Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 12 November 2019
The Boardroom, Hull Royal Infirmary
9.00am – 12.00pm

Agenda: Meeting to be held in public

	Opening Matters		
1	Apologies	verbal	Chair – Terry Moran
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair – Terry Moran
3	Minutes of the meeting of 10 September 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	attached	Carla Ramsay – Director of Corporate Affairs
	8.1 BAF 6 – Research and Innovation	attached	James Illingworth – R&D Manager
	Director Reports		
9	9.1 Quality Report 9.2 HCAI Report 9.3 Patient Experience Report	attached attached attached	Chief Nurse – Beverley Geary
10	Nurse and Midwifery Staffing Report	attached	Chief Nurse – Beverley Geary
11	Quality Committee Minutes 30 September/28 October 2019	attached	Chair of Committee – Martin Veysey
12	Performance and Finance Report 12.1 Winter Plan	attached	Chief Operating Officer – Teresa Cope/Chief Financial Officer – Lee Bond

13	Five Year Plan Submission	verbal	Lee Bond – Chief Financial Officer/Director of Strategy and Planning – Jacqueline Myers
14	Performance and Finance Minutes 30 September/28 October 2019	attached	Chair of Committee – Tony Curry
	Governance and Assurance		
15	Trust Strategy Implementation Update	attached	Director of Strategy and Planning - Jacqueline Myers
16	IM&T Review Paper	attached	Non-Executive Director – Tony Curry
17	Staff Survey Results Q2	attached	Director of Workforce and OD - Simon Nearney
18	Audit Minutes October 2019	attached	Non-Executive Director - Tracey Christmas
19	Quality Accounts Update/Quality Improvement Plan	attached	Chief Nurse – Beverley Geary
20	Learning from Deaths Guidance	attached	Chief Medical Officer - Makani Purva
	20.1 Perinatal Mortality Review Tool	attached	Chief Medical Officer - Makani Purva
21	7 Day Services Report	attached	Chief Medical Officer – Makani Purva
22	Guardian of Safe Working Report	to follow	Guardian of Safe Working – Androniks Mumdzjans
23	Freedom to Speak Up Report	attached	Director of Corporate Affairs - Carla Ramsay
24	Standing Orders	attached	Director of Corporate Affairs - Carla Ramsay
25	Any Other Business		
26	Any questions from members of the public		
27	**Date and time of the next meeting: Tuesday 28 January 2020, 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	✓	✓	✓	✓							4/4
A Snowden	✓	✓	-	-							2/2
S Hall	✓	x	✓	✓							3/4
V Walker	✓	✓	x	✓							3/4
T Christmas	✓	✓	✓	✓							4/4
M Gore	✓	x	✓	✓							3/4
C Long	x	✓	✓	✓							3/4
L Bond	✓	✓	✓	✓							4/4
T Cope	xMK	✓	xMK	✓							2/4
K Phillips	-	-	-	-							0/0
M Purva	✓	x	✓	✓							3/4
M Veysey	✓	x	✓	✓							3/4
B Geary	✓	✓	✓	✓							4/4
J Jomeen	✓	✓	✓	x							3/4
In Attendance											
T Curry	✓	✓	✓	x							3/4
J Myers	✓	✓	x	✓							3/4
S Nearney	✓	x	✓	✓							3/4
C Ramsay	✓	✓	✓	x							3/4
R Thompson	✓	x	✓	✓							3/4

	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 on 10 September 2019

Present:	Mr T Moran CB	Chairman (Chair)
	Mr C Long	Chief Executive Officer
	Mr S Hall	Vice Chair
	Mr L Bond	Chief Financial Officer
	Mrs V Walker	Non Executive Director
	Mrs T Christmas	Non Executive Director
	Mr M Gore	Non Executive Director
	Prof M Veysey	Non Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mrs T Cope	Chief Operating Officer
In Attendance:	Ms J Myers	Director of Strategy and Planning
	Mr S Nearney	Director of Workforce & OD
	Mrs G Johnson	Director of Infection Prevention and Control
	Ms K Rudston	Assistant Chief Nurse
	Mrs H Russell	Organ Donation Team
	Mrs A Wray	Organ Donation Team
	Mrs L Cochrane	Organ Donation Team
	Dr P Gunasekera	Organ Donation Team
	Ms P Burns	Clinical Scientist (HSST) Medical Microbiology
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Prof. J Jomeen, Non Executive Director, Mr T Curry, Non Executive Director and Ms C Ramsay, Director of Corporate Affairs.	
2	**Declarations of interests** **2.1 Changes to Directors' interests since the last meeting** Mr Nearney declared that his wife had taken a post as an Auxiliary Nurse for the Trust. Mrs Walker declared that she was a Cabinet Member for East Riding Council. **2.2 To consider any conflicts of interest arising from this agenda** There were no declarations made.	
3	**Minutes of the meeting of 23 May 2019 and 30 July 2019** Both sets of minutes were approved as an accurate record of the meetings.	
4	**Matters Arising from the minutes of 30 July 2019** Mrs Thompson to follow up the possibility of a Board to Board meeting with Humber Foundation Trust. Mr Long advised that although the Trust wanted to vaccinate as many members of the public, there were not enough flu vaccinations to do this. The vaccination programme would be for all staff and vulnerable groups	**RT**

only.

4.1 Action Tracker
Dr Purva responded to the item relating to the SHMI spike and advised that this was due to the heatwave experienced in July 2018. She stated that there was nothing untoward to report.

Ms Myers to discuss the stakeholder support development session with Ms Ramsay. **JM/CR**

Prof Veysey advised that the Quality Committee would be reviewing infection control issues at its next meeting.

4.2 Board Reporting Framework
The Board received and accepted the framework.

4.3 Board Development Framework
The Board received and accepted the framework.

5 Chair's Opening Remarks
Mr Moran reflected that even though the Trust was in uncertain times, staff were still taking great responsibility to lead and care for patients to the best of their ability. On behalf of the Board he expressed sincere thanks for the efforts colleagues were making. .

Mr Moran reported that this meeting was Mrs Walker's last and stated that he was very sad to see her leave. Mrs Walker was now a Cabinet Member for the East Riding of Yorkshire and responsible for adult and carer services. Mr Moran spoke of her time at the Trust and how she had been a member of the Quality Committee, Chair of the Charitable Funds Committee and more recently Vice Chair. He also spoke of her dedication to patients and always seeking to do the right thing by them. He thanked her, on behalf of the Board for her time and effort which was above and beyond any reasonable ex[ectation of the time commitment required. Mrs Walker stated that she would miss the Trust and the friends and colleagues she had met during her terms of office.

On behalf of the Board, Mr Moran thanked Mrs Anne Shaw the Chair of North Lincolnshire and Goole NHS FT for her commitment to the partnership agenda as it had been announced that she was stepping down at the end of the month. He stated that he and Mrs Shaw agreed on ensuring that patients were the main priority of both Trusts.

6 Chief Executive's Briefing
Mr Long presented his report and advised that Mrs Greta Johnson had been appointed as the new Director of Infection Prevention and Control. He thanked Dr Peter Moss for his level of attention to detail whilst in his role of the DIPC and the great work he had achieved.

Mr Gore asked about the waiting list size increase and Mr Long stated that this was a short term problem and the list size would be reduced by the end of the year.

7 Patient Story
Dr Purva's first patient story was regarding communication and how a

patient needed to have information regarding their care to be sent to the DVLA to ensure they could drive again. The complaint was around the patient not being able to contact the consultant. The complaint was investigated and the Health Group Business Manager had helped get the patient an appointment with the Consultant.

Dr Purva also spoke of a patient that had been discharged from care with a cannula still in their arm. This had been overlooked. Mr Moran asked what learning had been communicated following this and Dr Purva assured him that the investigation had been completed and actions were in place.

A patient had complimented the Trust after having chest pains and being brought into the hospital. They experienced a quick turnaround for tests and was then discharged. They described the excellent care across the emergency pathway. Another compliment related to a patient's family member ringing the ward and having someone pick up the phone immediately. Dr Purva stated that little things like this, even when the Trust was under pressure, really made a difference.

Mr Long spoke of the negative press the Trust had received following a patient receiving a partially filled corned beef sandwich and how another patient had written to him complimenting on the quality of the hospital food to the point that his wife had now felt intimidated by it. Mr Gore added he had also received a number of positive comments regarding the hospital food.

The agenda was taken out of order at this point.

17 Guardian of Safe Working Report

Dr Purva presented the quarterly report which highlighted concerns raised by the Junior Doctors in the form of exception reports. The report sought to assure the Board that actions had been taken to address the issues.

Dr Purva advised that the Trust had received funding for an admin post and this would be advertised and in place in the next 2-3 months.

Mr Gore asked for clarity around the cardiology exception reports and Dr Purva advised that it related to 27 episodes on one night. The Junior Doctor had taken sick leave and had since left the Trust. These reports would be closed down.

Resolved:

The Trust received and accepted the report.

18 – Organ Donation – Performance Update

Mrs Cochrane gave the presentation and advised that the Team had changed and now included 2 clinical leads.

Performance remained consistent, referrals were above 95% and 6 monthly and annual audits were carried out to capture any missed referrals.

Consent also remained consistent with 11 families being referred in 2019/20 and 5 of those families going on to donate.

Mrs Cochrane highlighted 2019/20 plans for the team such as organ donation week, Humber Street Sesh, Health Expo and Student Invasion.

There was to be a Gift of Life installation with a memorial that the Fundraising Teams were organising in partnership with families of donors.

Mrs Wray gave a moving account of a patient who had died and the Team had approached the family regarding a donation. This had not been an easy thing to do, but the family did donate and the recipient of the organ had contacted the family to thank them.

Mr Hall asked about the support given to relatives and Mrs Wray advised that the Trust write and telephone and offer home visits. There is also an opportunity to receive an award in relation to the gift of life a donor had created..

Mrs Geary asked if the new Opt Out initiative would impact on the current team's capacity and Mrs Wray advised that the number of specialist nurses had been increased to accommodate this.

Mr Gore advised that on 7 February 2020 the Song for Hull concert would be held at the Bonus Arena and invited the Team to attend if they had availability.

Resolved:
The Board received and accepted the update and thanked the Organ Donation Team for attending the meeting.

8 Board Assurance Framework 5

Ms Myers presented the report which related to the partnership and integrated system risk. Ms Myers stated that the Humber Coast and Vale STP's aim was to become an Integrated Care System by March 2021.

There was a discussion around developing the care model and the measures around the quality of patient outcomes and access arrangements. Mr Gore suggested that some options may be controversial but if they were in the patients' interest, outlining the advantages and making a good case to patients was key. The model would include new ways of working for all partners and Ms Myers advised that the necessary ground work was underway..

Ms Myers advised that all of the workstreams highlighted in the document were in train and the governance was being reviewed to ensure it was robust. She advised that the model was a challenge for all partners involved so clear objectives and direction were important.

Prof Veysey stated that the 3 main Trusts within the ICS all used different digital systems and asked whether this would be addressed. Mr Bond advised that the development of the healthcare record would help but that there was still collaboration work to do in this area.

Mrs Walker asked if the introduction of the social care ward would be used for learning and assessing patient experience. Ms Myers advised that the Trust was learning from the community ward work and that it was key to have good project support and to establish efficient ways to share data.

Mr Long added that Primary Care was struggling with capacity but again needed to be a key player in the ICS.

The Board reviewed the risk and agreed that it should remain at 12 but would be reviewed again in March 2020. **JM**

Resolved:
The Board received the report and approved the risk rating of 12.

9.1 Quality Report
Mrs Geary presented the report and advised that a Never Event had been declared relating to wrong site surgery. The investigation had commenced and the regulators had been informed.

There had been no news regarding the CQC requests for information and Mrs Geary expressed her concern that this could mean the inspection being held in the Trust's highly pressurised Winter period. She also advised that the Trust had a new CQC relationship manager with their first meeting in October 2019.

Mr Moran was disappointed to hear of another wrong site surgery Never Event and Mr Bond asked if the Trust learning from the events was being shared. Prof Veysey stated that it was difficult to comment without the outcome of the investigation being known and the other wrong site surgery events had all been very different with different outcomes.
Resolved:
The Board received and accepted the report.

9.2 HCAI Report
Ms Geary presented the report and advised that the Trust had reported another MRSA bacteraemia. She advised that the investigation was underway for this complex patient.

The Infection Reduction Committee was reviewing the assessment from the WHO infection prevention and control framework and developing an action plan to focus on the areas for improvement.

Mrs Geary also advised that she was now the Senior Responsible Owner for antimicrobial prescription reductions for the region. The aim was to reduce prescriptions by 5% annually with all partners in the region having this objective.

Resolved:
The Board received and accepted the report.

9.3 Patient Experience Report
Mrs Geary presented the report and advised that the Volunteer Services was recruiting for reading volunteers who would read to stories and poetry to patients. Pet therapy was also being risk assessed. Dining companions were being recruited as part of the seasonal plan and this would include admin staff already working at the hospital.

A well received celebration event had been put on for the volunteers which included a cream tea.

The Patient Experience Team was looking to recruit more members to the Patient and Public Council.

Resolved:
The Board received and accepted the report.

10 Nursing and Midwifery Report

Mrs Geary presented the report and advised that it July and August had been challenging months due to it being difficult to recruit bank and agency staff due to the holidays. She advised that the new trainee nurses would be joining the Trust in October as well as a cohort of Pilipino nurses. Nurses were being recruited that would work differently and these included, Nurse Associates, Apprentices and Senior Healthcare workers.

There was a discussion around the Red Flags and Mr Moran asked if the Trust was an outlier in any way. Mrs Geary advised that Trusts recorded Red Flags differently or not at all but she agreed to put a trend chart into the report. **BG**

Mrs Geary added that the HR metrics in Appendix 2 were due to staffing numbers over the Summer months and were monitored through the monthly performance management meetings. She advised that these should stabilise once the new nurses were in place.

Resolved:
The Board received and accepted the report.

11 Quality Committee Minutes

Prof Veysey presented the minutes and advised that 30 day readmissions had been reviewed by the Committee, project leaders had been added to the Quality Improvement Programme and nutrition rates had been raised as a concern.

Prof Veysey advised that the complaint rates were monitored and the learning from Serious Incidents review. He reported that a new Serious Incident Committee had been established.

Resolved:
The Board received and accepted the minutes.

12 Performance and Finance Report

Mrs Cope presented the performance update and advised that the ED was now working to a system wide consolidated action plan following the visit from NHS Improvement.

Mrs Cope advised that the East Riding Council had contributed to a discharge facility ward which was a positive development.

Mrs Cope updated the Board regarding cancer performance and advised that the national guidance changes had adversely impacted on the services, but that performance was now back on track from August.

Mr Gore stated that the number of ED attendances had not increased significantly from last year and asked why performance was substantially worse. Mrs Cope advised that the issues were multifactorial. She

informed the Board that the time of presentation was key and work was ongoing to re-map the workforce in line with demand in the evenings. There was also more demand through the ambulance route so work around the admission pathways was going on. There were more patients being admitted straight to specialities, meaning flow is compromised. Mrs Cope advised that the bed base was being reviewed and the local urgent treatment centres highlighted to urge patients to use them if appropriate.

Finance
Mr Bond informed the Board that at Month 5 the Trust was reporting a £1.7m deficit which was in line with plan. Income was slightly up on non-elective work but not showing a huge variance. The Trust was down in drugs and Wet AMD.

The Health Group positions were stable with no major issues to report. Mr Bond advised that year to date the Trust was in line with plan. The CRES shortfall for year end was currently at £5.5m.

There were a number of emerging cost pressures such as the lung health check recruitment costs, the introduction of a streaming facility in ED and the assessment area expansion in AMU.

Resolved:
The Board received and accepted the report.

15 Performance and Finance Minutes
Mr Hall presented the minutes and advised that the Committee had been presented with the ED recovery plan which encompassed all actions including partner actions.

There had been a discussion around the Full Hospital Policy to ensure ownership from the Health Groups.

The Committee had received a presentation regarding the ENT service and the recovery plans in place to review theatre lists.

Mr Hall reported that the CRES target was at 18% of the final plan and a stock take would be carried out with Health Group attendance at the Committee to allow plans to be reviewed.

Mr Moran thanked Mr Hall for his excellent chairing of the Committee for the past 5 years as he would be stepping down as a result of being appointed Vice Chair. He would nevertheless remain a member. Mr Moran reported that Mr T Curry would take over as Chair from October 2019.

Resolved:
The Committee received and accepted the minutes.

13 Five Year Plan Submission
Ms Myers presented the plan to the Board. She advised that the Trust was on track with its first submission and had completed the first version of the model.

There was a discussion around achieving 92% RTT targets by 2024 and

Mr Moran asked about the Trust's credibility should it miss this target. Ms Myers advised that the Trust was not an outlier in this area and improvement plans were in place.

Ms Myers advised that the plan would be submitted for information at a Board Development session but that it did not require Board sign off.

Resolved:
The Board received and accepted the plan.

14 Urgent and Emergency Care Business Case

Mrs Cope presented the business case and advised that it had been received at the Performance and Finance Committee in July 2019. The business case had been reduced to £19.3m and the CT and MRI scanner upgrade would be started earlier than first thought.

Work on the front entrance of the Tower Block and the relocation of the paediatric service was outlined in the updated business case.

Mr Hall advised that the Performance and Finance Committee had supported the business case but noted that the case had reduced in value since presented. Mr Bond asked how the Surgical Ambulatory Care Unit was being funded as it was not in the original business case. Mrs Cope advised that the new Same Day Emergency Care Standards needed to reflect a different model and more ambulatory assessment would be required.

Resolved:
The Board received and approved the business case for submission to the STP.

16 Developing Workforce Standards

Mr Nearney presented the report which responded to the new NHS I guidance around reporting all staffing vacancies to the Board. Mr Nearney advised that the information was already received at the Performance and Finance Committee but would come to the Board from January 2020.

Mr Bond stated that information was received at the Board regarding nurse staffing but there was a gap regarding the medics. Mr Nearney reiterated that workforce numbers were received at the Performance and Finance Committee and Prof Veysey added that workforce reports were also received at the Quality Committee.

Resolved:
The Board received and accepted the report.

19 Responsible Officer Report

Dr Purva presented the report and assured the Board that doctors were receiving regular appraisals and completing their revalidation to the necessary national levels. Once approved by the Board the report would be submitted to NHS Improvement.

Resolved:
The Board received and accepted the report.

20 Safeguarding Annual Reports

Ms Rudston presented the Annual Safeguarding reports for Adults, Young People and Children.

Ms Rudston thanked Mrs Walker for being the NED representative for Safeguarding but requested a new NED due to Mrs Walker leaving the Trust at the end of September 2019. Mr Moran agreed to discuss this at the next NED meeting and let her know. **RT**

Ms Rudston reported that the named doctor role had been recruited to and the small Safeguarding Team offer a bespoke and credible service.

Mr Long asked about safeguarding against the frail elderly and in particular pressure damage that is acquired in the care home setting. Ms Rudston advised that work was ongoing to ensure nursing home reporting was robust.

Mrs Walker thanked Ms Rudston and the Safeguarding Team for the comprehensive reports that included detailed information and assurance.

Resolved:
The Board received and accepted the reports.

21 Director of Infection Prevention and Control

Mrs Johnson presented the report and advised that Dr Moss had written the report but he had now stood down as the DIPC. Mrs Johnson reported on the infections such as MRSA, C Difficile and e-Coli giving performance updates for each area. The Operational Quality Committee and Infection Reduction Committee both monitored infection control issues with escalation to the Quality Committee if appropriate.

Mrs Johnson advised that work was ongoing with the surgical teams regarding surgical site infection surveillance, orthopaedic total hip and knee replacements and fractured neck of femur.

Mrs Johnson spoke of the Norovirus outbreak in 2018/19 and the cost of cleaning to the organisation, how the flu vaccination programme would be managed and the transfer of cleaning services over to OCS in 2018. Other risks to the Trust were around patients with TB and neonatal pseudomonas. The previously vacant Infection Control Doctor role had been recruited to.

Mr Long asked about the surgical site infection data and how robust the collecting of surveillance data was. Mrs Johnson advised that full buy in was required and full training was being rolled out.

Resolved:
The Board received and accepted the report.

22 Standing Orders

Mrs Thompson presented the report and requested approval for the use of the Trust seal and an amendment to Standing Orders. The change to Standing Orders was due to an inconsistency in the Scheme of Delegation and Standing Financial Instructions.

Resolved:
The Board received and accepted the report.

23 Workforce Race Equality Standard 2019 submission

Mr Nearney presented the report and advised that the Trust was making positive steps forward and the BME network was established and working well.

Mr Gore stated that the bullying and harassment scores had not improved as much as the Trust would like and Mr Nearney agreed but added that the score related to all staff and not just BME. It was important to create a working environment that was good for all staff.

Resolved:
The Board received and approved the report.

24 Workforce Disability Equality Standard 2019 submission

Mr Nearney informed the Board that it was now mandatory that this data was collected and presented to Boards.

He highlighted that a large proportion of staff at the Trust did not declare a disability and work was ongoing to encourage staff to declare. Mr Nearney advised that a Network Group had been established for staff in this category. Mr Moran suggested that each network group could have a Board champion. Prof Veysey added that the GMC had issued new guidance around medical students with disabilities and training programmes were being adapted to ensure students were not hindered which was increasing awareness. **SN**

Resolved:
The Board received and approved the report. An update to be received at the March 2020 Board meeting.

25 Staff Survey Results 2019/20 – Q1

Mr Nearney presented the report and highlighted that 1500 staff had completed the staff survey which meant a score of 7.12 out of 10 putting the Trust above the national average. The aim was to be in the top 20%. Mr Nearney stated that the overall scores were improving but there was still a lot of work to do.

Mr Nearney spoke of the Leadership Programme which was a success and the MRI department that had improved it's scores dramatically.

Mr Moran reflected that it was great to see the overall trend but was disappointed that some of the same areas were still in the red zone of low engagement... Mr Nearney assured the Board the HR Teams were working with the Health Groups were the scores were low.

Resolved:
The Board received and accepted the report.

26 Audit Minutes

The minutes were received by the Board.

27 Review of Board Effectiveness

Mrs Thompson presented the report which highlighted the process that had been followed to get the results and a summary of the feedback. The clear messages emerging were around strengthening partnership working and having a robust education and training programme of items.

There was a discussion around the amount of items on the agenda and how the items were dealt with on the agenda. There was a suggestion of having items for information only or items for approval or by exception. It was agreed that Mr Moran, Mr Long, Ms Ramsay and Mrs Thompson meet to discuss the Board agendas and how these could be more efficient. **RT**

Resolved:
The Board accepted and received the report.

27.1 Board Observations

Ms Burns introduced her item and advised that she was a Consultant Clinical Scientist trainee from Manchester who was completing a 5 year training programme which included a post graduate leadership and healthcare management review.

Ms Burns and colleagues had attended 37 different trust board meetings to observe and write up their findings. She reported that HUTH had scored in the top 5 of how Boards function particularly in the conscience and sensor category. Ms Burns stated that she would share the final report with the Board once it had been completed.

There was a discussion around the amount of Board papers and how the agendas could be streamlined to ensure the meetings were run more efficiently. Mr Moran suggested that he and Mr Long discussed this further with Ms Ramsay. Mr Long added that the Tier 1 Committees might be able to do more to receive reports before they were presented to the Board.

Ms Rudston stated that she was pleased to be invited to the Board to present her paper and felt that engaging with the Board was a positive experience. Mrs Johnson agreed and thanked the Board for the interest shown and engagement to the Infection Control report.

Resolved:
The Board received and accepted the update and thanked Ms Burns for attending the meeting.

28 EU Exit Operational Readiness

Ms Myers presented the report which highlighted the arrangements the Trust was putting into place due to the possibility of the UK leaving the EU without a deal on 31 October 2019.

She advised that increasingly large amounts of information were being received and preparations were ongoing should it occur. She added that the Health Groups were carrying out detailed risk assessments.

Resolved:
The Board received and accepted the report.

29 IM&T Review Report

It was agreed to defer this item given MR Curry was not available.

30 Any Other Business

There was no other business discussed.

31 Any questions from members of the public

There were no questions asked.

Date and time of the next meeting:

Tuesday 12 November 2019, 9am – 1pm, The Boardroom, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (November 2019)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2019						
July 2019	BAF Risk 4	Stakeholder support deep dive session to be arranged	CR/TM	September 2019		
COMPLETED						
July 2019	Board Development Framework	Stakeholder engagement to be added to the NED agenda	CR	September 2019		
	Performance Report	SHMI spikes to be clarified	MP	September 2019		

Actions referred to other Committees

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

Trust Board Annual Cycle of Business 2018 - 2019 - 2020			2018							2019								2020	
Focus	**Item**	**Frequency**	**Jan**	**Mar**	**Apr**	**May**	**May Ext.**	**July**	**Sept**	**Nov**	**Jan**	**Feb**	**Mar**	**May**	**May Ext.**	**July**	**Sept**	**Nov**	**Jan**	**Mar**
Strategy and Planning	Operating Framework	annual									x								x	
	Operating plan	bi annual			x						x		x						x	
	5 Year Plan	new item															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		
	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	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	
	Statement of elimination of mixed sex accommodation	annual				x								x						
	Audit letter	annual					x								x					
	Learning from Deaths Guidance	quarterly	x			x				x			x			x		x		x
	Workforce Race Equality Standards	annual							x				x				x			
	Workforce Disability Equality Standards	annual															x			
	Modern Slavery	annual				x								x						
	Emergency Preparedness Statement of Assurance	annual							x							x				
	Annual CNST 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 1 and BAF 3: CQC and journey to outstanding	Area 2 and BAF 4: Same Day Emergency Care standards		Area 3 and BAF 5: Partnership working/ICS development and stock-take		Area 1 and BAF 7.2 - Long-term plan development

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

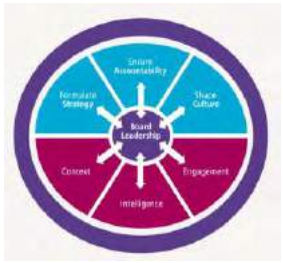
Other topics to consider:
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

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

	Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first	Failure to put in place 2-3 credible year plan to address the underlying deficit position BAF 7.3 Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality

Principles for the Board Development Framework 2017 onwards

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



Overarching aim:

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

Area 1 – High Performing Board

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

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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

12 November 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:	Pathology modernisation, outpatients transformation, Patients Know Best launch, Health Expo	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 12 November 2019

1. Key messages from September and October 2019

Pathology Modernisation Update

Members of the Board will be aware that we have been working in Partnership with York FT for the past 12-15 months to develop a long term proposition for the delivery of Pathology services across the Northern part of the STP.

Discussions to date have been supported by work done with McKinsey and also with advice from NHSI. We are now almost at a point where a draft business case is available for consideration.

There are a number of significant issues which remain outstanding, such as the proposed legal form of the new service model. However, it is hoped that these can be resolved by the end of the calendar year such that a final case can be presented to both Trust Boards in early 2020.

Hospital Outpatients Service To Undergo Major Transformation

Outpatient services at Hull Royal Infirmary and Castle Hill Hospital are to be transformed as part of a major plan to save patients time, money and stress.

Hospital consultants and GPs will work more closely after our trust, Hull Clinical Commissioning Group and East Riding of Yorkshire Clinical Commissioning Group were selected to take part in the transformation programme.

The Elective Care Transformation Programme, part of the NHS Long Term Plan to improve the efficiency of the health service, aims to save patients the time, stress and hassle of travelling to hospital appointments lasting just a few minutes when they could be seen closer to home.

Around one million outpatient appointments are handled by the hospital each year and many of those could be treated sooner if they were seen closer to home or through another format rather than attending for face-to-face hospital consultations.

The trust and the CCGs submitted a joint bid to NHS Improvement to join the programme, which was launched in March 2017, and the area was chosen as one of eight to take part.

GPs and consultants attended an event this month to discuss how they could work together better to benefit patient care, reduce the time patients are waiting for follow-up appointments and alternative ways of treating patients without the need for face-to-face appointments.

'Patients Know Best' System Introduced To Help Patients Keep Track Of Appointments

More than one quarter of a million patients in Hull and the East Riding will be invited to sign up for a new digital online system to allow them to keep track of hospital visits and play an active role in their own health care.

Our trust is introducing the Patients Know Best online system initially for outpatient appointments so patients can receive electronic notification of their appointments as soon as they are booked using a computer, tablet device or smartphone.

Around 271,000 people who have been referred to the trust for treatment or investigations by their GPs and patients who are already undergoing treatment will be invited to join, with more patients set to benefit in the coming months.

People who wish to join the scheme but do not have digital access will be able to give permission for their relatives or carers to sign up for the online system on their behalf to help them manage and keep track of their hospital appointments.

Patients can decide who has access to their records, such as family members, carers or health professionals involved in their care, and what information they can see. They will have the option of restricting access to information, such as certain health matters.

In the future, the PKB system will enable people with long-term conditions to play an active role in their own healthcare, such as sending their own glucose, weight or heart readings to their health teams, preventing unnecessary visits to hospital. It may also see patients being given access to their test results and inpatient attendance records.

Castle Hill Team Becomes First In Country To Achieve Service Quality Standard

A team of healthcare science professionals in Cottingham have become the first in the country to achieve a new standard which assures cancer patients of quality care.

Safety, treatment planning and equipment maintenance were among the areas reviewed as the Radiotherapy Physics Team at Castle Hill Hospital took part in the independent two-year pilot Medical Physics and Clinical Engineering (MPACE) accreditation scheme. MPACE independently reviews all aspects of healthcare science which underpin the radiotherapy treatment provided to patients.

Now the 36-strong team are the first radiotherapy physics team in the country to achieve service standard BS 70000:2017, assuring patients around the quality and safety of the service they're receiving and the competence of staff delivering treatment.

Around 170 patients receive radiotherapy treatment for cancer every day at the Queen's Centre at Castle Hill Hospital, with some patients receiving daily radiotherapy sessions for up to a month at a time.

Hull's First Chief Registrar Takes Up His Post

Hull's first Chief Registrar has been appointed to empower the city's junior doctors to improve patient safety at Hull Royal Infirmary and Castle Hill Hospital.

Our trust has created the role of Chief Registrar to provide a link between its senior leadership team, managers and its doctors in training.

Dr Alexander McNeil, is a paediatrician entering his eighth year of training as a junior doctor. He studied medicine at Hull York Medical School and has worked at the trust since 2012, is one of 71 registrars working for 43 NHS organisations in the country.

He will spend two days a week in the role supported by Chief Medical Officer Dr Makani Purva. The rest of his working week will be devoted to clinical duties at Hull Women and Children's Hospital and in the children's ward and High Dependency Unit on the 13th floor of Hull Royal Infirmary.

Multi-Million Pound Equipment Used In Fight Against Cancer Unveiled At Castle Hill

A new piece of equipment which is set to be instrumental in the fight against cancer was unveiled at Castle Hill Hospital in October.

Members of Hull University Teaching Hospitals NHS Trust's Radiotherapy Team launched their Varian Halcyon linear accelerator on Friday 11 October.

The Trust was the first in the north and only the second department in the country to begin using the machine, paid for through the national Radiotherapy Modernisation Fund, when it was initially installed in June.

Now the Halcyon, which is both faster and quieter than its counterparts, is providing a better all-round experience for both patients and staff.

The trust's Radiotherapy Team collectively delivers treatment for approximately 170 patients every week from across East Yorkshire and Northern Lincolnshire.

A team of radiotherapy physicists and equipment technicians have worked hard to get the Halcyon equipment set up, and over the summer months, the machine has been used to deliver treatment to some 120 patients.

As relative pioneers of the Varian Halcyon, members of the trust's Radiotherapy Team are now set to host a national education day for professionals in November to share their learning, and they will also be taking part in customer satisfaction testing for the manufacturer, Varian.

Health Expo Attracts over 1500 Visitors

Local NHS organisations came together once again to showcase some of the innovations and amazing healthcare teams there are across the region, as the Hull and East Riding Health Expo returned to the DoubleTree by Hilton, Hull on Thursday 10 October.

Now in its fourth year, the Hull and East Riding Health Expo is an annual exhibition and celebration organised by our trust, East Riding of Yorkshire Clinical Commissioning Group (CCG), Hull CCG, City Health Care Partnership CIC and Humber Teaching NHS Foundation Trust.

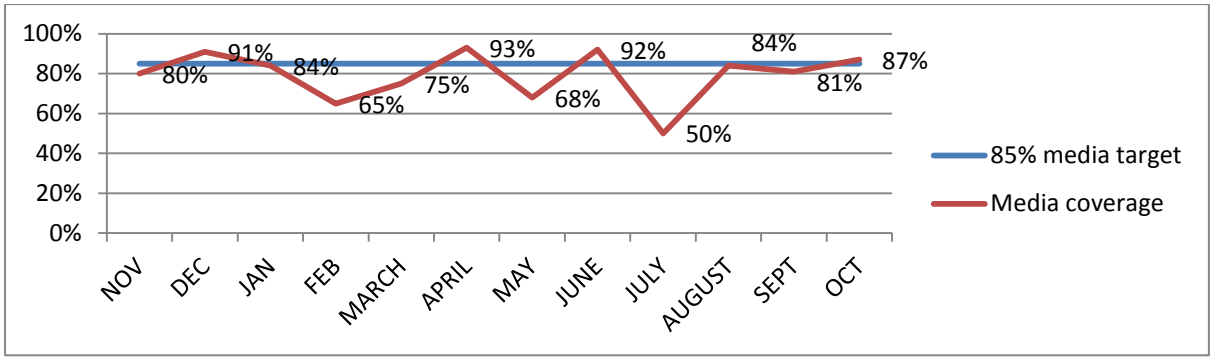
Coinciding with World Mental Health Day the Health Expo was themed around mental health. Advice, information and practical help with all manner of mental health issues was available to attendees.

One of the most popular sections of the Health Expo in previous years has been the careers fair, and this year was no different with over 650 local students from ten different schools and colleges in attendance. . Organised in partnership with the University of Hull and Hull York Medical School, those who are looking to embark on a career in the NHS, find out about the diverse range of careers available in the NHS or who wanted information on returning to work after a career break were well catered for.

2. Media Coverage

The Communications team issued 17 news releases in September and October 2019.

In September 81% of our media coverage was positive and in October 87% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been met or exceeded in nine months out of the last 12.



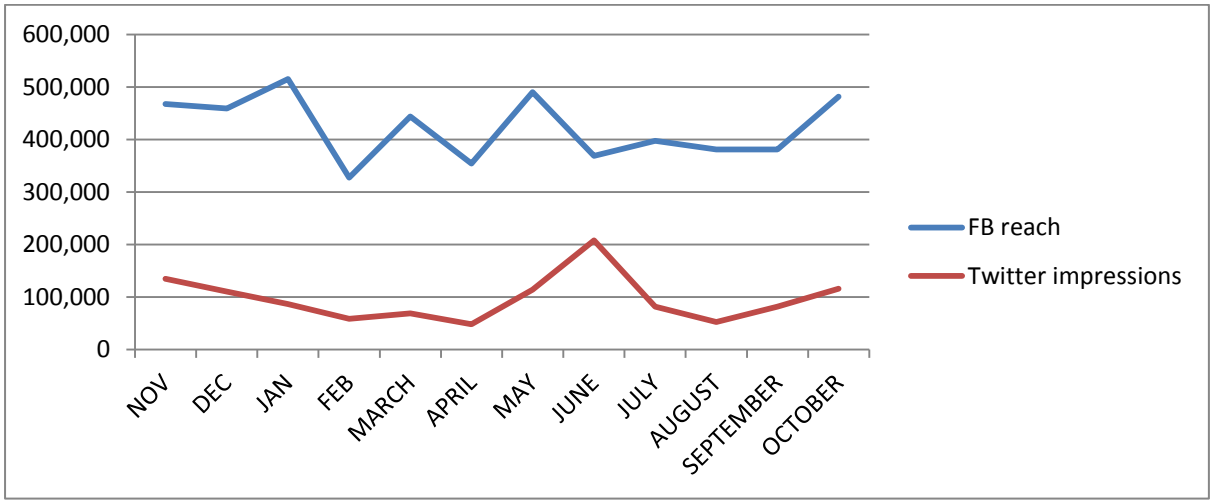
Facebook reach is the number of people that have seen content within a certain period, it can also be called unique impressions.

- In September total "reach" for all posts on trust Facebook pages was 380,685
- In October total "reach" for all posts on trust Facebook pages was 481,491

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

- @HEYNHS Twitter account impressions 81,100 (September)
- @HEYNHS Twitter account impressions 115,300 (October)

Social media reach and impressions November 2018 - October 2019



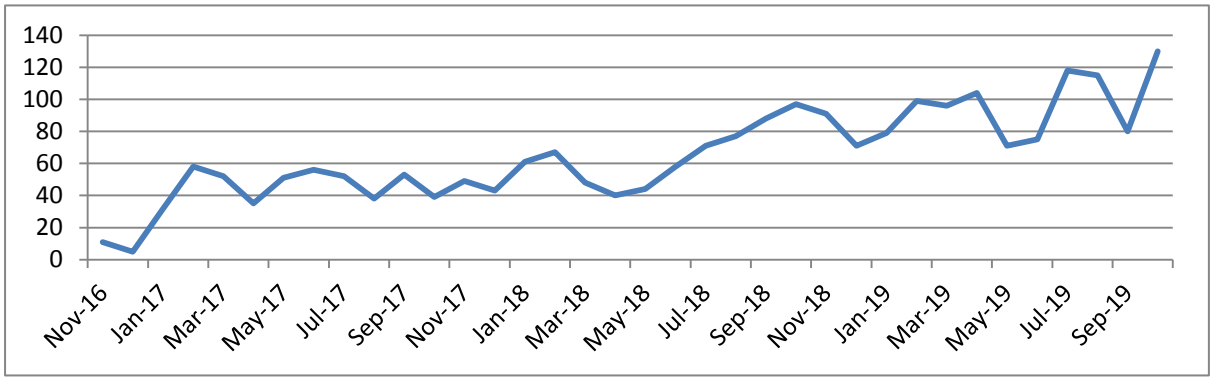
3. Moments of Magic

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

In September and October 2019 we received 80 and 130 Moments of Magic nominations, respectively.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2016-2019



NHS
Hull University Teaching Hospitals
NHS Trust

LONG TERM GOALS - September 2019 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance September	Trend v Previous Month
G	Never Events	0	0	↓
R	Complaints (QIP - closed within 40 working days)	90%	70.73%	↓
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	80	18	-
R	Safety Thermometer - Harm Free Care	95%	93.79%	↓
R	Venous Thromboembolism (VTE) Risk Assessment (Q1 1920)	95%	92.68%	↓
R	Mortality - HSMR (July 2019)	<100	84.9	↓
G	Friends & Family Test - Inpatients (August 19 - Trust v National %)	95.68%	98.62%	↑
R	Friends & Family Test - Emergency Department (August 19 - Trust v National %)	86.18%	81.09%	↓

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

Workforce

RAG	Indicator	Target	Performance September	Trend v Previous Month
G	Staff Retention/Turnover	<9.3%	8.90%	↑
G	Staff Sickness	<3.9%	3.60%	↑
R	Staff Vacancies	<5.0%	5.93%	↓
R	Staff WTE in post (<0.5% from Plan)	7535	7559	↑
R	Staff Appraisals - AFC Staff	85%	81.00%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	94.80%	↑
G	Statutory/Mandatory Training	85%	91.20%	↑
G	Temporary Staff/Bank/Overtime costs (Medical YTD)	£7.428m	£7.129m	-
G	Staff: Friends & Family Test - Place of Work (Q1 1920 v National)	66%	69%	↓
G	Staff: Friends & Family Test - Place of Care (Q1 1920 v National)	81%	82%	↓

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance September	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	80.95%	72.13%	↓
G	52 Week Referral To Treatment Breaches	0	0	0	→
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	10.05%	↓
R	Emergency Department: 4 Hour Wait Standard	95%	90.0%	73.86%	↓
R	Cancer: ADJUSTED 62 Days Referral To Treatment (August Data)	85%	75.70%	65.90%	↓
G	Length of Stay (August Data)	<5.2	-	5	↑
R	Clearance Times	12 weeks	-	16.6	↓
R	Waiting List Size	52,800	52,900	53,792	↑
G	Available Clinic Slot Utilisation	80%	-	93.60%	↓
R	Theatre Utilisation	90%	-	86.25%	↑
R	Appointment Slot Issues	35% (TBC)	-	53.50%	↑

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	2
Corporate Non-Clinical Risks	1

Finance

RAG	Indicator	Target	Performance September	Trend v Previous Month
G	Capital Expenditure	6.4m	4.8m	↑
G	Statement of Comprehensive Income Plan - Year to Date	-4.676m	-4.674m	-
G	CRES Achievement Against Plan	£5.052m	£5.89m	-
R	Invoices paid within target - Non NHS	95%	91.8%	↑
R	Invoices paid within target - NHS	95%	81.9%	↑
A	Risk Rating	1	3	→

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 12 November 2019

Title:	Board Assurance Framework
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs Rebecca Thompson - Corporate Affairs Manager

Purpose:	The purpose of this report is to present the 2019-20 Board Assurance Framework, for the Trust Board with recommended Quarter 2 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. 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. Q1 ratings were recommended to remain the same as year-start ratings; following detailed review by Board Committees, the Q2 ratings are recommended to stay the same, as there is no significant and growing gap in assurance in any particular BAF area. A useful challenge was put in by the Performance and Finance Committee to review the mitigating actions included against each BAF risk to sense check that these are adequate and complete and, if implemented as planned, would start to reduce the risk rating of the BAF risks in Q3 and Q4.	

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 Q2 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, for the committee to review the key BAF risk areas relating to the work of this Committee for this financial year. It is also an opportunity to highlight any positive assurance or areas requiring further assurance linked to the Committee's agenda that might be available at this time and to contribute to the Trust Board Q2 ratings.

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

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 and was outlined in a report received by the Trust Board at its meeting in July 2019, appended to this paper.

