HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

Tuesday 30 July 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	verbal	Chair – Terry Moran
	2.2 To consider any conflicts of interest arising from this agenda		
3	Minutes of the meeting of 14 and 23 May 2019,	attached	Chair – Terry Moran
4	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker 4.2 Board Reporting Framework 2017/20 4.3 Board Development Framework 2017/19	attached	Director of Corporate Affairs – Carla Ramsay
	4.4 Any other matters arising from the minutes	verbal	Chair – Terry Moran
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	Board Assurance Framework 2018/19	attached	Director of Corporate Affairs – Carla Ramsay
	8.1 BAF Risk 4 - There is a risk that the Trust does not meet contractual performance requirements	attached	Deputy Chief Operating Officer – Michelle Kemp
	Director Reports		
9	Quality Report	attached	Chief Nurse – Beverley Geary
10	Nurse and Midwifery Staffing Report	attached	Chief Nurse – Beverley Geary
11	Fundamental Standards	attached	Chief Nurse – Beverley Geary
12	Quality Committee Minutes April, May and June 2019	attached	Chair of Committee – Martin Veysey

13	Performance and Finance Report	attached	Deputy Chief Operating Officer – Michelle Kemp/Lee Bond – Chief Financial Officer
14	Performance and Finance Minutes April, May and June 2019	attached	Chair of Committee – Stuart Hall
	Governance and Assurance		
15	Staff Survey Q4 2019/20 Results	attached	Director of Workforce and OD – Simon Nearney
16	Standing Orders	attached	Director of Corporate Affairs – Carla Ramsay
17	Audit Committee Minutes Extra meeting 23 May 2019 and verbal update 25 July 2019	attached	Chair of the Committee – Tracey Christmas
18	Guardian of Safe Working Report	attached	Chief Medical Officer – Makani Purva
19	Learning from Deaths Guidance	attached	Chief Medical Officer – Makani Purva
20	Annual CNST Premium/Standards	attached	Chief Nurse – Beverley Geary
21	Annual Safety Report	attached	Chief Nurse – Beverley Geary
22	Freedom to Speak up Report	attached	Director of Corporate Affairs – Carla Ramsay
23	Review of Board Effectiveness	to follow	Director of Corporate Affairs – Carla Ramsay
24	Lung Health Check	attached	Deputy Chief Operating Officer – Michelle Kemp
25	Any Other Business	verbal	Chair – Terry Moran
26	Any questions from members of the public	verbal	Chair – Terry Moran
27	**Date and time of the next meeting: Tuesday 10 September 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	✓	✓									2/2
A Snowden	✓	✓									2/2
S Hall	✓	x									1/2
V Walker	✓	✓									2/2
T Christmas	✓	✓									2/2
M Gore	✓	x									1/2
C Long	x	✓									1/2
L Bond	✓	✓									2/2
T Cope	xMK	✓									1/2
K Phillips	✓	✓									2/2
M Purva	✓	x									1/2
M Veysey	✓	x									1/2
B Geary	✓	✓									2/2
J Jomeen	✓	✓									2/2
In Attendance											
T Curry	✓	✓									2/2
J Myers	✓	✓									2/2
S Nearney	✓	x									1/2
C Ramsay	✓	✓									2/2
R Thompson	✓	x									1/2

	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

Minutes of the Trust Board held 14 May 2019

Present:	Mr T Moran CB	Chairman
	Mrs V Walker	Vice Chair/Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Prof M Veysey	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Mr L Bond	Deputy Chief Executive/Chief Financial Officer
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
	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 J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Corporate Affairs Manager

No Item **Action**

1 Apologies

Apologies were received from Mr C Long, Chief Executive Officer and Mrs T Cope, Chief Operating Officer

Mr Moran welcomed Mr Tony Curry who had been appointed as the new Associate Non-Executive Director. He added that Mr Curry had a wealth of knowledge in the digital arena and would be reviewing the Trust's IT systems and processes.

Mr Moran also welcomed Mrs Michelle Kemp to the Board as the Deputy Chief Operating Officer and congratulated her on her appointment.

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda

There were no declarations made.

3 Minutes of the meeting of 12 March 2019

Item 11 – Trust Strategy – paragraph 2, second sentence to read, "She had received contributions from a number of staff and external stakeholders….."

Following this change the minutes were approved as an accurate record of the meeting.

Minutes of the meeting of 26 March 2019

Item 3 – Operating Plan – paragraph 10 to read – Ms Myers noted that the advantage of committing to the control total was the potential to access additional funds, which could support would support patient care, so the

benefits and the risks needed to be carefully evaluated.

Item 4 – Any Other Business – sentence 2 to read, “he reported that any PSF money would be discussed with the centre to determine how it would be spent.”

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

4 Matters Arising

There were no matters arising from the minutes.

4.1 Action Tracker

The Tracker was reviewed by the Board. All items were either on the Agenda or had been dealt with.

4.2 Board Reporting Framework

Ms Ramsay presented the updated framework which highlighted the Board schedule up to March 2020.

There was one addition to the framework relating to workforce safeguarding which would be received by the Performance and Finance Committee in June and the Board in July 2019.

The 7 day standards would be added and received by the Board every 6 months.

Resolved:

The Board received and accepted the updated Board Reporting Framework.

4.3 Board Development Framework

Ms Ramsay presented the Board Development Framework and highlighted the next sessions which would be review of the Staff Survey and the Trans2Performance session on 8/9 July 2019. There would also be an opportunity at the June Board Development to review the Trust Strategy and what areas the Board would need to focus on.

Mr Gore also suggested a productivity session linked to the commercial strategy.

Resolved:

The Board received and accepted the Board Development Framework.

4.4 Any Other Matters Arising

4.4.1 Gender Pay Gap Report

Mr Nearney presented the report which had been presented at the previous meeting in March 2019. The report had an error in it and the corrected version was presented. The incorrect figures was in table 3.2 and should have read 38.25%. The figure read 83.25% in the incorrect version.

Resolved:

The Board received and thanked Mr Nearney for the corrected version.

4.4.2 – Strategy Scorecard

Ms Myers presented the comprehensive review of the Trust’s commitments

under each of the goals set out in the Trust Strategy. Each area was outcome focussed and had a lead executive driving the milestone plans. The Scorecard would be monitored at the Board and would be colour coded. Mr Gore welcomed the document and asked that reducing outpatient cancellations be added to it. Mrs Geary advised that a huge amount of work was ongoing around reducing cancellations and DNA rates and Ms Myers agreed to work it into the document.

Mrs Walker thanked the Executive Team for their work on the document adding that the vast majority of the actions had very specific outcomes. She added that there were a small number of that required more clarity but overall supported the document.

Prof Veysey asked about the research item and stated that it should be more specific. Ms Myers advised that as it was a new strand to the Strategy the baseline was being established and would be reviewed and updated within the 5 year strategy timeframe.

Mr Moran liked the transparency of the document and asked that it be monitored on a 6 monthly basis by the Board.

Resolved:
The Board received and approved the approach to the Strategy Scorecard.

5 Chair's Opening Remarks

Mr Moran thanked Ms Myers for publishing the Trust Strategy and spoke of the considerable time the Board had taken in development sessions to develop it. He had enjoyed reading the completed version.

Mr Moran also highlighted that it was mental health awareness week and that this would feature in the planned Health Expo later in the year.

Mr Moran asked that the mission statement in the Trust Strategy be displayed at each Board meeting.

6 Chief Executive's Briefing

Mr Bond presented the report and advised that the Trust had appointed 10 qualified doctors from Pakistan, the Trust had seen improved cataract surgery safety rates and the medical examiner role pilot would be commenced at Castle Hill Hospital at the end of the Summer.

Mr Bond also reported that the Emergency and Acute Medicine Health Group, following consultation would be changed to accommodate the Acute element being transferred back into the Medicine Health Group. The Emergency Care element would remain under separate leadership for the rest of the financial year.

Mr Bond spoke about the regional pharmacy work to develop a joint business case with acute trusts and the amount of work that had gone into the project. He advised that the whole process had been rejected due to the financial gain not being proportionate to the risks involved.

Mr Bond reported that the Trust had received a letter from NHS England regarding issues with capital funds nationally. Trusts had been asked to resubmit their capital plans in light of this. Mr Bond advised that critical

safety and backlog issues would be prioritised over transformational investments.

Mandatory GSHQ Board Level Cyber training would be carried out by NHS Improvement. This would be worked into a Board Development session.

Mr Bond raised the case of Flowers vs Yorkshire Ambulance Service and advised that if the case was won it could have implications for all NHS trusts in relation to annual leave pay linked with actual hours worked.

The Board discussed the current STP plans and it was agreed that Ms Myers would bring her specialist services BAF risk report to a future meeting covering off the Humber Acute, York/Scarborough and Pathology Reviews.

Resolved:
The Board received and accepted the report.

7 Patient Story

Dr Purva gave two examples of poor practice around discharge of patients, both around transfer of information to the families/carers and future places of care. She added that both issues had been resolved quickly and both patients had the information required.

Dr Purva also spoke of a letter that had been received by the Trust from a clinical negligence claim's solicitor and the care his father had received at the hospital. It had been a very positive and detailed letter, naming nurses and doctors that had cared for his father. He reported that the care given had been outstanding and even just before his father died very honest and compassionate conversations had taken place. He had suggested that the care team should receive Golden Hearts for their dedication.

It was agreed that the letter be shared with the Board members and the staff involved would be notified and thanked.

Resolved:
The Board received and accepted the report.

8 Board Assurance Framework 2018/19 – Year End Report

Ms Ramsay presented the year end 2018/19 BAF report and highlighted the financial section as the risk had been reduced due to the control total being achieved.

She advised that the other risk ratings would be remaining the same although due to the nature of the risks would be carried over to 2019/20. The Board had given much scrutiny to the BAF at each meeting and Ms Ramsay felt assured that the correct level of review was taking place.

Resolved:
The Board received and approved the year end 2018/19 BAF.

8.1 Board Assurance Framework 2019/20

Ms Ramsay presented the 2019/20 BAF and advised that only minor amendments to the risk wording had taken place. There was a brand new area relating to Research and Innovation which had been added to the BAF as well as the financial risks had been separated out into 3 areas (finance,

underlying financial position and capital).

Mr Gore asked if the new taxation rule changes should be included and Mr Moran agreed to discuss the issue further at the Remuneration Committee.

Resolved:
The Board received and approved the 2019/20 BAF.

9 Quality Report

Mrs Geary presented the report to the Board and reported that the Trust had declared a Never Event relating to a retained swab. The investigation was ongoing with the Health Group and Dr Purva would chair the panel.

Serious incidents reported were in comparison with previous years and were monitored in detail at the Quality Committee.

Mrs Geary reported that NRLS reporting was a positive picture with an improving safety culture and improving trends. Mr Moran commended the staff involved and reported that the Trust was not far off the best performing Trusts which was great credit to staff.

Mrs Geary updated the Board regarding Cdiffile and advised that the Trust had reported 32 infections against and upper threshold of 52. There had been 3 cases of MRSA against a threshold of 0 and 44 cases of MSSA mainly linked to device related infection. Mrs Geary advised that a lines management group had been established and would report to the Infection Reduction Committee. E-coli performance was at the same level as previous years and the Trust was working with system partners to reduce the infections.

Mrs Geary reported that the Trust's Friends and Family Test had been above the national target with 98.36% of patients (out of the 4727 asked) would be extremely likely to recommend the hospital.

Mrs Geary and Dr Purva had met with the CQC and had been advised that there were no visits planned at present.

Mr Hall asked about MSSA Bacteraemia and how the Trust was focussing on reducing the avoidable cases. Mrs Geary advised that a device group had been established to review areas of practice as well as the products used and listening to staff members. The outcomes would be reported to the Quality Committee.

Resolved:
The Board received and accepted the report.

10 Nursing and Midwifery Staffing Report

Mrs Geary presented the report and advised that all areas of staffing were safe but that it continued to be a challenge.
The care hours per patient day trend was discussed by the Board and Mrs Geary assured the Board that it was not significant in terms of numbers.

The international student recruitment was ongoing and a 4th cohort of apprenticeships and nursing associates being put into place.

There was a discussion around the continuing 4 times daily safe care reviews and how staff were moved accordingly. Mrs Geary advised that the wards were busier at midnight, acuity was going up and vacancies were static.

Mrs Geary advised that she had commissioned a piece of work around staff safety to risk assess patient safety. This would include the expectations set out for staff and how visible the senior staff where. The results of the assessment would be received at the Board.

Prof Jomeen added that there was really strong partnership work between the University and the Trust to work on flexible entry points and different approaches to staffing requirements.

Resolved:
The Board received and accepted the report.

11 Quality Accounts

Mrs Geary presented the Quality Accounts and requested that the Board delegate final sign off to the Quality Committee.

Mr Moran asked if the Board was content with the document in relation to the Trust's performance, internal controls and was it in line with the guidance.

Mr Gore asked if the Tracking Access issue should have been included and Ms Ramsay advised that it would be reported in the Annual Report and not in the Quality Accounts.

Ms Myers added that the agreed scorecard should mirror the Quality Accounts or if not have a reasonable explanation for the difference.

Resolved:
The Board received the Quality Accounts and delegated sign off responsibility to the Quality Committee.

12 Quality Committee Minutes March and April 2019

Prof Veysey presented the minutes and highlighted the NRLS information showing an improved position.

He added that there had been a presentation from the PLACE Team and the valuable patient led data that these audits presented.

There was a discussion around GIRFT and Mr Gore asked about the financial benefits and when they would be seen. Dr Purva advised that by improving quality and safety practices and improving patient experience then through efficiency the financial benefits would come.

Resolved:
The Board received and accepted the minutes.

13 Performance and Finance Report

Mrs Kemp presented the report and advised that the Trust was not achieving its 4 hour ED, RTT and 62 day cancer targets. She advised that all areas of performance were measured weekly at the Performance and Accountability meetings.

Mrs Kemp explained that there were differences in the reporting metrics of the ED target at different acute hospitals which depended on whether the Trust was reporting Type 1,2 or 3 metrics. The Trust was only measured on Type 1. The Chief Operating Officer was discussing this with NHS Improvement and whether any adjustments should be made.

Mr Moran asked if other Trusts were cheating or whether HUTH was not reporting correctly and Mrs Kemp advised that the overall system allowed for variation and that there was inconsistency in reporting. Work was ongoing to ensure the delivery of the urgent care standards and there was a strong plan in place.

Mrs Kemp advised that there were improvements in ambulance handovers since the improvement plan had been embedded. The Trust had also seen improvements in length of stay and the Trust was working with the Emergency Care Intensive Support Team.

Cancer performance was in a positive position for February and breast, lung and skin had achieved the standards although there were still challenges around access to diagnostics although the 6 week performance had improved. Mr Hall added that diagnostic performance was the best it had been for the year.

A key area that the Performance and Finance Committee was monitoring was the 104 day standard and Mrs Kemp advised that at the end of March there were 20 patients waiting but had complex clinical pathways. 4 of the 20 patients were late transfers from other trusts.

The Board discussed average discharge times and how the Trust was aiming to get earlier discharges and have effective flow through the hospital. Prof Veysey added that once the hospital is full it has a compounding effect.

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**

Mr Moran asked how the ED department had sustained 90% performance earlier in the year but was no longer sustaining good performance. Mrs Kemp advised that the team was listening to staff and reviewing what and why things were achieved or not.

Resolved:
The Board received and accepted the report.

Finance Report
Mr Bond presented the report and advised that subject to a satisfactory audit the Trust had achieved a £25m surplus. He advised that this had come from an amount of money received from a donation that had then been matched by a bonus PSF payment and a further bonus payment from the centre.

Mr Bond advised that the Trust had not achieved PSF money for quarters 1 and 4 due to ED performance. There was still an issue around the underlying Health Group run rates which would be reviewed in 2019/20.

Mrs Walker asked when the Trust would be making a small surplus or

breaking even for providing services rather than receiving bonus payments. Mr Bond advised that if the Trust achieved its forward plans it would be 2021/22 when the Trust would be solvent.

Mr Hall expressed his concern regarding the unidentified CRES and the non-recurrent schemes in the future.

Mrs Christmas advised that it was important that staff understand how the Trust had come to a surplus position at the end of a financially difficult year.

Resolved:
The Board received and accepted the report.

14 Performance and Finance Minutes March and April 2019
The minutes were received by the Board. Any issues were raised in item 13 of this meeting.

14.1 Laundry Services Contract
Mr Moran advised that the Laundry Services Contract had been reviewed at the Performance and Finance Committee who had endorsed it. Due to the value of the contract, it required Board approval.

Resolved:
Following endorsement by the Performance and Finance Committee, the Board approved the contract.

15 People Strategy Refresh
Mr Nearney presented the People Strategy and advised that it had been received at the Board Committees, Health Groups and that staff, the Trade Unions and Patient Council had also had chance to review it.

He reported that the Trust was building on the successes already seen and had kept the 7 key themes. Regular updates would be received at the Board reporting on progress.

Resolved:
The Board approved the People Strategy.

16 Equality Objectives – Progress Update
Mr Nearney presented the Trust's ongoing progress relating to the Equality Objectives and although 4 measures had been achieved there was more work to do.

Mr Nearney highlighted work ongoing regarding bullying and harassment with BME staff including equality training, the leadership programme and promoting the Trust's values.

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

Resolved:
The Board received and accepted the report.

17 Statement of Elimination of Mixed Sex Accommodation

Mrs Geary presented the report and advised that the Trust was compliant and that monthly returns were completed. There had been no PALS concerns or complaints relating to mixed sex accommodation in the last year.

Mr Gore asked about transsexual patients and Ms Ramsay advised that processes were in place on a case by case basis and guidance was available for staff to deal with any individual wishes.

Resolved:
The Board received and approved the statement of compliance.

18 Modern Slavery Statement

Mr Nearney presented the report which highlighted the employment and procurement policies ensuring the appropriate checks were in place to prevent slavery and human trafficking.

Resolved:
The Board received and approved the statement.

19 Information Governance Update

Ms Ramsay reported that since the introduction of the GDPR standards it was now mandatory that Trust Boards were briefed regarding Information Governance on a regular basis. She advised that the Audit Committee also had regular updates and the Trust had well embedded processes and had implemented the new Data Security and Protection Toolkit.

The toolkit had replaced the Information Governance Toolkit and focussed on system security and cyber security. The Trust had a 6 month improvement plan in place.

Ms Ramsay reported that the Trust was diligent in reporting any Information Governance errors and all breaches were investigated accordingly. Any wilful breaches such as inappropriately accessing medical records was taken very seriously.

Board members were reminded to update their Information Governance training were applicable.

Resolved:
The Board received and accepted the report.

20 Fit and Proper/Director Declarations of Interest

Ms Ramsay presented the report and advised that all of the Board members had completed their declarations and there was nothing untoward to report.

Mr Bond stated that a slight change to his declaration was required as he had recently become a Trustee of HFMA.

Resolved:
The Trust Board received and accepted the report.

21 Seven Day Working Assurance Framework

Dr Purva presented the report and advised that out of the 10 standards in the framework there were 2 that were not compliant. These 2 standards had

action plans in place to work towards compliance.

There was a discussion around lack of documentary evidence and missing signatures and how mitigating factors were being applied as well as ensuring the responsible clinician was capturing the patient reviews. Mr Hall asked what the target percentage was that the Trust should be achieving and Dr Purva advised that it was 90% The Trust was currently achieving 44%. Electronic patient records would ensure better recording of the audits. Mr Gore added that it was important to capture the information so that the clinical coding team could code effectively.

Dr Purva added that the Trust was working with NHS Improvement, who had been supportive in the changes to the policy to delegate responsibility.

There was a discussion around the highest rates of death being one day after admission and Dr Purva agreed to review the figures outside of the meeting to clarify what this related to.

Resolved:
The Board received and approved the report.

22 Standing Orders

Ms Ramsay presented the report and advised that a number of contracts had been signed under the Trust seal for various building works around the Trust.

She also reported that the Internal Auditors had reviewed the Trust Board Committee structure and had made minor recommendations which meant that a change to standing orders was required and was detailed in the report.

Ms Ramsay also advised that standing orders had been changed to incorporate the Trust's name change.

Resolved:
The Trust Board approved:

- The use of the Trust seal
- The change to standing orders to incorporate Internal Audit recommendations relating to the Board and Committee review
- The change to standing orders to incorporate the Trust name change

23 Trade Union Facility Time Publication Requirements

Mr Nearney presented the report and advised that following the Trade Union Act 2017 all Trusts now had to publish their time spent doing Trade Union activities as a percentage of the pay bill. The Trust's percentage was 0.02%.

Mr Nearney added that there was tension in the system due to releasing staff for Trade Union activities, but this was being worked through on a case by case basis.

Resolved:
The Board received and accepted the report.

24 Continued use of the Health Trust Europe Total Workforce Solutions Framework Agreement

Mr Nearney presented the report and advised that the cost of the agreement

to provide agency staff was £3m. Mr Bond added that there was a sizeable tax saving to the Trust if it used the framework. Mr Hall added that the Performance and Finance Committee had reviewed and endorsed the framework.

Resolved:
The Board approved the continued use of the framework agreement.

25 Audit Committee Minutes April 2019
Mrs Christmas presented the minutes and advised that the outgoing Internal Auditors had provided their opinion statement for 2018/19 and given the Trust substantial assurance which was an improvement on last year.

RSM the new Internal Auditors had presented their audit plan for 2019/20.

Mr Bond informed the Board of an accounting error relating to depreciation that had been highlighted in the Annual Accounts. The Audit Committee had discussed this at length and the External Auditors were also aware of the issue.

Resolved:
The Board received and accepted the minutes.

26 Charitable Funds Minutes February 2019
The minutes were received and accepted by the Board.

27 Any Other Business
There was no other business discussed.

28 Questions from members of the public
There were no questions received.

29 Date and time of the next meeting:
The Trust Board in July to be re-arranged due to a Board Development session being held.

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2019						
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		
14 May	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		
COMPLETED						
May 2019	Board Assurance Framework – Seven Day Hospital Services	Seven Day Hospital Services Standards to be presented to the Board	MP	May 2019		Completed

Actions referred to other Committees

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

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	
	Trust Strategy Refresh	annual			BD			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. sustainabilty and backlog maintenance	annual				BD				BD							x			
	Research and Innovation Strategy	annual							x								x			
	Assurance Against Equalities Ojbectives	annual												x						
	IM&T Strategy	annual												x						
Quality	Patient story	each meeting	x	x		x		x	x	x	x		x	x		x	x	x	x	x
	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																		
	National Staff survey	annual		x									x							x
	Quality Improvement Plan (inc. Quality Accounts and CQC actions)	quaterly				x							x					x		
	Safeguarding annual reports	annual							x								x			
Regulatory	Annual accounts	annual					x								x					
	Annual report	annual					x								x					
	DIPC Annual Report	annual							x								x			
	Responsible Officer Report	annual							x								x			
	Guardian of Safe Working Report	quarterly		x				x		x	x					x		x		x
	Statement of elimination of mixed sex accommodation	annual				x								x						
	Audit letter	annual					x								x					
	Learning from Deaths Guidance	quarterly	x			x				x			x			x		x		x
	Workforce Race Equality Standards	annual							x				x							
	Modern Slavery	annual				x								x						
	Emergency Preparedness Statement of Assurance	annual							x								x			
	Annual CNST premiun/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			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

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

17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy					
		Area 1 and BAF 1: Draft 2018-19 BAF							
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents							Area 2 and BAF 7.1: Tower Block strategy
		Area 1 and BAF 1: Draft 2018-19 BAF							
18/07/2018 - at EMC	Area 2 and BAF 6 & 7.2: Strategy refresh - clincial strategy								
31 July 2018				Area 4 and BAF 3: Deep Dive - Never Events					Area 1 and BAF 7.1: Financial strategy including STP and ICO
				Area 3 and BAF 3 & 4: Elective Care e-Learning RTT					
25 September 2018		Area 1 and BAF 1: What does the Board spend its time on?		Area 1 and BAF 3: Journey to Outstanding					
27 November 2018			Area 1 and BAF 2: People Strategy Refresh	Area 4 and BAF 4: Estates/Tower Block strategy					
29 January 2019			Area 4 and BAF 4: Emergency Department Interim Arrangements						
26 March 2019		Area 1 and BAF 1: 2019-20 BAF							
		Area 1 and BAF 4: Trust Board and orgnaisaitonal improvement capacity and capability							
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 2 and BAF 4: Same Day Emergency Care standards			Area 3 and BAF 5: Partnreship working/ICS development and stock-take		

26-Nov-19	Strategic drivers/balanced scorecare review							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									

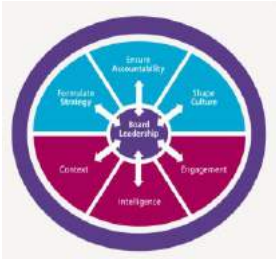
Other topics to consider:
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

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

30 July 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:	First heart patient undergoes new TAVI procedure at Castle Hill Hospital, Hull emergency care workers inspire national campaign, new eye surgery lab opens in Hull to offer first-class training for surgeons	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive' Report

Trust Board 30 July 2019

1. Key messages from May and June 2019

First heart patient undergoes new TAVI procedure at Castle Hill Hospital
A man has become our first patient to undergo a new heart procedure which saves people having to travel across Yorkshire for treatment.

David Morris underwent Transcatheter Aortic Valve Implantation (TAVI) after our trust was commissioned to set up the new service by NHS England.

Performed at Castle Hill Hospital, heart patients in Hull, the East Riding, North Yorkshire and Northern Lincolnshire no longer have to travel to Sheffield or Leeds for treatment.

Some patients with heart disease are not considered fit or well enough for major heart surgery if they require valve replacements. Instead, they are often suitable for TAVI, which puts less strain on the body as the heart does not need to be stopped and placed on bypass.

During the procedure, a catheter with a balloon on the tip is inserted into an artery in either the upper leg or the chest which is then passed into the heart and positioned near the opening of the aortic value. The balloon is then inflated, creating space for a new tissue value which is put in position and expanded.

Hull emergency care workers inspire national campaign
Emergency Department (ED) staff from Hull have inspired a new nationwide promotional campaign centred on patients with a learning disability.

The Learning Disability Pledge was promoted by the Makaton Charity as part of Learning Disability Awareness Week (17-23 June 2019), and was based on a piece of work which originated in the ED at Hull Royal Infirmary.

Authored by consultant in emergency medicine, Dr Liz Herrieven and play specialist, Laura Burton, their ED Pledge for people with a learning disability has been in place for some time, with scores of colleagues and co-workers in the department signing up.

Having spotted this piece of work on Twitter, the Makaton Charity got in touch and now Liz and Laura's work has laid the foundations for the LD Pledge, a national movement which seeks to raise awareness of the needs and rights of people with a learning disability in accessing equitable health care.

Liz and Laura both feature in a short YouTube video which the Makaton Charity has also released, which urges all healthcare professionals to find out more and to take the LD Pledge themselves.

New Eye Surgery Lab opens in Hull to offer first-class training for surgeons
A new eye surgery lab offering some of the best training facilities in the country has opened in Hull to help train the next generation of surgeons in Yorkshire.

The trust has enlarged and upgraded its Hull Institute of Learning and Simulation Eye Surgery Lab to train junior doctors in eye surgery, including cataract surgery, one of the most common surgical procedures in the UK.

The ‘wet lab’ will be known as “The Stephen Foster Room” in memory of former patient Stephen Foster who raised £27,000 in a single day to thank eye surgeons and neurosurgeons after suffering a brain haemorrhage while out golfing. Mr Foster died recently but his family and friends were invited to the official opening ceremony attended by trust Chief Executive Chris Long during May.

Between six and eight surgical trainees in ophthalmology per year from the Yorkshire Deanery will come to the lab throughout the next seven years before becoming fully qualified eye surgeons. Junior doctors from other hospitals throughout the country will also be invited to training events and workshops at the lab. As well as learning techniques for cataract surgery, the surgical trainees will also practice techniques used to deal with known complications such as advanced anterior vitrectomy, required when the clear membrane surrounding the lens of the eye ruptures or breaks.

Survivors’ stories shared as Hull plays host to national Sepsis Congress
Former Hull Kingston Rovers captain Shaun Lunt shared his experience of a near fatal illness with health professionals at a national Sepsis Congress hosted by the Sepsis Team at the trust. Shaun was subject to a potentially deadly blood infection which resulted from an abscess in his spine back in September last year.

He was joined at the congress by some 250 health professionals from across the country and big screen inspiration, Tom Ray. Tom lost his arms and legs and had part of his faced removed as a result of sepsis, and the 2016 film ‘Starfish’ tells his own moving story and that of his family.

Our trust introduced its sepsis team in 2015, as part of a national initiative to drive up survival rates. The team now comprises consultant Dr Kate Adams and clinical nurse specialists Donna Gotts and Rachel Harris, all of whom are working to improve in-hospital screening and the provision of potentially life-saving antibiotics in the first hour, and supporting colleagues working within the ambulance service, GPs and community staff.

The Sepsis Congress was a huge success and was held at the Bonus Arena on Tuesday 18 June. Speakers at the event included Dr Michael Porter, Lecturer in Molecular Genetics and a sepsis survivor himself, local GPs Dr James Moult and Dr Scot Richardson, and Dr Richard Fawcett, Consultant in Emergency Medicine at the Royal Stoke University Hospital who also flies with the Midlands Air Ambulance and serves as Clinical Director for the 208 Field Hospital Royal Army Medical Corps.

New mums posting on Facebook risking serious infection
The Hey Baby team at the trust is urging women to keep dressings over their wounds to prevent infection which could lead to sepsis.

New mothers are risking a serious infection by ripping off their dressings to post images of their caesarean section scars on Facebook.

There are around 250,000 cases of sepsis in the UK every year and it claims the lives of almost one in five of those who contract the severe infection.

Women who have just given birth or had a caesarean section are at greater risk of developing sepsis along with pregnant women, the very young and the very old, people with compromised immune systems, people with cancer or liver disease and those who have undergone surgery.

Hull achieves global recognition for its clinical simulation expertise
A world-class training facility in Hull which prepares NHS staff for medical emergencies is achieving recognition on a global stage as it plays host to two international teams.

Hull Institute of Learning and Simulation (HILS) has designed an 'operating theatre' and four-bedded ward to mirror the exact conditions staff will face when working in emergency medicine and critical care or performing keyhole surgery.

Workshops train health professionals in skills using hi-tech equipment including mannekins which respond to 'pain' and surgical equipment to practice surgery.

Now, the centre is showcasing its facilities and ground-breaking work to visitors from Iceland and India. Members of the Landspitali simulation team Thorstein and Baldur , based in Iceland, visited HILS last month to discover how the centre uses simulation to improve health care ahead of setting up their own centre later this year.

During their three-day visit, they learned about the training programme, the role of the simulation technicians and other activities the service offers as part of a long-term partnership set up between the two organisations.

Dr Sree Kumar, an oversees fellow from India, is also spending eight weeks with the team to learn how to set up a run a successful simulation centre back at Sri Ramachandra University in Chennai on the Bay of Bengal in eastern India. The trust has signed a Memorandum of Understanding with the university to take forward the simulation agenda and hopes to establish joint research projects and exchange programmes in the future.

Top marks for Hull Hospitals team training next generation of radiographers
Radiographers at the trust have been given top marks after their support for students was ranked first in the UK. The team in our Radiology Department work in conjunction with the University of Leeds to train 45 student radiographers in a clinical setting every year.

Now, they've learned the BSc (Hons) Diagnostic Radiography course has been ranked first in the UK for medical technology by the Complete University Guide.

The trust has been training student radiographers since the late 1990s. The students come for 19 weeks' training in the first year of their course, 16 weeks in the second year and 14 weeks in their third year before qualification.

With practical experience making up 40 per cent of their three-year course, the students work at Hull Royal Infirmary, Castle Hill Hospital, East Riding Community Hospital and the Urgent Treatment Centre at Bransholme under the supervision of fully qualified staff.

They are placed on the clinical rota and work shifts to gain experience in all aspects of the job, from emergency x-rays and CT scans to theatre work, learning how to position patients correctly.

Second and third-year students also work evening shifts in the Emergency Department.

Glittering ceremony honoured hospital staff at Hull's Hilton
The ninth annual Golden Hearts ceremony was held at the Hilton Hotel in Hull on Friday 7 June.

Fifteen awards, including a Lifetime Achievement Award to David Haire (Project Director – Fundraising) were presented to individuals and teams working at Hull Royal Infirmary and Castle Hill Hospital during the ceremony, hosted by former Chief Nurse Mike Wright.

The winners were:

- Making It Better award: HEY Baby Team
- Great Leader: Lindsey Harding

- Team Spirit: Renal Dietetic Team
- Lessons Learned: Karen Harrison, Tissue Viability
- Apprentice of the Year: Andrew Eagle
- University Partnership Working: Academic Respiratory Team and Wolfson Palliative Care Research Centre
- Moments of Magic: Jenny Wilson
- Health Group Trophy: Clinical Support Health Group
- Outstanding Individual of the Year (Scientific, Technical and Therapeutic): Julie Randall
- Outstanding Individuals of the Year (Non-clinical): Stuart Cutts and Tania Hicks
- Outstanding Individual of the Year (Clinical): Dr Kamrudeen Mohammed
- Outstanding Individual of the Year (Nursing and Midwifery): Chloe Tennyson
- Outstanding Team of the Year (Non-Clinical): Radiotherapy Physics
- Outstanding Team of the Year (Clinical): Kidney Transplant Team
- Lifetime Achievement: David Haire

The Golden Hearts celebration is funded by the trust's staff lottery and through the generous sponsorship of Minstergate/Beerhouse, Go MAD, T2, KCOM, Savilles, Managers in Partnership, HYA Training, Simply Health, OCS, DoubleTree by Hilton Hotel, Interact, Cambio and the University of Hull.

Congratulations to everyone who was nominated for an award.

Wimbledon strawberries and cream treat for army of compassionate volunteers
Volunteers who help patients and staff at our hospitals got their own taste of Wimbledon this month to thank them for their dedication.

The trust laid on a strawberries and cream tea during Wimbledon fortnight for around 70 volunteers at Hull Royal Infirmary and Castle Hill Hospital.

We have more than 450 volunteers who give up their time every day and week, without whom we wouldn't be able to provide the standard of care we wish to provide. Many thanks to all of our volunteers for their incredible support.

2. Media Coverage

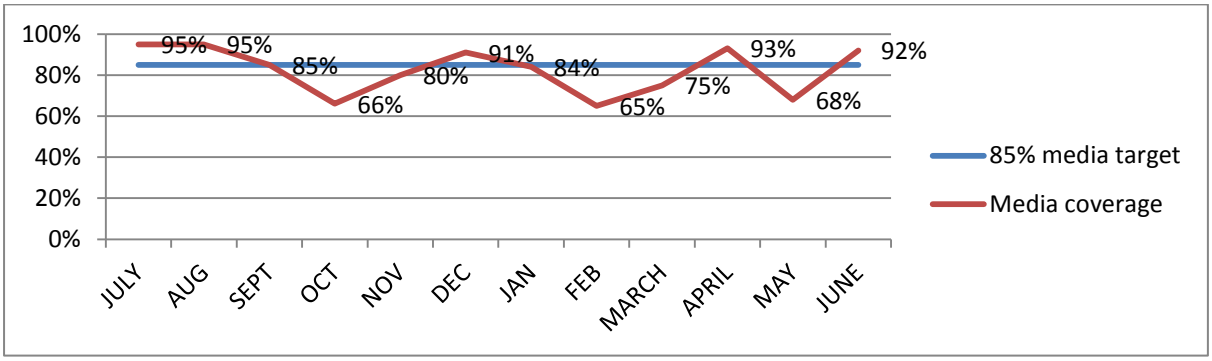
The Communications team issued 17news releases in May and 12 in June.

In May 68% of our media coverage was positive and in June 92% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been exceeded in eight months out of the last 12.

May's media coverage was adversely impacted upon by a story about a patient who was attacked in bed by another patient. The story was published worldwide, even featuring in the New York Post.

More positive news coverage was received thanks to an announcement that Transcatheter Aortic Valve Implantation (TAVI) procedures were now being carried out at Castle Hill Hospital, and praise for our staff after the obstetrics team saved a 28-year-old woman from the rare, life-threatening placenta accrete condition.

In June meanwhile, the trust received national and international coverage after Lord Prescott issued a statement praising the care he had received on the stroke ward.



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

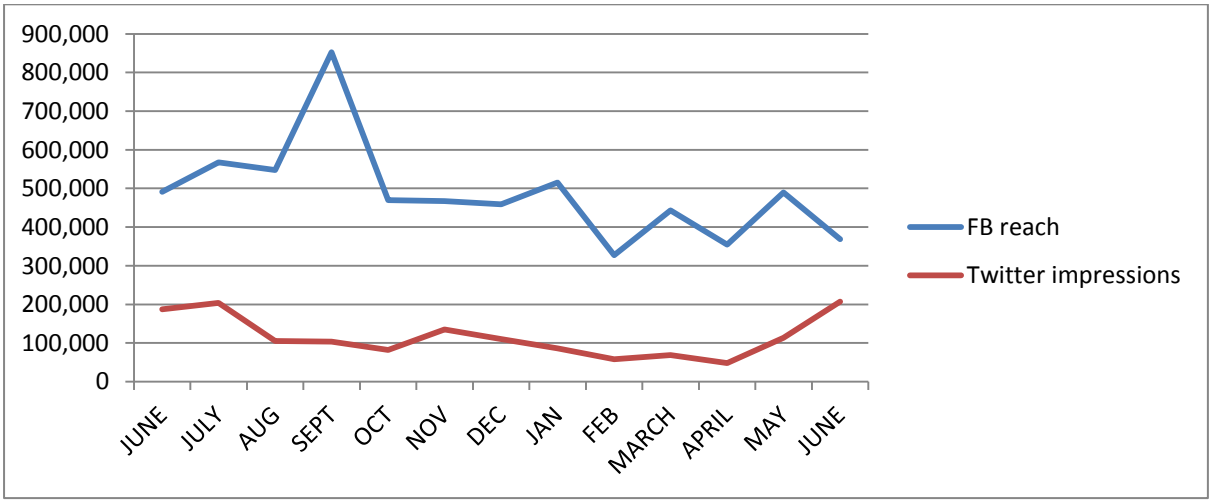
- In May total "reach" for all posts on trust Facebook pages was 489,901
- In June total "reach" for all posts on trust Facebook pages was 368,630

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.

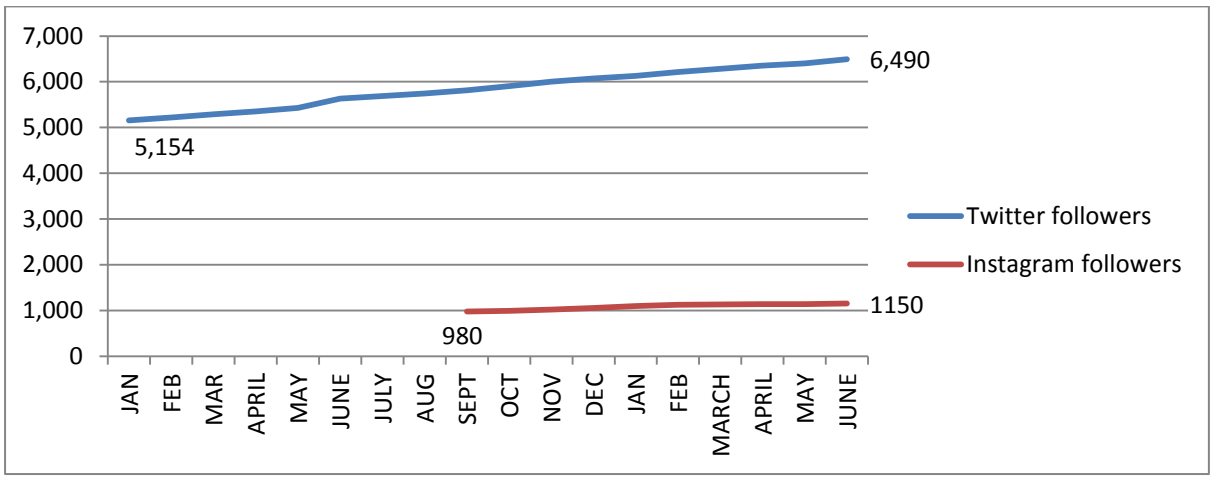
- @HEYNHS Twitter account impressions 113,600 (May)
- @HEYNHS Twitter account impressions 207,400 (June)

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 June 2018 - June 2019



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



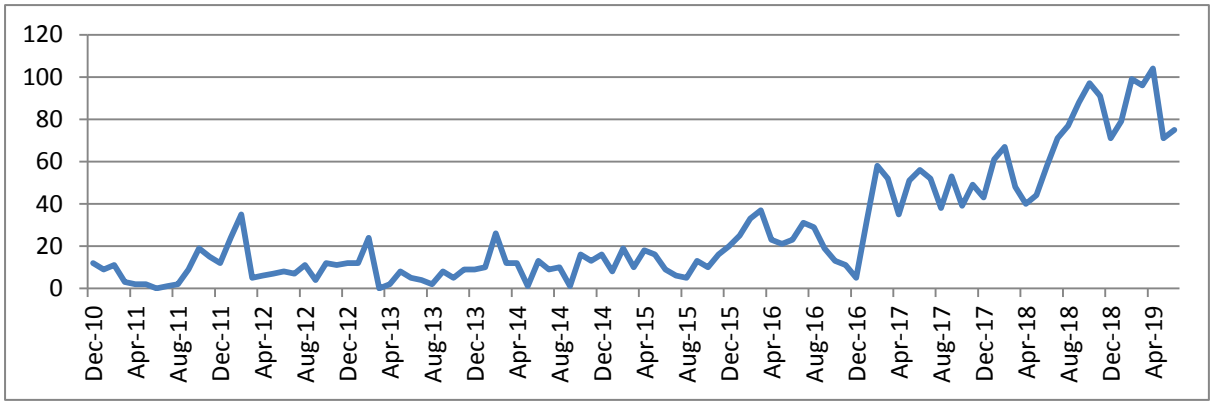
3. Moments of Magic

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

In May and June we received 71 and 75 Moments of Magic nominations, respectively.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2010-2019



NHS
Hull University Teaching Hospitals
NHS Trust

LONG TERM GOALS - June 2019 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance June	Trend v Previous Month
R	Never Events	0	2	⇧
R	Complaints (QIP - closed within 40 working days)	90%	81.60%	⇧
R	Healthcare Associated Infections - MRSA	0	1	⇧
G	Healthcare Associated Infections - C.Diff (YTD target)	80	11	-
R	Safety Thermometer - Harm Free Care (May 2019)	95%	93.87%	⇨
R	Venous Thromboembolism (VTE) Risk Assessment (Q4 1819)	95%	92.75%	⇨
R	Mortality - HSMR (March 2019)	<100	88.4	⇨
G	Friends & Family Test - Inpatients (May 19 - Trust v National %)	95.66%	98.46%	⇧
R	Friends & Family Test - Emergency Department (May 19 - Trust v National %)	85.58%	81.64%	⇧

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

Workforce

**latest position*

RAG	Indicator	Target	Performance May*	Trend v Previous Month
G	Staff Retention/Turnover	<9.3%	9.11%	⇨
G	Staff Sickness	<3.9%	3.47%	⇨
R	Staff Vacancies	<5.0%	6.79%	⇨
R	Staff WTE in post (<0.5% from Plan)	7499	7421	⇨
R	Staff Appraisals - AFC Staff	85%	82.00%	⇨
G	Staff Appraisals - Consultant and SAS Doctors	90%	92.60%	⇨
G	Statutory/Mandatory Training	85%	91.40%	⇨
G	Temporary Staff/Bank/Overtime costs (Medical YTD)	£2.476m	£2.295m	-
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 June	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	78.90%	75.75%	⇩
G	52 Week Referral To Treatment Breaches	0	0	0	⇨
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	8.71%	⇧
R	Emergency Department: 4 Hour Wait Standard	95%	90.0%	78.00%	⇧
G	Cancer: ADJUSTED 62 Days Referral To Treatment (May Data)	85%	70.90%	73.10%	⇨
G	Length of Stay (May Data)	<5.2	-	4.8	⇩
R	Clearance Times	12 weeks	-	15.2	⇧
G	Waiting List Size	52,800	52,950	52,931	⇩
G	Available Clinic Slot Utilisation	80%	-	93.20%	⇩
R	Theatre Utilisation	90%	-	83.20%	⇩
R	Appointment Slot Issues	35% (TBC)	-	50.00%	⇩

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

Finance

RAG	Indicator	Target	Performance June	Trend v Previous Month
G	Capital Expenditure	£9.1m	1.7m	⇧
G	Statement of Comprehensive Income Plan - Year to Date	£0.74m	-1.4m	-
G	CRES Achievement Against Plan	£1.655m	£2.646m	-
R	Invoices paid within target - Non NHS	95%	89.8%	⇩
R	Invoices paid within target - NHS	95%	82.8%	⇧
A	Risk Rating	1	2	⇨

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 30 July 2019

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

Purpose:	The purpose of this report is to present the 2019-20 Board Assurance Framework, with recommended Quarter 1 ratings for Board approval	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives. Discussions were held at the Board Development session in March 2019 to frame the risks for 2019-20 and the Board approved a 2019-20 Board Assurance Framework at its meeting in May 2019. The Board Committees of Performance and Finance have reviewed the BAF at each of their meetings since approval. Positive assurance and gaps in assurance have been captured at these meetings. Q1 ratings are recommended to remain the same as year-start ratings. A programme of more strategic discussion about each BAF area has been mapped to public Trust Board and Board Development meetings for 2019-20 and is appended in this paper. This continues the principle started last year for the BAF to drive strategic discussion at the Board.	

Recommendation:	The Trust Board is asked to review the BAF and asked highlight any positive assurance or additional gaps in control of concern that might need to be flagged up at this point in time. The Trust Board is also asked to review and approve the proposed Q1 ratings for each BAF area.

Hull University Teaching Hospitals NHS Trust

Trust Board

Board Assurance Framework

1. Purpose of this report

The purpose of this report is to present the 2019-20 Board Assurance Framework, with recommended Quarter 1 ratings for Board approval.

2. Background

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

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

The Board successfully put in place a new approach to hold more frequent Board discussions framed more around the Trust's strategic objectives and risks to their achievement. This will continue in 2019-20 as is mapped to public Trust Board and Board Development sessions as attached at Appendix 2.

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

3. Board Assurance Framework (BAF) 2019-20

The Trust Board approved the 2019-20 BAF at its May 2019. The full BAF is attached.

BAF risks 7.1-7.3 are the highest-rated risks on the BAF, all currently scored at 20.

There are 4 BAF risk areas that fall directly under the Terms of Reference of Performance and Finance Committee:
BAF 4: great clinical services (responsiveness and waiting times)
BAF 7.1 – 7.3 financial sustainability (ability to meet financial plan, ability to make progress against underlying financial position, capital funding)

There are 2 BAF risk areas that fall directly under the Terms of Reference of the Quality Committee:
BAF 3: high quality care
BAF 6: research and innovation

There are 3 BAF risk areas that indirectly fall under the Terms of Reference of the Quality Committee:
BAF 1: honest, caring and accountable culture: staff culture and engagement link directly with quality of care and quality of support services
BAF 2: valued, skilled and sufficient staff
BAF 4: great clinical services (if risks relating to responsiveness and waiting times impact on quality of care or actual harm to patients

An element included in the BAF is the corporate risk register. The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 21 risks on the corporate risk register. Of these 16 risks, 15 map to risk areas on the BAF, as follows:

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 7 corporate risks
BAF 3 quality of care = 2 corporate risks
BAF 4 performance = 5 corporate risks
BAF 5 clinical services = 0 corporate risks (but some ties to staffing risks at BAF 3)
BAF 6 research and innovation = 0 corporate risks
BAF 7.1 financial plan = 0 corporate risks
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 2 corporate risks

There is a corporate risk in relation to contingency planning and the unknown affect and risk from Brexit (specifically a No Deal Brexit scenario). This does not map to a specific BAF risk but is a risk across the organisation. It is not live at present until further there is clarity on the Brexit situation.

The number of corporate risks has decreased by 5 in the last 6 months due to successes in mitigating these risks back down to operational risks as well as changes in circumstances/ability to manage a certain level of risk. The number of high-rated operational risks has grown in the last 6 months, reflecting that Health Groups and Corporate Services are managing higher levels of risk in their own operational areas.

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

Staffing has the greatest number of corporate risks and is one of the highest-rated areas on the Board Assurance Framework. The next greatest area of corporate risk is waiting times, access and performance (BAF 4).

The financial risk to the Trust's strategic aims, as represented by BAF 7.1-7.3 does not reflect back in to corporate risks in the organisation, but are implied by the staffing and performance risks (use of agency/overtime to cover vacancies as mitigation for staffing and delivery risks, which also impacts on the ability to reverse the run-rate increases).

A new corporate risk on the impact on the Trust (particularly financial) from the changes in pension allowance rules is being written up, for discussion at the Non Clinical Quality Committee in the first instance – the largest element of this risk is the need to bring in locum/agency shifts to cover additional work that Consultants may no longer be willing to continue; from a service point of view, maintaining levels of additional work with locum shifts would mitigate the impact from a patient waiting time point of view, but the result of this mitigation would be greater financial pressures as locum costs are likely higher than the cost of extra sessions conducted by substantive Consultants.

The Board Committees of Performance and Finance and Quality have reviewed the BAF at each of their meetings since approval. Positive assurance and gaps in assurance have been captured at these meetings and are included in the attached BAF

At this point in time, given the long-term strategic nature of BAF risk areas and no significant events have taken place that particularly affect the starting risk ratings, the Q1 ratings are recommended to remain the same as year-start ratings.

4. Recommendations

The Trust Board is asked to review the BAF and asked highlight any positive assurance or additional gaps in control of concern that might need to be flagged up at this point in time.

The Trust Board is also asked to review and approve the proposed Q1 ratings for each BAF area.

Carla Ramsay
Director of Corporate Affairs

July 2019

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

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

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

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

Trust does not capitalise on opportunities brought by the name change and growing partnership with the University, missing opportunities for staff and patients

FINANCE
Financial sustainability

Strategic risks:
Failure to deliver 2019-20 financial plan and associated increase in regulatory attention

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

PATIENTS
High quality care
Great clinical services

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

INFRASTRUCTURE
High quality care
Financial sustainability

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

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

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

PARTNERS
Partnership and integrated services

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

BOARD ASSURANCE FRAMEWORK 2019-20 AS APPROVED BY THE MAY 2019 TRUST BOARD AND REVIEWED BY PERFORMANCE AND FINANCE AND QUALITY COMMITTEES UP TO JULY 2019

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement	None	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy focusses on staff culture and engagement – wide consultation on the refresh Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff – continues in 2019 with additional cohorts Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas Continuous examples and feed back to staff as to how speaking up makes a difference Medical engagement needs to be a journey of improvement – this could be more planned	**15**				**5 x 1 = 5**	**<u>Positive assurance</u>** Trust Board time-out – 2 days of board development mirroring the Remarkable People management training being rolled out in the trust – taking on the role of leading cultural development and leading by example Staff survey results – maintaining staff engagement score with plans in place to further engage and improve **<u>Further assurance required</u>** Engagement of medical workforce in Trust strategy and objectives; feeling empowered in to lead teams to make improvement

		Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first			staffing numbers Regular reports to the Trust Board on the People Strategy							

Risk Appetite

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse, OPD vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists CCSHG: lack of compliance with blood transfusion competency assessments	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy articulates changing workforce requirements New Workforce Monitoring requirements at Trust Board level Workforce Transformation Committee – staying ahead of the game with meeting changing workforce requirements, international recruitment and new roles Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 19-20; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in	Need clarity as to what 'sufficient' and 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs Unknown impact of taxation rule changes on pension annual allowances in relation to the availability of staff to work additional hours 'Sufficient' staff and service developments in order to deliver seven-day services in line with national requirements Linked with BAF 6 – empowering staff to innovate Need to build in *Developing Workforce Safeguards* for visibility at Trust Board on safe staffing across the Trust and staffing metrics	**15**				5 x 2 = 10	**Positive assurance** Nursing training and investment in new roles – over 150 graduate adult branch nurses recruited to start in September 2019; first take of qualified nursing associates in June 2019 and new take of trainees; projection on filling vacancies on track for next 3 years **Further assurance required** Understanding of local impact through pension taxation changes as well as national action to mitigate risk

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

Risk Appetite

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

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient	CCSHG: Risk to patient safety involving discharge medicines Corporate: Embedding ReSPECT process	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) was updated in light of latest CQC report and has been further updated from the new CQC report published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee Opportunities to move to good and outstanding care identified	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)	**12**				4 x 2 = 8	**<u>Positive assurance</u>** **<u>Further assurance required</u>** Further development of organisational learning from SIs including Never Events Quality concerns raised by NHSI team visiting ED in July 2019 – quick timescale on actions required

		and stakeholder engagement, detailed in a strategy										

Risk Appetite

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

GOAL 4 – GREAT CLINICAL SERVICES

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

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

Risk Appetite

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

GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**3 (impact)** **4 (likelihood)** **= 12**	The Trust has key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is playing a key role in the Humber Acute Review (CEO and DOSP) The Trust is playing a key role in the STP workforce workstream (DOWOD) The Trust has a seat on the Hull Place Board (CEO) The Trust is participating in the East Riding Place Based initiatives The Trust has a partnership meeting with CHCP	Understanding if the risks in other trusts or STP partners will impact on the Trust being able to deliver its strategy Risk of being an accountable organisation without being to influence all aspects that would bring success for our patients	**12**				4 x 1 = 4	**<u>Positive assurance</u>** **<u>Further assurance required</u>** Progress update on Humber Coast and Vale clinical services review and partnership role of Trust; impact assessment of Scarborough and York clinical services review

Risk Appetite

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

GOAL 6 – RESEARCH AND INNOVATION

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

Risk Appetite

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

GOAL 7 – FINANCIAL SUSTAINABILITY

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

Risk Appetite

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

GOAL 7 – FINANCIAL SUSTAINABILITY

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

Risk Appetite

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

GOAL7 – FINANCIAL SUSTAINABILITY

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

Risk Appetite

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

Appendix 2

Board Assurance Framework 2019-20
Trust Board topics mapped to Board Development and public Trust Board meetings as development or deep dive topics

BAF 1: There is a risk that staff engagement does not continue to improve (CEO)
To be discussed:
30 July 2019 – Board Development deep dive in to BAF 1 – continued cultural development and staff engagement

BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust (Dir. W&OD, support from CMO, CNO)
To be discussed:
10 September 2019 – public Trust Board (new Developing Workforce Standards in place by this point – deep dive report)

BAF 3: 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 (CNO, CMO)
To be discussed:
August 2019 Board Development

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 (COO)
To be discussed:
30 July 2019 – public Trust Board (deep dive report)
24 September 2019 – Trust Board development (deep dive in to emergency Same Day Care Standards and the Trust's SDEC opportunity)

BAF 5: 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 (Dir. S&P)
To be discussed:
10 September 2019 – public Trust Board to detail progress and current risks
24 September 2019 – Trust Board development (deep dive in to partnership and ICP developments)

BAF 6: 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. (CEO/CMO)
To be discussed:
12 November 2019 – public Trust Board - half-year update on Research and Innovation strategy
26 November 2019 – Board Development (deep dive in to Research Strategy and partnership opportunity with the University of Hull)

BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20
To be discussed:
Reported at public Trust Board at each meeting, monitoring monthly at Performance and Finance Committee and reported up to the Trust Board

BAF 7.2: 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
To be discussed:
30 July 2019 – Trust Board development, including productivity and efficiency opportunity
Timing for public board TBC – will be dependent on whether this needs to be submitted to the Centre

BAF 7.3: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

To be discussed:

26 November 2019 – Board development, including an update on the long-term Hull Royal Infirmary plans brought previously by Duncan Taylor)

30 July 2019 public Trust Board as part of capital planning update

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK UPDATE
GOAL 4 – GREAT LOCAL SERVICES

1. PURPOSE

Goal 4 of the Board Assurance Framework identifies the principle risk of the Trust not meet its operational planning guidance requirements for Emergency Department (ED), Referral to Treatment Time (RTT), Diagnostic and 62 day cancer waiting times in 2019/20. Failure to achieve the operational planning guidance requirements carries the risk of causing distress to patients and risk of reputation damage to the Trust.

This paper provides the Trust Board with an update on performance against the operational planning guidance requirements for Emergency Department (ED), Referral to Treatment (RTT), Diagnostics and 62 Day Cancer Waiting Times for 2019/20 as at the end of Q1. The paper also considers the key risks and mitigating actions being taken to achieve the operating plan requirements by March 2020.

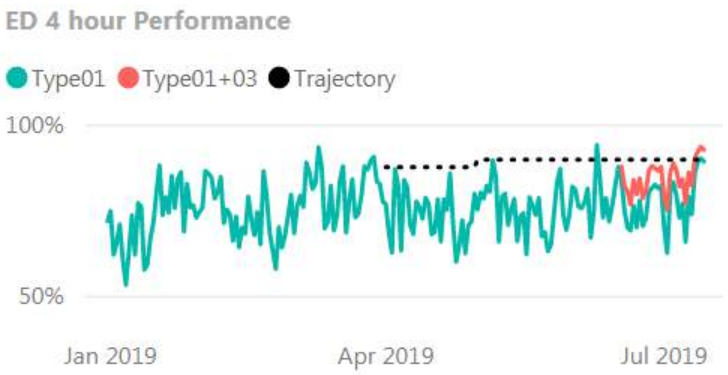
2. EMERGENCY DEPARTMENT (ED)

The constitutional standard for ED performance is 95% and the operational planning requirements are for the Trust to achieve 90% performance at the end of Q1. This has not been achieved with performance of 73.5%, 75.2% and 84.5% for April, May and June respectively.

Over recent months the local system has had a number of meetings with NHSE/I regarding current ED performance and the local A&E Delivery Board has held a system wide summit in May to agree the system wide 'High Impact' actions to improve ED performance. An improvement trajectory has been agreed which is expected to achieve 90% ED performance by the end of September. This will also bring the Trust back on tracked against the Operating Plan trajectory.

From the 17 June 2019, Type 3 activity undertaken within the Urgent Treatment Centres (UTC's) in Bransholme and Beverley is included within the daily data submission for the Trust which brings the Trust more into line with other Trusts nationally whose performance includes a proportion of Type 3 activity (which ordinarily improves the overall performance position for Trusts).

Graph 1: ED 4 Hour Performance %



As at 15 July, performance for the month of July was 85% and the Improvement trajectory agreed with NHSI/E was being met, with all Q1 actions complete.

On the 8th July, the Trust hosted a visit from NHSI including Mr Bas Sen, Emergency Department Consultant and Regional Advisor to NHSI. The visit was further intended to support the Trusts Improvement work. On the day of the visit the ED had a record number of departs (484 departs) and there were significant challenges with timely access to medical beds, resulting in a number of patients waiting for beds within the ED.

The visiting team made a number of recommendations to support improvement flow from ED, all of which were already being progressed by the Trust but will be accelerated to ensure as much progress as possible is made over the next few months; the recommendations included creation of a separate Surgical Ambulatory Care Unit; to consider an alternative area for patients presenting with Mental Health concerns to wait for their mental health assessment and to consider moving the Frailty Intervention Team (FIT) out of the ED. In addition the team recommended that medical leadership be strengthened in support of managing hospital flow and that the Trust takes steps to increase weekend discharge and achieve discharges earlier in the day. The Trust is taking comprehensive action against all of the recommendations via fortnightly meeting with the Health Group Triumvirates.

The key risks to the delivery of the Operating Planning trajectory for the ED standard for the remainder of the year are:

2.1 Inpatient Bed Capacity on the HRI Site

Approximately 25% of all breaches of the 4 hour standard are attributed to waiting for an inpatient bed. Additionally, long waits to be seen within the ED account for a further 40% of all ED breaches. There is a clear correlation between long waits to be seen and there being inadequate flow out of the Emergency Department into Inpatient beds. Inadequate flow out of ED results in the department becoming overcrowded and the ED team treating patients beyond their decision to admit time.

The bed modelling refresh for the HRI site completed in June 2019, has identified that there is an average 89 bed deficit across the site (at a 90% bed occupancy rate) with 62 of the overall bed deficit within the Medicine Health Group bed base. The refresh has modelled the impact of excluding any zero length of stay patients which reduces the deficit to 55 beds (at 90% occupancy). This assumes that any Zero length of stay patients could be managed through an Ambulatory Care pathway however this requires further analysis to provide assurance this would be achievable.

