**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**TRUST BOARD**

**TUESDAY 12 MARCH 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<br>2.1 Changes to Directors' interests since the last meeting<br><br>2.2 To consider any conflicts of interest arising from this agenda | verbal | Chair – Terry Moran |
| 3 | Minutes of the meeting of 29 January 2019/26 February 2019 | attached | Chair – Terry Moran |
| 4 | Matters Arising | verbal | Chair – Terry Moran |
| | 4.1 Action Tracker<br>4.2 Board Reporting Framework 2018/19/2019/20<br>4.3 Board Development Framework 2018/19/2019/20 | 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 | Mortality/Medical Examiner Role | attached | Interim Chief Medical Officer – Makani Purva/Associate Chief Medical Officer - Kate Adams |
| 9 | Board Assurance Framework – BAF Risk 5 – Specialist Services | to follow | Director of Strategy and Planning – Jacqueline Myers |
| 10 | Paediatric Transition Service | presentation | Head of Outpatient Services – Eileen Henderson |
| 11 | Trust Strategy 2019 – 2024 | attached | Director of Strategy and Planning – Jacqueline Myers |
| 12 | **Director Reports**<br>12.1 Quality Report | attached | Chief Nurse – Mike Wright |

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|---|---|---|---|
| | 12.2 Nurse and Midwifery Staffing Report | attached | Chief Nurse – Mike Wright |
| | 12.3 National Staff Survey 2018 results | attached | Director of Workforce and OD – Simon Nearney |
| | 12.4 Quality Improvement Plan - Update | attached | Chief Nurse – Mike Wright |
| | 12.5 Quality Committee Minutes January and Summary Report February 2019 | attached | Chair of the Committee – Martin Veysey |
| | 12.6 Performance and Finance Report | attached | Chief Operating Officer – Teresa Cope – Deputy Finance Director – Steve Evans |
| | 12.7 NHS Operational Planning and Contracting 2019/20 Update | verbal | Director of Strategy and Planning – Jacqueline Myers |
| | 12.8 Performance and Finance Minutes January and Summary Report February 2019 | attached | Chair of the Committee – Stuart Hall |
| 13 | **Governance and Assurance** | | |
| | 13.1 Internal Auditors Update | verbal | Chair of Audit Committee – Tracey Christmas |
| | 13.2 Charitable Funds Summary Report February 2018 | attached | Chair of the Committee – Vanessa Walker |
| | 13.3 Freedom to Speak Up Report | attached | Director of Corporate Affairs – Carla Ramsay |
| | 13.4 Gender Pay Gap Annual Report | attached | Director of Workforce and OD – Simon Nearney |
| | 13.5 Standing Orders | attached | Director of Corporate Affairs – Carla Ramsay |
| 14 | EU Exit Operational Readiness | attached | Director of Strategy and Planning – Jacqueline Myers |
| 15 | Any Other Business | verbal | Chairman |
| 16 | Any questions from members of the public | verbal | Chairman |
| 17 | **Date and time of the next meeting: Tuesday 14 May 2019 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary** | | |

**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 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 7/8 |
| A Snowden | ✓ | ✓ | x | ✓ | ✓ | ✓ | - | - | | 5/6 |
| S Hall | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| V Walker | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| T Christmas | x | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 6/8 |
| M Gore | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | | 7/8 |
| T Sheldon | x | ✓ | ✓ | - | - | - | - | - | | 1/3 |
| C Long | ✓ | x | ✓ | ✓ | ✓ | x | ✓ | ✓ | | 6/8 |
| L Bond | ✓ | ✓ | ✓ | ✓ | x | ✓ | x | x | | 5/8 |
| M Wright | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| T Cope | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| K Phillips | ✓ | ✓ | ✓ | ✓ | - | - | - | - | | 4/4 |
| M Purva | - | - | - | - | ✓ | ✓ | ✓ | ✓ | | 4/4 |
| M Veysey | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | | 6/7 |
| **In Attendance** | | | | | | | | | | |
| J Jomeen | - | - | x | x | ✓ | ✓ | ✓ | x | | 3/6 |
| J Myers | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| S Nearney | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |
| C Ramsay | x | ✓ | ✓ | * | * | ✓ | ✓ | ✓ | | 5/8 |
| R Thompson | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 8/8 |

*****Carla Ramsay – career break

**Hull and East Yorkshire Hospitals NHS Trust**
**Minutes of the Trust Board**
**Held on Tuesday 29 January 2019**

| | | |
|---|---|---|
| Present: | Mr T Moran CB | Chairman |
| | Mrs V Walker | Non-Executive Director/Vice Chair |
| | Mr S Hall | Non-Executive Director |
| | Mrs T Christmas | Non-Executive Director |
| | Mr M Gore | Non-Executive Director |
| | Mr C Long | Chief Executive Officer |
| | Mr M Wright | Chief Nurse |
| | Dr M Purva | Chief Medical Officer |
| | Mrs T Cope | Chief Operating Officer |
| In Attendance: | Mr S Nearney | Director of Workforce and OD |
| | Ms C Ramsay | Director of Corporate Affairs |
| | Ms J Myers | Director of Strategy and Planning |
| | Mr S Evans | Deputy Finance Director |
| | Dr M Kumar | Guardian of Safe Working |
| | Mrs J Cairns | Head of Midwifery |
| | Mr D Bovill | Health and Safety Manager |
| | Mrs R Thompson | Corporate Affairs Manager (Minutes) |

**No** **Item** **Action**

**1 Apologies:**

Apologies were received from Mr L Bond, Chief Financial Officer, Prof M Veysey, Non-Executive Director and Ms J Jomeen, Non-Executive Director

Mr Moran welcomed Mrs Beverley Geary to the Trust who was observing the Board. Mrs Geary would be taking over as Chief Nurse when Mr Wright retired in March 2019. Mr Moran also welcomed Mrs Walker to her first meeting as Vice Chair.

**2 Declarations of interests**

**2.1 Changes to Directors' interests since the last meeting**

Mr Moran declared that he had been appointed as a Trustee of Cat Zero.

**2.2 To consider any conflicts of interest arising from this agenda**

There were no conflicts of interest raised.

3 **Minutes of the meeting of 13 November 2018**

Page 4 – first line to be removed from the minutes.
Page 6 – paragraph 2 correction of the spelling of Dr Lily. It should read Dr Lillie.
Page 6 – paragraph 5 HSIB would be reviewing specific maternity incidents.
Page 6 – paragraph 6 and action plan would be developed and any concerns would be raised at the Quality Committee.
Page 6 – paragraph 10 sentence to change to…."key issue and cases are being analysed".
Page 7 – paragraph 8 Mr Wright advised that 112 new nursing recruits had commenced with the Trust.

Following the above changes the minutes were approved as an accurate record.

**4 Matters Arising**

There were no matters arising from the minutes.

**4.1 Action Tracker**

There were no items on the action tracker. Mr Hall asked for a more comprehensive tracker be adopted showing cleared and uncleared actions for all meetings including where all actions have been cleared.

**4.2 Board Reporting Framework 2018/19**

Ms Ramsay presented the report and advised that the framework would be altered for next year to incorporate a full board in January 2020.

**4.3 Board Development Framework**

Mr Moran stated that the January 2019 development session had been taken up by a deep dive into emergency care and the interim management arrangements. He asked for the original January items to be rescheduled. He added that he thought the development sessions had been a productive source of discussion and learning for the Board. This of course would be reviewed more systematically as part of the board effectiveness review.

**4.4 Any other matters arising from the minutes**

There were no other matters arising from the minutes.

**5 Chairs Opening Remarks**

Mr Moran stated that the agenda was busy once again and asked members of the Board to highlight any emerging issues or any key points of interest only when introducing their papers or commenting during discussion.

**6 Chief Executive's Briefing**

Mr Long presented his briefing and highlighted the Trust's name change event which was being held 1st February 2019. He thanked Prof. Julie Jomeen for the support and commitment she had put into the event and asked the Board to free up their time to attend where possible.

Mr Gore asked about the dashboard and highlighted theatre utilisation which was at 80%. Mrs Cope advised the Hospital Improvement Team were reviewing this and that it would be discussed at the next Performance and Finance Committee.

**7 Patient Story**

Dr Purva's first patient story was regarding a breast feeding mother who wanted to feed her child. She was in Outpatients and staff told her to go to the disabled persons' toilet. The problem was identified and staff given training and signposted to the trust policy. The correct facility is now being used.

Dr Purva also spoke of a child inpatient who had a feeding tube in place. The child's mother asked if it would be possible to have a similar tube attached to the child's teddy bear. The team agreed to do this which brought comfort to the child.

Dr Purva's third story related to the staff that support patient families when their relative is approaching end of life. She spoke of the very positive

feedback relatives had given about the support and compassion they had received from staff and of the continuity of care from staff between shifts.

**8 Board Assurance Framework**

Ms Ramsay presented the report which highlighted quarter 3 updates following board and committee discussions.

Ms Ramsay advised that the Performance and Finance Committee had discussed BAF risk 4, operational standards and whether or not the likelihood should increase from 16 to 20 risk rating.

The Committee had agreed to leave the risk rating at 16 as performance was being managed and was, in some respects, improving despite the ongoing challenges in ED, cancer and RTT standards. On that basis the Board agreed there was no reason to change the risk rating from 16.

The Board agreed to receive the updated Quality Improvement Programme at the March 2019 meeting. Mr Wright added that this was received at every Quality Committee for scrutiny. **MW**

The Board also agreed to receive a report relating to BAF risk 5 – specialist services. **JM**

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

***The agenda was taken out of order at this point***

**10.6 Guardian of safe working report**

Dr Muthukumar presented the report and highlighted the exception reports that were reliant on the Junior Doctors raising any concerns. The rota system was not integrated with the Trust's e-rostering system and so hours were not always recorded correctly. Dr Muthukumar advised that at the current time the Trust would need to employ someone to manually transfer the data set from one system to the other.

Mr Nearney reported that work was ongoing with Human Resources to address the issues.

Mrs Walker referred to a previous Board discussion about poor junior doctor facilities and accommodation. She wanted to commend Mr D Haire for his work for identifying Charitable Funds for the upgrading doctor accommodation..

Mr Gore stated that he had attended the Junior Doctor forum and although it had been poorly attended, was a useful discussion. Dr Purva advised that attendance was probably due to busy workloads and clinical requirements.

**Resolved:**
The Committee received and accepted the report although noting further efforts were needed to systemise reporting in order to provide the Board with greater assurance.

***The agenda returned to order at this point***

**9.1 Quality Report**
Mr Wright presented the report and highlighted the serious incidents and Safety Thermometer both having been fully scrutinised at the Quality Committee.

Mr Wright reported that the Trust had a case of MRSA bacteraemia. The patient had complex needs and there would be more details in the March 2019 report. C Difficile performance was an improved positon but there were still challenges with MSSA and E-coli.

Norovirus continues to be challenging and was being robustly managed, but 1300 bed days had been had been lost because of it. There were also more cases of flu.

Mr Wright reported that the Trust was back on track with complaints and the Friends and Family Test scores were showing that 98.68% of patients asked would recommend the Trust.

Mr Wright reported that the CQC had not contacted the organisation regarding any inspection dates so far this year.

Learning from deaths was included in the report and Mr Wright advised that the Quality Committee had discussed this in detail. The Safeguarding annual reports for both Adults and Children had been well received at the Quality Committee, providing good assurance.

Mr Moran asked about the number of PALS cases received and had noted the welcome reduction in numbers over recent months. Mr Wright advised that much work had been carried out to ensure patients appointments were changed and communicated. He was reviewing the trend on a monthly basis.

**Resolved:**
The Committee received and accepted the report

**9.2 Nursing and Midwifery Staffing Report**
Mr Wright presented the report which highlighted the staffing across the Trust. He reported that nurses were being spread more thinly due to hospital pressures and we were constantly risk assessing by holding safety briefings 6 times per day.

He advised that another 130 registered nurses had been given their notional allocations upon qualifying.

In response to a question Mr Wright clarified that there were a number of red flags which meant the ward needed extra help. He stressed that each red flag was addressed.

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

**9.3 Fundamental Standards**
Mr Wright presented the report and advised that steady progress was being made although there had been delays in data collection over the winter months due to hospital pressures. He reported that the most challenging

area was around nutrition but that this was being monitored through the Quality Improvement Plan.

Mr Moran asked for clarity around H9 and the 3 red standards as this was not consistent with the earlier staffing report. Mr Wright agreed to check the standards and respond to Mr Moran.

Mr Hall added that the report was useful when the Non-Executives were visiting wards as it gave information to inform questioning of the staff. Mr Wright encouraged the Board to question ward Sisters regarding their ward's performance.

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

**9.4 Clinical Negligence Schemes for Trusts – Maternity**
Mr Wright presented the paper which highlighted year 2 of the scheme and reduction in CNST premium. The previous year had seen a £16k reduction but the standards were much more stringent in year 2. Standard 4 was the biggest risk which related to the Trust having a consultant obstetrician and a consultant anaesthetist at every emergency caesarean.

Mrs Cairns had attended the Board and a discussion took place regarding the time investment to ensure the standards were met and action plans were in place to ensure the correct staff grades covered caesarean sections. Mr Long asked that the wording in the report be changed so that it was understood that experienced senior doctors were always in attendance and did not just relate to consultants.

Mr Hall asked how much of the issue was due to ineffective rota planning and Dr Purva advised that it was not always possible for consultants to be present but that an experienced member of staff could cover which was much better for the patient and her baby.

Mrs Cairns reminded the Board that any element of non-compliance regarding the standards and the Trust receives no reduction.

Mr Wright added that work was ongoing with reviewing baby deaths and the saving baby life care bundle.

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

**9.5 Quality Committee Minutes – December 2018**
Mrs Walker presented the minutes and spoke of the richer depths of information received which meant that discussions were more informed.

She also reported that the Committee was encouraging visits from relevant members of staff to also inform discussions.

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

**9.6 Performance and Finance report**
Mrs Cope presented the performance section of the report and highlighted

that the key priorities were to maintain the focus on reducing the size of the waiting list and also reduce 52 week waiters to zero.

There was slow but steady progress with the waiting list volumes, but there had been 4 x 52 week waits in December and issues in January due to a theatre being out of action. Cancer performance was still an issue with challenges around diagnostics. The Trust continued to make progress around the 104 day cancer standard.

The National Intensive Support Team were working with the Trust regarding cancer and reviewing the front end and booking processes to ensure that they were robust.

Mrs Cope spoke of the Emergency Department and Ambulance turnaround in December and how challenging this had been. Performance had been below 80% in December with capacity constraints and delayed discharges due to very ill patients. She advised that work was ongoing across the whole healthcare system.

Mr Hall added that in the Performance and Finance Committee concerns relating to back office departments such as haematology and pathology had also been discussed.

**Finance Report**

Mr Evans presented the report and advised that the Trust was in deficit by £1.7m due to the non-delivery of the PSF funding due to failing the ED standard in quarter 3. He added that a correction exercise had been carried out and the breach position was being challenge. The results had been sent to NHS I for their confirmation. If accepted we will receive the PSF funding for Q3.

Health Group positions were still challenging with medical staffing agency costs being one of the main issues.

Mr Evans advised that the Trust was still forecasting delivery of the financial plan. The biggest challenge would be the underlying issues regarding the Health Group run rates.

Mr Hall added that all Trust reserves had been utilised and CRES would be around 83% delivery. The Trust had also been declined for the STF bid of £28m for backlog maintenance. Mr Moran asked if there would be any other opportunity to bid and Ms Myers advised that there would be a further assessment in the Autumn.

**Resolved:**

The Board received and accepted the report.

**9.7 NHS Operational Planning and Contracting Guidance 2019/20**

Ms Myers briefed the Board regarding the Finance and Operating guidance that had been received from the Centre. The Trust was expected to achieve a surplus in 2019/20 which was challenging for the Trustwith the level of funding in the system. Support from the Commissioners would be required going forward.

The Trust Board had agreed to an extra Board in February 2019 to discuss the financial planning for 2019/20 further.

Ms Myers also advised that the operational planning process was underway and would come to the Board in March 2019 for approval.

**Resolved:**
The Operating Plan and Contracting Guidance 2019/20 was received and accepted by the Board.

**9.8 Performance and Finance Minutes – December 2018**
The minutes were received and accepted by the Board.

**10.1 Health and Safety Report**
Mr Bovill attended the Board to present the Health and Safety report. He reported that it was an improving picture but that the Trust was not being complacent. Key issues highlighted were slips, trips and falls relating to the fabric of the estate and the increasing number of bariatric patients.

Mr Hall asked about Health and Safety training compliance and Mr Bovill reported that compliance was in the high 80s. He added that there was extended training for key members of staff who worked in challenging environments or had increased lifting requirements.

Mr Moran thanked Mr Bovill for a clear and detailed report.

**Resolved:**
The Committee received and accepted the report.

**10.2 Audit Committee Minutes – January 2019**
Mrs Christmas gave a verbal update and advised that the Committee had received an annual report from Grant Thornton which would be shared with board members.

The Committee had discussed internal and external effectiveness, audit plans, debts over 3 months old and more than £50k and legal fees. She reported that the Trust had been given a payment holiday due to the lack of expenditure with the legal contractor.

There was a discussion around the outstanding debts relating to NLAG and how the two Trusts were working together to pay tour respective debts.

Mrs Christmas also spoke about the outstanding audit actions and the work ongoing to close down the audit recommendations.

**Resolved:**
The Trust Board received and accepted the update.

**10.3 Charitable Funds Committee – November 2018**
Mrs Walker presented the minutes and advised that the meeting was looking more strategically at its role now that the revised arrangements were in place with the Wishh.

Ms Ramsay to discuss the new Non-Executive Director attendee at the meeting with Mr Moran, following Mr Snowden's retirement from the Trust.

**Resolved:**

The Committee received and accepted the minutes.

**10.4 Board Assurance Framework – Seven Day Hospital Services**
Dr Purva presented the standards that the Trust would be measured against relating to the standard of care provided to patients in out of hours and at weekends.

The first part of the draft was a self-assessment and this would be used as baseline data. An action plan would be developed to address any emerging issues.

Ms Myers advised that this would also form part of strategy discussions and focus would be placed on the current consultant contract. Mrs Cope added that it was difficult to maintain the flow at weekends and more support services were required.

There was a discussion around regulator expectations and the report becoming more onerous. Dr Purva reported that the process was being used as a pilot and that there was work to be done. It was agreed that the item would be brought back in summer 2019 to review progress. **MP**

**Resolved:**
The Committee received and accepted the report.

**10.5 Flu Vaccination Report**
Mr Nearney presented the report and advised that 83% of staff had been vaccinated and that the Trust was in the top 10 of all Trusts.

He advised that the Occupational Health Team had been proactive, vaccinating wards early and actually going out to wards to make it easier for staff to have the vaccination.

Mr Moran commented on this being an excellent achievement by all concerned.

**Resolved:**
The Trust Board received and accepted the report.

**11 Any Other Business**

**11.1 The Board was being asked to approve four contracts because of their value. There was some discussion about the approvals process and Mr Long proposed he should be asked to satisfy himself that all necessary governance steps had been taken but in the meantime suggested that the Board consider each contract and provide conditional approval, if happy, pending his due diligence checks.**

**The Board agreed Mr Long's proposal.**

**11.2 – Contract recommendation paper for the provision of orthotic and prosthetic services including the supply of consumables**

The Trust Board approved the contract subject to Mr Long's diligence checks being satisfactory.

**11.3 Contract recommendation paper for the continued use of the Heath Trust Europe Total Workforce Solutions Framework agreement.**

The Trust Board approved the contract subject to Mr Long's diligence checks being satisfactory.

**11.4 Recommendation Paper – Supply of Gas**
The Trust Board approved the contract subject to Mr Long's diligence checks being satisfactory.

**11.5 Recommendation Paper – Supply of Electricity**
The Trust Board approved the contract subject to Mr Long's diligence checks being satisfactory.

Other than the items listed in Any Other Business there was no other business discussed.

**12 Any questions from members of the public**
There were no questions from members of the public.

**13 Date and time of the next meeting:**
Tuesday 26 February 2019, 2.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

**Hull and East Yorkshire Hospitals NHS Trust**
**Minutes of the Extraordinary Trust Board**
**Held on 26 February 2019**

| | | |
|---|---|---|
| **Present:** | Mr T Moran CB | Chairman |
| | Mrs V Walker | Non-Executive Director/Vice Chair |
| | Mr S Hall | Non-Executive Director |
| | Mrs T Christmas | Non-Executive Director |
| | Mr C Long | Chief Executive Officer |
| | Mr L Bond | Chief Financial Officer |
| | Mrs T Cope | Chief Operating Officer |
| | Mr M Wright | Chief Nurse |
| | Dr M Purva | Chief Medical Officer |
| **In Attendance:** | Ms C Ramsay | Director of Corporate Affairs |
| | Mr S Nearney | Director of Workforce and OD |
| | Mrs R Thompson | Corporate Affairs Manager (Minutes) |

| No | Item | Action |
|---|---|---|

**1 Apologies:**

Apologies were received from Prof M Veysey, Non-Executive Director, Mr M Gore, Non-Executive Director, Ms J Myers, Director of Strategy and Planning and Prof J Jomeen, Non-Executive Director

**2 Declarations of interests**

**2.1 Changes to Directors' interests since the last meeting**

There were no declarations received.

**2.2 To consider any conflicts of interest arising from this agenda**

There were no declarations received.

**STP Financial Plan 2019/120**

Mr Bond gave a presentation which set out the Sustainability and Transformation Partnership (STP) financial performance for 2018/19 and the proposed funding for 2019/20. He spoke about the need for ever closer working across the STP area to achieve our respective budgets and spending controls.

He stated that if delivered, the control totals would significantly improve the provider landscape and if we could deliver performance and spending targets further funding could be achieved which could deliver a balanced budget. Current plans are however £14m short of the control totals set, this is compounded by a further financial risk across the STP area involving commissioners and provider trusts.

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**Resolved:**

The Board received and accepted the STP Financial Plan 2019/20.

**Trust Financial Framework 2019/20**

Mr Bond presented the Trust's financial framework for 2019/20 which included the control total offer and level of efficiency required.

Mr Bond outlined the financial plan that brought the Trust from a deficit to a potential surplus.

He reported that an increase in urgent care prices, with £1bn of the 18/19 PSF going into Commissioner allocations would enable payments to Trusts and a reduced 2019/20 PSF would be paid to Trusts based upon financial performance.

There was a discussion around CRES and the 2019/20 Target of £17.1m (3%). Mr Bond advised that there were no contingency plans in place and this would need to be delivered to achieve the control total. Mr Bond highlighted the schemes currently in place and the risks to their delivery. These totalled £7.7m. Mr Wright expressed his concern regarding the grip required to meet the CRES targets and the need for all staff to understand the issues.

Mr Long added that working with the STP partners could produce cost savings through reviewing services to deliver efficiencies.

Mr Bond highlighted a number of risks to achieving the control total. These were regarded as significant but not beyond our ability to deliver. The difficulty being that not all savings to date were recurrent. After a full discussion the Board believed it was better to accept the proposed control total and continue the planning with that certainty.

**Resolved:**
The Trust Board received and approved the control total proposed.

**Capital Programme Summary 2019/20**
Mr Bond reported that over the next 3 years, the Trust has a capital requirement of over £70m much in relation to a backlog in maintenance requirements and for replacement equipment. This does not allow for new developments or increased capacity for growth or investment in new technology.

Mr Bond highlighted the capital programme and advised the energy scheme, equipment, backlog maintenance and IM&T had been included in the £31.7m capital requirement.

There was a discussion around the STP capital bids and how capital bids would be managed efficiently across the area. This presented risks to timescales given the inherently long approvals processes.

Mr Moran suggested that the strategic risk regarding infrastructure be an early item for Board discussion as part of the Board Assurance Framework.

**Resolved:**
The Board received and accepted the capital planning assumptions and to discuss the risk at the Board meeting in May.

**Any Other Business**
There was no other business discussed.

**Date and time of the next meeting:**
Tuesday 12 March 2019, 9am-12pm, The Boardroom, Hull Royal Infirmary

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**TRUST BOARD ACTION TRACKING LIST (March 2019)**

## Actions arising from Board meetings

| Action NO | PAPER | ACTION | LEAD | TARGET DATE | NEW DATE | STATUS/ COMMENT |
|---|---|---|---|---|---|---|
| **March 2019** | | | | | | |
| 8 | Board Assurance Framework | Receive the updated Quality Improvement Programme at the March 2019 meeting. | MW | March 2019 | | On Agenda |
| 8 | Board Assurance Framework | To receive a report relating to BAF risk 5 – specialist services. | JM | March 2019 | | On Agenda |
| 10.4 | Board Assurance Framework – Seven Day Hospital Services | Seven Day Hospital Services Standards to be presented to the Board in Summer 2019. | MP | July 2019 | | |
| **COMPLETED** | | | | | | |

## Actions referred to other Committees

| Action NO | PAPER | ACTION | LEAD | TARGET DATE | NEW DATE | STATUS/ COMMENT |
|---|---|---|---|---|---|---|
| | | | | | | |
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| 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** | **Feb** | **Mar** |
| Strategy and Planning | Operating Framework | annual | | | | | | | x | | | | | | | | | | | x | | |
| | Operating plan | bi annual | | | | | | | | | x | | | 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 | x |
| | Winter plan | annual | | | | | | | x | | | | | | | | | | x | | | |
| | IM&T Strategy | new strategy | | | | | | | | | | | | | 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 | | | | |
| | Estates Strategy inc. sustainabilty and backlog maintenance | annual | | | | | | | | x | | | | | BD | | | | BD | | | |
| | Research and Innovation Strategy | annual | | | | | | | | | x | | | | | | | x | | | | |
| | IM&T Strategy | annual | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | |
| | Other patient surveys | annual | x | | | | | | | | | | | | | | | | | | | |
| | National Staff survey | annual | x | | | | | | | | | | 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 | | | | | | |
| | Learning from Deaths Guidance | quarterly | | | | | | | x | | | x | | | x | | | | x | | | x |
| | Workforce Race Equality Standards | annual | | | | | | x | | | | | | | | | | x | | | | x |
| | Modern Slavery | annual | | x | | | | | | | | | | | x | | | | | | | |
| | Emergency Preparedness Statement of Assurance | annual | | | | | | | x | | | | | | | | | x | | | | |
| | Information Governance Update (new item Jan 18) | bi-annual | | | | | | | | | | x | | BD | | | 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 | | | | | |
| | Annual Governance Self Declaration and Statement | 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 | | | | | | | | | | 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 | | | | | | | |
| | Freedom to Speak up Report | quarterly | x | | | | x | | | | x | | | | x | | | | x | | | x |
| | Going concern review | annual | | x | | | | | | | | | | | | x | | | | | | |
| | Seven Day Working Assurance Framework | New item | | | | | | | | | | | | | | | | | | | x | |
| | Preparation for EU Exit | New item | | | | | | | | | | | | | | | | | | | | x |
| | Review of Board & Committee effectiveness | annual | | | x | | | | | | | | | | x | | | | | | | |

**Hull University Teaching 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 | | | | | | | |

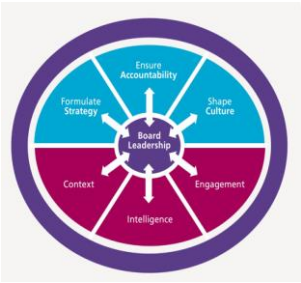
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 27 March 2018 | Areas 2 and BAF 4 & 5: Strategy refresh - key strategic issues (partnerships, infrastructure) | | | | | | | |
| | | | | | | | | |
| 17 April 2018 | Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan | Area 4 and BAF 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 | Area 4 and BAF 4: Estates/Tower Block strategy | | | | |
| | | | | | | | | |
| 29 January 2019 | | | Area 4 and BAF 4: Emergency Department Interim Arrangements | | | | | |
| | | | | | | | | |
| 26 March 2019 | | Area 1 and BAF 1: 2019-20 BAF | | | | | | |
| | | Area 1 and BAF 4: Trust Board and orgnaisaitonal improvement capacity and capability | | | | | | |
| | | | | | | | | |
| 28-May-19 | | | | | | | | |
| | | | | | | | | |
| 30-Jul-19 | | | | | | | | |
| | | | | | | | | |
| 24-Sep-19 | | | | | | | | |
| | | | | | | | | |
| 26-Nov-19 | | | | | | | | |
| | | | | | | | | |

Other topics to schedule:
Board team development (Martin Johnson)
Performance Deep Dive
Workforce data reporting
Strategic drivers/factors Deep Dive
Estates/Tower Block update

| 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<br>The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey<br>The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve<br><br>What could prevent the Trust from achieving this goal?<br>Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal<br>Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement<br>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<br>There are recurring risks of under-recruitment and under-availability of staff to key staffing groups<br>There is a risk that the Trust continues to have shortfalls in medical staffing<br><br>What could prevent the Trust from achieving this goal?<br>Failure to put robust and creative solutions in place to meet each specific need<br>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<br><br>What could prevent the Trust from achieving this goal?<br>Lack of progress against Quality Improvement Plan<br>That Quality Improvement Plan is not designed around moving to good and outstanding<br>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<br><br>What could prevent the Trust from achieving this goal?<br>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<br>The level of activity on current pathways for full 18-week compliance is not affordable to commissioners<br>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<br>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<br>In addition, there is a risk to Trust's reputation and/or damage to relationships<br><br>What could prevent the Trust from achieving this goal?<br>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<br>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<br><br>What could prevent the Trust from achieving this goal?<br>The Trust being enabled, and taking the opportunities to lead as a system partner in the STP<br><br>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<br><br>What could prevent the Trust from achieving this goal?<br>Planning and achieving an acceptable amount of CRES<br>Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit<br>Failure of local health economy to stem demand for services<br><br>BAF 7.2: Principal risk:<br>There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability<br><br>What could prevent the Trust from achieving this goal?<br>Lack of sufficient capital and revenue funds for<br><br>investment to match growth, wear and tear, to support service reconfiguration, to replace equipment<br>BAF 7.3: Principal risk:<br>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<br><br>What could prevent the Trust from achieving this goal?<br>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 UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**TRUST BOARD**

**12th MARCH 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: | | |
| 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: | Trust name change confirmed, changes to executive team, HUTH in top ten trusts for flu vaccinations. | |

| | |
|---|---|
| Recommendation: | That the board note significant news items for the Trust and media performance. |

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**CHIEF EXECUTIVE BRIEFING**

**MARCH 2019 TRUST BOARD**

## 1. KEY MESSAGES FROM NOVEMBER AND DECEMBER

### Name change confirmed

The trust received its official Establishment Order from the Department of Health and Social Care during February. The order, signed by the Secretary of State, confirmed the name change from 1st March 2019 to Hull University Teaching Hospitals NHS Trust (HUTH).

The trust works in partnership with the University and Hull York Medical School to provide expert teaching and to undertake first class research and development to further advance patient treatment. It is hoped that the name change will help us to recruit a high calibre of clinical staff, medical trainees and other healthcare professionals.

The Trust consulted with a range of partners including Clinical Commissioning Groups, local authorities, Hull York Medical School and the University of Hull on the proposal to change its name, and received strong support.

### Changes to the executive team

Chief Nurse, Mike Wright, retired from the trust on Friday 8th March. Beverley Geary, former Chief Nurse at York Teaching Hospital NHS Foundation Trust, is Mike's successor and has been working alongside Mike for a week before taking on the role in full.

From 1st April, 2019 Lee Bond will assume formally the role of Deputy Chief Executive for our organisation.

In addition, former Northern Lincs & Goole Hospitals Chief Nurse, Tara Filby, has joined the senior nursing team on a year's secondment as Assistant Chief Nurse, Special Projects. Among the issues Tara has been tasked with looking at are the fundamentals of nursing care, specifically those areas where the Care Quality Commission is seeking improvement ahead of our next inspection.

### Hull among top 10 NHS trusts for flu vaccine

Our trust been named among the top ten NHS trusts in the country for protecting patients, staff and their families from flu this winter.

HUTH achieved the national target of 75 per cent by mid-November, the fastest it has been reached in the trust's history. By January 21, 6,500 staff – including 83 per cent involved in direct patient care – had received the flu jab, one of the best vaccination rates in the country.

Last year, staff took 5,575 days off sick through colds and flu. Research shows a 10 per cent increase in staff vaccinations can result in a 10 per cent decrease in sickness absence. Evidence from NICE also suggests a link between lower staff vaccination rates and increased patient deaths.

Plans are already under way to encourage even more staff to take up the offer of free vaccinations next winter including volunteer vaccinators based in every ward and department.

### Hull midwifery team wins prestigious award for VR headsets

Virtual reality headsets giving Hull parents-to-be an immersive experience of labour and birth have helped hospital staff win a national award in midwifery.

Our Women and Children's Hospital became the first in the world to offer VR headsets to around 400 prospective parents so they can see what it's like to use a birthing pool in the midwifery-led unit or a birthing ball in the labour ward. As well as using the headsets to tour the Fatima Allam Birth Centre, women who know they're having a caesarean section are offered the opportunity to see inside an operating theatre before coming into hospital.

In February our midwives and Hull Institute of Learning and Simulation (HILS) won the "Use of Technology" award at a British Journal of Midwifery ceremony in Leeds.

Well done to everyone involved in this innovative project.

**Tesla electric car 'drives' children to Hull operating theatres**
Children undergoing surgery at Hull Royal Infirmary are to be 'driven' to the operating theatres in a Tesla electric car.

The miniature version of the electric car has been donated to Acorn Ward at Hull Women and Children's Hospital and will be used to transport children to theatre as well as for scans.

The Tesla Owners Club UK and the Christian Blandford Fund, a charity helping children facing long stays in NHS hospitals, are donating the car to make the experience of undergoing surgery less daunting to younger patients.

Both the Trust and the WISHH Charity welcome this thoughtful donation which will certainly help children to relax in the period before they have to receive their treatment.

**Hull Truck Theatre screens Jack Lear live for hospital patients**
Hull Truck Theatre piloted a new way to open up access to its work by live streaming a performance of Jack Lear to patients and residents at Hull Royal Infirmary and Haworth Court Care Home.

The free live stream took place on Wednesday 30 January, 2pm. With the aim of connecting the theatre to an audience that faces the physical barrier of getting to the venue, Hull Truck Theatre streamed the production into seminar spaces and lounges on-site at the hospital and care home. This way the elderly residents and patients alike could enjoy the production from stage to screen, in the comfort of their own space.

Jack Lear by Ben Benison is a story which is set on the banks of the River Humber. A gritty re-telling of Shakespeare's King Lear, the production was directed by and features Hull stalwart and Hull Truck Theatre Patron, Barrie Rutter OBE in the title role.

Many thanks to Hull Truck for working with our staff and patients.

**Hospital ward opens cinema for patients with memory problems**
Hull Royal Infirmary has opened a £7,000 cinema showing footage of Yorkshire throughout the decades to help patients with memory problems.

The film booth – complete with cinema seats and a giant screen – has been set up in the middle of Ward 80 to help people reminisce about their past and share memories of growing up in the city. The ward is the Progression to Discharge Unit where patients recovering from recent illness spend time recuperating before they are discharged home with support or to a care home.

The cinema helps to keep people mobile, encouraging them to move around the ward to prevent muscle wastage and get back into a more normal routine following a hospital stay.

The booth has been designed in the style of an old cinema with film posters advertising classics like Gone With The Wind and Casablanca on the outside. Footage from the

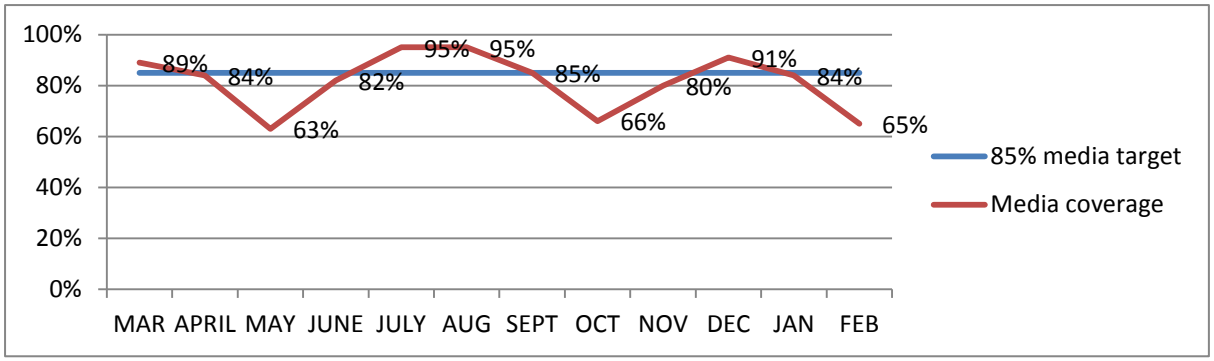
Yorkshire Film Archive shows street scenes and images from rugby matches and sporting events from the 1950s and 60s.

WISHH, the independent charity supporting Hull's hospitals, was able to fund the £7,000 cost of the cinema thanks to the generosity of its supporters and members of the public.

## 2. MEDIA COVERAGE

The Communications team issued 20 news releases in January and 11 in December.

In January 84% of our media coverage was positive and in February 65% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been exceeded in all but three months out of the last 12:




In February three patient inquests, the withdrawal of breast oncology from Scarborough and the clinical admin review impacted on our media performance.

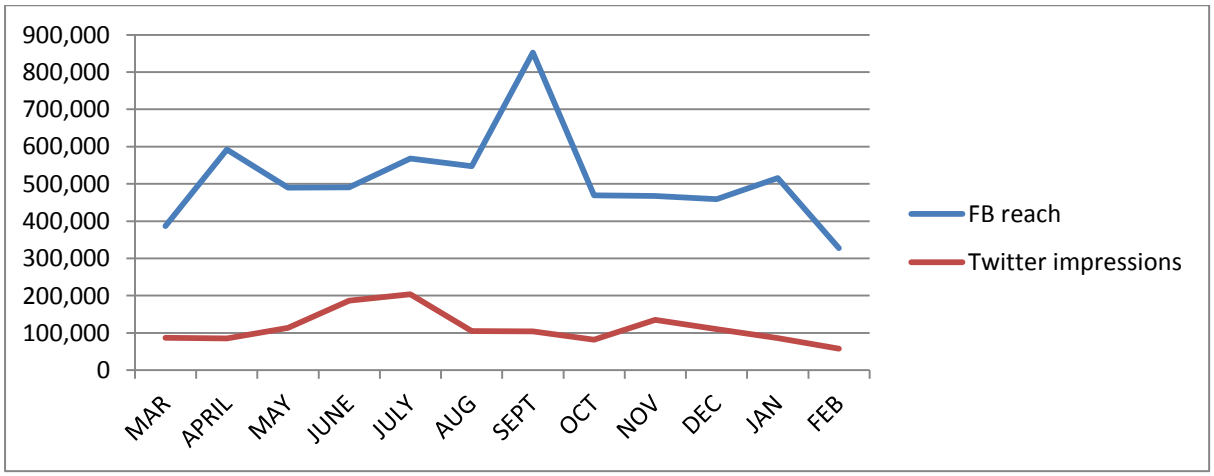
Facebook reach is the number of people that have seen content within a certain period, it can also be called unique impressions.

- In January total "reach" for all posts on trust Facebook pages was 515,273
- In February total "reach" for all posts on trust Facebook pages was 327,230

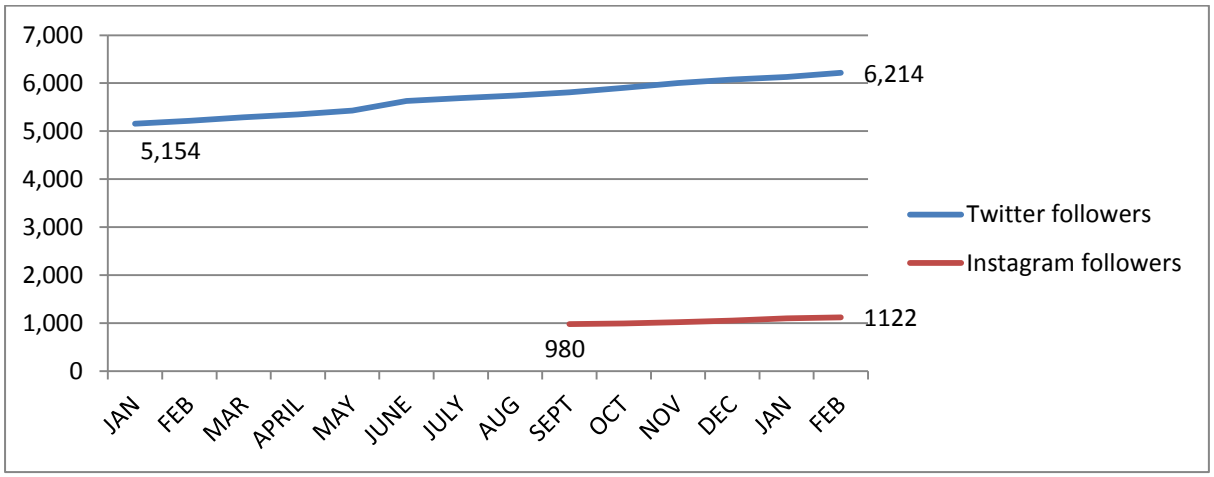
Twitter impressions are a total tally of all the times a Tweet has been seen. This includes not only the times it appears in a followers' timeline but also the times it has appeared in search or as a result of someone liking the Tweet.

- @HEYNHS Twitter account impressions 86,500 (January)
- @HEYNHS Twitter account impressions 58,000 (February)

**Social media reach and impressions January-February 2019**



The number of people 'following' the Trust on Twitter and Instagram continues to increase:



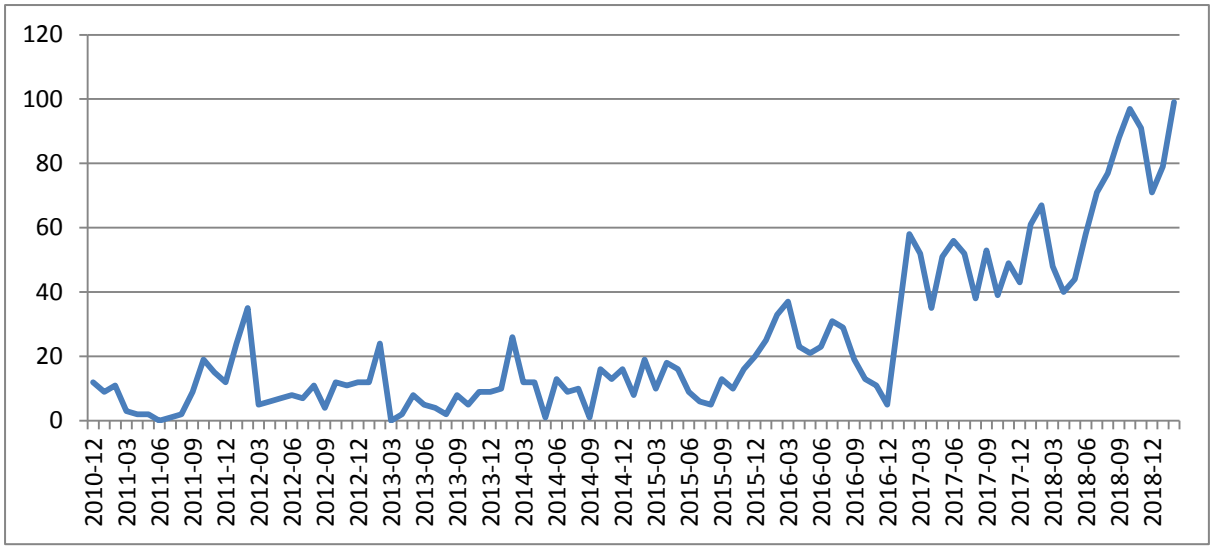

## 3. MOMENTS OF MAGIC

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 January and February we received 79 and 99 Moments of Magic nominations, respectively.

Please visit the intranet to read the most recent nominations.

**Number of Moments of Magic submitted by month 2010-2019**



NHS
Hull University Teaching Hospitals
NHS Trust

# LONG TERM GOALS - January 2019 data

Great Staff | Great Care | Great Future

## Quality

| RAG | Indicator | Target | Performance January | Trend v Previous Month |
|---|---|---|---|---|
| G | Never Events | 0 | 0 | ⇨ |
| R | Complaints (QIP - closed within 40 working days) | 90% | 85.29% | ⇩ |
| R | Healthcare Associated Infections - MRSA | 0 | 1 | ⇧ |
| G | Healthcare Associated Infections - C.Diff (YTD target) | 52 | 29 | - |
| R | Safety Thermometer - Harm Free Care | 95% | 94.78% | ⇧ |
| R | Venous Thromboembolism (VTE) Risk Assessment (Q3 1819) | 95% | 92.19% | ⇩ |
| R | Mortality - HSMR (December 2018) | <100 | 109.4 | ⇧ |
| G | Friends & Family Test - Inpatients (December 18 - Trust v National %) | 95.32% | 98.68% | ⇧ |
| R | Friends & Family Test - Emergency Department (December 18 - Trust v National %) | 86.46% | 81.98% | ⇩ |

| Category | No. of Risks Rated 15 and above |
|---|---|
| Corporate Clinical Risks | 5 |

## Workforce

| RAG | Indicator | Target | Performance January | Trend v Previous Month |
|---|---|---|---|---|
| G | Staff Retention/Turnover | <9.3% | 9.10% | ⇨ |
| G | Staff Sickness | <3.9% | 3.39% | ⇩ |
| R | Staff Vacancies | <5.0% | 5.38% | ⇧ |
| R | Staff WTE in post (<0.5% from Plan) | 7394.1 | 7462 | ⇧ |
| R | Staff Appraisals - AFC Staff | 85% | 83.60% | ⇧ |
| G | Staff Appraisals - Consultant and SAS Doctors | 90% | 91.40% | ⇩ |
| G | Statutory/Mandatory Training | 85% | 91.30% | ⇧ |
| R | Temporary Staff/Bank/Overtime costs (Medical YTD) | £10.4m | £13.5m | - |
| 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 January | Trend v Previous Month |
|---|---|---|---|---|---|
| R | 18 Weeks Referral To Treatment | 92% | 83.30% | 79.90% | ⇩ |
| R | 52 Week Referral To Treatment Breaches | 0 | 15 | 23 | ⇧ |
| R | Diagnostic Waits: 6+ Week Breaches | <1% | - | 8.00% | ⇩ |
| R | Emergency Department: 4 Hour Wait Standard (95%) | 95% | 90.0% | 72.50% | ⇩ |
| R | Cancer: ADJUSTED 62 Days Referral To Treatment (December Data) | 85% | 82..1% | 76.70% | ⇧ |
| G | Length of Stay (December Data) | <5.2 | - | 5.1 | ⇧ |
| R | Clearance Times | 12 weeks | - | 14.5 | ⇩ |
| G | Waiting List Size | 55,140 | 55,000 | 53,421 | ⇩ |
| G | Available Clinic Slot Utilisation | 80% | - | 90.90% | ⇧ |
| G | Theatre Utilisation | 90% | - | 91.20% | ⇧ |
| R | E-Referrals - GP Engagement | 100% by October 2018 | - | 98.2% | ⇩ |
| R | Appointment Slot Issues | 35% (TBC) | - | 38.70% | ⇩ |

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

## Finance

| RAG | Indicator | Target | Performance January | Trend v Previous Month |
|---|---|---|---|---|
| G | Capital Expenditure | £33.6m | £11.2m | ⇧ |
| R | Statement of Comprehensive Income Plan - Year to Date | 2.68 | 1.673 | - |
| R | CRES Achievement Against Plan | £13.2m | £11m | - |
| R | Invoices paid within target - Non NHS | 95% | 91% | ⇨ |
| R | Invoices paid within target - NHS | 95% | 71% | ⇧ |
| R | Risk Rating | 3 | 3 | ⇨ |

| Category | No. of Risks Rated 15 and above |
|---|---|
| Corporate Non-Clinical Risks | 0 |

# The Medical Examiner System

Dr K Adams

Associate CMO Mortality and Morbidity

# The Problem

- Poor practice going unrecognised and unchallenged
- Death certification poor and often frankly wrong
- Bereaved families left confused and unsupported
- SJRs not as effective as anticipated

# The Solution

- A nationwide system of independent Medical examiners
- Scrutinise every death in a timely manner
  - Review of the notes
  - Discussion with a Dr involved in the patient's care
  - Discussion with the family
- Feed any concerns picked up back in to the Trust

# The Idea

- Improve patient safety
- Provide reassurance to the next of kin
- Identify problems with care in a timely manner
- Ensure the correct referrals are made to the coroner
- Improve the accuracy of death certification
- Reduction in cases of litigation against the NHS

# The Proposal for HEYHT

- 2 consultants in ME role every day Mon – Fri
- Additional Bereavement office staff as backbone of the service
- Pilot period in CHH from May 2019
- Fully implemented across both sites by April 2020

# Problems with this plan

- Money
- Staff
- Office space

# The Opportunity

- We have the chance to do something really exciting that has the potential to improve patient care and patient safety BUT
- We need to do it properly for it to be effective
- The ME needs to have the power to report and or change things where needed

NHS
Hull University Teaching Hospitals
NHS Trust

# Transition of a young person into adult care our developments to date

**Trust Board 12th March 2019**

**The Trust Transition Steering Group**

# Background and context

- Following the February 2014 CQC inspection the Trust was required to improve its processes and service for the transition of children and young people to adult services.

- QiP was established with the aim of ensuring there are effective and robust processes in place for young people who transition to the adult care services.

# What have we done

- Transition steering group (refreshed 2017)
- Bench mark against NICE
- Virtual email group
- Quality Improvement  (QiP)
- Reviewed research
- Guideline development
  - Transition of a young person into adult services
  - Children and Young People in Outpatient Departments

# Evidence/Guidance

- Transition from children's to adults' services for young people using health or social care services

  **NICE guideline [NG43] Published date: February 2016**
- Transition from children's to adults' services

  **Quality standard [QS140] Published date: December 2016**

- Royal College of Nursing (2013) Adolescent transition care: guidance for nursing staff (2nd edition), London: RCN.
- ***Supporting young people in their transition to adults' services: summary of NICE guidance***

  *BMJ 2016; 353 doi: https://doi.org/10.1136/bmj.i2225 (Published 11 May 2016)*

- **From the Pond to the Sea Care Quality Commission June 2014**

# Agreeing documentation – Ready Steady Go

## Ready Steady Go: Moving through the programme

### Ready Steady Go: Each Young person (YP) progresses at their own pace


**11-12 yrs**
YP and carer Introduced to Ready Steady Go programme with information leaflet + video
*www.uhs.nhs.uk /readysteadygo*

**11 – 13 yrs**
YP completes **Ready**
Issues addressed in bite sized pieces.
YP and carer introduced to concept of shared decision making and confidentiality
When ready YP seen on own for a few minutes during clinic.
Agree goals

**14 – 16 yrs**
YP completes **Steady**
Issues addressed in bite sized pieces
Aim to see YP for longer on own in clinic. Keep carer fully involved
Duplicate clinic letters offered to YP
Agree goals

**16 – 18 yrs**
YP completes **Go**.
Issues addressed in bite sized pieces
Work towards YP conducting whole clinic on own. Keep carers involved
Referral letter to adult team.
YP meets adult team.
On-going issues highlighted to adult team. Ideally all issues addressed prior to transfer.
Write transfer letter
Agree goals

**1st adult clinic**
YP +/- carer completes **Hello**
Issues addressed in bite size pieces by HCP.
Clinic letters sent to YP
Periodically **Hello** completed again to ensure knowledge + skills maintained
Any issues addressed.
Agree goals

**Carer completes parent/carer questionnaire alongside YP questionnaires. Any issues discussed. Goals agreed.**

**YP with learning difficulties completes as much as possible alongside carer who is YP advocate.**

# Main services

- Diabetes (surveyed patients)
- Rheumatology
- Respiratory
- Cystic Fibrosis (moved to CHH)
- Neuro disability

# Linking with our patients and carers

We think some are services well developed

- Survey
  - Diabetes
  - Young people gastro conditions
- Family Involvement Group (FIG)
- Patient/carers stories
- Audit to assure compliance

# Developed our relationships with Partners

- Hull City Council
- East Riding County Council
- Humber Teaching Foundation Trust
- City Health Care Partnerships
- GP’s
- Yorkshire and Humber Transition Network

# Challenges

- Young people with complex needs transitioning to more than one service whereas will have been seen by one paediatrician

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**TRUST BOARD**

**DATE 12 March 2019**

| | | |
|---|---|---|
| Title: | Trust Strategy 2019 - 2024 | |
| Responsible Director: | Jacqueline Myers, Director of Strategy and Planning | |
| Author: | Jacqueline Myers, Director of Strategy and Planning | |
| Purpose: | The purpose of this paper is to seek Trust Board approval for the Trust Strategy 2019 - 2024 | |
| BAF Risk: | All | |
| Strategic Goals: | Honest, caring and accountable culture | X |
| | Valued, skilled and sufficient staff | X |
| | High quality care | X |
| | Great local services | X |
| | Great specialist services | X |
| | Partnership and integrated services | X |
| | Financial sustainability | X |
| Key Summary of Issues: | Over the last year, the Trust Board has held a number of workshops to review and refresh key elements of its vision, long term goals and its strategies to achieve them. It has also engaged with senior clinical and operational leaders and external partners on this matter.<br><br>A draft of the revised Trust Strategy was shared will all staff and partner organisations during the month of February 2019 and the final draft before the Trust Board encompasses further comments from a wide range of staff and partners.<br><br>This Trust Strategy is intended to set the Trust direction for the period 2019 – 2024, with regular review during this period. Once approved, an implementation framework, incorporating a balanced strategic scorecard, will be brought forward for the Board's consideration and approval. Thereafter, updates on progress in implementing the strategy will be provided at least twice per annum. | |
| Recommendation: | 1. That the Trust Board approves the Trust Strategy 2019 – 2024<br>2. That the Board note the document will be professionally formatted once the content is approved. | |

**COVER PAGE**

**FORMATTING TO BE DESIGNED INCLUDING NEW TRUST LOGO**

# HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

# TRUST STRATEGY

# 2019 – 2024

## FOREWORD

**We are delighted to be sharing our Trust Strategy, which sets out our ambitions for 2019 – 2024. Patient care and safety sit at the heart of this strategy, with our aims for outstanding quality of care and clinical services.**

**The last 3 years have been a challenging time for the NHS nationally and for us as a Trust. We are very proud of the way our teams have responded to those challenges, developed our services and improved the care we provide to our patients and service users. Our most recent Care Quality Commission inspection in 2018, whilst still giving an overall rating of 'requires improvement', demonstrated real progress in all areas.**

**Discussion with our patients and service users, staff and partners, has made clear, that whilst much in the Trust Strategy, including the Vision: Great Staff, Great Care, Great Future, is still relevant and reflects their priorities, there is a strong desire for a more ambitious strategy that builds on the foundations laid to date. In particular, there is a wish to go further in our aims for the quality of our care, research and innovation, and in our role as a wider system leader, working with others to improve the health of the population.**

**The aim of this strategy is to clearly state our vision, mission and long term goals and then set out how we plan to achieve them. Delivery of this strategy will be facilitated by key enabling strategies and the strategies of each of our health groups.**

**The Trust is an extraordinary place to work and we are fortunate to employ so many remarkable people. We are excited about the ambitions we have set out in our strategy and look forward to working with our staff, patients and service users and partners to deliver on those commitments.**

***Insert signatures***

**Terry MoranCB**
**Trust Chairman**

**Chris Long**
**Trust Chief Executive**

**TRUST STRATEGY 2019 – 2024** **OUR BIG AMBITIONS**

| | |
|---|---|
| **Great Staff** | **We will have one of the most engaged and satisfied staff in the NHS**<br><br>**We will be the employer of choice locally and regionally**<br><br>**We will have fewer vacancies and lower turnover**<br><br>**Our leadership team will be more diverse**<br><br>**We will provide leadership to the health and social care system, support the emerging Integrated Care System** |
| **Great Care** | **We aim to achieve an 'Outstanding' overall rating by the CQC**<br><br>**We will increase harm free care**<br><br>**More of our patients will recommend us to friend and family; we will become one of the highest rated Trusts**<br><br>**Working with partners, we will transform the care for frail, older patients and those with long term conditions**<br><br>**We will radically improve our outpatient service, using technology to enable better access**<br><br>**We will further develop our specialist cancer, cardiac and major trauma services** |
| **Great Future** | **We will forge lasting and impactful partnerships with our neighbouring hospitals that sustain acute services**<br><br>**We will develop our new international partnerships to mutually benefit our research and training programmes**<br><br>**Our research programme will deliver ambitious goals and secure good national rankings in key areas**<br><br>**We will become a 'digital first' organisation**<br><br>**We will agree an ambitious estates plan that delivers our clinical strategy and replaces or renews our oldest clinical facilities**<br><br>**We will secure the long term financial health in the Trust and working with partners, across the system** |

## PURPOSE OF THIS STRATEGY

This strategy sets out the Trust's approach to the achievement of its vision, including how it will lead and support the development of the vision and strategy for our wider health and social care system. It does so by defining some long term goals, setting the scope and level of ambition for each goal over the next 5 years, and providing guidance on the approach or 'strategy' we plan to take in achieving those goals.

We have engaged extensively with staff from across the Trust and in discussion with our patients and service users and with partners in the Humber, Coast and Vale Health and Care Partnership. It reflects a collective view of how we should approach making our vision a reality.

The intended audience for this strategy is our patients and service users and their families and carers, our staff, and our partners, all of who have important roles to play.

Teams will draw on this strategy to shape their priorities and ways of working and in doing so will ensure alignment with our common purpose.

## CONTEXT

### Trust profile

Hull University Teaching Hospitals NHS Trust (HUTHT) is a large acute trust situated in Kingston upon Hull and the East Riding of Yorkshire. We have two main sites, the Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). Our services include:

- A full range of urgent and planned general hospital services
- The Queen's Cancer Centre
- A Cardiac Centre
- A Major Trauma Centre
- A range of other specialist services.

We are also:

- A university teaching hospital
- A partner in the Hull York Medical School
- A clinical research institution with Hull University as our key partner.

In 2019, the Trust adopted a new name in recognition of its close working relationship with the University of Hull and its strengthened commitment to research.

The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided

primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

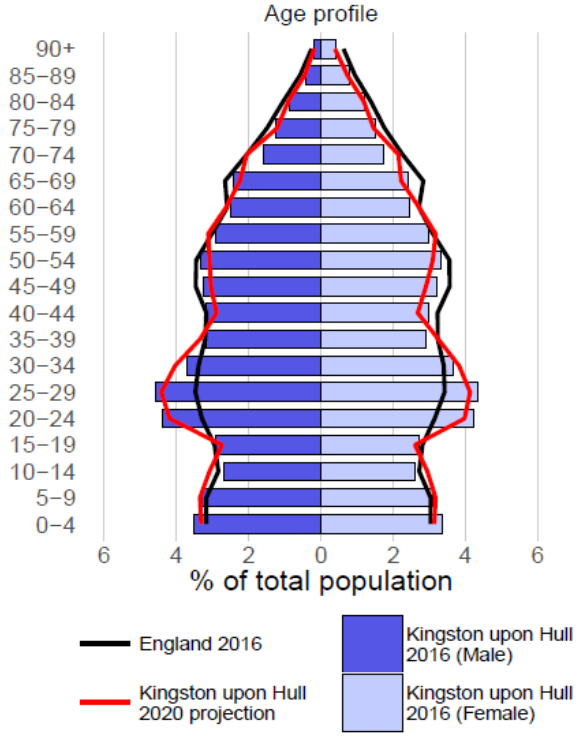
The Trust provides specialist services to a catchment population of between 1.05 million and 1.8 million extending from York and Scarborough in North Yorkshire to Grimsby and Scunthorpe in northern Lincolnshire.

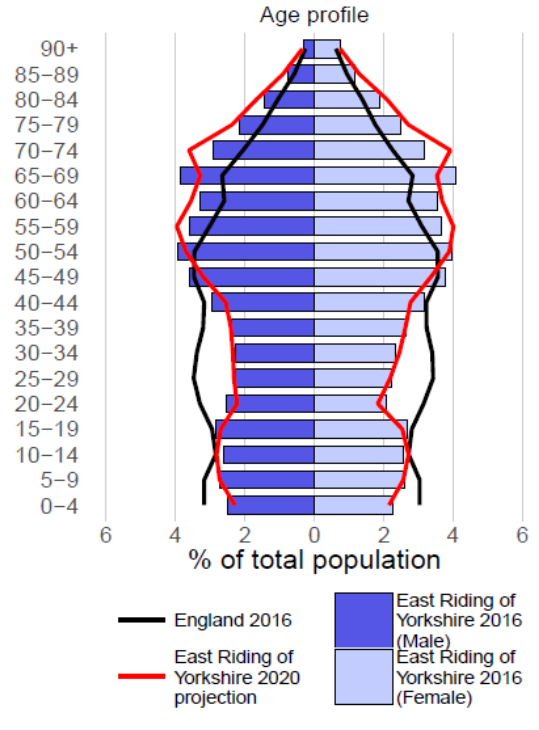
**Demographic context**

Hull is a geographically compact city of circa 260,000 people. It was identified as the 3rd most deprived local authority in England in 2017. The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average. 28% (14,300) of children in Hull live in low income families and the health and wellbeing of children is worse than the England average.

The East Riding of Yorkshire is a predominantly rural area, populated by circa 340,000 people. The geography of the East Riding makes it difficult for some people to access services. The health of people living in the county and their life expectancy is better than the England average. 11.6% (6,095) of children live in low income families and the health and wellbeing of children is better than the England average.

The age profiles for the two Local Authorities are very different. Hull has a higher proportion of residents aged 20-39 years, while the East Riding has a twice the number of people aged 50 years and over compared to Hull.



***Age profile of Local Authority Populations in 2016***
*(Male/Female, England average, 2020 Projection)*

**The Crude Birth Rates (CBR)[1] for the East Riding and Hull are 8.5 and 13.6 respectively, with the General Fertility Rates (GFR)[2] being 56.3 and 65.7. People are living longer, many with multiple and complex needs, and with higher expectations of their health and social care services. Within the next 20 years, the number of people aged 80 years and over in Hull and the East Riding is expected to increase from 33,000 to 55,300. Births are predicted to decline slightly.**

**The populations of North Lincolnshire (171,000) and North East Lincolnshire (160,000) have lower life expectancies than the England average, with the health of people in North East Lincolnshire being generally worse than the England average. Like Hull, North East Lincolnshire is one of the 20% most deprived authorities in England. The percentage of children living in low income families in North and North East Lincolnshire is 18% and 26% respectively. As with Hull and the East Riding, the number of people aged 80 years and over is expected to increase over the next 20 years, from 18,200 in 2018 to 30,700 by 2038.**

**The levels of educational attainment[3] at GCSE level as outlined in the Local Authority Child Health Profiles published by Public Health England (2018) show that, against the England average score of 44.6, children in the East Riding of Yorkshire (47.2) and North Lincolnshire (44.8) attained an average score above the national average. Hull (42.6) and North East Lincolnshire (43.8) were below the national average.**

**The health and wellbeing of a population is impacted by common factors such as obesity and smoking. The Public Health Outcomes Framework shows that the percentage of adults who are overweight or obese in the four local authority areas is significantly higher than the rate for England (61.3%), i.e.:**

| | |
|---|---|
| **Kingston upon Hull** | **65.8%** |
| **East Riding of Yorkshire** | **68.4%** |
| **North Lincolnshire** | **66.9%** |
| **North East Lincolnshire** | **64.7%.** |

**Nationally excess weight in adults is predicted to reach 70% by 2034. This rate of overweight and obesity affects the physical and mental state and impacts on the life expectancy of those affected due to an increase in the prevalence of long term conditions.**

[1] Crude Birth Rate: All births per 1,000 population of all ages
[2] General Fertility Rate : All live births per 1,000 women aged 15 to 44
[3] GCSE attainment (average attainment 8 Score)

Smoking is a leading cause of preventable death in the UK. Three out of the four Humber local authorities have higher than the England (14.9%) rate for smoking in adults, i.e.:

| | |
|---|---|
| Kingston upon Hull | 23.1% |
| East Riding of Yorkshire | 10.8% |
| North Lincolnshire | 20.8% |
| North East Lincolnshire | 20.0%. |

It is estimated that 22% of all admissions to hospital for respiratory diseases, and 47% of admissions for cancers that can be caused by smoking, were attributable to smoking. The number of pregnant women smoking at the time of delivery was significantly worse than the England average in all four local authorities.

