Hull University Teaching Hospitals NHS Trust

OPERATIONAL PLAN

2019/20

Remarkable people.
Extraordinary place.

Hull University Teaching Hospitals NHS Trust

Operational Plan 2019/20

1. Introduction

Hull University Teaching Hospitals NHS Trust (HUTH Trust) is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. The Trust employs 7,486 WTE staff, has an annual turnover of £573m (2018/19) and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

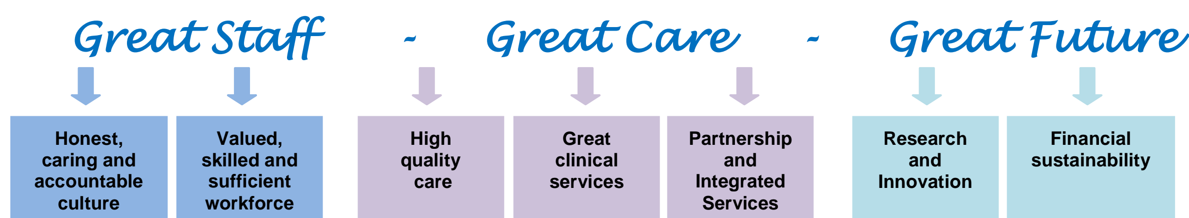
The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

2. Vision, Values and Goals

Our vision is *'Great Staff, Great Care, Great Future'*, as we believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community.

We have developed a set of organisational values - *'Care, Honesty, Accountability'* - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2019-2024.



On 1st March 2019 the Trust formally changed its name to Hull University Teaching Hospitals NHS Trust in order to strengthen links with Hull University, particularly in respect of teaching and academic opportunities, and to bring about positive benefits in respect of recruitment, especially in relation to clinical posts across medical, nursing and professions allied to health. Research and innovation features as one of our seven organisational goals as it reflects the Trust's aspiration to be a research centre of excellence, engendering an innovation culture.

3. Local Health and Care System

The local health system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

3.1 Humber Coast and Vale Health and Care Partnership (HCaV HCP)

The Humber Coast and Vale Health and Care Partnership is working towards achieving Integrated Care System (ICS) status by 2020, underpinned by Integrated Care Partnerships (ICPs) covering North Yorkshire and York; Hull and the East Riding of Yorkshire; North East Lincolnshire and North Lincolnshire.

The Humber Coast and Vale vision for 2021 is for a system that supports everyone to manage their own care better, reduces dependence on hospitals, and uses resources more efficiently. In order to realise this vision, the HCP's key area of focus is the development of new arrangements for the integration of care delivery, specifically between primary, community and social care, and between in-hospital and out-of-hospital care in each locality and ICP.

The Trust's role in delivering this plan is to work openly and collaboratively with partners to support the development of new models of care and the closer integration of health and social care services. The Trust is also supporting two reviews of acute or secondary care, one across the Humber region and one across the York and Scarborough areas. The Trust is working closely with local partners on the Humber Acute Services Review to identify opportunities for collaboration and joint working, in particular with colleagues from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG).

3.2 Commissioning Intentions of Hull and East Riding CCGs

The commissioning intentions of both Hull and East Riding of Yorkshire CCGs have been developed in response to the challenges arising from an ageing population, an increase in the number of people living with multiple long-term conditions and the need to address local health inequalities. They also incorporate the priorities for improvement within the Humber Coast and Vale HCP and the ambitions within the NHS Long Term Plan. The priorities of the Hull and East Riding Integrated Care Partnership in 2019/20 include:

- Further development of the Frailty pathway
- Community paediatrics
- End of Life Care for children and young people with complex health needs
- Ambulance diversionary pathways for care homes
- Reduction in elective waiting lists and progress towards sustainable list sizes
- Pathway review and redesign for musculo-skeletal/back pain, respiratory medicine, diabetes, ophthalmology
- Outpatient transformation
- Programme of system redesign to promote self-management/self-care, early identification and intervention, community pathways, reduced clinical variation and increased use of technology.

4. Activity Planning and Service Developments

4.1 Capacity and Demand

The Trust has developed its workload forecasts and service delivery plans for 2019/20 using recognised capacity and demand models. The Trust's plan for elective activity in 2018/19 was to achieve the national requirement to have a waiting list no larger than at 31 March 2018 and to have no 52 week waiters. The Trust will deliver a reduced overall waiting list size. There were some delays in eliminating 52 week waiters, but this is expected to be achieved by the year end. Waiting list backlogs in some specialties are still significantly above NHS Intensive Support Team recommended levels. We will continue to address these during 2019/20, albeit at a pace dictated by the available resource to support backlog clearance.

Appendix 1 provides a summary of the Trust's improvement trajectories for 2019/20 in respect of:

- Emergency Department (ED) 4 hour wait threshold
- 18 weeks wait - incomplete pathway
- 2ww, 31 and 62 day cancer thresholds
- Diagnostics threshold
- 52 week waits

The Trust has set an ED 4 hour wait improvement trajectory of 90% by March 2020. A significant contributor to achievement of this target is the new primary care streaming area adjacent to the ED which opened in March 2019 and operates between 8 am and 10 pm, 7 days per week. The facility is seeing approximately 50 patients per day. In conjunction with our Commissioners, a revised model of primary care delivery has been developed and is expected to be agreed by April 2019, with implementation during Quarter 1 2019/20.

Patient flow through the Trust is a significant factor in the delivery of the ED 4 hour wait target. As part of the learning from winter 2018/19 and the Trust's forecast bed modelling, a number of initiatives have been agreed to increase bed capacity and reduce the number of delayed transfers of care. An additional medical ward has been funded on the Hull Royal Infirmary site to improve flow through the medical bed base. In addition, the local system, led by East Riding of Yorkshire Council, has developed a proposal for a social care discharge facility to be open on the Castle Hill Hospital site from September 2019 to March 2020. Discharge targets for all out of hospital community and social care partners have been agreed to ensure consistent flow of complex/supported discharges each day.

The Trust has set an improvement trajectory of 85% RTT performance by March 2020. This will be achieved through the ongoing focus on reducing the number of waits over 36 weeks, utilisation of additional diagnostic capacity (CT, MRI and endoscopy) during the year, and the embedding of the Outpatient Improvement Programme which has a particular focus on capacity and demand alignment, pathway improvements and reducing waiting times for first outpatient appointments. These initiatives, together with actions to improve accuracy of recording and data validation will ensure that waiting list sizes are reduced.

Over the last year the Trust has experienced significant challenges in some specialties in relation to patients waiting in excess of 52 weeks for treatment. The Trust is committed to ensuring that no patient waits over 52 weeks during 2019/20, however it is acknowledged that late referrals from other organisations may impact on our efforts to realise this ambition. The work outlined above to reduce waits over 36 weeks is coupled with targeted initiatives. For example, theatre capacity within the ENT service will be increased by 3 sessions per week in 2019/20 and two additional ENT Consultants have been appointed and will take up post in March and August 2019. In addition, a contract is in place with Pioneer Healthcare to undertake adult and paediatric ENT cases using the Trust's theatres at the weekend. Independent Sector activity via Spire Healthcare will be utilised where necessary, including provision for Plastic Surgery procedures under local anaesthesia.

Improvements in diagnostic service provision and cancer waiting times will be delivered through increased capacity in MRI, CT and endoscopy. Additional diagnostic capacity has been funded through the Aligned Incentive Contract for 2019/20. It is acknowledged that, whilst the additional investment in diagnostic provision will not eliminate diagnostic breaches, it will enable the Trust to reduce the number of breaches to 3% by the end of the year.

Delivery against the national cancer thresholds will be improved in 2019/20 through the provision of additional diagnostic capacity outlined above, additional Consultant appointments in Breast Surgery and Head and Neck Surgery, as well as through ongoing improvement work within the colorectal, lung and prostate cancer pathways.

The Trust will continue to work to increase productivity, to redesign pathways to drive improvement against the waiting time thresholds, and will work with commissioners and primary care to agree referral protocols and reduce the number of inappropriate referrals.

4.2 Activity Plan

In 2017/18 the Trust agreed an Aligned Incentive Contract (AIC) with Hull and East Riding Clinical Commissioning Groups for a two year period. This marked a fundamental change from an organisational-based Payment by Results (PbR) contract to a system contract with shared risk, shared opportunity and shared vision. It provides all parties with a common goal: the effective management of patient pathways irrespective of organisational boundaries and involves:

- a move away from the standard PbR contract
- a fixed value contract
- commitment to system-wide improvement
- incentives to reducing activity
- joint responsibility – ensuring patients receive the right care in the right setting as efficiently as possible

- a single monitoring system
- a revised governance structure.

The CCG contracts are based on forecast out-turn and generally reflect growth in Ophthalmology activity (Wet AMD injections), Diagnostics, high cost drugs and additional capacity in Urology and ENT. The Trust has concluded the negotiations with the Specialist Commissioning contract to reflect outturn activity plus growth in high cost drugs, cancer services and trauma, mechanical thrombectomy and Cardiothoracic Surgery.

The Trust has not seen any growth overall in non-elective admissions in 2018/19. Comparing the first 11 months of this year with this year's plan and last year highlights over 3% and 1% reductions respectively and therefore the planning assumption for 2019/20 reflects this – with only minimal growth overall incorporated to reflect a 2% growth in ED attendances and increases in specific surgical specialties relating to Trauma and Cancer.

4.3 Service Developments and Transformational Change

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced. In 2018/19 the Trust was successful in its bid for Wave 4 capital investment to improve the urgent and emergency care pathways within the Hull Royal Infirmary through the reconfiguration of accommodation and the procurement of additional diagnostic equipment, including MRI and CT. During 2019/20 the Trust will be developing detailed plans to deliver this major development by 2022. In the interim, we will work with commissioners and primary care colleagues to increase the level of primary care streaming and will also focus on measures to improve patient safety and flow between the ED and the Acute Medical Unit (AMU).

The Trust is one of four Trusts to be awarded Lorenzo Digital Exemplar (LDE) status and is working with Lorenzo supplier, DXC, to optimise the Lorenzo Care Suite and transform five key care pathways:

- Unplanned Pathway – Emergency Department/Acute Medical Unit
- Unplanned Pathway – Elderly Care
- Outpatients Optimisation
- Oncology Pathways
- Planned Breast Pathway (including Theatres).
- Lorenzo Theatres.

The realisation of the Trust's Digital Strategy will be accelerated through the LDE programme. Across all departments operational arrangements are being systematically reviewed and revised in order to maximise productivity and contribute to the achievement of cash releasing efficiency savings. Each Health Group has drawn up an integrated programme of service developments that will deliver significant safety, quality and financial benefits, aligned to the delivery of the Humber Coast and Vale Sustainability and Transformation Plan. These service developments include:

- **Surgical Services**
    - Further development as a Major Trauma Centre, including review of patient pathways, theatre and bed capacity.
    - Development of a regional centre for the management of pancreatic cancer patients in conjunction with Sheffield Teaching Hospitals FT
    - Continue to develop the Humber and Yorkshire Coast Bowel Cancer Screening Programme, incorporating the full roll out of the locality Bowel Scope Programme.
    - Continuing development of Endoscopy Services to ensure sufficient capacity and facilities to retain JAG accreditation.
    - Partnership working with NLAG and York FTs on the further development of Urology Services across the HC&V HCP.
    - Development and expansion of robotic surgery.
    - Continued review and improvements to the productivity of Trust theatres.

- **Medical Services**
  - Support the Humber Acute Services Review in the development of sustainable regional services for cardiology, neurology and stroke.
  - Further development of the hyper acute stroke service to ensure compliance with best practice standards
  - Further development of Frailty Intervention model to extend services to 7 days a week
  - Working collaboratively with partners on the development of the Hull Integrated Care Centre.

- **Emergency and Acute Medicine**
  - Development of plans for the reconfiguration of the Ground Floor of the Hull Royal Infirmary to facilitate the flow of urgent and emergency care admissions from the Emergency Department to the acute assessment areas.
  - Development and expansion of Same Day Emergency Care (SDEC).
  - Further development of the Primary Care stream.
  - Maximise the utilisation of the discharge lounge and progress the implementation of nurse-led discharge.

- **Family and Women's Services**
  - Development of plans for the relocation and centralisation of paediatric services within the Women's and Children's Hospital
  - Integration of community and acute paediatric medicine services through the transfer of community paediatric service from City Healthcare Partnership CIC to HUTH.
  - Review of Paediatric and Neonatal Surgery in conjunction with Sheffield Children's NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust with the aim of developing a regional service model.
  - Development of transformation programme for Obstetric and Gynaecology services
  - Participation in the HC&V Local Maternity System (LMS) and delivery of the ambitions within Better Births[1] (2016).
  - Participation in Wave 3 of the National Maternity and Neonatal Safety Collaborative.
  - Development of a Plastic Surgery Hand Unit
  - Development and expansion of the Humber Diabetic Eye Screening Programme
  - Review of breast cancer and breast screening services.

- **Clinical Support Services**
  - Development of the Pathology collaborative relationship with York FT, including the joint procurement of a Laboratory Information System.
  - Procurement of a Primary Care Pathology Requesting and Reporting solution.
  - Work with partners to identify opportunities to consolidate specialist pathology services within the Trust, in particular virology, molecular diagnostics and immunology.
  - Development of Psychological Services
  - Replacement of the Radiology Information System and Picture Archiving and Communication System (PACS)
  - Effective procurement and commissioning of replacement Radiology and Radiotherapy equipment.
  - Consolidation of HUTH and NLAG Haematology Service, and collaboration with NHS England on the development of a longer term model for Haematology services across the HCP.
  - Development of a Cancer Assessment Unit at Castle Hill Hospital and further development of the ambulatory chemotherapy service.
  - Development of a service model for Mechanical Thrombectomy for hyper acute stroke.
  - Replacement of final Linear Accelerator.

The Trust has an established Improvement Programme, with Director level leadership and dedicated project management resource, to drive service changes forward at scale and pace. The Improvement Programme is currently focussing on theatre efficiency, outpatient services and urgent and emergency care.

4.4 Winter Plan

As in previous years, the Trust will seek to continually strengthen both its internal arrangements for the management of Winter Pressures and to work with local providers and commissioners across

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

health and social care to ensure a robust and comprehensive system response. Provision for a range of enhanced resources in winter, including increased acute medical bed capacity, is built into our operational plans (see Section 4.1).