An additional 22 bedded General Medicine Ward is due to open on the HRI site from late September 2019 which will reduce the deficit and a Social Care Discharge facility led by East Riding of Yorkshire Council is expected to open on the Castle Hill Hospital site for patients who are medically ready for discharge from December 2019. Whilst initially only planned as a 6 month pilot over the winter period, it is hoped that the Out of Hospital system would continue to fund this facility should it prove to be successful over the duration of the pilot. There is also the potential to expand the facility to 20 beds.

However this still leave a deficit of a minimum of 19 beds.

Since January 2019 out of hospital partners have been allocated daily discharge targets for

patients requiring a supported discharge from hospital. This has largely worked well with strong commitment from partners to deliver against these targets. It is hoped that going into the Winter period the daily discharge targets for all providers can be increased to reduce the number of medically fit patients in the Trust each day mitigating against the known bed deficit the position. However even if the daily discharge targets were increased there would remain considerable risk about the achievement of this based on last year's delivery where all providers experienced capacity constraints, particularly relating to timely access to packages of care and the ability to access nursing and residential homes assessment and placements during the weekend periods.

2.2 Demand (and variance in demand)

Whilst the overall growth in ED activity for 18/19 was only 2.5% higher than the previous year it has been confirmed that the local system sees significant levels of variance in attend patterns with levels of attends well in excess of contracted daily levels of activity on frequent (at least weekly) occasions (See Graph below).

This has been particularly evident during Q1, with a record number of ED departures on Monday 8th July at 484, (against a contract levels of 390 attends) and the busiest ever week for the Trust in May 2019. The local system is currently undertaking some with work with the Emergency Care Intensive Support Team (ECIST) reviewing demand profiles across both the Trust and the local Urgent Treatment Centres to help the local system to understand and plan for the variance in demand.

Graph 2: ED Type 1 Daily Departures

Graph 2b: Variation Points

1 **1/4/19**, 445 departs, 102 breaches, performance 77.1% *(Monday)*
2 **21/4/19**, 439 departs, 108 breaches, performance 75.4% & 24/4/19, 442 departs, 176 breaches, performance 60.2% - *Easter bank holiday weekend 19 – 22 May (Sunday / Wednesday)*
3 **20/5/19**, 460 departs, 120 breaches, performance 73.9% *(Monday)*
4 **28/5/19**, 323 departs, 41 breaches, performance 87.3% (*Tuesday) Bank Holiday 27 May*
5 **12/6/19**, 329 departs, 70 breaches, performance 78.7% *(Wednesday)*
6 **29/6/19**, 343 departs, 63 breaches, performance 81.6% (type 1 & 3 = 86.8%) *(Saturday)*
7 **8/7/19**, 483 departs, 164 breaches, performance 66% (type 1 & 3 = 77.1%) *(Monday)*

2.3 Workforce

Despite the Trust putting additional investment in the ED staffing budgets in previous years, there remains times where the workforce available is not sufficient to meet the demand of the service. A full review of the ED Medical Staffing rosters has taken place over recent months based on the last years demand. This demonstrates that additional senior medical staffing is required, notably within the evening and overnight periods.

There are currently 15.7 WTE Consultants in post against an establishment of 18.5 WTE. 2 Consultants will leave in the next few months to take up new posts overseas; one at the end of July and one in December 2019. Recruitment to new Consultant roles is progressing with interviews planned for August. It is anticipated that 2 appointments may be made during this process. The Trust is also currently out to advert for a Paediatric Emergency Medicine Consultant and hopefully if can appoint to this role.

In addition, over recent months there have been concerted attempts to secure appropriate levels of GP provision to operate the Primary Care Area of ED to the agreed service specification; however this has been unsuccessful and equally the lack of GP capacity for the Primary Care Streaming Service has been raised as a specific concern in the feedback from the NHSI visit on the 8th July. The Trust continues to raise this matter with CCGs via the local A&E Delivery Board and is prompting a wider strategic debate regarding the future configuration of Unplanned Care.

3. REFERRAL TO TREATMENT TIME (RTT)

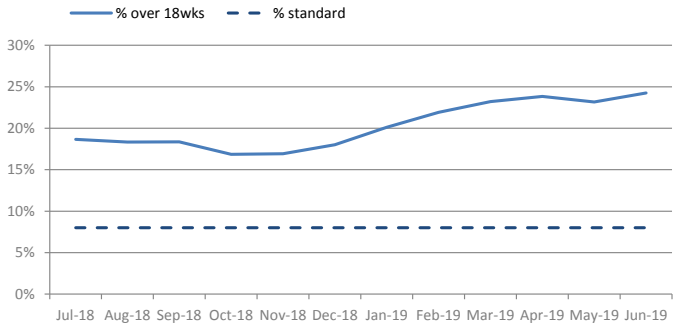
The operating plan trajectory is for the Trust to achieve 85% RTT by March 2020. Delivery for Q1 was;

	Target	**Actual**
April	77.58%	76.2%
May	78.3%	76.3%
June	78.9%	75.75%

The Trust is therefore not currently achieving its Operating Plan trajectory.

The overall number of over 18 week patients has increased by 515 since the March 18 position. The overall increase is 4.01%. At the end of June, the Trust's clearance rate was 15.2 weeks (the IST recommends a clearance rate of 12 weeks or less for sustainability and delivery of the 92% standard).

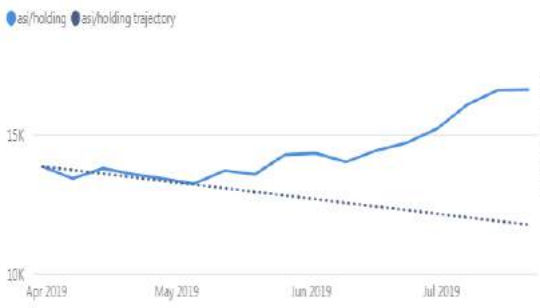
Graph 3: % Over 18 week waits



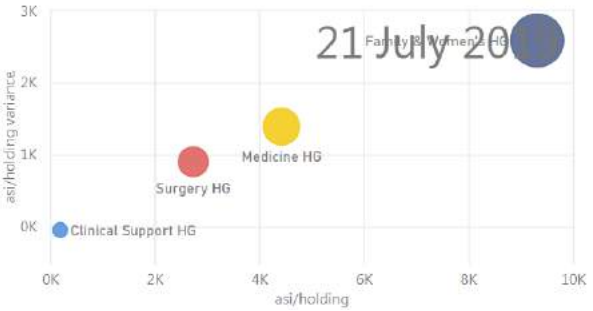
There are continued challenges in meeting sustainable list size, and the single largest issue for RTT sustainability is the significant numbers in excess of the sustainable list size for first outpatient appointment. The Trust focus for each Health Group this year will be to ensure improvements at the front end of the pathway and each Health Group have developed their own recovery plan to ensure that this can be done.

To enable the Trust to deliver a 6-week wait for first outpatient appointment, the Trust is required to reduce outpatient numbers waiting 1st appointment list by some 12,932 patients (position as at 14/07/19) equating to a reduction of approximately 31.4% from the current levels which is proving difficult to achieve.

Graph 4: ASI/Holding List Size



Graph 5: Variance from Baseline by HG

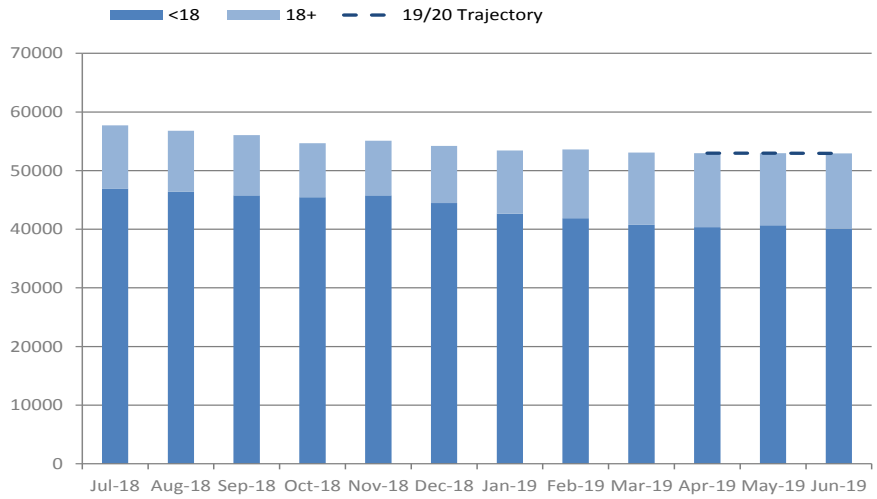


It is also extremely unlikely, given the contracting position that we would be able to deliver this level of sustainability and therefore the focus continues to be clearance of over 36 week waits and eliminate 52 week breaches. Each Health Group, however, will continue to reduce ASI / Holding, RTT list size overall and reduce follow up backlogs to a maximum of 3 months where capacity allows.

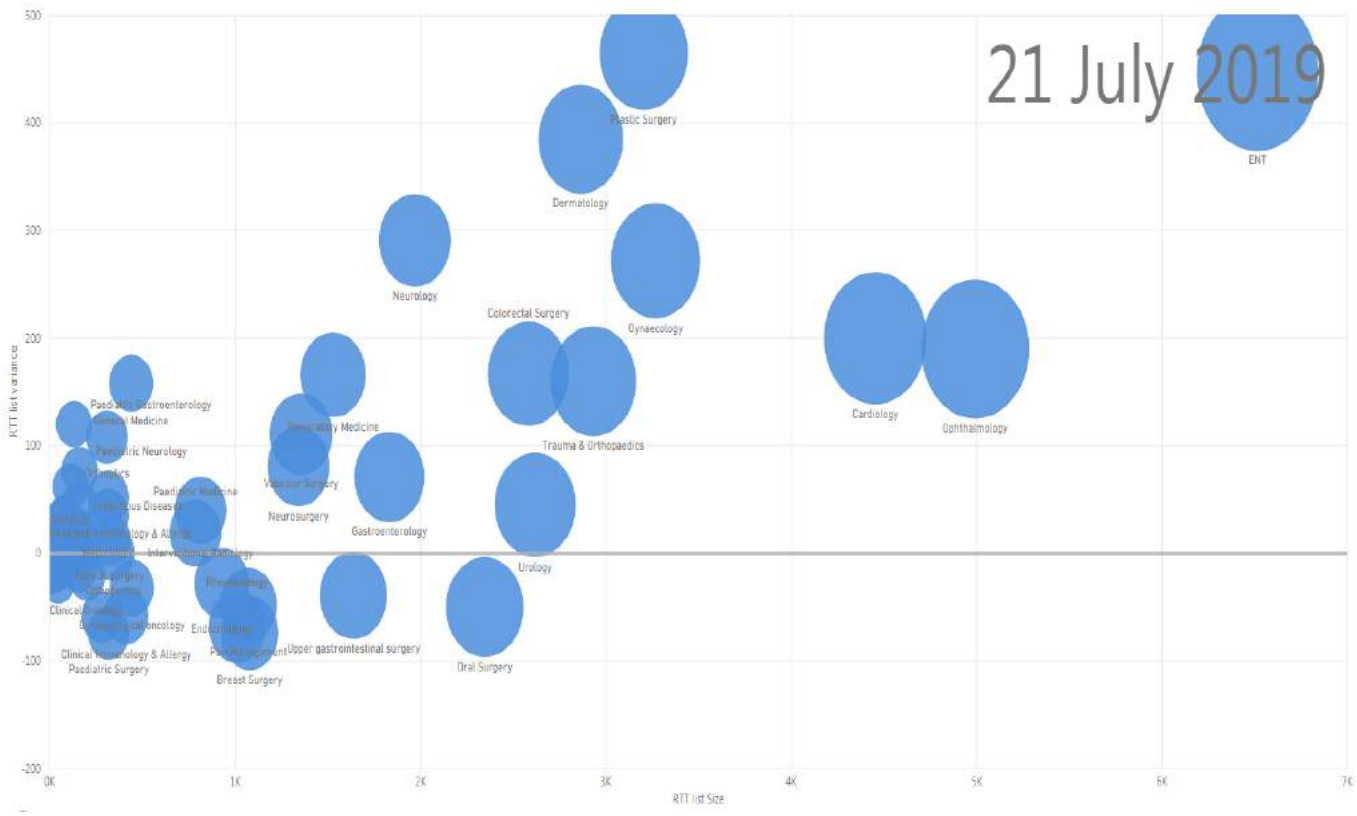
3.1 Waiting List Volume

The Trust succeeded in reducing its Waiting List Volume (WLV) in 2018/19 to below the March 2018 baseline position. This was the first time in a number of years that the Trust has succeeded in reducing its Waiting List Volume overall, against a national picture of seeing Waiting List Volumes increasing. The Trust has, during Q1, continued to meet the WLV reduction trajectory. However, as the WLV has reduced, the proportion of patients waiting over 18 weeks has increased (see below).

Graph 6: Incomplete RTT List Size



Graph 7: Incomplete WLV Variance from Baseline by Specialty



3.2 52 Week Waits

The Trust did successfully achieved the requirement of having zero 52 week breaches as at the end of March 2019 and has maintained this position during Q1.

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 (see above).

ENT, Gynaecology, Ophthalmology and Plastic Surgery clearance is currently between 48-52 weeks (therefore a number of patients are treated in the month where they would become a 52 week breach). Additional funding for 3 x additional theatre sessions for ENT is in place from 19/20 however the additional sessions will not be mobilised until Q3 due to recruitment of additional theatre staff and therefore the Trust continues to work with an Independent Sector provider to manage the waiting list position to avoid 52 week breaches. The same Independent Sector provider is also supporting the Trust with Ophthalmology waits and Paediatric Gastroenterology waits.

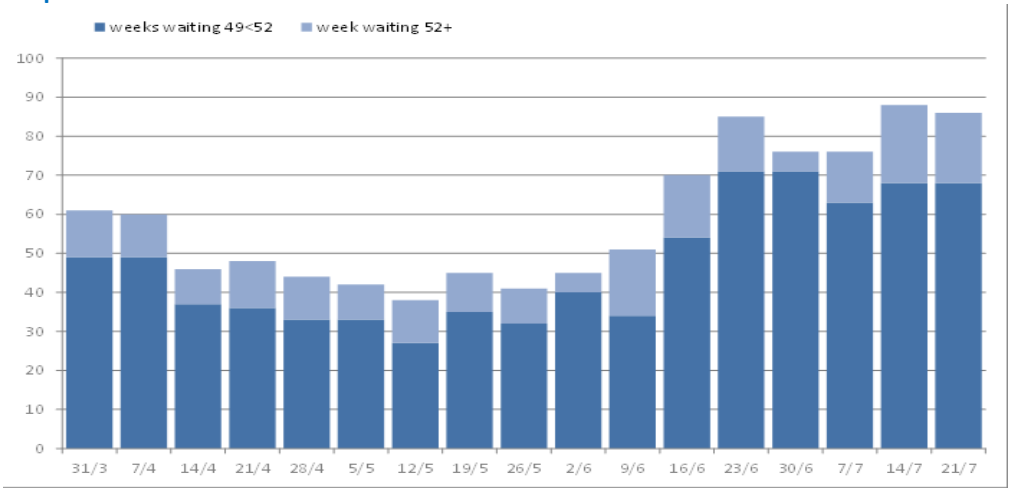
A sustainable solution for Gynaecology is currently being considered via the Performance and Activity meeting and as part of the planning for Winter 19/20 as Gynaecology elective

activity has been adversely impacted over the past two winters. It is unlikely that Gynaecology activity could be reduced to the levels of the previous 2 winters without incurring 52 week breaches.

Whilst the volume over 18 weeks in Cardiology is one of the 5 highest specialties there are predominantly on the non-admitted pathway and clearance is down to 40-44 weeks and therefore the risks associated with 52 week breaches in Cardiology is significantly greater than the other 4 specialties if the patient converts to requiring surgical treatment.

There remains a risk to the 52 week position from late inter provider transfers (IHTs), however, work to improve the notification process has been undertaken with local provider to mitigate risk associated.

Graph 8: 48+ Week Waits



The Trust has set an internal stretch ambition to reduce the follow-up backlog by 50% during 19/20 and have a transformation programme in place focussed on delivering this. 3 specialties have been identified for phase 1 of the work; ENT, Cardiology and Urology. The approach involves comprehensive administrative and clinical validation of every follow-up and re-design work, supported by the Trusts' Improvement Team focussing on progressing alternatives to face to face follow-ups, follow-up by other appropriately trained professional, use of alternative access plans (where clinically appropriate). The work will also review the 'front end' of the pathway to better manage referrals into the Trust.

The NHS pension changes have resulted in a number of Consultants opting to reduce their job plans and there is less willingness from Consultants to undertake additional sessions to support delivery of specialty activity plans. The Trust is now collating information on how many Consultants are opting to reduce their job plans on a monthly basis and this information is being shared with the Finance and Performance Committee

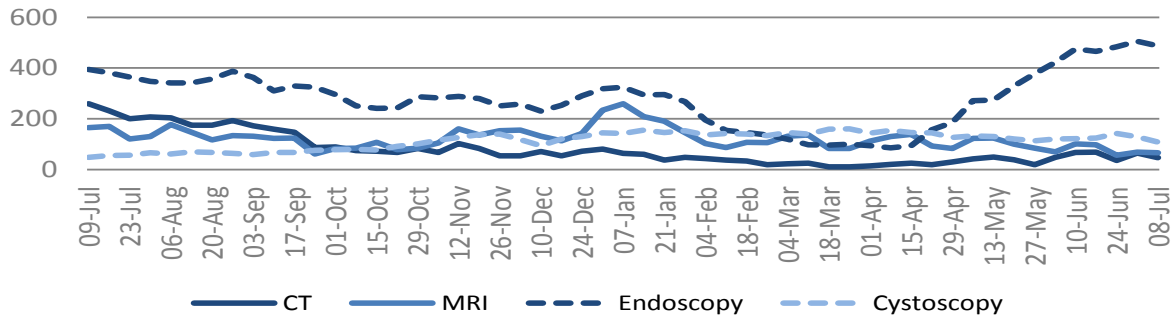
4. DIAGNOSTICS

The national standard is for no more than 1% of patients waiting over 6 weeks for diagnostic tests. The Trust has set a trajectory which delivers no more than 3% of patients waiting over 6 weeks by March 2020 as it is widely acknowledged that the Trust is under-provided in diagnostic capacity, notably CT and MRI.

March 2019 saw the Trust achieve its best ever performance against the 6 week diagnostic standard at 3.83%, however this was achieved with additional sessions delivered in MRI, CT and Endoscopy during Q4 2018/19 funded via the Cancer Alliance. Since April, performance against the diagnostic standard as deteriorated with 4.59% breaches recorded for April, 7.65% for May and 8.71% for June and therefore the Trust is not meeting the Operating Plan reduction trajectory.

Endoscopy, MRI, CT and Cystoscopy have the highest number of breaches and account for 80% of all breaches of the 6 week diagnostic standard.

Graph 9: 6 week Diagnostic Breaches



Mobile MRI vans continue to be used in order to manage capacity due to increased activity and to provide service cover due to scanner replacement. A new replacement scanner is due in November 19 which will improve efficiency.

Overtime continues to be run on all available CT scanners in order to try and meet service demand. Although the number of CT breaches has reduced overall and stabilised there are still considerable service pressures and delays in all variations of CT scanning, particularly CT Colonoscopy which impacts primarily on the Cancer pathway.

Ultrasound demand has increased in recent months due to the loss of a local independent Ultrasound provider; however a recovery plan is in place which is expected to eliminate 6 weeks breaches from October 2019.

The number of Endoscopy breaches has increased during Q1 partly due to the continuing increase in demand for services on an urgent basis, particularly through the colorectal 2ww service. So far during 2019/20, the colorectal 2ww service has received 300 more referrals when compared to the same time period last year. Whilst the service has worked to maximise the use of all available sessions, this has been a challenge during this period due to nurse staffing issues. During May, the service used 89.5% of available weekday sessions and in June; the service used 87.1% of sessions.

During June the service completed the staff consultation to support the introduction of 6/7 day working along with the delivery of extended days. Extended working day and 6/7 day working is anticipated to commence from September once additional nurse staffing has been recruited.

Endoscopy accounts for approximately 60% of all breaches against the 6 week standard and therefore the once the service begins the new working patterns from September, the

numbers of breaches are expected to reduce to performance levels that was achieved at the end of Q4 2018/19 (assuming demand remains stable). Options for using Independent Sector providers to support the management of the Endoscopy waiting times is currently being considered by the Surgery Health Group.

Given the actions being taken, performance against the 6 weeks diagnostic standard is expected to improve from October 2019.

5. CANCER 62 DAY RTT

The national Cancer RTT standard is 85%. The Trusts Operating Plan identifies that the Trust will achieve 85% (adjusted) performance by the end of March 2020. The Trust achieved its operating plan trajectory for April and May (See below)

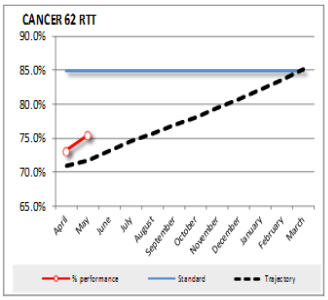
62d Cancer Waiting Times

	2018/19											
ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
treatments	158	165.5	164	172.5	176.5	168.5	176.5	169.5	165.5	179	136	152
breaches	46.5	49	53.5	53.5	55.5	52	54.5	54	45.5	61.5	40.5	45
% performance	70.6%	70.4%	67.4%	69.0%	68.6%	69.1%	69.1%	68.1%	72.5%	65.6%	70.2%	70.4%
adjusted performance	76.5%	75.2%	71.6%	73.9%	70.3%	73.4%	73.6%	74.9%	76.7%	70.1%	75.3%	78.6%

	2019/20											
TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
treatments	158	166	164	173	177	169	177	170	166	179	188	188
breaches	46	47	44	44	43	39	39	35	32	32	31	28
% performance	70.9%	71.7%	73.2%	74.6%	75.7%	76.9%	78.0%	79.4%	80.7%	82.1%	83.5%	85.1%
standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

	April	May	June	July	August	September	October	November	December	January	February	March
ACTUAL												
% performance	73.1%	75.4%										

note: cancer data is released 1 month behind



Timely access to diagnostics, particularly Endoscopy, MRI and CT and Histology turnaround times are a large contributor to the 62 day standard not being achieved and this is widely acknowledged across the Humber Coast and Vale ICP and by the HCV Cancer Alliance. The Trust has been successful for national Wave 4 capital funding of £19.3m which will include procurement of an additional MRI and additional CT for the Hull Royal Infirmary site, however it is likely to be circa 2 years before this available.

New breach allocation guidance from April 2019 also risks adversely impacting on performance as the organisation is no longer required to calculate repatriations for those referrals sent to the Trust after day 38. Whilst the changes to the rules could impact on all tumour sites, Urology is likely to be impacted the greatest due to the lack of Robotic capacity which is not expected to be resolved until 2020.

6. SUMMARY AND RECOMMENDATIONS

At the end of Q1, the Trust is **NOT** meeting the Operating Plan trajectory for the ED 4 hour standard, RTT and Diagnostics however is meeting the operating trajectory for Cancer 62 day RTT (adjusted), Waiting List Volume, and 52 weeks.

The Trust faces significant and sustained challenges in achieving the Operating Plan trajectories for 2019/20 as described in the paper.

For the 4 hour standard, whilst there are robust plans in place, all of the key risks identified in the paper have not been fully mitigated against and therefore the risk of not consistently achieving the 90% standard for the remainder of the year is high.

Whilst many of the risks identified are being actively managed and can be well quantified, the impact associated with Consultants reducing their job plans and not undertaking additional sessions is perhaps the greatest, but currently, not fully quantified, risk affecting a large number of specialties. RTT will be impacted greatest by this as non elective and cancer demand will be prioritised above planned activity. Therefore the risk of the RTT trajectory not being met by March 2020 is high (16)

The trajectory for Waiting List Volume has been met for the last 3 months. All Health Groups have programmes of clinical and administrative validation in place and programmes to improve data quality are RTT compliance are being rolled out as part of the Administration Hubs mobilisation programme. Therefore the risk of the WLV trajectory not being met is considered to be moderate. (9)

Equally the 52 week trajectory has been met for the last 3 months, however some specialities are under severe pressure and additional actions by the Executive team will be required to reduce the risk. The risk is therefore considered major (12)

With regards Cancer 62 days RTT, the trajectory has been achieved for April and May however the continued increase in demand and lack of sufficient diagnostic capacity pose real challenge to this standard being consistently achieved this year. The risk is therefore considered Major.

Target	Risk of target not being achieved by March 2020	Risk Score L x I
Emergency Department	High	4 x 4 (16)
Referral to Treatment	High	4 x 4 (16)
Waiting List Volume	Moderate	3 x 3 (9)
52 weeks	Major	3 x 4 (12)
62 Day Cancer RTT	Major	3 x 4 (12)
Diagnostic	Moderate	3 x 3 (9)

Teresa Cope, Chief Operating Officer
22nd July 2019.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
JULY 2019

Title:	QUALITY REPORT JULY 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 • Healthcare Associated Infections (HCAI) • Patient Experience Matters • 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: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required

QUALITY REPORT
JULY 2019

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission
- Learning from Deaths
- Reporting to NHS Early Notification Scheme

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

The Trust Board is requested to receive this report and:

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

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

2. PATIENT SAFETY

2.1 National Safety Strategy

On the 2nd July 2019, NHS England and NHS Improvement launched The NHS Patient Safety Strategy - Safer Culture, Safer Systems, Safer Patients. This strategy was developed following consultation across the country in December 2018. It was developed to ensure that Patient Safety was a "golden thread" running through healthcare. The document states that "*Getting this right could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24".*

The aim of the strategy is to continuously improve patient safety. To do this the NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both:

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**insight)**
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**involvement)**
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (**improvement)**

A gap analysis is currently being undertaken to review the requirements for the organisation.

2.2 Never Events (NE)

To date in 2019/20 there have been four 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

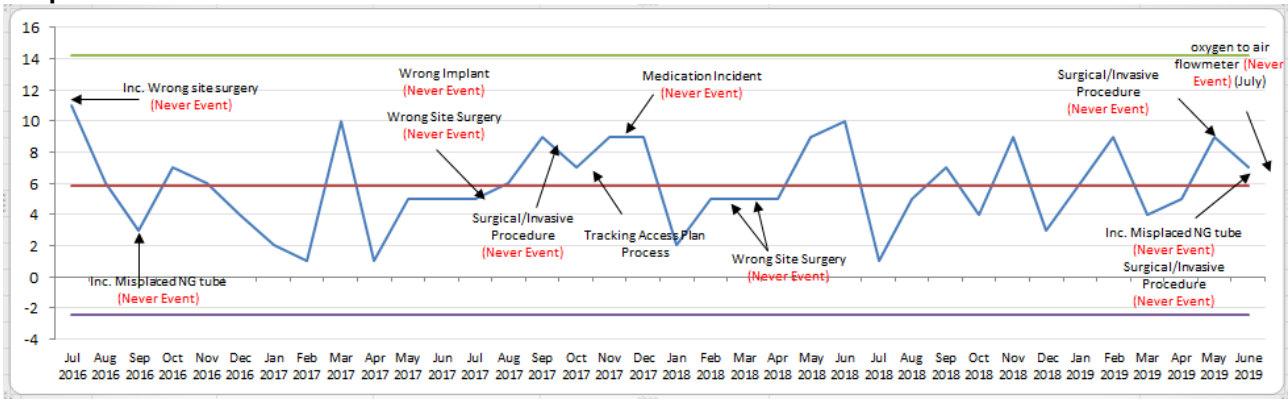
Immediate action was taken by the relevant teams to ensure escalation in a timely manner. All Never Events were declared internally and with regulators and commissioners. The Investigation process has begun. In relation to the Retained Swab, a simulation exercise has taken place.

The Trust has developed a Safety Improvement Plan to provide strategic direction to ensure a renewed focus on patient safety at all levels of the organisation.

2.3 Serious Incidents reporting rates

To date in 2019/20 the Trust has reported 27 Serious Incidents. See Section 2.4 below for details of Serious Incidents reported during May and June 2019.

Graph 1: Serious Incident SPC chart



2.4 Serious Incidents declared in May and June 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 May and June 2019 is contained in the following tables and each of these is now under investigation. Anything of significance will be reported to the Quality Committee in due course and anything of undue concern will be escalated to the Trust Board, as required.

Serious Incidents declared May 2019

Ref Number	Type of SI	Health Group
9862	Surgical/Invasive Procedure - incorrectly sited guidewire	Family & Women's
9995	Maternity/Obstetric Incident - potential delayed delivery	Family & Women's
10001	Maternity/Obstetric Incident – potential delayed delivery	Family & Women's
10272	Adverse Media Attention - patient assault of another patient	Surgery
10523	**Never Event: Retained Foreign Object – theatre swab**	Surgery
10862	Delayed Diagnosis of a pneumothorax	Clinical Support
10863	Diagnostic Incident - incorrect cancer diagnosis	Clinical Support
11123	Maternity/Obstetric Incident – potential delayed delivery	Family & Women's
11236	Medical Device Incident – part of catheter found in patient	Surgery
11721	Delayed Diagnosis of fractures following fall outside of hospital	Emergency & Acute Medicine

Serious Incidents declared June 2019

Ref Number	Type of SI	Health Group
12225	Delayed Diagnosis and delay of surgery	Family & Women's
12484	Hospital acquired Pressure Ulcer	Medicine
12800	**Never Event: Misplaced NG Tube**	Surgery
12801	**Never Event: Surgical/Invasive Procedure – removal of wrong tooth**	Surgery
12863	Sub-Optimal Care of the Deteriorating Patient – patient did not receive timely treatment	Clinical Support
13130	Hospital acquired Pressure Ulcer	Surgery
13689	Maternity/Obstetric Incident ¯ baby born in poor condition	Family & Women's

3. SAFETY THERMOMETER – HARM FREE CARE

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

The NHS Safety Thermometer point prevalence audit results for May 2019 and June 2019 are attached as **Appendix One**.

From the 882 in-patients surveyed on Friday 14th June 2019, the results are, as follows:

- **93.4%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2.1% [n=19]** 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 **97.9%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 882 patients, 64 did not require a VTE risk assessment. Of the remainder, 754/818 had a VTE risk assessment undertaken. This is **92%** compliance on the day. VTE incidence on the day of audit was **5** patients; **4** of which were with a pulmonary embolism and **1** was with a deep vein thrombosis.

- There were **6** new pressure ulcers on the census day, all of which were Cat 2. However, 36 patients had pre-hospital admission pressure ulcers (33 at Cat 2, 2 at Cat 3 and 1 at Cat 4). These have been fed back to commissioners to manage but this problem seems to be increasing. .
- There were **10** patient falls recorded within three days of the audit day. Of these, 9 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 **11/184** patients with a catheter **(5.9%)**. Of the **11** patients with infections, **7** 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.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2019/2020 April to June

Organism	**2019/20 Threshold**	**2019/20 Performance**		
Clostridium Difficile	**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	6	5
MRSA Bacteraemia	**Zero**	1 Trust apportioned case June 19 (over threshold)		
MSSA bacteraemia	**Locally agreed CCG stretch target of 50**	15 Trust apportioned cases (30%) April 2019 = 6 May 2019 = 5 June 2019 = 4		

Gram Negative Bacteraemia		
Organism	**2019/20 Threshold**	**2019/20 Performance**
E.coli bacteraemia	73 (Total 2018/19 = 112)	**24 (33%)**
Klebsiella	Baseline monitoring	**10**
Pseudomonas aeruginosa	Baseline monitoring	**9**

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

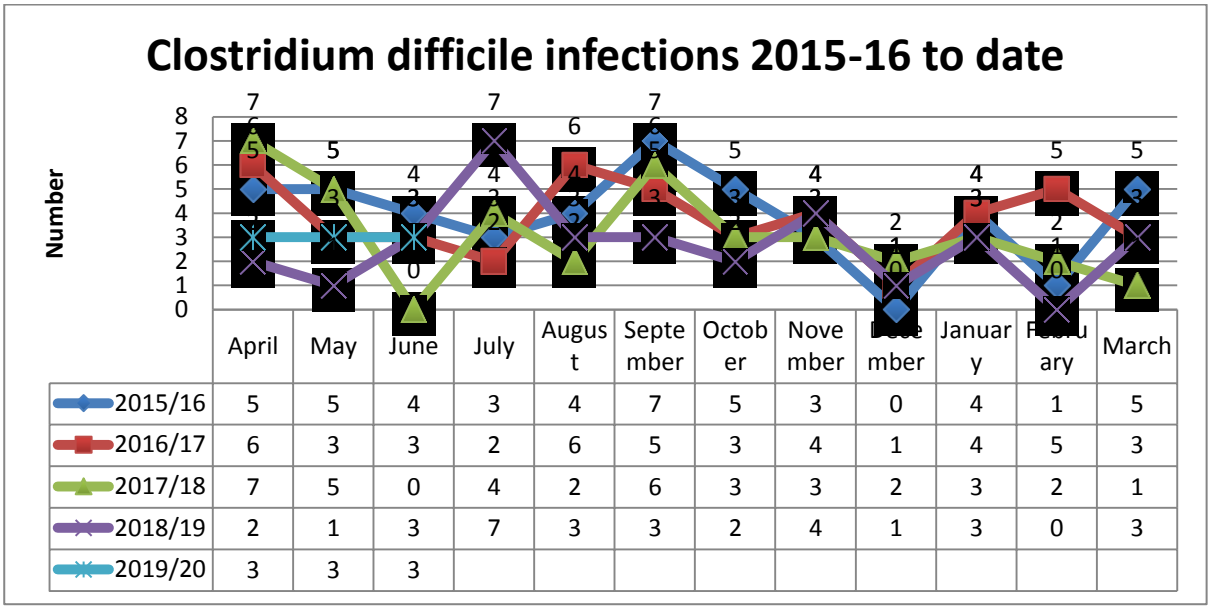
4.1.1. *Clostridium difficile*

Root cause analysis (RCA) investigations are conducted for each infection and outcomes of RCA investigations for all Trust onset cases shared collaboratively with commissioners. In addition, to reflect the changes to the CDI reporting algorithm, the Trust are responsible for investigating the community onset healthcare apportioned (COHA) cases where a patient has had a hospital admission in the previous 4 weeks. With the respective Commissioners and community teams responsible for leading on the investigation of the community onset indeterminate association cases and community onset community apportioned cases. To reflect this change in the reporting algorithm and the perceived increase in Trust apportioned cases, NHS Improvement CDI case objective for 2019/20 for the Trust is 80 cases. Another change is the reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission – prudent and prompt sampling on admission if a patient has diarrhoea.

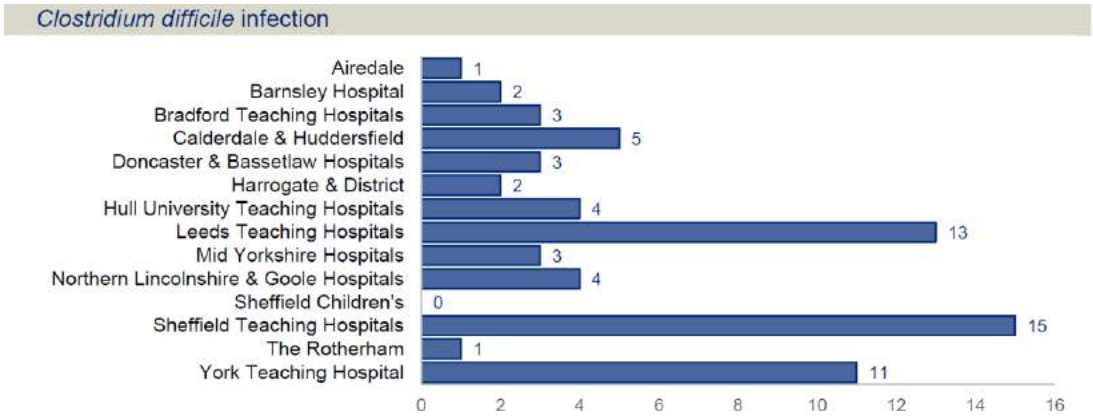
At quarter one, the Trust reported 9 HOHA and 6 COHA infections against an upper threshold of 80 (19% of threshold). From the 1st April 2019, a total of seven cases are apportioned to the Medical Health Group and two to Clinical Support but no cases identified in the Families & Women's Health Group and/or Surgical Health Group. At quarter one, two Trust reported cases relate to the same patient with a relapse in symptoms.

Clostridium difficile RCA completed (HOHA cases)	Clostridium difficile RCA outstanding (HOHA cases)	Outcome of Trust RCA investigation (HOHA cases)	Cases awaiting consideration at Commissioner led HCAI Review Group	Number of HOHA cases tabled at Commissioner led HCAI Review Group and outcome
9 (2 cases reported for same patient)	2/9	6/9 to date deemed no lapses	2/9	4/9 – all deemed no lapses

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



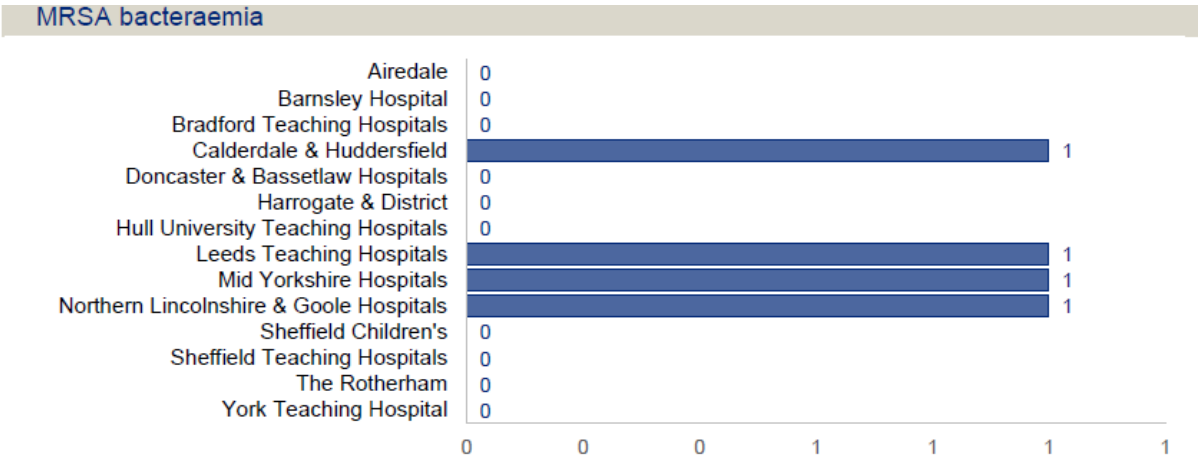
The following table shows the distribution of acute hospital C.*difficile* cases across the Yorkshire and the Humber region, during April and May 2019 (source: Public Health England)



4.1.2 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, awaiting formal review meeting. Case findings demonstrate a causal link with the insertion, ongoing care and management of peripheral vascular cannula. Patient developed cellulitis and thrombophlebitis at a cannula site, deemed the causal factor for the MRSA bacteraemia and avoidable. Patient and next of kin fully aware of investigation and likely findings.

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

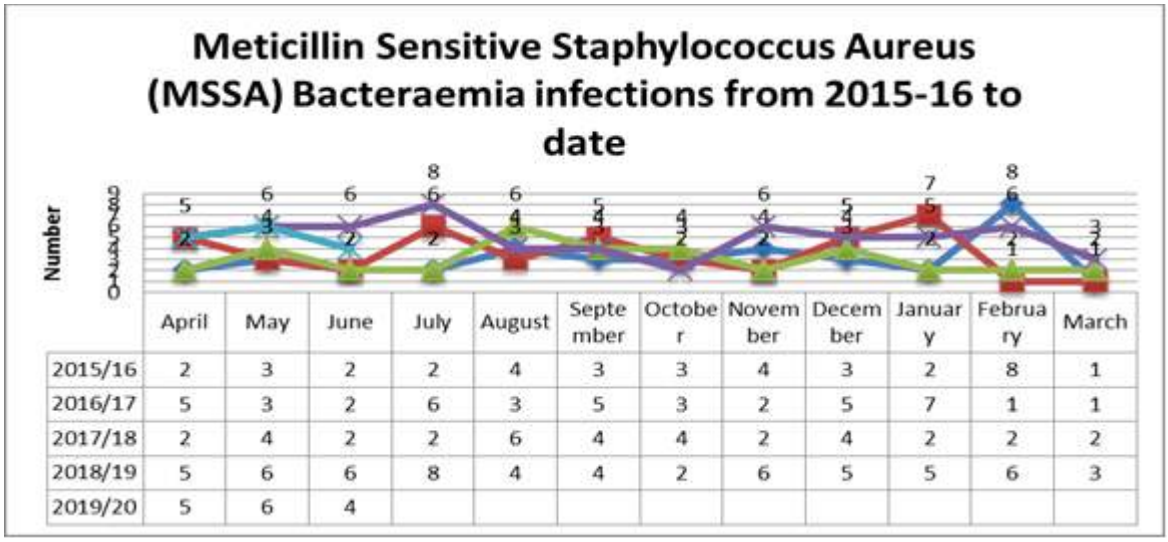


4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

Organism	2019/2020 Threshold	2019/20 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	50	**15 (30%)**	Of the 15 reported cases 5 are associated with intravenous device management. 5 represent patients with underlying infections some positive for MSSA previously. The remaining 5 patients include cases of hospital apportioned pneumonia and/or possible infection associated with previous pacemaker insertion. All cases are reviewed by the IPCT and RCAs are being completed by the respective HGs

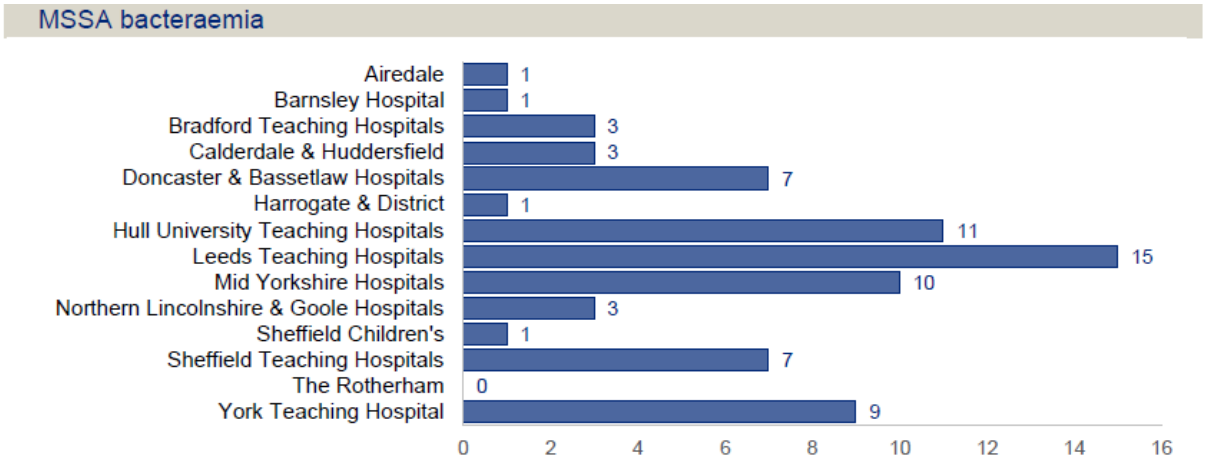
MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection again for 2019/20 but the need for continued and sustained improvements regarding this infection remains a priority.
During quarter one, MSSA bacteraemia cases remain relatively static month on month, 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:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	2	3	2	2	4	3	3	4	3	2	8	1
2016/17	5	3	2	6	3	5	3	2	5	7	1	1
2017/18	2	4	2	2	6	4	4	2	4	2	2	2
2018/19	5	6	6	8	4	4	2	6	5	5	6	3
2019/20	5	6	4									

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



4.1.4 *Escherichia-coli* Bacteraemia

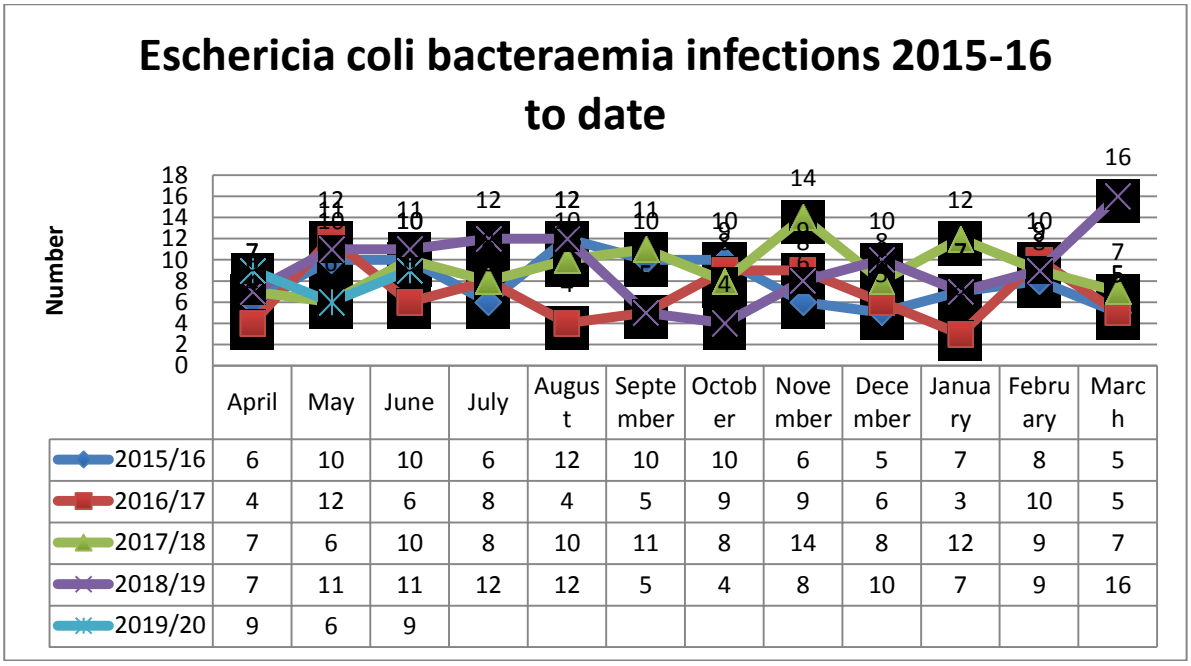
E. coli is now the commonest cause of bacteraemia reported to Public Health England.
E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.
For the operational period 1st April 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)
E. coli bacteraemia	73 (after 10% reduction)	24 (33%)	24	Twenty four cases Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 12 cases detected in the Surgical HG, 6 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

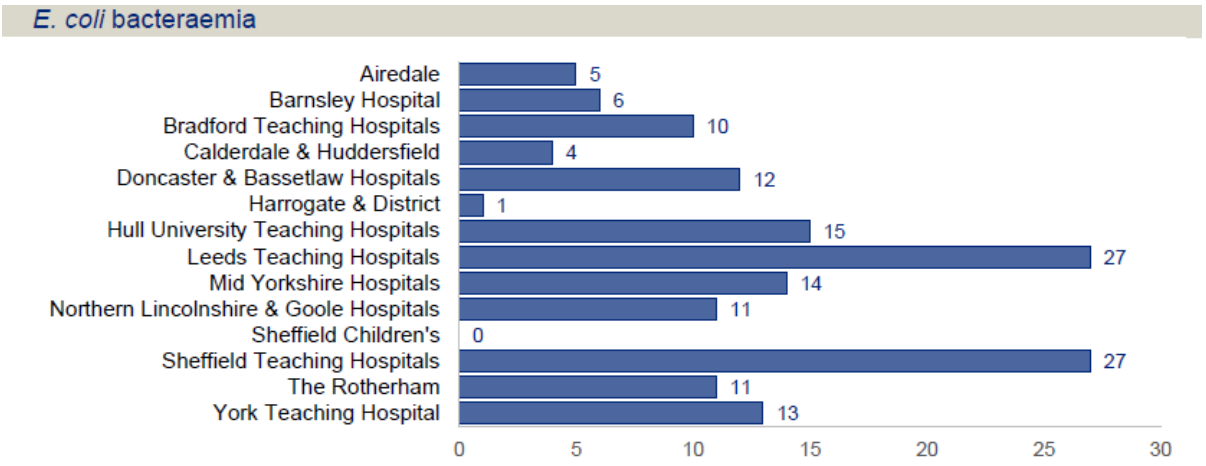
				urological surgery, biliary and urinary sepsis. Ongoing review of cases continues by the IPCT with those deemed possibly preventable or preventable requiring an RCA by the HG. The cases requiring an RCA relate to urinary tract infections and delay in treatment. Further commentary to follow in subsequent HCAI quarterly and exception reports.

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



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	6	10	10	6	12	10	10	6	5	7	8	5
2016/17	4	12	6	8	4	5	9	9	6	3	10	5
2017/18	7	6	10	8	10	11	8	14	8	12	9	7
2018/19	7	11	11	12	12	5	4	8	10	7	9	16
2019/20	9	6	9									

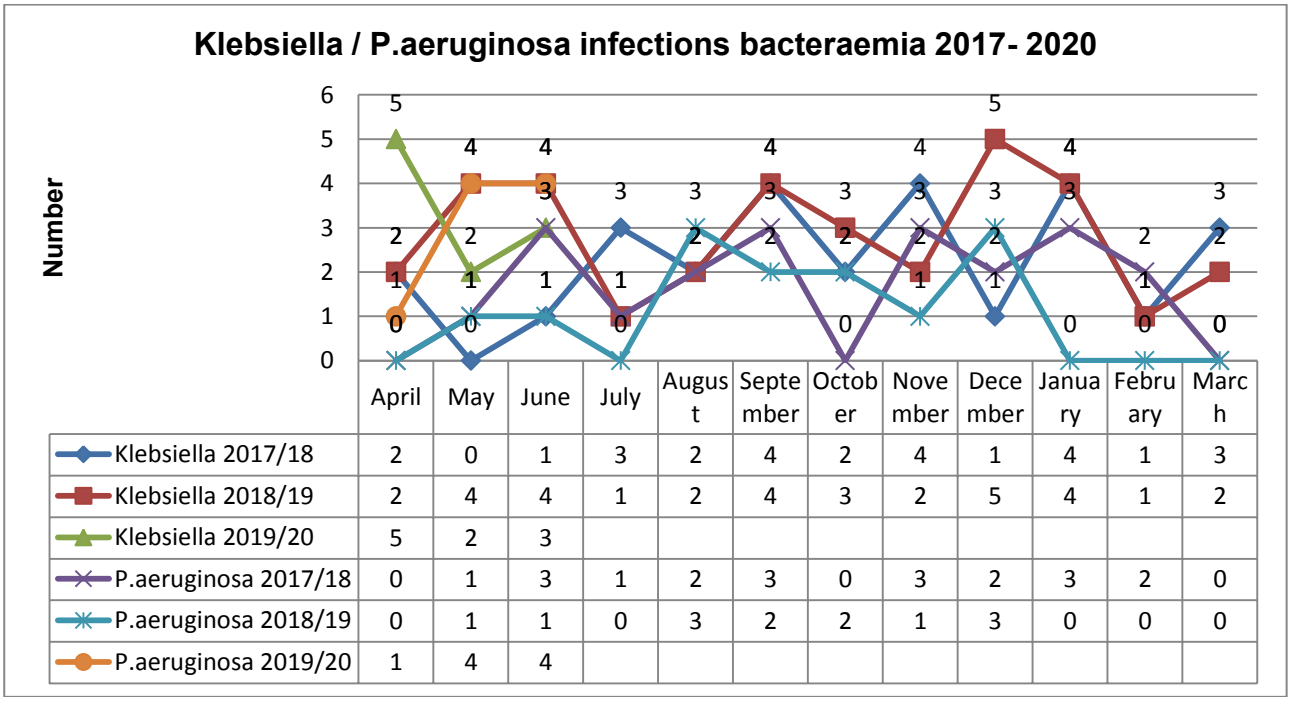
The main points here are the concerns over the high resistance rates to commonly-used antibiotics and, also, the learning around the care of patients with urinary catheters and indwelling vascular devices both in hospital and the community. All of these are areas of increased focus and actions currently. 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 May 2019 (source: Public Health England)



4.1.5 Gram negative bacteraemia – reporting for 2019/20

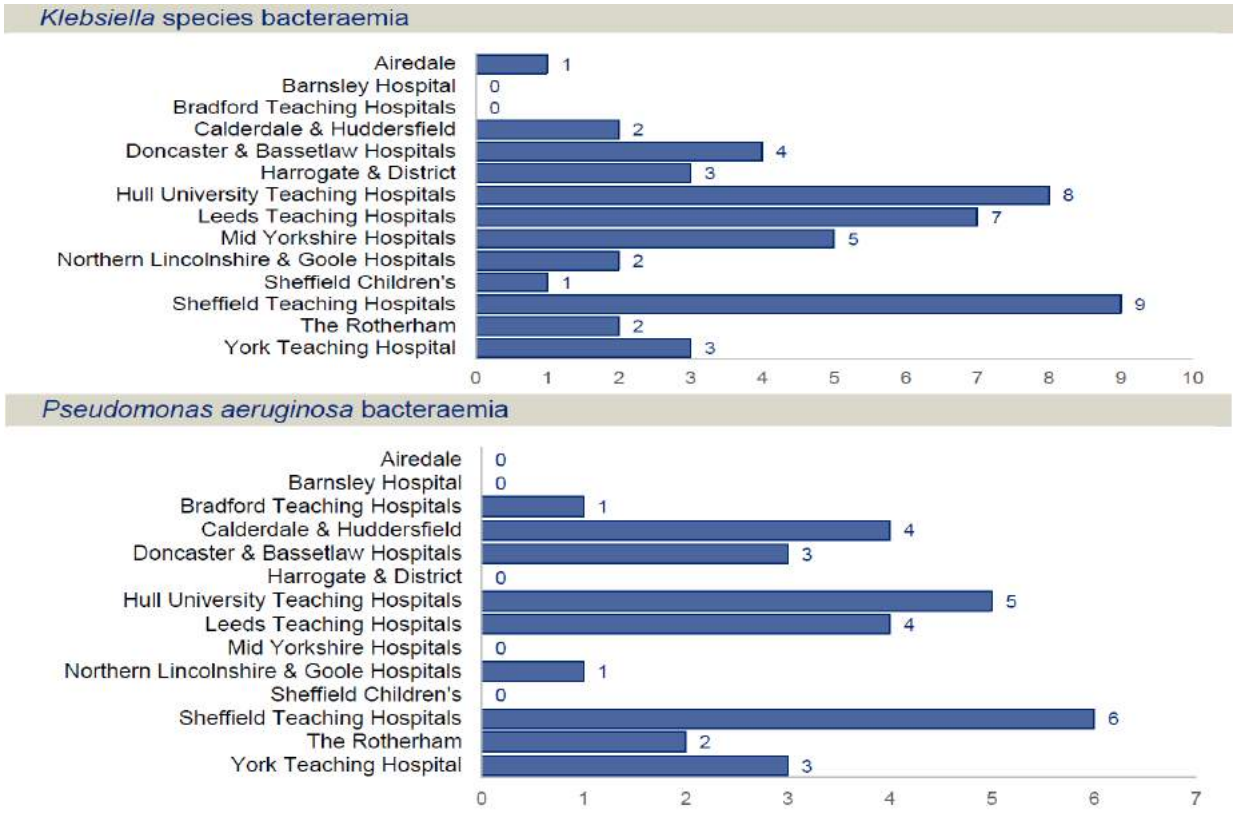
For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England require NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections 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.



	April	May	June	July	August	September	October	November	December	January	February	March
Klebsiella 2017/18	2	0	1	3	2	4	2	4	1	4	1	3
Klebsiella 2018/19	2	4	4	1	2	4	3	2	5	4	1	2
Klebsiella 2019/20	5	2	3									
P.aeruginosa 2017/18	0	1	3	1	2	3	0	3	2	3	2	0
P.aeruginosa 2018/19	0	1	1	0	3	2	2	1	3	0	0	0
P.aeruginosa 2019/20	1	4	4									

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 May 2019 (source: Public Health England)



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

4.2 Infection Outbreaks

A number of cases of diarrhoea and vomiting have resulted in bay closures has been reported during April, May and June 2019. These have occurred predominantly in the Medicine Health Group – wards H8, H5, H500 and H36. Closures have been short-lived with no causative organism detected but areas affected have been cleaned prior to reopening.

4.2.1 Infection incidents

Pseudomonas aeruginosa in NICU

The board is aware of the incidence of Pseudomonas aeruginosa found on screening of babies in the Neonatal Intensive Care Unit (NICU). Screening takes place on admission and on a weekly basis thereafter. At quarter end a colonised case was detected during May 2019 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. During May 2019, similar variable number tandem repeats (VNTR) profiles were identified in babies nursed at different intervals on the unit from December 2018 to May 2019 onwards. These represent commonly found strains both in humans and the environment so it is difficult to illicit clinical relevance, however this prompted the IPCT to request Estates and Facilities to undertaken water sampling of all outlets on the unit. All water samples from across the unit were negative, apart from a shower in a parent's overnight room (suggesting lack of access for flushing

purposes). Incident meetings have been held at regular intervals with Public Health England involvement. 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, this is expected to commence from the 23rd July 2019 – updates will be provided in future reports.

Confirmed Measles case

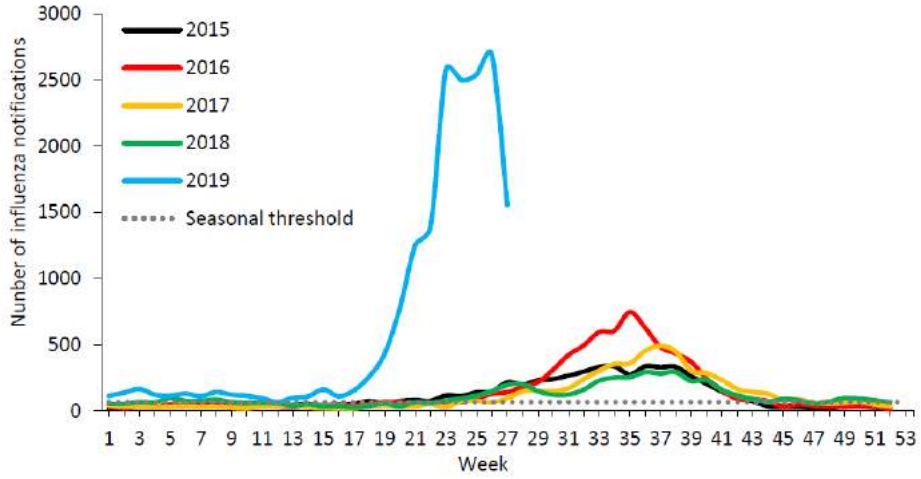
On the 15th April 2019 an incident meeting was held to discuss a case of confirmed measles reported in a patient who presented to the Emergency Department. Although there was a delay in diagnosis – possibly partially attributed to the delayed serology sample from AAU reaching Virology but more likely due to the clinical presentation, which was atypical and MMR history, the patient was managed appropriately and transferred to the Infectious Diseases ward. The Trust was commended by Public Health England for active management by ID and early intervention reducing any potential transmission events by enforcing side-room, droplet precautions and ultimately transferring care to ID unit along with rapid management and review of all contacts – mostly undertaken at the weekend by the on call Infectious Diseases Consultant and Lead Nurse and rapid review of staff by the OH department.

4.2.2 Influenza Trends 2018/19 and early concerns about the 2019/20 season

The 2018/19 Influenza season has ended during this quarter and was another successful and well managed season for Hull University Teaching Hospitals NHS Trust with limited impact on clinical activity, albeit one ward closure in January 2019. This was due to a combination of early recognition, prompt isolation and the judicious use of rapid respiratory panel testing, inclusive of influenza to ensure best use of isolation capacity.

We have received reports from a number of sources that the current southern hemisphere influenza season is very severe (See chart below as an example from Western Australia). 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.

Influenza notifications in Western Australia by week, 2015 to 2019



Influenza notifications reported to the Department of Health decreased this week, but remain much higher than peaks of previous 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 01/07/2019 and 07/07/2019. 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.

5. PATIENT EXPERIENCE

The board are aware that we are currently reviewing the terms of reference, membership and work-plan for the patient experience agenda, including engagement and involvement actions. The activity data for complaints and PALs is attached as a separate report at **Appendix two**. As of the September Board Patient Experience will have a separate paper which will report quarterly on activity and improvement projects.

5.1 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 8 cases with the PHSO currently. During the month of April, May and June no new cases were opened and 2 cases were closed and were partly up held both with actions and lessons learned.

5.2 Young Health Champions Volunteering Programme

The Trust has been successful in a bid for funding with the Pears Foundation to develop a two year project specifically on developing young volunteers. As this project is currently being scoped a full outline and update will be presented in the next Board paper regarding this positive development.

