

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD Tuesday 10 September 2019 THE BOARDROOM, HULL ROYAL INFIRMARY 9.00AM – 12.00PM

AGENDA: MEETING TO BE HELD IN PUBLIC

Opening Matters

1	Apologies	verbal	Chair – Terry Moran
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair – Terry Moran
3	Minutes of the meeting of 23 May 2019 and 30 July 2019	attached	Chair – Terry Moran
4	Matters Arising 4.1 Action Tracker 4.2 Board Reporting Framework 2017/20 4.3 Board Development Framework 2017/19 4.4 Any other matters arising from the minutes	verbal attached verbal	Chair – Terry Moran Director of Corporate Affairs – Carla Ramsay Chair – Terry Moran
5	Chair's Opening Remarks	verbal	Chair – Terry Moran
6	Chief Executive's Briefing	attached	Chief Executive Officer – Chris Long
7	Patient Story	verbal	Chief Medical Officer – Makani Purva
8	BAF 5 – Humber Coast and Vale STP development into ICS and Trust role	attached	Director of Strategy and Planning – Jacqueline Myers
	Director Reports		
9	9.1 Quality Report 9.2 HCAI Report 9.3 Patient Experience Report	attached attached attached	Chief Nurse – Beverley Geary
10	Nurse and Midwifery Staffing Report	attached	Chief Nurse – Beverley Geary
11	Quality Committee Minutes 2019	attached	Chair of Committee – Martin Veysey
12	Performance and Finance Report	attached	Chief Operating Officer – Teresa Cope/Chief Financial Officer – Lee Bond
13	Five-year plan submission requirements	attached	Chief Financial Officer – Lee Bond/Director of Strategy and Planning Jacqueline Myers

14	Urgent and Emergency Care Business Case	attached	Teresa Cope – Chief Operating Officer/Director of Strategy and Planning – Jacqueline Myers
15	Performance and Finance Minutes	attached	Chair of Committee – Stuart Hall
16	Governance and Assurance Developing Workforce Standards	attached	Director of Workforce and OD – Simon Nearney
17	Guardian of Safe Working Report	attached	Dr Mumdzjans – Guardian of Safe Working
18	Organ Donation Team – Performance update	presentation	Organ Donation Team
19	Responsible Officer Report	attached	Chief Medical Officer – Makani Purva
20	Safeguarding Annual Reports	attached	Chief Nurse – Beverley Geary
21	Director of Infection Prevention and Control Report	to follow	DIPC – Greta Johnson
22	Standing Orders	attached	Director of Corporate Affairs – Carla Ramsay
23	Workforce Race Equality Standard 2019 submission	attached	Director of Workforce and OD – Simon Nearney
24	Workforce Disability Equality Standard 2019 submission	attached	Director of Workforce and OD – Simon Nearney
25	Staff Survey Results 2019/20 – Q1	attached	Director of Workforce and OD – Simon Nearney
26	Audit Minutes July 2019	attached	Chair of the Committee – Tracey Christmas
27	Review of Board Effectiveness	attached	Director of Corporate Affairs – Carla Ramsay
	27.1 – Board Observations	verbal	Clinical Scientist - Phillipa Burns
28	EU Exit Operational Readiness	attached	Director of Strategy and Planning – Jacqueline Myers
29	IM&T Review Report	attached	Non-Executive Director- Tony Curry
30	Any Other Business	verbal	Chair – Terry Moran
31	Any questions from members of the public	verbal	Chair – Terry Moran

**Date and time of the next meeting:
Tuesday 12 November 2019 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary**

Attendance

	2019					2020					
Name	14/5	24/5	30/7	10/9	12/11	28/1	10/3	12/5	28/5	7/7	Total
T Moran	✓	✓	✓								3/3
A Snowden	✓	✓	-								2/2
S Hall	✓	x	✓								2/3
V Walker	✓	✓	x								2/3
T Christmas	✓	✓	✓								3/3
M Gore	✓	x	✓								2/3
C Long	x	✓	✓								2/3
L Bond	✓	✓	✓								3/3
T Cope	xMK	✓	xMK								1/3
K Phillips	✓	✓	✓								3/3
M Purva	✓	x	✓								2/3
M Veysey	✓	x	✓								2/3
B Geary	✓	✓	✓								3/3
J Jomeen	✓	✓	✓								3/3
In Attendance											
T Curry	✓	✓	✓								3/3
J Myers	✓	✓	x								2/3
S Nearney	✓	x	✓								2/3
C Ramsay	✓	✓	✓								3/3
R Thompson	✓	x	✓								2/3

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

*Carla Ramsay – career break

Hull University Teaching Hospitals NHS Trust

Extraordinary Trust Board in public

**Minutes of the meeting held 23 May 2019 at 2.00 pm, Board Room,
Alderson House, Hull Royal Infirmary**

Present:

Terry Moran CB	Trust Chairman
Chris Long	Chief Executive
Tracey Christmas	Non-Executive Director/Committee Chair
Lee Bond	Chief Financial Officer
Julie Jomeen	Non-Executive Director
Teresa Cope	Chief Operating Officer
Vanessa Walker	Non-Executive Director
Beverley Geary	Chief Nurse

In attendance:

Jacqueline Myers	Director of Strategy and Planning
Tony Curry	Associate Non-Executive Director
Carla Ramsay	Director of Corporate Affairs (minutes)

1. Apologies

Apologies were received and accepted from Martin Gore, Martin Veysey, Simon Nearney, Stuart Hall, Makani Purva. The meeting had a quorum.

2. Declarations of interest

Mrs Walker noted that she had been appointed Portfolio Holder for East Riding of Yorkshire Council for Adult and Carer Services. This did not create a conflict of interest for the items on today's agenda. There were no other declarations of interest received.

3. Audited Accounts 2018/19

The draft audited accounts were presented to the meeting.

3.1 Audit Findings Report

Mr Bond presented the Audit Findings Report. The report provides a clean audit opinion.

There are two unadjusted misstatements in the accounts being recommended to the Board by the Audit Committee, as noted in the report. One relates to the calculation on depreciation; this has been debated in detail with the auditors and with the Audit Committee and the Trust is holding its position not to adjust the accounts for this change in guidance. The value put on this by the auditors is up to £2m. The second is an impairment charge that does not affect the Income and Expenditure statement of the Trust as it is a movement of reserves. The Audit Committee recommends that the Chief Finance Officer with the Audit Committee chair agree a final form of words with the auditors on this.

A third item was brought to the attention of the Board, also discussed in detail at the Audit Committee. The Trust received a donation of £3.4m, which the Trust has treated as income in the year and has contributed to the Trust achieving a surplus position. The view of the auditors is to defer it as income next year (2019-20) as it is not matched to proposed expenditure. The auditors are also checking that the receipt of the funds is legal. The Trust has stated to the auditors that Trusts can receive donated funds, quoting relevant legislation as well as the space in the accounts template to detail this; the auditors are undertaking their own due diligence on this. The Audit Committee recommends that the Audit Committee

Chair is given delegated authority to resolve this outstanding issue, which will be one further unadjusted misstatement in the accounts.

Mr Moran asked that all three of these misstatements are below the threshold for materiality; Mr Bond confirmed this is the case.

On this basis of the acceptance of the unadjusted misstatements noted above, including one adjustment to the accounts (impairment charge) and agreement of final wording on this, as well as giving delegated authority to the Audit Committee chair to complete the work on the one outstanding issue on the donation, the Trust Board approved the audited accounts as recommended by the Audit Committee.

Mr Moran noted the observation made by the auditors that larger trusts are subject to greater levels of scrutiny this year, so the position of the trust to have a clean audit opinion and value for money assessment, and going concern status, all reflect back well on the Trust.

4. Letter of Representation

Mr Bond presented this item. The letter will be updated to reflect the three points from the Audit Findings Report above. On this basis, the Audit Committee recommends this for Board approval. The Board approved the letter, with necessary amendments to be made.

5. Annual Report 2018/19

Ms Ramsay presented this report, which forms the text of the annual report, from which a publication version is produced. She confirmed it contained all necessary disclosures and there were no significant issues of internal control to draw to the Trust Board's attention. The Audit Committee recommend the Board approves the annual report; on the basis of this recommendation, the annual report 2018-19 was approved.

6. NHS Improvement Self-Assessment

Ms Ramsay presented this set of self-assessment statements, which are required of all NHS Trusts, and are spot-check audited by NHS Improvement through random sample. All Trusts are required to consider if they have adequate governance systems and systems of internal control in place to discharge the duties of the Trust. Board members approved the set of self-assessment statements as an accurate reflection of the Trust's arrangements, with no issues of non-compliance disclosed.

7. Questions from the public

None

8. Any Other Business

None

Date and time of next meeting

To be confirmed, July 2019 (being re-arranged due to Board Development)

Hull University Teaching Hospitals NHS Trust
Trust Board Meeting
Held on Tuesday 30th July 2019

Present:	Mr T Moran CB	Chairman (Chair)
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Prof M Veysey	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mrs M Kemp	Deputy Chief Operating Officer

In Attendance:	Mr T Curry	Associate Non-Executive Director
	Mr S Nearney	Director of Workforce and OD
	Ms C Ramsay	Director of Corporate Affairs
	Ms J Cairns	Head of Midwifery (Item 20 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	Apologies: Apologies were received from Mrs T Cope, Chief Operating Officer, Mrs V Walker, Non-Executive Director and Ms J Myers, Director of Strategy and Planning	
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting Mr Moran advised that from 1 August 2019 he was now Chair of SLP College. Mr Bond advised that he was now a member of the GS1 advisory Board for Scan4Safety. 2.2 To consider any conflicts of interest arising from this Agenda There were no conflicts of interest raised.	
3	Minutes of the meeting 14 May 2019 Page 6 – Item 10 – paragraph 4 – should read, “Mrs Geary had commissioned a piece of work around senior staff visibility”. Page 7 - Item 13 – paragraph 3 – should read, “Mr Moran asked if mistakes were being made by other Trusts or whether HUTH was not....” Following the above amendments the minutes were approved as an accurate record of the meeting. Minutes of the meeting 23 May 2019 The minutes had not been included in the pack and would be received at the September 2019 Trust Board meeting.	RT

4 Matters Arising

Item 14.1 – Laundry Services Contract – Mr Bond advised that a legal challenge had been received by the outgoing laundry supplier and this was being addressed.

4.1 Action Tracker

Mr Gore expressed his concern that the performance of the ENT specialty continued to deteriorate. Mr Hall advised that both the Quality Committee and the Performance and Finance Committee were reviewing this area.

Mr Nearney advised that the 'other' information was not collected as part of the Equality Objectives. Mr Moran asked that the enquiry be shared with the Equality Steering Group to determine whether steps could be taken to enable the Trust to monitor a broader range of equality measures.

SN

4.2 Board reporting framework 2017/20

Ms Ramsay presented the Board Reporting Framework to the Board. There were no changes to report.

4.3 Board development framework 2017/19

Ms Ramsay presented the framework and advised that she had included all risks in the forward programme of Board meetings. The Board discussed Integrated Care Systems and how Board members could attend more stakeholder events to become more visible and engage more in the discussions. Mr Long advised that he was attending a meeting with the York Trust along with other stakeholder leaders.

Prof Veysey had attended the NHS Providers Quality Conference and had been impressed by the work of NHS Humber FT. He added that the Quality Committee had discussed the possibility of a Board to Board with Humber to review the mental health agenda. Prof Jomeen added that there was a need to engage with partner organisations and understand their business.

Mr Moran asked that an item relating to stakeholder engagement be added to the next Non Executive meeting.

CR

5 Chair's Opening Remarks

Mr Moran stated that although there were difficulties within the Hospital he could not doubt the commitment and resourcefulness of the staff he had met and he asked the Board not to take this for granted. He thanked all staff for their hard work during such a challenge period.

6 Chief Executive's Briefing

Mr Long began by thanking staff for doing a fantastic job even though the pressures of Winter had not eased and demand was still high. He expressed his concern that some staff were at risk of 'burning out' and stressed the importance of taking care of staff. Mr Gore added that it was important that staff were taking their annual leave and also having a lunch break. Mr Long advised that annual leave was not carried over into the following year to encourage staff to take it.

Mr Long also spoke about car parking and the increasing pressure at the Castle Hill site. He reported that something radical was needed to address

the shortage of spaces for both patients and staff. Mrs Christmas asked if any of the space could be developed and Mr Long advised that the Local Authorities restrict car parking space due to environmental issues.

Prof Jomeen expressed her concern regarding staff being stretched, especially the new student nurses. She asked how they were being looked after. Mrs Geary advised that the Trust had a preceptorship programme which meant that the nurses were well supported.

Resolved:

The Board received and accepted the report.

7 Patient Story

Dr Purva relayed two negative stories one regarding a patient that had undergone procedures over a number of years but did not have a clear idea regarding future treatment and prognosis. The outcome was that the teams had worked together to provide a prognosis and this had been received by the GP who had spoken to the patient.

Dr Purva also expressed her disappointment as a patient had their surgery dates cancelled 3 times. The patient was very forgiving but Dr Purva explained the stress and worry caused by the cancellations would be difficult to overcome. The surgery for this patient had been arranged and undertaken.

There were 3 positive stories, one was a lady who had a great experience during her delivery in the labour ward, the second related to the Maxillofacial department and in particular Mr Crank and the third was Elderly Medicine where a patient was looked after on the ward after an experience in ED.

The Board discussed the complaint regarding the hospital food and how a patient had been given a corned beef sandwich. Mr Moran stated that although unacceptable the food in general was very good in the hospital and whilst visiting a ward the previous week had received only positive reports from all of the patients he chatted with.

Resolved:

The Board received and accepted the update.

8 Board Assurance Framework

Ms Ramsay presented the framework and advised that it was a summary of the last 3 months. The framework had been to the Quality, Performance and Finance and Audit Committees for review and any assurance or gaps in assurance had been updated. She added that there were no changes to the risk ratings since the last Board meeting in May 2019.

Ms Ramsay advised that a detailed discussion had been carried out regarding BAF 1 and 2 in the Performance and Finance Committee yesterday. The conclusion of the debate was to keep the risk rating of 15 but the challenge had been fair.

Resolved:

The Board received and accepted the Board Assurance Framework.

8.1 Board Assurance Risk 4

Mrs Kemp presented the report which detailed the risks to the Trust not meeting its constitutional standards. The current risk rating at quarter 1 was 16.

Mrs Kemp advised that the Trust was not meeting the operational standards in ED, RTT and some of the cancer standards. The Trust was managing to hold the 52 week waits at zero but there were risks associated with some specialties.

Mrs Kemp advised that A&E was a high risk with a challenging overall capacity position. The teams were reviewing bed modelling and flow as priorities.

RTT was also a high risk although the waiting list volume was below trajectory. She advised that there was a huge effort around validation.

Cancer performance was high risk with pathology turnarounds, access to diagnostics and late referrals being the main issues.

There were a number of actions in place to improve diagnostic performance with endoscopy accounting for 60% of all breaches. The service was beginning new working patterns from September to ease the pressure and a review of independent sector providers was also being undertaken. Prof Veysey added that pressure from other Trust's patients coming to the organisation was compounding the issue as well as doctors relocating to Leeds and Sheffield rather than Hull.

Mrs Kemp stated that in her opinion the risk rating should remain at 16 and asked the Board to support this.

Mr Moran suggested that the Board had a deep dive into the performance issues at the development session in August 2019. He added that if necessary he would speak to key partners and stakeholders to enlist their help. Mr Moran said that it was important to know what was in the Trust's gift to fix and those issues where external support was needed. Mr Moran and Ms Ramsay to discuss a deep dive session outside of the meeting.

TM/CR

Resolved:

The Committee received and accepted the report and agreed that the risk rating should remain at 16.

9 Quality Report

Mrs Geary presented the report and advised that the National Patient Safety strategy was focussing on culture, staff support and wellbeing. She advised that work had started on the gap analysis to ensure the correct processes were in place. Mrs Geary also reported that there would be a national Patient Safety Conference in September that the Trust was involved with.

Mrs Geary advised that there had been 9 hospital acquired C difficile cases and 6 community acquired cases against a threshold of 80 cases. She reported that there were no lapses in care for these patients.

There had been 1 MRSA bacteraemia and 15 cases of MSSA this year. A task and finish group had been established to review the MSSA cases.

Mrs Geary reported on the flu epidemic currently in Australia and how we could see a peak in the UK. A detailed plan for the flu vaccination had been put into place and it was agreed that as many people as possible, including carers and patient families should be vaccinated. Extra staff would be required to complete the programme and the Trust was working with the CCGs to engage with the GPs. Mr Long had written to both CCGs along these lines to seek agreement.

There was a discussion around Never Events and the issues around the 'stop the line' initiative. Dr Purva advised that there was still work to do and a task and finish group had been established which included lecturers from the University of Hull to monitor the issues and to accelerate its wider implementation across the Trust.

Mr Bond stated that of the 39 complaints closed in the last 3 months 19 had been re-opened. Mrs Geary advised that further training was being offered to managers who provided complaints responses. She reported that there was also a QIP to review re-opened complaints.

Mr Moran asked about the pseudomonas that had been reported in NICU. Mrs Geary advised that the Trust had increased its screening and this was resulting in more cases being found. All of the cases had been sent to Public Health England for checking, staff were being extra vigilant and a new cleaning agent was being used on sinks.

Resolved:

The Board received and accepted the report.

10 Nursing and Midwifery Staffing Report

Mrs Geary presented the report and advised that 'care hours per patient day' metric was showing an upward trend and a detailed risk assessment of each ward was included in the report.

Mrs Geary advised that the registered Nurse vacancies were at 10% with the Medical Health Group being the biggest risk. She reported that the risks were reviewed ward by ward and shift by shift to ensure patient and staff safety.

The Trust was currently pursuing 157 branch nurses who were due to qualify in September 2019. Interviews had also taken place for student nurse apprenticeships and 10 had been appointed. Work was ongoing with the overseas nurses to ensure they were on the programme to NMC Registration. The Trust has also launched 'once a nurse always a nurse' to call for any internationally trained nurses living in the area.

Mrs Geary stated that the reported red flags required extra nursing time and is related to the requirement for 1:1 supervision. This was being addressed through the implementation of the Enhanced Care Team and the lead nurse recruitment was under way with a planned start time in September 2019.

The Board discussed care hours per patient day and when the data could

be used. Mr Moran also asked what good looked like. Mrs Geary was unsure of the start dates and advised that the variables were a number of things such as sickness levels, skill mix and patient acuity.

Resolved:

The Board received and accepted the report.

11 Fundamental Standards

Mrs Geary reported that the overall picture was an improving one with a reduction in the red ratings. 80% of standards were either blue or green.

Mrs Geary advised that she was introducing a new standard to recognise and respond to a deteriorating patient. This would be highlighted in the next report to the Board.

Prof Veysey commended the standards and the audit process and wanted a wider group of people to be included in the process such as the doctors and other clinical and non-clinical staff. Dr Purva agreed and stated that it would also help with the division between doctors and nurses.

Mr Gore was impressed with the progress made and commended the process and the teams working within it. He stated that it gave real time ward to board assurance.

There was a discussion around the wards that were rated as amber and the issues around infection control. Mrs Geary advised that she was working with the wards and the main issue was around basic hand hygiene and doctors being bare below the elbows.

Mrs Geary advised that work was ongoing around the nutrition standard and how it was measured. She advised that this was reported regularly to the Quality Committee. Mr Moran asked that the infection control issues were also reviewed in the Quality Committee.

MV

Resolved:

The Board received and accepted the report.

12 Quality Committee Minutes April, May and June 2019

Prof Veysey presented the minutes and gave a verbal update regarding the July 2019 minutes. Prof Veysey advised that the Trust's relationship with NHS Humber FT was discussed along with the growing concerns relating to mental health provision. Mr Long advised that he was in conversation with Humber FT.

The Quality Improvement Programme had been streamlined and the projects had been reviewed and triangulated. The measurement of the projects was now in SPC charts rather than RAG ratings. Prof Veysey raised the need for an Executive sponsor for each of the QIPs to make sure that the projects were owned and the lead accountable.

He added that the GIRFT had been removed from the QIP and Dr Purva was leading on the GIRFT programme.

There had been positive feedback received from the Friends and Family

Test regarding patient experience.

The Research and Innovation Strategy had been presented to the Committee and had been links to patient experience. The PHD programme was also being rolled out and was proving positive in the organisation.

The Board discussed the Community Paediatric contract and the operating plan to ensure all children were seen by mid- August 2019.

The agenda was taken out of order at this point

20 Annual CNST Premium/Standards

Ms Cairns presented the Maternity incentive scheme which was in its 2nd year and if successful would mean a 10% reduction in the Clinical Negligence Maternity premium. She reported that work had started early to ensure robust evidence was provided for all of the 10 standards. The evidence had been successfully uploaded to NHS Resolution. Ms Cairns detailed the 10 standards and the evidence that had been submitted.

Mr Moran reminded the Board that the evidence had been provided in the report via hyperlinks. Ms Cairns advised that safety actions: 1,3,4,5 and 10 would require a formal declaration of approval recorded in the minutes of actions plans and evidence submitted.

The Board discussed Midwife staffing levels and Ms Cairns advised that the Trust was compliant with staffing levels.

Resolved:

The Board:

- Had reviewed the evidence submitted and agreed it would demonstrate achievement of the 10 maternity standards
- Gave permission for Mr Long to sign the Board declaration

The agenda returned to order at this point

13 Performance and Finance Report

Performance

Mrs Kemp presented the report to the Board. As the Board had discussed performance in item 8.1 it was agreed that the report would be received for information.

Mr Moran expressed his concern regarding the SHMI and the clear spikes in performance. Dr Purva agreed to check the figures and report any issues back to the Board and Quality Committee.

MP

Finance

Mr Bond presented the report and advised that the Trust was reporting a deficit of £1.4m which was in line with plan. This included £1.3m of SPF monies.

Income was above plan with activity up against every point of delivery. There had been issues with the Specialist Commissioners and a change in coding. This had resulted in a £0.8m provision being held for a potential

claim.

The Surgery Health Group had seen deterioration in month of £0.3m which was due to high medical staffing costs to cover junior doctor gaps.

The CRES plan was slightly above plan at the end of June 2019 but the Trust still had approximately £6m to find in the financial year.

Mr Bond advised that the Trust was still forecasting that it would deliver its financial plan.

The position assumed that the Trust received additional income to cover the costs incurred in delivering the new Community Paediatrics Service that had transferred from CHCP.

Mr Bond advised that the Trust's liquidity position was stable.

The Capital plans were currently being updated across the STP to sit within the control total set by NSHI.

Resolved:

The Board received and accepted the report.

14 Performance and Finance Minutes April, May and June 2019

Mr Hall presented the Performance and Finance minutes to the Board and verbally updated regarding the July 2019 meeting.

He advised that the consultant pension situation would now be reviewed by the Committee on a monthly basis and any issues would be escalated to the Board. Prof Jomeen also stated that the national pay award would also impact on the Trust.

He reported that endoscopy accounted for 60% of all diagnostic breaches.

Mr Gore added positive news relating to the elective activity being delivered, the waiting list was not increasing and 52 week wait performance was holding at zero breaches.

Mr Hall reported that the amount of CRES identified and deliverable was still not enough to reach the target set. Work was ongoing with the Health Groups to identify more savings.

Mr Long had written to the CCGs regarding the availability of GPs to attend the primary care streaming at the hospital. The problem was particularly bad on Mondays and Tuesdays.

Mrs Christmas asked about the financial risks associated with the transfer of Community Paediatrics. Mr Bond advised that the range of services to be supplied was being discussed along with costings.

Resolved:

The Board received and accepted the minutes.

15 Staff Survey Q4 2019/20 Results

Mr Nearney presented the Q4 staff survey and advised that less than 800

staff had responded which was disappointing. He added that there were positive outcomes in that staff recommended the Trust as a place to receive treatment and a place to work. Overall the headline figure had continued the past positive trend. Mr Nearney reported that a Board Development session had been planned after the Board meeting to review the results in more detail.

Mr Nearney reported that Elderly Medicine and Women's and Children's teams had made especially good progress and deserved particular mention.

Mr Nearney stated that he remained concerned about the lack of progress with engagement in Cardiology and Theatres.

Resolved:

The Board received and accepted the report.

16 Standing Orders

Ms Ramsay reported that EU tendering requirements had changed recently and the report set out the changes. Standing Orders had been amended accordingly and the Board were asked to approve the changes.

Resolved:

The Board received the report and approved the changes to the EU tendering requirements.

17 Audit Committee Minutes extra meeting held 23 May 2019

Mrs Christmas presented the minutes and advised that the donation item had been discussed further and now signed off.

Audit Committee Minutes 25 July 2019

Mrs Christmas verbally updated the Board and advised that the new internal auditors had been in attendance and had produced 2 audits since commencing with the Trust. The reports were comprehensive and the new auditors were working well with the Trust teams.

Resolved:

The Board received and accepted the minutes and verbal update.

18 Guardian of safe working report

Dr Purva presented the report and which highlighted the exception reports from Junior Doctors. The reports were being reviewed by the Education Supervisor who would look to address the issues.

Dr Purva reported that historically the data had not been robust and a band 4 administrators had been recruited to ensure reports were chased and were accurate. Dr Mumdzjans was to replace Dr Muthukumar as the Guardian of Safe Working.

Mr Moran highlighted cardiology as having the highest number of reports outstanding and Dr Purva advised that a large amount were from one member of staff.

The Board discussed ward rounds and how they could be carried out earlier. Dr Purva explained that some ward rounds such as surgery meant that a later start at the end of the lists would give better anticipation of the

tasks to be asked. She advised that it was not straight forward.

Resolved:

The Board received and accepted the report.

19 Learning from deaths guidance

Dr Purva presented the report which highlighted the statistics into how many deaths the Trust had seen in a quarterly period.

Dr Purva advised that the main causes of death were from pneumonia, sepsis or acute cerebrovascular disease. A minimal criteria was set nationally for undertaking structured judgement case reviews and these would be escalated to a serious incident status if appropriate. Dr Purva advised that no reviews had been escalated in the quarter.

Dr Purva advised that a learning report was presented to the Mortality and Morbidity Committee as well as the Quality Committee.

Resolved:

The Board received and accepted the report.

21 Annual Safety Report

Mrs Geary presented the report and advised that there had been 27 reportable incidents in year which was a reduction from the previous year.

The Health and Safety manager was working closely with the Security team and the Police to ensure all incidents were investigated appropriately.

Mrs Geary advised that a Task and Finish Group had been established to review access to services for patients with obesity following incidents in this area.

Mr Hall suggested cross referencing mandatory training to ensure all staff were trained in Health and Safety.

Resolved:

The Board received and accepted the report.

22 Freedom to speak up report

Ms Ramsay presented the report and advised that there were no new themes to report. Staff behaviours were still the most common theme identified. Ms Ramsay explained that her role was to listen and offer advice on what to do once a member of staff had spoken about their issue.

Ms Ramsay also spoke of the other ways in which staff could report concerns.

Mr Moran queried the concern for patient safety in a service on page 9 of the report and Ms Ramsay advised that advice had been given to the members of staff, the Executive team had been involved and actions had been addressed.

Resolved:

The Board received and accepted the report.

23 Review of Board Effectiveness

It was agreed that this item would be received at the next meeting in September 2019.

CR

24 Lung Health Check

Mrs Kemp advised that Board that a Nationally directed programme relating to checking patients that met a set criteria for lung cancer. Each patient would receive a health assessment and a CT scan to look for early signs of lung cancer. Mrs Kemp was leading the programme and mapping out the operational delivery plan.

The programme was a pilot scheme and Mrs Kemp advised that she would be working with Manchester and Liverpool Hospitals to understand their experiences.

The Board agreed that the pilot was a fantastic way to detect early signs of cancer. Prof Veysey expressed his concern regarding recruitment of clinicians, sourcing of equipment and general capacity issues. Mr Bond advised that the numbers would be small in the first instance but would need supporting if rolled out further.

Mr Nearney added that 50 members of staff would be recruited to carry out the pilot.

Resolved:

The Board received and accepted the report.

25 Any other business

Mr Moran suggested that Integrated Care Systems should feature on Board agendas on a regular basis and Mr Long agreed to include a specific section of his report to the Board in his CEO briefing.

CL

26 Any questions from members of the public

There were no questions from members of the public.

27 Date and time of the next meeting:

Tuesday 10 September 2019, 9.00am - 1.00pm, The Boardroom, HRI

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
July 2019						
	Board Development Framework	Stakeholder engagement to be added to the NED agenda	CR	September 2019		
	BAF Risk 4	Stakeholder support deep dive session to be arranged	CR/TM	September 2019		
	Performance Report	SHMI spikes to be clarified	MP	September 2019		
COMPLETED						
9 July	Review of Board Effectiveness	Report to be received by the Board	CR	September 2019		On Agenda
	Any Other Business	Integrated Care System to be included in Chris Long's briefing	CL	September 2019		Included in report
14 May	Performance and Finance Report	Mr Gore highlighted that ENT performance was deteriorating rapidly and Mr Moran asked the Quality committee to review the waiting times and how this was impacting on patient care.	MK/MV	July 2019		ENT presentation at Performance and Finance Committee
	Equality Objectives	Mr Moran asked for more clarity around item 1 and the group named as 'other'. He stated that more transparency and openness should be displayed to protect all characteristics. Mr Nearney agreed to review this and understand why only certain protected characteristics are listed.	SN	July 2019		Equality Steering Group to review

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
July 2019						
	Fundamental Standards	Infection control issues to be discussed at the Quality Committee	MV	September 2019		

Trust Board Annual Cycle of Business 2018 - 2019 - 2020			2018		2019														2020		
Focus	Item	Frequency	Jan	Mar	Apr	May	May Ext.	July	Sept	Nov	Jan	Feb	Mar	May	May Ext.	July	Sept	Nov	Jan	Mar	
Strategy and Planning	Operating Framework	annual									x								x		
	Operating plan	bi annual			x						x		x						x		
	5 Year Plan	new item																			
	Trust Strategy Refresh	annual			BD		x										x	x			
	Financial plan	annual	x	x	x					x	x	x							x	x	
	Capital Plan	annual		x								x								x	
	Performance against operating plan (IPR)	each meeting	x	x		x		x	x	x	x	x	x	x		x	x	x	x	x	
	Winter plan	annual								x								x			
	IM&T Strategy	new strategy				x															
	Research and Innovation Strategy	new strategy			BD																
	Scan4Safety Charter	new item																			
	Equality, Diversity and Inclusion Strategy	new strategy		x																	
	Digital Exemplar	new item																			
	People Strategy	Refresh Strategy									BD			x							
	Strategy Assurance	Trust Strategy Implementation Update	annual				x												x		
People Strategy inc OD		annual							x									x			
Estates Strategy inc. sustainability and backlog maintenance		annual				BD				BD									x		
Research and Innovation Strategy		annual							x									x			
Assurance Against Equalities Objectives		annual												x							
Quality	IM&T Strategy	annual												x							
	Patient story	each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
	Quality Report	each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
	Nurse staffing	monthly	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
	Fundamental Standards (Nursing)	quarterly		x				x	x		x					x			x		
	Quality Accounts	bi-annual				x				x				x				x			
	National Patient survey	annual		x										x							
	Other patient surveys	annual												x							
	National Staff survey	annual		x									x			x	x			x	
	Quality Improvement Plan (inc. Quality Accounts and CQC actions)	quarterly				x							x					x			
Regulatory	Safeguarding annual reports	annual							x									x			
	Annual accounts	annual					x								x						
	Annual report	annual					x								x						
	DIPC Annual Report	annual							x									x			
	Responsible Officer Report	annual							x									x			
	Guardian of Safe Working Report	quarterly		x				x		x	x					x			x		
	Statement of elimination of mixed sex accommodation	annual				x								x							
	Audit letter	annual					x								x						
	Learning from Deaths Guidance	quarterly	x			x				x			x			x		x		x	
	Workforce Race Equality Standards	annual							x				x					x			
	Workforce Disability Equality Standards	annual																x			
	Modern Slavery	annual				x								x							
	Emergency Preparedness Statement of Assurance	annual							x							x					
	Annual CNST premium/maternity standards	annual																x			
	Information Governance Update (new item Jan 18)	bi-annual	x		BD			x						x		x				x	
	Corporate	H&S Annual report	annual						x								x				
		Chairman's report	each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x
Chief Executive's report		each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
Board Committee reports		each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
Cultural Transformation		bi annual				x		x								x				x	
Self Certification and Statement		annual					x									x					
Standing Orders		as required	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
Board Reporting Framework		monthly	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
Board Development Framework		monthly	x	x		x		x	x	x	x		x	x		x	x	x	x	x	
Board calendar of meetings		annual							x												
Board Assurance Framework		quarterly				x			x	x	x			x		x		x	x	x	
Review of directors' interests		annual				x								x							
Gender Pay Gap		annual		x									x							x	
Fit and Proper person		annual				x								x							
Freedom to Speak up Report		quarterly				x				x			x			x		x	x		
Going concern review		annual					x									x					
Seven Day Working Assurance Framework		New item										x		x						x	
Preparation for EU Exit		New item											x								
Developing Workforce Safeguards		bi-annual																x		x	
Review of Board & Committee effectiveness		annual				x												x			

**Hull University Teaching Hospitals NHS Trust
Board Development Programme 2017-20**

Overarching aims:

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

[illegible]

17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy					
		Area 1 and BAF 1: Draft 2018-19 BAF							
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents							Area 2 and BAF 7.1: Tower Block strategy
		Area 1 and BAF 1: Draft 2018-19 BAF							
18/07/2018 - at EMC	Area 2 and BAF 6 & 7.2: Strategy refresh - clinical strategy								
31 July 2018				Area 4 and BAF 3: Deep Dive - Never Events					Area 1 and BAF 7.1: Financial strategy including STP and ICO
				Area 3 and BAF 3 & 4: Elective Care e-Learning RTT					
25 September 2018		Area 1 and BAF 1: What does the Board spend its time on?		Area 1 and BAF 3: Journey to Outstanding					
27 November 2018			Area 1 and BAF 2: People Strategy Refresh	Area 4 and BAF 4: Estates/Tower Block strategy					
29 January 2019			Area 4 and BAF 4: Emergency Department Interim Arrangements						
26 March 2019		Area 1 and BAF 1: 2019-20 BAF							
		Area 1 and BAF 4: Trust Board and organisational improvement capacity and capability							
8-9 July 2019		Area 1 and BAF 1: Two days' time out with Martin Johnson							
30-Jul-19			Area 4 and BAF 1: Staff Survey (Board Minutes)						BAF 7.2 and Area 2: Trust long-term finance plan (including productivity and efficiency opportunity)
12-Aug-19				Area 1 and BAF 3: CQC and journey to outstanding	Area 2 and BAF 4: performance				
				Area 1 and BAF 3 - McKinsey insights (TBC)					
24-Sep-19			Area 1 and BAF 2: cyber security training (via NHSI) - mandated board training (90 minutes)	Area 1 and BAF 3: CQC and journey to outstanding	Area 2 and BAF 4: Same Day Emergency Care standards		Area 3 and BAF 5: Partnership working/ICS development and stock-take		Area 1 and BAF 7.2 - Long-term plan development

							Area 1 and BAF 5: Brexit regional planning		
26-Nov-19	Strategic drivers/balanced scorecare review	Area 1 and BAF 1: Trust Board and cultural development						Area 2 and BAF 6: Research and Innovation strategy and developments	Area 2 and BAF 7.3: Tower Block/infrastructure update
28-Jan-20	Operational and financial planning 2021 onwards								
									Area 2 and BAF 7.3 Long term buildings plan
24-Mar-20									

Other topics to consider:
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and Integrated Services	Research and Innovation	Financial Sustainability
	BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation What could prevent the Trust from achieving this goal? Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage	BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	BAF 3: Principal risk: There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating What could prevent the Trust from achieving this goal? That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy	BAF 4: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to	BAF 5: Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 6:Principal risk: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas. What could prevent the Trust from achieving this goal? Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Increased competition for research funding What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP	BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit BAF 7.2 Principal risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year What could prevent the Trust from achieving this goal? Lack of achievement of sufficient recurrent CRES Failure by Health Groups and corporate services to work within their budgets

Risk that some staff do not acknowledge their role in valuing their colleagues
Risk that some staff or putting patient safety first

Failure to put in place 2-3 credible year plan to address the underlying deficit position
BAF 7.3 Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

What could prevent the Trust from achieving this goal?

Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality

Principles for the Board Development Framework 2017 onwards

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

Overarching aim:

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

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?
- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?
- How can we build further resilience, trust and honesty into our relationships?
- Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?



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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

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

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	STP update, helipad opens for testing, car parking engagement sessions are underway	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 10 September 2019

1. Key messages from July and August 2019

Humber, Coast and Vale Health and Care Partnership (HCAV HCP, our Sustainability and Transformation Partnership or STP)

The partnership has been successful in gaining a place on the Integrated Care System (ICS) Accelerator Programme. This 15 week programme, aimed at helping STPs fulfil the criteria to become ICSs will commence this month. At the end of the programme, the regulator will take stock and determine whether we have made sufficient progress to be designated as an ICS from 1 April 2020. There are requirements in terms of governance, risk sharing, planning, finance and performance.

The next phase of the Humber Acute Services Review has commenced, with 3 streams of work: Maternity and Paediatrics, Urgent and Emergency Care and Planned Care. Deloitte have been retained to support this phase of the review. The first set of workshops occurred between 23 August and 6 September. The review is designed to agree future models of care, that improve the quality and sustainability of services. It is expected to have a set of options to recommend for consultation by the end of the calendar year.

STPs are required to agree and submit a long term plan, in response to the NHS England Long Term Plan, published in January 2019. First drafts are due in September 2019 and final agreed plans in November 2019. Much of the planning is being devolved to the sub-systems and we are working with partners across Hull and East Riding to agree our ambitions and align our plans.

We have agreed with Northern Lincolnshire and Goole Foundation NHS Trust, to create a Joint Cancer Delivery Board, to work closely together on diagnostic and treatment pathways and the configuration and function of our cancer multi-disciplinary teams. This work will complement the wider remit of the Humber, Coast and Vale Cancer Alliance, which is working to prevent cancer, increase awareness of signs and symptoms and support people living with and beyond cancer, as well as on some specific projects to increase diagnostic capacity.

A review of the commissioning arrangements in the Partnership has been commenced. This is due to report to the next meeting of the Partnership Executive.

First flight touches down on hospital's new £500,000 helipad

The first helicopter to land on a new £500,000 helipad in Hull touched down on Friday 2nd August.

A five person crew from Lincs & Notts Air Ambulance was the first to fly in and step foot on the newly completed helipad to the rear of Hull Royal Infirmary.

The helipad, situated behind Hull Royal Infirmary's Emergency Department, has been funded entirely by the HELP Appeal.

Test flights will continue over the next few weeks until all 15 agencies who regularly fly patients in to Hull Royal Infirmary, including Yorkshire Air Ambulance, the Search & Rescue helicopter, and the Embrace children's air ambulance have all completed at least one landing.

Queen's Centre awarded Macmillan Quality Environment Mark

The Queen's Centre at Castle Hill Hospital has been awarded the Macmillan Quality Environment Mark (MQEM). Created by Macmillan Cancer Support, the MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

This is the third time that the Queen's Centre for Oncology and Haematology has been successful in receiving this award, having already achieved the required standards in 2013 and 2016.

In meeting Level 5 MQEM standards, Queen's Centre has demonstrated to users of its environment that it is:

- welcoming and accessible to all
- respectful of people's privacy and dignity
- supportive to users' comfort and well-being
- giving choice and control to people using your service
- listening to the voice of the user.

Hull is one of three acute hospital trusts within the Humber, Coast and Vale region (Hull University Teaching Hospital, York Teaching Hospital and Northern Lincolnshire and Goole NHS Foundation Trust) to have been awarded the MQEM award since the scheme began back in 2010.

Two apprentices helping patients with epilepsy become first to qualify with degrees

Two members of the neurophysiology team have become the first apprentices at Hull University Teaching Hospitals NHS Trust to qualify with degrees.

Beth Walker and Mike Duke achieved first-class honours health care science practitioner apprenticeship degrees after completing their courses at the University of the West of England in Bristol. They completed the year of their Level 2 apprenticeship and then started the second year of their degree course, travelling to Bristol for a week each semester and taking part in online lectures and Skype classes with their lecturers while putting their skills into practice.

Their job mainly entails working with patients with neurophysiology conditions such as epilepsy and they conduct diagnostic tests including EEGs.

Many congratulations to Beth and Mike.

Car parking staff engagement

Staff engagement sessions are underway in an attempt to address car parking issues at both main hospital sites. Ten events are being held to ask staff for their views on parking and how we can improve the provision of parking for the workforce.

Five options have been tabled to generate a discussion with attendees and an online survey has also been launched asking for staff to send in their ideas. To date, 1,000 staff have completed the survey.

Following the engagement sessions the main themes will be fed back to staff via corporate communications and for discussion at the JNCC and LNC meetings.

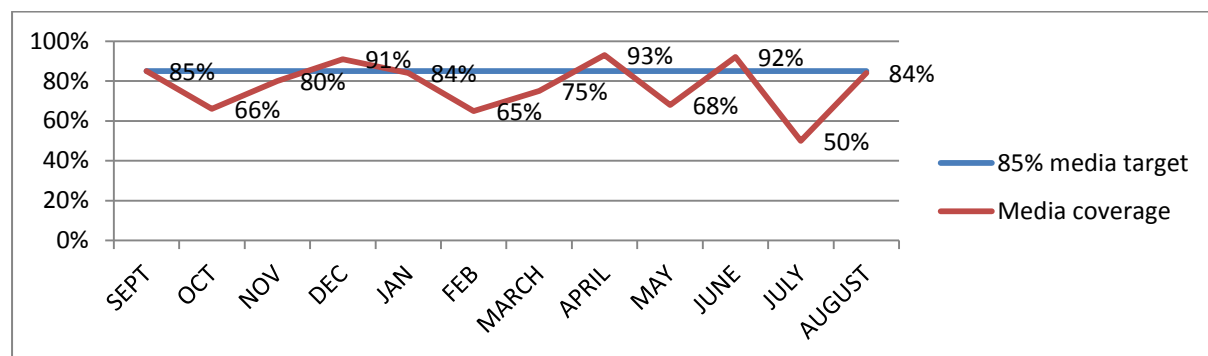
2. Media Coverage

The Communications team issued 11 news releases in July and August 2019.

In July 50% of our media coverage was positive and in August 84% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been met or exceeded in eight months out of the last 12.

July's news coverage was adversely affected by a family complaint that their baby had not received adequate treatment for a feeding problem, as well as a story about an autistic boy who had a negative experience in the Emergency Department. The trust received national coverage for a story about the poor quality of a sandwich served to a patient.

The trust received significant positive coverage for the first test landings at the new HRI helipad,



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

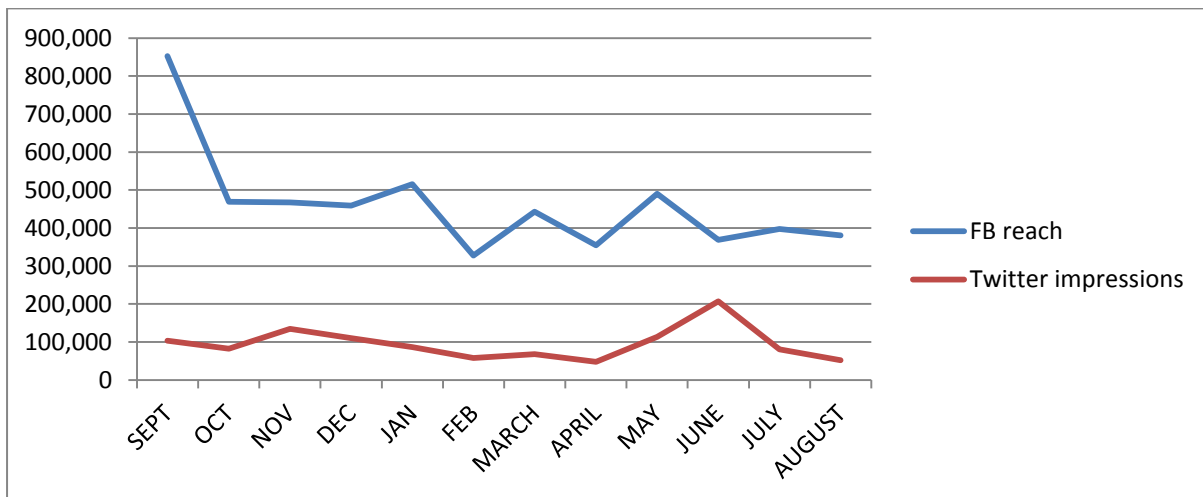
- In July total “reach” for all posts on trust Facebook pages was 397,522
- In August total “reach” for all posts on trust Facebook pages was 380,627

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

- @HEYNHS Twitter account impressions 81,100 (July)
- @HEYNHS Twitter account impressions 52,300 (August)

Twitter has seen a significant surge in impressions over the last two months. This was largely thanks to the Golden Hearts Awards coverage and to the live tweeting from the Sepsis Congress.

Social media reach and impressions September 2018-August 2019



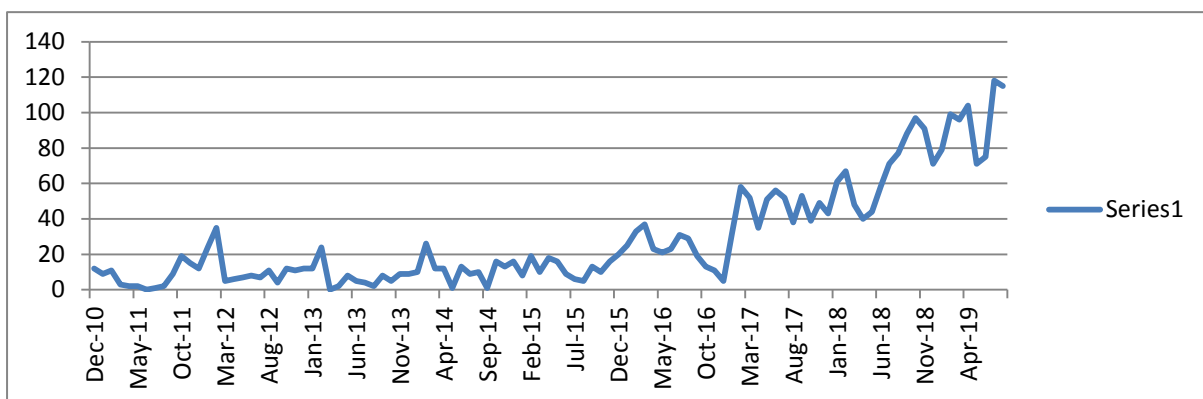
3. Moments of Magic

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

In July and August 2019 we received 118 and 115 Moments of Magic nominations, respectively.

[Please visit the intranet to read the most recent nominations.](#)

Number of Moments of Magic submitted by month 2010-2019



LONG TERM GOALS - July 2019 data

Great Staff

Great Care

Great Future

Quality

RAG	Indicator	Target	Performance July	Trend v Previous Month
R	Never Events	0	1	↓
R	Complaints (QIP - closed within 40 working days)	90%	58.50%	↓
G	Healthcare Associated Infections - MRSA	0	0	↓
G	Healthcare Associated Infections - C.Diff (YTD target)	80	11	-
R	Safety Thermometer - Harm Free Care	95%	94.04%	↑
R	Venous Thromboembolism (VTE) Risk Assessment (Q1 1920)	95%	92.68%	↓
R	Mortality - HSMR (May 2019)	<100	92.1	↑
G	Friends & Family Test - Inpatients (June 19 - Trust v National %)	95.71%	97.97%	↓
R	Friends & Family Test - Emergency Department (June 19 - Trust v National %)	85.65%	83.53%	↑

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

Workforce

RAG	Indicator	Target	Performance July	Trend v Previous Month
G	Staff Retention/Turnover	<9.3%	8.90%	↓
G	Staff Sickness	<3.9%	3.55%	↑
R	Staff Vacancies	<5.0%	6.60%	↓
R	Staff WTE in post (<0.5% from Plan)	7514	7464	↑
R	Staff Appraisals - AFC Staff	85%	82.20%	↓
G	Staff Appraisals - Consultant and SAS Doctors	90%	91.80%	↓
G	Statutory/Mandatory Training	85%	91.20%	↓
G	Temporary Staff/Bank/Overtime costs (Medical YTD)	£4.95m	£4.58m	-
G	Staff: Friends & Family Test - Place of Work (Q4 1819 v National)	65%	73%	↑
G	Staff: Friends & Family Test - Place of Care (Q4 1819 v National)	80%	86%	↑

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance July	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	79.60%	75.18%	↓
G	52 Week Referral To Treatment Breaches	0	0	0	→
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	9.05%	↑
R	Emergency Department: 4 Hour Wait Standard	95%	90.0%	74.45%	↓
R	Cancer: ADJUSTED 62 Days Referral To Treatment (June Data)	85%	73.20%	63.90%	↓
G	Length of Stay (June Data)	<5.2	-	4.9	↑
R	Clearance Times	12 weeks	-	17.3	↑
R	Waiting List Size	52,800	52,933	53,521	↑
G	Available Clinic Slot Utilisation	80%	-	92.80%	↓
R	Theatre Utilisation	90%	-	84.00%	↓
R	Appointment Slot Issues	35% (TBC)	-	54.30%	↑

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

Finance

RAG	Indicator	Target	Performance July	Trend v Previous Month
R	Capital Expenditure	2.7m	3.4m	↑
G	Statement of Comprehensive Income Plan - Year to Date	-2.869m	-2.869m	-
G	CRES Achievement Against Plan	£3.349m	£3.512m	-
R	Invoices paid within target - Non NHS	95%	90.7%	↑
R	Invoices paid within target - NHS	95%	82.3%	↓
A	Risk Rating	1	3	↑

Category	No. of Risks Rated 15 and above
Corporate Non-Clinical Risks	1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

DATE 10 September 2019

Title:	Achievement of the Trust's Long Term Goal: Partnership and Integration	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this report is to apprise the Board of the key issues in relation to BAF risk 5; actions that have been taken to date to mitigate this risk and further work planned.	
BAF Risk:	GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES – Humber, Coast and Vale Health and Care Partnership	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	
Key Summary of Issues:	- This risk is a system risk; the Trust as a key system partner can take a wide range of actions to partially mitigate it. - The HCAV HCP is working towards becoming an ICS; this is subject to arrange of conditions, including delivery of financial plans and performance trajectories - The Trust is going to take action to strengthen its impact as a partner	
Recommendation :	- That the risk score for Goal 5, partnership and integration, remains 12 (likelihood 3 x impact 4 = 12), - That a further review of the management of this risk be scheduled for March 2020. - That the actions that have been taken to manage this risk are added to the BAF. - That Trust Board notes the contents of the paper and indicates any areas where further action or assurance is sought.	

1 Purpose

The purpose of this report is to apprise the Board of the key issues in relation to BAF risk 5: That the Humber, Coast and Vale Health and Care Partnership (HCAV HCP) does not develop and deliver credible and effective plans to improve the health and care for its population and meet the expectations of the NHS Long Term Plan. In particular the expectations in relation to integration and transformation of care for our patients rely on effective partnership working.

This report also reviews progress in managing this risk to delivery of our long term goal of 'partnership and integration' and makes a recommendation for the Q3 and 4 2019/20 risk rating.

2 Background to the risk

The HCAV HCP was formed in 2016, 1 of 44 sustainability and transformation partnerships (STPs) created to cover the population of England. STPs were created as vehicles to drive the collaborative working across health and social care organisations in pursuit of the health improvement aims set out in the NHS Five Year Forward View, published in 2014.

The HCAV HCP covers the populations of the Vale of York, Scarborough and Ryedale, Hull, East Riding and North and North East Lincolnshire, around 1.4 million people. It incorporates many NHS organisations, including 3 acute hospital trusts, 3 mental health trusts, a wide range of community healthcare providers, 2 ambulance trusts, 6 local authorities, 6 providers of child and adult social care and as of May 2019, almost 30 primary care networks.

The goals for healthcare in England in the next 10 years were elucidated in the NHS Long Term Plan, published earlier this year. This plan cements some key expectations that only increase the need for organisations to plan and deliver services in cooperation: that care outside hospital settings will be the key focus for investment and that 'system' performance will be the measure of success. In addition, it is clear that despite any definite commitment to legislative change to facilitate system working, the regulators plan to increasingly manage their relationships with individual organisations via the medium of the STP. Access to national programmes of investment is also being mediated by STPs.

The NHS Long Term Plan set out a requirement for all STPs to become Integrated Care Systems (ICSs) by April 2021. STPs are assessed against a 'system maturity matrix', which has 5 domains, each assessment against 4 stages of maturity: emerging, developing, maturing and thriving. The 5 domains are:

- Leadership, partnerships and change capability
- Architecture and strong financial management and planning

- Integrated care models
- Track record of delivery
- Coherent and defined population

To become an ICS, STPs have to be assessed as 'maturing' within these 5 domains. With ICS status brings a regulatory framework that devolves functions and resources previously reserved to NHS England and Improvement down to the STP team.

The HCAV HCP's programme of work and the governance structure in place to support it is multifaceted and extensive (see fig 1 below).

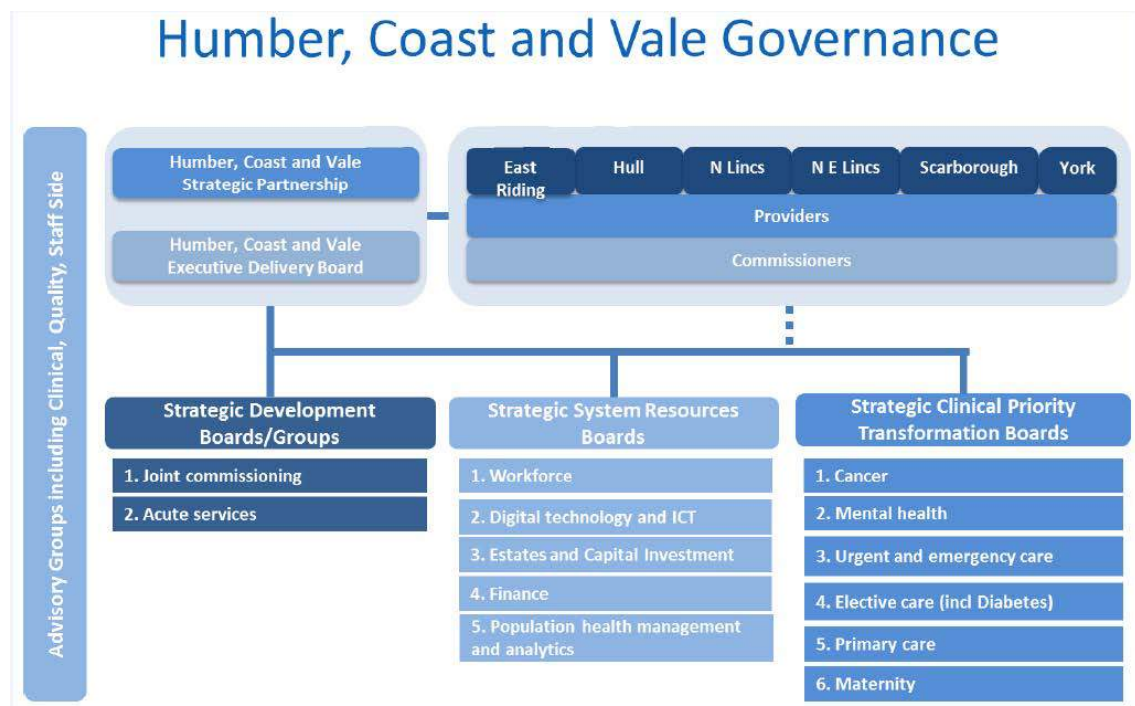


Figure 1

The Trust has a key role to play in many of the programmes of work, making the demands upon us as a partner wide ranging and challenging to meet. In summary, the programmes where we have the greatest role to play are:

- In the Hull and East Riding 'Place' programmes
- In the Acute Services Reviews (particularly the Humber Acute Service Review, but to a lesser extent the also the Scarborough Review)
- In the Cancer, Urgent and Emergency Care, Elective Care and Maternity Clinical Priority Programmes

We also need to support the cross cutting strategic programmes for Workforce, Digital, Estates and Capital and Finance.

3 Appraisal of the risk

This risk is, by its very nature, a difficult one for the Trust to mitigate, requiring successful working relationships and new models of care to be forged not just between the Trust and its many partners, but also by other partnerships within the HCP where the Trust is not a direct participant.

As the largest acute trust and only tertiary centre in Humber, Coast and Vale, the Trust is certainly a key player in many areas of the HCP and has resources and expertise at its disposal that can be leveraged for the benefit of the wider system. There are positive steps the Trust can take to mitigate this risk, albeit not entirely.

4 Actions taken to date to mitigate the risk

As previously reported, the Trust has taken on a wide range of leadership roles within the HCP, to support its development as a functioning partnership. The Trust Chief Finance Officer is the HCP's Finance Lead, the Trust CEO is the Digital Lead and Trust Execs lead two of the four Cancer Alliance Programmes and key elements of the Workforce Programme.

The HCP has been accepted into the ICS Accelerator Programme. This 15 week programme, which commences this month, will support the HCP to address the requirements of the system maturity matrix, with a view to achieving ICS status in March 2020. This process will likely be successful in ensuring our partnership has all of the expected leadership, governance, planning and performance management arrangements. It is therefore anticipated that achievement of ICS status will hang on the delivery of the 2019/20 financial plans and performance trajectories.

The Trust is an active participant in the Hull and East Riding Place Boards. We have established a provider collaborative across Hull and East Riding as it was felt that the place Boards were not addressing the integration of care delivery across primary, community and secondary care. With the creation of the Primary Care Networks, it has also become important to build relationships with these organisations. This has now been developed further with a formal CEO Board and a quarterly clinical meeting with a work programme to improve services for frail, older people, the provision of community paediatrics and diversionary pathways away from ED.

The Humber Acute Service Review has launched a wide ranging review of services models, sub-dividing the work into three areas of focus:

- Maternity and Paediatrics
- Urgent and Emergency Care
- Planned Care – priority specialties being ENT, Ophthalmology, Urology,

Orthopaedics, General Surgery and Gastro.

This stage of the review is being supported by Deloitte, and is due to make recommendations in relation to options for future service models, by the end of the calendar year. The Trust is working closely with colleagues from Northern Lincolnshire and Goole Foundation NHS Trust on this work, with Clinical Leads agreed from each Trust, for each workstream.

A further agreed development is the creation of a Humber Cancer Delivery Board, to support redesign of diagnosis and treatment pathways across the Humber and review the multi-disciplinary team arrangements. This Board will be chaired by the Trust's CEO. The first meeting is planned for October 2019.

Further work planned

Reflecting on the last 3 years of partnership working, it would be fair to state that the agreement and delivery of new care models has been limited and progress remains slow. This situation is not unique to the HCAV HCP; indeed it is the experience of many systems; however some have been working together for much longer periods and have had the benefit of stable leadership teams during that time.

It is clear from dialogue with leaders from across the Trust, that there is a wide range of views on both the purpose and efficacy of partnership working in general and the range of current initiatives in particular. In order to address this and by doing so improve the impact of the Trust's contribution to the system programme of work, the following actions will be taken during 2019/20:

- A Stakeholder Survey will be commissioned, with a view to acquiring actionable intelligence on how we are perceived as partners
- We will develop our working relationships with the Primary Care Networks, assigning a lead senior relationship manager to each and co-ordinating Trust offers of support.
- We will provide training to our senior clinical and operational managers on our goals as partners, expectations and permissions, building on the results of the planned survey.

In relation to the Hull and East Riding sub-system, the Trust will continue to work with partners in this patch to plan and deliver a programme of service redesign aimed at strengthening the community services and support networks available to support frail elderly people and those with long term conditions. Learning from the work to date in this area, it is clear that there are a some critical success factors:

- That the work has clinical leadership and support from the GPs, the community and the hospital team

- That the work is supported by strong and effective programme management arrangements
- That the pathways are supported by digital solutions that enable information sharing across teams

The Trust will work with partners across Hull and East Riding to ensure these arrangements are in place.

Lastly, by November 2019, the HCP will have agreed its Five Year System plan. This is largely being developed within the six 'places'. The Trust is working with its CCG partners to ensure the elements of the NHS Long Term Plan that pertain to acute services are addressed (see separate Board paper for more detail).

56 Recommendations

1. That the risk score for Goal 5, partnership and integration, remains 12 (likelihood 3 x impact 4 = 12),
2. That a further review of the management of this risk be scheduled for March 2020.
3. That the actions that have been taken to manage this risk are added to the BAF.
4. That Trust Board notes the contents of the paper and indicates any areas where further action or assurance is sought.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Board of Directors September 2019

Title:	QUALITY REPORT September 2019
Responsible Directors:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	Beverley Geary, Executive Chief Nurse

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

Recommendation	The Trust Board is requested to receive this report and: • Accept the report for information • Decide if any further information and/or actions are required

QUALITY REPORT

August 2019

EXECUTIVE SUMMARY

Information is provided in the report on the following topics:

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Care Quality Commission
- Learning from Deaths
- Reporting to NHS Early Notification Scheme

The information to board on infection prevention and patient experience is reported in separate board reports.

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

QUALITY REPORT

September 2019

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Care Quality Commission
- Learning from Deaths
- Reporting to NHS Early Notification Scheme

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

The Trust Board is requested to receive this report and:

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

This report covers the reporting period July and August 2019, where possible. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE)

To date 19/20 there have been five Never Events declared.

SI 2019/10523 – Retained foreign object of a swab, declared 13 May 2019

SI 2019/12801 - An incorrect wisdom tooth was removed from a patient, declared 10 June 2019

SI 2019/12800 - This relates to a mis-placed NG tube which the patient was fed through, declared 10 June 2019

SI 2019/15108 – Unintentional connection of a patient requiring oxygen to an air flowmeter

SI 2019/18796 – Wrong site surgery performed on a patient declared 27 August 2019

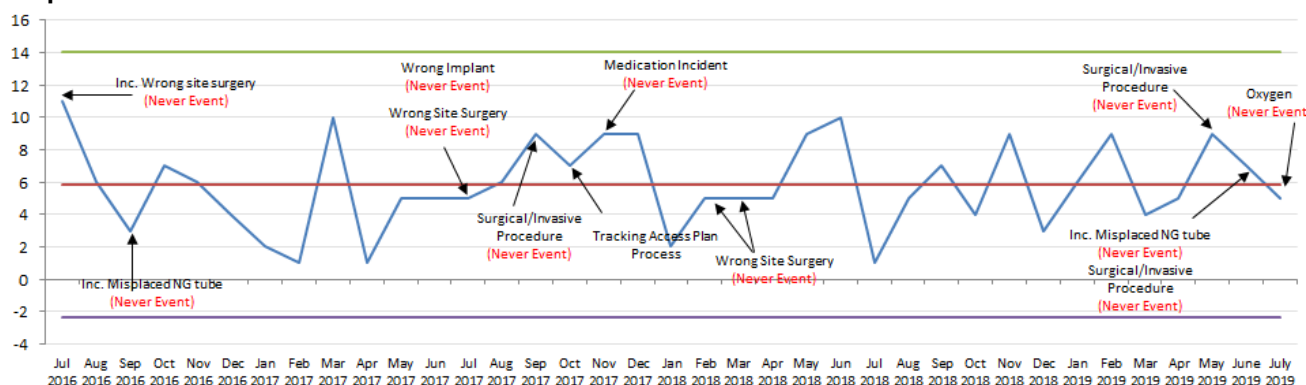
The investigations have completed in August 2019 for two of the Never Events, 10523 and 12801. Both events occurred within the Maxillofacial Department, and the Chief Medical office chaired both investigations, used a simulation on both investigations, and invited a patient representative and non-executive director to be part of the panel. The findings will be reported in full to the September Quality Committee.

The Trust is now in the process of implementing a Safety Improvement Plan to provide strategic direction to ensure a renewed focus on patient safety at all levels of the organisation. This has begun with the appointment of a Patient Safety Project Manager for a secondment of six months to work across the Governance, HIP and Organisational Development Departments.

2.2 Serious Incidents reporting rates

To date in 2019/20 the Trust has reported 27 Serious Incidents. See Section 2.3 below for details of Serious Incidents reported during July and August 2019.

Graph 1: Serious Incident SPC chart



2.3 Serious Incidents declared in July and August 2019

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

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

A summary of the incidents declared during July 2019 is contained in the following tables and each of these is now under investigation. There have been no serious incidents declared in August 2019. Anything of significance will be reported to the Quality Committee in due course and anything of undue concern will be escalated to the Trust Board, as required.

Table 3: Serious Incidents declared July 2019

Ref Number	Type of SI	Health Group
14406	Hospital acquired pressure ulcer	Medicine
14412	Medication Incident - patient was placed on air driven nebuliser when they should have been placed on oxygen	Emergency Medicine
14417	Medical Device Incident relating to infant with IV cannula	Family & Women's
14933	Sub-optimal care of a deteriorating patient – an oncology patient did not receive timely care	Clinical Support
15108	Never Event: Unintentional Connection of a patient requiring oxygen to an air flowmeter	Emergency Medicine

3. SAFETY THERMOMETER – HARM FREE CARE

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

The NHS Safety Thermometer point prevalence audit results for July 2019 and August 2019 are attached as Appendix One. In August four wards did not submit data (H7, H36, H80, C33). From the 831 in-patients surveyed on Friday 9th August 2019, the results are, as follows:

- **95%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.56% [n=13]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98.44%**. This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 831 patients, 53 did not require a VTE risk assessment. Of the remainder, 731/778 had a VTE risk assessment undertaken. This is **93.9%** compliance on the day. VTE incidence on the day of audit was **6** patients; **4** of which were with a pulmonary embolism and **2** was with a deep vein thrombosis.
- There were **3** new pressure ulcers on the census day, 2 of which were Cat 2 and 1 Cat 3. However, 27 patients had pre-hospital admission pressure ulcers (18 at Cat 2, 4 at Cat 3 and 5 at Cat 4).
- There were **9** patient falls recorded within three days of the audit day. Of these, 8 resulted in no harm to the patient and 1 with low harm.
- Patients with a catheter and a urinary tract infection were low in number at **6/159** patients with a catheter (**3.7%**). Of the **6** patients with infections, **3** of these were infections that occurred whilst the patient was in hospital.

Overall, performance with the Safety Thermometer remains positive, but continues to be reviewed monthly. Each ward receives its own results and feedback and ward sisters/charge nurses develop actions to address these.

The Safety thermometer information is attached at appendix 1.

4. OTHER QUALITY UPDATES

4.1 Care Quality Commission (CQC)

The CQC continues to interact with the Trust on a regular basis. General information requests continue to be received on, for example, completed Serious Incidents, staffing levels and complaints. The latest quarterly engagement meeting between the CQC and the Trust also took place on the 31 July 2019 via a teleconference attended by the Trust Inspector from the CQC along with the Chief Nurse, Chief Medical Officer and Acting Deputy Director of Quality Governance from Hull University Teaching Hospitals NHS Trust (HUTH). This was a positive and informative meeting with no concerns raised by either parties. The CQC confirmed that changes were being made in provision of Inspectors and Inspection Managers across the organisation. Changes may or may not be made to team members linked to HUTH. A letter will be sent to HUTH Chief Executive confirming any changes in August 2019. Planned changes will then commence in September 2019.

At the present time, the CQC have not informed the Trust of any further focus groups or planned inspections. The CQC have attended the Operational Quality Committee and the Trust Board to observe practice, no feedback for action has been received. They also requested to visit the Emergency Department on 31 July 2019; however this is to be re-arranged on request from the CQC.

4.2 Learning from Deaths

The Royal College of Surgeons has developed a "Good Practice Guide", which is a document intended to serve as a practical guide for setting up, running and participating in high quality Mortality and Morbidity (M&M) meetings. This guide can be adapted to suit specific Specialties but ensures that the ethos of learning remain standardised throughout different M&M meetings.

Mortality and Morbidity meetings play an essential role in learning from not only death, but also patient morbidity. Advance preparation and effective organisation is essential for ensuring that the time invested in M&M meetings is productive and leads to quality learning. If meetings are ran inefficiently, participants can become disengaged from the process and are less likely to attend consistently and engage in discussions.

It has been identified that while speciality level M&M meetings are established and being held regularly they are not standardised across the Trust. The Trust is therefore to trial the Good Practice Guide within a Surgery Health Group speciality M&M, allowing for any refinements to be made before roll-out to all M&M meetings across the Trust. This is expected to then support the delivery of standardised, high quality M&M discussions across the Trust.

4.3 Reporting to NHS Early Notification Scheme

During July and August one case has been referred to the NHS Resolution as part of the Early Notification Scheme. However, this case has not been confirmed as accepted, and further information is awaited, as the baby was transferred to Sheffield Teaching Hospitals. A decision will be reported within the next report. Brief outline of details are

Mother with known drug and alcohol abuse, non-concordant with antenatal care, admitted in labour with thick meconium at 38+2 weeks. The baby was known to have numerous congenital abnormalities and was born in poor condition with no respiratory effort, pale and floppy and was admitted to NICU for active cooling due to seizures, HIE grade 2 and moderate neonatal encephalopathy. Baby was transferred to Sheffield Teaching Hospitals due to neonatal capacity. No deficiencies in care identified. The case is being investigated by the Healthcare Safety Investigation Branch and has been accepted by the Each Baby Counts project.

5. RECOMMENDATION

The Board is requested to receive this report and:

- Accept the report for information and assurance
- Request any further information for assurance and any other actions that are required to provide assurance regarding the quality of care to patients.

Beverley Geary
Chief Nurse

Makani Purva
Chief Medical Officer

September 2019

Appendix One: Safety Thermometer

SAFETY THERMOMETER NEWSLETTER August 2019



= Harmfreecare

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 9th August on both hospital sites. 831 patients were surveyed

95% of our patients received HARM FREE CARE

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

1.56% (13) of our patients suffered a New Harm

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

98.44% Of our Patients received NO NEW HARM

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

HARM FREE CARE %: How is HEY performing March 19 – August 2019

	Mar 19	April 19	May 18	June 19	July 19	Aug 19
Harm Free Care %	93.7%	93.7%	93.8%	93.4%	93.8%	95%
Sample: Number of patients	891	932	865	882	873	831
Total Number of New Harm	12	17	16	19	16	13
NEW HARM FREE CARE %	98.6%	98.1%	98.5%	97.9%	98%	98.4%

Harm Descriptor: Venous Thromboembolism

	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosis	OTHER
Total Number/Proportion of patients treated for a NEW VTE A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients were admitted with a primary diagnosis of pulmonary embolism	6	0.72%	4	2	0
Total Number/Proportion of patients documented with a VTE RISK ASSESSMENT not applicable		53	6.38%	% once not applicable patients removed	
Total Number/Proportion of patients documented with a VTE RISK ASSESSMENT		731	87.97%	93.9%	
Total Number/Proportion of patients with NO documented VTE RISK ASSESSMENT		47	5.66%	6.1%	

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of Pressure Ulcers	30	3.61%	20	5	5
Total Number/Proportion of OLD Pressure Ulcers An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	27	3.25%	18	4	5
Total Number/Proportion of Pressure Ulcers that were classed as NEW A NEW pressure ulcer is defined as developing 72 hours since admission.	3	0.36%	2	1	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a Fall (During the last 3 days whilst an inpatient)	9	1.08%
Severity No Harm : fall occurred but with no harm to the patient	8	0.96%
Severity Low Harm : patient required first aid, minor treatment, extra observation or medication	1	0.12%
Severity Moderate Harm : longer stay in hospital	0	0.0%
Severity Severe Harm : permanent harm.	0	0%
Severity Death : direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	159	19.3%	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	6	0.72%	3.7%
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital	3	0.36%	1.8%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	3	0.36%	1.8%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 13th September 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Health Care Associated Infections (HCAI)
Responsible Director:	Beverley Geary – Chief Nurse
Author:	Greta Johnson – Director of Infection Prevention & Control/ Lead Nurse

Purpose of the report:	The purpose of this report is to provide the Board with information on Trust performance and provide assurance that suitable systems and processes are in place in the Trust to prevent and control infections. This paper provides the board with an update on: • Performance in respect of alert organisms/ infections benchmarked against Trust and national standards • Clinical activity and incidents • Other relevant points for the board to consider	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	

Recommendation:	The Trust Board is asked to receive the report and advise if any further information is required.

HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

HCAI Performance Report

April - July 2019

The purpose of this report is to provide the Board with information on Trust performance and provide assurance that suitable systems and processes are in place in the Trust to prevent and control infections. This paper provides the board with an update on:

- Performance in respect of alert organisms/ infections benchmarked against Trust and national standards
- Clinical activity and incidents
- Other relevant points for the board to consider

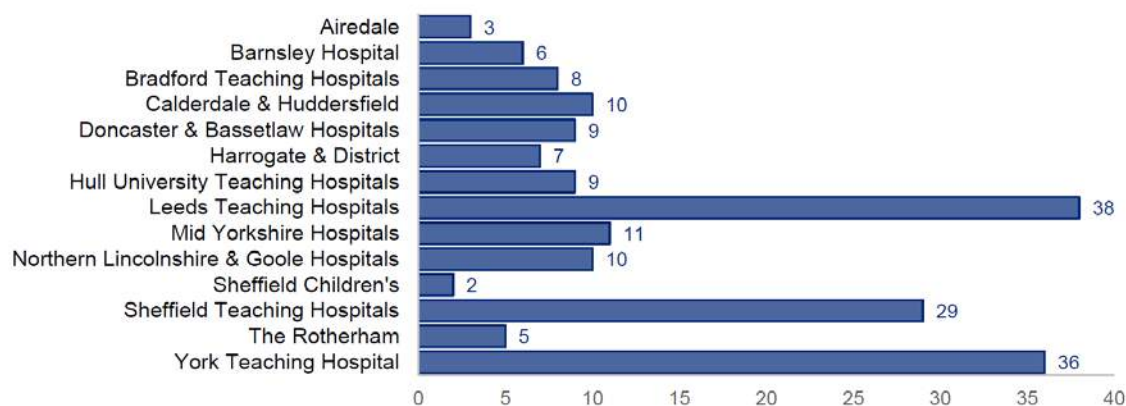
Organism	2019/20 Threshold	2019/20 Performance		
<i>Clostridium Difficile</i>	80	Hospital onset/ Healthcare apportioned (HOHA)	Community onset/ Healthcare apportioned (COHA) (Hospital admission in previous 4 weeks)	Community onset/ indeterminate association (COIA) (Hospital admission in previous 12 weeks)
		9 April = 3 May = 3 June = 3 July = 0	8	10
MRSA Bacteraemia	Zero	1 Trust apportioned case June 19 (over threshold)		
MSSA bacteraemia	Locally agreed CCG stretch target of 50	19 Trust apportioned cases (38%) April 2019 = 6 May 2019 = 5 June 2019 = 4 July 2019 = 4		

Gram Negative Bacteraemia		
Organism	2019/20 Threshold	2019/20 Performance
<i>E.coli</i> bacteraemia	73 (Total 2018/19 = 112)	33 (45%)
Klebsiella	Baseline monitoring	12
Pseudomonas aeruginosa	Baseline monitoring	11

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

The following table shows the distribution of acute hospital *Clostridium difficile* cases across the Yorkshire and the Humber region, during April and July 2019 (source: Public Health England)

Clostridium difficile infection

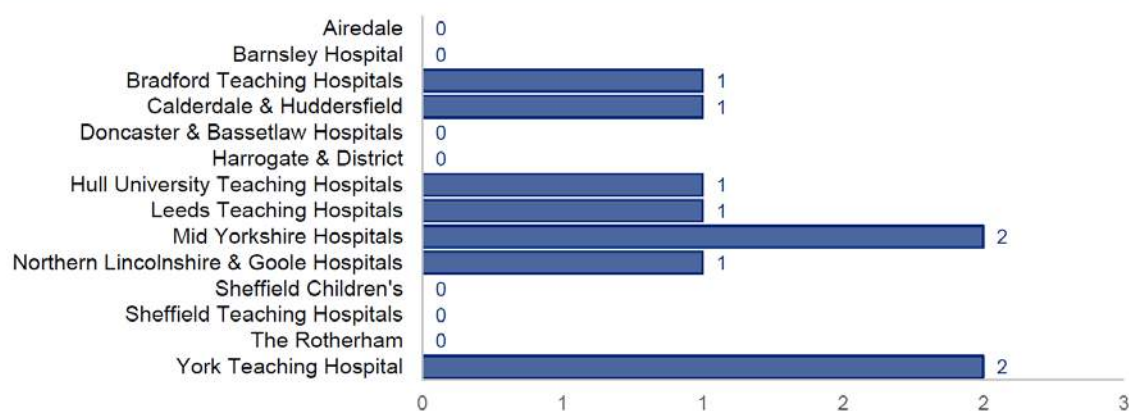


Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

Organism	2019/20 Threshold	2019/20 Performance (Trust apportioned)	Outcome of PIR Investigation / Final assignment
MRSA bacteraemia	Zero tolerance	1 case June 2019 reported in the Medicine Health Group Over threshold	June 2019 – Post Infection Review investigation completed and outcome meeting held. Case deemed avoidable, secondary to cellulitis and thrombophlebitis at a cannula site.

The following table shows the distribution of acute hospital MRSA Bacteraemia across the Yorkshire and the Humber region, during April and July 2019 (source: Public Health England)

MRSA bacteraemia



Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

Organism	2019/2020 Threshold	2019/20 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	50	19 (38%)	Of the 19 reported cases investigated it has identified the following mixed trends 31.5% CVCs, 15.8% pneumonia (HAP/VAP), 15.8% SSI, 15.8% skin and soft tissue infections, 5.2% PVCs, 5.2% UTI, 5.2% possible contaminant and 5.2% unknown. Ongoing work around CVC usage continues with some cases being managed by other teams outside of the Trust. All cases are reviewed by the IPCT and RCAs are being completed by the respective HGs

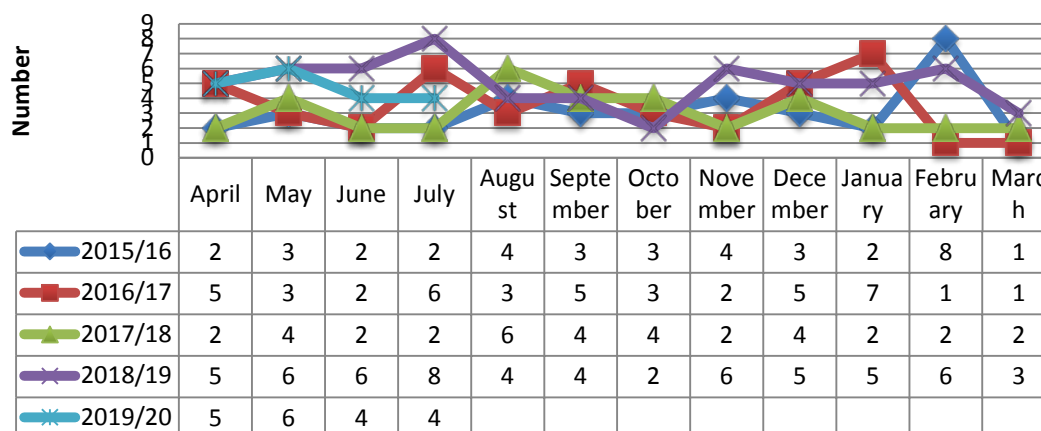
MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection again for 2019/20 but the need for continued and sustained improvements regarding this infection remains a priority.

By July 2019, MSSA bacteraemia cases remain relatively static month on month with a slight reduction noted, but a continued focus on intravenous device management remains - insertion, reason for use and continued management of peripheral cannulas, PICC, Hickman and central lines.

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

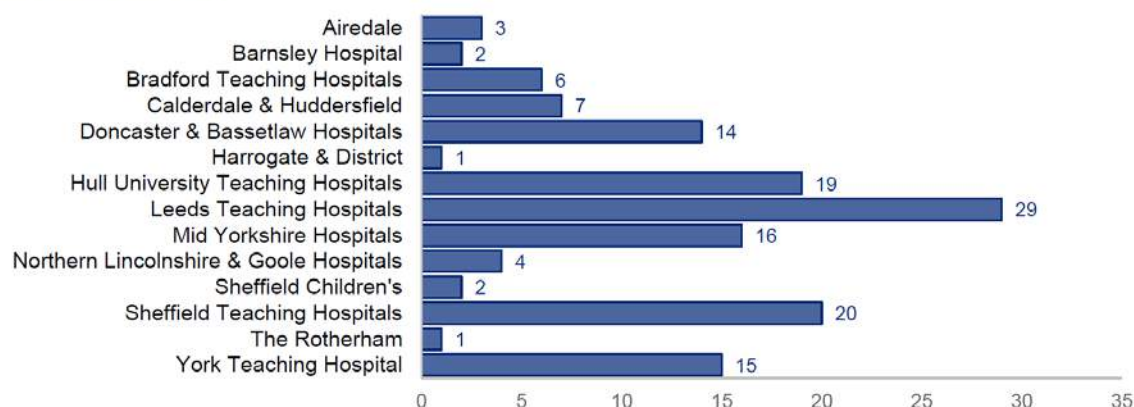
The following graph highlights the Trust's performance from 2015/16 to date with this infection

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia infections from 2015-16 to date



The following table shows the distribution of acute hospital MSSA Bacteraemia across the Yorkshire and the Humber region, during April and July 2019 (source: Public Health England)

MSSA bacteraemia



Escherichia-coli Bacteraemia

E. coli is now the commonest cause of bacteraemia reported to Public Health England.

E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England require a 10% reduction in *E.coli* bacteraemia cases. In addition, NHS Trusts will continue to report cases of bloodstream infections due to *Klebsiella* species and *Pseudomonas aeruginosa*. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024.

The focus of attention is on the reduction of urinary tract infections, which are responsible for the largest burden of *E.coli* infections. The Trust, along with system partners, across Hull and East Riding are involved in a number of projects to try and reduce the burden of these

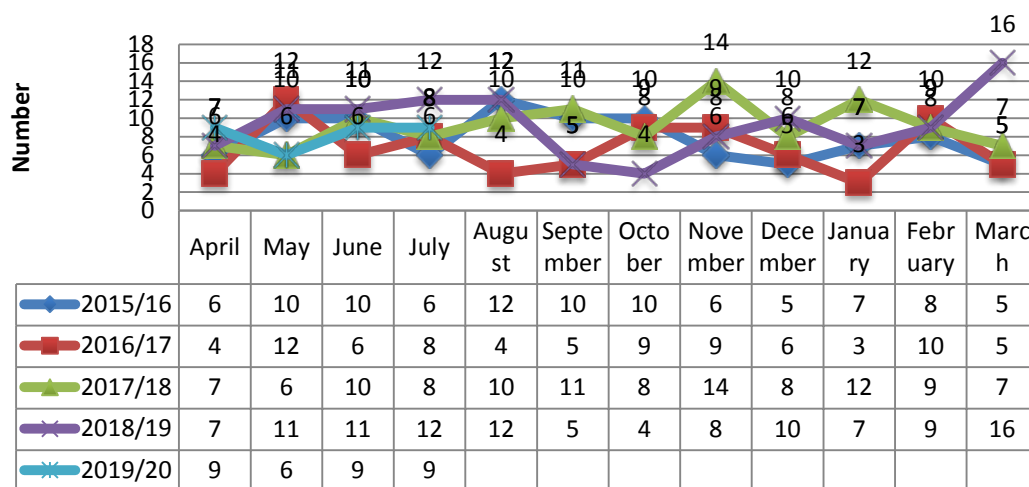
infections including prudent assessment of patients with suspected urinary tract infections and less reliance on inaccurate diagnostic tools.

In addition, Antimicrobial Resistance CQUINs for 2019/20 are focusing on the improving the management of lower Urinary Tract Infection in older people (CQUIN 1a) both from a diagnostic and antibiotic treatment perspective. Further information on Trust progress with regards to this CQUIN will be shared in future quarterly and exception reports.

Organism	2019/20 Threshold	2019/20 Performance (Trust apportioned)	No. of cases investigated clinically	Outcome of Clinical Investigation (avoidable/ unavoidable)
<i>E. coli</i> bacteraemia	73 (after 10% reduction)	33 (45%)	33	Thirty three Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 15 cases detected in the Surgical HG, 12 cases in the Medical HG, 6 cases detected in Clinical Support HG and none to date in the Families & Women's HG. Review of cases suggests ongoing causes related to complex abdominal and urological surgery, biliary and urinary sepsis. Ongoing review of cases continues by the IPCT with those deemed possibly preventable or preventable requiring an RCA by the HG. The cases requiring an RCA relate to urinary tract infections and delay in treatment.

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

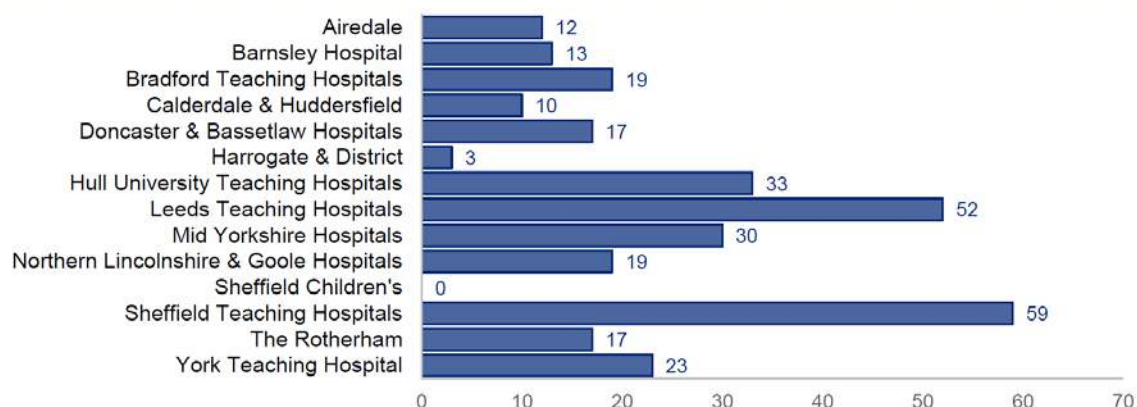
Escherichia coli bacteraemia infections 2015-16 to date



The main points here are the concerns over the high resistance rates to commonly-used antibiotics and, also, the learning around the care of patients with urinary catheters and indwelling vascular devices both in hospital and the community. All of these are areas of increased focus and actions currently. Trends associated with *E.coli* are reflected in the graph above, including those associated with the extreme weather variations that are experienced during summer months, when the increase in people admitted to hospital with dehydration occurs, as does the burden of *E.coli* infection.

The following table shows the distribution of acute hospital *E.coli* Bacteraemia across the Yorkshire and the Humber region, during April and July 2019 (source: Public Health England)

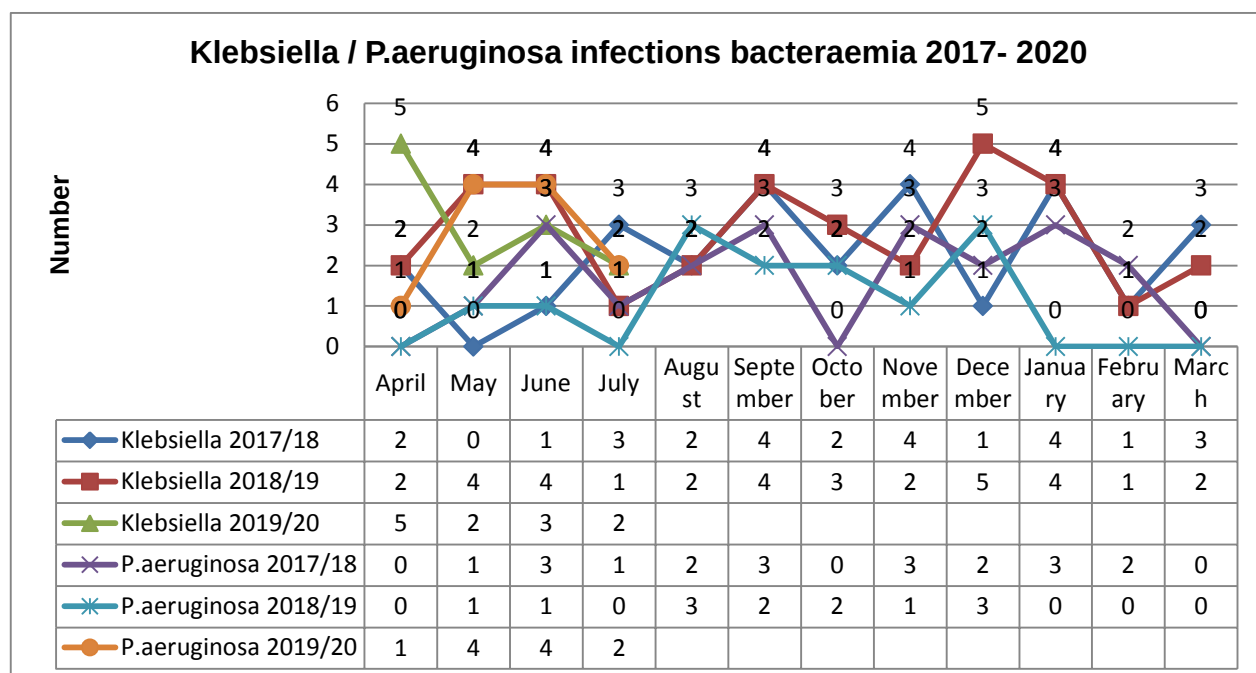
E. coli bacteraemia



Gram negative bacteraemia – reporting for 2019/20

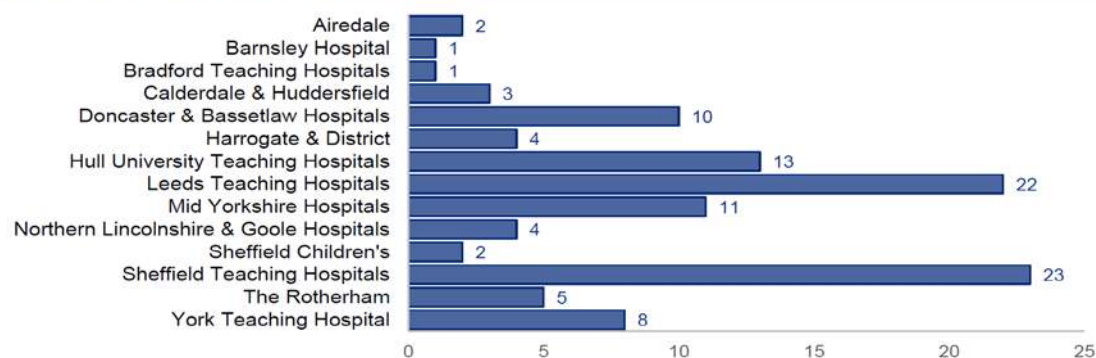
For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England require NHS Trusts to continue to report cases of bloodstream infections due to *Klebsiella* species and *Pseudomonas aeruginosa*. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024.

Review of cases to date suggests similar risk factors as those found with *E.coli* bacteraemia, with *Klebsiella* related to respiratory infections.

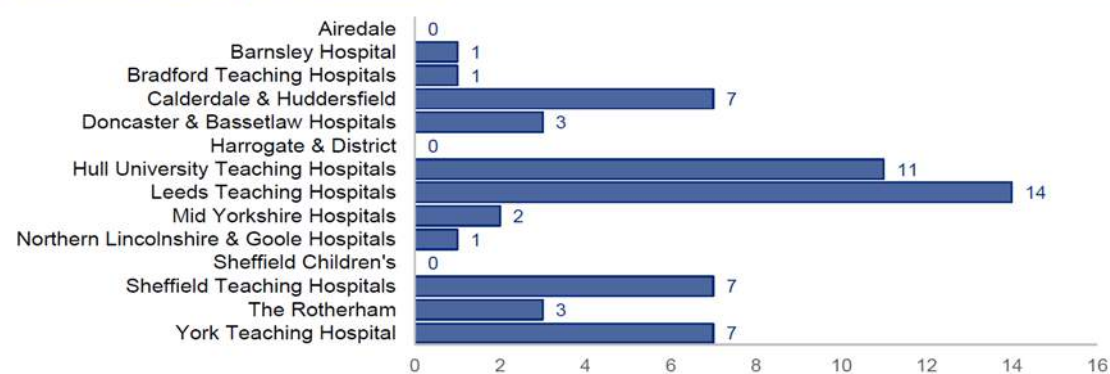


The following two tables show the distribution of acute hospital *Klebsiella* and *Pseudomonas aeruginosa* bacteraemia respectively across the Yorkshire and the Humber region, during April and July 2019 (source: Public Health England)

Klebsiella species bacteraemia



Pseudomonas aeruginosa bacteraemia



The Antimicrobial Resistance (AMR) Strategy 2019 - 2024 acknowledges the challenges associated with meeting the requirements of halving the burden of GNBSI's by 2020/2021 and has therefore adopted a systematic approach to preventing these infections and is aiming to deliver a 25% reduction by 2021-2022 with the full 50% reduction by 2023-2024.

Infection Outbreaks during July 2019

One bay was closed on H100 on the 2nd July 2019 with patients affected by diarrhoea and vomiting, no causative organism was identified and affected patients were isolated, enabling the affected bays to be cleaned and reopened the following day.

One bay was closed on C29 on the 3rd July 2019 with two patients affected with vomiting, a further 4 patients, all isolated, also had symptoms of D&V. One patient in isolation was identified with *Clostridium difficile*, otherwise no causative organism was identified and affected patients were isolated, enabling the affected bays to be cleaned and reopened the following day.

Infection incident

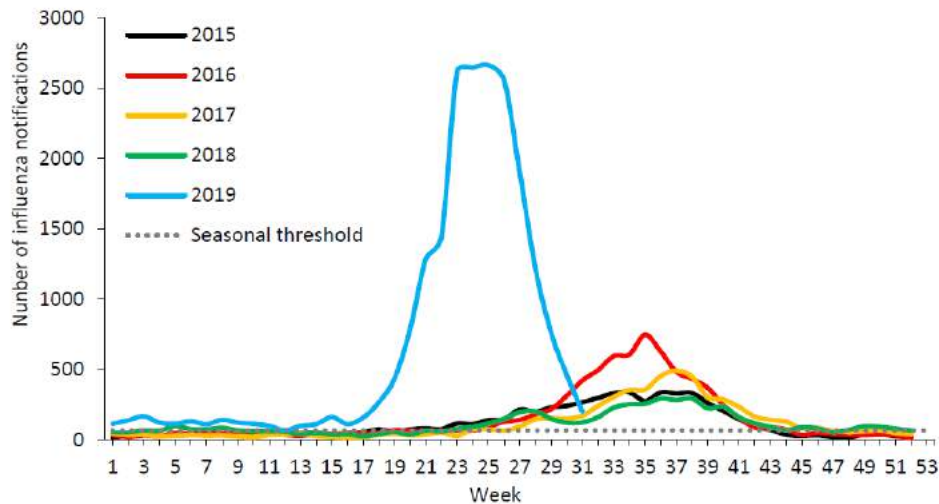
***Pseudomonas aeruginosa* in NICU**

During July 2019, the screening of babies for *Pseudomonas aeruginosa* has continued on the Neonatal Intensive Care Unit (NICU). These take place on admission and on a weekly basis thereafter. A case was detected during July 2019 from a sputum sample but no bacteraemia cases have been identified since August 2018. To date, there is no evidence to suggest person to person transmission but some strains have been identified from babies nursed on the unit but at separate dates/times, often months apart suggesting a possible environmental source but none found to date. Colonised cases represent commonly found strains both in humans and the environment so it is difficult to illicit clinical relevance. Water sampling across the unit yielded no positive results, apart from a shower which has since been removed. Incident meetings have been held at regular intervals with Public Health England involvement. All cases with additional data has been supplied to PHE so additional epidemiology studies can be undertaken to determine trends. A pilot of a novel cleaning agent used to clean and decontaminate hand wash basins will commence on the unit, following a period of staff training and pre-pilot sampling. The pilot commences on the 2nd August 2019 on the unit and will last 2 weeks. Further updates will be provided in future reports.

Southern Hemisphere Influenza Seasonal Activity 2019/20

We have continued to receive reports from a number of sources regarding the current southern hemisphere influenza season – the number of cases and the impact on healthcare. (See chart below as an example from Western Australia). The activity represents an earlier start to the season; of note is the marked epidemic curve with a steady decrease in cases which is reassuring. Although this does not automatically mean a severe season for the UK in 2019/20 it is not unusual for our pattern to follow that of the southern hemisphere. Planning for the 2019/20 influenza vaccination is already in place with winter planning meetings being organised and held. Additional discussions about options related to respiratory viral testing in the Emergency Department are also underway.

Influenza notifications in Western Australia by week, 2015 to 2019



Influenza notifications reported to the Department of Health decreased again this week, and has returned to levels usually seen during previous influenza seasons.

The graph is a summary of all influenza notifications received by the DoH, Western Australia to the end of the current reporting week, for which cases had date of symptom onset or specimen collection between 29/07/2019 and 04/08/2019. The seasonal threshold defines a value above which may indicate epidemic seasonal influenza activity. The threshold value is calculated based on analysis of seasonal influenza data from the past four years.

Other Points of Interest

World Health Organisation (WHO) Infection Prevention and Control (IPC) Assessment Framework (IPCAF)

The Infection Prevention and Control (IPC) Assessment Framework (IPCAF) is a tool to support the implementation of the World Health Organization (WHO) Guidelines on core components of IPC programmes at the acute health care facility level. The IPC team completed the assessment, facilitated by the Quality Service Manager for Pathology and presented the findings at Infection Reduction Committee. The assessment has highlighted a number of key areas from which improvements can be made these include education & development, along with developing and delivering multi modal strategies. A Trust wide IPC action plan is being developed as a consequence of the assessment and will be presented at the next Trust Board.

Gram-negative Bloodstream Infection (GNBSI) ambition

The ambition to reduce GNBSI by 50% by March 2024 is a complex challenge with more than 50% of infections occurring in people outside of hospital settings, Achieving this ambition will require strategic executive oversight and leadership to implement a cross system agenda that is collaborative and inclusive of both health and social care. During July 2019, NHS England and NHS Improvement wrote to Chief Executives and key leaders both in Clinical Commissioning Groups and Acute Trusts, requesting that a senior responsible officer (SRO) be nominated who would represent the sustainability and transformation

partnership (STP) for our area. Beverley Geary has been nominated to be the SRO for Humber, Coast and Vale STP. The Chief Nurse and the Director of Infection Prevention & Control will be attending a meeting in Newcastle on the 12th September 2019 organised by NHS England and NHS improvements, bringing together healthcare leaders in the North East. A report following this meeting and Trust plans to reduce the burden of GNBSI will be discussed at subsequent Trust Board meetings.

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Patient Experience Board Report – July and August 2019
Responsible Director:	Beverley Geary – Chief Nurse
Author:	Beverley Geary – Chief Nurse

Purpose of the report:	The purpose of the report aims to provide an overview of the feedback from the Patient Experience and Engagement Department which involves Complaints, Pals, PHSO, Friends and Family Test, Volunteers, Patient Council and National Surveys.	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	

Recommendation:	The Trust Board is asked to receive the report and advise if any further information is required.

Hull University Teaching Hospitals NHS Trust

Trust Board

Patient Experience Report

1. Purpose of the report

This report aims to provide an overview of the feedback from the Patient Experience and Engagement Department which involves Complaints, Pals, PHSO, Friends and Family Test, Volunteers, Patient Council and National Surveys.

An analysis against other comparable periods is presented to indicate any trends or variation in activity.

The Trust uses the information gathered to review themes and trends and consider where improvements can be made to change services for the benefit of patients and staff.

2. Complaints

Complaints Received by Health Group and Subject July and August 2019

Whilst the number of complaints received for July and August are very similar, Surgery Health Group received 11 more complaints in August (21) than in the month of July (10) with Treatment being the subject of 13 complaints. The complaints received were over a wide incident timeframe (see page 5) over the previous two year period and not specific to recent activity. Family and Women's Health Group received 6 more in July (14) than in August (8), again the main subject was Treatment.

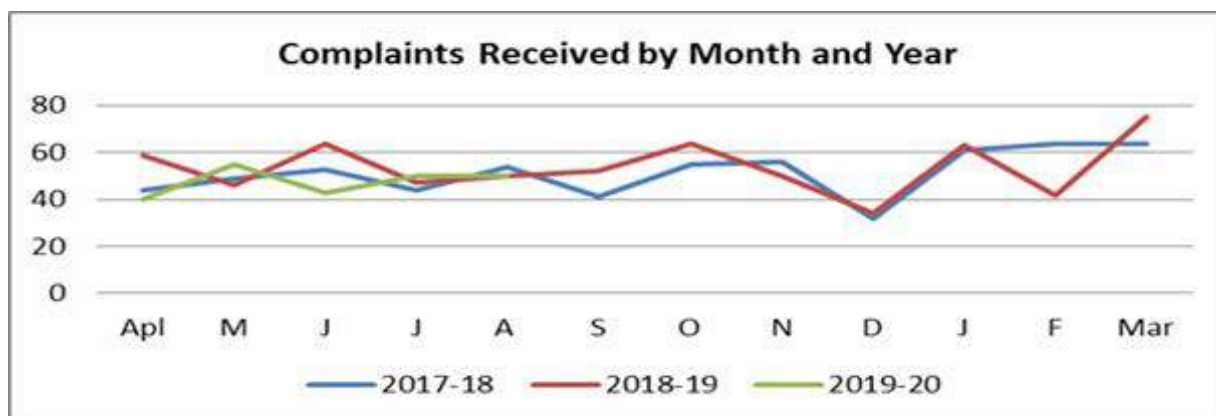
Complaints by Health Group and Subject (primary)		Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	July	0	0	0	0	1	0	0	0	0	0	0	1
	August	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Support	July	0	1	1	0	1	0	0	0	0	0	0	3
	August	0	0	0	0	0	0	0	0	0	0	2	2
Emergency & Acute	July	0	0	0	0	0	0	0	1	0	0	5	6
	August	0	0	0	0	0	0	0	0	0	0	3	3
Family & Women's	July	0	1	1	1	0	0	1	0	0	0	10	14
	August	0	0	1	1	1	0	0	0	0	0	5	8
Medicine	July	1	0	2	2	2	2	0	0	0	0	4	13
	August	1	0	3	3	0	0	0	0	1	0	6	14
Surgery	July	0	0	1	1	3	0	0	0	0	0	5	10
	August	0	1	2	2	2	1	0	0	0	0	13	21
Totals:	July	1	2	5	4	7	2	1	1	0	0	24	47
	August	1	1	6	6	3	1	0	0	1	0	29	48

Complaints are usually investigated on complaints that relate to concerns that have occurred within the last 12 months, however if a patient has only recently become aware of a problem or it is an ongoing issue, then the team will consider if it is possible to investigate and provide information that will assist the patient or contribute to learning for the organisation. This information is helpful when looking for seasonal activity. Graph 1 below indicates the date the issue occurred of complaints received between 1 April 2019 to 31

August 2019. The number of complaints received in the month of May 2019 was high at 52 and the graph below indicates that over the period 1 April 2019 to 31 August 2019, the concerns for May was also higher. Whilst issues relating to August 2019 is comparatively very low, this figure will rise over the next few months as complaint letters are received and processed.

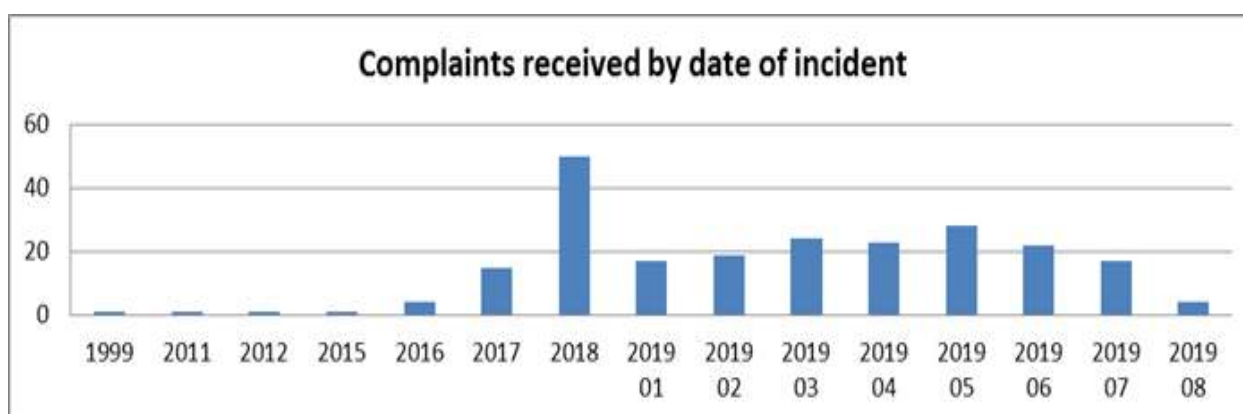
The number of complaints received since April 2019 to end of August 2019 has averaged 45 each month with April seeing the lowest at 40 complaints and May the highest at 52. As the timeframe of when the incident may have been received is over several years, there is no significance to the number of complaints received in a month as to what is happening in the Trust.

Graph 1



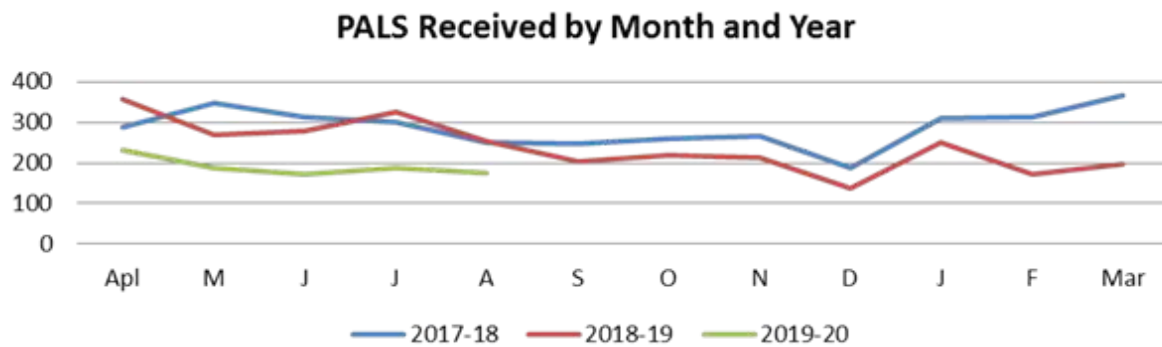
Graph 2

Graph 2 below indicates the date the issue occurred of complaints received between 1 April 2019 to 31 August 2019. The number of complaints received in the month of May 2019 was high 52 and the graph below indicates that over the period 1 April 2019 to 31 August 2019, the concerns for May was also higher. Whilst issues relating to August 2019 is comparatively very low, this figure will rise over the next few months as complaint letters are received and processed.



2.1 Patient Advice and Liaison (PALS)

The recording of PALS cases changed in August 2018 when the decision was made not to record issues of general signposting. The effect of this can be seen on the graph below. It is expected that in the months going forward from now, similar contacts will be made with the PALS team as in the year 2018-19, however themes and trends will be reviewed on an ongoing basis. Some examples of PALS and outcomes are stated below.



The family felt they were put under extreme pressure to arrange the discharge for the patient when they were not ready for him at home and he was also still unwell. Wife of the patient avoided visiting during the day due to be approached by staff.

Actions: Communication regarding the patient's progress and treatment was inadequate with the family. Patient's family has been invited to attend to speak to the clinic teams on the specific wards to discuss their experience and the impact this had on them during the patient's stay. Consideration to be given regarding how to improve the quality of communication with patients and families regarding discharge planning.

The Patient was unhappy at the way in which an endoscopy was undertaken by a trainee member of staff. The patient also felt that it was unsuitable for people accompanying patients to be partaking of food and drink in the waiting area when patients had been required to fast.

Actions: The trainee Endoscopist will receive additional consent process and communication training. The Endoscopy Unit Sister will review the signage in the reception areas to ensure these are clear.

A baby was born by elective caesarean. Mother felt that checks were not undertaken adequately at birth and a fracture above his elbow was missed resulting in pain and incorrect treatment.

Actions: A review will be undertaken of the 'flow chart for management of brachial plexus injury' with creation of a guideline for the management of new born infants where brachial plexus injury is suspected. To be shared with obstetrics and general paediatrics. Creation of a patient information leaflet for safety netting advice for possible delayed symptoms following shoulder dystocia or brachial plexus injury.

PALS Received by Health Group and Subject - July and August 2019

PALS by Health Group and Subject (primary)		Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	July	1	3	0	3	2	0	2	1	0	0	0	12
	August	4	2	0	2	0	0	1	3	0	0	1	13
Clinical Support	July	0	2	0	0	7	0	0	0	0	0	3	12
	August	0	0	0	2	3	0	0	1	0	0	1	7
Emergency & Acute	July	1	1	0	0	1	3	1	0	0	0	3	10
	August	0	0	0	0	0	0	0	0	0	0	4	4
Family & Women's	July	2	4	0	5	21	0	0	0	0	0	8	40
	August	0	1	0	5	29	1	0	0	0	0	6	42
Medicine	July	4	3	0	3	8	4	0	1	0	0	3	26
	August	5	3	1	6	9	2	0	1	0	0	9	36
Surgery	July	6	5	1	5	18	0	0	0	0	0	12	47
	August	3	2	2	5	14	0	1	0	0	0	12	39
Totals:	July	14	18	1	16	57	7	3	2	0	0	29	147
	August	12	8	3	20	55	3	2	5	0	0	33	141

The number of PALS cases in Emergency Medicine increased in July from 4 to 10 in August with the main difference being issues relating to Discharge and Medicine Health Group who had 26 in July but 36 in August with the main increase being relating to Treatment. Surgery Health Group saw a higher number of PALS cases in July (18) for delays, waiting times and cancellations.

2.2 Compliments

Below is an a compliment the Trust received in the month of August. Compliments are logged in PALS and then sent to the Health Group to share with their teams.

“My Dad died peacefully at the Queen’s Centre yesterday, days after learning that there were no further myeloma treatment options available to him and 31 hours after understanding that palliative care for him would be extremely limited.

My mother and I were just talking about all the people who cared for my Dad and we thought of you and wanted to thank you. On the 26th June Dad underwent a spinal operation to remove a myeloma related back compression. You were the lead consultant. Specifically, we wanted to let you know that Dad’s wound healed extremely well. Once he had adequately recovered from the sepsis, he underwent the third line of treatment for myeloma and began to show a remarkable recovery. He gained lots of weight and began to feel and move his feet and legs again. Dad could even flex his thighs and we were all very hopeful. This was without any formal physiotherapy, but with lots of encouragement, passive exercises and massages from his wife and children. He was enthusiastically waiting to begin physiotherapy and had been referred for it. Dad was in a great mood and began to make and take telephone calls, go outside and follow national and international politics again. Sadly, at the same time as this period of apparent recovery, a secondary cancer had begun to develop. By the time we realised this, he was left with no treatment choices. Dad maintained both his dignity and agency to the very end, two things that were really important to him and which we fought to maintain, even when he could not do so for himself. On

Saturday evening Dad asked for all medical equipment to be removed from his body and to be allowed to sleep. Morphine was administered and he fell into a restful and comfortable sleep. He died shortly thereafter.

We are eternally grateful for the care you took of our Dad, both during and after his operation. Your efforts gave him time to continue to hope, to spend quality time with his wife, children and grandchildren and to speak with the many family and friends who could not be by his side during his illness.

Please extend our thanks to your entire team for all they did for our Dad.”

2.3 Parliamentary Health Service Ombudsman (PHSO) cases

If a complaint is unhappy with the response received from the Trust, they have the right to contact the Parliamentary Health Service Ombudsman(PHSO) to request an investigation into their complaint.

The Trust has 7 cases with the PHSO currently. During the months of July and August there was 1 new investigation and 1 case was closed. The case that was closed was partly upheld with actions.

The PHSO will sometimes ask for information regarding a previous Trust complaint and we may be asked for information regarding a previous Trust complaint and we may be asked to look at it again to find further resolution and to avoid further investigations for the PHSO.

2.4 National Inpatient Survey

The National Inpatient Survey was undertaken during the month of July 2018, the results of which were provided in June 2019. The Trust uses Picker as the contractor to undertake the survey and the results below gives comparisons with the 76 other Acute Trusts that also use Picker to provide this service. HUTH was rated 33 out of the 77 Trusts for positive feedback by Picker. The CQC published the overall report for all Acute Trusts. The CQC report can be viewed at: <https://www.cqc.org.uk/provider/RWA/survey/3#undefined> Each trust also received a rating of ‘Better’, ‘About the same’ or ‘Worse’ and HUTH was rated ‘about the same’ compared with other Trusts.

