HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

TUESDAY 14 MAY 2019
THE BOARDROOM, HULL ROYAL INFIRMARY
9.00AM – 12.30PM

AGENDA: MEETING TO BE HELD IN PUBLIC
Opening Matters

1	Apologies	verbal	Chair – Terry Moran
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair – Terry Moran
3	Minutes of the meeting of 12 March 2019/26 March 2019	attached	Chair – Terry Moran
4	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker 4.2 Board Reporting Framework 2017/20 4.3 Board Development Framework 2017/19	attached	Director of Corporate Affairs – Carla Ramsay
	4.4 Any other matters arising from the minutes	verbal	Chair – Terry Moran
	4.4.1 Gender Pay Gap Report - update	attached	Director of Workforce and OD – Simon Nearney
	4.4.2 Strategy Scorecard	attached	Director of Strategy and Planning – Jacqueline Myers
5	Chair's Opening Remarks	verbal	Chair – Terry Moran
6	Chief Executive's Briefing	attached	Chief Executive Officer – Chris Long
7	Patient Story	verbal	Interim Chief Medical Officer – Makani Purva
8	Board Assurance Framework 2018/19 – Year End Report 8.1 – Draft Board Assurance Framework 2019/20	attached	Director of Corporate Affairs – Carla Ramsay
	Director Reports		
9	Quality Report	attached	Chief Nurse – Beverley Geary
10	Nurse and Midwifery Staffing Report	attached	Chief Nurse – Beverley Geary
11	Quality Accounts	attached	Chief Nurse – Beverley Geary
12	Quality Committee Minutes March and April 2019	attached	Chair of Committee – Martin Veysey

1

13	Performance and Finance Report	attached	Chief Operating Officer – Teresa Cope/Lee Bond – Chief Financial Officer
14	Performance and Finance Minutes March and April 2019	attached	Chair of Committee – Stuart Hall
	14.1 Laundry Services Contract for approval	attached	Chief Financial Officer – Lee Bond

Governance and Assurance

15	People Strategy Refresh	attached	Director of Workforce and OD – Simon Nearney
16	Equality Objectives – Progress update	attached	Director of Workforce and OD – Simon Nearney
17	Statement of Elimination of Mixed Sex Accommodation	attached	Chief Nurse – Beverley Geary
18	Modern Slavery Statement	attached	Director of Workforce and OD – Simon Nearney
19	Information Governance Update	attached	Director of Corporate Affairs – Carla Ramsay
20	Fit and Proper/Director Declarations of Interest	attached	Director of Corporate Affairs – Carla Ramsay
21	Seven Day Working Assurance Framework	attached	Chief Medical Officer – Makani Purva
22	Standing Orders	attached	Director of Corporate Affairs – Carla Ramsay
23	Trade Union Facility Time Publication Requirements	attached	Director of Workforce and OD – Simon Nearney
24	Continued use of the Health Trust Europe Total Workforce Solutions Framework Agreement	attached	Director of Workforce and OD – Simon Nearney
25	Audit Committee Minutes	attached	Chair of Committee – Tracey Christmas
26	Charitable Funds Minutes	attached	Chair of Committee – Vanessa Walker
27	Any Other Business		
28	Any questions from members of the public		
29	**Date and time of the next meeting: Tuesday 9 July 2019 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary**		

Attendance

Name	30/1	2018 13/3	15/5	24/5	10/7	11/9	13/11	29/1	2019 26/2	12/3	Total
T Moran	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	10/11
A Snowden	✓	✓	x	✓	✓	✓	✓	-	-	-	6/7
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
V Walker	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	10/11
T Christmas	x	x	✓	✓	✓	✓	✓	✓	✓	✓	9/11
M Gore	✓	✓	✓	x	✓	✓	✓	✓	x	✓	9/11
T Sheldon	x	✓	✓	✓	-	-	-	-	-	-	3/4
C Long	✓	x	✓	✓	✓	✓	x	✓	✓	✓	9/11
L Bond	✓	✓	✓	x	✓	x	✓	x	✓	x	7/11
M Wright	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	10/11
T Cope	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
K Phillips	✓	✓	✓	x	✓	-	-	-	-	-	4/5
M Purva	-	-	-	-	-	✓	✓	✓	✓	✓	5/5
M Veysey	x	✓	✓	x	✓	✓	✓	✓	x	✓	8/11
B Geary	-	-	-	-	-	-	-	-	-	✓	1/1
J Jomeen	-	-	x	✓	x	✓	✓	✓	x	✓	5/8
In Attendance											
T Curry	-	-	-	x	-	-	-	-	-	-	-
J Myers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
S Nearney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
C Ramsay	x	✓	✓	✓	*	*	✓	✓	✓	✓	7/8
R Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11

*Carla Ramsay – career break

Hull University Teaching Hospitals NHS Trust
Trust Board Minutes held on 12 March 2019

Present:	Terry Moran CB	Chairman
	Mrs V Walker (from 9.10am)	Vice Chair/Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Prof M Veysey (from 9.25am)	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mrs B Geary	Chief Nurse
	Mrs T Cope	Chief Operating Officer
	Dr M Purva	Chief Medical Officer
In Attendance:	Ms J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Nearney	Director of Workforce and OD
	Dr K Adams	Associate CMO Mortality and Morbidity (Item 8 only)
	Mrs E Henderson	Head of Outpatient Services (Item 10 only)
	Dr C Wood	Consultant Paediatrics (Item 10 only)
	Ms V Brown	Charge Nurse Paediatrics (Item 10 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	**Item**	**Action**

1   Apologies:
Apologies were received from Mr L Bond, Chief Financial Officer

Mr Moran welcomed the Board for the first time as Hull University
Teaching Hospitals NHS Trust. He congratulated staff involved on the
name change process and stated that the new partnership with the
University was an important development in the future direction and
development of the trust and in the quality of services delivered.

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

2.2 To consider any conflicts of interest arising from this agenda
There were no conflicts declared.

3   Minutes of the meeting of 29 January 2019/26 February 2019
The minutes of the meeting of 29 January 2019
Item 9.1 Quality Report – Mr Wright reported that there had been a
second case of MRSA bacteraemia.
Item 9.4 Clinical Negligence Schemes for Trusts – Maternity
Paragraph 1 - Only a consultant obstetrician was present at every
emergency caesarean. Consultant anaesthetist to be removed from the
minutes.
Paragraph 3 – the words "which was much better" to be removed from
the sentence.

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

The minutes of the meeting 26 February 2019
The minutes were approved as an accurate record of the meeting.

4   Matters Arising
There were no matters arising.

4.1 Action Tracker
The Board reviewed the action tracker. All items were either on the agenda or had been added to the workplan.

4.2 Board Reporting Framework
The Board Reporting Framework was reviewed by the Board. There were no items discussed.

4.3 Board Development Framework
The Board reviewed the Development Framework. Mr Gore asked what would be happening in the wake of the SPV in the future. Mr Evans advised that work was ongoing with Mr Taylor and Ms Myers to work up the plans.

5   Chair's Opening Remarks
Mr Moran formally welcomed Mrs Geary (the new Chief Nurse) to the Trust.

Mr Moran advised that it was Mr Wright's last meeting as Chief Nurse. He stated that Mr Wright had started his working life in the room that the Board meeting was being held. It was therefore fitting that his last formal meeting at the Trust was in the very same room. Mr Moran reported that in his two years of knowing Mr Wright he had come to view Mr Wright as an outstanding public servant, adding great value to the Trust who had shown inspiring leadership to the nursing profession. He added that the work carried out by Mr Wright showed his compassion for patients and their families. Mr Moran summed up Mr Wright's qualities in two words, which were wisdom and truth. He thanked Mr Wright on behalf of the Board for the dedication and professionalism which had positively impacted many staff over the years and importantly improved the care of patients.

Mr Moran also spoke about his review of nominations for the Golden Hearts Awards later in the year. It was a great reminder of the remarkable people we have and of the terrific things they have achieved. He found it difficult to choose a winner in almost all of the categories. He was looking forward to the celebration event.

6   Chief Executive's Briefing
Mr Long echoed Mr Moran's comments about Mr Wright and added that the Mr Wright returned to the Trust in troubled times and was a key player in re-building the foundations of a unified Board. Mr Long wished Mr Wright a happy retirement and welcomed Mrs Geary to the Board.

Mr Long spoke about the changes to NHS England and NHS

Improvement and reported that Simon Stevens had taken over from Ian Dalton to drive the integration agenda and the challenge to integrate services fully and effectively.

Regionally, Richard Barker had been appointed and the performance targets were being reviewed.

He advised that the Trust was going into the new year financially stronger but that there would still be challenges for the Executive Team to manage.

Mr Gore asked about national media coverage and how the Trust was promoted nationally. Dr Purva advised that working with the University of Hull was ensuring that the Trust's professional journal coverage was wider.

Mr Moran noted that the Balanced Scorecard for theatre utilisation was green and Mr Hall noted that the appointment slot issues target had yet to be confirmed.

7 Patient Story

Dr Purva spoke of two members of staff that came into the Hospital as patients and their experiences. Both experienced problems during triage but once they were on their respective wards the care had been excellent and both parties had nothing but praise for the staff. Learning from their experience was being implemented.

8 Mortality/Medical Examiner Role

Dr Adams presented the presentation which highlighted the need for Medical Examiners to ensure Death Certificates were scrutinised and correctly completed in a timely way.

The role of the Medical Examiner (ME) is to undertake an independent review of each death and is currently being trialled nationally, but eventually each Trust would have its own ME function. Dr Adams thought that 2 consultants, 5 days per week would be required, one at Hull Royal Infirmary and one at Castle Hill Hospital. She added that this would improve referrals to the coroner. Dr Adams had identified 4 consultants who had volunteered to carry out the role.

Dr Adams also stated that 3 Band 6 medical officers would be required to support the consultants. There would be a pilot starting at Castle Hill Hospital from May 2019 and would hopefully be fully implemented by April 2020. Having a medical examiner is a statutory requirement from April 2021.

Prof Veysey expressed his concern that the process was almost a mini coroner role and would slow down the already slow process. It was agreed that a more detailed discussion would take place following the pilot at the Quality Committee.

Resolved:
The Board was supportive of the approach and agreed that the Quality Committee should discuss the pilot and the Structured Judgement Reviews in more detail.

9   Board Assurance Framework – BAF Risk 5 - Specialist Services

Ms Myers presented the report which set out a number of developments and actions that had significantly mitigated the risk. These included new national guidance driving more local decision making, the elimination of a non-compliance issue in relation to catchment population, development of the Trust's service portfolio and development of new clinical networks.

Due to these mitigations, Ms Myers proposed reducing the risk rating from 12 to 8.

Resolved:
The Board approved the reduction in risk rating from 12 to 8.

The meeting was taken out of order at this point

11   Trust Strategy 2019-2024

Ms Myers presented the refreshed strategy and advised that key staff such as the Medical Directors and other Health Group staff had been included in the development of it. The Trust's vision had been maintained but there had been a change to the long term goals with Research and Innovation being given a clearer focus.

Ms Myers advised that the document had been reduced in length and was now a much easier document to read . She had received emails from a number of staff and external stakeholders as well as members of the Patient Council.

Prof Veysey asked how the Board would receive Research and Innovation at the Board and Ms Myers advised that it would be managed through the Board Assurance Framework. Prof Jomeen asked about Clinical Academic careers and where they would be reviewed and Mr Nearney advised that these would be included in the People Strategy.

Mr Moran reminded colleagues that board members had been intimately involved with the development of the draft strategy and therefore he believed it represented the Board's collective input. He thanked Ms Myers on behalf of the Board.

Resolved:
The Board received and approved the updated Five year strategy.

12   12.1 Quality Report

Mr Wright presented the report and advised that the Trust had not had a Never Event since March 2018. He highlighted the serious incidents section but advised that the Quality Committee reviewed these in some detail. There had been a dip in VTE performance but other than that the Safety Thermometer was looking positive.

Mr Wright reported that there had been 3 MRSA bacteraemia infections reported, but that each case was complicated. He advised that work was ongoing with MSSA and e-Coli to ensure any avoidable cases due to line and catheter care were reduced.

There had been Norovirus outbreaks during the winter and summer

months and work was ongoing within the building to minimise the infection being spread.

The Patient Experience Team was reporting that complaints were static and the Friends and Family results positive.

Mr Wright had attended the Joint Health and Wellbeing Board meeting where he had updated the members regarding progress within the Trust. This had been positively received.

Mr Wright reported that there had been improvements in the safer surgery checklist results with the main operating theatres performing well.

Resolved:
The Board received and accepted the report.

12.2 Safer Staffing Report
Mr Wright presented the report which gave an overview of quality metrics and fill rates and each ward's rag rating. He reported that establishments were being funded effectively and was looking at ways to use any CRES money in different ways.

Mr Hall commended the Trust's engagement with new students and how they were introduced to the teams and Mr Nearney advised that the close working relationship with the University was working well.

Mr Gore complimented the report and stated that a similar report for medical staffing would be useful.

Resolved:
The Board received and accepted the report.

10   Paediatric Transition Service
Mrs E Henderson, Dr Chris Wood and Ms V Brown attended the meeting to present their update regarding Paediatric Transition to the Board. There were often complicated transitions from childhood clinical pathways into adult clinical pathways particular in complex cases.

Mrs Henderson highlighted the Transition Steering Group which had been set up following a CQC visit and transition was also a Quality Improvement Project. A virtual email group had been established to share learning and information and the service kept up to date with NICE guidance.

Mrs Henderson spoke about the 5 main services diabetes, rheumatology, respiratory, cystic fibrosis and neuro disability and children with these conditions and how they transition. Due to improving clinical processes more children were transitioning and much work was happening in the service and with patients and carers. An evening clinic had been added to one service to ensure patients did not have to miss work or school.

The services had good connections with the Councils, Humber NHS Foundation Trust, CHCP and GPs as well as other healthcare partners.

Ms Brown spoke of teenage patients that were nursed on wards with

babies and how the work around transition with health and social care was ensuring this did not happen. Work was also ongoing with families and carers to reduce anxieties and help vulnerable children and adults.

Mr Long asked about research programmes in the transition area and Mr Wood advised that there were research programmes in place but there could be more.

As the Non-Executive lead Mrs Christmas commended the Group for their hard work and engagement with partners.

Mr Moran had contact with a multi-agency Group that was looking at all services involved at both national and regional level and offered to supply the details should the team want them.

Resolved:
The Board received and accepted the report.

12.3 National Staff Survey
Mr Nearney presented the report and advised that 44% of staff had completed it.

He reported that there had been 32 key findings but that this had been reduced down to 10 with each theme being marked out of 10. The Trust was performing at 7/10 currently. Overall this was very good news as in previous years the trust had been below the national average and this time our progress had reached the national average.

Mr Nearney expressed his disappointment at the Health and Wellbeing statistics following the work that the Trust had done around this, as well as the quality of appraisals which had also not scored well.

The Medicine and Surgery Health Groups were showing issues in their results and Mr Nearney was to meet with the Triumvirates to discuss these issues further.

Prof Veysey stated that on reviewing reports and discussions at the Quality Committee he felt that cultures were improving and sickness rates were coming down. Mr Moran suggested that further discussion should take place at a Board Development session to build on the work already ongoing.

Resolved:
The Board received and accepted the report.

13.3 Freedom to speak up report
Ms Ramsay presented the report and highlighted the themes and trends relating to the cases. She advised that poor relationships between managers and staff and poor communication were the common themes emerging.

She reported that conversations with senior staff were ongoing to address team morale and behaviours within departments. Ms Ramsay stated that the Trust was in a good position and work was in line with the National Audit Office framework.

Mr Moran asked if there were any concerns or issues that Ms Ramsay was aware but not covered in the report. Ms Ramsay was not aware of anything further.

Mr Moran suggested that more time be spent on this issue in a Board Development session when the staff engagement results were also discussed.

Resolved:
The Board received and accepted the report.

13.5 Standing Orders
Ms Ramsay presented the report which highlighted the use of the Trust seal.

Resolved:
The Board received the report and approved the use of the Trust seal.

12.4 Quality Improvement Plan
Mr Wright presented the Quality Improvement Plan and highlighted pressure ulcers, VTE and Nutrition as the key areas of focus. The plan was being updated for 2019/20.

Mr Wright advised that Mrs T Filby (Assistant Chief Nurse for Special Projects) would be reviewing the fundamental standards work to align with the QIP and in particular looking at the Nutrition standard.

Resolved:
The Board received and accepted the report.

12.5 Quality Committee Minutes January and Summary Report February 2019
The Board received and accepted the minutes.

12.6 Performance and Finance Report
Mrs Cope presented the performance section of the report and advised that the Trust had achieved PSF funding from Emergency Care for quarter 3. She added that the new Primary Care area in the ED was now seeing 50 patients per day.

Length of stay was reducing and the focus was on patients that had been in hospital 21 days or over. The Emergency Care Intensive Support Team were working with the Trust on length of stay agreeing new targets and working with community partners.

Cancer performance was seeing incremental improvements as was diagnostic performance. Additional investment in quarter 4 had relived some pressure in both areas but there was still work to do to sustain performance.

The Trust was working to ensure 52 week waits were at zero and focus work was ongoing in key specialities.

Mr Evans updated the Board regarding the financial summary and

advised that the Trust was still forecasting to deliver the Control Total. Health Group performance had deteriorated in month and the Trust had over performed against its contract activity by £1.3m.

Resolved:
The Board received and accepted the Performance and Finance Report.

12.7 NHS Operational Planning and Contracting 2019/20 Update
Ms Myers advised that there would be an Extraordinary Board held on 26th March 2019 to approve the plan. There was still work ongoing with contracts and the Specialist Commissioners to finalise the plans. Ms Myers advised that she had received detailed feedback following the draft plan but there were still concerns around the financial element which would be finalised by the 26th March 2019.

Resolved:
The Board received and accepted the verbal update.

12.8 Performance and Finance Minutes January and Summary Report February 2019
Mr Hall presented the minutes and advised that the Performance and Finance Committee had focussed on the Emergency Department and the new GP facility, it had recognised the Ambulatory Care Unit utilisation and that the tracking access issue was now officially closed. Mr Moran added that the way in which the tracking access issue had been dealt with was excellent.

Mr Hall was pleased to announce that 30% of CRES schemes had been identified for 2019/20 which was an improvement in month.

Resolved:
The Board received and accepted the minutes.

The meeting was adjourned at 11.45am to incorporate a private agenda item relating to Trans2 Performance

The meeting reconvened at 12pm

13.1 Internal Auditors Update
Mrs Christmas advised that the new Internal Auditors had been appointed (RSM) and there had been no challenges made during the stand still period.

Resolved:
The Board received and accepted the verbal update.

13.2 Charitable Funds Summary Report February 2019
Mrs Walker presented the summary report and welcomed Martin Gore who had joined the Committee.   She added that 2 members of staff had been appointed to the Wishh Charity to fundraise on behalf of the Trust.

Resolved:
The Committee received and accepted the summary.

13.4 Gender Pay Gap Report
Mr Nearney presented the report which highlighted the key issues around the gender pay gap. This Trust was 31% disadvantaged in terms of female workers but once medical staff had been removed from the calculation this reduced to 3%.

There was a discussion around the Clinical Excellence Awards and how more male doctors put themselves forward than female doctors. Dr Purva advised that in the current round of Clinical Excellence Awards there had been a shift in the number of female doctors applying. Mr Nearney added that the Trust was not an outlier.

Resolved:
The report was received and accepted by the Board.

14   **EU Exit Operational Readiness**
Ms Myers presented the paper which set out the arrangements in place if a no-deal Brexit occurred.

The key risk to the Trust was the access to supplies, drugs and machine parts.

There was a discussion around avoiding stock piling and how stocks would be managed beyond the 29th March. Ms Myers advised that the Trust was making arrangements with its suppliers and stocks were being managed nationally.

Resolved:
The Board received and accepted the report.

15   **Any other business**
There was no other business discussed.

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

17   **Date and time of the next meeting:**
Tuesday 14 May 2019, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Extra Ordinary Trust Board to approve the Operating Plan 2019/20
Minutes of the meeting held 26 March 2019

Present:

Mr T Moran CB	Chairman
Mrs V Walker	Non-Executive Director/Vice Chair
Mr S Hall	Non-Executive Director
Mr M Gore	Non-Executive Director
Prof M Veysey	Non-Executive Director
Prof J Jomeen	Non-Executive Director
Mr C Long	Chief Executive Officer
Mr L Bond	Chief Financial Officer
Dr M Purva	Chief Medical Officer
Mrs B Geary	Chief Nurse
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
Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies**	

Apologies were received from Mrs T Christmas – Non Executive Director
and Prof M Veysey – Non Executive Director

Mr Moran expressed his concern as there had been no email to staff
notifying them of the Public Board meeting or that it had been added to
the website. This would be rectified for future Extraordinary meetings.

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

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

3   Operating Plan 2019/20
Ms Myers presented the plan which highlighted all of the key elements for
the forthcoming year. She reported that all the contracts with the
Commissioners were now in place along with performance trajectories
and the financial Control Total.

Ms Myers reported that there were outstanding issues with the Workforce
Plan and that the numbers of new staff had changed since the plan was
circulated. Mr Moran expressed his concern that the figures had changed
at the late stage and requested the breakdown of the 145 staff which
included apprenticeships, advanced care practitioners and physicians
associates as soon as possible.

Ms Myers advised that feedback from NHS Improvement in relation to the
draft plans submitted stated that insufficient non-elective growth had
been included. In the Trust's case a modest element of growth had been
included.

Mrs Walker stated that there were a number of abbreviations in the plan that would not be easy to read for members of the public. Ms Myers agreed to update the plan accordingly.

Mr Gore commended the HR teams for the additional 68 medical staff now in post. He added that this was a great achievement against the national background and medic shortages.

Mr Bond advised that the Commissioning contracts were now in place with the growth incorporated. He spoke about the Trust's energy costs (gas and electricity) and that £2m had been added to the forecast to accommodate the increased prices.

Mr Bond had presented to the Performance and Finance Committee a 5 year look back of the level of deficit the Trust had faced and that it was consistent which highlighted further the level of challenge in 2019/20. Mr Bond was not as confident as he was in previous years that the Trust would achieve the financial plan. He would be working closely with system partners across the Humber system to review costs and efficiencies.

Mr Long shared Mr Bond's concern and stated that although he recommended accepting the control total, much work was needed to close the gap throughout the year.

The Trust Board discussed the whether to accept the control total or re-negotiate the terms. Mr Long added that he did not accept that the control total was undeliverable but was uncomfortable with the challenge that was required to achieve it.

Ms Myers stated that the reason the Trust would sign up to additional funds would be for the benefits to the patients and the risks must be balanced.

Mr Moran added that the safety of patients was the Trust's first priority and that even in difficult financial situations this would not be compromised.

It was agreed that a development session would be used to discuss the financial plan and how any risks would be mitigated.

Resolved:
The Board received the Operating Plan and agreed:
- The Control Total with the necessary due diligence from the finance teams being carried out
- The Operating plan subject to minor changes and submission of the workforce figures to the Board

4   **Any Other Business**
Mr Bond raised the Capital risks, specifically the Energy Business Case and the replacement equipment loan and how the Trust would cover these costs in 2019/20. He reported that any PSF money would now be used to pay off loans and would not be used for Capital expenditure. Mr Bond advised that he was talking to Humber Coast and Vale partners regarding the Energy Business Plan.

5   **Date and time of the next meeting:**
Tuesday 14 May 2019, 9am – 12pm, The Boardroom, Hull Royal
Infirmary

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

Actions arising from Board meetings

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

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT

Trust Board Annual Cycle of Business 2017 - 2018 - 2019

Focus	Item	Frequency	Apr (2017)	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan (2018)	Mar	Apr	May	May Ext.	July	Sept	Nov	Jan (2019)	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	each meeting	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				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			
	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				
	Self Certification and Statement	annual		x												x						
	Standing Orders	as required		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
	Board calendar of meetings	annual						x									x					
	Board Assurance Framework	quarterly	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							

Date							
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			Staff Survey (Board Minutes) Terry wanted it asap				
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 The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve

What could prevent the Trust from achieving this goal? Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence | BAF 2: There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There are recurring risks of under-recruitment and under-availability of staff to key staffing groups There is a risk that the Trust continues to have shortfalls in medical staffing

What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence | BAF 3: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years

What could prevent the Trust from achieving this goal? Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like | BAF 4: There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements

What could prevent the Trust from achieving this goal? For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a | BAF 5: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships

What could prevent the Trust from achieving this goal? Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP | BAF 6: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role

What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP

The effectiveness of STP delivery, of which the Trust is one part | BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2017-18

What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services

BAF 7.2: Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for |

investment to match growth, wear and tear, to support service reconfiguration, to replace equipment
BAF 7.3: Principal risk: There is a reputational risk as a result of the Trust's ability to service creditors on time, with the onward risk that businesses refuse to supply

What could prevent the Trust from achieving this goal? Lack of sufficient cashflow

Principles for the Board Development Framework 2017 onwards

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

<u>**Overarching aim:**</u>
- 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

<u>**Area 1 – High Performing Board**</u>
- 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?
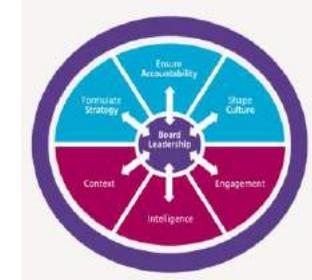
Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect
from everyone in order to have a culture that delivers outstanding patient care
- Is this reflected 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?

<u>**Area 2 – Strategy Development**</u>
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

<u>**Area 3 – Looking Outward/Board education**</u>
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

<u>**Area 4 – Deep Dive and exceptions**</u>
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

14 May 2019

Title:	Gender Pay Gap Reporting – amendment to previous report
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Louise Whiting, Employment Policy and Resourcing Manager Andy Barker, Workforce Planning and Information Manager

Purpose:	The purpose of this report is to share with the Board for completeness and audit purposes an amended copy of the Trust's Gender Pay Gap Report for the pay period including 31 March 2018.
BAF Risk:	Risk 2 – workforce
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	✓
	High quality care	✓
	Great Clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Gender Pay Gap Report was tabled and agreed at the March 2019 Board meeting. This contained one transposed number which is corrected in the attached, revised report, section 3.2, page 6, Pay Quartiles by Gender. The document has not otherwise been altered. Throughout the Board paper the data was reported to 2 decimal places, to assist the Trust better analyse the data and progress made, although the national reporting site only requires this to be done to 1 decimal place. The national reporting data was included, but shown in bold italics and bracketed for ease of reference. In the original report the figure to 2 decimal places was (and remains) 38.25% however the bracketed figure for the Upper Quartile % Headcount was transposed as 83.3% – rather than 38.2% (to account for rounding and to equal 100%). The revised report was been published on the Trust's website and data uploaded to the Gov.UK website in the prescribed format in line with statutory requirements to meet the 30 March 2019 deadline.

Recommendation:	The Board is requested to note the amendment to this report.

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

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%)*
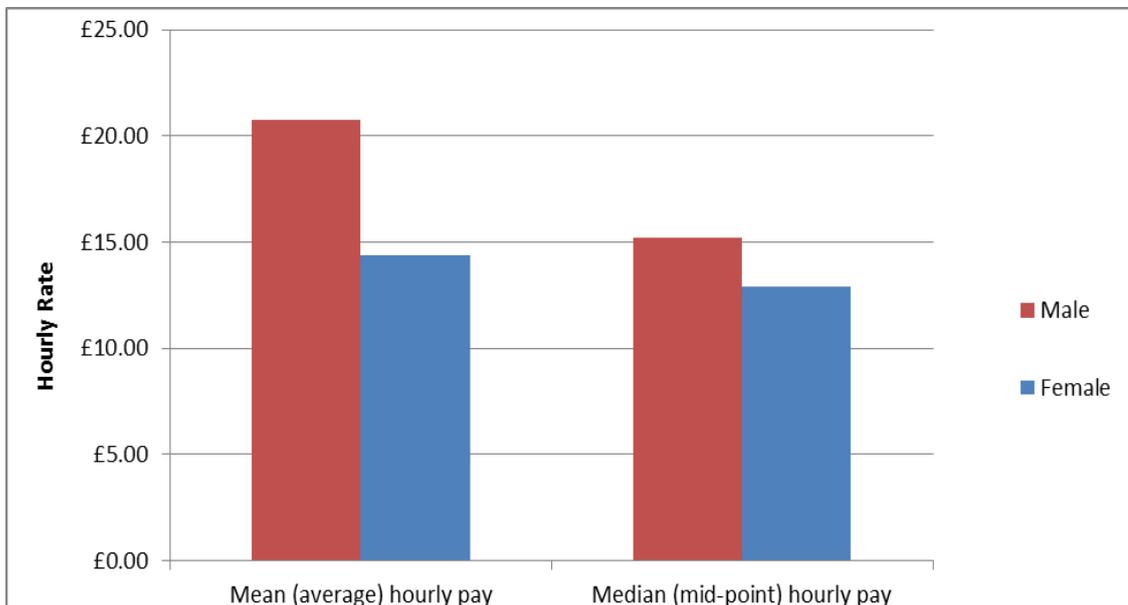
- The mean gender pay gap is 30.74% (i.e. this means that women's average earnings are 30.74% less than men's).
- The median gender pay gap is 15.12% (i.e. this means that women's average median earnings are 15.12% less than men's).

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

| Quartile	Male			Female			Total
	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% *(38.2%)*	£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%)*
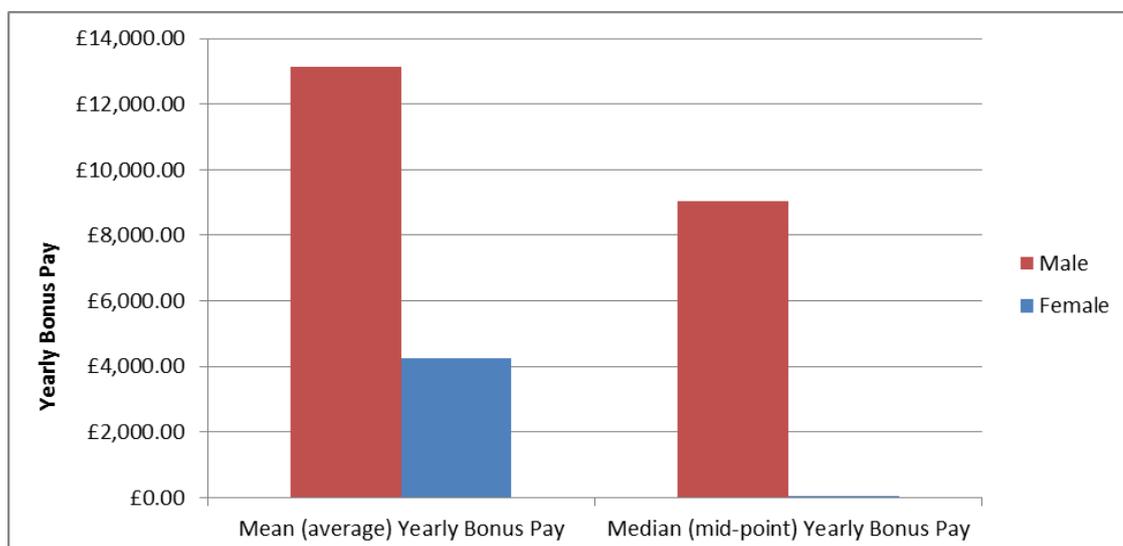
3.3.1 Key Findings
- The mean gender bonus gap is 30.03% when long service awards* are excluded from the data, rising to 67.79% when they are included in line with national guidance.
- The median gender bonus gap is 36.67% when long service awards* are excluded from the data, rising to 99.45% when they 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

Bonus Type	Male		Female		Total Headcount
	Headcount	%	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
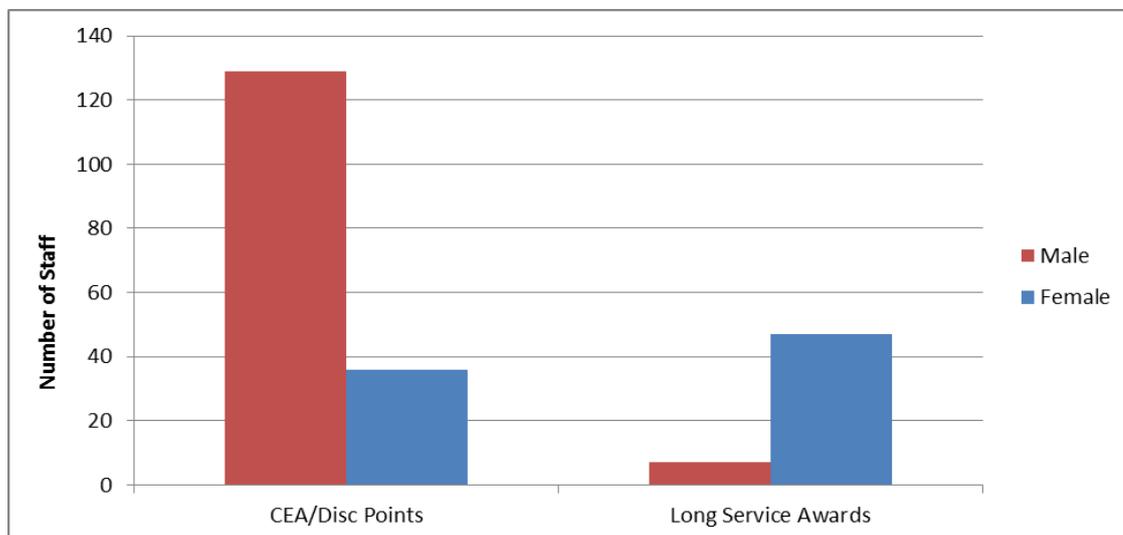
3.5.1 Key Findings
- This year the Trust has two types of bonus that meet reporting requirements – Clinical Excellence Awards (CEAs - which are awarded based on the performance of Consultant Medical Staff subject to national and local eligibility criteria in recognition of excellent practice over and 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 What Have we Done to Date?
- 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 Next Steps
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

Tuesday 14 May 2019

Title:	Strategy Scorecard 2019-2024
Responsible Director:	Jacqueline Myers – Director of Strategy and Planning
Author:	Jacqueline Myers – Director of Strategy and Planning

Purpose:	The purpose of this report is to present the Strategy Scorecard 2019-24 for approval by the Trust Board.
BAF Risk:	N/A
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	The Trust Board approved the refreshed Trust Strategy 2019-2024 at the March 2019 Board meeting. As a follow-up action, the Board agreed to receive a Strategy Scorecard 2019-24 for approval.

Recommendation:	The Trust Board is asked to approve the Strategy Scorecard 2019-24.

(Draft) Strategy Implementation Scorecard 2019-2024
2019 starting position

Great Staff	Staff survey overall result top 20% of Trusts	Staff report able to make improvements top 20% of Trusts
	Staff engagement score top 20% of Trusts	More BME staff in leadership roles
	80% of staff recommend us as a place to work	95% of posts are filled with permanent staff
	At least a 92% retention rate	Improve the health and wellbeing of our staff
Great Care	Achieve 'Outstanding' overall CQC rating	Increase harm free care year on year
	Increase the length of time between SIs and NEs	Deliver the 4 priority 7 day working standards
	Fewer complaints and PALS relating to outpatient services	Patient Friends and Family Test score : in top 20% of Trusts
	Improve transition from children's to adult services	Provide patient electronic access to medical records
	Extend access to latest surgical and drug treatments	Achieve and sustain 28 day and 6 week diagnostic targets
	Deliver 10,000 health prevention interventions	Reduce hospital stays for patients in the last year of life
	Reduce admissions for patients with long term conditions	Deliver year on year reductions in our length of stay
	Ensure our integrated teams have access to shared care records	Meet the standard for fractured neck of femur
	Deliver standards for urgent and emergency care	Reduce face to face outpatient appointments
	Expand and update our diagnostic capacity	Deliver the 'Better Birth' ambitions
	Centralise inpatient paediatrics and improve the NICU	Deliver the clinical access standards for cancer and electives
	Secure sustainable specialist paediatric service	Continue to improve our major trauma survival rates
	Improve timely access to acute and elective cardiac care	Improve the cancer stage of presentation and survival rates
	Establish a mechanical thrombectomy service	Working with partners, support the progression of the HCAV HCP into an ICS
	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
	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
Great future	Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit	Secure a 'top 20' national ranking for 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	Working with partners, achieve financial balance across our ICP
	Improve the quality of our estate and increase the productivity per square metre	Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy
	Become greener by reducing our energy consumption and waste	Become a digital first organisation; removing paper

Strategy Implementation Scorecard 2019-2024
2019 starting position

Staff survey overall result top 20% of Trusts		
Exec Owner S Nearney		
Milestone	By When	Progress
4 of the key findings in the top 20% and 6 equal too or better than the national average	March 2020	
6 of the key findings in the top 20% and 4 equal too or better than the national average	March 2021	

Staff report able to make improvements top 20% of Trusts

Exec Owner: S Nearney

Milestone	By When	Progress
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2020	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2021	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.4%	March 2022	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2023	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2024	
Achieve top 20% ranking	March 2024	

Staff engagement score top 20% of Trusts

Exec Owner: S Nearney

Milestone	By When	Progress
National Staff Survey result for staff engagement – 7.1	March 2020	
National Staff Survey result for staff engagement – 7.2	March 2021	
National Staff Survey result for staff engagement – 7.3	March 2022	
Achieve top 20% ranking	March 2022	

More BME staff in leadership roles

Exec Owner: S Nearney

Milestone	By When	Progress
Number of BME staff in leadership roles will increase by 0.5% to 6.25%	March 2020	
Number of BME staff in leadership roles will increase by 0.75% to 7%	March 2022	
Number of BME staff in leadership roles will increase by 1% to 8%	March 2024	

Strategy Implementation Scorecard 2019-2024
2019 starting position

At least 80% of staff recommend us as a place to work		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey question . Staff response will be 67%	March 2020	
National Staff Survey question . Staff response will be 70%	March 2021	
National Staff Survey question . Staff response will be 74%	March 2022	
National Staff Survey question . Staff response will be 77%	March 2023	
National Staff Survey question . Staff response will be 80%	March 2024	

95% of posts are filled with permanent staff

Exec Owner: S Nearney

Milestone	By When	Progress
94.2% of posts filled with permanent staff	March 2020	
94.6% of posts filled with permanent staff	March 2021	
95% of posts filled with permanent staff	March 2022	

At least a 92% retention rate		
Exec Owner: S Nearney		
Milestone	By When	Progress
91% staff retention rate	March 2020	
91.5% staff retention rate	March 2021	
92% staff retention rate	March 2022	

Improve the health and wellbeing of our staff

Exec Owner: S Nearney

Milestone	By When	Progress
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2020	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2021	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2022	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2023	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2024	
Achieve 6.4 point score which will deliver a top 20% ranking	March 2024	

Achieve 'Outstanding' overall CQC rating

Exec Owner: C Long

Milestone	By When	Progress
Achieve overall 'Good' rating	Mar 2020	
Sustain overall 'Good rating' and achieve 'Outstanding' rating in 2 core services	Mar 2022	
Sustain overall 'Outstanding' rating	Mar 2024	

Increase harm free care year on year

Exec Owner: Makani P

Milestone	By When	Progress
Establish mechanisms to measure harm and establish a baseline	September 2019	
Identify areas of improvement to achieve harm free care	November 2019	
Focus on one area of improvement	January 2020	
Roll out to wider areas and Embark on further areas of improvement	January 2022	

Increase the length of time between SIs and NEs

Exec Owner: Makani Purva

Milestone	By When	Progress
Refresh mechanisms to capture and manage SIs	November 2019	
Full launch of Stop the Line Campaign	March 2020	
Develop and deliver projects to address key themes	March 2020	
Continually capture real time data	March 2020	
Embed proactive safety culture	December 2022	

Achieve compliance with the 4 clinical priority standards for 7 day services by March 2020

Exec Owner: Makani Purva

Milestone	By When	Progress
Develop a series of metrics to support reporting of progress against the 7DS standards	July 2019	
Identify those specialties who continue to under-perform against the standards and agree specific actions to address the shortfalls in delivery	August 2019	
Provide six monthly updates on progress to the Trust Board in accordance with the 7DS Board Assurance Framework	Ongoing	

Fewer complaints and PALS relating to Outpatient Services

Exec Owner: B Geary

Milestone	By When	Progress
Baseline report based on 2018/19 to be completed	June 2019	
Focussed patient engagement to be undertaken	July 2019	
Action plan to be developed and approved by the OP Governance Group	July 2019	
Quarterly monitoring to commence against baseline	Oct 2019	
Development and deployment of Trust annual outpatient survey	2020/2021	

Patient Friends and Family Test score : in top 20% of Trusts

Exec Owner: B Geary

Milestone	By When	Progress
Identify themes in F&FT and agree action plan to address	Sept 2019	
Delivery improvement on 2018/19 baseline	March 2020	
Following launch of successor scheme to F&FT, develop and deploy plan to achieve top 20% rank	TBC	

Improve transition from children's to adult services

Exec Owner: T Cope

Milestone	By When	Progress
Baseline audit against NICE standards	March 2019	Complete
Broader transition partnerships developed and activated	March 2020	
Patient and carer levels of knowledge regarding condition and adult services enhanced	March 2020	
Robust patient experience measurement tool developed	March 2021	
Delivery model for transition clinics reviewed and changes implemented as indicated	March 2022	
Tool deployed and shows improved experience	2022 - 2024	

Provide patient electronic access to medical records

Exec Owner: L Bond

Milestone	By When	Progress
Go Live with 'Patient Knows Best' system	Jul 2019	
Rollout, linked to the Yorkshire and Humber Care Record programme	Sept 2020	
Deliver plan to maximise patient take up, with focus on long term conditions	Sept 2021	

Extend access to latest surgical and drug treatments

Exec Owner: Makani P

Milestone	By When	Progress
Increased commercial research activity year on year from 2018/19 baseline.	March 2020 (Yr 1)	Engagement with Y&H CRN 2019/20 Annual Plan
Increased research workforce capability to deliver increased activity.	On-going from 2019/20	To appoint 2 R&D funded Clinical Research Fellows from August 2019. Submit at least 1 Medical Research Council CARP (Clinical Academic Research Partnership) application with UoH (deadline June 2019). Supporting UoH and Trust initiatives (PhD Scholarships and other pump-priming initiatives).
Increased research awareness from Trust visitors, carers and patients.	On-going from 2019/20	Development of a 'research prospectus' by Q1. 'Comms and Engagement group' established. Comms strategy under development.

Strategy Implementation Scorecard 2019-2024
2019 starting position

Achieve and sustain 28 day and 6 week diagnostic targets

Exec Owner: T Cope

Milestone	By When	Progress
Determine the Capacity requirements in each modality and target	August 2019	
Understand the impact of referrals from outside HUTH	August 2019	
Project growth in demand over the next 5 years	August 2019	
Factor in changing technologies or therapies over the next five years	August 2019	
Develop staged milestones required to achieve the targets	Sept 2019	
Breach percentage against the 6 week standard reduced to 2%	March 2020	
6 week standard achieved	March 2021	
28 day standard achieved	September 2021	

Deliver 10,000 health prevention interventions

Exec Owner: Makani P

Milestone	By When	Progress
Establish baseline levels of delivery	March 2020	
Develop a programme plan to increase level of health prevention activity delivered by the Trust, based on brief intervention and sign posting to smoking cessation, healthy weight and alcohol services	March 2020	
Deliver a minimum of 10,000 interventions	March 2024	

Reduce hospital stays for patients in the last year of life

Exec Owner: T Cope

Milestone	By When	Progress
Embed SAFER principles across the organisation, with Home First as a priority.	1st July 2019	
Use Red2Green days to reduce any unnecessary waiting.	1st July 2019	
Work with the Discharge Hub to support advanced care planning.	1st June 2019	
Ensure all RESPECT forms are appropriate and up to date.	1st July 2019	
Develop and implement an improvement plan, for the above.	1st June 2019	
Develop and implement an improvement plan for diagnostics, equipment and treatments/medications to allow patients to leave hospital sooner.	1st July 2019	

Reduce admissions for patients with long term conditions

Exec Owner: T Cope

Milestone	By When	Progress
Introduce Hospital at Home for COPD patients.	December 2019	
Work with the ICC/ED/ Care homes to prevent Frailty patients being admitted.	December 2019	
Increase access to ACU/MDCU to prevent in-patient admissions.	July 2019	
Audit with a multidisciplinary team x 60 sets of case notes to establish if all patients needed admission or could they have gone elsewhere. Evaluate and present to partner organisations.	June 2019	
Work with partner organisation to identify alternatives to hospital i.e. social care/ see & treat/ step up beds.	December 2019	
Identify the highest cohort of long term conditions, working with the speciality teams to help prevent hospital admission.	June 2019	

Deliver year on year reductions in our length of stay

Exec Owner: T Cope

Milestone	By When	Progress
Deliver 40% reduction in number of occupied bed days of patient with a length of stay of 21 days or greater. Baseline 126 patients Target 77 patients	March 2020	
Make year on year reductions in length of stay of patients who are in hospital 7 days or longer.	March 2022 - 24	
Work collaboratively with out of hospital partners to reduce delays in the transfer of care for patients with a length of stay of 7 days or greater. Baseline – 15%	March 2020	
Improve pre-operative length of stay in Surgery	March 2020	

Ensure our integrated teams have access to shared care records

Exec Owner: L Bond

Milestone	By When	Progress
Agree benefits case for the Yorkshire and Humber Care Record Programme (YHCR), ensuring it achieves functional shared care records for Humber, Coast and Vale (HCAV)	March 2020	
Develop and agree investment plan for the YHCR	March 2020	
Complete YHCR rollout in HCAV	March 2021	

Strategy Implementation Scorecard 2019-2024
2019 starting position

Meet the standard of fractured neck of femur

Exec Owner: T Cope

Milestone	By When	Progress
Hull & East Yorkshire NHS Trust to have a designated NOF Theatre (9) and 7 established theatre sessions.	September 2019	3 sessions to start 13.5.19 2 additional sessions to start 22.7.19 2 further sessions to start 2.9.19
Recruit to vacant Ortho-geriatrics post.	April 2021	Project group established April 2019 to review current service provision to meet the pre and post operative assessment demand.
Fractured NOF bed to be available at all times on the 12th floor at HRI to accommodate all confirmed NOFS within the 4 hour target.	December 2019	Pilot to pre alert all suspected NOF from 1.5.19 for 6 months. Evaluate the trauma bed base to accommodate trauma & major trauma demand.
Neck of Femur MDT to be established weekly.	May 2019	
Deliver target of surgical treatment within 36 hours of arrival in ED	September 2020	

Strategy Implementation Scorecard 2019-2024
2019 starting position

Deliver standards for urgent and emergency care		
Exec Owner: T Cope		
Milestone	**By When**	**Progress**
Develop ED recovery and improvement plan linked to agreed performance standards trajectory	10th May 19	
Sign off of ED recovery and improvement plan via UCDG	1st June 19	
Primary Care Streaming (PCS) service specification developed and signed off by CCGs and HUTH	1st June	
PCS Implementation plan developed and signed off by UCDG	1st June	
Develop and implement ACU improvement plan	1st July	
Develop and implement AMU improvement plan	1st August	
Develop and implement Discharge Lounge improvement plan	1st September	
4 hour standard in line with agreed trajectory throughout 2019-20	31 March 2020	
Improvement to Ambulance Handover performance in line with agreed trajectory throughout 2019-20	31 March 2020	

Reduce face to face outpatient appointments

Exec Owner: T Cope

Milestone	By When	Progress
Programme for reducing the number of face to face outpatient follow-ups agreed by the Out-Patient Improvement Board.	April 2019	Approach agreed via the OPD Improvement Board.
Phase 1 specialties for the reduction programme, support by the Trust Improvement Team, identified.	April 2019	
Phase 2 specialties for the reduction programme, supported by the Trust Improvement Team, identified	September 2019	
Phase 3 specialties for the reduction programme, supported by the Trust Improvement Team, identified	April 2020	
Out-patient follow-up volume reduced by 50% from baseline at 31/3/19.	June 2020	
Phase 4 specialities for the reduction programme, supported by the Trust Improvement Team, identified	September 2020	

Expand and update our diagnostic capacity

Exec Owner: L Bond

Milestone	By When	Progress
Replace oldest CT and Gamma Camera	March 2020	
Explore options for accelerating access to Wave 4 capital	March 2020	
Agree business case for expanded endoscopy capacity	March 2020	
Install additional MRI and CT and commission additional endoscopy capacity	No later than March 2022	
Agree demand requirements across the STP for key modalities through to 2024	March 2020	
Agree and deliver further diagnostic capacity that meets forecast demand	March 2023	

Deliver the 'Better Birth' ambitions

Exec Owner: B Geary

Milestone	By when	Progress
Continuity of Carer	35% of women to be on a pathway for CoC by March 2020. 51% by March 2021	
All women to have access to digital personalised care plan	March 2021	
Maternity Voices Partnership to be in place	MVP to be in place by March 2019	
Prevention of Cerebral Palsy in pre-term infants Avoiding Term Admissions to neonatal units Reducing smoking (to 6% nationally)	Reducing stillbirths and morbidity by 2025	
Improved safety systems and culture, working with the Local Maternity System	March 2021	
Workforce development – agree STP wide recruitment strategy and training standards	March 2021	

Centralise inpatient paediatrics and improve the NICU

Exec Owner: J Myers

Milestone	By When	Progress
Agree plan for future configuration of paediatrics	Mar 2020	
Agree funding stream for plan	Mar 2021	
Agree plan for improvement of NICU	Mar 2020	
Complete implementation of plans	Mar 2022	

Deliver the clinical access standards for cancer and electives

Exec Owner: T Cope

Milestone	By When	Progress
Deliver Improvement in the 62 day Cancer performance to 85% (adjusted)	March 2020	
Deliver 62 day cancer performance standard (unadjusted)	September 2021	
Reduce ASI / Holding by 50% from baseline position (31/3/19)	March 2020	
Eliminate ASI / Holding	March 2021	
Improve RTT performance to 84.5%	March 2020	
Reduce total waiting list volume by 3,000 from baseline 31/3/19	March 2020	
Improve RTT performance to 92%	December 2021	

Secure sustainable specialist paediatric service

Exec Owner: J Myers

Milestone	By When	Progress
Agree an approach to the service review with NHSE Specialist Commissioners	Mar 2020	
Undertake review and agree recommendations	Mar 2021	
Fully implement agreed revised service model	Mar 2022	

Continue to improve our major trauma survival rates

Exec Owner: T Cope

2016 - 94.7%
2017 - 95.9%
2018 -98.2%

Milestone	By When	Progress
Maintain accuracy of TARN data collection, monitoring and outcomes.	Annually	Review and validate quarterly dashboards on coding accuracy and escalate actions through the Major Trauma Board.
Maintain performance of 2018 baseline performance levels	Annually	

Improve timely access to acute and elective cardiac care

Exec Owner: T Cope

Milestone	By When	Progress
Work with peripheral Trusts to ensure optimisation undertaken prior to transfer, reduce pre-op LOS	April 2020	
Revised referral form to confirm readiness for elective procedure and prevent delays in patient pathway	October 2019	
Scope the benefit of implementing a Cardio-thoracic Surgical Admissions Ward	Sept 2019	
Implement day of surgery admissions	October 2020	
Introduce one stop clinic to include pre- assessment for thoracic patients to improve patient pathway and experience	Dec 2019	
Achieve timely access: Acute inpatients operated on within 7 days of being fit for surgery. Elective patient wait to under 30 week waits.	March 2021	

Improve the cancer stage of presentation and survival rates

Exec Owner: Makani P

Milestone	By When	Progress
Supporting research programmes that focus on local and national issues for cancer stage of presentation.	On-going	The Trust supports and facilities research undertaken with HYMS and UoH as part of £5m YCR funding. Recent example projects – 'Cancer Diagnosis via Emergency Presentation Study' (EMPRESS) and a range of patient reported outcomes surveys (PROMS) across multiple tumour sites.
Development of a research programme around PET CT and cyclotron facilities at CHH	On-going	Current work has focussed on non-cancer. Cancer research is likely to develop further in 2019-20.
Establish and maintain support for the Daisy Tumour Bank and collection of human samples to aid research in this area.	On-going	The bank is established in the Daisy Building at CHH with R&D Manager as liaison officer on behalf of the Trust.
Support research programmes around tumour microenvironment (microfluidics).	On-going	The work of Professor John Greenman and colleagues in the University of Hull Daisy Laboratories has continued to expand in 2018-19 with a focus on the utilisation of samples across colorectal, lung, head and neck, brain and thyroid cancers. Around 70 tumour samples have been used in various microfluidic devices and the work is part of that for 3 PhD students and 1 MD student.

Strategy Implementation Scorecard 2019-2024
2019 starting position

Establish a mechanical thrombectomy service

Exec Owner: T Cope

Mechanical thrombectomy will be routinely delivered for patients, of all ages with proximal occlusion of the internal carotid or middle cerebral arteries who present early after the stroke before there is irreversible ischaemic damage to the brain.

Milestone	By When	Progress
Develop a 9-5pm Monday- Friday mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2018	Current service is Monday-Friday 9-5pm and ad hoc dependant upon availability of skilled Neurointerventionists & Vascular Radiologists.
Develop a 24/7 mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2017-27	There is a ten year programme planned to train and support mechanical thrombectomy as the tertiary service grows and the skilled clinicians required for a 24/7 day service are available.
Develop HASU & Stroke unit which will fully support mechanical thrombectomy. Providing the correct bed base for stroke services.	2018/19	HASU originally had 4 x speciality beds this has now moved to x 8, with a view to moving to x 12 as the tertiary service develops & expands.
Staff & resource HASU & Stroke unit to fully support mechanical thrombectomy. Specialist staff required for supporting patients post mechanical thrombectomy.	2018/19	The business case from 2017, delivered extra registered nurses, consultant and therapy staff to support the move from 4 HASU beds to 8 in 2018, recruitment continues for SALT & consultant posts.
Monitor mechanical thrombectomy outcomes through the SSNAP data collection.	Ongoing	Quarterly monitoring continues, with the SSNAP data being uploaded nationally and reported locally.

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

Exec Owner: J Myers

Milestone	By When	Progress
Support STP team to complete the system 5 year plan	Dec 2019	
ICS established in shadow form	Mar 2021	
ICS fully established	Mar 2022	

Establish an ICP that can show measurable improvement to the health of its population

Exec Owner: J Myers

Milestone	By When	Progress
Working with partners, establish a governance structure to develop the ICP	Oct 2019	
Support creation of ICP infrastructure and work programme	Mar 2020	
Support the development of ICP population health capability and agree improvement targets	Mar 2021	
Demonstrate improved population health in target areas	Mar 2024	

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

Exec Owner: J Myers

Milestone	By When	Progress
Agree with all partners the approach and method for the review of acute services	Jun 2019	
Ensure effective participation and leadership from HUTH teams and reps	Mar 2020	
Ensure effective scrutiny, and review of all service proposals for alignment to both Trust and review goals	Mar 2020	
Working with colleagues and partners, oversee timely and effective implementation of service changes.	Mar 2022	

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

Exec Owner: J Myers

Milestone	By When	Progress
Ensure effective participation in the review by all relevant Trust teams	Mar 2020	
Represent HUTH on the review steering group and ensure active support for solutions and alignment to HUTH strategy	Mar 2020	

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

Exec Owner: Makani P

Milestone	By When	Progress
Exchange programme for doctors in key specialities.	August 2019 - sustained on-going programme over the next few years	
Development of educational resources facilitated by an exchange programme of staff and resources.	May 2019 and on-going	Overseas simulation fellowship opportunities- to commence the first fellowship by May 2019 and follow up with others by May 2020
Development of joint research opportunities and projects and Joint Research Conference.	December 2019	Links currently established in Diabetes, Microfluidics, Sports Science.

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

Exec Owner: Makani P

Milestone	By When	Progress
Be an active and influential voice as part of the HHTU Advisory Board.	June 2019	R&D Manager part of interview panel for Operations Manager .
Provide access to Trust expertise and staffing (i.e. Quality Assurance Team) as a formal contribution to the HHTU core staffing infrastructure.	On-going	R&D QA support provided as part of development activities of HHTU including complex drug study setup. MHRA report shared with HHTU.
Provide a clear pathway allowing efficient and easy access to the HHTU and UoH research methods support.	March 2019 and on-going.	Supported the HHTU and UoH ICAHR launch in March 2019: ICAHR
Maximise the exploitation of Hull Health Trials Unit facilities (i.e. outsourcing skills and expertise to external partners).	On-going	HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU.

Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio

Exec Owner: Makani P

Milestone	By When	Progress
Ensuring equity of access to research for our patients - increasing the number of patients recruited into NIHR Portfolio studies.	March 2020	Target for 2019/20 is 6,000 participants. Delivery monitored monthly.
Embracing Y&H CRN systematic early review processes to encourage all clinicians to regularly look for opportunities to participate in research.	On-going from April 2019	Expression of interest monitored by Y&H CRN monthly. HUTH R&D to assess barriers and capacity issues.
Proactive and realistic feasibility and assessment of capability and capacity (C&C).	On-going from April 2019	Mechanism developed to capture and monitor timelines for C&C – R&D to 'unblock' delivery barriers.
Maximising resource utilisation - improved flexibility and responsiveness in our agreed priority areas.	December 2019	Appointment of Lead Research Nurse expected by June 2019 to formalise robust line management structure.

Achieve all Department of Health and NIHR research performance metrics

Exec Owner: Makani P

Milestone	By When	Progress
Provide enhanced performance management data to research teams and Health Groups on all local and national metrics (NIHR High Level Objectives (HLOs)).	April 2019	[Power BI research performance dashboards](#) developed and available on Pattie.
Provide quarterly performance report for Trust Board.	July 2019 and quarterly thereafter	Further executive summary dashboards will be made available by June 2019.
Focus on Recruitment to Time and Target (RTT) metrics (80% compliance for commercial and non-commercial studies).	Achieve 12 month rolling target for closed studies by March 2020.	Q1 performance available via RTT dashboards by July 2019.

Secure three new long-term commercial research partnerships

Exec Owner: C Long

Milestone	By When	Progress
Working with our university colleagues, identify potential partners that align to Trust Research and Innovation Strategy goals and undertake initial discussions	Mar 2020	
Set goals for shortlisted partnerships and broker arrangements	Mar 2021	
Agreements in place with 3 new commercial research partners	Mar 2022	

Secure 'top 5' national status with our Academic Oncology Research Unit

Exec Owner: Makani P

Milestone	By When	Progress
Consider Y&H CRN/ NIHR 'peer-review' of the Oncology/Haematology research unit infrastructure and delivery models.	December 2019	Senior research Nurse is influential member of Y&H CRN Oncology research nursing group. Discussion has commenced on formalised programme.
Establish baseline position on NIHR KPIs for Oncology.	Q2 2019/20	Power BI dashboards currently being developed. Some data already available on Pattie HUTH is currently 2nd in Y&H for recruitment after month 1.
Define objectives to achieve KPIs for Oncology.	Q3 2019/20	Based on baseline position. National data to be collated at end of Q1. Focus is TYA and SABRE trials.
Establish commercial 'preferred site' status for Oncology/Haematology.	2020/21	Development of an industry engagement document by Q2 2019-20.

Working with partners, achieve financial balance across ICP

Exec Owner: L Bond

Milestone	By When	Progress
Deliver HUTH contribution to Hull and East Riding system financial plan for 2019/20	March 2020	
Agree Hull and East Riding system plan for 2020/21 that eliminates recurrent deficits	April 2020	
Deliver HUTH contribution to Hull and East Riding system financial plan for 2020/21	March 2021	
Working with NLAG, development and delivery of the financial plan to support the output of the Humber Acute Services Review	March 2021	
Working with York Trust, development and delivery of the financial impact of the Pathology collaboration	March 2021	

Improve the quality of our estate and increase the productivity per square metre

Exec Owner: D Taylor

Milestone	By When	Progress
Delivery of Estates Rationalisation Programme Phase 2	Late 2019 TBC	Wilson building demolition Summer 2019. Phase 2 programme under review pending capital investment
Carter Metric - Non-clinical space <35% (under utilised space at 0%, Carter Metric 2.5%)	Late 2019 onwards	Currently 33.8%, further opportunities identified in Phase 2 Estates Rationalisation Programme
Implement office accommodation strategy including flexible and agile working.	Summer 2019	Suite 36 and rationalisation of Staff Res/Admin Block at implementation stage. Refresh of office accommodation strategy progressing
Upgrade vacant old cardiac theatres to robotic theatres	Dec 2019	Design team being appointed
Reprovide staff accommodation both sites	Late 2020/2021	Brief being established

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

Exec Owner: L Bond

Milestone	By When	Progress
Complete and sign off the refresh of the Development Control Plan for HRI	Oct 2020	
Complete and sign off the refresh of the Development Control Plan for CHH	March 2021	
Agree approach to business case(s) for capital funding	Oct 2021	
Achieve business case(s) approval and secure capital funding stream(s)	March 2023	

Become greener by reducing our energy consumption and waste

Exec Owner: D Taylor

Milestone	By When	Progress
Reduce Energy Consumption: • Implementation of mandatory energy efficiency training • Implementation of energy reduction & monitoring team • Reduce CO2 emissions in-line with government targets (Subject to Capital for Energy project)	Q2 2019 Q3 2019 End 2020	
Implementation of energy innovation project (This is a 2 year project form approval of the capital)	Est 2019-2021	
Delivery of invest to save schemes	Q2 2019 onwards	
Reduce waste to landfill: • Implementation of waste reduction and monitoring team • Develop staff training package to support correct waste segregation • Comms plan delivered	Q2 2019 Q1 2019 Q3 2019	

Become a digital first organisation; removing paper

Exec Owner: L Bond

Milestone	By When	Progress
Agree capital financing for the Trust Digital Strategy	Sept 2019	
Agree plan for e-casenotes	March 2021	
Complete network upgrade	March 2021	
Complete rollout of e-prescribing	March 2021 (CHH) March 2021 (HRI)	
Complete rollout of e-observations	March 2022	
Deploy e-casenotes solution	March 2023	

Strategy Implementation Scorecard 2016-21 – 2018 progress report

Colour Rating	Definition
	Delivered
	On track to be fully delivered by deadline
	Not currently on track but confidence in plans to recover and deliver by deadline
	Not on track and low or moderate risk to delivery by deadline
	Not on track and high risk to delivery by deadline

Hull University Teaching Hospitals NHS Trust

Trust Board

14 May 2019

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

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.
BAF Risk:	N/A

Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	The paper contains updates on recent successes in international medical recruitment, the interim Emergency Department Health Group arrangements and successes in medical staff positions and service developments. It also includes as an update on a request just received from NHSI/E on Trusts' capital expenditure plans for 2019/20. Appended to the paper is an update on Regional Pharmacy developments, which Boards are asked to receive at their forthcoming public boards to note.	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 14 May 2019

1.   Key messages from March and April 2019

HUTH recruits ten new doctors through international partnership
The trust has launched an international partnership with Pakistan to bring ten qualified doctors to work at Hull Royal Infirmary and Castle Hill Hospital.

Our hospitals have partnered with the College of Physicians and Surgeons (CPSP), Pakistan's national institution which regulates medical education and professional development among its postgraduate doctors.

CPSP will benefit from their doctors receiving the best training at a major teaching hospital in the UK while the trust will be able to fill medical vacancies at a time of national recruitment pressures in the NHS.

Doctors will come to Hull for two years and then return to Pakistan. The plan is to bring further cohorts to Hull every year. The first of the Pakistani doctors are set to arrive in Hull next month and the trust is now progressing a similar partnership with universities in India.

Inflammatory Bowel Disease expert at Hull unit takes on global research role
The trust's leading expert in inflammatory bowel disease (IBD) has been appointed to promote clinical research at a globally recognised medical association.

Consultant Gastroenterologist Professor Shaji Sebastian, based IBD Unit in the Department of Gastroenterology, has been appointed to the ClinCom board of the European Crohn's and Colitis Organisation (ECCO).

Professor Sebastian was elected to the three-year post responsible for overseeing and promoting clinical research throughout the national study groups of the organisation, partners and members around the world.

His appointment was made at the ECCO annual congress in Copenhagen last week, attended by more than 8,000 delegates from around the world.

ECCO's mission is to improve the care of patients with IBD in all its aspects through international guidelines for practice, education, research and collaboration in the area of IBD.

Professor Sebastian leads the Hull IBD Unit, is gastroenterology Local Clinical Research Network speciality co-lead at the National Institute for Health Research and holds a honorary chair in gastroenterology at Hull York Medical School at the University of Hull.

Hull Eye Hospital one of safest in UK for cataract surgery
Our ophthalmology team has been credited with some of the best safety rates in the country for bringing waiting times down to just seven weeks for patients needing cataract removals.

The dedicated team at the Eye Hospital sees around 5,000 patients a year for cataract surgery, caused as people grow older and the lens inside the eye becomes cloudy, affecting vision. Now, despite treating around 100 patients in need of cataract surgery every week, the ophthalmology team has almost halved waiting times from around 12 weeks to just seven.

Everyone from the reception staff to the people in our appointments team and the clinical staff carrying out the procedure has worked hard to ensure people are seen as quickly as

possible. The national standard is 18 weeks but the vast majority of our patients see the consultant for their first appointment within seven weeks of being referred to the hospital by their optician. Most operations are then done within five weeks, meaning the whole process from initial referral to surgery is completed within 12 weeks.

Congratulations and thanks to everyone involved in such a remarkable achievement.

How to make sure we know what you want in an emergency
People with complex health conditions are being urged to chat to hospital consultants, GPs or specialist nurses to ensure their wishes are followed in a medical emergency.

In April our trust became the eighth NHS trust in the country to introduce ReSPECT, used by staff to help people with complex needs, those nearing the end of their lives or people at risk of sudden deterioration or cardiac arrest. ReSPECT allows people to draw up a plan with health professionals, such as whether or not they wish to be resuscitated or "brought back" if their heart stops in a future medical emergency or if they agree to a particular treatment to save their lives.

ReSPECT forms were introduced at the trust last year to replace "Do Not Attempt CPR" forms after concerns were raised over the limitations of restricting people's options to either resuscitation or not, and to encourage conversations between patients and clinicians about the quality of life and care that each person would wish for themselves.

Medical examiners introduced to improve scrutiny of deaths
As briefed to the Trust Board in March 2019, Medical Examiners are to be introduced through a pilot scheme at Castle Hill Hospital to provide enhanced scrutiny of deaths.

Our trust will introduce the new role as a pilot scheme this month before the new system is rolled out to Hull Royal Infirmary by April next year.

Independent Medical Examiners are part of the Government's response to public inquiries into Dr Harold Shipman, the Francis Inquiry into Mid Staffordshire NHS Foundation Trust and deaths of patients at Southern Health NHS Foundation Trust.

The Medical Examiners at Castle Hill will be part of a national network and their role will be independent, enabling them to scrutinise deaths because they will not have been involved with the patient or their care before their deaths. They will scrutinise all deaths by reviewing patient notes and discussing the case with a doctor involved in the patient's care and supporting junior doctors to fill out death certificates correctly.

Dramatic reduction in stillbirths after new guidelines are introduced in Hull
Stillbirth has been reduced by more than one third in two years at Hull Women and Children's Hospital after maternity services adopted national guidelines to save babies' lives.

Medical and Midwifery teams at Hull University Teaching Hospitals Trust have reduced stillbirths by 36 per cent from 25 in 2016/17 to 14 so far in 2018/19.

Helping women to stop smoking when they become pregnant, monitoring women at risk of stillbirth more closely and checking babies' heart rates more effectively during labour have all played a part in achieving the dramatic reduction.

Stillbirths account for 4.7 in every 1,000 births in the UK, one of the highest rates among richer countries. However, the rate can vary by as much as 25 per cent between different regions in England.

Well done to our staff for delivering this vital improvement.

Memory boxes to help children after their brothers and sisters die in hospital
Memory boxes are to be given to children to help them cope with the death of a brother, sister or parent at hospitals in Hull, North Lincolnshire and South Yorkshire.

Abbie's Fund, set up by Katy Cowell in memory of her daughter, has donated white, pink and blue boxes for brothers and sisters of babies and children who die at the Neonatal Intensive Care Unit, the Labour & Delivery Suite, the Children's Emergency Department or the Children's Wards at Hull Royal Infirmary. "Hug Me" hearts, where children struggling to ask for a hug can simply present the heart to a trusted adult to show what they need will be put inside the boxes.

Boxes will also be delivered to Adult Intensive Care Units at Hull and Grimsby to help children experiencing the death of a mother or father and to neonatal units in Doncaster and Scunthorpe.

Family finger print pictures, where every member of the family contributes their fingerprint to a family tree alongside their loved one, "heart in the hand" keyrings, teddies, clay moulds for hand and foot prints are among the items included in the box.

Update on Emergency and Acute Medicine Health Group
In January 2019, an interim Emergency and Acute Medicine Health Group was put in place within the Trust. This has been subject to consultation with postholders and across the Trust recently. A further interim period for Emergency Medicine to be joined by outpatient services within a fifth health group is being put forward from 1 July 2019 to continue a level of additional senior management support to these services, to run until April 2020. During this time, further review and consultation will take place to review the success and further lessons learned and to determine any future permanent structural arrangements that would be subject to Board review and approval.

Update on Regional Pharmacy Developments
The Board will recall that there has been a regional piece of work on-going for around two years to explore whether a regional pharmacy supply chain could be set up. A update is attached to this report, which all partner organisations have been asked to note at their next public board meetings. In summary, the market testing undertaken for a regional pharmacy supply chain has meant that an outsourced solution is not being progressed. The attached paper notes the next steps that will be taken as a result.

Letter received from Chief Finance Officer, NHS England/Improvement
NHS Trusts received a letter on 7 May 2019 from the Chief Finance Officer of NHS England/Improvement, regarding capital plans for 2019/20. Trusts are being asked to review and resubmit their capital plans for 2019/20 by 15 May 2019 as part of a national undertaking by NHS England/Improvement and a requirement of the final operational plan resubmission work of each Trust, following first submission on 4 April 2019. Trusts are required to submit capital plans that are deliverable and only contain expenditure based on defined funding sources that have already received approval. Trusts are asked to minimise additional requirements only to urgent or critical expenditure in 2019-20. All Trusts together with NHS England/Improvement are required to work within the capital limit set for the NHS and are asked to consider deferring expenditure where possible. The Board will be kept appraised of the Trust's submission, and will continue to review the Trust's capital position through the Performance and Finance Committee.

2.   Media Coverage

2.1 Trust Media Coverage
The Communications team issued 14 news releases in March and 14 in April.

In March 75% of our media coverage was positive and in April 93% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been exceeded in nine months out of the last 12:
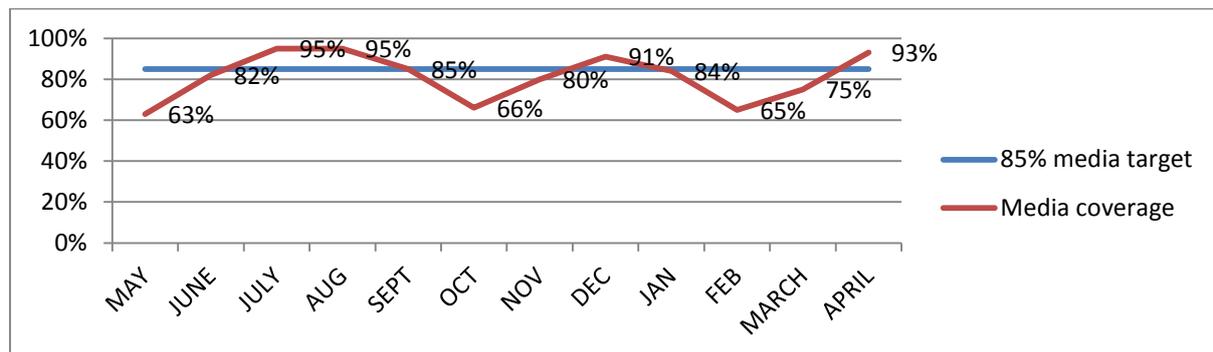
Facebook reach is the number of people that have seen content within a certain period; it can also be called unique impressions.

- In March total "reach" for all posts on trust Facebook pages was 443,383
- In April total "reach" for all posts on trust Facebook pages was 354,195

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 68,400 (January)
- @HEYNHS Twitter account impressions 47,600 (February)

Social media reach and impressions April 2018 - April 2019
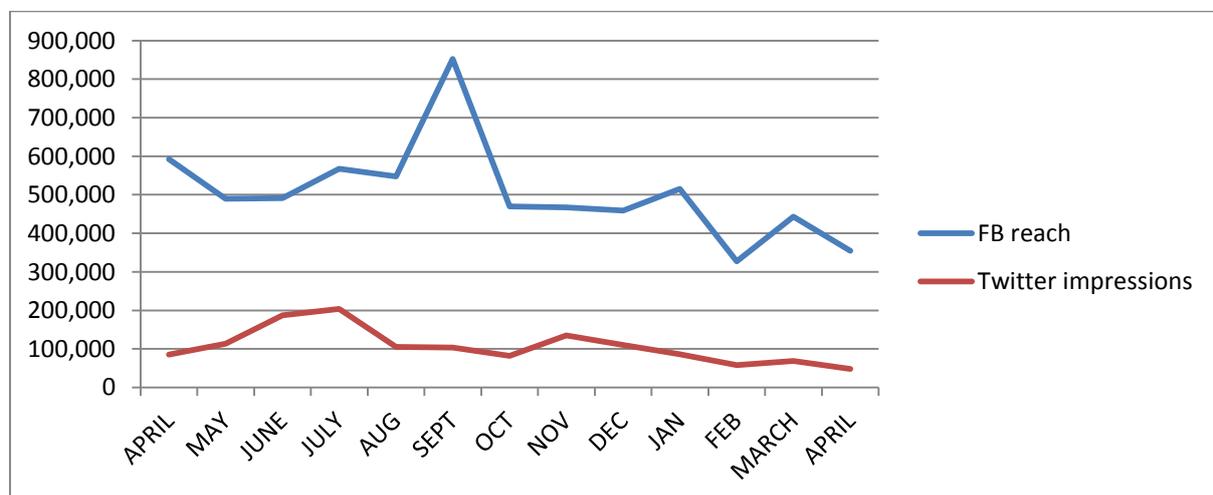
The number of people 'following' the Trust on Twitter and Instagram continues to increase:
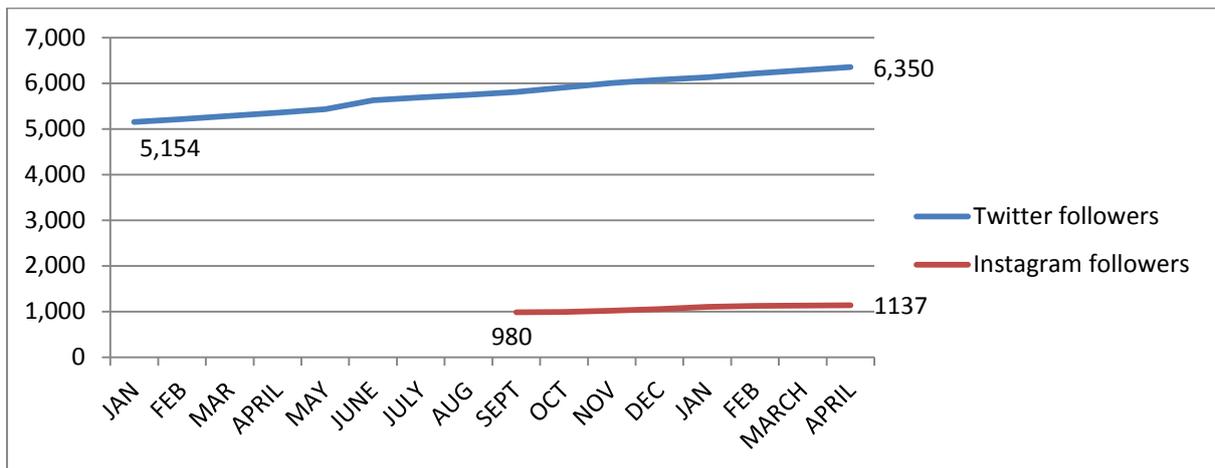
2.2 Item of national media interest

The Executive team is currently monitoring the outcome of the Flowers vs. East of England Ambulance Service Employment Tribunal appeal. The outcome of this case could have implications for all NHS trusts in relation to annual leave pay linked with actual hours worked for staff on Agenda for Change terms and conditions. The Board will be kept appraised of this situation via the Performance and Finance Committee, depending on the outcome of the case. The appeal is scheduled to be heard in May 2019.

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 March and April we received 96 and 104 Moments of Magic nominations, respectively. 104 is the highest the trust has ever received in one month.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2010-2019

West Yorkshire Association of Acute Trusts

Airedale **NHS**
NHS Foundation Trust

Bradford Teaching Hospitals **NHS**
NHS Foundation Trust

Calderdale and Huddersfield **NHS**
NHS Foundation Trust

Harrogate and District **NHS**
NHS Foundation Trust

The Leeds Teaching Hospitals **NHS**
NHS Trust

The Mid Yorkshire Hospitals **NHS**
NHS Trust

Hull and East Yorkshire Hospitals **NHS**
NHS Trust

Northern Lincolnshire and Goole **NHS**
NHS Foundation Trust

York Teaching Hospital **NHS**
NHS Foundation Trust

REGIONAL SUPPLY CHAIN COLLABORATION (RSCC)

The RSCC Programme Board, on behalf of WYAAT Trusts and Regional Partners, met in March to discuss and evaluate the Best and Final Offer from the potential Supplier. The Project Board felt that although the benefits of this proposed new operating model were apparent, it was not possible to demonstrate overall value for the NHS with sufficient surety to justify recommending trusts progress to contracting with the Supplier.

The recommendation from the Project Board not to progress to contracting was supported by the WYAAT Programme Executive, and subsequently taken to the WYAAT Committee in Common (CIC) for discussion on 30th April.

The CIC approved, as Chair's action, the recommendation from the Project Board and WYAAT Programme Executive not to proceed with an outsourced regional pharmacy supply chain.