5.3 PICKER Survey

The Trust has received the results from the PICKER survey undertaken in July 2018. The information was embargoed until June 2019 and work has begun via a commissioned task and finish group to review the areas where the Trust falls below the national comparable standard. A full outline on the results and actions will be presented in the next Board paper regarding this matter. The 2019 PICKER survey will commence at the end of July 2019 and the results expected in Spring 2020 (embargoed initially).

6. OTHER QUALITY UPDATES

6.1 Care Quality Commission (CQC)

The CQC continues to interact with the Trust on a regular basis. General information requests continue to be received on, for example, completed Serious Incidents, staffing levels and complaints. The next quarterly engagement meeting is due to take place at the end of July 2019.

6.2 Learning from Deaths

The Trust continues to meet the criteria for the Learning From Deaths Framework. Work is progressing well with the development of the Medical Examiner role and a review will be completed as part of the new NHS National Safety Strategy, to ensure all criteria are met.

6.3 Reporting to NHS Early Notification Scheme

No cases have been reported to date in the 2019-20 financial year under the NHS Early Notification Scheme.

7. RECOMMENDATION

The Trust Board is requested to receive this report and:

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

Beverley Geary
Chief Nurse

Makani Purva
Chief Medical Officer

July 2019

Appendix One Safety Thermometer point prevalence audit results, May 2019 and June 2019
Appendix Two Activity Data for Complaints and PALs to June 2019

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER May 2019

Absence of harm from

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

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 10th May on both hospital sites. 865 patients were surveyed

93.8% of our patients received HARM FREE CARE

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

1.85% (16) of our patients suffered a New Harm

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

98.15% 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 December 18 – May 2019

	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 18
Harm Free Care %	**92%**	**94.4%**	**93.7%**	**93.7%**	**93.7%**	**93.8%**
Sample: Number of patients	**872**	**881**	**911**	**891**	**932**	**865**
Total Number of New Harm	**18**	**21**	**16**	**12**	**17**	**16**
NEW HARM FREE CARE %	**98%**	**97.7%**	**98.3%**	**98.6%**	**98.1%**	**98.5%**

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	6	0.69%	5	1	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	59	8.09%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	736	85.09%	91%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	70	6.82%	9%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	37	4.28%	32	4	1
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.	31	3.58%	26	4	1
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	6	0.69%	6	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	18	2.08%
Severity **No Harm**: fall occurred but with no harm to the patient	13	1.50%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	4	0.46%
Severity **Moderate Harm**: longer stay in hospital	1	0.12%
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	**168**	**19.42%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**8**	**0.92%**	**4%**
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**	**8**	**0.92%**	**4%**
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**	**0**	**0%**	**0%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 14th June 2019

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER June 2019

Absence of harm from

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

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 14th June on both hospital sites. 882 patients were surveyed

93.4% of our patients received HARM FREE CARE

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

2.1% (19) 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

97.9% 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 January 19 – June 2019

	Jan 19	Feb 19	Mar 19	April 19	May 18	June 19
Harm Free Care %	94.4%	93.7%	93.7%	93.7%	93.8%	93.4%
Sample: Number of patients	881	911	891	932	865	882
Total Number of New Harm	21	16	12	17	16	19
NEW HARM FREE CARE %	97.7%	98.3%	98.6%	98.1%	98.5%	97.9%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	5	0.57%	4	1	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	64	7.26%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	754	85.49%	92%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	64	7.26%	8%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	42	4.76%	39	2	1
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.	36	4.08%	33	2	1
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	6	0.68%	6	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	10	1.13%
Severity **No Harm**: fall occurred but with no harm to the patient	9	1.02%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	1	0.11%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

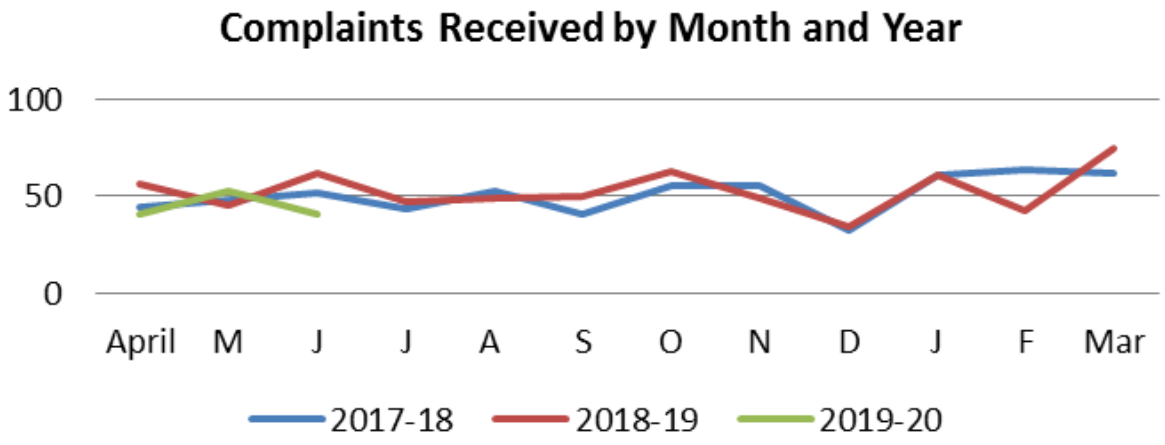
Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	**184**	**20.86%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**11**	**1.26%**	**5.9%**
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital	**4**	**0.45%**	**2.1%**
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	**7**	**0.79%**	**3.8%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 12th July 2019

Appendix Two
Activity Data for Complaints and PALS

The following graph sets out comparative complaints data from 2017 to date. There were 42 new complaints in the month of April 2019, 54 in the month of May 2019 and 41 in the month of June 2019.



The following table indicates the number of complaints by subject area that were received for each Health Group during the months of April, May and June 2019.

Complaints Received by Health Group and Subject – April, May and June 2019

Complaints by Health Group and Subject (primary)	Month	Attitude	Care and Comfort	Communica-tion	Delay, Waiting Times and Cancellations	Discharge	Hotel Services	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	April	0	0	1	0	0	0	0	0	0	1
	May	0	0	0	0	0	0	0	0	0	0
	June	0	0	0	0	0	0	0	0	0	0
Clinical Support	April	0	0	0	0	0	0	0	0	1	1
	May	0	0	0	1	1	0	0	0	2	4
	June	0	0	1	0	0	0	0	0	2	3
Emergency & Acute	April	0	0	0	0	1	0	0	0	5	6
	May	0	0	1	2	0	0	0	0	7	10
	June	2	0	0	0	0	0	0	0	3	5
Family and Women's	April	0	1	2	0	0	0	0	0	2	5
	May	0	0	3	2	0	0	0	0	4	9
	June	1	0	1	1	0	0	0	0	6	9
Medicine	April	1	5	2	0	2	0	0	0	2	12
	May	0	3	1	2	0	1	0	0	8	15
	June	0	1	1	1	0	2	1	0	5	11
Surgery	April	0	0	2	3	0	0	0	0	12	17
	May	1	0	2	2	1	0	2	0	8	16
	June	0	0	0	1	1	0	1	0	10	13
Totals:	April	1	6	7	3	3	0	0	0	22	42
	May	1	3	7	9	2	0	3	0	29	54
	June	3	1	3	3	1	2	2	0	26	41

Performance against the 40-working day complaint response standard

The standard for complaints to be closed within 40 working days is 85%. The standard has not been achieved in this quarter.

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

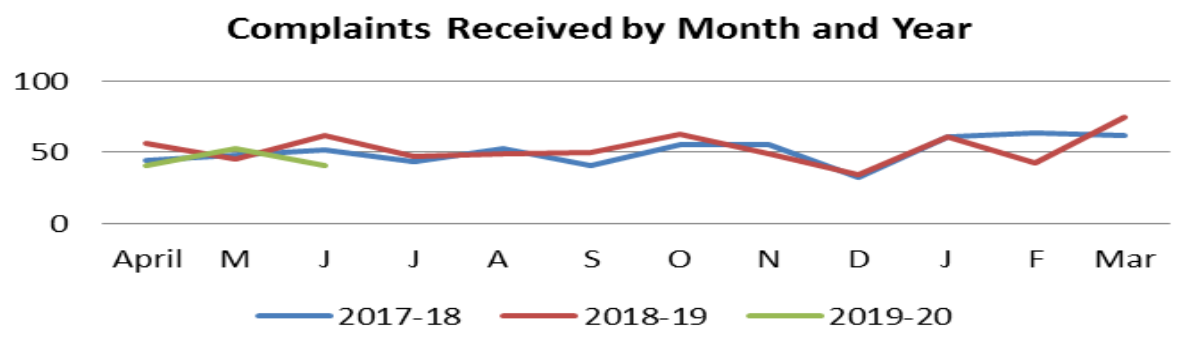
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
77.5%	77.5%	81.6%									

The following tables indicate performance by Health Group and the outcome of the complaints for the months of April - June 2019.

April 2019	Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened	Dissatisfied with response
Corporate Functions	0	0 (100%)	0	0	0	0	0	0
Clinical Support	2	2 (100%)	0	2	0	1	1	1
Emergency and Acute	6	6 (100%)	4	0	1	1	0	0
Family and Women's	17	16 (94%)	0	14	2	1	1	0
Medicine	8	6 (75%)	3	5	0	1	5	2
Surgery	16	8 (50%)	3	10	3	0	2	1
Totals:	49	38 (77.5%)	10	31	6	4	9	4

May 2019	Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened	Dissatisfied with response
Corporate Functions	1	1 (100%)	1	0	0	0	0	0
Clinical Support	2	2 (100%)	0	2	0	0	0	0
Emergency and Acute	6	6 (100%)	1	4	1	0	0	0
Family and Women's	6	5 (83.3%)	1	4	1	0	1	1
Medicine	23	17 (73.9%)	4	15	3	1	4	3
Surgery	20	14 (70%)	9	11	0	0	4	4
Totals:	58	45 (77.5%)	16	36	5	1	9	8

June 2019	Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened	Dissatisfied with Response
Corporate Functions	0	0 (100%)	0	0	0	0	0	0
Clinical Support	2	2 (100%)	1	0	1	0	0	1
Emergency and Acute	10	9 (90%)	1	8	1	0	0	0
Family and Women's	9	7 (77.7%)	1	7	1	0	1	1
Medicine	8	8 (100%)	3	5	0	1	10	2
Surgery	20	14 (70%)	3	15	2	1	3	1
Totals:	49	40 (81.6%)	9	35	5	1	14	5

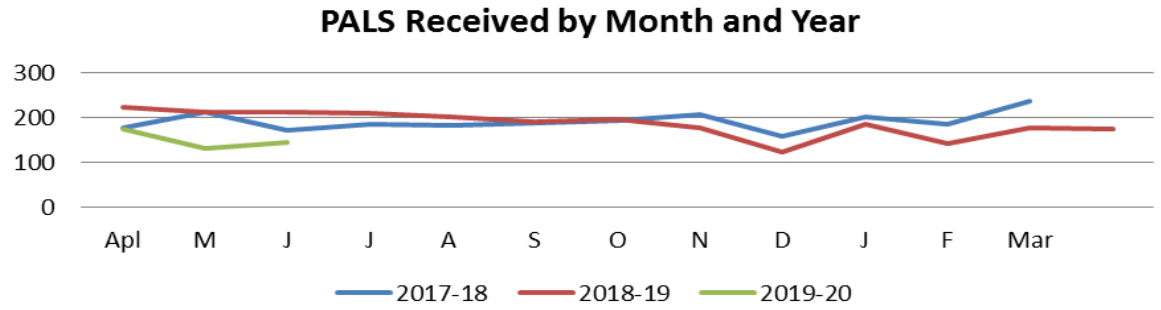


Patient Advice and Liaison Service (PALS)

In April, there were 173 PALS contacts, followed by a significant decrease in May of 133. June has slightly increased to 143.

The following table indicates that Delays, Waiting times and Cancellations continues to be the highest subject reported to PALS. In the month of April, May and June 42 concerns were regarding the patient not being happy with the treatment plan in place and 43 for delays in receiving an outpatient appointment.

Complaints by Health Group and Subject (primary)	Month	General Advice	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	April	2	1	0	2	0	0	2	0	0	0	0	7
	May	1	3	0	0	1	0	0	1	0	0	1	7
	June	1	0	0	1	0	1	0	3	0	0	0	6
Clinical Support	April	0	2	0	5	8	0	1	0	0	0	3	19
	May	2	2	0	0	4	1	0	0	0	0	3	12
	June	1	2	0	1	1	0	0	0	0	0	0	5
Emergency & Acute	April	0	3	2	2	0	2	0	0	0	0	8	17
	May	0	1	0	0	0	1	0	0	0	0	4	6
	June	2	3	1	2	0	0	0	0	0	0	6	14
Family and Women's	April	3	1	3	1	22	1	0	0	0	0	18	49
	May	3	4	2	0	13	1	0	0	0	0	12	35
	June	3	1	0	2	23	0	0	0	0	0	14	43
Medicine	April	5	3	0	3	6	4	0	0	0	0	8	29
	May	3	2	1	3	12	1	0	0	1	0	7	30
	June	2	4	3	11	4	3	0	0	0	0	7	34
Surgery	April	7	4	0	4	20	1	0	0	0	0	16	52
	May	4	2	1	5	12	2	0	0	0	1	16	43
	June	3	4	2	2	15	0	0	0	0	0	15	41
Totals:	April	17	14	5	17	56	8	3	0	0	0	53	173
	May	13	14	4	8	42	6	0	1	1	1	43	133
	June	12	14	6	19	43	4	0	3	0	0	42	143



HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
JULY 2019

Title:	NURSING AND MIDWIFERY (SAFE) STAFFING REPORT – JULY 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
JULY 2019

1. PURPOSE OF THIS REPORT

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

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

2. BACKGROUND

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

The last report on this topic was presented to the Trust Board in May 2019 (February and March 2019 position).

In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England[4]. 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.

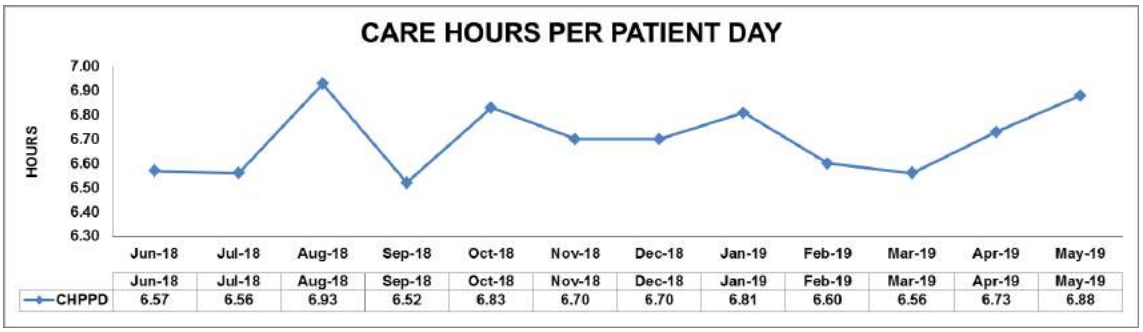
This report presents the 'safer staffing' positions for April and May 2019 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staffing.

[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 Five 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.



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
CHPPD	6.57	6.56	6.93	6.52	6.83	6.70	6.70	6.81	6.60	6.56	6.73	6.88

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 6.88 being recorded for May 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.

As part of the 2018/19 annual audit plan, the internal auditors (MIAA) undertook a review in relation to safe staffing levels in the Trust. In summary the report concluded that `*the Trust has a strong system of internal control which has been effectively designed to meet the system objectives and that controls are consistently applied in all areas reviewed*`.

To conclude the Trust received a `High Assurance` rating, with the following recommendations:

1. The Trust should ensure that all safer staffing reports are communicated to the public via the internet after they have been approved by the Trust Board – this was actioned immediately.
2. The Trust should ensure that validation checks and approval as part of the monthly submission to UNIFY are formally evidenced.

In response to recommendation two, the Trust has developed a formal validation process which is illustrated in appendix 4, which requires a recorded formal sign off by the Deputy Chief Nurse, or delegated individual in their absence.

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 will be presented to the Trust Board at a later date.

Appendix One provides the Nursing Staffing Key metrics for April 2019.
Appendix Two provides the Nursing Staffing Key metrics for May 2019.
Appendix Three provides the Nurse Staffing Quality Indicators for June 2019,
Appendix Four Nurse Staffing Validation Flow Chart.
Appendix Five 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 therefore deemed to be safely staffed	
C31	**MEDIUM**	This ward has 9.08 wte RN vacancies. Actions taken have mitigated the risk & no quality indicators are triggering currently; this continues to be closely monitored	Utilising bank/agency, medium term support from pilot bank, support from other inpatient wards, DTU, CNS team member & 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 3.54 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**	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. 1 x trainee Nursing Associate qualifying in June 2019.
H36	**LOW**	No staffing related quality concerns	
H5/RHoB	**LOW**	No staffing related quality concerns	
H50	**LOW**	No staffing related quality concerns	
H500	**LOW**	No staffing related quality concerns.	Staff continue to be flexed across the fifth floor as required following reviews by Senior Matron.
H70	**MEDIUM**	This ward requires a high presence from the Senior Matron to support the ward focus on quality concerns.	Utilising some agency and bank. RN pool nurses allocated for continuation and stability. B6s and B7 staff providing weekend cover and Senior Matron support. Plan in place to allocate RNs from winter ward in May.
H8	**LOW**	No staffing related quality concerns	Additional non-registered staff in post, awaiting x3 non – registered nurse new starters
H9	**MEDIUM**	No quality concerns, high visibility and support from Senior Matron.	Senior Matron supporting the ward. Additional Band 6 RN 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**	This ward is requiring a higher level of senior nurse support. One SI declared for tissue viability.	Bank and agency utilised. Flexing staff across the floor to maintain safety. Senior Sister redeployed from H110 to provide additional senior nurse support. Additional non- registered nurses being recruited to support Registered nurse workforce. Two international nurses to be allocated to ward. Additional band 6 being recruited to provide senior support at weekends and out of hours.
H110	**LOW**	No staffing related quality concerns	
CDU	**LOW**	No staffing related quality concerns	
C26	**LOW**	No staffing related quality concerns	
C28/CMU	**LOW**	No staffing related quality concerns	

4.1.2 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
H4	**LOW**	No staffing related quality concerns	
H40	**MEDIUM**	No staffing related quality concerns, however increasing demand for major trauma capacity	Maternity Leave 5.4% Vacancy 2.59 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	6.50 Vacancy RN recruitment ongoing. Long-term sickness, requiring use of agency and bank
H100	**LOW**	No staffing related quality concerns	
H12	**LOW**	No staffing related quality concerns	
H120	**LOW**	No staffing related quality concerns	
HICU	**LOW**	No staffing related quality concerns	
C9	**LOW**	No staffing related quality concerns	
C10	**LOW**	No staffing related quality concerns	
C11	**LOW**	No staffing related quality concerns	
C14	**LOW**	No staffing related quality concerns	
C15	**MEDIUM**	No staffing related quality concerns.	4.84 wte RN vacancies, Maternity is 9.5% Increasing service demands high staff turnover, R/N support provided from ambulatory care unit. X2 SI related Pressure sores in last quarter, which following investigation using the Yorkshire Contributory Factors Framework (YCFF) were not related to staffing levels. 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 13th 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 13th 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 13th 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 May 2019 are 135.03 wte (10.4%) and 10.48 (2.9%) for Non Registered Nurses. 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 specialities through the development of bespoke advertising campaigns and rotational programmes. In addition the Trust has developed a brochure which outlines the career pathways for both non – registered and registered nurses entitled `Nursing with us: The whole picture` which will be used as part of the Trust recruitment campaign but also as part of the Trusts retention strategy.

The Trust is currently pursuing 157 adult branch nurses who are due to qualify in September 2019; This is a combination of applicants from the University of Hull through the Trusts `direct interview campaign` and direct applications from other Universities via NHS Jobs and through the Trust's dedicated recruitment website.

The Trust has deployed 60 nurses from the Philippines with 53 of those nurses having successfully secured their OSCE and now in receipt of their pin numbers. To date the Trust has a 100% OSCE pass rate which is excellent. The Trust has also been complimented by the Test Centres on how well prepared the candidates have been. There are currently an additional seven nurses preparing to take their OSCE.

The majority of recent recruits have been deployed to the medicine health group and it has been made clear to the nurses that the expectation is that they remain within the Health Group for at least six months after the completion of the OSCE.

The retention rates are good with only 2 nurses having left the Trust. Equally we are now beginning to see the nurses bringing their families to the UK which is an indication of an intention to stay.

In addition 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.

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

The Trust is currently in the process of recruiting to all three additional nursing workforce streams:

- Trainee Nurse Associate
- Nurse Apprentice
- Senior Health Care support worker apprentice.

The results of which will be reported to the Trust Board in 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.

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

- 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.

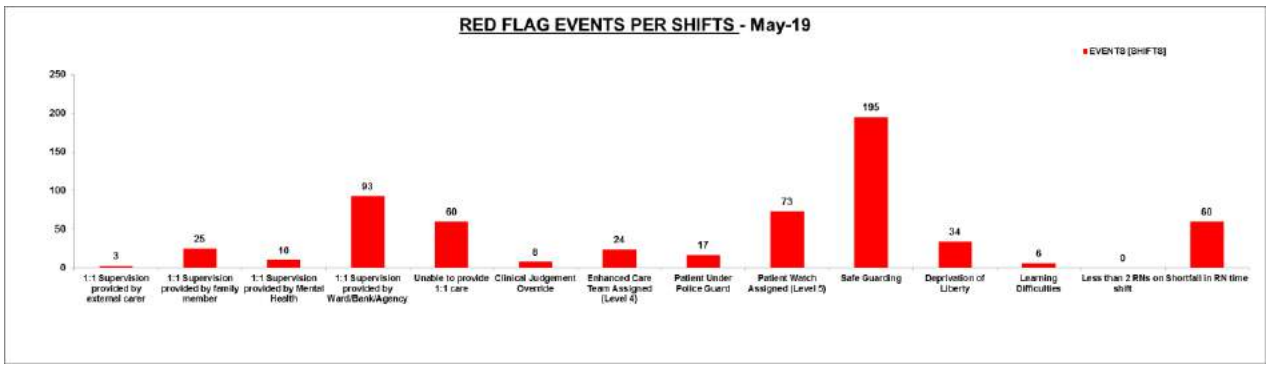
When a 'Red Flag' event occurs, it requires an immediate escalation response by the Registered Nurse in charge of the ward. The event is recorded in SafeCare and all appropriate actions to address them are recorded in SafeCare, which provides an audit trail. Actions may include the allocation or redeployment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

<u>The 'red flags' suggested by NICE, are:</u>

- 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 February and May 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.



May-19	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	3	0%
	1:1 Supervision provided by family member	25	4%
	1:1 Supervision provided by Mental Health	10	2%
	1:1 Supervision provided by Ward/Bank/Agency	93	15%
	Unable to provide 1:1 care	60	10%
	Clinical Judgement Override	8	1%
	Enhanced Care Team Assigned (Level 4)	24	4%
	Patient Under Police Guard	17	3%
	Patient Watch Assigned (Level 5)	73	12%
	Safe Guarding	195	32%
	Deprivation of Liberty	34	6%
	Learning Difficulties	6	1%
	Less than 2 RNs on shift	0	0%
	Shortfall in RN time	60	10%
	TOTAL:	608	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 advertised 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 April and May 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 Safeguards[6]' sets out the future requirements for reporting staffing levels across a broader range of professional groups. Work is under way to determine what this will look like and the first versions of the reports in response of this will be presented to the Trust Board.

10. RECOMMENDATION

The Trust Board is requested to:

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

Author Jo Ledger
Deputy Chief Nurse
July 2019

Appendix One: Nurse Staffing Key Metrics – April 2019
Appendix Two: Nurse Staffing Key Metrics – May 2019
Appendix Three: Nurse Staffing Quality Indicators – June 2019
Appendix Four: Nurse Staffing Validation Flow Chart.
Appendix Five: CHPPD Description, Methodology, Benefits and Limitations

APPENDIX FIVE - 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

Apr-19

KEY METRICS ROTA: 15th Apr 2019 - 12th Mar 2019

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST									NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M1]						TEMPORARY STAFFING [15th Apr - 12th May-19]				UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE							ROTA APPROVALS [42 DAYS]		ADDITIONAL DUTIES			UNFILLED ROSTER [<20%]	HOURS BALANCES [4 WEEKS] [NET + / - 2%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]		
					Other care staff not currently included in CHPPD HPW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]	TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [< 1%]	STUDY DAY [<2.3%]	WORKING DAY [1%]	MAT LEAVE [<2.5%]	FULL [DAYS]	PARTIAL [DAYS]	TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [%]	HOURS BALANCE [%]	NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	7.13	6.7%	2.96	12.9%	10.16	129.08	3.9%	3.9%	0.0%	99.4%	19.6%	3.7%	12.4%	1.0%	1.9%	0.3%	0.3%	60.0	59.0	0.3	0.0	0.3	8.0%	1.0%	87.5	87.5	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1214	5163.2	2984.8	6.7	7.55	-0.84	7.31	-0.60	10.63	20.6%	5.06	18.0%	15.90	79.63	6.0%	5.1%	0.9%	66.9%	27.5%	5.9%	15.9%	0.8%	2.7%	0.0%	2.2%	38.0	31.0	0.3	0.0	0.3	11.8%	0.7%	199.9	248.7	48.8
	H36	GENERAL MEDICINE	24	LOW	399.0	599	1973.3	1628.0	6.0	7.55	-1.54	7.31	-1.30	0.49	3.6%	-2.47	-31.1%	-1.94	21.59	11.7%	8.9%	2.8%	63.0%	31.5%	6.2%	16.3%	3.8%	1.2%	3.2%	0.8%	47.0	47.0	1.0	0.3	0.7	23.6%	1.2%	-78.9	115.5	194.4
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	585	2073.3	1752.7	6.5	6.94	-0.40	7.74	-1.20	5.11	26.7%	0.32	2.4%	5.70	32.27	20.6%	17.8%	2.8%	77.3%	24.1%	6.0%	16.0%	0.3%	0.8%	1.0%	0.0%	34.0	27.0	0.1	0.0	0.1	10.0%	0.8%	-3.5	25.5	29.0
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	743	2796.3	1667.3	6.0	6.74	-0.73	6.38	-0.37	2.29	9.5%	3.24	24.6%	5.63	37.25	10.0%	8.6%	1.4%	32.4%	24.6%	13.7%	10.0%	0.2%	0.7%	0.0%	0.0%	37.0	31.0	0.6	0.5	0.1	20.7%	-0.3%	165.0	218.0	53.0
	H50	NEPHROLOGY	19	LOW	283.5	561	1610.3	1155.8	4.9	7.23	-2.30	7.00	-2.07	-0.58	-3.9%	-0.26	-11.1%	-0.88	17.20	4.9%	4.9%	0.0%	82.9%	27.3%	6.2%	11.9%	0.0%	1.2%	2.7%	5.3%	71.0	69.0	0.0	0.0	0.0	19.2%	-1.2%	-40.0	19.3	59.3
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	707	1640.5	1654.0	4.7	6.74	-2.08	6.38	-1.72	5.77	35.3%	2.51	19.1%	8.63	29.53	5.8%	5.5%	0.3%	54.1%	21.3%	3.2%	15.1%	0.0%	3.0%	0.0%	0.0%	25.0	24.0	0.1	0.0	0.1	15.3%	3.6%	-38.5	16.0	54.5
	H70	GENERAL MEDICINE	30	MEDIUM	441.0	884	2071.6	2370.3	5.0	7.55	-2.53	7.31	-2.29	12.66	58.6%	-1.04	-7.9%	12.21	34.75	36.7%	29.9%	6.8%	72.6%	36.3%	3.9%	14.4%	4.4%	2.8%	8.8%	2.0%	33.0	33.0	0.0	0.0	0.0	20.4%	8.1%	373.3	413.8	40.5
	H8	GERIATRIC MEDICINE	27	LOW	220.5	778	1886.7	1625.3	4.5	6.94	-2.43	6.74	-2.23	2.04	12.5%	0.64	4.9%	2.80	29.53	7.6%	7.3%	0.3%	62.7%	28.2%	6.0%	15.5%	0.6%	2.9%	0.9%	2.3%	58.0	47.0	0.1	0.0	0.1	23.0%	-4.9%	74.0	102.0	28.0
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	809	1527.2	2761.0	5.3	6.94	-1.64	6.74	-1.44	1.57	14.4%	-0.43	-2.7%	1.28	26.82	16.9%	13.1%	3.8%	78.6%	28.6%	7.1%	13.7%	0.4%	0.9%	2.7%	3.8%	38.0	35.0	1.0	0.3	0.7	23.1%	2.9%	144.0	161.5	17.5
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	878	1781.0	2151.5	4.5	6.94	-2.46	6.74	-2.26	3.60	22.0%	-0.26	-1.7%	3.56	32.03	11.0%	9.2%	1.8%	49.2%	25.6%	1.6%	13.1%	0.0%	3.2%	3.7%	4.0%	69.0	68.0	0.0	0.0	0.0	17.0%	1.0%	35.3	55.5	20.3
	H90	GERIATRIC MEDICINE	29	LOW	252.0	850	1693.8	1781.5	4.1	6.94	-2.85	6.74	-2.65	1.86	11.4%	-1.15	-8.7%	0.82	29.53	2.3%	2.3%	0.0%	44.0%	30.0%	6.6%	17.4%	0.2%	1.8%	1.3%	2.7%	68.0	68.0	0.2	0.0	0.2	19.0%	1.2%	12.8	68.3	55.5
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	787	1829.3	1821.0	4.6	7.55	-2.91	7.41	-2.77	7.10	32.9%	-1.45	-13.9%	5.98	32.03	8.1%	8.1%	0.0%	30.7%	28.2%	1.2%	15.1%	2.5%	2.9%	5.4%	1.1%	32.0	24.0	0.0	0.0	0.0	23.2%	1.0%	30.0	49.5	19.5
	H110	STROKE / NEUROLOGY	24	LOW	252.0	582	2555.9	2104.8	8.0	7.55	0.46	7.41	0.60	6.90	25.3%	-2.84	-27.2%	4.31	37.72	11.3%	11.3%	0.0%	50.3%	26.8%	8.2%	10.9%	0.0%	3.2%	0.9%	3.6%	59.0	34.0	0.0	0.0	0.0	21.9%	2.3%	-41.5	305.8	347.3
	CDU	CARDIOLOGY	9	LOW	0.0	99	1069.0	119.0	12.0	7.93	4.07	7.73	4.27	2.18	17.0%	0.31	12.7%	2.66	15.25	3.2%	3.2%	0.0%	100.0%	38.5%	12.7%	12.9%	1.3%	2.7%	1.3%	7.6%	48.0	34.0	0.0	0.0	0.0	52.7%	-1.2%	0.0	0.0	0.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	744	2703.0	1005.5	5.0	8.46	-3.48	9.93	-4.95	0.17	0.7%	-0.75	-9.5%	-0.57	32.03	1.5%	1.5%	0.0%	10.6%	22.3%	2.7%	16.0%	0.0%	1.9%	0.5%	1.2%	53.0	48.0	0.0	0.0	0.0	14.8%	4.2%	3.5	60.5	57.0
	C28 /CMU	CARDIOLOGY	27	LOW	277.2	718	3931.6	1037.5	6.9	7.44	-0.52	7.87	-0.95	10.67	28.1%	-1.01	-12.5%	9.94	46.04	0.4%	0.4%	0.0%	6.4%	24.8%	10.2%	10.7%	0.6%	1.8%	1.5%	0.0%	43.0	20.0	0.3	0.3	0.0	28.4%	0.1%	72.5	165.3	92.8
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	771	2252.8	1415.3	4.8	8.39	-3.63	8.71	-3.95	3.99	18.5%	1.15	11.0%	5.32	32.03	7.8%	7.8%	0.0%	70.6%	24.3%	4.6%	12.3%	2.9%	4.3%	0.2%	0.0%	31.0	10.0	0.1	0.1	0.0	18.8%	-1.0%	71.2	71.2	0.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	404	2407.5	1474.6	9.6	8.39	1.22	8.71	0.90	2.59	12.1%	-1.02	-11.0%	1.69	30.68	6.4%	6.2%	0.2%	34.9%	23.6%	6.5%	10.1%	0.0%	1.4%	0.3%	5.3%	41.0	27.0	0.1	0.0	0.1	10.8%	-0.2%	126.3	159.0	32.8
	H6	GENERAL SURGERY	28	LOW	283.5	719	2259.8	1522.3	5.3	6.99	-1.73	7.26	-2.00	1.01	5.3%	1.28	10.9%	2.34	31.01	15.6%	15.6%	0.0%	72.2%	28.7%	1.5%	20.9%	0.3%	2.9%	1.2%	1.9%	60.0	56.0	0.0	0.0	0.0	9.7%	0.7%	-34.0	18.0	52.0
	H60	GENERAL SURGERY	28	LOW	126.0	748	2387.0	1724.5	5.5	6.99	-1.49	7.26	-1.76	-0.54	-2.8%	1.91	16.2%	1.34	31.01	9.8%	9.5%	0.3%	63.3%	28.4%	6.8%	12.7%	0.0%	0.9%	1.4%	6.6%	59.0	55.0	0.2	0.0	0.2	7.3%	-2.6%	-23.5	22.0	45.5
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	824	2539.3	1792.0	5.3	6.99	-1.73	7.26	-2.00	6.00	24.9%	-1.08	-10.1%	5.17	34.76	11.6%	7.6%	4.0%	46.3%	29.2%	2.3%	13.7%	0.0%	0.7%	0.6%	11.9%	59.0	56.0	0.2	0.2	0.0	13.7%	-6.6%	-48.5	33.0	81.5
	H100	GASTROENTEROLOGY	27	LOW	239.4	795	2124.5	1665.5	4.8	6.63	-1.86	6.29	-1.52	1.71	8.7%	0.79	6.1%	2.59	32.68	6.8%	6.8%	0.0%	54.3%	24.7%	4.0%	14.9%	0.0%	2.4%	0.0%	3.4%	62.0	53.0	0.0	0.0	0.0	16.4%	3.7%	-58.5	6.0	64.5
	H12	ORTHOPAEDIC	28	LOW	252.0	744	2371.5	2034.5	5.9	7.13	-1.21	7.25	-1.33	2.72	12.6%	-0.36	-2.7%	2.49	34.75	13.4%	13.1%	0.3%	64.5%	27.5%	2.1%	16.5%	0.2%	0.8%	1.3%	6.6%	33.0	27.0	0.2	0.0	0.2	10.5%	-1.0%	19.5	36.5	17.0
	H120	ORTHO / MAXFAX	22	LOW	283.5	589	2011.4	1663.0	6.2	7.13	-0.89	7.25	-1.01	1.25	7.6%	0.23	2.0%	1.56	28.17	10.8%	10.6%	0.2%	65.9%	27.2%	2.1%	14.1%	0.5%	2.6%	1.0%	6.9%	25.0	21.0	0.0	0.0	0.0	13.0%	2.3%	50.0	59.5	9.5
	HICU	CRITICAL CARE	22	LOW	252.0	525	12739.6	981.3	26.1	27.13	-0.99	26.60	-0.46	5.32	5.1%	-0.36	-4.9%	5.01	112.20	0.1%	0.1%	0.0%	101.9%	23.4%	3.7%	11.8%	0.4%	0.9%	0.9%	5.7%	67.0	55.0	0.0	0.0	0.0	12.6%	1.4%	496.7	561.7	65.0
	C9	ORTHOPAEDIC	35	LOW	252.0	812	2522.8	1565.8	5.0	7.13	-2.09	7.25	-2.21	2.48	11.3%	1.75	13.6%	4.34	34.79	9.5%	9.5%	0.0%	49.7%	34.6%	9.3%	15.5%	0.0%	5.1%	2.3%	2.4%	55.0	53.0	0.0	0.0	0.0	16.4%	0.4%	42.3	42.3	0.0
	C10	GENERAL SURGERY	21	LOW	252.0	545	2289.3	950.5	5.9	6.99	-1.05	7.26	-1.32	3.98	22.0%	2.26	28.0%	6.46	26.15	16.2%	16.2%	0.0%	71.9%	19.7%	3.7%	13.3%	0.8%	1.9%	0.0%	0.0%	59.0	53.0	0.2	0.0	0.2	8.6%	-1.7%	107.8	149.3	41.5
	C11	GENERAL SURGERY	22	LOW	252.0	498	2137.3	888.8	6.1	6.99	-0.91	7.26	-1.18	2.00	9.7%	2.02	25.1%	4.12	28.61	8.6%	8.6%	0.0%	38.5%	27.7%	7.5%	16.7%	1.1%	1.3%	1.1%	0.0%	55.0	53.0	0.0	0.0	0.0	22.7%	3.1%	-156.0	47.8	203.8
	C14	GENERAL SURGERY	27	LOW	252.0	688	2383.9	1204.4	5.2	6.99	-1.77	7.26	-2.04	0.55	2.7%	-0.03	-0.3%	0.55	29.84	7.1%	7.1%	0.0%	58.1%	30.2%	6.2%	16.9%	0.0%	2.4%	1.3%	3.4%	48.0	48.0	0.0	0.0	0.0	12.7%	2.9%	-31.8	38.8	70.5
	C15	UROLOGY	26	MEDIUM	283.5	597	2344.2	1451.3	6.4	6.47	-0.11	6.67	-0.31	4.74	23.0%	0.41	3.9%	5.38	31.01	10.8%	10.8%	0.0%	48.3%	25.8%	3.6%	11.1%	0.0%	4.2%	0.1%	6.8%	40.0	24.0	0.0	0.0	0.0	16.3%	0.7%	145.0	178.0	33.0
	C27	CARDIOTHORACIC	26	LOW	283.2	736	2716.5	1213.5	5.3	8.46	-3.12	9.93	-4.59	2.82	11.9%	-0.86	-10.0%	2.08	32.24	2.1%	2.1%	0.0%	70.7%	24.7%	2.6%	17.3%	0.0%	1.5%	1.1%	2.2%	54.0	53.0	0.0	0.0	0.0	15.1%	5.7%	4.5	8.0	3.5
	CICU	CRITICAL CARE	22	LOW	157.5	368	8636.8	724.3	25.4	27.13	-1.69	26.60	-1.16	2.77	3.1%	-1.03	-14.1%	1.77	98.08	0.9%	0.9%	0.0%	66.3%	28.7%	4.1%	14.8%	1.4%	1.4%	2.5%	4.5%	63.0	55.0	0.0	0.0	0.0	21.8%	7.0%	-564.7	72.0	636.7
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	354	1738.6	1100.0	8.0	6.58	1.44	9.03	-1.01	5.65	30.9%	2.38	21.3%	8.34	29.46	8.5%	8.5%	0.0%	46.6%	28.2%	9.0%	8.3%	0.7%	1.5%	1.1%	7.6%	58.0	55.0	0.0	0.0	0.0	28.8%	0.5%	-45.0	21.5	66.5
	H130	PAEDIATRICS	20	LOW	205.8	385	2352.5	890.5	8.4	11.44	-3.02	12.20	-3.78	-0.42	-2.0%	0.19	2.9%	-0.25	27.50	0.0%	0.0%	0.0%	-	28.5%	3.4%	14.2%	0.0%	0.6%	0.8%	9.5%	59.0	55.0	0.0	0.0	0.0	18.6%	0.9%	-11.0	12.0	23.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	246	1714.0	595.5	9.4	8.02	1.37	7.70	1.69	-0.12	-1.1%	0.37	9.5%	0.24	14.62	6.7%	6.7%	0.0%	68.4%	17.2%	0.7%	14.8%	0.0%	0.1%	1.6%	0.0%	50.0	45.0	0.0	0.0	0.0	27.2%	-2.3%	-35.0	17.5	52.5
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	357	2088.8	1369.8	9.7	10.11	-0.42	15.48	-5.79	-1.65	-3.93%	-0.39	-1.73%	-2.04	64.53	2.3%	2.3%	0.0%	88.1%	30.7%	12.7%	13.1%	0.4%	2.3%	1.0%	1.2%	65.0	60.0	0.0	0.0	0.0	11.1%	-3.1%	0.0	0.0	0.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1097	2891.8	1566.0	4.1	10.11	-6.05	15.48	-11.42							0.3%	0.3%	0.0%	39.3%	19.1%	3.3%	11.4%	0.6%	1.4%	0.0%	2.4%	65.0	60.0	0.4	0.3	0.1	8.7%	-1.3%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	225	2285.0	407.0	12.0	9.11	2.85	11.01	0.95	0.28	1.4%	-1.23	-19.3%	-0.94	26.64	1.1%	1.1%	0.0%	44.4%	29.9%	10.1%	14.6%	0.0%	2.5%	2.7%	0.0%	48.0	-24.0	0.0	0.0	0.0	19.3%	-4.6%	11.0	11.0	0.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	290	1478.0	383.0	6.4	11.20	-4.78	10.70	-4.28	0.45	9.6%	-0.33	-7.1%	0.22	19.48	0.0%	0.0%	0.0%	-	19.5%	0.3%	16.8%	1.7%	0.6%	0.1%	0.0%	31.0	30.0	0.0	0.0	0.0	23.3%	0.5%	-65.5	6.5	72.0
	LABOUR	MATERNITY	16	LOW	369.5	263	5666.8	1334.3	26.6	10.11	16.51	15.48	11.14	-13.29	-127.3%	-4.43	-42.4%	-18.99	55.36	3.3%	3.3%	0.0%	92.4%	23.3%	4.5%	13.3%	0.4%	2.4%	2.6%	0.1%	65.0	60.0	0.3	0.3	0.0	4.6%	-5.8%	14.0	50.0	36.0
	NEONATES	NEONATOLOGY	26	LOW	157.5	680	7752.5	351.0	11.9	13.26	-1.34	12.98	-1.06	6.78	129.9%	1.4	26.8%	9.48	77.01	2.8%	2.8%	0.0%	83.1%	34.1%	7.1%	15.1%	0.7%	1.0%	0.9%	9.3%	46.0	45.0	1.2	1.2	0.0	19.5%	-2.6%	23.0	23.0	0.0
	PAU	PAEDIATRICS	10	LOW	0.0	85	1205.5	0.0	14.2	11.44	2.74	12.20	1.98	1.13	10.8%	0	0.0%	1.13	10.44	0.0%	0.0%	0.0%	-	13.8%	6.3%	6.1%	0.0%	1.4%	0.0%	0.0%	56.0	55.0	0.1	0.1	0.0	9.1%	1.9%	-23.0	0.0	23.0
	PHDU	PAEDIATRICS	4	LOW	0.0	85	1334.0	165.8	17.6	11.44	6.20	12.20	5.44	1.07	9.2%	0	0.0%	1.07	12.66	3.8%	3.8%	0.0%	100.0%	28.6%	12.8%	14.5%	0.0%	1.3%	0.0%	0.0%	59.0	55.0	0.0	0.0	0.0	2.7%	-7.0%	0.0	12.0	12.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	323	1436.3	845.3	7.1	7.76	-0.70	7.91	-0.85	0.22	2.8%	-0.78	-9.8%	-0.53	19.40	0.0%	0.0%	0.0%	-	21.6%	0.2%	19.8%	0.0%	1.5%	0.1%	0.0%	48.0	48.0	0.0	0.0	0.0	8.4%	-0.2%	-26.5	0.0	26.5
	C29	REHABILITATION	15	LOW	147.0	456	1468.0	2306.0	8.3	7.69	0.59	6.66	1.62	1.77	11.3%	1.59	10.2%	3.47	28.28	6.7%	6.7%	0.0%	63.5%	26.3%	3.5%	18.9%	0.0%	3.0%	0.9%	0.0%	54.0	54.0	0.8	0.8	0.0	15.4%	3.5%	62.0	94.0	32.0
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	642	1677.8	1098.3	4.3	7.92	-3.60	7.14	-2.82	1.18	14.9%	0.3	3.8%	1.63	21.59	13.7%	13.3%	0.4%	68.0%	28.3%	4.9%	14.2%	3.9%	2.3%	1.3%	1.7%	60.0	56.0	0.0	0.0	0.0	6.2%	-1.9%	14.0	30.5	16.5
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	709	1877.1	1289.0	4.5	7.92	-3.45	7.14	-2.67	5.64	54.0%	2.16	20.7%	8.34	27.95	12.2%	7.3%	4.9%	68.4%	19.6%	6.9%	10.3%	0.3%	2.1%	0.0%	0.0%	51.0	48.0	0.3	0.2	0.1	9.4%	-1.5%	16.5	67.0	50.5
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	655	1754.5	1381.5	4.8	7.92	-3.13	7.14	-2.35	1.96	24.7%	0.03	0.4%	2.24	21.59	6.8%	4.4%	2.4%	57.9%	23.3%	3.1%	17.9%	0.0%	2.2%	0.1%	0.0%	54.0	53.0	0.1	0.1	0.0	10.5%	-2.2%	32.0	34.0	2.0
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	696	2743.8	1228.1	5.7	8.21	-2.50	7.23	-1.52	1.09	13.7%	-2.01	-25.3%	-0.78	35.22	7.7%	7.7%	0.0%	79.3%	32.8%	5.2%	15.5%	0.1%	1.3%	0.3%	10.4%	48.0	47.0	0.0	0.0	0.0	15.8%	2.7%	-44.0	35.5	79.5
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR			TOTALS:	10473.6	29449	131895.2	66202.7	6.73	8.84	-42.54	9.25	-62.62	134.72	10.4%	9.96	1.9%	151.00	1802.02	7.5%	6.8%	0.7%	62.1%	26.4%	5.5%	14.1%	0.7%	1.9%	1.3%	3.0%	51.0	44.2	8.2	4.7	3.5	16.6%	0.3%	1063.9	4029.8	2965.8

HEY NURSE STAFFING KEY METRICS DASHBOARD

May-19

KEY METRICS ROTA: 14th May 2019 - 9th June 2019

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST: Other care staff not currently included in CHPPD HPW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M2]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN- Est. [WTE]	TEMPORARY STAFFING [13th May - 9th Jun-19]: TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE: 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%]	ROTA APPROVALS [42 DAYS]: FULL [DAYS]	PARTIAL [DAYS]	ADDITIONAL DUTIES: TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [<20%]: UNFILLED ROSTER [%]	HOURS BALANCES [4 WEEKS] [NET + /- 2%]: HOURS BALANCE [%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]: NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	6.11	5.8%	3.31	15.2%	9.48	126.79	5.9%	5.4%	0.5%	83.1%	28.1%	9.1%	15.1%	1.1%	2.0%	0.5%	0.3%	59.0	51.0	0.4	0.0	0.4	14.3%	0.9%	62.3	62.3	0.0
MEDICINE	AMU	GENERAL MEDICINE	45	LOW	178.5	1179	5397.3	2975.5	7.1	7.55	-0.45	7.31	-0.21	10.92	21.2%	4.32	15.4%	15.45	79.63	4.1%	3.5%	0.6%	55.8%	26.2%	6.3%	13.4%	0.0%	3.2%	1.1%	2.2%	26.0	25.0	0.0	0.0	0.0	16.3%	-0.1%	39.7	102.2	62.5
MEDICINE	H36	GENERAL MEDICINE	24	LOW	399.0	657	2027.0	1861.5	5.9	7.55	-1.63	7.31	-1.39	0.99	7.3%	-2.47	-31.1%	-1.41	21.59	6.4%	5.6%	0.8%	49.4%	23.2%	2.3%	9.2%	3.6%	3.4%	2.1%	2.6%	59.0	59.0	4.5	1.4	3.1	23.0%	1.7%	189.4	311.5	122.1
MEDICINE	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	615	2188.5	1727.5	6.4	6.94	-0.57	7.74	-1.37	5.61	29.4%	1.30	9.9%	7.20	32.27	29.8%	28.0%	1.8%	89.5%	25.4%	5.2%	15.5%	2.0%	2.7%	0.0%	0.0%	26.0	26.0	0.1	0.0	0.1	6.5%	1.5%	-8.0	31.0	39.0
MEDICINE	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	770	2923.0	1729.0	6.0	6.74	-0.70	6.38	-0.34	3.11	12.9%	2.72	20.7%	5.96	37.25	12.8%	11.4%	1.4%	39.3%	27.6%	13.6%	13.6%	0.3%	0.1%	0.0%	0.0%	41.0	38.0	1.0	1.0	0.0	18.7%	-1.4%	49.5	55.5	6.0
MEDICINE	H50	NEPHROLOGY	19	LOW	283.5	577	1681.2	1291.8	5.2	7.23	-2.08	7.00	-1.85	-0.08	-0.5%	-0.26	-11.1%	-0.35	17.20	3.6%	3.6%	0.0%	67.6%	26.8%	3.4%	14.9%	2.1%	0.9%	2.2%	3.3%	60.0	59.0	1.1	1.1	0.0	17.0%	-1.6%	-60.5	11.0	71.5
MEDICINE	H500	RESPIRATORY MEDICINE	24	LOW	157.5	718	1665.0	1804.5	4.8	6.74	-1.91	6.38	-1.55	4.77	29.1%	2.01	15.3%	7.07	29.53	6.7%	6.1%	0.6%	27.6%	16.7%	1.5%	13.3%	0.0%	1.7%	0.2%	0.0%	17.0	5.0	0.0	0.0	0.0	19.0%	3.2%	23.5	56.0	32.5
MEDICINE	H10	GENERAL MEDICINE	27	MEDIUM	441.0	246	2070.1	2566.8	18.8	7.55	11.30	7.31	11.54	13.16	61.0%	-2.04	-15.5%	11.73	34.75	26.3%	21.4%	4.9%	66.0%	33.8%	5.2%	13.2%	4.0%	5.2%	6.2%	0.0%	31.0	31.0	0.6	0.6	0.0	20.8%	9.1%	220.6	309.6	89.0
MEDICINE	H8	GERIATRIC MEDICINE	27	LOW	220.5	822	1867.3	1763.5	4.4	6.94	-2.52	6.74	-2.32	2.18	13.3%	0.14	1.1%	2.45	29.53	5.5%	4.9%	0.6%	73.0%	27.7%	3.2%	11.8%	1.2%	3.9%	2.8%	4.8%	60.0	60.0	0.5	0.4	0.1	24.1%	-4.5%	42.5	73.0	30.5
MEDICINE	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	833	1488.4	2795.0	5.1	6.94	-1.80	6.74	-1.60	2.07	18.9%	0.66	4.2%	2.92	26.82	14.0%	9.4%	4.6%	85.0%	32.7%	6.3%	12.3%	0.9%	1.5%	7.1%	4.6%	34.0	34.0	0.7	0.3	0.4	21.4%	1.6%	141.5	158.5	17.0
MEDICINE	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	914	1875.4	2353.9	4.6	6.94	-2.31	6.74	-2.11	3.10	18.9%	-0.76	-4.9%	2.53	32.03	12.7%	11.1%	1.6%	47.9%	25.7%	3.6%	14.1%	0.0%	4.8%	3.2%	0.0%	54.0	33.0	0.3	0.3	0.0	20.7%	1.3%	-31.8	60.2	92.0
MEDICINE	H90	GERIATRIC MEDICINE	29	LOW	252.0	881	1748.3	1952.0	4.2	6.94	-2.74	6.74	-2.54	2.36	14.4%	-1.65	-12.5%	0.85	29.53	4.0%	4.0%	0.0%	75.8%	24.8%	5.4%	10.4%	0.0%	3.7%	2.6%	2.7%	82.0	67.0	0.6	0.6	0.0	19.6%	0.3%	-17.0	119.5	136.5
MEDICINE	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	854	1894.7	2112.5	4.7	7.55	-2.86	7.41	-2.72	7.10	32.9%	-1.95	-18.7%	5.48	32.03	7.7%	7.1%	0.6%	62.1%	27.1%	2.3%	14.4%	1.0%	3.6%	5.8%	0.0%	26.0	19.0	1.2	1.1	0.1	16.6%	-0.8%	37.5	69.5	32.0
MEDICINE	H110	STROKE / NEUROLOGY	24	LOW	252.0	583	2739.7	2093.0	8.3	7.55	0.74	7.41	0.88	6.90	25.3%	-2.84	-27.2%	4.31	37.72	13.7%	13.7%	0.0%	65.6%	29.3%	8.9%	14.4%	0.2%	2.2%	0.8%	2.8%	61.0	61.0	0.0	0.0	0.0	23.7%	3.4%	15.8	174.5	158.8
MEDICINE	CDU	CARDIOLOGY	9	LOW	0.0	92	1086.8	170.9	13.7	7.93	5.74	7.73	5.94	1.08	8.4%	0.52	21.3%	1.68	15.25	0.0%	0.0%	0.0%	0.0%	29.2%	10.2%	10.2%	0.0%	1.3%	0.0%	7.5%	62.0	48.0	0.0	0.0	0.0	47.3%	-1.9%	0.0	0.0	0.0
MEDICINE	C26	CARDIOLOGY / CTS	26	LOW	236.5	748	2703.0	1005.5	5.0	8.46	-3.50	9.93	-4.97	0.17	0.7%	-0.75	-9.5%	-0.57	32.03	0.8%	0.8%	0.0%	41.7%	21.2%	2.2%	13.9%	0.0%	3.1%	0.5%	1.5%	79.0	76.0	0.0	0.0	0.0	14.4%	4.0%	-51.0	17.0	68.0
MEDICINE	C28 /CMU	CARDIOLOGY	27	LOW	277.2	727	4072.5	938.0	6.9	7.44	-0.55	7.87	-0.98	10.12	26.7%	-1.01	-12.5%	9.38	46.04	1.6%	1.6%	0.0%	12.9%	27.6%	10.6%	13.6%	0.6%	2.8%	0.0%	0.0%	63.0	52.0	0.3	0.2	0.1	26.5%	3.5%	65.0	192.0	127.0
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	772	2441.4	1458.3	5.1	8.39	-3.34	8.71	-3.66	4.51	20.9%	1.15	11.0%	5.87	32.03	9.3%	9.3%	0.0%	74.2%	22.6%	5.3%	9.2%	0.0%	6.8%	1.3%	0.0%	38.0	38.0	0.2	0.1	0.1	20.5%	-0.8%	37.0	58.3	21.3
SURGERY	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	380	2504.5	1546.6	10.7	8.39	2.27	8.71	1.95	2.59	12.1%	-1.02	-11.0%	1.69	30.68	6.6%	6.1%	0.5%	34.3%	27.1%	7.3%	11.4%	0.2%	2.8%	0.0%	5.4%	12.0	9.0	0.4	0.3	0.1	15.6%	0.3%	17.0	68.5	51.5
SURGERY	H6	GENERAL SURGERY	28	LOW	283.5	734	2227.9	1528.8	5.1	6.99	-1.87	7.26	-2.14	1.01	5.3%	1.28	10.9%	2.34	31.01	18.1%	17.8%	0.3%	68.1%	28.9%	4.9%	14.8%	0.1%	2.2%	3.3%	3.6%	59.0	57.0	0.2	0.0	0.2	11.6%	-0.2%	33.8	77.8	44.0
SURGERY	H60	GENERAL SURGERY	28	LOW	126.0	755	2344.8	1759.8	5.4	6.99	-1.55	7.26	-1.82	-0.04	-0.2%	1.91	16.2%	1.87	31.01	15.5%	15.3%	0.2%	73.4%	27.8%	5.6%	13.0%	0.4%	0.7%	1.2%	6.9%	59.0	57.0	0.4	0.1	0.3	7.5%	-2.6%	69.0	112.0	43.0
SURGERY	H7	VASCULAR SURGERY	30	MEDIUM	283.5	859	2724.8	1806.5	5.3	6.99	-1.71	7.26	-1.98	6.50	27.0%	-1.08	-10.1%	5.69	34.76	14.1%	9.9%	4.2%	59.9%	31.0%	2.5%	11.8%	3.1%	0.5%	0.4%	12.7%	58.0	57.0	0.0	0.0	0.0	12.8%	-5.0%	-20.5	34.3	54.8
SURGERY	H100	GASTROENTEROLOGY	27	LOW	239.4	820	2250.6	1691.0	4.8	6.63	-1.82	6.29	-1.48	2.21	11.2%	0.79	6.1%	3.11	32.68	9.1%	8.5%	0.6%	50.5%	27.1%	1.7%	17.4%	0.3%	2.0%	1.3%	4.4%	61.0	60.0	0.4	0.2	0.2	18.6%	3.0%	8.5	18.0	9.5
SURGERY	H12	ORTHOPAEDIC	28	LOW	252.0	733	2409.8	1880.3	5.9	7.13	-1.28	7.25	-1.40	2.72	12.6%	0.11	0.8%	2.96	34.75	12.6%	12.6%	0.0%	50.0%	28.7%	3.8%	14.7%	0.5%	1.1%	0.8%	7.8%	26.0	18.0	0.0	0.0	0.0	12.7%	0.4%	12.3	72.8	60.5
SURGERY	H120	ORTHO / MAXFAX	22	LOW	283.5	598	2127.5	1576.4	6.2	7.13	-0.94	7.25	-1.06	0.57	3.5%	0.23	2.0%	0.83	28.17	4.9%	4.9%	0.0%	65.2%	21.6%	1.0%	8.8%	0.0%	3.9%	1.0%	6.9%	45.0	25.0	0.2	0.1	0.1	13.6%	2.6%	20.0	50.0	30.0
SURGERY	HICU	CRITICAL CARE	22	LOW	252.0	438	11675.3	785.8	28.5	27.13	1.32	26.60	1.85	4.98	4.8%	0.12	1.6%	5.15	112.20	0.2%	0.2%	0.0%	104.3%	28.7%	4.9%	14.7%	1.1%	1.0%	1.3%	5.7%	61.0	55.0	0.0	0.0	0.0	23.9%	0.6%	-517.3	43.0	560.3
SURGERY	C9	ORTHOPAEDIC	35	LOW	252.0	798	2500.5	1549.5	5.1	7.13	-2.05	7.25	-2.17	2.48	11.3%	1.75	13.6%	4.34	34.79	4.7%	4.7%	0.0%	30.8%	31.3%	8.4%	15.7%	1.3%	1.5%	3.2%	1.2%	47.0	47.0	0.1	0.0	0.1	15.0%	-0.2%	-28.0	28.5	56.5
SURGERY	C10	GENERAL SURGERY	21	LOW	252.0	544	2268.3	1098.3	6.2	6.99	-0.80	7.26	-1.07	3.98	22.0%	2.26	28.0%	6.46	26.15	13.2%	13.2%	0.0%	70.8%	17.3%	5.9%	9.2%	0.0%	2.2%	0.0%	0.0%	61.0	55.0	0.1	0.1	0.0	9.9%	0.6%	78.3	114.0	35.8
SURGERY	C11	GENERAL SURGERY	22	LOW	252.0	539	2405.8	1047.5	6.4	6.99	-0.58	7.26	-0.85	2.80	13.6%	2.26	28.0%	5.20	28.61	11.7%	11.7%	0.0%	65.7%	24.4%	7.5%	13.6%	0.4%	1.6%	1.3%	0.0%	62.0	55.0	0.2	0.1	0.1	14.2%	2.8%	-0.8	79.3	80.0
SURGERY	C14	GENERAL SURGERY	27	LOW	252.0	726	2473.2	1227.5	5.1	6.99	-1.89	7.26	-2.16	0.73	3.6%	-0.03	-0.3%	0.74	29.84	4.8%	4.8%	0.0%	52.5%	28.3%	4.4%	13.9%	0.0%	2.4%	1.8%	5.8%	62.0	55.0	0.1	0.1	0.0	12.3%	2.1%	90.0	105.5	15.5
SURGERY	C15	UROLOGY	26	MEDIUM	283.5	655	2427.9	1619.3	6.2	6.47	-0.29	6.67	-0.49	4.84	23.5%	0.35	3.4%	5.43	31.01	7.5%	7.2%	0.3%	41.6%	27.4%	3.5%	13.5%	0.0%	1.6%	1.3%	7.5%	19.0	18.0	0.1	0.1	0.0	13.1%	0.0%	45.8	68.3	22.5
SURGERY	C27	CARDIOTHORACIC	26	LOW	283.2	725	2835.5	1196.0	5.6	8.46	-2.90	9.93	-4.37	2.64	11.2%	-0.86	-10.0%	1.89	32.24	0.9%	0.9%	0.0%	84.5%	23.9%	4.6%	12.1%	0.0%	2.5%	1.8%	2.9%	48.0	47.0	0.0	0.0	0.0	12.8%	4.7%	0.0	0.0	0.0
SURGERY	CICU	CRITICAL CARE	22	LOW	157.5	500	10701.5	826.0	23.1	27.13	-4.08	26.60	-3.55	2.95	3.3%	-0.53	-7.2%	2.45	98.08	0.7%	0.7%	0.0%	58.3%	31.0%	4.7%	17.5%	1.8%	1.1%	2.6%	3.3%	61.0	55.0	0.5	0.4	0.1	14.3%	4.2%	385.5	446.3	60.8
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	419	1870.5	1111.3	7.1	6.58	0.54	9.03	-1.91	4.02	22.0%	2.88	25.8%	7.12	29.46	7.9%	7.9%	0.0%	40.4%	25.9%	6.3%	9.8%	1.6%	1.9%	1.2%	5.1%	48.0	48.0	0.1	0.1	0.0	25.4%	-0.9%	-77.5	17.0	94.5
FAMILY & WOMEN'S	H130	PAEDIATRICS	20	LOW	205.8	448	2241.5	839.0	6.9	11.44	-4.56	12.20	-5.32	-0.1	-0.5%	0.19	2.9%	0.09	27.50	0.0%	0.0%	0.0%	-	29.2%	3.1%	13.5%	0.0%	2.1%	0.8%	9.7%	48.0	48.0	0.0	0.0	0.0	21.1%	1.6%	-12.0	0.0	12.0
FAMILY & WOMEN'S	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	151	1563.8	542.0	13.9	8.02	5.93	7.70	6.25	-0.12	-1.1%	0.37	9.5%	0.24	14.62	1.6%	1.6%	0.0%	19.2%	21.6%	2.8%	16.1%	0.0%	1.5%	0.1%	1.1%	65.0	62.0	0.2	0.2	0.0	19.8%	-2.7%	46.0	46.0	0.0
FAMILY & WOMEN'S	H31 MAPLE	OBSTETRICS	20	LOW	0.0	432	2151.2	1454.0	8.3	10.11	-1.76	15.48	-7.13	-2.61	-6.22%	-0.39	-1.73%	-3.00	64.53	0.6%	0.6%	0.0%	86.7%	27.3%	6.3%	13.9%	2.3%	3.8%	0.2%	0.8%	59.0	55.0	0.1	0.1	0.0	11.6%	-2.0%	0.0	0.0	0.0
FAMILY & WOMEN'S	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1180	2940.5	1601.3	3.8	10.11	-6.26	15.48	-11.63							1.1%	1.1%	0.0%	80.0%	21.3%	2.1%	14.6%	0.6%	3.0%	1.0%	0.0%	59.0	55.0	0.0	0.0	0.0	10.5%	-2.6%	-12.0	0.0	12.0
FAMILY & WOMEN'S	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	261	2216.3	438.5	10.2	9.11	1.06	11.01	-0.84	0.28	1.4%	-1.23	-19.3%	-0.94	26.64	2.1%	2.1%	0.0%	84.1%	30.6%	9.7%	15.8%	1.1%	3.6%	0.4%	0.0%	69.0	48.0	0.4	0.4	0.0	22.1%	-5.2%	24.0	24.0	0.0
FAMILY & WOMEN'S	H35	OPHTHALMOLOGY	12	LOW	285.6	272	1541.0	332.0	6.9	11.20	-4.31	10.70	-3.81	0.95	20.3%	-0.33	-7.1%	0.82	19.48	0.7%	0.0%	0.7%	100.0%	13.9%	0.9%	11.0%	0.0%	2.0%	0.0%	0.0%	46.0	46.0	0.0	0.0	0.0	23.6%	0.8%	-102.0	0.0	102.0
FAMILY & WOMEN'S	LABOUR	MATERNITY	16	LOW	369.5	324	5723.3	1419.0	22.0	10.11	11.93	15.48	6.56	-13.29	-127.3%	-4.43	-42.4%	-18.99	55.36	2.2%	2.2%	0.0%	104.9%	27.4%	6.9%	14.0%	0.4%	3.0%	2.6%	0.5%	56.0	55.0	0.1	0.1	0.0	7.6%	-5.8%	23.0	23.0	0.0
FAMILY & WOMEN'S	NEONATES	NEONATOLOGY	26	LOW	157.5	581	7554.0	368.0	13.6	13.26	0.38	12.98	0.66	6.06	116.1%	1.4	26.8%	8.62	77.01	2.5%	2.5%	0.0%	87.4%	34.8%	6.6%	13.6%	1.6%	1.5%	0.4%	11.1%	26.0	25.0	0.1	0.0	0.1	21.1%	-1.9%	-12.0	0.0	12.0
FAMILY & WOMEN'S	PAU	PAEDIATRICS	10	LOW	0.0	95	1249.8	0.0	13.2	11.44	1.72	12.20	0.96	1.13	10.8%	0	0.0%	1.13	10.44	3.4%	3.4%	0.0%	98.6%	29.1%	9.0%	17.4%	0.0%	2.7%	0.0%	0.0%	55.0	-3.0	0.0	0.0	0.0	15.2%	-0.1%	0.0	12.0	12.0
FAMILY & WOMEN'S	PHDU	PAEDIATRICS	4	LOW	0.0	75	1402.5	93.8	20.0	11.44	8.51	12.20	7.75	1.07	9.2%	0	0.0%	1.07	12.66	3.2%	3.2%	0.0%	100.0%	26.0%	8.7%	13.2%	0.0%	4.0%	0.1%	0.0%	50.0	48.0	0.0	0.0	0.0	6.4%	-7.4%	141.5	158.5	17.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	349	1454.0	816.0	6.5	7.76	-1.26	7.91	-1.41	0.06	0.8%	-0.78	-9.8%	-0.71	19.40	0.5%	0.0%	0.5%	37.3%	21.7%	2.0%	15.7%	0.0%	3.0%	0.6%	0.4%	46.0	42.0	0.0	0.0	0.0	12.7%	4.0%	-40.5	11.5	52.0
CLINICAL SUPPORT	C29	REHABILITATION	15	LOW	147.0	464	1443.5	1629.0	6.6	7.69	-1.07	6.66	-0.04	1.77	11.3%	1.59	10.2%	3.47	28.28	1.7%	1.7%	0.0%	71.7%	29.9%	10.6%	14.9%	0.0%	3.2%	1.2%	0.0%	51.0	47.0	0.0	0.0	0.0	17.3%	3.1%	-51.0	24.5	75.5
CLINICAL SUPPORT	C30	CLINICAL ONCOLOGY	22	LOW	220.5	646	1693.2	1460.5	4.9	7.92	-3.04	7.14	-2.26	1.18	14.7%	0.59	7.4%	1.92	21.68	9.5%	9.5%	0.0%	53.7%	25.4%	7.4%	10.1%	0.0%	3.0%	1.5%	3.4%	65.0	61.0	1.0	0.8	0.2	8.7%	-2.0%	6.8	122.3	115.5
CLINICAL SUPPORT	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	667	1801.5	1224.5	4.5	7.92	-3.38	7.14	-2.60	6.14	58.8%	2.16	20.7%	8.89	27.95	12.9%	11.3%	1.6%	68.5%	24.3%	4.3%	15.8%	1.4%	2.7%	0.1%	0.0%	59.0	59.0	0.3	0.3	0.0	10.0%	-3.9%	167.0	196.5	29.5
CLINICAL SUPPORT	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	638	1794.9	1428.0	5.1	7.92	-2.87	7.14	-2.09	1.96	24.7%	0.03	0.4%	2.24	21.59	4.0%	1.6%	2.4%	45.3%	16.7%	0.4%	14.5%	0.0%	1.1%	0.7%	0.0%	58.0	49.0	0.2	0.1	0.1	5.7%	-1.7%	11.0	11.0	0.0
CLINICAL SUPPORT	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	709	2851.8	1172.9	5.7	8.21	-2.53	7.23	-1.55	1.39	17.5%	-1.51	-19.0%	0.06	35.22	7.9%	7.6%	0.3%	62.8%	30.4%	6.2%	14.2%	0.6%	1.2%	0.5%	7.7%	53.0	49.0	0.0	0.0	0.0	16.6%	2.7%	-47.5	114.0	161.5
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR			TOTALS:	10473.6	29503	135240.8	67668.3	6.88	8.84	-28.35	9.25	-48.43	135.03	10.4%	10.48	2.1%	152.20	1799.82	7.0%	6.4%	0.6%	62.6%	26.3%	5.4%	13.5%	0.7%	2.5%	1.4%	2.9%	50.6	44.9	16.7	10.7	6.0	16.7%	0.2%	1014.2	3939.8	2925.6