## Local health and social care system and partners

Hull and the East Riding are served by separate Clinical Commissioning Groups (CCGs). This Trust provides virtually all of Hull CCG's secondary services and around 60% of East Riding of Yorkshire's. Community services in Hull and East Riding are predominantly provided by City Health Care Partnership (CHCP); mental health services are provided by Humber Teaching NHS Foundation Trust. Social care is provided by the two local authorities: Hull and East Riding of Yorkshire Councils.

The General Practice Forward View (NHSE, 2016) set out a plan to stabilise and transform general practice, outlining a number of high impact changes that could free up GP time to care. Within Hull and the East Riding of Yorkshire, a number of GP practices have seen the opportunity of merging with other practices to enable investment in additional services for patients and service users. Others are coming together under a federated model to enable the development of primary care at scale. These groups of practices are likely to evolve into the Primary Care Networks heralded by the NHS Long Term Plan.

Local health, local authority and other public and voluntary sector partners are working together on 'Place' plans, which seek to improve the health and wellbeing of local populations, often by addressing the wider determinants of health such as education, housing and employment and by sharing resources and expertise. As a Trust we are part of the 'Hull' and 'East Riding' Place programmes.

## Regional strategic context

The Trust sits within the Humber, Coast and Vale Health and Care Partnership (HCAV HCP). The Partnership is made up of 6 CCGs (Vale of York, Scarborough and Ryedale, Hull, East Riding of Yorkshire, Northern Lincolnshire and North East Lincolnshire) and includes all of the health providers and local authorities within that geography. There are three acute Trusts within the Partnership: Northern Lincolnshire and Goole Hospitals

**NHS Foundation Trust (NLAG), York Teaching Hospitals NHS Foundation Trust and this Trust.**

**Systems are required to develop a 5 year plan by July 2019 and as part of this, Hull and East Riding commissioners and providers, will set out their plan to achieve financial and sustain balance, whilst delivering improvements to the population's physical and mental health and wellbeing and meeting their care needs in primary, community and secondary care.**

**During 2018, the two NHS regulators, NHS England and NHS Improvement, combined their functions at supra-regional level, and appointed joint leadership teams. The HCAV HCP falls within the North East patch, which includes Northumbria, Tyne, Wear, Teesside, Yorkshire and the Humber area.**

**National strategic context**

**In January 2019, the NHS set out its Long Term Plan, which sets out the national goals and strategic direction for the NHS in England for the next 10 years. This is supported by the 5 year funding settlement announced in June 2018 of an additional £20.5 billion in real teams over 5 years for the NHS in England. New funding settlements for capital, public health, education and training and adult social care are promised for autumn 2019.**

**A key focus of the plan is significant investment into enhanced primary and community services, built around primary care networks, aimed at reducing the reliance on acute services to care for frail older people and those with long-term conditions. Development and delivery of this service model will be supported by the creation of Integrated Care Systems (ICSs) across England by April 2021. Locally this will be either on the Humber, or Humber, Coast and Vale footprint.**

**The plan sets out a range of interventions aimed at preventing poor health and reducing health inequalities; most notably committing to halve the rate of childhood obesity. Specific new expectations in relation to hospital care include:**

- **All inpatients and service users to have an agreed clinical plan and expected date of discharge within 14 hours of admission**
- **Stillbirths and maternal and neonatal deaths to halve by 2025**
- **Most women to receive continuity of care during their pregnancy by 2021.**
- **Three quarters of all cancers to be diagnosed in stage 1 or 2 by 2028**
- **Suspected cancer patients and service users to have either a definitive diagnosis or cancer ruled out within 28 days of referral**
- **Face to face outpatients and service users will reduce by a third.**

**In relation to elective waiting times, the plan states that it anticipates that health systems will have sufficient resources to improve waiting times and list sizes to the point where the 18 week standard can be met within 5 years.**

The plan includes a range of measures to improve the availability of a suitably skilled workforce and also sets out an ambitious digital agenda. It sets out some revisions to the financial regime, together with the expectation that the provider sector will return to balance in 2021, with all providers achieving balance within 5 years.

Finally, the plan sets out a limited suite of legislative changes, to facilitate more integration between organisations, ease the path for mergers and reduce the requirements to have competition in relation to the award of NHS contracts.

# Our Vision and Long Term Goals


# Our Mission

To provide outstanding care, contribute positively to improving the health of local people, be a great employer and partner, live our values and spend our money effectively.

# Our Values

| CARE | HONESTY | ACCOUNTABILITY |
|---|---|---|
| We are polite and courteous, welcoming and friendly. We smile and we make time to listen to our patients and staff. We consider the impact our actions have on patients and colleagues. We take pride in our appearance and our hospitals and we try to remain positive. | We tell the truth compassionately. We involve patients in decisions about their care and we are honest when things go wrong. We always report errors and raise concerns we have about care. Our decisions and actions are based on facts not stories and opinions. | We are all responsible for our decisions and actions and the impact these have on care. All staff are responsible for maintaining high standards of practice and we take every opportunity to continuously learn. Everyone is encouraged to speak up and contribute their ideas to improve the care we provide. |
| We do not treat anyone unfairly . We do not let our mood affect the way we treat people. We don't talk negatively about colleagues or other teams. Offensive language, shouting, bullying and spreading rumours are unacceptable. | We do not withhold information from colleagues or patients. We never discourage staff from reporting concerns. We are not careless with confidential information. We do not present myths as facts. | We do not unfairly blame people. We positively embrace change and we don't discourage people from having opinions. Controlling behaviours and silo working should not be exhibited in our Trust. |

## GREAT STAFF

Our staff members are our most precious resource. If we achieve our aspirations in relation to our people, we will be able to deliver on all of our ambitious goals. The Trust's People Strategy sets out a range of commitments under our 'Great Staff' long term goals, which together will create a positive culture aligned to our values and ensure we have the right staff to meet our patients' and service users' needs.

STAFF PROFILE

- We employ 9,132 people (7,403 Whole Time Equivalents)
- 12% of our people have declared themselves to be from a black or ethnic minority (BME)
- 2% of people have declared themselves as having a disability
- The gender breakdown of our employees is 24% male and 76% female.
- 2% of our employees have declared their sexual orientation as LGBT
- 42% of employees do not disclose any religious belief or affiliation; 35% have declared they are Christian

## HONEST, CARING AND ACCOUNTABLE CULTURE

One of our key priorities is the creation of a positive working culture, because we know that investing in our staff's development, and supporting and caring for them, will enable them to deliver great care; with commitment, compassion and courage.

In a 2017/18 cultural survey, staff described our current working culture with 6 positive descriptor values and only 4 limiting ones, which was a significant improvement on the previous survey in 2015. We will ensure that our future plans address the remaining concerns of our staff, in relation to levels of hierarchy, bureaucracy and short-termism in our Trust, and continue to foster the positive culture our staff desire. We understand, however, that creation of a positive culture is a long road along which we have taken just the first few steps.

Over the last 3 years the Trust has focused on improving staff engagement through a strategic programme of activity, based on effective communication, recruiting talented people, health and wellbeing, training and development, reward and recognition.

We have also developed an approach to quality and service improvement and established a programme with the twin aims of delivering improvement programmes and developing the improvement capability and capacity of the Trust. This programme is based on empowering staff to lead improvement in their services from the front line and equipping them with the skills to do it. The staff engagement score for the organisation has steadily improved over recent years and is now above the national average.

**The Trust's People Strategy sets out the framework for driving further improvement in our culture through 4 themed programmes:**

- 
- **Leadership capability and capacity**
- **Empowering staff to lead improvement**
- **Equality, Diversity and Inclusion**
- **Employee engagement, communication and recognition.**

**Over the next 5 years we will:**

**Move our staff satisfaction survey results into the top 20% of Trusts**

**Improve the overall engagement score on the staff satisfaction survey to the top 20% of Trusts**

**Increase the percentage of staff reporting that they feel able to make improvements to the top 20% of Trusts**

**Increase the number of black and ethnic minority staff in leadership roles**

**Our strategies to achieve this will be:**

- **Provision of tailored leadership development for all staff in leadership positions or aspiring to attain one**
- **Development of the medical leadership roles, skills and knowledge to equip medics to lead clinical and operational teams**
- **Using coaching, mentoring and reverse mentoring, particularly for our BME staff, to obtain leadership roles**
- **Delivery of a communication campaign to support staff to feel able to declare any disability or protected characteristic**
- **Increased recognition and knowledge amongst staff of our Hull Improvement Approach**
- **Further development of the Improvement Programme, including skills training for all staff and development of a community of expert practice**
- **Delivery of schemes to encourage front line innovation and improvement**
- **Improving our internal communication to be more interactive and auditing to ensure penetration right through the organisation.**

## VALUED, SKILLED AND SUFFICIENT WORKFORCE

**We will become the employer of choice locally and in the NHS regionally, with staff choosing to start and continue their careers with us. We will also increasingly attract staff to our posts from across the UK and wider world.**

**Recruiting and retaining the staff we need is a challenge, however through innovative and proactive strategies we will address this deficit.**

**We will engage with schools, colleges and the University to encourage local people to take up NHS careers. We will create new roles and new ways of working between staff groups to help bridge the gaps in those specialities or teams where it remains difficult to recruit. We will provide strong leadership to the workforce development efforts for our region.**

**We will create a community of support for staff so they feel valued, supported in their health and wellbeing and able to care compassionately for colleagues, patients and service users and their friends and family**

**Our People Strategy tackles our long-term goal to develop a valued, skilled and sufficient workforce under 3 key themes:**

- **Recruitment and retention**
- **Health and Wellbeing**
- **Learning and Development.**

**Over the next 5 years we will:**

**Increase the percentage of staff recommending us as a place to work to 80%**

**Increase our positions filled to 95%**

**Increase our retention rate to 92%**

**Create a range of new roles and working arrangements to improve cover in our hardest pressed teams**

**Improve the health and wellbeing of our staff**

**Our strategies to achieve this will be:**

- **An extensive package of health and wellbeing initiatives**
- **An enhanced recruitment approach, building on our brand: 'Remarkable People, Extraordinary Place'**
- **Working with Hull University, the Deanery and Health Education England in the development of increased local training opportunities**
- **Development and deployment of new roles, including physician associates, advanced clinical practitioners and nursing associates**
- **Continued use of ward support staff, hygienists, discharge planners and administrators**
- **With our partners, continue our successful apprenticeship programme and support for the Health and Social Care Academy to proactively recruit local people.**
- **Offer an enhanced package of health and wellbeing support to our staff, including 24/7 121 'first aid' pastoral support**

# GREAT CARE

**The provision of high quality care for our patients and service users is our top priority and indeed our very purpose. Over the next 5 years we will deliver ambitious and significant improvements in the quality of our care, in the areas our patients and service users, staff and partners have highlighted as of concern. We will also build on our areas of strength to become even better; increasing the reliability and consistency of the care we give and ensuring our staff members are supported to be kind and compassionate.**

**The Trust will take particular care to ensure vulnerable people, of all ages, are able to access our services and are supported to remain safe, have a good experience of care and achieve the best possible outcomes.**

**In 2018, the Trust attained a 'Good' rating from the Care Quality Commission (CQC) in the 'Well Led' domain and received a 'Good' rating for the majority of its services, although the overall rating remained 'Requires Improvement'. This was the culmination of steady improvement over the last 4 years.**

**Over the next 5 years the Trust aims to achieve an 'Outstanding' overall rating from the CQC, with some services attaining an 'Outstanding' rating within 3 years.**

# HIGH QUALITY CARE - OUR QUALITY STRATEGY

**Safe Care**

**The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas.**

**Safe staffing levels are a key determinant of our ability to deliver harm free care to our patients and service users. The Trust has one of the most sophisticated systems for matching nurse and midwifery staffing levels to patient need in the country and has been much commended for its development.**

**The Trust has ambitious plans to invest in technology aimed directly at improving the safety of patient care. In the next 5 years we will increasingly move over to digital rather than paper-based systems to support care, for example by rolling out fully e-prescribing and e-observations systems.**

**Over the last 3 years the Trust has undertaken a range of actions to embed the use of the World Health Organisation's (WHO) safer surgery checklist into all of its surgical and interventional procedure services. We will continue with our efforts to develop a safety culture.**

**We understand that being open about our mistakes and learning from them is crucial to maintaining safe care for patients and service users.**

**Whilst the Trust has made really good progress in reducing the incidence of some hospital acquired infections, we must remain vigilant as new threats are emerging.**

**The Trust has robust systems for identifying and acting upon safeguarding concerns. Working with our health and social care partners, we will further develop these arrangements.**

**As a Trust we have already made progress towards the provision of 7 day services for acute patients and service users. We will continue to focus our 7 day services efforts on acute services.**

**In the last 5 years the Trust has made improvements to its mortality as measured by the Hospital Standard Mortality Ratio, however, we recognise the limitations of this measure. Building on the structured and systematic process we have developed to learn from deaths in our hospitals, we will focus on identifying actions we can take to reduce avoidable harm and death.**

**Our clinical strategy includes commitments to reduce the length of time patients spend in hospital. This is because we know that patients and service users have better outcomes if we minimise the time they spend in a hospital bed, whilst ensuring they get all of the support they need at point of discharge. Long stays in hospital are associated with reduced muscle mass, loss of urinary function and as a result less ability to live independently.**

**We also include a commitment to reduce face to face outpatient appointments. This is because we know we can offer a more responsive and flexible service, reducing the need for patients to travel and appointments are of limited value, for example because they just involve passing on normal results.**

**Over the next 5 years we will:**

**Increase the rate of harm free care year on year**

**Increase the average length of time between serious incidents, including never events**

**Achieve the four priority clinical standards in relation to 7 Day Services, i.e.:**

- **Standard 2 – Time to Consultant Review**
- **Standard 5 – Timely access to diagnostics**
- **Standard 6 – Access to Consultant-directed interventions**
- **Standard 8 – Ongoing review.**

**Our strategies to achieve this will be:**

- **Improve and sustain performance in the 'fundamentals of care' audits and rollout of the system to all clinical areas**
- **Use of 'census audits' to identify and improve practice in relation to key topics**
- **Sustained delivery of safe staffing levels taking into account national guidance**
- **Creation of 'digital nurse' roles to support the optimal deployment of technology**
- **Reduced medication errors, supported by the implementation of an e-prescribing system**
- **Improved detection and management of deteriorating patients and service users, supported by the implementation of e-observations**
- **Implementation of a 'Stop the Line' policy and culture within the Trust**
- **Improvement of the organisation's culture and further development of our learning systems to support increased reporting of incidents and evidence of lessons learnt, including the use of patient stories**
- **Provision of a clean and well maintained environment, evidenced Patient Led Assessments of the Care Environment inspections**
- **To develop plans to replace our oldest patient areas with environments that meet the latest standards in relation in infection control**
- **Improved detection and referral of victims of domestic abuse**
- **Implementation of the national 7 day working standards**
- **Development and delivery of an improvement plan based on the themes identified from the learning from deaths process.**

## Patient Experience and Engagement

**We are proud to be recognised by many of our patients and service users for providing great care; we receive many compliments on the commitment and compassion of our staff. The Trust has been rated 'Good' by the CQC for Care in our 2018 inspection report.**

**Our patients and service users and our partners have, however, identified some areas for improvement. Many formal complaints and Patient Advice and Liaison Service (PALS) concerns relate to difficulties with our outpatient services. Our Patient Council has highlighted that having access to accurate, legible and easy to read patient information is a key determinant of patient experience.**

**We also know that the environment within which care is delivered has a huge impact on patient experience. We were delighted in 2018 to secure significant capital funding to renew the urgent and emergency care infrastructure, which as part of the enabling works will include a new main entrance at the HRI and increased lift capacity in the tower block.**

**The Trust is a recognised leader in dementia care and has made a range of improvements to its care of patients and service users with dementia, including the innovative 'Butterfly Scheme', which highlights that a patient is living with dementia, a 'Nostalgia Café' on one of our elderly medicine wards and the creation of the Reminiscence Garden at Castle Hill Hospital.**

**Improving the experience of children with a long-term condition who are transitioning to adult services is also a priority for the Trust.**

**In the last few years the Trust has significantly increased its patient engagement and involvement. The Patient Council was been refreshed. Its chair is a member of our Executive Management Committee and patient representatives are involved in key Trust operational meetings.**

**We benefit from the support of many enthusiastic and dedicated volunteers, who enhance the experience of our patients and service users. Building on the massive volunteer recruitment undertaken for 'Hull 2017 – City of Culture' and by improving our volunteering opportunities, we have expanded the reach and impact of our volunteer programme, creating a young volunteers arm and an award winning 'Young Health Champions' initiative.**

**Over the next 5 years we will:**

**Increase patient and service user satisfaction with outpatient services year on year, as evidenced by fewer complaints**

**Increase the percentage of patients and service users who would recommend the Trust to friends and family to the top 20% of Trusts**

**Improve the experience of children transitioning to adult services**

**Provide patients and service users with the ability to electronically access their own care record**

**Our strategies to achieve this will be:**

- **Completion of the Clinical Administration and Outpatients Improvement Programme**
- **Introduction of new standards for patient information and a system to maintain them**
- **Implementation an electronic care record patient access system**
- **Development of a business case and capital bid for the delivery of environmental improvements associated with our clinical strategy**
- **Delivery of our dementia strategy to achieve excellence in the care of patients and service users living with this condition**
- **Complete the implementation of a new system of support for children transitioning to adult services**
- **Further increases in our volunteer workforce**

**Great Outcomes**
We intend that our patients and service users will benefit from cutting edge techniques and have access to advances in diagnosis and treatment as the evidence base develops.

We also recognise the critical importance of access to timely, high quality diagnostics is also a key driver for improved.

Many of our patients and service users suffer from multiple conditions and we will ensure we support them to effectively manage those conditions when they are in our care, for example patients and service users with diabetes.

We recognise that we are in a position to make a larger contribution to health prevention, as we have over a million patient contacts each year.

Over the next 5 years we will:

Expand our patients and service users' access to minimally invasive and robotic surgery and to the next generation genomic treatments

Achieve and sustain the 6 week diagnostic target

Achieve year on year increases in daycase rates and reductions in the average length of stay for inpatients

Deliver 10,000 health prevention interventions, aimed at reducing smoking, obesity and alcohol abuse

Our strategies to achieve this will be:

- To expand our robotic and minimally invasive surgery programme
- To develop and implement plans to make the latest cancer treatments available
- Procure and staff additional CT and MRI scanners
- Increase our endoscopy capacity and renew our scoping equipment
- To work with our surgical teams to increase daycase rates
- To reconfigure and renew our daycase and outpatient facilities
- To ensure all of our inpatient wards implement daily ward rounds and effectively utilise criteria based discharge
- To ensure no patient stays in hospital only to access a diagnostic test
- With our public health and other provider partners, deployment of an 'Every contact counts' plan utilising our staff to provide advice and signposting to prevention services

## GREAT CLINICAL SERVICES - OUR CLINICAL SERVICES STRATEGY

**The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.**

**We are also one of only three specialist services providers in Yorkshire, providing services for a population that ranges from 1.1 to 1.8 million. As such, we are able to make highly specialist clinical services, such as radiotherapy and neurosurgery, available to a population that would otherwise have to travel an additional 60 miles or more.**

**Our clinical services strategy gives equal priority and focus to local and specialist services, thereby maintaining a portfolio of services that meets the needs of the population we serve.**

**We face some tough challenges in the coming years as our population ages and the demands for health care grow. We know that to meet these challenges effectively we need to work ever more closely with our partners across the health and social care system, planning and delivering services together, breaking down the barriers that have grown up between services.**

**We recognise the need to support an increased focus on prevention and self-care; to play our part in helping people to live well and facilitating those with long term conditions to take a greater role in managing them and receive more of their care closer to home. We also know that our patients would greatly benefit from closer collaboration integration of the care of their mental and physical health**

**In the last 2 years, in common with many hospitals, we have been unable to deliver some of the NHS Constitution standards for waiting times. Acknowledging the planned review of these standards, it remains our ambition to provide timely access to care for all of our patients.**

### Urgent and Emergency Services

**Over the last four years we have made a wide range of improvements to the Trust's urgent and emergency services. We have a new state of the art emergency department (ED) and have substantially increased our number of ED consultants. We have expanded our range of acute assessment units and pathways and increased the senior medical involvement in them. We have created a Frailty Intervention Team; a multi-disciplinary team, which provides expert review of frail older people in the ED, thereby avoiding unnecessary admissions and have worked with our community health colleagues to support the new community frailty service in Hull.**

**It is clear, however, that further work is needed, with teams across the Trust and with our system partners, to secure sustainable delivery of safe and**

**timely urgent and emergency care, without compromising other services, especially at times of peak demand.**

**Our specialist palliative care services have been recognised for the excellent services they provide and they work closely with the innovative and high quality end of life care services provided in the community. In the next five years, we will work with partners to understand and respond to individual patients and service users' wishes towards the end of life so that patients and service users are able to die in their preferred place.**

**Over the next 5 years we will:**

**Working with partners, transform the care of frail, older people, improving experience and choice and reducing admission to hospital in the last year of life**

**Working with community and mental health partners, deliver an integrated, seamless pathway and service for a wide range of long term conditions**

**Support more patients and service users with long term conditions to receive care in their communities**

**Deliver year on year reductions in our average length of stay for inpatients**

**Ensure our integrated teams have access to shared care records**

**Meet the standard for time to theatre for patients and service users with a fractured neck of femur**

**Working with partners, ensure patients and service users approaching the end of life have an advanced care plan in place**

**Increase the number of patients who receive primary care for minor injuries and ailments when they present in the ED**

**Deliver sustained improvement in our performance against the Emergency Care Standard**

**Our strategies to achieve this will be:**

- **Increase streaming of patients presenting with minor ailments and injuries into our co-located primary care service**
- **Closer working between our medical and surgical teams in response to patients and service users presenting acutely.**
- **Working with our partners, to complete the development of community based services for frail, older people**
- **Working with partners, redesign and implement new pathways for a range of long term conditions, including COPD, heart failure, diabetes and Parkinson's disease.**

- **To extend the range and hours of our acute assessment services and 'hot' clinics**
- **To expand the orthopaedic trauma theatre capacity**
- **Working with partners, to redevelop and right-size the services for patient leaving hospital**
- **Working with partners, to implement a shared care record**
- **To roll out the ReSPECT tool, which facilitates advanced care planning**

**Elective (Planned) Services**

**We provide an extensive portfolio of elective services, the majority of which are provided on the CHH site, with some at HRI and a small proportion in community settings.**

**We will continue to pursue our ambitious plans to develop the CHH site as an elective care centre of excellence, which will deliver major improvements in patient experience, productivity and efficiency. This will include a capital plan to redevelop state of the art outpatient and daycase facilities at CHH.**

**A fundamental redesign of outpatient models of care is long overdue. Over the last 2 years, the Trust has started this work, with the transition to electronic referrals and a massive expansion in provision of specialist advice and guidance to GPs as an alternative to referral. We also now have the ability to undertake virtual consultations.**

**Building on these foundations, we will transition our outpatient service offer to one which radically reduces face to face appointments, builds in appropriate diagnostics and remote surveillance, where appropriate, and facilitates more patient control of long term condition management.**
**We recognise that diagnostic testing is growing in importance in healthcare and we need to make a step change in our provision, against a backdrop of severe national shortages of key specialists.**

**Our maternity services are well thought of and have been recognised as 'Good' in their most recent CQC inspection. With the generosity of a local donor, we have been able to open a Midwifery Led Unit alongside our Obstetric Service. We will continue to improve our service in line with the expectations laid down in 'Better Births', the National Strategy for Maternity Services, including reducing infant and maternal deaths and providing more continuity of carer for expectant mothers and their babies.**

**Paediatric services were also rated 'Good' by the CQC. We recognise that there are opportunities to further enhance these services by fully co-locating them in the Women's and Children's Hospital and to improve the sustainability of the more specialist services, by forming clinical networks with other providers in the Region.**

**Over the next 5 years we will:**

**Agree the plan and funding to renew our daycase and outpatient facilities at CHH**

**Design and deliver a transformed outpatient model of care**

**Move our benchmark score in the national outpatient survey into the top 20% of Trusts**

**Expand and update our diagnostic capacity in the key modalities of MRI, CT, nuclear medicine and endoscopy**

**Deliver the 'Better Birth' ambitions including the reduction in maternal and infant deaths**

**Centralise inpatient paediatrics and improve the neonatal unit environment**

**Reduce our waiting list size and improve performance against the RTT and CWT standards**

Our strategies to achieve this will be:

- Development of a business case for the renewal and improvement of daycase and outpatient services
- Delivery of a wide ranging outpatient improvement programme
- Delivery of our 5 year diagnostic equipment investment strategy
- Investment in technology to share and report images across our HCAV providers
- Creation of clinical networks and new models of care and workforce for our smaller secondary care elective services including ENT, urology and specialist paediatrics
- Leadership and implementation locally of the agreed plans to deliver the 'Better Births' ambitions
- Agreement with commissioners of a plan to tackle the backlog of patients waiting for treatment

**Specialist Services**

The Trust is a centre for the provision of specialist cancer, cardiac, major trauma, neurosurgery, vascular and stroke services. Patients and service users are referred to our specialist services from NLAG and York Teaching Hospital NHS Foundation Trusts. Over the last few years we have formalised this relationship via the Humber Coast and Vale Hospital Partnership Board and through the creation of a range of clinical networks.

During 2016/17, we agreed a long term strategy for specialised services in the Trust with the Yorkshire and Humber NHS England Specialised Commissioning Team. We cemented our future as one of three tertiary centres in the region, along with Leeds and Sheffield. In our last Trust Strategy we set the intention to refine our specialist service portfolio, ensuring that we provide only those services that we can be confident will be

**sustainable in terms of workforce and able to meet the required service and quality standards. This strategy has served us well. We have created new partnerships; with Leeds for soft tissue sarcoma and with Sheffield for pancreatic surgery. We have built our credibility with the commissioners and been contracted for new services including steriotactic ablative radiotherapy, mechanical thrombectomy and trans-aortic valve insertion.**

**In the next 5 years we will continue to develop our specialist services along these lines, in particular building services around the 3 key areas of Cancer, Cardiac and Major Trauma and associated services.**

**In cancer services, we will work with our hospital partners to assure the future provision of high quality, sustainable haematology and oncology services. We will ensure our patients and service users continue to access the latest evidence based non-surgical therapies and we will work with partners to diagnose cancers at an earlier stage. In these ways we will improve 1 and 5 year survival rates. We will also improve our support to patients and service users post treatment to help them live well with and beyond cancer.**

**Building on the improvements made to our major trauma services in the last 3 years, we will continue to strengthen our pathways and provision; opening a new state of the art helipad on the HRI site and agreeing plans that ensure we have sufficient inpatient beds and specialist staffing.**

**We will develop our stroke services, in partnership with colleagues in NLAG and also in our community services, to ensure we have high quality services that have the capacity to offer the full range of services to our patients and service users. As part of this work we will agree the stroke service strategy for the Humber patch, develop our mechanical thrombectomy service and improve the access to high quality stroke rehabilitation in the community.**

**In radiology and pathology we will further develop the emerging clinical alliances and develop new roles and the use of technology to secure high quality services that can cope with the forecast continued growth in demand and complexity and the workforce challenges.**

**Over the next 5 years we will:**

**Secure sustainable high quality specialist paediatric medicine and surgery for our population**

**Continue to improve our major trauma survival rates**

**Improve timely access to acute and elective cardiac care**

**Improve the stage of presentation and 1 and 5 year survival rates for cancer patients and service users we treat**

### Establish a mechanical thrombectomy service

### Integrate radiology reporting and image sharing across the HCAV patch

### Create a resilient and sustainable pathology services across the Hull/York Alliance

**Our strategies to achieve this will be:**

- **Working with partners, through a new operational delivery network for specialist paediatrics, to agree and implement a sustainable clinical service model for specialist paediatric medicine and surgery**
- **To open a new state of the art helipad on the HRI site**
- **To agree and implement our next stage strategy for major trauma, including improved care pathways for major haemorrhage and older trauma and review of the ward capacity requirements**
- **To establish a cancer strategic board and set out our plans for improving stage of presentation and 1 and 5 year survival rates**
- **To develop and implement a plan for the managed implementation of immunotherapy treatments for cancer**
- **As part of the Humber Acute Services Review, to agree and implement a new service model for cardiology**
- **Implementation of improved support for people living with and beyond cancer, as per the national strategy**
- **As part of the Humber Acute Services Review, to agree and implement a new end to end pathway for stroke care in the Humber patch**
- **To implement the radiology data and workload sharing system**
- **To agree and implement the long term plan for the transformation and integration of pathology services in the Hull/York network**

## PARTNERSHIP AND INTEGRATED SERVICES

**In our 2016-2021 Trust Strategy we made a powerful commitment to work in a collaborative and proactive way, at all levels, to foster positive relationships with our partners and more closely integrate our services with other providers in primary, community and mental health and social care. We did this because we want our patients and service users to receive care that has neither duplication nor gaps, is simple to navigate and is responsive to their individual needs, and supports them to avoid hospital admission.**

**In 2018, the HCAV Partnership took the important decision that it was ready to begin the process, outlined in national planning guidance, to become an integrated care system (ICS). Underpinning this, more locally, there will be a number of integrated care partnerships (ICPs). One of these will be the Hull and East Riding ICP. The Trust will play an active role, as a key system leader**

**in the patch, in bringing the providers within Hull and East Riding together to agree the priorities and governance of our ICP.**

**We expect that the Hull and East Riding ICP will develop some infrastructure and expertise to understand our population's health and shape services to improve it, with particular regard to prevention, self-care and enhancing primary and community care services to support frail older people and those with long term conditions, close to where they live.**

**Across our HCP, the hospital sector is under significant financial and performance pressure and has some longstanding sustainability issues, in relation to its smaller district general hospitals. As the largest and only tertiary services provider in the patch, we will provide leadership to the development of sustainable hospital services for the future.**

**In particular, we will further develop our close working relationship with NLAG, to support the provision of high quality, sustainable healthcare for the population of the Humber Region. We anticipate that over the next 5 years many specialties will have an integrated service delivery model for the Humber region. In the face of serious workforce challenges and the need to offer increasingly complex treatments such as immunotherapies, this is likely to be the best way to secure delivery of high quality care for the whole population.**

**A critical partnership for the Trust is with the University of Hull. In recognition of the importance of this relationship, the Trust has adopted a new long term goal: research and innovation.**

**We have recently established links with two excellent international organisations: The College of Physicians and Surgeons of Pakistan (CPSP) and the Sri Ramanchandra Medical Centre and Institute of Education and Research in Chennai, India (SRMC). Over the next 5 years we expect to build lasting and mutually beneficial partnerships that will incorporate workforce sharing, training and research initiatives.**

**Over the next 5 years we will:**

**Working with partners, support the progression of the HCAV HCP into an ICS**

**Working with partners in Hull and East Riding establish an ICP that can show measurable improvement to the health of its population**

**Working with partners across the Humber region, secure safe and sustainable acute hospital services for the population**

**Support the work to create a sustainable clinical model for hospitals services in Scarborough**

### Establish mature programmes of workforce development and research with our international partners

**Our strategies to achieve this will be:**

- **To fulfil leadership roles within the HCAV Partnership and influence and support its overall direction and development, utilising the full spectrum of leaders across our organisation, from front-line staff to board members**
- **To build relationships between our consultants and local GP**
- **To lead the development of a provider collaborative across Hull and East Riding, as a precursor to the ICP**
- **To engage with public health teams on the development of population health management capability**
- **To support the development of specialty based clinical networks**
- **To lead the HCAV Hospital Partnership Board**
- **To jointly lead the Humber Acute Services Review**
- **To engage with the Scarborough Acute Review**
- **To agree and implement a joint specialist medical training programme with CPSP**
- **To agree and implement a programme of research with SRMC**

## GREAT FUTURE

## GREAT RESEARCH AND INNOVATION

**Our purpose in developing a new long term goal of 'great research and innovation' is to demonstrably improve the lives of the population we serve, by establishing the Trust as a nationally recognised research centre of excellence, with a culture of innovation.**

**As a university teaching hospital, we have the opportunity, working with our partner, University of Hull, to exploit collaborations in a wide range of fields, to mutual benefit, building on the 'Memorandum of Understanding' signed in 2016 between the Trust and the University.**

**The Trust has built a strong reputation in running and contributing to local and national clinical trials and has a number of internationally and nationally recognised research programmes. In response to this, the University, in conjunction with the Trust, is facilitating the establishment of the Hull Health Trials Unit. The unit will be made available to the whole of the health community in Hull and East Riding.**

**The Trust recognises the impact of commercially funded research on the NHS. Without this research many new drugs, medical devices and other advances would not reach our patients and service users. We pride**

**ourselves on our ability to consistently meet the expectations of our research partnerships with industry.**

**We will define and develop the scope and reach of our research programmes ensuring we deliver a research plan that 'plays to our strengths'. Our initial areas of research focus shall be cardiovascular disease, diabetes, endocrinology, renal, oncology and haematology. To complement the above, the following 'growth areas' will be supported to reach their full potential: imaging, gastroenterology, rheumatology, surgery and critical care, unplanned care and palliative care.**

**We recognise our vision for research and innovation will not be fully achieved without inclusive and influential membership of established national networks such as: the NIHR Collaborations for Leadership in Applied Health Research and Care, Northern Health Science Alliance, Yorkshire & Humber Academic Health Science Alliance and local NHS Innovation Hub. We will establish stronger engagement by the Trust in these networks.**

**In the next 5 years we will:**

**Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit**

**Secure a 'top 20' national ranking for number of patients and service users recruited to studies in the NIHR Clinical Research Network (CRN) portfolio**

**Achieve all Department of Health and NIHR research performance metrics**

**Secure three new long-term commercial research partnerships**

**Secure 'top 5' national status with our Academic Oncology Research Unit as measured by CRN national performance data**

**Our strategies to achieve this will be:**

- **To provide access to Trust expertise as a contribution to the HHTU staffing infrastructure.**
- **To provide a clear pathway allowing efficient and easy access to the HHTU and research methods support**
- **To ensure high visibility of reports containing local and regional metrics data are available to health group clinical and operational managers.**
- **To establish joint areas of unique strength to be pursued for mutual benefit, for example: Virtual Reality, Simulation training and 3D printing**
- **To establish a pathway for all potential opportunities arising from membership of the research and innovation networks.**
- **To design and implement a streamlined process for staff to generate and submit research and innovation ideas**

- To appoint 10 innovation champions
- Development of an industry engagement document showcasing our facilities, expertise and capabilities.
- To attain NIHR Research Fellowship for 50% of our identified research priority areas
- Development of a proactive, strategic approach to new clinical academic appointments and replacement posts
- To ensure consistent and proactive engagement with the key research networks

## FINANCIAL SUSTAINABILITY

The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.

The NHS Long Term Plan makes it clear that it is the financial health of the system will be the measure for success in the future. In Hull and East Riding we are already moving in this direction, having had an 'aligned incentive' contract in place between the Trust and the 2 local CCGs for 2 years. This contract shares objectives and risk across the partners. It facilitates service change to occur by agreement at cost rather than tariff.

Agreement on the approach to addressing the backlog of patients and service users waiting to be treated, and therefore the delivery of timely access to care for all of our patients in a challenge we need to address as a system.

The Trust compares well to its peers, in relation to its reference costs (97 for 2017/18 when 100 is the mean and lower is better) and across the range of indicators in the 'Model Hospital' data, including weighted activity units. We have also engaged meaningfully with the national 'Getting it Right First Time' (GIRFT) Programme. The Trust has a wide ranging programme of work seeking to drive improvements to its performance against these metrics.

The Trust is already in the process of implementing a range of initiatives to maximise the effective deployment of staff and reduce agency usage

has robust plans to reduce vacancies over the next 5 years and this will facilitate a reduction in agency costs, We will also continue to maximise the opportunities to reduce our supplies costs through active participation in local, regional and national initiatives, including roll out of the GS1 'scan for safety' technology.

**The outlook for income growth is modest, unless the Trust grows its share of the overall NHS activity. We expect to see some increase as new models of care for the more specialist secondary care medicine and surgery (that which is not already reserved to the tertiary centre). The Trust's role in delivery of the integrated models of care at place is yet to be determined.**

**Our Estates Strategy sets out clear plans to enable our clinical service strategy, keep our patients and service users safe with renewal of the infrastructure, reducing our environmental impact and improving resilience. We plan to concentrate our services in fewer, more modern and better maintained and serviced buildings. In this way we will be able to use our limited capital resource to improve the patient environment and reduce the burden of backlog maintenance, particularly in the highest risk category, for example by renewing the HRI operating theatre plant.**

**Over the next 5 years, we will seek to secure the capital funding for our ambitious plans to renew the HRI site and complete the implementation of our clinical services strategy, including centralisation of children's inpatients and service users, the redevelopment of our elective daycase and outpatient facilities at CHH and the delivery of new service arrangements arising from the acute service reviews.**

**Our refreshed Digital Strategy sets out a vision to radically extend the use of digital technology to enhance the safety of clinical care and the experience of our patients and service users and staff. Key aims in the next 5 years include renewal of the network at HRI, full roll out of e-casenotes, e-prescribing and e-observation systems, Wi-Fi throughout our buildings for both patient access and to facilitate mobile working and shared care records with local partners.**

**Over the last 3 years we have modernised our back office functions, improving the service offered to operational teams, reducing cost and improving electronic systems.**

**Over the next 5 years we will:**

**Working with partners, achieve financial balance across our health system**

**Increase our productivity and efficiency, as measured by the Model Hospital and GIRFT metrics**

**Improve productivity and value in its use of key resources: beds, theatres, diagnostic services and outpatient clinics**

**Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy**

**Improve the quality of our estate, removing from use our most out of date infrastructure and increasing the productivity per square metre**

**Become greener by reducing our energy consumption and waste**

**Renew the HRI network and deliver WiFi across the Trust**

**Become a digital first organisation, removing paper and creating shared care records with partners**

**Make our 'back office' functions more cost effective**

**Our strategies to achieve this will be:**

- **Agreement of the Hull and East Riding 5 year plan**
- **Continue to apply a programme approach to the delivery of improvements against the 'Model Hospital' and GIRFT metrics**
- **Rollout of GS1 asset tagging technology**
- **Close working with partners to agree the financial and income arrangements to support new models of care.**
- **Development of a business case and submission of a capital bid for delivery of our clinical strategy and site renewal plans**
- **Delivery of the Energy Business Case**
- **Collaboration with system partners to maximise use of overall estate**
- **Delivery of our Digital Strategy, including being an 'Exemplar' site for the Lorenzo system**
- **Collaboration with system partners to agree arrangements to share overheads and back office costs**

## DELIVERY OF THIS STRATEGY

**This strategy clearly defines our priority goals and our measures for success as well as our approach to achieving them. Henceforth it will set the agenda for our annual objectives and plans. Each year we will set out in detail in our Annual Operating Plan and Quality Account the distance we are aiming to travel towards achievement of our long term goals.**

**To support the delivery of this strategy, a number of more detailed enabling strategies have been developed:**

- **The People Strategy**
- **The Research and Innovation Strategy**
- **The Estates Strategy**
- **The Digital Strategy**

**The Trust Strategy which been developed and refreshed, with involvement of staff, patients and service users and partners, is the framework within which individual services set their detailed long term and annual plans. These are focussed in the same areas and on the same approaches as are articulated here, but include richer service specific detail and emphasis.**

**Overall delivery of the Trust Strategy will be overseen by the Trust Board, with a balanced scorecard used to highlight progress towards achievement of our long term goals. Each commitment in the strategy will have a lead executive director and a plan which sets out the baseline performance as at March 2019, the target performance and the milestones to be passed along the journey to full delivery of the commitment. Formal review of progress will take place twice each year.**

## REFERENCES


**Humber, Coast and Vale Sustainability and Transformation Plan, October 2016**

**The General Practice Forward View (NHSE, 2016)**

**Better Births, NHS England, February 2016**

**Hull City Council Joint Strategic Needs Assessment, 2017**

**East Riding of Yorkshire Council Joint Health and Wellbeing Strategy 2016 –2019**

**'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (The Lord Carter Review) Department of Health, February 2016**

**Operational Planning Guidance for NHS Trusts, NHE England and NHS Improvement, October 2018 and January 2019**
**The NHS Long Term Plan, NHE England and NHS Improvement, January 2019**

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**TRUST BOARD**
**12th MARCH 2019**

| | |
|---|---|
| **Title:** | QUALITY REPORT MARCH 2019 |
| **Responsible Directors:** | EXECUTIVE CHIEF NURSE<br>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:<br>• Patient Safety Matters including Never Events and Serious Incidents<br>• Safety Thermometer<br>• Healthcare Associated Infections (HCAI)<br>• Patient Experience Matters<br>• Care Quality Commission<br>• Learning from Deaths<br>• Safer Surgery Checklist<br>• Maternity and Obstetric Matters<br><br>Areas of good practice are presented alongside those that require actions and improvement. | |

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

**QUALITY REPORT**
**MARCH 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
- Safer Surgery Checklist
- Maternity and Obstetric Matters

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

**QUALITY REPORT**
**MARCH 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
- Safer Surgery Checklist
- Maternity and Obstetric Matters

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 January and February 2019, where possible. Any other known matters of relevance since then will be described, also.

## 2. PATIENT SAFETY

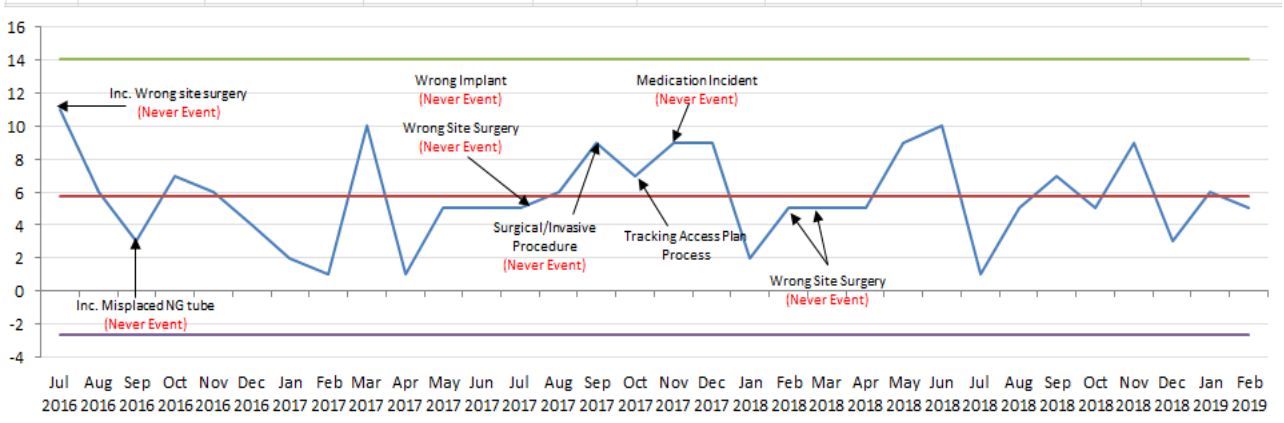
### 2.1 Never Events (NE)

No Never Events were reported during January and February 2019, with the last one reported in March 2018.

### 2.2 Serious Incidents reporting rates

As at 25th February 2019, the Trust had declared 68 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




### 2.3 Serious Incidents declared in January and February 2019

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 any areas that require attention and

improvement. The Quality Committee members have reported receiving 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.

A summary of the incidents declared during January and February (as at 22nd February 2019) is contained in the following tables and each of these is now under investigation. Anything of significance 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 6 Serious Incidents in January 2019.

Table 1: Serious Incidents declared January 2019

| Ref Number | Type of SI | Health Group |
|---|---|---|
| 97 | Treatment Delay due to difficulties in communication between Scarborough Hospital and specialities within the Trust. | Surgery |
| 764 | Mortuary Incident. There was a delay in death paperwork being processed. | Clinical Support |
| 1372 | Treatment Delay. Three patients did not receive timely follow up within Ophthalmology Department. | Family and Women's |
| 1761 | Delayed diagnosis of ovarian cyst. | Family and Women's |
| 2070 | Maternity/Obstetric Incident, postnatal mother diagnosed with Acute Kidney Injury. | Family and Women's |
| 2075 | Treatment Delay. Patient did not receive timely follow up within the Dermatology Department. | Family and Women's |

The Trust declared 8 Serious Incidents in February 2019 (as at 22 February 2019).

Table 2: Serious Incidents declared February 2019

| Ref Number | Type of SI | Health Group |
|---|---|---|
| 3624 | Patient sustained injury due to in-hospital fall | Family and Women's |
| 3657 | Delayed diagnosis of cancer | Surgery |
| 3683 | Medication Incident, patient did not receive insulin treatment in timely manner | Medicine |
| 3765 | Hospital Acquired Pressure Ulcer | Surgery |
| 4056 | Medication Incident: patient reacted to anti-emetic drug following surgery | Surgery |
| 4414 | Retained throat pack (not Never Event) | Surgery |
| 4426 | Treatment Delay – patient did not receive timely follow up within Ophthalmology | Family and Women's |
| 4420 | Maternity/Obstetric Incident - Unexpected admission to ICU with severe sepsis | Family and 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 February 2019 are attached as **Appendix One**.

From the 905 in-patients surveyed on Friday 8th February 2019, the results are, as follows:

- **93.7%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.7% [n=16]** 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 **98.3%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 905 patients, 33 did not require a VTE risk assessment. Of the remainder, 761/872 had a VTE risk assessment undertaken. This is **87.2%** compliance on the day, which is lower than usual. VTE incidence on the day of audit was patients; **4** of which **3** were with a pulmonary embolism and **1** was with a deep vein thrombosis.
- There were **7** new pressure ulcers on the census day, all of which were Cat 2. However, 46 patients had pre-hospital admission pressure ulcers (40 at Cat 2, 1 at Cat 3 and 5 at Cat 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 **11** patient falls recorded within three days of the audit day. Of these, 10 resulted in no harm to the patient and 1 with moderate harm.
- Patients with a catheter and a urinary tract infection were low in number at **7/174** patients with a catheter **(4%)**. Of the **7** patients with infections, **4** 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 January 2019

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) | **29 (56% of threshold)** |
| MRSA bacteraemia infections (post 48 hours) | Zero | **3 1 case reported October 5th 2018 1 case reported November 22nd 2018 1 case reported 29th January 2019 (over threshold)** |
| MSSA bacteraemia | 44 | **50 (over threshold)** |
| **Gram Negative Bacteraemia** | | |
| *E.coli* bacteraemia | 73 | **87 (over threshold)** |
| Klebsiella | Baseline monitoring period | **30** |
| Pseudomonas aeruginosa | Baseline monitoring period | **13** |

As can be seen, it is proving to be a very challenging year in relation to HCAI performance against certain reportable organisms. The current performance against the upper threshold for each are reported in more detail, by organism:

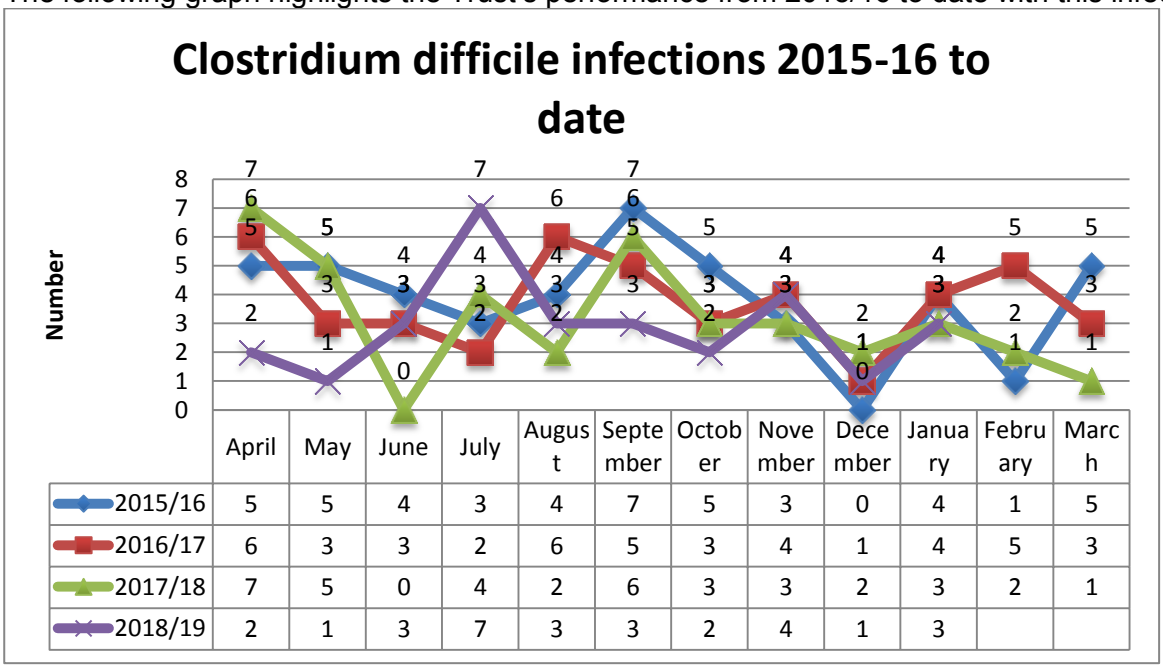
#### 4.1.1. *Clostridium difficile*

*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 ten (January 2019), the Trust reported 29 infections against an upper threshold of 52 (56% of threshold). This is very positive performance against what is a very challenging infection to avoid and manage with certain patients. One Trust onset *C. difficile* case was reported during December 2018 and a further three during January 2019. From the 1st April 2018, a total of fifteen cases are apportioned to the Medical Health Group, eight to the Surgical Health Group, five to Clinical Support and the remaining one in the Families & Women's Health Group. Four Trust reported cases are patients that have been detected previously with *C.difficile* since 1st April 2018 but with repeated samples.

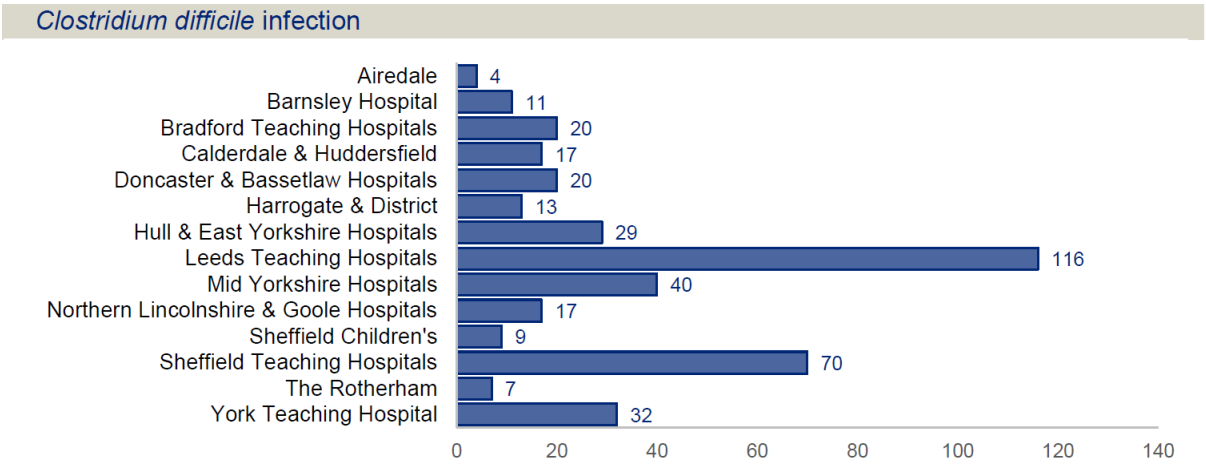
| Organism | 2018/19 Threshold | 2018/19 Performance (Trust apportioned) | Lapses in practice / suboptimal practice cases |
|---|---|---|---|
| Post 72-hour *Clostridium difficile* infections | 53 (45) | **29 (56% of threshold)** | All 29 cases have been subject to RCA investigation. Of the twenty nine cases, twenty cases have been reviewed by Commissioners with seventeen deemed to have no lapses in practice. Three cases identified a lapse in practice due to suboptimal antimicrobial prescribing. Five cases are awaiting consideration by the commissioners. The remaining four cases are awaiting final RCA meetings with the 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 | 1 | 3 | | |

The following table shows the distribution of acute hospital *c.difficile* cases across the Yorkshire and the Humber region, year to date, at January 2019 (source: Public Health England)




### 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 | **3 cases - 1x October 2018 1x November 2018 - both in the Surgery Health Group 1x January 2019 in the Medicine Health Group**<br><br>**Over threshold** | October 2018 case –deemed unavoidable by Public Health England (PHE) following investigation. However, practice issues were identified with associated learning for the HG.<br><br>November 2018 case – deemed avoidable due to lapses in practice associated with consistency of device management and poor documentation associated with decolonisation treatment.<br><br>January 2019 case – Post Infection Review (PIR) investigation underway but early indications suggest deep-seated infection associated with a previous history of MRSA treated by Primary Care – bacteraemia deemed unavoidable currently by Infectious Diseases team but this is subject to further review |

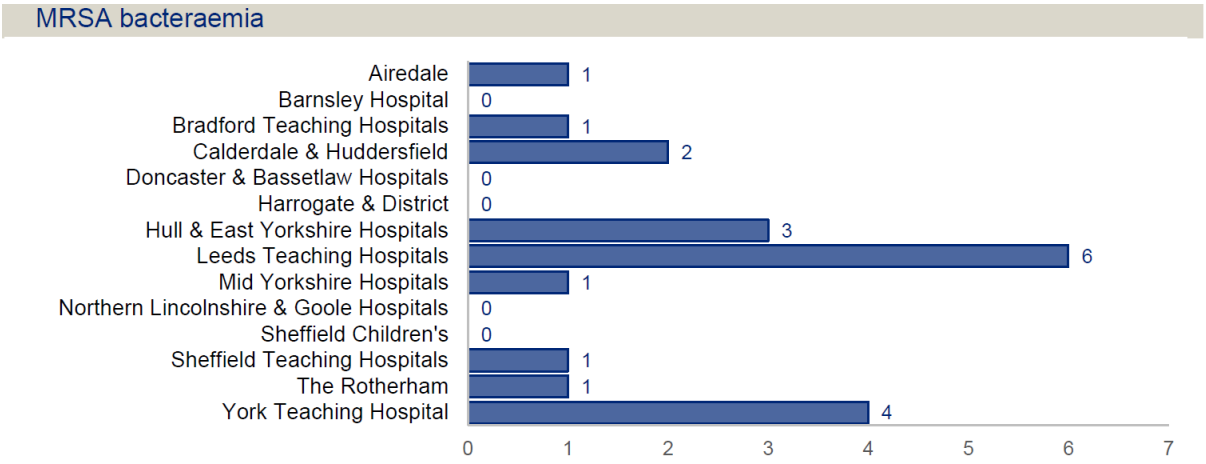
The Trust reported one case of a patient with an MRSA Bacteraemia on 5th October 2018. The infection related to a patient with complex health needs following major colorectal surgery with no

previous MRSA history, including negative colonisation tests x3, prior to acquiring the bacteraemia. A Post Infection Review (PIR) investigation, in collaboration with the nursing and surgical teams was completed and reviewed by the commissioners with the bacteraemia deemed unavoidable by PHE. However, lapses in practice during the course of the investigation were identified, which have been addressed and include prudent wound and device care by medical and nursing staff.

The Trust reported the second case of a patient with an MRSA bacteraemia on the 22nd November 2018. The infection related 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. The patient acquired MRSA in his sputum during the course of his ICU stay and was confirmed as being colonised with MRSA in multiple sites increasing the risk of developing a bacteraemia. A meeting was held to discuss post-operative management and tissue viability issues, which acknowledged the complexity of the surgery, the length of time in theatre and the unstable and vulnerable state of the patient's condition whilst nursed on ICU; all of which contributed to the patient's outcome. The MRSA bacteraemia was deemed avoidable, in spite of the circumstances, due to a lack of assurance regarding device management and prescription/administration of decolonisation treatment.

The Trust reported the third case of a patient with an MRSA bacteraemia on the 29th January 2019. This case is under investigation via a PIR process by both the Trust and Commissioners. The patient had a previous history of MRSA in November 2017 and was managed by their GP at that time. On this admission, the patient was admitted with an acute cardiac episode to Acute Assessment Unit (AAU), transferred to H36 and then Cardiac Monitoring Unit (CMU) at CHH. The patient was screened for MRSA on admission and, on transfer to CMU, was found to be nasal/axilla and groin negative on both occasions. The patient has been reviewed by the Infectious Diseases team who suspected a deep source for the infection, therefore. Endocarditis was diagnosed following trans-oesophageal echocardiography, which will require prolonged antimicrobial therapy and subsequent cardiac surgery. The attribution of this infection (in terms of Trust or CCG) is yet to be determined.

The following table shows the distribution of acute hospital MRSA Bacteraemias across the Yorkshire and the Humber region, year to date, at January 2019 (source: Public Health England)




### 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 10, the Trust is already over threshold for this infection, a trend reported by Public Health England in quarterly reports for Yorkshire & the Humber. This is of significant concern at this stage in the year.

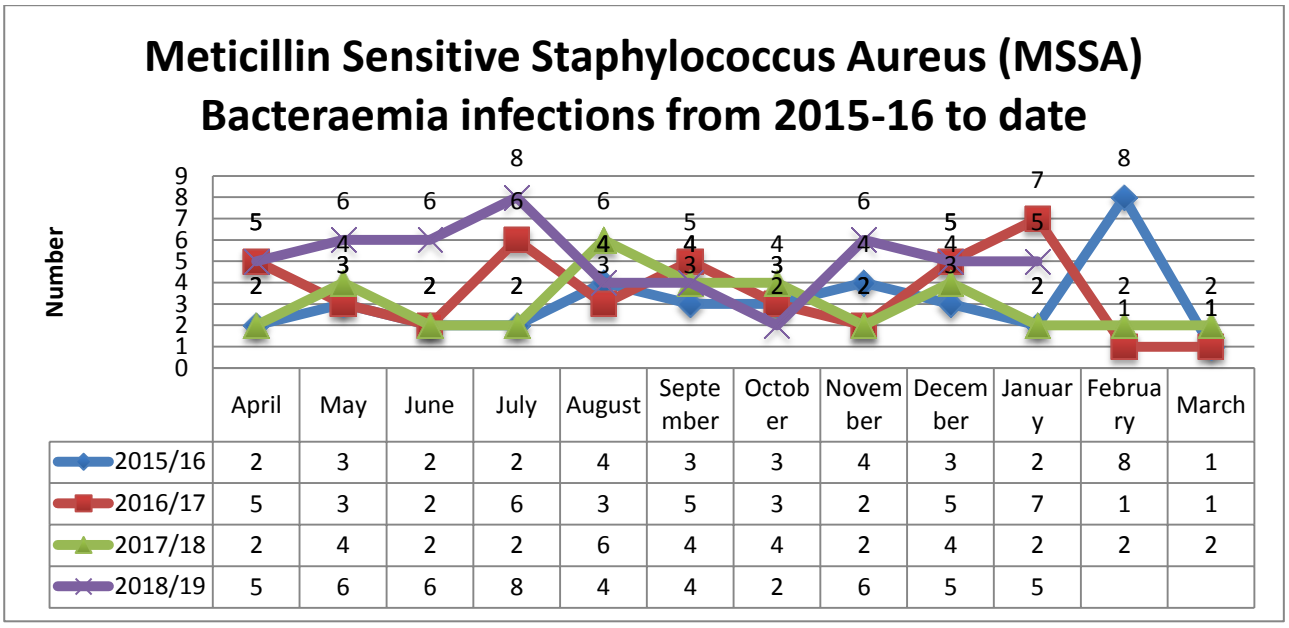
| Organism | 2018/19 Threshold | 2018/19 Performance (Trust apportioned) | Outcome of RCA Investigation (avoidable/ unavoidable) |
|---|---|---|---|
| MSSA bacteraemia | 44 | **50**<br>**Over threshold** | RCA investigations have been completed on 39 of the 50 reported cases. The remaining eleven are under way. 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 (vascular access device management best practice standards), 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 IPCT, in collaboration with ID physicians, medical and surgical teams from the 1st September 2018. In addition a working party has been formed to focus on device insertion, reason for use and ongoing management.

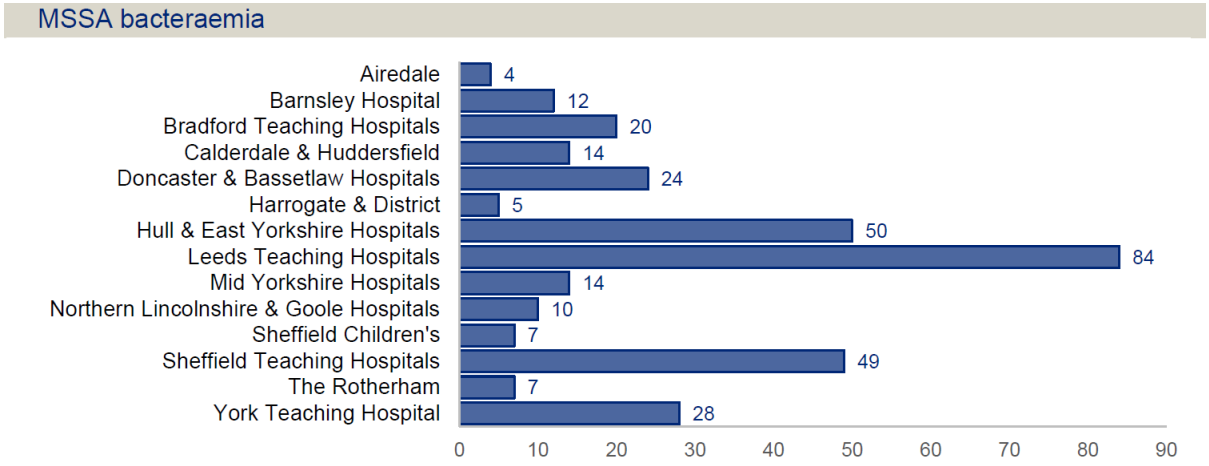
Concerns regarding patients who inject recreational drugs and present with abscesses and deep infections is ongoing both as hospital and community onset cases.