The decision made at CIC will now be ratified by each respective trust board, following which the RSCC Project Team will formally inform the Supplier and other stakeholders of the decision.

For governance purposes, WYAAT trusts are planning to formally report this decision and outcome at their next Public Board meeting. You may wish to take a similar approach within your organisation.

The Project Board are now working to identify further collaboration opportunities which may support efficiencies and quality improvements concerning the delivery of pharmacy services and the management of medicines.

Your Chief Pharmacist will be able to provide any further information you may require.

Yours sincerely

Martin Barkley
Senior Responsible Owner, Pharmacy Regional Supply Chain Collaboration
Chief Executive, Mid Yorkshire Hospitals NHS Trust

LONG TERM GOALS - March 2019 data

NHS Hull University Teaching Hospitals NHS Trust

Great Staff	Great Care	Great Future

Quality

RAG	Indicator	Target	Performance March	Trend v Previous Month
G	Never Events	0	0	→
R	Complaints (QIP - closed within 40 working days)	90%	89.39%	↑
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	52	32	-
R	Safety Thermometer - Harm Free Care	95%	93.71%	↑
R	Venous Thromboembolism (VTE) Risk Assessment (Q4 1819)	95%	92.75%	↑
R	Mortality - HSMR (January 2019)	<100	109.2	↓
G	Friends & Family Test - Inpatients (February 19 - Trust v National %)	95.51%	98.51%	↓
R	Friends & Family Test - Emergency Department (February 19 - Trust v National %)	85.28%	82.97%	↑

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

Workforce

RAG	Indicator	Target	Performance March	Trend v Previous Month
G	Staff Retention/Turnover	<9.3%	9.10%	↓
G	Staff Sickness	<3.9%	3.45%	↑
R	Staff Vacancies	<5.0%	5.11%	↓
R	Staff WTE in post (<0.5% from Plan)	7406	7486	↑
R	Staff Appraisals - AFC Staff	85%	84.30%	↓
G	Staff Appraisals - Consultant and SAS Doctors	90%	92.80%	↓
G	Statutory/Mandatory Training	85%	91.50%	↓
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£12.8m	£16.3m	-
G	Staff: Friends & Family Test - Place of Work (Q3 1819 v National)	63%	63%	↓
R	Staff: Friends & Family Test - Place of Care (Q3 1819 v National)	71%	70%	↓

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance March	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	85.00%	76.79%	↓
G	52 Week Referral To Treatment Breaches	0	0	0	↓
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	3.83%	↓
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	90.8%	80.65%	↑
R	Cancer: ADJUSTED 62 Days Referral To Treatment (February Data)	85%	83.00%	75.30%	↑
G	Length of Stay (February Data)	<5.2	-	5	↑
R	Clearance Times	12 weeks	-	14.5	↑
G	Waiting List Size	55,140	54,641	53,083	↓
G	Available Clinic Slot Utilisation	80%	-	91.60%	↑
G	Theatre Utilisation	90%	-	90.36%	↑
R	E-Referrals - GP Engagement	100% by October 2018	-	98.4%	↑
R	Appointment Slot Issues	35% (TBC)	-	53.55%	↑

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

Finance

RAG	Indicator	Target	Performance March	Trend v Previous Month
G	Capital Expenditure	38.4m	£23.5m	↑
G	Statement of Comprehensive Income Plan - Year to Date	£2.36m	£25.2m	-
R	CRES Achievement Against Plan	£19.9m	£14.4m	-
R	Invoices paid within target - Non NHS	95%	91.6%	↑
R	Invoices paid within target - NHS	95%	72.5%	↑
G	Risk Rating	3	2	↓

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 May 2019

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

Purpose:	The purpose of this report is to present the year-end 2018-19 Board Assurance Framework, for approval by the Board	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	The Trust Board has held detailed discussions on all BAF risk areas year to date, starting with those with the highest risk ratings. During this financial year, BAF 2: Staffing was increased following discussion at the July 2018 Board meeting from a rating of 16 to 20. In March 2019, the Board agreed a recommendation to reduce the risk rating for BAF 5 (great specialist services) from 12 to 8. All other risk ratings have remained the same year to date. As a year-end position, the Board is asked today to consider reducing the risk rating on BAF 7.1 on the basis of achieving the Control Total for the year and reducing the risk on BAF 7.2 on the basis of likelihood, as the risk has not had the material impact it could have this year.	
	The Performance and Finance Committee had an in-depth review of waiting lists and cancer waiting times at its December 2018 and was asked to take a view on BAF 4 on performance as to whether this should increase now that quarter performance figures are known. This was discussed at the January 2019 Trust Board. The Quality Committee looked at communications as a common issue in incidents but no recommendation to change risk ratings.	
	The process by which the BAF is used by the Trust Board to inform the Board's meeting agenda has changed during 2018-19, and is used more pro-actively to lead discussion areas at public Trust Board meetings.	

Recommendation:	The Trust Board is asked to approve the final position of the Board Assurance Framework for 2018-19

Hull University Teaching Hospitals NHS Trust

Trust Board

Board Assurance Framework

1.   Purpose of this report
The purpose of this report is to present the year-end 2018-19 Board Assurance Framework, for approval by the Board

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

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

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

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

3.   Board Assurance Framework (BAF) 2018-19
At the Trust Board in July 2018, the Board discussed four of the BAF risks with the highest risk ratings in Q1:
BAF 2 – staffing. Q1 risk rating = 15, increased to 20
BAF 4 – performance. Q1 risk rating = 16
BAF 6 – STP and partnership working = 16, review again in 3 months' time
BAF 7.1 – achievement of financial plan = 20

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

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

At the March 2019 Board meeting, the Trust Board discussed:
BAF 5 – Great Specialist Services = 8 (agreed to reduce from 12)

Through these detailed discussions, the Board increased the risk rating of BAF 2 – staffing and agreed to increase the risk rating to 20. The Board recognised the work already in place

and ongoing and agreed that this would be reviewed with a view of reducing it providing the Board were assured that actions in place mitigated the risk satisfactorily.

The other risk ratings were unchanged for Q2. In respect of BAF 7.1, the Board agreed to leave the risk rating at 20 but there was concern around the end-of-year loading to achieve the CRES. The Performance and Finance Committee is to keep monitoring the situation and escalate any emerging issues.

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

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

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

The Performance and Finance Committee at its January meeting debated in detail whether to recommend that the risk rating for this BAF area increases on the basis of likelihood, as the ED target was not met in Q1 and was not on track in Q3. At the January 2019 Board meeting, the Trust Board picked up this discussion from the Performance and Finance Committee regarding BAF 4 and whether the risk rating should be increased, in light of performance this financial year against performance targets. Following detailed discussion, it was agreed that performance in some areas is on track and plans are in place to bring in performance at the right levels of the end of the financial year. On this basis, the risk rating was not increased; the rating on likelihood would need to increase to 'almost certain' that the Trust would not meet its performance measures and with current plans in place and areas of improvement, this is not the position the Trust is in.

The Performance and Finance Committee has kept careful overview throughout the year on the Trust's performance against the Financial Plan and achievement of the agreed Control Total. The March 2019 received assurance that the Trust remained on track to achieve the Control Total and the main financial plan measures, therefore has not proposed a change in rating for year-end.

The Quality Committee was also asked whether for its view on Q3 ratings to feed in to Trust Board discussions. The Quality Committee held detailed discussion at its November 2018 meeting on a general risk around communication linked with serious incidents and whether

the risk that the Trust fails to learn from incidents is increasing. Concluding these discussions, It was not felt that this was an increase in risk in the organisation but there should be increased recognition of communications as an underlying issue and specific actions in QIP projects where communication can be a root cause to improve communications and reduce risk of harm or poor patient experience.

The Trust Board received an update paper on BAF 5 (great specialist services) and on the basis of actions taken during the year that have mitigated the likelihood of this risk, such as New national guidance driving more local decision making, Elimination of a non-compliance issue in relation to catchment population, development of the Trust's service portfolio and quality standard performance and the development of new clinical networks, the Trust Board agreed to reduce the risk rating from 12 to 8.

The Performance and Finance and the Quality Committees have reviewed the proposed year-end position of the Board Assurance Framework, as has the Audit Committee from a process point of view.

The Performance and Finance Committee would recommend reducing the risk rating for BAF 7.1 on the Trust's financial plan and control total to 5 (based on 1 for likelihood and 5 for impact), on the basis that the Trust has now confirmed it has met the control total for the year and is reporting a surplus financial position at year end. On this basis, the risk regarding capital funding and infrastructure can also be reduced in Q4 risk rating, as the risk has not materialised this year, but is carried over to next year.

The Quality Committee discussed whether the risk rating for BAF 3 could be reduced, given there is a positive picture of improvement in quality as reported to the Board this year, such as improvements in Fundamental Standards overall, increased substantive nurse and medical staffing, no Never Event recorded last financial year and maintaining the same low harm rates to patients. The Board is asked to consider this or whether this is balanced against not achieving other key quality metrics during the year, such as VTE assessment.

All BAF risk areas have been reviewed and positive assurance, gaps in assurance and control measures have been updated, per the version of the BAF attached.   There are no other particular areas of risk or assurance that have been escalated during this time other than the notes above.

The Board discussed the 2019-20 Board Assurance Framework, which is a separate paper on today's agenda. It was agreed that there are some particular pressure points that will need to be included in this year's Board Assurance Framework and continue to need active monitoring by Board Committees, particularly capital and infrastructure, and making quality improvements and a safety culture, as well as a long-term staffing plan. These will form Board and Committee discussions during the year.

The Audit Committee has reviewed the Board Assurance Framework process during the financial year and has not identified any specific gaps in process that it would recommend the Trust addresses. The Trust's internal auditor team has also reviewed the processes around the Board Assurance Framework and has given an opinion that the Trust's Board Assurance Framework meets NHS requirements, "is visibly used by the Board and clearly reflects the risks discussed by the Board. No significant issues were raised for the attention of the Audit Committee."

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

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

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

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

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

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

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

4.   Recommendations

The Trust Board is asked to approve the final position of the Board Assurance Framework for 2018-19

Carla Ramsay
Director of Corporate Affairs

May 2019

PEOPLE

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

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

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

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

FINANCE

Financial sustainability

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

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

PATIENTS
High quality care
Great local services
Great specialist services

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

INFRASTRUCTURE

High quality care
Financial sustainability

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

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

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

PARTNERS

Partnership and integrated services

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

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

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating (Imp x likeliho od)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey There is a risk that the Trust fails to embed a safety culture *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues	None	4 (impact) 3 (likelihood) = 12	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Chief Executive cultural briefings in 2018 on management behaviours and 'stop the line' Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores Continuous examples and feed back to staff as to how speaking up makes a difference	12	12	12	12	4 x 1 = 4	**Positive assurance** Positive receipt by clinicians of the Never Event session – to follow up Detailed discussion at September 2018 on staff culture and the People Strategy – positive assurance about continued progress on workforce, including increases in engagement score and workstreams underpinning the People Strategy to continuously improve staff engagement. Board development discussion and workshop on revising the People Strategy in November 2018 and engagement events with Health Groups to be held. March 2019 – receipt of staff survey results for 2018. Improvement in staff engagement score as well as in staff reporting an increased safety culture in the organisation. **Further assurance required** Recent staff engagement score shows some slowing of progress – whilst the score is on an upward trend, there are concerns about continued progress March 2019 staff survey requires an action plan to bring up engagement scores in some areas/services

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

Risk Appetite

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development

Support from Chief Medical Officer and Chief Nurse | *Principal risk:* Staff do not come on the journey of improvement – seen in staff engagement and staff FFT scores

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

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

What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need.

Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans | F&WHG: anaesthetic cover for under-two's out of hours

SHG: registered nurse, OPD vacancies

Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG

F&WHG – inability to access dietetic review of paediatric patients – staffing

Medicine HG: multiple junior doctor vacancies

F&WHG: Shortage of Breast pathologists | 5 (impact)

3 (likelihood)

= 15 | People Strategy 2016-18 in place

Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices (including nursing); Advanced Clinical Practitioners and Physicians Associates being deployed and recruited to cover Junior Doctor and nursing roles, in addition the Trust has introduced new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience

Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 18-19; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles

Golden Hearts – annual awards and monthly Moments of Magic – valued staff

Health Group Workforce Plans in place to account at | Need clarity as to what 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs | 15 | 20 | 20 | 20 | 5 x 2 = 10 | **Positive assurance** New roles being put in place and supported by the Trust in 18-19 including Physicians Associates, further ACPs, nursing apprenticeships

Progress on recruitment during 18-19 with qualified nursing staff – recruitment from university graduates and international recruitment

New programme being put in place with trainee doctors from Pakistan

Improved fill rates from September 2018 university recruitment of newly qualified nurses; higher fill rate in junior doctor rotas than previously

Recruitment to some specific posts – success seen in Anaesthetics

Further assurance required Variable pay spend predicted to continue during 18-19; some HGs already under some pressure even with re-set budgets

Reviewed in detail at July 2018 Trust Board – risk rating increased, to be reviewed in September 2018 with a view to the risk rating coming back down after mitigating actions – reviewed at September 2018 and not yet to decrease. Nursing fill rates improved with new intake of graduate nurses but still not in better quartile.

Difficulties seen in winter planning and staffing – lower fill rates than last year and less ability to flex staff this winter to further increase winter capacity |

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

Risk Appetite

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

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like That the Trust does not increase its public, patient and stakeholder	MHG: Hyper Acute Stroke Unit capacity CCSHG: lack of compliance with blood transfusion competency assessments CCSHG: Risk to patient safety involving discharge medicines Corporate: Embedding ReSPECT process Pathology results reviewed by requesting clinicians	3 (impact) 3 (likelihood) = 9	Setting expectations on a safety culture in the Trust – Never Event session to be followed up by Chief Executive briefings sessions and the 'Stop The Line' campaign Quality Improvement Plan (QIP) was updated in light of latest CQC report and has been further updated from the new CQC report published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)	9	9	9	9	3 x 2 = 6	**Positive assurance** Detailed understanding at Board development on next steps to reach good and outstanding – shared understanding with Board and EMC on the progress that is required; underscores ambition to be outstanding by 2021-22 No Never Event reported in 2018-19 Improving picture reported to the Board – improvements across Fundamental Standards, improvements in substantive medical and nursing staffing rates Achieving requirements for Learning from Deaths framework to date **Further assurance required** CQC rating of 'requires improvement' – shows a lot of progress since last report but still work to do to progress to 'good' overall – no CQC inspection during 2018-19 to revise rating Targeting intervention/quality improvement plans for improving communications, as the most common factor in serious incidents Not a full suite of quality indicators achieved in 2018-19 – VTE, 28-day readmissions; some elements of the QIP not achieved

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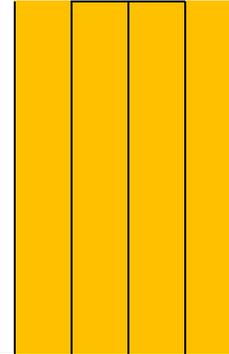
Risk Appetite
The Trust remains focussed on delivery of high quality services for its patients; the Trust does not want to compromise patient care and does not have an appetite to take risks with quality of care. The Trust acknowledges that the risk environment is increasing in relation to the Trust's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

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet operational planning guidance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 18-19, with an associated risk of distress caused to patients and the ability of the Trust to secure STF monies. *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce its list size compared to the position at 31 March 2018; this will require targeted work by each specialty ED performance did improve following a period of intensive support and improvement focus but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG Capacity of intra-vitreal injection service MHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target	4 (impact) 4 (likelihood) = 16	Trajectories set against sustainable waiting lists for each service, to move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Capacity and demand work in cancer pathways	Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	16	16	16	16	4 x 2 = 8	**Positive assurance** Q2 & Q3 ED trajectory met Improvement starting to be seen in diagnostic waiting times (Dec 18) Volume of long-waiting cancer patients (104 day waits) decreasing Met waiting list reduction target at year-end Met 52-week target at year-end **Further assurance required** Reviewed in detail at July 2018 Trust Board; detailed understanding of current actions and underlying issues. Specific services reviewed at September and October 2018 Performance and Finance Committee meetings in respect of RTT – extraordinary P&F Committee being considered to bring shared understanding and recommendation to the Trust Board on how to progress with RTT. Extra session o P&F Committee November 2018 to understand delivery plans and what is deliverable; year-end position showing that 6 main requirements of the Trust in 18-19 will most likely not be met in full Detailed exception reporting throughout the year – performance variable month-to-month in cancer, diagnostic and ED – year-end position confirms these are not met

| | | backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues

A focus on 62-day cancer targets has brought about improvements and a continued focus is required to make further gains | | | | | | |
|---|---|---|---|---|---|---|---|

Risk Appetite

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

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk:* There is a risk that reductions in the Trust's patient population for (some) of its specialist services may present sustainability challenges. *What could prevent the Trust from achieving this goal?* Actions relating to this risk may be taken by other organisations than the Trust and the Trust may struggle to influence these decisions, particularly in relation to patient populations beyond the Humber geography.	None	3 (impact) 4 (likelihood) = 12	The Trust chairs the HCAV STP Hospital partnership Board The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is a member of the Yorkshire and Humber Oversight Group for Specialised Commissioning	Ongoing discussions and evolution of the STP and also its links to local health economy programmes of work	12	12	12	8	4 x 2 = 8	**Positive assurance** Engagement work with acute partners in the STP – active participation in 2 x acute services reviews Positive relationship with NHS England as commissioner of specialised services Mitigating actions taken affect in 18-19 – update to March 29 Trust Board providing positive assurance and enabling reduction in risk rating to target risk rating **Further assurance required** Role and pace of change achievable through STP

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

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds.

What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP

The effectiveness of STP delivery, of which the Trust is one part | None | 4 (impact)

4 (likelihood)

= 16 | The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO)

The Trust is playing a key role in the Humber Acute Review (CEO and DOSP)

The Trust is playing a key role in the STP workforce workstream (DOWOD)

The Trust has a seat on the Hull Place Board (CEO)

The Trust is participating in the East Riding Place Based initiatives
The Trust has a partnership meeting with CHCP | | 16 | 16 | 16 | 16 | 4 x 2 = 8 | **Positive assurance** Some progress seen during year; Letter of Intent between main provider organisations to work more as an Integrated Care Partnership and more progress towards working as an Integrated Care System at STP level. Scarborough acute service review commenced; progress detailed at November 2018 Trust Board

Further assurance required

Reviewed in detail at July 2018 Trust Board; detailed understanding of current position and actions being taken – gap in assurance on scale and pace of change/partnership development

Progress detailed at November 2018 Trust Board – evidence of sustaining progress is required to mitigate and manage this risk level down |

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

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2018-19 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	None	5 (impact) 4 (likelihood) = 20	Health Group budgets revisited for 2018-19 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES. Weekly Productivity and Efficiency Board (PEB) in place; outputs monitored by Performance and Finance Committee HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Year 2 of Aligned Incentives Contract with local commissioners; consistent approach to income Investment in staffing shortfalls and recruitment to drive reductions in variable pay Will start discussions with CCG colleagues on system solutions Discussions with NHSI over control total re:	Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position Locum and agency spend Delivery of recurrent CRES	20	20	20	5	5 x 1 = 5	**Positive assurance** Financial position to month 7 in line with plan; financial risks and HG position reviewed in detail each month and mitigating action taken in second half of year to remain on track to achieve control total Year-end position confirms that the financial plan requirements were met for 2018-19 – risk rating moved to low risk as a result as risk did not crystallise at year-end **Further assurance required** Reviewed in detail at July 2018 Trust Board and further review at month 6 identifies issues that require solutions, including gaps in achievement of financial plan through: non-development of SPV this year (£2.9m), CNST premium (£0.5m), Hep C CQUIN (£0.6m) and health group forecasts; November 2018 position shows same gaps. M8 figures from Health Groups did not match forecast – new overspends seen – continued in further months; HG required to have tight grip on spending in Q4 Grip and control applied through Q4 but financial risks being carried in to 2019-20, with a more difficult set of financial requirements and continued issue of the Trust's underlying financial position, which closes at £24m at year-end. Accurate forecasting and control not yet where it should be

SPV

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

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2018/19 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**5 (impact)** **4 (likelihood)** **= 20**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Remedial fire works undertaken in the short-term – also secured £4.9m capital funding for works Applied for £2.6m emergency capital Applied to convert £3.7m bonus PSF received in 2017-18 to capital	Insufficient funds to manage the totality of risk at the current time Programme enables the Trust to run on a day-to-day basis but is not addressing the root causes sufficiently, except fire safety The level of risk increases as the Trust manages 'as is'	**20**	**20**	**20**	**10**	5 x 2 = 10	**Positive assurance** No major issues so far this financial year – tightly managed capital position and no new issues to overcome Additional capital funding received and loan funding applied for to improve position in-year – discussed in detail at November 2018 Trust Board Fire stopping works and network upgrade plans, plus helipad and Ward 36, progressed in Q3 and Q4 in line with capital plan and project plans **Further assurance required** Need response to funding applications Lack of headroom to manage further system problems, e.g. unexpected equipment failure November 2018 Trust Board discussed lack of long-term availability of larger sums of capital funding – risks to Trust on infrastructure and backlog maintenance remain significant No additional capital funding for underlying issues, such as backlog maintenance or more onerous capital pressures, such as theatre ventilation or generators – emergency loan applications not fully approved Capital funding that is available does not address key infrastructure risks or high risk points of failure

Risk Appetite

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 May 2019

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

Purpose:	The purpose of this report is to present the 2019-20 Board Assurance Framework, for approval by the Board	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives. Discussions were held at the Board Development session in March 2019 to frame the risks for 2019-20. These have been captured in the attached draft Board Assurance Framework and the draft has been subject to review by Board members prior to being received at today's meeting.	

Recommendation:	The Trust Board is asked to approve the Board Assurance Framework 2019-20

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

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

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

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

FINANCE
Financial sustainability

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

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

PATIENTS
High quality care
Great local services
Great specialist services

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

INFRASTRUCTURE
High quality care
Financial sustainability

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

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

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

PARTNERS
Partnership and integrated services

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

BOARD ASSURANCE FRAMEWORK 2019-20 AS PRESENTED TO THE MAY 2019 TRUST BOARD FOR APPROVAL

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some	None	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy focusses on staff culture and engagement – wide consultation on the refresh Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas Continuous examples and feed back to staff as to how speaking up makes a difference Medical engagement needs to be a journey of improvement – this could be more planned					**5 x 1 = 5**	**Positive assurance** **Further assurance required**

		staff continue not to engage			People Strategy					
		Risk that some staff do not acknowledge their role in valuing their colleagues								
		Risk that some staff or putting patient safety first								

Risk Appetite

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse, OPD vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists	5 (impact) 3 (likelihood) = 15	Refreshed People Strategy articulates changing workforce requirements New Workforce Monitoring requirements at Trust Board level Workforce Transformation Committee – staying ahead of the game with meeting changing workforce requirements, international recruitment and new roles Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 19-20; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in	Need clarity as to what 'sufficient' and 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs Unknown impact of taxation rule changes on pension annual allowances in relation to the availability of staff to work additional hours 'Sufficient' staff and service developments in order to deliver seven-day services in line with national requirements Linked with BAF 6 – empowering staff to innovate Need to build in *Developing Workforce Safeguards* for visibility at Trust Board on safe staffing across the Trust and staffing metrics					5 x 2 = 10	**Positive assurance** **Further assurance required**

					environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training					
					Nursing safety brief several times daily to ensure safe staffing numbers on each day					
					Employment of additional junior doctor staff to fill junior doctor gaps					
					Regular reports to the Trust Board from the Guardian of Safe Working					

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

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient	MHG: Hyper Acute Stroke Unit capacity CCSHG: lack of compliance with blood transfusion competency assessments CCSHG: Risk to patient safety involving discharge medicines Corporate: Embedding ReSPECT process Pathology results reviewed by requesting clinicians	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) was updated in light of latest CQC report and has been further updated from the new CQC report published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee Opportunities to move to good and outstanding care identified	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)					4 x 2 = 8	**Positive assurance** **Further assurance required**

		and stakeholder engagement, detailed in a strategy									

Risk Appetite

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

GOAL 4 – GREAT CLINICAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog *What could prevent the Trust from achieving this goal?* ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG Capacity of intra-vitreal injection service MHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target	**4 (impact)** **4 (likelihood)** **= 16**	Assessment per HG and service as to what performance improvement is projected for 2019-20 Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Capacity and demand work in all pathways Plan to review medical base ward capacity to meet demand Further work on flow and bed availability, including working to EDD and work on Safer Validation of the follow-up backlog, implementing harm reviews if necessary, and plans to bring down backlog	Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories Need to innovate with partners to meet increasing demands, patient acuity and complexity and social needs that affect the care and discharge planning for hospital patients					4 x 2 = 8	**Positive assurance** **Further assurance required**

		A focus on 62-day cancer targets has brought about improvements and a continued focus is required to make further gains Deliverability of performance trajectories in 19-20								

Risk Appetite

A range of plans are being put in place to further manage these issues in to 2019-20. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. The Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope of the Aligned Incentives Contract where the activity comes under the local commissioners' contracts, and fit within the funding from NHS England for specialised commissioning services. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes.

GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds.

What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP

The effectiveness of STP delivery, of which the Trust is one part | None | 3 (impact)

4 (likelihood)

= 12 | The Trust has key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO)

The Trust is playing a key role in the Humber Acute Review (CEO and DOSP)

The Trust is playing a key role in the STP workforce workstream (DOWOD)

The Trust has a seat on the Hull Place Board (CEO)

The Trust is participating in the East Riding Place Based initiatives
The Trust has a partnership meeting with CHCP | Understanding if the risks in other trusts or STP partners will impact on the Trust being able to deliver its strategy

Risk of being an accountable organisation without being to influence all aspects that would bring success for our patients | | | | | 4 x 1 = 4 | **Positive assurance**

Further assurance required |

Risk Appetite

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

GOAL 6 – RESEARCH AND INNOVATION

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Chief Executive Chief Medical Officer	*Principal risk:* There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas. *What could prevent the Trust from achieving this goal?* Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Increased competition for research funding	None	3 (impact) 4 (likelihood) = 12	Strengthened partnership with the University of Hull Secured name change to represent full trust status as a recruitment and research support strategy Actions against Strategic Goals within Trust Strategy for Research and Innovation in place	Being able to unlock the potential, creativity and innovation from the workforce Financial ambitions for research vs. financial reality and balance of risk between failure to pump prime research capacity and capability and being able to deliver the Trust's ambitions against this strategic goal					3 x 2 = 6	**Positive assurance** **Further assurance required**

Risk Appetite
As stated above, the Trust needs to balance the risk of investment in R&I capacity and capability against competing priorities, with its organisational reputation and the benefits that being a research-strong organisation will bring, in relation to funding, clinical service development and recruitment of high-calibre staff; there is an appetite to innovate in this area and go on a journey of development

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2019-20 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit	None	**5 (impact)** **4 (likelihood)** **= 20**	Health Group budgets revisited for 2019-20 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES, managing to budget and reliable forecasting Weekly Productivity and Efficiency Board (PEB) in place; outputs monitored by Performance and Finance Committee HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Year 3 of Aligned Incentives Contract with local commissioners; consistent approach to income	Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position Accurate forecasting and control Grip and control of locum and agency spend Delivery of recurrent CRES					5 x 3 = 15	**Positive assurance** **Further assurance required**

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

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year *What could prevent the Trust from achieving this goal?* Lack of achievement of sufficient recurrent CRES Failure by Health Groups and corporate services to work within their budgets so as not to further increase the Trust's underlying deficit Failure to put in place 2-3 credible year plan to address the underlying deficit position	None	**5 (impact)** **4 (likelihood)** **= 20**	Health Group budgets revisited for 2019-20 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES, managing to budget and reliable forecasting Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Will start discussions with CCG colleagues on system solutions	Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position Plan to address underlying financial position over 2-3 years Ability of local health economy to stem demand for services Accurate forecasting and control					5 x 1 = 5	**Positive assurance** **Further assurance required**

Risk Appetite
The Board has an appetite to discuss a long-term financial plan to address the underlying financial position and to understand the risks that form part of the underlying issues as well as potential solutions. This is becoming an increasing priority.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: cyber-security	5 (impact) 4 (likelihood) = 20	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Applied to convert bonus PSF received in 2018-19 to capital	Insufficient funds to manage the totality of risk at the current time Programme enables the Trust to run on a day-to-day basis but is not addressing the root causes sufficiently – the level of risk increases as the Trust manages 'as is'					5 x 1 = 10	**Positive assurance** **Further assurance required**

Risk Appetite

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

Title:	QUALITY REPORT MARCH 2019
Responsible Directors:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	Beverley Geary, 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 clinical services	Y
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	

Key Summary of Issues	Information is provided in the report on the following topics: • Patient Safety Matters including Never Events and Serious Incidents • Safety Thermometer • Healthcare Associated Infections (HCAI) • Patient Experience • Care Quality Commission • Learning from Deaths • Reporting to NHS Early Notification scheme Areas of good practice are presented alongside those that require actions and improvement.

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

<p style="text-align:center">QUALITY REPORT
MARCH 2019</p>

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
- Care Quality Commission
- Learning from Deaths
- Reporting to NHS Early Notification scheme

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

QUALITY REPORT
MAY 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
- Reporting to NHS Early Notification scheme

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 March and April 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 have been reported to date during 2019/20, with the last one reported in March 2018.

2.2 Serious Incidents reporting rates
At 2018/19 year end the Trust reported a total of 72 Serious Incidents, with no Never Events reported. See Table 1 below with previous year's comparison.

3. **Table 1:** Total number of Never Events and Serious Incidents (SIs) declared 2016/17, 2017/18 and 2018/19:

	2016/17	2017/18	2018/19
Total Never Events declared	2	6	0
Total Serious Incidents declared	67	63	72
Total*	**68**	**69**	**72**

* Excludes any which have been de-escalated from Serious Incident status

To date in 2019/20 the Trust has reported five Serious Incidents. See Section 2.3 below for details of Serious Incidents reported during March 2019 and April 2019.

Graph 1: Serious Incident SPC chart

2.3 Serious Incidents declared in March and April 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 report 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 March and April 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 last Quality Report was produced on the 22 February 2019. Following the production of the report a further Serious Incident was reported in February 2019. See Table 2 below.

Table 2: Serious Incidents declared after 22 February 2019

Ref Number	Type of SI	Health Group
4883	Surgical/Invasive Procedure – wrong level nerve root block (not a never event)	Surgery

The Trust declared 4 Serious Incidents in March 2019.

Table 3: Serious Incidents declared March 2019

Ref Number	Type of SI	Health Group
5864	Delayed diagnosis – patient attended ED and was discharged, shortly after patient died at home.	Medicine
6685	Medication Incident – Insulin was not administered to patient	Surgery
6972	VTE Incident – catastrophic PE event	Family and Women's/Surgery
7191	In-hospital fall relating in fracture	Medicine

The Trust declared 5 Serious Incidents in April 2019.

Table 4: Serious Incidents declared April 2019

Ref Number	Type of SI	Health Group
7618	Sub-Optimal Care of the Deteriorating Patient with intracranial bleed	Clinical Support
7883	Surgical/Invasive Procedure – cervical cerclage retained post birth. Retrospective SI, and not Never Event.	Family & Women's
8872	Hospital acquired Pressure Ulcer	Medicine
9167	Treatment Delay within the ED department	Emergency & Acute Medicine
9399	Delayed Diagnosis of cancer	Surgery

2.4 National Reporting and Learning System, relating to incidents reported to the NRLS during the date period April to September 2018

The most recent formal NRLS report was received in March 2019, relating to incidents reported to the NRLS between April and September 2019. The key messages from the report were:

- There is no evidence for potential under-reporting of incidents
- We have reported less incidents than for the same reporting months 2017. This was predicted as work has been undertaken during 2018 to refine what incidents we report to the NRLS (ensuring only patient safety incidents are reported).
- We are reporting regularly and in a timely manner to the NRLS

The NRLS report states that incident reporting patterns should be interpreted alongside other information such as our NHS Staff Survey results on reporting culture and practice (para 1, page 4 of appendix 1). The Trust's 2018 NHS Staff Survey results, again published in March 2019, has shown improvements around how our staff feel about our patient safety culture, shown in figure below (extract from 2018 staff survey results)

	Q17a My organisation treats staff who are involved in an error, near miss or incident fairly				Q17c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again				Q17d We are given feedback about changes made in response to reported errors, near misses and incidents			
	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Best	64.1%	64.3%	64.9%	69.5%	80.7%	76.6%	76.1%	82.3%	63.2%	72.9%	71.4%	72.0%
Your org	54.1%	53.4%	55.8%	58.5%	65.6%	69.4%	70.6%	75.0%	52.8%	60.3%	63.1%	68.8%
Average	52.1%	53.7%	54.3%	58.5%	67.1%	68.2%	68.6%	69.9%	53.2%	54.9%	56.4%	58.9%
Worst	39.1%	37.6%	39.5%	42.8%	52.0%	54.7%	52.2%	55.8%	39.5%	40.9%	41.1%	43.2%

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.

933 patient were surveyed
- HFC = 93.7%
- New Harms = 17
  - Pressure Ulcers = 5
  - Falls = 2
  - UTI + Catheter = 4
  - VTE = 6

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.

A detailed report of the April results of the NHS Safety Thermometer point prevalence audit are attached as Appendix One.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2018/19 as at 31st March 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)	32 (62% 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	60 (over threshold)
Gram Negative Bacteraemia		
E.coli bacteraemia	73 (Total 2017/18 = 112)	112 (over threshold)
Klebsiella	Baseline monitoring period	34
Pseudomonas aeruginosa	Baseline monitoring period	13

As can be seen, it has proved 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*

At year end, the Trust reported 32 infections against an upper threshold of 52 (62% of threshold). This is positive performance against what is a very challenging infection to avoid and manage with certain patients. From the 1st April 2018, a total of fifteen cases are apportioned to the Medical Health Group, ten to the Surgical Health Group, six 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	52 (45)	32 (62% of threshold)	All 32 cases have been subject to RCA investigation. Of the thirty two cases, thirty cases have been reviewed by Commissioners with twenty five deemed to have no lapses in practice. Five cases identified as a lapse in practice due to suboptimal antimicrobial prescribing. Two remaining cases detected towards the end of March 2019 are awaiting consideration by the commissioners.

Trust's performance from 2015/16 to date with CDI:

Clostridium difficile infections 2015-16 to date

	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	0	3

Distribution of acute hospital C.*difficile* cases across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

Clostridium difficile infection

Hospital	Cases
Airedale	5
Barnsley Hospital	15
Bradford Teaching Hospitals	22
Calderdale & Huddersfield	18
Doncaster & Bassetlaw Hospitals	20
Harrogate & District	19
Hull & East Yorkshire Hospitals	32
Leeds Teaching Hospitals	130
Mid Yorkshire Hospitals	46
Northern Lincolnshire & Goole Hospitals	19
Sheffield Children's	11
Sheffield Teaching Hospitals	84
The Rotherham	8
York Teaching Hospital	41

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

| 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 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. November 2018 case – deemed avoidable due to lapses in practice associated with consistency of device management and poor documentation associated with decolonisation treatment. January 2019 case – deemed unavoidable. Patient presented with endocarditis and a previous history of MRSA treated by Primary Care. No hospital care and interventions had contributed to the patient developing the bacteraemia.

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. The patient had a previous history of MRSA in November 2017 and treated 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. Endocarditis was diagnosed following trans-oesophageal echocardiography, which required prolonged antimicrobial therapy and subsequent cardiac surgery. The patient is managed jointly by both Infectious Diseases and Cardiology teams. The case was deemed hospital onset due to the timing of the sample but deemed unavoidable.

Distribution of acute hospital MRSA Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

MRSA bacteraemia

Hospital	Cases
Airedale	1
Barnsley Hospital	0
Bradford Teaching Hospitals	1
Calderdale & Huddersfield	2
Doncaster & Bassetlaw Hospitals	0
Harrogate & District	0
Hull & East Yorkshire Hospitals	3
Leeds Teaching Hospitals	7
Mid Yorkshire Hospitals	1
Northern Lincolnshire & Goole Hospitals	0
Sheffield Children's	0
Sheffield Teaching Hospitals	2
The Rotherham	1
York Teaching Hospital	4

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 year end, the Trust was over threshold for this infection.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	44	60 Over threshold	RCA investigations have been completed on 44 of the 60 reported cases. The remaining sixteen cases are being completed and reviewed by the clinical team responsible for the patients involved. 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 4 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.

There are no national thresholds for MSSA bacteraemia in 2018/19 however, 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 ongoing. In addition a working party has been formed to focus on device insertion, reason for use and management. Updates on actions and results will be submitted to board in a future report for assurance.

Trust's performance from 2015-16 to date:

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia infections 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	6	3

Distribution of acute hospital MSSA Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

MSSA bacteraemia

Trust	Cases
Airedale	8
Barnsley Hospital	16
Bradford Teaching Hospitals	21
Calderdale & Huddersfield	16
Doncaster & Bassetlaw Hospitals	26
Harrogate & District	7
Hull & East Yorkshire Hospitals	59
Leeds Teaching Hospitals	93
Mid Yorkshire Hospitals	17
Northern Lincolnshire & Goole Hospitals	12
Sheffield Children's	7
Sheffield Teaching Hospitals	68
The Rotherham	12
York Teaching Hospital	31

*(Please note the above report records 59 cases at year end but the final number was 60 cases)*

4.1.4 *Escherichia-coli* Bacteraemia

During 2018/19, Trusts were required 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 continuing across Hull and East Riding. However, management and reduction of this infection continues to be a challenge.

| 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)	112 (over threshold)	112	One hundred and twelve Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 53 cases detected in the Surgical HG, 38 cases in the Medical HG, 5 cases detected in Families & Women's HG and the remaining 16 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.

Eschericia coli bacteraemia infections 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	9	16

The main concerns ar 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 occurred, with a resultant increase in *E.coli* infection.

Distribution of acute hospital E.*coli* Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

E. coli bacteraemia

Hospital	Count
Airedale	18
Barnsley Hospital	35
Bradford Teaching Hospitals	42
Calderdale & Huddersfield	52
Doncaster & Bassetlaw Hospitals	65
Harrogate & District	17
Hull & East Yorkshire Hospitals	112
Leeds Teaching Hospitals	221
Mid Yorkshire Hospitals	70
Northern Lincolnshire & Goole Hospitals	51
Sheffield Children's	8
Sheffield Teaching Hospitals	167
The Rotherham	28
York Teaching Hospital	72

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

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. Of note during the last financial year, has been an

increase in the number of patients with this infection who have been previously hospitalised outside of the UK.

Klebsiella/ Pseudomonas aeruginosa bacteraemia infections from 2017 to date

|	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	4	1	2
P.aeruginosa 2017/18	0	1	3	1	2	3	0	3	2	3	2	0
P.aeruginosa 2018/19	0	1	1	0	3	2	2	1	3	0	0	0

Distribution of acute hospital Klebsiella and Pseudomonas aeruginosa bacteraemia respectively across the Yorkshire and the Humber region, at year end, 2018/18 (source: Public Health England)

Klebsiella species bacteraemia

Hospital	Count
Airedale	2
Barnsley Hospital	8
Bradford Teaching Hospitals	11
Calderdale & Huddersfield	16
Doncaster & Bassetlaw Hospitals	21
Harrogate & District	4
Hull & East Yorkshire Hospitals	38
Leeds Teaching Hospitals	85
Mid Yorkshire Hospitals	18
Northern Lincolnshire & Goole Hospitals	13
Sheffield Children's	7
Sheffield Teaching Hospitals	76
The Rotherham	7
York Teaching Hospital	20

Pseudomonas aeruginosa bacteraemia

Hospital	Count
Airedale	2
Barnsley Hospital	4
Bradford Teaching Hospitals	5
Calderdale & Huddersfield	4
Doncaster & Bassetlaw Hospitals	14
Harrogate & District	4
Hull & East Yorkshire Hospitals	13
Leeds Teaching Hospitals	29
Mid Yorkshire Hospitals	13
Northern Lincolnshire & Goole Hospitals	12
Sheffield Children's	1
Sheffield Teaching Hospitals	30
The Rotherham	1
York Teaching Hospital	18

The Antimicrobial Resistance (AMR) Strategy 2019 - 2024 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.

4.2 Outbreaks

February 2019 and March 2019 continued to be challenging months for Norovirus.

During February 2019, a bay closure (H100) was required due to patients with diarrhoea & vomiting but no causative organism was detected.

Further bay closures were required on wards H80 and H100 during March due to patients with diarrhoea & vomiting, again no causative organism was detected.

A full ward closure of H11 was necessary during March 2019; the ward was affected with an abrupt outbreak of diarrhoea and vomiting, this was confirmed as Norovirus. At least 85% of patients nursed on the ward were affected 3 staff members were also symptomatic. The outbreak was protracted with previous affected patients who had resolution of symptoms becoming symptomatic again. Issues with cleaning during the outbreak and also staff understanding of IPC measures/ precautions during an outbreak were also identified. Education is being planned and delivered by the IPCT to staff on the 11th floor in conjunction with the senior matron. A reflective examination of the outbreak and management, and lessons learned has been commissioned by the Chief Nurse.

All areas affected were cleaned by the Cleaning Action Team prior to being reopened.

4.2.1 Infection incident

During February 2019 and March 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 during January 2019 and again a further case in April 2019. To date, there is no evidence to suggest person to person transmission. However, some strains have been identified from babies that could suggest a possible environmental source but none found to date. Further Estates and Facilities works are being undertaken to reduce the possible environmental burden including reconfiguring sideroom layout/ scoping and the pilot of novel wash hand basin cleaning agent.

4.2.2 Influenza trends

The influenza vaccination campaign for 2018/19 commenced on the 1st October 2018 and at year end, 83% of the Trust's healthcare workforce had taken up the influenza vaccine, which was a significant achievement.

Increases in influenza activity continued during February 2019, with all affected patients detected with the Influenza A strain. In addition, respiratory syncytial virus (RSV) activity continued during February 2019, albeit in lower numbers 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 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.

During February 2019 there were a further ninety four cases of Influenza A detected and during March 2019 this dropped dramatically to eighteen cases.

The increase in influenza cases requiring admission had a significant 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 reported 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 following illustrate the distribution of Influenza strains for FY 17/18 and 18/19 respectively.

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

Influenza Activity at Hull & East Yorkshire Hospitals NHS Trust

	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 A was the predominant strain, with no Influenza B activity reported to date.

Influenza Activity 2018/19 at Hull & East Yorkshire Hospitals NHS Trust

|	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Flu A	0	1	76	161	94	18
Flu B	0	0	0	0	0	0

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 Jan-May 2018 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 Nov 2018-March 2019					
Age at Death	20-40yrs	41-60yrs	61-80yrs	81-100yrs	Total
Flu A	2	1	8	6	17
Flu B	None	None	None	None	0
Total	2	1	8	6	**17**

5. PATIENT EXPERIENCE

The following graph sets out comparative complaints data from 2016 to date. There were 47 new complaints in the month of February 2019 and 76 in the month of March 2019. For the financial year 2018-19, a total of 640 complaints were received. The number of complaints received in the month of March 2019 was the highest received in one month during the last four years', however there was no theme or trend identified.


Complaints Received by Month and Year

Broadly speaking, complaints reflect activity in the previous three months. Below indicates the complaints received during the financial year 2018/19 and the months in which the incident resulting in a complaint occurred. 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.

Incident date relating to complaints received during the financial year 2018/19:

Incident date of Complaint

Date	Value
2001	1
2011	1
2012	1
2013	3
2014	3
2015	6
2016	28
2017	86
Jan-18	24
Feb-18	20
Mar-18	44
Apr-18	40
May-18	45
Jun-18	40
Jul-18	44
Aug-18	45
Sep-18	39
Oct-18	40
Nov-18	35
Dec-18	29
Jan-19	31
Feb-19	22
Mar-19	13

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. This line graph indicates that the increase in complaints in the month of March 2019 is in relation to inpatient concerns as Emergency admissions and Outpatient activity remains consistent and is low.

Complaints as a proportion of Episodes of Care

	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%	0.07%	0.07%
IP Admissions	0.16%	0.23%	0.17%	0.17%	0.17%	0.16%	0.26%	0.27%	0.16%	0.24%	0.17%	0.29%
OP Activity	0.04%	0.02%	0.03%	0.03%	0.03%	0.03%	0.02%	0.02%	0.02%	0.03%	0.02%	0.02%

The following table indicates the number of complaints by subject area that were received for each Health Group during the months of February and March 2019.

Complaints Received by Health Group and Subject – February and March 2019

Complaints by Health Group and Subject (primary)	Month	Attitude	Care and Comfort	Communica-tion	Delay, Waiting Times and Cancellations	Discharge	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	Feb	0	0	0	0	0	0	0	0	**0**
	Mar	0	0	0	0	0	0	0	0	**0**
Clinical Support	Feb	0	0	0	0	0	0	0	0	**0**
	Mar	1	2	0	0	0	0	0	0	**3**
Emergency & Acute	Feb	0	1	0	1	1	0	0	5	**8**
	Mar	1	0	0	0	3	0	0	5	**9**
Family and Women's	Feb	1	1	1	0	0	0	0	7	**10**
	Mar	5	0	2	4	1	0	0	10	**22**
Medicine	Feb	0	5	1	0	1	0	0	5	**12**
	Mar	2	3	0	0	4	0	0	11	**20**
Surgery	Feb	1	0	5	0	0	1	0	10	**17**
	Mar	2	0	4	0	1	0	0	15	**22**
Totals:	**Feb**	**2**	**7**	**7**	**1**	**2**	**1**	**0**	**27**	**47**
	Mar	**11**	**5**	**6**	**4**	**9**	**0**	**0**	**41**	**76**

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 February - March 2019:

- The wife of a patient who had died in hospital raised concerns that it had not been made clear to her and her husband that he was at the 'end of life'. His sudden death caused considerable distress for the family.
  Outcome: The Clinical Director will discuss the concerns raised with his consultant colleagues and the medical staff to consider improved communication with families in terminal situations. The concerns will also be discussed with the nursing staff involved and the wider team for reflective learning purposes.

- A patient was admitted to ED at midnight. She was later discharged with medication but this, alongside her own was too much and could have had serious consequences.
  Outcome: Medication lists are to be confirmed with medical and nursing staff prior to the giving of new prescriptions. This complaint will be used anonymously as a training example for all staff.

- Patient's relatives were unhappy with the decision to discharge the patient, after which the patient required immediate readmission.
  Outcome: Failed discharge issues will be discussed at the next Orthopaedic Governance Meeting. The Ward Sister will also speak with the nursing team regarding the failure to seek a rheumatology review for the patient, which resulted in a missed opportunity to avoid the failed discharge.

- Family raised issues regarding the delay in obtaining a death certificate.
  Outcome: The doctor completing the death certificate thought the death needed to be reported to the Coroner but this was not necessary and delayed the signing of the death certificate. The consultant discussed with the doctor the details of the complaint so that he could learn and improve his practice.

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 February and March 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%	90%	89%

The following tables indicate performance by Health Group and the outcome of the complaint for the months of February and March 2019.

February 2019	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	0 (100%)	0	0	0	0	1
Clinical Support	1	1 (100%)	0	1	0	0	0
Emergency and Acute	7	7 (100%)	0	7	0	0	1
Family and Women's	7	7 (100%)	0	7	0	0	0
Medicine	17	16(94%)	0	20	0	0	3
Surgery	18	14 (78%)	4	9	3	2	5
Totals:	50	45 (90.%)	4	41	3	2	10

March 2019	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	0 (100%)	0	0	0	0	0
Clinical Support	3	3 (100%)	2	1	0	0	1
Emergency and Acute	11	11 (100%)	0	7	4	0	0
Family and Women's	16	16 (100%)	0	12	4	0	0
Medicine	22	20(91%)	1	13	3	0	7
Surgery	14	9 (64%)	2	9	2	1	1
Totals:	66	59 (89.39%)	5	42	13	1	9

As can be seen from the previous table, performance is variable across the Health Groups, with Clinical Support, Emergency and Acute and the Family and Women's Health Groups achieving 100% of complaints closed within 40 days in both February and March 2019. Medicine Health Group achieved the standard of 85% of complaints closed within 40 days with 94% in February and 91% in March. Surgery Health Group closed 18 complaints during the month of February, 14 of which were within 40 days and 14 during the month of March, 9 of which were within 40 days. This will be managed through the monthly performance and accountability meetings with Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

As with complaints received, February saw a decreased number of contacts with the PALS team with an increase in March 2019. There were 9 compliments, 147 concerns and 21 requests for general advice in February. In March 2019, PALS received 1 comment/ suggestion, 2 compliments, 182 concerns and 16 requests for general advice. During the 2018-19 financial year, PALS received a total of 15 comments/suggestions, 150 compliments, 2253 concerns and 465 requests for general advice. The PALS team also receive many calls each day for general signposting and information which is not included in these statistics. 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 decreased in February but increased in the month of March, as was the case with formal complaints. This increase is in line with previous years' activity for the same period.

PALS Concerns Received by Month and Year

The following table indicates that Delays, Waiting times and Cancellations continues to be the highest subject received by PALS.   In the month of February, 40 concerns were regarding the patient not being happy with the treatment plan in place and 20 for delays in receiving an outpatient appointment. In the month of March, 54 patients were not satisfied with the treatment plan in place and again, 20 concerns were received from patients who had experienced a delay in receiving an outpatient appointment.

Complaints by Health Group and Subject (primary)	Month	General Advice	Attitude	Care and Comfort	Communica-tion	Waiting Times and Cancellation	Discharge	Environment	Hotel	Safeguardin g	Special Needs	Treatment	Total
Corporate Functions	Feb	0	2	0	2	1	0	0	3	0	0	0	8
	Mar	3	3	0	3	1	0	0	1	0	0	0	11
Clinical Support	Feb	0	1	1	1	4	1	0	0	0	0	4	12
	Mar	1	2	0	3	3	0	0	0	0	0	3	12
Emergency & Acute	Feb	3	1	0	1	0	1	1	0	0	0	4	11
	Mar	1	3	0	0	1	0	0	0	0	0	4	9
Family and Women's	Feb	0	3	0	3	20	1	0	0	0	1	8	36
	Mar	3	2	0	4	24	0	0	0	0	0	15	48
Medicine	Feb	3	1	1	6	8	3	1	0	0	1	7	31
	Mar	3	4	0	5	10	1	0	0	0	0	11	34
Surgery	Feb	0	4	1	7	17	0	0	0	0	0	20	49
	Mar	8	2	0	3	26	6	0	0	0	0	23	68
Totals:	Feb	6	12	3	20	50	6	2	3	0	2	43	147
	Mar	19	16	0	18	65	7	0	1	0	0	56	182

5.2.1   Examples of outcomes from PALS contacts:

- A disabled 90 year old gentleman travelled over 100 miles to an Audiology appointment however, due to traffic, mobility and parking difficulties, he was 15 minutes late and staff turned him away unable to conduct his lengthy assessment. Family members contacted PALS.
  Outcome: Swift arrangements were made for an appointment at CHH. It was very late in the day and PALS staff liaised with site security services to ensure that a parking space was available near to the Audiology unit at CHH to avoid unnecessary delay. Close liaison was made with the gentleman's driver by telephone to ensure that he had adequate directions from HRI to CHH. The Audiology service were kept abreast of progress from HRI. The gentleman had his assessment and his long journey was not wasted.

- A patient attended Ward 15 CHH where he lost hearing aid, cash and personal belongings.
  Outcome: Staff on the ward conducted a search and the property was located and returned to the patient without delay.

- A patient moved to the area and quickly experienced a great deal of difficulty in obtaining specialist medication for her rare condition. GP services were unable to dispense the drugs without a hospital consultation and it was recognised that her medication would quickly run out.
  Outcome: Despite the fact that the patient's referral was not indicated as urgent, the service went to some lengths to liaise with NHS providers in the patient's hometown in order that appropriate arrangements could be made for her ongoing medication requirements. As a result, her treatment is ongoing and without any damaging delays in her medication regime.

5.2.2 Compliments

- A patient expressed his sincere gratitude to the staff working within Ophthalmology and the Neurology service following referral to the Trust by his GP after experiencing pain within his eye. The staff involved very quickly recognised the potential for underlying neuro complications and as a consequence, arranged for scans and further assessments. It was identified that the patient had a tear in his carotenoid artery in his brain and, as a result of the swift diagnosis, he received timely and appropriate treatment that minimised his exposure to brain damage and contributed to a swift recovery. Special thanks were extended to all of the staff who demonstrated initiative and professionalism.

- A patient attended the Early Pregnancy Assessment Unit (EPAU) following a silent miscarriage of a much wanted and cherished pregnancy. The staff members involved demonstrated a great deal of compassion and empathy and assisted the patient through a most difficult treatment path. The patient expressed her gratitude and thanks for the warmth and support provide to her and pointed out that the professionalism and help assisted her to deal with a horrifying situation.

- The parent of a 14 year old child expressed her admiration and thanks to the staff in Paediatric ED and Ward 130 after it was necessary to admit her daughter. She indicated that despite being extremely busy, the teams involved displayed professionalism and empathy and supported both her and her daughter during a very traumatic time. She pointed out that these "amazing people made such a difference".

5.3 Friends and Family Test (FFT)

The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for March with 4,727 compared to February 2019 when 5,375 were received. The March 2019 inpatient results indicate that **98.36%** were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set-target of **95%**. This is positive news for the Trust and its staff. The Patient Experience Team is working with wards to collect patient feedback on a daily basis.

5.3.1 Inpatient Summary – all areas

5.3.2   Friends and Family Emergency Department (ED)

1,495 patients who attended the Emergency Department in March 2019 responded to the Friends and Family Test with **82.88%** of patients giving positive feedback and **8.70%** negative feedback. The remainder were neither positive nor negative.

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 10 cases with the PHSO currently. During the month of February and March no new cases were opened and 1 case was closed, which was not 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, staffing levels and complaints. The latest quarterly engagement meeting between the CQC and the Trust also took place on the 23 April 2019. The engagement meeting was attended by the Inspection Manager and Trust Inspector from the CQC along with the Chief Nurse, Interim Chief Medical Officer Acting Deputy Director of Quality Governance and the Compliance Team Leader from Hull University Teaching Hospitals NHS Trust. This was a positive and informative meeting with no concerns raised by either parties. The CQC confirmed that their inspection processes, information gathering tool (Provider Information Request) and inspection schedule are under review to further improve their inspection methodology and to ensure inspections are more risk based and focused.

At the present time, the CQC have not informed the Trust of any further focus groups or planned inspections. However the CQC have confirmed that they will be attending the Operational Quality Committee, Quality Committee and the Trust Board to observe practice and they have also requested to visit a clinic area of choice. Arrangements will be made for this to take place before August 2019.

During the meeting the CQC stated that they had identified a number of concerns regarding the management and governance arrangements of sub-contracts in relation to Ambulance services used to transport patients between sites, this was a problem regionally and not specific to HUTH. Following the meeting it was confirmed that this had been investigated locally and all arrangements were adequate.

6.2 Learning from Deaths

In response to the requirement that all Trusts in England are to establish non-statutory Medical Examiner schemes by April 2019, a number of key aims have been identified to allow for successful delivery of the medical examiner role.

The key aims are:
- To introduce a system of effective medical scrutiny applicable to all non-coronial deaths;
- Enable matters of a clinical governance nature to be reported to support local learning and changes in practice and procedures;
- Provide information on public health surveillance
- Increase transparency for the bereaved and offer them the opportunity to raise any concerns;
- Improve the quality and accuracy of Medical Certificates of Cause of Death.

The Trust is undertaking a pilot project which will see the implementation of an ME system on a phased basis from May 2019 at Castle Hill Hospital. Two consultant medical staff will undertake the ME role each day, Monday to Friday, with the Bereavement Office staff providing administrative support to the MEs. The pilot will run for 6 months with a review at 3 months.

6.3 Reporting to NHS Early Notification Scheme

From April 2017 Trusts were required to proactively report all maternity incidents to NHS Resolution which met the following criteria identified by the RCOG as potential markers for severe brain injury:

Eligible babies include those born at term (≥37 completed weeks of gestation), following labour, that had a severe brain injury diagnosed in the first seven days of life and were:
- Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)
- Actively therapeutically cooled
- Had all three of the following signs: decreased central tone; comatose; seizures of any kind

The aim of the Scheme is to commence investigations at an early stage where there is a risk of liability, to preserve records and witness evidence and identify areas for learning and change in practice.

In 2018/19, there have been six cases with incident date in year and have been reported and accepted by NHSR as having met the criteria. A further three cases were reported but rejected. A brief summary of the cases accepted by NHSR is detailed below:

Table 4: Summary of cases accepted by NHSR under Early Notification Scheme

Incident Date	Description
04/08/2018	Decision for IOL at 38 weeks due of growth above 90th centile and mild polyhydramnios. Risk of shoulder dystocia discussed. Delivery in theatre with Ventouse, head delivered on two pulls but shoulder dystocia encountered and managed with McRoberts position, suprapubic pressure and internal manoeuvres. Born in poor condition Apgar 5@10, no heart rate achieved for 5 minutes and full resuscitation performed. Transferred to NICU and therapeutically cooled. Discharged home at day 12 with no obvious adverse outcome.
15/11/2018	G2 P1 39+2 spontaneous labour, prolonged second stage and second stage syntocinon commenced meconium noted at delivery, apgar 1@1 and 3@5 unexpected admission to NICU. Cord gases 6.98 and <6.80. Active cooling, grade 3 HIE and seizures.
21/01/2019	G1PO 39 + 3 spontaneous labour and normal birth. Apgars 1@1, 4 @ 5 and 7@10. Admitted to NICU, intubated and actively cooled for 72 hours. Weight 2480 gms. Diagnosis of HIE grade 3 in NICU. Severe neonatal encephalopathy and seizures. MRI findings inkeeping with severe hypoxic insult.
23/02/2019	Attended at 37+4 with reduced fetal movements. Reduced growth on USS. CTG suspicious and grade 1 LSCS performed. Floppy and pale on delivery with HR <60bpm. Lip smacking at 4 hours of age and CFM showed seizure activity treated with Keppra and Midazolam. MRI at day 8 showed unusual pattern of brain injury and in hypoxia/ischaemia and possibility of concomitant hypoglycae,ia/metabolic insult queried.
04/03/2019	Prim, 41+1, spontaneous labour and delivery uneventful. Baby born in poor condition requiring resuscitation and admitted to NICU for HIE grade 2 with active cooling for 72 hours due to poor cord gases, abnormal tone and moderately abnormal CFM. MRI at day 8 showed no significant hypoxic brain insult or intracranial abnormality
16/03/2019	Primip T+10. In labour with prolonged rupture of membranes poor CTG had an FBS 7.33, developed sepsis and commenced on antibiotics. Grade 2 emergency caesarean section and baby born in poor condition transferred to NICU at 47.34 minutes of age requiring ongoing treatment for seizures and was actively cooled. MRI at day 7 showed infarction and increased CSF in left hemisphere indicating possible parenchymal hypoplasia.

Investigation of cases is on-going with NHSR, HSIB and solicitors instructed by NHSR.

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

Beverley Geary   **Makani Purva**
Chief Nurse   Chief Medical Officer

14th May 2019

Appendix One: Safety Thermometer – December 2018

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
14th MAY 2019

Title:	QUALITY REPORT MARCH 2019
Responsible Directors:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	Beverley Geary, 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 clinical services	Y
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	

Key Summary of Issues	Information is provided in the report on the following topics: • Patient Safety Matters including Never Events and Serious Incidents • Safety Thermometer • Healthcare Associated Infections (HCAI) • Patient Experience • Care Quality Commission • Learning from Deaths • Reporting to NHS Early Notification scheme Areas of good practice are presented alongside those that require actions and improvement.

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

QUALITY REPORT
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
- Care Quality Commission
- Learning from Deaths
- Reporting to NHS Early Notification scheme

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

QUALITY REPORT
MAY 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
- Reporting to NHS Early Notification scheme

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 March and April 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 have been reported to date during 2019/20, with the last one reported in March 2018.

2.2 Serious Incidents reporting rates

At 2018/19 year end the Trust reported a total of 72 Serious Incidents, with no Never Events reported. See Table 1 below with previous year's comparison.

3. Table 1: Total number of Never Events and Serious Incidents (SIs) declared 2016/17, 2017/18 and 2018/19:

	2016/17	2017/18	2018/19
Total Never Events declared	2	6	0
Total Serious Incidents declared	67	63	72
Total*	**68**	**69**	**72**

* Excludes any which have been de-escalated from Serious Incident status

To date in 2019/20 the Trust has reported five Serious Incidents. See Section 2.3 below for details of Serious Incidents reported during March 2019 and April 2019.

Graph 1: Serious Incident SPC chart

2.3 Serious Incidents declared in March and April 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 report 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 March and April 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 last Quality Report was produced on the 22 February 2019. Following the production of the report a further Serious Incident was reported in February 2019. See Table 2 below.

Table 2: Serious Incidents declared after 22 February 2019

Ref Number	Type of SI	Health Group
4883	Surgical/Invasive Procedure – wrong level nerve root block (not a never event)	Surgery

The Trust declared 4 Serious Incidents in March 2019.

Table 3: Serious Incidents declared March 2019

Ref Number	Type of SI	Health Group
5864	Delayed diagnosis – patient attended ED and was discharged, shortly after patient died at home.	Medicine
6685	Medication Incident – Insulin was not administered to patient	Surgery
6972	VTE Incident – catastrophic PE event	Family and Women's/Surgery
7191	In-hospital fall relating in fracture	Medicine

The Trust declared 5 Serious Incidents in April 2019.

Table 4: Serious Incidents declared April 2019

Ref Number	Type of SI	Health Group
7618	Sub-Optimal Care of the Deteriorating Patient with intracranial bleed	Clinical Support
7883	Surgical/Invasive Procedure – cervical cerclage retained post birth. Retrospective SI, and not Never Event.	Family & Women's
8872	Hospital acquired Pressure Ulcer	Medicine
9167	Treatment Delay within the ED department	Emergency & Acute Medicine
9399	Delayed Diagnosis of cancer	Surgery

2.4 National Reporting and Learning System, relating to incidents reported to the NRLS during the date period April to September 2018

The most recent formal NRLS report was received in March 2019, relating to incidents reported to the NRLS between April and September 2019. The key messages from the report were:

- There is no evidence for potential under-reporting of incidents
- We have reported less incidents than for the same reporting months 2017. This was predicted as work has been undertaken during 2018 to refine what incidents we report to the NRLS (ensuring only patient safety incidents are reported).
- We are reporting regularly and in a timely manner to the NRLS

The NRLS report states that incident reporting patterns should be interpreted alongside other information such as our NHS Staff Survey results on reporting culture and practice (para 1, page 4 of appendix 1). The Trust's 2018 NHS Staff Survey results, again published in March 2019, has shown improvements around how our staff feel about our patient safety culture, shown in figure below (extract from 2018 staff survey results)

Q17a	2015	2016	2017	2018
Best	64.1%	64.3%	64.9%	69.5%
Your org	54.1%	53.4%	55.8%	58.5%
Average	52.1%	53.7%	54.3%	58.5%
Worst	39.1%	37.6%	39.5%	42.8%

Q17c	2015	2016	2017	2018
Best	80.7%	76.6%	76.1%	82.3%
Your org	65.6%	69.4%	70.6%	75.0%
Average	67.1%	68.2%	68.6%	69.9%
Worst	52.0%	54.7%	52.2%	55.8%

Q17d	2015	2016	2017	2018
Best	63.2%	72.9%	71.4%	72.0%
Your org	52.8%	60.3%	63.1%	68.8%
Average	53.2%	54.9%	56.4%	58.9%
Worst	39.5%	40.9%	41.1%	43.2%

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.

933 patient were surveyed
- HFC = 93.7%
- New Harms = 17
  - Pressure Ulcers = 5
  - Falls = 2
  - UTI + Catheter = 4
  - VTE = 6

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.

A detailed report of the April results of the NHS Safety Thermometer point prevalence audit are attached as Appendix One.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2018/19 as at 31st March 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)	32 (62% 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	60 (over threshold)
Gram Negative Bacteraemia		
E.coli bacteraemia	73 (Total 2017/18 = 112)	112 (over threshold)
Klebsiella	Baseline monitoring period	34
Pseudomonas aeruginosa	Baseline monitoring period	13

As can be seen, it has proved 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*

At year end, the Trust reported 32 infections against an upper threshold of 52 (62% of threshold). This is positive performance against what is a very challenging infection to avoid and manage with certain patients. From the 1st April 2018, a total of fifteen cases are apportioned to the Medical Health Group, ten to the Surgical Health Group, six 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	52 (45)	32 (62% of threshold)	All 32 cases have been subject to RCA investigation. Of the thirty two cases, thirty cases have been reviewed by Commissioners with twenty five deemed to have no lapses in practice. Five cases identified as a lapse in practice due to suboptimal antimicrobial prescribing. Two remaining cases detected towards the end of March 2019 are awaiting consideration by the commissioners.

Trust's performance from 2015/16 to date with CDI:

Clostridium difficile infections 2015-16 to date

	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	0	3

Distribution of acute hospital C.*difficile* cases across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

Clostridium difficile infection

Hospital	Cases
Airedale	5
Barnsley Hospital	15
Bradford Teaching Hospitals	22
Calderdale & Huddersfield	18
Doncaster & Bassetlaw Hospitals	20
Harrogate & District	19
Hull & East Yorkshire Hospitals	32
Leeds Teaching Hospitals	130
Mid Yorkshire Hospitals	46
Northern Lincolnshire & Goole Hospitals	19
Sheffield Children's	11
Sheffield Teaching Hospitals	84
The Rotherham	8
York Teaching Hospital	41

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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 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. November 2018 case – deemed avoidable due to lapses in practice associated with consistency of device management and poor documentation associated with decolonisation treatment. January 2019 case – deemed unavoidable. Patient presented with endocarditis and a previous history of MRSA treated by Primary Care. No hospital care and interventions had contributed to the patient developing the bacteraemia.

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. The patient had a previous history of MRSA in November 2017 and treated 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. Endocarditis was diagnosed following trans-oesophageal echocardiography, which required prolonged antimicrobial therapy and subsequent cardiac surgery. The patient is managed jointly by both Infectious Diseases and Cardiology teams. The case was deemed hospital onset due to the timing of the sample but deemed unavoidable.

Distribution of acute hospital MRSA Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

MRSA bacteraemia

Hospital	Count
Airedale	1
Barnsley Hospital	0
Bradford Teaching Hospitals	1
Calderdale & Huddersfield	2
Doncaster & Bassetlaw Hospitals	0
Harrogate & District	0
Hull & East Yorkshire Hospitals	3
Leeds Teaching Hospitals	7
Mid Yorkshire Hospitals	1
Northern Lincolnshire & Goole Hospitals	0
Sheffield Children's	0
Sheffield Teaching Hospitals	2
The Rotherham	1
York Teaching Hospital	4

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 year end, the Trust was over threshold for this infection.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	44	60 Over threshold	RCA investigations have been completed on 44 of the 60 reported cases. The remaining sixteen cases are being completed and reviewed by the clinical team responsible for the patients involved. 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 4 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.

There are no national thresholds for MSSA bacteraemia in 2018/19 however, 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 ongoing. In addition a working party has been formed to focus on device insertion, reason for use and management. Updates on actions and results will be submitted to board in a future report for assurance.

Trust's performance from 2015-16 to date:

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia infections 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	6	3

Distribution of acute hospital MSSA Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

MSSA bacteraemia

Hospital	Cases
Airedale	8
Barnsley Hospital	16
Bradford Teaching Hospitals	21
Calderdale & Huddersfield	16
Doncaster & Bassetlaw Hospitals	26
Harrogate & District	7
Hull & East Yorkshire Hospitals	59
Leeds Teaching Hospitals	93
Mid Yorkshire Hospitals	17
Northern Lincolnshire & Goole Hospitals	12
Sheffield Children's	7
Sheffield Teaching Hospitals	68
The Rotherham	12
York Teaching Hospital	31

(Please note the above report records 59 cases at year end but the final number was 60 cases)

4.1.4 *Escherichia-coli* Bacteraemia

During 2018/19, Trusts were required 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 continuing across Hull and East Riding. However, management and reduction of this infection continues to be a challenge.

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)	112 (over threshold)	112	One hundred and twelve Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 53 cases detected in the Surgical HG, 38 cases in the Medical HG, 5 cases detected in Families & Women's HG and the remaining 16 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.

Eschericia coli bacteraemia infections 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	9	16

The main concerns ar 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 occurred, with a resultant increase in *E.coli* infection.

Distribution of acute hospital E.*coli* Bacteraemia across the Yorkshire and the Humber region, at year end, 2018/19 (source: Public Health England)

4.1.5 Gram negative bacteraemia – reporting for 2018/19

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. Of note during the last financial year, has been an

increase in the number of patients with this infection who have been previously hospitalised outside of the UK.

Klebsiella/ Pseudomonas aeruginosa bacteraemia infections from 2017 to date

	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	4	1	2
P.aeruginosa 2017/18	0	1	3	1	2	3	0	3	2	3	2	0
P.aeruginosa 2018/19	0	1	1	0	3	2	2	1	3	0	0	0

Distribution of acute hospital Klebsiella and Pseudomonas aeruginosa bacteraemia respectively across the Yorkshire and the Humber region, at year end, 2018/18 (source: Public Health England)

Klebsiella species bacteraemia

Hospital	Value
Airedale	2
Barnsley Hospital	8
Bradford Teaching Hospitals	11
Calderdale & Huddersfield	16
Doncaster & Bassetlaw Hospitals	21
Harrogate & District	4
Hull & East Yorkshire Hospitals	38
Leeds Teaching Hospitals	85
Mid Yorkshire Hospitals	18
Northern Lincolnshire & Goole Hospitals	13
Sheffield Children's	7
Sheffield Teaching Hospitals	76
The Rotherham	7
York Teaching Hospital	20

Pseudomonas aeruginosa bacteraemia

Hospital	Value
Airedale	2
Barnsley Hospital	4
Bradford Teaching Hospitals	5
Calderdale & Huddersfield	4
Doncaster & Bassetlaw Hospitals	14
Harrogate & District	4
Hull & East Yorkshire Hospitals	13
Leeds Teaching Hospitals	29
Mid Yorkshire Hospitals	13
Northern Lincolnshire & Goole Hospitals	12
Sheffield Children's	1
Sheffield Teaching Hospitals	30
The Rotherham	1
York Teaching Hospital	18

The Antimicrobial Resistance (AMR) Strategy 2019 - 2024 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.

4.2 Outbreaks

February 2019 and March 2019 continued to be challenging months for Norovirus.

During February 2019, a bay closure (H100) was required due to patients with diarrhoea & vomiting but no causative organism was detected.

Further bay closures were required on wards H80 and H100 during March due to patients with diarrhoea & vomiting, again no causative organism was detected.

A full ward closure of H11 was necessary during March 2019; the ward was affected with an abrupt outbreak of diarrhoea and vomiting, this was confirmed as Norovirus. At least 85% of patients nursed on the ward were affected 3 staff members were also symptomatic. The outbreak was protracted with previous affected patients who had resolution of symptoms becoming symptomatic again. Issues with cleaning during the outbreak and also staff understanding of IPC measures/ precautions during an outbreak were also identified. Education is being planned and delivered by the IPCT to staff on the 11th floor in conjunction with the senior matron. A reflective examination of the outbreak and management, and lessons learned has been commissioned by the Chief Nurse.

All areas affected were cleaned by the Cleaning Action Team prior to being reopened.

4.2.1 Infection incident

During February 2019 and March 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 during January 2019 and again a further case in April 2019. To date, there is no evidence to suggest person to person transmission. However, some strains have been identified from babies that could suggest a possible environmental source but none found to date. Further Estates and Facilities works are being undertaken to reduce the possible environmental burden including reconfiguring sideroom layout/ scoping and the pilot of novel wash hand basin cleaning agent.

4.2.2 Influenza trends

The influenza vaccination campaign for 2018/19 commenced on the 1st October 2018 and at year end, 83% of the Trust's healthcare workforce had taken up the influenza vaccine, which was a significant achievement.

Increases in influenza activity continued during February 2019, with all affected patients detected with the Influenza A strain. In addition, respiratory syncytial virus (RSV) activity continued during February 2019, albeit in lower numbers 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 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.

During February 2019 there were a further ninety four cases of Influenza A detected and during March 2019 this dropped dramatically to eighteen cases.

The increase in influenza cases requiring admission had a significant 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 reported 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 following illustrate the distribution of Influenza strains for FY 17/18 and 18/19 respectively.

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

Influenza Activity at Hull & East Yorkshire Hospitals NHS Trust

	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 A was the predominant strain, with no Influenza B activity reported to date.

Influenza Activity 2018/19 at Hull & East Yorkshire Hospitals NHS Trust

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Flu A	0	1	76	161	94	18
Flu B	0	0	0	0	0	0

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 Jan-May 2018 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 Nov 2018-March 2019					
Age at Death	20-40yrs	41-60yrs	61-80yrs	81-100yrs	Total
Flu A	2	1	8	6	17
Flu B	None	None	None	None	0
Total	2	1	8	6	**17**

5. PATIENT EXPERIENCE

The following graph sets out comparative complaints data from 2016 to date. There were 47 new complaints in the month of February 2019 and 76 in the month of March 2019. For the financial year 2018-19, a total of 640 complaints were received. The number of complaints received in the month of March 2019 was the highest received in one month during the last four years', however there was no theme or trend identified.

Complaints Received by Month and Year

Broadly speaking, complaints reflect activity in the previous three months. Below indicates the complaints received during the financial year 2018/19 and the months in which the incident resulting in a complaint occurred. 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.

Incident date relating to complaints received during the financial year 2018/19:

Incident date of Complaint

Period	Count
2001	1
2011	1
2012	1
2013	3
2014	3
2015	6
2016	28
2017	86
Jan-18	24
Feb-18	20
Mar-18	44
Apr-18	40
May-18	45
Jun-18	40
Jul-18	44
Aug-18	45
Sep-18	39
Oct-18	40
Nov-18	35
Dec-18	29
Jan-19	31
Feb-19	22
Mar-19	13

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. This line graph indicates that the increase in complaints in the month of March 2019 is in relation to inpatient concerns as Emergency admissions and Outpatient activity remains consistent and is low.

Complaints as a proportion of Episodes of Care

	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%	0.07%	0.07%
IP Admissions	0.16%	0.23%	0.17%	0.17%	0.17%	0.16%	0.26%	0.27%	0.16%	0.24%	0.17%	0.29%
OP Activity	0.04%	0.02%	0.03%	0.03%	0.03%	0.03%	0.02%	0.02%	0.02%	0.03%	0.02%	0.02%

The following table indicates the number of complaints by subject area that were received for each Health Group during the months of February and March 2019.

Complaints Received by Health Group and Subject – February and March 2019

Complaints by Health Group and Subject (primary)	Month	Attitude	Care and Comfort	Communica-tion	Delay, Waiting Times and Cancellations	Discharge	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	Feb	0	0	0	0	0	0	0	0	**0**
	Mar	0	0	0	0	0	0	0	0	**0**
Clinical Support	Feb	0	0	0	0	0	0	0	0	**0**
	Mar	1	2	0	0	0	0	0	0	**3**
Emergency & Acute	Feb	0	1	0	1	1	0	0	5	**8**
	Mar	1	0	0	0	3	0	0	5	**9**
Family and Women's	Feb	1	1	1	0	0	0	0	7	**10**
	Mar	5	0	2	4	1	0	0	10	**22**
Medicine	Feb	0	5	1	0	1	0	0	5	**12**
	Mar	2	3	0	0	4	0	0	11	**20**
Surgery	Feb	1	0	5	0	0	1	0	10	**17**
	Mar	2	0	4	0	1	0	0	15	**22**
Totals:	**Feb**	**2**	**7**	**7**	**1**	**2**	**1**	**0**	**27**	**47**
	Mar	**11**	**5**	**6**	**4**	**9**	**0**	**0**	**41**	**76**

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 February - March 2019:

- The wife of a patient who had died in hospital raised concerns that it had not been made clear to her and her husband that he was at the 'end of life'. His sudden death caused considerable distress for the family.
  Outcome: The Clinical Director will discuss the concerns raised with his consultant colleagues and the medical staff to consider improved communication with families in terminal situations. The concerns will also be discussed with the nursing staff involved and the wider team for reflective learning purposes.
- A patient was admitted to ED at midnight. She was later discharged with medication but this, alongside her own was too much and could have had serious consequences.
  Outcome: Medication lists are to be confirmed with medical and nursing staff prior to the giving of new prescriptions. This complaint will be used anonymously as a training example for all staff.

- Patient's relatives were unhappy with the decision to discharge the patient, after which the patient required immediate readmission.
  Outcome: Failed discharge issues will be discussed at the next Orthopaedic Governance Meeting. The Ward Sister will also speak with the nursing team regarding the failure to seek a rheumatology review for the patient, which resulted in a missed opportunity to avoid the failed discharge.

- Family raised issues regarding the delay in obtaining a death certificate.
  Outcome: The doctor completing the death certificate thought the death needed to be reported to the Coroner but this was not necessary and delayed the signing of the death certificate. The consultant discussed with the doctor the details of the complaint so that he could learn and improve his practice.

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 February and March 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%	90%	89%

The following tables indicate performance by Health Group and the outcome of the complaint for the months of February and March 2019.