HEY NURSE STAFFING QUALITY INDICATORS

JULY 2019 (June 19 activity) (YTD Apr 19-Jun 19)

HR METRICS

IN PATIENT FALLS WITH HARM

ON ADMISSION & HOSPITAL ACQUIRED PRESSURE ULCERS

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	STAFF APPRAISAL [85%]	STAFF RETENTION [90.7%]	OVERALL MAND. TRAINING [90%]	I.G. TRAINING [95%]	BLOOD TRANS. [90%]	FIRE TRAINING [90%]	RESUS TRAINING [90%]	TISSUE VIABILITY TRAINING [90%]	MODERATE		SEVERE / DEATH		TOTALS		MASD				CATEGORY 2				CATEGORY 3				CATEGORY 4				DEEP TISSUE INJURY				UNSTAGEABLE				DEVICE RELATED [TOTAL]		TOTALS						
																		ON ADMISSION		HOSPITAL ACQUIRED		ON ADMISSION		HOSPITAL ACQUIRED		ON ADMISSION		HOSPITAL ACQUIRED		ON ADMISSION		HOSPITAL ACQUIRED		ON ADMISSION		HOSPITAL ACQUIRED		ON ADMISSION		HOSPITAL ACQUIRED				ON ADMISSION		HOSPITAL ACQUIRED		REQUIRE RCA		
												MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD	RCA Outstanding
EAM	ED	ACUTE MEDICINE	NA	92.6%	89.6%	93.9%	92.5%	98.1%	89.7%	94.4%	94.3%					0	0	10	26			84	38			14	37			1	4			12	51			20	56					141	212	0	0			
	AMU	ACUTE MEDICINE	45	87.1%	86.6%	95.9%	94.3%	97.1%	92.9%	75.7%	88.6%					0	0	2	8			11	25			2	6			1	2			6	16			1	6		1			23	63	0	1			
	H36	ACUTE MEDICINE	22			87.3%	95.7%	91.3%	65.2%	43.5%	81.6%					0	0					3	6				1	1	1					2	2	1	1		1	1	1	5	10	2	3			
MEDICINE	EAU	ELDERLY MEDICINE	21	100.0%	94.0%	97.5%	100.0%	90.3%	96.8%	96.8%	93.5%	1	1		1	1	2	4	19	1	1	13	33			1	1				1			1	7			1	11					20	72	0	0			
	H5 / RHOB	RESPIRATORY	26	62.9%	86.4%	85.5%	69.4%	94.4%	69.4%	83.3%	78.1%					0	0	1	1	1	1	2	4				1														1			3	6	0	0			
	H50	RENAL MEDICINE	19	96.0%	95.9%	93.6%	89.5%	94.7%	100.0%	94.7%	72.2%	1	1			1	1	1	1			2	8				1								1		1							3	11	0	1			
	H500	RESPIRATORY	24	55.6%	96.2%	84.7%	88.9%	92.6%	85.2%	70.4%	100.0%					0	0				1	1	3																					1	3	0	0			
	H70	ENDOCRINOLOGY	30	75.9%	89.9%	89.9%	89.7%	69.0%	89.7%	82.8%	89.7%	1	5			1	5		1	1	1		1																					0	2	0	0			
	H8	ELDERLY MEDICINE	27	93.8%	94.4%	95.1%	93.8%	93.8%	93.8%	90.6%	89.7%					0	0	3	5		3		5	2	2										2	1	1	2	4	1	1	2	2	5	16	4	4			
	H80	PDU	27			75.3%	88.9%	50.0%	70.4%	74.1%	54.5%					0	0			1	1				1																		0	0	0	1			
	H9	ELDERLY MEDICAL	30	82.1%	81.3%	88.2%	84.2%	89.5%	84.2%	92.1%	93.8%		1			0	1		1	1	2	1	2												1	1					1	1	1	4	1	1			
	H90	ELDERLY MEDICINE	29	100.0%	90.9%	96.9%	96.9%	96.9%	100.0%	90.6%	97.4%	1	1	1	2	2	3		1			1	2																					1	3	0	1			
	H11	STROKE / NEURO	28	88.9%	84.2%	85.5%	84.8%	84.8%	84.8%	75.8%	100.0%					0	0						1	1	1		1																0	2	1	1			SUI/2019/14406
	H110	STROKE / NEURO	24	78.8%	96.9%	83.6%	78.9%	76.3%	71.1%	78.9%	84.8%					0	0	1	2	1	3	2	2	4	7												1					1	3	3	4	4	8			
	CDU	CARDIOLOGY	9	92.3%	69.2%	92.4%	88.2%	94.1%	94.1%	94.1%	94.1%					0	0					1	1												1								1	2	0	0			
	C26	CARDIOLOGY	26	81.6%	98.3%	86.9%	86.1%	97.2%	86.1%	72.2%	92.6%					0	0		1			1	1		1																		1	2	0	1			
	C26 /CMU	CARDIOLOGY	27	60.0%	80.3%	86.1%	87.8%	95.1%	78.0%	73.2%	85.4%					0	0	2	3	2	3		3	2	2	1	1												2	1		1	3	9	2	3			
SURGERY	H4	NEURO SURGERY	28	89.3%	91.7%	84.2%	78.1%	90.6%	78.1%	75.0%	90.9%					0	0	1	2				2	1	1																		1	4	1	1			
	H40	NEURO / TRAUMA	15	52.9%	80.3%	85.9%	68.8%	81.3%	75.0%	71.9%	93.8%					0	0				1			1																	1	2	0	0	0	3			
	H6	ACUTE SURGERY	28	93.5%	96.5%	87.4%	90.0%	90.0%	70.0%	83.3%	81.6%					0	0			1	2			1																			0	0	0	1			
	H60	ACUTE SURGERY	28	96.8%	84.9%	85.2%	83.3%	96.7%	73.3%	80.0%	96.7%	1	1			1	1	1	3	1	2														1								1	4	0	0			
	H7	VASCULAR SURGERY	30	50.0%	97.1%	81.2%	71.1%	86.8%	65.8%	63.2%	90.0%					0	0	1	1		1	5	8		3		1								5	1	2	2	10	1	2		1	8	25	2	7			
	H100	GASTRO	24	85.3%	92.2%	89.1%	76.5%	97.1%	73.5%	76.5%	73.9%	1	1			1	1	2	3	0	2				2												2					1	2	3	0	4			
	H12	ORTHOPAEDIC	28	86.5%	93.2%	96.1%	92.1%	100.0%	84.2%	94.7%	78.9%					0	0	2	3	1	4		3	1	2									1	2	1	1		1			1	3	8	2	4			
	H120	ORTHO / MAXFAX	22	67.7%	96.6%	98.2%	93.5%	100.0%	93.5%	96.8%	89.5%					0	0				1		3	1	3												1		1	1	2	0	4	1	5			
	HICU	CRITICAL CARE	22	79.6%	92.6%	91.8%	86.7%	94.2%	91.7%	82.5%	89.4%					0	0		2	1	4		1	1	3										1		2				1	5	0	4	1	5			
	C9	ORTHOPAEDIC	35	70.7%	94.0%	91.2%	84.6%	92.3%	76.9%	71.8%	81.6%					0	0				1	1	1		2												1	1				1	2	0	3			
	C10	COLORECTAL	21	65.2%	75.9%	83.5%	91.3%	91.3%	73.9%	78.3%	76.9%					0	0			1	2	1	2																			1	2	0	0			
	C11	COLORECTAL	22	64.0%	92.6%	93.4%	96.3%	100.0%	85.2%	77.8%	88.2%					0	0				1															1						0	0	0	1			
	C14	UPPER GI	27	87.5%	87.5%	82.2%	62.9%	88.6%	80.0%	85.7%	93.5%					0	0				2	2	3	2	5											1	1						2	3	3	6			SUI/2019/13130
	C15	UROLOGY	26	46.7%	85.1%	87.2%	84.8%	78.8%	84.8%	72.7%	80.0%					0	0	1	4	1	2	1	3	3	4				1							1	1				1	1	2	0	4	5			
	C27	CARDIOTHORACIC	26	78.4%	91.5%	89.3%	86.1%	88.9%	83.3%	66.7%	91.7%					0	0																									0	0	0	0			
	CICU	CRITICAL CARE	22	84.2%	92.1%	94.6%	86.5%	94.2%	86.5%	88.5%	85.7%					0	0			1	1			1	1												2					1	3	0	0	1	3			
FAMILY & WOMEN'S	C16	ENT / BREAST	30	51.9%	100.0%	93.7%	92.6%	88.9%	77.8%	66.7%	81.8%					0	0					2	2	1												1	1					1	2	2	1	2			
	H130	PAEDS	20	80.0%	82.2%	90.6%	97.0%	77.4%	78.8%	69.7%	93.8%					0	0							1																		1	0	0	0	1			
	H30 CEDAR	GYNAECOLOGY	9	94.1%	100.0%	93.3%	100.0%	100.0%	68.8%	93.8%	94.3%					0	0				1																					0	0	0	0			
	H31 MAPLE	MATERNITY	20	98.7%	94.3%	91.5%	92.3%	88.5%	84.6%	92.3%	87.5%					0	0																									0	0	0	0			
	H33 ROWAN	MATERNITY	38		94.3%																																					0	0	0	0			
	H34 ACORN	PAEDS SURGERY	20	93.5%	87.4%	97.1%	100.0%	100.0%	86.7%	83.3%	83.3%					0	0											1													1	0	0	0	1			
	H35	OPHTHALMOLOGY	12	95.0%	95.5%	98.1%	100.0%	94.7%	94.7%	100.0%	85.0%					0	0																									0	0	0	0			
	LABOUR	MATERNITY	16	77.2%	99.0%	88.9%	96.1%	93.4%	86.8%	84.2%	67.7%					0	0																									0	0	0	1			
	NEONATES	CRITICAL CARE	26	84.0%	85.6%	95.9%	96.4%	96.4%	86.9%	92.9%	93.4%					0	0																									0	0	0	0			
	PAU	PAEDS	10	100.0%	100.0%	95.6%	100.0%	100.0%	84.6%	84.6%	94.7%					0	0																									0	0	0	0			
	PHDU	CRITICAL CARE	4	66.7%	78.0%	94.0%	91.7%	100.0%	91.7%	75.0%	76.9%					0	0							1																	1		2	0	0	0	2			
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	19	80.0%	100.0%	93.9%	100.0%	90.0%	90.0%	85.0%	86.7%					0	0							1																			0	0	0	1			
	C29	REHABILITATION	15	57.1%	96.6%	88.0%	82.1%	82.1%	75.0%	82.1%	88.9%					0	0			1	3	1	1	2				1															1	1	0	3			
	C30	ONCOLOGY	22	89.5%	84.7%	98.1%	95.5%	90.9%	95.5%	90.9%	89.3%					0	0		1			1	3												1				1	4					2	9	0	0			
	C31	ONCOLOGY	27	88.9%	88.4%	87.3%	100.0%	95.2%	86.4%	81.8%	100.0%					0	0	1	4		1	3	9				1							3	4		1		2					7	20	0	1			
	C32	ONCOLOGY	22	88.9%	94.4%	95.7%	100.0%	100.0%	100.0%	91.3%	85.7%					0	0				1	4	8												2			1	3	1				5	13	0	1			
	C33	HAEMATOLOGY	28	64.7%	92.2%	91.9%	92.1%	100.0%	86.8%	73.7%	100.0%					0	0				2		2	1	1										2								0	4	1	1			
TOTALS :				80.3%	90.6%	90.5%	89.3%	91.3%	83.7%	81.5%	87.4%	6	11	0	1	3	0	7	14	33	92	16	50	0	143	186	20	49	18	51	1	3	2	8	0	0	25	99	8	23	28	101	2	12	10	30	249	529	31	87	0	0	0	0

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
SAFE STAFFING VALIDATION FLOW CHART

STAGE 1 VALIDATION

- All Nurse Rosters signed off by Charge Nurse & Senior Matron 6 weeks in advance.
- Nurse in Charge records attendance on Safe Care at the beginning of each Shift.
- Ward Charge Nurse confirms accuracy of shifts worked each week.

STAGE 2 VALIDATION

- Information Services run Safe Staffing Report
- Senior Matron reviews and validates each rota checking for accuracy and shift anomalies.
- Confirmation of supervisory shifts worked and CHPPD shifts in calculation.
- Health Group Nurse Director confirms accuracy.

STAGE 3 VALIDATION

- Information Services run validated Safe Staffing Report.
- Report checked by Chief Nurse Information Officer and ensure all in-patient wards are present and reviews all recorded data for accuracy.

SAFE STAFFING REPORT PASSED STAGE 3 VALIDATION?

YES

NO

STAGE 4 VALIDATION

AUTHORISATION BY DEPUTY CHIEF NURSE TO UPLOAD to NHS DIGITAL

BACK TO HEALTH GROUP FOR STAGE 2 VALIDATION

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

29 JULY 2019

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

Purpose:	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits	
BAF Risk:	BAF Risk 3 – High Quality Care	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	Good progress continues to be made overall. Although elimination of all Red-rated fundamental standards has not been achieved fully, significant improvements have been made. The number of fundamental standards rated as Blue and Green have both increased to approximately 80% of the total (up from 78% in December 2018). Areas with red-rated standards are receiving help and support to help them improve. The Trust has had its first clinical area with all Blue Rated scores within CICU2 at CHH	

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

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

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits were introduced in 2015 and have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in January 2019. Good progress is being made and this report presents the position as at the end of June 2019.

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

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

Trust has had its first clinical area with all Blue Rated scores within CICU2 at CHH.

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

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and her Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our nursing and midwifery teams. The last report on this topic was presented to the Trust Board in January 2019. This provides a progress report up to the end of June 2019.

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

Table to illustrate the Nine Fundamental Standards – Inpatient Areas

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

Table 1

In July 2019 we are introducing our tenth fundamental standard – Recognise & Respond, as illustrated in **Appendix One**. This fundamental standard will assess clinical areas against our "Recognition of the Deteriorating Patient Policy. The fundamental standard will follow the agreed format:

- Observations of environment and patients' documentation
- Discussion with staff members

It will specifically assess clinical areas on:

- Acuity
- NEWS2
- Sepsis
- ReSPECT

The `Recognise and Respond` audits will be completed by members of the Critical Care Outreach Team and Sepsis Team. A trajectory has been set to have assessed all adult inpatient areas against this standard by December 2019. The results of which will be reported in Quarter Four`s Trust Board report.

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

Table to illustrate the Seven Fundamental Standards – Outpatient Areas

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

Table 2

2. ASSESSMENT PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

3. CURRENT POSITION

The results are shown for fifty two clinical areas. Firstly, Table 3 below illustrates the overall Trust position in relation to all of the ward fundamental standards as at the 30th June 2019 and the number of wards that are performing at each level.

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

Current Trust Position for all Ward Fundamental Standards: June 2019								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
36 wards	25 wards	3 wards	52 wards	18 Wards	24 wards	22 wards	11 Wards	47 wards
15 wards	24 wards	14 wards	0 wards	30 Wards	9 wards	16 wards	15 Wards	5 wards
1 wards	3 wards	35 wards	0 wards	4 Wards	15 wards	12 wards	16 Wards	0 wards
0 wards	0 wards	0 wards	0 wards	0 Wards	1 wards	1 wards	4 Wards	0 wards

Table 3

The following tables illustrate progress made in relation to each fundamental standard from January 2019 to June 2019, across the four Health Groups. In some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of the fundamental standard assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken currently and, as a priority, to address those fundamental standards rated Red.

3. STAFF EXPERIENCE

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
2	3	3	4	3	**7**	**7**	7	5	**11**	**16**	15	5	**9**	**9**	**10**
3	2	2	2	7	**3**	**3**	3	11	**6**	**1**	2	12	**9**	**10**	**8**
1	1	1	0	0	**0**	**0**	0	1	**0**	**0**	0	2	**1**	**0**	**1**
0	**0**	**0**	0	0	**0**	**0**	0	0	**0**	**0**	0	0	**0**	**0**	**0**

Progress since January: 29 reviews have been completed during this period. There are no Red-rated areas for this standard. The predominant rating for this standard across all the Health Groups is Blue with 36 of the 52 areas now rated as Blue overall.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
1	3	4	3	8	9	9	7	10	9	10	7	11	9	10	8
4	3	3	3	2	1	1	3	6	6	4	8	4	7	6	10
1	0	0	0	0	0	0	0	1	2	3	2	4	3	3	1
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since January: 32 reviews have been completed during this period. There is one outstanding review which could not be completed due to the IT improvement work taking place, within the tower block. There are no areas Rated Red. The predominant rating for this standard is Green. There has been a slight decrease in Blue rated areas within Family & Women's Health, Surgery and Medicine Groups which relate to failure to complete the required nurse cleaning at a weekend. Plans to address this issue are on-going and discussed under the infection control standard.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
0	0	0	0	0	0	0	0	5	5	5	2	4	4	2	1
3	4	4	3	3	3	1	1	5	4	2	6	7	5	4	4
3	2	2	3	7	7	8	9	7	8	9	9	8	9	12	14
0	0	0	0	0	0	1	0	0	0	1	0	0	1	1	0

Progress since January: 46 reviews have been completed during this period with 3 outstanding reviews for this standard this quarter, with a plan for these to be completed by the end of July 2019. There are no areas rated Red for this standard. Across all the Health Groups, the predominant rating remains Amber. The two main issues for this standard are the non-compliance of the multi-disciplinary team (Doctors & Allied Health Professionals) not adhering to the "Five Moments of Hand Hygiene". In order to address this, all future audits will identify the staff groups who are non-compliant; this will then be escalated through the individual Health Group governance structures to be actioned. Secondly, failure to clean equipment consistently at weekends. Although some areas have addressed this issue by pooling their ward hygienists/housekeepers to provide seven day cover, work continues to address this issue in conjunction with the Infection Control Team.

This standard is currently being reviewed by the Infection Control Team and the Practice Development Matron, the plan is to have a revised standard in place by Quarter 3.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
6	6	6	6	10	10	10	10	16	16	17	17	15	16	19	19
0	0	0	0	0	0	0	0	1	1	0	0	4	3	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since January: **43** reviews have been completed during this period. There are 5 outstanding reviews for this standard, with a plan to complete by the end August 2019. All areas are presently rated as Blue for this fundamental standard.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
2	3	3	3	5	7	7	6	4	4	5	5	5	5	4	4
3	3	3	3	5	3	3	4	13	12	11	11	8	12	13	12
1	0	0	0	0	0	0	0	0	1	1	1	6	2	2	3
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since January: 31 audits have been completed during this period. There are no outstanding reviews or Red Rated areas for this standard. The predominant rating for this standard is Green across the majority of the Health Groups apart from Family & Women's Health Group which is predominantly rated as Blue. The improvements are related to sustained compliance in 24 hour monitoring of medication fridges and controlled drugs checks.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
0	0	0	0	6	8	8	9	3	4	3	7	2	3	3	8
2	3	3	4	1	1	1	0	4	4	5	3	2	3	4	2
4	3	3	2	3	1	1	1	10	9	9	7	11	7	7	5
0	0	0	0	0	0	0	0	0	0	0	0	1	3	2	1

Progress since June: 32 reviews have been completed during this period, with 3 outstanding reviews for this standard, with a plan to complete by the end of August 2019. The number of Red Rated areas has reduced to one overall for this standard.

The Red rated score relates to H70 who have been rated Red for their last two reviews, although progress had been made with an increase in scores from 62% to 71%. Work continues under the supervision of the Senior Matron and Nurse Director to ensure all actions agreed are implemented and embedded.

There has been an increase in the number of Blue and Green-rated clinical areas within all the Health Groups. A sustained focus on addressing the themes highlighted through the use of the Yorkshire Contributory Factors Framework (YCFF) has supported the improvements in this fundamental standard. The Yorkshire Contributory Factors Framework is a tool which has an evidence base for optimizing learning and addressing causes of patient safety incidents (PSI`s) by helping clinicians and members of the Quality team identify contributory factors of PSIs.

An example of sustained change following the use of the YCFF in relation to this fundamental standard is ward 8 at HRI. Following the occurrence of a category 4 pressure ulcer in June 2018, the team have successfully achieved a Green rated and subsequent Blue rated score to date.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
0	1	1	1	4	4	6	6	4	6	6	7	2	1	4	8
6	3	2	2	4	4	2	2	9	8	8	7	10	8	4	5
0	2	3	3	1	1	1	1	4	3	3	3	6	8	8	5
0	0	0	0	0	0	0	0	0	0	0	0	1	2	3	1

Progress since June: 34 reviews have been completed during this period. There are 5 outstanding reviews, with a plan to complete by the end of August 2019. There has been an increase in Blue-rated scores within Surgery, Family and Women's & Medicine. There is one Red rated area for this standard within Medicine, which is H70. This is the second Red Rated score in relation to this fundamental standard for H70, and is due to the inconsistent re - assessment of patients when they have been transferred from the Acute Assessment Unit. In order to address this issue the Nursing Documentation has been reformatted and is currently being embedded within the clinical area, led by the Senior Matron and Nurse Director, in accordance with the fundamental standards escalation process, outlined on page 5 of this document.

In general there are no major concerns with this standard. Please note that this standard does not assess the documentation associated with, Nutrition, Infection Control and Tissue Viability as these are covered separately.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
2	5	5	3	4	3	2	0	3	4	4	4	2	2	2	4
4	1	1	3	1	2	4	3	5	4	6	5	4	4	3	4
0	0	0	0	1	1	1	4	7	6	3	7	6	7	4	5
0	0	0	0	1	1	0	0	2	3	4	1	4	3	7	3

Progress since June: 37 reviews completed during this period. This is the most challenging standard to achieve consistently high scores in. The majority of clinical areas are Rated Green or Blue but there are still four areas rated as Red for this fundamental standard.

Following the completion of the annual nutrition census, the results were triangulated with the themes obtained from the Fundamental Standard on Nutrition. The results were presented to the ward sisters/charge nurses at an extraordinary meeting, chaired by the DCN and attended by the dietetic team. A robust set of actions were agreed. This has resulted in a significant improvement in this standard, particularly in the Medicine Health Group, which had 7 Red Rated areas in April 2019 and at the time of this report being compiled, the Health Group had 3.

Although good progress has been made in relation to this Fundamental Standard, it is acknowledged that two of the clinical areas in medicine have been rated red for a significant period of time, (H80/H11). Additional support is currently been provided by the Senior Matrons for these areas, to ensure the actions agreed by the DCN following the extraordinary meeting are being implemented.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19	Jun 18	Dec 18	Mar 19	June 19
2	6	6	6	6	8	10	10	9	14	14	15	9	14	13	16
3	0	0	0	4	2	0	0	5	3	3	2	5	4	6	3
1	0	0	0	0	0	0	0	3	0	0	0	5	1	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Progress since January: 22 reviews completed during this period. There are no Red-rated areas for this standard. There has been an increase in Blue-rated clinical areas for this standard across all the Health Groups and a reduction in Amber and Green-rated standards. There are no major concerns with this standard.

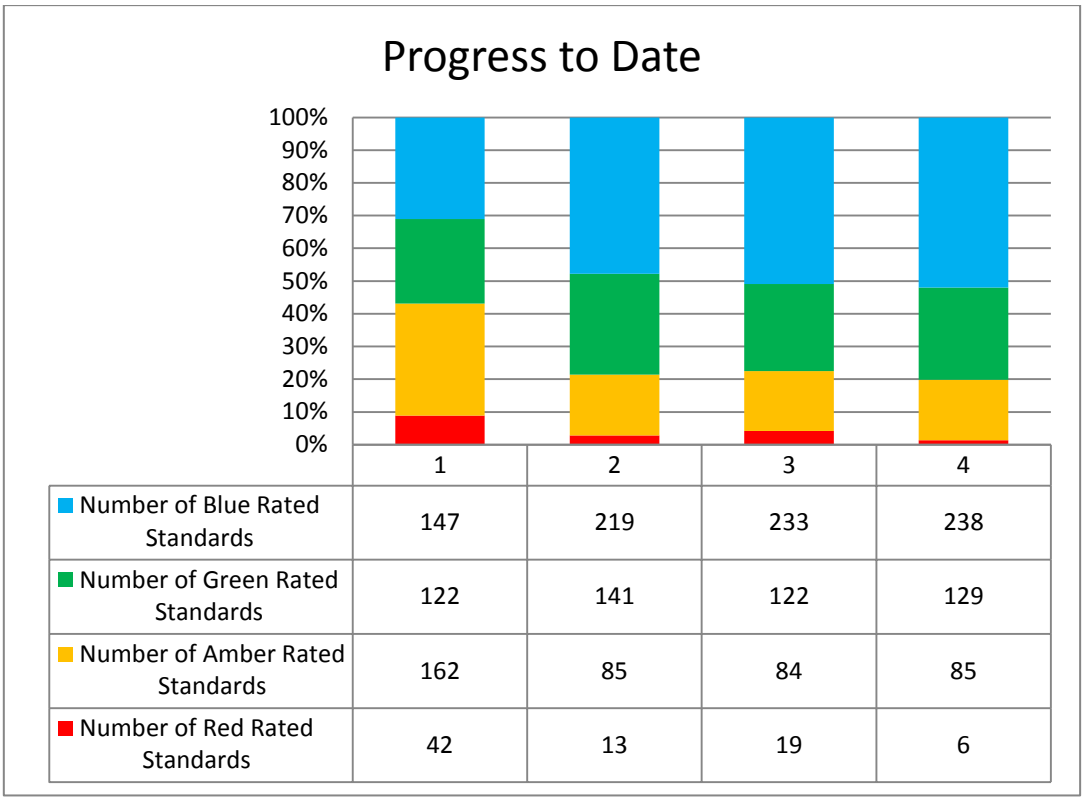
11. OVERALL POSITION:
47 of the 52 clinical areas reviewed have no Red Standards. Figure 1 illustrates the progress that has been made from a Trust perspective over the last six months in the increase in standards rated Blue and Green.

There are 6 standards rated as red, currently:

- 4 - Nutrition
- 1 - Patient centred Care
- 1 - Tissue Viability

The breakdown of these is, as follows:

No. of Red Standards	Clinical Areas
One	H120, H80, H11, AMU
Two	H70



	1	2	3	4
Number of Blue Rated Standards	147	219	233	238
Number of Green Rated Standards	122	141	122	129
Number of Amber Rated Standards	162	85	84	85
Number of Red Rated Standards	42	13	19	6

Column 1: July 2016 / Column 2: December 2018 / Column 3: March 2019 / *Column 4: June 2019*
Figure 1

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

12. AREAS FOR IMPROVEMENT

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

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

In order to validate the fundamental standard process, an independent review of the Fundamental Standards audit process and was keen to understand the rationale for any unwarranted variation between clinical areas in achievement of the Fundamental Standards. A review was undertaken by the Assistant Chief Nurse – Special Projects, supported by the Practice Development Matron (PDM) who leads the Fundamental Standards process and the Deputy Chief Nurse (DCN).

The review highlighted a number of examples of good practice and good governance including:

- Comprehensive quarterly Board report providing assurance.
- Fundamental standards process incorporates CQC Key Lines of Enquiry.

- Audits are consistent, unannounced and undertaken by ‘subject experts’.
- Ward Sisters display their results on the ward and discuss areas for improvement at team meetings or 1:1s.
- The Deputy Chief Nurse holds 6 monthly meetings with each Ward Sister to go through the Fundamental Standards audit results and relevant action plans. This provides a mechanism for local ownership and accountability but also a mechanism for corporate identification of themes and trends in areas for improvement.
- Standards are also reviewed regularly at the Quality Committee along with relevant sections of the QIP.

A number of recommendations were presented by the Assistant Chief Nurse for discussion and action as required. These included:

- Further strengthen the governance of the process by developing a ‘ward to board’ quality assurance framework for nursing, which includes the 3 existing processes of fundamental standards audits, Matrons handbooks and census audits, how they are triangulated and used to drive improvements.
- Develop a monitoring framework which tracks completion of audits and escalation of non-completion within the required time frame.
- Medium risk wards to have assurance handbook completed monthly in full.
- Agree a framework for Senior Matrons to engage with front-line staff to help embed standards through face-to-face engagement, education and recognition of success.
- Consider how we recognise and celebrate positive achievements identified more widely and whether this should be linked to an accreditation status for exemplar wards.

These recommendations were accepted by the senior nursing team and are in the process of being implemented and agreed through the corporate Patient Effectiveness, Experience and Safety (PEES) meeting.

Although elimination of all Red-rated fundamental standards has not been achieved fully, significant improvements have been made, as demonstrated in the charts above. The number of fundamental standards rated as Blue and Green have both increased to approximately 80% of the total (up from 76% in September 2018).

In addition the Trust has had its first clinical area with all Blue Rated scores within CICU2 at CHH. The Chief Nurse and Senior Nursing Team are currently reviewing how these wards will be accredited and their success celebrated. It is envisaged that this process will be incorporated into the Nursing Quality Assurance Framework, which is currently being developed by the DCN and Practice development Matron, which will be presented to the Trust Board at a later date.

13. SUMMARY

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

14. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

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

Joanne Ledger
Deputy Chief Nurse

Caroline Grantham
Practice Development Matron
July 2019

Appendix One: Fundamental Standard Ten - Recognise & Respond

Appendix Two: Overview Fundamental Standards June 2019

Appendix One: Fundamental Standard 10 - RECOGNISE & RESPOND (Deteriorating patient)			Yes/No/NA
CHECK ENVIRONMENT			
1		The resuscitation trolley is easily accessible, clean & sealed	
2		Checking schedules identify and record that checking procedures have been completed: Daily	
3		Monthly	
4		All resuscitation boxes are in date	
		Checking schedule states oxygen & suction in working order on resus trolley	
		Oxygen & Suction checked by assessor	
5		Oxygen cylinders are stored correctly: within box or chained to a wall	
6		Oxygen cylinders in date	

ASK STAFF					
		Ask three RGNs State Grade			
7		Which patients should be monitored on the Spo2 scale 2?			
8		Who makes this decision and where should it be documented?			
9		State four patients who should have accurate fluid balance monitoring?			
10		How would you assess a patient for new confusion?			
11		What would trigger a sepsis screen?			
		Can the RGN state at least 3 Red Flags			
		How long do you have to complete the sepsis 6?			
12		Who would you escalate your concerns about a patient to?			
13		What would you do if your concerns about a patient where not met?			
14		If a patient requires O2 therapy and there is no piped oxygen at the bed space how do you ensure patient receives o2 therapy?			

CHECK DOCUMENTATION			**Yes (Y) No (N) or Not Applicable (NA)**									
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Acuity Check												
15		Acuity Score Set By Ward										
16		Do you agree with this acuity score?										
17		If No state score you have assessed patient to be:										
Deteriorating Patient Bundle												
18		Every paper chart clearly state: Patient ID, chart number, Clinical area where observations performed & date, year plus time of observations. (observations performed in that clinical area only, for last 4 days max)										
19		All observations recorded in NUMBERS not “dots & arrows”										

20		The frequency of observations recorded is reflected by the NEWS score										
21		All physiological observations recorded at least every 8 hrs										
22		NEWS score calculated correctly										
23		All patients transferred into clinical area had their observations recorded within 15 mins of transfer. If no, state time it took to complete observation — Completed										
		Time frame										
24		If scale 2 SpO2 used and the patient has a diagnosis of hypercapnic respiratory failure, which is demonstrated by a high PCO2 on an arterial blood gas, is this is clearly documented in the patient's medical notes										
25		If the patient has a NEWS score above 1 does the evaluation state any actions taken or escalation. This may be recorded in the patient's additional information.										
26		Patient has NEW CONFUSION/ALTERED MENTAL STATE recorded on their NEWS2 chart. Patient assessed for delirium										
Sepsis Pathway												
27		Patient has had a NEWS score of ≥5 or ONE parameter of 3 in the previous 48hrs (within this clinical area)										
		Sepsis screening commenced										
28		RED FLAG/S Triggered										
		Stated which Red Flags										
29		Patient referred for medical review										
30		SEPSIS 6 commenced										
		State date & time started										
31		Oxygen administered										
32		Blood cultures taken										
33		Blood taken for lactate (VBG or ABG)										
34		IV antibiotics administered										
35		IV Fluids administered										
36		Urine sample taken										
37		Hourly fluid balance monitoring commenced										
38		Where all above activities completed within one hour										
		If no state time:										
Fluid Balance Chart												

39		Fluid balance chart clearly states patient's name, DOB & date (check maximum of 4 charts per patient)										
40		All inputs are recorded as mls (check maximum of 4 charts per patient)										
41		All outputs are recorded as mls (check maximum of 4 charts per patient)										
42		Fluid balance chart correctly totalled (check maximum of 4 charts per patient)										
43		Running totals are completed 4hrly (check maximum of 4 charts patient)										
44		Patient has a positive/negative overall balance of 1000mls in the previous 24hrs this was escalated to the medical team										
45		Patient has been appropriately commenced on fluid balance monitoring – ask nurse caring for patient										
		State reason for fluid balance monitoring										
ReSPECT FORMS												
		Respect form Section One										
46		Are two of the following demographics clearly documented on the respect form: Full name, DOB, Address, NHS number										
46		Is the "date completed" box filled in?										
		Respect form Section Four										
48		Has the clinician indicated what the focus for emergency care & treatment should be?										
49		State: Life sustaining or Symptom control										
50		Has a box for resuscitation status been completed?										
		Respect Form section 7										
51		Has the respect form been signed correctly?										

Rating following visit	**Total Yes's**	**Total No's**	**Score**	**Review Due:**

Comments

Process

- Adult In-Patients areas audited randomly initially then reviewed as per percentage score from their previous review.
- Questions to Staff
    - Ask three RGNs (if posible)
    - State grade and please note if member of staff questioned is a permanent member of the clinical team or bank staff etc.
- Acuity Scores
    - Check a maximum of Ten Patient Records
    - State acuity score of the patient as stated by clinical area.
    - If you do not agree with this acuity score state the acuity score you believe the patient to be.
- NEWS 2 Bundle
    - Check a maximum of ten individual patient's bundles
    - Only audit the data for that clinical area
    - Review bundles a maximum of four days previously
    - Audit each of the 4 days documentation against the questions e.g. If the patients has only been an inpatient on that clinical area for 3 days and only two charts are completed correctly: mark as 2/3 in the relevant box.
- Sepsis Bundle
    - Check with Nurse in Charge number of patients with a NEWS score above 5 or one parameter of 3 within last three days
    - Review these patients records (maximum of ten patients)
    - Only audit data for that clinical area.
- Fluid Balance Chart
    - Check a maximum of ten patients on Fluid Balance Charts
    - Only audit data for that clinical area
    - Review FBC for a maximum of four days previously.
    - Audit each of the 4 days documentation against the questions e.g. If the patients has only been an inpatient on that clinical area for 3 days and only two charts are completed correctly: mark as 2/3 in the relevant box.
- ReSPECT Document
    - Check with nurse in charge number of patients with a ReSPECT form in place. Pick ten random patients.

Plan for Initial Roll Out

- 52 Reviews to complete
- All need completing by December 2019
    - 25 wards are priority HRI Tower Block
- Query Number of Reviewers
    - Sepsis x 2
    - Critical Care Outreach x 3
        - Each reviewer to complete a minimum of 2 reviews a month
- Following initial reviews each clinical area will be re-reviewed according to their overall rating.

July		August		September		October		November		December	
Reviews Required		Reviews Required		Reviews Required		Reviews Required		Reviews Required		Reviews Required	
Sepsis	Critical Care Outreach	Sepsis	Critical Care Outreach	Sepsis	Critical Care Outreach	Sepsis	Critical Care Outreach	Sepsis	Critical Care Outreach	Sepsis	Critical Care Outreach
H10	H5	H8	H4	H100	Paeds ED	C26	C29	CICU1 & 2	C11		
H110	H50	H9	H40	H36/H1	Cedar	C28	C30	C27	C14		
H11	H500	H80	H6	H35	Acorn	C7	C31	C16	C15		
AMU	H90	ED Resus	H60	HICU	Rowan	C33	C32	Labour	C5DW		
	H200		H12		Maple		C9		NICU		
	H7		H120		H130 & PHDU		C10				

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
30th July 2019

Title:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS – MATERNITY INCENTIVE SCHEME – YEAR TWO**
Responsible Director:	Beverley Geary - Executive Chief Nurse
Author:	Beverley Geary, Executive Chief Nurse Janet Cairns, Head of Midwifery Lisa Pearce Divisional General Manager

Purpose	The purpose of this report is to provide information and assurance in relation to the self-assessment against the ten safety actions requiring Trust Board approval, and sign off for submission to NHS Resolution.	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	The service is declaring full compliance against the ten maternity safety actions which have been subject to a confirm and challenge led by the Family and Women's Health Group Triumvirate.	

Recommendation	The Trust Board is requested to: • Review the evidence submitted and agree that the evidence demonstrates achievement of the ten maternity safety actions, and meets the required standards • Give their permission to the chief executive to sign the Board declaration form for submission to NHS Resolution By 15 August 2019 • Decide if any further information and/or assurance are required.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD JULY 2019

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

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information and assurance in relation to the self-assessment against the ten safety actions and sign off for submission to NHS Resolution in readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2019/20.

The Trust Board is required to approve a declaration form to be submitted by 12 noon on Thursday 15 August 2019 to NHS Resolution.

This report presents the following:

- Background
- The Trust's position in relation to compliance with the CNST safety actions
- Required evidence to be reviewed by the Board
    - Review of perinatal mortality in the Trust
    - Review of data submission to the Maternity Services Data Set
    - Action plan for Avoiding Term Admissions Into Neonatal units (ATAIN) programme
    - Demonstrating an effective system of medical workforce planning
    - Demonstrating an effective system of midwifery workforce planning
    - Compliance with Saving Babies Lives Care Bundle
    - Effective patient feedback mechanisms
    - Evidence of multidisciplinary maternity emergencies training
    - Identification that the local maternity safety champions are discussing and escalating local issues to the Board level champion routinely
    - All qualifying incidents under NHS Resolution Early Notification Scheme
- Formal recording in Board minutes for:
    - Review of perinatal mortality
    - Action plan for ATAIN
    - Action plan for medical workforce planning for Elective Caesarean Section cover
    - Confirmation of compliance with Anaesthesia Clinical Services Accreditaion (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6
    - Bi-annual Trust Board nursing and midwifery staffing reports
    - Review of qualifying incidents for NHS Resolution Early Notification Scheme
- Board declaration and sign off
- Summary of evidence

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST). This is administered by NHS Resolution (formerly the NHS Litigation Authority).

Due to the 'high-risk' nature of maternity services by definition, specific premia are calculated for these services; compliance against the 10 safety actions provides for an incentive of 10%. The Maternity CNST premium for the Trust for 2019/20 is £4.71m; therefore, the possible benefit to the Trust if all ten standards are met is £471k.

The standards have been augmented and now require much more detailed and very specific evidence in order to assure compliance. In addition, the Trust Board is required by NHS Resolution to be cited on the details of this and the Trust Board is required also to 'permit' the Chief Executive to sign the submission declaration on its behalf for submission in August 2019.

The evidence will be subject to external verification by the Care Quality Commission, NHS Digital, the National Neonatal Research Database and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths). Trust will then be notified of a successful submission in September 2019.

CNST Conditions of Scheme

4. THE MATERNITY INCENTIVE SCHEME

The 10 maternity safety actions are, as follows:

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

The Trust can demonstrate full compliance with all ten maternity safety actions. The self-assessment has been validated by the Head of Midwifery, the Clinical Lead for Maternity Services and the Divisional General Manager. The safety actions have been subject to a confirm and challenge from the Triumvirate of the Family and Women's Services Health Group and the Chief Nurse as the Executive Maternity Safety Champion.

Safety Action	Compliance	Board Request
1	COMPLIANT	Formal Board approval of Perinatal Mortality Review Tool reports
2	COMPLIANT	Board Declaration of assurance following evidence review
3	COMPLIANT	Formal Board approval of action plan for Avoiding Term Admissions into Neonatal Units (ATAIN)
4	COMPLIANT	Formal Board approval of action plan and recording of the results of the 2018 General Medical Council National Training survey. Board to record in the minutes the proportion of Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met.
5	COMPLIANT	Bi Annual Chief Nurse staffing report to Trust Board outlining: • Birthrate Plus® outcomes • Planned versus actual staffing levels • Midwife : Birth ratio • Compliance with supernumerary status and 1:1 care in labour
6	COMPLIANT	Board Declaration of assurance following evidence review
7	COMPLIANT	Board Declaration of assurance following evidence review
8	COMPLIANT	Board Declaration of assurance following evidence review
9	COMPLIANT	Board Declaration of assurance following evidence review
10	COMPLIANT	Board to record in the minutes the incidents reported to NHSR Early Resolution 2018/19

5. FINANCIAL IMPLICATIONS

If the Trust is successful in its application, this will result in a circa £471k saving against its CNST contributions for 2019/20 which is identified as part of the Family and Women's Health Group cost reducing efficiency savings (CRES) for 2019/20. A Quality Impact Assessment (QIA) has been undertaken as part of the Health Group Governance process for the CRES programme.

QIA Evidence

6. SAFETY ACTIONS

All ten maternity safety actions require Trust Board assurance of compliance against the minimal evidential requirements. This section of the report comprises information that the Trust Board is required to see in order to be able to comply with the evidential requirements of the Safety Actions.
Safety Actions: 1, 3, 4, 5 and 10 require a formal declaration of approval recorded in the minutes of actions plans and evidence submitted

6.1. Safety Action 1 Perinatal Mortality Review Tool (PMRT)

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

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

Safety Action 1 Evidence

6.2. Safety Action 2 Maternity Services Data Set

The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, admissions and re-admissions, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests. The quality and completeness of the data submission, relating to 3 mandatory criteria and 14 out of 19 optional criteria will be cross referenced by NHS Resolution and the deadline for submission is 30 June 2019.

Safety Action 2 Evidence

6.3. Safety Action 3 Avoiding Term admissions to Neonatal Unit (ATAIN)

The service has a transitional care facility which is managed by the Neonatal Unit situated on the postnatal ward. There are guidelines in place for admission and discharge and all data is recorded on the 'Badgernet' system. The maternity staff have undertaken e-learning for ATAIN and 100% of staff are compliant with this training. The Board is requested to formally record in the minutes the action plan for ATAIN which and has been agreed with both the Neonatal Operational Delivery Network (ODN) and the Local Maternity System (LMS) Board

Safety Action 3 Evidence

6.4. Safety Action 4 Medical Workforce Staffing

6.4.1. GMC National Training Survey

The board is requested to formally record in the minutes the results of GMC National Training Survey *Question: To what extent do you agree or disagree with the following statement? 'In my current post, educational/training opportunities are RARELY lost due to gaps in the rota'.*

Strongly agree	0.00
Agree	23.81
Neither agree nor disagree	14.29
Disagree	52.38
Strongly disagree	9.52
Not applicable	0.00
Grand Total	100.00

Safety Action 4 Action plan to address lost opportunities for education

6.4.2 Anaesthesia Clinical Services Accreditation (ACSA) standards.

The Board is requested to formally record the proportion of ACSA standards met:

Standard	Standard Description	Standard Met
1.2.4.6	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	**YES**
2.6.5.1	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident	**YES**
2.6.5.2	A separate anaesthetist is allocated for elective obstetric work	**YES**
2.6.5.3	Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies	**YES**
2.6.5.4	Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)	**YES**
2.6.5.5	There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit) *in HUTH this care is provide on the General ICU/HDU areas*	**N/A**
2.6.5.6	The duty anaesthetist for obstetrics should participate in labour ward rounds	**YES**

Safety Action 4 Action plan for Consultant cover for ELSC pathway

6.5. Safety Action 5 Midwifery Workforce

The Trust Board will receive bi-annual reports from the Chief Nurse which outline the systematic process to calculate midwifery staffing. These reports will include evidence to assure that the labour ward coordinator has supernumerary status and that women receive one to one care in labour.

Safety Action 5 Evidence

6.6 Safety Action 6 Saving Babies Lives (SBL) Care Bundle

The Trust Board has received reports which have identified full compliance with the SBL Care Bundle Version 1 published in 2016. The Trust submits quarterly surveys to the Clinical Network regarding compliance. Saving Babies Lives Care Bundle 2 was published in May 2019 and has delayed the submission and publication of Survey 13.

Safety Action 6 Evidence

6.7 Safety Action 7 Patient Feedback mechanism for maternity services

Maternity Voices Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. An MVP creates and maintains a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners. HUTH Trust feed into two MVPs for Hull and the East Riding of Yorkshire respectively. The MVPs have supported patient surveys and workshops to improve the maternity care services.

Safety Action 7 Evidence

6.8 Safety Action 8 Multidisciplinary Training

90% of all staff groups have undertaken an in-house multi-professional emergencies training session between August 2018 and August 2019.

Safety Action 8 Evidence

6.9 Safety Action 9 Maternity Safety Champions

The Trust is in Wave 3 of the Maternal and Neonatal Health Safety Collaborative and is actively engaged with supporting quality and safety improvement activity within the Trust and the Yorkshire and Humber Local Learning System.

The service is addressing two areas for safety improvement:
1. Stabilisation of the extremely pre-term infant
2. Reducing smoking in pregnancy

Safety Action 9 Evidence

6.10 Safety Action 10 NHS Early Resolution Scheme

The Trust Board is required to have sight of records of qualifying Early Notification Incidents and numbers reported to NHS Resolution Early Notification Team in the financial year 2018/19.

Safety Action 10 Evidence

7. SUMMARY

In summary, following a rigorous self-assessment process led by the Family and Women Health Group, the Trust has achieved compliance with all of the required CNST Incentive safety actions. The new standards require Board oversight, assurance and endorsement on all of the evidence required before being able to submit the Trust's application. The evidence is provided by means of hyper-links in this document and has been considered through a confirm and challenge process led by the Family and Women's Health Group Triumvirate.

8. RECOMMENDATIONS

The Trust Board is requested to:

- Review the evidence submitted and agree that the evidence demonstrates achievement of the ten maternity safety actions, which meet the required standards
- Give their permission to the chief executive to sign the Board declaration form for submission to NHS Resolution
    - Board Declaration Form
- Decide if any further information and/or assurance are required.

Janet Cairns
Head of Midwifery

Beverley Geary
Executive Chief Nurse

July 2019

Evidence Summary Table

Safety Action 1	Evidence available	Action Met	Further action required
Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	• Trust Board Reports • Overview of Deaths	**YES**	
Safety Action 2	**Evidence available**	**Action Met**	**Further action required**
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	• Confirmation from NHS Digital of compliance	**YES**	
Safety Action 3	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	• ATAIN compliance • Transitional Care Policy • Badgernet Data • ATAIN report • LMS and Neonatal ODN approval	**YES**	
Safety Action 4	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate an effective system of medical workforce planning?	• ACSA Standard compliance and action plan • RCOG survey results and action plan	**YES**	
Safety Action 5	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate an effective system of midwifery workforce planning?	• 1:1 care in labour • Supernumerary status of the Labour Ward Coordinator • Birthrate Plus® report • Escalation policy • TB reports of nursing and midwifery staffing	**YES**	

Safety Action 6	Evidence available	Action Met	Further action required
Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	• Saving Babies Lives Surveys • Trust Board updates • Perinatal Mortality Presentation	**YES**	
Safety Action 7	**Evidence available**	**Action Met**	**Further action required**

Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	• Maternity Voices Partnership (MVP) Work Plans
	• Patient Engagement
	  ○ Whose Shoes event
	  ○ Picker survey
	  ○ MVP survey
		YES	

Safety Action 8	**Evidence available**	**Action Met**	**Further action required**
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	• Training compliance data	**YES**	
Safety Action 9	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	• Local Learning Systems • Maternal and Neonatal Safety Collaborative • Maternity Safety Champions	**YES**	
Safety Action 10	**Evidence available**	**Action Met**	**Further action required**
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	• Qualifying incidents for 2018/19	**YES**	

Appendix Two: FUNDAMENTAL STANDARDS June 2019

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C7	99%	Jan 20	96%	Sept 19	89%	Oct 19	100%	Mar 20	93%	Jan 20	90%	Sept 19	93%	Jan 20	97%	Dec 19	97%	Dec 19
C29	97%	Jan 20	95%	Oct 19	90%	Nov 19	96%	Mar 20	93%	Sept 19	**89%**	Oct 19	**95%**	Sept 19	90%	Mar 20	95%	Oct 19
C30	96%	May 20	91%	Mar 20	**83%**	Aug 19	100%	Mar 20	96%	April 20	94%	Dec 19	91%	Jan 20	**93%**	Sept 19	97%	Aug 19
C31	98%	May 20	97%	Mar 20	86%	Jan 20	100%	Mar 20	93%	Sept 19	94%	Mar 20	86%	Sept 19	95%	Sept 19	96%	Aug 19
C32	93%	Oct 19	93%	Mar 20	92%	June 19	100%	Mar 19	96%	April 20	82%	Jan 20	**86%**	July 19	91%	Mar 20	97%	Dec 19
C33	93%	Feb 20	93%	July 19	**80%***	Oct 19	95%	Jan 20	96%	Dec 19	86%	Sept 19	80%	July 19	96%	Nov 19	98%	Dec 19

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	95%	Dec 19	95%	Sept 19	81%	Jan 20	100%	Jan 20	97%	April 20	98%	Jan 20	100%	Dec 19	88%	Dec 19	96%	Jan 20
Cedar H30	98%	Feb 20	95%	Sept 19	80%*	Aug 19	100%	Feb 20	96%	Dec 19	97%	Jan 20	82%	Aug 19	85%	Sept 19	100%	Feb 20
H31Maple	92%	Feb 20	93%	April 20	**80%***	Sept 19	97%	Jan 20	93%	Oct 19	100%	April 20	100%	Jan 20	NA		96%	April 20
H33Rowan	95%	Nov 19	93%	April 20	85%	Dec 19	95%	Feb 20	94%	April 20	100%	April 20	100%	Jan 20	NA		98%	April 20
ACORN	93%	Dec 19	93%	April 20	84%	Nov 19	100%	Mar 20	92%	Oct 19	98%	June 20	90%	Oct 19	**83%**	Jan 20	97%	Mar 20
H35	98%	Nov 19	95%	Sept 19	91%	Mar 20	100%	Mar 20	98%	Dec 19	96%	Jan 20	95%	Feb 20	89%	Nov 19	99%	Nov 19
H130	96%	Mar 20	97%	Nov 19	**88%**	Oct 19	100%	Mar 20	94%	Jan 20	97%	Jan 20	92%	Oct 19	**92%**	Sept 19	97%	Mar 20
Labour	91%	Aug 19	96%	July 20	**87%**	**Nov 19**	95%	Jan 20	96%	July 20	100%	June 20	96%	July 20	NA		98%	April 20
NICU	**96%**	Mar 20	95%	Sept 19	**87%**	Sept 19	96%	Mar 20	95%	April 20	96%	July 19			85%	Dec 19	95%	Mar 20
PHDU	98%	Mar 20	100%	June 20	**83%**	Oct 19	100%	Feb 20	100%	April 20	84%	Jan 19	97%	July 19	**89%**	Jan 20	96%	Mar 20

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C9	97%	Dec 19	86%	Dec 19	**91%**	April 20	100%	Jan 20	90%	July 19	**90%**	Jan 20	96%	June 20	**90%**	Mar 20	99%	Dec 19
C10	95%	Oct 19	91%	Mar 20	80%*	July 19	100%	Feb 20	96%	Apr 20	**96%**	May 20	89%	Mar 20	90%	Sept 19	100%	Oct 19
C11	98%	Oct 19	95%	Oct 19	91%	April 20	100%	Feb 20	94%	Jan 20	**85%**	Sept 19	84%	Dec 19	95%	Dec 19	100%	June 20
C14	97%	Oct 19	93%	Mar 20	86%	Nov 19	97%	Feb 20	92%	Jan 20	**85%**	Sept 19	89%	Oct 19	92%	Dec 19	98%	Aug 19
C15	93%	Jan 20	85%	Oct 19	91%	April 20	97%	July 19	84%	Oct 19	**80%***	Aug 19	96%	Jan 20	84%	Aug 19	94%	Oct 19
C27	98%	Feb 20	97%	Feb 20	81%	Oct 19	100%	Mar 20	89%	Jan 20	**82%**	Sept 19	94%	Sept 19	**84%**	Oct 19	97%	Oct 19
CICU1	94%	Mar 20	100%	Sept 19	94%	April 20	100%	May 20	96%	July 20	93%	Feb 20	96%	June 19	100%	May 20	100%	Feb 20
CICU2	95%	May 20	100%	Sept 19	97%	July 20	100%	May 20	98%	July 20	**95%**	July 20	95%	June 20	95%	May 20	95%	Aug 19

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	96%	Feb 20	100%	June 20	**97%**	Sept 19	100%	Feb 20	95%	April 20	**96%**	April 20	87%	Jan 20	**80%**	**Dec 19**	97%	Oct 19
H40	95%	Mar 20	93%	Mar 20	83%	Dec 19	100%	Feb 20	93%	Jan 20	**96%**	Jun 19	89%	Jan 19	**93%**	April 20	100%	July 20
H6	95%	Jan 20	93%	July 19	**80%***	Sept 19	97%	July 19	94%	Sept 19	**83%**	Nov 19	84%	Feb 20	**82%**	Nov 19	90%	Oct 19

H60	96%	Dec 19	93%	April 20	**88%**	Aug 19	100%	Mar 20	89%	April 20	**80%***	Aug 19	97%	Mar 19	**82%**	Jan 20	98%	Dec 19
H7	97%	Mar 20	95%	July 20	**92%**	Oct 19	100%	Mar 20	97%	May 20	**91%**	Jan 20	**94%**	Jan 19	**97%**	April 20	96%	April 20
H12	98%	Dec 19	93%	Mar 20	86%	Nov 19	100%	Jan 20	89%	Jan 20	95%	Jan 20	95%	Nov 19	**90%**	Nov 19	95%	Sept 19
H120	96%	Mar 20	93%	Mar 20	**92%**	Feb 20	100%	Feb 20	89%	Jan 20	**98%**	Mar 20	91%	Oct 19	**64%**	July 19	95%	Sept 19
H100	95%	April 20	89%	Mar 20	**80%***	July 19	100%	Mar 20	94%	Feb 20	**86%**	April 19	93%	Mar 20	81%	Dec 19	97%	Jan 20
HICU1 & 2	95%	Aug 19	100%	Nov 19	87%	July 19	100%	May 20	94%	April 20	100%	May 20	97%	July 20	**89%**	Dec 19	95%	Aug 19

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	97%	Oct 19	**91%**	Mar 20	80%*	Oct 19	100%	July 19	94%	Sept 19	96%	June 20	**84%**	July 19	95%	Dec 19	97%	Oct 19
C26	94%	Sept 19	97%	Feb 20	84%	Jan 20	100%	Mar 20	95%	Dec 19	96%	Sept 19	93%	April 20	95%	Mar 20	97%	May 20
C5DU	95%	May 20	97%	Feb 20	91%	April 20	97%	June 19	93%	Jan 20	100%	Sept 19	96%	June 20	100%	Mar 20	99%	Feb 20

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H200/EAU	91%	Feb 20	95%	June 20	**84%**	Dec 19	100%	Feb 20	93%	Sept 19	**96%**	June 20	98%	May 20	**80%**	Aug 19	96%	July 20
H5	95%	Oct 19	95%	Nov 19	**80%***	Oct 19	96%	Feb 20	92%	Sept 19	80%*	Nov 19	**97%**	Jan 20	**89%**	Mar 20	97%	Nov 19
H50	95%	April 20	93%	Mar 20	**81%**	Oct 19	100%	Mar 20	91%	Sept 19	**98%**	May 20	**99%**	Jan 20	**88%**	Jan 20	95%	July 19
H500	98%	Jan 20	93%	Mar 20	**80%***	July 19	100%	Feb 20	89%	Sept 19	**91%**	Jan 20	97%	Jan 20	**92%**	Mar 20	97%	Oct 19
H10	94%	Oct 20	94%	Mar 20	**81%**	July 19	100%	Feb 20	93%	Sept 19	**71%**	Aug 19	**65%**	Aug19	**81%**	Aug 19	**90%**	Mar 20
H8	92%	Mar 20	95%	Oct 19	94%	Feb 20	**100%**	Feb 20	84%	Oct 19	98%	May 20	82%	Nov 19	83%	July 19	95%	Sept 19
PDU/H80	96%	June 20	91%	Mar 20	**82%**	Dec 19	100%	June 19	89%	Oct 19	95%	June 20	96%	May 20	66%	Aug19	92%	Nov 19
H9	93%	Oct 19	94%	July 19	80%*	Dec 19	100%	Mar 20	85%	Dec 19	85%	Oct 19	91%	Feb 20	**89%**	Feb 20	100%	May 20
H90	97%	Mar 20	97%	May 19	84%	Dec 19	100%	Feb 20	89%	Sept 19	**98%**	June 20	92%	Jan 20	95%	May 20	94%	Dec 19
H11	90%	Oct 19	**93%**	Mar 20	82%	July 19	97%	May 19	89%	Sept 19	**82%**	July 19	**80.1%**	July 19	**69%**	Sept 19	98%	July 20
H110	88%	Dec 19	**89%**	April 20	80%*	Sept 19	100%	Feb 20	87%	Oct 19	**88%**	Dec 19	95%	July 19	82%	Nov 19	98%	Nov 19

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due			Rating	Next due			Rating	Next due
Majors ED	95%	Nov 19	**95%**	July 20	81%	Oct 19	100%	Feb 20	96%	Oct 19			87%	Dec 19			100%	Jan 20
Paeds ED	95%	June 20	**92%**	April 20	97%	Sept 19	100%	Mar 19	95%	May 20			90%	June 19			100%	Jan 20
Emergency Care	93%	Feb 20	**100%**	Nov 19	93%	June 19	97%	July 19	100%	May 20			94%	Mar 20			100%	Jan 20
AMU	93%	Jan 20	93%	Aug 19	80%*	Oct 19	100%	Feb 20	94%	Jan 20	**82%**	July 19	**87%**	Dec 19	**64%**	Oct 19	96%	Sept 19
H36	96%	July 19	86%	Feb 20	**91%**	Mar 20	97%	Feb 20	92%	Sept 19	93%	Nov 19	**95%**	Feb 20	**92%**	July 19	97%	Sept 19

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

Hull University Teaching Hospitals NHS Trust

Quality Committee

Meeting Date:	29 April 2019	**Chair:**	Prof M Veysey	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Serious Incidents themes and trends – discussion around how the Committee closes the loop and embeds learning
- Benchmarking NPSA – Trust highlighted as a good reporter
- Quality Accounts Update – The Committee approved the draft accounts that would be sent to the stakeholders for comments
- People Strategy Refresh – an opportunity for Committee members to give any feedback to Mr Nearney regarding the strategy
- PLACE – An update was received regarding the PLACE audits. The process was being reviewed and the new process would commence in September 2019
- Learning from Deaths update – SJRs being carried out – emerging issues were communication and training.
- IPR – Mrs Cope to attend future meetings to highlight quality indicators
- OQC – the focus on VTE was discussed
- Board Assurance Framework – End of year BAF was presented. The Committee were invited to feedback any comments to Ms Ramsay.