A total of 62 questions from the survey can be positively scored. Of these 61 can be compared historically between the 2017 and 2018 surveys. Box A shows the key points from the report. Box B below indicates that the Trust did significantly better on 1 question but significantly worse on 3 questions. There was no significant difference on 57 of the questions asked in the 2017 survey. Box C shows how we compare with other Acute Trusts who also used Picker. A working group with members from each health group has been formed to review the results and consider what actions are required to learn and improve from the survey. The 2019 survey was undertaken in July this year and the results will not be known until Spring 2020.

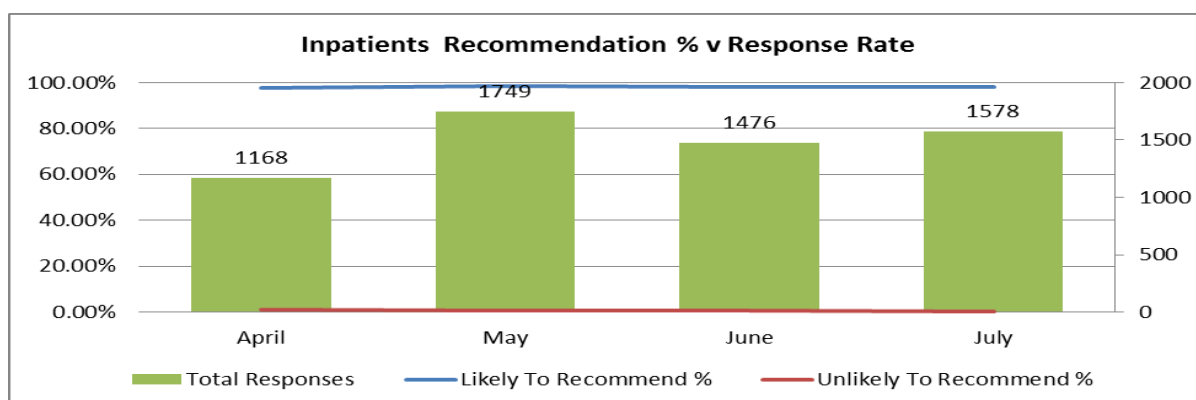
1250 Invited to complete the survey	1175 Eligible at the end of survey	46% Completed the survey (539)	43% Average response rate for similar organisations	45% Your previous response rate

2.5 Friends and Family Test (FFT)

The Trust's Friends and Family test for all areas, including the Emergency Department had a higher number of responses for July 2019 with 5,897, compared to June 2019 when 4,872 were received. The July 2019 inpatient results indicate that 98.10% were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set-target of 95%.

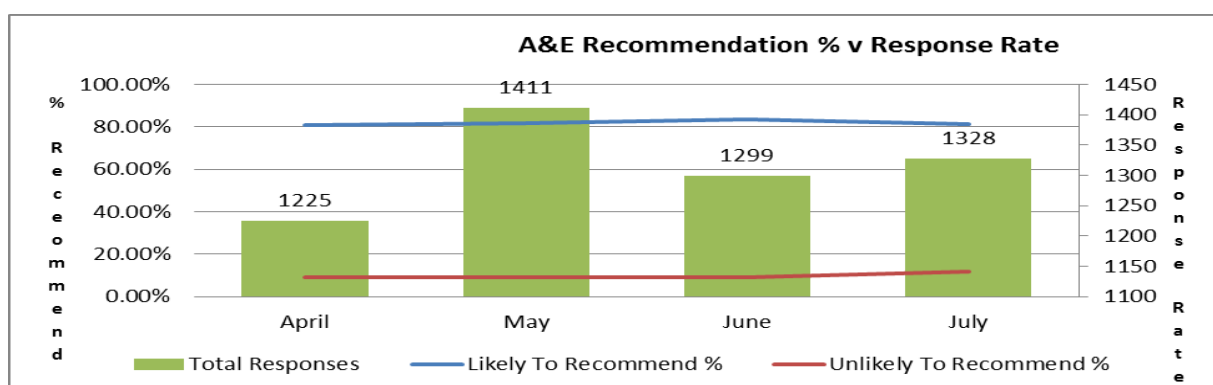
Inpatient summary – all areas

Below is the results of the Friends and Family Test for the month of July 2019. August data will be available to the Trust mid September.



2.5.1 Friends and Family Emergency Department (ED)

1,299 patients who attended the Emergency Department in June 2019 responded to the Friends and Family Test with 83.53% of patient giving positive feedback and 8.85% negative feedback. 1,328 patients that attended the Emergency Department in July 2019 responded to the Friends and Family Test with 81.17% of patients giving positive feedback and 11.82% negative feedback. The remainder were neither positive nor negative.



2.6 The Volunteer Service

The Trust is currently recruiting volunteers from the Reading Room project, these volunteers were sign posted to the Trust after they enjoyed being part of the City of Culture volunteers. Volunteers visit the wards and read short stories and poetry to the patients. This is focused for the patients on the Medical Elderly wards.

Pets As Therapy is a national charity founded in 1983 by Lesley Scott-Ordish who enhance health and wellbeing in the community through the visits of trusted volunteers with their behaviourally assessed animals. Pets As Therapy provide a visiting service in hospitals, hospices, nursing and care homes, special needs schools and a variety of other venues all across the UK. This is providing a positive experience for patients in the Discharge Lounge and the medical elderly wards.

As part of the support towards the Seasonal Plan, the Patient Experience Team are busily recruiting Dining Companions for patients who may need assistance with feeding. The volunteers will be trained specifically with feeding by one of our clinical nurse educators. They will also be part of serving meals and refreshment to patients.

A cream tea was held in honour of the volunteers across the Trust to say thank you for all their support that they give to patients and their families and supported by Charitable Funds. The long service awards were presented by the Head of Workforce.

The Young Health Champions are steadily being recruited. The team are working closely with all of the schools and colleges in the local area to encourage all young people to volunteer. This has resulted in some of the young volunteers wanting to become apprentices and gain permanent employment within the Trust.

2.7 The Pears Foundation

In April 2019 the Patient Experience team were delighted to hear that their funding application had been approved by the Pears Foundation.

Pears Foundation aims to benefit society by promoting understanding of key issues through research and educational programmes; driving engagement in social progress across the UK, particularly in young people and supporting organisations focused on wellbeing for everyone.

Pears will support and develop the Young Volunteer services at Hull University Teaching Hospitals Trust.

Since the start of the Young Health Champions volunteering programme in October 2015 the team have helped over 300 young adults in the Hull and East Riding area from school leavers to college students and those that are moving into Higher Education at Hull University. This will also support the unemployed young adults by giving them the opportunity to volunteer in the hospital. Several of Young Health Champions have also been able to fulfil their dreams and gained an apprenticeship at the Trust within Estates, Pathology and Healthcare.

The Patient Experience Voluntary Services Team encourage and support and pride themselves on arranging experiences that the Young Health Champions will remember for the rest of their life's helping to give them a platform required for a future within the NHS. With the funding from the Pears Foundation it will enable the team to expand on some of their ideas going forward and to help young adults have a wonderful and successful career in healthcare. The team will be reporting each month on the progress of the service and how the funding has helped youngsters in Hull and surrounding areas.

The Senior Patient Experience Officer who leads on the Young Volunteer Service is working closely with the Corporate Nursing Team to support volunteers into Nursing and Health Care Pathways.

Born in Hull raised by HUTH "Believe in the young people and the magic will happen"

2.8 Patient and Public Council

The Patient and Public Council meet once a month at the Trust Headquarters. Over the past six months the Council members have taken an integral part in reviewing the council's membership and its role and responsibilities.

Marie Stern is the Chair of the Patient Council and is a significant support to the Patient Experience Agenda and the Trust. Marie has her own Blog on Pattie which is well received by the Trust employees.

The Council have refreshed and reviewed the groups Terms of Reference which was shared at the Patient Experience and Engagement Committee.

The Patient Council are currently low in membership and are actively seeking to recruit more members by the end of the year.

Currently the Council representatives will meet with the Health groups on a monthly basis to look at what is working well in their areas, what is not working so well and what how they may have improved either the environment or process through complaints and lessons learned.

3. Recommendation

The Board/Committee is asked to:

- Receive and accept this report

Beverley Geary

Chief Nurse

September 2019

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

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

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

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

SEPTEMBER 2019

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations)^{1,2}, NHS Improvement³ and the Care Quality Commission.

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

2. BACKGROUND

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

The last report on this topic was presented to the Trust Board July 2019 (April 2019 and May 2019 position).

In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England⁴. In this report, Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as being due to the absence of a single means of consistently recording, reporting and monitoring staff deployment. This led to the development of benchmarks and indicators to enable comparison across peer trusts as well as wards and the introduction of the Care Hours per Patient Day (CHPPD) measure is in line with the second of Lord Carter's recommendations. CHPPD has since become the principal measure of nursing, midwifery and healthcare support staff deployment on inpatient wards. This replaces the 'planned versus actual' methodology used previously.

This report presents the 'safer staffing' positions for June and July 2019 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staffing.

¹ National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*

² National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing

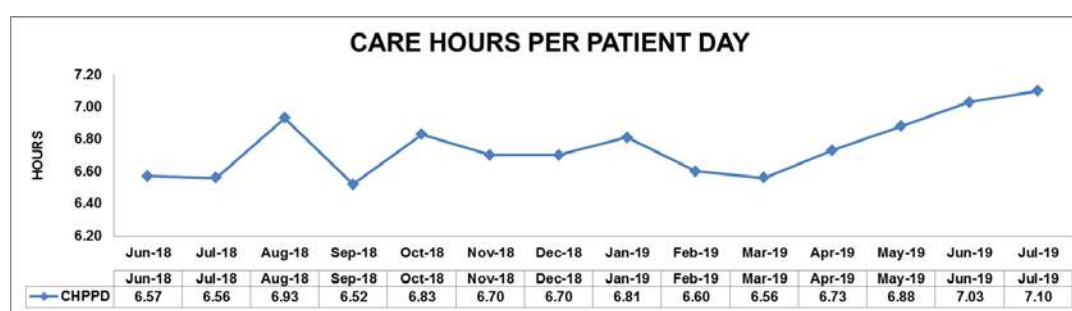
³ NHS Improvement (June 2018) Care hours Per patient Day (CHPPD) Guidance for acute and acute specialist trusts

⁴ An independent report for the Department of Health by Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

3. CARE HOURS PER PATIENT DAY

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

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



CHPPD provides a number that needs to be considered alongside other qualitative and quantitative information, which is described in the next section. It is important not to reach conclusions by considering this number and its trends in isolation. However, as illustrated in the above table it can be seen that the CHPPD continues to improve, with a CHPPD of 7.10 being recorded for July 2019. This is the result of a concentrated effort by all of the Senior Nurses in conjunction with the E-roster team to ensure that the E-roster KPI's are achieved consistently across all ward and critical care areas. In addition the work commissioned to ensure all available and appropriate staff are included in the CHPPD e.g. discharge assistants has now been concluded and are therefore included in the CHPPD calculation. However, the Trust still remains in the lower 25th Quartile as indicated through the Model Hospital Metrics, with a peer medium of 7.9 CHPPD and national medium 8.1 CHPPD (May 2019 data). With regards to the Quality and Safety metrics the Trust continues to perform well against both peers and national performance.

4. PROFESSIONAL STAFFING SAFETY RISK ASSESSMENTS

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

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

- Ward systems and process

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

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

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

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

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

Appendix One provides the Nursing Staffing Key metrics for June 2019.

Appendix Two provides the Nursing Staffing Key metrics for July 2019.

Appendix Three provides the Nurse Staffing Quality Indicators for July 2019,

Appendix Four provides the definitions of CHPPD.

The following tables take all of these metrics into consideration and show the current position of each inpatient area in relation to safe staffing as determined and summarised by the Chief Nurse, Deputy Chief Nurse and Nurse Directors. The Risk Rating is an assessment utilised to offer additional support to any ward rating at medium or high risk.

The Risk Ratings have been agreed as follows:

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

4.1 Nursing and Midwifery Staffing Risk Assessments – April to May 2019

4.1 4 Clinical Support Health Group

Ward	Professional Risk Assessment	Rationale for risk rating	Actions
C7	LOW	Not triggering any quality indicators and no staffing issues so deemed to be safely staffed	
C29	LOW	Not triggering any quality indicators and deemed to be safely staffed	
C30	LOW	1.74 RN vacancies, not triggering any quality indicators and deemed to be safely staffed	
C31	MEDIUM	This ward has 8.08 wte RN vacancies. Actions taken have mitigated the risk; whilst no quality indicators are triggering there are concerns and further support for the ward team being implemented.	Over recruited to non-registered posts to support. Utilising bank/agency, medium term support from pilot bank, support from other inpatient wards, CNS & 5 beds currently closed due to staffing.
C32	MEDIUM	This ward has 3.27 wte RN vacancies; no quality indicators are triggering	Utilising bank and agency, support from other inpatient wards
C33	MEDIUM	This ward has 4.45 wte RN vacancies & ML at 2.6 wte; the actions taken are supporting the ward and no quality indicators are triggering; this continues to be closely monitored	Utilising bank and agency, support from other inpatient wards and have over recruited to non-registered posts to support

4.1.1 Medicine Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk assessment	Comments/Mitigation
AMU	LOW	No staffing related quality concerns	Staff support from H36 on rotation, support from nurse bank.
EAU	MEDIUM	There are 5.2wte RN vacancies. Although not triggering on quality issues, nursing staff vacancies are thought to be affecting continuity of care, due to the high use of temporary staff.	Three month agency contract agreed to support continuity. There are 3.0wte additional non registered staff in post. 1 x Trainee Nursing Associate qualified in June 2019.
H36	LOW	No staffing related quality concerns	
H5/RHoB	LOW	No staffing related quality concerns	
H50	LOW	No staffing related quality concerns	
H500	LOW	No staffing related quality concerns.	Staff continue to be flexed across the fifth floor as required, following reviews by Senior Matron.
H10	MEDIUM	There are 7.65wte RN vacancies. This ward requires a high presence from the Senior Matron to support the ward focus on quality concerns.	Utilising some agency and bank. RN pool nurses allocated for continuation and stability. B6s and B7 staff providing weekend cover and Senior Matron support. Ward is supported by 3.0 wte RNs transferred in from the closure of the winter ward.
H8	LOW	No staffing related quality concerns	Additional non-registered staff in post, awaiting x3 non – registered nurse new starters
H9	MEDIUM	There are 2.83wte RN vacancies. No quality concerns, high visibility and support from Senior Matron.	Senior Matron supporting the ward. Additional Band 6 RN now in post to support the ward therefore increasing senior nurse cover. The ward has improved its fundamental standards audit scores and has no red scores.
PDU H80	LOW	No staffing related quality concerns	
H90	LOW	No staffing related quality concerns	Additional non registered nurses in post.
H11	MEDIUM	There are 5.09 wte RN vacancies. This ward is requiring a higher level of senior nurse support.	Bank and agency utilised. Flexing staff across the floor to maintain safety. Additional non- registered nurses transferred in from the winter ward and additional progress to discharge assistant to support Registered nurse workforce. Two international nurses to be allocated to ward. Additional band 6 in post to provide senior support at weekends and out of hours.
H110	LOW	No staffing related quality concerns	
CDU	LOW	No staffing related quality concerns	
C26	LOW	No staffing related quality concerns	
C28/CMU	LOW	No staffing related quality concerns	

4.1.2 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
H4	MEDIUM	No staffing related quality concerns, however high demand for neuro / spinal capacity	Vacancy 5.02 wte. Using Bank and Agency, flexible working with H40. Recruitment expected in Sep-19
H40	MEDIUM	No staffing related quality concerns, however increasing demand for major trauma capacity	Maternity Leave 5.4% Vacancy 2.52 wte. Using Bank, Agency and support from ICU to ensure appropriate skill mix.
H6	LOW	No staffing related quality concerns	Using bank and agency plus mutual support with H6.
H60	LOW	No staffing related quality concerns	
H7	MEDIUM	No staffing related quality concerns	5.25 wte Vacancy RN recruitment ongoing, requiring use of agency and bank
H100	LOW	No staffing related quality concerns	
H12	LOW	No staffing related quality concerns	
H120	LOW	No staffing related quality concerns	
HICU	LOW	No staffing related quality concerns	
C9	LOW	No staffing related quality concerns	
C10	LOW	No staffing related quality concerns	
C11	LOW	No staffing related quality concerns	
C14	LOW	No staffing related quality concerns	
C15	MEDIUM	No staffing related quality concerns.	3.70 wte RN vacancies, Maternity is 6.3% Increasing service demands high staff turnover, R/N support provided from ambulatory care unit. Additional Senior Matron support for 3 months. The ward is currently in the process of pursuing 6 new recruits who will commence in September 2019.
C27	LOW	No staffing related quality concerns	
CICU	LOW	Not triggering any quality concerns but under review	

4.1.3 Family and Women's Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
C16	LOW	No staffing related quality concerns	The ward has 3.4wte Registered nurse vacancies but are managing this with overtime and bank.
H130	LOW	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours to cover across the 13 th Floor and Acorn ward. There are a number of staff on Maternity leave. Recruitment into 50% of Maternity leave is in progress.
Cedar H30	LOW	No staffing related quality concerns	Utilising bank and agency on occasion.
Maple H31	LOW	No staffing related quality concerns	Sickness absence at 4.94% and a number of vacancies. This being managed by the senior team on a daily basis with bank and overtime.
Rowan H33	LOW	No staffing related quality concerns	Sickness absence at 4.94% and a number of vacancies. This being managed by the senior team on a daily basis with bank and overtime.
Acorn H34	LOW	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours to cover across the 13 th Floor and Acorn ward.
H35	LOW	No staffing related quality concerns	Utilising bank and agency when required.
NICU	MEDIUM	Although not triggering on quality issues, there are concerns with staffing levels.	There are currently 9 staff on Maternity Leave. Vacancies have been recruited to but candidates will not commence until completion of training in September 2019. Bank and overtime are being utilised and flexing paediatric staff resources. Additional short term actions in place to minimise staffing shortfalls.
PAU	LOW	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours to cover across the 13 th Floor and Acorn ward. The Junior and Senior Sister are supporting clinical shifts frequently.
PHDU	LOW	No staffing related quality concerns	Due to vacancy and LTS, there are some staffing shortfalls; however, this is being managed by flexing staff across the paediatric units. The Junior and Senior Sister are supporting clinical shifts frequently, whilst new staff develop the skill level necessary.
Labour	LOW	No staffing related quality concerns	Sickness absence rate is 6.77%. This is managed by the senior team using bank and overtime. Birth rate plus review completed.

5. RECRUITMENT AND RETENTION

Appendix 2, illustrates the Trust's position in relation to Registered and Non – Registered Nurse vacancies across all wards, intensive care units and the Emergency Department. The registered nurse vacancies reported for July 2019 are 143.16 (11.1%) compared to 135.03 wte (10.4%) registered nurses in May 2019. The non – registered nurse vacancies for July 2019 are 5.99 (1.2%) compared to 10.48 (2.9%) for non-registered nurses in May 2019. However, as illustrated in appendix 2 there are a number of specialties, particularly in the Medical Health Group where the percentage of vacancies is significantly higher. In order to address this issue, the following recruitment and retention strategies continue.

Robust recruitment continues within a number of specialties through the development of bespoke advertising campaigns and rotational programmes. In addition the Trust has developed a brochure which outlines the career pathways for both non – registered and registered nurses entitled 'Nursing with us: The whole picture' which will be used as part of the Trust recruitment campaign but also as part of the Trusts retention strategy.

The Trust is currently pursuing 142 adult branch nurses who are due to commence employment with the Trust in September 2019; This is a combination of applicants from the University of Hull through the Trusts 'direct interview campaign' and direct applications from other Universities via NHS Jobs and through the Trust's dedicated recruitment website.

In addition the Trust was successful in obtaining additional funding from the Joint Nursing Directorate of NHS Improvement and NHS England to support the development of clinical placement infrastructure and the availability of clinical placements for 2019 pre – registration nursing intake. The Trust is currently working with the University of Hull to implement the above concept, the results of which will be reported to the Trust Board in November 2019.

The Trust has now deployed 60 nurses from the Philippines over a period of two years. 53 have successfully completed their OSCE and 7 are in training. The Trust has a 100% OSCE pass rate. It is anticipated that the 7 will be ready for their OSCE in September. Out of the 60 deployed there have been 2 leavers so retention is good.

A further 10 nurses will be arriving on 16 September and all are due to be deployed to surgery (theatres and endoscopy only, to support the delivery of increased activity planned for these departments). This cohort will immediately begin their OSCE training with the Practice Development team and be ready for their OSCE exam in November, 2019.

In addition the Medical Health Group are considering recruiting a further 10 international nurses to support the opening of the new medical ward and the DME and Stroke specialties. A financial model is currently being developed by the Team supported by the Chief Nurse and Deputy Chief Nurse.

As reported to the Trust Board in May 2019, the Trust launched an advertising campaign 'Once a Nurse.....Always a Nurse', aimed at supporting existing international staff to obtain the qualifications they require to attain their NMC registration.



The campaign yielded 7 members of Trust staff who wish to pursue obtaining their NMC registration and a number of applicants working for external Health Care Providers. The Practice Development Team is currently working with Human Resource colleagues to determine what support is required to achieve NMC registration for the above individuals.

From the perspective of the Nurse Associate Trainees the Trust is pleased to announce that the first cohort has successfully completed the programme and the majority have obtained their NMC registration and are currently in the process of completing their induction programme.

In addition the Trust has successfully recruited to all three additional nursing workforce streams:

- 15 Trainee Nursing Associates (in addition to the 4 that commenced the programme in June 2019).
- 14 Nurse Apprentices.
- 13 Senior Health Care support worker apprentices.

All of who are due to commence their programmes September 2019.

From the perspective of the Senior Health Care support worker apprenticeship the Trust in conjunction with the University of Hull and Hull College have been successfully shortlisted for the `Nursing Times Workforce Awards` which takes place September 2019.

6. ENSURING SAFE STAFFING

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

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

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

7. RED FLAGS AS IDENTIFIED BY NICE (2014)

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

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

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

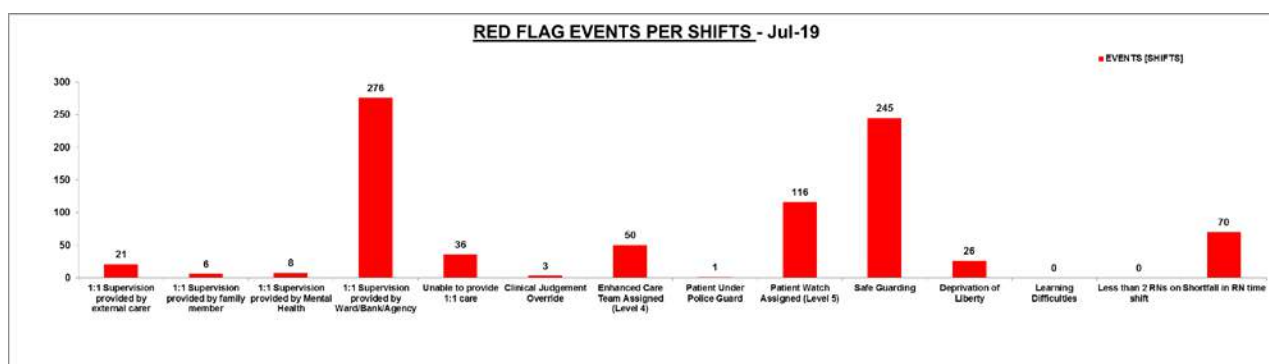
In addition, it is important to keep records of on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

The 'red flags' suggested by NICE, are:

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

The following graph illustrates the number of 'Red Flags' identified during July 2019. The Trust is not yet able to collect data on all of these categories as the systems

required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time in line with the digital roll out programme.



Jul-19	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	21	2%
	1:1 Supervision provided by family member	6	1%
	1:1 Supervision provided by Mental Health	8	1%
	1:1 Supervision provided by Ward/Bank/Agency	276	32%
	Unable to provide 1:1 care	36	4%
	Clinical Judgement Override	3	0%
	Enhanced Care Team Assigned (Level 4)	50	6%
	Patient Under Police Guard	1	0%
	Patient Watch Assigned (Level 5)	116	14%
	Safe Guarding	245	29%
	Deprivation of Liberty	26	3%
	Learning Difficulties	0	0%
	Less than 2 RNs on shift	0	0%
	Shortfall in RN time	70	8%
TOTAL:		858	100%

As illustrated earlier, the most frequently reported red flag that requires extra nursing time is related to the requirement for 1:1 supervision of some sort for patients. As indicated in the previous Board Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which is in the process of being established substantively following a successful trial. The ECT lead nurse post has been recruited into with a planned start date of September 2019. In the interim, the Chief Nurse has requested that there is a clear audit trail in relation to the completion of the required assessment documentation for those patients requiring 1:1 supervision and mitigation where there is an inability to meet this requirement. This information will be collated through SafeCare and reviewed by the senior nursing team on a monthly basis, to ensure patient safety is being maintained.

7.1 Maternity Red Flags

The red flags for maternity services are:

- Delayed or cancelled time critical activity.

- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

There have been no Red flags raised in June and July 2019, for the maternity services.

8. RISK ASSESSMENT

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

9. SUMMARY

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

NHS Improvement has issued revised guidance on how trusts are to publish workforce data from the next financial year onwards. 'Developing Workforce Safeguards⁶' sets out the future requirements for reporting staffing levels across a broader range of professional groups. However, following a review, it has been agreed that the information provided to the Trust Board through the current Nursing and Midwifery (Safe) Staffing Report fulfils the 'Developing Workforce Safeguards' from a Nursing and Midwifery perspective. A paper is being presented to the September 2019 Trust Board outlining the proposed mechanisms for reporting against the 'Workforce Safeguards' for all other Health Care Disciplines.

RECOMMENDATION

The Trust Board is requested to:

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

Author Jo Ledger
Deputy Chief Nurse
September 2019

Appendix One: Nurse Staffing Key Metrics – June 2019

Appendix Two: Nurse Staffing Key Metrics – July 2019

Appendix Three: Nurse Staffing Quality Indicators – August 2019

Appendix Four: CHPPD Description, Methodology, Benefits and Limitations

APPENDIX FOUR - CHPPD Description, Methodology, Benefits and Limitations

What is Care Hours Per Patient Day (CHPPD)?

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

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

How is CHPPD calculated?

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

CHPPD is calculated, as follows:

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

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

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

Which staff are included?

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

Further anticipated benefits of using CHPPD

The guidance advises further that using CHPPD provides:

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

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

The limitations of using CHPPD

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

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

HEY NURSE STAFFING KEY METRICS DASHBOARD																																								
Jun-19					CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST								NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M3]					TEMPORARY STAFFING [10th Jun - 7th Jul-19]				UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE						ROTA APPROVALS [42 DAYS]		ADDITIONAL DUTIES			UNFILLED ROSTER [$<20\%$]	HOURS BALANCES [4 WEEKS] [NET +/- 2%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]					
KEY METRICS ROTA: 10th Jun 2019 - 7th Jul 2019																																								
HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	Other care staff not currently included in CHPPD M3	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	RN [WTE]	RN % [$<10\%$]	NON -RN- [WTE]	NON -RN-% [$<10\%$]	TOTAL VACANCY [WTE]	RN & NON -RN- Est. [WTE]	TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [$<1\%$]	STUDY DAY [$<2.3\%$]	WORKING DAY [1%]	MAT LEAVE [$<2.5\%$]	FULL [DAYS]	PARTIAL [DAYS]	TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [%]	HOURS BALANCE [%]	NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	6.62	6.3%	3.60	16.5%	10.28	126.79	4.2%	3.7%	0.5%	79.4%	24.6%	7.2%	12.7%	1.1%	3.0%	0.3%	0.3%	57.0	57.0	0.2	0.0	0.2	14.7%	2.1%	36.0	36.0	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1141	5177.3	2838.9	7.0	7.55	-0.52	7.31	-0.28	11.18	21.7%	4.32	15.4%	15.72	79.63	4.1%	3.5%	0.6%	59.2%	25.3%	6.4%	11.8%	0.6%	3.3%	0.2%	3.0%	28.0	23.0	0.7	0.5	0.2	15.3%	0.6%	29.0	94.5	65.5
	H36	GENERAL MEDICINE	24	LOW	399.0	648	2457.3	2184.5	7.2	7.55	-0.39	7.31	-0.15	0.00	0.0%	0.00	0.0%	0.00	21.59	7.5%	6.7%	0.8%	47.4%	22.0%	2.0%	11.6%	0.8%	3.3%	1.7%	2.6%	60.0	58.0	10.8	10.0	0.8	26.3%	3.3%	401.9	647.9	246.0
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	583	1982.5	1888.5	6.6	6.94	-0.30	7.74	-1.10	5.78	30.3%	0.48	3.7%	6.56	32.27	44.2%	42.4%	1.8%	74.3%	28.7%	4.3%	19.1%	0.6%	0.4%	1.1%	3.2%	27.0	23.0	0.1	0.0	0.1	38.0%	2.8%	48.5	54.5	6.0
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	734	2848.6	1976.3	6.6	6.74	-0.17	6.38	0.19	3.38	14.0%	2.88	21.9%	6.40	37.25	11.6%	10.2%	1.4%	37.2%	20.8%	6.0%	11.8%	1.7%	1.3%	0.0%	0.0%	41.0	33.0	0.9	0.6	0.3	18.9%	-0.1%	245.3	277.8	32.5
	H50	NEPHROLOGY	19	LOW	283.5	560	1598.8	1194.8	5.0	7.23	-2.24	7.00	-2.01	0.37	2.5%	-0.26	-11.1%	0.13	17.20	1.5%	1.5%	0.0%	56.5%	25.5%	6.4%	13.3%	0.0%	1.8%	1.2%	2.8%	39.0	33.0	0.2	0.0	0.2	17.3%	-1.0%	-31.7	54.5	86.2
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	702	1746.5	1780.5	5.0	6.74	-1.72	6.38	-1.36	4.44	27.1%	1.85	14.1%	6.56	29.53	10.6%	10.0%	0.6%	42.9%	25.0%	1.7%	17.9%	1.8%	2.7%	0.0%	0.9%	-36.0	0.0	0.1	0.1	0.0	18.1%	3.0%	-20.0	28.0	48.0
	H10	GENERAL MEDICINE	30	MEDIUM	441.0	765	2016.8	2372.8	5.7	7.55	-1.81	7.31	-1.57	11.65	54.6%	-2.79	-21.2%	9.41	34.50	17.7%	12.8%	4.9%	53.7%	23.4%	3.3%	9.3%	3.0%	3.1%	4.7%	0.0%	13.0	12.0	0.7	0.6	0.1	24.0%	13.9%	97.5	97.5	
	H8	GERIATRIC MEDICINE	27	LOW	220.5	794	1763.8	1708.0	4.4	6.94	-2.57	6.74	-2.37	2.44	14.9%	-0.03	-0.2%	2.56	29.53	3.5%	2.9%	0.6%	67.8%	28.7%	1.8%	12.5%	0.0%	3.7%	6.9%	3.8%	48.0	48.0	0.2	0.1	0.1	18.2%	-3.3%	20.0	64.5	44.5
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	807	1524.0	2679.8	5.2	6.94	-1.73	6.74	-1.53	2.24	20.5%	-2.15	-13.5%	0.29	26.82	10.0%	5.4%	4.6%	91.0%	33.2%	9.4%	14.3%	0.5%	1.3%	4.9%	2.8%	27.0	24.0	0.3	0.2	0.1	19.0%	1.9%	107.5	138.0	30.5
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	508	1923.5	2377.3	8.5	6.94	1.53	6.74	1.73	3.26	19.9%	-1.26	-8.1%	2.20	32.03	8.6%	7.0%	1.6%	72.2%	15.8%	4.0%	8.8%	0.0%	3.0%	0.0%	0.0%	68.0	61.0	0.1	0.0	0.1	13.2%	3.1%	-46.3	34.0	80.3
	H90	GERIATRIC MEDICINE	29	LOW	252.0	849	1766.5	1883.8	4.3	6.94	-2.64	6.74	-2.44	2.53	15.5%	-1.48	-11.3%	1.20	29.53	3.8%	3.8%	0.0%	78.3%	25.5%	10.7%	7.4%	1.0%	2.8%	0.8%	2.8%	75.0	73.0	0.3	0.0	0.3	13.5%	1.1%	15.8	94.8	79.0
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	831	1814.3	2096.5	4.7	7.55	-2.84	7.41	-2.70	7.10	32.9%	-2.49	-23.9%	4.94	32.03	9.7%	9.1%	0.6%	55.9%	23.9%	2.0%	11.4%	0.0%	2.5%	5.6%	2.4%	45.0	42.0	0.8	0.4	0.4	17.3%	1.2%	82.5	106.0	23.5
	H110	STROKE / NEUROLOGY	24	LOW	252.0	607	2570.6	2112.3	7.7	7.55	0.16	7.41	0.30	6.90	25.3%	-2.84	-27.2%	4.31	37.72	14.3%	14.3%	0.0%	58.3%	28.8%	10.0%	10.4%	1.4%	3.8%	0.0%	3.2%	38.0	27.0	0.1	0.0	0.1	19.8%	4.4%	39.3	270.8	231.5
	CDU	CARDIOLOGY	9	LOW	0.0	95	1021.2	89.5	11.7	7.93	3.76	7.73	3.96	0.71	5.5%	0.50	20.5%	1.27	15.25	6.2%	6.2%	0.0%	42.5%	31.0%	8.2%	12.4%	0.8%	1.0%	1.1%	7.5%	59.0	58.0	0.0	0.0	0.0	47.5%	-2.1%	0.0	0.0	0.0
C26	CARDIOLOGY / CTS	26	LOW	236.5	150	2703.0	1005.5	24.7	8.46	16.26	9.93	14.79	0.17	0.7%	-0.75	-9.5%	-0.57	32.03	0.5%	0.5%	0.0%	100.0%	20.0%	1.7%	13.8%	0.0%	3.0%	1.5%	0.0%	69.0	58.0	0.1	0.0	0.1	16.7%	4.9%	-52.0	69.0	121.0	
C28 /CMU	CARDIOLOGY	27	LOW	277.2	707	3987.0	1043.0	7.1	7.44	-0.33	7.87	-0.76	9.98	26.3%	-1.01	-12.5%	9.23	46.04	1.7%	1.7%	0.0%	24.9%	26.0%	5.9%	15.3%	0.4%	1.9%	2.5%	0.0%	53.0	30.0	0.1	0.0	0.1	28.7%	6.1%	76.3	105.8	29.5	
SURGERY	H4	NEUROSURGERY	28	MEDIUM	157.5	784	2363.0	1317.5	4.7	8.39	-3.70	8.71	-4.02	4.68	21.7%	1.15	11.0%	6.05	32.03	10.3%	10.3%	0.0%	62.3%	27.0%	7.1%	14.2%	0.3%	5.3%	0.1%	0.0%	34.0	33.0	0.3	0.2	0.1	19.7%	-0.6%	31.0	54.0	23.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	384	2362.3	1648.3	10.4	8.39	2.05	8.71	1.73	2.57	12.0%	-1.02	-11.0%	1.67	30.68	9.8%	9.3%	0.5%	42.8%	23.4%	3.4%	13.4%	0.3%	0.7%	0.2%	5.4%	38.0	37.0	0.9	0.3	0.6	16.0%	0.4%	162.5	162.5	
	H6	GENERAL SURGERY	28	LOW	283.5	730	2267.8	1453.8	5.1	6.99	-1.89	7.26	-2.16	1.08	5.6%	1.28	10.9%	2.42	31.01	17.9%	17.6%	0.3%	65.5%	28.1%	5.7%	12.7%	0.1%	3.4%	2.5%	3.7%	65.0	55.0	0.3	0.1	0.2	13.1%	1.3%	3.6	44.3	40.7
	H60	GENERAL SURGERY	28	LOW	126.0	739	2268.3	1632.5	5.3	6.99	-1.71	7.26	-1.98	0.46	2.4%	2.24	19.0%	2.72	31.01	12.5%	12.3%	0.2%	58.2%	24.6%	3.3%	13.1%	0.4%	0.6%	0.3%	6.9%	58.0	55.0	0.1	0.0	0.1	11.1%	-0.8%	-58.3	37.0	95.3
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	834	2428.9	1716.8	5.0	6.99	-2.02	7.26	-2.29	5.66	23.5%																									

HEY NURSE STAFFING KEY METRICS DASHBOARD																																								
Jul-19					CARE HOURS PER PATIENT DAY [CHPPD] [hrs]									NURSING & MIDWIFERY VACANCIES					TEMPORARY STAFFING					UNAVAILABILITY						ROTA APPROVALS		ADDITIONAL DUTIES			UNFILLED ROSTER	HOURS BALANCES	STAFF REDEPLOYMENT			
KEY METRICS ROTA: 8th Jul 2019 - 4th Aug 2019					PEER HOSPITALS - CHKS LIST									[FINANCE LEDGER M4]					[8th Jul - 4th Aug-19]				HEADROOM 21.6% EXCLUDES MATERNITY LEAVE						[42 DAYS]					[<20%]	[4 WEEKS]	[INBOUND INC. 208 & ECT]				
HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	Other care staff not currently included in CHPPD HW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	RN [WTE]	RN % [<10%]	NON -RN [WTE]	NON -RN % [<10%]	TOTAL VACANCY [WTE]	RN & NON -RN -Est [WTE]	TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [≤ 1%]	STUDY DAY [≤ 2.3%]	WORKING DAY [1%]	MAT LEAVE [≤ 2.5%]	FULL [DAYS]	PARTIAL [DAYS]	TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [%]	HOURS BALANCE [%]	NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	7.39	7.0%	3.69	16.9%	11.15	126.79	4.8%	4.7%	0.1%	86.2%	25.3%	5.9%	15.2%	1.2%	1.6%	0.4%	1.0%	59.0	51.0	0.4	0.3	0.1	14.4%	1.0%	85.5	93.0	7.5
	AMU	GENERAL MEDICINE	45	LOW	178.5	1151	5114.5	2584.5	6.7	7.55	-0.86	7.31	-0.62	11.80	22.9%	4.15	14.8%	16.18	79.63	3.5%	3.3%	0.2%	38.3%	30.5%	5.2%	19.0%	0.0%	2.1%	0.6%	3.6%	27.0	27.0	0.8	0.6	0.2	17.7%	0.5%	142.0	210.0	68.0
	H36	GENERAL MEDICINE	24	LOW	399.0	664	1797.3	1263.0	4.6	7.55	-2.94	7.31	-2.70	0.00	0.0%	0.00	0.0%	0.00	21.59	7.6%	5.1%	2.5%	57.6%	21.9%	3.4%	12.3%	0.0%	1.9%	1.7%	2.6%	67.0	67.0	0.1	0.0	0.1	21.2%	3.4%	-185.5	202.0	387.5
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	582	1969.0	2014.5	6.8	6.94	-0.10	7.74	-0.90	5.86	30.7%	0.07	0.5%	6.24	32.27	23.2%	23.0%	0.2%	70.0%	28.3%	4.5%	14.9%	0.0%	0.5%	0.4%	8.0%	28.0	21.0	0.2	0.0	0.2	30.2%	2.6%	49.0	58.0	9.0
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	749	2910.3	1824.6	6.3	6.74	-0.42	6.38	-0.62	3.68	15.3%	2.84	21.6%	6.67	37.25	12.6%	11.2%	1.4%	43.1%	35.1%	4.9%	19.1%	0.8%	0.1%	0.0%	10.2%	28.0	6.0	0.3	0.3	0.0	16.0%	0.4%	88.8	150.8	62.0
	H50	NEPHROLOGY	19	LOW	283.5	573	1620.5	1087.8	4.7	7.23	-2.50	7.00	-0.27	0.83	5.6%	0.26	-11.1%	0.63	17.20	4.8%	4.8%	0.0%	66.1%	29.4%	5.2%	15.9%	0.0%	2.3%	3.1%	2.9%	67.0	39.0	0.0	0.0	0.0	17.1%	-1.9%	1.5	38.0	36.5
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	721	1889.0	1753.0	5.1	6.74	-1.69	6.38	-1.33	4.02	24.6%	1.76	13.4%	6.03	29.53	12.7%	12.7%	0.0%	44.7%	30.2%	5.8%	17.3%	1.5%	1.9%	0.0%	3.7%	38.0	6.0	0.0	0.0	0.0	20.6%	3.9%	91.0	104.5	13.5
	H10	GENERAL MEDICINE	30	MEDIUM	441.0	827	2004.0	2488.5	5.4	7.55	-2.12	7.31	-1.88	11.65	54.6%	-2.79	-21.2%	9.41	34.50	18.6%	14.1%	4.5%	58.5%	23.3%	2.7%	12.3%	3.0%	1.7%	3.6%	0.0%	31.0	30.0	0.8	0.6	0.2	19.4%	20.1%	68.5	138.5	70.0
	H8	GERIATRIC MEDICINE	27	LOW	220.5	478	1860.1	1932.5	7.9	6.94	0.99	6.74	1.19	2.49	15.2%	-0.11	-0.8%	2.53	29.53	5.9%	5.3%	0.6%	45.5%	29.6%	5.0%	16.9%	0.1%	2.1%	2.3%	3.2%	61.0	48.0	0.3	0.1	0.2	11.9%	-2.5%	58.0	86.5	28.5
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	748	1532.0	2942.8	6.0	6.94	-0.96	6.74	-0.76	2.07	18.9%	-4.20	-26.4%	-1.94	26.82	11.4%	6.5%	4.9%	85.4%	32.7%	8.7%	15.9%	1.1%	1.5%	2.7%	2.8%	33.0	33.0	0.2	0.2	0.0	16.9%	1.4%	153.5	153.5	0.0
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	913	1833.4	2315.5	4.5	6.94	-2.40	6.74	-2.20	3.35	20.5%	-1.67	-10.7%	1.88	32.03	4.6%	3.7%	0.9%	64.0%	20.7%	6.7%	12.0%	0.0%	2.0%	0.0%	0.0%	69.0	68.0	0.2	0.1	0.1	8.8%	3.8%	47.8	134.0	86.3
	H90	GERIATRIC MEDICINE	29	LOW	252.0	509	1776.5	1917.6	7.3	6.94	0.32	6.74	0.52	2.61	15.9%	-1.40	-10.6%	1.37	29.53	4.8%	4.8%	0.0%	103.4%	30.9%	9.8%	14.7%	0.2%	2.5%	0.9%	2.8%	95.0	88.0	0.6	0.4	0.2	18.6%	1.6%	92.2	133.9	41.8
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	849	1848.8	2229.3	4.8	7.55	-2.75	7.41	-2.61	6.85	31.7%	-3.04	-29.1%	4.13	32.03	7.5%	7.5%	0.0%	44.3%	30.3%	0.9%	15.8%	3.0%	1.7%	5.9%	3.0%	45.0	21.0	1.0	0.7	0.3	17.5%	1.4%	95.3	102.8	7.5
	H110	STROKE / NEUROLOGY	24	LOW	252.0	614	2577.0	2342.0	8.0	7.55	0.46	7.41	0.60	7.40	27.1%	-2.84	-27.2%	4.83	37.72	10.8%	10.8%	0.0%	45.8%	29.0%	9.8%	13.3%	0.1%	2.8%	0.0%	3.0%	39.0	19.0	0.0	0.0	0.0	20.8%	5.3%	90.0	522.0	432.0
CDU	CARDIOLOGY	9	LOW	0.0	135	1133.5	115.0	9.2	7.93	1.32	7.73	1.52	0.77	6.0%	0.49	20.1%	1.32	15.25	4.4%	4.4%	0.0%	39.2%	30.8%	1.0%	13.8%	6.9%	0.0%	1.0%	8.1%	61.0	9.0	0.0	0.0	0.0	44.3%	-1.2%	0.0	0.0	0.0	
C26	CARDIOLOGY / CTS	26	LOW	236.5	155	2703.0	1005.5	23.9	8.46	15.47	9.93	14.00	0.43	1.8%	-0.75	-9.5%	-0.30	32.03	0.2%	0.2%	0.0%	12.5%	21.1%	2.6%	15.3%	0.0%	3.0%	0.2%	0.0%	66.0	39.0	0.0	0.0	0.0	18.2%	5.8%	3.0	11.0	8.0	
C28 /CMU	CARDIOLOGY	27	LOW	277.2	735	4228.0	986.5	7.1	7.44	-0.35	7.87	-0.78	9.65	25.4%	-1.01	-12.5%	8.89	46.04	0.2%	0.2%	0.0%	11.1%	22.8%	5.9%	11.7%	0.7%	2.0%	0.9%	1.6%	45.0	19.0	0.0	0.0	0.0	23.7%	5.2%	86.5	94.5	8.0	
SURGERY	H4	NEUROSURGERY	28	MEDIUM	157.5	771	2426.0	1347.6	4.9	8.39	-3.50	8.71	-3.82	5.02	23.3%	1.15	11.0%	6.40	19.99	11.7%	11.7%	0.0%	71.5%	26.9%	9.0%	13.7%	0.0%	2.6%	1.6%	0.0%	32.0	32.0	0.4	0.3	0.1	20.4%	-1.1%	101.1	126.1	25.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	392	2583.0	1789.3	11.2	8.39	2.76	8.71	2.44	2.52	11.8%	-1.02	-11.0%	1.62	5.27	12.0%	10.2%	1.8%	48.8%	25.9%	5.4%	14.4%	0.8%	0.6%	0.1%	4.6%	39.0	39.0	0.0	0.0	0.0	15.8%	0.6%	143.3	192.3	49.0
	H6	GENERAL SURGERY	28	LOW	283.5	723	2389.8	1627.3	5.6	6.99	-1.43	7.26	-1.70	1.64	8.5%	1.28	10.9%	3.01	9.69	24.9%	24.3%	0.6%	71.3%	33.2%	9.3%	16.3%	0.3%	2.9%	0.6%	3.8%	54.0	54.0	0.1	0.0	0.1	12.9%	1.8%	68.5	90.5	22.0
	H60	GENERAL SURGERY	28	LOW	126.0	776	2362.6	1699.3	5.2	6.99	-1.76	7.26	-2.03	0.96	5.0%	2.41	20.4%	3.42	11.03	10.7%	10.7%	0.0%	51.3%	23.5%	1.6%	16.0%	0.0%	0.7%	0.0%	5.2%	58.0	54.0	0.0	0.0	0.0	11.4%	-0.2%	-15.0	32.0	47.0
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	860	2175.4	1716.5	4.5	6.99	-2.46	7.26	-2.73	5.25	21.8%	-1.08	-10.1%	4.39	12.62	13.0%	11.2%	1.8%	35.7%	29.4%	2.9%	15.6%	0.0%	0.9%	0.0%	10.0%	55.0	54.0	0.0	0.0	0.0	24.7%	-3.7%	61.2	94.7	33.5
	H100	GASTROENTEROLOGY	27	LOW	239.4	828	2184.3	1809.0	4.8	6.63	-1.81	6.29	-1.47	2.22	11.3%	0.81	6.2%	3.14	9.62	8.3%	8.3%	0.0%	57.2%	23.7%	3.1%	16.2%	0.0%	0.5%	0.7%	3.2%	60.0	59.0	0.0	0.0	0.0	16.7%	2.3%	2.0	57.5	55.5
	H12	ORTHOPAEDIC	28	LOW	252.0	742	2285.0	2149.3	6.0	7.13	-1.15	7.25	-1.27	2.56	11.9%	0.41	3.1%	3.09	8.89	12.6%	12.3%	0.3%	49.5%	34.3%	9.8%	14.1%	0.1%	1.3%	1.6%	7.4%	35.0	32.0	0.2	0.2	0.0	15.4%	1.0%	30.8	102.8	72.0
	H120	ORTHO / MAXFAX	22	LOW	283.5	558	2024.9	1320.4	6.0	7.13	-1.13	7.25	-1.25	0.57	3.5%	0.19	1.6%	0.79	2.82	10.6%	10.6%	0.0%	74.7%	31.1%	2.0%	13.8%	0.6%	3.6%	3.2%	7.9%	33.0	32.0	0.0	0.0	0.0	10.1%	1.2%	-8.0	30.8	38.8
	HICU	CRITICAL CARE	22	LOW	252.0	479	12346.3	768.3	27.4	27.13	0.25	26.60	0.78	2.82	2.7%	0.35	4.8%	3.20	2.85	0.1%	0.1%	0.0%	33.3%	26.6%	5.4%	16.1%	0.3%	0.6%	1.0%	3.2%	62.0	55.0	0.1	0.1	0.0	17.2%	1.1%	74.4	113.3	38.8
	C9	ORTHOPAEDIC	35	LOW	252.0	688	2439.0	1499.5	5.7	7.13	-1.41	7.25	-1.53	2.51	11.5%	1.80	13.9%	4.42	12.72	4.3%	4.3%	0.0%	25.4%	31.4%	7.3%	17.2%	0.0%	2.1%	1.9%	2.9%	48.0	40.0	0.0	0.0	0.0	19.7%	0.5%	-69.5	0.0	69.5
	C10	GENERAL SURGERY	21	LOW	252.0	504	2196.3	985.0	6.3	6.99	-0.68	7.26	-0.95	3.68	20.3%	1.26	15.6%	5.14	19.67	14.0%	14.0%	0.0%	55.5%	21.0%	4.0%	12.7%	0.0%	3.9%	0.4%	0.0%	47.0	44.0	0.2	0.2	0.0	14.4%	3.3%	-102.5	0.0	102.5
	C11	GENERAL SURGERY	22	LOW	252.0	554	2163.5	990.0	5.7	6.99	-1.30	7.26	-1.57	3.45	16.8%	1.88	23.3%	5.50	19.22	5.1%	5.1%	0.0%	37.9%	21.9%	3.0%	15.5%	0.6%	1.8%	1.0%	0.0%	54.0	48.0	0.0	0.0	0.0	22.3%	5.0%	82.5	82.5	0.0
	C14	GENERAL SURGERY	27	LOW	252.0	709	2660.8	1298.3	5.6	6.99	-1.41	7.26	-1.68	0.91	4.5%	-0.52	-5.3%	0.44	1.46	7.2%	6.9%	0.3%	60.0%	25.6%	1.9%	13.7%	0.2%	3.7%	0.2%	5.9%	45.0	44.0	0.2	0.2	0.0	12.6%	3.5%	149.8	149.8	0.0
	C15	UROLOGY	26	MEDIUM	283.5	640	2488.0	1515.0	6.3	6.47	-0.22	6.67	-0.42	3.70	18.0%	0.36	3.5%	4.24	13.67	2.6%	2.6%	0.0%	29.7%	23.2%	3.6%	11.4%	0.0%	1.7%	0.2%	6.3%	38.0	34.0	0.1	0.1	0.0	10.6%	0.9%	25.5	48.5	23.0
C27	CARDIOTHORACIC	26	LOW	283.2	770	2871.3	1108.0	5.2	8.46	-3.29	9.93	-4.76	2.76	11.7%	-0.69	-8.0%	2.19	6.78	1.1%	1.1%	0.0%	57.9%	20.9%	2.7%	13.6%	0.0%	1.5%	0.0%	3.1%	49.0	41.0	0.0	0.0	0.0	7.4%	3.2%	32.0	53.0	21.0	
CICU	CRITICAL CARE	22	LOW	157.5	453	10422.7	754.8	24.7	27.13	-2.46	26.60	-1.93	2.82	3.1%	0.35	4.8%	3.20	3.26	1.0%	1.0%	0.0%	95.8%	24.9%	4.8%	14.0%	0.0%	0.9%	0.7%	4.5%	61.0	55.0	0.0	0.0	0.0	17.5%	3.5%	-70.5	107.5	178.0	

**Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 29 July 2019**

Present:	Prof M Veysey Prof J Jomeen Mr S Hall Mrs V Walker Mrs B Geary Dr M Purva Mr D Corral Ms C Ramsay Mrs K Southgate	Non-Executive Director (Chair) Non-Executive Director Vice Chair Non-Executive Director Chief Nurse Chief Medical Officer Chief Pharmacist Director of Corporate Affairs Acting Deputy Director of Quality Governance and Assurance

In Attendance:	Mrs R Thompson Corporate Affairs Manager (Minutes)

No	Item	Action

1	Apologies: Apologies were received from Mrs M Stern, Patient Council Chair and Mrs A Green, Lead Clinical Research Therapist	

2	Declarations of interest There were no declarations made.	

3	Minutes of the meeting of 1 July 2019 The minutes were approved as an accurate record of the meeting.	

3.1 Matters Arising

Dr Purva updated the Committee regarding 30 day readmissions and advised that performance was where it was expected to be with the usual seasonal fluctuations. The Committee agreed that the action had been completed and would not need to be added to the Action Tracker.

3.2 Action Tracking List

Prof Veysey agreed to raise the idea of having a Humber Board to Board at the July 2019 Trust Board meeting.

The End of Life Team to attend the Committee in September 2019.

3.3 Any Other Matters Arising

There were no other matters arising.

3.4 Workplan 2019/20

Ms Ramsay advised that the Workplan had been set for the year and there were no issues to report.

4.1 Quality Improvement Programme

Mrs Southgate presented the item and advised that the new QIP was progressing well. Mrs Southgate reported that look back exercises relating to the deteriorating patient and nutrition would be carried out and the findings would be published in the next report.

There was a discussion around the new presentation of the report and the Committee agreed that the new SPC charts worked well to show the upper and lower control limits. Mrs Walker stated that it was key to capture patient experience outcomes as well as the quality improvements. Mrs Geary advised that she was changing the Quality Report and this would include the work ongoing regarding patient experience.

Prof Veysey asked that a senior lead be attributed to each QIP so that if the Committee had any issues it could invite the relevant lead to discuss the issues further. He added that this would ensure accountability when delivering the plans. Mrs Southgate agreed to add leads into the report.

KS

Mrs Southgate advised that the revised QIP had been presented to the Operational Quality Committee to measure baselines and ensure that projects were measurable and achievable.

Resolved:

The Committee received and accepted the report.

4.2 Quality Report July 2019

Mrs Geary presented the report and highlighted the National Patient Safety Strategy and conference relating to getting the right care first time, staff wellbeing and supporting staff.

Mrs Geary reported that the Trust was reporting 93.4% harm free care in June 2019, this was out of 882 patients surveyed.

Mrs Geary updated the Committee regarding healthcare associated infections and advised that the Trust C-difficile performance was good, there had been 1 MRSA and a number of MSSA Bacteraemia which had taken the Trust over its threshold. The themes coming out of the MSSA Bacteraemia investigations was around lines management and a task and finish group had been set up to review this. Mrs Geary also advised that due to increased MRSA screening a number of pseudomonas had been found on NICU and this was being addressed.

There had been a peak of influenza in Australia of both A and B types. Mrs Geary expressed her concern and advised that there was a robust and detailed flu plan commencing in October 2019. The plan was to vaccinate as many people attending the Trust as possible, including visitors and patient's families. The Committee discussed the nursing home residents and the difficulties that the GPs were facing to manage the amount of patients to be vaccinated. Mrs Walker made the point that issues such as this would encourage Integrated Care working and the principles of working as a system, pooling budgets which would help the health population through preventative measures.

Mrs Geary spoke about the young volunteer project and how the Trust had received funding to develop the initiative. She reported that the volunteers were really making a difference and that they could be new staff for the future. Prof Jomeen was keen to review and enhance the pathways into the programmes.

Mrs Geary advised that she had a meeting with the CQC next week and that

they had requested a tour of the Emergency Department.

Resolved:

The Committee received and accepted the report.

4.3 Integrated Performance Report

The Committee reviewed the report and Mr Hall advised that the areas being covered by the Performance and Finance meeting would be ED, the feedback from the NHS IE visit, cancer, RTT and diagnostics.

The Committee discussed ED performance and how performance and patient experience were being affected. Mr Hall stated that from a quality perspective there were no issues.

The Committee also discussed 30 day readmission performance, mortality, and endoscopy as areas of concern. Mrs Geary suggested a narrative be added to the indicators in the report, especially where there had been a long period of not achieving the targets, or exception reports be prepared for poor performance to highlight any impact on patients.

BG

Resolved:

The Committee received and accepted the report.

4.4 Mortality – Learning from deaths framework

Dr Purva presented the report which provided assurance that there were no serious reasons for mortality amongst patients.

Dr Purva reported that the 3 most common causes of death were pneumonia, sepsis and stroke. There were 3 ongoing Structured Judgement Reviews currently ongoing and these were carried out when patients met the serious investigation criteria.

Prof Veysey asked about the Medical Examiner role and how this was being progressed. Dr Purva advised that work was ongoing to recruit and the role would be in place October/November 2019. Dr Purva added that she was visiting a Trust in Aberdeen in September to review the Scottish framework and how they manage reviews. A report would be brought to the meeting in October 2019 to update the Committee regarding the Medical Examiner and the morbidity framework.

Prof Jomeen expressed concern regarding the report format and was unclear of the governance structure around mortality. Dr Purva assured her that the Mortality and Morbidity Committee was the main committee that reviewed hospital deaths and this committee fed up to the Operational Quality Committee. Scrutiny of each SJR and triangulation of complaints were being carried out and the learning report would be presented to the Quality Committee also on a 6 monthly basis.

Mrs Southgate added that any major updates would be included in the Quality Report to the Board.

Resolved:

The Committee received and accepted the report.

4.5 Fundamental Standards

Mrs Geary presented the report and advised that it was an improving picture with 80% now showing blue or green. There was still work to be done mainly with patient documentation, tissue viability and nutrition. Mrs Geary had commissioned a review into the standards to ensure the right collection criteria was in place.

Mrs Geary advised that a new fundamental standard had been added around the deteriorating patient. Recognise and respond would be added to the deteriorating bundle and reported at future Board meetings.

Prof Veysey congratulated the progress that had been made with the fundamental standards. Mr Hall asked about patient discharge and whether this would fit into the audits and Mrs Geary advised that all aspects of care were being reviewed.

Mrs Geary had removed the term 'worry ward' from the standards and the Yorkshire Contributory Factor framework was being implemented to provide a supportive environment for all staff.

There was a discussion around fundamental standards and how they were nurse led and the need for other clinical and non-clinical staff to become more engaged and accountable. Dr Purva questioned the amount of questions in the audit and Mrs Geary advised that she was looking to strip back and change the questions to make the audits more meaningful.

Resolved:

The Committee received and accepted the report.

4.6 Medicines Safety and Optimisation

Mr Corral presented the Annual Assurance Report on medication and gave a presentation relating to dangerous drugs.

The presentation set the context to dangerous drugs and how they are controlled and monitored. Mr Corral spoke of the recommended actions which the CQC had informed the Trust to take which included, reporting, sharing information, introducing a controlled drug register and working up Service Level Agreements with other providers.

Resolved:

The Committee received and accepted the report and presentation relating to medicine safety and optimisation.

5.1 Serious Incidents

Mrs Southgate presented the report and highlighted the Serious Incidents and Never Events that had been reported in month.

Mr Hall added that he had attended a Never Event investigation and was concerned about staff 'Stopping the Line' and then the issues not being rectified. Mrs Southgate advised that a full launch of the 'Stop the Line' initiative would be implemented on 17th September 2019 which was Patient Safety Day. A full training programme would be offered to staff. Mrs Geary added that her slogan 'everyone is a safety champion' would also be launched.

Mrs Southgate reported that the findings and learning from the Never Events would be presented to the Committee in due course.

BG

Resolved:

The Committee received and accepted the report.

6.1 Operational Quality Committee Report

Dr Purva presented the summary report to the Committee.

6.2 Board Assurance Framework

Ms Ramsay presented the report and advised that it contained the Q1 ratings following being reviewed at the Board and Committees previously. Ms Ramsay advised that there were no major changes to note and any positive assurance or gaps in assurance had been added to the report.

Ms Ramsay advised that each of the risks would be monitored by the Board either in public or at development sessions.

Prof Jomeen mentioned non-medical staff and how these roles would be supported and the risks around poor placements and poor role modelling.

Resolved:

The Committee received and accepted the report.

7 Any Other Business

Dr Purva gave an update regarding the WHO checklist. She reported that the Trust was now auditing the checklist and the results were positive. All theatres had been audited and the roll out to other areas had started.

A task and finish group had been established to give more training where necessary and the University had released 5 lecturers to also give training and write up their experiences as a paper challenging the processes. Mr Kotwal, Associate Medical Director was the lead and was championing the initiative from the front line.

8 Chairman's summary to the Board

Prof Veysey agreed to provide a summary for the Board.

9 Date and time of the next meeting:

Tuesday 27 August 2019, 8.30am – 10.30am, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held 27 August 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr S Hall	Vice Chair/Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Council Chair
In Attendance:	Ms K Rudston	Assistant Chief Nurse (Item 4.2)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	Apologies: Apologies were received from Dr Purva, Chief Medical Officer, Mrs K Southgate, Acting Deputy Director of Quality Governance and Assurance and Prof J Jomeen, Non-Executive Director	
2	Declarations of Interest Mrs Walker declared an interest in item 4.2 and the Safeguarding Adults report as she sat on the East Riding Safeguarding Adults Board.	
3	Minutes of the meeting 29 July 2019 The minutes of the meeting held 29 July 2019 were approved as an accurate record.	
	3.1 Matters arising from the minutes Mrs Green asked for clarity around when the Medical Examiner update would be received at the Committee. Ms Ramsay advised that it would be included in the October 2019 Learning from Deaths report and this was on the workplan.	
	3.2 Action tracking list The QIP leads had been added to the document. The outcomes of the Never Events would be included in the Serious Incident report as soon as the investigations had been completed.	
	3.3 Any other matters arising There were no other matters arising.	
	3.4 Workplan 2019/20 Ms Ramsay advised that all reports had been received apart from the Trustwide learning report which had been deferred to September 2019 due to annual leave.	
	4.1 Quality Improvement Programme Mrs Geary presented the report and advised that project leaders had now been allocated to each QIP. She reported that the QIP was updated every month and projects were on track. There was a discussion around the Matron's Handbook and how this was	

being used. Mrs Geary advised that an audit was taking place relating to the Handbook and the outcome of the audit would determine the next steps.

The Committee discussed QIP05 (Medicine Optimisation) and QIP06 (Deteriorating Patient) and work was ongoing to ensure the risks were mitigated.

There was a detailed discussion regarding nutrition and the vacancies relating to specialist dietetic staff. Mrs Geary advised that there was a lot of work going on around nutrition such as patients requesting a larger meal in the middle of the day and a lighter meal on an evening. Other patients had asked for finger buffet style food. The Trust was responding to these requests. Mrs Geary added that a task and finish group had been established to review nutrition and improve performance.

Resolved:

The Committee received and accepted the report.

4.2 Safeguarding Annual Report

Safeguarding Children and Young People

Ms Rudston presented the report and highlighted changes to the local Safeguarding Children's Board, new 24 hour paediatric nursing in ED, the work ongoing with domestic abuse, the Anlaby Suite move and that policies and procedures had been updated.

One of the key areas of work was to recruit a named Doctor to the service and Dr Clarkson had been appointed to start around Christmas time.

Ms Rudston advised that Safeguarding training was at 68% compliant. The CCG had changed the compliance level to 85%, so the Trust was working towards this new target.

Ms Rudston reported that it was key to ensure the local authorities and the Trust worked closely together and work was ongoing with the CAHMs service at Humber FT to ensure maximum engagement.

Prof. Veysey asked about the downward trend in numbers and Ms Rudston advised that it was due to other organisations such as schools, local authorities working with the hospital to reduce referrals due to earlier interventions. He asked how the Trust compared nationally and Ms Rudston agreed to review this.

KR

Safeguarding Adults

Mrs Walker declared an interest in the item as she sat on the East Riding Adult Safeguarding Board.

Ms Rudston presented the report and advised that there had been no compliance issues raised during the 2018 CQC inspection. She added that there had been a successful Enhance Care Team pilot carried out with approval to recruit to a substantive team in 2019/20.

Ms Rudston highlighted some key points from 2018/19 such as a review with Humber FT regarding patients detained under the Mental Health Act, which had resulted in achieving 80% compliance, the review of the domestic abuse policy, e-Learning packages being implemented and a new flagging

system for patients with learning difficulties.

Key areas of focus for 2019/20 included a review of the Training Document for Safeguarding, implementation of domestic abuse training and working with the Community to ensure programmes are shared.

Ms Rudston advised that all Serious Incidents relating to Safeguarding were checked by herself and she thanked the Compliance Team for their help and support in this.

Mrs Walker asked how safe the pathways were for vulnerable patients and was it dependant on the quality of the staff. Ms Ramsay advised that full assessments were carried out with very specific instructions in line with the Mental Health Act. Work was ongoing to work closely with Humber FT to ensure all patients with mental health needs were treated appropriately. Ms Rudston added that some patients were very complex and a lot of support was needed.

Mrs Green commended the report and advised that clinicians often sought support from the Safeguarding teams which was reassuring.

Resolved:

The committee received and accepted the report.

4.3 Integrated Performance Report

The Committee discussed the Trust's performance around the constitutional standards and asked whether this was impacting on patient care, in particular in the Emergency Department. Mrs Geary agreed to produce an exception report for the next meeting to assure the Committee that patients were safe and were being cared for appropriately.

BG

The Committee discussed the Friends and Family Test results and how positive they were. Mrs Geary added that the Trust had a million contacts with patients per year and only received 12 complaints per week.

Mrs Walker added that she had received a positive story via a patient and the bowel screening service. The patient was not kept waiting and was treated in a kind and compassionate way.

Resolved:

The Committee received and accepted the report.

4.4 Quality Report

Mrs Geary presented the report and advised that she was working with teams to produce quarterly quality reports in each area such as infection control and patient experience. Mrs Geary was working with Dr Purva to produce the new report.

Mrs Geary informed the Committee that a Never Event had been declared relating to wrong site surgery. The investigation would take place and the outcome would be presented to the Committee. The Never Event relating to the NG tube investigation had been completed and would be presented to the Commissioners next week.

The number of patients with harm free care was being reported at 93.8%.

Mrs Geary reported that 19 MSSA bacteraemia cases had been reported by the Trust since April 2019. All cases would be subject to root cause analysis. The Trust had also reported 9 hospital onset and 6 community onset CDifficile cases. The investigations were ongoing to review any themes and trends emerging.

Mr Hall asked for clarification around pressure sores that were not acquired in the hospital and whether these were reported to the CCGs. Mrs Geary assured the Committee that they were reported appropriately.

Resolved:

The Committee received and accepted the report.

5.1 Workforce and people strategy update

The item was deferred to the September 2019 meeting.

5.2 Serious incidents – Lessons learned – Themes and trends

Mrs Geary presented the report and advised that the first meeting of the newly formed Serious Incident Committee had been positive and interesting. The Committee was reviewing the Serious Incident investigation process as well as engaging with the commissioners and highlighting themes and trends.

There was a discussion around closing down actions and Mrs Geary advised that all actions were reviewed and closed down. Any issues were raised at the Performance and Accountability meetings.

Mrs Stern spoke of the Serious Incident meetings that she had attended with Mr Hall and how re-enactments of incidents were helping staff to understand and learn from what had gone wrong. Mr Hall added it had made him appreciate the devastating effect incidents could have on clinicians and all staff involved.

Resolved:

The Committee received and accepted the report.

6.1 Operational Quality Committee

The Committee received the summary of the committee held 14 August 2019.

6.2 Board Assurance Framework

Ms Ramsay presented the report and advised that nothing had changed since the Q1 ratings had been agreed at the Board meeting in July 2019. She advised that she would add today's discussion regarding the downward trends in performance.

Resolved:

The Committee received and accepted the report.

7

Any Other Business

Prof. Veysey to speak to Prof. Jomeen regarding her chairing the meeting in September 2019. Mrs Walker agreed to chair if Prof. Jomeen was unavailable.

8 Chairman's Summary to the Board

Prof. Veysey to summarise the meeting to the Board in September 2019.

9 Date and time of the next meeting:

Monday 30 September 2019, 9.00am – 11.00am, The Committee Room,
Hull Royal Infirmary

Integrated Performance Report

2019/20

September 2019

July data

The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined in the NHS Improvement – Single Oversight Framework.

Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

Variation

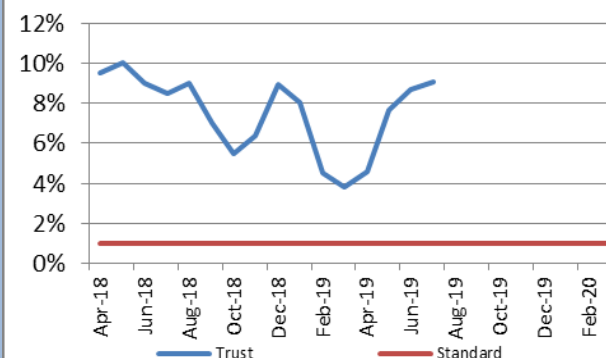
Diagnostic Waiting Times: 6 Weeks

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

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target during July with performance of 9.05%

DIAGNOSTICS



Breaches in month were:

Magnetic Resonance Imaging	31
Computed Tomography	45
Non-obstetric ultrasound	48
Cardiology - echocardiography	6
Neurophysiology - peripheral neurophysiology	1
Respiratory physiology - sleep studies	1
Urodynamics - pressures & flows	22
Colonoscopy (3 paed)	291
Cystoscopy	102
Gastroscopy (46 paed)	302
TOTAL	849

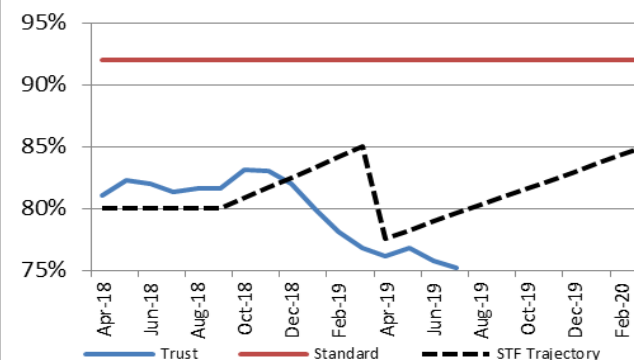
Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the July improvement trajectory of 79.6%

July performance was 75.18%. This failed to meet the national standard of 92%.

INCOMPLETE PATHWAYS



The RTT return is grouped in to 19 main specialties.

During the month there were 10 specialties that failed to meet the improvement trajectory

Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

Variation

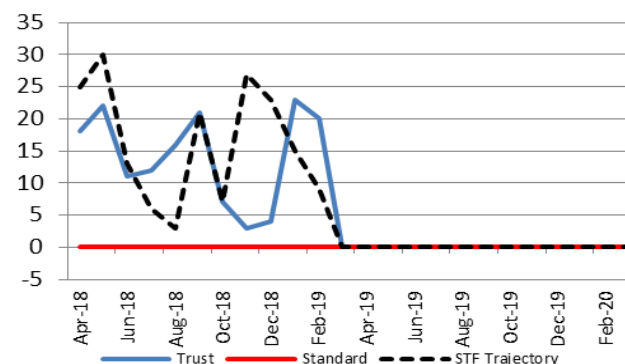
Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

Performance achieved the improvement trajectory of zero breaches during July

The Trust achieved the national standard of zero breaches.

RTT - 52 week wait



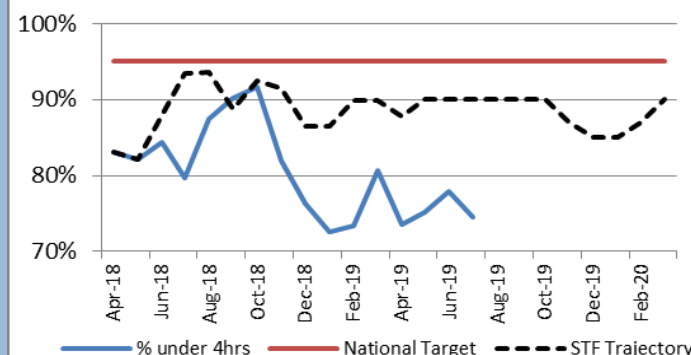
ED Waiting Times (HRI only)

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

Performance failed to achieve the planned trajectory of 90% with performance of 74.5% for July

This has failed to achieve the national 95% threshold.

EMERGENCY DEPARTMENT (TYPE 1 HRI ONLY)



Performance has decreased 3.5% during July

Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

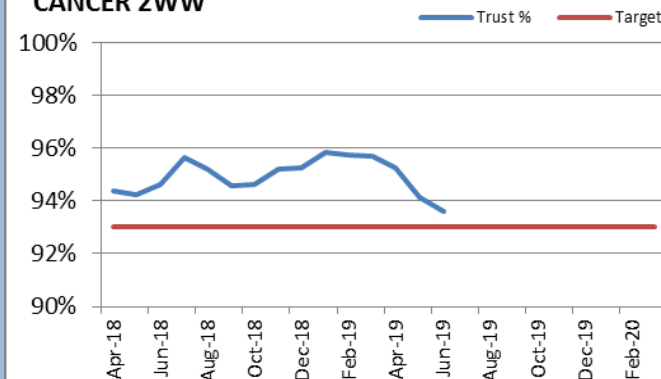
Variation

Cancer: Two Week Wait Standard

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

June performance achieved the 93% standard at 93.6%

CANCER 2WW

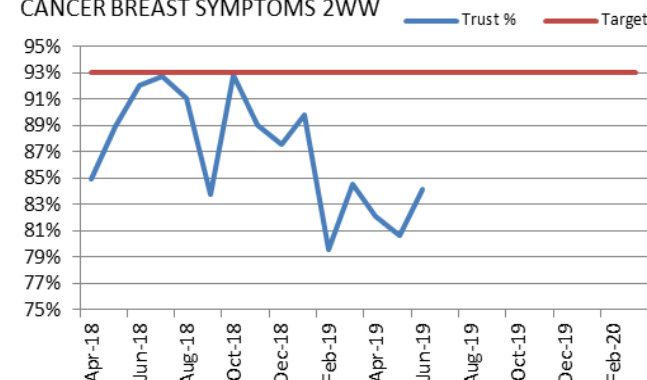


Cancer: Breast Symptom Two Week Wait Standard

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

June performance failed to achieve the 93% standard at 84.1%

CANCER BREAST SYMPTOMS 2WW



Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

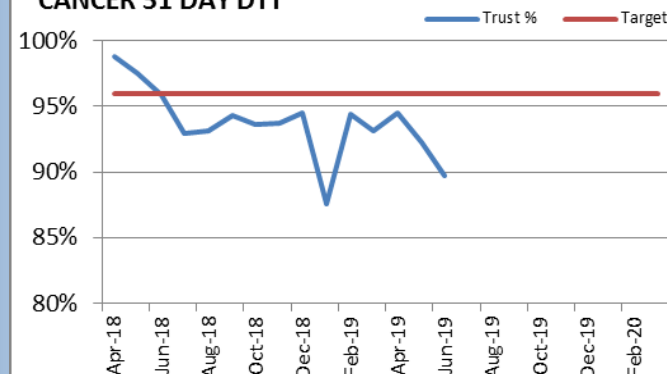
Variation

Cancer: 31 Day Standard

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

June performance failed to achieve the 96% standard at 89.7%

CANCER 31 DAY DTT

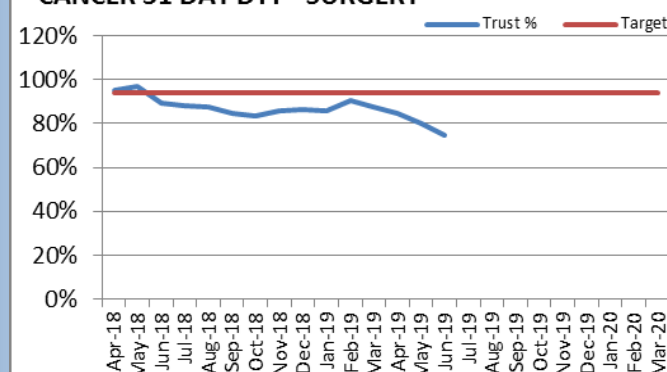


Cancer: 31 Day Subsequent Surgery Standard

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

June performance failed to achieve the 94% standard at 74.6%

CANCER 31 DAY DTT - SURGERY



Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

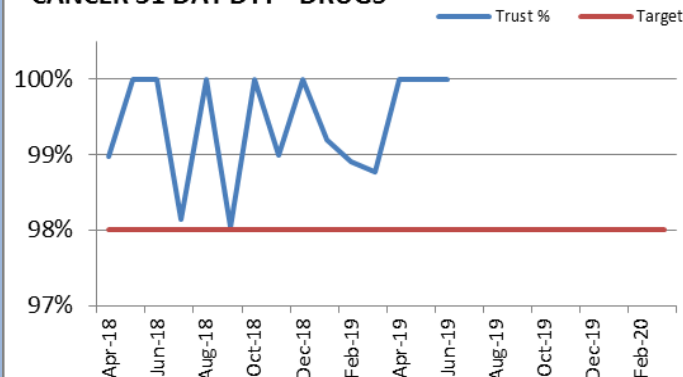
Variation

Cancer: 31 Day Subsequent Drug Standard

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

June performance achieved the 98% standard at 100%

CANCER 31 DAY DTT - DRUGS

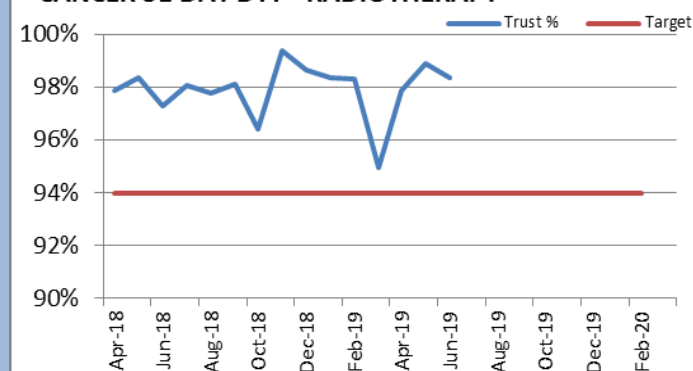


Cancer: 31 Day Subsequent Radiotherapy Standard

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

June performance achieved the 94% standard at 98.4%

CANCER 31 DAY DTT - RADIOTHERAPY



Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

Variation

Cancer: ADJUSTED - 62 Day Standard

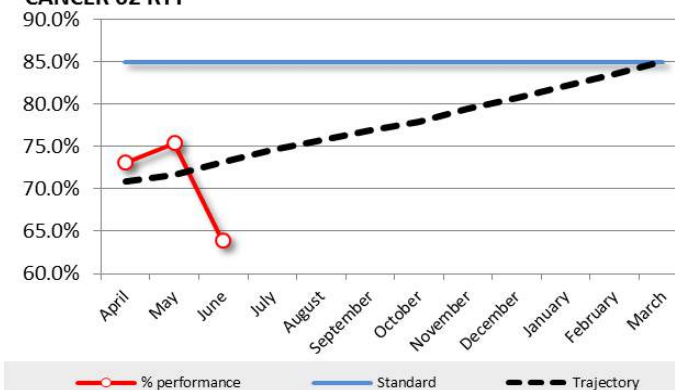
All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%

The latest adjusted performance available is June 2019.

June adjusted performance failed to achieve the 73.2% improvement trajectory with performance of 63.9%

Performance failed to achieve the national standard

CANCER 62 RTT

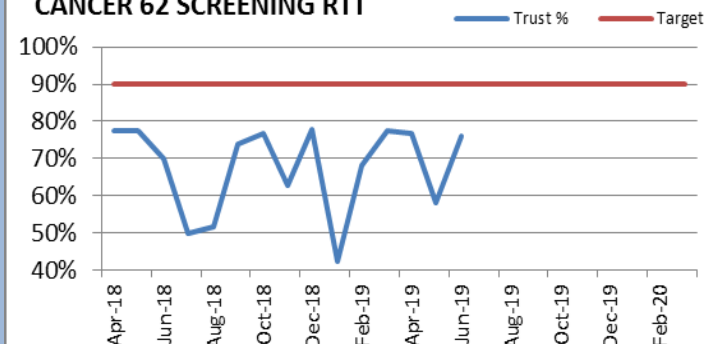


Cancer: 62 Day Screening Standard

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

June performance failed to achieve the 90% standard at 76.1%

CANCER 62 SCREENING RTT



Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

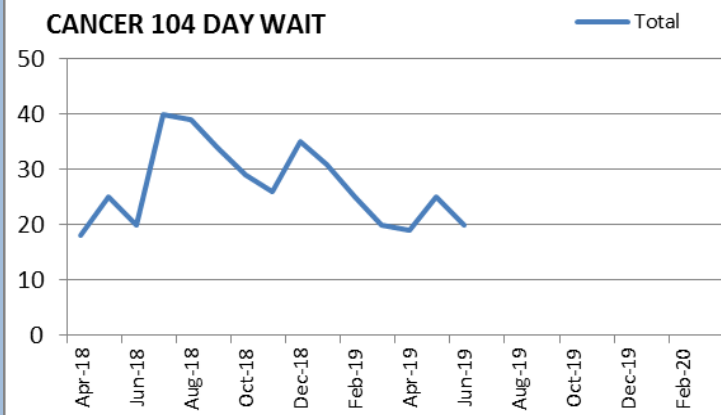
Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 20 patients waiting 104 days or over at the end of June

CANCER 104 DAY WAIT



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

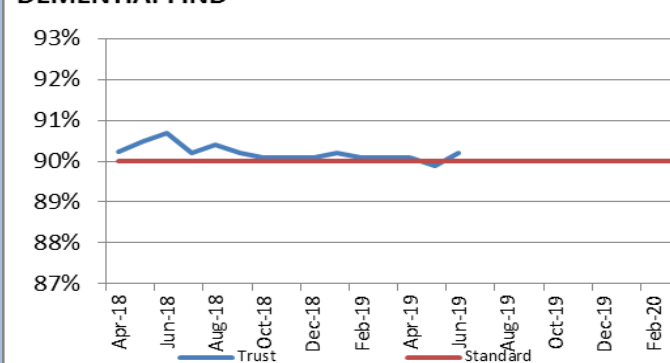
% of all patients asked the dementia case finding question within 72 hours of admission, or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question cannot be completed

The latest performance available is June 2019.

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard at 90.2%

DEMENTIA: FIND



Integrated Performance Report - September 2019

RESPONSIVE

Description

Aggregate Position

Trend

Variation

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

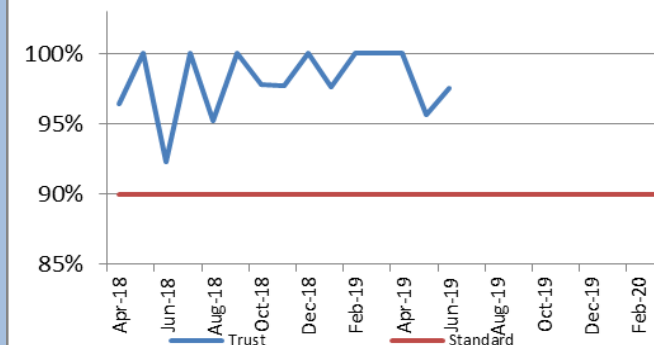
% of patients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations.

The latest performance available is June 2019

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard at 97.5%

DEMENTIA: ASSESS/INVESTIGATE



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

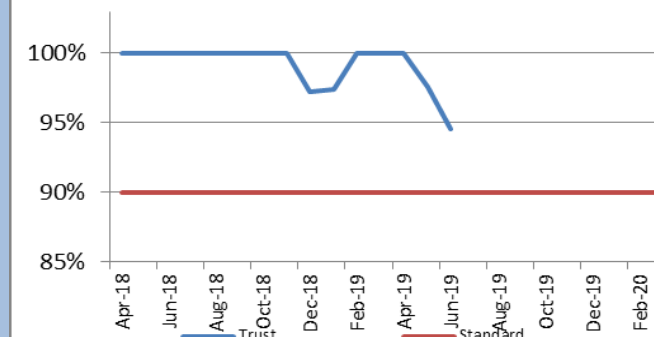
% of patients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.

The latest performance available is June 2019.

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard at 95%

DEMENTIA: REFERRAL



Integrated Performance Report - September 2019

SAFE

Description

Aggregate Position

Trend

Variation

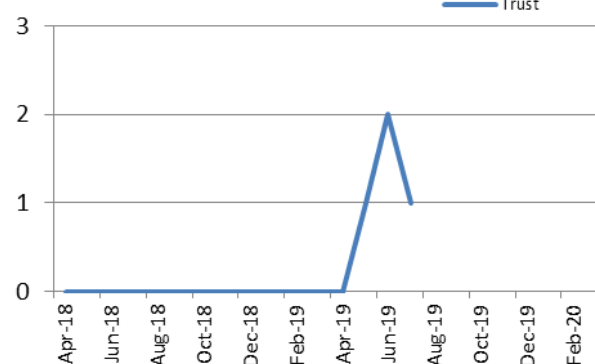
Occurrence of
any Never

Occurrence of
any Never
Events

The latest available
performance is July
2019

There was 1 case
reported during July
2019.

NEVER EVENTS



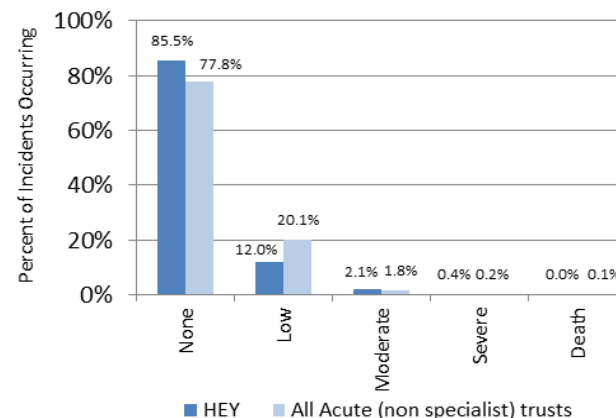
Further
information is
included in
the Board
Quality report

Potential
under-
reporting of
patient safety

Number of
incidents
reported per
1000 bed days

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

The Trust reported 7,984
incidents (rate of 48.83) during
this period. This rates the
Trust in the highest 25% of
reporters



Degree of Harm:

None 6,874
Low 849
Moderate 226
Severe 24
Death 11

Integrated Performance Report - September 2019

SAFE

Description

Aggregate Position

Trend

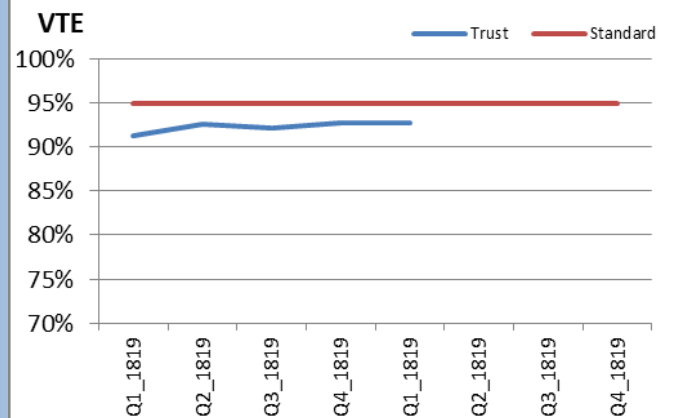
Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 92.68% for Q1 2019/20.



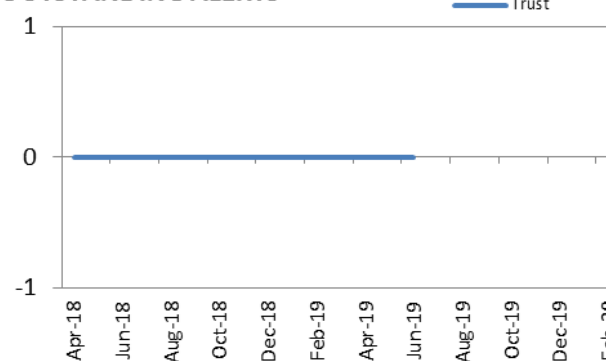
Patient Safety Alerts Outstanding

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

There have been zero outstanding alerts reported at month end for July 2019.

There have been no outstanding alerts year to date.

OUTSTANDING ALERTS



Integrated Performance Report - September 2019

SAFE

Description

Aggregate Position

Trend

Variation

MRSA Bacteraemia

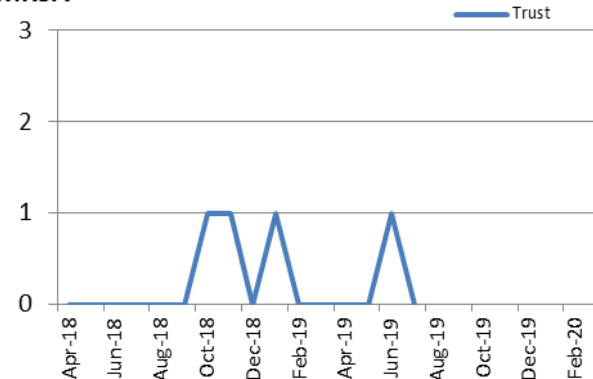
National objective is zero tolerance of avoidable MRSA bacteraemia

The Trust reported 3 cases of acute acquired MRSA bacteraemia during 2018/19.

There were no cases reported during July 2019.

There has been 1 case reported year to date.

MRSA



Further information is included in the Board Quality report

Clostridium Difficile

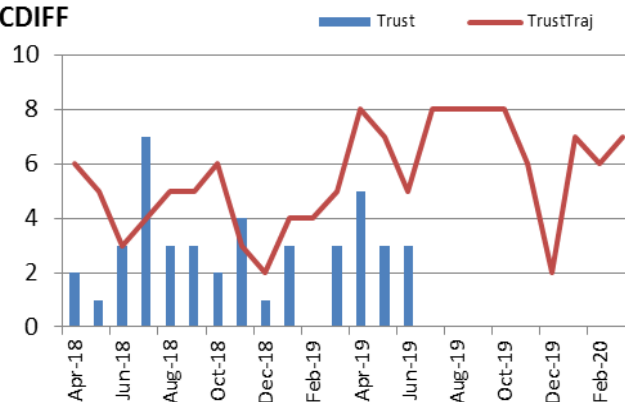
The Clostridium difficile target for 2019/20 is no more than 80 cases

There were 32 cases during 2018/19

There were zero incidences reported during July which achieved the monthly trajectory of no more than 8 cases

Year to date position is 11 cases against the trajectory of no more than 28 cases.

CDIFF



Further information is included in the Board Quality report

Integrated Performance Report - September 2019

SAFE

Description

Aggregate Position

Trend

Variation

Escherichia
Coli

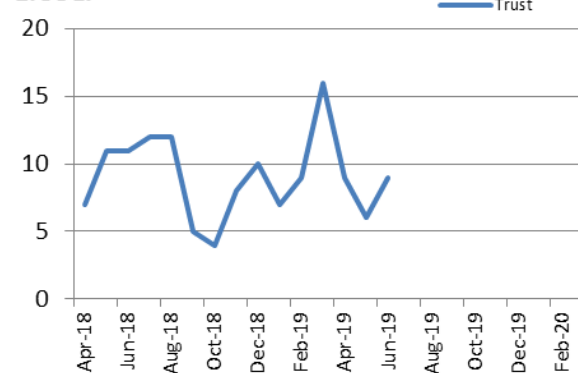
Number of
incidence of
E.coli
bloodstream
infections

There were 112 cases
during 2018/19

There were 9 incidences
reported during July
2019.

There have been 33
incidences reported year
to date.

E.COLI



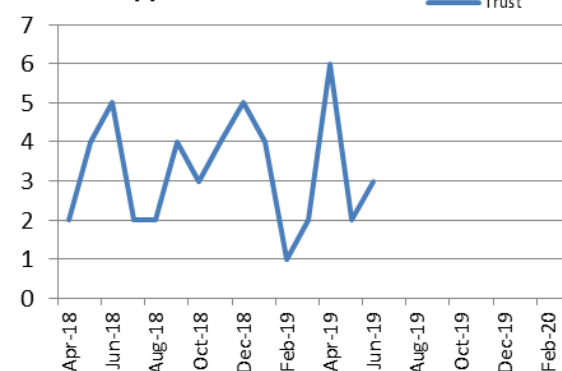
Klebsiella spp
bacteraemia

Number of
incidence of
Klebsiella spp
bacteraemia

There were 2 cases
reported during July
2019.

There have been 13
incidences reported
year to date.

Klebsiella spp bacteraemia



Integrated Performance Report - September 2019

SAFE

Description

Aggregate Position

Trend

Variation

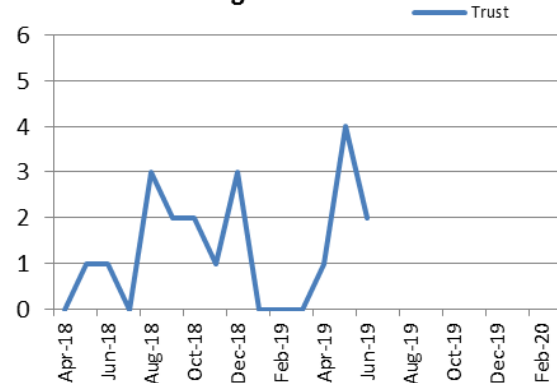
**Pseudomonas
aeruginosa
bacteraemia**

Number of
incidence of
Pseudomonas
aeruginosa
bacteraemia

There were 2 incidences
reported during July
2019.

There have been 9
incidences reported
year to date.

Pseudomonas aeruginosa bacteraemia



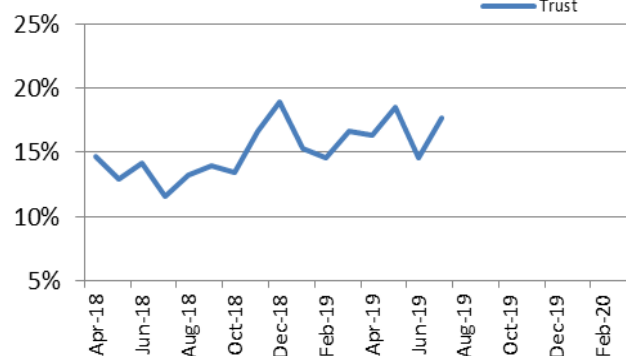
**Emergency C-
section rate**

Maternity:
Emergency C-
section rate per
month

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

Performance for July
failed to achieve this
standard at 17.7%

EMERGENCY C-SECTION



Further information
is included in the
Board Quality
report

Integrated Performance Report - September 2019

EFFECTIVE

Description

Aggregate Position

Trend

Variation

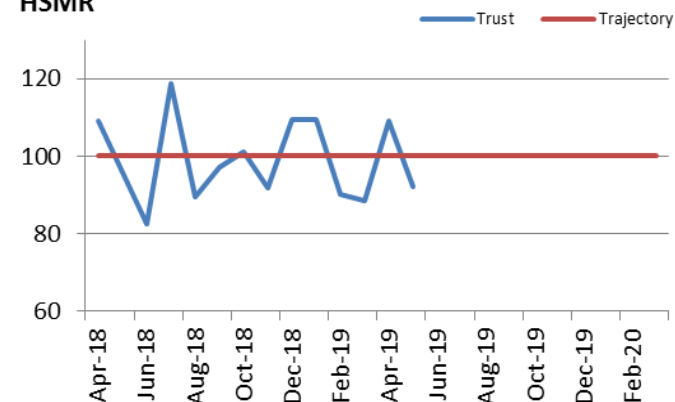
HSMR

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

May 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and May achieved this at 92.1

HSMR



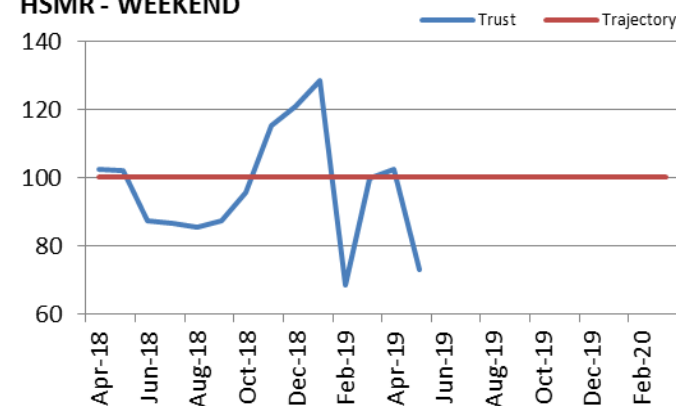
HSMR
WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

May 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and May achieved this at 72.8

HSMR - WEEKEND



Integrated Performance Report - September 2019

EFFECTIVE

Description

Aggregate Position

Trend

Variation

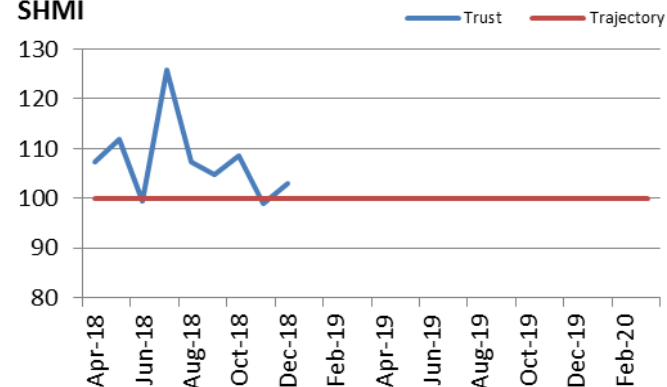
SHMI

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

December 2018 is the latest published performance

The standard for SHMI is to achieve less than 100 and December 2018 failed to achieve this at 102.9

SHMI



30 DAY READMISSIONS

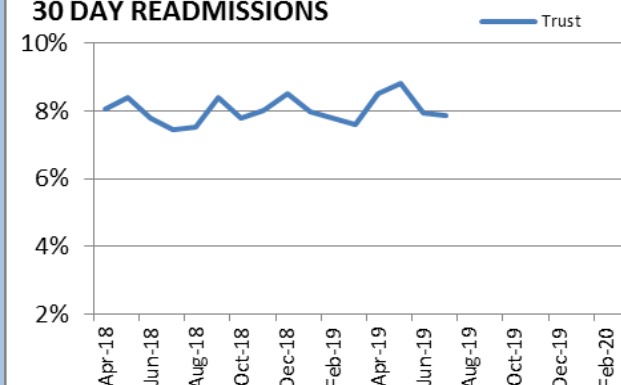
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is July 2019

The Trust should aim to achieve less than or equal to 2018/19 performance of 7.9%.

The Trust achieved this measure with performance of 7.88%.

30 DAY READMISSIONS



Integrated Performance Report - September 2019

CARING

Description

Aggregate Position

Trend

Variation

Inpatient
Scores from
Friends and
Family Test -
% positive

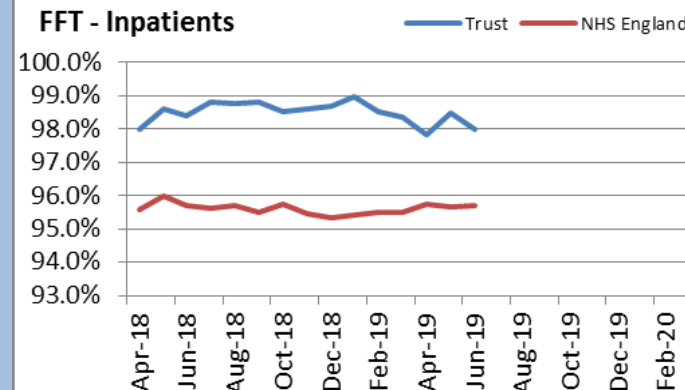
Percentage of
responses that
would be Likely
& Extremely
Likely to
recommend
Trust

Performance for June
was 97.97%

The latest published
data for NHS England
is June 2019.

July performance will
be published in
September.

FFT - Inpatients



A&E Scores
from Friends
and Family
Test - %

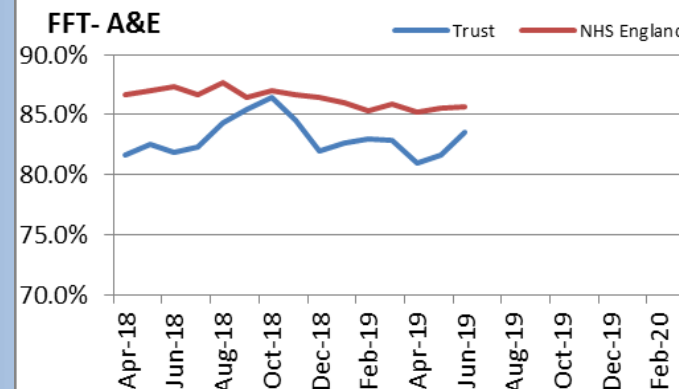
Percentage of
responses that
would be Likely
& Extremely
Likely to
recommend
Trust

Performance for June
was 83.53%

The latest published
data for NHS England is
June 2019.

July performance will
be published in
September.

FFT- A&E



Integrated Performance Report - September 2019

CARING

Description

Aggregate Position

Trend

Variation

Maternity
Scores from
Friends and
Family Test -
% Positive

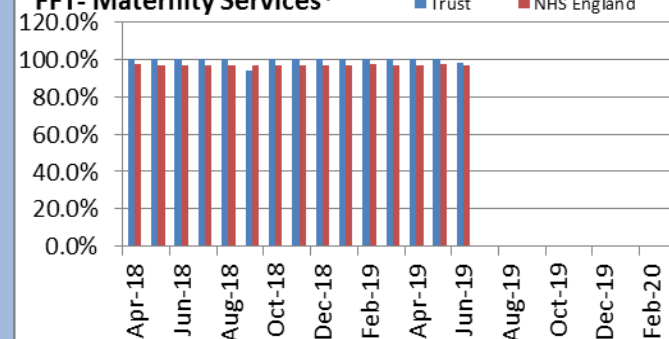
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for June was 98.31%

The latest published data for NHS England is June 2019.

July performance will be published in September.

FFT- Maternity Services*



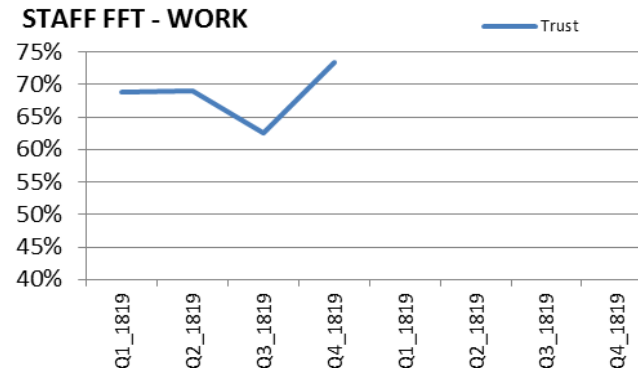
* Question relates to Birth Settings

Relative
Position in
Staff Surveys

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

Performance for Q4 shows 73% of surveyed staff would recommend the Trust as a place to work, this has increased from the Q3 position of 63%.

STAFF FFT - WORK



Integrated Performance Report - September 2019

CARING

Description

Aggregate Position

Trend

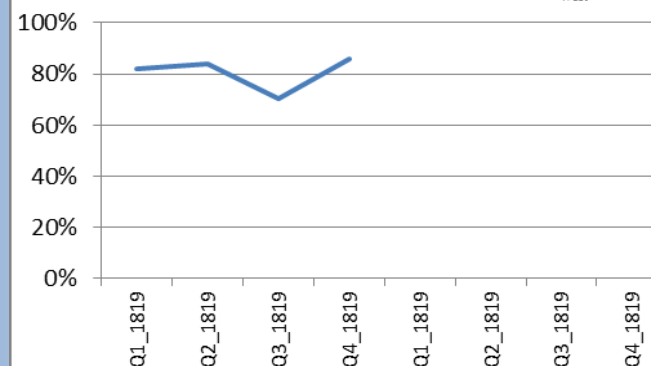
Variation

Relative
Position in
Staff Surveys

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

Performance for Q4 shows 86% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has increased from the Q3 position of 70%.

STAFF FFT - CARE



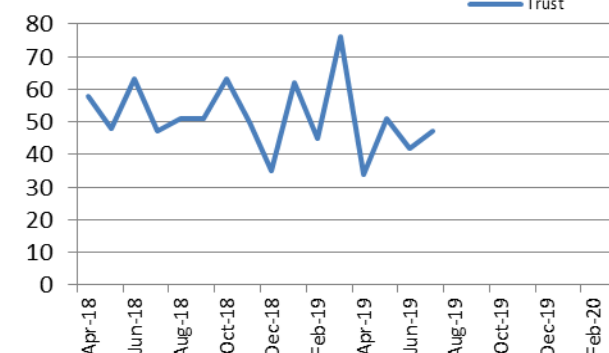
Written
Complaints
Rate

The number of complaints received by the Trust

The latest available position is July 2019.

The Trust received 47 complaints during July, this has increased from the June position of 42 complaints

WRITTEN COMPLAINTS



There have been 174 complaints year to date

Integrated Performance Report - September 2019

CARING

Description

Aggregate Position

Trend

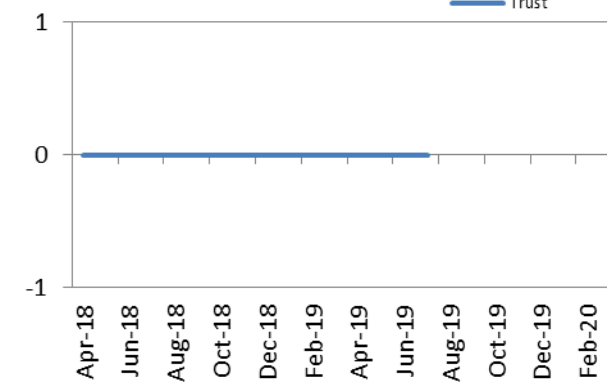
Variation

Mixed Sex Accommodation Breaches

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

There were no occurrences of mixed sex accommodation breaches throughout July 2019.

MIXED SEX ACCOMODATION



Integrated Performance Report - September 2019

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

Variation

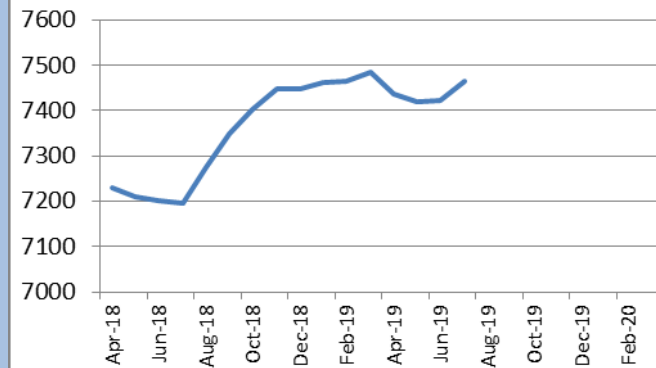
WTEs in post

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

The latest available performance is July.

Trust level WTE position as at the end of July was 7464

WTE in post

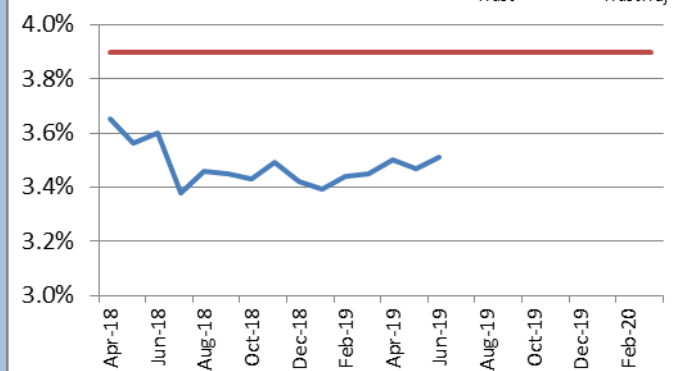


Sickness Absence Rates

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

Performance for July achieved the standard of less than 3.9% with performance of 3.55%

SICKNESS RATE



Integrated Performance Report - September 2019

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

Variation

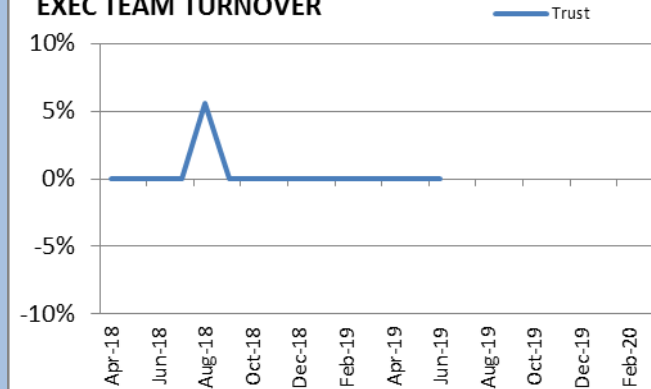
Executive Team Turnover

Percentage turnover of the Trust Executive Team

During August 2018 Kevin Phillips resigned as Chief Medical Officer, Kevin continues to undertake Clinical work.

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

EXEC TEAM TURNOVER



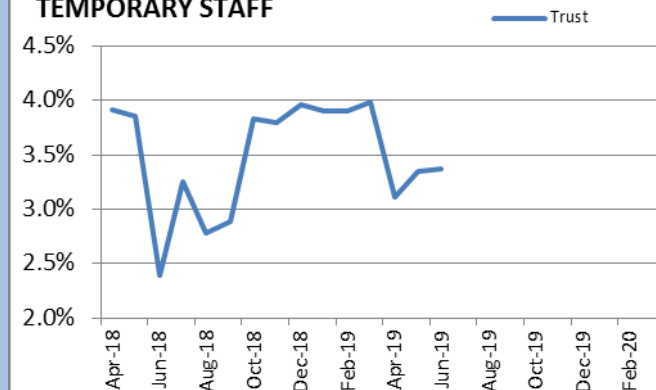
Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

July performance was 3.46%

TEMPORARY STAFF



FINANCIAL SUMMARY: 4 MONTHS TO 31st JULY 2019

1. At the end of July the Trust is reporting a deficit of £2.9m which is in line with plan.
2. The position includes £1.9m of Provider Sustainability Funding (PSF) on the basis that it is in line with its plan.
3. The Trust has estimated that the level of income delivered at month 4 is £2.0m above plan after accounting for the AIC. The Trust is above plan on pass through drugs (£0.9m), Non elective (£2.7m) and devices (£0.7m). The Trust is currently subject to a coding review from Specialist Services and estimated income has been reduced by £0.9m for the first quarter as a provision against the potential claim. The Trust has also received queries from other CCG commissioners outside the AIC regarding the level of growth on non-elective income as the increase appears to be driven by price growth rather than volume growth.
4. Health groups and Corporate are reporting a gross overspend of £0.2m at month 4 which is unchanged for the second consecutive month. There have been variations at health group level with the biggest concern being on pass through drugs under AIC which increased by £0.3m in month to £0.8m over. This was offset in month by Surgery Health Group position improving due to increased income whilst expenditure remained in line with plan. Surgery still have pressures in Medical staffing in Anaesthetics but these were offset by other vacancies in month. Wet AMD injection drug costs in Family & Women's Health Group are now £0.2m underspent due to activity remaining below plan. This is being partially offset by pressures from use of Pioneer in ENT and Paediatric Gastro. The Clinical Support budget is unchanged with £0.5m underspend at month 4 due to the level of vacancies. Medicine and Emergency Health Groups were both on plan in month 4 although ED nursing continues to overspend.
5. The above position includes a small over delivery in CRES to date which remains at £0.1m above plan with £3.6m being delivered against a target of £3.5m. The target to date is only 18% of the annual plan. The Trust still needs to identify another £4.4m of schemes to achieve the CRES target whilst also ensuring all schemes currently identified deliver their risk adjusted projections. Movement on identifying schemes remains slow and is very challenging. This is the biggest risk to achieving the control total.
6. The position assumes that the Trust receives additional income to cover the costs incurred in delivering the new Community Paediatrics service that has transferred from CHCP. The demand and capacity models are expected to be signed off in September with the agreed costs as part of the model.
7. The Trust has spent £3.2m on agency costs at month 4 which is £0.2m above the plan set to achieve the agency cap, a slight improvement in month. The additional spend has been on Nursing and Healthcare scientific and technical staff. In both these areas overall pay remains below plan although nursing did show a small overspend in Month.
8. The Trust is currently forecasting that it will deliver its financial plan in 19/20. Based on Health Group forecasts and the potential release of £0.8m slippage on reserves this would still require another £6.2m of actions to achieve. The main pressure is on CRES with current plans being £4.4m below target. Health Groups are forecasting they will identify £2.3m of this in the final 8 months but this would still leave a £2.1m shortfall. There is also medical staffing pressures in Surgery (£1.1m) and pressure on high cost drugs under AIC (£1.6m).
9. Further risks may also have to be managed. These include covering the impact of pensions changes on consultant activity, costs of covering winter and the final impact of the coding challenge on specialist services income.
10. The Trusts liquidity position continues to be relatively stable and has been boosted by the PSF bonus funding from 18/19.
11. The reported capital position at month 4 shows gross capital expenditure of £3.4m compared with plan of £2.7m. The main areas of variance relate to IT, buildings maintenance and the radio-pharmacy development which is ahead of the expected profile. The forecast position for capital expenditure is £26.6m as per the submitted plans in July. The official control total position has still not been confirmed but unofficially the Trust has been told that the July submission will be the minimum given.
12. The underlying position is a deficit £9.0m which is reduced from the £11.6m deficit at the end of 18/19.