February 2019	N°Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	0 (100%)	0	0	0	0	1
Clinical Support	1	1 (100%)	0	1	0	0	0
Emergency and Acute	7	7 (100%)	0	7	0	0	1
Family and Women's	7	7 (100%)	0	7	0	0	0
Medicine	17	16(94%)	0	20	0	0	3
Surgery	18	14 (78%)	4	9	3	2	5
Totals:	50	45 (90.%)	4	41	3	2	10

March 2019	N°Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	0 (100%)	0	0	0	0	0
Clinical Support	3	3 (100%)	2	1	0	0	1
Emergency and Acute	11	11 (100%)	0	7	4	0	0
Family and Women's	16	16 (100%)	0	12	4	0	0
Medicine	22	20(91%)	1	13	3	0	7
Surgery	14	9 (64%)	2	9	2	1	1
Totals:	66	59 (89.39%)	5	42	13	1	9

As can be seen from the previous table, performance is variable across the Health Groups, with Clinical Support, Emergency and Acute and the Family and Women's Health Groups achieving 100% of complaints closed within 40 days in both February and March 2019. Medicine Health Group achieved the standard of 85% of complaints closed within 40 days with 94% in February and 91% in March. Surgery Health Group closed 18 complaints during the month of February, 14 of which were within 40 days and 14 during the month of March, 9 of which were within 40 days. This will be managed through the monthly performance and accountability meetings with Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

As with complaints received, February saw a decreased number of contacts with the PALS team with an increase in March 2019. There were 9 compliments, 147 concerns and 21 requests for general advice in February. In March 2019, PALS received 1 comment/ suggestion, 2 compliments, 182 concerns and 16 requests for general advice. During the 2018-19 financial year, PALS received a total of 15 comments/suggestions, 150 compliments, 2253 concerns and 465 requests for general advice. The PALS team also receive many calls each day for general signposting and information which is not included in these statistics. 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 decreased in February but increased in the month of March, as was the case with formal complaints. This increase is in line with previous years' activity for the same period.

PALS Concerns Received by Month and Year

PALS Concerns Received by Month and Year — line chart showing 2016-17, 2017-18, 2018-19

The following table indicates that Delays, Waiting times and Cancellations continues to be the highest subject received by PALS.   In the month of February, 40 concerns were regarding the patient not being happy with the treatment plan in place and 20 for delays in receiving an outpatient appointment. In the month of March, 54 patients were not satisfied with the treatment plan in place and again, 20 concerns were received from patients who had experienced a delay in receiving an outpatient appointment.

Complaints by Health Group and Subject (primary)	Month	General Advice	Attitude	Care and Comfort	Communica-tion	Waiting Times and Cancellation	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	Feb	0	2	0	2	1	0	0	3	0	0	0	8
	Mar	3	3	0	3	1	0	0	1	0	0	0	11
Clinical Support	Feb	0	1	1	1	4	1	0	0	0	0	4	12
	Mar	1	2	0	3	3	0	0	0	0	0	3	12
Emergency & Acute	Feb	3	1	0	1	0	1	1	0	0	0	4	11
	Mar	1	3	0	0	1	0	0	0	0	0	4	9
Family and Women's	Feb	0	3	0	3	20	1	0	0	0	1	8	36
	Mar	3	2	0	4	24	0	0	0	0	0	15	48
Medicine	Feb	3	1	1	6	8	3	1	0	0	1	7	31
	Mar	3	4	0	5	10	1	0	0	0	0	11	34
Surgery	Feb	0	4	1	7	17	0	0	0	0	0	20	49
	Mar	8	2	0	3	26	6	0	0	0	0	23	68
Totals:	**Feb**	**6**	**12**	**3**	**20**	**50**	**6**	**2**	**3**	**0**	**2**	**43**	**147**
	Mar	**19**	**16**	**0**	**18**	**65**	**7**	**0**	**1**	**0**	**0**	**56**	**182**

5.2.1 Examples of outcomes from PALS contacts:

- A disabled 90 year old gentleman travelled over 100 miles to an Audiology appointment however, due to traffic, mobility and parking difficulties, he was 15 minutes late and staff turned him away unable to conduct his lengthy assessment. Family members contacted PALS.
Outcome: Swift arrangements were made for an appointment at CHH. It was very late in the day and PALS staff liaised with site security services to ensure that a parking space was available near to the Audiology unit at CHH to avoid unnecessary delay. Close liaison was made with the gentleman's driver by telephone to ensure that he had adequate directions from HRI to CHH. The Audiology service were kept abreast of progress from HRI. The gentleman had his assessment and his long journey was not wasted.

- A patient attended Ward 15 CHH where he lost hearing aid, cash and personal belongings.
Outcome: Staff on the ward conducted a search and the property was located and returned to the patient without delay.

- A patient moved to the area and quickly experienced a great deal of difficulty in obtaining specialist medication for her rare condition. GP services were unable to dispense the drugs without a hospital consultation and it was recognised that her medication would quickly run out.
  Outcome: Despite the fact that the patient's referral was not indicated as urgent, the service went to some lengths to liaise with NHS providers in the patient's hometown in order that appropriate arrangements could be made for her ongoing medication requirements. As a result, her treatment is ongoing and without any damaging delays in her medication regime.

5.2.2 Compliments

- A patient expressed his sincere gratitude to the staff working within Ophthalmology and the Neurology service following referral to the Trust by his GP after experiencing pain within his eye. The staff involved very quickly recognised the potential for underlying neuro complications and as a consequence, arranged for scans and further assessments. It was identified that the patient had a tear in his carotenoid artery in his brain and, as a result of the swift diagnosis, he received timely and appropriate treatment that minimised his exposure to brain damage and contributed to a swift recovery. Special thanks were extended to all of the staff who demonstrated initiative and professionalism.

- A patient attended the Early Pregnancy Assessment Unit (EPAU) following a silent miscarriage of a much wanted and cherished pregnancy. The staff members involved demonstrated a great deal of compassion and empathy and assisted the patient through a most difficult treatment path. The patient expressed her gratitude and thanks for the warmth and support provide to her and pointed out that the professionalism and help assisted her to deal with a horrifying situation.

- The parent of a 14 year old child expressed her admiration and thanks to the staff in Paediatric ED and Ward 130 after it was necessary to admit her daughter. She indicated that despite being extremely busy, the teams involved displayed professionalism and empathy and supported both her and her daughter during a very traumatic time. She pointed out that these "amazing people made such a difference".

5.3 Friends and Family Test (FFT)

The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for March with 4,727 compared to February 2019 when 5,375 were received. The March 2019 inpatient results indicate that **98.36%** were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set-target of **95%**. This is positive news for the Trust and its staff. The Patient Experience Team is working with wards to collect patient feedback on a daily basis.

5.3.1 Inpatient Summary – all areas

22

5.3.2 Friends and Family Emergency Department (ED)

1,495 patients who attended the Emergency Department in March 2019 responded to the Friends and Family Test with **82.88%** of patients giving positive feedback and **8.70%** negative feedback. The remainder were neither positive nor negative.

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 10 cases with the PHSO currently. During the month of February and March no new cases were opened and 1 case was closed, which was not 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, staffing levels and complaints. The latest quarterly engagement meeting between the CQC and the Trust also took place on the 23 April 2019. The engagement meeting was attended by the Inspection Manager and Trust Inspector from the CQC along with the Chief Nurse, Interim Chief Medical Officer Acting Deputy Director of Quality Governance and the Compliance Team Leader from Hull University Teaching Hospitals NHS Trust. This was a positive and informative meeting with no concerns raised by either parties. The CQC confirmed that their inspection processes, information gathering tool (Provider Information Request) and inspection schedule are under review to further improve their inspection methodology and to ensure inspections are more risk based and focused.

At the present time, the CQC have not informed the Trust of any further focus groups or planned inspections. However the CQC have confirmed that they will be attending the Operational Quality Committee, Quality Committee and the Trust Board to observe practice and they have also requested to visit a clinic area of choice. Arrangements will be made for this to take place before August 2019.

During the meeting the CQC stated that they had identified a number of concerns regarding the management and governance arrangements of sub-contracts in relation to Ambulance services used to transport patients between sites, this was a problem regionally and not specific to HUTH. Following the meeting it was confirmed that this had been investigated locally and all arrangements were adequate.

6.2 Learning from Deaths

In response to the requirement that all Trusts in England are to establish non-statutory Medical Examiner schemes by April 2019, a number of key aims have been identified to allow for successful delivery of the medical examiner role.

The key aims are:
- To introduce a system of effective medical scrutiny applicable to all non-coronial deaths;
- Enable matters of a clinical governance nature to be reported to support local learning and changes in practice and procedures;
- Provide information on public health surveillance
- Increase transparency for the bereaved and offer them the opportunity to raise any concerns;
- Improve the quality and accuracy of Medical Certificates of Cause of Death.

The Trust is undertaking a pilot project which will see the implementation of an ME system on a phased basis from May 2019 at Castle Hill Hospital. Two consultant medical staff will undertake the ME role each day, Monday to Friday, with the Bereavement Office staff providing administrative support to the MEs. The pilot will run for 6 months with a review at 3 months.

6.3 Reporting to NHS Early Notification Scheme

From April 2017 Trusts were required to proactively report all maternity incidents to NHS Resolution which met the following criteria identified by the RCOG as potential markers for severe brain injury:

Eligible babies include those born at term (≥37 completed weeks of gestation), following labour, that had a severe brain injury diagnosed in the first seven days of life and were:
- Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)
- Actively therapeutically cooled
- Had all three of the following signs: decreased central tone; comatose; seizures of any kind

The aim of the Scheme is to commence investigations at an early stage where there is a risk of liability, to preserve records and witness evidence and identify areas for learning and change in practice.

In 2018/19, there have been six cases with incident date in year and have been reported and accepted by NHSR as having met the criteria. A further three cases were reported but rejected. A brief summary of the cases accepted by NHSR is detailed below:

Table 4: Summary of cases accepted by NHSR under Early Notification Scheme

Incident Date	Description
04/08/2018	Decision for IOL at 38 weeks due of growth above 90th centile and mild polyhydramnios. Risk of shoulder dystocia discussed. Delivery in theatre with Ventouse, head delivered on two pulls but shoulder dystocia encountered and managed with McRoberts position, suprapubic pressure and internal manoeuvres. Born in poor condition Apgar 5@10, no heart rate achieved for 5 minutes and full resuscitation performed. Transferred to NICU and therapeutically cooled. Discharged home at day 12 with no obvious adverse outcome.
15/11/2018	G2 P1 39+2 spontaneous labour, prolonged second stage and second stage syntocinon commenced meconium noted at delivery, apgar 1@1 and 3@5 unexpected admission to NICU. Cord gases 6.98 and <6.80. Active cooling, grade 3 HIE and seizures.
21/01/2019	G1P0 39 + 3 spontaneous labour and normal birth. Apgars 1@1, 4 @ 5 and 7@10. Admitted to NICU, intubated and actively cooled for 72 hours. Weight 2480 gms. Diagnosis of HIE grade 3 in NICU. Severe neonatal encephalopathy and seizures. MRI findings inkeeping with severe hypoxic insult.
23/02/2019	Attended at 37+4 with reduced fetal movements. Reduced growth on USS. CTG suspicious and grade 1 LSCS performed. Floppy and pale on delivery with HR <60bpm. Lip smacking at 4 hours of age and CFM showed seizure activity treated with Keppra and Midazolam. MRI at day 8 showed unusual pattern of brain injury and in hypoxia/ischaemia and possibility of concomitant hypoglycae, ia/metabolic insult queried.
04/03/2019	Prim, 41+1, spontaneous labour and delivery uneventful. Baby born in poor condition requiring resuscitation and admitted to NICU for HIE grade 2 with active cooling for 72 hours due to poor cord gases, abnormal tone and moderately abnormal CFM. MRI at day 8 showed no significant hypoxic brain insult or intracranial abnormality
16/03/2019	Primip T+10. In labour with prolonged rupture of membranes poor CTG had an FBS 7.33, developed sepsis and commenced on antibiotics. Grade 2 emergency caesarean section and baby born in poor condition transferred to NICU at 47.34 minutes of age requiring ongoing treatment for seizures and was actively cooled. MRI at day 7 showed infarction and increased CSF in left hemisphere indicating possible parenchymal hypoplasia.

Investigation of cases is on-going with NHSR, HSIB and solicitors instructed by NHSR.

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

Beverley Geary   **Makani Purva**
Chief Nurse   Chief Medical Officer

14th May 2019

Appendix One: Safety Thermometer – December 2018

Hull and East Yorkshire Hospitals **NHS**
NHS Trust

SAFETY THERMOMETER NEWSLETTER April 2019

Absence of harm from

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

═ Harmfreecare

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 12th April on both hospital sites. 932 patients were surveyed

93.8% 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.

1.82% (17) 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

98.18% 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 November 18 – April 2019

	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19
Harm Free Care %	93.5%	92%	94.4%	93.7%	93.7%	93.7%
Sample: Number of patients	845	872	881	911	891	932
Total Number of New Harm	20	18	21	16	12	17
NEW HARM FREE CARE %	97.6%	98%	97.7%	98.3%	98.6%	98.1%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	6	0.64%	5	1	0
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**		44	4.7%	**% once not applicable patients removed**	
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**		835	89.5%	**94%**	
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**		53	5.69%	**6%**	

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	44	4.72%	40	0	4
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	39	4.18%	36	0	3
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	5	0.54%	4	0	1

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	9	0.97%
Severity **No Harm**: fall occurred but with no harm to the patient	7	0.76%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.21%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	165	17.7%	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	6	0.64%	3.6%
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital	2	0.21%	1.2%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	4	0.43%	2.4%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 10th May 2019

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
MAY 2019

Title:	NURSING AND MIDWIFERY (SAFE) STAFFING REPORT – MAY 2019
Responsible Director:	Beverley Geary - EXECUTIVE CHIEF NURSE
Author:	Joanne Ledger – DEPUTY CHIEF NURSE

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to nursing and midwifery (safe) staffing levels
BAF Risk:	BAF Risk 2: There is a risk that a lack of skilled and sufficient staff could compromise the quality and safety of clinical services BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care

Strategic Goals:	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great clinical services	Y
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	Y
Key Summary of Issues:	The structure of this report has been revised and information is provided in the report on the following topics: • Compliance with the national reporting requirements on this topic • Nursing and Midwifery Staffing Levels for inpatient areas • The use of the new Care Hours Per Patient Day (CHPPD) Metric • An overall 'professional staffing safety risk assessment' to help contextualise and summarise this information to make it more meaningful

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
NURSING AND MIDWIFERY STAFFING REPORT
MAY 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 March 2019 (January 2019 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 February and March 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.

CARE HOURS PER PATIENT DAY

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
CHPPD	6.57	6.56	6.93	6.52	6.83	6.70	6.70	6.81	6.60	6.56
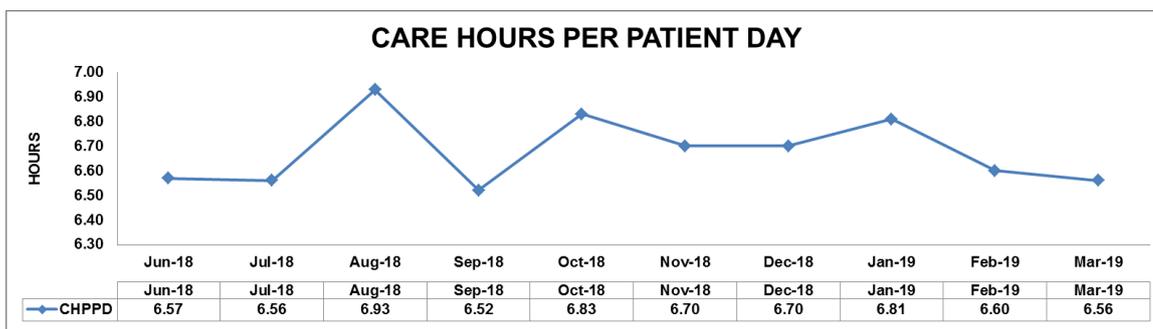
CHPPD provides just a number that needs to be considered alongside other qualitative and quantitative information, which is described in the next section. It is important not to reach conclusions by considering this number and its trends in isolation. However, as can be seen from the above graph, although it remains relatively stable, there has been a drop in the CHHPD position reported in February and March 2019 from the previous months. Further analysis is required to determine the causal factors, which will be presented to the Trust Board in the next staffing report.

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 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.

Each of the clinical areas are reviewed in relation to all of the Nurse Sensitive Metrics, as illustrated in appendices 1 and 2. These metrics are reviewed at each of the Health Group governance meetings with particular attention given to those areas rated as a `Medium` Risk, to determine any potential or actual deterioration.

Going forward each Nurse Director will be required to provide a comprehensive plan for those areas rated `Medium` risk, outlining the actions required to address the workforce issues on a sustainable basis, which will be monitored by the Chief Nurse and the Deputy Chief Nurse as part of the Senior Nurse performance meetings.

In order to support this process further, the Chief Nurse has commissioned a piece of work, to develop a framework which supports staff to articulate their expectations of the Senior Nursing team on a daily basis, but also a mechanism for staff to be part of developing medium and long term plans, to address staffing issues, within their clinical area.

Appendix One provides the Nursing Staffing Key metrics for February 2019.
Appendix Two provides the Nursing Staffing Key metrics for March 2019.
Appendix Three provides the Nurse Staffing Quality Indicators for April 2019
Appendix Four provides the definitions of CHPPD

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

The Risk Ratings have been agreed as follows:

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

4.1 Nursing and Midwifery Staffing Risk Assessments – February to March 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 Nursing Associate qualifying in June 2019.
H36	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, awaiting x3 non – registered nurse new starters
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. The ward has 2 red fundamental standards nutrition and patient centred care; the remaining standards are amber and green.
PDU H80	LOW	No staffing related quality concerns	
H90	LOW	No staffing related quality concerns	Additional non registered nurses in post.
H11	MEDIUM	This ward is requiring a higher level of senior nurse support. One SI declared for tissue viability	Bank and agency utilised. Flexing staff across the floor to maintain safety. Senior Sister redeployed from H110 to provide additional senior nurse support. Additional non- registered nurses being recruited to support Registered nurse workforce. Two international nurses to be allocated to ward. Additional band 6 being recruited to provide senior support at weekends and out of hours
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 2.78 wte. Using Bank and Agency to support.
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	2.75 wte RN vacancies, Maternity is at 10% Support has been provided from other wards in surgery
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. X2 SI related Pressure sores in last quarter.
C27	LOW	No staffing related quality concerns	
CICU	LOW	Not triggering any quality concerns but under review	

4.1.3 Family and Women's Health Group

C16	**LOW**	No staffing related quality concerns	Ward fully operational at 30 beds, following Winter period and support to the winter ward. Utilising bank and agency when required.
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	
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	The Ward Sister is providing additional cover to ensure the correct skill mix is in place when there are shortfalls in staffing
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**	RN vacancy of 1.22 wte, however, 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 MHG with a RN on the winter ward, deemed to be safely staffed	
C30	**LOW**	Despite 2.18 wte RN vacancies (15.9% of registered workforce), not triggering any quality indicators therefore deemed to be safely staffed	
C31	**MEDIUM**	RN vacancies of 7.64 wte but various actions taken in order to support the ward. Not currently triggering quality indicators but being closely monitored.	Actions taken include - support from Day Unit, Specialist nurse, utilising bank and agency in addition to 5 beds being closed, only opened when urgent capacity is required.
C32	**MEDIUM**	This ward has 1.95 wte RN vacancies & 4.8% Maternity Leave; a RN is also currently working in the MHG supporting the winter ward. No quality indicators are triggering.	Utilising bank and agency support from other inpatient wards on review at SafeCare.
C33	**MEDIUM**	This ward has 2.44 wte RN vacancies but high ML at 18% 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. In addition the Trust has developed a brochure which outlines the career pathways for both non – registered and registered nurses entitled `Nursing with us: The whole picture` which will be used as part of the Trust recruitment campaign but also as part of the Trusts retention strategy.

The Trust is currently pursuing 152 adult branch nurses who are due to qualify in September 2019; This is a combination of applicants from the University of Hull through the Trusts `direct interview campaign` and direct applications from other Universities via NHS Jobs and through the Trust's dedicated recruitment website. An induction day has been planned for the 5th June, where the new recruits will meet some of the Executive Team.

To support the smooth transition of the new recruits into the organisation, it has been agreed with the University of Hull that student nurses in their final placements will spend one day a week in the area to which they have been recruited. This will allow them to become orientated to their new place of work and meet their new team members.

The Trust has recruited 53 international nurses who have been deployed from the Philippines. 43 of the nurses have successfully taken their OSCE and have their NMC pin numbers. In addition 10 nurses are booked to take their OSCE in the week commencing the 13th May 2019. Recently the focus has been on deploying the nurses to medicine although there are recruits with expertise in theatres and ICU from which the Trust benefits. Out of the 53 nurses unfortunately two have left the Trust. There are a further 7 nurses awaiting deployment within the next few weeks

The Trust has agreed to fund a fourth cohort of 20 Nurse Associate Trainees and 15 Nurse Apprentices. In order to increase the pool of suitable candidates the Trust has advertised externally.

Given the successful implementation of the Health Care Support Worker apprenticeship scheme, in partnership with the University of Hull and Hull College, the Trust plans to recruit a second cohort as part of the agreed nursing workforce plan.

6. **ENSURING SAFE STAFFING**
The safety brief reviews 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 where 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 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 February and March 2019.

The following graph illustrates the number of 'Red Flags' identified during February and March 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.

RED FLAG EVENTS PER SHIFTS - Mar-19

Category	Events [Shifts]
1:1 Supervision provided by external carer	23
1:1 Supervision provided by family member	3
1:1 Supervision provided by Mental Health	21
1:1 Supervision provided by Ward/Bank/Agency	273
Clinical Judgement Override	13
Enhanced Care Team Assigned (Level 4)	26
Patient Under Police Guard	18
Patient Watch Assigned (Level 5)	50
Safe Guarding	185
Less than 2 RNs on shift	0
Shortfall in RN time	66

Mar-19	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	23	3%
	1:1 Supervision provided by family member	3	0%
	1:1 Supervision provided by Mental Health	21	3%
	1:1 Supervision provided by Ward/Bank/Agency	273	40%
	Clinical Judgement Override	13	2%
	Enhanced Care Team Assigned (Level 4)	26	4%
	Patient Under Police Guard	18	3%
	Patient Watch Assigned (Level 5)	50	7%
	Safe Guarding	185	27%
	Less than 2 RNs on shift	0	0%
	Shortfall in RN time	66	10%
	TOTAL:	**678**	**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. 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.

9. SUMMARY

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

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.

10. RECOMMENDATION

The Trust Board is requested to:

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

Author Jo Ledger
Deputy Chief Nurse
May 2019

Appendix One: Nurse Staffing Key Metrics – February 2019
Appendix Two: Nurse Staffing Key Metrics – March 2019
Appendix Three: Nurse Staffing Quality Indicators – April 2019
Appendix Four: CHPPD Description, Methodology, Benefits and Limitations

APPENDIX FOUR - CHPPD Description, Methodology, Benefits and Limitations

What is Care Hours Per Patient Day (CHPPD)?
CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level.

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

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

CHPPD is calculated, as follows:

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

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

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

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

Further anticipated benefits of using CHPPD
The guidance advises further that using CHPPD provides:

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

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

The limitations of using CHPPD

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

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

HEY NURSE STAFFING KEY METRICS DASHBOARD

Feb-19
KEY METRICS ROTA: 21st Jan 2019 - 17th Feb 2019

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	PROF RISK ASSESS	Other care staff HPW	Cumulative Count	RN/RM	CARE STAFF	OVERALL	MODEL HOSP PEER	VAR vs PEER	MODEL HOSP NAT'L	VAR vs NAT'L	RN [WTE]	RN %	NON-RN [WTE]	NON-RN %	TOTAL VAC [WTE]	RN & NON-RN Est [WTE]	TEMP TOTAL	BANK %	AGENCY %	BANK & AGENCY FILL	UNAVAIL TOTAL	SICK	ANN LEAVE	OTHER	STUDY	WORK DAY	MAT LEAVE	FULL [DAYS]	PARTIAL [DAYS]	ADD TOTAL	LEGIT	AVOID	UNFILLED ROSTER %	HOURS BAL %	NET VAR [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.63	6.0%	0.59	2.7%	6.28	115.34	4.6%	2.7%	1.9%	80.7%	24.0%	3.6%	17.1%	0.0%	2.5%	0.2%	0.6%	49.0	45.0	0.2	0.1	0.1	10.4%	1.6%	48.0	48.0	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1168	4851.9	2613.5	6.4	7.55	-1.16	7.31	-0.92	9.82	22.2%	6.12	26.2%	16.16	67.57	7.6%	7.5%	0.1%	60.5%	28.9%	8.6%	14.8%	0.9%	3.0%	0.1%	1.5%	45.0	34.0	0.4	0.2	0.2	9.2%	0.2%	114.5	236.5	122.0
	H36	GENERAL MEDICINE	24	LOW	399.0	609	2029.0	1430.0	5.7	7.55	-1.87	7.31	-1.63	1.41	9.7%	-1.38	-17.4%	0.13	22.51	9.1%	5.5%	3.6%	50.9%	27.1%	2.9%	14.6%	3.9%	2.0%	3.7%	0.0%	51.0	51.0	1.2	0.3	0.9	18.7%	-0.2%	42.0	192.5	150.5
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	572	1852.8	1649.0	6.1	6.94	-0.82	7.74	-1.62	4.66	24.4%	-1.28	-9.7%	3.62	32.27	20.2%	18.6%	1.6%	59.6%	22.3%	4.5%	13.6%	1.3%	0.5%	1.9%	0.5%	35.0	19.0	0.1	0.1	0.0	19.4%	-1.6%	-19.5	29.0	48.5
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	689	2619.3	1451.0	5.9	6.74	-0.83	6.38	-0.47	2.12	8.6%	3.24	24.6%	5.45	37.84	12.0%	8.6%	3.4%	37.9%	32.1%	9.0%	15.6%	0.0%	3.6%	3.9%	0.0%	25.0	-2.0	0.0	0.0	0.0	17.9%	-0.8%	97.5	154.5	57.0
	H50	NEPHROLOGY	19	LOW	283.5	522	1665.8	1137.2	5.4	7.23	-1.86	7.00	-1.63	-0.17	-1.1%	0.43	5.1%	0.25	23.54	0.6%	0.6%	0.0%	40.9%	23.9%	2.3%	15.7%	0.0%	2.2%	1.0%	2.7%	44.0	-2.0	0.1	0.1	0.0	12.8%	-0.9%	-68.0	10.0	78.0
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	663	1512.6	1483.5	4.5	6.74	-2.22	6.38	-1.86	6.36	37.5%	1.45	11.9%	8.19	29.10	10.3%	10.0%	0.3%	58.0%	22.0%	2.3%	14.0%	0.7%	4.0%	1.0%	0.0%	-1.0	-2.0	0.0	0.0	0.0	12.5%	1.3%	22.1	50.6	28.5
	H70	GENERAL MEDICINE	30	MEDIUM	441.0	831	2136.8	2172.8	5.2	7.55	-2.89	7.31	-2.12	10.44	52.0%	-0.24	-2.0%	10.72	32.22	30.0%	22.8%	5.5%	72.7%	36.5%	2.0%	13.8%	4.0%	0.7%	1.5%	3.8%	28.0	11.0	1.9	1.3	0.6	16.1%	22.8%	455.0	467.5	12.5
	H8	GERIATRIC MEDICINE	27	LOW	220.5	745	1725.4	1544.5	4.4	6.94	-2.55	6.74	-2.35	2.29	13.8%	0.65	4.9%	3.08	29.78	2.6%	2.6%	0.0%	56.0%	22.5%	2.0%	13.8%	0.0%	1.5%	2.5%	2.2%	68.0	68.0	0.4	0.2	0.2	15.9%	-3.7%	-15.5	45.5	61.0
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	748	1402.0	2368.5	5.0	6.94	-1.90	6.74	-1.70	8.26	49.7%	-1.63	-12.4%	7.13	29.78	9.8%	6.0%	3.8%	76.6%	31.1%	8.8%	13.9%	1.8%	1.8%	1.6%	3.2%	24.0	24.0	0.1	0.1	0.0	14.1%	3.1%	94.5	122.0	27.5
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	825	1456.5	1941.0	4.1	6.94	-2.82	6.74	-2.62	4.85	29.2%	-1.76	-13.4%	3.38	29.78	14.0%	9.0%	5.0%	52.1%	36.7%	7.8%	15.9%	0.0%	3.1%	3.9%	6.0%	48.0	48.0	0.2	0.0	0.2	21.7%	0.7%	112.5	118.0	5.5
	H90	GERIATRIC MEDICINE	29	LOW	252.0	800	1549.8	1725.0	4.1	6.94	-2.85	6.74	-2.65	2.11	12.7%	-1.15	-8.7%	1.09	29.78	4.2%	3.5%	0.7%	88.0%	32.8%	4.5%	22.3%	0.3%	2.2%	0.7%	2.8%	51.0	51.0	0.0	0.0	0.1	10.5%	1.1%	76.5	114.0	37.5
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	773	1790.8	1811.5	4.7	7.55	-2.89	7.41	-2.75	6.53	29.0%	2.47	23.2%	9.29	33.16	8.2%	7.9%	0.3%	43.1%	24.7%	5.1%	11.9%	1.0%	0.7%	2.5%	3.5%	47.0	40.0	0.1	0.0	0.1	17.5%	-0.2%	11.5	84.0	72.5
	H110	STROKE / NEUROLOGY	24	LOW	252.0	586	2501.9	1857.8	7.4	7.55	-0.11	7.41	0.03	5.14	22.8%	-1.76	-15.8%	3.61	33.64	18.9%	18.7%	0.2%	54.2%	30.7%	6.3%	13.5%	0.5%	4.5%	3.9%	2.0%	46.0	40.0	0.1	0.0	0.1	24.1%	2.3%	-1.0	138.3	139.3
	CDU	CARDIOLOGY	9	LOW	0.0	105	1118.0	230.5	12.8	7.93	4.91	7.73	5.11	1.45	11.3%	-0.12	-4.1%	1.44	15.74	8.3%	8.3%	0.0%	71.3%	38.4%	9.6%	18.4%	0.6%	2.3%	2.1%	5.4%	53.0	46.0	0.0	0.0	0.0	33.4%	1.3%	0.0	0.0	0.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	806	2525.8	903.3	4.3	8.46	-4.21	9.93	-5.68	1.80	7.0%	0.25	3.2%	2.12	33.73	4.8%	4.4%	0.4%	42.0%	31.2%	9.3%	11.3%	1.2%	1.9%	3.6%	3.9%	19.0	16.0	0.0	0.0	0.1	19.1%	5.5%	-47.8	12.3	60.0
	C28 / CMU	CARDIOLOGY	27	LOW	277.2	646	3750.0	731.5	6.9	7.44	-0.50	7.87	-0.93	5.99	15.7%	0.57	5.9%	6.72	47.78	2.3%	2.3%	0.0%	53.3%	25.9%	3.1%	15.8%	0.0%	2.3%	2.5%	2.2%	36.0	10.0	0.0	0.0	0.0	21.8%	0.0%	17.0	240.0	223.0
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	703	2278.4	1160.2	4.9	8.39	-3.50	8.71	-3.82	3.24	14.8%	1.15	11.0%	4.54	32.28	11.6%	11.6%	0.0%	59.9%	35.8%	6.3%	14.8%	0.3%	10.3%	0.8%	3.3%	41.0	41.0	0.3	0.1	0.2	21.5%	-3.3%	69.5	85.5	16.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	372	2271.3	1269.0	9.5	8.39	1.13	8.71	0.81	2.78	13.4%	-1.02	-9.2%	1.89	31.95	11.9%	6.4%	5.5%	56.1%	31.2%	9.3%	13.7%	0.0%	2.2%	0.4%	5.6%	47.0	45.0	0.2	0.0	0.2	11.4%	1.1%	19.3	70.3	51.0
	H6	GENERAL SURGERY	28	LOW	283.5	671	2193.0	1411.5	5.4	6.99	-1.62	7.26	-1.89	0.91	4.8%	1.06	10.0%	2.02	29.74	10.3%	10.0%	0.3%	64.5%	24.2%	5.6%	11.1%	1.0%	4.1%	2.4%	0.0%	52.0	52.0	0.0	0.0	0.0	6.4%	1.9%	4.5	8.5	4.0
	H60	GENERAL SURGERY	28	LOW	126.0	694	2097.3	1619.3	5.4	6.99	-1.63	7.26	-1.90	-0.64	-3.4%	1.97	18.5%	1.30	29.74	13.8%	12.4%	1.4%	75.4%	28.9%	5.6%	15.3%	0.3%	1.0%	0.3%	6.4%	53.0	53.0	0.0	0.0	0.0	6.0%	-0.8%	130.3	147.8	17.5
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	784	2437.8	1604.0	5.2	6.99	-1.83	7.26	-2.10	2.75	12.6%	1.25	9.5%	4.13	34.89	13.2%	11.7%	1.5%	54.0%	32.2%	4.7%	17.2%	0.0%	0.8%	0.4%	9.1%	55.0	54.0	0.0	0.0	0.0	13.1%	-1.8%	-65.3	51.3	116.5
	H100	GASTROENTEROLOGY	27	LOW	239.4	737	2017.5	1557.8	4.9	6.63	-1.78	6.29	-1.44	0.52	2.7%	2.00	16.5%	2.55	31.23	5.6%	5.3%	0.3%	48.9%	26.9%	6.1%	14.7%	0.6%	0.9%	1.5%	3.4%	54.0	54.0	0.0	0.0	0.1	10.9%	3.7%	54.0	84.0	30.0
	H12	ORTHOPAEDIC	28	LOW	252.0	694	2114.8	1749.5	5.6	7.13	-1.56	7.25	-1.68	2.89	13.2%	-0.36	-2.7%	2.66	35.00	6.0%	6.0%	0.0%	46.3%	29.0%	7.3%	11.4%	3.0%	1.5%	2.8%	3.0%	46.0	45.0	0.0	0.0	0.1	12.9%	1.3%	46.3	68.3	22.0
	H120	ORTHO / MAXFAX	22	LOW	283.5	555	1897.2	1553.3	6.2	7.13	-0.91	7.25	-1.03	2.96	15.0%	0.23	2.0%	2.88	28.42	13.9%	13.1%	0.8%	67.3%	29.2%	3.1%	16.1%	0.1%	3.4%	3.0%	3.5%	53.0	45.0	0.0	0.0	0.1	10.2%	2.3%	26.0	43.0	17.0
	HICU	CRITICAL CARE	22	LOW	252.0	421	11339.2	768.8	28.8	27.13	1.63	26.60	2.16	5.42	5.2%	-0.36	-4.9%	5.11	112.20	0.6%	0.0%	0.6%	49.4%	27.3%	3.5%	15.0%	0.4%	1.7%	2.0%	4.7%	62.0	59.0	0.5	0.5	0.0	12.2%	1.3%	89.8	171.3	81.5
	C9	ORTHOPAEDIC	35	LOW	252.0	785	2381.2	1498.0	4.9	7.13	-2.19	7.25	-2.31	3.37	15.4%	1.47	12.7%	4.99	33.39	6.4%	6.4%	0.0%	37.7%	27.1%	9.0%	14.3%	0.1%	1.0%	0.3%	2.4%	55.0	47.0	0.0	0.0	0.0	12.9%	1.1%	31.8	55.3	23.5
	C10	GENERAL SURGERY	21	LOW	252.0	505	2093.5	793.0	5.7	6.99	-1.27	7.26	-1.54	3.14	17.2%	1.03	13.2%	4.34	26.08	7.1%	7.1%	0.0%	48.5%	18.6%	2.1%	9.7%	1.1%	2.3%	3.4%	0.0%	54.0	52.0	0.0	0.0	0.1	8.6%	0.3%	66.0	95.5	29.5
	C11	GENERAL SURGERY	22	LOW	252.0	492	2121.5	885.5	6.1	6.99	-0.88	7.26	-1.15	0.72	4.0%	1.79	22.9%	2.55	26.08	4.2%	4.2%	0.0%	49.3%	22.1%	1.7%	17.7%	0.3%	2.1%	0.3%	0.0%	61.0	52.0	0.0	0.0	0.0	11.8%	2.4%	-57.3	51.3	108.5
	C14	GENERAL SURGERY	27	LOW	252.0	571	2128.0	872.5	5.3	6.99	-1.74	7.26	-2.01	1.79	8.8%	1.37	15.1%	3.25	29.38	6.5%	5.8%	0.7%	42.1%	27.8%	8.9%	10.9%	0.1%	2.7%	2.4%	2.8%	47.0	39.0	0.1	0.1	0.0	21.8%	1.5%	-14.5	71.8	86.3
	C15	UROLOGY	26	MEDIUM	283.5	470	2175.2	1229.0	7.2	6.47	0.77	6.67	0.57	1.88	9.1%	0.41	3.4%	2.38	32.71	12.5%	7.3%	5.2%	60.6%	27.8%	6.9%	11.7%	0.2%	1.0%	0.5%	7.5%	-26.0	-26.0	0.1	0.1	0.1	11.5%	1.6%	-55.0	41.0	96.0
	C27	CARDIOTHORACIC	26	LOW	283.2	646	2568.7	877.0	5.3	8.46	-3.13	9.93	-4.60	2.93	12.4%	-0.86	-10.0%	2.19	32.22	1.7%	1.7%	0.0%	61.6%	23.9%	4.6%	15.6%	0.0%	2.6%	1.1%	0.0%	60.0	47.0	0.0	0.0	0.0	12.0%	2.9%	18.0	18.0	0.0
	CICU	CRITICAL CARE	22	LOW	157.5	372	8772.2	492.8	24.9	27.13	-2.22	26.60	-1.69	3.47	3.7%	0.21	2.8%	3.72	100.50	1.9%	1.7%	0.2%	88.0%	30.5%	7.4%	13.6%	1.2%	1.4%	2.7%	4.2%	61.0	59.0	0.0	0.0	0.0	18.6%	4.8%	-183.0	24.0	207.0
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	383	1719.1	1035.2	7.2	6.58	0.61	9.03	-1.84	5.87	31.7%	2.35	21.1%	8.54	29.65	13.8%	13.8%	0.0%	49.1%	22.0%	2.9%	9.8%	0.0%	0.4%	0.7%	8.2%	30.0	30.0	0.2	0.1	0.1	18.3%	-1.7%	-50.5	25.5	76.0
	H130	PAEDIATRICS	20	LOW	205.8	473	2260.0	715.5	6.3	11.44	-5.15	12.20	-5.91	-0.96	-4.5%	0.19	3.6%	-0.81	26.59	0.0%	0.0%	0.0%	-	32.0%	3.8%	16.1%	0.3%	0.9%	3.1%	7.8%	58.0	55.0	0.0	0.0	0.0	17.3%	1.8%	12.0	12.0	0.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	238	1554.6	510.5	8.7	8.02	0.66	7.70	0.98	1.57	21.1%	0.12	3.1%	1.90	11.33	21.3%	21.3%	0.0%	64.6%	29.5%	7.0%	21.0%	0.0%	1.5%	0.0%	0.0%	53.0	52.0	0.0	0.0	0.1	19.0%	0.9%	-59.5	38.0	97.5
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	290	1914.3	1237.0	10.9	10.11	0.76	15.48	-4.61	1.18	2.55%	2.11	7.79%	3.29	73.34	0.7%	0.7%	0.0%	80.0%	28.6%	11.6%	13.2%	0.0%	2.2%	0.5%	1.1%	67.0	62.0	0.0	0.0	0.0	13.4%	-0.8%	0.0	0.0	0.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	911	2677.9	1463.5	4.5	10.11	-5.56	15.48	-10.93							1.4%	1.4%	0.0%	80.0%	26.1%	6.1%	14.5%	0.5%	1.8%	1.0%	2.2%	67.0	52.0	0.0	0.0	0.0	9.6%	0.0%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	308	2295.5	414.0	8.8	9.11	-0.31	11.01	-2.21	0.78	3.8%	-0.5	-9.6%	0.32	26.00	2.0%	2.0%	0.0%	77.5%	27.3%	6.8%	12.4%	0.0%	4.3%	0.0%	0.0%	28.0	-11.0	0.0	0.0	0.0	11.4%	-3.6%	-12.0	0.0	12.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	276	1342.5	252.5	5.8	11.20	-5.42	10.94	-4.92	0.7	25.8%	1.74	64.2%	2.70	13.84	0.8%	0.2%	0.6%	41.1%	21.5%	4.7%	16.2%	0.0%	0.6%	0.0%	0.0%	47.0	47.0	0.0	0.0	0.0	20.4%	0.9%	-426.5	34.0	460.5
	LABOUR	MATERNITY	16	LOW	369.5	252	5142.3	1213.5	25.2	10.11	15.11	15.48	9.74	-7.03	-51.3%	-2.07	-15.1%	-9.61	63.84	2.0%	2.0%	0.0%	88.3%	28.3%	9.1%	14.1%	1.0%	1.2%	1.3%	1.6%	62.0	62.0	0.0	0.0	0.0	6.0%	-3.1%	0.0	0.0	0.0
	NEONATES	NEONATOLOGY	26	LOW	157.5	671	7243.7	327.0	11.3	13.26	-1.98	12.98	-1.70	6.69	88.7%	1.4	18.6%	8.98	74.51	4.3%	4.3%	0.0%	91.9%	27.8%	2.8%	13.6%	0.4%	5.1%	1.1%	4.8%	38.0	28.0	0.0	0.0	0.0	11.1%	-0.6%	0.0	0.0	0.0
	PAU	PAEDIATRICS	10	LOW	0.0	81	1253.8	0.0	15.5	11.44	4.04	12.20	3.28	1.13	10.8%	0	0.0%	1.13	10.44	5.4%	5.4%	0.0%	80.2%	18.2%	1.7%	14.6%	0.0%	2.9%	0.0%	0.0%	62.0	54.0	0.0	0.0	0.0	1.2%	3.6%	0.0	0.0	0.0
	PHDU	PAEDIATRICS	4	LOW	0.0	66	1271.5	152.7	21.6	11.44	10.14	12.20	9.38	0.53	4.6%	0	0.0%	0.53	11.66	2.8%	2.8%	0.0%	102.4%	18.2%	0.7%	14.6%	0.0%	1.6%	0.0%	0.0%	62.0	55.0	0.0	0.0	0.0	1.0%	-4.6%	0.0	0.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	320	1356.5	658.8	6.3	7.76	-1.46	7.91	-1.61	-0.07	-0.9%	-0.78	-9.5%	-0.86	20.22	5.1%	4.6%	0.5%	47.9%	30.5%	5.7%	19.0%	0.0%	2.9%	2.9%	0.0%	27.0	27.0	0.0	0.0	0.0	11.6%	-0.5%	-75.0	16.0	91.0
	C29	REHABILITATION	15	LOW	147.0	419	1377.5	2279.8	8.7	7.69	1.04	6.66	2.07	1	6.4%	1.59	10.1%	2.65	28.89	18.4%	17.8%	0.6%	77.5%	24.0%	2.7%	15.7%	0.7%	3.6%	1.3%	0.0%	27.0	27.0	2.0	0.0	0.0	5.7%	4.1%	122.3	133.3	11.0
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	598	1578.9	942.3	4.2	7.92	-3.70	7.14	-2.92	1.42	17.8%	1.19	14.9%	2.79	21.97	5.1%	4.7%	0.4%	50.2%	29.4%	5.8%	15.1%	0.3%	3.7%	4.5%	0.0%	34.0	33.0	0.0	0.0	0.0	6.0%	-1.3%	23.3	41.8	18.5
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	663	1806.0	1015.5	4.3	7.92	-3.62	7.14	-2.84	1.99	16.9%	3.13	26.6%	5.12	25.74	9.3%	6.3%	2.8%	52.0%	26.1%	10.1%	20.1%	0.0%	0.9%	0.1%	0.0%	48.0	48.0	0.1	0.0	0.1	11.8%	-1.4%	88.0	121.5	33.5
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	590	1600.3	1306.2	4.9	7.92	-2.99	7.14	-2.21	1.98	23.8%	-0.04	-0.4%	2.48	23.57	3.2%	1.7%	0.0%	45.0%	21.6%	2.5%	14.3%	0.0%	0.9%	0.0%	3.1%	52.0	48.0	0.1	0.0	0.0	6.7%	-3.1%	-10.0	22.0	32.0
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	626	2340.9	1093.8	5.5	8.21	-2.72	7.23	-1.74	1.68	21.0%	-2.01	-25.2%	-0.12	35.44	3.4%	3.4%	0.0%	38.1%	33.5%	1.8%	12.0%	0.0%	1.6%	1.4%	16.7%	30.0	25.0	0.0	0.0	0.0	17.1%	4.1%	4.5	45.5	41.0
TOTALS:					10473.6	27725	124109.8	59009.0	6.60	8.84	-45.40	9.25	-65.48	135.12	12.3%	12.68	2.5%	158.06	1786.40	7.8%	6.8%	1.0%	60.7%	27.5%	5.5%	14.7%	0.6%	2.3%	1.7%	2.8%	44.7	38.2	9.6	5.7	3.9	13.7%	1.0%	736.1	3638.6	2902.5

WARD — WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR

HEY NURSE STAFFING KEY METRICS DASHBOARD

Mar-19
KEY METRICS ROTA: 18th Feb 2019 - 17th Mar 2019

Column group headers:
- CARE HOURS PER PATIENT DAY [CHPPD] [hrs] — PEER HOSPITALS - CHKS LIST
- NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M12]
- TEMPORARY STAFFING [18th Feb - 17th Mar-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]

HEALTH GROUP	WARD	CODE	SPECIALITY CODE	BEDS	PROF. RISK ASSESS.	Other care staff CHPPD HPW	Cumulative Count	RN/RM	CARE STAFF	OVERALL	MODEL HOSP PEER	VAR vs PEER	MODEL HOSP NAT	VAR vs NAT	RN [WTE]	RN %	NON-RN [WTE]	NON-RN %	TOTAL VAC [WTE]	RN & NON-RN Est [WTE]	TEMP TOTAL	BANK %	AGENCY %	BANK & AGENCY FILL RATE	UNAVAIL TOTAL	SICK RN & AN	ANNUAL LEAVE	OTHER	STUDY DAY	WORKING DAY	MAT LEAVE	FULL [DAYS]	PARTIAL [DAYS]	ADD TOTAL [WTE]	LEGIT [WTE]	AVOID [WTE]	UNFILLED ROSTER %	HOURS BALANCE %	NET VAR [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE		ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	3.11	3.3%	0.59	2.7%	3.73	115.34	6.1%	4.1%	2.0%	95.8%	25.7%	5.0%	17.3%	0.2%	2.2%	0.7%	0.3%	40.0	38.0	0.2	0.1	0.1	8.8%	0.3%	43.5	43.5	0.0
	AAU	AMU	GENERAL MEDICINE	45	LOW	178.5	1173	5300.9	2835.6	6.9	7.55	-0.61	7.31	-0.37	8.82	20.0%	6.12	26.2%	15.14	67.57	8.3%	7.8%	0.5%	57.1%	32.7%	7.5%	18.5%	0.4%	4.5%	0.4%	1.4%	45.0	41.0	0.4	0.2	0.2	12.5%	0.5%	220.4	239.4	19.0
	Ward 36 HRI	H36	GENERAL MEDICINE	24	LOW	399.0	654	1873.5	1600.5	5.3	7.55	-2.24	7.31	-2.00	1.41	9.7%	-1.38	-17.4%	0.13	22.51	11.6%	8.1%	3.5%	65.8%	27.8%	3.2%	12.2%	3.2%	2.7%	6.5%	0.0%	52.0	52.0	1.2	0.2		18.6%	1.3%	-110.0	107.5	217.5
	EAU	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	577	2011.0	1923.5	6.8	6.94	-0.12	7.74	-0.92	6.66	34.9%	-1.28	-9.7%	5.73	32.27	19.0%	17.2%	1.8%	65.2%	20.7%	3.7%	12.0%	0.4%	1.1%	3.5%	0.0%	51.0	47.0	0.1	0.1	0.0	12.5%	-2.2%	31.5	50.3	18.8
	Ward 5 + RSU	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	763	2878.8	1646.9	5.9	6.74	-0.81	6.38	-0.45	1.88	7.6%	3.24	24.6%	5.20	37.84	16.9%	10.5%	6.4%	42.6%	35.7%	10.0%	18.1%	0.0%	3.6%	3.8%	0.2%	44.0	25.0	0.2	0.2	0.0	23.7%	-2.5%	135.8	173.3	37.5
	Ward 50 HRI	H50	NEPHROLOGY	19	LOW	283.5	565	1673.5	1169.8	5.0	7.23	-2.20	7.00	-1.97	-1.17	-7.7%	0.43	5.1%	-0.82	23.54	4.7%	4.3%	0.4%	64.7%	30.2%	3.8%	17.2%	0.0%	2.1%	3.1%	4.0%	53.0	26.0	0.1	0.1	0.0	18.4%	-1.6%	-49.0	47.0	96.0
	Ward 500 HRI	H500	RESPIRATORY MEDICINE	24	LOW	157.5	718	1538.0	1610.8	4.4	6.74	-2.35	6.38	-1.99	6.36	37.5%	1.45	11.9%	8.19	29.10	10.7%	10.7%	0.0%	62.5%	24.3%	1.6%	16.1%	0.0%	4.6%	1.7%	0.0%	-16.0	-18.0	0.0	0.0	0.0	12.9%	2.9%	26.0	45.0	19.0
	Ward 70 HRI	H70	GENERAL MEDICINE	30	MEDIUM	441.0	920	2261.3	2431.8	5.1	7.55	-2.45	7.31	-2.21	8.44	42.1%	0.46	-2.0%	8.62	32.22	27.4%	18.8%	8.6%	68.9%	31.4%	1.6%	12.8%	4.1%	0.6%	3.6%	3.7%	11.0	11.0	1.9	1.6	0.3	16.2%	9.9%	187.0	234.0	47.0
	Ward 8 HRI	H8	GERIATRIC MEDICINE	27	LOW	220.5	809	1897.3	1584.0	4.3	6.94	-2.64	6.74	-2.44	2.29	13.8%	0.65	4.9%	3.08	29.78	3.6%	3.6%	0.0%	47.5%	24.8%	3.5%	13.6%	0.7%	3.3%	1.4%	2.3%	44.0	44.0	0.2	0.2	0.0	22.1%	-4.3%	4.3	72.3	68.0
	H80	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	832	1554.6	2772.3	5.2	6.94	-1.74	6.74	-1.54	7.26	43.7%	-1.63	-12.4%	6.07	29.78	8.3%	3.0%	5.3%	74.6%	30.2%	3.2%	18.6%	3.2%	1.2%	2.0%	2.0%	31.0	30.0	0.2	0.1	0.1	18.8%	2.8%	130.4	160.9	30.5
	Ward 9 HRI	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	920	1629.3	2053.0	4.0	6.94	-2.94	6.74	-2.74	3.85	23.2%	-1.76	-13.4%	2.32	29.78	17.3%	12.9%	4.4%	41.0%	45.8%	6.5%	22.7%	0.0%	3.0%	7.8%	5.8%	67.0	34.0	0.2	0.2	0.0	27.4%	1.2%	158.0	178.0	20.0
	Ward 90 HRI	H90	GERIATRIC MEDICINE	29	LOW	252.0	880	1760.3	1832.0	4.1	6.94	-2.86	6.74	-2.66	2.11	12.7%	-1.15	-8.7%	1.09	29.78	3.7%	3.7%	0.0%	96.6%	30.8%	6.0%	14.5%	0.3%	2.0%	4.3%	2.7%	48.0	44.0	0.1	0.0	0.1	18.1%	1.4%	3.5	91.5	88.0
	Ward 11 HRI	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	836	1844.1	1865.0	4.4	7.55	-3.11	7.41	-2.97	6.53	29.0%	2.47	23.2%	9.29	33.16	7.8%	7.8%	0.0%	40.8%	35.9%	6.9%	15.1%	0.0%	3.1%	7.7%	3.1%	75.0	68.0	0.2	0.0	0.2	20.7%	-1.6%	23.5	54.0	30.5
	Ward 110 HRI	H110	STROKE / NEUROLOGY	24	LOW	252.0	611	2666.3	1965.8	7.6	7.55	0.03	7.41	0.17	5.14	22.8%	-1.76	-15.8%	3.61	33.64	20.7%	19.9%	0.8%	62.4%	35.0%	7.7%	16.0%	0.9%	5.5%	3.1%	1.8%	74.0	68.0	0.1	0.0	0.1	21.3%	2.2%	-17.0	590.0	607.0
	Cardiac Day Ward	CDU	CARDIOLOGY	9	LOW	0.0	104	997.3	225.5	11.8	7.93	3.83	7.73	4.03	1.45	11.3%	-0.12	-4.1%	1.44	15.74	4.2%	4.2%	0.0%	38.5%	37.7%	6.5%	23.1%	0.0%	1.1%	0.0%	7.0%	33.0	31.0	0.0	0.0	0.0	31.2%	0.3%	0.0	0.0	0.0
	Ward 26 + Hob	C26	CARDIOLOGY / CTS	26	LOW	236.5	872	2724.0	930.8	4.2	8.46	-4.27	9.93	-5.74	1.66	6.4%	0.25	3.2%	1.97	33.73	1.7%	1.3%	0.4%	40.4%	29.4%	4.1%	18.4%	0.3%	2.1%	2.0%	2.5%	13.0	11.0	0.0	0.0	0.0	19.0%	5.2%	-8.5	57.5	66.0
	Ward28/CMU	C28 /CMU	CARDIOLOGY	27	LOW	277.2	713	3962.3	953.0	6.9	7.44	-0.55	7.87	-0.98	7.87	20.6%	0.57	5.9%	8.65	47.78	8.3%	5.9%	2.4%	33.2%	25.9%	3.1%	15.8%	0.0%	2.3%	2.5%	2.2%	64.0	48.0	0.1	0.1	0.0	25.2%	0.0%	52.0	240.0	188.0
SURGERY	Ward 4 HRI	H4	NEUROSURGERY	28	LOW	157.5	784	2373.9	1467.4	4.9	8.39	-3.49	8.71	-3.81	3.24	14.8%	1.15	11.0%	4.54	32.28	14.0%	14.0%	0.0%	57.1%	38.2%	9.7%	17.7%	0.2%	7.9%	1.9%	0.8%	55.0	55.0	0.3	0.1	0.2	22.5%	-2.1%	70.8	75.3	4.5
	Ward 40 HRI	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	363	2561.5	1453.0	11.1	8.39	2.67	8.71	2.35	2.78	13.4%	-1.02	-9.2%	1.89	31.95	8.0%	5.1%	2.9%	40.5%	33.8%	9.6%	13.5%	0.6%	2.6%	2.1%	5.4%	49.0	46.0	0.4	0.2	0.2	12.5%	-0.9%	42.0	175.0	133.0
	Ward 6 HRI	H6	GENERAL SURGERY	28	LOW	283.5	727	2355.1	1442.0	5.2	6.99	-1.77	7.26	-2.04	0.91	4.8%	1.06	10.0%	2.02	29.74	11.1%	11.1%	0.0%	64.2%	29.3%	5.3%	17.4%	1.1%	3.6%	1.9%	0.0%	58.0	58.0	0.0	0.0	0.0	10.1%	1.3%	49.5	70.5	21.0
	Ward 60 HRI	H60	GENERAL SURGERY	28	LOW	126.0	765	2469.9	1586.5	5.3	6.99	-1.69	7.26	-1.96	-0.64	-3.4%	1.97	18.5%	1.30	29.74	12.2%	10.1%	2.1%	65.5%	31.9%	5.4%	16.3%	0.1%	0.4%	3.4%	6.3%	61.0	60.0	0.0	0.0	0.0	7.6%	0.0%	-28.5	23.0	51.5
	Ward 7 HRI	H7	VASCULAR SURGERY	30	MEDIUM	283.5	889	2693.0	1837.0	5.1	6.99	-1.89	7.26	-2.16	2.75	12.6%	1.25	9.5%	4.13	34.89	12.6%	9.9%	2.7%	56.2%	31.0%	3.0%	14.2%	0.5%	2.6%	0.5%	10.2%	60.0	60.0	0.0	0.0	0.0	12.3%	-2.4%	4.5	80.5	76.0
	Ward 100 HRI	H100	GASTROENTEROLOGY	27	LOW	239.4	804	2402.0	1786.5	5.0	6.63	-1.67	6.29	-1.33	0.52	2.7%	2.00	16.5%	2.55	31.23	7.0%	7.0%	0.0%	49.3%	30.1%	7.9%	15.7%	0.5%	1.3%	1.3%	3.4%	56.0	55.0	0.2	0.0	0.2	14.9%	2.7%	-16.5	32.0	48.5
	Ward 12 HRI	H12	ORTHOPAEDIC	28	LOW	252.0	803	2402.0	2106.0	5.6	7.13	-1.52	7.25	-1.64	2.89	13.2%	-0.36	-2.7%	2.66	35.00	11.0%	8.6%	2.4%	50.4%	32.2%	6.4%	14.1%	2.8%	1.2%	1.7%	6.0%	44.0	42.0	0.1	0.0	0.1	13.9%	0.3%	76.5	88.0	11.5
	Ward 120 HRI	H120	ORTHO / MAXFAX	22	LOW	283.5	610	1993.5	1563.5	5.8	7.13	-1.30	7.25	-1.42	2.50	15.0%	0.23	2.0%	2.88	28.42	12.1%	11.1%	0.0%	64.5%	32.9%	2.1%	15.7%	0.0%	2.6%	5.6%	7.0%	-4.0	-29.0	0.0	0.0	0.1	11.4%	-0.5%	10.0	17.5	7.5
	ICU HRI	HICU	CRITICAL CARE	22	LOW	252.0	432	11697.2	846.8	29.0	27.13	1.91	26.60	2.44	5.42	5.2%	-0.36	-4.9%	5.11	112.20	0.4%	0.3%	0.1%	97.9%	30.4%	5.2%	17.9%	0.2%	1.0%	1.0%	5.1%	60.0	58.0	0.5	0.5	0.0	18.3%	1.6%	233.0	317.5	84.5
	Ward 9 CHH	C9	ORTHOPAEDIC	35	LOW	252.0	918	2566.5	1665.0	4.6	7.13	-2.52	7.25	-2.64	3.37	15.4%	1.47	12.7%	4.99	33.39	7.5%	7.0%	0.5%	49.2%	30.0%	4.6%	16.0%	0.4%	2.3%	4.5%	2.2%	45.0	40.0	0.1	0.1	0.0	11.6%	0.9%	22.0	30.5	8.5
	Ward 10 CHH	C10	GENERAL SURGERY	21	LOW	252.0	553	2219.7	982.8	5.8	6.99	-1.20	7.26	-1.47	3.14	17.2%	1.03	13.2%	4.34	26.08	10.9%	10.5%	0.4%	48.9%	22.2%	1.7%	16.7%	1.1%	1.5%	1.2%	0.0%	65.0	40.0	0.2	0.0	0.2	15.2%	-1.7%	57.0	94.3	37.3
	Ward 11 CHH	C11	GENERAL SURGERY	22	LOW	252.0	600	2354.3	1032.0	5.6	6.99	-1.35	7.26	-1.62	0.72	4.0%	1.79	22.9%	2.55	26.08	2.6%	1.9%	0.7%	96.3%	17.5%	2.1%	11.6%	0.4%	0.0%	5.0%	0.0%	55.0	40.0	0.1	0.1	0.0	8.4%	3.7%	-35.8	31.8	67.5
	Ward 14 CHH	C14	GENERAL SURGERY	27	LOW	252.0	712	2470.8	1088.8	5.6	6.99	-1.99	7.26	-2.26	1.79	8.8%	1.37	15.1%	3.25	29.38	8.9%	7.9%	1.0%	53.5%	31.1%	5.6%	15.8%	0.0%	3.6%	3.3%	2.8%	40.0	35.0	0.1	0.1	0.0	16.9%	2.2%	103.5	111.0	7.5
	Ward 15 CHH	C15	UROLOGY	26	MEDIUM	283.5	600	2413.5	1426.5	6.4	6.47	-0.07	6.67	-0.27	1.98	9.1%	0.41	3.4%	2.38	32.71	13.7%	11.7%	2.0%	65.1%	31.6%	9.1%	14.2%	0.0%	1.7%	0.3%	6.3%	26.0	20.0	0.1	0.1	0.1	14.7%	-0.4%	7.8	55.8	48.0
	Ward 27 CHH	C27	CARDIOTHORACIC	26	LOW	283.2	736	2815.8	1136.3	5.4	8.46	-3.09	9.93	-4.56	2.93	12.4%	-0.86	-10.0%	2.19	32.22	1.4%	1.4%	0.0%	46.6%	23.1%	4.9%	14.0%	0.2%	2.1%	1.9%	0.0%	59.0	58.0	0.0	0.0	0.1	11.5%	2.6%	-24.0	14.5	38.5
	ICU CHH	CICU	CRITICAL CARE	22	LOW	157.5	388	9019.0	629.5	24.9	27.13	-2.26	26.60	-1.73	3.47	3.7%	0.21	2.8%	3.72	100.50	1.8%	1.8%	0.0%	68.8%	32.0%	6.3%	16.4%	1.1%	1.6%	2.3%	4.3%	62.0	59.0	0.0	0.0	0.1	23.8%	6.0%	-408.0	31.5	439.5
FAMILY & WOMEN'S	Ward 16 CHH	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	394	1762.0	1155.3	7.4	6.58	0.82	9.03	-1.63	5.87	31.7%	2.35	21.1%	8.54	29.65	13.6%	12.4%	1.2%	52.3%	30.9%	3.7%	15.8%	0.0%	2.2%	1.4%	7.8%	26.0	17.0	0.0	0.0	0.0	17.8%	-3.1%	-16.5	48.0	64.5
	Ward 130 HRI	H130	PAEDIATRICS	20	LOW	205.8	465	2476.0	825.0	7.1	11.44	-4.34	12.20	-5.10	-0.96	-4.5%	0.19	3.6%	-0.81	26.59	0.0%	0.0%	0.0%	-	30.6%	0.7%	17.7%	1.0%	0.6%	1.1%	9.5%	53.0	37.0	0.2	0.2	0.0	13.0%	1.5%	34.0	34.0	0.0
	Cedar Ward	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	221	1677.0	583.0	10.2	8.02	2.21	7.70	2.53	1.57	21.1%	0.12	3.1%	1.90	11.33	19.4%	19.4%	0.0%	82.6%	20.9%	1.1%	15.8%	0.0%	2.2%	1.8%	0.0%	51.0	41.0	0.1	0.0	0.1	18.2%	-1.2%	-33.3	23.5	56.8
	Maple Ward	H31 MAPLE	OBSTETRICS	20	LOW	0.0	394	2186.8	1349.0	9.0	10.11	-1.14	15.48	-6.51	1.18	2.55%	2.11	7.79%	3.29	73.34	0.6%	0.6%	0.0%	100.0%	26.9%	10.9%	11.8%	0.0%	2.0%	0.7%	1.3%	62.0	62.0	0.1	0.0	0.1	10.4%	-2.2%	0.0	0.0	0.0
	Rowan Ward	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1064	2932.3	1620.5	4.3	10.11	-5.83	15.48	-11.20							1.6%	1.6%	0.0%	79.5%	29.5%	6.9%	15.7%	1.8%	2.1%	0.8%	2.2%	62.0	62.0	0.1	0.0	0.1	5.8%	-1.4%	0.0	0.0	0.0
	Acorn H34	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	245	2399.8	429.5	11.5	9.11	2.44	11.01	0.54	0.78	3.8%	-0.5	-9.6%	0.32	26.00	2.1%	2.1%	0.0%	49.5%	25.0%	5.4%	15.7%	0.3%	2.7%	0.9%	0.0%	24.0	16.0	0.0	0.0	0.0	14.8%	-4.3%	-23.0	0.0	23.0
	Ward 35 HRI	H35	OPHTHALMOLOGY	12	LOW	285.6	296	1515.0	369.0	6.4	11.20	-4.84	10.70	-4.34	0.7	25.8%	-0.26	-9.6%	0.70	13.84	3.8%	3.8%	0.0%	43.7%	35.3%	15.9%	17.3%	0.0%	2.7%	0.9%	0.0%	46.0	45.0	0.0	0.0	0.0	19.7%	-3.5%	-170.5	3.8	174.3
	Labour Ward	LABOUR	MATERNITY	16	LOW	369.5	273	5673.5	1448.0	26.1	10.11	15.98	15.48	10.61	-7.03	-51.3%	-1.91	-13.9%	-9.45	63.84	0.9%	0.9%	0.0%	97.5%	22.8%	10.4%	7.0%	1.2%	2.3%	1.7%	0.0%	58.0	58.0	0.1	0.1	0.0	5.3%	-3.5%	20.0	20.0	0.0
	NICU HRI	NEONATES	NEONATOLOGY	26	LOW	157.5	706	7661.4	434.5	11.5	13.26	-1.79	12.98	-1.51	6.69	88.7%	1.4	18.6%	8.98	74.51	4.2%	4.2%	0.0%	81.7%	32.9%	5.7%	12.0%	0.3%	9.2%	0.8%	4.9%	51.0	51.0	0.0	0.0	0.0	12.5%	-1.4%	0.0	0.0	0.0
	PAU	PAU	PAEDIATRICS	10	LOW	0.0	119	1377.0	0.0	11.6	11.44	0.14	12.20	-0.62	1.13	10.8%	0	0.0%	1.13	10.44	6.9%	6.9%	0.0%	69.6%	21.5%	1.4%	18.6%	0.0%	1.3%	0.0%	0.0%	52.0	51.0	0.0	0.0	0.0	3.4%	3.7%	0.0	0.0	0.0
	PHDU	PHDU	PAEDIATRICS	4	LOW	0.0	81	1422.5	87.3	18.6	11.44	7.20	12.20	6.44	0.53	4.6%	0	0.0%	0.53	11.66	1.5%	1.5%	0.0%	100.0%	22.0%	0.7%	17.1%	0.0%	4.0%	0.2%	0.0%	52.0	51.0	0.0	0.0	0.0	1.7%	-7.5%	0.0	0.0	0.0
CLINICAL SUPPORT	Ward 7 CHH	C7	INFECTIOUS DISEASE	12	LOW	157.5	323	1436.3	845.3	7.1	7.76	-0.70	7.91	-0.85	-0.07	-0.9%	-0.78	-9.5%	-0.86	20.22	4.1%	2.5%	1.6%	78.1%	29.0%	3.0%	20.1%	0.0%	3.3%	2.6%	0.0%	46.0	45.0	0.0	0.0	0.0	11.4%	-2.1%	-48.0	0.0	48.0
	Ward 29 CHH	C29	REHABILITATION	15	LOW	147.0	456	1468.0	2306.0	8.3	7.69	0.59	6.66	1.62	1	6.4%	2.59	16.4%	3.65	28.89	13.2%	13.0%	0.2%	85.7%	26.9%	3.8%	16.2%	0.3%	4.0%	2.2%	0.4%	34.0	34.0	2.0			2.4%	1.3%	42.0	53.0	11.0
	Ward 30 CHH	C30	CLINICAL ONCOLOGY	22	LOW	220.5	642	1677.8	1098.3	4.3	7.92	-3.60	7.14	-2.82	1.42	17.8%	1.19	14.9%	2.79	21.97	8.5%	7.3%	1.2%	61.8%	30.0%	6.5%	16.6%	0.4%	4.3%	1.5%	0.7%	46.0	46.0	0.0	0.0	0.0	6.4%	-2.4%	43.8	91.8	48.0
	Ward 31 CHH	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	709	1877.1	1289.0	4.5	7.92	-3.45	7.14	-2.67	1.96	16.9%	2.13	18.1%	4.29	25.74	8.5%	5.8%	2.7%	58.7%	27.8%	3.4%	22.2%	0.0%	1.6%	0.6%	0.0%	47.0	47.0	0.1	0.0	0.1	8.8%	-2.8%	44.5	88.5	44.0
	Ward 32 CHH	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	655	1754.5	1381.5	4.8	7.92	-3.13	7.14	-2.35	2.28	23.8%	-0.04	-0.4%	2.48	23.57	7.6%	5.3%	2.3%	56.9%	22.6%	6.8%	17.0%	0.5%	0.5%	0.8%	3.0%	49.0	49.0	0.0	0.0	0.0	8.5%	-2.5%	22.0	44.0	22.0
	Ward 33 CHH	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	696	2743.8	1228.1	5.7	8.21	-2.50	7.23	-1.52	1.68	21.0%	-2.01	-25.2%	-0.12	35.44	4.1%	3.5%	0.6%	47.6%	40.0%	4.6%	18.4%	0.2%	2.0%	2.3%	12.5%	46.0	46.0	0.0	0.0	0.0	16.0%	2.7%	-55.0	30.5	85.5
TOTALS:						10473.6	30370	133221.8	65898.9	6.56	8.84	-48.20	9.25	-68.28	130.10	12.3%	12.68	2.5%	158.06	1786.40	8.3%	7.1%	1.2%	63.6%	29.5%	5.2%	16.1%	0.6%	2.6%	2.3%	2.9%	46.5	41.1	10.2	6.8	3.4	14.6%	0.1%	855.1	4069.6	3214.5

Legend notes: WARD (yellow) = WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR

HEY NURSE STAFFING QUALITY INDICATORS

APRIL 2019 (Mar 19 activity) (YTD Apr 18 - Mar 19)

HR METRICS / IN PATIENT FALLS WITH HARM / ADMITTED WITH & HOSPITAL ACQUIRED PRESSURE ULCERS

Note: The table below combines the HR Metrics columns, the In-Patient Falls With Harm columns, and the right-hand Pressure Ulcer TOTALS columns. The detailed pressure-ulcer sub-category matrix (MASD, Category 2/3/4, Deep Tissue Injury, Unstageable, Device Related) is highly dense and is summarised by the TOTALS columns shown.

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 Viab. Training [85%]	Falls Mod Month	Falls Mod YTD	Falls Sev/Death Month	Falls Sev/Death YTD	Falls Tot Month	Falls Tot YTD	PU Adm Month	PU Adm YTD	PU HA Month	PU HA YTD	Req RCA
EAM	ED	ACUTE MEDICINE	NA	86.5%	88.8%	93.4%	90.9%	97.3%	89.1%	90.9%	88.8%					0	0	164	1868	0	1	
EAM	AMU	ACUTE MEDICINE	45	75.4%	88.2%	94.9%	95.7%	95.7%	91.3%	84.1%	97.1%					0	0	14	168	0	1	
EAM	H1	ACUTE MEDICINE	22	91.3%	95.0%	93.2%	96.0%	95.8%	80.0%	72.0%	87.0%		1			0	1	0	9	0	0	
MEDICINE	EAU	ELDERLY MEDICINE	21	90.0%	91.2%	96.4%	100.0%	96.9%	93.8%	87.5%	93.8%	3	5			0	8	15	182	0	0	
MEDICINE	H5 / RHOB	RESPIRATORY	26	86.1%	87.9%	88.4%	91.9%	94.6%	70.3%	75.7%	86.5%					0	0	1	14	1	15	
MEDICINE	H50	RENAL MEDICINE	19	96.2%	92.8%	94.5%	100.0%	95.2%	90.5%	90.5%	85.7%	1				0	1	2	22	0	2	
MEDICINE	H500	RESPIRATORY	24	84.6%	92.7%	83.1%	88.0%	92.0%	80.0%	56.0%	72.0%	1				0	1	1	36	0	2	
MEDICINE	H70	ENDOCRINOLOGY	30	72.4%	89.4%	86.2%	82.8%	62.1%	79.3%	72.4%	82.8%					0	0	1	19	3	9	1
MEDICINE	H8	ELDERLY MEDICINE	27	84.4%	90.3%	90.6%	90.6%	93.8%	87.5%	81.3%	93.8%	2				0	2	3	12	1	9	
MEDICINE	H80	PDU	27	86.7%	90.1%	94.3%	79.4%	91.2%	88.2%	88.2%	88.2%	4	4			0	8	0	2	0	9	
MEDICINE	H9	MEDICALLY READY FOR DISCHARGE	30	87.1%	83.4%	89.6%	94.1%	88.2%	52.9%	76.5%	76.5%	3	2			0	5	1	6	1	3	
MEDICINE	H90	ELDERLY MEDICINE	29	96.8%	91.7%	97.7%	100.0%	84.8%	97.0%	93.9%	87.9%	1	3			0	4	0	10	0	4	
MEDICINE	H11	STROKE / NEURO	28	61.5%	86.9%	89.9%	93.1%	79.3%	75.9%	72.4%	79.3%	3	1			0	4	0	5	0	5	
MEDICINE	H110	STROKE / NEURO	24	84.4%	90.8%	90.6%	97.2%	77.8%	86.1%	80.6%	83.3%		1			0	1	0	26	1	9	
MEDICINE	CDU	CARDIOLOGY	9	71.4%	68.6%	95.9%	93.3%	86.7%	93.3%	60.0%	93.3%					0	0	0	4	0	0	
MEDICINE	C26	CARDIOLOGY	26	94.6%	98.3%	90.2%	94.6%	97.3%	86.5%	75.7%	81.1%	1	1			0	2	0	3	0	11	
MEDICINE	C28 /CMU	CARDIOLOGY	27	76.7%	85.2%	90.4%	86.4%	95.5%	88.6%	95.5%	81.8%					0	0	0	7	1	7	
SURGERY	H4	NEURO SURGERY	28	86.7%	88.5%	86.7%	78.8%	90.9%	81.8%	81.8%	84.8%	1				0	1	0	11	0	3	
SURGERY	H40	NEURO / TRAUMA	15	85.3%	85.6%	89.5%	90.9%	78.8%	69.7%	78.8%	78.8%					0	0	1	8	2	9	
SURGERY	H6	ACUTE SURGERY	28	93.9%	96.5%	92.5%	96.9%	87.5%	81.3%	87.5%	84.4%	1				0	1	1	7	0	3	
SURGERY	H60	ACUTE SURGERY	28	91.2%	95.0%	83.9%	93.9%	97.0%	60.6%	69.7%	72.7%					0	0	2	16	1	1	
SURGERY	H7	VASCULAR SURGERY	30	94.6%	97.0%	86.0%	89.5%	84.2%	78.9%	68.4%	86.8%					0	0	6	61	1	11	
SURGERY	H100	GASTRO	24	85.3%	92.6%	86.8%	85.7%	82.9%	80.0%	68.6%	74.3%	1				1	1	0	4	2	15	
SURGERY	H12	ORTHOPAEDIC	28	94.6%	95.9%	96.4%	92.3%	97.4%	89.7%	97.4%	92.3%		1			0	1	2	16	4	11	1
SURGERY	H120	ORTHO / MAXFAX	22	86.7%	94.6%	93.1%	90.0%	96.7%	70.0%	90.0%	93.3%					0	0	1	13	1	12	
SURGERY	HICU	CRITICAL CARE	22	78.0%	91.2%	89.0%	89.5%	94.3%	87.1%	54.8%	82.1%					0	0	1	9	3	16	1
SURGERY	C9	ORTHOPAEDIC	35	92.3%	92.4%	91.0%	80.0%	92.5%	75.0%	72.5%	92.5%	1				0	1	1	7	0	7	
SURGERY	C10	COLORECTAL	21	81.8%	72.7%	84.6%	90.9%	77.3%	90.9%	72.7%						0	0	0	2	1	4	
SURGERY	C11	COLORECTAL	22	88.5%	92.8%	91.8%	93.1%	96.6%	79.3%	96.6%	86.2%					0	0	3	9	0	0	
SURGERY	C14	UPPER GI	27	93.8%	93.4%	76.9%	88.2%	90.6%	52.9%	79.4%	68.8%					0	0	0	0	1	4	
SURGERY	C15	UROLOGY	26	51.9%	80.4%	82.6%	74.2%	74.2%	80.6%	51.6%	77.4%	1				0	1	1	0	5	12	
SURGERY	C27	CARDIOTHORACIC	26	89.5%	88.9%	90.8%	91.7%	88.9%	75.0%	77.8%	80.6%	1				0	1	1	5	0	1	
SURGERY	CICU	CRITICAL CARE	22	87.8%	90.4%	95.4%	92.4%	96.2%	91.4%	84.6%	94.2%					0	0	0	3	0	7	
FAMILY & WOMEN'S	C16	ENT / BREAST	30	89.3%	93.4%	96.6%	100.0%	89.7%	86.2%	79.3%	93.1%					0	0	0	2	0	1	
FAMILY & WOMEN'S	H130	PAEDS	20	84.4%	83.8%	91.9%	100.0%	75.8%	80.0%	68.6%	72.7%		1			0	1	0	0	0	0	
FAMILY & WOMEN'S	H30 CEDAR	GYNAECOLOGY	9	88.5%	100.0%	94.0%	91.3%	100.0%	91.3%	95.7%	91.3%					0	0	0	1	0	0	
FAMILY & WOMEN'S	H31 MAPLE	MATERNITY	20	92.5%	92.5%	93.4%	91.3%	88.8%	83.8%	93.8%	91.3%					0	0	0	0	0	0	
FAMILY & WOMEN'S	H33 ROWAN	MATERNITY	38													0	0	0	0	0	0	
FAMILY & WOMEN'S	H34 ACORN	PAEDS SURGERY	20	93.3%	87.0%	96.9%	100.0%	100.0%	93.3%	93.3%	71.4%					0	0	0	0	0	1	
FAMILY & WOMEN'S	H35	OPHTHALMOLOGY	12	94.7%	95.3%	96.2%	95.0%	90.0%	90.0%	90.0%	100.0%					0	0	0	6	0	3	
FAMILY & WOMEN'S	LABOUR	MATERNITY	16	79.1%	97.5%	89.0%	91.1%	93.3%	81.1%	91.1%	84.4%					0	0	0	0	0	0	
FAMILY & WOMEN'S	NEONATES	CRITICAL CARE	26	88.0%	85.0%	95.2%	97.6%	90.4%	89.2%	94.0%	100.0%					0	0	0	0	0	1	
FAMILY & WOMEN'S	PAU	PAEDS	10	85.7%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	92.3%					0	0	0	0	0	0	
FAMILY & WOMEN'S	PHDU	CRITICAL CARE	4	85.7%	84.1%	87.6%	100.0%	100.0%	92.3%	76.9%	100.0%					0	0	0	0	0	0	
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	19	90.5%	100.0%	94.1%	95.2%	90.5%	95.2%	85.7%	95.2%	1				0	1	0	2	0	3	
CLINICAL SUPPORT	C29	REHABILITATION	15	65.4%	96.5%	94.2%	89.3%	82.1%	89.3%	78.6%	85.7%	1				0	1	0	0	0	6	
CLINICAL SUPPORT	C30	ONCOLOGY	22	100.0%	80.4%	92.3%	100.0%	95.5%	77.3%	72.7%	100.0%					0	0	6	60	0	10	
CLINICAL SUPPORT	C31	ONCOLOGY	27	78.3%	98.2%	87.9%	88.5%	96.2%	76.9%	84.6%	80.8%					0	0	7	76	1	7	1
CLINICAL SUPPORT	C32	ONCOLOGY	22	80.0%	94.1%	93.3%	95.7%	100.0%	82.6%	87.0%	95.7%	2				0	2	4	46	0	3	
CLINICAL SUPPORT	C33	HAEMATOLOGY	28	75.7%	97.0%	89.4%	87.5%	100.0%	77.5%	70.0%	82.5%					0	0	2	27	0	5	
TOTALS :				**85.3%**	**90.7%**	**91.1%**	**92.1%**	**90.9%**	**82.8%**	**80.7%**	**86.1%**	1	30	0	19	1	49	241	2784	29	245	0

Pressure-ulcer sub-category TOTALS (from TOTALS row): MASD 0/0 admitted, 2/2 HA; Category 2 154/1753 admitted, 17/136 HA; Category 3 21/159 admitted, 0/2 HA; Category 4 2/50 admitted, 0/2 HA; Deep Tissue Injury 30/433 admitted, 8/79 HA; Unstageable 34/413 admitted, 4/26 HA; Device Related 4/63. Require RCA 2/2.