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 | 6 | 5 | 5 | | |

The following table shows the distribution of acute hospital MSSA Bacteraemias across the Yorkshire and the Humber region, year to date, at January 2019 (source: Public Health England)




### 4.1.4 *Escherichia-coli* Bacteraemia

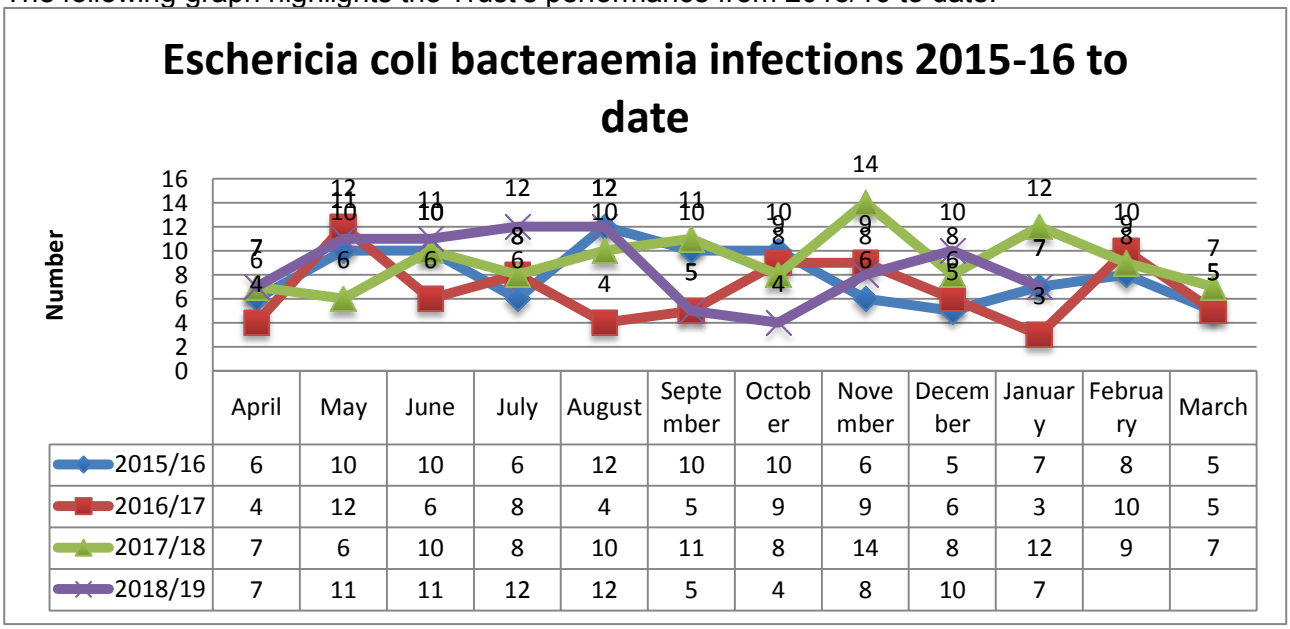
There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals. However, when strains of *E. coli* are outside 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 are required by NHS Improvement to achieve a 10% reduction in E. *coli* bacteraemia cases. 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. However, this has continued to be a very challenging year for the management of patients with this infection.

| 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) | **87 (over threshold)** | 87 | Eighty seven Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 43 cases detected in the Surgical HG, 26 cases in the Medical HG, 6 cases detected in Families & Women's HG and the remaining 12 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 an RCA by the HG. The cases requiring an 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. |

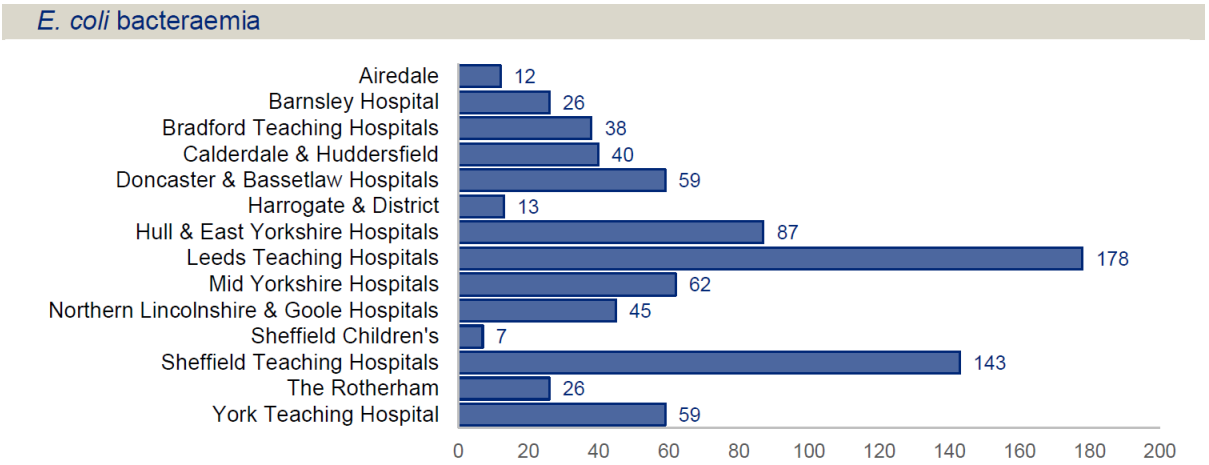
The following graph highlights the Trust's performance from 2015/16 to date:




| | 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 | 10 | 7 | | |

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 currently. Trends associated with E.*coli* are reflected in the graph above, including those associated with the extreme weather variations that were experienced last summer, when the increase in people admitted to hospital with dehydration occurs, as does the burden of *E.coli* infection.

The following table shows the distribution of acute hospital E.*coli* Bacteraemias across the Yorkshire and the Humber region, year to date, at January 2019 (source: Public Health England)

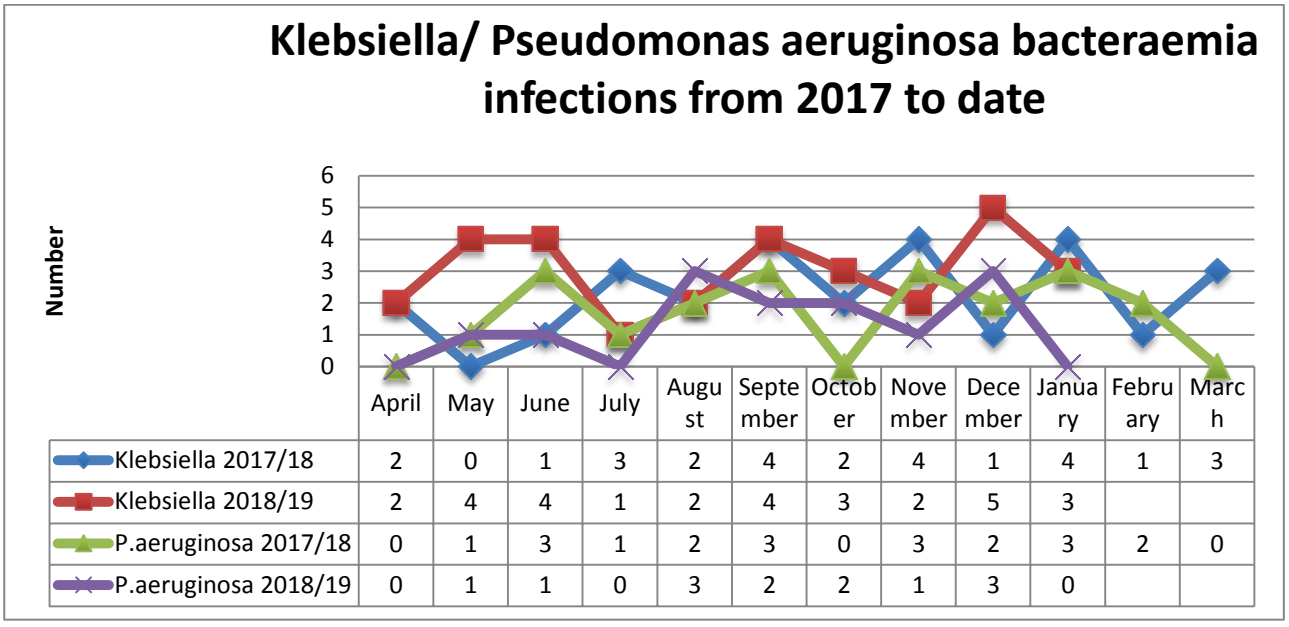



### 4.1.5 Gram negative bacteraemia – reporting for 2018/19

If gram-negative bacteria enter the circulatory system, it 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 yet 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.



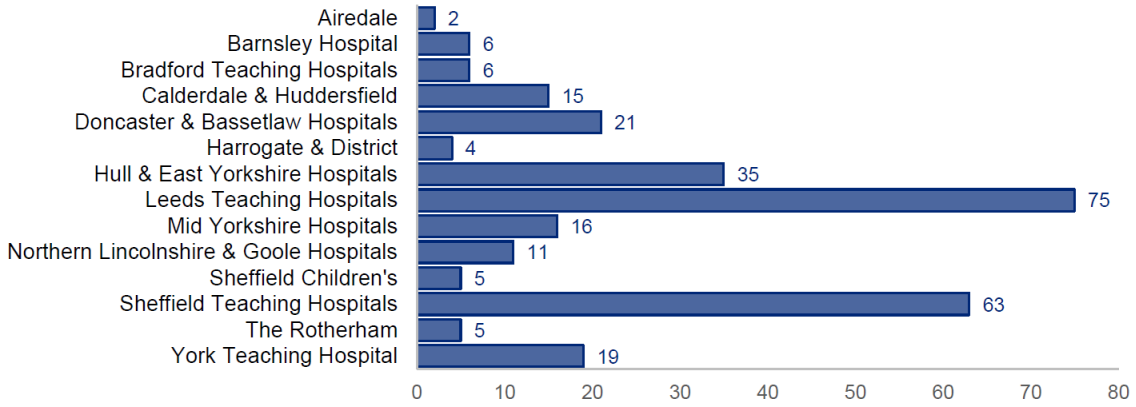

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Klebsiella 2017/18 | 2 | 0 | 1 | 3 | 2 | 4 | 2 | 4 | 1 | 4 | 1 | 3 |
| Klebsiella 2018/19 | 2 | 4 | 4 | 1 | 2 | 4 | 3 | 2 | 5 | 3 | | |
| 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 | 3 | 0 | | |

During December 2018, one case of hospital onset Klebsiella pneumoniae was detected and found subsequently to be resistant to the standard antibiotic treatment for that infection. The sample was sent for typing and was confirmed as a Carbapenemase Producing Enterobacteriaceae (CPE) positive case. CPE infections are very difficult to treat and can be easily transferrable to other people. Extensive microbiological investigation of all previous CPE positive cases has been

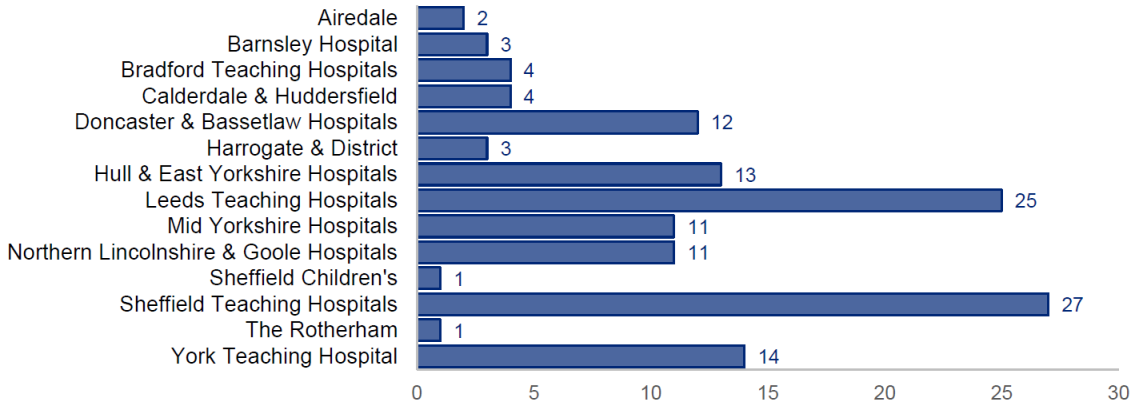
undertaken. Isolates were sent to Public Health England for further investigation and all of the CPE positive cases to date have been unique in terms of their genetic profiles. This indicates that there has not been any onward transmission to others within the Trust, which is reassuring.

The following two tables show the distribution of acute hospital Klebsiella and Pseudomonas aeruginosa bacteraemias respectively across the Yorkshire and the Humber region, year to date, at January 2019 (source: Public Health England)

*Klebsiella* species bacteraemia




*Pseudomonas aeruginosa* bacteraemia




**4.1.6 Antimicrobial Resistance (AMR) Strategy 2019 - 2024**

On the 24th January 2019, the Department for Health and Social Care published a document entitled, 'Tackling antimicrobial resistance 2019–2024: The UK's five-year national action plan'. The document sets out the UK's 2019-2024 national action plan to tackle AMR within and beyond the UK. A significant stance is on preventing infections and the plan has a strong focus on infection prevention & control (IPC), including improving the professional capacity and capability for Infection Prevention and Control teams. The document acknowledges the issue of importing resistance especially from patients that are repatriated to the UK who are at higher risk of drug-resistant infections; an issue experienced within this Trust over the last 12 months. The action plan advocates stronger surveillance, a systematic approach to understanding transmission and how the built environment can contribute to transmission of drug resistant organisms and the antimicrobial resistance.

The action plan acknowledges the challenges associated with meeting the requirements of halving the burden of GNBSI's by 2020/2021 and has therefore adopted a systematic approach to preventing these infections and is aiming to deliver a 25% reduction by 2021-2022 with the full 50% reduction by 2023-2024.

The action plan also states that England will adopt the IPC and care standards developed in Scotland as the national standards, with regulators utilising these and the Health and Social Care Act 2008: code of practice on the prevention and control of infections as annual measurements of compliance for trusts. The IPCT is undertaking a gap analysis of both the AMR strategy and the National Infection Prevention & Control Manual to inform the Board of what this will mean in practice and reporting for the future.

### 4.2 Infection Outbreaks

December 2018 and January 2019 have been particularly challenging months for Norovirus. During December 2018, full ward closures caused by confirmed Norovirus were required on the following wards: H70, H9, H80 & H90. In addition, bay closures were required due to patients with diarrhoea & vomiting (some confirmed Norovirus) on H110 and H500. Staff were not particularly affected in these areas.

All areas affected were cleaned by the Cleaning Action Team prior to being reopened. The outbreaks started at the beginning of December 2018 and the last affected ward (H90) was cleaned and reopened on 26th December 2018.

During January 2019, Ward H80 was closed on the 4th January 2019 due to an outbreak of diarrhoea and vomiting with confirmed Norovirus. The ward was cleaned and opened from the 9th January 2019 onwards with the ward fully reopening on the 12th January 2019. In addition, ward H90 had a bay closed on the 8th January 2019 with diarrhoea and vomiting with confirmed Norovirus. This bay was cleaned and reopened on the 12th January 2019. Unfortunately, on the 29th January 2019, ward H80 was affected with a further outbreak of diarrhoea & vomiting, again with confirmed Norovirus. Two bays were closed initially, with the index case being a relative that vomited on the ward. A third bay was also closed subsequently but the ward was cleaned and reopened on the 1st February 2019.

#### 4.2.1 Infection incident

During December 2018 and January 2019, the screening of babies for Pseudomonas aeruginosa has continued on the Neonatal Intensive Care Unit (NICU). These take place on admission and on a weekly basis thereafter. A colonised case with one baby was detected on the 11th January 2019 but no bacteraemia cases have been identified since August 2018. To date, there have been no microbiological links to any cases that have been detected, which indicates that these have not been transmitted between patients.

#### 4.2.2 Influenza trends

The influenza vaccination campaign for 2018/19 commenced on the 1st October 2018 and by the 31st January 2019, 83% of the Trust's healthcare workforce had taken up the influenza vaccine, which is a significant achievement.

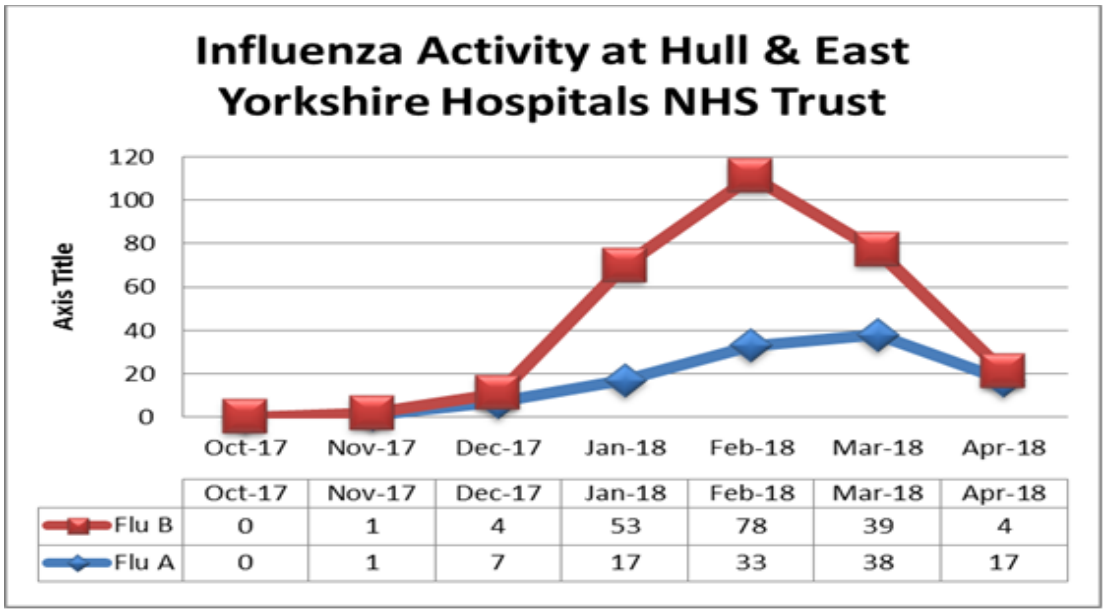
Increases in influenza activity continued during January 2019, with all affected patients detected with the Influenza A strain. In addition, respiratory syncytial virus (RSV) activity continued during January 2019 in both children and adults. One case of influenza A was reported on the 27th November 2018. However, this increased dramatically in December 2018, with seventy six cases of Influenza A being detected in the Trust. The majority of these were from samples taken taken in the Emergency Department (ED), Acute Medical Unit (AMU), and the Ambulatory Care Unit (ACU). During January 2019, a further one hundred and sixty one cases of Influenza A were detected; again from samples taken in the ED, AMU, and ACU.

The increase in influenza cases requiring admission has had a significnt impact on the organisation and the need for isolation (single room) facilities. In some cases, due to a lack of side room capacity, some patients with influenza A needed to be cohorted and treated in bays with one another to help try and reduce the spread of infection. There was one outbreak of influenza A on Ward C29 (Rehabilitation), which resulted in the ward being closed from the 10th January 2019 until 16th January 2019. The cause of this outbreak was a patient that became symptomatic with respiratory symptoms following home leave and whose household contacts were also affected by

influenza-like symptoms. The patient mobilised widely around the unit prior to additional cases being detected in other patients. In total, 7 patients were affected with Influenza A, inclusive of the index case.

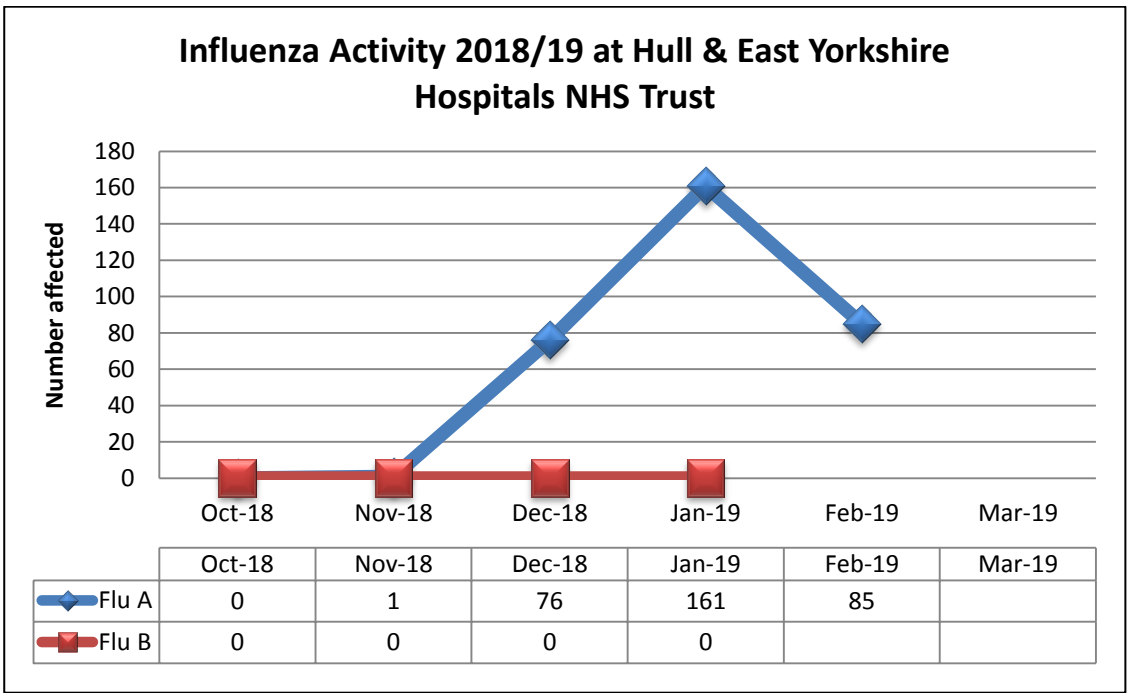
The following two graphs show the distribution of Influenza strains for FY 17/18 and 18/19 respectively.

In 2017/18, Influenza B was the more predominant strain.




| | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|
| Flu B | 0 | 1 | 4 | 53 | 78 | 39 | 4 |
| Flu A | 0 | 1 | 7 | 17 | 33 | 38 | 17 |

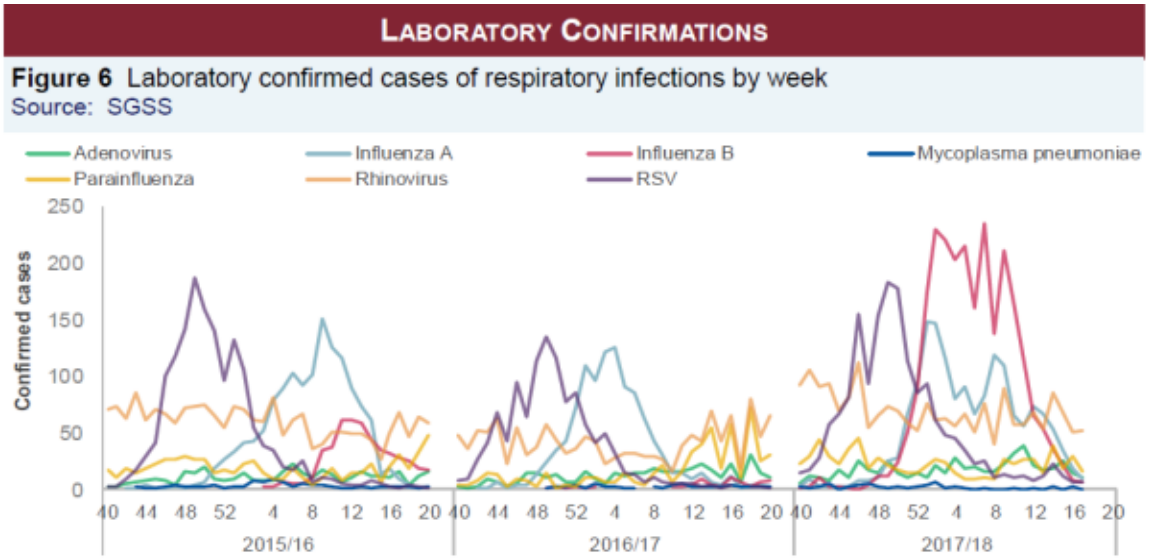
In 2018/19, influenza B is the more predominant strain, with Influenza B activity yet, to date.



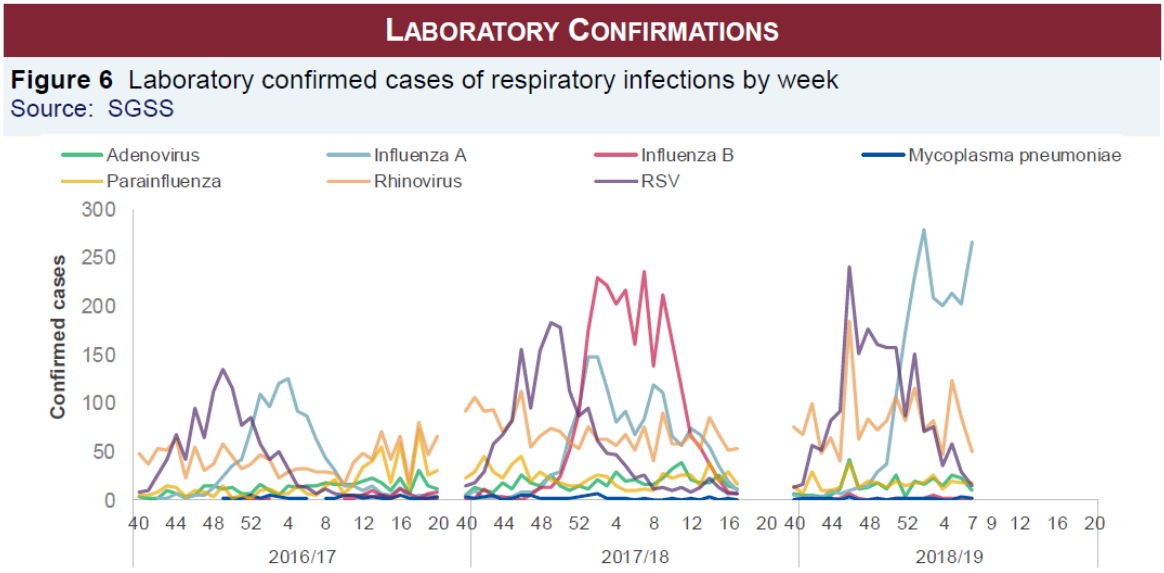

| | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|
| Flu A | 0 | 1 | 76 | 161 | 85 | |
| Flu B | 0 | 0 | 0 | 0 | | |

The following two charts are from Public Health England and report the trends for respiratory infections over the Yorkshire and the Humber region over the past two years. As can be seen, this Trust's profile mirrors that which has been occurring over the region

2017/18 up to April 2018 – PHE regional influenza data




2018/19 up to 17th February 2019 – PHE regional influenza data

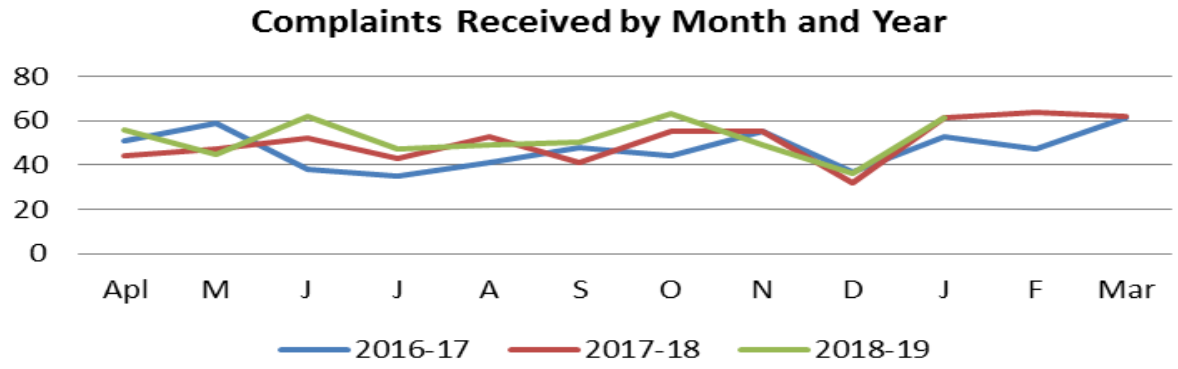


The following table shows patient deaths that have occurred in hospital over the current and last 'influenza season' periods. Whilst they cover slightly different time periods (due to the variable nature of the pattern of these infections), there have been fewer deaths so far this year from influenza compared to last year.

| 2017/18 Influenza season<br>Jan-May 2018<br>Deaths occurring mainly in February and March 2018 | | | | | |
|---|---|---|---|---|---|
| Age at Death | 20-40yrs | 41-60yrs | 61-80yrs | 81-100yrs | Total |
| Flu A | 1 | 1 | 3 | 5 | 10 |
| Flu B | 0 | 3 | 5 | 4 | 12 |
| Total | 1 | 4 | 8 | 9 | **22** |
| 2018/19 Influenza season<br>Nov 2018-February 2019 | | | | | |
| Age at Death | 20-40yrs | 41-60yrs | 61-80yrs | 81-100yrs | Total |
| Flu A | 2 | 1 | 7 | 4 | 14 |
| Flu B | None | None | None | None | 0 |
| Total | 2 | 1 | 7 | 4 | **14** |

## 5. PATIENT EXPERIENCE

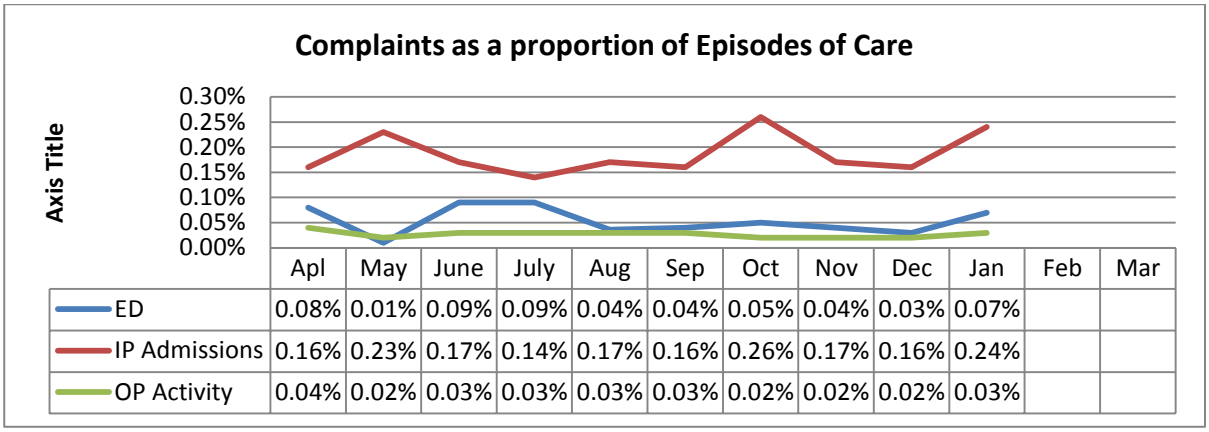
The following graph sets out comparative complaints data from 2016 to date. There were 61 new complaints recorded in the month of January 2019. There was an increase in complaints in January in comparison to the previous month, December 18, where 36 complaints were received. However, this is in line with the trends identified for December in previous years.




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. All complaints closed in January 2019 were catergorised as level 2. During this period, 1 complaint was not investigated as it was de-escalated to a PALS.

Broadly speaking, complaints reflect activity in the previous three months. With regards to the complaints that were received during January 2019, these relate mainly to events that took place between October 2018 and January 2019. There are no specific themes as to the complaints received. 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 sometime after the actual event. As such, the Trust takes a pragmatic approach to these.

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% | 0.07% | | |
| IP Admissions | 0.16% | 0.23% | 0.17% | 0.14% | 0.17% | 0.16% | 0.26% | 0.17% | 0.16% | 0.24% | | |
| OP Activity | 0.04% | 0.02% | 0.03% | 0.03% | 0.03% | 0.03% | 0.02% | 0.02% | 0.02% | 0.03% | | |

The following table indicates the number of complaints by subject area that were received for each Health Group during the month of January 2019. This month has seen Emergency and Acute Medicine complaints being recorded within a separate Health Group.

*Complaints Received by Health Group and Subject – January 2019*

| Complaints by Health Group and Subject (primary) | Attitude | Care and Comfort | Communica-tion | 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 | 0 | 0 | 0 | 1 | 4 |
| Emergency & Acute | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 4 | 8 |
| Family and Women's | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 11 | 12 |
| Medicine | 2 | 4 | 1 | 2 | 4 | 0 | 0 | 8 | 21 |
| Surgery | 0 | 1 | 1 | 2 | 0 | 1 | 0 | 11 | 16 |
| Totals: | 2 | 6 | 4 | 6 | 7 | 1 | 0 | 35 | 61 |

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 January 2019:**

- A 3 year old child attended ED with a foreign object up his nose. It was difficult to remove the object and the child had to return the following day. Initial attempts to remove the object failed and the patient became distressed. It was agreed that he would need to return again and have it removed under a general anaesthetic. The child reported to his mother that he had not been given a sticker so it must be that he had not been brave.
  **Outcome:** Senior Matron contacted the parent and discussed the concern in detail, making suitable arrangements for the child to return to the hospital to have the object removed under a general anaesthetic. An assortment of stickers was provided to the child with an apology that the department did not have any available on his last visit and assurance that he had been very brave.

- A patient had bilateral knee replacements resulting in one leg being shorter than anticipated and has since been advised by an osteopath that this this was the cause of his constant pain.
  **Outcome:** The patient was advised that it is highly unlikely that any measurable leg length discrepancy will have arisen as a result of the knee replacement procedures undertaken. The procedures were undertaken without any complications. Osteopaths will occasionally refer to a 'pelvic imbalance' in an assessment of patients, which is not indicative of confirmation of a difference in the bony length of the legs. The patient has been offered the opportunity of a consultation with an Orthopaedic Surgeon, if he feels this would be beneficial.

**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 achieved in January 2019.

*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% | 85% | | |

*The following table indicates performance by Health Group and the outcome of the complaint for the month of January 2019.*

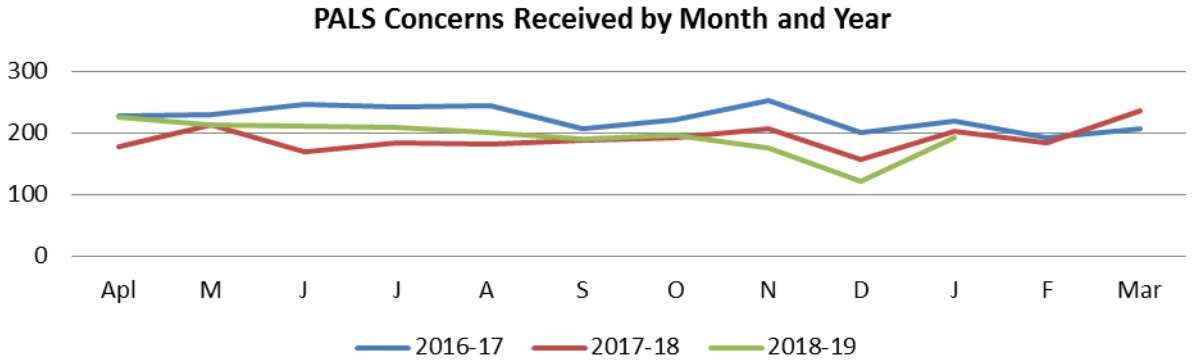
| January 2019 | N° Closed | Within 40 days | Upheld | Partly Upheld | Not Upheld | Not Investigated | Re-opened |
|---|---|---|---|---|---|---|---|
| **Corporate Functions** | 0 | N/A | 0 | 0 | 0 | 0 | 0 |
| **Clinical Support** | 7 | 5 (71.4%) | 1 | 5 | 1 | 0 | 2 |
| **Emergency and Acute** | 4 | 4 (100%) | 0 | 2 | 0 | 0 | 0 |
| **Family and Women's** | 3 | 3 (100%) | 1 | 3 | 0 | 1 | 1 |
| **Medicine** | 5 | 4 (80%) | 2 | 1 | 1 | 0 | 3 |
| **Surgery** | 15 | 13 (86.6%) | 4 | 11 | 0 | 1 | 3 |
| **Totals:** | 34 | 29 (85.29%) | 8 | 22 | 2 | 2 | 9 |

As can be seen from the previous table, performance is variable across the Health Groups, with Emergency and Acute and the Family and Women's Health Groups achieving 100% of complaints closed within 40 days. Surgery Health Group closed 15 complaints during the month of January, 13 of which were within 40 days. Clinical Support and Medicine Health Group did not attain the standard set during the month of January. This will continue to be managed through the monthly performance and accountability meetings with Health Groups.

### 5.2 Patient Advice and Liaison Service (PALS)

As with complaints received, January saw an increased number of contacts with the PALS team. There were 7 comments and suggestions, 21 compliments, 193 concerns and 37 requests for general advice. This information has been shared with the Health Groups in order that they can review and consider any actions that are necessary.

The following graph illustrates that the number of concerns received by PALS had reduced steadily over the last five months but increased in the month of January. This increase is in line with previous years' activity for the same period.




The following table indicates that Delays, Waiting times and Cancellations continues to be the highest category received by PALS, with Family and Women's and Surgery Health Groups receiving 25 and 30 concerns respectively within the month of January 2019. 31 of the concerns were regarding elective waiting times; 30 for the waiting time for an outpatient appointment and 13 regarding the cancellation of a clinic appointment.

| 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 | 1 | 2 | 0 | 0 | 0 | 1 | 1 | 4 | 0 | 0 | 0 | 9 |
| Clinical Support | 0 | 1 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 7 | 18 |
| Emergency and Acute | 1 | 3 | 1 | 0 | 3 | 1 | 1 | 0 | 1 | 0 | 5 | 16 |
| Family and Women's | 1 | 5 | 0 | 4 | 25 | 1 | 1 | 0 | 0 | 0 | 12 | 49 |
| Medicine | 4 | 3 | 0 | 7 | 13 | 1 | 1 | 0 | 0 | 0 | 10 | 39 |
| Surgery | 5 | 6 | 0 | 5 | 30 | 2 | 0 | 0 | 0 | 0 | 13 | 61 |
| Totals: | 12 | 20 | 1 | 16 | 81 | 6 | 4 | 4 | 1 | 0 | 47 | 192 |

### 5.5.1 Examples of outcomes from PALS contacts:

- The relative of a patient contacted the PALS team and raised concerns regarding the lack of spaces available for disabled car park users.
  **Outcome**: Work is under way to revise the current provision of disabled parking bays. This includes the removal and replacement of bays that are not compliant currently with building regulations.

  At the end of this work, the car park to the front of the tower block will be for the sole use of blue-badge holders, except for six bays, which will be for emergency on-call and drop-off purposes. These will have signage making it clear of their intended purpose. A similar exercise will be undertaken at the entrance to the Wilson Building car park, also.

  In addition to this, the British Parking Association (BPA) will be on site this month to start the assessments for Disabled Parking Accreditation (DPA). When this is achieved, the hospital will be one of only four sites in the Hull area to achieve the standard. Once HRI has gained accreditation, the aim will be to achieve the same standards at CHH.

- A relative contacted the PALS team as they had been advised that the patient's treatment had been delayed and they were concerned as his condition was deteriorating. They did not feel that the hospital had a suitable treatment plan in place that was in the best interest of the patient who was now becoming anxious.
  **Outcome:** The Consultant contacted the relative directly and explained the plan in detail, clarifying any misunderstandings. The relative was very pleased with the information and that the consultant had taken the time to explain what was happening and why it was being undertaken in that way.

- A patient attended the hospital for an Ultrasound guided biopsy of his prostate. The patient did not know to inform the department that he was on Apixaban (anticoagulant) and needed to stop this prior to his procedure being performed.
  **Outcome:** A patient information leaflet is sent to patients with their appointment letter. This has now been updated to reflect all of the new anticoagulants that are available and provides clear instructions on when to stop them.

### 5.2.2 Compliments

- The mother of a young patient wrote to the Trust and advised: "My son was taken into Children's A&E on Saturday morning, 19 January. The nurse who took care of us there was called Rebecca and she had a special interest in epilepsy. This was fortunate as my son began fitting when the doctor was trying to insert a cannula. She was calm and helpful throughout. My son was taken to Resus as the seizures did not respond to Midazolam, his

rescue medication. A Consultant, (Simon) arrived and was able to insert the cannula and gave my son a dose of Lorezapam, which stopped his seizures. It was a frightening morning but they worked well as a team and they were both reassuring and I know that they gave my son, the very best care. Please pass on my thanks."

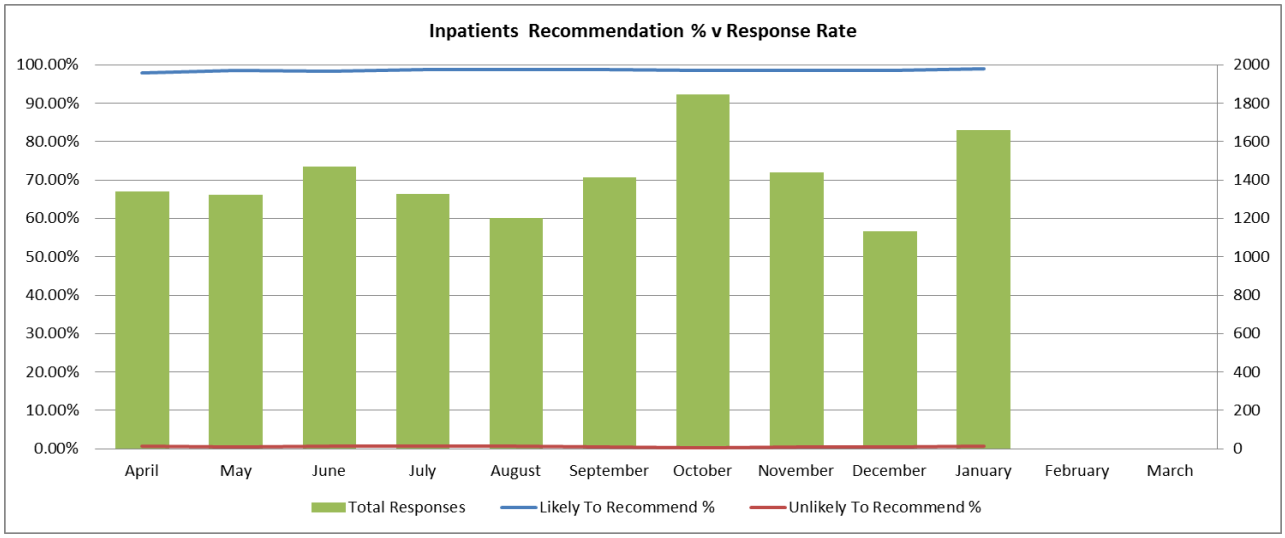
- The wife of a patient wrote to the hospital to state: "My husband has been in Hull Royal twice recently. I would like you to know, I think everyone you meet is so friendly and helpful. The doctors on the ward (8) have telephoned me to tell me what is being done etc. and the nurses are so kind to my husband. So, once again, many thanks to you all."

- A comment was received via the Trust's webpage that stated: "Unfortunately I cannot remember the doctor's name I saw in A&E minors on the 13 January 2019, however I do remember I was seen midday in room 7. I would just like to say how outstanding he was! He introduced himself and ensured that every avenue was covered. Not only did he consider my presenting complaint he also looked at me holistically and found that I had a heart arrhythmia. His attitude was refreshing and he really seemed to love his job! He has really changed my perception of the NHS."

### 5.3 Friends and Family Test (FFT)

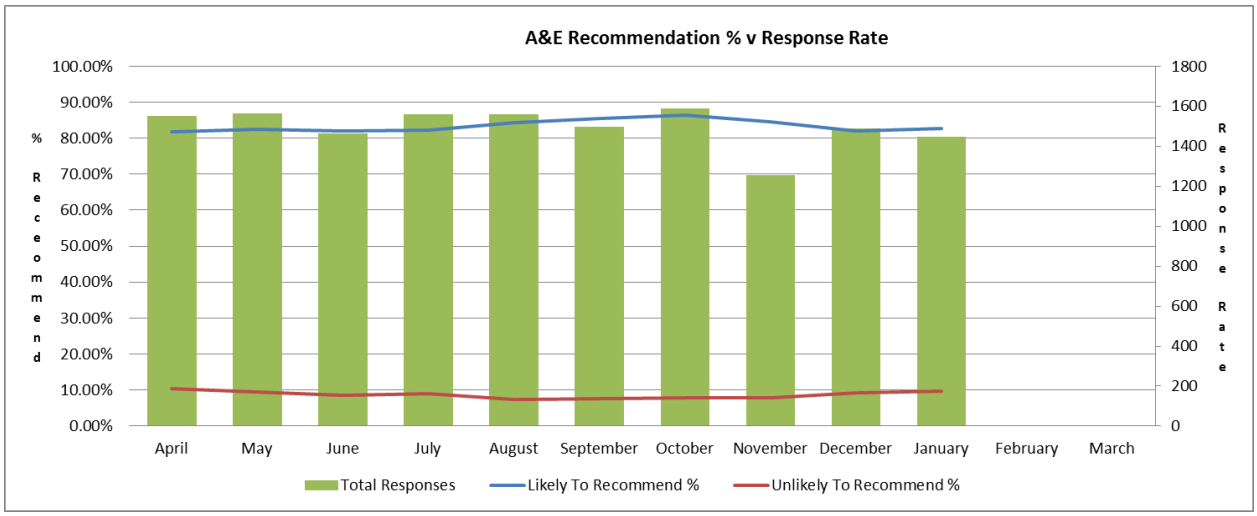
#### 5.3.1 Inpatient Summary – all areas

The Trust's Friends and Family test for all areas, including the Emergency Department, had a higher number of responses for January with 5,274 compared to December 2018 when 4,337 were received. The January 2019 inpatient results indicated that **98.98%** 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.




#### 5.3.2 Friends and Family Emergency Department (ED)

1,446 patients who attended the Emergency Department in January 2019 responded to the Friends and Family Test with **82.64%** of patients giving positive feedback and **9.68%** negative feedback. The remainder were neither positive nor negative.




### 5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 11 cases with the PHSO currently. During the month of January 2 new cases were opened and 1 case was closed, which was partly upheld.

## 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.

Also, the Chief Nurse and Acting Deputy Director of Quality Governance and Assurance attended the Joint Health and Wellbeing Board for the Hull and East Riding Local Authorities at Beverley County Hall on 18th February 2019 to present an update on progress made since the last CQC inspection. The session comprised a presentation and a comprehensive question and answer session. This appeared to be well received by both local authorities.

### 6.2 Learning from Deaths

During January and February 2019, there were a total of 407 deaths within the Trust, compared to a total of 505 deaths for January and February 2018, a total decrease of 98 fewer deaths (19.4%). Of these deaths (January – February 2019), 17 received a full Structured Judgement Review (4.17%).

Of the 407 deaths, eight patients had elective surgery undertaken during their hospital stay. The National Quality Board states that all elective procedure mortality cases will require a case-note review. Currently, the Structured Judgement Review is the chosen methodology for these cases. Of these eight elective procedure cases, four cases have had a Structured Judgement Review completed. A further two are ongoing at the time of writing, with the remaining two yet to commence. The learning from these will be taken through the Trust's Mortality Committee.

The Mortality Committee has undergone a change of name, now known as the "Trust Mortality and Morbidity Committee", to reflect a positive shift into learning from morbidity, in addition to patient death. The Terms of Reference have been updated accordingly and were agreed at the February 2019 Committee. The Mortality and Morbidity Committee now has core members from Palliative Care, to allow for a greater depth of knowledge and to help direct further learning.

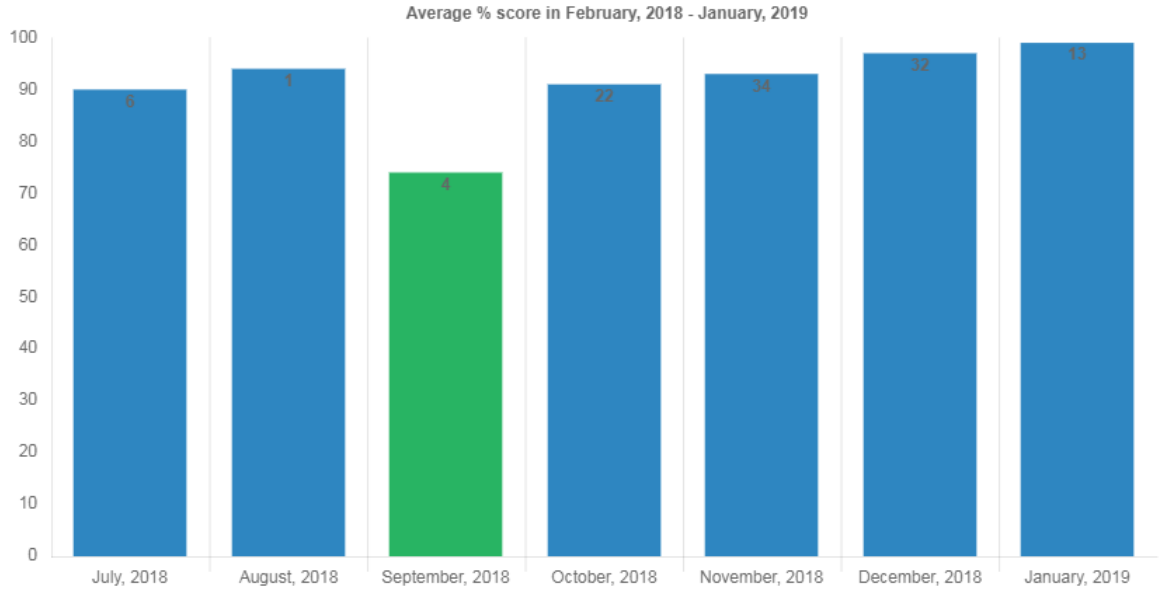
### 6.3 Safer Surgery Checklist

The organisation had an unfortunate series of never events (2016-2018) predominately due to wrong site surgery. A quality improvement project (QIP) was implemented under the leadership of the Deputy Chief Medical Officer in 2017 to understand the causal factors contributing to the never events. The QIP progress and milestones were monitored through the operational quality committee. A key finding from the exercise, which involved focus groups with staff and observational audits was a poor safety culture within theatres and areas where interventional procedures were undertaken. The task and finish group set up to address this issue and implemented two actions. These were, to address a process change through embedding a checklist and, also, to implement a 'stop the line policy' and approach to empower front line staff to raise concerns and challenge poor safety practices in the operating environment without fear of retribution.

The checklist was created using a 'Plan-Do-Study-Act' methodology with active input from front line staff. A standardised checklist has now been embedded in all theatre and radiology areas undertaking interventional procedures ensuring that the right checks are in place for the right patient to receive the right treatment at the right time. A training video was created to impart knowledge to staff on how to deliver the checklist and this has now been viewed by over 90% of the relevant staff. The compliance is monitored by the operational quality committee and is now mandatory training for staff in those areas.

In addition, the task and finish group trained assessors across the organisation to conduct periodic observational audits of all areas where interventional procedures occur. The data is captured on a software programme that automatically generates compliance data and this is shared with the front line staff. The nursing directors of all the health groups have plans in place to display the compliance data on a dashboard creating a 'league table' of excellence to motivate staff to perform better. Currently, the compliance is of a very high standard with all areas achieving over 90% compliance and is monitored monthly by the operational quality committee.

The following chart shows the latest reported data for the main operating theatres.




Future plans will address the roll out of the checklists in maternity and other areas where interventional procedures are undertaken. Also, work is underway to agree a standardised reporting format for these data across all areas. The continuous surveillance of performance is part of the 'business as usual' framework and will continue to provide assurance to the Board that good practice remains embedded ensuring that patients continue to receive high quality care.

### 6.4 Maternity and Obstetric matters

### 6.4.1 Update actions following CQC maternity outlier alert for Elective Caesarean Section ref. C224/AS

As the Trust Board is aware, the Trust has been an outlier in relation to the number of elective caesarean sections (C/S) carried out for some time. This section provides an update on the progress made since the closure of the CQC alert in relation to this matter in June 2018. All actions from that alert have now been met and closed.

As background, the most common reasons for Elective C/S include:

1. Previous Caesarean Section
2. Breech presentation
3. Difficult previous vaginal birth including vaginal trauma, shoulder dystocia and traumatic delivery.

#### 6.4.1.1. Identified Actions

From previous audits, it was identified that there was an increase in elective C/S due to women having had one or more previous C/S for fetal distress or progress in labour. There was a guideline amendment to ensure that consultant presence is required if there is to be a C/S in the second stage of labour, to reduce this number.

The Birth after Caesarean Section (BAC) Clinic, was established in October 2018 and, although this has not reduced the numbers of C/S, there has been a perceived improved experience for women. This is an element that could be audited via a patient satisfaction survey for the service.

The implementation of a continuity of carer team has also the potential to impact on the elective C/S rates. Currently, out of 35 births using this model of care, only two have resulted in an emergency C/S and one elective C/S. Commissioner funding has been secured to deliver a second continuity team in East Hull. The team is collecting data including patient experience as part of an outcomes audit for this model of care.

Women that have had a previous traumatic birth are managed by the tokophobia and perinatal mental health pathways, which have been developed in collaboration with the University of Hull and the Perinatal Mental Health team. This pathway increases the awareness of the short term and long term risks of C/S and promotes normality, whilst educating and informing service users. There is further work underway with the CCG's to promote and inform women about C/S.

The service has implemented the use of Epi-Scissors to prevent vaginal trauma during childbirth, in particular during an instrumental delivery and is currently collecting data regarding the use of the Epi-scissor and associated birth trauma.

The service is updating how Cardiotocograph (CTG) training is delivered; aiming to base it on having an in depth understanding of physiological changes with a practical application of the pathophysiology. From April 2019, there will be CTG workshops to introduce this to the teams.

Ongoing audits are being undertaken to review the reasons for elective and emergency C/S and will be reported back to the service via the perinatal mortality meetings and mandatory training.

### 6.4.2 Clinical Negligence Scheme for Trusts – Year 2

Further to the presentation on the new CNST Year 2 standards at the January 2019 Trust Board, work is under way to try and resolve the medical staffing issue in relation to consultant obstetrician presence at all elective caesarean sections. Further work is underway with the Surgery HG to resolve the outstanding training issues. Otherwise, all other actions appear to be on track.

For the Trust Board in May 2019, a more comprehensive update on progress against meeting these standards will be given.

## 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**
Executive Chief Nurse

**Makani Purva**
Executive Chief Medical Officer

March 2019

**Appendix One:** Safety Thermometer – February 2019

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 February 2019

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 8th February on both hospital sites. 905 patients were surveyed

## 93.7% 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.

## 1.7% (16) 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

## 98.3% 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 September 18 – February 2019

| | Sept 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 |
|---|---|---|---|---|---|---|
| Harm Free Care % | 94.2% | 94.8% | 93.5% | 92% | 94.4% | 93.7% |
| Sample: Number of patients | 833 | 898 | 845 | 872 | 881 | 911 |
| Total Number of New Harm | 23 | 18 | 20 | 18 | 21 | 16 |
| NEW HARM FREE CARE % | 97.24% | 98% | 97.6% | 98% | 97.7% | 98.3% |

| 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 | 4 | 0.44% | 3 | 1 | 0 |

| | | | |
|---|---|---|---|
| Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable** | 33 | 3.6% | **% once not applicable patients removed** |
| Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT** | 761 | 84% | 87.2% |
| Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT** | 111 | 12.4% | 12.8% |

| Harm Descriptor: Pressure Ulcers | Number | % | Cat 2 | Cat 3 | Cat 4 |
|---|---|---|---|---|---|
| Total Number/Proportion of **Pressure Ulcers** | 46 | 5.08% | 40 | 1 | 5 |
| Total Number/Proportion of **OLD Pressure Ulcers**<br>An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission. | 39 | 4.31% | 33 | 1 | 5 |
| Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW**<br>A NEW pressure ulcer is defined as developing 72 hours since admission. | 7 | 0.77% | 7 | 0 | 0 |

| Harm Descriptor: Falls<br>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**<br>(During the last 3 days whilst an inpatient) | 11 | 1.22% |
| Severity **No Harm**: fall occurred but with no harm to the patient | 10 | 1.11% |
| Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication | 0 | 0% |
| Severity **Moderate Harm**: longer stay in hospital | 1 | 0.11% |
| 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** | **174** | **19.23%** | |
| **Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu** | **7** | **0.77%** | **4%** |
| **Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu<br>An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital** | **3** | **0.33%** | **1.7%** |
| **Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu<br>An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital** | **4** | **0.44%** | **2.3%** |

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

**Friday 8th March 2019**

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**TRUST BOARD**
**MARCH 2019**

| | |
|---|---|
| **Title:** | NURSING AND MIDWIFERY (SAFE) STAFFING REPORT – MARCH 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<br><br>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:<br><br>• Compliance with the national reporting requirements on this topic<br>• Nursing and Midwifery Staffing Levels for inpatient areas<br>• The use of the new Care Hours Per Patient Day (CHPPD) Metric<br>• 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:<br><br>• Receive this report<br>• Decide if any further actions and/or information are required. |

# HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
## NURSING AND MIDWIFERY STAFFING REPORT
## MARCH 2019

### 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 January 2019 (November – December 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 January 2019 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 staffing.

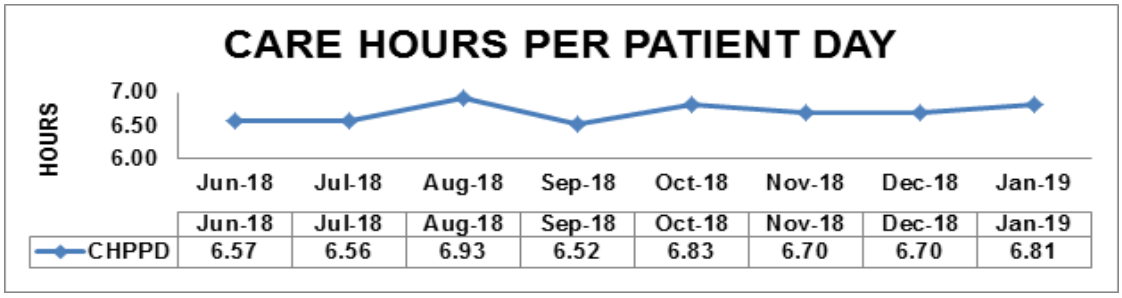
### 3. CARE HOURS PER PATIENT DAY

**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

[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

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 | Jan-19 |
|---|---|---|---|---|---|---|---|---|
| CHPPD | 6.57 | 6.56 | 6.93 | 6.52 | 6.83 | 6.70 | 6.70 | 6.81 |

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-Jan, which is positive.

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 January 2019.
**Appendix Two** provides the Nurse Staffing Quality Indicators for January 2019
**Appendix Three** provides the Workforce Model
**Appendix Four** provides the definitions of CHPPD
**Appendix Five** provides the Nursing and Midwifery Establishment Review Summary

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:<br>• Although not triggering on quality issues, nursing staff vacancies are thought to be affecting/possibly affecting the quality of care being provided.<br>• Ward is under review/watchful observation by the nurse director and senior matron.<br>• 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 – January 2019
## 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 | |
| H5/RHoB | **LOW** | No staffing related quality concerns | |
| H50 | **LOW** | No staffing related quality concerns | |
| H500 | **LOW** | No staffing related quality concerns. | The ward has been downgraded to a low risk since the last review due to improvements in recent Fundamental Standards 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. RN pool nurses allocated for continuation and stability. B6s and B7 staff providing weekend cover and Senior Matron support. |
| H8 | **LOW** | No staffing related quality concerns | Additional non-registered staff in post. |
| H9 | **MEDIUM** | 3 red fundamental standards score although not thought to be related to staffing levels. Under surveillance. | Senior Matron supporting the ward. Additional Band 6 RN to 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 staff 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** | No staffing related quality concerns | Additional HASU beds now open. |
| CDU | **LOW** | No staffing related quality concerns | |
| C26 | **LOW** | No staffing related quality concerns | 2.2 WTE vacancies with high unavailability (maternity leave). Additional support obtained to cover maternity leave from nurse bank and from staff within cardiology. |
| 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

| | | | |
|---|---|---|---|
| C16 | **LOW** | No staffing related quality concerns | 9 beds currently closed to release registered nursing staff to support winter ward. 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 to support weekend opening over winter period.. |
| Maple H31 | **LOW** | No staffing related quality concerns | |
| Rowan H33 | **LOW** | No staffing related quality concerns | |
| Acorn H34 | **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. |
| 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 | 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. |
| PHDU | **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. |
| Labour | **LOW** | No staffing related quality concerns | Midwife to birth ratio 1:32. |

### 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 1.42 wte RN vacancies (14% of registered workforce), not triggering any quality indicators therefore deemed to be safely staffed | |
| C31 | **MEDIUM** | Continue to have RN vacancies of 3.24 wte and supporting the winter ward with a RN. | Actions - support from Day Unit, Specialist nurse, utilising bank and agency in addition to 5 beds being closed, only opened when urgent capacity is required. This continues to be closely monitored. |
| C32 | **MEDIUM** | This ward has 2.27 wte RN vacancies & 4.8% Maternity Leave; no quality indicators are triggering | Utilising bank and agency support from other inpatient wards on review at SafeCare. |
| C33 | **MEDIUM** | This ward has 1.44 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.

The Trust is currently perusing 130 adult branch nurses who are due to qualify September 2019; this has been through the Trust's `direct to interview campaign`. The Education and Development Team in conjunction with the Practice Development Matrons have organised an event on Thursday 7th March at the University solely for the Team to "catch-up" with the students that have been offered a place with the Trust and to encourage further recruitment from this cohort of students.

A number of students from other universities have applied for posts advertised via NHS Jobs and through the Trust's dedicated recruitment website. The scale of this is being determined currently.

The Trust has now deployed 53 international nurses into both the Medicine Health Group and Surgery Health Group from the Philippines since August 2017. 41 of the nurses have passed their OSCE and have their NMC pin numbers, two have recently partially failed their OSCE and will be rebooked within the next two weeks, a further 10 nurses arrived at the end of February and have started their OSCE training. Out of the 53 nurses who have been deployed, there has been some internal movement and one nurse has left the Trust. A further nurse has handed in her notice.

### 5.1 Workforce Model

**Appendix Three** illustrates the workforce model which has been developed to consider the future projected impact of the current workforce initiatives in relation to Nursing Workforce numbers.

This has been developed assuming 'all other things remain unchanged'. Also, it is acknowledged that healthcare is dynamic and regulatory requirements may change, also. Nonetheless, the table demonstrates clearly that with ongoing investment into the Nurse Apprenticeship, Nursing Associate and International Nurses programmes, in conjunction with ongoing robust recruitment campaigns, these all have the potential to put the Trust into a much more positive position within the next three years in relation to substantive nursing staff in post. This position will be further supported by the ongoing retention work being undertaken currently throughout the organisation in relation to career pathway developments, flexible retirement and working patterns. However, this will need to be refreshed over time and will be subject to available funding support. Nonetheless, it starts the discussion and provides a basis upon which this work can develop.

## 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; hence the decision to have this overseen by the most senior nurses in the Trust. 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)

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.