Integrated Performance Report - September 2019

ORGANISATIONAL HEALTH

Description

Aggregate Position

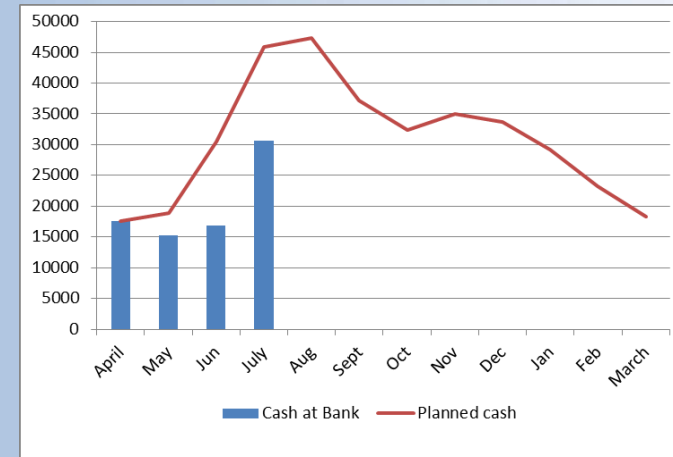
Trend

Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of July we had £30.604m of cash and cash equivalents, comprising of monies in the bank of £30.585m and £0.019m in petty cash floats. The cash position remains stable and the availability of cash is reflected in our BPPC performance, which although lower than the required standard is good and improving. At £30.604m cash was lower than planned as invoices are starting to be processed more quickly together with the PSF funding now been received.

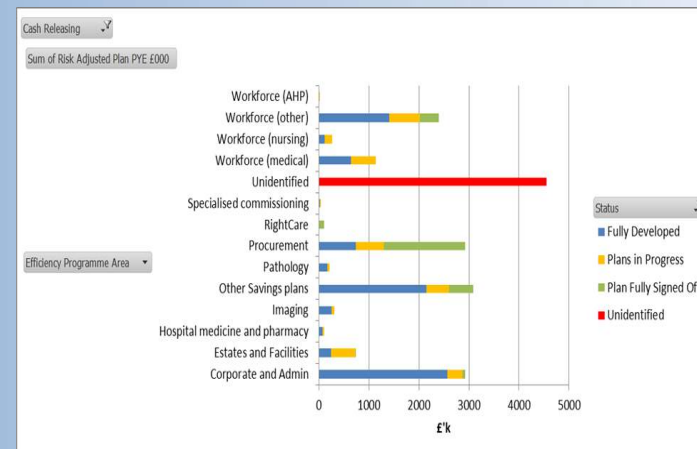


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 4 the planned level of savings is £3.7m, the actual savings are £3.5m thereby creating a £0.2m variance from the plan.

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



Integrated Performance Report - September 2019

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

Variation

Risk Rating

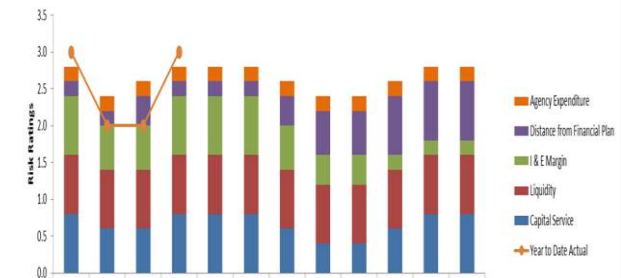
Financial Sustainability Risk Rating

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

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

As at month 4 the Trust is reporting a YTD deficit £2.9m against a planned position of £2.9m deficit. This has resulted in liquidity & capital, being rated at a 3, I&E margin being rated at a 4. Variance from financial plan as 1 & Agency being rated as a 2. Giving an overall risk rating of 3.

2019/20 Risk Rating Analysis



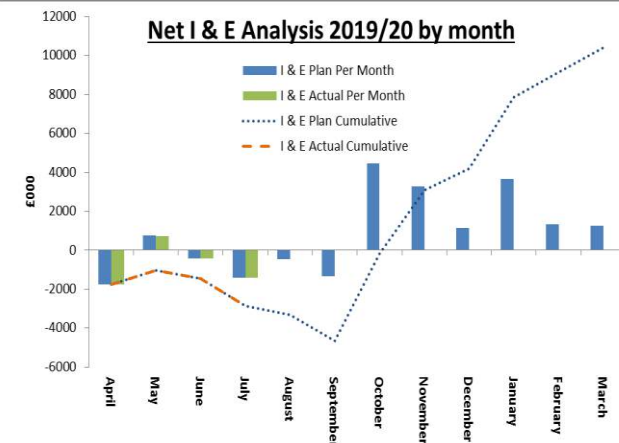
Income & Expenditure

Net income and Expenditure

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

As at month 4 the Trust has delivered a deficit of £2.9m against a planned deficit of £2.9m

Net I & E Analysis 2019/20 by month



Trust Board – September 2019

Performance Report Executive Summary

1. Purpose

The purpose of this paper to provide an Executive Summary to the Performance Report covering July performance data against the national standards and the Trust's Operating Plan trajectories for 19/20

Performance against all 'responsiveness' indicators is monitored weekly by the Performance and Activity Meeting, chaired by the Chief Operating Officer and monthly by the Performance and Finance Committee. All Health Groups are required to outline the key reasons for failure of each of the standards and/or Operating Plan trajectory, and outline the agreed actions required to address underperformance against each standard, and further to identify and agree recovery timelines for improvement of performance to the required level.

2. Unplanned Care

2.1 ED Performance

There was a 3.5% deterioration in Type 1 ED performance for July compared with June 2019 meaning that the Trust was 3% behind its recovery trajectory at the end of the month. With the inclusion of the Type 3 activity for Bransholme and Beverley Urgent Treatment Centres performance was 83% overall for July. The agreed recovery trajectory requires the Trust to achieve 90% by the end of September. The average number of daily attends for July was 398 per day which was just below the agreed activity plan.

A further system wide Summit meeting with NHSI was held on the 6th August with further actions for Improvement agreed across the system. A consolidated system action plan has been pulled together, identifying all of the actions that have arisen from the system wide summit at the end of May, the NHSI visit on the 8th July and Internal Trust action to respond to the surges in demand which are particularly seen on Mondays and Tuesdays of each week. The consolidated action plan is shown at Appendix 1.

Increasing the number of beds both in the Hospital and the wider system is a key component of the system wide Improvement Plan, responding to the bed deficit identified by the refresh of the Trust bed modelling exercise completed in quarter 1. Consequently, an additional 22 bed general medicine ward will open on the Hull Royal Infirmary site at the end of September. In addition, East Riding of Yorkshire Council (ERYC) will open a Social Care Discharge facility on the Castle Hill Hospital site from December 2019. The facility will initially open with 14 beds and will be a facility for those patients who are deemed to be no longer in need of acute care whilst their out of hospital service becomes available. The Trust has worked in close partnership with ERYC on this development from the outset and are highly supportive of the development and the opportunity it affords the hospital and the wider system. It is expected that further community capacity is also commissioned for Winter 19/20 to enable the system wide Delayed Transfer of Care (DTOC) targets to be consistently achieved.

The Trust continues to report Zero 12 hour trolley waits.

3. Planned Care

The Trust reported a position of 75.18% against the planned trajectory of 79.6% for July. As previously reported to the Trust Board, the commissioned level of activity is below that required to deliver the 92% national standard.

The 2019/20 operating plan requirement is to have no more patients on the RTT list than at the March 2019 baseline which was 53,083. Whilst the Waiting List Volume reduction trajectory has been achieved for months 1-3, the actual waiting list volume position at the end of July was 53,531 against a trajectory of 52,933, meaning that the trajectory for July has not been achieved.

ENT, Gynaecology, Ophthalmology, Plastic Surgery and Cardiology are the key specialities with the greatest volume of patients over 18 weeks accounting for approximately half of all patients over 18 weeks. Recovery plans are in place in all specialties to improve their RTT positions and the Performance and Finance Committee in August undertook a 'deep dive' review into ENT.

The Trust continues to report zero 52 week breaches and have maintained this position year to date. There however remains continued risk of late Inter Hospital Transfers (IHTs) from other Trusts impacting on the delivery of the standard however these continue to be managed in accordance with the IHT policy and exception reported accordingly should they breach.

4. Diagnostics

Performance against the diagnostic standard has deteriorated in July to 9%, a reduction of 0.3% on the performance reported for June.

Endoscopy accounts for approximately 70% of all breaches against the 6 week standard. Endoscopy has seen a significant increase in demand, particularly in relation to the urgent and Cancer pathway demand and this has impacted on the 6 week standard as more routine work has been displaced. During June the Endoscopy service has completed a consultation exercise with staff to support the introduction of 6/7 day working along with the delivery of extended days. These revised arrangements will commence from September with evening and weekend sessions planned. It is expected that endoscopy breaches will be back to operating plan trajectory levels during Q4.

The additional MRI and CT scanner on the ground floor of HRI, confirmed within the 19/20 capital programme is also hugely welcome and will begin support improved delivery against the diagnostic standard from 2020/2021.

5. Cancer Standards

The Trust continues to achieve the 2 Week standard, however there was a significant deterioration in the 62 day RTT performance compared with previous months and the operating plan trajectory for June was not met.

As reported to the July Trust Board, new breach allocation guidance was implemented in April 2019 and June is the first month where the impact of the new guidance is evident on performance. Whilst there are a number of scenarios to the new guidance, one is that the Trust incurs the full impact of any breaches of the standard if a provider refers to the Trust before day 38 (where previously this breach was 'shared' to the referring organisations). Approximately 8% of the deterioration in June is

as a result of the changes to the breach reallocation guidance, a further 2% deterioration was attributable to a slight deterioration in performance in the skin tumour site due to increase demand over the summer period and a decrease in colorectal performance due to diagnostic delays. Whilst the performance for July is not yet confirmed, the position is an improving one and is expected to be closer to the performance levels seen in April and May 2019.

6. Summary

There continues to be strong oversight and management of performance against the national standards and the operational plan trajectories via the weekly Performance and Activity Meetings for Cancer, RTT and Emergency and Flow with regular deep dives undertaken within the Performance and Finance Committee.

The Trust continues to be challenges around ED, Cancer 62 day and RTT performance however there is equally some excellent work being undertaken both within the Trust and in partnership with out of hospital / system partners which should equally be acknowledged.

Teresa Cope
Chief Operating Officer
31st August 2019

HULL AND EAST RIDING A&E DELIVERY BOARD

SYSTEM WIDE HIGH IMPACT ACTION PLAN

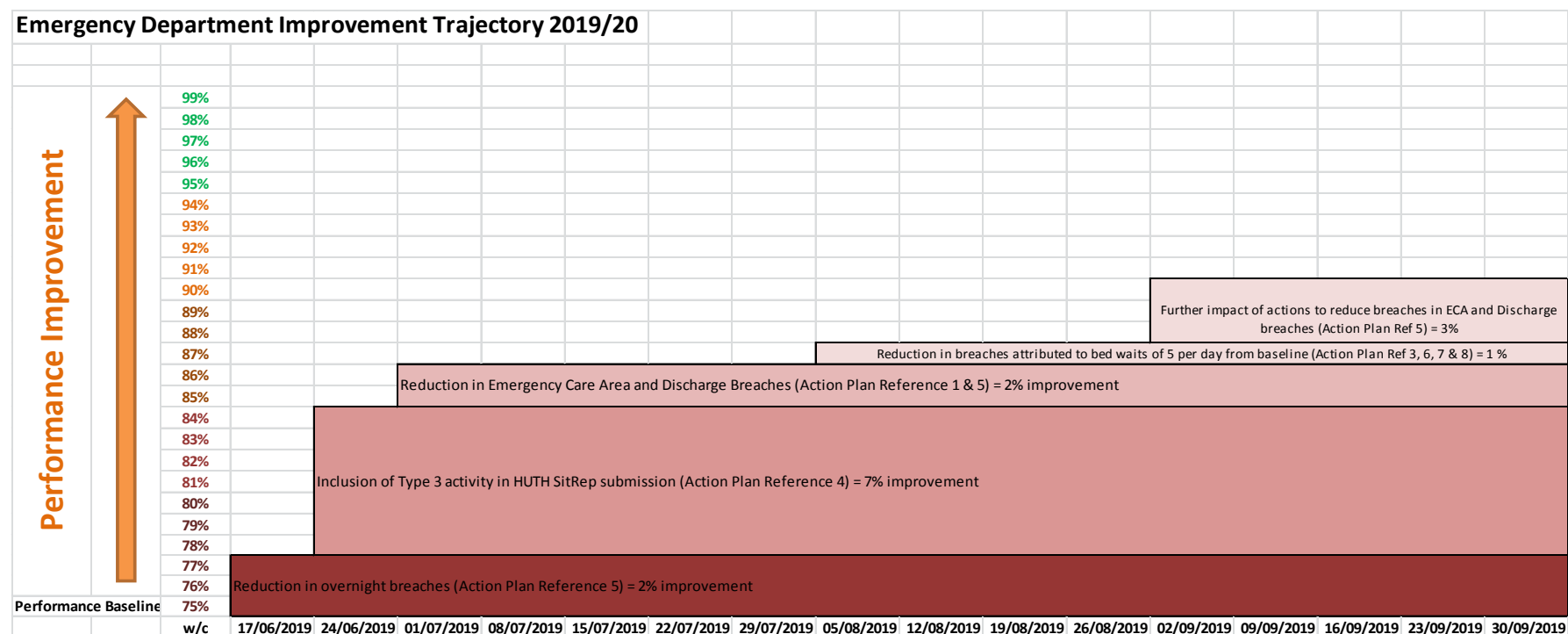
The Hull and East Riding A&E Delivery Board has signed off 8 Programmes of work which will be delivered by the Unplanned Care Delivery Group (UCDG) during 19/20 aimed to Improve the Urgent and Emergency Pathway. A PMO approach exists for each work stream with PIDS / Charters agreed for all work streams, a system wide Dashboard with monthly reporting and regular deep dives by the AEDB into each of the work streams to monitor progress. The actions below have been identified by the system wide ED Summit held in May/June 2019 and incorporate the recommendations made from the NHSI Visit on 8th July 2019 and initial feedback from the system data analysis led by ECIST.

This action plan will be reviewed

- Internally within Hull University Teaching Hospital fortnightly via Emergency Performance and Flow Performance and Activity Meeting
- System wide monthly by the Unplanned Care Delivery Group and the A&E Delivery Board

Metric for each of the actions are captured within the EPF P&A Dashboard and the system wide Unplanned Care Delivery Group / A&E Delivery Board Dashboard

The Agreed Trajectory for Improvement is detailed below



	Objective	Actions	Exec Lead & Workstream Lead	Impact expected From	Expected Performance Outcomes	Risks to delivery	Update
1	Full Capacity Protocol and Improved Resilience	Further updates to FCP to strengthen Medical and Nursing Leadership to flow issues within the HUTH and learning from its 'live' use.	HUTH COO HUTH – DCOO and CDN (W1)	Aug 19	Handover trajectory achieved. Shortened recovery time from time of increased pressure.	None Identified	FCP implemented from 1 st July and used operationally since Implementation. FCP response section for Site Management team, Transport and Medical and Nursing leadership added. Full Implementation of updated FCP will be from w/c 25 th August
		Senior Medic on call to be scoped and piloted over winter to support flow.	MHG Medical Director	1 st Oct	Timely support and resolution of flow matters. Support to site team and on call management team		
		Increase HUTH staffing on Monday and Tuesday to response to demand surge (circa 450 ED attends)	HUTH COO	1 st Aug	Reduced number of discharge breaches in ECA.	Ability to secure additional workforce in all key areas.	Additional staff within ED, Site Team and key medicine specialties have been implemented on Monday and Tuesday each week. Reviewed weekly as part of Weekend Planning meeting.
		Strengthen Out of Hospital coordination of flow / response to surges in activity	Director of Commissioning ERCCG	1 st October	Improved timeliness of response to surge demand and increases in the WIP / DTOC lists		
2	Improve AM discharges and Weekend Discharges	Embed SAFER actions following Hospital wide audit in May 2019	HUTH CNO/CMO (W8)	1 st June	LLOS Improvement in line with Operating Plan trajectory. Flow Optimised		Project Plan in place with Senior Matron Clinical Lead appointed and Project Support by HUTH Improvement Team. LLOS Improvement is being achieved in line with reduction trajectory. 
		Increase Criteria Led Discharges across HUTH	HUTH CNO/CMO	1 st Sept	Increase weekend discharges. Achieve discharges earlier in the day. Reduce breaches attributable to bed delays.		Project Plan currently being developed with Senior Matron Clinical Lead appointed and Project Support by HUTH Improvement Team. Project on CLD will commence from 1 st September.
		Change Consultant of the week rota to start midweek (not a Monday or Tuesday)	HUTH Health Group Medical Directors	1 st October	Even out flow during the week		
		Improve levels of	CHCP – COO	1 st Sept	Increase weekend discharges.	Care Homes willingness	Weekend Targets for Discharge are agreed with all out of

		Complex / Supported Discharges at the weekend	(W8)		Weekend Targets for Discharge are agreed with all out of hospital partners and monitored	to asses / admit over weekend period. Ability for POC to commence over weekend period	hospital partners and monitored daily as a system. System calls are scheduled when target discharges are not achieved. System have agreed an Out of Hospital coordinator role is required for the Winter period and identification of person to undertake this role is progressing led by ERCCG. Post expected to be in place from 1 st November – 1 st April 2020
		Earlier Identification of patients suitable to transfer to CHH and Increased use of discharge lounge by Surgery	SHG Medical Director	1 st Aug	Increased AM transfer to CHH	Clinical criteria for CHH will mean that numbers of patients able to transfer will fluctuate	Implemented and monitoring via EPF P&A meeting fortnightly.
3	Increase bed capacity (address gap identified in bed modelling review July 2019)	Additional Medicine Ward on HRI site (22 beds)	HUTH MHG	24 th Sept	Improved flow from ED and reduction in ED breaches attributed to Bed Waits	Recruitment to all nursing and medical posts	Recruitment on going and no slippage on timescales expected. Mobilisation being monitored via HUTH internal Winter Planning meetings. Ward expected to open from week commencing 24 th September 2019.
		Additional Winter Ward 1 st Dec- 31 st March (22 beds)	HUTH DCOO	1 st Dec	Improved flow from ED and reduction in ED breaches attributed to Bed Waits	Ability to staff ward (Nursing and Medical)	New Action Agreed by the HUTH Executive Team 12th Aug for additional medicine ward for 4 months. Planning being undertaken by the internal winter planning group with feedback to the weekly Executive Team.
		Additional Assessment Space (12 spaces) co-located with AMU	HUTH Director of Estates HUTH MHG Medical Director	1 st Jan	Opportunity to expand assessment / SDEC opportunity. Role and function of the additional space to be defined.		
		Cedar Ward to move from 5 day ward to 7 days ward over the winter period	HUTH FWHG	1 st Nov	Increased flow.	Recruitment to nursing staff	Planning being undertaken by the internal winter planning group to open Cedar Ward 7 days over winter period.
		Social Care Discharge Facility (14 beds)	Director of Adult Social Care - ERYC	2 nd Dec	Reduce DTOC for ERYC	CQC registration GP Cover	Contract has been awarded with standstill period ending on 23 rd August 2019. Mobilisation plan in place and CQC registration for the facility being progressed. Due to open on 2 nd December 2019
		Additional capacity commissioned by community equivalent to 19 beds	CHCP - COO	1 st Oct	Reduce DTOC rates by increasing access to intermediate healthcare beds Capacity will assist in addressing overall bed deficit and support they system in achieving an overall daily WIP target of a maximum of 22.	Fragility of care home market. Recruitment of therapists to care for people within the additional beds	New Action; Agreed at AEDB July CHCP have produced a proposal for Hull CCG to support the procurement of an additional 19 beds across Hull. The beds will be additional level 3 and 4 ICT but can also be used flexibly to support the wider system, 10 of the proposed beds are in a nursing care home.
		Implement a pilot across Driffield area,	CHCP COO	31 st Oct	Improved patient flow through both HUTH and community beds will	Recruitment to staff mitigated via existing	Pilot agreed in July 2019 as part of the ICT transformation programme.

		to support delivery of short term care packages as part of an enhanced CHCP ICT offer to prevent delayed discharges from HUTH and ICT community beds	EROYCCG AD		reduce DTOCs awaiting ERIC packages.	CHCP bank.	
4a	ED Improvement (HUTH Internal)	Increase Medical staffing, ANPs Progresses Chasers during evening and overnight period.	HUTH COO	1 st June	Reduce evening and overnight breaches	Ability to secure additional workforce	Additional 170 hours of medical cover above funded base levels in July. August 383 hours (month to date – 16/8) due to additional senior medical cover in place over Junior Dr handover week.
	Reduce Discharge Breaches ECA						
	Improve Time to first seen Majors	Review Paediatric ED operating hours.	HUTH COO	1 st Oct	Reduce overnight breaches		
		Increase GP and ANP staffing to Primary Care Steaming Area.	HUTH COO & CCG Lead	1st Aug		National and local shortage of GPs and potential to adversely impact other systems e.g. GP OOH/Extended and Enhanced Access which could result in increased demand for ED	
		Implement Front Door Streaming ECA	HUTH EMHG	1 st Aug	Reduce discharge breaches RCA		
		All internal referral to ED from specialties to to be referred to EPIC	HUTH Medical Directors	1 st Aug			Has been implemented from w/c 12 th August and will be monitored via EPF P&A meeting
4b	Reduce Proportion Type 1 Minors activity	Extend the Hours of Storey Street to create a Hull UTC and co-located OOH	Hull CCG Director of Integrated Commissioning. CHCP COO	1 st November	Reduce ECA attends	Estates provision – though ground floor would support development Access to X Ray Agreement to increase opening hours to 24/7 of the Wilberforce HC	New Action - Agreed as part of system meeting w/c 5 Aug.
		Increase Radiography Provision at Bransholme and Beverley	HUTH COO	1 st October	Reduced ECA attends	National and local shortage of radiographers	New Action; Agreed as part of system meeting w/c 5 Aug. HUTH Radiology are attempting to source additional radiographers.
		Progress co-located	Hull CCG	TBC			New Action; Agreed as part of system meeting w/c 5 Aug.

		UTC with HRI ED	Director of Integrated Commissioning				
		Offer patients not requiring emergency care direct access to community based UTC GP OOH, walk in and extended access	HUTH COO CHCP COO	Aug 19	Diversion from A&E will free up staff within A&E to focus on genuine emergency care including life threatening cases	Local people may be reluctant to take up choice offer, once within ED	Onward referral information refreshed by CHCP in Aug 19 and shared with HUTH team.
		Review of Paediatric and 0-20 year ED Activity	CHCP COO HFT COO	Dec 19	Reduce paediatric and 0-20 year attends ED attends by offering diversionary pathways including rapid access to health visiting, Urgent Care Paediatric ANPs and explore the provision of on line GP consultations e.g. for the 16-20 age group.	Funding to procure E Health Solutions may pose a risk Retention of ANP paediatrics due to GP pressures in primary care.	New Action agreed at A&E Delivery Board July 2019 E Consultation forms part of the CHCP transformation plan and additional funding could result in widening the offer to NON CHCP registered patients e.g. frequent flyers. CHCP and Humber each provide 0-19 services and so can look to offer alternative pathways for 0-20 year olds HUTH have provided detailed/anonymised activity data relating to 0-20 year olds to support this work
5	Reduce Mental Health Breaches and TID for Mental Health patients	Open Additional S136 Suite at Miranda House	HFT COO	March 2020	Reduce TID and Mental Health breaches Work is currently on track to complete on time and HTFT will consider ways to bring this date forward of possible.		
		Restore staffing levels to Core 24 compliant levels	HFT COO	September 2019	Reduce TID and Mental Health breaches Some recruitment completed, more underway and action plan to address shortfall is in place		
		Limited Street Triage Pilot to commence	HFT COO	TBC 2019	Reduce ED attends Work in place to work in place between HTFT and Humberside police commencement date to be finalised by September 2019		
6	Maximise Same Day Emergency Care Opportunities	Incorporate Surgical Ambulatory Care Service into Medical Ambulatory Care Unit (via modular extension)	HFT SHG & MHG Medical Director	1 st Dec	Increased SDEC provision. Reduced breaches in ED for speciality waits.		Unable to use Westbourne Suite (planned space) as this is agreed location for additional CT scanner which has been brought forward to 19/20. Agreement to combine Medical and Surgical Ambulatory Care Unit and add modular unit to this to create sufficient space. <u>Will be all surgical specialities</u> . 6 th Floor Surgery Assessment Facility will continue to be used.
		Daily Ultrasound provision to the 6 th floor Surgical Ambulatory Assessment Area	SHG Medical Director	1 st Sept	Increased SDEC provision.		Confirmed as commencing from 1 st September.

		Review AMU conversion rate and opportunity for increased SDEC on AMU / ACU	HFT MHG Medical Director	1 st October	Reduce conversion rate to base wards. Increased SDEC for Medicine specialties .		
		Review space utilised by Frailty Intervention Team in ED	HFT MHG Medical Director	1 st Sept			Extended FIT pilot has been undertaken and further pilot will commence on 21 st August to undertake FIT in cubicles 1-3 in ED.
7	Diversionary Pathway (including Care Home Programme)	Increase Direct to speciality pathways within HUTH	ICP Programme Director	31 st October	Increase direct access for ambulance crews to key specialties – Urology and Gynaecology		Current pathways have been reviewed.
		Increase alternative to ED pathways in the community (focus on Care Homes and Respiratory)	ICP Programme Director	1 st September	Increase ambulance use of community pathways including district nursing and to UTCs Reduce ED attends and NEL admissions from Care Homes Reduce the number of Care Home respiratory admissions		Top 20 referring Care Homes have been identified across Hull and East Riding. Full MDT Outreach Implemented from Hull ICC. Integrated Care Planning for each resident with direct access to OOH services for the top 20 care homes. Model now being rolled out to other homes. NP support model in place for Hessle Care Homes as part of phase 1 of roll out across ER. Respiratory Physios have been recruited and are now in post. They will manage respiratory exacerbation of respiratory conditions in Care Home resident and provide care homes

Teresa Cope, Chief Operating Officer
22nd August 2019.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

DATE 10 September 2019

Title:	Implementing the NHS Long Term Plan – 5 Year System Planning Update	
Responsible Director:	Lee Bond, Chief Finance Officer and Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this report is to apprise the Board of the requirements in relation to 5 year planning for sustainability and transformation partnerships (STPs) and provide a briefing on the approach being taken and progress to date in relation to these requirements, in the Humber Coast and Vale Health and Care Partnership (HCAV HCP).	
BAF Risk:	All	
Strategic Goals:	Honest, caring and accountable culture	x
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	X
Key Summary of Issues:	- The NHS Long Term Plan (LTP) Implementation Framework sets out the requirement for STPs to agree a 5 year plan. - HCAV HCP is approaching this planning at sub-system level and the Trust is working with partners in Hull and East Riding to ensure the plan addresses the acute sector requirements in the LTP. - Timescales are tight, with the first draft to be submitted on 27 September 2019 and final agreed plans to be submitted by 15 November 2019.	
Recommendation:	- That the Trust Board notes the contents of the paper. - That the Trust Board considers the planned further briefings on the system process and advises of any further assurance required.	

1. INTRODUCTION

The NHS Long Term Plan (LTP), published in January 2019, set out a 10 year program of phased improvements to NHS Services and outcomes. It was followed in June 2019 with the publication of the NHS LTP Implementation Framework which set out the approach and timetable that STPs/Integrated Care Systems (ICS) are to follow in creating their 5 year strategic plans. The 5 years includes the current year, 2019/20 as year 1, so the planning period is through to April 2024.

This paper has been written to provide a brief summary of key characteristics and milestones required in the production of the strategic plans and to outline the work being done by HUTH in meeting the deadlines for submission.

2. INTEGRATED APPROACH

In creating their 5 year plans, STPs/ICSs are expected to bring together a number of organisations and wider partners and adopt a common set of principles in the development and delivery of plans.

These plans are required to be clinically led, locally owned, contain realistic assumptions over workforce and not only deliver a balanced financial position but also deliver on all of the commitments in the long term plan including the access standards. The scale and pace of local implementation in the plans should be based on local needs and priorities.

Importantly the plans need to set out how systems will maintain and improve performance against the waiting times standards for cancer treatment and ED and to reduce waits for elective care.(The ED and RTT standards are currently under review and may change in emphasis). Crucially, system plans should show how local urgent and emergency care services will continue to develop to provide an integrated network of community and hospital based care.

Systems also need to set out plans to increase the use of digital tools. The target of removing a third of face-to-face out-patient appointments visits by the end of the period is one of the biggest challenges within this arena.

Service transformation in the LTP is focussed on a small number of key areas:

- Maternity and neonatal services
- Children and young people
- Learning disabilities and autism
- Cardiovascular disease
- Stroke care
- Diabetes
- Respiratory disease

From a funding perspective, CCGs have been notified of their five-year allocations. In addition to this, there will be opportunities to access additional funding for specific initiatives and developments (such as the Lung Health Check program).

There are 3 main tests that the plans must meet from a financial perspective.

1. How organisations will return to balance (a desire to achieve a minimum 0.5% surplus)
2. All providers deliver cash releasing productivity growth of at least 1.1% a year, with providers in deficit delivering an additional 0.5% per annum (it is believed that a maximum expectation of 2% is in place)
3. System plans must demonstrate appropriate reductions in the growth in demand for care.

3. TIMESCALES AND SUBMISSION REQUIREMENTS

Each STP/ICS is required to submit a strategic delivery plan which sets out what the system plans to deliver over the next 5 years.

This delivery plan is supported by a number of templates that provide evidence of the financial, activity, and workforce models that underpin the delivery of the system goals.

In Humber, Coast and Vale, we are working to develop 3 sub-system delivery plans (North Yorkshire & Scarborough, Hull and East Riding, North and North East Lincs) which will be amalgamated into a single STP submission.

The initial system submission is required by 27 September with a final submission required for 15 November. This plan will then inform the agreement of the 2020/21 operational plan which is due in February/March 2020.

4. HULL AND EAST RIDING APPROACH

In common with the other health economies within our STP, the Hull and East Riding economy is now actively preparing its plans to meet these challenging timescales.

For HUTH an exercise is underway to develop a 5 year base case upon which various modelling assumptions can be overlaid in order to develop the 5 year plan.

For version one of the models, we are including the following planning assumptions:

- Financial balance to be achieved and sustained
- 2% growth in elective referrals per annum (based on 3 year trend)
- Clearance of the follow up backlog to maximum 3 months, assuming 70% to be seen
- Achievement of the 92% RTT target at Trust level by April 2024
- Achievement of the 1/3 reduction in face to face outpatient attendances by April 2024 (building back in some resource for alternative models)
- Both reduction in face to face and clearance on backlogs to be phased into the plan as 20% years 2&3 and 30% years 4&5.
- Further expansion of diagnostic capacity in years 4&5, in particular endoscopy, MRI and CT – further work in progress to define
- 2.4% growth in ED attends (based on 3 year trend)

- Full year effect of expansion of acute medical bed base in 2019/20
- No further growth in acute bed base, but further investment into same day emergency care capacity to handle additional activity (details tbc)
- Growth in non-surgical cancer treatments above general growth trend to be negotiated with the specialised commissioners
- Inclusion of the Lung Health Check costs

This process is high level and is an iterative one in terms of the requirement to ensure that the plan can be delivered and be afforded within the resource constraints of the STP. From a delivery perspective, the availability of capital resource to provide physical capacity such as diagnostic equipment is a real consideration as is the availability of suitably qualified and skilled workforce.

Over the next 2 weeks it is our intention to develop this model with commissioning partners. Whilst our scale of ambition would be to achieve all of the milestones laid out in the LTP by the end of the period, this may not be wholly deliverable. The challenge for the economy is to make as much sustainable progress as can be afforded in the period.

This process is being replicated in the other two sub systems with regular opportunities in the timetable for the whole STP to meet and discuss progress.

For certain specific issues, such as cancer, the existing STP wide cancer network are co-ordinating the development of plans specific to those services utilising any specific or targeted financial allocations that may have been made available for that purpose.

It is hoped that each of the economies will submit their sub system plans to the STP office by 20th September, and an amalgamated plan can be produced for submission the following week.

Following the submission of the 1st draft, the Trust will work through operational plans, including workforce and capital, with the Health Groups, to test the deliverability of the draft plans. This work will form the basis of the operational plan for 2020/21 and the high level plans for 2021 – 2024.

The national planning timetable requires the final agreed plan to be submitted no later than 15 November. This timeframe does not allow for the plan to be reviewed and approved by the Board of each partner in the STP prior to agreement by the Partnership Executive and submission. The Trust Board will receive a further update on progress at the planned development day at the end of September.

5. Recommendations

1. That the Trust Board notes the contents of the paper.
2. That the Trust Board considers the planned further briefings on the system process and advises of any further assurance required.

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

10 September 2019

Title:	Strategic Outline Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary
Responsible Director:	Teresa Cope, Chief Operating Officer
Authors:	Jackie Railton, Assistant Director, Strategy and Planning Alison Drury, Deputy Director of Finance Fionnuala Raitt, Head of Capital Planning

Purpose:	The purpose of this paper is to present for Trust Board approval the Strategic Outline Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and innovation	
	Financial sustainability	✓
Summary Key of Issues:	The combined impact of increasing numbers of complex patients being admitted to the Hull Royal Infirmary, increased length of stay, delayed transfers of care and insufficient inpatient medical beds to meet demand, is impacting negatively on the ability of the Trust to manage the urgent and emergency care patient pathway from admission to discharge in a timely manner, resulting in increased waiting times in the Emergency Department, increased waiting times for diagnostic tests, longer lengths of stay in the Acute Medical Unit and a poor patient experience. The attached Strategic Outline Case seeks approval to invest an estimated £19.3m of capital funding in the reconfiguration and transformation of urgent and emergency care facilities at the Hull Royal Infirmary to enable the better management of the acutely ill patient. This will involve the provision of additional diagnostic capacity (CT, MRI, Ultrasound and endoscopy equipment) and the relocation of adult assessment and paediatric services to create additional inpatient capacity.	

Recommendation:	The Trust Board is asked to: • note the contents of this paper • approve the Strategic Outline Case: and • approve the release of the Strategic Outline Case to the Humber Coast and Vale Health and Care Partnership for incorporation into the Partnership's overarching Urgent and Emergency Care submission.

Hull University Teaching Hospitals NHS Trust

Trust Board – September 2019

Strategic Outline Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary

1. Purpose of Paper

The purpose of this paper is to present for Trust Board approval the Strategic Outline Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary.

2. Background

In July 2018 the Trust submitted a capital bid totalling £19.3m to improve the provision of urgent and emergency care at the Hull Royal Infirmary through the reconfiguration and transformation of patient pathways, modernisation and expansion of clinical facilities and the supporting infrastructure. In particular, the capital bid aimed to:

- Reconfigure the ground floor of the Tower Block to provide:
 - o increased assessment unit capacity
 - o increased diagnostic scanning capacity (additional MRI and CT scanners and associated infrastructure).
- Increase adult inpatient capacity through the relocation of paediatric inpatient services from the 13th floor of the Tower Block to the Women's and Children's Hospital to create two 24-bedded wards allowing the reconfiguration of medical and surgical inpatient services.
- Provide replacement and additional endoscopes to meet the increasing demand for endoscopy services.

In December 2018, the Department of Health and Social Care (DHSC) confirmed that the Trust's scheme had been included in the list of projects that had been allocated funding to support STP transformation across the country. The release of the £19.3m capital allocation to the Trust is dependent upon the approval of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHS Improvement, DHSC, Government Ministers and HM Treasury.

The Performance and Finance Committee received a paper in January 2019 outlining the proposed approach to the development of the Strategic Outline Case, acknowledging that, since submission of the capital bid, there had been a number of developments which needed to be taken into consideration, including the future utilisation of Ward H36 and the need to increase the amount of Same Day Emergency Care delivered across the Trust.

The Draft Strategic Outline Case was submitted to the Performance and Finance Committee on 29 July 2019 and has been revised following comments received.

3. Strategic Outline Case

The Strategic Outline Case for the Urgent and Emergency Care Development is attached. The format is in accordance with HM Treasury's '*Guide to Developing the Project Business Case*'.¹(2018).

1

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749086/Project_Business_Case_2018.pdf

The case for change identifies that, with the current configuration of services, and limited assessment, diagnostic and inpatient capacity, the safety of patients requiring urgent and emergency care is being compromised. Key factors include:

- Poor patient flow from emergency admission to discharge.
- Increasing numbers of attendances to the Emergency Department (ED) by patients whose care could be more appropriately managed in primary care.
- Insufficient assessment capacity for surgical patients resulting in an inpatient admission.
- Assessment areas located across a number of floors in the Tower Block with poor access to diagnostic facilities
- Insufficient diagnostic capacity in CT, MRI, ultrasound and endoscopy to meet demand leading to increased waiting times for diagnostic tests and increased waiting times in the Emergency Department, assessment units and on the inpatient wards. For example: the daily average number of breaches of the 4 hour waiting time threshold in the Emergency Department attributed to waiting time for diagnostic tests increased from 4.7 breaches per day in 2017/18 to 10.3 breaches per day in Quarter 1 of 2019/20.
- An MRI facility that is located outside of the Tower Block, necessitating the transfer of emergency and inpatients across the hospital site.
- A shortfall in the provision of adult inpatient beds at the Hull Royal Infirmary resulting in longer waits for admission to the Acute Medical Unit, an increase in the number of medical outliers on surgical wards and the cancellation of elective surgical activity.
- Higher bed occupancy rates. In the case of medical beds, bed occupancy exceeds 90% resulting in increased pressure at times of high demand leading to backlogs and overcrowding in the ED.
- Increased pressure on bed availability due to the number of patients whose transfer/discharge has been delayed (an average of 858 bed days per month in 2018/19)
- Inadequate accommodation for children on the paediatric wards leading to privacy and dignity issues.
- Paediatric services on the 13th floor include the inpatient ward, paediatric high dependency unit and paediatric assessment unit. These are remote from the diagnostic facilities and critical care facilities on the 2nd floor of the Tower Block, and from the paediatric surgical ward in the Women's and Children's Hospital.
- Lack of parental accommodation, particularly for those whose children are being treated in the Paediatric High Dependency Unit and Neonatal Intensive Care Unit.

The poor flow along the urgent and emergency care pathways has resulted in the following:

- Failure to comply with the 15 minute standard for ambulance/ED handover leading to queuing of ambulances outside the ED.
- Failure to comply with the 4 hour waiting time threshold in the ED. The Trust has not met the 95% threshold (annual total) for the last four years.
- Failure to comply with 7 Day Hospital Services Clinical Standard 5 (Timely Access to Diagnostics)
- Inability to meet demand in growth for diagnostic imaging due to lack of capacity in CT, MRI, ultrasound and endoscopy
- Failure to comply with national 18 week Referral to Treatment (RTT), cancer and diagnostic waiting time thresholds.
- Poor patient experience as a result in increased waiting times for assessment, diagnostics, treatment and/or admission to hospital, increased length of stay, and multiple transfers between wards/departments.

- A Care Quality Commission rating of 'Requires Improvement' for responsiveness in Urgent and Emergency Care and for the failure to comply with NHS access standards.

Using the Options Framework within the national business case guidance, the Trust identified a long list of options which in turn led to a Preferred Way Forward. This comprised the following elements:

- Reconfigure the front entrance to the Emergency Department, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional endoscopes, relocate the Elderly Assessment Unit, relocate the paediatric department from the 13th floor of the Tower Block and create additional adult inpatient capacity.
- This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a larger diagnostic suite on the ground floor with a Surgical Ambulatory Care Unit.
- The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases.
- The project will be implemented over 3 years.
- It will be funded through STP Wave 4 funding totalling £19.3m.

In order to determine the preferred option for recommendation, a further short listing exercise was undertaken comprising the preferred way forward, the Business As Usual (BAU) option as a benchmark for Value for Money (VfM), together with a 'Do Minimum' and a 'less ambitious' option. The indicative costs of the shortlisted options, over the life of the scheme, are set out below.

	Business as Usual	Do Minimum	Preferred Way Forward	Less Ambitious PWF
	£000	£000	£000	£000
Capital Costs	0	(13,900)	(19,268)	(18,964)
Revenue Costs	(538,240)	(480,080)	(574,583)	(551,341)
Total Costs	(538,240)	(493,980)	(593,851)	(570,305)
Cash Releasing Benefits	0	533,450	536,123	536,123
Total Net Costs	(538,240)	39,470	(57,728)	(34,182)
Total Costs Discounted	(104,270)	(74,246)	(90,526)	(86,128)
Total Benefits Discounted	0	103,921	104,433	104,433
Value for Money Ratio	0.0	1.4	1.2	1.2

The table shows the value for money is positive for all options apart from the 'Business as Usual' as expected. However, as the main benefits accrue to the CT/MRI replacement and the Surgical Ambulatory Care Unit, (which is included in all of the 'do something' options) the value for money favours the 'do minimum', which excludes the Paediatrics reconfiguration. Further work will be undertaken to try and quantify additional savings associated with this element of the case or even how the Trust would incur additional costs if the paediatric relocation was not progressed.

A summary showing the capital cost of the preferred way forward is shown in the table overleaf.

Capital Expenditure	Preferred Way Forward
	£000
Equipment	4,844
IM&T	20
Building	14,404
Total	19,268
STP PDC Funding	19,268
Shortfall in Funding	(0)

At this stage of the business case no VAT recovery on the capital project has been assumed until the work can be progressed on to the detailed designs, contract and procurement process. The lifecycle replacement of the assets is currently excluded from the case as this will be the responsibility of the Trust to fund over the life of the assets.

The capital cost includes 23 % for optimism bias and risk. The figures will be further refined once the project enters into the detailed design and tender award process.

The revenue running costs of the scheme make provision for the staffing requirements for the operation of the additional scanners and the additional ambulatory care/assessment capacity, the maintenance of the scanners and the additional endoscopes, as well as the capital charges associated with the capital investment.

The estimate of the first full year of revenue costs are shown in the table below, excluding inflation:

Revenue Costs Summary					
		Pay	Non-pay	Cap Charges	TOTAL
		£000	£000	£000	£000
CT/MRI		(1,234)	(317)		(1,551)
Ultrasound		(245)			(245)
SACU		(599)	(130)		(728)
Scopes			(176)		(176)
Facilities			(274)	(1,459)	(1,733)
TOTAL		(2,077)	(897)	(1,459)	(4,433)
Less Costs from Business as Usual		1,910	2,099		4,009
NET COST		(167)	1,202	(1,459)	(424)

4. Next Steps

Subject to Trust Board approval, the Strategic Outline Case will be submitted to the Humber Coast and Vale Health and Care Partnership for incorporation into the overarching Partnership bid submission to NHS England/Improvement. It is anticipated that Treasury approval will be received by March 2020.

In the interim, work will be undertaken to develop the Outline Business Case (OBC) for the UEC development with a provisional date for submission for Board approval in April 2020 and submission of the Full Business Case by November 2020. The earliest date for commencement of work on site is expected to be February 2021.

5. Recommendation

The Trust Board is asked to:

- note the contents of this paper
- approve the Strategic Outline Case: and
- approve the release of the Strategic Outline Case to the Humber Coast and Vale Health and Care Partnership for incorporation into the Partnership's overarching Urgent and Emergency Care submission.

Teresa Cope
Chief Operating Officer

30 August 2019

Hull University Teaching Hospitals NHS Trust

**Reconfiguration and Transformation of Urgent and
Emergency Care Facilities at the Hull Royal Infirmary**

Strategic Outline Case

August 2019

Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary

Strategic Outline Case

Contents	Page No
0.0 Executive Summary	1
0.1 Introduction	1
0.2 The Strategic Case	1
0.2.1 Strategic Context	1
0.2.2 The Case for Change	3
0.2.3 Summary	4
0.2.4 Investment Objectives	5
0.2.5 Potential Scope and Service Requirements	5
0.2.6 Main Benefits and Risks	7
0.2.6.1 Main Benefits	7
0.2.6.2 Main Risks	8
0.2.7 Constraints and Dependencies	9
0.2.7.1 Constraints	9
0.2.7.2 Dependencies	9
0.3 The Economic Case	10
0.3.1 Critical Success Factors	10
0.3.2 Long List of Options	10
0.3.3 Determining the Preferred Way Forward	11
i. Service Scope	12
ii. Service Solution	12
iii. Service Delivery	12
iv. Implementation Timeframes	12
v. Funding Mechanism for the Project	13
0.3.4 Summary of the Long List Using the Options Framework	13
0.3.5 Preferred Way Forward	14
0.3.6 Shortlist Options	15
0.3.7 Summary Assessment of Options	18
0.3.8 Indicative Costs	18
0.4 Commercial Case	19
0.4.1 Required Services	19
0.4.2 Potential for Risk Transfer	19
0.4.3 Proposed Charging Mechanisms	19
0.4.4 Proposed Contract Lengths	19
0.4.5 Personnel Implications	19
0.4.6 Procurement Strategy	19
0.4.6.1 Building	19
0.4.6.2 Equipment Procurement	21
0.5 Financial Case	21
0.5.1 Financial Position of the Trust	21
0.5.2 Capital Expenditure	21
0.5.3 Revenue Costs	23
0.5.4 Accounting Treatment	23
0.5.5 Impact on the Statement of Comprehensive Income (SoCI)	23
0.6 Management Case	24
0.6.1 Project Management Arrangements	24
0.6.2 Project Reporting Structure	24

Contents	Page No
0.6.3 Outline Project Plan	26
1.0 The Strategic Case	27
1.1 Strategic Context	27
1.1.1 Organisational Overview	27
1.1.1.2 Historical Financial Performance	29
1.1.2 Business Strategy and Aims	29
1.1.2.1 National Context	29
1.1.2.1.1 NHS Spending Review 2018	29
1.1.2.1.2 NHS Long Term Plan	30
1.1.2.1.3 Safer, Faster, Better (NHSE, 2015)	30
1.1.2.1.4 Improving Patient Flow (2017)	31
1.1.2.1.5 Seven Day Hospital Services Programme	31
1.1.2.1.6 NHS Access Standards	32
1.1.2.2 Local Context	32
1.1.2.2.1 Local Population Demographics	32
1.1.2.2.2 Humber Coast and Vale Health and Care Partnership	34
1.1.2.2.2.1 HC&V Clinical Service Strategy	35
1.1.2.2.2.2 HC&V Estates Strategy (2018)	35
1.2 Trust Response to the Strategic Context	36
1.2.1 Trust Strategy 2019-24	36
1.2.2 Trust Digital Strategy 2018-23	37
1.2.3 Trust Estates Strategy 2017-22	38
1.3. The Case for Change	38
1.3.1 Investment Objectives	38
1.3.2 Existing Arrangements and Business Needs	38
1.3.2.1 Activity	39
1.3.2.2 Diagnostic Waits	40
1.3.2.2.1 CT	41
1.3.2.2.2 MRI	42
1.3.2.2.3 Ultrasound	44
1.3.2.2.4 Endoscopy	45
1.3.2.3 Trust Performance	47
1.3.2.4 Emergency Department	48
1.3.2.5 Primary Care Streaming	51
1.3.2.6 Patient Flow from the Emergency Department	51
1.3.2.7 Delayed Transfers of Care (DTOCs)	55
1.3.2.8 Same Day Emergency Care	56
1.3.2.9 Care Quality Commission	57
1.3.2.10 Trust Financial Position	57
1.3.2.11 Summary	58
1.4 Potential Scope and Service Requirements	58
1.5 Main Benefits and Risks	59
1.5.1 Main Benefits	59
1.5.2 Main Risks	59
1.6 Constraints and Dependencies	62
1.6.1 Constraints	62
1.6.2 Dependencies	62

Contents	Page No
2. The Economic Case	63
2.1 Introduction	63
2.2 Critical Success Factors	63
2.3 Long List of Options	63
2.3.1 Determining the Preferred Way Forward	67
i. Service Scope	67
ii. Service Solution	67
iii. Service Delivery	72
iv. Implementation Timeframes	75
v. Funding Mechanism for the Project	76
2.3.2. Summary of the Long List Using the Options Framework	77
2.3.3 Preferred Way Forward	77
2.4 Shortlist Options	78
2.5 Summary Assessment of Options	81
2.6 Indicative Costs	81
3. Overview of the Commercial Case	83
3.1 Required Services	83
3.2 Potential for Risk Transfer	83
3.3 Proposed Charging Mechanisms	83
3.4 Proposed Contract Lengths	83
3.5 Personnel Implications	83
3.6 Procurement Strategy	83
3.6.1 Building	83
3.6.2 Equipment Procurement	85
3.7 FRS 5 Accountancy Treatment	85
4. Overview of the Financial Case	86
4.1 Financial Position of the Trust	86
4.2 Capital Expenditure	87
4.3 Revenue Costs	87
4.4 Accounting Treatment	88
4.5 Impact on the Statement of Comprehensive Income (SoCI)	88
5. Overview of the Management Case	90
5.1 Programme Management Arrangements	90
5.2 Project Management Arrangements	90
5.2.1 Project Reporting Structure	91
5.2.2 Project Roles and Responsibilities	92
5.2.2.1 Project Board	92
5.2.2.2 Worksteam Teams	93
5.2.2.3 Project Director	93
5.2.2.4 Project Manager	93
5.3 Outline Project Plan	93
5.4 Use of Special Advisors	94
Appendices	
Appendix 1: Shortlisted Options – Indicative Costs	95
Appendix 2: Preferred Way Forward – Capital Costs	96

Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary

Strategic Outline Case

0.0 Executive Summary

0.1 Introduction

This Strategic Outline Case seeks approval to invest an estimated £19.3m of capital funding in the reconfiguration and transformation of urgent and emergency care facilities at the Hull Royal Infirmary to enable the better management of the acutely ill patient. This will involve the provision of additional diagnostic capacity (CT, MRI, Ultrasound and endoscopy equipment) and the relocation of adult assessment and paediatric services to create additional inpatient capacity.

0.2 Strategic Case

0.2.1 Strategic Context

The strategic drivers for this investment and associated strategies, programmes and plans are as follows:

- The NHS Long Term Plan (2019) requires major changes to the NHS service model, including redesigning and reducing pressure on emergency hospital services. Every acute Trust with a Type 1 Emergency Department is required to have a comprehensive model of Same Day Emergency Care (SDEC) and to increase the proportion of acute admissions that are discharged on the day of attendance. In addition, avoidable admissions must be reduced through the establishment and expansion of acute frailty services. For patients arriving in the Emergency Department following a stroke, heart attack, major trauma, severe asthma attack or with sepsis, patient pathways must be improved to ensure timely assessment and treatment to reduce the risk of death and disability.
- Safer, Faster, Better (NHSE 2015) sets out the design principles that local health and social care communities need to adopt to deliver safer, faster, better urgent and emergency care. These include utilising ambulatory models of care and ensuring assessment and review by senior clinical decision-makers.
- Improving Patient Flow (NHSI 2017) describes how the consequences of poor patient flow can lead to Emergency Departments becoming crowded, stressful and unsafe, patients may be admitted as 'outliers' to wards that are not best suited to manage their care, and inpatients are moved between wards to make room for newcomers. This leads to worse clinical outcomes, particularly for frail older people who suffer more harm events and may decondition due to extended periods in hospital beds. The Guide outlines areas of focus, in particular streaming to co-located primary care services, timely assessment of patients in the Emergency Department, same day emergency care in a non-inpatient setting, consultant-led acute assessment services, ready access to diagnostics and in-reach services to support patient care and early discharge.
- Care Quality Commission – The Trust was rated as 'Requires Improvement' for responsiveness in relation to urgent and emergency care and failure to comply with NHS access targets. The Trust also received criticism for the poor quality of accommodation for children on the 13th Floor of the Tower Block resulting in a lack of privacy and dignity, and for the lack of parental accommodation.

- Humber Coast and Vale Health and Care Partnership (HC&V HCP) – The Trust sits within the HC&V HCP which works across a geographical area of more than 1,500 square miles. In its Sustainability and Transformation Plan (2016), the Partnership acknowledged that it is facing unprecedented demand for services whilst at the same time being impacted by insufficient diagnostic capacity, shortages in specific staff groups (eg diagnostic staff, medical staff in ED, Acute Medicine and some surgical specialties), an ageing workforce and funding constraints, both capital and revenue.

The Partnership's vision for Urgent and Emergency Care is aligned to the ambitions within the NHS Long Term Plan and include:

- o Improvements in Emergency Department performance
- o Increasing the delivery of Same Day Emergency Care
- o Increasing ambulatory care pathways
- o Increased utilisation and expansion of primary care streaming
- o Reduction in length of stay of 'stranded' and 'super-stranded' patients
- o Improved emergency mental health provision
- o Improved ambulance handover times in ED
- o Reductions in delayed transfers of care.

The Partnership's Estates Strategy (2018) aims to provide facilities to support the transformation of urgent and emergency care and diagnostics, reduce the estate footprint where possible, increase efficiency and reduce running costs.

The Trust's response to the strategic context has been to redevelop our Emergency Department, implement primary care streaming in the ED, create a Frailty Intervention Team providing expert review of frail older people within the ED, expansion of acute medical assessment capacity and to redesign our urgent and emergency care pathways. However, the Trust acknowledges that there is much more to be done if the organisation is to address national and local drivers for change. The Trust's business strategy (Trust Strategy 2019-24) is based upon the delivery of high quality care and the provision of great clinical services. It acknowledges the need to work with teams across the Trust, and with system partners, to secure sustainable delivery of safe and timely urgent and emergency care, without compromising other services, especially at times of peak demand. To that end, the Trust has set specific goals which include:

- Increasing the percentage of minor ailment and injury patients who are seen within the primary care service co-located with the ED
- Closer working between medical and surgical teams for those patients and service users presenting with acute conditions
- Improving diagnostic provision and patient flow through the Trust for those patients who present within the ED through the procurement and staffing of additional CT and MRI scanners and increasing our endoscopy capacity
- Continued partnership working with partners to complete the development of community-based services for frail older people, integrated with specialist support from the Trust
- Redesign of pathways for a range of long term conditions, including COPD, heart disease, diabetes and neurological conditions
- Sustained compliance with the four clinical priority Seven Day Standards
- Working with partners to implement a shared care record.

The Trust's Estates Strategy is aligned to the HC&V HCP's Estates Strategy and seeks to provide facilities that support service transformation, the sustainable delivery of clinical

services and the elimination of high risk backlog maintenance issues, whilst increasing service efficiency and resilience. Key features of the Estate Strategy include:

- o modernising services to reduce costs and improve performance
- o maximising space utilisation
- o targeted investment in plant and equipment
- o reviewing working practices and skill mix
- o investment in energy efficiency schemes
- o utilisation of technology and improved data analysis.

The nucleus for all emergency admissions to the Trust is the Hull Royal Infirmary and the Tower Block in particular. This houses the Emergency Department, Acute Medical Unit, Medical Ambulatory Care Unit, Elderly Assessment Unit, operating theatres, critical care facilities, inpatient wards and clinical support services (eg Radiology and Pharmacy). Delivery of the Estates Strategy will support the Trust in achieving its ambitions for improving clinical services, in particular the development of urgent and emergency care.

0.2.2 The Case for Change

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 and has an annual turnover of £573m (2018/19).

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.8 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. It is a recognised centre for Major Trauma, Cardiac, Cancer, Vascular and Hyper Acute Stroke and provides a number of regional specialist services. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

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.

Trust services are delivered from two hospital sites – Hull Royal Infirmary and Castle Hill Hospital – with some outpatient services being delivered within neighbouring Acute Trusts, primary care and community facilities across the Humber Coast and Vale Health and Care Partnership. The Trust is a University Teaching Hospital and a major partner in the Hull York Medical School.

The Hull Royal Infirmary is the Trust's emergency centre taking the majority of non-elective admissions to the Trust. With the current configuration of services, and limited assessment, diagnostic and inpatient capacity, the safety of patients requiring urgent and emergency care is being compromised. Key factors include:

- Poor patient flow from emergency admission to discharge.
- Increasing numbers of attendances to the ED by patients whose care could be more appropriately managed in primary care.
- Insufficient assessment capacity for surgical patients resulting in an inpatient admission.
- Assessment areas located across a number of floors in the Tower Block with poor access to diagnostic facilities
- Insufficient diagnostic capacity in CT, MRI, ultrasound and endoscopy to meet demand leading to increased waiting times for diagnostic tests and increased waiting times in the Emergency Department, assessment units and on the inpatient

wards. For example: the daily average number of breaches of the 4 hour waiting time threshold in the Emergency Department attributed to waiting time for diagnostic tests increased from 4.7 breaches per day in 2017/18 to 10.3 breaches per day in Quarter 1 of 2019/20.

- An MRI facility that is located outside of the Tower Block, necessitating the transfer of emergency and inpatients across the hospital site.
- A shortfall in the provision of adult inpatient beds at the Hull Royal Infirmary resulting in longer waits for admission to the Acute Medical Unit, an increase in the number of medical outliers on surgical wards and the cancellation of elective surgical activity.
- Higher bed occupancy rates. In the case of medical beds, bed occupancy exceeds 90% resulting in increased pressure at times of high demand leading to backlogs and overcrowding in the ED.
- Increased pressure on bed availability due to the number of patients whose transfer/discharge has been delayed (an average of 858 bed days per month in 2018/19)
- Inadequate accommodation for children on the paediatric wards leading to privacy and dignity issues.
- Paediatric services on the 13th floor include the inpatient ward, paediatric high dependency unit and paediatric assessment unit. These are remote from the diagnostic facilities and critical care facilities on the 2nd floor of the Tower Block, and from the paediatric surgical ward in the Women's and Children's Hospital.
- Lack of parental accommodation, particularly for those whose children are being treated in the Paediatric High Dependency Unit and Neonatal Intensive Care Unit.

The poor flow along the urgent and emergency care pathways has resulted in the following:

- Failure to comply with the 15 minute standard for ambulance/ED handover leading to queuing of ambulances outside the ED.
- Failure to comply with the 4 hour waiting time threshold in the ED. The Trust has not met the 95% threshold (annual total) for the last four years.
- Failure to comply with 7 Day Hospital Services Clinical Standard 5 (Timely Access to Diagnostics)
- Inability to meet demand in growth for diagnostic imaging due to lack of capacity in CT, MRI, ultrasound and endoscopy
- Failure to comply with national 18 week Referral to Treatment (RTT), cancer and diagnostic waiting time thresholds.
- Poor patient experience as a result in increased waiting times for assessment, diagnostics, treatment and/or admission to hospital, increased length of stay, and multiple transfers between wards/departments.
- A Care Quality Commission rating of 'Requires Improvement' for responsiveness in Urgent and Emergency Care and for the failure to comply with NHS access standards.

The Trust has a recurrent underlying deficit of circa £8.6m. The Trust expects to achieve a return to surplus early in the next 5 year period, however this will require significant changes to the way in which clinical services are configured, delivered and resourced. Capital funding will be required to address accommodation deficiencies, increase diagnostic capacity and improve urgent and emergency care pathways.

0.2.3 Summary

The combined impact of increasing numbers of complex patients being admitted, increased length of stay, delayed transfers of care and insufficient inpatient medical beds to meet demand, is impacting negatively on the ability of the Trust to manage the patient pathway from admission to discharge in a timely manner, resulting in increased waiting times in the

Emergency Department, increased waiting times for diagnostic tests, longer lengths of stay in the Acute Medical Unit and a poor patient experience.

There is therefore a need to increase diagnostic and assessment capacity to reduce waiting times in the Emergency Department, improve patient flow through the urgent and emergency care pathway and reduce the reliance on admission to an inpatient bed for those patients who can be seen, diagnosed, treated and discharged the same day. This will require capital investment to provide additional and replacement diagnostic equipment and to enable the reconfiguration of urgent and emergency care services within the Tower Block of the Hull Royal Infirmary.

0.2.4 Investment Objectives

The investment objectives for this project are as follows:

- Investment objective 1: To increase the proportion of acute admissions/ presentations discharged on the day of attendance by 2023.
- Investment objective 2: To achieve compliance with Urgent and Emergency Care standards through continued and sustained improvement against the agreed baseline.
- Investment objective 3: To achieve a minimum of 90% compliance with the 7 Day Hospital Services Clinical Standard 5 for MRI, CT, Ultrasound and Upper GI Endoscopy
- Investment objective 4: To reduce the number of outliers and non-clinical inter-ward transfers by 50%
- Investment objective 5: To improve the clinical adjacencies of services to optimise clinical safety and efficiency, reduce clinical risk and improve patient and carer experience.

0.2.5 Potential Scope and Service Requirements

In order to determine the potential scope of the project in terms of operational capabilities and service changes required to satisfy the Trust's business needs, the organisation undertook a series of workshops with key stakeholders. Arising from these workshops was a list of the core, desirable and optional changes required to increase service capacity and delivery, improve organisational performance and achieve the investment objectives of the project (see table below).

Category	Service Requirements
Core	• A front entrance to the Emergency Department which enables the effective triage and streaming of 'walk-in' attendances • Additional diagnostic capacity to facilitate the timely diagnosis and treatment of patients across the urgent and emergency care pathway, from the ED, to the assessment, ambulatory care units and inpatient wards, in particular CT, MRI and endoscopy • Additional assessment capacity to increase the number of patients seen, treated and discharged the same day, thereby reducing the need to occupy an inpatient bed. • Co-location of additional diagnostic capacity with ED and assessment facilities • Assessment facilities to be accommodated on the ground floor of the Tower Block to facilitate patient flow • Increased flexibility in bed capacity within the Tower Block to ensure the appropriate number of beds matched to specialty and acuity.
Desirable	• Relocation of paediatric services from the 13th floor of the Tower Block • Additional ultrasound capacity

Category	Service Requirements
Optional	None of the service requirements identified were considered to be 'optional'

Consideration was given to the extent to which improvements could be made to the urgent and emergency care pathway within the Trust. A scoping exercise was undertaken to understand the actions that the Trust could undertake to address its business needs, ranging from 'do nothing' and making minimal changes within existing resources, to the potential scope for change if additional investment became available. The following service scope options were identified:

1. Business as usual – continue to experience delays in the diagnosis and treatment of patients who present to the ED or via direct GP referral to the assessment and ambulatory care areas. Continue to experience delays in accessing diagnostic services for inpatients and experience high levels of bed occupancy and increased length of stay, with increasing pressure on the availability of inpatient beds. Retain paediatric assessment and inpatient services on 13th floor of the Tower Block, remote from diagnostic and critical care facilities.
2. Emergency Department – increase primary care stream capacity.
3. Emergency Department and maximise utilisation of diagnostic equipment through extended working.
4. Emergency Department and additional MRI and CT scanning facilities on the Hull Royal Infirmary site, but not co-located with the ED and existing assessment areas. Additional/replacement endoscopes.
5. Emergency Department and additional MRI and CT scanning facilities co-located on the ground floor of the Tower Block. Additional/replacement endoscopes.
6. As in No. 5 but with additional assessment capacity to enable the increased provision of Same Day Emergency Care.
7. As in No. 6 above, but with additional ultrasound scanning capacity.
8. Emergency Department, additional MRI and CT scanning facilities on the ground floor of the Tower Block, additional/replacement endoscopes, additional assessment capacity, relocation of the Elderly Assessment Unit, relocation of paediatrics. Additional adult inpatient capacity.
9. As in No. 8 above but with the inclusion of additional ultrasound capacity.
10. As per No. 9 above and with consolidation of paediatric assessment, high dependency and inpatient wards within the Women's and Children's Hospital.

An assessment of the Service Scope was undertaken as part of the Options Framework identified in HM Treasury's 'Guide to Developing the Project Business Case' (2018). Details on the outcome of the Options Framework in relation to the identification of the Preferred Way Forward and the subsequent Preferred Option are identified in the Economic Case.

0.2.6 Main Benefits and Risks

0.2.6.1 Main Benefits

The main benefits of the investment are identified in the table below:

	Cash Releasing Benefits (CRB)	Non-cash Releasing Benefits (non-CRB)	Quantifiable but not readily monetisable Benefits (QB)	Qualitative but not readily quantifiable Benefits (Qual)
Direct public sector benefits (to the Trust)	- Reduced downtime on existing scanners - Reduction in cost of hiring in mobile scanners to meet backlogs in demand - Reduction in staffing costs - Contributes to realisation of Trust's financial plan - Cost avoidance from the ability to do more Same Day Emergency Care resulting in less inpatient bed requirements - Cost avoidance from the increased LOS of inpatient diagnostics – bed growth not required	Increased efficiency and productivity of existing staff	- Achievement of key ED waiting time targets - Reduction in medical outliers - Reduction in length of stay - Timely access to diagnostics, ie MRI, CT, ultrasound, endoscopy - Compliance with SDEC requirements - Compliance with NHS 7 DS Clinical Standards - Increased assessment capacity - Midnight bed occupancy levels for acute medical beds below 90% occupancy levels across every quarter in the year - Reduction in need to cancel elective surgery due to insufficient beds - Improved staff satisfaction - Increased staff retention - Improved RTT and cancer waiting times	- Improved flow of emergency medical and surgical admissions throughout the hospital - Improved patient pathways for urgent and emergency care - Compliance with CQC inspection requirements in relation to Responsive Domain - Earlier diagnosis and treatment of the patient, including reduced risk of deterioration of condition - Greater flexibility in the management of peaks in non-elective activity. - Realisation of ambitions in Trust Strategy and People Strategy - Compliance with JAG accreditation requirements
Indirect public sector benefits (to other public sector organisations)	Contributes to realisation of STP financial plan		- Contributes to improved waiting times and access to healthcare across the wider STP as part of the patch-wide reconfiguration of Urgent and Emergency Care - Supporting increased provision of GP direct access to diagnostics - Improved waiting times in ED will have a positive impact on access to services for Mental Health provider organisation in-reaching to the Trust	Realisation of ambitions within the STP long term plan.

	Cash Releasing Benefits (CRB)	Non-cash Releasing Benefits (non-CRB)	Quantifiable but not readily monetisable Benefits (QB)	Qualitative but not readily quantifiable Benefits (Qual)
Wider benefits to UK society			- Improved patient satisfaction - Reduction in waiting times for diagnosis and treatment	Improved patient experience

At this stage, the potential for dis-benefits as a result of the proposals to reconfigure urgent and emergency care flow through the Tower Block at Hull Royal Infirmary is low.

0.2.6.2 Main Risks

The main risks identified at this early stage of the project are categorised below.

Risk Categories	Description	Mitigating Actions
Business risks	Project timescales slip due to insufficient workforce capacity to manage the schemes.	The Trust will provide dedicated project management resource to support the project to achieve implementation within the set timescales.
	Delays in the finalisation of the detailed briefs for the different elements of the reconfiguration programme	Communication and engagement with key stakeholders and the development of realistic timelines, with the interdependencies plotted and planned into the project timescales.
	Inability to recruit to radiographer posts to support the additional CT/MRI provision	Recruitment campaign via national and local press, internally, as well as via career fairs and university events. Trust has approved the restructuring of the radiographer service to provide additional opportunities for career development and progression to assist with recruitment and retention of radiographers.
	Inability to recruit to nursing posts to support the additional assessment and ambulatory care capacity	Recruitment campaign via national and local press, internally, as well as via career fairs and university events.
	Programme of building works negatively impact on delivery of services	Communication and engagement with key stakeholders. Risk assessments undertaken. Schedule of works developed in conjunction with clinical services. Clear signage marking alternative routes where necessary. Alternative accommodation provided whilst enabling works undertaken.
	Programme of building works negatively impacted by need to liaise with Private Finance Initiative (PFI) approvals process affecting the second floor link bridge from the WCH into the second floor of the Tower Block	Close dialogue with PFI team to ensure sufficient time to identify and manage any legal implications arising from the proposed project.
	The design does not support the brief.	Regular checking of the brief to record compliance and derogations. Design development approved by project team and signed off by clinical teams.
	The project impacts negatively on the provision of emergency care and on	A project plan will be developed that will limit disruption. This will be communicated to key

Risk Categories	Description	Mitigating Actions
Service risks	patient and public access during the construction phase.	stakeholders, patients and visitors.
	Project timescales are adversely impacted by delays in the manufacture and delivery of CT and MRI equipment	Early discussions held with a number of manufacturers as part of specification development. Procurement process will include delivery dates and a contingency built into the plans for the reconfiguration of the ground floor. Project team experienced in the procurement of CT and MRI equipment
	Delays in the delivery of engineering plant	Early discussions will be held with potential contractors regarding delivery timescales to mitigate this risk and an appropriate contingency built into the project plans.
	UEC capital developments at neighbouring Trusts may result in HUTH receiving a greater number of ED attendances than anticipated.	Progress and impact of capital works at all three Trusts will be monitored via the HC&V Wave 4 Capital Development Steering Group.
External risks	NHS capital funding may not be forthcoming due to changes in national policy	Submission of SOC, OBC, FBC in line with required timescales for Wave 4 developments. Strong case for change and demonstrable value for money.

0.2.7 Constraints and Dependencies

0.2.7.1 Constraints

The project is subject to the following constraints:

- **Budget:** The Trust has a limited capital programme over the next 5 years. The capital funding from the Wave 4 STP bids is fixed at £19.3m and needs to be maintained within the envelope.
- **Timeliness:** Capital funding may not be available until 2021 when the Full Business Case is approved.
- **Existing physical layout/footprint of the Tower Block:** The Hull Royal Infirmary opened in 1967 and backlog maintenance poses a significant risk. There are limited options available to increase the footprint, which are largely restricted to the front of the building.

In addition:

- The existing spaces may not meet current guidance, so derogations may be required;
- The structural frame and immovable elements of the building may not permit certain layouts to be achieved;
- The positions of lifts and stairs will influence layouts and the flow of patients; and
- Natural light and ventilation/cooling are a factor to consider when planning accommodation, and what is practicable within the spaces being considered.

0.2.7.2 Dependencies

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Urgent and Emergency Care Wave 4 developments of other acute Trusts within Humber Coast and Vale HCP

- Lorenzo Digital Exemplar Programme which aims to digitise specific clinical pathways
- Humber Acute Services Review
- Unplanned Care Board
- A&E Delivery Board
- CCG commissioning intentions
- Ongoing replacement of Radiology Imaging equipment.

0.3 The Economic Case

0.3.1 Critical Success Factors

The key Critical Success Factors (CSFs) for the Urgent and Emergency Care Expansion project were developed during an 'options workshop' held by UEC Development Programme Board on 1st May 2019. The CSFs have been used alongside the investment objectives for the project to evaluate the long list of possible options.

Critical Success Factor	Description
CSF1: Strategic fit and business needs	The option meets the agreed investment objectives, related business needs and service requirements. It provides holistic fit and synergy with other strategies, programmes and projects.
CSF2: Potential value for money	The option optimises the potential return on expenditure, business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation), and assists in improving the overall value for money (economy, efficiency and effectiveness).
CSF3: Supplier capacity and capability	The market place and potential suppliers are able to deliver the required services and deliverables.
CSF4: Potential affordability	The option can be funded from available sources of finance and aligns with sourcing constraints
CSF5: Potential Achievability	The organisation is able to innovate, adapt, introduce, support and manage the required level of change associated with the option. It is able to manage any associated risks and has the capacity and capability to provide the necessary supporting skills. The organisation will be able to engender the acceptance of staff.

0.3.2 Long List of Options

The initial long list of options was as follows:

Option Name	Description
1.1 Business as Usual (BAU)	Urgent and emergency care pathways from the Emergency Department to assessment, admission and/or discharge are compromised by a lack of diagnostic and assessment capacity.
1.2 Emergency Department	Reconfigure the 'walk in' entrance to the Emergency Department
1.3 Emergency Department and Maximising existing diagnostic capacity	Reconfigure 'walk in' entrance to the Emergency Department and maximise utilisation of diagnostic equipment through extended wo
1.4 ED and additional MRI/CT (not on ground floor). Endoscope provision	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner on the HRI site, but not co-located with the ED and

Option Name	Description
	AMU. Provide additional/ replacement endoscopes.
1.5 ED and additional CT/MRI co-located on the ground floor. Endoscope provision	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes.
1.6 ED and additional CT/MRI co-located on the ground floor. Endoscope provision. Additional assessment capacity	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes. Provide additional assessment capacity on the ground floor
1.7 ED, additional CT/MRI and Ultrasound co-located on the ground floor. Endoscope provision. Additional assessment capacity	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner, 1 x additional MRI scanner and 1 x additional ultrasound scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes. Provide additional assessment capacity on the ground floor
1.8 ED, additional CT and MRI co-located on the ground floor. Endoscope provision. Additional assessment capacity. EAU relocated. Additional inpatient capacity	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional MRI and 1 x additional CT scanning facilities on the ground floor of the Tower Block. Provide additional/replacement endoscopes, additional assessment capacity, relocate the Elderly Assessment Unit from the 2 nd floor to the Ground Floor, and transfer paediatrics from the 13 th to the 2 nd floor. Create additional adult inpatient capacity.
1.9 ED, additional CT and MRI co-located on the ground floor. Endoscope provision. Additional assessment capacity. EAU relocated. Additional inpatient capacity. Additional ultrasound provision	As in Option 8 above but with the inclusion of additional ultrasound capacity on the ground floor of the Tower Block.
1.10 As Option 9 with consolidation of paediatric services on the W&CH site	As per Option 9. Paediatric services would be relocated from the 13 th floor of the Tower Block to the Women's and Children's Hospitals.

0.3.3 Determining the Preferred Way Forward

The HM Treasury's Options Framework provides a structured approach to identifying and filtering a broad range of options and has been used in a number of public sector schemes. The Framework identifies and filters choices for:

- i. the operational/service scope
- ii. service solution
- iii. service delivery vehicles
- iv. implementation timeframes; and
- v. funding mechanism for the project.

It is necessary to include a 'Business as Usual' option, a 'Do Minimum' option, a range of 'Intermediate' options and a 'Do Maximum' option. At each stage in the 5 step process, the options are assessed to determine whether they are unrealistic and should be 'discounted (D)', or if they can be 'carried forward (CF)' or are the 'preferred way forward (PWF)'.

i. Service Scope

Each of the 10 options identified above was assessed against the 'core' and 'desirable' service requirements as outlined in Section 0.2.5 to determine which of the options could be discounted and which should be taken forward for further appraisal. The outcome was that Options 1.2, 1.3, 1.4 and 1.5 were discounted at this early stage as they did not meet the core requirements to increase primary care streaming, provide additional CT, MRI and endoscopy capacity, increase assessment capacity and increase the adult inpatient bed capacity. They also failed to meet the desirable requirements – additional ultrasound capacity and relocation of paediatrics.

The outcome of the service scope assessment is summarised below.

Project	1.1 BAU	1.2	1.3	1.4	1.5	1.6 Do Min	1.7 Interm	1.8 Interm	1.9	1.10 Do Max
1.Scope Outcome	CF	D	D	D	D	CF	CF	CF	PWF	CF

Option 1.1 was carried forward as the 'BAU' option, with Option 1.6 becoming the 'Do Minimum', Options 1.7 and 1.8 as two 'Intermediate' options and Option 1.10 being the 'Do Maximum' option. At this stage Option 1.9 was the option which was identified as the 'Preferred Way Forward'.

ii Service Solution

Consideration was given to the possible service solutions for the 6 remaining options. The advantages and disadvantages of the service solutions identified are listed overleaf. The service solutions included actions such as creating a new entrance to the minors/GP streaming area of the Emergency Department and creating additional floor space on the ground floor by creating an extension to the front of the Tower Block.

Consideration was also given to how additional assessment capacity could be provided on the ground floor by creating a Surgical Ambulatory Care Unit (SACU). The service solutions were based on the potential size of the SACU.

In addition the solutions looked at the potential locations for additional diagnostic capacity and for the relocation of paediatrics.

Project	2.1 BAU	2.2 Do Min Two storey	2.3 Interm Two storey with ultrasound	2.4 Interm Three storey	2.5 Interm Three storey larger SACU	2.6 Two storey, Paed new build
2. Service Solution Outcome	CF	CF	CF	CF	PWF	D

iii. Service Delivery

The next stage in the Options Framework looked at potential options for delivering the preferred scope and service solution. They focus on the sizing, sequencing and phasing of the UEC reconfiguration project.

The outcome of this assessment resulted in the measured term contract and P22 partner options being discounted. The preferred way forward was to deliver the building works via a series of tenders.

Project	3.1 BAU	3.2 OJEU contract	3.3 P22 Partner	3.4 Tender small packages of work
3. Service Delivery Outcome	CF	CF	D	PWF

iv. Implementation Timeframes

Consideration was then given to the options for implementing the programme of work to enable the reconfiguration of accommodation at the Hull Royal Infirmary. The BAU option was no longer applicable. Consideration was given to phasing of the works over a one year, two year or three year period.

Initial estimates in relation to the timescale for the project indicate that a 3 year implementation period is less risky and more realistic in terms of the planning, tendering and delivery of the project. The preferred way forward for the Trust was to implement the project over 3 years. The option for implementation in one year was discounted.

Project	4.1 3 years	4.2 2 years	4.3 1 year
4. Implementation Outcome	PWF	CF	D

v. Funding Mechanism for the Project

This section of the Options Framework considers the funding options to deliver the project's preferred scope, solution, method of service delivery and implementation.

This Strategic Outline Case has been developed following a successful bid for STP capital funding of £19.3m to improve the provision of urgent and emergency care at the Hull Royal Infirmary. Therefore the funding options include the bid funding (subject to a successful business case). Other options for funding are also explored below.

Project	5.1 Trust Capital	5.2 External Capital Funding	5.3 Loan Funding
5. Funding Outcome	D	PWF	D

0.3.4. Summary of the Long List Using the Options Framework

The outcome of the long list options appraisal to determine the preferred way forward is summarised below.

Project	BAU	Option	Option	Option	Option	Do Min	Interm	Interm	Interm	Do Max
Service Scope	BAU	ED only	ED and existing diagnostics	ED and additional diagnostics	Ground floor devlpnt	CT MRI and asmnt	CT/MR U/snd Asmnt	Plus EAU paed inpt	Plus ul/snd	Plus paed WCH
	CF	D	D	D	D	CF	CF	CF	PWF	CF
Service solution	BAU					Single storey	SS with ul/sound	Three storey Small SACU	Three storey Large SACU	Two store Paed new build
	CF					CF	CF	CF	PWF	D
Service Delivery	BAU					OJEU	P22 Partner	Tenders		
	CF					CF	D	PWF		
Impl/ ation						3 year	2 year	1 year		
						PWF	CF	D		
Funding						Trust cap	External (STP)	Loan		
						D	PWF	D		

0.3.5 Preferred Way Forward

The preferred way forward comprises the following elements:

- Reconfigure the front entrance to the ED, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional endoscopes, relocate the EAU, relocate the paediatric department, create additional adult inpatient capacity.
- This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a larger diagnostic suite on the ground floor with a large size Surgical Ambulatory Care Unit.
- The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases.
- The project will be implemented over 3 years.
- It will be funded predominantly through STP Wave 4 funding.

However, it should be noted that this is just the preferred way forward. It is not the preferred option at this stage. National guidance recommends that a further level of appraisal be undertaken to determine the preferred option.

0.3.6 Shortlist Options

In order to determine the preferred option for recommendation, guidance suggests that the preferred way forward ('recommended option') be assessed against three or more shortlisted options generated from the Options Framework outlined above. The Business As Usual (BAU) option is included as a benchmark for Value for Money (VfM), with a 'Do Minimum' and either a 'less ambitious' or 'more ambitious' option. The shortlist of options is summarised below. The numbering in each of the coloured boxes map to the option choices set out in the long list option framework in section 2.2.1.

Options	Business as Usual (BAU)	Do Minimum	Preferred Way Forward (PWF)	Less Ambitious PWF
Scope	1.1	1.6	1.9	1.8
Solution	2.1	2.2	2.5	2.4
Delivery	3.1	3.2	3.4	3.4
Implementation	n/a	4.2	4.1	4.1
Funding	n/a	5.2	5.2	5.2

A description of the shortlisted options, their advantages and disadvantages are given overleaf.

Description of Shortlisted Options

Name	Description	Advantages	Disadvantages
Business as Usual (BAU)	Urgent and emergency care pathways from the Emergency Department to assessment, admission and/or discharge are compromised by a lack of diagnostic and assessment capacity Current configuration of services and locations would be retained. The Trust would continue to use its in-house estates team to deliver business as usual	None	Delays in the diagnosis and treatment of patients who present to the ED or via direct GP referral to the assessment and ambulatory care areas. Delays in accessing diagnostic services for inpatients, high levels of bed occupancy and increased length of stay, with increasing pressure on the availability of inpatient beds. Paediatric assessment and inpatient services on 13th floor of the Tower Block are inadequate and remote from diagnostic and critical care facilities. The buildings and infrastructure will continue to contribute to delays in the urgent and emergency care pathway, resulting in longer waiting times, increased length of stay and a poor patient experience. Ongoing costs of outsourcing Would require more inpatient beds.
Do Minimum	Two storey extension to enable creation on ground floor of co-located imaging suite for CT and MRI, small SACU. New entrance to minors/GP area. Relocation of chapel and kitchen. The Trust would issue a single tender via an Official Journal of the European Union (OJEU) compliant framework. Building works would be phased over 2 years Funded from external Capital Funding (STP) only	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. Additional assessment capacity will enable increased provision of Same Day Emergency Care (SDEC) leading to reduced acute admissions where appropriate. Having one contract would require fewer contractual arrangements and legal documentation Enables the Trust to plan works around seasonal peaks in demand. Full benefits of reconfiguration could be delivered sooner. External funding and therefore additional to Trust's own capital allocation	Necessitates the reconfiguration of the ground floor of the Tower Block. No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity Whilst some inpatient capacity may be freed up through reduction in LOS, there will remain a requirement for additional inpatient beds over and above the existing establishment. Does not enable relocation of EAU and paediatrics. Paediatric services would remain on 13th floor. Size of SACU may be insufficient to address future needs. Potential for single point of failure – 'all eggs in one basket'. Less time for planning, design, tender and delivery of the project. Less contingency for delays. Capped at £19.3m for the whole scheme including building works and equipment.
Preferred Way Forward	Reconfigure the front entrance to the ED, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care	Necessitates reconfiguration of areas on the ground floor and 2nd floor of the Tower Block. Also enabling works to 13th floor. Paediatric services not relocated to the Women's and

Name	Description	Advantages	Disadvantages
	endoscopes, relocate the EAU, relocate the paediatric department, create additional adult inpatient capacity. This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a larger diagnostic suite on the ground floor with a large size Surgical Ambulatory Care Unit. The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases. The project will be implemented over 3 years. It will be funded predominantly through STP Wave 4 funding.	facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. CT/MRI, ultrasound and endoscopy capacity would be increased, reducing waiting times for diagnostics and assisting in the delivery of SDEC, reduced LOS and potentially freeing up some inpatient capacity. A larger SACU will enable the Trust to address growth in demand. Ability to utilise existing preferred contractors. Design and tender can be phased, with a shorter pre-tender timescale. Enables the Trust to plan works around seasonal peaks in demand. Provides contingency for delays. Minimises disruption to services. Allows for effective planning and tendering of the project	Children's Hospital. Later cost certainty (only complete after last phase is tendered). More parties involved in project, more contracts to manage. Multiple site set ups on site taking up more space. Interface between phases/handovers more difficult Contract management resource higher, valuations, contract admin duplicated multiple times. Full benefits of the reconfiguration works would take longer to be realised. The Trust has a shortfall on its existing capital funding and therefore would have to prioritise spend.
Less Ambitious PWF	Create 3 storey extension to the Tower Lock. Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional MRI and 1 x additional CT scanning facilities on the ground floor of the Tower Block. Provide additional/replacement endoscopes, additional assessment capacity, relocate the Elderly Assessment Unit from the 2nd floor to the Ground Floor, and transfer paediatrics from the 13th to the 2nd floor. Create additional adult inpatient capacity - Smaller SACU. The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases. The project will be implemented over 3 years. Funding of £19.3m provided via Wave 4 STP capital development funding	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. CT/MRI and endoscopy capacity would be increased, reducing waiting times for diagnostics and assisting in the delivery of SDEC, reduced LOS and potentially freeing up some inpatient capacity. Design and tender can be phased, with a shorter pre-tender timescale. Enables the Trust to plan works around seasonal peaks in demand. Provides contingency for delays. Minimises disruption to services. Allows for effective planning and tendering of the project External funding only	No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity. Necessitates reconfiguration of areas on the ground floor and 2nd floor of the Tower Block. Also enabling works to 13th floor. Paediatric services not relocated to the Women's and Children's Hospital. Later cost certainty (only complete after last phase is tendered). More parties involved in project, more contracts to manage. Multiple site set ups on site taking up more space. Interface between phases/handovers more difficult Contract management resource higher, valuations, contract admin duplicated multiple times. Full benefits of the reconfiguration works would take longer to be realised. Capped at £19.3m for the whole scheme including building works and equipment.

0.3.7 Summary Assessment of Options

A summary assessment of the four shortlisted options was undertaken to determine the extent to which each option complied with the Investment Objectives and Critical Success Factors identified in Sections 1.3.1 and 2.2. The outcome is detailed below.

Options	Business as Usual (BAU)	Do Minimum	Preferred Way Forward (PWF)	Less Ambitious PWF
Investment Objectives:				
1. Increase proportion of acute admissions/ presentations discharged on day of attendance	X	P	Y	P
2. Achieve compliance with UEC standards	X	P	Y	P
3. Achieve 90% compliance with 7DS Clinical Standard 5 for CT, MRI, Upper GI Endoscopy and Ultrasound	X	P	Y	P
4. Reduce the number of outliers and non-clinical inter-ward transfers by 50%	X	P	Y	Y
5. Improve clinical adjacencies of services to optimise clinical safety and efficiency, reduce clinical risk and improve patient/carers experience	X	P	Y	Y
Critical Success Factors:				
CSF 1: Strategic fit and business needs	X	P	Y	Y
CSF2: Potential value for money	X	P	Y	Y
CSF3: Supplier capacity and capability	X	P	Y	Y
CSF4: Potential affordability	X	Y	Y	Y
CSF5: Potential achievability	X	P	Y	Y
Summary:	Discounted	Possible	Preferred Way Forward	Possible

Key: X= Does not achieve P = Partial achievement Y = Achieves

0.3.8 Indicative Costs

The indicative costs for each of the short-listed options are set out below. They include some allowance for 'optimism bias' and the 'cost of risk'.

	Business as Usual	Do Minimum	Preferred Way Forward	Less Ambitious PWF
	£000	£000	£000	£000
Capital Costs	0	(13,900)	(19,268)	(18,964)
Revenue Costs	(538,240)	(480,080)	(574,583)	(551,341)
Total Costs	(538,240)	(493,980)	(593,851)	(570,305)
Cash Releasing Benefits	0	533,450	536,123	536,123
Total Net Costs	(538,240)	39,470	(57,728)	(34,182)
Total Costs Discounted	(104,270)	(74,246)	(90,526)	(86,128)
Total Benefits Discounted	0	103,921	104,433	104,433
Value for Money Ratio	0.0	1.4	1.2	1.2

The table above shows the value for money is positive for all options apart from the 'Business as Usual' as expected. However, as the main benefits accrue to the CT/MRI replacement and the Surgical Ambulatory Care Unit (which is included in all of the 'do

something' options), the value for money favours the 'do minimum', which excludes the Paediatrics reconfiguration. Further work will be undertaken to try and quantify additional savings associated with this element of the case or even how the Trust would incur additional costs if they did not progress the paediatric relocation.

0.4 Commercial Case

0.4.1 Required Services

The required products and services in relation to the preferred way forward are briefly as follows:

- Design team/consultancy appointments
- Project Management resource - either 'in-house' or external consultancy
- Building contract
- Supply of equipment

0.4.2 Potential for Risk Transfer

An initial assessment of the potential allocation of risk has been undertaken and is demonstrated in the following risk matrix.

Risk Category	Potential Allocation		
	Trust	Private	Shared
1. Design risk	✓		
2. Construction and development risk			✓
3. Transition and implementation risk	✓		
4. Availability and performance risk	✓		
5. Operating risk	✓		
6. Variability of revenue risks	✓		
7. Termination risks	✓		
8. Technology and obsolescence risks	✓		
9. Control risks	✓		
10. Residual value risks	✓		
11. Financing risks	✓		
12. Legislative risks	✓		

0.4.3 Proposed Charging Mechanisms

The Trust envisages that the project will be split into multiple phases with a contract for each phase.

0.4.4 Proposed Contract Lengths

This has not been determined at this stage. The draft programme for the preferred way forward indicates a combined project duration of up to three years.

0.4.5 Personnel Implications

It is anticipated that Transfer of Undertakings (protection of Employment) (TUPE) will not apply to this investment.

0.4.6 Procurement Strategy

0.4.6.1 Building

The Trust has explored the following procurement options:

- One project tender via an OJEU compliant Framework such as Yorbuild.
- ProCure22 Partner
- Several small packages of work via Trust tendering system (each project value would be below OJEU threshold.)

An assessment of the advantages and disadvantages of each of these is summarised overleaf.

One project tender via an OJEU compliant Framework	
Advantages • Having one contract would require fewer contractual arrangements and legal documentation. • There would be a single point of contact for the entire project, making project management easier. • It would be easier to manage phases in the project and handovers, particularly where there is overlap. • Fewer contractors on site would negate the need for separate contractor sites. • Framework mechanism provides for KPIs and performance management of contractor. • Whole project is priced as one.	Disadvantages • Potential for single point of failure – ‘all eggs in one basket’. If contractor does not perform well on the early phases it is difficult to avoid using them for the remainder of the project. Risk that would have to terminate the contract and re-tender the remaining work. • Use of Framework will attract a fee increasing the cost of the scheme overall. • Limited choice of contractors available on the Framework. • Will take longer to mobilise early phases as entire Project would have to be ready to tender. • Timescale pre-tender would be longer • More intense Project briefing/sign off period
ProCure 22 Partner	
Advantages • Negotiated terms and rates pre-arranged • Short timescale for securing a contractor to begin work on site • Cost certainty early - Guaranteed Maximum Price (GMP) arrangement • Design and Build option available	Disadvantages • Does not always offer the best value for money. • P22 rates are high compared to market rates • GMP usually high to absorb risk • Changes to design during contract are expensive. • Small pool of contractors • Contractors are larger national contractors and have bigger overheads. • Full cost cannot be guaranteed until full scope of works agreed and costed.
Tender small packages of work via Trust tendering system	
Advantages • Ability to utilise existing preferred contractors. • Larger pool of contractors to draw from. • No Framework fee • Tried and tested Tendering process • Design and tender can be phased, with a shorter pre-tender timescale. • Quicker to mobilise early phases as these could be released before later phases are designed and ready to tender. • Fewer design team resources required on a phased tendered approach. • Phased project briefing/sign off • Less risk of single point of failure, as risk is spread over several phases.	Disadvantages • Later cost certainty (only complete after last phase is tendered). • More parties involved in project, more contracts to manage. • Multiple site set ups on site taking up more space. • Interface between phases/handovers more difficult • Contract management resource higher, valuations, contract admin duplicated multiple times.

At this stage the Trust envisages procuring several smaller projects separated into phases to deliver the key elements of the project in relation to the preferred way forward.

0.4.6.2 Equipment Procurement

The following procurement route options will be considered for the procurement of the equipment outlined in the case for change.

- Full OJEU tender
- Direct purchase using NHS Framework Agreements
- Mini competition and purchase using NHS Framework Agreements.

The majority of the items of equipment are covered by existing NHS Framework Agreements. Each of these agreements has been put in place following a thorough procurement process conducted by NHS Supply Chain. Key issues relating to quality, reliability, timescales and value for money have been assessed through these procurement processes. The Framework Agreements have also been set up to comply with current procurement standards and regulations. As a principle, therefore, the Trust will seek to use the existing Framework Agreements in order to avoid repeating procurement work that has already been completed.

It is anticipated that the mini competition process will be used to inform the evaluation and selection of equipment that is being purchased using Framework Agreements. The Trust is keen to maximise the extent to which the equipment impacts positively on service delivery. Appropriate opportunity will therefore be created in each procurement process to explore options and ideas with different equipment suppliers.

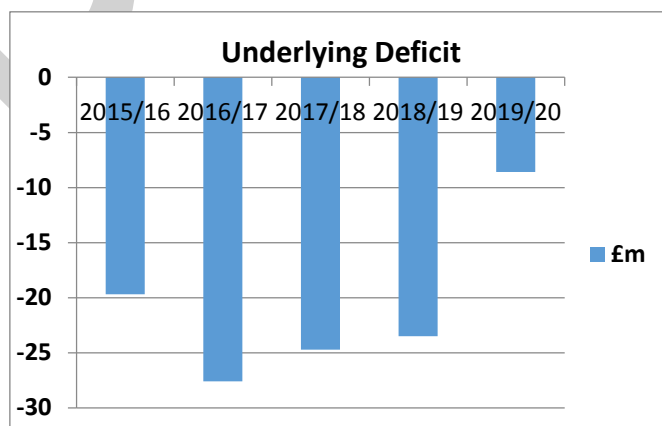
The Trust will work with NHS Supply Chain to achieve best value for money through the procurement process.

0.5 Financial Case

0.5.1 Financial Position of the Trust

The Trust reported an adjusted surplus of £25.2m in 2018/19 which was supported by the receipt of £10.7m core Performance and Sustainability Funding (PSF), along with £16.5m of incentive PSF. In addition, the Trust managed to deliver the financial position through non-recurrent income streams and balance sheet management. The true underlying financial position as at the end of 2018/19 was a deficit of circa £23.5m.

Moving into 2019/20, the underlying position of the Trust was boosted by the tariff price increases, contributing £8.8m for HUTH along with the recovery of the Marginal Rate Emergency Tariff (MRET) of £2.1m. Additional CRES above the 1.1% tariff assumption along with the gains from the above have resulted in an improved underlying position, currently assessed at circa £8.6m deficit. The journey of improvement is depicted below



The Trust has developed a financial plan for 2019/20 and whilst the Trust is forecasting to deliver its £1.4m control total surplus (excl PSF) in this year, the latest forecast of the recurrent underlying position is circa £8.6m due to the non-recurrent nature of the identified CRES schemes. The assumption in delivering the Trust's control total for 2019/20 includes the delivery of an overall £18.8m efficiency programme.

The plan for 2019/20 delivers an overall financial risk rating of 3 which is mainly due to the high liquidity and capital service cover risk ratings of 4 as the maximum risk rating can only be a 3, whilst there are ratings of 4 in the assessments.

Plan Risk Ratings	Plan 31/03/2020 Rating
Capital Service Cover rating	4
Liquidity rating	4
I&E Margin rating	1
Variance From Control total rating	1
Agency rating	1
OVERALL RISK RATING	3

The Trust has developed a Capital Programme for 2019/20 which is based on assessments received and reviewed at the Trust's Capital Resource Allocation Committee (CRAC). CRAC undertook an exercise to quantify the funding requirements for the next three years. These assessments were based on a "do minimum" basis and did not make any provision for expansion in capacity or any developments. Over the 3 year period capital investment totalling £71m was identified versus circa £30m of internal resources from depreciation. The capital funding constraint is a major risk for the Trust and particularly with regard to the increases in demand for diagnostics and the impact on equipment requirements and non-elective pathways.

0.5.2 Capital Expenditure

A summary showing the capital cost of the preferred way forward is shown in the table below.

Capital Expenditure	Preferred Way Forward £000
Equipment	4,844
IM&T	20
Building	14,404
Total	19,268
STP PDC Funding	19,268
Shortfall in Funding	(0)

At this stage of the business case no VAT recovery on the capital project has been assumed until the work can be progressed on to the detailed designs, contract and procurement process.

The lifecycle replacement of the assets is currently excluded from the case as this will be the responsibility of the Trust to fund over the life of the assets.

The capital cost includes 23 % for optimism bias and risk. The figures will be further refined once the project enters into the detailed design and tender award process.

0.5.3 Revenue Costs

The revenue running costs of the scheme make provision for the staffing requirements for the operation of the additional scanners and the additional ambulatory care/assessment capacity, the maintenance of the scanners and the additional endoscopes, as well as the capital charges associated with the capital investment.

The estimate of the first full year of revenue costs are shown in the table below, excluding inflation:

Revenue Costs Summary					
		Pay	Non-pay	Cap Charges	TOTAL
		£000	£000	£000	£000
CT/MRI		(1,234)	(317)		(1,551)
Ultrasound		(245)			(245)
SACU		(599)	(130)		(728)
Scopes			(176)		(176)
Facilities			(274)	(1,459)	(1,733)
TOTAL		(2,077)	(897)	(1,459)	(4,433)
Less Costs from Business as Usual		1,910	2,099		4,009
NET COST		(167)	1,202	(1,459)	(424)

0.5.4 Accounting Treatment

The ownership of the assets is confirmed and would appear on the asset register for HUTH. These assets would be treated as on balance sheet for HUTH and therefore subject to the relevant accounting standards under IFRS regulations.

The split of costs between revenue and capital is confirmed as being in line with the current capitalisation policy.

0.5.5 Impact on the Statement of Comprehensive Income (SoCI)

The impact on the Trust's SoCI is illustrated below.

There is support from the local commissioners who recognise that until this development is completed, there will be cost pressures within the Trust relating to outsourcing and additional bed capacity. The assumption is therefore that these cost pressures would be funded within the Aligned Incentive Contract (AIC) and therefore the savings have been included to show the net change in costs. The net increase of £424k is mainly driven by the additional capital charges of the development.

Revenue Expenditure Full Year Effect	Preferred Way Forward £000
Pay	
Medical Staff	(574)
Nursing & Midwifery Staff	(308)
Scientific, Therapeutic & Technical Staff	(698)
Administrative & Clerical	(69)
Healthcare Assistants & Other Support Staff	(428)
Cost Avoidance Pay	1,910
Total Pay	(167)
Non-Pay Expenditure	
Clinical Supplies & Services	(210)
Establishment Expenditure	(344)
Premises & Fixed Plant (maintenance)	(344)
Cost Avoidance Non Pay	2,099
Total Non-Pay Expenditure	1,202
Operating Expenses Total	1,034
Non Operating Items	
Depreciation (+ve)	(845)
PDC Dividends Payable (+ve)	(614)
Total Non Operating Items	(1,459)
Retained Surplus / (Deficit) for the Year	(425)

Impact on Statement of Comprehensive Income

0.6 Management Case

0.6.1 Project Management Arrangements

The Trust places particular importance on effective project management arrangements and will establish robust project structures, systems and processes to ensure that the Urgent and Emergency Care Development at HUTH is delivered successfully.

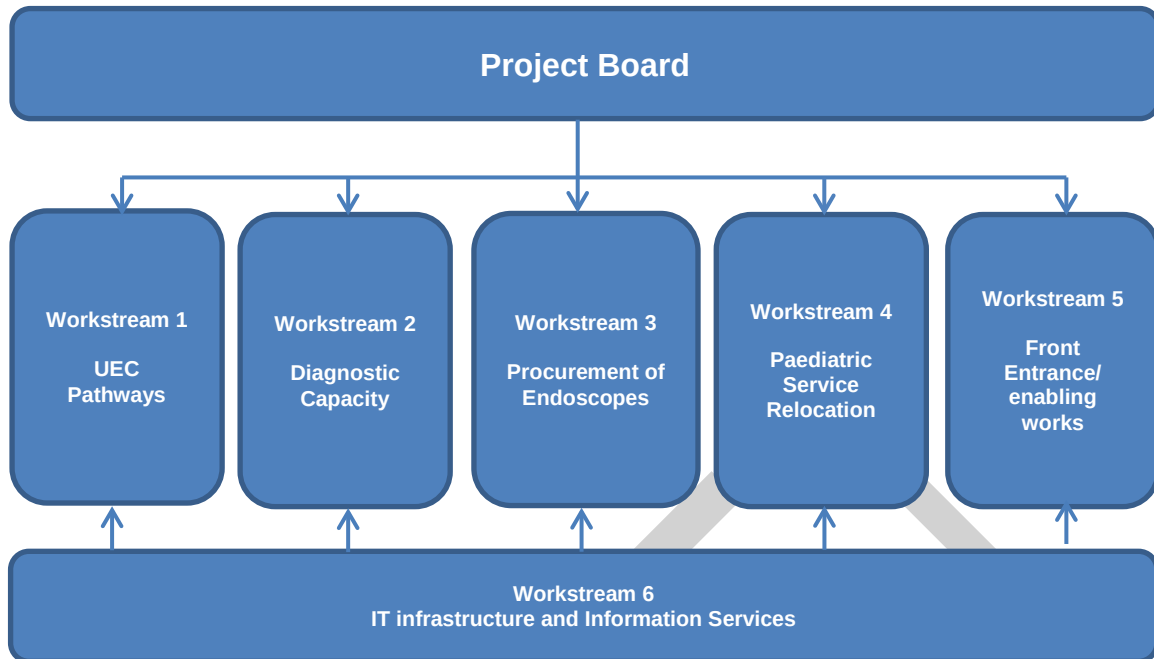
Given the scale and complexity of the development, it is essential that each stage is properly managed and resourced. This will ensure that changing service needs are appropriately considered, that service requirements are reflected in the reconfiguration of the Tower Block, procurement plans and equipment specifications, and that anticipated benefits are realised. The project will be managed in accordance with Capital Investment Manual principles.

0.6.2 Project Reporting Structure

In order to agree the preferred clinical model and the reconfiguration of services, a project reporting structure has been established with 6 linked workstreams as follows:

1. Urgent and Emergency Care Pathways
2. Diagnostic Capacity
3. Procurement of Endoscopes
4. Paediatric Service Relocation
5. Front Entrance/enabling works
6. IT infrastructure and Information Services.

The reporting structure is set out below:



The Project Board reports to the Executive Management Committee (EMC) and Capital Resource Allocation Committee (CRAC) and has been established in accordance with the Trust's Standing orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Project Board will agree the scope of the project and ensure that it is governed, directed, delivered and managed on time within the resources available. The Project Board will maintain their knowledge and control of the project through monthly meetings.

The Project Board will be chaired by the Senior Responsible Owner (SRO) for the project. The SRO is the Chief Operating Officer who has been delegated responsibility by the Executive Management Committee. In the absence of the SRO a nominated deputy will chair the meeting.

The SRO will ensure that:

- the project meets its objectives and delivers the expected benefits;
- the overall development project and each aspect of the project within it are managed in an appropriate manner;
- the business case is continually reviewed throughout the duration of the development project.
- an appropriate project organisation structure and communication processes are established;
- all changes to the scope of the project and the approach to delivering the brief are approved;
- adequate resources are made available to the project.

Each of the project workstreams reports formally to the Project Board via the workstream lead. The workstream teams will meet at least monthly.

Terms of Reference for the Board and workstreams have been developed and will be reviewed accordingly as the project moves through the planning, detailed design and delivery phases.

A project budget will be established to enable the business case to be developed. This will include funding to appoint external consultants and design team(s).

0.6.3 Outline Project Plan

Key dates in the provisional Management Control Plan are provided below:

Milestone Activity	Timescale
Strategic Outline Case completed	Sept 2019
Outline Business Case	April 2020
Full Business Case	Oct 2020
Construction start date	Jan 2021

1.0 The Strategic Case

This section sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme. Its purpose is to explain and revisit how the scope of the proposed project fits within the existing business strategies of the organisation and provides a compelling case for change, in terms of the existing and future operational needs of the organisation.

1.1 Strategic Context

1.1.1 Organisational Overview

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 and has an annual turnover of £573m (2018/19).

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.8 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. It is a recognised centre for Major Trauma, Cardiac, Cancer, Vascular and Hyper Acute Stroke and provides a number of regional specialist services. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

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.

Trust services are delivered from two hospital sites – Hull Royal Infirmary and Castle Hill Hospital – with some outpatient services being delivered within neighbouring Acute Trusts, primary care and community facilities across the Humber Coast and Vale Health and Care Partnership. The Trust is a University Teaching Hospital and a major partner in the Hull York Medical School.

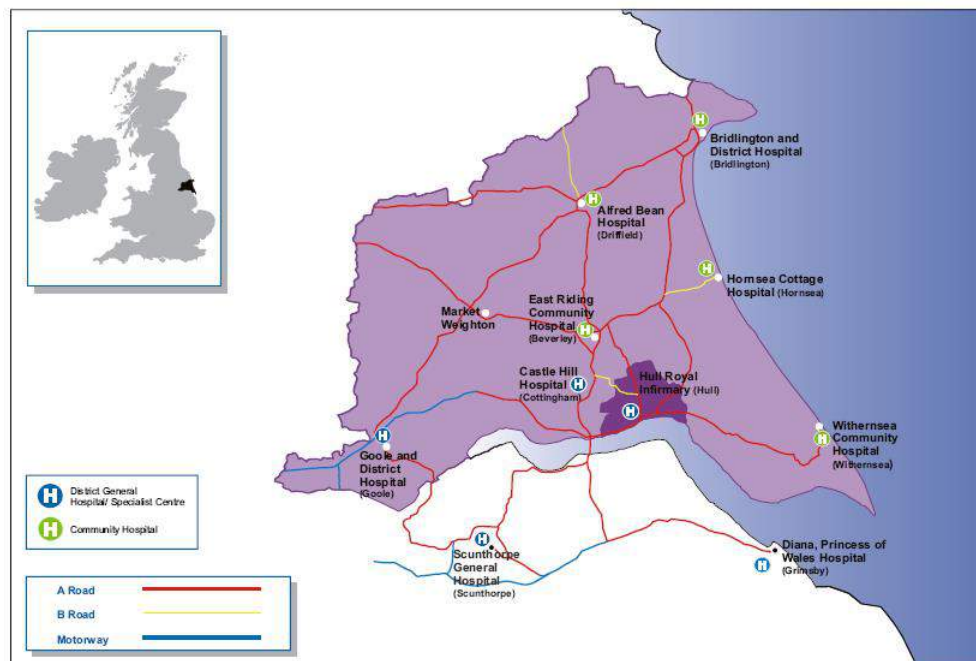
- **Hull Royal Infirmary (HRI)** is situated at the centre of the city of Kingston Upon Hull and provides a comprehensive range of medical and surgical services. It is the Trust's emergency centre, with a major Emergency Department supported by a full range of diagnostic and treatment facilities. The site also accommodates the Women and Children's Hospital and the Eye Hospital.
- **Castle Hill Hospital (CHH)** is situated in the semi-rural setting of the East Riding of Yorkshire, 6 miles from the Hull Royal Infirmary. The hospital focuses primarily on elective care for a range of medical and surgical specialties.

Bed capacity at each site is as follows:

HOSPITAL	INPATIENT BEDS	DAY SURGERY CAPACITY	TOTAL
Hull Royal Infirmary	755	15	770
Castle Hill Hospital	385	18	403
TOTAL	1,150	33	1,173

* Inpatient capacity excludes delivery beds

The Trust is some distance from other major acute NHS hospital providers. The nearest District General Hospitals are located at Grimsby (33 miles), Scunthorpe (25 miles), York (46 miles) and Scarborough (45 miles). The nearest alternative NHS providers of specialist services are Leeds (60 miles) and Sheffield (65 miles).



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

There are three acute Trusts within the Partnership: Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG), York Teaching Hospitals NHS Foundation Trust and this Trust.

The Trust's 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. Our vision will be delivered through the realisation of our organisational goals.



A comprehensive inspection was undertaken by the CQC in June 2016 at which time the Trust retained its 'Requires improvement' rating. A Well-Led Inspection of the Trust was undertaken in 2018 where 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.

	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

1.1.1.2 Historical Financial Performance

Key indicators of the Trust's historical financial performance are shown below.

		Actual 2016/17	Actual 2017/18	Actual 2018/19
Turnover	£m	561.1	579.8	629.2
EBITDA	£m	13.8	4.8	37.6
Retained Surplus/(Deficit)*	£m	2.7	-7.5	25.4
Total Assets Employed	£m	188.4	183.8	206.4
External Financing Limit		Achieved	Achieved	Undershot
Capital Resource Limit		Achieved	Achieved	Achieved
Public Sector Payment Policy	%	23%	45.60%	90.90%
Reference Cost Index		94.4	96.9	N/A

Notes

1) "Achieved" is defined as within £250k

2) Payment policy percentage is based on number of invoices for NHS and non-NHS

Whilst the Trust met its financial requirements for 2018-19, the underlying financial health of the organisation remains a concern. The Trust has a recurrent deficit of circa £8.6m and is working with local commissioners and NHS Improvement to agree a longer term plan of recovery within with requirements of the NHS Long Term Plan and the move with partners towards an Integrated Care System.

1.1.2 Business Strategy and Aims

The Trust's Strategy (2019-24) has been developed in response to the national, regional and local drivers for change.

1.1.2.1 National Context

1.1.2.1.1 NHS Spending Review 2018

The funding settlement announced by the Prime Minister in June 2018 promised that revenue funding for the NHS in England would grow by an average of 3.4% in real terms per year over the following five years, delivering a real terms increase of £20.5bn by 2023/24.

In the November 2018 budget, the Chancellor set out his expectation that the NHS would:

- return to financial balance
- achieve cash-releasing productivity growth of at least 1.1% a year with all savings reinvested in front line care

- reduce growth in demand for care through better integration and prevention
- reduce variation across the health system, improving providers' financial and operational performance; and
- make better use of capital investment and its existing assets to drive transformation.

1.1.2.1.2 NHS Long Term Plan

The NHS Long Term Plan (NHS, Jan 2019)¹ set out the intention to prevent as much illness as possible and, where illness could not be prevented, to ensure that, where possible, people were treated in the community and primary care. However there was also an acknowledgement that, if care was required at hospital, as many people as possible should receive treatment without being admitted as an inpatient. Where people were admitted to a hospital bed, the aim was to ensure that they received health and social care support to go home.

The NHS Long Term Plan requires major changes to the NHS service model including redesigning and reducing pressure on emergency hospital services. By expanding and reforming urgent and emergency care services it is intended that, over the life of the Long Term Plan, patients will get the care they need fast, pressure on Emergency Departments will be reduced and seasonal variations will be offset by improved capacity and resilience. The Long Term Plan requires that every acute hospital with a Type 1 Emergency Department will have a comprehensive model of Same Day Emergency Care (SDEC). In overall terms, it is intended that the proportion of acute admissions across the NHS that are discharged on the day of attendance will increase from a fifth to a third.

In addition, hospitals are required to reduce avoidable admissions through the establishment and expansion of acute frailty services and the NHS Clinical Standards Review 2019 will develop new ways to look after patients with the most serious illness and injury in order to ensure that they receive the best possible care in the shortest possible timeframe. For people who arrive in the Emergency Department (ED) following a stroke, heart attack, major trauma, severe asthma attack or with sepsis, it is intended that patient pathways will be improved to ensure timely assessment and treatment that reduces the risk of death and disability.

The NHS Long Term Plan highlights the fact that over 15bn diagnostic tests are undertaken every year and feature in four out of every five patient pathways. The number of patients referred for diagnostic tests has risen by over 25% in the last 5 years and it is acknowledged nationally that capacity in diagnostic services has not kept pace with the growth in demand.

1.1.2.1.3 Safer, Faster, Better (NHSE, 2015)

'Safer, Faster, Better'² built on the work of Professor Sir Bruce Keogh and his comprehensive review of the NHS urgent and emergency care system in England. It set out the design principles, drawn from good practice, that local health and social care communities needed to adopt to deliver safer, faster and better urgent and emergency care for people in all age groups with physical or mental health problems. Examples of good practice outlined in the document include:

- patients on the urgent and emergency care pathway should be seen by a senior clinical decision-maker as soon as possible.

¹ www.longtermplan.nhs.uk

² 'Transforming Urgent and Emergency Care in England. Safer, Faster, Better - Good Practice in Delivering Urgent and Emergency Care. A Guide for Local Health and Social Care Communities' (NHSE, Aug 2015. Updated April 2016) <https://improvement.nhs.uk/documents/701/Safer-Faster-Better.pdf>

- promptly assess and place patients into the most appropriate care stream to meet their needs.
- consider all potential acute admissions for ambulatory emergency care unless their care needs can only be met by an inpatient hospital stay.
- hospitals and local health and social care communities should prioritise activities aimed to achieve the earliest possible discharge of patients.
- all emergency hospital admissions should be seen and have a thorough clinical assessment by a competent consultant as soon as possible but at the latest within 14 hours of admission to hospital.
- there should be a senior review of the care plan and its delivery, for every patient, in every bed, seven days a week.
- management of low risk surgical conditions through an ambulatory emergency care unit. This may be nurse-led, supported by consultant-led surgical teams.