APPENDIX 3

Hull University Teaching Hospitals NHS Trust
Trust Board
14 May 2019

Title:	Quality Accounts 2018/19
Responsible Director:	Chief Nurse – Beverley Geary
Author:	Compliance Team Leader – Leah Coneyworth

Purpose:	The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2018/19 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication in June 2019.	
BAF Risk:	BAF risk 3	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	**QUALITY AND SAFETY PRIORITIES** The quality and safety priorities for 2019/20 were approved following consultation in February 2019 with patients, staff, Trust members and stakeholders. The agreed quality and safety priorities for 2019/20 are: **Safer Care (Patient Safety)** • To improve nutrition and hydration • To improve medicine optimisation • To improve care, management, detection and treatment of the deteriorating patient • To reduce avoidable hospital acquired pressure • To reduce avoidable acute kidney injury • To ensure all appropriate patients are risk assessed for VTE **Better Outcomes (Clinical Effectiveness)** • To improve mental health care for adults and children • To improve dementia care **Improved Experience (Patient Experience)** • To improve outpatient services • To listen to and act on patient experience to improve services	

Recommendation:	The Trust Board is requested to: • Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication in June 2019 • Note the key dates detailed in section 4 of this report

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
QUALITY ACCOUNTS 2018/19

2. **PURPOSE OF THE PAPER**

The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2018/19 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication in June 2019.

3. **QUALITY AND SAFETY PRIORITIES**

The quality and safety priorities for 2019/20 were approved following consultation in February 2019 with patients, staff, Trust members and stakeholders. The agreed quality and safety priorities for 2019/20 are:

Safer Care (Patient Safety)
- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired pressure
- To reduce avoidable acute kidney injury
- To ensure all appropriate patients are risk assessed for VTE

Better Outcomes (Clinical Effectiveness)
- To improve mental health care for adults and children
- To improve dementia care

Improved Experience (Patient Experience)
- To improve outpatient services
- To listen to and act on patient experience to improve services

4. **QUALITY ACCOUNTS**

3.1 Draft

The first draft of the 2018/19 Quality Accounts is attached at Appendix A. The draft will continue to be updated with up to date information, data and any amendments made to content e.g. errors, additional content and any suggested changes.

3.2 Stakeholder Statements

The Operational Quality Committee approved the first draft of the Quality Accounts for distribution to key stakeholders on 03 May 2019. The key stakeholders are the main commissioners (NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group), Healthwatch Hull, Healthwatch East Riding of Yorkshire, Hull Overview and Scrutiny Committee (OSC) and East Riding OSC.

The stakeholders have 28 days to provide a 500 word statement each on the content of the Quality Accounts. The deadline for the stakeholders to return their statements is 31 May 2019. Once all statements have been received the Trust will respond with its statement, all of which will be included in the Quality Accounts before publication.

5. **NEXT STEPS**
- May and June – internal audit to be undertaken an assessment to ensure the Trust has met all requirements before publishing the quality accounts
- May 2019 – The Compliance Team will continue to complete the draft Quality Account, ensuring all information is included as required

- May 2019 – Trust Board to provide delegated responsibility to the Quality Committee for final ratification and approval before publication
- May 2019 - deadline for the stakeholder statements to be returned
- June 2019 – the Compliance Team will review the statements, consider any suggested amendments and respond with the Trust statement
- June 2019 – submit the final version to the Quality Committee for final sign off before for publication
- June 2019 – publication of the 2018/19 Quality Accounts on NHS Choices and send to the Secretary of State and NHS England in adherence to the legal requirements

6.   RECOMMENDATIONS

The Trust Board is recommended to:
- Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication.
- Note the key dates detailed in section 4 of this report

Leah Coneyworth
Compliance Team Manager
May 2019

Quality Account

2018/19

Great Staff - Great Care - Great Future

Contents

What is a Quality Account?

What is a Quality Account?
The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a Quality Account look like?
Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). This toolkit can be accessed via **https://www.gov.uk/government/news/quality-accounts-toolkit**.

The Quality Account must include:
Part 1 (Introduction)
- A statement from the Board (or equivalent) of the organisation summarising the quality of NHS services provided

Part 2 (Looking back at the previous financial year's performance)
- Organisation priorities for quality improvement for the previous financial year
- A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

Part 3 (Looking forward at the priorities for the coming financial year)
- A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience
- A series of statements from Stakeholders on the content of the Quality Account

Providers are able to add additional sections and information; however the Quality Account must have an introduction, it must then look back at previous performance and then look forward at the priorities for the coming financial year.

What does it mean for Hull University Teaching Hospitals NHS Trust?
The Quality Account allows NHS healthcare organisations such as Hull University Teaching Hospitals NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas e.g. service delivery and to inform the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?
By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare organisation it is scrutinising each and every one of its services, providing particular focus on those areas that requires the most attention.

How will the Quality Account be published?
In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30 June 2019. Hull University Teaching Hospitals NHS Trust also makes its Quality Account available on the website **http://www.hey.nhs.uk/about-us/corporate-documents/**

If you require any further information about the 2018/19 Quality Account please contact:
The Compliance Team on **01482 482352** or e-mail us at **quality.accounts@hey.nhs.uk**

Part 1: Introducing our Quality Account

This section includes:

- A statement on quality from the Chief Executive, Chris Long
- An overview of some of our success stories from 2018/19

Statement on Quality from the Chief Executive

Welcome to Hull University Teaching Hospitals NHS Trust's 2018/19 Quality Account…

I am pleased to present Hull University Teaching Hospitals NHS Trust's Quality Account. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2019/20. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.

In Part 5 of this report (page 70) we set out the quality and safety improvement priorities for 2019/20. These priorities were identified through consultation with staff, Trust members, Health & Well Being Boards, Healthwatch, Clinical Commissioning Groups and the local community. As a result, the following quality and safety improvement priorities were identified:

Safer Care (Patient Safety)
- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce pressure ulcers
- To reduce avoidable acute kidney injury
- To ensure all appropriate patients are risk assessed for VTE

Better Outcomes (Clinical Effectiveness)
- To improve mental health care for adults and children
- To improve dementia care

Improved Experience (Patient Experience)
- To improve outpatient services
- To listen to and act on patient experience to improve services

Many staff and our stakeholders have been involved in the development of the Quality Account. Comments from the stakeholders on the content of the Quality Account are included in full in Part 6 of this report (from page 76). We welcome involvement and engagement from all staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2018/19 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

Chris Long
Chief Executive

Overview of 2018/19 – Celebrating Success

The following table provides an overview of our successes during 2018/19. Some of the year's highlights include:

April 2018	**Hessle Epilepsy Society Fundraising** A group of volunteers from Hessle Epilepsy Society raised funds to support people with epilepsy and presented thousands of pounds worth of equipment to the Trust.	
May 2018	**Whooping Cough Vaccine** Hull University Teaching Hospitals NHS Trust became one of the first hospital trusts in the country to offer women a vaccine to protect their new-born babies from whooping cough.	
June 2018	**More than three quarters of services rated as "Good"** NHS inspectors rated more than three-quarters of the Trust's services good. Of the services inspected, the Care Quality Commission rated 26 of the 33 areas at Hull Royal Infirmary and Castle Hill Hospital as good.	
July 2018	**The NHS Turned 70** The NHS Celebrated its 70th Anniversary. An event was held at the Double Tree Hilton, Hull, to celebrate.	
August 2018	**Quilt of Memories** A three year project designed to honour those lost to leukaemia and other cancers received its official unveiling at Castle Hill Hospital in Cottingham. Over two hundred pairs of hands were involved in making the 'Quilt of Memories', a giant patchwork quilt which includes 140 individually hand-crafted quilt blocks.	
September 2018	**Dementia Friendly A&E** Two frontline nurses spearheaded a drive to make Hull's A&E department a friendlier place for patients with dementia and their families. Carers are now able to stay with relatives when they are taken to the Emergency Department at Hull Royal Infirmary.	
October 2018	**Baby Loss Awareness Week** Midwives and child care experts staged a special event at Hull Women and Children's Hospital to mark the start of Baby Loss Awareness Week. Hull University Teaching Hospitals NHS Trust is supporting the 60 charities raising awareness of miscarriage, stillbirth and baby loss in the UK.	

November 2018	**Veteran Aware Hospital** As the nation marked the 100th anniversary of the end of the First World War, the NHS celebrated the first wave of new Veteran Aware hospitals. Hull University Teaching Hospitals NHS Trust is one of the 24 acute hospital trusts accredited by the Veterans Covenant Hospital Alliance (VCHA) to lead the way in improving NHS care for veterans and members of the Armed Forces community.	
December 2018	**Mental Health Crisis Support** Humber Teaching NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust teamed up to ensure people in mental health crisis are supported as much as those facing physical health emergencies this winter. Posters and social media platforms were used to highlight the different services in the community, saving people the anxiety of travelling to the Emergency Department at Hull Royal Infirmary.	
January 2019	**Dignity Action Day** Staff at the Queen's Centre celebrated Dignity Action Day, at the Queens Centre Castle Hill. The event showcased examples of how staff have been working to ensure patients are treated with both dignity and respect.	
February 2019	**Top Ten Trust for Flu Vaccine** Hull was named among the top ten NHS trusts in the country for protecting patients, staff and their families from flu last winter. Hull University Teaching Hospitals NHS Trust achieved the national target of 75% by mid-November 2018, 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	
March 2019	**World Kidney Day** A specialist kidney team marked 50 years since the service was launched in Hull as part of this year's World Kidney Day. Hull has a dedicated kidney unit at Hull Royal Infirmary, satellite units led by nurses in Bridlington, Grimsby and Scunthorpe and patient outreach clinics at Bridlington, Goole, Grimsby and Scunthorpe. People who have undergone treatment for kidney treatment, including dialysis and transplants joined staff to mark the global awareness day.	

Part 2: Review of our Quality Achievements

This section includes:

- An overview of the 2018/19 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2018/19 priorities

Overview of 2018/19 – Performance against Priorities

The following table provides an overview of performance against all targets during 2018/19. We recognise that not all of our quality and safety improvement priorities for 2018/19 have been achieved in full; however significant improvement in some areas is demonstrated and we will continue to work and further improve on these areas during 2019/20.

Key

🟩	Target achieved
🟧	Target was not achieved, but improvements were made on the previous year
🟥	Target was not achieved, performance remained the same or deteriorated
⬜	Targets were discontinued*

*The reasons why the targets were discontinued can be found on pages 11 to 26, detailed on the relevant priority area pages.

Quality and Safety Improvement Priority	Target	Status
Nutrition and Hydration	100% of Patients (who's current clinical condition allows) will have their weight recorded during their current in-patient episode	🟧
	85% of Patients will have their Food Record Chart completed consistently & correctly	🟥
	85% of patients will have had their nutritional screening tool completed daily in the last 5 days	🟩
	85% of patients will have had their nutritional screening tool completed correctly	🟩
	85% of appropriate patients will have snacks offered	🟩
	85% of patients (with a Hydration chart) will have their FRC completed consistently & correctly	🟥
	85% of patients will feel they have enough choice at meal times	🟩
	85% of patients will feel that they get the right amount of food & drink	🟩
Medicine Optimisation	80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247)	🟩
Deteriorating Patient	Indicators removed in year to accommodate the launch of NEWS2	⬜
Avoidable Hospital Acquired Infections	To have 0 Hospital acquired MRSA bacteraemia	🟥
	To not exceed <=99% of threshold of 52 Hospital acquired Clostridium Difficile	🟩
	To not exceed <=99% of threshold of 44 Hospital acquired MSSA	🟥
	To not exceed <=99% of threshold of 73 Hospital acquired E. Coli	🟥
Avoidable Hospital Acquired Pressure Ulcers	Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas	🟧
	85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas	🟧
	To have no avoidable hospital acquired Stage 3 pressure ulcers	🟩
	To have no avoidable hospital acquired Stage 4 pressure ulcers (target included July 2018)	🟩
	To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	🟧
	To have no more than 23 avoidable hospital acquired SDTI	🟧
	To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)	🟥
	All root cause analysis investigations of hospital acquired pressure sores completed within 14 days	🟧
	Fully quorate at Trust's Wound Management Committee	🟩
	100% compliance with duty of candour – written	🟥

	100% compliance with duty of candour – verbal	
	100% compliance with duty of candour – feedback	
Acute Kidney Injury	Delivery of the AKI quality improvement project	
Patient Falls	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	
	To further reduce the number of patient falls per 1000 bed days for patient falls	
	To reduce the number of falls resulting in a fracture neck of femur	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H9	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H90	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H8	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H80	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For EAU	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For C29	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For C31	
	50% of Allied Health Professionals to have completed the falls prevention e-learning	
Sepsis	2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis – Inpatient	
	2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Emergency Department	
	2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Inpatient	
	2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Emergency Department	
	To improve the number of staff completing SOBs training	
Avoidable Mortality	To review all deaths where family, carers or staff have raised a concern about the quality of care provision.	
	To review all deaths of patients who are identified to have a learning disability and/or severe mental illness *The Trust has signed up to the Learning Disabilities Mortality Review Programme (LeDeR). Deaths of patients with learning difficulties are reviewed under this framework, which was developed by the University of Bristol.*	
	To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.	
	To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.	
Transition between Paediatric and Adult care	Procedural document ensuring the effective transition for young people to adult services embedded	
Patient Experience	Continue to achieve =>85% of formal complaints closed within the 40 day target	
	To Reduce the number of repeat complaints by 20% <83	

The following section of the Quality Account provides a more detailed account on achievements and areas for further improvement for each of the priorities above.

Nutrition and Hydration

What we aimed to achieve in 2018/19:

The aim of this project was to improve patients' nutrition by completing the required actions and improvements from the March 2018 Nutritional Prevalence re-audit and to improve compliance with the Nutrition Fundamental Standards.

The priority aimed to achieve the following specific targets by the end of March 2019 however these were discontinued in December 2018:

- 100% of wards to achieve a minimum of 80% compliance on the Nutrition Fundamental Standard: Amber
- 100% of wards to achieve a minimum of 80% compliance with completion of Food Record Charts on the Matrons Handbook
- 100% of wards to achieve a minimum of 80% compliance with completion of Fluid Balance Charts (Paper Copies) on the Matrons Handbook

In January 2019, the project was amended to provide greater clarity and the following targets were included and agreed:

- 100% of Patients (whose current clinical condition allows) will have their weight recorded during their current in-patient episode (Data collected monthly via Classic Safety Thermometer)
- 85% of Patients will have their Food Record Chart completed consistently & correctly (Data collected via Fundamental Standards)
- 85% of patients will have had their nutritional screening tool completed daily in the last 5 days (Data collected via Fundamental Standards)
- 85% of patients will have had their nutritional screening tool completed correctly (Data collected via Fundamental Standards)
- 85% of patients with a Hydration Record Chart (HRC) will have it completed consistently & correctly (Data collected via Matrons Hand Book Quarterly)
- 85% of patients will feel they have enough choice at meal times (Data collected via Matrons Hand Book Quarterly)
- 85% of patients will fell that they get the right amount of food & drink (Data collected via Matrons Hand Book Quarterly)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
100% of Patients (who's current clinical condition allows) will have their weight recorded during their current in-patient episode	No baseline	88%	
85% of Patients will have their Food Record Chart (FRC) completed consistently & correctly	No baseline	68.9%	
85% of patients will have had their nutritional screening tool completed daily in the last 5 days	No baseline	89%	
85% of patients will have had their nutritional screening tool completed correctly	No baseline	94.8%	
85% of appropriate patients will have snacks offered	No baseline	98%	
85% of patients (with a Hydration chart) will have their FRC completed consistently & correctly	No baseline	50.7%	
85% of patients will feel they have enough choice at meal times	No baseline	89%	
85% of patients will feel that they get the right amount of food & drink	No baseline	91%	

Safer Care ▸ Better Outcomes ▸ Improved Experience

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

This project was reviewed part-way through the year to consider the impact it was having on improving nutrition and hydration. During the review it was noted that in order to consider if previous years improvements had been embedded, it was necessary to focus on gathering data using the Matron Handbook audits and the Nutrition Fundamental Standards to obtain a better understanding. This enabled the Teams to gain greater clarity of the areas within the Trust where documentation was being completed well or poorly. Within year, the Teams also focused on the review and implementation of key policies, guidelines and care bundles.

Further improvements identified:

Further improvements in Nutrition and Hydration have been identified and it is therefore a quality and safety priority for 2019/20 (see page 71) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.

The focus for further improvements will be:

- Focussed Task and Finish Group for key clinical areas such as Medical Elderly wards to review existing processes for supporting patients who require assistance
- Enhancement of existing nutritional training for non-registered nursing staff
- Nutrition Census, which is a type of audit looking at all processes around a specific area, completed and actions agreed to address any shortcomings
- Review of the Pre-Operative Fasting of Adults, Infants and Children process undergoing a general anaesthetic

Medicine Optimisation

What we aimed to achieve in 2018/19:

The aim of this project was to ensure our patients receive the right medicines, at the right dose at the right time as well as compliance with best practise guidance and regulations. This would be achieved by addressing any medicine management issues raised by the CQC and within the Trust Quality Accounts, as well as potential areas for improvement highlighted from Trust governance systems such as incident reporting, audits and others including the discharge liaison teams and patient feedback.

This priority aimed to achieve the following specific targets by the end of March 2019:

- 80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247) by March 2019 (Baseline 16%)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247)	16%	100%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project was measured by the attainment of 80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care". This was achieved in July 2018 at 88% and rose to 100% compliance in November 2018 and remained at this rate for the rest of the 2018/19 programme. In addition a number of other actions were implemented including:

- Introduction of a Biosimilar for Adalimumab to maximise resources in a safe manner. A biosimilar is a biologic medical product that is almost an identical copy of an original product that is manufactured by a different company. The use of which can usually save NHS Trusts a significant amount of money. Around 80% of patients on Adalimumab were transferred onto the biosimilar at time of closure
- Additional support for adult cystic fibrosis patients by the introduction of an annual medication review
- Improving the knowledge and awareness on VTE prevention by the introduction of additional training around the topic; initially by Pharmacists however this will is being considered for roll out to other professions by the Trust Thrombosis Committee
- Review of current medication pre-packs available on wards to facilitate speedier discharge for patients
- Visit to centre of excellence in Sheffield to share initiatives and practices to improve safe use and prescribing of insulin and subsequent review of ward stock lists to replace insulin cartridges with pens
- Project on the 5th floor at Hull Royal Infirmary on utilising, and potentially expanding, the number of pharmacists transcribing discharge prescriptions to contribute to improving morning discharge figures
- A Task and finish group set up to produce medicines management competencies for registered nurses

Further improvements identified:

Further improvements in Medicines Optimisation have been identified and it is therefore a quality and safety priority for 2019/20 (see page 72) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.

The focus for further improvements will be to improve key aspects of the medicines management discharge process which will in turn have a positive impact on the experience of many patients at the point of discharge.

Deteriorating Patient

What we aimed to achieve in 2018/19:

The aim of this project is to ensure that the Trust's Recognition of the Deteriorating Patient Policy is fully implemented ensuring patient's observations are completed in a timely manner and where deterioration is detected they are appropriately escalated for medical review and treatment. The project will also support the Trust-wide adoption of the revised National Early Warning Score (NEWS2) by March 2019.

At the start of the project, we aimed to achieve the following specific targets by the end of March 2019 however were discontinued in June 2018:
- Demonstrate improvement on the re-audit of the annual Census Clinical Observation Audit in 2018
- Continue to achieve >85% compliance with the Fundamental Standard Patient Centred Care

The following targets were included and agreed that these would be monitored until March 2019. However, during the year, NEWS2 was launched nationally. The Trust commenced the roll-out programme for NEWS2 and discontinued the performance indicators below whilst NEWS2 was embedded:
- Improve compliance with a NEWS Score 1-4 with documented escalation in the Census Audit
- Improve compliance with a NEWS Score 5-6 with documented escalation in the Census Audit
- Improve compliance with a NEWS Score 7+ with documented escalation in the Census Audit

Actual outcome:

As stated above, the targets for this project were discontinued in year and are therefore not reported within this review. It should be noted that whilst the specific performance indicators were not measured the improvements achieved are detailed in the following section e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project moved towards the focus on the delivery of NEWS2. Key improvements were:
- Rollout of NEWS2 across the Trust. National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
- Development and ratification of a revised Recognition of the Deteriorating Patient Policy which is compliant with NICE CG50. NICE CG50 is published guidance with the aim to improve the recognition and response to the physical deterioration of patients with the objective to improve physical health provision and outcomes for our patients.
- Updated corresponding deteriorating patient bundle devised for use with appropriate patients
- Over 50% of relevant Trust staff have completed the newly developed NEWS2 training along with a high number of face-to-face training sessions delivered

Further improvements identified:

Further improvements in Deteriorating Patient have been identified and it is therefore a quality and safety priority for 2019/20 (see page 72) and will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.   The focus for further improvements will be to improve the levels of required escalation of deteriorating patients measured by the reduction in the number of incidents rated moderate and above, by ward, Health Group and at Trust Level following the roll out of eObservations. eOberservations is a system that records patient vital signs, via shared mobile devices which is being rolled out across the Trust during 2019.

Avoidable Hospital Acquired Infections

What we aimed to achieve in 2018/19:

The aim of this project was to reduce the number of avoidable hospital acquired infections by ensuring compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) 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.

This priority aimed to achieve the following specific targets by the end of March 2019:
• To have 0 Hospital acquired MRSA bacteraemia
• To not exceed the threshold of 53 for Hospital acquired Clostridium Difficile
• To not exceed the threshold of 44 for Hospital acquired MSSA
• To not exceed the threshold of 73 Hospital acquired E. Coli

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To have 0 Hospital acquired MRSA bacteraemia	1	3	🟥
To not exceed <=99% of threshold of 52 Hospital acquired Clostridium Difficile	38	32	🟩
To not exceed <=99% of threshold of 44 Hospital acquired MSSA	36	59	🟥
To not exceed <=99% of threshold of 73 Hospital acquired E. Coli	110	112	🟥

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

It was noted that the Trust achieved its target in relation to Clostridium Difficile with 32 reported which is a reduction on the 38 reported and well below the <=99% threshold of 52.

The aim of zero hospital acquired MRSA bacteraemia was not achieved, with three reported within 2018/19 which was an increase on 2017/18 figures by two. The threshold of <=99% of 44 hospital acquired MSSA was not achieved, with 59 reported over 2018/19 and was a significant increase on 2017/18 reported figures of 36. In addition, the threshold of <=99% of 73 hospital acquired E. Coli was not achieved, with 112 reported, an increase of two from the 2017/18 annual figure.

E.coli prevalence audit and weekly snapshot audits of Hand Hygiene were completed throughout the year and documentation was reviewed for Infection Prevention and Control bundles and catheter competencies for nursing staff.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. This is due to the work that is still to be completed which will focus on embedding current practice rather than new quality improvement initiatives. The focus will be on a refreshed Infection Prevention and Control strategy and the completion and monitoring of an Infection Prevention and Control Action Plan which is a national requirement of all trusts to have in place. In addition, numbers of hospital acquired infections will continue to be monitored at the Trust Board.

Avoidable Hospital Acquired Pressure Ulcers

What we aimed to achieve in 2018/19:
The aim of this project was to reduce the number of avoidable hospital acquired pressure ulcers. It was also to embed the existing clinical and governance processes for the management of pressure ulcers by ensuring that nursing staff are compliant with training and that lessons are learnt from Root Cause Analysis investigations and incidents.

This priority aimed to achieve the following specific targets by the end of March 2019:
* Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas (Baseline 78.5%)
* All root cause analysis investigations of hospital acquired pressure sores completed within 14 days (Baseline 55.6%)
* Fully quorate at Trust's Wound Management Committee (Baseline - not quorate)

However additional targets were included within the 2018-19 programme:
* 85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas
* To have no avoidable hospital acquired Stage 3 pressure ulcers
* To have no avoidable hospital acquired Stage 4 pressure ulcers
* To have no more than 8 avoidable hospital acquired unstageable pressure ulcers
* To have no more than 23 avoidable hospital acquired SDTI
* To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)
* 100% compliance with duty of candour – written
* 100% compliance with duty of candour – verbal
* 100% compliance with duty of candour – feedback

Actual outcome:
The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas	78.5%	84.9%	🟧
85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas	62.4%	81.4%	🟧
To have no avoidable hospital acquired Stage 3 pressure ulcers	1	0	🟩
To have no avoidable hospital acquired Stage 4 pressure ulcers (target included July 2018)	0	0	🟩
To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	13	9	🟧
To have no more than 23 avoidable hospital acquired SDTI	37	37	🟧
To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)	52	61	🟥
All root cause analysis investigations of hospital acquired pressure sores completed within 14 days	74.5%	84%	🟧
Fully quorate at Trust's Wound Management Committee	Not quorate	Quorate	🟩
100% compliance with duty of candour – written	100.0%	86.4%	🟥
100% compliance with duty of candour – verbal	100.0%	95.5%	🟥
100% compliance with duty of candour – feedback	93.6%	100%	🟩

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project had a number of milestones in place to review and update Health Group reports that were submitted to the Trust's Wound Management Committee in order to record and demonstrate learning. In addition, a scoping exercise was completed to review the number of Tissue Viability link nurses. Health Groups were also requested to include confirmation that all clinical areas have an embedded safety brief twice daily and a daily assessment of high risk patients for pressure ulcers. The aim of these milestones were to ensure that Health Groups reported on these at the Wound Management Committee and appropriate learning was achieved which would in turn drive improvements in the number of reported pressure ulcers.

Further improvements identified:

Further improvements in pressure ulcers have been identified and it is therefore a quality and safety priority for 2019/20 (see page 73) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.

The focus for further improvements will be on the implementation of NHS Improvements national framework as well as to improve the care of patients within the Trust and to reduce the number of avoidable pressure care damage by ensuring that appropriate risk assessments, a plan of care and meaningful interventions are carried out on all relevant patients.

Acute Kidney Injury

What we aimed to achieve in 2018/19:

The aim of this project was to increase compliance with NICE Quality Standard 76 – Acute Kidney Injury (AKI), in order to have a positive impact on patient mortality, morbidity and length of stay, thereby reducing costs per patient. The project aims to increase compliance specifically the following Quality Statements from NICE Quality Standard 76:

- Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.
- Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level and urine output monitored.
- Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

This priority aimed to achieve the following specific targets by the end of March 2019:

- Delivery of the AKI quality improvement project

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Delivery of the AKI quality improvement project	No baseline	Partially delivered*	

* The project sustained some delays due to the casenote review element of the re-audit taking longer than expected. As such, the project will be continued into 2019/20 to review the findings from the re-audit and additional milestones agreed if required. However, this project has been rated as Green due to all elements of improvement work having been completed within year.

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

During the project term, the lead delivered training on Acute Kidney Injury, and how it impacts on patient mortality, morbidity and length of stay, to selected clinical groups within key areas of the Trust, including, the Renal Department and Acute Assessment Unit, along with targeted training delivered to Junior Doctors at their induction. An Acute Kidney Injury toolkit was developed for use on the acute medical unit to be used alongside the training.

Further improvements identified:

Further improvements in Acute Kidney Injury have been identified and it is therefore a quality and safety priority for 2019/20 (see page 73) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.

The focus for further improvements will be the completion of the report following the re-audit to ascertain the improvements made by completing the training and developing the toolkit. Compliance with the NICE Quality Standard 76 Quality Statements 2, 3 and 4 will be assessed and additional actions if required will be part of the 2019/20 project.

Patient Falls

What we aimed to achieve in 2018/19:
The aim of this project was to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the Multi Factorial Assessment Tool (MFAT). It also focused on the outcomes for the patient following a fall to learn lessons from the root cause analysis investigations completed along with the achievement of compliance with the MFAT which will drive forward improvements in falls prevention.

This priority aimed to achieve the following specific targets by the end of March 2019:
- To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above (Baseline 0.17)
- To further reduce the number of patient falls per 1000 bed days for patient falls (Baseline 7.47)
- Continue to achieve >50% of clinical staff in the identified high risk areas to have completed the falls prevention e-learning
- To reduce the number of falls resulting in a fracture neck of femur (Baseline 27)

Actual outcome:
The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	0.17	0.161	🟩
To further reduce the number of patient falls per 1000 bed days for patient falls	7.47	7.30	🟩
To reduce the number of falls resulting in a fracture neck of femur	27	16	🟩
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H9	50%	100%	🟩
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H90	60%	47.1%	🟥
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H8/80	81%	78.8%	🟩
50% of registered and non-registered nurses to have completed the falls prevention e-learning For EAU	61%	57.1%	🟩
50% of registered and non-registered nurses to have completed the falls prevention e-learning For C29	16%	22.6%	🟧
50% of registered and non-registered nurses to have completed the falls prevention e-learning For C31	62%	50%	🟩
50% of Allied Health Professionals to have completed the falls prevention e-learning	17%	15.9%	🟥

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:
The project, whilst not achieving all performance indicators, has achieved the overall aim, which is to be compliant with NICE guidance. This is evidenced by the annual achievement of a reduction in number of falls per 1000 bed days including those rated moderate or above, and a reduction in the number of fractured neck of femurs reported. The project also developed focussed action plans for high risk falls areas including Department of Medical Elderly and Oncology and a new Multi Factorial Assessment Tool (MFAT) documentation and review of falls prevention care bundle. Following this, the Falls NICE guidance was reviewed and compliance assured.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. However it was identified that auditing of compliance with NICE and subsequent falls documentation will form part of the focus for 2019/20 for the Trust Falls Committee.

Sepsis

What we aimed to achieve in 2018/19:

The aim of this project was to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients on the sepsis pathway across the organisation. In addition, the focus will be on the development of appropriate coding for patients.

This priority aimed to achieve the following specific targets by the end of March 2019:
- The percentage of patients who met the criteria for sepsis screening and were screened for sepsis (Baseline of inpatient 92% and ED 87%)
- The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour (Baseline of inpatient 64.7% and ED 55.6%)
- To improve the number of staff completing Sepsis and Observations training (SOBs) training (target included in July 2018)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Inpatient	92.0%	85.2%	🟥
2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Emergency Department	87.0%	94%	🟩
2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour – Inpatient	64.7%	73.5%	🟧
2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Emergency Department	55.6%	52.2%	🟥
To improve the number of staff completing SOBs training	1188	1705	🟩

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of the project was to continue the education, increase awareness and understanding within the Trust of how to recognise sepsis and the management of patients using the sepsis pathway. The project has achieved the aim as demonstrated by the completion of the majority of agreed milestones around training of staff, the attendance and production of several key awareness events and the continued increase in nursing staff trained between April and December 2018:
- A number of training sessions and awareness events were facilitated or attended by the Trust Sepsis Team, including the Regional Conference and Patient Safety Congress
- Numbers of nursing staff trained rose from 1223 in April 2018 to 1705 in December 2018
- A coding project was commenced following discrepancies with the incidences of sepsis and the clinical reviews. This was contributed to by the over diagnosis of sepsis. The Sepsis Team wanted to further understand how the diagnosis made by clinicians is converted into coding and how it affects the funding for the patients care. A pilot was developed and the Sepsis and Coding Teams reviewed notes. This has resulted in a more accurate reporting of sepsis for the Trust and a greater understanding of sepsis
- Since the appointment of the Sepsis Team there have been dramatic improvements in the Trusts CQUIN figures resulting in the Trust receiving a letter from NHS England congratulating on the results.

The project did not meet a number of the targets for a number of reasons. During 2018/19 the way that the data was collected for the CQUIN audits changed and a wider more random s maple of patients were reviewed, using the criteria of patients scoring a NEWS of 5 rather than focusing on those which were admitted with 'sepsis'. In addition, the pressures which the Trust's Emergency Department managed during the winter period have impacted on the ability to deliver Intravenous (IV) antibiotics within the hour. The results show that whilst screening within inpatient areas was not optimum, the management of sepsis patients once identified has improved on last year's figures for the same time period. When the audit data was reviewed, it was found that, in general, the majority of patients received IV antibiotics within an acceptable time period although not within the hour.

The Trust's Sepsis Team are continuing to review the audit data to provide focused education for specific areas and clinical staff whilst promoting positive feedback to staff who have shown good sepsis identification or management. The introduction of more electronic clinical systems across the Trust over 2019/20 such as ePrescribing and eObservations will also improve audit results.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. However it was identified that some improvements are required around the CQUIN results. This will continue to be monitored by the Trust Sepsis Team and further projects considered if specific improvements are required.

Avoidable Mortality

What we aimed to achieve in 2018/19:

The aim of this project was to aid the organisation in the delivery of the national objective of a standardised approach to review of hospital mortality. This project prepared the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.

This priority aimed to achieve the following specific targets by the end of March 2019:
• Review all deaths where family, carers or staff have raised a concern about the quality of care provision.
• Review all deaths of patients who are identified to have a learning disability and/or severe mental illness*
• Review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.
• Review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.
• To move towards learning from patient morbidity, in addition to mortality. The Trust Mortality Committee was renamed, with a new terms of reference written to reflect this move towards learning from morbidity *and* mortality.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To review all deaths where family, carers or staff have raised a concern about the quality of care provision.	No baseline	100%	
To review all deaths of patients who are identified to have a learning disability and/or severe mental illness	No baseline	100%	
*The Trust has signed up to the Learning Disabilities Mortality Review Programme (LeDeR). Deaths of patients with learning difficulties are reviewed under this framework, which was developed by the University of Bristol.	No baseline	100%	
To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.	No baseline	100%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The avoidable mortality project has made significant progress during 2018/19. Key areas of improvement have focused on:
• Development of a standardised "quarterly themes and trends" report template, to be completed by selected Specialties
• Implementation and development of the Surgical Mortality Steering Group
• System-wide reviews commissioned and undertaken by the Trust, collaborating with the Hull CCG and CHCP.
• Focussed Structured Judgement reviews commissioned and undertaken, focusing on the deteriorating patient.
• Initial Mortality Screening form developed and launched within selected Medicine Health Group Specialties.
• E-learning package designed and rolled out, for use in training Structured Judgement reviewers and implemented for all relevant staff to access on HEY247, which is a Trust internally managed education system for all staff to access and complete training.

- Further reviews commissioned and undertaken surrounding end of life planning, in particular, planning for end of life for patients who are admitted to the Trust from a care home.
- Inclusion of palliative care Consultants at the Trust Mortality and Morbidity Committee.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. The role of the upcoming Trust Medical Examiner will allow for full scrutiny to be applied to all in-hospital deaths. The Trust aims to implement the Medical Examiner role from April 2019.

Transition between Paediatric and Adult care

What we aimed to achieve in 2018/19:

The aim of this project was to ensure there are effective and robust processes in place for young people who transition to the adult care services.

This priority aimed to achieve the embedding of the procedural document ensuring the effective transition for young people to adult services by the end of March 2019.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Procedural document ensuring the effective transition for young people to adult services embedded	No baseline	Assurance received	🟩

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of this project was to ensure there are effective and robust processes in place for young people who transition to the adult care services following concerns raised at the February 2014 CQC inspection which required the Trust to improve its processes and services for the transition of children and young people to adult services. The report completed by the lead evidenced compliance with the toolkit and Transition guideline, although numbers were minimal. One recommendation was made, which was to amend the current Trust Transition guideline to allow the use of other nationally recognised transition toolkits as required, for example 'Goals for Diabetes'.

The key milestone for the project was to establish a baseline review of compliance following the implementation of the 'Ready Steady Go' toolkit within the Trust. This was completed, along with the amendment to the guideline which was identified as a recommendation of the review. The lead has also completed a re-review of the NICE Guidance for Transition, although a formal BCR will be completed at a later date.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority due to the achievement of the aim.

Patient Experience

What we aimed to achieve in 2018/19:

The aim of this priority was to seek and act on feedback from our patients their relatives and carers. This will enable the Trust to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes.

This priority aimed to achieve the following specific targets by the end of March 2019:
- Continue to achieve >85% of formal complaints closed within the 40 day target and actions recorded where appropriate
- To reduce the number of repeat complaints by 20% <83

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Continue to achieve =>85% of formal complaints closed within the 40 day target	92.85%	86%	
To Reduce the number of repeat complaints by 20% <83	104	102	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project performed well with 86% formal complaints closed within 40 days for 2018/19 and a total of 102 repeat complaints for 2018/19 which was a slight reduction on the baseline of 104 although did not meet the target of a reduction of 20%. The project completed a number of milestones throughout the year to increase volunteer numbers and volunteer contribution onto the ward and specific work streams including falls prevention. Interpreter services were also a focus and a reduction in spend was achieved along with the Trust interpreter policy reviewed. Focussed training for ward staff was also delivered by the Trust Patient Experience Team.

Further improvements identified:

Further improvements in patient experience have been identified and it is therefore a quality and safety priority for 2019/20 (see page 75) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 62-65.

The focus for further improvements will be:
- Improved patient engagement with new and existing groups
- Increased engagement with key staff groups to review how complaints can be prevented
- Focussed engagement with key wards and senior nursing teams to implement patient engagement initiatives
- Increasing the profile of the Staff Advice and Liaison Service (SALS) to disseminate learning, themes and trends
- Increasing the profile of existing interpreter provision

Part 3: Review of our Quality Performance

This section includes:

- **Trust performance for 2017/18 and 2018/19 against the NHS Outcomes Framework quality indicators and planned actions the Trust intends to/has taken to improve performance**
- **Learning from Deaths**
- **Seven Day Services**
- **An overview of the patient safety incident reporting rates and actions taken to improve incident reporting across the organisation**
- **An overview of serious incidents and never events and actions taken to learn lessons**
- **Trust compliance with the national patient safety alerts**
- **NHS Staff Survey Results and Cultural Transformation**

The NHS Outcomes Framework: Quality Indicators

What is the NHS Outcomes Framework?

Measuring and publishing information on health outcomes are important for encouraging improvements in quality. The White Paper: *Liberating the NHS* outlined the Coalition Government's intention to move the NHS away from focusing on process targets to measuring health outcomes.

The NHS Outcomes Framework reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. Performance against the quality indicators that are relevant to Hull University Teaching Hospitals NHS Trust are detailed below. They relate to:
- Summary hospital level mortality (SHMI)
- Patient reported outcome measures (PROMS)
- Readmission rate into hospital within 28 days of discharge
- The Trust's responsiveness to the personal needs of our patients
- Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- The C.Difficile infection rate, per 100,000 bed days
- The number of patient safety incidents reported and the level of harm

The Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
- Performance information is consistently gathered and data quality assurance checks made as described in the next section.

The table below details performance against the Summary hospital level mortality (SHMI):

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
• the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period*	109	108	100	69	126
• the banding of the SHMI for the Trust for the reporting period*	2	2	2	3	1
• the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	26.7%	27.9%	33.6%	59.5%	14.3%

*Most recent data on NHS Digital for period October 2017 - September 2018, published in February 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
- Avoidable mortality was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2018/19 can be found on page 23-24.
- The Trust has met all requirements of the NHS Improvement Learning From Deaths Outcome Framework.
- The Trust has prepared for the introduction of the Medical Examiner role from the 1st April 2019.

The table below details performance against the Patient Reported Outcome Measures (PROMs):
Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, in England, based on responses to questionnaires before and after surgery. NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

Along with the evidence found in the consultation, the rationale for this decision is that:
• Surgical treatment of varicose veins is currently much less frequent and the condition is usually not a major cause of patient debility;
• Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there is no condition-specific PROM for groin-hernia surgery, means that the existing PROM has limited value.

Prescribed Information	2017/18 Finalised Data	2018/19	National Average	Best performer	Worst performer
• groin hernia surgery EQ-5D Average health gain	0.131	--	--	--	--
• varicose vein surgery EQ-5D Average health gain	***	--	--	--	--
• hip replacement surgery EQ-5D Average health gain (Primary)*	0.476	0.454	0.468	0.566	0.372
• hip replacement surgery EQ-5D Average health gain (Revision)*	***	0.237	0.289	0.380	0.141
• hip replacement surgery Oxford Hip score Average health gain (Primary)*	22.9	22.8	22.7	26.3	18.3
• hip replacement surgery Oxford Hip score Average health gain(Revision)*	***	11.5	13.9	17.7	10.7
• knee replacement surgery EQ-5D Average health gain (Primary)*	0.302	0.32	0.338	0.417	0.233
• knee replacement surgery Oxford Knee score Average health gain (Primary)*	17.1	16.8	17.3	20.6	13.0
• knee replacement surgery EQ-5D Average health gain (Revision)*	***	0.272	0.292	0.328	0.196
• knee replacement surgery Oxford Knee Score Average health gain (Revision)*	***	13	13.1	15.6	9.4

* Most recent (Finalised) data From NHS Digital covers April 2017 – March 2018 published in February 2019
***Average health gain could not be calculated as there were fewer than 30 modelled records
-- NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
• The Trust will focus its attention to improving compliance with the PROMs and improving outcomes for patients. A consultant lead and a Governance lead has been assigned to monitor compliance with the PROMS targets and to undertake improvement work. Further information on actions taken and achievements will be reported in next year's Quality Account.

The table below details performance against the Readmission rate into hospital within 28 days of discharge

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
• the percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	9.1%	9.0%	8.8	0.2	16.8
• the percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	7.3%	7.6%	7.7	0.4	11.1

* Taken from CHKS for period April 2018 to December 2018

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
• The Trust will continue to monitor performance against this indicator and will undertake any improvement work if required.

The table below details performance against the Trust's responsiveness to the personal needs of our patients

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
The Trust's responsiveness to the personal needs of its patients during the reporting period.	66.0	68.5	68.6	85.0	60.5

* Most recent data from NHS digital covers August 2017 - January 2018, published in August 2018

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
• Patient experience was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2017/18 can be found on page 26.
• Patient experience has been identified as a quality and safety priority again for 2019/20, which can be found on page 75.

The table below details performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	67.32%	84%	81%	100%	52%

* Most recent data from NHS England covers July 2018 – September 2018 (Cumulative), published in November 2018

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
• The Trust continues to undertake improvement work to improve the NHS Staff Survey results for staff engagement, bullying and harassment and experiences of working for Hull University Teaching Hospitals NHS Trust. An update on the work undertaken during 2018/19 can be found on pages 39-40.

The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	90.34%	92.04%	95.59%	100%	71%

* Most recent data from NHS England covers April 2018 - December 2018 (Cumulative), published in March 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
- VTE was a quality and safety priority for 2018/19 and progress has been made. Coding of patients and relevant cohorting has been reviewed. Health Groups and lead Medical Directors continue to monitor the position closely. In order to make further improvements, individual actions from wards are being managed through the medical leadership. VTE will continue to be a priority in 2019/20, which can be found on page 73.

The table below details performance against the C.Difficile infection rate, per 100,000 bed days

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
The rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	13.2	11.4	13.7	0.0	91.0

* Most recent data from Gov.uk Statistics covers April 2017 - March 2018, published in July 2018

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
- Avoidable hospital acquired infections was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2018/19 can be found on page 15.

The table below details performance against the number of patient safety incidents reported and the level of harm

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
• the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,	58.5	51.3	45.5	158.3	14.9
• the number and percentage of such patient safety incidents that resulted in severe harm or death	0.10	0.56	0.27	0	4.34

* Most recent data from NHS Digital covers October 2017 – March 2018, published in November 2018

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:
- Learning from incidents and a breakdown of results and actions being taken can be found on page 35.

Learning from deaths update

This section provides an update against the prescribed information for learning from deaths, as well as an update on other key areas of work that have taken place to identify quality improvement both within the Trust and across the wider, more complex system of health care providers.

	Prescribed Information	Trust update
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure	During 2018/19, 2290 of Hull University Teaching Hospitals NHS Trust patients died within the hospital setting. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 523 in the first quarter • 532 in the second quarter • 621 in the third quarter • 614 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure	By April 1st, 2019, 315 case record reviews and 12 investigations have been carried out in relation to 2290 of the deaths included in item 27.1. Any Serious Incident investigation where the patient has died will incorporate a full case note review. In 12 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 4 in the first quarter • 2 in the second quarter • 3 in the third quarter • 3 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this	12 deaths, representing 0.52% of the total patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • representing 0.53% for the first quarter • representing 0.37 % for the second quarter • representing 0.48% for the third quarter • representing 0.47% for the fourth quarter These numbers have been estimated by consideration of all Serious Incidents that occurred within the reporting period, where patient death was likely to be due to problems in the care provided.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3	The following themes were identified from case reviews and investigations, where problems in care were more likely than not to have contributed to the patient death: • Sub-optimal care of deteriorating patient • Delay in the identification and treatment of Sepsis • End of life care
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see	The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include: • Deteriorating Patient Quality Improvement Project commenced for 2019-20 • Revised policy, "CP326 – Recognition of the Deteriorating

Prescribed Information		Trust update
	item 27.4)	Patient Policy" • Sepsis Awareness Campaign launched • Introduction of the ReSPECT form
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period	Assessments of the impacts of actions mentioned in 27.5 are currently ongoing and will form part of the Quality Improvement Plan for 20199-20
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	0 case record reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of 2018/19.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this	0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Seven day Services in the NHS

What does it mean to provide seven day services?

Seven day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. The seven day services programme is designed to improve hospital care with the introduction of seven day consultant-led services that are delivered consistently over the coming years.

10 clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are the four standards that all NHS Trusts must adopt and implement by 2020. Implementation of these standards is monitored by NHS Improvement.

The four standards are:
- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – On-going review by consultant twice daily if high dependency patients, daily for others

What do seven day services mean to patients?

Implementation of the four priority clinical standards will ensure patients:
- Do not wait longer than 14 hours to initial consultant review
- get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- get access to specialist, consultant-directed interventions
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

Monitoring of the Clinical Standards at Hull University Teaching Hospitals NHS Trust

The Trust has undertaken a stocktake of progress against compliance with the four priority clinical standards and is working to achieve full compliance.

Standard	Compliance	Actions to address
Standard 2 Time to First Consultant Review	Partial compliance	Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system. Undertake specific work with each specialty to address shortfalls in delivery.
Standard 5 Diagnostic Services	Partial compliance	Recruitment to vacant posts Outsourcing of radiology reporting and development of in-house overnight reporting services to improve reporting turnaround times. Increased CT/MRI capacity through redevelopment of the ground floor of the Tower Block and purchase of additional CT/MRI scanners
Standard 6 Consultant-directed interventions	Fully compliant	
Standard 8 On-going review	Partial compliance	Review of medical staffing resource in key areas, including recruitment to vacant posts and review of job plans. Adoption of a standardised model for the identification of those patients requiring/not requiring a consultant review.

Patient Safety Incidents

The Trust encourages incident reporting and believes that a strong incident reporting culture (i.e. a high level of incident reporting), is a sign of a good patient safety culture.

Figure 1 is taken from the latest NHS England National Reporting and Learning Service (NRLS) data report published March 2019. This shows our incident reporting rates compared to other acute Trusts of a similar size. Our Trust is highlighted below and shows no evidence for potential under-reporting of incidents.
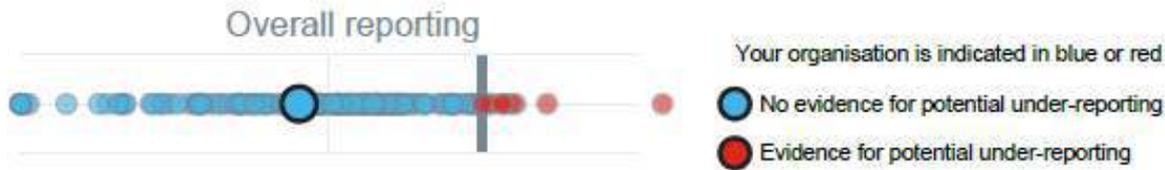
The NRLS report states that incident reporting patterns should be interpreted alongside other information such as our NHS Staff Survey results on reporting culture and practice.

The Trust's 2018 NHS Staff Survey results, again published in March 2019, has shown improvements around how our staff feel about our patient safety culture, including that more staff now feel that;

✓ *We treat staff involved in an error, near miss or incident fairly*

✓ *When errors, near misses or incidents are reported, we take action to ensure that they do not happen again*

✓ *Staff are given feedback about changes made in response to reported errors, near misses and incidents*

Figure 2; extract from 2018 Staff Survey Results

Q17a	2015	2016	2017	2018
Best	64.1%	64.3%	64.9%	69.5%
Your org	54.1%	53.4%	55.8%	58.5%
Average	52.1%	53.7%	54.3%	58.5%
Worst	39.1%	37.6%	39.5%	42.8%

Q17c	2015	2016	2017	2018
Best	80.7%	76.6%	76.1%	82.3%
Your org	65.6%	69.4%	70.6%	75.0%
Average	67.1%	68.2%	68.6%	69.9%
Worst	52.0%	54.7%	52.2%	55.8%

Q17d	2015	2016	2017	2018
Best	63.2%	72.9%	71.4%	72.0%
Your org	52.8%	60.3%	63.1%	68.8%
Average	53.2%	54.9%	56.4%	58.9%
Worst	39.5%	40.9%	41.1%	43.2%
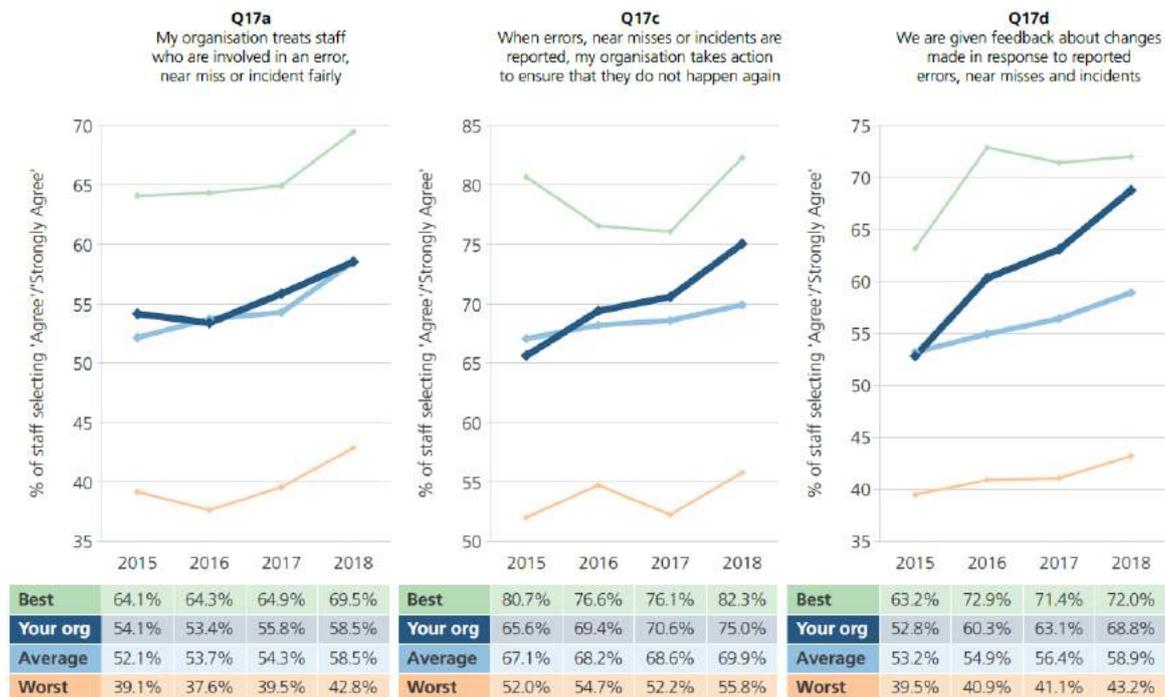
Serious Incidents and Never Events

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Some Serious Incidents are called Never Events. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Figure 3: Total number of Never Events and Serious Incidents (SIs) declared 2016/17, 2017/18 and 2018/19:

	2016/17	2017/18	2018/19
Total Never Events declared	2	6	0
Total Serious Incidents declared	67	63	72
Total*	**68**	**69**	**72**

* Excludes any which have been de-escalated from Serious Incident status

Types of Serious Incident (SI) and Never Events declared during 2016/17, 2017/18 and 2017/18

Serious Incident type	2016/17	2017/18	2018/19
Treatment Delay	17	11	13
Treatment Delay – lost to follow up *(extracted as own category from 2017/18)*	-	8	0
Patient Fall	8	2	3
Delayed Diagnosis	2	1	8
Pressure Ulcer	4	8	7
Surgical/Invasive Procedure incident	2	7	3
Sub-optimal care of the deteriorating patient	8	3	6
12 hour ED trolley breaches	0	0	0
Drug Incident	2	1	4
Unexpected Death	10	10	8
HCAI/Infection Control Incident	1	1	0
Never Event – Retained Foreign Object	0	0	0
Never Event – Wrong Site Surgery	1	3	0
Never Event – Misplaced Naso-gastric Tube	1	0	0
Never Event – Wrong Implant	-	1	0
Never Event – Surgical Invasive Procedure	-	1	0
Never Event – Medication Incident	-	1	0
Retained dressing (not a Never Event)	0	0	0
Retained foreign object (not a Never Event)	2	0	1
Wrong Site Surgery (not a Never Event)	0	0	1
Unplanned NICU admission	2	4	1
Absconded Patient	3	0	0
Maternity/Obstetric Incident *(prior to 17/18 these SI's were reported under different categories)*	-	5	8
Others	6	0	9
Totals	**68**	**67**	**72**

The Trust has not declared a Never Event in 2018/19. This is following the Trust declaring 6 Never Events in 2017/18; more than in any other previous reporting period. Following this increase in Never Events during 2018/19 the Trust put in place actions to improve our patient safety culture and minimise the possibility of a Never Event occurring, including developing a 'Stop the Line' policy which empowers all staff to stop a procedure if they witness unsafe acts.

The Trust believes that being able to achieve a year without a Never Event shows how we have learnt from our previous Never Events, and reflects improvements in our patient safety culture.

One of the ways the Trust is improving its patient safety culture is by adopting the 'Just Culture' approach to staff involved in incidents. Just Culture is a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. The Trust wants to ensure that staff feel supported when mistakes do happen, which will allow for lessons to be learned so that the same errors can be prevented from being repeated.

The Quality Governance and Assurance Department are launching a new way of supporting staff involved in Serious Incidents. Second Person Support Team is a group of Trust staff who will act as a support or listening ear to staff who have been involved in a Serious Incident/Never Event and would like someone to support them through the process, helping them understand about the investigation procedures. This does not replace line management or Occupational Health support. It can be very traumatic for staff to be involved in a serious incident, and then to have to go an investigation process and it is hoped this new service will act as some additional support to staff.

The Serious Incident investigations continue to improve in quality and in the outcome of investigations, including action plans which are implemented to prevent further incidents of harm occurring. The Quality Governance and Assurance Department have throughout the year, worked to improve how patients and their families are involved in the investigations. Patients and their representatives are regularly invited to ask questions to the investigation panel, the answers to which are incorporated into the final report. Meetings are often held with patients and their representatives during and following investigations to allow them to be part of the investigation.

We will continue to be open and honest when Serious Incidents, and Never Events, do occur, to ensure that these are fully investigated, with appropriate actions taken as a result. The Trust is committed to providing the best care to our patients and our responses to the Serious Incidents and Never Events are much improved and the learning and actions arising from the investigations is helping to improve the patient safety within the organisation.

Patient Safety Alert Compliance

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the NRLS and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

NHS Improvement issue three types of alert, Warning Alerts issued in response to new or under-recognised patient safety issues which ask healthcare providers to take constructive action to reduce the risk of harm occurring; Resource Alerts issued in response to already well-known issues which ask health care providers to plan implementation of new resources and Directive Alerts, issued because a specific, defined action to reduce harm has been developed which can be widely adopted through standardisation of practice or equipment.

Coordination of patient safety alerts is carried out by the Quality Team who work with various Trust departments and Health Groups to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

NHS England NPSAS alerts issued 2017/18 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/W/2018/002	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	17-Apr-18	31-May-18	Action complete and matter resolved
NHS/PSA/RE/2018/003	Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)	25-Apr-18	21-Jun-18	Action complete and matter resolved
NHS/PSA/RE/2018/004	Resources to support safer modification of food and drink	27-Jun-18	01-Apr-19	Action complete and matter resolved
NHS/PSA/RE/2018/005	Resources to support safer care for patients at risk of autonomic dysreflexia	25-Jul-18	25-Jan-19	Action complete and matter resolved
NHS/PSA/RE/2018/006	Resources to support the safe and timely management of hyperkalaemia (high level of potassium in the blood)	08-Aug-18	08-May-19	Action required: On-going
NHS/PSA/RE/2018/007	Management of life threatening bleeds from arteriovenous fistulae and grafts	12-Nov-18	13-May-19	Action required: On-going
NHS/PSA/RE/2018/008	Safer temporary identification criteria for unknown or unidentified patients	05-Dec-18	05-Jun-19	Action required: On-going
NHS/PSA/W/2018/009	Risk of harm from inappropriate placement of pulse oximeter probes	18-Dec-18	18-Jun-19	Action required: On-going
NHS/PSA/D/2019/001	Wrong selection of orthopaedic fracture fixation plates	11-Feb-19	10-May-19	Action required: On-going

NHS Staff Survey and Cultural Transformation

NHS Staff Survey Results 2018

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%.

In previous national staff surveys 32 key themes were identified. This has been reduced to 10 in the 2018 survey. Each key finding is comprised of a cluster of questions, which can be found in the full version of the Trust's report, which was published in March 2019.

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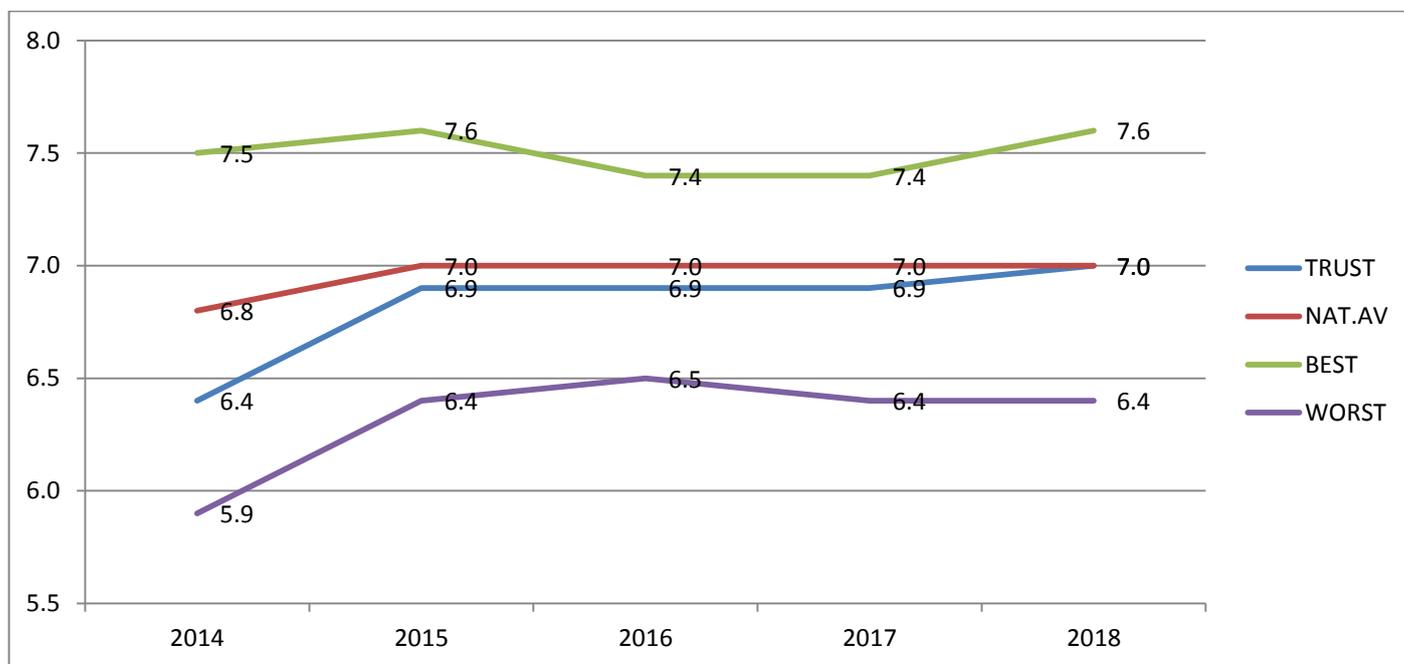
For the nine component questions the Trust improved on all but two. Once again the lowest score is staff saying they are able to make improvements happen, which correlates with the cultural survey in 2017 where staff described the Trust as overly bureaucratic and hierarchical.

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.

Part 4: Statistics of Assurance from the Board

This section includes:

Statements of assurance from the Board (the contents of these statements are prescribed). Statements include:
- Review of services
- Participation in clinical audit
- Participation in clinical research
- Goals agreed with commissioners
- What others say about the Trust – Care Quality Commission
- Quality Improvement Plan
- Care Quality Commission – Duty of Candour
- Data quality, information governance and clinical coding error rates

Statements of Assurance from the Board

Review of services

During 2018/19 the Hull University Teaching Hospitals NHS Trust provided 43 NHS services within 5 Health Groups and 15 Divisions.

The Hull University Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 43 of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by the Hull University Teaching Hospitals NHS Trust for 2018/19.

Participation in clinical audits

During 2018/19, 55 national clinical audits and 2 national confidential enquiries covered NHS services that Hull University Teaching Hospitals NHS Trust (formerly Hull University Teaching Hospitals NHS Trust) provides.

During that period Hull University Teaching Hospitals NHS Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

For those national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2018/19, the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are listed in the last column:

Audit	Participated	% of Cases Submitted
Peri- and Neonatal		
National Neonatal Audit Programme (NNAP)	Yes	Data submission closes 30 April 2019
National Maternity and Perinatal Audit (NMPA)	Yes	Data submission closes 30 April 2019
Children		
Feverish Children (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Paediatric Intensive Care (Paediatric Intensive Care Audit Network - PICANet)	Yes	Data submission closes 30 April 2019
National Paediatric Diabetes Audit (NPDA)	Yes	Data submission closes 30 April 2019
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data submission closes 30 April 2019
Blood and Transplant		
Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%
Acute care		
Seven Day Hospital Services	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	Data submission closes 30 April 2019

Audit	Participated	% of Cases Submitted
Non-Invasive Ventilation – Adults (British Thoracic Society)	Yes	Data submission closes 31 May 2019
National Asthma and COPD Audit Programme	Yes	Data submission closes 30 April 2019
Vital Signs in Adults (care provided in Emergency Departments – College of Emergency Medicine)	Yes	100%
VTE Risk in Lower Limb Immobilisation (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	Data submission closes 31 May 2019
National Audit of Care at the End of Life (NACEL)	Yes	100%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
Diabetes in Pregnancy Audit	Yes	Data submission closes 30 April 2019
Diabetes Footcare Audit	Yes	Data submission closes 30 April 2019
National Diabetes Inpatient Audit (NADIA)	Yes	100% (organisational Audit only)
NaDIA-Harms (Diabetic Inpatient Harms in England)	Yes	25% - data being validated
Inflammatory Bowel Disease Programme / IBD Registry	No	The Trust is purchasing the software to take part in 2019/20
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%
BAUS Urology Audit – Female Stress Urinary Incontinence	Yes	Data submission closes 30 April 2019
UK Cystic Fibrosis Registry	Yes	Data submission closes 30 April 2019
Neurosurgical National Audit Programme	Yes	Data submission closes 30 April 2019
National Ophthalmology Audit	Yes	Data submission closes 30 April 2019
National Audit of Dementia	Yes	100%
Elective procedures		
National Joint Registry (NJR)	Yes	Data submission closes 30 April 2019
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Data submission closes 30 April 2019
National Vascular Registry	Yes	Data submission closes 30 April 2019
BAUS Urology Audit - Nephrectomy	Yes	Data submission closes 30 April 2019
BAUS Urology Audit – Radical Prostatectomy	Yes	Data submission closes 30 April 2019
BAUS Urology Audit - Cystectomy	Yes	Data submission closes 30 April 2019
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	Yes	Data submission closes 30 April 2019
Adult Cardiac Surgery Audit (ACS)	Yes	Data submission closes 30 April 2019
National Bariatric Surgery Registry (NBSR)	Yes	Data submission closes 30 April 2019
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	Data submission closes 30 April 2019
National Heart Failure Audit	Yes	Data submission closes 30 April 2019
Cardiac Rhythm Management (CRM)	Yes	Data submission closes 30 April 2019
National Cardiac Arrest Audit (NCCA)	Yes	Data submission closes 30 April 2019

Audit	Participated	% of Cases Submitted
Renal disease		
Renal Replacement Therapy (Renal Registry)	Yes	Data submission closes 30 April 2019
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	Data submission closes 30 April 2019
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	Data submission closes 30 April 2019
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes	Data submission closes 30 April 2019
National Prostate Cancer Audit	Yes	Data submission closes 30 April 2019
Trauma		
Major Trauma (Trauma and Audit Research Network)	Yes	Data submission closes 30 April 2019
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	100%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
National Audit of Breast Cancer in Older People	Yes	Data submission closes 30 April 2019
Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP)	Yes	Data submission closes 30 April 2019
Infection		
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Pulmonary Embolism	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)		
Maternal Infant and Perinatal Programme (MBBRACE-UK)	Yes	100%

The reports of 26 national clinical audits were reviewed by Hull University Teaching Hospitals NHS Trust in 2018/19 and Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed actions
National audit	
Neonatal intensive and special care (National Neonatal Audit Programme - NNAP)	• To deliver a presentation to both Obstetric and Midwifery teams at the Perinatal Mortality Meeting, highlighting the importance of documenting and giving magnesium sulphate when possible • All staff on the Neonatal Unit and Labour ward should be made aware of the recent changes to equipment and the risk of overheating babies. To put in place practices to ensure the babies temperature is monitored on a regular basis on the labour ward before transferring to the Neonatal Unit • To highlight to nursing staff at monthly Neonatal Unit Meetings the importance of recording parental presence on a ward round on the babies 'Daily Update Sheet.'
National Chronic Obstructive Pulmonary	• To update the Trust Oxygen Policy, in line with Royal College of Physicians

Audit	Proposed actions
Disease Audit (COPD)	(RCP) Guidance • To introduce a new Oxygen training package, in line with the new policy • A proforma for the initiation of non-invasive ventilation (NIV) in the Emergency Department has been introduced, featuring the NIV criteria, ceiling of care, time of initiation and other key information. • For the Acute Respiratory Assessment Service (ARAS) nurses to state clearly during reviews that follow-up arrangements should be clearly documented in the Immediate Discharge Letter (IDL), in order to improve data quality. • To explore the feasibility of visiting GP practices to assist in identifying patients that are receiving suboptimal care, in order to improve readmission rates. • To pursue the possibility of Respiratory Medicine being able to have a protected bed base for COPD patients • All spirometry results are now accessible from all desktop computers in the organisation. Further work is being carried out to ensure that spirometry results from tests carried out anywhere in the Trust are accessible via Lorenzo
Lung cancer (National Lung Cancer Audit)	• To establish when scan data is being logged by the National Team, to assist with identifying potential issues
National Bowel Cancer Audit (NBOCA)	• To add operation notes onto Lorenzo to help improve data capture and submission
Heart failure (Heart Failure Audit)	• To investigate the causes for low referral rate to Heart Failure Nurse follow up – particularly in patients with Left Ventricular Systolic Dysfunction (LVSD) patients
National Diabetes Footcare Audit (NDFA)	• To disseminate results with Vascular Surgery and Imaging to highlight key areas for improvement.
National Diabetes Inpatient Audit (NaDIA)	• To explore the possibility of setting up a mandatory training module for all clinical staff on the subject of diabetes. • To communicate the importance of insulin timing and treatment to staff across the Trust (through Lessons Learned/ Newsletter/ Pattie). • To send a copy of the outcome form / report to the Trust Catering Services Manager, to ensure that the patient feedback included within the report (in relation to catering) is passed on.
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	• To liaise with HICOM and IT Services to agree the pathology interface license for Twinkle system to improve data collection from Lorenzo to Twinkle. • To ensure Micro albumin tests are now being done at the time of clinic appointment in the Paediatrics Department • To undertake a casenote audit to understand if there are any variances in practice between Hull CCG and East Riding CCG patient cohorts.
National Audit of Dementia – Spotlight Audit on Delirium Assessment	• To carry out a Trust wide teaching session on delirium and dementia • To re-audit the delirium screen and assessment • To arrange a meeting with the Lorenzo team to introduce a section on cognition on the Immediate Discharge Letter to enable transfer of information • To undertake a junior doctor teaching session on delirium recognition and assessment (including history taking) • To provide a teaching session on the importance of filling out the dementia and delirium care bundle

Audit	Proposed actions
National Cardiac Arrest Audit (NCAA)	• To continue to share learning from the NCAA (including ceilings of care and the prescription of appropriate resuscitation) in the Consultant mandatory update training • To continue the implementation and audit of the ReSPECT process
Fractured Neck of Femur (College of Emergency Medicine)	• To provide training for nurses, emphasizing the importance of documenting pain score on handover, as well as ensuring documentation of date and time within the NEWS score. • To implement a mandatory field for the documentation of pain assessment as part of the new Emergency Department digital documentation. • To re-audit against the same standards, incorporating nursing documentation (e.g. NEWS scoring), as this was not included initially. • Business Intelligence data shows that mean performance against the 4 hour target for admission for the past 12 months (ending August 2018) is 82.23% which is an improvement on the audit results of 61%. • To disseminate results of the audit to all Emergency Department staff.
Pain in Children (College of Emergency Medicine)	• To educate staff on carrying out and documenting pain scoring. • To educate staff on the documentation of analgesia given, and the importance of recording a reason wherever analgesia is not given. • To amend the CAS card to include a section for documenting reasons for why analgesia has not been given. • To discuss the possibility of having pain scoring and analgesia added to the triage section of the patient's Lorenzo record. • To implement a system of patient-led evaluation of pain after analgesia. This will include education of nursing staff on the new system and the creation of posters to be shown in patient waiting areas to ensure that patients are aware of the system. • To develop a business case for improved nursing cover, in order to improve triage times. • To disseminate results to all Emergency Department staff, to raise awareness of the issues and key learning points. • To undertake a re-audit and present the results to the Clinical Effectiveness, Policies and Practice Development Committee.
Procedural Sedation in Adults (College of Emergency Medicine)	• To introduce a proforma for patients undergoing sedation in the Emergency Department to ensure all relevant data is recorded
Myocardial Ischaemia National Audit Project (MINAP)	• No further action required
National Audit of Percutaneous Coronary Interventions (PCI)	• No further action required
Sentinel Stroke National Audit Programme (SSNAP)	• To review cases where an eligible patient (according to the Royal College of Physicians guideline minimum threshold) is not thrombolysed • To download Trust data prior to the submission deadlines, in order to review and ensure the quality of the thrombolysis data. • To undertake an audit of swallow screening on the Stroke ward • To communicate with the Stroke Co-ordinators to highlight the need to refer all patients to Speech and Language Therapy that are marked as suffering dysarthria on the NIHSS (National Institutes of Health Stroke Scale)
National Emergency Laparotomy Audit	• No actions identified as the data submission was low and the data

Audit	Proposed actions
(NELA)	therefore inaccurate. 100% of patients have been submitted for 2018.
National Hip Fracture Database	• Theatre space will be increased as of February 2019. A further 7 theatre lists a week are to be available to the trauma service, including a dedicated hip fracture list every day. A new trauma consultant has also been employed. • To speak to anaesthetic lead to determine whether the number of nerve blocks given during a GA can be increased. • To remind the orthopaedic team that intertrochanteric fractures should be treated with a SHS as this is more cost efficient. • To hold 'Time out' sessions to involving the various disciplines contributing to hip fracture care to review patient pathways.
National Vascular Registry	• To present a paper at the Operational Quality Committee, seeking to address the Trustwide issues identified in the report
National Oesophago-Gastric Cancer Audit	• For presentation at the June meeting of the Clinical Effectiveness, Policies and Practice Development Committee
National Audit of Breast Cancer in Older People (NABCOP)	• No further action required
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Perioperative Diabetes	• For presentation at the June meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Cancer Care in Children, Teens and Young Adults	• For presentation at the June meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Acute Heart Failure	• For presentation at the May meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Other Enquiries/Reviews	
MBRRACE-UK Perinatal Mortality Surveillance	• For presentation at the June meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Saving Lives, Improving Mothers' Care	• For presentation at the June meeting of the Clinical Effectiveness, Policies and Practice Development Committee

An update regarding the implementation of the actions identified as a result of a national clinical audit report published in 2017/18 has been provided below. Actions taken in response to reports published in 2018/19 will be included in the Quality Accounts for 2019/20.

Audit	Proposed actions	Progress
National audit		
National Diabetes Inpatient Audit (NaDIA)	• To introduce a formalised foot risk assessment sheet	• Foot care documentation is currently being reviewed, supported by senior ward staff, vascular nurse specialists and podiatry
National Audit of Cardiac Rhythm Management (CRM) devices	• To meet with the Cardiac Physiologists to discuss the best method of ensuring that acute complications are recorded and uploaded • To disseminate the results of the audit to the Cardiac Physiologists and to remind the staff of the importance of submitting complete data	Awaiting confirmation

National Audit of Dementia (NAD)	• To implement 'John's Campaign', enabling carers to stay with patients beyond regular visiting hours (including meal times and overnight)	• This has been implemented Trustwide. Relatives are able to stay over in a room on floor 8 which has a sofabed and ensuite facilities. Carers are encouraged to stay with patients at mealtimes.
	• To carry out a Quality Improvement Programme to improve the recording of dementia / delirium screening on discharge documentation	• A Quality Improvement Programme has been undertaken and will be extended, once the screening process is recorded electronically
	• To introduce nutritional assistants on the Department of the Medical Elderly wards, to better ensure that the nutritional needs of patients are met	• Nutritional assistants were introduced as part of a 1 year apprentice scheme. Currently, trained young volunteers are assisting with nutrition. The menu has been completely reviewed following patient feedback.
	• To provide further training to ward staff to ensure that patients and carers are offered the Butterfly Scheme and John's Campaign	• This training is ongoing, to ensure all staff are aware of the Butterfly Scheme and John's Campaign
	• To raise awareness of the Butterfly Scheme and John's Campaign around the wards through the use of posters and communications	• Ward areas and lift lobbies display posters and the dementia action week 2019 will also be used to drive these campaigns forward
	• To meet with the intranet team to discuss options for publicising the Dementia Champions through the intranet	• All the intranet pages have been reviewed and updated
National Audit of Inpatient Falls (NAIF) (Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• To update the Falls Prevention and Mobility Care Bundle	• This has been completed and is in use on the wards
	• To develop a tailored continence care plan for use in the Department of Medicine for the Elderly	• A care plan is currently being developed to be used across the whole Trust
	• To roll out training for issuing walking aids to patients on admission when appropriate	• E- Learning is now available and some training has also been delivered face to face on the ward. A task and finish group to try and improve training is to be established
	• To carry out falls prevention training to raise awareness of the key issues as highlighted by the audit (lying and standing blood pressure; vision assessment; availability of mobility aids)	• The new E-learning is almost completed. Training is delivered to specific staff groups if requested. All wards have instructions on how to complete lying and standing blood pressure. One of the Department for Medical Elderly consultants is going to undertake a small project on one ward to try to improve this
National Diabetes Audit	• To review the pathway for insulin pump patients, to ensure that insulin pumps are prescribed appropriately	• The pathway has been reviewed and revised
	• To expand the Diabetes Specialist Nurse (DSN) team to release additional DSN resource and to support the management	• The Diabetes Specialist Nurse team has been expanded (2 additional posts) using transformation bid

	• of complex Type 1 patients • To implement System One as a replacement to ProWellness. In relation to the National Diabetes Audit, this will make the data much more reliable and accessible and so improve the usefulness of the audit data	• funding • System One will be implemented on 1 April 2019
National Diabetes Footcare Audit	• To capture all cases of re-ulceration or multiple ongoing ulceration into the audit • To review the Lorenzo podiatry referral page to encourage output referrals and education to team • To review staff resource over next 24 months to aim to enable additional resource for ward foot checks	• Audit forms for all new ulcerations are being completed and all community podiatrists are being encouraged to send forms in • A referral flow chart for Diabetic foot referrals is being developed. Also, documentation for checking Diabetic inpatients feet is being developed. This will then be cascaded to all wards and the referral pathway promoted. • Staff training has been offered but there has been limited uptake due to staffing levels
National Hip Fracture Database (NHFD)	• To define criteria for 120 day follow up • To liaise with the anaesthetic lead regarding nerve blocks	• The criteria has been defined by the national team and the service is considering how best to meet the 120 day follow up • Action complete
National Neonatal Audit Programme (NNAP)	• To audit the group of patients that did not receive a timely parental consultation to identify the underlying reasons for this. • To identify a more proactive way of recognising patients for review which will allow for real time data entry • To provide education and training to reinforce the prescription of Magnesium Sulphate in mothers who deliver babies < 30 weeks of gestation	
National Paediatric Diabetes Audit (NPDA)	• To plan a schedule of regular patient education sessions	• A schedule of patient education sessions have been programmed for the year
National Emergency Laparotomy Audit (NELA)	• To arrange a meeting with Department of the Medical Elderly (DME) regarding the assessments given to patients aged 70 years and over • To employ a data entry clerk	• A meeting has taken place but as yet, there is no funding available to pay for DME input • A clerk has been appointed and 100% participation has been achieved for 2018/19.
National Pregnancy in Diabetes Audit (NPID)	• To raise awareness amongst the team regarding preconceptual care and referral to the 'MOT' • To discuss the possibility of having a	• One of the Consultants in General Medicine and Endocrinology spoke at the Diabetes Hot Topics Day for primary care in May 2018 to promote pre-conceptual care. The team produced small cards to hand out to women of child-bearing age to raise awareness • The Diasend transmitter has been

	'Diasend' machine in the clinic, to review glucose readings • To review the management of gestational diabetes patients, and to establish whether current arrangements are affecting the care of women with T1 / T2 diabetes	purchased • The gestational diabetes maternity pathway remains under review. A meeting has been arranged between the diabetes and midwifery team to discuss how more time can be devoted to pre-existing T1/T2 patients as well as looking after the gestational diabetes patients.
Sentinel Stroke National Audit Programme (SSNAP)	• To remind all staff of the need to ensure documentation of the reasons for why a patient does not fit the Royal College of Physicians criteria for thrombolysis, where applicable • To discuss the pathway for pre-alerts with the Ambulance Service. • To implement a system to enable the Stroke Co-Ordinator to highlight any patients that have been unable to give a formal swallow assessment • To adjust working patterns to provide occupational therapy every day rather than Monday to Friday only • To remind staff of the importance of mood and cognition screening for each patient • To remind staff to discharge patients from the care of Speech and Language Therapy (SLT) promptly when no further therapy is required.	• A recent report shows that the Trust now shows 100% compliance – the service has also reviewed and, where appropriate, made amendments to any patient where data quality has been an issue • This has been discussed with the Ambulance Service • A standalone swallow audit has been undertaken. Recommendations from this are that a swallow screen should be checked as part of the Hyper Acute Stroke Unit admission, if this is not already undertaken by the Stroke Coordinator • A 7 day service with 5 day staffing is now provided • Occupational Therapists have changed their paperwork to appropriately record mood and cognition screen and performance has improved significantly, increasing from 58% in June 2018 to 93% in September 2018 • This is one process, along with others, that is being reviewed on an ongoing basis to see how this affects SLT performance. Recent results have shown an improvement in performance.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Treat As One (Mental Health in General Hospitals)	• To develop an Enhanced Care Team (ECT) for 1 to 1 supervision including patients with mental health needs	• The ECT pilot service has been evaluated and agreement has been reached to roll this out across the Trust as a substantive service. The post of ECT Manager is currently being advertised.
Inspiring Change (Acute Non-Invasive Ventilation)	• To revise the operational policy to meet NCEPOD recommendations • To develop a proforma to ensure the use of acute non-invasive ventilation acts as a flag to consider referral to palliative care	

	services	
Other Enquiries/Reviews		
Perinatal Mortality Surveillance Enquiry -Term, Singleton, Intrapartum Stillbirth and Intrapartum Related Neonatal Death	- To appoint a Bereavement Midwife as lead reporter - To appoint an Obstetric Lead for Stillbirths and bereavement care - To review all stillbirths using a local audit tool	- A bereavement midwife has been appointed as lead reporter - A Consultant has been appointed as lead for stillbirths and bereavement care - All stillbirths are reviewed using the Perinatal Mortality Review Tool
Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015	To use a perinatal mortality review tool by the multidisciplinary team (MDT) for all stillbirths and related neonatal deaths. From reviews, themes will be highlighted and action plans devised and disseminated	Perinatal Mortality Review Tool implemented and used by the MDT. Lessons learnt shared with the wider team and actions put in place. Quarterly report submitted to the board (as per CNST maternity incentive scheme).

