£1,073.86
	Family + Womens Health	£1,687.95
	Medicine	£1,240.38
	Other Operating Expenditure	£0.00
	Surgery	£378,560.68
Agency Prof And Tech Total		***£431,654.14***
Agency Scientific	Clinical Support Services	£37,307.36
	Corporate Directorates	£0.00
	Family + Womens Health	£0.00
	Medicine	£0.00
	Surgery	£0.00
Agency Scientific Total		***£37,307.36***
Allied Health Total		***£1,754,655.27***
NON CLINICAL		
Subjective Name	**4CCN - Level 4 Cost Centre Name**	**Total**
Agency Admin And Clerical	Clinical Support Services	£102,564.62
	Corporate Directorates	£721,821.90
	Family + Womens Health	£21,444.13
	Medicine	£11,634.98
	Other Operating Expenditure	£4,560.22
	Reserves	£0.00
	Surgery	£50,549.98
Agency Admin And Clerical Total		***£912,575.83***
Agency Consultants	Clinical Support Services	£976,614.41
	Corporate Directorates	£45,934.00
	Family + Womens Health	£111,048.27
	Medicine	£1,681,993.03
	Other Operating Expenditure	£0.00
	Reserves	£0.00
	Surgery	£5,629.41
Agency Consultants Total		***£2,821,219.12***
Agency Maintenance And Works	Clinical Support Services	£0.00

11.2.2 - Appendix One - Trust Agency Spend 2017- 18

Works	Corporate Directorates	£0.00
Agency Maintenance And Works Total		***£0.00***
Agency Other	Clinical Support Services	£0.00
	Corporate Directorates	£96,995.86
	Family + Womens Health	£0.00
	Medicine	£9,040.79
	Other Operating Expenditure	£0.00
	Reserves	£0.00
	Surgery	£0.00
Agency Other Total		***£106,036.65***
Agency Senior Managers	Corporate Directorates	£0.00
	Family + Womens Health	£0.00
	Medicine	£0.00
Agency Senior Managers Total		***£0.00***
Non Clinical Total		***£3,839,831.60***
Grand Total		***£10,027,043.71***
Total Workforce Solutions Framework Spend		***£4,779,444.02***