For Winter 2018/19 the Trust created additional medical capacity of 27 beds (winter ward) through reductions in elective surgical capacity and redeployment of nursing resource. Additional physiotherapy, occupational therapy, radiology, pharmacy and pathology support was put in place to support timely patient flow and discharge. Our bed modelling indicates that in order to hold medical bed occupancy below 90%, we need additional beds throughout the year and further additional capacity for the peak demand period of December–April. As outlined in Section 4.1, we are proposing to convert the current winter ward into a year round component of the medical bed complement and for the 2019/20 winter period, we will open a social care discharge facility which, whilst being located on one of our hospital sites, may be operated as a step down facility by one of our partners.

In addition, the Trust will be undertaking a review of assessment pathways out of the ED, taking into account the need to increase delivery of Same Day Emergency Care (SDEC). The outcome of the review will inform future bed modelling assumptions.

The Trust's enhanced patient flow management model is led by a Director of the Day. In addition the Trust has a 24/7 Site Management Team. The Trust's escalation and response arrangements are in line with the national Operational Pressures Escalation Levels (OPEL) Framework.

Non-urgent elective inpatient activity will be reduced in line with historic trends over a 2-3 year period from late December 2019 to February 2020. During this period, there will be an emphasis on increasing the level of outpatient and day case activity. In order to mitigate against any deterioration in 18 week RTT performance as a result of the reduced elective activity during the winter period, the Trust has reviewed its activity profile up to November 2019, taking account of seasonal variations in available capacity.

4.5 Urgent Care Developments in the Local Health Economy

The Trust is working with local commissioners, health and social care providers to achieve greater integration and redesign of urgent care in the local health economy. Locally, all parties have responded to the national initiatives under the Integrated Urgent Care Strategy.

Urgent Care teams continue to work together in:

- Development of the Integrated Care Centre in Hull to deliver specialist care, better management of long term conditions and services for frail, elderly patients.
- Supporting Hull and East Riding CCGs in their plans to reconfigure and enhance urgent care treatment centres.
- Supporting City Health Care Partnership CIC in the delivery of community health services in Hull and the East Riding of Yorkshire.
- Continuing to develop an integrated Emergency Department minor illness/injuries service provided through a multi-disciplinary team, including acute, primary and community care specialists.

5. Quality Planning

The provision of high quality care is the top priority for the Trust. Over the next five years we will deliver ambitious and significant improvements in the quality of our care in the areas of concern highlighted by our patients, staff and partners, utilising new research and innovation opportunities to deliver a real and lasting difference to the experiences of our patients.

5.1 The Trust's Approach to Quality Improvement, Leadership and Governance

The Chief Nurse and Chief Medical Officer have the Executive Lead responsibility for Quality within the Trust.

The Trust's Strategy has a stated aim of achieving a CQC rating of Outstanding by 2024, with some services achieving an outstanding rating within the next 3 years. It sets out the organisation's long term goals and is supported by an implementation plan and four further underpinning strategies - the Trust's People Strategy (2019-22), Estates Strategy (2017-2022), Research and Innovation Strategy (2018-2023), and Digital Strategy (2018-2023). Delivery of the whole of this agenda will support collectively the achievement of improved CQC ratings.

The Trust has developed its improvement approach based on the NHS Change Model and with support from the NHS Advancing Change Team and the Yorkshire and Humber Academic Health Sciences Network (AHSN).

The Trust has also created a comprehensive Improvement Programme which aims to facilitate the delivery of large scale programmes of improvement and to develop the Trust's capability and capacity for continuous improvement.

The Trust promotes a multi-disciplinary approach to improvement and has created a single quality and service improvement training package. Our approach involves front line staff leading change through engagement, small scale testing, measurement of impact and sharing successes for wider adoption. They are supported by the Trust's Improvement Team who are accredited AHSN 'Gold' Improvement trainers.

The Trust has developed a suite of improvement techniques, tools and project management documentation to ensure a consistent approach to improvement across the organisation.
Trust Improvement Programmes are supported by the Trust Programme Management Office and are governed by the Improvement Programme Board, which is the Executive Management Committee in session, with the addition of the Improvement Programme Director, Lead Clinician and the Sponsor of each live programme. The purpose of the Programme Board is to approve programme charters, which cover the aims, stakeholders and measures of success, allocate PMO resource and then oversee the delivery of programmes, helping to unblock difficulties and challenge the project teams to achieve. Each programme or project has a steering group and provides a regular progress report to the Programme Board.

Each Health Group has its own monthly Health Group Board and sub-Divisional Boards, which consider quality performance and quality priorities within their specific services/groupings.
At corporate level, there are a number of mechanisms that provide governance and assurance with regard to the Trust's quality performance. The Chief Nurse chairs the monthly Operational Quality Committee, which includes the membership of the Chief Medical Officer, Deputy CMO, Chief Pharmacist, Deputy Director of Quality Governance and Assurance, Assistant Chief Nurses, the risk team, and senior clinical members of each Health Group. This meeting considers all of the key quality priorities for the organisation and seeks assurance and evidence in relation to their delivery.

The Operational Quality Committee provides matters for escalation and communication to the Trust's Executive Management Committee (EMC), which is chaired by the Chief Executive and comprises membership of the corporate executive directors and health group medical, nursing and operations directors. The chair of the Trust's Patients' Council is a member of this committee also, and presents an independent challenge from a patient/service user perspective.

The Operational Quality Committee also reports to the Trust's Quality Committee, which is a committee of the Trust Board. This is chaired by a non-executive director (NED) and comprises membership of two additional NEDs, the Chief Nurse, Chief Medical Officer, Chief Pharmacist and Deputy Director of Quality Governance and Assurance. This committee seeks assurance on behalf of the Trust Board on key areas of quality performance and concerns.

In order to enhance the organisation's ability to manage quality and safety, the Trust has:

- A corporate quality governance and assurance team;
- A dedicated Improvement Team that supports the delivery of improvement projects, utilising quality improvement and project management expertise;
- Appointed a Deputy Chief Medical Officer (Quality) to work directly with the clinical teams;
- Reviewed the nursing structure and established four Quality Matron posts, one for each Health Group;
- Created a Deputy Director post for Quality Assurance and Governance. The clinical governance structure, including the role of the Quality Safety Managers, has been reviewed to ensure that their work is aligned to the Trust's quality priorities.
- Appointed to a new post of Clinical Outcomes Manager with the remit to develop a structured case note review process for implementation across the organisation.
- Adopted the Yorkshire Contributory Factors Framework for investigating patient safety incidents.

The Trust will assess the impact of the additional investment in quality improvement through the Trust's Integrated Performance Report and associated Board reports which include data in the quality KPIs (safety thermometer results, hospital acquired infection rates, etc), waiting time and access thresholds, serious incidents, nurse staffing levels, Friends and Family survey results.

5.2 Quality Priorities 2019/20

The Trust has consulted widely on its quality and safety improvement priorities for 2019/20. These are:

Safer Care (Patient Safety):

- To improve nutrition and hydration
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable patient falls
- To improve medicine optimisation
- To reduce avoidable hospital acquired pressure ulcers

Improved Experience (Patient Experience)

- To listen to and act on patient experience to improve services

Better Outcomes (Clinical Effectiveness)

- To improve the management of children and young people's mental health assessment
- To improve the governance of patients detained under the Mental Health Act within the Trust
- To improve the experience of staff working in the Trust's Outpatient areas
- To improve the care of people with dementia

The Trust's Quality Accounts 2018/19 are in the process of being finalised and will set out in detail the actions that the Trust will take to achieve its quality priorities, the measures for success and the arrangements for monitoring and reporting on progress.

5.3 Quality Improvement Plan

A comprehensive inspection was undertaken by the CQC in June 2016. Whilst it was acknowledged that the Trust had made improvements since the last inspection, these were not significant enough to change the rating for the Trust as a whole. The Trust therefore retained its 'Requires improvement' rating.

The CQC undertook a Well-Led Inspection of the Trust on 27 February – 1 March 2018. It was noted that the Trust had improved in relation to performance within the Effective and Well-led domains, however improvement was still required in relation to the Safe domain at both hospital sites, and the response domain at Hull Royal Infirmary. As a consequence, the Trust retained its 'Requires Improvement' rating.

In response to the CQC inspections, the Trust developed an overarching and integrated Quality Improvement Plan which brought together all of the Trust's key quality priorities and required actions. This is a dynamic document that is reviewed and updated monthly. A copy of the Quality Improvement Plan 2018/19 is attached at Appendix 2 and contains the details of the priorities.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hull Royal Infirmary	Requires improvement ➔🡐 Jun 2018	Good ➔🡐 Jun 2018	Good ➔🡐 Jun 2018	Requires improvement ➔🡐 Jun 2018	Good 🡑 Jun 2018	Requires improvement ➔🡐 Jun 2018
Castle Hill Hospital	Requires improvement ➔🡐 Jun 2018	Good 🡑 Jun 2018	Good ➔🡐 Jun 2018	Good 🡑 Jun 2018	Good 🡑 Jun 2018	Good 🡑 Jun 2018
Overall trust	Requires improvement ➔🡐 Jun 2018	Good 🡑 Jun 2018	Good ➔🡐 Jun 2018	Requires improvement ➔🡐 Jun 2018	Good 🡑 Jun 2018	Requires improvement ➔🡐 Jun 2018

In addition to the actions outlined within the Quality Improvement Plan, the Trust is taking steps to address a number of other local and national quality initiatives:

- National Clinical Audits – During 2017/18, the Trust participated in 46 clinical audits and 4 national confidential enquiries. The data submission rates and outcomes of the audits are reported in the Quality Accounts.

- Seven Day Services – All acute service providers are required to complete a self-assessment of 7DS compliance on a bi-annual basis and gain Board assurance through adoption of the NHS Board Assurance Framework for Seven Day Hospital Services. The first of the reports to the Board took place in January 2019 and was based on the analysis of audit data and health group self-assessments. Compliance with the four priority Clinical Standards was assessed as follows:

Standard	Compliance	Actions to address
Standard 2 Time to First Consultant Review	Not met	Identification of under-performing specialties and development of action plans to address the shortfalls in delivery of the standard Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system.
Standard 5 Diagnostic Services	Compliant	Recruitment to vacant posts and review of staffing rotas to enable extension of diagnostic services.
Standard 6 Consultant-directed interventions	Compliant	
Standard 8 Ongoing review	Not met	Review of medical staffing resource in key areas, including recruitment to vacant posts and review of job plans.

A further baseline audit was undertaken in March 2019 against which progress in achievement against the 7DS will be assessed. Action plans will be developed and implemented for any service areas which continue to under-perform against the standards. The Trust will also be initiating a standard process for determining patient review requirements. The review of urgent and emergency care pathways as part of the reconfiguration of accommodation within the Hull Royal Infirmary, investment in e-rostering and e-job planning, as well as reviews in medical staffing will all inform the development of seven day services and compliance with the standards. An updated assessment will be reported to the Board in May 2019, with a further update in November 2019. The Trust intends to achieve compliance with the priority clinical standards by March 2020.

- Safe Staffing – The Trust continues to meet the requirements of the National Quality Board, including the reporting to the Trust Board (each time it meets in public) on:
  - Planned versus actual fill rates
  - Average nurse/carer to patient ratios
  - High level quality indicators on each ward
  - Number of occasions when staffing levels deemed to be inadequate (red alerts)

- o Any areas of concern and the actions that are being taken to address these.

The Trust undertakes safety briefing reviews six times a day, seven days a week. These are led by a Health Group Nurse Director or the Deputy Chief Nurse, with input from the Senior Matrons, and review the nursing and midwifery staffing levels in all inpatient areas across the Trust including patient acuity and workload assessments. These ensure at least minimum safe staffing levels at all times. Staffing levels are assessed directly from the live e-roster and SafeCare software.

- The Trust uses accredited tools to help determine the appropriate staffing level for each area. These include the Safer Nursing Care Tool (Shelford Tool) for adults', children's and critical care areas; Birth-Rate Plus for maternity, NICE for the Emergency Department and the College of Emergency Medicine's Guidance for Acute Assessment Units.

- Care Hours Per Patient Day (CHPPD) – The Trust is developing the use and reporting of the CHPPD metric. This is now part of the functionality of the Trust's e-rostering software.

- Better Births Review – The Trust has agreed an action plan with commissioners and is working towards compliance with the recommendations of Better Births by 2020. Actions include enhancing continuity of care, better postnatal and perinatal mental health care, strengthening multi-professional working and ensuring systems are in place to enable effective working across organisational boundaries.

- End of Life Care – The Trust has implemented a series of measures to improve the provision of care and support for patients and their relatives. This includes:
  - o Provision of 'Sage and Thyme' Communication Skills training. This is designed to train all grades of staff on how to listen and respond to patients or carers who are distressed or concerned.
  - o Nurse Director membership of the End of Life Steering Group.
  - o Closer working between the Palliative Care Team and wider healthcare teams to improve patient care and achieve enhanced supportive care for advanced cancer patients.

- National CQUINs – Through achievement of the Trust's quality priorities, Quality Improvement Plan, service developments, People Strategy and the initiatives outlined above, the Trust will seek to achieve compliance with the national CQUINs 2019/20.

- Healthcare Associated Gram Negative Bacterial Bloodstream Infections (BSIs) – The Trust and Commissioners have agreed a joint action plan with the aim of achieving the required reductions in both hospital and community settings of E.Coli Bacteraemia. Trust measures include more targeted identification, treatment and appropriate management of cases. In addition, cases are reviewed by an Infectious Diseases Consultant. Similar actions are being developed in relation to cases of Klebsiella infection and Pseudomonas aeruginosa.

- Learning from Deaths – The Trust has adopted the 'Measuring and Monitoring Safety Framework' and has applied this to aid learning from deaths. The framework consists of five dimensions and associated questions that the Trust can use to help understand the safety of its services. In addition, all mortality reviews are undertaken using the online mortality review form within the Lorenzo Electronic Patient Record. This is based on the Structured Judgement Review (SJR) methodology. During 2018 a significant number of SJRs specifically stated that there were issues related to the identification and prompt treatment of the deteriorating patient. In addition, the root causes of a number of serious patient safety incidents were related to the sub-optimal care of the deteriorating patient.

The following actions have been implemented to promote quality improvement in relation to patient care:

- Introduction and roll out of the revised National Early Warning Score (NEWS2). The Trust has developed a local Deteriorating Patient Observation Bundle to meet the NEWS2 requirements.
- Inclusion of an outreach nurse on the Serious Incident review panel
- Phased implementation of electronic observations (e-obs)
- Development of a quality improvement plan for the deteriorating patient
- Dedicated deteriorating patient policy which has been updated to enhance patient safety and care.

In addition to mortality, the Trust's Mortality Committee has broadened its focus to investigate morbidity and near misses, with the aim of identifying learning and embedding better system improvements, thereby leading to less harm and better patient care.