The reports of 260 local clinical audits were reviewed by the provider in 2018/19 and Hull University Teaching Hospitals NHS Trust. For a full list of the proposed actions Hull University Teaching Hospitals NHS Trust intends to take following local audits reviewed during 2018/19, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: **quality.accounts@hey.nhs.uk** or reviewed online via the Quality Accounts page at: **www.hey.nhs.uk/qualityaccounts**

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was 5,317.

Commitment to research as a driver for improving the quality of care and patient experience
The Trust is committed to providing the best possible care to patients and recognises the value of high quality peer-review research as a fundamental tool in the successful promotion of health and well-being for the population it serves. To achieve this, the Trust has focused on research activity which addresses NHS priorities, is of national and international quality and is cost-effective.

Every study the Trust participates in will, in some way, have a direct or indirect benefit to institutions, staff, patients, carers, policy makers and academics. The collective benefits for our population of participating in research include more personalised, protocol driven care with often more frequent oversight of clinical outcomes and safety assessments. Frequently, research participation allows for increased interactions between clinical staff and patients, providing more time to make assessments of patients' needs and anxieties and therefore supporting a trusting relationship to flourish.

Research portfolio and activity
The Trust was involved in processing 127 new clinical research studies of which 73 commenced during the reporting period 2018/19. In total 99 studies opened in the reporting period. This compares with 105 new submissions and 96 commencing in 2017/18. The Trust used national systems to manage the studies in proportion to risk. Of the 99 studies given permission to start, 80 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 142 studies actively reporting accruals (patient recruitment) under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 171 portfolio studies reporting accruals for the period 2017/18.

The number of recruits into the Trust portfolio studies for the periods 2018/19 and 2017/18 was 4,210 and 7,312 respectively. A target of 6,000 patient accruals has been set for 2019/20. The largest topic area of portfolio adopted studies across 2018/19 is Oncology (Cancer) and Haematology with 39 studies between them. The top five therapeutic areas of Trust research in 2018-19 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (39)
2) Cardiovascular (27) (Cardiology Int + Academic, Cardiothoracic, Diabetes, Vascular, Respiratory)
3) Gastroenterology and Hepatology (17)
4) Musculoskeletal (9)
5) Renal Disorders (8)

64% of commercial portfolio studies completed in 2018/19 recruited on time and to an agreed target. This has helped the Trust maintain a strong relationship with pharmaceutical and medical device companies that allows us to be part of offering novel technologies and treatment to our patients in more and more therapeutic areas.

In the last year, over 168 publications, abstracts and book chapters have resulted from our involvement in portfolio and non-portfolio research across nine specialty areas (Vascular, Diabetes, Oncology, Haematology, Neurosurgery, Ophthalmology, Dermatology, Neurology, Cardiology, Hepatology, Renal and microfluidics). This shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Research impact
Demonstrating specific project outcomes and impact through research for the population we serve is fundamental. Below are some examples of the difference research participation has made to patient outcomes and changes in service delivery at Hull University Teaching Hospitals NHS Trust:

Ophthalmology:
The teams' research successes are that they continue to deliver a large number of clinical trials within Ophthalmology including several industry funded IMP studies testing new therapies for wet AMD and diabetic maculopathy - both common causes of blind registration within the western world.

The team has an excellent track record of recruiting to time and target and have over-recruited to several studies whilst providing invaluable expertise in supporting the ophthalmology aspects of the management of a number of oncology research participants.

The main aim for the next 12 months is to expand the Ophthalmology substantive research team to avoid turning down many industry funded studies yearly due to lack of capacity. As part of this we aim to involve more newly appointed clinicians in research, building on our success this year of training and delegating two new SAS doctors and 2 FY3 doctors as co-investigators within RCTs.

Diabetes and Endocrinology:
There has been a considerable downturn in the number of commercial clinical trials in the UK as a whole, often with studies being withdrawn at short notice which impacts on resource planning; furthermore there has been a significant drop in the number of trials in Diabetes. However, the team have found strength in new relationships forged as a result of the downturn with a new working relationships, sharing of resource and best practice with the Renal research team and going forward we hope to build on this fresh coupling and are already working on new studies together which would otherwise not have been conducted in our Trust.

Despite the lack of studies, the team certainly performed extremely well with the studies we have, as an example, recruiting the highest number of patients in the UK for the SOTA- EMPAG Sanofi Aventis study randomising 11 patients. The nearest UK competitor only randomised 2.

In late 2018-19 the team have been successful in securing a £50,000 grant from the OSPREY charity to conduct a large cohort study in Osteoporosis which will also attract a good number of accruals for the Trust as a whole.

The year going forward looks even more promising with many new studies in the pipeline for 2019-20 with a key priority on maintain strong relationships with pharma companies and increasing output back to previous levels.

Academic Oncology and Haematology Research Department:
The Academic Oncology Trials Unit is now in its 20th year, and has experienced an exciting and successful year.

2018-19 saw the completion of the department's reconfiguration and the fruitions of newly implemented processes and practices that are now fully embedded. These initiatives have been successful in building on our distinguished reputation across the Yorkshire & Humber CRN, increasing capacity for studies both in terms of set up and delivery, and improved collaboration between PIs and research staff. Our prominence externally also continues to flourish in terms of preferred site choice for notably several of the largest pharmacological companies in the world.

In line with the Trust Research and Innovation Strategy, our key priority moving forward into the next year is to secure 'top 5' national status within the Unit as measured by CRN data and encouraging Research Nurse led studies.

The Haematology department led the recruitment of patients with rare diseases and cancer into the NHS 100,000 genome project enabling 236 local patients and their families to undergo advanced genetic diagnosis. This has led to patients with rare diseases with a previously unknown causation to receive a precise diagnosis and prognosis for their condition. In addition the Haematology department is also leading on the recruitment of patients with rare haematological and immunological conditions into an associated project; the 'NIHR BioResource - Rare Diseases Programme' and has to date recruited 59 patients into these studies. The hope is that we can expand recruitment into the rare diseases programme to include patients with inherited eye disorders.

The department continues to recruit well into interventional phase II/III clinical studies and is amongst the leading 10% of sites recruiting to FLAIR and one of the top recruiters into the Mantle cell Biobank study. Additionally the Trust sponsored portfolio study, funded by Cancer Research UK, 'Cell shape recognition technology', is recruiting ahead of target with 116 participants.

We wish to continue to support phase II/III across all major haematological disease areas with an emphasis on increasing the number of commercial studies on our portfolio.

Vascular Surgery Research:
The Vascular department continues to be highly involved in research activities, key outputs include the production of a final report for Professor Ian Chetter's NIHR Programme Grant (Surgical wounds healing by secondary intention: characterising and quantifying the problem and identifying effective treatments). This important work summarizes seven years of wound research.

An AVSU led NIHR RfPB application has reached staged 2; High Intensity Interval Training In pATiEnts with intermittent claudication (INITIATE): a proof-of-concept prospective cohort study to assess acceptability and clinical efficacy.

In 2018 Professor Chetter became a NIHR Senior Investigator and was awarded an NIHR HTA grant (£1.7 million) for a pragmatic multicentre randomised controlled trial to assess the clinical and cost effectiveness of negative pressure wound therapy versus usual care for surgical wounds healing by secondary intention (SWHSI 2).

The department was successfully awarded a PhD cluster with HYMS and has subsequently welcomed three new PhD students who are currently conducting their own research projects. For the second and third year respectively the AVSU has hosted the Annual Specialist Registrar Educational (ASPIRE) ST7/ST5 programmes, these national training programmes were developed for the next generation of Vascular Surgeons. The core working group for the Vascular Research Collaborative, a National Steering Group, is based in the AVSU and continues to lead a national priority setting project; a list was created of the ten most important questions which needed to be addressed by vascular research in the UK, phase one results have been submitted for publication. Phase two will focus on gathering patient and carer perspectives over the next year. The AVSU undertakes a range of commercial and non-commercial studies and is recognised as the highest recruiting site on a number of studies.

Key priorities for the next year will be to set up / begin to successfully deliver SWHSI 2 and to complete the next phase of the national priority setting project which is focussed on patient and carer priorities.

Neurology:
Hull is the third biggest headache research centre in the UK after the National and Kings in London. The team is chosen to be the centre in all new agents in migraine and have been involved in both Phase IIb to Phase IV trials. The department has always recruited more than the given target and many patients have benefited from participating in the clinical trials. Some of the most benefited patients have been on national and regional television to discuss their success

stories. The department also participates in original research and have a research fellow completing her PhD later this year. The unit is considered as being pioneer in the treatment of Migraine using Botox.

One of the key challenges is to raise funds to continue producing quality research from the centre. The team has been chosen to be the centre in many new clinical trials over the next year or two and this will help raise funds towards research physicians conducting both therapeutic aspect of the research and original scientific papers. Dr Fayyaz Ahmed is one of the specialty leads for the NIHR local CRN and is involved in many non-commercial NIHR funded research projects.

Neurosurgery:
The neurosurgery research team continues to build its research profile with limited resources contributing to several national studies including national cauda equina study, global neurotrauma outcome study and the national TBI transfer study.

Renal Research:
The PIVOTAL TRIAL published in the NEJM this year will impact clinical practice and NICE guidelines. PIVOTAL is the largest renal clinical trial ever undertaken exclusively in the UK, supported by Kidney Research UK. Proactive IV irOn Therapy in haemodiALysis patients (PIVOTAL). PIVOTAL compared proactive, high-dose and reactive low-dose courses of intravenous iron treatment. The trial demonstrated that a higher-dose of intravenous iron reduced the risk of death, heart failure, and reduced both erythropoietin (EPO) dose requirements and the need for blood transfusions in comparison to those receiving lower doses of iron.

In addition, the 'iron and the heart study' has been a huge landmark 3 centre study in collaboration with Kings College London and Salford Royal, the University of Hull and Academic Cardiology to successfully recruit to time and target. This study is currently in the analysis phase with results due in 2019-20.

The key priority for the renal research team is to rebuild the department after a challenging year of unfortunate and unexpected circumstances. The collaboration with Diabetes to form a cluster will be a first step towards strengthening and expanding the research department with cross-fertilization of expertise, jointing working in overlapping studies. This harmonisation will ultimately enhance the quality and quantity of the research.

Hepatology Research:
The Hepatology Research department has been incredibly active in raising the profile of research within the trust. They recently organised a liver teaching day for nurses and allied healthcare professionals to address management, treatment and symptom awareness of these patients. This was done in conjunction with a number of specialist nurses in the hope of optimising care. The event had a fantastic turnout, and received positive feedback. As a result they will be organising their second session in 2019 taking into consideration the feedback received.

The locally led COMMANDS study which closed last year led to a change in clinical practice. The liver service now uses the COMMANDS pathway for all community hepatology referrals via a new hepatology advice and guidance service. This was as a direct result of the benefits we observed during our interventional study.

One of the teams' research nurses (Bronwen Williams) was guest speaker at Barcelona Liver Clinic - one of the leading hepatology centres in Europe; where they were invited to speak on previous work in NAFLD research and service innovation (COMMANDs).

Another research nurse (Tania Nurun) presented at the name change event on 1st February to discuss the fantastic collaboration with the University of Hull.

The team Clinical Trials Assistant (Julie Wilcox) won an award for Gastroenterology research team member from the Yorkshire and Humber Clinical Research Network.

The teams' focus will be maintaining their portfolio activity, whilst further developing an investigator –led research portfolio. Particular emphasis will be placed on preventable liver disease (alcohol-related and fatty liver disease). Integrating research into the broader clinical service will be an important aspect of this work.

Dermatology:
The National reputation of the departmental research output has led us to supervise a Psychology PhD from the University of Hull on 'Attention bias in patients with Psoriasis'.

Our BADBIR study data collection shows our departmental performance in measuring PASI and DLQI scores above the national average scoring 100%.

Research Impact: the dermatology clinical protocols reflect change in practice based on our evidence based research in treating conditions like Psoriasis, Acne and Bullous Pemphigoid.

The key priority for development for dermatology over the forthcoming financial year is to take on more industry studies and continue to build on the success of the current BADBIR Study.

Microfluidics:
Academic researchers in Hull apply lab-on-a-chip technology for environmental analysis on-site, for clinical diagnostics at the point-of-care and for the synthesis of smart materials. The work of Professor John Greenman and colleagues in the University of Hull Daisy Laboratories has continued to expand in 2018-19 with a focus on the utilisation of samples across colorectal, lung, head and neck, brain and thyroid cancers. Around 70 tumour samples have been used in various microfluidic devices and the work is part of that for 3 PhD students and 1 MD student.

Research infrastructure developments

Daisy Tumour Bank:
Hull York medical School and the University of Hull, in partnership with the Trust, established the Daisy Tumour Bank. It provides a resource of tissue and blood samples for ethically approved cancer research across the UK and the European Economic Area, to benefit cancer patients in the future.

Licensed by the Human Tissue Authority, the Daisy Tumour Bank is located at Castle Hill Hospital allowing the timely collection of samples from patients undergoing procedures at the hospital.

Donations of very small amounts of tissue or blood can go a long way in generating lots of useful information, including improvements to cancer treatments, discovering new treatments, and determining the causes and mechanisms of cancer – helping to improve outcomes for those patients living with cancer. In 2018-19 the Trust continued to support this venture by facilitating research that contributes to this invaluable repository.

Hull Health Trials Unit:
The official launch of the Hull Health Trials Unit (HHTU) in 2018-19 signals the start of an exciting and hopefully impactful journey in which the Trust will be a major collaborator. HHTU has a growing portfolio of studies at various stages of the research process – design, funding application, set-up and management. The unit works with a mixture of internal and external collaborators across a range of disease areas. In conjunction with access to the University of Hull Institute for Clinical and Applied Health Research (ICAHR) and the Methods Hub, Trust researchers are now able to push forward strong research grant applications to national funding bodies and research councils supported by local infrastructure. In 2018-19 a number of National Institute for Health Research (NIHR) grants have successfully been awarded that will utilise these resources.

Goals agreed with our commissioners

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

Use of the CQUIN payment framework
A proportion of Hull University Teaching Hospitals NHS Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and

Innovation payment framework.

There are no local Clinical Commissioning Group (CCG) schemes as there are several national CQUIN schemes mandated to all Trust's to deliver in 2017/18 which have continued into 2018/19.

The breakdown of the National CQUIN indicators is based on 2.5% of contract value of which:
- 1.5% mandated for 7 national schemes (£5m) equally weighted across each of the schemes
- 1% spilt (£3m) between 0.5% engagement with the Sustainability and Transformation Partnership (STP) and 0.5% of the CQUIN scheme will also be held within the risk reserve, If a provider delivers its control total in 2017/18

National CQUIN schemes 2018/19 for CCGs include:
- NHS Staff Health and Wellbeing
- Proactive and Safe Discharge
- Reducing impact of serious infections
- Improving services for people in A/E with mental health
- Advice and Guidance
- NHS e Referral
- Preventing ill health from tobacco/alcohol

Conclusion to CQUIN 2018/19 will not be known until June 2019
Assumptions have been made on the performance to date.
Underachievement in Sepsis has continued in 2018/19 to a value of 200k. There will be an expected underachievement in reduction of antibiotic assumption

2018/19 National Achievement:

CQUIN Indicator / No.	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Expected £ 8,057,808	Under Achieved £
1a Improvement of health and wellbeing of NHS staff	Achieved	Achieved	Achieved	expect to achieve	268,569	TBC
1b Healthy food for NHS staff, visitors and patients	Achieved	Achieved	Achieved	expect to achieve	268,569	
1c Improving the uptake of flu vaccinations for frontline clinical staff **Annual target**	Not required	Not required	Not required	achieved	268,569	
2a Timely identification of patients with sepsis in emergency departments and acute inpatient settings	Partial Achievement – 10% payment	Partial Achievement – 10%	Partial Achievement – 10%	expect underachieve	201,447	120k
2b Timely treatment of sepsis in emergency departments and acute inpatient settings	Partial Achievement – 10% payment	Partial Achievement – 10%	Partial Achievement – 10%	expect underachieve	201,447	120k
2c Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis	Achieved	Achieved	Achieved	expect to achieve	201,447	
2d Reduction in antibiotic consumption per 1,000 admissions	Achieved	Achieved	Achieved	expect part achievement	201,447	TBC
4 Improving services for people with mental health needs who present to A&E	Achieved	Achieved	Achieved	expect to achieve	805,789	
6 Advice & Guidance	Annual target	Annual target	Annual target	on track to deliver	805,789	
7 ASI (E-referrals) **Annual target**	Not required	Not required	Not required	Not required	-	-
9a Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco Screening	Achieved	Achieved	Achieved	expect to achieve	40,289	

9b Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco Brief Advice-	Achieved	Achieved	Achieved	expect to achieve	161,158	
9c Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco referral and medication	Achieved	Achieved	Achieved	expect to achieve	201,447	
9d Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Alcohol Screening **Annual Target**	Annual target	Annual target	Annual target	on track	201,447	
9e Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Alcohol Brief Advice or Referral **Annual target**	Annual target	Annual target	Annual target	on track	201,447	

STP – annual value £1,594,872

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 2.8% (£3.04m)

The CQUIN payment will be based on actual contract expenditure; however CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Tariff Payment System and all other expenditure contracted on "pass through" basis. CQUIN funding for Operational Delivery Networks previously paid via a 0.1% top slice of the 2.5% acute payment will continue to be made in addition to the 2.8% CQUIN payment outlined

The NHSE specialised schemes include a continuation of 2016/17 schemes: Hep C, HIV, spinal network, and haematrak. New schemes include medicines optimisation and local benchmarking of local prices in HIV.

Public Health England (PHE) has built into each of the screening services hosted by HUTH a CQUIN namely for Health Inequalities. Armed Forces (AF) CQUIN includes use of the covenant, systems and process to identify AF personnel, promote the Trust as AF friendly organisation, employment opportunity to AF in the Trust.

2018/19 NHSE Achievement:

Goal No	Goal Description	Trigger	Trigger Description	Goal Weighting %	CQUIN value 3,256,503	Under Achieved value at Q3
BI1	Improving HCV pathways through ODNs	Trigger A	Managed resources within indicative financial budget forecast	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B1	ODN MDT decisions aligned to NHS England published run-rate	0.31%	360,743	300k
	Improving HCV pathways through ODNs	Trigger B2	ODN Treatment cost per patient relative to lowest acquisition cost	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B3	ODN Prioritisation of patients with highest clinical need	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B4	ODN Effectiveness in sustaining benefits of treatment	0.31%	360,743	
	Improving HCV pathways through ODNs		Governance and Partnership	0.09%	100,000	
BI2	Haemophilia Haemtrack Patient Home Reporting	Trigger 1	Regular Haemtrack versus registered against target/baseline	0.02%	27,333	-5,239
	Haemophilia Haemtrack Patient Home Reporting	Trigger 2	User who provide an update against	0.02%	27,333	-5,239

			target/baseline			
	Haemophilia Haemtrack Patient Home Reporting	Trigger 3	Accuracy of records against target/baseline	0.02%	27,333	
CA2	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 1	Collection of baseline-data and quarterly updates of proportion of SACT that is wasted	0.04%	45,200	
	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 2	Reporting proportion / breakdown of SACT by volume that is bought in against prepared in-house with price comparisons	0.04%	45,200	
	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 3	Publication of policy for the safe and robust re-utilisation of SACT that would otherwise have been wasted	0.04%	45,200	
	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 4	Evidence of local process for routine implementation of dose-bands associated with new drugs to market	0.01%	15,067	
GE2	Activation system for patients with long term conditions.	Measure 1	Measurement and Reporting	0.01%	15,000	
	Activation system for patients with long term conditions.	Measure 2	Performance	0.04%	45,000	
GE3	Medicines optimisation	Trigger 1	Faster adoption of prioritised best value medicines and treatment regimens as they become available	0.09%	105,639	
	Medicines optimisation	Trigger 3	Cost effective dispensing routes	0.09%	105,639	
	Medicines optimisation	Trigger 5	Reporting of all NHS England excluded drugs data to allow upload to the Pharmex system	0.09%	108,840	
GE4	Local price benchmarking	Trigger 1	Achievement of Year Two milestones set out in the Business Case.	0.01%	16,000	
	Local price benchmarking	Trigger 2	Agreed signed contract variation for revised Price Schedule reflecting achievement of cost and price reduction as planned.	0.02%	24,000	
TR3	Spinal Surgery Networks Data, MDT, oversight.	Trigger 1	Regional Spinal Network	0.03%	33,333	
	Spinal Surgery Networks Data, MDT, oversight.	Trigger 2	Data	0.03%	33,333	
QIPP	Spinal Surgery Networks Data, MDT, oversight.	Trigger 3	MDT Governance	0.03% 0.52%	33,333 600,000	

Conclusion to CQUIN 2018/19 will not be known until June 2019. Assumptions have been made on the performance to date. There is under achievement in the Heamatrack to a value of £10k and approximately £300k for underachievement of the Hep C CQUIN Schemes. Total income loss of approx. £310k. The Trust has achieved all the PHE and Armed forces CQUIN schemes to date

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from the following email address: **quality.accounts@hey.nhs.uk**

What others say about the Trust

About the Care Quality Commission

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services. The CQC Operating Model was revised and in June 2017 the CQC confirmed they will focus on eight core services and four additional services. The additional services may be inspected depending on the level of activity and risk.

The eight core services are:
- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients

The four additional services are:
- Gynaecology
- Diagnostic Imaging
- Rehabilitation
- Spinal Injuries

When inspecting these eight core services, the CQC will focus on the following five key questions:
- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

The CQC continue to use the ratings as detailed in their Operating Model; they are an important element of the CQC approach to inspection and regulation. The ratings are outstanding, good, requires improvement and inadequate. You can find more about the CQC and the standards here: **www.cqc.org.uk**

Statement on Compliance with the Care Quality Commission

Hull University Teaching Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against Hull University Teaching Hospitals NHS Trust during 2018/19.

Hull University Teaching Hospitals NHS Trust has not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission rated Hull University Teaching Hospitals NHS Trust as 'Requires Improvement'

The Care Quality Commission (CQC) have not undertaken an inspection during the 2018-19 period. The CQC did undertake inspections in previous years that the organisation is progressing on improving ratings. The CQC undertook a well-led inspection in February 2018. The unannounced element was undertaken between 07 and 09 February 2018 and the announced element between 27 February and 01 March 2018. The inspection covered the Maternity, Medicine, Surgery and the Outpatient core services across Hull Royal Infirmary and the Castle Hill Hospital.   The Trust has received

an overall rating of 'Requires Improvement' when the reports were published on 01 June 2018.

A breakdown of the Trust's current ratings from the February 2018 inspection is detailed in the tables below.

Table 1 - Overall rating for Hull University Teaching Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led
Overall domain for the Trust	Requires Improvement	Good	Good	Requires Improvement	Good
Overall Trust rating	Requires Improvement				

Table 2 – Ratings for Hull Royal Infirmary (HRI)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency Care	Good	Good	Good	Requires Improvement	Good	Good
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity	Good	Good	Good	Good	Good	Good
Children and Young People	Requires Improvement	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Requires Improvement	Good	Good
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for HRI	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Table 3 – Ratings for Castle Hill Hospital (CHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Good	Inspected but not rated	Good	Requires Improvement	Good	Good
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for CHH	Requires Improvement	Good	Good	Good	Good	Good

Areas for improvement

Following the factual accuracy check of the draft report and receipt of the final reports from the February 2018 the Trust has accepted the areas for improvement. There are 11 'must do' actions and 17 'should do' actions. The areas for improvement are as follows:

Medical care:
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staffing line with best practice and national guidance taking into account patient's dependency levels. In particular the correct staffing levels for patients cared for in hyper acute stroke (HASU) beds and include nursing and medical staff.
- Ensure that patients are escalated for medical reviews in line with the trust policy when the trigger is alerted when using the National Early Warning Score (NEWS).
- Ensure that patient risk assessments are completed, in particular falls, nutrition and mental capacity assessments.
- Ensure that registered nurses follow the correct steps when administering medicines in line with their nurse policy and NMC regulations and sign medication charts after it has been given to patients
- Ensure that all medical outlier patients are moved in line with the referral criteria and are reviewed in line with the trust's policy
- Ensure that staff understand the principles of mental capacity and deprivation of liberty safeguards
- Ensure that a patient's lack of mental capacity is recorded within their records and reviewed
- Ensure that all staff groups meet the requirements for mandatory training and achieve the trust's set target over a 12 month period
- Continue to develop and embed the documentation in relation to dementia care

Surgery:
- Ensure the effective use and auditing of best practice guidance such as the five steps for safer surgery checklist within theatres.
- Ensure that all instruments used are clean, ready for use and stored in appropriate packaging to ensure traceability.
- Ensure that all patients' records are filed appropriately and stored securely
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patient's dependency levels. This includes both nursing and medical staff.
- Ensure that patients are fasted pre-operatively in line with best practice recommendations
- Ensure that action plans developed in response to national audit results clearly address all the concerns highlighted in the audit and the actions the trust has put in place
- Improve on national treatment performance standards
- Ensure that 85% of staff have up to date appraisals in line with their own target.
- Ensure that all patients' records are stored in an organised manner and ensure that loose entries are filed

- Ensure that all patients have weights recorded in their record
- Ensure mandatory training compliance for medical and dental staff meets their own target over a 12 month period
- Investigate and address the reasons for the number of cancelled operations to bring this in line with the England average
- Improve compliance with abbreviated mental test scores for patients over 75 who have been in hospital for longer than 72 hours.

Maternity:
- Ensure that all medical records are stored securely
- Continue to reduce the elective caesarean section rate in comparison with the England average
- Continue to address the lack of capacity in antenatal day unit and causes of regular long waits for women to be seen or receive results of scans and tests

Outpatients:
- Continue to take action to address the performance to meet the national standards for referral to treatment and care
- Ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment
- Ensure they develop processes to formally monitor patient waiting times

Outstanding practice
Examples of outstanding practice were identified by the CQC during the February 2018 inspection, including:
- A specialist bereavement midwife had been recruited and staff had raised funds to decorate a bereavement room in the antenatal day unit for use by families experiencing pregnancy loss.
- A midwifery led unit had been opened, utilising some labour ward rooms but with recruitment of separate staff. This had been developed with input from local women, midwives and other local services.
- The trust had a vulnerabilities midwife who was key in supporting women living with complex physical or psychological health needs. They based this service around "care of the complex woman with complex social factors perinatal guidelines (toolkit)". Examples of vulnerable women included, sex workers, women involved in abuse of drugs or alcohol, women living with learning disabilities and women living with HIV. The specialist vulnerabilities midwife was involved from booking onwards, in development of birth plans, and worked closely with the perinatal mental health team.
- The perinatal mental health team concentrated on multi-agency working, and included the specialist midwives, substance misuse services and their wrap around services.
- The eye hospital was given an ophthalmology award in 2017, for the introduction of the virtual reviewing service for patients with glaucoma. These awards celebrate outstanding work within ophthalmology practice.
- The trust used a computer system that allowed staff to be aware of where bed availability was and this was updated by staff on the ward. In turn this then provided staff at the safety brief meeting a true reflection of the current issues.
- The system allowed the senior managers to review and plan where the risks were to nurse staffing and manage these safely and effectively. A record of the decision made were made during the meetings and logged onto the system to provide an audit trail.
- The trust had introduced different roles to support the patient pathway, these included discharge assistants and nutritional apprentices.

Quality Improvement Plan

The Quality Improvement Plan (QIP) is a high level plan which defines the improvement goals the Trust is working towards for improving quality and safety across the organisation. The plan includes the must do and should do actions from the CQC re-inspection in May 2015, comprehensive inspection in June 2016, well-led inspection in February 2018, areas of work the Trust is pursuing to improve, quality and safety priorities as detailed in the Quality Account and the Trust's 'Sign up to Safety' Pledges.

The table below details the quality improvement projects for 2018/19:

Ref	QIP Project	Aim	Source	Status
QIP05	Medicines Optimisation	The aim of this project is to ensure our patients receive the right medicines, at the right dose at the right time as well as compliance with best practise guidance and regulations.	CQC Action, Quality Accounts and Sign up to Safety	Closed – aim achieved, new project opened for 2019-20
QIP06	Deteriorating Patient	The aim of this project is to ensure that the Trust's Recognition of the Deteriorating Patient Policy is fully implemented ensuring patient's observations are completed in a timely manner and where deterioration is detected they are appropriately escalated for medical review and treatment. The project will also support the Trust-wide adoption of the revised National Early Warning Score (NEWS2) by March 2019.	CQC Action, Quality Accounts and Sign up to Safety	Closed – new project opened for 2019-20
QIP08	Infection Control	The aim of this project is to reduce the number of avoidable hospital acquired infections by ensuring compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) 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.	Quality Accounts, Sign Up to Safety and Trust action	Closed – improvements made, aim not achieved fully
QIP09	Falls	The aim of this project is to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the Multi Factorial Assessment Tool (MFAT). It will also focus on the outcomes for the patient following a fall to learn lessons from the root cause analysis investigations completed along with the achievement of compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention.	CQC Action, Quality Accounts and Sign up to Safety	Closed –aim achieved
QIP10	Pressure Ulcers	The aim of this project is to embed the existing clinical governance processes for the management of pressure ulcers by ensuring that nursing staff are compliant with training and that lessons are learnt from Root Cause Analysis investigations and incidents. This will provide assurance that patients at risk of pressure damage are being provided with safe, high quality care to prevent avoidable hospital acquired pressure ulcers.	Quality Accounts, Sign up to Safety and Trust action	Closed – new project opened for 2019-20
QIP12	Children and Young People with Mental Health needs and CAMHS	The aim of this project is to improve the management of children and young people who have been admitted onto the 13th floor who are at risk of self-harm and suicidal intent.	CQC Action	Closed – improvements made, aim not achieved fully
QIP14	VTE	The aim of this project is to ensure patients are appropriately risk assessed for VTE on admission and to demonstrate that the Trust is compliant with the relevant contractual requirements.	Trust action	Closed – new project opened for 2019-20
QIP15	Sepsis	The aim of this project is to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients on the sepsis pathway across the organisation. In addition, the focus will be on the development of appropriate coding for patients.	Quality Accounts and Sign Up to Safety	Closed – aim achieved

QIP19	Governance	The aim of this project is to continue to improve the governance arrangements across the organisation to ensure good governance and robust management of risk, performance and continuous improvement and learning.	Trust action	Closed - aim achieved
QIP22	Nutrition	The aim of this project is to improve patient's nutrition by achieving and monitoring the required actions / improvements from the March 2018 Nutritional Prevalence re-audit and developing any required actions to improve compliance with the Nutrition Fundamental Standards.	CQC Action, Quality Accounts and Sign up to Safety	Closed – new project opened for 2019-20
QIP23	Dementia	The aim of this project is to continue to review and promote Dementia Care across the Trust through a variety of multi - disciplinary events, policy review and further dementia friendly assignments.	CQC action and Trust action	Closed – new project opened for 2019-20
QIP26	Records	The aim of this project is to ensure all patients records are filed appropriately, stored securely and accessible for authorised people only in order to deliver safe care and treatment.	CQC action and Trust action	Closed - aim achieved
QIP28	Patient Experience	The aim of this project is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes.	Quality Accounts and Sign up to Safety	Closed – aim achieved, new project opened for 2019-20
QIP30	Avoidable Mortality	The aim of this project is to aid the organisation in the delivery and development of the national objective of a standardised approach to review of hospital mortality. This project will prepare the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.	Quality Accounts and Sign Up to Safety	Closed – aim achieved
QIP36	Transition from Children's to Adult Services	The aim of this project is to ensure there are effective and robust processes in place for young people who transition to the adult care services.	CQC Actions, Quality Account and Sign up to Safety	Closed – aim achieved
QIP37	ReSPECT	The aim of this project is to complete the launch of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and fully embed the process across the organisation.	Trust action	Closed – aim achieved
QIP38	Consent	The aim of this project is to review and strengthen the governance arrangements regarding the development, approval and the central monitoring of the Trust consent forms. The project will also commence the development work of the transfer of the Trust consent forms onto Lorenzo.	Trust action	Closed – aim achieved
QIP39	Outpatients	The aim of this project is to strengthen the existing governance arrangements with a particular focus on developing a robust central risk register for Outpatient Services. In addition, to include a further review of how incident and complaints information is escalated and managed via the existing governance structure to enable a cohesive and healthy learning culture.	CQC action and Trust action	Closed – aim achieved, new project opened for 2019-20
QIP41	Getting it Right First Time (GIRFT) – Paediatric	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Paediatric Surgery.	Trust action	Closed – transferred to GIRFT Steering

				Group
QIP42	Getting it Right First Time (GIRFT) – Ophthalmology *	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Ophthalmology	Trust action	
QIP44	Getting it Right First Time (GIRFT) – Obstetrics and Gynaecology*	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Obstetrics and Gynaecology in December 2017.	Trust action	
QIP45	Safer Maternity Care (CNST incentive Scheme)	The aim of this project is to ensure the implementation of the 10 key elements of the Safer Maternity Care (CNST Incentive Scheme) and to provide assurance to the Trust Board that the Maternity standards meet the standards.	Trust action	Closed – aim achieved
QIP46	Handover*	The overall aim of this project is to develop a handover process that supports learning and integrates patient care with Junior Doctor training and development. The lead plans to create a daily handover session for Junior Doctors, with senior clinical involvement, across the medical services where admissions, cases and treatments are discussed and responsive actions put in place if concerns are raised.	Trust action	Closed – no longer required
QIP47	Acute Kidney Injury	The project aims to increase compliance specifically the following Quality Statements from NICE Quality Standard 76: • Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition. • Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level and urine output monitored. • Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.	Quality Accounts, Sign up to Safety and Trust action	Closed – new project opened for 2019-20
QIP48	Mental Health	Ensure that patients are legally detained under the Mental Health Act appropriately and patients are cared for without prejudice and staff are trained adequately to make adjustments accordingly. This will be achieved by the development of a robust governance system for Mental Health within the Trust which includes data collection, audit and evaluation of patient experience alongside a training programme for relevant staff.	CQC action and Trust action	Closed – new project opened for 2019-20
QIP49	Getting it Right First Time (GIRFT)	The specific objectives of the Trust level GIRFT Programme are to: • Lead and co-ordinate the Trust's response to the national GIRFT Programme • Oversee delivery across all existing GIRFT action plans • Identify opportunities to extrapolate or replicate improvements in other settings • Prepare for GIRFT re-visits/progress checks • Oversee delivery of the actions required through the Litigation in Surgical Specialties work stream • Provide cross group reporting to the Trust's Carter Group and QIP Committee	Trust action	Closed – transferred to GIRFT Steering Group

The first row cell reads "Surgery*" in the second column.

Underpinning the overall Quality Improvement Plan is a detailed work plan for each improvement area which sets out the objective of the project, the targets to be monitored and achieved, key milestones and improvement goals.

The Quality Improvement Plan is supported by robust governance arrangements which monitor the delivery of the plan and each of the improvement areas. Progress is reported by a monthly progress report submitted by the leads to the Trust's Operational Quality Committee chaired by the Chief Nurse on a monthly basis. This enables independent challenge and assurance. The Trust Board's Quality Committee maintains an overview of the delivery of the Quality Improvement Plan.

The areas identified in the 2018/19 Quality Improvement Plan were due to be improved by the end of March 2019. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2019 Operational Quality Committee. Achievements made against the Quality Account priorities in the plan are all detailed in this Quality Account report (see pages 9 to 26).

All improvement areas which require further action and monitoring because they were either, not fully improved or some improvements were made but require further monitoring to ensure they are embedded into practice were all carried forward onto the 2019/20 Quality Improvement Plan. Further information on the 2019/20 Quality Improvement Plan will be provided in next year's Quality Account.

A full copy of the Quality Improvement Plan can be found on **http://www.hey.nhs.uk/about-us/cqc/**

Care Quality Commission - Duty of Candour

What is Duty of Candour?
The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

How is the Trust Implementing Duty of Candour?
The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature.

Duty of Candour is monitored within the Trust's Quality Governance and Assurance Department, who ensures that response to patients and their representatives, is sent in a timely manner, and to check the quality and content of letters, to ensure that information sent to patient and their representatives is open and honest.

What is the Trust's compliance with Duty of Candour?
The CQC assessed the Trust in June 2016 and February 2018 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements and that the Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust expects that a verbal apology is given within 10 days of the incident occurring, that a written apology is also given within 10 days of the incident occurring, and that a written explanation of the incident is sent within 10 days of the completion of the incident investigation. This compliance is monitored to a target of 90% compliance, allowing for those incidents which require more time to provide an open and honest apology and response.

This graph shows from April 2016 to March 2019; each element of the duty of candour compliance, monitored against the 90% target (fixed target).

Chart 1: Duty of Candour compliance rates

Duty of Candour Compliance Rates - Apr 16 to date
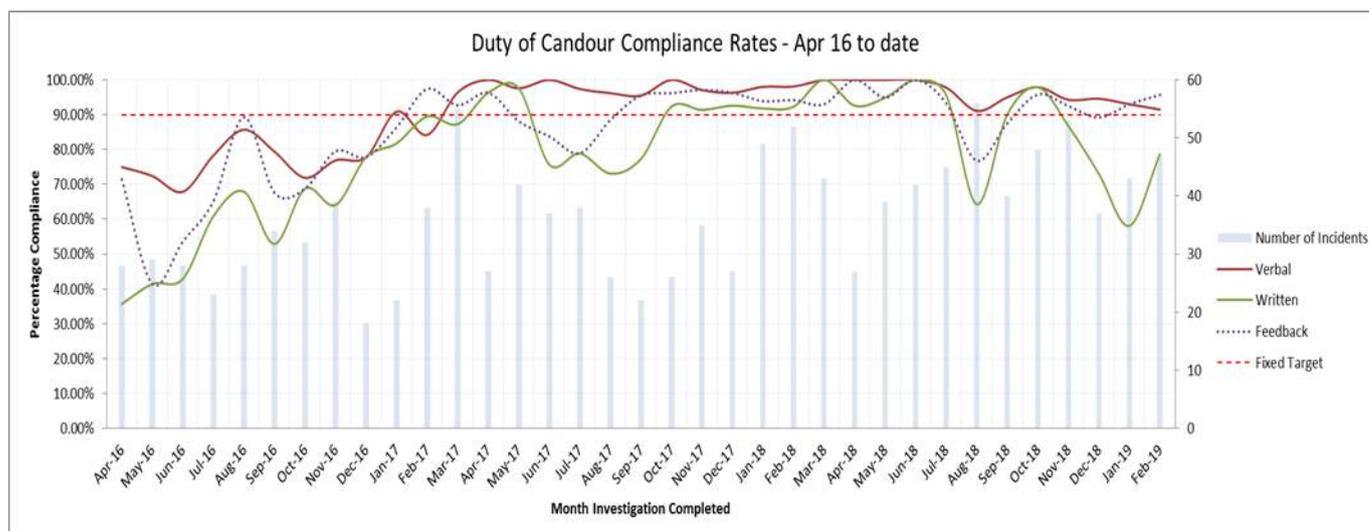
Data Quality

NHS number and general practice code validity

Hull University Teaching Hospitals NHS Trust submitted records during 2017/18 to the Secondary Users service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was:
99.86% for admitted patient care;
99.95% for outpatient care; and
99.01% for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Information Governance Toolkit

The Information Governance Toolkit (IG Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance. It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisations and between organisations.

The Information Governance Assurance Statement is a required element of the IG Toolkit and is re-affirmed by the annual submission with a minimum of level two compliance demonstrating the organisation has robust and effective systems in place for handling information securely and confidentially.

Hull University Teaching Hospitals NHS Trust's Information Governance Assessment Report overall score for 2017/18 was 71%. Thirteen standards were reaching Level 2 and above, but further evidence was required for two standards. Action plans are in place for all of these.

The IG Toolkit was audited and assessed as achieving Significant Assurance.

There is a statement regarding data quality of Trust's waiting list data within the Annual Governance Statement in this annual report.

Clinical Coding Error Rate

Hull University Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. The recommendations below are drawn from the internal specialty audits performed during 2016/17. The following information provides an update on the implementation of the recommendations.

Recommendation	Priority	Progress Update	Status
R1 - Engagement should be encouraged with clinicians across all specialties with examples of good coding and bad coding to highlight where any problems are occurring and why, and the impact this has coding outcomes	High	Concentrate on surgical specialties and increasing the number of coding validation sessions being done. The number of validation sessions has remained steady however more clinicians are keen to assist and be contacted on an ad hoc basis.	Validations maintained in previous areas. Significant engagement from CTS and Cardiology this financial year
R2 - Continue to achieve 95% for flex and 100% for freeze dates of each month post implementation of Lorenzo.	High	Maintain targets throughout Lorenzo implementation phase. Flex dates took longer to come back to pre-Lorenzo levels than anticipated.	Complete
R3 - Post Lorenzo implementation look to achieve higher levels of completion at flex 97% and be regularly 85-90% complete by early income reporting.	Medium	Targets met every month for 12 months	Complete
R4 - Improve case note quality by monitoring the state of the case notes and assessing the availability of information and report any issues.	Medium	Casenote quality forms part of the audit reports and is reported to the speciality as part of audit feedback	Complete
R5 - Achieve Level 3 in all internal specialty audits. Level 3 = 95% primary diagnosis, 90% secondary diagnosis, 95% primary procedure, 90% secondary procedure.	Medium	To ensure coding quality regular audits should be of the highest standard achievable. Audits will assess the training needs of individual staff members and training will be delivered to fill knowledge gaps.	Consistently achieved level 2 – mandatory. Continue training programme to try and achieve Level 3 – Satisfactory - next financial year
R6 - Improve coding depth in all areas through regular coding audit and clinical engagement.	Medium	Where possible, coding depth across all specialties should meet or exceed peer. Where this is not the case investigations and audits should be carried out to ensure the level achieved is accurate.	Coding depth has improved or remained similar to peer across most specialities.
R7 – Ensure coders are maintaining standards and receive regular audit feedback	Medium	Regular feedback post audit	Audit programme complete for 18/19. New Audit programme for 19/20 will being April 2019
R8 – Histology results should be checked in	Medium	Encouraged to make better use of daily	Ongoing issue

a timely fashion.		histology report.	highlighted at most audits. Continuing to work with team leaders to find effective process for ensuring histology reports are accessed in a timely manner.
R9 - Adjust proformas in preparation for HRG4+	Medium		Ongoing

Part 5: Looking forward – our plans for the future

This section includes:

- Information on how the Trust consulted on the 2019/20 quality and safety priorities
- Information on each quality and safety improvement priority, including what the Trust wants to achieve, what targets will be used to monitor performance and where progress and performance will be reported to

Our Plans for the Future – Consultation

For 2019/20 the Trust has put together a list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2018/19
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2018/19
- Looking at national priorities and local priorities that have been agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN)
- Looking at what our regulators have identified as priorities, such as compliance with the CQC Fundamental Standards
- Review of the NHS Outcomes Framework (15 patient safety collaboration priority areas)

In order to seek the views of our staff, Trust patient members, stakeholders and our local community on what they thought the priorities should be for 2019/20 the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff and patient members and stakeholders to consult on the 2019/20 priorities in February and March 2019
- Relevant committees were also asked for their comments and ideas:
  o Operational Quality Committee for consultation on all priorities and approval of the 2019/20 priorities
  o Quality Committee for approval of the 2019/20 priorities
  o Trust Board for ratification of the 2019/20 priorities

The Trust has identified these quality improvement priorities for 2019/20 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2019/20

Safer Care (Patient Safety)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired pressure ulcers
- To reduce avoidable acute kidney injury
- To ensure all appropriate patients are risk assessed for VTE

Better Outcomes (Clinical Effectiveness)

- To improve the care of people with Dementia within the Trust
- To improve the governance of children and adult patients requiring Mental Health care within the Trust

Improved Experience (Patient Experience)

- To improve the experience of staff working in the Trust's outpatient areas
- To listen to and act on patient experience to improve services

Safer Care (Safe, Caring, Responsive and Well-led)

1. Nutrition and Hydration

What do we want to achieve?

The aim of this project is to:

- To ensure patient's nutrition and hydration needs are risk assessed in accordance with Trust Policy (CP335)
- To ensure patients are weighed in accordance with Trust Policy (CP335)
- To ensure that patients are fasted pre-operatively in accordance with policy

How will we measure this priority?

- Percentage of Patients weighed within 24hrs of admission
- Percentage of Patients weighed every 72hrs
- Percentage of Weight recorded on Drug Chart
- Percentage of Weighs plotted on weight graph
- Percentage of Daily Nutrition Risk Assessments
- Percentage of Appropriate referral to Dietician
- Percentage of Care plans stating "low, Medium or High Risk"
- Percentage of hydration charts completed

How will we monitor and report on progress?

This project will be monitored by the Nutritional Steering Group. It will be led by the Health Group Triumvirates and it is sponsored by the Deputy Chief Nurse.

2. Medication Optimisation

What do we want to achieve?

The aim of this project is to improve key aspects of the medicines management discharge process by: increased referrals to the Transfer of Care around Medicines Scheme, improved turnaround times of dispensing discharge prescriptions for the patient lounge, improved timeliness of IDSs from Boots to Queen Centre and improved accessibility of SIP feeds.

How will we measure this priority?

1. 70% of dispensing discharge perceptions within an hour for patient lounge by March 2020
2. 50% increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020

How will we monitor and report on progress?

This project will be monitored by the Safer Medication Practice Committee and it is led by the Chief Pharmacist.

3. Deteriorating Patient

What do we want to achieve?

The aim of this project is to ensure all patients with an elevated NEWs score to be escalated in line with Trust Policy (which incorporates NEWS2).

How will we measure this priority?

- Percentage of patients that have a NEWS Score above 1 have evaluation states actions taken or escalation documented

How will we monitor and report on progress?

This project will be monitored by the Operational Quality Committee. It will be led by the Health Group Triumvirates and it is sponsored by the Deputy Chief Nurse.

4. Pressure Ulcers

What do we want to achieve?

The aim of this project is to be open and transparent skin damage reporters, improving safety and patient experience through robust assessment, care planning and evaluation by sharing best practice from areas with low reported incidents and to improve understanding of key themes and trends from all reported incidents.

How will we measure this priority?

- 100% completion of Root Cause Analysis of all Pressure Ulcer Serious Incidents within 14 days

How will we monitor and report on progress?

This project will be monitored by the Wound Management Committee. It will be led by the Health Group Triumvirates and it is sponsored by the Tissue Viability Nurse.

5. Acute Kidney Injury

What do we want to achieve?

The aim of this project is to increase compliance, specifically with the following Quality Statements from NICE Quality Standard 76:

- Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.
- Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored.
- Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

How will we measure this priority?

Percentage compliance with:

- Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.
- Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored.
- Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

How will we monitor and report on progress?

This project will be monitored by the Operational Quality Committee. It will be led by a Consultant Nephrologist and sponsored by another Consultant Nephrologist.

6. Venous Thromboembolism (VTE)

What do we want to achieve?

The aim of this project is to ensure all appropriate patients are risk assessed for VTE and where necessary receive the correct treatment.

How will we measure this priority?

- 0 VTE Serious Incidents
- Achieve 95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital

How will we monitor and report on progress?

This project will be monitored by the Thrombosis Committee. It will be led by the Health Group Medical Directors and sponsored by the Chief Medical Officer.

> All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Better Outcomes (Effective, Safe and Caring)

1. Mental Health (Children and Adults)

What do we want to achieve?

The aim of this project is to develop a robust governance system for Mental Health within the Trust for both children and adults.

How will we measure this priority?

- To achieve 95% compliance with paediatric relevant staff trained in CAMHS
- To achieve 95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm
- To achieve zero CAMHS related incidents
- 95% of staff can identify why it is important to know which patient's haven't got capacity (taken from Safeguarding Fundamental Standards Inspections)
- 95% if staff can explain what additional actions are required if a patient hasn't got capacity in order for them to be safe and inform their care (taken from Safeguarding Fundamental Standards Inspections)

How will we monitor and report on progress?

This project will be monitored by the Safeguarding Committee and it will be led by the Assistant Chief Nurse.

2. Dementia

What do we want to achieve?

The aim of this project is to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and dementia documentation is consistently completed to the appropriate level.

How will we measure this priority?

- Baseline established of Trust Tier 1 (non-clinical) staff to be trained and 'Dementia Aware'
- Baseline established of Tier 2 (clinical) staff to be trained using the appropriate training
- 90% compliance with dementia/delirium screening assessments undertaken
- 75% compliance on H8, H9, H90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol and the Reach Form
- 75% staff awareness of John's campaign
- 75% relative/carer awareness of Johns campaign

How will we monitor and report on progress?

To be monitored through the Operational Quality Committee and led by Department of Medical Elderly Consultant (DME) and Dementia Nurse.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Improved Experience (Caring, Responsive and Well-led)

1. Patient Experience

What do we want to achieve?

The aim of this project is to improve engagement with staff and patients. It also seeks to improve the profile of key services e.g. SALs and Interpreters. It aims to learn lessons to reduce the number of repeat events.

How will we measure this priority?

- Reduce the number of complaints by 10%
- Continue to reduce the cost saving on interpreter services (baseline £325.4k)

How will we monitor and report on progress?

This project will be monitored by the Patient Experience Committee and will be led by the Head of Patient Experience.

2. Outpatient Services

What do we want to achieve?

The aim of this project is to continue to strengthen the existing governance arrangements for Outpatient Services with a particular focus on gathering and understanding patient and staff experience.

How will we measure this priority?

- 90% of OP areas rated green or blue Patient Experience Fundamental Standard (currently 92.3%)
- 90% of OP areas rated green or blue Staff Experience Fundamental Standard (currently 92.5%)
- Outpatient Governance Committee held (monthly)
- Friends and Family Test Scores for Outpatients above 95% (currently 98% on NHS choices website)
- Increase in positive compliments or comments on NHS Choices
- Improved waiting times at clinics

How will we monitor and report on progress?

This project will be monitored by the Outpatient Committee and led by the Head of Outpatient Services.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Part 6:
Annex
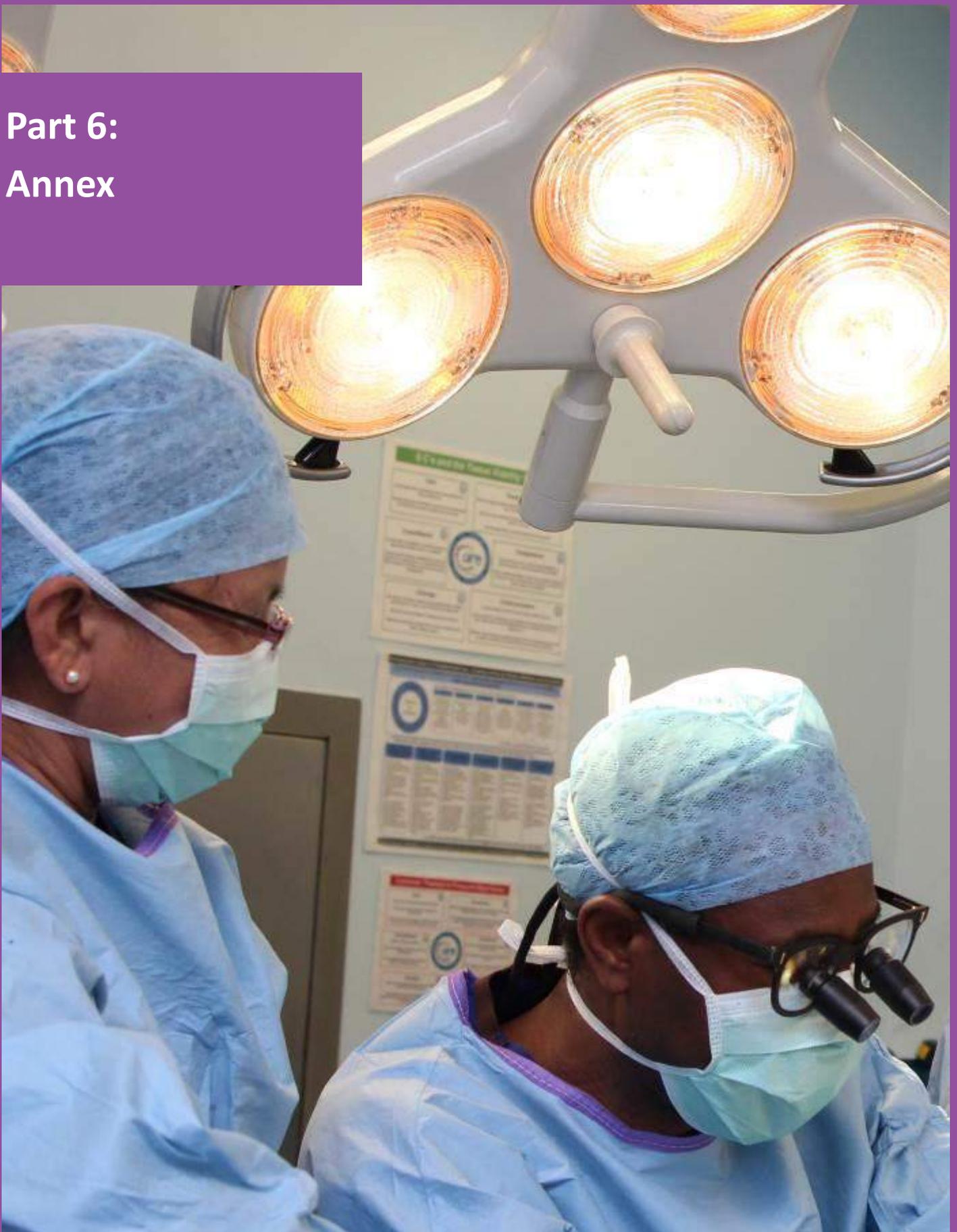
This section includes:

- Statements on the content of the Quality Account from our Stakeholders
- Trust response to the Stakeholder statements
- Statement of Directors responsibility
- Statement of assurance from the Independent Auditors
- Abbreviations
- Information on how to provide feedback to the Trust on the Quality Account

Statements from Key Stakeholders

The Trust is required to send a copy of its quality account to the following organisations for their comments:

- The NHS England and relevant Clinical Commissioning Group (CCG) (where 50 per cent or more of the relevant health services that the Trust provides are provided under agreements with NHS England, the Trust should send its quality account to NHS England, otherwise to the relevant CCG)
- The appropriate Local Health watch organisation; and
- The appropriate Overview and Scrutiny Committee (OSC)

The first draft of the Trust's 2018/19 Quality Account was forwarded to key stakeholders on the 03 May 2019 with a request for statements of no more than 500 words to be received before the 31 May 2019. The key stakeholders are:

- NHS England and relevant CCGs - NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group
- Healthwatch Kingston Upon Hull
- Healthwatch East Riding of Yorkshire
- Hull City Council Overview and Scrutiny Committee
- East Riding of Yorkshire Overview and Scrutiny Committee (OSC)

As required in the Department of Health guidance, different organisations were requested to comment on specific questions.

The commissioners were asked to:

- Confirm in a statement, to be included in the provider's Quality Account, whether or not they consider the document contains accurate information in relation to services provided and set out any other information they consider relevant to the quality of NHS services provided;
- Take reasonable steps to check the accuracy of data provided in the Quality Account against any data they have been supplied during the year (e.g. as part of a provider's contractual obligations)

The Local Healthwatch and the Overview and Scrutiny Committees were asked to consider:

- Whether the Quality Account is representative
- Whether is gives a comprehensive coverage of the provider's services
- Whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to the Quality Account

The statements received can be found below. No amendments have been made to these statements.

Section to be completed – end of May 2019

Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group

Healthwatch Kingston upon Hull

Healthwatch East Riding of Yorkshire

Hull City Council Overview and Scrutiny Committee

East Riding of Yorkshire Overview and Scrutiny Committee

Statement of Directors' Responsibility

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

To be signed upon completion – June 2019

Independent Auditor's Report

Section to be completed - June 2019

Abbreviations and definitions

Acute Kidney Injury (AKI)	Acute Kidney Injury is caused by reduced blood flow to the kidneys, usually in someone who is already unwell with another health condition. This reduced blood flow could be caused by: low blood volume after bleeding, excessive vomiting or diarrhoea, or as seen with severe dehydration.
C.Difficile	Clostridium difficile infection is a type of bacteria which may live in the bowel and can produce a toxin that can affect the digestive system
Care Bundle	Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections
Care Quality Commission (CQC)	The organisation that regulates and monitors the Trust's standards of quality and safety
CHH	Castle Hill Hospital
Chronic Obstructive Pulmonary Disease (COPD)	COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease
Clinical Audit	This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done
Clinical Outcomes	A clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease
Commissioning for Quality & Innovation (CQUIN)	A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative
DATIX	DATIX is the Trust wide incident reporting system
duty of candour	Involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment
e.Coli	is a bacterium usually found in the gut. Most strains are not harmful, but some produce toxins that can lead to illnesses
ED	The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year.
e-Learning Package	A training programme that individuals or groups can complete online via an internal education system known as HEY247
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care
eObservations	electronic observation and decision support system designed to improve patient safety and outcomes, allows patient vitals to be viewed from any connected device
ePrescribing	Electronic prescribing system
Friends and Family Test	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care

Fundamental Standard Inspections	a formal review process, which reviews objectively the quality of care delivered by our clinical teams, is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care
Health Groups	Health Groups are the areas of the Trust delivering care to our patients. There are four Health Groups; Clinical Support, Family and Women's, Medicine, and Surgery. These four Health Groups are headed by a Consultant (Medical Directors) who is the Accountable Officer. They are supported in their role by a Director of Nursing and an Operations Director
HUTH	Hull University Teaching Hospitals NHS Trust
HRI	Hull Royal Infirmary Hospital
Lorenzo	The Trust's electronic patient record system
MRSA	Methicillin-resistant Staphylococcus Aureus is a type of bacterial infection that is resistant to a number of widely used antibiotics
MSSA	Methicillin-sensitive Staphylococcus Aureus (MSSA) is a type of bacteria (germ) which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.
Multi Factorial Assessment Tool (MFAT).	An **assessment** with **multiple** components that aims to identify a person's risk factors for falling.
National Patient Safety Agency Alerts	Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices
Never Event	A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'
NEWS2	National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHS England	NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system
NHS Outcomes Framework	This framework has been developed to provide national level accountability for the outcomes that the NHS delivers. Its purpose is threefold: to provide a national level overview of how well the NHS is performing, wherever possible in an international context; to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.
NIHR	The National Institute for Health Research commissions and funds research in the NHS and in social care
NRLS	National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.

Pressure Ulcer	Open wounds that form when prolonged pressure is applied to the skin. Patients who spend prolonged periods of time in a bed are prone to such ulcers. A pressure ulcer can be avoided if the appropriate preventative actions are taken
QIP	Quality Improvement Plan (QIP) - The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey HEY is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts and our Sign Up to Safety Pledges.
Quorate	When a meeting is **quorate**, there are enough people there to make official decisions by voting
Root Cause Analysis (RCA)	RCA is a method of problem solving that tries to identify the root causes of faults or problems
SDTI	The National Pressure Ulcer Advisory Panel defines an **SDTI** as a "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
Sepsis	Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection
Serious Incident (SI)	An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
Sign up to safety pledges	The Pledge made by the Trust to reduce all avoidable deaths and avoidable harm
SOBs	Sepsis and Observation Training
Stakeholders	A group of people who have a vested interest in the way Hull University Teaching Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care.
Tissue viability	Tissue viability is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors
VTE	**Venous thromboembolism** (**VTE**) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).

How to provide Feedback

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information which is meaningful to you and reflects, in part, the aspects of quality that matter most to you.

If you have any feedback regarding the 2018/19 Quality Account please e-mail your comments to:
quality.accounts@hey.nhs.uk

However, if you prefer pen and paper, your comments are welcome at the following address:

The Compliance Team
Quality Governance and Assurance Department
Medical Education Centre
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

Hull University Teaching Hospitals NHS Trust

Quality Committee

Meeting Date:	29 April 2019	**Chair:**	Prof M Veysey	**Quorate (Y/N)**	Y

Key issues discussed:
- Serious Incidents themes and trends – discussion around how the Committee closes the loop and embeds learning
- Benchmarking NPSA – Trust highlighted as a good reporter
- Quality Accounts Update – The Committee approved the draft accounts that would be sent to the stakeholders for comments
- People Strategy Refresh – an opportunity for Committee members to give any feedback to Mr Nearney regarding the strategy
- PLACE – An update was received regarding the PLACE audits. The process was being reviewed and the new process would commence in September 2019
- Learning from Deaths update – SJRs being carried out – emerging issues were communication and training.
- IPR – Mrs Cope to attend future meetings to highlight quality indicators
- OQC – the focus on VTE was discussed
- Board Assurance Framework – End of year BAF was presented. The Committee were invited to feedback any comments to Ms Ramsay.

Decisions made by the Committee:
None required

Key Information Points to the Board:
As key issues discussed

Matters escalated to the Board for action:
None

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee held 29 April 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mrs V Walker	Vice Chair
	Mr S Hall	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Interim Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance

In Attendance:	Mr S Nearney	Director of Workforce and OD (Item 4.4 only)
	Mrs C Gorman	Hotel Services Manager (Item 4.6 only)
	Mrs Z Ridge	Deputy Head of Facilities (Item 4.6 only)

No	Item	Action
1	**Apologies**	

Apologies were received by Prof J Jomeen, Non-Executive Director and Mrs A Green, Lead Clinical Research Therapist

Prof Veysey advised that item 4.5 (GIRFT) would be deferred to the next meeting in May 2019.

2 Declarations of Interest
There were no declarations made.

3 Minutes of the meeting held 29 March 2019
The minutes were approved as an accurate record of the meeting.

3.1 Matters Arising
There were no matters arising from the minutes.

3.2 Action Tracking List
Mrs Southgate advised that she was waiting for information regarding the DKA update from the service, so would add it to her next Serious Incident report in May 2019.

KS

3.3 Any Other Matters Arising
There were no other matters discussed.

3.4 Workplan 2019/20
Ms Ramsay presented the Workplan and advised that it would be remapped against the new Trust Strategy to incorporate the new goals. Any changes would be proposed to the Committee for approval.

4 4.1 Serious Incident Report
Mrs Southgate presented the report and advised that no Never Events had been declared in 2018/19.

Mrs Southgate advised that the report format had been changed slightly

to give more information regarding Serious Incident investigations. There had been a number of Serious Incidents de-escalated in month and the report also included learning and recommendations following closed Serious Incidents.

There was a discussion around closing the loop and how the 6 monthly learning report could capture the learning after the incident investigation. This would give assurance to the Committee, along with snapshot audits that learning was being embedded. Mrs Walker added that the measure of learning meant that the incident did not happen again. Prof Veysey stated that mistakes will happen but it was important that processes and systems were in place to minimise the risk.

Mrs Geary advised that she was proposing to the Executive Team that a Serious Incident Committee be established to oversee learning and that the recommendations are signed off. She added that the Operational Quality Committee reviewed Serious Incidents at an operational level.

Resolved:
The Committee received and accepted the report.

4.2 Benchmarking NPSA – Staff Survey Results
Mrs Southgate presented the item which highlighted how the Trust was performing against its peers in relation to Serious Incident reporting.

Mrs Southgate advised that it was a positive story and indicated that staff felt more able to report incidents and were confident in how to. She added that the Trusts severe and death reporting was slightly elevated in comparison to other Trusts and this was being investigated to ensure they had been categorised correctly.

The Committee discussed the change in position since 2014 and the turnaround that had been achieved. Dr Purva stated that it was important to sustain this position. Mrs Stern asked if the Committee was confident that all incidents were being reported and Dr Purva advised that the systems in place were better and Mrs Southgate added that wards were now subject to independent audits.

Resolved:
The Committee received and accepted the report.

Mrs C Gorman and Mrs Z Ridge attended the meeting.
The agenda was taken out of order at this point.

4.6 PLACE Update
Mrs Gorman and Mrs Ridge gave a presentation regarding the PLACE non clinical assessments of the care environment. They advised that it was introduced in 2013 and was led by patients to focus on improvements.

Mrs Gorman advised that the process was currently being reviewed and the new process would start in September on a minimum of 10 wards. The team of reviewers would include patients and clinical and estates staff. Each review would use independent staff to the wards and the results would be shared. The team currently had 15 assessors and was

looking to recruit more. The types of things to be audited are cleanliness, food and hydration, privacy and dignity, general wellbeing, the state of the buildings and whether the environment is dementia and disability friendly.

Mrs Ridge advised that the scoring is submitted nationally and each hospital is benchmarked. Mrs Ridge also advised that any issues picked up are shared with the nursing teams straight away and feedback given after each audit.

The EF and D Management Committee reviewed any estate type issues such as hearing loops, flooring and handrails and good progress had been made in these areas.

Mrs Ridge advised that funding was an issue as there was no set budget for PLACE but that the improvements had to come out of the capital budget.

Mrs Stern added that she was currently an assessor and the process probed patients for their views (should they want to give them) and anything shared was recorded for submission to NHS Digital.

Resolved:
The Committee received and accepted the update and requested a follow up after the new process had been implemented.

Mrs C Gorman and Mrs Z Ridge left the meeting

4.3 Quality Accounts Update
Mrs Southgate presented the Draft Quality Accounts for the Committee to review them before they were sent to the Trust's stakeholders for their comments.

Mrs Southgate advised that there were still areas requiring information before the CEO statement was added. The Quality Improvement Plan was being updated to incorporate the key projects.

Mrs Southgate advised that the CQC, duty of candour and data quality were some of the projects included and that KPIs, aims and objectives were being finalised.

Mr Hall asked if the report was prescribed as it was not an easy read and Mrs Southgate confirmed that is was.

Resolved:
The Committee received and accepted the Draft Quality Accounts.

4.7 Learning from Deaths Update
Dr Purva updated the Committee regarding the number of deaths in Quarter 4 and the Structured Judgement Reviews carried out. She advised that there were themes emerging and two of these were communication and training. Actions were in place to address these issues.

Dr Purva also mentioned the Medical Examiner role and how this would

be piloted in May 2019.

The Committee discussed end of life care and how many patients die in the hospital that could have died at home or in a nursing home. Dr Purva advised that the there was much work to do and was very complex.

Resolved:
The Committee received and accepted the report.

Mr Nearney joined the meeting

4.4 People Strategy Refresh
Mr Nearney attended the meeting to update the Committee regarding the People Strategy Refresh. Mr Nearney also presented a high level report that summarised the last 3 years progress for context.

Mr Nearney reported that a Board time out session had taken place and he would be presenting the final strategy at the Board meeting in May 2019 as well as presenting to the Performance and Finance Committee in April 2019.

The document had been circulated to the Patient Council, management teams, staff, the Triumvirates and the Board for comments and feedback had been received.

There was a discussion around the recruitment campaign and how new roles were having an impact on difficult to recruit and other vacancies. Mr Nearney added that work was ongoing to look at joint posts with partners and managing integrated services.

Resolved:
The Committee received and accepted the report.

Mr Nearney left the meeting.

5.   **5.1 Integrated Performance Report**
Ms Ramsay advised that Mrs Cope the Chief Operating Officer would be attending the meeting from May 2019 onwards which would mean that items in the IPR affecting quality of care could be discussed in more detail.

Resolved:
The Committee received and accepted the report.

5.2 Operational Quality Committee
Dr Purva presented the item and advised that the Committee had discussed the VTE Quality Improvement Plan in detail. Performance was at 92% and work was ongoing to achieve the standard and embed the practices.

Resolved:
The Committee received and accepted the report.

6.   **Board Assurance Framework**
Ms Ramsay presented the draft BAF year-end position, giving the

Committee the opportunity to comment on any gaps or errors and give feedback on the quarter 4 ratings. Ms Ramsay reported that the BAF would be presented to the Board in May 2019 for final approval.

The Committee discussed the new Trust objective of research and innovation and the risk of not achieving it and whether it should be included in the 2019/20 BAF.

Resolved:
The Committee received and accepted the report.

7. **Any Other Business**
    Prof Veysey asked if the June meeting could be re-arranged to the following week due to annual leave.   **RT**

8. **Chairman's Summary to the Board**
    The Chair agreed to summarise the meeting to the Board.

9. **Date and time of the next meeting:**
    Wednesday 29 May 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust

Quality Committee
Held on 25 March 2019

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
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Mrs S Murray	Head of Occupational Therapy
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance

In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action

1 Apologies

Mrs A Green – Lead Clinical Research Therapist and Mrs S Bates – Deputy Director of Quality Governance and Assurance, Mrs M Stern – Chair of Patient Council

2 Declarations of Interest

There were no declarations of interest.

3 Minutes of the meeting held 25 February 2019

Prof Jomeen to be changed to a Non-Executive Director from an Associate Non-Executive Director on the minutes from January 2019.

Following this change the minutes were approved as an accurate record.

3.1 Matters Arising

There were no matters arising.

3.2 Action Tracking List

Mrs Geary agreed to circulate the Maternity Dashboard. **BG**

There was a discussion around Getting it right first time and how getting the quality element right could possibly lead to financial savings.

Dr Purva to provide an update relating to GIRFT at the next meeting. **MP**

3.3 Any other matters Arising

There were no other matters arising.

3.4 Workplan 2018/19, 2019/20

Ms Ramsay presented the 2018/19 workplan and advised that it was updated and on track for the year.

Ms Ramsay also presented the 2019/20 workplan and advised that a new section had been added regarding Education and a paper

introducing the item would be received at the April 2019 meeting. Mrs Walker, Prof Veysey and Ms Ramsay had met to discuss this item and how it should be presented to the committee. There was a discussion around how the Trust supported education and also the wider remit of how lessons are taught and disseminated to ensure the Trust was a learning organisation. Prof Jomeen added that a focus on clinical research was required and Mrs Walker added that behaviours and communications should also come under this agenda item.

It was agreed that the Committee would invite Mr Nearney in June 2019 to give an update on the People strategy and become part of the learning discussion.   **RT/SN**

Resolved:
The Committee received and accepted the workplans.

4.1 Serious Incidents – Lessons Learned
Mrs Southgate presented the report and advised that there had been non Never Events since March 2018.

There had been 1 serious incident de-escalated by the Commissioners following review and analysis.

There had been a number of Serious Incidents closed in the month one of which was a maternity incident relating to the use of latex gloves and an adverse reaction. The Committee discussed the use of latex gloves and why the Trust had latex and non-latex in stock.

She also mentioned a medication incident relating to the contract held with Boots and a stock holding issue. Mrs Southgate added that Boots had communicated well with the Trust during the process.

Mr Hall asked about the process around de-escalation of incidents and Mrs Southgate advised that the Trust made recommendations to the Commissioners based on the national framework. It was ultimately the Commissioners responsibility to de-escalate.

There was a discussion around a delayed diagnosis of a patient with learning difficulties and Mrs Walker was concerned that the patient attended a follow up appointment and was not seen. Mrs Southgate agreed to review the recommendations as to why this had happened.

Prof Veysey expressed his concern that the MDT protocol had not been followed for this patient and Mrs Southgate advised she would look into this as well.

Prof Jomeen spoke about the Serious Incident where there was a delay in recognition of the development and treatment of diabetic ketoacidosis (DKA) which resulted in the woman being admitted to the Acute Medical Unit (AMU) and subsequently to the Hull Royal Intensive Care Unit (ICU). Prof Jomeen was concerned that the process was fundamental and should have been carried out as part of basic care. Mrs Southgate, Mrs Geary and Dr Purva would review the Serious Incident and provide and update in the next report.   **KS/BG/MP**

Ms Ramsay asked for a review of the Terms of Reference for Serious Incident panels to be reviewed to ensure chairs of panels were using appropriate guidance.

Resolved:
The Committee received and accepted the report.

4.2 Quality Improvement Programme
Mrs Southgate presented the Quality Improvement Programme and highlighted the projects that would be carried over from 2018/19 and new 2019/20 projects.

Projects being carried over included medicines optimisation (discharge), the deteriorating patient, infection control, falls, pressure ulcers, mental health and VTE. The introduction of NEWS 2 and wifi coverage would impact greatly on these areas.

The nutrition QIP had not performed as well as it could have but Mrs Southgate added that the performance indicators were being reviewed and work was ongoing with Mrs Ledger and Mrs Filby. Prof Jomeen expressed her concern regarding nutrition as this should be basic care and recording of care.

The Committee discussed Patient Experience and the engagement required for a 'Good' or 'Outstanding' Trust. Prof. Veysey suggested that Mrs Stern as Chair of the Patient Council could help in this matter.

The GIRFT (Getting it Right First Time) was no longer part of the QIP and the project had its own governance arrangements in place.

Mr Hall asked about the process around setting QIPs and smart objectives and Mrs Southgate advised that a meeting took place to discuss the project and set objectives. The Operational Quality Committee monitored each one on a monthly basis.

Prof Veysey asked how the Committee could monitor the indicators in a better way and have an earlier warning that projects were going off track. Mrs Southgate advised that she was setting up a sub committee to review the projects in more detail to ensure they were on track.

Resolved:
The Committee received and accepted the report.

4.3 Benchmarking NPSA
Mrs Southgate advised that the data would not be available until the middle of the week and would provide a report to the April 2019 meeting.

Mrs Southgate added that she would provide details regarding the staff survey results around reporting incidents and the significant improvements that had been made.

Resolved:
The Committee received and accepted the update.

5.1 Integrated Performance Report
The Committee received the report.   Mr Hall asked about 30 day readmissions and where this area was being discussed. Dr Purva advised that it would be the Quality Committee. Dr Purva stated that 30 day readmissions were reviewed and there were no issues to escalate at this time.

Mr Hall updated the Committee with the items from the report that would be the focus of the Performance and Finance Committee meeting that afternoon, they were diagnostic waiting times, RTT, 52 week waits and ED. Mr Hall was interested in the plans for the new GP facility in the Emergency Department.

The Committee discussed benchmarking performance against the indicators in the Integrated Performance Report.

Resolved:
The committee received and accepted the report.

5.2 Operational Quality Committee Report
Dr Purva presented the summary report to the Committee. She highlighted the Health Group escalation reports, and how claims were being reported at the Health Group governance meetings. Dr Purva also highlighted the issues around the outpatient backlog and the new processes being put into place.

There was a discussion around the Quality Accounts priorities and how the consultation and engagement process was being managed. Dr Purva added that work was ongoing to triangulate Serious Incident investigations with QIP outcomes to inform the Quality Accounts.

The summary sheet was discussed and how reports were being escalated to the Quality Committee. Ms Ramsay agreed to discuss this further with Mrs Geary and Mrs Southgate.