1.1.2.1.4 Improving Patient Flow (2017)

The NHS Improvement 'Good Practice Guide: Focus on Improving Patient Flow'³ describes how the consequences of poor patient flow can lead to Emergency Departments becoming crowded, stressful and unsafe; patients may be admitted as 'outliers' to wards that are not best suited to manage their care; and inpatients are moved between wards to make room for newcomers. This leads to worse clinical outcomes, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds.

The Guide outlines areas of focus, in particular:

- seamless ambulance/hospital handovers without delays
- streaming to co-located primary care services
- timely assessment of patients in the Emergency Department
- timely assessment and interventions by an all age liaison mental health team
- same day emergency care in a non-inpatient setting
- acute assessment services, consultant-led, 24/7, supported by a multi-disciplinary team
- ready access to diagnostics and in-reach services to support patient care and early discharge
- frailty pathways.

1.1.2.1.5 Seven Day Hospital Services Programme

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were developed in 2013 through the Seven Day Services Forum⁴, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. Four of the standards were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant.

The purposes of the standards are to deliver safer patient care, to improve patient flow through the acute system, to enhance patients' experience of acute care, to reduce the

³ https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017_13_July_2017.pdf

⁴ <https://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

variation in appropriate clinical supervision at weekends and, potentially, to mitigate excess mortality that has been shown in studies to be associated with weekend admission to hospital.

To achieve each standard a provider must be able to meet the required level of care for at least 90% of its patients.

1.1.2.1.6 NHS Access Standards

The current access standards in urgent and emergency care are detailed in the Handbook to the NHS Constitution⁵. These include Ambulance Trust response times and a maximum four hour wait in Accident and Emergency (A&E) from arrival to admission, transfer or discharge.

Since the introduction of the A&E standard there have been significant changes in the way in which urgent and emergency care is delivered. As outlined in Section 1.1.2.1.2, the NHS Long Term Plan provides details on how the service model can be improved further, including the accelerated roll out of Same Day Emergency Care and an increasing focus on the management of acute life-threatening conditions, such as heart attacks and strokes. Given that models of care have changed and will change further, the NHS National Medical Director was charged in 2018 with leading a clinical review of access standards across the NHS. His Interim Report⁶ recommends the testing of four access standards to understand their impact on clinical care, patient experience and the management of services, when compared to the current approach of the single 4 hour access standard. The proposed access standards are:

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres
- Time to emergency treatment for critically ill and injured patients
- Time in A&E
- Utilisation of Same Day Emergency Care.

Testing of the urgent emergency care proposals commenced in May 2019 at a selection of sites across England, prior to wider implementation. The implications for patient care include:

- Timely clinical assessment to identify anybody who is in need of immediate treatment, and allows patients to be directed to the service and practitioner best able to meet their needs at an early stage in the patient's journey.
- Delivery of a complete package of treatment in the first hour after arrival for life-threatening conditions such as stroke, heart attack, major trauma, critically ill patients, acute severe asthma, and for those experiencing a mental health crisis.
- Reduced risk of patient harm through long waits for admission or inappropriate admission.
- Reduction in overnight admissions and improved patient experience.

1.1.2.2 Local Context

1.1.2.2.1 Local Population Demographics

Hull is a geographically compact city of circa 260,000 people. It was identified as the 3rd most deprived local authority in England in 2017. The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower

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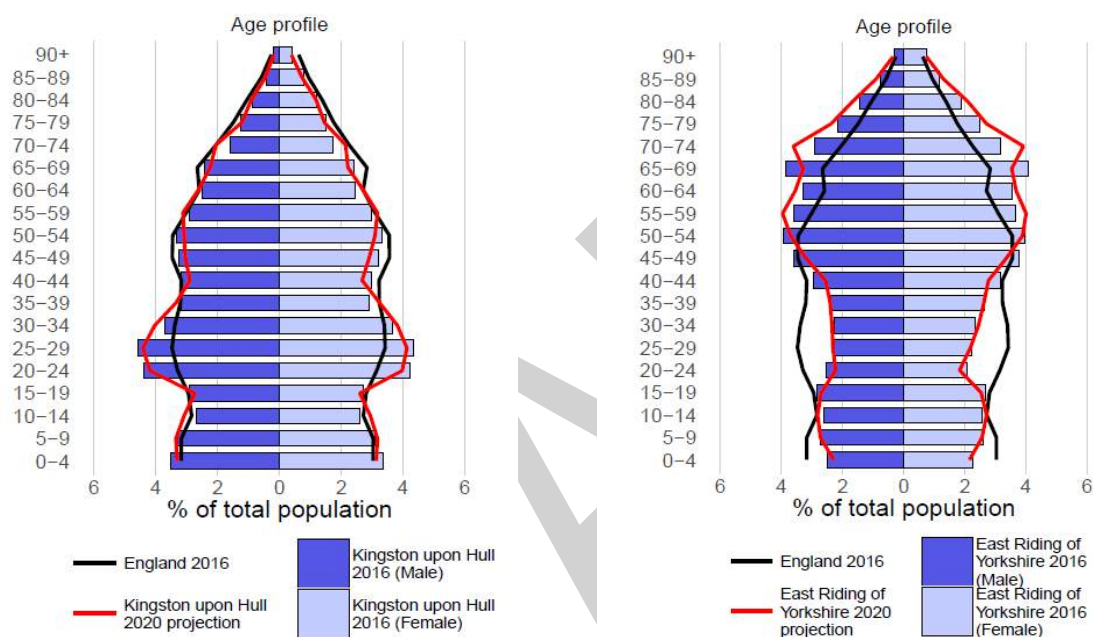
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770675/The_Handbook_to_the_NHS_Constitution_-_2019.pdf

6 <https://www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf>

than the England average. 28% (14,300) of children in Hull live in low income families and the health and wellbeing of children is worse than the England average.

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

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

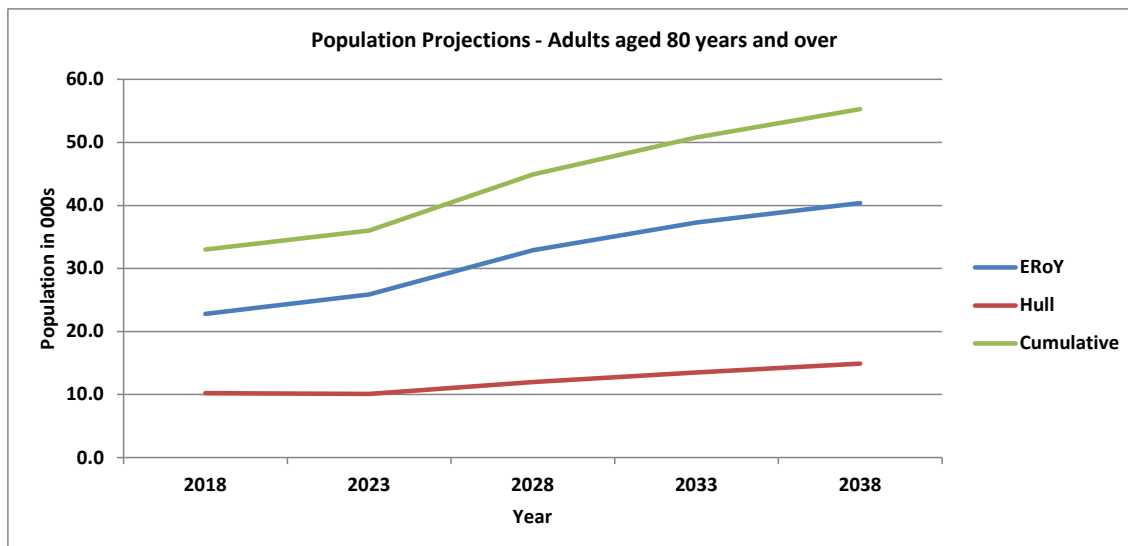


Age profile of Local Authority Populations in 2016 (Male/Female, England average, 2020 Projection)

The Crude Birth Rates (CBR)⁷ for the East Riding and Hull are 8.5 and 13.6 respectively, with the General Fertility Rates (GFR)⁸ being 56.3 and 65.7. People are living longer, many with multiple and complex needs, and with higher expectations of their health and social care services. Within the next 20 years, the number of people aged 80 years and over in Hull and the East Riding is expected to increase from 33,000 to 55,300. Births are predicted to decline slightly.

⁷ Crude Birth Rate: All births per 1,000 population of all ages

⁸ General Fertility Rate : All live births per 1,000 women aged 15 to 44



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

1.1.2.2.2 Humber Coast and Vale Health and Care Partnership

The Trust sits within the Humber Coast and Vale Health and Care Partnership (HC&V HCP). The Partnership works across a geographical area of more than 1,500 square miles taking in cities, market towns and many different rural and coastal communities. The area covered by the HCP stretches along the east coast of England from Scarborough to Cleethorpes and along both banks of the Humber. It incorporates the cities of Hull and York and large rural areas across East Yorkshire, North Yorkshire and Northern Lincolnshire.

Humber Coast and Vale has a diverse population with significant health and social care challenges. Approximately 23% of the 1.4 million population lives in some of the most deprived areas of England, with very significant variations in life expectancy. The current variation for men is 20 years and for women it is 17 years. These variations, when combined with the ageing population (8.9% are aged over 75 years), have resulted in increasing strain on the HCP's health and care services.



In its Sustainability and Transformation Plan (2016)⁹ the Partnership acknowledged that it was facing an unprecedented demand for services at a time when delivery of the NHS Constitutional standards remains challenging.

⁹ https://humbercoastandvale.org.uk/wp-content/uploads/2017/08/HCV-October-Submission_FINAL-VERSION-PUBLISHED.pdf

Actions to improve performance and meet the increasing demand are impacted by a number of issues, including:

- An ageing workforce
- Gaps in skills and workforce numbers
- Shortages in specific staff groups eg diagnostic staff (radiography, endoscopy and sonography); medical staff in ED, Acute Medicine and surgical specialties; medical staff in primary care, registered nurses, experienced social workers, appropriately qualified care staff
- Insufficient diagnostic capacity
- Funding constraints, both capital and revenue, leading to a potential funding gap of more than £420m by 2020/21.

The Partnership's vision, developed in response to these challenges is for a system that supports everyone to manage their own care better, reduces dependence on hospitals, and uses resources more efficiently.

1.1.2.2.2.1 HC&V Clinical Service Strategy

The Partnership's Clinical Service Strategy is seen as an enabler to the realisation of its vision. The strategy places increasing emphasis on prevention and supported self-care; on the integration and enhancement of primary, community and social care; and the development of networked models of acute service provision.

- **Acute Services Reviews**

The Partnership is conducting two reviews of acute hospital services – one across the Humber area and the other focussing on Scarborough Hospital. Both reviews are looking at how to provide the best possible care for the local population within the resources available. This includes improving integration with community and primary care and delivering some aspects of care out of hospitals in GP surgeries or other community settings.

During 2019/20 it is intended to develop a Humber-wide acute services clinical strategy aimed at securing person-focussed, safe and sustainable services which are able to make the best use of new models of care and new technology.

- **HC&V Urgent and Emergency Care**

The Partnership's vision for Urgent and Emergency Care is aligned to the ambitions within the NHS Long Term Plan. Key deliverables include:

- o 24/7 integrated urgent care accessible via NHS 111 or online
- o Improvements in Emergency Department (ED) performance
- o Increase in the delivery of Same Day Emergency Care
- o Increased ambulatory care pathways
- o Reduction in length of stay for 'stranded' and 'super-stranded' patients
- o Primary Care Streaming – increased utilisation and expansion
- o Improved emergency mental health provision
- o Improved ambulance handover times in ED
- o Reductions in delayed transfers of care.

1.1.2.2.2.2 HC&V Estates Strategy (2018)

The Partnership's Estates Strategy sets out its ambition to reduce or eliminate critical infrastructure risk and to provide fit-for-purpose health care facilities, ensuring increased resilience for clinical service delivery. The objectives of the Partnership's Estates Strategy are:

- Modernisation – including the provision of facilities to support transformed urgent and emergency care and diagnostics
- Rationalisation – including reduction in footprint where possible
- Utilisation – increased efficiency and reduced running costs.

The Strategy states: “Transformation of urgent and emergency care services across the region is our highest clinical priority”. It goes on to acknowledge that “immediate further investment in infrastructure to support urgent and emergency care and diagnostics is required to provide the physical environments needed to deliver the innovative service models that we have developed”.

1.2 Trust Response to the Strategic Context

1.2.1 Trust Strategy 2019-24

The Trust’s mission is to lead the provision of outstanding care and to contribute to improved population health, by being a great employer and partner, living our values and spending money wisely.

In the last four years, the Trust has made a wide range of improvements to our urgent and emergency services, including:

- Redevelopment of the Emergency Department
- Implementation of primary care streaming within the ED
- Creation of a Frailty Intervention Team providing expert review of frail older people within the ED
- Expansion of acute assessment capacity
- Redesign of urgent and emergency care pathways.

The Trust has worked with local commissioners, health and social care providers to achieve greater integration and redesign of urgent care in the local health economy. Actions included:

- Development of an 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.
- Development of an integrated Emergency Department minor illness/injuries service provided through a multi-disciplinary team, including acute, primary and community care specialists.

However, the Trust acknowledges that there is much more to be done if it is to address national and local drivers for change. The Trust’s business strategy (Trust Strategy 2019-24)¹⁰ is based upon the delivery of high quality care and the provision of great clinical services. It acknowledges the need to work with teams across the Trust, and with system partners, to secure sustainable delivery of safe and timely urgent and emergency care, without compromising other services, especially at times of peak demand. To that end, the Trust has set specific goals which include:

- Increasing the percentage of minor ailment and injury patients who are seen within the primary care service co-located with the ED

¹⁰ <https://www.hey.nhs.uk/downloads/trust-strategy/>

- Closer working between medical and surgical teams for those patients and service users presenting with acute conditions
- Improving diagnostic provision and patient flow through the Trust for those patients who present within the ED through the procurement and staffing of additional CT and MRI scanners and increasing our endoscopy capacity
- Continued partnership working with partners to complete the development of community-based services for frail older people, integrated with specialist support from the Trust
- Redesign of pathways for a range of long term conditions, including COPD, heart disease, diabetes and neurological conditions
- Sustained compliance with the four clinical priority Seven Day Standards
- Working with partners to implement a shared care record.

1.2.2 Trust Digital Strategy 2018-23

The Trust's Digital Strategy has been informed by key policy themes, both nationally and locally, as well as information and technology regulatory requirements. It creates a framework for the organisation's digital work programme and contextualises how that will support the Trust in achieving its objectives.

The Strategy sets out the ambition to build upon the Trust's investment in technology, to develop the workforce with the skills they need to successfully embrace the challenges of the future, and to exploit the transformational opportunities that investment offers.

The key strategic objectives within the Trust's Digital Strategy are:

- Achievement of the Healthcare Information and Management Systems Society (HIMMS) Level 7 for electronic records and full compliance with the Acute Digital Maturity Assessment.
- Elimination of paper-based records, underpinned by the Lorenzo electronic care record, incorporating e-prescribing and medicines administration, e-Observations and escalations.
- Digital-by-default pathway management of all patients, from e-Referrals to e-Discharge, delivering on national policy objectives and eliminating paper process delays and risks.
- Patients and carers able to interact digitally with Trust clinicians.
- Delivering sustainable transformation through technology.
- Fully upgraded data network and unified communications service, supporting agile working, clinical mobility, NHS mail and One-Password Single-Sign-On for all staff.
- Compliance with national Digital policy, including Accessible Information Standard, Cyber Security, Information Governance and General Data Protection Regulations.

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.

1.2.3 Trust Estates Strategy 2017-22

The Trust's Estates Strategy is aligned to the HC&V HCP's Estates Strategy and seeks to provide facilities that support service transformation, the sustainable delivery of clinical services and the elimination of high risk backlog maintenance issues, whilst increasing service efficiency and resilience. Key features of the Estate Strategy include:

- Improving key areas to assist in the delivery of high quality care, including the relocation of services from our oldest buildings to improve facilities
- Reducing the size of the overall estate
- Reducing backlog maintenance
- Realisation of the ambition to be benchmarked in the Top 20% of Trusts in the annual PLACE scores
- Modernising services to reduce costs and improve performance, including:
 - o Maximising space utilisation
 - o Targeted investment in plant and equipment
 - o Reviewing working practices and skill mix
 - o Investment in energy efficiency schemes
 - o Utilisation of technology and improved data analysis.

The nucleus for all emergency admissions to the Trust is the Hull Royal Infirmary and the Tower Block in particular. This houses the Emergency Department, Acute Medical Unit, Medical Ambulatory Care Unit, Elderly Assessment Unit, operating theatres, critical care facilities, inpatient wards and clinical support services (eg Radiology and Pharmacy). Delivery of the Estates Strategy will support the Trust in achieving its clinical service strategy, in particular the development of urgent and emergency care services.

1.3. The Case for Change

1.3.1 Investment Objectives

The investment objectives for this project are as follows:

- Investment objective 1: To increase the proportion of acute admissions/ presentations discharged on the day of attendance by 2023.
- Investment objective 2: To achieve compliance with Urgent and Emergency Care standards through continued and sustained improvement against the agreed baseline.
- Investment objective 3: To achieve a minimum of 90% compliance with the 7 Day Hospital Services Clinical Standard 5 for MRI, CT, Ultrasound and Upper GI Endoscopy
- Investment objective 4: To reduce the number of outliers and non-clinical inter-ward transfers by 50%
- Investment objective 5: To improve the clinical adjacencies of services to optimise clinical safety and efficiency, reduce clinical risk and improve patient and carer experience.

1.3.2 Existing Arrangements and Business Needs

As outlined above, the Hull Royal Infirmary is the Trust's emergency centre taking the majority of non-elective admissions to the Trust, while Castle Hill Hospital focuses predominantly on elective care. The following sections describe how, with the current level of elective and non-elective facilities, including diagnostic service provision, the Trust is unable to meet the nationally mandated access thresholds for ED attendances, 7 day

services, diagnostic waits, Referral to Treatment Times (RTT) and cancer treatment, resulting in a poor patient experience as a result of increased waiting times and delays in access to diagnosis and treatment.

1.3.2.1 Activity

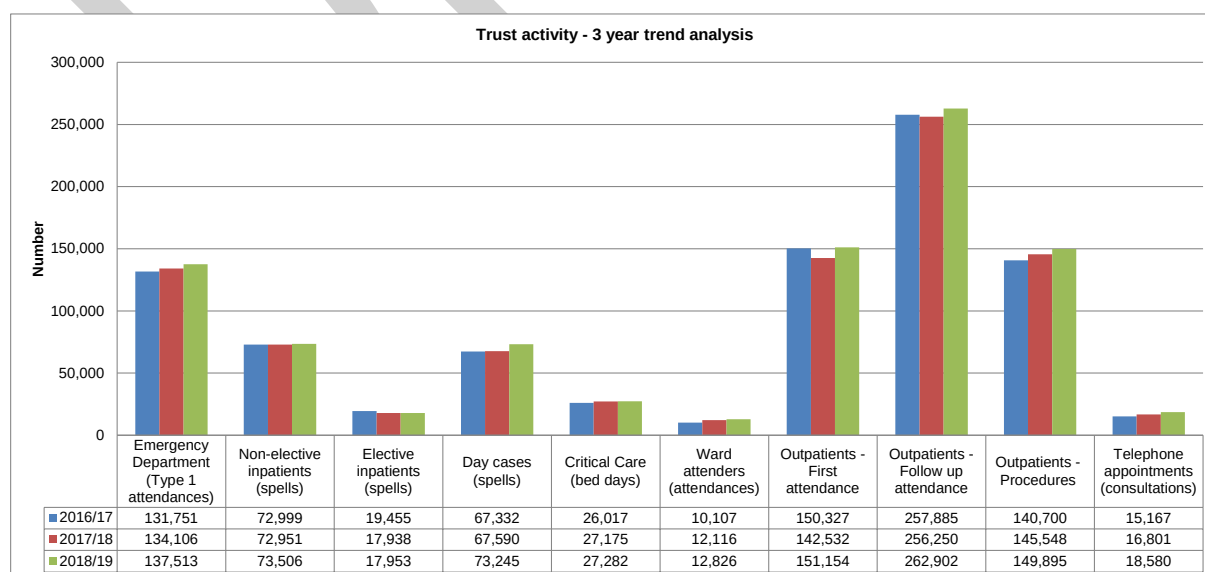
A comparison of the activity trends by point of delivery over the last three years is summarised below.

Point of Delivery	Unit	Actual Activity			Difference between 2017/18 and 2018/19 (%)
		2016/17	2017/18	2018/19	
Emergency Department	Attendances (Type 1)	131,751	134,106	137,513	2.5%
Non-elective inpatients	Spells	72,999	72,951	73,506	0.8%
Elective inpatients	Spells	19,455	17,938	17,953	0.1%
Day cases	Spells	67,332	67,590	73,245	8.4%
Critical Care	Bed days	26,017	27,175	27,282	0.4%
Ward attenders	Attendances	10,107	12,116	12,826	5.9%
Outpatients - First	Attendances	150,327	142,532	151,154	6.0%
Outpatients - Follow ups	Attendances	257,885	256,250	262,902	2.6%
Outpatients - Procedures	Procedures	140,700	145,548	149,895	3.0%
Telephone appointments	Consultations	15,167	16,801	18,580	10.6%

Since April 2016 elective inpatient spells have decreased from 19,445 (2016/17) to 17,953 (2018/19), whilst day cases have increased from 67,332 to 73,245 (spells). Over the same period, non-elective inpatient episodes increased by 507 spells and ward attendances increased by 2,719.

Outpatient activity increased over the three year period – new attendances by 827, follow up attendances by 5,017 and follow up procedures by 9,195. The number of telephone consultations undertaken also saw an increase from 15,167 in 2016/17 to 18,580 in 2018/19 as the Trust has sought to reduce the number of unnecessary face to face consultations.

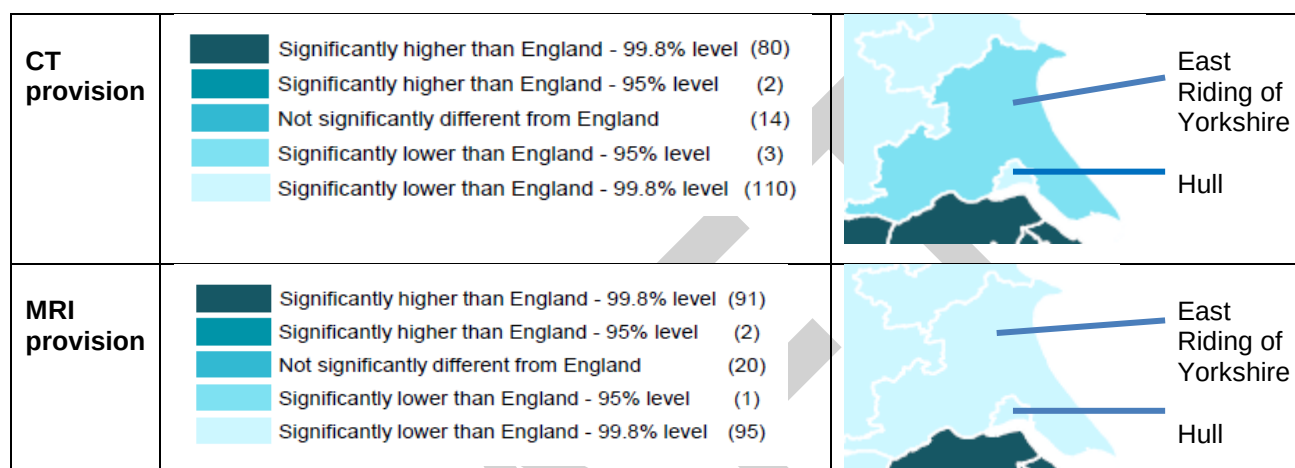
Type 1 attendances to the Emergency Department totalled 131,751 in 2016/17, with attendances increasing to 137,513 in 2018/19.



The Trust is forecasting continuing growth in the rate of emergency attendances (c.2% per annum) and non-elective admissions (c. 1% per annum) in future years and therefore needs to be able to meet the increased demand through increased capacity in diagnostics, same day emergency care provision, assessment facilities and inpatient beds.

1.3.2.2 Diagnostic Waits

The 2nd Atlas of Variation in NHS Diagnostic Services in England (Jan 2017) highlighted the considerable variation in CT and MRI provision experienced within the Humber Coast and Vale footprint, with Hull being in the lowest quintile for both CT and MRI provision (see below), and the East Riding of Yorkshire being in the lowest quintile for MRI.



The Trust's CT and MRI provision is split across its two main hospital sites as follows:

- Hull Royal Infirmary : 2 CT scanners (split between the ground and 2nd floors of the Tower Block)
3 MRI scanners (housed in a separate building opposite the Tower Block)
- Castle Hill Hospital : 2 CT scanners (co-located)
2 MRI scanners (co-located)

The capacity of the existing fixed site scanners is insufficient to meet current levels of demand, resulting in the movement of patients between sites, the use of mobile scanners and extended hours on the fixed scanners in order to meet the national diagnostic waiting time standard ($\leq 1\%$). Whilst good progress was made in 2018/19 to reduce the waiting times, the diagnostic standard was only achieved for CT in the last two months of the financial year. MRI remained at 3.25% at March 2019.

In February 2019, the Trust reviewed its performance against Standard 5 (Timely Access to Diagnostics) as part of the bi-annual assessment of progress towards compliance with the 10 clinical standards outlined in the Board Assurance Framework for Seven Day Hospital Services (NHSE, 2018)¹¹

Under this priority standard hospital inpatients must have scheduled 7 day access to diagnostic services. To be compliant with the standard, 90% or more of patients must have had their scan performed and reported on within the required timescales. The results from the February 2019 audit are shown below.

¹¹ https://improvement.nhs.uk/documents/3494/7DS_Board_assurance_guidance_v2a.pdf

Standard	Modality	Weekday	Weekend	Total
Urgent – Performed within 12 hours	CT MRI Ultrasound	91% 84% 100%	97% 67% 100%	92% 83% 100%
Urgent – Reported within 12 hours	CT MRI Ultrasound	83% 81% 100%	90% 56% 100%	84% 79% 100%
Routine – Performed within 24 hours	CT MRI Ultrasound	91% 94% 99%	96% 80% 96%	92% 92% 98%
Routine – Reported within 24 hours	CT MRI Ultrasound	88% 92% 99%	96% 80% 96%	90% 90% 98%

The results reflect the physical capacity constraints in relation to imaging, particularly MRI. However, the results also reflect the difficulties the Trust is experiencing in realising timely turnaround times for its radiology reporting, which is due to a lack of Consultant Radiologists, particularly in the sub-specialty areas. The Trust is using outsourcing services to improve reporting turnaround times and is looking to develop an innovative in-house overnight reporting service to improve reporting times further.

1.3.2.2.1 CT

The two scanners at the Hull Royal Infirmary are not co-located. One is situated on the ground floor of the Tower Block adjacent to the Emergency Department. The other is situated on the second floor of the Tower Block within the Radiology Department.

- **Ground floor CT Scanner (ED scanner)**

This mid-range CT scanner is 5 years old and runs 24 hours per day, 7 days per week. The machine is now on a secondary lease which expires on 24th March 2021. The scanner supports imaging of all patients within the ED, AMU and ACU. It also provides imaging for inpatients and fracture clinic patients.

In addition to the CT scanner room, there is an associated control room and waiting room. The waiting room is very small and patients often wait on the corridor for their imaging. There is a lack of cannulation accommodation or toilet facilities within the CT suite on the ground floor. The nearest facilities are within ED. There is a reporting room adjacent to the control room that has 2 reporting bays.

- **2nd floor CT Scanner**

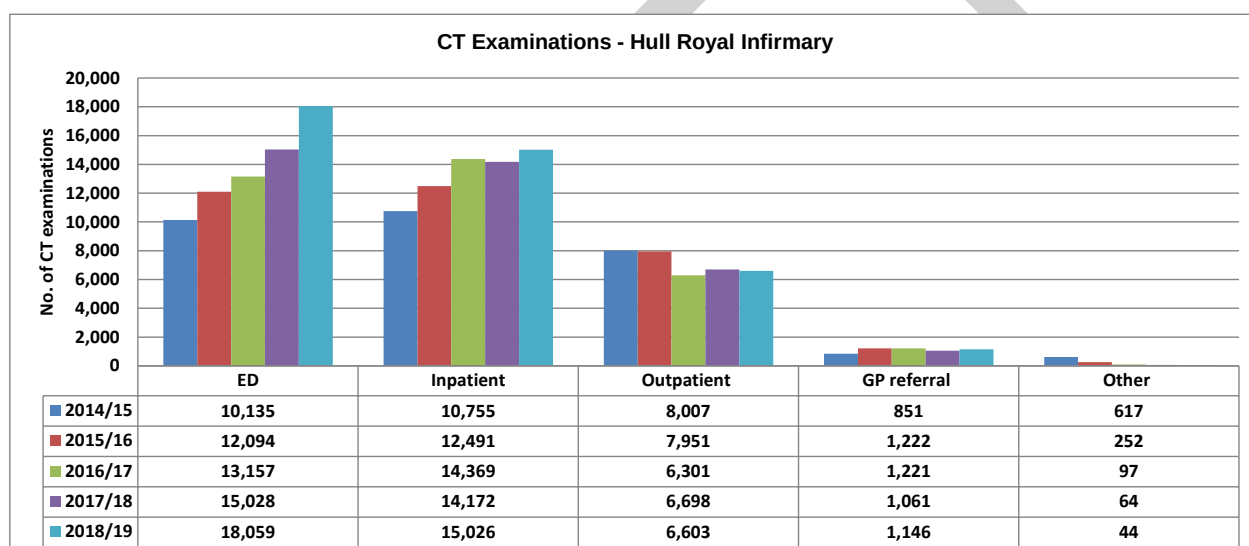
This CT scanner is owned by the Trust. It operates Monday to Friday between 8am and 6pm and on occasional weekends and supports imaging of inpatients, outpatients, interventional cases, walk in patients and GP referrals. The scanner acts as the backup scanner for the ground floor CT scanner. The equipment is currently 13 years old and is due for replacement in 2019/20. The equipment provides a basic and very limited range of examinations. The radiation doses are also approximately 40% higher than the other CT scanners in the Trust due to its age.

The actual scan room is minimal in size. The control room sits adjacent to the scanner room. There is a prep room, store room, toilet and small waiting room associated with the CT scanner.

The demand for CT scans within the Trust is growing year on year. The table below shows total growth in demand over the last 5 years.

Year	Rate of growth
2014-2015	
2015-2016	9.12%
2016-2017	8.63%
2017-2018	2.69%
2018-2019	10.96%

At the Hull Royal Infirmary the largest growth has been in Emergency Department and inpatient examinations. In order to meet the increased demand, a proportion of GP and outpatient workload has been transferred to the Castle Hill Hospital CT scanners.



In 2018/19 the number of CT examinations at the Hull Royal Infirmary totalled 40,878. It is estimated that the average growth in CT imaging will be 8% per annum, therefore CT examinations are expected to increase to 60,063 by March 2024. However, with changes to cancer pathways, treatment targets and the introduction of the Hull NHS Lung Health Check service, it is likely that this average growth will increase further. There is therefore a need to increase the number of CT scanners available at the Hull Royal Infirmary to ensure that future demand needs are met.

1.3.2.2.2 MRI

The three MRI scanners at the Hull Royal Infirmary provide emergency, inpatient and outpatient services to the Trust. In addition, on call MRI services are provided on behalf of the whole Humber Coast and Vale Health and Care Partnership footprint.

The MRI facilities are located outside the main Tower Block in a separate building accessed via the main access road on site. The Trust does not have any MRI scanning facilities co-located within the Emergency Department which presents a clinical risk when transferring major trauma cases for MRI scans. Additional MRI scanning capacity is provided on an ad-

hoc basis through the leasing of a mobile MRI scanner. However, the mobile scanner can only be used for low risk, ambulatory patients and is not suitable for emergency cases.

The scanners at Hull Royal Infirmary consist of:

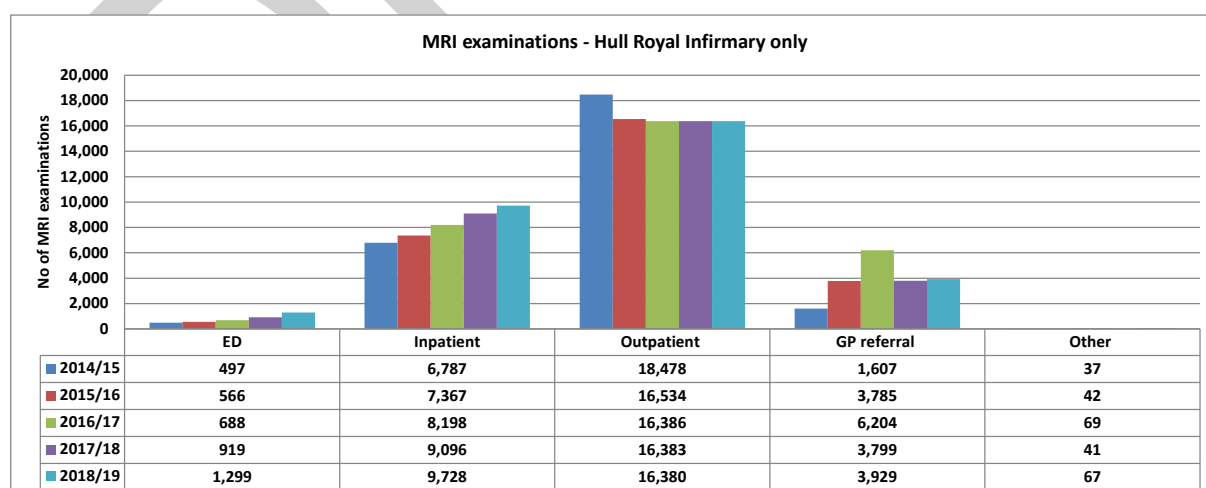
- GE 750 Optima 3T scanner which was installed in 2008 (previously owned by the University of Hull but purchased by the Trust in 2017). A software upgrade was undertaken in 2018 to facilitate more advanced imaging.
- Siemens Aera 1.5T installed in 2017 and is used for advanced MRI imaging and high resolution imaging. The lease is due to expire in 2024.
- GE Artist 1.5T purchased in 2019 and currently being installed. Capable of high resolution imaging and whole body MRI. (Scanning capacity currently being provided via a mobile unit).

The demand for MRI images within the Trust is growing year on year. The table below shows total growth in demand over the last 5 years.

Year	Rate of growth
2014-2015	
2015-2016	3.52%
2016-2017	7.28%
2017-2018	-2.52%
2018-2019	2.93%

The Trust has sought to keep pace with demand by maximising existing resources wherever possible, through review of protocols, extended working days, investment in new technology, including software upgrades. However, in addition to the increase in referrals for MRI scans, the service has noted an overall increase in the complexity of scanning required which has increased the scanning time, impacting on service availability contributing to under-performance against the diagnostic waiting time requirements.

At the Hull Royal Infirmary the largest growth has been in Emergency Department and inpatient examinations. In order to meet the increased demand, a proportion of GP and outpatient workload has been transferred to the Castle Hill Hospital CT scanners.



In 2018/19 the number of MRI examinations at the Hull Royal Infirmary totalled 31,403. It is estimated that the average growth in MRI imaging will be 3% per annum, therefore MRI examinations are expected to increase to 36,405 by March 2024. The service will be unable to meet this increase in demand without increased static capacity.

1.3.2.2.3 Ultrasound

The Ultrasound Department at the Hull Royal Infirmary comprises 4 units in the main Tower Block, with obstetric ultrasound (6 units) provided in the Women's and Children's Hospital which is also located on the Hull Royal Infirmary site. A further 4 ultrasound units are located at Castle Hill Hospital, with portable units being available across both sites. The Trust also provides community ultrasound services from 4 units situated in Hull and the East Riding of Yorkshire. Four of the main frame diagnostic units have exceeded the recommended age for replacement – 7 years – resulting in a reduction in flexibility of service and limitations on the range of examinations that can be undertaken.

Within the Tower Block three units are located on the second floor of the Tower Block within the Radiology Department, and one stand-alone unit is situated on the ground floor of the Tower Block adjacent to the Emergency Department.

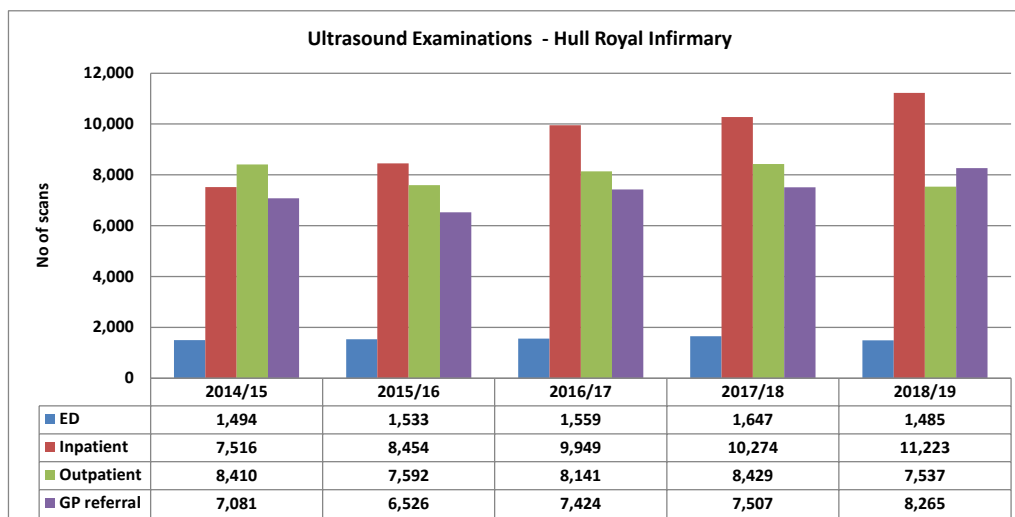
Referrals from the Emergency Department, acute medical and surgical admissions units, the Medical Ambulatory Care Unit and patients on the acute stroke pathway are scanned in either the ground floor or second floor ultrasound facilities. This unplanned activity impacts on and is impacted by referrals for diagnostic ultrasound from the inpatient wards and planned activity such as ultrasound-guided interventional procedures which are complex and time-consuming.

The ultrasound machine on the ground floor of the Tower Block is now 9 years old and has limited imaging capabilities which restrict its use, necessitating the transfer of emergency department and assessment unit/ambulatory care patients up to the second floor Ultrasound Department. The ultrasound facilities on the ground floor are inadequate to meet the needs of the service, with no dedicated patient waiting and a lack of privacy and dignity. Patients in wheelchairs or on trolleys/beds are required to wait in the main hospital corridor.

The demand for ultrasound scanning within the Trust continues to grow. The table below shows total growth in demand over the last 5 years.

Year	Rate of growth
2014-2015	
2015-2016	7.6%
2016-2017	14.6%
2017-2018	-1.3%
2018-2019	5.7%

The chart below shows the year on year increase in inpatient ultrasound examinations undertaken at the Hull Royal Infirmary. In order to manage this increase and the demand from the Emergency Department, the Trust has sought to maximise its capacity through the review of protocols and extending working days. In order to support the demand for acute Emergency Department, assessment unit and inpatient scans, all non-urgent GP and outpatient ultrasound referrals have been transferred to Castle Hill Hospital or to ultrasound facilities in the community. However, this has impacted on the waiting times for outpatient and GP diagnostic scans which increased to 6 weeks during 2018/19.



There is a need to increase the Trust's ultrasound scanning capacity, particularly on the ground floor of the Tower Block, in order to ensure that urgent and emergency cases are scanned in a timely manner and in accordance with the priority clinical standards for 7 day services, and that the Trust has sufficient outpatient and GP referral capacity to meet the required diagnostic waiting time threshold.

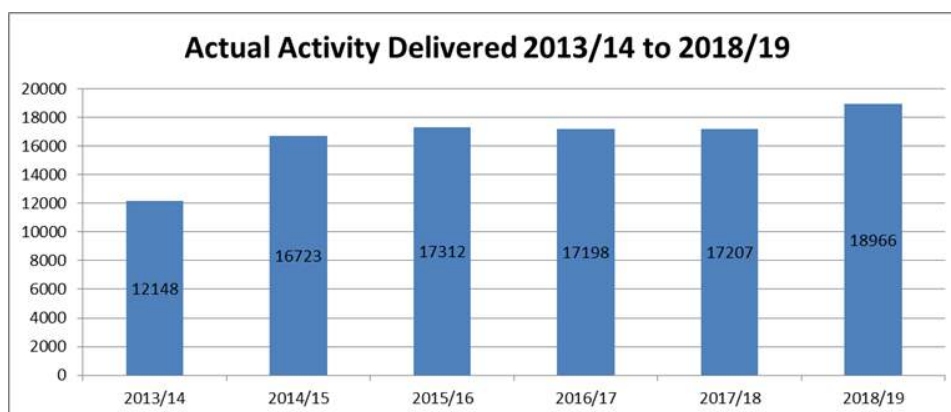
1.3.2.2.4 Endoscopy

The Endoscopy Service provides core diagnostic and therapeutic endoscopy inpatient and outpatient services to a range of patients across all disciplines, primarily to patients from Gastroenterology, Colorectal and Upper GI Surgery and Acute Medicine. It is an integral part of a number of cancer pathways providing a service to the wider network region.

The Trust's endoscopy service is delivered from both hospital sites. The unit at the Hull Royal Infirmary is based on the second floor of the Tower Block and has 3 endoscopy rooms. The service at Castle Hill Hospital is based at two locations on the site, totalling 5 endoscopy rooms. The endoscopy service within the Trust is one of the largest in the region, performing in excess of 18,000 endoscopic procedures per annum. The service is also a tertiary referral centre for specialist procedures such as Endoscopic Ultrasound (EUS) and Endo-bronchial Ultrasound (EBUS).

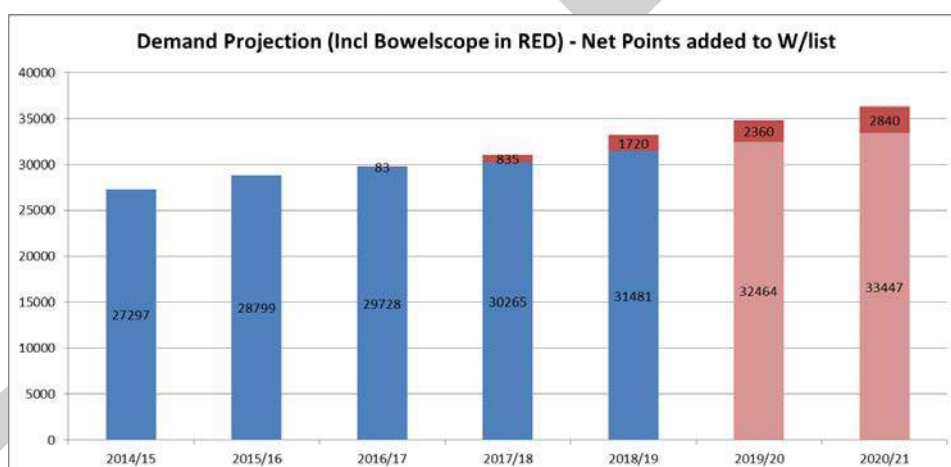
The service provides a 24 hour bleed endoscopy service at both hospital sites and for tertiary referrals across the Humber Coast and Vale footprint. The service is accredited as a regional training centre and is a screening centre for the National Bowel Cancer Screening and Bowel Scope Programmes. In addition, capsule endoscopy, oesophageal function and GI Physiology clinics are provided at Castle Hill Hospital.

In December 2012 the Trust undertook a major procurement of scopes to replace the Trust's stock of endoscopes, moving from a lease agreement to capital purchase. The 2012 procurement programme had an anticipated life span of 7 years for return-on-investment, benefit realisation and life of scopes. Nearly seven years later, the scopes have been heavily used and 8-10 scopes are out of service at any one time and with the supplier for servicing or repair. In-session reprocessing is causing deterioration of the scopes. The Trust has considered a Managed Equipment Service, however the cost is prohibitive and therefore a rolling programme of replacement is required, together with a need to increase the number of scopes to meet the increased demand for endoscopy services. The current number of scopes is insufficient to enable the service to meet demand, leading to increasing waiting times. In addition, the high number of scopes requiring repair is leading to cancellation of procedures, again increasing waiting times.



The growth in demand since the procurement in 2012 has been exacerbated by additional activity streams including direct-access endoscopy, extended eligibility for the National Bowel Cancer Scope Programme and the planned increases in activity through the Bowel Cancer Screening Programme.

The service is anticipating that the recent increases in the demand for endoscopy services will continue over the coming years. This can be seen from the growth in points added to the Endoscopy waiting list, which continues to grow at 3-4% per annum, as shown below.

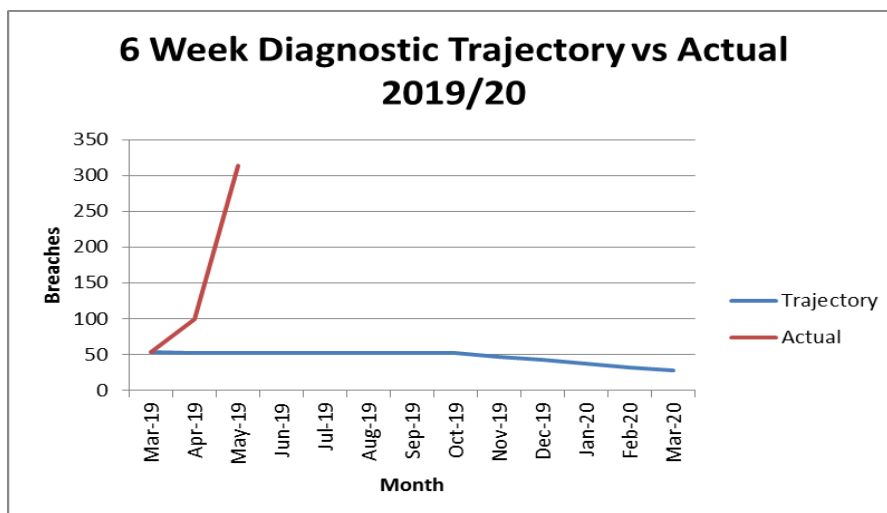


In addition to the above increases in the overall activity levels, it is anticipated that there will continue to be increases in demand in a number of subspecialty areas, such as Endoscopic Ultrasound (EUS). The growth experienced in this area since 2016 has been significant and the majority of this work is for cancer patients or suspected cancer patients.

Year	Endoscopic Ultrasound Activity 2016-19	
04/01/2016 – 30/12/2016	587	
02/01/2017 – 29/12/2017	590	
01/01/2018 – 28/12/2018	666	
01/01/2019 – 31/05/2019	391 (5 months)	938 (FYE – 12 months)

From a performance perspective, the Trust's position in relation to the 6 week diagnostic waiting time is deteriorating with 314 breaches of the standard at the end of May 2019 compared to the March 2019 position of 54 breaches. Whilst this is partly due to shortages

in staffing, the service is also impacted by the number, condition and availability of endoscopes.



Without capital investment to replace existing scopes and to purchase additional scopes, there is a very real risk that the service will fail to secure accreditation with the Joint Advisory Group (JAG). This would severely impact on the ability of the Trust to deliver core and tertiary services, resulting in poor patient experience, outcomes and financial loss to the organisation.

1.3.2.3 Trust Performance

The Trust's performance against national and constitutional thresholds is demonstrated below. It is acknowledged that increased waiting times for access to diagnostic tests, including CT, MRI, Ultrasound and Endoscopy are impacting negatively on patient pathways, both elective and non-elective.

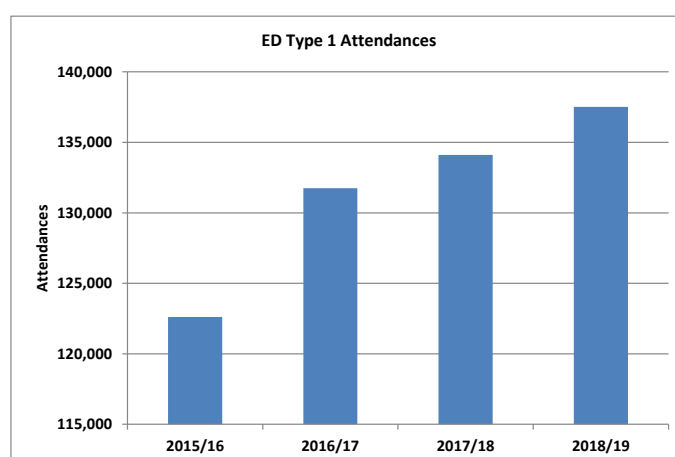
PERFORMANCE HEADLINES			
Metric		Threshold	2018/19
Emergency Department < 4 hour wait	National	95%	81.9%
18 weeks referral to treatment (RTT)	Incomplete	92%	76.8% *
52 week waits	National	0	0 *
Cancer – GP 2 week wait	All cancers	93%	95.1%
	Breast	93%	88.4%
Cancer – 31 days to first treatment	All cancers	96%	94.1%
Cancer – 31 days to second or subsequent treatment	Drug	98%	99.2%
	Radiotherapy	94%	97.8%
	Surgery	94%	88.2%
Cancer – 62 days GP to first treatment	All cancers	85%	69.2%
Cancer – 62 days screening to first treatment	All cancers	90%	66.8%
Cancer – 104 day waits	All cancers		342
Stroke - % of patients spending at least 90% of their time on a Stroke Ward		80%	85.4%
Stroke - % of patients admitted directly to a Stroke Ward within 4 hours		90%	86.1%
Diagnostic waits (6+ weeks)	National	< 1%	7.48%

* Position as at March 2019

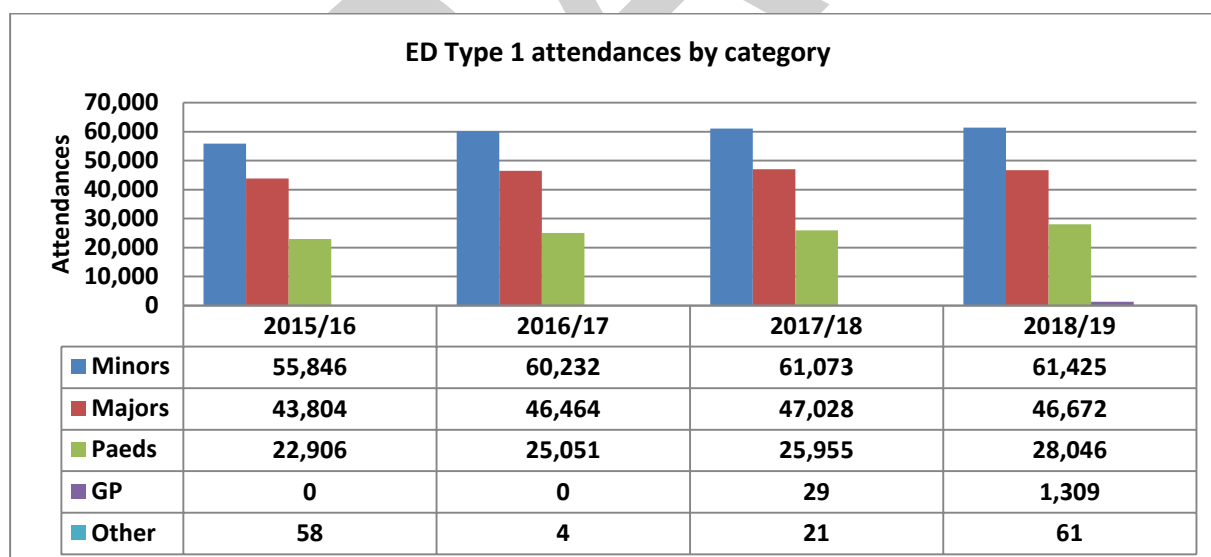
1.3.2.4 Emergency Department

The Emergency Department at the Hull Royal Infirmary is a Type 1 Emergency Department, ie it has 'a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients'¹².

Total Type 1 attendances has increased year on year from 122,614 in 2015/16 to 137,513 in 2018/19, an increase of 12% (see table below). Of the 137,513 attending in 2018/19, 45% were minor cases, 34% major cases, 20% paediatrics and 1% of attendances were managed in the primary care stream.



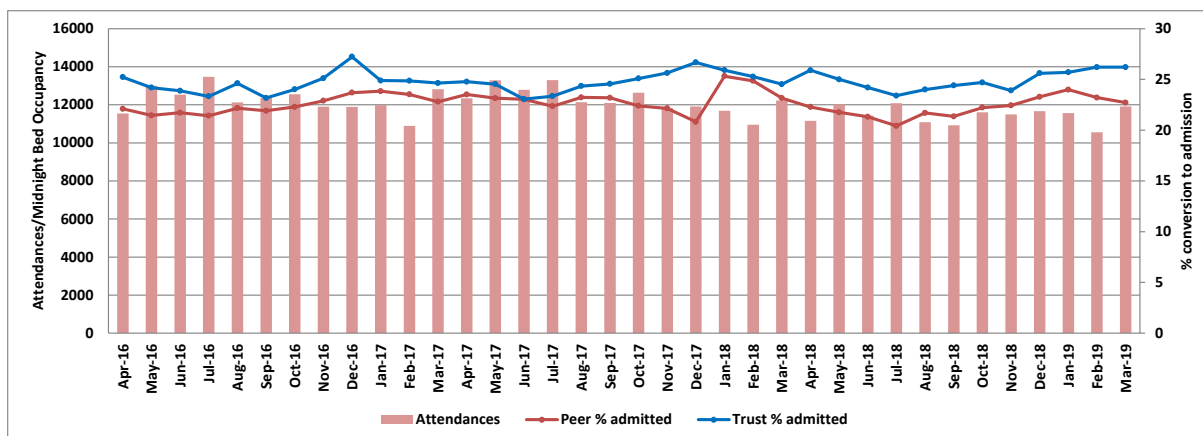
The chart below shows the Type 1 attendances split by patient category and shows the year on year increase in minor and paediatric attendances. 2018/19 saw a decline in the number of major attendances compared to 2017/18.



The ED attendance to inpatient admission conversion rate was 24.9% in 2018/19. Whilst this has decreased overall compared to previous years, partly in response to GP pathway changes, the percentage of ED attendances admitted to a bed remains higher than the Trust's peer group (see below).

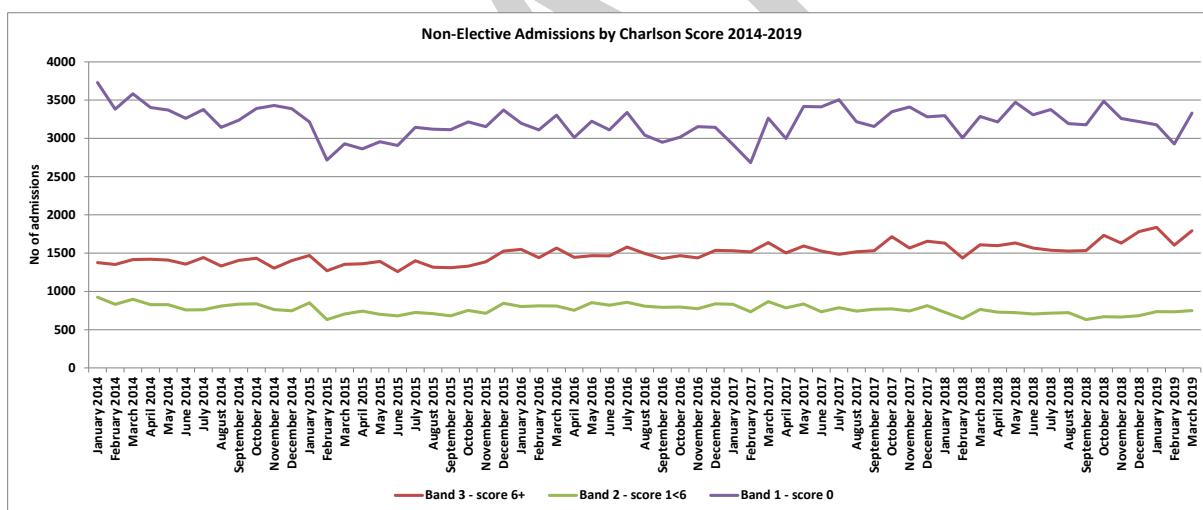
¹² NHS Data Dictionary

https://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp?shownav=1

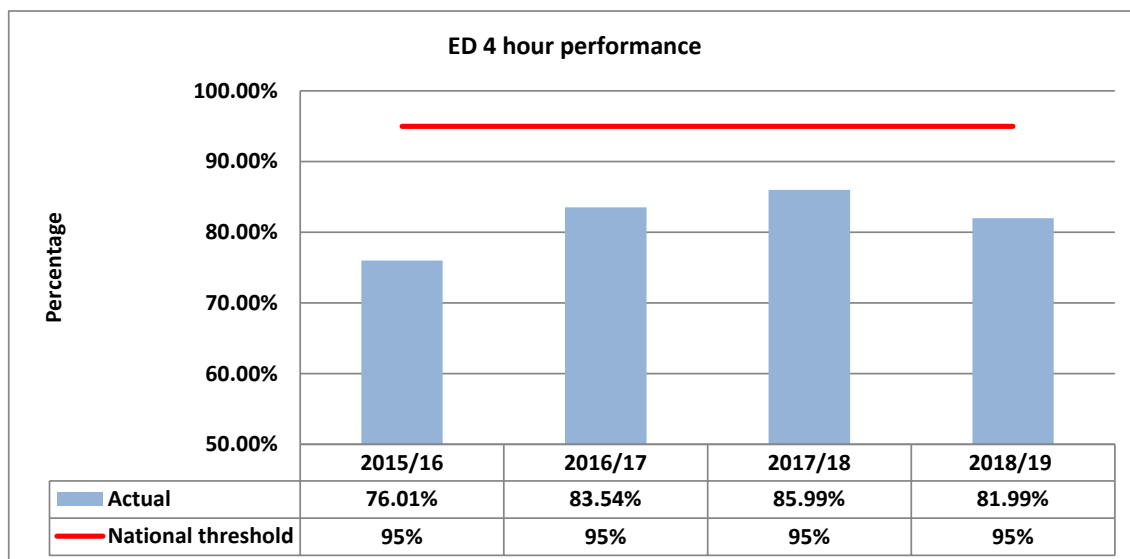


This can be explained in part by the fact that the Trust has seen an increase in the number of non-elective admissions with multiple co-morbidities, reflecting the complex health needs of the local population.

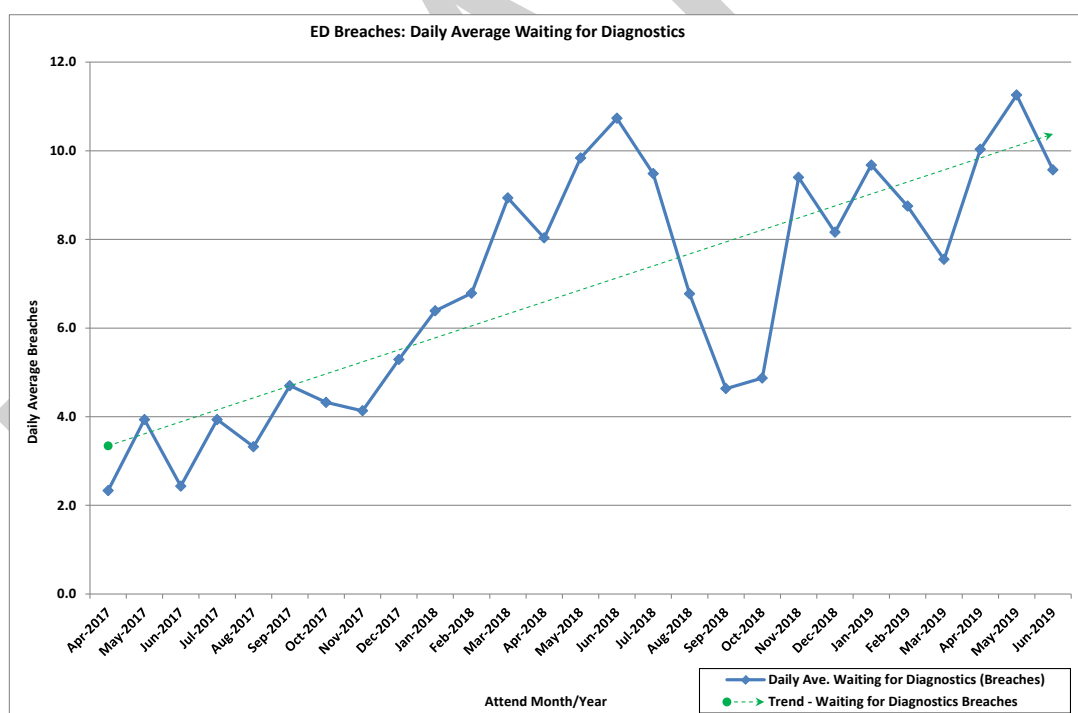
The Charlson Comorbidity Index predicts the one-year mortality for a patient who may have a range of co-morbid conditions such as heart disease or cancer (a total of 22 conditions). Each condition is assigned a score from 0-6 depending on the risk of dying associated with each one and the scores are banded to provide a total score and prediction of mortality. The chart below demonstrates the increase over time of non-elective admissions with multiple co-morbidities.



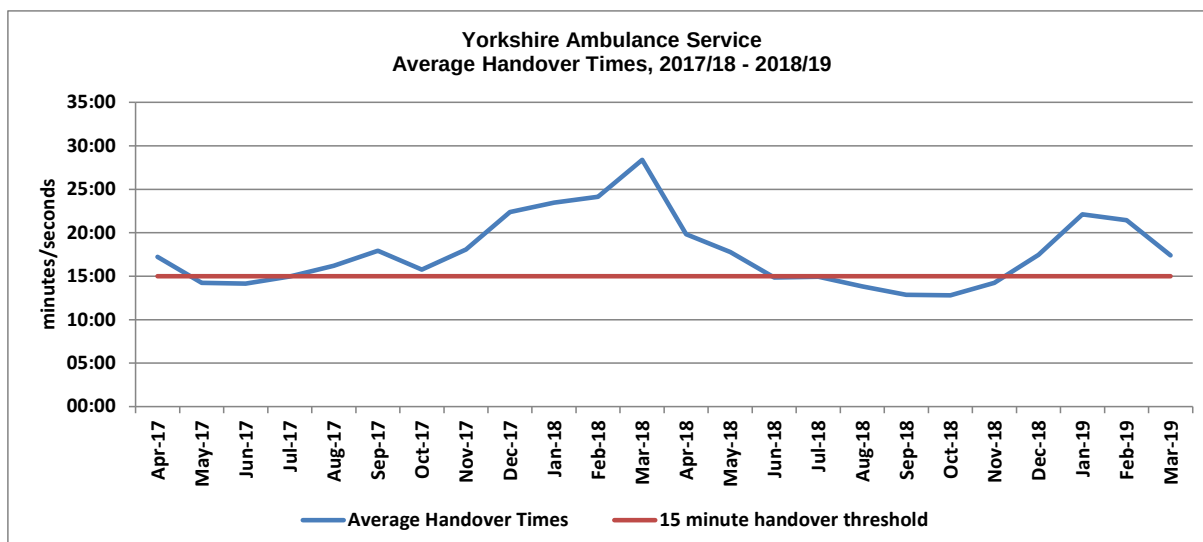
The increase in attendances to the ED, particularly for the more complex patients, has impacted on access to diagnostics and inpatient bed availability, and has resulted in increased waiting times in the Emergency Department, with patients routinely waiting in excess of the 4 hour waiting time target of 95%. The table below shows that the Trust has failed to achieve the 4 hour standard (yearly total) over the last four years.



The daily average number of breaches of the 4 hour waiting time threshold in the Emergency Department which can be attributed to waiting time for diagnostic tests has increased from 4.7 breaches per day in 2017/18 to 10.3 breaches per day in Quarter 1 of 2019/20. The chart below demonstrates the increasing trend in ED breaches due to waiting time for diagnostics.



The slowdown in patient flow through the department has impacted on access at the front door, particularly during the winter period, with ambulance handover waiting times exceeding the 15 minute standard. This has resulted in patients waiting longer to be admitted to the Emergency Department and has meant that ambulance crews are unable to be released to return to duty. The table below shows the average time by month for ambulance/ED handovers.



1.3.2.5 Primary Care Streaming

As outlined in Section 1.1.2.1.3, a key recommendation of 'Safer, Faster, Better' was the effective streaming of patients who present to the Emergency Department. A primary care streaming model has been in place within the Trust since 2016 to support patients to access the right level of care and minimise unnecessary ED visits, however a recent review identified that, of the circa 180 attendances to the ED per day, only circa 5% of patients were seen by a GP within the integrated primary care area. Evidence suggests that, where GP streaming has been introduced in other NHS organisations, circa 20-25% of patients are streamed to primary care. This therefore suggested that the current model within the Trust was not being optimised.

The Unplanned Care Board, in conjunction with local commissioners and health care partners, undertook a review of the options available to increase throughput within the primary care area, drawing on the experiences of case studies from other acute Trusts. The review concluded that additional staffing resource, changes in practice and redesign of patient flow would lead to increased primary care service utilisation. This would be enabled by a redesign of the primary care area and entrance to the Emergency Department.

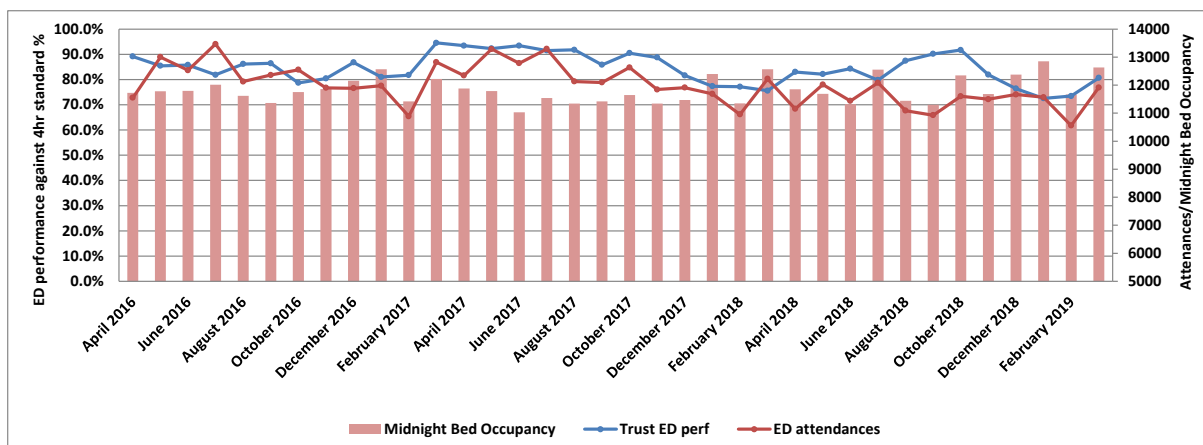
1.3.2.6 Patient Flow from the Emergency Department

The Hull Royal Infirmary site comprises the main Tower Block (610 beds), Women's and Children's Hospital (111 beds excluding labour and delivery beds), the Eye Hospital (12 beds) and a new ward built in 2018 at the rear of the Tower Block consisting of 22 beds.

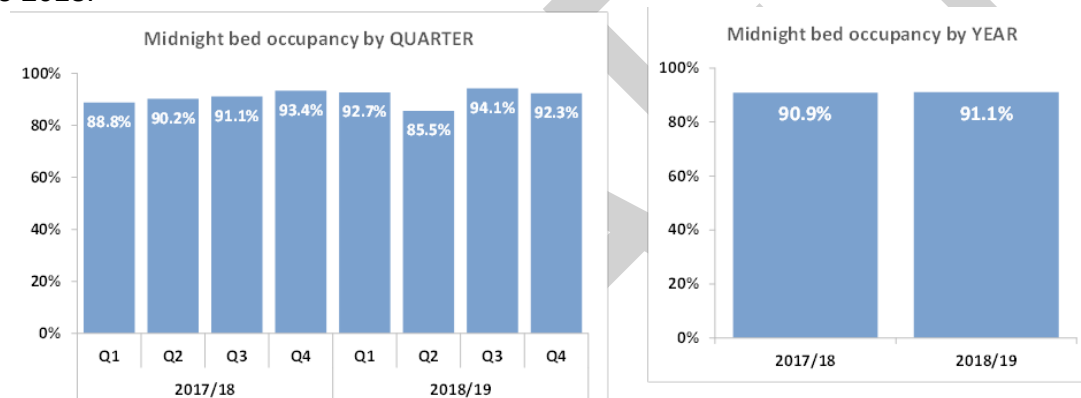
In 2015, NHS England¹³ noted that "ED crowding adversely affects every measure of quality and safety for patients of all ages, and for staff, and creates a 'negative spiral of inefficiency'. The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates."

The following chart shows the relationship between increased midnight bed occupancy, ED attendances and Trust ED performance over the last 3 years.

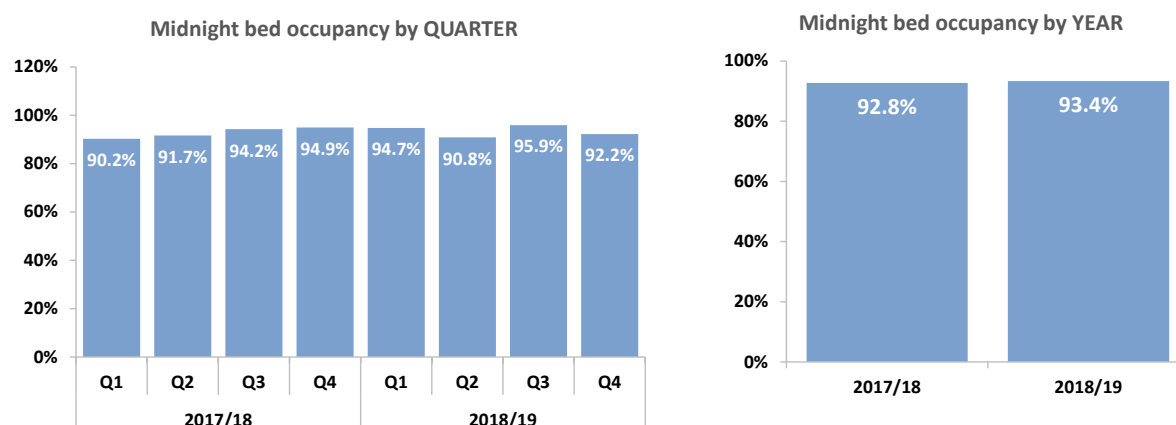
¹³ 'Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care. A guide for local health and social care communities' NHS England (2015) <https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf>



Midnight bed occupancy for the adult inpatient wards at the Hull Royal Infirmary (excluding obstetrics and critical care beds) increased from 90.9% in 2017/18 to 91.1% in 2018/19. However this figure masks the bed pressures experienced in the winter periods. For example, in the winter of 2017/18, the average midnight bed occupancy for adult inpatient wards at Hull Royal Infirmary exceeded 90% over the 12 month period from July 2017 to June 2018.



When broken down further, it is significant that medical beds at the Hull Royal Infirmary were above 90% bed occupancy in every quarter over the last two years, averaging 92.8% in 2017/18 and 93.4% in 2018/19.



In their evidence review of bed occupancy as part of the development of guidelines for emergency and acute medical care in the over 16s, NICE¹⁴ recommended that healthcare

¹⁴ NICE - Emergency and acute medical care in over 16s: service delivery and organisation – Chapter 3: Bed occupancy (2018)

providers should plan capacity to minimise the risks associated with occupancy rates exceeding 90%.

Bed modelling has demonstrated a shortfall in adult inpatient beds at the Hull Royal Infirmary totalling 55 beds on average (based on 2018/19 elective and non-elective FCE activity at 90% bed occupancy), of which medical beds account for 37 beds.

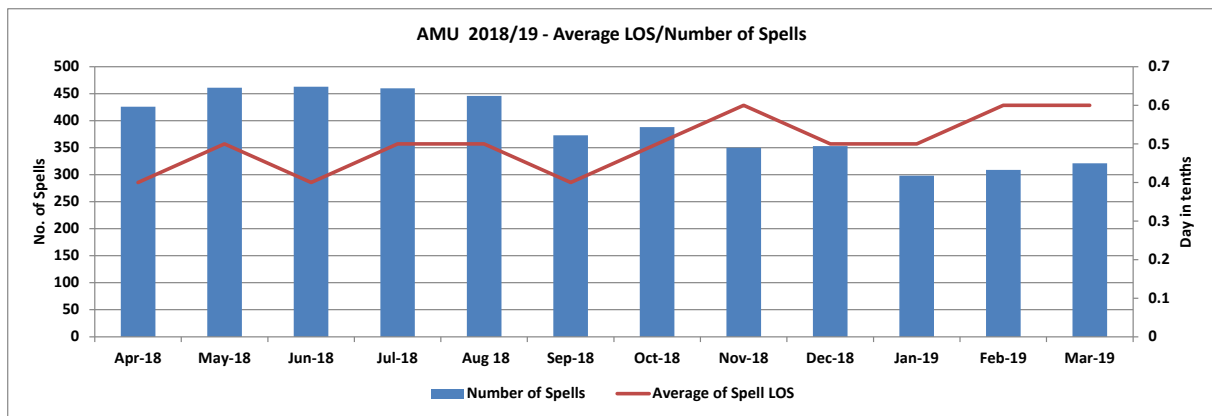
Elective and Non-Elective	HRI Bed Establishment 2018/19	85% occupancy bed requirement	Variance	90% occupancy bed requirement	Variance
Q1 2018/19	567	665	-98	628	-61
Q2 2018/19	566	644	-78	609	-43
Q3 2018/19	566	666	-100	629	-63
Q4 2018/19	592	682	-90	644	-52
Average Total	573	664	-91	628	-55

Assessment and ambulatory care services are distributed throughout the Tower Block with variable access to diagnostic services due to the location. For example:

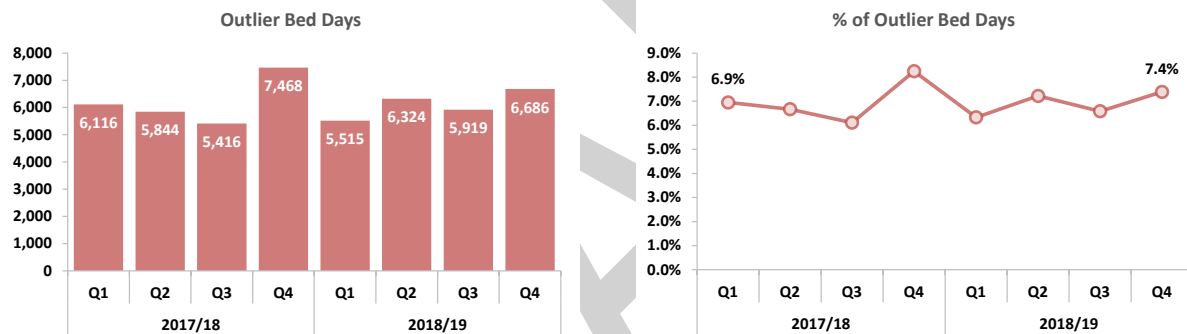
- The Acute Medical Unit (AMU) comprises 45 beds and is based on the ground floor of the Tower Block, as is the Medical Ambulatory Care Unit (MACU). They each have access to the Emergency Department CT scanner, x-ray and ultrasound facilities on the ground floor.
- The Elderly Assessment Unit (21 beds) is located on the second floor of the Tower Block, with access to second floor CT scanning and x-ray facilities in-hours and via the ground floor diagnostic services out of hours.
- The Medical Ambulatory Care Unit comprises 4 cubicles with 2 x trolleys and 2 x treatment chairs for patients who are being assessed/treated. The MACU is operational Monday to Friday 08.00 to 22.00 hours and Saturday/Sunday 08.00 – 20.00 hours. The opening hours are often flexed at times of peak demand.
- Surgical assessment is undertaken on the 6th floor general surgical wards. Access to diagnostics is problematic as it necessitates patients being transferred to the ground or second floors for their scans.
- The Paediatric Assessment Unit comprises 6 beds and is located on the 13th floor of the Tower Block necessitating transfer up and down the Tower Block in order to access diagnostic imaging. In some cases this may also include sedation.

The lack of available beds on the adult inpatient wards results in patients waiting longer on the Acute Medical Unit (AMU) for a specialist bed to become available, which then impacts on the ability to move patients out of the Emergency Department and into the AMU.

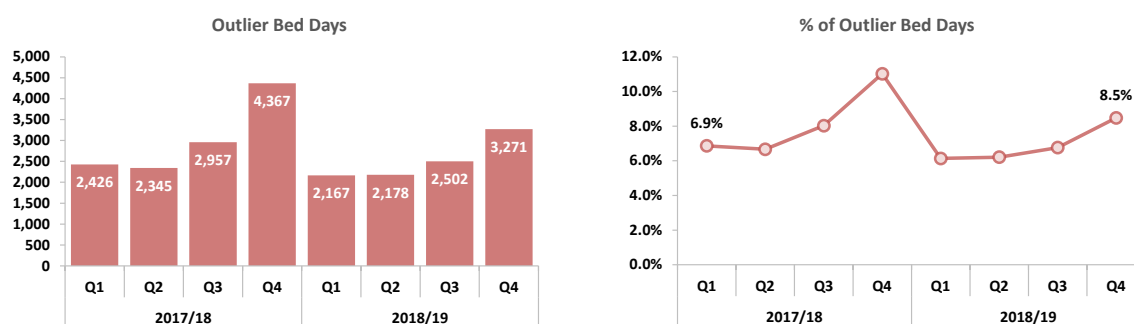
The average length of stay for patients admitted and discharged from the AMU in 2018/19 was 12 hours (0.5). It was noted that whilst the number of spells per month declined over the year, the average LOS increased from 9.6 hours (0.4) to 14.4 hours (0.6).



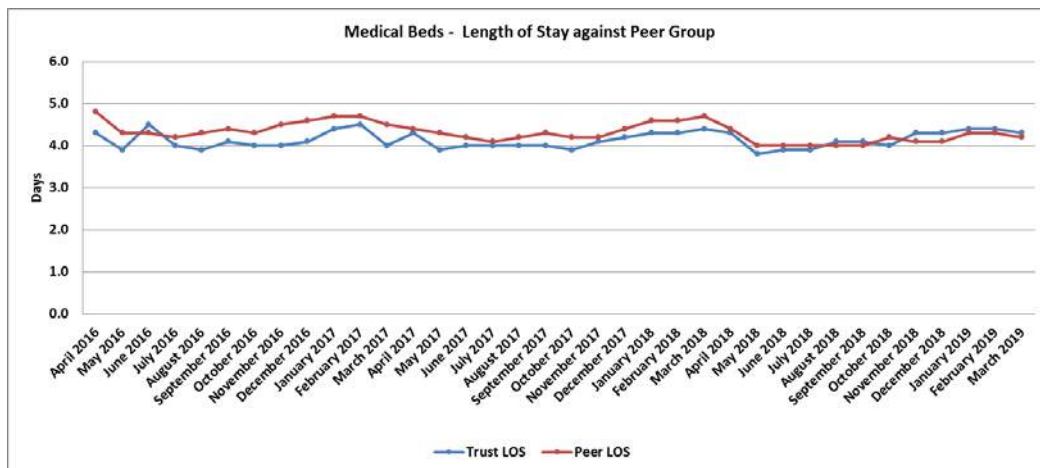
In 2017/18 the number of bed days lost to outliers across the Trust (midnight census) totalled 24,844. This reduced to 24,444 in 2018/19. However, over the last two years, the number of outliers as a percentage of bed days has increased from 6.9% in Q1 of 2017/18 to 7.4% in Q4 of 2018/19.



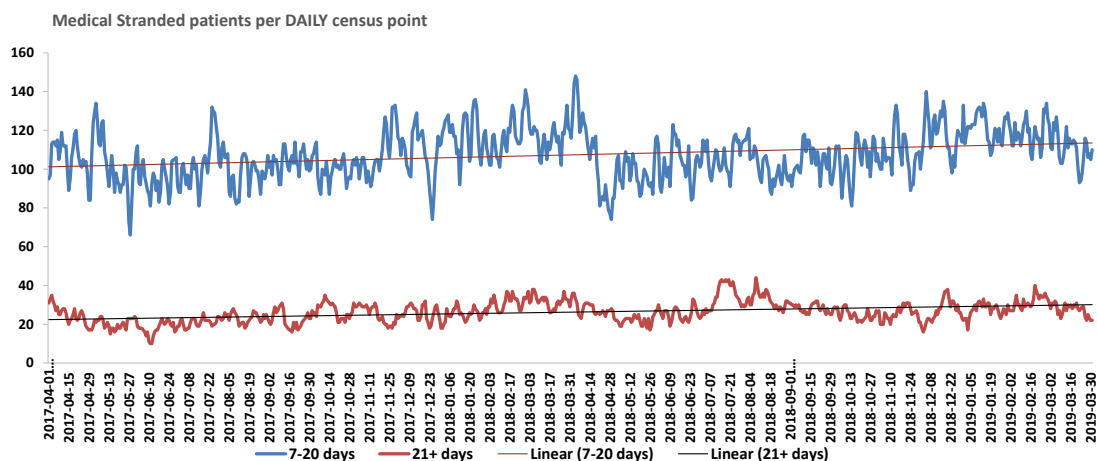
The percentage of medical outlier bed days across the Trust is given below and shows an increase from 6.9% in Q1 of 2017/18 to 8.5% in Q4 of 2018/19.



The average length of stay for medical inpatient beds has been increasing since November 2017, mirroring the peer trend. However, despite a fall in ALOS from March 2018 to May 2018, there has been a steady increase in the ALOS and the gap between the Trust and peer LOS has decreased as the Trust's LOS has increased. Since October 2018 the Trust LOS has exceeded that of its peer group.



The Trust's inpatient capacity is also impacted by the number of stranded (7-20 days stay) and super-stranded (21+ days) patients. The following chart shows the increasing trend for both stranded and super-stranded medical inpatients at the Hull Royal Infirmary from April 2017 to March 2019.



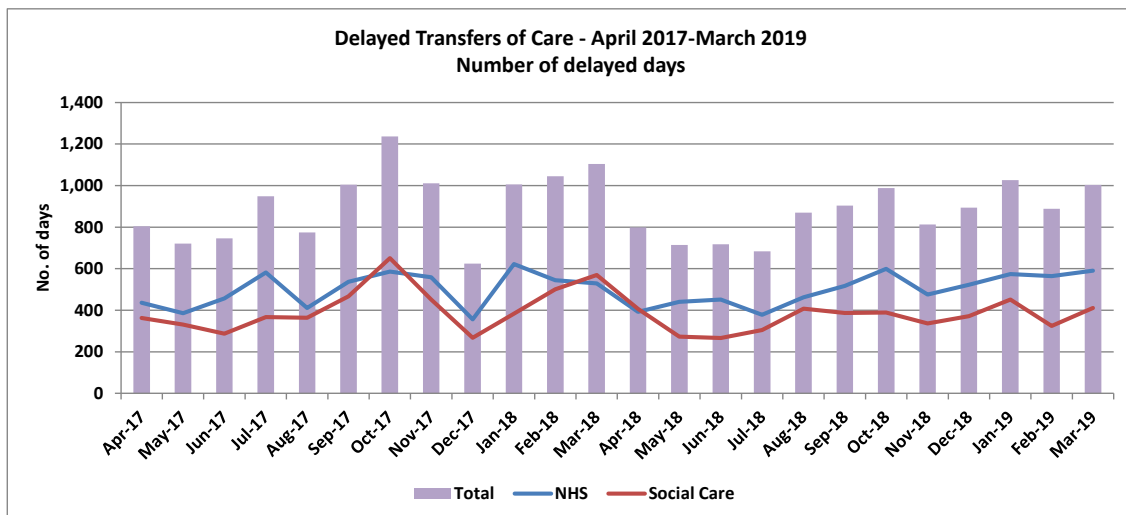
1.3.2.7 Delayed Transfers of Care (DTOCs)

NHS England defines a patient as being ready for transfer when:

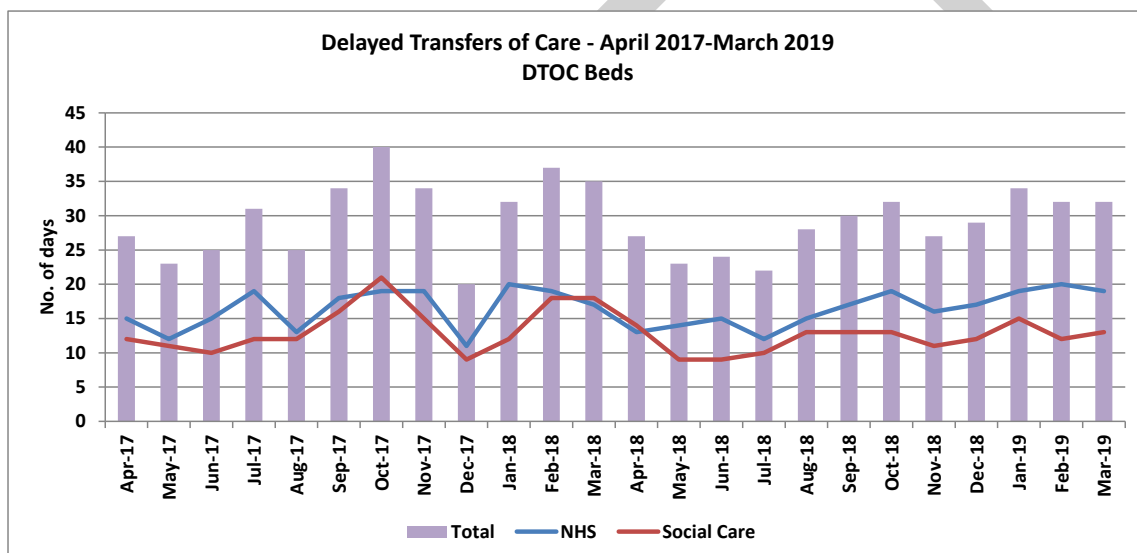
- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

A 'delayed transfer of care' occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

In 2017/18, 11,027 bed days were taken up by patients whose discharge/transfer had been delayed. This represented an average of 919 bed days per month. The total number of bed days taken by DTOCs reduced in 2018/19 to 10,300 bed days, a monthly average of 858 bed days.



When viewed in terms of numbers of beds occupied by DTOCs, the average number of inpatient beds lost per month was 30 beds in 2017/18 and 28 beds in 2018/19.



As outlined in Section 1.2.6 above, the Trust has identified a shortfall in adult inpatient beds at the Hull Royal Infirmary totalling 55 beds on average (based on 2018/19 bed days consumed). With circa 28 beds per month occupied by DTOC patients, the impact of these delays for the Trust is to increase the pressure on inpatient bed availability, creating delays in the flow of patients onto base wards.

1.3.2.8 Same Day Emergency Care

The ambitions in the NHS Long Term Plan, as set out in Section 1.1.2.1.2, include the development of a comprehensive model of Same Day Emergency Care (SDEC). SDEC activity refers to the investigation, care and treatment of patients for whom admission to hospital would have been the default option in the absence of an SDEC service. Along with other Type 1 Emergency Care providers, the Trust is required to increase the level of SDEC activity it undertakes in order to reduce demand on inpatient beds and to improve the experience and outcomes for patients.

An initial review of inpatient spells and Medical Ambulatory Care Unit outpatient attendances by the conditions outlined in the Directory of Ambulatory Emergency Care (Ambulatory

Emergency Care Network, Feb 2018¹⁵) identified the potential opportunity that could be afforded to the Trust if it was to increase the level of SDEC undertaken. The potential opportunity ranged from 4,009 to 7,360 based on 2018/19 activity and would result in a reduction in inpatient bed days estimated at between 12 and 22 beds based on the assumption of 90% bed occupancy and each attendance averaging 1 bed day. This reduction would help to offset the impact of DTOCs on bed availability outlined in section 1.2.7 above.

In order to increase the capacity to deliver more SDEC the Trust will need to increase its diagnostic capacity and also create additional assessment and ambulatory care capacity, particularly in relation to surgical services.

1.3.2.9 Care Quality Commission

Following the 2018 inspection by the Care Quality Commission, the Hull Royal Infirmary was rated overall as 'Requires Improvement'. This was due in part to the 'Requires Improvement' rating for responsiveness in Urgent and Emergency Care and the failure to comply with NHS access standards. The Trust therefore needs to improve the timeliness of delivery of urgent and emergency care.

At an earlier inspection in 2015, the CQC had noted that the Trust lacked appropriate accommodation for children undergoing oncology treatment. The accommodation on the 13th Floor of the Tower Block did not have cubicles with ensuite facilities for children requiring isolation, resulting in a lack of privacy and dignity. The CQC also noted that there was a lack of parental accommodation on the 13th floor.

Whilst the Trust has been able to take some remedial actions to improve the facilities on the ward, the standard of accommodation remains a concern and subsequent CQC inspections have noted that, whilst there is a desire to relocate paediatric services from the 13th floor, there is a lack of capacity within the Tower Block or within the Women's and Children's Hospital to enable the relocation to take place. At the present time, the Paediatric Assessment Unit, Paediatric High Dependency Unit and Paediatric Medicine inpatient ward remain remote from the diagnostic facilities and critical care facilities within the Tower Block and paediatric and parental accommodation remains as a risk on the Trust Risk register.

1.3.2.10 Trust Financial Position

As outlined in Section 1.1.1.3 the Trust has a recurrent underlying deficit of circa £8.6m. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus within the next 5 years. The Trust expects to achieve a return to surplus early in the 5 year period, however this will require significant changes to the way in which clinical services are configured, delivered and resourced. Capital funding will be required to address accommodation deficiencies, increase diagnostic capacity and improve urgent and emergency care pathways.

The Trust's 3 year Capital Programme to 2022 has identified a total investment requirement of £71m as follows:

- Equipment replacement (with no provision for expansion) - **£33m over 3 years**
- Replacement of existing IT network and essential system replacements to meet nationally mandated timescales for system architecture and capability - **£17m over 3 years**
- Backlog maintenance programme to bring the condition of the Trust's estate to Condition B over 10 years - **£7m per year.**

¹⁵ <https://www.ambulatoryemergencycare.org.uk/uploads/files/1/AEC-Directory%206th%20edition%20February%202018.pdf>

1.3.2.11 Summary

The combined impact of increasing numbers of complex patients being admitted, increased length of stay, delayed transfers of care and insufficient inpatient medical beds to meet demand, is impacting negatively on the ability of the Trust to manage the patient pathway from admission to discharge in a timely manner, resulting in increased waiting times in the Emergency Department, increased waiting times for diagnostic tests, longer lengths of stay in the Acute Medical Unit and a poor patient experience.

There is therefore a need to increase diagnostic and assessment capacity to improve patient flow, reduce waiting times in the Emergency Department, improve patient flow through the urgent and emergency care pathway and reduce the reliance on admission to an inpatient bed for those patients who can be seen, diagnosed, treated and discharged the same day. This will require capital investment to provide additional and replacement diagnostic equipment and to enable the reconfiguration of urgent and emergency care services within the Tower Block of the Hull Royal Infirmary.

1.4 Potential Scope and Service Requirements

In order to determine the potential scope of the project in terms of operational capabilities and service changes required to satisfy the business needs identified above, the Trust undertook a series of workshops with key stakeholders. Arising from these workshops was a list of the core, desirable and optional changes required to increase service capacity and delivery, improve organisational performance and achieve the investment objectives of the project (see table below).

Category	Service Requirements
Core	• A front entrance to the Emergency Department which enables the effective triage and streaming of 'walk-in' attendances • Additional diagnostic capacity to facilitate the timely diagnosis and treatment of patients across the urgent and emergency care pathway, from the ED, to the assessment, ambulatory care units and inpatient wards, in particular CT, MRI and endoscopy • Additional assessment capacity to increase the number of patients seen, treated and discharged the same day, thereby reducing the need to occupy an inpatient bed. • Co-location of additional diagnostic capacity with ED and assessment facilities • Assessment facilities to be accommodated on the ground floor of the Tower Block to facilitate patient flow • Increased flexibility in bed capacity within the Tower Block to ensure the appropriate number of beds matched to specialty and acuity.
Desirable	• Relocation of paediatric services from the 13th floor of the Tower Block • Additional ultrasound capacity
Optional	• None of the service requirements identified were considered to be 'optional'

Consideration was given to the extent to which improvements could be made to the urgent and emergency care pathway within the Trust. A scoping exercise was undertaken to understand the actions that the Trust could undertake to address its business needs, ranging from 'do nothing' and making minimal changes within existing resources, to the potential scope for change if additional investment became available. The following service scope options were identified:

1. Business as usual – continue to experience delays in the diagnosis and treatment of patients who present to the ED or via direct GP referral to the assessment and ambulatory care areas. Continue to experience delays in accessing diagnostic services for inpatients and experience high levels of bed occupancy and increased length of stay, with increasing pressure on the availability of inpatient beds. Retain paediatric assessment and inpatient services on 13th floor of the Tower Block, remote from diagnostic and critical care facilities.
2. Emergency Department – increase primary care stream capacity.
3. Emergency Department and maximise utilisation of diagnostic equipment through extended working.
4. Emergency Department and additional MRI and CT scanning facilities on the Hull Royal Infirmary site, but not co-located with the ED and existing assessment areas. Additional/replacement endoscopes.
5. Emergency Department and additional MRI and CT scanning facilities co-located on the ground floor of the Tower Block. Additional/replacement endoscopes.
6. As in No. 5 but with additional assessment capacity to enable the increased provision of Same Day Emergency Care.
7. As in No. 6 above, but with additional ultrasound scanning capacity.
8. Emergency Department, additional MRI and CT scanning facilities on the ground floor of the Tower Block, additional/replacement endoscopes, additional assessment capacity, relocation of the Elderly Assessment Unit, relocation of paediatrics. Additional adult inpatient capacity.
9. As in No. 8 above but with the inclusion of additional ultrasound capacity.
10. As per No. 9 above and with consolidation of paediatric assessment, high dependency and inpatient wards within the Women's and Children's Hospital.

An assessment of the Service Scope was undertaken as part of the Options Framework identified in HM Treasury's 'Guide to Developing the Project Business Case' (2018). Details on the outcome of the Options Framework in relation to the identification of the Preferred Way Forward and the subsequent Preferred Option are identified in the Economic Case.

1.5 Main Benefits and Risks

This section describes the main benefits and risks associated with the implementation of the potential scope of the project as they relate to the Trust's business needs and investment objectives.

1.5.1 Main Benefits

The main benefits are identified in the table below:

	Cash Releasing Benefits (CRB)	Non-cash Releasing Benefits (non-CRB)	Quantifiable but not readily monetisable Benefits (QB)	Qualitative but not readily quantifiable Benefits (Qual)
Direct public sector benefits (to the Trust)	Reduced downtime on existing scanners	Increased efficiency and	- Achievement of key ED waiting time targets - Reduction in medical	Improved flow of emergency medical and

	Cash Releasing Benefits (CRB)	Non-cash Releasing Benefits (non-CRB)	Quantifiable but not readily monetisable Benefits (QB)	Qualitative but not readily quantifiable Benefits (Qual)
	- Reduction in cost of hiring in mobile scanners to meet backlogs in demand - Reduction in staffing costs - Contributes to realisation of Trust's financial plan - Cost avoidance from the ability to do more Same Day Emergency Care resulting in less inpatient bed requirements - Cost avoidance from the increased LOS of inpatient diagnostics – bed growth not required	productivity of existing staff	outliers - Reduction in length of stay - Timely access to diagnostics, ie MRI, CT, ultrasound, endoscopy - Compliance with SDEC requirements - Compliance with NHS 7 DS Clinical Standards - Increased assessment capacity - Midnight bed occupancy levels for acute medical beds below 90% occupancy levels across every quarter in the year - Reduction in need to cancel elective surgery due to insufficient beds - Improved staff satisfaction - Increased staff retention - Improved RTT and cancer waiting times	surgical admissions throughout the hospital - Improved patient pathways for urgent and emergency care - Compliance with CQC inspection requirements in relation to Responsive Domain - Earlier diagnosis and treatment of the patient, including reduced risk of deterioration of condition - Greater flexibility in the management of peaks in non-elective activity. - Realisation of ambitions in Trust Strategy and People Strategy - Compliance with JAG accreditation requirements
Indirect public sector benefits (to other public sector organisations)	Contributes to realisation of STP financial plan		- Contributes to improved waiting times and access to healthcare across the wider STP as part of the patch-wide reconfiguration of Urgent and Emergency Care - Supporting increased provision of GP direct access to diagnostics - Improved waiting times in ED will have a positive impact on access to services for Mental Health provider organisation in-reaching to the Trust	Realisation of ambitions within the STP long term plan.
Wider benefits to UK society			- Improved patient satisfaction - Reduction in waiting times for diagnosis and treatment	Improved patient experience

At this stage, the potential for dis-benefits as a result of the proposals to reconfigure urgent and emergency care flow through the Tower Block at Hull Royal Infirmary is low.

1.5.2 Main Risks

The main risks identified at this early stage of the project are categorised below.

Risk Categories	Description	Mitigating Actions
Business risks	Project timescales slip due to insufficient workforce capacity to manage the schemes.	The Trust will provide dedicated project management resource to support the project to achieve implementation within the set timescales.
	Delays in the finalisation of the detailed briefs for the different elements of the reconfiguration programme	Communication and engagement with key stakeholders and the development of realistic timelines, with the interdependencies plotted and planned into the project timescales.
	Inability to recruit to radiographer posts to support the additional CT/MRI provision	Recruitment campaign via national and local press, internally, as well as via career fairs and university events. Trust has approved the restructuring of the radiographer service to provide additional opportunities for career development and progression to assist with recruitment and retention of radiographers.
	Inability to recruit to nursing posts to support the additional assessment and ambulatory care capacity	Recruitment campaign via national and local press, internally, as well as via career fairs and university events.
	Programme of building works negatively impact on delivery of services	Communication and engagement with key stakeholders. Risk assessments undertaken. Schedule of works developed in conjunction with clinical services. Clear signage marking alternative routes where necessary. Alternative accommodation provided whilst enabling works undertaken.
	Programme of building works negatively impacted by need to liaise with Private Finance Initiative (PFI) approvals process affecting the second floor link bridge from the WCH into the second floor of the Tower Block	Close dialogue with PFI team to ensure sufficient time to identify and manage any legal implications arising from the proposed project.
	The design does not support the brief.	Regular checking of the brief to record compliance and derogations. Design development approved by project team and signed off by clinical teams.
Service risks	The project impacts negatively on the provision of emergency care and on patient and public access during the construction phase.	A project plan will be developed that will limit disruption. This will be communicated to key stakeholders, patients and visitors.
	Project timescales are adversely impacted by delays in the manufacture and delivery of CT and MRI equipment	Early discussions held with a number of manufacturers as part of specification development. Procurement process will include delivery dates and a contingency built into the plans for the reconfiguration of the ground floor. Project team experienced in the procurement of CT and MRI

Risk Categories	Description	Mitigating Actions
		equipment
	Delays in the delivery of engineering plant	Early discussions will be held with potential contractors regarding delivery timescales to mitigate this risk and an appropriate contingency built into the project plans.
	UEC capital developments at neighbouring Trusts may result in HUTH receiving a greater number of ED attendances than anticipated.	Progress and impact of capital works at all three Trusts will be monitored via the HC&V Wave 4 Capital Development Steering Group.
External risks	NHS capital funding may not be forthcoming due to changes in national policy	Submission of SOC, OBC, FBC in line with required timescales for Wave 4 developments. Strong case for change and demonstrable value for money.

1.6 Constraints and Dependencies

1.6.1 Constraints

The project is subject to the following constraints:

- **Budget:** The Trust has a limited capital programme over the next 5 years. The capital funding from the Wave 4 STP bids is fixed at £19.3m and needs to be maintained within the envelope.
- **Timeliness:** Capital funding may not be available until 2021 when the Full Business Case is approved.
- **Existing physical layout/footprint of the Tower Block:** The Hull Royal Infirmary opened in 1967 and backlog maintenance poses a significant risk. There are limited options available to increase the footprint, which are largely restricted to the front of the building.

In addition:

- The existing spaces may not meet current guidance, so derogations may be required;
- The structural frame and immovable elements of the building may not permit certain layouts to be achieved;
- The positions of lifts and stairs will influence layouts and the flow of patients; and
- Natural light and ventilation/cooling are a factor to consider when planning accommodation, and what is practicable within the spaces being considered.

1.6.2 Dependencies

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Urgent and Emergency Care Wave 4 developments of other acute Trusts within Humber Coast and Vale HCP
- Lorenzo Digital Exemplar Programme which aims to digitise specific clinical pathways
- Humber Acute Services Review
- Unplanned Care Board
- A&E Delivery Board
- CCG commissioning intentions
- Ongoing replacement of Radiology Imaging equipment.

2. The Economic Case

2.1 Introduction

In accordance with HM Treasury's 'Guide to Developing the Project Business Case' and the requirements of HM Treasury's Green Book (*A Guide to Investment Appraisal in the Public Sector*), this section of the SOC documents the range of options that have been considered in response to the potential scope identified within the strategic case.

2.2 Critical Success Factors

The key Critical Success Factors (CSFs) for the Urgent and Emergency Care Expansion project were developed during an 'options workshop' held by UEC Development Programme Board on 1st May 2019. The CSFs have been used alongside the investment objectives for the project to evaluate the long list of possible options.

Critical Success Factor	Description
CSF1: Strategic fit and business needs	The option meets the agreed investment objectives, related business needs and service requirements. It provides holistic fit and synergy with other strategies, programmes and projects.
CSF2: Potential value for money	The option optimises the potential return on expenditure, business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation), and assists in improving the overall value for money (economy, efficiency and effectiveness).
CSF3: Supplier capacity and capability	The market place and potential suppliers are able to deliver the required services and deliverables.
CSF4: Potential affordability	The option can be funded from available sources of finance and aligns with sourcing constraints
CSF5: Potential Achievability	The organisation is able to innovate, adapt, introduce, support and manage the required level of change associated with the option. It is able to manage any associated risks and has the capacity and capability to provide the necessary supporting skills. The organisation will be able to engender the acceptance of staff.

2.3 Long List of Options

As outlined in Section 1.4 of the Strategic Case, the Trust has used HM Treasury's Options Framework to determine the preferred way forward for the organisation in addressing its business needs and realising its investment objectives.

The initial long list of options, their advantages and disadvantages and the extent to which they meet the agreed investment objectives and critical success factors is set out overleaf.

Long list of Options

Option Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
1.1 Business as Usual (BAU)	Urgent and emergency care pathways from the Emergency Department to assessment, admission and/or discharge are compromised by a lack of diagnostic and assessment capacity.	None	Delays in the diagnosis and treatment of patients who present to the ED or via direct GP referral to the assessment and ambulatory care areas. Delays in accessing diagnostic services for inpatients, high levels of bed occupancy and increased length of stay, with increasing pressure on the availability of inpatient beds. Paediatric assessment and inpatient services on 13 th floor of the Tower Block are inadequate and remote from diagnostic and critical care facilities.	Does not meet investment objectives or critical success factors.
1.2 Emergency Department	Reconfigure the 'walk in' entrance to the Emergency Department	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED.	This option does not provide the additional diagnostic and assessment capacity required to provide the improvements necessary across the whole UEC pathway. Trust performance would continue to be below the required thresholds and pressure would continue to increase in relation to adult inpatient admissions and length of stay.	Does not meet investment objectives or critical success factors
1.3 Emergency Department and Maximising existing diagnostic capacity	Reconfigure 'walk in' entrance to the Emergency Department and maximise utilisation of diagnostic equipment through extended working	As above. Additional capacity created on existing CT/MRI/ Ultrasound machines. Additional endoscopy procedures could be undertaken	Places additional demand on existing equipment which is nearing end of life and in need of replacement. Increased workload on the existing CT/MRI/ Ultrasound machines would lead to increased risk of breakdown/downtime. Increased utilisation of endoscopes would necessitate increased frequency of washing and accelerate wear and tear/need for repair. Patient safety would continue to be compromised (MRI is not co-located with the ED). Potentially more expensive eg staff overtime to deliver extended sessions.	Potential to improve performance against 7DS (IO3)
1.4 ED and additional MRI/CT (not on ground floor). Endoscope provision	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner on the HRI site, but not co-located with the ED and AMU. Provide additional/ replacement endoscopes.	As per Option 2. This would not require a reconfiguration of the ground floor of the Tower Block to accommodate the diagnostic equipment and associated facilities. Replacement and additional endoscopes would be provided.	Additional CT and MRI would not be co-located with the Emergency Department and AMU necessitating the transfer of patients from the ground floor (and in some cases outside of the building) resulting in risks to patient safety. No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay and release inpatient capacity.	Some progress towards IO1, IO2, IO3, IO4, but not able to realise full benefits of investment objectives. Some synergy with CSF1

Option Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
		CT/MRI and endoscopy capacity would be increased, reducing waiting times for diagnostics.		
1.5 ED and additional CT/MRI co-located on the ground floor. Endoscope provision	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes.	As per Option 2. CT/MRI and endoscopy capacity would be increased, reducing waiting times for diagnostics and assisting in the delivery of SDEC, reduced LOS and potentially freeing up some inpatient capacity.	Necessitates the reconfiguration of the ground floor of the Tower Block. No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay and release inpatient capacity. Does not realise the level of additional inpatient capacity required to meet current service needs. Does not provide additional assessment and ambulatory care required.	Some progress towards IO1, IO2, IO3, IO4, and IO5, but not able to realise full benefits of investment objectives. Some synergy with CSF1
1.6 ED and additional CT/MRI co-located on the ground floor. Endoscope provision. Additional assessment capacity	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner and 1 x additional MRI scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes. Provide additional assessment capacity on the ground floor	As per Option 5. Additional assessment capacity will enable increased provision of Same Day Emergency Care (SDEC) leading to reduced acute admissions where appropriate.	Necessitates the reconfiguration of the ground floor of the Tower Block. No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity Whilst some inpatient capacity may be freed up through reduction in LOS, there will remain a requirement for additional inpatient beds over and above the existing establishment. Paediatric services would remain on 13 th floor.	Some progress towards IO1, IO2, IO3, IO4, and IO5, but not able to realise full benefits of investment objectives. Some synergy with CSF1
1.7 ED, additional CT/MRI and Ultrasound co-located on the ground floor. Endoscope provision. Additional assessment capacity	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional CT scanner, 1 x additional MRI scanner and 1 x additional ultrasound scanner co-located with the ED and AMU. Provide additional/ replacement endoscopes. Provide additional assessment capacity on the ground floor	As per Option 6. Additional ultrasound capacity will increase the amount of SDEC provision that can be delivered, particularly with the additional assessment unit provision on the ground floor. Inpatient capacity will be improved as inpatient access to diagnostic services will be increased.	Necessitates the reconfiguration of the ground floor of the Tower Block. Level of inpatient capacity realised through increased diagnostic provision and assessment capacity will not be sufficient to address the shortfall in inpatient beds at HRI. Paediatric services would remain on 13 th floor.	Meets investment objectives Synergy with CSF1 and CSF2
1.8 ED, additional CT and MRI co-located on the ground floor.	Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional MRI	As per Option 6. Elderly Assessment Unit (EAU) is	Necessitates reconfiguration of areas on the ground floor and 2 nd floor of the Tower Block. Also enabling works to 13 th floor.	Meets investment objectives Synergy with CSF1 and

Option Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
Endoscope provision. Additional assessment capacity. EAU relocated. Additional inpatient capacity	and 1 x additional CT scanning facilities on the ground floor of the Tower Block. Provide additional/replacement endoscopes, additional assessment capacity, relocate the Elderly Assessment Unit from the 2 nd floor to the Ground Floor, and transfer paediatrics from the 13 th to the 2 nd floor. Create additional adult inpatient capacity.	relocated to the ground floor providing easier access to diagnostic services. Paediatrics is relocated to the second floor enabling easier access to diagnostics and critical care and meeting CQC inspection requirements in respect of patient and parental facilities. Improved patient flow along UEC pathways. Additional inpatient capacity created on vacated 13 th floor.	No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity. Paediatric services not relocated to the Women's and Children's Hospital.	CSF2
1.9 ED, additional CT and MRI co-located on the ground floor. Endoscope provision. Additional assessment capacity. EAU relocated. Additional inpatient capacity Additional ultrasound provision	As in Option 8 above but with the inclusion of additional ultrasound capacity on the ground floor of the Tower Block.	As per Option 8. Additional ultrasound capacity will increase the amount of SDEC provision that can be delivered, particularly with the additional assessment unit provision on the ground floor. Inpatient capacity will be improved as inpatient access to diagnostic services will be increased.	Necessitates reconfiguration of areas on the ground floor and 2 nd floor of the Tower Block. Also enabling works to 13 th floor. Paediatric services not relocated to the Women's and Children's Hospital.	Meets investment objectives Synergy with CSF1 and CSF2
1.10 As Option 9 with consolidation of paediatric services on the W&CH site	As per Option 9. Paediatric services would be relocated from the 13 th floor of the Tower Block to the Women's and Children's Hospitals.	As per Option 9. All paediatric inpatient activity (Acorn Ward and H130, Paed Assessment Unit, Paed High Dependency and Neonatal Intensive Care Unit) would be co-located, reducing the need for medical and nursing staff to work across a number of locations on the HRI site, leading to improved efficiencies and productivity in terms of staffing.	Necessitates reconfiguration of areas on the ground floor of the Tower Block. Also enabling works to 2 nd and/or 13 th floor. Insufficient capacity within the existing Women and Children's Hospital footprint to house relocated H130. Would necessitate an existing service moving out of WCH or a new build.	Meets investment objectives Synergy with CSF1 and CSF2. However unlikely to be an affordable option (CSF6)

2.3.1 Determining the Preferred Way Forward

The Options Framework provides a structured approach to identifying and filtering a broad range of options and has been used in a number of public sector schemes. The Framework identifies and filters choices for:

- vi. the operational/service scope
- vii. service solution
- viii. service delivery vehicles
- ix. implementation timeframes; and
- x. funding mechanism for the project.

It is necessary to include a 'Business as Usual' option, a 'Do Minimum' option, a range of 'Intermediate' options and a 'Do Maximum' option. At each stage in the 5 step process, the options are assessed to determine whether they are unrealistic and should be 'discounted (D)', or if they can be 'carried forward (CF)' or are the 'preferred way forward (PWF)'.

i. Service Scope

Each of the 10 options identified above was assessed against the 'core' and 'desirable' service requirements as outlined in Section 1.4 to determine which of the options could be discounted and which should be taken forward for further appraisal. The outcome was that Options 1.2, 1.3, 1.4 and 1.5 were discounted at this early stage as they did not meet the core requirements to increase primary care streaming, provide additional CT, MRI and endoscopy capacity, increase assessment capacity and increase the adult inpatient bed capacity. They also failed to meet the desirable requirements – additional ultrasound capacity and relocation of paediatrics.

The outcome of the service scope assessment is summarised below.

Project	1.1 BAU	1.2	1.3	1.4	1.5	1.6 Do Min	1.7 Interm	1.8 Interm	1.9	1.10 Do Max
1.Scope Outcome	CF	D	D	D	D	CF	CF	CF	PWF	CF

Option 1.1 was carried forward as the 'BAU' option, with Option 1.6 becoming the 'Do Minimum', Options 1.7 and 1.8 as two 'Intermediate' options and Option 1.10 being the 'Do Maximum' option. At this stage Option 1.9 was the option which was identified as the 'Preferred Way Forward'.

ii. Service Solution

Consideration was given to the possible service solutions for the 6 remaining options. The advantages and disadvantages of the service solutions identified are listed overleaf. The service solutions included actions such as creating a new entrance to the minors/GP streaming area of the Emergency Department and creating additional floor space on the ground floor by creating an extension to the front of the Tower Block.

Consideration was also given to how additional assessment capacity could be provided on the ground floor by creating a Surgical Ambulatory Care Unit (SACU). The service solutions were based on the potential size of the SACU.

In addition the solutions looked at the potential locations for additional diagnostic capacity and for the relocation of paediatrics.