During 2019/20 the Trust will be piloting a Medical Examiner service which will allow proper scrutiny to be applied to every in-hospital death. An Associate Chief Medical Officer reporting to the Chief Medical Officer has been appointed to oversee the implementation of the service.

The Trust has signed up to the Learning Disabilities Mortality Review (LeDeR) programme and has trained reviewers who undertake reviews of in-hospital and out-of-hospital deaths of people with a learning disability. The learning from these reviews is used to inform changes to care delivery.

- Learning and Actions from the Gosport Independent Panel – The report into the use of opioids without appropriate clinical indication at Gosport War Memorial Hospital was considered at the Trust's Safe Medication Committee. The Committee was assured that systems are in place within this Trust to prevent any similar occurrence. Arrangements are in place to conduct a review of pharmacy service provision to Dove House Hospice, in conjunction with our community partners, City Health Care Partnership.

The Trust has identified the top three risks to quality as:

- Failure to continuously improve quality
- Failure to embed a safety culture
- Failure to address waiting time standards and deliver the required trajectories.

Mitigating actions to address these risks include:

- Setting expectations on a safety culture in the Trust
- Achievement of actions within the Quality Improvement Plan
- Embedding Learning from Deaths
- Embedding the Fundamental Standards of Nursing Care on the wards and further roll out to outpatient areas and theatres
- Improvements to the flow of urgent and emergency care admissions from the ED to medical and surgical areas.
- Implementation of the 'Stop the Line' campaign
- Integrated approach to quality improvement
- Regular monitoring and reporting on quality and safety data
- Achievement of trajectories set against sustainable waiting lists for each service, moving the Trust leading to incremental progress against 18 week compliance

5.4 Summary of Quality Impact Assessment Process and Oversight of Implementation

The Trust has identified a series of cost improvement schemes during 2019/20 based on external benchmarking information, including GiRFT reviews and Model Hospital data, operational productivity opportunities identified in the Lord Carter Review (2015) and our own identification of efficiency opportunities.

The Trust's approach to Quality Impact Assessment (QIA) is based on guidance issued by the National Quality Board and CQC requirements. Our QIA policy and procedure was approved by the Executive Management Committee in July 2016 and refreshed in February 2018. It includes the requirement for completion of a standard QIA template. The Trust's QIA process ensures that all cost improvement schemes are assessed in the context of patient safety, service effectiveness and patient experience. All associated risks are identified. Each cost improvement scheme has identified milestones and checkpoints where the quality impact is reassessed during implementation, with post-implementation reviews to ensure that no unintended quality impacts have materialised. The senior officer responsible for each cost improvement scheme is accountable for ensuring that a QIA is undertaken.

Any scheme at a value of £100k or less requires approval by the respective Health Group Medical Director, Nurse Director, Operations Director and Head of Finance. All schemes over £100k in value require final approval and authorisation by the Executive Directors: Chief Nurse, Chief Medical Officer, Chief Operating Officer and Chief Finance Officer (or Deputy).

The reporting mechanism for schemes of £100k or less is via the appropriate Health Group Board and monthly Performance and Accountability meetings with Executive Directors. Schemes greater than £100k are monitored via the Operational Quality Committee, Quality Committee and Trust Board.

5.5 Triangulation of Quality Indicators

The Trust works with neighbouring Trusts to improve the triangulation of intelligence in order to provide meaningful data and assurance or early warning of potential risk. The Trust has used three processes, these are:

- Production of CQC core service reports which triangulate information from the five domains in order to provide an overview of key issues and potential risks. This covers workforce and quality.
- Utilisation of the Health Foundation Framework for safety measurement and monitoring.
- Monitoring and sharing of intelligence at the monthly 'CIRCLE' Group (Clinical Incident Review Creating a Learning Environment) which is made up of senior staff from a wide variety of disciplines to review concerns and issues or potential issues identified through data analysis.

The Trust also utilises an integrated performance dashboard approach to performance management which enables it to easily triangulate performance, quality, workforce and financial information to identify any areas of concern at an early stage.

Both the Quality Committee and the Performance and Finance Committee review the Integrated Performance Report (IPR) prior to its submission to the Trust Board. In addition to the IPR, the Trust Board also receives a Quality Report at each meeting in public, which provides them with further analysis on topics, such as:

- Patient safety matters, including an update on Never Events
- Healthcare Associated Infections
- Patient experience matters
- Other quality updates, such as progress against the Quality Improvement Plan
- Ward fundamental standards performance
- Mortality.

Through its programme of internal audits, the Trust seeks to ensure that key aspects of the quality agenda are operating at a local level within the organisation. Reviews include the Safer Care Audit and the Fundamental Standards Audit. The outcomes of these audits are reported to the Audit Committee.

The Trust, represented by the Chief Nurse and Chief Medical Officer, meets monthly with its main commissioners to review quality and clinical governance performance and agree priorities for improvement.

6. Workforce

In 2018/19 the Trust increased its staff in post by 229 wte to 7,486 wte. This is against the original planned increase of 150 wte. The Trust was therefore 79 wte over plan at the end of March 2019. Table 1 below provides a comparison of performance against plan for 2018/19 against the actual staff in post (wte) for 2018/19. The table also shows the actual increase from March 2018 to the actual position for March 2019. The staff group which was furthest from the 2018/19 plan and actual position at March 2019 is Medical Staff, which is 72 wte over plan.

During 2018/19 the Trust continued its 'Remarkable People, Extraordinary Place' recruitment campaign. This resulted in the successful recruitment of 116 newly qualified nurses from a number of Universities. In addition to this the Trust recruited Nurses from overseas, which saw an additional 43 nurses complete their Objective Structured Clinical Examination (OSCE) exam and join the Trust as a registered nurse.

	Staff in Post WTE				
Staff Group	**Actual 2017/18**	**Plan 2018/19**	**Actual 2018/19**	**Variance between Plan 2018/19 and Actual 2018/19**	**Variance between Actual 2017/18 and Actual 2018/19**
Nursing	**2985**	**3039**	**3029**	**-10**	**44**
Of which are Registered Nursing	1985	2015	2005	-10	20
Of which are Registered Midwife	162	162	166	4	4
Of which are Non Registered Nursing	838	862	858	-4	20
Medical Staff Group	**952**	**965**	**1037**	**72**	**85**
Allied Health Professionals & Technical	**880**	**894**	**939**	**45**	**59**
Healthcare Scientists	**436**	**451**	**433**	**-18**	**-3**
Admin, Estates & Senior Managers	**1474**	**1486**	**1498**	**12**	**24**
Healthcare Assistants and Support Staff	**530**	**572**	**550**	**-22**	**20**
Trust Total	**7257**	**7407**	**7486**	**79**	**229**

Table 1: Comparison of Performance against Staff in Post Plan 2017/18-2018/19

Table 2 shows the Actual 2018/19 position and the Plan for 2019/20. The plan shows an increase of 90 wte and the largest increase is in the Nursing staff group. The increase of 90 wte is in new posts and does not include any recruitment to existing vacancies. The Trust currently has approximately 425 wte vacancies.

Throughout 2019/20 the Trust is looking to increase the number of Apprenticeships and add to its Advanced Clinical Practitioners, Nurse Associates and Physician Associates workforce. Work is being undertaken by the Trust's Workforce Transformation Committee to develop further the recruitment and retention strategies for nursing staff and to secure funding for Nurse Apprenticeships. The increased staffing will support the expansion of services to improve patient pathways and enable the Trust to increase the provision of services at weekends.

Staff Group	Staff in Post WTE		
	Actual 2018/19	Plan 2019/20	Variance between Actual 2018/19 and Plan 2019/20
Nursing	**3029**	**3080**	**51**
Of which are Registered Nursing	2005	2006	1
Of which are Registered Midwife	166	166	0
Of which are Non Registered Nursing	858	908	50
Medical Staff Group	**1037**	**1058**	**21**
Allied Health Professionals & Technical	**939**	**953**	**14**
Healthcare Scientists	**433**	**433**	**0**
Admin, Estates & Senior Managers	**1498**	**1502**	**4**
Healthcare Assistants and Support Staff	**550**	**550**	**0**
Trust Total	**7486**	**7576**	**90**

Table 2: Actual 2018/19 vs Plan 2019/20

The Trust will continue to invest in and develop further its ‘Remarkable People, Extraordinary Place’ campaign to recruit to vacant posts, particularly in the hard-to-recruit-to staff groups. It is anticipated that our recruitment campaigns will enable the Trust to reduce its vacancy position, but, given the national shortage of qualified staff, recruitment will remain a significant challenge.

6.1 Workforce Planning

The workforce planning framework and methodology used by the Trust is the Calderdale Framework which provides a systematic, objective method of reviewing skill, role and service design and is used to examine past trends, understand current and future challenges, and forecast future workforce needs. The Framework incorporates a clinical risk assessment.

The Trust’s workforce planning is also informed by the ongoing review of clinical services, local population demographic change, commissioner intentions, capacity and demand modelling, strategic partnerships, the intelligence received from the Yorkshire and Humber workforce planning network, national policy and education and training establishments.

Health Groups and Divisions receive workforce intelligence packs, which include intelligence from the Electronic Staff Record (ESR), e-Job Planning and e-Rostering systems. Through the production of workforce plans and use of the intelligence data, opportunities for new roles will continue to be identified, including Apprenticeships, Nurse Associates, Advanced Clinical Practitioners and Physicians’ Associates.

Activity, finance and workforce plans are developed at a service, divisional and Health Group level and are formally signed off by their respective management teams. The plans are validated by the corporate finance, planning and workforce teams to ensure that they are robust, aligned to the Trust’s clinical and organisational strategies and comply with operational planning guidance. They are subject to a ‘Confirm and Challenge’ process with Executive Directors and support service leads before being signed off by the Executive Management Committee, Workforce Transformation Committee, Performance and Finance Committee and Trust Board. Performance monitoring is undertaken at each level of the organisation via the monthly performance management framework.

The current workforce challenges, risks and issues facing the Trust and wider HCP are detailed in Appendix 3 and Appendix 4. The Trust has a number of long-term vacancies (hard-to-fill posts over six months). A summary is provided in Appendix 5.

6.2 People Strategy 2019-22

It is acknowledged that the shape of the organisation will change as we, with our HCP partners, seek to deliver integrated, high quality care designed around patients’ needs, in both the acute and

community settings. The Trust will require a workforce with the right knowledge and skills and which is able to adapt to new roles and ways of working, some of which will be across organisational boundaries.

The Trust's focus will be 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. A number of workstreams have been identified as part of the People Strategy:

- Recruitment and retention
- Innovation, learning and continuous improvement
- Workforce culture and wellbeing
- Modernising the way we work
- Leadership capacity and capability
- Equality, inclusion and diversity
- Employee engagement and recognition

Progress against each of these workstreams is monitored by the Workforce Transformation Committee and reported to the Performance and Finance Committee and Trust Board on a quarterly basis. Reports are provided to the Executive Management Committee on a regular basis.

6.3 Workforce Development – Humber Coast and Vale HCP

The HCP has a well-established Local Workforce Strategy Board to address the shortage and development of clinical and non-clinical staff within the HCaV footprint. The two key initiatives being progressed at scale are:

- Support staff and development of an Excellence Centre to enable the system to attract and recruit more people to the health and social care sector and provide career and training information for partner organisations, staff and prospective staff.
- Advanced Practice – Develop advanced practitioners across HCaV in acute, community, mental health and primary care.

6.4 Workforce Transformation

The Trust has in place a programme for the modernisation of back office functions. The principle drivers are consistent with the Lord Carter of Coles' recommendations, but there is recognition that we need to make better use of technology, seek to standardise wherever possible, and improve our business processes in order to move to a paperless environment, in line with our Digital Strategy. A number of projects are underway:

- Deployment of patient e-observations, including clinical photography capability.
- Maximise the full benefits and complete the roll out of e-rostering across the Trust.
- Complete the roll out of e-job planning for Consultant staff and utilise data to improve service delivery.
- Improve the management of our temporary workforce and expand internal bank arrangements
- Complete the roll out of manager self-service so that end-to-end employment processes are fully automated.
- Continue to reduce time-to-recruit figures via the use of electronic recruitment systems across all staffing groups.
- Work with partner organisations to reduce duplication of corporate functions.
- Implement "streamlining" initiatives across HCaV to save time and money on employment checks and statutory mandatory training.

6.5 Management of Agency Staff

As identified above, the Trust has implemented e-rostering across the majority of wards and utilises the information provided by the system to monitor staffing levels, understand un-used hours and inform the allocation of permanent or bank staff to vacant shifts. Where shifts cannot be filled from the Nurse Bank, the Trust will look to bank staff before approaching Agency staff via the approved framework agencies. All agency spend is authorised at Director level.
The Trust has a number of medical staff vacancies. Where it has not been possible to fill these with permanent staff, the Trust has sought to appoint suitably qualified staff on fixed term contracts or to provide cover from the Bank or internal locums.

The Trust has developed and implemented several new roles to support clinical staff. These include the utilisation of non-registered staff to better support ward nursing teams, ie Recreational Assistants, Discharge Assistants and Nutritionists. Advanced Clinical Practitioners and Physician Associate roles are being implemented to supplement the medical workforce. In 2019/20 the Trust will seek to reduce its agency spend and increase its bank spend.

6.6 Impact of Workforce on Quality and Safety

The Trust has a series of workforce indicators which include sickness absence, turnover, appraisal, statutory/mandatory training, staff engagement and nursing/midwifery fill rates. Performance against these indicators are reported on a monthly basis to the Trust Board via the Integrated Performance Report which also provides the Board with updates on progress against KPIs for patient safety, clinical effectiveness, access and responsiveness and patient experience. The information on workforce within the Integrated Performance Report is supplemented by the monthly Nursing and Midwifery staffing report from the Chief Nurse.

Workforce issues and the potential impact on quality and safety are also monitored at a monthly meeting of the Chief Nurse and Director of Workforce. Action plans are developed to address any issues or risks identified. Health Groups and clinical leads monitor workforce issues on an ongoing basis. In addition, they review and re-submit their workforce risk registers every six months. This data informs the workforce returns for Health Education England and NHS Improvement.

Where service developments or transformational change programmes are likely to impact on the workforce, Health Group management teams are required to complete quality impact assessments which must be approved by the Health Group Board.

7. Financial Plan

7.1 Financial Forecasts and Modelling

The NHS Operational Planning and Contracting Guidance 2019/20 set out the financial regime for Providers in 2019/20. The financial framework included:

- A control total offer with a commitment to removing the concept of control totals in future years.
- Removal of the marginal rate emergency tariff (MRET) deduction, which will now be paid directly to the Trust.
- A tariff efficiency factor of 1.1% plus a further 0.5% for Trusts that have a deficit.
- Consolidation of the 2018/19 pay award into the tariff.
- Increase in urgent care prices, with a proportion of the 2018/19 Provider Sustainability Fund (PSF) going into CCG allocations to enable this to be paid to Trusts.
- A reduced 2019/20 PSF which will be paid to Trusts based upon financial performance only.