Decisions made by the Committee:
None required

Key Information Points to the Board:
As key issues discussed

Matters escalated to the Board for action:
None

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee held 29 April 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mrs V Walker	Vice Chair
	Mr S Hall	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Interim Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance
In Attendance:	Mr S Nearney	Director of Workforce and OD (Item 4.4 only)
	Mrs C Gorman	Hotel Services Manager (Item 4.6 only)
	Mrs Z Ridge	Deputy Head of Facilities (Item 4.6 only)

No	Item	Action
1	**Apologies** Apologies were received by Prof J Jomeen, Non-Executive Director and Mrs A Green, Lead Clinical Research Therapist Prof Veysey advised that item 4.5 (GIRFT) would be deferred to the next meeting in May 2019.	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held 29 March 2019** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising There were no matters arising from the minutes.	
	3.2 Action Tracking List Mrs Southgate advised that she was waiting for information regarding the DKA update from the service, so would add it to her next Serious Incident report in May 2019.	**KS**
	3.3 Any Other Matters Arising There were no other matters discussed.	
	3.4 Workplan 2019/20 Ms Ramsay presented the Workplan and advised that it would be remapped against the new Trust Strategy to incorporate the new goals. Any changes would be proposed to the Committee for approval.	
4	**4.1 Serious Incident Report** Mrs Southgate presented the report and advised that no Never Events had been declared in 2018/19. Mrs Southgate advised that the report format had been changed slightly	

to give more information regarding Serious Incident investigations. There had been a number of Serious Incidents de-escalated in month and the report also included learning and recommendations following closed Serious Incidents.

There was a discussion around closing the loop and how the 6 monthly learning report could capture the learning after the incident investigation. This would give assurance to the Committee, along with snapshot audits that learning was being embedded. Mrs Walker added that the measure of learning meant that the incident did not happen again. Prof Veysey stated that mistakes will happen but it was important that processes and systems were in place to minimise the risk.

Mrs Geary advised that she was proposing to the Executive Team that a Serious Incident Committee be established to oversee learning and that the recommendations are signed off. She added that the Operational Quality Committee reviewed Serious Incidents at an operational level.

Resolved:
The Committee received and accepted the report.

4.2 Benchmarking NPSA – Staff Survey Results
Mrs Southgate presented the item which highlighted how the Trust was performing against its peers in relation to Serious Incident reporting.

Mrs Southgate advised that it was a positive story and indicated that staff felt more able to report incidents and were confident in how to. She added that the Trusts severe and death reporting was slightly elevated in comparison to other Trusts and this was being investigated to ensure they had been categorised correctly.

The Committee discussed the change in position since 2014 and the turnaround that had been achieved. Dr Purva stated that it was important to sustain this position. Mrs Stern asked if the Committee was confident that all incidents were being reported and Dr Purva advised that the systems in place were better and Mrs Southgate added that wards were now subject to independent audits.

Resolved:
The Committee received and accepted the report.

Mrs C Gorman and Mrs Z Ridge attended the meeting.
The agenda was taken out of order at this point.

4.6 PLACE Update
Mrs Gorman and Mrs Ridge gave a presentation regarding the PLACE non clinical assessments of the care environment. They advised that it was introduced in 2013 and was led by patients to focus on improvements.

Mrs Gorman advised that the process was currently being reviewed and the new process would start in September on a minimum of 10 wards. The team of reviewers would include patients and clinical and estates staff. Each review would use independent staff to the wards and the results would be shared. The team currently had 15 assessors and was

looking to recruit more. The types of things to be audited are cleanliness, food and hydration, privacy and dignity, general wellbeing, the state of the buildings and whether the environment is dementia and disability friendly.

Mrs Ridge advised that the scoring is submitted nationally and each hospital is benchmarked. Mrs Ridge also advised that any issues picked up are shared with the nursing teams straight away and feedback given after each audit.

The EF and D Management Committee reviewed any estate type issues such as hearing loops, flooring and handrails and good progress had been made in these areas.

Mrs Ridge advised that funding was an issue as there was no set budget for PLACE but that the improvements had to come out of the capital budget.

Mrs Stern added that she was currently an assessor and the process probed patients for their views (should they want to give them) and anything shared was recorded for submission to NHS Digital.

Resolved:
The Committee received and accepted the update and requested a follow up after the new process had been implemented.

Mrs C Gorman and Mrs Z Ridge left the meeting

4.3 Quality Accounts Update
Mrs Southgate presented the Draft Quality Accounts for the Committee to review them before they were sent to the Trust's stakeholders for their comments.

Mrs Southgate advised that there were still areas requiring information before the CEO statement was added. The Quality Improvement Plan was being updated to incorporate the key projects.

Mrs Southgate advised that the CQC, duty of candour and data quality were some of the projects included and that KPIs, aims and objectives were being finalised.

Mr Hall asked if the report was prescribed as it was not an easy read and Mrs Southgate confirmed that is was.

Resolved:
The Committee received and accepted the Draft Quality Accounts.

4.7 Learning from Deaths Update
Dr Purva updated the Committee regarding the number of deaths in Quarter 4 and the Structured Judgement Reviews carried out. She advised that there were themes emerging and two of these were communication and training. Actions were in place to address these issues.

Dr Purva also mentioned the Medical Examiner role and how this would

be piloted in May 2019.

The Committee discussed end of life care and how many patients die in the hospital that could have died at home or in a nursing home. Dr Purva advised that the there was much work to do and was very complex.

Resolved:
The Committee received and accepted the report.

Mr Nearney joined the meeting

4.4 People Strategy Refresh
Mr Nearney attended the meeting to update the Committee regarding the People Strategy Refresh. Mr Nearney also presented a high level report that summarised the last 3 years progress for context.

Mr Nearney reported that a Board time out session had taken place and he would be presenting the final strategy at the Board meeting in May 2019 as well as presenting to the Performance and Finance Committee in April 2019.

The document had been circulated to the Patient Council, management teams, staff, the Triumvirates and the Board for comments and feedback had been received.

There was a discussion around the recruitment campaign and how new roles were having an impact on difficult to recruit and other vacancies. Mr Nearney added that work was ongoing to look at joint posts with partners and managing integrated services.

Resolved:
The Committee received and accepted the report.

Mr Nearney left the meeting.

5. **5.1 Integrated Performance Report**
Ms Ramsay advised that Mrs Cope the Chief Operating Officer would be attending the meeting from May 2019 onwards which would mean that items in the IPR affecting quality of care could be discussed in more detail.

Resolved:
The Committee received and accepted the report.

5.2 Operational Quality Committee
Dr Purva presented the item and advised that the Committee had discussed the VTE Quality Improvement Plan in detail. Performance was at 92% and work was ongoing to achieve the standard and embed the practices.

Resolved:
The Committee received and accepted the report.

6. **Board Assurance Framework**
Ms Ramsay presented the draft BAF year-end position, giving the

Committee the opportunity to comment on any gaps or errors and give feedback on the quarter 4 ratings. Ms Ramsay reported that the BAF would be presented to the Board in May 2019 for final approval.

The Committee discussed the new Trust objective of research and innovation and the risk of not achieving it and whether it should be included in the 2019/20 BAF.

Resolved:
The Committee received and accepted the report.

7. Any Other Business

Prof Veysey asked if the June meeting could be re-arranged to the following week due to annual leave. **RT**

8. Chairman's Summary to the Board

The Chair agreed to summarise the meeting to the Board.

9. Date and time of the next meeting:

Wednesday 29 May 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 29 May 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Mrs A Green	Lead Clinical Research Therapist
	Mr D Corral	Chief Pharmacist
	Mrs B Geary	Chief Nurse
	Mrs M Kemp	Deputy Chief Operating Officer
	Mrs M Stern	Chair of Patient Council
	Dr M Purva	Chief Medical Officer
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Prof. J Jomeen – Non-Executive Director, Mrs K Southgate – Acting Deputy Director of Quality Governance and Assurance, Ms C Ramsay – Director of Corporate Affairs, Mrs T Cope – Chief Operating Officer and Mrs V Walker – Non-Executive Director	
2	**Declarations of interest** There were no declarations made.	
3	**Minutes of the meeting held 29 April 2019** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters arising There were no matters arising.	
	3.2 Action Tracking List The DKA incident was discussed and Mrs Geary advised that a new Serious Incident Committee was being established to review incidents in a more structured way and review any emerging themes. She advised that the new Committee had been approved by the Executive Team and would be presented to the Executive Management Committee for final sign off. In relation to the DKA incident the Executives had met with the teams and investigations had taken place. There were no themes emerging. It was agreed that the item would be removed from the Action Tracker.	
	3.3 Any other matters arising There were no matters discussed.	
	3.4 Workplan The Committee discussed the Workplan and Mrs Geary stated that the Committee should feel assured that the Trust was delivering safe and high quality care. She also reported that she was changing the way the Quality Reports were presented in that she would have an overarching report with specific reports relating to Infection Control, Patient Experience etc. Mrs Stern added that a more formal input from the Patient Council members was required as they heard lots of stories about patient care in the hospital.	

It was agreed that the Workplan would be reviewed regularly and any specific items would be discussed between Mrs Geary, Dr Purva and Prof. Veysey for inclusion on the agendas.

4.1 Quality Improvement Programme
Mrs Daniel presented the report and advised that the QIP had been updated and approved at the Operational Quality Committee. The main change was the move from rag ratings to SPC charts. Mrs Daniel asked for any comments regarding the changes.

Prof. Veysey stated that having a front sheet summary of each QIP would be helpful and Mr Hall added that 3 months of historical data to capture trends would also be useful. Mrs Daniel agreed to add these to the report.

There were now 7 QIPs and it was agreed that rather than numbering the programmes they would be referred to by name.

Mrs Stern asked if the project leaders would be gathering information from the patient representatives and Mrs Daniel suggested that any issues be raised by the patient representatives at the Health Group governance meetings that they attended. Prof Veysey added that there should be a clear Executive sponsor and a clear lead for each QIP to ensure responsibility and accountability.

Resolved:
The Committee received and accepted the update Quality Improvement Programme.

4.2 Getting It Right First Time
Dr Purva gave a presentation which highlighted the GIRFT projects that had already been established, the improvements made and the potential opportunities and financial advantages.

She reported that the main advantages to the GIRFT process was that it was clinically led so encouraged peer to peer engagement and it set out to standardise clinical procedures were possible. Concentrating on the quality meant that resource savings would follow.

The process was nationally coordinated and other Trusts were receiving the same visits and recommendations were put into place. Dr Purva showed a list of specialties already visited which were mainly surgical specialties. Other areas such as medicine and litigation would be more difficult to be objective but in theory any area could apply the methodology.

Some of the benefits are safety improvements, better governance structures, improved monitoring of infections rates and improved access to acute lists.

Dr Purva gave an example of neurosurgery consent issues and to have a consent clinic put into place to give more time for the patients to be informed of their procedure and outcomes to inform patient choice.

Dr Purva also reported that GIRFT was interacting with Scan4Safety to look for local improvements and she used the example of loan kits and

how these had been bought much cheaper and was reducing variations in practice.

Dr Purva highlighted opportunities such as length of stay improvements and increasing day case procedures.

Prof Veysey remarked that the process felt chaotic and asked if there was a QIP like structure being implemented to monitor the GIRFT projects. Dr Purva advised that there was a work plan in place and was monitored through the Carter Group and the Operational Quality Committee.

Mrs Kemp advised that GIRFT was now operating on a STP level and was a national priority both with secondary and primary care. She reported that there was currently 41 active reviews within the organisation.

Resolved:
The Committee received and accepted the presentation.

4.3 Quality Report
Mrs Geary presented the report and advised that a Never Event had been declared in April 2019 regarding a retained swab. The investigation was ongoing.

NRLS reporting had been presented at the April 2019 Committee and discussed in detail, the Trust was reporting 93.7% harm free care, 98.36% of patients were happy to recommend the Trust to others as part of the Friends and Family Test and a working group had been established to review MSSA infection cases.

Mrs Geary also advised that her and the Governance Team had met with the CQC and they would be visiting the Trust in July to review the Emergency Department. The CQC would also be attending the Board and Committees in July 2019.

Resolved:
The Committee received and accepted the report.

4.4 Integrated Performance Report
Mr Hall highlighted ED performance and the telephone call from NHS Improvement to the Chief Financial Officer to submit an action plan to improve performance.

The Committee discussed the type of people attending ED and how many should actually be there and could have been seen elsewhere. Mr Hall added that the standard was due to change to average time waiting in the department and that the Trust should start measuring this immediately.

There was a discussion around mortality and weekend admissions relating to increased number of deaths and Dr Purva advised that there was no data to suggest weekend days were any different to week days. This was being monitored at the Mortality Committee.

Mrs Geary reported that ambulance handover time performance was good at 20 minutes, the Friends and Family Test scores were positive and harms were low with the Trust showing to be a good reporter of incidents.

Resolved:
The Committee received and accepted the report.

5.1 - Serious Incident Report – Lessons Learned – Themes and Trends
Mrs Daniel presented the report and advised that there had been a Never Event declared relating to a retained theatre swab. The investigation was being led by Dr Purva and the outcome would be shared with the Committee.

Mrs Daniel advised that 6 Serious Incidents had been investigated in March 2019 and the recommendations had been included in the report. One Serious Incident had related to delayed paperwork following a patient that had died and non-compliance with Trust Policy. This had been shared in the Lessons Shared bulletin that was presented with Team Brief.

There was work ongoing to reduce the length of time between Serious Incident work and how patterns are reported.

Resolved:
The Committee received and accepted the report.

6.1 Seven Day Services
Dr Purva presented the report for information. The report had previously been received at the Board meeting in May 2019.

Resolved:
The Committee received and accepted the report.

7.1 Quality Accounts
Mrs Daniel reported that the Quality Accounts would be signed off at the next Quality Committee and were currently with stakeholders for their comments. Mrs Thompson reminded the Committee that the date had been moved for the next meeting and Mrs Daniel agreed to check that this would be suitable for sign off.

Mr Hall asked if a summary sheet showing any changes to the Quality Accounts could be added to avoid having to read through the full accounts each time changes were made.

Resolved:
The Committee received and accepted the report.

Post meeting note: The change in committee date meant that sign off of the Quality Accounts would be breached. The Committee agreed to delegate authority to Prof. Veysey to sign off the Quality Accounts on their behalf. This was agreed by the auditors.

7.2 Operational Quality Committee
Dr Purva presented the summary report. She advised that the Committee had discussed the new QIP format and the programme in detail.

Dr Purva reported that VTE was no longer in the QIP but was reviewed at the Performance and Accountability meetings. The Committee discussed

VTE performance once the electronic solution had been implemented and Dr Purva advised that performance was at 92% with patients in hospital longer than 24 hours were at 95%.

Resolved:
The Committee received and accepted the report.

7.3 Board Assurance Framework
Mrs Thompson presented the BAF and advised that the report had been updated since the Board discussion in May 2019 and now included the Research and Innovation BAF risk.

Any comments regarding the updated BAF to be submitted to Ms Ramsay or Mrs Thompson.

Resolved:
The Committee received and accepted the report.

8 Any Other Business
Mr Hall advised that a report had been received at the Performance and Finance Committee regarding the patient safety benefits linked to the Scan4Safety project. It was agreed that the report would be circulated to all Committee members.

The Committee also discussed comparing the Scan4Safety against the accuracy of coding to see if there were any differences. Mr Hall advised that the Performance and Finance Committee had requested further information.

Resolved:
Mrs Thompson agreed to circulate the report to the Committee. **RT**

9 Chairman's Summary to the Board
Prof Veysey agreed to summarise the meeting to the Board.

10 Date and time of the next meeting:
Monday 1st July 2019, 9am – 11am – The Boardroom, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust

Quality Committee
Held on 1st July 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr D Corral	Deputy Chief Pharmacist
	Mrs B Geary	Chief Nurse
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance
	Mr J Illingworth	Head of Research and Innovation
	Mrs M Stern	Chair of Patient Council
	Mrs V Walker	Non-Executive Director
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Green	Lead Clinical Research Therapist
Attendance:	Mrs R Thompson	Corporate Affairs Manager

No	Item	Action
1	**Apologies:** Apologies were received from Dr M Purva, Chief Medical Officer, Mr S Hall, Vice Chair and Prof J Jomeen, Non-Executive Director	
2	**Declarations of Interest** Mrs Walker declared that she is now a portfolio holder for adult services for East Yorkshire Council.	
3	**Minutes of the meeting of 29 May 2019** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising There were no matters arising from the minutes.	
	3.2 Action Tracking List Ms Ramsay updated the Committee regarding the National System Breast Screening incident. The Trust had addressed the issue and the programme was no back on track. It was agreed to remove the item from the tracker.	
	3.3 Any Other Matters Arising There were no other matters arising.	
	3.4 Workplan 2019/20 The Workplan had been updated and was now in line with the new Trust objectives and the Chief Nurse had also reviewed the timing of some items.	
4	**4.1 Quality Improvement Programme** Mrs Southgate presented the programme in its new format. She reported that the projects were progressing well and she had received good updates regarding nutrition and the deteriorating patient. Reviews were also taking place mapping serious incident investigations to the nutrition and deteriorating patient indicators. Ms Ramsay asked how assured Mrs Southgate was and how managers	

were bought in to the projects. Mrs Southgate advised that the projects had clear aims and objectives, with good governance behind each one. The Operational Quality Committee were overseeing the projects.

Mrs Walker asked what the Matron's handbook was and Mrs Southgate advised that it was an auditing tool for each ward area against a set of questions. This handbook was as well as the fundamental standard audits that were carried out on a monthly basis.

Prof Veysey requested that specific leads be identified for each project to ensure that the lead was accountable for the actions and recommendations in place.

Mrs Southgate advised that the risk register would be mapped against the QIP to ensure all risks associated were understood.

Resolved:
The Committee received and accepted the report.

4.2 Quality Report May 2019
Mrs Geary advised that she was changing the report format and would be presenting separate reports for patient experience and Healthcare Associated Infections.

Mrs Geary highlighted the 3 Never Events that that had been declared. The retained swab and the wrong site surgery investigations were being chaired by Dr Purva and Mrs Geary was chairing the misplaced NG tube. The recommendations following the investigation would be received at the Committee. **BG**

Mrs Geary advised that Mr Long had held a meeting over both sites with clinical staff and a task and finish group had been established led by the Chief Executive. A number of simulation exercises would be held to ensure staff were aware that anyone could speak up.

Mrs Geary add that the Yorkshire Contributory Framework would be used for Serious Incident investigations. This framework monitors the impact on staff following a Serious Incident and how this was managed.

There had been 1 MRSA bacteraemia case, 42 MSSA cases and 25 C Difficile cases. A number of these were Community acquired, but of the hospital acquired cases there had been no lapses in care.

The Committee discussed the CQC and when they would be likely to inspect the Trust. Mrs Geary advised that they were visiting the Trust in July and would be spending their time in ED.

Resolved:
The Committee received and accepted the report.

4.3 Integrated Performance Report
The Committee reviewed the report. ED performance was improving and the Type 3 data was now included in the figures reported. The Trust was at 77.9% performance and 84.5% was the system performance.
Ms Ramsay advised that the whole system was looking and feeling better

but there was more work to do to bring the Trust up from the bottom of the pack.

Mrs Walker asked what else the Trust was doing to improve its performance and Ms Ramsay advised that a visit from the NHS I lead for ED was visiting the Trust on 8th July to offer support and advice. Ms Ramsay also advised that the Trust Board was holding a development session dedicated to emergency care in September 2019.

Mrs Southgate reported that the CQC would visit the Emergency Department and the Trust was currently undertaking a mock inspection to ensure policies and procedures were in place.

Mrs Walker was concerned about ED interventions and the effect this had on staff and was keen to ensure staff had the correct support systems in place.

There was a discussion around educating members of the public not to attend the ED unless it was appropriate. Mrs Geary advised that Newcastle Hospital was surrounded by district hospitals and also had clinical navigators on the front door which was helping with their level of attends and keeping them appropriate.

Prof Veysey highlighted the 30 day readmission rate and the downward trend. It was agreed that Dr Purva would speak to Dr Adams and provide the Committee with an update. **MP**

Mrs Walker expressed her concern regarding patients with mental health issues and how the liaison services were working with the Trust. Mrs Geary advised that she had met with the Chief Nurse of Humber who was shadowing the Crisis team to understand the issues.

The Committee discussed having a board to board with the Humber FT Trust to build on the partnership working. It was agreed that Prof Veysey would raise this issue of a board to board at the next Board meeting in July 2019. **MV**

Resolved:
The Committee received and accepted the report.

4.4 Clinical Audit Programme
Mrs Southgate presented the annual report which gave updates on the progress of clinical audits and NICE guidance compliance.

There was a discussion around the number of audits each Health Group completed and how they were prioritised. Mrs Southgate advised that organisational pressures had impacted on some of the areas.

Mrs Walker mentioned the End of Life team and the work they were doing around the national end of life audit. She suggested that the team attend the Quality Committee to give assurance around the patient centred culture. It was agreed that Mrs Thompson would invite the team to the meeting on 30th September 2019. **RT**

Resolved:
The Committee received and accepted the report.

5 5.1 Serious Incidents – Lessons Learned – Themes and Trends/ Never Event Safety Improvement Plan

Mrs Southgate presented the monthly Serious Incident report. This highlighted the number of Serious Incidents reported and the outcomes of completed investigations.

Mrs Southgate also presented a Never Event safety improvement plan following the 3 declared Never Events.

There had been 2 actions put into place following the declarations, one was a Trust wide briefing and the other was to establish a task and finish group. A number of simulations would take place as well as governance and Organisational Development investigation work being carried out. It was key that all staff knew that they could stop the line if they felt it was appropriate to do so. The Trust was also working with other Trusts such as Newcastle to review their best practices.

The Committee discussed the learning lessons wording in the Serious Incident report and it was agreed that Mrs Southgate would change the language to recommendations instead of lessons learned. Any learning would be included in the themes and trends report that was received quarterly.

Resolved:
The Committee received and accepted the reports.

6 6.1 Research and Innovation Strategy

Mr Illingworth presented the report and gave an update regarding the Research and Innovation Strategy. He advised that the Strategy linked to good patient experience, the Trust becoming more research aware and creating positive partnerships.

A research dashboard was being compiled to embed research as a metric to allow Health Groups to review their research targets and for Trust Board reporting purposes.

The Trust had a number of initiatives in place such as 3D printing, an creating an algorithm to find suitable oncology patients for trials, working with pharmaceutical companies and creating a more flexible workforce with less silo working.

The Trust was also integrating further with the University of Hull and was creating international partnerships with an Indian research company with 14 potential areas of research being reviewed.

There was a ‘Dragons Den’ like bidding process for small projects and the funding available would support at least 5 applications.

Mr Illingworth advised that there were PHD scholarships available and 3 had been appointed to. Mrs Geary stated that more support for staff who were applying for the scholarships should be given to help them complete

the application process. Mrs Green added that a group had been established with some of the current PHD students to help new students. Prof Veysey suggested getting a list of staff who have PHDs to ask them to mentor the next wave of students.

Prof Veysey commended the work already carried out but suggested more patient to partner involvement.

Resolved:
The Committee received and accepted the report.

7.1 Quality Accounts
Mrs Southgate advised that the Quality Accounts had been approved by the Chair of the Quality Committee as delegated by the Board, signed and uploaded to the Trust website.

Resolved:
The Committee received and accepted the report.

7.2 Operational Quality Committee Report
The summary report was presented to the Committee. There were no items of escalation.

Resolved:
The Committee received and accepted the report.

7.3 Board Assurance Framework
Ms Ramsay presented the Board Assurance Framework and advised that she had captured the comments received following the Board and May Committees. Ms Ramsay had also met with April Daniel to map the Corporate Risk Register to the Board Assurance Framework.

Resolved:
The Committee received and accepted the report.

7.4 Quality Assurance of CRES
Mrs Geary presented the report which outlined the procedure for any CRES schemes over £100k which might impact on Quality.

Mrs Geary highlighted COPD best practice tariff, Scan4Safety, cardiology bulk purchasing and vacancy factor savings. Mrs Geary had challenged the vacancy CRES scheme and assured the Committee that no posts would be held vacant to achieve CRES.

She assured the Committee that there were no schemes currently impacting on Quality.

Resolved:
The Committee received and accepted the report.

8 Any Other Business
Mrs Geary reported that since the Community Paediatric contract had transferred over to the Trust it had transpired that there was a backlog of patients and 2000 had not yet been seen. A task and finish group had been established to review the cases and identify any potential harm. Mrs

Geary added that there had been no harm identified yet.

The Committee discussed the learning from the incident and Mrs Geary advised that a look back exercise would take place and the findings presented to the Board.

9 Chairman's Summary to the Board

Prof Veysey agreed to summarise the meeting to the Trust Board

10 Date and time of the next meeting:

Monday 29 July 2019, 9.00am – 11.00am, The Boardroom, Hull Royal Infirmary

NHS
Hull University Teaching Hospitals
NHS Trust

Integrated Performance Report 2019/20

July 2019

June 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 - July 2019

Hull University Teaching Hospitals NHS Trust

RESPONSIVE

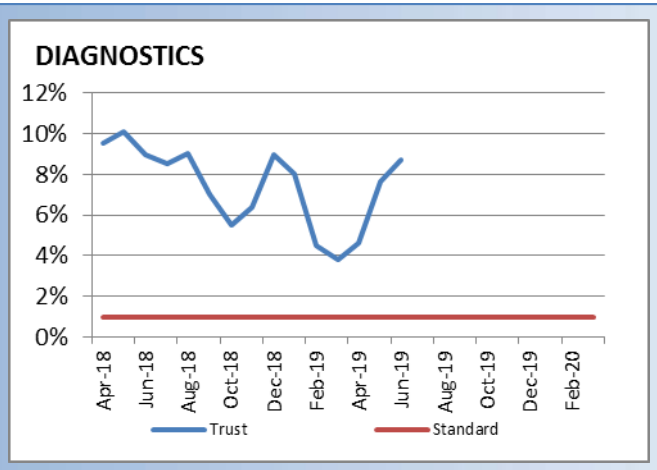
Description	Aggregate Position	Trend	Variation

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 June with performance of 8.71%

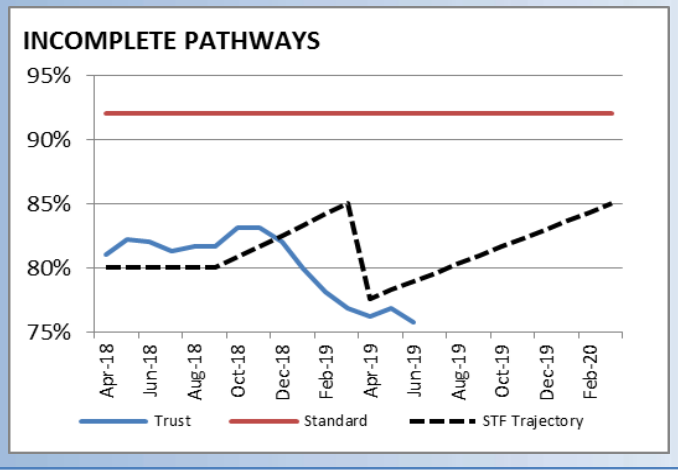


Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the June improvement trajectory of 78.9%

June performance was 75.75%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 7 specialties that failed to meet the improvement trajectory

Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

RESPONSIVE

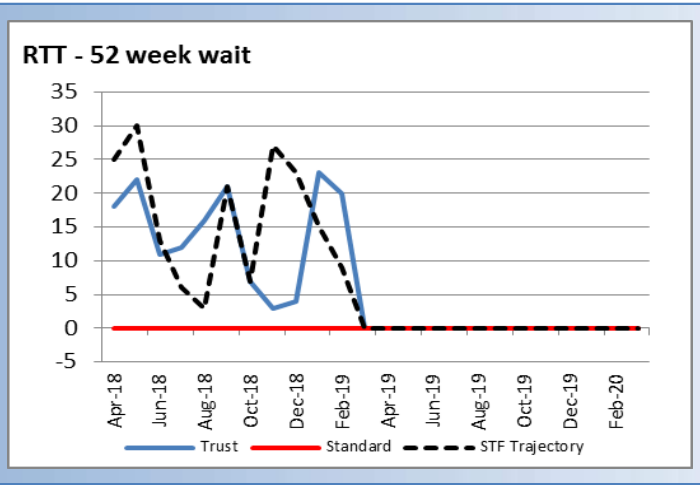
Description	Aggregate Position	Trend	Variation

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 June

The Trust achieved the national standard of zero breaches.

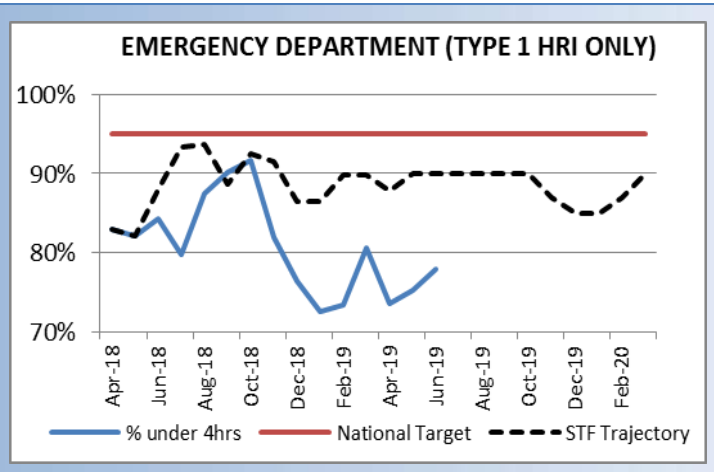


ED Waiting Times (HRI only)

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

Performance failed to achieve the planned trajectory of 90% with performance of 78.0% for June

This has failed to achieve the national 95% threshold.



Performance has increased 2.8% during June

Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

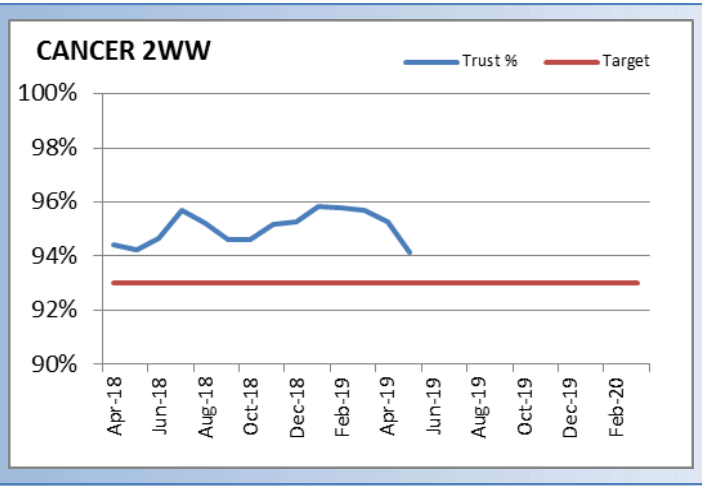
RESPONSIVE

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%.

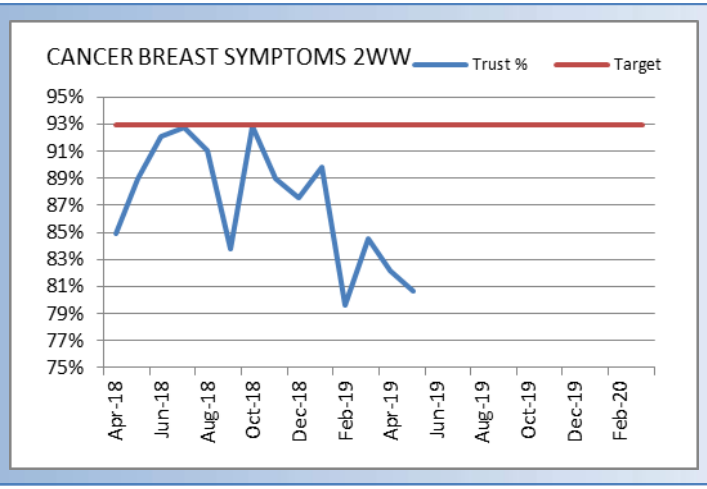
May performance achieved the 93% standard at 94.1%



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

May performance failed to achieve the 93% standard at 80.6%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

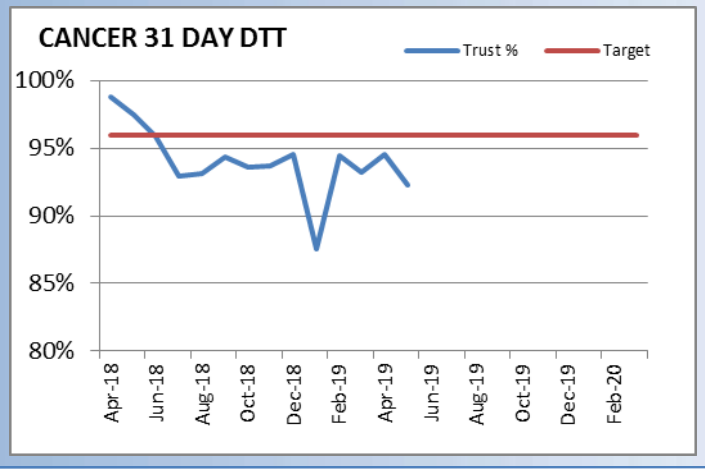
RESPONSIVE

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%.

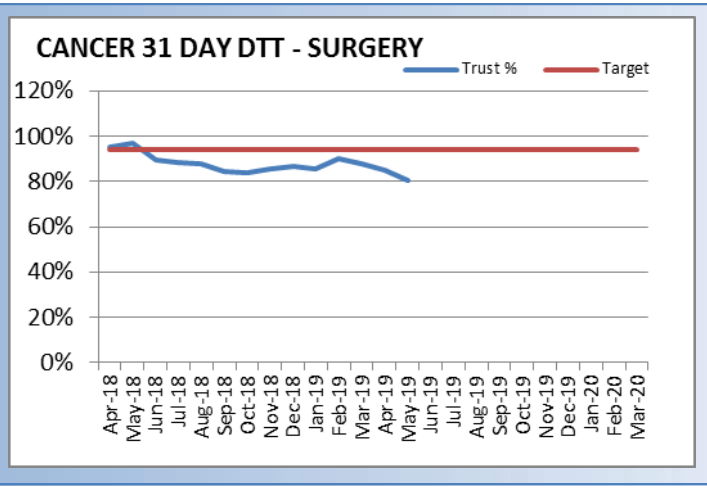
May performance failed to achieve the 96% standard at 92.3%



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%.

May performance failed to achieve the 94% standard at 80.3%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

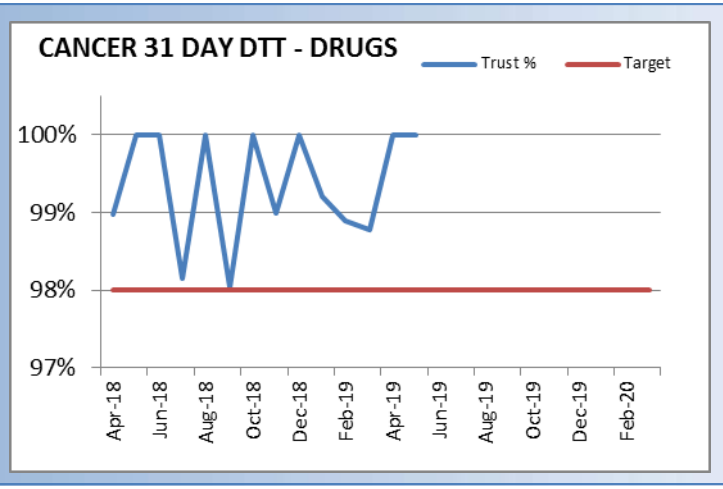
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Drug Standard

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

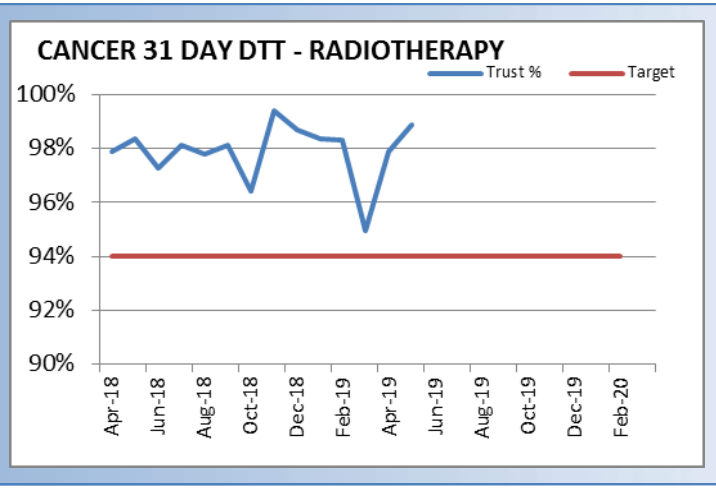
May performance achieved the 98% standard at 100%



Cancer: 31 Day Subsequent Radiotherapy Standard

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

May performance achieved the 94% standard at 98.9%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

RESPONSIVE

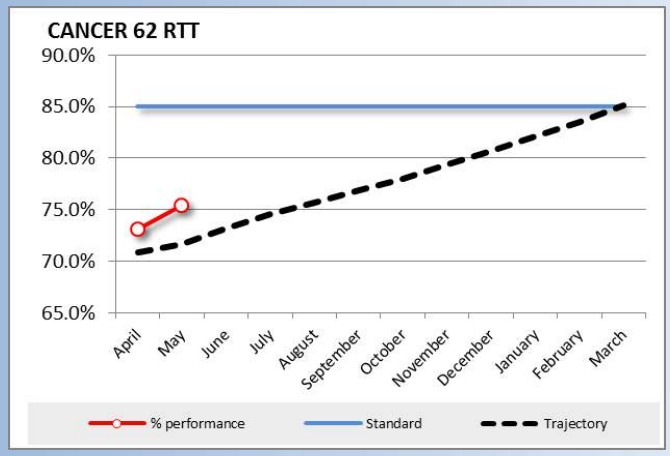
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

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

May adjusted performance achieved the 71.1% improvement trajectory with performance of 75.4%

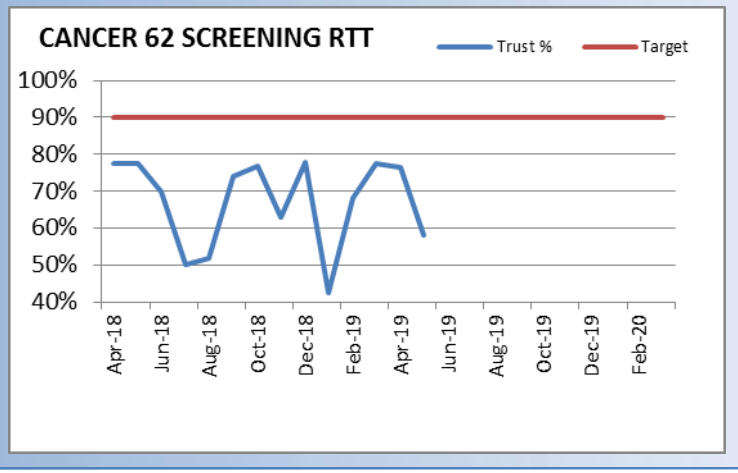
Performance failed to achieve the national standard



Cancer: 62 Day Screening Standard

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

May performance failed to achieve the 90% standard at 58.1%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

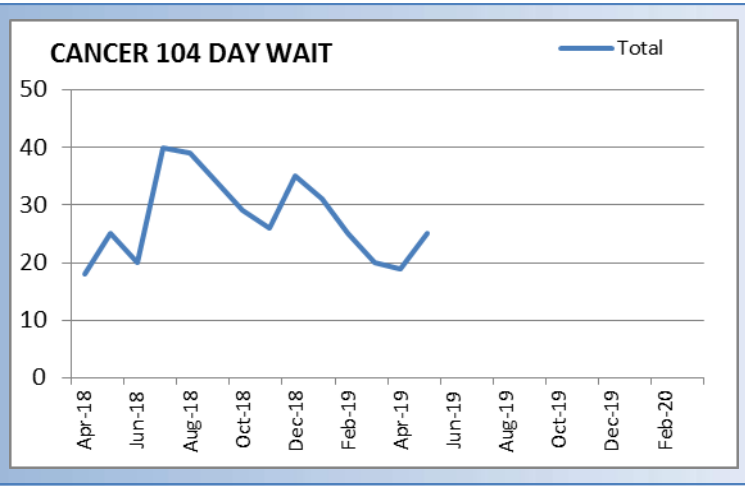
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 25 patients waiting 104 days or over at the end of May



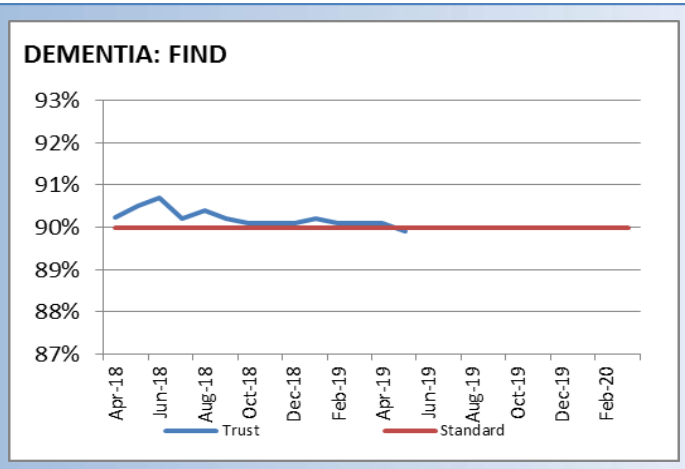
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is May 2019.

The standard for this indicator is to achieve 90%.

Performance for May failed to achieve this standard at 89.9%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

RESPONSIVE

Description	Aggregate Position	Trend	Variation

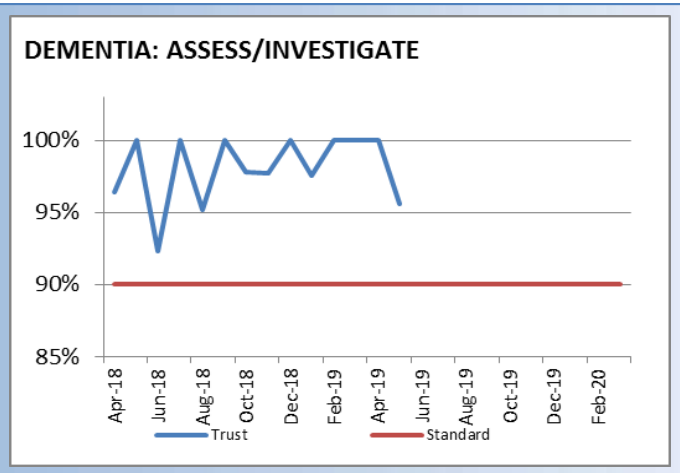
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 May 2019

The standard for this indicator is to achieve 90%.

Performance for May achieved this standard at 95.6%



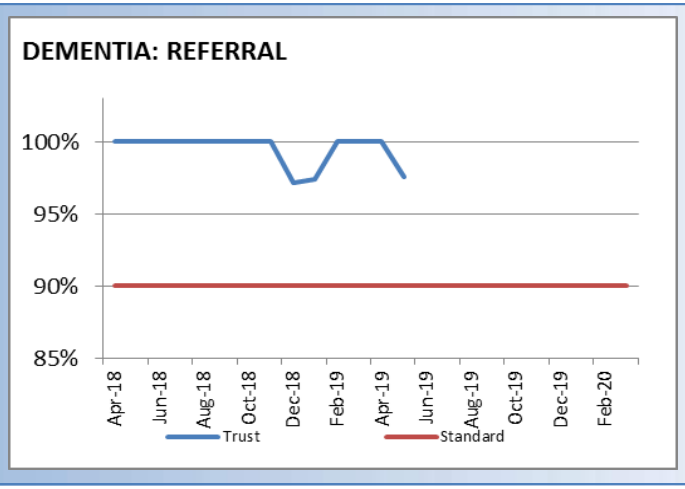
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 May 2019.

The standard for this indicator is to achieve 90%.

Performance for May achieved this standard at 97.6%



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

SAFE

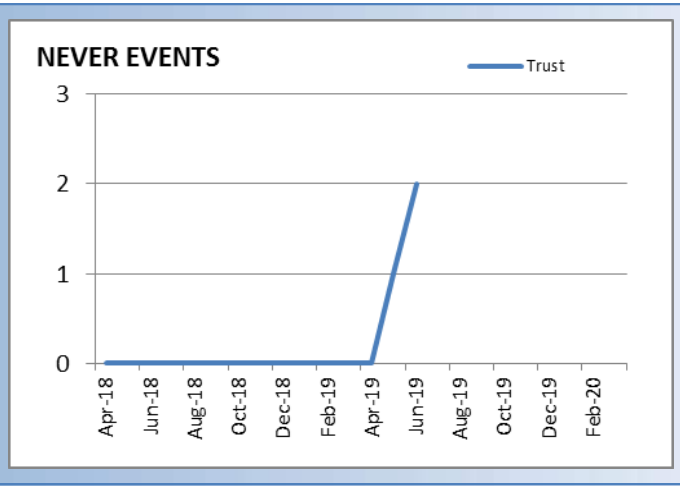
Description	Aggregate Position	Trend	Variation

Occurrence of any Never Event

Occurrence of any Never Events

The latest available performance is June 2019

There were 2 cases reported during June 2019.



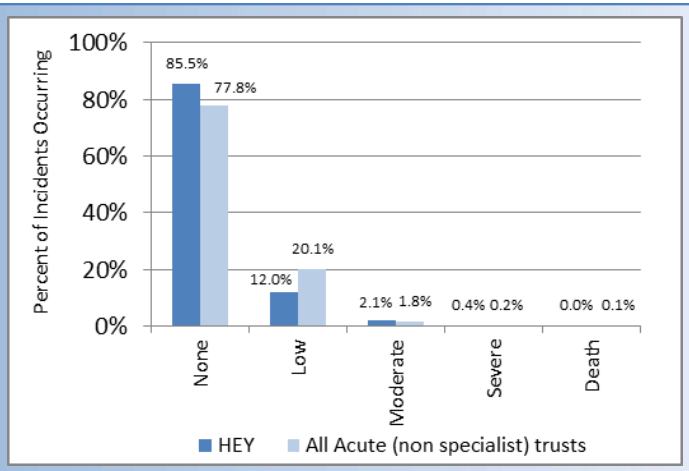
Further information is included in the Board Quality report

Potential under-reporting of patient safety incidents

Number of incidents reported per 1000 bed days

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

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



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

SAFE

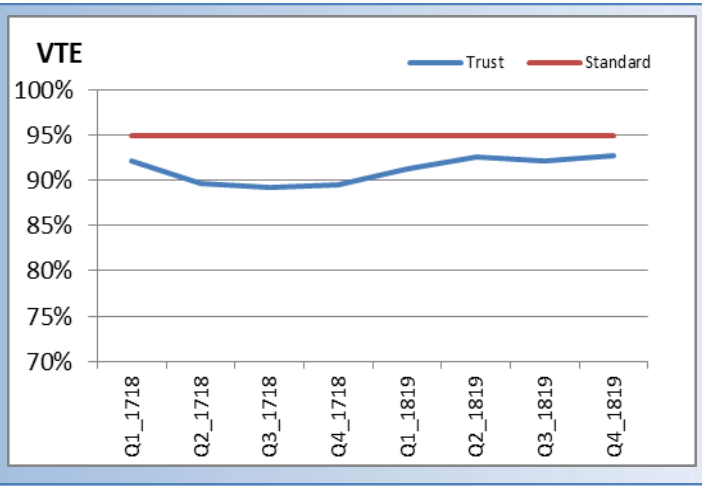
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 92.75% for Q4 2018/19.

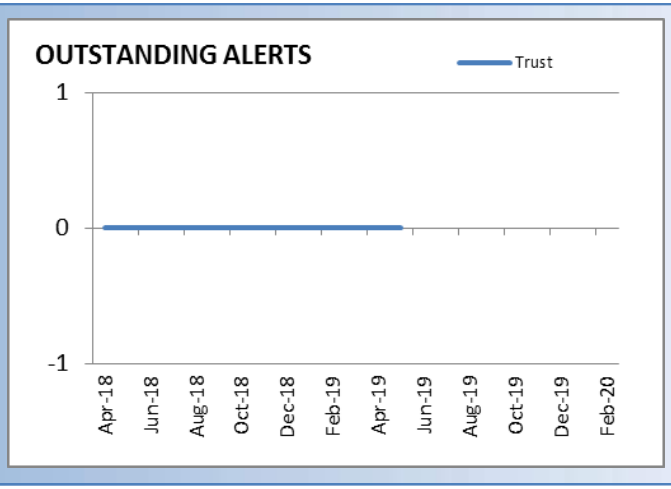


Patient Safety Alerts Outstanding

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

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

There have been no outstanding alerts year to date.



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

SAFE

Description	Aggregate Position	Trend	Variation

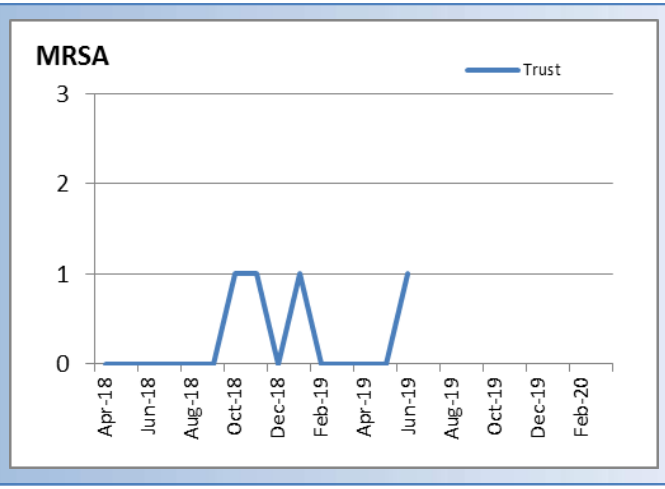
MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

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

There has been 1 case reported during June 2019.

There has been 1 case reported year to date.



Further information is included in the Board Quality report

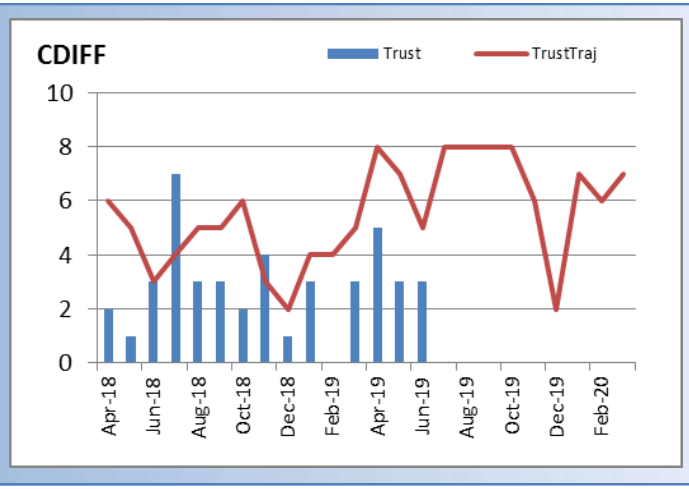
Clostridium Difficile

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

There were 32 cases during 2018/19

There were 3 incidences reported during June which achieved the monthly trajectory of no more than 5 cases

Year to date position is 11 cases against the trajectory of no more than 20 cases.



Further information is included in the Board Quality report

Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

SAFE

Description	Aggregate Position	Trend	Variation

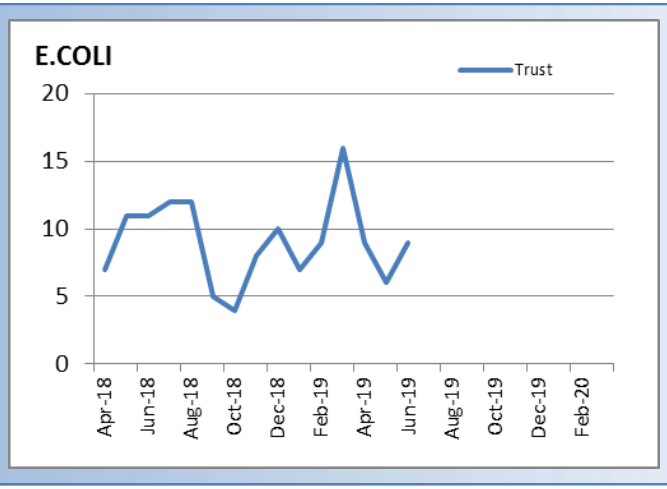
Escherichia Coli

Number of incidence of E.coli bloodstream infections

There were 112 cases during 2018/19

There were 9 incidences reported during June 2019.

There have been 24 incidences reported year to date.

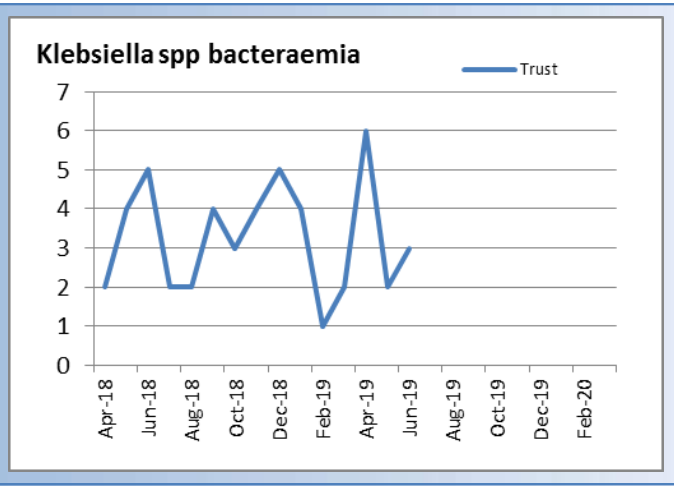


Klebsiella spp bacteraemia

Number of incidence of Klebsiella spp bacteraemia

There were 3 cases reported during June 2019.

There have been 11 incidences reported year to date.