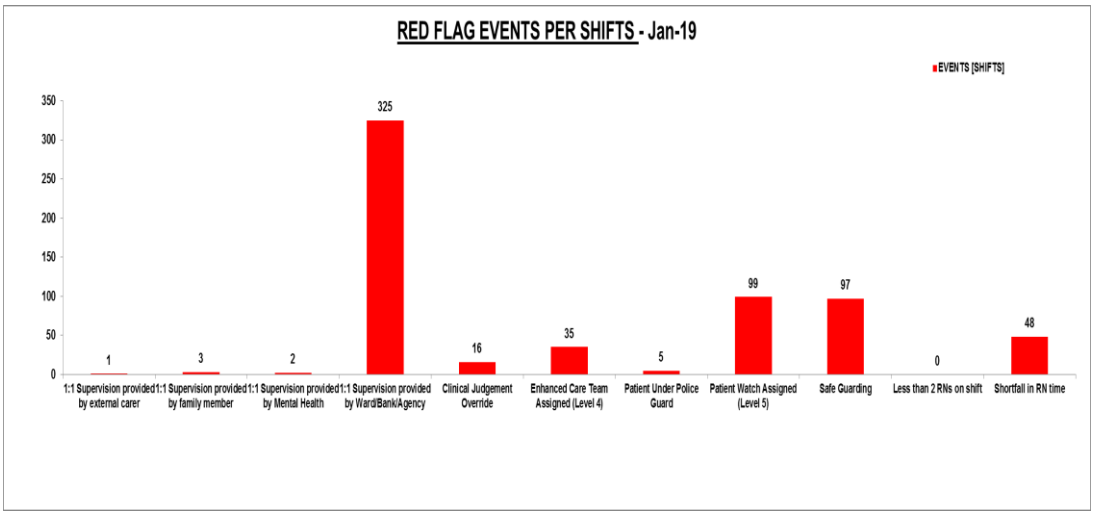
In addition, it is important to keep records of the on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

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.

A similar set of red flags is used in maternity services but none were raised in January 2019.

The following graph illustrates the number of ‘Red Flags’ identified during January 2019. 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.



| Jan-19 | RED FLAG TYPE | EVENTS [SHIFTS] | % |
|---|---|---|---|
| | 1:1 Supervision provided by external carer | 1 | 0% |
| | 1:1 Supervision provided by family member | 3 | 0% |
| | 1:1 Supervision provided by Mental Health | 2 | 0% |
| | 1:1 Supervision provided by Ward/Bank/Agency | 325 | 52% |
| | Clinical Judgement Override | 16 | 3% |
| | Enhanced Care Team Assigned (Level 4) | 35 | 6% |
| | Patient Under Police Guard | 5 | 1% |
| | Patient Watch Assigned (Level 5) | 99 | 16% |
| | Safe Guarding | 97 | 15% |
| | Less than 2 RNs on shift | 0 | 0% |
| | Shortfall in RN time | 48 | 8% |
| | **TOTAL:** | **631** | **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. TWICE YEARLY REVIEW OF NURSING AND MIDWIFERY (N&M) ESTABLISHMENTS

The National Quality Board guidance requires trusts to review Nursing and Midwifery establishments a minimum of twice a year in order to ensure that these are appropriate and relevant to meet the current needs/acuity of patients. This was last reported to the Trust Board in May 2018. The process is managed by senior nurses and midwives alongside sisters, charge nurses, the Trust's e-roster lead and heads of finance. The guidance requires trusts to use a validated establishment tool, where available, alongside professional judgement in determining required establishments. This process was concluded during February 2019 and is presented at **Appendix Five**.

In reviewing the nursing and midwifery establishments, the following factors are taken into consideration:

- Existing rota establishment and actual position
- The use of a validated tool, where available, and patient acuity data (including red flags)
- Shift patterns in use
- Compliance with e-roster rules and the Trust's Rota Policy
- Training needs analysis/compliance
- Any additional roles
- Number of active mentors for student nurse/midwife support
- Number of apprentices and other trainees
- Overarching professional judgement

In reviewing the nursing and midwifery budgets, the following issues have been resolved:

- Consistency in terms of how the uplift for annual leave, sickness and study leave are allocated and treated.
- Consistency with how annual leave and bank holiday entitlement are calculated and allocated
- Implementation of standardised shift patterns and break times.

The following tables illustrate the changes in relation to whole time equivalent registered and non-registered nursing and support staff in each of the health groups in conjunction with the financial implications.

| Summary Nursing Establishment review 2019/20 | | | |
|---|---|---|---|
| **Healthgroup** | **Net RN change wte** | **Net HCA change wte** | **Financial implication £** |
| Surgery | -0.69 | -2.75 | 19,451 |
| Medicine | -4.03 | 1.45 | -1,317 |
| Clinical Support | 0.03 | 0 | -34,196 |
| Family & Womens | -1.81 | -1.97 | 79,704 |
| **Total** | **-6.50** | **-3.27** | **63,642** |

The following table provides further details by health group.

| | SHG | MHG | CSS | F&Ws | Total |
|---|---|---|---|---|---|
| **RN (investment)/efficiency** | 22,908 | 133,796 | -996 | 60,092 | **215,800** |
| **B6 investment** | -74,700 | -58,100 | -33,200 | -24,900 | **-190,900** |
| **Non-RN (investment)/efficiency** | 62,136 | -32,763 | 0 | 44,512 | **73,886** |
| **Support Staff (investment)/efficiency** | 9,107 | -44,250 | 0 | 0 | **-35,143** |
| **Net (Investment) / efficiency** | **19,451** | **-1,317** | **-34,196** | **79,704** | **63,642** |

Narrative is provided in **Appendix Five**, justifying all establishment changes following the review. It incorporates the financial changes required to support an additional band 6 nurse in the majority of the ward areas. This has been funded, by agreement, through the reduction of the ward sisters/charge nurses' supervisory shift allowance from three to two days per week (at 7.5 hours per shift). To ensure this will not have a detrimental impact in the management requirements of their role, a Quality Impact Assessment is in the process of being completed; the outcome of which will be evaluated and mitigated, as required. However, it is not anticipated that this will raise any concerns.

Any budget anomalies have been resolved within the agreed and available financial envelope. Even where the establishment review is indicating that additional investment is required, these anomalies will be managed from within existing budgets overall. As such, no additional corporate investment is required and establishments are set and financed appropriately.

For the purpose of this review and in line with the new CHPPD reporting requirement, an attempt has been made to calculate the planned CHPPD in relation to each rota, i.e. how many care hours per patient per day can a ward expect when working at full establishment. The reason for this is that it then presents a baseline against which to measure actual performance. In addition, the required CHPPD, which is compiled from SafeCare has also been calculated and presented in **Appendix Five**. This is an initial attempt to gain greater clarity into what the current planned rotas provide and how this relates to actual patient acuity on a daily basis. As such, this is work in progress and will be developed over time and, therefore, should be heavily caveated at this time. This is because there are a number of factors that have the potential to alter the CHPPD significantly and, therefore, need further investigation and analysis. For example, if the patient acuity census is not completed in SafeCare on a given day, it will generate a CHPPD result of 0. It is therefore imperative that further work is completed over time to ensure that the data presented is factually correct.

The sum of this work, after all of the re-basing, suggests that there is an overall surplus in the nursing and midwifery budgets of £63,642, but £79k of this (before netting off) is within the Family and Women's Health Group. However, there is a proposal within that HG to increase the number of Neonatal Intensive Care Unit (NICU) staffing requirements in accordance with British Association of Peri-natal Medicine (BAPM) guidance. This discussion will be taken forward with the Chief Finance Officer to determine if these funds can be used for this purpose.

In addition to the establishment reviews, the Maternity Services undertook an independent workforce review using Birthrate Plus® (BR+) methodology, (the validated tool used in midwifery) in June 2018. This is based upon an understanding of the total midwifery time required to care for women. It sets a minimum standard of providing one-to-one midwifery care throughout established labour, and including measurements across the whole maternity pathway. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives. BR+ considers the case-mix of women over a three month period (July to September 2018). These data are then validated before submission. The service is currently reviewing the data obtained from the Birthrate Plus® analysis in conjunction with the clinical teams to determine the actual requirements to meet service and will be reported to the Trust Board at a later date.

## 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

Pressure on nursing and midwifery staffing levels continues but the Trust manages these and mitigates them well.

The establishment reviews demonstrate that nursing and midwifery budgets are set correctly without the need for additional corporate investment.

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 and the first versions of the reports in response of this will be presented to the Trust Board.

## 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**
**March 2019**

**Appendix One:** Nurse Staffing Key Metrics – January 2019
**Appendix Two:** Nurse Staffing Quality Indicators – January 2019
**Appendix Three:** Workforce Model
**Appendix Four:** CHPPD Description, Methodology, Benefits and Limitations
**Appendix Five** Establishment Review March 2019

## 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 **Appendix One** 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

## Jan-19

KEY METRICS ROTA: 24th Dec 2018 - 20th Jan 2019

| 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 M10] | | | | | | TEMPORARY STAFFING [24th Dec -18 to 20th Jan-19] | | | | 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 HFW | 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 | 4.90 | 5.3% | 0.59 | 2.7% | 5.49 | 115.34 | 5.8% | 3.7% | 2.1% | 86.0% | 19.0% | 6.2% | 8.8% | 0.1% | 1.3% | 0.3% | 2.3% | 54.0 | 53.0 | 0.4 | 0.0 | 0.4 | 10.1% | 2.4% | 54.5 | 54.5 | 0.0 |
| | AAU | AMU | GENERAL MEDICINE | 45 | LOW | 178.5 | 1280 | 5477.8 | 2868.2 | 6.5 | 7.55 | -1.03 | 7.31 | -0.79 | 10.78 | 24.4% | 6.70 | 28.7% | 17.48 | 67.57 | 9.2% | 7.8% | 1.4% | 70.9% | 28.6% | 12.0% | 11.6% | 0.8% | 2.6% | 0.0% | 1.6% | 46.0 | 45.0 | 0.3 | 0.0 | 0.3 | 13.3% | 0.6% | 221.5 | 260.0 | 38.5 |
| | Ward 36 HRI | H36 | GENERAL MEDICINE | 24 | LOW | 399.0 | 655 | 2229.8 | 1541.3 | 5.8 | 7.55 | -1.79 | 7.31 | -1.55 | -0.06 | -0.4% | 1.06 | 13.4% | 1.00 | 22.51 | 6.9% | 4.0% | 2.9% | 65.5% | 19.5% | 2.2% | 11.8% | 3.5% | 0.6% | 1.4% | 0.0% | 80.0 | 76.0 | 0.5 | 0.5 | 0.0 | 17.7% | 1.8% | 2.7 | 152.5 | 149.8 |
| | EAU | EAU | GERIATRIC MEDICINE | 21 | MEDIUM | 375.9 | 630 | 2249.6 | 1903.0 | 6.6 | 6.94 | -0.35 | 7.74 | -1.15 | 3.66 | 19.2% | -1.28 | -9.7% | 2.38 | 32.27 | 14.5% | 12.1% | 2.4% | 44.2% | 25.2% | 9.9% | 14.6% | 0.0% | 0.4% | 0.3% | 0.0% | 44.0 | 35.0 | 0.0 | 0.0 | 0.0 | 21.5% | -2.0% | -67.5 | 0.0 | 67.5 |
| | Ward 5 + RSU | H5 / RHOB | RESPIRATORY MEDICINE | 26 | LOW | 220.5 | 776 | 2937.0 | 1624.4 | 5.9 | 6.74 | -0.86 | 6.38 | -0.50 | 1.12 | 4.5% | 2.24 | 17.0% | 3.36 | 37.84 | 6.0% | 6.0% | 0.0% | 31.7% | 21.2% | 7.2% | 6.7% | 0.0% | 2.4% | 4.9% | 0.0% | 54.0 | 24.0 | 0.0 | 0.0 | 0.0 | 15.9% | -0.9% | 25.3 | 88.3 | 63.0 |
| | Ward 50 HRI | H50 | NEPHROLOGY | 19 | LOW | 283.5 | 575 | 1835.1 | 1293.3 | 5.4 | 7.23 | -1.79 | 7.00 | -1.56 | -1.17 | -7.7% | 0.23 | 2.7% | -0.94 | 23.54 | 3.0% | 2.6% | 0.4% | 85.8% | 16.5% | 2.3% | 10.8% | 0.0% | 0.3% | 0.6% | 2.5% | 69.0 | 68.0 | 0.2 | 0.0 | 0.2 | 12.2% | 0.7% | -74.8 | 51.5 | 126.3 |
| | Ward 500 HRI | H500 | RESPIRATORY MEDICINE | 24 | LOW | 157.5 | 722 | 1630.0 | 1718.6 | 4.6 | 6.74 | -2.10 | 6.38 | -1.74 | 7.36 | 43.4% | 1.25 | 10.3% | 8.61 | 29.10 | 14.1% | 13.9% | 0.2% | 69.8% | 26.7% | 11.6% | 10.7% | 0.0% | 2.4% | 2.0% | 0.0% | -30.0 | -37.0 | 0.4 | 0.2 | 0.2 | 13.6% | 2.7% | 171.7 | 191.2 | 19.5 |
| | Ward 70 HRI | H70 | GENERAL MEDICINE | 30 | MEDIUM | 441.0 | 909 | 2133.8 | 2200.5 | 4.8 | 7.55 | -2.78 | 7.31 | -2.54 | 8.74 | 43.6% | 0.76 | 6.3% | 9.50 | 32.22 | 23.3% | 18.9% | 4.4% | 71.3% | 25.1% | 3.7% | 10.6% | 5.3% | 0.3% | 1.2% | 4.0% | 76.0 | 76.0 | 1.7 | 0.5 | 1.2 | 18.3% | 24.0% | 526.3 | 555.8 | 29.5 |
| | Ward 8 HRI | H8 | GERIATRIC MEDICINE | 27 | LOW | 220.5 | 821 | 1897.1 | 1815.5 | 4.5 | 6.94 | -2.42 | 6.74 | -2.22 | 2.29 | 13.8% | 1.65 | 12.5% | 3.94 | 29.78 | 3.7% | 3.7% | 0.0% | 69.8% | 14.3% | 1.5% | 8.5% | 0.0% | 1.4% | 0.4% | 2.5% | 60.0 | 55.0 | 0.3 | 0.2 | 0.1 | 15.9% | -4.0% | -60.5 | 33.5 | 94.0 |
| | H80 | PDU H80 | GERIATRIC MEDICINE | 27 | LOW | 220.5 | 822 | 1545.2 | 2030.4 | 4.3 | 6.94 | -2.59 | 6.74 | -2.39 | 8.26 | 49.7% | -2.63 | -20.0% | 6.74 | 29.78 | 10.4% | 5.6% | 4.8% | 75.4% | 31.2% | 6.3% | 11.7% | 3.7% | 0.7% | 3.2% | 5.6% | 47.0 | 47.0 | 0.4 | 0.4 | 0.0 | 8.6% | 1.9% | 239.6 | 262.6 | 23.0 |
| | Ward 9 HRI | H9 | GERIATRIC MEDICINE | 30 | MEDIUM | 913.5 | 915 | 1841.3 | 2195.3 | 4.4 | 6.94 | -2.53 | 6.74 | -2.33 | 7.26 | 43.7% | -0.95 | -7.2% | 6.31 | 29.78 | 11.9% | 10.6% | 1.3% | 42.9% | 25.5% | 9.6% | 5.3% | 0.0% | 1.1% | 3.6% | 5.9% | 61.0 | 49.0 | 0.4 | 0.4 | 0.0 | 21.1% | 1.6% | 18.5 | 70.0 | 51.5 |
| | Ward 90 HRI | H90 | GERIATRIC MEDICINE | 29 | LOW | 252.0 | 889 | 1810.5 | 1872.9 | 4.1 | 6.94 | -2.80 | 6.74 | -2.60 | 1.11 | 6.7% | -0.95 | -7.2% | 0.16 | 29.78 | 2.9% | 2.6% | 0.3% | 98.5% | 20.6% | 3.6% | 10.9% | 2.5% | 1.3% | 0.9% | 1.4% | 54.0 | 41.0 | 0.3 | 0.2 | 0.1 | 8.1% | 0.4% | -47.8 | 53.5 | 101.3 |
| | Ward 11 HRI | H11 | STROKE / NEUROLOGY | 28 | MEDIUM | 126.0 | 856 | 1928.3 | 1913.7 | 4.5 | 7.55 | -3.06 | 7.41 | -2.92 | 4.89 | 21.7% | 0.76 | 7.1% | 5.65 | 33.16 | 8.2% | 8.2% | 0.0% | 41.0% | 26.9% | 7.7% | 9.7% | 2.5% | 0.3% | 3.2% | 3.5% | 72.0 | 49.0 | 0.2 | 0.2 | 0.0 | 21.3% | 1.5% | 57.0 | 94.0 | 37.0 |
| | Ward 110 HRI | H110 | STROKE / NEUROLOGY | 24 | LOW | 252.0 | 634 | 2760.5 | 2220.5 | 7.9 | 7.55 | 0.31 | 7.41 | 0.45 | 4.78 | 21.2% | -1.76 | -15.8% | 3.02 | 33.64 | 21.1% | 21.1% | 0.0% | 57.6% | 27.0% | 8.5% | 9.3% | 0.2% | 2.2% | 4.1% | 2.7% | 49.0 | 48.0 | 1.4 | 1.2 | 0.2 | 23.2% | 3.0% | -99.5 | 110.5 | 210.0 |
| | Cardiac Day Ward | CDU | CARDIOLOGY | 9 | LOW | 0.0 | 111 | 1256.3 | 176.5 | 12.9 | 7.93 | 4.98 | 7.73 | 5.18 | 1.45 | 11.3% | 0.15 | 5.1% | 1.60 | 15.74 | 0.0% | 0.0% | 0.0% | - | 41.8% | 5.7% | 24.7% | 0.6% | 0.4% | 3.0% | 7.4% | 47.0 | 38.0 | 0.0 | 0.0 | 0.0 | 51.8% | 1.0% | 0.0 | 0.0 | 0.0 |
| | Ward 26 + Hob | C26 | CARDIOLOGY / CTS | 26 | LOW | 236.5 | 991 | 2655.5 | 1055.5 | 3.7 | 8.46 | -4.72 | 9.93 | -6.19 | 2.00 | 7.8% | 0.25 | 3.2% | 2.25 | 33.73 | 5.5% | 5.5% | 0.0% | 61.5% | 26.2% | 9.0% | 9.7% | 0.0% | 0.7% | 2.9% | 3.9% | 70.0 | 51.0 | 0.1 | 0.0 | 0.1 | 20.8% | 6.4% | 106.5 | 160.5 | 54.0 |
| | Ward28/CMU | C28 /CMU | CARDIOLOGY | 27 | LOW | 277.2 | 726 | 4333.7 | 920.3 | 7.2 | 7.44 | -0.20 | 7.87 | -0.63 | 5.35 | 14.0% | 1.57 | 16.4% | 6.92 | 47.78 | 3.1% | 3.1% | 0.0% | 57.9% | 25.9% | 3.1% | 15.8% | 0.0% | 2.3% | 2.5% | 2.2% | 61.0 | 48.0 | 0.3 | 0.2 | 0.1 | 18.2% | 0.0% | -53.0 | 165.5 | 218.5 |
| SURGERY | Ward 4 HRI | H4 | NEUROSURGERY | 28 | LOW | 157.5 | 782 | 2575.5 | 1310.9 | 5.0 | 8.39 | -3.42 | 8.71 | -3.74 | 4.04 | 18.5% | 1.73 | 16.6% | 5.77 | 32.28 | 8.4% | 8.4% | 0.0% | 60.0% | 30.4% | 3.3% | 13.0% | 0.0% | 9.8% | 0.9% | 3.4% | 48.0 | 48.0 | 0.3 | 0.0 | 0.3 | 16.3% | -2.2% | 32.0 | 57.5 | 25.5 |
| | Ward 40 HRI | H40 | NEUROSURGERY / TRAUMA | 15 | MEDIUM | 105.0 | 388 | 2712.8 | 1389.3 | 10.6 | 8.39 | 2.18 | 8.71 | 1.86 | 3.86 | 18.5% | -1.02 | -9.2% | 2.84 | 31.95 | 13.7% | 7.9% | 5.8% | 70.9% | 29.6% | 6.5% | 15.0% | 0.3% | 0.1% | 2.0% | 5.7% | 45.0 | 45.0 | 0.3 | 0.3 | 0.0 | 8.4% | 0.4% | 48.0 | 112.5 | 64.5 |
| | Ward 6 HRI | H6 | GENERAL SURGERY | 28 | LOW | 283.5 | 694 | 2408.1 | 1585.3 | 5.8 | 6.99 | -1.24 | 7.26 | -1.51 | 1.91 | 10.0% | 1.06 | 10.0% | 2.97 | 29.74 | 10.8% | 10.5% | 0.3% | 60.5% | 26.9% | 10.2% | 13.3% | 0.3% | 1.6% | 1.5% | 0.0% | 86.0 | 66.0 | 0.1 | 0.1 | 0.0 | 8.4% | 2.7% | 12.0 | 39.5 | 27.5 |
| | Ward 60 HRI | H60 | GENERAL SURGERY | 28 | LOW | 126.0 | 768 | 2459.0 | 1761.5 | 5.5 | 6.99 | -1.49 | 7.26 | -1.76 | 0.36 | 1.9% | 1.97 | 18.5% | 2.33 | 34.89 | 9.6% | 8.7% | 0.9% | 76.2% | 24.1% | 4.6% | 8.1% | 0.7% | 0.1% | 4.1% | 6.5% | 82.0 | 74.0 | 0.0 | 0.0 | 0.0 | 6.3% | -1.5% | -15.5 | 28.0 | 43.5 |
| | Ward 7 HRI | H7 | VASCULAR SURGERY | 30 | MEDIUM | 283.5 | 849 | 2670.4 | 1753.5 | 5.2 | 6.99 | -1.78 | 7.26 | -2.05 | 2.75 | 12.6% | 1.09 | 8.3% | 3.84 | 29.74 | 7.4% | 7.1% | 0.3% | 45.5% | 26.2% | 2.4% | 10.5% | 0.3% | 5.4% | 0.6% | 7.0% | 53.0 | 52.0 | 0.2 | 0.1 | 0.1 | 14.1% | -2.3% | 29.2 | 61.0 | 31.8 |
| | Ward 100 HRI | H100 | GASTROENTEROLOGY | 27 | LOW | 239.4 | 817 | 2246.6 | 1872.7 | 5.0 | 6.63 | -1.59 | 6.29 | -1.25 | 0.52 | 2.7% | 1.94 | 16.0% | 2.46 | 31.23 | 4.1% | 4.1% | 0.0% | 45.4% | 21.9% | 4.7% | 13.4% | 0.3% | 0.3% | 1.0% | 2.2% | 67.0 | 67.0 | 0.1 | 0.1 | 0.0 | 10.8% | 5.1% | -19.0 | 11.0 | 30.0 |
| | Ward 12 HRI | H12 | ORTHOPAEDIC | 28 | LOW | 252.0 | 743 | 2502.3 | 1698.0 | 5.7 | 7.13 | -1.48 | 7.25 | -1.60 | 1.77 | 8.1% | -0.36 | -2.7% | 1.41 | 35.00 | 4.0% | 3.8% | 0.2% | 36.7% | 28.9% | 5.4% | 13.8% | 3.2% | 0.4% | 3.1% | 3.0% | 58.0 | 58.0 | 0.1 | 0.0 | 0.1 | 13.8% | 1.0% | 22.5 | 40.5 | 18.0 |
| | Ward 120 HRI | H120 | ORTHO / MAXFAX | 22 | LOW | 283.5 | 578 | 2319.8 | 1785.3 | 7.1 | 7.13 | -0.03 | 7.25 | -0.15 | 1.50 | 9.0% | 0.23 | 2.0% | 1.73 | 28.42 | 9.4% | 7.7% | 1.7% | 72.2% | 21.1% | 3.3% | 11.6% | 0.7% | 2.0% | 2.6% | 0.9% | 47.0 | 45.0 | 1.5 | 1.3 | 0.2 | 7.3% | 3.1% | 128.8 | 144.3 | 15.5 |
| | ICU HRI | HICU | CRITICAL CARE | 22 | LOW | 252.0 | 514 | 13195.2 | 1093.3 | 27.8 | 27.13 | 0.67 | 26.60 | 1.20 | 4.78 | 4.6% | -0.36 | -4.9% | 4.42 | 112.20 | 0.2% | 0.0% | 0.2% | 26.4% | 22.1% | 6.4% | 7.8% | 1.0% | 0.4% | 0.9% | 5.6% | 72.0 | 72.0 | 0.2 | 0.2 | 0.0 | 12.1% | 1.9% | 237.8 | 302.5 | 64.7 |
| | Ward 9 CHH | C9 | ORTHOPAEDIC | 35 | LOW | 252.0 | 609 | 2479.5 | 1425.0 | 6.4 | 7.13 | -0.72 | 7.25 | -0.84 | 3.37 | 15.4% | 1.47 | 12.7% | 4.84 | 33.39 | 6.9% | 6.9% | 0.0% | 39.6% | 32.4% | 14.8% | 13.0% | 0.0% | 0.9% | 1.1% | 2.6% | 65.0 | 62.0 | 0.0 | 0.0 | 0.0 | 22.3% | 1.4% | 5.0 | 40.5 | 35.5 |
| | Ward 10 CHH | C10 | GENERAL SURGERY | 21 | LOW | 252.0 | 573 | 2378.3 | 997.5 | 5.9 | 6.99 | -1.10 | 7.26 | -1.37 | 2.14 | 11.7% | 1.03 | 13.2% | 3.17 | 26.08 | 11.2% | 10.9% | 0.3% | 57.2% | 24.0% | 1.7% | 14.9% | 3.0% | 1.0% | 3.4% | 0.0% | 42.0 | 42.0 | 0.1 | 0.1 | 0.0 | 12.2% | -0.4% | 135.1 | 157.1 | 22.0 |
| | Ward 11 CHH | C11 | GENERAL SURGERY | 22 | LOW | 252.0 | 585 | 2335.3 | 962.3 | 5.6 | 6.99 | -1.35 | 7.26 | -1.62 | 0.72 | 4.0% | 1.79 | 22.9% | 2.51 | 26.08 | 1.3% | 1.3% | 0.0% | 18.2% | 16.5% | 1.4% | 13.4% | 0.1% | 0.9% | 0.7% | 0.0% | 55.0 | 43.0 | 0.1 | 0.1 | 0.0 | 12.8% | 5.2% | -14.0 | 28.0 | 42.0 |
| | Ward 14 CHH | C14 | GENERAL SURGERY | 27 | LOW | 252.0 | 527 | 2283.5 | 997.5 | 6.2 | 6.99 | -0.76 | 7.26 | -1.03 | 1.99 | 9.8% | 0.95 | 10.5% | 2.94 | 29.38 | 9.3% | 8.9% | 0.4% | 51.9% | 27.5% | 6.7% | 14.1% | 0.0% | 1.6% | 1.9% | 3.2% | 48.0 | 43.0 | 0.1 | 0.1 | 0.0 | 24.6% | 3.0% | 36.8 | 81.3 | 44.5 |
| | Ward 15 CHH | C15 | UROLOGY | 26 | MEDIUM | 283.5 | 694 | 2605.9 | 1362.3 | 5.7 | 6.47 | -0.75 | 6.67 | -0.95 | 1.26 | 6.1% | 0.41 | 3.4% | 1.67 | 32.71 | 13.3% | 8.3% | 5.0% | 59.7% | 29.1% | 8.3% | 9.5% | 0.0% | 0.2% | 0.8% | 10.3% | 34.0 | 34.0 | 0.3 | 0.1 | 0.2 | 12.7% | 0.8% | 75.3 | 81.3 | 6.0 |
| | Ward 27 CHH | C27 | CARDIOTHORACIC | 26 | LOW | 283.2 | 761 | 2869.8 | 1022.0 | 5.1 | 8.46 | -3.35 | 9.93 | -4.82 | 0.80 | 3.4% | -0.86 | -10.0% | -0.06 | 32.22 | 0.5% | 0.5% | 0.0% | 32.1% | 25.3% | 4.3% | 16.8% | 0.0% | 1.1% | 3.1% | 0.0% | 62.0 | 59.0 | 0.0 | 0.0 | 0.0 | 11.9% | 3.3% | 13.8 | 13.8 | 0.0 |
| | ICU CHH | CICU | CRITICAL CARE | 22 | MEDIUM | 157.5 | 489 | 10709.7 | 601.3 | 23.1 | 27.13 | -4.00 | 26.60 | -3.47 | 3.67 | 4.0% | 0.21 | 2.8% | 3.88 | 100.50 | 1.1% | 1.1% | 0.0% | 84.8% | 23.0% | 7.1% | 7.8% | 1.2% | 0.3% | 2.3% | 4.3% | 72.0 | 72.0 | 0.1 | 0.1 | 0.0 | 18.3% | 5.4% | -295.6 | 22.7 | 318.3 |
| FAMILY & WOMEN'S | Ward 16 CHH | C16 | BREAST / ENT / PLASTIC | 30 | LOW | 0.0 | 420 | 1951.8 | 1236.8 | 7.6 | 6.58 | 1.01 | 9.03 | -1.44 | 4.87 | 26.3% | 2.35 | 21.1% | 7.22 | 29.65 | 8.5% | 7.7% | 0.8% | 56.0% | 20.6% | 1.2% | 11.8% | 0.0% | 0.7% | 0.5% | 6.4% | 26.0 | 26.0 | 0.2 | 0.2 | 0.0 | 21.6% | 1.4% | -25.5 | 32.0 | 57.5 |
| | Ward 130 HRI | H130 | PAEDIATRICS | 20 | LOW | 205.8 | 440 | 2478.5 | 998.5 | 7.9 | 11.44 | -3.54 | 12.20 | -4.30 | -0.8 | -3.7% | 0.19 | 3.6% | -0.61 | 26.59 | 0.0% | 0.0% | 0.0% | - | 18.8% | 4.9% | 6.4% | 0.0% | 0.2% | 3.0% | 4.3% | 66.0 | 66.0 | 0.0 | 0.0 | 0.0 | 13.3% | 3.8% | -0.5 | 10.5 | 11.0 |
| | Cedar Ward | H30 CEDAR | GYNAECOLOGY | 9 | LOW | 0.0 | 307 | 1858.6 | 734.3 | 8.4 | 8.02 | 0.43 | 7.70 | 0.75 | 0.58 | 7.8% | 0.12 | 3.1% | 0.70 | 11.33 | 24.7% | 23.2% | 1.5% | 73.1% | 25.9% | 3.6% | 22.1% | 0.0% | 0.0% | 0.2% | 0.0% | 48.0 | 46.0 | 0.3 | 0.2 | 0.1 | 17.5% | 1.0% | 50.3 | 67.8 | 17.5 |
| | Maple Ward | H31 MAPLE | OBSTETRICS | 20 | LOW | 0.0 | 367 | 2165.3 | 1367.5 | 9.6 | 10.11 | -0.48 | 15.48 | -5.85 | 2.18 | 4.71% | 2.11 | 7.79% | 4.29 | 73.34 | 1.3% | 1.3% | 0.0% | 75.7% | 27.7% | 12.0% | 10.9% | 0.0% | 1.1% | 2.6% | 1.1% | 58.0 | 58.0 | 0.0 | 0.0 | 0.0 | 12.6% | 0.8% | 38.0 | 38.0 | 0.0 |
| | Rowan Ward | H33 ROWAN | OBSTETRICS | 38 | LOW | 0.0 | 1141 | 3052.2 | 1661.0 | 4.1 | 10.11 | -5.98 | 15.48 | -11.35 | | | | | | | 0.5% | 0.5% | 0.0% | 70.6% | 20.6% | 2.9% | 11.0% | 0.5% | 1.0% | 2.0% | 3.2% | 58.0 | 58.0 | 0.0 | 0.0 | 0.0 | 7.8% | 0.0% | -6.0 | 1.5 | 7.5 |
| | Acorn H34 | H34 ACORN | PAEDIATRIC SURGERY | 20 | LOW | 0.0 | 283 | 2463.9 | 482.5 | 10.4 | 9.11 | 1.30 | 11.01 | -0.60 | 1.78 | 8.6% | -0.5 | -9.6% | 1.28 | 26.00 | 1.5% | 1.5% | 0.0% | 71.5% | 27.6% | 9.0% | 13.8% | 0.0% | 1.0% | 3.8% | 0.0% | 68.0 | 66.0 | 0.0 | 0.0 | 0.0 | 16.4% | -1.7% | 19.0 | 19.0 | 0.0 |
| | Ward 35 HRI | H35 | OPHTHALMOLOGY | 12 | LOW | 285.6 | 311 | 1540.0 | 327.5 | 6.0 | 11.20 | -5.20 | 10.70 | -4.70 | 1.7 | 62.7% | 1.74 | 64.2% | 3.44 | 13.84 | 0.0% | 0.0% | 0.0% | 0.0% | 19.0% | 1.2% | 16.9% | 0.6% | 0.1% | 0.2% | 0.0% | 48.0 | 46.0 | 0.1 | 0.1 | 0.0 | 19.8% | 1.7% | -615.0 | 0.0 | 615.0 |
| | Labour Ward | LABOUR | MATERNITY | 16 | LOW | 369.5 | 277 | 5989.4 | 1270.0 | 26.2 | 10.11 | 16.10 | 15.48 | 10.73 | -6.96 | -50.8% | -2.11 | -15.4% | -9.07 | 63.84 | 0.9% | 0.9% | 0.0% | 97.5% | 22.8% | 10.4% | 7.0% | 0.2% | 1.2% | 2.3% | 1.7% | 58.0 | 58.0 | 0.3 | 0.3 | 0.0 | 5.3% | -3.5% | 52.5 | 54.0 | 1.5 |
| | NICU HRI | NEONATES | NEONATOLOGY | 26 | LOW | 157.5 | 547 | 7724.3 | 305.0 | 14.7 | 13.26 | 1.42 | 12.98 | 1.70 | 9.73 | 129.1% | 0.4 | 5.3% | 10.13 | 74.51 | 0.4% | 0.4% | 0.0% | 100.0% | 23.9% | 4.2% | 12.6% | 0.7% | 0.8% | 1.7% | 3.9% | 58.0 | 48.0 | 0.0 | 0.0 | 0.0 | 19.5% | 0.9% | -29.5 | 0.0 | 29.5 |
| | PAU | PAU | PAEDIATRICS | 10 | LOW | 0.0 | 96 | 1384.5 | 0.0 | 14.4 | 11.44 | 2.98 | 12.20 | 2.22 | 1.24 | 11.9% | 0 | 0.0% | 1.24 | 10.44 | 0.8% | 0.8% | 0.0% | 63.3% | 12.1% | 2.8% | 8.8% | 0.0% | 0.0% | 0.5% | 0.0% | 66.0 | 66.0 | 0.0 | 0.0 | 0.0 | 2.3% | 3.8% | 0.0 | 0.0 | 0.0 |
| | PHDU | PHDU | PAEDIATRICS | 4 | LOW | 0.0 | 70 | 1410.5 | 167.5 | 22.5 | 11.44 | 11.10 | 12.20 | 10.34 | 0.53 | 4.6% | 0 | 0.0% | 0.53 | 11.66 | 0.8% | 0.8% | 0.0% | 80.0% | 18.2% | 3.2% | 12.3% | 0.0% | 2.3% | 0.4% | 0.0% | 66.0 | 66.0 | 0.0 | 0.0 | 0.0 | 2.9% | -4.9% | 11.0 | 11.0 | 0.0 |
| CLINICAL SUPPORT | Ward 7 CHH | C7 | INFECTIOUS DISEASE | 12 | LOW | 157.5 | 295 | 1486.5 | 762.0 | 7.6 | 7.76 | -0.14 | 7.91 | -0.29 | -0.07 | -0.9% | -0.78 | -9.5% | -0.85 | 20.22 | 0.0% | 0.0% | 0.0% | 0.0% | 21.3% | 6.6% | 12.6% | 0.0% | 0.8% | 1.3% | 0.0% | 66.0 | 54.0 | 0.1 | 0.1 | 0.0 | 13.5% | -0.2% | -38.0 | 33.5 | 71.5 |
| | Ward 29 CHH | C29 | REHABILITATION | 15 | LOW | 147.0 | 460 | 1564.5 | 2248.5 | 8.3 | 7.69 | 0.60 | 6.66 | 1.63 | -0.16 | -1.0% | 2.59 | 16.4% | 2.43 | 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 | 2.0 | 1.0 | 1.0 | 4.1% | 2.3% | 74.5 | 85.5 | 11.0 |
| | Ward 30 CHH | C30 | CLINICAL ONCOLOGY | 22 | LOW | 220.5 | 617 | 1785.5 | 1129.8 | 4.7 | 7.92 | -3.20 | 7.14 | -2.42 | 0.42 | 5.3% | 0.19 | 2.4% | 0.61 | 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 | 0.1 | 0.0 | 0.1 | 6.6% | -4.1% | 21.3 | 53.8 | 32.5 |
| | Ward 31 CHH | C31 | CLINICAL ONCOLOGY | 27 | MEDIUM | 220.5 | 629 | 1954.1 | 1087.0 | 4.8 | 7.92 | -3.09 | 7.14 | -2.31 | 3.44 | 29.3% | 2.13 | 18.1% | 5.57 | 25.74 | 5.1% | 4.5% | 0.6% | 50.4% | 18.3% | 3.6% | 12.3% | 1.5% | 0.5% | 0.4% | 0.0% | 39.0 | 39.0 | 0.0 | 0.0 | | 9.0% | 0.1% | -12.0 | 38.0 | 50.0 |
| | Ward 32 CHH | C32 | CLINICAL ONCOLOGY | 22 | MEDIUM | 220.5 | 625 | 1808.0 | 1204.8 | 4.8 | 7.92 | -3.10 | 7.14 | -2.32 | 2.28 | 23.8% | -0.04 | -0.4% | 2.24 | 23.57 | 5.0% | 1.8% | 3.2% | 70.0% | 19.2% | 2.7% | 12.2% | 0.0% | 0.9% | 0.0% | 3.4% | 41.0 | 41.0 | 0.3 | 0.1 | 0.2 | 4.8% | -1.2% | 44.0 | 44.0 | 0.0 |
| | Ward 33 CHH | C33 | CLINICAL HAEMATOLOGY | 28 | MEDIUM | 220.5 | 666 | 2939.8 | 1233.6 | 6.3 | 8.21 | -1.94 | 7.23 | -0.96 | 0.8 | 10.0% | -2.03 | -25.4% | -1.23 | 35.44 | 2.8% | 2.3% | 0.5% | 65.9% | 31.7% | 3.3% | 7.7% | 0.2% | 1.3% | 0.6% | 18.6% | 40.0 | 39.0 | 0.1 | 0.0 | 0.1 | 13.8% | 1.6% | -102.5 | 5.0 | 107.5 |
| WARD | | | WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR | | TOTALS: | 10473.6 | 30234 | 140830.3 | 65183.1 | 6.81 | 8.84 | -35.66 | 9.25 | -55.74 | 129.72 | 10.2% | 27.28 | 5.4% | 164.08 | 1786.40 | 6.6% | 5.7% | 0.9% | 59.6% | 24.2% | 5.7% | 11.9% | 0.7% | 1.3% | 1.7% | 2.9% | 55.1 | 50.3 | 13.9 | 8.6 | 5.3 | 14.3% | 1.4% | 934.0 | 4018.6 | 3084.6 |

# HEY NURSE STAFFING QUALITY INDICATORS

FEBRUARY 2019
(Jan 19 activity) (YTD Apr 18 - Jan 19)

## 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 | MONTH | YTD | MONTH | YTD | MONTH | YTD | MONTH | YDT | MONTH | YTD | MONTH | YDT | MONTH | YTD | MONTH | YDT | MONTH | YTD | MONTH | YDT | MONTH | YTD | MONTH | YTD | MONTH | YDT | MONTH | YDT | RCA Outstanding |
| EAM | ED | ACUTE MEDICINE | NA | 83.5% | 88.1% | 91.8% | 91.0% | 91.9% | 88.3% | 90.1% | 84.3% | | | | | 0 | 0 | | | | | 101 | 966 | | | 12 | 103 | | | 2 | 28 | | | 20 | 238 | | 1 | 22 | 225 | | | 1 | 157 | 1560 | 0 | 1 | | 1 | 1 |
| | AMU | ACUTE MEDICINE | 45 | 84.6% | 87.7% | 92.5% | 94.4% | 95.8% | 90.1% | 76.1% | 97.2% | | | | | 0 | 0 | | | | | 13 | 80 | | | | 5 | | | | 2 | | | 6 | 32 | | 1 | 2 | 20 | | | | 21 | 139 | 0 | 1 | | 1 | |
| | H1 | ACUTE MEDICINE | 22 | 91.7% | 97.4% | 89.0% | 91.3% | 95.5% | 82.6% | 73.9% | 85.7% | | 1 | | | 0 | 1 | | | | | | 8 | | | | | | | | | | | | | | | | 1 | | | | 0 | 9 | 0 | 0 | | | |
| MEDICINE | EAU | ELDERLY MEDICINE | 21 | 96.8% | 85.5% | 97.3% | 97.1% | 97.1% | 91.2% | 82.4% | 97.0% | | 3 | | 5 | 0 | 8 | | | | | 16 | 99 | | | | 3 | | | 1 | 3 | | | 7 | 32 | | | | 21 | | | | 24 | 158 | 0 | 0 | | | |
| | H5 / RHOB | RESPIRATORY | 26 | 92.1% | 93.9% | 87.6% | 92.3% | 94.9% | 74.4% | 79.5% | 79.5% | | | | | 0 | 0 | | | | | | 7 | | 8 | | 1 | | | | | | | | 2 | | 3 | 2 | 2 | | 4 | 2 | 12 | 0 | 13 | | 10 | |
| | H50 | RENAL MEDICINE | 19 | 96.3% | 89.4% | 95.1% | 100.0% | 95.5% | 90.9% | 86.4% | 86.4% | | 1 | | | 0 | 1 | | | | | 2 | 12 | | 1 | | | | | | 1 | | | | 3 | 1 | 2 | 1 | 2 | | | | 3 | 18 | 1 | 3 | | 1 | |
| | H500 | RESPIRATORY | 24 | 88.5% | 92.3% | 83.7% | 75.0% | 95.8% | 83.3% | 79.2% | 75.0% | | 1 | | | 0 | 1 | | | | | 3 | 15 | | 2 | | | | | | | | | | 11 | | | | 7 | | | | 3 | 33 | 0 | 2 | | | |
| | H70 | ENDOCRINOLOGY | 30 | 67.9% | 87.5% | 84.9% | 88.9% | 63.0% | 74.1% | 59.3% | 96.3% | | | | | 0 | 0 | | | | | 1 | 13 | | 3 | | | | | | | | | | 1 | | | | 1 | 2 | | | 1 | 15 | 0 | 5 | | 5 | 1 |
| | H8 | ELDERLY MEDICINE | 27 | 93.8% | 87.9% | 87.7% | 87.5% | 93.8% | 75.0% | 75.0% | 90.3% | | 1 | | | 0 | 1 | | | | | 1 | 1 | | 5 | | | | | | | | 1 | 4 | | 2 | 1 | 1 | 1 | | | 3 | 6 | 0 | 8 | | 3 | 1 |
| | H80 | PDU | 27 | 93.6% | 91.7% | 94.6% | 84.8% | 93.9% | 90.9% | 90.9% | 81.3% | | 2 | 2 | 4 | 2 | 6 | | | | | | 2 | | 3 | | | | | | | | | | | 3 | | | | 3 | | 2 | 0 | 2 | 0 | 9 | | 4 | |
| | H9 | MEDICALLY READY FOR DISCHARGE | 30 | 88.1% | 90.6% | 86.9% | 88.2% | 76.5% | 82.4% | 61.8% | 70.6% | | 3 | | 2 | 0 | 5 | | | | | | 4 | | 1 | | | | | 1 | 1 | | | | | | | | | | | | 1 | 5 | 0 | 1 | | 3 | |
| | H90 | ELDERLY MEDICINE | 29 | 90.0% | 94.9% | 92.3% | 94.1% | 82.4% | 79.4% | 76.5% | 91.2% | | 1 | | 3 | 0 | 4 | | | | | | 6 | | 2 | | | | | | 2 | | | 2 | | 2 | | | | | | | 0 | 10 | 0 | 4 | | 2 | |
| | H11 | STROKE / NEURO | 28 | 62.1% | 87.2% | 90.3% | 90.0% | 83.3% | 80.0% | 70.0% | 73.3% | | 3 | | 1 | 0 | 4 | | | | | | 4 | | 4 | | | | | | | | | | | 1 | 1 | | | | | | 1 | 5 | 0 | 5 | | 3 | |
| | H110 | STROKE / NEURO | 24 | 81.3% | 91.5% | 88.4% | 86.5% | 75.7% | 89.2% | 73.0% | 78.4% | | | | 1 | 0 | 1 | | | | | 2 | 11 | | 2 | | 3 | | 1 | | | | | 2 | 1 | 4 | | | 1 | | | 1 | 2 | 16 | 1 | 8 | | | |
| | CDU | CARDIOLOGY | 9 | 85.7% | 75.0% | 83.3% | 82.4% | 88.2% | 76.5% | 52.9% | 64.7% | | | | | 0 | 0 | | | | | 1 | 4 | | | | | | | | | | | | | | | | | | | | 1 | 4 | 0 | 0 | | | |
| | C26 | CARDIOLOGY | 26 | 40.5% | 98.3% | 86.9% | 91.9% | 94.6% | 78.4% | 70.3% | 73.0% | | 1 | | 1 | 0 | 2 | | | | | | 1 | | 5 | | | | | | | | | 1 | | 1 | | | 1 | | | 1 | 2 | 0 | 7 | | 5 | |
| | C28 /CMU | CARDIOLOGY | 27 | 68.1% | 86.7% | 90.1% | 84.8% | 95.7% | 84.8% | 87.0% | 73.9% | | | | | 0 | 0 | | | | | | 5 | | 7 | | | | | | | | | | | | | | 1 | | | | 0 | 6 | 0 | 7 | | 5 | |
| SURGERY | H4 | NEURO SURGERY | 28 | 86.2% | 88.7% | 83.7% | 81.8% | 87.9% | 84.8% | 75.8% | 75.8% | | 1 | | | 0 | 1 | | | | | | 8 | | 2 | | 1 | | | | | | | | | | 1 | 2 | | 1 | | 1 | 1 | 11 | 0 | 3 | | 2 | |
| | H40 | NEURO / TRAUMA | 15 | 85.3% | 88.6% | 89.7% | 93.9% | 81.8% | 84.8% | 69.7% | 84.8% | | | | | 0 | 0 | | | | | | 4 | | 3 | | | | | | | | | | | | | | 1 | | | 5 | 0 | 5 | 0 | 6 | | 3 | |
| | H6 | ACUTE SURGERY | 28 | 78.1% | 96.5% | 86.4% | 93.5% | 83.9% | 71.0% | 77.4% | 87.1% | | 1 | | | 0 | 1 | | | | | | 3 | 1 | 2 | | | | | | | | | | 3 | 1 | 1 | | | | | | 0 | 6 | 2 | 3 | 2 | 2 | |
| | H60 | ACUTE SURGERY | 28 | 87.9% | 94.9% | 79.8% | 87.5% | 96.9% | 62.5% | 68.8% | 68.8% | | | | | 0 | 0 | | | | | 1 | 6 | | | | | | | | 1 | | | | 1 | | | | | | | 1 | 8 | 0 | 0 | | | |
| | H7 | VASCULAR SURGERY | 30 | 88.6% | 96.9% | 89.1% | 97.4% | 78.9% | 76.3% | 71.1% | 92.1% | | 1 | | | 0 | 1 | | | | | 3 | 36 | 1 | 3 | | 2 | | | | | | | | 2 | 2 | 6 | 1 | 16 | | 1 | 4 | 4 | 56 | 3 | 10 | 2 | 6 | |
| | H100 | GASTRO | 24 | 80.7% | 93.6% | 86.2% | 82.9% | 80.0% | 82.9% | 82.9% | 60.0% | | | | | 0 | 0 | | | | | | 4 | | 9 | | | | | | | | | | | 2 | | | | | 2 | 0 | 4 | 0 | 11 | | 8 | |
| | H12 | ORTHOPAEDIC | 28 | 89.5% | 97.2% | 96.1% | 94.9% | 97.4% | 97.4% | 94.9% | 92.3% | | | | | 0 | 0 | | | | | 1 | 5 | | 4 | | | | 1 | 1 | 1 | | | | 4 | | 1 | | | | 2 | 2 | 10 | 0 | 6 | | 3 | 1 |
| | H120 | ORTHO / MAXFAX | 22 | 86.2% | 94.5% | 94.3% | 93.5% | 96.8% | 80.6% | 90.3% | 96.8% | | | | | 0 | 0 | | | | | | 8 | | 6 | | | | | | | | | | 1 | | 2 | | 3 | | 2 | 4 | 0 | 12 | 0 | 10 | | 4 | |
| | HICU | CRITICAL CARE | 22 | 80.8% | 92.9% | 90.7% | 91.1% | 94.4% | 87.1% | 78.2% | 85.5% | | | | | 0 | 0 | | | | | 2 | 5 | | 2 | | | | | | | | | | 2 | 2 | 9 | | 1 | | 1 | 6 | 2 | 8 | 2 | 12 | 1 | 4 | |
| | C9 | ORTHOPAEDIC | 35 | 92.3% | 94.2% | 91.7% | 85.0% | 92.5% | 80.0% | 67.5% | 90.0% | | | | | 0 | 0 | | | | | 1 | 4 | 2 | 5 | | | | | | | | | | 1 | | 1 | | | | | | 1 | 5 | 2 | 6 | | | |
| | C10 | COLORECTAL | 21 | 87.0% | 84.3% | 82.9% | 87.0% | 87.0% | 69.6% | 95.7% | 69.9% | | | | | 0 | 0 | | | | | | 2 | | 1 | | | | | | | | | | | | 2 | | | | | 0 | 2 | 0 | 3 | | | |
| | C11 | COLORECTAL | 22 | 100.0% | 90.7% | 89.7% | 93.1% | 93.1% | 72.4% | 96.6% | 89.7% | | | | | 0 | 0 | | | | | | 1 | | | | 2 | | | | 1 | | | | 1 | | | | 1 | | | 0 | 6 | 0 | 0 | | | |
| | C14 | UPPER GI | 27 | 100.0% | 93.3% | 81.6% | 93.9% | 87.9% | 57.6% | 84.8% | 78.8% | | | | | 0 | 0 | | | | | | | | 2 | | | | | | | | | | | | 1 | | | | | 0 | 0 | 0 | 3 | | | |
| | C15 | UROLOGY | 26 | 64.0% | 77.8% | 82.9% | 83.9% | 77.4% | 74.2% | 67.7% | 83.9% | | 1 | | | 0 | 1 | | | | | | 10 | | 2 | | 2 | | | | 1 | | | | 2 | 1 | 5 | | 5 | | 2 | | 0 | 20 | 1 | 9 | 1 | 4 | 3 |
| | C27 | CARDIOTHORACIC | 26 | 94.6% | 91.8% | 89.5% | 91.7% | 86.1% | 75.0% | 72.2% | 86.1% | | | | | 0 | 0 | | | | | | 2 | | 1 | | | | | | | | | | 1 | | | | 1 | | | 0 | 4 | 0 | 1 | | 1 | |
| | CICU | CRITICAL CARE | 22 | 83.3% | 88.6% | 91.6% | 89.4% | 95.1% | 86.5% | 81.6% | 91.3% | | | | | 0 | 0 | | | | | 1 | 2 | | 2 | | | | | | | | | | 1 | | 4 | | 1 | | 3 | 1 | 3 | 0 | 7 | | | |
| FAMILY & WOMEN'S | C16 | ENT / BREAST | 30 | 96.4% | 93.4% | 96.3% | 100.0% | 82.8% | 86.2% | 86.2% | 96.6% | | | | | 0 | 0 | | | | | 1 | 1 | | | | | | | | | | | | | 1 | 1 | | | | | 1 | 1 | 1 | 1 | 1 | 1 | |
| | H130 | PAEDS | 20 | 87.9% | 85.6% | 93.0% | 100.0% | 77.4% | 97.0% | 69.7% | 67.7% | | | | | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | H30 CEDAR | GYNAECOLOGY | 9 | 81.5% | 100.0% | 96.3% | 100.0% | 100.0% | 95.7% | 82.6% | 91.3% | | | 1 | | 1 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | H31 MAPLE | MATERNITY | 20 | 94.9% | 94.5% | 94.5% | 92.7% | 84.1% | 82.9% | 93.9% | 90.2% | | | | | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | H33 ROWAN | MATERNITY | 38 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | H34 ACORN | PAEDS SURGERY | 20 | 96.7% | 80.2% | 97.2% | 96.7% | 100.0% | 93.3% | 86.7% | 85.2% | | | | | 0 | 0 | | | | | | | 1 | 1 | | | | | | | | | | | | | | | | | | 0 | 0 | 1 | 1 | 1 | 1 | |
| | H35 | OPHTHALMOLOGY | 12 | 93.8% | 94.8% | 97.4% | 94.4% | 94.4% | 77.8% | 94.4% | 100.0% | | | | | 0 | 0 | | | | | | 5 | | 2 | | | | | 0 | 1 | | | | | | | | | | | | 0 | 6 | 0 | 2 | | 1 | |
| | LABOUR | MATERNITY | 16 | 80.9% | 97.4% | 90.5% | 94.4% | 93.3% | 86.7% | 86.7% | 77.8% | | | | | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | NEONATES | CRITICAL CARE | 26 | 93.3% | 84.7% | 94.2% | 93.8% | 88.9% | 90.1% | 91.4% | 95.1% | | | | | 0 | 0 | | | | | | | | 1 | | | | | | | | | | | | | | | | | 1 | 0 | 0 | 0 | 1 | | |
| | PAU | PAEDS | 10 | 100.0% | 95.8% | 97.0% | 100.0% | 100.0% | 100.0% | 84.6% | 92.3% | | | | | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| | PHDU | CRITICAL CARE | 4 | 92.9% | 88.7% | 95.6% | 100.0% | 100.0% | 92.9% | 85.7% | 92.3% | | | | | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | | | |
| CLINICAL SUPPORT | C7 | INFECTIOUS DISEASE | 19 | 76.2% | 100.0% | 95.2% | 100.0% | 90.5% | 100.0% | 81.0% | 90.5% | | | | | 0 | 0 | | | | | | 2 | | 2 | | | | | | | | | | | | | | | | | | 0 | 2 | 0 | 2 | | | |
| | C29 | REHABILITATION | 15 | 60.7% | 97.6% | 92.0% | 80.8% | 84.6% | 80.8% | 80.8% | 73.1% | | 1 | | | 0 | 1 | | | | | | | | 5 | | | | | | | | | | | | | | 1 | | 1 | | 0 | 0 | 0 | 6 | | 4 | |
| | C30 | ONCOLOGY | 22 | 94.4% | 77.7% | 90.5% | 100.0% | 88.0% | 92.0% | 76.0% | 92.0% | | | | 1 | 0 | 1 | | | | | 4 | 35 | 1 | 6 | | | | | | | | | | 6 | | 3 | 1 | 8 | | 1 | 1 | 5 | 49 | 1 | 10 | | 2 | 1 |
| | C31 | ONCOLOGY | 27 | 77.3% | 94.0% | 84.0% | 75.0% | 100.0% | 79.2% | 75.0% | 100.0% | | | | | 0 | 0 | | | | | 2 | 25 | | 2 | | | | | 0 | 2 | | | 1 | 14 | | 4 | 3 | 21 | | | | 6 | 62 | 0 | 6 | 1 | 1 | 1 |
| | C32 | ONCOLOGY | 22 | 60.0% | 93.9% | 93.6% | 95.7% | 100.0% | 91.3% | 82.6% | 95.7% | | 2 | | | 0 | 2 | | | | | 2 | 34 | | | | 1 | | | 0 | 1 | | | 1 | 2 | | 2 | 1 | 1 | | 1 | | 4 | 39 | 0 | 3 | | 1 | |
| | C33 | HAEMATOLOGY | 28 | 81.1% | 95.5% | 88.6% | 76.2% | 100.0% | 83.3% | 81.0% | 78.6% | | | | | 0 | 0 | | | | | 1 | 14 | 2 | 3 | | | | | | | | | | | 5 | | 1 | | 5 | | 1 | | 1 | 24 | 2 | 5 | | 2 | |
| TOTALS : | | | | 84.8% | 91.1% | 90.3% | 91.0% | 90.1% | 83.3% | 79.5% | 84.7% | 0 | 24 | 3 | 18 | 3 | 42 | 0 | 0 | 0 | 0 | 159 | 1454 | 8 | 109 | 12 | 123 | 0 | 2 | 5 | 45 | 0 | 0 | 36 | 374 | 9 | 68 | 36 | 347 | 0 | 22 | 0 | 39 | 248 | 2343 | 17 | 201 | 9 | 93 | 9 |

## APPENDIX Three - Nursing workforce model

| Expected Turnover Percentage | 10% |
|---|---|

| | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 | 25/26 |
|---|---|---|---|---|---|---|---|---|---|
| Budgeted establishment | 2138 | 2138 | 2138 | 2138 | 2138 | 2138 | 2138 | 2138 | 2138 |
| Average in post | 1946 | 1946 | 1957 | 2000 | 2052 | 2129 | 2173 | 2218 | 2253 |
| Expected turnover in year | 0 | -221 | -196 | -200 | -205 | -213 | -217 | -222 | -225 |
| Additional turnover - special class leaving peak | | | -20 | | | | | | |
| Impact of bursary withdrawal on new entrants | | | | | | | | | |
| Attrition for other reasons e.g. ACP | | | -10 | -10 | -10 | -10 | -10 | -10 | -10 |
| Expected level of University entrants | 0 | 116 | 140 | 140 | 140 | 140 | 140 | 140 | 140 |
| Return to work scheme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other (non- university) recruitment | 0 | 83 | 97 | 97 | 97 | 97 | 97 | 97 | 97 |
| overseas nurses | 0 | 33 | 15 | 10 | 0 | 0 | 0 | 0 | 0 |
| Nurse associates | 0 | 0 | 17 | 15 | 40 | 15 | 20 | 15 | 20 |
| Nurse apprentices | 0 | 0 | 0 | 0 | 15 | 15 | 15 | 15 | 15 |
| In post at end of year | 1946 | 1957 | 2000 | 2052 | 2129 | 2173 | 2218 | 2253 | 2290 |
| Average vacancies at start of year | 192 | 192 | 181 | 138 | 86 | 9 | -35 | -80 | -115 |
| Closing vacancies | 192 | 181 | 138 | 86 | 9 | -35 | -80 | -115 | -152 |
| Increase/(Decrease) in vacancies in year | 0 | -11 | -43 | -52 | -77 | -44 | -45 | -35 | -37 |
| Accumulative yearly increase | | -11 | -54 | -106 | -183 | -227 | -272 | -307 | -344 |