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

3.1 Board review

Per the appended programme of updates and Board discussions, the Board to date has received a detailed briefing and specifically discussed:

BAF 1: There is a risk that staff engagement does not continue to improve (CEO)
Discussed at 30 July 2019 Board Development
Outcome: opportunity to reflect on staff feedback from Great Leaders programme and to take key messages into Trust Board team/cultural development

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)
Discussed at August 2019 Board Development
Outcome: understanding of direction of travel and key positives and challenges for the Trust – captured in BAF (positive assurance)

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)
Discussed at 30 July 2019 – public Trust Board (deep dive report)
Outcome: shared understanding of current position, contributing factors and forward-view for the year – captured in BAF (positive assurance and gaps in assurance)

BAF 5: That the Humber, Coast and Vale Health and Care Partnership (HCAV HCP) does not develop and deliver credible and effective plans to improve the health and care for its population and meet the expectations of the NHS Long Term Plan. In particular the expectations in relation to integration and transformation of care for our patients rely on effective partnership working
Discussed at 10 September 2019 public Trust Board to detail progress and current system working
Discussed at 24 September 2019 Trust Board development as part of five-year planning process
Outcome: updated wording to BAF risk, as well as shared understanding of current position and implications of five-year plan requirements, assumptions and partnership working – captured in BAF (positive assurance and gaps in assurance)

BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20
Reported at public Trust Board at each meeting, monitoring monthly at Performance and Finance Committee and reported up to the Trust Board
Outcome: routinely captured in BAF (positive assurance and gaps in assurance)

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
Discussed at 24 September 2019 Trust Board development, including productivity and efficiency opportunity
Outcome: discussion on current opportunities and the CRES programme this financial year and opportunities/assumptions for future years - captured in BAF (positive assurance and gaps in assurance)

BAF 7.3: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability
Discussed at 30 July 2019 public Trust Board as part of capital planning update
Outcome: intricacies of national funding position, current financial year and future years' requirements detailed against the current trust infrastructure status - captured in BAF (positive assurance and gaps in assurance)

3.2 Update on Committee Input

3.2.1 Performance and Finance Committee
There are 4 BAF risk areas that fall directly under the Terms of Reference of this 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)

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

The positive assurance and gaps in assurance fed back to date by the Performance and Finance Committee have been captured in the attached version of the BAF.

In respect of BAF 7.1, the Committee has noted throughout this financial year that that the Trust's financial plan includes a CRES programme that is planned to deliver greater savings in the second half of the year. The ability of Health Groups to identity savings for next financial year was also raised.
In respect of a Q2 rating, Committee members are asked to consider the Month 6 financial position as well as the request by the regulator to contribute to a system financial recovery plan by 7 October 2019

to determine, from a Q2 perspective, whether this risk rating should remain the same or whether the controls in place within the Trust mean that the risk level is being mitigated to keep the Trust on plan as far as possible.

In respect of BAF 4, the Trust continues to be challenged on RTT and cancer waiting times, with a downturn in cancer performance last month. To review these elements in more detail, an extra Performance and Finance Committee has been scheduled for November 2019, through which it would be prudent to capture the positive assurance and the gaps in assurance, to form a view on Q3 risk ratings as well as any escalation and recommendations to the Quality Committee and/or Trust Board.

3.2.2 Quality Committee
There are 2 BAF risk areas that fall directly under the Terms of Reference of this 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 this 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

The positive assurance and gaps in assurance fed back to date by the Committee have been captured in the attached version of the BAF.

The Committee has noted throughout the year that the trends on key quality/performance metrics have remained largely positive: there have been no breaches in mixed-sex accommodation requirements, no 12-hour trolley breaches, an improving position on fundamental standards, maintaining low harm rates on the safety thermometer. In addition, the Committee has challenged on organisational learning and how this feeds in to the Patient Safety campaign underway.

3.3 Corporate Risk Register
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 18 risks on the corporate risk register. Of these 18 risks, 17 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 = 6 corporate risks (pension risk shared with BAF 7.1)
BAF 5 clinical services = 0 corporate risks (with some ties to staffing risks at BAF 3)
BAF 6 research and innovation = 0 corporate risks
BAF 7.1 financial plan = 2 corporate risks (pension risk shared with BAF 4)
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 2 corporate risks

There is a corporate risk being put back on to the corporate risk register 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 and a Trust working group is managing risk assessment and contingency planning for Brexit at present.

Included in the above tally are two new corporate risks, which have been added in the last month: one on the risk of the upgrade to Windows 10 across the Trust, and the second on the impact of changes to public service pensions and taxation limits. These map to BAF 7.1 and BAF 7.1 and BAF 4 respectively.

The number of corporate risks had decreased by 5 in the last 6 months due to successes in mitigating these risks back down to operational risks but 3 new risks have been added more recently, as detailed above, have been added, reflecting the change in risk landscape affecting the organisation. 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).

Most recently, this is reflected in the number of concerns being raised regarding the national pensions issue the impact on services being able to run additional sessions to meet waiting time pressures. This has been captured in the new corporate risk on the impact on the Trust (particularly financial) from the changes in pension allowance rules is being written up, discussed last week at the Executive Management Committee. The largest financial 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, or the risk of non-delivery of the Trust's activity plan. 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. This links with BAF 7.1 with some elements in BAF 4.

3.4 Forward view

A useful challenge was put in by the Performance and Finance Committee in October 2019 to review the mitigating actions included against each BAF risk to sense check that these are adequate and complete and, if implemented as planned, would start to reduce the risk rating of the BAF risks in Q3 and Q4. The Director of Corporate Affairs is meeting with each Executive lead in November 2019 to review and update these, to feed in to the Board Committee meetings in November and December 2019, and to the Trust Board in January 2020, as well as BAF board development discussions during this period. This will pick up on the emerging risk issues raised under the corporate risk register, above, as well as long-standing corporate risks, specifically around staffing.

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 Q2 ratings for each BAF area

Carla Ramsay
Director of Corporate Affairs

November 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 OCTOBER 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 Risk that some	None	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy focusses on staff culture and engagement – wide consultation on the refresh Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff – 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 staffing numbers	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**	**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

		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			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 environment and	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**	**15**			5 x 2 = 10	**<u>Positive assurance</u>** 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 **<u>Further assurance required</u>** Understanding of local impact through pension taxation changes as well as national action to mitigate risk

					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 and stakeholder engagement,	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**	**12**			4 x 2 = 8	**Positive assurance** Maintained core quality standards throughout the year (no EMSA breaches, no 12-hour trolley breaches, improved position on fundamental standards, maintained low harm rates on safety thermometer) **Further assurance required** 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

		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 Extra PAF Nov 19 to review RTT, cancer and CRES	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**	**16**			4 x 2 = 8	**<u>Positive assurance</u>** Detailed understanding of ED performance and contributing factors, as well as current position with regulator – shared understanding 52 week wait zero return performance holding at the end of September 2019 **<u>Further assurance required</u>** Management of follow-up backlogs – capacity vs demand as well as affordability Improvement in ED performance relating to detailed understanding of Trust Board on this issue; 90% target for end Sept 19 risks non-achievement Downturn in cancer performance in Q2 as well as increases in demand – to review in more detail in Nov 19 extra PAF meeting Understanding of pensions issue on ability to meet activity plan Coding challenge with Specialist Commissioners requires further feedback

		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 Health and Care Partnership (HCAV HCP) does not develop and deliver credible and effective plans to improve the health and care for its population and meet the expectations of the NHS Long Term Plan. In particular the expectations in relation to integration and transformation of care for our patients rely on effective partnership working 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). Trust Execs lead two of the four Cancer Alliance Programmes.New Humber Cancer Delivery Board formed, starting Oct 19, chaired by HUTH CEO. 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 established a Provider Collaborative, to make progress between provider organisations around the integration agenda. The HCP has been accepted into the ICS Accelerator Programme, which is a 15 week programme starting Sept 19, to address the	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**	**12**			4 x 1 = 4	**<u>Positive assurance</u>** Detailed review of risk at Trust Board September 2019 – agreed to maintain the risk rating based on the assurance of the Trust's participation and role within key work streams and the governance structure, as well as the STP's acceptance in to the national accelerator programme. To be reviewed again in March 2020. **<u>Further assurance required</u>** Outputs of the Humber Acute Services Review Agreement and delivery of new care models has been limited and progress remains slow – however, this situation is not unique to the HCAV HCP;

					requirements of the system maturity matrix, with a view to achieving ICS status in March 2020 Formal CEO Board for the Primary Care Networks formed and a quarterly clinical meeting with a work programme to improve services for frail, older people, the provision of community paediatrics and diversionary pathways away from ED Further work planned on key areas of focus: • A Stakeholder Survey will be commissioned, with a view to acquiring actionable intelligence on how the Trust is perceived by partners • HUTH will develop working relationships with the Primary Care Networks, assigning a lead senior relationship manager to each and co-ordinating Trust offers of support. HUTH will provide training to our senior clinical and operational managers on our goals as partners, expectations and permissions, building on the results of the planned survey						

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**	**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 Specific risk assessment of additional costs from pensions can be mapped during the year Risk management in place on resource and costs relating to Windows 10 and ATP upgrades	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**	**20**			5 x 3 = 15	**<u>Positive assurance</u>** Financial plan delivered to M3 Financial Plan delivered to M6 **<u>Further assurance required</u>** New corporate risks drafted on impact of pensions and impact of Windows 10 and ATP (cyber security) – these articulate what might be added in financial risk terms to the 2019-20 financial plan delivery Health Group forecasts currently require £5.3m of actions to achieve plan and within this there are assumptions that have risk of around £2m, making the total risk £7.3m. The Trust also has additional pressures regarding key targets that may require further investment in the next few months (52 weeks, Lung Health Check, cancer, ED) which could cost £2m. Thus the total risk is £9.3m. The Trust will have a choice to make on these investments and agree what can be avoided. Discussions have commenced with Commissioners to determine what level of funding may be available but it will not be £9.3m. NHSI have written to the Hull and East Riding system to state that due to the level of financial risk reported by the Trust and East Riding CCG - the system has been placed in escalated oversight arrangements and requires a System Recovery Plan for 19/20. Chief Executives and Chief Finance Officers of all three organisations in the System will meet with NHSI on 7th October to discuss the recovery plan.

					Extra PAF Nov 19 to review RTT, cancer and CRES Five-year STP plan required for Nov 19						

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 Five-year STP plan required for Nov 19	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**	**20**			5 x 1 = 5	**Positive assurance** Board development session August 2019 to outline principles of five-year financial plan and ability of Trust to put in place credible long-term financial recovery plan **Further assurance required** Control totals for future years and assessment of achievability/requirements to achieve

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**	**20**			5 x 1 = 10	**Positive assurance** Some capital funding brought forward from £19.3m STP capital funding in to 2019-20; will not resolve full range of issues but is welcome additional capacity and facilities Extra capital funding received from NHS E/I - additional capital to support increased capacity and emergency care performance this winter **Further assurance required** Ability to source capital to address core infrastructure risks that are not covered by capital currently or likely available this financial year

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:
28 January 2020 – public Trust Board

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 (five year planning)

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:
24 September 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

Trust Board
12 November 2019

Title:	Research and Innovation Strategy Update
Responsible Director:	Dr Makani Purva, Chief Medical Officer
Author:	James Illingworth, R&D Manager

Purpose:	To provide the Trust Board with an update on progress against the Research and Innovation Strategy 2018-2023 and to highlight any perceived or actual risks to the delivery of this strategy.	
BAF Risk:	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.	
	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great clinical services	X
	Partnership and integrated services	X
	Research and Innovation	X
	Financial sustainability	X
Summary of Key Issues:	The first year of the R&I Strategy implementation has focussed on: • building a solid platform for increasing research awareness through the development of research performance dashboards • involving patient and the public in research 'co-design' and implementation of engagement initiatives such as the Patient Research Experience Survey • aligning 'research relevant' specialties to reduce silo working and form cluster arrangements for delivery of multi-morbidity research programmes • providing institutional support for the operational and strategic development of the Hull Health Trials Unit • embedding the UoH as our core academic partner through initiatives to enhance capability and capacity such as PhD Scholarships • building on our utilisation of regional and national network memberships to exploit research and innovation opportunities • commencing international research collaborations (India) Risks to highlight for escalation: • Anticipated funding reduction in 2020/21 from Y&H Clinical Research Network • Reduction in overall recruitment activity anticipated for 2019/20 due to focus on complex interventional activity. • Need to identify capacity internally to support research awareness communications initiatives.	

Recommendation:	Trust Board is asked to acknowledge progress made to date.

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Research & Innovation Strategy 2018-2023

Trust Board Progress Update: November 2019

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OUR VISION AND LONG TERM GOALS

GREAT STAFF

- HONEST CARING & ACCOUNTABLE CULTURE
- VALUED SKILLED & SUFFICIENT WORKFORCE

GREAT CARE

- HIGH QUALITY CARE
- GREAT CLINICAL SERVICES
- PARTNERSHIP & INTEGRATED SERVICES

GREAT FUTURE

- RESEARCH & INNOVATION
- FINANCIAL SUSTAINABILITY

OUR MISSION: To lead the provision of outstanding care and contribute to improved population health, by being a great employer and partner, living our values and spending money wisely

Research & Innovation Strategy

Overview

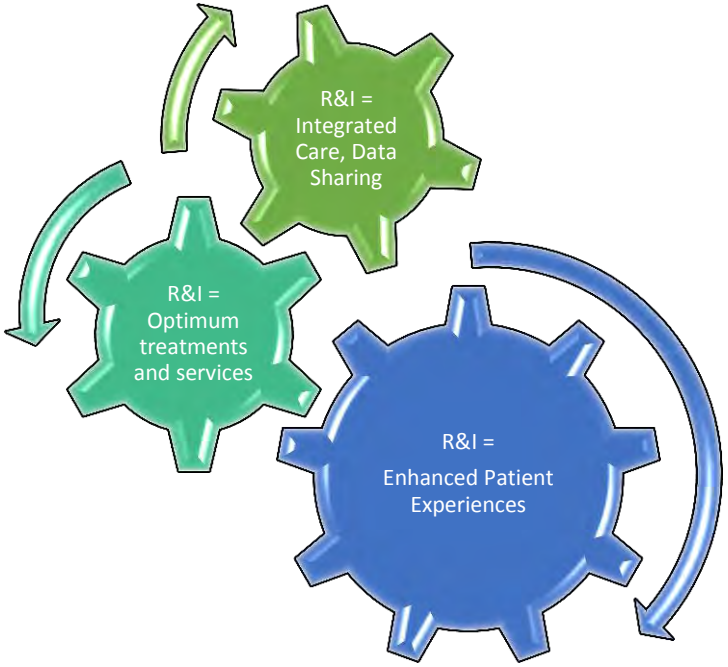
The Research and Innovation Strategy 2018-23 was approved by the Trust Board in July 2018. The Trust Research and Innovation Strategy will be delivered through three key priority themes:

1. *A Research Aware Organisation*
2. *Positive, Proactive Partnerships*
3. *Reputation through Research*

Research & Innovation Strategy

Overview

(1) Research Active & Aware Organisation



Research Aware Organisation

Hull University Teaching Hospitals NHS Trust

Achievements:

- Year 1 has focussed on generating institutional research awareness through metrics. The development of performance dashboards available on Pattie provide all staff with access to interactive, visually appealing reports that give real-time data intelligence for planning and forecasting purposes.
- Dashboards have been operational from April 2019 with development work on-going since October 2018. Reports are available on Pattie: http://chhbilive/reports/powerbi/Shared%20Reports/01.%20Dashboards/RD_Research%20Activity%20Report

On-going work:

- Linking to the Trust 'data warehouse' (used to collate and refresh all Trust key performance metrics) R&D should be able to marry overall Trust activity data to support feasibility assessment and live tracking of trial patients through the Trust (admissions and other visits).
- Executive Summary dashboards and performance reports to be provided quarterly for Trust Board and HG triumvirates from Q3*, 2019/20.*

Risks:

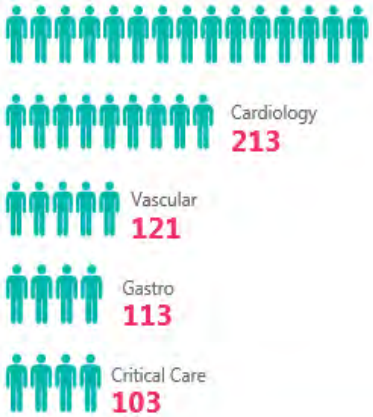
- Failure of teams to ensure timely and accurate data entry.

R&D Performance Dashboards

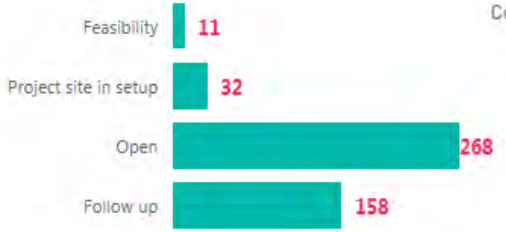
Hull University Teaching Hospitals NHS Trust

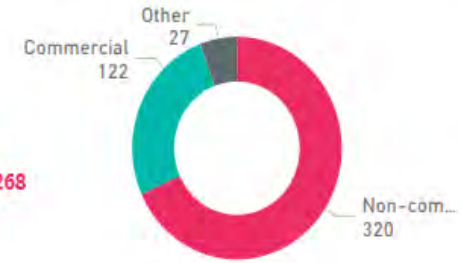
1,815 patients were recruited in **2019/20**

Top 5 Contributors



469 projects are currently being assessed for feasibility, set up, open, or in follow up.

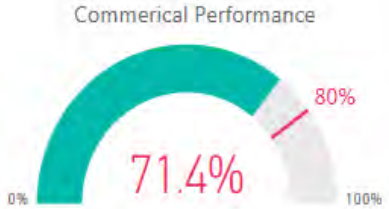


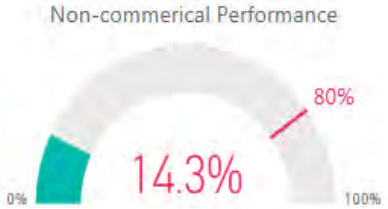


68.5% of projects were open to recruitment within 30 days.

24.4% of projects recruited their first patient within 70 days.

42.9% of projects achieved their recruitment target before the recruitment end date.





R&D Performance Dashboards

NHS
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Research & Development Dashboard | Recruitment Activity

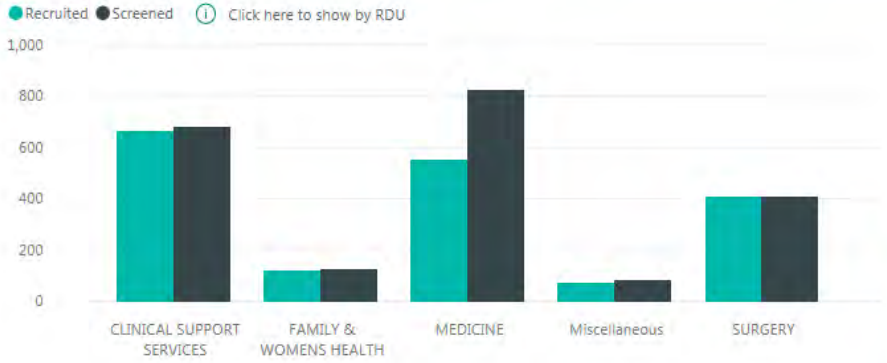
FISCAL YEAR: 2019/20 | HEALTH GROUP: All | SPECIALTY: All | RDU: All | DEPARTMENT: All | PROJECT TYPE: All | INVESTIGATOR: All

1,815
Recruited

2,115
Screened

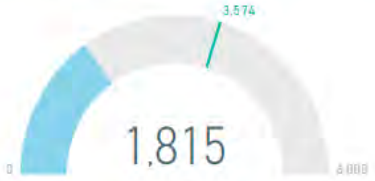
Summary
Recruitment
Project Status
RTT
Minimum Dataset
Data Quality
70 Day Target
Executive Summary

How many patients have we recruited and screened by clinical area?

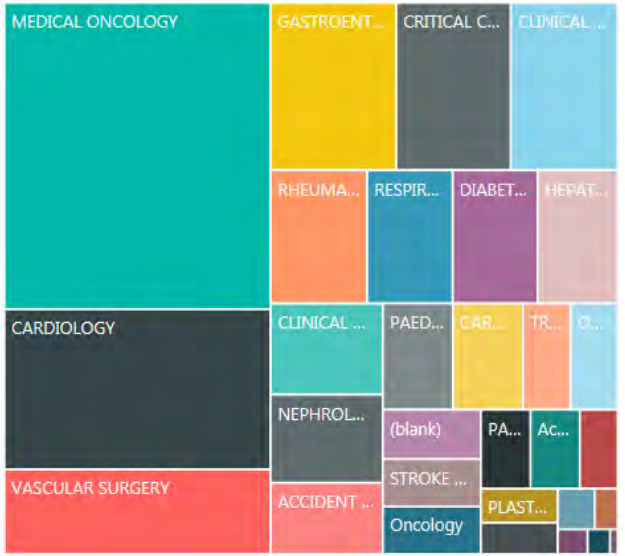


How many patient have we recruited and screened over time?

How are we performing against our recruitment target?



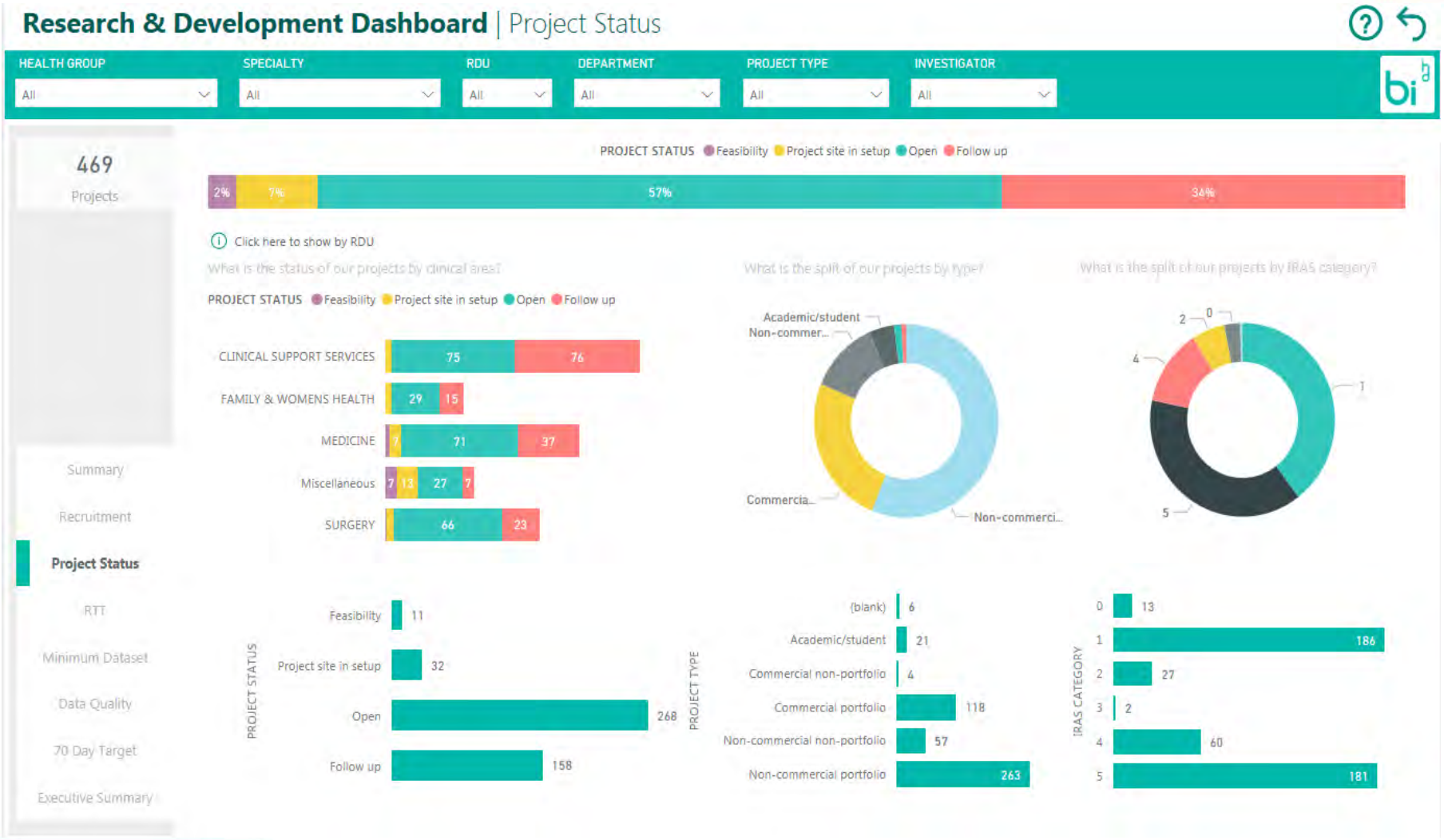
What is the recruitment distribution across departments?



Remarkable people.
Extraordinary place.

R&D Performance Dashboards

Hull University Teaching Hospitals NHS Trust



R&D Performance Dashboards

NHS
Hull University Teaching Hospitals

Research & Development Dashboard | Recruitment to Time & Target

HEALTH GROUP: All | SPECIALTY: All | RDU: All | DEPARTMENT: All | PROJECT TYPE: All | INVESTIGATOR: All

42% On Schedule

PROJECT TITLE: All

169 Projects Included | 99 Projects Excluded

OVER-RECRUITED PROJECTS: Yes, No

RTT STATUS: Red, Amber, Green

View RTT performance in more detail

See a list of excluded projects

Summary | Recruitment | Project Status | RTT | Minimum Dataset | Data Quality | 70 Day Target | Executive Summary

R1696 - FLAIR

Timeline 85.5%

Principal Investigator *Allsup, Dr David*
Recruitment Start Date *18 Dec 2014*
Recruitment End Date *01 Sep 2020*

77.1%

3 patient(s) required to stay on schedule
8.37% behind target

Project Target Participants	35
Current Target	30
Current Recruited	27

R1712 - Does Wnt Signalling Drive the Formation of Myelofibrosis in Human Patients?

Timeline 56.4%

Principal Investigator *Allsup, Dr David*
Recruitment Start Date *22 Oct 2014*
Recruitment End Date *27 Sep 2023*

217.5%

Recruitment on track
161.12% ahead of target

Project Target Participants	40
Current Target	23
Current Recruited	87

R1719 - Adjunctive Steroid Combination in Ocular Trauma (ASCOT) Study

Timeline 92.4%

Principal Investigator *Costen, Mark*
Recruitment Start Date *19 Nov 2014*
Recruitment End Date *31 Mar 2020*

40%

6 patient(s) required to stay on schedule
52.45% behind target

Project Target Participants	10
Current Target	10
Current Recruited	4

R1724 - GAST 3377

Timeline 87%

Principal Investigator *Sebastian, Shaji*
Recruitment Start Date *24 Nov 2014*
Recruitment End Date *01 Aug 2020*

100%

Recruitment on track
13.05% ahead of target

Project Target Participants	5
Current Target	5
Current Recruited	5

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Research Participation Opportunities

How do we give patients and carers the opportunity to participate in or become actively involved in clinical research studies?

Patient & Public Involvement & Engagement

Hull University Teaching Hospitals NHS Trust

Achievements:

- Focus has been on involving Patient Research Ambassadors (PRAs) in co-design and review (via Trans-Humber Consumer Research Panel – hosted by HUTH).
- Excellent feedback in annual external Trust R&D website review (2019).
- Patient Research Experience Survey (PRES) 2019 – Y&H CRN target reached.

On-going work:

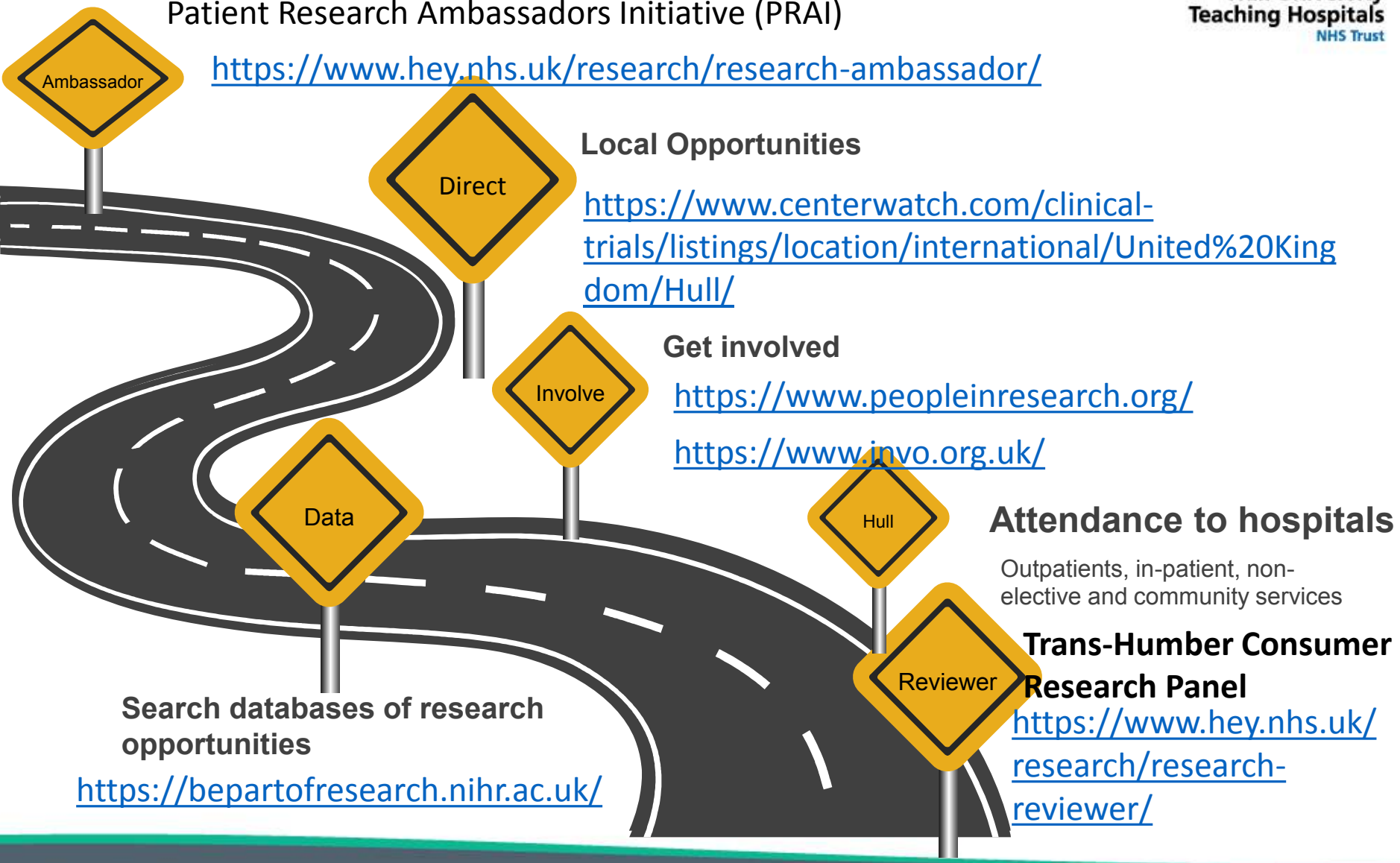
- Lead Research Nurse to look at putting PRAs in clinic settings.
- Lead Research Nurse to develop nursing mentorship programme that will engage nursing staff in research
- Lead Research Nurse to develop forum for support and mentorship of nurses and AHPs to develop their own research programmes
- Communications to be 'stepped up' to support the PRAs when in place (including clear visual presence in the Trust, research prospectus and further website development).

Risks:

- Capacity being made available to implement communications initiatives.

Research Participation: Road Map

Hull University Teaching Hospitals NHS Trust



Patient Research Ambassadors Initiative (PRAI)

https://www.hey.nhs.uk/research/research-ambassador/

Local Opportunities

https://www.centerwatch.com/clinical-trials/listings/location/international/United%20Kingdom/Hull/

Get involved

https://www.peopleinresearch.org/

https://www.invo.org.uk/

Attendance to hospitals

Outpatients, in-patient, non-elective and community services

Trans-Humber Consumer Research Panel

https://www.hey.nhs.uk/research/research-reviewer/

Search databases of research opportunities

https://bepartofresearch.nihr.ac.uk/

High Quality Care

Hull University Teaching Hospitals NHS Trust

Achievements:

- 'Cluster Arrangements'(clinical Synergies) for multi-morbidity research: Diabetes + Renal, ICU + Infectious Diseases, Cardiology + Interventional Cardiology + Cardiothoracic Surgery.

Ongoing work:

- Exploring the possibility of adding research participation opportunities into electronic appointment notification systems.
- Support provided for the development of 'Addictions' research (alcohol) with Humber and UoH – impact on ED services and link to Hepatology.
- Continue to implement 'Cluster Arrangements'.

Risks:

- Cluster arrangements limited by anticipated reductions in external Y&H CRN funding in 2020/21.

Hull Health Trials Unit (HHTU)

NHS
Hull University Teaching Hospitals
NHS Trust

Achievements:

- 'Provisional' accreditation status for HHTU confirmed by UKCRC. Full accreditation expected within 3 years.
- R&D Manager part of interview panel for Operations Manager.
- Formal contribution of R&D QA support provided as part of development activities of HHTU including complex drug study setup. MHRA report shared with HHTU.
- Supported the HHTU and UoH ICAHR launch in March 2019: ICAHR
- HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU.

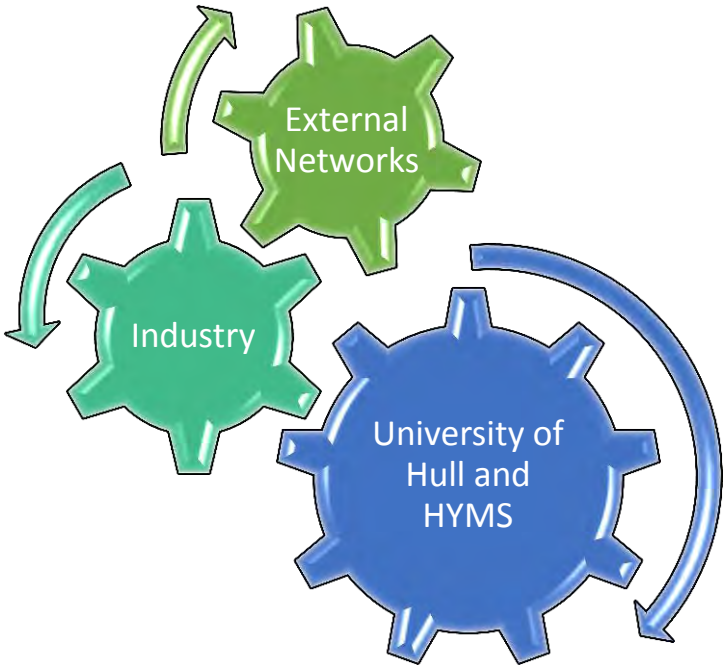
On-going work:

- Continue to be an influential voice in the operational and strategic development of the HHTU.
- Formally re-establish the HHTU Strategic Advisory Board with representation from the Trust to support the oversight of the full accreditation process.

Risks:

- Capacity for delivery of HUTH studies is limited – services need to meet demand from HUTH clinicians and UoH academics.

(2) Positive Proactive Partnerships



Local Collaborations

NHS
Hull University Teaching Hospitals
NHS Trust

Local Collaborative Alliances: UoH

NHS
Hull University Teaching Hospitals
NHS Trust

Achievements:

- UoH acknowledged as core academic partner with Trust name change in March 2019.
- Strategic and operational support for HHTU and ICAHR.
- Aligned research focus (PET-CT, Palliative/Respiratory , Rehabilitation, Gastroenterology, Infectious Diseases supported as part of jointly funded 'Research Support Funding' initiative).
- Addictions Research Collaborative –support for development of alcohol addiction research (first joint study to be undertaken in Q4 2019/20).

Ongoing work:

- Continue to explore programmes of joint working (Virtual Reality, 3D printing, clinical skills and simulation).

Risks:

- Lack of available funding to maintain and grow clinical and non-clinical academics.

Local Collaborative Alliances: Y&H CRN

Hull University Teaching Hospitals NHS Trust

Achievements:

- Proactive Partner Organisation of Y&H CRN – consistently achieving >= 80% of closed studies recruiting to time and target, *ranked 3rd in Y&H for commercial recruitment. Attracting commercial work with new companies (paediatrics) and preferred site status with AbbVie (Oncology) and Novo Nordisk (Diabetes).*
- *Q1 (2019/20) ranked 21st out of 198 providers for the volume of initiated clinical trials (interventional) in a 12 month rolling period (65 trials).*

On-going work:

- In 2018/19 (as at 26/04/19) ranked 37th out of 154 Acute Trusts for the number of open portfolio studies (145). Require around 240 open studies to secure 'top 20 national status'. Currently 203 open portfolio studies.
- Ranked 42nd in 2018/19 out 154 Acute Trusts for the number of participants recruited to studies (4,320). Secured 23rd place nationally in 2017/2018 (6,599). Likely to require circa 7,000 recruits to secure 'top 20 national status'.

Risks:

- Reduction in CRN funding in 2020/21. Lack of capacity in support services (pharmacy, imaging, labs) to allow increased research volume and range.
- 2019/20 overall recruitment forecast to be around 4,000 due to increase of low recruiting but highly complex interventional studies and reduction in large observational cohort studies.

Local Collaborative Alliances: Other

Hull University Teaching Hospitals NHS Trust

Achievements:

- Y&H Academic Health Science Network (AHSN): (*Innovate UK grant with Entia - medtech company (Renal PoC/telehealth/app)*, adoption of Accelerated Access Collaborative products (HeartFlow)).
- Y&H Northern Health Science Alliance (NHSA)
- Y&H Applied Clinical Research Network (ARC)
- Y&N CRN - Strong focus in 'research relevant' specialties (Cardiovascular, Diabetes, Oncology, Respiratory and Renal).

On-going work:

- Continue to explore 'research inclusive' STPs with our CCG partners. Maintain 'research relevant' focus (based on CCG disease prevalence data) and re-align priorities (Dementia, Mental Health, Stroke).

Risks:

- Lack of capacity to focus on delivering on communications initiatives to support network engagement (i.e. Research Facilities Prospectus).
- Lack of a strategic influential voice in the membership of these important networks (if future financial constraints limit membership).

Research Relevance

Total Recruitment by Specialty: Data as at 28/10/19. 'Orange' specialties = Hull and East Riding high disease prevalence.

Hull University Teaching Hospitals NHS Trust

Div	StudyManaging Specialty	BTH	DBTH	LTH	STH	YTH	SCH	Airedale	Barnsley	CHFT	HDFT	HEY	MYH	NLaG	Rotherham	BDCT	Humber	SHSC	SWYPT	LCH	YAS	CCGs	Non-NHS	TOTAL
	Cancer	120	125	4377	383	140	12	46	16	98	54	483	199	79	31					129				6292
1		**120**	**125**	**4377**	**383**	**140**	**12**	**46**	**16**	**98**	**54**	**483**	**199**	**79**	**31**					**129**				**6292**
	Cardiovascular...	130		394	180	63				69	10	237	115	108	7							68		1381
	Diabetes	19	3	412	36	3		4	4	6	4	41	12	6								213		763
	Metabolic and...		1	126	3	2	4		24	1	3	11										12		187
	Renal Disorders	50	4	85	166	80		9		10		56			2							4		466
	Stroke	111	9	73	77	9				86		21	5	2	11									404
2		**310**	**17**	**1090**	**462**	**157**	**4**	**13**	**28**	**172**	**17**	**366**	**132**	**116**	**20**									
	Children	64	12	313	62	2	137	8	2	5	4	39	11	2	1									
	Genetics			303	1		54																	
	Haematology	3	1	25	24	10		2			1			1										
3		**67**	**13**	**641**	**87**	**12**	**191**	**10**	**2**	**5**	**5**	**39**	**11**	**3**	**1**									
	Dementias and...	4		34	217	33	8				10		8			175	654	39	20	15	12	6	11	1269
	Mental Health	64		62	7	1	2						24			183	158	640	201	109	238	61	16	1856
	Neurological D...	5		92	72		2	8		4		14	1	2					7					207
4		**73**		**188**	**296**	**34**	**12**	**8**		**4**	**10**	**14**	**33**	**2**		**358**	**812**	**699**	**318**	**127**	**250**	**67**	**27**	**3332**
	Ageing	78		28	11						25	1	27						3				2	175
	Dermatology	34		63	24	8	1		4	2	44	3	10		10								1	204
	Health Servic...	10		282	9	10	4	15															7	572
	Musculoskele...	137	31	413	64	49	3	31	5		54	8	5	23	15									869
	Oral and Dent...	15		96	547						35					9								1675
	Primary Care	309											8			16	64	5				2187	16	2628
	Public Health	6103	42		27				17				28		12				102	123	18		1294	2	7768
5		**6686**	**73**	**882**	**682**	**67**	**8**	**46**	**26**	**2**	**158**	**12**	**78**	**23**	**37**	**973**	**64**	**42**	**112**	**173**	**52**	**69**	**3598**	**28**	**13891**
	Anaesthesia, ...	12	38	212	16	169	1	42	11	59	6	21	90		1										678
	Critical Care	30		33	4	15			1		2	35	10		3										133
	Gastroenterology	108	28	17	253	939		142	252	32	251	88	182	365	437										3094
	Hepatology	7		18	1	7			2			35		1											71
	Injuries and ...	41	2	134	48		69	23		7	29	57	18							8		37	10		483
	Ophthalmology	16		49	18	138				2	2	8													233
	Respiratory Di...	10		209	96	28				9		28												2	382
	Surgery	16	5	118	63	14		2	4	60		47	7		4										340
6		**240**	**73**	**790**	**499**	**1310**	**70**	**209**	**270**	**169**	**290**	**319**	**307**	**366**	**445**					**8**		**37**	**10**	**2**	**5414**
	Ear, Nose and...	8		3	19																				30
	Infection	95	7	59	88	57				75	8	6	2		21								39	69	526
	Reproductive...	49	1	146	163	24		5		29		6	10											9	442
UNK		**152**	**8**	**208**	**270**	**81**		**5**		**104**	**8**	**12**	**12**		**21**								**39**	**78**	**998**

2nd

2nd

3rd

4th Increased resource in Renal + cluster with Diabetes/Cardiology. Stroke 5th =Potential to increase Stroke

Limited resources and studies – potential for Humber partnership

3rd

International Collaborations

Hull University Teaching Hospitals NHS Trust

International Partnerships - HUTH signed an 'Agreement for Academic Exchange and Co-operation' with Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India in May 2019. This agreement has already yielded the following returns:

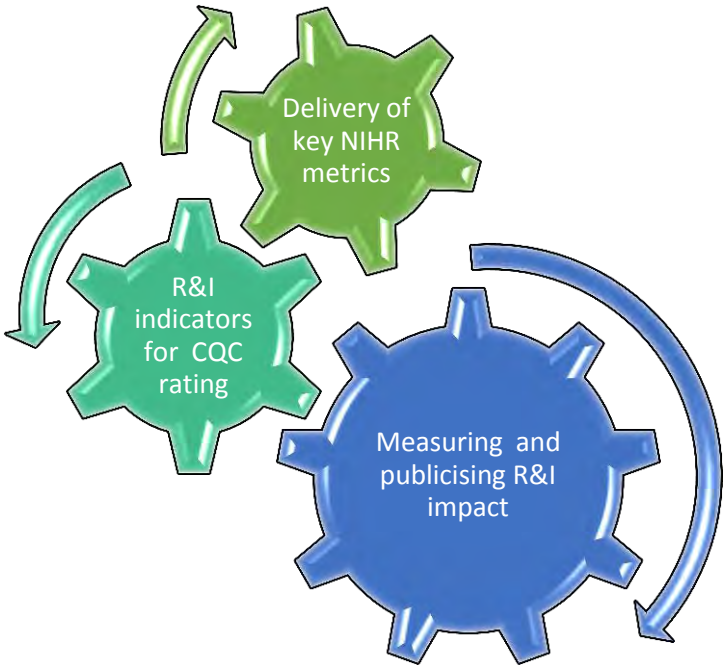
Overseas Simulation Fellow programme commenced in May 2019 with one SRIHER colleague visiting HUTH in May and June 2019.