The Trust received its control total on 16th January 2019, which is summarised at Appendix 6. The control total is to deliver a surplus of £10.4m after receipt of £8.97m non-recurring PSF and assumes gains from the new tariff/financial architecture of £12m and an efficiency saving of at least 1.6%.

The Trust has developed a financial plan for 2019/20 which starts with the forecast 2018/19 financial position. Whilst the Trust is forecasting to deliver its £10.2m control total deficit (excl PSF) in this year, the latest forecast of the recurrent underlying position is circa £24m due to the non-recurrent nature of the identified CRES schemes, along with other non-recurring actions that curtail expenditure and increase income in 2018/19. This position is circa £11m more than the starting position assumed by NHSI and hence will require a more challenging CRES target than the 1.6% referenced above. The assumptions in delivering the Trust's control total for 2019/20 are:

- **Inflation**

  The agenda for change pay award was funded directly from DHSC in 2018/19 non-recurrently and this is now reflected in the inflationary uplift as part of the 3.8%. The costs

overall for the Trust of agenda for change (including the 2018/19 element) is £12.2m and represents circa 2.2% of operating expenditure.

Overall pay inflation, including the above, accounts for £16m. The non-pay inflationary uplifts account for £2.4m (excluding pass through drugs) and therefore total inflation of £18.4m is currently in line with the 3.8% tariff increase. The Trust has excluded the pass through expenditure in calculating the inflation and efficiency components of its financial plan.

The Trust has recently received quotes with regard to energy prices for 2019/20 as previous fixed price arrangements have expired. This is an additional cost pressure of £2m which is not covered by the tariff uplift and is a risk to delivery of the plan.

- **Procurement Adjustment**
  The Trust has modelled a £1.7m impact of the 0.36% reduction in tariffs. After adjusting for the reduced prices for current supply chain spend expected at £1.1m this leaves £0.6m additional savings to be made by moving other non-pay spend onto supply chain. This £0.6m has been added onto the Trust 2019/20 CRES programme but remains a risk to delivery if opportunities to procure more from the centralised route are not realised.

- **Tariff Gains**
  The Trust has modelled the impact of the tariff gains by pricing 12 months' activity at both the new price and old price – adjusting for the elements with no gain for the Trust, such as inflation, efficiency, procurement and CQUIN. This indicates that the net gains included with the Trust's control total of £9.8m are feeding through into the new prices.

- **Activity**
  In terms of growth, the Trust has agreed the main priority areas with local CCG commissioners which are based on the improvements to RTT waiting times and reducing the risk of 52 week waits, diagnostics and cancer performance. The key areas of focus for 2019/20 are:
  - ENT – outpatient backlogs and constrained elective capacity;
  - Urology – increases in capacity due to significant (>26%) growth in demand – particularly in the cancer pathways;
  - Endoscopy;
  - Diagnostics and Direct Access– in addition to endoscopy, increased CT, MRI and Cardiac Echoes;
  - Wet AMD injections and Ophthalmology outpatients.

  Costs of circa £4.8m have been agreed with our main CCG commissioners covering the areas above in the main. The Trust will continue with an Aligned Incentive Contract with the main CCGs for 2019/20 and may consider extending this to other contracts from 2020/21

  The final contract agreement with the Specialised Commissioner secured growth in Cancer and Trauma areas of 5% as well as growth in Mechanical Thrombectomy, high cost drugs and funding to improve waiting times performance in Urology and Neurosurgery. The Trust has included circa £3.6m of income in the plan that is outside of the contract value due to the level of unidentified Quality Innovation Productivity and Prevention (QIPP) schemes (£3.1m) and allocations that are expected in-year for drugs that cannot be reflected in the opening contract value.

  There is an increase in the level of bowel scope activity reflected in the public health element of the contract although this is lower than anticipated due to the commissioners' prioritisation of the introduction of FIT and a review of the current programmes. The contract is however cost per case and therefore if the rollout progresses in line with the original business case there should be no risk in the receipt of the additional income.

7.2 Efficiency Savings for 2019/20

In order to deliver the control total, the Trust needs to deliver efficiency savings of £19.1m. This includes an additional £2m requirement due to the cost pressure relating to guidance on asset lives issued by the Royal Institute of Chartered Surveyors. The Trust is looking at how it can manage this additional requirement through central actions, including potential for Revenue to Capital transfers to offset. To date, schemes to the value of £12.8m have been identified which is 75.2% of the required target, excluding the depreciation uplift. However after risk adjustment this is reduced to £8.8m and 51.1% delivery. This shows the clear requirement for these schemes to be progressed as quickly as possible to maximise the full year potential of delivery. A summary of the efficiency saving position by Health Group is shown below (Table 3).

	Fully Developed			Plans in Progress			Total			CRES	Percentage	Pre	
		Non			Non			Non			of Target	Risk	
	Recurrent	Recurrent	Total	Recurrent	Recurrent	Total	Recurrent	Recurrent	Total	Target	Identified	Adjustment	
	£'k	£'k	£'k	£'k	£'k	£'k	£'k	£'k	£'k	£'k	%	£'k	%
Medicine	340		340	198	331	530	538	331	870	2,330	37.3%	1,273	54.6%
Emergency & Acute Medicine	225		225	20	38	58	245	38	283	821	34.4%	387	47.1%
Surgery	530		530	1,080	318	1,398	1,610	318	1,928	4,169	46.2%	2,878	69.0%
Family & Womens Health	137	800	937	28	223	251	165	1,023	1,188	2,191	54.2%	1,843	84.1%
Clinical Support Services	291		291	755		755	1,046	0	1,046	2,955	35.4%	2,325	78.7%
Corporate	2,046	18	2,064	271	14	285	2,317	33	2,349	2,813	83.5%	2,493	88.6%
Estates, Facilities & Development	6		6	436	18	453	442	18	459	1,196	38.4%	843	70.5%
Central	397		397	200		200	597	0	597	600	99.5%	800	133.3%
Total	**3,972**	**818**	**4,790**	**2,987**	**941**	**3,929**	**6,959**	**1,760**	**8,719**	**17,075**	**51.1%**	**12,843**	**75.2%**

Table 3: efficiency saving position by Health Group, 2019/20

The Trust continues to develop the programme further through its established governance structure, which includes weekly scrutiny at the Productivity and Efficiency Board (PEB). The PMO team is making extensive use of Model Hospital and GIRFT reviews to identify additional opportunities for savings.

7.3 Agency Rules

The draft financial plan assumes delivery of the agency ceiling for 2019/20 which is at £9.1m. The forecast outturn for this year is circa £10.9m and therefore this represents a requirement for a £1.8m reduction (16.5%). The Trust has embarked on implementing and expanding on schemes that seek to maximise new roles and reduce the reliance on agency. This includes nurse apprenticeships, nurse associates, physician associates, as well as investment in overseas recruitment of nurses and doctors.

In addition, the latest intelligence suggests that, from a junior medical staffing perspective, there are expected to be fewer gaps for the Trust in the new medical staff rotation which will help contribute to the delivery of the agency ceiling.

7.4 Capital Planning

The development of the Trust's Capital Programme is based on assessments received and reviewed at the Capital Resource Allocation Committee (CRAC). CRAC undertook an exercise to quantify the funding requirements for the next three years (to 2021/22) and reviewed prioritised lists for medical equipment, which had been scrutinised by the Medical Equipment Group; backlog maintenance and compliance which had been assessed by the Director of Estates, Facilities and Development; and IM&T capital which had been assessed by the Director of IT and Innovation.

These assessments were developed on the basis of "do minimum" and were presented to the Trust's Performance and Finance Committee in January 2019. They included:

- Equipment replacement but with no provision for expansion (estimated cost of £33m over the next 3 years)

- Replacement of the existing IT network and essential system replacements to meet nationally mandated timescales for system architecture and capability (estimated cost of £17m over the next three years)
- A backlog maintenance investment programme which would bring the condition of the Trust's estate to Condition B over 10 years (estimated cost of £7m per year).

Over the 3 year period capital investment totalling £71m was identified.

A further £13.9m has been identified for investment in energy efficient heating and lighting infrastructure which will generate a significant revenue benefit for the Trust. The expected profile of expenditure for this scheme would be £5m in 2019/20 with the remainder the following year. It is hoped that this can be funded by a specific loan from the Department of Health. The loan application has been submitted to NHSI and it is hoped that this will be approved in 2019/20, although recent communication from NHSI suggests this is unlikely to be approved given the national capital constraints and the Trust has been advised to source alternative funding streams. In addition, a further loan for the replacement of high risk equipment totalling £3.6m has also been submitted to NHSI. The Trust is awaiting approval of this and has included the funding in the 2019/20 capital plans despite the feedback to exclude this – given the clinical priority and significant risks, with no alternative source of funding.

As outlined in Section 4.3 above, the Trust was successful in securing a capital HCP bid for the reconfiguration of urgent and emergency care service provision totalling £19.2m. It is anticipated that the development will commence in 2020/21, subject to business case approval. However, fees will be needed prior to business case approval, estimated at £0.4m, and these are included in the capital programme for 2019/20. The HCP bid is a major investment for the Trust and will require a significant level of clinical redesign. The timescales for completion will be extremely challenging and the Trust will be working with, and will be reliant on, system partners to produce the necessary Strategic Outline Case (SOC).

In 2018 the Trust submitted an additional HCP bid relating to backlog maintenance and high risk equipment, totalling £28m. This bid was not successful in securing funding.
The Capital Programme 2019/20 will be funded predominantly through depreciation with some additional schemes expected to be funded from Public Dividend Capital (PDC) funding and new capital loans. The Trust has the ability to generate capital receipts from the sale of surplus land, particularly at Castle Hill Hospital. Phase 1 of the land sales has been finalised and it is hoped that the next sale of land will take place in 2020/21 with a capital receipt of £3m anticipated.

In addition to depreciation funding the Trust can use any Statement of Comprehensive Income (SOCI) surplus gained in-year for capital expenditure. For 2019/20 the Trust's control total would deliver a SOCI surplus of £10.4m, but given that the Trust has loans due of over £19m in 2019/20, this surplus, if delivered, would allow the Trust to repay £10.4m, with an additional loan request of £9m for the difference.

The Trust has a pre-commitment on its depreciation funding as it must first service the Trust's existing long term debt commitments (a combination of long term loans and Private Finance Initiative contracts). This is expected to cost £5.8m in 2019/20. This financing is the first call on the Trust's available cash resources from depreciation.

The Trust is anticipating a surplus in 2018/19 and there is agreement for this surplus to be ring-fenced for specific capital investments included in the programme for 2019/20 and a further two years.

The following table sets out at a summary level the anticipated source and applications of capital for 2019/20. This also shows whether the source of funding is the Trust's internally generated funds or items expected to be funded externally.

Resources:	£m Internal	£m External	£m Total
Depreciation	14.8		14.8
SOCI Surplus 2019/20	-		-
Donated Assets		0.1	0.1
Loan Funding - Energy		5.0	5.0
Loan Funding - Equipment		3.6	3.6
Matched Funding from 18/19	6.7		6.7
STP - Urgent & Emergency Care Fees		0.4	0.4
	21.5	**9.1**	**30.6**
Less Required Financing Commitments:			
Loan Repayments	(2.3)		(2.3)
PFI & Finance Lease Liabilities	(3.5)		(3.5)
Subtotal Capital Resources Available	**15.7**	**9.1**	**24.8**
Capital Programme:			
Energy Scheme		5.0	5.0
Brocklehurst/Daisy/Robotic Suite & equipment	6.7		6.7
Equipment (funded via loan)		3.6	3.6
STP - Urgent & Emergency Care (initial Fees)		0.4	0.4
Backlog Maintenance & Compliance	2.0		2.0
IM&T	2.0		2.0
Medical & Scientific Equipment	2.2		2.2
Other - Depreciation RICS	2.0		2.0
Other	0.8	0.1	0.9
Total Capital Programme	**15.7**	**9.1**	**24.8**

Table 4: Capital Programme, 2019/20

The above table shows the Trust has internal sources of funding totalling approximately £15.7m to use for capital expenditure in 2019/20. Over a 3 year period this equates to circa £34m of funding versus a requirement for £71m, a funding shortfall of £37m over the period. There is insufficient capital available to meet the requirements needed. The programme accounts for £6.7m ring-fenced developments, but does not provide for any further developments or expansions in capacity. The Trust needs to start addressing the capital needs in terms of capacity, especially for medical equipment where additional CT and MRI equipment is needed over and above what is currently provided for within the capital programme and the recent HCP allocation.

It is essential that the Trust starts to make some inroads into its backlog maintenance issues, the schemes identified for 2019/20 all provide essential support to the provision of clinical services at the Hull Royal infirmary site in particular and urgent replacement of the Trust's IT network. Failure of any part of this infrastructure would be critical for the Trust and is reflected as a high risk on the Trust's Risk Register and Board Assurance Framework.

7.4 Financial Plan - Expected Risk Rating

The draft plan for 2019/20 delivers an overall financial risk rating of 3, which is the same as the current forecast position for 2018/19. This is due to the high liquidity risk rating which, although reducing (from -26 days to -21 days), is still not below -14 days of operating expenditure.

	Forecast Out-turn 31/03/2019 Year End Rating	Plan 31/03/2020 Year End Rating
Capital service cover rating	4	3
Liquidity rating	4	4
I&E margin rating	3	1
Variance from control total rating	1	1
Agency rating	2	1
Plan risk rating after overrides	3	3

Table 5: Financial Plan - Expected Risk Rating, 2019/20

7.5 Summary

Whilst the draft financial plan for 2019/20 delivers the control total of £10.4m surplus, this requires an efficiency target of £19.1m which, based on historic delivery patterns, represents circa £9m of risk. Further work is ongoing to develop the efficiency programme and improve the level of identified schemes. System working with local partners will continue to focus on the identification of opportunities to improve productivity and streamline pathways to avoid new investment in capacity where possible.

8. Risks to Delivery of the Operational Plan

The Trust has undertaken an assessment of the risks to delivery of its operational plan and identified, where possible, mitigating actions. A standard risk matrix was used to assess likelihood of occurrence and severity of impact. Risk scores can range from 1 (very low risk) to 25 (high risk).