# Nursing Establishment Review 2019/20 - Appendix Five

| SURGERY GENERAL INFORMATION | | | | CURRENT ESTABLISHMENT [Budgeted WTE ] [1] | | | | EVIDENCE BASED STAFFING TOOL | Required CHPPD | PROFESSIONAL VIEW [WTE] | | | | REQUIREMENT (WTE) | | | | EXTRA BUDGET REQUIRED [£] -ve figures = additional funds required [inclusive of 28% uplift] | | | | | COMMENTS [Reasons for variances, decision, etc.] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HEALTH GROUP | WARD / DEPT | BEDS | SPECIALITY | RN | Non-RN | Support Staff | TOTAL | | | RN | Non-RN | Support Staff | TOTAL | RN | Non-RN | Support Staff | Planned CHPPD | Extra RN £ | RN funding for additional B6 | Extra Non-RN £ | Extra Support Staff £ | TOTAL £ | |
| SHG | HICU | 22 | Critical Care | 104.78 | 7.32 | 1.18 | 113.28 | SNCT | 15.12 | 104.88 | 7.32 | 1.18 | 113.38 | 0.10 | 0 | 0 | 29.4 | -3,320 | 0 | 0 | 0 | -3,320 | Minor rota adjustment |
| SHG | H4 | 30 | Neurosurgery | 21.84 | 10.44 | 1.00 | 33.28 | SNCT | 5.89 | 21.59 | 10.44 | 1 | 33.03 | -0.25 | 0 | 0 | 5.7 | 8,300 | -8,300 | 0 | 0 | 0 | Band 6 Uplift |
| SHG | H40 | 15 | Neurosurgery | 21.61 | 9.3 | 2.24 | 33.15 | SNCT | 8.02 | 21.36 | 9.3 | 2.24 | 32.9 | -0.25 | 0 | 0 | 11.4 | 8,300 | -8,300 | 0 | 0 | 0 | Band 6 Uplift |
| SHG | H6 | 26 | Acute Surgery | 19.11 | 11.8 | 1.43 | 32.34 | SNCT | 5.04 | 19.21 | 11.8 | 1.43 | 32.44 | 0.10 | 0 | 0 | 6 | -3,320 | -8,300 | 0 | 0 | -11,620 | Additional Band 6 funded plus rota adjustment to support short shifts |
| SHG | H60 | 26 | Acute Surgery | 19.11 | 11.8 | 1.43 | 32.34 | SNCT | 5.24 | 19.21 | 11.8 | 1.43 | 32.44 | 0.10 | 0 | 0 | 5.7 | -3,320 | -8,300 | 0 | 0 | -11,620 | Additional Band 6 funded plus rota adjustment to support short shifts |
| SHG | H7 | 29 | Vascular | 21.84 | 13.16 | 1.67 | 36.67 | SNCT | 4.61 | 24.09 | 10.67 | 1.67 | 36.43 | 2.25 | -2.49 | 0 | 5.9 | -74,700 | 0 | 56,262 | 0 | -18,438 | Introduction of Hob funded through overall SHG rota savings and additonal Non- AIC activity income, to prevent cancellations due to lack of ICU capacity. |
| SHG | H12 | 28 | Orthopaedic | 21.84 | 13.16 | 1.53 | 36.53 | SNCT | 6.73 | 21.59 | 13.16 | 1.53 | 36.28 | -0.25 | 0 | 0 | 7.5 | 8,300 | -8,300 | 0 | 0 | 0 | Band 6 Uplift |
| SHG | H120 | 22 | MaxFax / Ortho | 16.62 | 11.8 | 1.53 | 29.95 | SNCT | 6.52 | 16.37 | 11.8 | 1.53 | 29.7 | -0.25 | 0 | 0 | 6.5 | 8,300 | -8,300 | 0 | 0 | 0 | Band 6 Uplift |
| SHG | H100 | 23 | Gastroenterology | 18.49 | 14.52 | 1.89 | 34.9 | SNCT | 4.92 | 19.68 | 13.16 | 1.49 | 34.33 | 1.19 | -1.36 | -0.4 | 6 | -39,508 | 0 | 30,729 | 9,107 | 328 | Rota adjustments from professional skill mix review |
| SHG | CICU | 22 | Critical Care | 92.94 | 7.56 | 1.18 | 101.68 | SNCT | 16.62 | 87.76 | 7.32 | 1.18 | 96.26 | -5.18 | -0.24 | 0 | 25.8 | 171,976 | 0 | 5,423 | 0 | 177,399 | Adjusted for activity based on three years of activity data (Jan 2016 - Jan 2019) data source ICNARC |
| SHG | C9 | 29 | Orthopaedic | 21.77 | 12.63 | 1.80 | 36.2 | SNCT | 4.8 | 21.88 | 12.91 | 1.8 | 36.59 | 0.11 | 0.28 | 0 | 7.7 | -3,652 | 0 | -6,327 | 0 | -9,979 | Rota adjustments to support short shift provision |
| SHG | C10 | 21 | Colorectal | 18.25 | 7.83 | 1.00 | 27.08 | SNCT | 6.44 | 18.09 | 8.06 | 1 | 27.15 | -0.16 | 0.23 | 0 | 6.1 | 5,312 | -8,300 | -5,197 | 0 | -8,185 | Band 6 Uplift/ Shift pattern enhanced at a weekend to support theatre activity at the end of the week. |
| SHG | C11 | 22 | Colorectal | 19.27 | 7.83 | 1.00 | 28.1 | SNCT | 6.23 | 20.57 | 8.06 | 1 | 29.63 | 1.30 | 0.23 | 0 | 6.6 | -43,160 | 0 | -5,197 | 0 | -48,357 | Support change in case mix activity, ie, acuity of Gynae oncology patients, through the provision of increased Hob capacity. |
| SHG | C14 | 27 | Upper GI | 20.32 | 9.16 | 1.33 | 30.81 | SNCT | 5.24 | 20.07 | 9.76 | 1.33 | 31.16 | -0.25 | 0.6 | 0 | 7.8 | 8,300 | -8,300 | -13,557 | 0 | -13,557 | Uplift for additional Band 6 and skill mix review at the weekend to support theatre activity at the end of the week |
| SHG | C15 | 26 | Urology | 19.71 | 10.44 | 1.67 | 31.82 | SNCT | 5.23 | 20.57 | 10.44 | 1.67 | 32.68 | 0.86 | 0 | 0 | 6 | -28,552 | -8,300 | 0 | 0 | -36,852 | Uplift for additional Band 6 and skill mix review at the weekend to support additional weekend theatre lists /reduce current variable pay |
| SHG | C27 | 26 | Cardiothoracic | 23.73 | 8.62 | 2.00 | 34.35 | SNCT | 5.59 | 23.62 | 8.62 | 2 | 34.24 | -0.11 | 0 | 0 | 5.7 | 3,652 | 0 | 0 | 0 | 3,652 | Rota efficiency |
| | | | | **481.23** | **167.37** | **23.88** | **672.48** | | **7 (AVG)** | **480.54** | **164.62** | **23.48** | **668.64** | **-0.69** | **-2.75** | **-0.4** | **9.4 (AVG)** | **22,908** | **-74,700** | **62,136** | **9,107** | **19,451** | |

| MEDICINE GENERAL INFORMATION | | | | CURRENT ESTABLISHMENT [Budgeted WTE ] [1] | | | | EVIDENCE BASED STAFFING TOOL | Required CHPPD | PROFESSIONAL VIEW [WTE] | | | | REQUIREMENT (WTE) | | | | EXTRA BUDGET REQUIRED [£] -ve figures = additional funds required [inclusive of 28% uplift] | | | | | COMMENTS [Reasons for variances, decision, etc.] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HEALTH GROUP | WARD / DEPT | BEDS | SPECIALITY | RN | Non-RN | Support Staff | TOTAL | | | RN | Non-RN | Support Staff | TOTAL | RN | Non-RN | Support Staff | Planned CHPPD | Extra RN £ | RN funding for additional B6 | Extra Non-RN £ | - | TOTAL £ | |
| MHG | ED | NA | Acute Medicine | 84.01 | 18.88 | 6.60 | 109.49 | NICE | N/A | 84.64 | 21.1 | 8.58 | 114.32 | 0.63 | 2.22 | 1.98 | N/A | -20,916 | 0 | -50,161 | 0 | -71,077 | Uplift to support progress chaser in Emergency Care/24 hour Transfer Nurse provision to support the delivery of the 4 hour access target. |
| MHG | AMU | 45 | Acute Medicine | 44.19 | 23.58 | 1.14 | 68.91 | SNCT | 5.94 | 44.19 | 23.38 | 2.14 | 69.71 | 0.00 | -0.2 | 1 | 7.8 | 0 | 0 | 4,519 | 0 | 4,519 | Rota Efficiency |
| MHG | P/L | | Acute Medicine | 2.6 | 4.77 | - | 7.37 | N/A | N/A | 2.72 | 5.94 | 1.77 | 10.43 | 0.12 | 1.17 | 1.77 | N/A | -3,984 | | -26,436 | -44,250 | -74,670 | 24 hour cover for Patient Lounge/own porter provision - to support Patient Flow and release Winter planning money. |
| MHG | ACU | | Acute Medicine | 7.01 | 5.27 | - | 12.28 | N/A | N/A | 7.39 | 4.67 | 0 | 12.06 | 0.38 | -0.6 | 0 | N/A | -12,616 | 0 | 13,557 | 0 | 941 | Uplift to support extended working hours to supoort Patient Flow. |
| MHG | EAU | 21 | Elderly | 19.11 | 14.96 | 2.39 | 36.46 | SNCT | 6.18 | 19.11 | 13.16 | 2.39 | 34.66 | 0.00 | -1.8 | 0 | 6.8 | 0 | 0 | 40,671 | 0 | 40,671 | Rota Efficiency |
| MHG | H36 | 24 | Acute Medicine | 14.43 | 7.94 | 2.80 | 25.17 | SNCT | 4.98 | 13.65 | 7.94 | 2.8 | 24.39 | -0.78 | 0 | 0 | 5.7 | 25,896 | 0 | 0 | 0 | 25,896 | Rota Efficiency |
| MHG | H5 | 26 | Respiratory | 24.68 | 13.16 | 1.53 | 39.37 | SNCT | 6.2/8.48 | 24.09 | 13.16 | 1.53 | 38.78 | -0.59 | 0 | 0 | 6 | 19,588 | 0 | 0 | 0 | 19,588 | Rota Efficiency |
| MHG | H500 | 24 | Respiratory | 16.96 | 12.1 | 1.80 | 30.86 | SNCT | 5.68 | 16.37 | 13.16 | 1.8 | 31.33 | -0.59 | 1.06 | 0 | 5.9 | 19,588 | -8,300 | -23,951 | 0 | -12,663 | Increase in non registered nurse to support day shift/uplift for additional band 6 |
| MHG | H50 | 19 | Renal | 15.11 | 8.43 | 1.80 | 25.34 | SNCT | 5.76 | 14.86 | 7.94 | 1.8 | 24.6 | -0.25 | -0.49 | 0 | 5.8 | 8,300 | -8,300 | 11,072 | 0 | 11,072 | Uplift for additional band 6 |
| MHG | H70 | 30 | Endocrinology | 19.53 | 12.16 | 2.80 | 34.49 | SNCT | 5.04 | 21.59 | 13.16 | 2.8 | 37.55 | 2.06 | 1 | 0 | 5.6 | -68,392 | 0 | -22,595 | 0 | -90,987 | Uplift in registered nurses and non - registered to support patient acuity |
| MHG | H8 | 27 | Elderly | 16.62 | 13.16 | 0.88 | 30.66 | SNCT | 4.48 | 16.37 | 13.16 | 0.88 | 30.41 | -0.25 | 0 | 0 | 5 | 8,300 | -8,300 | 0 | 0 | 0 | Net saving required to fund additional band 6. |
| MHG | H80 | 27 | Elderly | 16.62 | 13.16 | 8.70 | 38.48 | SNCT | 4 | 10.93 | 15.89 | 8.7 | 35.52 | -5.69 | 2.73 | 0 | 4.4 | 188,908 | 0 | -61,684 | 0 | 127,224 | Progress to Discharge Model Embedded |
| MHG | H11 | 28 | Neurology / Stroke | 20.02 | 13.36 | 1.91 | 35.29 | SNCT | 5.8 | 21.59 | 10.44 | 1.91 | 33.94 | 1.57 | -2.92 | 0 | 5.4 | -52,124 | -8,300 | 65,977 | 0 | 5,553 | Skill Mix Review increase in Registered from Non Registered Additional Band 6 |
| MHG | H110 | 24 | Stroke | 25.52 | 11.12 | 2.40 | 39.04 | SNCT | 6.02/5.14 | 27.28 | 10.44 | 2.4 | 40.12 | 1.76 | -0.68 | 0 | 8.5 | -58,432 | 0 | 15,365 | 0 | -43,067 | Phase 2 of Business Case for increased HASU capacity, monies to be agreed and released to support the requiured investment. |
| MHG | H9 | 31 | Elderly | 16.62 | 13.16 | 0.88 | 30.66 | SNCT | 4.81 | 16.37 | 15.66 | 0.88 | 32.91 | -0.25 | 2.5 | 0 | 4.7 | 8,300 | -8,300 | -56,488 | 0 | -56,488 | Uplift for additional band 6/Uplift in non registered nurses due to high number of falls during the night. |
| MHG | H90 | 29 | Elderly | 16.62 | 13.16 | 0.53 | 30.31 | SNCT | 4.43 | 16.37 | 13.16 | 0.53 | 30.06 | -0.25 | 0 | 0 | 4.8 | 8,300 | -8,300 | 0 | 0 | 0 | Uplift for additional band 6 |
| MHG | C26 | 26 | Cardiology | 25.79 | 8.94 | 1.00 | 35.73 | SNCT | 5.48 | 24.09 | 7.94 | 1 | 33.03 | -1.70 | -1 | 0 | 4.6 | 56,440 | -8,300 | 22,595 | 0 | 70,735 | Uplift for additional band 6/Rota efficiency |
| MHG | C28 | 27 | Cardiology | 38.18 | 9.6 | 1.80 | 49.58 | SNCT | 5.97 | 37.98 | 8.06 | 1.8 | 47.84 | -0.20 | -1.54 | 0 | 8.9 | 6,640 | 0 | 34,796 | 0 | 41,436 | Rota Efficiency |
| MHG | CDU | 11 | Cardiology | 12.81 | 2.44 | - | 15.25 | SNCT | N/A | 12.81 | 2.44 | 0 | 15.25 | 0.00 | 0 | 0 | 16.1 | 0 | 0 | 0 | 0 | 0 | Cardiac Day Unit does not submit patient acuity |
| | | | | **436.43** | **219.35** | **38.96** | **694.74** | | **5.26 (AVG)** | **432.4** | **220.8** | **43.71** | **696.91** | **-4.03** | **1.45** | **4.75** | **6.6 (AVG)** | **133,796** | **-58,100** | **-32,763** | **-44,250** | **-1,317** | |

| CLINICAL SUPPORT GENERNAL INFORMATION | | | | CURRENT ESTABLISHMENT [Budgeted WTE ] [1] | | | | EVIDENCE BASED STAFFING TOOL | Required CHPPD | PROFESSIONAL VIEW [WTE] | | | | REQUIREMENT (WTE) | | | | EXTRA BUDGET REQUIRED [£] -ve figures = additional funds required [inclusive of 28% uplift] | | | | | COMMENTS [Reasons for variances, decision, etc.] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HEALTH GROUP | WARD / DEPT | BEDS | SPECIALITY | RN | Non-RN | Support Staff | TOTAL | | | RN | Non-RN | Support Staff | TOTAL | RN | Non-RN | Support Staff | Planned CHPPD | Extra RN £ | RN funding for additional B6 | Extra Non-RN £ | Extra Support Staff £ | TOTAL £ | |
| CS | C7 | 15 | Infectious Disease | 11.46 | 7.94 | 1.00 | 20.4 | SNCT | 4.78 | 11.46 | 7.94 | 1 | 20.4 | 0.00 | 0 | 0 | 9.4 | 0 | 0 | 0 | 0 | 0 | |
| CS | C29 | 15 | Rehabilitation | 11.85 | 15.66 | 0.53 | 28.04 | SNCT | 5.37 | 12.63 | 15.66 | 0.53 | 28.82 | 0.78 | 0 | 0 | 8.4 | -25,896 | -8,300 | 0 | 0 | -34,196 | Uplift for Band 6 and skill review to support increasing acuity. |
| CS | C30 | 22 | Oncology | 13.89 | 7.94 | 1.50 | 23.33 | SNCT | 4.79 | 13.64 | 7.94 | 1.5 | 23.08 | -0.25 | 0 | 0 | 5 | 8,300 | -8,300 | 0 | 0 | 0 | |
| CS | C31 | 27 | Oncology | 17.75 | 10.44 | 1.50 | 29.69 | SNCT | 5.86 | 17.5 | 10.44 | 1.5 | 29.44 | -0.25 | 0 | 0 | 6.3 | 8,300 | -8,300 | 0 | 0 | 0 | |
| CS | C32 | 22 | Oncology | 13.89 | 7.94 | 1.50 | 23.33 | SNCT | 5.16 | 13.64 | 7.94 | 1.5 | 23.08 | -0.25 | 0 | 0 | 5.1 | 8,300 | -8,300 | 0 | 0 | 0 | |
| CS | C33 | 28 | Haematology | 27.28 | 7.94 | 1.50 | 36.72 | SNCT | 5.3 | 27.28 | 7.94 | 1.5 | 36.72 | 0.00 | 0 | 0 | 7.5 | 0 | 0 | 0 | 0 | 0 | |
| | | | | **96.12** | **57.86** | **7.53** | **161.51** | | **5.2 (AVG)** | **96.15** | **57.86** | **7.53** | **161.54** | **0.03** | **0** | **0** | **6.9 (AVG)** | **-996** | **-33,200** | **0** | **0** | **-34,196** | |

| FAMILY & WOMENS GENERAL INFORMATION | | | | CURRENT ESTABLISHMENT [Budgeted WTE ] [1] | | | | EVIDENCE BASED STAFFING TOOL | Required CHPPD | PROFESSIONAL VIEW [WTE] | | | | REQUIREMENT (WTE) | | | | EXTRA BUDGET REQUIRED [£] -ve figures = additional funds required [inclusive of 28% uplift] | | | | | COMMENTS [Reasons for variances, decision, etc.] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HEALTH GROUP | WARD / DEPT | BEDS | SPECIALITY | RN | Non-RN | Support Staff | TOTAL | | | RN | Non-RN | Support Staff | TOTAL | RN | Non-RN | Support Staff | Planned CHPPD | Extra RN £ | RN funding for additional B6 | Extra Non-RN £ | Extra Support Staff £ | TOTAL £ | |
| F&W | H30 | 9 | Gynaecology | 11.07 | 3.79 | - | 14.86 | SNCT | 3.73 | 10.73 | 3.89 | 0 | 14.62 | -0.34 | 0.1 | 0 | 6.4 | 11,288 | -8,300 | -2,260 | 0 | 728 | Band 6 Uplift |
| F&W | H31+H33 | 57 | Maternity | 41.95 | 22.58 | - | 64.53 | BRP | 7.93/7.58 | 41.95 | 22.58 | 0 | 64.53 | 0.00 | 0 | 0 | 5.7 | 0 | 0 | 0 | 0 | 0 | |
| F&W | MLU | | Maternity | 11.17 | 5.22 | - | 16.39 | BRP | N/A | 11.17 | 5.22 | 0 | 16.39 | 0.00 | 0 | 0 | N/A | 0 | | 0 | 0 | 0 | |
| F&W | Rotation | | Maternity | 11.81 | 2.98 | - | 14.79 | BRP | N/A | 11.81 | 2.98 | 0 | 14.79 | 0.00 | 0 | 0 | N/A | 0 | 0 | 0 | 0 | 0 | |
| F&W | H34 | 20 | Paediatric | 20.78 | 5.22 | 3.30 | 29.3 | SNCT | 8.78 | 19.79 | 3.79 | 3.3 | 26.88 | -0.99 | -1.43 | 0 | 11.6 | 32,868 | 0 | 32,311 | 0 | 65,179 | Rota Efficiency |
| F&W | H35 | 12 | Ophthalmology | 15.06 | 5.34 | 1.00 | 21.4 | SNCT | 5.78 | 14.82 | 4.67 | 1 | 20.49 | -0.24 | -0.67 | 0 | 7.3 | 7,968 | -8,300 | 15,139 | 0 | 14,807 | Rota Efficiency |
| F&W | H130 | 20 | Paediatrics | 21.36 | 5.22 | 1.31 | 27.89 | SNCT | 9.51 | 21.43 | 5.22 | 1.31 | 27.96 | 0.07 | 0 | 0 | 8.2 | -2,324 | | 0 | 0 | -2,324 | Additional management shifts put in to support band 7 who covers three clinical areas |
| F&W | L&D | 19 | Maternity | 44.92 | 10.44 | 2.35 | 57.71 | BRP | 9.55 | 44.92 | 10.44 | 2.35 | 57.71 | 0.00 | 0 | 0 | 26.8 | 0 | 0 | 0 | 0 | 0 | |
| F&W | NICU | 26 | Critical Care | 71.89 | 5.22 | 1.50 | 78.61 | SNCT | 13.45 | 71.8 | 5.22 | 1.5 | 78.52 | -0.09 | 0 | 0 | 19.5 | 2,988 | 0 | 0 | 0 | 2,988 | Rota Efficiency |
| F&W | PAU | 10 | Paediatric | 10.44 | 0 | - | 10.44 | SNCT | 8.86 | 10.44 | 0 | 0 | 10.44 | 0.00 | 0 | 0 | 14.6 | 0 | | 0 | 0 | 0 | |
| F&W | PHDU | 4 | Paediatric | 11.66 | 0 | - | 11.66 | SNCT | 10.59 | 11.66 | 0 | 0 | 11.66 | 0.00 | 0 | 0 | 22.3 | 0 | | 0 | 0 | 0 | |
| F&W | C16 | 30 | ENT / Breast | 18.51 | 11.14 | 0.85 | 30.5 | SNCT | 5.51 | 18.29 | 11.17 | 0.85 | 30.31 | -0.22 | 0.03 | 0 | 9.7 | 7,304 | -8,300 | -678 | 0 | -1,674 | Uplift additional Band 6 |
| | | | | **290.62** | **77.15** | **10.31** | **378.08** | | **8.3 (AVG)** | **288.81** | **75.18** | **10.31** | **374.3** | **-1.81** | **-1.97** | **0** | **13.2 (AVG)** | **60,092** | **-24,900** | **44,512** | **0** | **79,704** | |

denotes work in progress

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**TRUST BOARD**

**12th MARCH 2019**

| | |
|---|---|
| Title: | NATIONAL STAFF SURVEY 2018 |
| Responsible Director: | DIRECTOR OF WORKFORCE AND OD – Simon Nearney |
| Author: | DIRECTOR OF WORKFORCE AND OD – Simon Nearney |

| | | |
|---|---|---|
| Purpose: | Inform the Board of the trust's performance in the 2018 National Staff Survey | |
| 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: | Overall improvement in performance equal to or better than the national average for acute trusts. | |

| | |
|---|---|
| Recommendation: | That the board note the contents of the report and the continuing improvements the Trust is making against the main areas of the staff survey. The Board is also requested to approve the broad actions in section 8 that will continue the progress made and enable the Trust to break into the top 20% of Trusts for staff engagement. |

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**NATIONAL STAFF SURVEY 2018**

## 1. PURPOSE OF THE REPORT

The purpose of this report is to inform the Trust Board of progress made in the National Staff Survey 2018.

It highlights the Trust's performance against ten key themes in the survey and shows scores by demographic, occupational groups and key service areas.

The report should be used to develop key actions for improvement prior to the launch of the 2019 survey in October.

## 2. BACKGROUND

The 2018 NHS National Staff Survey ran during October and November 2018. This was a full census survey in which 3185 staff returned a survey, equating to 39% of the workforce. The response rate nationally for acute trusts was 44%.

The Trust has received a full survey report, which is available online at www.nhsstaffsurveys.com. We also received a benchmarking report which benchmarks demographics, occupational groups and services against the Trust average for scores in the survey. Only the scores for quality of appraisal are not included in the benchmarking report.

Our survey data is provided by Capita. The final survey with national benchmarking comes from the NHS England Survey Co-ordination Centre and was embargoed until the 29th February 2019.

## 3. CHANGES TO REPORTING

In previous national staff surveys 32 key themes were identified. This has been reduced to 10 in the 2018 survey, as follows:

1. Staff Engagement
2. Safety Culture
3. Equality, Diversity and Inclusion
4. Health and Wellbeing
5. Immediate Managers
6. Morale
7. Quality of Appraisals
8. Quality of Care
9. Safe Environment – Bullying
10. Safe Environment – Violence

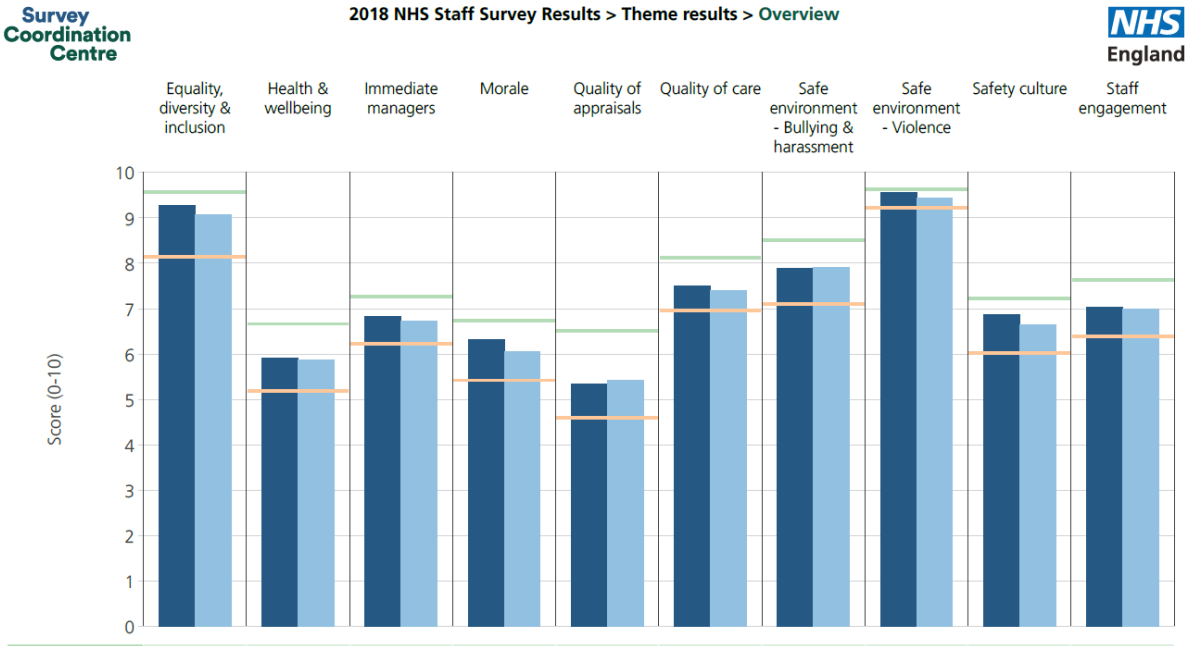
For each of the key themes organisations receive a score out of ten. This includes engagement, which had previously been a score out of five. Data for the past four, and in some cases five, years has been re-provided using the new calculation giving us trend information and enabling us to see progress and deteriorations.

Capita has advised that where we can see our percentage scores for individual questions then a shift of two or more percent represents a significant change from the previous year.

## 4. TEN KEY THEMES

Overall the Trust is better than or equal to the national average for nine of the ten key themes in the National Staff Survey. Only Quality of Appraisals is a worse score than the national average. The following section of the report provides the Trust's performance

compared with the national average, best score in the NHS and worst score in the NHS for each of the ten key themes. Trend data is visible for all indicators except Morale, which is calculated from a new set of questions in the survey.



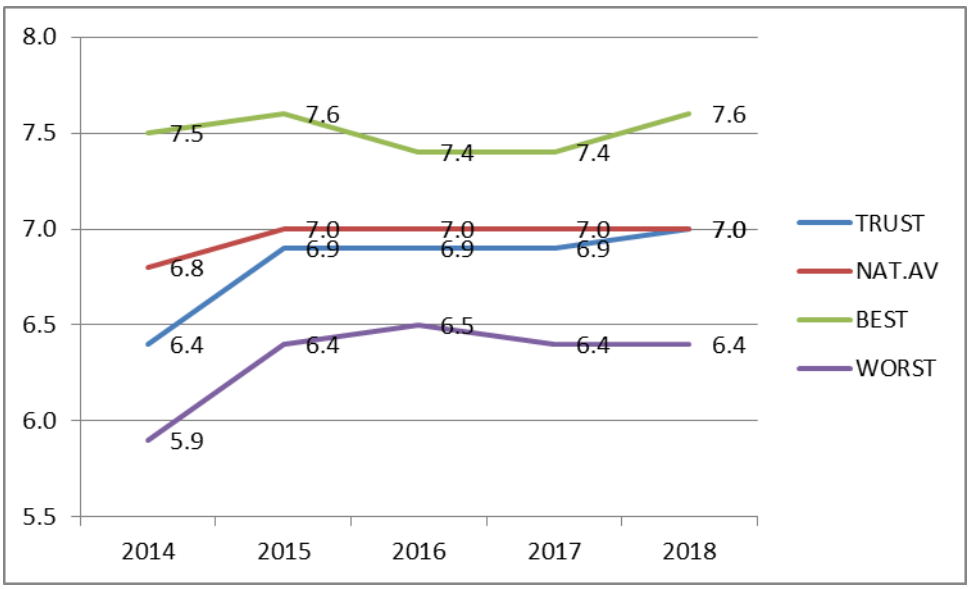

| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of appraisals | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement |
|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.6 | 6.7 | 7.3 | 6.7 | 6.5 | 8.1 | 8.5 | 9.6 | 7.2 | 7.6 |
| Your org | 9.3 | 5.9 | 6.8 | 6.3 | 5.3 | 7.5 | 7.9 | 9.6 | 6.9 | 7.0 |
| Average | 9.1 | 5.9 | 6.7 | 6.1 | 5.4 | 7.4 | 7.9 | 9.4 | 6.6 | 7.0 |
| Worst | 8.1 | 5.2 | 6.2 | 5.4 | 4.6 | 7.0 | 7.1 | 9.2 | 6.0 | 6.4 |
| No. responses | 3,164 | 3,184 | 3,178 | 3,176 | 2,765 | 2,820 | 3,166 | 3,174 | 3,182 | 3,183 |

This section also highlights demographics, occupational groups and service areas where performance is below the Trust average performance.

### i) Staff engagement

This is a key indicator for the Trust which aspires to be in the top 20% of organisations by 2020 for staff engagement. The Trust has improved again in terms of the overall score for engagement and is equal to the national average. (Please note that previously organisations received a score out of five, this is now out of ten).

Trend data has been provided for the past five years using the new method of calculation:




For the nine component questions the Trust improved on all but two. Once again the lowest score is staff saying they are able to make improvements happen, which correlates with the cultural survey in 2017 where staff described the Trust as overly bureaucratic and hierarchical.

Three scores are below the national average(*). However the score for recommending the Trust as a place to work has significantly improved. In 2017 the Trust was below the national average for this indicator. In 2018 the Trust is equal to the national average.

| Question | 2018 | 2017 | Diff |
|---|---|---|---|
| I look forward to going to work | 61.1 | 57.4 | 3 |
| I am enthusiastic about my job | 75.2 | 73.8 | 1 |
| Time passes quickly when I am working | 77.3 | 76.1 | 1 |
| There are frequent opportunities for me to show initiative in my role | 72.7 | 73.4 | 0 |
| I am able to make suggestions to improve the work of my team/department* | 73.4 | 73.3 | 0 |
| I am able to make improvements happen in my area of work | 56.6 | 55.2 | 1 |
| Care of patients / service users is my organisation's top priority* | 74.3 | 71.9 | 3 |
| I would recommend my organisation as a place to work | 62.6 | 58.6 | 4 |
| If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation* | 70.1 | 67.0 | 3 |
| **OVERALL SCORE FOR ENGAGEMENT** | **7.0** | **6.9** | |

Services where Staff Engagement is below the Trust average: acute surgery, cardiology, catering, governance, ENT, gastroenterology, medical admin, obstetrics, oral surgery, pathology, pharmacy, patient admin, portering, sterile services, surgical medical secretaries, switchboard, urology, vascular surgery.

Staff groups where Staff Engagement is below the Trust average:

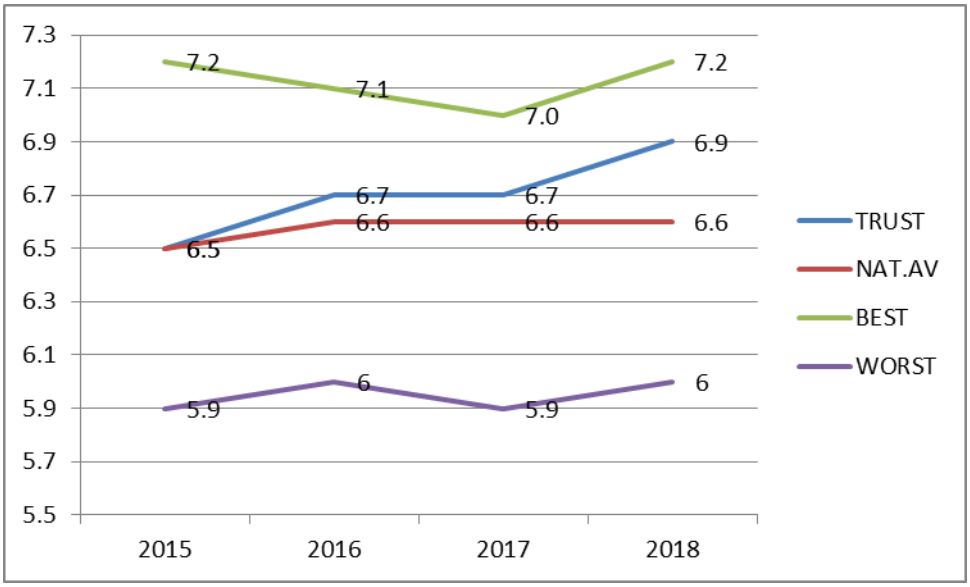
- Healthcare scientists
- Support to healthcare scientists
- Pharmacy staff

Demographic groups where Staff Engagement is below the Trust average:

- staff with a disability or long-term condition.

### ii) Safety Culture

The Trust has improved significantly against the Safety Culture theme in the past 12 months, with the biggest improvement made in terms of feedback provided to staff who report an incident. For the theme as a whole the Trust is performing better than the national average.




Six questions comprise this theme in the survey, and for all but one (*) the Trust is above the national average.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| My organisation treats staff who are involved in an error, near miss or incident fairly | 58.5 | 55.8 | 3 |
| When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again | 75.0 | 70.6 | 4 |
| We are given feedback about changes made in response to reported errors, near misses and incidents | 68.8 | 63.1 | 5 |
| I would feel secure raising concerns about unsafe clinical practice | 72.1 | 71.6 | 0 |
| I am confident that my organisation would address my concern | 62.0 | 57.9 | 4 |
| My organisation acts on concerns raised by patients / service users* | 72.3 | 71.2 | 1 |

Services where Safety Culture is below the Trust average: acute medicine, acute surgery, anaesthetics, cardiology, chest medicine, endocrinology, ENT, breast theatres, estates management, obstetrics, patient admin, sterile services, surgical medical secretaries, upper GI, vascular surgery.

Staff groups where Safety Culture is below the Trust average:

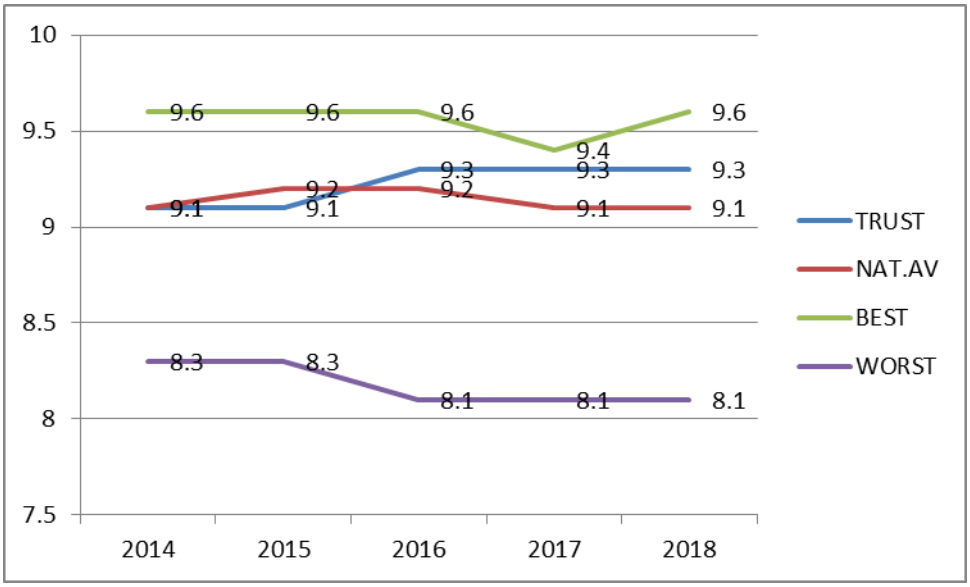
- doctors in training

Demographic groups where Safety Culture is below the Trust average:

- staff with a disability or long-term condition.

### iii) Equality, diversity and inclusion

For Equality, Diversity and Inclusion the Trust's performance has remained static since the 2017 survey. For the theme as a whole however, the Trust is performing better than the national average, and almost as well as the best performing trusts in the country.




Four questions comprise this theme in the survey. The Trust is above the national average for all of these indicators.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? | 88.7 | 88.7 | 0 |
| In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public? (low score is better) | 4.1 | 3.5 | 0 |
| In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? (low score is better) | 7.0 | 5.8 | 1 |
| Has your employer made adequate adjustment(s) to enable you to carry out your work? | 72.1 | 71.6 | 0 |

Services where equality, diversity and inclusion is below the trust average: cardiology, chest medicine, day surgery, ICU, infectious diseases, IT and information, medical admin, neonatology, pre-assessment, sterile services, surgical medical secretaries, switchboard, urology, vascular surgery.

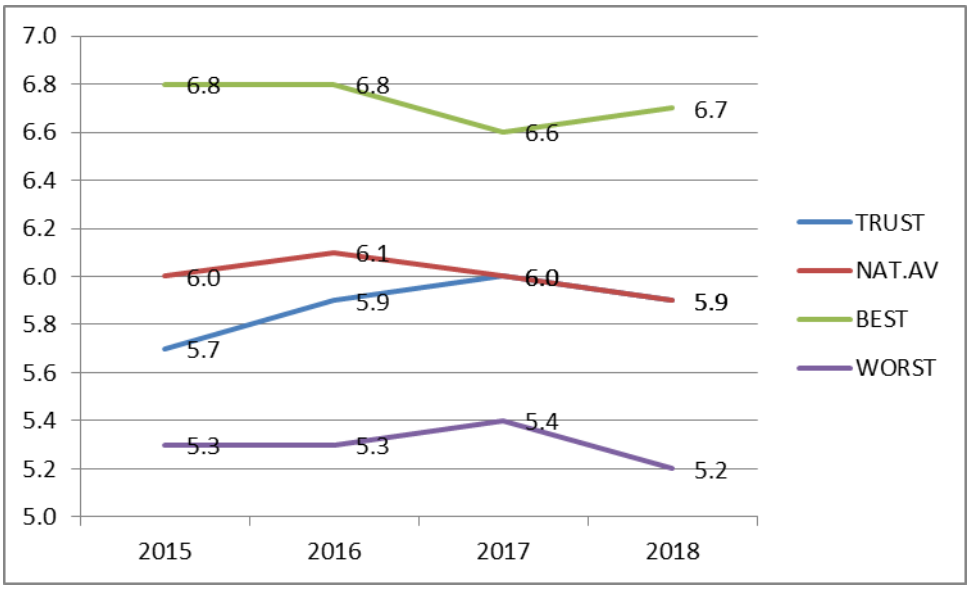
Demographic groups where equality, diversity and inclusion is below the national average:

- staff with a disability or long-term condition.

### iv) Health and wellbeing

For the Health and Wellbeing theme the Trust is performing at the level of the national average and similarly to the national picture is showing a slightly deteriorating performance.

For the question regarding staff feeling unwell as a result of work-related stress the Trust has deteriorated significantly.




Five questions comprise this theme in the survey. The Trust is worse than average for three of the indicators (*).

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| The opportunities for flexible working patterns | 52.9 | 51.4 | 1 |
| Does your organisation take positive action on health and well-being?* | 27.0 | 27.8 | 0 |
| In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? (low score is better)* | 28.5 | 27.2 | -1 |
| During the last 12 months have you felt unwell as a result of work related stress? (low score is better)* | 39.1 | 36.7 | -2 |
| In the last three months have you ever come to work despite not feeling well enough to perform your duties? (low score is better) | 54.3 | 53.9 | 0 |

Services where health and wellbeing is below the trust average: acute medicine, acute surgery, cardiology, chest medicine, governance, site management team, endocrinology, ENT/breast theatres, gastroenterology, obstetrics, oral surgery, orthopaedics, pathology, portering, pre-assessment, sterile services, stroke medicine, surgical medical secretaries, switchboard, theatres, upper GI, urology, vascular surgery.

Staff groups where health and wellbeing is below the trust average:

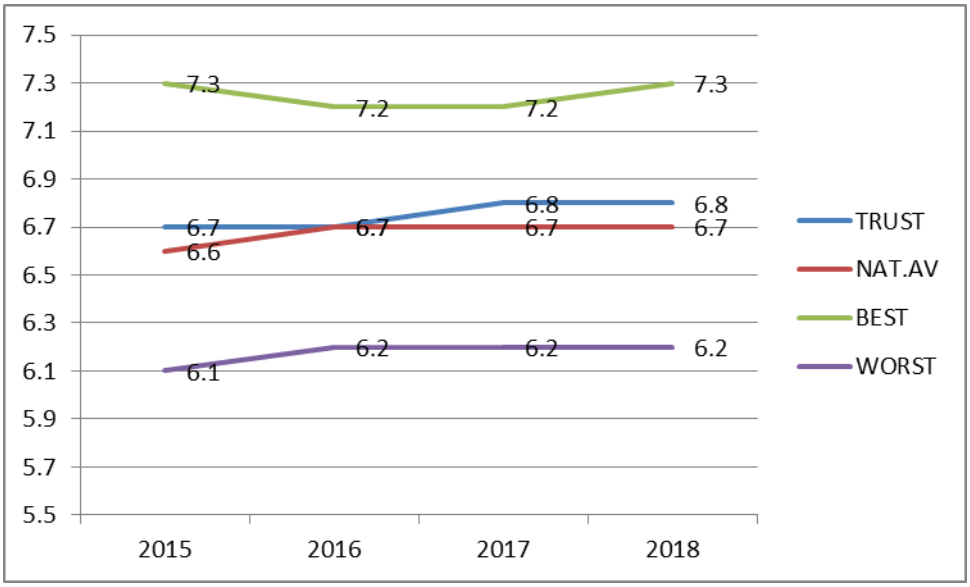
- registered nurses
- midwives

Demographic groups where health and wellbeing is below the national average:

- staff with a disability or long-term condition.

### v) Immediate Managers

Scores for immediate managers have improved, but not significantly in the 2018 staff survey, with the Trust performing slightly better than the national average for this theme.




Six questions comprise this theme in the survey. One indicator is worse than the national average (*), despite improving in year.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| The support I get from my immediate manager* | 68.5 | 67.8 | 0 |
| My immediate manager gives me clear feedback on my work | 60.7 | 60.3 | 0 |
| My immediate manager asks for my opinion before making decisions that affect my work | 54.1 | 53.9 | 0 |
| My immediate manager takes a positive interest in my health and well-being | 67.4 | 66.1 | 1 |
| My immediate manager values my work | 71.1 | 70.0 | 1 |
| My manager supported me to receive this training, learning or development | 58.8 | 57.7 | 1 |

Services where immediate managers is below the trust average: acute medicine, admin, cardiology, catering services, site management, CT surgery, endocrinology, ENT, estates management, medical admin, neonatology, obstetrics, pathology, patient admin, pharmacy, portering, pre-assessment, R&D commercial, sterile services, stroke medicine, surgical medical secretaries, switchboard, upper GI, urology.

Staff groups where immediate managers is below the trust average:

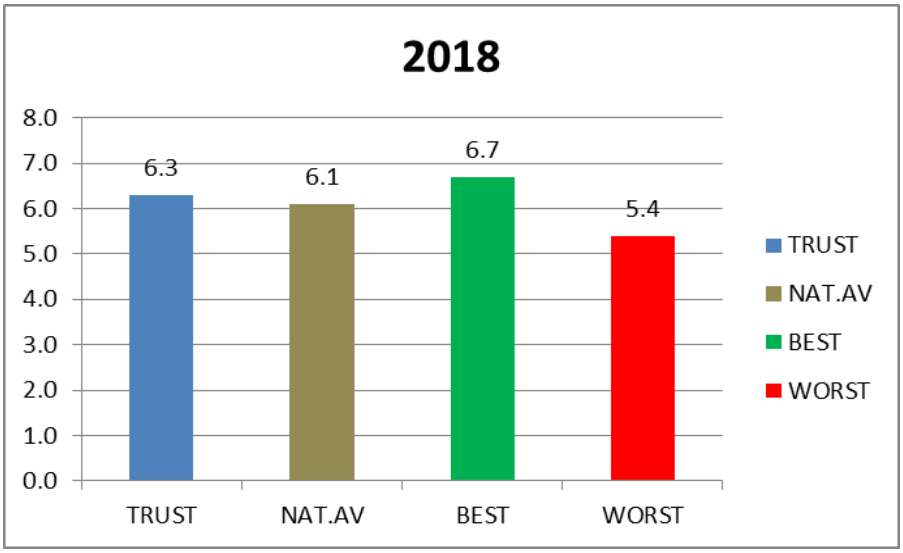
- consultants, pharmacy staff, midwives, admin and clerical, maintenance and ancillary

Demographic groups where immediate managers is below the national average:

- staff with a disability or long-term condition.
- Staff over 66-years-old

**vi) Morale**

2019 is the first year that a theme for morale has featured in the staff survey with some of the questions featuring for the first time. The Trust is ahead of the national average for this theme.




Nine questions comprise this theme in the survey. For all but two (*) the Trust is better than the national average.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| I am involved in deciding on changes introduced that affect my work area / team / department | 53.0 | 51.9 | 1 |
| I receive the respect I deserve from my colleagues at work* | 68.6 | N/A | |
| I have unrealistic time pressures | 23.9 | N/A | |
| I have a choice in deciding how to do my work | 56.7 | N/A | |
| Relationships at work are strained | 43.1 | N/A | |
| My immediate manager encourages me at work * | 67.4 | N/A | |
| I often think about leaving this organisation (low score is better) | 26.0 | N/A | |
| I will probably look for a job at a new organisation in the next 12 months (low score is better) | 15.0 | N/A | |
| As soon as I can find another job, I will leave this organisation (low score is better) | 10.1 | N/A | |

Services where morale is below the trust average: acute surgery, cardiology, governance, CT surgery, gastroenterology, medicine admin, pharmacy, pre-assessment, sterile services, stroke medicine, switchboard, theatres, training, upper GI, urology.

Staff groups where morale is below the trust average:

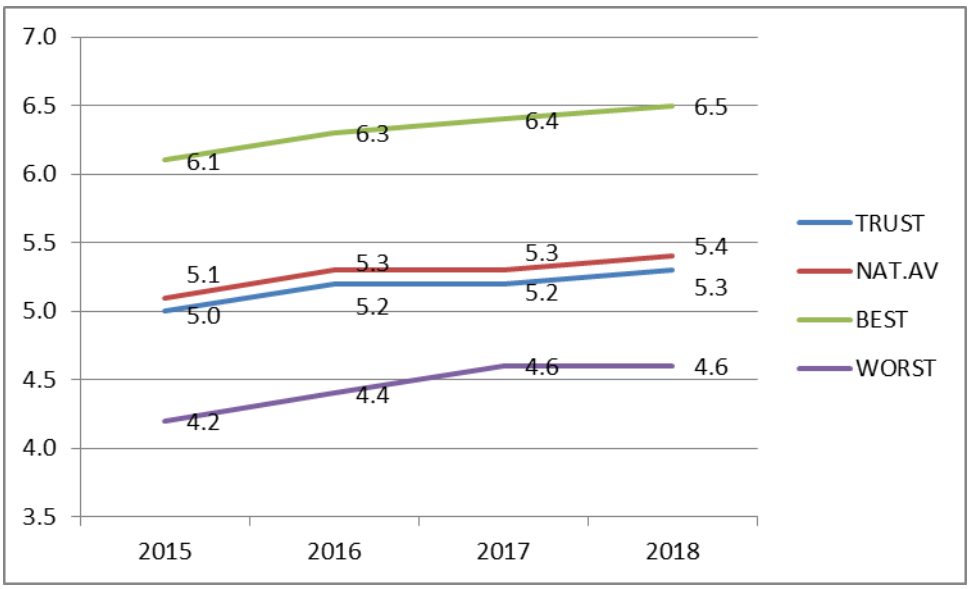
- pharmacy staff, admin and clerical

Demographic groups where health and wellbeing is below the national average:

- staff with a disability or long-term condition.

**vii) Quality of appraisals**

While overall the trust is slightly behind the national average for this theme staff indicated that the quality of appraisals has improved significantly.



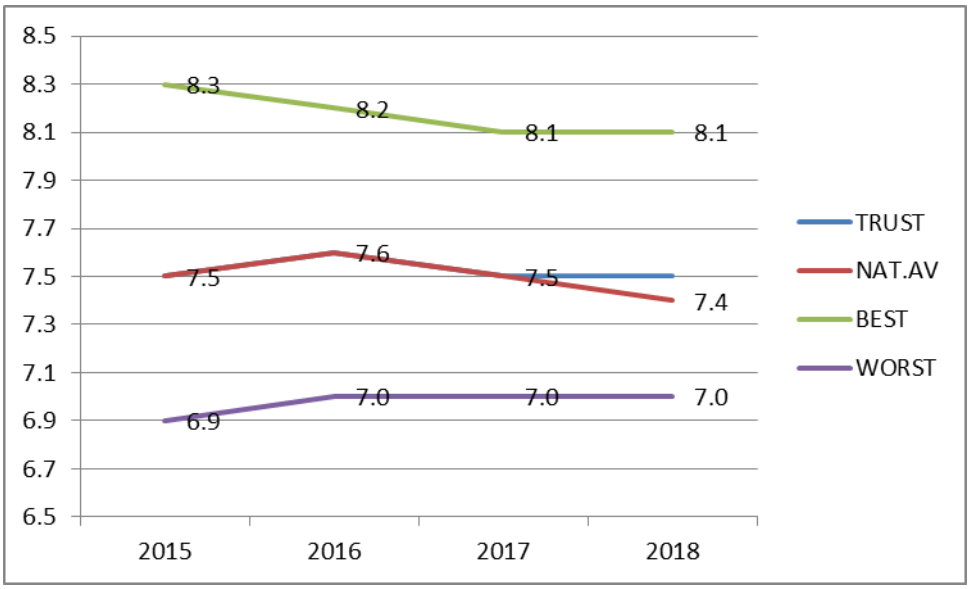

Four questions comprise this theme in the survey. For two indicators the Trust is below the national average.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| It helped me to improve how I do my job | 23.2 | 21.4 | 2 |
| It helped me agree clear objectives for my work | 37.0 | 35.9 | 1 |
| It left me feeling that my work is valued by my organisation* | 30.4 | 26.5 | 4 |
| The values of my organisation were discussed as part of the appraisal process* | 33.4 | 31.1 | 2 |

Internal benchmarking is not available for this data.

### viii) Quality of Care

For the theme of quality of care the Trust is performing slightly above the national average. There is no significant shift against this indicator since 2017 and over four years performance has gone backwards.



Three questions comprise this theme in the survey. The Trust is below the national average for one of these (*).

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| I am satisfied with the quality of care I give to patients / service users | 81.5 | 81.5 | 1 |
| I feel that my role makes a difference to patients / service users* | 88.6 | 89.3 | -1 |
| I am able to deliver the care I aspire to | 68.1 | 68.3 | 0 |

Services where quality of care is below the trust average: acute medicine, acute surgery, cardiology, chest medicine, governance, medical admin, obstetrics, paediatrics, pharmacy, sterile services, stroke medicine, surgical medical secretaries, urology.

Note: the following non-clinical services were removed from this cohort: estates management, finance and business, strategy and planning, switchboard, training.

Staff groups where quality of care is below the trust average:

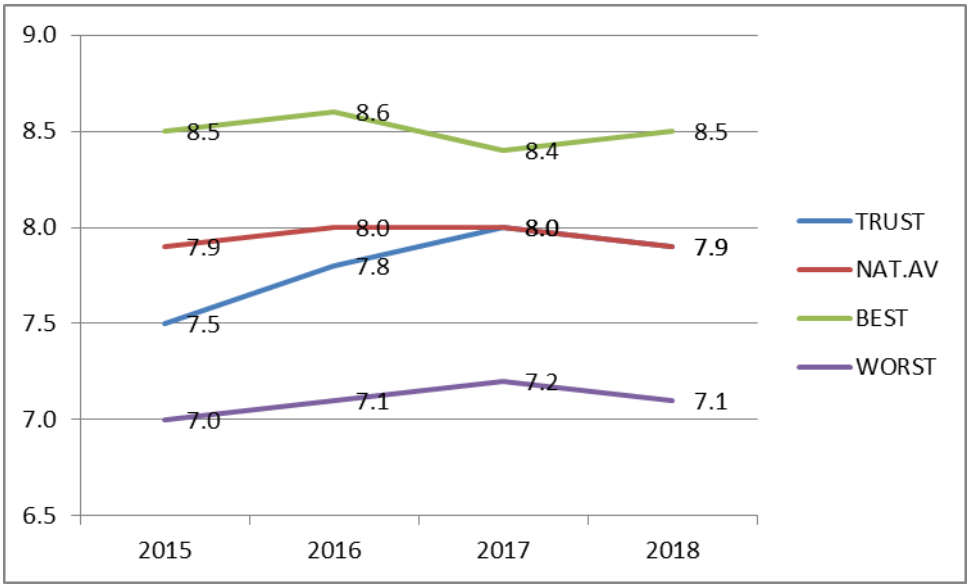
- midwives, corporate functions

Demographic groups where quality of care is below the national average:

- staff with a disability or long-term condition.

### ix) Bullying and harassment

For the theme of bullying and harassment the Trust is performing in line with the national average, however both Trust and national performance has deteriorated slightly in the last year, although this is not a significant deterioration.




Three questions comprise this theme in the survey and for all indicators a low score is better than a high score. The Trust is below the national average for two of these (*), and performance is deteriorating against two indicators.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|

| | | | |
|---|---|---|---|
| In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public? | 26.3 | 25.0 | -1 |
| In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?* | 15.5 | 14.7 | 0 |
| In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?* | 22.0 | 20.0 | -2 |

Services where bullying and harassment is below the trust average: acute medicine, acute surgery, cardiology, governance, site management, elderly medicine, emergency department, endocrinology, ENT, estates management, gastroenterology, medicine management, obstetrics, sterile services surgical medical secretaries, switchboard, urology, vascular surgery, women and children's management.

Staff groups where bullying and harassment is below the trust average:

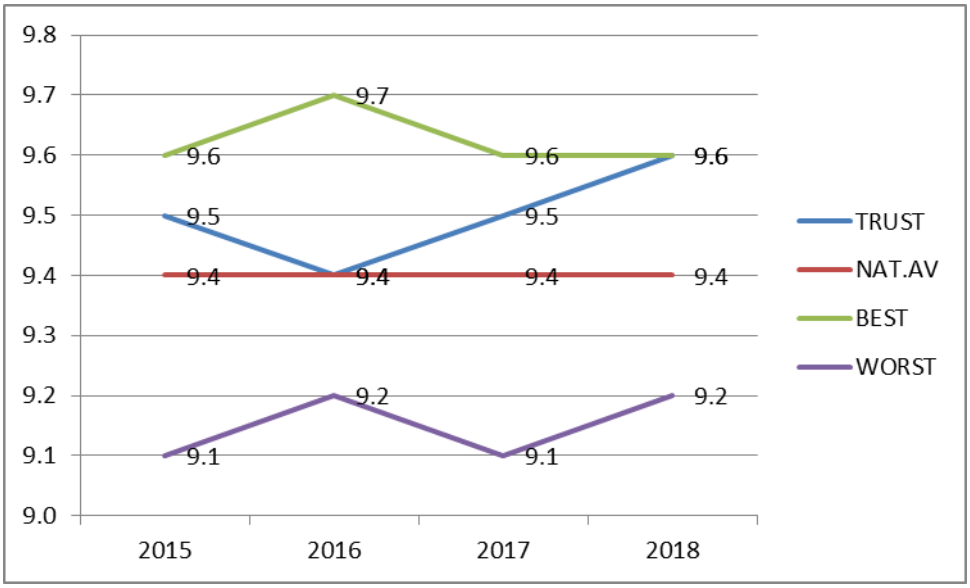
- consultants, registered nursing, midwives

Demographic groups where bullying and harassment is below the national average:

- staff with a disability or long-term condition.

**x) Violence**

For the theme of violence the Trust is performing as well as the best organisations in the country with scores improving significantly in the last three years.




Three questions comprise this theme in the survey and for all indicators a low score is better than a high score. The Trust is performing better than the national average for all three indicators and the number of staff experiencing violence at work has dropped significantly since last year.

| Question (%) | 2018 | 2017 | Diff |
|---|---|---|---|
| In the last 12 months how many times have you personally | 11.5 | 13.6 | 2 |

| | | | |
|---|---|---|---|
| experienced physical violence at work from patients / service users, their relatives or other members of the public? | | | |
| In the last 12 months how many times have you personally experienced physical violence at work from managers? | **0.5** | **0.7** | **0** |
| In the last 12 months how many times have you personally experienced physical violence at work from other colleagues? | **1.2** | **1.8** | **0** |

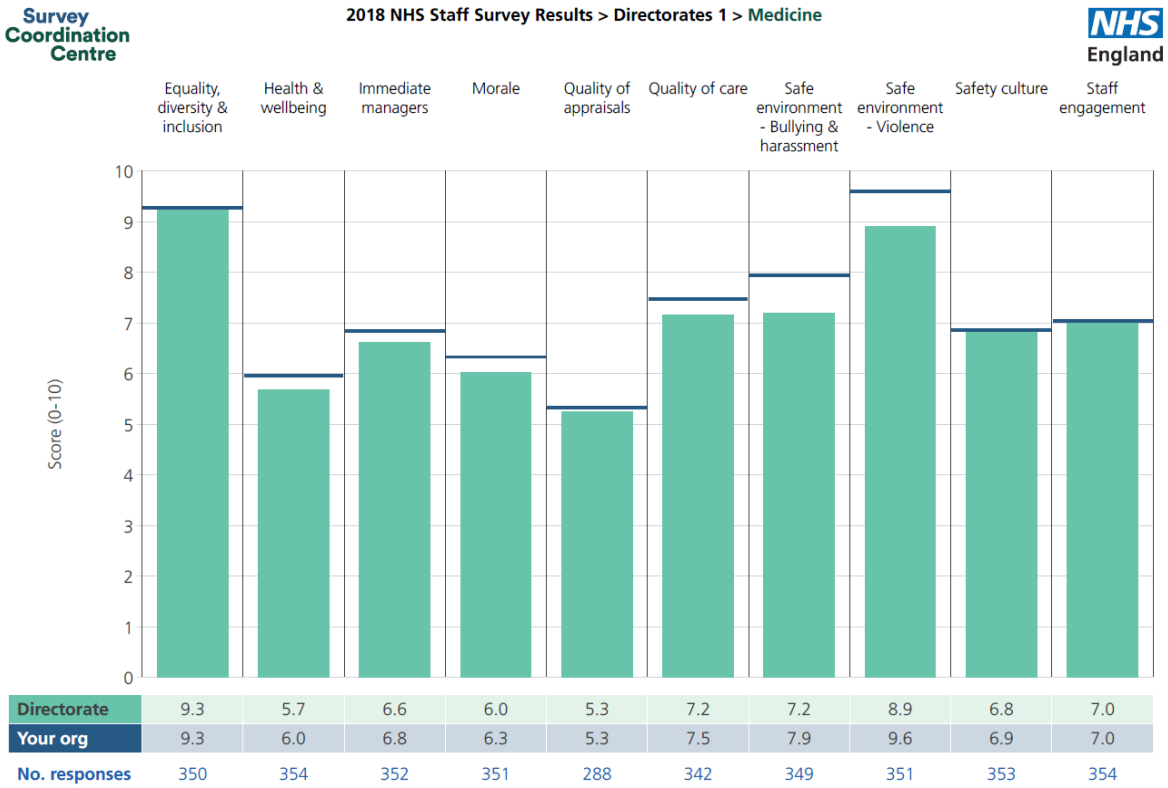
Only acute surgery reported experiencing violence from a colleague.

A number of services reported experiencing violence from patients, visitors etc: site management, elderly medicine, emergency department, endocrinology, ICU, orthopaedics, outpatients, plastic surgery, stroke medicine, theatre recovery, urology.

## 5. HEALTH GROUP AND DIRECTORATE PERFORMANCE

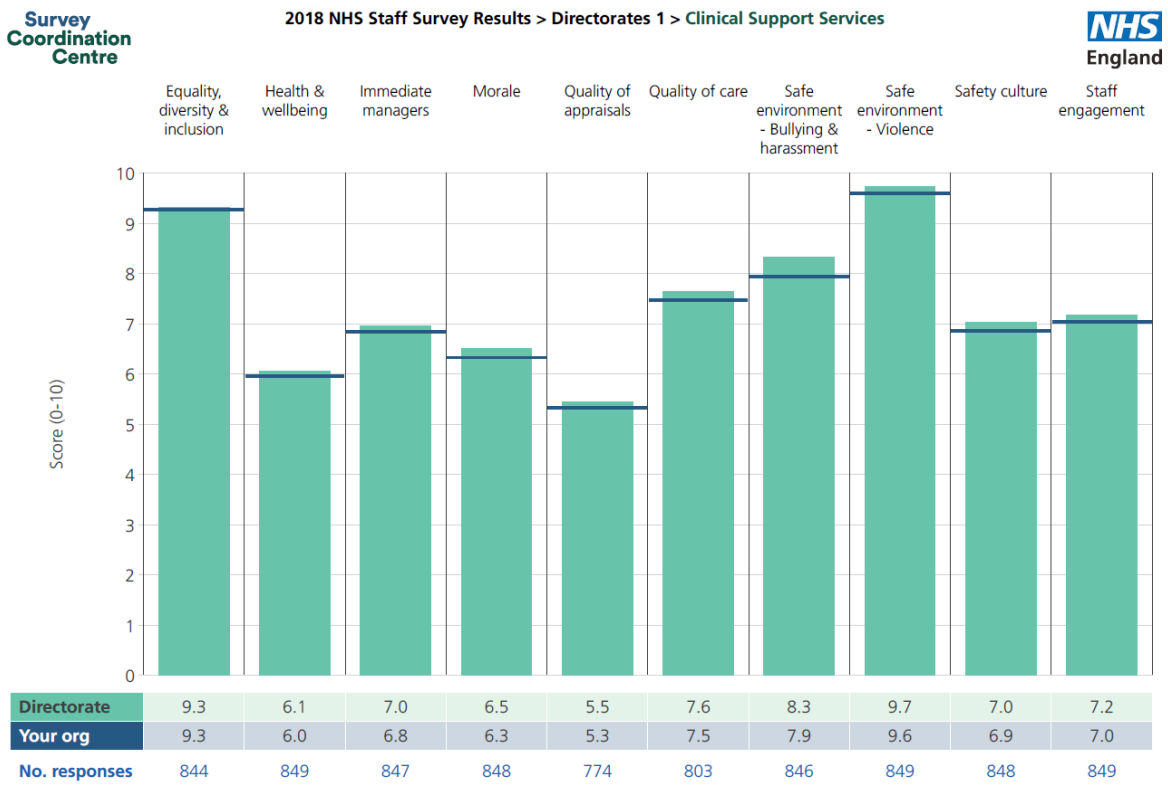
The staff survey data also highlights Health Group performance against each of the ten key themes and benchmarks this against Trust performance.