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

SAFE

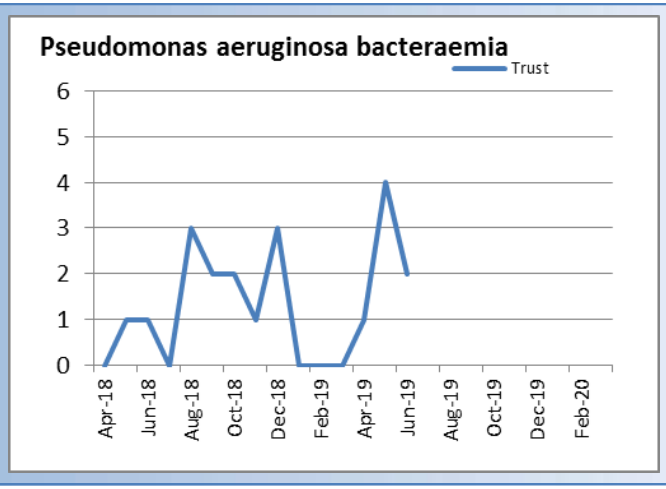
Description	Aggregate Position	Trend	Variation

Pseudomonas aeruginosa bacteraemia

Number of incidence of Pseudomonas aeruginosa bacteraemia

There has been 2 incidences reported during June 2019.

There have been 7 incidences reported year to date.

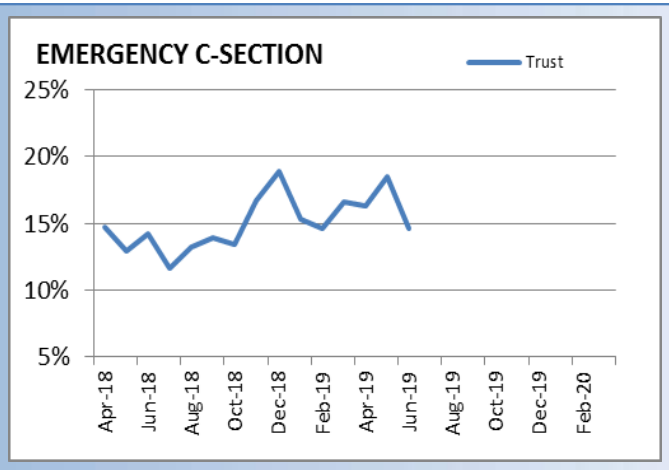


Emergency C-section rate

Maternity: Emergency C-section rate per month

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

Performance for June failed to achieve this standard at 14.6%



Further information is included in the Board Quality report

Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

EFFECTIVE

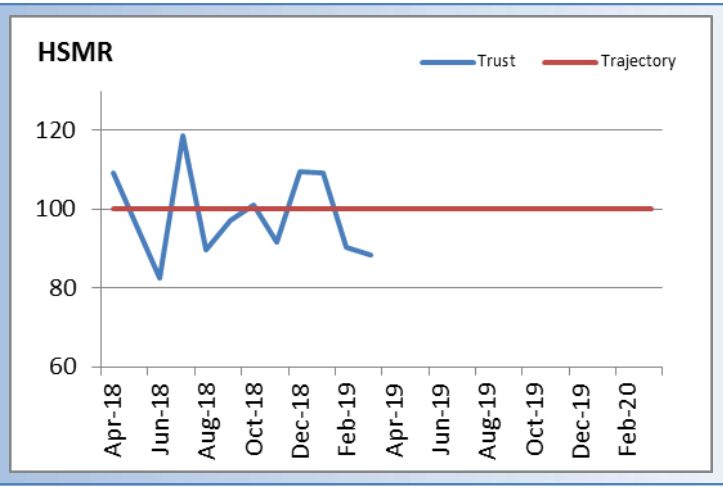
Description	Aggregate Position	Trend	Variation

HSMR

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

March 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and March achieved this at 88.4

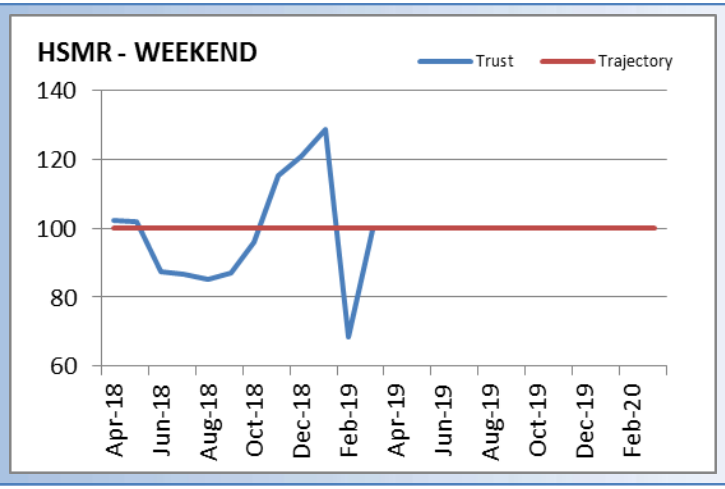


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

March 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and March failed to achieve this at 100.1



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

EFFECTIVE

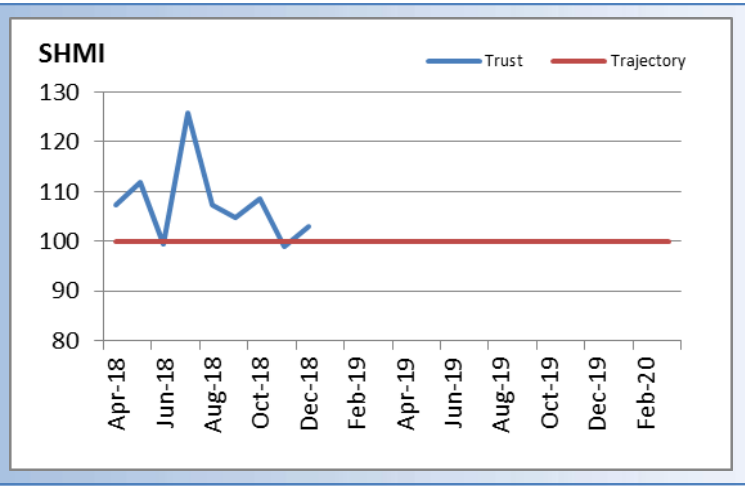
Description	Aggregate Position	Trend	Variation

SHMI

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

December 2018 is the latest published performance

The standard for SHMI is to achieve less than 100 and December 2018 achieved this at 95.6



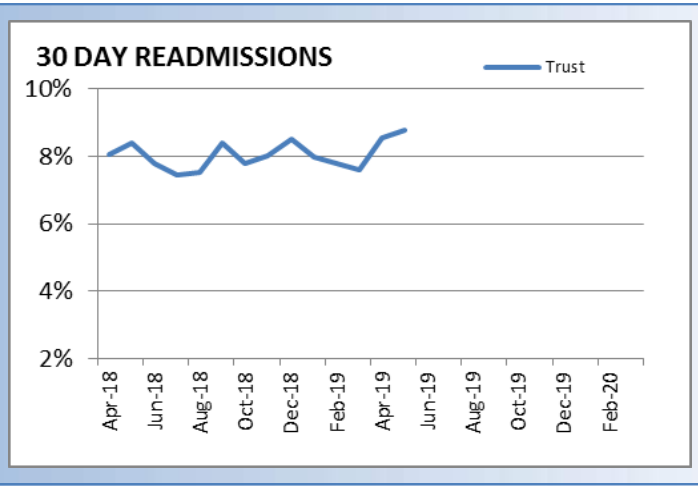
30 DAY READMISSIONS

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

The latest available performance is May 2019

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

The Trust failed to achieve this measure with performance of 8.79%.



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

CARING

Description	Aggregate Position	Trend	Variation

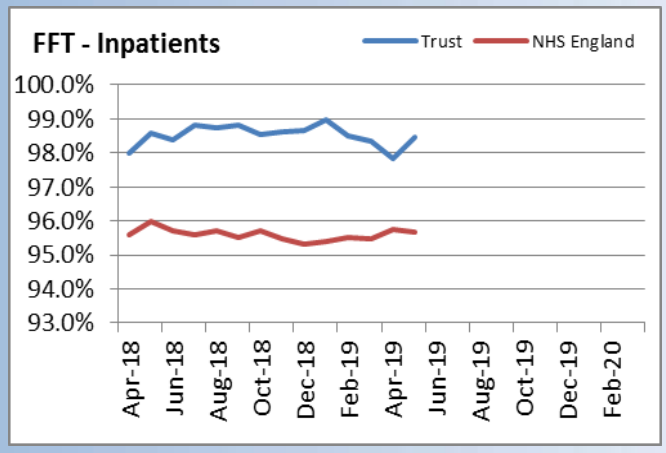
Inpatient Scores from Friends and Family Test - % positive

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

Performance for May was 98.46%

The latest published data for NHS England is May 2019.

June performance will be published in August.



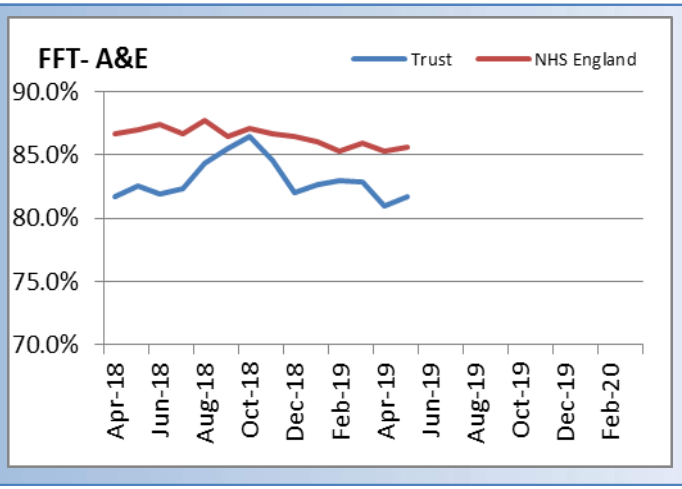
A&E Scores from Friends and Family Test - % positive

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

Performance for May was 81.64%

The latest published data for NHS England is May 2019.

June performance will be published in August.



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

CARING

Description	Aggregate Position	Trend	Variation

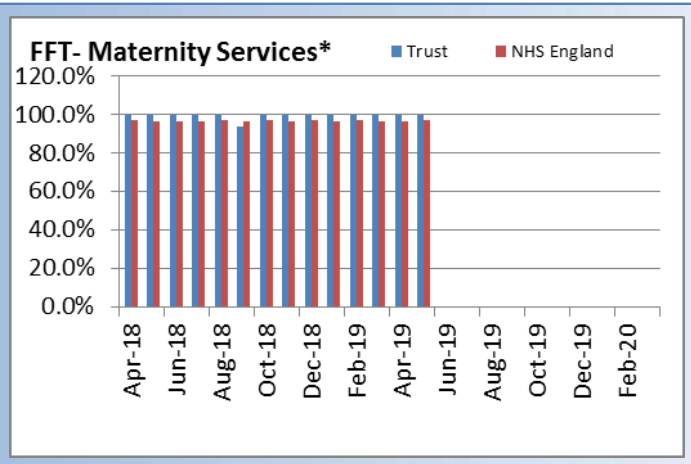
Maternity Scores from Friends and Family Test - % Positive

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

Performance for May was 100%

The latest published data for NHS England is May 2019.

June performance will be published in August.

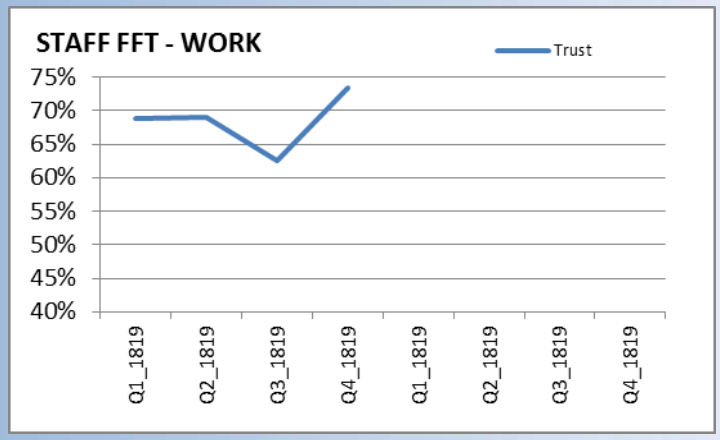


* Question relates to Birth Settings

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%.



Integrated Performance Report - July 2019

Hull University Teaching Hospitals NHS Trust

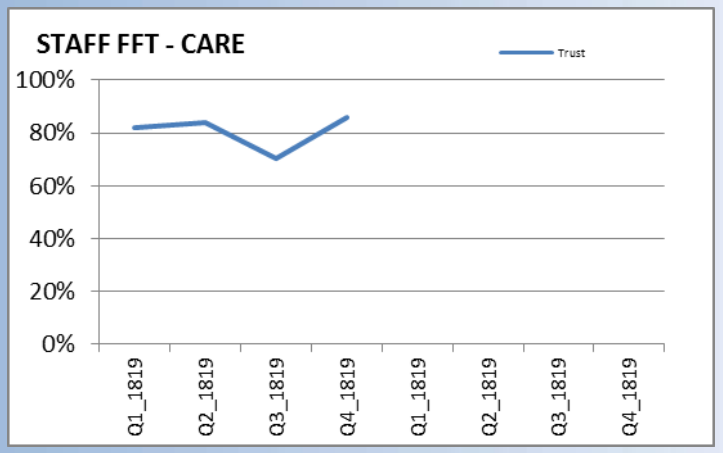
CARING

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%.

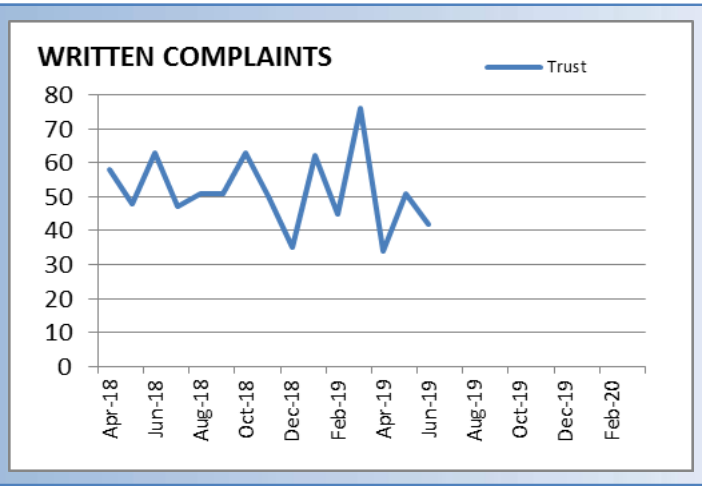


Written Complaints Rate

The number of complaints received by the Trust

The latest available position is June 2019.

The Trust received 42 complaints during June, this has decreased from the May position of 51 complaints



There have been 127 complaints year to date

Integrated Performance Report - July 2019

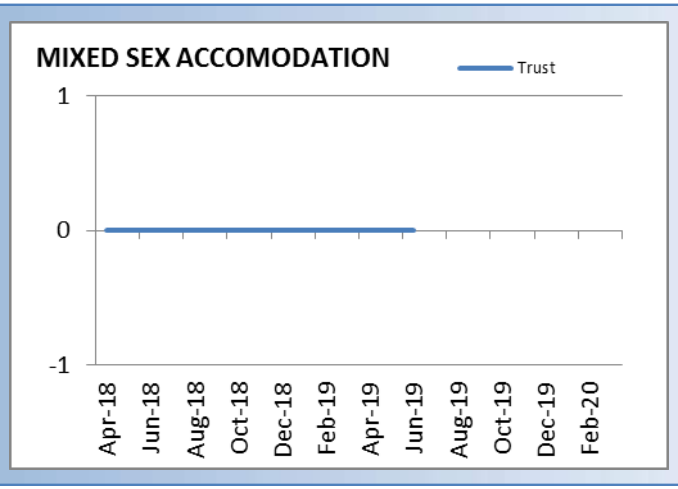
CARING

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 June 2019.



Integrated Performance Report - July 2019

ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

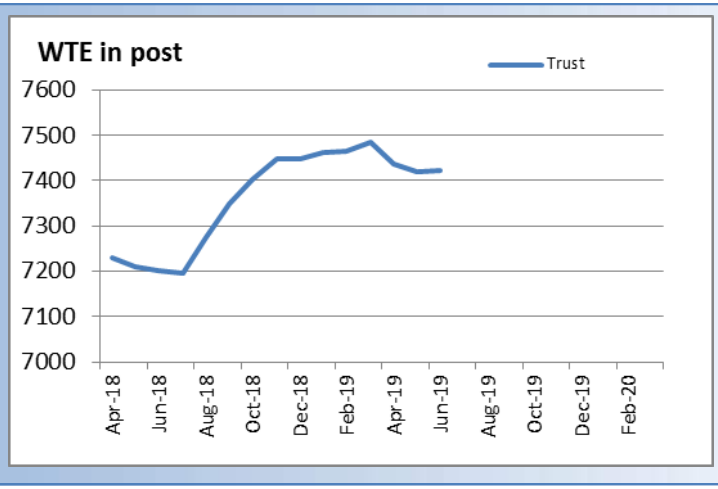
Description	Aggregate Position	Trend	Variation

WTEs in post

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

The latest available performance is June.

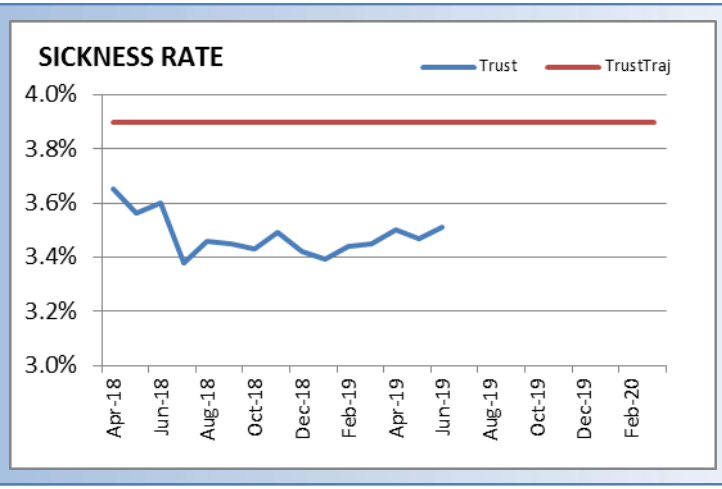
Trust level WTE position as at the end of June was 7422



Sickness Absence Rates

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

Performance for June achieved the standard of less than 3.9% with performance of 3.51%



Integrated Performance Report - July 2019

ORGANISATIONAL HEALTH

NHS Hull University Teaching Hospitals NHS Trust

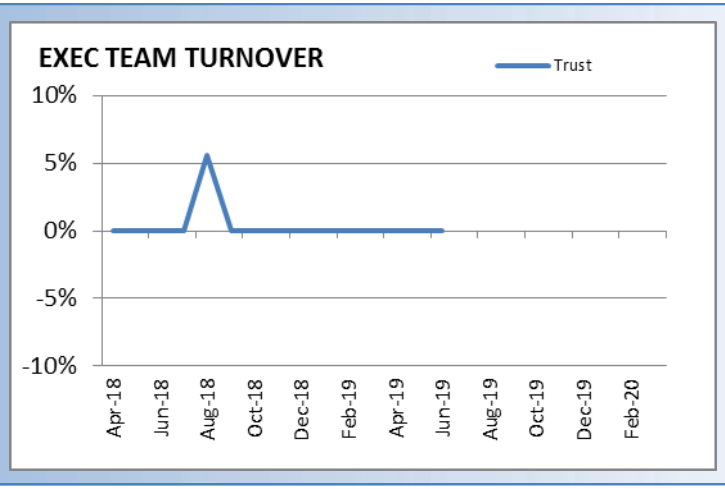
Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

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

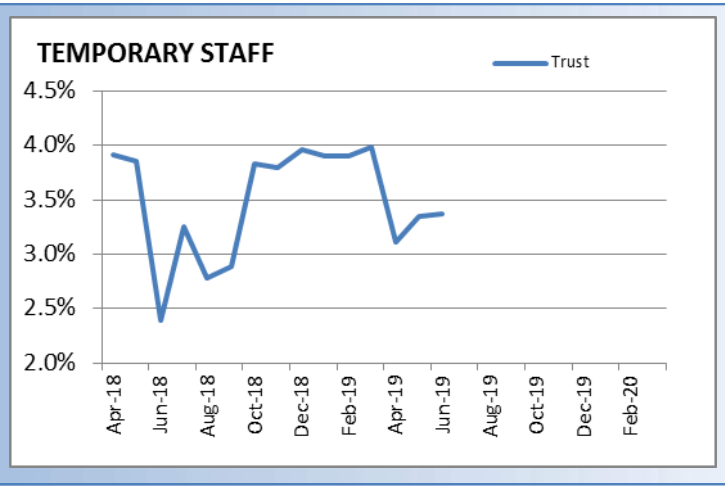


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

June performance was 3.37%



Integrated Performance Report - July 2019

ORGANISATIONAL HEALTH

NHS
Hull University Teaching Hospitals
NHS Trust

FINANCIAL SUMMARY: 3 MONTHS TO 30th JUNE 2019

1. At the end of June the Trust is reporting a deficit of £1.4m which is in line with plan.

2. The position includes £1.3m 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 3 is £1.4m above plan after accounting for the AIC. Gross income, the Trust is above plan on pass through drugs (£0.7m), Non elective (£1.5m) and devices (£0.4m). The Trust is currently subject to a coding review from Specialist Services and estimated income has been reduced by £0.8m for the first quarter as a provision against the potential claim. This offsets the in month gain on elective income. The assessment of the coding challenge should be completed by the end of July.

4. Health groups and Corporate are reporting a gross overspend of £0.2m at month 3. This is unchanged from month 2 but there have been variations at health group level. The level of high cost drug spend at £0.55m above plan relating to the AIC remains a concern although this improved slightly in month and may relate to timing issues and stock counts. This is partially offset by continued savings on Wet AMD injection drug costs of £0.15m in Family & Women's Health Group. The Surgery Health Group had the biggest movement in month with a £0.3m deterioration. This was driven by continuing high medical staff costs to cover junior doctor vacancies and additional locums to cover anaesthetic sessions. These locums are needed due to the reduction in PAs of substantive posts due to the impact of the costs of pensions. There was also an increased level of non pay over spend in month, mainly in theatres. The Clinical Support budget is £0.5m underspent at month 3 with the level of vacancies remaining high. Family & Women's HG is on plan excluding the injection drug gain. Medicine and Emergency Health Groups were close to plan in month 3 although ED nursing has overspent for the last 2 months.

5. The above position includes a small over delivery in CRES to date of £0.1m with £2.6m being delivered against a plan of £2.5m. The target to date is only 13% of the annual plan. The Trust still needs to identify another £5.5m of savings to deliver its annual financial plan alongside ensuring all schemes currently identified deliver their risk adjusted projections. This remains very challenging and 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 £2.5m on agency costs at month 3 which is £0.3m above the plan set to achieve the agency cap. The additional spend has being on Nursing and Healthcare scientific and technical staff. The additional nursing agency spend reflects the number of vacancies in nursing and the overall nursing budget is underspent.

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 £6.4m of actions to achieve. The main pressure is on CRES with current plans being £5.2m below target. Health Groups are forecasting they will identify £2.8m of this in the final 9 months but this would still leave a £2.4m shortfall. There is also medical staffing pressures in Surgery (£1.4m) and pressure on high cost drugs under AIC (£1.0m).

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 due to the additional cash received as part of the 18/19 reported surplus.

11. Capital plans are currently being updated across the STP to sit within the control total set by NHSI. Negotiations to date look favourable for HUTH as there are schemes in York and NLAG that will slip and contribute to the required reductions in 19/20. The final plan should be agreed by the end of July.

12. The underlying position is a deficit £8.6m which is only slightly changed from the £8.7m deficit at the end of 18/19.

Integrated Performance Report - July 2019

ORGANISATIONAL HEALTH

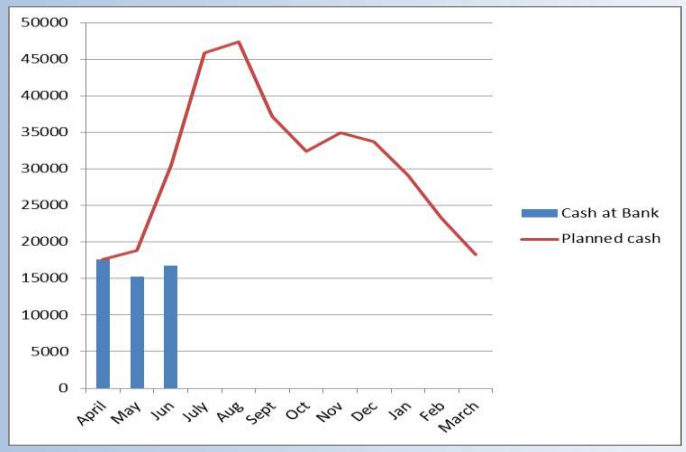
NHS Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of June we had £16.772m of cash and cash equivalents, comprising of monies in the bank of £16.755m and £0.017m 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 £16.772m cash was lower than planned as invoices are starting to be processed more quickly and the planned PSF funding had not been received in June.

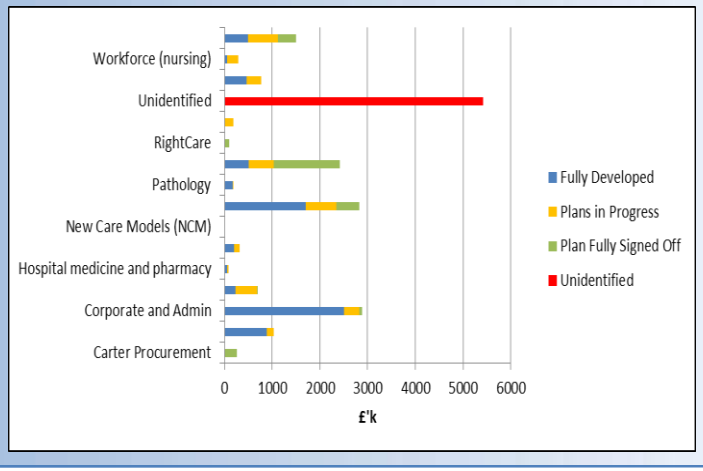


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 3 the planned level of savings is £2.5m, the actual savings are £2.6m thereby creating a £0.1m favourable 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 - July 2019

ORGANISATIONAL HEALTH

NHS Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

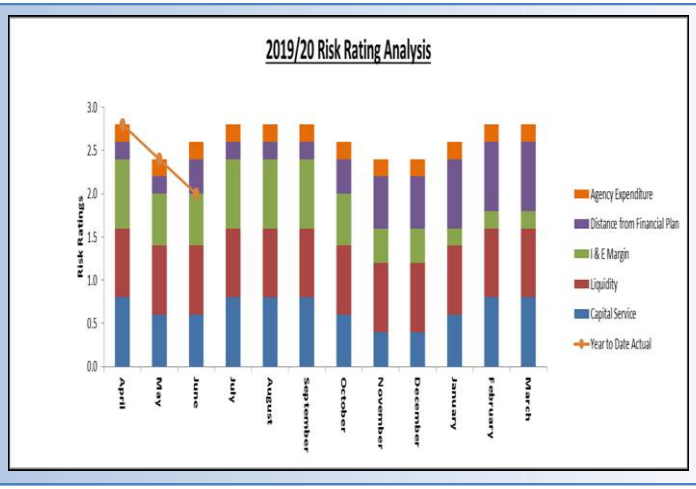
Risk Rating

Financial Sustain-ability Risk Rating

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

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

As at month 3 the Trust is reporting a YTD deficit £0.87m against a planned position of £1.4m deficit. This has resulted in liquidity being rated at a 3 , I&E margin and capital servicing being rated at a 3. Variance from control total as 1 & Agency being rated as a 2.
Giving an overall risk rating of 2.

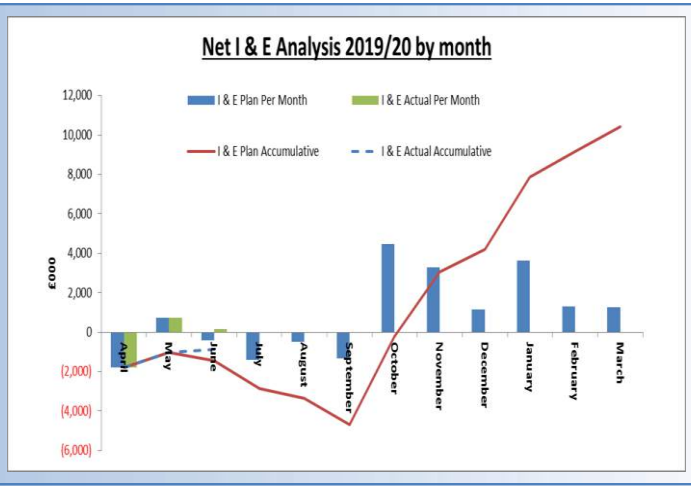


Income & Expenditure

Net income and Expenditure

The Net I & E analysis shows how the trust has performed in each month in terms of the overall performance against plan. The bars showing each months performance and plan in isolation and the lines showing the accumulative position of plan and actual.

As at month 3 the Trust has delivered a deficit of £0.87m against a planned deficit of £1.4m



Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

Meeting Date:	29 April 2019	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Board Assurance Framework – 2018/19 year end position was discussed, in particular BAF 7.1 relating to the Control Total
- Exception reporting – ED, Cancer, RTT, Outpatients, diagnostics and the Health Group positions at year end were discussed.
- IM&T/Digital Exemplar – an update regarding the network and wifi roll out and new team structure
- Demand and Activity – year end referral, activity and financial positions were presented
- Year End Financial position 2018/19 – Trust achieved £25.2m surplus – Trust achieved 85% of CRES plan
- 2019/20 Baseline Budgets – Health Groups underlying position £23.5m
- Variable pay – The Trust had spent £33m in year , mainly in Junior Doctors and consultant cover but also on nursing staff.
- Job Vacancy report – The Trust was performing well with a vacancy rate of just over 5%
- People Strategy Refresh – committee members were asked to submit comments regarding the strategy
- Capital Resource Allocation Committee minutes were received for information
- Lord Carter of Coles minutes were discussed
- Contract recommendation for the provision of Laundry Services was received.

Decisions made by the Committee:

- The Committee recommended approval of the Laundry Services contract to the Board

Matters escalated to the Board for action:

- The Committee recommends that the Board approve the Laundry Services Contract

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee held on 29 April 2019

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Nearney	Director of Workforce and OD
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Mr T Curry	Associate Non-Executive Director
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

Mr Hall welcomed Mr Curry to the meeting.

No	Item	Action
1	**Apologies:** Apologies were received from Mrs T Christmas, Non-Executive Director	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held on 25 March 2019** The minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** There was a discussion around the joint energy initiative with Hull City Council and Mr Bond advised that the discussions were ongoing. Mr Gore asked about a deep dive into physiotherapy from a productivity point of view and Mr Evans agreed to review this.	**SE**
5	**Action Tracking List** The action tracking list was reviewed by the Committee.	
6	**Workplan 2019/20** Ms Ramsay presented the plan and advised that all relevant items had been added to the agenda.	
7	**Board Assurance Framework – 2018/19 and 2019/20** Ms Ramsay presented the Board Assurance Framework and highlighted BAF risk 7.1 for review due to the Trust achieving its Control Total and year-end financial position. Mr Bond advised that it should be changed to a 5 risk rating for the year end but a new risk rating be established for 2019/20. Mr Hall highlighted the requirement for a definite diagnosis of cancer by 2020 and the increase to 40% reduction in long stay patients and whether these should be included in the 2019/20 BAF. Mr Gore also suggested that the pension tax issue be included in the financial section of the BAF. Ms Ramsay reported that the Board would discuss the BAF 2019/20 in May	

2019.

Resolved:
The Committee received and accepted the report.

8 8.1 Exception reports

Mrs Cope presented the report and advised that A&E performance had improved by 5.8% with overall performance at 82%.

Readmission rates had been built into the dashboard and was being reported by exception. The target to reduce patients length of stay had been increased to 40% from 25% and this did include the rehab patients so community working would be key to achieving the target.

The diagnostic position was at its best ever and work was ongoing to sustain this performance. Mr Hall and Mr Gore commended the teams for their contribution to this as well as the 52 week wait performance which had achieved the 0 target. There were still challenges with other Trusts regarding late referrals. Mr Hall also commended the work relating to follow ups.

Mrs Cope gave a presentation regarding the Health Group year-end positons against the 6 commitments set out at the beginning of the year. She reported that the waiting list volume had worsened in year but was now showing a more favourable position, outpatient follow ups had increased, the 52 week waits had been reduced to 0 and there was still work to do regarding cancer, the PTL and 104 day waiters.

Mrs Cope reported that the Trust's original aim was to eliminate the ASI/Holding but that it had shown an increase of 1591. This was now a priority for the Trust.

Mrs Cope advised that the Trust had achieved its waiting list size trajectory but this had impacted on RTT performance. She added that a significant level of recording errors meant that ongoing the level of validation was still necessary.

Work was ongoing to reduce the Outpatient follow up backlog and each Health Group had a plan in place to address this. Mr Hall asked for any emerging issues by exception. Mr Gore added that the Family and Women's Health Group had the biggest challenge with Ophthalmology and ENT.

Cancer 62 day was in a static position at the end of the year, but there had been an increase in 2 week referrals as well as diagnostic constraints relating to CT and PET issues.

The Committee discussed the ED internal controls and patient flow and what was driving the performance. Mr Gore asked about discharge times and Mrs Cope advised that the peak discharge times had moved out by 2 hours. Mrs Cope also spoke about medically fit patients and how the Trust was working with partners to ensure care packages are in place in a timely manner.

Mr Gore expressed his concern regarding the ENT RTT position and he wanted assurance that this was not impacting on patient safety. Mrs Cope

advised that the Health Group had a new Operations Director starting soon who was very productivity and performance focussed. The Committee agreed to invite Mrs Mizon to the meeting to give her reflections at the appropriate time. **RT**

Resolved:
The Committee received and accepted the report.

8.2 IM&T/Digital Exemplar – Progress Update
Mr Bond updated the Committee and advised that the IM&T department were looking to recruit 2 new roles to their team which included a nurse IT specialist and a medical IT specialist.

Mr Bond advised that the network and wifi was being rolled out at Castle Hill Hospital but there was a two year programme with significant investment to finish Hull Royal Infirmary.

Single sign on was going live from May 2019 and NHS Mail was being introduced.

Work was ongoing with the Lorenzo Digital Exemplar but e-Observations and e-Prescribing would not work at Hull Royal Infirmary until the network and wifi were in place.

Mr Bond advised that Mr Curry the new Associate Non-Executive Director would be reviewing the IM&T service and providing feedback to the Committee and the Board.

Resolved:
The Committee received and accepted the report.

9 9.1 Demand and Activity
Mrs Drury presented the report and advised that the Trust referrals overall are 3.7% above last year as at the end of March 2019 with all GP referrals being 1.5% above last year.

There was continued pressure on the 2 week wait referrals but non-cancer referrals were lower than last year.

Urology continued to be a concern overall and for 18/19 GP referrals were 30.4% higher. A business case was being developed to address this.

South Bank referrals were at 14% above last year, the non-GP referrals were in oral surgery, CTS, oncology, Ophthalmology and plastic surgery.

The CCGs continued to make lower referrals to Spire this year with similar referral reductions for Hull (33%) and ER CCG (30%).

Mr Bond highlighted a risk to the Ophthalmology Service with a prospective new entrant to the contract market. This could prove to be a genuine, and costly, threat to the Trust's current services and steps are being taken to counter the threat in this increasingly competitive market place.

Mr Bond agreed to keep the committee informed of progress in this area. **LB**

Outpatient first attendances were 1.7% above plan and follow ups were 4.9% above plan. These figures were slightly distorted by counting changes in Oncology. Mrs Drury added that face to face outpatient follow ups would be the key focus for 2019/20.

The overall Trust position for March (type 1) was 80.7% for March against last year at 74.9%. The full year position was 82% for the Trust and 89.4% for the system.

Mrs Drury reported that NHS England had commissioned a coding audit to review case mix changes from 17/18 to 18/19 which might impact on the Trust's financial position in 2019/20. Mrs Drury to report back at the June Committee. **AD**

Mr Gore asked when the Trust would see the Outpatients outcomes following the Patient Admin Review and Mrs Cope advised that it would be at the back end of the year. The key outputs would be reducing follow up backlogs, carrying out validation and reducing cancellations. A report to be presented to the Committee in December 2019. **TC**

Resolved:
The Committee received and accepted the report.

10 10.1 Year End Finance Report 31 March 2019

Mr Bond presented the paper and advised that the Trust had achieved the £10.2m control total deficit target, but due to missing the ED target in 2 quarters had only received £10.7m resulting in a small surplus of £0.5m

Mr Bond reported that the Trust received unexpected income gains in M12 totalling £8.2m, which enabled it to surpass the control total and qualify for reward funding from NHS I. In total, a further £17m of PSF had been received which improved the Trusts final year end outturn position to a surplus of £25.2m. Mr Bond added that this is now being subject to External Audit processes.

The Trust delivered £14.4m CRES and excluding the SPV scheme this meant 85% delivery. Only 60% of the CRES were recurrent which would impact on the 2019/20 opening position.

Health Group run rate positions were £5.8m overspent at month 12, with the main deterioration in the Surgery Health Group.

Agency spend was at £11.6m which was £2.7m above the plan. The majority of the spend related to junior medical staff and consultant cover.

The capital position at year end showed an expenditure of £23.5m.

Mr Bond advised that his main concern centred on the underlying run rate at £24.7m. The Trust would need to make CRES savings of £19m in 2019/20.

Mr Gore stated that the past year had felt different in that the Trust had made good progress both in financial terms and the Health Groups having more grip. He asked that the Committee thank them for their hard work over the year.

Resolved:
The Committee received and accepted the report.

10.2 Health Group Baseline Budgets 2019/20
Mr Evans presented the report which highlighted the process for setting health group baseline budgets. He reported that there was a potential risk of £10m to the delivery of the Trust's Control Total if £19.1m CRES was not delivered. There was only £9.8m identified at the present time.

Mr Evans advised that reserves of £12.3m had been set aside for winter, energy inflation and any unexpected expenditure throughout the year. Health Groups had been funded for agreed activity changes as part of contracts with Commissioners.

Mr Gore asked what would happen if the Trust refused to change the accounts due to the depreciation policy being interpreted in a different way. Mr Bond agreed to review this. **LB**

Resolved:
The Committee received and accepted the report.

10.3 Operational Productivity and Financial Recovery
Mr Bond gave a verbal update regarding the operational productivity and advised that he had a number of work streams to pull together to produce his report.

Resolved:
The Committee agreed to receive a written report at the next meeting in May 2019. **LB**

11 11.1 Variable Pay Report
Mr Nearney presented the report and advised that the Trust has spent £33m on variable pay to date which is significantly more than last year. He advised that the expenditure is closely linked to increased activity and £4m being spent on nursing which had come as an unwelcome surprise.

The Trust had done really well in terms of recruitment and work was ongoing to ensure the rotas were being used efficiently, especially in ED. Medicine had spent £11.4m on ED variable pay and a plan was being developed to reduce this in 2019/20.

Mr Gore asked about institutional overtime and how this could be addressed and suggested a report showing the list of people earning overtime on a regular basis. Mr Nearney agreed to produce this. **SN**

Resolved:
The Committee received and accepted the report.

11.2 Job Vacancy Report
Mr Nearney presented the report and advised that work was ongoing to recruit to the 40 consultant vacancies, with ED and Acute locums coming at a cost. He added that in benchmarking terms the Trust was an average performer regarding vacancies.

The Junior Doctor fill rate is currently 85% and Mr Nearney advised that

there would be 8 more junior doctors joining the Trust from Pakistan to complete their training. The vacancy rate was just over 5% which was a good position for the Trust.

Resolved:
The Committee received and accepted the report.

11.3 People Strategy Refresh
Mr Nearney presented the 3 year document which included key performance indicators and the Trust's objectives. He advised that the document had already been discussed at a Board Development session and this discussion had been reflected in the strategy.

Mr Nearney encouraged Committee members to feed back any comments to him before the Board meeting in May 2019 where the finalised strategy would be presented.

Resolved:
The Committee received and accepted the strategy.

12 12.1 Capital Resource Allocation Committee Minutes
The minutes were received for information.

12.2 Lord Carter of Coles Minutes
Ms Ramsay presented the minutes and highlighted her report within the minutes which was regarding productivity and efficiency and how it was seen and used at Trust Boards. She advised that there was still work to do to link the Trust Strategy to drive Board discussions.

There was a discussion around the model hospital work and how more time and money investment in the community services was required.

The Committee discussed the e-Rostering system and how to ensure the function delivered benefits for the medical and nursing teams and that it was being used to its maximum potential.

Resolved:
The Committee received and accepted the minutes.

13 13.1 Contract recommendation paper for the provision of Laundry Services
Ms Ramsay presented the paper which had been subjected to the full tender process, including a user panel and the new contract was more cost effective than the previous one.

Resolved:
The Committee received the paper and recommended approval by the Board. The paper would be received at the May 2019 Trust Board.

14 Items delegated by the Board
The Committee agreed to recommend approval of the Laundry Services to the Board meeting in May 2019.

15 Any Other Business
There was no other business discussed.

16 Date and time of the next meeting:
Tuesday 28 may 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held 28 May 2019

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr T Curry	Associate Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Evans	Deputy Director of Finance
	Mrs M Kemp	Deputy Chief Operating Officer
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr S Nearney, Director of Workforce and OD, Mrs A Drury, Deputy Director of Finance, Ms C Ramsay, Director of Corporate Affairs, Mrs T Cope, Chief Operating Officer	
2	**Declarations of interest** There were no declarations of interest received.	
3	**Minutes of the meeting held on 29 April 2019** The minutes of the meeting were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** There were no matters arising.	
5	**Action Tracking List** Mr Evans agreed to present the physiotherapy productivity deep dive information in the next PLCs paper which would be August 2019.	**SE**
	Mr Evans agreed to update the Committee regarding Patient Level Costing, to include comparative data, at the meeting in August 2019.	**SE**
	Ms Myers to update the Committee regarding bed modelling at the June 2019 meeting.	**JM**
6	**Workplan 2019/20** The Committee reviewed the workplan.	
7	**Board Assurance Framework** The Board Assurance Framework was presented and financial sustainability discussed. Mr Bond advised that the Trust had presented its financial plan to NHS I and was still waiting for guidance relating to the longer term planning process. Mr Gore stated that the Workforce risk rated at 5 felt low to him and asked how the risks, especially around the pension issues were being managed. Mr Bond advised that work was ongoing to evaluate its impact but some doctors were reducing their hours to compensate. Mrs Christmas stated that it was not a local issue and asked what was being done nationally to	

address the issue. Mr Bond advised that the Trade Unions were in discussions with the Treasury. Mr Hall suggested that the issue be raised at the next Board meeting in July 2019. **SH**

Resolved:
The Committee received and accepted the report.

8 Exception Reports

Mrs Kemp presented the report and advised that the Trust was being penalised by the way in which it was reporting 100% type 1 activity when other Trusts had blended in type 3 activity and this was showing an improved performance position.

The Emergency and Acute Medicine Health Group had put 2 actions in place, one was to look at patient flow through the department and the second one was to protect the medical resource in emergency care. NHSI had asked to see an improved performance in 2 and 4 weeks time. Maximising discharge capacity was also key. Mrs Kemp was working up the plan which would require CEO sign off.

There was a discussion around patients not being able to get GP appointments so they were attending the Emergency Department to ensure they were seen. There was now a GP facility at the front of the hospital but the throughput of patients was slow and our ability to staff it consistently was very sporadic.

Mrs Kemp advised that the reasons for the breaches were complex and it was important to have the right people in place to ensure discharges took place in a timely way. She advised that this came at a cost of £20k extra per month.

Mrs Kemp also reported that a new Performance and Activity meeting was being established for the Emergency and Acute Medicine Health Group and Mr Hall asked if he could attend the meeting for assurance purposes. Mr Gore stated that the Trust should bid for the Emergency Care Centre contract when it next came up.

The 62 day standard was below trajectory and Mrs Kemp advised that workforce related issues were the main driver. Work was ongoing across the networks to make the Trust more resilient. Breast symptomatic did not achieve in March and performance was at 84.5% against a trajectory of 93%.

62 day RTT standard was discussed and the possibilities around straight to test for imaging.

The Committee discussed diagnostic performance in detail and Mr Hall asked about 7 day services and how robust this was and what capacity options the Trust had. Mrs Kemp agreed to find out more information from the senior Operations team. **MK** Mr Gore asked why gastroscopy had increased in month and Mrs Kemp agreed to check the figures and report back to the Committee. **MK**

Mr Gore mentioned theatre start times and asked if information could be provided as to which lists did not start on time. He stated that the

information should be included on the CEO dashboard.

Resolved:
The Committee received and accepted the report.

8.2 Emergency and Acute Medicine Health Group Update
Mrs Kemp presented the Health Group update and highlighted job planning and a revised lead matrix aligned with the Trust objectives.

Mr Hall asked that Dr Hibbert attend the Committee in July 2019 to discuss job planning further within the Health Group. **RT**

Resolved:
The Committee received and accepted the update.

9 9.1 Demand and Activity
Mr Evans presented the report and advised that paediatric referrals from CHCP, ED and self referrals were showing growth and GP referrals were down. There had been an increase in 2 week wait referrals.

Specialties that had seen growth included breast, dermatology and trauma and orthopaedics. Urology had seen a decrease in the number of referrals.

Activity performance was showing elective was on plan, non-elective was above plan as was outpatients. Outpatient follow ups were being monitored. The Trust was reporting a £0.7m overtrade against the contract plan.

Resolved:
The Committee received and accepted the report.

10.1/10.2 Finance Report April 2019/CRES 2019/20
Mr Bond reported that in Month 1 the Trust was reporting a £1.8m deficit. He highlighted the overspend in the Surgery Health Group and the Community Paediatrics contractual disagreement in Family and Women's Health Group as the main concerns in month. He advised that a process had been instigated to manage the clinical considerations with a further process to review commissioning arrangements also being introduced.

In response to a sustained period of demand for service, costs incurred by the Medicine Health Group are above plan in the period to date.

The Clinical Support Health Group's main issues were the support cost of oncology and pass through drugs which caused issues with the Aligned Incentive Contract in 2018/19.

Mr Bond advised that the identified CRES plan was still far lower and work was ongoing with the Health Groups to identify schemes.

Mr Curry asked what the capital budget looked like and Mr Bond advised that the Trust had been asked to re-submit their capital plan but had heard nothing back from the Centre. He reported that even some of the 'must dos' were now unaffordable and many projects were on hold. The Capital Resource Allocation Committee was reviewing the issues closely and pragmatically allocating funds where they were absolutely necessary.

Mr Bond highlighted some good news regarding the loan for the energy upgrades from the Council. Both parties were moving forward positively and discussions were ongoing.

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Mr Gore highlighted receivables outstanding from Alliance medical, NLAG and CHCP. Mr Evans advised that these were all being followed up within the teams.

Resolved:
The Committee received and accepted the report.

10.3 Operational Productivity and Financial Recovery
Mr Bond updated the Committee and advised that he was in discussions with NHS I regarding operational productivity aligned with Right Care, Getting it Right First Time and model hospital data.

The Committee discussed staffing levels and Mr Gore suggested that data sharing and benchmarking with other organisations was key. Mr Bond added that the CQC now include use of resources in their inspection questioning.

Resolved:
The Committee received and accepted the update.

10.4 Procurement Strategy Update
Mr Bond presented the update and advised that the Trust was now 54th out of 140 Trusts on the PPIB index. Mrs Lumb was reviewing the Trust's top 100 items and these were highlighted on the appendices.

There was a discussion around standardisation of suppliers, data quality and working with the Health Groups to identify savings but resource issues had been identified. Mr Bond advised that he was reviewing this with the Head of Procurement.

Resolved:
The Committee received and accepted the report.

10.5 Patient Level Costing
Mr Evans presented the report and advised that the figures were a continuation from previous quarters. Work was ongoing with the Health Groups with the main deficit in the Surgery Health Group and Orthopaedics having the most opportunities.

Mr Evans advised that the price list was stable but in 19/20 would change again. A deep dive of physiotherapy was being undertaken. **SE**

The National data collection in August was now mandatory and work was ongoing. He agreed to update the Committee in August 2019 and this would be added to the workplan. The report would include more information regarding Trauma and Orthopaedics and benchmarking data.

SE

Resolved:
The Committee received and accepted the report.

11.1 Variable Pay Report
Mr Bond presented the report and advised that variable pay spend was £2.6m in first month with agency costs still high. The Medicine Health Group was the biggest problem with medical staffing still the main driver.

Mr Bond advised that nursing tended to be overtime costs rather than agency staffing. The Committee noted that the extra sessions were reducing and this was thought to be a reflection of the pension issues.

Resolved:
The Committee received and accepted the report.

11.2 Flowers Update
Mr Bond updated the Committee regarding the case regarding an ambulance services member of staff and holiday pay entitlement. Mr Bond advised that the outcome of this case could prove to be very costly to the NHS. Further updates would be brought to the Committee. **SN**

Resolved:
The Committee received and accepted the update.

12.1 Capital Resource Allocation Committee Minutes
The minutes were received for information.

12.2 Productivity and Efficiency Board Minutes
The minutes were received by the Committee. Mr Hall advised that the Non-Executives had an open invitation to the meeting.

13.1 Scan4Safety Update
Mr Bond presented the update and advised that Scan4Safety had gone live in cardiothoracic surgery and was now also live in Cardiology. There had been benefits seen already in terms of product recall and reduced stock values.

Mr Gore was keen to see a comparison between the Scan4Safety figures and the coding figures to see if they would score equally. Mr Evans agreed to provide further data regarding this. **SE**

Mr Bond advised that clinician buy in was key as the peer to peer challenge would drive better outcomes.

Resolved:
The Committee received and accepted the report.

13.2 Contract for the supply of Radiopharmaceuticals and related consumables
Mr Bond presented the contract and advised that the contract had been subjected to the purchasing tender process but had resulted in a 5% increase in cost.

Mr Bond advised that he would check the costing process with the procurement team and asked that the Committee delegate authority for him to sign it once clarified.

Resolved:
The Committee received the contract and delegated authority to Mr Bond to sign the contract (once the relevant checks had been carried out). **LB**

14 Items delegated by the Board
There were no items to delegate to the Board.

15 Any Other Business
There was no other business discussed.

16 Date and time of the next meeting:
Monday 24 June 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee
Held on 24 June 2019

Present:	Mr Stuart Hall	Vice Chair (Chair)
	Mr Martin Gore	Non-Executive Director
	Mrs Tracey Christmas	Non-Executive Director
	Mr Tony Curry	Associate Non-Executive Director
	Mrs Teresa Cope	Chief Operating Officer
	Mr Steve Evans	Deputy Director of Finance
	Mrs Alison Drury	Deputy Director of Finance
	Ms Carla Ramsay	Director of Corporate Affairs
	Mr Simon Nearney	Director of Workforce and OD
In Attendance:	Mrs J Railton	Assistant Director Strategy and Planning (Item 10.3)
	Mrs R Joyce	Programme Director – HIP (Item 13.1)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

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

The agenda was taken out of order at this point

10.3 Bed Modelling Update
Mrs Railton attended the meeting and updated the Committee regarding the bed modelling. Mrs Railton stated that the National Audit advised that occupancy above 80% meant Trusts would struggle to meet increased demand and that there would be a higher risk of healthcare associated infections. The Trust did not have sufficient beds available during the year to meet either the 85% or 90% requirements and the average midnight bed occupancy had also increased.

Mrs Railton advised that there was a shortfall of 99 beds across the Trust and added that a lot of effort went into managing the beds on a daily basis.

Mrs Railton also spoke about stranded and super stranded patients and how length of stay was being managed to reduce them.

Conversion rates in ED had reduced from 27% to 25% in 2018/19, due to recent pathway changes, but further work was required. Work was ongoing with GPs to ensure referrals are directed to the most appropriate healthcare provider. Castle Hill beds were also being reviewed to check bed capacity from an elective perspective.

There was a discussion around how some areas had better bed occupancy than others and how patients could be housed differently. Mrs Cope advised that the main opportunity was around same day emergency care which meant treating patients without admitting them to a bed.

Resolved:
The Committee received and accepted the report.

Mrs J Railton left the meeting

3 Minutes of the meeting held on 28 May 2019
The minutes of the meeting were approved as an accurate record.

4 Matters arising from the minutes
Mr Gore suggested that the average time of discharge be recorded on the CEO dashboard and Mrs Cope advised that she could give quarterly updates for the committee to escalate if necessary.

Mr Nearney gave the Committee an update regarding the Flowers vs. Ambulance Service case and advised that the Ambulance Service had lost the case but was appealing. Further updates would be received by the Committee when available.

5 Action Tracking List
The Committee reviewed the Action Tracking list.

6 Workplan
Ms Ramsay presented the workplan and advised that it was on track and no changes had been requested.

7 Board Assurance Framework
Ms Ramsay presented the report and advised that at month 2 assurance was being collected for each of the risks and the comments received by the Board had been added into the report.

She advised that BAF 2, 4 and 7.1, 7.2, 7.3 would be scrutinised by the Performance and Finance Committee with the workforce risks underpinning all of the issues.

The Committee discussed winter planning and how this had now changed to seasonal preparedness. Mrs Cope advised that BAF 4 would be presented to the Board in July 2019 and would highlight how confident the Trust was to deliver its constitutional standards.

Resolved:
The Committee received and accepted the report.

8.1 Exception Reports
Mrs Cope presented the report and highlighted the ED system wide improvement plan, which showed a range of actions to create a level of stability within the service. She advised that there were significant variants in the Trust's demand profile that could not be factored into the planning. The type 3 activity had now been included in the Trust's reporting which had resulted in a 6% improvement. Mrs Cope advised that the action plan was giving the Trust short term gains but a much more detailed piece of work needed to take place to look at how the system works with the Trust.

Mr Gore asked what was driving the demand and Mrs Cope advised that the Community needed to play a bigger part in addressing the issues.
Mr Gore was also keen to see the average time of discharge come down to clear beds before 5pm.

Mrs Cope advised that there was progress regarding the waiting list volumes,

which were static and the Trust was maintaining the zero 52 week waits. Regarding the waiting list volumes there was more work to do.

Mr Gore commended the teams regarding the waiting list and 52 week wait management.

Mr Gore expressed his concern regarding ENT RTT compliance as it had deteriorated and the backlog was increasing. Mrs Cope agreed to bring a report detailing recovery actions to a future meeting.

Mr Hall asked if validation was now business as usual and Mrs Cope advised that it was not yet embedded but extensive OD training was being carried out with the admin teams. There was also a discussion around follow ups and the confidence of consultants and junior doctors not to bring patients back if their follow up was not required.

Mrs Cope updated the Committee regarding diagnostics and advised that the Endoscopy staff were going through a change process regarding 6 day working with new rates of pay which was having an impact on performance. She also advised that CT, MRI and ultrasound had reached saturation point and demand was taking all of the capacity. Mrs Christmas stated that work rates for staff working 6 day weeks should be standardised across the Trust.

Resolved:
The Committee received and accepted the report.

9.1 Demand and Activity Report
Mrs Drury presented the report and advised that overall referrals had increased by 7.5% in the same period as last year. If Community Paediatrics were removed this figure reduced to 3.8%.

GP referrals were similar to last year with an increase in consultant to consultant referrals.

Hull was in line with last year with cancer 2 week wait referrals increasing. The East Riding was 12% above last year and was again seeing increases in cancer 2 week wait referrals.

There had been growth seen in ENT referrals and the CCG was reviewing ear wax referrals and different pathways. The CCGs were seeing a reduction in referrals to the Spire hospital and Advice and Guidance referrals were increasing.

Elective activity was overall below plan at the end of May, with trauma and orthopaedics, neurology, ophthalmology and dermatology all above plan.

The Emergency Department position was cumulatively at 74.4% and the system was at 84.8%. Non-elective was above plan with vascular, cancer and ambulatory care all seeing continued improvement.

Financially the Trust was £1.6m above plan.
There was a discussion around cataract patients being treated by another provider who were performing straight forward procedures and leaving the more complex cases for the Trust. This was impacting on the Trust's bottom line. Work was ongoing to work with the provider.

Southbank referrals had increased and a review was ongoing to determine the drivers of the increase.

Resolved:
The Committee received and accepted the report.

13.1 Improvement Programme Update
Mrs Joyce attended the meeting to update the Committee regarding the Improvement Programme. She advised that there were 3 key areas which were ensuring the appropriate improvement methodology was used, the improvement methodology was rolled out throughout the organisation and working hands on with the operational teams.

Projects included the Theatre Improvement Programme, implementing NATSSIPS into theatres to improve safety, redesigning Urgent and Emergency Care and the end to end admin review.

The team was also supporting the CMO in relation to GIRFT.

Mrs Joyce highlighted that the cost of the team was outweighed by the cost savings that they were making.

There was a discussion around the end to end admin review and how successful the project had been. Mrs Joyce stated that on the whole it had been successful as it was a whole system change, which impacted on 750 staff members.

Resolved:
The Committee received and accepted the report.

10.1 Finance Report, 10.2 CRES Report
Mr Evans presented the report and advised that the Trust had received a further £577k in cash due to an accountancy error made by another Trust.

The Trust was on plan and had reported a £1m deficit for month 2.

Income was £1.7m above plan mainly due to pass through drugs and devices.

CRES was slightly above plan with £1.8m delivered against a plan of £1.7m. He added that the majority of the identified schemes were back phased in the last 7 months of the year and there was still £6m of unidentified schemes.

Mrs Christmas expressed her concerns regarding the back phasing of the CRES and the lost opportunities this creates. Mr Evans advised that the Teams were struggling to identify schemes. Mrs Cope spoke about social care and how more work was required to ensure they met their targets which would then impact on the Trust's finances.

Mr Evans reported that Alliance Medical, CHCP and NLAG had paid the majority of their outstanding debts.

Resolved:
The Finance and CRES reports were received and accepted by the

Committee.

11.1 Variable Pay
Mr Nearney presented the report and advised that at month 2 the Trust had spent £5.1m on variable pay, which was a slight reduction. He advised that the Trust was doing more activity which was offsetting the variable pay.

The Surgery and Medicine Health Groups were both over spent but work was ongoing to better manage rotas, annual leave and study leave.

Resolved:
The Committee received and accepted the report.

12.1 Capital Resource Allocation Committee
Mr Hall asked about PAVU and whether this scheme would be going ahead due to funding issues. Mr Evans advised that the scheme financially outweighed the charitable funds that had been put aside for it. Ms Ramsay added that there had been major changes in critical care and that nurses had been upskilled and the project had moved on.

Resolved:
The Committee received and accepted the minutes.

14 Items delegated by the Board
There were no items discussed.

15 Any other business
There was no other business discussed.

16 Date and time of the next meeting:
The next meeting will be held Monday 29 July 2019, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust

Trust Board

30 July 2019

Title:	Q4 Staff FFT results
Responsible Director:	Director of Workforce and OD – Simon Nearney
Author:	Director of Workforce and OD – Simon Nearney

Purpose:	To inform the board of the staff FFT results for Q4 2018/2019	
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 receive this update to FFT performance and discuss and further actions required.

Hull University Teaching Hospitals NHS Trust

Trust Board

Staff FFT Q4 2018/2019

1 Purpose of the Report

To inform the board of the staff FFT results for Q4 2018/2019 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 all 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 four 2018/19 ran from 20th February until 22nd March. A total of 8,096 staff were invited to participate, with 757 staff responding, equivalent to a 9% response rate.