Resolved:
The Committee received and accepted the report.

6   **Board Assurance Framework**
Ms Ramsay presented the Board Assurance Framework and advised that the Board agreed the proposed quarter 3 ratings at its last meeting in March 2019.

She asked the Committee to review BAF 3 (Quality of Care) and look at whether the Trust had made progress or improvements to reduce the risk rating for 2019/20 or whether it should increase. Ms Ramsay stated that there had been assurances gained through the QIP and the Committee now received the Serious Incident Lessons Learned report which gave assurance.

Prof Veysey stated that he thought the quality agenda was in a steady state and there were no extreme shifts either way. He was assured that processes were now in place but that there was more work to do. Dr Purva added that the Trust should not down play its achievements.

The Committee discussed the Quality Improvement Programme and how that was fine tuning a number of issues such as VTE and the wifi implementation. These improvements would help to reduce the risk rating overall.

Resolved:
The Committee received and accepted the report.

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

8   **Chairman's Summary to the Board**
The Chairman agreed to summarise the meeting to the Board in May 2019.

9   **Date and time of the next meeting:**
Monday 29 April 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

Trust Board – May 2019

Performance Report – Executive Summary

1. Performance Summary

The April Performance Report (for March data) details the following 'responsiveness' indicators (please note February data for cancer standards) which have failed to meet the required _national standards_:-

- The 95% 4-hour Emergency Care standard;
- The RTT Incomplete 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;
- Diagnostic 6 week wait standard

Whilst the Trust did not meet the _national standards_ outlined above, the Trust also failed to achieve agreed improvement trajectories related to the Strategic Transformation Fund (PSF) as outlined below:-
- The 89.9% trajectory for the 4-hour Emergency Care standard;
- The 84.2% trajectory for the RTT Incomplete standard;
- The 82.0 % 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 and monthly by the Performance and Finance Committee.

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. Unplanned Care

2.1 Emergency Department

ED performance for March 2019 demonstrated a 5.8% improvement on the February position achieving 80.7% in March. The Trust achieved 82% overall for 2018/19 and 89.70% overall for the system. In March, The Trust was ranked 3rd out of the 10 comparator group hospitals all of which are Major Trauma Centres. (see below) for Type 1 performance. The Trust maintained its record of having Zero 12 hour trolley waits for 2018/29.

March 2019	
Newcastle	93.1%
Leeds	87.0%
Hull	80.7%
Manchester	76.5%
Stoke	73.8%
Liverpool	73.4%
Sheffield	73.0%
Coventry	70.3%
Birmingham	66.7%
Nottingham	60.0%

Type 1 activity for Hull contributes 100% of the overall performance activity. No Type 2 or Type 3 activity is counted within the overall Trust performance. This is a somewhat unusual position across the Hospital Trusts nationally and certainly amongst our comparator group of Major Trauma Centres (MTCs), where the average contribution of type 1 activity to overall performance is 70%, Consequently If local type 2 and type 3 activity (and performance) was included within the Trusts activity, this would bring our Type 1 contribution of overall performance to 70% (in line with other MTCs) and our overall ED performance would be at or above the national average consistently. We have raised this matter with local CCGs and with NHSE/I to consider how we could more and accurately contextualise and benchmark Trust performance whilst progressing with the internal plans to Improve performance.

2.2 Ambulance Handover

Ambulance Handover times Improved during March to 17 minutes 24 seconds, an Improvement of 4 minutes on the previous month. The Electronic Patient Record (EPR) handover system was sucessfully implemented in March 2019 with minimimal disruption and there continues to be highly effectively collabortive working between the Trust and Yorkshire Ambulance Service at time of peak demand and escalation.

2.3 Length of Stay – Reduction in the number of patients with a LOS of greater than 21 days

The Trust and wider system continue to make good progress against the length of stay reduction target (see below) and the Trust continue to work with the national Emergency Care Intensive Support Team (ECIST) following an initial visit in February 2019.

Approximately 15% of patients with a long length of stay are patients who are medically fit for discharge from acute care but require a discharge supported by out of hospital services and therefore a programme of work is in place with community partners to improve the timelinness of discharges from the Trust, overseen by the Unplanned Care Delivery Group and the A&E Delivery Board.

For 19/20 a further reductions in the length of stay for patients in hospital for 21 days or longer with the requirement of reducing the proportion of beds occupied by long stay patients by 40% against the 17/18 baseline. A delivery trajectory, supported by a detailed action plan has been agreed by the Trust and the A&E Delivery Board to meet the 40% reduction and this continue will monitored monthly via the Performance and Finance Committee.

3. Cancer Performance

The Trust continues to perform well against the 2 Week standard and consistently met the standard throughout 18/19. Trust performance against the 62 day standard for February was 75.3% following breach allocation to other organisations. Breast, Lung and Skin were the tumour sites who met the

national 85% standard with 91%, 91% and 100% performance respectively. Waits for diagnostic tests, particularly CT and MRI continue to be the main reason for patients breaching the standard.

There is no national target regarding the number of patients waiting over 104 days for Cancer treatment but the expectation is for Trusts to *eliminate* long waiters. Therefore the Trust have agreed a trajectory to reduce long waiting patients in addition to providing assurance that they are being actively tracked and clinically managed ensuring no patient comes to harm. The 104 patients are reviewed weekly in the Cancer performance meeting(s). At the end of March 2019, a total of twenty (1.7% of the total PTL size) patients were waiting to be treated beyond day 104, against a trajectory of no more than 23. 4 of the 20 patients were late transfers from other Trusts.

4. Elective Performance

4.1 Waiting List Volume

The Trust achieved its commitment to deliver a Waiting List Volume below the 31/3/18 baseline. The overall Trust position was -1558 below baseline at the end of March.

4.2 52 Week Wait

The Trust reported Zero patients waiting over 52 weeks at the end of March and has set a trajectory of Zero patients over 52 weeks for 19/20. There remains continued risk of late Inter Hospital Transfers (IHTs) from other Trusts impacting on the delivery of the standard however these will be managed in accordance with the Inter-Hospital Transfer policy and exception reported accordingly should they breach.

4.3 Diagnostic 6 week standard

There has continued to Improve performance against the 6 week diagnostic standard with the percentages of breaches reducing to 3.8% for March 2019, which is best monthly performance for the year.

Magnetic Resonance Imaging	63
Computed Tomography	5
Non-obstetric ultrasound	5
Cardiology - echocardiography	14
Urodynamics - pressures & flows	17
Colonoscopy	50
Flexi sigmoidoscopy	1
Cystoscopy	153
Gastroscopy	59
TOTAL	367

4.4 Follow-Up Reduction Programme

A reduction in follow-ups has been identified as a priority for 19/20 and the Outpatient Programme Board has agreed the approach that will be taken over the course of the year which is intended to reduce the volume of follow-up by a half. Work has already commenced on the circa 2,000 'Priority Follow-up' patients which is due to be concluded by mid May and 3 specialties have been identified for phase 1 of the work; ENT, Cardiology and Urology. The approach will involve comprehensive administrative and clinical validation of every follow-up and re-design work, supported by the Trust Improvement Team focussing on progressing alternatives to face to face follow-ups, follow-up by other appropriately trained professional, use of alternative access plans (where clinically appropriate). The work will also review the 'front end' of the pathway to better manage referrals into the Trust.

Integrated Performance Report

2019/20

May 2019

March 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.

Integrated Performance Report - May 2019

RESPONSIVE

Description	Aggregate Position	Trend	Variation

NHS Hull University Teaching Hospitals NHS Trust

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 March 2019

Diagnostic waiting times has failed to achieve target during March with performance of 3.83%

DIAGNOSTICS
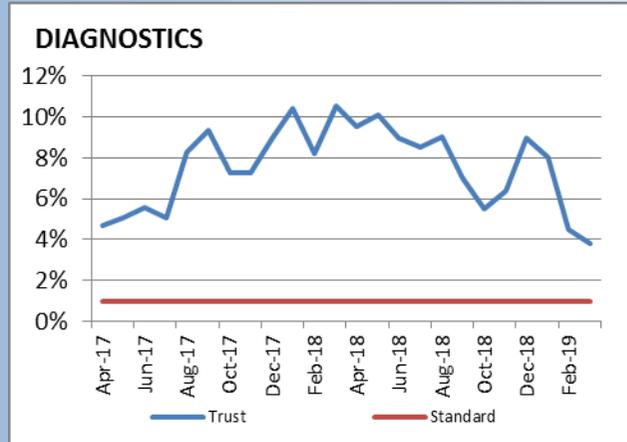
Referral to Treatment Incomplete pathway

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

The latest performance available is March 2019

The Trust failed to achieve the March improvement trajectory of 85.0%

March performance was 76.79%. This failed to meet the national standard of 92%.

INCOMPLETE PATHWAYS
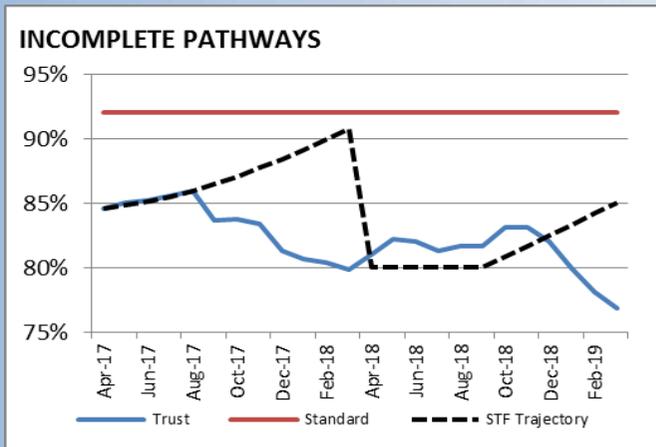
The RTT return is grouped in to 19 main specialties.

During the month there were 14 specialties that failed to meet the STF trajectory

Integrated Performance Report - May 2019

RESPONSIVE

NHS
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 week wait STF Improvement trajectory was revised 21st November 2018.

Performance achieved the improvement trajectory of zero breaches during March

The Trust achieved the national standard of zero breaches.

RTT - 52 week wait
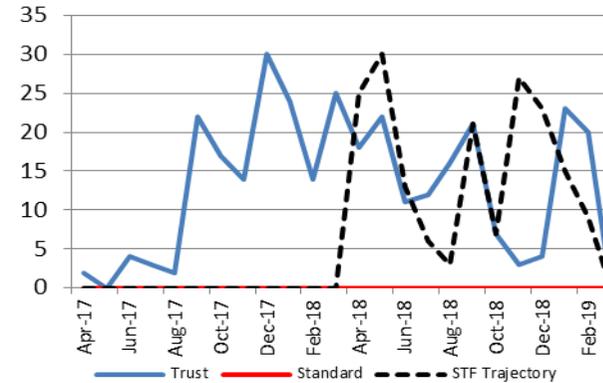
ED Waiting Times (HRI only)

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 90.8% with performance of 80.7% for March .

This has failed to achieve the national 95% threshold.

EMERGENCY DEPARTMENT (TYPE 1 HRI ONLY)
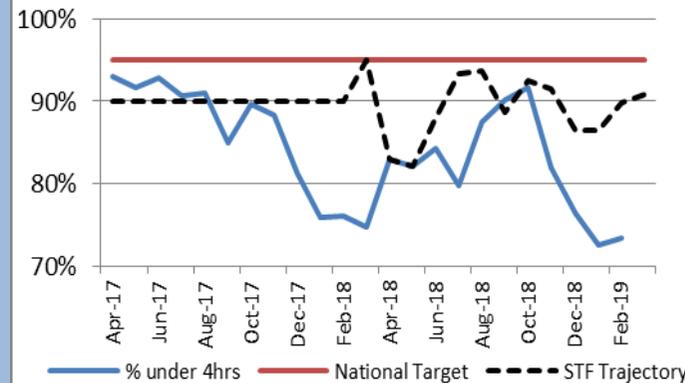
Performance has increased 7.2% during March

Integrated Performance Report - May 2019

RESPONSIVE

NHS
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%.

February performance achieved the 93% standard at 95.8%

CANCER 2WW
— Trust % — Target
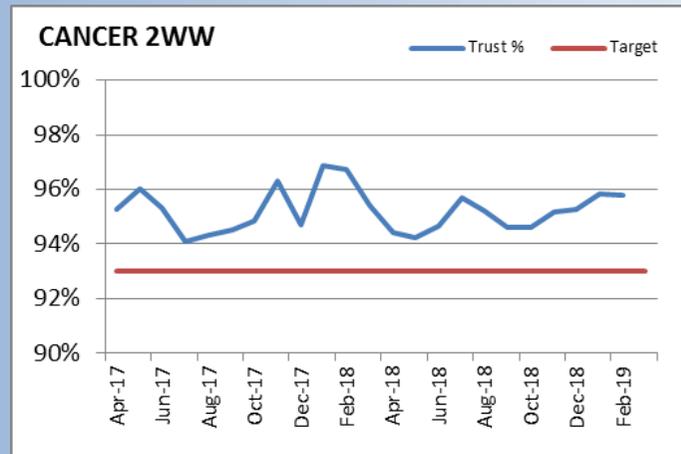
Cancer: Breast Symptom Two Week Wait Standard

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

February performance failed to achieve the 93% standard at 79.6%
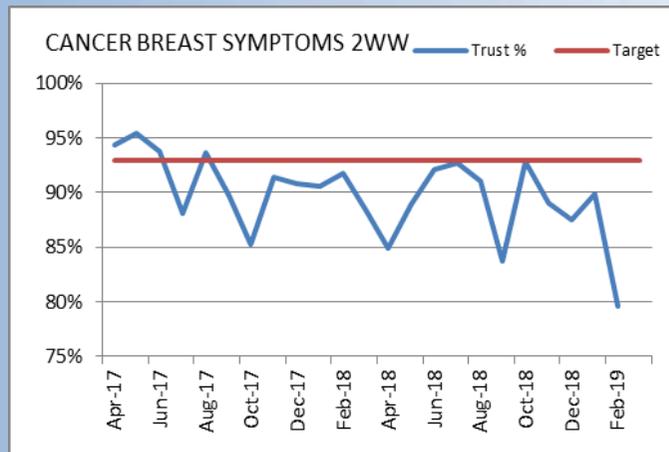
CANCER BREAST SYMPTOMS 2WW
— Trust % — Target

Integrated Performance Report - May 2019

RESPONSIVE

NHS
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%.

February performance failed to achieve the 96% standard at 94.4%

CANCER 31 DAY DTT
Trust %   Target
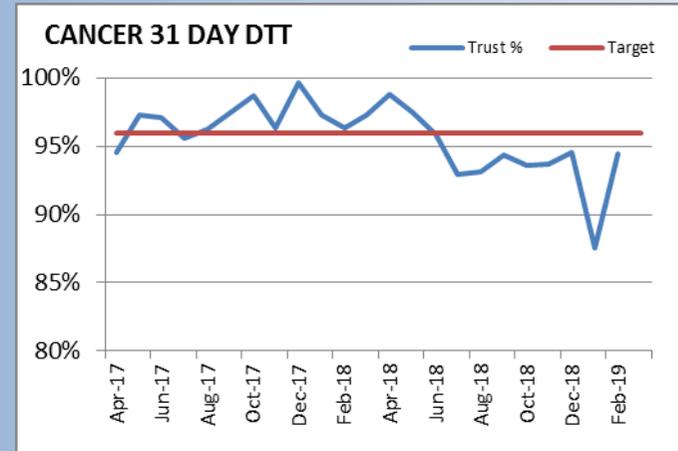
Cancer: 31 Day Subsequent Surgery Standard

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

February performance failed to achieve the 94% standard at 90.2%
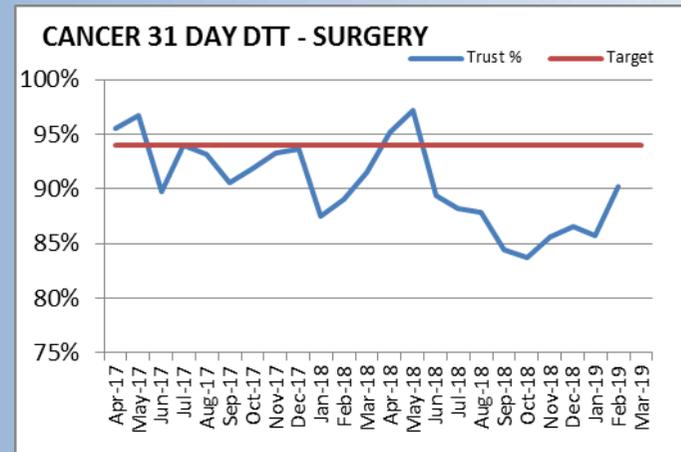
CANCER 31 DAY DTT - SURGERY
Trust %   Target

Integrated Performance Report - May 2019

RESPONSIVE

NHS
Hull University
Teaching Hospitals
NHS Trust

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%.

February performance achieved the 98% standard at 98.9%

CANCER 31 DAY DTT - DRUGS
— Trust %   — Target
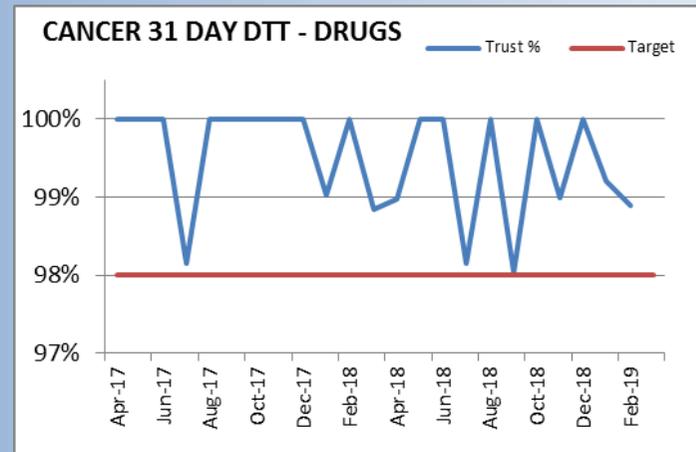
Cancer: 31 Day Subsequent Radiotherapy Standard

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

February performance achieved the 94% standard at 98.3%
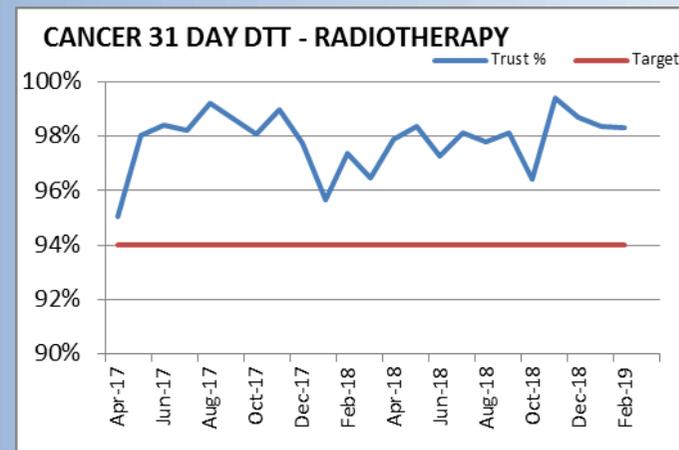
CANCER 31 DAY DTT - RADIOTHERAPY
— Trust %   — Target

Integrated Performance Report - May 2019

RESPONSIVE

NHS
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

February adjusted performance failed to achieve the STF trajectory of 83.0% with performance of 75.3%

CANCER 62 RTT

Legend: Adjusted Trajectory, % performance, Adjusted Performance, Standard
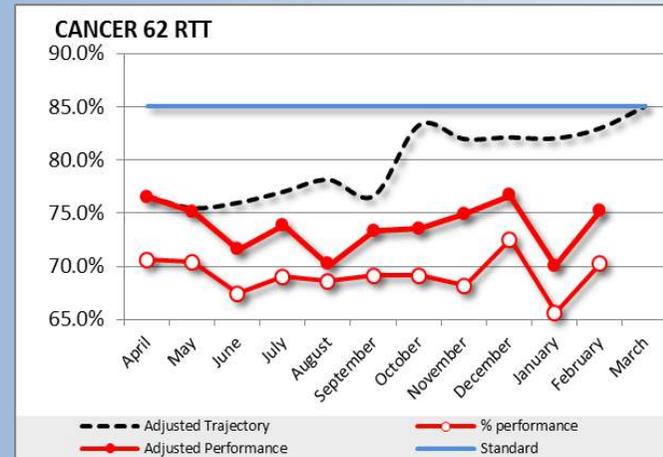
Cancer: 62 Day Screening Standard

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

February performance failed to achieve the 90% standard at 68.2%
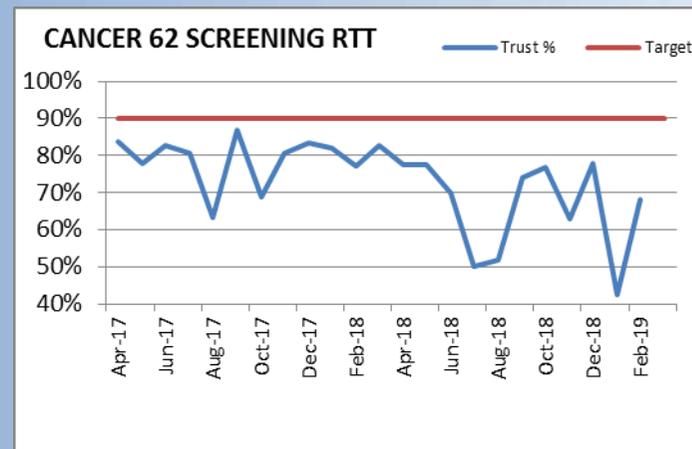
CANCER 62 SCREENING RTT

Legend: Trust %, Target

Integrated Performance Report - May 2019

RESPONSIVE

NHS
Hull University
Teaching Hospitals
NHS Trust

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 25 patients waiting 104 days or over at the end of February

CANCER 104 DAY WAIT
— Total
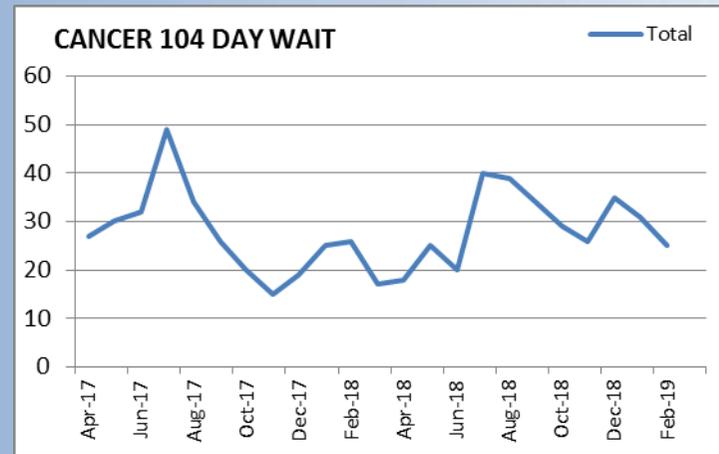
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 February 2019.

The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 90.1%

DEMENTIA: FIND
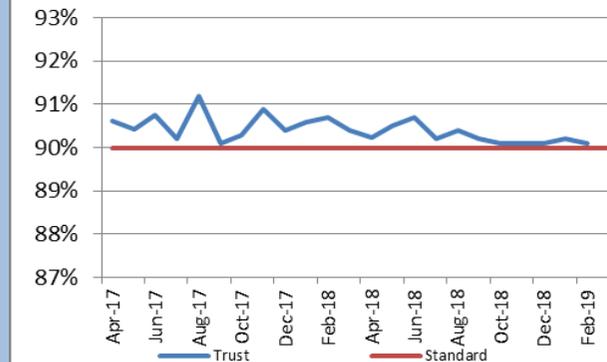
— Trust — Standard

Integrated Performance Report - May 2019

RESPONSIVE

NHS
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 February 2019

The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 100%

DEMENTIA: ASSESS/INVESTIGATE
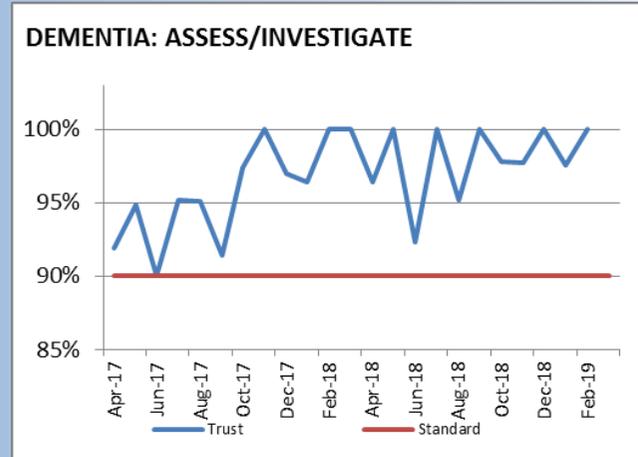
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 February 2019.

The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 100%

DEMENTIA: REFERRAL

Integrated Performance Report - May 2019

SAFE

NHS
Hull University
Teaching Hospitals
NHS Trust
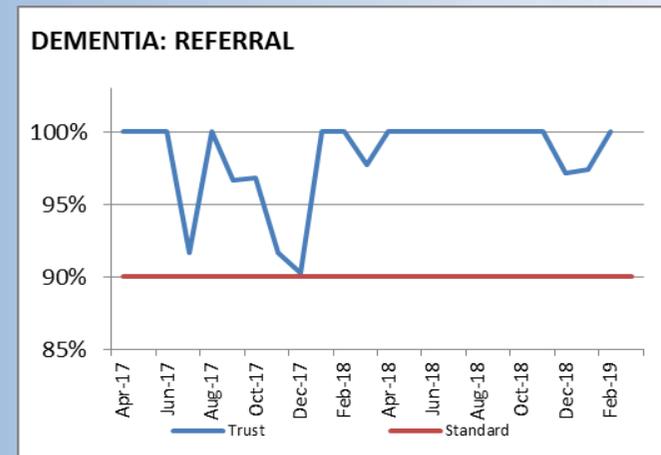
Description	Aggregate Position	Trend	Variation

Occurrence of any Never Event

Occurrence of any Never Events

The latest available performance is March 2019

The Trust reported 6 Never Events in 2017-18

There were no cases reported during March 2019.

NEVER EVENTS — Trust
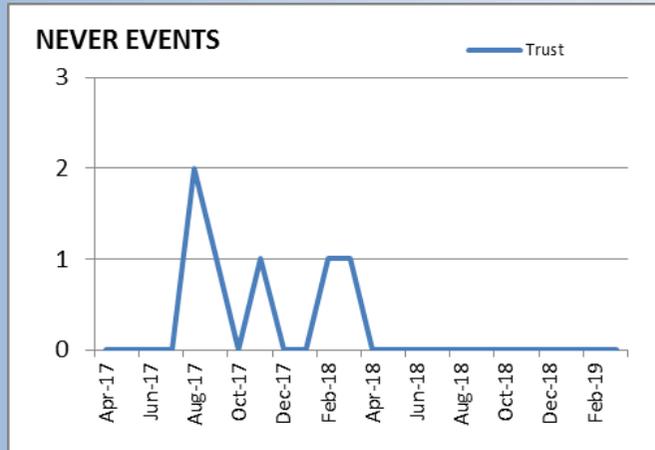
Further information is included in the Board Quality report

Potential under-reporting of patient safety incidents

Number of incidents reported per 1000 bed days

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

The Trust reported 7,984 incidents (rate of 48.83) during this period. This rates the Trust in the highest 25% of reporters
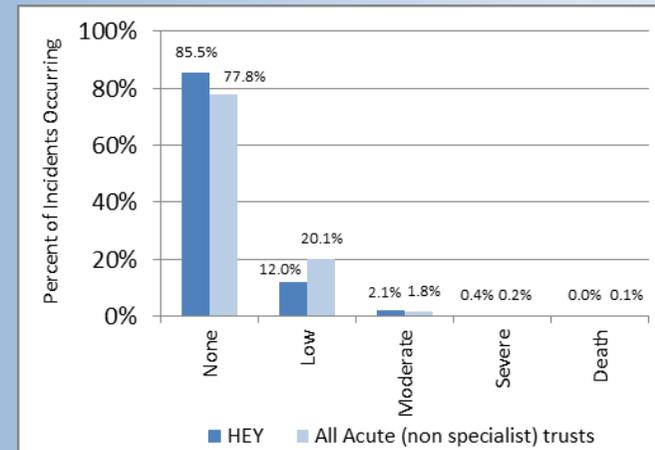
Percent of Incidents Occurring

	None	Low	Moderate	Severe	Death
HEY	85.5%	12.0%	2.1%	0.4%	0.0%
All Acute (non specialist) trusts	77.8%	20.1%	1.8%	0.2%	0.1%

■ HEY   ■ All Acute (non specialist) trusts

Integrated Performance Report - May 2019

NHS
Hull University Teaching Hospitals
NHS Trust

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.

VTE
— Trust — Standard

X-axis: Q1_1718, Q2_1718, Q3_1718, Q4_1718, Q1_1819, Q2_1819, Q3_1819, Q4_1819
Y-axis: 70% to 100%

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 March 2019.

There have been no outstanding alerts year to date.

OUTSTANDING ALERTS
— Trust

X-axis: Apr-17, Jun-17, Aug-17, Oct-17, Dec-17, Feb-18, Apr-18, Jun-18, Aug-18, Oct-18, Dec-18, Feb-19
Y-axis: -1 to 1

Integrated Performance Report - May 2019

SAFE

NHS
Hull University
Teaching Hospitals
NHS Trust

Description	Aggregate Position	Trend	Variation

MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

The Trust reported 1 case of acute acquired MRSA bacteraemia during 2017/18.

There were no cases reported during March 2019.

There have been 3 cases reported year to date.

MRSA
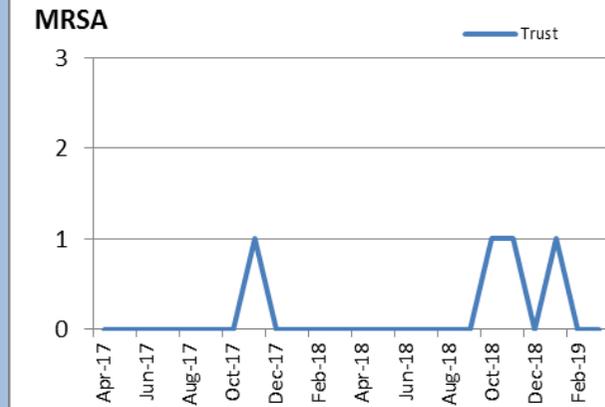
Further information is included in the Board Quality report

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 March which achieved the monthly trajectory of no more than 5 cases

Year to date position is 29 cases against the target of no more than 52 cases.

CDIFF

Further information is included in the Board Quality report

Integrated Performance Report - May 2019

NHS
Hull University
Teaching Hospitals
NHS Trust

Description	Aggregate Position	Trend	Variation

Escherichia Coli

Number of incidence of E.coli bloodstream infections

There were 110 cases during 2017/18

There were 16 incidences reported during February 2019.

There have been 112 incidences reported year to date.

E.COLI — Trust
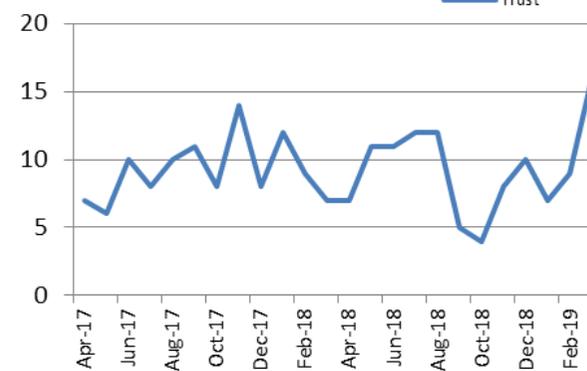
Klebsiella spp bacteraemia

Number of incidence of Klebsiella spp bacteraemia

There were 2 cases reported during March 2019.

There have been 38 incidences reported year to date.

Klebsiella spp bacteraemia — Trust

Integrated Performance Report - May 2019

SAFE

Description	Aggregate Position	Trend	Variation

Pseudomonas aeruginosa

Number of incidence of Pseudomonas aeruginosa bacteraemia

There has been zero incidences reported during March 2019.

There have been 13 incidences reported year to date.

Pseudomonas aeruginosa bacteraemia

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 March failed to achieve this standard at 16.80%

EMERGENCY C-SECTION
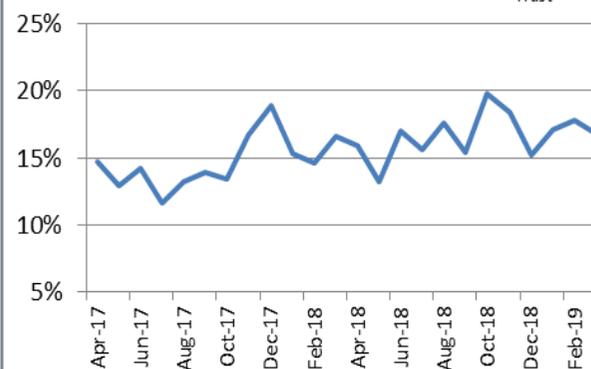
Further information is included in the Board Quality report

Integrated Performance Report - May 2019

EFFECTIVE

Description	Aggregate Position	Trend	Variation
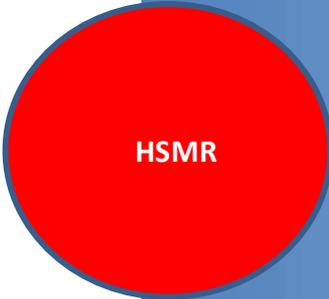
HSMR

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

January 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and January failed to achieve this at 109.2

HSMR — Trust / Trajectory chart, Apr-17 to Feb-19
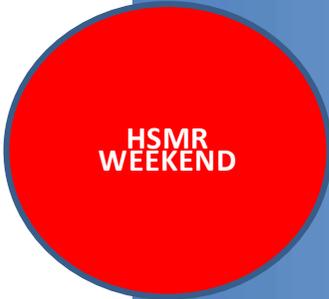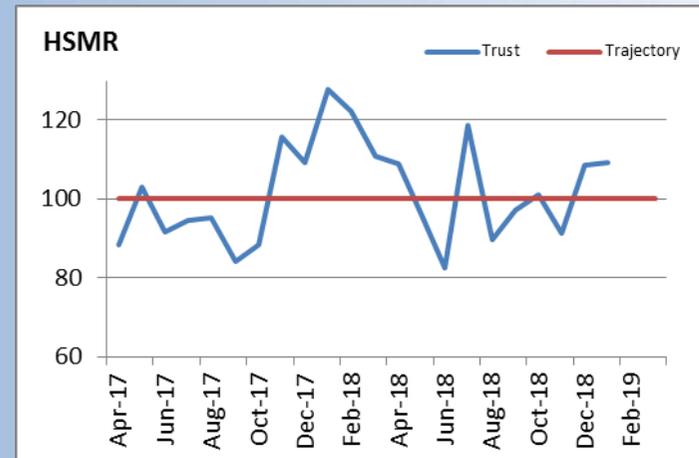
HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

January 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and January failed to achieve this at 129.0

HSMR - WEEKEND — Trust / Trajectory chart, Apr-17 to Feb-19

Integrated Performance Report - May 2019

EFFECTIVE

NHS
Hull University
Teaching Hospitals
NHS Trust

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.

September 2018 is the latest published performance

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

SHMI — Trust / Trajectory
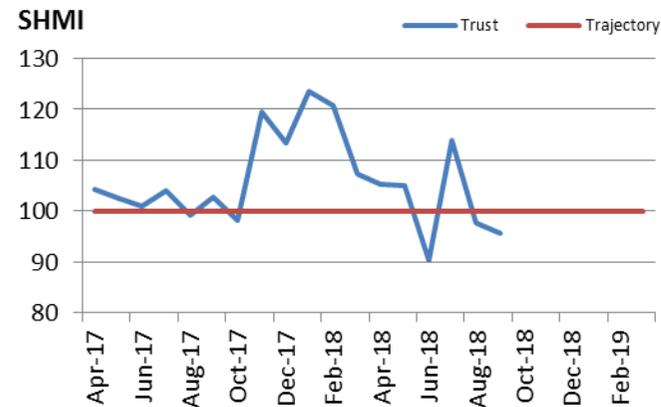
30 DAY READMISSIONS

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

The latest available performance is February 2019

The Trust should aim to achieve less than or equal to 2017/18 performance of 7.8%. The Trust achieved this measure with performance of 7.8%.
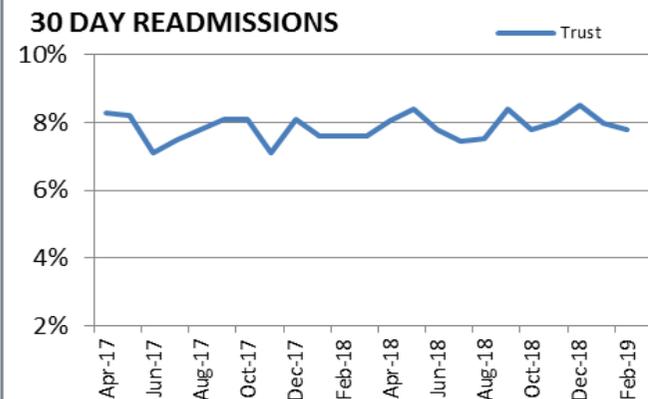
30 DAY READMISSIONS — Trust

Integrated Performance Report - May 2019

CARING

NHS
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 February was 98.98%

The latest published data for NHS England is February 2018.

March performance will be published on 9th May 2019.

FFT - Inpatients — Trust — NHS England
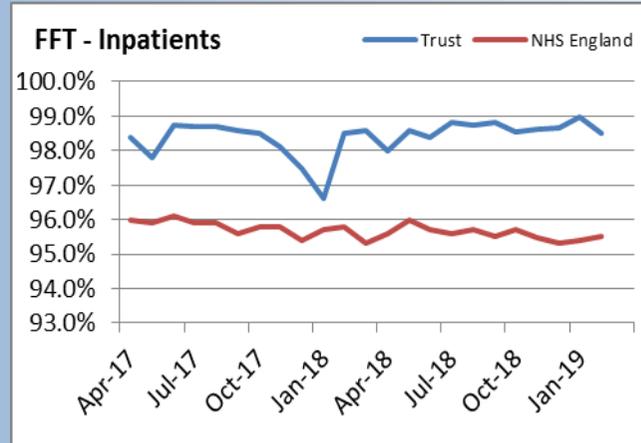
A&E Scores from Friends and Family Test - % positive

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

Performance for February was 82.64%

The latest published data for NHS England is February 2018.

March performance will be published on 9th May 2019.

FFT- A&E — Trust — NHS England

Integrated Performance Report - May 2019

CARING

NHS
Hull University
Teaching Hospitals
NHS Trust
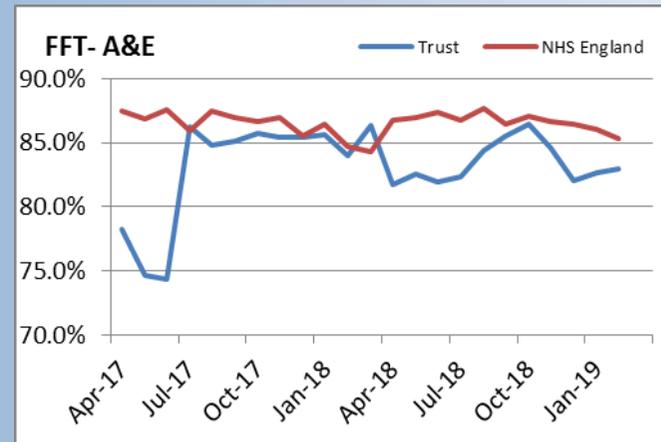
Maternity Scores from Friends and Family Test - % Positive

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

Performance for February was 100%

The latest published data for NHS England is February 2018.

March performance will be published on 9th May 2019.

FFT- Maternity Services*   ■ Trust   ■ NHS England
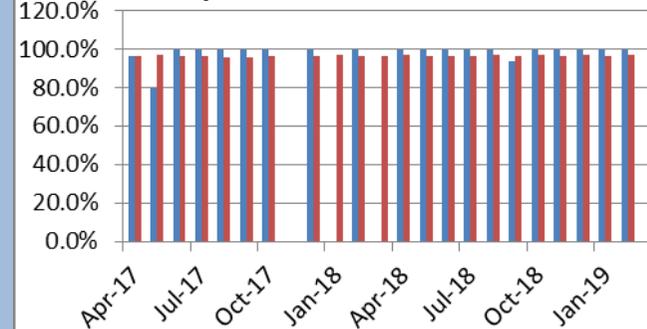
* Question relates to Birth Settings

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 Q3 shows 62.6% of surveyed staff would recommend the Trust as a place to work, this has decreased from the Q2 position of 69.1%.

STAFF FFT - WORK   — Trust

Integrated Performance Report - May 2019

CARING

NHS
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 Q3 shows 70.1% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has decreased from the Q2 position of 84.0%.

STAFF FFT - CARE — Trust

(Line chart: y-axis 60% to 90%; x-axis categories Q1_1718, Q2_1718, Q3_1718, Q4_1718, Q1_1819, Q2_1819, Q3_1819, Q4_1819)
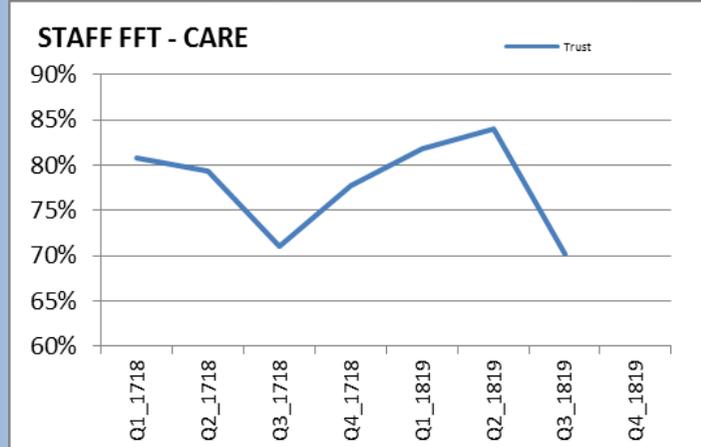
Written Complaints Rate

The number of complaints received by the Trust

The latest available position is March 2019.

The Trust received 76 complaints during March, this has increased from the February position of 45 complaints

WRITTEN COMPLAINTS — Trust

(Line chart: y-axis 0 to 80; x-axis months Apr-17 to Feb-19)
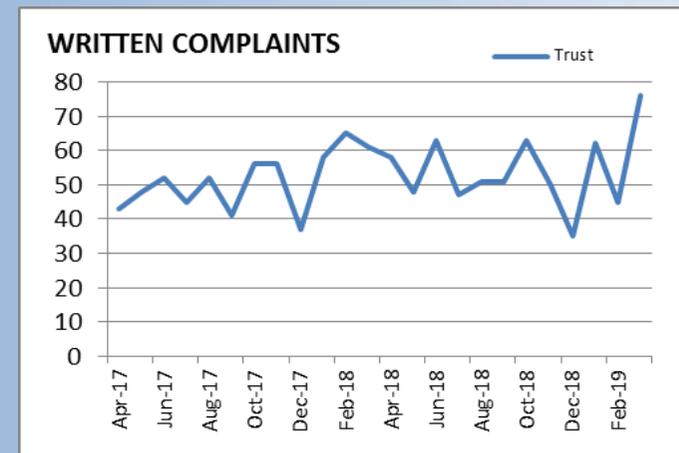
There have been 649 complaints year to date

Integrated Performance Report - May 2019

CARING

Description	Aggregate Position	Trend	Variation

Mixed Sex Accommodation Breaches

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

There were no occurrences of mixed sex accommodation breaches throughout March 2019.

MIXED SEX ACCOMODATION
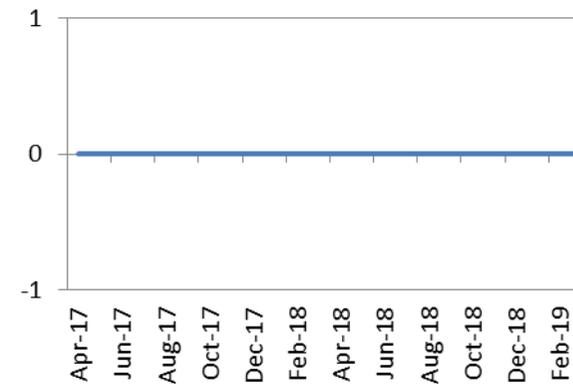
Integrated Performance Report - May 2019

ORGANISATIONAL HEALTH

NHS
Hull University
Teaching Hospitals
NHS Trust

Description	Aggregate Position	Trend	Variation

WTEs in post

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

Aggregate Position: Trust level WTE position as at the end of March was 7486

WTE in post — Trust
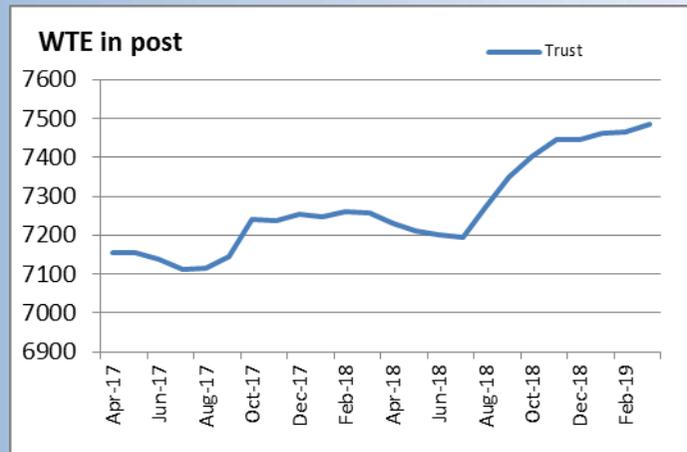
Sickness Absence Rates

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

Aggregate Position: Performance for March achieved the standard of less than 3.9% with performance of 3.45%
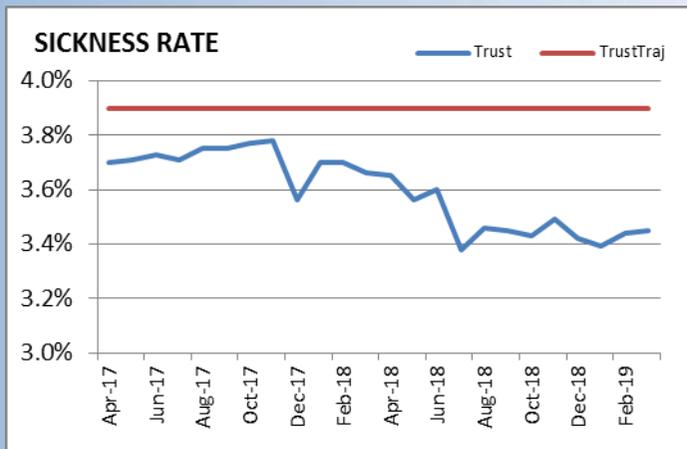
SICKNESS RATE — Trust — TrustTraj

Integrated Performance Report - May 2019

ORGANISATIONAL HEALTH

NHS 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 March.

EXEC TEAM TURNOVER — Trust
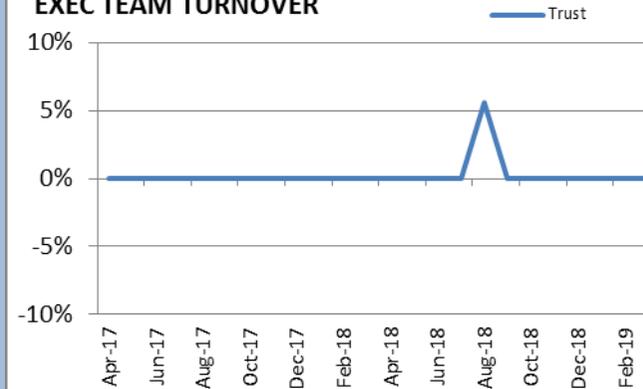
Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

March performance was 3.99%

TEMPORARY STAFF — Trust

NHS
Hull University
Teaching Hospitals
NHS Trust

FINANCIAL SUMMARY: 12 MONTHS TO 31st MARCH 2019

SUMMARY TRUST YEAR END POSITION

1. The Trust had a plan for the year of a £10.2m deficit. In return for which we would receive £12.6m Provider Sustainability Funding (PSF) and deliver a surplus of £2.4m. Of the PSF, £3.8m was contingent on achievement of the ED target.

2. The Trust achieved the £10.2m target. However it only hit 2 quarters of the ED target so only received £10.7m PSF resulting in a small surplus of £0.5m.

3. In month 12 the Trust received additional income from a number of parties that it was not expecting including a £3.9m donation from an external body. This totalled £8.2m and has increased the surplus to £8.7m.

4. The Trust will receive an additional £8.2m matched funding for delivery above the control total which will increase the surplus to £16.9m. The Trust has also just been notified of its bonus PSF which is a further £8.3m (including compensation of £0.5m re the agenda for change funding not received for the outsourced contract). Thus the final reported surplus is £25.2m.

DETAILED COMMENTARY

1. The Trust has received additional income of £4.3m in month including £2.9m from local Commissioners to reflect work undertaken under the AIC during the year. This takes the total additional income for the year to £12.7m overall.

2. The Trust has delivered £14.4m CRES against a target of £19.9m (72% delivery) with £1.7m delivered in month as per forecast. Excluding the £2.9m SPV scheme this gives 85% delivery. However on a recurrent basis only 60% of the target has been achieved with a £7.1m shortfall in the recurrent position which contributes towards the high level of CRES required in 19/20.

3. In month 12 the Dept of Health notified the trust that it would not be funding the agenda for change costs relating to staff employed by OCS who previously worked for the Trust. (£0.5m).

4. HG run rate positions are £5.8m overspent at month 12, an increase of £0.7m in month and £0.6m more than forecast. The main deterioration was in non pay spend within Surgery which is being reviewed in line with activity undertaken. Pathology non pay spend also continued to overspend.

5. Agency spend to the end of March is £11.6m which is £2.7m above planned level of £8.9m, an additional increase of £0.3m above plan in month. The variance is driven by agency medical staffing with the main variances relating to junior medical staff (£1.0m) and Consultant cover (£1.2m). There is also a small amount of Professional & Technical staff (£0.2m) Total agency has increased by £1.6m compared to 2017/18.

6. The reported capital position at month 12 shows gross capital expenditure of £23.5m (including PFI/IFRIC 12 impact) which, after accounting for disposals and donations, is in line with the agreed CRL. The capital position has reduced by £14.9m from the original financial plan, mainly as a result of slippage on loan funding into 2019/20 (£16.3m) relating to medical equipment and energy. In year, the Trust received PDC funding totalling £5.1m for the purchase of a linear accelerator (£1.7m), Winter Ward (£2.2m), HSLI (£0.9m), Digital Slide scanners (£0.2m), Patient Wi-Fi (£0.2m) and other cancer transformation (£0.1m). Of this PDC, £2m in relation to linear accelerator and slide scanners was reflected in the plan.

7. The Trusts liquidity position continues to be relatively stable and has been boosted by the additional cash received from year end agreements.

8. The Trusts underlying run rate stands at £24.7m reduced from £25.6m reported at end of 17/18. This underlying run rate includes the shortfall in recurrent CRES of £7.1m (see point 2) and is a key factor in driving the high level of CRES required in 19/20. NHSI have used £13m as the starting point for the Trusts control total for 19/20. In order to meet this assumption, additional savings of £11.7m are required to be delivered in on top of the general 1.6% CRES target that is built into the annual NHS financing system for Trusts in deficit.

Integrated Performance Report - May 2019

ORGANISATIONAL HEALTH

NHS Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of March we had £5.611m of cash and cash equivalents, comprising of monies in the bank of £5.597m and £0.014m in petty cash floats. The cash position remains stable and the availability of cash is reflected in our BPPC performance, which although lower than the required standard is good and improving. At £5.611m cash was higher than planned and was due to the receipt of £3.4m into the bank on 30 March. The Trust met its External financing limit for the year undershooting the target by £3.7m. The undershoot was primarily due to the late receipt of the £3.4m.
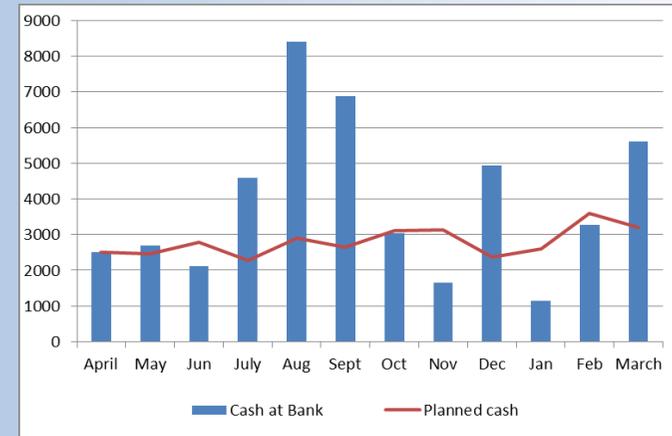
CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 12 the planned level of savings is £19.9m, the actual savings are £14.4m (72%) thereby creating a £5.5m 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.
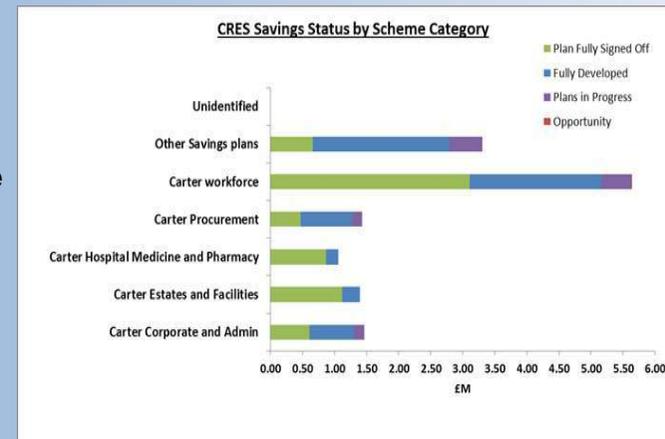
CRES Savings Status by Scheme Category

ORGANISATIONAL HEALTH

NHS
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 12 the Trust is reporting a YTD Surplus of £25.2m against a planned position of £2.4m deficit. This has resulted in liquidity and agency being rated at a 3 , I&E margin being rated as 1 and capital servicing as a 2. Giving an overall risk rating of 2.

2018/19 Risk Rating Analysis
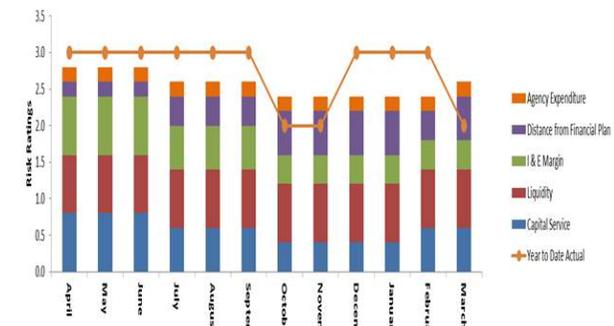
Income & Expenditure

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 12 the Trust has delivered a surplus of £25.2m against a planned deficit of £2.4m

Net I & E Analysis 2018/19 by month
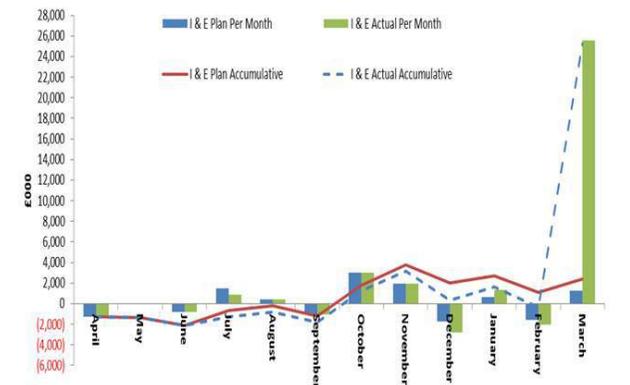
Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

Meeting Date:	29 April 2019	**Chair:**	Stuart Hall	**Quorate (Y/N)**	Y

Key issues discussed:
- Board Assurance Framework – 2018/19 year end position was discussed, in particular BAF 7.1 relating to the Control Total
- Exception reporting – ED, Cancer, RTT, Outpatients, diagnostics and the Health Group positions at year end were discussed.
- IM&T/Digital Exemplar – an update regarding the network and wifi roll out and new team structure
- Demand and Activity – year end referral, activity and financial positions were presented
- Year End Financial position 2018/19 – Trust achieved £25.2m surplus – Trust achieved 85% of CRES plan
- 2019/20 Baseline Budgets – Health Groups underlying position £23.5m
- Variable pay – The Trust had spent £33m in year , mainly in Junior Doctors and consultant cover but also on nursing staff.
- Job Vacancy report – The Trust was performing well with a vacancy rate of just over 5%
- People Strategy Refresh – committee members were asked to submit comments regarding the strategy
- Capital Resource Allocation Committee minutes were received for information
- Lord Carter of Coles minutes were discussed
- Contract recommendation for the provision of Laundry Services was received.

Decisions made by the Committee:
- The Committee recommended approval of the Laundry Services contract to the Board

Matters escalated to the Board for action:
- The Committee recommends that the Board approve the Laundry Services Contract

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee held on 29 April 2019

Present: Mr S Hall   Non-Executive Director (Chair)
               Mr M Gore   Non-Executive Director
               Mr L Bond   Chief Financial Officer
               Mrs T Cope   Chief Operating Officer
               Ms C Ramsay   Director of Corporate Affairs
               Mr S Nearney   Director of Workforce and OD
               Mr S Evans   Deputy Director of Finance
               Mrs A Drury   Deputy Director of Finance
               Mr T Curry   Associate Non-Executive Director

In Attendance: Mrs R Thompson   Corporate Affairs Manager (Minutes)

Mr Hall welcomed Mr Curry to the meeting.

No	Item	Action

1   Apologies:
    Apologies were received from Mrs T Christmas, Non-Executive Director

2   Declarations of Interest
    There were no declarations made.

3   Minutes of the meeting held on 25 March 2019
    The minutes were approved as an accurate record of the meeting.

4   Matters arising from the minutes
    There was a discussion around the joint energy initiative with Hull City
    Council and Mr Bond advised that the discussions were ongoing.

    Mr Gore asked about a deep dive into physiotherapy from a productivity
    point of view and Mr Evans agreed to review this.   **SE**

5   Action Tracking List
    The action tracking list was reviewed by the Committee.

6   Workplan 2019/20
    Ms Ramsay presented the plan and advised that all relevant items had been
    added to the agenda.

7   Board Assurance Framework – 2018/19 and 2019/20
    Ms Ramsay presented the Board Assurance Framework and highlighted
    BAF risk 7.1 for review due to the Trust achieving its Control Total and year-
    end financial position. Mr Bond advised that it should be changed to a 5 risk
    rating for the year end but a new risk rating be established for 2019/20.

    Mr Hall highlighted the requirement for a definite diagnosis of cancer by
    2020 and the increase to 40% reduction in long stay patients and whether
    these should be included in the 2019/20 BAF.

    Mr Gore also suggested that the pension tax issue be included in the
    financial section of the BAF.

    Ms Ramsay reported that the Board would discuss the BAF 2019/20 in May

2019.

Resolved:
The Committee received and accepted the report.

8   **8.1 Exception reports**
Mrs Cope presented the report and advised that A&E performance had improved by 5.8% with overall performance at 82%.

Readmission rates had been built into the dashboard and was being reported by exception. The target to reduce patients length of stay had been increased to 40% from 25% and this did include the rehab patients so community working would be key to achieving the target.

The diagnostic position was at its best ever and work was ongoing to sustain this performance. Mr Hall and Mr Gore commended the teams for their contribution to this as well as the 52 week wait performance which had achieved the 0 target. There were still challenges with other Trusts regarding late referrals. Mr Hall also commended the work relating to follow ups.

Mrs Cope gave a presentation regarding the Health Group year-end positons against the 6 commitments set out at the beginning of the year. She reported that the waiting list volume had worsened in year but was now showing a more favourable position, outpatient follow ups had increased, the 52 week waits had been reduced to 0 and there was still work to do regarding cancer, the PTL and 104 day waiters.

Mrs Cope reported that the Trust's original aim was to eliminate the ASI/Holding but that it had shown an increase of 1591. This was now a priority for the Executives.

Mrs Cope advised that the Trust had achieved it list size trajectory but this had impacted on RTT performance. She added that the level of errors which meant ongoing validation was still necessary.

Work was ongoing to clear the Outpatient follow up backlog and each Health Group had a plan in place to address this. Mr Hall asked for any emerging issues by exception reporting. Mr Gore added that the Family and Women's Health Group had the biggest challenge with Ophthalmology and ENT.

Cancer 62 day was in a static position at the end of the year, but there had been an increase in 2 week referrals as well as diagnostic constraints relating to CT and PET issues.

The 104 day cancer waits had been achieved in year.

The Committee discussed the ED internal controls and patient flow and what was driving the performance. Mr Gore asked about discharge times and Mrs Cope advised that the peak discharge times had moved out by 2 hours. Mrs Cope also spoke about medically fit patients and how the Trust was working with partners to ensure care packages are in place in a timely manner.

Mr Gore expressed his concern regarding the ENT RTT position and he wanted assurance that this was not impacting on patient safety. Mrs Cope advised that the Health Group had a new Operations Director starting soon who was very productivity and performance focusses. The Committee agreed to invite Mrs Mizon to the meeting to give her reflections at the appropriate time.

Resolved:
The Committee received and accepted the report.

8.2 IM&T/Digital Exemplar – Progress Update
Mr Bond updated the Committee and advised that the IM&T department were looking to recruit 2 new roles to their team which included a nurse IT specialist and a medical IT specialist.

Mr Bond advised that the network and wifi was being rolled out at Castle Hill Hospital but there was a two year programme with significant investment to finish Hull Royal Infirmary.

Single sign on was going live from May 2019 and NHS Mail was being introduced to give more cyber security.

Work was ongoing with the Lorenzo Digital Exemplar but e-Observations and e-Prescribing would not work until the network and wifi were in place at Hull Royal Infirmary.

Mr Bond advised that Mr Curry the new Associate Non-Executive Director would be reviewing the IM&T service and providing feedback to the Committee and the Board.

Resolved:
The Committee received and accepted the report.

9   9.1 Demand and Activity
Mrs Drury presented the report and advised that the Trust referrals overall are 3.7% above last year as at the end of March 2019 with all GP referrals being 1.5% above last year.

There was continued pressure on the 2 week wait referrals but non-cancer referrals were much lower than last year.

Urology continued to be a concern overall and for 18/19 GP referrals were 30.4% higher. A business case was being developed to address this.

South Bank referrals were at 14% above last year, the non-GP referrals were in oral surgery, CTS, oncology, Ophthalmology and plastic surgery.

The CCGs continue to see lower referrals to Sprire this year with similar referral reductions for Hull (33%) and ER CCG (30%).

Mr Bond highlighted private practice increasing in community optometrists and how this could impact on the CCGs financially and the Trust's staff and referrals. A number of cataract patients were being referred out of the area.

Outpatient first attendances were 1.7% above plan and follow ups were

4.9% above plan. These figures were slightly distorted by counting changes in Oncology. Mrs Drury added that face to face outpatient follow ups would be the key focus for 2019/20.

The overall Trust position for March (type 1) was 80.7% for March against last year at 74.9%. The full year position was 82% for the Trust and 89.4% for the system.

Non-elective, excluding maternity was 59 cases below plan (0.1%). The ambulatory care activity remained above plan by 12% and this is due to the success in the use of the ambulatory care unit to prevent unnecessary admission to the acute medical unit.

The income position reported at year end was a gross variance of £17.7m above plan before contract adjustments.

NHS England had commissioned a coding audit to review case mix changes from 17/18 to 18/19 which might impact on the Trust's financial position in 2019/20.

Mr Gore asked when the Trust would see the Outpatients outcomes following the Patient Admin Review and Mrs Cope advised that it would be at the back end of the year. The key outputs would be reducing follow up backlogs, carrying out validation and reducing cancellations.

Resolved:
The Committee received and accepted the report.

10   **10.1 Year End Finance Report 31 March 2019**
Mr Bond presented the paper and advised that the Trust had achieved the £10.2m target, but due to missing the ED target in 2 quarters had only received £10.7m resulting in a small surplus of £0.5m

Mr Bond reported that a number of additional funding had been received such as £8.2m for delivery of the Control Total and PSF funding that has given a final surplus of £25.2m. He added that the draft Annual Accounts have been submitted and considered at the Audit Committee and had also been submitted to the Auditors.

The Trust had delivered £14.4m CRES and excluding the SPV scheme this meant 85% delivery. Only 60% of the CRES was recurrent which would impact on the 2019/20 schemes.

Health Group run rate positions were at £5.8m overspent at month 12, with the main deterioration in the Surgery Health Group.

Agency spend was at £11.6m which was £2.7m above the plan. The majority of the spend related to junior medical staff and consultant cover.

The capital position at year end showed an expenditure of £23.5m. Mr Bond advised that Mr Taylor and the team had worked hard to deliver this even though it was £14.9m away from plan.

Mr Bond advised that the main issue was around the underlying run rate at £24.7m and the Trust would need to make CRES savings of £19m in

2019/20.

Mr Gore stated that the past year had felt different in that the Trust had made good progress both in financial terms and the Health Groups having more grip. He asked that the Committee thank them for their hard work over the year.

The Committee discussed Alliance Medical and their relationship with the Trust providing PET and CT staff and clinical waste disposal as areas of concern.

Resolved:
The Committee received and accepted the report.

10.2 Health Group Baseline Budgets 2019/20
Mr Evans presented the report which highlighted the process for setting health group baseline budgets. He reported that there was a potential risk of £10m to the delivery of the Trust's Control Total if £19.1m CRES was not delivered. There was only £9.8m identified at the present time.

Mr Evans advised that reserves of £12.3m had been set aside for winter, energy inflation and any unexpected expenditure throughout the year. Health Groups had been funded for agreed activity changes as part of contracts with Commissioners.

Mr Gore asked what would happen if the Trust refused to change the variation in the accounts due to the depreciation policy being interpreted in a different way. Mr Bond agreed to review this.

Resolved:
The Committee received and accepted the report.

10.3 Operational Productivity and Financial Recovery
Mr Bond gave a verbal update regarding the operational productivity and advised that he had a number of work streams to pull together to produce his report.

Resolved:
The Committee agreed to receive a written report at the next meeting in May 2019. **LB**

11   11.1 Variable Pay Report
Mr Nearney presented the report and advised that the Trust has spent £33m on variable pay to date which is significantly more than last year. He advised that the expenditure is closely linked to increased activity and £4m being spent on nursing which had come as a surprise.

The Trust had done really well in terms of recruitment and work was ongoing to ensure the rotas were being used efficiently, especially in ED. Medicine had spent £11.4m on ED variable pay and a plan was being developed to reduce this in 2019/20.

Mr Gore asked about institutional overtime and how this could be addressed and suggested a report showing the list of people earning overtime on a regular basis.

Resolved:
The Committee received and accepted the report.

11.2 Job Vacancy Report
 Mr Nearney presented the report and advised that work was ongoing to recruit to the 40 consultant vacancies, with ED and Acute locums coming at a cost. He added that in benchmarking terms the Trust was an average performer regarding vacancies.

The Junior Doctor fill rate is currently 85% and Mr Nearney advised that there would be 8 more junior doctors joining the Trust from Pakistan to complete their training. The vacancy rate was just over 5% which was a good position for the Trust.

Resolved:
The Committee received and accepted the report.

11.3 People Strategy Refresh
Mr Nearney presented the 3 year document which included key performance indicators and the Trust's objectives. He advised that the document had already been discussed at a Board Development session and this discussion had been reflected in the strategy.

Mr Nearney encouraged committee members to feed back any comments to him before the Board meeting in May 2019 where the finalised strategy would be presented.

Resolved:
The Committee received and accepted the strategy.

12   **12.1 Capital Resource Allocation Committee Minutes**
The minutes were received for information.

12.2 Lord Carter of Coles Minutes
Ms Ramsay presented the minutes and highlighted her report within the minutes which was regarding productivity and efficiency and how it was seen and used at Trust Boards. She advised that there was still work to do to link the Trust Strategy to drive Board discussions.

There was a discussion around the model hospital work and how more time and money investment in the community services was required.

The Committee discussed the e-Rostering system and how to ensure the function delivered benefits for the medical and nursing teams and that it was being used to its maximum potential.

Resolved:
The Committee received and accepted the minutes.

13   **13.1 Contract recommendation paper for the provision of Laundry Services**
Ms Ramsay presented the paper which had been subjected to the full tender process, including a user panel and the new contract was more cost effective than the previous one.

Resolved:
The Committee received the paper and recommended approval by the Board. The paper would be received at the May 2019 Trust Board.

14   Items delegated by the Board
The Committee agreed to recommend approval of the Laundry Services to the Board meeting in May 2019.

15   Any Other Business
There was no other business discussed.

16   Date and time of the next meeting:
Tuesday 28 may 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
To be held 25 March 2019

Present: Mr S Hall   Non-Executive Director (Chair)
                  Mrs T Christmas   Non-Executive Director
                  Mr M Gore   Non-Executive Director
                  Mr L Bond   Chief Financial Officer
                  Mrs T Cope   Chief Operating Officer
                  Mr S Nearney   Director of Workforce and OD
                  Ms C Ramsay   Director of Corporate Affairs
                  Mr S Evans   Deputy Director of Finance
                  Mrs A Drury   Deputy Director of Finance

In Attendance: Mrs R Thompson   Corporate Affairs Manager

No	Item	Action

1   Apologies
There were no apologies received.

2   Declarations of interest
There were no declarations received.

3   Minutes of the meeting held on 25 February 2019
The minutes were approved as an accurate record of the meeting.

4   Matters Arising from the minutes
There were no matters arising from the minutes.

5   Action Tracking List
All items on the Action Tracking list had been covered by the agenda or were not yet due.

6   Workplan 2018/19
It was agreed that radiology reporting would be removed from the workplan as this was now business as usual.   **RT**

Workplan 2019/20
It was agreed that Tracking Access could be removed from the workplan.   **RT**

Mr Bond agreed to bring a proposal to the Committee regarding productivity and efficiency and having this as a regular item on the agenda. He also suggested that financial planning recovery should be received bi-monthly by the Committee from May 2019.   **LB/RT**

Mr Gore suggested that a Board Development session regarding productivity to summarise the different strands would be useful.

7   Board Assurance Framework
Ms Ramsay presented the Board Assurance Framework and advised that the Board had agreed that the quarter 3 ratings should remain the same for BAF risk 4 which related to the constitutional standards.

Ms Ramsay reported that she would be present the year end BAF at the

next Committee as well as the new 2019/20 BAF. The Board development session in March would review the updated Trust objectives in terms of achieving the long terms goals in performance. The financial risks would also be discussed.

Resolved:
The Committee received and accepted the report.

8.1 Exception Reports
Mrs Cope presented the report and advised that the Primary Care facility in the Emergency Department was working well and 40 to 50 patients per day were being seen, which was 99% performance. It was taking the pressure off the Emergency Department and primary care streaming was being discussed and agreed with the local Commissioners. Work was ongoing on the rotas. Mr Hall asked about GP resource and Mrs Cope advised that she was discussing availability with the local GP Federations.

Mr Gore had compared last year's figures against current figures and this had shown negative performance. Mrs Cope advised that an action plan was in place and was being discussed operationally at the A&E Delivery Board.

The Committee discussed stranded and super stranded patients. Mrs Cope reported that the Trust was good at identifying patients that were medically fit for discharge in a timely way but that secondary assessments by community partners was slowing down the process. The Unplanned Care Delivery Group were reviewing these processes.

There were gradual improvements in cancer performance although this had deteriorated in January 2019 due to seasonal pressures. The key areas for focus were patient choice and diagnostic capacity. Some pathways were seeing increases in referrals and the Trust had met with the Cancer Alliance to review this. The Intensive Support Team had also visited the Trust to review capacity and demand. Mrs Cope added that the IST had assessed the booking process and commended it.

Mrs Cope reported that the Trust was on track to deliver zero 52 week waits from the end of March 2019. Results would not include late referrals from other Trusts.

Diagnostic performance had improved and was below 5% for the first time. Mr Hall recognised on behalf of the Committee the improvements made.

Mrs Cope advised that teams were focussing on clearing down the waiting list to 36 weeks which would impact on RTT but also expressed her concern about the 37,000 follow up backlog. This would be a key area of focus for 2019/20.

Mr Hall raised the 30 day readmission performance and stated that he had also raised this in the Quality Committee as to which Committee it should be reviewed at. The Committee agreed it should be the Quality Committee but that there were no emerging issues at the present time. Mrs Drury advised that further audits would be carried out at the end of quarter 2 and would report any issues to the Committee.

The agenda was taken out of order at this point

9.1 – Demand and Activity Report
Mrs Drury reported that at month 11 referrals were up 3.7% against last year's figures which amounted to 7500.

The breakdown shows:
2097 GP referrals (1.8%)
1080 C2C referrals (2.7%)
1249 Emergency Department referrals (4.9%)
3023 Other referrals (12.8%)

GP referrals pressure continues to be in Urology, Breast Surgery, Dermatology, Neurosurgery, Digestive Diseases (Gastro, Upper GI, Colorectal).

Mrs Drury advised that next year's plan had a small element of growth built into it. She highlighted ED (2%), endoscopy, ENT, urology, neurosurgery and MRI.

Mrs Drury reported that outpatients in month 11 were 2% above the contract level and elective was 3% up on last year's figures. Non-electives were 3% below plan.

Mr Gore asked about NLAG referrals and if the growth had been built into the contract. Mrs Drury advised that the growth had not been built into the contract and that there was a potential risk that the Trust would overtrade with the Southbank.

Resolved:
The Committee received and accepted the update.

10.5 Energy Cost Pressures
Mr Bond presented the paper which detailed the £2m problem following the newly negotiated gas and electricity contracts now in place. The contracts had been historic and the prices had been held for a number of years and were now subject to market conditions.

Mr Bond spoke of the combined heating and power plans and how much energy was costing the Trust. He added that it was important to invest in modern energy production and he was hoping to explore with Hull City Council the possibility of a loan to invest in more energy efficient production capacity.

Resolved:
The Committee received and accepted the report.

8.3 Winter Plan Update
Ms Myers reported that the winter plan was incorporated in the 2019/20 Operating Plan.

8.2 Operating Plan 2019/20
Ms Myers presented the Operating Plan 2019/20 and advised that all Commissioning Contracts were now in place.

Ms Myers reported that modest growth had been added in to the activity plans and an agreed set of performance trajectories were in place. The workforce element showed an increase of 72 staff which were mainly doctors.

Mr Hall asked about the changes to the constitutional standards and Ms Myers advised that the new standards had been reflected in the plan.

Mr Gore asked how realistic the RTT trajectory was as it appeared to be very challenging to achieve 85% by March 2020. Mrs Cope advised that the focus was on getting the list down to 36 weeks but that the overall size had begun to come down.

Ms Myers reported on zero 52 week waits, the emergency and acute medicine discharge lounge and having a GP facility in the hospital. She also mentioned the additions of the Model Hospital and GIRFT savings into the plan.

Ms Myers advised that NHS I had reviewed the draft plans of all Trusts and the general comments were that not enough provision for non-elective growth had been included. All Trusts had been given the opportunity to revisit their plans to review this.

Ms Myers spoke about the winter plan and how the bed model was being reviewed alongside the Winter ward to provide sufficient bed availability. There was collaboration work ongoing with Community partners and ward 20 at Castle Hill had been offered as a potential extra facility.

Mr Gore commended the increase in medical staff from 952 to 1020 and thanked the recruitment teams.

Resolved:
The Committee received and accepted the report.

10.1 Finance Report Month 11
Mr Bond advised that the Trust was reporting a SOCI deficit of £0.4m which is a shortfall of £1.4m against the plan. The shortfall relates to the non-delivery of the ED target for quarter 1 and potential non delivery of quarter 4.

In month the Trust had over performed against the contract by £2.2m after adjustment of the AIC contract. Overall elective activity was £1.6m above plan in month.

Mr Bond reported that the Health Group positions had stayed in line with expectations and were £5.1m overspent at month 11.

Resolved:
The Committee received and accepted the report.

10.2 CRES Delivery 2018/19 and 19/20 Update
The Trust was £2.2m below plan for CRES delivery at month 11 with £12.7m delivery against a target of £14.9m (85% delivery).

The Committee received a presentation which highlighted the 2019/20

CRES targets and identified CRES schemes.

Resolved:
The Committee received and accepted the report.

Financial Plan
Mr Bond presented a review of the Trust's financial position over the last 4 years and showed the consistency of the delivered results.

The Committee discussed the estimated £10m gap in the financial plan for 2019/20 and how this would be mitigated. Mr Bond suggested putting Financial Planning on the Committee workplan bi-monthly to ensure that this issue remained at the forefront of the Trust's thinking and ensured that the underlying position continues to be monitored closely. Mrs Cope added that out of hospital partners would need to take responsibility for long term conditions and other community led work streams.

Mr Bond expressed his concern regarding the estimated £10m gap in the plan. Mr Gore added his reservations regarding the control total. The Committee agreed to support the 2019/20 plan but noted the size of the challenge as currently presented.

Resolved:
The Committee received and accepted the update.

10.3 Patient Level Costing
Mr Evans presented the report and advised that there was additional resource in the costing team. Development of Patient Level Costing had been slower than expected but the Trust was now working with the clinical teams and the Health Groups.

Mr Gore asked for a full year of comparative data with a Trust of similar size. Mr Evans agreed to provide comparative data next time the report was due.

Mr Gore observed that he would like to see the data used to improve productivity, highlighting the substantial deficit in physiotherapy as an example. **SE**

Mr Gore suggested productivity to be considered as a Board development topic.

Resolved:
The Committee received and accepted the report.

10.4 Accounting Changes – Building Valuation
Mr Bond presented the report which highlighted changes in guidance to the way buildings are valued. He added that the changes would affect the 2019/20 finances and the finance teams were working towards a solution – current estimates were that this would cost circa £2m per annum. NHS Improvement had recognised that this was a problem nationally but there would be no change to the Control Totals.