Risk	Score	Mitigating Action	New Score
Failure of the proposed local QIPP schemes to reduce activity as intended	12 (moderate)	Work closely with commissioners on implementation plans and monitor closely Continue to work together to develop schemes to manage elective and non-elective demand	8 (moderate)
Inability to identify and deliver sufficient efficiency savings	20 (high)	Ongoing work with Health Groups and Corporate teams to identify and deliver schemes	20 (high)
Insufficient capital availability to deliver safe levels of investment in estate and IT infrastructure and equipment replacement	20 (high)	Agreement of safest balance of spend within tight budget and exploration of alternative sources of investment. Risk profile unchanged unless additional funding secured.	20 (high)
Insufficient cash liquidity	12 (moderate)	Access working capital loans	8 (moderate)
Failure to appoint to essential posts and impact on quality and safety	20 (high)	Recruitment campaigns Development of alternative staffing models Tight control of authorisation	16 (high)
Failure to deliver the Emergency Care trajectory	16 (high)	Agreement of a trajectory for 2019/20 Further work with partners on system resilience	12 (moderate)
Failure to deliver the cancer and/or elective RTT trajectories	9 (moderate)	Agreement of trajectories for 2019/20 Agreement of an activity plan to support delivery	9 (moderate)
Late or only partial impact of the HCP leading to pressure on Trust services	12 (moderate)	Provision of system leadership and support to developing schemes	9 (moderate)

Appendix 1

Accident and Emergency			Forecast Out-turn 31/03/2019 March 2019	Y1 M01 Plan 30/04/2019 Month 1	Y1 M02 Plan 31/05/2019 Month 2	Y1 M03 Plan 30/06/2019 Month 3	Y1 M04 Plan 31/07/2019 Month 4	Y1 M05 Plan 31/08/2019 Month 5	Y1 M06 Plan 30/09/2019 Month 6	Y1 M07 Plan 31/10/2019 Month 7	Y1 M08 Plan 30/11/2019 Month 8	Y1 M09 Plan 31/12/2019 Month 9	Y1 M10 Plan 31/01/2020 Month 10	Y1 M11 Plan 29/02/2020 Month 11	Y1 M12 Plan 31/03/2020 Month 12
Accident and Emergency - >4 hour wait	i		2,296	1,394	1,230	1,180	1,248	1,134	1,136	1,202	1,479	1,733	1,734	1,394	1,202
Accident and Emergency - Total Patients	i		11,914	11,443	12,301	11,795	12,478	11,340	11,359	12,024	11,374	11,555	11,560	10,725	12,016
Accident and Emergency - Performance % (95% standard)			**80.7%**	**87.8%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**87.0%**	**85.0%**	**85.0%**	**87.0%**	**90.0%**
Ambulance Handovers	i		March 2019	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Count of all patients arriving by ambulance (types 1, 2 and 3)	i		3,625	3,206	3,528	3,385	3,244	3,592	3,618	3,778	4,108	4,379	3,656	3,339	3,698
Count of handover delays 15-30 minutes	i		3,154	2,917	3,246	3,182	3,114	3,484	3,509	3,665	4,026	4,116	3,437	3,272	3,698
Count of handover delays 30-60 minutes	i		471	289	282	203	130	108	109	113	82	263	219	67	0
Count of handover delays 60+ minutes	i														
Diagnostics Test Waiting Times			March 2019	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Number Waiting < 6 Wks	i		8,940	8,944	8,823	8,362	8,101	7,517	7,809	8,282	8,779	8,331	8,920	8,467	8,486
Total Number Waiting	i		9,361	9,361	9,235	8,748	8,472	7,857	8,159	8,634	9,132	8,646	9,237	8,748	8,748
Performance % (1% standard)			**4.5%**	**4.5%**	**4.5%**	**4.4%**	**4.4%**	**4.3%**	**4.3%**	**4.1%**	**3.9%**	**3.6%**	**3.4%**	**3.2%**	**3.0%**
Referral to Treatment			As at 31 March 2019	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Number of incomplete RTT pathways <=18 weeks	i		41,870	42,149	42,428	42,708	42,987	43,266	43,545	43,824	44,103	44,383	44,662	44,941	45,220
Number of incomplete RTT pathways Total	i		53,600	53,567	53,533	53,500	53,467	53,433	53,400	53,367	53,333	53,300	53,267	53,233	53,200
Referral to treatment Incompletes - Performance % (92% standard)			**78.1%**	**78.7%**	**79.3%**	**79.8%**	**80.4%**	**81.0%**	**81.5%**	**82.1%**	**82.7%**	**83.3%**	**83.8%**	**84.4%**	**85.0%**
Number of incomplete RTT pathways >52 weeks	i		0	0	0	0	0	0	0	0	0	0	0	0	0
		NHSI forecasted 18/19 FOT	FOT FY 18/19	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Number of completed admitted RTT pathways	i	42,796	42,994	3,430	3,648	3,561	3,517	3,430	3,474	3,561	3,952	3,127	4,038	3,865	3,822
Number of completed non-admitted RTT pathways	i	163,797	165,882	13,571	14,409	13,738	14,409	14,409	13,906	14,073	13,906	11,560	14,576	14,576	14,409
Number of New RTT pathways (clock starts)	i	266,738	231,980	18,718	19,962	18,944	20,031	19,940	19,182	21,837	19,297	16,074	20,105	20,105	20,105
Cancer	i		March 2019	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Cancer Waiting Times - 2 Week Wait			i												
Number Seen < 2 Wks	i		1,473	1,396	1,564	1,336	1,525	1,512	1,495	1,792	1,625	1,438	1,427	1,498	1,498
Total Number Seen			1,546	1,501	1,682	1,437	1,640	1,626	1,608	1,927	1,747	1,546	1,534	1,611	1,611
Performance % (93% standard)			**95.3%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**	**93.0%**
Cancer Waiting Times - 2 Week Wait (Breast Symptoms)			i												
Number Seen < 2 Wks	i		155	254	298	221	231	228	189	220	271	165	174	183	183
Total Number Seen			177	299	335	240	248	245	203	237	291	177	187	196	196
Performance % (93% standard)			**87.6%**	**84.9%**	**89.0%**	**92.1%**	**93.1%**	**93.1%**	**93.1%**	**92.8%**	**93.1%**	**93.2%**	**93.0%**	**93.4%**	**93.4%**
Cancer Waiting Times - 31 Day First Treatment			i												
Number Treated < 31 Days	i		309	322	343	348	365	321	321	361	352	314	363	381	381
Total Number Seen			327	335	357	363	380	334	334	376	367	327	378	397	397
Performance % (96% standard)			**94.5%**	**96.1%**	**96.1%**	**95.9%**	**96.1%**	**96.1%**	**96.1%**	**96.0%**	**95.9%**	**96.0%**	**96.0%**	**96.0%**	**96.0%**
Cancer Waiting Times - 31 Day Surgery			i												
Number Treated < 31 Days	i		71	59	68	59	84	74	70	79	89	76	72	76	76
Total Number Seen			82	62	70	66	93	82	77	86	97	82	77	81	81
Performance % (94% standard)			**86.6%**	**95.2%**	**97.1%**	**89.4%**	**90.3%**	**90.2%**	**90.9%**	**91.9%**	**91.8%**	**92.7%**	**93.5%**	**93.8%**	**93.8%**
Cancer Waiting Times - 31 Day Drugs			i												
Number Treated < 31 Days	i		90	95	86	66	106	77	100	109	98	88	123	129	129
Total Number Seen			90	97	88	67	108	79	102	111	100	90	125	131	131
Performance % (98% standard)			**100.0%**	**97.9%**	**97.7%**	**98.5%**	**98.1%**	**97.5%**	**98.0%**	**98.2%**	**98.0%**	**97.8%**	**98.4%**	**98.5%**	**98.5%**
Cancer Waiting Times - 31 Day Radiotherapy			i												
Number Treated < 31 Days	i		149	134	173	138	149	171	150	184	158	142	172	181	181
Total Number Seen			151	143	184	147	158	182	160	196	168	151	183	192	192
Performance % (94% standard)			**98.7%**	**93.7%**	**94.0%**	**93.9%**	**94.3%**	**94.0%**	**93.8%**	**93.9%**	**94.0%**	**94.0%**	**94.0%**	**94.3%**	**94.3%**
Cancer Waiting Times - 62 Day GP Referral			i												
Number Treated < 62 Days	i		120	112	119	120	129	134	130	138	135	134	147	157	160
Total Number Seen			166	158	166	164	173	177	169	177	170	166	179	188	188
Performance % (85% standard)			**72.3%**	**70.9%**	**71.7%**	**73.2%**	**74.6%**	**75.7%**	**76.9%**	**78.0%**	**79.4%**	**80.7%**	**82.1%**	**83.5%**	**85.1%**
Cancer Waiting Times - 62 Day Screening			i												
Number Treated < 62 Days	i		28	21	21	21	26	23	20	33	40	30	28	29	29
Total Number Seen			36	27	27	27	33	29	25	41	49	36	33	35	35
Performance % (90% standard)			**77.8%**	**77.8%**	**77.8%**	**77.8%**	**78.8%**	**79.3%**	**80.0%**	**80.5%**	**81.6%**	**83.3%**	**84.8%**	**82.9%**	**82.9%**
Cancer Waiting Times - 62 Day Upgrade			i												
Number Treated < 62 Days	i		1	2	3	2	1	0	1	0	1	1	1	1	1
Total Number Seen			2	3	3	2	1	1	1	3	1	2	2	2	2
Performance % (no standard)			**50.0%**	**66.7%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**50.0%**	**50.0%**	**50.0%**	**50.0%**

Quality Improvement Overview Plan 2018-19

Appendix 2

Hull and East Yorkshire Hospitals NHS Trust

Introduction

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.

The plan outlines the trust's overall ambition to meets its vision of Great Staff, Great Care, Great Future. It is therefore not the intention that the improvement goals will all be achieved by March 2019 but rather significant progress can be demonstrated against all of them. The plan includes a number of key milestones and these will be reported on at the monthly Operational Quality Committee. The milestone dates are all the end of the month unless a specific date is recorded. The Plan will be reviewed and refreshed at the end of the financial year.

A separate monthly progress report will be produced to demonstrate progress against milestones and improvement goals.

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
Safety	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.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment*	Patients receive their correct medication at the right time, at the right dose and safely.	80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247)	16%	CQC Action, Quality Accounts and Sign up to Safety	Chief Medical Officer (Dr Makani Purva)	Chief Pharmacist (David Corral) and Clinical governance Pharmacist (Julie Randall)	Report on pilot of pharmacist transcribing on 5th floor at HRI circulated – **June 2018** Review of ERx infusion functionality completed – **June 2018** Electronic prescribing in QCOH implemented – **July 2018** Completed review of all improvement work undertaken in 2017/18 to ensure embedded – **July 2018**	Transcribing policy approved – **August 2018** System in place for annual medication review for adult CF patients – **August 2018** Review of medication processes on discharge completed **- September 2018** Review of ward stock lists to remove insulin cartridges & replace with pens/vials completed – **October 2018** Review of current pre-packs available on wards to facilitate discharge completed – **October 2018** Visit to centre of excellence (Sheffield) undertaken and a range of ideas to support safer use of insulin, including review of ward stock lists to remove insulin cartridges and replace with pens/vials introduced – **November 2018** Review Drug Policy for drug administration process, and consider if SOP required – **November 2018** Observations of ward drug rounds to be undertaken and presented to Nursing PEES meeting – **December 2018**	Baseline data of percentage of Patient's Own Drugs used collected – **March 2019** 80% of pharmacists to have completed e-learning module "VTE prevention in secondary care" achieved – **March 2019** Thrombosis committee to reviewed eLearning modules on anticoagulation for HEY247 – **March 2019** Biosimilar Adalimumab for 80% of appropriate patients within 12 months of product launch, and for 90% of new patients within 3 months of product launch or as advised by NHSE introduced – **March 2019** Baseline data for improving discharge prescription flow collected – **March 2019** Discharge bundle approved and implemented – **March 2019** Task and finish group to be set up to produce medicines management competencies for registered nurses – **March 2019**

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Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
Safety	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.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment*	Patients receive appropriate medical reviews in a timely manner.	Improve compliance with a NEWS Score 1-4 with documented escalation in the Census Audit (Baseline 10%) Improve compliance with a NEWS Score 5-6 with documented escalation in the Census Audit (Baseline 16%) Improve compliance with a NEWS Score 7+ with documented escalation in the Census Audit (Baseline 22%)	10% 16% 22%	CQC Action, Quality Accounts and Sign up to Safety	Chief Nurse (Mike Wright)	Nurse Director, Surgery Health Group (Steve Jessop)	Patient Safety Alert; Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) circulated to relevant leaders within the Trust responsible for deteriorating patient – **May 2018** Board reporting Committee identified to plan the adoption of the NEWS2 – **May 2018** Patient Safety Alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) actions identified by 21 June 2018 – **May 2018** NEWS2 champion identified and confirmation sent to NHS England – **May 2018**	Review completed of the SOBs training and NEWS2 requirements included – **August 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded – **August 2018** NEWS2 Guidance reviewed and incorporated into the Recognition Deteriorating Patient Policy (CP326) for implementation – **August 2018** Ratification of the revised Recognition Deteriorating Patient Policy (CP326) – **September 2018** Review completed on Datix incident form to ensure necessary information captured for learning – **September 2018** Deteriorating Patient bundle devised – **September 2018** O2 therapy documentation reformatted within paper drug card – **September 2018** Revised Recognition Deteriorating Patient Policy (CP326) launched and awareness raised – **October 2018** NEWS2 launched – **October 2018** Revised Recognition Deteriorating Patient Policy (CP326) reviewed and compliance achieved with NICE CG50 – **October 2018** Annual Census Clinical Observations Audit completed and actions agreed – **December 2018**	NEWS2 full adopted and rolled out – **March 2019** Outreach Lead Nurse to be involved with serious incidents review panel to identify lessons learned and improvement area for focus work – **March 2019** E-Obs rolled out at CHH – **March 2019** Deteriorating Patients are identified and appropriately escalated and treated in line with the Trust's Recognition Deteriorating Patient Policy (CP326) – **March 2019**
Safety	QIP08	**Infection Control**	Ensure the	To have 0 Hospital	1	Quality	Chief Medical	Director of	NHSi Urinary Tract	'No Dip' Project scoped with a	IPC bundle developed to