Visit from Professor Swaminathan to understand and explore our facilities for Oncology rehabilitation including a visit to Sports, Health and Exercise Unit at UoH to explore partnership working for further research in pre-habilitation and rehabilitation more widely.

Identification of 14 potential areas of research collaboration between the Trust and SRIHER (of which Microfluidics, Therapies/Rehabilitation, Infectious Diseases, Diabetes, Renal and clinical skills/simulation have already established strong links).

A commitment to a Joint Research Conference in Chennai in February 2020. A delegation representing HUTH and UoH will attend.

(3) Reputation through Research



Building Capability and Capacity

Hull University Teaching Hospitals NHS Trust

Achievements:

- 4 PhD Scholarships awarded in conjunction with UoH (2 AHPs).
- 6 areas and individuals supported with protected time or methodological support following the award of 'Research Support Funding' from HUTH/UoH and HYMS.
- 2 R&D Funded Clinical Research Fellows appointed (Renal and Cardiothoracic Surgery).
- 4 further Clinical Research Fellows (funded from NIHR RCF or other external sources – 2 in Orthopaedics, I in Gastroenterology (IBD)), 1 in Renal).
- Lead Research Nurse appointed October 2019.
- Vascular AHP leading an NIHR grant.
- Secured 1 NIHR Senior Investigator Award (Prof Chetter, Vascular Surgery)
- Secured multiple Academic Clinical Fellows (ACFs) in key clinical and academic areas for appointment in 2020.

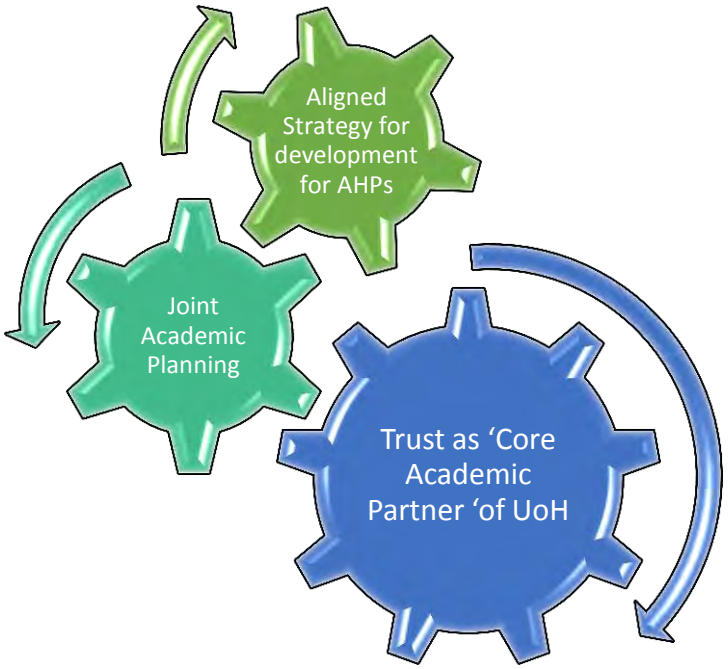
On-going work:

- Continue to explore joint strategy for clinical academic appointments with HYMS and UoH.
- Support further Consultant applications to *Medical Research Council (MRC) Clinical Academic Research Partnerships (CARP) - (allows up to 50% protected research time).*

Risks:

- Lack of available funding to maintain and grow clinical and non-clinical academics.
- Failure to produce tangible measurable outputs from investment.

Supporting Workforce Development



Building Capability and Capacity

Hull University Teaching Hospitals NHS Trust

*Formally adopting **'University Teaching Hospitals'** into our Trust name in March 2019 has been marked with a number of initiatives to support the increase of R&I capability and capacity:*

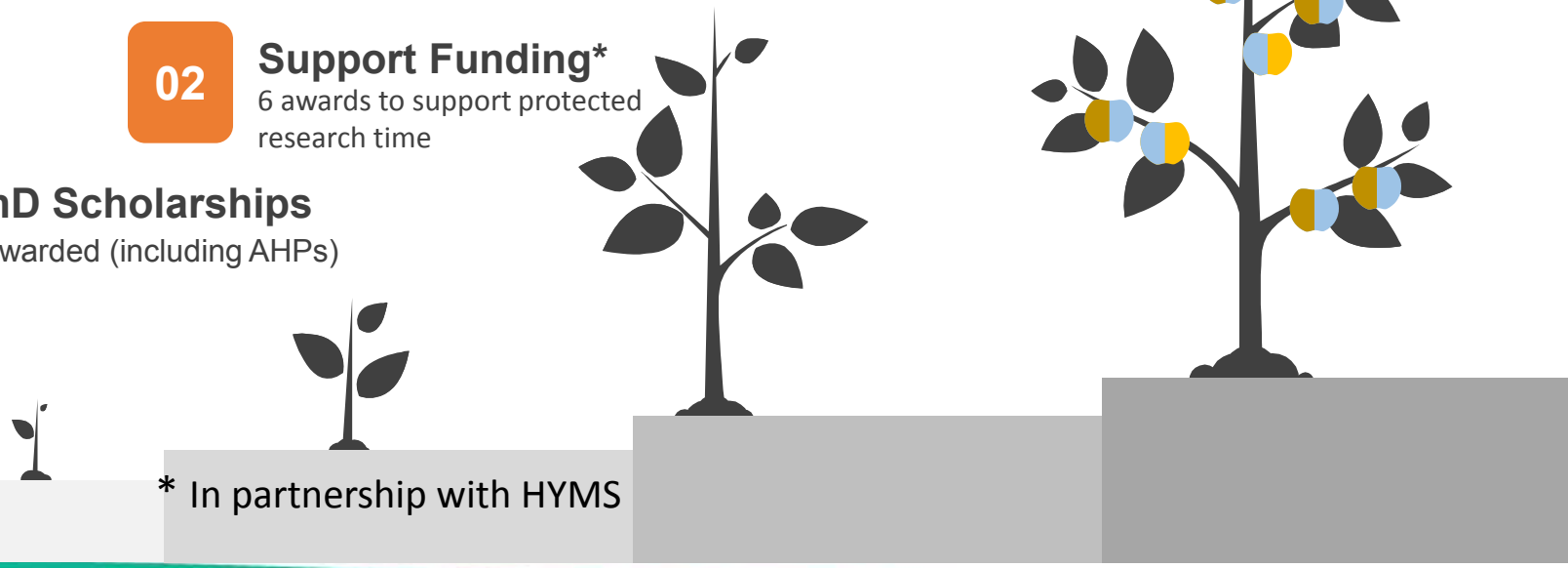
01 **PhD Scholarships**
4 awarded (including AHPs)

02 **Support Funding***
6 awards to support protected research time

03 **Clinical Research Fellows**
2 posts funded centrally in renal and cardiothoracic

04 **Lead Research Nurse**
Appointed 2019

05 **Support Services**
Pharmacy staff investment



* In partnership with HYMS

Early Career Researchers

- Miss Chu Bing (Plastic Surgery) – PhD Scholarship
- Mrs Pam Parkinson (Radiology) – PhD Scholarship
- Mr John Naylor (Physiotherapy) – PhD Scholarship
- Mrs Tania Nurun – (Nursing) Alcohol Addiction- PhD Scholarship
- Dr Boddington and Dr Xen (Renal) – Clinical Research Fellows
- Dr Manu (Cardiothoracic) – Clinical Research Fellow
- 2x Clinical Research Fellows in Orthopaedics (1 part funded by UoY)
- Clinical Research Fellow – Gastroenterology (IBD)

New Principal Investigators

Hull University Teaching Hospitals NHS Trust

- Imaging (Dr Imran Sunerji)
- PET-CT (Dr Najeeb Ahmed) – supported by HUTH RSF
- Surgery - Plastics (Mr Richard Pinder)
- Surgery – Cardiothoracic (Mr Dumbor Ngaage) – NIHR grant, RCF and HUTH RSF
- Surgery – Vascular (Mr Dan Carridice and Mr George Smith) NIHR applications submitted
- Neuro-rehabilitation (Dr Yomi) – supported by HUTH RSF
- Emergency Medicine (Dr Fraser Young)
- Addictions (Prof Tom Phillips) – link with Humber/HUTH/UoH
- Renal (Dr Tom Jorna)
- Infectious Diseases (Dr Patrick Lillie + Dr Easom) RSF

RSF = Research Support Funding (investment from HUTH, HYMS/UoH)

RCF = NIHR Research Capability Funding

Academic Clinical Fellows (ACFs)

NHS
Hull University Teaching Hospitals
NHS Trust

The NIHR have awarded us the following **5 ACF posts**, for appointment in 2020:

- **ACF Clinical Oncology or Medical Oncology**, under the Platform Science and Bioinformatics theme – this is the post proposed by Anthony Maraveyas and Leonid Nikitenko for an ACF to work under their supervision on molecular pathways of pancreatic cancer carcinogenesis from pancreatic cystic neoplasms to adenocarcinoma.
- **ACF Haematology**, ST3 entry under the Therapeutics or Clinical Pharmacology theme – this is the post proposed by Tim Palmer and David Allsup for an ACF to work on targeted re-purposing of diabetes medicines to reduce thrombosis in patients with myeloproliferative neoplasms.
- **ACF Vascular Surgery**, under the Older People and Complex Health Needs theme – this is the post proposed by Ian Chetter and Tim Palmer for an ACF to work on identifying changes in vascular inflammation associated with improved patient outcomes in peripheral arterial disease following structured exercise.
- **ACF General Surgery or Vascular Surgery** (formula post so no theme, and research plans not proposed in advance).
- **ACF Palliative Medicine** (formula post so no theme, and research plans not proposed in advance).

Plans for 2020/21

On-going work:

Alongside the identified areas of on-going work, the following areas will be of focus in 2020/21:

- Establishing 10 ‘Innovation Champions’ throughout the Trust and development of an ‘Innovation Pathway’.
- Secure ‘top 5’ national status with our Academic Oncology Research Unit as measured by CRN national performance data.
- Support the establishment of Hull as a national centre of excellence for research on PET-CT imaging and the development of radiopharmaceuticals.
- Achieve all Department of Health and NIHR research performance metrics (including >80% of studies recruiting to ‘time and target’).
- Secure three new long-term commercial research partnerships (with at least one of these from a Hull based company).
- Working with the University of Hull/HYMS Research Funding Office to develop strong partnerships with the major research funders
- Adoption of new research indicators for use as part of CQC’s monitoring and inspection programme to showcase the value that clinical research plays in improving health.

Glossary

ACFs	Academic Clinical Fellows
AHPs	Allied Health Professionals
CCG	Clinical Commissioning Group
ED	Emergency Department
HG	Health Group
HHTU	Hull Health Trials Unit
HUTH	Hull University Teaching Hospitals NHS Trust
HYMS	Hull York Medical School
IBD	Inflammatory Bowel Disease
ICAHR	Institute for Clinical and Applied Health Research
ICU	Intensive Care Unit
MHRA	Medicines and Healthcare products Regulatory Agency
MRC	Medical Research Council
NIHR	National Institute for Health Research
PRAs	Patient Research Ambassadors
PRES	Patient Research Experience Survey
QA	Quality Assurance
R&D	Research and Development
R&I	Research and Innovation
RCF	Research Capability Funding (NIHR)
RSF	Research Support Funding (HUTH + HYMS/UoH)
STP	Sustainability and Transformation Partnership
UKCRC	UK Clinical Research Collaboration
UoH	University of Hull
UoY	University of York
Y&H AHSN	Yorkshire and Humber Academic Health Science Network
Y&H ARC	Yorkshire and Humber Applied Research Collaborations
Y&H CRN	Yorkshire and Humber Clinical Research Network
Y&H NHSA	Yorkshire and Humber Northern Health Science Alliance

Hull University Teaching Hospitals NHS Trust
Quality Report
Prepared for the Trust Board

November 2019

Title:	Quality Report
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Kate Southgate, Acting Deputy Director of Quality Governance and Assurance

Purpose:	To provide assurance to the Trust Board on the progress being made against key clinical quality indicators including: Never Events and Serious Incidents; Incidents; Duty of Candour; Health and Safety; Clinical Audit; Mortality; Claims, CQC; Safety Improvement Programme, Stop the Line Campaign and the Quality Improvement Programme.	
BAF Risk:	BAF 3 – Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	All quality governance indicators remain within control limits. Of note is the declaration of five Never Events within the financial year. All have been declared and have had their investigation completed or are on track to complete to timescales. In addition, the Stop the Line campaign was launched in month to coincide with the first World Patient Safety Day on 17th September 2019.	

Recommendation:	It is recommended that the Trust Board receive this report for assurance and determine if further information is required.

QUALITY REPORT

LEAD: Beverley Geary, Chief Nurse

PURPOSE OF THE REPORT

The purpose of this report is to provide information and assurance to the Trust Board and Quality Committee in relation to matters relating to quality governance indicators.

ITEMS FOR ESCALATION IN MONTH (September 2019 data)

Safe:

- Declaration of 5 Never Events within 2019-20 to date. A simulation has been held into the latest Never Event to be reported was within Surgery (Orthopaedics (Trauma)) where wrong site surgery was performed on a patient's thumb.
- Feedback from our commissioners on the investigations into the completed Never Events for mis-placed NG tube and removal of incorrect tooth has been positive, welcoming the use of simulation in our investigations.
- During September 2019 three serious incidents were declared, one relates to an obstetric event and Healthcare Safety Investigation Branch are leading on this investigation, as per national HSIB processes. Another relates to issues around an ectopic pregnancy and the third relates to a retained Vac Pac dressing within a wound.
- The latest NRLS data was released in September 2019, relating to incidents reported Oct 18 – March 19. The data reports that
    - The Trust remains in the middle of the group (of acute trusts of similar size) for overall incident reporting rates. There is no evidence for potential under-reporting
    - There is no significant change in the numbers of incidents reported when compared to same months in the period Oct 17 – March 18
    - Timeliness of incident reporting – the report shows that incidents are reported to the NRLS in a regular and timely manner
    - Levels of Harm –shows us in line with comparative organisations
    - Incident reported types – Governance Directorate to undertake some work reviewing the top incident types and ensuing they are included in improvement projects (i.e. QIP)
- The process for managing duty of candour has been revised, it is expected that this revised process will improve the timeliness of providing feedback to patients and families and in the quality of information provided to patients and families.
- 1 reportable RIDDOR was declared in Quarter 2. This is lowest in a decade which is a positive and indicators the range of Health and Safety initiatives in place across the organisation.

Effective:

- An overview of National Audit requirements are included in the report. There are no items of risk noted within month.
- There are no areas of non-compliance identified with NICE Technology Appraisals
- All Learning From Deaths criteria have been met within month

Caring:

- No areas of reporting and escalation fall within this domain.

Responsive:

- 23 clinical negligence claims reported to NHSR in Quarter 2 with total reserve £3,990k. 55% of reserve allocated to two claims in Diabetes/Endocrinology and Colorectal Surgery:
- 34 clinical negligence claims closed within Quarter 2, of which liability denied in 6 and closed as a result of notification from NHS Resolution; 28 settled with damages £995k, Total cost (damages plus costs) of £2,098k.

Well-led:

- The Trust has confirmed participation in the NHSE and NHSI programme "Moving to Good". The intention of the programme is to help "Requires Improvement" rated Trusts to progress to a rating of "Good".
- The Trust continues to comply with all requests from CQC
- The internal CQC review into the Urgent and Emergency Core Service is progressing well and is now in the report writing stage.
- The internal CQC reviews into End of Life and Medical Care Services have commenced
- The CQC have not yet confirmed an inspection date; however preparations continue
- The Compliance Team are currently working with the Trust Board to complete a Trust-wide well-led self-assessment
- The QIP continues to progress well; however there are three projects which rely on Matron's Handbook data, deteriorating Patient, Nutrition and Dementia, are unable to demonstrate accurate achievement due to the low numbers of returns for these audits and deficiencies identified with many of the wards submission, such as blank sections and questions, using an old version of the form and not using e-obs to complete the paper audits and leaving these sections incomplete. There are also some significant delays to the completion of a number of milestones linked to the mental health QIP and the development of performance indicators to provide data to support achievement of aim. Some milestones are linked to outstanding CQC actions from the 2018 inspection.
- The NHS Safety Strategy was launched in July 2019. A gap analysis of the Trust's current position against the strategy was presented at October Operational Quality Committee. The work identified within the strategy and gap analysis will be incorporated into the patient safety programme work, see point below
- A new Patient Safety Board has been established, to deliver the aspects within the NHS patient safety strategy. The patient safety board has four work streams identified within it, these have been established as projects which will report to the board. The work streams are Stop the Line, Investigations, Just Culture and Patient Safety Champions. The first meeting of the Patient Safety Board is early November 2019.
- An update on the Never Event '10 point' plan was presented at October Operational Quality Committee. It was agreed that the actions within this plan have been completed, and any further work around the Trust's presentation of, and response to, Never Events, will be incorporated into the Patient Safety Board. The final sign off of the plan will be at the Quality Committee in November 2019.

RISKS TO DELIVERY

The declaration of 5 Never Events in the financial year has been noted as a risk within month. A full review has been undertaken to determine if themes and trends can be identified to prevent future events occurring. A full review has also been undertaken of compliance against Patient Safety Alerts to determine if residual risks remain. No risks were identified from this review and assurance was determined that a robust process was in place to ensure compliance with Alerts.

Included in this month's report:

	SAFE	• **Never Events and Serious Incidents** • **Incident Reporting Rates and NRLS** • **Duty of Candour** • **Health and Safety**
	EFFECTIVE	• **National Audit** • **NICE** • **Mortality**
	CARING	• **None**
	RESPONSIVE	• **Claims**
	WELL-LED	• **CQC – A focus on moving to good** • **Safety Improvement Programme** • **Quality Improvement Programme**

SAFE

NEVER EVENTS AND SERIOUS INCIDENTS

AREAS FOR ESCALATION

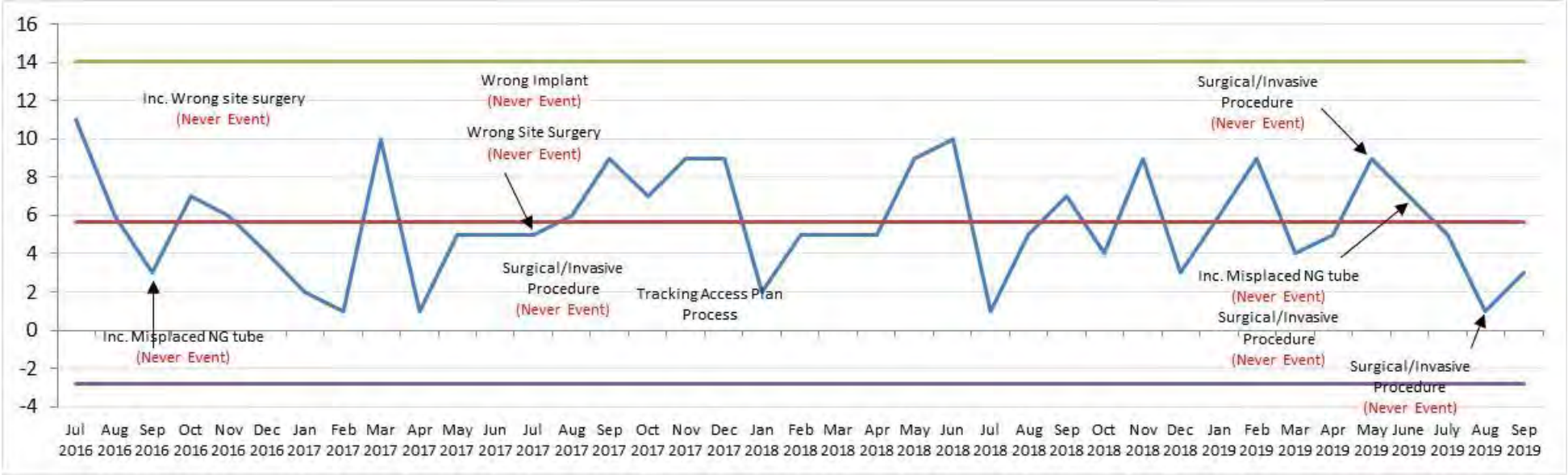
Declaration of 5 Never Events within 2019-20 to date. A simulation has been held into the latest Never Event to be reported was within Surgery (Orthopaedics (Trauma)) where wrong site surgery was performed on a patient's thumb.

Feedback from our commissioners on the investigations into the completed Never Events for mis-placed NG tube and removal of incorrect tooth has been positive, welcoming the use of simulation in our investigations.

During September 2019 three serious incidents were declared, one relates to an obstetric event and Healthcare Safety Investigation Branch are leading on this investigation, as per national HSIB processes. Another relates to issues around an ectopic pregnancy and the third relates to a retained Vac Pac dressing within a wound.

KEY UPDATES IN MONTH

The chart below indicates the trend in Never Events and Serious Incidents. 5 Never Events have been declared in 2019-20. Serious Incident numbers remain within control limits with 31 declared to date for 2019-20.



RISKS TO DELIVERY
Five Never Events have been declared in the early part of 2019-20, three are related to surgical/Invasive procedures. A general theme of not following due process has been identified and mitigating actions has been put in place in the individual service areas. In addition, a Trust wide programme of Safety Improvement has been developed. The risk to delivery relates to potential lack of engagement with key staff groups through the organisation.

INCIDENT REPORTING RATES

AREAS FOR ESCALATION

The latest NRLS data was released in September 2019, relating to incidents reported Oct 18 – March 19. The data reports that

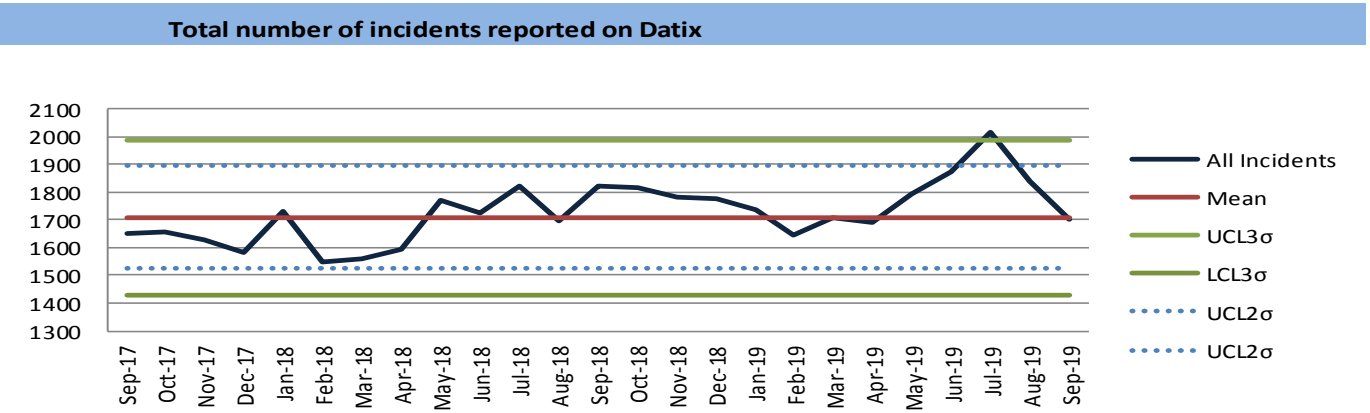
- The Trust remains in the middle of the group (of acute trusts of similar size) for overall incident reporting rates. There is no evidence for potential under-reporting
- There is no significant change in the numbers of incidents reported when compared to same months in the period Oct 17 – March 18
- Timeliness of incident reporting – the report shows that incidents are reported to the NRLS in a regular and timely manner
- Levels of Harm –shows us in line with comparative organisations
- Incident reported types – Governance Directorate to undertake some work reviewing the top incident types and ensuing they are included in improvement projects (i.e. QIP)

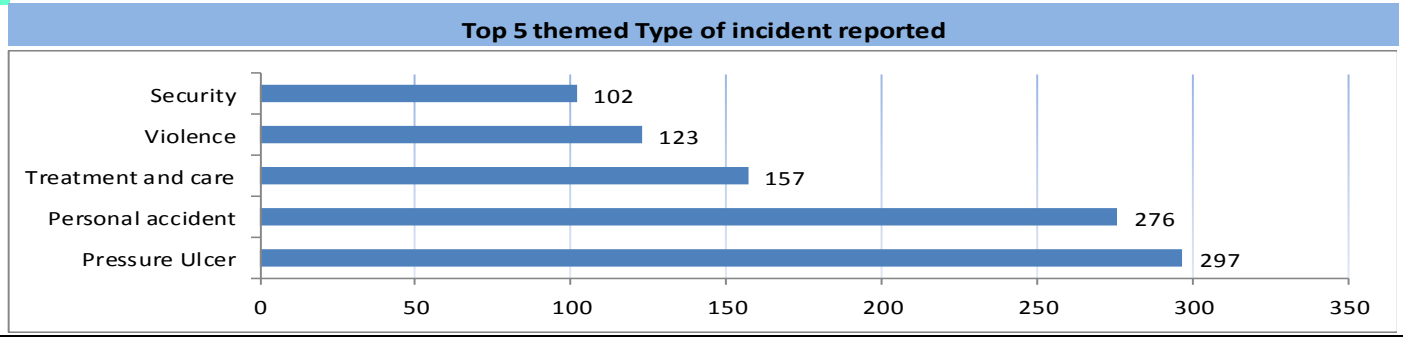
The report is shown at Appendix 1.

KEY UPDATES IN MONTH

Incident Reporting Rates by Health Group: The number of incidents reported remains within expected control limits. Pressure Ulcers account for the largest proportion of reported incidents.

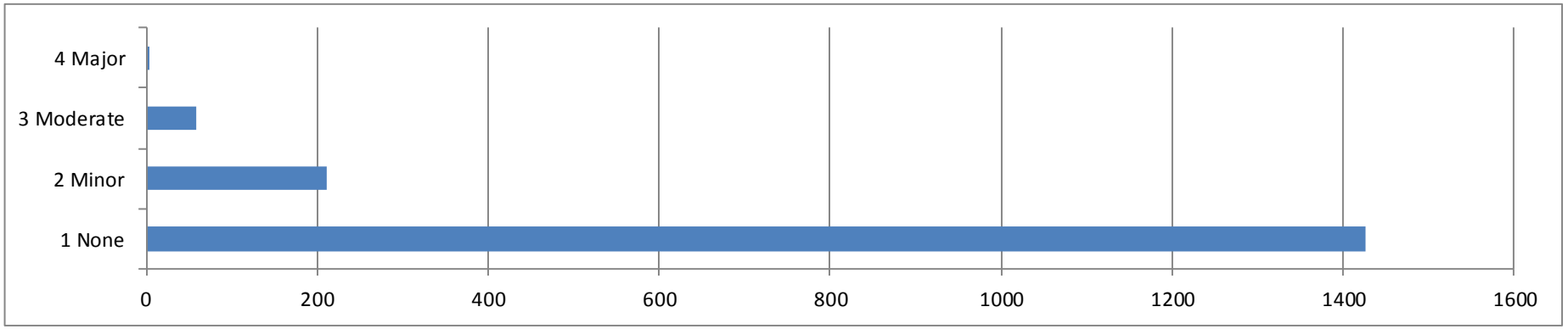
Analysis	
Within expected parameters	
UCL3σ	1988.46
LCL3σ	1430.36
Current month	
1701	
Month change	
-141	





INCIDENT REPORTING RATES

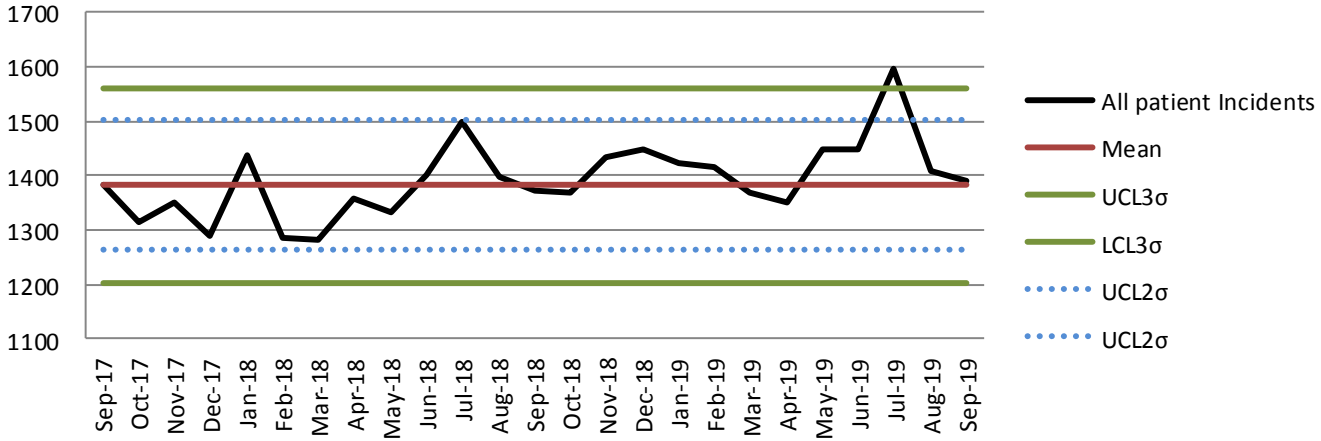
Severity of incidents reported



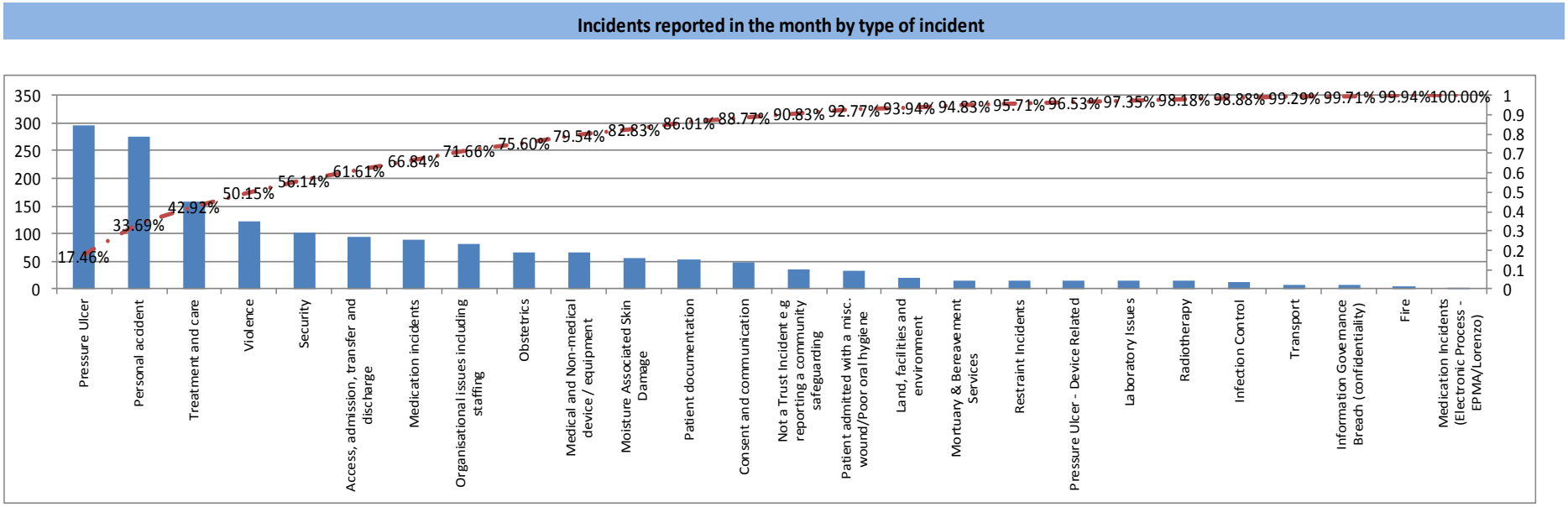
The severity of reporting rates remain consistent.

Total number of Patient incidents reported on Datix

Analysis
Within expected parameters
UCL3σ 1560.19
LCL3σ 1203.81
Current month
1389
Month change
-21



INCIDENT REPORTING RATES



The Graph shows that the top four reported types of incidents account for around 50% of the total incidents reported. The top ten types of incidents reported account for around 80% of incidents reported (applying the pareto 80/20 rule).

RISKS TO DELIVERY

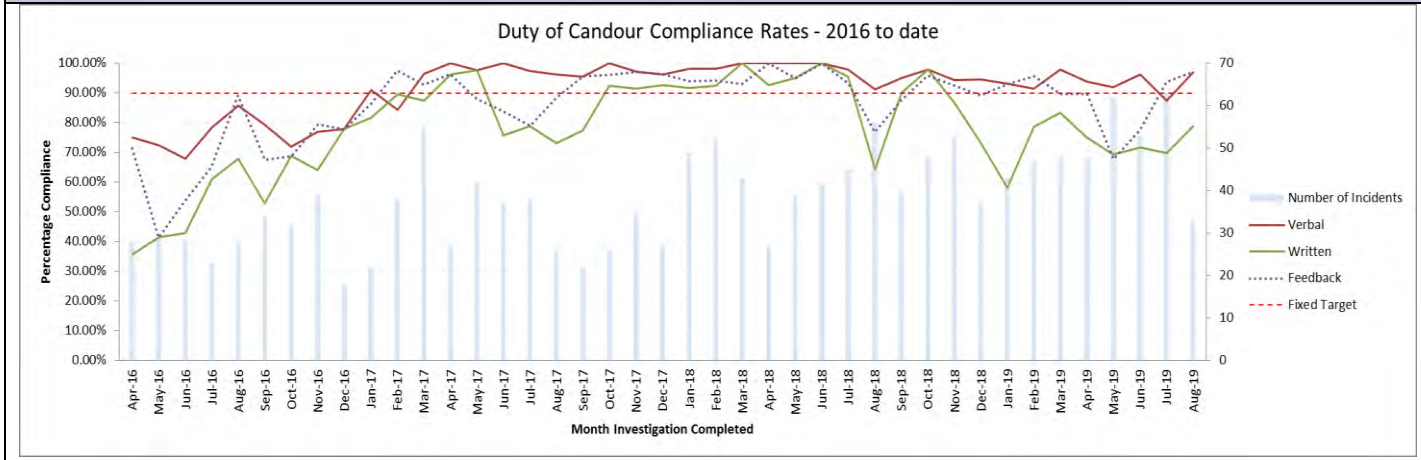
No risks to delivery have been identified within month.

DUTY OF CANDOUR

AREAS FOR ESCALATION

The process for managing duty of candour has been revised, it is expected that this revised process will improve the timeliness of providing feedback to patients and families and in the quality of information provided to patients and families.

KEY UPDATES IN MONTH

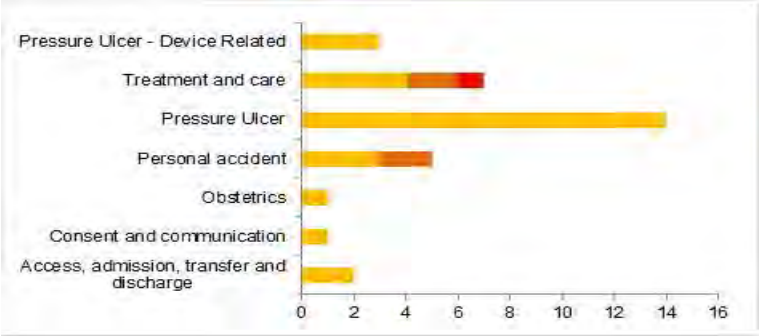


The process for managing duty of candour has been revised, it is expected that this revised process will improve the timeliness of providing feedback to patients and families (show in the green line) and in the quality of information provided to patients and families.

Incidents investigated in the last 12 month period with the compliance circles and types of incidents investigated in August 2019 – date remains one month behind to the timelag for completion of Duty of Candour.

Overall compliance for completed Duty of Candour incidents

Duty of Candour incident categories/severity



RISKS TO DELIVERY

No areas of risk identified, however, the Quality Governance Team will monitor closely the introduction of the revised process to ensure success.

Health And Safety

AREAS FOR ESCALATION

Of note there has only been 1 RIDDOR reported in Quarter 2.

KEY UPDATES IN MONTH

RIDDOR Apr 2019 - Mar 2020	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
	-	-	-	-	-								-
	-	-	-	-	-								-
something	-	-	-	-	-								-
d, object/liquid, electric or machinery	-	-	-	-	-								-
material or object non medical	-	-	-	-	-								-
dent	-	1	-	-	-	1							2
al sharps	-	-	-	-	-								-
l agent e.g. radiation, substance, bio agent,	-	-	-	-	-								-
Total	-	1	-	-	-	1							2
		1			1								

Of note there has only been 1 RIDDOR reported in Quarter 2.

Quarterly safety inspections are completed by each ward / department to assess and areas of risk. The number of departments completing and actioning safety inspections have decreased in Quarter 2.

CHH Quarterly Inspections

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017 - 2018	22	25 ▽	34 ▽	37 ▽	**118**
2018 - 2019	45 ▽	43 △	34 △	38 ▽	**160** ▽
2019 - 2020	39 ▽	36 △			**75**
Total	**106**	**104**	**68**	**75**	**353**

HRI Quarterly Inspections

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017 - 2018	30	37 ▽	42 ▽	41	**150**
2018 - 2019	48 ▽	57 ▽	45 △	50 ▽	**200** ▽
2019 - 2020	55 ▽	44 △			**99**
Total	**133**	**138**	**87**	**91**	**449**

- **New EL / PL Claims** – In quarter 2 there were 9 new non-clinical claims received.

Staff health and safety incidents reported by severity:

Risk Rating	Quarter 1	Rate		Quarter 2	Rate
No harm	32	0.43	FTE 7430	28	0.37
Minor	57	0.76		63	0.84
Moderate	3	0.04		4	0.01
Major	-	-		-	-
Catastrophic	-	-		-	
Total:	92			95	

Benchmarking review of HSE enforcement action undertaken. Areas of enforcement across the country have focused on confined spaces, Hoist slings and violence / aggression. No communication or areas of enforcement with HSE to the Trust within quarter 2

RISKS TO DELIVERY

No areas of risk identified

EFFECTIVENESS

CLINICAL AUDIT

AREAS FOR ESCALATION

No areas of escalation in month

KEY UPDATES IN MONTH

The Trust continues to comply with all requirements for national audits. Key learning has been identified in year and all requirements as outlined in the Quality Accounts have been adhered to.

<table>
<tr><th>Number of audits commenced</th><th colspan="2">Current stage of audits</th><th>Number of audits completed</th></tr>
<tr><td rowspan="6">245</td><td>Data collection</td><td>99</td><td rowspan="6">63</td></tr>
<tr><td>Data analysis</td><td>3</td></tr>
<tr><td>Report</td><td>4</td></tr>
<tr><td>Complete</td><td>63</td></tr>
<tr><td>Ongoing</td><td>76</td></tr>
<tr><td>Abandoned</td><td>0</td></tr>
<tr><th>Number of audits due to have commenced</th><td colspan="2" rowspan="2"></td><th>Number of audits due to have been completed</th></tr>
<tr><td>216</td><td>71</td></tr>
</table>

Clinical audit continues to be monitored throughout the Trust governance systems including within Health Groups, Clinical Effectiveness, Policy and Practice Committee and the Operational Quality Committee. There are no areas of concern noted by the Central Team or the Health Groups in month.

RISKS TO DELIVERY

No areas of risk identified

EFFECTIVENESS

NICE GUIDANCE

AREAS FOR ESCALATION

No areas of escalation in month

KEY UPDATES IN MONTH

Compliance with Technology Appraisals (TAGs) – Quarter 2

Health Group	Fully compliant	Partially compliant	Non-compliant	In progress
Clinical Support	15	0	0	1
Family and Women's Health	3	0	0	1
Medicine	2	0	0	2
Surgery	0	0	0	0
Trust-wide	0	0	0	0

Of note is that there are no areas of non- compliance with TAGs
The number of Interventional Procedures where compliance has not been fully ascertained is 3, ie they are in the process of being analysed.
The number of Quality Standards where compliance had not been fully ascertained fell from 19 at the end of Quarter 1 to 10 at the end of Quarter 2.
The number of Guidelines where compliance had not been fully ascertained fell from 43 at the end of Quarter 1 to 41 at the end of Quarter 2. Guidelines are not categorised as compliant until the Trust has formally adopted the guidelines.

RISKS TO DELIVERY

No areas of risk identified

MORTALITY

AREAS FOR ESCALATION

There are no areas for escalation in month.

KEY UPDATES IN MONTH

	Total number of In-hospital deaths in Q2	Of which were elective admissions / Day case deaths	Of which were Non-elective admissions
2018/19	532	22	510
2019/20	517	25	492

Number of Deaths:
The following illustrates the 3 most common causes of death during Q2 2019/20:

1. Pneumonia – 60deaths
2. Septicaemia – 53 deaths
3. Acute Cerebrovascular Disease – 35 deaths

Minimum Criteria from Learning From Deaths Framework:
All minimum criteria continue to be met.

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	1/1
LeDeR Reviews (internal HEY patients)	1/1
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.	2 (2 currently ongoing)

RISKS TO DELIVERY

No identified risks to delivery.