Medicine is equal to the Trust average for two key themes and worse for eight:



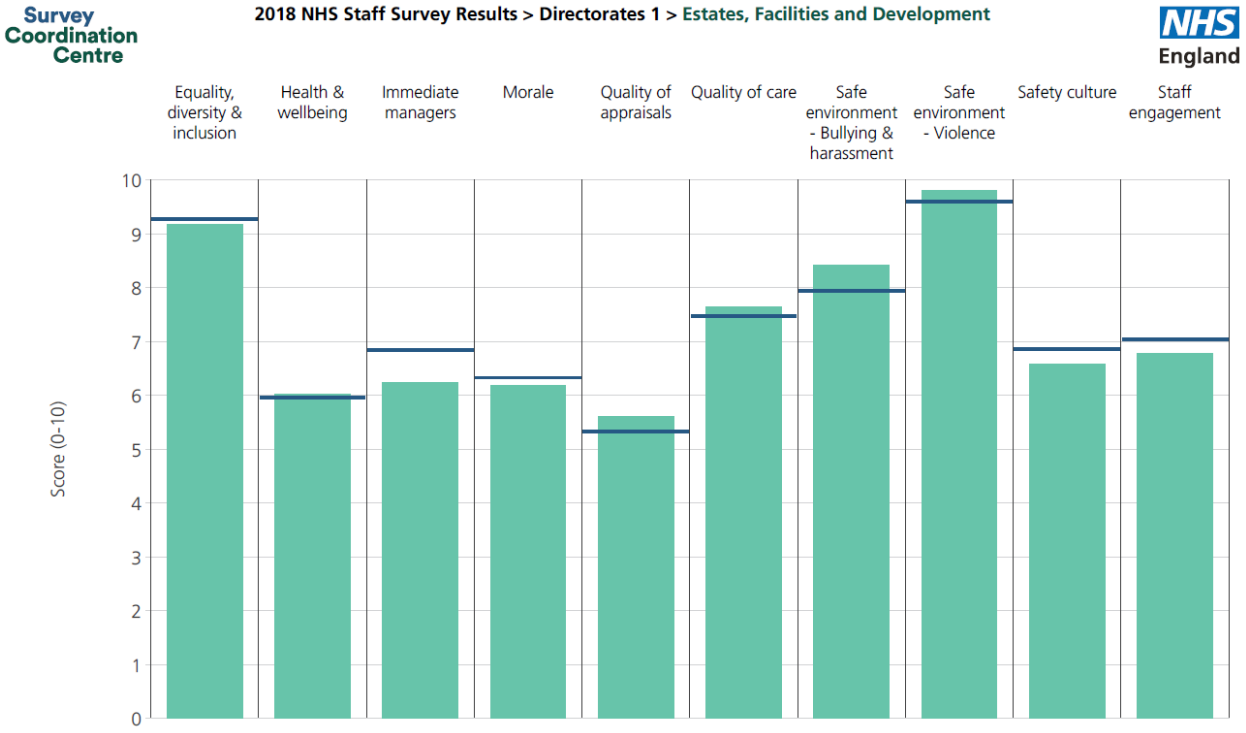

| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of appraisals | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement |
|---|---|---|---|---|---|---|---|---|---|---|
| Directorate | 9.3 | 5.7 | 6.6 | 6.0 | 5.3 | 7.2 | 7.2 | 8.9 | 6.8 | 7.0 |
| Your org | 9.3 | 6.0 | 6.8 | 6.3 | 5.3 | 7.5 | 7.9 | 9.6 | 6.9 | 7.0 |
| No. responses | 350 | 354 | 352 | 351 | 288 | 342 | 349 | 351 | 353 | 354 |

Clinical Support Services is equal to the Trust average for one and better for nine of the ten key themes:



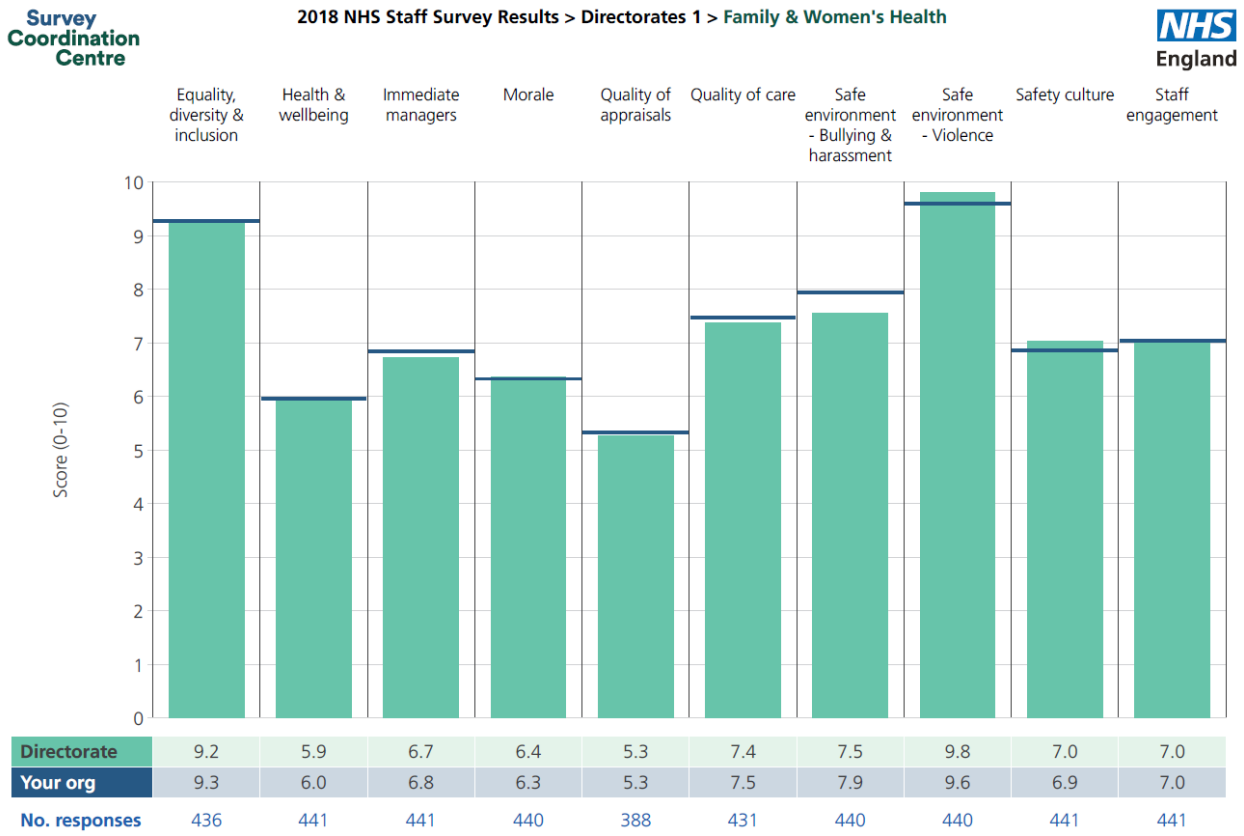

Corporate is worse than the Trust average for two of the ten key themes and better for eight:

Estates, Facilities and Development is equal with the Trust average for one of the key themes, better for four and worse for five.

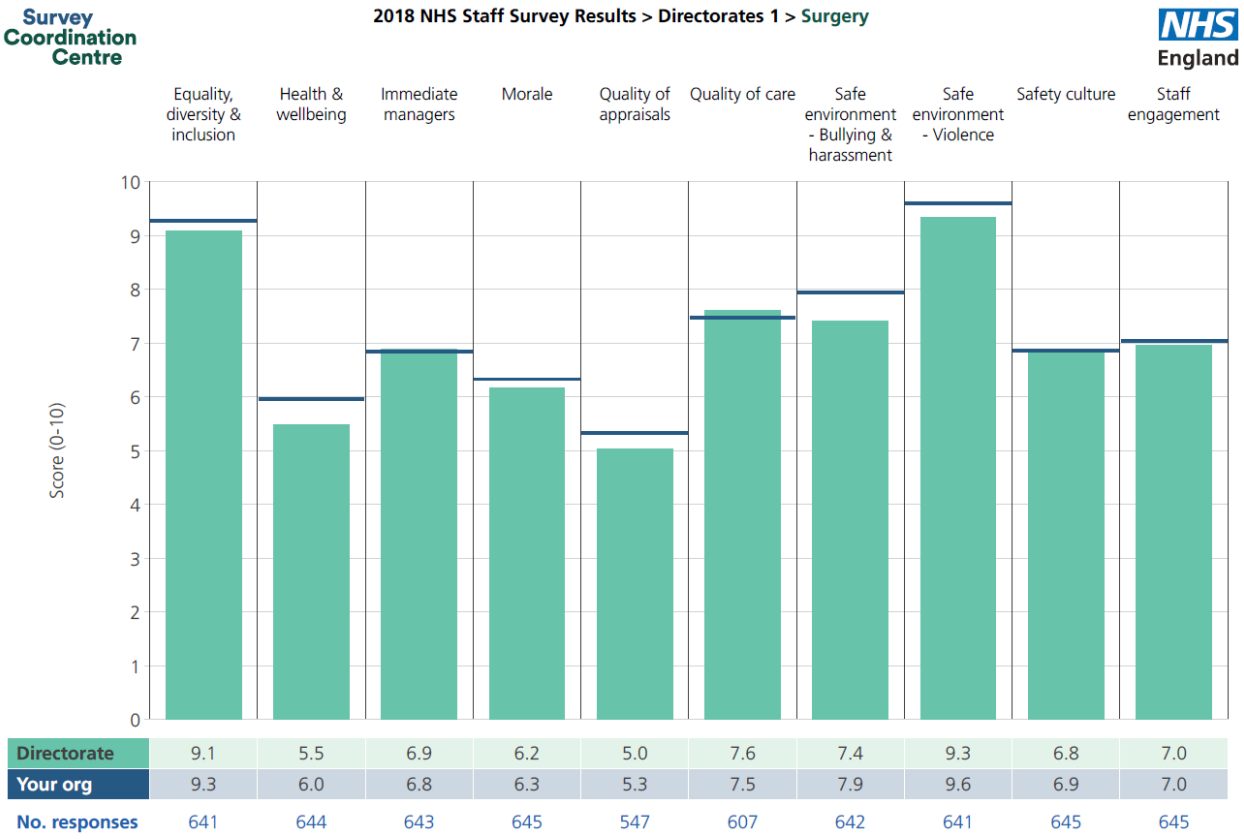



| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of appraisals | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement |
|---|---|---|---|---|---|---|---|---|---|---|
| Directorate | 9.2 | 6.0 | 6.2 | 6.2 | 5.6 | 7.7 | 8.4 | 9.8 | 6.6 | 6.8 |
| Your org | 9.3 | 6.0 | 6.8 | 6.3 | 5.3 | 7.5 | 7.9 | 9.6 | 6.9 | 7.0 |
| No. responses | 222 | 223 | 223 | 223 | 187 | 186 | 221 | 223 | 223 | 223 |

Family and Women's Health  is equal to the Trust average for two of the ten key themes, better for three and worse for five:




Surgery is equal to the Trust average for one of the ten key themes, better for two and worse for seven.



## 6. CAPITA REPORTING SERVICE AREAS WHERE ONE OR MORE OF THE TEN THEMES IS WORSE THAN THE TRUST AVERAGE

The 2018 survey data enables us to see which service areas are performing worse than the Trust average for the ten key themes. The table below shows Health Groups and Directorates which are performing worse than the Trust average for one or more of the key themes. The final column is the number of staff in each area who responded to the survey.

Clinical Support Services is the only Health Group or Directorate where all ten themes are equal to or better than the national average.

| | ENGAGEMENT | SAFETY CULTURE | EQUALITY DIVERSITY | HEALTH WELLBEING | IMMEDIATE MANAGERS | MORALE | QUALITY OF APPRAISALS | QUALITY OF CARE | BULLYING AND HARASSMENT | VIOLENCE | No. worse than Trust average | Highest number of returns per theme |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MEDICINE | | | | | | | | | | | 8 | 354 |
| CLINICAL SUPPORT SERVICES | | | | | | | | | | | 0 | 849 |
| CORPORATE | | | | | | | | | | | 2 | 673 |
| EF&D | | | | | | | | | | | 5 | 223 |
| F&WH | | | | | | | | | | | 5 | 441 |
| SURGERY | | | | | | | | | | | 7 | 645 |

## 7. CAPITA REPORTING AREAS WHERE ONE OR MORE OF THE TEN THEMES IS WORSE THAN THE TRUST AVERAGE

The 2018 survey data enables us to see which service areas are performing worse than the Trust average for nine of the ten key themes. Benchmarking data is not currently available at service level for Quality of Appraisals. The table below shows all services which are performing worse than the Trust average for one or more of the key themes. The final column is the number of staff in each area who responded to the survey.

| | ENGAGE--MENT | SAFETY CULTURE | EQUALITY DIVERSITY | HEALTH WELLBEING | IMMEDIATE MANAGERS | MORALE | QUALITY OF CARE | BULLYING AND HARASSMENT | VIOLENCE | No. worse than Trust average | Number of returns |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CARDIOLOGY | | | | | | | | | | 8 | 51 |
| STERILE SERVICES | | | | | | | | | | 8 | 20 |
| UROLOGY | | | | | | | | | | 8 | 15 |
| ACUTE SURGERY | | | | | | | | | | 7 | 18 |
| SURGICAL ADMIN | | | | | | | | | | 7 | 39 |
| OBSTETRICS | | | | | | | | | | 6 | 107 |
| SWITCHBOARD | | | | | | | | | | 6 | 13 |
| ACUTE MEDICINE | | | | | | | | | | 5 | 44 |
| GOVERNANCE | | | | | | | | | | 5 | 17 |
| ENDOCRINOLOGY | | | | | | | | | | 5 | 20 |
| MEDICAL ADMIN | | | | | | | | | | 5 | 21 |
| STROKE MEDICINE | | | | | | | | | | 5 | 17 |
| VASCULAR SURGERY | | | | | | | | | | 5 | 15 |
| CHEST MEDICINE | | | | | | | | | | 4 | 26 |
| SITE MANAGEMENT | | | | | | | | | | 4 | 20 |
| ENT | | | | | | | | | | 4 | 12 |
| GASTROENTEROLOGY | | | | | | | | | | 4 | 36 |
| PHARMACY | | | | | | | | | | 4 | 82 |
| PRE-ASSESSMENT | | | | | | | | | | 4 | 26 |
| UPPER GI | | | | | | | | | | 4 | 20 |
| ESTATES MANAGEMENT | | | | | | | | | | 3 | 52 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PATHOLOGY | | | | | | | | | | 3 | 147 |
| | **ENGAGE MENT** | **SAFETY CULTURE** | **EQUALITY DIVERSITY** | **HEALTH WELLBEING** | **IMMEDIATE MANAGERS** | **MORALE** | **QUALITY OF CARE** | **BULLYING AND HARASSMENT** | **VIOLENCE** | **No. worse than national average** | **Returns** |
| PATIENT ADMIN | | | | | | | | | | 3 | 218 |
| PORTERING | | | | | | | | | | 3 | 26 |
| CATERING SERVICES | | | | | | | | | | 2 | 110 |
| CT SURGERY | | | | | | | | | | 2 | 12 |
| ELDERLY MEDICINE | | | | | | | | | | 2 | 52 |
| ED | | | | | | | | | | 2 | 48 |
| ENT/BREAST THEATRES | | | | | | | | | | 2 | 13 |
| ICU | | | | | | | | | | 2 | 77 |
| NEONATAOLOGY | | | | | | | | | | 2 | 18 |
| ORAL SURGERY | | | | | | | | | | 2 | 19 |
| ORTHOPAEDICS | | | | | | | | | | 2 | 64 |
| THEATRES | | | | | | | | | | 2 | 69 |
| ADMIN | | | | | | | | | | 1 | 33 |
| ANAESTHETICS | | | | | | | | | | 1 | 47 |
| DAY CASE SURGERY | | | | | | | | | | 1 | 38 |
| INFECTIOUS DISEASES | | | | | | | | | | 1 | 22 |
| IT&INFORMATION | | | | | | | | | | 1 | 106 |
| MEDCINE MANAGEMENT | | | | | | | | | | 1 | 17 |
| OUTPATIENTS (MED) | | | | | | | | | | 1 | 18 |
| PAEDIATRICS | | | | | | | | | | 1 | 52 |
| PLASTIC SURGERY | | | | | | | | | | 1 | 15 |
| R&D COMMERCIAL | | | | | | | | | | 1 | 28 |
| THEATRE RECOVERY | | | | | | | | | | 1 | 25 |
| TRAINING | | | | | | | | | | 1 | 51 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS MANAGEMENT | | | | | | | | | | 1 | 14 |

## 8. ACTIONS FOR 2019

The National Staff Survey 2018 offers a clear indication of where the Trust needs to focus attention in 2019, both in terms of specific service areas and staff groups as well as broader Trust-wide actions. Progress against areas for improvement will be monitored at the Workforce Transformation Committee. These will include:

| Action | Required Outcome | Lead |
|---|---|---|
| Health Groups and services where performance is worse than the Trust average for the ten key themes to produce action plans to be reviewed monthly at Workforce Transformation Committee. | All areas to show a significant improvement against the ten key themes in the 2019 survey. | Director of Communications |
| Eight waves of the Remarkable People Leadership Programme to be delivered in year – this will include Trust Board and Health Group triumvirates. | Senior leaders are role models for good behaviours coaching teams to deliver great care in challenging environments. | Head of Organisational Development |
| Medical managers Remarkable People Leadership Programme to be delivered in year. | All clinical leads and directors receive development that is aligned to senior managers and which sets out clear expectations of a clinical leader | Head of Organisational Development |
| Focus groups to be held with staff who identify themselves as having a disability or long-term condition. | Significant improvement in responses from staff who identify themselves as having a disability or long-term condition. | Head of Organisational Development |
| Task and finish group to address issues of concern regarding the quality of appraisals. | Appraisal is a meaningful and productive conversation between manager and staff, discussing values of the Trust, setting clear objectives and enabling staff to feel valued and developed by the Trust. | Head of Education and Development |
| Review of staff networks for feeding back information to staff. Register of networks to be established and process for cascading information agreed. | Significant improvement to scores relating to communication and staff feedback in the 2019 staff survey. | Head of Communications |
| Task and finish group to address issues of bureaucracy and the difficulty staff have in delivering ideas for improvement. Actions to be agreed that will address the issues raised by staff. | Significant improvement to the scores relating to improvement in the staff survey, and a reduction in the number of staff highlighting bureaucracy as a limiting value in the 2019 Barrett Survey. | Programme Director for Improvement |

| | | |
|---|---|---|
| All current interventions aimed at improving staff health and wellbeing, including stress management, bullying and harassment to be reviewed. New actions to be agreed at the Workforce Transformation Committee. | The theme of health and wellbeing and scores for bullying and harassment improve significantly in the 2019 staff survey. | Head of Workforce Transformation |

## 9. RECOMMENDATIONS

The Trust Board is requested to note the contents of the report and the continuing improvements the Trust is making against the main areas of the staff survey. The Board is also requested to approve the broad actions in section 8 that will continue the progress made and enable the Trust to break into the top 20% of Trusts for staff engagement.

Officer to Contact:
Simon Nearney
Director of Workforce and OD
March, 2019

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**TRUST BOARD**
**12th MARCH 2019**

| | |
|---|---|
| **Title:** | Quality Improvement Programme Update (incorporating the CQC Action Plan) |
| **Responsible Director:** | EXECUTIVE CHIEF NURSE |
| **Author:** | Kate Southgate, Acting Deputy Director of Quality Governance and Assurance |

| | | |
|---|---|---|
| **Purpose** | The purpose of this report is to provide information and assurance to the Trust Board in relation to the development and progress of the Trust wide Quality Improvement Programme | |
| **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 provided in this report relates to the current progress of the 2018-149 Quality Improvement Programme. | |

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

**QUALITY IMPROVEMENT PROGRAMME UPDATE**
**(INCORPORATING THE CQC ACTION PLAN)**
**MARCH 2019**

## 1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the current position in relation to the Quality Improvement Programme

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

## 2. BACKGROUND

The Quality Improvement Programme was developed in October 2015 in conjunction with NHS Improvement. During 2015, the Trust worked closely with Claire Pacey, NHSI Improvement Director, to develop a tool that would move the Trust away from a multiple action-planning culture, towards a culture of continuous improvement through a single Quality Improvement Plan (QIP).

The purpose of the plan is to define, at a high level, the overall continuing quality improvement journey the Trust is making and the improvement goals the Trust is working towards each financial year. The plan includes all of the "Must" and "Should Do" recommendations from the CQC and includes detailed plans for each project area. However, the plan is broader than those actions and includes longer-term pieces of work that the Trust is pursuing to improve overall service quality and responsiveness across the organisation. For example, the QIP includes the objectives within the Trust's Quality Accounts and themes and trends identified across the organisation from matters such as Serious Incidents, Claims, Audits and Structured Judgement Reviews.

The plan outlines the Trust's overall ambition to meets its vision of Great Staff, Great Care, Great Future. Therefore, the intention is not that all improvement goals will be achieved at the end of each financial year end, but rather significant progress can be demonstrated against each of them. The plan includes a number of key milestones and these are reported on at the monthly Operational Quality Committee as well as via escalation through to the Quality Committee.

Each month, the Compliance Team meets with the relevant leads of each project to update against key milestone progress. Each milestone and each project is given a RAG rating. The ratings categories are, as follows:

| | |
|---|---|
| **Blue** | Milestone successfully achieved |
| **Green** | Successful delivery of the project is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly. |
| **Amber/Green** | Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery. |
| **Amber** | Successful delivery appears feasible but significant issues already exist that require management attention. These appear resolvable at this stage and if addressed promptly, should not present the project to overrun. |
| **Amber/Red** | Successful delivery is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and to determine whether resolution is feasible. |
| **Red** | Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable. |

The overall plan is reviewed and refreshed at the end of each financial year. At this stage current projects have three options:

1. If the project has met its overall aims and objectives the project can be closed, subject to sufficient evidence. The project will transfer to business as usual activity, which can range from periodic auditing to monitoring ongoing compliance, new pathways being developed and embedded to no further action being taken.
2. If the project has met its overall aims and objectives, the project lead may take the decision to under further improvement work and a project could be reopened for the next financial year with new aims and objectives
3. If the project has not met its aims and objectives, the project will remain open for the next financial year and the lead will be required to develop additional milestones to ensure the project is delivered successfully going forward

## 3. SUMMARY OF QIP 2018-19

The full QIP was presented and discussed at the Quality Committee meeting on Monday 25th February 2019. Attached at **Appendix One** is a summary of the current situation against each of the 2018-19 QIP projects as at the end of January 2019.

At the Quality Committee, discussions took place on the general themes being raised in relation to projects not achieving their overall aims and objectives. The focus was on ensuring that the aims and objectives for projects, going forward, are fit for purpose. In general, good progress has been made against many of the QIP projects, however; challenges remain in the following areas:

| QIP No. | Main Issues |
|---|---|
| QIP 8 - Infection Control | The project is focused on reducing the number of avoidable hospital acquired infections. This was to be achieved by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHS Improvement Urinary Tract Infection Collaborative Project. During the 2018-19 project, the team has only just commenced the work on the Care Bundle and work with the Collaborative UTI Project is in its early stages. However, the following performance indicators were not met:<br><br>• MRSA target not achieved – 3 reported cases to date with a threshold of 0.<br>• MSSA target not achieved – 50 reported cases to date, with a threshold of 44.<br>• E.coli target not achieved – 83 reported cases to date, with a threshold of 73.<br><br>Clostridium *difficile* reported 29 reported cases to date against an upper threshold of 53.<br><br>As a result, a revised project will be developed for 2019-20. This will include focus on the 5 year Antimicrobial Resistance Strategy and National Infection Prevention and Control Manual. |
| QIP 10 - Pressure Ulcers | The Pressure Ulcer QIP, changed leadership within year to give further challenge to the Health Groups. The four health group Nurse Directors were tasked with ensuring progress against the QIP. The project has seen a number of challenges within year and targets have not always been met. However, the project was to focus on implementing stretch targets for the Trust. Whilst the targets have not always been achieved, year on year progress has still been seen.<br><br>To date no Stage 3 or 4 avoidable hospital acquired pressure ulcers have been declared. However, 8 unstageable pressure ulcers have been declared to date (target of less than 8) and 28 Suspected Deep Tissue |

| | |
|---|---|
| | Injuries (SDTI) have been declared (target of less than 23). Milestones have been delivered to target timescales; however, ongoing performance would indicate that further work is required for the Trust to move forward with improved compliance. |
| QIP 12 - Children and Young People with MH needs and CAMHS | This project is linked to CQC Regulation Breach (Regulation 12 Safe Care and Treatment 12.2a and b). The Trust received actions from the CQC following inspections in 2015 and 2016 whereby further work was required to ensure and assure the quality of care given to patients with mental health needs. Two key actions were required as a result of this: undertaking clear risk assessments of patients and ensuring adequate support from mental health partners (including assisting in training). The project progressed well with the introduction of clear risk assessments. New documentation was developed and is currently being audited to ensuring this is embedded. The lead is reporting "good" compliance, however, results are awaited.<br><br>The action in relation to developing an SLA with mental health providers was transferred into QIP48 at the start of the 2018-19 QIP. Information on this is noted in the QIP48 update. |
| QIP 14 - VTE | This project has continued to be rated as Amber throughout the 2018-19 programme. The trajectory for compliance with completion of VTE has been challenging to meet. This has been compounded by the change in requirement for the assessment to be completed within 24 hours following hospital admission. Further scrutiny was given to the project by the Chief Medical Officer from August 2018 and a stretch performance trajectory was set. Performance against this has been as follows:<br><br>• August target of 60% exceeded with 77.3% achieved<br>• September target of 65% exceeded with 78.6% achieved<br>• October target of 70% exceeded with 80.7% achieved<br>• November target of 75% met with 75.9% achieved<br>• December target of 80% not met with 73.1% achieved<br>• January 2019 target of 85% exceed with 90% achieved<br>• In addition, 1 VTE SI was declared in September 2018 (target for the year was 0)<br><br>Due to the dip in performance in November and December 2018, further monitoring is required to ensure that progress is maintained. |
| QIP 22 - Nutrition | The aim of this project is to improve patients' nutrition and hydration. This project has at times, struggled to complete all of the assigned milestones and performance indicators. However, following a thorough review by leads across the Trust, it has been determined that the QIP has not been fit for purpose. Whilst the intentions of the project were correct, at times its execution has not been.<br><br>Following review of census/point prevalence information audit, it is clear that patients are being given the correct nutrition and hydration requirements. The issues relate to record keeping and nutrition, including snacks, not being recorded sufficiently. As such the QIP is being revised for the 2019-20 programme.<br><br>The Assistant Chief Nurse for Special Projects is undertaking a targeted piece of work to look at why ward staff do not meet the required record keeping standards for nutrition. |

| | |
|---|---|
| QIP 26 - Records | Despite assurances to the contrary, this project has just not started and has needed to be allocated to a new project lead. The new lead is in the process of launching a new Records Committee, new record keeping policy and new process to support this. |
| QIP 48 - Mental Health | This project has made progress within year, however, the main area for concern relates to the development of an SLA for CAMHS. The provision of mental health support for children and young people was an issue raised with by the CQC in 2015 and 2016. A number of challenges have occurred with working with another health provider (Humber FT), which includes a reliance on the sharing and recording of information. Initial meetings have been held to scope the production of the CHAMS SLA which will take the form of series of quality indicators, processes and improvements, which may negate the requirement for a specific SLA. |

In conjunction with the relevant leads, the Compliance Team is in the process of developing the 2019-20 QIP. This will be confirmed at the Operational Quality Committee in April 2019. The focus on the development of the plan for 2019-20 will be on ensuring that the projects are fit for purpose and that all aims and objectives are supported by SMART milestones. As part of the development of the 2019-20 programme, a 12-month review will be undertaken of previous projects to identify any areas that have not worked well in both the planning process as well as the individual projects themselves.

**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

**Kate Southgate**
**Acting Deputy Director of Quality Governance and Assurance**

March 2019

**Appendix One:** Summary of Quality Improvement Programme 2018-2019

| Programme Title: Quality Improvement | Executive Lead: Chief Medical Officer / Chief Nurse<br>Programme Lead: Head of Compliance |
|---|---|

**Overall Programme Objectives:**

The Objectives of the Quality Improvement Programme are to:

- Aid in the achievement of the Trust's overall ambition to meet its vision: Great Staff, Great Care, Great Future
- Deliver Trust wide quality improvement based on the priorities identified through programmes such as the Quality Accounts, Sign Up to Safety and CQC inspections
- Address MUST and SHOULD do actions identified by the CQC

| Overall delivery of programme | Current Overall Rating | A |
|---|---|---|

**Overview:**

There are currently 19 projects open on the Quality Improvement Programme for 2018/19 from an initial number of 26. Of the 19 open, seven are rated amber, and one rated amber/red. The majority of these have also been linked or developed in response to concerns raised by the CQC during inspections from 2015, 2016 and 2018. Failure to demonstrate achievement of these aims could represent a significant risk to the Trust. In addition, it has been identified that a number of projects are unlikely to achieve their aim by the end of March 2019, including the following:

| | |
|---|---|
| • QIP06 – Deteriorating Patient | • QIP14 – VTE |
| • QIP08 – Infection Control | • QIP22 Nutrition |
| • QIP10 – Pressure Ulcers | • QIP26 – Records |
| • QIP12 –CAMHS | • QIP48 – Mental Health |

Therefore, the overall rating of the project continues to be ***amber.*** A number of projects have already identified improvements to take forward or new areas of work for 2019/20 including QIP05 – Medicine Optimisation, QIP09 – Falls, QIP10 – Pressure Ulcers, QIP22 – Nutrition, QIP39 – Outpatient Services and QIP48 – Mental Health.

**Key activity during January 2019 - Current Position:**

1 project closed this period (December 2018: 0 project)

- QIP15 – Sepsis

6 projects currently rated Green (December 2018: 8 projects)

- QIP05 – Medicine Optimisation
- QIP09 – Falls
- QIP23 – Dementia
- QIP28 – Patient Experience
- QIP49 - GIRFT
- QIP47 – Acute Kidney Injury

5 projects currently rated Amber/Green (December 2018: 5 projects)

- QIP19 – Governance
- QIP36 – Transition from Children to Adult Services
- QIP37 – ReSPECT
- QIP38 – Consent
- QIP39 – Outpatients

7 projects rated Amber (December 2018: 6 projects)

- QIP06 – Deteriorating Patient
- QIP08 - Infection, Prevention and Control
- QIP10 – Pressure Ulcers
- QIP14 – VTE
- QIP12 – Children and Young People with Mental Health needs and CAMHS
- QIP26 – Records
- QIP48 – Mental Health

1 project rated Amber/Red (December 2018: 1 project)

- QIP22 – Nutrition

0 projects rated Red (December 2018: 0 projects)

| Project | Current Rating | Comments |
|---|---|---|
| **QIP05 – Medicine Optimisation** | **G** | This project has an overall rating of green. The project is successfully delivering most of its milestones to date and is on-track to deliver all other milestones at this stage.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP06 – Deteriorating Patient** | **A** | Updates from the Critical Care Outreach Team Lead Nurse have been provided and the project can report significant progress against the completion of milestones, including the roll-out of NEWS2 and the dissemination of the new Deteriorating Patient Policy. NEWS2 training has reached almost 1100 staff members and awareness of the policy will commence formally following ratification in February however staff are notified of the contents of the policy within the NEWS2 training which as reported has already commenced. The Critical Care Outreach Team Lead Nurse can confirm that the policy does adhere to NICE CG50 however formal sign off of this cannot be completed until the policy is ratified. The project remains rated at amber as key milestones have been delayed over the project term and the project is unlikely to be able to evidence compliance against the achievement of the aim until after April 2019. It is likely that this project will not meet the full aim by the project end date and that the focus for the 2019/20 QIP will be the monitoring of the policy and associated training to ensure that the project aim is achieved within the next project timescale.<br>**Update from February Quality Committee: noted both the progress made for this project and the continuing risk and areas for escalation** |
| **QIP08 – Infection Control** | **A** | There have not been any significant updates provided by the lead this month therefore review is required by the lead, along with updated HCAI indicator data. With the current downward trend of data against the four indicators, it is unlikely that the project will be able to evidence achievement with the aim. Continues to be rated amber due to indicator data.<br>**Update from February Quality Committee: noted the risks to delivery** |
| **QIP09 – Falls** | **G** | This project is currently rated Green. The aim of the project is to comply with NICE guidance. The Trust is compliant. Overall compliance with the project target to evidence a reduction in the number of all patient falls and falls rated moderate and above remain fairly consistent, with rates ranging between 0.10 and 0.357 and 6.62 to 8.35 respectively, meaning that for Six out of the initial nine months of the project, these indicators have been rated green. The number of fractured NoF remains low and is on track to stay under the baseline of 27. Five out of the seven wards monitored for registered staff trained in the non-mandatory falls prevention e-learning are below their baselines for December. This will be discussed at the health Groups Task and Finish Group meeting. Allied Health Professional; training compliance remains poor, however there was a slight improvement in December. Figures for the year so far remain similar to the baselines taken from March 2018. This will be monitored by the lead falls nurse.<br>**Update from February Quality Committee: Noted both the achievement of the aim and the risks to deliver of the additional targets** |
| **QIP10 – Pressure Ulcers** | **A** | Project remains at amber. This is predominantly due to the performance against targets. Training performance in general remains within the moderate rating for most health groups. Duty of candour performance indicators have shown some decrease in compliance. In addition, the targets for both avoidable HA SDTI and stage 2 pressure sores have both reached over 100% and will therefore remain red for the remainder of the year. The target for avoidable HA unstageable PS has reached 100% and will be rated red next period if any are reported. It should be noted however that these indicators were set internally by the Trust in order to drive improvement. When viewed against the last reported indicator data for 2017/18 QIP (December 2017) the Trust can demonstrate improvements against AHA S3 (3 last year, 0 this year) and AHA S4 (1 last year, 0 this year). For the same period in 2017/18, AHA unstageable was reported at nine and this period the figure is eight. AHA SDTI is slightly above last years reported figure of 25 (28 reported this period). Milestones are on track with some slippage however this is being well managed by the leads. |

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| | | **Update from February Quality Committee: Noted the risks to delivery of this project due to the performance against the targets and decide if any additional actions are required to ensure delivery.** |
| **QIP12 – Children & Young People with Mental Health needs and CAMHS** | **A** | The nurse led audit has commenced, with ten patients reviewed from inpatient data going from July 2018 to December 2018. A baseline report is being produced based on this data and initial figures show high compliance. This has been reinforced by regular 'spot checks' on the ward by the lead. Project remains rated amber and is likely to continue into 2019/20 until evidence can be reported that supports achievement of the aim.<br>**Update from February Quality Committee: noted both the progress and the continued risk** |
| **QIP14 – VTE** | **A** | Whilst the project can evidence good milestone completion, performance against the targets is not satisfactory and cannot fully support the aim of the project; therefore the project is rated amber and is unlikely to achieve the aim by the project end date. The indicator in relation to VTE SIs was breached in September 2018 and will remain non-complaint to the end date. Both Family and Women's and Surgery Health Groups can evidence good compliance with the indicator for the assessment within 24 hours however Medicine and Clinical Support's compliance is more sporadic. Whilst it is evident that improvements have been made over the project term, these are not consistent and will affect the likelihood of this project being able to evidence compliance with the overall aim. The leads have implemented a reminder letter to all junior doctors from the CMO. In addition, work is being carried out with the Information Team to ensure that cohorted areas with high compliance are included in the 24 hour figures, concerted efforts are been made during board rounds to promote improved compliance and discussions are taking place at service and performance meetings with specific action plans for each speciality. It should be noted that the indicator data for VTE prophylaxis from the Safety Thermometer has been reviewed by the Information Team and validated data provided which has decreased the compliance data for the year, however this amendment has not changed the RAG rating for the annual data.<br>**Update from February Quality Committee: noted the risks to delivery and performance** |
| **QIP15 – Sepsis** | **B** | Project closed – January 2019 |
| **QIP19 – Governance** | **A/G** | Project rated amber/green with good progress made on milestone completion with some slippage on a small number of milestones however these are being well managed by the leads. However, the project is unlikely to meet the indicator for procedural documents without additional milestones in place and the indicator in relation to PILs is unlikely to meet the required aim if the current trajectory is followed. Despite this performance against the indicators, it is likely that the project will be able to evidence achievement against the aim.<br>**Update from February Quality Committee: Noted the decrease in rating and associated risk to the project delivery** |
| **QIP22 – Nutrition** | **A/R** | The project has been reviewed by Senior Nursing Managers and the Compliance Team and it has been agreed to implement number of additional indicators using drilled down data from the Trust's Safety Thermometer, Fundamental Standards and Matron's Handbook audits. These will supersede the previous indicator data. It has been agreed that the focus for the remainder of the project will be to obtain an accurate and regular baseline assessment of nutrition and hydration documentation across the Trust in order for milestones to be developed to support specific areas of non-compliance. Following this review, a number of milestones have been closed as these cannot be actioned within the timescales of the project as the focus will be to obtain baseline data. However, two new milestones have been included which relate to the amendment of the process around the completion of food and beverage record charts by caterers at specific times. It is unlikely that that project will be able to evidence compliance with the aim however some assurance will be able to be obtained against the specific areas of concern raised by the CQC during the 2015, 2016 and 2018 inspections. Project remains amber/red.<br>**Update from February Quality Committee: Noted the amendments to the project indicators and the continued risk to the Trust** |

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| **QIP23 – Dementia** | **G** | This project has an overall rating of green. The project continues to successfully deliver all of the milestones as required and all remaining milestones are also on track to be achieved within the required timescales. The focus is on improving the compliance with the use of the Butterfly Scheme. Although the 75% compliance target with the butterfly symbol over the bed and reach out to me form has not been achieved, Q3 shows an improvement from Q2. It is hoped that by monitoring the compliance on the ward, keeping in regular contact with the nurses and regular teaching sessions the target will be achieved. 100% has been achieved with the awareness of John's Campaign. Quarter 3 data will be reviewed and reported in the next progress report. We have consistently achieved 90% in the dementia delirium screening assessment.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP26 – Records** | **A** | A number of unforeseen circumstances has meant that the planned Records Committee has been significantly delayed, which in turn has had an impact on the delivery of the majority of other milestones linked to this project. It is unlikely that this project will meet the agreed aim within the project timescale due to the delays outlined above; therefore the project's rating is amber to reflect this.<br>**Update from February Quality Committee: noted the risks to delivery** |
| **QIP28 – Patient Experience** | **G** | This project has an overall rating of green. The project has successfully delivered all required milestones to date and is on-track to achieve the remaining milestones before the end of the project. Project continues to deliver well, there are no concerns.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP30 – Avoidable Mortality** | **B** | Project closed – October 2018 |
| **QIP36 – Transition from Children to Adult Services** | **A/G** | Lead has drafted a report which has been circulated to the Transition Committee which evidences 'reasonable assurance' that the 'Ready Steady Go' toolkit is embedded. The report made only one recommendation that the Transition procedural document has a minor amendment which has been added as a milestone to this project. Only one milestone remains which requires additional staff members with the lead to complete a review of the NICE Guidance. It is expected that this project will be closed next period once assurance has been received at the relevant Trust Committees.<br>**Update from February Quality Committee: – Noted the progress made and assurance received** |
| **QIP37 – ReSPECT** | **A/G** | The project has an overall rating of Amber/Green. The project has delivered the milestones in relation to the launch of ReSPECT however further assurance required that this is embedded. The twice yearly Census Audit will be carried out before the end of March as this correlates to the first years roll-out. The policy states we will do two audits per year however as this is the first year of launch it was imperative we embedded into practice first. There will be 2 audits per year going forward into 2019/20.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP38 – Consent** | **A/G** | Project is on track for delivery within the agreed project end date, with some slippage from one milestone which is being actively managed by the lead. Continues to be rated amber/green.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP39 – Outpatient Services** | **A/G** | Project is on track to be able to demonstrate achievement of the aim within the project end date, with only some minor slippage reported for a number of milestones. Indicator data has remained consistently good, with only two out of ten committees not held, one of which was due to operational pressures. Focus for the 2019/20 QIP will be agreed next period. Project continues to be rated amber/green.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP41 – Getting it Right First Time –** | **B** | Project closed – June 2018 |

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|---|---|---|
| **Paediatric Surgery** | | |
| **QIP42 – Getting it Right First Time – Ophthalmology** | **B** | |
| **QIP44 - Getting it Right First Time – Obstetrics and Gynaecology** | **B** | |
| **QIP45 – Safer Maternity Services Standards** | **B** | Project closed – November 2018 |
| **QIP46 – Handover** | **B** | Project closed – June 2018 |
| **QIP47 – Acute Kidney Injury** | **G** | Project continues to progress well with around a third of the required number of notes audited. On track to complete within project timescale. Continues to be rated green.<br>**Update from February Quality Committee: Noted the continued good progress** |
| **QIP48 – Mental Health** | **A** | The project has progressed with two milestones closed however due to limited capacity within the team the five milestones that relate to the planned Mental Health Committee will not be achieved within year. However these will be carried forward to the 2019/20 QIP which will remain in place with the existing aim. Some challenges need to be recognised due to partnership working with another health agency (Humber FT) and reliant on the sharing and recording of information which has impacted in particular on the milestones in relation to the development of an SLA for CAMHS and the review of the existing mental health SLA. An initial meeting was held to scope the production of the CAMHS SLA which will take the form of a series of quality indicators, processes and improvements which will negate the requirement of an SLA.<br>**Update from February Quality Committee: Noted the progress against the CAMHS SLA which will reduce the potential risk against a potential future inspection by the CQC.** |
| **QIP49 – Getting it Right First Time** | **G** | The project is rated as Green. The GIRFT Delivery Group continues to meet monthly but is currently reviewing the governance and leadership arrangements in response to a major expansion in the scope and scale of the national programme. PMO and project management support is being provided to the GIRFT programme through Improvement team from mid-December 2018. Governance framework is currently being reviewed and will be confirmed by end of January 2019. The performance indicators are currently being reviewed with the national GIRFT team and Health Groups, following which the actual number of recommendations generated could be reported accurately. It is likely that this project will be closed in February 2019 and managed in a separate work programme.<br>**Update from February Quality Committee: Noted the continued good progress and likely future of the QIP.** |

## PROJECT RATINGS DURING 2018/19

| PROJECT RATINGS | APRIL 18 | MAY 18 | JUNE 18 | JULY 18 | AUG 18 | SEPT 18 | OCT 18 | NOV 18 | DEC 18 | JAN 19 | FEB 19 | MAR 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall QIP Rating | G | G | G | G | G | G | G | A/G | A | A | | |
| QIP05 – Medicines Optimisation | G | G | G | G | G | G | G | G | G | G | | |
| QIP06 – Deteriorating Patient | Under review | Under review | A/G | A/G | A/G | A/G | A | A | A | A | | |
| QIP08 – Infection Control | G | G | A/G | A/G | A/G | A | A | A/G | A | A | | |
| QIP09 – Falls | G | G | G | G | G | A/G | A | G | G | G | | |
| QIP10 – Pressure Ulcers | G | G | G | A/G | A/G | A/G | A/G | A/G | A | A | | |
| QIP12 – Children & Young People with Mental Health needs and CAMHS | A | A | A | A | A/G | A/G | A/G | A | A | A | | |
| QIP14 – VTE | Not in place | A | A | A | A | A | A | A | A | A | | |
| QIP15 – Sepsis | G | G | G | A/G | A/G | A/G | A/G | G | G | B | CLOSED | |
| QIP19 – Governance | Not in place | Not in place | G | G | G | G | G | G | G | A/G | | |
| QIP22 – Nutrition | G | G | G | A/G | A/G | A | A | A/R | A/R | A/R | | |
| QIP23 – Dementia | G | G | G | G | G | G | G | G | G | G | | |
| QIP26 – Records | Not in place | Under review | G | G | G | A/G | A/G | A/G | A/G | A | | |
| QIP28 – Patient Experience | G | G | G | G | G | G | G | G | G | G | | |

| PROJECT RATINGS | APRIL 18 | MAY 18 | JUNE 18 | JULY 18 | AUG 18 | SEPT 18 | OCT 18 | NOV 18 | DEC 18 | JAN 19 | FEB 19 | MAR 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QIP30 – Avoidable Mortality | G | G | A/G | G | G | G | B | CLOSED | | | | |
| QIP36 – Transition from Children to Adult Services | A/G | A/G | A/G | A/G | A/G | A/G | A/G | A/G | A/G | A/G | | |
| QIP37 – ReSPECT | G | G | G | G | G | G | G | A/G | A/G | A/G | | |
| QIP38 – Consent | Under review | A/G | A/G | A/G | A/G | A/G | G | A/G | A/G | A/G | | |
| QIP39 - Outpatients | G | G | A/G | A/G | A/G | A/G | A/G | A/G | A/G | A/G | | |
| QIP41 – Getting it Right First Time – Paediatric Surgery | A/G | A/G | B | TRANSFERRED INTO QIP49 | | | | | | | | |
| QIP42 – Getting It Right First Time - Ophthalmology | A/G | A/G | B | TRANSFERRED INTO QIP49 | | | | | | | | |
| QIP44 - Getting it Right First Time – Obstetrics and Gynaecology | G | A/G | B | TRANSFERRED INTO QIP49 | | | | | | | | |
| QIP45 – Safer Maternity Care (CNST) | G | A/G | G | G | G | G | G | B | CLOSED | | | |
| QIP46 – Handover | G | G | B | TRANSFERRED TO THE JUNIOR DOCTOR IMPROVEMENT PROGRAMME | | | | | | | | |
| QIP47 – Acute Kidney Injury | Under review | G | A/G | G | G | G | G | G | G | G | | |
| QIP48 – Mental Health | Under review | Under review | G | G | A/G | A/G | A/G | A | A | A | | |
| QIP49 - GIRFT | Not in place | Not in place | A/G | A/G | A/G | A/G | A/G | A/G | G | G | | |

**Hull and East Yorkshire Hospitals NHS Trust**

**Minutes of the Quality Committee**

**Held 28 January 2019**

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| **Present:** | Prof M Veysey | Non-Executive Director (Chair) |
| | Mrs V Walker | Non-Executive Director, Vice Chair |
| | Mr S Hall | Non-Executive Director |
| | Prof J Jomeen | Non-Executive Director |
| | Mr M Wright | Chief Nurse |
| | Ms C Ramsay | Director of Corporate Affairs |
| | Mr D Corral | Chief Pharmacist |
| | Mrs A Green | Lead Clinical Research Therapist |
| | Mrs K Southgate | Head of Compliance |
| | Mrs M Stern | Patient Council Chair |
| **In Attendance:** | Mrs R Thompson | Corporate Affairs Manager |

| No | Items | Actions |
|---|---|---|
| **1** | **Apologies:**<br>Dr M Purva, Chief Medical Officer, Mrs S Bates, Deputy Director of Quality Assurance and Governance. | |
| **2** | **Declarations of Interest**<br>There were no declarations received. | |
| **3** | **Minutes of the meeting of 17 December 2018**<br>Item 5.5 Safeguarding Annual Reports – paragraph 5 – the last sentence to be removed from the minutes. It was agreed that any safeguarding partnership working would be discussed at Board to Board meetings in the future.<br><br>Following the above change the minutes were approved as an accurate record. | |
| | **3.1 Matters Arising**<br>There were no matters arising from the minutes. | |
| | **3.2 Action Tracking List**<br>Prof Veysey to offer his availability to meet with Ms Ramsay regarding the workplan. Mrs Walker to join the meeting. | **MV** |
| | Mr Wright to circulate the maternity dashboard outside of the meeting via email. | **MW** |
| | There was a discussion around non-clinical appraisal rates and Mr Wright advised that he was not aware of any Serious Incidents relating to staff not having had their appraisals. He added that all staff group appraisal rates would be reported to the Board in the future. | |

**3.3 Any Other Matters Arising**
There were no other matters arising.

**3.4 Workplan**
Ms Ramsay advised that the Stop the Line was now incorporated into the workplan and was business as usual. Any future issues would be raised with the Committee.

**4.1 – Mortality - Learning from deaths framework**
Mrs Southgate presented the annual report which summarised the work that had taken place over the last year. Structured judgement reviews had been in place for 18 months and were fully integrated across the organisation, with 77 deaths being reviewed using this process. Mrs Southgate clarified that although some deaths had not been reviewed using the Structured judgement review process they were still reviewed in depth.

Mrs Southgate stated that a Tier 1 assessed the case and if any concerns were raised then a Tier 2 assessor would also review it. 43 death reviews had required escalation and 2 of these were declared as serious incidents.

There were themes emerging from the Structured Judgement reviews such as pneumonia and sepsis. Dr K Adams had been appointed as Associate Chief Medical Officer to review mortality issues. Key themes such as poor documentation and deteriorating patients would be monitored as part of the Quality Improvement Programme.

There was a discussion around outliers and whether deaths were reviewed in these areas and Mrs Southgate advised that areas such as readmissions within 28 days and cross working with the GPs would pick up outliers. Mr Wright added that the Trust did comply with NHS Improvement standards and any major issues would be picked up in the Serious Incident reporting.

There was a discussion around death certificates and how doctors sign them off, sometimes causing delays in the process. Mr Corral asked for clarity regarding the Medical Examiner role that would help speed up the death certificate process. Mr Wright advised that the Medical Examiner would be a nominated consultant(s) who would spend 10 sessions per week reviewing patients and case notes.

Ms Ramsay asked if there were any compliance or risk issues relating to the NHS Improvement Guidance for learning from deaths. Mrs Southgate advised there was issues around clinical engagement but stated that the Medical Examiner role should help with this.

There was also a discussion around nursing home patients that die in hospital after being transferred and the work that was ongoing with system partners.

Prof Veysey asked about post mortem data and Mr Wright suggested that this information would be monitored through the Mortality Committee. Mrs Walker asked for the dates of the Committee so that she could attend. **RT**

**Resolved:**
The Committee received and accepted the report.

**5.1 Serious Incidents – Lessons Learned – Themes and Trends**
Mrs Southgate presented the report and highlighted that the Trust had seen 55 serious incidents year to date and 9 had been declared in December and were under investigation. She also reported the serious incidents and actions closed in quarter 3.

The Committee discussed the Serious Incidents declared and Mrs Walker asked about discrimination against patients and Mr Wright reassured her that in his cross questioning during investigations he found it was more likely that staff needed more skills and technical training and was not down to discrimination.

Prof Veysey highlighted the eye surgery incident and asked about the patient. Mr Wright advised that a further operation was being carried out. He added that the surgeon was very distressed that the incident had happened.

The Committee discussed the system for recording tests and reviewing tests when the system is under pressure. The Trust was looking at Lorenzo and automating systems as much as possible.

**Resolved:**
The Committee received and accepted the report.

**5.2 Quality Improvement Programme Process**
Mrs Southgate updated the Committee regarding the end of year refresh for the 2019/20 QIP. Currently the teams were working through closing down completed actions and setting different, more relevant milestones if the project had changed direction.

Mr Wright advised that the Nutrition QIP would be re-written with new objectives and aims.

There was a discussion around challenging QIPs and the leads and Mr Wright assured the Committee that each project was scrutinised at the Operational Quality Committee. Prof Veysey suggested that any projects that were off track could be presented at the Quality Committee for further assurance. This would give better insight into the process for the committee and also support the Operational Quality Committee. **CR/MV**

**Resolved:**
The Committee received and accepted the report.

**6.1 Integrated Performance Report**
The Committee reviewed the report and Mrs Walker asked why the 52 week wait standard was green and Ms Ramsay advised that it was due to the Trust meeting it's trajectory.

Ms Ramsay advised that she was meeting with Mr Bond to review the performance report to look at longer term trends.

Prof Veysey highlighted VTE and advised that performance was improving although cancer performance was less favourable. Mr Hall added that cancer performance was also linked to diagnostic performance.

Mrs Walker asked about 104 day performance and Mr Wright advised that each week the Performance and Activity meeting monitored each patient separately to ensure the most effective and timely treatment was received.

**Resolved:**
The committee received and accepted the report.

**6.2 Operational Quality Committee**
Mr Wright advised that the Committee had been cancelled on 9 January 2019 due to operational pressures.

He reported that the WHO checklist had been audited in theatres and had achieved good compliance. New audit software had been installed making it easier to produce management reports.

**Resolved:**
The Committee received and accepted the report.

**7 Board Assurance Framework**
Ms Ramsay presented the report which summarised the risks for the Q3 position. She advised that there had not been much movement throughout the year but that the risks had been managed well by the Board. BAF 5 relating to Specialist Services would be picked up in March as part of the strategy refresh board item.

Mr Hall added that the BAF 4 risk relating to performance standards would be discussed at the Performance and Finance Committee that afternoon.

Ms Ramsay did not recommend any changes to any of the risk ratings and the Committee agreed. Mrs Green asked if any progress had been made relating to the integrated care system and acute services review and Ms Ramsay advised that there were no plans to progress in place yet other than to improve close working relationships with partners.

**Resolved:**
The Committee received and accepted the report.

**8 Committee Effectiveness Review**
Ms Ramsay presented the paper and advised that generally the scores were 4 and 5s but that there was a number of 3s that indicated the quality of the debate, open channels to the board and the best mix of skills were neither good nor bad.

The committee discussed this and agreed that the results had been captured back in May 2018 and that the level of debate had improved as had the skill mix of having Mrs Stern and Mr Hall on the Committee.

Mrs Stern offered to feed-back any Patient Council issues and it was agreed to make this a standing agenda item.

Ms Jomeen stated that the Committee valuated and revaluated quality issues and had a real desire to move things forward. The Committee agreed to invite relevant staff to future meetings to understand service and quality issues.

Prof Veysey felt that it was important for members to attend other relevant meetings and Mrs Thompson would email the Mortality/Infection Reduction and Operational Quality Committee dates to the NED members to allow them to attend. **RT**

**Resolved:**
The Committee received and accepted the report.

**9 Any Other Business**

Mrs Walker advised that she was in the Trust on Christmas Day visiting wards and patients and had spent time in the control room where she had witnessed patient outliers. Mr Wright advised that due to the pressures in the hospital it was difficult to ensure that patients where in the right place at all times. Ms Ramsay added that a review of the winter plan would be received at the Performance and Finance Committee which would highlight any issues such as this.

Mr Hall also spoke about the issues in phlebotomy and Mr Wright advised that a business was being developed regarding this area.

**10 Chairman's Summary to the Board**

Prof Veysey agreed to summarise the meeting to the Board.

**11 Date and time of the next meeting:**

Monday 25 February 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

# HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

## QUALITY COMMITTEE

| **Meeting Date:** | 25 February 2019 | **Chair:** | Prof M Veysey | **Quorate (Y/N)** | **Y** |
|---|---|---|---|---|---|

**Key issues discussed:**

- Lessons learned – themes and trends was received. Maternity serious incidents were discussed.
- Trustwide Learning Report - which triangulated all learning from areas such as audit, serious incidents, mortality reviews. It was agreed that this would be received quarterly.
- Quality Improvement Programme was received. A year end and 2019/20 report to be received at the March committee.
- WHO performance checklist performance was received – good progress had been made
- Integrated Performance Report – a discussion was held regarding performance impacting on patient care and how assurance was received regarding this.
- Operational Quality Committee – the meeting had been cancelled twice due to operational pressures. There were no issues raised.
- Board Assurance Framework – Quarter 3 risks were discussed.

**Decisions made by the Committee:**

None required

**Key Information Points to the Board:**

**Matters escalated to the Board for action:**

None

**Hull and East Yorkshire Hospitals NHS Trust**
**Minutes of the Quality Committee**
**Held 25 February 2019**

| | | |
|---|---|---|
| **Present:** | Prof M Veysey | Non-Executive Director (Chair) |
| | Mrs V Walker | Non-Executive Director |
| | Mr S Hall | Non-Executive Director |
| | Mr M Wright | Chief Nurse |
| | Dr M Purva | Chief Medical Office |
| | Mr D Corral | Chief Pharmacist |
| | Ms C Ramsay | Director of Corporate Affairs |
| | Mrs K Southgate | Acting Deputy Director of Quality Governance Assurance |
| | Ms J Jomeen | Associate Non-Executive Director |
| | Mrs M Stern | Patient Council Chair |
| | Mrs A Green | Lead Clinical Research Therapist |
| **In Attendance:** | Mr T Moran CB | Chairman |
| | Mrs T Filby | Assistant Chief Nurse for Special Projects |
| | Mrs R Thompson | Corporate Affairs Manager (Minutes) |

| No | Item | Action |
|---|---|---|
| **1** | **Apologies**<br>Mrs S Bates, Deputy Director of Quality Governance and Assurance<br><br>Prof Veysey thanked Mr Wright on behalf of the Quality Committee for his commitment and contributions over the years. This would be Mr Wright's last meeting before his retirement. | |
| **2** | **Declarations of Interest**<br>There were no declarations made. | |
| **3** | **Minutes of the meeting of 25 January 2019**<br>Item 9 – Any other business – Mrs Walker advised that she had spent time in the hospital at Christmas and it had come to her attention that there were patient outliers.<br><br>Following this change the minutes were accepted as an accurate record. | |
| | **3.1 Matters Arising**<br>Mr Wright advised that the Phlebotomy business case had been presented at the Executive Management Committee last week and had not been approved due to the costs. The service would be reviewing this and re-submitting the business case. | |
| | **3.2 Action Tracking List**<br>Mr Wright advised that the maternity dashboard was currently being developed and a summary would be circulated.<br><br>Prof. Veysey advised that a meeting was in place with Ms Ramsay and Mrs Walker and would report back to the next meeting. | |

**3.3 Any other matters arising**
There was no other matters arising.

**3.4 Workplan**
The Workplan was received for information. There were no changes to report.

**4.1 Serious Incidents - Lessons Learned Themes and Trends**
Mrs Southgate presented the report which highlighted the number of Serious Incidents. There had been 1 maternity incident de-escalated.

There was a discussion around maternity serious incidents and that 13 had been declared since April 2018. Mr Wright advised that a review by the Commissioners had been triggered due to the high number. Mr Wright wanted to review the incidents internally and did not feel that a full service review was necessary. The Committee discussed the Trust being an open organisation and a good reporter and how this compared with other Trusts. Dr Purva added that a full service review when not necessary could cause morale to be impacted. Mr Wright added that it could result in staff being less inclined to report incidents so openly.

**Resolved:**
The Committee received and accepted the report.

**4.2 Trustwide Learning Report**
Mrs Southgate presented the new report that the team had developed which triangulated all learning from areas such as audit, serious incidents, mortality reviews and claims to highlight any themes and trends emerging. Mrs Southgate asked the Committee if they thought it was useful and to feedback any questions or comments to her.

There was a discussion around end of life care and the new RESPECT form which had replaced the DNAR form. The Committee also discussed the work ongoing across primary care, hospices and other care providers to ensure end of life plans are adhered to.

The Committee discussed e-Observations and how electronic procedures were replacing manual ones such as blood pressure checks. The deteriorating patient was also discussed along with the wifi capabilities of the Tower Block. Mrs Stern stated that it was a fine line to improve electronic capability but not lose the human touch and nurse interaction with patients.

Mr Moran suggested that the Trust held ‘back to basics’ type days which concentrated on fundamental, manual observations.

Mr Hall advised that the Performance and Finance Committee was reviewing the next steps in rolling out the wifi and Ms Ramsay reported that the Board would be reviewing the Capital Plan at the February Board.

**Resolved:**
The Committee received and accepted the report. It was agreed that the report would be presented quarterly and would be added to the workplan. **RT**

**4.3 Quality Improvement Programme (Progress Report)**
Mrs Southgate presented the item and advised that the full QIP had been circulated and 19 projects were still open in February. A number had not met the aims and objectives but the team was working with the leads to review each QIP.

Mr Wright highlighted the Nutrition standard and how the charts were not being completed rather than patients not being fed. Mrs Filby (Assistant Chief Nurse – Special Projects) was reviewing this fundamental standard along with others not being delivered.

Mr Hall asked about infection control and why the lead had not formally updated the QIP. Mrs Southgate advised that this was due to hospital pressures and rather than a formal meeting an update was provided by email. Mrs Southgate advised that the QIP was amber due to the fact it was still on track.

Prof Jomeen asked if the QIPs were too ambitious in the current pressurised environment and Mr Wright assured her that they the milestones were reviewed annually to review that the correct milestones are in place.

Mrs Walker stated that she had met with Ms Rudston regarding the Service Level Agreement with Humber FT NHS Trust. Mr Wright advised that work was ongoing to ensure this happened but capacity at Humber was an issue. He added that the relationships with CAHMS had improved.

Mrs Southgate advised that the planning process for 2019/20 was underway and the key projects being taken forward were Medicine Optimisation, Falls, Pressure Ulcers, Nutrition, Outpatients and Mental Health. The new QIP would be presented to the Committee at the end of March and final sign off would be in April 2019.

Mr Wright advised that he would be presenting the summary of the QIP to the next Board meeting in March 2019.

**Resolved:**
The Committee received and accepted the report.

**4.4 World Health Organisation Checklist and SSIPS**
Dr Purva presented the item and advised that the new revised checklist was more patient focussed and was being audited by independed teams within the Trust. The Trust was aiming to achieve 100% compliance and was currently at 95%. She advised that the focus was to sustain performance.

Prof. Veysey stated that the theatre staff should be congratulated for the huge improvements seen so far. He asked how new and current staff where made aware of the checklist. Dr Purva advised that there was an e-learning module for new and existing staff and reporting was monitored at the Operational Qualit Committee and Performance and Accountability meetings.

Mr Wright added that the ‘stop the line’ initiative had empowered nurses and all staff to pause any procedures if they were not 100% sure the right

procedures were being followed.

Mr Moran suggested having an anonymised questionnaire sent to all staff involved to ensure the checklist was being adhered to properly. Dr Purva agreed that this was a good idea. Mr Wright added that results would be publicised outside theatres for all staff to see.

The programme was being rolled out to all theatres and was making good progress.

**Resolved:**
The Committee received and accepted the report.

**5.1 Integrated Performance Report**
The Committee members discussed the report and how the information was used between the Quality and Performance and Finance Committees.

Mr Moran highlighted a number of areas; RTT, HSMR and FFT in A&E and asked what assurance was being provided to ensure patient care was not being compromised. Mr Wright advised that pressures in A&E would mean patients reporting worse scores on the FFT. Mrs Stern added that one bad experience in A&E could outweigh good performance when patients were waiting to be seen.

Dr Purva reported that the HSMR standard was complicated and deaths data would need to be scrutinised further to ensure robust information was presented. She added that a report was being presented to the Board in March 2019.

Ms Ramsay added that assurance could be taken from the Quality Improvement Plan and Mr Wright's Quality Report to the Board.

**Resolved:**
The Committee received and accepted the report.

**5.2 Operational Quality Committee Report**
Mr Wright advised that due to operational pressures the last 2 Operational Quality Committee's had been cancelled. He added that there was no critical business to report.

**6 Board Assurance Framework**
Ms Ramsay presented the framework and advised that the Quarter 3 ratings had been discussed at the January Board meeting and that she was currently reviewing the Quarter 4 ratings. This would determine the end of year ratings and either give assurance or highlight gaps in assurance. The work in progress Quarter 4 report would be presented to the March Committee meeting.

**Resolved:**
The Committee received and accepted the report.

**7 Any Other Business**
Mrs Stern thanked Mr Wright for being a patient friend, and making her feel safe through his care and compassion.

**8 Chairman's Summary to the Board**

The Chairman agreed to summarise the meeting to the Board.

**9 Date and time of the next meeting:**

Monday 25 March 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

# Hull University Teaching Hospitals NHS Trust
# Trust Board – March 2019

## Performance Report
## Executive Summary

### 1. Performance Summary

The Performance Report (for January data) details the following 'responsiveness' indicators (please note December data for cancer standards) which have failed to meet the required *national standards*:-

- The 95% 4-hour Emergency Care standard;
- The RTT Incomplete standard;
- 52 Week Wait standard;
- The Breast Symptom Two Week Wait Cancer standard;
- The 31 day Decision to Treat Cancer standard;
- The 31 Day Subsequent Surgery Cancer Standard;
- The 62 day Referral to Treatment Cancer standard;
- The 62 day Screening Referral to Treatment Cancer standard;
- The cancelled operation 28 day readmission standard;
- Urgent Cancelled Operation for the second time;
- Diagnostic 6 week wait standard

Whilst the Trust did not meet the *national standards* outlined above, the Trust also failed to achieve all agreed improvement trajectories related to the Strategic Transformation Fund (PSF) as outlined below:-

- The 90% trajectory for the 4-hour Emergency Care standard;
- The 83.3% trajectory for the RTT Incomplete standard;
- The 52 Week Wait standard of zero breaches
- The 82.1 % trajectory for 62 day Referral to Treatment Cancer standard

Performance against all 'responsiveness' indicators is monitored weekly by the Performance and Activity Meeting, chaired by the Chief Operating Officer. All Health Groups are required to outline the key reasons for failure of each of the above standards and/or PSF trajectory, and to outline the agreed actions required to address underperformance against each standard, and further to identify and agree recovery timelines for improvement of performance to the required level.

### 2. Non Elective Standards

#### 2.1 Emergency Department

The Trust has received confirmation from NHS Improvement that it has achieved the Quarter 3 Provider Sustainability Funding (PSF). A hospital wide plan to deliver 95% system wide performance during March 2019 has been developed. From Saturday 2nd March additional space has opened to support the Emergency Care Area (ECA) providing a dedicated area for primary care streaming and speciality reviews. The space offers 4 assessment and treatment cubicles along with a separate waiting area and occupies the space which previously housed the discharge lounge.

#### 2.2 Length of Stay Reduction Programme

There has been a reduction in the number of patients who have a length of stay of 21 days or over (referred to as 'Super Stranded' patients) during November and December 2018 with 17 of the required 30 bed reduction (as defined by NHSI) achieved for the month of December.

During February, the Trust has commenced a piece of work with the national Emergency Care Improvement Support Team (ECIST) to review the Trusts processes for reviewing long length of stay patients and ensure that processes for managing these patients both internally and with out of hospital partners are fully optimised. The ECIST team reviewed 5 wards on the HRI site at their initial visit and identified some areas where LOS could be reduced including more oppportunities for delivery of IV antibiotic therapy in the community or at home. ECIST also identified that there were opportunities to work more effectively with out of hospital partners, particularly regarding Trusted Assessments and Discharge to Assess models as current processes where duplicating work for both hospital and out of hospital teams. All of the learning for the ECIST work and wider Length of Stay reviews will be taken forward by the Unplanned Care Delivery Board.

From January, the Trust has agreed daily discharge targets with all community partners to support effective flow of patients requiring a supported discharge from the Trust. This is working well and the number of supported discharges has increased since this commenced.