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		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.	Organisations compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) and reduce the number of avoidable hospital acquired infections	acquired MRSA bacteraemia To not exceed <=99% of threshold of 53 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	 72% (38) 82% (36) 150.7% (110)	Accounts, Sign Up to Safety and Trust action	Officer (Dr Makani Purva)	Infection Prevention & Control (Dr Peter Moss), Infection Control Consultant (Dr Rolf Meigh) and Lead Nurse Infection Prevention & Control (Greta Johnson)	Infection Collaborative Project team established - **May 2018** Initial NHSi Urinary Tract Infection Collaborative Project session attended by project team - **May 2018** Infection Prevention and Control Care Bundle review completed - **May 2018** Infection Prevention and Control Care Bundle review launched - **July 2018**	view to reducing automatic prescription of antibiotics which can lead to resistant UTIs based on a dipped urine sample which has commenced early 2018 within the Community - **September 2018** E.Coli prevalence audit completed - **September 2018** Weekly snapshot audits of Standard Precautions Practice inclusive of Hand Hygiene compliance and PPE usage on Medical Wards in place - **September 2018** 'Let's Talk Hydration' project scoped with a focus on how the project can positively impact on IPC and UTI rates - **September 2018** UTI collaborative PDSA pilot completed to improve practice in reducing the burden of urinary tract infection (UTI) (catheter/ non-catheter) - **October 2018** Catheter competency framework in place developed by the Practice Placement Facilitators -**October 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **December 2018** Review of catheter census findings and additional milestones identified - **December 2018**	include PVC VIP charts - **January 2019** PCV VIP chart training for staff scoped - **February 2019** Review of current provision of CVC insertion to agree process and policy moving forward **February 2019**
Safety	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*	Ensure that falls assessments, e-learning programmes and lessons Shared are embedded across the Trust to help eliminate all avoidable patient falls.	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above To reduce the number of falls resulting in a	0.17 27	CQC Action, Quality Accounts and Sign up to Safety	Chief Nurse (Mike Wright)	Assistant Chief Nurse (Jo Ledger) Chair of Falls Committee (Rosie Hoyle)	Complete the re-evaluation of the falls prevention care bundle, Which includes redesign of the MFAT and the introduction of an improved bed rails assessment. This is	Establish a task and finish group for identified high risk fall areas (DME & Oncology) – **August 2018** Development of an agreed action plan within DME & Oncology – **August 2018**	Explore a method of ensuring mobility aids are available 24/7. This is monitored by the FPC through the risk register action 2 – **March 2019** Bedside vision assessment

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		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. *Linked to a regulation breach. Regulation 12 Safe Care and Treatment*		fracture neck of femur Continue to achieve =>50% of clinical staff to have completed the falls prevention e-learning The high risk areas were identified as follows: - H9 - H90 - H8 - H80 - Elderly Assessment Unit (EAU) - C29 - C31 - Allied Health Professionals To further reduce the number of patient falls per 1000 bed days for all patient falls	50% 60% 80.6% 51.3% 61% 16% 62% 17.3% 7.47			Falls QSM (Bridget Wainman)	monitored by the FPC through the risk register action 1 – **May 2018** Development of 'fall prevention' poster campaign – **June 2018** Meeting with patient experience to explore the use of volunteers – **June 2018** Review of NICE guidance to ensure compliance. This is monitored by the FPC through the risk register action 6 – **June 2018** Approval and introduction falls specific SID. This is monitored by the FPC through the risk register action 5 – **July 2018** Auditing processes for the monitoring of the checks for injury and medical examination after a fall established – **July 2018** Pre-Audit of the identified test areas for the new MFAT – **July 2018**	Revised documentation to be tested in various areas. – **August 2018** Distance markers. This is monitored by the FPC through the risk register action 4 – **August 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded – **September 2018** Audit of the identified test areas post introduction of the new MFAT – **September 2018** Development of a staff information poster. This is monitored by the FPC through the risk register action 3 – **October 2018** Delivery of Action plans within DME & Oncology – **December 2018** Re-audit undertaken using the census tool to identify compliance with the accurate completion of falls risk assessment, clinical appropriateness use of the bedrails and individualised care plans – **December 2018**	to be developed in a proportionate format. This is monitored by the FPC through the risk register action 7 – **March 2019** Update e-learning in line with changes to nursing documentation. This is monitored by the FPC through the risk register action 10 – **March 2019**
Safety	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.*	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.	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	1 0 13 38	Quality Accounts, Sign up to Safety and Trust action	Chief Nurse (Mike Wright)	Health Group Nurse Directors (Mel Carr, Wendy Page, Debbie McLean and Steve Jessop)	Threshold of the Tissue Viability Fundamental Standards audits increased to drive up quality of care - **May 2018** Wound Management Committee agenda amended to include standard agenda item for the review of evidence from Health Groups which highlights all lessons learnt activity from tissue viability Serious Incident Investigations - **May 2018**	Wound Management process amended to include the requirement that all patients with pressure damage, either community or hospital acquired is reviewed by a Sister/Senior Matron daily - **August 2018** Training Needs Assessment for all Sisters and Senior Matrons amended to include the requirement to complete the higher level tissue viability training on an annual basis - **September 2018**	

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
				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% of root cause analysis investigations of finally approved hospital acquired pressure ulcers completed within 14 days 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas Overall Clinical Support Family and Women's Medicine Surgery Fully quorate at Trust's Wound Management Committee	52 97.4% 100% 74.2% (72/97) 78.5% 77.9% 79.8% 77.5% 84.0% Not quorate				Statement of assurance from all Health Groups that daily assessment of high risk patients are in place received at the Wound Management Committee - **June 2018** Statement of assurance from all Health Groups that all clinical areas have an embedded safety brief twice daily - **June 2018** Scoping exercise completed to assess the numbers of link nurse/staff roles in all clinical areas - **July 2018**	WMC template for HGs updated to include all QIP milestone requirements - **September 2018** Assurance on actions taken when HAPU occurs embedded in the WMC HG reports - **September 2018** Plan developed based on the results of link nurse review to ensure that at least one staff member fulfils this role in all areas - **September 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **December 2018**	
Safety	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.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment*	Accessible, responsive and safe service for Children and Young People with mental health needs	To achieve 100% compliance with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm	84%	CQC Action	Chief Medical Officer (Dr Makani Purva)	Senior Matron Children and Young People Services (Vanessa Brown)	Q3 and Q4 2017/18 audits of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **May 2018** Q1 2018/19 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **June 2018**	~~Service level agreement developed and signed off to formalise the external support from CAMHS to HEYHT - **September 2018**~~ Q2 2018/19 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **September 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are	Q4 2018/19 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **March 2019**

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Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
										embedded - **October 2018** Q3 2018/19 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **December 2018**	
Safety	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.*	Patients are appropriately risk assessed for VTE and in a timely manner	~~Achieve 95% compliance with the completion of the electronic VTE Risk Assessment within the first 14 hours of admission for: **CMO Removed Sep-18**~~ - Clinical Support - Family and Women's - Medicine - Surgery Achieve 95% compliance with the completion of the electronic VTE Risk Assessment within the first 24 hours of admission for: - Clinical Support - Family and Women's - Medicine - Surgery ~~Achieve 95% compliance with the completion of the electronic VTE risk re-assessment (during admission) For : **CMO REMOVED Sep-18**~~ - Clinical Support - Family and Women's - Medicine - Surgery To maintain 0 VTE Serious Incidents Achieve 95% pharmacological VTE prophylaxis for patients for whom it's applicable as measured by the monthly safety thermometer point prevalence audit **NEW PI**	TBC TBC TBC 0	Trust action	Chief Medical Officer (Dr Makani Purva)	Health Group Medical Directors; Colin Vize (Family and Women's), Jacqueline Smithson (Medicine), Russell Patmore (Clinical Support), Chris Shaw and Caroline Hibbert (Surgery)	Review completed of processes and tools used by high performing Trusts to achieve national compliance – **June 2018** Review completed on performance information criteria and national submissions – **June 2018** Deep dive completed on low performing specialities – **July 2018** Deep dive completed on low performing clinicians – **July 2018** Service level information provided by the Health Groups to Operational Quality Committee monthly – **July 2018**	Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded – **August 2018** Improvement programme developed for individual specialities – **August 2018** Audit completed (in one day) across HRI and CHH against the completion of the VTE assessment in the paper records and on Lorenzo – **August 2018** VTE performance included in Specialty performance reviews – **December 2018**	

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				ADDED SEPTEMBER 2018							
Safety	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.*	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.	CQUIN indicators: 2a: % of patients who met the criteria for sepsis screening and were screened for sepsis. 2b: % of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. Improve number of staff completing SOBs training	Inpatient – 92.0% ED – 87.0% Inpatient – 64.7% ED – 55.6% 1188	Quality Accounts and Sign Up to Safety	Chief Medical Officer (Dr Makani Purva)	Sepsis leads – Dr Kate Adams (Consultant Lead), Donna Gotts (Nurse Lead), Claire O'Brian (Nurse Lead)	Pilot wards determined for coding projects - **April 2018** Project plan developed for coding improvements - **May 2018** 30% of eligible staff trained in Sepsis since Feb 2017 (Year 1) – **June 2018** Pilot of coding wards concluded - **July 2018** Next steps determined following coding pilot - **July 2018** Poster presentation at Patient Safety Congress – **July 2018** Junior Doctor training completed at Summer Trust Induction **– July 2018**	Regional Conference Hosted – **September 2018**	Junior Doctor training completed at Winter Trust Induction – **January 2019** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **January 2019** 60% of eligible staff trained in Sepsis since Feb 2017 (Year 2) - **March 2019**
Effective ness	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.*	Robust and effective governance arrangements	To reduce the number of overdue procedural documents To have no more than 10% overdue patient information leaflets by the end of March 2019 To achieve a 20% reduction in the number of overdue audit actions by the end of March 2019	112 37% 46%	Trust action	Chief Nurse (Mike Wright)	Deputy Director of Quality Governance and Assurance (Sarah Bates)	Review completed of the Maternity core service – **July 2018** Advice sought from the CQC on the service map and the alignment of the core services to Health Groups – **July 2018** Review completed of the alignment of the CQC core services against the Trust's four Health Groups and the service map updated accordingly – **July 2018**	Development of one Governance Dashboard to aid the triangulation of data and identification of themes and trends – **August 2018** Focused work undertaken to encourage staff to report all incidents including staffing issues – **August 2018** Systems updated to include the CQC core services when reporting on Risks, Incidents, SIs and Never Events – **August 2018** Systems updated to include the CQC core services when reporting on the Trust clinical audit plan, NICE/NCEPOD and National Audits – **August 2018** Local overdue audit actions	Review completed of the Children and Young People core service – **January 2019** Review completed of the End of Life core service – **February 2019** Achieved 90% of all Trust departments completing all risk assessments of six key hazards – **January 2019** Review completed of the Surgery core service – **March 2019** Reduction in the number of overdue patient information leaflets achieved – **March 2019** Delivery of QIP30 – Avoidable Mortality –

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										followed up and included in the Health Group Governance Reports – **August 2018** All issues of concern arising from national audits clearly addressed on the outcome form – **August 2018** Systems updated to include the CQC core services when reporting on claims – **August 2018** Implementation of the Governance Dashboard – **September 2018** Review completed of the Critical Care core service – **September 2018** Triangulation of data processes agreed and implemented - **September 2018** Review completed of the 'Safe' domain – **September 2018** Development and approval of the Governance Learning Group terms of reference – **September 2018** Work undertaken with the Health Group Triumvirates to ensure they are able to clearly articulate the risks that are on their Health Group risk registers and are fully aware of controls and mitigating actions – **September 2018** Work undertaken with staff in ward areas and departments within the Health Groups to ensure there is alignment between their 'worry list' and the actual risk register – **September 2018** Revised process for the development of Patient	**March 2019**

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										Information Leaflets implemented – **September 2018** Outpatient services have robust and effective governance processes in place for the management of risk within Outpatients – **September 2018** Review completed of the Clinical Audit and Effectiveness arrangements and next steps agreed – **September 2018** Significant assurance received following the audit of claims function to assess compliance with NHS Resolution protocols, legislation and local operational policies and procedures – **September 2018** Establishment of the Governance Learning Group to review and discuss themes and trends for identification of learning and key areas of improvement – **October 2018** Review completed of the Emergency Department core service – **November 2018**	
Effective ness	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.* *Linked to a regulation breach. Regulation 12 - Safe care and treatment.*	Nutrition and hydration is an essential element of patients' care. Adequate nutrition and hydration helps to sustain life and good health and it also reduces the risk of malnutrition and dehydration while they are receiving care and treatment in hospital and provides patients with the nutrients they need to recover.	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	91.3% No baseline No baseline	CQC Action, Quality Accounts and Sign up to Safety	Chief Nurse (Mike Wright)	Chair of Nutrition Steering Group (Steve Jessop) and Practice Development Nurse (Caroline Grantham)	Completed review of all improvement work undertaken in 2016/17 and 2017/18 to ensure they are embedded - **April 2018** Patient Weights: Classic Safety Thermometer data collection tool reformatted to collect data monthly on patients being weighed within 24 hours of admission - **July 2018** Nutritional Screening Tool (NST): Continuation sheet developed for use with the nutritional bundle - **July**	Hydration E Learning Programme devised - **August 2018** Fluid Balance Chart reformatted - **August 2018** Opt Out of Nutrition Screening review for Outpatient Departments commenced - **August 2018** Hydration Policy drafted - **September 2018** Snack Trollies standardised - **October 2018** Food Record Charts process amended for Catering Staff to	Outpatient Department Nutrition Screening project scoped - **January 2019**