Resolved:
The Committee received and accepted the report.

15. Any Other Business

Mr Bond advised that Dr Patmore had raised risks to the Oncology Service and had written a business case outlining the issues and proposing a significant investment requirement. Mr Bond advised that the paper highlighted the issue of hard to fill posts and the investment that was required.

12.1 Capital Resource Allocation Committee Minutes

Mr Bond presented the minutes for information. There were no issues to raise.

11.1 Variable Pay Report

Mr Nearney presented the report and advised that at month 11 the Trust was reporting £30m in variable pay. Agency costs had increased and were £1m worse than last year's figures. Mr Nearney added that the Trust was £7m underspent on the pay budget.

Work was ongoing with the Health Groups to justify any extra agency expenditure.

The Committee discussed rota planning and ensuring that e-Roster was being utilised as comprehensively as possible to eliminate the need for last minute agency staff purchases.

Mr Gore suggested that HR should consider bringing forward plans to incentivise hard to fill posts to offset high premium costs in extra sessions and waiting list initiatives.

Resolved:
The Committee received and accepted the report.

Date and time of the next meeting:
Monday 29 April 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

CONTRACT RECOMMENDATION PAPER FOR THE PROVISION OF LAUNDRY SERVICES

COMPLIANT CONTRACT RECOMMENDATION

Trust Reference:	**HEY/16/221**
Type:	**New Contract Renewal**
Form:	**Services**
Period:	**36 Months**
Extension Option:	**Up to 24 Months**
Anticipated Contract Start Date:	**01 July 2019**
Health Group:	**Estates, Facilities and Development**
Division:	**Hotel Services**
Department:	**Linen Services**
Procurement Process Used:	**OJEU Open Tender**
Total Contract Value (Ex. VAT):	**£1,228,755 – Year 1** **£3,686,265 Variable (dependent on yearly annual price uplift based on CPI index)**
Cost Centre:	**126612**
Terms and Conditions which apply:	**NHS Terms and Conditions for the Provision of Services Contract Version (January 2018)**
G.D.P.R. Applicable:	**No**
Procedure compliant with Trust SFI's:	**Yes**

1.   **PURPOSE**

The purpose of this paper is to seek approval of the Chief Executive/Chief Financial Officer and Trust Board to award a contract for the provision of Laundry Services, to Synergy Health Managed Linen Services, trading as SynergyLMS.

2.   **BACKGROUND**

2.1   This is the renewal of a contract for the provision of Laundry Services.

2.2   The Procurement Department initially explored the options of procuring via a number of relevant framework providers as follows:

- Crown Commercial Service (CCS)
- London Procurement Partnership (LPP)
- NHS Shared Business Services (NHSSBS)

These routes where rejected for the following reasons:

- The Trust decided to tender on a localised basis due to the small number of potential bidders and limited market size

- One of the actual framework agreements from one of the above providers (LPP) included the following:
  - o Activity Based Income (ABI) – the framework was established with an Activity Based Income (ABI) charge of 1%. Each supplier would pay NHS LPP the ABI charge for all contracts awarded under the framework. Any pricing provided by suppliers will be inclusive of this charge. This may have resulted in increased costs for the Trust

3. PROCUREMENT PROCESS

3.1 The Procurement Department invited tenders and bids under the Open EU Procedure.

- 4 companies expressed an interest
- 2 bids were received

3.2 The Evaluation Group invited all prospective suppliers to undertake contractor site visits (HRI and CHH) during December 2018.

- 2 suppliers undertook site visits of HRI and CHH

3.3 Presentations from both the suppliers were also held during January 2019.

The presentations gave the suppliers the opportunity to present their bids (Linen Presentation & Sample Session) and to present samples of linen for the evaluation group to score and evaluate the quality of.

3.4 The evaluation group followed due process and requested various clarifications to a number of questions relating to the bids from the 2 bidders.

3.5 Following a clinical, technical, commercial and financial evaluation it was agreed to recommend a sole award to SynergyLMS as summarised below and attached:

- Appendix One - Final Scoring and Justification Linen Tender 2019 Amended.xlsx

3.6 A sole award option was recommended for the following reasons:

- SynergyLMS offered a full and comprehensive bid including all of the Trust's requirements

3.7 The successful bid from SynergyLMS was recommended for the following reasons:

Successful bidder 1 – SynergyLMS

- Lowest cost per quality point of £7,373
- Scored highest number of quality points of 500
- Lowest estimated whole life cost (from offer summary) of £3,686,265
- Overall ranking of 1st

3.8   The unsuccessful bid was rejected for the following reasons:

Unsuccessful bidder 1 - Berendsen Healthcare Ltd, trading as Elis

- Scored lowest number of quality points of 380
- 2nd lowest cost per quality point of £10,478
- Highest estimated whole life cost (from offer summary) of £3,981,669
- Overall ranking of 2nd

3.9   Due to the complexity of this contract and because of the proposed change with the service provider there will be a period of implementation prior to commencement of this contract. It is anticipated that the contract will commence on 01 July 2019.

4.   FINANCIAL IMPLICATIONS

4.1   CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum: (based on current cost per piece prices x current activity)	**£1,345,832**
Current cost inclusive of VAT per annum:	**VAT Reclaimable**
Current contract end date:	**30 June 20019**
Comments	

4.2   NEW COSTS

Proposed cost exclusive of VAT per annum:	**£1,228,755 – Year 1**
Proposed cost inclusive of VAT per annum:	**VAT Reclaimable**
Proposed contract start date:	**01 July 2019**
Duration of contract:	**36 Months**
Estimated value of total contract excluding VAT:	**£3,686,265 Variable (dependent on yearly annual price uplift based on CPI index)**

4.3 **FINANCIAL IMPACT**

SAVINGS (RECURRENT)

Savings per annum excluding VAT (based on current budget for 2019/20 of £1,383,100)	**£115,759 – Year 1 (Part Year Effect)** **£154,345 – Year 1 (Full Year Effect)**
Start Date of savings:	**01 July 2019**

Savings per annum excluding VAT (based on current cost of £1,345,832)	**£87,808 – Year 1 (Part Year Effect)** **£117,077 – Year 1 (Full Year Effect)**
Start Date of savings:	**01 July 2019**

4.4 **FUNDING DETAILS**

Source of Funding:	**Revenue**
Cost Centre:	**126612**
Expense Code:	**717300**
Financial Implications approved by:	**Paul O'Meara, Head of Finance**

5. **ADDED VALUE**

5.1 In addition to the above and as a consequence of this award SynergyLMS have also offered the following additional benefits:

- Financial breakdown providing elements of underwritten/guaranteed (£60k over 2 years – end of year 1: £30k/end of year 2: £30k) non recurrent substantial savings to the Trust, which mainly focused on the current core service. Relevant elements that did not require up front capital costs, but purely focusing on efficiencies (processes and procedures) of service and added value still with some innovations.

    The standardisation of linen, bed policy around standard bed pack to support the usage reduction.

    Added value in a resilience/priority of service element within their bid was extremely beneficial as these are focused on service delivery benefits that can be offered "free of charge" as part of the contract. Various opportunities identified with associated savings such as a future transport savings split.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

6. EVALUATION TEAM

6.1 The following colleagues comprised the membership of the evaluation team and are responsible for this recommendation:

- Ann Mason, Head of Facilities
- Zara Ridge, Deputy Head of Facilities
- Caroline Gorman, Hotel Services Manager
- Greta Johnson, Infection Control Lead
- Paul O'Meara, Head of Finance

7. RECOMMENDATION

7.1 The Chief Executive/Chief Financial Officer and Trust Board are requested to approve the awarding of this contract to SynergyLMS.

Duncan Taylor
Director of Estates, Facilities and Development

Procurement Department comments

This recommendation is compliant with Trust Standing Orders, Standing Financial Instructions and EU Regulations.

Procurement Department additional comments: None

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Laundry Services

Contract ref: HEY/16/221

The above recommendation **is** accepted.

Signed:……………………………………………………… Date:………………………

Chief Executive – Christopher Long / Chief Financial Officer – Lee Bond

Signed:……………………………………………………… Date:………………………

Trust Board

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Laundry Services

Contract ref: HEY/16/221

The above recommendation **is not** accepted.

Signed:……………………………………………………… Date:………………………

Chief Executive – Christopher Long / Chief Financial Officer – Lee Bond

Signed:……………………………………………………… Date:………………………

Trust Board

Reasons for rejection of recommendation:

Contracts Ref:	HEY/16/221	Supplier Ref:	N/A
Contracts Contact:	CS	Date submitted for approved:	16/04/2019

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
14th MAY 2019

Title:	PEOPLE STRATEGY 2019-22
Responsible Directors:	Simon Nearney Director of Workforce and OD
Author:	Simon Nearney Director of Workforce and OD

Purpose	The purpose of the report is to inform the Trust Board of the People Strategy 2019-22 and to seek approval	
BAF Risk	BAF Risk 1 and 3	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great clinical services	Y
	Partnership and integrated services	Y
	Research and Innovation	Y
	Financial sustainability	Y
Key Summary of Issues	The Trust has had a People Strategy in place for the past three years. This strategy has now been refreshed. The newly developed People Strategy 2019-22 sets out the vision for our workforce. It outlines how Hull University Teaching Hospitals NHS Trust working with partners plans to recruit, manage and develop the workforce in order to deliver the Trust's vision, values and priorities as set out in the refreshed Trust Strategy 2019-24. The strategy is made up of 7 strategic workforce themes; underneath each a number of actions will be developed and implemented over the lifetime of the strategy. The 7 themes are:- i) Recruit and retention of staff ii) Leadership capability and capacity iii) Innovation, learning and continuous improvement iv) Equality, inclusion and diversity v) Health and wellbeing vi) Employee engagement, communication and recognition vii) Modernising the way we work.	

Recommendation	The Trust Board is requested to approve the People Strategy 2019-22

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

TUESDAY 14TH MAY, 2019

PEOPLE STRATEGY 2019 – 2022

Purpose

1. The purpose of this report is to seek the Board's approval of the Trust's new People Strategy 2019-22.

Background

2. The Trust has had a People Strategy for the past three years which has put in place solid workforce foundations and delivered a lot, but the organisation requires a further strategy to continue the recruitment, management and development of our workforce to deliver our organisational goals.

3. The Workforce and Organisational Development Directorate with HR Business Partners, the Executive team, Health Group Triumvirates, managers and trade unions have developed this strategy. The Workforce Transformation Committee, Performance and Finance Committee and Quality Committee have contributed to and endorsed the strategy and recommend it for approval.

Current position

4. The People Strategy 2019-22 sets out the vision for our workforce. It outlines how Hull University Teaching Hospitals NHS Trust working with partners plans to manage and develop the workforce in order to deliver the Trust's vision, values and priorities as set out in the refreshed Trust Strategy 2019-24.

5. The strategy sets out the challenges facing HUTH over the next 4 years, the impacts upon our workforce and how we intend to respond in the short and longer term.

6. The NHS continues to face funding challenges which will continue for the lifespan of this strategy and therefore a key focus of the strategy is on service reform, repositioning the organisation and managing the transition as well as recruiting the best talent to deliver great care. Organisational culture will also remain a key priority, sustaining the significant improvements the Trust has made over the past 4 years and therefore to do this will require managers to operate as transformational and compassionate leaders and require a workforce that is flexible, skilled and productive.

7. Our organisation will continue to be focussed on quality and safety and improving the patient experience, but it will be leaner, intent on reducing costs and maximising productivity, whilst at the same time sustaining high performance. The shape of the organisation will change, as we and partners seek to improve services and modernise care pathways across organisational boundaries and deliver more services within local communities, building upon the successes of the past.

8. The Strategy proposes 7 strategic workforce themes; underneath each a number of actions will be developed and implemented over the lifetime of the strategy. The 7 themes are:-

     i) Recruit and retention of staff
     ii) Leadership capability and capacity
     iii) Innovation, learning and continuous improvement
     iv) Equality, inclusion and diversity
     v) Health and wellbeing
     vi) Employee engagement, communication and recognition
     vii) Modernising the way we work

Recommendation

9. The Trust Board is requested to approve the People Strategy 2019-22.

Officer to Contact:-

Simon Nearney
Director of Workforce and OD
Tel: 01482 676439

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PEOPLE STRATEGY 2019-2022

Contents

1.   FOREWORD

Great staff will deliver great care and great staff need to feel valued. We recognise that through investing in our workforce; their training and development, their opportunities and career pathways, the quality of our leaders and the support networks available to them, our patients will benefit. Our organisational vision: GREAT STAFF, GREAT CARE, GREAT FUTURE, emphasises the belief that by caring for our people we will deliver care that is safe, effective and efficient, and gives our patients an exceptional experience.

As a University Teaching Hospital and a partner in the Hull York Medical School, we are committed to providing opportunities for learning and development for all of our staff in a wide variety of clinical and non-clinical roles. That commitment extends to the development of new roles and the provision of apprenticeships, for which we have an excellent reputation on a national scale.

We are the largest employer in the Hull and East Yorkshire region with over 9,000 staff. We also have a large volunteering programme and also offer apprenticeships. We understand the important role we play in providing opportunities for improving skills and employment for local people and we have reflected this in our strategy.

We want all of our staff to say that they will recommend our organisation as a place to receive treatment and to work. This means creating an organisation that is recognised as an 'employer of choice'; where staff are passionate about what they do and feel that it's more than just a job; where our employees feel engaged, valued and empowered to strive continually to improve the care they give to patients and are proud to say they work for Hull University Teaching Hospitals NHS Trust.

Over the next four years, we face continuing challenges, not least of all with funding of our services and rising demand, but there are significant opportunities for us too. Our partnership with the University of Hull will benefit the Trust in terms of recruitment, research and development, treatment options for patients and career development for current and future staff.

We have made great progress in our ambition to be one of the best employers in the NHS with rapid and sustained improvements to our culture, reflected in significantly better staff survey results. The ability to maintain an effective relationship with our staff and a positive working culture will be crucial to our ongoing success. We are therefore committed to supporting our staff to be the very best they can, so that we provide the very best possible care to achieve our ambition of being an outstanding Trust.

Picture   Picture

Signature_____   Signature_____

Chief Executive   Chairman of the Trust

2.   INTRODUCTION

2.1 The need for change
As demand for care continues to grow and the services we can provide develop at pace, the NHS continues to face pressures on the funding it has available. A key focus of this strategy is on modernising our practices, using new technology, service transformation and reform, repositioning the organisation and managing that transition. The shape of the organisation will undoubtedly change as we and partners seek to improve patient experience and care pathways and deliver more services within local communities, building upon the successes of the past.

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. A key focus of the plan is significant investment to enhance 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 (ICS's) 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 neonatal deaths to halve by 2025
- most women to receive continuity of care during their pregnancy by 2021
- three quarter of all cancers to be diagnosed in stage 1 or 2 by 2028
- suspected cancer patients to have either a definitive diagnosis or cancer ruled out within 28 days of referral
- face to face outpatient appointments will reduce by a third

The Trust will continue to be focused on quality and meeting patient needs, but it will inevitably be leaner, intent on getting things right first time and sustaining high performance. As a result of 'Getting it Right First Time' service reviews and the use of 'model hospital' data, the Trust will work differently with partners to deliver health care services for the population of Hull, East Riding and surrounding areas.

To achieve more with fewer resources, our workforce needs to be skilled and productive. We also need to provide opportunities and time for staff to research and innovate. We will therefore continue to maximise our employees' performance and continue to develop new ways of working. Our focus in this regard is on creating the right organisational culture where we operate as one team, with a clear set of values and objectives and where we can clearly hold one another to account in a positive and supportive way. Our current leadership styles will also need to evolve to inspire, engage and empower a more flexible workforce.

Over the next three years, the Trust will need to redesign services around patient needs, and offer greater choice and personalised care that reflects an individual's health and care needs. Patient focus will inform all that we do in our community leadership and governance roles and as service providers and service enablers. These roles will require managers and staff to work differently in the future and across organisational boundaries, so our Integrated Care System (ICS) delivers outstanding and sustainable care.

2.2 Shifting the culture - Great Staff, Great Care, Great Future

The People Strategy has been developed to continue the shift in organisational culture and deliver a culture that has been defined and requested by our workforce. This is the key to delivering Great Staff which is the foundation of our organisational vision. Only through shifting the culture to that desired by staff can we aspire to deliver the change set out above.

Our Vision

Although we believe that our organising principle is to develop services around the patient and their needs, as an organisation we need to ensure that our greatest asset is trained, inspired and properly prepared to enable the best possible delivery of care. Therefore our vision is:-

GREAT STAFF, GREAT CARE, GREAT FUTURE

We will recruit and engage staff effectively and ensure our leaders understand our focus on caring for our workforce. We will develop, support and equip our staff to enable them to deliver the highest quality healthcare possible. We will provide the best facilities and environment we can to give a positive experience of delivering services. We will involve and communicate as often as possible and listen to views and ideas to improve care for patients.

We want all staff to be proud of the healthcare we deliver and for them to recommend our hospitals as places to receive care and treatment as well as places to work. If we can create this environment our staff will be Great Staff and the care they deliver will be Great Care. It is that which will guarantee our Great Future.

Our Values

A survey of Trust staff conducted in December 2014 enabled staff to select values which they felt best described their personal values, those in the current culture of the Trust and those in the desired culture of the Trust. As a direct consequence, the Trust values were changed to reflect our staff's values; namely Care, Honesty and Accountability.

These values epitomise 'how we work' rather than 'what we do'. They are about the way managers work with their staff, the way staff work with their managers, the way we all work and interact with each other across every role, every team, every ward and every department. They reflect both those elements which have contributed to the achievements of the Trust and those matters which need to be worked on for the future to both maintain and improve our performance which will be recognised by our Inspectorate, the Care Quality Commission (CQC).

Our staff have also described the behaviours they expect and don't expect to see in accordance with our values and these combine to create our 'Staff Charter' as follows:

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.

Cultural change takes time. If change is to be sustainable it needs to be driven by our managers and leaders. Our workforce has made a clear request of us in terms of the culture they want us to deliver, characterised by ten values:

- Accountability
- Care
- Continuous improvement
- Professionalism
- Teamwork
- Compassion
- Honesty
- Employee engagement
- Patient safety
- Respect

With these values clearly set out for us by our workforce we are committed to implementing the changes with a planned and measurable approach. To this end we have identified seven strategic workforce themes:-

1. Recruitment and retention
2. Leadership capability and capacity
3. Innovation, learning and continuous improvement
4. Equality, inclusion and diversity
5. Health and wellbeing
6. Employee engagement, communication and recognition
7. Modernising the way we work

Success for the Trust in the end will depend not only on effective leadership, our structures, systems and processes, but also on the way that our employees work effectively with and within them. This is a critical change of approach for our organisation with leaders held to account for the culture in their teams as well as quality and safety, performance and financial measures. In this respect our Trust will be a national leader in measuring and performance managing cultural health.

What we offer our employees as part of our written and 'psychological' contract and how we communicate and engage employees will set the tone and culture for our organisation. It will enable the Trust to overcome the challenges we face and provide safe and quality outcomes for patients.

These workforce themes will enable us to deliver the programme of cultural change set out by the Trust's Workforce Transformation Committee. The nine key features of the work plan are illustrated below:

People Strategy and Cultural Change

Recruitment and Retention

Innovation, Learning and Continuous Improvement

Equality, Inclusion and Diversity

Cultural Change Plan

Encourage creativity and innovation

Enable high performing managers

Create pride in our work

Work as Team HUTH

Sustain and improve behaviours

Monitor and measure engagement

Engage the medical workforce

Involve our patients

Reward and recognition

Modernising the way we work

Health & Wellbeing

Leadership Capability and Capacity (and Organisational Development)

Employee Engagement, Communication and Recognition

2.3 Key influences

The People Strategy takes into consideration other internal and external drivers, strategies and plans. Internally, these include the People Strategy work plan, the Trust Strategy 2019-24, the Trust Digital Strategy 2018-2023, the Sustainable Healthcare Strategy, the Equality, Diversity and Human Rights Strategy, the Research and Innovation Strategy 2018-2023 and the Staff Survey results. External drivers include the NHS Long Term Plan, NHS Employers Workforce Strategy, the Francis and subsequent reports (Berwick, Keogh and Cavendish), the NHS Leadership Academy Leadership Strategy and model, the Humber Coast and Vale ICS plan, feedback from our Friends and Family Test (I want Great Care) and from CQC service inspections.

The Strategy focuses on the priorities that will deliver high performance. It also complements and informs a number of other workforce strategy documents that have been developed by Humber Mental Health NHS Foundation Trust, Hull City Council, East Riding of Yorkshire Council and at a regional level, our commissioning partners, ICS and ICP system leaders.

3.   CONTEXT FOR THE PEOPLE STRATEGY

The Trust Strategy sets out the Trust's approach to the achievement of our vision. 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.

The goals are as follows:

The People Strategy is a key enabler for all of our goals. We believe that our Great Staff will deliver Great Care leading to a Great Future. We want to create a culture of excellence, high performance and continuous improvement. We will recruit the best staff, retain our talent and develop their skills in order to achieve these goals.

Success will come from having enthusiastic, creative and engaged staff who understand the journey we are on as an organisation and one of our key measures will be that of staff engagement, as set out in the National Staff Survey.

There is a more overt link between the People Strategy and our Honest, Caring and Accountable culture which is reflected in the workforce themes in section 5.

4.   WORKFORCE PROFILE as at 31st March, 2019

The Trust employs 9,214 people. This equates to 7,486 Whole Time Equivalents (WTE).

12% of our employees are from black and ethnic minority (BME). The BME population in Hull and East Riding is 4%.

We employ 2% of people who are declare themselves as disabled or having a long term health condition. 39% of the workforce have not declared whether they are disabled or not. Hull and East Riding's disabled population is 19%.

The gender breakdown of our employees is 76% female and 24% male. Within our region the gender population is 51% female and 49% male.

1% of our employees declare their sexual orientation as lesbian, gay or bisexual, however 34% of the workforce have not declared their sexual orientation.

26% of employees have declared their religion to be other than Christian, although 38% of our employees have not declared a religion.

HEY Statistics as at 31 March, 2019
Hull and East Riding statistics from the 2011 census

5. KEY WORKFORCE THEMES

5.1 Recruitment and Retention

The recruitment and retention of qualified, skilled and experienced staff to ensure our patients receive the best possible care (high quality, safe and effective) continues to be the Trust's priority.

The 2016-2019 People Strategy has delivered in terms of building and establishing the remarkable people, extraordinary place branding, setting up a number of innovative approaches to recruitment and retention including the introduction of new roles such as Nurse Apprenticeships, Nurse Associates, Advanced Clinical Practitioners and Physician Associates. The Trust has also significantly increased the number and range of apprenticeships with over 200 apprentices working for HUTH and has grown substantially its international recruitment of nursing and medical staff. The Trust has developed a long term partnership with the College of Physicians and Surgeons, Pakistan (CPSP) to enable recruits from across a range of medical and surgical specialities to work and train with HUTH.

The Trust is committed to building on the initiatives already in place and to focus on ensuring we are an employer of choice for local, national and international talent. The Trust is also committed to continuing our very successful 'grow our own' approach to ensuring we have the right people, in the right place, at the right time.

To deliver this we will:

Recruitment - Attract high quality candidates
- Embed and improve the Remarkable People, Extraordinary Place branding and utilise the Trust's new partnership with the University of Hull
- Develop a comprehensive 'grow our own' strategy encompassing all staff groups for example maximise opportunities to recruit into apprenticeship roles, offer development roles for professional staff including non-medical consultant roles, further develop roles such as ACP's and Anaesthetic Practitioners and offer training opportunities to medical staff wishing to pursue a career as a consultant
- Continually review our approach to induction ensuring all staff understand the values, goals and ambition of the trust, that the patient is at the centre of everything we do, but equally important is that enjoy work, smile and have fun
- Work with Hull York Medical School (HYMS) to deliver the expansion of the medical school and maintain a focus on recruiting medical staff through ensuring we offer quality placements and attractive roles; further develop the CPSP partnership and explore opportunities to establish other national and international partnerships
- Continue to recruit staff from overseas until such time as our 'grow our own' programmes develop the workforce numbers and skills we need
- Work with our ICS partners to promote the region, campaign for funding and develop sustainable workforce models across the Humber Coast and Vale
- Implement our Health and Care career framework for our future workforce and increase our presence at recruitment fairs utilising high quality and attractive materials

Recruitment - Process
- Streamline recruitment processes to make it simple for both applicant and manager and reduce the length of time it takes to recruit people
- Make better use of technology and social media to target the best talent

Retention
- Identify and develop talented individuals and support career development for all staff
- Regularly analyse exit interview information to understand and improve staff retention
- Develop robust succession plans to ensure a pipeline of skilled and experienced talent to take on leadership roles

5.2 Leadership Capability and Capacity (and Organisational Development)

The Trust is fully committed to ensuring that leadership and people management skills and capacity is enhanced at all levels in the organisations, including the Trust Board. We need managers who are confident in not only looking after our services but who also know how to look after their people. By 2022 we want managers that offer a compassionate and accountable approach ensuring that they support, empower, inspire and create an environment for all staff, from whatever background or ability to flourish. Great team working will become the norm supported by leaders who take personal responsibility, give great feedback, manage conflict and support staff well-being. Leaders will be able to use a coaching style and will support front line staff to engage in a process of continuous improvement.

To deliver this we will:

- Ensure all leaders, especially the Trust Board and our very senior managers role model our values and people management approach
- Re-brand what being a leader/manager means at HUTH so everyone is clear, with a central approach to leadership development activity
- Our leaders create a sense of belonging, engagement and act as ambassadors for our organisation through visible, high quality and effective people management that empowers individuals and enables them to flourish
- We have an inclusive approach that values diversity and recognises the value it can bring to the team and the people they serve
- We have a clear leadership and management framework for benchmarking our leadership roles so we can promote personal, performance and talent development
- Our leaders promote a learning and coaching culture that supports a compassionate style with personal accountability for delivering
- Leaders, managers and supervisors take personal responsibility for their approach and impact on their team and adapt their approach and mind-set accordingly
- All leaders are able to give/receive feedback and manage conflict to the benefit of both individuals, staff and ultimately patients
- Team development is valued as a 'business critical' activity
- Leaders understand and support use of the Trust's approach to continuous improvement and are able to demonstrate improvement activity and its impact on patient care, within their teams
- Leaders become transformational system leaders working across organisational boundaries to shape, influence, co-develop and jointly manage integrated services

5.3 Innovation, Learning and Continuous Improvement

As a major teaching and University hospital, the Trust is committed to the development of its staff and managers, enabling both to have the right skills to deliver high quality care and services. We want our people to be flexible to embrace change, to look outside for new ideas and to find creative ways to learn and improve services. Our ambition is to be known as a national leader for innovation and

research and a Trust that looks for potential in its people and develops every member of staff to be their best, where everyone works together to continuously learn and improve services.

To deliver this we will:

- Undertake a comprehensive review of all education services including governance arrangements and put measures in place to ensure provision is of an outstanding quality which is underpinned by a strong ethos of 'learning lessons' and improving services
- Continue to invest in learning environments to elevate the quality of the learning which will equal but preferably surpass expectations to be regarded as above and beyond those of our competitors
- Further enhance our reputation for the delivery of high quality learning by acting upon the outcomes of a range of quality assessment measures such as Health Education England Quality Standards and GMC and NETS quality surveys
- Ensure medical teaching and training is of high quality and remains a fundamental part of the Consultant job plan
- Ensure all staff have a high quality appraisal and have a personal development plan that is regularly reviewed by their manager
- Become a learning organisation where our workforce has a burning desire to learn and improve every day, that is 'curious' and continually seeks to push boundaries and deliver outstanding care
- Strengthen and nurture new and existing relationships with education commissioners, universities and colleges to influence commissioning decisions regionally and nationally to better meet local needs
- Use the opportunities presented by the Apprenticeship Levy to challenge and work with our services to create new roles and pathways for development
- Continue our partnership with local schools, colleges and the University of Hull and to promote the wide variety of career opportunities and help our community meet their aspirations for a future career in health with HUTH
- Develop and grow the Trust's medical research programme in partnership with the University of Hull which will drive national and international learning and pioneer new ways of working and practice
- Provide staff with the skills and confidence to undertake improvement work through the provision of a wide range of improvement resources, training and support
- Create an improvement community within the Trust to provide peer support and access to learning from other national and international health service providers
- Develop and deliver, in partnership with the University of Hull, an ambitious programme of research and innovation that drives change and is highly regarded nationally and internationally

5.4 Equality, Inclusion and Diversity

We will continue to develop an organisational culture that encourages every member of staff, whatever their role or background, to succeed. A Trust where our staff work hard to make a difference for patients, where staff access opportunities to learn, develop and grow and work in a positive environment free from discrimination.

To deliver this we will:

- Explore how we can continue to recruit and retain underrepresented groups and where identified take positive action

- Raise the profile of the Trust as an employer of choice by continuing to have, and explore further opportunities for, a presence at local events such as Hull Pride, Differently Abled and the Health Expo
- Promote and encourage the development of, and attendance at, equality related staff networks via the Staff Networks and Resourcing Protocol
- Work in partnership with our staff and trade union representatives and ICS partners on the wide range of equality issues that not only align to legislative requirements but support good practice and the Trust values – care, honesty and accountability
- Actively review and prioritise outcomes from the Workplace Race Equality Scheme, Gender Pay Report and the new Workplace Disability Equality Scheme to reduce differentials and support the continued development of an inclusive workforce characterised by dignity and mutual respect.
- Move from Disability Confident Employer to Disability Confident Leader status.
- Work towards a culture where both in employment and service provision no individual is discriminated against or treated less favourably due to age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation of transgender (Equality Act 2010)
- Work towards the vision as set out in the Trust's Equality, Inclusion and Diversity Strategy

5.5 Health and Wellbeing

There is a clear case that poor staff health and wellbeing has a significant impact on the performance of NHS organisations (Michael West, 2018). Investing in Health and Wellbeing delivers benefits for the Trust, staff, patients and wider community. The Trust takes seriously its responsibility to provide a wellbeing programme for staff, but at the same time, it is also important that staff take responsibility to look after themselves and each other and we will enable this by promoting and communicating best practice via our Health and Wellbeing programme. By 2022 the Trust will have a proactive health and wellbeing culture where managers actively promote healthy lifestyles and where staff have a good work/life balance.

To deliver this we will:

- Ensure staff have access to a quality Occupational Health service that is SEQOHS (Safe Effective Quality Occupational Health Service) accredited
- Continue to meet our obligations around the delivery of the CQUIN indicators that relate to healthier lifestyles and risky behaviours
- Continue to provide and communicate information via Pattie (the Trust intranet site), including the benefits accessible to staff through working for HUTH.
- Continue to provide the musculoskeletal service for staff together with the fast track outpatient appointment scheme and access to counselling and psychological support
- With support from the CCGs and public health we will offer staff free health checks or access to free health checks
- Develop training and education programmes that promote mental wellbeing and the recognition and management of stress
- Aim to achieve the standards advocated in the Stevenson / Farmer review, "Thriving at Work" and HEE report – "Staff and Learner Mental Health and Wellbeing"
- Further develop our programme to promote and provide opportunities for improving physical wellbeing
- Deliver the requirements of NHS England for the flu vaccination programme
- Promote and support the National and Regional recognition days
- Respond to staff requests and ideas for improving the programme as far as possible

5.6 Employee Engagement, Communication and Recognition

Engagement of the workforce and gaining the commitment of employees is a key strand of this strategy, and will be a key enabler for a positive working culture. We want our people to work in an environment of trust and openess, where employees feel well informed and listened to and where they feel valued and empowered to do the best job they can. We want our employees to be proud to work for the Trust and ensure their contribution is recognised and celebrated. Maintaining engagement through periods of change is a key challenge, this People Strategy seeks to address.

To deliver this we will:

- Promote digital over paper-based communications
- Reduce reliance on traditional media sources and focus on social media as well as Trust video channels
- Prioritise recruitment and retention/appropriate access issues for communication and marketing
- Promote the positive work our teams and individuals do more widely, with a focus on ensuring our workforce sees and learns more about the good and innovative practice across our organisation
- Enhance the Trust's reputation in the local community and with commissioners and partners
- Carry out the annual staff survey and quarterly FFT surveys to understand the views of our people and to re-affirm to staff that we listen to their ideas and act upon them through the delivery of a post-survey action plan
- Promote our vision, values and goals, ensuring our leaders are capable of articulating these and delivering their services in line with the needs of the organisation and the capacity and capability of their teams
- Manage change effectively by engaging, consulting and supporting employees appropriately and at the right time
- Deliver a structured programme of events through corporate communications and Lottery-funded engagement events and promotional activities
- Continuously develop the Trust's reward and recognition schemes, including Moments of Magic and Golden Hearts schemes
- Improve access to and systems of electronic communications, including social collaboration mechanisms and mobile information
- Maintain professional relationships with Trade Unions and provide appropriate forums and mechanisms for informal and formal consultation
- Continue to strengthen engagement with the medical workforce and ensure they are involved in decision-making at all levels

5.7 Modernising the Way We Work

The Trust must always strive to improve its performance in all service areas. This requires us to constantly review what we do and how we do it, which often results in changing our practice. Change inevitably impacts upon the workforce and therefore it's important we manage change well. Over the coming years we will see significant change in many areas of our business, different approaches, new technology and different ways of working. We must work together and with partners to deliver on the challenges ahead and enable staff to learn and continue to develop their skills to remain effective in their roles.

Some examples of these include:

- The Trusts Digital Strategy 2018 – 2023 will see the introduction of new IT systems and initiatives that will require different ways of working and re-training for many staff; e-prescribing, cloud computing, end to end digital transcriptions, e-observations, scan 4 safety and more
- As we embed the ICS, there will be a need for improved workforce planning at local and regional level and the continued introduction of new roles and new ways of working across organisational boundaries
- Understand the impact of the Humber Acute Services Review and implement innovative solutions that transcend organisational form to improve patient pathways and outcomes
- Further develop back office systems such as maximising the use of ESR through streamlining and manager self-service and the roll out of Health Roster and single sign on. All of these will reduce paper transactions, saving time and money
- Support and take a lead role in the ICS Excellence Centre and ACP / PA Faculty
- Work with partners to develop a 'back office' strategy and plan to develop and sustain support services over a larger geographical footprint

6.   MAKING IT HAPPEN…

The People Strategy belongs to us all and therefore Trust leaders, managers and staff must accept responsibility to deliver the agreed set of priorities to develop and sustain a world class workforce. Our partners including trade unions share our vision and will support us in our journey.

Elements of the Strategy that are critical to service areas will feature in Health Group Forward Plans describing the specific actions to be taken. This approach will complement the performance management framework of Health Group managers having accountability for the delivery of corporate and service priorities.

6.1 Governance Structure

- The People Strategy and work plan is managed by the Workforce Transformation Committee. The Committee is chaired by the Director of Workforce and OD and each Health Group and Directorate is represented. The Committee will meet monthly. The Committee will have lead responsibility and be accountable for ensuring the Strategy and work programme is implemented, embedded and delivered across the Trust to realise the full benefits.
- Health Group and Directorate representatives on the Committee will promote and lead the workforce agenda for their area, supported by their HR Business Partner. Health Groups will require managers to implement the People Strategy and to deliver their Health Group specific workforce agenda and to feed ideas and comments to the Committee.
- All workforce matters will be dealt with at this one Committee meeting and all delegates will be 'People Champions'.
- People Strategy progress reports will be presented to the Executive Management Committee and more specific matters will be considered at Performance and Finance and/or Quality Committee. In addition Staff Side Local Negotiating Committee (LNC) and the Joint Negotiating and Consultative Committee (JNCC) will be engaged in plans and informed of progress.
- The Health and Wellbeing Steering Group and Equality, Inclusion and Diversity Steering Group will both report to the Workforce Transformation Committee on a bi-monthly basis and whilst they do not form part of the formal governance

arrangements, they are an integral part of the People Strategy to inform and shape the workforce agenda.

7.   MEASURING SUCCESS

The Trust will measure the success of the Strategy through various means, but specifically through the following key performance indicators:-

7.1 Key Performance Indicators

- We will achieve an attendance rate above 96.1%
- All staff will receive an appraisal every year and have a development plan that is reviewed
- For the theme of Quality of appraisals as measured by the National Staff Survey the Trust will be in the top 20% of organisations by 2022
- Over 90% of our staff will complete their mandatory training every year
- By 2022 we will be in the top 20% of Trust's for 'overall engagement' as measured by the National Staff Survey
- By 2022 over 90% of our staff will say they are aware of our Trust's values as measured by National Staff Survey
- By 2022 over 50% of our staff will say that communication between senior management and staff is effective as measured by the National Staff Survey
- By 2022 over 80% of our staff will say that they would recommend our Trust as a place to work as measured by the National Staff Survey
- By 2022 100% of our staff will say that in the last 12 months they have never experienced harassment, bullying or abuse at work from other colleagues, in the National Staff Survey
- Increase the number of black and ethnic minority staff in leadership roles
- By 2022 have more than 95% of posts filled
- By 2022 staff retention will be 92%
- By 2022 62% of our staff will say that they can make improvements happen in their place of work as measured by the National Staff Survey (Best performing trust in England is 66%)

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

14 May 2019

Title:	Progress towards Achievement of the Trust's Equality Objectives 2016-20
Responsible Director:	Simon Nearney, Director of Workforce and Organisational Development
Author:	Jackie Railton, Assistant Director, Strategy and Planning

Purpose:	The purpose of this paper is to provide an update to the Board on the progress made towards achievement of the Trust's Equality Objectives 2016-20.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary Key of Issues:	- The Equality Act 2010 (Specific Duties) Regulations 2011 (Section 3) requires listed bodies to prepare and publish one or more specific and measurable equality objectives that they think will achieve the aims of the general equality duty. - The Trust's Equality Objectives for 2016-20 were published in April 2016 and the attached paper provides an update on progress towards the achievement of those objectives. - To date: 2 measures have not yet been achieved 7 measures have been partially achieved 5 measures achieving as per plan 4 measures have been achieved. - The Trust is due to review and refresh its equality objectives over the coming year and agree the equality objectives for the next four years (2020-24).	

Recommendation:	The Board is asked to note the content of this paper and the progress made against the current equality objectives.

Hull University Teaching Hospitals NHS Trust

Trust Board

Progress towards Achievement of the Trust's Equality Objectives 2016-20

1. Purpose
The purpose of this paper is to provide an update to the Trust Board on the progress made towards achievement of the Trust's Equality Objectives 2016-20.

2. Background
The Equality Act 2010 (Specific Duties) Regulations 2011 (Section 3) requires listed bodies to prepare and publish one or more specific and measureable equality objectives that they think will achieve the aims of the general equality duty and thereby:

- ☐ Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by or under the Act:
- ☐ Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- ☐ Foster good relations between people who share a protected characteristic and those who do not.

The purpose of setting equality objectives is to strengthen the Trust's performance of the general Equality Duty and to ensure that we are making year on year progress in advancing equality and human rights for all groups and beyond, with our patients and carers and those who work in the organisation.

The Trust's equality objectives (2016-2020) were approved by the Trust Board in April 2016. They are:

- ☐ To improve our evidence base for patient equality of access to services

- ☐ To make information more accessible to better meet the needs of people who have a disability, impairment or sensory loss

- ☐ To build an inclusive environment for all staff

- ☐ To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)

The Trust's equality objectives were linked to the achievement of the goals and outcomes within the NHS Equality Delivery System (EDS2), ie:

Goal 1 - Better health outcomes
Goal 2 - Improved patient access and experience
Goal 3 - A representative and supported workforce
Goal 4 - Inclusive leadership.

3. Progress Update
A review of progress in achieving the equality objectives has been undertaken and was reported to the Diversity and Inclusion Steering Group in January 2019, and to the Executive Management Committee in March 2019.

To date:

- 2 measures have not yet been achieved
- 7 measures have been partially achieved
- 5 measures achieving as per plan
- 4 measures have been achieved.

A detailed update on achievement against each of the goals and supporting measures is attached.

In undertaking the annual update against the key findings in the NHS Staff Survey, it is noted that the national reporting in 2018 has seen a departure from previous survey report formats with key findings being replaced by themes. Therefore, in some instances it is no longer possible to make a direct comparison with previous NHS Staff Survey results.

4. Next Steps

In accordance with the general equality duty, the Trust is due to review and refresh its equality objectives over the coming year and agree the equality objectives for the next four years (2020-24). The review will be informed by:

- Progress against our current equality objectives
- The requirements of the new NHS Equality Delivery System (EDS3) which is due to be launched in Spring 2019.
- Engagement with stakeholder groups, including staff and patients/service users.
- The findings and recommendations of key reports such as the Care Quality Commission Inspection Reports
- Results of national and local surveys, including NHS Patient Surveys, NHS Staff Surveys
- Compliance with the Accessible Information Standard
- Benchmarking against the NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard
- Gender Pay Gap reporting
- Analysis of patient and workforce equality data.

A paper on the outcome of the review and refresh process, together with suggested equality objectives for 2020-24, will be submitted to the Trust Board in Quarter 4 of 2019/20.

5. Recommendation

The Trust Board is asked to note the content of this paper and the progress made against the current equality objectives.

Simon Nearney
Director of Workforce and Organisational Development

9 April 2019

Hull University Teaching Hospitals NHS Trust

Progress Against Trust Equality Objectives 2016-20

Equality Objective	Measure	Position at February 2019	RAG Rating	Comments
1. To improve our evidence base for patient equality of access to services	Year on year percentage increase in the number of patients/service users for whom the Trust holds data by protected characteristic	**Gender – 100% achieved** **Marital status – 73% compared to 77%** (2015) **Religion or belief – 55% compared to 62%** (2015) **Age – 100%** **Ethnic group – 82% compared to 84%** (2015)	**Partially Achieved**	Demographic details updated via national spine with ongoing opportunities via face to face contacts to check patient details. Potential opportunity through implementation of Patient Knows Best to enable patients to update their demographic profiles.
	Improvement in the capture and recording of protected characteristic data on Datix	Gathering of protected characteristics data reviewed at PALS team training session on 20.8.18 with a view to improving data capture and recording.	**Partially Achieved**	
2. To make information more accessible, to better meet the needs of people who have a disability, impairment or sensory loss	Trust compliance with the conformance criteria specified within the Accessible Information Standard Specification (July 2015)	Process established to ensure recording of patient preferences within Lorenzo and alerting system in place on patient record. Process in place to provide clinical correspondence in line with patient preferences. However, full compliance not yet achieved as dependent upon staff checking and acting on preference alerts. Implementation of new Interpretation services includes increased access to British Sign Language interpretation. BrowseAloud software on Trust website to improve access to information. AIS training and information available to all staff via Pattie.	**Partially Achieved**	Trust is looking to utilise functionality within Patient Knows Best to address some of the communication preference issues in relation to digital correspondence. Similarly working with Synertec to address communication support preferences relating to paper-based correspondence eg braille, large print, easy read.

Hull University Teaching Hospitals NHS Trust

Equality Objective	Measure	Position at February 2019	RAG Rating	Comments
	Number of PALs issues/complaints raised by patients/service users whose information/communication support needs have not been met	2015/16 – 0.15% 2016/17 – 0.04% 2017/18 – 0.10% Main topics in 2017/18 related to lack of interpretation services, discrimination, failing to meet mental health needs, lack of access to facilities.	**Partially Achieved**	Whilst a minor improvement has been seen, it is noted that this relates only to reported issues. Discussion with members of the Hull Deaf Club highlighted a number of areas of concern in relation to timely and consistent provision of British Sign Language interpreters. The new interpretation contract includes provision of online BSL services, as well as face-to-face provision.
	Year on year improvement in the Trust's performance in national patient surveys in relation to communication with professionals	Inpatient survey satisfaction score – communication with doctors and nurses) 2015: 8.0/8.1 2016: 7.8/8.2 2017: 8.3/8.4	Achieving	
3. To build an inclusive environment for all staff	NHS Staff Survey KF7 – Year on year improvement in the percentage of staff able to contribute to improvements at work, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by 2020.	Baseline 2015 = 68% below, (worse than) average 2016 = 69% below (worse than) average 2017 = 69% below (worse than) average 2018 = 56.6% compared to average of 56.1%	Achieving	2018 Staff Survey results do not map directly to the Key Findings used, however Q4d – Able to make improvements happen in my work area – shows the Trust as slightly above average (56.6% compared to 56.1%)
	NHS Staff Survey KF10 – Year on year improvement in the number of staff receiving support from their immediate managers, with a view to achieving a score of 'above (better than) average by April 2018 and 'highest' (best) 20% of acute Trusts by April 2020.	Baseline 2015 = 3.70 (average for acute Trusts) 2016 = 3.72 average 2017 = 3.76 average 2018 = 68.5% compared to average of 68.6%	Achieving	Trust remains at average for acute Trusts when reviewed against the 2018 near equivalent question.
	NHS Staff Survey KF21 – Year on year improvement in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April	Baseline 2015 = **85% worse than average** 2016 = **88% above (better than) average**	Achieved	Closest mapped question in new 2018 survey results shows the Trust is above the average score.

Equality Objective	Measure	Position at February 2019	RAG Rating	Comments
	2018 and better than average by April 2020.	2017 = **89% highest (best) 20% of Trusts** 2018 = **88.7% compared to average of 83.9%**		
	NHS Staff Survey KF26 – Year on year improvement in the percentage of staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.	Baseline 2015 = **38% worst 20% of acute Trusts** 2016 = **31% worst 20% of acute Trusts** 2017 = **28% above (worse than) average** 2018 = **22% (worse than) average**	**Not Achieved**	Slight improvement in 2017 from being in the worst 20% to being worse than average. Closest 2018 survey question suggests that the Trust remains worse than average ie 22% compared to 20% average
	CQC Well led domain – Trust achieves and maintains an overall rating of 'good' or higher for this domain	Baseline 2015 = **requires improvement** 2016 = **requires improvement** 2018 = **good**	**Achieved**	
4. To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)	To increase the proportion of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) by 2% per annum over the next 4 years	Baseline 2015 = 1.43% 2016 = **2.25%** 2017 = **3.90%** 2018 = **4.13%**	**Partially Achieved**	Whilst the proportion of BME staff in Bands 8-9 and VSM has been increasing year on year compared to white staff, the Board did not have a BME member until 2018/19.
	To increase the relative likelihood of BME staff being appointed from shortlisting so that BME candidates are just as likely as White candidates to be appointed from shortlisting by April 2020.	Baseline 2015 =1.98 (white staff almost twice as likely to be appointed as BME staff) 2016 = **1.67** 2017 = **1.39** 2018 = **1.38**	**Partially Achieved**	White staff still more likely to be appointed from shortlisting than BME staff, but the gap is narrowing.
	To ensure that the relative likelihood of BME staff entering the formal disciplinary process is not disproportionate to that of White staff by April 2020.	Baseline 2015 = 2.13 (BME staff twice as likely to enter formal disciplinary compared to white staff) 2016 = **1.67** 2017 = **1.59** 2018 = **0.94**	**Achieved**	Performance has moved from BME being twice as likely to enter the formal disciplinary process to BME being less likely in 2017/18.

Jarailton/updated as at 06.03.19

Hull University Teaching Hospitals NHS Trust

Equality Objective	Measure	Position at February 2019	RAG Rating	Comments
	NHS Staff Survey KF25 – Reduction in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months with a view to achieving 'the lowest (best) 20% of acute Trusts' by April 2018	Baseline 2015 = 27% 2016 = 21% 2017 = 21% 2018 = 24% **(better than average of 29.8%)**	Achieving	
	NHS Staff Survey KF26 – Reduction in the percentage of BME staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.	Baseline 2015 = 57% 2016 = 30% 2017 = 27% 2018 = 29.6% **(worse than average of 28.6%)**	Not Achieved	
	NHS Staff Survey KF21 – Increase in the percentage of BME staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April 2018 and better than average by April 2020.	Baseline 2015 = 73% 2016 = 87% 2017 = 81% 2018 = 81.7% **(better than average of 72.2%)**	Achieved	
	NHS Staff Survey Q17b – Reduction in the percentage of BME staff who, in the last 12 months, have personally experienced discrimination at work from their manager/team leader or other colleagues, with a view to achieving better than average for acute Trusts for both White and BME staff	Baseline 2015: White 8% BME 16% 2016 = White 6% BME 13% 2017 = White 5% BME 11% 2018 = White 6.1% BME 13.2%	Partially Achieved	Average for acute Trusts: 2016 White 6% BME 14% 2017 White 7% BME 15% 2018 White 6.6% BME 14.6%
	The Board meets the WRES requirement on Board membership? (ie broadly representative of the population it serves)	Baseline 2015 = No BME rep 2016 = No BME rep 2017 = No BME rep 2018 = BME Interim CMO appointed	Achieving	

Key:		Not achieved	2
		Partially achieved	7
		Achieving as per plan	5
		Achieved	4
		Total number of measures:	18

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 May 2019

Title:	Eliminating Mixed-Sex Accommodation
Responsible Director:	Beverley Geary – Chief Nurse Officer
Author:	Beverley Geary – Chief Nurse Officer

Purpose:	To provide assurance that the Trust continues to meet national requirements on eliminating mixed-sex ward, bathroom and toilet facilities in in-patient areas	
BAF Risk:	BAF 3	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient workforce	
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary of Key Issues:	The Trust Board receives an annual statement on the Trust's position on mixed-sex accommodation. The situation remains the same as previous years: • The Trust has maintained single-sex accommodation for sleeping, toilet and bathing facilities in line with national requirements • There have been no complaints or PALS issues raised by patients this year regarding sharing accommodation with someone of the opposite sex • New ward accommodation built this year maintains these standards	

Recommendation:	The Trust Board is asked to review and accept the attached statement, and approve it for signature and publication on the Trust's website and in the annual report

ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

DECLARATION OF COMPLIANCE 2018/19

Hull University Teaching Hospitals NHS Trust is able to confirm that mixed sex accommodation has been virtually eliminated in all of its hospitals.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Hull University Teaching Hospitals NHS Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. Apart from a few exceptions for clinically justifiable reasons, patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

Wards within the Trust are grouped according to their clinical specialties. This allows patients with similar conditions to be cared for in one area with staff that are experienced in this type of care. This means that men and women may be on the same ward but will not share sleeping, bathing or toilet facilities.

There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

How well are we doing in meeting these standards?
The Trust has made physical changes to many inpatient accommodation areas to provide privacy screening/partitioning and additional toilet and bathing facilities. Toilet and bathroom signage has also been improved and this work continues. New ward accommodation that has been built in the last 12 months has maintained single-sex standards.

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust can be subject to a financial penalty of £250 for each of these breaches. In 2018/19, there were no breaches of these standards.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2018/19.

INFORMATION FOR PATIENTS AND SERVICE USERS

'Same gender-accommodation' means:

- The **room where your bed is** will only have patients of the same gender as you, and;
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both male and female patients on the ward but, apart from a few exceptions for clinically-justifiable reasons such as in intensive care or high dependency areas, they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through sleeping areas that are designated for people of the opposite gender to you.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to X-ray or the operating theatre).

Also, it is most likely that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting one other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed space/area.

If you need help to use the toilet or take a bath that requires special equipment to help secure your care and safety (e.g. you need a hoist or special bath), then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time as you.

The NHS and Hull University Teaching Hospitals NHS Trust will not turn patients away just because a "right-gender" bed is not immediately available for them. The patient's clinical need(s) will always take precedence.

What do I do if I think I am in mixed sex accommodation?
If you think you are in mixed accommodation and shouldn't be then please speak with the nurse in charge of the ward or area. This will be taken extremely seriously by staff and action will be taken to explain the reasons behind this and assurance will be provided that you will be moved to a same gender area/bay as soon as is reasonably practicable.

The Trust also wants to know about your experiences. Please contact the Patient Advice and Liaison Service (PALS) on telephone **01482 623065** or via email at: pals.hey@hey.nhs.uk if you have any comments or concerns about single gender accommodation. Thank you.

Signed:

Terry Moran CB   **Chris Long**
Chairman   **Chief Executive**

14 May 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

May 2019

Title:	Modern Slavery Statement
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Sarah Dolby, HR Advisor, Employment Policy and Resourcing

Purpose:	To share the Modern Slavery Statement 2018-19 for Board agreement and to update the Board on the steps the Trust has taken, and planned for next year, to make further progress in this area.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	Following the introduction of the Modern Slavery Act in 2015, there is a statutory requirement for the Trust to produce an annual statement describing what steps have or are being taken to tackle modern slavery (or state that no action has been taken if this is the case). The formal Statement needs to be approved and signed by the Trust Board, and must be published within six months of the end of the financial year on the Trust's website with a link in a prominent place on the homepage.	

Recommendation:	The Trust Board is asked to approve the attached Modern Slavery Statement for 2018-19, and for its publication the Trust's website and inclusion in the annual report.

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement

Trust Submission 2018-19

1   Purpose

The purpose of this paper is to share the Modern Slavery Statement for the financial year 1 April 2018 to 31 March 2019. The statement describes the steps the Trust has taken to meet the obligations of the Modern Slavery Act 2015.

2   Background

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains. The expectation is that statements evolve and improve year on year.

Section 54 of the Act recommends that organisations report on the following:
1.   organisational structure, business and supply chains;
2.   its policies in relation to slavery and human trafficking;
3.   due diligence processes in its business and supply chains;
4.   parts of its business/supply chains where there is a risk of slavery and human trafficking taking place, and steps taken to assess and manage that risk;
5.   effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;
6.   the training about slavery and human trafficking available to its staff.

The Act requires organisations to publish a slavery and human trafficking statement on their website and include a link in a prominent place on its homepage.

The Government has indicated that it plans to carry out an audit of organisations' statements after 31 March 2019 in order to follow up with those who are not compliant with the Act.

3   The Trust's Proposed Statement for 2018/2019

The proposed statement is contained within Appendix 1 and has been reviewed by the Workforce Transformation Committee and Modern Slavery Working Group.

The Action Plan in Appendix 2 provides an update for the Board detailing ongoing activities. The Modern Slavery Working Group will use the Action Plan to track any ongoing work that is taking place in relation to modern slavery and also use it to highlight where there are currently gaps that could be improved upon.

The formal statement needs to be approved and signed by the Trust Board, and must be published within six months of the end of the financial year on the Trust's website. The statement will also be included in the Trust's 2018/2019 Annual Report.

4   Recommendation

The Trust Board is asked to approve the statement for 2018-19, in order for it to be included in the Trust's Annual Report and published on the Trust's website.

Simon Nearney, Director of Workforce and Organisational Development
Sarah Dolby, HR Advisor - Employment Policy and Resourcing
May 2019

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement

1 April 2018 to 31 March 2019

1.   Introduction
With the Government spend on modern slavery increasing year-on-year (estimated at around £39 million in 2017/18 and £61 million in 2018/19)[1], it is important that organisations continue to support the Government's Modern Slavery Strategy, by taking steps to ensure that modern slavery (i.e. slavery and human trafficking) is not taking place in any part of its own business or supply chains.

2.   Statement
This statement sets out the steps that Hull University Teaching Hospitals NHS Trust has taken over the financial year 1 April 2018 to 31 March 2019 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains.

The statement covers the following:
• Organisational structure, business and supply chains
• Policies in relation to slavery and human trafficking
• Due diligence in our business and supply chains
• Assessing and managing risks in our business and supply chains
• Performance indicators
• Training in slavery and human trafficking

2.1   Organisational Structure, Business and Supply Chains
2.1.1   Organisational Structure and Business
On 1 March 2019, Hull and East Yorkshire Hospitals NHS Trust changed its name to Hull University Teaching Hospitals NHS Trust.

The organisation is a large acute NHS Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs just over 7,000 whole time equivalent staff and has an annual income of circa £560 million and has two main sites; Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

The Trust's organisational structures are available on the Trust's internet site https://www.hey.nhs.uk/downloads/structure/.

Further details regarding the Trust's business is provided in the Annual Report and Accounts 2018/19 which is available on the Trust's internet site https://www.hey.nhs.uk/about-us/corporate-documents/.

2.1.2   Supply Chains
The Trust's Procurement and Supplies Department is responsible for spending £120m non-pay which includes:
• £28m through the Supply Chain;
• £55m from goods ordered directly (not Supply Chain) through goods and service maintenance contracts;

---

[1] 2018 UK Annual Report on Modern Slavery
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749346/2018_UK_Annual_Report_on_Modern_Slavery.pdf

- £37m on other contracts, for example; car park and security, transport and all other service type contracts.

It must be noted that these figures are approximate and will fluctuate year on year.

2.2 Policies in Relation to Slavery and Human Trafficking

As detailed in the Trust's previous Modern Slavery Statement (from 1 April 2017 to 31 March 2018), Trust policies are subject to a thorough consultation and ratification process with input from staff side and management representatives, prior to being published on the Trust's intranet site.

Trust policies are available to staff via the Trust's intranet and are available to the public through a Freedom of Information request. The Trust continues to be committed to reviewing policies on a regular basis and in line with changes to legislation.

The Trust has a number of internal policies and procedures in place (shown below) to help safeguard against modern slavery. The relevant departments will continue to review these as appropriate and ensure that modern slavery is referenced where appropriate.

2.2.1 General Policies
Raising Concerns at Work (Whistleblowing) Policy
The policy, which provides staff with information about how to raise concerns about dangerous or illegal activity in the Trust, was updated in August 2018 to include information regarding the Whistleblowers Support Scheme which the Trust is supporting. The scheme supports current and former NHS staff who are having difficulty finding employment as a result of raising concerns about safety, risk, malpractice or wrongdoing at work.

Risk Policy and Procedures
This policy was updated in September 2018. The policy sets out the arrangements in place to ensure that risk is managed in a systematic and co-ordinated way. All risks and issues are recorded on DATIX and categorised within the risk register as such (risk or issue).

Health and Safety at Work Policy
This policy states that contractors are expected to conform to the relevant health, safety and welfare statutory requirements including giving due attention to any Codes of Practice and / or appropriate Guidance Notes issued by the HSAC / HSE or other authoritative bodies. This includes the Trust's own safety policies and procedures.

2.2.2 Recruitment Policies
Recruitment and Selection Policy (excluding Medical and Dental Staff)
This policy provides staff with the assurance that the Trust is devoted to preventing slavery and human trafficking in its corporate activities, this includes due diligence with regard to recruitment and selection, in which the Trust adheres to the National NHS Employment Checks Standards, which includes vigilant pre-employment screening.

Recruitment and Selection - Medical and Dental Consultant Staff
This policy is currently undergoing review and will be published in due course, following the consultation and ratification processes.

Pre-Employment Checks Policy (incorporates Criminal Record Checking Policy)
This policy provides a framework for the effective management of pre-employment checks required for the appointment of employees and engagement of agency, volunteer and honorary staff. The policy provides further detail of the NHS Employment Checks Standards and confirms that no person shall commence employment or be engaged in a role without the required checks taking place.

<u>Engaging Temporary Workers (Bank and Agency) Policy</u>
This policy details the process for employing agency workers and reinforces that these individuals comply with the standard NHS Employment checks.

2.2.3 Safeguarding Policies

The Trust continues to publish a broad range of policies relating to safeguarding, which were detailed in the previous statement. In addition to these, the Trust's Modern Slavery intranet page includes a number of factsheets on the following:

- Child slavery
- Domestic servitude
- Sexual exploitation
- Forced labour
- Forced marriage
- Forced marriage
- Modern slavery guidance
- National referral mechanism
- Modern slavery pathway

2.3 Due Diligence Processes in the Trust's Business and Supply Chains

2.3.1 Business

The Trust continues to be committed to preventing slavery and human trafficking in its corporate activities, and to ensuring that its supply chains are free from slavery and human trafficking. The Trust also has a responsibility to ensure that workers are not being exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

All employees; staff transferred into the Trust; doctors in training; volunteers (including students and trainees on work experience placement); agency staff, contracted out staff and other people accessing the Trust in an official capacity, e.g. those involved in the Patient Advocacy and Liaison Service (PALS), and those subject to an honorary contract, are subject to the necessary pre-employment checks in line with the NHS Employment Checks Standards, which verifies that an individual meets the preconditions of the role they are applying for.

All active agencies who supply ODP's and Nurses to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.

2.3.2 Supply Chains

The Trust continues to expect that the supply chains it works with to have suitable anti-slavery and human trafficking policies and processes in place.

To assist with this, the Procurement Department has embedded reference to the Modern Slavery Act in the Selected Questionnaire document, tender document and quotation document.

A central database has been set up in order to record and monitor the responses provided regarding modern slavery on the aforementioned documentation.

Since the amendments to the Selected Questionnaire document, tender document and quotation document, the Trust has awarded ten contracts to suppliers who are compliant with the Modern Slavery Act.

The Facilities Department has also put a process in place to monitor which of their suppliers are compliant with the Modern Slavery Act 2015.

Facilities have identified 30 suppliers, and out of these:

- 22 organisations have shared their modern slavery statement
- 6 organisations do not meet the requirement to produce an annual modern slavery statement (i.e. annual turnover is below £36m)
- 2 organisations have not yet provided their statement; however the Facilities team will continue to try and obtain these.

Transport services, which has recently moved under the Facilities department, will be included in the above process and therefore Facilities will report on these in the 2019/2020 statement.

2.4   Assessing and Managing Risks in our Business/Supply Chains

In terms of assessing the risk of trafficking and slavery within our business and supply chains, as detailed in the sections above, the Trust has a number of measures in place to safeguard against these.

Within our business; we acknowledge that with over 7000 whole time equivalent staff and contact with circa 1 million patients per year (through outpatient appointments, inpatient stays, day cases, attendances at the Emergency Department and ward attendances), there will continue to be the risk of slavery and human trafficking.

However within the Trust's business the following will continue to safeguard the Trust against slavery and human trafficking:

- All staff are employed on employment contracts which comply with UK law.
- All employees including those transferred into the Trust and doctors in training; volunteers (including students and trainees on work experience); agency staff, contracted out staff and other people accessing the Trust in an official capacity, e.g. those involved in the Patient Advocacy and Liaison Service (PALS), and those subject to an honorary contract undergo pre-employment checks.
- All Trust staff undertake mandatory safeguarding training, which covers modern slavery. There are no current plans to undertake any standalone sessions focussing purely on modern slavery, but the eLearning packages are available should staff wish to refresh their knowledge in this subject.
- Across the Trust there are Safeguarding Champions, who provide individuals with an understanding of the fundamentals for good safeguarding (which includes modern slavery and human trafficking). The Safeguarding Champions ensure consistency of expertise in all teams, act as a role model in the workplace, provide information in order for staff to identify people at risk of harm and take action and ensure documentation is completed correctly, accurately, timely and forwarded to the right place.
- In December 2018, the Trust's Modern Day Slavery pathway was published on the Trust intranet.
- Staff have a number of avenues in which they can raise concerns, e.g. via the Freedom to Speak up Guardian etc.
- Within Patient Experience, any suspicion regarding modern slavery or trafficking is escalated to management and reported.

Within the Trust's supply chains, updates to the Selected Questionnaire document, tender document and quotation document to include reference to the Modern Slavery Act 2015, reduces the risk of the Trust using suppliers who are non-compliant.

There is a higher risk of non-compliance when goods and services are procured outside of the tendering process. However these are subject to the Purchase Order Version of the

Terms and Conditions for both goods and services (January 2018) Reference is made in the version to slavery although not specifically to the Act. No further update of the Terms and Conditions has been issued since January 2018. An extract is provided below:

1.1.1   it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

1.1.2   it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.22 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy;

The Trust will continue to review its major suppliers, with a view to obtaining their ongoing commitment to compliance with the Act.

2.5   Performance Indicators

Compliance with the Trust's modern slavery agenda is measured via the following:

- All staff are required to complete mandatory safeguarding training (which includes modern slavery). As of March 2019, in excess of 90% of Trust staff are compliant with the required training.
- Relevant departments (e.g. Procurement, Facilities etc.) ask suppliers to provide assurance that they are compliant with the Modern Slavery Act 2015.
- All staff undergo the relevant pre-employment checks.
- Any modern slavery concerns are raised through the Trust's incident reporting system (DATIX) and referred to the Safeguarding Team for investigation. From 1 April 2018 to 31 March 2019, there were 5 referrals relating to modern slavery compared to 4 referrals in the previous year (1 April 2017 to 31 March 2018).

2.6   Training in Modern Slavery and Human Trafficking

As stated in section 2.5, staff undertake modern slavery training as part of their mandatory Safeguarding training.

In addition, the Trust also provides a 'Modern Slavery and Human Trafficking' voluntary eLearning module to help frontline healthcare staff identify and support victims of human trafficking. Promotion of this additional training will take place as part of the awareness-raising programme (see Action Plan for timescales).

Modern Slavery is also embedded into other relevant training programmes including Recruitment and Selection.

The Trust's Modern Slavery Working Group also intends to run a modern slavery event in 2019 to further staff education and raise awareness.

3.   Summary and Next Steps

Since the requirement for organisations to produce an annual Modern Slavery Statement, the Trust has continued to demonstrate an ongoing commitment to preventing slavery and human trafficking in any part of our business or supply chains.

The Trust's Action Plan (in Appendix 2) details the steps that the Trust will take to continue to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.

This will continue to be developed on an ongoing basis in light of any national changes or issues.

The Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed   _____   Signed   _____
          Mr Terry Moran   Mr Chris Long
          Chairman   Chief Executive

Dated   Dated

Appendix 2

Hull University Teaching Hospitals NHS Trust

Modern Slavery Action Plan

Updated April 2019

Open Actions:

Date Raised	Description	Owner	Comments	Due Date
April 2018	Monitor and review ongoing modern slavery legislation and best practice	ALL		Review at each meeting
April 2018	Review Modern Slavery Working Group attendees	ALL	• Identify other areas within the Trust to engage with e.g. risk.	Review at each meeting
August 2016	Obtain assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015	ALL	• Identify contacts within Capital Development, Medical Staffing and Workforce Planning to assist with obtaining assurances from suppliers. • Agencies supplying ODPs / Nurses to the Trust have been contacted. Outstanding responses chased. • Suppliers within Estates and Facilities have been contacted and outstanding responses are being chased. • More engagement and attendance is required from Estates and Capital. The Estates and Capital teams have been advised of the shared spreadsheet in which contractors and their compliance with the Modern Slavery Act 2015 need to be logged. • Ensure modern slavery forms part of the framework agreement for engaging temporary workers.	Ongoing (for review on an annual basis)
April 2018	Review Trust corporate policies and include references to modern slavery where appropriate	ALL	• Contact relevant departments to update policies as appropriate. • Ensure appropriate references in Safeguarding policies. • Continue to review policy list on a regular basis.	Review at each meeting

Date Raised	Description	Owner	Comments	Due Date
April 2018	Awareness-Raising Programme	ALL	• Group to arrange campaign. • Engage with Communications team. • Review progress re posters. • Promote voluntary modern slavery e-learning as part of the awareness-raising programme.	September 2019
Dec 2016	Link in with Modern Day Slavery Pathway for Hull and Wilberforce Institute for the study of Slavery and Emancipation	ALL	• Links with Humber Modern Slavery Partnership are in place and appropriate updates are shared with the group. • Link in with the Partnership to support the MS Campaign.	Ongoing
February 2017	Action Plan to be shared with WTC / Diversity and Inclusion Steering Group	SD	• Share the Action Plan with the committees every 6 months.	Ongoing

Completed Actions:

Date Raised	Description	Owner	Comments	Due Date
August 2016	All new nursing agencies will be asked for assurance at the point they supply staff to the Trust	JB	• Process has been set up to do this as and when required	Completed
December 2016	Set up shared folder	SD		Completed
August 2016	Update Recruitment and Selection training (incl. overview of modern slavery/key contacts)	SD	• Updated December 2016	Completed
August 2016	Review the process for changing bank details in ESR (re could staff be forced to change bank details?)	SD	• ESR self-service allows staff to change bank details electronically without notifying payroll • Agreed that this can be dealt with through raising awareness of modern slavery	Completed
December 2016	Put up posters around the Trust to raise awareness	ZD/JP	• Posters have been put up in key areas (nursing, PALS etc.)	Completed
February 2017	Modern slavery training	ZD/JP/BG	• Midwives now have a one hour mandatory training session on modern slavery	Completed

			• Review safeguarding presentation – all Safeguarding Adults Training has been reviewed and includes references to Modern Slavery • The new 'Modern Slavery and Human Trafficking' eLearning course is now available on HEY247	
December 2016	Update Trust's Safeguarding intranet	ZD/JP	• Key contacts updated including police contact	Completed

August 2016	Supplies to amend Pre-Qualification Questionnaire	TBC	• SD to chase Supplies for update and ask for volunteer to attend meetings – the PQQ has been updated (section 7) to include:
			  – "Are you a relevant commercial organisation as defined by section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act")?"
			  – "If you have answered yes to question 7.1 are you compliant with the annual reporting requirements contained within Section 54 of the Act 2015?"
				Completed

August 2016	Agree Modern Slavery Statement for 2016/2017 to national timescales and monitor ongoing work being done nationally	All	• 2016/2017 Statement to be produced by the end of June 2017. Statement approved in May 2017 and will be published on the Trust internet site (under Corporate Documents) and will also be contained within Trust's Annual Report	Completed
August 2016	Raising awareness re Modern slavery.	SD/JP/ZD/BG	• Comms on a monthly/quarterly basis for eNews (incl. sharing Salvation Army modern slavery training) – Articles on modern slavery have appeared in Trust comms in April 2017, May 2017, August 2017 and September 2017 • Share Flex newsletter with group	Completed
December 2016	Arrange awareness campaign	All	• Confirm availability of planned training dates • Additional meeting to be arranged to organise campaign asap	Completed
February	Undertake further work in its supply	All	• Supplies to work with the Steering Group	Completed

2017	chain, to identify and understand any significant risks				
December 2016	Obtain assurance from Hand Car Wash who clean Trust vehicles	AM	• The Trust Property Manager has confirmed that the hand car wash situated on Anlaby Road is privately run on private land and therefore has no connection with the Trust, although they have provided assurance by email.	Completed
December 2016	Modern slavery concern raised by Patient Experience	SD		Completed
August 2017	Letter from Siemens asking the Trust for assurance that obligations are met in accordance with the Modern Slavery Act 2015	SD/JL/DS	• Signed letter returned to Siemens	Completed
December 2016	Compile list of responses received from suppliers/agencies and create mechanism for annual review	ALL	• Currently all statements of assurance received have been saved electronically within individual departments. • Review how this can be stored centrally.	Completed
February 2017	Modern slavery training	JP/BG	• All Trust training is up-to-date with appropriate references to MS Act, including the children's safeguarding training. • Salvation Army link to modern slavery training is no longer used; a new site has been identified and is available on HEY247.	Completed
April 2018	Supplies and Procurement: • Identify a volunteer to take part in the Modern Slavery Steering Group • Review whether any provisions can be added into contingency plans • Set up process to quantify the number of organisations that, through the tender documentation, state they are	JL	• Robert Lawson has joined the MS Group from Procurement. • The SQ has been amended to request further information in relation to modern slavery, and to ask for a copy of the supplier's MS statement. Therefore there is no longer a requirement to add provisions into contingency plans. • As appropriate documents have been updated to include the same 'Modern Slavery' questions as detailed in the SQ. • Process set up to capture whether suppliers are	Completed

	compliant with the Modern Slavery Act 2015		compliant with the MS Act.	
April 2018	Review whether the NHS Terms and Conditions for the Supply of Good (Purchase Order Version) or NHS Terms and Conditions for the Provision of Services (Purchase Order Version) include reference to Modern Slavery	RL	Reference is made in the NHS Terms and Conditions for the Supply of Goods and Provision of Services to slavery although not specifically to the Act.	Completed
December 2017	Set up workspace on Trust intranet for Modern Slavery Group.	SD	- Requested January 2018. - Set up September 2018. - Relevant documentation (e.g. minutes, previous statements etc.) have been uploaded.	Completed

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 May 2019

Title:	Information Governance update including Serious Incidents Requiring Investigation (SIRI)
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	The Data Protection Act 2018 states a requirement that Trust Boards are regularly updated regarding Information Governance matters. The attached paper provides an update on information governance requirements in NHS Trusts as well as updating the Board on information governance incidents year to date. The report was received at the April 2019 Audit Committee and no concerns were raised.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary of Key Issues:	• The Trust has implemented the requirements of the General Data Protection Regulations (GDPR) from 25 May 2018 • The Trust has completed its first submission of the replacement for the Information Governance toolkit, the Data Security and Protection toolkit; this has been reviewed by the internal auditors and received 'substantial' assurance • No high-level risks on Information Governance are being raised at this point • The Trust has recorded 94 information governance incidents in the second half of 2018-19, four of which were reported externally to the Information Commissioner's Office as Serious Incidents Requiring Investigation (SIRIs). These are consistent figures with previous years.	

Recommendation:	The Trust Board is asked to receive and accept this update for information only.

Hull University Teaching Hospitals NHS Trust
Information Governance update including Serious Incidents Requiring Investigation (SIRI)

1. Purpose of the paper

To provide an update on information governance requirements in NHS Trusts as well as updating the Audit Committee on information governance incidents year to date.

2. Introduction

On 25 May 2018 the General Data Protection Regulation (GDPR) came into force. These replaced the Data Protection Act 1998 (DPA). The main concepts and principles are much the same as those in the DPA however the GDPR contain new elements and significant enhancements. For NHS organisations, the impact has largely been on the enhancements and additions being brought by GDPR.

Alongside this, the NHS Information Governance toolkit has been replaced by a new Data Security and Protection toolkit, which reflects the 10 new NHS data security standards that came out from the third Caldicott review of data in the NHS in 2017. The new toolkit places more emphasis on security arrangements within NHS trusts, with regular testing and compliance requirements expected.

The new toolkit is available here:
https://www.dsptoolkit.nhs.uk

3. Trust Position

3.1 Information Governance requirements

The Trust's Information Governance Committee oversaw the delivery of a detailed action plan that put in place the basic requirements for GDPR in time for 25 May 2018. A copy of this action plan was received by the Audit Committee in February 2018.

The action plan delivered the following requirements:
- A Data Protection Officer in place (the Director of Corporate Affairs)
- Updated Privacy Statements for staff and patients regarding the processing and handling of their personal and sensitive data, including an easy-read version for patients that has been requested by other Trusts as good practice
- Review and confirmation of the legal basis for processing personal data and personal sensitive data for each of the main areas of Trust business (i.e. patient records and staff records)
- An updated Humber-wide Data Sharing Agreement between all local NHS organisations on data sharing for legitimate (direct patient care) needs
- Updated IG training via the national training platform
- An updated policy for Subject Access Requests
- GDPR-specific guidance on the Trust intranet and through Trust bulletins for all staff

The Trust's Non Clinical Quality Committee has maintained oversight of any significant risks arising from GDPR; none have been reported to the Committee to date, and assurance has been provided that the Trust has the mandated requirements in place.

Under the GDPR, the Data Protection Officer is responsible for ensuring the Trust Board is briefed regularly on Data Protection and Information Governance issues. The next is scheduled for May 2019. These will continue to be routinely monitored by the Audit Committee in relation to compliance and shared at the Non-Clinical Quality Committee, as GDPR aims at managerial ownership of data protection requirements.

At present, there are no high-level or insurmountable risks being flagged up to the organisation; there will be a burden of compliance from both areas of work that the Committee's attention is drawn to; the release of the replacement for the IG toolkit also changes the emphasis of the Trust's work on data security, as detailed above. The Trust's Information Governance service successfully moved back in-house from Humber NHS Foundation Trust in February 2019.

In terms of IG structure in the organisation, following the start of GDPR, this is as follows:
- Senior Information Risk Officer (Exec Director lead) – Lee Bond, Chief Finance Officer
- Data Protection Officer – Carla Ramsay
- Caldicott Guardian – Dr Makani Purva
- Health Group Information Risk Owners

The post of Chief Clinical Information Officer is optional, but best practice, for NHS Trusts to have in place. The Chief Financial Officer is working on a plan to recruit to this, following the departure of the Digital Director.

Each of the 4 Health Groups has an appointed HIRO. The Estates, Facilities and Development directorate, Finance and Human Resources have appointed a HIRO specific to their areas; this strengthening of the Trust's IG arrangements and risk ownership is welcomed. All HIROs receive appropriate training.

3.2 Data Security and Protection Toolkit (DSPT)
The Information Governance Committee has been focussing on the new Data Security and Protection Toolkit requirements. This requires evidence gathering against 10 new standards, which focus more on system security and data flows compared with the previous IG toolkit.

The list of 10 standards is:
1. Personal confidential data
2. Staff responsibilities
3. Training
4. Managing data access
5. Process reviews
6. Responding to incidents
7. Continuity planning
8. Unsupported systems
9. IT protection
10. Accountable suppliers

NHS organisations no longer receive a rating following submission of the toolkit (Level 2 used to be the minimum acceptable standard). The requirement is to now meet all mandatory requirements in each of the 10 standards, or submit an acceptable action plan to meet all mandatory requirements within 6 months of toolkit submission.

A considerable amount of work and effort went in to the toolkit evidence gathering process. The Trust met the deadline to upload its responses to the toolkit by the deadline of 29 March 2019; the Trust was able to declare compliance with most standards, and submit a six-month development plan to achieve full compliance, to meet the requirement of all Trusts.

The Trust needs to take further action to achieve full compliance on:
- Publishing completed Data Privacy Impact Assessments on the Trust's website
- 95% compliance with Information Governance training across all staff – the percentage compliance at the time of submitting the toolkit was 92.2%
- Testing of the business continuity plan for data security incidents

- All software to be surveyed to understand if it is supported and up to date – testing of audit software required

The Trust's Improvement Plan was submitted with the toolkit submission and was accepted. The Trust must deliver this improvement plan by 30 September 2019.

In addition to this, the Trust's internal auditors selected four of the 10 standards of the new Data Security and Protection Toolkit.