**2.3 Stroke Care standard**s

The Trust continues to meet the standard for patients with symptoms of a stroke having a CT scan within 60 minutes of attending the hopsital and patients receiving at least 90% of their care on a stroke ward.

**3. Cancer Standards**

The Trust continues to perform well against the 2 Week standard and has consistently met the standard all year. The Trust also continues to meet the 31 day subsequent drug standard and the 31 day subsequent radiotherapy standard.

Whilst the Trust is not achieving the national standard for Cancer 62 day RTT, there was a 4.4% Improvement in performance December compared to November. There was also a 15% Improvement in the 62 day screening standard in December compared with November.

Additional investment in diagnostics (MRI, CT and Endoscopy) from December 2018 utilising Cancer Alliance funding is contributing toward improved performance and is gradually reducing waiting times for these tests. The additional investment is in place until the end of March and additional investment in CT, MRI and Endoscopy is prioritised for 2019/2020.

**4. Elective Standards**

**4.1 Waiting List Volume**

The Trust continues to maintain its Waiting List Volume below the 31/3/18 baseline.

**4.2 52 Week Wait standard**

The Trust has made a commitment to eliminate all 52 week breaches by the end of March.

The Trust had been meeting it trajectory, recording 3 x 52 week breaches in November and 4 x 52 week breaches in December. However, flooding of a number of theatres in the Centenary building in early January resulted in a loss of theatre capacity for 17 days and consequently resulted in a number of long wait patients being cancelled. This resulted in the Trust going off trajectory for January and February. Considerable efforts has been made to recover the trajectory and all patients that require treatment by the end of March have been dated.

There remains continued risk of late Inter-Hospital Transfers (IHT) from other Trusts impacting on the delivery of this standard, however these will be managed in accordance with the IHT policy and exception reported accordingly should they breach the 52 day standard.

**4.3 Diagnostic 6 week standard**

The January performance against the 6 week diagnostic standards improved by almost 1% compared with December which was largely as a result of additional investment in CT, MRI and Endoscopy capacity utilising Cancer Alliance funding. Continued Improvement has been achieved throughout February, with the number of breaches reducing by circa 200 for the month equating to a 2% Improvement on Januarys performance.

Teresa Cope,
Chief Operating Officer
4th March 2019

Hull University Teaching Hospitals NHS Trust

# Integrated Performance Report 2018/19

March 2019

January 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/

# Integrated Performance Report -March 2019

RESPONSIVE

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

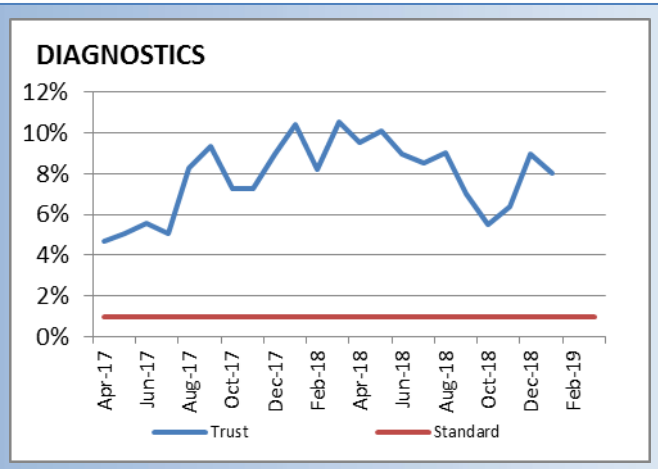
**Diagnostic Waiting Times: 6 Weeks**

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 January 2019

Diagnostic waiting times has failed to achieve target during January with performance of 8.02%



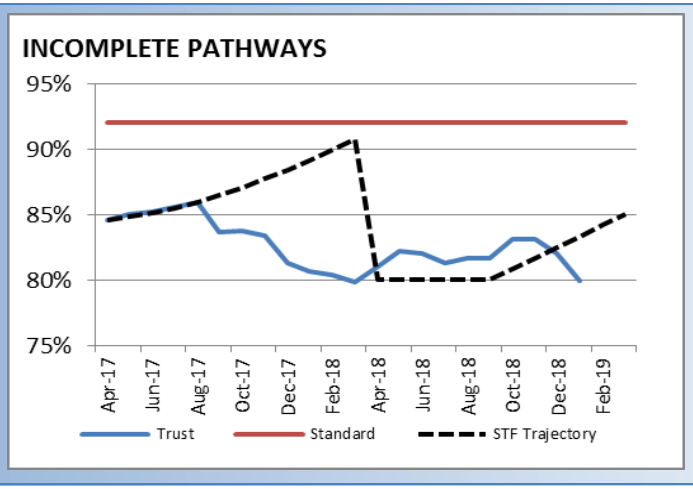

**Referral to Treatment Incomplete pathway**

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

The latest performance available is January 2019

The Trust failed to achieve the January improvement trajectory of 83.3%

January performance was 79.89%. This failed to meet the national standard of 92%.




The RTT return is grouped in to 19 main specialties.

During the month there were 10 specialties that failed to meet the STF trajectory

# Integrated Performance Report -March 2019

RESPONSIVE

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

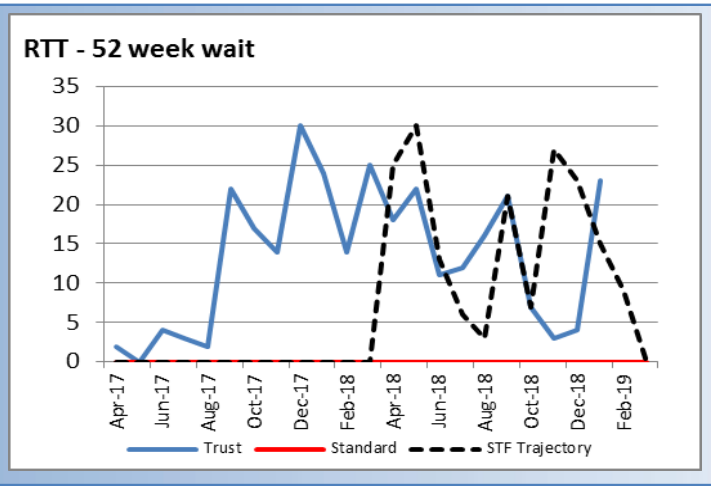
## Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

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

Performance failed to achieve the January improvement trajectory of 15 breaches with 23 breaches during January

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



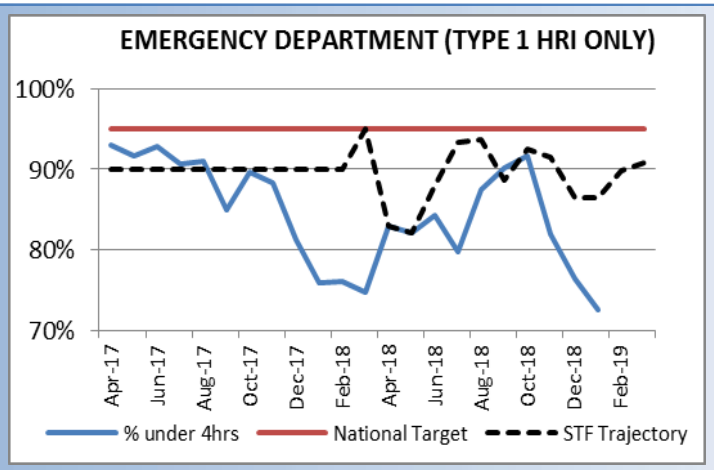

## ED Waiting Times (HRI only)

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 90% with performance of 72.5% for January.

This has failed to achieve the national 95% threshold.




Performance has decreased 3.8% during January from the December position.

# Integrated Performance Report -March 2019

RESPONSIVE

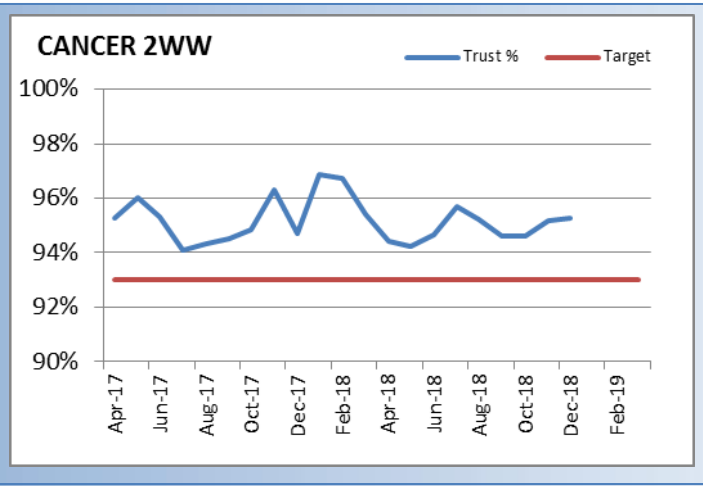
Hull University Teaching Hospitals NHS Trust

| 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%.

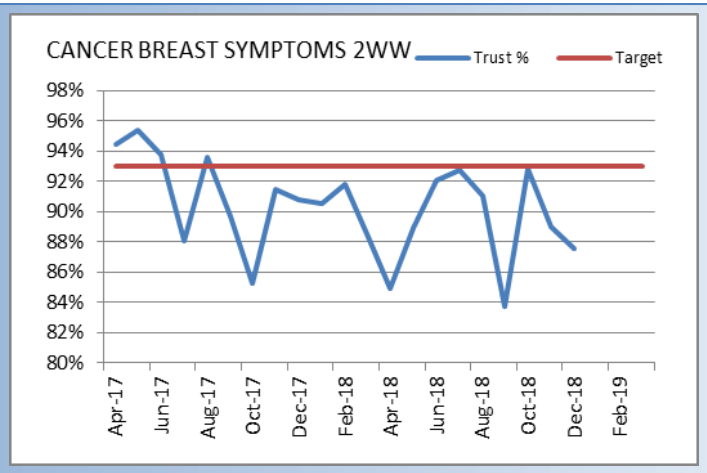
December performance achieved the 93% standard at 95.3%




**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.

December performance failed to achieve the 93% standard at 87.6%



# Integrated Performance Report -March 2019

RESPONSIVE

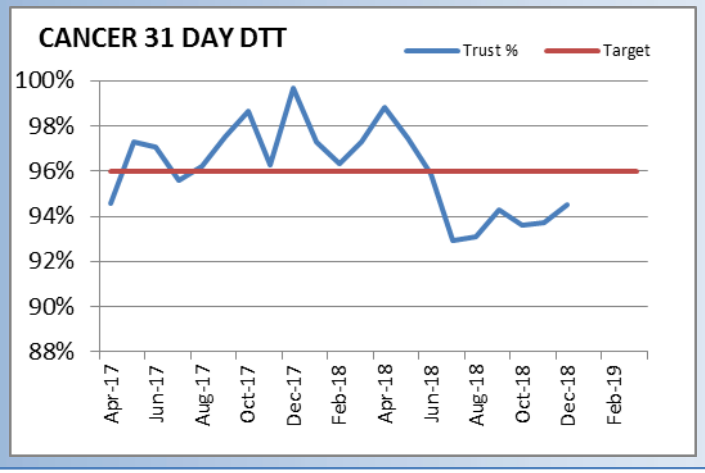
Hull University Teaching Hospitals NHS Trust

| 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%.

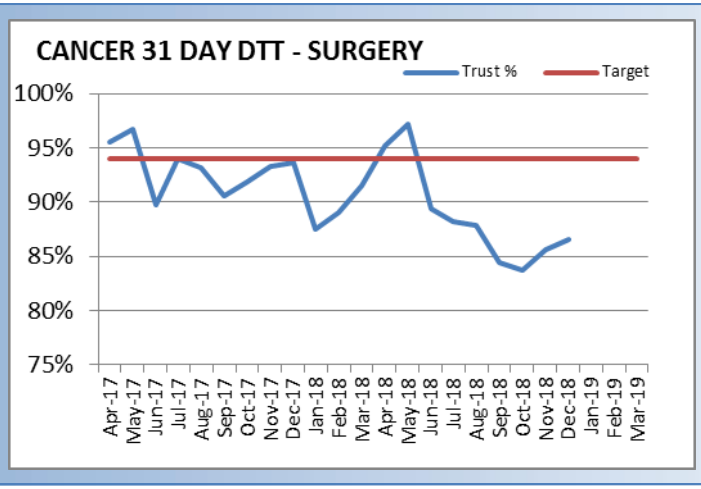
December performance failed to achieve the 96% standard at 94.5%




**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%.

December performance failed to achieve the 94% standard at 86.6%



# Integrated Performance Report -March 2019

Hull University Teaching Hospitals NHS Trust

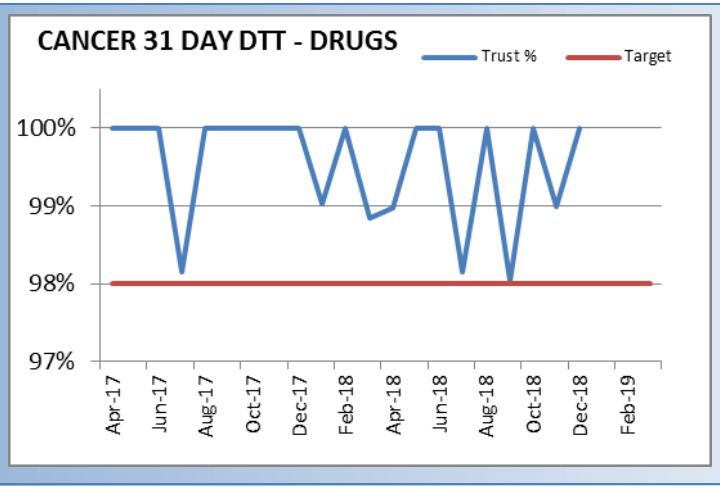
RESPONSIVE

| 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%.

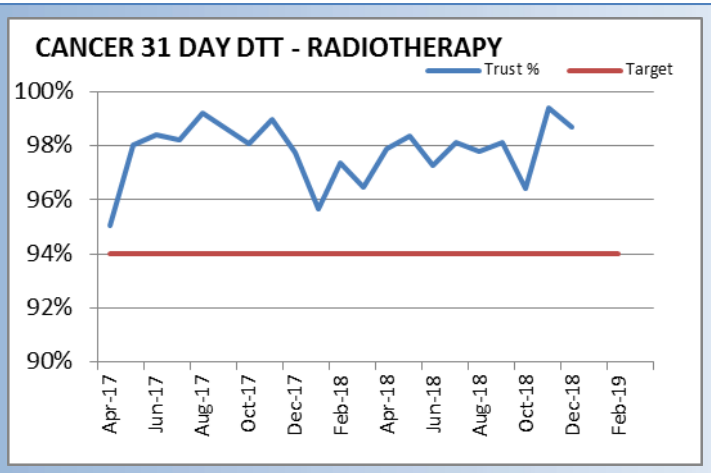
December performance achieved the 98% standard at 100%




**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%.

December performance achieved the 94% standard at 98.7%



# Integrated Performance Report -March 2019

RESPONSIVE

Hull University Teaching Hospitals NHS Trust

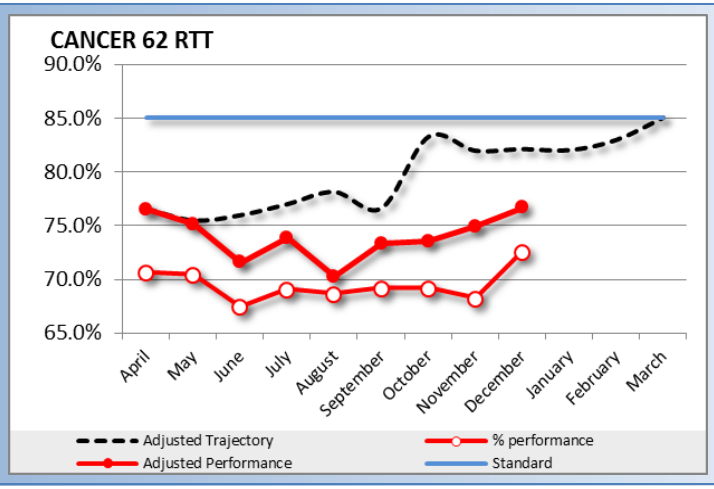
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**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

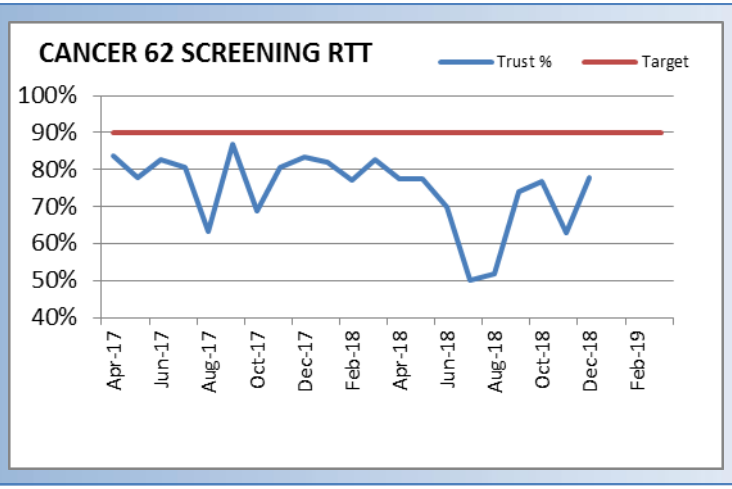
December adjusted performance failed to achieve the STF trajectory of 82.1% with performance of 76.7%




**Cancer: 62 Day Screening Standard**

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

December performance failed to achieve the 90% standard at 77.8%



# Integrated Performance Report -March 2019

RESPONSIVE

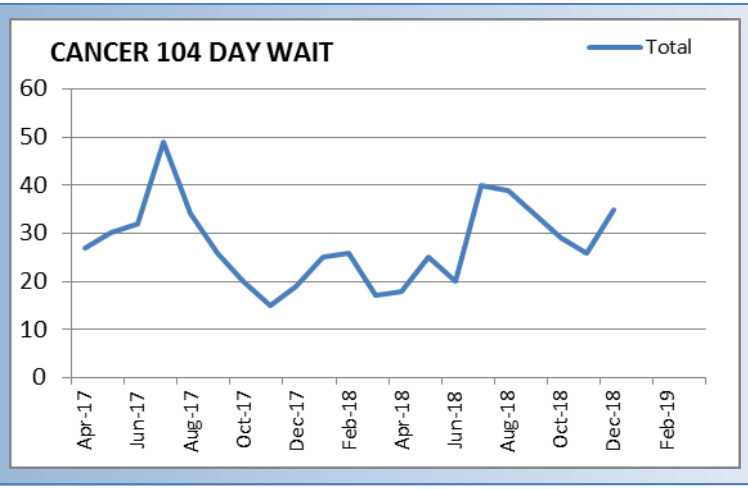
Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**Cancer: 104 Day Waits**

**Cancer 104 Day Waits**

**There were 35 patients waiting 104 days or over at the end of December**



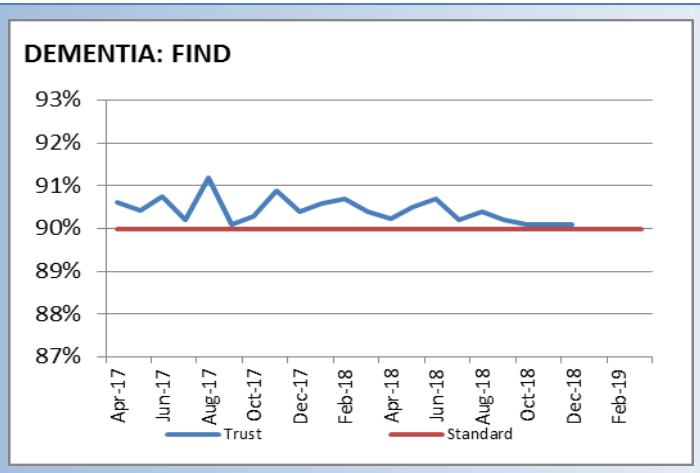

**Dementia: Aged 75 and over emergency admission greater than 72 hours**

**% 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 December 2018.**

**The standard for this indicator is to achieve 90%.**

**Performance for December achieved this standard at 90.10%**



# Integrated Performance Report -March 2019

RESPONSIVE

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

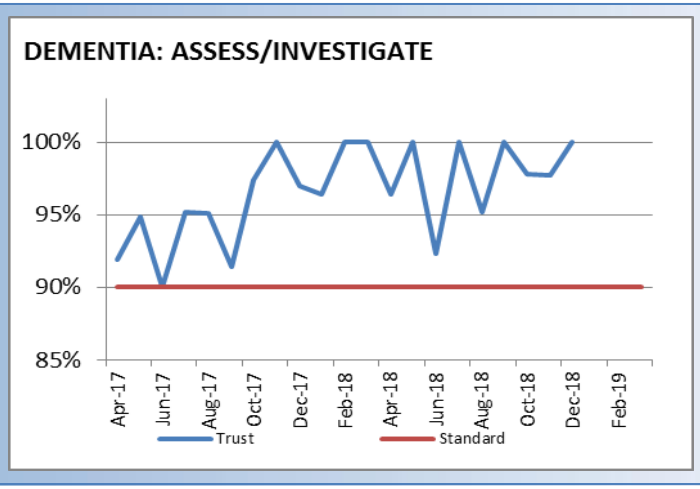
**Dementia: Aged 75 and over emergency admission greater than 72 hours**

% 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 December 2018

The standard for this indicator is to achieve 90%.

Performance for December achieved this standard at 100%



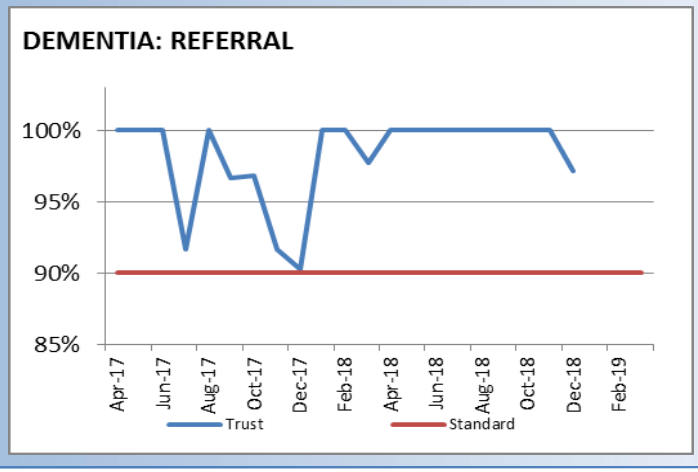

**Dementia: Aged 75 and over emergency admission greater than 72 hours**

% 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 December 2018.

The standard for this indicator is to achieve 90%.

Performance for December achieved this standard at 97.2%



# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## SAFE

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

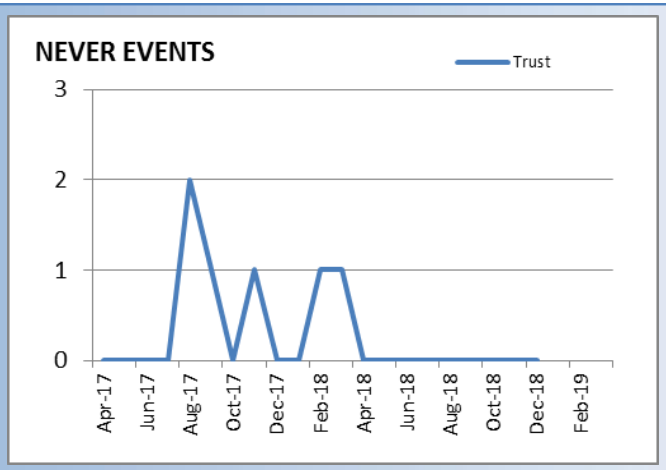
**Occurrence of any Never Event**

**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**

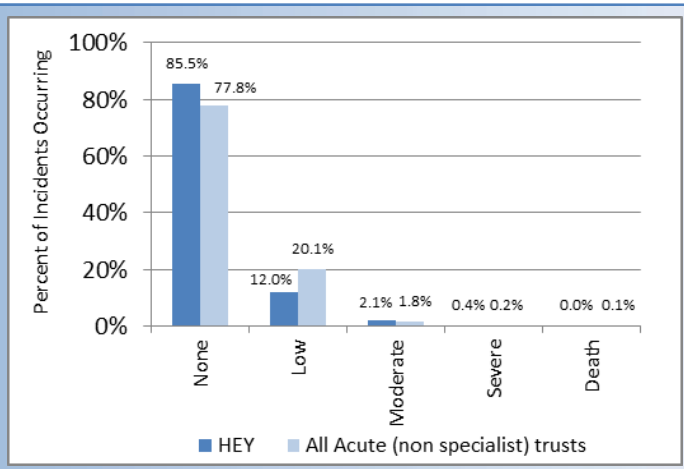
**Potential under-reporting of patient safety incidents**

**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**



# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## SAFE

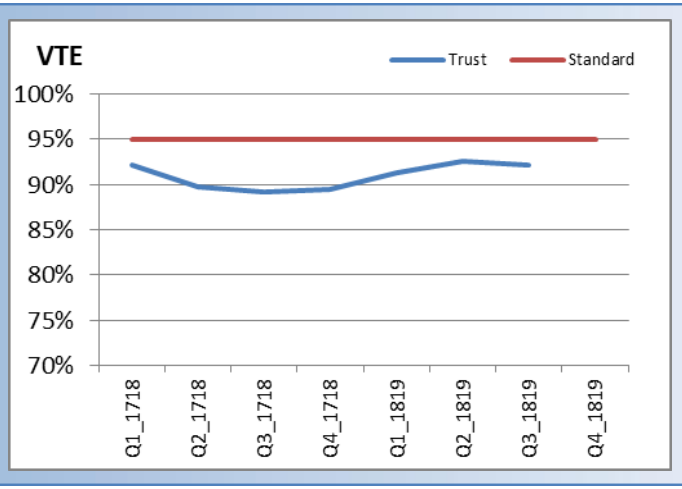
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**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 92.19% for Q3 2018/19.

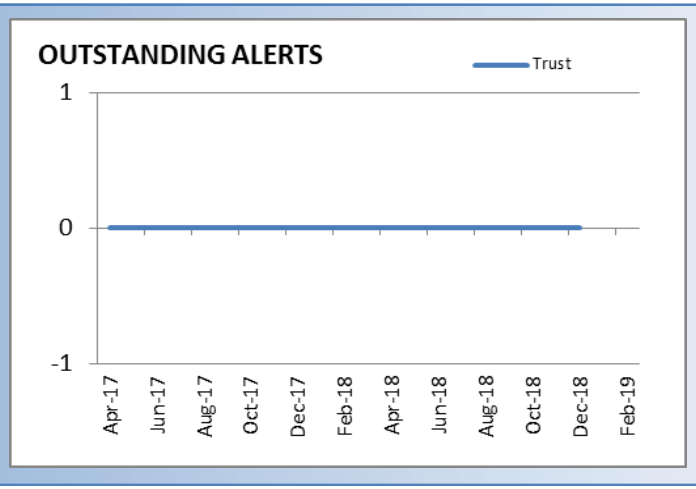



**Patient Safety Alerts Outstanding**

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

There have been zero outstanding alerts reported at month end for January 2019.

There have been no outstanding alerts year to date.



# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## SAFE

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

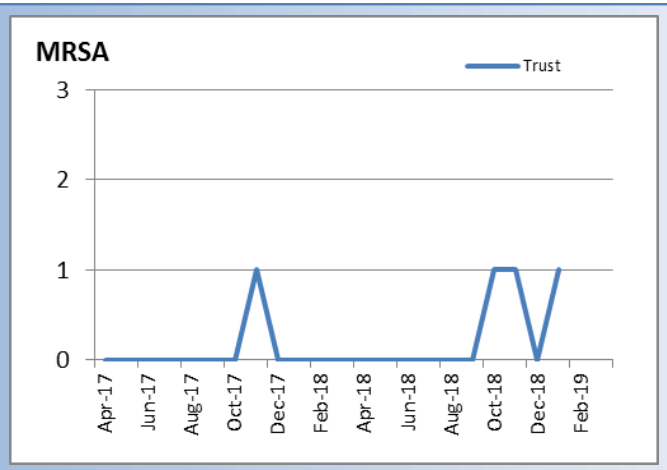
### MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

The Trust reported 1 case of acute acquired MRSA bacteraemia during 2017/18.

There was 1 case reported during January 2019.

There have been 3 cases reported year to date.




Further information is included in the Board Quality report

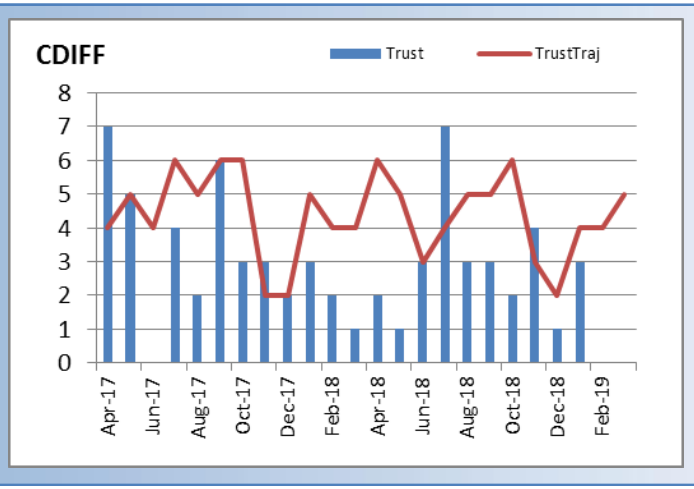
### Clostridium Difficile

The Clostridium difficile target for 2018/19 is no more than 52 cases

There were 38 cases during 2017/18

There were 3 incidences reported during January which achieved the monthly trajectory of no more than 4 cases

Year to date position is 29 cases against the target of no more than 52 cases.




Further information is included in the Board Quality report

# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## SAFE

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

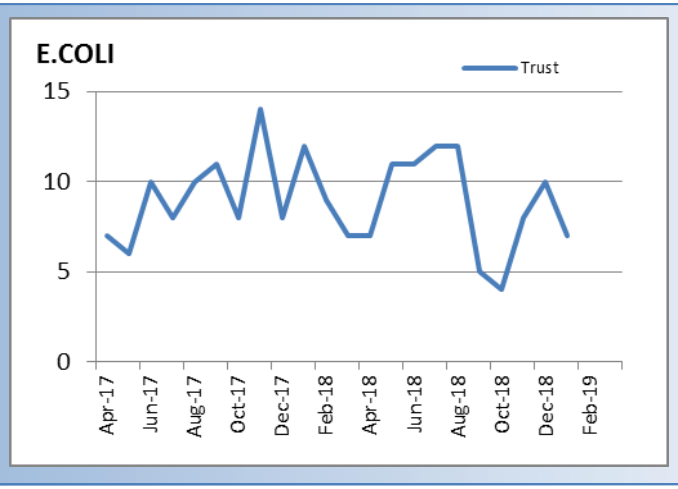
**Escherichia Coli**

**Number of incidence of E.coli bloodstream infections**

**There were 110 cases during 2017/18**

**There were 7 incidences reported during January 2019.**

**There have been 87 incidences reported year to date.**

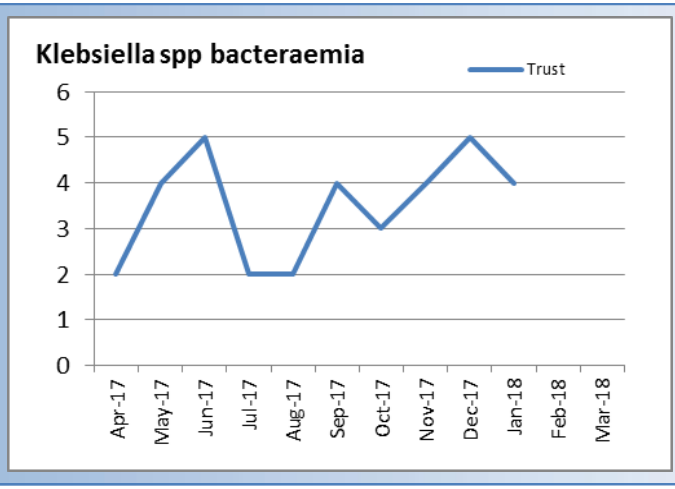



**Klebsiella spp bacteraemia**

**Number of incidence of Klebsiella spp bacteraemia**

**There were 4 incidences reported during January 2019.**

**There have been 35 incidences reported year to date.**



# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## SAFE

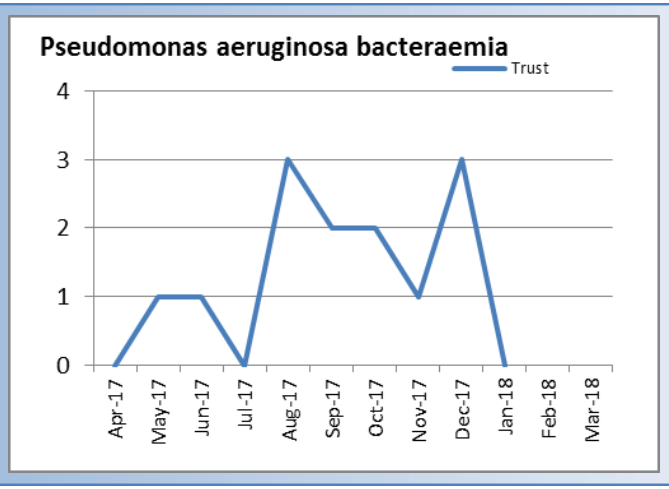
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**Pseudomonas aeruginosa**

**Number of incidence of Pseudomonas aeruginosa bacteraemia**

**There have been zero incidences reported during January 2019.**

**There have been 13 incidences reported year to date.**

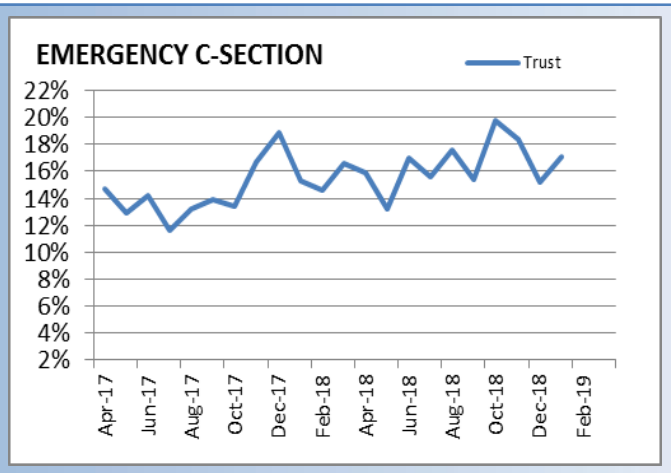



**Emergency C-section rate**

**Maternity: Emergency C-section rate per month**

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

**Performance for January failed to achieve this standard at 17.10%**




**Further information is included in the Board Quality report**

# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## EFFECTIVE

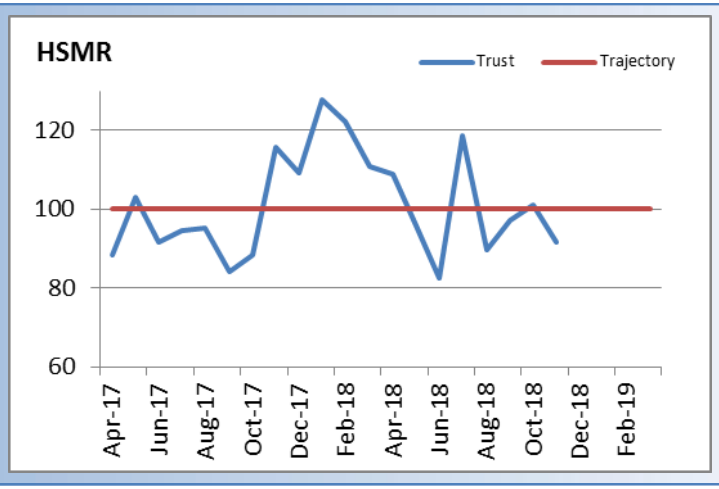
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

### 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

November 2018 is the latest available performance

The standard for HSMR is to achieve less than 100 and November 2018 achieved this at 91.5

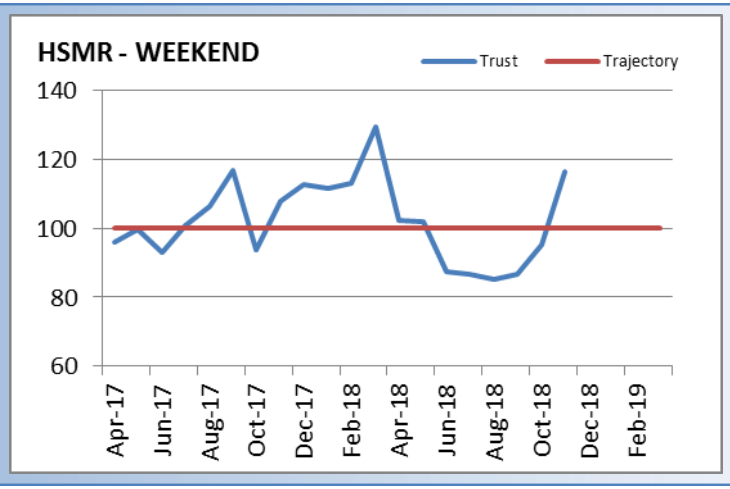



### HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

November 2018 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and November 2018 failed to achieve this at 116.2



# Integrated Performance Report - March 2019

Hull University Teaching Hospitals NHS Trust

## EFFECTIVE

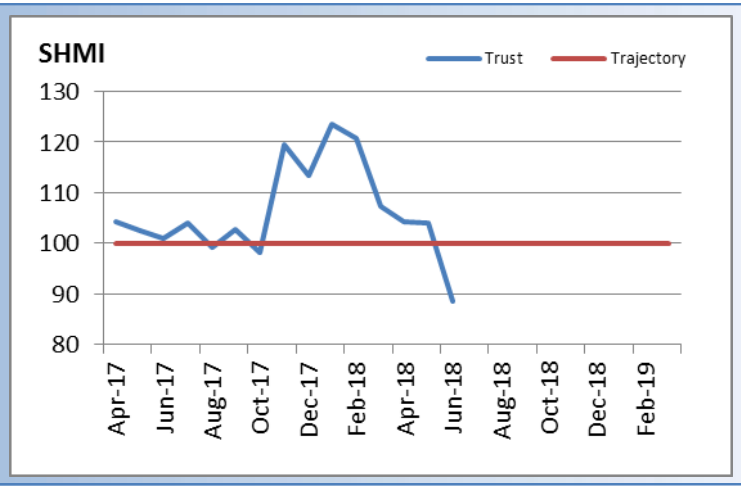
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

### 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.**

**June 2018 is the latest published performance**

**The standard for SHMI is to achieve less than 100 and June 2018 achieved this at 88.5**

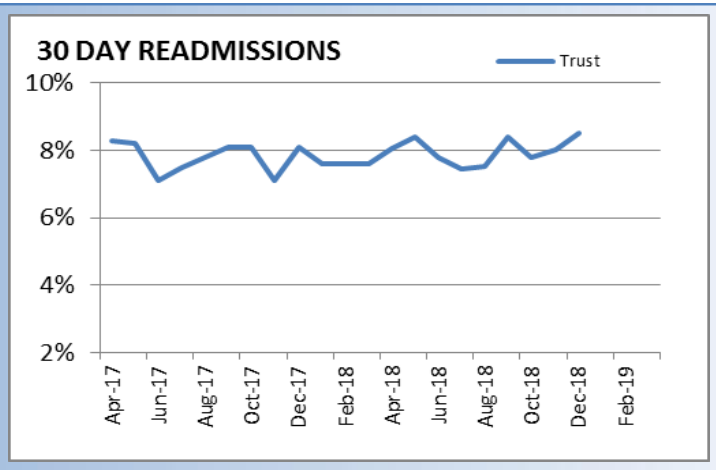



### 30 DAY READMISSIONS

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

**The latest available performance is December 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 8.52%.**



# Integrated Performance Report - March 2019

CARING

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

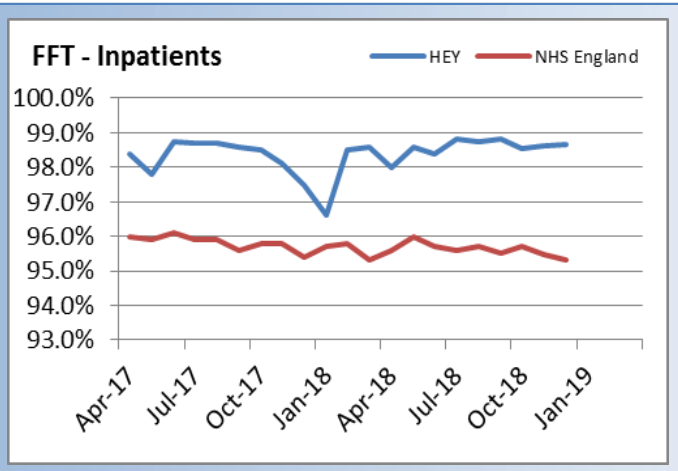
**Inpatient Scores from Friends and Family Test - % positive**

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

Performance for December was 98.61%

The latest published data for NHS England is December 2018.

January performance will be published on 7th March 2019.



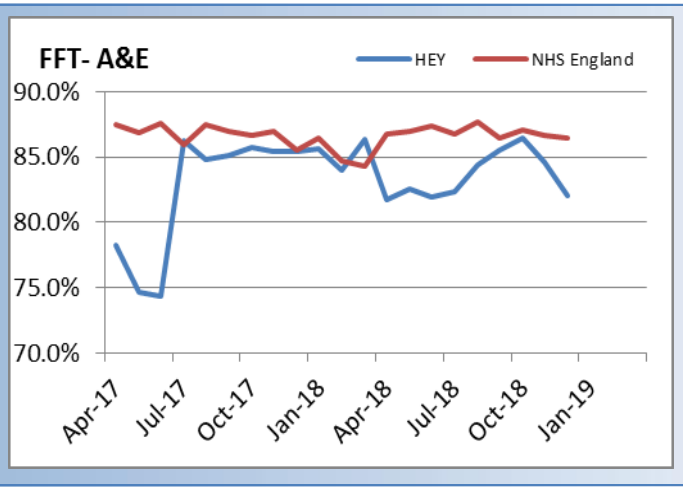

**A&E Scores from Friends and Family Test - % positive**

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

Performance for December was 84.55%

The latest published data for NHS England is December 2018.

January performance will be published on 7th March 2019.



# Integrated Performance Report - March 2019

CARING

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

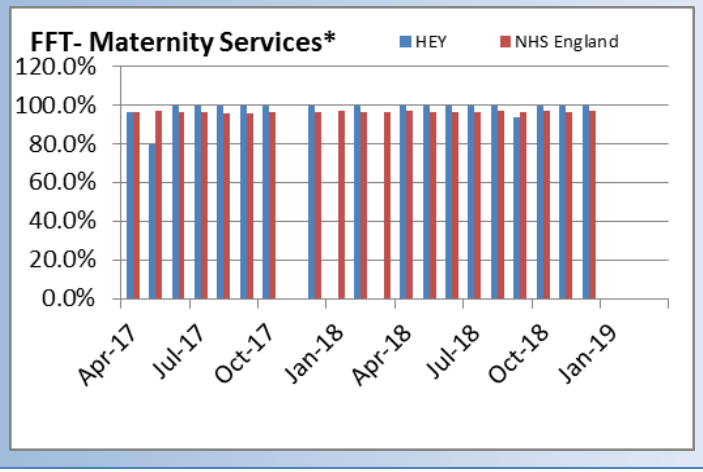
**Maternity Scores from Friends and Family Test - % Positive**

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

Performance for December was 100%

The latest published data for NHS England is December 2018.

January performance will be published on 7th March 2019.

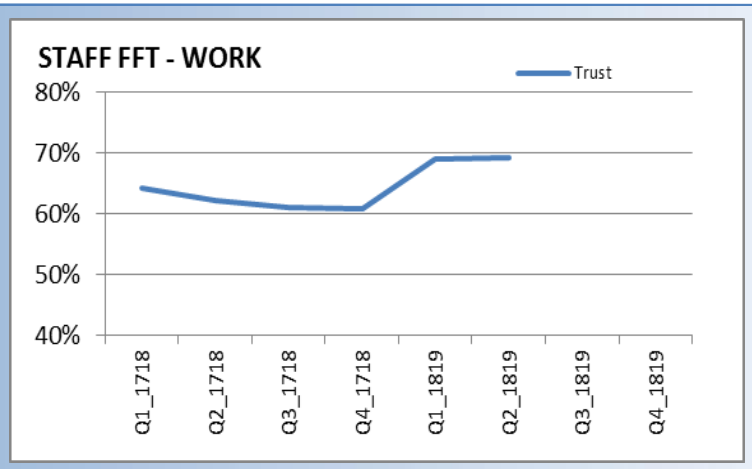



* Question relates to Birth Settings

**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%.



# Integrated Performance Report - March 2019

CARING

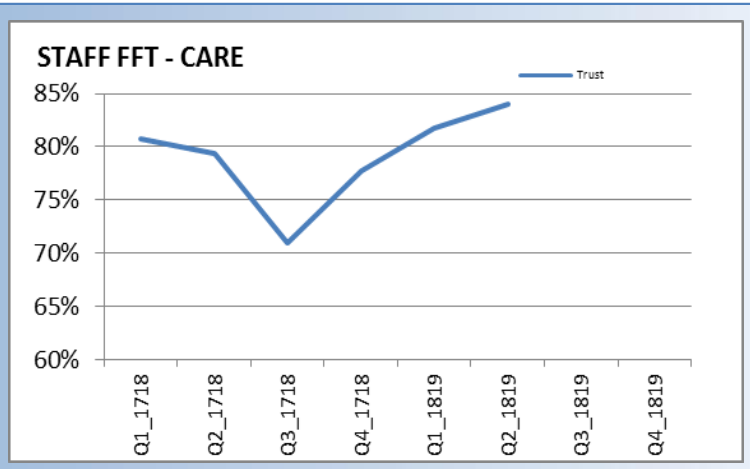
Hull University Teaching Hospitals NHS Trust

| 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%.

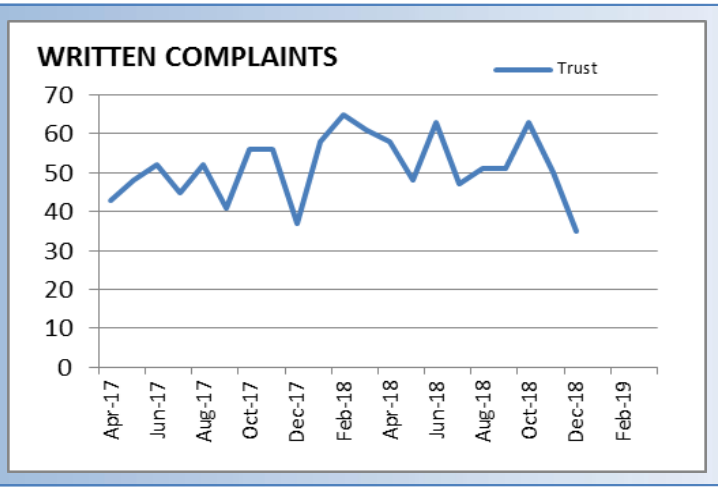



## Written Complaints Rate

The number of complaints received by the Trust

The latest available position is December 2018.

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

# Integrated Performance Report - March 2019

CARING

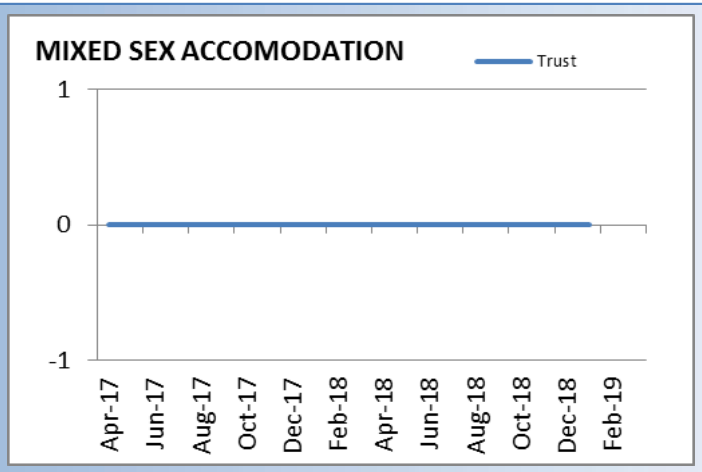
Hull University Teaching Hospitals NHS Trust

| 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 January 2019.**



# Integrated Performance Report - March 2019

## ORGANISATIONAL HEALTH

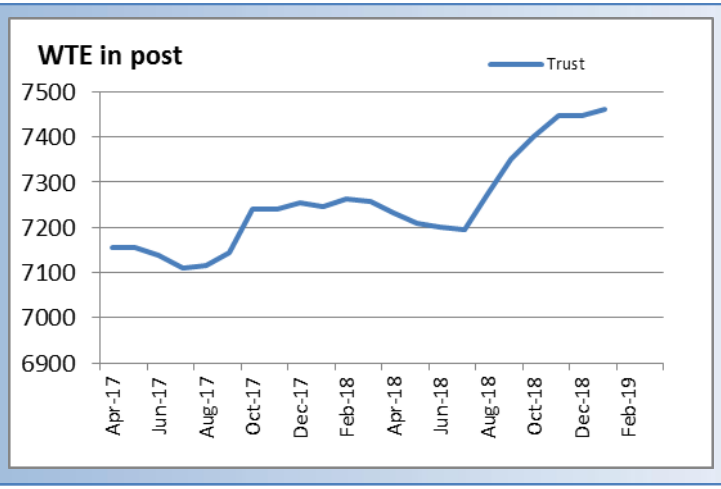
Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**WTEs in post**

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

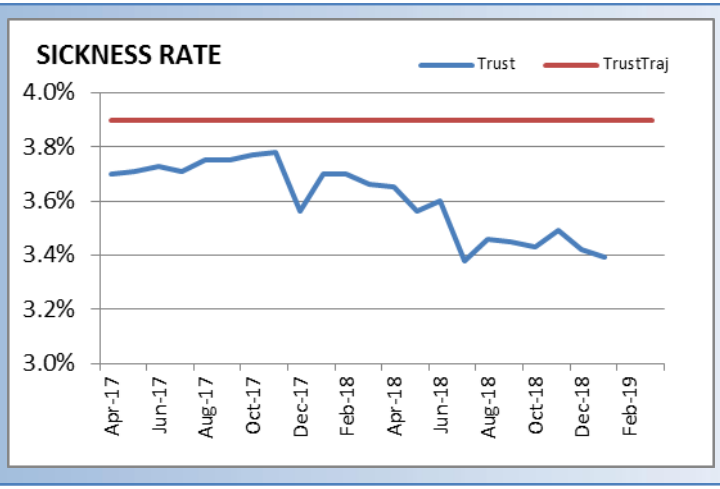
**Trust level WTE position as at the end of January was 7462**




**Sickness Absence Rates**

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

**Performance for January achieved the standard of less than 3.9% with performance of 3.39%**



# Integrated Performance Report - March 2019

## ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

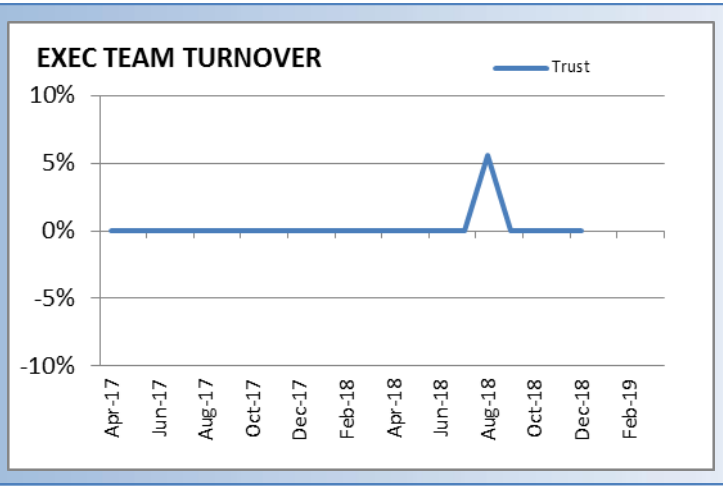
| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**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 January.**

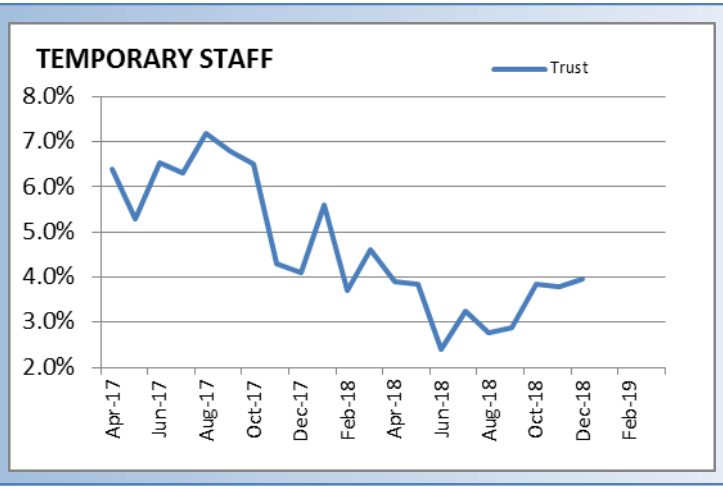



**Proportion of Temporary Staff**

**% of the Trusts pay spend on temporary staff**

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

**January performance was 3.90%**



# Integrated Performance Report - March 2019

ORGANISATIONAL HEALTH

NHS
Hull University Teaching Hospitals
NHS Trust

## FINANCIAL SUMMARY: 10 MONTHS TO 31st JANUARY 2019

1. At the end of January, the Trust is reporting a SOCI surplus of £1.7m which is a shortfall of £1.0m against plan. The shortfall relates to the non delivery of the ED target for quarter 1 and potential non delivery of Q4. The Trust was successful in its appeal regarding quarter3 ED performance and has received the full PSF for that period. In month the overall Health Group and Corporate position deteriorated by £0.7m which was £0.3m more than expected.

2. In month the Trust has over performed against contract on its clinical activity by circa £1.3m. The main areas of overtrade were in the admitted pathways as there was not the anticipated dip in elective activity in January. Overall elective activity was £1.8m above plan. However this increased the amount the Trust is now above the indicative AIC plan by £1.4m to £2.3m. An element of this relates to the additional Cancer and 52 week activity clearance undertaken which will be funded separately by the local commissioners.

3. The Trust is £2.1m below plan for CRES delivery at month 10 with £11.2m delivery against a target of £13.4m (84% delivery) with a £0.7m deterioration in month. This is partially offset by the phasing in of £0.4m of the CRES contingency reserve in month. The year end CRES forecast is now £2.8m (17%) below plan excluding the non delivery of the SPV, which would be covered by the release of the contingency and other reserves.

4. HG run rate positions are £4.4m overspent at month 10, an increase of £0.1m in month. Surgery Health Group deteriorated by £0.2m in the month with the majority being in medical and nurse staffing. Pass through drug costs under AIC reduced in month by £0.1m. CSS deteriorated by £0.2m due to non pay pressures in Pathology. Corporate budgets improved by £0.2m in month due to reduced use of agency staffing.

5. Health Groups and Corporate budgets are forecasting that they will be £7.8m overspent at year end, an increase of £0.3m in month. The main shortfall is CRES delivery at £2.8m (partially covered by CRES Contingency), and £1.8m cost of drugs not reimbursed under the AIC contract. The other main pressures remain medical and nurse staffing. Centrally we have assumed the position will be £0.75m worse than this in the overall forecast as delivery of the HG position will be challenging and requires real cost control in last 2 months.

6. The Trust is expecting to receive the agenda for change funding relating to staff employed by OCS who previously worked for the Trust but this has still not been officially confirmed and therefore remains a minor risk.

7. Agency spend to the end of January is £9.3m which is above planned level of £7.2m although the in month position was in line with plan. The variance is driven completely by agency medical staffing with the main variances relating to junior medical staff (£1.0m) and Consultant cover (£1.1m).

8. The Trust can currently offset the forecast overspend relating to the CRES (excluding SPV) by releasing the £2.5m CRES contingency reserve and a small amount of other reserves. However the shortfall relating to the SPV assumption of £2.9m still requires actions to be confirmed, along with actions for an additional £1.9m of pressures (including clinical waste and contract challenges from NHSE). The Trust is still in discussion with local commissioners to identify additional funding (£2m - £3m) and is also looking at a Revenue to Capital benefit (£1.3m). However other actions (£0.5m - £1.5m) will need to be identified including health groups maintaining grip on their forecast positions and a review of further income opportunities.

9. The reported capital position at month 10 shows gross capital expenditure of £11.2m which is below planned levels of £22.4m 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 February & March. The forecast position for capital expenditure is £21.1m which is £15.8m below initial planned figures mainly as a result of slippage on loan funding into 19/20 (£16.3m). The Trust is still awaiting final confirmation of HSLI bids and this has been excluded from the month 10 forecasts. Also excluded from the forecast is the use of the unspent depreciation (£0.4m) from 17/18 as this has still not been approved by NHSI.

10. The Trusts liquidity position continues to be relatively stable but this will become more difficult given the current expenditure trends and increased expenditure on capital. This will be managed through working capital including the timing of supplier payments.

11. The Trusts current underlying run rate stands at £23.5m reduced from £25.6m reported at end of 17/18

# Integrated Performance Report - March 2019

## ORGANISATIONAL HEALTH

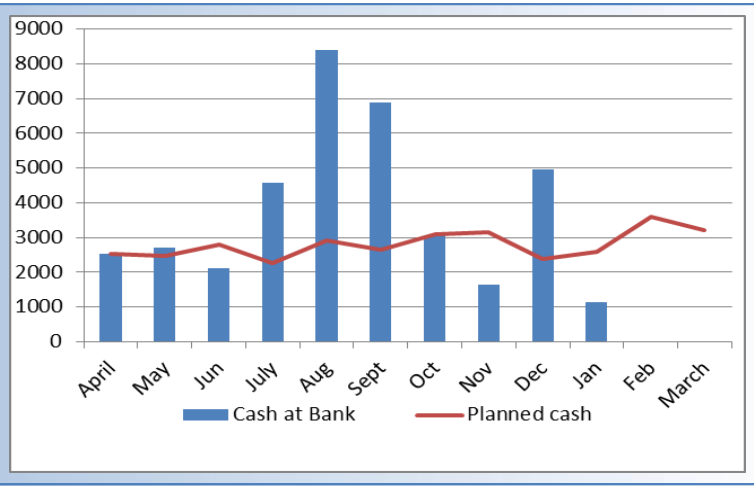
Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

**Cash Balance**

**Cash on deposit <3 months deposit**

At the end of January we had postive cash position of £1.148m, comprising of monies in the bank of £1.127m and £0.021m 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.

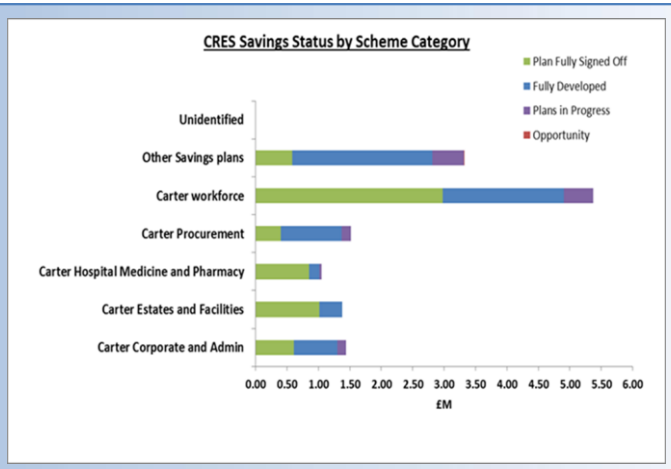



**CRES Achievement Against Plan**

**Planned improvements in productivity and efficiency**

At month 10 the Trust's planned level of savings is £13.3m, the actual savings to date is £11.2m thereby creating a £2.1m 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.



# Integrated Performance Report - March 2019

## ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

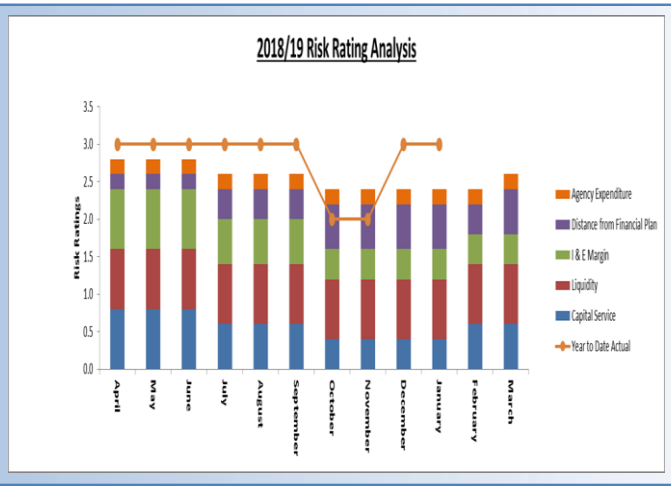
**Risk Rating**

**Financial Sustain-ability 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 10 the Trust is reporting a YTD deficit of £2.0m against a planned position of £2.7 deficit. This has resulted in liquidity & Capital Servicing being rated as a 4, & I&E margin being rated as 3. The distance from plan & the agency metric being rated as 2, giving an overall risk rating of 3.

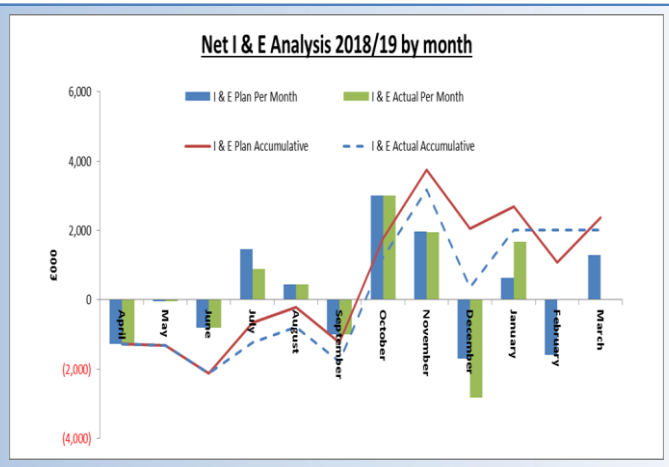



**Income & Expenditure**

**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 10 the Trust has delivered a deficit of £2.0m against a planned deficit of £2.7m



**Hull and East Yorkshire Hospitals NHS Trust**
**Minutes of the Performance and Finance Committee**
**Held on 28 January 2019**

| | | |
|---|---|---|
| **Present:** | Mr S Hall | Non-Executive Director (Chair) |
| | Mrs T Christmas | Non-Executive Director |
| | Mr M Gore | Non-Executive Director |
| | Mrs T Cope | Chief Operating Office |
| | Ms C Ramsay | Director of Corporate Affairs |
| | Ms J Myers | Director of Strategy and Planning |
| | Mr S Nearney | Director of Workforce and OD |
| | Mr S Evans | Deputy Director of Finance |
| | Mrs A Drury | Deputy Director of Finance |
| **In Attendance:** | Mrs R Thompson | Corporate Affairs Manager |

| No | Item | Action |
|---|---|---|
| 1 | **Apologies:**<br>Apologies were received from: Mr Lee Bond – Chief Financial Officer | |
| 2 | **Declarations of Interest**<br>There were no declarations received. | |
| 3 | **Minutes of the meeting held 17 December 2018**<br>The minutes were approved as an accurate record of the meeting. | |

**3.1 Matters Arising**

Mrs Cope advised that the June Leitch report would be presented to the Executive Team for comments and the key points would be summarised to the next Committee meeting in February. **TC**

Mr Hall advised that he had spoken with Mr Bond regarding using Avastin and it had been agreed that this was an operational issue and not for the Committee to discuss further. Mr Evans agreed to raise any concerns if he had them.