Service Solutions

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
2.1 Business as Usual (BAU)	Retain current configuration of services and locations	None	The buildings and infrastructure will continue to contribute to delays in the urgent and emergency care pathway, resulting in longer waiting times, increased length of stay and a poor patient experience.	Does not meet investment objectives or critical success factors.
2.2 Two storey extension to enable creation on ground floor of co-located imaging suite for CT and MRI, small SACU. New entrance to minors/GP area.	Create additional floor space on the ground floor of the Tower Block by extending the main front entrance to the Tower Block to enable accommodation to be released for a co-located imaging suite for CT and MRI. Procure additional CT/MRI scanners. Procure additional/replacement endoscopes. Create a small SACU by adding extension to existing MACU. Provide a new entrance to the minors/GP primary care area of the ED. Relocation of chapel and kitchen. Provision of additional lift capacity for easier access to first floor outpatient area	Additional CT and MRI capacity will be created enabling earlier diagnosis and treatment for attendees to the Emergency Department, the AMU, MACU and SACU. Creation of a SACU will enable surgical referrals from ED and GPs to be assessed and diagnosed on the ground floor, freeing up capacity on the 6 th floor where surgical cases are currently admitted pending further investigation. Increases the Trust's ability to undertake SDEC. New entrance to ED provides opportunity for increased utilisation of primary care area.	Does not address ultrasound scanning requirements, or enable relocation of EAU and paediatrics. Size of SACU may be insufficient to address future needs.	Some progress towards IO1, IO2, IO3, IO4, and IO5, but not able to realise full benefits of investment objectives. Some synergy with CSF1, CSF2
2.3 Two storey extension to enable creation on ground floor of co-located imaging suite for CT/MRI/Ultrasound, small SACU. New entrance to minors/GP area.	Create additional floor space on the ground floor of the Tower Block by extending the main front entrance to the Tower Block to enable accommodation to be released for a co-located imaging suite for CT/MRI and ultrasound . Procure additional CT/MRI and ultrasound scanners. Procure additional/replacement endoscopes. Create a small SACU by adding extension to existing MACU. Provide a new entrance to the minors/GP primary care area of the ED.	As Solution 2 above, but with additional ultrasound scanning facilities on the ground floor which would increase the ability of services to deliver SDEC and provide more timely diagnostics for inpatients, leading to reduced length of stay and freeing up inpatient bed capacity.	Does not address the requirement to relocate EAU and paediatrics. Size of SACU may be insufficient to address future needs.	Some progress towards IO1, IO2, IO3, IO4, and IO5, but not able to realise full benefits of investment objectives. Some synergy with CSF1, CSF2

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
	Relocation of chapel and kitchen. Provision of additional lift capacity for easier access to first floor outpatient area			
2.4 Three storey extension to enable creation on ground floor of co-located imaging suite for CT/MRI, small SACU. New entrance to minors/GP area.	Create additional floor space across three floors by extending the main front entrance to the Tower Block (3 storey build). This will create space on the ground floor for a co-located imaging suite for CT/MRI, a small SACU extension to the existing MACU and a new entrance to the minors/GP primary care area of ED. The first floor of the extension will house a relocated staff dining area/rest facility and relocated prayer rooms. Two additional lifts will be incorporated into the build to give access to the first and second floors of the Tower Block. EAU will be relocated from H200 to H36. The staff dining room on the 2nd floor will be relocated to the 1st floor extension. Endoscopy washer facilities will be relocated to the new 2nd floor extension. The vacated dining room and H200 space will be converted into ward accommodation to enable paediatrics to be relocated from the 13th floor to the second floor. Parental accommodation will be created in the new 2nd floor extension. Procure additional/replacement endoscopes.	The relocation of EAU will ensure closer proximity with ground floor diagnostic services. Paediatrics would be relocated to accommodation that meets privacy and dignity requirements, is closer to diagnostic services and critical care facilities. Being located on the 2nd floor, paediatric staff would have easier access via the link corridor to paediatric cases on Acorn Ward in the W&CH. Parental accommodation would be adjacent to the new paediatric ward and would be fit for purpose. Endoscopy services on the 2nd floor would have a new reception area and endoscope washers co-located with the Endoscopy suite. Vacated 13th floor would provide the Trust with the opportunity to reconfigure its existing adult inpatient accommodation within the Tower Block and provide much needed decant facilities.	Size of SACU may be insufficient to address future needs. Does not address ultrasound scanning requirements,	Meets investment objectives Synergy with CSF1 and CSF2
2.5 Three storey extension to enable creation on ground floor of co-located	Create additional floor space across three floors by extending the main front entrance to the Tower Block (3 storey build).	As per Solution 4 but with the addition of ultrasound. A larger SACU will enable the Trust to		Meets investment objectives Synergy with CSF1 and CSF2

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
imaging suite for CT/MRI/Ultrasound, larger SACU. New entrance to minors/GP area.	This will create space on the ground floor for a co-located imaging suite for CT/MRI/Ultrasound, a larger SACU located adjacent to the AMU and a new entrance to the minors/GP primary care area of ED. The first floor of the extension will house a relocated staff dining area/rest facility and relocated prayer rooms. Two additional lifts will be incorporated into the build to give access to the first and second floors of the Tower Block. EAU will be relocated from H200 to H36. The staff dining room on the 2nd floor will be relocated to the 1st floor extension. Endoscopy washer facilities will be relocated to the new 2nd floor extension. The vacated dining room and H200 space will be converted into ward accommodation to enable paediatrics to be relocated from the 13th floor to the second floor. Parental accommodation will be created in the new 2nd floor extension. Procure additional/replacement endoscopes.	address growth in demand, particularly in relation to increased SDEC.		
2.6 Two storey extension to enable creation on ground floor of co-located imaging suite for CT/MRI/Ultrasound, larger SACU. New entrance to minors/GP area. Create a new build Paediatric facility adjacent to the W&CH.	Create additional floor space across two floors by extending the main front entrance to the Tower Block (2 storey build). This will create space on the ground floor for a co-located imaging suite for CT/MRI/Ultrasound, a larger SACU located adjacent to the AMU and a new entrance to the minors/GP primary care area of ED. The first floor of the extension will house a relocated staff dining area/rest facility and relocated prayer rooms. Two additional lifts will be	As per solution 3. A larger SACU will enable the Trust to address growth in demand, particularly in relation to increased SDEC. The relocation of EAU will ensure closer proximity with ground floor diagnostic services. The provision of a new build facility for the paediatric services relocated from the 13th floor will ensure that accommodation is fit for purpose. The	Locating paediatric services adjacent to the W&CH would result in their being remote from the CT/MRI and ultrasound diagnostic services provided within the Tower Block. This would result in children and young people having to be transferred to and from the paediatric facility to the Tower Block or MRI Centre for diagnostic tests. The paediatric service would also be remote from the critical care services within the Tower Block.	Some progress towards IO1, IO2, IO3, IO4, and IO5, but not able to realise full benefits of investment objectives. Some synergy with CSF1, CSF2

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
	incorporated into the build to give access to the first floor of the Tower Block. EAU will be relocated from H200 to H36. Procure additional/replacement endoscopes The vacated dining room and H200 space will be converted into adult inpatient ward accommodation Build a new Paediatric facility adjacent to the W&CH.	relocated paediatric wards will be in closer proximity to existing paediatric services within the W&CH, Parental accommodation will be provided within the new build. Accommodation would be freed up on the 2nd and 13th floors and provide the Trust with the opportunity to reconfigure its existing adult inpatient accommodation within the Tower Block and provide much needed decant facilities.		

An assessment was undertaken to determine the extent to which each proposed service solution could be delivered in line with scoping options identified in section 2.2.1.i. As in the previous case, each option was either 'discounted', 'carried forward' or identified as the 'preferred way forward'. The Business as Usual (BAU) and Do Minimum options were carried forward by default as per the Options Framework guidance. The 'Do Maximum' option which included a new build adjacent to the Women's and Children's Hospital was discounted at this stage due to distance from diagnostic facilities and being unaffordable. The preferred way forward in relation to the service solution was for a three storey extension to the front of the Tower Block with a larger SACU adjacent to the AMU.

Project	2.1 BAU	2.2 Do Min Two storey	2.3 Interm Two storey with ultrasound	2.4 Interm Three storey	2.5 Interm Three storey larger SACU	2.6 Two storey, Paed new build
2. Service Solution Outcome	CF	CF	CF	CF	PWF	D

iii. Service Delivery

The next stage in the Options Framework looked at potential options for delivering the preferred scope and service solution. The options for service delivery, their advantages and disadvantages, are listed overleaf. They focus on the sizing, sequencing and phasing of the UEC reconfiguration project.

The outcome of this assessment resulted in the measured term contract and P22 partner options being discounted. The preferred way forward was to deliver the building works via a series of tenders.

Project	3.1 BAU	3.2 OJEU contract	3.3 P22 Partner	3.4 Tender small packages of work
3. Service Delivery Outcome	CF	CF	D	PWF

Service Delivery

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
3.1 Business as Usual (BAU)	Under this option the Trust would continue to use its in-house estates team to deliver business as usual	In-house knowledge of HRI Tower Block and infrastructure	Services would only be able to make small incremental changes to UEC pathways.	Does not meet investment objectives or critical success factors.
3.2 One project tender	The Trust would procure via an Official Journal of the European Union (OJEU) compliant framework	Having one contract would require fewer contractual arrangements and legal documentation. There would be a single point of contact for the entire project, making project management easier. It would be easier to manage phases in the project and handovers, particularly where there is overlap. Fewer contractors on site would negate the need for separate contractor sites. Framework mechanism provides for KPIs and performance management of contractor. Whole project is priced as one.	Potential for single point of failure – ‘all eggs in one basket’. If contractor does not perform well on the early phases it is difficult to avoid using them for the remainder of the project. Risk that would have to terminate the contract and re-tender the remaining work. Use of Framework will attract a fee increasing the cost of the scheme overall. Limited choice of contractors available on the Framework. Will take longer to mobilise early phases as entire Project would have to be ready to tender. Timescale pre-tender would be longer More intense Project briefing/sign off period	Supports delivery of the investment objectives and CSF3
3.3 ProCure22 Partner	ProCure22 (P22) is a Construction Procurement Framework administrated by the Department of Health and Social Care for the development and delivery of NHS and Social Care capital schemes in England.	Negotiated terms and rates pre-arranged Short timescale for securing a contractor to begin work on site Cost certainty early - Guaranteed Maximum Price (GMP) arrangement Design and Build option available	Does not always offer the best value for money. P22 rates are high compared to market rates GMP usually high to absorb risk Changes to design during contract are expensive. Small pool of contractors Contractors are larger national contractors and have bigger overheads. Full cost cannot be guaranteed until full scope of works agreed and costed.	Supports delivery of the investment objectives and CSF3
3.4 Tender small packages of work via Trust tendering system	The Trust would utilise its own tendering process to tender small packages of work.	Ability to utilise existing preferred contractors. Larger pool of contractors to draw from. No Framework fee Tried and tested Tendering process Design and tender can be phased, with a shorter pre-tender timescale. Quicker to mobilise early phases as these	Later cost certainty (only complete after last phase is tendered). More parties involved in project, more contracts to manage. Multiple site set ups on site taking up more space. Interface between phases/handovers more difficult Contract management resource higher, valuations, contract admin duplicated multiple times.	Supports delivery of the investment objectives and CSF3

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
		could be released before later phases are designed and ready to tender. Fewer design team resources required on a phased tendered approach. Phased project briefing/sign off Less risk of single point of failure, as risk is spread over several phases.		

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iv. Implementation Timeframes

Consideration was then given to the options for implementing the programme of work to enable the reconfiguration of accommodation at the Hull Royal Infirmary. The BAU option was no longer applicable. Consideration was given to phasing of the works over a one year, two year or three year period.

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
3 years	Building works would be phased over 3 years	Enables the Trust to plan works around seasonal peaks in demand. Provides contingency for delays. Minimises disruption to services. Allows for effective planning and tendering of the project	Full benefits of the reconfiguration works would take longer to be realised.	Meets investment objectives and CSFs
2 years	Building works would be phased over 2 years	Enables the Trust to plan works around seasonal peaks in demand. Full benefits of reconfiguration could be delivered sooner.	Less time for planning, design, tender and delivery of the project. Less contingency for delays. Potential for increased operational disruption	Meets investment objectives and CSFs
1 year	Building works would be phased over 1 year	Full benefits of reconfiguration could be delivered in just over a year	Little time to plan, design, tender and deliver the project. No contingency for delays. Potential disruption to services over busy seasonal periods impacting on patient flow and increasing waiting times.	Meets investment objectives and CSFs

Initial estimates in relation to the timescale for the project indicate that a 3 year implementation period is less risky and more realistic in terms of the planning, tendering and delivery of the project. The preferred way forward for the Trust was to implement the project over 3 years. The option for implementation in one year was discounted.

Project	4.1 3 years	4.2 2 years	4.3 1 year
4. Implementation Outcome	PWF	CF	D

v. Funding Mechanism for the Project

This section of the Options Framework considers the funding options to deliver the project's preferred scope, solution, method of service delivery and implementation.

This Strategic Outline Case has been developed following a successful bid for STP capital funding of £19.3m to improve the provision of urgent and emergency care at the Hull Royal Infirmary. Therefore the funding options include the bid funding (subject to a successful business case). Other options for funding are also explored below.

Name	Description	Advantages	Disadvantages	Investment objectives and critical success factors
Trust Capital	Development would be funded from the Trust's own capital programme	None	The Trust has insufficient capital to support a development of this scale. As identified earlier, it already has a shortfall of £37m on its 3 year capital programme	Does not address investment objectives or CSF4
External Capital Funding (STP) only	Funding of £19.3m has been awarded as part of the STP Wave 4 capital development funding	External funding and therefore additional to Trust's own capital allocation	Capped at £19.3m for the whole scheme including building works and equipment.	Addresses investment objectives and CSF4
Loan Funding	Trust would seek to obtain a loan to cover the cost of the UEC development	External funding and therefore additional to Trust's own capital allocation	Cost of development would be increased overall as Trust would be required to pay back the original loan plus interest Trust does not have sufficient funding to meet loan repayments.	Meets investment objectives Does not meet CSF4

An appraisal of the funding sources was undertaken, the results for which are set out below.

Project	5.1 Trust Capital	5.2 External Capital Funding	5.3 Loan Funding
5. Funding Outcome	D	PWF	D

2.3.2. Summary of the Long List Using the Options Framework

The outcome of the long list options appraisal to determine the preferred way forward is summarised below.

Project	BAU	Option	Option	Option	Option	Do Min	Interm	Interm	Interm	Do Max
Service Scope	BAU	ED only	ED and existing diagnostics	ED and additional diagnostics	Ground floor devlpnt	CT MRI and asmnt	CT/MR U/snd Asmnt	Plus EAU paedts inpt	Plus ul/snd	Plus paedts WCH
	CF	D	D	D	D	CF	CF	CF	PWF	CF
Service solution	BAU					Single storey	SS with ul/sound	Three storey Small SACU	Three storey Large SACU	Two store Paed new build
	CF					CF	CF	CF	PWF	D
Service Delivery	BAU					OJEU	P22 Partner	Tenders		
	CF					CF	D	PWF		
Impl/ation						3 year	2 year	1 year		
						PWF	CF	D		
Funding						Trust cap	External (STP)	Loan		
						D	PWF	D		

2.3.3 Preferred Way Forward

The preferred way forward comprises the following elements:

- Reconfigure the front entrance to the ED, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional endoscopes, relocate the EAU, relocate the paediatric department, create additional adult inpatient capacity.
- This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a larger diagnostic suite on the ground floor with a large size Surgical Ambulatory Care Unit.
- The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases.
- The project will be implemented over 3 years.
- It will be funded through STP Wave 4 funding.

However, it should be noted that this is just the preferred way forward. It is not the preferred option at this stage. National guidance recommends that a further level of appraisal be undertaken to determine the preferred option.

2.4 Shortlist Options

In order to determine the preferred option for recommendation, guidance suggests that the preferred way forward ('recommended option') be assessed against three or more shortlisted options generated from the Options Framework outlined above. The Business As Usual (BAU) option is included as a benchmark for Value for Money (VfM), with a 'Do Minimum' and either a 'less ambitious' or 'more ambitious' option. The shortlist of options is summarised below. The numbering in each of the coloured boxes map to the option choices set out in the long list option framework in section 2.2.1.

Options	Business as Usual (BAU)	Do Minimum	Preferred Way Forward (PWF)	Less Ambitious PWF
Scope	1.1	1.6	1.9	1.8
Solution	2.1	2.2	2.5	2.4
Delivery	3.1	3.2	3.4	3.4
Implementation	n/a	4.2	4.1	4.1
Funding	n/a	5.2	5.2	5.2

A description of the shortlisted options, their advantages and disadvantages are given overleaf.

Description of Shortlisted Options

Name	Description	Advantages	Disadvantages
Business as Usual (BAU)	Urgent and emergency care pathways from the Emergency Department to assessment, admission and/or discharge are compromised by a lack of diagnostic and assessment capacity Current configuration of services and locations would be retained. The Trust would continue to use its in-house estates team to deliver business as usual	None	Delays in the diagnosis and treatment of patients who present to the ED or via direct GP referral to the assessment and ambulatory care areas. Delays in accessing diagnostic services for inpatients, high levels of bed occupancy and increased length of stay, with increasing pressure on the availability of inpatient beds. Paediatric assessment and inpatient services on 13th floor of the Tower Block are inadequate and remote from diagnostic and critical care facilities. The buildings and infrastructure will continue to contribute to delays in the urgent and emergency care pathway, resulting in longer waiting times, increased length of stay and a poor patient experience. Ongoing costs of outsourcing Would require more inpatient beds.
Do Minimum	Two storey extension to enable creation on ground floor of co-located imaging suite for CT and MRI, small SACU. New entrance to minors/GP area. Relocation of chapel and kitchen. The Trust would issue a single tender via an Official Journal of the European Union (OJEU) compliant framework. Building works would be phased over 2 years Funded from external Capital Funding (STP) only	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. Additional assessment capacity will enable increased provision of Same Day Emergency Care (SDEC) leading to reduced acute admissions where appropriate. Having one contract would require fewer contractual arrangements and legal documentation Enables the Trust to plan works around seasonal peaks in demand. Full benefits of reconfiguration could be delivered sooner. External funding and therefore additional to Trust's own capital allocation	Necessitates the reconfiguration of the ground floor of the Tower Block. No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity Whilst some inpatient capacity may be freed up through reduction in LOS, there will remain a requirement for additional inpatient beds over and above the existing establishment. Does not enable relocation of EAU and paediatrics. Paediatric services would remain on 13th floor. Size of SACU may be insufficient to address future needs. Potential for single point of failure – 'all eggs in one basket'. Less time for planning, design, tender and delivery of the project. Less contingency for delays. Capped at £19.3m for the whole scheme including building works and equipment.
Preferred Way Forward	Reconfigure the front entrance to the ED, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care	Necessitates reconfiguration of areas on the ground floor and 2nd floor of the Tower Block. Also enabling works to 13th floor. Paediatric services not relocated to the Women's and

Name	Description	Advantages	Disadvantages
	endoscopes, relocate the EAU, relocate the paediatric department, create additional adult inpatient capacity. This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a larger diagnostic suite on the ground floor with a large size Surgical Ambulatory Care Unit. The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases. The project will be implemented over 3 years. It will be funded through STP Wave 4 funding.	facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. CT/MRI, ultrasound and endoscopy capacity would be increased, reducing waiting times for diagnostics and assisting in the delivery of SDEC, reduced LOS and potentially freeing up some inpatient capacity. A larger SACU will enable the Trust to address growth in demand. Ability to utilise existing preferred contractors. Design and tender can be phased, with a shorter pre-tender timescale. Enables the Trust to plan works around seasonal peaks in demand. Provides contingency for delays. Minimises disruption to services. Allows for effective planning and tendering of the project	Children's Hospital. Later cost certainty (only complete after last phase is tendered). More parties involved in project, more contracts to manage. Multiple site set ups on site taking up more space. Interface between phases/handovers more difficult Contract management resource higher, valuations, contract admin duplicated multiple times. Full benefits of the reconfiguration works would take longer to be realised. The Trust has a shortfall on its existing capital funding and therefore would have to prioritise spend.
Less Ambitious PWF	Create 3 storey extension to the Tower Lock. Reconfigure 'walk in' entrance to the Emergency Department and provide 1 x additional MRI and 1 x additional CT scanning facilities on the ground floor of the Tower Block. Provide additional/replacement endoscopes, additional assessment capacity, relocate the Elderly Assessment Unit from the 2nd floor to the Ground Floor, and transfer paediatrics from the 13th to the 2nd floor. Create additional adult inpatient capacity - Smaller SACU. The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases. The project will be implemented over 3 years. Funding of £19.3m provided via Wave 4 STP capital development funding	Walk in patients can be triaged and signposted to the most appropriate professional, allowing an increase in the utilisation of the co-located primary care facility and less demand placed on the 'minors' side of the ED, potentially reducing waiting times in ED. CT/MRI and endoscopy capacity would be increased, reducing waiting times for diagnostics and assisting in the delivery of SDEC, reduced LOS and potentially freeing up some inpatient capacity. Design and tender can be phased, with a shorter pre-tender timescale. Enables the Trust to plan works around seasonal peaks in demand. Provides contingency for delays. Minimises disruption to services. Allows for effective planning and tendering of the project External funding only	No additional ultrasound capacity, thereby impacting on the ability to maximise Same Day Emergency Care, reduce length of stay, reduce outliers and release inpatient capacity. Necessitates reconfiguration of areas on the ground floor and 2nd floor of the Tower Block. Also enabling works to 13th floor. Paediatric services not relocated to the Women's and Children's Hospital. Later cost certainty (only complete after last phase is tendered). More parties involved in project, more contracts to manage. Multiple site set ups on site taking up more space. Interface between phases/handovers more difficult Contract management resource higher, valuations, contract admin duplicated multiple times. Full benefits of the reconfiguration works would take longer to be realised. Capped at £19.3m for the whole scheme including building works and equipment.

2.5 Summary Assessment of Options

A summary assessment of the four shortlisted options was undertaken to determine the extent to which each option complied with the Investment Objectives and Critical Success Factors identified in Sections 1.3.1 and 2.2. The outcome is detailed below.

Options	Business as Usual (BAU)	Do Minimum	Preferred Way Forward (PWF)	Less Ambitious PWF
Investment Objectives:				
1. Increase proportion of acute admissions/ presentations discharged on day of attendance	X	P	Y	P
2. Achieve compliance with UEC standards	X	P	Y	P
3. Achieve 90% compliance with 7DS Clinical Standard 5 for CT, MRI, Upper GI Endoscopy and Ultrasound	X	P	Y	P
4. Reduce the number of outliers and non-clinical inter-ward transfers by 50%	X	P	Y	Y
5. Improve clinical adjacencies of services to optimise clinical safety and efficiency, reduce clinical risk and improve patient/carers experience	X	P	Y	Y
Critical Success Factors:				
CSF 1: Strategic fit and business needs	X	P	Y	Y
CSF2: Potential value for money	X	P	Y	Y
CSF3: Supplier capacity and capability	X	P	Y	Y
CSF4: Potential affordability	X	Y	Y	Y
CSF5: Potential achievability	X	P	Y	Y
Summary:	Discounted	Possible	Preferred Way Forward	Possible

Key: X= Does not achieve P = Partial achievement Y = Achieves

2.6 Indicative Costs

The indicative costs for each of the short-listed options are set out below. They include some allowance for 'optimism bias' and the 'cost of risk'.

	Business as Usual	Do Minimum	Preferred Way Forward	Less Ambitious PWF
	£000	£000	£000	£000
Capital Costs	0	(13,900)	(19,268)	(18,964)
Revenue Costs	(538,240)	(480,080)	(574,583)	(551,341)
Total Costs	(538,240)	(493,980)	(593,851)	(570,305)
Cash Releasing Benefits	0	533,450	536,123	536,123
Total Net Costs	(538,240)	39,470	(57,728)	(34,182)
Total Costs Discounted	(104,270)	(74,246)	(90,526)	(86,128)
Total Benefits Discounted	0	103,921	104,433	104,433
Value for Money Ratio	0.0	1.4	1.2	1.2

Appendix 1 provides a more detailed summary of the indicative costs for each of the shortlisted options.

The table above shows the value for money is positive for all options apart from the 'Business as Usual' as expected. However, as the main benefits accrue to the CT/MRI replacement and the Surgical Ambulatory Care Unit (which is included in all of the 'do something' options), the value for money favours the 'do minimum', which excludes the Paediatrics reconfiguration. Further work will be undertaken to try and quantify additional savings associated with this element of the case or even how the Trust would incur additional costs if they did not progress the paediatric relocation.

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3. Overview of the Commercial Case

This section of the SOC describes the proposed procurement strategy for the investment as per the preferred way forward outlined in the Economic Case.

3.1 Required Services

The required products and services in relation to the preferred way forward are briefly as follows:

- Design team/consultancy appointments
- Project Management resource - either 'in-house' or external consultancy
- Building contract
- Supply of equipment

3.2 Potential for Risk Transfer

An initial assessment of the potential allocation of risk has been undertaken and is demonstrated in the following risk matrix.

Risk Category	Potential Allocation		
	Trust	Private	Shared
1. Design risk	✓		
2. Construction and development risk			✓
3. Transition and implementation risk	✓		
4. Availability and performance risk	✓		
5. Operating risk	✓		
6. Variability of revenue risks	✓		
7. Termination risks	✓		
8. Technology and obsolescence risks	✓		
9. Control risks	✓		
10. Residual value risks	✓		
11. Financing risks	✓		
12. Legislative risks	✓		

3.3 Proposed Charging Mechanisms

The Trust envisages that the project will be split into multiple phases with a contract for each phase.

3.4 Proposed Contract Lengths

This has not been determined at this stage. The draft programme for the preferred way forward indicates a combined project duration of up to three years.

3.5 Personnel Implications

It is anticipated that Transfer of Undertakings (protection of Employment) (TUPE) will not apply to this investment.

3.6 Procurement Strategy

3.6.1 Building

The Trust has explored the following procurement options:

- One project tender via an OJEU compliant Framework such as Yorbuild.
- ProCure22 Partner
- Several small packages of work via Trust tendering system (each project value would be below OJEU threshold.)

An assessment of the advantages and disadvantages of each of these is summarised overleaf.

One project tender via an OJEU compliant Framework	
Advantages • Having one contract would require fewer contractual arrangements and legal documentation. • There would be a single point of contact for the entire project, making project management easier. • It would be easier to manage phases in the project and handovers, particularly where there is overlap. • Fewer contractors on site would negate the need for separate contractor sites. • Framework mechanism provides for KPIs and performance management of contractor. • Whole project is priced as one.	Disadvantages • Potential for single point of failure – ‘all eggs in one basket’. If contractor does not perform well on the early phases it is difficult to avoid using them for the remainder of the project. Risk that would have to terminate the contract and re-tender the remaining work. • Use of Framework will attract a fee increasing the cost of the scheme overall. • Limited choice of contractors available on the Framework. • Will take longer to mobilise early phases as entire Project would have to be ready to tender. • Timescale pre-tender would be longer • More intense Project briefing/sign off period
ProCure 22 Partner	
Advantages • Negotiated terms and rates pre-arranged • Short timescale for securing a contractor to begin work on site • Cost certainty early - Guaranteed Maximum Price (GMP) arrangement • Design and Build option available	Disadvantages • Does not always offer the best value for money. • P22 rates are high compared to market rates • GMP usually high to absorb risk • Changes to design during contract are expensive. • Small pool of contractors • Contractors are larger national contractors and have bigger overheads. • Full cost cannot be guaranteed until full scope of works agreed and costed.
Tender small packages of work via Trust tendering system	
Advantages • Ability to utilise existing preferred contractors. • Larger pool of contractors to draw from. • No Framework fee • Tried and tested Tendering process • Design and tender can be phased, with a shorter pre-tender timescale. • Quicker to mobilise early phases as these could be released before later phases are designed and ready to tender. • Fewer design team resources required on a phased tendered approach. • Phased project briefing/sign off • Less risk of single point of failure, as risk is spread over several phases.	Disadvantages • Later cost certainty (only complete after last phase is tendered). • More parties involved in project, more contracts to manage. • Multiple site set ups on site taking up more space. • Interface between phases/handovers more difficult • Contract management resource higher, valuations, contract admin duplicated multiple times.

At this stage the Trust envisages procuring several smaller projects separated into phases to deliver the key elements of the project in relation to the preferred way forward.

3.6.2 Equipment Procurement

The following procurement route options will be considered for the procurement of the equipment outlined in the case for change.

- Full OJEU tender
- Direct purchase using NHS Framework Agreements
- Mini competition and purchase using NHS Framework Agreements.

The majority of the items of equipment are covered by existing NHS Framework Agreements. Each of these agreements has been put in place following a thorough procurement process conducted by NHS Supply Chain. Key issues relating to quality, reliability, timescales and value for money have been assessed through these procurement processes. The Framework Agreements have also been set up to comply with current procurement standards and regulations. As a principle, therefore, the Trust will seek to use the existing Framework Agreements in order to avoid repeating procurement work that has already been completed.

It is anticipated that the mini competition process will be used to inform the evaluation and selection of equipment that is being purchased using Framework Agreements. The Trust is keen to maximise the extent to which the equipment impacts positively on service delivery. Appropriate opportunity will therefore be created in each procurement process to explore options and ideas with different equipment suppliers.

The Trust will work with NHS Supply Chain to achieve best value for money through the procurement process.

3.7 FRS 5 Accountancy Treatment

It is envisaged that the assets underpinning the delivery of service will be on the balance sheet of the organisation.

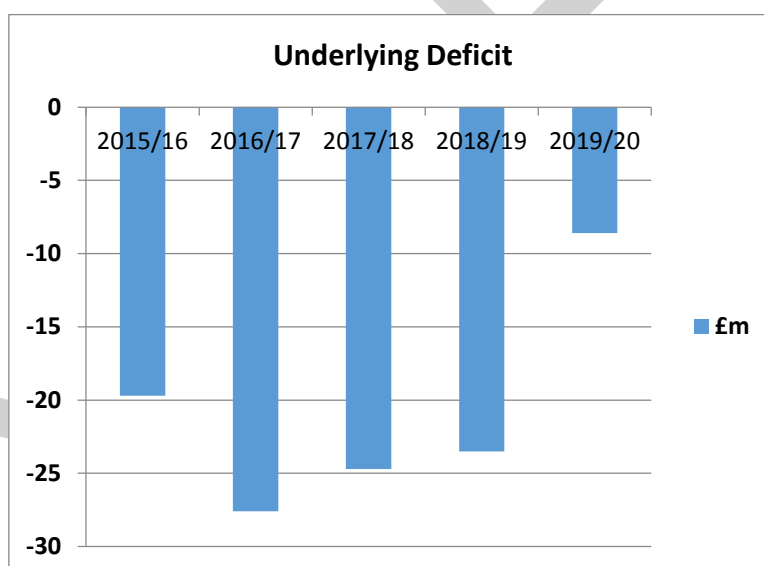
4. Overview of the Financial Case

The purpose of this section is to set out the likely financial implications of the preferred way forward which is to reconfigure the front entrance to the ED, provide additional CT, MRI and Ultrasound on the ground floor of the Tower Block, replace and provide additional endoscopes, relocate the EAU, relocate the paediatric department, and create additional adult inpatient capacity. The main source of capital funding is Public Dividend Capital from the Wave 4 STP allocations.

4.1 Financial Position of the Trust

The Trust reported an adjusted surplus of £25.2m in 2018/19 which was supported by the receipt of £10.7m core Performance and Sustainability Funding (PSF) along with £16.5m of incentive PSF. In addition, the Trust managed to deliver the financial position through non-recurrent income streams and balance sheet management. The true underlying financial position as at the end of 2018/19 was a deficit of circa £23.5m.

Moving into 2019/20, the underlying position of the Trust was boosted by the tariff price increases, contributing £8.8m for HUTH along with the recovery of the Marginal Rate Emergency Tariff (MRET) of £2.1m. Additional CRES above the 1.1% tariff assumption along with the gains from the above have resulted in an improved underlying position, currently assessed at circa £8.6m deficit. The journey of improvement is depicted below.



The Trust has developed a financial plan for 2019/20 and whilst the Trust is forecasting to deliver its £1.4m control total surplus (excl PSF) in this year, the latest forecast of the recurrent underlying position is circa £8.6m due to the non-recurrent nature of the identified CRES schemes. The assumption in delivering the Trust's control total for 2019/20 includes the delivery of an overall £18.8m efficiency programme.

The plan for 2019/20 delivers an overall financial risk rating of 3 which is mainly due to the high liquidity and capital service cover risk ratings of 4 as the maximum risk rating can only be a 3, whilst there are ratings of 4 in the assessments.

Plan Risk Ratings	Plan 31/03/2020 Rating
Capital Service Cover rating	4
Liquidity rating	4
I&E Margin rating	1
Variance From Control total rating	1
Agency rating	1
OVERALL RISK RATING	3

The Trust has developed a Capital Programme for 2019/20 which is based on assessments received and reviewed at the Trust's Capital Resource Allocation Committee (CRAC). CRAC undertook an exercise to quantify the funding requirements for the next three years. These assessments were based on a "do minimum" basis and did not make any provision for expansion in capacity or any developments. Over the 3 year period capital investment totalling £71m was identified versus circa £30m of internal resources from depreciation. The capital funding constraint is a major risk for the Trust and particularly with regard to the increases in demand for diagnostics and the impact on equipment requirements and non-elective pathways.

4.2 Capital Expenditure

A summary showing the capital cost of the preferred way forward is shown in the table below.

Capital Expenditure	Preferred Way Forward £000
Equipment	4,844
IM&T	20
Building	14,404
Total	19,268
STP PDC Funding	19,268
Shortfall in Funding	(0)

The detailed estimations of the scheme's capital costs are included at Appendix 2. At this stage of the business case no VAT recovery on the capital project has been assumed until the work can be progressed on to the detailed designs, contract and procurement process.

The lifecycle replacement of the assets is currently excluded from the case as this will be the responsibility of the Trust to fund over the life of the assets.

The capital cost includes 23 % for optimism bias and risk. The figures will be further refined once the project enters into the detailed design and tender award process.

4.3 Revenue Costs

The revenue running costs of the scheme make provision for the staffing requirements for the operation of the additional scanners and the additional ambulatory care/assessment

capacity, the maintenance of the scanners and the additional endoscopes, as well as the capital charges associated with the capital investment.

The estimate of the first full year of revenue costs are shown in the table below, excluding inflation:

Revenue Costs Summary					
		Pay £000	Non-pay £000	Cap Charges £000	TOTAL £000
CT/MRI		(1,234)	(317)		(1,551)
Ultrasound		(245)			(245)
SACU		(599)	(130)		(728)
Scopes			(176)		(176)
Facilities			(274)	(1,459)	(1,733)
TOTAL		(2,077)	(897)	(1,459)	(4,433)
Less Costs from Business as Usual		1,910	2,099		4,009
NET COST		(167)	1,202	(1,459)	(424)

Note that the above table includes the savings that have been assumed relating to savings from the costs of the Business as Usual (BAU) and this is mainly from the continued outsourcing and the requirement for additional bed capacity if the additional diagnostics and ambulatory care/assessment capacity was not progressed.

4.4 Accounting Treatment

The ownership of the assets is confirmed and would appear on the asset register for HUTH. These assets would be treated as on balance sheet for HUTH and therefore subject to the relevant accounting standards under IFRS regulations.

The split of costs between revenue and capital is confirmed as being in line with the current capitalisation policy.

4.5 Impact on the Statement of Comprehensive Income (SoCI)

The impact on the Trust's SoCI is illustrated overleaf.

There is support from the local commissioners who recognise that until this development is completed, there will be cost pressures within the Trust relating to outsourcing and additional bed capacity. The assumption is therefore that these cost pressures would be funded within the Aligned Incentive Contract (AIC) and therefore the savings have been included to show the net change in costs. The net increase of £424k is mainly driven by the additional capital charges of the development.

Revenue Expenditure Full Year Effect	Preferred Way Forward £000
Pay	
Medical Staff	(574)
Nursing & Midwifery Staff	(308)
Scientific, Therapeutic & Technical Staff	(698)
Administrative & Clerical	(69)
Healthcare Assistants & Other Support Staff	(428)
Cost Avoidance Pay	1,910
Total Pay	(167)
Non-Pay Expenditure	
Clinical Supplies & Services	(210)
Establishment Expenditure	(344)
Premises & Fixed Plant (maintenance)	(344)
Cost Avoidance Non Pay	2,099
Total Non-Pay Expenditure	1,202
Operating Expenses Total	1,034
Non Operating Items	
Depreciation (+ve)	(845)
PDC Dividends Payable (+ve)	(614)
Total Non Operating Items	(1,459)
Retained Surplus / (Deficit) for the Year	(425)

Impact on Statement of Comprehensive Income

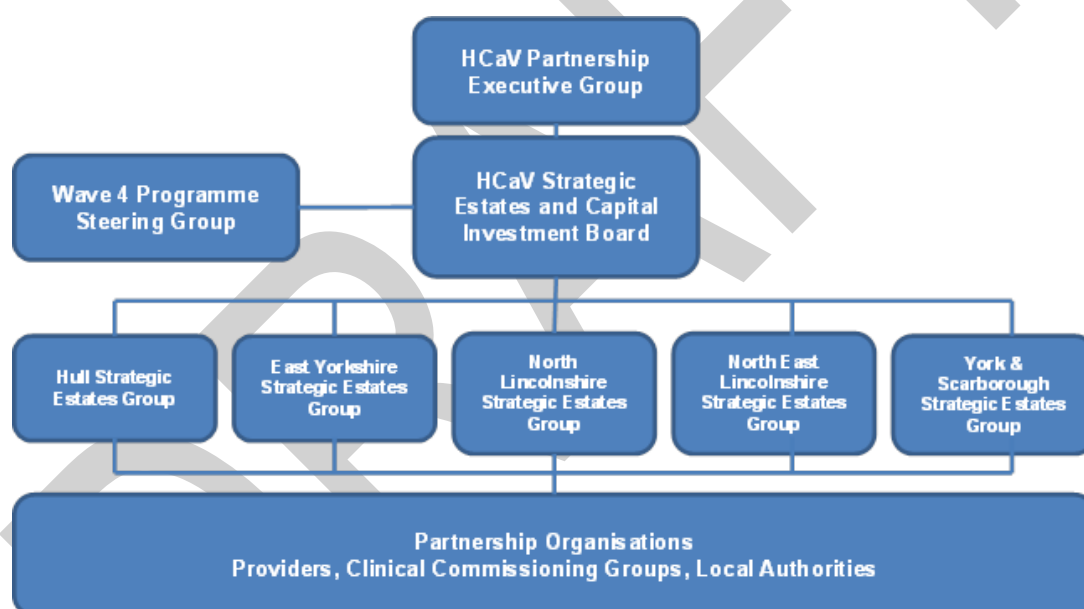
5. Overview of the Management Case

This section sets out the future project management arrangements. Its purpose is to explain the actions that will be required to ensure the successful delivery of the scheme in accordance with best practice.

5.1 Programme Management Arrangements

The scheme is an integral part of the Humber Coast and Vale (HCaV) Partnership Wave 4 STP programme which comprises a portfolio of projects with a total capital value of £88.5m for the reconfiguration of facilities at four acute hospital sites (including accommodation, diagnostic equipment and enabling engineering infrastructure). It is intended to support the transformation of urgent and emergency care services, enabling safer and more effective management of the acutely ill patient.

A separate Steering Group has been established to oversee the planning and delivery of the Partnership's Wave 4 programme and reports to the HCaV Strategic Estates and Capital Investment Board as set out below. The Partnership Executive group acts as the overall Programme Board and will have a key role in supporting the organisations in the partnership in decision-making and overseeing the progress of the Wave 4 Development Programme.



HCV Estates Governance Structure

5.2 Project Management Arrangements

The Trust places particular importance on effective project management arrangements and will establish robust project structures, systems and processes to ensure that the Urgent and Emergency Care Development at HUTH is delivered successfully.

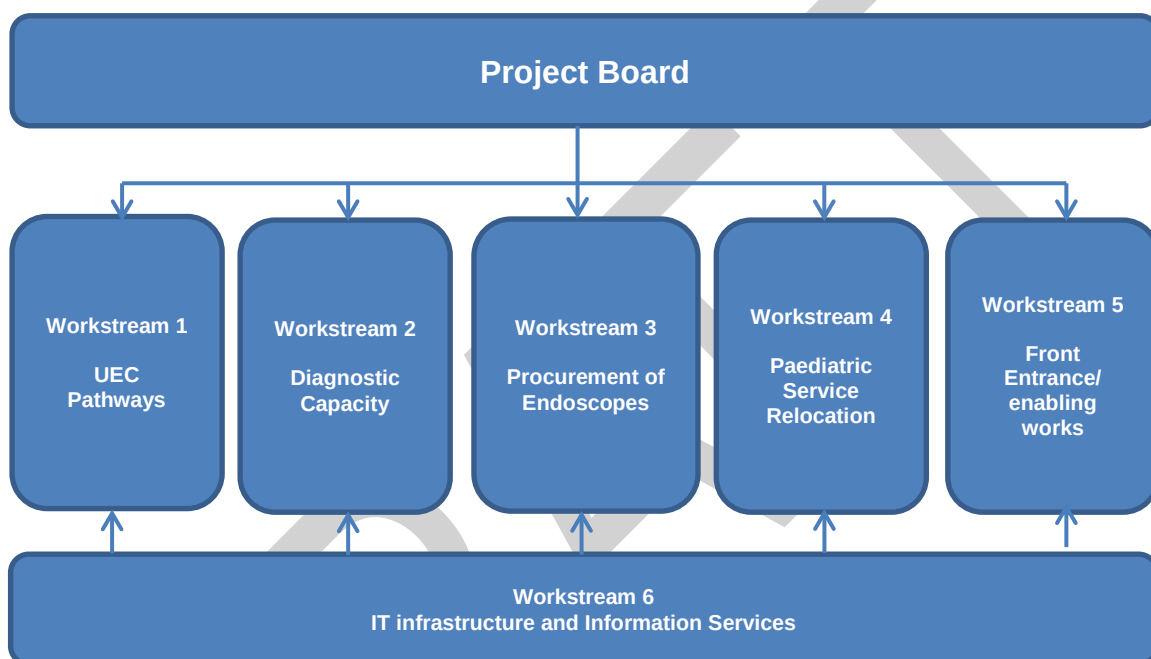
Given the scale and complexity of the development, it is essential that each stage is properly managed and resourced. This will ensure that changing service needs are appropriately considered, that service requirements are reflected in the reconfiguration of the Tower Block, procurement plans and equipment specifications, and that anticipated benefits are realised. The project will be managed in accordance with Capital Investment Manual principles.

5.2.1 Project Reporting Structure

In order to agree the preferred clinical model and the reconfiguration of services, a project reporting structure has been established with 6 linked workstreams as follows:

7. Urgent and Emergency Care Pathways
8. Diagnostic Capacity
9. Procurement of Endoscopes
10. Paediatric Service Relocation
11. Front Entrance/enabling works
12. IT infrastructure and Information Services.

The reporting structure is set out below:



The Project Board reports to the Executive Management Committee (EMC) and Capital Resource Allocation Committee (CRAC) and has been established in accordance with the Trust's Standing orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Project Board will agree the scope of the project and ensure that it is governed, directed, delivered and managed on time within the resources available. The Project Board will maintain their knowledge and control of the project through monthly meetings.

The Project Board will be chaired by the Senior Responsible Owner (SRO) for the project. The SRO is the Chief Operating Officer who has been delegated responsibility by the Executive Management Committee. In the absence of the SRO a nominated deputy will chair the meeting.

The SRO will ensure that:

- the project meets its objectives and delivers the expected benefits;
- the overall development project and each aspect of the project within it are managed in an appropriate manner;

- the business case is continually reviewed throughout the duration of the development project.
- an appropriate project organisation structure and communication processes are established;
- all changes to the scope of the project and the approach to delivering the brief are approved;
- adequate resources are made available to the project.

Each of the project workstreams reports formally to the Project Board via the workstream lead. The workstream teams will meet at least monthly.

Terms of Reference for the Board and workstreams have been developed and will be reviewed accordingly as the project moves through the planning, detailed design and delivery phases.

A project budget will be established to enable the business case to be developed. This will include funding to appoint external consultants and design team(s).

5.2.2 Project Roles and Responsibilities

5.2.2.1 Project Board

The Project Board is responsible for:

- Ensuring that the Project objectives and the scope of the workstreams have been clearly defined and any material changes are formally approved by the Executive Management Committee and also Humber Coast and Vale (HCaV) HCP.
- Providing overall strategic direction for the Project.
- Approving and signing off all key project documentation. These shall include but are not limited to specific project briefs, the Strategic Outline Case, the Outline Business Case and the Full Business Case.
- Agreeing all major plans.
- Ensuring a robust Project timetable has been produced and is monitored.
- Ensuring that the Project is effectively monitored and authorising any major deviations from the agreed project stage plans.
- Overseeing the delivery of all the projects within the defined parameters of time, cost and to the required quality and specification.
- Ensuring that the cost implications of the Project are fully set out within financial plans and that it remains within the Trust's overall affordability.
- Ensuring an effective project management reporting system is in place including current and planned expenditure relating to the delivery of the Project.
- Communicating information about the Project and the associated workstreams to key stakeholder groups including HCaV Partnership.
- Ensuring that the required resources are available to successfully deliver the Project.
- Ensuring there is an effective risk management system in place and that regular reports on risks and issues are effectively acted upon.
- Approving plans for post project reviews and ensuring these are scheduled and take place.
- Resolving any deviations from plans and escalating as necessary
- Resolving conflicts between the workstreams, end users, contractors and escalating as necessary.

Membership of the Project Board is as follows:

- Chief Operating Officer (Senior Responsible Owner and Chair)
- Director of Strategy and Planning (Vice Chair)

- Chief Financial Officer
- Director of Estates, Facilities and Development
- Member of Health Group Triumvirates
- UEC Development Project Leads
- Improvement Lead

The Project Board will receive regular progress updates from the workstream leads regarding individual projects and will oversee the timeline for procurement and the allocation of resources.

5.2.2.2 Workstream Teams

The individual teams leading the workstreams are responsible for:

- Reviewing the urgent and emergency care pathways by determining the existing arrangements and what is required to close the gap between where we are now and where we want to be in the future.
- Designing and implementing new models of care for the acutely ill patient.
- Agreeing the future facilities requirements, key functional relationships and service support spaces to support the new models of care.
- Completing a project briefing document in respect of their individual workstream.
- Communicating information about their workstream to the organisation and stakeholders as necessary.
- Ensuring effective staff engagement in the planning, design and development process.
- Providing documentation that will give assurance that the workstream is being managed efficiently and in line with Trust policies and procedures.
- Managing the workstream to ensure continued service delivery and performance targets, supported by contingency plans and monitoring of timescales.
- Resolving deviations from plans or escalating as necessary.

5.2.2.3 Project Director

A Project Director will be appointed to oversee the Urgent and Emergency Care Project.

5.2.2.4 Project Manager

A dedicated Project Manager has been appointed and is currently working under the direction of the Director of Estates, Facilities and Development to obtain, manage and monitor external consultants, contractors and suppliers, as well as implement the project plan. The Project Manager will develop a Management Control Plan with each Workstream Team that will specify actions and timescales, consistent with those set out in the overarching UEC Development Project Plan.

The Project Manager will also ensure that adequate communication mechanisms exist within the project and between the workstreams and the rest of the Trust.

5.3 Outline Project Plan

Key dates in the provisional Management Control Plan are provided below:

Milestone Activity	Timescale
Strategic Outline Case completed	Sept 2019
Outline Business Case	April 2020
Full Business Case	Oct 2020
Construction start date	Jan 2021

5.4 Use of Special Advisors

Special Advisors have been used in accordance with the Treasury Guidance: Use of Special Advisors. Details are set out in the table below.

Special Advisors	Advisor
Financial	QS – Derrick Kershaw Partnership (DKP)
Architect	HLM Architects
Local Council Planning	Kingston Upon Hull City Council

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Shortlisted Options – Indicative Costs

	Preferred Way Forward						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6-60	Total
	£000	£000	£000	£000	£000	£000	£000
Capital Costs	(11,690)	(5,062)	(2,516)	0	0	0	(19,268)
Revenue Costs	(1,493)	(4,122)	(4,867)	(5,031)	(5,112)	(553,958)	(574,583)
Total Costs	(13,183)	(9,184)	(7,383)	(5,031)	(5,112)	(553,958)	(593,851)
Cash Releasing Benefits	2,124	4,347	4,447	4,549	4,654	516,002	536,123
Total Net Costs	(11,059)	(4,837)	(2,936)	(482)	(458)	(37,956)	(57,728)
Total Costs Discounted	(10,423)	(6,124)	(4,689)	(2,675)	(2,584)	(64,032)	(90,526)
Total Benefits Discounted	2,017	3,917	3,784	3,656	3,533	87,527	104,433
Value for Money Ratio	0.2	0.6	0.8	1.4	1.4	1.4	1.2
	Less Ambitious Preferred Way Forward						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6-60	Total
	£000	£000	£000	£000	£000	£000	£000
Capital Costs	(11,143)	(5,062)	(2,759)	0	0	0	(18,964)
Revenue Costs	(1,397)	(3,926)	(4,671)	(4,831)	(4,910)	(531,606)	(551,341)
Total Costs	(12,540)	(8,988)	(7,430)	(4,831)	(4,910)	(531,606)	(570,305)
Cash Releasing Benefits	2,124	4,347	4,447	4,549	4,654	516,002	536,123
Total Net Costs	(10,416)	(4,641)	(2,983)	(282)	(256)	(15,604)	(34,182)
Total Costs Discounted	(9,907)	(5,975)	(4,748)	(2,528)	(2,443)	(60,526)	(86,128)
Total Benefits Discounted	2,017	3,917	3,784	3,656	3,533	87,527	104,433
Value for Money Ratio	0.2	0.7	0.8	1.4	1.4	1.4	1.2
	Do Minimum						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6-60	Total
	£000	£000	£000	£000	£000	£000	£000
Capital Costs	(10,175)	(1,913)	(1,812)	0	0	0	(13,900)
Revenue Costs	(1,240)	(3,432)	(4,042)	(4,191)	(4,258)	(462,917)	(480,080)
Total Costs	(11,415)	(5,345)	(5,854)	(4,191)	(4,258)	(462,917)	(493,980)
Cash Releasing Benefits	2,124	4,326	4,425	4,527	4,631	513,417	533,450
Total Net Costs	(9,291)	(1,019)	(1,429)	336	373	50,500	39,470
Total Costs Discounted	(8,939)	(3,372)	(3,704)	(2,248)	(2,173)	(53,810)	(74,246)
Total Benefits Discounted	2,017	3,898	3,765	3,638	3,515	87,087	103,921
Value for Money Ratio	0.2	1.2	1.0	1.6	1.6	1.6	1.4
	Business as Usual						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6-60	Total
	£000	£000	£000	£000	£000	£000	£000
Capital Costs	0	0	0	0	0	0	0
Revenue Costs	(4,249)	(4,347)	(4,447)	(4,549)	(4,654)	(515,994)	(538,240)
Total Costs	(4,249)	(4,347)	(4,447)	(4,549)	(4,654)	(515,994)	(538,240)
Cash Releasing Benefits	0	0	0	0	0	0	0
Total Net Costs	(4,249)	(4,347)	(4,447)	(4,549)	(4,654)	(515,994)	(538,240)
Total Costs Discounted	(3,953)	(3,836)	(3,707)	(3,581)	(3,461)	(85,733)	(104,270)
Total Benefits Discounted	0	0	0	0	0	0	0
Value for Money Ratio	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Preferred Way Forward – Capital Costs

Capital Costs Summary

	Cost Exc. VAT £	VAT £	Cost Incl. VAT £
1. Departmental Costs (from Form SOC2)	8,627,500	1,725,500	10,353,000
2. On-Costs (from Form SOC3) 0.00 % of Departmental Cost	0	0	0
3. Works Cost Total (1+2) at PUBSEC 250 (*Tender Price index level 1975 = 100 base)	8,627,500	1,725,500	10,353,000
4. Provisional location adjustment (if applicable) -10.00 % (of line 3)	-862,750	-172,550	-1,035,300
5. Sub-Total (3+4)	7,764,750	1,552,950	9,317,700
6. Fees 10.00 % (of sub-total 5)	776,475	n/a	776,475
7. Non-Works Costs (from Form SOC4)	14,058	2,812	16,870
8. Equipment Cost (from Form SOC2) 31.87 % (of Departmental Cost)	2,750,000	550,000	3,300,000
9. Contingencies 10.00 %	1,130,528	226,106	1,356,634
10. TOTAL (for approval purposes)	12,435,811	2,331,867	14,767,678
10A. Optimism Bias (after mitigation) 15.00 %	1,865,372	373,074	2,238,446
10B. TOTAL (for approval purposes)+Optimism Bias	14,301,183	2,704,941	17,006,124
11. Inflation : at + 13.18 %	1,884,897	376,979	2,261,876
12. FORECAST OUTTURN BUSINESS CASE TOTAL (to suit award of contract for Works in 4Q2020)	16,186,080	3,081,920	19,268,000

NB: Fees (including uplift for contingencies, optimism bias and inflation) equates to 6.87% of the Forecast Outturn Business Case Total (excluding VAT)

**Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
Held on 29 July 2019**

Present:	Mr S Hall	Vice Chair (Chair)
	Mr M Gore	Non-Executive Director
	Mr T Curry	Associate Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs M Kemp	Deputy Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mr D Taylor	Director of Estates Facilities and Development (Item 8.1.3 only)
	Mrs J Railton	Assistant Director Strategy and Planning (Item 8.1.3 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	Apologies for Absence: Apologies were received from Mrs T Christmas, Non-Executive Director and Mrs T Cope, Chief Operating Officer	
2	Declarations of interest There were no declarations of interest raised.	
3	Minutes of the meeting held on 24 June 2019 Item 13.1 Improvement Programme Update – paragraph 4, a sentence to be added to the minutes; “The Committee discussed and questioned the savings generated by the HIP team, they also questioned whether the savings would have been delivered without the team’s involvement.” Following the above amendment the minutes were approved as an accurate record.	
4	Matters arising from the minutes Mrs Kemp agreed to send Mr Gore a report showing the average time of discharges.	MK

The agenda was taken out of order at this point

8.1.3 Urgent and emergency care business case

Mrs Railton and Mr Taylor presented the draft strategic outline business case to the Committee. She advised that the business case detailed the proposed reconfiguration of the front entrance to allow for Primary Care streaming to allow for the siting of an additional CT and MRI scanner Paediatrics would be relocated to a second floor extension.

The projected cost over 3 years was £23m.

There was a discussion around moving paediatrics and Mr Taylor advised that the move offered good links with diagnostics and theatres. There was also clinical buy in from the Paediatric service.

Mr Bond expressed his concern regarding the £23m costs as the Wave 4 scheme funding was for £19m. He was also concerned regarding the 13th floor and the empty paediatric ward as only a basic ward accommodation scheme had been built into the costings.

The Committee discussed the issues and costs at length as well as the next steps. Mrs Railton advised that the next step was to discuss the business case with the Humber Coast and Vale HCP Wave 4 Steering Group.

Mr Gore suggested that the team presented the brief as it was and built in the impact on patient care if the upgrades were not carried out. He also stated that they were necessary to meet the increase in demand.

Resolved:

The committee noted the contents of the business case and agreed the release for review and comparison by the HCaV HCP Wave 4 Steering Group. The Committee also asked the project team to review the costs with a view to developing a further option that remained within the original £19m funding limit. Further option to be presented to the Committee.

JR/DT

The agenda returned to order at this point

5 Action Tracking List

Mr Bond had not yet received the report from NHS Improvement relating to productivity and efficiency opportunities.

LB

Mrs Kemp updated the Committee regarding 7 day working and advised that GI endoscopy and gastroscopy would be increasing to beyond 5 days in September.

It was agreed that the Scan4Safety item could be removed from the tracker.

6 Workplan

The workplan was reviewed by the Committee. It was agreed that Same Day Emergency Care would be added to the workplan to receive reports on a quarterly basis.

CR

7 Board Assurance Framework

Ms Ramsay presented the report and advised that it would be presented at the Board tomorrow. The report included the Q1 ratings, positive assurance and any gaps in assurance. None of the risk ratings had been changed since the last report.

Ms Ramsay advised that all of the BAF topics would be covered either in board development session or in the Trust Board meetings. The highest risks would be discussed earlier in the year to ensure forward plans were in place.

There was a discussion around the two staffing risks and Mr Bond asked if they were set too high. Mr Nearney stated that staff behaviours, leadership, culture and engagement all contributed to staff morale which impacts on productivity. Mr Nearney wanted both risk ratings to remain at 15.

The Committee discussed BAF 4 and contractual performance. Mr Gore

was concerned that the Trust was not achieving its trajectories in some areas and was not confident that performance could be recovered by the year end. Further discussion regarding BAF 4 would be held at the Board meeting tomorrow.

Resolved:

The Committee received and accepted the report.

8 8.1 Exception reports

Mrs Kemp advised that the Trust had seen improvements in ED and the number of patients not treated within 28 days following last minute cancellations. The Trust was also managing to hold the zero 52 week wait position.

ED Performance had improved in June following the inclusion of type 3 activity and was at 84.5%.

The performance for July 2019 was 85.6% with average daily attends of 404 patients. The Chief Executive and Chief Operating Officer were discussing ED on weekly performance calls with NHS I.

Mrs Kemp also spoke about the recent visit from NHS I and Mr Bas Sen (Regional Clinical Advisor). The visit lasted all day on 8th July 2019 and the team witnessed a stretched Emergency Department. An action plan has been put into place since the visit and meetings held with the Health Groups to ensure the actions are implemented. There was now a full capacity protocol in place and action cards outlining the escalation rules should the protocol be triggered.

There was a discussion around increasing discharges earlier in the day and balancing this with crowding at the front end. Mrs Kemp spoke of a mental health patient that had been on a ward for 3 weeks and the lack of provision from the mental health service to ensure timely discharges.

The Committee discussed the Primary Care position and the patients attending the ED who cannot get an appointment with their GP.

Mr Nearney reported that there would be new management arrangements in ED and a new Medical Director would be recruited. The issue around GP cover in ED had been escalated to the Chief Executive who was discussing recruitment difficulties with the CCGs.

RTT was below the planned trajectory at 75.75%. ENT, gynaecology, ophthalmology, plastic surgery and cardiology are the key specialties with patients over 18 weeks. This accounted for half of all patients over 18 weeks.

52 week breaches were holding at zero but there were a number of risk areas and cardiology was the biggest risk.

Diagnostics had seen a deterioration in June to 8.71%. One of the reasons for the increase in demand was due to recent health campaigns.

Cancer 62 day screening had deteriorated in May due to access to diagnostics and 62 day cancer performance was also down due to

operational factors such as theatre capacity and access to the theatre which houses the robot.

Mr Gore expressed his concern regarding ENT performance and Mrs Kemp advised that the risks were being managed on a daily basis by the Operational Management Team.

The Committee discussed 'Same Day Emergency Care' and same day discharges. Mrs Kemp advised that a task and finish group had been established to review this. She reported that Lorenzo was not able to accommodate Same Day Emergency Care yet.

Resolved:

The Committee received and accepted the report.

8.1.1 Update on reducing 21 day LOS by 20%

As at 24th June the Trust had achieved 19 (15%) occupied bed day reduction against the 19/20 target of 49 bed reduction by March 2020. This was just above the trajectory submitted.

Resolved:

The Committee received and accepted the update.

8.1.2 Feedback from ECIST visit

It was agreed that this item would be discussed at the Board Development session on 12th August 2019.

Resolved:

The Committee agreed to receive this item at the Board Development session on 12th August 2019.

9.1 Demand and Activity Report

Mrs Drury presented the report and advised that referrals on the whole had increased from this time last year by 5.1%.

The main reason for the increase in non-GP referrals was due to the transfer of community paediatrics from CHCP as well as increases in ED referrals, optometrists and dentists, consultant to consultant and self-referrals.

Referrals to Spire were still lower than the last two years but there had been an increased number of cataract patients using private providers. Advice and guidance referrals had increased by 100%.

Overall elective activity is 53 cases above plan at the end of June but areas that are below plan include; ENT, cardiology, oral surgery, neurosurgery and Trauma and Orthopaedics.

Outpatients were above plan by 9.8% and there was a drive to reduce face to face follow ups by having telephone appointments.

The Trust had seen significant increases in ED attends with daily averages above 400.

Non elective was above plan with some case mix changes being reviewed.

The coding team were helping with case mix queries.

Resolved:

The Committee received and accepted the report.

10.1 Finance Report

Mr Bond presented the report and advised that at the end of June the Trust was reporting a deficit of £1.4m which was in line with the plan. This included PSF on the basis that it is in line with plan.

Mr Bond advised that income has been reduced by £0.8m due to an accrual for a potential claim from Specialist Commissioners on the grounds of incorrect costing and coding.

Mr Bond advised that the Health Groups were mainly in line with plan apart from the Surgery Health Group which was showing a £300k deterioration. He reported that this was mainly due to agency costs for consultants due to gaps in the Junior Doctor rotas and cover in anaesthetics following recent job planning exercise, where a number of doctors had reduced their job plan commitments. Anecdotally this is due to the pension tax issue.

There was an assumption in the plan that the Trust receives additional income to cover the costs incurred in delivering the Community Paediatrics service that had now transferred from CHCP.

Mr Bond advised that liquidity was stable and the Trust was still waiting to hear about the Capital plan from the centre.

Mr Bond advised that the Trust is currently forecasting that it would deliver the financial plan.

Resolved:

The Committee received and accepted the report.

10.2 CRES Report

Mr Bond presented the CRES report and expressed his concern regarding the lack of schemes which could cause a £5-6m problem.

Mr Gore suggested benchmarking against other Trusts to uncover new schemes and Mr Bond advised that he was working with Nottingham and Coventry Hospitals and would report back any progress.

SE

At month 3 the Trust was reporting £2.6m savings against the £2.5m target.

Resolved:

The Committee received and accepted the report.

10.3 Impact of pension issue on consultant activity

Mr Bond presented the report which included a return that the Trust was expected to complete on a monthly basis collecting information regarding consultants reducing their hours due to the pension cap.

Mr Bond advised that the numbers were low at the moment but expected them to grow in the future. He added that he was working with Mr Nearney and KPMG to work with the Consultants to come up with a solution and

manage income and pensions in a different way. Once a way forward was agreed a paper would be presented to the Remuneration Committee.

Resolved:

The Committee received and accepted the report. It was agreed that the same report would be presented on a monthly basis.

LB

11.1 Variable Pay Report

Mr Nearney presented the report and advised that the Trust had spent £7.6m on variable pay. Benchmarking information showed that the Trust was not an outlier.

Mr Nearney advised that policies were in place to ensure any expenditure over the NHS I cap would be signed off by the appropriate authorised personnel and reported to NHS I.

Resolved:

The report was received and accepted by the Committee.

11.2 Job Vacancy Report

Mr Nearney presented the report and advised that the Trust's current position was at 12.3% consultant vacancy rate.

The Junior Doctor vacancy rate was at 13.45% and the current nurse and midwifery vacancies were 9.22%.

Mr Nearney advised that work was ongoing with the Health Groups, e-Rostering had been launched for the junior doctors and Nursing Associates were in place. He also spoke of the leadership programme for clinical leads to ensure junior doctors were supported.

Resolved:

The Committee received and accepted the report.

12 Assurance and Governance

12.1 Capital Resource Allocation Committee Minutes

The minutes were received for information.

12.2 Carter Minutes

The meeting of 18th June 2019 had been cancelled.

13 Other Items

There were no other items on the agenda.

14 Items delegated by the Board

There were no items delegated by the Board.

15 Any other business

Mrs Thompson advised that the timing for the Performance and Finance Committee in August would be changing from 1.30pm – 4.30pm to 12pm – 3pm. She agreed to send an email nearer the time to confirm.

RT

Mr Gore spoke about the transitional changes to the pension issues and a problem that had been raised by the BMA relating to senior clinicians and protection around their pensions. Mr Bond added that the issue was creating

major problems for the NHS as a whole.

16 Date and time of the next meeting:

Tuesday 27 August 2019, 12pm – 3pm, The Committee Room, HRI

**Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance meeting
Held on 27 August 2019**

Present:	Mr S Hall	Vice Chair/Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mrs A Drury	Deputy Finance Director
	Ms C Ramsay	Director of Corporate Affairs

In Attendance:	Mr M Gill	Auditor RSM
	Mr C Vize	Medical Director, F&W Health Group
	Mrs J Harrison-Mizon	Director of Operations, F&W Health Group
	Mr D Haire	Divisional General Manager, F&W Health Group
	Mrs R Thompson	Corporate Affairs Manager

Mr Hall introduced the Committee to Mr Mike Gill from RSM who was in attendance due to an audit of the Committee governance processes.

No	Item	Action

1 Apologies:

Apologies were received from Mrs T Christmas, Non-Executive Director, Mr S Nearney, Director of Workforce and OD and Mr S Evans, Deputy Director of Finance.

2 Declarations of interest

There were no declarations of interest made.

3 Minutes of the meeting held on 29 July 2019

Item 8.1 – paragraph 12, sentence to read, “Mr Gore expressed his ongoing concern regarding ENT performance....”

Following this change the minutes were approved as an accurate record of the meeting.

4 Matters arising from the minutes

Item 8.1 – paragraph 7. Mr Bond asked if the new Medical Director had been recruited within the ED and Mrs Cope reported that an appointment had been made and would be in post by October 2019.

Item 10.2 CRES Report – paragraph 2. Mr Bond reported that he would bring benchmark information from Coventry Hospital Trust to the next meeting.

LB

4.1 UEC Update

Mr Bond advised that a new option (which incorporated the Capital Programme and the MRI/CT developments) had been developed around the £19m mark and the final version would be presented to the Board.

5 Action Tracking List

The follow up report to be removed from the Tracker as it was included on this agenda.

6 Workplan

Ms Ramsay presented the Workplan and advised that the Lord Carter of Coles minutes had been moved to September 2019 as the previous meeting was cancelled and the Same Day Emergency Care pilot report would be received in October 2019.

7 Board Assurance Framework

Ms Ramsay presented the report and advised that none of the ratings had changed since the BAF was agreed at the Board in July 2019.

Ms Ramsay reported that a number of risk areas would be considered in the meeting such as the impact of the consultant pension issue and capital funding for the critical infrastructure developments. Mr bond added that 2 major capital schemes would be supported over the next 4 years and would be included in the long term plan.

Mr Gore asked that the movement on the size of the waiting list be added into the BAF.

Mr Hall asked that consideration be paid to the BAF and any risk areas be raised as the meeting progressed.

Resolved:

The Committee received and accepted the report.

8.1 Exception Reports

Mrs Cope wanted the Committee to appreciate the hard work and effort that the staff working in ED had achieved in light of the recent pressures.

Mrs Cope reported that there was a single plan in place that covered the hospital and system option and had been to the A&E Delivery Board for final sign off. Mrs Cope was confident of the actions in place around flow, bed capacity and system working. Additional bed space had been highlighted and Same Day Emergency Care should help with demand.

Mrs Cope reported that the Trust was under scrutiny and the whole system was expected to achieve 90% by September 2019.

Mr Curry asked if the NHS Improvement actions had been added to the plan following their recent visit and Mrs Cope advised that it had been included in the plan.

Mr Bond asked if the items in the plan could be ranked to prioritise to the system the key areas of focus. Mrs Cope agreed and suggested that getting medically fit patients discharged efficiently was key.

TC

There was a discussion around the volumes in ED and although similar to last year Mrs Cope explained that more patients were being admitted through tertiary routes, there were more breaches due to bed rates and issues around primary care.

The Committee acknowledged the unrecognisable face of primary care and the chronic national shortage of GPs but agreed that the Trust needed to concentrate on what it could influence.

There was a discussion on spikes in attendances and how difficult Mondays could upset the rest of the week. Mrs Cope also spoke about full capacity protocol and how it was becoming the norm to activate it as every day the hospital was full.

Mrs Cope advised that the plan was to have a Medical Director on call rota as it was thought that flow being led by a medic would have more ability to affect change.

Mrs Cope reported that the Trust was not making the waiting list volume progress as planned mainly due to workforce challenges and high volumes of patients.

The Trust 62 RTT Cancer performance had dropped 10% since May 2019. The National Breach Re-allocation Guidance was having an impact on performance as the Trust was no longer required to calculate repatriations for those referrals sent after day 38. It also meant that the Trust would not receive the activity if the patient was outside of the 24 day timescale.

Mrs Cope highlighted that histology turn-around times had shown improvement across the majority of tumour sites, the breast services was now up to full complement of medical staff, a new model was being explored with Primary Care relating to skin cancer and there was a new consultant in post from September 2019 for Head and Neck.

Mr Gore asked about the outpatients transition and how it was progressing. Mrs Cope agreed to provide an update at the next meeting.

TC

Mr Bond asked about the recovery timescales in endoscopy and Mrs Coper advised that it would be the end of Q4 before the service would recover completely.

Resolved:

The Committee received and accepted the report.

The agenda was taken out of order at this point

9.1 Demand and Activity Report

Mrs Drury presented the report and advised that at the end of July 2019 overall referrals were showing an increase of 5.6%. GP referrals were in line with last year's cumulative numbers.

The increase in non-GP referrals was due to the transfer of community paediatrics and ED referrals as well as consultant to consultant.

Overall elective activity was lower than plan in ENT, cardiology, oral surgery neurosurgery and trauma and orthopaedics.

Outpatient activity including procedures were 7.8% above plan and follow up activity was also above plan. Work was ongoing to reduce face to face follow ups and use other means of communicating with patients.

ED activity was below plan a July 2019, with daily averages of 400. Non-Elective admissions were above plan. Ambulatory care attendances were on plan at the end of July 2019.

The income position at month 4 was an overtrade of £1.7m associated with AIC commissioners. The action taken by the Specialist Commissioner following the coding audit at the beginning of the year was still awaiting confirmation.

Mr Bond advised that the Trust must become more competitive regarding optometrist fees as private practices were offering shorter waiting times and a one-stop-shop type service. The Trust was developing its service to compete.

Resolved:

The Committee received and accepted the report.

10.1 Finance

Mr Bond presented the report and advised that the Trust was reporting a deficit of £2.9m which was in line with plan.

The Trust was above plan by £2m after accounting for the AIC. The Trust is currently subject to a coding review from Specialist Commissioners and estimated income has been reduced by £0.9m for the first quarter as a provision against a potential claim. There had also been communication from other Specialist Commissioners regarding next year's contract and income levels.

The Health Groups and Corporate Services were reporting a gross overspend of £0.2m at month 4.

The Committee discussed the pension issue and Mr Bond had provided a report showing the level of impact relating to the reduced PAs. Mr Bond also mentioned the Flowers overtime case which was a national piece of work and how this could also impact on the Trust.

Resolved:

The committee received and accepted the report.

10.2 CRES 2019/20

Mr Bond presented the CRES report and advised that at month 4 schemes worth £16.4m had been identified but when risk adjusted this became £14.4m which is 77% of the target. Mr Bond expressed his concern regarding the ambitious forecasts of the Health Groups along with emerging costs within the system that had not been accounted for.

A CRES stock take would be carried out with the Health Groups in October 2019.

Mr Curry asked what the implication of missing the CRES target was and Mr Bond advised that the Trust would not receive PSF monies.

Resolved:

The Committee received and accepted the report.

10.3 Impact of Pension Issue on Consultant Activity

Mr Bond presented the report which highlighted the impact of Consultants reducing their hours from April 2019 to July 2019. The report also detailed

the loss of activity for the next 3 months.

Resolved:

The Committee received and accepted the report.

10.4 Productivity and Efficiency

Mr Bond advised that he had spoken with NHS Improvement and had asked when the Trust could see its Productivity and Efficiency report as he had already seen York's version. Mr Bond advised that he should see it the last week of August and would share it with the committee in due course, once the Commissioners and the teams had a plan in place.

LB

Resolved:

The Committee received and accepted the report.

10.5 Long Term Plan Development

Mr Bond presented the report which outlined the Trust's requirements when producing its forward plans which would include STP and Integrated Care Services.

He reported that the Commissioners would have an amount of money to spend on non-elective, RTT, Cancer and the Trust would have to develop plans to achieve their targets. NLAG, York and Scarborough would also have to have integrated plans agreed with the Commissioners and produce a combined narrative.

Mr Bond advised that the plan would need to be in place by November 2019. He reported that the capital application for the patch would also have to be factored into the plans.

Resolved:

The Committee received and accepted the report.

12.1 Capital Resource Allocation Committee minutes

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

11.1 Variable Pay Report

Mr Bond presented the report and highlighted the development of the Bank within medical staffing to reduce agency pay. He expressed his concern regarding the NHS I agency cap performance and the increase in nursing agency staff.

Resolved:

The Committee received and accepted the report.

11.2 Workforce Transformation Progress Report

Mr Bond presented the report and advised that as of 1st February 2019 157 student nurses had been interviewed and offered positions to start in September 2019. The Trust had also offered 8 paediatric nurses' posts.

A further 70 nurses has been recruited in the last 12 months. The first cohort of 17 nurse associates were in the process of obtaining their NMC registration and another 60 nurses had been deployed from the Philippines. The majority of the recruits would be working in the Medicine Health Group and another 10 nurses would be joining the Trust in September 2019 with skills in endoscopy

and theatres.

There are 213 members of staff working to an apprenticeship standard with a further 75 waiting to start.

Mr Bond also spoke of the Leadership Programme for non-medical and medical leaders, the HEY coaching and mentoring network and a number of health and wellbeing initiatives. Rainbow lanyards had been given out to a number of staff to support Hull Pride 2019.

Mr Bond advised that the Flu Vaccination programme would shortly commence with a push to vaccinate as many members of staff as possible due to the Australian pandemic.

Resolved:

The Committee received and accepted the report.

Mr Vize, Mrs Harrison-Mizon and Mr Damien Haire joined the meeting to deliver the ENT presentation

8.2 Outpatient Follow Up Report

Mrs Cope presented the report and advised that the Trust had not made enough progress into creating capacity to reduce the waiting lists. The demand on Non-Elective and Cancer was also impacting on progress. Ophthalmology had been hugely impacted. Mr Vize informed the Committee that 2 consultants had left the Ophthalmology Department and 2 had reduced their PAs due to the pension issue.

Mrs Cope reported that a number of specialities such as Immunology had a clear plan in place but some still had work to do. A comprehensive stock take was required, with different clinical conversations with health partners taking place. Mrs Cope suggested a deep dive at a future meeting.

TC

Resolved:

The Committee received and accepted the report.

13.1 ENT Performance

Mr Haire gave the ENT performance presentation and gave a service overview which included a growing patient list size, long waits for outpatient and subsequent surgical intervention and a challenging 52 week position.

As from the end of March 2019 the service had not had any 52 week waits and the Committee commended the teams for achieving this. Mr Haire reported that the service had only 9 wte consultants with 2 registrars in the pipeline.

The ENT specialty had a target of 92% and was currently at 56%. The average wait for surgery was 40 weeks. Mr Vize added that the Service was picking up cases from NLAG when they were a way through the pathway. The Trust had offered sessions and specialty doctors to ensure this was kept to a minimum.

Mr Haire reported that there was a 10-15% error rate on the list size and validation work was necessary. Mr Bond asked how many of the 30 consultant lists were under used per week and Mr Haire reported that all

sessions were full.

A number of recovery actions were in place such as 6 day working, use of the private sector and working with the CCGs to determine what could be managed in Primary Care. Also an ENT Network Board had been established.

Mr Gore asked if the Service was safe and Mr Vize assured the Committee that once patients were in the Trust they received excellent care. Mrs Cope agreed that she had no clinical concerns but was worried about the level of backlog and how it would be managed.

Resolved:

The Committee received and accepted the presentation.

Mr Vize, Mrs Harrison-Mizon and Mr Damien Haire left the meeting.

14 Items delegated by the Board

There were no items to discuss.

15 Any Other Business

There was no other business discussed.

16 Date and time of the next meeting:

Monday 30 September 2019, 1.30pm – 4.30pm, The Boardroom, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	NHS Improvement - Developing Workforce Safeguards
Responsible Directors:	Simon Nearney Director of Workforce and OD
Author:	Simon Nearney Director of Workforce and OD

Purpose	The purpose of the report is to inform the Board of the new NHS Improvement recommendations with regard to the planning and deployment of staff and the Trust's response.	
BAF Risk	BAF risk 1 and 2	
Strategic Goals	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Key Summary of Issues	NHS Improvement has launched new recommendations to improve workforce planning and effective workforce deployment within Trusts. Our Trust currently undertakes workforce planning as part of the business planning cycle and provides comprehensive data to the Board and Performance and Finance Committee on workforce numbers, vacancies and current challenges. However given the new regulations the Trust proposes some changes to strengthen and comply with the new recommendations.	

Recommendation	The Trust Board is requested to note the contents of the report, provide any feedback and approve the proposed changes to current practice.

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

NHS Improvement Developing Workforce Safeguards

1. Purpose

The purpose of the report is to inform the Trust Board of the new NHS Improvement recommendations with regard to the planning and deployment of staff and to detail the Trust's current position and response.

2. Background

NHS Improvement (NHSI) have launched new workforce recommendations to assist Trusts improve workforce planning and effective workforce deployment. Despite the national workforce shortages, NHSI believe health systems and Trust Boards need to be more robust when making decisions regarding staffing especially in our current financial climate. Board must ensure that decisions made regarding its staffing does not have an adverse impact on the quality of care, as well as patient, service user and staff experience.

The recommendations are designed to help Trust manage common workforce problems, to support Trusts in making informed, safe and sustainable workforce decisions. The document has been developed with sector leaders and frontline staff and builds on the National Quality Board's (NQB) guidance.

From 2019 NHSI will assess Trusts' compliance with the triangulated approach to deciding staffing requirements described in the NQB guidance. NHSI will use information collected through the Single Oversight Framework (SOF) and will request Trusts to include a specific workforce statement in the annual governance statement.

By implementing the recommendations Trust Boards can be assured that their workforce decisions promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, Use Of Resources assessment and the Board's statutory duties.

3. New Recommendations

NQB's guidance states that providers:-

- Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet, care and treatment needs safely and effectively
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- Must use an approach that reflects current legislation and guidance where it is available

The Trust already has a systematic approach to workforce planning and has been successful in recruiting, deploying, managing and developing staff within the Trust. However the Trust still has vacancies in medical, nursing and clinical support functions.

However, to ensure compliance against the recommendations, the Trust has assessed itself against each one and stated the current position and any further action that is required.

Recommendation 1

Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.

Trust Response

NQB's 2016 guidance is embedded. The Chief Nurse presents a safer staffing report to the Board at every meeting detailing registered nurse numbers/per patient ratio, gaps and identifies where wards have fallen below set staffing levels.

Recommendation 2

Trusts must ensure that the three components are used in their safe staffing processes:

- Evidence based tools (where they exist)
- Professional judgement
- Outcomes

An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year.

Trust Response

The Trust uses the Six Steps Workforce Planning tool and has set registered nurse staffing per patient ratio (minimum 1 to 7). E-Rostering has been in use for some years and the safer staffing module has been implemented, so up to date registered and unregistered nurse staffing is consistently understood and monitored. The Trust Site Management Team formally review nurse staffing four times per day, 7 days per week and if staffing is short on a ward, then bank staff are deployed or staff from other wards who have more than their minimum establishment are transferred to the ward in need. The acuity of patients is also factored in and professional judgement is used to ensure patient safety and quality of care is maintained. Nurse staffing on wards is also cross referenced with fundamental standards. Wards that are challenged are highlighted, discussed and plans put into place to address.

Recommendation 3

We will base our assessment on the annual governance statement [requirements], in which trusts will be required to confirm their staffing governance processes are safe and sustainable.

Trust Response

Each service develops an annual operational plan that focuses on activity to be delivered in the forthcoming year. The activity is triangulated with finance and a workforce plan. Service changes, workforce issues and finances are addressed and the plan submitted to the Health Group. The Health Group develops a high level plan and this goes through a "confirm and challenge" process before it is accepted and submitted to the Executive. The Trust Operational Plan is then presented and approved by the Board. The workforce plan is based upon the Six Steps workforce planning principles. The Trust has also developed a People Strategy 2019-22 which sets out the Trust's vision for our staff, which focuses on 7 workforce themes:-

1. Recruitment and retention
2. Leadership capability and capacity
3. Innovation, learning and continuous improvement
4. Equality, inclusion and diversity
5. Health and wellbeing
6. Employee engagement, communication and recognition
7. Modernising the way we work

The workforce planning guidance will be reviewed and updated for the 2020/21 operational planning round and further guidance and support will be offered for managers to strengthen this area.

Recommendation 4

We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.

Trust Response

As stated the nurse staffing report is presented at Board at every meeting. In addition all other staffing vacancies, sickness absence, statutory mandatory training, appraisal rates and staff turnover is reported quarterly to the Trust Board's Performance and Finance Committee (PAF). The last report was presented in July, 2019 and therefore in future this report will be presented to the Board in January, 2020 and thereafter every 6 months. This will ensure the full Board has sight of all staffing matters. The Trust's culture / staff engagement programme is also presented to the Board every quarter and other workforce reports including the Workforce Race Equality Scheme (WRES), Workforce Disability Equality Scheme (WDES), Equality and Inclusion Plan and Gender Pay Report are presented annually. The Guardian of Safe Working report is presented quarterly to the Trust Board as well as the Freedom to Speak Up Guardian.

Recommendation 5

As part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

Trust Response

This is done when the Trust's annual Operational Plan is signed off and in future the report will include a specific statement from the Chief Medical Officer and Chief Nurse that they are satisfied with the outcome and that staffing is safe, effective and sustainable.

Recommendation 6

Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.

Trust Response

The Trust has a workforce plan and it is updated annually. It is presented to the Board with the financial plan as part of the Operational Plan and it is formally signed off. The workforce position is also raised formally and commented upon in the Trust's Annual Report and monitored through the Performance and Finance Committee.

Recommendation 7

They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.

Trust Response

The nurse staffing report does cross reference quality and fundamental standards and this is done at every Board meeting. The Board has reviewed the Model Hospital staffing Data at a recent Board development time. Model Hospital Data is monitored and assessed at the Trust Carter Steering Group which is chaired by the Chief Financial Officer and reported to the Performance and Finance Committee. This matter requires further discussion.

Recommendation 8

As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.

Trust Response

Full quality impact assessments are carried out before any service or policy change. This is embedded in Trust policy and practice.

Recommendation 9

Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.

Trust Response

This is currently undertaken to ensure new roles in the Trust are developed and managed well; a new Advanced Practice Lead has been appointed. The lead role works across the Trust with specialities to ensure generic and more specialist competences are developed and delivered.

Recommendation 10

Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.

Trust Response

The Trust has several ways in which operational challenges are escalated such as a Datix being reported, an employee raising a concern to the Freedom to Speak Up Guardian or a Junior Doctor submitting an exception report to the Guardian of Safe Working, amongst other routes. Service issues and risks are regularly discussed at team, service and Health Group meetings and recorded as formal Health Group risks. These risks are debated at Trust Executive level and if appropriate are escalated to the Corporate Risk Register and ultimately the Trust Board via the Board Assurance Framework (BAF). Risks are formally rated in terms of likelihood and severity and mitigating actions agreed to manage those concerns accordingly. Risks included in the BAF include staffing numbers, organisational culture, patient safety, financial, performance and quality issues. A key factor in managing and mitigating risk is continuous learning and improvement which is getting stronger across the Trust, but requires further development.

The Trust Board discuss each BAF risk as per the Board programme of work, so every matter is debated in detail and the risk rating is reviewed.

4. Conclusion

The Trust already presents comprehensive staffing reports to the Board and Performance and Finance Committee. In future all staffing reports highlighting vacancies, gaps and risks will be reported to the Board. The Trust also has an annual operational planning round which triangulates finance, quality and workforce, to ensure there are strong governance arrangements in place for safer staffing, systems and processes across the Trust. The Trust has a methodical approach to assessment, escalation and management of risk, especially workforce risks. The Board takes seriously its duty to fund and provide safe staffing levels

and would not hesitate to escalate a matter that they believed would compromise patient safety and quality of care.

The Trust is in a positive position with regard to workforce safeguards, but there are several proposed changes within the report that will strengthen the Trust's ability to deploy sufficiently skilled and experienced staff to care for patients safety and effectively.

5. Recommendation

The Trust Board is requested to note the contents of the report, provide any feedback and approve the proposed changes to current practice.

Officer to Contact:-

Simon Nearney
Director of Workforce and OD
Tel: 01482 676439

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Quarterly Report on Safe Working Hours: Junior Doctors in Training - for quarter 1 April 2019 to 30 June 2019
Responsible Director:	Makani Purva, Chief Medical Officer
Author:	Nagarajan Muthukumar, Guardian of Safe Working Hours

Purpose:	The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate	
BAF Risk:	BAF Risk 2	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	There were a total of 49 exception reports with a total of 49 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to volume of work and practices such as late ward rounds which lead to trainees staying beyond the contracted hours.	

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

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING April 2019 – 30 June 2019

EXECUTIVE SUMMARY

The Guardian Report for this Trust Board Meeting covers the quarter from April 2019 to June 2019

Exception Reporting patterns and responses

There were a total of 49 exception reports with a total of 49 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to volume of work and practices such as late ward rounds which lead to trainees staying beyond the contracted hours. Other reasons include missed educational and training opportunities as well as staying beyond contracted hours in the interest of patient care and staff shortage.

In this quarter the following were the number of episodes of exceptions reported trainees by Health Group

Clinical Support - 0
Family and Women – 1
Medicine – 15
Surgery - 33
GP placement – 0

Exception Report trends:

Vascular surgery: This was the area with the most exception reports (12 episodes) in this quarter. The main reason for reporting was the volume of work which leads to overstay. Trainee representatives in JDF have pointed out that tasks such as blood tests and performing ECGs which were of limited educational value took up significant amount of time. The DME has agreed to add the issue of phlebotomy and ECG to the agenda for discussion in the senior leader meeting which will be led by HEE and is to be held in the near future.

Summary

At the current time there still is no system in place to robustly capture all instances where trainees have breached the safe working hours as required by the Junior Doctor Contract 2016. I am informed that the newly appointed Guardian who is due to start in September will be provided with the administrative support that this requires.

Questions for consideration

The Trust Board is requested to receive this report and:

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

N.Muthukumar

Consultant Trauma & Orthopaedic Surgeon
Guardian of Safe Working Hours

Encl:

Appendix 1: Board Report GSW 1 April 2019 – 30 June 2019

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING 1 April – 30 June.

1. PURPOSE OF THIS REPORT

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from October to December 2018 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. HIGH LEVEL DATA

Number of doctors / dentists in training (total):	555
(establishment)	
	478.1 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	478.1
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours
per week	
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee
(max; varies between HGs)	

All trainees in the Trust are now on the 2016 terms and conditions of service (TCS) and have received their work schedules. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hour's adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the

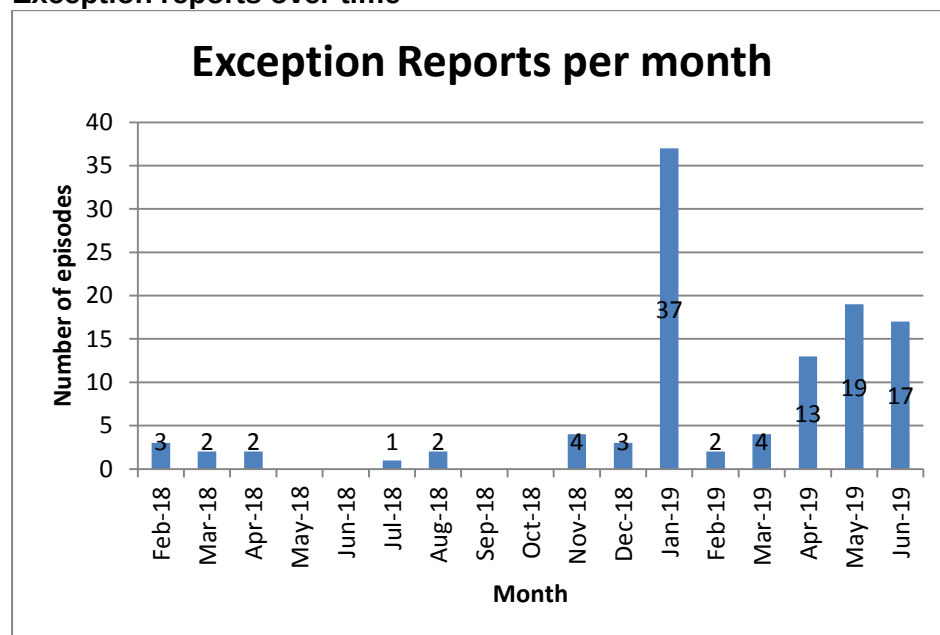
reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions. The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

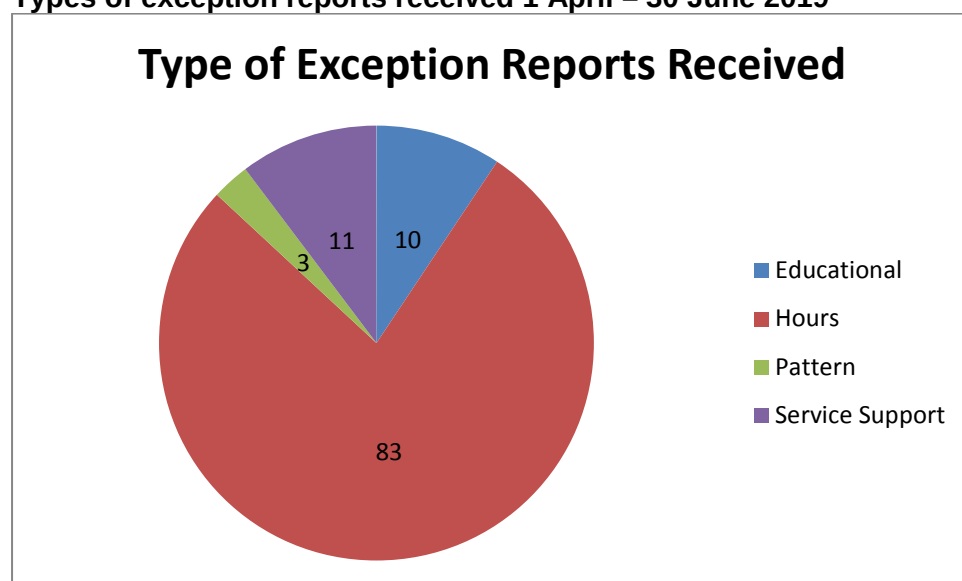
3. JUNIOR DOCTOR WORKING HOURS

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region. In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern. There were 49 exception report episodes submitted between 1 April and 30 June 2019 and 59 carried forwards from the previous quarter.

Exception reports over time



Types of exception reports received 1 April – 30 June 2019



Exception reports (episodes) by specialty 1 April – 30 June 2019

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
Acute Internal Medicine		2		2
Cardiology	36			36
Colorectal Surgery	7	5	12	
Elderly Medicine		6	3	3
ENT		8	3	5
Gastroenterolog y	1	1	2	
General Surgery		2	2	
General Surgery / Vascular	2		2	
Haematology	1		1	
Neurosurgery	3	4	7	
Oncology	2		2	
Orthopaedic Surgery		1		1
Paediatrics		1	1	
Respiratory		7	6	1
Rheumatology	4		4	
Surgery nights CHH	3		3	
Vascular Surgery		12	8	4

Exception reports (episodes) by grade 1 April – 30 June 2019

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	46	36	36	46
F2	4	3	3	4
CT1	3	2	5	
CT2		1	1	
GPS T1	1	4	2	3
ST3	1	1	2	
ST4	1		1	
ST5	3	2	5	

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades, as time goes on and as they get used to the contract and the exception reporting mechanism. Numbers are small, however, and it is not possible to draw conclusions from these reports yet.

Exception reports (episodes) by rota 1 April – 30 June 2019

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 32 - Neurosurgery ST	2	3	5	
23 - Vascular Surgery F1 (inc. ENT/Uro)	2	15	12	5
Rota 124b General Surgery (Uro/ENT) SHO	4	3	7	
Rota 133 - Neurosurgery (ENT) F2 & CT		2	2	
Rota 134 - Orthopaedics F2		1	1	
Rota 14 - Medicine SHO blp 431	3			3
Rota 15 - Medicine SHO (blp 450)	1	1	2	
Rota 18 - Medicine F1		7	6	1
Rota 25 - Acute-Elective Surgery F1	7	5	8	4
Rota 4 - Medicine F1	37	8	8	37
Rota 6 - RMO	2	1	3	
Rota 60 - Paediatric F1		1	1	
Rota 8 - Oncology/Haematology SHO	1	2	3	

Exception reports (episodes) - response time 1 April – 30 June 2019

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	15	1	26	40
F2			6	1
CT1	2		3	
CT2				1
GPST 1			2	3
ST3			2	
ST4			1	
ST5	1		4	

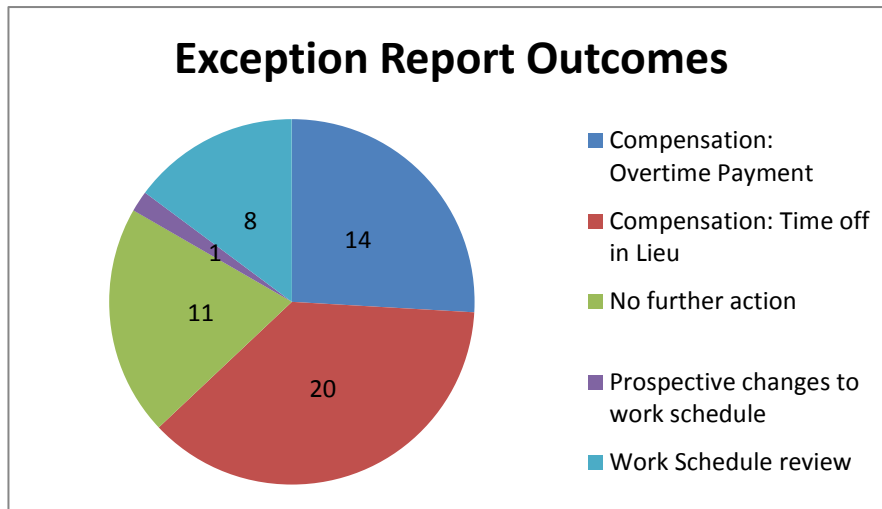
The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.

This is shown in the table below:

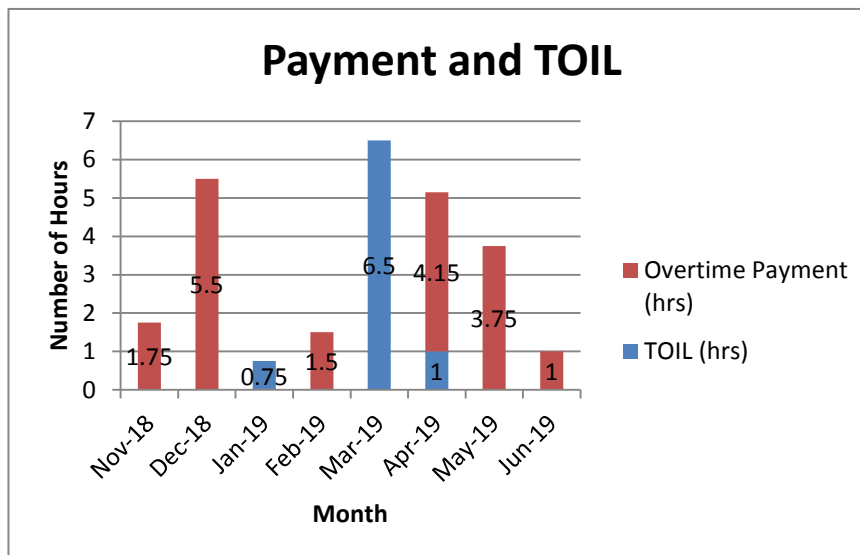
Department (base dept)	No of reports (episodes)	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
Acute Internal Medicine	2	1		1			
Cardiology	36					36	Supervisor unable to meet with trainee as trainee has been off sick
Elderly Medicine	6			3		3	Waiting for Doctors agreement
ENT	13			8		5	
Gastroenterology	2			2			
General Surgery	6	1		5			
General Surgery / Lower	6	4		2			
General Surgery / Vascular	8	2		2		4	
Haematology	1			1			
Medical Oncology	2			2			
Neurosurgery	7	3		4			
Orthopaedic Surgery	1					1	
Paediatrics	1		1				
Respiratory	7	6				1	Waiting for doctors agreement
Rheumatology	4			4			
Urology	5			5			
Vascular Surgery	1			1			

Outcomes of completed exception reports 1 April – 30 June 2019



This shows broadly similar proportions of time versus payment compared to the last quarter. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Work schedule reviews

There are currently no ongoing work schedule reviews as a result of exception reports by trainees. However, as part of the agreement of NHS Employers and the BMA on changes to the 2016 Terms and Conditions of Service, Medical Staffing will be reviewing all rotas within the Trust in line with the agreed working hours limits and working with the Health Groups and Doctors in Training to change rota patterns to be compliant with the updated T&Cs as required.

a) Locum bookings April to June 2019

i) Bank April to June 2019

The Trust currently has an informal medical bank in place which strives to fill as many shifts internally as it can. With the successful creation of a Nurse and Clerical Bank the Trust is looking at creation of a formal Medical Bank in line with the 2016 TCS. We are now at the Stage that a provider has been found and we are setting up the Infrastructure to go live with an External Bank during the 2nd Quarter 2019. A paper has gone to the Executive to agree standard rates for the new Bank which will hopefully provide higher fill rates and create greater consistency with the rates paid.

The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade				
Grade	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
F1*	102	0	796.50	0.00
F2	654	33	4952.18	255.05
CT/ST-2/GPSTR	952	32	8730.75	271.00
ST3+	1032	34	10681.05	330.00
TOTAL	2740	99	25160.48	856.05

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

Locum Bookings (bank) by department				
Speciality	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
Acute Medicine	262	11	2115.15	57.80
Breast Surgery	34	4	425.00	50.00
Cardiology	16	4	136.50	50.00
Cardiothoracic Surgery	206	3	1690.25	37.50
Chest Medicine	57	0	551.65	0.00
Colorectal Surgery	181	9	1913.50	178.00
Elderly Medicine	133	18	1189.60	140.00
Endocrinology	36	11	249.33	65.50
ENT	92	4	698.50	25.00
Gastroenterology	31	0	244.25	0.00
General Medicine	141	0	1167.00	0.00
General Surgery	77	0	791.50	0.00
Haematology	4	0	60.00	0.00
Neonatal Medicine	19	0	247.00	0.00
Neurology	209	0	1745.30	0.00
Neurosurgery	222	21	2036.75	103.50
Obstetrics and Gynaecology	2	0	24.00	0.00
OMFS	51	0	444.50	0.00
Oncology	85	1	850.95	12.50
Paediatric Surgery	73	0	641.50	0.00

Paediatrics	31	0	355.00	0.00
Plastic Surgery	22	0	392.00	0.00
Renal	23	0	258.25	0.00
Rheumatology	64	1	636.50	4.25
Stroke	1	0	8.00	0.00
Trauma & Orthopaedics	477	9	4198.00	117.00
Upper GI	103	0	1044.00	0.00
Urology	85	3	1017.50	15.00
Vascular Surgery	3	0	29.00	0.00
TOTAL	2740	99	25160.48	856.05

Locum bookings (bank) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	3	0	30.00	0.00
Compassionate/ Special Leave	5	0	52.50	0.00
Extra Cover	257	32	1988.95	209.80
Maternity/Paternity Leave	64	0	518.00	0.00
Sickness	176	5	1681.75	63.00
Study Leave	6	0	67.25	0.00
Vacancy	2229	62	20822.03	583.25
TOTAL	2740	99	25160.48	856.05

ii) Agency April to June 2019

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	102	9	796.50	106.50
F2	654	28	4952.18	249.00
CT/ GPSTR/ST-2	952	367	8730.75	3731.75
ST3+	1032	283	10681.05	2974.50
Total	2740	687	25160.48	7061.75

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Acute Medicine	262	57	2115.15	571.50
Breast Surgery	34	11	425	138.00
Cardiology	16	3	136.5	34.50
Cardiothoracic Surgery	206	46	1690.25	415.00
Chest Medicine	57	10	551.65	122.50
Colorectal Surgery	181	42	1913.5	430.50
Elderly Medicine	133	7	1189.6	79.00
Endocrinology	36	4	249.33	48.00
ENT	92	8	698.5	81.00
Gastroenterology	31	0	244.25	0.00
General Medicine	141	90	1167	742.50
General Surgery	77	49	791.5	478.50
Haematology	4	0	60	0.00
Neonatal Medicine	19	3	247	39.00
Neurology	209	61	1745.3	513.50
Neurosurgery	222	25	2036.75	323.00
Obstetrics and Gynaecology	2	0	24	0.00
OMFS	51	0	444.5	0.00
Oncology	85	11	850.95	128.00
Paediatric Surgery	73	1	641.5	8.00
Paediatrics	31	3	355	34.00
Plastic Surgery	22	4	392	73.00
Renal	23	8	258.25	100.00
Rheumatology	64	17	636.5	208.75
Stroke	1	0	8	0.00
Trauma & Orthopaedics	477	142	4198	1576.50
Upper GI	103	56	1044	616.00
Urology	85	29	1017.5	301.00
Vascular Surgery	3	0	29	0.00
TOTAL	2740	687	25160.48	7061.75

Locum bookings (agency) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	3	0	30.00	0.00
Compassionate/Special Leave	5	0	52.50	0.00
Extra Cover	257	29	1988.95	268.00
Maternity/Paternity Leave	64	3	518.00	37.50
Sickness	176	40	1681.75	493.00
Study Leave	6	0	67.25	0.00
Vacancy	2229	615	20822.03	6263.25
Total	2740	687	25160.48	7061.75

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they have to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover; for example sickness is not mentioned as a reason for seeking cover. This has probably been included in the catch-all term 'vacancy' but will need to be teased out in future.

iii) **Emergency Department**

The Emergency Department books its own bank doctors directly; these figures are currently reported slightly differently.

Locum Bookings (bank) by 1.04.2019 to 30.06.2019 AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	382	315	382	3593.16	3012.66
Total					

Locum Bookings (bank) by 1.04.2019 to 30.06.2019 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	1064	577	682	8480.9	4390.25

b) Locum work carried out by trainees April to June 2019

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current

systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Base Speciality	Grade	Number of hours worked	Number of hours rostered per week	Opted out of EWTD
General Practice	F2	225.58	40:00	Yes
General Practice	GPSTR	219.50	40:00	Yes
General Practice	F2	144.00	40:00	Yes
Neurology	ST3+	130.25	45:30	Yes
Neurosurgery	ST3+	127.00	47:45	Yes
Palliative Care	GPSTR	102.50	41:30	Yes
Respiratory Medicine	GPSTR	88.50	47:00	Yes
Gastroenterology	CT2	87.00	47:00	Yes
Neurosurgery	F2	82.85	47:00	No
General Practice	F2	56.75	40:00	Yes

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Especially at F2 level, doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis. The appointment of rota co-ordinators is in progress across the Trust as part of the roll-out of e-roster for medical staff, and entry of this data will be a key part of their role.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has EWTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of these rules however Medical Staffing are not responsible for overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required.

Vacancies – table showing vacancies among medical training grades and by rota on 10th July 2019. Detailed below is a table indicating the rota establishment and WTE in post as of 10th July 2019 and Doctor in Training establishment as of 10th July 2019.

Hull University Teaching Hospitals NHS Trust - Junior Doctor Rota Establishment Effective 10/07/2019

Department	Trainee Establishment						Rota Establishment						In Post						% Posts Filled 17/04/2019	% Posts Filled 10/07/2019
	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total		
Academic	0	5	0	0	0	5	0	5	0	0	0	5	0	5	0	0	0	5	100.00%	100.00%
Acute Medicine	3	6	9	0	6	24	3	6	9	0	6	24	3	6	9	0	3	21	87.50%	87.50%
Anaesthetics	4	4	15	0	28	51	4	4	16	0	32	56	4	4	16	0	27	51	83.93%	91.07%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	2	0	1	0	1	4	80.00%	80.00%
Cardiology	2	1	4	1	9	17	2	1	4	1	12	20	2	1	4	1	12	20	120.00%	100.00%
Cardiothoracic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	3	0	0	8	11	91.67%	91.67%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	1	1	50.00%	50.00%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	0	1	0	2	100.00%	100.00%
Elderly Medicine	5	3	6	6	6	26	5	3	6	7	6	27	4	3	7	7	5	26	96.30%	96.30%
Emergency Medicine	0	12	7	5	14	38	0	12	7	5	8	32	0	12	7	4	9	32	103.13%	100.00%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	3	0	2	0	3	8	88.89%	88.89%
ENT	1	1	2	1	4	9	1	1	3	1	6	12	1	1	2	1	4	9	91.67%	75.00%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	2	0	4	9	90.00%	90.00%
General Practice	0	18	0	39	0	57	0	18	0	39	0	57	0	13	0	27.8	0	40.8	71.58%	71.58%
General Surgery	0	1	0	0	0	1	0	1	2	0	0	3	0	1	0	0	0	1	33.33%	33.33%
Haematology	1	0	2	0	4	7	1	0	2	0	7	10	1	0	1	0	5.6	7.6	86.00%	76.00%
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	0	0	0.00%	0.00%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	5	9	2	0	2	0	2	6	66.67%	66.67%
Lower GI Surgery	7	0	2	0	3	12	7	0	2	0	6	15	7	0	1	0	6	14	100.00%	93.33%
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	2	3.5	0	6	13.5	96.43%	96.43%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1	0	4	0	10.8	15.8	83.16%	83.16%
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	7	4	11	24	0	2	7	4	11	24	100.00%	100.00%
Oncology	3	1	3	4	5	16	3	1	8	4	12	28	3	1	7	4	12	27	100.00%	96.43%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	8	10	1	1	0	0	7	9	100.00%	90.00%
Oral & Maxillofacial Surgery	0	2	10	0	2	14	0	2	10	0	6	18	0	2	6	0	6	14	77.78%	77.78%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	0	6	0	0	6	0	0	6	100.00%	100.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	7	0	7	14	0	0	4.6	0	6.5	11.1	79.29%	79.29%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	4	6	0	0	2	0	3	5	83.33%	83.33%
Paediatrics	3	4	3	2	8	20	4	4	3	2	8	21	3	3	2	2	8	18	85.71%	85.71%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	0	2	0	2	100.00%	100.00%
Plastic Surgery	0	0	3	0	5	8	0	0	4	0	7	11	0	0	4	0	4.8	8.8	80.00%	80.00%
Psychiatry	5	5	0	4	0	14	5	5	0	4	0	14	5	3	0	4	0	12	85.71%	85.71%
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Radiology	0	0	0	0	24	24	0	0	0	0	24	24	0	0	0	0	20.8	20.8	86.67%	86.67%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	2	1	2	0	5	10	100.00%	100.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	2	2	1.5	8	19.5	97.50%	97.50%
Rheumatology	0	0	1	2	3	6	0	0	1	2	3	6	0	0	1	1.5	3	5.5	91.67%	91.67%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0.00%
Trauma & Orthopaedics	0	4	3	1	9	17	0	11	4	1	15	31	0	8	2	0	13	23	75.00%	74.19%
Upper GI Surgery	7	0	2	0	4	13	7	0	4	0	7	18	7	0	3	0	5	15	94.44%	83.33%
Urology	1	3	2	0	3	9	1	3	2	0	5	11	1	3	1	0	4	9	81.82%	81.82%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	6	12	5	0	1	0	4.8	10.8	90.00%	90.00%
TOTAL	70	84	114	74	213	555	71	91	131	75	267	635	69	79	112.1	60.8	229.3	550.2	88.16%	86.65%

Increased vacancies since last report	
Decreased vacancies since last report	
No change in vacancies since last report	

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment effective 10/07/2019

Department	Trainee Establishment							Trainee In Post							% Filled
	F1	F2	CT/ST	GPST	ST	Total		F1	F2	CT/ST	GPST	ST	Total		
Academic	0	5	0	0	0	5		0	5	0	0	0	5		100.0%
Acute Medicine	3	6	9	0	6	24		3	5	6	0	2	16		66.7%
Anaesthetics	4	4	15	0	28	51		4	4	15	0	22	45		88.2%
Breast Surgery	2	0	1	0	2	5		2	0	0	0	1	3		60.0%
Cardiology	2	1	4	1	9	17		2	0	3	1	9	15		88.2%
Cardiothoracic Surgery	0	3	0	0	3	6		0	2	0	0	3	5		83.3%
Chemical Pathology	0	0	0	0	2	2		0	0	0	0	1	1		50.0%
Dermatology	1	0	0	1	0	2		1	0	0	1	0	2		100.0%
Elderly Medicine	5	3	6	6	6	26		4	3	6	6	5	24		92.3%
Emergency Medicine	0	12	7	5	14	38		0	11		5	13	29		76.3%
Endocrinology	3	0	2	0	4	9		3	0	2	0	2	7		77.8%
ENT	1	1	2	1	4	9		1	1	2	1	4	9		100.0%
Gastroenterology	3	0	2	0	5	10		3	0	2	0	4.6	9.6		96.0%
General Practice	0	18	0	39	0	57		0	18	0	34	0	52		91.2%
General Surgery	0	1	0	0	0	1		0	0	0	0	0	0		0.0%
Haematology	1	0	2	0	4	7		1	0	2	0	3.6	6.6		94.3%
Histopathology	0	0	0	0	4	4		0	0	0	0	0	0		0.0%
HIV/GUM	0	1	0	0	0	1		0	1	0	0	0	1		100.0%
Infectious Diseases	2	0	2	0	5	9		2	0	2	0	2	6		66.7%
Lower GI Surgery	7	0	2	0	3	12		7	0	0	0	3	10		83.3%
Neurology	2	2	4	0	5	13		2	2	3	0	5	12		92.3%
Neurosurgery	1	1	2	0	4	8		1	1	1	0	3.8	6.8		85.0%
Obstetrics & Gynaecology	0	2	7	4	11	24		0	2	7	4	10	23		95.8%
Oncology	3	1	3	4	5	16		3	1	3	4	5	16		100.0%
Ophthalmology	1	1	0	0	6	8		1	1	0	0	6	8		100.0%
Oral & Maxillofacial Surgery	0	2	10	0	2	14		0	2	5	0	1	8		57.1%
Paediatric Emergency Medicine	0	0	6	0	1	7		0	0	6	0	0	6		85.7%
Paediatric Neonatal Medicine	0	0	7	0	7	14		0	0	3.6	0	6.5	10.1		72.1%
Paediatric Surgery	0	0	2	0	0	2		0	0	2	0	0	2		100.0%
Paediatrics	3	4	3	2	8	20		3	4	2	2	8	19		95.0%
Palliative Care	0	0	0	2	0	2		0	0	0	2	0	2		100.0%
Plastic Surgery	0	0	3	0	5	8		0	0	3	0	4.8	7.8		97.5%
Psychiatry	5	5	0	4	0	14		5	4	0	3	0	12		85.7%
Public Health Medicine	0	1	0	0	0	1		0	0	0	0	0	0		0.0%
Radiology	0	0	0	0	24	24		0	0	0	0	20.8	20.8		86.7%
Renal Medicine	2	1	2	0	5	10		2	1	2	0	4	9		90.0%
Respiratory Medicine	6	2	2	2	8	20		6	2	2	1	7	18		90.0%
Rheumatology	0	0	1	2	3	6		0	0	1	1	3	5		83.3%
Stroke Medicine	0	0	0	0	1	1		0	0	0	0	0	0		0.0%
Trauma & Orthopaedics	0	4	3	1	9	17		0	4	3	1	8	16		94.1%
Upper GI Surgery	7	0	2	0	4	13		7	0	2	0	3.6	12.6		96.9%
Urology	1	3	2	0	3	9		1	3	2	0	3	9		100.0%
Vascular Surgery	5	0	1	0	3	9		5	0	1	0	2.8	8.8		97.8%
TOTAL	70	84	114	74	213	555		69	77	88.6	66	177.5	478.1		86.1%

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

The gaps in rota that was an area of concern particularly in some specialties have improved since last August. This is probably due in part to the continued relaxation in visa rules.