RESPONSIVE

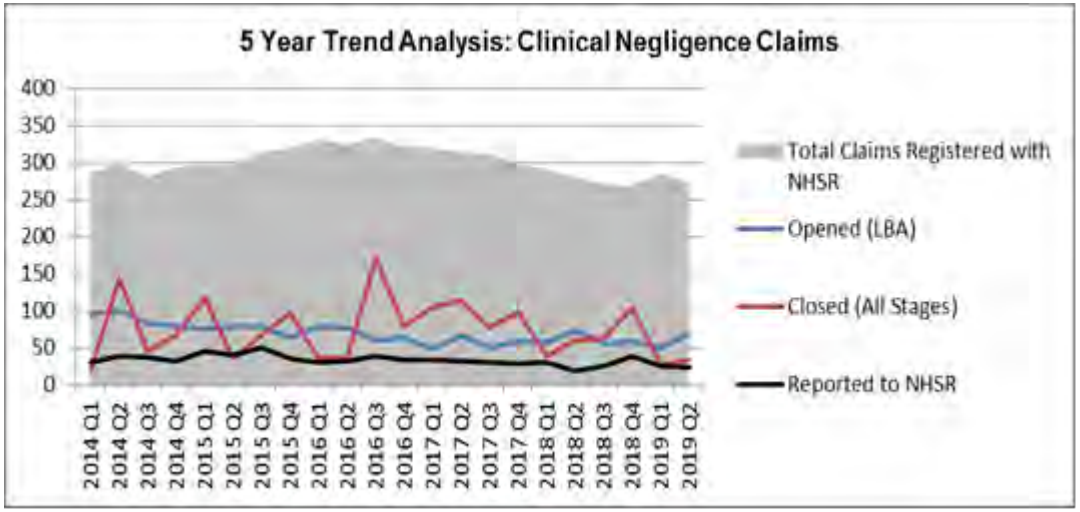
CLAIMS

AREAS FOR ESCALATION

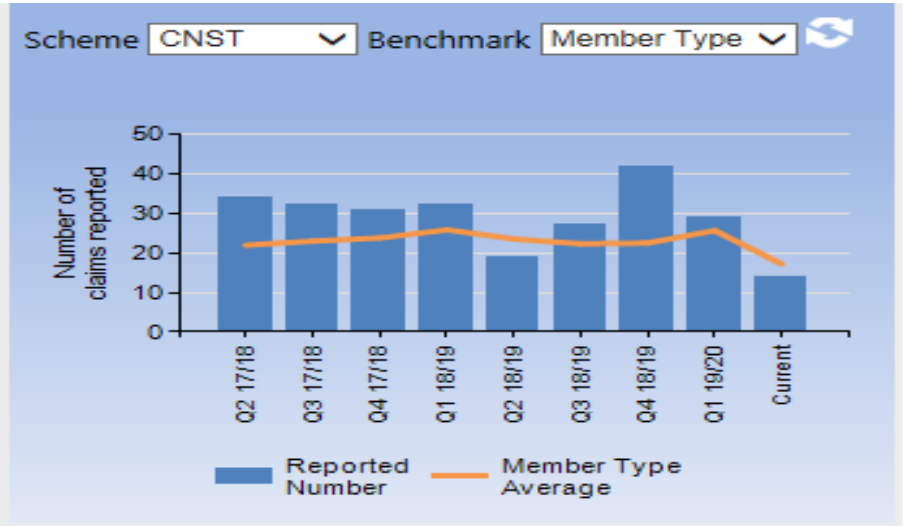
There are no areas for escalation in month.

KEY UPDATES IN MONTH

5-Year Trend Clinical Negligence Claims



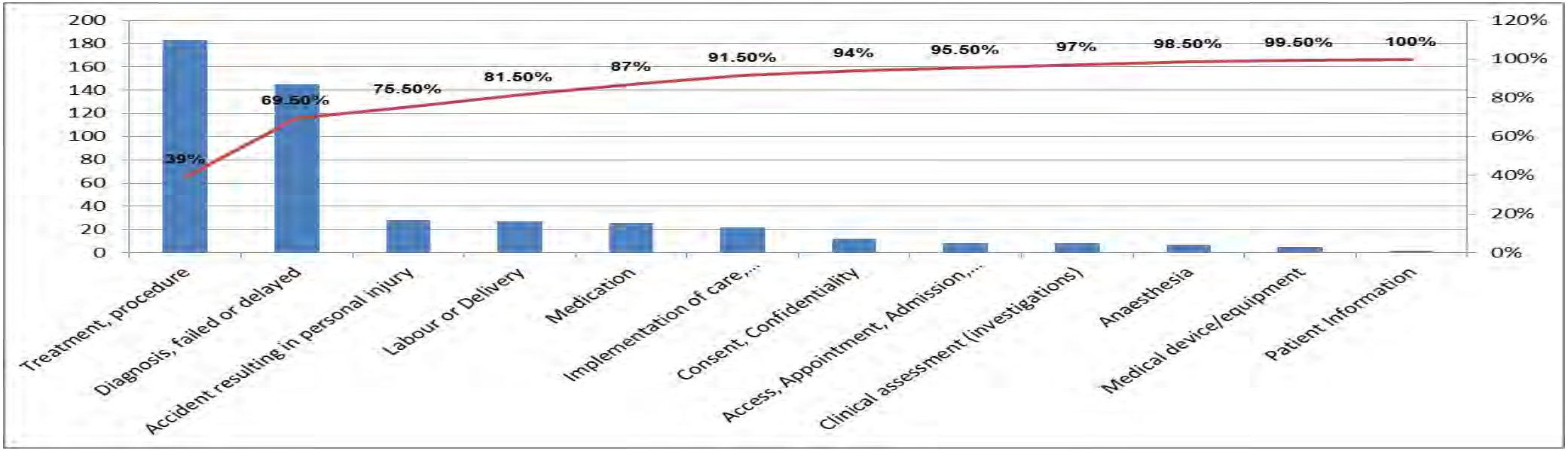
Number of Claims reported to NHSR (full Q2 data not available)



- 23 clinical negligence claims reported to NHSR in Quarter 2 with total reserve £3,990k. 55% of reserve allocated to two claims: Alleged delay in treatment of right diabetic foot ulcer resulting in trans-tibial amputation (Diabetes/Endocrinology £1,125k) and alleged inadequate prescription of DVT prophylaxis; alleged delayed and inadequate neurovascular examination following bowel surgery, resulting in below knee amputation and subsequent above knee amputation due to alleged failure of the first operation (Colorectal £1,075k).
- 34 clinical negligence claims closed within Quarter 2, of which liability denied in 6 and closed as a result of notification from NHS Resolution; 28 settled with damages £995k, Total cost (damages plus costs) of £2,098k.
- Largest claim settled in sum of £300k, Total payment £595k relating to delay in diagnosis and treatment of an infection following below knee amputation resulting in avoidable pain and suffering. Denied causation in respect of above knee amputation on basis that necrotising fasciitis would not have been avoided with earlier antibiotics. Root cause: No universally agreed protocol for prophylactic antibiotics in 2009. However, subsequent delay in medical review leading to delay in administration of antibiotics/exploration of wound and surgical excision of necrotic tissue. Settled on litigation risk basis on Counsel/Solicitors advice.
- 6 settled claims had been declared as serious incidents previously with damages £147k, Total cost £325.8k
- No Early Notification cases referred to NHSR.

- Mediation held in 3 claims of which damages settled below reserve in two cases and third case settled at damages reserve.

5-Year rolling trend settled claims – Incident type



RISKS TO DELIVERY

No identified risks to delivery.

WELL-LED

KEY UPDATES

Quality Improvement Programme:

The plan continues to be reviewed and scrutinised at Operational Quality Committee and the Quality Committee. Good progress continues to be made. The majority of project indicators continue to display positive performance against their targets however the three projects which rely on Matron's Handbook data, Deteriorating Patient, Nutrition and Dementia, are unable to demonstrate accurate achievement due to the low numbers of returns for these audits and deficiencies identified with many of the wards submission, such as blank sections and questions, using an old version of the form and not using e-obs to complete the paper audits and leaving these sections incomplete.

CQC: A focus on CQC activity is outlined in the section below.

NHS Patient Safety Strategy:

- The NHS Safety Strategy was launched in July 2019. A gap analysis of the Trust's current position against the strategy was presented at October Operational Quality Committee. The work identified within the strategy and gap analysis will be incorporated into the patient safety programme work, see point below
- A new Patient Safety Board has been established, to deliver the aspects within the NHS patient safety strategy. The patient safety board has four work streams identified within it, these have been established as projects which will report to the board. The work streams are Stop the Line, Investigations, Just Culture and Patient Safety Champions. The first meeting of the Patient Safety Board is early November 2019.
- An update on the Never Event '10 point' plan was presented at October Operational Quality Committee. It was agreed that the actions within this plan have been completed, and any further work around the Trust's presentation of, and response to, Never Events, will be incorporated into the Patient Safety Board. The plan will have final sign off at the Quality Committee in November 2019

RISKS TO DELIVERY

- The delays in the delivery of improvements against Nutrition, Deteriorating Patient and Mental Health could pose a risk to the Trust's next inspection. These issues remain overdue from the 2018 inspection.

CQC – PREPARATIONS FOR MOVING TO GOOD

KEY UPDATES

This section provides an update against activities in relation to preparedness for the forthcoming inspection.

Moving to Good Initiative:
The Trust is committed to achieving a CQC rating of Good at our next inspection. The Trust has been invited by NHSE and NHSI to take part in the Moving to Good Initiative. This is a 12 month programme which includes: board and senior manager level development on quality improvement and statistical process control; workshops, tools and support on culture, governance, staff engagement and quality improvement and; network and peer support from other trusts in the region. The aim of the initiative is to help organisations meet their full potential and move from a rating of requires improvement to good.

Internal CQC Core Service Reviews:
A programme of reviews across the organisation has commenced.

- The Maternity and Critical Care Core Service Reviews are complete and the reports have been signed off by the services. Action plans have been produced and are monitored through the services governance committees. Regular updates are provided to the Governance Team and meetings are held with the leads to update on progress and to provide the supporting evidence.
- Since the last CQC inspection, the Trust has taken over the management of some community paediatric services. As part of the transition from the previous organisation a mock CQC inspection of Sunshine House for outpatient facilities was undertaken in July 2019. The review found areas requiring improvement in relation to infection control, medicines management and leadership. An action plan was developed and is being managed via the Paediatric Stabilisation Group. A return visit is due to take place once all actions are due to be completed in November 2019.
- The Urgent and Emergency Core Service Review is currently underway. A mock inspection was also undertaking of the Urgent and Emergency services in July 2019, a number of actions were identified for improvement and feedback to the service for action. The main area of concern was compliance with the management of sharp bins. The draft report is in progress and will be shared with the service for review and comment in October 2019.
- The Children and Young People Core Service Review is now complete and a draft report has been circulated to service leads. The review concluded that the service had made significant improvements since the last inspections two years ago. The service demonstrated that an overall rating of “Good” could be maintained if standards continue to be met and the remaining issues from the 2016 are addressed.
- The Medical Care Core Service Review has commenced in October 2019. The first stage of the review is the agreement of the terms of reference and completion of a mock Provider Information Request (PIR) return from the service.
- The End of Life Core Service Review has commenced. The last time the service was reviewed was two years ago and it was rated as Good. At the previous inspection three minor actions were noted, all of which have been completed. It is the Trust’s aim to achieve a rating of ‘Outstanding’ at the next inspection. The Nurse Director for Clinical Support Health Group has already completed an initial review of the service and areas of good and outstanding practice have been noted. Work has also been undertaken to review other Trusts where the service has been rated as Outstanding. Initial reviews would suggest that our Trust has similar services on offer to those currently rated as outstanding. A full core service review has now commenced and is due to conclude by December 2019.

Well-led Self-Assessment:
In October 2019 the Compliance Team commenced a Well-Led Self-Assessment with the Executive Team. This will be completed in three stages:

- Stage 1 of the review will seek to assess a range of data and information currently available using the CQC key lines of enquiries in the well-led domain as the basis for the assessment.

- Stage 2 focuses on Interviews the Executive Team, Non-Executive Directors and other key leads such as Equality and Diversity Lead, Freedom to Speak up Guardian, Safeguarding Lead and the Chief Pharmacist. Stage 2 will also include focus groups with NEDs and Staff side representatives.
- Stage 3 will be a final review, conclusions, next steps and an overall self-assessment rating determined. It is the intention to complete the review by the end of the calendar year.

Progress review against Previous CQC Actions:

- A full assessment of progress against the previous inspection actions between 2015 and 2018 was completed by the Compliance Team in September 2019 to ensure all closed actions had the relevant evidence and/or assurance to support the closure of the action and to identify any gaps in progress for further action. Following the 2015, 2016 and 2018 inspections the Trust has received a total of 107 compliance actions from the CQC. Following the review it has been identified that 21 (19.6%) actions remain open, requiring further improvement. Therefore 80.4% of actions have been address and has evidence to support the closure of the actions.
- Outstanding actions relate to:
    - Documentation in ED about children in the same households as adults with risk taking behaviours or other vulnerabilities so that they could be brought to the attention of paediatric liaison services.
    - Completion and documentation of risk assessments including; falls, nutrition, NEWS and children with mental health needs
    - Improve facilities on the 13th floor
    - Ensure compliance with the completion of syringe driver checks
    - Compliance with NICE CG83 rehabilitation after critical illness
    - Storage of records
    - Performance against national treatment standards
    - Embed documentation relating to dementia care
    - Knowledge regarding mental health and deprivation of liberty standards

Keys Risks:

A summary of key risks to the next inspection, identified so far are as follows:

Maternity	Critical Care	Children and Young People	Urgent and Emergency Care
Antenatal Day Unit environment and capacity issues	Consultant staffing highlighted in 2014 and 2016	Safeguarding policies / guidelines out of date	The management of sharp bins
Incident codes were not always categorised appropriately	National targets not being met	SLA with Humber not developed	Performance against national targets
Continue to monitor outcomes including looking beyond the guidance and going one step further to prevent harm	No Never Event reported for 2016 inspection - now: Never Event declared and near misses reported	Duty of Candour not being met	No NE reported for 2016 inspection - now: Never Event declared and near misses reported
	Not achieved - 50% of nurses with post registration qualification	Staff did not have the knowledge and competencies to meet the needs of children with mental health needs	

	No document evidence that patients were seen within 12 hours by consultant or twice daily ward rounds taking place at last inspection	The facilities on the 13th Floor	
	Rehabilitation was not in line with national guidance	Paediatric Governance arrangements. It was noted that improvements were required in relation to the Governance Meetings themselves, with not all key areas of business discussed or minuted.	
	Psychological support not always available		
	Risk register was not always updated as required and staff were not always able to articulate clearly the risks for the area.		

RISKS TO DELIVERY

- The number of open and outstanding actions from the 2015, 2016 and 2018 CQC inspections; these are also linked to the key issues raised above. All of which will potentially impact on the Trust rating following the next inspection.

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 12 November 2019

Title:	Infection Prevention & Control Report for the period April – September 2019
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Greta Johnson, DIPC/ Lead Nurse, Department of Infection

Purpose:	The purpose of this report is to provide the Board with information on Trust performance and provide assurance that suitable systems and processes are in place in the Trust to prevent and control infections. This paper provides the Board with an update on any actions arising from the last 6 months, performance in respect of alert organisms/ infections benchmarked against Trust and national standards, clinical activity and incidents (including seasonal infections) and other relevant points for the Board to consider.	
BAF Risk:	Outbreaks and increased incidences of healthcare associated infections impacting on current Trust thresholds	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	x
	High quality care	x
	Great clinical services	x
	Partnership and integrated services	x
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	• Two Trust apportioned MRSA bacteraemia cases, one deemed avoidable, the other unavoidable, following Post Infection Review investigation • Twenty seven Trust apportioned MSSA bacteraemia cases – a reduction in number of cases reported for the same time period 2018/19. All Trust apportioned cases are investigated using a root cause analysis (RCA) process. • Sixteen hospital onset healthcare associated *Clostridium difficile* cases and thirteen community onset healthcare associated cases reported, year to date. The external threshold for reportable cases of *C.difficile* is no more than eighty cases. To date all twenty nine cases are investigated using a root cause analysis (RCA) process and tabled at a commissioner led HCAI review group. To date, two lapses in practice have been identified. • Gram negative bacteraemia: *Escherichia coli* (*E.coli*), Klebsiella species and *Pseudomonas aeruginosa.* The Trust is required to report all cases of these bacteraemia to Public Health England (PHE). To date, fifty seven E.coli bacteraemia have been reported (58 in 2018/19), twenty one Klebsiella (17 in 2018/19) and thirteen Pseudomonas aeruginosa (7 in 2018/19). Any differences should be treated with caution due to small numbers and natural variation. • Increase in community apportioned cases of Legionnaires Disease detected amongst patients admitted to the Trust	

Recommendation:	The Board of Directors is asked to note the report for information and assurance regarding action taken to reduce avoidable HAI.

Healthcare Associated Infections (HCAI)

HCAI Performance Report

April – September 2019

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)
		16	13	10
MRSA Bacteraemia	**Zero**	2 Trust apportioned cases June 19 & August 19 (over threshold) – 1x avoidable/ 1x unavoidable		
MSSA bacteraemia	**Locally agreed CCG stretch target of 50**	27 Trust apportioned cases (54%)		

Gram Negative Bacteraemia		
Organism	**2019/20 Threshold**	**2019/20 Performance**
E.coli bacteraemia	73 (Total 2018/19 = 112)	57(78%) (51%)
Klebsiella	Baseline monitoring	21
Pseudomonas aeruginosa	Baseline monitoring	13

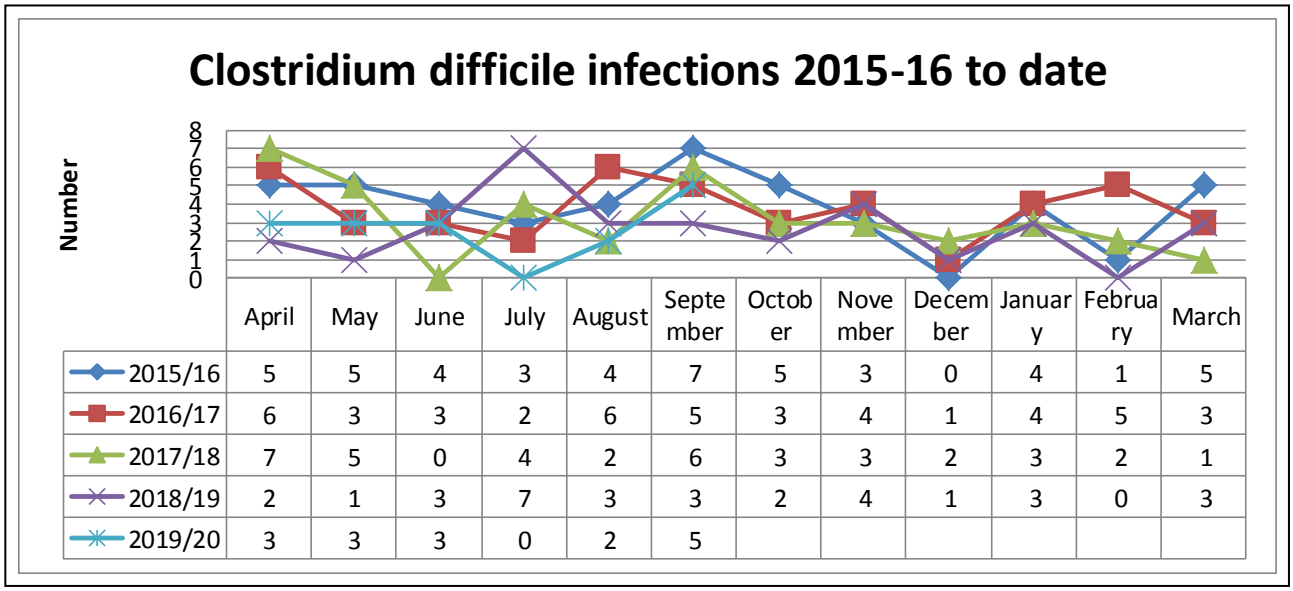
The current performance against the upper threshold for each are reported in more detail, by organism:

Clostridium difficile (CDI)

By September 2019, the Trust reported 16 HOHA and 13 COHA infections against an upper threshold of 80 (36% of threshold). Of the HOHA cases, from the 1st April 2019, a total of eight cases are apportioned to the Medical Health Group, six to Surgical Health Group two to Clinical Support but no cases identified in the Families & Women's Health Group. At quarter two, two Trust reported cases relate to the same patient with a relapse in symptoms.

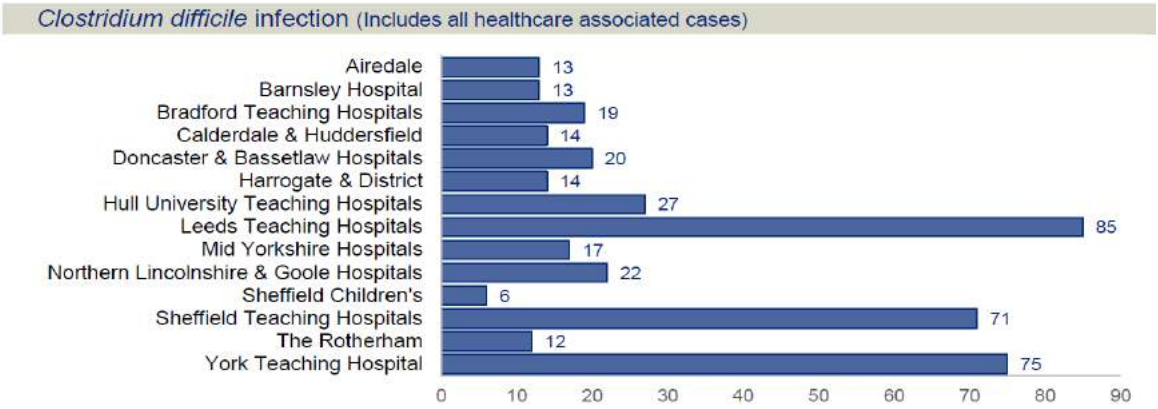
Clostridium difficile RCA completed (HOHA cases)	Clostridium difficile RCA outstanding (HOHA cases)	Outcome of Trust RCA investigation (HOHA cases)	Cases awaiting consideration at Commissioner led HCAI Review Group	Number of HOHA cases tabled at Commissioner led HCAI Review Group and outcome
16 (2 cases reported for same patient)	5/16	7/9 to date deemed no lapses	5/16	11 cases tabled to date with 9 deemed no lapses in practice

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



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	5	5	4	3	4	7	5	3	0	4	1	5
2016/17	6	3	3	2	6	5	3	4	1	4	5	3
2017/18	7	5	0	4	2	6	3	3	2	3	2	1
2018/19	2	1	3	7	3	3	2	4	1	3	0	3
2019/20	3	3	3	0	2	5						

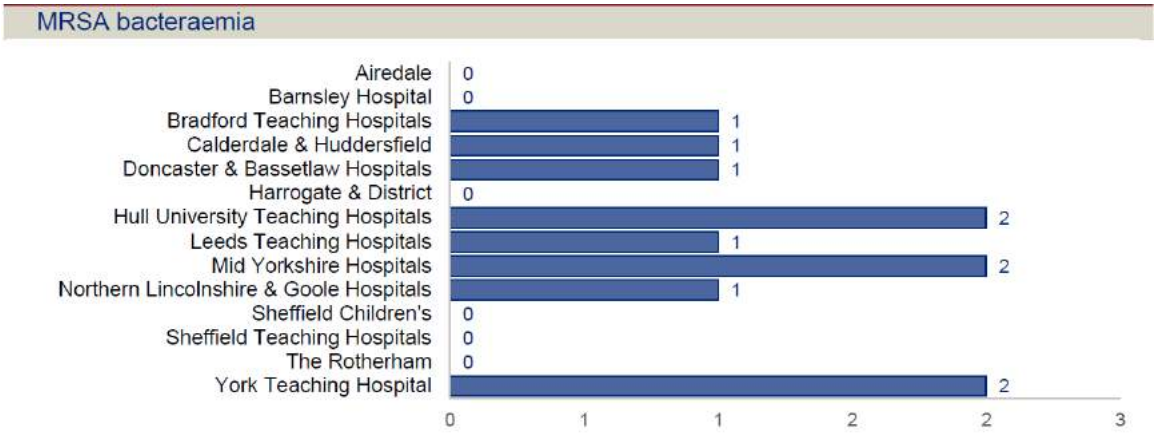
The following table shows the distribution of acute hospital *Clostridium difficile* cases across the Yorkshire and the Humber region, during April and September 2019 (source: Public Health England)



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	2 cases reported. June 2019 reported in the Medicine Health Group and a further case reported in the Surgical Health Group in August 2019 Over threshold	June 2019 – Post Infection Review investigation completed and outcome meeting held. Case deemed avoidable, secondary to cellulitis and thrombophlebitis at a cannula site. August 2019 - Post Infection Review investigation completed and outcome meeting held. Case deemed unavoidable.

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



Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

Organism	2019/2020 Threshold	2019/20 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	50	27 (54%)	Of the 27 reported cases 21 have been investigated via RCA to date by the Health Groups and returned to the IPCT. With a further 6 cases under investigation and awaiting review. Of the 21 completed cases it has identified the following mixed trends 24% CVCs, 19% pneumonia (HAP/VAP), 9.5% SSI,

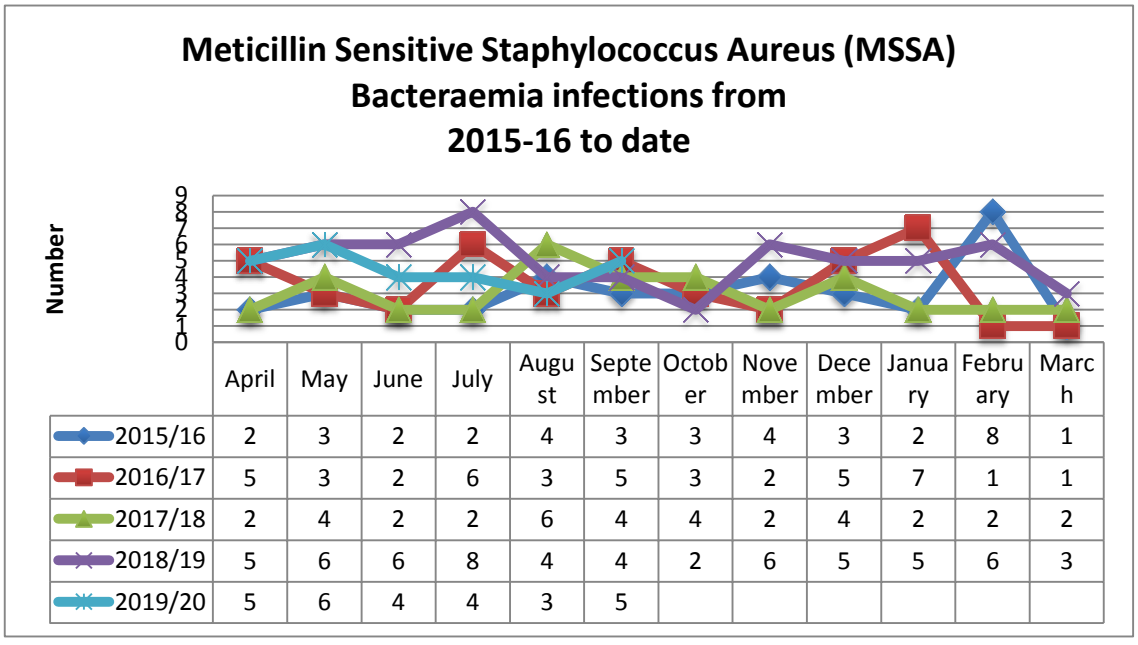
			9.5% skin and soft tissue infections, 9.5% PVCs, 9.5% UTI, 9.5% possible contaminant and 9.5% unknown. Ongoing work around CVC usage continues with some cases being managed by other teams outside of the Trust. All cases are reviewed by the IPCT and RCAs are being completed by the respective HGs

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

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

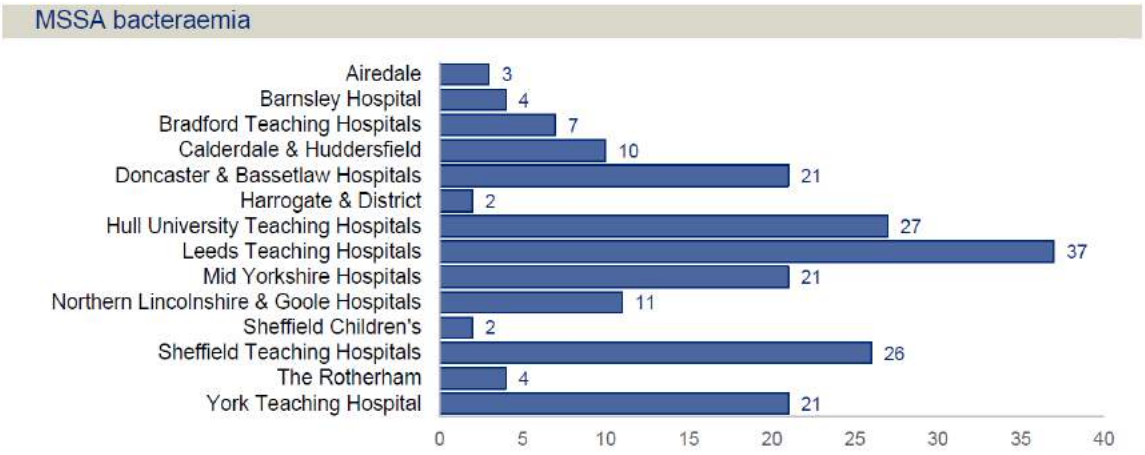
Concerns regarding patients who inject recreational drugs and present with abscesses and deep infections is ongoing both as hospital and community onset cases.

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



	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	4	3	5						

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



***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.

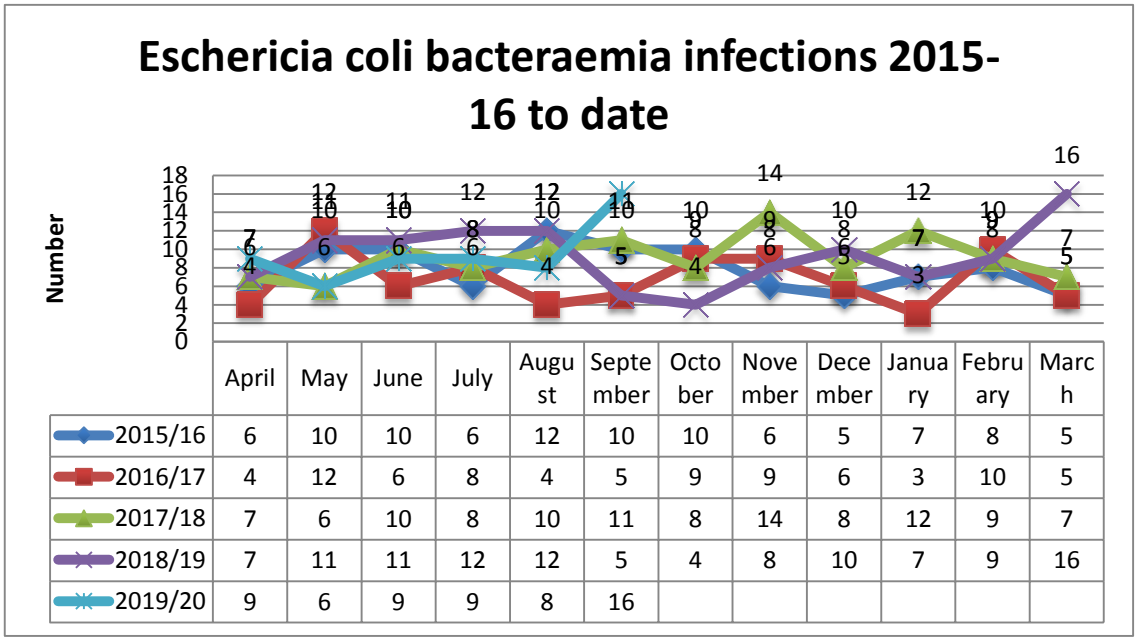
The focus of attention is on the reduction of urinary tract infections, which are responsible for the largest burden of *E.coli* infections. The Trust, along with system partners, across Hull and East Riding are involved in a number of projects to try and reduce the burden of these infections including 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) (Total 2018/19 = 112)	57(78%) (51%)	57	Fifty seven Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 32 cases detected in the Surgical HG, 15 cases in the Medicine HG, 9 cases detected in Clinical Support HG and one case in the Families & Women's HG. Review of cases suggests

				ongoing causes related to complex abdominal and urological surgery, biliary and urinary sepsis. Ongoing review of cases continues by the IPCT with those deemed possibly preventable or preventable requiring an RCA by the HG. The cases requiring an RCA relate to urinary tract infections and delay in treatment.

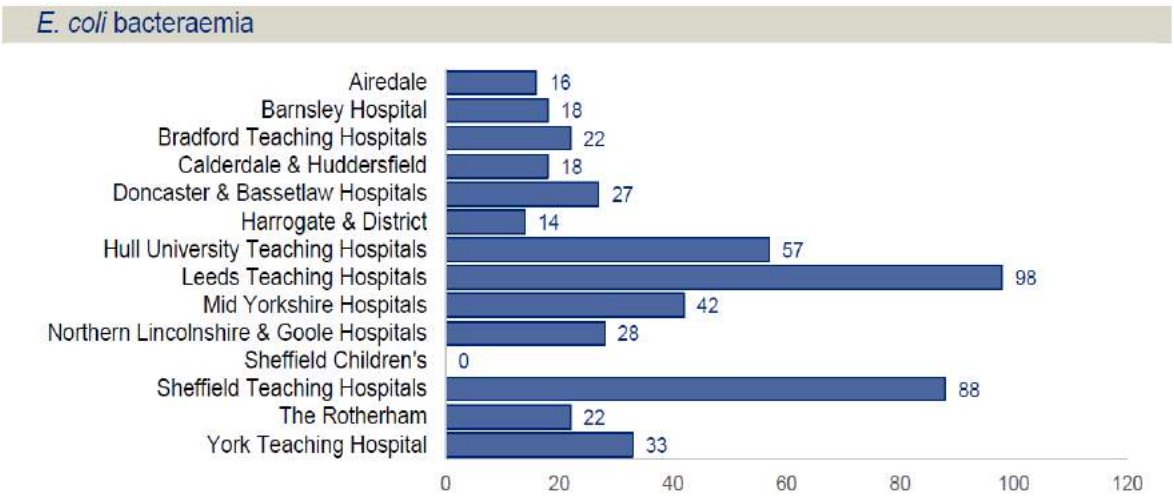
The following graph highlights the Trust's performance from 2015/16 to date:



	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	9	8	16						

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.

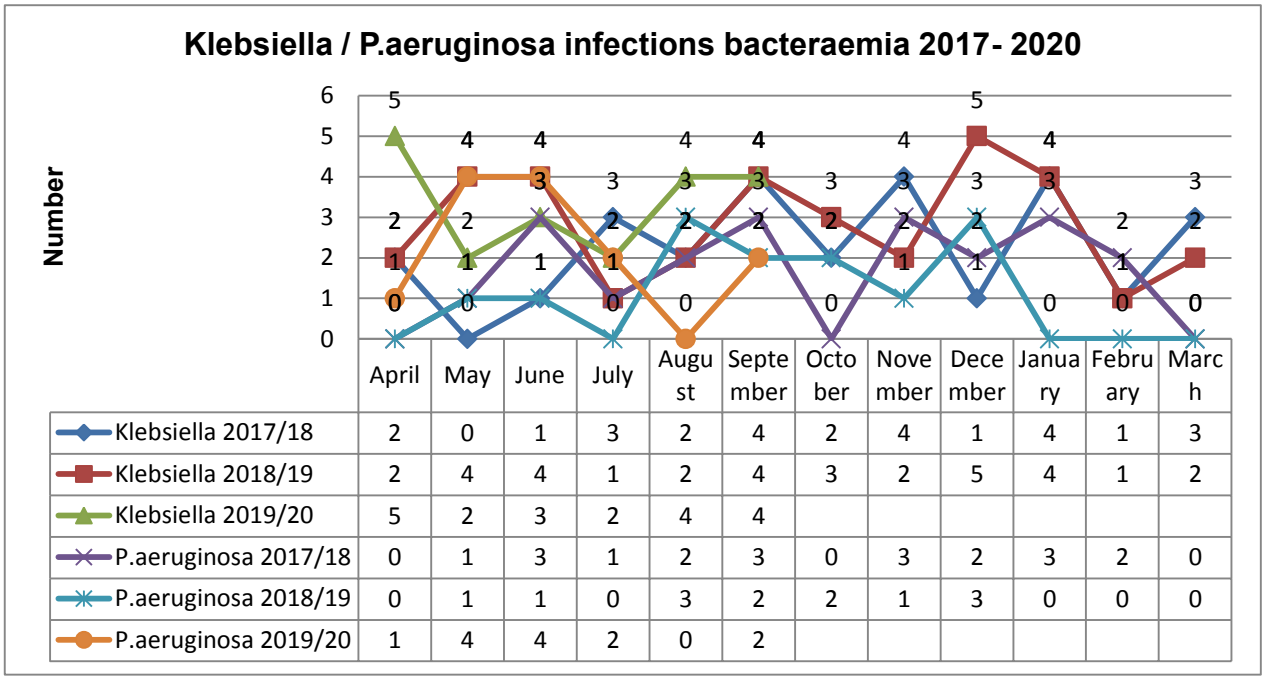
The following table shows the distribution of acute hospital E.*coli* Bacteraemia across the Yorkshire and the Humber region, during April and September 2019 (source: Public Health England)



Gram negative bacteraemia – reporting for 2019/20

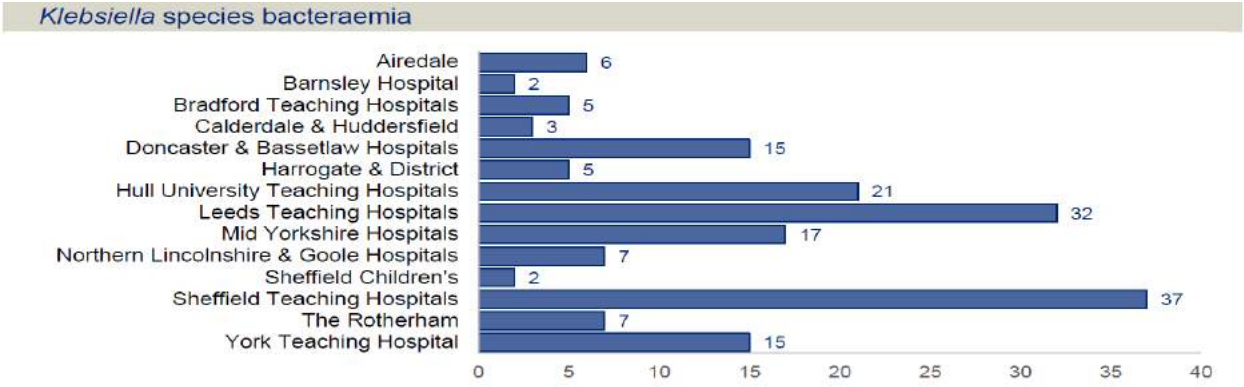
For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England require NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and *Pseudomonas aeruginosa*. This is to support the government initiative to reduce Gram-negative bloodstream infections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

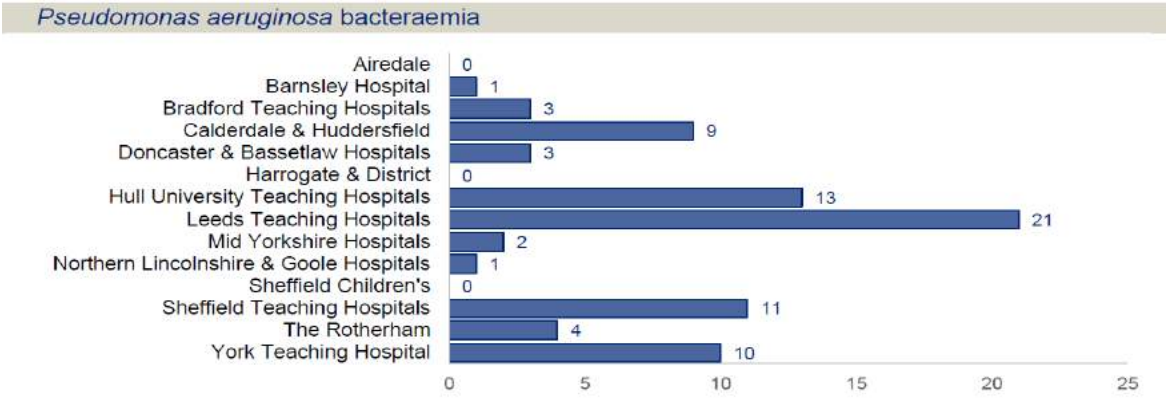
Review of cases to date suggests similar risk factors as those found with *E.coli* bacteraemia, with both Klebsiella and *Pseudomonas aeruginosa* associated with respiratory and urinary infections.



	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	2	4	4						
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	2	0	2						

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 September 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.

Infection Outbreaks during August & September 2019

No outbreaks of diarrhoea and vomiting reported during August 2019, resulting in bed/ward closures.

On the 4th September 2019 a bay was closed on AMU with patients affected by diarrhoea and vomiting. The bay was reopened once the patients were isolated and the bay was cleaned appropriately by the Cleaning Action Team. One staff member was affected but no causative organism was identified.

Infection incident

Pseudomonas aeruginosa in NICU

During August and September 2019, the screening of babies for Pseudomonas aeruginosa has continued on the Neonatal Intensive Care Unit (NICU). These take place on admission and on a weekly basis thereafter.

A further colonised case was detected during September 2019 from a weekly screening sample but no bacteraemia cases have been identified since August 2018. To date, there is no evidence to suggest person to person transmission but some strains have been identified from babies nursed on the unit but at separate dates/times, often months apart suggesting a

possible environmental source but none found to date. Colonised cases represent commonly found strains both in humans and the environment so it is difficult to illicit clinical relevance. Water sampling across the unit yielded no positive results, apart from a shower which has since been removed. Incident meetings have been held at regular intervals with Public Health England involvement. All cases with additional data has been supplied to PHE so additional epidemiology studies can be undertaken to determine trends.

A pilot of a novel cleaning agent used to clean and decontaminate hand wash basins was undertaken during August 2019 for two weeks, following a period of staff training. Pre and post pilot sampling was undertaken which demonstrated a 50% reduction in the presence of Pseudomonas aeruginosa in the hand wash basins. A further meeting has been held with the company with a scope to pilot the product for a longer period (6 months) and assess the impact on both the environment and neonatal screening. Further updates will be provided in future reports.

Legionnaires Disease

During August 2019, two cases of Legionnaires Disease were detected in patients admitted to the Trust. One community apportioned case, responded extremely well to treatment and was discharged from HAAU within 48 hours and is being followed by Public Health England (PHE). The second case not thought to be linked to the first and again community apportioned in origin, was admitted on the 28th July 2019 and detected with Legionella on the 3rd August 2019. The patient had a history of respiratory infections for 3 months prior to the admission and had risk factors associated with contact with vaporised/ aerosolised water in the incubation period. Again this case is being investigated by PHE.

Both cases, especially the latter case, have served as a reminder to medical, nursing & estates staff of the propensity of Legionnaires Disease to affect patients and the importance of measures taken in the Trust to mitigate risks such as flushing little used outlets and also regular water sampling and remedial action when Legionella species is detected in the water supply. Focus on improving assurance regarding flushing little used outlets is required and discussed at the Water Safety Committee, in additional a recurring agenda item has been added to the Infection Reduction Committee to ensure water safety remains a priority to the Health Groups and the Board and tabled monthly to provide assurance.

During September 2019, a further case of Legionnaires Disease was detected in a patient admitted to the Trust. Following investigation it was deemed the case was community acquired and the patient had previous recent travel history which is being followed up by PHE. No links to the two previously reported cases were identified during the investigation.