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									2018	complete Morning & Afternoon Snack sections - **October 2018** Nutrition White Boards standardized - **December 2018** Hydration Policy ratified - **December 2018**	
Effectiveness	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.*	Continue to work towards models of excellence, ensuring staff training and awareness, the quality of care for patients and the working environment and experience for our staff will be improved.	Continue to achieve 90% compliance with dementia/delirium screening assessments undertaken Continue to achieve 75% compliance on H8/80, H9/90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol Continue to achieve 75% staff awareness of Johns campaign Aim to achieve 75% relative/carer awareness of Johns campaign	95% Butterfly Symbol 75% and the Reach Form 87.5% 87% No baseline	CQC action and Trust action	Chief Medical Officer (Dr Makani Purva)	Lead Consultant (Dr Yoghini Nagandran) and Lead Dementia Nurse (Kay Brighton)	Cinema area on Ward 80 created – **May 2018** Meeting with volunteer service manager to discuss utilising patient volunteers – **June 2018**	Audit completed to review transfers of care and quality of information (admissions, transfers and discharges) – **August 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded – **August 2018** Staff training session on how to de-escalate challenging behaviour in patients arranged – **October 2018**	Participated in the national audit of dementia 2018/19 and review audit outcomes – **February 2019** Action plan developed from the 2018/19 dementia audit – **March 2019** Dementia care bundle embedded into practice on elderly care wards – **March 2019** Discharge communication improved through linking dementia screening to the IDL via Lorenzo – **March 2019**
Effectiveness	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.* *Linked to a regulation breach. Regulation 12 - Safe care and treatment.*	Available, accurate and well maintained patient records	These will be set following a review of the Census findings in October 2018	TBC	CQC action and Trust action	Chief Nurse (Mike Wright)	Deputy Chief Nurse (Jo Ledger)		Records Committee established – **September 2018** Census Audit for records completed and action plan agreed – **September 2018** Review completed of CP185 Patient Documentation Policy and CP292 Information Governance Policy – **October 2018** Performance targets agreed following review of the Census Audit findings – **October 2018**	
Experience	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.*	Patient feedback will be acted upon in a timely manner and it will be used to inform service improvement.	Continue to achieve >85% of formal complaints closed within the 40 day target To Reduce the number of repeat complaints by 20% <83	92.85% 104	Quality Accounts and Sign up to Safety	Deputy Director of Quality Governance & Assurance (Sarah Bates)	Head Of Patient Experience and Engagement (Louise Beedle)	Data against the 85% of formal complaints closed within the 40 day target for 2017/18 reviewed to ensure accurate as anomalies have been identified – **May 2018** Interpreters Policy and	Investigated alternative methods of complaints evaluation survey to increase response rates – **November 2018**	The spend on interpreters reduced by 15% - **March 2019** 'you said, we did' boards around the Trust re-introduced – **March 2019** Maintained a level of 450

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									supporting tools implemented – **May 2018** Completed review of all improvement work undertaken in 2017/18 to ensure embedded – **June 2018**		active volunteers within the Trust – **March 2019** Bank of volunteers to support wards and patients with the tower block developed – **March 2019** Virtual BSL interpretation introduced – **March 2019** Worked with the Falls lead nurse to consider how the volunteer service can support staff effectively in minimising falls – **March 2019** Complaints team provided bespoke training for each ward on the handling of concerns from patients and visitors to reduce the number of formal complaints – **March 2019**
Effective ness	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.*	Reduction in 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 To review all patients subject to care interventions from which a patient's death would be wholly unexpected To review all patients who underwent Elective Procedures during their last episode To review a further sample of patient deaths fitting the "deteriorating patient" criteria.	100% 100% 100% 100% No baseline	Quality Accounts and Sign Up to Safety	Chief Medical Officer (Kevin Philips)	Clinical Outcome Manager (Chris Johnson)	Developed a standardised "Quarterly themes and trends" report template, to be completed by each Speciality on a quarterly basis - **April 2018** Standardised Quarterly themes and trends report template trialled within selected Specialities - **May 2018** Initial Mortality Screening form developed - **May 2018** Mortality Review-Quality Assurance Process embedded - **June 2018** Process in place to allow the identification of patients who match the "Deteriorating Patient" criteria - **June 2018** Multi-agency review	SJR reviews undertaken on patients who had an unplanned ICU admission – including living patients - **August 2018** Initial Mortality screening form implemented in Medicine Health Group - **September 2018** E-learning package tested and sent for consultation and feedback sought - **September 2018** E-learning package developed and implemented on HEY247 - **November 2018**	

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									undertaken on Atrial Fibrillation (Stroke) mortality patients - **June 2018** E-learning package designed for use in training Structured Judgement reviewers - **July 2018** Standardised Quarterly themes and trends report full implemented across all Specialities - **July 2018** Initial Mortality screening form trials completed and feedback gathered - **July 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **July 2018**		
Effective ness	QIP36	**Transition from Childrens 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.* *Linked to a regulation breach. Regulation 12 Safer Care and Treatment*	To provide a service that ensures an effective transition from Paediatric services to adult services.	Embedding of the procedural document ensuring the effective transition for young people to adult services	Implemented	CQC Actions, Quality Account and Sign up to Safety	Chief Nurse (Mike Wright) and Chief Medical Officer (Dr Makani Purva)	Family and Women's Operations Director (Michelle Kemp) and Head of Outpatient Services (Eileen Henderson)		Ready, Steady, Go toolkit implemented in Diabetes, Epilepsy and Cystic Fibrosis and audited in order to learn any lessons prior to implementing across the other speciality services – **September 2018** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **October 2018**	
Safety	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.*	ReSPECT process is fully embedded across the organisation.	Improve compliance from the baseline ReSPECT Census audit	No baseline	Trust action	Chief Medical Officer (Dr Makani Purva)	Resuscitation Manager (Neil Jennison)	Launch of ReSPECT – **April 2018** Completed review of all improvement work undertaken in 2017/18 to ensure embedded - **May 2018**	Each Health Group to have a register in place which details the registered senior healthcare professionals who have had training in the assessment of capacity and consent and have had this role delegated by a consultant which allows them to document patient wishes including DNACPR and complete the ReSPECT process – **August 2018**	Twice yearly ReSPECT audit completed and next steps agreed – **March 2019**
Effective ness	QIP38	**Consent** *The aim of this project is to review and strengthen the governance*	To have centrally governed electronic consent forms	To have all consent forms managed and monitored through a	No baseline	Trust action	Chief Medical Officer (Dr Makani Purva)	Deputy Director of Quality Governance and	Scoping paper regarding the Admin and Clinical review of the consent	Consent MDT Working Group established – **August 2018**	Pilot of the Lorenzo consent forms completed in Breast – **January 2019**

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		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.		central process by March 2019				Assurance (Sarah Bates)	forms presented to Operational Quality Committee for approval and identification of leads – **July 2018**	Record (spreadsheet) of all consent forms held by the Trust reviewed and updated with all Health Groups to ensure all consent forms are recorded and monitored centrally – **September 2018** Admin and clinical review of consent forms completed and next steps agreed – **October 2018** All consent forms transferred onto Lorenzo for the monitoring process to be implemented – **October 2018** Consent Policy reviewed and updated to strengthen the consent guidance and include all legal requirements – **December 2018**	Pilot of the Lorenzo consent forms in Breast analysed and next steps agreed – **January 2019** Consent e-learning module developed using the revised policy and case studies from incidents and claims – **February 2019** Lorenzo consent forms fully developed – **March 2019** To have new printed consent forms available for patients in clinics which do not have access to Lorenzo – **March 2019** Consent forms linked to up to date patient information leaflets and leaflets available at the time of consent – **March 2019** Development, approval and monitoring process for the Trust consent forms developed and implemented – **March 2019** Consent e-learning module approved and launched – **March 2019**
Effective ness	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.*	Robust leadership and governance structure strengthened for outpatients	Outpatients governance committee held	Delivered	CQC action and Trust action	Chief Operations Officer (Ellen Ryabov)	Head of Outpatient Services (Eileen Henderson)	Outpatient Governance Committee Terms of Reference reviewed particularly in relation to quoracy - **May 2018** Outpatient Governance Committee work plan developed - **May 2018** Progress report for the NATSSIPS project phase 2 which deals with the roll out in Outpatient Department received at Outpatient Governance Committee - **May 2018**	Review of governance support completed with agreed roles and responsibility - **August 2018** Local Outpatient Department Clinical Audit plan developed - **August 2018** Review of admin support completed with agreed roles and responsibility - **August 2018** Outpatient Governance Committee review complete - **September 2018**	

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									Report from Outpatient Department Fundamental Standards programme detailing trust compliance with records storage submitted to the Outpatient Governance Committee - **May 2018** HR Metrics Report included on Outpatient Governance Committee agenda - **June 2018** Quarterly Complaints themes and trends report included on Outpatient Governance Committee agenda - **June 2018** All outpatient related risks reviewed together as a recognised outpatient risk register and included on agenda - **June 2018** Trial in Gynaecology for Lorenzo clinic waiting times commenced - **June 2018** Rollout of Bespoke Outcome Sheet in Lorenzo tested in Gynaecology trial commenced in Neurology - **June 2018** Assurance received from poor performing areas from PLACE audits to Outpatient Governance Committee that actions are in place - **July 2018** Clinic waiting time audit project scoped - **July 2018**	Thematic review of Outpatients Core Service including well led and responsive completed - **September 2018** Outpatient Strategy reviewed - **October 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **October 2018** Local Outpatient Department Patient Survey considered - **November 2018** Intranet staff zone for Outpatient Governance developed - **December 2018**	
Effectiveness	QIP41	**Getting it Right First Time (GIRFT) – Paediatric Surgery*** *The aim of this project is to ensure there is an effective and well led response to the recommendations*	Improved Paediatric Surgical services	Full implementation of the project	Partial delivery	Trust action	Chief Nurse (Mike Wright)	Family and Women's Divisional General Manager (Lisa	Achieve a negative appendicectomy rate of 10% - **May 2018** Repairs of umbilical	Audit of the coding of acute scrotal exploration to ensure consistent coding practices completed – **August 2018**	Introduction of a day case hypospadias surgery – **March 2019** Completed review of all

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		and actions arising from the GIRFT review of Paediatric Surgery.						Pearce)	hernias in children under the age of 3 audit results presented and next steps agreed – **May 2018** Circumcisions and review/decision making process and the use of high dose topical steroid audit results presented and next steps agreed – **May 2018**	Board Level Review of Paediatric Surgical Services possibly tied to local STPs completed – **December 2018**	improvement work undertaken in 2017/18 to ensure embedded – **March 2019**
Effective ness	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.*	Improved Ophthalmology services	Full implementation of the project	Partial delivery	Trust action	Chief Nurse (Mike Wright)	Family and Women's Divisional General Manager (Damian Haire)	Improved engagement with community optometry colleagues to reduce number of false positive referrals – **June 2018** Review options for increased presence of HEY ophthalmology service in the community completed – **June 2018** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded – **July 2018**		
Effective ness	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.*	Improved Obstetrics and Gynaecology services	Full implementation of the project	No baseline	Trust action	Chief Nurse (Mike Wright)	Family and Women's Divisional General Manager (Lisa Pearce)	"Elephant Kiosk" implemented to increase the response rate for the Friends and Family Test – **April 2018** Feedback from the Maternity Voices Partnership embedded into the patient experience pathway – **April 2018** Patient stories included in Trust and Divisional Board meetings – **April 2018** Audit of indications for hysterectomies is considered and next steps agreed – **April 2018** Pathways for performing	Endometrial ablations pathways reviewed and approved for these procedures to be undertaken in an outpatient / ambulatory setting to free up theatre capacity – **September 2018** Audit of indications for hysterectomies to be carried out – **October 2018**	

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									day-case procedures reviewed and revised if required – **April 2018** Implementation of STOMP (Medway) or OASI (Croydon) perineal care bundles for third- and fourth-degree tears to reduce tear rate considered and next steps agreed – **April 2018** Reviewed the NHSLA narrative behind each claim and disseminated for learning from claims – **April 2018** Test completed of the learning from the claims to ensure lessons learned are embedded – **April 2018** PTFU (Patient Triggered Follow Up) system for Benign Gynaecology and Gynaecology to keep the ratio low or reduce further considered and next steps agreed – **May 2018** Review undertaken to establish if there is the ability to increase the number of consultants in the team and if the theatre utilisation and capacity could be increased – **May 2018** Surgical volume data is included in appraisals – **May 2018** Introduction of the recording of vaginal repairs on the BSUG database considered – **May 2018** Coding and booking process for TOT reviewed; increase the recording of		

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									day case procedures – **May 2018** Introduced the recording of TVTs on the BSUG database – **May 2018** Pathways for the injections of BOTOX reviewed and approved these procedures to be undertaken in an outpatient / ambulatory setting to free up theatre capacity – **May 2018** Coding of colposcopy treatments reviewed to ensure they're being coded correctly on the new system – **May 2018** Publication of survival data on the Trust website considered to share the good outcomes for Gynaecology – **May 2018** Hot debrief and discharging mother with a letter to inform future mode of delivery considered and next steps agreed – **May 2018**		
Safety	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.*	Achievement of the 10 key elements and safer maternity care services for patients.	Achievement of the 10 key elements of the Safer Maternity Care by June 2018	No Baseline	Trust action	Chief Nurse (Mike Wright)	Head of Midwifery (Jan Cairns)	Use of the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths implemented – **May 2018** Data is submitted to the Maternity Services Data Set (MSDS) to the required standard – **May 2018** Transitional care facilities in place and operational to support the implementation of the ATAIN Programme – **May 2018** Effective system of		

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									medical workforce planning in place and demonstrated – **May 2018** Effective system of midwifery workforce planning in place and demonstrated – **May 2018** Compliance achieved with all 4 elements of the Saving Babies' Lives (SBL) care bundle – **May 2018** Patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum implemented and feedback acted on – **May 2018** 90% compliance with in house training for emergencies achieved - **May 2018** Safety champions meet bi-monthly with Board level champions to escalate locally identified issues – **May 2018** 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme reported – **May 2018** Assurance provided to the Trust Board that the 10 key elements of the Safer Maternity Care are achieved - **June 2018**		
Effective ness	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*	If successful, this project will increase training and learning for Junior Doctors in a safe, open and supportive environment in addition to increasing	Delivery of the Handover quality improvement project (implementation plan)	No baseline	Trust action	Chief Medical Officer (Dr Makani Purva)	Consultant in Infectious Diseases (Dr Anda Samson)	Engagement plan with senior medical clinicians commenced - **April 2018** Junior Doctor shift times reviewed to ensure overlap period - **May 2018** Existing handover	Handover process trial at Hull Royal site commenced - **August 2018** Junior Doctor and Consultant survey to review opinions on amended handover process made live - **December 2018**	Junior Doctor and consultant survey results reviewed - **January 2019**

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		senior clinical involvement, across the medical services where admissions, cases and treatments are discussed and responsive actions put in place if concerns are raised.	patient safety by addressing learning needs and concerns raised at each handover. This will also increase Junior Doctor morale by ensuring they feel part of a wider medical service team rather than service specific.						arrangements scoped - **May 2018** Additional leads recruited for the handover process - **May 2018** Mapping of all Junior Doctor staff across medical services - **May 2018** Junior Doctor and Consultant survey to review opinions on current handover processes made live - **May 2018** Junior Doctor and consultant survey results reviewed to inform draft handover process - **June 2018** Handover process drafted - **June 2018** Handover process approved at relevant committee - **July 2018** Launch plan for the handover process developed including location and timings - **July 2018**		
Safety	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*	Positive impact on patient mortality, morbidity and length of stay, thereby reducing costs per patient	Delivery of the quality improvement project (implementation plan)	No baseline	Quality Accounts, Sign up to Safety and Trust action	Chief Medical Officer (Dr Makani Purva)	Consultants in Nephrology and Urgent Care (Dr Sofia Sofroniado, Prof Sunil Bhandari, Dr Martin Chanayireh)	AKI Toolkit developed for use on AMU and Ward 1 HRI - **June 2018** AKI awareness presentation delivered to Renal consultants - **June 2018** AKI training session delivered to existing Junior Doctors and Nursing staff - **June 2018**	Business case for additional clinic for AKI review scoped – **August 2018** AKI training session delivered to August intake of Junior Doctors - **September 2018** AKI re-audit commenced - **November 2018**	