Hull University Teaching Hospitals NHS Trust
Trust Board
10 September 2019

Title:	Responsible Officer Report	
Responsible Director:	Dr Makani Purva –Chief Medical Officer/Responsible Officer	
Author:	Dr Makani Purva –Chief Medical Officer/Responsible Officer	
Purpose:	The Responsible Officer has a duty, defined in the ‘Framework for Quality Assurance of Responsible Officers and Revalidation’ (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS Improvement (NHSI), formally the Trust Development Authority.	
BAF Risk:	BAF 3 – High Quality Care	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Trust has an appointed Responsible Officer, who is trained and supported to perform the role • The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on Revalidation • The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice • There is a good appraisal system in place, which is developmental and formative in nature • The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC) • Uptake of appraisal in the Trust continues to surpass the NHS England target of 90%. Maintaining this high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential administrative support and the Trust having sufficient numbers of trained medical Appraisers • The current percentage of Doctors having appraisal in 2018/19 is 93.4% which surpasses the NHSE target of 90%	
Recommendation:	The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by 27 th September 2019	

1. Purpose of the Paper

The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and now NHS Improvement (NHSI), formally the Trust Development Authority. The Framework for Quality Assurance, in defining the purpose of the annual report, states that: "The Trust Board should understand its responsibilities under the Responsible Officer Regulations. It should also understand the appraisal and Revalidation process within the organisation, and be aware of progress in establishing and maintaining a successful Revalidation programme for medical staff. NHS England requires that the Trust Board demonstrates fulfilment of these requirements by formally acknowledging receipt of this paper, and returning a statement of compliance signed by the Chairman."

2. Background

Following public and professional concern about the regulation of the medical profession a new system of assurance was introduced from the end of 2012. A Statutory Instrument passed in 2010 mandates the appointment of a 'Responsible Officer' for each organisation employing Doctors. The Responsible Officer has a duty to confirm that the Doctors for whom they are responsible are fit to practise, and comply with General Medical Council guidance on Good Medical Practice. This Statutory Instrument is the legislation underpinning the General Medical Council process of Revalidation, which applies to all Doctors in the United Kingdom who require a licence to practise. A licence is required by all Doctors working at Hull University Teaching Hospitals NHS Trust. Revalidation is the process by which Doctors have to demonstrate to the General Medical Council that they are fit to practise. The purpose of Revalidation is to assure patients and the public, employers, and other healthcare professionals that licensed Doctors are up to date and working appropriately. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking that there are effective systems in place for monitoring the conduct and performance of their Doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and Revalidation process for their Doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Previous reports outlining progress in implementing appraisal and Revalidation have been submitted to the Trust Board (2012, 2013, 2014 2015, (with an interim update in February 2015), 2016 and 2017, 2018), and to the Quality Committee.

The Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

Recommendation to the General Medical Council for Revalidation of individual Doctors is the responsibility of the Responsible Officer. The Responsible Officer is supported in discharging this duty by a Revalidation Panel consisting of representation from senior clinical management, the Senior Appraiser Team, Appraisal, a representative from the Local Negotiating Committee, and the Head of HR Services. The Panel meets on a monthly basis. Appraisal and Revalidation processes are overseen by the Appraisal and Revalidation Committee, chaired by the Responsible Officer. This committee reviews progress against appraisal and Revalidation targets, and determines actions to address failures to meet these targets. The Appraisal and Revalidation Committee meets monthly and reports by exception to the Operational Quality Committee.

The Trust is required to maintain an accurate record of Doctors with a prescribed connection to the organisation (as a Designated Body). This is done using the GMC Connect system, and is kept up-to-date by the HUTH Revalidation Team. Doctors transferring between Designated Bodies are required to provide their new RO with details of their previous Designated Body, so that information can be exchanged between the two ROs. The Trust has developed a standard form to respond to requests for information from other Designated Bodies.

The Trust is required to complete an annual report (with quarterly updates) to NHS England describing the extent of compliance with its obligations as a Designated Body. This report is called the Annual Organisational Audit (AOA).

Dr Makani Purva is the Trust's appropriately trained and appointed Responsible Officer for the Hull University Teaching Hospitals NHS Trust Designated Body and Dove House Hospice Designated Body via a Service Level Agreement (SLA).

Policy and Guidance

Appraisal and Revalidation is conducted in accordance with the Revalidation and Appraisal for Medical Staff policy. This policy underwent a full review in 2017 and is due for a full review in October 2019. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull University Teaching Hospitals NHS Trust) does not undertake an appraisal within the 12 month period required is also in place and underwent a full review in August 2019.

In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), the Trust has put in place the Maintaining High Professional Standards Policy for Medical and Dental Staff and supporting procedures. The policy and supporting procedures are also based on the National Clinical Assessment Service (NCAS) document 'Back on Track' and is in line with the Department of Health document 'Tackling Concerns Locally'. The Maintaining High Professional Standards Policy for Medical and Dental Staff replaces the Disciplinary and Capability for Medical and Dental Staff and Remediation and Capability for Medical and Dental Staff policies.

4. Restrictions, Remediation, and Investigations

Hull University Teaching Hospitals NHS Trust was the Designated Body for 587 Doctors in 2018/19: this included 455 Consultants, 41 Specialty and Associate Specialist (SAS) Doctors and 91 other Doctors (mainly short term Trust Grade Doctors).

Table 1 shows the number of Doctors for whom the Trust is the Designated Body who were either under active investigation by the General Medical Council, or who had current notices on their licence to practise as a result of previous GMC investigations. In addition to these Doctors, there were also a number of trainees working at the Trust who were either under investigation by the GMC or who had warnings on their licence: the Designated Body for these Doctors is the

Health Education England (Yorkshire and the Humber) and therefore these are not contained in the table below.

Type of sanction	Consultant	Non-Consultant
Licence warning	0	2
Undertakings	1	0
Conditions	0	0
Under investigation	0	0

Table 1. Number of Doctors for whom the Trust is Designated Body who during the reporting period had GMC notices or were under investigation:

During 2018/19, 4 Doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust were under internal investigation. Three of these cases are closed and 1 is ongoing.

The outcomes of the investigations are summarised below in Table 2:

Grade	Type of Investigation	Investigation Outcome
Consultant	Bullying & Harassment	Closed and no case to answer
Consultant	Grievance	Resignation
Consultant	Grievance	Closed and no case to answer
Consultant	Disciplinary	Ongoing

Table 2. Medical disciplinary investigations 2018/19 for medical staff for whom the Trust is the Designated Body:

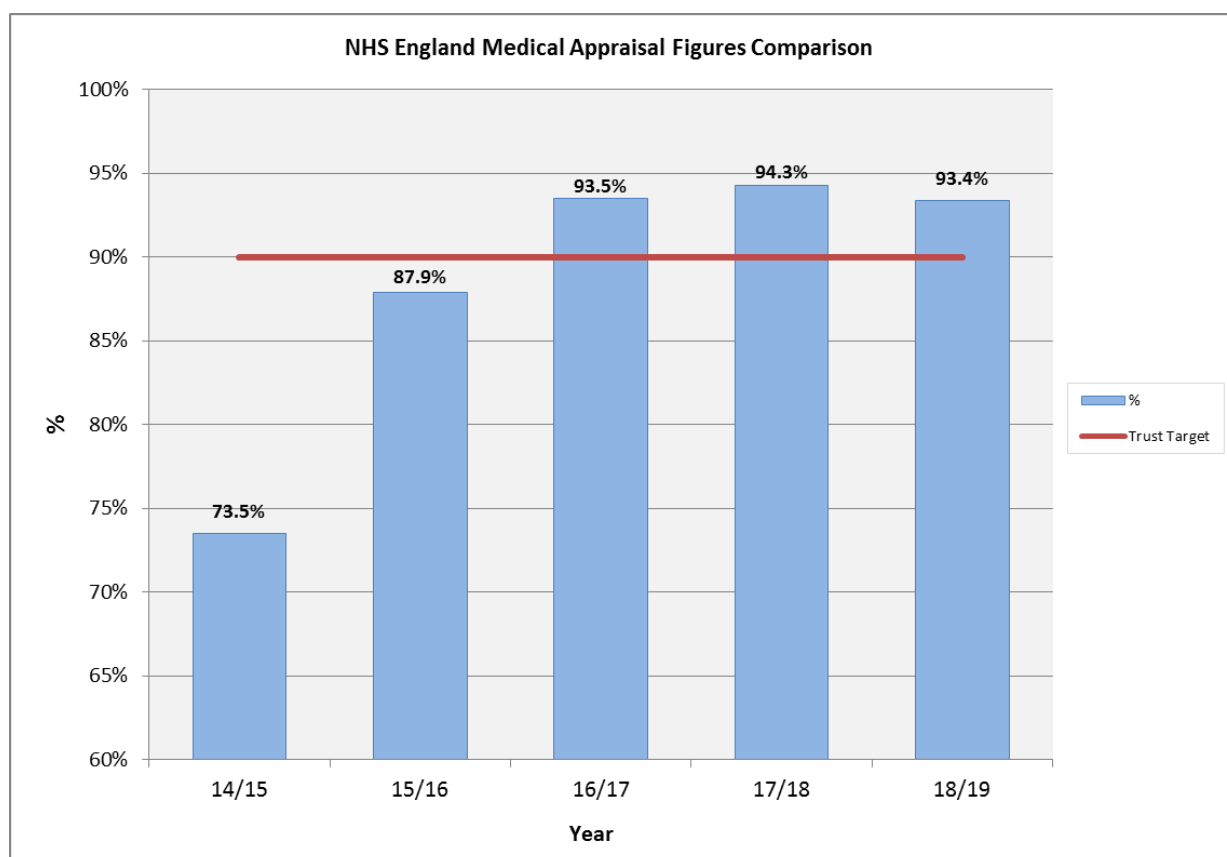
5. Medical Appraisal

Appraisal rates

The 2018/19 NHS England Annual Organisational Audit (AOA) shows that Hull University Teaching Hospitals NHS Trust's appraisal rate is 93.4% compared with the 2017/18 AOA which was 94.3%. This represents a decrease of 0.9%. However, when compared with the other 52 Designated Bodies in the same sector (Acute hospital/secondary care non-foundation trust), Hull University Teaching Hospitals NHS Trust has a better appraisal rate (93.4%) compared to the same sector appraisal rate of 89.6%.

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer.

The graph below shows the NHS England medical appraisal figures for the Trust for the reporting periods 2014/15, 2015/16 2016/17, 2017/18 and 2018/19 against the Trust 90% performance target:



Audit of all missed or incomplete appraisals

Doctor factors (total)	Number
Maternity/Adoption leave during appraisal period	4
Sickness absence during appraisal period	3
Personal circumstances during appraisal period	3
Prolonged leave	2
Lack of time of doctor	27
Total number of Doctors	39

Since the information above was submitted to NHS England on 12/04/2019, 31 out of the 39 doctors have completed their annual appraisal albeit overdue, with 3 doctors leaving/retiring from the Trust. The remaining 5 doctors (3 of which have agreed mitigating circumstances e.g. long term absence or maternity leave) remain outstanding as at 31st July 2019. The 2 remaining doctors are being managed under the Trust's Medical Escalation Policy.

Appraisers

The Trust currently has 68 'active' trained Appraisers, including 2 'Senior Appraisers'. The Senior Appraisers are responsible for ensuring that the training of the Appraiser team is up-to-date, delivering training to new Appraisers and the Quality Assurance of appraisals. Each Appraiser is responsible for carrying out up to 10 appraisals per year. There is an annual Appraiser Network Meeting which provides the opportunity for the Trust's medical Appraisers to

share best practice and receive updates on local and national processes surrounding Revalidation and appraisal.

Quality Assurance

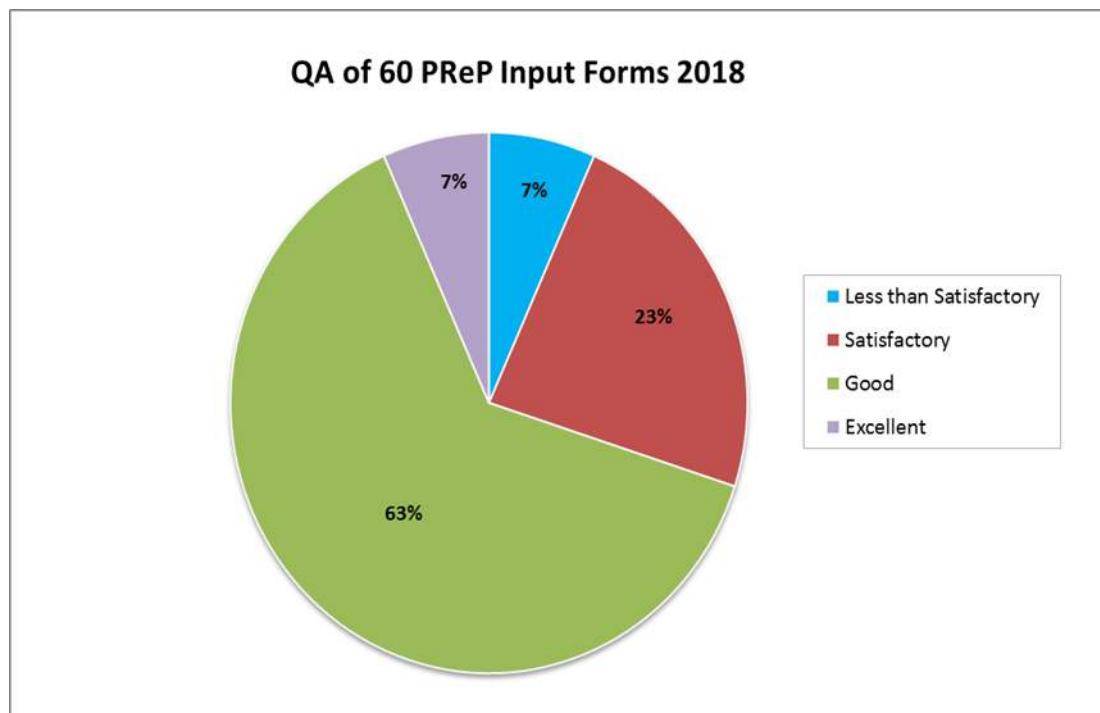
Every Doctor being appraised completes an anonymous feedback form on the appraisal process and their Appraiser. To complete the appraisal process, every Doctor must complete this feedback questionnaire otherwise their appraisal will remain incomplete. This means that 93.4% of Doctors completed anonymous feedback in the 2018/19 appraisal year. This feedback is then provided to the Appraisers after they have appraised 5 Doctors and this is included in their own appraisal as supporting information for appropriate discussion and reflection.

There is a bi-annual Revalidation Bulletin which is circulated to all Doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust. This bulletin provides updates from the Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team and provides Doctors with the opportunity to raise any queries they may have in relation to the Revalidation and appraisal process.

The Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team attend quarterly NHS England regional RO Network and Medical Appraisal Lead (MAL) Networks, which provide updates from NHS England and the GMC on matters surrounding Revalidation and appraisal.

All appraisal inputs and outputs of those Doctors due for Revalidation are reviewed by the Senior Appraiser Team and HUTH Revalidation Team prior to the monthly Revalidation Panel in the form of a Revalidation checklist. Any concerns are raised by the Senior Appraiser Team/HUTH Revalidation at the monthly Revalidation Panel chaired by the Responsible Officer for appropriate discussion and action. Reflections on good or bad practice in completing these outputs are then used in the ongoing Appraiser training programme.

The Senior Appraiser Team provided Quality Assurance on a sample of 60 PReP appraisal input forms (the Trust's electronic appraisal system for Medical staff) in 2018/19. This equates to circa 10% of the current number of doctors whom the Trust is the Designated Body for. The results of this QA exercise are as follows:



Clinical Governance

The Trust is continuing to develop systems to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. Doctors are sent information specific to them in relation to claims, complaints and Serious Incidents (SI's) by the HUTH Revalidation Team in the months leading up to their annual appraisal. Doctors are also able to request a report (at any time) to support appraisal. Work is ongoing with the Clinical Governance team to improve the quality of information received.

Following discussion and agreement by the Responsible Officer at the Revalidation and Appraisal Committee in December 2017, the HUTH Revalidation Team has commenced producing a report (with effect from January 2018) which provides individual Consultants with a summary of their acknowledgement performance on the Radiology Harvard alert system. This report, which links into improved patient safety, has been produced in conjunction with the Trust's Clinical Information Officer for the Clinical Support Services Health Group and can be used as supporting information in a Consultant's annual appraisal.

Doctors who provide work outside of the NHS e.g. via the private and/or independent sector are required to provide evidence of no complaints/serious incidents in their annual appraisal, as well as declaring these roles in their scope of work. Similarly, if there are any complaints/serious incidents, these must be declared and discussed as appropriate.

6. Monitoring Performance

All Doctors being considered for Revalidation must demonstrate participation in regular appraisal. However appraisal in itself is neither an objective assessment of a Doctor's performance, nor of their compliance with trust policies and procedures. The Revalidation Panel therefore also requires confirmation from each Doctor's clinical managers that there are no concerns about performance or conduct. At present, this takes the form of a signed statement from the relevant Health Group Medical Director, based on personal knowledge and information from line managers. In any case the Revalidation process (occurring as it does once every 5 years) should not be the point at which concerns first come to light.

7. Revalidation Recommendations

The Trust made 89 recommendations on Revalidation to the GMC between 1st April 2018 and 31st March 2019. The Responsible Officer has three options in making a recommendation: recommendation for Revalidation, deferral, or failure to engage. It is not possible to recommend 'non-Revalidation'. The Trust has not made any notifications of failure to engage. The breakdown of recommendations is shown in Table 3.

Recommendation	Number of Doctors
Revalidate	85
Defer	4
Total Recommendations	89

Table 3. GMC recommendations April 2018 – March 2019

In total, 96% of recommendations submitted by the RO in the 2018/19 financial year were for a positive recommendation. The reasons for deferral are incomplete appraisal, incomplete multi-source feedback (MSF 360), or a combination of both.

8. Recruitment and engagement background checks

The Trust's Human Resources department has in place a system for checking identity, current and previous GMC Conditions or Undertakings, appropriate recent references, details of last (or

current) Responsible Officer, qualification check, and police clearance. The Responsible Officer continues to use an 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes Revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NCAS investigations, local conditions or undertakings, and any unresolved performance concerns. In March 2018 the Trust introduced the Engaging Temporary Workers – Bank and Agency Policy. This policy sets out the process that must be adhered to for authorising, sourcing and booking temporary workers including the booking of agency staff through approved national procurement frameworks.

9. Responding to Concerns and Remediation

Revalidation should not be the expected route for identifying concerns about an individual Doctor's conduct or capability, occurring as Revalidation is only every 5 years. Appraisal may sometimes identify areas for improvement, but again it is unlikely that serious concerns will come to light purely through appraisal, which is principally a formative and developmental process. More commonly problems will be identified either through investigation of a specific incident, or following expression of concern by staff or patients.

Where there is concern about a Doctor's conduct or capability they are investigated under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NCAS. If misconduct is proved a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NCAS will be put in place. In the majority of capability cases the first option is to consider remediation and support.

In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Sometimes this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on Revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice
- There is a good appraisal system in place, which is developmental and formative in nature
- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC)
- Uptake of appraisal in the Trust continues to surpass the NHS England target of 90%. Maintaining this high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential administrative support and the Trust having sufficient numbers of trained medical Appraisers

- The current percentage of Doctors having appraisal in 2018/19 is 93.4% which surpasses the NHSE target of 90%

11. Recommendations

The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by 27th September 2019.

Appendix 1

Annex E – Designated Body Statement of Compliance

The Board of University Teaching Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Dr Makani Purva is the Trust's appropriately trained and appointed Responsible Officer for Hull University Teaching Hospitals NHS Trust and Dove House Hospice for 2018/19.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

This record is maintained and kept up-to-date by the Trust's Revalidation Team

3. There are sufficient numbers of trained Appraisers to carry out annual medical appraisals for all licensed medical practitioners;

There are 68 Appraisers, conducting between 6 and 10 appraisals each annually

4. Medical Appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers¹ or equivalent);

There are routine Appraiser network meetings, as well as formal and informal review of appraisal inputs, outputs and user experience.

5. All licensed medical practitioners² either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

The 2018/19 NHSE AOA Comparator Report dated 18/07/2019 shows that Hull University Teaching Hospitals NHS Trust's appraisal rate is 93.4% and Dove House Hospice is 83.3% for 2018/19

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹ (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for Doctors to include at their appraisal;

The systems are in place

7. There is a process established for responding to concerns about any licensed medical practitioners¹ fitness to practise;

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;³

The Trust requests information on all new licensed practitioners using a standard RO Transfer Form. The Trust RO responds to similar requests for information from other organisations.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners⁴ have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

There is a monthly Revalidation & Appraisal Committee whose responsibility is to ensure continual improvement and address any identified weaknesses or gaps in compliance. The key members of this committee are; The RO, a Health Group Medical

¹ <http://www.england.nhs.uk/Revalidation/ro/app-syst/>

² Doctors with a prescribed connection to the designated body on the date of reporting.

³ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11:
<http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

Director (or delegate), The Senior Appraiser Team, LNC Chair, Head of HR Services and the HUTH Revalidation Team.

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Hull University Teaching Hospitals NHS Trust

Name:

Role:

Date:

Signed:

Hull University Teaching Hospitals NHS Trust

Trust Board

10th September 2019

Title:	Safeguarding Children and Young People Annual Report 2018/19 Safeguarding Adults Annual Report 2018/19
Responsible Director:	Chief Nurse, Mrs Beverley Geary
Author:	Assistant Chief Nurse, Kate Rudston

Purpose:	To advise the Board via the annual reports on the Trust Safeguarding service, achievements and governance during 2018/2019 and set out key priorities for 2019/2020.	
BAF Risk:	BAF 3 – High Quality Care	
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great clinical services	X
	Partnership and integrated services	X
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Trust has statutory responsibilities to safeguard adults, children and young people that access its services and premises. The challenges facing vulnerable adults, children and young people, in particular, remain significant in this health economy. The safeguarding agenda continues to increase each year with specific emphasis on key national priorities such as Domestic Abuse, Mental Health, Learning Disabilities, Female Genital Mutilation and Child Exploitation to name a few. The requirement for early and proactive safeguarding input places increasing demands on the safeguarding services and this can be challenging with the continued stretch of public services with regards to local authority capacity. Nonetheless, the Trust continues to work with local partners effectively and manage the responsibilities associated with safeguarding to a high standard. The Trust continues to meet its statutory obligations in terms of having the required Safeguarding Leads and Named Professionals in post. In addition, the Trust participates actively as a member of both Local Safeguarding Adults and Children Boards for Hull and the East Riding. Delivery of key objectives from 2017/2018 are outlined in both reports but a summary of significant developments are. • Implementation of Domestic Abuse plan and the continuation of	

	this into 2019/2020. • Enhanced Care Team Pilot and business case for substantive team approved and for full implementation in 2019/2020. • Implementation of the Child Protection Information System (CP-IS). • Good partnership working with safeguarding stakeholders and Hull and Safeguarding Boards. • No regulatory issues raised with regards to Safeguarding during 2018/2019 • No concerns or contract variations with regards to the Safeguarding Contract with NHS Hull and East Riding Clinical Commissioning Groups. The annual reports offer significant assurance on the Trust Safeguarding arrangements with clear objectives outlined for 2019/2020.

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

**SAFEGUARDING CHILDREN &
YOUNG PEOPLE**

ANNUAL REPORT

2018 – 2019

DRAFT

INDEX	PAGE NUMBER
1. Purpose	3
2. Executive Summary	3
3. Background	4
4. Local Context	5
5. Management and Organisational Arrangements	7
5.1 The Anlaby Suite	
5.2 Team Structure	
5.3 Roles and responsibilities	
5.4 Child Sexual Abuse Assessment Service (CSAAS)	
5.5 Internal governance	
5.6 External governance	
6. Training and Development	12
6.1 Safeguarding Children Training	
6.2 Safeguarding Supervision Training	
6.3 Female Genital Mutilation (FGM)	
7. Managing Individual Cases/ Activity	12
7.1 Referrals to Childrens Social Care	
7.2 Child Protection Medicals	
7.3 Child Deaths	
8. Safeguarding Supervision	16
8.1 Caseload Holder Supervision	
8.2 Planned Group Supervision for Non-Caseload Holders	
8.3 Ad-hoc Supervision	
9. Safeguarding Children	17
9.1 Early Help and Safeguarding Hub (EHASH)	
9.2 Mental Health	
9.3 Child Sexual Exploitation	
10. Midwifery	18
10.1 FGM	
10.2 Domestic Abuse	
10.3 Caring for Vulnerable Women	
10.4 Modern Day Slavery	
11. Serious Incidents	20
11.1 Serious Incidents	
11.2 Serious Case Reviews/Learning Lessons Reviews	
12. Key Actions for 2018-2019	21

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Children and Young People. The report will identify Safeguarding Children and Young People activity within the Trust over 2018/2019, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2019/2020.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities (section 11 Children Act 2004) to safeguard the best interests of children and young people that access its services and premises.

Safeguarding children referrals by Trust staff are made to a range of Local Authority Children's Services in the locality of the child's home address. The majority of referrals are made to Hull Local Authority Children's Services. Safeguarding referrals for children/unborns to Hull Local Authority Children's Services in the 2018/2019 reporting period were less than previous years. This is largely due to the positive work that has been undertaken between the Safeguarding Children's Team and the Hull Local Authority to improve quality of referrals in line with the Hull Safeguarding Children Boards (HSCB) Thresholds Guidance (May 2018) rather than a decline in the number of safeguarding concerns leading to a referral. The progress in improving the process to ensure that the Trust's Children's Safeguarding Team receive outcomes from the safeguarding children referrals to the both Hull and East Riding Children's Services continues to be an area of practice and feedback that requires further work.

The Trust's named professionals and the safeguarding team continue to strengthen the safeguarding arrangements in the Trust playing an active part in safeguarding children and adults at risk across the wider multi-agency partnership.

The Trust continues to meet its statutory obligations in terms of having the required Named Nurse, Interim Named Doctor(s) and Named Midwife in post. In addition, the Trust participates actively as a member of both Local Safeguarding Children Boards for Hull and the East Riding.

The Trust participated in a Care Quality Commission (CQC) Review of Health Services for Children Looked after and Safeguarding in Kingston upon Hull in January 2017. The Trust did not receive a rating from this inspection. The recommendations and action plan are monitored by the NHS Hull Clinical Commissioning Group (CCG) and Safeguarding Committee.

Following on from last year's annual report the key actions completed in 2018/2019 are:

- A positively improved safeguarding culture amongst health services leaders.
- An improved Interface of adult safeguarding referrals and Children's services.
- Young people over 16 and up to 18 are given the choice of whether to be seen in paediatric emergency department (ED) or Adult ED.
- 24 hour Paediatric Nursing in the ED.
- Improved quality of referrals to Children's Social Care.
- Strengthened Safeguarding Supervision arrangements in line with the Trust Safeguarding Supervision Policy (CP 341) to ensure that all Trust staff who have a safeguarding concern can access planned and/or ad-hoc safeguarding supervision. This includes a review of resource and capacity for safeguarding supervision within maternity services.

- Raised awareness and assessment/identification of children that access Trust services and who may be at risk of Child Sexual Exploitation.
- The Specialist Adult Safeguarding Nurse supported by the Named Midwife has led work on the key priority area of Domestic Abuse. There is now a Domestic Abuse policy for the Trust and a structured eLearning program which includes DA and Routine Enquiry for Domestic Abuse.
- Safeguarding children policies and procedures are up to date.
- All Serious Incidents (SI's) declared within the Trust which involve a child (under 18) are now reviewed by the Named Nurse/Named Doctor to determine if there are any safeguarding issues that need to be considered.
- The estates and facilities of the Anlaby Suite were reviewed in line with the Trust's Capital and Estates strategy. The Anlaby Suite was relocated to a new purpose-built unit on the HRI site in October 2018.
- The Child Protection Information System (CP-IS) was successfully implemented in the Trust in December 2018.
- The Vulnerability Pathway for Women with Complex Social Factors who access the Trust's maternity services has been reviewed against National Guidance and in partnership with the Local Authority Children's Services and primary care provider services to ensure that those women requiring early help/additional support and further assessment are identified early in pregnancy to promote health and wellbeing and improved outcomes.

3. BACKGROUND

Working Together to Safeguard Children 2018¹ sets out the statutory framework and the legislation relevant to safeguarding and promoting the welfare of children for all organisations and agencies who have functions relating to children. While the Childrens Act 1989² places a duty on local authorities to take the lead role and meet this requirement in relation to children in need in their area, safeguarding children and young people and protecting them from harm is everyone's responsibility. The Children Act 1989 was amended in 2004 and sets out the statutory responsibility for key agencies under Section 11.

Section 11 of Children Act 2004³ places duties on a range of organisations and individuals to ensure their functions and any services they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. NHS organisations are subject to Section 11 as health professionals are felt to be in a 'strong position to identify welfare concerns' and have 'a critical role to play in safeguarding and promoting the welfare of children' (Working Together 2015).

Hull University Teaching Hospitals Trust (HUTHT) is an NHS organisation that provides acute and specialist health care to children. It works in close partnership with local health providers such as City Health Care Partnership, Humber Teaching NHS Foundation Trust and the Hull and East Riding Clinical Commissioning Groups. The Trust Safeguarding Children's services also works closely with Children's Social Care and the Police.

The Trust is a member of the two local Safeguarding Children's Boards in Hull and East Riding. During 2018/19, attendance of the Trust representatives at both was good and attendance at the subgroups for both Local Safeguarding Children's Boards (LSCB's) has continued.

¹ HM Government. Working together to safeguard children - A guide to inter-agency working to safeguard and promote the welfare of children, July 2018.

² The Childrens Act 1989 – Government Legislation, Parliament of the United Kingdom

³ The Childrens Act 2004 – Government Legislation, Parliament of the United Kingdom

In June 2018, the government announced that all local authorities would need to make arrangements to replace their Local Safeguarding Children Boards by September 2019. Instead of each locality having access to a Local Safeguarding Children Board, the government wants each locality to have access to a team of Safeguarding Partners, who will work collaboratively to strengthen the child protection and safeguarding system.

The move to replace the Local Safeguarding Children Board will introduce a team of Safeguarding Partners to each locality. These Safeguarding Partners will be a team of key professionals from three sectors: the local authority; the clinical commissioning group for any area that falls under the local authority; and the chief officer of police for any area that falls under the local authority.

Together, these Safeguarding Partners will be in charge of agreeing on and implementing new safeguarding strategies that will strengthen their multi-agency working and, in turn, improve the provision of safeguarding and child protection arrangements in the local area. In order to achieve this, the Safeguarding Partners must set out how they will work together with all relevant agencies and make clear their arrangements for conducting local reviews.

Both Hull and East Riding are both working through the new arrangements and the governance under each local authority. The Trust continues to work as a partner for each local authority and contributes actively to the new arrangement proposals.

The strategy of HUTHT, in line with the two LSCBs and partner agencies is to ensure Trust staff are provided with the skills, support and reporting mechanisms in order that they can fulfil their section 11 responsibilities and recognise safeguarding concerns, escalate and report these appropriately, sharing information with other agencies in a timely manner.

HUTHT contribute to all local Child Death Reviews, Serious Case Reviews and Lessons Learned where they have had contact with a child and/or their family. Recommendations and actions from these reviews are monitored through the Trust Safeguarding Committee.

The Trust has remained compliant with the requirements for the statutory Named Professional Posts. The Named Doctor role has continued to be covered by Dr Chris Wood (the local area Designated Doctor) as Interim Named Doctor throughout 2018/2019. Recruitment to the Named Doctor post has proved difficult due to the specialist nature of the role. This is recognised as a national problem and not just a local issue. It is expected that the Trust will recruit to the role of Named Doctor in August 2019. The Named Nurse Mrs Sandra Park has remained in post. The Named Midwife Mrs Patricia Darley was recruited to her role in January 2018 and remains in post.

The Safeguarding Children's service remains under the leadership and management of the Assistant Chief Nurse/Safeguarding Lead, Miss Kate Rudston. In March 2019 the Trust Executive Director Lead for Safeguarding Mr Michael Wright retired from the Trust and Mrs Beverley Geary was recruited to the role of Trust Executive Chief Nurse and Director Lead for Safeguarding.

The Trust Safeguarding Children's Service continues to work with Hull and East Riding of Yorkshire partners to meet the challenges of the wider safeguarding agenda by contributing to Learning Lessons reviews (LLR's), Serious Case Reviews (SCR's), Joint Targeted Area Inspections (JTAI's) and Care Quality Commission (CQC) and Ofsted Inspections.

During the reporting period 2018/2019 there have been no reported concerns about the Safeguarding Children's service or the Anlaby Suite with regards to Section 47 Child Protection Medicals. The NHS Hull Clinical Commissioning Group remains satisfied with the provision and standards of the Safeguarding Children's service and compliance with

safeguarding children training. No contract notices have been received regarding the Safeguarding Children's service.

The term "children" within the *Working Together to Safeguarding Children* (2018) document, and the Children's Act of 1989 and 2004 respectively, define that "a child is anyone who has not yet reached their 18th birthday". Therefore, the term 'children' means 'children and young people', throughout this report.

4. LOCAL CONTEXT

Hull University Teaching Hospitals NHS Trust (HUTHT) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs over 9000 staff (headcount) and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care 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.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the 3rd most deprived local authority in England in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average.

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull. Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are either South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

From a Safeguarding Children perspective, the local landscape and population is an increasing challenge and in particular with rates of abuse, neglect and harm which are closely linked with deprived areas. The increase in the ethnic minority population is also a challenge for Safeguarding Children due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Abuse and Prevent (the Governments agenda on anti-terrorism and preventing vulnerable people from being radicalised).

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

5.1 THE ANLABY SUITE

The Anlaby Suite was relocated on the Hull Royal Infirmary site close to the Women and Children's Hospital, urgent care services, and support services in October 2018. It is now a purpose-built unit that provides dedicated facilities for the provision for undertaking Section 47 Child Protection medical examinations (S47 Medicals).

The Anlaby Suite is furnished with fixtures and fittings intended to meet the required forensic standards for a sexual assault referral centre (SARC), as well as maintaining a child friendly environment. The Anlaby Suite is also used by the Police 24/7 as an interview facility for children, young people and vulnerable individuals who require DVD interviews following an allegation/disclosure of harm and or a criminal act.

Access to the service is by referral from the police or Children's Social Care as part of a S47 investigation when there is suspicion of, or actual harm, abuse or neglect that has occurred to the child or young person and they require medical examination. There is an agreement with both Hull and East Riding Local Safeguarding Children Boards that the Anlaby Suite and the Trust practitioners provide this service locally. The service is provided Monday to Friday (excluding bank holidays) and 8.30am to 4.30pm. Outside of these hours, there is an agreement that the Police and Children's Social Care can request a S47 Medical via the General Paediatric Consultant although this is only in circumstances when it cannot wait and is deemed in the best interest of the child or young person and in cases of injury in non-mobile babies.

The service is also commissioned by NHS England to provide a Child Sexual Assault Assessment Service (CSAAS) for the Humberside Police and Local Authority Area for children under the age of 16 years and for 16 to 17 year olds with vulnerabilities (see section 5.4) This service is provided Monday to Friday 8.30am to 4.30pm (excluding weekends and bank holidays).

The Safeguarding Children's Team support the administrative function of the Section 47 medicals. The governance around Section 47 Child Protection Medical processes has continued to improve during 2018/2019 by inputting key performance activity into an auditable database that can be provide information to regulators or contract commissioners as requested and as part of the contract arrangements with NHS England.

The Anlaby Suite continues to be the base for the Trust's Safeguarding Children's Team including the Named Nurse for Safeguarding Children, Named Midwife and Interim Named Doctor for Safeguarding Children.

During the transition arrangements of moving the service the new build in October 2018, the service was supported by the Paediatric Outpatient Service for approximately four weeks and use of the clinic rooms. There was no disruption to service provision during this period which was commended by both the Police and Local Authorities and reflected in the Hull and East Riding LSCB minutes formally. The move to the new building and environment has proved to be hugely positive for staff, service users and external agencies, providing a discreet and bespoke environment to suit the sensitivities of the service.

5.2 SAFEGUARDING TEAM STRUCTURE

The Working Together to Safeguard Children 2018 document states that all providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor

and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding.

Named practitioners have a key role in promoting good professional practice within their organisation and agency, providing advice and expertise for fellow practitioners, and ensuring safeguarding training is in place. They should work closely with their organisations/agency's safeguarding lead on the executive board, designated health professionals for the health economy and other statutory safeguarding partners. The requirements for statutory and lead roles are also referenced in the *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2015*.

The Trust for 2018/2019 has remained compliant with the requirements for the statutory Named Professional Posts and the following structure is currently in place.

- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children
- Named Midwife for Safeguarding Children
- Safeguarding Educator/Safeguarding Supervision Co-ordinator
- Safeguarding Children Practitioners (2 WTE)
- Administrator for S47 Child Protection Medicals
- Management Assistant

5.3 ROLES & RESPONSIBILITIES

The Safeguarding Children's team provides specialist advice, support and supervision pertaining to the safeguarding of children and young people to HUTHT staff. Additional child protection support and advice is available via the on-call consultant paediatrician so that there is 24 hours, 7 days a week cover.

The Named Doctor works closely with the Assistant Chief Nurse, Named Nurse and Named Midwife to support the wider safeguarding agenda and ensure that Trust staff feel supported and empowered to act on their safeguarding concerns. To support the wider 'Think Family' approach the Named Nurse and Named Midwife have established and maintained robust communication processes with the Trust Adult's Safeguarding team for activity and cases that involve children and adults.

The Safeguarding Children's Team and Named Leads continue to be responsible for the following key duties:

1. Medical examinations under Section 47 Children Act 1989 in partnership with the Local Authorities Children's Social Care (CSC) services and the Police.
2. Advice and support (safeguarding supervision) to staff members in relation to safeguarding children and young people matters presenting within the Trust.
3. Training of Trust staff and to contribute to the training resources across the local health partnership and to pre-registration nursing and midwifery training.
4. Administration of safeguarding children activities within the Anlaby Suite.
5. Compliance with regulatory standards in relation to Safeguarding Children and Young People.
6. Compliance with LSCB's policies and procedures including information sharing and good partnership working across agencies.
7. Compliance or working towards compliance of Commissioner contracts as per annum.
8. Participation in Serious Case Reviews and Serious Incidents, reports and ensuring the actions from learning lessons are implemented and embedded.

9. Review of all Safeguarding Children's referrals and incidents involving children and young people occurring in the Trust.
10. Reporting on all activity and items for escalation to the Trust Safeguarding Committee.
11. Providing leadership on the Safeguarding children and young people's agenda.
12. Advising the Trust's Safeguarding Lead and Chief Nurse on any impending or likely changes that will impact on the Safeguarding Children and young people agenda and activity.

The Trust is required to have a Senior Designated Officer (SDO), who manages allegations against staff for safeguarding children concerns. This role is held by the Assistant Chief Nurse/Safeguarding Lead who has implemented a number of changes to improve the governance of the role. The Trust's Policy has been revised to reflect this and includes include both adults and children. In the absence of the Assistant Chief Nurse/Safeguarding Lead, the SDO role is covered by is covered by Mrs Christine Davidson, Specialist Nurse for Safeguarding Adults.

The role of the SDO is to ensure that safeguarding allegations that are raised against Trust staff are managed according to the LSCBs policies and procedures.

5.4 CHILD SEXUAL ASSAULT ASSESSMENT SERVICE (CSAAS)

HUTHT has continued to be commissioned by NHS England during 2018/2019, to provide a Child Sexual Assault Assessment Service (CSAAS) for the Humberside Police area i.e. East Yorkshire, Hull, North Lincolnshire and North-East Lincolnshire, for children and young people under the age under 16 years and for 16 to 17year olds with vulnerabilities. The CSSAS covers core hours 8.30 am to 4.30pm with the weekend and bank holiday cover provided by Sheffield Children's Hospital and Mountain Health Care in Dewsbury. Professionals undertaking the assessments are trained specifically to undertake this role.

The service continues to provide medical and forensic assessment for sexual abuse at the request of the local Children's Social Care department and Humberside Police, offering holistic medical and nursing support. This includes sexual health assessment, screening and treatment where necessary, contraception emergency contraception, and post exposure prophylaxis for HIV. Assessment also supports identification of those at risk of self-harm or Child Sexual Exploitation. Information and evidence is gathered to assist the Children's Social Care service and the Police in the investigation of possible abuse.

Links with local sexual health services, local Children and Adolescents Mental Health Service (CAMHS) services and local Children's Independent Sexual Violence Advisers (ISVAs) via the Police and Crime Commissioner Office for Humberside aims to provide on-going support for child victims as necessary

Quarterly data performance reports i.e. SARC-IPS and Management Information (MI) are submitted to NHS England by the Named Nurse and Lead CSSAS nurse using the NHS England's report template and they inform the quarterly contract meeting to review service provision and activity. This meeting is attended by the Assistant Chief Nurse, Trust Senior Contracts Manager, the Named Doctor and the Named Nurse for Safeguarding Children.

Professionals completing the assessments are trained specifically to undertake the role of Forensic Medical Examiner (FME). In 2018 NHS England raised concerns about the ability of the Trust to provide sufficient medical coverage of the CSAAS in line with contract specifications. Despite the recruitment in 2018 of additional medical staff to the Trust paediatric medical services, the capacity to cover the CSAAS service has not significantly improved in 2018/2019, with Dr Wood undertaking the majority of child sexual assault examinations and continuing to flex his workload so that assessments are undertaken as

requested by Social Care and the Police in a timely manner. It is expected that the Trust will be recruiting to the role of Named Doctor and CSAAS medical lead in August 2019.

Further areas of CSAAS service development for 2019/2020 are

- To continue to develop the role of the Lead CSAAS nurse to support the following areas of development.
- CSAAS service promotion through networking and the delivery of a service specific training package to key stakeholders of the service across the Humberside area, specifically the Southbank.
- Strengthen communication pathways with Sexual Health Service in the Humberside area.
- Strengthen data recording and reporting so that there is qualitative narrative about the referrals, S47 discussions and services user contact. The changes will also support exception reporting if required.

5.5 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Children Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP 278). The Policy is supported by procedures, protocols and guidelines. All of the documents are underpinned by the LSCBs Policies and Procedures. All are available on the Trust's intranet for Safeguarding Children.

The overall accountability for Safeguarding in the Trust is the Chief Executive. The delegated Executive Director responsible for Safeguarding is the Chief Nurse with the Assistant Chief Nurse undertaking the role as Safeguarding Lead. The Named Nurse reports directly to the Safeguarding Lead, but also has a direct professional line to the Chief Nurse.

Safeguarding activity is monitored within HUTHT through the Safeguarding Committee, which meets monthly. The Safeguarding Children report is presented monthly detailing activity and items for discussion and consideration. The Safeguarding Committee report to the Trust's Operational Quality Committee and escalates issues by exception when required.

The Named Nurse reviews all reported incidents (DATIX) within the Trust related to children to ensure there are no missed safeguarding concerns and the risk rating for each incident is appropriate. Serious Incidents (SI's) may be declared internally to the Trust or externally by the designated safeguarding professionals. All SI's relating to children in 2018/2019 were shared with the Safeguarding Lead for a safeguarding overview. If a SI has a child or midwifery element then the SI is sent to the Named Nurse to determine if there are any safeguarding issues.

All Serious Case Review's (SCR's) and SI reports are reviewed, quality checked and signed off by the Safeguarding Lead or a Senior Manager/Director before leaving the organisation.

5.6 EXTERNAL GOVERNANCE

In 2018/2019 HUTHT was represented on the Hull and East Riding Safeguarding Children's Board (HSCB) by the Assistant Chief Nurse/Safeguarding Lead.

In addition, HUTHT is represented on LSCB's sub committees by the Named professionals and staff working within the Safeguarding Children Team. The LSCBs monitor the Trust safeguarding performance through:

A Section 11 self-assessment Audit of Safeguarding Children arrangement is completed on a minimum of 3 yearly basis but usually annually as requested by the local LSCBs. The

Section 11 audit was last submitted to East Riding Safeguarding Children's Board in March 2018. Submission was accompanied by the requirement to attend a Challenge Panel event with Board members and the agency in April 2018. The ERSCB held a Challenge Panel with the partners of the Board and HEYHT was represented by the Named Nurse and Assistant Chief Nurse. Feedback was positive by the Independent Board Chair and Manager on the work undertaken and planned with regards to the Section 11 requirements. The Trust also completed a Section 11 self-assessment audit for the North Lincolnshire Multi Agency resilience and Safeguarding Board (MARS) as the Trust provides the CSAAS for children living in this area.

**Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.*

The Trust is also monitored and/or inspected by the following agencies with regards to Safeguarding Children arrangements:

- Ofsted – Ofsted is been responsible for inspecting the Local Authorities and their Partner Agencies in relation to their Safeguarding Children and Looked after Children arrangements. HUTHT was last inspected in June 2011.
- NHS England and the Care Quality Commission (CQC) – CQC monitor and review the Safeguarding Children Standards of the Trust. The Trust was inspected in January 2017 (as part of the NHS Hull CCG inspection) and a number of recommendations were identified for Safeguarding Children. The CQC inspection in June 2016 identified a number of areas of concern regarding Safeguarding Children These actions have been completed.
- NHS Hull Commissioners – As part of the Quality Contract with the Trust Commissioners, the Trust has a number of key performance indicators for Safeguarding Children and Adults. The Trust delivered the majority of the performance for 2018/2019 with agreed indicators carried forward to 2019/2020. There is no financial target attached to the key performance indicators. The Assistant Chief Nurse/Safeguarding Lead attends the bi-monthly Quality Delivery Group meetings with the Commissioners and receives any questions regarding safeguarding from the Contract Monitoring Board to which the quarterly reports are submitted. This was established in 2013 and has proved to be a positive link with the Commissioners and enabled the Safeguarding agenda to be discussed, challenged and supported.

5.7 SERVICE USER AND STAKEHOLDER FEEDBACK/INVOLVEMENT

The Anlaby Suite staff actively promotes feedback from all service users and Stakeholders i.e. children, parents/carers, police and local authority staff, who access the service. During the period of 2018/2019 the feedback was strongly positive across all service users and stakeholders. Engagement in this process can be limited by the sensitivity of the case, however all feedback is used to develop improved communication pathways and service improvement specifically service user experience. An action outstanding from 2018/2019 carried forward for 2019/2020:

- To develop a service user leaflet/document that can support those that attend the service including what to expect and information relating to referrals to other services.

As part of the CSSAS contract a quarterly feedback report is submitted to NHS England and monitored through the quarterly contract meetings.

6. TRAINING AND DEVELOPMENT

6.1 SAFEGUARDING CHILDREN TRAINING

Training and education of staff for Safeguarding Children continues to be a high priority for the Trust. In 2018/2019 HUTHT remained compliant with training at over 80% across the 4 levels of safeguarding children training.

Intercollegiate level of training	Current compliance (%) Target 80%
Level 1 (Basic)	92.1%
Level 2 (Intermediate)	89.9%
Level 3 (Advanced, multi-agency)	84.3%
Level 4/5	100 %
Threshold	59.2%

Table 1: Compliance rates at 31st March 2019

Compliance with Threshold training is improving on a monthly basis with a 3 year plan to achieve over 80% compliance by 2020. This is on target to be achieved.

The compliance with Safeguarding Children Training is monitored closely by the Training and Education department, the Named Nurse for Safeguarding Children and the Assistant Chief Nurse. Training data is submitted monthly to the Trust Safeguarding Committee so that any areas of concern are reviewed and actions agreed if required.

6.2 SAFEGUARDING SUPERVISION TRAINING

In 2018/2019 Safeguarding Supervision training developed further as part of the training partnership with the community health provider City Health Care Partnership (CHCP) and Humber Mental Health Trust and was jointly delivered with CHCP and Humber Mental Health Trust. There have been an additional 18 supervisors trained in the Trust 2018/2019. Feedback from the joint training has been very positive. All training is available on the Trust Intranet site.

7. MANAGING INDIVIDUAL CASES/ ACTIVITY

7.1 CPIS

The Child Protection Information system (CP-IS) was implemented in the Trust on 12th December 2018. The CP-IS is a national system that connects Children's Social Care (CSC) IT systems with those used by the NHS. CP-IS gives health professionals the ability to see if there is a 'Child Care Alert' on a child's Summary Care Record (SCR) and whether a child is subject to a child protection plan (CPP), a pre- birth CPP or is a Child Looked After (CLA) regardless of which local authority the child resides in. In turn, local authorities can see where, when and how often a child in their care has made an unscheduled visit to the NHS through emergency departments, minor injury units and other unscheduled paediatric and maternity settings.

The Standard Operating Procedure (SOP) was written as part of the implementation the CP-IS and is available on the Trust Intranet to support staff in reviewing the SCR to see if a 'Child Care Alert' is present and to use this information to inform their assessment of the reason for the child's attendance at Trust.

The effectiveness of CP-IS is being evaluated locally, and further work is required with health and LA partners to incorporate the CP-IS into existing communication pathways to support the work to safeguard children. The Safeguarding Children team are continuing to support staff to raise awareness and embed in practice routine review of alerts/safeguarding communication in records and in accessing this information via the SCR.

7.2 REFERRALS TO SOCIAL CARE

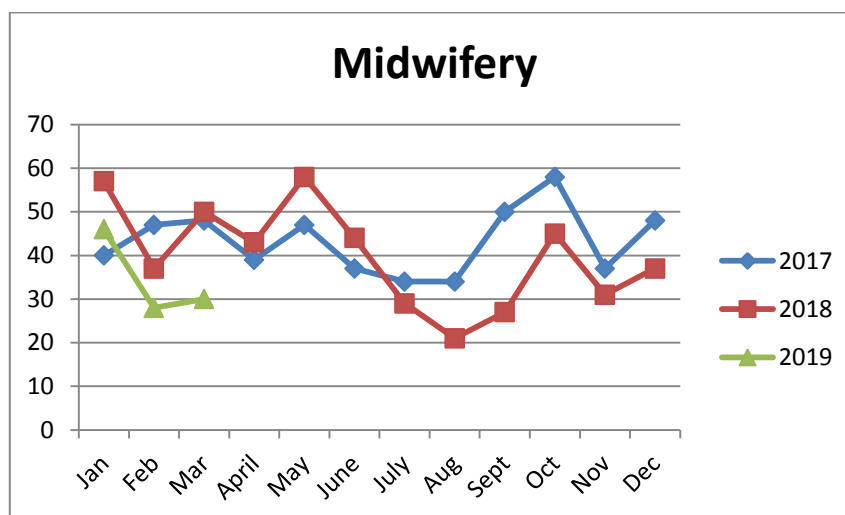
During the reporting period of 2018/2019, staff from the Safeguarding Children Team continued to visit the Paediatric Emergency Department (ED), the Paediatric wards/Assessment Unit and Neonatal Intensive Care Unit areas daily to undertake face to face paediatric liaison with Trust staff. The Named Midwife has also continued to visit the maternity service areas regularly. This supportive approach has resulted in a raised awareness of Thresholds of Need (HSCB 2018) and has contributed to an improvement in the quality of referrals from Women and Children's Services and Paediatric ED.

Prior to 2018/2019 there had been a year on year increase in the number of safeguarding children referrals made by the Trust, however concerns about the quality of referrals were raised by the LA Children's Services across the partnership with specific reference to Thresholds of Need. Practitioners from the Trust safeguarding team have participated in LA led multiagency safeguarding audits throughout the year to support the LA work to improve the quality of referrals and outcomes. As a result, the number of referrals made by the Trust has decreased as the quality of referrals has improved.

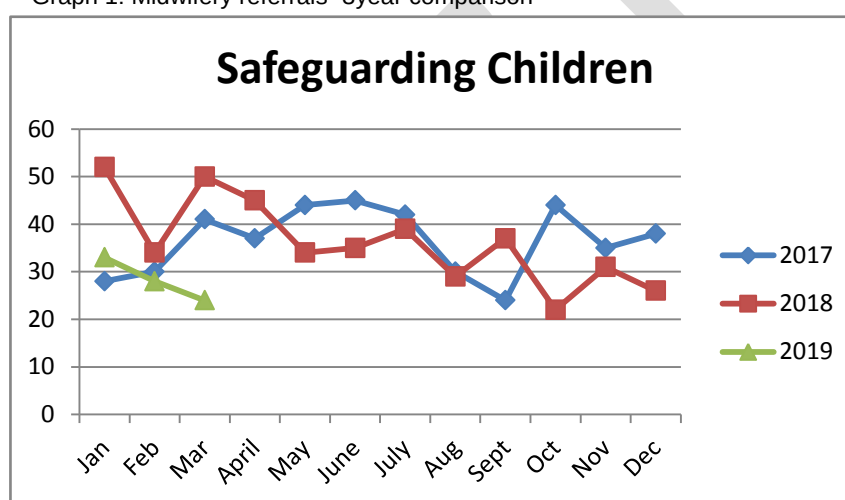
The Safeguarding Children team reviews all referrals which help monitor the quality of referrals and ensure that Trust the policy for children and women with vulnerabilities is adhered too. Further work is needed to support the work of the LA to improve communication and feedback to the referrers, and the outcome of their referrals.

Number of referrals made to Children's Social Care Teams by staff group	2016-2017	2017-2018	2018-2019
HEYHT Midwifery	586	528	501
HEYHT Safeguarding Children	409	475	439
Total number of referrals made	995	1003	940

Table 2: Number of safeguarding Children referrals a 3 year comparison.



Graph 1: Midwifery referrals- 3year comparison



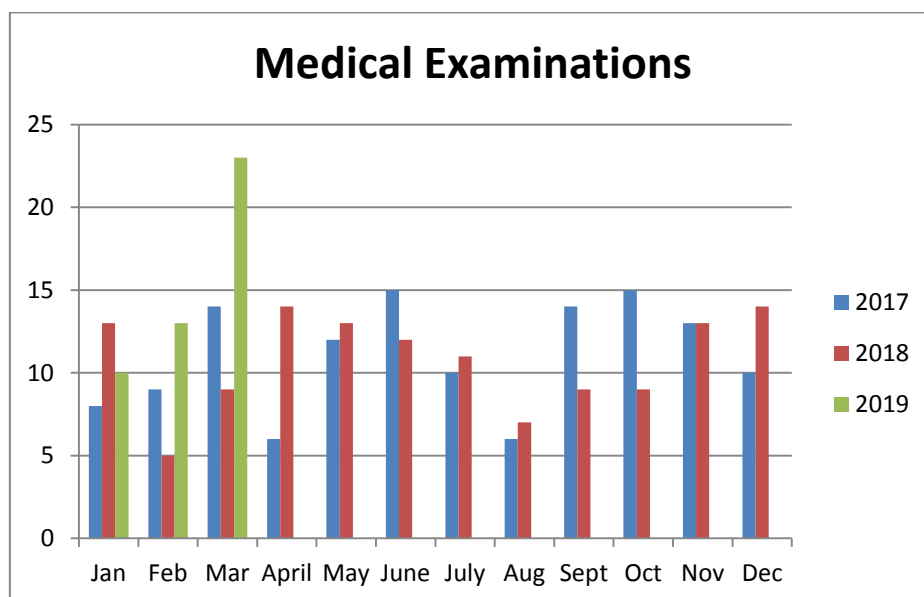
Graph 2: Safeguarding Children referrals-3year comparison

7.2 CHILD PROTECTION MEDICALS

The following table illustrates the number of S47 Child Protection Medicals carried out during office hours within the Anlaby Suite over the last 3 years. In total, there were 149 medical examinations carried out 2018 - 2019, which remains relatively stable.

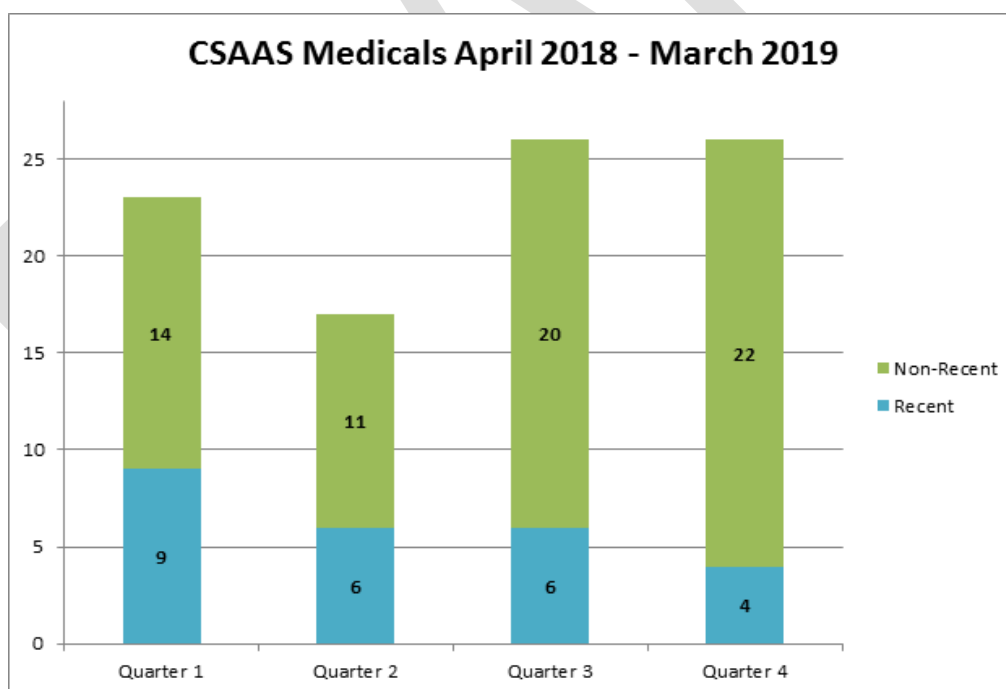
Examination	2016-2017	2017-2018	2018-2019
Sexual Abuse	62	54	74
Physical Abuse	47	56	46
Neglect	15	8	3
Other	0	7	7
Follow up/ Outpatient	16	6	19
Total	140	131	149

Table 3: Number of child protection medicals with reason for attendance



Graph 3; Section 47 Medical examinations including Forensic Medical Examinations Jan 2017-March 2019

The S47 Medicals are undertaken by a trained paediatric, forensic medically Consultant in the Trust and the reports are submitted to the lead agencies to support the S47 investigation. These are used to inform the evidence for court and care proceedings and/or criminal charges against the perpetrator/s.



Graph 4: number of Section 47 Medical examination including Forensic Medical Examinations completed Jan 2017-March 2019.

The figures in the previous table (Graph 4) includes; follow ups and other Anlab Suite activity, including FGM medicals and Sexual Transmitted Infection (STI) screening in under 13 year olds.

7.3 CHILD DEATHS

The Named Nurse and the Named Doctor act as the central point within the Trust for the notification and subsequent sharing of information with other agencies in regard to child deaths. Access to a Designated Doctor for Child Deaths is a requirement for every LSCB as part of the Child Death Review process. Dr Mary Barraclough, Consultant Paediatrician at HUTHT carries out this role.

The Child Death Overview Panel (CDOP) collates information in relation to the number of child deaths locally and their categorisation as either expected or unexpected. HUTHT provides reports to the CDOP's and as a member of Hull and the East Riding Safeguarding Children Boards. The CDOPs provide annual reports, to which HUTHT receive.

8. SAFEGUARDING SUPERVISION

In 2018/2019 the Safeguarding Supervision Coordinator continued to strengthen the safeguarding supervision process by conducting a review of resources and capacity needed for all staff working with children and their families, including maternity services. The review included a needs analysis of the staff, identifying the model of supervision they require commensurate with their role and workload in line with the Safeguarding Supervision Policy and whether they require regular planned individual supervision (caseload holder), regular planned group supervision (caseload holder or areas with high paediatric traffic) or access to ad hoc supervision. Compliance with Safeguarding Supervision in the Trust's Women's and Children's services is monitored by the Safeguarding Supervision Coordinator and reported quarterly to the Safeguarding Committee.

8.1 Caseload Holder Supervision

Caseload holder supervision is for staff who work with a caseload of patients, with paediatric involvement. This planned quarterly supervision is either delivered on a 1:1 or as a group, in accordance with the type of caseload held. Shared caseloads require planned group supervision; individual caseloads require 1:1 supervision.

The planned quarterly caseload holder safeguarding supervision is well established in specialist paediatric areas, working with an individual or shared caseload, with excellent engagement from staff and positive feedback received from supervisees. The Trust's paediatric areas have an overall 85% compliance with safeguarding supervision for caseload holders.

Compliance with planned quarterly caseload holder safeguarding supervision in Community Midwifery Services has however been impacted by reduced staffing level, high workload and changes in working practices. Efforts continue to progress this, supported by the Named Midwife, Safeguarding Supervision Coordinator and maternity service managers. A cascade approach to safeguarding supervision has been implemented with the Community Maternity Services. The Named Midwife supervises the Community Sisters who then provide safeguarding supervision for the supervisors in each community midwifery team. Using this different approach had ensured that each community midwifery team has access to safeguarding supervision. The Named Midwife and Safeguarding Supervision Coordinator have made themselves available to support this model of planned group supervision in the community midwifery teams.

8.2 Planned Group Supervision for Non-Caseload Holders

Planned group safeguarding supervision is for all staff in clinical areas with high paediatric traffic. Planned group safeguarding supervision is delivered on paediatric study days. At times there have been operational difficulties for the wards in maintaining the study days, which has affected the uptake of planned group safeguarding supervision. This year (2019/20) will see a new approach of staff being rostered onto study days across all

paediatric wards including Neonatal Intensive Care Unit (NICU). Staff working on the paediatric wards will also have safeguarding supervision requirement incorporated into their annual appraisal review.

Senior midwives (who are trained as safeguarding supervisors) within hospital based maternity services are receiving regular planned group safeguarding supervision by the Named Midwife. This cascade approach is used with the senior staff then providing supervision to other team members. In addition a safeguarding supervision/teaching session is delivered on midwives mandatory study days.

8.3 Ad-hoc Supervision

Ad-hoc safeguarding supervision is available to all staff across the Trust regardless of work area. The safeguarding children team provide this service during office hours. Ad-hoc safeguarding supervision is also available with any of the 64 trained safeguarding supervisors, working in the clinical areas across the Trust. In addition a practitioner from the Safeguarding Children Team visits the paediatric and maternity wards daily to give staff access to daily ad-hoc supervision.

9. SAFEGUARDING CHILDREN

9.1 EHASH (Early Help and Safeguarding Hub)

Both Hull and East Riding Local Authorities operate an EHASH team for all safeguarding children and early help referrals. The EHASH in East Riding has remained the same with little change in its arrangements during 2018/19. The Named Nurse attends the Hull Strategic EHASH management meeting and the Named Midwife attends the Hull EHASH Operational Management Group meeting to support improved communication and feedback in relation to safeguarding referrals. Hull EHASH has undergone several operational changes during 2018/19 and these changes continue as part of the review of partnership arrangements and establishment of the Learning Hub in 2019/20.

9.2 MENTAL HEALTH

Work has been completed to review the communication processes between Child and Adolescent Mental Health services (CAMH's) and the Trust, where a young person with a mental health care plan is receiving care within the Trust. This included the review of the transfer of care process and improvements to documentation for children in the Trust in relation to safeguarding concerns.

A database was set up (2017) by the Safeguarding Children Team to collate data relating to children and young people who attend the hospital via the Emergency Department with Self-harm. This data was submitted to the Safeguarding committee for review and also submitted to the ERSCB; however the data collection did not clearly identify the LA area of the child and was a combined Hull and East Riding of Yorkshire report. To address this changes were made to the data collection tool and reports can now be submitted to ERSCB and HSCB that provides data for the children in the respective LA areas. This work is contributing to the strategic work on children's mental health and has been well received by the Board partners.

9.3 CHILD EXPLOITATION including County Lines and Missing Children

Child Sexual Exploitation (CSE) remains a priority area of work across both Hull and East Riding of Yorkshire Safeguarding partnerships. This work has extended to include Child Criminal Exploitation (CCE). The Trust Safeguarding Children's Team continue to contribute and support this work representing the Trust at the CSE/CCE Strategic and operational meetings.

10. MIDWIFERY

10.1 FEMALE GENITAL MUTILATION (FGM)

The FGM training programme implemented in 2017/2018 has been continued in 2018/2019, aiming to embed the knowledge and skills into practice. This has included the delivery of bespoke FGM training sessions on Labour and Delivery Suite, Antenatal and Postnatal areas and Community Midwifery.

On average the Trust receives two to three newly identified cases of FGM at the Trust each month. This figure has remained fairly static during 2018/2019. In contrast the total number of FGM cases reported through the National Dataset from the Trust has increased. These differences are caused as women move into the area and then remain for future pregnancies. The dataset is completed at each new episode of care within the Trust hence the total number of cases rising if families of childbearing age move into area and continue to live here.

Midwives have shown that they are confident in asking questions as part of the antenatal booking related to history and risk factors for FGM. They are following the FGM Policy and this is evidenced in the completion of good quality referrals where the family have been given the opposing statement and the National Dataset updated.

The Named Midwife has reviewed the process for risk assessment related to FGM. Evidence has been obtained, through discussion with other Trusts, regarding the widespread use of the *FGM Risk Assessment Tool in practice*. (DOH,2016).⁴

The aim is to introduce the risk assessment tool into existing assessment process' to support professionals to identify and assess and document the risk of FGM for women/children and support ongoing discussion with women and family members.

The Named Midwife is working closely with a Trust departments and the Information Team regarding the process for a structured implementation of the risk assessment tool into practice.

FGM-IS is a National Information system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM). FGM-IS supports safeguarding because:

- Family history is known to be relevant when considering potential risk to a girl of undergoing FGM
- A record will be created when a family history has been identified using the FGM-IS
- When a professional sees the FGM-IS indicator, they know a family history of FGM has been identified and they can treat the child accordingly.

The Trust has been working closely with NHS Digital and local health partners in preparation for the implementation of the FGM-IS in HUTHT. A Standard Operating Procedure (SOP) has been developed which has been ratified by the Trust. The SOP sets out the procedure that will be followed by the Trust Safeguarding Team to record an FGM alert of the child's record when a female child is born to a woman who has confirmed FGM. It also includes instruction to staff on how to view the FGM-IS via the summary care record (SCR) when a female child presents within Hull University Teaching Hospital NHS Trust.

⁴ Department of Health (2016) Female Genital Mutilation Risk and Safeguarding; Guidance for Professionals

It is expected that FGM-IS will be implemented in the Trust in 2019/20 supported by the wider safeguarding partnership.

The Named Midwife has liaised effectively with NHS Digital regarding the process and has identified potential areas which require further clarification nationally in the recording of FGM and sharing of information. This communication has proved to be very important for the national implementation of this project and work continues with regards strengthening the process.

10.2 DOMESTIC ABUSE

There has been an increased focus on Domestic Abuse (DA) for all midwives during 2018/2019. All midwives are receiving an update as part of their annual mandatory training to update their knowledge regarding Routine Enquiry for Domestic Abuse (RE), local services and the Trust Domestic Abuse Policy (note: Draft Policy with expected final date of ratification September 2019).

Communication pathways are well established between agencies and the children's safeguarding team. The Trust receives information from the Multi-Agency Risk Assessment Conference (MARAC), Domestic Abuse Partnership (DAP) and Humberside Police for all pregnant women involved in a Domestic Abuse incident. This information is shared with practitioners who are providing direct care for the woman and her family. This information sharing has helped to ensure that woman receives an enhanced level of care and midwives are more involved with the multi-agency partners who are supporting the woman and her family.

The Safeguarding Adult Specialist Nurse continues to lead the development of a Domestic Abuse Strategy for the Trust, supported by the Named Midwife. The Trust Domestic Abuse policy has been written (awaiting ratification) and a structured e-Learning program has been developed which includes DA and Routine Enquiry.

It is recommended that all Midwives and Midwifery assistants complete this training in addition to the face to face training which is offered. It has been agreed by the Professional Education Committee that Domestic Abuse and Routine Enquiry training will become part of the mandatory uptake by all nursing, midwifery and allied professional staff groups. This will be delivered as part of the roll out program across the trust.

10.3 CARING FOR VULNERABLE WOMEN

The Trust's Vulnerability Risk Assessment Toolkit for pregnant women (Supporting women with complex health needs guideline 451) is an invaluable resource used by all midwives to assist in their assessment and identification of those women and their families who require additional support and service delivery. The assessment helps the professional(s) to ensure that the woman is placed on the correct pathway and receives the appropriate support and intervention based on their individual circumstances.

The toolkit was updated in 2018/2019 following multi agency audits of safeguarding referrals from Trust maternity services identified that midwives were at times basing their referrals on process and procedure rather than assessment of individual circumstances.

The threshold training which midwives are required to attend, the community midwifery update sessions and changes to the toolkit have helped to improve the quality of referrals and to ensure that it is clearly documented why a woman is being referred and the risk factors associated with the referral.

Other changes include:

- Frequent attenders have been added as a vulnerability factor to the Trust guidance and toolkit.
- Midwives are all now trained to routinely use electronic records for adding safeguarding alerts and safeguarding information.

The Named Midwife represents the Safeguarding Children's Team at internal operational meetings in maternity services and represents the Trust at external partnership meeting contributing to the wider discussion about safeguarding issues. The Named Midwife also actively contributes to service improvement across the partnership by participation in regular quarterly multi-agency audits of cases focusing on key themes to promote good communication pathways between agencies.

10.4 MODERN DAY SLAVERY

The Named Midwife is a member of the Humber Modern Slavery Partnership and attends regular meetings and cascades this information through safeguarding supervision with the senior maternity management team. Links have also been developed with the project lead for 'Ashiana' in Hull. This new project works with women who are victims or potential victims of modern day slavery, human trafficking and sexual exploitation. Discussions are taking place regarding a joint training programme for the Midwifery teams. Feedback and key actions are fed into the Trust Safeguarding Committee.

11. SERIOUS INCIDENTS/SERIOUS CASE REVIEWS

11.1 SERIOUS INCIDENTS

Serious Incidents where a child has been or neglected or the child has died or been seriously harmed are included in the safeguarding children monthly reports to the Safeguarding Committee. Cases can be reported as an SI by the Trust or reported on STEISS by a Designated Nurse for Safeguarding Children.

In 2018/2019, there was one Serious Incident's (SI's) declared in relation to a child who died following a firearm incident. The case was investigated by the police and the case is ongoing. A Rapid Review report (under the new Working Together 2018 guidance) was compiled and submitted by the HSCB to the National Child Safeguarding Practice Review Panel and has received a response supporting the decision NOT to undertake an SCR. This incident was reported widely via the local and national media.

11.2 SERIOUS CASE REVIEWS/ LESSONS LEARNED REVIEWS

The Trust continues to participate in three Serious Case Reviews (SCR's) in the 2018/2019 reporting period and two Lessons Learned Reviews (LLR) across Hull and East Riding. HUTHT contributes to the process in relation to its contacts with the child and their family. The level of involvement in the review process varies on a case by case basis ranging from a scoping exercise to the completion of an agency report with recommendations and actions for HUTHT. Updates on the progress of these reviews are reported monthly into the Safeguarding Committee

All Serious Case Review's (SCR's) and SI reports are reviewed, quality checked and signed off by the Safeguarding Lead or a Senior Manager/Director before leaving the organisation.

The Named Nurse and Named Midwife, supported by the Assistant Chief Nurse/Safeguarding Lead, take lead responsibility for recommendations, actions from SCR's and LLR's and support the implementation of changes in practice. Progress against Serious

Case Review recommendations are reviewed and monitored by the LSCB's. The Trust is on track with the delivery of actions associated with these reviews.

12. KEY ACTIONS for 2019-2020

The Trust has identified a number of actions required to strengthen the Safeguarding Children's arrangements in the Trust and continue on from 2017/18. The actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Children's Board activities and from Lesson's Learned Reviews and Serious Care Reviews. A summary of work planned for 2019/2020 is as follows:

- To strengthen the communication between the Local Authorities and the Trust re the Outcome of safeguarding referrals made.
- Continue to strengthen the Safeguarding Supervision arrangements within the Trust particularly with out of hour's arrangements and governance.
- To continue to raise awareness and assessment/identification of children that access Trust services and who may be at risk of Child Sexual Exploitation (CSE) and extend this those children at risk of Child Criminal Exploitation (CCE) 'County Lines'.
- To implement DA training for staff relevant to their role.
- To implement FGM-IS.
- To progress the recruitment to the Named Doctor for Safeguarding Children and review of the medical staffing resource/capacity of the CSAAS.
- Continue to work to strengthen the communication process between Child and Adolescent Mental Health services (CAMHS) and the Trust to ensure that, where a young person with a mental health care plan is receiving care within the Trust, there is a clear plan of care documented within the records to ensure their safety while they remain in the care of Trust services.
- Continue to develop the governance, pathways and Quality Assurance process for the Child Sexual Assault Assessment Service (CSAAS).
- Review the process for reporting safeguarding children activity to the Safeguarding Committee
- To continue the work on improving the risk assessment process of women who have had FGM.
- To embed the use of CP-IS in paediatric and maternity unplanned care settings (ward and assessment units)

REPORT END

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Date: August 2019

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

SAFEGUARDING ADULTS

ANNUAL REPORT

2018 - 2019

DRAFT

INDEX	PAGE NUMBER
1. Purpose	3
2. Executive Summary	3
3. Background	5
4. Local Context	8
5. Management and Organisational Arrangements	9
5.1 Roles and responsibilities	
5.2 Internal governance	
5.3 External governance	
6. Training and Development	18
6.1 Safeguarding Adult Training	
7. Safeguarding Adult Activity	19 - 29
7.1 Total Referrals Reported to Trust Safeguarding Team	
7.2 Total Referrals sent to the Local Authority	
7.3 Referrals against Care Homes	
7.4 Referrals raised against the Trust by the Trust	
7.5 Summary of Referrals received	
7.6 Outcomes of Closed Investigations	
7.7 Complaints sent to the Safeguarding Adults Team	
7.8 Deprivation of Liberty Safeguards	
7.9 Yorkshire Ambulance Service Referrals	
7.10 Independent Mental Capacity Advocate requests	
7.11 Multi-Agency Public Protection Arrangements Alerts	
7.12 Information Requests	
7.13 Human Trafficking Concerns	
7.14 Domestic Violence and Domestic Homicide Reviews	
7.15 Datix Incidents for Safeguarding Adults	
8. Safeguarding Adult Reviews	30
9. Key Achievements in 2017/18	30
10. Key Actions for 2019/20	31
11. Report Author	32

ANNUAL REPORT FOR SAFEGUARDING ADULTS – 2018/19

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Adults. The report will identify Safeguarding Adults activity within the Trust over 2018/19, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2019/20.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities to safeguard adults at risk of harm, abuse and neglect that access its services and premises. The challenges facing vulnerable adults remain significant in this health economy and, in particular, the increase in people that have complex needs, such as Mental Health, Dementia and Learning Disabilities.

The Trust continues to meet its regulatory and contract obligations in relation to Safeguarding Adults and is a proactive member of both Local Authority Safeguarding Adult Boards.

In terms of highlights during 2018/19:

- A satisfactory review of Safeguarding Adults by the Care Quality Commission – no compliance issues raised during the inspection undertaken in February 2018 or areas of concern.
- Positive feedback from NHS Hull and East Riding Clinical Commissioning Groups about the governance and progression of Safeguarding Adults agenda items.
- The successful Enhanced Care Team Pilot and approval to recruit to a substantive team in 2019/20.
- The implementation of the revised Mental Health Legislation Service Level Agreement improving the provision of MH training and data sharing.
- The consistent training compliance of over 80% for Safeguarding Adults, Mental Capacity, Prevent Health Wrap and Deprivation of Liberty Safeguards.
- Positive feedback from Hull and East Riding Safeguarding Adult Board Managers and Chairs regarding the Trust arrangements for Safeguarding Adults.
- Established and positive partnership working with a range of external agencies to improve the care and treatment of patients with vulnerabilities including those under detention.
- The development of a Trust Domestic Abuse Policy for Patients and Visitors. This includes a plan to introduce Routine / Selective Enquiry across the organisation over the next three years from 2019/20.
- The hosting of an Independent Domestic Abuse Advisor (IDVA) from the Hull Community Safety Partnership, for two days a week.
- Supporting the Learning Disabilities Mortality Review (LeDeR) programme with staff from the Trust undertaking reviews at the request of Hull and East Riding CCG Local Area Contact.
- Review, revision and enhancement of the processes and governance of the LeDeR programme.
- Introduction of specific eLearning packages and staff face to face information sessions for Learning Disabilities and Autism.
- Successfully hosting stands at the Differently Abled event in February 2018; development of quiet areas, communication and distraction tools for patients with Learning Disabilities (LD) and Autism in outpatient departments at Hull Royal and Castle Hill hospitals; development of a Patient Promise charter in the Emergency Department for children with LD and or Autism;

development of a poster specifically for learning disabled people to help them recognise domestic abuse.

- Implementation of a 'flagging' system for LD patients in partnership with City Health Care Partnership (and including East Riding CCG).
- Improved feedback to referrers on the quality of the safeguarding referrals raised.

There have been a number of challenges during 2018/19 for safeguarding but overall the Trust is in a strong position for 2019/20. The Trust understands the areas which require focus and strengthening and these are fully sighted on moving forward. There have been many positive aspects to comment on over the past year and in particular; good partnership working with the local authority Safeguarding Adult boards, internal governance of safeguarding, staff knowledge and training, and an experienced and credible safeguarding team. The Safeguarding Adult team have had a full time vacancy for the latter half of 2018/19 which was challenging for the team in managing the operational aspects of safeguarding but despite this the team continued to deliver a high quality service.

All of these positive aspects will continue into 2019/20 and support the safeguarding work planned.

Key areas for focus in 2019/20 are:

- Following a health family review of the Intercollegiate Training Document for Safeguarding Adults, NHSE 2018, working with local health partners to produce a Level 3 training programme which can be implemented across health in Hull and East Riding.
- Strong focus on Mental Health, Autism and Learning Disabilities training.
- Improved data on persons detained under the Mental Health Act.
- Development of bespoke training packages for Mental Health to be delivered by Humber Teaching Foundation Trust.
- Development of bespoke training and awareness packages for safeguarding adults to specialist teams in the Trust.
- Review of the Prevent Health Wrap Training Plan and in line with the Prevent Training and Competencies Framework (NHSE October 2017) and changes in commissioner contract compliance (from 80% to 85%).
- Implementation of Domestic Abuse training, processes, policies and risk assessment.
- Continued implementation of electronic flagging for patients with complex needs such as learning disabilities and severe autism.
- One to one supervision of patients and the progression the Enhanced Care Team implementation.
- Review of the Liberty Protection Safeguards and how this will be implemented into the Trust through training, and support from the safeguarding team.
- Review and strengthen the safeguarding audits to enable a greater assurance of staff understanding of their responsibilities to patients, carers and their teams.
- Work with Board partners to support safeguarding audit and assurance programmes across the community.
- Strengthen the LeDeR reviewer's team to enable the trust to support this programme.
- Develop a survey for capturing internal feedback about the Trusts Safeguarding Service.

The Trust has identified a number of actions required to strengthen the Safeguarding Adult's service. Actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Adult's Board activities and from the lessons learned from Case Reviews.

In the last annual report for 2017/18 a summary of work was planned as detailed below. A brief update follows each statement:

- Development and implementation of Restraint Care Plan
 - ✓ This was implemented in 2017. Further work is required to audit the implementation of the care plan.
- Development of Enhanced Care Team (pilot commences in September 2017)
 - ✓ This was completed and the pilot commenced as planned and extended so improved data could be gathered.
- Continued development of Safeguarding Champions
 - ✓ Further training dates were delivered in 2017/18 and a review of roles and responsibilities for the Champions has taken place.
- Review and update of the Safeguarding Adults Policy
 - ✓ This was updated and is available on the Trust Intranet site.
- Delivery of the Trust QIP for Safeguarding Adults.
 - ✓ Key areas from previous CQC inspections were delivered and the Trust QIP for Safeguarding closed.
- Delivery of the Prevent key performance indicator
 - ✓ Compliance of 80% was delivered by end of April 2018 and assisted by the introduction of the Home Office Prevent Health Wrap online learning tool.
- Review of Safeguarding Adults Level 2 training – combining with Level 2 Childrens Safeguarding
 - ✓ This was undertaken and amendments taken to combine. Feedback from staff has been very positive with regards to the revision of the training.
- Review of Mental Health training requirements
 - ✓ An analysis has taken place against MH and Autism standards and this work will continue into 2019/20. Improved communication with Humber Trust has continued.
- Progression of actions detailed in the NCEPOD – Mental Health in General Hospitals
 - ✓ Work is ongoing with all actions identified and this will be strengthened by the establishment of a specific MH committee in 2019/20.
- Revision of Safeguarding Concern Form
 - ✓ This has been completed and is available on the Trust Intranet site.
- Review of Domestic Abuse training, policies and assessment processes
 - ✓ This has been undertaken and will be progressed during 2019/20.
- Implement information on patients detained under the Mental Health Act
 - ✓ Work is progressing on this and the Service Level Agreement updated with Humber Teaching NHS Foundation Trust to reflect required improvements.
- Delivery of actions from Mersey Internal Audit Agency 2017
 - ✓ These have been completed.
- Progression of electronic Safeguarding Flagging processes and applications to client groups such as Learning Disabilities
 - ✓ This has been completed and will continue in collaboration with Community health and social care partners. A consent form was developed and upload of information from service users has commenced.
- Implement the Learning Disability Mortality Reviews (LeDeR) and processes
 - ✓ This has been completed and processes reviewed and enhanced.
- Commence NHS Improvement Pilot for Learning Disabilities standards and assessment of provider (December 2017)
 - ✓ This was delayed by NHSI and received by the Trust in summer 2019 so will be carried forward to 2019/20.

3. BACKGROUND

The Care Act* came into force in 2015 and replaces all previous guidance such as 'No Secrets 2001'**.

What has changed under the legislation of the Care Act?

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect (hereafter referred to as "adults"). It is an important part of what many public services do, but the key responsibility is with local authorities in partnership with the police and the NHS. The Care Act 2014 puts adult safeguarding on a legal footing and from April 2015 each local authority must:

- make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom
- set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Group/s) and the power to include other relevant bodies
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

*The Care Act 2014, Department of Health, 2014

** No Secrets Guidance on developing and implementing, Department of Health, 2000

It also updates the scope of adult safeguarding:

- Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) –
 - (a) has needs for care and support (whether or not the authority is meeting any of those needs),
 - (b) is experiencing, or is at risk of, abuse or neglect, and
 - (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In effect this means that regardless of whether they are providing any services, councils must follow up any concerns about either actual or suspected adult abuse. Safeguarding Adult Boards have been strengthened and have more powers than the current arrangements set up by "No Secrets*" but they are also have to be more transparent and subject to greater scrutiny. All organisations who are involved in adult safeguarding need to reflect the statutory guidance, good practice guidance and ancillary products that have been developed when devising their training and implementation plans for staff. Policies and procedures should be based on the processes laid out in the statutory guidance.

Key messages of the Care Act 2014

The statutory guidance enshrines the six principles of safeguarding:

1. **empowerment** - presumption of person led decisions and informed consent
2. **prevention** - it is better to take action before harm occurs
3. **proportionality** - proportionate and least intrusive response appropriate to the risk presented
4. **protection** - support and representation for those in greatest need
5. **partnerships** - local solutions through services working with their communities
6. **accountability** - accountability and transparency in delivering safeguarding.

It signalled a major change in practice - a move away from the process-led, tick box culture to a person-centered social work approach which achieves the outcomes that people want. Practitioners must take a flexible approach and work with the adult all the way through the enquiry and beyond where necessary. Practice must focus on what the adult wants, which accounts for the possibility that individuals can change their mind on what outcomes they want through the course of the intervention.

The NHS is a key component of safeguarding and the local Clinical Commissioning Groups (CCGs) are one of the three statutory core partners of the Safeguarding Adults Boards.

The CCG is in the best position to ensure that NHS providers meet their responsibilities through its commissioning arrangements with them. However Safeguarding Adult Boards are free to invite additional partners to sit on the Board. For example, many SABs also have local NHS Provider Trusts on their Boards. Many Boards have also found it extremely helpful to have a representative GP on their Board who can communicate directly with their colleagues to emphasise the importance of their role in protecting adults at risk of abuse and neglect.

*No Secrets Guidance on developing and implementing, Department of Health, 2000

There have been a number of high profile hospital scandals that have highlighted the need for vigilance and action among staff and managers. The NHS has particular duties for patients less able to protect themselves from harm, neglect or abuse. All commissioners and contractors have a responsibility to ensure that service specifications, invitations to tender, service contracts and service level agreements promote dignity in care and adhere to local multi-agency safeguarding policies and procedures. Commissioners must also assure themselves that care providers know about and adhere to relevant CQC Standards. Contract monitoring must have a clear focus on safeguarding and robustly follow up any shortfalls in standards or other concerns about patient safety.

NHS managers, commissioners and regulators will want assurance that when abuse or neglect occurs, responses are in line with local multi-agency safeguarding procedures, national frameworks for Clinical Governance and investigating patient safety incidents. Therefore these services must produce clear guidance to managers and staff that sets out the processes for initiating action and who is responsible for any decision making. To prevent cases falling through the net, the NHS and the local authority should have an agreement on what constitutes a 'serious incident' and what is a safeguarding concern and appropriate responses to both.

With regards to Safeguarding Adults, the Hull University Teaching Hospitals NHS Trust works in close partnership with local health providers such as City Health Care Partnership, Humber Teaching NHS Foundation Trust and the Hull and East Riding Clinical Commissioning Groups as well as the Police, Local Authorities, the Probation and the Prison Service.

The Trust is a member of the two local Safeguarding Adults Boards in Hull and in East Riding. During 2018//19, attendance of the Trust representatives at both was excellent.

The CQC undertook a full inspection of the fundamental standards in February 2018 and the Trust's Safeguarding Lead was interviewed with regards to Safeguarding Adults and Children, Learning Disabilities, Restraint, Mental Capacity and Deprivation of Liberty Safeguards. There

were no compliance concerns raised with regards to Safeguarding Adults, Mental Capacity, Best Interests, Learning Disabilities, Deprivation of Liberty and detainment of patients using the correct legal frameworks. There is work to improve documentation with regards to Mental Capacity and Best Interests and this was referenced in the final report. Staff understanding of the subject was generally good, but this was not always reflected in patient records.

The Trust is required to submit quarterly reports on Safeguarding to the Trust's Commissioners as part of the locally set Key Performance Indicators. These are presented to the Contract Monitoring Board and then discussed at the Quality Delivery Group which is a sub group of the Contract Monitoring Board and whose membership consists of local and specialist commissioners with Trust representatives. The Trust's Chief Nurse and Assistant Chief Nurse/Safeguarding Lead attend this meeting and have received positive feedback regarding the progression of safeguarding during 2018/19. No contractual concerns have been raised and permission to share good practice and reports was granted to the NHSE lead commissioner for the South Bank as the Trust's information and governance of safeguarding adults was deemed to be of a very high standard.

4. LOCAL CONTEXT

In February 2019 the Trust changed its name from Hull and East Yorkshire Hospitals NHS Trust (HEYHT) to Hull University Teaching Hospitals NHS Trust (HUTH).

It is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs in excess of 9000 staff and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care 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.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the 3rd most deprived local authority in England in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average (2018 Public Health Outcomes Framework)

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull.

Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are Eastern European, South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

From a Safeguarding Adult perspective, the local landscape and population is an increasing challenge and in particular with rates of abuse, neglect and harm which are closely linked with

deprived areas. The increase in the ethnic minority population is also a challenge for Safeguarding Adults due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Abuse and Prevent (the Government's agenda on anti-terrorism and preventing vulnerable people from being radicalised). Financial abuse has seen a significant increase in its reporting in this area and this has resulted in the Safeguarding Adult Board in Hull working with financial institutions to raise awareness and help prevent this type of abuse. The increase in people who self neglect and who are hoarders is also a concern locally and numerous services use a significant amount of resources working with these individuals. Fire risks attached to these individuals is significant and the Humberside Fire and Rescue work proactively with individuals and the housing associations to try and minimise the risk. The increase in the population requiring mental health services is also a concern locally. The Trust works closely with Humber Teaching NHS Foundation Trust regarding mental health and is a member of the Mental Health Crisis Care Concordat, the Mental Health and Dementia Strategic Steering Group (East Riding) and the recently established Suicide Prevention Group (Humber, Coast and Vale).

Resource limitations in all public sectors are proving challenging for all agencies to meet the increasing safeguarding agenda. Increase in referrals, advocacy requirements, deprivation of liberty applications, social work resources are just some of the local challenges that the Safeguarding Adult Partnership are facing and in individual organisations. The importance of good working relationships and communication between agencies is key protecting adults at risk from abuse.

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

The Executive Trust Lead for Safeguarding Adults and Children is the Chief Nurse, Mrs Beverley Geary.

The Trust's Lead for Safeguarding Adults and Children is Assistant Chief Nurse, Miss Kate Rudston.

From 1st April 2018 to October 2018, there were two Safeguarding Adult Specialist Nurses, Christine Davidson (0.8 WTE) and Janet Page (1.0WTE). Janet left the team in October and the post remained vacant for the remainder of the financial year. The post has been recruited to in 19/20 with post holder commencing in September 2019. The Assistant Chief Nurse has supported the operational function of safeguarding adults whilst the vacancy has been recruited to.

A new substantive role for the Enhanced Care Team Matron and Lead for the Mental Capacity Act (1.0 WTE) is being recruited to and will commence in post in Autumn 2019 with a full team to support one to one supervision in the Trust (15 x WTE at Band 2).

These posts will work under the management of the Assistant Chief Nurse.

The Assistant Chief Nurse manages the operational function and governance of Safeguarding in the Trust including; Mental Capacity, Restraint, Deprivation of Liberty Safeguards, Consent, Prevent, Mental Health and managing safeguarding allegations against staff. To ensure resilience in the team for safeguarding allegations against staff, Mrs Davidson has also undergone the training to become a Designated Officer.

This structure is supported by the Chief Nurse, the Executive Board and Health Group Directors.

The Assistant Chief Nurse has open access to the Executive Directors and the Chief Executive Officer on matters pertaining to Safeguarding and meets with the Chief Nurse regularly to discuss safeguarding issues.

The Non-Executive Director champion for Safeguarding, Learning Disabilities and Mental Health is Mrs Vanessa Walker, who has significant experience in the role of Non-Executive Director and is also a strong advocate for all matters pertaining to Safeguarding and access to acute NHS services for people with complex needs and vulnerabilities. This working arrangement continues and is working well. Safeguarding continues to be embedded in all aspects of governance in the Trust and work continues with patient experience, risk and governance to ensure that information is triangulated and acted upon with regards to protecting vulnerable children, young people and adults at risk.

Learning Disabilities is also covered under the portfolio of Safeguarding and the Trust hosts a Learning Disabilities Liaison Nurse, Michaela Marr, who is employed by Humber Teaching NHS Foundation Trust. The Learning Disabilities Nurse meets at least monthly with the Safeguarding Adults Team and also with the Assistant Chief Nurse to ensure that any patient issues are identified quickly and escalated to rectify satisfactorily.

The Trust holds a monthly safeguarding committee which covers all of the portfolio items.

The Trust Safeguarding Committee reports to the Operational Quality Committee. The Safeguarding Committee met seven times out of possible 12 during 2018/19. Meetings in May and June 2018 were cancelled due to the Chair unavailable due to an unexpected absence from work. Three meetings in September, November and February were cancelled due to significant operational pressures in the trust at that time. Due to the absence of the Assistant Chief Nurse and Chair of the Safeguarding Committee, a review of resilience in the team has taken place and enhanced so that business continuity for the Committee is maintained when unexpected events occur.

The Safeguarding Adult's team is a small team which manages a series of items such as Mental Health, Deprivation of Liberty, Making Safeguarding Personal, Safeguarding Adult Reviews and Domestic Abuse. The requirements with Multi Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC) are also significant as partnership working with the Police, Prisons and Probation has continued to increase and improve over the past year. Regular meetings take place with the personnel from the police and local prisons and this had led to a real improvement in the transfer of care of this population, improving communication and learning lessons from when pathways have not gone as well as expected. The Safeguarding team also facilitates and chairs meetings with the Learning Disability liaison teams from the community and the Trust LD Liaison Nurse, CCG representatives and LD leads from the acute trust health groups. In 2018/19 the Trust requested a medical lead for LD and Dr Elizabeth Herrievan, a consultant working in Emergency Department, volunteered for the role and is already making significant improvements.

The Compliance team within the Trust Governance department provides the administration and governance processes for Safeguarding Adults and this support has been invaluable in the excellent improvements that Safeguarding Adults has made. Annabelle Baron-Medlam, Compliance Manager and Leah Coneyworth, Compliance Team Manager, have led and supported the improvements in the governance of Safeguarding Adults and work closely with the team, ensuring the information is cleansed regularly and that the operational processes are compliant. The Assistant Chief Nurse and Safeguarding Adults Specialist Nurses meet regularly with the Compliance team to ensure systems are up to date and innovative ideas are progressed.

All data received and sent from the Trust with regards to Safeguarding Adults is captured by the Compliance Team and intelligence gathered to provide not only an internal view but also a local picture. This information can help inform areas of concern not just within the Trust with regards to high levels of safeguarding reporting but also externally. For example if a local care provider is causing a high level of referrals to be placed by Trust staff then this is not only detected quickly but

also sent to the relevant Designated Professional for Safeguarding Adults in the Clinical Commissioning Group.

5.1 ROLES & RESPONSIBILITIES

The Safeguarding Adults Team provides specialist advice, support and supervision pertaining to the safeguarding of adults at risk or suffering from harm, abuse or neglect to all Trust staff and volunteers.

A dedicated Safeguarding Adults Telephone is in operation Monday to Friday 8.30am to 4.30pm (excluding bank holidays). Outside of these hours, the Site Matron team provide advice and support.

Safeguarding Adult referrals are all submitted electronically. A revised form has been developed in collaboration with members of the East Riding Safeguarding Board subgroups and was introduced into the Trust in May 2019. The purpose for the change was to ensure staff take note of the Care Act criteria and Making Safeguarding Personal in particular. The feedback from staff suggest it is easier to use and quicker to complete, despite there being more information collected on the form.

The Safeguarding Adults team's responsibilities are as follows:

1. Provide specialist advice on safeguarding adult's issues, mental capacity, consent, Prevent, mental health, best interests, Deprivation of Liberty Safeguards, human trafficking, domestic abuse and learning disabilities.
2. Support and supervision to staff in relation to incidents that have occurred or are disclosed as part of safeguarding adults reviews/referrals.
3. Bespoke training to staff and ensure the safeguarding adults training is updated as required and in line with any lessons learnt locally or nationally.
4. Compliance with regulatory and contract standards in relation to Safeguarding Adults.
5. Compliance with Safeguarding Adult Boards policies and procedures including information sharing and good partnership working across agencies.
6. Undertake Safeguarding Adult Investigations (section 42 under the Care Act) and Reviews and advise on Serious Incidents, ensuring actions from learning lessons are implemented and embedded.
7. Review and triage all safeguarding adult referrals and Deprivation of Liberty applications.
8. Review, support and triage all Independent Mental Capacity Advocate (IMCA) requests.
9. Reporting on all activity and items for escalation to the Trust Safeguarding Committee.
10. Support and advice on detainment of patients under the Mental Health Act or Mental Capacity Act.
11. Develop and undertake audits as required.
12. Provide leadership and visibility on Safeguarding Adults.
13. Advise on potential areas of concern to the Trust Executive Directors.

Training attended by the Safeguarding Adults team in 2018/19 explored the Human Rights Act and the Equality Act and some of the examples of how case law has been applied in an acute care setting. The learning from these study days will be developed internally for the Senior Leads in 2019/20 to raise awareness and improve confidence in this complex area.

5.2 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Adults Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP277). The Trust has Mental Capacity Act, Deprivation of Liberty Safeguards, Consent and Physical Restraint Policy (CP354).

A new policy has been developed during 2018/19 – Domestic Abuse Policy for Patients and Visitors (awaiting final ratification at date of this report). There is already a Domestic Abuse Policy for staff support. The Policy for patients covers all aspects of domestic abuse including, legislation and guidance frameworks, types of abuse, victim profiles, training towers and routine enquiry. The Trust will start rolling out a three year programme of training to all clinical staff in 2019 that will enable the routine enquiry of domestic abuse to all women over the age of 16 years attending the hospital for treatment. This programme will be supported by the Trust safeguarding adults and child teams and the Independent Domestic Violence Advocate.

Safeguarding Policies are supported by procedures, protocols and guidelines. All of the documents are underpinned by the Safeguarding Adult Board Policies and Procedures as well as Department of Health guidance. All are available on the Trust intranet Safeguarding Adult Site.

All Safeguarding Adult's activity is recorded in a monthly report and presented to the Safeguarding Committee.

All Safeguarding Adult's Investigation Reports and Reviews are reviewed, quality checked and approved by the Assistant Chief Nurse before they leave the organisation.

The Safeguarding Adult's team review all complaints that may have a safeguarding element within them. An opinion is offered on the complaint with regards to Safeguarding and this is sent to the lead patient experience officer.

All Serious Incidents when they are declared are sent to the Assistant Chief Nurse for review and opinion on Safeguarding. During 2018/19, the Serious Incident panel have continued to see improvements in the reference to safeguarding and mental capacity in all reports submitted. A development of a Serious Incident and Safeguarding Checklist has been developed and this will be implemented in 2019/20 to assist the panel with their review of the investigation and final review. This process will provide further assurance to the commissioners and regulators with regards to the Trust seeing safeguarding as part of the core business and at the heart of patient safety and care.

The Trust has contributed to six Domestic Homicide Reviews which were commissioned in 2018/19 by the Hull Community Safety Partnership. Two reports have been approved by the Home Office but they have not been published due to sensitivities concerning living children related to the victims. Key actions Hull University Teaching Hospitals NHS Trust included:

- Using the case study in training once published
- Introduce Routine Enquiry to all clinical areas in the Trust

These actions are being progressed as part of the Domestic Abuse work and policy development.

Mental Health and Learning Disabilities

During 2016/17, the Trust developed a draft Learning Disability and Mental Health Strategy. A committee and sub group of the Safeguarding Committee was established to specifically focus on Learning Disabilities and Mental Health and its membership includes external representatives and health partners. The strategy was intended to be completed in 2017/18 but has not progressed as expected. It has been delayed due to various changes in the mental health agenda locally and nationally, and in particular the work that Humber Teaching NHS Foundation Trust is leading on. A decision was taken to establish a specific Mental Health Committee in the Trust which will capture all policy work, activity, training, and quality and experience domains. This is being developed and will be implemented during 2019/20.

NHS Improvement were due to publish guidance; Learning Disability Improvement Standards for NHS Trusts in 2018. The standards, the first of their kind aimed solely at NHS Trusts, are intended to help the NHS measure the quality of service they provide to people with learning disabilities, autism or people with both complex needs. Once these are published, the Safeguarding Adults team will scope the work associated with these standards and identify key areas of work as required. As part of the information gathering to inform these standards the Trust completed an extensive questionnaire developed and submitted to NHSI in 2018. At the time of this report there have been no published standards from that survey. The Trust will action the standards when they are received in 2019/20.

The Trust revised the Service Level Agreement with Humber Legislation Department for Mental Health Support. This will provide improved governance and structure to activity, training support and advice. Communication between adult mental health service leads in Humber Teaching NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust has been strengthened and it is anticipated that better data for this item will emerge in 2019/20

Learning Disabilities Mortality Review programme (LeDeR)

The LeDeR programme was commissioned by NHS England in 2015 to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points and
- Provide support to local areas in their development of action plans to take forward the lessons learned

There are two specific ways that healthcare professionals may be involved in the LeDeR Programme:

- I. One is with regard to notifying the death of any of their patients with a learning disability.
- II. The other is to input into a review into the circumstances leading to the death, of those aged 4 years and over. This may involve sharing information about a patient who has died or participating in a multi-agency review where knowledge and perspectives in primary care will be of significant importance.

The LeDeR programme is part of a suite of programmes previously known as confidential enquiries. It has approval from the Secretary of State under section 251 of the NHS Act 2006 to process patient identifiable information without the patient's consent.

Service condition 26 of the NHS Standard Contract requires any provider of services to the NHS to participate in the projects within the National Clinical Audit and Patient Outcomes Programme relevant to the Services.

The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account. If individuals and organisations are to be able to learn lessons from the past it is important that the reviews are trusted and safe experiences that encourage honesty, transparency and the sharing of information in order to obtain maximum benefit from them.

Deaths of patients with a Learning Disability that occur within the Trust

All deaths are monitored via the Trust Business Intelligence Analyser. Any deceased patients who have had a diagnosed Learning Disability are identifiable via this system and will be escalated to the Safeguarding Team, by a named member of the Governance Team. Once the death has been verified by the Safeguarding Team, the local area contact (LAC) will then be notified (Hull/East Riding CCG), as well as notification given to the LeDeR team based at Bristol University, via the

web based form. Trained reviewers will then be assigned to a review case with all subsequent learning fed back to the LAC via the Clinical Outcomes Manager and to the LeDeR team via the web-based portal.

The Trust has developed a notification process which is co-ordinated by the Governance Team. Flow charts have been developed to accompany the processes and a briefing paper submitted to the Trust Mortality Committee and Safeguarding Committee outlining the developments.

The Trust is represented and attends the Hull and East Riding LeDeR Strategic Steering Group where quality assurance reviews are undertaken on all local reports as well as discussing themes and trends that are emerging.

A number of reviewers are trained in the acute Trust with further training planned for 2019/20 to ensure continuity and resilience with its obligations to LeDeR investigations. The Trust has undertaken or is in the process of reviewing eight cases for both the Hull and East Riding CCG's.

Enhanced Care Team

At the Executive Management Committee in March 2017 a proposal was presented to introduce an Enhanced Care Team (ECT) across the Trust. This team would be trained to provide support and care specific needs to vulnerable patients who required 1 to 1 supervision. The suggested benefits of which would reduce the requirement of using agency security personnel as well as improving the quality of the care and patient experience. However, it was noted that due to the nature of the acute service it may not be possible to completely eliminate all patient watches by security guards.

The Pilot focussed on a full service team that could offer 1 to 1 nursing supervision to a variety of patients with specifically identified complex needs and eventually encompass paediatrics if approved for Trust-wide implementation.

The ECT provides supervision, support and nursing care to patients identified as Level 4 (risk assessment tool on PATTIE) who pose a potential or actual risk to themselves and who have been identified as requiring an enhanced level of care and supervision (Security are allocated to Level 5 patients who are at risk to others). Through effective monitoring they can quickly identify changes in the patient's condition and wellbeing and identify factors that may exacerbate or inhibit challenging behaviours. This is achieved by establishing good communication techniques with patients, promoting coping skills, being aware of the needs of the individual patient and facilitating a rapid and appropriate response. The team undertake nursing care duties for that one patient including participation in washing, dressing, nutrition and toileting needs and document and report to the Registered Nurse responsible for the patient and they liaise with relatives/carers or other members of the medical profession e.g. physiotherapists or doctor. The team receive a full handover regarding the patient from the nurse in charge of the patient and deliver a full handover to the person taking over the care from them, either at the end of the shift or when the Enhanced Supervision ceases. The ECT complete an activity log identifying activities undertaken and behaviours observed to ensure that patient's receiving one to one continuous supervision are fully engaged, stimulated and interactive. The log helps reinforce holistic care and better utilisation of the staff member providing the dedicated one to one care. The ECT are identified by a different uniform to that of other healthcare workers and to clarify their specific role.

The Pilot was extended and following a presentation to the Trust Executive Management Committee in September 2018, the recommendation to implement a team substantively was approved. Work up for the model progressed in early 2018 with funding secured in 2019/20. Work is well underway on the recruitment to the team with expected full implementation date for the team October 2019.

5.3 EXTERNAL GOVERNANCE

During 2018/19, the Trust was represented on the Hull and East Riding Safeguarding Adults Boards by the Assistant Chief Nurse. In addition, the Trust is represented on the Safeguarding Adult Boards sub committees by the Safeguarding Adult Specialist Nurses.

The overarching purpose of a Safeguarding Adult's Board is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centered and outcome-focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

Safeguarding Adult Boards have three core duties. They must:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

The Hull and East Riding Safeguarding Adult's Boards are structured differently.

The East Riding Safeguarding Adult's Board incorporates a wide range of members and is supported by sub groups; Training, Audit and Assurance, Business Implementation Group and Safeguarding Adult Review Group. The East Riding Safeguarding Adult Board requests an annual self-assessment to be completed by partners and this is followed up by a challenge panel event. This was undertaken in 2018/19 and the Board Chair and Manager were extremely satisfied with the Trusts arrangements and governance of Safeguarding Adults.

The Hull Safeguarding Adult's Board consists of an Executive Board consisting of the three statutory partners stated in the Care Act 2014; the Police, the Clinical Commissioning Group and the Local Authority. In addition to the core partners, the Independent Chair, the Board Manager, and the Chair of the Strategic Delivery Group are also members. The Board is supported by a Strategic Delivery Group which consists of the wider partnership. The Assistant Chief Nurse chairs the Strategic Delivery Group and this is referenced and commended in the Hull Safeguarding Adults Board Annual Report 2018/19.

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework - NHS England

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Adult and Childrens Boards, and in regular monitoring meetings with their commissioners (Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England, July 2015).

Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic abuse, the Mental Capacity Act and Deprivation of Liberty Safeguards at a level commensurate with their role. The intercollegiate document by NHS England was published in

2018 and set out the specific requirements for Safeguarding Adults. The Trust has begun work with the health family and CCG named safeguarding practitioners to review the document and develop clear levels of compliant training across all services. This will form one of the key priorities for 2019/20

The Trust is compliant with mandatory training for all staff and has consistently maintained a position of over 80% for Safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards in 2018/19.

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies including a chaperoning policy.
- Effective training of all staff commensurate with their role.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Identification of a named lead for adult safeguarding and a Mental Capacity Lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the Mental Capacity Act 2005 and the Children Act 1989/2004.

The Trust is compliant with the above arrangements and all of these elements are included in the local commissioning contract/key performance indicators to which the Trust reports quarterly to NHS Hull Clinical Commissioning Group.

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, Designated Professionals and the Safeguarding Boards.

All providers are required to have a Mental Capacity Act Lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training. The named lead(s) will work closely with the Clinical Commissioning Group adult safeguarding lead.

Due to a reduced safeguarding team there was only one specific audit of Mental Capacity and Associated Documentation. The results were circulated to the Health Group leads, escalated to

the Operational Quality Committee and extracts included in the Trust Governance Newsletter. However, the Fundamental Standards audits carried out on every ward in the trust captures some of the elements of the specific audit. These results are monitored by the safeguarding team and the health group nursing managers. The fundamental audit results in 2018/19 for Safeguarding are mostly blue and demonstrate that staff generally understand safeguarding, their responsibilities and who to contact for advice and support.

The Trust Safeguarding Adults Team have all attended external higher level training in Mental Capacity, Consent, Best Interest and Deprivation of Liberty and provide advice and expertise to colleagues as and when requested or sought. Where legal advice is required for complex cases or court of protection applications then this is referred to the Trust solicitors.

The Trust is compliant with the requirements of named leads for Safeguarding Adults, Mental Capacity Act and Managing Safeguarding Allegations against Staff. The Assistant Chief Nurse undertakes this role and is also the Prevent Lead for the organisation.

Care Quality Commission

All providers of health services are required to be registered with the Care Quality Commission. In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported.

In April 2015, new fundamental standards of safety and quality were introduced which all providers of regulated health and social care activities must meet. The standards set the benchmark below which care must not fall. One of the standards relates to safeguarding.

The fundamental standard on safeguarding states that children and adults using regulated services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they become aware of them.

In addition, the standard states that care or treatment must not:

- (i) discriminate on the grounds of any of the protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation)
- (ii) include acts intended to control or restrain an adult or child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint
- (iii) be degrading to the adult or child
- (iv) significantly disregard the needs of the adult or child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority. Under the Mental Capacity Act 2005, the Care Quality Commission is responsible for monitoring how hospitals and care homes operate the Deprivation of Liberty Safeguards.

There are two Key Lines of Enquiry (KLOE) questions relating to safeguarding that the CQC inspect for NHS hospitals. These are:

- KLOE S3: Are there reliable systems, processes and practices in place to keep people safe and to safeguard them from abuse and neglect?
- Prompt – are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements?

And

- KLOE E6: Is people's consent to care and treatment always sought in line with legislation and guidance?
- Prompt – Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004?
- Prompt – Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty?

The Trust was last inspected in February 2018 by the Care Quality Commission. There were no issues identified with regards to Safeguarding Adults. The published report refers to some gaps in documentation of Mental Capacity and Best Interest Decision Making, but generally provides overall assurance of staff understanding of safeguarding adults and mental capacity. No issues were raised with regards to the care of patients with Learning Disabilities.

6. TRAINING AND DEVELOPMENT

6.1 SAFEGUARDING ADULTS TRAINING

Training and education of staff for Safeguarding Adults, Mental Capacity and Deprivation of Liberty continues to be a high priority for the Trust.

Safeguarding Adults training is updated regularly and in line with any changes in national guidance or legislation. The training is aligned to the key principles of the local Safeguarding Adult Boards Policies and Procedures.

Safeguarding adults training compliance is shown in the table below:

Compliance (as of 31st March 2019)	% Compliance Target 80%
Safeguarding Adults Level 1	92.2%
Safeguarding Adults Level 2	90.2%
Mental Capacity Act	88.9%
Deprivation of Liberty Safeguards	89.5%

The Trust is required to be 80% compliant or above with all levels of safeguarding training and this has been consistently above this target throughout 2018/19.

The main area of concern during 2018/19 was the failure to achieve 80% compliance for the Prevent training against the training needs analysis. This was a key performance indicator set by the Trust commissioners. Compliance at the end of March 2019 for staff who required to

undertake the Health Wrap training was 82.2%. This trajectory has been increased to 85% for 2019/20.

7. SAFEGUARDING ADULTS ACTIVITY 2018/19

All data is captured by the Trust's Compliance Team and the databases are cleansed regularly with regular meetings with the Safeguarding Adults Team. This is to ensure that all referrals are followed up as required and outstanding actions addressed in a timely manner.

SUMMARY OF SAFEGUARDING ADULT'S REFERRALS MADE

INTRODUCTION

The section of the annual report 2018/19 provides an update on activity relating to safeguarding and vulnerable adults and to provide assurance that the revised processes implemented are embedded in practice.

All data contained in this report is correct as of 31st March 2019.