Other Points of Interest

Winter Planning

Since August 2019, the DIPC and IPCT have played an active part in winter planning, attending the Winter Planning Group meetings and ensuring staff are prepared to deal with the challenges faced at this time of year, especially with respect to Norovirus and Influenza. Working closely with the Head of Emergency Planning to ensure key messages are clear and concise both for staff and our patients.

Device Management Campaign

As an action of the Device Task, Challenge & Finish Group, the Infection Prevention & Control team will be launching a device management campaign during October 2019 to tackle the issue of invasive devices which patients have inserted by doctors, nurses and

AHPs across the Trust. Linking in with NHS Wales who have kindly provided their 1000Lives campaign material, we have been able to replicate the posters and thank our Welsh colleagues at the same time. Posters will be displayed in public and clinical areas with a version for patients to empower them to challenge clinical staff on whether an invasive device is required and a version for staff to remind them of the importance of prompt removal and safe ongoing management.

In addition, care bundles for central venous devices will be launched along with documentary evidence of staff across the Trust who are competent to insert and also those who are competent to care for patients post insertion of a central venous device.

Further information will be shared in future reports.

Gram-negative Bloodstream Infection (GNBSI) ambition

The ambition to reduce GNBSI by 50% by March 2024 is a complex challenge with more than 50% of infections occurring in people outside of hospital settings, Achieving this ambition will require strategic executive oversight and leadership to implement a cross system agenda that is collaborative and inclusive of both health and social care. During July 2019, NHS England and NHS Improvement wrote to Chief Executives and key leaders both in Clinical Commissioning Groups and Acute Trusts, requesting that a senior responsible officer (SRO) be nominated who would represent the sustainability and transformation partnership (STP) for our area. Beverley Geary has been nominated to be the SRO for Humber, Coast and Vale STP. The Chief Nurse and the Director of Infection Prevention & Control will be attending a meeting organised by NHS England and NHS improvements, bringing together healthcare leaders in the North East.

Internal measures include quality improvement projects which will be aimed at the Emergency Department, AMU and Elderly Medicine to improve the assessment and treatment of patients with urinary tract infections (UTI's), in line with the latest CQUIN.

Further reports on both measures and Trust plans to reduce the burden of GNBSIs will be discussed at subsequent Trust Board meetings.

Hull University Teaching Hospitals NHS Trust

Trust Board

November 2019

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

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Patient Experience Report

1. Purpose of the report

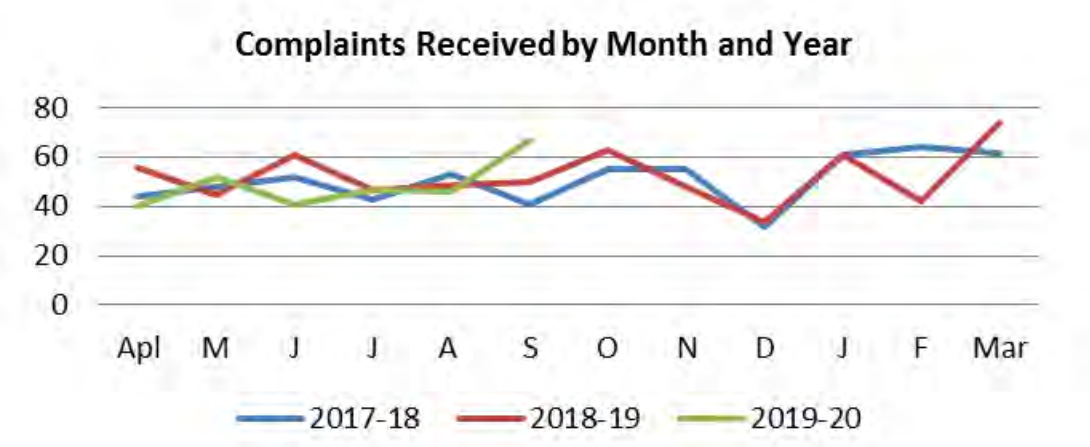
This report aims to provide an overview of the feedback from the Patient Experience and Engagement Department which involves Complaints, Pals, PHSO, Friends and Family Test, Volunteers, Patient Council and National Surveys.

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

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

5. PATIENT EXPERIENCE

The following graph sets out comparative complaints data from 2017 to date. There were 47 new complaints in the month of July 2019, 48 in the month of August 2019 and 67 in the month of September 2019. September saw a steep rise in the number of complaints received relative to previous months (47 in July and 48 in August). However, the complaints are not reflective of activity in the month received and can often be about episodes of care several months, or even years previously.



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

Complaints Received by Health Group and Subject – July, August and September 2019

Complaints by Health Group and Subject (primary)	Month	Advice	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	July	0	0	0	0	1	0	0	0	0	0	0	1
	August	0	0	0	0	0	0	0	0	0	0	0	0
	September	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Support	July	0	1	1	0	1	0	0	0	0	0	0	3
	August	0	0	0	0	0	0	0	0	0	0	2	2
	September	0	0	1	0	0	1	0	0	1	0	3	6
Emergency & Acute	July	0	0	0	0	0	0	0	1	0	0	5	6
	August	0	0	0	0	0	0	0	0	0	0	3	3
	September	0	0	1	0	0	1	0	0	1	0	3	6
Family and Women's	July	0	1	1	1	0	0	1	0	0	0	10	14

	August	0	0	1	1	1	0	0	0	0	0	5	8
	September	0	4	0	0	1	0	0	0	0	1	10	16
Medicine	July	1	0	2	2	2	2	0	0	0	0	4	13
	August	1	0	3	3	0	0	0	0	1	0	6	14
	September	0	5	9	1	0	2	0	0	0	0	6	23
Surgery	July	0	0	1	1	3	0	0	0	0	0	5	10
	August	0	1	2	2	2	1	0	0	0	0	13	21
	September	0	0	2	0	1	0	0	0	0	0	10	13
Totals:	July	1	2	5	4	7	2	1	1	0	0	24	47
	August	1	1	6	6	3	1	0	0	1	0	29	48
	September	0	9	12	1	2	4	0	0	1	1	37	67

September saw an increase in the number of complaints received, with the greater numbers being attitude (9), care and comfort (12) and treatment (37). Complaints regarding treatment remain the highest recorded category across all months. The Patient Experience Team continues to work with all Health Groups to highlight themes and trends and to ensure a timely response to complainants.

5.1 Examples of outcomes from complaints closed during July, August and September 2019:

- A baby was born by elective caesarean and the mother felt that checks were not undertaken adequately at birth and a fracture above the baby's elbow missed, resulting in pain and incorrect treatment.

Outcome – A review of the 'flow chart for management of brachial plexus injury' was undertaken with the creation of a guideline for the management of new born infants where brachial plexus injury is suspected. This has been shared with obstetric and general paediatric colleagues. The creation of a patient information leaflet for safety netting advice for possible delayed symptoms following shoulder dystocia or brachial plexus injury will be developed.

- Father of a young patient wanted to know why his son was wrongly diagnosed, which resulted in surgery with a large scar.

Outcome – The patient's symptoms were indicative of appendicitis, however when examined in theatre, it was clear this was not the cause of the problem and therefore was not removed. The cause of the bleeding could not be identified and therefore, once the patient was stable and following discussion with colleagues in Leeds, he was transferred to Leeds with all the information gathered from the investigations undertaken at this hospital so that consultants at Leeds who had previous knowledge of similar cases could quickly diagnose and treat the patient for pancreatitis immediately on arrival.

- A patient felt she had been incorrectly diagnosed after an X-ray of her wrist following an accident.

Outcome - Scaphoid injuries can be very difficult to diagnose in the first few days after the injury because imaging of the wrist is often normal until up to ten days post-injury. Clinical examination did suspect that a bony injury may have occurred and was therefore treated with a wrist splint which was entirely reasonable. The patient was referred to the Fracture Clinic for further management.

5.1.2 Performance against the 40-working day complaint response standard

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

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%	58.5%	72.5%	70.7%						

The following tables indicate performance by Health Group and the outcome of the complaint for the months of July - September 2019.

July 2019	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened	Dis-satisfied

Corporate Functions	0	0	0	0	0	0	0	0
Clinical Support	3	2 (66.6%)	1	1	1	0	1	1
Emergency & Acute Med	3	1 (33.3%)	1	2	0	1	2	2
Family and Women's	8	5 (62.5%)	2	3	3	1	1	1
Medicine	18	11 (61.1%)	2	16	0	0	1	1
Surgery	9	5 (55.5%)	2	5	2	2	1	1
Totals:	41	24 (58.5%)	8	27	6	3	6	6

August 2019	**N° Closed**	**Within 40 days**	**Upheld**	**Partly Upheld**	**Not Upheld**	**Not Investigated**	**Re-opened**	**Dis-satisfied**
Corporate Functions	0	0	0	0	0	0	0	0
Clinical Support	4	3 (75%)	0	4	0	0	1	1
Emergency & Acute Med	4	4 (100%)	1	1	2	0	1	1
Family and Women's	9	6 (66.6%)	2	5	2	0	1	1
Medicine	12	11 (91.6%)	1	10	1	2	1	0
Surgery	11	5 (45.45%)	3	6	2	1	1	1
Totals:	40	29 (72.5%)	7	26	6	2	5	4

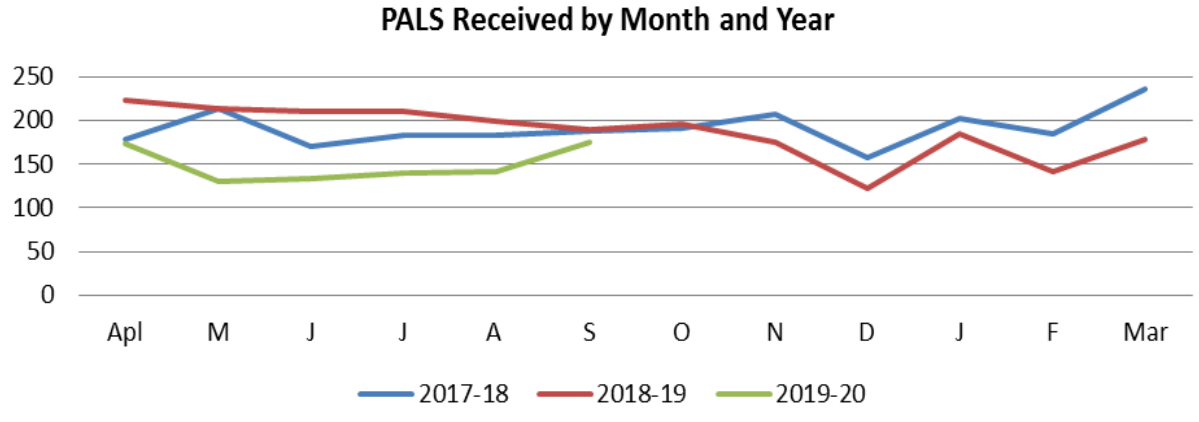
September 2019	**N° Closed**	**Within 40 days**	**Upheld**	**Partly Upheld**	**Not Upheld**	**Not Investigated**	**Re-opened**	**Dis-satisfied**
Corporate Functions	0	0	0	0	0	0	0	0
Clinical Support	2	2 (100%)	0	2	0	0	0	0
Emergency & Acute Med	4	3 (75%)	0	4	0	0	0	0
Family and Women's	8	4 (50%)	2	3	3	1	1	1
Medicine	13	10 (77%)	5	7	1	2	1	1
Surgery	14	10 (71%)	11	3	0	1	1	1
Totals:	45	29 (70.73%)	17	19	4	4	3	3

As can be seen from the previous tables, performance is variable across the health groups, with all health groups struggling to achieve 100% of complaints closed within 40 days. This will be managed through the monthly performance and accountability meetings with Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

As with complaints received, September saw an increased in the number of contacts with the PALS team. There were 12 compliments, 127 concerns, 3 comments and 32 requests for general advice in July. In August 2019, PALS received 1 comment/ suggestion, 11 compliments, 141 concerns and 21 requests for general advice. In the month of September 4 comments, 15 compliments, 175 concerns and 19 contacts for general advice were received. The PALS team also receive many calls each day for general signposting and information that is not included in these statistics. This information has been shared with the Health Groups in order that they can review and consider any actions that are necessary.

The following graph illustrates that the number of concerns received by PALS had decreased in February but increased in the month of March, as was the case with formal complaints. This increase is in line with previous years' activity for the same period.



The following table indicates that Delays, Waiting times and Cancellations continues to be the highest subject received by PALS. In the month of July, 21 concerns were regarding the length of time a patient had been waiting for an outpatient appointment. 25 patients contacted PALS in August indicating they were not satisfied with the treatment plan in place. 43 in September reported they had waited longer than expected for an outpatient appointment.

PALS by Health Group and Subject (primary)	Month	General Advice	Attitude	Care and Comfort	Communica-tion	Delay, Waiting Times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	July	1	3	0	3	2	0	2	1	0	0	0	12
	August	4	2	0	2	0	0	1	3	0	0	1	13
	September	1	2	0	3	1	0	1	3	0	0	0	11
Clinical Support	July	0	2	0	0	7	0	0	0	0	0	3	12
	August	0	0	0	2	3	0	0	1	0	0	1	7
	September	0	1	0	0	12	3	0	1	0	0	3	20
Emergency & Acute	July	1	1	0	0	1	3	1	0	0	0	3	10
	August	0	0	0	0	0	0	0	0	0	0	4	4
	September	2	2	0	1	2	0	0	0	0	0	3	10
Family and Women's	July	2	4	0	5	21	0	0	0	0	0	8	40
	August	0	1	0	5	29	1	0	0	0	0	6	42
	September	3	8	1	4	31	0	0	0	0	0	3	50
Medicine	July	4	3	0	3	8	4	0	1	0	0	3	26
	August	5	3	1	6	9	2	0	1	0	0	9	36
	September	3	3	2	3	18	3	0	0	0	0	2	34
Surgery	July	6	5	1	5	18	0	0	0	0	0	12	47
	August	3	2	2	5	14	0	1	0	0	0	12	39
	September	2	7	0	3	29	3	0	0	0	0	6	50
Totals:	July	14	18	1	16	57	7	3	2	0	0	29	147
	August	12	8	3	20	55	3	2	5	0	0	33	141
	September	11	23	3	14	93	9	1	4	0	0	17	175

5.2.1 Examples of outcomes from PALS contacts:

- The sister of a patient had a number of concerns regarding the care and attention the patient has received since admission. She had been transferred form Scunthorpe DG Hospital on Friday 14 June.
  Outcome - PALS visited the patient on the ward and discussed her concerns. The PALS Officer met with the Ward Manager who agreed to monitor the care and attention and inform the patient as soon as the planned nerve root block procedure could go ahead. This had been delayed as the patient had a blood clot in her leg that has been present during her stay at Scunthorpe DG. Patient was reassured that she was being cared for in the most appropriate way.
- The patient had some concerns over the lack of prompt requests for pain relief; had not seen a doctor for two days after her operation and she felt some staff were dismissive and lacked compassion. In contrast some staff were indeed excellent in all respects.
  Outcome - PALS discussed the patient's concerns with the Ward Sister who met with the patient in order to learn of her experience and address this with members of staff in order to ensure best practice was undertaken to ensure quality care for all patients.

5.2.2 Compliments

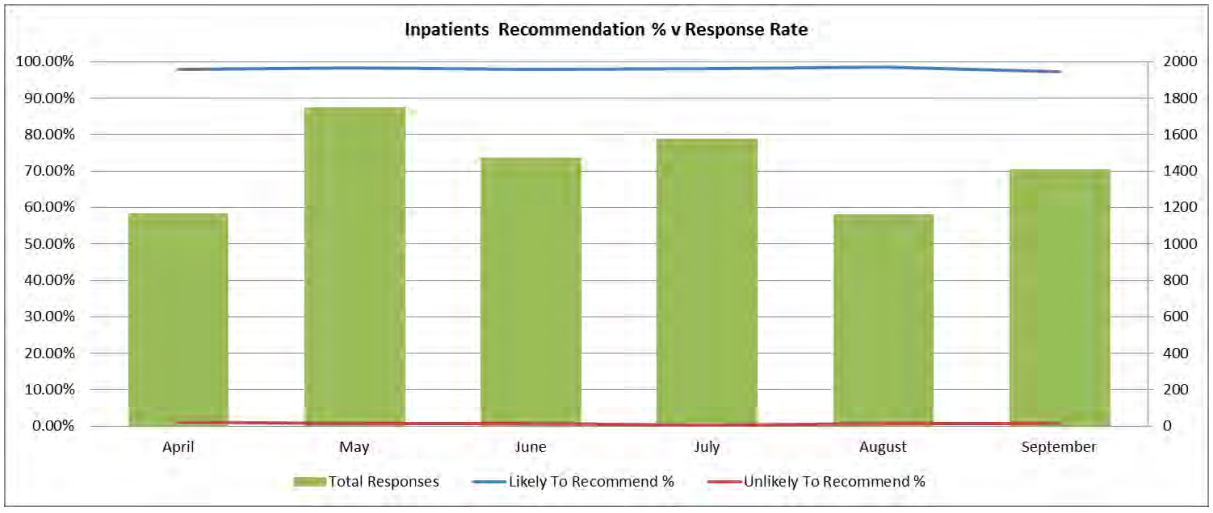
- I visited the mortuary at Hull Royal Infirmary on Friday 28 June to view my recently deceased father. I just wanted to say how well thought out the viewing area was, it

made the experience a lot easier and the note cards are a really nice touch. The way that the deceased are presented too was really comforting; I had expected a clinical steel bed and white sheets. The staff members we met were so kind and it was so reassuring to get immediate answers to my questions. It's obvious how much care and pride they take in their work. I'm sorry if this email is a bit strange, the experience of visiting the mortuary was the complete opposite of what I expected, so I just wanted to say you're doing a great job.

- My mother was recently admitted on 22 July with a broken hip. She had an operation on 24 July and was discharged on 1 August. She spent this time in Ward 12. I think this treatment deserves credit. I did not think Mum would survive the operation. She clearly received the best of care.
- Whilst she was in hospital we managed to get through to the ward by phone much more easily than in the past. The discharge nurse, Hannah, was especially helpful. I had occasion to ring her earlier this week and phone was immediately picked up by the ward clerk. That represents a change from previous experience.
- Thank you so much to all staff in the MRI department (particularly nurse Julie) who helped me overcome mobility issues to have a breast scan yesterday. I had already tried once and been sent home as I was unable to get onto the table. Yesterday Julie and the team ensured that I was able to have my scan and throughout it all they showed a fantastic level of sensitivity, professionalism and humour. I was so anxious beforehand but am so relieved now. Thank you to everyone involved.

5.3 Friends and Family Test (FFT)

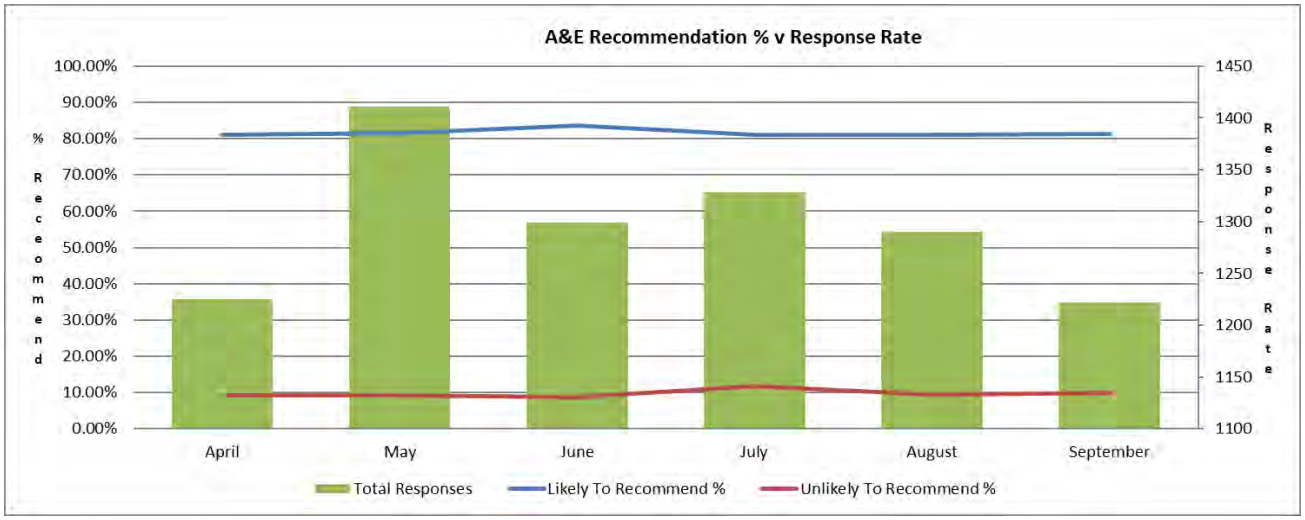
The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for September with 4,674 compared to July 2019 when 5,897 were received. The September 2019 inpatient results indicate that **97.23%** were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set target of **95%**. This is positive news for the Trust and its staff. The Patient Experience Team is working with wards to collect patient feedback daily.



5.3.1 The Friends and Family Test 2020

New developments for the Friends and Family Test will start to emerge by April 2020.
This will include less focus on the response rate and more focus on "why is it you said that?" and more thought given on "what was your overall experience?".
There will be more time to respond for patients within the Maternity Services and a new set of questions to be asked.

5.3.2 Emergency Department - 1,222 patients who attended the Emergency Department in September 2019 responded to the Friends and Family test with 81.34% of patients giving positive feedback.



5.4 Parliamentary and Health Service Ombudsman (PHSO)

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

The Trust has 8 cases with the PHSO currently. During the month of July, August and September 2 new cases were opened and 2 cases was closed, which was not upheld.

5.5 Volunteer Service

The Patient Experience Team is busy recruiting volunteers which will have a positive impact on patient experience. A large cohort will be trained as dining companions, it is hoped that this will improve the experience and timeliness of meal times.

5.6. Young Health Champions

The Patient Experience Department are again working in partnership with all of the schools and colleges across the city. Encouraging the youth of Hull and East riding to volunteer at the Trust and think about health care as a career. Successful programmes such as Young Medical Scholars has given a spring board and insight into those applying for medical schools. Between the months of July, August and September there has been two volunteers on the Young Health Champion Programme gaining apprenticeships at the Trust.

NHS England has connected with the Lead of the Voluntary Services to engage further with more diverse and hard to reach groups of the community and encourage them to apply for volunteering to create more opportunities for a career in Health Care.

5.7 Patient and Public Council

Recruitment is now underway for new Patient Council Members. The Council have been busy attending PLACE visits in the Trust which significantly supports the Patient Experience Agenda.

Hull University Teaching Hospitals NHS Trust

Trust Board
November 2019

Title:	Nursing and Midwifery (SAFE) Staffing Report – November 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
November 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 September 2019 (August 2019 and September 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.

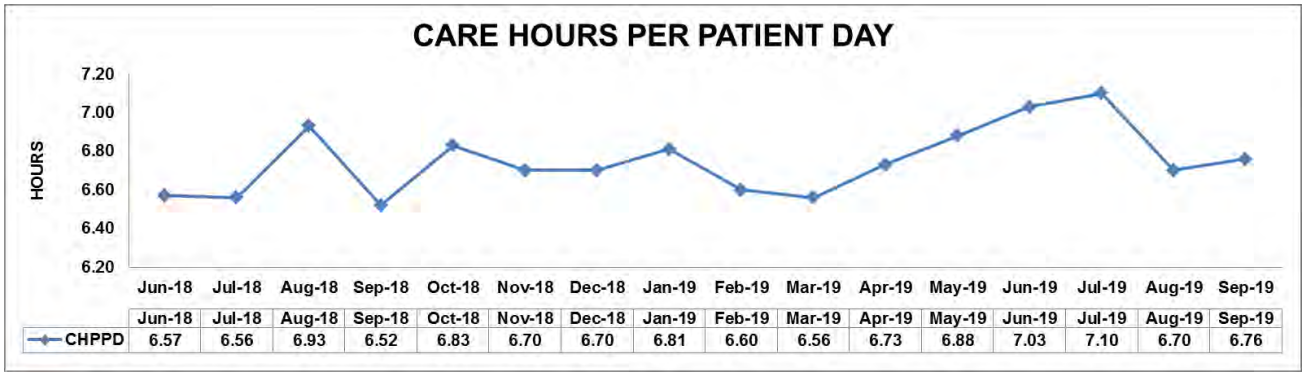
This report presents the 'safer staffing' positions for August and September 2019 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staffing.

[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*
[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing
[3] NHS Improvement (June 2018) Care hours Per patient Day (CHPPD) Guidance for acute and acute specialist trusts
[4] An independent report for the Department of Health by Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

3. CARE HOURS PER PATIENT DAY

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

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



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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	7.03	7.10	6.70	6.76

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. As illustrated in the above table despite the CHPPD improving in previous months, there has been a drop in August (CHPPD 6.70) and September (CHPPD 6.76).Initial analysis indicates that the reduction is related to the fill rates of both registered nurses (RN) and non-registered nurses. The number of RN vacancies has risen from 143.16 (8.0%) reported for July 2019 to 157.03 (8.7%). Overall unavailability of both registered and non-registered nurses was 0.5% higher in September compared to July 2019.

(Please note that the number vacancies reported to the Trust Board for July 2019 were correct however, there was a miscalculation with regards to percentages, this has now been corrected and resubmitted).

The Trust still remains in the lower 25th Quartile as indicated through the Model Hospital Metrics, with a peer median of 8.8 CHPPD and national median 8.2 CHPPD (July 2019 data). With regards to the Quality and Safety metrics the Trust continues to perform well against both peers and national performance.

4. PROFESSIONAL STAFFING SAFETY RISK ASSESSMENTS

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

- Establishment levels
- Vacancy rates, sickness and absence levels
- Patient acuity
- Skill mix (level of experience of the nursing/midwifery staff)
- Mitigation (other roles, additional support, other professionals, variable pay)
- Level of bed occupancy

- Care hours per patient day (CHPPD)
- Leadership – quality and consistency
- Team dynamics
- Ward systems and process

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

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

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

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

Appendix One provides the Nursing Staffing Key metrics for August 2019.
Appendix Two provides the Nursing Staffing Key metrics for September 2019.
Appendix Three provides the Nurse Staffing Quality Indicators for October 2019.
Appendix Four provides the definitions of CHPPD.
Appendix Five provides the Nursing and Midwifery Establishment Review Summary.

The following tables take all of these metrics into consideration and show the current 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 – August to September 2019

The following vacancy numbers presented by each of the Nurse Directors reflect the appointment of the newly Registered Nurses. All other unavailability is illustrated in appendices 1 and 2.

4.1 4 Clinical Support Health Group

Ward	Professional Risk Assessment	Rationale for risk rating	Actions	Number of R/N vacancies following appointment of new recruits.
C7	**Low**	Not triggering any quality indicators and no staffing issues so deemed to be safely staffed		0 RN vacancies
C29	**Low**	Not triggering any quality indicators and deemed to be safely staffed	The B7 Sister is leaving and the post currently being recruited to.	0 RN vacancies
C30	**Low**	No vacancies with the new registrants commencing in role. Not triggering any quality indicators and deemed to be safely staffed	We are currently increasing the number of inpatient beds on C30 whilst reducing the size of C31 so next months' risk assessment will reflect these changes.	0 RN vacancies
C31	**Medium**	Some quality indicators are triggering, complaints, SI and staff morale. There are concerns and further support for the ward team and leaders being implemented.	Over recruited to non-registered posts to support. Utilising bank/agency & 5 beds closed where possible due to staffing. The support from pilot bank and the CNS has now ceased but we continue to move staff within the unit to support. Due to the concerns and desire	2.08 wte RN vacancies – (12%)

			to share the burden of the staffing challenges, we are currently increasing the number of inpatient beds on C30 whilst reducing the size of C31 so next months' risk assessment will reflect these changes	
C32	**Medium**	No quality indicators are triggering	Utilising bank and agency, support from other inpatient wards	1.27 wte RN vacancies (9%)
C33	**Medium**	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	2.89 wte RN vacancies (11%)

4.1.1 Medicine Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk assessment	Actions	Number of vacancies following appointment of new recruits
AMU	**LOW**	No staffing related quality concerns	Staff support from H36 on rotation, support from nurse bank.	4.19 RN vacancies (9%)
EAU	**LOW**	No staffing related quality concerns		1.22 RN vacancies (6%)
H36	**LOW**	No staffing related quality concerns		Over recruited 0.95 wte RN (7%)
H5/ RHoB	**LOW**	No staffing related quality concerns	Staff continue to be flexed across the fifth floor as required following reviews by Senior Matron.	2.59 RN vacancies (11%)
H50	**LOW**	No staffing related quality concerns		1.73 wte RN vacancies (12%)
H500	**LOW**	No staffing related quality concerns.		0 RN vacancies
H10	**LOW**	This ward has required a high presence from the Senior Matron to support the ward and focus on quality concerns. Now an improving picture	Utilising some agency and bank. RN pool nurses allocated for continuation and stability. B6s and B7 staff providing weekend cover.	5.65 wte RN vacancies – (26%)

H8	**LOW**	No staffing related quality concerns		1.72 RN vacancies (10%)
H9	**LOW**	No staffing related quality concerns	Additional non-registered staff in post. Skill mix is improved. Nurse Associate now in post	3.47 wte RN vacancies – (21%)
PDU (H80)	**LOW**	This ward requires a high presence from the Senior Matron to support the ward focus on quality concerns.	Nutrition fundamental remains in the red, action plan in place, but has improved slightly.	0.99 wte. RN vacancies (8%)
H90	**LOW**	No staffing related quality concerns		3.13 wte. RN vacancies (19%)
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. Additional non-registered nurses being recruited to support Registered nurse workforce. Two international nurses allocated to ward. Additional band 6 recruited to provide senior support at weekends and out of hours. Further establishment revision in progress to assess additional requirements.	5.09 wte RN vacancies – (24%)
H110	**LOW**	No staffing related quality concerns		5.62 wte RN vacancies (21%)
CDU	**LOW**	No staffing related quality concerns		1.02 wte RN vacancies (8%)
C26	**LOW**	No staffing related quality concerns	Staff will be flexed to support vacancies elsewhere in Health Group.	Over established by 3.62 RN`s (15%)
C28/ CMU	**LOW**	No staffing related quality concerns	.	1.91 RN vacancies (5%)

4.1.2 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions	Number of vacancies following appointment of new recruits
H4	**LOW**	No staffing related quality concerns, however high demand for neuro / spinal capacity	Use of bank when appropriate and Matron supporting with daily reviews.	0 wte RN vacancies
H40	**MEDIUM**	No staffing related quality concerns, however increasing demand for major trauma capacity	Using Bank, Agency and support from ICU to ensure appropriate skill mix as patient acuity very high. Ward requires high level of support from Senior Matron	0.8 wte. RN vacancy (4%)
H6	**LOW**	No staffing related quality concerns		0 RN wte vacancies
H60	**LOW**	No staffing related quality concerns		0 RN vacancies
H7	**LOW**	No staffing related quality concerns		0 RN vacancies
H100	**LOW**	No staffing related quality concerns		1.0 wte. RN vacancy (5%)
H12	**LOW**	No staffing related quality concerns		2 RN wte vacancies (9%)
H120	**MEDIUM**	No staffing related quality concerns	Ward requires high level of support from Senior Matron due to Mat leave and new starters.	0.57 RN wte, vacancy (3%)
HICU	**LOW**	No staffing related quality concerns	ICU staff work across sites to provide appropriate cover. Support from agencies required occasionally when unit has high number of level 3 beds.	5 RN wte. vacancies (5%)
C9	**LOW**	No staffing related quality concerns		0.45 RN wte. vacancy (2%)
C10	**LOW**	No staffing related quality concerns		0 RN vacancies
C11	**MEDIUM**	No staffing related quality concerns	Ward requires high level of support from Senior Matron. RN support from C10 and bank and agency.	5.25 RN wte vacancies (26%)

C14	**MEDIUM**	staffing related quality concerns raised with increased infection rates	Ward has high acuity. Support provided by ban/agency and matron provides a high level of support. Work progressing to identify if further HOB capacity is required on the ward.	2.0 RN wte vacancies (10%)
C15	**MEDIUM**	No staffing related quality concerns.	, Ward still requiring high level of support from senior Matron due to 5 new starters and maternity leave. Outcomes for the ward are continuing to improve	0 wte RN vacancies
C27	**LOW**	No staffing related quality Concerns	.	3 RN wte vacancies (13%)
CICU	**LOW**	Not triggering any quality concerns	. ICU staff work across sites to provide appropriate cover. Support from agencies required occasionally when unit has high number of level 3 beds.	6 RN wte vacancies (7%)

4.1.1 Family and Women's Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions	Number of vacancies following appointment of new recruits
C16	**MEDIUM**	Whilst there are no identified staffing related quality concerns flagged at present.	Senior Matron monitoring staffing and patient acuity. Utilising bank and agency when required.	5.34wte vacancy (29%)
H130	**MEDIUM**	There are no identified staffing related quality concerns flagged at present, there are a 3.61wte staff on Maternity leave.	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. Recruitment into 50% of Maternity leave. New recruits have commenced in post and are waiting for PIN numbers. They are currently working in a supernumerary capacity.	2.02wte vacancy (10%)
Cedar H30	**LOW**	No staffing related quality concerns	Utilising bank and agency on occasion.	0 vacancies
Maple H31	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime. New recruits are due to commence in post.	0 vacancies
Rowan H33	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime. New recruits are due to commence in post.	0 vacancies
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.	0 vacancies
H35	**LOW**	No staffing related quality concerns	Utilising bank and agency when required.	0 vacancies

NICU	**MEDIUM**	Not triggering on quality issues, there are concerns with staffing.	Vacancies have been recruited to. New recruits have now commenced on post, but are waiting PIN numbers and will be on a 6 week intensive induction program. Bank and overtime are being utilised and flexing paediatric staff resources. Additional short term actions in place to minimise staffing shortfalls. Approach made to Agencies for short term contracts, and request to Chief Nurse/Deputy Chief Nurse to approve overtime pay levels for 3 months. Approval gained for short term only and to review.	4.64 wte vacancies (6%)
PAU	**MEDIUM**	Not triggering on quality issues, there is 1.64wte vacancy that impacts on a small team.	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.	1.64 wte RN vacancies (16%)
PHDU	**MEDIUM**	Although not triggering on quality issues, there is 0.7wte vacancy that impacts on a small team.	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.	0.7wte RN vacancies (6%)
Labour	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime. New recruits are due to commence in post. Birth rate plus review completed, but a need for further training on using the tool has been identified. .	0 vacancies

5. RECRUITMENT AND RETENTION

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

The Trust has successfully appointed:

- 129 adult branch nurses.
- 20 Midwives.
- 5 Child Branch.
- 10 ODPs.

All of whom have commenced employment with the Trust during September/October 2019; This is a combination of applicants from the University of Hull through the Trusts `direct interview campaign` and direct applications from other Universities via NHS Jobs and through the Trust's dedicated recruitment website.

In addition the Trust currently has 51 Trainee Nurse Associates, 22 Student Nurse Apprentices and 23 Health Care Support Worker Apprentices completing their training programmes, throughout 20/21.

The Trust has now deployed 60 nurses from the Philippines over a period of two years. 60 have successfully completed their OSCE, 10 new recruits are working towards completion of their OSCE in December 2019 (split between Endoscopy CHH/HRI & Theatres HRI). 8 more nurses are due to arrive in the UK during November 2019, of these 7 are allocated to Medicine and 1 for Surgery.

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

As reported to the Trust Board in July 2019, work continues to support existing international staff to obtain the qualifications they require to attain their NMC registration.

The impact of all of the above initiatives will be presented to the next Trust Board as part of the Nursing Workforce Modelling.

6. ENSURING SAFE STAFFING

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

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

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

7. RED FLAGS AS IDENTIFIED BY NICE (2014)

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

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

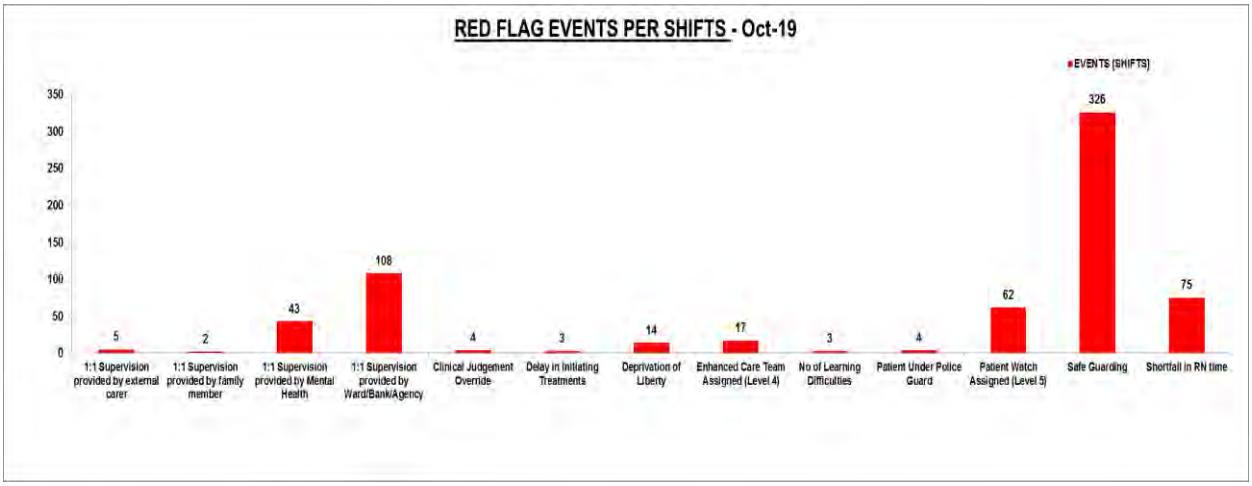
When a 'Red Flag' event occurs, it requires an immediate escalation response by the Registered Nurse in charge of the ward. The event is recorded in SafeCare and all appropriate actions to address them are recorded in SafeCare, which provides an audit trail. Actions may include the allocation or redeployment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

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

The 'red flags' suggested by NICE, are:

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

The following graph illustrates the number of 'Red Flags' identified during July 2019. The Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time in line with the digital roll out programme.



Sep-19	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	5	1%
	1:1 Supervision provided by family member	2	0%
	1:1 Supervision provided by Mental Health	43	6%
	1:1 Supervision provided by Ward/Bank/Agency	108	16%
	Clinical Judgement Override	4	1%
	Delay in Initiating Treatments	3	0%
	Deprivation of Liberty	14	2%
	Enhanced Care Team Assigned (Level 4)	17	3%
	No of Learning Difficulties	3	0%
	Patient Under Police Guard	4	1%
	Patient Watch Assigned (Level 5)	62	9%
	Safe Guarding	326	49%
	Shortfall in RN time	75	11%
	TOTAL:	666	100%

As illustrated earlier, the most frequently reported red flag that requires extra nursing time is related to the requirement for 1:1 supervision of some sort for patients. As indicated in the previous Board Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which is in the process of being established substantively following a successful trial. The ECT lead nurse post has been recruited into with a commencement date of the 4th November 2019. Recruitment of the non-registered workforce will commence November 2019, with an expected implementation date for the full ECT, January 2020. 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.

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 August and September 2019, for the maternity services.

8. TWICE YEARLY REVIEW OF NURSING AND MIDWIFERY (N&M) ESTABLISHMENTS

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

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

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

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

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

- Implementation of standardised shift patterns and break times.
- Rota adjustments to support staff members who require shorter shift patterns.

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

Summary Nursing Establishment review 2019/20			
Healthgroup	**Net RN change wte**	**Net HCA change wte**	**Net Support Staff change wte**
Surgery	0.00	0	0
Medicine	0.49	-0.38	0
ED	0.48	-0.23	0
Clinical Support	2.38	0.23	0
Family & Womens	0	0	0
Total	**3.35**	**-0.38**	**0**

The following table provides further details by health group.

Financial Impact £ (-ve figs = additional funding required)	**SHG**	**ED**	**MHG**	**CSS**	**F&Ws**	**Total**
RN (investment)/efficiency	0	(23,264)	(15,875)	(77,105)	0	**(116,244)**
B6 investment	0	0	(7,775)	0	0	**(7,775)**
Non-RN (investment)/efficiency	0	4,927	8,140	(4,927)	0	**8,140**
Support Staff (investment)/efficiency	0	0	0	0	0	**0**
(Investment) / efficiency	**0**	**(18,337)**	**(15,510)**	**(82,032)**	**0**	**(115,879)**
Funding available (sourced from within HG budgets)	**0**	**18,337**	**15,510**	**82,032**	**0**	**115,879**
Net (Investment) / efficiency	**0**	**0**	**0**	**0**	**0**	**0**

Narrative is provided in **Appendix Five**, justifying all establishment changes following the review.

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

For the purpose of this review and in line with the new CHPPD reporting requirement, an attempt has been made to calculate the planned CHPPD in relation to each rota, i.e. how

many care hours per patient per day can a ward expect when working at full establishment. The reason for this is that it then presents a baseline against which to measure actual performance. In addition, the required CHPPD, which is compiled from SafeCare has also been calculated and presented in **Appendix Five**. This is an initial attempt to gain greater clarity into what the current planned rotas provide and how this relates to actual patient acuity on a daily basis. As such, this is work in progress and will be developed over time and, therefore, should be heavily caveated at this time. This is because there are a number of factors that have the potential to alter the CHPPD significantly and, therefore, need further investigation and analysis. For example, if the patient acuity census is not completed in SafeCare on a given day, it will generate a CHPPD result of 0, this has the potential to significantly alter the `Required CHPPD`. In addition, the planned CHPPD as presented in appendix 5, is calculated on 100% and 85% bed occupancy at 23:59 7 days a week, which is not reflective of a number of clinical areas. It is therefore imperative that further work is completed over time to ensure that the data presented is factually correct.

As reported to the Trust Board in March 2019, following the last establishment reviews, the Maternity Services undertook an independent workforce review using Birthrate Plus® (BR+) methodology, (the validated tool used in midwifery) in June 2018. This is based upon an understanding of the total midwifery time required to care for women. It sets a minimum standard of providing one-to-one midwifery care throughout established labour, and including measurements across the whole maternity pathway. The principles underpinning the methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives. BR+ considers the case-mix of women over a three month period (July to September 2018). Following, receipt of the formal report (December 2018) the Maternity services are working to finalise a proposed clinical model.

9. RISK ASSESSMENT

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

10. SUMMARY

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

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
November 2019

Appendix One: Nurse Staffing Key Metrics – August 2019
Appendix Two: Nurse Staffing Key Metrics – September 2019
Appendix Three: Nurse Staffing Quality Indicators – October 2019
Appendix Four: CHPPD Description, Methodology, Benefits and Limitations
Appendix Five: Nursing and Midwifery Establishment Review Summary.

APPENDIX FOUR - CHPPD Description, Methodology, Benefits and Limitations

What is Care Hours Per Patient Day (CHPPD)?

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

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

How is CHPPD calculated?

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

CHPPD is calculated, as follows:

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

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

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

Which staff are included?