The final report relating to tracking access to be received at the February 2019 meeting. **TC**

**3.2 – Action Tracker**

Mrs Drury provided an update regarding the Productivity report. The Health Groups had plans in place to improve productivity and the plans were being monitored through confirm and challenge meetings. She added that the Health Groups had a much better grip on the detail.

**Workplan**

Ms Ramsay presented the item and advised that all items were up to date and had been received by the Committee.

***The agenda was taken out of order at this point***

**8.1 NHS Operational Planning and Contracting Guidance 2019/20**
Ms Myers presented the update which set out the Operational and Contracting guidance for 2019/20. The financial section aimed to address the new long term plan and the Government's commitment to bring the provider sector back into balance, with all providers being in balance by 2023/24. Ms Myers advised that the control total for 2019/20 would mean a £1.5m surplus before STP and £10m after. Ms Myers added that there was concern around the CCG growth and how their £5.2m would be allocated.

Ms Myers added that the RTT trajectory meant that the Trust would return to delivery in 5 years and Community Paediatrics was still work in progress.

There were other initiatives built into the plan such as 'Right care, right place, right time, GIRFT , same day emergency care and reducing outpatients by a third. The 2019/20 requirements were to hold the RTT waiting lists, and reduce 52 week waits to zero. Ms Myers advised that the teams were working through the plan and the Finance section would be discussed in February and the Operational plan in March 2019.

**Resolved:**
The Committee received and accepted the update.

**9.1 Exception Reports - Performance**
Mrs Cope presented the report and Mr Hall thanked her for the amount of work that had gone into the newly prepared executive summary. The summary highlighted the areas that had improved and the areas that had deteriorated.

Mrs Cope reported that there had been leadership changes in the Emergency Department in December and that it had been a challenging month on all levels. Ambulance handovers had deteriorated and the Trust had declared Opel 4 status over the Christmas and New Year period. Norovirus had reduced the bed capacity and work was ongoing with partners to reduce the numbers of patients coming through the system. She added that the new team were now in place and had a robust plan to ensure progress was made.

Mrs Cope also advised that a different model of Primary Care could be offered by a GP working at the front door. Mr Hall stressed the need for having the right people in place with rotas optimised. Mrs Cope assured the Committee that the Senior Team had oversight and responsibility for the rotas and staff and that the rotas were being transferred over to the e-roster system.

Mrs Cope reported that the 62 day standard delays in the breast cancer pathway remain the same; insufficient OPA capacity; histology turnaround times and MRI capacity and reporting turnaround times.

There had been a drop in performance relating to diagnostics but CT and MRI, although contributors to the breaches, were much more in control.

There was a discussion around the Clinical Admin Review and how this would help patients to get their appointments in a more efficient way. The staff were being consulted regarding the process and the new hubs would be operational in the Summer. Mr Nearney added that 756 staff had been

affected by the review but in the main the new ways of working had been well received with a few staff expressing their concerns. Mr Nearney added that the unions had been happy with the Trust's approach.

Mrs Cope reported that there had been a flood in the Centenary building which had affected theatres. This had resulted in a number of 52 week wait cases being cancelled. Mrs Cope added that the Trust would be declaring more in January but then would be back on track.

**Resolved:**
The Committee received and accepted the report.

**7 Board Assurance Framework**

Ms Ramsay presented the report and advised that the key risk areas to be discussed were ED, RTT, diagnostics and cancer performance. She advised that the Trust had missed its ED trajectory for Q3 but had validated a number of breaches that had been wrongly declared and submitted the information to the Centre.

Mrs Cope clarified that if the risk likelihood increased it would mean that the Trust was not in control of its position. The Committee agreed that the Trust was in a stronger position than last year and did not want to increase the likelihood risk to 20. The risk would remain at 16. The Committee also discussed the mitigating actions in place and how robust the plans were.

**Resolved:**
The Committee received the report and agreed to leave the risk rating at 16.

***The Agenda returned to order at this point***

**10.1 - Demand and Activity Report**

Mrs Drury presented the report and advised that GP referrals had been below the same period as last year but were now higher than the same period last year. Referrals from the East Riding and the South Bank were up but Hull's were down. The Advice and Guidance referrals had seen growth in the period.

ENT referrals lower than last year but December saw an increase against last year. There were 35% reductions to the Spire and elective inpatients was lower than plan, with variances starting to reduce.

The Trust was overtrading due to the plans being lower and the activity levels being the same. Mrs Drury advised that future planning would look at re-basing the capacity and looking at different ways to treat patients.

The ED submitted figures for quarter 3 was 89.96% against a trajectory of 90%, the contract was 0.9% above plan and the Trust was lower than plan on medical admissions.

Financially after adjustments the Trust was £4.9m above plan.

**Resolved:**
The Committee received and accepted the report.

**11.1 Monthly Finance Report**
Mr Evans presented the report and advised that the Trust was £1.7m away from plan with failure to deliver Q3 ED standards.

In December 2019 the run rate got worse and there had been a deterioration of pass through drugs and devices. The Trust had no further contingency reserves and the Surgery Health Group was under pressure due to nursing budgets and use of agency and bank staff.

**Resolved:**
The Committee received and accepted the report, noting the lack of reserves and underlying run rate of £24m.

**11.2 CRES Delivery 2018/19**
Mr Evans presented the report and advised that CRES was delivering in line with expectations. He reported that the year-end figure would be 82% delivery.

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

**11.3 Capital planning 2019/20**
Mr Evans presented the report which highlighted that in addition to depreciation funding, the Trust could use any SOCI surplus gained in year for capital expenditure. For 2019/20 the Trust's control total would deliver a SOCI surplus of £10.4m. Work is ongoing to understand this and the probability of delivering this. If accepted the plan initially would be to repay revenue loans that are due (£5.4m) and the balance of £5m would be used within the capital programme. At this stage there is a significant risk to the capital programme with regards to the SOCI surplus, as it depends on the Trust accepting and delivering the control total and also the approval from NHSI to utilise the SOCI surplus for capital purposes.

**Resolved:**
The Committee received and accepted the report.

**11.4 Urgent and Emergency Care Capital Development Briefing**
Mr Evans presented the report which highlighted the planning process and the governance structure for the outline business case relating to STP ED upgrades which would be across the STP. The outline business case would come to the Performance and Finance meeting in April 2019 and the Board in May 2019. **SE**

**Resolved:**
The Committee received and accepted the report.

**12.1 Variable Pay Report**
Mr Nearney presented the report and advised that £25m had been spent on variable pay with £8m being spent on agency.

The Surgery Health Group was overspent by £3.6m on their pay budget due to agency spend to deliver activity and extra clinics. Medicine Health Group were £1.25m overspent but he added that the service now had the consultants in the medical elderly wards that they needed, so should be in a better position going forward. The Trust was also employing registrars in

August 2019.

There was a discussion around the consultant rota and how swaps were being managed. Mr Nearney agreed to provide an update at the next meeting in February 2019. **SN**

**Resolved:**
The report was received and accepted by the Committee.

**12.2 Job Vacancy Report**
Mr Nearney presented the report which highlighted that there were 46 consultant vacancies and that the vacancy rate was less than 1%. The Junior Doctors were 89% fill rate and the Trust had new doctors from Pakistan starting with the Trust. Nursing was at 5% vacancies but again there were initiatives in place such as the apprenticeship programmes to help minimise the risks.

Mr Gore asked if head hunters were used and Mr Nearney advised that the Trust was using companies that could employ speciality doctors. The Trust had also appointed a recruitment manager who was working with teams to manage advertising and marketing. He advised that there was still difficulties in some areas.

**Resolved:**
The Committee received and accepted the report.

**13 13.1 Capital Resource Allocation Committee**
The report was presented for information. Mr Hall commended the work ongoing to upgrade the Junior Doctors accommodation area.

There was a discussion around the procurement of Windows 10 and this would be monitored through the Capital Resource Allocation Committee.

**Resolved:**
The Committee received and accepted the report.

**14 Other Items**
There were no other items discussed.

**15 Items delegated by the Board**
There were no items delegated by the Board.

**16 Any Other Business**
There was no other business received.

**17 Date and time of the next meeting:**
Monday 25 February 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

**Hull and East Yorkshire Hospitals NHS Trust**

**Performance and Finance Committee**

| **Meeting Date:** | 25 February 2019 | **Chair:** | Stuart Hall | **Quorate (Y/N)** | **Y** |
|---|---|---|---|---|---|

**Key issues discussed:**

- Board Assurance Framework – Quarter 3 risks (in particular the BAF 4 – constitutional standards) were discussed.
- Performance – ED performance had deteriorated in month, cancer performance was showing improvement, as was RTT. Work to eliminate 52 week waits was ongoing.
- Tracking Access Final Report – The issue was now closed with all patients seen or booked to be seen
- Demand and Activity Report – referrals were showing a 3% increase on last years figures
- Finance Report – The Trust reporting a surplus of £1.7m which was £1m away from plan. Q3 ED performance had been met so SPF monies had been received. The Committee discussed the risks of not achieving the Q4 target
- CRES 2018/19 position was at 63%. 2019/20 CRES was discussed.
- The Procurement Strategy was discussed and the Trust's position regarding the Purchasing Price Index
- The Variable Pay report was presented – the e-Rostering business case had been approved and was being implemented. The Trust's variable pay was £3m higher than it was the previous year
- CRAC minutes – IT network and the risks was discussed by the Committee

**Decisions made by the Committee:**

**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 25th February 2019**

| | | |
|---|---|---|
| **Present:** | Mr S Hall | Non-Executive Director (Chair) |
| | Mr M Gore | Non-Executive Director |
| | Mrs T Christmas | Non-Executive Director |
| | Mr L Bond | Chief Financial Officer |
| | Mrs T Cope | Chief Operating Officer |
| | Ms C Ramsay | Director of Corporate Affairs |
| | Mr S Evans | Deputy Finance Director |
| | Mrs A Drury | Deputy Finance Director |
| | Mr S Nearney | Director of Workforce and OD |
| **In Attendance:** | Mr T Moran CB | Chairman |
| | Mrs R Thompson | Corporate Affairs Manager (Minutes) |

| No. | Item | Action |
|---|---|---|
| 1 | **Apologies:**<br>There were no apologies received. | |
| 2 | **Declarations of interest**<br>There were no declarations of interest received. | |
| 3 | **Minutes of the meeting held on 28 January 2019**<br>Item 12.2 – The sentence to read, Mr Nearney presented the report which highlighted that there were 46 (when including locums and agency) consultant vacancies and that the vacancy rate was less than 1%. The Junior Doctors were 89% fill rate and the trust had new doctors from Pakistan starting with the Trust in April.<br><br>Following the above amendment the minutes were approved as an accurate record of the meeting. | |
| 4 | **Matters arising from the minutes**<br>Mr Nearney gave an update regarding the Clinical Admin Review which was currently at the consultation stage. Mr Moran advised that a number of consultants had opposed the position and written to him stating this. Mr Nearney advised that any issues were being flagged and responded to. | |
| 5 | **Action Tracker**<br>Mr Bond updated the Committee regarding the STP Capital bid business case. He advised that the business cases must be improved internally by NHS I and the Department of Health and could take up to six months for each stage. He added that an emergency capital loan could be requested for kit purchases or urgent building works. | |
| 6 | **Workplan 2018/19**<br>The Workplan was received for information. | |
| 7 | **Board Assurance Framework**<br>Ms Ramsay presented the BAF that had been reviewed since the January Board meeting and to include any quarter 3 updates. It was agreed at the Board meeting that the BAF 4 (Constitutional Standards) risk would remain | |

the same but the discussion points had been added to the document.

Ms Ramsay advised that she would be producing the year end BAF and making recommendations for the new 2019/20 BAF at the April 2019 meeting.

**Resolved:**
The Committee received and accepted the report.

**8.1 Performance Report**
Mrs Cope advised that the ED standard had been achieved in quarter 3 due to the validation work that had taken place. Work was ongoing to ensure delivery of the standard in March. Ms Ramsay advised that daily reviews were being carried out to ensure breaches were validated.

Mrs Cope advised that performance had deteriorated in February and the Committee discussed the reasons for this and what had changed. Norovirus had impacted on performance as had delays in discharge.

Mrs Cope updated the Committee regarding the Improvement Director's report and the improvement plan in place regarding the day to day management of the Emergency Department. There was more potential regarding ambulatory flow and work was ongoing regarding length of stay. Work was continuing with system partners. Mrs Cope advised that the plan was in place along with the new management team and work was ongoing to get wider commitment from the consultants.

The Committee discussed patients breaching the 4 hour standard but then being discharged. Mrs Cope advised that the Emergency Care Improvement Support Team would be coming into the Trust to review performance and length of stay.

Mr Hall asked about the work ongoing with Yorkshire Ambulance Service and Mrs Cope advised that the Trust was working with YAS to look at best practices and interventions such as the FIT model.

Mrs Cope advised that there had been improvements in the cancer performance due to more national funding and additional diagnostic capacity. She added that the conversion rate in some pathways were reducing.

Mrs Cope reported that the waiting list volume remained below the baseline and that work was ongoing to eliminate 52 week waits. There were currently 7 patients to left to date. NLAG and York late referrals would not be included.

Work was ongoing to improve theatre utilisation.

**Resolved:**
The Committee received and accepted the report.

**8.2 Tracking Access Report**
Mrs Cope presented the report and advised that the action plan had been closed with failsafe reports now in place.

Mr Moran asked if there had been any further harm recorded and Mrs Cope advised that there had only been 3 serious incidents and all patients had been apologised to and had received their treatment. Mr Moran commended the staff involved in the management of the issue and added that it was a remarkable outcome.

Mr Hall stated that the matter was now closed.

**Resolved:**
The Committee received and accepted the report.

**9.1 Demand and Activity Report**
Mrs Drury presented the report and advised that referrals were showing a 3% increase compared to last year including GP referrals.

She advised that the East Riding Spire referrals had reduced and there had been increases in referrals around breast care due to national campaigns. The breast surgery vacancy would be filled in June 2019 which would ease the capacity issue.

There had been improvements within elective patients and activity was above plan in January 2019

Day cases above plan and ED had delivered its Q3 positon due to focussed validation work. Non-elective was below plan with ambulatory care and the FIT model helping to reduce admissions. Mrs Cope agreed to include further information in her next report regarding the Ambulatory Care Unit and how it was being utilised. **TC**

**Resolved:**
The Committee received and accepted the report.

**10.1 Finance Report**
At the end of January, the Trust was reporting a SOCI surplus of £1.7m which was a shortfall of £1.0m against plan. The shortfall related to the non-delivery of the ED target for quarter 1 and potential non delivery of Q4. The Trust was successful in its appeal regarding quarter 3 ED performance and has received the full PSF for that period. In month the overall Health Group and Corporate position deteriorated by £0.7m which was £0.3m more than expected. Mr Bond had met with the Health Groups to discuss their performance and future month end forecasts.

He reported that the Trust could offset the forecast overspend relating to the CRES (excluding SPV) by releasing the £2.5m CRES contingency reserve and a small amount of other reserves. However the shortfall relating to the SPV assumption of £2.9m still required actions to be confirmed, along with actions for an additional £1.9m of pressures (including clinical waste and contract challenges from NHSE). The Trust was still in discussion with local commissioners to identify additional funding (£2m - £3m) and is also looking at a Revenue to Capital benefit (£1.3m). However other actions (£0.5m - £1.5m) will need to be identified including health groups maintaining grip on their forecast positions and a review of further income opportunities.

There was a discussion around NHS debtors and the work ongoing to clear

the outstanding debts. Mr Evans advised that the balances were due to timing and cash flow issues both at other Trusts and within the Organisation.

**Resolved:**
The Committee received and accepted the report.

**10.2 CRES Delivery 2018/19 and 19/20 Update**
Mr Bond presented the report and as at 13th February the Trust had identified schemes to the value of £17.2m which when risk adjusted is expected to deliver £16.1m. This is 81% of the required target. The full year effect currently stands at £12.6m which is 63%. These are all unchanged from last month.

Mr Bond reported that the 2019/20 savings had been capped at 3% and the level of reserves for 2019/20 had been discussed.

There was a discussion around the way that buildings were valued and how this was changing which would impact on the Trust. Mr Bond advised that this was not included in the financial plan. There were issues around energy and depreciation and Mr Bond would provide a paper to the March Committee. **LB**

**Resolved:**
The Committee received and accepted the report.

**10.3 Procurement Strategy**
Mr Bond presented the Procurement Strategy update which highlighted the Trust's position on the Purchasing Price Index.

Mr Bond spoke about the future operating model which had now 'gone live' with Supply Chain Co-ordination Limited and how 80% of the Trust's purchases would be bought through set categories. This could result in £1.5m savings for the Trust.

There was a discussion around benchmarking and collaborations with other Trusts and how nationally mandated products were driving savings. Mr Hall added that additional programmes had been identified as part of the Carter savings. Mr Bond agreed to share any useful reports from the Carter meetings. The Committee already received the meeting minutes.

**Resolved:**
The Committee received and accepted the report.

**11.1 Variable Pay Report**
Mr Nearney presented the report and advised that the Trust was £3m worse than last year regarding variable pay. He advised that the e-Rostering business case had been approved at the Executive Management Committee in January and that the project teams were now implementing it.

Mr Hall asked if all rotas were fully populated and how did swaps and holiday entitlement take place. Mr Nearney reported that there was a robust process in place to request annual leave and that the internal auditors would be auditing the services to ensure compliance.

Mr Nearney advised that the Trust was working hard to appoint new doctors and 10 had been appointed from Pakistan. There was also a robust plan in place for nursing recruitment. He added that although recruitment was improving, covering the activity was coming at a cost.

**Resolved:**
The Committee received and accepted the report.

**12.1 Capital Resource Allocation Committee minutes**
Mr Bond presented the minutes and advised that the Trust was replacing Pathology server.

The electronic generator report had been received at the Committee and Mr Taylor was reviewing the post implementation of the project.

The Committee discussed the IT network upgrade and the use of e-Observations and Mr Bond advised that it was a bid in the capital plan but there were other bids to consider also and would be a matter of which bid took clinical priority.

**Resolved:**
The Committee received and accepted the minutes.

**13 Other Items**
There were no other items raised.

**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 25 March 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

# Hull and East Yorkshire Hospitals NHS Trust

## CHARITABLE FUNDS COMMITTEE

| **Meeting Date:** | 25 February 2019 | **Chair:** | Mrs V Walker | **Quorate (Y/N)** | Y |
|---|---|---|---|---|---|

**Key issues discussed:**

- Project Director Report
- Financial report for the year to date as at 31 December 2018 was received
- Fund balances
- Legacies update
- Maternity initiative - Whose Shoes
- Investment update – COIF to attend next Committee meeting
- Legacies update

**Decisions made by the Committee:**

- Agreed funding requests for general charitable funds
- Agreed the Charitable Funds budget for 2019/20
- Agreed the Administration Charge for 2019/20
- Approved supporting funding for the “Song for Hull” event
- Financial support for Kingstown Radio was approved for 1 year
- Agreed to support the shortfall for the Retinal Camera – Fundraising appeal

**Key Information Points to the Board:**

**Matters escalated to the Board for action:**

Nothing to escalate, key issues discussed captured above

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Tuesday 12 March 2019**

| | |
|---|---|
| **Title:** | Freedom to Speak Up Guardian update |
| **Responsible Director:** | Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian |
| **Author:** | Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian |

| | | |
|---|---|---|
| **Purpose:** | To provide a quarterly update from the Freedom to Speak Up Guardian | |
| **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 receives a quarterly report from the Freedom to Speak Up Guardian on the issues being raised by staff and a 'read-across' of issues raised through other routes.<br><br>The key concern raised by staff, consistent with previous quarters, is individual examples of poor behaviours and/or bullying behaviours between colleagues.<br><br>All issues have action taken, as far as the individual who is raising concerns is comfortable with. The intelligence is also used to feed in to wider Trust organisational development programmes. | |

| | |
|---|---|
| **Recommendation:** | The Trust Board is asked to receive and accept this report, and approve use of this information in the Trust's annual report |

**Hull University Teaching Hospitals NHS Trust**

**Freedom to Speak Up Guardian Quarter 3 report**

## 1. Purpose of the paper

To provide a quarterly update from the Freedom to Speak Up Guardian

## 2. Introduction

The National Guardian's Office requires Freedom to Speak Up Guardians to be able to report directly to the Trust's Board. This report provides a quarterly update on concerns raised by staff through the Trust's Freedom to Speak Up Guardian (FTSUG) and review of other concerns raised by staff.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Whistleblowing Policy
- Staff Advice and Liaison Service (SALS)
- Anti-fraud service
- Through their line manager
- Freedom to Speak Up Guardian
- Through the Bullying and Harassment Policy or through a formal grievance

There are other routes as well as ways in which staff can receive support if they are experiencing difficulties at work. These are captured in Appendix 1.

In addition, professional organisations such as the Nursing and Midwifery Council and the General Medical Council (GMC) also issue guidance such as the GMC's *Raising and acting on concerns about Patient Safety* (2012), which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

All Trusts from 1 April 2017 were required to have a Freedom to Speak Up Guardian in place. The Trust Board agreed an outline position as to how the Guardian role would be used within the Trust; the main purpose of the Guardian role is to be part of creating or furthering a positive culture that supports staff to raise concerns and to make continuous improvement to a culture that supports the highest standards of care and openness.

## 3. Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting.

### 3.1 Main activities in 2018

The main activities this calendar year have been to promote the role of the Freedom to Speak Up Guardian (FTSUG), to network and learn from other Trust's about the use of the role, and to review key findings that have been published by the National Freedom to Speak Up Guardian, Dr Henrietta Hughes.

Available on Pattie is an updated page on the Freedom to Speak Up Guardian role, the route available to support staff in speaking up, and an introductory video. Further written guidance on the difference between different speaking up routes (grievance, whistleblowing, etc) has also been uploaded as guidance to staff and managers from a national best practice guide.

The FTSUG has continued to attend staff meetings to introduce the role, and also attended the induction training day for newly qualified midwives. The FTSUG writes a regular blog on speaking up, encouraging staff to report issues through any route with which they are comfortable, and reinforcing positive messages that speaking up makes a difference.

### 3.2 National Freedom to Speak Up Guardian

The National Guardian's Office has also completed a number of case reviews in NHS Trusts since its inception, most in 2018. These have taken place in:
Royal Cornwall Hospitals NHS Trust
Nottinghamshire Health NHS Trust
Derbyshire Community Health Services NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust

A case review has been announced at Brighton and Sussex University Hospitals NHS Trust.

All case reviews are conducted by the National Guardian and a team from her office, through a process of interviews with staff and senior managers. All reviews have resulted in recommendations for each NHS Trust as well as learning for the wider NHS.

Some key points of learning are:

- Review of Whistleblowing policies and practice, as to how employees are supported to raise concerns and do not suffer a detriment – all Trusts should have reviewed and updated their policies in line with NHS England model document requirements
- Managers are no always aware of the impact that they have on employees, and the way in which employees feel supported or not when raising concerns
- Staff often feel unsupported or do not know where to turn when bullying is carried out by their manager and part of the culture of the senior management team

In respect of these three specific points, our organisation has updated its policy in line with NHS England guidance – this has been reviewed by the Audit Committee and update reports on whistleblowing arrangements provided periodically.

One of the key parts of the FTSUG role in the last 6 months has been to be part of the Workforce Transformation Committee and work within the Trust to support managers in engaging with their staff and look at culture within their own teams. A specific training programme has been put in place to support this, and the FTSUG has been part of the discussions to determine where best to target this support.

In addition, the National Guardian's Office published a self-assessment tool and asked all Trust Boards to receive an assessment from their FTSUG in Spring/Summer 2018. This Trust's self-assessment was presented and accepted by the Trust Board in July 2018. This confirmed that the Trust had the FTSUG requirements in place and had identified some areas to develop the use of the role further. These are:

- Promoting the FTSUG and other routes for speaking up as part of the Trust's continued work on cultural development (professional behaviours) and patient safety ('Stop the Line')
- Promoting the FTSUG role within clinical areas and with Trust middle management tier
- Further development of feedback as to how speaking up makes a positive difference

It is noted that NHS Improvement's Compliance team has taken stock of all Trusts' FTSUG self-assessments. The Trust has provided the July 2018 self-assessment and has been in dialogue with NHSI in this regard. It is a standard clause in the NHS contract that all NHS Trusts have in place a Freedom to Speak Up Guardian. In addition, the FTSUG is interview in all CQC well-led assessments, including the one received by the Trust in February 2018.

**4.3 Freedom to Speak Up Guardian – Trust Contacts**
The National Guardian's Office also sets out a requirement to report to the Trust Board the number of contacts that the Freedom to Speak Up Guardian has received. The Trust's FTSUG has continued to do so.

The Trust's figures are as follows:

From 1 April 2017 – 31 March 2018, the FTSUG has been contacted as follows:

| **Route of contact** | **Number of contacts** |
|---|---|
| Contacted via anti-bullying Tsar | 5 |
| Contacted directly by the member of staff | 4 |
| Requesting advice for a colleague | 2 |
| Contacted via SALS | 3 |
| Signposted by manager | 1 |
| Signposted by Occupational Health | 1 |
| Signposted by a FTSGU in another Trust | 1 |
| **Total** | **17** |

The contacts with the FTSUG 1 April 2017 – 31 March 2018 have come from the following areas:

| **Quarter** | **No. contacts** | **Service area** | **Health Group/ Corporate services** |
|---|---|---|---|
| Apr - June 2017 | 7 | All individual services<br>– no repeated issues<br>- one 'worry ward' as reported to Trust Board | 6 - Medicine<br>0 - Clinical Support<br>1 – Surgery<br>5 – Corporate<br>3 – F&W<br>2 – Not specified |
| July - Sept 2017 | 1 | | |
| Oct – Dec 2017 | 8 | | |
| Jan – Mar 2018 | 1 | | |
| **Total** | **17** | | |
| | | | |
| | | | |
| | | | |
| | | | |

The following types of concern were raised 1 April 2017 – 31 March 2018:

| **Type of concern** | **Number of contacts** |
|---|---|
| Concerns about bullying behaviour | 7 |
| Concerns about HR process involving the member of staff – concerns about fair treatment | 3 |
| Concern about patient safety | 3 |
| Concerns about workload | 0 |
| Concerns about inappropriate behaviour | 1 |
| Concerned about role within the Trust | 1 |
| Unspecified – contacted for general support | 2 |
| **Totals** | 17 |

From 1 April 2018 – 28 February 2019, the FTSUG has been contacted as follows:

| **Route of contact** | **Number of contacts** |
|---|---|
| Contacted via anti-bullying Tsar | 0 |
| Contacted directly by the member of staff | 14 |
| Requesting advice for a colleague | 5 |
| Contacted via SALS | 0 |
| Signposted by manager | 0 |
| Signposted by Occupational Health | 0 |
| Signposted by a FTSGU in another Trust | 1 |
| **Total** | **20** |

The contacts with the 1 April 2018 – 28 February 2019 have come from the following areas:

| **Quarter** | **No. contacts** | **Service area** | **Health Group/ Corporate services** |
|---|---|---|---|
| Apr - June 2018 | 3 | All individual areas except one | 3 - Medicine<br>1 - Clinical Support<br>1 – Surgery<br>9 – Corporate<br>5 – F&W<br>0 – Not specified<br>1 – external |
| July - Sept 2018 | 3 | | |
| *Oct – Dec 2018* | 9 | | |
| *Jan – Mar 2019* | 6 | | |
| **Total** | | | |
| | | | |
| | | | |
| | | | |
| | | | |

The following types of concern were raised 1 April 2018 – 28 February 2019:

| **Type of concern** | **Number of contacts** |
|---|---|
| Concerns about bullying behaviour | 16 |
| Concerns about HR process involving the member of staff – concerns about fair treatment | 1 |
| Concern about patient safety | - |
| Concerns about workload | - |
| Concerns about inappropriate behaviour | 2 |
| Concerned about role within the Trust | - |
| Unspecified – contacted for general support | 1 |
| **Totals** | 20 |

**4.4 Making a difference**

There are some specific examples as to where issues have been raised via the FTSUG and action has been taken as a result.

With the permission of the individual raising concerns, the FTSUG has been able to escalate concerns in order that senior managers can support managers who have issues within their teams;

on some occasions, the senior managers are not aware of an issue and are able to provide more support as a result.

Some issues have resulted in formal HR action being taken by the individual concerned, having taken advice as to what the process involves and what support is available.

There are some specific positive outcomes that the FTSUG can share at the Board meeting.

**4. 'Read across'**
The Trust has several data sources that already capture where staff are speaking up about issues of concern.

When presenting the first Freedom to Speak Up Guardian's report to the Trust Board, the Board agreed the following principles:

- That the Guardian's role can help 'sense-check' organisational culture, to see if staff feel increasingly enabled to raise concerns about patient safety and staff welfare, and also report if staff are being treated detrimentally as a result of raising concerns
- That the Trust Board did not want the Guardian to start producing lengthy reports to try to cross-refer numerous data sources
- That the Guardian should not work on rumour or conjecture, or read correlation or causation into issues falsely

On this basis, the Guardian has reviewed the following:

- Each Quality report to the Trust Board from January 2017, including the ward dashboard as an appendix to the report
- Each nursing Safer Staffing report to the Trust Board from January 2017
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The detail of all SALS cases – concern, plus role and grade of staff member and department working in
- The headline National Staff Survey data and the quarterly cultural/staff friends and family test

**4.1 Staff Advice and Liaison Service**
One such source is the Staff Advice and Liaison Service (SALS). SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. The SALS contacts per year are counted below.

| **Time period** | **No. contacts** | **Service area 18-19** | **Health Group/ Corporate services 18-19** |
|---|---|---|---|
| Jan 15 - Mar 15 | 22 | Two areas of repeated concerns – action taken | 2 - Medicine<br>3 - Clinical Support<br>9 - Surgery<br>5 – Corporate<br>1 – F&W<br><br>All others not specified |
| Apr 15 - Mar 16 | 57 | | |
| Apr 16 – Mar 17 | 51 | | |
| April 17 – Mar 18 | 33 | | |
| Apr 18 – Dec 18 | 27 | | |
| | | | |
| | | | |
| | | | |

The SALS contacts April 2018 – December 2018 principally related to the following:

| Type of concern | Number of contacts |
|---|---|
| Concerns about bullying behaviour | 17 |
| Concerns about HR process involving the member of staff – concerns about fair treatment | 1 |
| Concern about patient safety | - |
| Concerns about workload | - |
| Concerns about inappropriate behaviour | 8 |
| Concerned about role within the Trust | 0 |
| Not specified – calling for general support | 2 |
| **Totals** | 27 |

The single issue raised most frequently through either route concerns staff behaviour. This reflects also the national staff survey results, shared with the Board previously, wherein bullying behaviours remain one of the areas of concern for this Trust.

**4.2 Whistleblowing**

The Trust's *Raising Concerns at Work (Whistleblowing)* Policy is intended to assist staff who believe they have discovered malpractice or impropriety. The Trust's policy was reviewed in 2016 to take account of new NHS national guidance on whistleblowing, to reference the role of the Freedom to Speak Up Guardian and to reference junior doctors' rights to whistleblow to a third party. The Trust's policy is up to date against national NHS requirements as well as employment law requirements.

Since 2015, the following issues have been reported under the Whistleblowing policy or dealt with under the Whistleblowing policy. In order to protect the position of staff raising concerns, the following information does not provide specific details:

| Date | Issue |
|---|---|
| January 2015 | Concerns about a support service |
| February 2015 | Concerns about patient care and bullying culture in a particular department |
| February 2015 | Concerns raised through an exit interview about patient care and safety in a particular department |
| November 2015 | Allegations of bullying and harassment against a particular member of staff |
| February 2016 | Concerns about patient care and safety in a particular department |
| October 2016 | Concerns about the clinical practice and conduct of a colleague |
| December 2016 | Concerns about proper application of proper processes to staff recruitment |
| May 2017 | Concerns passed on to the organisation by the Care Quality Commission |
| May 2017 | Concerns about the clinical practice of a particular member of staff |

| | |
|---|---|
| September 2017 | Anonymous contact regarding the recruitment of someone external to the Trust |
| October 2017 | Concerns about quality of care in a particular clinical service |
| March 2018 | Concerns about a particular third-party contract with the Trust |

All of the above concerns are all formally investigated and the person or persons raising the concern receive a formal response if they have identified themselves. For completed cases, the Trust has followed its own policy in investigating and responding to the concerns raised and is monitoring should any member of staff raise a concern about suffering a detriment to their employment position as a result of blowing the whistle.

**5.3 Analysis**

There is a consistency between the staff survey results and the issues coming through the SALS service, and with the individual Guardian cases – they largely concern staff behaviours, communication between teams and individuals and the way in which staff and managers are supported to improve team relations or work through difficult issues, such as performance management.

There are no new issues emerging from the Guardian's work or read-across that the organisation is not already aware of.

The Trust's Audit Committee has received regular updates on speaking up arrangements in the Trust, to receive assurance as to whether these are robust. At the moment recent presentation in October 2018, no gaps in assurance or control were identified.

There are some key messages, captured in the conclusion, which the Trust Board may wish to ensure are reflected in the updated People Strategy; it is through the workstreams for the People Strategy through which some of the longer-term issues raised by staff might be best improved, for example, support to teams with long-standing relationship issues, managers working in complex and stressful areas, and supporting staff with comprehensive support when they need to raise a concern, to allay the fears of doing so.

**5. Conclusion**

The Trust encourages staff to speak up about concerns at work and has put in place a number of mechanisms to help staff to do so. The Guardian is not aware of any reported issues in respect of a member of staff who has suffered a detriment as a result of blowing the whistle; some staff have raised concerns about the way in which their line manager has responded to their concerns, which needs further work by the Trust. There are also staff who are concerned about raising concerns as they do not think their manager or the Trust will support their position.

In relation to the 'read across' as Freedom to Speak Up Guardian, the Guardian offers the following observations:

- Most members of staff making direct contact with the Freedom to Speak Up Guardian have been isolated cases – in terms of each coming from a different part of the Trust and being individual cases
- Those are two areas where the same areas have arisen, one through SALS and one from FTSUG. In both cases, escalation action was taken and the concerns are being addressed
- Some cases are coming from the areas with lower staff engagement scores from the most recent staff Friends and Family test and have been fed in to a process by which some teams have been identified to participate in a new management development programme in the Trust ('What is it like to be managed by me?')

**6. Recommendation**
The Trust Board is asked to receive and accept this report, and approve use of this information in the Trust's annual report

**Carla Ramsay**
Director of Corporate Affairs
March 2019

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**12 March 2019**

| | |
|---|---|
| Title: | Gender Pay Gap Reporting |
| Responsible Director: | Simon Nearney, Director of Workforce and OD |
| Author: | Louise Whiting, Employment Policy and Resourcing Manager<br>Andy Barker, Workforce Planning and Information Manager |

| | | |
|---|---|---|
| Purpose: | The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2018, prior to publication of the data in line with statutory requirements. | |
| BAF Risk: | Risk 2 – workforce | |
| 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: | New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010.<br><br>The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2019) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format. | |

| | |
|---|---|
| Recommendation: | The Board is requested to note and approve content of this report.<br><br>Once approved by the Board, the report will be published on the Trust and Gov.UK websites. |

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Gender Pay Gap Reporting**

## 1 PURPOSE OF THIS REPORT

The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2018, prior to publication of the data in line with statutory requirements.

## 2 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010. The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage. The Government anticipates that reducing the gap at workforce level will help to narrow the gap at a national level, and hence boost the UK economy.

The Regulations have been brought in to highlight any imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

## 3 REPORTING REQUIREMENTS

The Trust is required to publish six gender pay gap measures;

- **Mean pay gap** – the difference between the mean hourly rate of pay (excluding overtime) of male and female employees
- **Median pay gap** – the difference between the median hourly rate of pay (excluding overtime) of male and female employees
- **Mean bonus gap** – the difference between the mean bonus paid to male and female employees who received a bonus in the relevant pay period
- **Median bonus gap** – the difference in the median bonus pay for male and female employees who received a bonus

- **Bonus distribution by gender** – the proportions of male and female employees who received bonus pay
- **Pay distribution by gender** – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands

The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2018. The figures must be calculated using the mechanisms set out in the gender pay gap reporting legislation.

In the period prior to the publication of the first gender pay gap reports last year, there was uncertainty within the NHS about how to calculate the bonus pay gap and debate about which payments should be deemed 'bonus pay', which should be 'ordinary pay', or fall into both or neither category. Guidance on payments which are regularly made by NHS organisations and how they should be classified for the purposes of the pay and bonus gap calculations has subsequently been provided. Consequently this report includes Clinical Excellence Awards as 'bonus pay' (and not also in ordinary pay as previously). Payments to Consultants for Additional Programmed Activities are now included in 'ordinary pay' (these were not previously included in the data).

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2019) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

## 4 THE PROPOSED GENDER PAY GAP REPORT FOR 2018

The Trust's overarching Gender Pay Gap Report, the second report since the regulations were introduced, is attached for the Board's approval (see Appendix 1). This includes supporting narrative with key findings following a more in-depth analysis of the data, to help understand the Gender Pay Gap Reporting outcomes.

## 5 RECOMMENDATION

The Board is requested to note and approve content of this report.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites.

**Simon Nearney**
**Director of Workforce & OD**
March 2019

**APPENDIX 1**

**Hull University Teaching Hospitals NHS Trust**

**Gender Pay Gap Reporting**

## 1 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage. The Government anticipates that reducing the gap at workforce level will help to narrow the gap at a national level, and hence boost the UK economy.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

The Regulations have been brought in to highlight any imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it.

Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

## 2 NHS PAY STRUCTURE

The majority of staff at the Trust are paid on the national Agenda for Change Terms and Conditions of Service. The basic pay structure for these staff is across 9 pay bands and staff are assigned to one of these on the basis of job weight as measured by the NHS Job Evaluation System (the system measures the job and not the post holder). This makes no reference to gender or any other personal characteristics of existing or potential job holders. Within each band there are a number of pay progression points.

Medical and Dental staff have different sets of Terms and Conditions of Service, depending on seniority. However, these too are set across a number of pay scales, for basic pay, which have varying numbers of thresholds within them.

There are separate arrangements for Very Senior Managers, such as Chief Executives, and Directors. There are also separate arrangements for Casual Workers.

## 3 GENDER PAY GAP DATA 2018

The figures set out below have been calculated using the standard methodologies used in the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, utilising the national NHS Electronic Staff Record Business Intelligence report functionality.

The analysis does not look at whether there are differences in pay for men and women in equivalent posts. Therefore the results will be affected by differences in the gender composition across the Trust's various professional groups and job grades.

National reporting requirements require the Trust to report the six gender pay gap measures to one decimal point (these six measures are shown in bold italics throughout the document), however to assist the Trust better analyse the data and progress made, the data is shown to two decimal places.

Hull and East Yorkshire Hospitals NHS Trust's Gender Pay Gap Data for the snapshot date of 31 March 2018 is as follows;

### 3.1 Mean and Median Gender Pay Gap

| Gender | Mean (average) hourly pay | Median (mid-point) hourly pay |
|---|---|---|
| **Male** | £20.79 | £15.21 |
| **Female** | £14.40 | £12.91 |
| **£s difference** | £6.39 | £2.30 |
| **% difference** | 30.74% ***(30.7%)*** | 15.12% ***(15.1%)*** |


- The mean gender pay gap is 30.74% (i.e. this means that women's average earnings are 30.74% less than men's).
- The median gender pay gap is 15.12% (i.e. this means that women's average median earnings are 15.12% less than men's).

Note; Gender pay gap calculations are based on ordinary pay which includes; basic pay (including for Medical and Dental staff Additional Programmed Activities), allowances (including shift premiums), extra amounts for on-call, pay for leave but

excludes; overtime, expenses, payments into salary sacrifice schemes (even though employees opted into the schemes voluntarily, as they provide a benefit in kind), Clinical Excellence Awards and Pensions.

### 3.1.1 Key Findings

- The Trust has an overall gender split of 76.87% female and 23.13% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 23.13% of the workforce, there are a disproportionate number of males, 38.25% in the highest paid quartile, predominantly medical staff.
- The mean gender pay gap for the whole economy (according to the October 2018 Office for National Statistics Annual Survey of Hours and Earnings figures) is 17%, while the Trust's mean gender pay gap is 30.74% in favour of males. The median gender pay gap for the whole economy is 17.9%, compared to the Trust average of 15.12%. Whilst the Trust's median figure is lower than the national average the mean figure is not.
- Medical staff pay has a strong impact on the mean and median data. If Medical staff were excluded from the data above the mean (average) hourly pay gap is 3.61% or £0.51, and the median (mid-point) hourly pay is 0.32% or £0.04. Nationally the Consultant workforce is predominately male. In recent years women have made up the majority of medical graduates, and this should impact on data in the years ahead.

## 3.2 Pay Quartiles by Gender

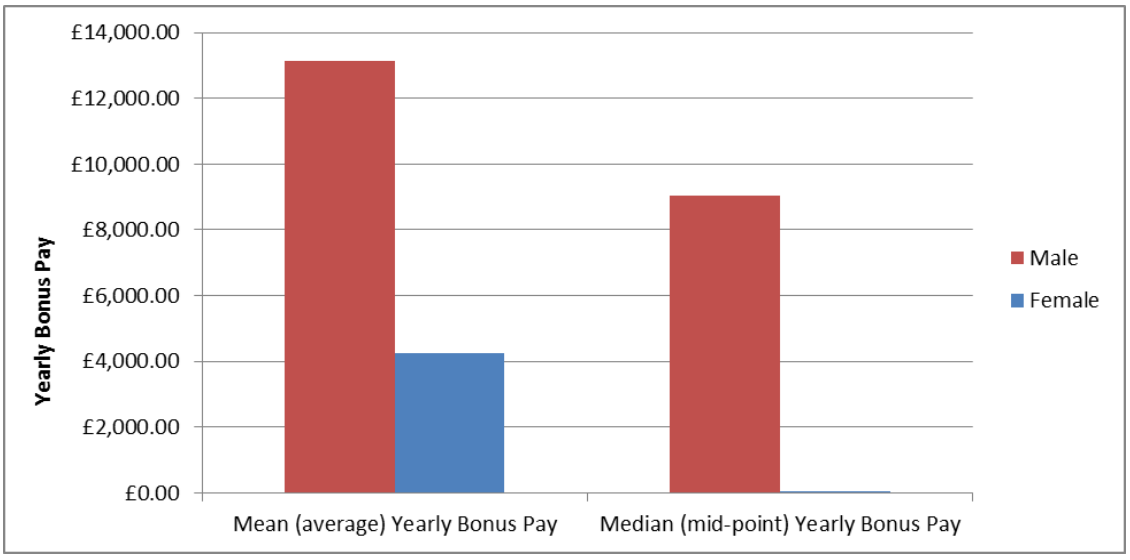
| | Male | | | Female | | | Total |
|---|---|---|---|---|---|---|---|
| **Quartile** | **Headcount** | **% Headcount** | **Mean (Average) Hourly Pay** | **Headcount** | **% Headcount** | **Mean (Average) Hourly Pay** | |
| Lower | 392 | 18.99% ***(19%)*** | £8.64 | 1672 | 81.01% ***(81%)*** | £8.80 | 2064 |
| Lower Middle | 350 | 16.97% ***(17%)*** | £11.64 | 1713 | 83.03% ***(83%)*** | £11.46 | 2063 |
| Upper Middle | 378 | 18.32% ***(18.3%)*** | £15.41 | 1685 | 81.68% ***(81.7%)*** | £15.71 | 2063 |
| Upper | 789 | 38.25% ***(83.3%)*** | £33.45 | 1274 | 61.75% ***(61.8%)*** | £23.95 | 2063 |
| Total | 1909 | 23.13% ***(23%)*** | £20.79 | 6344 | 76.87% ***(77%)*** | £14.40 | 8253 |

### 3.2.1 Key Findings

- Based on the Trust's overall gender split (76.87% female and 23.13% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. There are a disproportionate number of males, 38.25%, in the upper quartile compared to 61.75% being female. There is a mean gender pay gap of 28.40% and £9.50 in the upper quartile.
- Within the Medical staff group there is a disproportionate gender split (34.87% females and 65.13% male). In the Upper Quartile for Medical staff the split is 32.19% female and 67.81% male. Medical staff account for the majority of the Trust's highest earners.
- The Trust has a split of 58.57% full time and 41.43% part time staff. 92.54% of part time staff are female. The majority of part time staff are in the lower quartiles (58.47% are in the lower and lower middle).
- Only 27.87% of staff in the upper quartile are part time. This is disproportionate when compared with the Trust wide figure of 41.43% of staff being part time. 90.09% of these are female staff.
- The gender pay gap calculations are based on pay excluding the value of payments made into salary sacrifice schemes (even though employees opt into the schemes voluntarily, as they provide a benefit in kind). The Trust operates a number of salary sacrifice schemes. As payment into these schemes reduces the salary and hourly rate of pay this has impacted on the Trust's data, including the mean female average and where females fall in pay quartiles (i.e. they might otherwise fall into a higher quartile). 80.39% of those who pay into salary sacrifice schemes are female staff compared to 19.61% of male staff, particularly the high values schemes i.e. Family Car Lease and Childcare Vouchers. This is especially so in the Lower Middle and Upper Middle quartiles.

### 3.3 Mean and Median Gender Bonus Gap

| Gender | Mean (average) Yearly Bonus Pay | Median (mid-point) Yearly Bonus Pay |
|---|---|---|
| Male | £13,153.50 | £9,040.50 |
| Female | £4,236.09 | £50 |
| £s difference | £8,917.41 | £8,990.50 |
| % difference | 67.79% ***(67.8%)*** | 99.45% ***(99.5%)*** |



### 3.3.1 Key Findings

- The mean gender bonus gap is 30.03% when long service awards* are excluded from the data, rising to 67.79% when they are included in line with national guidance.
- The median gender bonus gap is 36.67% when long service awards* are excluded from the data, rising to 99.45% when they are included.

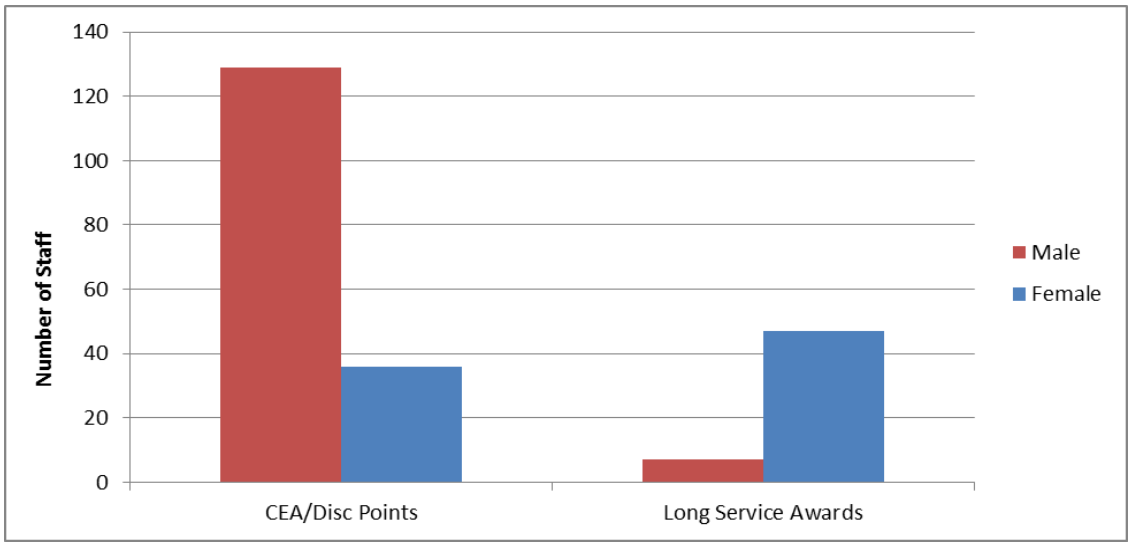
## 3.4 Bonus Distribution by Gender

| Gender | % Receiving Bonus |
|---|---|
| Male | 7.12% ***(7.1%)*** |
| Female | 1.08% ***(1.1%)*** |

- The proportion of male employees receiving a bonus is 6.76% excluding long service awards* (7.12% when included) and the proportion of female employees receiving a bonus is 0.57% excluding long service awards (1.08% when included).

## 3.5 Bonus Type by Gender

| | Male | | Female | | |
|---|---|---|---|---|---|
| **Bonus Type** | **Headcount** | **%** | **Headcount** | **%** | **Total Headcount** |
| **CEA/Discretionary** | 129 | 78.18 | 36 | 21.82 | 165 |
| **Long Service Awards** | 7 | 12.96 | 47 | 87.04 | 54 |
| **Total** | 136 | 62.10 | 83 | 37.90 | 219 |




### 3.5.1 Key Findings

- This year the Trust has two types of bonus that meet reporting requirements – Clinical Excellence Awards (CEAs - which are awarded based on the performance of Consultant Medical Staff subject to national and local eligibility criteria in recognition of excellent practice over and above contractual requirements), and Long Service Awards.
- *The Trust's gender bonus data is significantly distorted by the Trust's Long Service award scheme as, given the gender makeup of our workforce, more females receive an award. Calculations have therefore been made both including and excluding this data. Including long service awards, the median bonus pay for

females is £50. Excluding long service awards, the median bonus pay for females is £5,725.61. This compares to £9,040.50 for males (the figure is the same inclusive or exclusive of the long service award).

- The Long Service Award scheme is applicable to any employee, whether male or female, who has achieved 25 years substantive service within the NHS. Staff are invited to attend an awards ceremony to be presented with a certificate and a token gift to the value of £50, or a donation of the same value to a registered charity of their choice, in recognition of their contribution and commitment.
- If long services awards are excluded, the mean bonus pay gap reduces from 67.79% (£8,917.41) to 30.03% (£4,163.27) and the median bonus pay gap reduces from 99.45% (£8,990.50) to 36.67% (£3,314.89).
- The difference in bonus pay is also driven by the payment of higher (accumulated) bonuses for Consultant Medical staff where there is a greater proportion of men. CEA and Discretionary points account for 75.34% of all bonuses awarded. Those eligible for CEA/Discretionary points are consistent with the Consultant gender split (25.65% female and 74.35% male), however when it comes to applying, fewer females applied than were eligible compared to males.
- The proportion of male medical staff currently receiving accumulated CEAs is higher than females (78.18% male compared to 21.82% female).
- Within the 12 months up to 31 March 2018 the proportion of male medical staff who applied for and received a new CEA was 53.66%, for females this was higher at 71.43%.
- A greater number of the Trust's female Consultants work flexibly on a part-time basis (6.49% male, 25.24% female). This distorts both the mean and median bonus pay as CEA bonus payments are pro-rated for part-time employees. This part-time split is reflected in those with CEAs (6.25% of male CEAs are for part-time Consultants, 25% of Female CEAs are for part-time Consultants).

## 4 NATIONAL CHANGES

The Department of Health and Social Care has set up an independent review to understand the causes of the gender pay gap in medicine and to make implementable recommendations to narrow it. This will look at the pay gap across doctors' careers and in different areas of medicine.

Nationally agreed changes to the local Clinical Excellence Awards scheme effective from 1 April 2018 will impact on the Trust Gender Pay Gap data. Whilst existing local awards awarded prior to April 2018 will remain consolidated and pensionable until at least 2021, new local awards post April 2018 will be time limited, payable for up to three years and non-pensionable. These changes will impact on the 2019 Gender Pay Gap report, as awards are made retrospectively.

Reform of the pay structure for Agenda for Change staff as part of the 3-year pay deal (covering the years 1 April 2018 to 31 March 2021), which includes the removal of a number of pay points from pay bands, the removal of overlaps between pay bands, shorter timeframes to progress to the top of pay bands, the move away from automatic annual progression), and upskilling of band 1 to band 2 will gradually have an impact for staff paid under these terms and conditions. Again this will impact on the 2019 Gender Pay Gap Report.

These national changes will be pivotal in helping reduce the Trust's gender pay gap.

## 5 SUMMARY OF RESULTS AND ACTIONS

The Trust is committed to ensuring all staff are treated and rewarded fairly irrespective of gender.

The Trust is using the workforce gender pay gap figures to help understand the underlying causes for its gender pay gap and to identify suitable steps to minimise it.

The Trust gender pay gap data, which shows the difference in average pay between men and women in the workforce, reflects that the Trust has a majority of men in higher-paid roles, predominantly medical staff.

The Trust's mean gender pay gap at 30.74% has reduced since the 2017 report (32.85%) but remains higher than the average national figure of 17%. The Trust's median gender pay gap has reduced significantly (from 22.89% to 15.12%) to below the national average of 17.9%. Excluding medical and dental staff these figures would be 3.61% and 0.32% respectively. The Trust's bonus data (excluding long service awards) remains high, but is comparable to other large Acute Trusts with a high proportion of Medical staff, who have paid CEAs.

Both the mean and median hourly pay gap percentages across the health sector are significantly affected by the presence of the Medical consultant body due to both their high base wage and the Clinical Excellence Awards bonus scheme (that follows national guidance).

**5.1 <u>What Have we Done to Date?</u>**

- Reviewed output of exit data to better understand blocks to gender pay progression, to help identify and implement actions to improve this.
- Reviewed training, including the introduction of mandatory Equality and Diversity training for all staff, to include greater emphasis on unconscious bias in Recruitment and Selection training. This has incorporated reviewing the values based recruitment element of the recruitment process to tap into inclusive behaviour more directly.
- A Coaching and Mentoring Network is in place within the Trust, with two of our qualified coaches trained in Coaching for Inclusion practices.
- Gender Pay Gap Report for Medical and Dental staff tabled at relevant Groups/committees.
- Encouraged a greater proportion of eligible female Consultants to apply for local Clinical Excellence Awards; some of the Trust's current higher level local female award holders kindly agreed to provide mentorship to any female Consultants who were thinking of submitting an application for the 2018 round of awards.
- As part of the Trust's commitment to developing a comprehensive 'grow our own' approach across all staff groups, increased the number and range of apprenticeships (with 200 apprentices now in post), and promoting these as non-stereotypical male/female roles.

**5.2 <u>Next Steps</u>**

The Trust is committed to addressing the gender pay gap and is undertaking a range of actions and initiatives to reduce this including;

- Further developing the evidence base of data to ensure effective gender monitoring is in place, for example increasing the frequency of targeted recruitment reports by demographics, for medical and dental staff.
- Continue to review and update appropriate policies and practises, for example recruitment and selection, in partnership with staff side representatives and managers.
- Taking steps to make the most of flexible working, including a review of flexible working arrangements across the Trust, removing barriers to this, and ensuring

that the Trust's culture supports staff to do so at all levels, including senior staff and Medics.

- Analyse data from recent retention surveys. This includes both a nurse retention survey and a survey sent to nursing staff who are within 5 years of retirement, to ascertain what would make them consider flexible retirement and remain working for the Trust.
- Encouraging female participation in leadership development programmes and reviewing career and talent development opportunities so that capable employees of both genders can progress.
- Reviewing reward processes as part of implementation of national changes to terms and conditional to ensure fairness and consistency in their approach and application.
- Continue to produce a separate Gender Pay Gap report for Medical and Dental staff to help monitor progress, including the result of national changes made to local CEA schemes (which will start to impact in the next reporting period – 31 March 2019).
- Continue to encourage a greater proportion of eligible female consultants to apply for CEA awards.
- The Government Equalities Office has just (February 2019) published new guidance[1] to help employers close the gender pay gap. These will be reviewed and actioned accordingly.
- The Trust has signed up (with a number of other Trusts) to a research project by the Behavioural Insights Team (which works in conjunction with the Government Equalities Office to work towards gender equality in the NHS) to help the Trust explore evidence-based initiatives to reduce the gender pay gap in relation to CEAs.

Solutions to the gender pay gap lie in culture changes both in society and organisations. None of the initiatives will, in themselves, remove the gender pay gap, and it may be several years before some have any impact at all. In the interim the Trust is committed to reporting on an annual basis on what it is doing to reduce the gender pay gap, and the progress it is making.

Nationally most of the issues driving gender pay gaps require a longer term view. The gap in both the Trust's mean and median gender pay shows there is more work to be done. The Trust will take steps to reduce our pay gap and continue to explore best practise across the sector and beyond.

[1] 'Reducing the Gender Pay Gap and Improving Gender Equality in Organisations: Evidence-based Actions for Employers' and 'Eight Ways to Understand your Organisation's Gender Pay Gap'

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**12 March 2019**

| | |
|---|---|
| **Title:** | Standing Orders |
| **Responsible Director:** | Director of Corporate Affairs – Carla Ramsay |
| **Author:** | Director of Corporate Affairs – Carla Ramsay |

| | | |
|---|---|---|
| **Purpose:** | To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions. | |
| **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's seal has been used, for review by the Trust Board. | |

| | |
|---|---|
| **Recommendation:** | The Trust Board is requested to:<br>• Authorise the use of the Trust's seal |

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Standing Orders March 2019**

## 1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

## 2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows:

| SEAL | DESCRIPTION OF DOCUMENTS SEALED | DATE | DIRECTOR |
|---|---|---|---|
| 2019/01 | Deed of variation between East Riding of Yorkshire Council and Hull and East Yorkshire Hospitals NHS Trust and Persimmon Homes – variation to include one new clause relating to future mortgage owners and not being bound to any Housing Association in respect of affordable housing | 30.01.19 | Chris Long – Chief Executive Officer/ Lee Bond – Chief Financial Officer |
| 2019/02 | Contract documents for the provision of Technical Advisors Services for CHP and Boiler Upgrade enabling works at Hull Royal Infirmary on behalf of Hull and East Yorkshire Hospitals NHS Trust – LHL Group :Hoare Lea LLP | 30.01.19 | Lee Bond – Chief Financial Officer/ Carla Ramsay – Director of Corporate Affairs |

## 3 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal

**Carla Ramsay**
Director of Corporate Affairs
March 2019

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**12 March 2019**

| | |
|---|---|
| Title: | EU Exit Operational Readiness |
| Responsible Director: | Jacqueline Myers – Director of Strategy and Planning |
| Author: | Alan Harper – Assistant Director of Strategy and Planning |

| | | |
|---|---|---|
| Purpose: | To brief Trust Board regarding operational readiness and planning for EU Exit. | |
| 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: | A Trust group has been established to manage action contained within the DHSC guidance. The group is chaired by the Director of Strategy and Planning and includes the Assistant Director of Strategy and Planning responsible for Emergency Planning and Leads for each of the areas of activity the Department is focussing on in its 'no deal' exit contingency planning.<br><br>Each Lead is undertaking EU Exit readiness planning, has carried out risk assessments and is planning for wider potential impacts within their respective services. They are also testing individual business continuity plans against EU Exit risk scenarios to ensure they are fit for purpose and provide regular progress updates to the group. | |

| | |
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| Recommendation: | Trust Board is asked to:<br>• note the establishment of Trust Operational Readiness Group; and<br>• note the action taken to date. |

# HULL UNIVERSITY HOSPITALS NHS TRUST

## TRUST BOARD – 12 MARCH 2019

## EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

## EU EXIT OPERATIONAL READINESS

### 1. PURPOSE OF PAPER

The purpose of this paper is to brief Trust Board regarding EU Exit guidance received from the Department of Health and Social Care (DHSC) in December and action that has taken place following receipt of this guidance.

### 2. BACKGROUND

On 21 December DHSC published EU Exit Operational Readiness Guidance, which set out actions providers of health care services in England should take in preparation for EU Exit.

The guidance built on information issued by the Secretary of State for Health and Social Care on 7 December and was developed with input from NHS England and NHS Improvement. The guidance contained action Trusts should take if the UK leaves the EU without a ratified deal – a 'no deal' exit, and ensures the organisation is prepared for, and can manage, the risks in such a scenario.

### 3. ACTION TO DATE

#### 3.1 EU Exit National Operational Response Centre

Working closely with NHS England and Improvement, and Public Health England, DHSC set up a national Operational Response Centre to:

- lead on responding to any disruption to the delivery of healthcare caused or affected by EU Exit
- co-ordinate EU Exit related information flows and reporting, and
- operate through usual regional reporting and escalation mechanisms

The Trust has access to all up to date and relevant health related EU Exit planning information and guidance, for a potential no-deal Brexit. This is available on the gov.uk website.

#### 3.2 Trust Senior Responsible Officer (SRO) for EU Exit

Jacqueline Myers, Director of Strategy and Planning, is the Trust's nominated SRO for EU Exit.

#### 3.3 Dedicated EU Exit email address (from 19 December)

Following a request from NHSE the Trust established a dedicated EU Exit email address (EUEXIT@hey.nhs.uk) to ensure information is cascaded directly to relevant people at the same time. The NHSE suggested list was expanded to include Corporate Affairs, Pharmacy, Procurement, HR, Contracting, IT, Infrastructure / Development, Radiation Physics and Communications.

#### 3.4 Trust Operational Readiness Group: EU Exit

A Trust group was established to manage action contained within the DHSC guidance. The group is chaired by the Director of Strategy and Planning and includes the Assistant Director of Strategy and Planning responsible for Emergency Planning and Leads for each of the areas of activity the Department is focussing on in its 'no deal' exit contingency planning as noted below:

- supply of medicines and vaccines (David Corral)
- supply of medical devices and clinical consumables (Julie Lumb)
- supply of non-clinical consumables, goods and services (Julie Lumb)
- workforce (Helen Knowles)
- reciprocal healthcare (Tracy Sowersby)
- research and clinical trials (James Illingworth)
- data sharing, processing and access (Tracy Sowersby)
- Radiation Physics (Andy Beavis)

Each Lead is undertaking EU Exit readiness planning, has carried out risk assessments and is planning for wider potential impacts within their respective services. They are also testing individual business continuity plans against EU Exit risk scenarios to ensure they are fit for purpose and provide regular progress updates to the group.
The group met on 14 January, and 20 February. A third meeting will take place on 13 March when the latest guidance and action within each area will be reviewed.

**3.5 NHSE Regional EU Exit workshop: 12 February**
The Trust was represented at the workshop, hosted by the NHS England EU Exit Strategic Commander. Issues discussed included national context, local preparations, national work stream actions, operational response and challenges.

**3.6 Communication with staff**
The Trust Team Brief on 5 March was used to advise staff across the organisation regarding guidance received from the DHSC associated with EU Exit. This included the establishment of the Trust Operational Readiness Group, the designated Trust Leads for individual areas of activity and action they are taking, including EU Exit readiness planning and testing business continuity plans against EU Exit scenarios.

## 4. UPDATES / PROGRESS

The Director of Strategy and Planning will ensure Trust Board and the Executive Team are regularly updated regarding progress and any areas of concern.

## 5. RECOMMENDATIONS

The Board is asked to:

- note the establishment of Trust Operational Readiness Group; and
- note the action taken to date.

**Alan Harper**
**Assistant Director of Strategy and Planning**
**6 March 2019**