The four standards selected for internal audit testing were:
Data Standard One – Personal confidential Data
Data Standard Four - Managing Data Access
Data Standard Six – Responding to incidents
Data Standard Ten – Accountable suppliers

The internal auditors gave an internal audit opinion of 'substantial assurance', based on there being an adequate and active Information Governance framework in place, that the Trust could demonstrate evidence against meeting the new Toolkit requirements or identify actions for compliance and that there was a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

The IG Committee continues its work on System Level Security Process assessments and understanding any risks regarding data flows, in accordance with GDPR. This will form a large proportion of the routine work of the Information Governance Committee for the new financial year.

3.3 Serious Incidents Requiring Investigation (SIRIs)
The Trust records all IG incidents on its Datix incident system. Each incident is given a rating against Information Commissioner Office guidance; higher score incidents are classed as Serious Incidents Requiring Investigation (SIRI) and must be reported to the Information Commissioner's Office (ICO).

All IG incidents are reviewed at the Information Governance Committee, including SIRIs.

The Trust has recorded the following IG incidents between 1 October 2018 to 28 February 2019:

Classification	Count	
Disclosed in error	25	3 reported to ICO
Lost or stolen paperwork	17	
Non-secure disposal - paperwork	3	
Unauthorised access/disclosure	6	1 reported to ICO
Other	43	
Total	94	

'Other' incidents are most commonly mis-filed paperwork in medical records, which are rectified at the time.

The Information Governance Committee reviews any specific points of learning that can be usefully cascaded in the organisation through the staff newsletter and team brief.

Summary

An email was sent internally to 28 staff which inadvertently had a file attached that contained personal details of 219 staff members including employees address and salary information. The email was recalled as soon as it was discovered.
Member of Trust staff accessed Trust system to review relative's test result. This was investigated and action taken with the member of staff at the time.
Patient returned documentation belonging to another patient that she had accidentally picked up with her handheld records at her last visit. Action was taken to contact the patients on the documentation and provide apologies and assurance as to what had happened with the paperwork. The paperwork accidentally picked up is now electronic and no longer printed out.
An email was sent internally to 30 staff which included, in error, a panel hearing document relating to one of the staff instead of the correct document. The email was immediately recalled.

All IG incidents are investigated and the outcome recorded on Datix; for those reported to the ICO, the investigation is forwarded to the ICO for consideration of any further actions the Trust should take or any penalty to be levied on the Trust. The most significant breaches can result in a substantial financial penalty.

Of the four incidents reported to the ICO in the last period per the table above, the ICO has responded to the first incident and confirmed no further action is required by the Trust – the submission and actions taken at the time were sufficient. The outcome is awaited on the other three incidents.

4.   Recommendation
The Committee is asked to receive and accept this update, and to request any further information or areas of assurance

Carla Ramsay
Director of Corporate Affairs

April 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 May 2019

Title:	Declarations of Interest and Fit and Proper Persons Declarations
Responsible Director:	Terry Moran CB – Chairman
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.
BAF Risk:	N/A
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary of Key Issues:	The Trust Board receives an annual report on any issues raised by the latest Declarations of Interests by Board members, as well as any issues relating to a Board member's suitability as a Fit and Proper Person, in respect of CQC requirements. A full review has been undertaken for all Trust Board members. There are no issues of concern or non-compliance to report to the Board.

Recommendation:	The Trust Board to review and confirm there is assurance that: • that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons • that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Hull University Teaching Hospitals NHS Trust

Trust Board

Declarations of Interest and Fit and Proper Persons Declarations

1.   Purpose
To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.

2.   Background
In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non-Executive Directors.

The Trust Board confirm compliance annually for all Board members and Trust Directors. In addition, arrangements are in place through the Disclosure and Barring Service to ensure that the Trust is informed of any subsequent issues that may be a cause of concern in relation to Board members.

3.   Procedure
At the end of every financial year all Board members and Trust Directors are asked to complete a declaration of interest form which includes the Fit and Proper Person declaration. Any material issues included on the declarations are reviewed by the Chairman and/or Director of Corporate Affairs to determine if it is relevant to the individual remaining a Fit and Proper Person.

Any changes in, or conflicts of, declared interests are entered onto the declaration register held by the Director of Corporate Affairs and reported in the Trust's Annual Report as well as to the Trust Board in-year. Board members' interests are also published on the Trust's website and kept up to date as interests change.

Appendix A details the most recent completed declarations by Board members and Trust Directors, for review by the Trust Board for assurance. Appendix B details declared interests of Trust Board members. Appendix C contains the Fit and Proper Person Assessment criteria, for reference.

4.   Recommendation
The Trust Board to review and confirm there is assurance that:
- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Carla Ramsay
Director of Corporate Affairs
May 2019

**Fit and Proper Person Declarations for Board Members and Trust Directors
Completed 2019**

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Mr Terry Moran	Chairman	✓	No	No
Mr Andy Snowden	Non-Executive Director/Vice Chair until 31/12/2018	✓	No	No
Mrs Vanessa Walker	Non-Executive Director Vice Chair from 01/01/2019	✓	No	No
Mrs Tracey Christmas	Non-Executive Director	✓	No	No
Mr Martin Gore	Non-Executive Director	✓	No	No
Mr Stuart Hall	Non-Executive Director	✓	No	No
Prof. Martin Veysey	Non-Executive Director	✓	No	No
Prof. Julie Jomeen	Non-Executive Director	✓	No	No
Mr Tony Curry	Associate Non-Executive Director from 01/04/2019	✓	No	No
Mr Chris Long	Chief Executive Officer	✓	No	No
Mrs Beverley Geary	Chief Nurse – from 04/03/2019	✓	No	No
Mr Mike Wright	Chief Nurse – until 31/03/2019	✓	No	No
Dr Makani Purva	Interim Chief Medical Officer	✓	No	No
Mr Lee Bond	Chief Financial Officer	✓	No	No
Ms Teresa Cope	Chief Operating Officer – full time post from 28/01/2019	✓	No	No
Ms Ellen Ryabov	Joint Chief Operating Officer - until 27/01/2019	✓	No	No
Ms Jacqueline Myers	Director of Strategy and Planning	✓	No	No
Mr Simon Nearney	Director of Workforce and Organisational Development	✓	No	No
Ms Carla Ramsay	Director of Corporate Affairs	✓	No	No

Declarations of Board Members' Interests

Any declarations of interest made by Board members in 2019 and currently on the Trust's Register of Business Interests

Name	Role	Declared interest
Mr Terry Moran	Chairman	Trustee of Cat Zero Charity since February 2019
Mrs Vanessa Walker	Non-Executive Director Vice Chair – from 01/01/19	Chair of Wellington Care (HEY Mind) Trustee of Hull & East Yorkshire MIND Elected Member of East Riding Council
Mr Andy Snowden	Non-Executive Director/Vice Chair – until 31/12/18	Director, Trinity Wharf Management Company, Hull Sole Proprietor Andy Snowden & Associates (Leadership, Organisational Development, Executive Coaching) Associate, Phoenix Consultancy (USA), Training & development contracts with the NHS
Mrs Tracey Christmas	Non-Executive Director	None
Mr Martin Gore	Non-Executive Director	Board Member Together Housing Financial Advisor - UK Anti-Doping Agency
Mr Stuart Hall	Non-Executive Director	Partner is member of Clinical assembly, Clinical Senate Yorkshire and Humber
Prof. Martin Veysey	Non-Executive Director	Honorary consultant contract with York Teaching Hospital NHS Foundation Trust Wife is a Trainee Nurse Practitioner at Leeds Teaching Hospitals NHS Trust Programme Director at Hull York Medical School who send students on placement within HEY Gastroenterologist and Clinical Lead of Research
Prof. Julie Jomeen	Non-Executive Director	Multi-professional Advisory Panel member. Possibility of joint clinical research projects within the Trust and the University of Hull will be submitted for grant funding with Julie as a principal or co-investigator. Dean Faculty of Health Sciences University of Hull from Feb 2017. Provider of educational programmes leading to professional registrations as Healthcare Practitioners.

Fit and Proper Persons Declarations

Detail of what declarations must be made

Disclosure	Y/N
Have you been convicted of a criminal offence in the UK or elsewhere?	
Do you consent to the Trust obtaining an automatic annual notification under the DBS?	
Are you on the Safeguarding (children and adults) barred list?	
Have you been prohibited from holding office under the Companies Act or the Charities Act?	
Do you have undischarged creditors?	
Do you have a debt relief order?	
Are you an undischarged bankrupt?	
Do you have a bankruptcy restriction order?	
Are there any reasons related to health that mean that you are unable to fulfil your role?	
Have you ever been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals?	
Do you have an outstanding referral to your professional body for an issue relating to a CQC regulated activity?	
Are there any other factors that you consider your employer should be aware of that could impact on the Fit and proper persons Test?	

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

14 May 2019

Title:	Board Assurance Framework for Seven Day Hospital Services – May 2019 Update
Responsible Director:	Dr Makani Purva, Interim Chief Medical Officer
Author:	Jackie Railton, Assistant Director, Strategy and Planning

Purpose:	The purpose of this paper is to present to the Trust Board the bi-annual assessment of the Trust's progress towards compliance with the ten clinical standards outlined in the Board Assurance Framework for Seven Day Hospitals Services (NHSE, 2018).	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Trust is required to submit its bi-annual return on compliance with the 7 Day Services Clinical Standards, together with a copy of this Board Report, to the regional and national 7DS teams by June 2019. The February 2019 Seven Day Services audit of medical records showed that the Trust is non-compliant with priority clinical standards 2, 5 and 8. This report provides on update on the actions endorsed by the Board in January 2019 and the progress made to date.	

Recommendation:	The Board is asked to: • Note the contents of this paper and the Trust's performance against the 7DS clinical standards. • Approve the actions outlined • Approve the submission of the bi-annual return to NHSE/I.

Hull University Teaching Hospitals NHS Trust

Board Assurance Framework for Seven Day Hospital Services

May 2019

1. Purpose of Paper

The purpose of this paper is to present to the Trust Board the bi-annual assessment of the Trust's progress towards compliance with the ten clinical standards outlined in the Board Assurance Framework for Seven Day Hospitals Services (NHSE, 2018)[1].

2. Background

In January 2019 the Board received a paper outlining the requirements of the NHS Board Assurance Framework for Seven Day Hospital Services (7DS BAF). The paper provided details of the findings from the April 2018 7DS survey in relation to the 4 priority clinical standards and the Trust's self-assessment of compliance with the remaining 6 standards for continuous improvement.

Full implementation of the 7DS BAF is now required, with submission on a bi-annual basis of a Board-approved self-assessment and action plan to the regional and national 7DS teams. The deadline for the next submission is June 2019.

3. Spring 2019 Self-Assessment Process

During the week commencing 11 February 2019, the Trust undertook a randomised audit of emergency admissions, the sample size being 35 patients per day (total 245 patients). The audit included a review of the medical casenotes to ascertain whether there was evidence of compliance with two of the four priority clinical standards:

- Standard 2 – Time to First Consultant Review, ie all emergency admissions must be seen, and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

- Standard 8 – Ongoing Review, ie all patients with high dependency needs are seen and reviewed by a consultant twice daily and, once a clear pathway of care has been established, patients are reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

A Trust is viewed as being compliant with the standards if performance at 90% or over is achieved.

3.1 Compliance with Clinical Priority Standards 2

Of the 245 casenotes reviewed, 175 patients were admitted on a weekday and 70 at the weekend. Overall, 193 patients were seen by a consultant within 14 hours of admission, a compliance rate of 79%. This represents an improvement on the audit results of April 2018 (77%) and March 2017 (69%).

When split by weekday and weekend, performance was 76% and 85.7% respectively.

---

[1] https://improvement.nhs.uk/documents/3494/7DS_Board_assurance_guidance_v2a.pdf

The Trust's performance against this standard was impacted by the lack of documentary evidence in 19 sets of casenotes, eg: no signature, designation or date/time had been recorded.

Appendix 1 provides a breakdown of performance against Standard 2 by day of admission (Table 1), and admitting specialty (Table 2).

3.2 Compliance with Clinical Priority Standard 8

The audit of 245 admissions determined that a total of 710 once daily reviews were required to comply with Standard 8. The Trust achieved an overall compliance rate of 67% which, when broken down by weekday and weekend performance, delivered compliance rates of 72% and 52% respectively. When review by an ST3+ was taken into account, the Trust achieved a compliance rate of 80%.

For those higher acuity patients who required twice daily review by a consultant, the Trust achieved 44% compliance, which increased to 67% when reviews by an ST3+ was included in the calculation.

Of the 710 possible reviews during the audit period, no documentary evidence of compliance with Standard 8 could be found in 45 instances, the majority of which occurred over the weekend.

Appendix 2 provides a breakdown of the daily and twice daily review performance by day of the week.

3.3 Timely Access to Diagnostics – Standard 5

Under this priority standard, hospital inpatients must have scheduled 7 day access to diagnostic services. During the audit week in February 2019 a review was undertaken of the urgent and routine CT, MRI and Ultrasound diagnostic requests. The results are shown below.

Standard	Modality	Weekday	Weekend	Total
Urgent – Performed within 12 hours	CT MRI Ultrasound	91% 84% 100%	97% 67% 100%	92% 83% 100%
Urgent – Reported within 12 hours	CT MRI Ultrasound	83% 81% 100%	90% 56% 100%	84% 79% 100%
Routine – Performed within 24 hours	CT MRI Ultrasound	91% 94% 99%	96% 80% 96%	92% 92% 98%
Routine – Reported within 24 hours	CT MRI Ultrasound	88% 92% 99%	96% 80% 96%	90% 90% 98%

It is acknowledged that the Trust requires additional MRI and CT capacity and this is to be addressed through the redevelopment of the ground floor of the Tower Block at Hull Royal Infirmary through the Urgent and Emergency Care capital funding awarded to the Trust in 2018/19.

However, the results outlined above reflect the difficulties the Trust is experiencing in realising timely turnaround times for its radiology reporting, which is due to a lack of Consultant Radiologists, particularly in the sub-specialty areas. The Trust is using outsourcing services to improve reporting turnaround times and is looking to develop an innovative in-house overnight reporting service to improve reporting times further.

3.4 Access to Consultant-Directed Interventions – Standard 6
The Trust is compliant with this standard.

4. Actions to address under-performance against Standards 2 and 8
In the Trust's Operational Plan 2019/20 the organisation set out its ambition to be compliant with all four of the clinical priority standards by March 2020.

A series of actions were endorsed by the Board in January 2019. These are set out below, together with details on progress to date.

Actions	Progress
Utilising the results from the February 2019 audit to determine which specialties continue to under-perform against the standards and undertake specific work with each specialty to address shortfalls in delivery against Standards 2 and 8.	Analysis of the results will be shared with the Health Groups to enable them to review 7DS consultant cover arrangements and identify those areas where improvements are required in the recording and completion of patient records.

Areas for particular focus over the next few months will include Acute Medicine, Acute Surgery and Geriatric Medicine. |
| Reinforce to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. | |
| Encourage specialties to take account of 7DS standards compliance requirements when developing individual consultant job plans and service level operational plans. | |
| Review systems and processes for determining ongoing review requirements (Standard 8) and ensure that these are robust in all acute specialties. | Following discussion with the regional 7DS NHSE/I team, the Trust has identified a standardised model for the identification of those patients requiring or not requiring a consultant review (see Appendix 3).

This has been circulated to the Health Groups for comment with the intention of adopting this model across the organisation. Specialities will then be audited against the criteria for review to determine compliance. |
| Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. | This work is ongoing as part of the development of the digital care record. |
| Develop a series of metrics to support the reporting process against the 7DS standards (eg: mortality, average length of stay, emergency readmission rates) | Work has begun on developing metrics for use in future Board reports.

The 7DS Task and Finish Group has focussed initially on mortality indicators to investigate whether there is any variation in mortality depending on what day a patient is admitted. Appendix 4 provides an overview of the outcome of the review which found that there is no significant variation between day of admission and outcome from a mortality perspective. |

5. Next Steps
The Trust is required to submit its bi-annual return (Appendix 5), together with a copy of this Board Report, to the regional and national 7DS teams by June 2019.

It should be noted that in the national template, the Trust is shown as compliant with Standard 5 in relation to the question asked, ie does the Trust have the required diagnostic tests and reporting available on site or off site by formal arrangement. However, the national template does not allow Trusts to self-assess in relation to the specific requirement in the standard relating to timescales for delivery as outlined in section 3.3 above. There is therefore a disparity in what is reported in the national template and what Trusts are actually required to deliver.

6. Recommendation
The Board is asked to:

- Note the contents of this paper and the Trust's performance against the 7DS clinical standards.
- Approve the actions outlined
- Approve the submission of the bi-annual return to NHSE/I.

Dr Makani Purva
Interim Chief Medical Officer

30 April 2019

7DS Audit Results – Standard 2

Table 1: Time from admission to 1st consultant review by day of the week (based on day of admission)

	Day of admission										Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend		Total
Number of patients reviewed by a consultant within 14 hours	29	26	25	28	25	29	31	133	60		193
Number of patients reviewed by a consultant outside of 14 hours	6	9	10	7	10	6	4	42	10		52
Total	35	35	35	35	35	35	35	175	70		245
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	82.86%	74.29%	71.43%	80.00%	71.43%	82.86%	88.57%	76.00%	85.71%		78.78%
Number of patient notes with documentation issues (these are counted as 'review outside of 14 hours') - e.g. no time recorded, no review documented, no staff designation recorded.	4	3	4	4	4	0	0	19	0		19

Table 2: Time to 1st consultant review within 14 hours of admission by admitted specialty

	Weekday				Weekend			
Admitting specialty	Within 14 hours	Outside of 14 hours	Total	Proportion reviewed within 14 hours	Within 14 hours	Outside of 14 hours*	Total	Proportion reviewed within 14 hours
Acute Internal Medicine	71	13	84	85%	31	3	34	91%
Cardiology	3	2	5	60%	1	1	2	50%
Cardio-thoracic Surgery	0	0	0	0%	0	0	0	0%
Diabetes and Endocrinology	0	0	0	0%	0	0	0	0%
Emergency Medicine	0	0	0	0%	0	0	0	0%
Gastroenterology	1	0	1	100%	0	0	0	0%
General Surgery	12	3	15	80%	9	2	11	82%
Geriatric Medicine	17	4	21	81%	6	3	9	67%
Haematology	1	0	1	100%	0	0	0	0%
Infectious Diseases	0	0	0	0%	0	0	0	0%
Intensive Care Unit	1	0	1	100%	0	0	0	0%
Neurology	0	0	0	0%	0	0	0	0%
Neurosurgery	1	1	2	50%	3	0	3	100%
Obstetrics and Gynaecology	0	2	2	0%	0	0	0	0%
Oncology	1	6	7	14%	1	1	2	50%
Ophthalmology	1	1	2	50%	1	0	1	100%
Paediatric intensive care unit (PICU)	0	0	0	0%	0	0	0	0%
Paediatric Medicine	2	3	5	40%	1	1	2	50%
Paediatric Surgical Wards	2	0	2	100%	0	0	0	0%
Palliative Care	0	0	0	0%	0	0	0	0%
Renal Medicine (Nephrology)	2	1	3	67%	0	0	0	0%
Respiratory Medicine (Thoracic Medicine)	5	1	6	83%	0	0	0	0%
Rheumatology	0	0	0	0%	0	0	0	0%
Stroke Medicine	3	1	4	75%	3	0	3	100%
Trauma and Orthopaedic Surgery	5	3	8	63%	1	0	1	100%
Urology	1	0	1	100%	0	1	1	0%
Vascular Surgery	0	1	1	0%	0	0	0	0%
Other	3	1	4	75%	1	0	1	100%
Total	132	43	175	75%	58	12	70	83%

7DS Audit Results – Standard 8

Table 3: Twice daily reviews

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
					Day of review					
Twice daily reviews required & received from Consultant	0	0	1	3	1	2	1	5	3	8
Twice daily reviews required & received from ST3+	0	0	2	5	2	2	1	9	3	12
Twice daily reviews required & not received	0	2	2	1	0	0	1	5	1	6
Total number of daily reviews	0	2	4	6	2	2	2	14	4	18
Percentage - Receiving twice daily reviews by Consultant	0%	0%	25%	50%	50%	100%	50%	36%	75%	44%
Percentage - Receiving twice daily reviews by ST3+ or Consultant	0%	0%	50%	83%	100%	100%	50%	64%	75%	67%

Table 4a: Once daily Consultant reviews

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
					Day of review					
Once daily reviews required & received	84	75	72	67	75	44	58	373	102	475
Once daily reviews required & not received from Consultant	25	29	29	31	28	46	47	142	93	235
Total number of daily reviews	109	104	101	98	103	90	105	515	195	710
Percentage - Receiving required once daily reviews	77%	72%	71%	68%	73%	49%	55%	72%	52%	67%

Table 4b: Once daily Consultant or ST3+ reviews

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
					Day of review					
Once daily reviews required & received	95	92	86	85	88	58	62	446	120	566
Once daily reviews required & not received from Consultant	14	12	15	13	15	32	43	69	75	144
Total number of daily reviews	109	104	101	98	103	90	105	515	195	710
Percentage - Receiving required once daily reviews	87%	88%	85%	87%	85%	64%	59%	87%	62%	80%
Documentation issues (No review documented	2	2	4	1	1	15	20	10	35	45

Proposed criteria for categories

High Acuity (2x Daily Consultant Review)	Downstream Specialty Wards				
	Category 1	De-Escalation	**Category 2**	De-Escalation	**Category 3**

High Acuity (2x Daily Consultant Review)

Acute Assessment AAU/ MAU/ SAU

High Dependency ICU/ HDU/ NICU

A+E

Escalation

Escalation

Escalation

Escalation

Category 1

De-Escalation / Escalation

A core expectation is the emphasis on an "opt-out" system where the default position is daily Consultant review

Reviewer: Consultant
Review Frequency: Daily
Patient Description : *All*
- New patient to hospital & ward/ unit
- Sick/Unwell patient
- No diagnosis or unconfirmed
- Deteriorating patients, appropriately identified and responded to
- Patients awaiting consultant input for discharge

Medicine Only
- Non invasive ventilation

Surgery Only
- Patient awaiting theatre

Review Content
- Review diagnosis / existing care plans
- Follow up investigations or request new
- Defined management plan & risk stratification
- Determine appropriate category & review process based on team competencies including escalation process

Category 2

De-Escalation / Escalation

A core expectation is that a consultant – led review is not likely to influence the patients care pathway

Reviewer: To be determined by the consultant.
Review Frequency: Daily
Additional Consultant Reviews for Surgical & T&O patients at least weekly and for Medical patients twice weekly
Patient Description
- Patient is physiologically stable
- Diagnosis either confirmed or appropriate tests underway
- On correct care pathway and progress on schedule
- No specific communication tasks or care strategy questions outstanding
- Stable but discharge date not imminent

Review Content
- Identify /respond / escalate any deterioration
- Escalate back up to Category 1
- Follow up investigations or request new
- Utilise Board Rounds/ MDT / Handovers to get Consultant support where necessary

Category 3

A core expectation is patients are medically FIT

Reviewer: To be determined by the consultant.
Review Frequency: Daily

Patient Description
- Medically Fit patients waiting for discharge
- Patients waiting for external agencies input for discharge
- Or waiting to be discharged that day via Nurse Led / AHP or Criteria led discharge

Review Content
- Identify /respond / escalate any deterioration
- Escalate back up to Category 1 or 2
- Utilise Board Rounds/ MDT / Handovers to get Consultant support where necessary

Mortality Analysis
Summary of deaths by day admitted and day died

	Day Died						
Mon	Mon 14%	Tue 21%	Wed 16%	Thu 15%	Fri 13%	Sat 11%	Sun 10%
Tue	Tue 17%	Wed 19%	Thu 16%	Fri 13%	Sat 14%	Sun 11%	Mon 10%
Wed	Wed 16%	Thu 20%	Fri 15%	Sat 14%	Sun 13%	Mon 11%	Tue 11%
Thu	Thu 16%	Fri 19%	Sat 16%	Sun 14%	Mon 14%	Tue 10%	Wed 11%
Fri	Fri 14%	Sat 20%	Sun 17%	Mon 13%	Tue 15%	Wed 11%	Thu 10%
Sat	Sat 16%	Sun 20%	Mon 16%	Tue 14%	Wed 10%	Thu 14%	Fri 10%
Sun	Sun 17%	Mon 19%	Tue 17%	Wed 14%	Thu 13%	Fri 11%	Sat 10%
TOTAL	Mon 14%	Tue 15%	Wed 14%	Thu 15%	Fri 14%	Sat 14%	Sun 14%

(Row label: Day Admitted)

Admitted MON
Mon 14%, Tue 21%, Wed 16%, Thu 15%, Fri 13%, Sat 11%, Sun 10%

Admitted TUE
Tue 17%, Wed 19%, Thu 16%, Fri 13%, Sat 14%, Sun 11%, Mon 10%

Admitted WED
Wed 14%, Thu 21%, Fri 16%, Sat 15%, Sun 13%, Mon 11%, Tue 10%

Admitted THU
Thu 16%, Fri 19%, Sat 16%, Sun 14%, Mon 14%, Tue 10%, Wed 11%

Admitted FRI
Fri 14%, Sat 20%, Sun 17%, Mon 13%, Tue 15%, Wed 11%, Thu 10%

Admitted SAT
Sat 16%, Sun 20%, Mon 16%, Tue 14%, Wed 10%, Thu 14%, Fri 10%

Admitted SUN
Sun 17%, Mon 19%, Tue 17%, Wed 14%, Thu 13%, Fri 11%, Sat 10%

NHS — Hull University Teaching Hospitals NHS Trust: 7 Day Hospital Services Self-Assessment - Spring 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance In the audit carried out in February 2019, the casenotes of 245 patients were reviewed to assess compliance with standard 2 during the week of 11/02/2019-17/02/2019. Of the 245 casenotes reviewed, 175 patients were admitted on a weekday while 70 patients were admitted during the weekend. Of the patients admitted Monday - Friday, 76% (133 out of 175) were seen by a Consultant within 14 hours, while 85.7% (60 out of 70) of patients admitted during the weekend received a Consultant review within 14 hours Overall 79% of patients were reviewed within 14 hours of admission. This represented an improvement on the April 2018 position (77%). Actions for improvement include: • Continue to explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. • Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. * Undertake specific work with each specialty to address shortfalls in delivery.		No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Ultrasound	Yes available on site	Yes available on site	
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance An audit of urgent and routine CT, MRI and Ultrasound requests received for the 7 days commencing 11 February 2019 showed that urgent CT and Ultrasound scans were peformed within 12 hours for more than 90% of patients. MRI averaged 83%. CT/MRI reporting times averaged 84% and 79% respectively for urgent cases. This reflects the	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Emergency Renal Replacement Therapy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance

During the week of the audit (11/02/2019-17/02/2019), there were a total of 710 reviews required for patients that required one review per day .
Of these reviews 515 were required on a weekday, with 373 of them being carried out (72%).
Of the 195 patient reviews that were required on a weekend, 102 reviews were carried out (52%).
During the audit week, there were a total of 18 patients that required twice daily reviews. 67% were reviewed by a consultant (64% on a weekday, 75% at the weekend).
N.B. These figures also include reviews that were delegated by the Consultant to another competent member of the multidisciplinary team, as per the advice given by NHS England.

Surgery Health Group - The standard is met for those patients within critical care beds. However, not all acutely ill patients in beds on wards will receive the twice daily standard on a weekend. They will be reviewed through on-call should care be affected and deviate from the agreed care pathway.

HASU - Reviewed daily by ward-based consultant. On call consultant may review patients out of hours but this is not embedded. Patients will be reviewed further at any time if required.

Cardiology - Reviewed daily. Patients will be reviewed further at any time if required. | Once Daily: No the standard is not met for over 90% of patients admitted in an emergency

Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency | Once Daily: No the standard is not met for over 90% of patients admitted in an emergency

Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency | Standard Not Met |

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards, highlighting areas where progress has been made since 2015

Standard 1: Patient Experience - Compliant - Information given to patients does not differ at weekends or weekdays.
Standard 3: MDT Review - Partially Compliant - Pharmacy support to majority of ward or board rounds not available at weekends, but is available on call or for dispensing. 7 day MDT assessment will be undertaken by appropriate staff and in accordance with clinical need, but not all modalities will be present. Speech and Language Therapy, Occcupational Therapy and Dietetic Services are mainly 5 day services (though some Saturday services in dietetics).
Standard 4: Shift Handovers - Partially Compliant - Within Medicine Health Group there are twice daily shift handovers at designated times. Clinical data recorded electronically on CAYDER.   Oncology, Haematology and Rehabilitation Medicine are fully compliant.
Standard 7: Mental Health - Partially Compliant - There is a Mental Health Hospital Liaison Team available 24/7.   Response times vary according to clinical need and capacity and are not recorded on Trust systems.
Standard 9: Transfer to Community, Primary and Social Care - Partially Compliant - There is no integrated care record shared between primary and secondary services. Advice may be sought from specialties via the on call rota 24/7. System wide work is ongoing to share care plans between providers. OOH access to external services (eg Social services) only available in emergency situations. Transport is available 7 days. Oncology/Haematology Services have employed 2 discharge co-ordinators to ensure, where possible, all unnecessary prolonged stays are avoided over a weekend.
Standard 10: Quality Improvement - Compliant - Nurse staffing ratios do not differ for weekday or weekend provision, but may be flexed according to capacity, demand and exceptional circumstances (eg large local events). Services participate in Peer Reviews, mortality reviews, grand rounds, national audit (SSNAP), GIRFT, benchmarking exercises, governance meetings, business meetings, DATIX and SI reviews and investigations. The Trust is accredited via the Deanery as a training provider, which is also subject to quality assurance processes. |

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met.

Hyperacute Stroke -
* All patients admitted before 1700 hours will have a consultant review.
* Non-thrombolysed stroke admissions between 1700 hours and 0900 hours the next day will be seen by a consultant the next morning due to 1.00 wte Stroke Consultant vacancy.
* Level 2 patients are reviewed twice daily, seven days a week. |

Template completion notes
Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Hull University Teaching Hospitals NHS Trust

Trust Board

14 May 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 workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary of Key Issues:	The Trust's seal has been used, for review by the Trust Board. The Trust's internal auditors recently reviewed the Trust's Board Committee Structure and gave an opinion of 'substantial assurance' for the arrangements in place. This paper seeks to make some minor changes to Committee Terms of Reference and, accordingly, Trust Standing Orders in order to complete remedial actions against the technical findings of the internal audit. Two amendments are also requested to Standing Orders to reflect the Trust's name change.	

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal • Approve the proposed amendments to Board Committee Terms of Reference and, where indicated, subsequent amendments to the Trust's Standing Orders • Approve the proposed amendments to the Trust's Standing Orders as a result of the name change

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders May 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
2019/03	Hull and East Yorkshire Hospitals NHS Trust and Hull and East Yorkshire Medical Research Centre (The Daisy Appeal) Development agreement for lease and underlease relating to the construction and letting of premises known as the new cyclotron and radio-pharmacy facility at Castle Hill Hospital	11.03.19	Chris Long – Chief Executive Officer
2019/04	Deed of variation relating to PET scanning medical research and clinical facility at Castle Hill Hospital between Hull and East Yorkshire Hospitals NHS Trust and Hull and East Yorkshire Medical Research Centre (The Daisy Appeal)	11.03.19	Chris Long – Chief Executive Officer
2019/05	DSSR Consulting Engineers, Hull University Teaching Hospitals NHS Trust and Hull and East Yorkshire Medical Research Centre – Consultant's deed of warranty in favour of a landlord of a development at Castle Hill Hospital	11.03.19	Chris Long – Chief Executive Officer
2019/06	DSSR Consulting, Hull University Teaching Hospitals and Hull and East Yorkshire Medical Research Centre – Consultant's deed of warranty in favour of a landlord of a development at Castle Hill Hospital	11.03.19	Chris Long – Chief Executive Officer
2019/07	DSSR Consulting, Hull University Teaching Hospitals and Hull and East Yorkshire Medical Research Centre – Consultant's deed of warranty in favour of a landlord of a development at Castle Hill Hospital	11.03.19	Chris Long – Chief Executive Officer
2019/08	Hobson and Porter Limited, Hull University Teaching Hospitals NHS Trust, The Hull and East Yorkshire Medical Research Centre – Contractor's deed of warranty in favour of a landlord of a development at Castle Hill Hospital (Design and Build)	11.03.19	Chris Long – Chief Executive Officer

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2019/09	Morgan Lloyd Jones Project Management Limited, Hull University Teaching Hospitals NHS Trust, Hobson and Porter Limited – consultants deed of warranty in favour of a landlord of a development at Castle Hill Hospital	27.03.19	Chris Long – Chief Executive Officer
2019/10	Provision of cost consultants and principle designer services for energy projects at Hull Royal Infirmary, SSU Harrow Street and Sykes Street Clinic	27.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2019/11	Contract documents for the provision of technical advisors services for BMS to BEMS upgrade – Hull Royal Infirmary, SSU Harrow Street and Castle Hill Hospital	27.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2019/12	Hull and East Yorkshire Hospitals NHS Trust and MPH Building Systems Limited – Contract design, construction and installation of new weathertight modular shell ward block	27.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2019/13	Hull and East Yorkshire Hospitals NHS Trust and DKP Consulting – MRI Scanner replacement	27.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay Director of Corporate Affairs
2019/14	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction Limited – Craven Building enabling work – modular units relocation	27.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay Director of Corporate Affairs
2019/15	Hull University Teaching Hospitals NHS Trust and Healthcare Solutions (Hull) Ltd – Documents relating to replacement bank account – deed of novation in respect of the custody agreement relating to Hull and East Yorkshire Hosptials NHS Trust.	28.03.19	Lee Bond – Chief Financial Officer and Carla Ramsay Director of Corporate Affairs
2019/16	Hull University Teaching Hospitals NHS Trust and Trustees for Cottingham Young Peoples Sports Foundation – Lease relating to premises know as two sports fields at the former De La Pole Hospital , Cottingham	02.04.19	Lee Bond – Chief Financial Officer and Carla Ramsay Director of Corporate Affairs
2019/17	Thornton Associates (Yorkshire) Limited, Hull University Teaching Hospitals NHS Trust and the Hull and East Yorkshire Medical Research Centre	10.04.19	Chris Long – Chief Executive Officer
2019/18	Humber Teaching NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust – counterpart/lease of rights of way relating to	16.04.19	Lee Bond – Chief Financial Officer and Carla Ramsay

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
	land at Willerby, Hull		Director of Corporate Affairs
2019/19	Hull University Teaching Hospitals NHS Trust and Yorkshire Ambulance Service – Lease relating to premises known as land forming part of Hull Royal Infirmary, Anlaby Road, Hull	16.04.19	Lee Bond – Chief Financial Officer and Carla Ramsay Director of Corporate Affairs
2019/20	Hull University Teaching Hospitals NHS Trust and Alan Wood Partnership Limited and Hobson and Porter Limited – Consultants deed of warranty in favour of a landlord of a development at Castle Hill Hospital – Cyclotron and radiotherapy building	25.04.19	Chris Long – Chief Executive Officer

3   Amendment to Board Committee Terms of Reference

The Trust's internal auditors recently reviewed the Trust's Board Committee Structure and gave an opinion of 'substantial assurance' for the arrangements in place. The following section seeks to make some minor changes to Committee Terms of Reference and, accordingly, Trust Standing Orders in order to complete remedial actions against the technical findings of the internal audit.

Audit Committee

The internal auditors recommended an addition to these Terms of Reference for the minimum number of meetings that each Committee member should attend per year. It is proposed that this should be 75% of arranged meetings, which is the same as other Board Committees. It is proposed that this is added to paragraph 1.5 of the Audit Committee Terms of Reference.

The internal auditors also noted that Trust's Standing Orders, carried through to the Audit Committee Terms of Reference, include the following paragraph 3.4 (f) regarding the external auditors:

(f)   To develop and implement a policy on the engagement of the external auditor to supply non audit services.

The internal audit report recommend the removal of this clause, as it has not been used since it was inserted in 2013. It was included as, at the time, the Trust was an aspirant Foundation Trust and was putting in place governance requirements and recommendations to support Foundation Trust working, which has not materialised. This paragraph was in a model set of Audit Committee terms of reference adopted anticipation of Foundation Trust status but is redundant for the Trust's current status, so is recommended for approval from the Terms of Reference and Trust Standing Orders.

The Board is asked to approve these two changes to Audit Committee Terms of Reference. The Board is also asked to approve the change to Trust Standing Orders by removing

Remuneration Committee

The internal auditors recommended an addition to these Terms of Reference for the minimum number of meetings that each Committee member should attend per year. It is proposed that this should be 75% of arranged meetings, which is the same as other Board Committees. It is proposed that this is added to paragraph 6 of the Remuneration Committee Terms of Reference.

Quality Committee
In recent months, the Chair of the Patient Council has attended the Quality Committee and it is recommended that this post is added to the membership of this Committee.

It is also recommended that the Associate Non-Executive Director post, currently listed as a member of the Quality Committee has the following wording added alongside this post: (if Committee membership is determined by the Trust Chairman for the current post-holder). This is due to the changes in the post-=holder in recent months, who will be

These two recommendations would amend paragraph 3 of the Terms of Reference.

The internal audit report noted that the Quality Committee Terms of Reference lists some reporting committees, which is out of date.

It is proposed that the reporting committees are listed as Operational Quality Committee and the Non-Clinical Quality Committee, which mirrors current practice. The other listed committees (Clinical Harm Group, Mortality Committee, Patient Experience & Engagement Forum and the Executive Nursing Board) all report in to the Operational Quality Committee. The Board is recommended to approve these changes to paragraph 13 of the Quality Committee Terms of Reference.

Performance and Finance Committee
Paragraph 11 of the current Terms of Reference state that the reporting committees are to be confirmed. It is recommended that this paragraph is amended to read, in line with current practice:
The committees reporting in to the Performance and Finance Committee are Capital Resource Allocation Committee and the Carter Steering Group.

Charitable Funds Committee
There were no recommendations regarding the Charitable Funds Committee Terms of Reference.

4   Changes to Standing Orders

As a result of the Trust's name change, it is recommended that an additional sentence is added to the end of paragraph 1.1 of Trust Standing Orders, as follows (recommended additional sentence underlined):
Hull and East Yorkshire Hospitals NHS Trust is a statutory body which came into existence on 1st October 1999 under the Hull and East Yorkshire Hospitals NHS Trust Establishment Order 1999 No 2675. On 1st March 2019, the organisation changed its name to Hull University Teaching Hospitals NHS Trust as a result of The Hull and East Yorkshire Hospitals National Health Service Trust (Establishment) (Amendment) Order 2019 No. 346.

The Board is also asked to approve that any other references to Hull and East Yorkshire Hospitals NHS Trust, except for those in paragraph 1.1 above, are replaced with the Trust's new name in Standing Orders.

5   Recommendations
The Trust Board is requested to:
- Authorise the use of the Trust's seal

- Approve the proposed amendments to Board Committee Terms of Reference and, where indicated, subsequent amendments to the Trust's Standing Orders
- Approve the proposed amendments to the Trust's Standing Orders as a result of the name change

Carla Ramsay
Director of Corporate Affairs
May 2019

Hull University Teaching Hospitals NHS Trust
Trust Board
14 May 2019

Title:	Trade Union Facility Time Publication Requirements
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Louise Whiting, Employment Policy and Resourcing Manager

Purpose:	The purpose of this report is to share with and seek Trust Board approval for the Trust's Trade Union Facility Time Reporting data for the period 1 April 2018 to 31 March 2019, 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 clinical services	
	Partnership and integrated services	✔
	Research and Innovation	✔
	Financial sustainability	
Summary Key of Issues:	Under the Trade Union (Facility Time Publications Requirements) Regulations 2017, all public sector organisations that employ over 49 full time employees are required to publish certain data relating to facility time usage within their annual reports, on their organisation website and also through the Governments reporting service, by 31 July each year.

The Facility Time regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services. |

| 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 and included in the Trust Annual Report. |
|---|---|

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
TRADE UNION FACILITY TIME PUBLICATION REQUIREMENTS

1   PURPOSE OF THIS REPORT
The purpose of this report is to explain the background to the Trust's reporting requirements in relation to Trade Union Facility Time, provide an overview of the specific annual reporting requirements, together with Trust data for the second reporting period.

2   BACKGROUND
The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

The Facility Time regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

The percentage of the Civil Service pay bill spent on facility time fell after the implementation of similar reforms, from 0.26% in 2012 to just 0.07% for the 1st quarter of 2015.

It is not however expected that it will result in a significant impact on trade union representatives carrying out their trade union duties for which there is a legal entitlement to reasonable paid time off work.

The Government will assess the information published by public sector employers on facility time before deciding whether regulations to introduce limits on the level of facility time that public sector employers provide, in proportion to their total pay bill, are appropriate.

3   ANNUAL REPORTING REQUIREMENTS
The second report (covering the period 1 April 2018 to 31 March 2019) must be published by 31 July 2019 on the Trust's website and included in the Trust Annual Report. The information must also be reported via the government portal before 31 July 2019 so that it can be placed on the Gov.UK website.

The requirement applies only where an employer has at least one trade union representative and 50 or more employees for seven months during the reporting period, which is the period of 12 months beginning 1 April each year. As such the regulations apply to the Trust.

The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation. The Trust's proposed report also contains brief narrative to contextualise the required data (Appendix 1).

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4   TRUST DATA 2018/2019

The Trust's mandatory data for the second reporting period 1 April 2018 to 31 March 2019 (detailed in Appendix 2) highlights that the Trust percentage of total pay bill spent on facility time, at 0.02% is less than the Civil Service 2015 data (0.07%). The percentage is the same as that for the first reporting period 2017 – 2018.

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017, utilising data submitted from staff side representatives (taken from national NHS Electronic Staff Record, HealthRoster, Job Planning systems or paper returns).

Whether in providing support to individual staff members at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (e.g. Job Evaluation Panels, Joint Negotiating and Consultative Committees, Collective Agreements, Policy Sub-Groups, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

5   COMPARATIVE DATA

At a time when the whole public sector needs to ensure it delivers value for money, the reforms encourage public sector employers, including the Trust, to monitor and, where appropriate, evaluate the amount of money spent on this, in the interests of transparency and accountability.

As part of this assessment the Trust has used the 2017 - 2018 data published on the Cabinet Office website to compare the percentage of the pay bill it spent on facility time in 2017 – 2018 (0.02%) with comparable NHS organisations both nationally and more geographically based (i.e. with a headcount of 5001 to 9999), as well as with local (non-comparable sized) Trusts.

Analysis of the data of the 53 Trusts nationally who formally reported via the national reporting tool by the July 2018 deadline shows:
- the percentage of the pay bill spent on facility time ranged from 0 to 0.65%,
- the mode was 0.01% (the percentage value that appears most often),
- the medium was 0.03% (the middle value in the list of numbers),
- data for Trusts more geographically based are shown in Table 1 below.

Table 1: Comparable Sized NHS Trusts (headcount 5001 to 9999) Data 2017 – 2018

Trust Name	% of Pay Bill Spent on Facility Time	Higher/Lower % than the Trust (0.02%)
Bradford Teaching Hospitals NHS Foundation Trust	0.02	Same
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	0	↓
Mid Yorkshire Hospitals NHS Trust	0.02	Same
York Teaching Hospital NHS Foundation Trust	0.02	Same
Northumberland, Tyne and Wear NHS Foundation Trust	0.05	↑
South Tees Hospitals NHS Foundation Trust	0.02	Same
County Durham and Darlington NHS Foundation Trust	0.03	↑
Tees, Esk and Wear Valleys NHS Foundation Trust	0.04	↑
Nottinghamshire Healthcare NHS Foundation Trust	0.04	↑

A further comparison was also undertaken against other (non-comparable sized) local Trusts.

Table 2: Non-Comparable Local NHS Trusts Data 2017 – 2018

Trust Name	% of Pay Bill Spent on Facility Time	Higher/Lower % than the Trust (0.02%)
Humber NHS Foundation Trust	0.04%	↑
Northern Lincolnshire and Goole Foundation Trust	0.036%	↑
Leeds Teaching Hospitals NHS Trust	0.04%	↑

The analysis provides assurance that, based on the figures for last year (2017 – 2018), the data for the Hull University Teaching Hospitals NHS Trust was within reasonable limits.

The Trust will again compare the percentage of pay it has spent on facility time for 2018 – 2019 with other NHS Trusts once they have submitted their data for the second reporting period deadline.

6   THE PROPOSED REPORT FOR 2018/19
Attached for the Board's approval (as Appendix 1 and 2), is the proposed report to meet the Trade Union Facility Time Publication Requirements for the second reporting period 1 April 2018 to 31 March 2019.

7   RECOMMENDATION*.*
The Trust Board are asked to note and approve content of this report.

Once approved by the Board, the report will be published within the 2018/19 Annual Report and on the Trust website, prior to the 31 July 2019 deadline. It will also be placed on the Government portal.

Simon Nearney
Director of Workforce
May 2019

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRADE UNION FACILITY TIME PUBLICATION REQUIREMENTS
REPORTING PERIOD; 1 APRIL 2018 TO 31 MARCH 2019 INCLUSIVE

Introduction
The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

Background to the New Reporting Requirements
The Facility Time regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

Annual Reporting Requirements
The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation.

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

Trust Data 2018/2019
The Trust's data for the reporting period 1 April 2018 to 31 March 2019 is attached as Appendix 2.

Whether in providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (for example: Joint Negotiating and Consultative Committees, Job Evaluation Panels, Collective Agreements, Policy Sub-Groups, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

At a time when the whole public sector needs to ensure it delivers value for money, the Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

**The Trade Union (Facility Time Publication Requirements) Regulations 2017
Reporting Period; 1 April 2018 to 31 March 2019 inclusive**

Table 1: Relevant union officials
Total number of Trust employees who were relevant union officials during the relevant period, 1 April 2018 to 31 March 2019:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number (of trade union representatives)
68	63.18

Table 2: Percentage of time spent on facility time
Hull University Teaching Hospitals NHS Trust's employees, who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	28
1%-50%	40
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time
The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

	Figures
Total cost of facility time	£73,299
Total pay bill	£352,425,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 4: Paid trade union activities
As a percentage of total paid facility time hours, the number of staff hours spent by employees who were relevant union officials during the relevant period on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	1.58%

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Hull and East Yorkshire Hospitals NHS Trust

Meeting

Date

Title:	Continued use of the HealthTrust Europe Total Workforce Solutions Framework Agreement for Lot 2 (Managed and Collaborative Bank Solutions) and Lot 5 (Direct Engagement)
Responsible Director:	Simon Nearny
Author:	Sue Richards Karen Towse Marcus Raw

Purpose:	The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement
BAF Risk:	

Strategic Goals:		
	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	
	Financial sustainability	✓

Summary Key of Issues:	The Trust previously signed up to this framework agreement provided by HealthTrust Europe to provide managed and collaborative bank solutions and direct engagement. This solution allows the Trust to engage temporary staff via a "direct engagement," (vat recovery) model. This paper seeks to gain approval to extend the Trust's access to this framework for a further 12 months.

Recommendation:	The Chief Executive / Chief Finance Officer and Trust Board are requested to approve the extension of access to the HealthTrust Europe's Total Workforce Solutions Framework Agreement (Lots 2 and 5).

ATTENTION: RETURN TO: ALEX BLOUNT
ONCE SIGNED FOR FORMAL DISTRIBUTION

PAPERS FOR APPROVAL

Date Rec.	Details	Value (+ VAT)	Sent to/Date	PAF Approval (Y/N)	Approved Date	Reasons for Retention	Forwarded to/ Date
25/04/19	HEALTHTRUST EUROPE TOTAL WORKFORCE SOLUTIONS FRAMEWORK AGREEMENT FOR LOT 2 (MANAGED AND COLLABORATIVE BANK SOLUTIONS) AND LOT 5 (DIRECT ENGAGEMENT) HEY/19/131/A HEY/19/131/B	£3,031,432.99	LB. 01/05/19	Y			

On completion of approval please return Alex Blount, Alderson House Reception

Action for signature

Up to £100,000 – Chief Executive or Chief Financial officer

£100,000 – £1,000,000 – Chief Executive or Chief Financial Officer & Chairman

£1,000,000 – £3,000,000 – Performance & Finance Committee

Over £3,000,000 – Approved by Trust Board (signed by CEO on behalf of Trust Board)

(Ref. 2381)

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

CONTRACT EXTENSION RECOMMENDATION PAPER FOR THE CONTINUED USE OF THE HEALTHTRUST EUROPE TOTAL WORKFORCE SOLUTIONS FRAMEWORK AGREEMENT FOR LOT 2 (MANAGED AND COLLABORATIVE BANK SOLUTIONS) AND LOT 5 (DIRECT ENGAGEMENT)

COMPLIANT CONTRACT RECOMMENDATION

Status:	**Official Contract Extension**
Trust Reference:	**HEY/19/131/A – Lot 2: Managed and Collaborative Bank Solutions (All Staff Groups)** **HEY/19/131/B – Lot 5: Direct Engagement**
Type:	**Contract Extension**
Original Contract Term:	**12 months with an option to extend for up to 36 months**
Original Period of Contract:	**(01/05/2018 - 30/04/2019)**
Period of official extension taken:	**0 Months**
Periods of official extension period remaining:	**36 Months**
Period and dates of this official compliant extension period being recommended:	**12 Months (01/05/2019 - 30/04/2020)**
Health Group:	**Corporate**
Division:	**Workforce and O.D.**
Department:	**Human Resources**
Original Procurement Process Used:	**HealthTrust Europe Total Workforce Solutions Framework (Direct Award)**
Total Contract Extension Value (Ex. VAT):	**£3,031,432.99 Variable**
Cost Centre:	**All Trust clinical departments can use this framework.**
Terms and Conditions which apply:	**NHS Framework Agreement for the Provision of Services.**
G.D.P.R. Applicable:	**Yes**
Procedure Compliant with Trust SFI's:	**Yes**

1. PURPOSE

1.1 The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement (Lots 2 and 5) with Liaison Financial Services Limited for a period of 12 months from 1st May 2019 to 30th April 2020.

2. BACKGROUND

2.1 In May 2018 the Trust signed up to Lot 2, and Lot 5 of HealthTrust Europe's Framework Agreement for Total Workforce Solutions for the provision of

4. FINANCIAL IMPLICATIONS

4.1 CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum:	£3,031,432.99
Current cost inclusive of VAT per annum:	£3,637,719.40
Current contract end date:	30/04/19
Comments	

4.2 PROPOSED EXTENSION COSTS

Proposed cost exclusive of VAT per annum:	£3,031,432.99
Proposed cost inclusive of VAT per annum:	£3,637,719.40
Proposed contract extension start date:	01/05/19
Duration of extension:	12 months
Value of total contract extension including VAT:	£3,637,719.40
Comments;	

4.3 FUNDING DETAILS

Source of Funding:	Revenue
Cost Centre:	All Trust clinical departments can use this framework.
Financial Implications approved by:	Karen Towse

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Please indicate approval or rejection of this paper by signing in the appropriate box below.

Scheme of Delegation as per Section D Point 9.12 of Corporate Policy 105 – Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions (February 2017)

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Total Workforce Solutions Framework Agreement (Lots 2 and 5)

Contract ref: HEY/19/131/A, HEY/19/131/B

The above recommendation is accepted.

Signed: .... Date: ....

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed: .... Date: ....

Trust Board
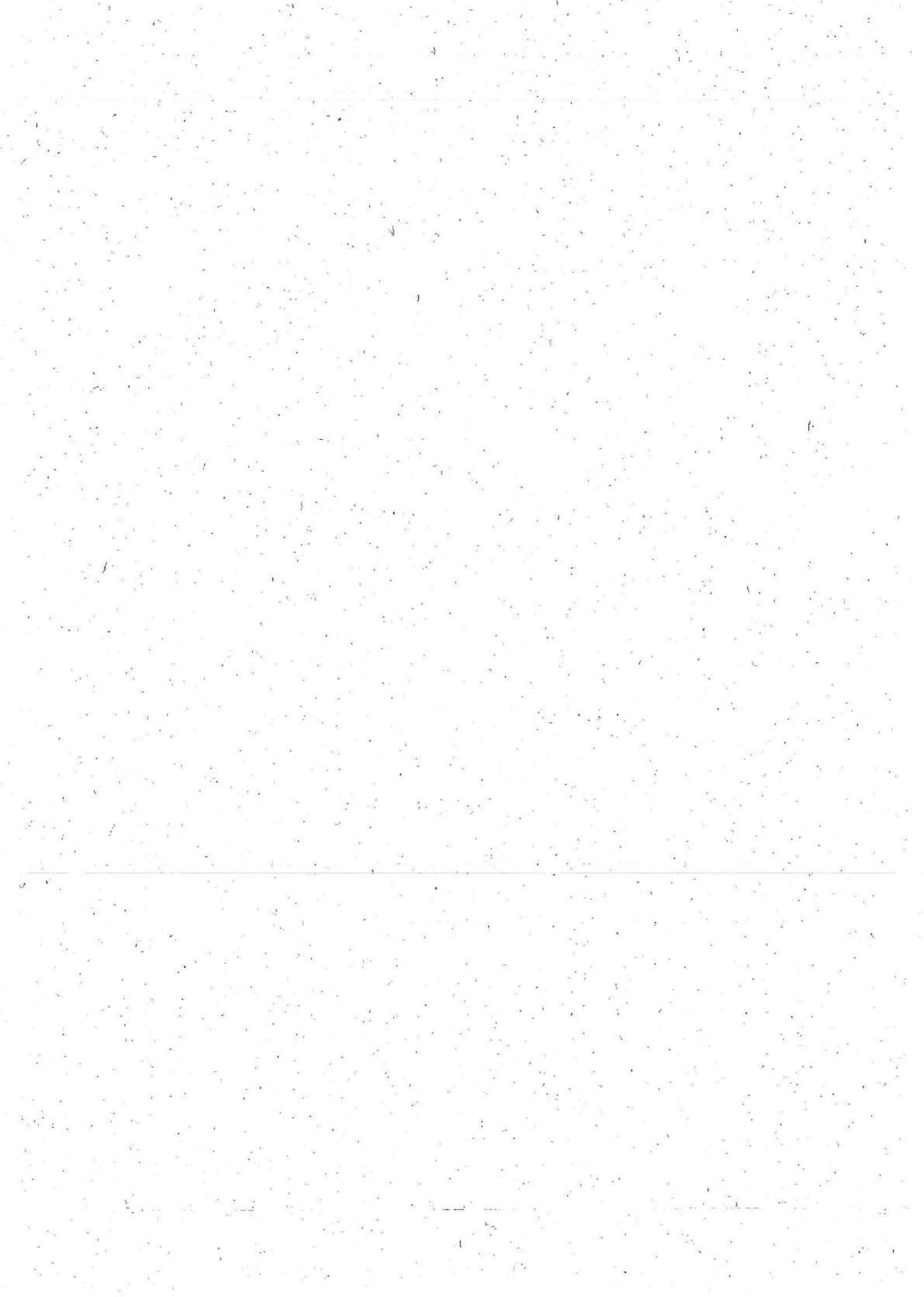
Hull and East Yorkshire Hospitals NHS Trust

Audit Committee

Meeting Date:	25 April 2019	Chair:	Tracey Christmas	Quorate (Y/N)	Y

Key issues discussed:
- MIAA (Internal Auditors) presented their end of year audit update, Head of Audit Opinion Statement, audit follow up report and Anti-Fraud end of year plan. The Audit Committee thanked MIAA for their hard work over the years.
- RSM (New Internal Auditors) presented their audit plan and counter fraud plan for 2019/20 and also their 3 year plan for audit and counter fraud. The Committee welcomed RSM to the Trust.
- Grant Thornton presented their report and advised that work on the Trust's annual accounts had begun.
- Minutes from the Performance and Finance, Quality and Charitable Funds meetings were received
- The Committee received a verbal update regarding the Annual Report to include progress against the timescales.
- Quality Accounts were received as a progress update.
- An Information Governance update was received and the new Data Protection and Security Toolkit highlighted
- The year end BAF was received by the Committee to review the process and content.
- Technical accounting matter was explained to the Committee and would appear in the accounts as an adjustment error
- The Annual Accounts were presented to the Committee and had been sent to the external auditors
- Directors expenses were presented with no issues
- Losses and special payments were discussed
- Single Source Waivers were received
- Financial Scheme of Delegation – changes to allow the CFO to sign for PFI and Supply chain invoices over £500k
- Whistleblowing update was received by the Committee

Decisions made by the Committee:
- The Committee agreed to the changes in the financial scheme of delegation

Matters escalated to the Board for action:
- There were no matters to escalate to the Board

Hull University Teaching Hospitals NHS Trust
Minutes of the Audit Committee held on 25 April 2019

Present: Mrs T Christmas Non-Executive Director (Chair)
             Mr M Gore   Non-Executive Director
             Prof M Veysey   Non-Executive Director

In Attendance: Mr L Bond   Chief Financial Officer
                    Mrs D Roberts   Deputy Director of Finance
                    Ms C Ramsay   Director of Corporate Affairs
                    Mrs K Southgate Acting Deputy Director of Quality Governance
                                     and Assurance (Item 17 only)
                    Mr G Kelly   Grant Thornton
                    Mr P Sethi   Grant Thornton
                    Mr Gary Baines   MIAA (Item 5 only)
                    Mr R Barnett   RSM (Item 6 onwards)
                    Mrs A Deegan   RSM (Item 6 onwards)

No	Item	Action
1	**Apologies:**	

Apologies were received from Mr D Davies, MIAA

2 **Declarations of Interest**
       There were no declarations received.

3 **Minutes of the meeting held in January 2019**
       Item 9 – Mrs Roberts clarified that Mr Bond did not sign off all of the
       IT orders but did sign off the credit card statement relating to IT
       orders.

       Following this alteration the minutes were approved as an accurate
       record of the meeting.

4 **Matters Arising**
       Mr Gore expressed his concern regarding the Pathology stand-alone
       IT system and Mr Bond assured him that the new Associate Non-
       Executive Director Mr T Curry would be reviewing a host of areas,
       including Pathology, and preparing a report to the Board. He added
       that Mrs Sowersby was preparing a report to the Performance and
       Finance Committee by way of a progress update.

       4.1 Action Tracker
       Mrs Roberts advised that she would be reviewing the Credit Control
       Policy in the Summer.   **DR**

       The management response paper regarding the transport tender
       had not yet been received at EMC, but Mrs Roberts assured the
       Committee that processes were in place and monitored regularly.

       Ms Ramsay advised that the Trust had a Hospital Accommodation
       procedure which detailed the process and how accommodation was
       charged to staff.

       4.2 Workplan 2018/19 and 2019/20
       The 2018/19 workplan was presented for information and Ms

Ramsay advised that all items had been presented that should have.

The 2019/20 workplan was presented. Mr Kelly asked if the Annual Audit Letter could be moved to the July meeting and the ISO 260 remain at the May 2019 meeting.

5   **Internal Auditors – MIAA**
5.1 Internal Audit Progress Report
Mr Baines presented the report and advised that the majority of the Audits had been given significant assurances but there were a small number such as the Locality Reviews still showing gaps in assurance. Mrs Christmas advised that a new sister had started on ward 15 and this was having a positive effect on the issues there. There were action plans in place and Mr Baines stated that staff had been welcoming to the Audit team.

The significant reviews included the core financial systems, data protection procedures and the Board Assurance Framework. Mr Baines advised that there were 3 reviews still outstanding and waiting for management responses. These were Junior Doctor contracts, tracking access and CQC.

There was a discussion around cyber security and the risks associated with this area. Mr Bond advised that investment was required and would be managed through the IG Toolkit.

The managing attendance policy, volunteers and effectiveness reviews were also discussed.

Resolved:
The Committee received and accepted the progress report.

5.2 Head of Internal Audit Opinion Statement
Mr Baines reported that the overall opinion for the period 1st April 2018 to 31st March 2019 was substantial assurance. There was a good system of internal controls and that it had been a good year for the Trust.

Mr Baines highlighted the risk based reviews which showed the majority of the Audits giving substantial assurance.

Resolved:
The Committee received and accepted the report.

5.3 Follow Up Report
Mr Baines reported that he would work with Ms Ramsay to ensure the follow up actions were managed appropriately. He thanked Ms Ramsay for her help and support and stated that the process had improved and was working well. He advised that he would inform RSM of the outstanding actions as part of the handover process.

Mr Gore requested that a written report could be received at the next meeting of the Committee to detail the progress being made.

Resolved:
The Committee receive and accepted the report.

5.4 Anti Fraud Report
Mr Baines presented the report and highlighted the wide range of work carried out over 2018/19. He advised that there were no allegations of fraud to carry over into 2019/20.

Resolved:
The Committee received and accepted the report.

Mrs Christmas thanked Mr Baines and Mr Davies for their hard work over the years and wished them well for the future.

Mr Baines left the Committee

Mrs Christmas welcomed Mr Barnett and Mrs Deegan as they joined the Committee

5 **5.5 Internal Auditors - RSM**
Mr Barnett presented the 1 and 3 year internal audit strategy and highlighted the robust planning process and initial meetings with the Executives and Non-Executive Directors.

Mr Barnett advised that RSM's approach was detailed in the report and how the plan linked to the strategic risks of the Trust. There would be 4 follow ups per year to ensure management had implemented the actions raised in the Audits.

Mr Barnett confirmed that the team would remain in line with RSM's tender submission and that there were no conflicts of interest with the agenda and would declare if any arose.

The 3 year strategy was not set in stone but would have a rolling review and would require interaction from both sides.

Ms Ramsay advised that the Board Assurance Framework was changing to incorporate revised organisational strategic objectives and these would need to be incorporated into the plan.

It was agreed that RSM would share their plan with Mrs Christmas, Mr Gore and Mr Bond to review the scope and approach.   **AH/TC/LB/MG**

Resolved:
The Committee received and accepted the 1 and 3 year plans.

5.6 Counter Fraud Plan 2019/20
Mrs Deegan presented the strategy and the proposed areas of work. The mandated tasks would be key to ensure compliance with the Counter Fraud Authority. Mrs Deegan was developing a communications plan and would be building on the work already done by MIAA.

Mrs Deegan reported that a payroll exercise would be carried out to analyse and test the data. There was also a national requirement to

carry out a risk measurement exercise around procurement for provider organisations. Mr Bond asked about the timescales and Mrs Deegan advised that it would be in June 2019.

Mrs Deegan reported that the 3 key areas for focus would be recruitment, procurement and the mandated fraud initiatives. Mr Bond added that the potential risks around locums and doctor timesheets was also an area for review.

The Committee discussed how raising fraud awareness with staff was important and how a new Internal Audit company could re-energise staff and encourage them to report any instances of fraud. Mrs Deegan reported that she would be targeting any difficult areas.

Mrs Deegan suggested that she would be attending 3 Audit Committee meetings but would provide and update at each one.

Resolved:
The Committee received and accepted the report.

6   **6.1 External Auditors**
Mr Sethi presented the report and advised that work had started to prepare the final accounts at year end. He reported that he had met with finance managers in preparation for this and a number of Trust staff had attended a workshop in February hosted by Grant Thornton.

Mr Sethi advised that work on the Trust's charitable funds would start in August 2019 and other deliverables for the year had been set out in the report.

Mr Sethi also spoke about the IT Network Security Policy and the work ongoing with that and the testing of operating expenditure.

In the sector update Mr Sethi highlighted the lack of investment in NHS infrastructure and how this would be a major issue for many Trusts in 2019/20. The Committee discussed this issue and Mr Bond advised that options were being reviewed as a priority as the lack of capital funding could begin to impact on patient safety for many trusts.

Mr Sethi also reported that workforce availability was also an issue for trusts.

Resolved:
The Committee received and accepted the report.

7   **Board Committee Minutes**
        7.1 Performance and Finance March 2019
There were no issues raised.

7.2 Quality March 2019
Mr Gore asked for clarity around the GIRFT and why this was not still measured in the Quality Improvement Plan. Mr Bond advised that it had its own governance arrangements in place and formally

reported to the Carter meeting.

Clarity was sought around the process for the Quality Accounts sign off and Prof Veysey advised that the Board had delegated responsibility to the Quality Committee due to timing issues.

7.3 Charitable Funds February 2019
There were no issues raised.

8   **Draft Annual Report**
Ms Ramsay verbally updated the Committee and gave assurance that the process was on track for the May submission. The performance and financial information was now available for year end and this would be added and form part of the Annual Governance Statement.

Mr Kelly added that he would work with Ms Ramsay regarding the Annual Report to give benchmarking feedback.

Resolved:
The Committee received and accepted the verbal update.

Mrs Southgate joined the meeting

The agenda was taken out of order at this point

17   **Quality Accounts**
Mrs Southgate attended to update the Committee on progress against the Quality Accounts. She advised that the Clinical Audit section was still to be included but assured the Committee that it would be completed within the prescribed timescales. The Quality Accounts would be reviewed by the Trust's stakeholders and their comments would be added to the document.

Prof. Veysey advised that the Quality Committee would be reviewing the document at its meeting on 29 April and would sign them off at the end of May for publication at the end of June 2019.

There was a discussed around the Board members who did not sit on Quality Committees and how they could input into the agreed priorities earlier. Mrs Southgate agreed to highlight the proposed priorities at the January 2020 Board meeting to enable all Board member to have their input.

Mr Gore asked for clarity around Never Events and Prof Veysey confirmed that the Trust had not declared any in 2018/19.

Mr Gore also asked for the wording around Sepsis to be clarified and Mrs Southgate agreed to review this. He also stated that the Tracking Access issue did not appear in the document. Ms Ramsay advised that this would be covered in the Trust's Annual Report.

Resolved:
The Committee received and accepted the report.

9   Information Governance Update

Ms Ramsay updated the Committee and advised that little had changed since October 2018 other than two more Information Risk Officers being appointed giving a greater level of ownership.

There had been no significant IG breaches and there were no actions outstanding from the Information Commissioning Officer.

The new Data Security and Protection Toolkit had taken the place of the IG Toolkit and was based on 10 new standards mainly linked to data security. Four out of the 10 had been selected for audit. She advised that the Trust was declaring compliance in most areas.

The Committee discussed benchmarking against other Trusts and Ms Ramsay advised that the standards were very subjective and it would be difficult to do this.

Mr Bond asked that all Non-Executive Directors complete their Information Governance training on-line.

Resolved:
The Committee received and accepted the report.

10   Board Assurance Framework

Ms Ramsay presented the BAF and advised that it was the year end version for review by the Committee of either process or content. She reported that the BAF had been used actively throughout the year informing Board level strategic discussions.

Mr Gore asked about the pensions tax issue in BAF 2 and whether this was a major risk. Mr Bond advised that this was being worked through the Remuneration Committee and that it was a national issue.

Mr Gore also spoke about BAF 3 and hydration, BAF 4 in relation to ED and BAF 7.3 and the risk to capital expenditure. Mr Bond advised that it was important to capture the current positions and any mitigating actions. He added that BAF 7.1 would need to be reviewed for Q4 to take into account the Trust achieving its Control Total.

Resolved:
The Committee received and accepted the report.

11   Technical Accounting Matter

Mr Bond presented the Accounts and reported that the Trust had achieved a £25m surplus for 2018/19. He gave a breakdown of how the Trust had achieved the surplus and advised that it was mainly due to PSF monies and a £9m incentive bonus for hitting the Control Total.

He spoke of an issue around how depreciation had been valued over the last 3 years and how this would be accounted for as an unadjusted error and would not be put through the Accounts. The

error would not affect the balance sheet.

Resolved:
The Committee received and accepted the report.

12   Annual Accounts 2018/19
Mr Bond presented the Accounts and advised that they had been submitted to Grant Thornton for scrutiny. Mr Kelly added that the Going Concern disclosure would also be reviewed.

Mrs Roberts asked for any comments on the Accounts to be emailed to her within the next 10 days.

Resolved:
The Committee received and accepted the report.

13   Review of Directors Expenses
Mrs Roberts presented the report and advised that the director expenses payments were in line with the same period last year. The appendix detailed the expenses by Board member. Mrs Roberts advised that there were no issues with the levels of claims.
Resolved:
The Committee received and accepted the report.

14   Losses and Special Payments
Mrs Roberts presented the report which gave details regarding patient property losses whilst being cared for in the hospital. The other element of the report related to permanent injury payments.

Resolved:
The Committee received and accepted the report.

15   Single Source Waivers
Mr Bond presented the report and advised that there was a process in place for any single source waivers such as kit and equipment only manufactured by one supplier. Mr Bond advised that he signed off all single source waivers and would challenge any issues accordingly.

Resolved:
The Committee received and accepted the report.

16   Financial Scheme of Delegation
Ms Ramsay presented the updated Scheme of Delegation and requested approval of the Committee to allow the Chief Financial Officer to sign off any invoices over £500k relating to PFI schemes and NHS Supply Invoices only.

Both of these areas had purchasing schedules in place and an agreed pricing contract.

Resolved:
The Committee received the paper and agreed to allowing the CFO signing off PFI and NHS Supply invoices greater than £500k.

18   Whistle Blowing Procedures and Freedom to Speak Up
Ms Ramsay presented the regular update to give assurance to the Committee that speaking up arrangements were in place. Ms Ramsay spoke of the Freedom to Speak up Guardian role and the Staff Advice Liaison Service as areas of good practice.

Mr Bond asked if more people were reporting concerns and Ms Ramsay advised that reporting was regular but had not increased significantly. She added that the Trust had robust support routes and met the national requirements.

Mrs Christmas advised that she had taken over from Mr Snowden as the Non-Executive Director lead for Whistle Blowing and the policy had been updated to reflect this.

Resolved:
The Committee received and accepted the report.

19   Any Other Business
Mrs Christmas asked for clarity around the timings of the May meeting to approve the Accounts. Mrs Thompson agreed to email the date and time to the Committee members.

20   Date and time of the next meeting:
Thursday 23rd May 2019, 1pm – 2pm, The Committee Room, Hull Royal Infirmary

HULL UNIVERISTY TEACHING 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 UNIVERISTY TEACHING HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

HELD ON MONDAY 25 FEBRUARY 2019

THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT: Mrs V Walker, (Chair), Vice Chair, Non Executive Director
                          Mr M Gore, Non Executive Director
                          Mr D Haire, Project Director, Fundraising
                          Mr L Bond, Chief Financial Officer

IN ATTENDANCE: Mrs D Roberts, Deputy Director of Finance
                          Ms C Ramsay, Director of Corporate Affairs
                          Mrs L Roberts, Personal Assistant (Minutes)

1   APOLOGIES FOR ABSENCE
No apologies were received.

2   DECLARATIONS OF INTEREST
Mr Gore declared an interest in agenda item 8 – Song for Hull

3   MINUTES OF THE MEETING 25 OCTOBER 2018
The minutes of the meeting held 25 October 2018 were approved as an accurate record.

4   MATTERS ARISING
There were no matters arising.

5   ACTION TRACKER
The item in relation to the Committee effectiveness review would be included on the agenda for the next Committee meeting.

David Haire advised that a report on benefits realisation would be presented at the next Committee meeting.

6   WORKPLAN 2019/20
The Committee received and agreed the draft 2019/20 workplan.

7   PROJECT DIRECTOR'S REPORT
The paper was presented to the Committee by Mr Haire who gave an overview of the fundraising activities.

Charitable Funds Transitional Arrangements – WISHH Charity
Work was on going to ensure the smooth transition of the management of charitable funds by the WISHH charity.

The ELFS system had been set up for the management of financial activities for the WISHH charity.

The Charity Manager/Fundraiser and the Administrative Officer posts had been recruited to.

The new staff had been communicating with the Health Groups and introducing themselves to Trust Staff. Open sessions would be taking place across both hospital sites in March 2019 for staff to find out more about the WISHH Charity.

Replacement of the Brocklehurst Building to enhance research capacity
The Committee was informed that the proposed scope and costs for the replacement of the Brocklehurst Building were still subject to on-going discussion.

Other Potential Benefactor Supported Projects
The opportunity to secure benefactor support and significant financial contributions for a number of projects was being explored.

Creating a Dementia Friendly Environment – Wards 8 and 80
The project brief was being updated and work would progress after the winter period.

Kingstown Radio
A recommendation to renew the annual financial support of £6k for the Kingstown Radio would be discussed under the Fund Balances and Spending Plans agenda item of this meeting.

Paediatric Services – Fundraising Activities
It was advised that the WISHH Charity were supporting a number of initiatives for Paediatric Services.

13th Floor Paediatric wards
A fundraising press release had been issued resulting in £6k been raised for wall stickers for the wards. The Deep, Hull had also decorated 2 rooms on the paediatric wards.

Paediatric Outpatient and Day Unit Facilities
A brief for improving the environment had been produced and options for fundraising were being explored.

Outpatient Facilities for Children with Complex Disabilities
A report is awaited from the Family and Women's Health Group in relation to the outpatient facilities for children with complex disabilities.

Retinal Camera
The Committee was informed by Mr Haire that to date the family had raised £74.8k for the retinal camera appeal to purchase £86k of equipment. A request for the £11.2k shortfall from charitable funds would be made under agenda item - Fund Balances and Bids for General Funds of this meeting.

Whilst supportive, Mr Bond expressed concerns regarding the use and maintenance required for the machinery. It was agreed that Mr Haire would look at a business case to support this and circulate to Committee members.

Health Groups – Amalgamation of Charitable Funds
The work to reduce the number of charitable funds held by Health Groups had been completed.

It was advised that the total number of Health Group funds had been reduced from circa 200 to 77.

Hospital Arts Strategy
Plans were being put into place to progress with the individual projects detailed within the Hospital Arts Strategy. A great deal of external interest had been received from artists in relation to this work.

Mr Haire requested Committee support for the WISHH Charity to consider the Hospital Arts Strategy as a strategic fundraising appeal. The Committee agreed to this approach.

Resolved
The Committee:
- Received the report and accepted the contents
- Agreed to receive a business case surrounding the retinal camera   **DH**

8   SONG FOR HULL

Mr Gore gave the Committee members an overview of the "Song for Hull" initiative and asked the Committee to support this by granting £2.5k of charitable funds to secure the Bonus Arena in Hull as the venue.

The event would feature a number of local schools and the theme would be "when I grow up", which would feature aspirations. There would be an opportunity for the Trust to promote careers within the NHS.

Following a discussion it was agreed that the Charitable Funds Committee were supportive of the event and approved the £2.5k required from the appropriate fund.

9   FINANCIAL REPORT AS AT 31 DECEMBER 2018

Mrs Roberts presented the Financial Report to the Committee and advised on the financial position of the charitable funds as at 31 December 2018.

Total income received as at 31 December 2018 was £646k, which was significantly lower than plan. Total expenditure for the period was £444k which was also less than estimated.

The Brown Shipley portfolio had been sold in October 2018, which produced realised gains of £83k. These were offset against losses on the COIF fund and gave a net gain of £49k.

At 31 December 2018 net assets were £2.084m and the Trusts investment portfolio and reserves of cash equated to £2.116m.

A total of £40k was owed to suppliers for purchases of goods and services, with the majority owed to the NHS Trust. A reserved £247k of funds to meet the expected expenditure commitments of fund holders, with a further £500k to be paid to the NHS Trust in respect of the Helipad scheme.

Upon review of Appendix C – Transactions over £100, Mrs Walker requested that information on the outcome and benefits from granted funding is included in future reports.

Resolved
The Committee:
- Received and accepted the report
- Agreed to the outcome and benefits from granted funded to be included in future reports   **DR**

10   INVESTMENT UPDATE

Mrs D Roberts gave the Committee an overview of the investments and advised that a representative from CCLA would attend the next meeting to provide a COIF update.

It was noted that the Trusts decision to close the investment portfolio with Brown Shipley and invest in COIF had been wise due to the economic changes in the market.

Mrs D Roberts agreed to enquiry whether the investments included bonds.

Resolved

The Committee:
- Agreed to receive an update on investments at the next meeting.   **DR**
- Agreed to receive clarification on the inclusion of bonds within investments. **DR**

11   FUND BALANCES AND BIDS FOR GENERAL FUNDS

Mr Haire presented the Fund Balances and Spending Plans paper to the Committee and gave an overview of the current position.

It was advised that as at 31 December 2018 the charity had £2,076m available to spend.

There were 18 funds with a balance in excess of £20k, the balance of these funds combined equated to £1.234m. At this point the amalgamation of the number of separate funds for the Medicine and Surgery Health Groups was not complete.
It was noted that the Health Group's expenditure had increase over the last 6-9 months.

There was a discussion regarding a -£6k inclusion in Appendix A of the report, Mrs D Roberts agreed to clarify the details.

Two requests for funding were received:

Kingstown Radio Service

A request of £6k was made to fund the annual grant for 2019 for the Kingstown Radio Service.

Subject to a review after one year and the receipt of a strategic plan for the radio station it was agreed to support the request for £6k.

Retinal Camera Appeal

A funding request for £11.2k was made to support the shortfall for the Retinal Camera Fundraising appeal.

The funding request was approved.

Resolved

The Committee:
- Received and accepted the report
- Approved the bids for general charitable funds as noted above
- Agreed to receive clarification regarding the -£6k entry in Appendix A of the report **DR**

12   LEGACY REPORT

Mr Haire presented the Legacy Update report to the Committee.

The paper included the legacies that had been received by the Trust since the last report in October 2018, along with the notification of legacies that would be received at a future date.

It was advised that the on-going legal issues in respect of a legacy would be shortly concluded, with the Trust receiving a payment of circa £26k.

Resolved

The Committee received the report and accepted the contents.

13   DRAFT BUDGET 2019/20

Mrs Roberts presented the draft budget 2019/20 paper to the Committee for approval in accordance with good practice.

The administration charge was proposed at £60k. The included the costs of managing investments estimated at £12k, along with a modest loss of £20k in the market value of investments.

It was advised that the expenditure reflected the current run-rate along with the financial support that had been committed to WISHH.

Resolved
The Committee received the report and accepted the draft budget 2019/20.

14   ADMINISTRATION CHARGE
The paper was presented to the Committee by Mrs Roberts who advised on the administration charge for 2019/20.

Resolved
The Committee received the report and agreed the administration charge for 2019/20.

15   CHAIRS SUMMARY OF THE MEETING
Mrs Walker summarised the meeting.

16   ANY OTHER BUSINESS
There was no other business discussed.

17   DATE AND TIME OF THE NEXT MEETING
TBC