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

Further anticipated benefits of using CHPPD

The guidance advises further that using CHPPD provides:

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

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

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

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

HEY NURSE STAFFING KEY METRICS DASHBOARD

Aug-19

KEY METRICS ROTA: 5th Jul 2019 - 1st Sep 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 M5]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN- Est. [WTE]	TEMPORARY STAFFING [5th Aug - 1st Sep]: 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	6.66	6.4%	3.74	17.1%	10.46	126.79	5.4%	5.2%	0.2%	86.6%	26.1%	4.9%	16.4%	1.6%	1.7%	0.3%	1.2%	60.0	48.0	0.4	0.0	0.4	13.4%	0.4%	85.3	96.3	11.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	1262	5041.4	2612.8	6.1	7.55	-1.48	7.31	-1.24	11.51	22.3%	3.51	12.5%	15.24	79.63	3.5%	3.2%	0.3%	37.5%	28.3%	3.6%	18.9%	0.0%	1.7%	0.0%	4.1%	34.0	31.0	0.2	0.0	0.2	9.7%	0.3%	184.1	213.1	29.0
	H36	GENERAL MEDICINE	24	LOW	399.0	670	1635.8	1358.5	4.5	7.55	-3.08	7.31	-2.84	5.82	42.6%	-0.30	-3.8%	5.95	21.59	5.5%	3.1%	2.4%	49.0%	26.2%	1.0%	19.0%	0.0%	1.5%	2.1%	2.6%	65.0	65.0	1.7	1.0	0.7	21.9%	2.9%	-149.8	191.3	341.0
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	618	1944.5	1896.5	6.2	6.94	-0.72	7.74	-1.52	3.50	18.3%	2.62	19.9%	6.30	32.27	28.1%	24.8%	3.3%	63.1%	28.7%	3.6%	14.2%	0.3%	0.6%	1.1%	8.9%	48.0	27.0	0.0	0.0	0.0	25.4%	-0.5%	-40.5	18.0	58.5
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	752	2805.0	1864.0	6.2	6.74	-0.53	6.38	-0.17	1.33	5.5%	-0.26	-2.0%	1.13	37.25	7.7%	6.3%	1.4%	30.5%	25.2%	4.2%	15.8%	0.4%	0.2%	4.6%	0.0%	25.0	21.0	0.7	0.6	0.1	18.8%	0.1%	153.5	207.5	54.0
	H50	NEPHROLOGY	19	LOW	283.5	576	1500.3	1073.8	4.5	7.23	-2.76	7.00	-2.53	3.52	23.7%	1.71	73.1%	5.47	17.20	0.7%	0.7%	0.0%	15.7%	26.4%	2.3%	18.4%	0.0%	0.4%	2.3%	3.0%	59.0	54.0	0.0	0.0	0.0	18.6%	-1.3%	-6.0	17.0	23.0
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	730	1892.0	1658.0	4.9	6.74	-1.88	6.38	-1.52	2.07	12.7%	-0.16	-1.2%	2.04	29.53	8.4%	7.7%	0.7%	61.7%	28.6%	5.3%	17.5%	0.0%	2.1%	0.0%	3.7%	26.0	21.0	0.0	0.0	0.0	21.1%	4.1%	48.3	70.5	22.3
	H10	GENERAL MEDICINE	30	MEDIUM	441.0	822	1891.7	2299.0	5.1	7.55	-2.45	7.31	-2.21	10.94	51.3%	-3.23	-24.5%	8.22	34.50	15.7%	11.6%	4.1%	50.4%	29.7%	8.5%	17.1%	2.9%	0.9%	0.3%	0.0%	32.0	31.0	0.3	0.1	0.2	25.0%	22.2%	77.5	178.5	101.0
	H8	GERIATRIC MEDICINE	27	LOW	220.5	820	1712.7	1971.8	4.5	6.94	-2.45	6.74	-2.25	2.95	18.0%	-1.92	-14.6%	1.21	29.53	1.8%	1.8%	0.0%	32.3%	27.5%	4.2%	17.5%	0.6%	1.8%	0.2%	3.2%	75.0	74.0	0.0	0.0	0.0	19.4%	-1.6%	41.5	69.5	28.0
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	560	1433.8	2729.0	7.4	6.94	0.49	6.74	0.69	2.49	22.8%	-1.35	-8.5%	1.37	26.82	12.5%	6.9%	5.6%	70.3%	39.7%	8.7%	22.7%	2.2%	0.3%	2.9%	2.9%	34.0	34.0	0.4	0.3	0.1	14.8%	1.3%	154.5	177.5	23.0
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	918	1792.8	2090.7	4.2	6.94	-2.71	6.74	-2.51	20.67	126.3%	12.57	80.3%	34.50	32.03	3.0%	2.1%	0.9%	29.4%	28.7%	5.9%	21.5%	0.0%	1.1%	0.2%	0.0%	59.0	56.0	0.2	0.1	0.1	15.0%	2.0%	-19.3	55.0	74.3
	H90	GERIATRIC MEDICINE	29	LOW	252.0	885	1673.9	1775.8	3.9	6.94	-3.04	6.74	-2.84	-9.73	-59.4%	-15.80	-120.1%	-26.12	29.53	2.1%	2.1%	0.0%	77.8%	34.6%	11.0%	21.7%	0.3%	1.6%	0.0%	0.0%	116.0	74.0	0.0	0.0	0.0	29.8%	1.0%	39.0	59.0	20.0
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	852	1716.3	2212.0	4.6	7.55	-2.94	7.41	-2.80	6.58	30.5%	-3.37	-32.3%	3.51	32.03	3.1%	2.5%	0.6%	21.5%	30.5%	0.4%	16.1%	3.2%	1.6%	3.8%	5.4%	38.0	23.0	0.2	0.1	0.1	12.3%	1.6%	104.0	128.0	24.0
	H110	STROKE / NEUROLOGY	24	LOW	252.0	617	2301.0	2268.7	7.4	7.55	-0.14	7.41	0.00	7.49	27.5%	-2.84	-27.2%	4.92	37.72	11.5%	11.3%	0.2%	40.8%	34.7%	13.8%	14.1%	0.5%	1.3%	0.5%	4.5%	25.0	24.0	0.1	0.1	0.0	22.0%	3.5%	144.5	277.3	132.8
	CDU	CARDIOLOGY	9	LOW	0.0	65	860.3	77.5	14.4	7.93	6.50	7.73	6.70	0.82	6.4%	0.49	20.1%	1.37	15.25	0.0%	0.0%	0.0%	0.0%	39.8%	5.3%	20.3%	4.2%	0.6%	1.9%	7.5%	52.0	5.0	0.0	0.0	0.0	60.4%	1.1%	0.0	0.0	0.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	155	2703.0	1005.5	23.9	8.46	15.47	9.93	14.00	0.38	1.6%	-0.75	-9.5%	-0.35	32.03	2.0%	1.7%	0.3%	37.1%	31.9%	10.1%	19.8%	0.3%	1.7%	0.0%	0.0%	48.0	37.0	0.2	0.1	0.1	12.5%	3.2%	-13.5	24.0	37.5
	C28 /CMU	CARDIOLOGY	27	LOW	277.2	681	4043.8	1086.8	7.5	7.44	0.09	7.87	-0.34	8.69	22.9%	-1.01	-12.5%	7.91	46.04	0.3%	0.3%	0.0%	3.4%	29.9%	8.7%	18.2%	0.2%	2.1%	0.5%	0.2%	31.0	21.0	0.0	0.0	0.0	27.8%	2.6%	62.8	128.8	66.0
SURGERY	H4	NEUROSURGERY	28	MEDIUM	157.5	839	2348.5	1347.3	4.4	8.39	-3.98	8.71	-4.30	5.42	25.1%	1.27	12.2%	6.94	32.03	19.8%	19.8%	0.0%	58.6%	36.6%	12.8%	21.8%	0.0%	2.0%	0.0%	0.0%	41.0	41.0	0.5	0.5	0.0	21.0%	-2.7%	62.0	99.0	37.0
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	406	2754.0	1523.8	10.5	8.39	2.15	8.71	1.83	2.59	12.1%	-0.98	-10.5%	1.73	30.68	5.6%	4.5%	1.1%	26.7%	27.8%	4.6%	20.4%	0.7%	0.9%	0.1%	1.1%	53.0	46.0	0.5	0.5	0.0	18.8%	0.5%	361.5	367.5	6.0
	H6	GENERAL SURGERY	28	LOW	283.5	743	2287.1	1656.3	5.3	6.99	-1.68	7.26	-1.95	2.42	12.6%	1.28	10.9%	3.83	31.01	20.5%	20.2%	0.3%	60.6%	28.9%	2.5%	19.3%	1.8%	1.0%	0.4%	3.9%	62.0	56.0	0.0	0.0	0.0	14.8%	2.3%	36.5	58.5	22.0
	H60	GENERAL SURGERY	28	LOW	126.0	771	2211.8	1758.7	5.1	6.99	-1.84	7.26	-2.11	1.27	6.6%	2.42	20.5%	3.76	31.01	14.7%	13.9%	0.8%	57.8%	26.2%	2.9%	22.2%	0.0%	0.9%	0.2%	0.0%	55.0	55.0	0.1	0.0	0.1	13.2%	-0.4%	-24.8	46.0	70.8
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	860	2508.8	1731.8	4.9	6.99	-2.06	7.26	-2.33	5.07	21.1%	-1.08	-10.1%	4.20	34.76	9.3%	8.5%	0.8%	39.7%	25.2%	1.5%	14.8%	0.0%	0.8%	0.2%	7.9%	58.0	56.0	0.2	0.1	0.1	15.7%	-4.1%	17.5	47.5	30.0
	H100	GASTROENTEROLOGY	27	LOW	239.4	822	2178.3	1670.5	4.7	6.63	-1.95	6.29	-1.61	2.44	12.4%	0.82	6.3%	3.38	32.68	8.4%	8.4%	0.0%	49.8%	28.5%	5.3%	18.6%	0.0%	1.3%	0.2%	3.1%	61.0	51.0	0.4	0.0	0.4	17.7%	2.4%	70.0	98.0	28.0
	H12	ORTHOPAEDIC	28	LOW	252.0	601	2389.1	1944.5	7.2	7.13	0.08	7.25	-0.04	2.47	11.4%	-0.03	-0.2%	2.55	34.75	11.0%	11.0%	0.0%	45.0%	32.6%	5.5%	17.1%	0.6%	0.3%	1.9%	7.2%	40.0	35.0	0.3	0.2	0.1	16.3%	1.8%	-15.3	32.0	47.3
	H120	ORTHO / MAXFAX	22	LOW	283.5	634	2028.7	1484.9	5.5	7.13	-1.59	7.25	-1.71	0.68	4.2%	0.36	3.1%	1.08	28.17	11.8%	11.5%	0.3%	78.3%	30.6%	1.9%	14.3%	0.6%	1.0%	1.8%	11.0%	46.0	40.0	0.0	0.0	0.0	6.7%	1.1%	33.5	56.0	22.5
	HICU	CRITICAL CARE	22	LOW	252.0	418	9844.5	726.0	25.3	27.13	-1.84	26.60	-1.31	7.03	6.7%	0.00	0.0%	7.10	112.20	0.1%	0.1%	0.0%	20.0%	27.4%	5.1%	16.5%	0.2%	1.0%	1.4%	3.2%	67.0	55.0	0.1	0.1	0.0	22.5%	3.5%	-447.6	31.3	478.9
	C9	ORTHOPAEDIC	35	LOW	252.0	647	2280.0	1333.3	5.6	7.13	-1.55	7.25	-1.67	2.52	11.5%	1.81	14.0%	4.45	34.79	3.6%	3.6%	0.0%	21.4%	32.4%	11.2%	15.3%	0.0%	1.9%	1.1%	2.9%	39.0	38.0	0.1	0.1	0.0	22.7%	0.2%	-201.0	41.5	242.5
	C10	GENERAL SURGERY	21	LOW	252.0	465	2312.4	882.4	6.9	6.99	-0.12	7.26	-0.39	3.45	19.1%	1.06	13.2%	4.70	26.15	8.5%	8.5%	0.0%	44.8%	25.5%	4.5%	17.2%	1.0%	2.7%	0.1%	0.0%	54.0	52.0	0.1	0.1	0.0	13.6%	3.2%	8.0	155.0	147.0
	C11	GENERAL SURGERY	22	LOW	252.0	529	2257.9	969.5	6.1	6.99	-0.89	7.26	-1.16	3.54	17.2%	1.80	22.3%	5.51	28.61	4.3%	4.3%	0.0%	40.3%	21.2%	3.1%	16.9%	0.0%	0.9%	0.3%	0.0%	54.0	52.0	0.3	0.1	0.2	17.2%	4.8%	-132.5	87.0	219.5
	C14	GENERAL SURGERY	27	LOW	252.0	794	2574.5	1146.0	4.7	6.99	-2.30	7.26	-2.57	1.26	6.3%	-1.10	-11.3%	0.22	29.84	4.8%	4.5%	0.3%	59.5%	30.1%	2.5%	17.8%	0.2%	2.6%	1.1%	5.9%	52.0	51.0	0.2	0.1	0.1	11.4%	0.6%	111.5	125.5	14.0
	C15	UROLOGY	26	MEDIUM	283.5	600	2466.5	1568.5	6.7	6.47	0.26	6.67	0.05	3.19	15.5%	0.38	3.6%	3.73	31.01	8.9%	8.9%	0.0%	53.1%	26.4%	2.2%	16.2%	0.0%	1.1%	0.3%	6.6%	33.0	30.0	0.2	0.1	0.1	13.5%	0.4%	-6.0	84.5	90.5
	C27	CARDIOTHORACIC	26	LOW	283.2	758	3013.0	1150.3	5.5	8.46	-2.97	9.93	-4.44	2.48	10.5%	-0.45	-5.2%	2.13	32.24	3.6%	3.6%	0.0%	76.4%	21.3%	2.7%	14.4%	0.0%	1.2%	0.0%	3.0%	56.0	55.0	0.2	0.2	0.0	7.4%	5.0%	42.8	59.0	16.3
	CICU	CRITICAL CARE	22	LOW	157.5	457	8304.8	671.8	19.6	27.13	-7.49	26.60	-6.96	2.60	2.9%	0.67	9.2%	3.30	98.08	1.1%	1.1%	0.0%	89.5%	31.2%	7.0%	18.0%	0.0%	0.6%	1.0%	4.6%	63.0	55.0	0.0	0.0	0.0	22.0%	4.5%	39.8	149.8	110.0
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	428	1912.9	1166.8	7.2	6.58	0.62	9.03	-1.83	3.65	20.0%	3.35	30.0%	7.20	29.46	10.8%	10.8%	0.0%	51.6%	24.2%	1.1%	21.0%	0.0%	1.1%	1.0%	0.0%	47.0	47.0	0.3	0.2	0.1	20.7%	0.8%	-35.3	38.5	73.8
	H130	PAEDIATRICS	20	LOW	205.8	372	1887.8	779.5	7.2	11.44	-4.27	12.20	-5.03	1.02	4.9%	0.19	2.9%	1.26	27.50	0.5%	0.5%	0.0%	100.0%	43.7%	7.9%	19.5%	1.5%	0.0%	0.8%	14.0%	53.0	52.0	0.0	0.0	0.0	31.1%	-0.3%	58.0	58.0	0.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	163	1411.2	444.5	11.4	8.02	3.36	7.70	3.68	0.08	0.8%	0.37	9.5%	0.46	14.62	1.8%	1.8%	0.0%	20.8%	19.2%	1.8%	17.4%	0.0%	0.0%	0.0%	0.0%	59.0	59.0	0.2	0.1	0.1	19.8%	-0.2%	0.0	0.0	0.0
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	380	2176.8	1435.0	9.5	10.11	-0.61	15.48	-5.98	-0.30	-0.72%	-0.26	-1.15%	-0.56	64.53	1.8%	1.8%	0.0%	91.8%	22.7%	5.8%	14.3%	0.0%	2.6%	0.0%	0.0%	66.0	61.0	0.0	0.0	0.0	15.7%	-2.5%	-0.5	12.0	12.5
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1138	2846.9	1629.5	3.9	10.11	-6.18	15.48	-11.55							1.0%	1.0%	0.0%	82.4%	25.7%	5.4%	16.1%	0.2%	1.2%	0.1%	2.7%			0.0	0.0	0.0	11.0%	-2.4%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	263	2341.0	394.5	10.4	9.11	1.29	11.01	-0.61	0.28	1.4%	-1.23	-19.3%	-0.94	26.64	2.5%	2.5%	0.0%	103.2%	27.2%	5.7%	18.7%	0.0%	0.9%	1.1%	0.8%	62.0	61.0	0.0	0.0	0.0	10.9%	-6.3%	6.5	6.5	0.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	324	1485.0	428.0	5.9	11.20	-5.30	10.70	-4.80	0.93	6.3%	-0.33	-7.1%	0.66	19.48	0.6%	0.6%	0.0%	16.3%	29.1%	7.5%	15.9%	0.0%	0.6%	1.2%	3.9%	69.0	0.0	0.0	0.0	0.0	28.8%	-3.8%	42.5	50.5	8.0
	LABOUR	MATERNITY	16	LOW	369.5	317	5521.4	1439.5	22.0	10.11	11.85	15.48	6.48	-7.67	-17.1%	-3.62	-34.7%	-11.46	55.36	5.0%	4.4%	0.6%	60.2%	25.8%	7.5%	16.9%	0.0%	1.4%	0.0%	0.0%	65.0	61.0	0.3	0.1	0.2	12.5%	-1.7%	23.5	34.5	11.0
	NEONATES	NEONATOLOGY	26	LOW	157.5	611	7609.9	295.0	12.9	13.26	-0.32	12.98	-0.04	5.71	8.0%	1.4	26.8%	7.19	77.01	3.0%	3.0%	0.0%	80.9%	36.4%	5.0%	17.9%	0.4%	0.7%	0.7%	11.7%	45.0	41.0	0.0	0.0	0.0	22.4%	-0.8%	-22.0	0.0	22.0
	PAU	PAEDIATRICS	10	LOW	0.0	81	1176.1	0.0	14.5	11.44	3.08	12.20	2.32	1.33	12.7%	0	0.0%	1.33	10.44	4.0%	4.0%	0.0%	83.0%	25.0%	1.9%	22.0%	1.1%	0.0%	0.0%	0.0%	64.0	52.0	0.0	0.0	0.0	14.2%	0.8%	0.0	0.0	0.0
	PHDU	PAEDIATRICS	4	LOW	0.0	80	1404.5	132.2	19.2	11.44	7.77	12.20	7.01	1.26	10.8%	0	0.0%	1.26	12.66	6.9%	6.9%	0.0%	100.5%	28.1%	0.0%	23.0%	0.0%	1.1%	4.0%	0.0%	64.0	52.0	0.1	0.1	0.0	15.6%	-5.4%	22.0	22.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	312	1418.5	707.8	6.8	7.76	-0.94	7.91	-1.09	0.56	4.9%	-0.58	-7.3%	0.03	19.40	6.6%	6.6%	0.0%	58.1%	29.9%	9.2%	18.6%	0.0%	1.3%	0.8%	0.0%	53.0	48.0	0.2	0.1	0.1	17.7%	4.2%	37.8	70.5	32.7
	C29	REHABILITATION	15	LOW	147.0	457	1625.5	1838.0	7.6	7.69	-0.11	6.66	0.92	1.29	10.2%	1.59	10.2%	2.98	28.28	0.7%	0.7%	0.0%	41.3%	28.5%	9.1%	17.5%	0.0%	1.6%	0.0%	0.3%	46.0	45.0	0.1	0.1	0.0	11.9%	3.1%	-7.5	14.0	21.5
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	663	1569.5	1279.5	4.3	7.92	-3.62	7.14	-2.84	1.78	13.0%	0.31	3.9%	2.22	21.68	8.1%	8.1%	0.0%	58.4%	30.3%	8.0%	17.5%	0.0%	1.0%	0.4%	3.4%	54.0	53.0	0.2	0.2	0.0	7.6%	-2.3%	19.0	59.0	40.0
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	731	1519.3	1568.2	4.2	7.92	-3.70	7.14	-2.92	7.04	40.2%	1.62	15.5%	9.06	27.95	17.2%	11.0%	6.2%	55.4%	27.5%	8.5%	11.6%	4.9%	1.3%	1.2%	0.0%	53.0	53.0	0.2	0.2	0.0	15.9%	2.2%	94.7	105.7	11.0
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	661	1771.2	1235.8	4.5	7.92	-3.37	7.14	-2.59	2.1	15.4%	0.03	0.4%	2.28	21.59	10.6%	8.6%	2.0%	72.8%	28.4%	5.3%	17.7%	0.0%	1.1%	1.3%	3.0%	48.0	48.0	0.2	0.1	0.1	12.2%	-4.4%	-12.5	29.0	41.5
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	640	2523.1	1074.6	5.6	8.21	-2.59	7.23	-1.61	2.31	8.5%	-0.95	-12.0%	1.44	35.22	7.2%	6.3%	0.9%	54.4%	35.9%	3.8%	19.8%	1.9%	0.9%	1.2%	8.3%	48.0	48.0	0.3	0.3	0.0	21.1%	0.1%	-24.5	85.5	110.0
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR				TOTALS:	10473.6	28948	126908.8	65394.4	6.64	8.84	-32.45	9.25	-52.53	155.49	8.6%	3.77	0.2%	159.26	1799.57	6.7%	6.0%	0.7%	53.2%	29.1%	5.4%	17.9%	0.6%	1.2%	0.9%	3.1%	52.2	44.8	9.7	6.0	3.7	18.2%	0.9%	1023.6	4034.9	3011.3

HEY NURSE STAFFING KEY METRICS DASHBOARD

Sep-19

KEY METRICS ROTA: 2nd Sep 2019 - 29th Sep 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 M6]						TEMPORARY STAFFING [2nd Sep - 29th Sep]				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	8.07	7.7%	3.74	17.1%	11.89	126.79	3.3%	3.1%	0.2%	80.1%	24.4%	5.6%	14.5%	1.0%	1.6%	0.6%	1.1%	56.0	52.0	0.0	0.0	0.0	12.8%	0.6%	109.5	109.5	0.0
	AMU	GENERAL MEDICINE	45	LOW	178.5	835	5057.3	2512.8	9.1	7.55	1.52	7.31	1.76	12.60	24.4%	3.51	12.5%	16.35	79.63	10.3%	9.5%	0.8%	64.5%	29.6%	4.9%	15.7%	0.4%	4.6%	0.0%	4.0%	49.0	49.0	0.0	0.0	0.0	9.5%	0.4%	310.9	328.9	18.0
	H36	GENERAL MEDICINE	24	LOW	399.0	430	1655.3	1363.8	7.0	7.55	-0.53	7.31	-0.29	5.82	42.6%	-0.30	-3.8%	5.95	21.59	4.6%	2.4%	2.2%	43.2%	27.2%	0.4%	15.7%	0.0%	4.0%	4.7%	2.4%	63.0	63.0	0.0	0.0	0.0	20.9%	2.3%	86.9	240.8	153.8
	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	616	1870.5	1935.5	6.2	6.94	-0.76	7.74	-1.56	6.28	32.9%	-0.30	-2.3%	6.31	32.27	23.1%	20.2%	2.9%	75.8%	28.5%	2.7%	13.6%	0.0%	2.4%	1.1%	8.7%	43.0	25.0	0.0	0.0	0.0	47.1%	0.7%	-15.5	8.0	23.5
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	739	2795.3	2039.0	6.5	6.74	-0.20	6.38	0.16	3.50	14.5%	2.62	19.9%	6.27	37.25	8.0%	8.0%	0.0%	38.3%	25.7%	5.0%	14.4%	0.0%	3.2%	3.1%	0.0%	38.0	31.0	0.1	0.1	0.0	15.3%	-2.2%	58.6	133.5	74.9
	H50	NEPHROLOGY	19	LOW	283.5	562	1510.7	1038.5	4.5	7.23	-2.69	7.00	-2.46	1.33	9.0%	-0.26	-11.1%	1.16	17.20	0.5%	0.5%	0.0%	52.9%	23.8%	3.0%	15.9%	0.0%	1.7%	0.1%	3.1%	69.0	59.0	0.0	0.0	0.0	15.2%	0.0%	-18.5	19.5	38.0
	H500	RESPIRATORY MEDICINE	24	LOW	157.5	701	1852.5	1723.0	5.1	6.74	-1.64	6.38	-1.28	3.52	21.5%	1.71	13.0%	5.45	29.53	6.3%	4.7%	1.6%	77.5%	25.8%	3.7%	14.4%	1.8%	2.0%	0.2%	3.7%	25.0	-17.0	0.0	0.0	0.0	21.1%	3.2%	61.5	73.5	12.0
	H10	GENERAL MEDICINE	30	MEDIUM	441.0	795	2076.0	2120.8	5.3	7.55	-2.27	7.31	-2.03	10.99	51.5%	-3.53	-26.8%	7.97	34.50	16.7%	11.9%	4.8%	67.4%	28.4%	10.3%	13.1%	3.2%	1.6%	0.1%	0.1%	21.0	19.0	0.0	0.0	0.0	23.3%	27.0%	73.8	162.8	89.0
	H8	GERIATRIC MEDICINE	27	LOW	220.5	795	1718.1	1875.0	4.5	6.94	-2.42	6.74	-2.22	2.07	12.7%	-0.16	-1.2%	2.04	29.53	5.1%	5.1%	0.0%	81.1%	27.6%	3.8%	14.7%	1.3%	3.2%	1.3%	3.3%	39.0	30.0	0.0	0.0	0.0	12.7%	-1.8%	25.0	72.5	47.5
	PDU H80	GERIATRIC MEDICINE	27	LOW	220.5	808	1456.8	2738.3	5.2	6.94	-1.75	6.74	-1.55	2.07	18.9%	-4.20	-26.4%	-1.94	26.82	11.3%	5.4%	5.9%	82.9%	32.5%	13.4%	12.7%	2.2%	0.4%	0.9%	2.9%	39.0	38.0	0.0	0.0	0.0	5.3%	2.0%	126.3	132.3	6.0
	H9	GERIATRIC MEDICINE	30	MEDIUM	913.5	885	1735.0	2130.0	4.4	6.94	-2.57	6.74	-2.37	2.07	12.7%	-1.92	-12.3%	0.28	32.03	5.1%	4.2%	0.9%	83.3%	27.6%	6.7%	16.9%	0.9%	2.2%	0.7%	0.2%	75.0	67.0	0.0	0.0	0.0	14.6%	1.6%	52.3	101.8	49.5
	H90	GERIATRIC MEDICINE	29	LOW	252.0	860	1595.5	1824.8	4.0	6.94	-2.96	6.74	-2.76	2.49	15.2%	-1.35	-10.3%	1.29	29.53	6.6%	6.6%	0.0%	90.7%	30.9%	10.3%	11.0%	0.9%	2.9%	5.8%	0.0%	107.0	101.0	0.0	0.0	0.0	15.4%	1.8%	111.0	166.0	55.0
	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	828	1559.5	2099.5	4.4	7.55	-3.13	7.41	-2.99	6.58	30.5%	-3.37	-32.3%	3.51	32.03	5.5%	2.4%	3.1%	20.7%	32.1%	4.8%	12.7%	3.2%	2.6%	2.4%	6.4%	45.0	33.0	0.0	0.0	0.0	21.2%	0.8%	95.0	106.0	11.0
	H110	STROKE / NEUROLOGY	24	LOW	252.0	624	2239.7	2162.0	7.1	7.55	-0.50	7.41	-0.36	7.49	27.5%	-2.84	-27.2%	4.92	37.72	11.2%	11.2%	0.0%	36.7%	30.7%	5.8%	18.5%	0.8%	1.4%	0.1%	4.1%	24.0	14.0	0.0	0.0	0.0	25.6%	3.2%	20.7	172.7	152.0
	CDU	CARDIOLOGY	9	LOW	0.0	83	912.3	75.0	11.9	7.93	3.97	7.73	4.17	0.82	6.4%	0.49	20.1%	1.37	15.25	3.8%	3.8%	0.0%	40.7%	37.7%	11.1%	17.5%	0.0%	1.6%	0.0%	7.5%	53.0	-4.0	0.0	0.0	0.0	16.5%	1.7%	-30.0	0.0	30.0
	C26	CARDIOLOGY / CTS	26	LOW	236.5	666	2558.2	1034.5	5.4	8.46	-3.07	9.93	-4.54	0.38	1.6%	-0.75	-9.5%	-0.35	32.03	1.4%	1.4%	0.0%	60.2%	21.6%	3.5%	14.0%	0.3%	2.0%	0.0%	1.8%	67.0	65.0	0.0	0.0	0.0	11.6%	4.0%	-24.3	11.8	36.0
	C28 /CMU	CARDIOLOGY	27	LOW	277.2	670	4015.8	980.5	7.5	7.44	0.02	7.87	-0.41	8.69	22.9%	-1.01	-12.5%	7.91	46.04	0.4%	0.4%	0.0%	8.3%	26.3%	8.4%	14.0%	0.7%	2.6%	0.6%	0.0%	52.0	33.0	0.0	0.0	0.0	28.2%	1.3%	45.0	169.7	124.7
SURGERY	H4	NEUROSURGERY	28	MEDIUM	157.5	745	1629.3	1191.3	3.8	8.39	-4.60	8.71	-4.92	5.69	26.4%	1.18	11.3%	7.13	32.03	18.0%	18.0%	0.0%	89.1%	29.2%	7.7%	11.8%	0.4%	6.7%	2.6%	0.0%	41.0	34.0	0.2	0.1	0.1	17.4%	-3.3%	34.3	54.8	20.5
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	105.0	345	1692.3	1020.5	7.9	8.39	-0.53	8.71	-0.85	2.75	12.9%	-1.23	-13.2%	1.65	30.68	4.4%	4.4%	0.0%	20.2%	19.3%	1.2%	15.2%	0.5%	1.8%	0.4%	0.2%	48.0	42.0	0.2	0.1	0.1	19.4%	2.5%	60.8	93.8	33.0
	H6	GENERAL SURGERY	28	LOW	283.5	673	1705.0	1230.0	4.4	6.99	-2.63	7.26	-2.90	2.94	15.3%	0.95	8.1%	4.04	31.01	20.8%	20.4%	0.4%	73.8%	33.2%	2.9%	17.3%	0.7%	5.8%	2.8%	3.7%	48.0	47.0	0.1	0.0	0.1	8.4%	1.0%	62.3	78.3	16.0
	H60	GENERAL SURGERY	28	LOW	126.0	700	1650.3	1397.5	4.4	6.99	-2.64	7.26	-2.91	1.40	7.3%	2.41	20.4%	3.88	31.01	10.8%	10.8%	0.0%	54.8%	21.6%	1.6%	17.8%	0.0%	1.9%	0.3%	0.0%	59.0	53.0	0.1	0.1	0.0	11.1%	-0.5%	-1.5	39.5	41.0
	H7	VASCULAR SURGERY	30	MEDIUM	283.5	455	1887.3	1358.0	7.1	6.99	0.14	7.26	-0.13	5.14	21.3%	-1.52	-14.3%	3.83	34.76	9.8%	8.7%	1.1%	50.8%	26.6%	2.7%	13.7%	0.0%	2.7%	1.1%	6.4%	47.0	41.0	2.1	2.1	0.0	20.8%	-2.2%	-35.3	44.0	79.3
	H100	GASTROENTEROLOGY	27	LOW	239.4	788	1615.3	1284.5	3.7	6.63	-2.95	6.29	-2.61	2.43	12.4%	0.98	7.5%	3.53	32.68	7.5%	7.5%	0.0%	53.2%	20.2%	2.3%	12.2%	0.0%	1.4%	0.7%	3.6%	58.0	58.0	0.1	0.0	0.1	15.7%	2.8%	-12.5	30.0	42.5
	H12	ORTHOPAEDIC	28	LOW	252.0	577	1786.0	1453.8	5.6	7.13	-1.52	7.25	-1.64	2.51	11.6%	-0.12	-0.9%	2.51	34.75	9.0%	8.7%	0.3%	45.5%	27.3%	5.3%	16.4%	0.8%	1.3%	1.5%	2.0%	33.0	33.0	0.1	0.1	0.0	13.0%	-0.2%	9.0	65.0	56.0
	H120	ORTHO / MAXFAX	22	LOW	283.5	587	1486.2	1361.9	4.9	7.13	-2.28	7.25	-2.40	0.76	4.6%	0.28	2.4%	1.09	28.17	14.8%	14.5%	0.3%	74.2%	34.8%	4.5%	13.4%	0.4%	3.1%	2.7%	10.7%	32.0	3.0	0.0	0.0	0.0	9.2%	3.1%	86.5	113.0	26.5
	HICU	CRITICAL CARE	22	LOW	252.0	454	7684.8	730.8	18.5	27.13	-8.59	26.60	-8.06	7.80	7.4%	-0.66	-9.0%	7.21	112.20	0.4%	0.0%	0.4%	32.8%	28.9%	8.5%	14.7%	0.2%	1.2%	1.1%	3.2%	65.0	54.0	0.0	0.0	0.0	16.5%	2.5%	-208.5	6.5	215.0
	C9	ORTHOPAEDIC	35	LOW	252.0	631	1898.7	1103.5	4.8	7.13	-2.37	7.25	-2.49	2.36	10.8%	1.85	14.3%	4.32	34.79	8.5%	8.5%	0.0%	47.7%	28.7%	6.9%	13.3%	0.3%	2.5%	2.9%	2.8%	66.0	65.0	0.0	0.0	0.0	13.6%	0.3%	-88.5	51.0	139.5
	C10	GENERAL SURGERY	21	LOW	252.0	374	1525.3	690.0	5.9	6.99	-1.07	7.26	-1.34	3.30	18.2%	0.59	7.3%	4.07	26.15	8.2%	8.2%	0.0%	38.4%	28.8%	6.6%	14.1%	5.1%	2.4%	0.6%	0.0%	55.0	55.0	0.0	0.0	0.0	22.5%	2.5%	-232.0	69.0	301.0
	C11	GENERAL SURGERY	22	LOW	252.0	495	1584.5	713.8	4.6	6.99	-2.35	7.26	-2.62	3.60	17.5%	1.65	20.5%	5.43	28.61	9.2%	9.2%	0.0%	57.5%	28.4%	8.5%	14.8%	0.3%	2.4%	2.4%	0.0%	65.0	65.0	0.0	0.0	0.0	22.1%	5.5%	65.0	144.0	79.0
	C14	GENERAL SURGERY	27	LOW	252.0	705	1878.3	954.0	4.0	6.99	-2.97	7.26	-3.24	1.37	6.8%	-1.16	-11.9%	0.28	29.84	8.1%	7.0%	1.1%	63.4%	28.5%	3.5%	15.1%	0.0%	2.0%	2.5%	5.4%	44.0	42.0	0.0	0.0	0.0	10.1%	-0.9%	134.8	164.3	29.5
	C15	UROLOGY	26	MEDIUM	283.5	679	1839.4	1050.5	4.3	6.47	-2.21	6.67	-2.41	3.05	14.8%	0.21	2.0%	3.41	31.01	12.2%	11.9%	0.3%	68.7%	29.9%	6.6%	13.3%	0.0%	3.0%	0.0%	7.0%	50.0	39.0	0.0	0.0	0.0	13.0%	2.2%	116.5	150.5	34.0
	C27	CARDIOTHORACIC	26	LOW	283.2	714	2067.0	732.8	3.9	8.46	-4.54	9.93	-6.01	2.47	10.5%	-0.13	-1.5%	2.44	32.24	3.4%	3.4%	0.0%	73.1%	27.8%	3.4%	17.2%	0.0%	2.3%	1.7%	3.2%	48.0	47.0	0.0	0.0	0.0	12.4%	2.1%	13.3	39.8	26.5
	CICU	CRITICAL CARE	22	LOW	157.5	430	5932.0	500.8	15.0	27.13	-12.17	26.60	-11.64	1.29	1.4%	0.88	12.0%	2.18	98.08	3.1%	2.8%	0.3%	86.9%	30.6%	8.5%	14.4%	0.0%	1.2%	0.9%	5.6%	61.0	54.0	0.0	0.0	0.0	20.5%	5.6%	-311.8	96.0	407.8
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	398	1912.9	1166.8	7.7	6.58	1.16	9.03	-1.29	3.93	21.5%	3.39	30.4%	7.53	29.46	17.9%	17.9%	0.0%	56.8%	28.6%	3.9%	17.1%	0.0%	3.1%	4.5%	0.0%	51.0	23.0	0.0	0.0	0.0	24.9%	0.3%	-155.7	19.0	174.7
	H130	PAEDIATRICS	20	LOW	205.8	476	1887.8	779.5	5.6	11.44	-5.84	12.20	-6.60	1.3	6.2%	-0.27	-4.1%	1.09	27.50	2.8%	2.8%	0.0%	100.6%	33.7%	4.8%	10.4%	1.1%	3.0%	0.8%	13.6%	49.0	49.0	0.1	0.1	0.0	19.0%	-1.0%	91.5	91.5	0.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	193	1411.2	444.5	9.6	8.02	1.60	7.70	1.92	0.13	1.2%	0.26	6.7%	0.40	14.62	7.8%	6.8%	1.0%	50.6%	15.8%	1.6%	11.5%	0.0%	1.9%	0.8%	0.0%	51.0	47.0	0.2	0.2	0.0	16.0%	-0.6%	55.1	91.7	36.6
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	332	2176.8	1435.0	10.9	10.11	0.77	15.48	-4.60	0.07	0.17%	-0.22	-0.97%	-0.15	64.53	0.4%	0.4%	0.0%	80.0%	23.9%	6.9%	14.0%	0.0%	3.0%	0.0%	0.0%	67.0	58.0	0.1	0.1	0.0	13.2%	-2.7%	-12.0	0.0	12.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	970	2846.9	1629.5	4.6	10.11	-5.50	15.48	-10.87							1.3%	1.3%	0.0%	94.6%	24.9%	3.7%	15.7%	0.5%	2.2%	0.1%	2.7%			0.0	0.0	0.0	11.3%	-3.0%	12.0	12.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	215	2341.0	394.5	12.7	9.11	3.61	11.01	1.71	0.28	1.4%	-1.36	-21.4%	-1.07	26.64	1.8%	1.8%	0.0%	89.7%	31.4%	9.0%	17.4%	0.0%	1.3%	0.2%	3.5%	-24.0	0.0	0.1	0.1	0.0	11.9%	-3.8%	0.0	23.0	23.0
	H35	OPHTHALMOLOGY	12	LOW	285.6	292	1485.0	428.0	6.6	11.20	-4.65	10.70	-4.15	0.88	5.9%	-0.33	-7.1%	0.61	19.48	0.5%	0.5%	0.0%	126.4%	18.2%	5.7%	10.5%	0.0%	2.0%	0.0%	0.0%	52.0	47.0	0.0	0.0	0.0	0.7%	-0.4%	-113.9	7.6	121.5
	LABOUR	MATERNITY	16	LOW	369.5	281	5521.4	1439.5	24.8	10.11	14.66	15.48	9.29	-7.24	-16.1%	-3.51	-33.6%	-10.91	55.36	1.9%	1.9%	0.0%	88.8%	26.2%	7.1%	15.1%	0.0%	1.1%	2.1%	0.8%	58.0	58.0	0.0	0.0	0.0	7.0%	-5.4%	0.0	6.5	6.5
	NEONATES	NEONATOLOGY	26	LOW	157.5	500	7609.9	295.0	15.8	13.26	2.55	12.98	2.83	5.92	8.3%	1.4	26.8%	7.40	77.01	1.6%	1.6%	0.0%	92.8%	32.4%	3.7%	11.8%	0.3%	2.8%	0.7%	13.1%	59.0	33.0	0.0	0.0	0.0	22.9%	-1.0%	-47.0	0.0	47.0
	PAU	PAEDIATRICS	10	LOW	0.0	111	1176.1	0.0	10.6	11.44	-0.84	12.20	-1.60	1.44	13.8%	0	0.0%	1.44	10.44	3.3%	3.3%	0.0%	88.5%	25.0%	0.9%	21.8%	0.0%	2.3%	0.0%	0.0%	53.0	49.0	0.0	0.0	0.0	7.0%	-4.6%	24.0	24.0	0.0
	PHDU	PAEDIATRICS	4	LOW	0.0	82	1404.5	132.2	18.7	11.44	7.30	12.20	6.54	1	8.6%	0	0.0%	1.00	12.66	5.6%	5.6%	0.0%	100.0%	22.7%	0.0%	18.5%	0.0%	3.9%	0.3%	0.0%	50.0	49.0	0.0	0.0	0.0	2.3%	-7.0%	-23.0	0.0	23.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	157.5	430	1405.5	825.5	5.2	7.76	-2.57	7.91	-2.72	0.68	5.9%	-0.61	-7.7%	0.13	19.40	4.4%	3.9%	0.5%	60.1%	17.1%	5.3%	9.4%	0.0%	1.6%	0.8%	0.0%	47.0	35.0	0.0	0.0	0.0	10.9%	8.6%	-23.0	12.0	35.0
	C29	REHABILITATION	15	LOW	147.0	446	1504.5	1652.5	7.1	7.69	-0.61	6.66	0.42	1.18	9.4%	1.43	9.1%	2.70	28.28	1.2%	0.8%	0.4%	44.2%	30.4%	4.9%	19.4%	0.0%	5.2%	0.0%	0.9%	53.0	35.0	0.0	0.0	0.0	16.1%	0.7%	-72.5	0.0	72.5
	C30	CLINICAL ONCOLOGY	22	LOW	220.5	639	1551.3	1233.2	4.4	7.92	-3.56	7.14	-2.78	1.85	13.6%	0.19	2.4%	2.18	21.68	12.3%	11.5%	0.8%	74.0%	31.7%	10.7%	11.3%	0.8%	3.7%	2.0%	3.2%	63.0	56.0	0.0	0.0	0.0	4.6%	-4.0%	58.0	70.0	12.0
	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	714	1622.0	1746.6	4.7	7.92	-3.20	7.14	-2.42	7.14	40.8%	1.09	10.4%	8.64	27.95	16.2%	9.7%	6.5%	52.6%	29.7%	12.8%	13.0%	0.0%	2.2%	1.7%	0.0%	55.0	53.0	0.0	0.0	0.0	15.9%	1.9%	105.8	155.8	50.0
	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	639	1731.8	1318.3	4.8	7.92	-3.15	7.14	-2.37	2.26	16.6%	0.03	0.4%	2.46	21.59	7.5%	6.3%	1.2%	65.8%	27.0%	5.5%	12.3%	0.7%	2.9%	2.8%	2.8%	63.0	56.0	0.0	0.0	0.0	10.0%	-5.0%	5.0	23.0	18.0
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	682	2540.6	1299.8	5.6	8.21	-2.58	7.23	-1.60	2.58	9.5%	-0.85	-10.7%	1.82	35.22	7.2%	6.3%	0.9%	47.0%	31.5%	5.6%	14.1%	1.1%	1.9%	0.5%	8.3%	62.0	56.0	0.2	0.2	0.0	19.1%	-0.2%	42.6	132.8	90.2
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR			TOTALS:	10473.6	27649	112599.4	60647.1	6.27	8.84	-73.11	9.25	-93.19	157.03	8.7%	-1.12	-0.1%	155.91	1799.57	7.3%	6.5%	0.8%	64.9%	27.5%	5.5%	14.5%	0.6%	2.5%	1.3%	3.0%	50.9	42.7	3.7	3.3	0.4	15.5%	0.8%	727.3	3917.1	3189.9