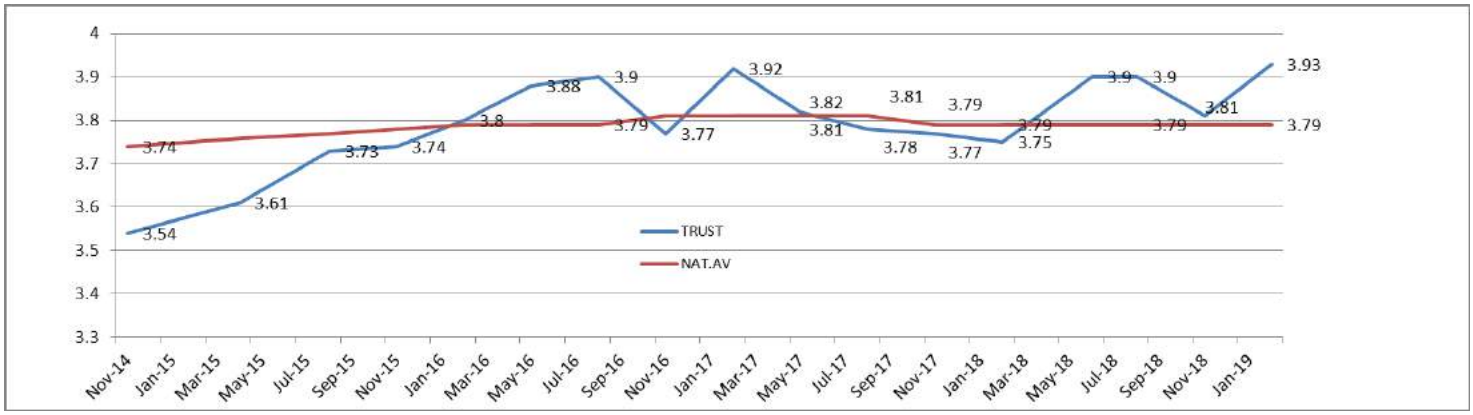
3 Overall score for engagement

Question	Positive %	Score
Q1 How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family if they needed care or treatment?	86	4.15
Q2 How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family as a place to work?	73	3.86
Q3 There are frequent opportunities to show initiative in my role	76	3.95
Q4 I am able to make suggestions to improve the work of my team/department	78	3.97
Q5 I am able to make improvements happen in my place of work	63	3.69
Q6 Care of patients/service users is my organisation's top priority	80	4.10
Q7 I look forward to going to work	63	3.68
Q8 I am enthusiastic about my job	75	3.97
Q9 Time passes quickly when I am at work	77	4.01
Average:	**75**	**3.93**

For the final time in Q1 engagement is a score out of five. The national average remains unchanged at 3.79. A change in the calculation of overall engagement means that from Q1 we will receive a score out of ten.

Question 7 is the lowest score in the survey while question 5 is routinely challenging for the Trust and the NHS as a whole. This theme was reflected in the Barrett survey which identified issues of Hierarchy and Bureaucracy as limiting values and barriers to delivering improvements.

The trend scores since 2014 are as follows, where this graph shows the Trust average compared with the national average:



4 Health group scores

The Medicine Health Group has shown a significant improvement since Q2 on its overall score for engagement.

		Q1	Q2	Q4
Trust	Hull University Teaching Hospitals NHS Trust	3.90	3.90	3.93
Health Group	Clinical Support Services (133)	3.86	3.86	3.95
Health Group	Corporate (152)	4.03	3.92	4.02
Health Group	Family & Women's Health (137)	4.00	3.93	3.96
Health Group	Estates Facilities and Development (98)	3.98	3.86	3.92
Health Group	Medicine (156)	3.78	3.98	3.94
Health Group	Surgery (69)	3.81	3.87	3.79
Respondents		1339	1340	757

5 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 Q4 this is ranked as follows, where green is above the Trust target score of 3.88, amber is between national average and the target score and red is below the national average. Staff groups are highlighted in light blue.

AREA	RESPONDENTS	ENGAGEMENT SCORE
WAC Management	15	4.81
Family and Women's Management	22	4.48

Physiotherapy	14	4.46
General Management	80	4.34
Therapies	23	4.33
Neurophysiology	13	4.33
HR, OD, Communications, Workforce Planning	28	4.30
Medicine Management Team	10	4.28
Digestive Diseases	10	4.20
Paediatrics	11	4.17
Elderly Medicine	21	4.17
Information & Coding	22	4.15
Care Records Service	11	4.12
Surgery Management	11	4.10
Retinal Screening	12	4.08
Registered Nurses and Midwives	122	4.06
Corporate	152	4.02
Allied Health Professionals, Healthcare Scientists, Scientific and Technical	126	4.02
Pharmacy	15	4.01
Pharmacy	16	3.99
Estates Management	30	3.98
Hull Royal Infirmary	419	3.98
Compliance, Capital Schemes and Estates Development, Grounds and Gardens, Property Services	17	3.97
Family & Women's Health	137	3.96
Imaging	20	3.96
Clinical Support Services	133	3.95
Medicine	156	3.94
Specialist Services	26	3.94
Trust	757	3.93
Estates, Facilities & Development	89	3.92
Castle Hill Hospital	314	3.91
Surgical Specialties	40	3.91
Nursing or Healthcare Assistants	99	3.90
Theatres	23	3.89
Ophthalmology	21	3.89
Clinical Support Management	19	3.87
Emergency Department inc. Paediatrics	35	3.86
Finance & Business and Planning	16	3.86
Orthopaedics	10	3.86
Women’s and Children’s	58	3.85
Facilities	44	3.83

Surgery	69	3.79
Administrative Staff	220	3.78
Medical and Dental	31	3.74
Pathology	19	3.74
Obstetrics	19	3.72
Cardiology	15	3.70
Wider Healthcare Team	48	3.66
Trauma	15	3.58
Theatres	10	3.43
Acute Medicine	10	3.20

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.

Overall engagement remains low in pathology, obstetrics, cardiology and acute medicine (inc, site team). These areas were among the top ten lowest scoring areas for staff engagement in the national staff survey, conducted during November 2018.

6 Work programme

The current 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 Remarkable People management programme, designed to ensure all managers working at the Trust are developed to be a HUTH Leader is now well underway. 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.

All HUTH managers will undertake a behavioural-based programme designed to ensure they have the skill set and tools to engage, empower and inspire their teams to deliver great care. The Trust needs to its managers to be transformational leaders, who are effective communicators, actively listen to their staff and encourage their teams to continually learn and improve. The programme will be robustly measured using 10 core development areas against which all managers will be reviewed giving them clear areas for development to be discussed in their appraisal.

This work is being undertaken by the Trust's Organisational Development team with support from Communications and Engagement and Education and Development.

Supporting the People management programme will be the ongoing and successful Great Leaders Bitesize courses offering leadership and personal development in a range of areas from financial management to managing people as a coach.

8 Recommendations

The Trust Board is requested to receive this update to FFT performance and discuss and further actions required.

Simon Nearney
Director of Workforce and OD
July 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

30 July 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:	There are some recommended changes to Standing Orders to take account of changes in EU tendering threshold values.	

Recommendation:	The Trust Board is requested to: • Approve the changes to Standing Orders

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders May 2019

1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2. Changes to Standing Orders

Any changes to Standing Orders require Trust Board approval. Following a recent internal audit on procurement, it was noted that the EU limits on tenders were out of date and require revision.

Section 9.1 of Standing Financial Instructions in Standing Orders, and the Financial Scheme of Delegation, are recommended to change from:

Value of Goods/Services	Tender/quotation requirement
Less than £10k (including VAT)	Use NHS supply chain and established contracts where possible otherwise obtain a quotation (see guidance below)
Between £10k and up to £50k (including VAT)	Obtain a quotation (see guidance below)
£50k to £106k (including VAT)	Undertake a local tender exercise (see guidance below)
More than £106k (Including VAT)	Tender exercise using EU procurement procedures

Programmes of "works" have an EU tender threshold of £4,104,394

*The table below shows the 6 OJEU limits

Goods and Services – central procurement including NHS Trusts	£106,047
Goods and service sub central government (including NHS foundation Trusts)	£164,176
Goods and services – utilities and defence	£328,352
Light touch regime services – public sector rules	£589,148
Light touch regime services – utilities	£785,530
Works	£4,104,394

To be changed to (changes highlighted in grey):

Value of Goods/Services	Tender/quotation requirement
Less than £10k (including VAT)	Use NHS supply chain and established contracts where possible otherwise obtain a quotation (see guidance below)

Between £10k and up to £50k (including VAT)	Obtain a quotation (see guidance below)
£50k to £118,133 (including VAT)	Undertake a local tender exercise (see guidance below)
More than £118,133 (Including VAT)	Tender exercise using EU procurement procedures

Programmes of "works" have an EU tender threshold of £4,551,413

*The table below shows the 6 OJEU limits

Goods and Services – central procurement including NHS Trusts	£118,133
Goods and service sub central government (including NHS foundation Trusts)	£164,176
Goods and services – utilities and defence	£328,352
Light touch regime services – public sector rules	£589,148
Light touch regime services – utilities	£785,530
Works	£4,551,413

4 Recommendations

The Trust Board is requested to:

- Approve the changes to Standing Orders

Carla Ramsay
Director of Corporate Affairs
July 2019

Hull University Teaching Hospitals NHS Trust

Extraordinary Audit Committee

Minutes of the meeting held 23 May 2019 at 1.00 pm, Chris Long's Office Alderson House, Hull Royal Infirmary

Present:

Tracey Christmas	Non-Executive Director/Committee Chair
Martin Veysey	Non-Executive Director

In attendance:

Lee Bond	Chief Financial Officer
DI Roberts	Deputy Director of Finance
Terry Moran CB	Trust Chairman
Chris Long	Chief Executive
Perminder Sethi	Grant Thornton, external auditors
Gareth Kelly	Grant Thornton, external auditors
Carla Ramsay	Director of Corporate Affairs (minutes)

1. Apologies

Apologies were received and accepted from Martin Gore. The meeting had a quorum.

2. Declarations of interest

None.

3. Audited Accounts 2018/19

The draft audited accounts were presented to the meeting.

3.1 Audit Findings Report

Mr Kelly presented the Audit Findings Report. Grant Thornton stated in the Audit Findings Report that the auditors anticipate issuing an unqualified audit opinion subject to the satisfactory completion of one outstanding issue. The report also confirmed that an unqualified Value for Money opinion would also be issued, and would not include a paragraph regarding material uncertainty in relation to Going Concern.

There were three items of discussion:

- Recent changes to RICS guidance: The Trust's opinion is that the revised RICS guidance is new guidance, prospective in nature, and therefore would not result in an additional depreciation charge of £2m. Grant Thornton's view is that the guidance is clarification of existing guidance and therefore would generate an additional £2m depreciation charge in 2018/19. After detailed discussion and challenge from the Trust that Grant Thornton's own interpretation of the guidance would only result in an unadjusted misstatement of £500k which related to the period January to March 2019, it was agreed that the Trust's view would be reflected in the report .Grant Thornton will work with Mr Bond on the wording in the unadjusted misstatements section, for agreement with the Audit Committee Chair and promised to raise the Trusts view at the next panel meeting. The Committee noted that despite this the unadjusted misstatement may remain at £2m. This matter will be briefed to the Board.
- An impairment treatment suggested by Grant Thornton has been accepted by the Trust, which has an impact of £1.57m. This will be reflected in an update to the accounts and briefed to the Board accordingly.

- Donation: the Trust received a donation of £3.4m from an external source that it has included in its accounts. Grant Thornton is taking further advice on this point and will need to confirm a final position in the next day. After detailed discussion, it was agreed that the Trust Board would be asked to approve the accounts, with the above two points raised, and with the delegated authority for the Audit Committee Chair to have final approval of the accounts pending the satisfactory resolution of this final point with the auditors today or tomorrow. It was agreed that this point would be concluded so that the accounts can still be approved pending final action at the public board meeting today and that the submission deadline of Wednesday next week would definitely be met.

4. Letter of Representation
Mr Bond confirmed that the letter is fine from the Trust's perspective. It will be recommended to the Trust Board for signature, pending an updated version to reflect the three points above.

5. Annual Report
Ms Ramsay presented this report. She confirmed it contained all necessary disclosures and there were no issues of concern or non-compliance to make the Audit Committee aware of. Mr Long confirmed that the Annual Governance Statement did not raise any significant issues of internal control. The Audit Committee agreed to recommend this to the Board for approval.

6. Losses and compensation/fraud disclosure
Mr Bond updated the Committee on email contact that had been received from NHS Improvement two days ago. The NHS Counter Fraud Authority has given a valuation to the National Audit Office on NHS fraud cases, which includes a value of £670k in respect of the former Chief Executive of this organisation. Mr Bond was asked if he believed all necessary disclosures had been made. Mr Bond gave an overview of what he believed the NHS Counter Fraud Authority calculation consisted and reminded the Audit Committee about the way in which these issues had been brought to the Audit Committee at the time; this case is from before 2014. Audit Committee members noted that the fraud cases that were being brought by the Crown Prosecution Service against the former Chief Executive and the former Chief Nurse have not gone ahead, therefore the fraud remains allegations only. The Audit Committee confirmed that it believed all necessary disclosures to the Trust were made at the time alongside the full disclosures to the Trust's auditors of that time.

7. Any other business
None

Date and time of next meeting
25 July 2019, 9.00 am – 12 noon, Committee Room, HRI

Hull University Teaching Hospitals NHS Trust

Trust Board

30 July 2019

Title:	Quarterly Report on Safe Working Hours
Responsible Director:	Makani Purva, Chief Medical Officer
Author:	Nagarajan Muthukumar, Guardian of Safe Working Hours

Purpose:	**PURPOSE OF THIS REPORT** The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate	
BAF Risk:	BAF Risk 2 - Staffing	
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:	There were a total of 91 exception reports with a total of 109 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to staff shortages, volume of work and practices such as late ward rounds which lead to trainees staying beyond the contracted hours or missed educational and training opportunities.	

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

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING 1 January 2019 – 31 Mar 2019

EXECUTIVE SUMMARY

The Guardian Report for this Trust Board Meeting covers the quarter from January 2019 to March 2019

Exception Reporting patterns and responses

There were a total of 91 exception reports with a total of 109 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to staff shortages, volume of work and practices such as late ward rounds which lead to trainees staying beyond the contracted hours or missed educational and training opportunities. In a few instances the trainees appear to be staying over in the interest of patient care. There were a few reports about the work schedule not reflecting the actual work time and these led to work schedule reviews.

In this quarter the following were the number of episodes of exceptions reported trainees by Health Group

Clinical Support - 23
Family and Women – 1
Medicine – 38
Surgery - 29
GP placement – 0

Exception Report trends:
Oncology & Haematology: Following a spate of reports from trainees in the Oncology unit in the last quarter, there was a task and finish group set up by the CMO to look into various aspects of the working in the department. There has been a reduction in the number of the exceptions reported in this quarter (23 episodes).

Cardiology: There were 23 episodes reported by one trainee in the unit all of which were submitted by a single trainee. These are currently still open as the trainee has been on sick leave and a meeting with the supervisor has not been possible.

Summary

Exception reporting seems to be a good early-warning system to indicate where there may be issues. The main issues raised and areas of concern for this quarter have been highlighted in this report. At the current time there still is no system in place to robustly capture all instances were trainees have breached the safe working hours as required by the Junior Doctor Contract 2016. The Guardian has had meeting with the Director of Workforce & OD, the Chief Medical Officer as well as the Head of HR Services to try and address this issue. It has been suggested that the creation of the post of Junior Doctors' Hours Monitoring Officer which sits in the Medical Staffing might be a solution.

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 Jan 2019 – 31 Mar 2019

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING 1 January – 31 March 2019

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): (establishment)	555 478.1 (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: per week	2 PAs / 8 hours
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.

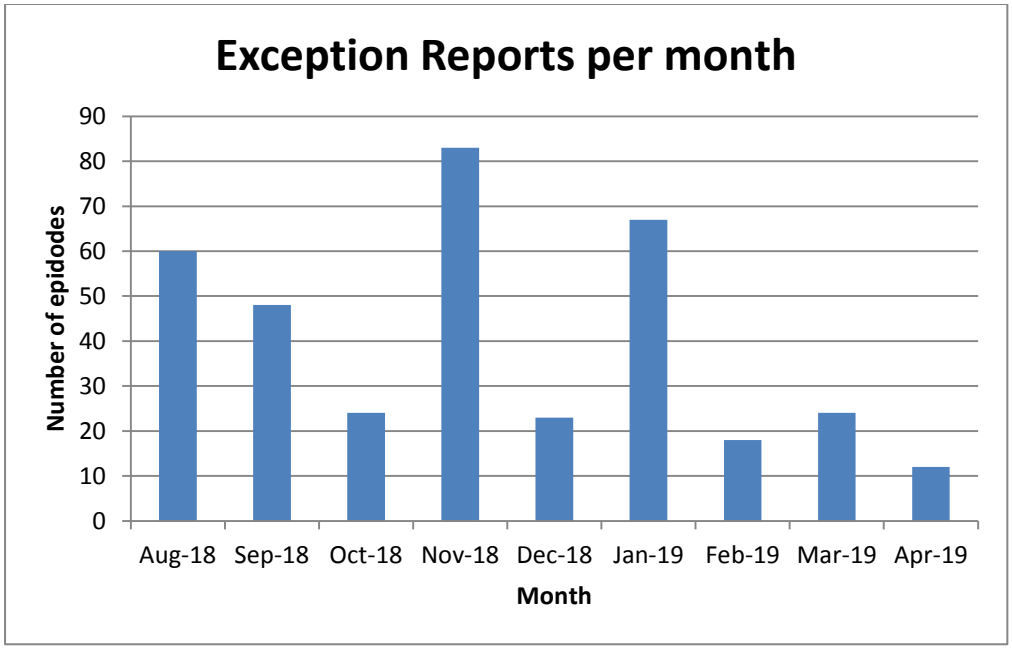
3. JUNIOR DOCTOR WORKING HOURS

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.

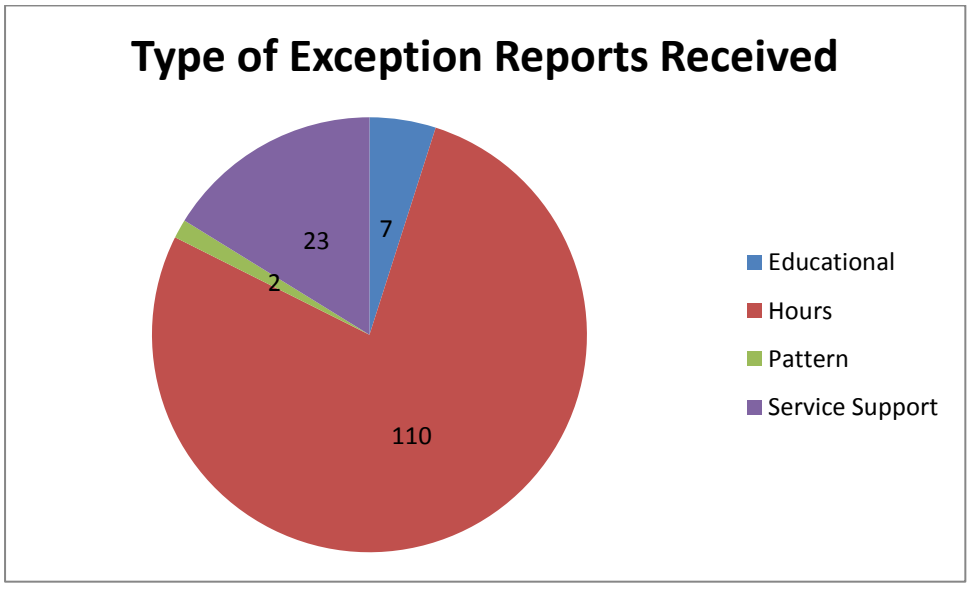
In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern.

There were 109 exception report episodes submitted between 1 January and 31 March 2019 and 33 carried forwards from the previous quarter.

Exception reports over time



Types of exception reports received 1 January 2018 – 31 March 2019



Exception reports (episodes) by specialty 1 January – 31 March 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	0	6	6	0
Acute Surgery HRI	1			1
Breast Surgery	1		1	
Cardiology		36		36
Colorectal Surgery	4	10	14	
Critical Care		4	4	
Elderly Medicine	1	9	10	
Emergency Medicine		1	1	
Endocrinology	1		1	
Endocrinology & Diabetes		1	1	
ENT		4	4	
Gastroenterology	4		1	3
General Surgery / Vascular	2		2	
Haematology		10	9	1
Infectious Diseases	3		3	
Medicine Nights		1	1	
Neurosurgery		4		4
Obstetrics & Gynaecology		1	1	
Oncology	5	13	18	
Rheumatology	3	2	2	3
Surgery nights CHH	3		3	
Trauma & Orthopaedics	1	4	1	4
Upper GI Surgery		5	3	2
Vascular	2		2	

Exception reports (episodes) by grade 1 January – 31 March 2019

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1		83	41	42
F2	6	5	7	4
CT1	4	14	13	5
CT2	1	6	3	4
GPST1	1	3	4	0
GPST2	0	11	10	1
ST3	2	0	0	2
ST4	1	0	0	1
ST5	0	4	0	4
ST6	0	1	1	0

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 January – 31 March 2019

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 32 - Neurosurgery ST	0	4	0	4
23 - Vascular Surgery F1 (inc. ENT/Uro)	4	0	2	2
Rota 1 - A&E F2	1	0	1	0
Rota 124b General Surgery (Uro/ENT) SHO	3	0	0	3
Rota 133 - Neurosurgery (ENT) F2 & CT	0	4	0	4
Rota 134 - Orthopaedics F2	0	4	4	0
Rota 135 - Orthopaedic & Plastic Surgery CT	1	0	1	0
Rota 14 - Medicine SHO blp 431	0	8	8	0
Rota 15 - Medicine SHO (blp 450)	3	2	2	3
Rota 18 - Medicine F1	6	4	10	0
Rota 18B - Crit Care F1 (Aug 18)	0	1	1	0
Rota 18B - Medicine F1	0	3	3	0
Rota 25 - Acute-Elective Surgery F1	6	15	18	3
Rota 4 - Medicine F1	4	42	9	37
Rota 5 - Medcine SHO (blp 215)	0	1	0	1
Rota 51 - O&G ST1-2	0	1	0	1
Rota 6 - RMO	3	1	1	3
Rota 8 - Oncology/Haematology SHO	1	20	20	1

Exception reports (episodes) - response time 1 January - 31 March 2019

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	16	5	19	43
F2			3	8
CT1	7	2	4	5
CT2			3	4
GPST 1		2	2	
GPST 2	2	6	2	1
ST3				2
ST4				1
ST5				4
ST6	1			

The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

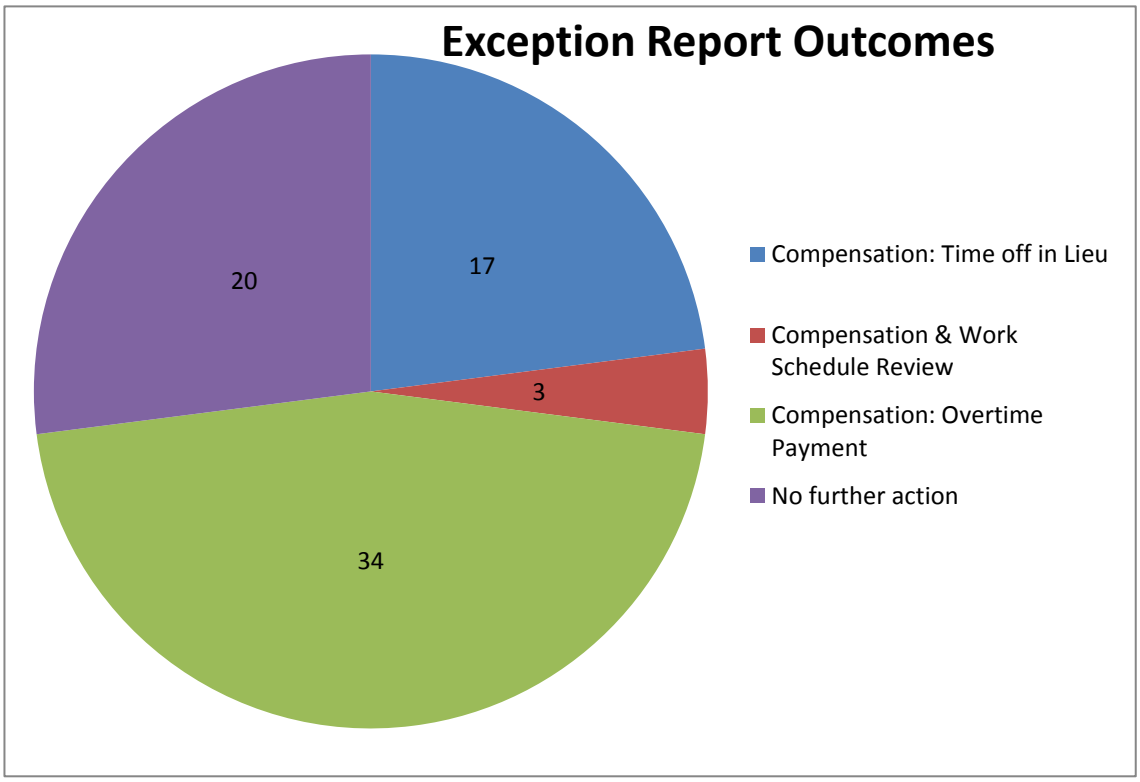
Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.`

This is shown in the table below:

Department (base dept)	No of reports (episodes)	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open
Acute Internal Medicine	6	4	1	1		0
Cardiology	36					36
Colorectal Surgery	1					1
Elderly Medicine	10	1	6	3		0
Emergency Medicine	1			1		
Endocrinology & Diabetes	2			2		
ENT	7		4			3
Gastroenterology	4			3		1
General Oncology	2		2			
General Surgery	10	5	0	5		

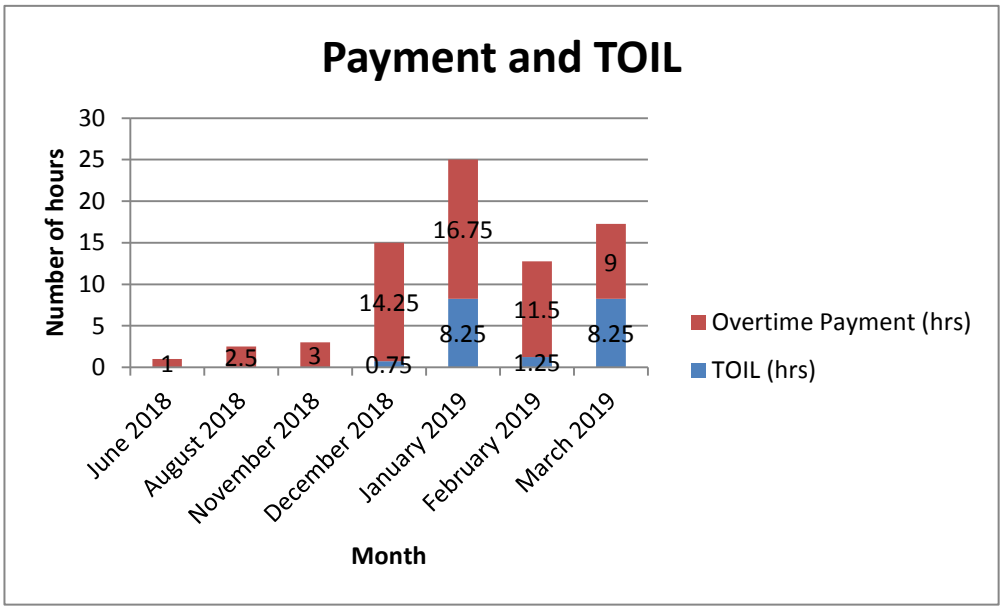
General Surgery / Breast	1			1		
General Surgery / Lower	4	2	2			
General Surgery / Upper	5	2	3			
General Surgery / Vascular	4			2		2
Haematology	10	6		3		1
ICU / Anaesthetics	4	1		3		
Infectious Diseases	3					3
Medical Oncology	7	2	1	4		
Neurology / Stroke Medicine	1					1
Neurosurgery	4			3		1
Obs & Gynae	1					1
Oncology	9	5	1	3		
Rheumatology	5	1		1		3
Trauma & Orthopaedics	5				5	

Outcomes of completed exception reports 1 January – 31 March 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

A work schedule review has been requested by the Guardian following a spate of exception reports by trainees from Oncology department.

Rota 25 – F1 Acute/Elective Surgery – This rota is currently being reviewed after feedback from trainees on staffing levels during their time in Acute Surgery and start time of the long days at Castle Hill Hospital during their time working in Elective Surgery. The change to the rota pattern has been agreed by all parties and we are currently in discussion about when the change will come into effect. This will likely be in conjunction with the August rotation or if sooner will follow the 6 week deadline as stipulated in the Junior Doctors' Terms and Conditions of Service.

Rota 19 – F2/CT Acute Assessment Unit – The change in this rota pattern is currently under review after discussions between Junior Doctors and the Department. We are amending the rota pattern to give more handover time and moving shifts to give less onerous weeks in the rota.

Rota 32 – ST3+ Neurosurgery – The Junior Doctors and Consultants have been discussing changing their rota pattern. This is not currently being run through the rota until feedback from the department.

a) Locum bookings January to March 2019

i) Bank January to March 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*	141	0	1,320.25	0.00
F2	654	90	5,199.00	718.50
CT/ST-2/GPSTR	1,383	31	13,278.50	223.50
ST3+	1,032	13	10,888.50	107.50
TOTAL	**3,210**	**134**	**30,686.25**	**1,049.50**

**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	239	10	1,939.50	47.50
Anaesthetics	6	0	66.00	0.00
Breast Surgery	75	0	773.00	0.00
Cardiology	63	9	573.50	37.50
Chest Medicine	13	0	115.25	0.00
Colorectal	128	14	1,593.00	164.00

CT Surgery	166	0	1,440.00	0.00
Elderly Medicine	137	5	1,129.50	24.00
Endocrinology	30	0	223.25	0.00
ENT	245	1	2,477.00	7.00
Gastroenterology	28	0	222.75	0.00
General Surgery	72	0	812.00	0.00
Haematology	2	0	48.00	0.00
Neonatal Medicine	47	0	579.50	0.00
Neurology	143	1	1,140.25	8.00
Neurosurgery	169	23	1,734.25	183.50
Obstetrics and Gynaecology	3	0	36.00	0.00
OMFS	67	8	745.50	32.00
Oncology	82	3	800.75	37.50
Orthopaedics	407	35	4,293.00	348.00
Paediatric Surgery	68	0	630.00	0.00
Paediatrics	28	0	336.00	0.00
Plastic Surgery	13	0	213.50	0.00
Radiology	1	0	4.00	0.00
Renal	11	0	107.50	0.00
Rheumatology	27	3	249.50	16.50
Upper GI	208	21	2,193.50	136.00
Urology	63	0	785.50	0.00
Vascular Surgery	8	0	84.50	0.00
Winter Pressures	661	1	5,340.25	8.00
TOTAL	**3,210**	**134**	**30,686.25**	**1,049.50**

Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	8	0	87	0.00
Compassionate/Special Leave	23	0	289	0.00
Extra Cover	213	0	1821.5	0.00
Maternity/Paternity Leave	70	0	536	0.00
Sickness	192	0	2037	0.00
Study Leave	9	0	114	0.00
Vacancy	2,695	134	25,801.75	1,049.50
TOTAL	**3,210**	**134**	**30,686.25**	**1,049.50**

ii) Agency January to March 2019

Locum bookings (agency) by grade				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	141	99	1,320.25	1,030.50
F2	654	186	5,199.00	1,865.50
CT/ GPSTR/ST-2	1,383	1,199	13,278.50	11,641.25
ST3+	1,032	714	10,888.50	7,176.50
Total	**3,210**	**2,198**	**30,686.25**	**21,713.75**

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	239	58	1939.50	690.00
Anaesthetics	6	0	66.00	0.00
Breast Surgery	75	68	773.00	686.00
Cardiology	63	18	573.50	217.00
Chest Medicine	13	8	115.25	90.25

Colorectal	128	70	1593.00	889.50
CT Surgery	166	109	1440.00	916.50
Elderly Medicine	137	11	1129.50	130.75
Endocrinology	30	9	223.25	89.00
ENT	245	199	2477.00	2064.00
Gastroenterology	28	8	222.75	89.50
General Surgery	72	72	812.00	812.00
Haematology	2	0	48.00	0.00
Neonatal Medicine	47	47	579.50	579.50
Neurology	143	128	1140.25	1,024.00
Neurosurgery	169	112	1734.25	1,196.00
Obstetrics and Gynaecology	3	3	36.00	36.00
OMFS	67	20	745.50	160.00
Oncology	82	38	800.75	444.75
Orthopaedics	407	283	4293.00	3,141.50
Paediatric Surgery	68	58	630.00	529.00
Paediatrics	28	28	336.00	336.00
Plastic Surgery	13	4	213.50	52.00
Radiology	1	0	4.00	0.00
Renal	11	4	107.50	49.00
Rheumatology	27	10	249.50	121.75
Upper GI	208	146	2193.50	1,681.50
Urology	63	25	785.50	313.00
Vascular Surgery	8	6	84.50	75.00
Winter Pressures	661	656	5340.25	5,300.25
TOTAL	**3,210**	**2,198**	**30,686.25**	**21,713.75**

Locum bookings (agency) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	8	6	87.00	75.00
Compassionate/Special Leave	23	23	289.00	289.00
Extra Cover	213	151	1821.50	1260.75
Maternity/Paternity Leave	70	61	536.00	500.00
Sickness	192	118	2037.00	1421.25
Study Leave	9	9	114.00	114.00
Vacancy	2,695	1,830	25801.75	18053.75
Total	**3,210**	**2,198**	**30,686.25**	**21,713.75**

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 1.10.2018 to 31.12.2018 1AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	521	459	521	4960.083	4468.083
Total					

Locum Bookings (bank) by 1.10.2018 to 31.12.2018 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	1215	621	1215	10108.6	4825.5

b) Locum work carried out by trainees January to March 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**
Intensive Care Medicine	CT	127.00	46:30	Yes
Cardiothoracic Surgery	ST3+	187.50	47:30	Yes
General Practice	F2	77.50	40:00	Yes
Chest Medicine	ST3+	105.00	45:30	Yes
Neurology	ST3+	79.75	45:45	Yes
General Practice	F2	100.00	40:00	Yes
Oncology	GPSTR	104.00	46:30	Yes
General Practice	GPSTR	110.50	40:00	Yes
Oncology	F2	67.50	46:30	Yes
Oncology	GPSTR	35.00	46:30	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 17th April 2019. Detailed below is a table indicating the rota establishment and WTE in post as of 17th April 2019 and Doctor in Training establishment as of 17th April 2019.

Hull University Teaching Hospitals NHS Trust - Junior Doctor Rota Establishment Effective 17/04/2019

	Trainee Establishment						Rota Establishment						In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Posts Filled 10.01.2019	% Posts Filled 17.04.2019
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	83.33%	87.50%
Anaesthetics	4	4	15	0	28	51	4	4	16	0	32	56	4	4	16	0	23	47	79.66%	83.93%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	2	0	1	0	1	4	60.00%	80.00%
Cardiology	2	1	4	1	9	17	2	1	4	1	12	20	2	1	4	1	16	24	145.00%	120.00%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	3	0	0	8	11	75.00%	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	92.59%	96.30%
Emergency Medicine	0	12	7	5	14	38	0	12	7	5	8	32	0	12	7	5	9	33	100.00%	103.13%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	3	0	2	0	3	8	77.78%	88.89%
ENT	1	1	2	1	4	9	1	1	3	1	6	12	1	1	2	1	6	11	83.33%	91.67%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	2	0	4	9	96.00%	90.00%
General Practice	0	18	0	39	0	57	0	18	0	39	0	57	0	13	0	27.8	0	40.8	91.23%	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	2	0	5.6	8.6	86.00%	86.00%
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	0	0	0.00%	0.00%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	5	9	2	0	2	0	2	6	66.67%	66.67%
Lower GI Surgery	7	0	2	0	3	12	7	0	2	0	6	15	7	0	2	0	6	15	100.00%	100.00%
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	2	3.5	0	6	13.5	100.00%	96.43%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1	0	4	0	10.8	15.8	88.42%	83.16%
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	7	4	11	24	0	2	7	4	11	24	95.83%	100.00%
Oncology	3	1	3	4	5	16	3	1	8	4	12	28	3	1	8	4	12	28	96.43%	100.00%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	8	10	1	1	0	0	8	10	100.00%	100.00%
Oral & Maxillofacial Surgery	0	2	10	0	2	14	0	2	10	0	6	18	0	2	6	0	6	14	77.78%	77.78%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	0	6	0	0	6	0	0	6	100.00%	100.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	7	0	7	14	0	0	4.6	0	6.5	11.1	72.14%	79.29%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	4	6	0	0	2	0	3	5	50.00%	83.33%
Paediatrics	3	4	3	2	8	20	4	4	3	2	8	21	3	3	2	2	8	18	90.48%	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	90.00%	100.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	2	2	1.5	8	19.5	100.00%	97.50%
Rheumatology	0	0	1	2	3	6	0	0	1	2	3	6	0	0	1	1.5	3	5.5	100.00%	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	8	4	1	15	28	0	8	2	0	11	21	83.87%	75.00%
Upper GI Surgery	7	0	2	0	4	13	7	0	4	0	7	18	7	0	4	0	6	17	97.33%	94.44%
Urology	1	3	2	0	3	9	1	3	2	0	5	11	1	3	1	0	4	9	100.00%	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**	**88**	**131**	**75**	**267**	**632**	**69**	**79**	**116.1**	**61.8**	**231.3**	**557.2**	**89.41%**	**88.16%**

Increased vacanices 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 17/04/2019

	Trainee Establishment						Trainee In Post						
Department	F1	F2	CT/ST1-	GPSTR	ST	Total	F1	F2	CT/ST1-	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	100.0%
Acute Medicine	3	6	9	0	6	24	3	5	6	0	2	16	66.7%
Anaesthetics	4	4	15	0	28	51	4	4	15	0	22	45	88.2%
Breast Surgery	2	0	1	0	2	5	2	0	0	0	1	3	60.0%
Cardiology	2	1	4	1	9	17	2	0	3	1	9	15	88.2%
Cardiothroacic Surgery	0	3	0	0	3	6	0	2	0	0	3	5	83.3%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	100.0%
Elderly Medicine	5	3	6	6	6	26	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 AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

30 JULY 2019

Title:	**MORTALITY – LEARNING FROM DEATHS QUARTER 1 2019/20**	
Responsible Director:	**CHIEF MEDICAL OFFICER**	
Author:	**Chris Johnson, Clinical Outcomes Manager**	
Purpose:	The purpose of this report is to provide the Trust Board of the Trusts continuing commitment to learning from patient mortality and improving quality, in line with the Learning from Deaths Framework.	
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: • Mortality Statistics as per National LFD framework • Themes • Actions Taken • Any other updates	

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

MORTALITY - LEARNING FROM DEATHS
SUMMARY OF QUARTER 1 2019/20

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide a summary of mortality statistics and learning in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 1, 2019/20 (April 1st 2019 to June 30th 2019).

Information relating to themes and actions taken are obtained from the Trust Datix reporting system, for cases that were completed within Quarter 1, 2019/20.

2. SUMMARY OF TRUST MORTALITY IN Q1 2019/20

The following table provides a breakdown of patient deaths that occurred within the Trust during Q1 2019/20, drawing comparison to last year:

	Total number of In-hospital deaths in Q1	Of which were elective admissions / Day case deaths	Of which were Non-elective admissions
2018/19	523	24	499
2019/20	552	19	533

2.1 Most Common Causes of Death

The following illustrates the 3 most common causes of death during Q1 2019/20:

1. Pneumonia – 77deaths
2. Septicaemia – 45 deaths
3. Acute Cerebrovascular Disease – 36 deaths

2.2 Minimal Criteria for Structured Judgement Review (National LFD Framework)

The National Quality Board set minimal criteria for undertaking structured judgement case note reviews. These are illustrated below, along with the Trusts compliance against these criteria during Q1 2019/20 (number of patients receiving review against total number of patients in criteria):

Criteria	Number of cases receiving full SJR (out of total amount of deaths)
Deaths where a concern was raised about the quality of care provision	3/3
LeDeR Reviews (internal HEY patients)	3/3
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	0 / 0 (no alerts)
Number of deaths that underwent a Serious Incident Investigation and completed, within Q1, where it is likely that problems in care contributed to patient death.	0 (3 currently ongoing)

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

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

2.3 Structured Judgment Review Statistics
During Q1 2019/20, a total of 34 Structured Judgement Reviews were undertaken. This is 7.2% of all in-hospital deaths for this quarter. The following table provides a breakdown of review types:

Total Number of SJR undertaken in Q1	Cases escalated to Tier 2	Cases requiring Triumvirate decision	SJR cases escalated and declared as a Serious Incident
34	6	0	0

2.4 Deaths Investigated and Finalised as Serious Incidents
There were 0 Serious Incident Investigations that completed within Quarter 1, where the patient deaths were more likely than not to have been due to problems in care.

However, there are currently 3 Serious Incidents that are awaiting completion that *may* indicate that death was more likely than not to have been due to problems in the delivery of care. These outcomes will be available in the next report.

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Safety Team Annual Report 2018/19

Title:	Safety Team Annual Report 2018/19
Responsible Director:	Chief Nurse
Author:	David Bovill, Trust Safety Manager

Purpose	The purpose of this report is to provide information and assurance to the Trust Board and others, in relation to matters relating to the management of Safety within the Trust.	
BAF Risk	N/A	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	Information is provided in the report on the following topics: • Safety Dept. KPI's • General RIDDOR Reportable Incidents • RIDDOR: Occupational Health • Annual incidents by Health Group • Non-reportable slip trip falls • Timeliness of Reporting of incidents to the HSE • Inspections • Staff incidents reported by severity • EL / PL Claims • Manual Handling • Objectives for 2019/20	

SUMMARY

- Communication with the Health and Safety Executive (HSE)**:** 2018/19 saw no contact from the regulator – the HSE - regarding any safety issues.
- Reportable Incidents: The Trust's Safety Team reported 27 incidents to the HSE under the requirements of the RIDDOR regulations in 2018/19. The most common causes were slips, trips and falls, and moving and handling related injuries. This is an increase from the previous year, with the main rise caused by slip accidents. This has resulted in an increased focus on the management of this hazard. Paradoxically, the incidence of less serious cases of slips, trips and falls (non-RIDDOR reportable incidents) has decreased sharply in 2018/19: 54 compared with 102 in 2017/18 and 96 the year before that.
- In terms of timeliness of reporting to the HSE, just three of the 27 incidents were reported after the 15 day target: a significant reduction from previous years.
- The Trust's Occupational Health Team reported 20 incidents to HSE; 12 needle-sticks and 8 cases of other exposure to blood borne viruses. There were no reported cases of work-related dermatitis for the third year running.
- Claims: The number of new staff claims against the Trust was 14 in 2018/19. This is a reduction of five compared with the previous year.
- Link Staff: Following increasing the available training for new departmental Safety Link Staff and Moving and Handling Link Trainers, the Trust has increased these numbers by 47 and 14 respectively. These staff volunteer to be the 'eyes and ears' for safety in their work areas, and so are given extra training to fulfil this important role.
- Key areas of safety management focus in 2018/19 included working at height and slips, trips and falls prevention. Further, a working group has been set up by the Manual Handling Lead to establish current physical and knowledge-based barriers that restrict or prevent access to our services for patients with obesity.
- The number of quarterly inspection checklists performed on the wards and departments and sent through to the Safety Team increased by 111 in 2018/19, compared with the previous year.

Safety Department Annual Report, 2018 / 2019.

Contents:

1. KPI's

Key Performance Indicators (KPI's) – Monitored quarterly - and covering the following topics:

- **Number (and rate – No. / 7175 employees x 100) of RIDDOR reportable incidents.** This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses. The target for RIDDOR reportable incidents should always be as few as possible, though an organisation as large and complex as HEYT would certainly alert the regulator (HSE) if no such incidents were reported.

- **Total staff slips, trips and falls incident rate (not just RIDDOR).** The justification for this choice of KPI is that it is the single biggest cause of staff injury. The target improvement here would be a steady decrease, though with caution regarding incident reporting rates generally.

- **EL / PL Claims –** new employees' / public liability claims received (non-clinical).

- **Numbers of hazards identified by site quarterly inspections** by the Safety Team; a pro-active measure. We would want to see a reduction in the number of hazards identified in any given area upon subsequent inspections if the corrective actions have been taken.

- **Staff accidents reported by severity**. Numbers of those classed as either severe or catastrophic. A good reporting culture in the organisation would have staff recording high numbers of near misses, no harm or minor harm incidents. For this reason, an increase in overall staff incidents should not necessarily be seen as a negative outcome. However, we would want to see low numbers of those incidents classed as major or catastrophic, as such incidents are unlikely to go unreported.

2. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013

General RIDDOR Reportable Incidents: totals and rates (per headcount x 100):

Table 1: Quarter 4

	Quarter 3			Quarter 4	
	Total	Rate		Total	Rate
Slip, trip or fall	6	0.08	▽	2	0.02
Moving and handling	1	0.01	▽	-	-
Struck by or against something	1	0.01	▽	-	-
Contact with hot/cold object/liquid, machinery or electricity	-	-	-	-	-
Contact with sharp material or object, non-medical	-	-	-	-	-
Other Personal Accident	-	-	▲	2	0.02
Contact with other medical sharps	-	-	-	-	-
Exposure to harmful agent e.g. radiation, substance, bio agent	-	-	-	-	-
Total	**8** ▲			**4**	

We have witnessed a decrease of **4** incidents during quarter 4 when compared to quarter 3.

Table 2: Annual

RIDDOR Apr 2018 - Mar 2019	FTE 7175													
	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Rate
Slip- trip fall	-	-	-	-	2	-	3	-	3	2	-	-	10	0.13
Manual handling	1	2	1	2	1	1	1	-	-	-	-	-	9	0.12
Struck by or against something	-	-	-	-	-	-	1	-	-	-	-	-	1	0.01
Contact with hot/cold, object/liquid, electric or machinery	1	-	-	-	-	-	-	-	-	-	-	-	1	0.01
Contact with sharp material or object non medical	-	-	-	-	-	2	-	-	-	-	-	-	2	0.02
Other personal accident	-	2	-	-	-	-	-	-	-	1	1	-	4	0.05
Contact other medical sharps	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Exposure to harmful agent e.g. radiation, substance, bio agent,	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	2	4	1	2	3	3	5	-	3	3	1	-	27	
	7			8			8			4				

Table 3: Three Year Comparison

Incident Category	2016 - 2017 Total	Rate		2017 - 2018 Total	Rate		2018 - 2019 Total	Rate		Total
Slip, trip or fall	10	0.12	-	5	0.06	▽	10	0.13	▲	**25**
Moving and handling	9	0.1	▲	8	0.11	▽	9	0.12	▲	**26**
Struck by or against something	4	0.04	▽	2	0.02	▽	1	0.01	▽	**7**
Contact with hot/cold object/liquid, machinery or electricity	1	0.01	▲	-	-	▽	1	0.01	▲	**2**
Contact with sharp material or object, non-medical	1	0.01	-	-	-	▽	2	0.02	▲	**3**
Other Personal Accident	6	0.07	-	1	0.01	▽	4	0.05	▲	**11**
Contact with other medical sharps	-	-	▽	1	0.01	▲	-	-	▽	**1**
Exposure to harmful agent e.g. radiation, substance, bio agent	1	0.01	▽	1	0.01	-	-	-	▽	**2**
Total	**32**		▽	**18**		▽	**27**		▲	**77**

The annual total for reportable incidents shows an overall total of **27** this is an increase from the previous year **18** of **9**, however, this is still a decrease of **5** incidents when compared to the total of two years ago **32**. Historically speaking, between 2004 and 2014, the Trust averaged between 50 and 60 reportable incidents so the 'big picture' is positive though no reason for complacency.

There has been an increase in the slips, trips and falls category over the past year when compared to the previous year and moving handling has increased by **1** when compared to the previous year (see later for analysis). The increase in RIDDORs from the previous year

was primarily due to slip incidents, prompting Safety to focus attention on the management of this hazard. Safety 'took over' the Trust's *'Lessons Shared'* newsletter to focus on this hazard.

3. Annual RIDDOR incidents by Health Group:

RIDDOR incidents by HG

Table 4: Quarter 4

Health Group	FTE	Quarter 3	Rate		Quarter 4	Rate
Clinical Support	1646	1	0.06	▽	-	-
Family and Women's Health	1087	1	0.09	▽	-	-
Surgery	1807	1	0.05	-	2	0.11
Corporate Directorates	1450	2	0.13	-	1	0.06
Medicine	1185	3	0.25	▽	1	0.08
Total:	**7175**	**8**		▽	**4**	

During quarter 4 we witnessed a decrease of **4** incidents when compared to quarter 3.

Table 5: Annual

Health Group	FTE	Q1	Rate		Q 2	Rate		Q 3	Rate		Q4	Rate	
Clinical Support	1646	-	-	-	-	-	-	3	0.18	▽	-	-	▽
Family and Women's Health	1087	-	-	-	-	-	-	2	0.18	▽	-	-	▽
Surgery	1807	2	0.11	▲	2	0.11	-	2	0.11	▲	2	0.11	-
Corporate Directorates	1450	3	0.06	▲	1	0.06	▽	-	-	-	1	0.06	▲
Medicine	1185	2	0.16	▲	5	0.42	▲	1	0.08	▽	1	0.08	-
Total:	**7175**	**7**		▲	**8**		▲	**8**		-	**4**		▽

Surgery **8** and Medicine **8** had the most incidents for the year with Corporate **5 –** Clinical Support **3 -** Family Women's Health **2**.

Table 6: Three Year Comparison

Health Group	FTE	2016 - 2017 Total	Rate		2017 - 2018 Total	Rate		2018 - 2019 Total	Rate	
Clinical Support	1646	2	0.12	▽	2	0.12	-	3	0.18	▲
Family and Women's Health	1087	4	0.36	▲	3	0.27	-	2	0.18	▽
Surgery	1807	6	0.33	▽	4	0.22	▽	8	0.44	▲
Corporate Directorates	1450	9	0.62	▲	4	0.27	▽	5	0.34	▲
Medicine	1185	11	0.92	▲	5	0.42	▽	9	75	▲
Total:	**7175**	**32**		▽	**18**		▽	**27**		▲

Medicine had the most incidents with **9** and Surgery had the second most incidents with **8** and both show a significant increase when compared to the previous year.

4. RIDDOR Reportable slip trip falls:

Table 7: Quarter 4

FTE 7175	Quarter 3		Quarter 4
Incidents	6	▼	2
Rate	0.08		0.02

There was no change during quarter 4 when compared to quarter 3.

Table 8: Annual

FTE 7175	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Incidents	6 ▲	4 ▼	6 ▲	2 ▼
Rate	0.08	0.05	0.08	0.02

Table 9: Three Year Comparison

Date	2016 - 2017		2017 - 2018		2018 - 2019	
Incidents	10	-	5	▼	10	▲
Rate	0.13		0.6		0.13	

When compared to the previous 12 months there has been an increase of **5** equating to a **50%** increase.

5. Non-RIDDOR reportable slip trip falls:

Non-reportable staff slips trip falls by HG:

Table 10: Quarter 4

Health Group	Quarter 3		Rate	Quarter 4		Rate
Clinical Support	2	▲	0.12	1	▲	0.06
Family and Women's Health	2	-	0.18	1	▲	0.09
Surgery	5	▼	0.27	1	▲	0.05
Corporate Directorates	8	▲	0.55	2	▲	0.13
Medicine	1	▼	0.08	-	▼	-
Total:	**18**	-		**5**	▼	

We have witnessed a significant decrease during quarter 4 by **13** when compared to quarter 3.

Table 11: Annual

Health Group	FTE	Q1		Rate	Q2		Rate	Q3		Rate	Q4		Rate
Clinical Support	1646	1	▽	0.06	1	-	0.06	2	△	0.12	1	△	0.06
Family and Women's Health	1087	2	▽	0.18	2	-	0.18	2	-	0.18	1	△	0.09
Surgery	1807	7	▽	0.38	9	△	0.49	5	▽	0.27	1	▽	0.05
Corporate Directorates	1450	1	△	0.06	3	△	0.21	8	△	0.55	2	▽	0.13
Medicine	1185	2	-	0.16	3	△	0.25	1	▽	0.08	-	▽	-
Total:	**7175**	**13**	▽		**18**	△		**18**	-		**5**	▽	

There have been **54** non-reportable staff slips trip falls over the past twelve months

Table 12: Three Year Comparison

FTE 7175			2016 - 2017		2017 - 2018			2018 - 2019		
Health Group		FTE	Total	Rate	Total		Rate	Total		Rate
Clinical Support		1646	12	0.72	10	▽	0.6	5		0.3
Family and Women's Health		1087	20	1.83	20	-	1.83	7		0.64
Surgery		1807	17	0.94	24	△	1.32	22		1.21
Corporate Directorates		1450	32	2.2	32	-	2.2	14		0.96
Medicine		1185	15	1.26	16	△	1.35	6		0.5
Total:		**7175**	**96**		**102**	△		**54**	▽	

We have witnessed a significant decrease (**54)** over the past 12 months when compared to the previous year, with Corporate Directorate showing the overall highest group with **78** over the past three years

6. RIDDOR – reported by the Occupational Health Department:

RIDDOR – reported by Occupational Health – by category:

Table 13: Quarter 4

Incident by Category	FTE	Quarter 3		Rate	Quarter 4		Rate
Needle Stick Injuries	7175	4	-	0.05	4	-	0.05
Exposure To Blood Born Viruses		2	△	0.02	6	△	0.08
Work Related Dermatitis		-	-	-	-	-	-
Total		**6**	△		**10**	△	

During quarter 4 we witnessed an increase of **4** incidents when compared to quarter 3.

Table 14: Annual

Incident by Category	FTE	Q1	Rate		Q2	Rate		Q3	Rate		Q4	Rate
Needle Stick Injuries	7175	-	-	▽	4	0.05	△	4	0.08	-	4	0.05
Exposure To Blood Born Viruses		-	-	▽	-	-	-	2	0.02	△	6	0.08
Work Related Dermatitis		-	-	-	-	-	-	-	-	-	-	-
Total		**-**	▽		**4**	△		**6**	△		**10**	△

We witnessed the most reportable incidents during quarter 4 **10** with an increase with exposure to blood born viruses **6.**

Table 15: Three Year Comparison

Incident by Category	2016 - 2017	Rate	2017 - 2018	Rate	2018 - 2019	Rate
Needle Stick Injuries	9 ▲	0.12	7 ▽	0.09	12 ▲	0.16
Exposure To Blood Born Viruses	7 ▽	0.09	7 ▽	0.08	8 ▲	0.11
Work Related Dermatitis	- ▽	-	- -		- -	
Total	**16** ▲		**14** ▽		**20** ▲	

When compared to the previous 12 months, we have witnessed an overall increase of **6**. However, for the third consecutive year running there have been no reportable cases of Dermatitis.

7. Timeliness of Reporting of incidents to the HSE:

The reporting of incidents in accordance to regulation 4.2 of the RIDDOR Regulations 2013 - **within 15 days** (NB: The following information does *not* include Occupational Health reportable incidents)

Timeliness of Reporting of incidents to the HSE during 2018 – 2019:

Table 16: Quarter 4 - FTE 7175

Reported	Reported on time	Reported late
Quarter 4	**4**	-
Rate	0.05	-

Quarter 4 shows there were no late reporting of incidents to the HSE

Table 17: Annual

Reported	Reported on time	Reported late	Total
Quarter 1	6	1	**7**
Rate	0.08	0.01	
Quarter 2	7	1	**8**
Rate	0.09	0.01	
Quarter 3	7	1	**8**
Rate	0.09	0.01	
Quarter 4	4	-	**4**
Rate	0.05	-	
Total	**24**	**3**	**27**

On balance, we have seen a decrease over the past twelve months for the late reporting of incidents.

Table 18: Three Year Comparison:

Reported	Reported on time	Reported late		
2016 - 2017	25	7	Total:	**32**
2017 - 2018	13	5	Total:	**18**
2018 - 2019	24	3	Total:	**27**
Total	**62**	**15**		

We have seen a year on year improvement in the timeliness of reporting of incidents to the HSE: the proportion of those reported late has reduced for the second consecutive year. (It should be noted that the HSE has never contacted the Trust regarding late reporting).

8. Quarterly Site Inspections:

Hull Royal Infirmary:

Table 19: Area inspected on a quarterly basis over the past three years:

	Quarter 1	Quarter 2	Quaretr 3	Quarter 4	
	Area 1	Area 2	Area 3	Area 1	Total
2016 - 2017	16	22	15	-	**53**
2017 - 2018	7	26	5	-	**38**
2018 - 2019	18	8	9	27	**62**
Total	**41**	**56**	**29**	**27**	153

When compared to the previous year, we have seen an increase in the total number of defects found: **62** from **38**.

Table 20: Defects found and acted upon at the HRI Estate.

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	
Moderate	18	8	9	27	**62**
Low	-	-	-	-	
Very low	-	-	-	-	
Overal total	**18**	**8**	**9**	**27**	**62**

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-		
Moderate	1	1		26	**28**
Low	-	-	-		
Very low	-	-	-		
Overal total	**1**	**1**		**26**	**28**

Castle Hill Hospital:

Table 21: Area inspected on a quarterly basis over the past three years:

	Quarter 1	Quarter 2	Quaretr 3	Quarter 4	
	Area 1	Area 2	Area 3	Area 1	Total
2016 - 2017	9	6	15	-	**30**
2017 - 2018	10	2	14	-	**26**
2018 - 2019	6	6	6	9	**27**
Total	**25**	**14**	**35**	**9**	83

When compared to the previous year **26** we have seen a slight increase (**27)** in the number of defects found.

Table 22: Defects found at the CHH Estate, by quarter and severity:

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	1	-	-	-	**1**
Moderate	4	6	6	8	**4**
Low	1	-	-	-	**1**
Very low	-	-	-	1	**1**
Overal total	**6**	**6**	**6**	**9**	27

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	2	6	3	6	**17**
Low	-	-	-	-	**-**
Very low	-	-	-	-	**-**
Overal total	**2**	**6**	**3**	**6**	17

When compared to the previous year, we have seen a slight increase **27** against **26** however, **17** of these defects have already been acted upon leaving a deficit of **10.**

9. Staff incidents reported by severity:

Table 23: Staff incident severity

Risk Rating	2016 - 2017		2017 - 2018		2018 - 2019		Total
No harm	224	-	127	▽	271	△	**622**
Minor	378	-	348	▽	387	△	**1113**
Moderate	21	-	19	▽	17	▽	**57**
Major	-	-	-		-	-	**-**
Catastrophic	-	-	-		-	-	**-**
Total:	**623**	-	**494**	▽	**675**	△	**1792**

The above pattern is seen as encouraging: given that high reporting combined with low severity rating is seen as a positive indicator of organisational safety culture, the fact that we have seen an increase in reported low severity ratings and a decrease in the moderate category, combined with zero incidents classified as either major or catastrophic, is welcomed.

10. Safety Focal Persons, (SFP's):

The Safety department identified a gap in the training of new Safety Focal Persons (SFP) and as a result have taken charge of providing the necessary training needed for staff to become an SFP.

The new revised training course has been reduce from its original 3 days to just 1 day thus reducing the time staff spend away from the workplace while still managing to maintain and keep all of the key elements and cores skills needed for a staff member to become an SFP.

Since advertising the new revised course there has been a keen interest from staff across the Trust with 47 staff who have since undertook the training course in the past 12 months, with excellent feedback received from the delegates.

The number of quarterly safety inspection checklists performed by SFP's on the wards and departments and sent through to the Safety Team increased by 111 in 2018/19, compared with the previous year.

11. MOVING AND HANDLING QUARTER 4 and ANNUAL REPORT, (Quarter 4 01/01/2019 – 31/03/2019)

Executive Summary

15 new Link Trainers have been trained and all other areas currently without Link Trainers have places booked on future courses. 30 Link trainers have attended an update to refresh their skills and knowledge and 80% of the remaining Links have already booked to attend future dates.

10 manual handling related incidents have been reported to the HSE under RIDDOR this year. No themes or trends could be identified (given the low numerical sample size).

The 'Patients with Obesity – Access to Services' task and finish group is on track to deliver its final report in October. The aim of this group is to identify physical and knowledge based barriers that restrict or prevent patients with obesity from accessing our services. A sub-group to explore transport issues has also been set up and will feed its findings in to the final report.

A full hoist audit has been carried out and equipment in need of replacement has been prioritised and escalated to the Equipment Management Committee for consideration.

By the end of the year training compliance has fallen below the Trust target of 85% and currently sits at 79.2%. Corporate Directorates currently sits at the lowest compliance rate of 69.6%.

Manual Handling incidents continue on a downward trend as they have done for the last 5 years despite incident reporting as a whole increasing.

Practical induction sessions for new starters are now available again and ClinicalSkill.net is also available as a way for nursing staff to update on their practical patient handling knowledge.

Summary of KPI Performance Indicators for 2018/19

Manual Handling RIDDORs
10 incidents in total were reported to the HSE under RIDDOR during 2018/19 for incidents on Datix logged as manual handling activities. These were split evenly between patient handling and inanimate load handling incidents. 60% of the RIDDOR incidents reported were of Moderate severity and the other 40% were Minor. 50% of the incidents involved pushing or pulling activities and so some focus is going to be placed on these as we move into the new training year.

Link Trainers
There are currently 141 active Link Trainers across the organisation and all areas currently without a Link Trainer have places booked on future courses.

Patient Handling Assessments
86% of patient care records reviewed had comprehensive handling assessments completed had been reviewed and updated appropriately. Feedback on the others was provided to help improve future compliance.