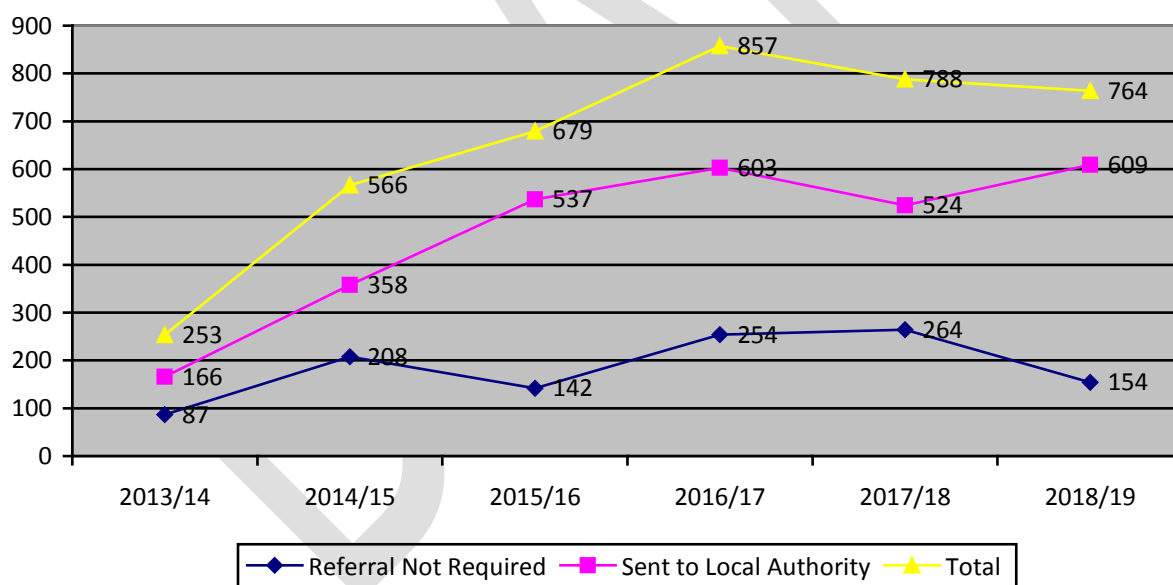
7.1 SUMMARY OF SAFEGUARDING ADULT REFERRALS MADE

Total Reported

As of 31st March 2019, 3936 referrals have been processed by the Safeguarding Adults Team:

*NB 2013/14 data commenced in October 2013

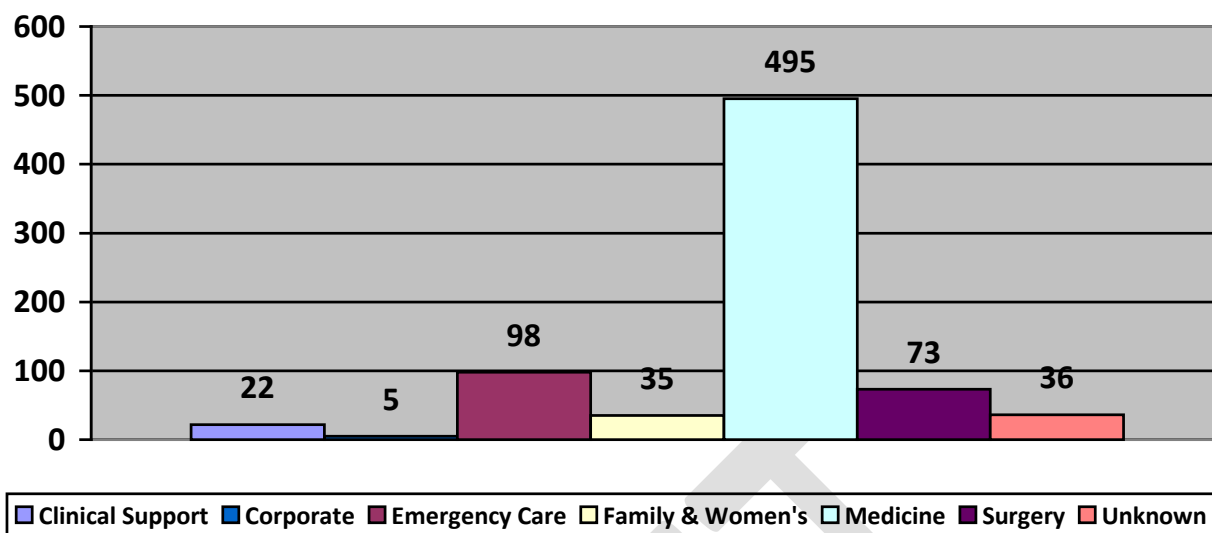
**Year to date



Referrals Made by Health Group

The Medicine Health Group continues to be the highest reporter of concerns; however this can be attributed to the majority of referrals originating in the ED. In January 2019 the Trust implemented an additional Health Group, Emergency Care, which includes ED and AAU and will likely be the highest reporter in 2019/20. This will allow for better reporting of Medical ward referrals to identify themes and trends.

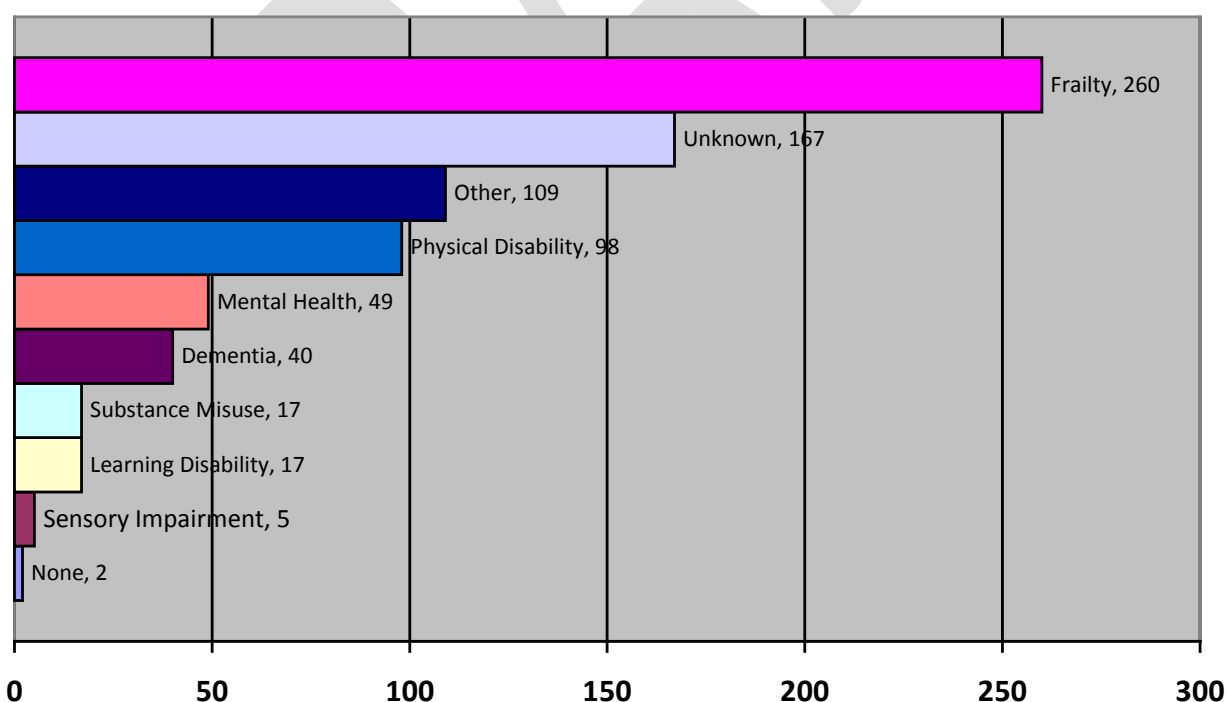
The graph below shows the total number of referrals made by reporter per Health Group:



Referrals Made By Client Group

As previously reported, frailty continues to be the most common client group for YTD, with 34% of all referrals using this as the primary client group. 36% of referrals have 'other' or 'unknown' as the primary client groups. The Safeguarding Adults Specialist Team has implemented a new referral form in May 2019 which will prompt staff to review the client group before submission. This will provide greater clarity for future reports regarding the most common client group for referrals.

The graph below shows the total number of referrals made by client group:

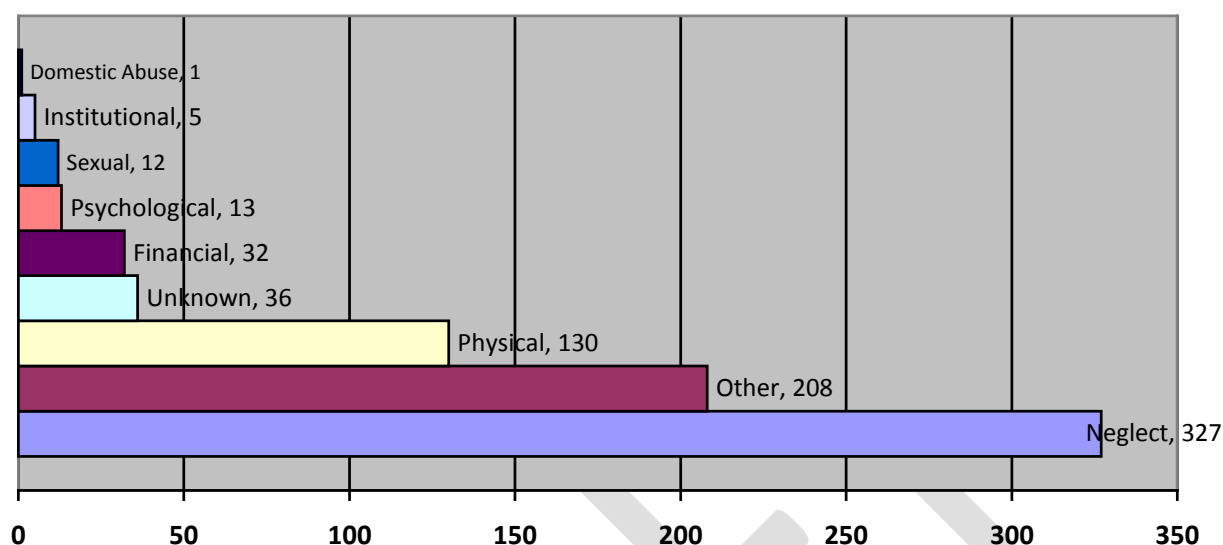


Referrals Made By Abuse Type

YTD figures continue to show a trend for 'neglect' and 'other' as the most common abuse type. However, when reviewed against the themes identified from each referral, a high number are being incorrectly classified. As previously reported, Domestic Violence is a common reason for referral;

however this is not reflected in the reporting. Again, the new referral from that has been implemented from May 2019 will support more accurate reporting.

The graph below shows the total number of referrals made by abuse type:



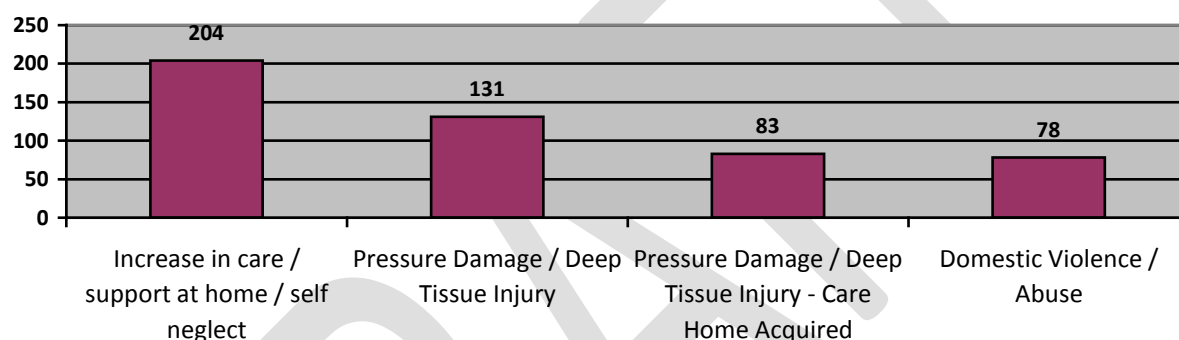
Theme	Total YTD	Theme	Total YTD
Mental Health / Vulnerable Person	23	Physical abuse / assault - other resident	3
Missed appointment	16	Sexual abuse / assault - stranger/unknown/professional	3
General neglect / lack of personal cares	16	Sexual abuse / assault - other resident	3
Attempted suicide / intentional overdose / self-harm	16	Inappropriate restraint	3
Failure to follow care plans / escalate	16	Homeless	2
Financial abuse - family	14	DOLs / Capacity	2
Financial abuse - friend / neighbour	14	Sexual abuse / assault - friend	2
Unwitnessed fall / multiple falls	14	Patient Absconded	2
Deliberate Neglect - family / partner	11	Sexual abuse / assault - family	1
Unexplained bruising / marks	11	Hospital - physical abuse from Staff Member	1
Unaccompanied for appointment / admission inc. no history/information	10	Financial abuse - unknown	1
Failure to follow care plans / escalate - medication	10	Communication	1
Physical abuse / assault - stranger/unknown	10	FGM	1
Injuries / deterioration from neglect / unexplained	9	Deliberate neglect - nursing home	1
Unsafe patient home environment	8	Hospital - medication error	1
Hospital acquired pressure damage / deep tissue injury	7	PREVENT	1
Physical abuse / assault - family	7	Hospital - Patient Absconded	1
Human Trafficking / Modern Slavery Concern	5	other	1
Physical abuse / assault - Health	4	Not enough information	1

Professional / Nursing home			
Physical abuse / assault - friend / neighbour	4	Hospital - Failure to follow care plans / escalate	1
Psychological / emotional abuse - family	4	Security Watch	1
Accidental Overdose	4	Psychological / emotional abuse - carers	1
		Financial abuse - partner	1

This table shows the themes and numbers of all other referrals received within 2018/19

Referrals Made – Themes and Trends

On a monthly basis, the Compliance Team review all referrals made and identify the reason why a referral has been made, in order to identify themes and trends. This information is included in the monthly escalation report reported to the Safeguarding Committee. Whilst this may not always be apparent and can be subjective, it has provided useful information to Trust.



7.

7.2 Total Sent To Local Authority April 2018 – March 2019

The table below shows how many of the referrals met the criteria to be sent to the local authority and how many were not sent as a rolling annual overview:

Local Authority	Total Submitted 2018/19	Total Closed 2018/19	Total Open (all years)
Hull	373	387	153
East Riding	197	76	252
North Lincolnshire	29	22	7
North East Lincolnshire	5	8	1
North Yorkshire	2	2	3
Lincolnshire	2	0	3
Blackpool	1	1	0
Peterborough City Council	1	0	0
Doncaster	1	1	0
York	0	1	0
Total	611	498	419

Reviewing the figures has indicated that in general Hull Local Authority has improved their processes and a higher number of referrals are being closed following feedback.

The Trust Compliance team contact the Local Authorities on a bi-monthly basis to follow up outstanding referrals and so that this information can be captured and the case closed

7.3 Referrals made against Nursing / Residential Homes

The Compliance Team closely monitor themes of concerns reported against nursing and residential homes and identify any issues that require escalation and further investigation by the relevant safeguarding adult team as a theme against a particular nursing home. This detailed and confidential information is sent to the Hull and East Riding Clinical Commissioning Groups Designated Safeguarding Adult Nurses/Professionals on a quarterly basis, where it is expected that this will be triangulated with other intelligence on these providers.

Referrals Made – Themes and Trends

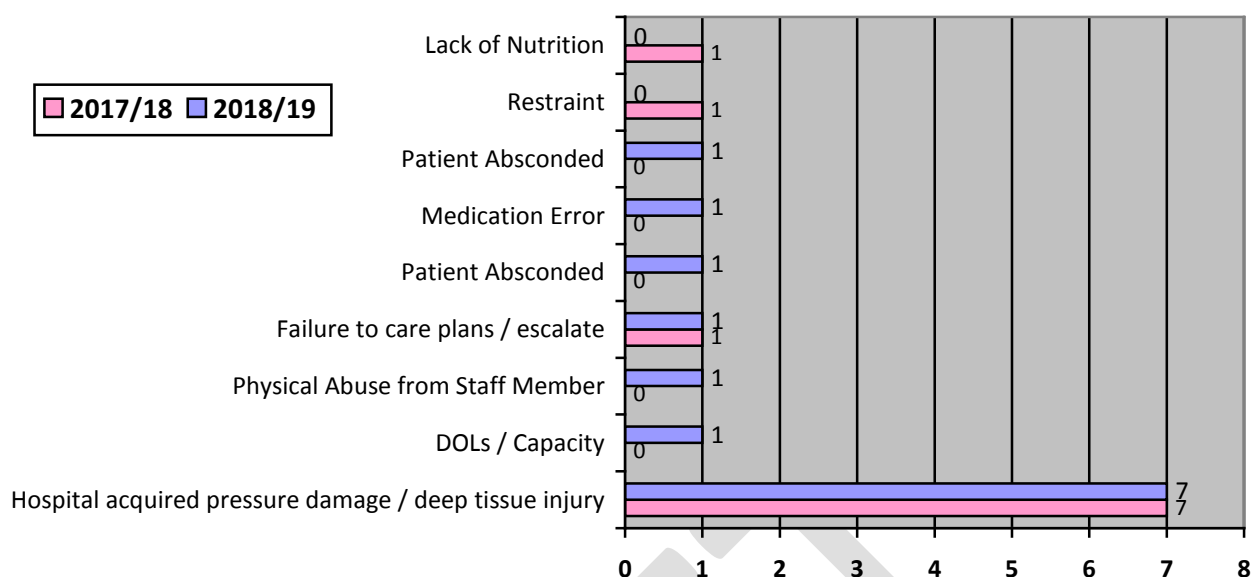
On a monthly basis, the Compliance Team review all referrals made and identify the reason why a referral has been made, in order to identify themes and trends. Whilst this may not always be apparent and can be subjective, it has provided useful information to Trust.

The top five themes for the year 2018/19 are stated below. These have not changed from the previous year and are as follows:

- Increase in care / support at home / self neglect
- Pressure Damage / Deep Tissue Injury - Care Home Acquired
- Pressure Damage / Deep Tissue Injury
- Domestic abuse
- General neglect / lack of personal cares

7.4 Referrals Made Against Trust by the Trust

13 referrals were made in 2018/19 regarding care within the trust. The table below shows a comparison against the figures for 2017/18. 10 referrals were made by trust staff against trust care in 2017/18 compared to the 13 from 2018/19. The highest proportion is regarding pressure damage which is the same for both years:



Referrals linked to Serious Incidents

In 2018/19 there were five referrals made that link to SI investigations:

- 3381 - Hospital - Failure to follow care plans / escalate
- 3405 - Hospital - medication error
- 3328 - Hospital - Patient Absconded
- 3185 - Hospital acquired pressure damage / deep tissue injury
- 3521 - Hospital acquired pressure damage / deep tissue injury

There has been one referral made against the Trust that links to an SI investigation.

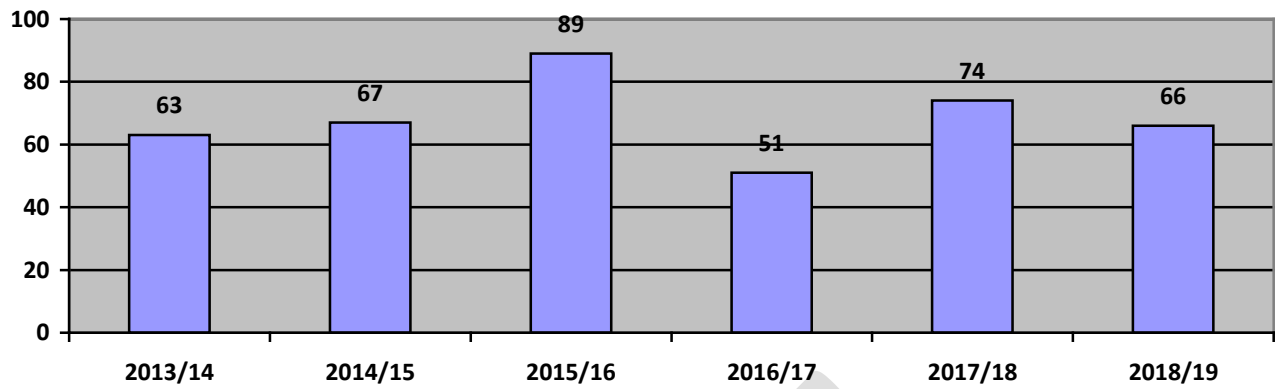
- 0547 - Hospital acquired pressure damage

A new process has been implemented by the SI Team and Compliance Team for the linking of SIs and Safeguarding referrals. The SI team send details of all SIs declared to the Compliance Team who cross check the safeguarding databases for that patient and provide details of any and all referrals made at any time for that patient. This process remains embedded with no concerns raised.

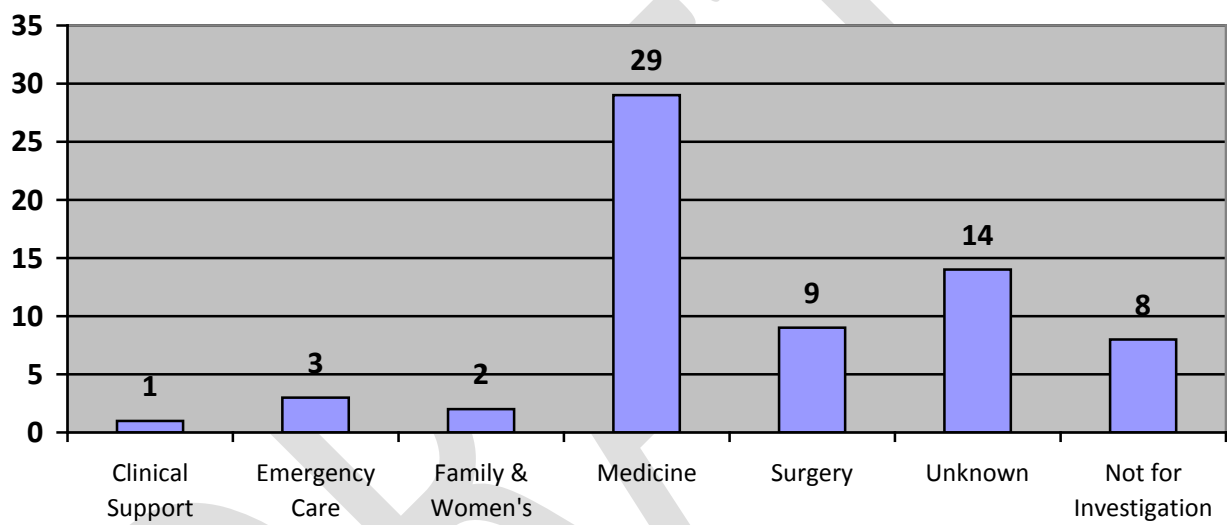
7.5 SUMMARY OF SAFEGUARDING ADULT REFERRALS RECEIVED

Total Reported

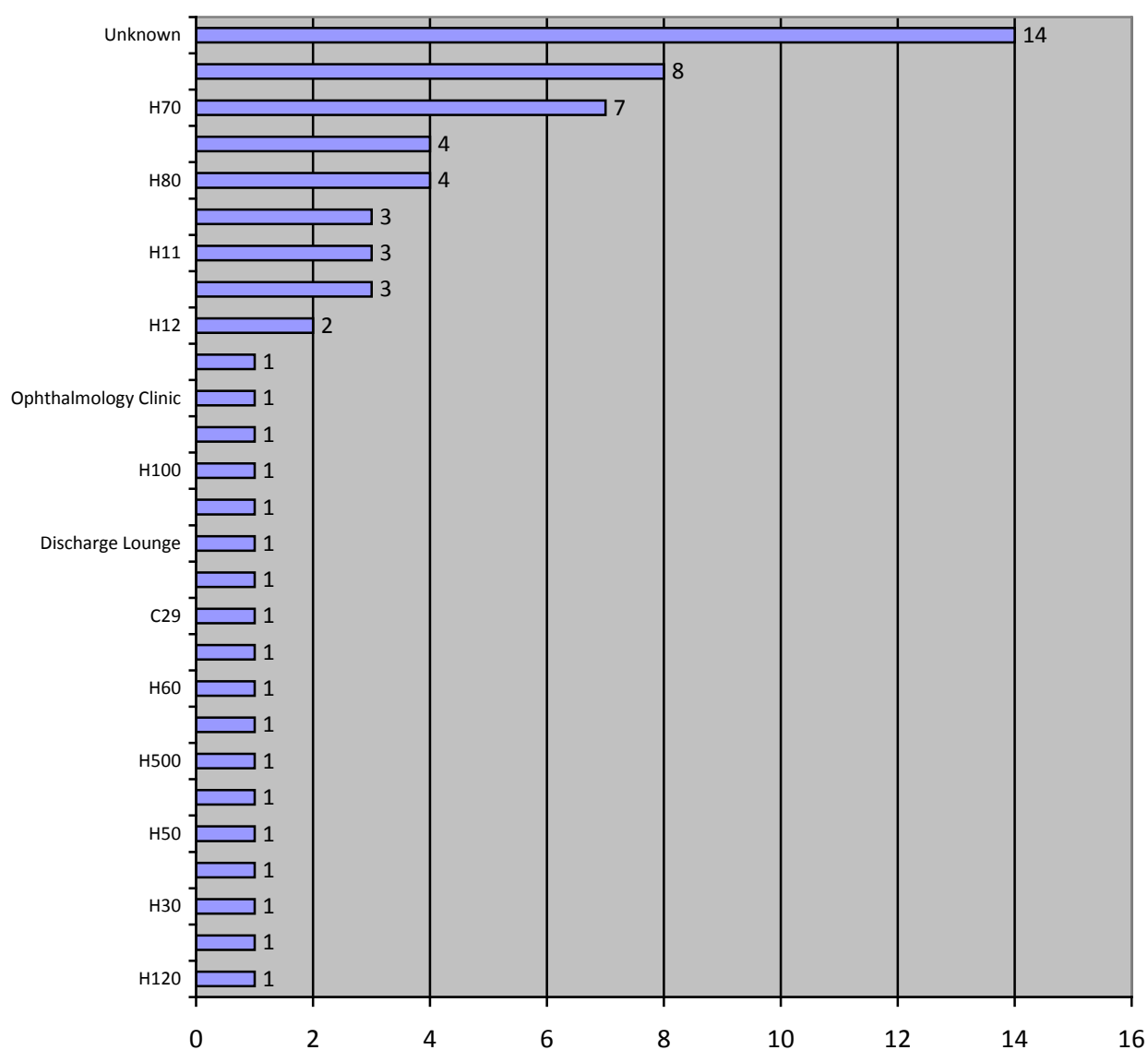
As of the date of writing this report, 472 formal referrals have been made to the Safeguarding Adults Team. The graph below shows the number of referrals from 2013 onwards. Overall there has been a decrease since 2015/16.



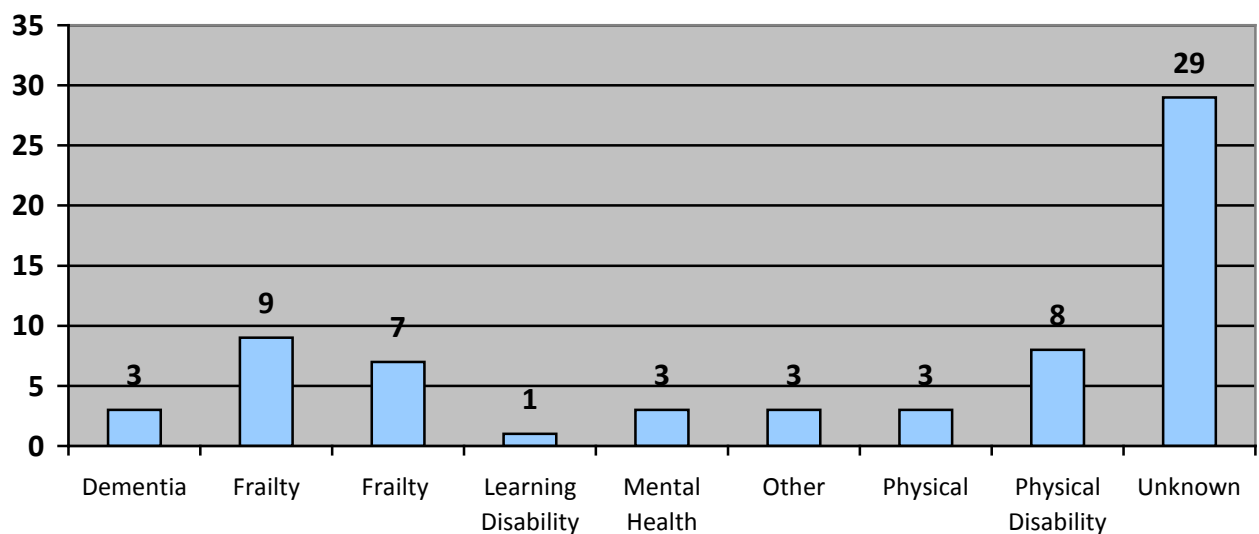
Referrals Received by Health Group 2018/19



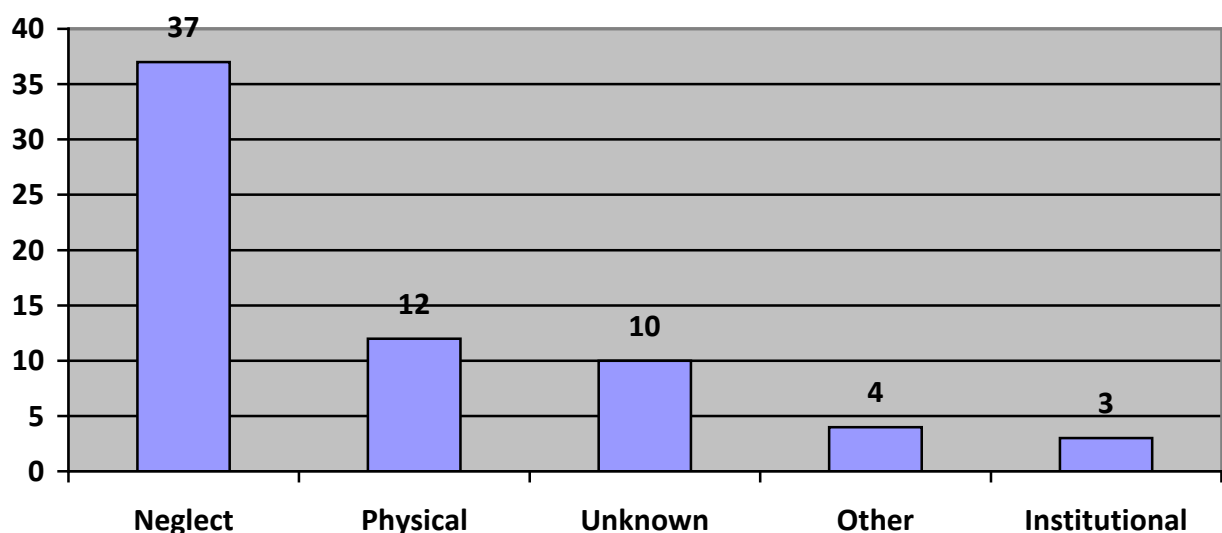
Referrals Received by Ward 2018/19



Referrals Received By Client Group 2018/19



Referrals Received By Abuse Type 2018/19



Referrals Received – Themes and Trends

Of the 66 referrals received, 58 required investigation. 20 of these related to hospital acquire pressure damage, 9 to general deterioration and / or neglect, three to unexplained bruising, 1 to restraint, 1 to alleged physical abuse, one to an undiscovered fracture, two related to not following care plans and one related to inappropriate care during personal care.

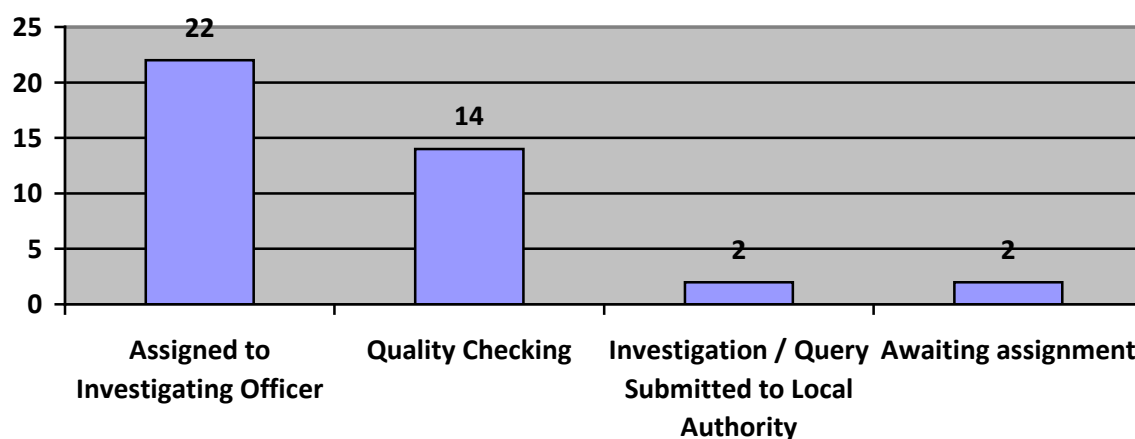
The remaining 20 related to various aspects of the discharge process, including medication not provided, or incorrect medication, incorrect or missing IDLs, and patient been discharged without appropriate social or nursing care in place.

It should be noted that it can be difficult to assign a particular 'theme' to many referrals received as these often encompass a number of concerns and can contain elements of

patient complaints therefore one specific reason is often not able to be identified for the purposes of reporting.

Open formal referrals

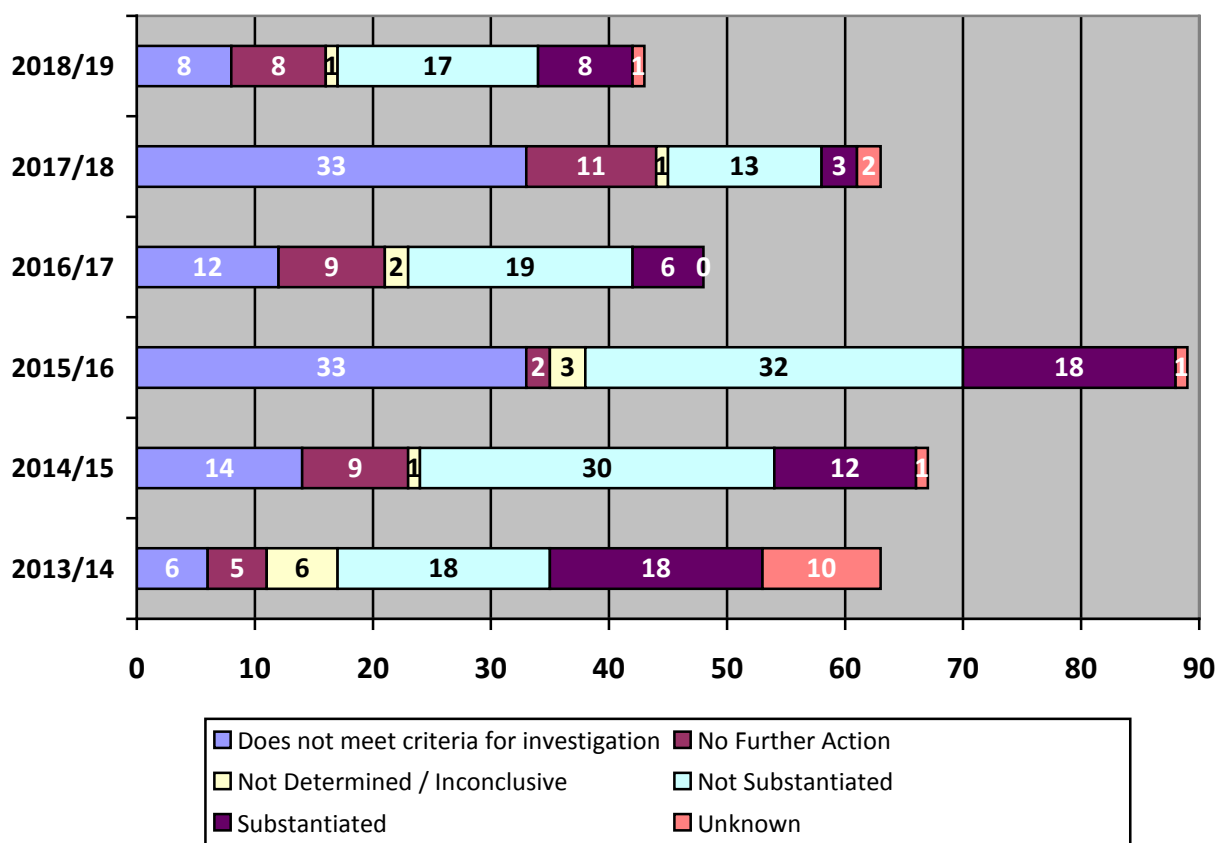
Of the 472 formal referrals made to the Trust, 38 are currently open. The table below shows the stage within the investigation process the referrals are in; this has not changed significantly since the previous quarter:



7.6 Outcome of Closed Investigations

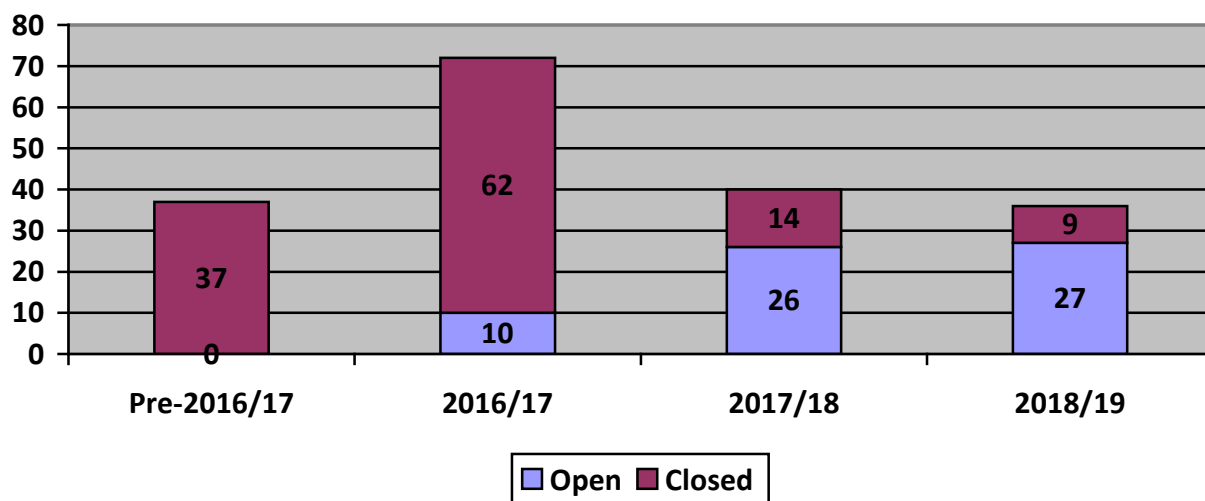
The following graph shows the number of closed referrals from 2013 onwards with the outcome of the investigation, including how many were substantiated. It should be noted that the number of referrals that were substantiated for previous years may increase as there are a number of referrals that are in the process of investigation.

Overall, the number of substantiated referrals is 66, which represents 15.1% of closed referrals. 26% (113) did not meet the criteria for investigation. These percentages have not changed significantly since the last report.



7.7 Complaints Sent to Safeguarding Adults Team for Consideration

From January 2016, a new process was introduced where any complaints that may have implications for safeguarding are sent to the Safeguarding Adults Team for awareness. As of the date of writing this report, 186 complaints have been sent to the Safeguarding Adults Team for review:



7.8 DEPRIVATION OF LIBERTY (DOLS) APPLICATIONS

Since July 2014 301 DOLs applications were received by the Compliance Team for review and /or action. 33 have been processed in 2018/19:

Year	Total Received for Action	Sent to Local Authority					Not Sent to Local Authority
		Awaiting decision from LA	Approved	Not Approved	Cancelled before Decision	Total Sent to LA	
2014 / 15	34	0	4	1	25	31	4
2015 / 16	69	0	6	0	58	64	5
2016 / 17	75	0	2	1	70	73	2
2017 / 18	86	0	0	0	77	77	9
2018 / 19	33	9	1	0	19	29	4
Total	297	9	13	2	249	274	24

Reasons for not sending an application to the local authority include non-completion of forms, not meeting criteria, patient discharged or regaining capacity.

Cancellation reasons include patient regaining capacity, patients being discharged and a small number of patients that were deceased before the application was approved.

7.9 YAS REFERRALS

The Trust has not received any YAS referrals since July 2018. This has been escalated to the Local Authority a number of occasions however there has not been any notifications that the current process has been amended.

7.10 INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) REFERRALS

There have been 16 applications made in 2018/19. All were processed sufficiently by the Compliance Team although feedback from the Local Authority remains an area for improvement and will continue to be reviewed and escalated.

7.11 MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS ALERTS

There have been 10 alerts made in 2018/19. All were dealt with immediately and alerts placed on hospital records and where required ward staff made aware.

7.12 INFORMATION REQUESTS

In 2018/19 there have been 12 formal information requests. All were dealt with and responded to. These were predominantly request for details on an inpatient stay and/treatment or police enquiries.

7.13 HUMAN TRAFFICKING CONCERNS

The Compliance Team had developed a specific log for any human trafficking concerns or information, however during the last quarter it become apparent that these are being reported as safeguarding concerns and are as such included on the main referrals made register.

There were three referrals in relation to Human Trafficking / Modern Slavery in 2017 and these were reported in the 2018/19 Q3 report.

There were five reported in 2018/19.

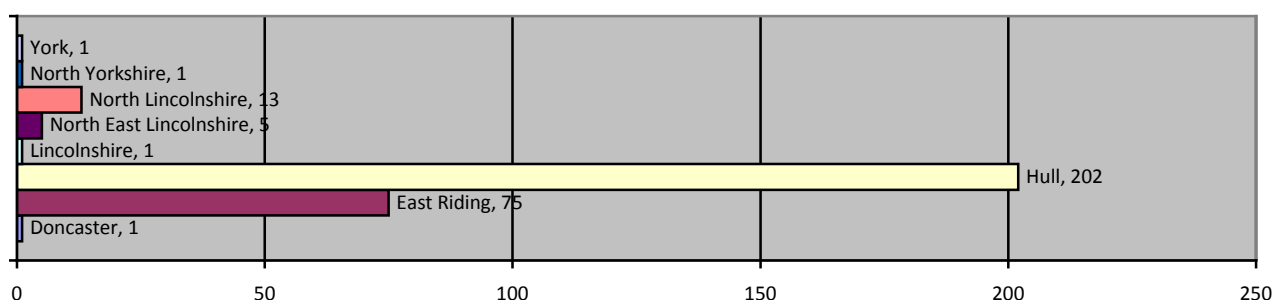
7.14 DOMESTIC VIOLENCE AND DOMESTIC HOMICIDE REVIEWS

The Compliance Team now holds a separate database with all domestic violence related safeguarding adult's referrals to aid information sharing and assessment of regular patients accessing the trust. This is reported on each month via the escalation report.

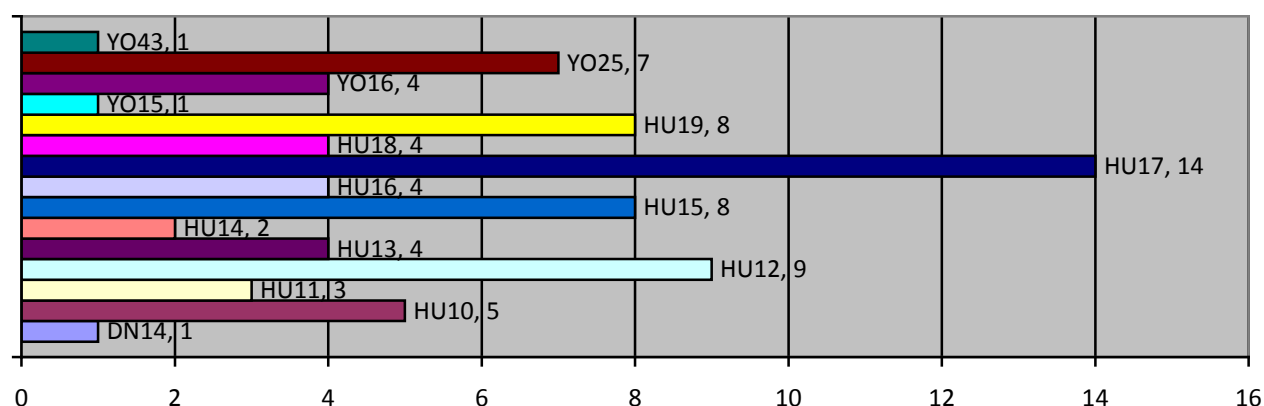
There have been 298 referrals made with the reason for referral as domestic violence / abuse since June 2014 and March 2019. At the March 2019 Safeguarding Committee, further analysis of the data was requested and some key observations are below:

- Of the 298 referrals, 266 (89.3%) were made on behalf of female patients against male perpetrators
- There were no particular months of the year that had higher numbers of referrals made
- Of the 78 referrals made from April 2018 – March 2019, 63 (80.8%) did not indicate that children were present or involved in the household, 15 referrals mentioned children; of these
 - o five related to physical abuse whilst pregnant
 - o three related to children being present for that incident or previous incidents
 - o five had children in the house but had not witnessed the incident
 - o two referrals mentioned children who were not currently living in the household as were under social services care
- A breakdown of the number of referrals for domestic violence / abuse between June 2014 and March 2019 by postcode areas and for each council is illustrated below:

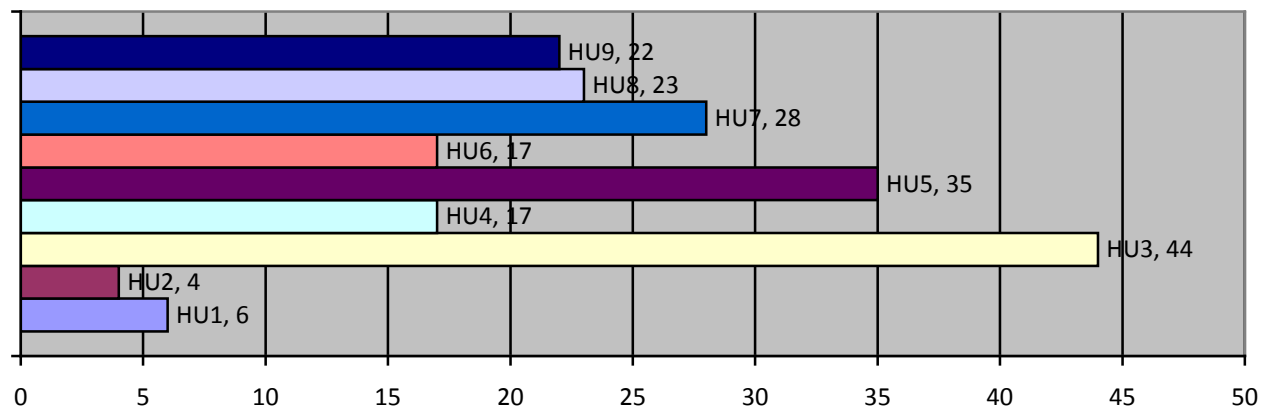
All Councils



East Riding Council



Hull City Council



7.15 DATIX INCIDENTS FOR SAFEGUARDING

All Datix incidents that have been reported with safeguarding adult's criteria are cross referenced with the safeguarding adult's database and escalated to the Senior Matrons for action. This ensures that there is a final approval stage and the incident closed in a timely manner.

The Safeguarding Adults Nursing Team continue to complete a feedback message to the reporter of the incident where required.

Reports on outstanding DATIX incidents are sent to the Health Groups monthly and so this is cleansed as necessary.

8. SAFEGUARDING ADULT REVIEWS

The Trust has participated in several Safeguarding Adult Reviews during 2018/19 for both Hull and East Riding Safeguarding Adult Boards.

Not all of the investigations are published; this is the decision of the Safeguarding Adult Board. The learning from these cases is feedback to the Trust Safeguarding Committee.

9. KEY ACHIEVEMENTS IN 2017/18

A list of key operational and strategic achievements are stated as follows:

- Delivery of the Trust Quality Improvement Plan
- Implementation of the LeDeR processes and continuation of improved governance
- Development of new Safeguarding Adult Referral (pending upload to Trust Intranet)
- Review and implementation of the Safeguarding Training Day
- Development and pilot of the Enhanced Care Team
- Compliance to regulatory standards for Safeguarding Adults – February 2018, Care Quality Commission

- Compliance and positive feedback from Commissioners with regards to key performance indicators for Safeguarding Adults and additional developments under the portfolio of safeguarding
- Reviewed and improved information sharing processes for MAPPA and MARAC and input of Safeguarding alerts on Lorenzo
- Completion of Mental Capacity Act and Restraint Audit
- Good rating for safeguarding fundamental audits across the Trust
- Improvements in data management and governance with Compliance Team
- Scoping of NHS Learning Disability Standards
- Continued good attendance and support to Hull and East Riding Safeguarding Adult Boards
- Scoping of Domestic Abuse work for 2018/19 setting the direction for 2019/20
- Sustained compliance of training above 80% for Safeguarding Adults, MCA and Deprivation of Liberty Safeguards
- Contribution and participation in Safeguarding Adult Reviews and Domestic Homicide Reviews

10. KEY ACTIONS FOR 2019/20

The Trust has identified a number of actions required to strengthen the Safeguarding Adult's service. Actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Adult's Board activities and from the lessons learned from Case Reviews

A summary of work planned in 2019/20 is as follows:

- Development and implementation of Domestic Abuse training plan and policies including Routine Enquiry
- Support partnership working with Domestic Abuse Partnership and develop honorary post for Independent Domestic Violence Advocate (IDVA)
- Implement substantive Enhanced Care Team
- Continued development of Safeguarding Champions
- Review of Mental Health, Autism and Learning Disability training requirements
- Review of the NLS Learning Disability Standards; undertaking a gap analysis of the standards and implementing actions where gaps are identified
- Progression of actions detailed in the NCEPOD – Mental Health in General Hospitals
- Upload of revised electronic Safeguarding Adults Concern Form
- Improved data for patients detained under the Mental Health Act
- Improved data and analysis of Learning Disabilities Liaison nurse activity and contacts
- Continued progression of electronic Safeguarding Flagging processes and applications to client groups such as Learning Disabilities
- Delivery of the Mental Health Quality Improvement Plan and establish a Mental Health Committee
- Implementation of Safeguarding audit plan
- Review and revision of Prevent Health Wrap Training Needs Analysis and revised trajectory of training compliance

REPORT END

Report Author: Kate Rudston, Assistant Chief Nurse and Trust Safeguarding Lead

With thanks to report contributors: Christine Davidson, Safeguarding Adult Specialist Nurse and Annabelle Baron-Medlam, Compliance Manager.

Date: August 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Director of Infection Prevention and Control Annual Report 2018/19
Responsible Director:	Beverley Geary – Chief Nurse
Author:	Greta Johnson – DIPC/Lead Infection Control Nurse

Purpose:	This report provides an overview of the work done in accordance with the Infection Prevention and Control Strategy during the financial year 2018-19. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases more generally. It also describes areas where improvement is needed.	
BAF Risk:	BAF 3 – High Quality Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	Internal and external reviews have confirmed that in the Trust has appropriate systems and processes in place for the prevention and control of healthcare associated infection. Performance against mandatory local and national targets has been satisfactory, with the exception of an increase in MSSA bacteraemia. The Trust has a strong antimicrobial stewardship programme, and there has been documented improvement in antimicrobial prescribing. There have been significant improvements in some specific aspects of infection prevention and control (e.g. management of <i>C difficile</i>, clinical engagement in root cause analysis, completion of ward level audits and increased partnership working). There are weaknesses in the Trust estate and facilities for managing patients with infections: - limited number of single rooms - inadequate isolation facilities in paediatrics Solutions to these estate issues are being considered as part of a wider Trust strategy There is inadequate resource (clinical and administrative) to support	

	the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections. There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.
Recommendation:	The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)
ANNUAL REPORT 2018-19

1 PURPOSE OF THE REPORT

This report provides an overview of the work done in accordance with the Infection Prevention and Control Strategy during the financial year 2018-19. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases more generally. It also describes areas where improvement is needed.

2 BACKGROUND

This report is required by the Code of Practice for the Prevention and Control of Healthcare Associated Infection contained in the Health and Social Care Act 2008.

3 INFECTION PREVENTION & CONTROL ARRANGEMENTS

Dr Peter Moss, who was the Trust **Director of Infection Prevention and Control**, during this period, was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) strategy. Kevin Phillips, Chief Medical Officer, had executive responsibility for infection prevention and control, which in turn during 2018/19 transferred to Dr Makani Purva. The Trust does not currently have an **Infection Control Doctor**. Expert advice on the microbiological aspects of infection control is provided by Dr Debbie Wearmouth (HEY Consultant Microbiologist), and Dr Neil Todd (York FT Consultant microbiologist). The **Lead Nurse for the Department of Infection** is responsible for the infection prevention & control team and Infectious Diseases specialist nurse teams.

The **Infection Reduction Committee (IRC)** meets monthly, under the chairmanship of the DIPC. The IRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate.

The **Infection Prevention and Control Committee (IPCC)** meet bimonthly. According to the Terms of Reference this committee should be chaired by the Infection Control Doctor; in the absence of anyone in this role it is chaired variously by the Lead IPC nurse or the DIPC. The IPCC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, from the Department of Infection, from Occupational Health, from the Estates & Facilities Directorate, from the

Sterilisation and Decontamination Unit, and from Pharmacy. It reports to the Infection Reduction Committee. The IPCC has responsibility for guiding Infection Prevention and Control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment.

The **clinical IPC team** is composed normally of an Infection Prevention and Control Doctor, which we do not formally have but expert advice is provided by Dr Wearmouth and Dr Todd, specialist Infection Prevention and Control nurses, and supporting secretarial and administrative staff. The nursing team is managed by the Lead Nurse for the Department of Infection and for the period covered by this report consisted of 1.0 WTE band 7, 2.0 WTE band 6 and 2 WTE band 5 IPC Nurses, supported by a secretary and a part-time administrative assistant. The national recommendation is for 1 nurse per 250 acute beds (as part of a fully supported team); 83% of English NHS Trusts achieve this figure. Advertisement of IPC posts and recruitment during 2018/19 continued, which at times was challenging, a theme experienced by other organisations over the same time period. A further 1.0 WTE band 7 nurse was recruited during 2018/19 but was unable to start with the service until 1st April 2019 because of a protracted notice period by their previous employers. Further recruitment into the remaining posts in line with the IPC team structure will continue during 2019/20. Continuing to delivering an effective IPC proactive and reactive service has remained a challenge but support from the Consultant Microbiologist, Infectious Diseases Consultants, Corporate Nursing team and site team enabled a safe responsive service to continue. There is currently no system analyst, data manager, or epidemiological support for the team.

The **Department of Infection clinical team** includes 7 full time consultant Infectious Disease physicians, 1 Consultant Microbiologist, 1 consultant Virologist and Specialist Nurses in HIV (2), viral hepatitis (4), sepsis (2), and Outpatient Antibiotic Therapy (4), as well as a team of ward-based nurses managing the infectious disease ward at Castle Hill Hospital. During 2018/19 there remained a lack of resilience with regards consultant microbiologist capacity with one post not recruited to (in a national shortage specialty). This was noted as a risk on the Health Group Pathology Risk Register during 2018/19 in addition to at least 3 consultants making decreases to their core working hours during this time frame. Agreement to advertise once again for a Consultant Microbiologist and ID consultant was undertaken which took place during February – April 2019 with interviews planned during May 2019.

4 OTHER RELEVANT COMMITTEES

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the IPCC, and report to IRC. There have been concerns about frequency of some meetings but attendance has improved during the past year, and consultant microbiology vacancies have made it difficult to provide adequate clinical support for these functions although Dr Todd has supported where possible. The chair of the Water Safety Committee, which is a mandatory institution, saw an improvement in attendance by Health Groups and Fresenius Renal Unit. The Water Safety Committee has

also benefitted from the addition of an Authorising Engineer for water safety. Water safety issues are also reviewed regularly by IRC.

The Trust's designated Board level **Decontamination Lead** (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development.

5 THE WIDER INFECTION PREVENTION TEAM

In addition to the core clinical IPC team (DIPC, Infection Control Doctor, IPC nurses, etc.) an increasing number of other clinicians are being recruited to support the Trust's efforts.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Study days, which are facilitated by the Infection Prevention and Control Team, are held twice a year to disseminate new information and guidance. The Link Practitioners are then supported by the Infection Prevention and Control Team to be proactive in implementing this guidance within their workplace.

Access to infection prevention and control information can also be obtained from the Trust Patient page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required.

6 SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

Public Health England Fingertips data

PHE produce regularly-updated information on a variety of IPC parameters, benchmarking NHS Trusts against other organisations in England (<https://fingertips.phe.org.uk/profile/amr-local-indicators/data>). The huge amount of information available can be grouped in various ways: the appendices contain spine plots of the performance of the Trust against all other acute NHS trusts in England in overall performance on all HAI targets (Appendix 1), in antimicrobial prescribing data (Appendix 2) and in other IPC measured initiatives (Appendix 3). These data, which are a mixture of 2017-18 and 2018-19 (depending on availability of information) show that against the NHS initiative targets, HEY has performed at or better than the benchmark in all cases. For the wider range of HAI targets the Trust generally falls between the 25th and 75th centile, but was a significant negative outlier for Trust-attributed Meticillin Sensitive *Staphylococcus Aureus* (MSSA) blood stream infections (BSI). Performance was excellent for the antimicrobial prescribing targets: the Trust was better than the benchmark value in all criteria, and was a significant (positive) outlier in some areas.

i. Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

The Trust had achieved a year on year reduction in cases of MRSA BSI since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA BSI by the Department of Health, and the Trust met its target for 2011-12 (8 cases against a threshold of 9), and 2012-13 (6 cases against a threshold of 7).

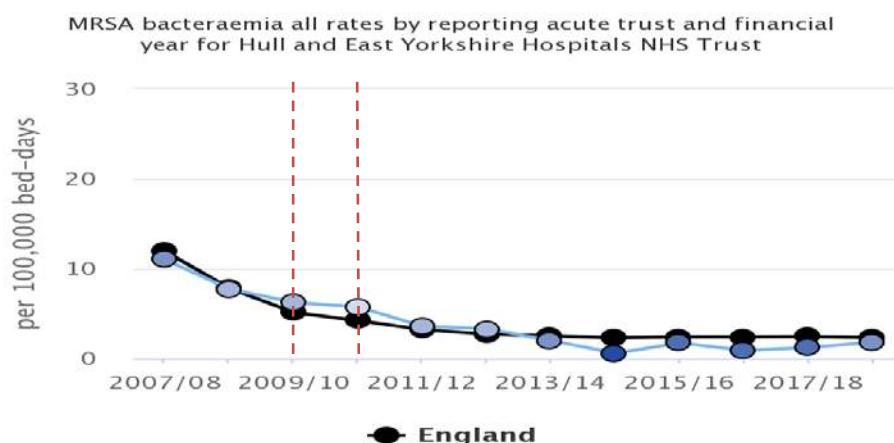


Figure 1. MRSA BSI rates in England 2007-2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust (red lines indicate introduction of universal screening)

For 2013-14 the Department of Health moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, at least *in camera*, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figure 1). The numbers of total and Trust-attributed MRSA BSI diagnosed in the Trust for the last 6 years are shown in Table 1.

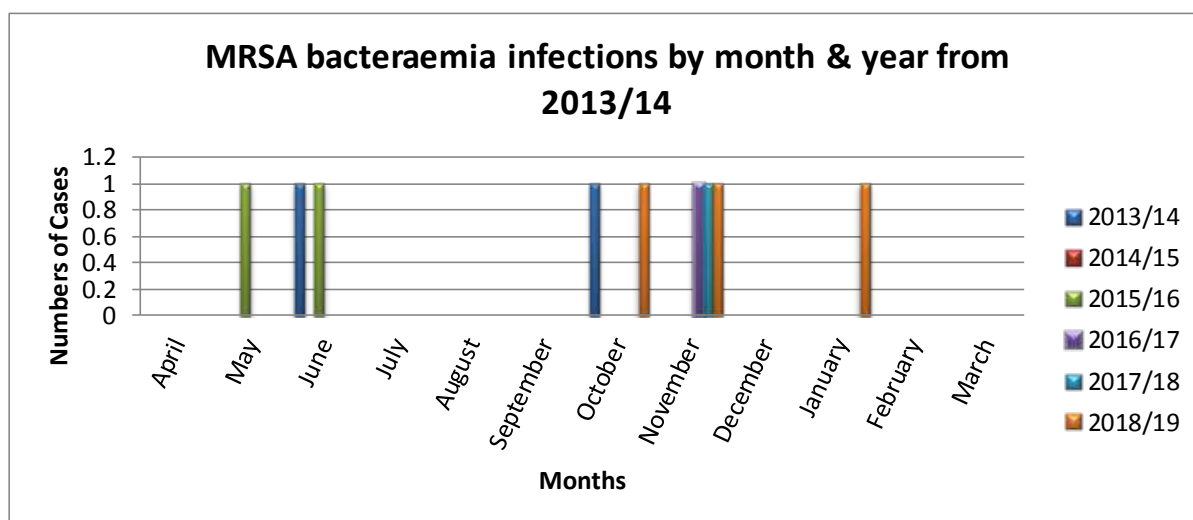


Table 1. MRSA bloodstream infection diagnosed in HEYHT 2013-19

During 2018/19 a marked increase in both Trust and Community apportioned cases were noted – in total 3 Trust apportioned and 3 Community apportioned cases were detected.

In October 2018, a Trust apportioned MRSA bacteraemia case was reported in a surgical patient. Post infection review (PIR) investigation highlighted patient had complex abdominal surgery during September 2018, further complicated by post-operative haematoma and subsequent surgery again during September 2018. Patient had complex multiple comorbidities but no history of previous MRSA colonisation and/or infection. MRSA was cultured in blood cultures, central line tip, and nasal/wound swabs. Patient was noted to

have a deep seated abdominal collection due to complications associated with the original surgery and this could have been the source although not corroborated. Involvement of the Infectious Diseases team, targeted intravenous IV antibiotics and decolonisation treatment resulted in the patient subsequently having repeated negative blood cultures and MRSA screens and was discharged home during December 2019. Outcome of the PIR and discussed with Public Health England (PHE) and Commissioners concluded that the case due to the identified complexities was deemed unavoidable however the Trust reserved the right to acknowledge suboptimal practice and learning identified during the course of the investigation regarding management of complex patients, specifically prudent wound and device care.

In November 2018, a further Trust apportioned MRSA bacteraemia was reported in a cardiothoracic patient. Post infection review (PIR) investigation highlighted patient had complex high risk cardiothoracic surgery during October 2018, further complicated by an extensive stay in intensive care due to post-operative complications. The patient was originally an elective admission and was not previously MRSA positive yet became colonised with MRSA during the admission including a positive sputum sample, the patient developed an infected stenotomy wound which was deemed to be the likely source of the bacteraemia. Outcome of the PIR following discussion with Public Health England (PHE) and Commissioners concluded that the case in spite of the identified complexities was deemed avoidable because of lapses in practice associated with consistency of device management and poor documentation associated with decolonisation treatment.

The third Trust apportioned MRSA bacteraemia was reported in January 2019. The case was determined as Trust apportioned due to the timing of the sample but following review by the Infectious Diseases team, the patient was diagnosed with a deep seated infection thought to be present on and the reason for the admission e.g. endocarditis requiring prolonged antimicrobial therapy and subsequent cardiac surgery. The patient had a previous history of MRSA managed by the GP. Outcome of the PIR following discussion with Public Health England (PHE) and Commissioners concluded that there were no lapses of practice by both the Trust and Primary Care and the case was deemed unavoidable.

Of the three Community apportioned cases, two represented patients recently admitted to the Trust therefore the PIR reflected the care those patients received whilst in hospital. Outcome of the PIRs following discussion with Public Health England (PHE) and Commissioners concluded that two were deemed unavoidable and the remaining case avoidable due to lapses of care identified whilst the patient received care in the community from their General Practitioner, District Nurse and Care Home.

Among other measures to try to reduce the number of MRSA BSI, the Department of Health in 2010 mandated that all patients admitted to hospital in England must be screened for MRSA skin colonisation. This has proved difficult to implement in practice, and the efficacy of such universal screening (as opposed to testing patients at higher risk) has always been debated. In 2014 the DH Expert Advisory Group on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) reviewed the available evidence, and recommended that all Trusts move from a policy of universal screening to one of selective screening of high risk patients. However many Trusts have been reluctant to make this change for fear of a reversal in the downward trend in MRSA BSI, and only one organisation

in Yorkshire has fully implemented the ARHAI recommendation. On the advice of previous ICDs HEY continued to attempt universal screening for MRSA colonisation. However, during 2018/19 the DIPC presented an options appraisal to the Executive Team in July 2018, setting out a number of screening options. Option 4 was the preferred option - combine the national recommendation with local policies and procedures to improve practice in preventing a range of Healthcare Associated Infections (HAI). These would include reviewing past screening results to identify any additional areas which might qualify as 'high risk', and development of a checklist for transfers from other healthcare facilities to ensure appropriate screening for a panel of HAIs (including MRSA). A proforma was developed to assist clinical areas with identifying which patients, which areas and when HCAI screening will be completed. To date this has not been formally adopted, especially with an increase in MRSA bacteraemia cases experienced during 2018/19 and the Trust continues to screen all admissions for MRSA on admission. It is hoped that the proforma and preferred option will be launched during 2019/20, however, there are impending changes nationally again with regards to MRSA screening.

ii *Clostridium difficile* Associated Diarrhoea (CDAD)

The Trust has participated in the mandatory surveillance of *Clostridium difficile* since 2004. In 2011-12 the Trust performed particularly poorly in preventing hospital acquired C difficile infection. In this period there were 105 cases of CDAD attributed to the Trust, against a maximum threshold of 60 set by the Department of Health. Following a number of interventions the number of cases in 2012-13 fell to 58, and the Trust has maintained a steady improvement in performance since then (*Figure 2*). In 2018-19 there were 32 cases reported, against a threshold of 52 and a locally agreed Commissioner led stretch target of 45.

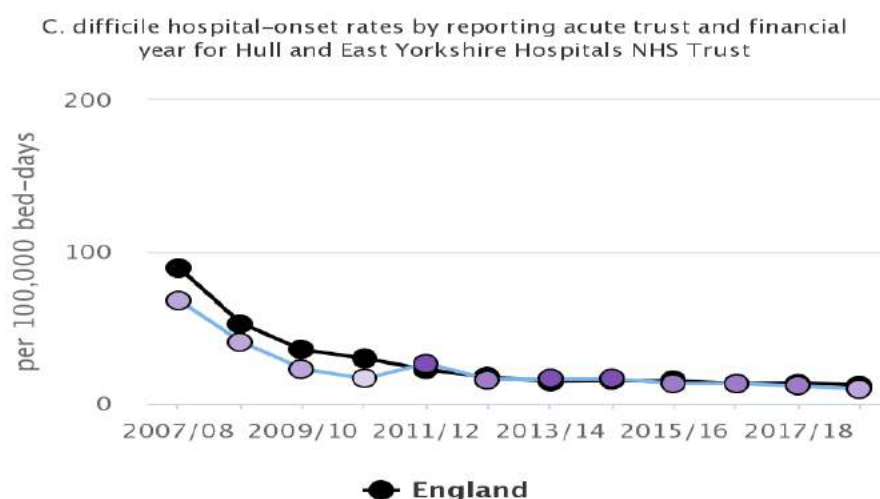


Figure 2. C. difficile rates in England 2007-2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

From 2015-16 there was an opportunity for cases of *C difficile* for which the commissioners agreed that there had been no lapses of care (and the infection was therefore unavoidable) would be highlighted and removed from any financial penalty, although still included in the total. The Trust agreed a very strict definition with the commissioners, whereby any deviation from Trust or national guidance (even if not necessarily contributory to the development of infection) was classed as a lapse of care. Despite that over 87% of the reported cases in 2018-19 were agreed to have been unavoidable through a robust consultation process with the IPC representatives of the commissioners. The continuing reduction in the number of Trust-attributed cases is a reflection of improved infection control processes on the general wards, and dramatically improved antibiotic prescribing practices across the Trust.

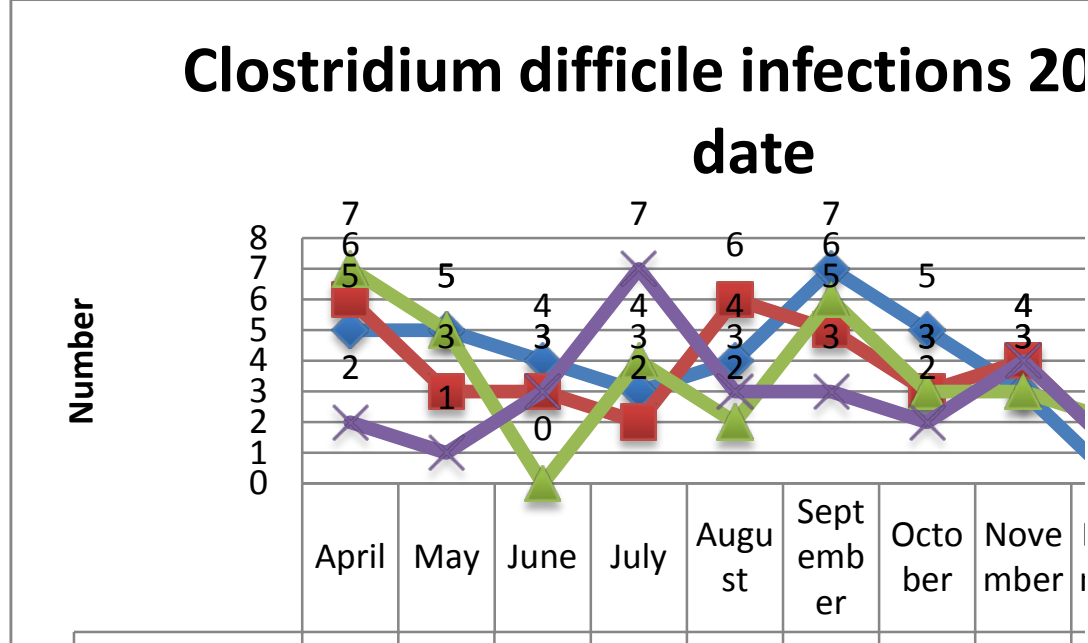


Table 2. CDAD infection diagnosed in HEYHT 2013-19

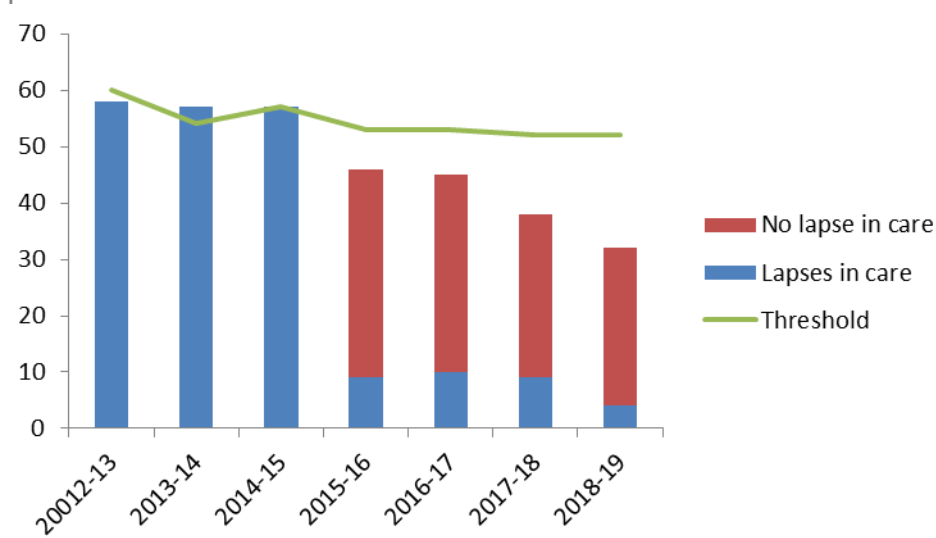


Table 3. Annual reported number of Trust-attributed *C difficile* infections 2011 – 2019 including identified lapses in practice.

All cases of *C difficile* infection are subject to a Root Cause Analysis (RCA). The RCA process is led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPC team. Summary outcomes are presented to the IRC. In most cases there were no significant failures of care apparent that had led to the development of CDAD. One key identified issue for improvement related to antimicrobial stewardship and adhering to the Trust antimicrobial prescribing guidance.

NHS Improvement provided guidance in March 2018 in preparation for *C.difficile* reporting during 2019/20. Changes to the *C.difficile* reporting algorithm for the financial year 2019/20 are reducing the number of days to identify hospital onset healthcare associated cases from 3 days to 2 days following admission and adding a prior healthcare exposure element for community onset cases. *Clostridium difficile* activity during 2018/19 provided the opportunity to determine the impact the changes would have on cases apportioned to the Trust and on reflection with the new reporting parameters the Trust would have had an additional 40% of cases to investigate. During 2018/19 the IPCT requested wards/ departments to complete a RCA for patients who had been detected with a community associated CDAD but had been in hospital in the preceding 4 weeks – this will be an expectation moving forward during 2019/20. A threshold for Trust apportioned cases has been set by NHS Improvement at 80 cases for 2019/20 to reflect the changing CDAD reporting requirements.

Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. Root cause analysis of MSSA BSI cases are completed and reported via the Infection Reduction Committee. There have been year to year fluctuations, but during 2018/19 HEY reported a significant increase in the rate of MSSA BSI at HEY, and it remains the one major HAI indicator for which we are significantly worse than the national benchmark.

From a national perspective, rates of Meticillin-Sensitive *Staphylococcus aureus* (MSSA) bacteraemia continued to increase moderately from 2011/12 when the PHE HCAI surveillance was introduced. The rate increased from 21.5 cases per 100,000 population in 2017/18 to 21.7 per 100,000 population in 2018/19.

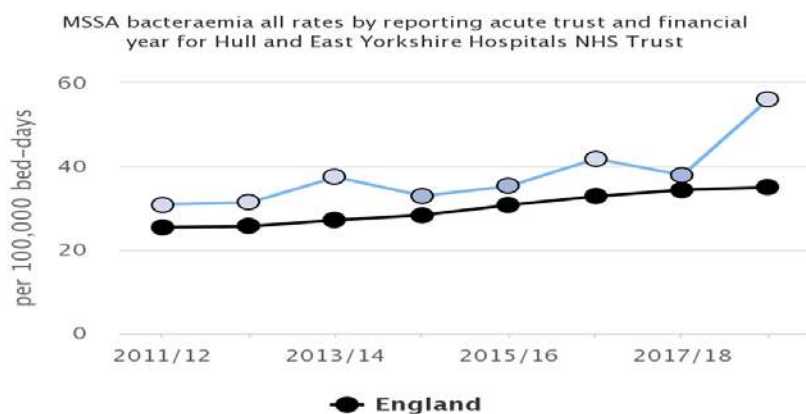


Figure 3. MSSA BSI rates in England 2011 - 2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust (PHE Fingertips)

Meticillin Sensitive Staphylococcus (MSSA) Bacteraemia infections from 16 to date

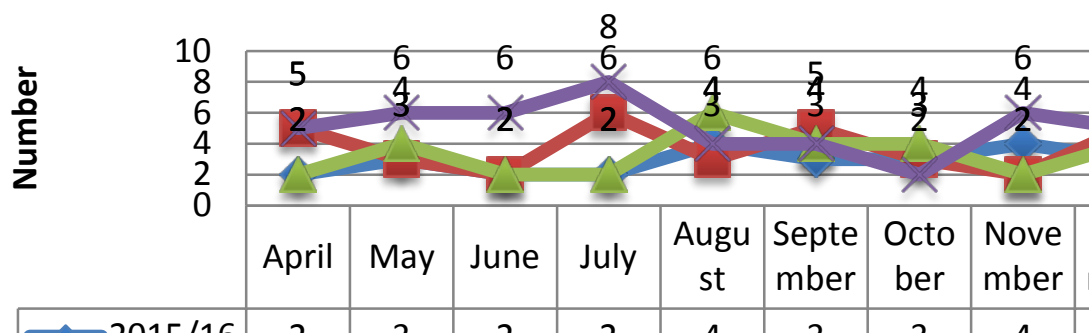


Table 5. MSSA bloodstream infection diagnosed in HEYHT 2015-19

Reasons for the relatively high rate of MSSA BSI during 2018/19 relate predominantly to poor intravascular line insertion and care, specifically peripheral vascular devices and these should be avoidable. During 2018/19, in response to the number of MSSA bacteraemia reported and outcomes of RCAs, a Device Task, Challenge & Finish Group was formed with attendance from Consultants, Senior Nurses across all Health Groups, along with Nurse Educators and Supplies. The purpose of the group is to understand the systems, processes, products and human factors responsible for increasing the risk of infection and mitigating those risks by making it easier for clinical staff to do the right thing. Other cases associated with intravenous drug use and chronic ulcers are more difficult to address, but further work is needed to investigate why such a high proportion of our overall MSSA BSI cases are hospital-apportioned. Of interest is an associated increase in Community Apportioned MSSA bacteraemia cases across Hull & East Riding of Yorkshire which will warrant further investigation.

Escherichia coli bacteraemia

Mandatory surveillance of *E coli* bacteraemia was introduced in 2011. This organism is the commonest cause of bacteraemia in hospital (41,060 cases reported in 2017-18), and numbers are increasing year on year. There is also a steady increase in the proportion of these organisms which produce Extended Spectrum Beta Lactamase (ESBL), an enzyme which makes them highly antibiotic-resistant. These facts have led PHE, NHSI, and ARHAI to focus on reducing the rate of Gram negative bacteraemia, and especially blood stream infection due to *E coli*. The Department of Health has announced a formal intention to reduce the incidence of *E coli* bacteraemia by 50% by 2020 (although it has been widely questioned whether this is a realistic ambition).

National benchmark data show a total of 41,060 cases of *E. coli* bacteraemia were reported by NHS Trusts in England between 1 April 2017 and 31 March 2018. Of the 41,060 *E. coli* cases, 7,704 (18.8%) were hospital-onset. National benchmark data show that HEY is above the national mean rate of hospital-attributed *E coli* BSI (24/100 000 bed days, compared to a mean of 22.4 in 2016-17) (Figure 4). The HEY figure for 2017-18 is 33.7/100 000 bed days.

The majority of *E coli* BSI diagnosed in HEY are the cause of admission rather than being hospital-acquired (usually related to urine or gall bladder infections), and are therefore considered as 'non-attributable' to the Trust. However a proportion of *E coli* bloodstream infections are acquired in hospital, associated with urinary catheters, wound infections, vascular devices, and ventilator-associated pneumonia. Even for the 'community-attributable' bacteraemia the situation is not as straightforward as it may seem, as infections developing in the community may be related to a previous admission to hospital. Although surveillance of cases is reported, it is difficult to determine which infections were potentially avoidable without robust investigation (which is difficult given the large number of cases). For a 6 month period, ending April 2018 one of the Infectious Diseases consultants carried out bedside and case note review of all patients with trust and community attributed *E coli* BSI. The work involved was significant, and this is not sustainable as ongoing practice but it identified a number of key trends. Of the Trust attributable cases, 50% were deemed avoidable, mainly related to urinary tract infections and patients with indwelling urinary catheters – a focus for further improvement moving forward. Of the community attributable cases 63% were deemed unavoidable which challenges efforts to address the continuing rise in cases in the community and meet the required thresholds of a reduction of 50% of all gram negative bloodstream infections (GNBSIs) by 2021.

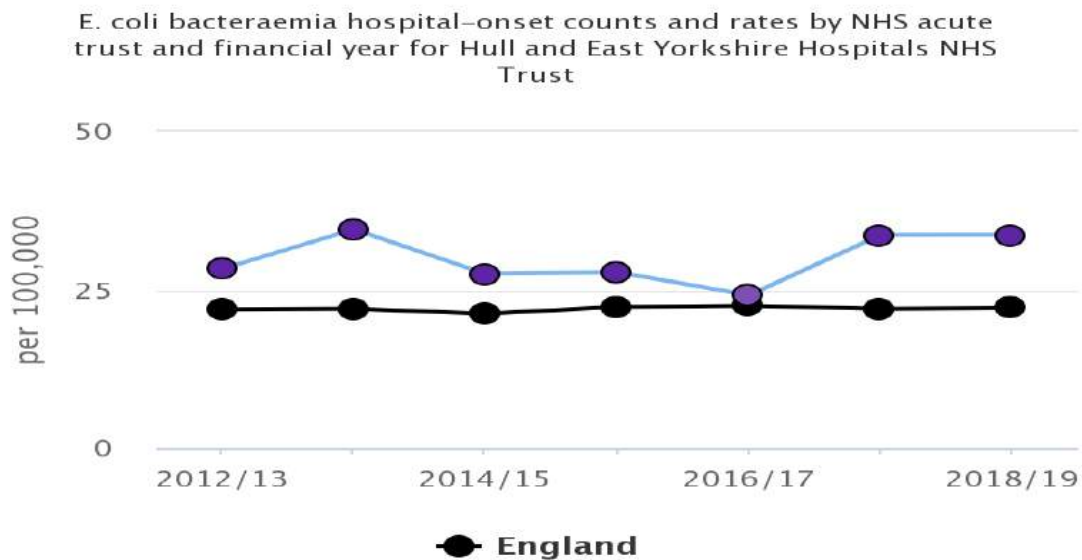


Figure 4. E.coli BSI rates in England 2012 - 2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust (PHE Fingertips)

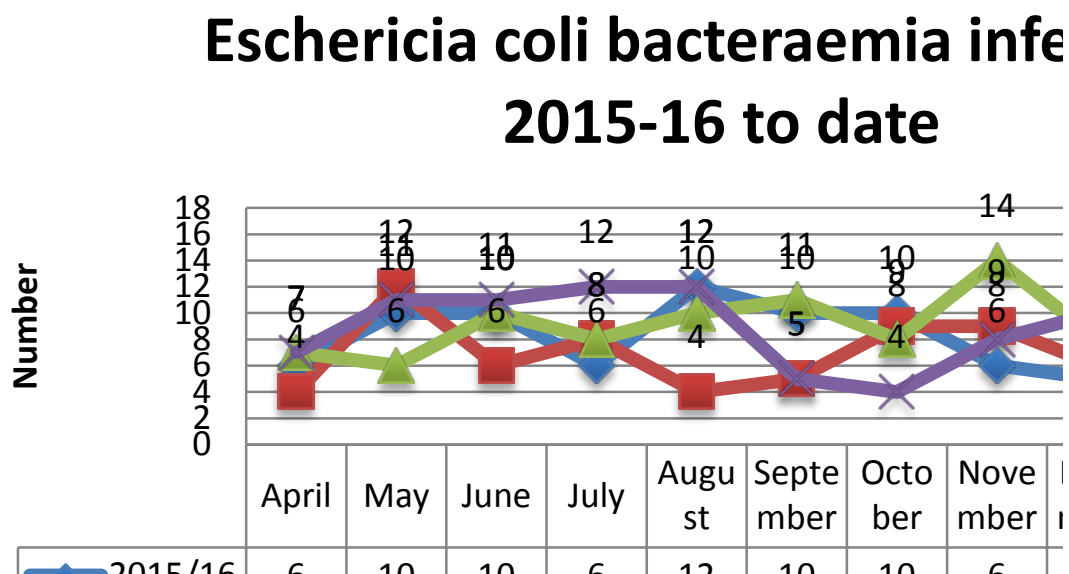


Table 5. E. coli bloodstream infection diagnosed in HEYHT 2015-19

Klebsiella and Pseudomonas Aeruginosa bacteraemia

For the operational period 1st April 2018 to 31st March 2019, PHE and NHS England required NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024. Both of these organisms demonstrate similar risk factors as those found with E.coli bacteraemia, with both reported for cases of respiratory and urinary tract infections.

Klebsiella/ Pseudomonas aeruginosa bacteraemia infections from 2017 to 2019

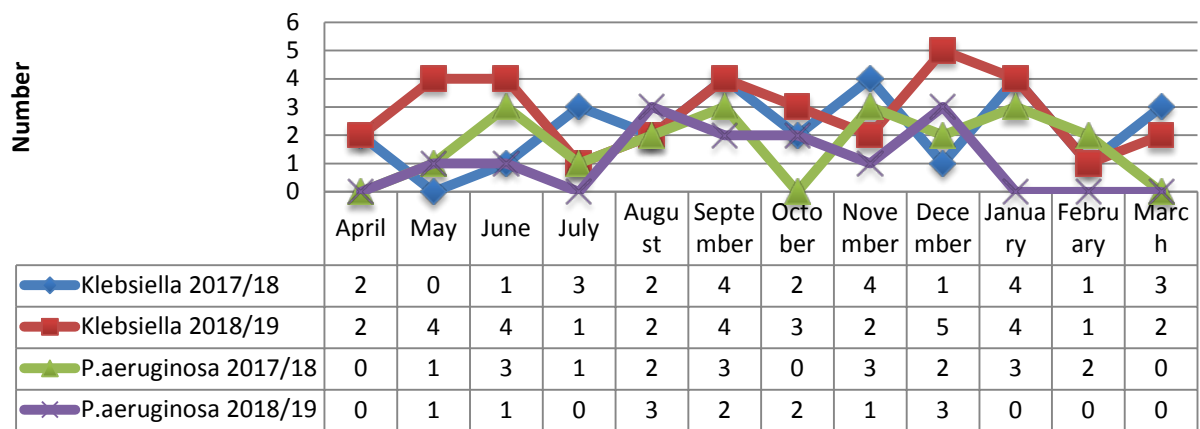


Table 6. *Klebsiella* and *Pseudomonas aeruginosa* bloodstream infections diagnosed in HEYHT 2017-19

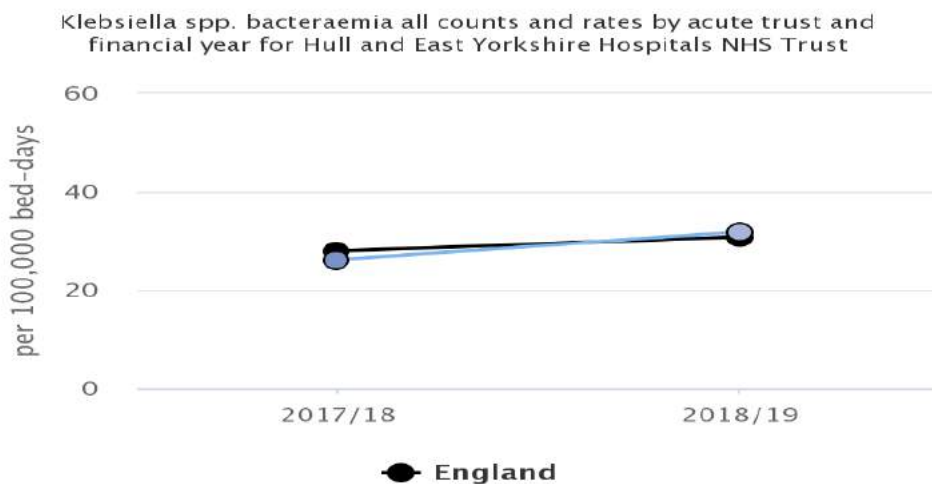


Figure 4. *Klebsiella* BSI rates in England 2017 - 2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust (PHE Fingertips)

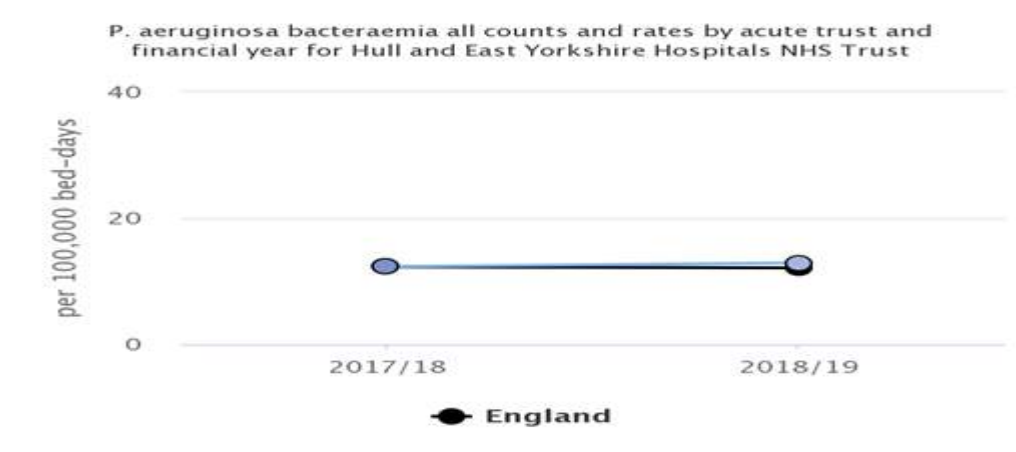


Figure 5. Pseudomonas aeruginosa BSI rates in England 2017 - 2019 in comparison with Hull and East Yorkshire Hospitals NHS Trust (PHE Fingertips)

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2018/19 this included orthopaedic surveillance (hip replacements) and was undertaken during October to December 2018; in addition from January 2019 to March 2019 because of concerns raised regarding perceived increase in wound infections amongst fractured neck of femur patients, repair of neck of femur fracture surveillance was undertaken. From October 2018 through to March 2019, Caesarean Section surgical site surveillance was undertaken following a number of measures introduced by Women's & Childrens Health Group to improve the outcomes of mothers having both emergency and elective C-sections, early indications suggest a reduction from the significantly high numbers previously identified. The Trust awaits the formal results of the majority of completed surgical site surveillance programmes undertaken during 2018/19. One surveillance program included data collection following repair of neck of femur fractures during January – March 2019, surveillance which had not been undertaken since 2013/14 and was prompted by concerns about patient outcomes following surgery. Recently PHE forwarded results which demonstrate an infection rate higher than the national average, the respective Health Group and speciality are formulating an action plan to address this, with further surveillance planned during 2019/20.

7 OUTBREAKS AND RESISTANT ORGANISMS

The Trust's policy on outbreaks and incidents of infection has been followed by the IPC team. Incident and Outbreak Control Group meetings have been held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patients are cared for, and seeking to prevent further cases.

Norovirus

The majority of Incident/Outbreak Control meetings were called because of Norovirus, facilitated by liaison following bed meetings which were attended by members of the Infection Prevention & Control Team. The overall number of Norovirus cases locally and

nationally over the year was below nationally expected numbers and the local situation was in line with national epidemiology.

During 2018/19, outbreaks of diarrhoea & vomiting, mainly affecting medical elderly wards were reported. The majority of these were identified as being caused by Norovirus. Of note were outbreaks caused by Norovirus reported during July and August 2018, which is uncommon affecting wards other than medical elderly wards. Wards H110 and H11 were particularly affected during this period with protracted outbreaks and an increased number of patients affected. This was due in part to patient movement across the 11th floor to provide prudent hyper acute stroke care and an initial assessment that symptom causation was as a result of other medical issues e.g. constipation, feed related and extension of existing stroke symptoms.

In accordance with national guidance hospital outbreaks of Norovirus were managed with partial restrictions but some complete ward closures were necessary, as in keeping with trends associated with 2017/18.

All areas affected by Norovirus were closed and cleaned in full accordance with IPC guidance. Opportunities to review existing policies, procedures and communication strategies with internal and external partners continued throughout 2018/19 with the embedding of a discharge policy, to facilitate safe discharge from affected wards, although this has remained a challenge during 2018/19.

Carbapenemase producing Enterobacteriaceae (CPE)

Infections with multi-drug resistant Gram negative bacteria are becoming increasingly common in Britain, and there have been a number of healthcare associated outbreaks (including some in other acute trusts in Yorkshire). During 2018/19 Hull and East Yorkshire Hospitals NHS Trust experienced an increase in imported infected and/or colonized patients, all of whom brought the organism in from elsewhere. During 2018/19, one case of Trust attributable CPE was detected in a patient with a complex history and multiple comorbidities who had been an inpatient for five months and received multiple courses of antibiotics with involvement from Infectious Diseases. This particular case was investigated thoroughly along with transmission routes and comparison with imported cases of CPE with no commonalities found. The Trust continues to identify and respond as per the national toolkit on prevention and management of CPE and during 2018-19 met the requirements of the toolkit e.g. identifying, screening and managing at risk patients and those with active infection. During 2018/19 in response to an increase in admissions and transfers of patients with CPE and a concern regarding the propensity for CPE to survive in healthcare environments, reactive cleaning of ward/department areas using Hydrogen Peroxide Vapours (HPV) was conducted where patients had been nursed and/or treated. This was invariably needed out of normal working hours and conducted by an external company who specialise in HPV decontamination. This represents a cost burden to the Trust in the long term with HPV decontamination out of hours costing the Trust £97,055.00 excluding VAT for 2018/19.

Invasive Group A Streptococcus (IGAS)

During 2018/19, the Trust continued to see a number of patients admitted with IGAS and managed as inpatients. This was a similar picture as seen in 2017/18, with previous clusters in noted in March and September 2017. Public Health England continues to investigate an increase in infections amongst people who inject drugs in the local community and across Yorkshire. During 2018/19, co-infections with MSSA, in addition to IGAS were noted in the same group of patients. MSSA isolates were sent to PHE for typing with some commonalities noted suggesting transmission prior to admission e.g. sharing of drug talking equipment. The continuing rate of infection amongst this group provides the opportunity to address possible inequalities experienced by this group of often difficult to reach patients.

Influenza

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

Nationally an increase in influenza was noted during December 2018 and January 2019 and this was demonstrated across Yorkshire & the Humber with a number of secondary care providers affected by admissions of flu like illness.

During November 2018, the Microbiology laboratory introduced new molecular testing (Biofire film array multiplex PCR system). This provided rapid respiratory panel testing including influenza, enabling prudent management and treatment of respiratory viral infections and improving patient flow.

Cases of Influenza in patients admitted to the Trust were first noted during November 2018, with just 1 case reported, this significantly increased to 76 cases in December 2018. These cases represented normal seasonal flu activity with more cases of Influenza A noted which was expected. Patients were screened, isolated, treated and managed appropriately.

From December 2018, as previously, the Trust were required to report Influenza data to NHS Improvement on a daily basis including number of inpatients with Influenza nursed in ICU settings, inpatients in other clinical areas with Influenza and the number of reported cases in the previous 24hour period.

During January 2019, the Trust continued to experience a significant number of Influenza A cases reported, occurring mainly in younger patients, some 'at risk' who had not been previously vaccinated. One Hundred and sixty one cases of Influenza A were reported during January 2019.

During February and March 2019 the Trust continued to experience Influenza, albeit less numbers than January 2019. Influenza A dominated throughout winter with no incidences of Influenza B reported.

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

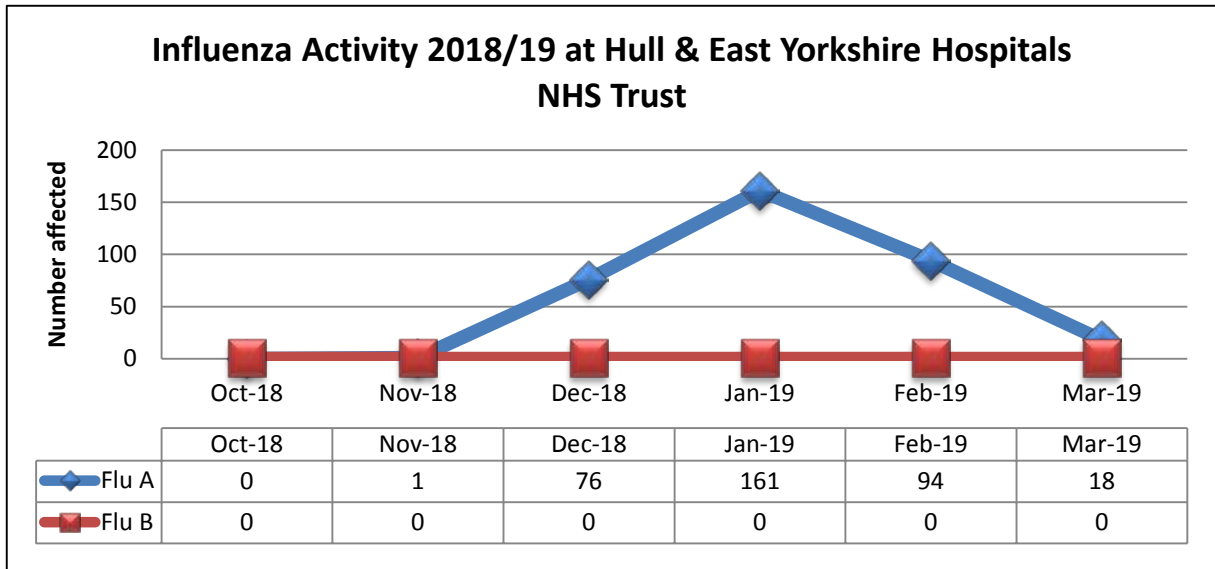


Table 6. Represents influenza activity at the Trust since October 2018 until the end of March 2019

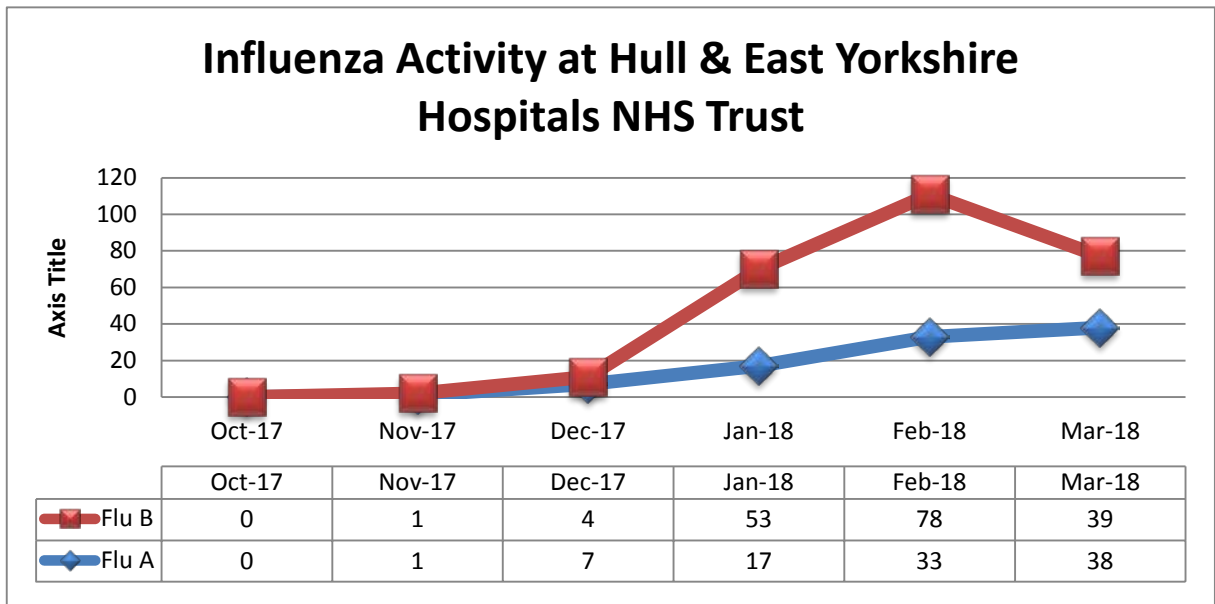


Table 7. As comparison, represents influenza activity at the Trust since October 2017 until the end of March 2018

LABORATORY CONFIRMATIONS

Figure 6 Laboratory confirmed cases of respiratory infections by week
Source: SGSS

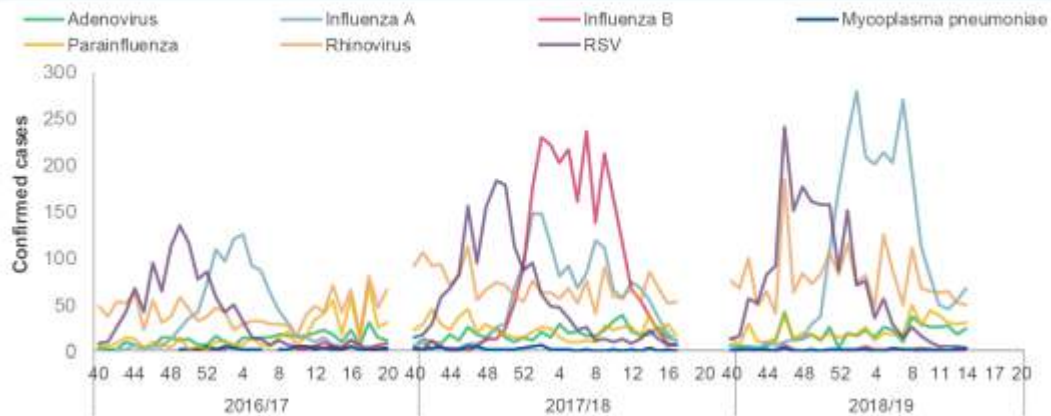


Table 8. Represents activity of respiratory infections including Influenza A & B across the Yorkshire & Humber region up to the 1st April 2019. (PHE Field Epidemiology Service)

In addition to reporting cases of influenza the Trust were also required to report on deaths attributed to influenza - there were fewer deaths in 2018/19 compared to 2017/18 from Influenza. Patient populations most at risk continue to be the age group 61-100yrs; hence the ongoing need for targeted influenza vaccine campaigns for at risk patients.

8 ISOLATION FACILITIES

There have been, for many years, concerns about the Trust's isolation facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.

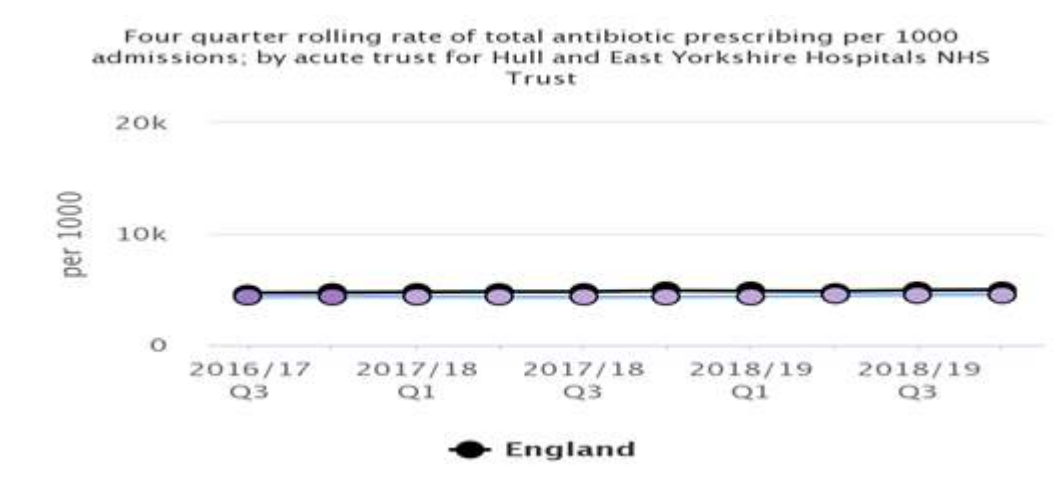
The opening of ward C7 has a positive impact on patient management, particularly those patients with difficult to treat infections and infectious diseases requiring specialist isolation facilities. It also means that we can manage several patients at once with conditions requiring long term isolation, for example multidrug resistant tuberculosis.

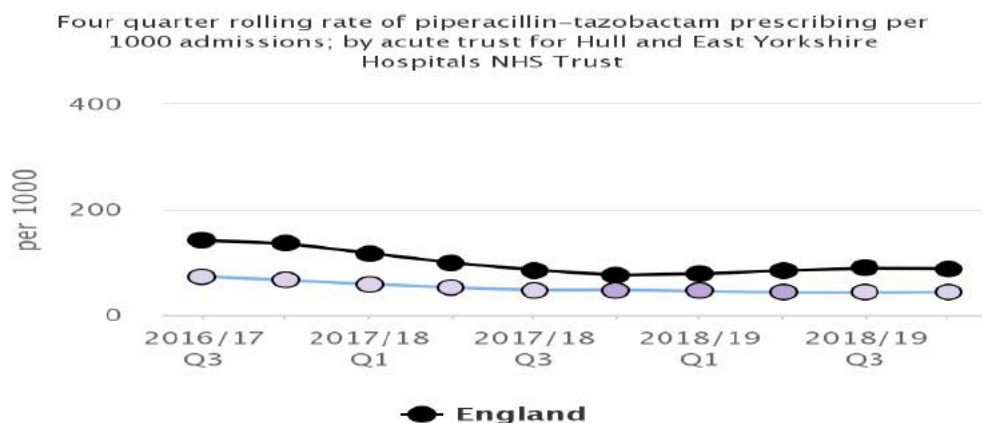
There remain concerns about the organisation's ability to isolate children, especially those with airborne infections. Although plans are discussed and implemented to minimise the risk of infections, especially during winter with risk assessments and liaison with IPCT - there have been, and will continue to be, cases of hospital transmitted influenza and respiratory syncytial virus (RSV) until more suitable facilities for isolating children with these infections are provided.

Following a number of reported outbreaks on the Neonatal Intensive Care Unit over the last 3-4 years which cited the environment as being a contributory factor, the financial year 2018/19 continued to provide the opportunity to address areas of concern. The cubicles adjacent to the 'red room' were reconfigured, enabling safer nurse to neonate staffing ratios. This included the use of sliding doors which can be sealed between each of the cubicles; in addition the bed capacity in the 'blue room' was reduced by one cot space. Further plans have been drafted to reconfigure the 'blue room' with a recommendation from the Department of Infection for this to be addressed as soon as is practicable given the tertiary nature of this level 3 unit.

9 ANTIMICROBIAL STEWARDSHIP

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control strategy. This is useful in reducing the development of *C difficile* infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship. In 2018-19 CQUIN targets for reduction in the use of the broad spectrum antibiotics Meropenem and Piperacillin/Tazobactam were achieved, even though we started from low baseline usage compared to national average. The Trust did not achieve the overall antibiotic usage reduction target required by the CQUIN (this is in part due to technical issues with the way in which 'amount' of antibiotic is recorded). The following two charts report total antibiotic prescribing per 1000 admissions and rolling rate of piperacillin-tazobactam prescribing per 1000 admissions in comparison with the England average.





The Antibiotic Control Advisory Team (ACAT), under the leadership of Dr Gavin Barlow for the purpose of this report, continues to work on improving antibiotic usage within the Trust. Advice on the use of antibiotics is included in consultants' mandatory training day. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, prescribing in patients at high risk of *C difficile*, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on the intranet. ACAT meets regularly to review antibiotic usage, and reports to IRC. Regular audits of the quality of antimicrobial prescribing are carried out by Pharmacy staff; these are presented at IRC and any areas requiring improvement are highlighted to Health Groups. This process is supported by the dedicated antimicrobial prescribing section of the drug chart, which makes it more difficult to inadvertently overprescribe antibiotics. These (and other) measures have led to an objectively measured improvement in the quality of prescribing, and an increased diversity of antibiotics used. RCA for CDAD have also shown a considerable reduction in cases which could be attributed to poor antibiotic prescribing.

During 2018/19 electronic prescribing and medicines administration (EPMA) was successfully rolled out across the Clinical Support Health Group. There were issues regarding the documentation of indication and duration on the electronic system affecting the overall Trust position when audited by Pharmacy teams. This is being addressed by training, prompts and escalation by the respective consultants, with improvement noted.

10 DECONTAMINATION

The Trust Decontamination Committee chaired by the Director of Estates, Facilities & Development meets quarterly and covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. The Trust endoscopy users, sterile services department and theatre report into this group. This committee reports to the Infection Reduction Committee.

The frequency of the Trust Decontamination Committee meeting on a quarterly basis was not met during 2018/19 with two meetings being held in that timeframe with concerns raised by the Infection Prevention & Control Team – the committee is currently under review, with a view that the Surgical Health Group will chair and organise the meetings during 2019/20.

Central Sterile Services Department (CSSD) has been audited and meets the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008. For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only).

During 2018/19 embedded support for CSSD and theatres by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments, has continued.

11 WATER SAFETY

The Water Safety Group (WSG) continues to work to raise awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance. During 2018/19 attendance at the WSG from respective Health Groups was noted, better and continued clinical representation is needed to effectively assess and respond to risks to patient safety and translate the work of the WSG to the clinical environment.

Flushing on both Trust sites is now firmly established, with improved compliance now seen. In an effort to reduce the associated administration and data storage burden the Estates department initiated a successful trial of a software based solution to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The new system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system.

Any positive water samples culturing both *Legionella* and/or *Pseudomonas* are reported by Public Health England to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients.

12 CLEANING SERVICES

Hull and East Yorkshire Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospital's performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2017/18 the Trust decided to tender for the cleaning services contract, basing the tender on an output specification rather than a traditional input specification. A traditional 'input' specification will set out in detail the exact services to be performed by the contractor in a prescriptive manner, whereas an 'output' specification aligned to the national specifications for cleanliness in the NHS: a framework for setting and measuring performance, define what is to be delivered, but not how it will be delivered. The infection prevention and control team along with senior nursing teams, Facilities, Health & Safety and Finance worked in collaboration to define the Trust requirements to inform the tender. Following a lengthy tendering process a decision was made to award the tender to OCS and

during March 2017, mobilisation commenced with OCS, supported by Mitie during their de-mobilisation phase.

Mitie provided cleaning services for Hull and East Yorkshire Hospitals NHS Trust up to and including the 31st May 2018, with the service transferred to Office Cleaning Services (OCS) following a period of mobilisation on the 1st June 2018, both of which were managed and monitored by the Trust's Facilities department.

The change in contract provided the opportunity to review cleaning processes and products, still utilising Tristel disinfection but rationalising use to blood/bodily fluid spillage and infections, in line with national guidance, along with use of micro-fibre cleaning methods. A change in contract, systems and processes has remained a challenge for both the Trust and OCS, especially following mobilisation. Standards of cleanliness were monitored and maintained during the transition with ongoing monitoring from both Facilities and the infection prevention and control team to ensure the contract is being delivered to the required standards and Trust expectations.

13 PLACE INSPECTIONS

The annual Patient Led Assessment of the Environment (PLACE) inspection of the Trust sites this year achieved an overall score of 98.9% for cleanliness

14 TRAINING AND EDUCATION

Education and training are essential to the strategy to limit healthcare associated infections (HCAI) in the Trust. They form part of every staff job description, and an integral part of the appraisal process.

Infection prevention & control education forms part of the mandatory induction programme for all staff. Additionally infection prevention and control is included in junior doctor orientation and as part of the consultants' mandatory training programme. Staff attendance at mandatory infection control updates is recorded centrally.

The infection prevention and control team conduct ad hoc education sessions to staff groups which have included security and Estates staff.

15 OTHER ACHIEVEMENTS IN 2018-19

The Trust has always worked in collaboration with commissioners and other partners in reducing avoidable infections. Although some national targets and CQUINs divide healthcare associated infections into 'acute-attributed' and 'community-attributed' these are artificial distinctions. Many infections diagnosed in the community have their origins in hospital, and vice versa. It is therefore essential that a 'whole system' approach is taken to tackling healthcare associated infections. The Trust continues to meet regularly with partners in a number of forums, and during 2018/19 the successful collaborative review process for *C difficile* was extended to other HCAs, especially MSSA and E.coli bacteraemia.

A continued reduction in the number of consultant microbiologists during 2018/19 provided the opportunity to change the way clinical infection advice is provided. Significant laboratory results (such as positive blood cultures) are now often followed up by a bedside visit from an

ID physician, rather than being phoned to the ward: this has resulted in continued positive feedback from some clinical teams. Regular infection in reach ward rounds now take place in a number of areas (e.g. orthopaedics, vascular surgery, diabetes, neurosurgery, cardiology/cardiothoracic), in addition to the specific visits requested through 'Ask Infection'.

16 OTHER RISKS IN 2018-19

During 2018/19, a number of incidences have occurred involving the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients. The infection prevention and control team have worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and Public Health England to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local commissioners.

17 EXTERNAL INSPECTIONS

Although the Trust has not had a formal CQC inspection for the financial year 2018/19, other audits of Trust services and facilities have been undertaken by the Trust's external auditors Mersey Internal Audit Agency (MIAA) and commended services including that of Ward C7, Infectious Diseases.

18 KEY POINTS AND RECOMMENDATIONS

- Internal and external reviews have confirmed that in the Trust has appropriate systems and processes in place for the prevention and control of healthcare associated infection.
- Performance against mandatory local and national targets has been satisfactory, with the exception of an increase in MSSA bacteraemia.
- The Trust has a strong antimicrobial stewardship programme, and there has been documented improvement in antimicrobial prescribing.
- There have been significant improvements in some specific aspects of infection prevention and control (e.g. management of *C difficile*, clinical engagement in root cause analysis, completion of ward level audits and increased partnership working).
- There are weaknesses in the Trust estate and facilities for managing patients with infections:
 - limited number of single rooms
 - inadequate isolation facilities in paediatrics

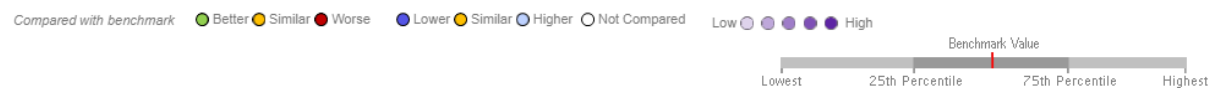
Solutions to these estate issues are being considered as part of a wider Trust strategy

- There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections.
- There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.