HEY NURSE STAFFING QUALITY INDICATORS

OCTOBER 2019
September 19 activity) (YTD Apr 19-Sep 19)

HR METRICS

IN PATIENT FALLS WITH HARM

ON ADMISSION & HOSPITAL ACQUIRED PRESSURE ULCERS

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	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	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YDT	RCA Outstanding
EM	ED	ACUTE MEDICINE	NA	92.9%	95.9%	96.9%	85.7%	92.9%	88.7%		1		1	0	2	6	51			84	558			9	77			1	11			19	112			26	131					145	940	0	0			
MEDICINE	AMU	ACUTE MEDICINE	45	92.0%	90.3%	93.1%	91.7%	70.8%	90.3%		1			0	1	2	16			14	72		1		8				2			7	34			2	17					25	149	0	1			
	H36	ACUTE MEDICINE	22	87.9%	86.2%	84.0%	80.0%	60.0%	87.5%					0	0	1	3			1	7		1		1								1				3				1	2	15	0	1			
	EAU	ELDERLY MEDICINE	21	91.1%	87.9%	87.9%	87.9%	90.9%	90.9%		1		1	0	2	4	30			5	53			1	5				1			2	17			2	13					14	119	0	0			
	H5 / RHOB	RESPIRATORY	26	82.3%	93.3%	84.6%	74.4%	93.3%	92.3%					0	0		3		1		5				1								1					1				0	10	0	1			
	H50	RENAL MEDICINE	19	94.0%	82.1%	93.3%	93.3%	75.0%	100.0%		1			0	1		2				12				1								1		1		1					0	17	0	1			
	H500	RESPIRATORY	24	86.0%	89.3%	89.3%	78.6%	74.4%	75.0%					0	0				1		3																1					0	4	0	0			
	H70	ENDOCRINOLOGY	30	88.9%	82.9%	76.9%	88.5%	69.2%	92.3%		6			0	6		1		2		2		1																		0	3	0	1			
	H8	ELDERLY MEDICINE	27	86.8%	91.4%	77.1%	82.9%	82.9%	94.3%	1	2		1	1	3	2	7	2	11		6		3							1	3		3	1	5		1		3	4	21		7			
	H80	PDU	27	89.7%	87.5%	71.0%	81.3%	78.1%	80.6%	1	1	1	2	2	3				1				1																		0	0	0	1			
	H9	ELDERLY MEDICAL	30	94.1%	89.2%	91.4%	88.6%	97.1%	85.7%	1	2			1	2		1	2	4	1	5										1		1							1	7	0	1			
	H90	ELDERLY MEDICINE	29	91.7%	84.8%	93.1%	75.9%	86.2%	96.6%		1		3	0	4		1				2												1							0	3	0	1			SUI/2019/12484
	H11	STROKE / NEURO	28	78.2%	72.7%	93.8%	75.0%	59.4%	71.9%					0	0						2	1	1		1															0	3	1	1			SUI/2019/14406
	H110	STROKE / NEURO	24	80.2%	84.6%	69.7%	60.6%	75.8%	72.7%					0	0		2	2	5		3	2	8										1		1				2	0	6	2	9			
	CDU	CARDIOLOGY	9	94.2%	87.5%	93.8%	100.0%	87.5%	100.0%					0	0		1																							0	1	0	0			
	C26	CARDIOLOGY	26	86.8%	87.5%	93.8%	62.5%	62.5%	71.9%					0	0		1		1	1	2	1	3																	1	3	1	3			
	C28 /CMU	CARDIOLOGY	27	88.6%	83.3%	92.9%	78.6%	71.4%	90.5%					0	0		5	1	8		3	1	4		1		1						1				3		1	4	0	12	1	6			
SURGERY	H4	NEURO SURGERY	28	85.0%	74.2%	86.2%	69.0%	62.1%	96.6%					0	0		2			1	3		2																1		1	5	0	3			
	H40	NEURO / TRAUMA	15	85.0%	82.1%	71.0%	87.1%	64.5%	80.6%					0	0				1				2																1		1	0	0	0	3			
	H6	ACUTE SURGERY	28	84.8%	80.8%	85.7%	85.7%	78.6%	85.7%					0	0				3	1	1										2				1					1	4	0	0			
	H60	ACUTE SURGERY	28	92.7%	90.0%	96.2%	100.0%	80.8%	100.0%				1	0	1		3		2	2	4												1							2	11	0	0			
	H7	VASCULAR SURGERY	30	80.2%	96.2%	81.1%	73.0%	54.1%	81.1%	2	2			2	2	1	3	1	5	2	13		2		1						5		5	3	21	1	1	1	2	6	43	1	8			
	H100	GASTRO	24	89.5%	88.9%	100.0%	82.1%	67.9%	89.3%		1			0	1		5		2	1	1	1	3								2			1				1		1	6	1	6			
	H12	ORTHOPAEDIC	28	88.0%	93.1%	97.4%	87.2%	84.6%	89.7%					0	0		4	1	6	1	5	2	9								3				1			1		1	13	2	9			
	H120	ORTHO / MAXFAX	22	97.6%	100.0%	96.6%	93.1%	93.1%	93.1%					0	0	1	3	2	6	3	7		7												1	2	7	4	11	0	9			
	HICU	CRITICAL CARE	22	91.0%	92.0%	91.2%	77.9%	86.7%	84.1%					0	0		3	2	8		2		3								2		3	1	1		1		6	1	8	0	7			
	C9	ORTHOPAEDIC	35	89.1%	93.1%	89.2%	75.7%	64.9%	91.9%		2			0	2			1	2	1	3		3																	1	4	0	5			
	C10	COLORECTAL	21	88.5%	96.2%	88.5%	88.5%	80.8%	76.9%					0	0				3	1	3																			1	3	0	0			
	C11	COLORECTAL	22	84.4%	78.1%	88.9%	81.5%	70.4%	96.3%					0	0		1		2	1	1	1	2					1	1				1								2	3	1	3			
	C14	UPPER GI	27	86.3%	85.7%	90.9%	87.9%	93.9%	84.8%					0	0						3		8																1		2	0	3	0	9			SUI/2019/13130
	C15	UROLOGY	26	85.3%	91.7%	77.1%	85.7%	65.7%	85.7%					0	0		6	2	9	3	11	1	7					1	2		1	2	1	2			1	2			5	0	2	9			
	C27	CARDIOTHORACIC	26	92.0%	89.3%	90.6%	96.9%	59.4%	90.6%					0	0				2	1	2	1	2																	1	2	1	2			
	CICU	CRITICAL CARE	22	94.4%	93.0%	94.0%	90.0%	88.0%	97.0%					0	0				2				1								3				1			3	0	0	0	5			
FAMILY & WOMEN'S	C16	ENT / BREAST	30	95.3%	78.1%	87.5%	95.8%	87.5%	95.8%					0	0		1		1	1	4										1									1	5	0	1			
	H130	PAEDS	20	84.6%	90.5%	71.0%	63.6%	54.5%	71.0%					0	0				1																					0	0	0	0			
	H30 CEDAR	GYNAECOLOGY	9	96.6%	93.8%	87.5%	93.8%	87.5%	93.8%					0	0																									0	0	0	0			
	H31 MAPLE	MATERNITY	20	93.5%	88.7%	90.1%	93.0%	85.9%	87.3%					0	0																									0	0	0	0			
	H33 ROWAN	MATERNITY	38																																					0	0	0	0			
	H34 ACORN	PAEDS SURGERY	20	93.9%	93.1%	96.3%	93.1%	86.2%	77.8%					0	0																									0	0	0	0			
	H35	OPHTHALMOLOGY	12	97.9%	100.0%	94.4%	94.4%	94.4%	100.0%					0	0					1	1																			1	1	0	0			
	LABOUR	MATERNITY	16	89.9%	93.5%	94.6%	82.4%	91.9%	82.4%					0	0																									0	0	0	1			
	NEONATES	CRITICAL CARE	26	94.6%	88.5%	97.4%	92.2%	90.9%	92.2%					0	0																									0	0	0	0			
	PAU	PAEDS	10	87.8%	91.7%	91.7%	83.3%	66.7%	75.0%					0	0																									0	0	0	0			
	PHDU	CRITICAL CARE	4	93.6%	83.3%	90.9%	75.0%	83.3%	81.8%					0	0		1				1		1																1		2	0	2	0	2			
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	19	90.8%	75.7%	90.0%	85.0%	90.0%	90.0%					0	0								2																		0	0	0	2			
	C29	REHABILITATION	15	92.7%	91.3%	78.6%	89.3%	85.7%	100.0%	2	3		2	2	5			1	4		1	2	4				1				1										0	2	2	5			
	C30	ONCOLOGY	22	88.0%	75.0%	87.0%	87.0%	73.9%	100.0%					0	0		2				6										2			1	9			1	1	1	19	0	0			
	C31	ONCOLOGY	27	71.4%	90.5%	70.8%	75.0%	70.8%	62.5%					0	0	2	7		2	2	22				1		2			1	9		2		5					5	44	0	2			
	C32	ONCOLOGY	22	94.4%	84.8%	95.2%	95.2%	85.7%	81.0%	1	2			1	2		1		1	2	15										3		1		4					2	23	0	1			
	C33	HAEMATOLOGY	28	86.2%	84.0%	100.0%	72.7%	69.7%	84.8%					0	0			2	5		4		2		1						2				1					0	8	0	2			
TOTALS :				89.2%	87.8%	88.4%	84.0%	78.1%	87.3%	8	26	0	1	11	0	9	37	19	166	20	102	0	130	848	13	83	10	98	0	2	3	17	0	0	31	205	1	33	36	222	1	10	6	41	229	1533	15	128	0	0	0	0

SURGERY GENERAL INFOR		
HEALTH GROUP	WARD / DEPT	BEDS
SHG	**HICU**	22
SHG	**H4**	30
SHG	**H40**	15
SHG	**H6**	26
SHG	**H60**	26
SHG	**H7**	29
SHG	**H12**	28
SHG	**H120**	22

SHG	**H100**	23
SHG	**CICU**	22
SHG	**C9**	29
SHG	**C10**	21
SHG	**C11**	22
SHG	**C14**	27
SHG	**C15**	26
SHG	**C27**	26

MEDICINE GENERAL INFOR		
HEALTH GROUP	**WARD / DEPT**	**BEDS**

MHG	**AMU**	45
MHG	**P/L**	
MHG	**ACU**	
MHG	**EAU**	21
MHG	**H36**	24
MHG	**H5**	26
MHG	**H500**	24
MHG	**H50**	19
MHG	**H70**	30
MHG	**H8**	27
MHG	**H80**	27
MHG	**H11**	28
MHG	**H110**	24
MHG	**H9**	31
MHG	**H90**	29
MHG	**C26**	26

MHG	**C28**	
MHG	**CDU**	11

CLINICAL SUPPORT GENERNAL II		
HEALTH GROUP	**WARD / DEPT**	**BEDS**
CS	**C7**	15
CS	**C29**	15
CS	**C30**	22
CS	**C31**	27
CS	**C32**	22
CS	**C33**	28

FAMILY & WOMENS GENERAL IN		
HEALTH GROUP	WARD / DEPT	BEDS
F&W	**H30**	9
F&W	**H31+H33**	57
F&W	**MLU**	
F&W	**Rotation**	
F&W	**H34**	20
F&W	**H35**	12
F&W	**H130**	20
F&W	**L&D**	19
F&W	**NICU**	26
F&W	**PAU**	10

F&W	**PHDU**	4
F&W	**C16**	30

Emergency Departmer		
HEALTH GROUP	**WARD / DEPT**	**BEDS**
ED	**ED**	NA

MATION	CURRENT ES [Budge	
SPECIALITY	RN	Non-RN
Critical Care	104.88	7.32
Neurosurgery	21.59	10.44
Neurosurgery	21.36	9.3
Acute Surgery	19.21	11.8
Acute Surgery	19.21	11.8
Vascular	24.09	10.67
Orthopaedic	21.59	13.16
MaxFax / Ortho	16.37	11.8

Gastroenterology	19.68	13.16
Critical Care	87.76	7.32
Orthopaedic	21.88	12.91
Colorectal	18.09	8.06
Colorectal	20.57	8.06
Upper GI	20.07	9.76
Urology	20.57	10.44
Cardiothoracic	23.62	8.62
	480.54	**164.62**

MATION	CURRENT ES [Budge	
SPECIALITY	**RN**	**Non-RN**

Acute Medicine	44.19	23.38
Acute Medicine	2.72	5.94
Acute Medicine	7.39	4.67
Elderly	19.11	13.16
Acute Medicine	13.65	7.94
Respiratory	24.09	13.16
Respiratory	16.37	13.16
Renal	14.86	7.94
Endocrinology	21.59	13.16
Elderly	16.37	13.16
Elderly	11.66	15.89
Neurology / Stroke	21.59	10.44
Stroke	27.28	10.44
Elderly	16.37	15.66
Elderly	16.37	13.16
Cardiology	24.09	7.94

Cardiology	37.98	8.06
Cardiology	12.81	2.44
	348.49	**199.7**

NFORMATION	CURRENT ES [Budge	
SPECIALITY	**RN**	**Non-RN**
Infectious Disease	11.46	7.94
Rehabilitation	12.63	15.66
Oncology	13.64	7.94
Oncology	17.5	10.44
Oncology	13.64	7.94
Haematology	27.28	7.94
	96.15	**57.86**

FORMATION	CURRENT ES [Budge	
SPECIALITY	RN	Non-RN
Gynaecology	10.73	3.89
Maternity	42.63	22.58
Maternity	11.17	5.22
Maternity	11.81	2.98
Paediatric	19.79	3.79
Ophthalmology	14.82	4.67
Paediatrics	20.88	5.22
Maternity	44.92	10.44
Critical Care	71.8	5.22
Paediatric	10.44	0

Paediatric	11.66	0
ENT / Breast	18.29	11.17
	288.94	**75.18**

nt	CURRENT ES [Budge	
SPECIALITY	**RN**	**Non-RN**
ED & Paeds	95.31	21.1

STABLISHMENT eted WTE]		EVIDENCE BASED STAFFING TOOL	Re
Support Staff	TOTAL		Re
1.18	113.38	SNCT	
1.8	33.83	SNCT	
3.08	33.74	SNCT	
2.23	33.24	SNCT	
2.43	33.44	SNCT	
2.67	37.43	SNCT	
2.4	37.15	SNCT	
2.4	30.57	SNCT	

2.77	35.61	SNCT	
2.18	97.26	SNCT	
2.8	37.59	SNCT	
2	28.15	SNCT	
1.91	30.54	SNCT	
2.33	32.16	SNCT	
2.47	33.48	SNCT	
2.85	35.09	SNCT	
37.5	**682.66**		

STABLISHMENT eted WTE]		EVIDENCE BASED STAFFING TOOL	Re
Support Staff	TOTAL		

5.47	73.04	SNCT	
0	8.66		
0	12.06		
2.83	35.1	SNCT	
2.8	24.39	SNCT	
2.53	39.78	SNCT	**6.**
2.8	32.33	SNCT	
2.8	25.6	SNCT	
3.8	38.55	SNCT	
0.88	30.41	SNCT	
8.7	36.25	SNCT	
2.42	34.45	SNCT	
3.4	41.12	SNCT	**7.**
0.88	32.91	SNCT	
1.53	31.06	SNCT	
2.43	34.46	SNCT	

2.6	48.64	SNCT	8.
0	15.25	SNCT	
45.87	**594.06**		

STABLISHMENT eted WTE]		EVIDENCE BASED STAFFING TOOL	Re
Support Staff	TOTAL		
1.91	21.31	SNCT	
1.53	29.82	SNCT	
2.5	24.08	SNCT	
2.5	30.44	SNCT	
2.3	23.88	SNCT	
2.5	37.72	SNCT	
13.24	**167.25**		

STABLISHMENT eted WTE]		EVIDENCE BASED STAFFING TOOL	Re
Support Staff	TOTAL		
0.8	15.42	SNCT	
2	67.21	BRP	8.
0	16.39	BRP	
0	14.79	BRP	
0.73	24.31	SNCT	
3.35	22.84	SNCT	
1.5	27.6	SNCT	
3.35	58.71	BRP	
3.86	80.88	SNCT	
1	11.44	SNCT	

0	11.66	SNCT	
1.85	31.31	SNCT	
18.44	**382.56**		

STABLISHMENT eted WTE]		EVIDENCE BASED STAFFING TOOL	Re
Support Staff	TOTAL		
13.66	130.07	NICE	

equired CHPPD	PROFESSIO [WT	
equired CHPPD	RN	Non-RN
16.83	104.88	7.32
6.25	21.59	10.44
8.56	21.36	9.3
5.84	19.21	11.8
5.41	19.21	11.8
6.1	24.09	10.67
6.56	21.59	13.16
6.74	16.37	11.8

5.43	19.68	13.16
15.1	87.76	7.32
5.18	21.88	12.91
6.61	18.09	8.06
6.23	20.57	8.06
5.55	20.07	9.76
5.48	20.57	10.44
5.55	23.62	8.62
	480.54	**164.62**

equired CHPPD	PROFESSIO [WT	
	RN	Non-RN

6.22	44.19	23.38
0	2.72	5.22
0	7.39	4.67
6.2	19.11	13.16
5.12	13.65	9.3
18/9.73	24.82	14.86
6.03	16.37	10.44
6.06	14.86	7.94
6.27	21.59	13.16
4.6	16.37	13.16
4.93	11.66	15.89
6.18	21.59	10.44
92/6.67	27.04	10.44
5.79	16.37	15.66
5	16.37	13.16
5.76	24.09	7.94

04/6.33	37.98	8.06
0	12.81	2.44
	348.98	**199.32**

equired CHPPD	PROFESSIO [WT	
	RN	Non-RN
4.88	11.46	7.94
6.13	12.63	13.16
5.12	18.95	10.44
5.73	14.86	7.94
5.34	14.86	7.94
5.83	25.77	10.67
	98.53	**58.09**

equired CHPPD	PROFESSIO [WT	
	RN	Non-RN
4.64	10.73	3.89
35/8.74	42.63	22.58
8.99	11.17	5.22
0	11.81	2.98
8.85	19.79	3.79
5.59	14.82	4.67
9.55	20.88	5.22
9.73	44.92	10.44
13.36	71.8	5.22
8.88	10.44	0

12.68	11.66	0
5.58	18.29	11.17
	288.94	**75.18**

equired CHPPD	PROFESSIO [WT	
	RN	**Non-RN**
0	95.79	20.87

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NAL VIEW E]		
Support Staff	TOTAL	RN
1.18	113.38	0.00
1.8	33.83	0.00
3.08	33.74	0.00
2.23	33.24	0.00
2.43	33.44	0.00
2.67	37.43	0.00
2.4	37.15	0.00
2.4	30.57	0.00

2.77	35.61	0.00
2.18	97.26	0.00
2.8	37.59	0.00
2	28.15	0.00
1.91	30.54	0.00
2.33	32.16	0.00
2.47	33.48	0.00
2.85	35.09	0.00
37.5	**682.66**	**0.00**

NAL VIEW E]		
Support Staff	TOTAL	RN

5.47	73.04	0.00
0	7.94	0.00
0	12.06	0.00
2.83	35.1	0.00
2.8	25.75	0.00
2.53	42.21	0.73
2.8	29.61	0.00
2.8	25.6	0.00
3.8	38.55	0.00
0.88	30.41	0.00
8.7	36.25	0.00
2.42	34.45	0.00
3.4	40.88	-0.24
0.88	32.91	0.00
1.53	31.06	0.00
2.43	34.46	0.00

2.6	48.64	0.00
0	15.25	0.00
45.87	**594.17**	**0.49**

NAL VIEW E]		
Support Staff	TOTAL	RN
1.91	21.31	0.00
1.53	27.32	0.00
2.5	31.89	5.31
2.5	25.3	-2.64
2.3	25.1	1.22
2.5	38.94	-1.51
13.24	**169.86**	**2.38**

NAL VIEW E]		
Support Staff	TOTAL	RN
0.8	15.42	0.00
2	67.21	0.00
0	16.39	0.00
0	14.79	0.00
0.73	24.31	0.00
3.35	22.84	0.00
1.5	27.6	0.00
3.35	58.71	0.00
3.86	80.88	0.00
1	11.44	0.00

0	11.66	0.00
1.85	31.31	0.00
18.44	**382.56**	**0**

NAL VIEW E]		
Support Staff	TOTAL	RN
13.66	130.32	0.48

ent Review 2019/20

ADDITIONAL REQUIREMENT (WTE)		
Non-RN	Support Staff	Planned CHPPD
0	0	22.53
0	0	5.39
0	0	10.12
0	0	5.31
0	0	5.35
0	0	5.58
0	0	5.93
0	0	6.23

0	0	6.1
0	0	19.38
0	0	4.81
0	0	6
0	0	6.2
0	0	5.29
0	0	5.77
0	0	6.01
0	**0**	

ADDITIONAL REQUIREMENT (WTE)		
Non-RN	**Support Staff**	**Planned CHPPD**

0	0	**7.27**
-0.72	0	**0**
0	0	**0**
0	0	**7.5**
1.36	0	**5.28**
1.7	0	**9.43**
-2.72	0	**5.55**
0	0	**6.08**
0	0	**6.43**
0	0	**5**
0	0	**6.22**
0	0	**5.63**
0	0	**11.47**
0	0	**4.86**
0	0	**4.77**
0	0	**5.93**

0	0	12.76
0	0	0
-0.38	**0**	

-8139.98

ADDITIONAL REQUIREMENT (WTE)		
Non-RN	**Support Staff**	**Planned CHPPD**
0	0	7.98
-2.5	0	8.13
2.5	0	6.5
-2.5	0	5.18
0	0	5.13
2.73	0	6.2
0.23	**0**	

ADDITIONAL REQUIREMENT (WTE)		
Non-RN	Support Staff	Planned CHPPD
0	0	3.44
0	0	5.5
0	0	24.08
0	0	0
0	0	4.9
0	0	6.88
0	0	6.16
0	0	13.1
0	0	12.01
0	0	8.56

0	0	12.85
0	0	4.62
0	**0**	

ADDITIONAL REQUIREMENT (WTE)		
Non-RN	**Support Staff**	**Planned CHPPD**
-0.23	0	0

Planned CHPPD @ 85% of Bed Occupancy	Extra RN £
26.51	0
6.34	0
11.90	0
6.25	0
6.29	0
6.57	0
6.98	0
7.33	0

7.17	0
22.80	0
5.66	0
7.06	0
7.30	0
6.22	0
6.79	0
7.07	0
	0

Planned CHPPD @ 85% of Bed Occupancy	**£ Extra RN (negative = funding required)**

8.85	0
0.00	0
0.00	0
8.82	0
6.21	0
11.09	-23,650
6.53	0
7.16	0
7.56	0
5.88	0
7.32	0
6.62	0
13.49	7,775
5.72	0
5.62	0
6.98	0

15.01	0
0.00	0
	-15,875

Planned CHPPD @ 85% of Bed Occupancy	£ Extra RN (negative = funding required)
9.39	0
9.56	0
7.65	-172,028
6.09	85,528
6.04	-39,524
7.31	48,919
	-77,105

Planned CHPPD @ 85% of Bed Occupancy	£ Extra RN (negative = funding required)
4.04	0
6.48	0
28.33	0
0	0
5.77	0
8.09	0
7.24	0
15.41	0
14.13	0
10.08	0

15.11	0
5.44	0
	0

Planned CHPPD @ 85% of Bed Occupancy	**£ Extra RN (negative = funding required)**
0	-23,264

EXTRA BUDGET REQUIRED [£] -ve figures = [Inclusive of 28% upli	
RN funding for additional B6	**Extra Non-RN £**
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**

EXTRA BUDGET REQUIRED [£] -ve figures = [Inclusive of 28% upli	
£ RN funding for additional B6 (negative = funding required)	**£ Extra Non-RN (negative = funding required)**

0	0
0	15,423
0	0
0	0
0	-29,133
0	-36,416
0	58,265
0	0
0	0
0	0
0	0
0	0
-7,775	0
0	0
0	0
0	0

0	0
0	0
-7,775	**8,140**

EXTRA BUDGET REQUIRED [£] -ve figures = [Inclusive of 28% upli	
£ RN funding for additional B6 (negative = funding required)	**£ Extra Non-RN (negative = funding required)**
0	0
0	53,553
0	-53,553
0	53,553
0	0
0	-58,479
0	**-4,927**

EXTRA BUDGET REQUIRED [£] -ve figures = [Inclusive of 28% upli	
£ RN funding for additional B6 (negative = funding required)	£ Extra Non-RN (negative = funding required)
0	0
0	0
	0
0	0
0	0
0	0
	0
0	0
0	0
	0

	0
0	0
0	**0**

EXTRA BUDGET REQUIRED [£] -ve figures = [Inclusive of 28% upli	
£ RN funding for additional B6 (negative = funding required)	**£ Extra Non-RN (negative = funding required)**
0	4,927

additional funds required ft]	
Extra Support Staff £	TOTAL £
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**

additional funds required ft]	
£ Extra Support Staff (negative = funding required)	**£ TOTAL (negative = funding required)**

	0
0	15,423
	0
	0
	-29,133
	-60,066
	58,265
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0

	0
	0
0	**-15,510**

additional funds required ft]	
£ Extra Support Staff (negative = funding required)	**£ TOTAL (negative = funding required)**
0	0
0	53,553
0	-225,581
0	139,081
0	-39,524
0	-9,560
0	**-82,032**

additional funds required ft]	
£ Extra Support Staff (negative = funding required)	£ TOTAL (negative = funding required)
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**

additional funds required ft]	
£ Extra Support Staff (negative = funding required)	**£ TOTAL (negative = funding required)**
0	-18,337

COMMENTS

[Reasons for variances, decision, etc.]

No additional funding required.

COMMENTS

[Reasons for variances, decision, etc.]

Align Non Reg requirement for Ward changes -

Align Non Reg requirement for Ward changes -

Skill mix changes between H5 & H500.

Skill mix changes between H5 & H500.

Uplift for additional band 6 - net affect.

Funding will be resourced within MHG buc

COMMENTS

[Reasons for variances, decision, etc.]

Review of skill mix requirement within CSS Wa

Review of skill mix requirement within CSS Wa

Review of skill mix requirement within CSS Wa

Review of skill mix requirement within CSS Wa

Review of skill mix requirement within CSS Wa

nursing budgets (rebalance of budget to

COMMENTS

[Reasons for variances, decision, etc.]

No additional funding required.

COMMENTS
[Reasons for variances, decision, etc.]

Review of Management and Skill mix, B7 fun

Non RN (mid pt B2 plus On Costs)	21,421	19/20 rates
RN (mid pt B5 plus On Costs)	32,397	19/20 rates
Non RN (mid pt B2 plus On Costs)	21,421	19/20 rates
B7	48,467	19/20 rates

- reduction in wte.

- increase in wte.

lgets - relign budgets to actual substan

rds.

rds.

rds.

rds.

rds.

ding will be resourced from aligning budg

tive spend.

ets to actuals.

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on Monday 30 September 2019

Present:	Mrs V Walker	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance
	Mrs M Stern	Patient Council Chair
In Attendance:	Dr K Sahria	Consultant in Palliative Medicine (Item 4.1 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies** Apologies were received from Dr M Purva, Chief Medical Officer, Prof. M Veysey, Non-Executive Director and Prof. J Jomeen, Non-Executive Director	
2	**Declarations of Interest** Mrs Walker declared her interest that she was a Cabinet Member for Adult and Carer Services.	
3	**Minutes of the meeting of 27th August 2019** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising There were no matter arising.	
	3.2 Action Tracking List The Committee reviewed the action tracker.	
	3.4 Workplan 2019/20 Mr Corral agreed to bring a paper on drug shortages in November 2019. The Trust Wide Learning Report to be next received in March 2020.	**DC** **KS**
	4.1 End of Life Care Mrs Walker welcomed Dr K Saharia, Consultant in Palliative Medicine to the meeting. Dr Saharia gave a presentation which identified the amount of people expectedly dying in hospital and how the last days of life are managed. She advised that it was sometimes difficult to recognise when people were dying and that communication was key. Dr Saharia spoke of the 7 day service, out of hours service, the Chaplaincy and Bereavement Services who all worked together with the End of Life Steering Group to ensure that expected deaths were as comfortable and planned as possible. The SPICT tool was used to identify the deteriorating patient.	

Dr Saharia advised that the RESPECT process was being promoted and implemented and was a personal care plan for patients. The End of Life study day was open to all clinical staff on how to recognise distress and respond appropriately.

A new electronic co-ordination of care system was being piloted in York with STP funding

Dr Saharia reported that there were always room for improvements and a good death was to be the expectation of the Trust.

There was a discussion around the patients preferred place of death and that sometimes people change their minds when they become ill. The Trust will do what it can to facilitate patient's needs and wants. Once a patient had died the death certificate would be streamlined through the Bereavement Services when the new Medical Examiner role was in place.

Dr Saharia advised that the Mortality Committee monitored deaths as well as identifying any themes and trends around unexpected deaths.

Resolved:
The Committee received and accepted the report.

4.2 Quality Improvement Programme
Mrs Southgate presented the report and advised that there were issues with completion of the Matron's handbook and with the Mental Health project. Mrs Geary was reviewing the Matron's handbook with the Nursing Executive Committee and assured the Committee that the work had been completed but not uploaded due to time pressures.

Mrs Walker expressed frustration regarding the Mental Health issues and had spoken with the Chair of Humber FT on a number of occasions. Mrs Geary advised that significant progress had been made with CAHMS but there were an increasing number of complex patients especially young people.

Ms Ramsay added that the Trust was seeing 40 patients per day with mental health issues. Although the Crisis Team was in place and working well the numbers could be overwhelming.

Resolved:
The Committee received and accepted the report.

4.3 Integrated Performance Report
The report was reviewed by the Committee. Mr Hall asked about the reduction in WET AMD injections and whether this would impact on quality and the provision of the service. Ms Ramsay suggested that Mr Evans would be able to answer the question at the Performance and Finance meeting later that day.

Mrs Walker asked about the Cancer 104 day waits and how this was being managed. Ms Ramsay advised that the operations teams had sight of each patient to ensure their treatment started as soon as possible. She added that the Trust measured this independently and that it was not a

constitutional standard. There were also changes to the reporting measures that NHSI/E were piloting.

Resolved:
The Committee received and accepted the report.

4.4 Quality Report
Mrs Geary presented the report and advised that the investigations relating to the Never Events would be in the next month's report to the Committee.

Duty of Candour compliance had dropped in the last month, the National Audit requirements had been identified and the 'Stop the Line Campaign' had been launched. Mrs Geary reported that the Board had received a CQC presentation regarding how the hospital moves to a 'Good' rating.

There was a discussion around the Duty of Candour and what the issues were regarding the drop in compliance. Mrs Geary advised that the letters of apology and investigation were being done but not within the correct timeframes. Work was ongoing to work with the teams to ensure letters go out in a timely way.

Emergency Department Assurance
Mrs Geary presented the report which gave assurance that patients were being given food and drinks and that there were no pressure ulcers reported. There had been one fall with harm, but she assured the Committee that the department was calm, quiet and dignified and patients were receiving good care.

There was a discussion around patients coming into ED and where they were held if it was full. Mrs Geary advised that they were held in the Atrium were the paramedics could escalate any issues.

Resolved:
The Committee received and accepted the reports.

4.5 Trustwide Learning Report
Mrs Southgate presented the report which highlighted the different sources of information to inform learning within the Trust. Mrs Walker did not think that learning was the most appropriate wording for the report as it highlighted themes and actions but there was no evidence to support that staff were learning.

Mr Corral advised that the new Serious Incident Committee focussed on the learning from Serious Incidents and the Stop the Line campaign was a good example of a learning organisation. The Hospital Improvement Team were also involved in learning from recommendations and getting the messages to staff.

Mrs Walker suggested changing the name of the report to the Themes Understood and Actions Taken report.

Mrs Stern agreed and stated that there was a wider piece to inform the public through social media or other means that the Trust was a learning organisation.

Resolved:
Mrs Southgate agreed to change the title of the report and this would be reflected on the workplan. The Committee received and accepted the report. **KS**

4.6 Staff Survey Q1
Mrs Thompson advised that the report had been received by the Board in September 2019.

Resolved:
The Committee received and accepted the report.

5.1 Workforce Transformation Committee Progress Update
Mrs Geary spoke of the international workforce recruitment and the identified EU nationals. There were no risks involved and support was in place for settled status. She also mentioned the Apprenticeship programme and the positive uptake of apprenticeships.

Resolved:
The Committee received and accepted the report.

5.2 Serious Incidents – Lessons Learned – Themes and Trends
Mrs Southgate presented the report and advised that 2 out of the 5 Never Event investigations had been closed.

There was a discussion around SI 20197618 and poor documentation. The findings had been discussed with the Team involved and the recommendations would be shared more widely.

Mrs Walker suggested a Trustwide Learning Programme where themes and recommendations could be shared more widely to encourage learning.

Resolved:
The Committee received and accepted the report.

6.1 Operational Quality Committee Report
Mrs Southgate presented the report and highlighted the 'Stop the Line' campaign and that the Committee had discussed the Quality Improvement Programme.

There was a discussion around whether more information was required regarding the meeting, but it was agreed that any major issues would be flagged and therefore not necessary.

Resolved:
The Committee received and accepted the report.

6.2 Board Assurance Framework
Ms Ramsay presented the BAF which included the Q1 ratings signed off by the Board in July 2019.

Ms Ramsay assured the Committee that the right questions were being asked by the Committees and risks were escalated to Board appropriately. She advised that a Board Development session relating to the Research and Innovation risk would be carried out in either November 2019 or

January 2020.

The Committee discussed risks such as Brexit and its impact on staffing numbers and ageing clinical equipment that was not fit for purpose.

Resolved:
The Committee received and accepted the report.

6.3 NICE Compliance
Mrs Southgate presented the report which gave assurance regarding implementation of NICE guidance and compliance levels.

The Committee discussed the non-compliant areas and asked that an explanation be added to the report. This would allow the Committee to determine whether it needed further assurance. More narrative would be included.

Resolved:
The Committee received and accepted the report. The Committee requested more narrative around the items of non-compliance. **KS**

7 Any Other Business
As it was Mrs Walkers last meeting, Mrs Green thanked her on behalf of the Committee for her commitment and contributions over the years. Mrs Walker thanked the Committee and stated that she was sad to leave the Trust and the fantastic people working in it.

8 Chairman's Summary to the Board
A summary would be prepared for the Board meeting.

9 Date and time of the next meeting:
Monday 28 October 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 28 October 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Prof J Jomeen	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Acting Deputy Director of Quality Governance
	Mrs A Green	Lead Clinical Research Therapist
In Attendance:	Dr A McNeil	Chief Registrar
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs M Stern, Patient Council Chair	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held 30th September 2019** Item 4.3 Integrated Performance Report – WET AMD should read wet AMD. Following this change 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 The Committee reviewed the tracking list. Mrs Thompson to speak to Ms Rudston regarding reduced safeguarding referrals and how the Trust's performance compared to other Trusts.	**RT/KR**
	3.3 Any Other Matters Arising There were no other matters discussed.	
	3.4 Workplan The Committee reviewed the workplan. There were no issues raised.	
	4.1 Quality Improvement Programme Mrs Southgate presented the item and advised that work was ongoing regarding the Matron's Handbook to ensure that data was being completed as planned. The paper book was being reviewed with Mr Jessop to streamline the process into an electronic upload of data. Mrs Southgate advised that Mrs Filby had been working with the nursing teams regarding the Nutrition QIP to ensure that records were completed.	

The Acute Kidney Injury QIP was now being managed as business as usual.

There was a discussion around clinic start times and Mr Hall asked if the performance figure of 70% was good. Mrs Southgate agreed to discuss this with the QIP lead and find out how the Trust benchmarked against others. **KS**

The Committee also discussed the outpatient programme in some detail. Work was ongoing to text patients their appointments as well as other ways to improve the patient experience. It was agreed that Mrs Henderson would be invited to the December 2019 meeting to inform the Committee of the progress.

Dr Purva expressed her concern regarding the Acute Kidney Injury QIP and how the outstanding clinical actions were being met. Mrs Southgate agreed to include this in her report at the next meeting. **KS**

Prof Jomeen asked for clarity around the rag rating colours on the final sheet of the report. Mrs Southgate agreed to check these and re-circulate the report. **KS**

Mrs Geary expressed her concern regarding the dementia QIP and the low performance of 30% it was reporting. A number of actions were in place to address this.

The Committee discussed the Medicine Optimisation QIP and the decreasing performance around dispensed prescriptions. It was agreed that the language would be changed to clarify the QIP aim.

Resolved:
The Committee received and accepted the report.

4.2 Integrated Performance Report
Ms Ramsay advised that the report would be changing in the next couple of months due to national reporting changes and measures being re-set by the regulator.

The Committee expressed little optimism for the performance results in the report. Ms Ramsay reported that robust scrutiny was given to the report at the Board, Performance and Finance and there was much work ongoing to address the issues. She added that the Trust was not reporting an increased level of harm.

The Committee discussed the CDifficile cases on H50 and Mrs Geary advised that a root cause analysis meeting was being established to review them.

Mr Hall asked if there were any concerns relating to the Community Paediatric transfer of service and Mrs Geary advised that the Trust had requested an independent chair from the clinical senate to oversee the transition.

There was a discussion around emergency C-Section rates and whether

the 12% target was realistic in a city with complex health needs. Ms Ramsay agreed to review the Maternity Dashboard with a view to the Committee seeing it more regularly.

The Committee discussed VTE assessment performance and whether the correct patients were receiving the prophylaxis. Dr Purva reported that the Safety Thermometer audits captured that the prescription is allocated.

Resolved:
The Committee received and accepted the report.

4.3 Quality Report
Mrs Geary presented the report and advised that there had been 3 Serious Incidents declared in September 2019 and the Trust was currently reviewing its process for managing Duty of Candour. There had been a meeting with the Commissioners who had been impressed by the simulation processes around Serious Incident used to feed back to staff.

The Serious Incident Committee had been established and was discussing learning, key themes and near misses as well as part of its remit.

Mrs Geary advised that a 10 point plan had been submitted to NHS Improvement as part of the National Patient Safety strategy relating to Never Events. This plan required sign off by the Quality Committee and would be included on the next agenda in November 2019. **RT**

The Trust had been invited to take part in the 'Moving to Good' initiative by NHS Improvement which was seen as a positive way forward.

A new Patient Safety Board had been established, to deliver the aspects within the NHS patient safety strategy. The patient safety board has four work streams identified within it, these have been established as projects which will report to the board. The work streams are Stop the Line, Investigations, Just Culture and Patient Safety Champions. The first meeting of the Patient Safety Board is early November 2019.

Resolved:
The Committee received and accepted the report.

4.4 Mortality – Learning from Deaths/Medical Examiner
Dr Purva presented the learning from deaths paper and advised that the Structured Judgement Reviews were ongoing along with the Serious Incident investigations and any outcomes would be shared by the Committee. She added that themes and trends of deaths were discussed at the monthly Mortality and Morbidity meetings.

Dr Purva advised that the Medical Examiner role would be launched in April next year and the Trust was currently recruiting for the Medical Examiner Officer roles which would be in place by December 2019.

Prof Veysey stated that 4.5% was a low number of Structured Judgement Reviews to be taking place. Dr Purva advised that this was the number expected of the Trust. Mrs Southgate added that the Trust was adopting the Aberdeen model of recording mortality and morbidity and near misses using the Datix reporting system.

Resolved:
The Committee received and accepted the report.

4.5 World Health Organisation Checklist – SSIPS
Dr Purva presented the update and advised that work was ongoing to improve how data was captured in theatres. She advised that the data was then presented at the Performance and Accountability meetings where any areas of concern were raised.

Dr Purva reported that the Trust was compliant in most areas but that there was still work to do around cultures and behaviours. Dr McNeil added that a task and finish group had been established with him as the lead to review this area.

Dr Purva advised that the team had visited Guys and St Thomas's Hospital where the surgeon led the checklist procedures and would not commence unless everyone was engaged in the process. Dr Purva stated that the checklists were followed at the Trust but it felt more of a tick box exercise than a group participation process.

Mr Hall suggested having champions of the checklist in the organisation to push the engagement and compliance. Dr Purva agreed and added that WHO checklist compliance was discussed at annual appraisals to encourage team working.

Resolved:
The Committee received and accepted the update.

5.1 Serious Incidents – Lessons Learned – Themes and Trends
Mrs Southgate presented the report which highlighted the outcome of the Never Event relating to the misplaced NG Tube. New procedures had been put into place to ensure this did not happen again.

Mrs Southgate also detailed another serious incident which was regarding protocol around an oxygen flow meter and the action to ensure oxygen and air could not be mixed was now in place.

Pressure Ulcers were now being investigated as part of the Yorkshire Contributory Factor Framework which was a more inclusive learning experience.

A high profile patient assault was also included in the report.

Resolved:
The Committee received and accepted the report.

6.1 Operational Quality Committee Report
Dr Purva presented the report and advised that the Committee had discussed the Missing Patient Protocol and the Trust was working with the Police to ensure the policy was in date and appropriate.

The mattress replacement system had also been discussed as there was an issue around the availability of air mattresses.

Resolved:
The Committee received and accepted the report.

6.2 Board Assurance Framework
Mrs Thompson advised that the BAF report had been agreed at the September 2019 Board meeting and that the changes made since then were relating to BAF 7.1 in the further assurance required section. The items added related to the consultant pensions issue, Health Group run rates and the five year financial plan.

Ms Ramsay added that any comments or recommendation that the Committee had to make following this meeting would be captured for the November 2019 Board meeting.

The Committee discussed the invitation from the CQC to be included in their 'working towards good' programme as positive assurance in the BAF, but agreed that the risk ratings should not be changed.

Prof Veysey asked about Research and Innovation and how the recruitment levels were not what they should be and therefore Trust performance was being impacted. Dr Purva advised that the next Board meeting would feature a report detailing where the Trust was in regard to Research and Innovation.

Resolved:
The Committee received and accepted the report.

7 Any Other Business
Mr Hall advised that there was a deep dive relating to performance in the ENT service being undertaken. Any quality outcomes would be provided to the Committee.