Summary of Key Activity for 2018/19

Link Trainers
Work continues to update Pattie with new pages and information to assist the Link Trainers in their roles and ensure that staff are able to access information relating to manual handling easily.

15 new Link Trainers have been trained creating key supports for their areas. They will now be able to sign off staff for the practical element of the manual handling training and ensure important information and standards are maintained in their departments.

30 Link Trainers attended an update to refresh their knowledge and skills and 80% of the rest of the Link Trainers have booked and are waiting to attend future updates.

Bi-monthly newsletter 'The Back Issue' is being distributed to Link Trainers. This is created by the Manual Handling Lead and includes updates on equipment, training and practical skills. This acts as an additional resource to keep them up to date in between their annual face to face updates.

Equipment – Access and provision
The 'Patients with Obesity – Access to Services' task and finish group started in October and is reviewing what physical and knowledge based barriers prevent or restrict access to services across the Trust for patients with obesity. The group have now established topics for consideration and work continues to work through these. A sub-group has been formed to explore issues specifically relating to transport and representatives from all patient transport groups are attending.

Risk 1726 – Hoist provision
This risk has now been updated and downgraded to a Low risk due to the information gathered during the hoist audit and hoists that have been replaced and swapped.

Three hoists have already been replaced as they were to become obsolete and removed from the service contract. Following the Pro-act full hoist audit carried out by the Trust Manual Handling Lead and Arjo, five more hoists were identified as a priority for replacement due to

age and usage. This information has been escalated to the Equipment Management Committee for consideration and approval. Currently 9% of the hoists are older than 15 years and so several hoist swaps are taking place to ensure that the equipment is placed to best meet needs and minimise any risks associated with any potential breakdowns. A full servicing contract continues to ensure hoists are kept in working order.

Complaints
Several complaints have been received throughout the year regarding the inability to cater for patients who attend with their own specialist slings. This unfortunately has resulted in some patients losing confidence in the Trust as well as some adverse media coverage.

With a joint effort between the Matrons, staff and the Manual Handling Lead these issues have been resolved and actions taken include the following;

- A tour of the area with the family to show how equipment can now be used to meet the needs of the patient.
- Hoists replaced with ones that will allow spreader bars to be swapped to accommodate 'loop' slings.
- The updating of information on Pattie on where compatible hoists can be acquired.
- The purchase of interchangeable spreader bars to allow the patient to use their own specialist sling.
- Alerts sent to all Link Trainers and this to be included in this year's updates.
- An article to be places in the Lessons Shared Newsletter (March Issue).
- An alert has been placed on the patient's Lorenzo record explaining where the correct equipment and advice can be found.

Safety Alerts
<u>Minstrel Hoist – Risk of Spreader Bar Detachment</u>
Medical Device Alert MDA/2019/004 was issues on 30th January 2019. This related to the Minstrel Hoist and risk of spreader bar detachment. Although there is a Minstrel hoist in the Trust it is not affected by this alert and no further action is required.

<u>Monkey pole incidents – C9 & H120</u>
Following two separate incidents where the handles failed an internal safety alert has been sent out reminding all relevant areas that both straps and handles need to be replaced every 5 years.

Neither of the patients involved in the incidents suffered any adverse effects due to the equipment failures.

INCIDENTS

Table 1: ALL Manual Handling Incidents by HG 2018/19

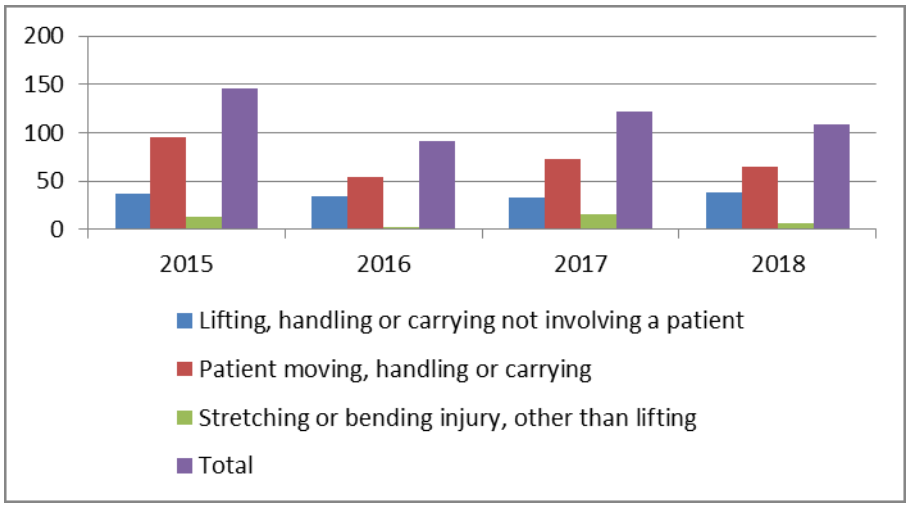
	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	Total
Corporate Functions	5	12	7	3	3	25
Clinical Support - Health Group	0	8	4	7	3	22
Emergency and Acute Medicine - Health Group	0	0	0	0	1	1
Family and Women's Health - Health Group	1	1	3	1	3	8
Medicine - Health Group	3	17	7	3	3	30
Surgery - Health Group	10	6	7	6	2	21
Total	19	44	28	20	15	107

The end of year figures show a downward trend in manual handling incidents reported for the 4th quarter running. This equates to a 66% reduction or incidents reported in Q4 when compared with Q1. *(Incident reporting in general saw a slight rise in quarters two and three and remained the same in quarters one and four. This could be interpreted as supporting evidence that the reduction in manual handling incidents has seen a genuine change in adverse activity).*

Although still the highest reporter for this year, Medicine Health Group has also seen the greatest reduction of incidents reported in Q4 when compared with those reported in Q1 with 77%. This is closely followed by Corporate Functions with 75%. The reduction is spread fairly evenly across the Health Groups but one significant peak at the beginning of the year was due to staff sustaining injuries whilst caring for a bariatric patient.
Manual handling incidents reported in Q4 of 2019 are 22% lower than in the same quarter in 2018.

In 2018/19 manual handling incidents accounted for 3.2% of all personal accidents and 0.5% of all incidents reported on Datix.

Chart 1: Four Year Comparison by Sub-category

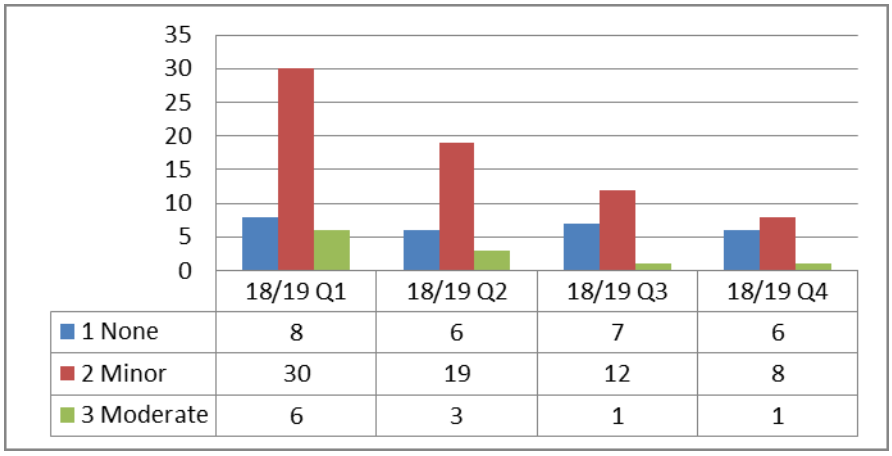


The chart above shows a four year comparison of manual handling incidents. There has been an overall downward trend seen across the four years with patient handling incidents and those other than lifting following this trend as well.

The subcategory that has seen the greatest reduction of incidents reported in Q4 compared with Q1 is 'Patient moving, handling or carrying'. Over the course of the year there have been a number of incidents initially reported under this sub-category that were actually patient falls (staff misinterpreting the wording of 'patient moving') and were therefore re-assigned. But, as this cleansing work has been carried out throughout the year it is assumed that the overall results would not be affected by this misreporting.

In 2018/19 patient handling incidents accounted for 61% of manual handling incidents and remains the highest sub-category reported.

Chart 2: All Manual Handling Incidents by Severity 2018/19



	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
1 None	8	6	7	6
2 Minor	30	19	12	8
3 Moderate	6	3	1	1

For 2018/19 Minor incidents account for 65% of the manual handling incidents reported with 25% being No Harm and 10% reported as Moderate.

Of the Moderate incidents 55% related to patient handling activities but there were no particular themes or trends that could be identified.

55% of the Moderate incidents recorded were also reported to the HSE under RIDDOR. All were reported for staff being off work for more than 7 days (not including the day of incident) as a result of the incident.

Some actions identified as a result of the investigations include;

- Plans to replace unsuitable equipment and a revision of local protocols as to staff numbers to carry out the activities.
- Removal of faulty equipment.
- Support, training and information given to injured parties on handling practice and use of equipment.

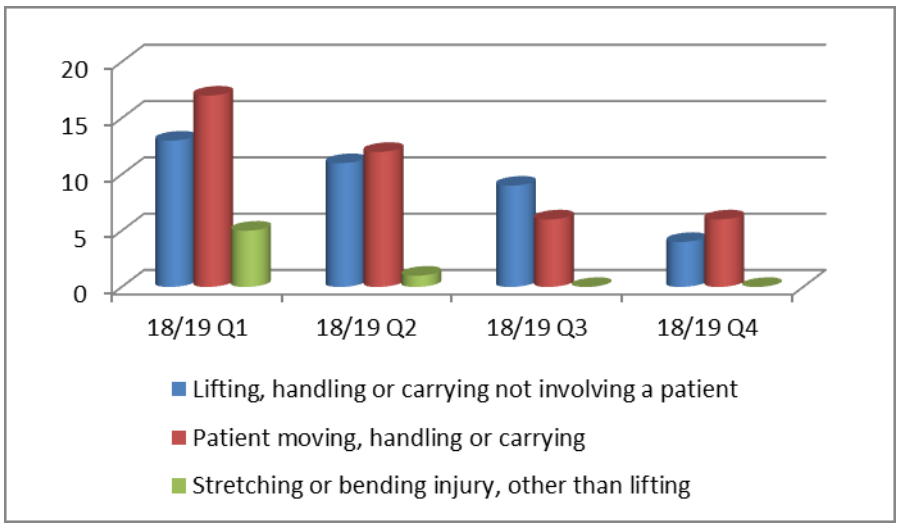
STAFF INCIDENTS

79% of the manual handling incidents reported in 2018/19 were to staff. The chart below shows a steady downward trend in staff incidents. The Specialty with the greatest number of

incidents for 2018/19 was catering which accounted for 14% of staff incidents closely followed by Chest Medicine with 12%.

42% of the Catering incidents related to injuries sustained whilst transporting goods on trolleys. This is being looked into by the catering department.

Chart 3: Staff Manual Handling Incidents by Sub-category.



TRAINING

Compliance for manual handling training figures has seen a significant reduction across all Health Groups in Q4 when compared with Q3. Corporate Directorates have seen the greatest drop of 17.8%. Non-clinical staff only have to complete training once every three years and can be achieved via e-learning on HEY 24/7 or as part of the face to face Safety Day. Clinical staff are required to complete training every year. Two out of the three years either by e-learning or Safety Day attendance and a review of practical skills via the Link Trainer should be carried out once every three years as part of that cycle.

The Manual Handling module of ClinicalSkills.net has also now been brought on line for nursing staff to access. Successful completion of the assessment will count as their practical update. Work is ongoing to bring other staff groups online.

Uptake of the manual handling induction session for new starters has been slow with only small numbers attending and some session have had no-one booked. Additional promotion has been done via the Link Trainer network and the Professional Education Committee.

In 2018/19 service specific training session has been carried out for Retinal Screening staff, the new HCA Apprentices, Winter Ward HCAs, Speech and Language Therapists and Associate Physicians. Although this can only be done when capacity allows, the Manual Handling Lead continues to work with workforce leads to ensure practical manual handling skills remain as part of induction programmes.

Table 3: Monthly Training Compliance Across All Health Groups (HG) For Q4 and End of Q3 and Q4 Comparison.

Health Group	Q1 2018	Q2 2018	Q3 2018	Q4 2019	E/O Q3 / Q4 Comparison
Clinical Support Services	89.1	87.2	89.3	81.0	-8.3%
Corporate Directorates	88.9	87.4	87.4	69.6	-17.8%
Estates, Facilities and Development	96.3	97.2	91.3	91.3	-
Family & Women's Health	88.6	87.6	90.0	85.6	-4.4%
Medicine	81.3	84.4	88.7	80.7	-8.0%
Surgery	82.9	83.7	84.9	75.2	-9.7%
Total	**87.8**	**86.7**	**88.1**	**79.2**	**-8.9%**

12. Employers Liability / Public Liability Claims

EL Claims: The number of new staff claims against the Trust was 14 in 2018/19. This is a reduction of five compared with the previous year. The commonest cause of associated accident / incident was slips / trips / falls.

Summaries of the 14 claims are as follows:

Patient fell on Security Guard causing dislocation of knee.
Alleged fall due to slip on water in kitchen area sustaining fracture to knee.
Sustained fractures to 4th and 5th metatarsals and alleged nerve damage to toes when battery pack on chair hoist fell onto foot when chair picked up as a result of the battery being fitted incorrectly.
Trip over metal hinged flap in car park in front of Anlaby Suite sustaining fracture to right shoulder and humerus requiring surgery, and soft tissue injuries to arm, leg and body and laceration to right knee.
Fall from ramp of food delivery van whilst manoeuvring trolley sustaining lower back pain.
Alleged electric shock from defective cable supplying mattress resulting in numbness and loss of sensation and disorientation.
Tripped over raised concrete sustaining a fall causing a broken and grazed nose, whiplash, bruised left knee and broken glasses.

Bed rail sheared off side of bed falling onto toe causing injury
Claimant working in surgical theatre as auxiliary nurse. Post-surgery was asked to put all rubbish/disposables in to a bag to go in to the bin. When placing bag in to the bin, Claimant suffered laceration injury to her left hand from a scalpel which had not been disposed of by the surgeon with the rest of the sharps.
Alleged that sustained tendon damage and impingement in right arm requiring physiotherapy, injections and decompression surgery as a result of being pulled across a bed by a patient and hitting a wall.
Whilst walking up a ramp the claimant was carrying a tray with drinks and slipped on the ramp. The part of the ramp had not been gritted and did not have anti-slip on. Claimant has suffered damage to her ankle.
Fall down access hatch whilst trying to hang coat. Alleged injuries to rib cage, lower back, left claf, left knee, concussion, headaches and flashbacks. Liability transferred to Mitie.
Claimant was pulling food trolley from catering van and had to lift to prevent food from falling, injuring back.
Sustained laceration to hand when crushed between bed and wall when manoeuvring bed out of theatre suite. Root cause: no risk assessment or evidence of instruction to staff regarding movement of beds

PL Claims: Four new (non-clinical) claims were made against the Trust in 2018/19 by members of the public. In all four cases, the Trust is denying liability. They were:

Alleged trip over raised tile on leaving lift whilst pushing cage sustaining injury to back.
Fall on gritted zebra crossing sustaining fracture to left arm and displaced knee. Liability denied. Wrong defendant.
Domestic sustained puncture to hand from broken needle whilst picking up rubbish from floor using paper towels. Liability denied.
Alleged that blood spurted from clinical waste bag when lifted and covered Claimant's face and entered mouth resulting in requirement for a course of treatment. Contractor (Mitie) responsible for provision of PPE and training, therefore liability denied.

Closed Claims:

Some 15 EL Claims were closed in 2018/19, of which 10 were settled. 12 PL claims were closed in the same period. Nine of these were denied, with just three settled.

13. Priorities / challenges for 2019/20

- **Elimination of slip / trip hazards across sites:** Focus to continue on these hazards – the biggest single cause of staff accidents in the Trust.
- **Risk assessments:** 90% of all wards and departments having all 6 key risk assessments in place. Introduce random quality checks of the risk assessments.
- **Working at height**: completion of the review, assessment and risk reduction for work on all flat roofs throughout the Trust;
- **Moving and handling training**: review and delivery of acceptable levels of practical training / competency assessment for all clinical staff.
- **The 'Patients with Obesity – Access to Services'** task and finish group started in October and is reviewing what physical and knowledge based barriers prevent or restrict access to services across the Trust for patients with obesity. The group have now established topics for consideration and work continues to work through these. A sub-group has been formed to explore issues specifically relating to transport and representatives from all patient transport groups are attending.
- **Audit of vehicle / pedestrian segregation at the HRI site**: (CHH done in 2018/19).
- **Review of areas of safety relating to patients**: particularly self-harm potential and potential for ingestion of harmful substances.
- **Closer working with Security**: in relation to the hazard of violence against staff.

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 30 July 2019

Title:	Freedom to Speak Up Guardian update
Responsible Director:	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian
Author:	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian

Purpose:	To provide a quarterly update from the Freedom to Speak Up Guardian	
BAF Risk:	BAF 1	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary of Key Issues:	The Trust Board receives a quarterly report from the Freedom to Speak Up Guardian on the issues being raised by staff and a 'read-across' of issues raised through other routes. The key concern raised by staff, consistent with previous quarters, is individual examples of poor behaviours and/or bullying behaviours between colleagues. All issues have action taken, as far as the individual who is raising concerns is comfortable with. The intelligence is also used to feed in to wider Trust organisational development programmes.	

Recommendation:	The Trust Board is asked to receive and accept this report, and fee back any observations on how further to develop the Freedom to Speak Up Guardian role in the Trust

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 1 report

1. Purpose of the paper

To provide a quarterly update from the Freedom to Speak Up Guardian

2. Introduction

The National Guardian's Office requires Freedom to Speak Up Guardians to be able to report directly to the Trust's Board. This report provides a quarterly update on concerns raised by staff through the Trust's Freedom to Speak Up Guardian (FTSUG) and review of other concerns raised by staff.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Whistleblowing Policy
- Staff Advice and Liaison Service (SALS)
- Anti-fraud service
- Through their line manager
- Freedom to Speak Up Guardian
- Through the Bullying and Harassment Policy or through a formal grievance

There are other routes as well as ways in which staff can receive support if they are experiencing difficulties at work. These are captured in Appendix 1.

In addition, professional organisations such as the Nursing and Midwifery Council and the General Medical Council (GMC) also issue guidance such as the GMC's *Raising and acting on concerns about Patient Safety* (2012), which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

All Trusts from 1 April 2017 were required to have a Freedom to Speak Up Guardian in place. The Trust Board agreed an outline position as to how the Guardian role would be used within the Trust; the main purpose of the Guardian role is to be part of creating or furthering a positive culture that supports staff to raise concerns and to make continuous improvement to a culture that supports the highest standards of care and openness.

3. Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting.

3.1 Main activities in 2019

The main activities this calendar year have been to promote the role of the Freedom to Speak Up Guardian (FTSUG), to network and learn from other Trust's about the use of the role, and to review key findings that have been published by the National Freedom to Speak Up Guardian, Dr Henrietta Hughes.

Available on Pattie is a page on the Freedom to Speak Up Guardian role, the route available to support staff in speaking up, and an introductory video. Further written guidance on the difference between different speaking up routes (grievance, whistleblowing, etc) has also been uploaded as guidance to staff and managers from a national best practice guide.

The FTSUG has continued to attend staff meetings to introduce the role, and also attended the induction training day for newly qualified midwives. The FTSUG writes a regular blog on speaking up, encouraging staff to report issues through any route with which they are comfortable, and reinforcing positive messages that speaking up makes a difference.

3.2 National Freedom to Speak Up Guardian
The National Guardian's Office has also completed a number of case reviews in NHS Trusts since its inception, most in 2018. One has been published so far in 2019:
Brighton and Sussex University Hospitals NHS Trust

All case reviews are conducted by the National Guardian and a team from her office, through a process of interviews with staff and senior managers. All reviews have resulted in recommendations for each NHS Trust as well as learning for the wider NHS. All Trusts are expected to review the recommendations and implement them locally as appropriate.

Some key points of learning from the most recent review are:

- Some staff in minority groups felt more vulnerable in raising concerns; raising concerns was a barrier to a number of staff irrespective of background, too – there was a general culture where speaking up was not encouraged, but there were increased barriers for staff from BME backgrounds in particular
- The Trust should implement all actions arising out of the NGO gap analysis published in 2018
- The Trust should undertake a 'roadshow' style series of events for 6 months to promote the FTSUG role and
- The Trust should take reasonable steps to ensure its network of cultural ambassadors reflects the diversity of the workforce
- The Trust should increase its training and support to those in a speaking up role to be able to raise difficult issues and handle difficult conversations

In respect of these points, the FTSUG plans to:
Work with the Workforce Transformation Committee on refreshing the role of the Professionalism Champions and the elements of speaking up that exist in this role
Work with the Chief Nurse and the Chief Medical Officer on the new patient safety campaign, linking speaking up with patient safety and recognising the barriers that exist for staff in speaking up
Revisit the Equality and Diversity Steering Group on supporting the Trust's staff networks (BME and LGBT+) and supporting staff to speak up

In addition, the National Guardian's Office published a self-assessment tool and asked all Trust Boards to receive an assessment from their FTSUG in Spring/Summer 2018. This Trust's self-assessment was presented and accepted by the Trust Board in July 2018. This confirmed that the Trust had the FTSUG requirements in place and had identified some areas to develop the use of the role further. These are:

- Promoting the FTSUG and other routes for speaking up as part of the Trust's continued work on cultural development (professional behaviours) and patient safety ('Stop the Line')
- Promoting the FTSUG role within clinical areas and with Trust middle management tier
- Further development of feedback as to how speaking up makes a positive difference

4.3 Freedom to Speak Up Guardian – Trust Contacts
The National Guardian's Office also sets out a requirement to report to the Trust Board the number of contacts that the Freedom to Speak Up Guardian has received. The Trust's FTSUG has continued to do so.

The Trust's figures are as follows:

From 1 April 2017 – 31 March 2018, the FTSUG has been contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	5
Contacted directly by the member of staff	4
Requesting advice for a colleague	2
Contacted via SALS	3
Signposted by manager	1
Signposted by Occupational Health	1
Signposted by a FTSGU in another Trust	1
Total	**17**

The contacts with the FTSUG 1 April 2017 – 31 March 2018 have come from the following areas:

Quarter	**No. contacts**	**Service area**	**Health Group/ Corporate services**
Apr - June 2017	7	All individual services – no repeated issues - one 'worry ward' as reported to Trust Board	6 - Medicine 0 - Clinical Support 1 – Surgery 5 – Corporate 3 – F&W 2 – Not specified
July - Sept 2017	1		
Oct – Dec 2017	8		
Jan – Mar 2018	1		
Total	**17**		

The following types of concern were raised 1 April 2017 – 31 March 2018:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	7
Concerns about HR process involving the member of staff – concerns about fair treatment	3
Concern about patient safety	3
Concerns about workload	0
Concerns about inappropriate behaviour	1
Concerned about role within the Trust	1
Unspecified – contacted for general support	2
Totals	17

From 1 April 2018 – 31 March 2019, the FTSUG has been contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	0
Contacted directly by the member of staff	17
Requesting advice for a colleague	5
Contacted via SALS	0
Signposted by manager	0
Signposted by Occupational Health	0
Signposted by a FTSGU in another Trust	1
Total	**23**

The contacts with the 1 April 2018 – 31 March 2019 have come from the following areas:

Quarter	**No. contacts**	**Service area**	**Health Group/ Corporate services**
Apr - June 2018	3	All individual areas except one	4 - Medicine (inc. Emergency) 1 - Clinical Support 1 – Surgery 11 – Corporate 5 – F&W 0 – Not specified 1 – external
July - Sept 2018	3		
Oct – Dec 2018	9		
Jan – Mar 2019	9		
Total	**23**		

The following types of concern were raised 1 April 2018 – 31 March 2019:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	17
Concerns about HR process involving the member of staff – concerns about fair treatment	2
Concern about patient safety	-
Concerns about workload	-
Concerns about inappropriate behaviour	2
Concerned about role within the Trust	1
Unspecified – contacted for general support	1
Totals	23

From 1 April 2019 – 30 June 2019, the FTSUG has been contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	-
Contacted directly by the member of staff	3
Requesting advice for a colleague	-
Contacted via SALS	-
Signposted by manager	-
Signposted by Occupational Health	-
Signposted by a FTSGU in another Trust	-
Total	**3**

The contacts with the 1 April 2019 – 30 June 2019 have come from the following areas:

Quarter	**No. contacts**	**Service area**	**Health Group/ Corporate services**
Apr - June 2019	3	All separate contacts	0 - Medicine (inc. Emergency) 1 - Clinical Support 1 – Surgery 1 – Corporate 0 – F&W 0 – Not specified 0 – external
July - Sept 2019			
Oct – Dec 2019			
Jan – Mar 2020			
Total			

The following types of concern were raised 1 April 2019 – 30 June 219:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	-
Concerns about HR process involving the member of staff – concerns about fair treatment	-
Concern about patient safety	1
Concerns about workload	-
Concerns about inappropriate behaviour	1
Concerned about role within the Trust	1
Unspecified – contacted for general support	-
Totals	3

4.4 Making a difference
There are some specific examples as to where issues have been raised via the FTSUG and action has been taken as a result.

With the permission of the individual raising concerns, the FTSUG has been able to escalate concerns in order that senior managers can support managers who have issues within their teams;

on some occasions, the senior managers are not aware of an issue and are able to provide more support as a result.

Some issues have resulted in formal HR action being taken by the individual concerned, having taken advice as to what the process involves and what support is available.

There are some specific positive outcomes that the FTSUG can share at the Board meeting.

4. 'Read across'
The Trust has several data sources that already capture where staff are speaking up about issues of concern.

When presenting the first Freedom to Speak Up Guardian's report to the Trust Board, the Board agreed the following principles:

- That the Guardian's role can help 'sense-check' organisational culture, to see if staff feel increasingly enabled to raise concerns about patient safety and staff welfare, and also report if staff are being treated detrimentally as a result of raising concerns
- That the Trust Board did not want the Guardian to start producing lengthy reports to try to cross-refer numerous data sources
- That the Guardian should not work on rumour or conjecture, or read correlation or causation into issues falsely

On this basis, the Guardian has reviewed the following:

- Each Quality report to the Trust Board from January 2017, including the ward dashboard as an appendix to the report
- Each nursing Safer Staffing report to the Trust Board from January 2017
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The detail of all SALS cases – concern, plus role and grade of staff member and department working in
- The headline National Staff Survey data and the quarterly cultural/staff friends and family test

4.1 Staff Advice and Liaison Service
One such source is the Staff Advice and Liaison Service (SALS). SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. The SALS contacts per year are counted below.

Time period	**No. contacts**	**Service area 18-19**	**Health Group/ Corporate services 18-19**
Jan 15 - Mar 15	22	Two areas of repeated concerns – escalation action taken by SALS	1 - Medicine 7 - Clinical Support 9 - Surgery 5 – Corporate 2 – F&W All others not specified
Apr 15 - Mar 16	57		
Apr 16 – Mar 17	51		
April 17 – Mar 18	33		
Apr 18 – Mar 19	34		

The SALS contacts April 2018 – December 2018 principally related to the following:

Type of concern	Number of contacts
Concerns about bullying behaviour	20
Concerns about HR process involving the member of staff – concerns about fair treatment	1
Concern about patient safety	1
Concerns about workload	-
Concerns about inappropriate behaviour	8
Concerned about role within the Trust	3
Not specified – calling for general support	2
Totals	34

The single issue raised most frequently through either route concerns staff behaviour. This reflects also the national staff survey results, shared with the Board previously, wherein bullying behaviours remain one of the areas of concern for this Trust.

4.2 Whistleblowing

The Trust's *Raising Concerns at Work (Whistleblowing)* Policy is intended to assist staff who believe they have discovered malpractice or impropriety. The Trust's policy was reviewed in 2016 to take account of new NHS national guidance on whistleblowing, to reference the role of the Freedom to Speak Up Guardian and to reference junior doctors' rights to whistleblow to a third party. The Trust's policy is up to date against national NHS requirements as well as employment law requirements.

Since 2015, the following issues have been reported under the Whistleblowing policy or dealt with under the Whistleblowing policy. In order to protect the position of staff raising concerns, the following information does not provide specific details:

Date	Issue
January 2015	Concerns about a support service
February 2015	Concerns about patient care and bullying culture in a particular department
February 2015	Concerns raised through an exit interview about patient care and safety in a particular department
November 2015	Allegations of bullying and harassment against a particular member of staff
February 2016	Concerns about patient care and safety in a particular department
October 2016	Concerns about the clinical practice and conduct of a colleague
December 2016	Concerns about proper application of proper processes to staff recruitment
May 2017	Concerns passed on to the organisation by the Care Quality Commission
May 2017	Concerns about the clinical practice of a particular member of staff

September 2017	Anonymous contact regarding the recruitment of someone external to the Trust
October 2017	Concerns about quality of care in a particular clinical service
March 2018	Concerns about a particular third-party contract with the Trust
May 2019	Concerns about staff behaviour – moved to a Grievance investigation in the first instance
June 2019	Concerns about patient safety within a service

All of the above concerns are all formally investigated and the person or persons raising the concern receive a formal response if they have identified themselves. For completed cases, the Trust has followed its own policy in investigating and responding to the concerns raised and is monitoring should any member of staff raise a concern about suffering a detriment to their employment position as a result of blowing the whistle.

5.3 Analysis

There is a consistency between the staff survey results and the issues coming through the SALS service, and with the individual Guardian cases – they largely concern staff behaviours, communication between teams and individuals and the way in which staff and managers are supported to improve team relations or work through difficult issues, such as performance management.

There are no new issues emerging from the FTSUG's work or read-across that the organisation is not already aware of.

The Trust's Audit Committee has received regular updates on speaking up arrangements in the Trust, to receive assurance as to whether these are robust. At the moment recent presentation in March 2019, no gaps in assurance or control were identified.

There are some key messages, captured in the conclusion, which are reflected in the updated People Strategy; it is through the workstreams for the People Strategy through which some of the longer-term issues raised by staff might be best improved, for example, support to teams with long-standing relationship issues, managers working in complex and stressful areas, and supporting staff with comprehensive support when they need to raise a concern, to allay the fears of doing so.

5. Conclusion

The Trust encourages staff to speak up about concerns at work and has put in place a number of mechanisms to help staff to do so. The Guardian is not aware of any reported issues in respect of a member of staff who has suffered a detriment as a result of blowing the whistle; some staff have raised concerns about the way in which their line manager has responded to their concerns, which needs further work by the Trust. There are also staff who are concerned about raising concerns as they do not think their manager or the Trust will support their position.

In relation to the 'read across' as Freedom to Speak Up Guardian, the Guardian offers the following observations:

- Most members of staff making direct contact with the Freedom to Speak Up Guardian have been isolated cases – in terms of each coming from a different part of the Trust and being individual cases
- There are some cases where staff have contacted more than one area for advice and support, such as SALS and FTSUG – this is encouraged so that staff know there is support available

6. Recommendation
The Trust Board is asked to receive and accept this report, and fee back any observations on how further to develop the Freedom to Speak Up Guardian role in the Trust

Carla Ramsay
Director of Corporate Affairs
July 2019

APPENDIX A

HOW TO RAISE CONCERNS

If you are concerned about patient safety or staff welfare at the Trust, there are a number of places you can turn to

Speak up at any time
At any time, if you are concerned about patient safety or staff welfare in the Trust, you can contact any of the following:

- Your line manager or member of your management team
- Your staff side/union representatives
- The Human Resources team
- Occupational Health
- The Trust's Freedom to Speak Up Guardian
- Your Professionalism Champion
- The Staff Advice Liaison Service (SALS)
- The Chaplains' team

SALS – Staff Advice and Liaison Service
SALS is a confidential advice line for staff experiencing bullying in the workplace.

If you have any queries about poor behaviours and bullying this should be your first port of call. Whether you want to get things off your chest or you need advice on what actions you can take to make work life better, please contact the Staff Advice Liaison Service on CHH ext. 4317 or email SALS.Team@hey.nhs.uk

Occupational Health
The Occupational Health service can help you if you are feeling anxious or stressed about work-related issues. It is a confidential service, and you can self-refer at any time. If a situation in your team is having a detrimental effect on you, please consider speaking to a member of the Occupational Health team about it. Contact details are available on Pattie.

Human Resources Team
The Trust's Human Resources team is there to advise you when you are feeling concerned. You can contact your Human Resources Business Partner or member of your HR team for advice at any time.

Contact details are available on Pattie.

Chaplains' Team
The Trust's Chaplaincy team is available to staff and patients to support their welfare. A list of local chaplains and contact details can be found on Pattie.

Union Representatives
The Trust has good working relationships with trades unions; if you are a member of a union and have a concern about your workplace, you can contact your local Union representative for advice.

A full list of local union representatives can be found on Pattie, under Trade Union Contacts

Through the Raising Concerns at Work (Whistleblowing) Policy
The policy is available from Pattie. The first page is a useful flowchart for how to raise concerns under this policy.

It is a way of raising concerns about dangerous or illegal activity in the Trust. There are legal protections built in to whistleblowing to encourage staff to speak up without repercussions on their employment.

Your Professionalism Champion
The Professionalism Champions act as first responders for any team member who has concerns about the behaviour of colleagues. They are able to signpost colleagues to the relevant reporting and support services, including SALS, Occupational Health, HR etc. They are also able to help staff in raising a formal concern.

A list of Professionalism Champions is available on Pattie under Professional and Cultural Transformation. Dr Purva is Cultural Ambassador for the Trust, and can help individuals look at team behaviours and dynamics, specifically with medical staff.

Freedom to Speak Up Guardian
All Trusts have a Freedom to Speak Up Guardian. For our organisation, it is Carla Ramsay, Director of Corporate Affairs on HRI ext. 4920 or carla.ramsay@hey.nhs.uk

The Freedom to Speak Up Guardian is a senior manager who staff can turn to and discuss issues in the workplace if they are concerned about patient safety or staff welfare. The Freedom to Speak Up Guardian has a key role in helping to raise the profile of raising concerns in the Trust and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. The Freedom to Speak Up Guardian does not get involved in investigations or complaints, but helps give advice where needed, and has a role to ensure organisational policies are followed correctly.

Incident report – you should always report on Datix any incident concerning patient or staff safety in the normal way, via Pattie

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Trust Board Meeting

30th July 2019

Title:	**The Hull Lung Health Check Programme**
Responsible Director:	**Teresa Cope**, Chief Operating Officer
Author:	**Michelle Kemp,** Deputy Chief Operating Officer

Purpose:	To brief the Board about the forthcoming Hull Lung Health Check (LHC) Programme. To inform the Board that this programme forms part of a national scheme and contributes to the NHS Long Term Plan ambition around improving outcomes for patients with cancer.	
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 LHC Programme sets out to identify lung cancer at an early stage, with the intention to deliver better clinical outcomes for more patients with this condition. The programme will generate additional clinical activity for a number of services within HUTH over the next four years and this paper sets out the operational and financial plan to support delivery.	

Recommendation:	The Trust Board is requested to note: • The opportunity to improve lung cancer outcomes for the people of Hull and to contribute to the NHS Long Term Plan ambitions around improving cancer survival rates through earlier detection. • The proposal for HUTH to be the secondary care provider for the Hull LHC programme starting in October 2019, and the plan for delivery of the additional activity generated by the LHC Programme from October 2019 through to March 2023 according to the proposed activity schedule. • The investment required to set up and deliver the programme in HUTH and the status of discussions with Hull CCG and NHSE Commissioners around the commissioning impact of the programme over the next four years. • The risks associated with the set up and delivery of the LHC programme and the need for ongoing monitoring of the actual activity generated, alongside any future impact on the rates of late detection of lung cancer in the Hull population. • That HUTH plans to contribute to the wider national and international knowledge base on this subject through the development of an academic research project to support this work in partnership with the University of Hull.

Hull Lung Health Check Programme

1. Introduction

The city of Hull has been selected as one of ten pilot areas for the national Lung Health Check (LHC) initiative. The public health aim and main benefit of the initiative is to achieve earlier identification of lung cancer leading to better clinical outcomes for a higher proportion of patients. By studying the impact and benefits of the programme for the people of Hull, there is also an important opportunity to contribute to the wider knowledge base nationally and internationally.

The LHC pilot initiative is a four year programme that has a target launch date in Hull of October 2019. It is aimed at a cohort of men and women aged between 55 and 75 who are registered with a Hull GP; have a Hull postcode, and who have ever smoked.

Manchester and Liverpool have been operating the LHC programme as early pilot sites and have produced useful data which have been used as a basis for capacity modelling.

2. Background

Lung cancer is the third most common cancer in the UK and is the leading cause of cancer death, accounting for 21% of all cancer deaths in 2016. Around 35,600 people die from lung cancer every year in the UK – equating to nearly 100 people every day (Cancer Research UK). Every nine minutes someone is diagnosed with lung cancer and every 12 minutes someone dies (Roy Castle Lung Cancer Foundation). It is therefore essential to reduce the number of people diagnosed with late stage lung cancer as this will give more patients a better chance of successful treatment and survival.

Lung cancer screening and the new NHS England Lung Health Check (LHC) programme have been developed as a potential way to reduce late stage diagnosis, and Hull is one of ten pilot sites chosen to roll out the first wave of the TLHC programme, linked to its high prevalence of smoking, deprivation profile and its current ranking of the highest mortality rate from lung cancer in the country. 51% of lung cancers in the city are diagnosed at a late stage (Stage 4) which has traditionally meant that outcomes are poor for some patients.

The LHC programme will help improve cancer survival rates by inviting people aged 55-74 who have been identified as being at increased risk of lung cancer, for a lung health check appointment. Based on this appointment, some people will be offered a Low Radiation Dose Computed Tomography (LDCT) scan (chest scan) if appropriate, through a mobile unit, which is provided by a separate provider organisation in the community setting, and with any relevant further activity indicated through findings, to be provided by HUTH.

The NHS Long Term Plan sets out an ambition that more people will survive cancer and by 2028, the proportion of cancers diagnosed at stage one and two will rise from half to three-quarters of cancer patients.

Based on the schemes already undertaken in Manchester and Liverpool, the project will not just identify more cancers quickly but pick up a range of other respiratory and cardiac health conditions including chronic obstructive pulmonary disease (COPD) and coronary artery calcification (CAC).

3. LHC Programme delivery planning

In response to the planned start of the LHC programme in Hull in October 2019, HUTH has developed an operational delivery plan covering relevant provision of the Trust's secondary and tertiary services including lung cancer services, respiratory medicine, cardiology and thoracic surgery services along with the associated oncology, radiology, radiotherapy, laboratory medicine and support services.

The delivery plan is based on the stated activity volumes arising from the outputs of the Humber Coast and Vale Cancer Alliance's LHC programme, which involves lung health assessments and CT scans and which will result in additional referrals to HUTH for further clinical investigations as part of lung cancer and non-cancer clinical pathways.

The report provides a summary of the provider and commissioner impact of the programme and presents an outline of the resources and investment required for HUTH to deliver the clinical activity that will result from the LHC programme - subject to final confirmation of the resourcing plan by Hull CCG and NHSE Specialised Commissioning Group, and subject to identification of funding sources for the non-activity related costs of the programme to HUTH.

A significant investment of circa £9.9 million is required by Commissioners to cover the costs of the additional clinical activity within HUTH over the next four years to deliver the LHC Programme. This represents a major investment in the health, well-being and health outcomes of the people of Hull.

As the local secondary care provider, HUTH is developing a comprehensive implementation plan to ensure that all clinical and non-clinical services within HUTH can support the launch and operation of the LHC programme over the next four years, subject to adequate mitigation of key risks involving workforce, equipment and infrastructure.

As part of the progression, development and roll out of the LHC programme the Humber Coast and Vale Cancer Alliance, which is hosted by East Riding or Yorkshire CCG, has formulated five working groups as detailed below:

Table 1. LHC Working group structure

Working Group 1	Engagement and communication with communities and GP Practices
Working Group 2	Primary care engagement, identify and invite eligible participants, secure facilities and site to deliver LHCs
Working Group 3	Undertaking LHC Assessments: staffing, operational policy and protocols
Working Group 4	Secondary Care Investigations & Treatment for LHC participants
Working Group 5	Data & Information Management

The HUTH delivery plan concentrates on the objectives of the LHC Programme's Working Group 4: Secondary Care Investigations & Treatment for LHC participants. This working group is led by Dr Gavin Anderson, HUTH Cancer Lead Clinician, and Responsible Clinician for LHC Programme and Clinical Lead for Lung Cancer Services at HUTH.

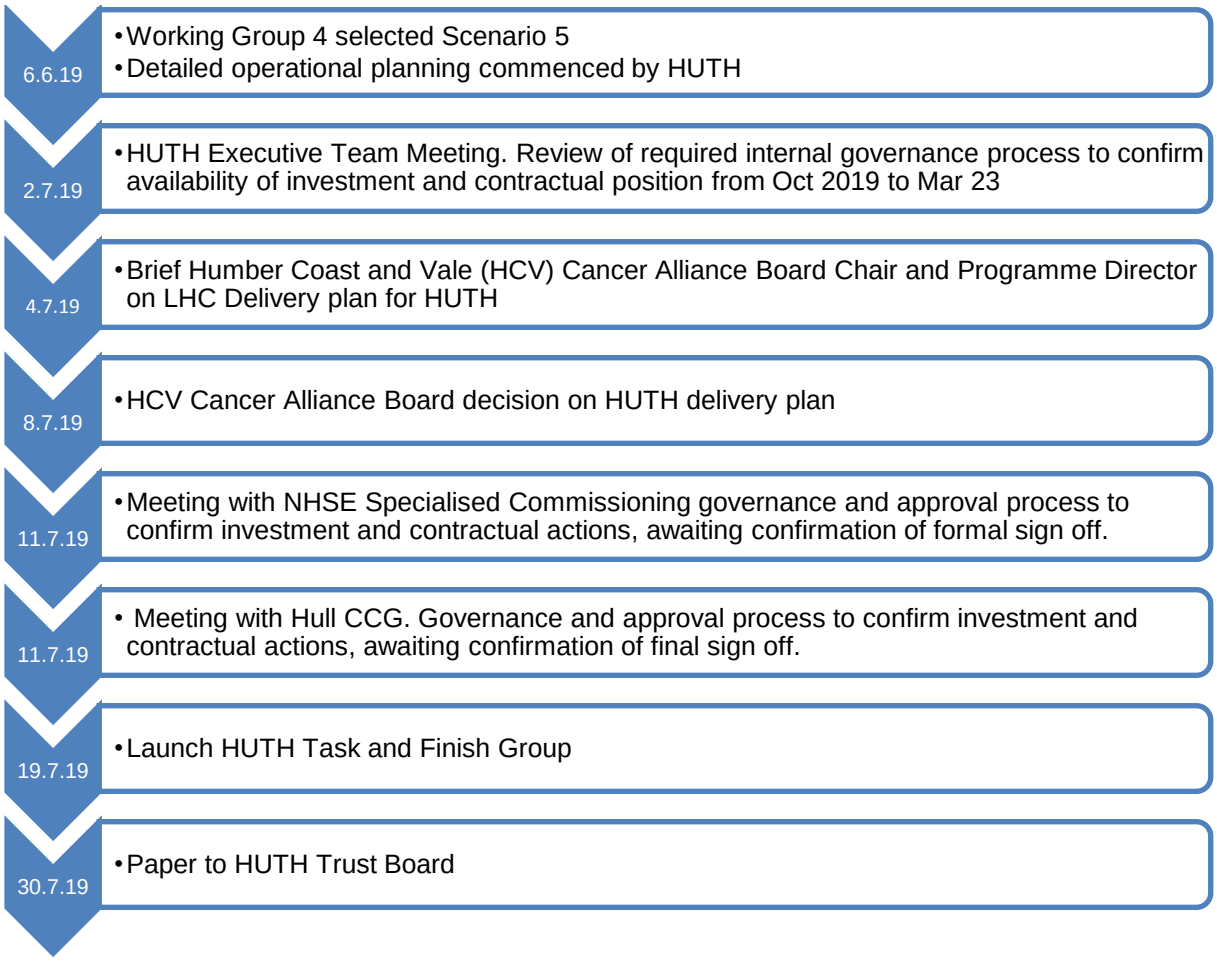
4. Organisational response to support delivery of the LHC Programme

Figure A. HUTH Departments that will be involved in delivery of the clinical activity and other work arising from the LHC programme.

HUTH has developed a delivery plan based on the costs of delivering the activity generated by the LHC Programme between October 2019 and March 2023.

The HUTH team outlined the governance process shown below in order to gain assurance that adequate investment will be secured and any contract variations for 2019-20 agreed. Assurance has also been sought around the contractual provisions for 2020 to 2023 to reflect the additional activity expected from the LHC Programme.

Figure B. Governance and approval process for implementation of LHC activity in HUTH.



5. Operational context

For the Hull area, at the start of the programme there will be 50,498 people in the 55 to 75 year old age category and 64% or 32,268 of those people have ever smoked. The modelling is based on 50% or 16,134 of these people being invited to attend for assessment as part of the LHC programme. Detailed modelling based on the findings summarised by Crosbie et al 2019 from the Manchester pilot of the LHC initiative[1] has been used to develop the Hull LHC delivery plan.

A key operational feature of the LHC initiative is that it is based on the identification of a one off cohort of patients based on the eligibility factors of age and ever smoking. At this stage and for the purposes of the ten LHC pilot programmes, no further patients will be added to the eligible cohort as they move into the age range for the programme. This differentiates the LHC programme from other health screening programmes.

Working Group 4 met on 6th June 2019 and considered five activity scenarios provided by the HCV LHC programme team. The scenarios covered proposed activity volume models from the programme launch in October 2019 through to March 2023. Scenario 5 was selected because it is based on a steady increase of LHCs. It is useful to note that the pre-hospital initial assessments and LDCT scans take place in the community setting during years 1 and 2, follow up scans begin during Q4 of year 1 and continue to the end of year 4.

The delivery modelling for HUTH is based on the following participant modelling formula:

Table 2. Participant modelling and four year activity impact illustration based on lung cancers found via LHC programme (figures represent the totals over four years).

Participant modelling – figures relate to the full four year period			
Stage	No.	%	Comment
Total eligible population	50,498	100.0%	Aged 55-74/364
Ever smoked	32,268	63.9%	Of Total eligible population
Appointments booked	16,134	50.0%	Of Ever Smoked
Non attendees	1,291	8.0%	Of Appointments Booked
LHC's performed	14,843	92.0%	Of Appointments Booked
Positive LHC's	8,312	56.0%	Of LHC's analysed
Excluded from CT scan	249	3.0%	Of Positive LHC's
Initial CT scans performed	8,063	97.0%	Of Positive LHC's
Indeterminate - require second scan	1,145	14.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	6,660	82.6%	Of Initial CT Scans performed
Activity Impact of Cancers Identified – figures relate to the full four year period			
Findings	No.	%	Comment
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	476	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	242	50.8%	Of Needing clinic investigation
24 months follow-up	6,660	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	160	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	105	65.5%	Of Needing clinic investigation
Total cancers found	346	N/A	Including those found at initial, 3, 12 and 24 months scans
Surgery	177	51.0%	Of Cancers found
Stereotactic Body Radiation Therapy (SABR)	42	12.2%	Of Cancers found
Chemo-Radiation	32	9.1%	Of Cancers found
Radiation treatment (XRT)	32	9.1%	Of Cancers found
Surgery and Adj Chemo	27	7.7%	Of Cancers found
No Treatment	16	4.6%	Of Cancers found
Chemo	16	4.6%	Of Cancers found
Best Standard Care	5	1.5%	Of Cancers found

Based on the planned volume of LHC assessments and scans provided in the community combined with the modelling formulae above; a forecast has been developed to show the additional activity that will need to take place within HUTH in order to deliver the Hull LHC programme. From the Manchester and Liverpool pilots, it is known that there will be also be some detection of non-cancer findings involving respiratory and cardiac conditions. This work has also been included in the HUTH delivery plan to ensure provision of the capacity to provide treatment and care for this group of patients.

6. Operational delivery planning

The activity impact modelling above has been used to develop the operational delivery plan for each year of the programme. This information has been used as the basis for service delivery planning across thirteen clinical and non-clinical service departments within HUTH.

Table 3. Expected numbers of patients entering HUTH pathways via LHC route based on Scenario 5 profile and clinical impact modelling for Year 1:

HUTH ACTIVITY YEAR 1										
Service element	Clinical investigation	Cancers found	Non-cancer findings (respiratory)	Non-cancer findings (Cardiology – excludes all CAC)	Surgery	SABR	Chemo Rad	Surgery + Adj Chemo	No treatment	Chemo
Oct 19	0	0	79	40	0	0	0	0	0	0
Nov 19	6	3	99	50	0	0	0	0	0	0
Dec 19	7	4	99	50	0	0	0	0	0	0
Jan 20	7	4	264	134	2	0	0	0	0	0
Feb 20	21	11	297	150	2	0	0	0	0	0
Mar 20	24	12	327	166	2	0	0	0	0	0
TOTAL	**65**	**34**	**1165***	**590****	**6**	**0**	**0**	**0**	**0**	**0**

*Discussions are ongoing around the proportion of non-cancer respiratory findings that would be managed in secondary and primary care respectively.

**Cardiology activity excludes Coronary Artery Calcification (CAC) and assumes that 80% of findings are notified to the patient's GP with a letter.

Table 4. Expected numbers of patients entering HUTH pathways via the LHC route based on scenario 5 profiles and clinical impact modelling for Year 2:

HUTH ACTIVITY YEAR 2										
Service element	Clinical investigation	Cancers found	Non-cancer findings Respiratory	Non-cancer findings (Cardiology)	Surgery	SABR	Rad or Chemo & Rad	Surgery + Adj Chemo	No treatment	Chemo
Apr 20	26	13	327	166	5	1	1+1	1	0	1
May 20	28	14	327	166	6	1	1+1	1	1	1
Jun 20	28	14	327	166	7	2	1+1	1	1	1
Jul 20	28	14	327	166	7	2	1+1	1	1	1
Aug 20	28	14	327	166	7	2	1+1	1	1	1
Sep 20	28	14	327	166	7	2	1+1	1	1	1
Oct 20	28	14	327	166	7	2	1+1	1	1	1
Nov 20	28	14	264	134	7	2	1+1	1	1	1
Dec 20	24	12	264	134	7	2	1+1	1	1	1
Jan 21	24	12	264	134	7	2	1+1	1	1	1
Feb 21	24	12	327	166	6	1	1+1	1	1	1
Mar 21	29	15	327	166	6	1	1+1	1	1	1
TOTAL	**323**	**162**	**3735***	**1891****	**79**	**20**	**24**	**12**	**11**	**12**

*Discussions are ongoing around the proportion of non-cancer respiratory findings that would be managed in secondary and primary care respectively.

**Cardiology activity excludes CAC and assumes that 80% of findings are notified to the patient's GP with a letter.

Table 5. Expected numbers of patients entering HUTH pathways via the LHC route based on scenario 5 profiles and clinical impact modelling for Year 3.

HUTH ACTIVITY YEAR 3								
Service element	Clinical investigation	Cancers found	Surgery	SABR	Rad or Chemo & Rad	Surgery + Adj Chemo	No treatment	Chemo
Apr 21	29	15	6	2	1+1	1	0	1
May 21	6	3	7	2	1+1	1	0	1
Jun 21	7	3	7	2	1+1	1	0	1
Jul 21	7	4	1	0	0	0	0	0
Aug 21	7	4	2	0	0	0	0	0
Sep 21	4	2	2	0	0	0	0	0
Oct 21	4+3	2+2	1	0	0	0	0	0
Nov 21	4+3	2+2	1	0	0	0	0	0
Dec 21	4+3	2+2	2	0	0	0	0	0
Jan 22	4+9	2+6	2	0	0	0	0	0
Feb 22	4+10	2+6	2	0	0	0	0	0
Mar 22	3+11	1+7	4	1	1	1	0	0
TOTAL	**122**	**68**	**37**	**7**	**7**	**4**	**0**	**3**

Table 6. Expected numbers of patients entering HUTH pathways via the LHC route based on scenario 5 profiles and clinical impact modelling for Year 4.

HUTH ACTIVITY YEAR 4								
Service element	Clinical investigation	Cancers found	Surgery	SABR	Rad or Chemo & Rad	Surgery + Adj Chemo	No treatment	Chemo
Apr 22	3+11	8	4	1	1+1	1	0	0
May 22	3+11	8	4	1	1+1	1	0	0
Jun 22	3+11	9	4	1	1+1	1	0	0
Jul 22	4+11	9	4	1	1+1	1	0	0
Aug 22	4+11	7	4	1	1+1	1	0	0
Sep 22	11	7	4	1	1+1	1	0	0
Oct 22	11	7	4	1	1+1	1	0	0
Nov 22	11	6	4	1	1+1	1	0	0
Dec 22	9	6	4	1	1+1	1	0	0
Jan 23	9	6	3	1	1+1	1	0	0
Feb 23	11	7	3	1	1+1	1	0	0
Mar 23	11	7	3	1	1+1	1	0	0
TOTAL	**145**	**87**	**44**	**12**	**24**	**12**	**0**	**0**

Each service has reviewed the activity modelling information shown in tables 3 to 6 and has developed a delivery plan covering the following elements:

- Current issues affecting the service
- Workforce requirements or impacts
- Relevant process requirements, eg referral management and tracking
- Links with other relevant pieces of work, eg developments in respiratory services
- Resources required to deliver the programme
- Delivery risks

7. Financial context

All additional resources included within the detailed service level delivery plans have been through a first line costing exercise that has been subject to a round of internal challenge. This process has been overseen by the HUTH Chief Operating Officer and led by the Deputy COO to gain assurance and clarity on the delivery costs of the programme.

Following the presentation of the activity costs to the Humber Coast and Vale Cancer Alliance Board on 8th July 2019, an urgent meeting with Hull CCG and NHSE Specialised Commissioning team took place on 11th July 2019 to discuss the commissioning impact of the activity costs arising from the LHC programme. Both commissioners gave strong indications that the activity related costs of the programme would be fully funded and covered via contract variation during 2019-20 and contract planning for 2020-21. Costs are split at broadly 55%:45% between Hull CCG and NHSE respectively. Both commissioning organisations are now working through formal approval procedures within their respective organisations and confirmation of formal sign off is expected by mid-August 2019.

Table 7. Outline costs to deliver the additional activity from the LHC programme and first draft income forecast based on tariff (NB not adjusted for inflation)

	Service	Year 1	Year 2	Year 3	Year 4	TOTAL
1	Performance and BI	26,692	6,456	6,456	6,456	46,060
2	Cancer Management and Nursing	64,096	128,192	128,192	128,192	448,672
3	Clinical investigations - Radiology	53,929	107,855	107,855	107,855	377,494
4	Clinical Investigations – Cell Path	30,750	174,506	174,506	174,506	554,268
5	Lung Cancer Pathway	69,318	367,909	367,909	367,909	1,173,045
6	Lung Nodule Pathway	44,805	89,610	89,610	89,610	268,830
7	Respiratory Medicine (non-cancer)	246,607	493,212	493,212	493,212	1,726,243
8	Cardiology	120,290	240,578	240,578	240,578	842,024
9	Thoracic Surgery	80,250	874,636	874,636	874,636	2,704,158
10	Radiotherapy and Clinical Oncology	144,994	533,612	533,612	533,612	1,745,830
COSTS		**881,731**	**2,976,606**	**2,976,606**	**2,976,606**	**9,886,624**

These costs will be further refined during July and August 2019 alongside ongoing discussions within HUTH and with Hull CCG and the NHSE Specialised Commissioning teams.

Table 8 below summarises the non-activity related costs needed to deliver the programme and the shaded areas indicate the items for which funding has been agreed through other sources. The non-shaded areas, which total 392k of capital and 342k of non-capital funding

(pay) do not yet have an agreed source of funding at the time of this report, but preparations are being made to submit a bid for charitable funding support to Yorkshire Cancer Research or Cancer Research UK

Table 8. Items to be funded via other sources, eg LHC Programme funding or Charitable funding eg YCR.

	Service	Equipment Years 1 & 2	Year 1	Year 2	Year 3	Year 4
1	Clinical Administration	82,000				
3	Cancer Management and Nursing	7,000				
5	Clinical Investigations – Cell Path	35,500				
8	Respiratory Medicine (non-cancer)	48,000				
10	Thoracic Surgery	218,500				
12	Research fellow and database management	-	33,468	66,936	66,936	66,936
13	Project and clinical programme management	1,000	18,000	36,000	36,000	36,000
14	Responsible Clinician role	-	10,000	10,000	10,000	10,000
15	Responsible Radiologist role	-	10,000	10,000	10,000	10,000
16	Responsible Assessor role*	-	10,000	10,000	10,000	10,000
COSTS		**392,000**	**81,468**	**132,936**	**132,936**	**132,936**

NB * The Responsible Assessor role will be provided by HUTH via an honorary contract arrangement until Q2 of 2020-21 in order to provide support, quality and safety oversight of the assessment function until HUTH becomes the provider of the assessment service.

7. Critical and high priority actions required to support an October 2019 launch

The highest priority actions for HUTH is the recruitment of the additional clinical workforce and identification of a source of funding for the non-activity based costs of the programme.

The recruitment process for NHS Consultants can take several months. In order to support the LHC activity, the Consultant recruitment process, particularly in Lung Cancer/Respiratory Medicine would need to commence as soon as possible.

Subject to approval of the activity costs by the commissioners, which is expected by mid-August, and identification of a funding solution for the capital equipment and programme costs, and based on all of the service delivery plans, a project schedule is being developed

that puts the actions in priority order linked to how the activity comes through to the various specialties. This implementation plan will be overseen by Working Group 4.

8. Outline summary of delivery risks and key assumptions

A number of caveats, assumptions and risks are involved with delivery of the LHC programme:

- Participant modelling is based on the formulae developed from the early pilot programmes and the response to the Hull LHC programme could differ from those assumptions.

- The size, timing and scale of the programme in Hull differ from the pilots in Liverpool and Manchester, so a bottom up costing approach has been used in order to reflect the local situation.

- There is a risk of additional activity requirements once patients are in treatment, for example additional cardiology investigations and monitoring for patients undergoing chemotherapy and radiotherapy treatments.

- Requirements cannot be quantified with certainty until all pathways have been implemented, this will be achieved through close monitoring of the forecast versus actual activity seen once the programme starts.

- This programme is a pilot being commissioned by NHS England. Pilots are also offered elsewhere in the country and are at differing stages of maturity. The pilot could therefore become a commissioned programme within the timeframe of this local pilot and the offer would in this case have to be extended to all populations without the associated pilot support.

- As at July 2019, four months before go live, some pathways have not yet been agreed by either primary or secondary care. These pathways will be confirmed as part of detailed implementation planning.

- There is a risk that not all elements of the programme will be in place before the proposed start date of October 2019. Mitigating actions will be identified wherever possible to minimise risks around service delivery.

- It is anticipated that some elements of delivery could be at premium cost depending on when substantive appointments can be made.

- The service plans show that 392k of capital equipment is needed to deliver the programme. This cannot be supported from the Trust's capital allocation due to the current pressure on this budget. Therefore another funding solution is needed and discussions around a bid to Yorkshire Cancer Research for charitable funding support have commenced. Failure to identify a viable source of funding for this will result in delay or cancellation of the start of the programme.

- The LHC is designed as a four year pilot programme. Careful risk assessment of the long term costs of recruiting additional substantive workforce will be undertaken to assess the medium and longer term cost implications.

9. Recommendations

The Trust Board is requested to note:

- The opportunity to improve lung cancer outcomes for the people of Hull and to contribute to the NHS Long Term Plan ambitions around improving cancer survival rates through earlier detection.

- The proposal for HUTH to be the secondary care provider for the Hull LHC programme starting in October 2019, and the plan for delivery of the additional activity generated by the Lung Health Check Programme from October 2019 through to March 2023 according to the proposed activity schedule.

- The investment required to set up and deliver the programme in HUTH and the status of discussions with Hull CCG and NHSE Commissioners around the commissioning impact of the programme over the next four years.

- The risks associated with the set up and delivery of the LHC programme and the need for ongoing monitoring of the actual activity generated, alongside any future impact on the rates of late detection of lung cancer in the Hull population.

- That HUTH plans to contribute to the wider national and international knowledge base on this subject through the development of an academic research project to support this work in partnership with the University of Hull.

Michelle Kemp
Deputy Chief Operating Officer HUTH

July 2019

References

[1] Crosbie PA, et al. Implementing lung cancer screening baseline results from a community based 'Lung health Check' pilot in deprived areas of Manchester. British Medical Journal, Thorax 2019; 74:405-409