The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

Peter Moss
Director of Infection Prevention and Control
August 2019

Appendix 1. HCAI benchmarking data via PHE Fingertips 2018/19



Indicator	Period	Hull and East Yorkshire Hospitals	Trust type	England	England		
		Count	Value	Value	Value	Lowest	Highest
E. coli bacteraemia all rates by reporting acute trust and financial year	2018/19	481	144.6	115.8*	125.2*	0.0	211.5
E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year	2018/19	112	33.7	25.0*	22.1*	0.0	69.3
E. coli bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month	May 2019	383	115.1	91.2	104.4	0.0	196.4
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	109	32.8	25.0	22.3	0.0	66.8
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	492	147.9	116.2	126.6	0.0	218.1
E. coli completion of risk factor information, by NHS acute trust New data	Jun 2019	41	80.4%	51.6%	59.9%	0.0%	100.0%
E. coli known risk factor information, by NHS acute trust New data	Jun 2019	203	94.9%	68.6%	73.1%	0.0%	100.0%
E. coli completion of antibiotic information, by NHS acute trust New data	Jun 2019	41	80.4%	48.5%	55.4%	0.0%	100.0%
E. coli known antibiotic information, by NHS acute trust New data	Jun 2019	89	78.8%	67.0%	71.2%	0.0%	100.0%
Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year	2018/19	106	31.9	32.0*	30.8*	0.0	55.4
Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year	2018/19	38	11.4	11.9*	9.2*	0.0	36.4
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	100	30.1	32.3	31.2	0.0	57.3
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	40	12.0	11.9	9.3	0.0	34.7
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month	May 2019	60	18.0	20.5	21.8	0.0	44.1
P. aeruginosa bacteraemia all counts and rates by acute trust and financial year	2018/19	43	12.9	13.2*	12.1*	0.0	53.7
P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year	2018/19	13	3.9	6.2*	4.4*	0.0	38.1
P. aeruginosa bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month	May 2019	32	9.6	7.3	7.8	0.0	20.8
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	17	5.1	6.3	4.5	0.0	38.2
P. aeruginosa bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	49	14.7	13.6	12.3	0.0	59.0
MRSA bacteraemia all rates by reporting acute trust and financial year	2018/19	6	1.8	2.1*	2.3*	0.0	8.2
MRSA hospital-onset counts and rates by reporting acute trust and financial year	2018/19	3	0.9	0.8*	0.8*	0.0	6.8
MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month	May 2019	7	2.1	2.2	2.3	0.0	9.0
MRSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month	May 2019	4	1.2	1.4	1.5	0.0	6.7
MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month	May 2019	3	0.9	0.8	0.8	0.0	4.7
MSSA bacteraemia all rates by reporting acute trust and financial year	2018/19	187	56.2	35.7*	35.0*	0.0	68.3
MSSA hospital-onset rates by reporting acute trust and financial year	2018/19	59	17.7	11.1*	9.6*	0.0	23.4
MSSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month	May 2019	132	39.7	24.7	25.6	0.0	49.5
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month	May 2019	59	17.7	11.3	9.7	0.0	25.5

MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month	May 2019	191	57.4	36.0	35.3	0.0		62.9
C. difficile all rates by reporting acute trust and financial year	2018/19	111	33.4	35.3*	35.6*	0.0		168.0
C. difficile hospital-onset rates by reporting acute trust and financial year	2018/19	32	9.6	14.3*	12.2*	0.0		79.7
C. difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month	May 2019	108	32.5	34.6	35.3	0.0		166.6
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month	May 2019	40	12.0	16.1	14.0	0.0		86.8
C. difficile infection counts and 12-month rolling rates of community onset-healthcare associated, by reporting acute trust and month	May 2019	32	9.6	6.3	6.6	0.0		22.6
C. difficile infection Hospital-Onset Healthcare Associated (HOHA) counts and rates, by acute trust and financial year	2018/19	38	11.4	16.3*	14.1*	0.0		90.0
C. difficile infection community-Onset Healthcare Associated (COHA) counts and rates, by acute trust and financial year	2018/19	35	10.5	6.2*	6.6*	0.0		18.0
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute trust and quarter	2018/19 Q3	0	0.0	0.0*	14.0	-	Insufficient number of values for a spine chart	-
Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter	2018/19 Q3	0	0.0	65.7*	64.2	-	Insufficient number of values for a spine chart	-
Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year	2017/18	-	*	0.5	0.5	0.0		8.3
Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year	2017/18	0	0.0	0.4	0.4	0.0		9.1

Compared with benchmark: ● Better ● Similar ● Worse ● Lower ● Similar ● Higher ● Not Compared

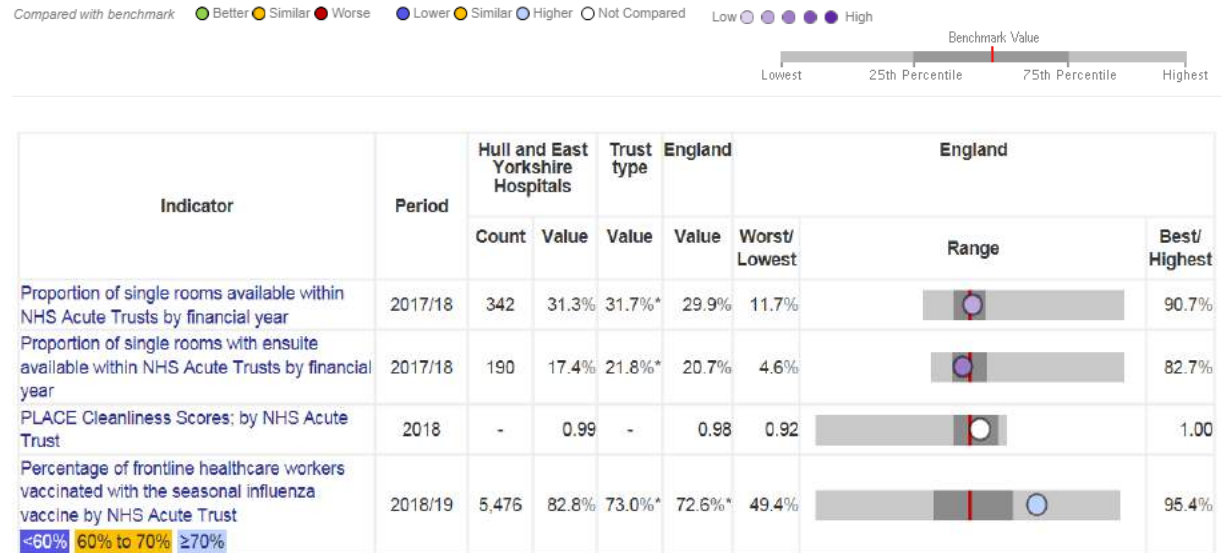
Low ● ● ● ● High

Benchmark Value

Lowest 25th Percentile 75th Percentile Highest

28 | Page

Appendix 3. Infection Prevention & Control Metrics via PHE Fingertips



Hull University Teaching Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Standing Orders
Responsible Director:	Director of Corporate Affairs – Carla Ramsay
Author:	Director of Corporate Affairs – Carla Ramsay

Purpose:	To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary of Key Issues:	The Trust's seal has been used, for review by the Trust Board. The paper also contains one amendment to the Scheme of Delegation to make a specific point about proposals for new areas of work clearer and consistent with the rest of Standing Orders.	

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal • Approve the recommended amendment to the Scheme of Delegation

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders September 2019

1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2019/21	Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust – Deed of Surrender and variation relating to rooms at Beverley Community Hospital	26 July 2019	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs

3 Standing Orders

The Trust's Standing Orders may only be varied by the Trust Board.

Currently, paragraph 9.20 in Standing Financial Instructions section of Standing Orders relates to the Trust bidding for new contracts of work (i.e. the Trust submitting a bid to another organisation's tender process to take on a new clinical service).

In the Trust's Scheme of Delegation section of Standing Orders, this power remains reserved to the Trust Board as part of its duties relating to Strategy, Planning and Budget. However the language in the Scheme of Delegation is ambiguous and relies upon knowledge of paragraph 9.20 in Standing Financial Instructions to interpret it. There is also an inconsistency between paragraph 9.20 in Standing Financial Instructions and the detail in the Scheme of Delegation about whether this applies to all new areas of work or just non-NHS related new areas of work.

Paragraph 9.20 states:

9.20 Trust submission of bids for new areas of work

It is part of the Chief Executive's executive powers to approve tender submissions. The Chief Executive discharges this responsibility through the Chief Operating Officer who will sign off the final tender response and the Chief Financial Officer who will sign off the final financial model.

Within the procurement timeline sufficient time will be allowed for a final review of the Invitation to Tender (ITT) response or bid submission by the appropriate Trust Committee and, where required, for any necessary alterations to be made to the final submission. The Chief Operating Officer and Chief Financial Officer are required to sign off this final version prior to submission.

The Committees providing relevant sign-off based on the total value of the contract bid for are:

- *Health Group Triumvirate/Directorate sign off – value up to £100K*

- *Executive Management Committee for £100k - £2m*
- *Performance and Finance Committee (value £2m - £5m)*
- *Trust Board (value over £5m)*

In the event that there is insufficient time within the tendering process to enable sign off at the appropriate committee, authority will be given to the Chief Operating Officer and Chief Financial Officer (or in their absence another member of the Executive Team) to sign off the final ITT for submission. If it is a bid of a value of more than £2m, this will also require the signature of the Chairman (or in their absence another Non-Executive Director).

This is reflected in the Scheme of Delegation in Standing Orders as:

- *Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £5,000,000 over a 3 year period or the period of the contract if longer.*

It is therefore recommended that the Scheme of Delegation wording is changed to:

- *Approve proposals for new areas of business to the Trust amounting to £5,000,000 or more (further detail on timings relating to tender processes for new work are set out in Standing Financial instructions)*

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve the recommended amendment to the Scheme of Delegation

Carla Ramsay

Director of Corporate Affairs

September 2019

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES) Trust Submission 2019

Title:	Workforce Race Equality Standard (WRES) Trust Submission
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Sarah Dolby, HR Advisor, Employment Policy and Resourcing

Purpose:	The purpose of this paper is to present for consideration by the Board the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2018/19 and proposed Action Plan for 2019/20.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	
Summary Key of Issues:	Next steps are identified within the 2019/20 Action Plan (Appendix 3).	

Recommendation:	The Board is asked to approve the WRES return and action plan prior to it being published on the Trust internet site.

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES) Trust Submission 2019

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2018/19 and proposed action plan for 2019/20.

2 Background

The NHS Workforce Race Equality Standard (WRES) was commissioned in 2015 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WRES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;
- To produce action plans to close the gaps in workplace experience between White and Black and Minority Ethnic (BME) staff; and
- To improve BME representation at the Board level of the organisation.

By using the WRES, NHS England expects that all NHS organisations will, year on year, improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

The report should be read in the context that 1111 staff self-declared as BME, and 150 staff did not declare their ethnicity.

3 Workforce Race Equality Standard (WRES) Submission 2019

The Trust is required to submit and publish a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2019. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 30 August 2019.
- Reporting Template (see Appendix 1) which is supported by an accompanying data report (available in Appendix 2) for indicator 1. For the benefit of the Executive Management Committee and Board, the Reporting Template compares the data submitted by the Trust over a 4 year period (2015 to 2019).
- WRES Action Plan (2019/20) which is based on the outcomes from the technical data results and is intended to address any disparities in the experiences of BME staff compared to White staff. The 2019/20 Action Plan builds on the 2018/19 Action Plan.

Both the Reporting Template and the Action Plan must be published on the Trust's external website by 27 September 2019.

4 Achievements throughout 2018/2019

Achievements and developments during 2018/19 include:

- 2 BME staff members have taken part in the Coaching and Mentoring Plan Programme to support career development for staff
- 1 BME staff member is taking part in the Trust Rise and Shine programme.

- World Food events were held at both CHH and HRI to celebrate the diverse mix of people and cultures which make up our workforce.
- Humberside Police held a number of Hate Crime Awareness sessions across both sites for staff to find out more about hate crimes/hate incidents and how to report them.

5 Key Findings from Data Set as at 31 March 2019

There has been an improvement across many of the key indicators, as follows:

- The Trust now has BME representation on the Board, following the appointment of a BME staff member as the Chief Medical Officer.
- The Trust has seen an increase of 123 BME employees since the 2017/18 data submission.
- There has been some positive movement in the number of BME staff achieving higher bands in the clinical workforce (non-medical) group. The number of BME staff in bands 6, 7 and 8b shows an increase of 12.
- The number of BME staff being shortlisted has increased, which has resulted in an increase in the likelihood of BME staff being appointed following shortlisting.
- BME staff are now less likely to enter into the formal disciplinary process than White staff.
- The data shows that BME staff are now more likely to access non-mandatory training and CPD than White staff.

6 Next Steps

- The Trust will hold the first BME Summit in October 2019. The aim of this event will be to kick-start our refreshed BME Network priorities, which BME staff will be instrumental in shaping. The event will support, encourage and explore opportunities for bringing out the best in its members, both personally and professionally.
- Increase awareness of coaching, leadership training, BME events and support available to staff through regular communications via weekly news, Pattie and Team Brief.

The above points are examples of planned next steps. For full details of actions, please see the WRES Action Plan for 2019/20 in Appendix 3.

7 Recommendation

The Board is asked to note the content of this report and its appendices and approve the WRES return and action plan.

Simon Nearney
Director of Workforce and Organisational Development

August 2019

Workforce Race Equality Standard Reporting Template

Workforce Race Equality Standard

Name of organisation:	Hull University Teaching Hospitals NHS Trust
Date of report:	31 March 2019
Name and title of Board lead for the Workforce Race Equality Standard:	Teresa Cope, Chief Operating Officer
Name of lead compiling this report:	Sarah Dolby, HR Advisor
Names of commissioners this report has been sent to:	Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group
Name of co-ordinating commissioner this report has been sent to:	Hull Clinical Commissioning Group
Unique URL link on which this report and associated Action Plan will be found:	https://www.hey.nhs.uk/about-us/equality/
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however the ethnic status of 150 staff is not stated, which represents 1.6% of the total workforce.

Any matters relating to reliability of comparisons with previous years: N/A

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 9,214

Proportion of BME staff employed within the Trust at the date of the report: 12.1% of the total staff employed, however as noted above, 1.6% of staff did not declare their ethnicity.

3. Self-Reporting

The proportion of total staff who have self-reported their ethnicity: 9064 / 98.4%

Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity? All new starters to the organisation continue to be asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity? To improve the quality of data stored within ESR, ESR Self Service will be re-launched, highlighting to staff that they can update their personal information, including ethnicity, marital/partnership status and disability status.

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2019 and activity during the financial year 2018/19.

5. Workforce Race Equality Indicators

The table below shows high level summary points. Please see the accompanying WRES Action Plans for further details.

Indicator		Comparison	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	Implications of the data and background narrative	Action taken and planned
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. <i>(For this workforce indicator, compare the data for White and BME staff.)</i>	Non-clinical (White)	23.13%	20.26%	23.84%	24.51%	The Trust has seen an increase of 123 BME employees since the 2017/18 data submission. Whilst BME staff continue to be under-represented in the higher pay bands in comparison to White staff, there has been some positive movement across the clinical workforce (non-medical), which shows an increase of 12 BME staff in bands 6, 7 and 8b. The clinical workforce (medical and dental) has also seen an increase of 69 BME staff.	Exit data provides an insight into staff experience within the Trust. The Trust continues to analyse exit data provided by BME staff. To date no adverse trends have been identified. See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		Non-clinical (BME)	0.53%	0.55%	0.59%	0.64%		
		Clinical non-medical (White)	59.35%	60.96%	57.41%	55.52%		
		Clinical non-medical (BME)	3.67%	3.68%	4.10%	4.46%		
		Clinical medical and dental (White)	5.91%	6.09%	6.01%	6.28%		
		Clinical medical and dental (BME)	5.67%	6.78%	6.44%	6.96%		
2	Relative likelihood of staff being appointed from shortlisting across all posts. <i>(For this workforce indicator, compare the data for White and BME staff.)</i>	White	0.15% 5174 shortlisted / 791 appointed	0.20% 4507 shortlisted / 879 appointed	0.22% 3661 shortlisted / 794 appointed	0.20% 4383 shortlisted / 894 appointed	The data shows that the number of BME staff shortlisted has increased and so has the likelihood of them being appointed following shortlisting.	All staff who shortlist and interview are appropriately trained and aware of the impact of unconscious bias. See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	0.09% 665 shortlisted / 61 appointed	0.14% 483 shortlisted / 68 appointed	0.16% 520 shortlisted / 82 appointed	0.23% 611 shortlisted / 141 appointed		
		Relative likelihood	1.67	1.39	1.38	0.88		

Appendix 1

Indicator		Comparison	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	Implications of the data and background narrative	Action taken and planned
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year. <i>(For this workforce indicator, compare the data for White and BME staff.)</i>	White	0.0027% (21 White staff)	0.0001% (10 White staff)	0.0097% (75 White staff)	0.0092% (73 White staff)	The data shows that there are the same number of White and BME staff entering the formal disciplinary process. The relative likelihood of BME staff entering a formal disciplinary process compared to White staff has improved year on year.	The Trust has robust policies in place which provide a framework for those going through the formal and informal disciplinary processes. Further work to review the level of support available to staff going through a disciplinary process is planned. See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	0.0055% (5 BME staff)	0.0002% (2 BME staff)	0.0091% (9 BME staff)	0.0063% (7 BME staff)		
		Relative likelihood	2.13	1.59	0.94	0.69		
4	Relative likelihood of staff accessing non-mandatory training and CPD. <i>(For this workforce indicator, compare the data for White and BME staff.)</i>	White	0.95% (6529 White staff)	0.75% (5793 White staff)	0.73% (5679 White staff)	0.85% (6794 White staff)	The Trust continues to see a marginal improvement in the likelihood metrics.	Staff can record their own training and CPD undertaken outside of HEY247 on the HEY247 system. All staff are to be encouraged to utilise this facility going forward. See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	0.91% (686 BME staff)	0.70% (685 BME staff)	0.74% (734 BME staff)	0.90% (1001 BME staff)		
		Relative likelihood	1.06	1.07	0.99	0.95		

Indicator		Comparison	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	Implications of the data and background narrative	Action taken and planned
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. <i>(Compare the responses for White and BME staff.)</i>	White	25.60%	25.60%	25.02%	25.15%	The data shows an increase of both BME and White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	26.67%	21.00%	20.95%	24.07%		
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. <i>(Compare the responses for White and BME staff.)</i>	White	34.92%	30.56%	27.59%	28.18%	The number of staff experiencing bullying from other staff has increased for both White and BME staff over the last 12 months.	See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	56.67%	29.77%	27.12%	29.59%		
7	KF 21. Percentage believing that trust provides equal opportunities for career progression	White	85.49%	88.30%	89.60%	89.59%	The data shows an improving position for BME staff and a marginal improvement for White staff.	See Action Plan for further details. Actions link to EDS2 goals and the Trust

Indicator		Comparison	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	Implications of the data and background narrative	Action taken and planned
	or promotion. <i>(Compare the responses for White and BME staff.)</i>	BME	72.73%	87.32%	80.60%	81.68%		Equality objectives.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues <i>(Compare the responses for White and BME staff.)</i>	White	7.60%	6.02%	5.32%	6.06%	The number of staff reporting that they had experienced discrimination at work from their manager/team leader or colleagues in the last 12 months has increased for both White and BME staff, albeit the increase for BME staff is more than for White staff.	See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.
		BME	16.13%	12.84%	11.04%	13.19%		
9	Percentage difference between the organisations' Board voting membership and its overall workforce. <i>(Compare the difference for White and BME staff.)</i>	% difference between for White and BME staff	-9.9%	-11%	-11.1%	-5.8%	Following the appointment of the Chief Medical Officer the Trust now has a BME representative on the Board, leading to an improvement on this indicator.	The Trust acknowledges that whilst this is a positive step, it still needs to improve. Targeted recruitment for Executive and Non-Executive Directors is being explored. See Action Plan for further details. Actions link to EDS2 goals and the Trust Equality objectives.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

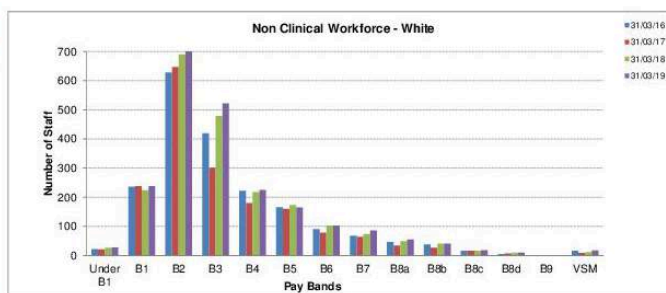
None

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

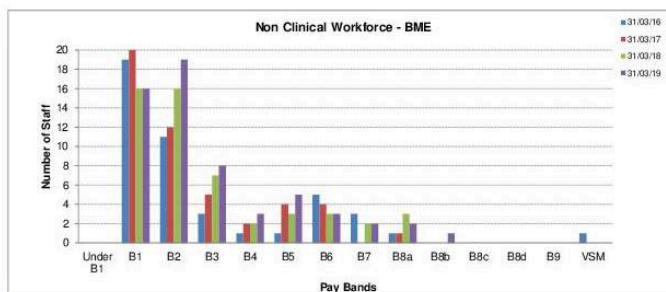
The Draft WRES Action plan is attached.

Breakdown of Staff Employed across AfC Paybands

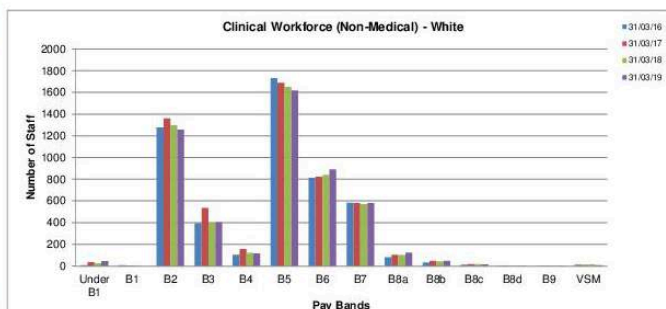
Non Clinical Workforce - White	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Under B1	22	21	27	28	1
B1	237	238	224	238	14
B2	628	647	690	748	58
B3	420	301	479	522	43
B4	222	180	218	225	7
B5	166	160	174	165	-9
B6	91	79	103	103	0
B7	68	65	74	86	12
B8a	47	35	50	55	5
B8b	38	27	41	41	0
B8c	17	17	17	19	2
B8d	5	7	10	10	0
B9	0	0	0	0	0
VSM	17	9	12	18	6
Total	1978	1786	2119	2258	139



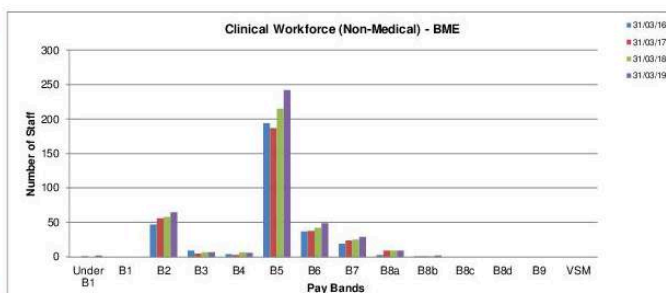
Non Clinical Workforce - BME	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Under B1	0	0	0	0	0
B1	19	20	16	16	0
B2	11	12	16	19	3
B3	3	5	7	8	1
B4	1	2	2	3	1
B5	1	4	3	5	2
B6	5	4	3	3	0
B7	3	0	2	2	0
B8a	1	1	3	2	-1
B8b	0	0	0	1	1
B8c	0	0	0	0	0
B8d	0	0	0	0	0
B9	0	0	0	0	0
VSM	1	0	0	0	0
Total	45	48	52	59	7



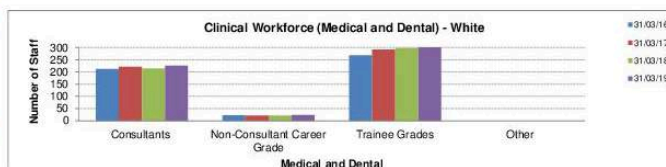
Clinical Workforce (Non-Medical) - White	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Under B1	9	36	26	45	19
B1	8	6	6	0	-6
B2	1279	1360	1299	1257	-42
B3	395	535	400	405	5
B4	105	158	121	116	-5
B5	1733	1688	1652	1619	-33
B6	814	824	842	891	49
B7	583	581	571	580	9
B8a	80	103	102	123	21
B8b	34	48	43	48	5
B8c	14	18	17	16	-1
B8d	4	4	4	4	0
B9	4	4	3	3	0
VSM	14	10	16	9	-7
Total	5076	5375	5102	5116	14



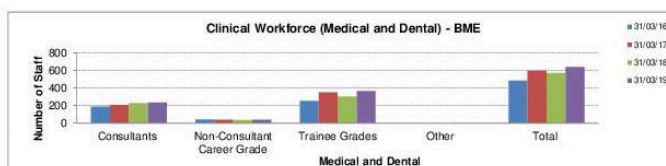
Clinical Workforce (Non-Medical) - BME	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Under B1	0	1	0	2	2
B1	0	0	0	0	0
B2	47	56	58	65	7
B3	9	5	7	7	0
B4	4	3	7	6	-1
B5	194	187	215	242	27
B6	37	38	42	49	7
B7	19	24	25	29	4
B8a	3	9	9	9	0
B8b	1	1	1	2	1
B8c	0	0	0	0	0
B8d	0	0	0	0	0
B9	0	0	0	0	0
VSM	0	0	0	0	0
Total	314	324	364	411	47



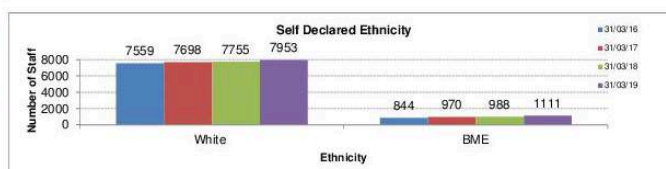
Clinical Workforce (M&D) - White	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Consultants	213	222	215	226	11
Non-Consultant Career Grade	23	22	21	24	3
Trainee Grades	269	293	298	329	31
Other	0	0	0	0	0
Total	505	537	534	579	45



Clinical Workforce (M&D) - BME	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
Consultants	189	207	230	234	4
Non-Consultant Career Grade	42	39	37	39	2
Trainee Grades	254	352	305	368	63
Other	0	0	0	0	0
Total	485	598	572	641	69



Ethnicity Declared	31/03/16	31/03/17	31/03/18	31/03/19	Variance between 31/03/18 to 31/03/19
White	7559	7698	7755	7953	198
BME	844	970	988	1111	123
Not Stated	149	148	144	150	6
Grand Total	8552	8816	8887	9214	327



Workforce Race Equality Standard Action Plan 2019/2020

The Action Plan has been developed, based on the 2018/19 WRES technical data results, to help close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff.

Action	Metric	Delivery Timescale	Lead Responsibility
Aim: Increase the percentage of BME staff in each of the AfC Bands 1-9 / Medical and Dental subgroups and VSM (including executive Board members) and provide all staff with equal opportunities for career progression / promotion			
1. Review Workforce Data	WRES indicator 1, 7 and 9	October 2019	HR Advisor Employment Policy and Resourcing / Workforce Planning
- Review current staff profile to identify where there are current shortfalls of BME staff to enable development of aspirational goals for diversity at each level of the organisation and to target recruitment and development efforts - Track and monitor access of internal and external leadership programmes and coaching in order to see progress.		Ongoing	Head of Organisational Development
2. Development and Recruitment		Ongoing	Director of Workforce and OD
- Continue to ensure that the process for appointment of Executive and Non-Executive Director posts encourages applications from as diverse a pool of talent as possible and demonstrates the Trust's commitment to diversity and inclusion. - Ongoing development with the executive and senior team to succession plan and manage talent.		Ongoing	Director of Workforce and OD / Head of Organisational Development
3. BME Engagement		October 2019	Head of HR Services/ HR Advisor Employment Policy and Resourcing / Senior Organisational Development Practitioner
Host the first BME Summit to kick-start refreshed BME Network priorities.		Ongoing	Director of Communications / Head of Organisational Development / Head of HR Services
Review the monthly corporate induction to build in signposting support for BME staff.		Ongoing	Head of HR Services / HR Advisor Employment Policy and Resourcing / Senior Organisational Development Practitioner
Encourage BME staff to join the BME Network.		Ongoing	

Action	Metric	Delivery Timescale	Lead Responsibility
Develop a 'Pulse Survey' to better understand the lived experience of Trust BME staff.		Ongoing	Senior Organisational Development Practitioner / Head of HR Services
Encourage BME staff leaving the Trust to complete exit interviews in order for positive/negative feedback to be sought to identify key themes.		Ongoing	HR Advisor Employment Policy and Resourcing / HR Managers
Explore how to embed inclusion in job descriptions and appraisals.		Ongoing	Head of HR Services / HR Advisor Employment Policy and Resourcing
4. Connect Senior Stakeholders with BME Community		Ongoing	Head of Organisational Development
- Mentoring - identify and train mentors (senior stakeholders) who can provide mentorship to BME staff in order to connect the executive and senior management team with the BME community. - Reverse mentoring - harness the skills and knowledge of BME colleagues to mentor senior colleagues through sharing and learning from lived experiences.			
Aim: Continue to ensure that BME staff are subject to equal opportunities for shortlisting			
5. Recruitment and Interviews	WRES indicator 2		
Continue the development of Values Based Recruitment (VBR) to ensure that it is an inclusive process end to end (shortlisting, scoring scales, questions).		Ongoing	Head of Organisational Development / Head of HR Services
Continue to promote 'Interviewing Skills' training (to build awareness of bias) and target those actively interviewing within the organisation.		Ongoing	Head of Organisational Development / Head of HR Services
Refresher training for managers who interview regularly.		Ongoing	Head of Organisational Development / Head of HR Services / HR Advisor Employment Policy and Resourcing
Develop guidance for candidates explaining the interview process.		Ongoing	HR Advisor Employment Policy and Resourcing / Head of Organisational Development

Action	Metric	Delivery Timescale	Lead Responsibility
Aim: Reduce the number of staff entering the formal disciplinary process. Ensure there are support mechanisms in place for those going through the process. Reduce the level of staff reporting that they have experienced discrimination at work from a manager/team leader or other colleagues			
6. Disciplinary Procedures	WRES indicator 3 and 8	Ongoing	Head of HR Services / HR Advisor Employment Policy and Resourcing
Review responses gathered from 'Pulse Survey to identify positives/negatives relating to BME staff going through a disciplinary process to review the level of support available to staff.		Ongoing	Head of HR Services / HR Advisor Employment Policy and Resourcing
Ensure panels are diverse for disciplinary hearings, recruitment etc. as appropriate		Ongoing	Head of HR Advisory Services
Review NHS Improvement guidance published in May 2019 re the application of disciplinary procedures against Trust disciplinary policies and procedures. Make adjustments as appropriate and raise awareness and understanding of these to those instrumental in the disciplinary process (e.g. Inclusion workshop).			
Aim: Ensure that BME staff continue to have the same opportunity to access non-mandatory training and CPD as White staff			
7. Marketing of Development Opportunities	WRES indicator 4	Ongoing	Head of Organisational Development
- Internally – ensure fair and equal opportunity and access to leadership programmes, coaching and accredited programmes (ensuring that marketing and application process is inclusive). - Externally – promote the Leadership Academy's 'Stepping Up' and 'Ready Now' programmes more proactively through BME Network.		Ongoing	Head of Organisational Development
Encourage BME staff to sign up to the Leadership Academy website.		Ongoing	Head of Organisational Development
8. Refresh Leadership Programmes		Ongoing	Head of Organisational Development
- Increase awareness and understanding of barriers/ issues that BME staff may experience in all leadership programmes. Address unconscious bias in leadership programmes and at senior level. - Review content of 'Be Remarkable (Medical and non-medical)', 'Rise and Shine' and 'Supervisors Programme' training to ensure they build inclusive leadership capability.		Ongoing	Head of Organisational Development
Refresh Great Leaders Bitesize sessions.		Ongoing	Organisational Development / HR Advisory Service
Refresh 'What's it like to be managed by me?' Bitesize Course. Line managers are critical to the development of staff and enable staff to realise their potential.			Head of Organisational Development
9. Coaching		Ongoing	Head of Organisational Development
- Upskill the Coaching Network by signposting training like 'Coaching for Inclusion' (Yorkshire Leadership Academy). - Maximise the opportunities for BME staff to be developed as a coach.		Ongoing	Head of Organisational

Action	Metric	Delivery Timescale	Lead Responsibility
			Development
Proactively advertise coaching to the BME community.		Ongoing	Head of Organisational Development
10. HEY247			
Encourage staff to record their own training and CPD undertaken outside of HEY247 on the HEY247 system and review whether the data can be reported.		Ongoing	Head of Education / HR Advisor, Employment Policy and Resourcing
Explore whether there is an opportunity to add a focus on equality and inclusion into the appraisal system.		Ongoing	Head of Education / Head of Organisational Development / Head of HR Services
Aim: Reduce the level of staff experiencing harassment, bullying or abuse from patients, relatives, the public or from staff in last 12 months			
11. Zero Tolerance Approach			
Consider a renewed campaign to promote the Trust's zero tolerance approach to incidents of bullying, harassment or abuse of its staff	WRES indicator 5 and 6	Ongoing	Head of HR Services / HR Advisor, Employment Policy and Resourcing / Communications
Empower all staff to implement a zero tolerance approach to bullying, harassment or abuse.		Ongoing	Head of HR Services / HR Advisor, Employment Policy and Resourcing / Communications

Hull University Teaching Hospitals NHS Trust

**Workforce Disability Equality Standard (WDES)
Trust Submission 2019**

Title:	Workforce Disability Equality Standard (WDES) Trust Submission
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Liz Dearing, HR Manager

Purpose:	The purpose of this paper is to present for consideration by the Board the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2019 and proposed action plan.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	
Summary Key of Issues:		

Recommendation:	The Board is asked approve the WDES return and action plan prior to publishing on the Trust internet site.

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES) Trust Submission 2019

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2019 and proposed action plan.

2 Background

The NHS Workforce Disability Equality Standard (WDES) was commissioned in 2019 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WDES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators;
- To produce action plans to close the gaps in workplace experience between disabled and non-disabled staff; and
- To improve disabled representation at the Board level of the organisation.

By using the WDES, NHS England expects that all NHS organisations will, year on year, improve workforce disability equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WDES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

3 WDES Submission 2019

The Trust is required to submit and publish a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2019. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 1 August 2019 and has done so.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WDES Action Plan which is based on the outcomes from the technical data results and is intended to address any disparities in the experiences of disabled staff compared to non-disabled staff (see Appendix 3).
- This report should be read in the context that only 183 staff self-reported with a disability whereas when completing the Staff Survey (December 2018) a higher number of staff reported themselves as disabled.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 30 September 2019.

4 Key Findings for 2019

The WDES seeks to ask questions in the following areas:

1. The percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce at 31 March 2019.
2. The relative likelihood of Disabled staff compared to Non-disabled staff being appointed from shortlisting across all posts.
3. The relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process.

4. The percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse.
5. The percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. The percentage of Disabled staff compared to Non-disabled staff saying they have felt pressure from their managers to come to work when they have not felt well enough to do their duties.
7. The percentage of Disabled staff compared to Non-disabled staff saying they are satisfied with the extent to which their organisation values their work
8. The percentage of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.
9. A) The staff engagement scores for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.
B) Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?
10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce at 31 March 2019.

The key findings from the technical data for 2019 are:

- The Trust employed 9,214 staff at 31 March 2019.
- Of the 9,214 staff, 41.66% (3,839) had not declared being disabled or non-disabled and are recorded as 'unknown or null'.
- 183 staff have reported as Disabled on ESR.
- The metric with the highest disparity between Non-disabled staff and Disabled staff is staff experiencing harassment, bullying or abuse from managers in the last 12 months (Staff Survey December 2018 data)
- The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that said the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months (Staff Survey December 2018 data).

The data for 4 to 9 B) above is from the Staff Survey and inherently more staff report themselves as disabled when completing the staff survey compared to the staff who report themselves as disabled through ESR.

The data shows there are improvements to be made across all of the indicators. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR.

5 WDES Action Plan

The draft WDES Action Plan for 2019/20 is available in Appendix 3.

6 Recommendation

The Board is asked to note the content of this report and its appendices and endorse the WDES return and action plan.

Simon Nearney
Director of Workforce and Organisational Development
August 2019

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2019
Name and title of Board lead for the Workforce Disability Equality Standard:	Teresa Cope, Chief Operating Officer
Name of lead compiling this report:	Liz Dearing, HR Manager
Names of commissioners this report has been sent to:	Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group
Name of co-ordinating commissioner this report has been sent to:	Hull Clinical Commissioning Group
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however 41.66% of the workforce have not declared as disabled or non-disabled, which represents 3,839 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 9,214

Proportion of disabled staff employed within the Trust at the date of the report: 1.99% of the total staff employed as self-declared through ESR.

3. Self-Reporting

The proportion of total staff who have self-reported disabled/non-disabled: 58.34%

Have any steps been taken to increase declaration rates? All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

Are any steps planned during the current reporting period to improve the level of self-reporting? To improve the quality of data stored within ESR, ESR Self Service will be re-launched, highlighting to staff that they can update their personal information, including ethnicity, marital/partnership status and disability status.

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2019 and activity during the financial year 2018/19.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2018/19	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective												
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2019: <table><tr><td>Non-clinical workforce (Non-disabled) =</td><td>13.25%</td></tr><tr><td>Non-clinical workforce (Disabled) =</td><td>0.59%</td></tr><tr><td>Clinical workforce (non-medical Non-disabled) =</td><td>33.01%</td></tr><tr><td>Clinical workforce (non-medical Disabled) =</td><td>1.20%</td></tr><tr><td>Clinical workforce (medical and dental non-disabled) =</td><td>9.72%</td></tr><tr><td>Clinical workforce (medical and dental Disabled) =</td><td>0.16%</td></tr></table>	Non-clinical workforce (Non-disabled) =	13.25%	Non-clinical workforce (Disabled) =	0.59%	Clinical workforce (non-medical Non-disabled) =	33.01%	Clinical workforce (non-medical Disabled) =	1.20%	Clinical workforce (medical and dental non-disabled) =	9.72%	Clinical workforce (medical and dental Disabled) =	0.16%	In total 58.34% of Trust staff declared themselves as disabled or non-disabled. The highest percentage of disabled employees are within the clinical workforce (medical and dental) whilst the lowest percentage of disabled employees are within the clinical workforce (non- medical)	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
Non-clinical workforce (Non-disabled) =	13.25%															
Non-clinical workforce (Disabled) =	0.59%															
Clinical workforce (non-medical Non-disabled) =	33.01%															
Clinical workforce (non-medical Disabled) =	1.20%															
Clinical workforce (medical and dental non-disabled) =	9.72%															
Clinical workforce (medical and dental Disabled) =	0.16%															
2	Relative likelihood of Non - disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.21 Disabled: 0.14 Relative likelihood: 1.49	The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.												
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-disabled staff. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled: 0.01 Non-disabled: 0.00 Relative likelihood: 1.67	The numbers of staff entering the formal capability process are low, however the relative likelihood of entering the formal capability process is greater for Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.												

	Indicator	Data for reporting year 2018/19	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
4 a) i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Non-disabled: 23.5% Disabled: 32.2% (From Staff Survey December 2018)	The percentage of Non-disabled and disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public is high.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months.	Non-disabled: 12.8% Disabled: 24.6% (From Staff Survey December 2018)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from managers is high and within this metric the disparity between Non-disabled and Disabled staff is the highest.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months.	Non-disabled: 19.8% Disabled: 30.8% (From Staff Survey December 2018)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from other colleagues is high.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	Non-disabled: 42.1% Disabled: 40.6% (From Staff Survey December 2018)	The percentage of staff reporting harassment, bullying or abuse at work is low. This metric has the smallest disparity between Non-disabled and Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
5	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 90.5% Disabled: 82.1% (From Staff Survey December 2018)	The percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion is less than the percentage for Non-disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
6	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 22.9% Disabled: 32.9% (From Staff Survey December 2018)	The Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties is high, however it is higher for Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2018/19	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 51.7% Disabled: 35.0% (From Staff Survey December 2018)	The percentage of staff saying they are satisfied with the extent to which their organisations values their work is low and lower for Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	75.7% (From Staff Survey December 2018)	The percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work is low.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the overall score for the organisation.	Non-disabled staff: 7.2 Disabled: 6.6 Organisation: 7 (From Staff Survey December 2018)	The staff engagement score for Disabled staff is lower than for Non-disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9b	Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?	Yes	The Trust has carried out an anonymous survey, held one to one discussions and listening events with staff who identified themselves as having a disability.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	Non-disabled: 0.08% Disabled: 0.0% (From ESR)	Considering the percentage of staff who have self-reported as Non-disabled and the percentage of staff who have self-reported as Disabled the disaggregated percentage difference would be expected to be very low. The Trust acknowledges that, in respect of disability, the Board is not representative of the population it serves. Within Hull and East Riding the disabled population is 19%.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

None

7. Organisations should produce a detailed WDES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WDES Action Plan or provide a link to it.

The Draft WDES Action plan is attached.

Hull University Teaching Hospitals NHS Trust				31st MARCH 2019						
				DISABLED		NON-DISABLED		DISABILITY UNKNOWN OR NULL		OVERALL STAFF
				Total Disabled	% Disabled / ratio	Total Not Disabled	% Not Disabled / ratio	Total Unknown or Null	% Unknown or Null / ratio	Total
INDICATOR	DATA ITEM		MEASURE	Verified data	Verified data	Verified data	Verified data	Verified data	Verified data	Verified data
Percentage of staff in A/C paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2019		1a) Non Clinical Staff								
	1	Bands 1	Headcount	6	2%	122	47%	130	50%	258
	2	Bands 2	Headcount	19	2%	448	58%	306	40%	773
	3	Bands 3	Headcount	11	2%	242	45%	281	53%	534
	4	Bands 4	Headcount	7	3%	112	49%	111	48%	230
	5	Bands 5	Headcount	4	2%	100	58%	67	39%	171
	6	Bands 6	Headcount	0	0%	55	52%	51	48%	106
	7	Bands 7	Headcount	3	3%	52	57%	36	40%	91
	8	Bands 8a	Headcount	2	3%	25	41%	34	56%	61
	9	Bands 8b	Headcount	1	2%	16	39%	24	59%	41
	10	Bands 8c	Headcount	0	0%	8	42%	11	58%	19
	11	Bands 8d	Headcount	0	0%	7	64%	4	36%	11
	12	Bands 9	Headcount	0	0%	0	0%	0	0%	0
	13	VSM	Headcount	0	0%	10	56%	8	44%	18
	14	Other	Headcount	1	4%	24	86%	3	11%	28
		1b) Clinical Staff								
	15	Bands 1	Headcount	0	0%	0	0%	0	0%	0
	16	Bands 2	Headcount	22	2%	847	63%	467	35%	1336
	17	Bands 3	Headcount	7	2%	194	46%	219	52%	420
	18	Bands 4	Headcount	4	3%	60	49%	58	48%	122
	19	Bands 5	Headcount	50	3%	1160	62%	671	36%	1881
	20	Bands 6	Headcount	17	2%	475	50%	461	48%	953
	21	Bands 7	Headcount	9	1%	235	38%	375	61%	619
	22	Bands 8a	Headcount	2	1%	47	35%	85	63%	134
	23	Bands 8b	Headcount	0	0%	16	32%	34	68%	50
	24	Bands 8c	Headcount	0	0%	3	19%	13	81%	16
	25	Bands 8d	Headcount	0	0%	2	50%	2	50%	4
	26	Bands 9	Headcount	0	0%	1	33%	2	67%	3
	27	VSM	Headcount	0	0%	2	20%	8	80%	10
	28	Medical & Dental Staff, Consultants	Headcount	2	0%	245	52%	223	47%	470
	29	Medical & Dental Staff, Non-Consultants career grade	Headcount	2	3%	38	58%	25	38%	65
	30	Medical & Dental Staff, Medical and dental trainee grades	Headcount	11	1%	613	83%	119	16%	743
	31	Other	Headcount	3	6%	33	70%	11	23%	47
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By Voting membership of the Board The data for this metric should be a snapshot as of 31st March 2019	32	Total Board members	Headcount	0		9		7		
	33	of which: Voting Board members	Headcount	0		7		5		
	34	: Non Voting Board members	Auto-Populated	0		2		2		
	35	Total Board members	Auto-Populated	0		9		7		
	36	of which: Exec Board members	Headcount	0		4		4		
	37	: Non Executive Board members	Auto-Populated	0		5		3		
	38	Number of staff in overall workforce	Headcount	183		5192		3839		
	39	Total Board members - % by Disability	Auto-Populated	0%		56%		44%		
	40	Voting Board Member - % by Disability	Auto-Populated	0%		58%		42%		
	41	Non Voting Board Member - % by Disability	Auto-Populated	0%		50%		50%		
	42	Executive Board Member - % by Disability	Auto-Populated	0%		50%		50%		
	43	Non Executive Board Member - % by Disability	Auto-Populated	0%		63%		38%		
	44	Overall workforce - % by Disability	Auto-Populated	2%		56%		42%		
	45	Difference (Total Board - Overall workforce)	Auto-Populated	-2%		0%		2%		
	46	Difference (Voting membership - Overall Workforce)	Auto-Populated	-2%		2%		0%		
	47	Difference (Executive membership - Overall Workforce)	Auto-Populated	-2%		-6%		8%		

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN 2019/2020

Action Plan to be tabled at Diversity and Inclusion Steering Group, Workforce and OD and Workforce Transformation Committee.

No.	WDES Indicator	Metric	Actions	Delivery Timescale	Lead Responsibility
1.	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Staff by Pay Banding Comparison (see Appendix 2)	Explore establishing a Disability network and continue working towards Level 3 – Disability Confident Scheme.	Ongoing	Head of HR Advisory Services/Head of HR Services
			Explore opportunities to increase the number of Disabled staff who complete exit interviews.	December 2019	
2.	Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff	Non-disabled: 0.21 Disabled : 0.14 Relative likelihood: 1.49	Review how the Trust can promote unconscious bias training to existing recruiting managers.	December 2019	Head of OD / Head of HR Services
			Reinforce with recruiting managers the principles of VBR.	December 2019	
3.	Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff	Non-disabled: 0.00 Disabled: 0.01 Relative likelihood: 1.67	Continue to monitor and support all staff as required.	Ongoing	Head of HR Advisory Service
4. a) i	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	Non-disabled: 23.5 Disabled: 32.2	Consider a renewed campaign to promote the Trust's zero tolerance approach to incidents of bullying, harassment or abuse of its staff.	December 2019	Head of HR Advisory Services/Director of Communications
4. a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	Non-disabled: 12.8 Disabled: 24.6	Consider promoting the support available to report and share staff experiences of harassment, bullying or abuse from managers eg Freedom to Speak, Staff Advice & Liaison Service	December 2019	Head of HR Advisory Services/Director of Communications
4. a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	Non-disabled: 19.8 Disabled: 30.8	Consider promoting the support available to report and share staff experiences of harassment, bullying or abuse from managers.	December 2019	Head of HR Advisory Services/Director of Communications
4. b)	Percentage of staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	Non-disabled: 42.1 Disabled: 40.6	Ensure the Culture and Wellbeing Committee explores the reasons for staff experiencing harassment, bullying or abuse from staff and develop appropriate action plans.	ongoing	Head of HR Advisory Services

Appendix 3

No.	WDES Indicator	Metric	Actions	Delivery Timescale	Lead Responsibility
5.	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 90.5 Disabled: 82.1	Consider and share with departments/specialties information gathered from actions within 9. b).	December 2019	Head of HR Advisory Services/HR Managers
6.	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 22.9 Disabled: 32.9	Consider and share with departments/specialties the information gathered from actions within 9. b).	December 2019	Head of HR Advisory Services/HR Managers
7.	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 51.7 Disabled: 35.0	Consider information gathered from actions within 9. b). Continue to develop staff engagement action plans at departmental/specialty level.	Ongoing	Head of HR Advisory Services/HR Managers
8.	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	75.7	Consider information gathered from actions within 9. b).	December 2019	Head of HR Advisory Services/HR Managers
			Promote the benefits of reasonable adjustments via reference to the Supporting and Managing Attendance Policy	Ongoing	
9. a)	The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Non- disabled: 7.2 Disabled: 6.6 Overall: 7.0	To examine qualitative and quantitative data collected by SALS to determine trends and identify departments, roles or pay bandings where review and action is required.	Ongoing	HR Manager/Deputy Director Governance, Quality and Safety / Head of OD
			Consider integrating equality, diversity and inclusion in cultural briefings.	December 2019	
9. b)	Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	Yes	Anonymous survey, 1:1 discussions and listening events. Information to be collated to identify recommendations.	November 2019	Head of HR Advisory Services/Director of Communications
10.	Percentage difference between the organisations' Board voting membership and its overall workforce	Non-disabled: 0.08% Disabled: 0.0%	Continue to ensure that the process for appointment of Executive and Non-Executive Director posts encourages applications from as diverse a pool of talent as possible and demonstrates the Trust's commitment to diversity and inclusion.	Ongoing	Director of Workforce and OD

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

10 September 2019

Title:	Q1 Staff Survey FFT results
Responsible Director:	Director of Workforce and OD – Simon Nearney
Author:	Director of Workforce and OD – Simon Nearney

Purpose:	To inform the Trust Board of the staff survey FFT results for Q1 2019/2020	
BAF Risk:	Recruitment and retention of staff	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	✓
Summary of Key Issues:	• Sustained improvement to staff engagement score • Engagement above national average	

Recommendation:	The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Staff Survey FFT Q1 2019/2020

1 Purpose of the Report

To inform the Trust Board of the staff survey FFT results for Q1 2019/2020 and outline actions currently underway to sustain and further improve this performance.

2 Background

From 1st April 2014 all organisations providing acute, community, ambulance and mental health services are required to implement the Staff Friends and Family Test (Staff FFT); giving staff the opportunity at least once a quarter to answer two standard questions:

- how likely are you to recommend your trust as a place to work?
- how likely are you to recommend your trust to friends and family if they needed care or treatment?

The third quarter test is not undertaken because it coincides with the NHS National Staff Survey.

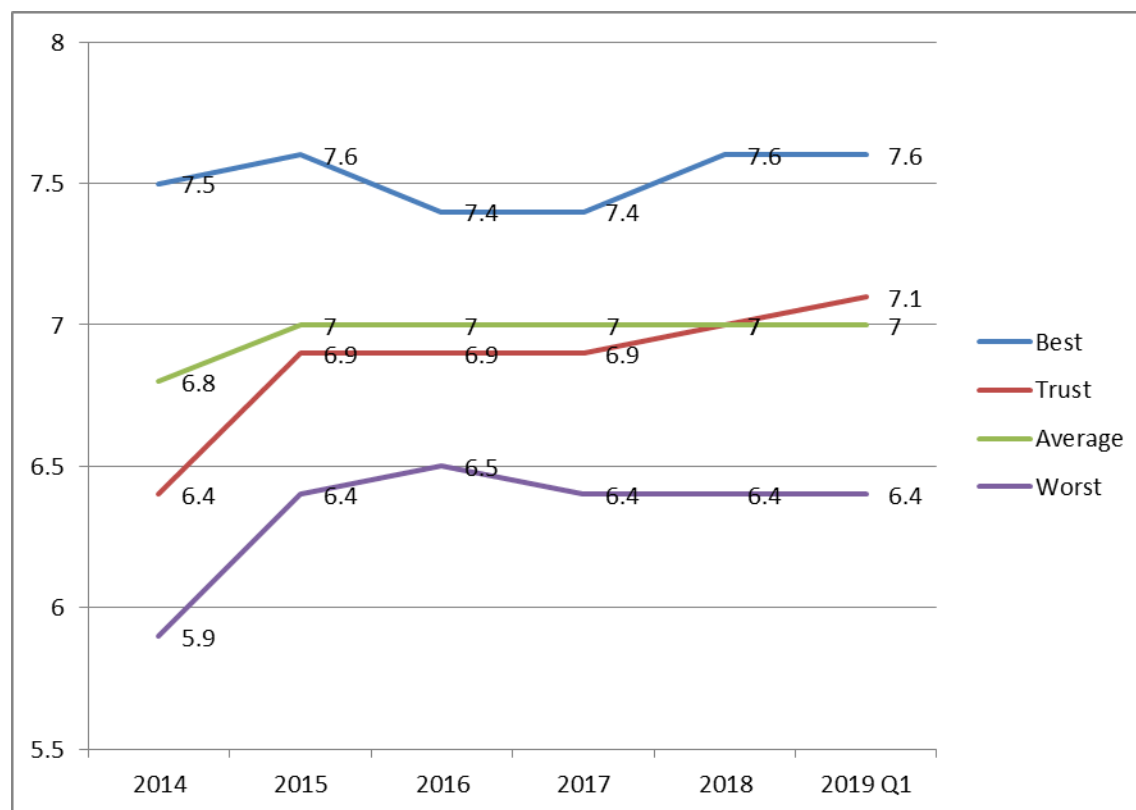
Hull University Teaching Hospitals NHS Trust Staff FFT for quarter one 2019/2020 ran from 24th May until 28th June 2019. 8,096 staff were invited to participate, with 1,427 responding, equivalent to an 18% response rate.

3 Overall score for engagement

Question	Positive %	Score (max of 5)	Score (max of 10)
Q1 How likely are you to recommend Hull University Teaching Hospitals NHS Trust to friends and family if they needed care or treatment?	82%	4.08	7.69
Q2 How likely are you to recommend Hull University Teaching Hospitals NHS Trust to friends and family as a place to work?	69%	3.72	6.79
Q3 There are frequent opportunities to show initiative in my role	74%	3.90	7.25
Q4 I am able to make suggestions to improve the work of my team / department	76%	3.93	7.32
Q5 I am able to make improvements happen in my place of work	61%	3.62	6.56
Q6 Care of patients / service users is my organisation's top priority	75%	3.97	7.42
Q7 I look forward to going to work	59%	3.55	6.38
Q8 I am enthusiastic about my job	75%	3.91	7.26
Q9 Time passes quickly when I am at work	74%	3.95	7.38
Average:	71%	3.85	7.12

A change in the calculation of overall engagement means that from Q1 we will receive a score out of ten.

The trend scores since 2014 are as follows, where this graph shows our trust average score compared with the national average, best trust in the country and worst trust in the country:



4 Engagement scores ranked by department/staff group

For all areas where 10 or more staff complete a survey the Trust receives an overall score for engagement. In Q1 this is ranked as follows, where green is above the Trust target score of 7.36 (top 20% of trusts), amber is between national average (7.0) and the target score and red is below the national average. Staff groups are highlighted in light blue.

AREA	RESPONDENTS	ENGAGEMENT SCORE
MRI Department	12	8.44
Critical Care	10	8.32
Medicine Management Team	15	8.28
General Management	108	8.15
Occupational Therapy	15	8.13
Ward Catering HRI	26	7.94
H31 Maple and H33 Rowan Wards	19	7.91
Physiotherapy	36	7.90
HR, OD, Communications, Workforce Planning	32	7.88
Radiology (inc. Screening) HRI	15	7.83
Family and Women's Management	34	7.82
Microbiology Department	10	7.81

Workforce and OD	50	7.77
Therapies	66	7.73
Nursing Services and Chaplains	10	7.70
Retinal Screening	14	7.66
Strategy and Planning and HEY Improvement Team	16	7.65
Endocrinology	12	7.61
Imaging	79	7.58
Fracture Clinic	11	7.57
Admin	18	7.56
Strategy and Planning	17	7.50
Compliance, Capital Schemes and Estates Development, Grounds and Gardens, Property Services	14	7.48
Radiation Physics Department	31	7.41
Finance & Business and Planning	21	7.38
Paediatrics	18	7.36
Day Case Surgery	12	7.36
Dietetics	10	7.35
Nuclear Medicine Department	10	7.28
Family and Women's Health Group	242	7.26
Specialist Services	86	7.26
Registered Nurses and Midwives	243	7.26
Orthopaedics	25	7.26
Information & Coding	38	7.25
Corporate	221	7.25
Surgical Specialties	72	7.25
Estates Management	34	7.24
Finance and Business	76	7.24
Clinical Support Services	385	7.22
Ophthalmology	47	7.19
Digestive Diseases	32	7.19
Radiology (inc. Screening) CHH	12	7.17
Castle Hill Hospital	553	7.16
Allied Health Professionals / Healthcare Scientists / Scientific and Technical	309	7.16
Hull Royal Infirmary	827	7.12
Women and Childrens	126	7.12
Trust	1427	7.12
Nursing or Healthcare Assistants	238	7.11
Chest Medicine	13	7.10
Obstetrics	85	7.07
Trauma	37	7.07

Emergency Department inc. Paediatrics	53	7.05
Research and Development	12	7.03
Elderly Medicine	41	7.00
Wider Healthcare Team	91	6.99
Medicine	178	6.99
DME Medical Staff / Specialist Nurses	11	6.98
Theatres	14	6.97
Estates, Facilities & Development	127	6.96
Chest Medicine	11	6.94
Estates at CHH & SSU	10	6.94
Facilities	70	6.94
Emergency and Acute Medicine	74	6.93
Outpatient Clinics CHH	12	6.89
Surgery	162	6.88
Clinical Support Management	47	6.85
Acute Medicine	20	6.85
Pathology	50	6.84
Administrative Staff	343	6.82
Clinical Governance	11	6.82
Chief Nurse	18	6.80
Supplies / Procurement	12	6.80
Governance	14	6.78
Acute Assessment Unit	14	6.78
Gynaecology	10	6.76
Theatres	58	6.75
Medical and Dental	54	6.73
Other	23	6.71
Renal	10	6.70
Pharmacy	35	6.70
Pharmacy	37	6.62
Care Records Service	13	6.58
Community Midwifery	20	6.47
Outpatients	26	6.47
IT	18	6.47
Radiotherapy	18	6.37
Cardiology	31	6.34
Ophthalmology Outpatients	20	6.27
WCH Labour and Delivery	29	6.12
Blood Sciences	25	6.04
Junior Doctors	18	5.90
Medical Outpatients HRI	12	5.87

Specialties Division	21	5.78
Cath Labs / Cardiac 5 Day Ward CHH	11	5.72
Catering Retail HRI	10	5.61

Management scores are significantly higher than other areas and may account for the discrepancy between FFT surveys and the national survey engagement scores. In the national staff survey management scores are weighted in recognition of the fact that staff with management responsibility respond more positively to the staff survey than other staff.

6 Work programme

The current staff survey work programme falls under eight key areas indicated as follows:

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

Embed a culture of learning, innovation and improvement, connected to patient safety.	Significant improvement to the scores relating to improvement in the staff survey, and a reduction in the number of staff highlighting bureaucracy as a limiting value in the 2019 Barrett Survey.	Programme Director for Improvement
All current interventions aimed at improving staff health and wellbeing, including stress management, bullying and harassment to be reviewed. New actions to be agreed at the Workforce Transformation Committee.	The theme of health and wellbeing and scores for bullying and harassment improve significantly in the 2019 staff survey.	Head of Workforce Transformation

7 Leadership development

The bespoke Be Remarkable development programme, designed to ensure all managers working at the Trust are developed to be a HUTH Leader is now well underway. This focuses on compassionate leadership, self-awareness, quality improvement and supportive performance management.

The pilot cohort received excellent feedback and has helped to shape two further cohorts of 15 staff, a cohort for consultants, the Trust Board and the Health Groups. The consultant cohort has provided very positive feedback on the programme, and shown high levels of engagement.

A manager in Clinical Support attended the Be Remarkable programme as part of the pilot cohort. In 2017 the service engagement score was within the bottom 20% of scores for the Trust. In Q1 the service scored higher than any other department and / or staff groups.

The Executive Team has pledged to work with the OD team to identify cohorts of Be Remarkable attendees to work on specific common goals, as well as job roles which would most benefit from participation on the programme.

Two more medical cohorts are being recruited for 2020/2021.

8 Recommendations

The Trust Board is requested to note the content of the report and provide any feedback.

Officer to Contact:

Simon Nearney
Director of Workforce and OD
August 2019

Hull University Teaching Hospitals NHS Trust

Minutes of the meeting held 25 July 2019

Present: Mrs T Christmas Non-Executive Director (Chair)
Mr M Gore Non-Executive Director

In Attendance: Mr L Bond Chief Financial Officer
Mrs D Roberts Deputy Director of Finance
Ms C Ramsay Director of Corporate Affairs
Mr P Sethi Grant Thornton
Mr A Hussain RSM
Mr R Barnett RSM
Mrs A Deegan RSM

No	Item	Action

1	Apologies: Apologies were received from Prof M Veysey, Non-Executive Director, Gareth Kelly, Grant Thornton	

2	Declarations of interest There were no declarations received.	

The agenda was taken out of order at this point.

6	External Auditors	

	6.1 Quality Account Report	

	Mr Sethi presented the Quality Account Report and advised that Grant Thornton had completed 2 audits regarding VTE and patient safety incidents. He advised that the work had gone well and both areas had been given a clean qualified opinion. Mr Gore offered his congratulations to the teams involved.	

	6.2 Annual Audit Letter 2018/19	

	Mr Sethi presented the end of audit year work undertaken for 2018/19. He advised that the Trust had received an unqualified opinion and had been given a clean value for money conclusion.	

Mr Sethi reported that although the Trust had achieved a £25m surplus there was still work to do regarding the Trust's Cost Improvement Plan. Mr Bond asked if the Trust was in line with other Trusts and Mr Sethi reported that the challenges were across a number of Trusts. There were improvements being made with the Trusts that were working closely with the CCGs and taking a system wide approach.

Resolved:

The Committee received and accepted the report.

Mr Sethi left the meeting.

The agenda returned to order at this point.

3 Minutes of the meeting 25 April and 23 May 2019

The minutes of the meetings held on 25 April and 23 May 2019 were approved as accurate records.

4 Matters Arising

There were no matters arising from the minutes.

4.1 Action Tracker

The Credit Control Policy was under review and would be presented to the Committee on completion.

DR

All other items on the Tracker were completed and would be removed.

4.2 Workplan 2019/20

Ms Ramsay presented the Workplan and advised that all items had been received by the Committee and there were no changes to report.

5 Internal Auditors – MIAA

5.1 Internal Audit Close Down Report

Ms Ramsay presented the report which highlighted the follow up actions completed by MIAA and the actions still outstanding. MIAA had also provided final reports for Tracking Access and Junior Doctors contracts.

Ms Ramsay advised that she had been working on the outstanding actions and 36 had been closed down. MIAA had handed over 54 actions to be reviewed and RSM had offered to help manage these and continue to make progress. Ms Ramsay advised that she was hoping to close down the Pathology actions following a meeting she had booked with the team today (25.07.19).

The Committee discussed the consultant job planning recommendations and Mrs Christmas asked for clarity around the high risk area. Ms Ramsay agreed to review this and highlight the high risk for the next meeting.

CR

There was a discussion around tracking access and how the initial issue had been reviewed and closed down. Mr Bond advised that the new admin teams were working through the waiting list and now following a single process. He added that there was more work to do to ensure the patient tracking list was clean.

Resolved:

The Committee received and accepted the reports.

Internal Auditors – RSM

5.2 Internal Audit Update Report

Mr Hussain presented the report and advised that 2 reports had been finalised which were Safeguarding Adults and Health Group governance. He advised that another 5 audits were planned in for review and start dates had been agreed..

Mr Hussain reported that there was a sound framework in place for safeguarding adults but the audit had only been given partial assurance due to compliance and quoracy of Safeguarding meetings. Mr Bond asked who the lead was for the Safeguarding report and Mr Hussain advised that Mrs Geary, the Chief Nurse would be addressing the issues and taking over as

Chair of the Safeguarding meetings.

Mr Hussain also reported that the Health Group governance review had been given partial assurance. He advised that there was a lack of standardisation within the processes and some terms of reference needed to be more robust.

Mr Bond thanked RSM for their report and the detail shown with each audit undertaken. He asked how the Trust had responded to their information requests and Mr Hussain advised that there had been excellent interaction from all staff.

Resolved:

The Committee received and accepted the report.

5.3 Counter Fraud Update Report

Mrs Deegan presented the report which highlighted 5 referrals and 2 bogus emails. She added that staff knew how to raise the issues detailed in the report and to the right people.

She reported that the Trust was complying with the national procurement exercise and RSM were assisting where necessary with the process. Mrs Deegan advised that RSM were working with the Trust Communications team to address the Communication plan with staff. The plan would include ward visits, stands at induction and raising awareness with teams.

Mrs Deegan spoke about the ABPI database showing staff who work for the Trust who had been given gifts or hospitality by the Pharmaceutical companies. This database would be checked against the Trust's gifts and hospitality register to ensure staff were being transparent and honest.

Mrs Deegan informed the Committee that an attempt on fraud had been alleged around overtime payments. Mr Gore suggested that any staff earning high levels of overtime should be checked as well as reviewing the welfare element of the extra hours worked. Mrs Deegan advised that this would form part of the work being carried out by RSM.

Resolved:

The Committee received and accepted the report.

7 Committee Matters

7.1 Performance and Finance 28 May/ 24 June 2019

There were no issues raised from the minutes.

7.2 Quality 29 May/1 July 2019

The Committee discussed having a quality representative in attendance at the meetings to review the risk management elements or any other quality related issues.

7.3 Charitable Funds 26 June 2019

There were no issues raised from the minutes.

8 Review of Reference Costs

Mr Bond presented the report which outlined the process of the annual national cost collection exercise. He stated that the Trust was appropriately resourced but there had been practical issues with the software provider and running the database.

Mr Bond added that the Trust was carrying out a benchmarking exercise with Nottingham and Coventry Hospital Trusts, who were similar in size and portfolio.

Mr Gore asked about the differences between reference costs and patient level costing and Mr Bond advised that reference costs was based on the total number of attendances against the costs and patient level costing was based on much more granular information about the patient. He added that the costing software was key.

Resolved:

The Committee received and accepted the report.

9 Review of Credit Card Spending

Mrs Roberts presented the two papers regarding credit card spending, one was for Q4 2018/19 and the other related to Q1 2019/20.

Mrs Roberts advised that the spend was higher than the previous years and this was due to supplier issues meaning IT purchases had increased and volume increases in recruitment employment checks.

Mr Bond assured the Committee that he signed off a number of the credit cards with senior managers signing off the others.

Resolved:

The Committee received and accepted the report.

10 Review of Directors Expenses

Ms Ramsay presented the report which detailed the Board's expenses. She reported that claims were comparable with previous quarters and that there was nothing untoward to highlight.

Resolved:

The Committee received and accepted the report.

11 Review of Debts >£50k and over 3 months old

Mrs Roberts presented the report and advised that there were a number of invoices over £50k relating to NLAG, CHCP, Humber FT, Bayer, Yorkshire and Humber and Sheffield Teaching Trust. Mrs Roberts assured the Committee that all invoices were in hand and being followed up by the finance team and ELFS and that she did not expect any issues with the payments.

Resolved:

The Committee received and accepted the report.

12 Legal Fees

Ms Ramsay presented the report and advised that the Trust had a fixed fee contract in place with Capsticks and this covered such legal services as employment, property and commercial leases. Any large tribunal cases were excluded from the contract due to the nature of the cases, but as yet this service had not been used. The costs were £10k per month with the main expenditure being routine employment cases.

The Trust also used DAC Beachcroft for work relating to the Cyclotron and any CNST work.

Ms Ramsay advised that Hempsons were being used for a case, but only because both Capsticks and DAC Beachcroft were representing other clients involved in an investigation.

Resolved:

The Committee received and accepted the report.

13 Receive Declarations/Gifts and Hospitality Registers

Ms Ramsay presented the report which highlighted the declarations and gifts and hospitality registers. Ms Ramsay advised that she read every declaration and reported that there was nothing untoward to highlight to the Committee. She added that the Pharmaceutical Industry was now reporting where gifts had been given to managers and this was being used as a cross check against the Trust register.

There was a discussion around the estimated values and how these were not added in all cases. Ms Ramsay advised that the team did follow up with the members of staff who had not stated a value, but did not always get a response.

Mr Gore asked how a senior clinician received his honorarium payments and on what basis. Ms Ramsay agreed to find out whether they were built into the clinician's job plan.

CR

Resolved:

The Committee received and accepted the report.

14 Information Governance update on Serious Incidents Requiring Investigation

Mr Bond presented the report and advised that there had been a number of incidents reported to the Information Commissioner relating to Information Governance breaches.

Mr Bond advised that internal communications would be sent out to all staff as well as senior managers re-enforcing the procedures. Disciplinary action would be taken on any members of staff breaking the rules.

Resolved:

The Committee received and accepted the report.

15 Board Assurance Framework

Ms Ramsay presented the report which showed how the BAF was constructed and how it was used by the Board and Committees. The risks had been based against the key issues relating to the Trust's strategic

goals. Any assurance or mitigation actions would populate the BAF as the year progressed.

Ms Ramsay advised that each BAF risk would be subjected to a deep dive at different Board meetings making the process open and transparent.

Mr Gore asked about the national pension issue being captured in the BAF. Ms Ramsay advised that she had added this into the BAF and that a paper would be presented to the Performance and Finance meeting in July 2019 for further discussion. Mr Bond advised that a return would now be submitted on a monthly basis to the Centre regarding this issue. He added that he was in discussions with KPMG to review new ways of managing earnings in light of this national issue.

Mr Hussain commented that he liked the format of the report but wanted to see dated mitigating plans. Mr Bond added that he had concerns regarding the Risk Management processes below the BAF and Mr Hussain advised that RSM were undertaking a Risk Management Audit in August 2019.

Resolved:

The Committee received and accepted the report.

16 Any Other Business

Mrs Christmas informed the Committee that it was Mrs Roberts' last meeting and thanked her for all her hard work and contribution throughout her time at the Trust and as an attendee of the Audit Committee.

Date and time of the next meeting:

Thursday 24 October 2019, 9.00am – 12.00pm, The Committee Room, HRI

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 10 September 2019

Title:	Trust Board Effectiveness Review
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	The purpose of this report is to present feedback from Trust Board members on the effectiveness of the arrangements for the Board and agree any actions to be taken for improvement.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary of Key Issues:	The members of the Trust Board and each Board Committee have been asked to complete a pro forma with questions on Board and Board Committee effectiveness. The amalgamated (modal average) scores for the Trust Board and comments are attached to this report. The verbatim comments have also been put into the amalgamated report for information. There are some specific points for the Trust Board to consider, as detailed in this report – overall Board members felt the Trust Board was effective in all areas, with some discussion items identified from comments. The specific scores and comments received for each of the Trust Board Committees will be going to the next Committee meetings to identify any actions required at Committee level. There are no significant gaps in assurance or governance at Board Committee level to make the Trust Board aware of; as with the Trust Board, comments received have helped identify useful areas to review to improve effectiveness. The Trust Board will be appraised of these discussions and actions through the presentation of Committee minutes in due course.	
Recommendation:	The Trust Board is asked to review the attached report and average scores and agree any relevant improvement actions that should be taken in response.	

Trust Board

Trust Board Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and adopted a more detailed pro forma last year to gain greater levels of feedback.

2. Process

Each Trust Board member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the modal average of the scores given by Trust Board members. The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 12 responses submitted from a possible 14. Each response gave a score to each question.

3. Summary of feedback

Overall, members and attendees feel that the Trust Board is performing effectively in all areas.

The narrative comments help point to some potential areas for development (these have been summarised below – verbatim comments are in the attached appendix):

- The Board sets itself objectives and measures its performance against them on an annual basis – should this be done specifically for the Trust Board annually?
- The Trust Board could involve/engage more with partner organisations particularly around the Integrated Care System agenda
- Patient representation could be enhanced
- Could be more focus at the Trust Board/Board Committee level on education and training, and quality of teaching
- Agendas can be quite full but likely contain what must go to the Trust Board – the meetings are well managed
- There is an opportunity to review the scorecards received and discussed at the Trust Board
- There is an opportunity to look at succession planning

Trust Board members are invited to share their thoughts on the collective scores and comments and agree any action that would make positive progress in board effectiveness.

4. Recommendation

The Trust Board is asked to review the attached report and average scores and agree any relevant improvement actions that should be taken in response.

Carla Ramsay

Director of Corporate Affairs

September 2019

Assessment of the effectiveness of the Board

Key

1. Hardly ever / poor
2. Occasionally / below average
3. Some of the time / average
4. Most of the time / above average
5. All of the time / fully satisfactory

Please give each question a score or N/A by entering 'x' in the appropriate box. You can provide comments against any question to give examples, illustrate what improvement would look like or describe something that is done well, and you would want to see remain the same.

Behaviours

	Question	N/A	1	2	3	4	5	Comment
1.	Setting the strategy All Board members support and debate the organisation's strategy and values, enabling them to set the tone from the top					X		No commercial strategy. Organisation does not bid for any services. There is some dominance of certain members and views but in general this is well managed by the chair and certainly all members are felt enabled to give their views Lots of time given to the strategy refresh process in development days
2.	Strategy All Board members have a clear understanding of the organisation's core business, its strategic direction and the financial and human resources necessary to meet its objectives.					X		Lacks focus on productivity. Relies on being 'in the pack' rather than focussing on being upper quartile. Haven't objectively tested this but appears mixed
3.	Board performance The Board sets itself objectives and measures its performance against them on an annual basis.				X			The objectives are clear the measurement process less so it sometimes feels Should this be a separate exercise from the strategy and annual plan?

	Question	N/A	1	2	3	4	5	Comment
4.	Managing Board meetings and discussions Board meetings encourage a high quality of debate with robust and probing discussions.					X		Questions usually come from NEDs to executive and should be bi-directional, seeking advice and support when appropriate. This has improved over the last 2 years Time is a constraint
5.	Managing internal Board relationships Board members make decisions objectively in the best interests of the organisation and feel collectively responsible for achieving organisational success.					X		
6.	Managing the Board's relationships with others The Board communicates effectively with all of the organisation's stakeholders and seeks their feedback.				X			No external review of board performance, ie no formal peer review? I would like to see more involvement from the various external stakeholders where necessary and include a specific agenda item on ICS progress. More to do on this Opportunity to strengthen the focus on ICS/HASR at Board
7.	Consideration of impact Consideration is given to the impact of decisions on stakeholders.					X		
8.	Board members' own skills Board members recognise the role which they and each of their colleagues is expected to play and have the appropriate skills and experience for that role.					X		Balanced set of skills
9.	Reaction to events The Board responds positively and constructively to events in order to enable effective decisions and implementation and to encourage transparency.					X		Things often happen quickly and Board members are informed rather than being involved. Could there be more use of virtual board meetings or discussion?

	Question	N/A	1	2	3	4	5	Comment
10.	There are no surprises Board members are kept fully informed of sensitive and difficult issues.					X		
11.	Chairman The Chairman's leadership style and tone promotes effective decision-making constructive debate and ensures that the Board works as a team.					X		I will not rate myself! Excellent Chair of meetings and effective in giving voice to NED viewpoint. This is very strong Busy agendas can sometimes be difficult to manage in a timely fashion and not to be rushing the later items
12.	Decisions After a decision has been made, it is clear who is responsible for implementing it, and by when.					X		
13.	Chairman and Chief Executive Officer The Chairman and Chief Executive work well together and their different skills and experience complement each other.					X		I will not rate myself!
14.	Attendance and contribution to meetings All Board members attend and actively contribute at meetings.					X		Some do not say very much. Generally this is good – see comments above to Q1 about some dominant views
15.	Open channel of communications The Board has open channels of communication with executive management and others and is properly briefed.					X		This seems to be on a continual trajectory of improvement
16.	Risk and control frameworks The Board's approach to reviewing risk in the organisation is open and questioning, and looks to learning points from events, rather than blame.						X	

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	Composition The Board is the right size and has the best mix of skills to ensure its optimum effectiveness.					X		Patient representation could be enhanced
2.	Terms of reference The terms of reference for the Board are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.					X		As far as possible given national requirements for many items to receive Board sign off
3.	Committees of the Board The Board's committees are properly constituted, perform their delegated roles and report back clearly and fully to the Board.					X		PAF remit too broad to do it justice I feel there is a slight lack of accountability at board level for education and the quality of the educational environment as well as for the delivery of the research strategy – how this would be achieved is a matter for discussion but it may benefit from some debate at a development session The links/division of labour between the operational structure and the sub committees is a bit unclear
4.	Secretariat The secretariat functions acts as an appropriate conduit for the provision of information to the Board and support to the Chairman and the Non-executive Directors.					X		
5.	Executive Directors The contribution of the executive directors, as a member of the Board rather than senior executives, is effective.					X		Could ask more questions of the NEDS and seek their advice more actively
6.	Non-Executive Directors The Non-Executive Directors contribute effectively to the development of strategy and the monitoring of the performance of management, providing both support and challenge.					X		Some ask few questions. Some more than others

	Question	N/A	1	2	3	4	5	Comment
7.	Meetings and administration The Board meets sufficiently often, such that agenda items can be properly covered in the time allocated.					X		Sometimes not. Agendas can be full and difficult to manage in the time allowed Too much on the agenda Again sometimes difficult given volume of must dos but well managed and benefit of time out is worth the pressure on the 2 monthly meetings Sufficient development sessions to support wider debates on key items as required
8.	Quantity of information The quantity of information received is appropriate and helps board members fulfil their role.					X		Not sure productivity is adequately evaluated or discussed. CE never discusses dashboard. Often significant paperwork to read pre meetings – I'm not sure if this can be streamlined at all though I think the performance report is due a review and we need to look again at use of trend/SPC Sometimes excessive information
9.	Quality of information The quality of information received is appropriate and helps board members fulfil their role.					X		
10.	Timeliness of information Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary				X			Frequent late papers.
11.	Agenda items The Board cycle agenda covers all matters of importance to the organisation, and includes consideration of corporate reputation, its enhancement and the risks surrounding it.					X		Productivity not discussed. I think that the patients story could be brought to life with video clips or even sound recordings from actual patients or representatives to bring the item to life.

								See comments above re education and research – I would like to see the board better sighted Do we need to explicitly address reputation in its own right?
12.	Annual reporting The organisation makes best use of its annual reporting.					X		This seems more of a task than something that is made the best of to showcase achievements and note challenges. Limited by rigid constraints
13.	External stakeholders The Board has defined its external stakeholders and ensures that the organisation has the right level of contact with them.				X			Not well enough. This needs to be done and an annual stakeholder survey instated. Could do more on ICS/partnerships Partnership surgery planned this year Opportunity to strengthen this stakeholder map
14.	Risk management The Board uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					X		New BAF reporting system working well
15.	Induction and training Board members receive proper induction on appointment and ongoing training is available to meet development needs.				X			This needs to be more structured and include the formal trust induction event. Recently addressed.
16.	Succession planning There is appropriate succession planning for key Board members and senior executives.				X			Needs more structure and routine consideration.
17.	Performance evaluation Board members are individually subject to an annual performance evaluation that measures their contributions and commitment.					X		Yes – in place

Hull University Teaching Hospitals NHS Trust

Trust Board 10 September 2019

Title:	Emergency Preparedness, Resilience and Response (EPRR) European Union (EU) Exit Operational Readiness
Responsible Director:	Jacqueline Myers, Senior Responsible Officer for EU Exit
Author:	Jackie Railton, Assistant Director, Strategy and Planning

Purpose:	The purpose of this paper is to brief the Trust Board on progress with planning for the exit of the United Kingdom (UK) from membership of the European Union (EU) and the European Economic Area (EEA) on 31 st October 2019, with particular reference to the possibility of an exit with 'no deal' in place with current EU and EEA partners.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and innovation	
	Financial sustainability	
Summary Key of Issues:	The Trust has established an EU Exit Operational Readiness Group to manage actions in preparation for the EU Exit. This includes: • supply of medicines and vaccines • radiopharmaceuticals and equipment • supply of medical devices and clinical consumables • supply of non-clinical consumables, goods and services • workforce • reciprocal healthcare • research and clinical trials • data sharing, processing and access • estates, facilities and infrastructure • clinical service provision. In the event of a No Deal exit, customs controls may result in delays at ports/ferry terminals and their environs. Initial risk assessments have identified that access and egress to the hospital sites may be impacted if traffic gridlock develops and is potentially sustained over a number of days. Work is ongoing to identify mitigating actions and to develop a Trust EU Exit Action Plan.	

Recommendation:	The Board is asked to: • note the content of this paper and the work that is taking place to prepare the Trust for the UK's exit from the EU on 31st October 2019; and • endorse the approach to the assessment of risk, the development of action plans and the testing of business continuity plans.

Hull University Teaching Hospitals NHS Trust

Trust Board

Emergency Preparedness, Resilience and Response (EPRR)

European Union (EU) Exit Operational Readiness

1. Purpose of Paper

The purpose of this paper is to brief the Trust Board on progress with planning for the exit of the United Kingdom (UK) from membership of the European Union (EU) and the European Economic Area (EEA) on 31st October 2019, with particular reference to the possibility of an exit with 'no deal' in place with current EU and EEA partners.

2. Background

In November 2018 the Board received a paper providing an overview of issues relating to the UK's exit from the EU, in particular in relation to workforce, safety standards, research and development and supplies.

A further briefing was provided in March 2019 following the publication of the *EU Exit Operational Readiness Guidance*¹ (DHSC, 2018) which summarised the Government's contingency plans and covered actions that all health and adult social care organisations should take in preparation for the EU Exit. At that time the UK's exit from the EU was expected at the end of March 2019, but was subsequently deferred to 31st October 2019. The legal default in UK and EU law remains that, unless and until a deal is agreed and ratified, there is a possibility of a no deal exit at the end of the extension period.

3. Trust Preparations for EU Exit Operational Readiness

As part of the planning for the original EU exit date, the Trust undertook the following actions:

- **Identification of the Trust Senior Responsible Officer (SRO) for EU Exit**
NHS England (NHSE) was advised that Jacqueline Myers, Director of Strategy and Planning is the Trust's SRO for EU Exit.
- **Dedicated HUTH EU Exit Email Address**
The Trust established a dedicated EU Exit email address (EUEXIT@hey.nhs.uk) to ensure information was cascaded directly to relevant people at the same time. The NHSE suggested list was expanded to include Corporate Affairs, Pharmacy, Procurement, HR, Contracting, IT, Infrastructure / Development and Communications.
- **Trust Operational Readiness Group: EU Exit**
This group was established to manage actions contained within the DHSC Guidance issued in December 2018. Chaired by the Director of Strategy and Planning, its membership included the Emergency Planning Lead and the leads for each of the seven areas of activity that the DHSC was focussing on in its 'no deal' exit contingency planning, ie:
 - supply of medicines and vaccines (David Corral)
 - supply of medical devices and clinical consumables (Julie Lumb)

¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768077/eu-exit-operational-readiness-guidance.pdf

- supply of non-clinical consumables, goods and services (Julie Lumb)
- workforce (Helen Knowles)
- reciprocal healthcare (Tracy Sowersby)
- research and clinical trials (James Illingworth)
- data sharing, processing and access (Tracy Sowersby).

An extra area of activity identified by the Trust was in relation to radiopharmaceuticals and equipment (Andy Beavis).

Each lead was responsible for carrying out risk assessments and action planning for their respective areas on the wider potential impacts of a no deal EU exit and for testing their business continuity plans against EU exit risk scenarios to ensure that they were fit for purpose.

With the extension of the UK's membership of the EU to 31st October 2019, the work of the group was stood down for a time, but has now been re-established and the membership has been extended to include clinical service representatives and members of the Trust's Estates team. This is in response to the additional potential risks that the instigation of customs delays could have in the Humber area immediately after the UK leaves membership of the EU (see below).

4. Humber No Deal Risk Scenario

As a result of a no deal exit, EU member state border controls will be strengthened which could potentially cause delays affecting first the UK's outbound flow of freight and, consequently, the UK's inbound flow of freight. There are 10 scheduled roll on/roll off ferry crossings each day from the Humber ports of Hull, Immingham, Goole and Grimsby, a further 5 lift on/lift off ferry crossings per week and various container traffic and other port traffic. All ferries depart at a similar time from the Humber ports (usually between 18.30 and 20.30 hours) and must unload their cargo before they can reload. There are 6,700 heavy goods vehicle movements on the Humber Docks each day. Delays to ferry sailings therefore have the potential to cause major queuing on local and strategic road networks.

The Humber Local Resilience Forum is currently working through the various scenarios which could impact on the local area and restrict traffic movement. The Trust via the EU Exit Operational Readiness Group is examining the implications for services in respect of patients, staff and access to supplies. Initial risk assessments have identified that access and egress to the hospital sites may be impacted if traffic gridlock develops and is potentially sustained over a number of days.

There are a number of issues for the Trust to consider when assessing the level of risk to the organisation:

- to what extent can we utilise our severe weather and pandemic influenza plans as a principle to manage staff shortages, access and egress to hospital sites, availability of patient transport, etc?
- what would the triggers be for reducing elective work if the Humber ports scenario continued over several days?
- what would the triggers be for admitting high risk patients to ensure patient safety eg maternity, renal, oncology?
- would we look to utilise the Mass Casualty Framework to free up bed capacity for 'safety' admissions?
- What are the implications for off-site services (eg Central Decontamination Unit) and community services (eg community midwifery, community paediatrics)?

- What would be the implications for specialist pathways eg Trauma, critical care, Embrace (paediatrics and neonates), cardiology/cardiothoracic?
- What would be the impact on the supply chain?
- Would we need to consider divert arrangements?
- What would be the implications for recovery?

On completion of the risk assessments, a Trust EU Exit Action Plan will be developed which will include escalation triggers and actions.

5. Next Steps

At a local, regional and national level EU exit planning is gathering pace. The Trust is working with partner agencies, including the Humber Local Resilience Forum and the Humber Local Health Resilience Partnership, to ensure preparedness as far as possible for the exit of the UK from the EU.

Trust representatives have participated in Humber area workshops and regional EU Exit teleconferences. Further updates on the national situation will be provided at a regional EU Exit workshop in Leeds on 5th September 2019.

NHS England has indicated that it will be undertaking an assurance exercise in early September together with regional events to assess the level of preparedness across health and social care organisations.

Planning for an EU exit, with the increasing likelihood of a 'no deal' scenario, will continue within the Trust with reporting via the EU Exit Operational Resilience Group. As the national picture becomes clearer and further information is received from the centre, the Trust's plans will be revised and updated.

6. Recommendation

The Board is asked to:

- note the content of this paper and the work that is taking place to prepare the Trust for the UK's exit from the EU on 31st October 2019; and
- endorse the approach to the assessment of risk, the development of action plans and the testing of business continuity plans.

Jackie Railton
Assistant Director, Strategy and Planning

28 August 2019

Hull University Teaching Hospital NHS Trust

Trust Board

June 2019

Title:	Review of Information Technology
Responsible Director:	Tony Curry
Author:	Tony Curry

Purpose of the report:	This report presents a high-level assessment of the Trust's information technology resources and its ability to meet the Trust's current needs and ambitions of becoming a digital organisation.	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and enough staff	✓
	High quality care	
	Great clinical services	✓
	Partnership and integrated services	
	Research and Innovation	✓
	Financial sustainability	✓
Summary Key of Issues:	The Trust makes extensive use of information technology and in 2018 launched a 5-year digital strategy. The digital strategy sets out the overall direction for information technology with the ambition of increasing digitisation. Implementation of the strategy according to current timetable depends on securing around £18m of funding over the next 3 years and this will be very challenging in the current climate. A large part of the strategy is about replacing IT assets which have reached end-of-life i.e. both systems and hardware. This modernisation will support but not in itself deliver strategic change. The flagship initiative in the strategy is the Lorenzo Digital Exemplar (LDE). Successful implementation will be transformative and yield significant improvements in patient care and with a reduction in costs. However, its full implementation depends on the modernisation programme. Delivery is likely to protract, and it will be important to maintain commitment and focus to make sure it is delivered. As the modernisation of systems and hardware will take several years to complete and because many items are also important to day-to-day service, setting priorities is crucial to achieving the best balance of outcomes both operationally and strategically. The Digital Strategy Board originally proposed at the start of the strategy should be instigated to improve oversight of the change agenda, to define priorities, budget and timescales. The Trust's spend on information technology is low compared to the sector average for healthcare organisations. IT will continue to require significant and ongoing investment to 'catch-up' and then transform. Delivering the modernisation required in reasonable timescales will mean committing additional investment or accepting longer lead times for meaningful change. Given the constraints on capital now and in the	

	future, alternative and more sustainable approaches to funding should be considered. Whilst existing computer disaster recovery arrangements should support the recovery of some systems it is likely that recovery procedures would take time to deploy. There is a need to review arrangements to make sure they support the timely recovery of critical systems. There are also gaps in existing IT security measures some of which should be addressed with the planned upgrade to Windows 10 later this year. Both areas require further work and investment to improve current arrangements. The importance of these requirements needs to be considered alongside other priorities to make sure they are not overlooked. Recent turnover has led to gaps in the leadership and management of the IM&T function. Resolving leadership, management and governance will be vital to establish proper accountability, authority and to oversee the change agenda. A number of IT functions currently operate autonomously in other departments (i.e Oncology, Radiology, Pharmacy and Pathology). However many of the core housekeeping and support are the same and the current approach misses the opportunity to consolidate and rationalise the services to free-up much needed effort to support the Trust's IT agenda. The management team should further consider whether current staffing levels are appropriate for current and future workloads and to provide out-of-hours cover.
Recommendation:	The Board is asked to note the contents of this report and the recommendations made.

Hull University Teaching Hospitals NHS Trust

Trust Board

Review of Information Technology

1. Purpose of the report

This report presents a high-level assessment of the Trust's information technology and its ability to meet the Trust's current needs and its ambitions of becoming a digital organisation.

2. Introduction

The Trust has a significant dependency on information technology, it is important to understand its current evolution, the role it plays and the opportunities to further exploit IT to support the Trust's vision and strategic goals. The report comments on the current state of information technology, the digital strategy and the capacity and capability to operate services and manage change. It does not examine the detailed management of the IM&T function or comment on specific systems.

The specific objectives of the review were to:

- Undertake a high-level assessment of the Trust's current adoption of IT/digital resources including effectiveness and security;
- Undertake a high-level assessment of the IT strategy and plans for development and deployment of IT/digital resources; and
- Undertake a high-level assessment of our capability and capacity in terms of people and skills.

The review was based on a review of key documentation and discussions with key managers within IM & T.

The term Information Technology is used to refer to a wide range of resources including:

- the computer infrastructure i.e. servers, data networks, desktop computers
- the clinical and administrative and information systems e.g. pathology system, finance system, management information systems.

3. Background

IM&T Department

Most information technology is managed by the Trust's IM&T function.

The IM & T department has three core teams:

- (1) **IT Services** manages the computer infrastructure,
- (2) **Digital Services** (CRS) manages and deploys the clinical and administrative systems and,
- (3) **Information Services** includes commissioning and data quality, clinical coding, patient administration, performance and reporting functions.

This report references the IT Services and Digitisation Services teams because they have a key role delivering information technology solutions. The Information Services team delivers specialist functions but in the context of this report is user of information technology solutions.

3.1 Effectiveness and security of current IT/digital resources

This section considers the general scope and use of information technology and makes specific comments about the adequacy of business continuity and disaster recovery arrangements.

3.1.1 Systems

Computer systems at the Trust have been introduced over a long period of time and cover a wide range of hospital departments and functions such as cardiology, pathology, bed management.

These systems deliver a very valuable but largely utility service. Systems are mainly organised around hospital departments e.g. cardiology department operates the cardiology system. There is limited integration of systems which means data can be duplicated and inconsistent. Whilst these systems continue to provide good support many are now obsolete and need to be replaced.

It worth noting that the next generation of systems has improved greatly compared to the last generation. Modern systems typically offer better integration, mobile working and self-service as standard.

3.1.2 Hardware

Clinical and administrative systems are supported by a lot of computer hardware; computer servers, data networks, printers and personal computers etc. Much of the hardware in use is old and due for replacement.

As well as impending hardware obsolescence, the advent of new clinical systems such as electronic observation (eOBS) and electronic prescribing (ePMA) is also driving the need for better technology in this case to support mobile computing at the bedside.

Technical diversity has become an issue. The IT systems introduced by some hospital departments in the past have not conformed with the de facto standard and this has resulted in multiple computer operating systems and unnecessary complexity. The failure to achieve a common standard also underlies some security, resilience and support issues. It is important that the Trust defines and adheres to technical standards going forward to reduce complexity and risk. A technology architecture and road map which describes the desired state should be developed and used to govern future procurement of technology. Decisions about systems must have strong governance and oversight to make sure that long-term interests as well as short-term interests are served.

The Trust has now reached a cyclical point where many of its technology assets both systems and hardware are due for replacement. Whilst assets will continue to support the hospital services, the urgency to systematically replace assets is building with the risk of continuity problems if hardware or software support fails. New systems are planned or underway for cardiology, electronic prescriptions, electronic observations, scan4safety, bed management, imaging, pathology, maternity records and management information. Replacement of worn-out hardware has also started with work on the data network and computer servers.

3.1.3 Current IT Spend

Based on industry benchmarking data the average spend on IT in the healthcare sector is around 3.49% ⁽¹⁾ of income which would equate to annual spend of £18.5m for the Trust. Recent spend data indicates operating costs at around £5.5m/annum ⁽²⁾. Capital spend in 2018/19 was around £3.6m plus around £2.4m of external funding. These costs exclude the salaries of 18 IT staff in other departments. However, if these salaries are included at average rates (say £1m), the total spend appears to be in the region of £12.5m which is less than the benchmark average.

1.Deloitte 2016-2017 Global CIO Survey

2.Excluding the cost of the Information Services team

Obviously, benchmarks don't reflect local circumstances or affordability and averages will mask some wide variability, however, they provide a useful comparator for understanding typical spend.

Whilst the Trust has continued to invest in IT during tough financial conditions, a long period of low investment combined with a break-fix policy (for some IT assets) has contributed to the high levels of obsolescence now faced.

The cost of refreshing some IT assets (systems and hardware) may in part be met from other sources e.g. NHSI, STP, however, the burden of cost will be borne by the Trust and at a time when there are many competing demands for capital. The pace of the current modernisation programme and the Trust's digital ambitions will be mainly driven by the availability of capital. Much of the investment needed reflects the cost of maintaining the Trusts operational IT as distinct from delivering transformational change.

The Trust also faces a significant increase in IT operating costs in 2021 as it starts to pay commercial rates for the Lorenzo system as NHSI funding comes to an end. This cost is expected to be around £1m per annum. This will add to the current cost pressures.

A growing response to the challenges of funding large capital IT programmes can be met in part by increasing the use of the Cloud (see further below). It is also worth considering whether leasing IT assets offers a more reliable way of managing key assets over the longer term as the availability of capital becomes more problematic. Downward pressure on operating budgets is acknowledged. Management should consider the options for future funding of IT which avoids the current swings in capital requirements which can be difficult to respond too and manage.

Spend at current levels delivers a low cost but essential service. Without extraordinary budget it will be difficult to deliver significant service improvements in the short to medium i.e. 1 to 3 years. There is an increased risk of inertia if investment is slower than the rate of obsolescence. External funding is and will continue to help but is unlikely to address the investment deficit.

3.1.4 Priorities

With many projects underway there is a risk that critical items may stall for the lack of funding. It is also possible that some initiatives may be more beneficial if delivered quickly. For example, implementing a new bed management solution to support the improvement needed in ED performance might be considered a worthy priority. Another influence is priorities, which are set externally either as conditions of funding such as the Pathology System funded by the STP or the need to comply with national directives such as the Windows 10 upgrade.

In summary, there is a heavy tension between maintaining existing services through the modernisation programme and the expectation of delivering strategic transformation. In

these circumstances understanding and choosing priorities is crucial to achieving the best balance of outcomes. There is no obvious mechanism for deciding these priorities. Instigating the Digital Strategy Board as originally proposed would provide a forum for deciding priorities.

3.1.5 Collaboration

A valid question is why hospitals don't collaborate more on IT services to manage costs and deliver more innovation? One significant barrier is the wide variety of technologies and systems currently used by Trusts as well as different ways of working. Switching to common technologies will usually mean unifying working practices too and this is a significant task.

Reaching a decision to collaborate is difficult as each Trust generally has different priorities as well as limited capital. In these circumstances, aligning desire with need is difficult. Without a common cause and adequate funding progress is difficult. The collaborations emerging from the STP initiative should deliver some common systems such as the pathology system currently being discussed. The availability of external funding eliminates one key barrier to a common approach.

Use of the Cloud perhaps offers the greatest opportunity in the medium long term for reducing the complexity and cost of delivering IT services. Cloud systems will play an increasing role commoditising what most would agree should be the availability of standard off-the-shelf solution for hospitals.

Moving to the Cloud will take time and it is likely that the Trust will need to operate a hybrid model in the short to medium term using a combination on premise systems, shared services and Cloud-based services. However, in the medium-long term the bias is likely to shift to Cloud provision.

A Cloud approach is likely to succeed where national systems have struggled in the past because each Trust will be able to manage the transition according to its own priorities, timescales and affordability.

3.1.6 Cloud Computing

The historical bias for large capital programmes to deliver IT is fast eroding. Increasingly, software suppliers are switching delivery of their systems to the cloud.

As well as turnkey systems, some organisations are also using the cloud for general computing requirements such as backup, disaster recovery and data storage to reduce investment in on premise IT facilities.

Initial concerns in the sector about data security have largely been overcome.

Cloud computing offers many key benefits:

- It reduces upfront capital investment and switches more of the cost to ongoing revenue charges
- It eliminates or significantly reduces asset refresh costs because these are absorbed in the ongoing running costs
- It transfers responsibility for day to day aspects of the operation to the supplier
- It delivers highly resilient services
- It reduces the complexity of on premise IT
- It commoditises making the true cost more transparent.

The Trust makes only limited use of the Cloud and the most significant Cloud system is the Lorenzo system which is delivered as a managed service. It has been suggested that the

reason for the limited uptake is the lack of a clear policy as well as the challenges of switching costs away from capital budgets to revenue budgets (which are also under pressure).

Cloud solutions must become a key consideration. There is a need for clear direction to make sure that its use is not overlooked especially given the constraints on capital.

3.1.7 Business Continuity

Maintaining the operation of clinical systems is vital to the delivery of care. The availability of systems depends on having resilient IT which can be recovered quickly following any incident. This is often achieved by having a separate backup system at a different location. Such arrangements are designed to overcome disaster scenarios relating to loss of power, fire, water damage, denial of access etc.

The Trust has two separate computer facilities split across its two hospital sites. However, neither of these can support the processing of all the Trust's central IT systems. Whilst current arrangements would support the recovery of some systems it is likely that recovery procedures would take time and the Trust may need to revert to manual procedures until systems were restored. This could lead to service degradation and interruptions if timescales protracted. A further factor is the recent changes and introduction of systems which increase the criticality and dependency on some systems e.g. eOBS, ePMA, Scan4Safety etc. It is not clear whether specific priorities have been decided with clear plans to support their rapid recovery.

Actions are underway to improve disaster recovery with the provision of new computer facilities at both hospitals. The upgrade at Castle Hill Hospital was completed in 2018/19. Investment plans for 2019/2020 include budget proposals to upgrade Hull Royal Infirmary. Once completed, the IT facilities at either hospital should be capable of supporting all central systems. However, completing these arrangements depends on making capital available in the 2019/20 budget. The Trust also has the option of using a Cloud based service for disaster recovery. This would reduce the need for some of the upfront capital investment and replace this with an ongoing revenue charge.

Business continuity arrangements are important given the current dependency on IT which is also set to increase. Any major sustained loss of IT which affected patient care would be very serious and likely to attract adverse publicity which would be difficult to defend.

Management needs to carefully assess the priority of completing business continuity arrangements against other investment priorities.

3.1.8 Security

Cyber security is a requirement in terms of data privacy and for business continuity. The latter was heightened by the disruption caused to the NHS by the WannaCry computer virus in 2017. Recent independent reviews of the Trust's cyber security have highlighted issues, most of which management have since confirmed have been addressed. A recommendation remains to improve the traceability and accounting of all software licences given the importance of this to security protection. The upgrade to Windows 10 later this year is expected to include software that will do this. There is also an issue relating to the software versions of certain clinical systems which makes security improvements problematic.

Cyber defences have evolved gradually over time in response to the emergence of threats. The Trust has implemented a range of security defences which offer protection. However, security is not a static issue and new threats emerge frequently and this means constant scrutiny of security threats and countermeasures. Similar to other organisations, the Trust's

security controls have evolved 'bottom up' over time and it is not clear whether there is a complete understanding of risk which has been approved by senior management alongside a mitigation strategy.

Like many other organisations cyber security is currently managed at a technical level within the IT function. However, this focuses the responsibility for cyber security too narrowly making it a technical issue rather than the corporate issue it has become. Achieving strong security sometimes means inconvenience and additional cost, with the true cost of achieving strong security often overlooked.

In response to national policy, the Trust now faces the significant task of upgrading to the Windows 10 operating system. This upgrade is partly in response to the security concerns posed if the Trust were to remain on Windows 7 which becomes unsupported in January 2020. However, completing this upgrade will require significant effort as well as some extraordinary budget because many of the Trust's PCs need to be upgraded at the same time to be able to use Windows 10.

Public sensitivity to data breaches is heightened because of the constant flow of adverse publicity. A further consideration is the recent Data Protection legislation due to GDPR, which poses greater sanctions for organisations who fail to protect personal data.

The IM&T management team should raise the profile of cyber security to make sure it attracts the commitment and resources to be fully effective. Specifically, there is a need to develop a clear strategy for cyber security aligned to risk.

3.1.9 Lorenzo Initiative

As already noted, the Trust has a wide range of systems involved in patient care. The Lorenzo system is noteworthy given its strategic importance.

The decision to implement Lorenzo represents a very significant improvement to the information management related to the delivery of clinical care. Introducing the Lorenzo electronic patient record is fundamental to the Trust's digital ambitions.

As an early adopter of Lorenzo, the Trust has benefited from high levels of external funding from the NHSI. This funding continues with the Lorenzo Digital Exemplar (LDE) Programme and the Trust continues as a key player in a small but influential group who are now exploiting the wider development and deployment of Lorenzo.

It is pleasing to note that the Trust's foresight and commitment to the Lorenzo initiative has equipped it with a key system that it needs to transform care with the bulk of its cost covered externally. Given cost pressures it is unlikely that the Trust would have achieved the same progress outside of this initiative.

The Trust is also set to benefit from funding made available under the STP initiative with the current focus on a new Pathology system. Other systems are envisaged as funds are agreed and allocated.

3.1.10 Summary

The Trust has a basic IT service which has reached a cyclical point where significant investment is needed to modernise. A lot of work is underway and planned, much of this will preserve current service and some will pave the way for transformation. With such a big change agenda and only limited investment it is important to maintain a focus on critical items and priorities to make sure the right things get done. Basic 'housekeeping' requirements such as security and business continuity should not be overlooked.

Importantly, more consideration should be given to the use of the Cloud as an alternative to investing in on premise assets.

3.2 IT strategy and plans for development and deployment of IT/digital resources

This section deals with the Trust's Digital Strategy, it repeats several points already made but within the context of the current strategy.

The Trust has developed a digital strategy which sets out the vision for improving digital services over the period 2108 – 2023. This includes the ambition for a joined-up care record, better patient information, patient self-service and using technology to drive greater efficiency. The strategy also reflects NHS national policy requirements and the STP technology objectives.

Whilst the ambition for greater digitisation emerges, the strategy document is difficult to read because there is a conflation of tactical ambitions such as replacing clinical systems and strategic ambitions such as 'paper-free at the point of care'. This arises in part because of the overwhelming need for modernisation. Many of the initiatives in the strategy will replace existing solutions with more up to date solutions. New solutions such as Scan4Safety will address gaps in the current portfolio.

The real digital transformation will come from exploiting the Trust's portfolio of technology solutions once these are updated to create better ways of working. The principal agent for this in the Digital Strategy is the LDE programme. The successful implementation of LDE will be transformational because it will align the use of technology along patient pathways rather than within the current boundaries of clinical departments. This should deliver a joined-up patient record and patient care plan supported by high levels of automation which in turn reduce the administrative burden placed on clinical and other staff. Positive results would signal the opportunity to accelerate investment to deliver transformation faster

The digital strategy of necessity has a range of inwardly focussed initiatives reflecting the modernisation programme. There are several initiatives which are aimed at increasing the integration with other providers (e.g. GP Portal) and the ability of patient to self-serve some aspects of their care management – the Patient Knows Best (PKB) initiative.

3.2.1 Strategy Core Themes

The Digital Strategy as currently documented embodies 3 core themes:

(1) Upgrading the hospitals technology infrastructure

The work needed to modernise the hospitals core technology infrastructure to replace worn out assets and deliver better technology. This work is essential to current operational service as well as a precursor for transformation.

(2) Replacing and introducing new clinical systems

Replacing some of the Trust's older clinical systems with new systems because of obsolescence and to deliver improved functionality.

(3) Re-engineering working practices for key patient pathways

Changing working practices for several patient pathways to deliver more joined-up ways of working. This work will exploit the new technology and systems outlined above.

Many of the initiatives are interdependent. For example, improving patient pathways requires the appropriate clinical systems to be in place which in turn requires a modern infrastructure.

3.2.2 Implementation Plans

Current plans for the strategy encompass 52 initiatives in the period 2019 – 2022. This represents a complex portfolio of change which delivers the new hardware infrastructure, new clinical systems and the first phases of new patient pathways (LDE).

There was a clear demonstration of dependencies and sequencing of projects. The current plans are in part driven by several macro-level factors including national mandates (to upgrade to Windows 10 and move to NHS Mail etc.), the availability of external funding (LDE, pathology etc.) and the availability of internal funding. As already stated, the plans do not convey any specific priorities or benefits (albeit some items appear to be more important than others) but demonstrate phasing of initiatives over time with the assumption that adequate funding is made available.

A good level of planning information was evident especially the LDE programme, which serves as the umbrella project for many of the current strategic initiatives.

3.2.3 Investment

Delivering the strategy as currently planned will require investment of around £18m. Budget proposals call for around £7.5m capital in 2019/20 (including approximately £3m of external funding), £6.5m in 2020/21 (including approximately £2.2m of external funding) and £3.5m in 2021/22. More investment will be needed beyond this to complete the work on other patient pathways (extending the scope of LDE) and for further modernisation.

If this level of funding is not available, the timescales for implementing the strategy will protract. This has implications for initiatives which are more critical to day to day services. Conversely, there is an opportunity to accelerate plans if more investment can be made available. In both cases there is a need to set the priorities to achieve the best outcomes for the investment available.

3.2.4 Governance & Oversight

The strategy document proposes a governance structure with two main oversight groups:

- A Digital Strategy Board
- A Digital Programme Board

Whilst the Digital Programme Board is extant, the Digital Strategy Board remains to be constituted. Both Boards require broad membership which is reflective of the users they serve.

The current challenges which are likely to emerge in relation to investment and priorities make board oversight an imperative. The Digital Strategy Board should be constituted and oversee the digital agenda with an initial focus of reviewing scope, budget, timescales and priorities.

3.2.5 Summary

Whilst the current digital strategy sets out the overall direction for digitisation the supporting documentation is less clear about how systems fit together so it is difficult to establish an overall view of the target state. There is a need to develop systems and technical architectures to increase awareness of the desired state to allow for greater debate challenge and certainty. Much of the strategy is concerned with modernising IT as opposed to real strategic transformation. The singular strategic initiative is the LDE programme. LDE should transform ways of working once modernisation is complete. Affordability is likely to constrain progress in which case priorities and benefits need to be clear to make sure critical items receive attention. With so many competing initiatives there is a danger of change overload especially given the small size of the teams involved in delivery.

Much of the strategy is inwardly focussed, partly of necessity. More consideration needs to be given to the integration with other providers, the community and patients if a joined-up care system is to be realised in the future.

In many respects the current strategy is foundational rather than transformational.

3.3 Capability and Capacity

This section deals with skills and capacity of the IM&T function to manage existing systems and deliver strategic change.

The department delivers a vital service to the Trust not only supporting day to day operations but increasingly supporting many change initiatives. The volume of change now is very significant. IT Services has a small number of staff and is trying to absorb this extra work. The Digital Services team is similarly challenged but has addressed some of the work demand with temporary workers funded by capital projects.

The loss of senior management in the department has created some uncertainty.

The successful delivery of key initiatives such as ePMA and network upgrades indicate a good level of capability.

Alongside funding, people capacity is an issue which if unaddressed will have an impact on the rate of modernisation and transformation.

3.3.1 Leadership

Following several leadership changes and the loss of the most recent Digital Services Director (IM & T Director) the director role is currently vacant. The affairs of the IM & T are being managed by the Deputy Director of Digital Services and Administration reporting to the Chief Financial Officer.

In response to the turnover is a proposal to create a new digital services structure with triumvirate reporting lines, which includes roles for both a clinical and nursing lead (pro tem). This approach appears reasonable because it should lead to greater ownership and engagement with new solutions as these emerge. The benefits of strong clinical leadership in IT projects have been cited in the successful deployment of ePMA at the Queen's Centre.

Resolving the leadership of the IM&T function with the appointment of a senior officer is key to galvanising the department after a period of uncertainty as well as to re-establish proper accountability and authority. Alongside this management should reassess the subordinate departments to make sure the structure and staffing levels are appropriate.

3.3.2 IT Services Team

Whilst there is evidence of a good management control within the IM & T department generally, management of the IT department appears more problematic. The current lack of a senior manager means there is a gap in key skills and critically the technical leadership of the department. This is evident given the lack key planning tools such as a technology architecture, applications architecture and security architecture. Whilst IT are involved in decisions about technology initiated elsewhere in the hospital, their degree of influence has been questioned. This has been voiced as the departments failure to plan and lead and conversely their view that they can be too easily overruled.

The IT department has a very low number of staff (16 WTE) when considering the scale of the Trust's IT operation. This places the Trust at a ratio of 1:600 users which is very high compared to known benchmarks which for some organisations can be as low as 1:75. Whilst this delivers a very low-cost operation it carries with it the risk of a de minimis service. Whilst there was no evidence of serious service issues, concerns were raised about the capacity of the IT department to support current and emerging change initiatives. IT staff also raised concerns about the current workload and their inability to cope with the current demand and to become more pro-active.

With only a small team there is a major focus on day-to-day service. Where the team are involved in change initiatives there is evidence that modern technologies are being deployed. The department's response to new initiatives appears to be largely reactive and transactional. It is not clear how much long-term planning is carried out.

3.3.3 Devolved IT Functions

As already noted, the Trust has several autonomous IT functions embedded in other hospital departments i.e. Oncology, Radiology, Pharmacy and Pathology. There are 18 staff carrying out IT related roles who do not sit within the central IT department. This exceeds the number of staff within the central function who operate the Trust's other systems. The reasons for this diversity are not entirely clear. Although the devolution of IT functions may have proven useful in the past, it is now associated with difficulties maintaining technical standards, software management and providing adequate cover when staff are absent. Whilst an element of specialisation is recognised much of the core management and support activity is similar across all systems and could therefore be consolidated whilst maintaining strong links and specialism to clinical teams.

Centralising the management of all IT activities and staff would potentially support greater alignment of technical solutions, standards and working practices as well as being a larger multi-skilled team that would support greater opportunities for career development and progression.

3.3.4 Digitisation Services (Care Records Service (CRS)) Team

The Trust has established a change management function which supports new change initiatives as well as maintaining and enhancing existing systems. This group are primarily responsible for the delivery the initiatives set out in the Digital Strategy. With a significant volume of work which exceeds capacity temporary work contractors are often used to address the deficit. The Trust also benefits from a high level of support from DXC as part of the LDE initiative. However, this has led to an ongoing and high dependency on temporary workers to support key initiatives. This presents issues in terms of continuity of knowledge and delivery aligning budget to employment contracts and project timescales is often difficult and imprecise. Local market conditions in Hull make it difficult to recruit key IT skills, the use of temporary contracts further reduces appeal. Given the value and importance of this work, the management team should consider the benefits of creating substantive posts where the volume of work and or skill requirements make this more appropriate in the medium and long term.

A further factor is an apparent grading disparity that can arise when similar roles are available within the Trust with higher salary grades. Key project staff have been lost to other hospital roles. The impact of grade disparity on staff turnover and retention should be reviewed and addressed.

3.3.5 Summary

The skills needed to achieve transformative change are evident. There has/continues to be a dependency on external advisors (DXC) for some strategic elements but skills transfer is evident. Resources in IT Services and Digitisation Services are modest considering the amount of change underway and proposed. It is not clear whether the resource requirements of the Digital Strategy have been defined or fully budgeted. The use of fixed contractors and external consultants (for LDE) is to a large extent propping up the current change agenda. Gaps in funding increase the risk of discontinuity and rework. Operational staffing appears de minimis and could be improved by merging all IT functions within the central department.

4. Recommendations

The Board is asked to consider the report and following recommendations

- Update the current digital strategy and plans to be clear about the target state priorities, costs and benefits. Confirm the ambitions, timescales and affordability.
- Instigate the Digital Strategy Board to improve oversight and management of the digital agenda.
- Consider the options for funding of IT which avoids the current swings in capital requirements.
- Develop a system and a technical architecture and road maps which describe the target state of Information Technology.
- Set clear direction to make sure that Cloud solutions are not overlooked.
- Develop a clear strategy for cyber security aligned to the Trust's appetite for risk and allocate the budget needed to address critical items on the basis of managing risk across the Trust.
- Confirm the full suite of business continuity arrangements.
- Appoint a leader for the IM&T function
- Review the IM & T department to make sure the structure remains relevant and staffing levels are appropriate and consider the consolidation of all IT staff within the central IT services department to create a stronger central function.
- Review the impact of grade disparity on staff turnover and retention in CRS.

Tony Curry

Associate Non-Executive Director

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