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		a urine dipstick test performed as soon as acute kidney injury is suspected or detected.									
Effective ness	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.*	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.	Delivery of the quality improvement project (implementation plan)	No baseline	CQC action and Trust action	Chief Nurse (Mike Wright)	Assistant Chief Nurse (Kate Rudston)		Review of existing SLA to ensure that monthly reports are received as per agreement - **August 2018** Develop SLA for CAMHS to include data collection requirements of referrals - **September 2018** Review of Mental Health, Learning Disabilities and Autism training requirements for front facing staff completed - **October 2018** Training Needs Analysis developed for front facing staff - **October 2018** Workshop for external agencies and Trust representatives to scope Terms of Reference for a Mental Health Committee - **October 2018** Terms of Reference agreed by appropriate committee - **November 2018** Training Needs Analysis approved at relevant committee - **December 2018** Mental Health Care plan developed including audit requirements - **December 2018**	Mental Health Committee commenced - **January 2019** Patient Experience process for Mental Health patients scoped - **February 2019** Training plan developed for April 2019 implementation - **March 2019** Completed review of all improvement work undertaken in 2017/18 to ensure they are embedded - **March 2019**
Effective ness	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*	Improved medical and surgical care within the NHS by reducing unwarranted variations.	Full delivery of all actions	No baseline	Trust action	Chief Nurse (Mike Wright)	Operations Director, Family and Women's Health (Michelle Kemp)	Orthopaedic Spinal Surgery action plan delivered – **June 2018** Cranial action plan delivered – **June 2018** Ophthalmology action plan delivered – **June 2018**		Orthopaedics action plan delivered – **March 2019** Neuro Spinal Surgery action plan delivered – **March 2019** Vascular action plan delivered – **March 2019** Urology action plan delivered – **March 2019** ENT and Head and Neck

Quality Improvement Overview Plan 2018-19

Hull and East Yorkshire Hospitals NHS Trust

Domain	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure For 2018/19	Baseline From 2017/18	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		• *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*									Surgery action plan delivered – **March 2019** Paediatric and Neonatal Surgery action plan delivered – **March 2019** Obstetrics and Gynaecology action plan delivered – **March 2019** Cardiothoracic action plan delivered – **March 2019** Cardiothoracic action plan delivered – **March 2019** Medical Negligence (Litigation in Surgical Specialties) action plan delivered – **March 2019**

**project closed*

Appendix 3

Workforce Challenges

Description of Workforce Challenge	Impact on workforce	Initiatives in place
Recruitment and retention of registered nurses.	Difficulty in recruiting to establishment; difficulty in rostering; increased reliance on the use of overtime, bank and agency.	Continued focus on recruitment of newly qualified nurses from local Universities. Trust is working collaboratively with Health Education England to support the Nursing Associate and Nursing Apprenticeship training programmes. First 17 Registered Nursing Associates due to qualify in May 2019. Further cohort of 10 wte nurses from the Philippines to be recruited in 2019. Participation in career promotion events, including job fairs, School, College and University visits.
Medical staff recruitment, particularly in specialties where there is a nationally recognised shortage of consultant medical staff. Affected areas include: Critical care and anaesthetics, Radiology, Haematology, Oncology, Cellular Pathology, Emergency Department, Acute Medicine, Elderly Medicine, as well as some smaller specialties.	Difficulty in recruiting to establishment; difficulty in providing senior consultant cover in areas impacted by consultant shortfalls; increased reliance on agency and locums; remaining staff impacted by need to utilise waiting list initiatives and increased frequency of on call and cover for colleagues' leave.	Shared appointments with neighbouring Trusts, outsourcing of radiology reporting, training and recruitment of medical associate roles eg ANNPs, PAAs, PAs, ACPs and ACCPs across a wide range of specialties. Succession planning and support to middle grades with a view to retaining on qualifying as a consultant. BMJ campaign for consultants. Utilisation of head hunting services. Establishment of a 'medical bank'.
Recruitment and retention of AHPs ie Dietetics, Occupational Therapy, Physiotherapy, Radiography	Difficulty in recruiting to establishment; increased reliance on agency and bank staff.	Targeted recruitment campaigns. Joint working with community provider and creation of acute/community rotations in physiotherapy, also being considered for Dietetics. Development of undergraduate programme with Hull University, to commence in September 2020, providing locally trained source of physiotherapists for healthcare providers across the local health community. Relocation packages offered to qualified radiographers.
Potential loss of medical, nursing, AHP and technical staff from EU countries as a result of Brexit, with future recruitment of EU staff impacted by the exit from the EU. Potential visa implications for existing EU staff.	Increased vacancy factor across a range of staff groups and specialties, leading to increased reliance on overtime, bank and agency. Difficulty in rostering and providing safe staffing levels.	An action plan has been developed to raise and monitor workforce issues relating to Brexit. This includes participation in the Trust's Operational Readiness Group. EU staffing data provided to Divisional service managers to help inform them in developing their workforce plans

Workforce risks and mitigating actions

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
Inability to recruit sufficient numbers of registered nurses in order to meet full establishment levels	High	Use of overtime, bank and agency to address gaps in rosters. Six times daily safety briefing reviews to ensure minimum safe staffing levels maintained. Nursing Development Group formed to oversee recruitment and retention. Continued utilisation of overseas recruitment programme. Continued utilisation of 'Remarkable People, Extraordinary Place' recruitment campaign. Attendance at recruitment fairs and targeted recruitment of final year University students. Development and promotion of new roles including nurse apprenticeships, nurse associates, Advanced Clinical Practitioners, Physicians Associates	2018 recruited 33 nurses from the Philippines, a further 10 will be taking their OSCE examinations in February 2019, with a further 10 joining the Trust in 2019. 150 final year nurse students interviewed in January 2019 ready to be employed in Sept/Oct 2019 following successful completion of their degrees.
High level of Consultant vacancies (46.58 wte) as at January 2019 (vacancy rate of 10.61%)	High	Trust is currently employing 43.66 wte locum or agency consultants in order to provide service continuity. Ongoing recruitment campaigns in place, together with utilisation of head hunting services. Development of alternative roles and redesign of clinical pathways underway eg reduction in number of consultant face to face follow up appointments, utilisation of MDT as alternative to consultant input where clinically appropriate. Succession planning, shared appointments with other acute providers. Outsourcing of radiology reporting. Change of Trust name to emphasise and promote links with Hull University and the Trust's increasing focus on research and innovation. Exploration of re-instigating the Associate Specialist role locally.	Taking into account the locum/agency cover, the consultant vacancy rate is 0.67%, however this belies the fact that the Trust is heavily reliant on locums and therefore there is a continued risk to the sustainability of services. This is further impacted by growth in referrals from North Lincolnshire and Goole FT, increasing pressure on consultant-led services.
Junior doctor vacancies (vacancy rate of 11.29%)	High	Current complement of junior doctors includes doctors from HEE/Deanery, Trust-employed doctors recruited to fill gaps in junior doctor rotas and overseas doctors on MTI training programmes. The Trust has entered into partnership with the College of Physicians and Surgeons in Pakistan (CPSP) which will see us collaborate on research and clinical trials and offer high quality training places for junior and senior fellows in a range of specialties. Ongoing recruitment campaigns to attract junior doctors. Trust is a major partner in the Hull York Medical School. Establishment of a medical bank.	8 doctors from CPSP have been offered a post with the Trust, with a further 35 applicants being interviewed in January/February 2019. It is anticipated that these doctors will be in the Trust by April 2019.
Vacancies across a range of AHP groups, particularly dietetics, physiotherapy,	High	Shortages are mainly at B5 and B6, therefore targeted recruitment campaigns for final year students. Exploration of acute/community rotation in dietetics along similar lines to that established in physiotherapy. Career progression programmes in place.	Each AHP group has workforce plans in place and work continues to proactively recruit and retain skilled and experienced staff.

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
occupational therapy, speech and language therapy and radiographers. Vacancy factors are compounded by the fact that overseas applicants at B5 level require a Tier 2 visa as they do not meet the minimum earning criteria (£30k). In addition, when Tier 2 visas expire for those staff not earning £35.5k pa, the Trust is unable to retain the staff as the staff are not eligible for settlement (indefinite leave to remain).		Development of new roles including Exercise Professional in Physiotherapy, Consultant Sonographers, Reporting Radiographers. Utilisation of apprenticeships and physiotherapy assistants. Relocation package for Radiographers Refer-a-Friend Scheme. Promotion of flexible working options.	The Trust continues to work with the Universities and our community health care partners to provide posts locally for newly qualified AHPs and to provide career development opportunities for those wishing to progress in the profession.

Long-term vacancies (hard-to-fill posts over six months)

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Registered Theatre staff – Nurses and Operating Department Practitioners (ODPs) – ongoing recruitment difficulties	40.00 wte	Impact on rostering and service delivery, including potential cancellation of theatre lists	Roll out of Anaesthetic Nurse role to work alongside the theatre nurses (ongoing) Continue to advertise nursing and ODP posts. Utilisation of agency staff when required Offer paid secondment opportunities/university fees to existing employees wishing to study for the ODP degree course. Exploring ODP apprenticeship scheme (September 2019)
Paediatric Gastroenterologist	1.00 wte	Inability to provide a local paediatric gastroenterology service	Ad hoc cover arrangements during 2018. The Trust is seeking to make an appointment to a locum consultant post pending recruitment to a permanent post in partnership with Sheffield Children's Hospital (ongoing)
Consultant Haematologist	1.55 wte	Reduced capacity to meet increasing demand.	1.00 wte currently covered by a locum. Existing consultant staff covering the shortfall, however this is not sustainable.
Consultant Microbiologist	1.30 wte	Reduction in availability of microbiology services, increase in turnaround and reporting times	0.50 wte covered by York Microbiologist undertaking additional sessions Cover also being provided by Infectious Disease Consultants. Trust working with York FT on the formation of a Pathology Network and the delivery of a single laboratory service which will include Microbiologist cover
Consultant in Cellular Pathology	3.80 wte	Reduction in availability of cellular pathology services, increase in turnaround and reporting times	3.00 wte vacancies covered by locums in 2018/19. Contracts to be extended whilst substantive appointments being sought. Exploring partnership working with Leeds Teaching Hospitals. Development of flexible working with home digital reporting.
Consultant Radiologists	2.60 wte	Increased turnaround times for radiology reporting. Inability to meet increased demand. Reduction in service delivery at sub-specialty level.	3.00 wte external consultants currently employed on personal service contracts. Ongoing recruitment to vacant posts. Service considering proposals for new ways of working. Neuro-radiology imaging reporting out of hours has been outsourced since October 2018.
Consultant Clinical Oncologists	2.15 wte	Increased workload on remaining substantive posts as staff seek to maintain service delivery and cancer performance thresholds, whilst also experiencing increasing demand as a result of ageing population and introduction of new therapies.	Vacancies covered by specialty doctors acting as Locum Consultants and 1.00 wte agency. Consultant Therapy Radiographer roles being introduced to relieve pressure on the service Workforce strategy being developed. Ongoing recruitment campaigns

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Consultants in Acute Medicine	2.50 wte	Increased workload on remaining substantive posts.	3.0 wte locums in place. Ongoing recruitment campaigns.
Consultants in Elderly Medicine	2.20 wte	Increased workload on remaining substantive posts.	Vacancies are being covered by agency locums on a long term basis. Potential candidates coming available in next 10 months. Recruitment campaign under development. Two specialty doctors appointed to support the permanent medical workforce.
Consultants in Emergency Medicine	4.00 wte	Increased workload on remaining substantive posts, rostering pressures. Impacts on waiting times in the ED.	3.00 wte Locum consultants in place (also covering a shortfall in middle grade doctors) Ongoing recruitment campaign
Consultant in Neurophysiology	1.00 wte	Impacts on service delivery, waiting times	0.6 wte locum cover 0.2 wte reporting arrangements with a Consultant based in Italy. Ongoing recruitment campaign.
Consultant in Oral and Maxillofacial Surgery (Facial Deformity)	1.00 wte	Impacts on service delivery, waiting times	Interviews scheduled for February 2019.
Consultant in Intensive Care	3.00 wte	Increased workload on remaining substantive posts, reliance on premium pay agency cover	Utilisation of long term agency consultants. Recruitment campaign includes relocation package.
Consultant in ENT (Head and Neck Surgery)	1.00 wte	Post is one of two Head and Neck Surgeons. Impact is increased reliance on existing Head and Neck specialist, impacting on waiting times and access to services.	Appointment made in April 2018, however the candidate appointed is unable to start until August 2019. Vacancy currently being covered by Trust locums.
Consultant Vascular Surgeon	1.00 wte	Increased workload on remaining substantive posts. Impact on waiting times and access to services.	No appointment made following interviews in December 2018. To advertise for a locum pending a substantive appointment being made. Ongoing recruitment campaign

Financial control total and PSF, FRF and MRET funding for 2019/20

HUTH Trust Financial Control Total	£ million
Rebased baseline position excluding PSF	**-13.092 Deficit**
£1bn PSF transferred into urgent and emergency care prices	9.764
CNST net change in tariff income and contribution (1)	-1.523
Other changes (2)	1.603
Subtotal before efficiency	**-3.248 Deficit**
Additional efficiency requirement up to 0.5%	2.626
2019/20 control total (excluding PSF, FRF and MRET funding)	**-0.622 Deficit**
MRET central funding	2.077
Subtotal before PSF and FRF allocations	**1.455 Surplus**
Non recurring PSF allocation	8.973
Subtotal before FRF allocation	**10.428 Surplus**
Non recurring FRF allocation	**0.000**
2019/20 control total (including PSF, FRF and MRET funding)	**10.428 Surplus**

(1) CNST net change in tariff income and contribution
- Changes to tariff income as set out in '2019/20 Planning Prices: An Explanatory Note' and to changes in CNST contribution levels between 2018/19 and 2019/20

(2) Other changes include the impact of:
- Pricing changes in the national tariff - including changes to MFF, top ups and other price relativities
- Distributional impact of Agenda for Change cost increases relative to tariff income increase
- Impact of changes to MFF for Health Education England (HEE) tariffs
- Other changes include increases in overseas patient income, commercial income and inflationary impacts.