8 Chairman's Summary to the Board
The Chair agreed to summarise the meeting at the next Board.

9 Date and time of the next meeting:
Monday 25 November 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

Trust Board – November 2019

Performance Report - Executive Summary

1. Purpose

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

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

2. Unplanned Care

ED performance for September 2019 was 82.5% (combined), which is a slight deterioration from the previous month and meant that the agreed recovery trajectory, which required the Trust to achieve 90% by the end of September, was not achieved. Performance for Quarter 2 was 85% against a trajectory of 90%

The System Wide Improvement Plan, which was agreed in August 2019, continues to be monitored internally via the Emergency Performance and Flow meeting fortnightly basis and by the Unplanned Care Delivery Group and the A&E Delivery Board monthly. The action plan with latest updates is shown at Appendix 1.

The additional medicine ward at HRI has now opened to 18 beds. In addition, Hull CCG have commissioned 19 additional Level 3 and Level 4 beds in the community from early November and the Social Care Discharge facility at Castle Hill Hospital is scheduled to open on the 2nd December, which will provide 14 beds for East Riding of Yorkshire patients who are medically fit and waiting for their package of care to commence or their Care Home placements to become available.

Capital works to create the new front entrance to the Emergency Care Area(ECA) of ED commenced on the 21st October and is due to be completed by mid December. Equally the extension to the Ambulatory Care Unit (ACU) to accommodate a number of surgical specialties is also expected to be completed by mid December along with an additional 12 bedded space adjacent to the Medical Assessment Unit which will be used as an initial assessment and triage area. The revenue consequences for these schemes have been agreed by the Executive Team. There has also been agreement to re-locate the Elderly Assessment Unit (EAU) to H36 and move the Frailty Invervention Team (FIT) from ED to be co-located with EAU on H36. This will provide more physical space for the Majors part of ED.

The Trust continues to report Zero 12 hour trolley waits.

3. Planned Care

The Trust reported a position of 72.1% for RTT against the planned trajectory of 80.9% for September.

The 2019/20 requirement is to have no more patients on the RTT list than at the March 2019 baseline which was 53,083. The actual position at the end of September was +709 above the required trajectory but the Trust is expecting to be back on trajectory by the end of October.

Data quality issues have been identified as a contributing reason why the Trust is off trajectory against the Waiting List Volumes reduction plan. Audit and validation work undertaken over the last 2 months confirms that there remain issues with RTT clocks not being stopped at the appropriate time and RTT clock being started in error despite training being provided to all staff. Consequently a number of additional actions have been agreed between the Clinical Administration Hubs, Health Groups and the Performance and Information Department via the OPtimise Board to improve RTT data quality and this will continue to be closely monitored by the weekly Performance and Activity Meeting.

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

At the start of the year 4 key elective standards were set for each Health Group to achieve during 19/20;

- That there would be zero 52 weeks
- That their waiting list volume would reduce from the baseline position of 31/3/19.

A further 2 ‘stretch’ targets were also set for each Health Group;

- That a 50% reduction is ASI / Holding would be achieved by end March 2020
- That a 50% reduction in the number of follow-ups would be achieved by end March 2020

All Health Groups have undertaken a comprehensive ‘stock take’ review of their position at Month 6 against each of the 4 elective standards and confirmed their expected forecast outturn position. Some additional investment has been secured to support gynaecology, ENT and Plastic Surgery with its elective performance.

From the stocktake review, all Health Groups have confirmed that they will meet their Waiting List Volume reduction targets by March 2020 and will maintain zero 52 weeks breaches.

The **Clinical Support Health Group** has confirmed that they also expect to meet the 50% reduction in ASI / Holding and the 50 % reduction in follow-ups by March 2020.

The **Family and Womens Health Group** expect to achieve the 50% reduction in ASI / Holding in Breast Services and Paediatric Medicine only, however has made progress in reducing ASI / Holding in Dermatology, Gynaecology and Paediatric Surgery against its baseline position at the start of the year.

The Health Group will not achieve the 50% reduction in the follow-up backlog in any specialties but is expected to make progress overall in the number of follow-ups compared with their position at the start of the year.

The **Medicine Health Group** will achieve the 50% reduction in ASI / Holding in 4 specialties Diabetes, Endocrinology, Nephrology and Rheumatology and, will make good progress in all other specialties against the baseline position at the start of the year. The exception to this is Cardiology and Neurology whose ASI / Holding position has deteriorated in year.

The Health Group is expected to meet the 50% reduction in the follow-up backlog in 5 specialties; DME, Neurology, Respiratory, Rheumatology and stroke.

The **Surgery Health Group** will achieve the 50% reduction in ASI / Holding across the Health Group overall and in all specialties with exception of Oral Surgery and Orthodontics

The Health Group will not achieve the 50% reduction in follow-ups but will make significant progress in reducing the number of follow-ups in the backlog for all specialties, except Gastroenterology and Urology, from the position at the start of the year.

Diagnostics
Performance against the diagnostic standard has Improved slightly in September to 10%, an improvement of 1.15% on August's position.

Endoscopy accounts for approximately 70% of all breaches of the diagnostics 1% standard. From September, some CT Colonscopy activity has been commissioned from the Spire Hospital which will help improve waiting times and the additional evening and weekend sessions scheduled in the Endoscopy service have started to impact positively on the diagnostics position with 76 less Endoscopy breaches in September compared with August and 100 breaches less in October compared with September. During October, the Endoscopy service has delivered 30 additional lists above its normal weekday activity.

The number of diagnostics breaches is expected to be back on trajectory from mid Quarter 4.

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

4. Cancer Standards

The Trust continues to achieve the 2 Week standard, despite the continued growth in activity seen this year. The Cancer 62 day RTT position for August deteriorated slightly on the July position however the performance for September 2019 is provisionally 78% and therefore significantly improved on previous 4 months. Work has been undertaken with all Health Groups during to ensure that all clinical and managerial teams fully understand all of the 6 scenario's within the revised breach allocation guidance which came into effect from April 2019.

The additional CT Colonscopy capacity commissioned from the Spire Hospital will assist with reducing the number of breaches in the Colorectal pathway. Patient compliance / patient choice is becoming a significant contributing factor to Cancer 62 day breaches, particularly in the diagnostic phase of the pathway, prior to cancer being confirmed or ruled out. Further work is being undertaken to understand how pathway compliance can be improved by improving the support to patients during what is, without doubt, a very anxious and worrying time. The Trust has also engaged with the National Cancer Intensive Support Team to support a review of both the Upper GI and the Gynaecology pathway to identify if any Improvements can be made to these pathways.

As part of the Health Groups 'stock take', the Cancer 62 day position and 104 day wait position for each tumour site has been reviewed.

The **Clinical Support Health Group** is reporting that it will meet the Cancer 62 day standard for Haematology and reduce its 104 days waits against the March 2019 baseline.

The **Family and Womens Health Group** will reduce its 104 day waits from the March 2019 baseline and will meet the 85% Cancer RTT standard for Skin and Head and Neck tumour sites by March 2020.

The **Medicine Health Group** is reporting that it will achieve the Cancer Standard for Lung by March 2020 and will reduce its 104 days waits against the March 2019 baseline.

The **Surgery Health Group** is reporting that it will not achieve the 85% cancer standard for any of its 3 tumour sites; Colorectal, Upper GI and Urology tumour sites but will continue to make performance improvements over the next 6 months. The Health Group will reduce its 104 day waits against the March 2019 baseline.

5. Summary

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

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

The Trust has continued to maintain zero 52 week breaches YTD and, following the Health Group stock take review at Month 6, the Trust expects to maintain this position for the remainder of the year. Equally the Trusts Waiting List Volume has remained under control all year, being at, or just over, the trajectory YTD. The Health Group stock take also confirms that the Trust intends to deliver a Waiting List Volume which is below the volume at the start of the year.

A 50% reduction in the ASI/ Holding volume and a 50% reduction in the follow-up backlog levels were set as internal ‘stretch target’. Whilst these stretch targets have not consistently been achieved in all Health Groups, the majority of specialties are reporting improved positions at M6 against their positions at the start of the year and expecting further Improvement over the second half of the year.

Integrated Performance Report 2019/20

November 2019

September data

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

Integrated Performance Report

RESPONSIVE

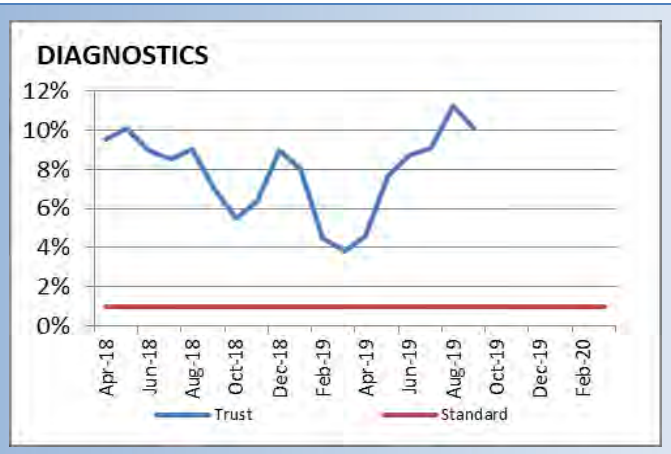
Description	Aggregate Position	Trend	Variation

Diagnostic Waiting Times:

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 the target during September with performance of 10.05%



Breaches in month were:

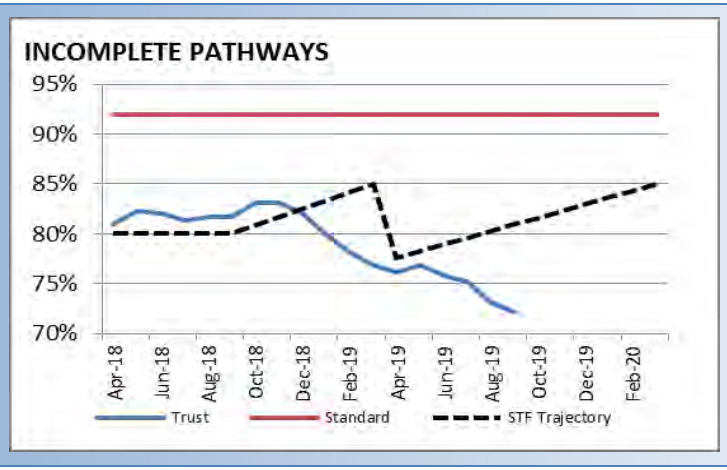
Magnetic Resonance Imaging	29
Computed Tomography	124
Neurophysiology	3
Urodynamics - pressures & flows	15
Colonoscopy (x2 Paed)	287
Flexi sigmoidoscopy	2
Gastroscopy (x38 Paed)	322
Cystoscopy	62
TOTAL	**844**

Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the September improvement trajectory of 80.9%

September performance was 72.13%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 15 specialties that failed to meet the improvement trajectory

Integrated Performance Report

RESPONSIVE

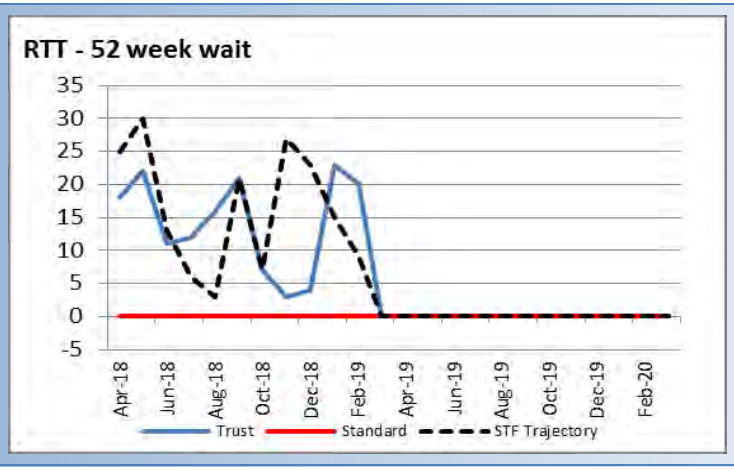
Description	Aggregate Position	Trend	Variation

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 September

The Trust achieved the national standard of zero breaches.

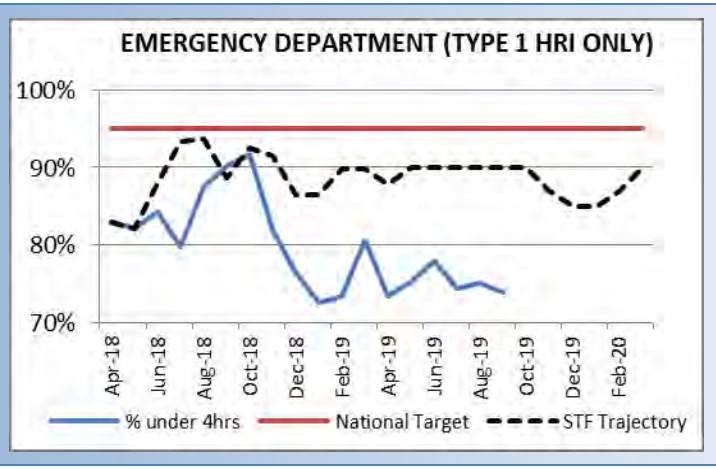


ED Waiting Times (HRI only)

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 73.9% for September

This has failed to achieve the national 95% threshold.



Performance has decreased 1.2% during September

Integrated Performance Report

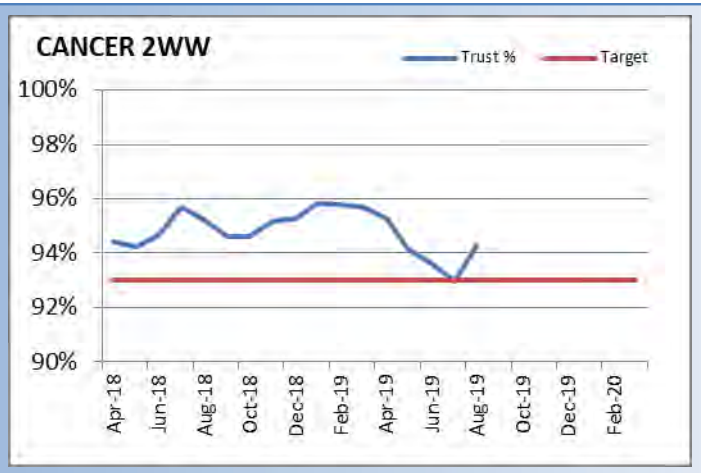
RESPONSIVE

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%.

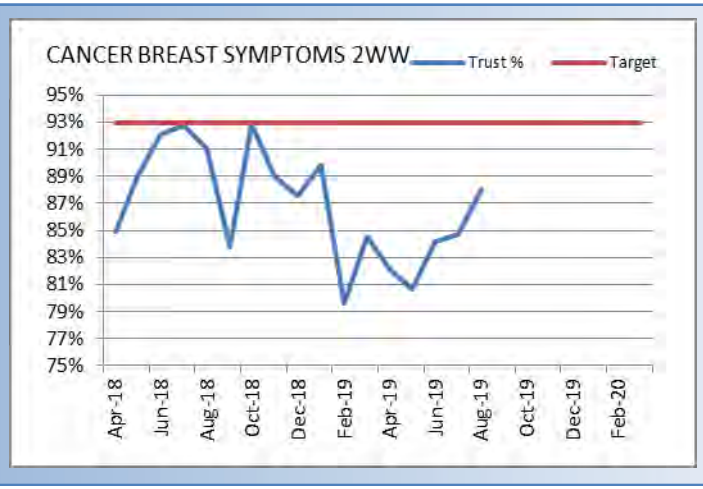
August performance achieved the 93% standard at 94.3%



Cancer: Breast Symptom Two Week Wait Standard

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

August performance failed to achieve the 93% standard at 88.0%



Integrated Performance Report

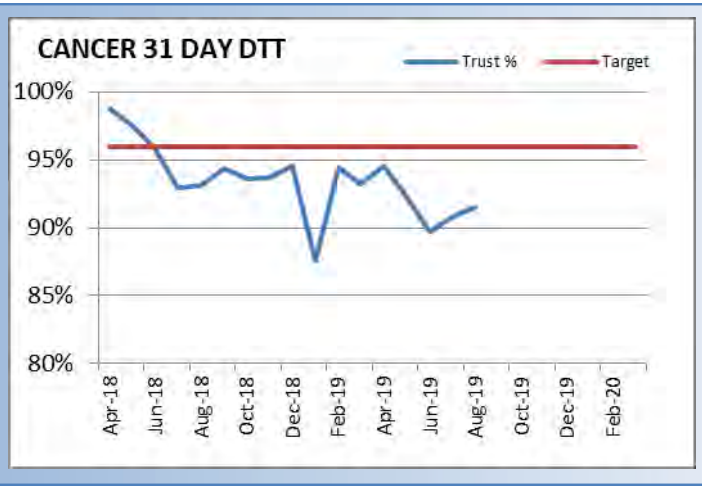
RESPONSIVE

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%.

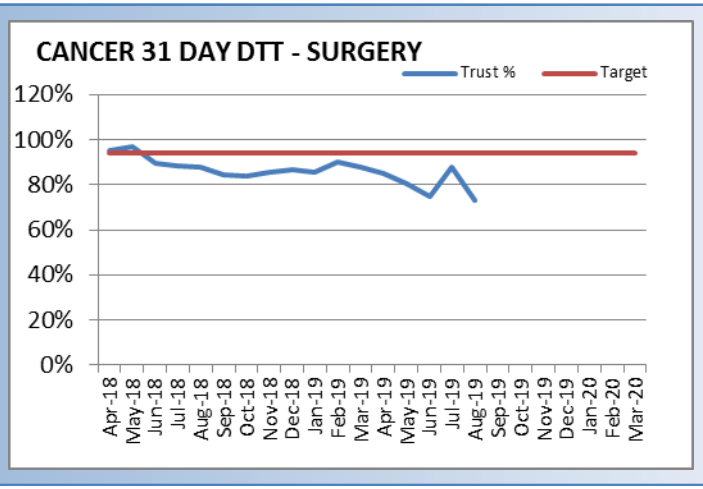
August performance failed to achieve the 96% standard at 91.5%



Cancer: 31 Day Subsequent Surgery Standard

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

August performance failed to achieve the 94% standard at 73.2%



Integrated Performance Report

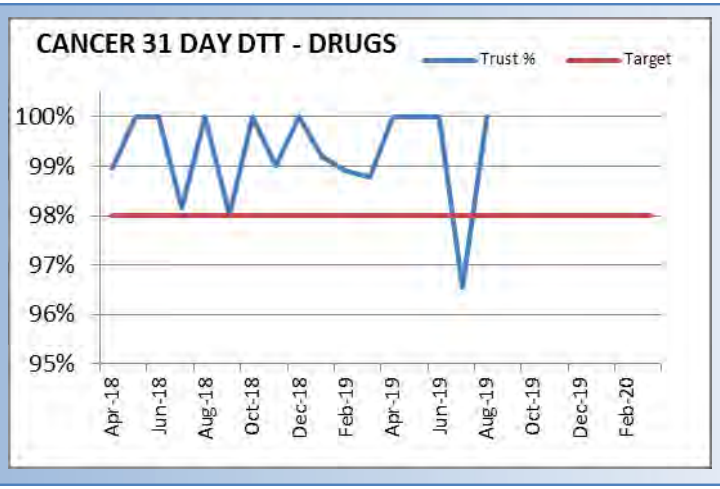
RESPONSIVE

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%.

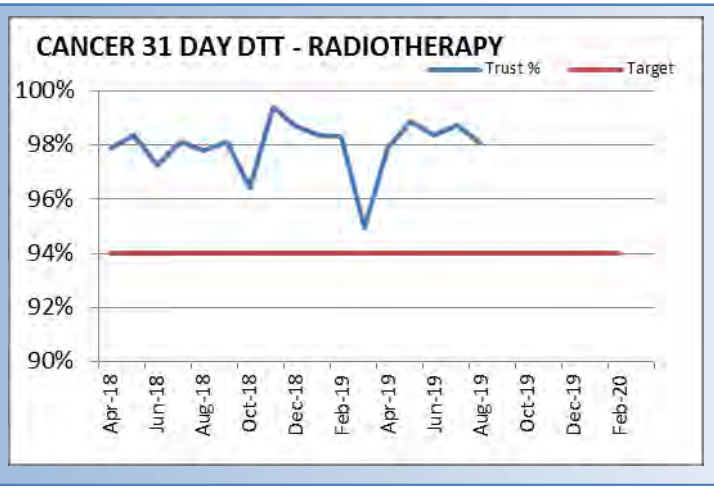
August performance achieved the 98% standard at 100%



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%.

August performance achieved the 94% standard at 98.1%



Integrated Performance Report

RESPONSIVE

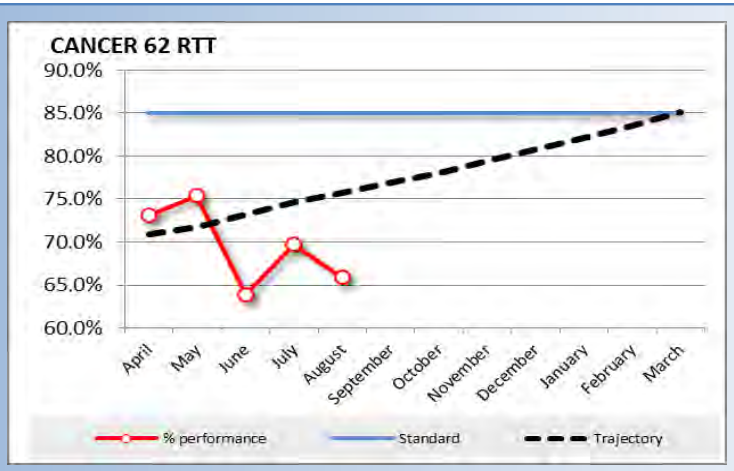
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

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

August performance failed to achieve the 75.7% improvement trajectory with performance of 65.9%.

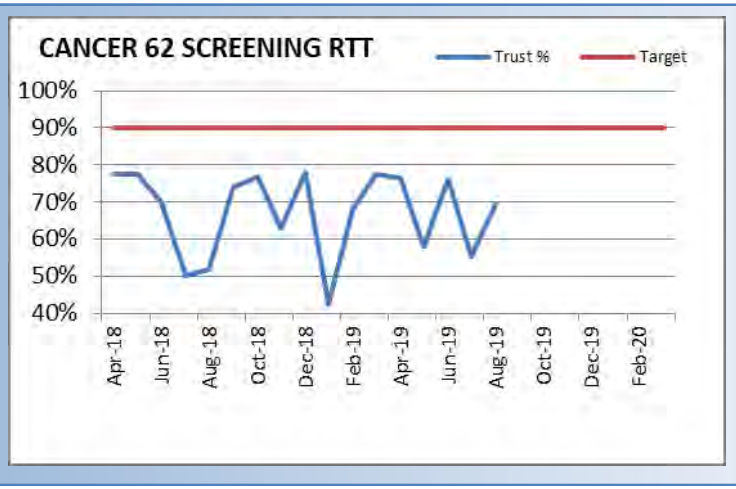
Performance failed to achieve the national standard



Cancer: 62 Day Screening Standard

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

August performance failed to achieve the 90% standard at 69.6%



Integrated Performance Report

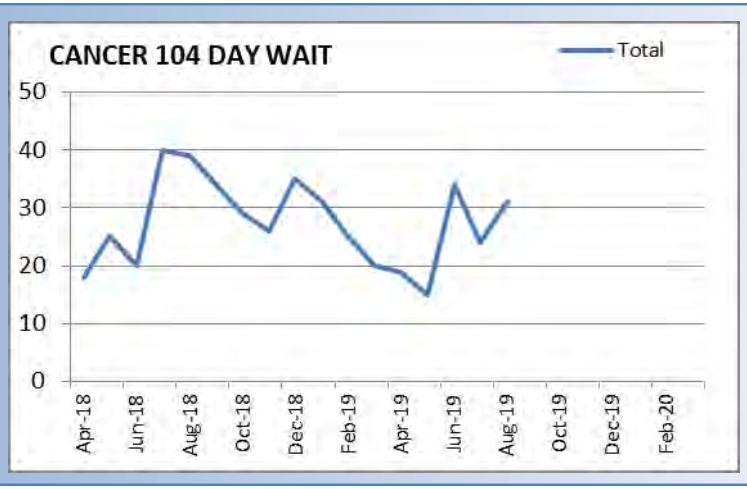
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 31 patients waiting 104 days or over at the end of August



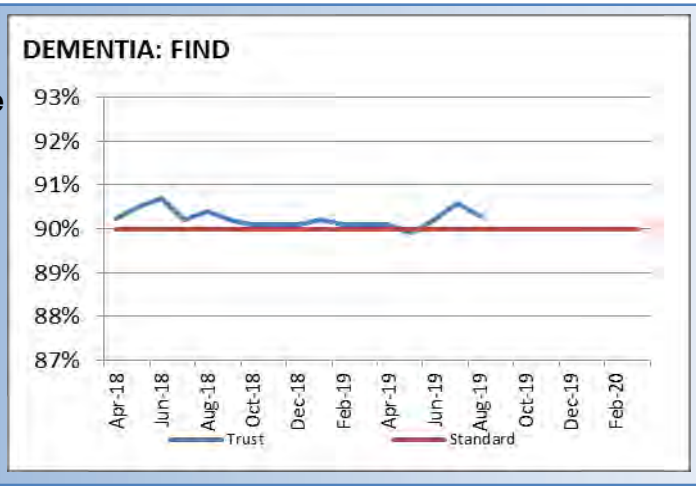
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 August 2019.

The standard for this indicator is to achieve 90%.

Performance for August achieved this standard at 90.3%



Integrated Performance Report

RESPONSIVE

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

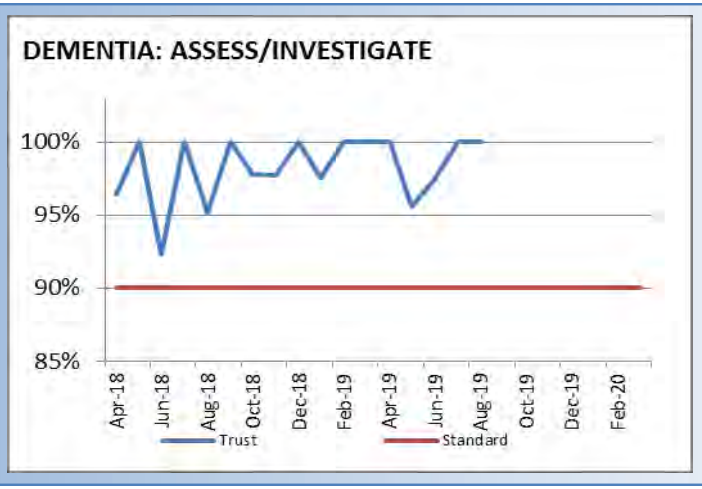
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is August 2019

The standard for this indicator is to achieve 90%.

Performance for August achieved this standard at 100%



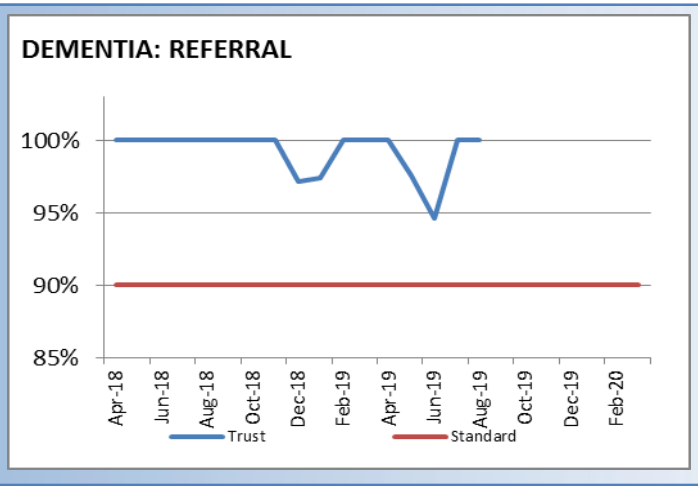
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is August 2019.

The standard for this indicator is to achieve 90%.

Performance for August achieved this standard at 100%



Integrated Performance Report

SAFE

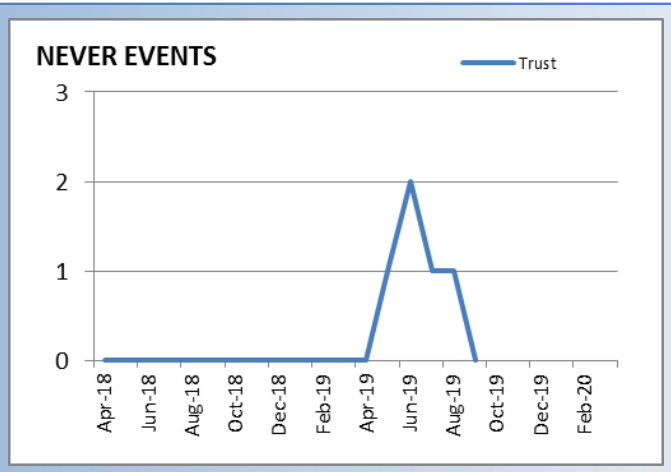
Description	Aggregate Position	Trend	Variation

Hull University Teaching Hospitals NHS Trust

Occurrence of any Never

Occurrence of any Never Events

There were zero cases reported during September 2019.



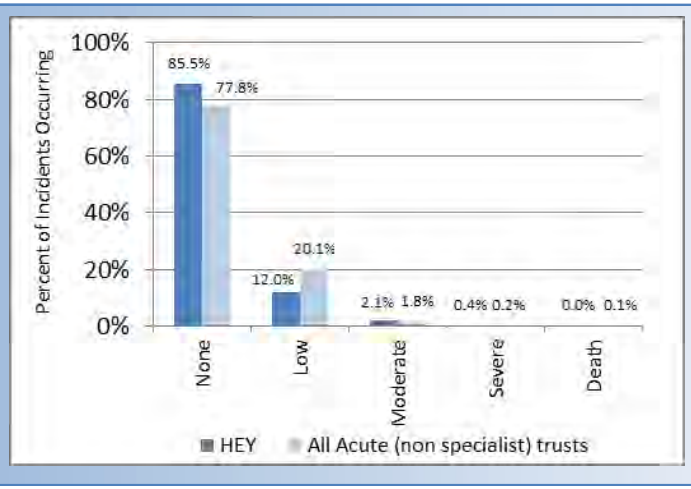
Further information is included in the Board Quality report

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



Degree of Harm:

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

Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

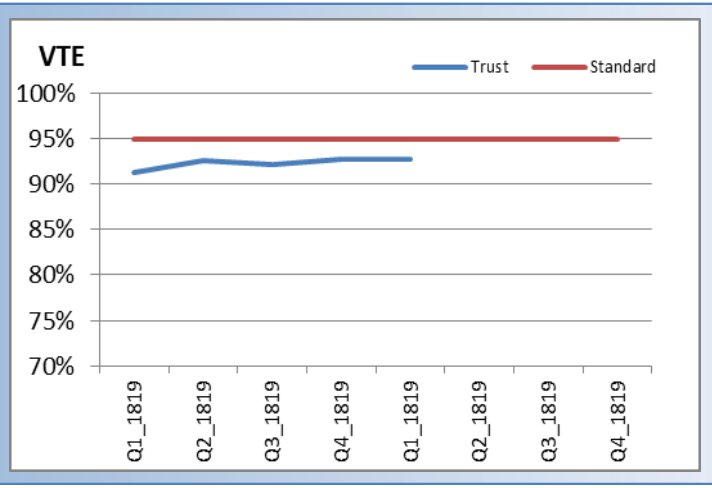
Hull University Teaching Hospitals NHS Trust

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

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

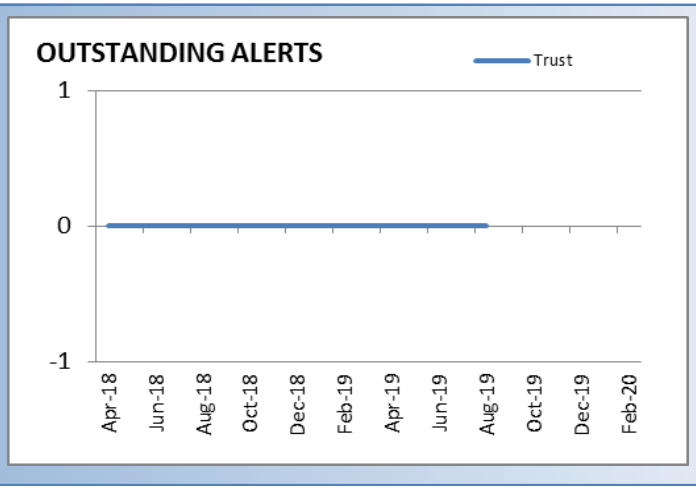


Patient Safety Alerts Outstanding

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

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

There have been no outstanding alerts year to date.



Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

Hull University Teaching Hospitals NHS Trust

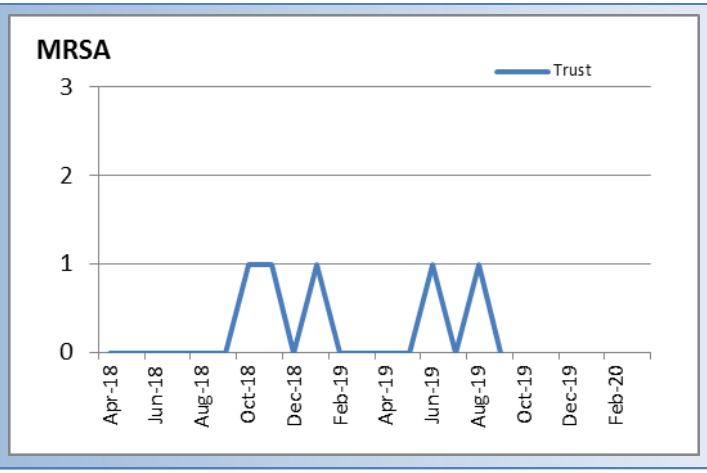
MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

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

There were no cases reported during September 2019.

There have been 2 cases reported year to date.



Further information is included in the Board Quality report

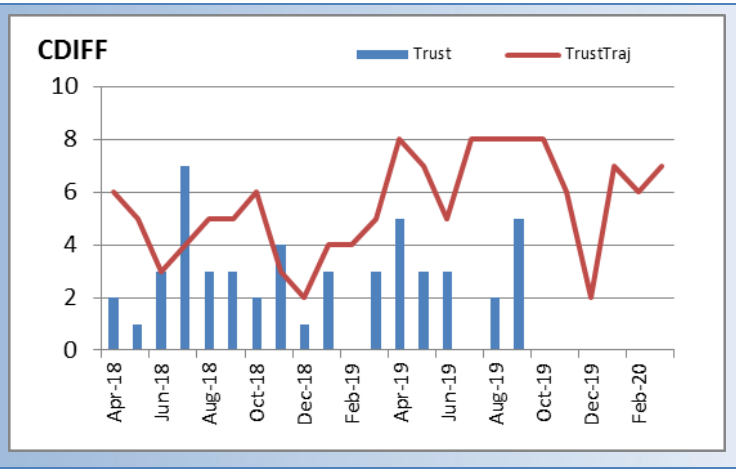
Clostridium Difficile

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

There were 32 cases during 2018/19

There were 5 cases reported during September which achieved the monthly trajectory of no more than 8 cases

Year to date position is 18 cases against the trajectory of no more than 80 cases.



Further information is included in the Board Quality report

Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

Hull University Teaching Hospitals NHS Trust

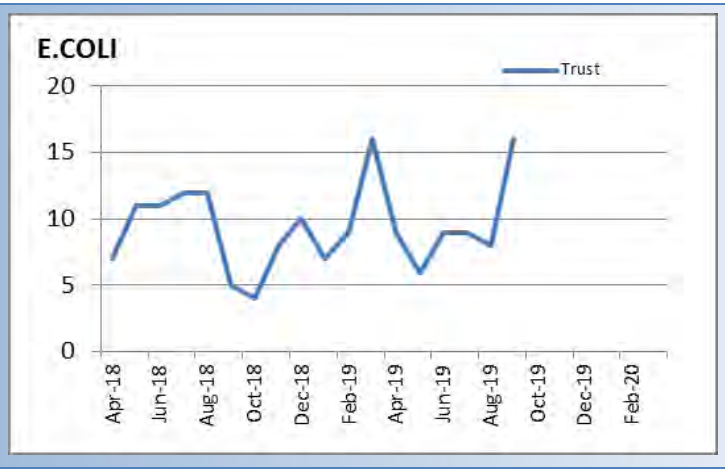
Escherichia Coli

Number of incidence of E.coli bloodstream infections

There were 112 cases during 2018/19

There were 16 incidences reported during September 2019.

There have been 57 incidences reported year to date.

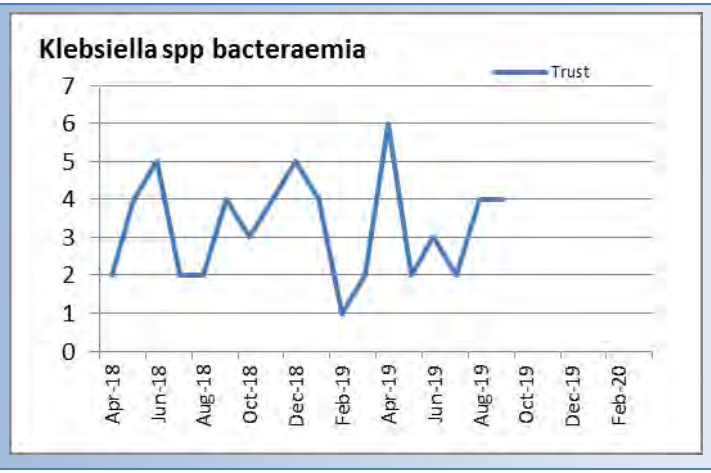


Klebsiella spp bacteraemia

Number of incidence of Klebsiella spp bacteraemia

There were 4 cases reported during September 2019.

There have been 21 incidences reported year to date.



Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

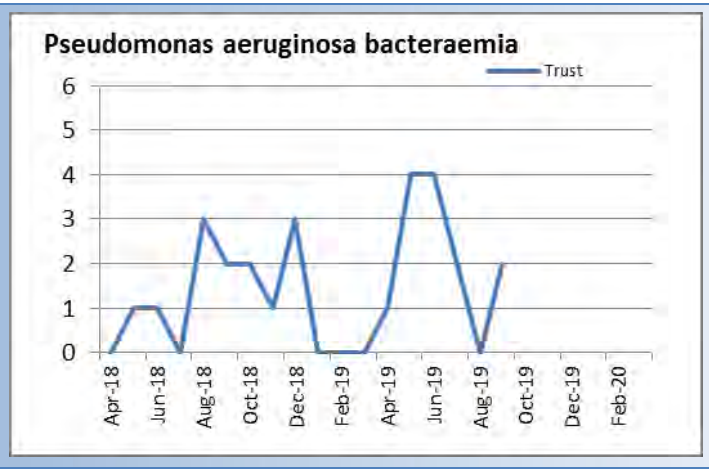
Hull University Teaching Hospitals NHS Trust

Pseudomonas aeruginosa

Number of incidence of Pseudomonas aeruginosa bacteraemia

There have been 2 incidences reported during September 2019.

There have been 11 incidences reported year to date.

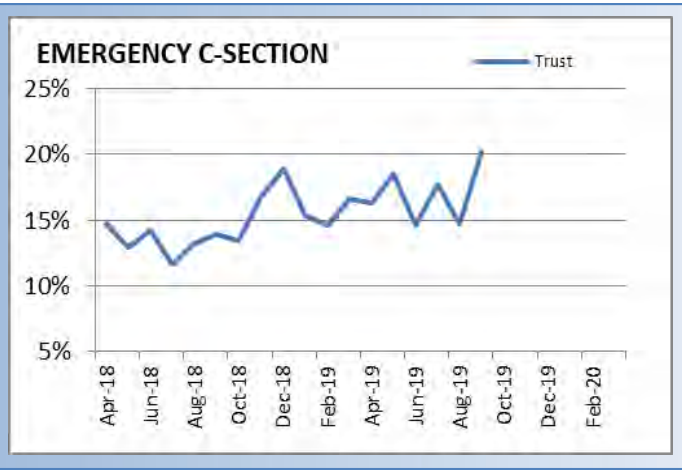


Emergency C-section rate

Maternity: Emergency C-section rate per month

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

Performance for September failed to achieve this standard at 20.2%



Further information is included in the Board Quality report

Integrated Performance Report

EFFECTIVE

Description	Aggregate Position	Trend	Variation

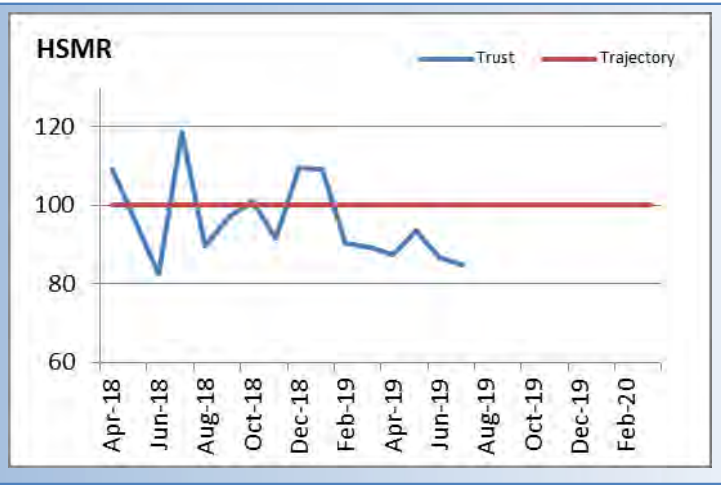
Hull University Teaching Hospitals NHS Trust

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

July 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and July achieved this at 84.9

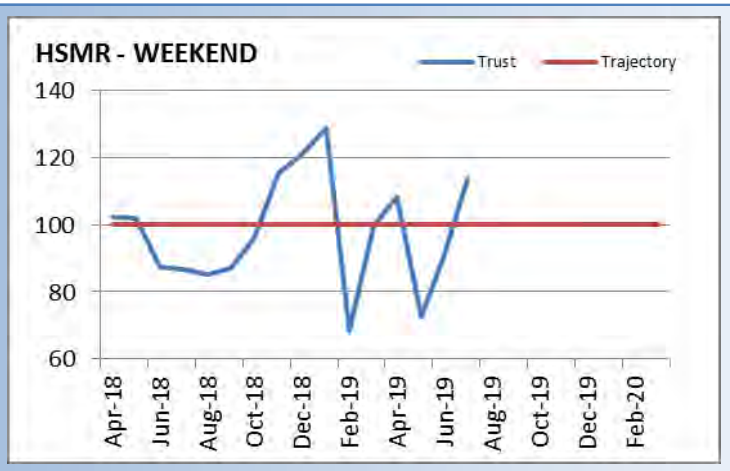


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

July 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and July failed to achieve this at 113.7



Integrated Performance Report

EFFECTIVE

Description | Aggregate Position | Trend | Variation

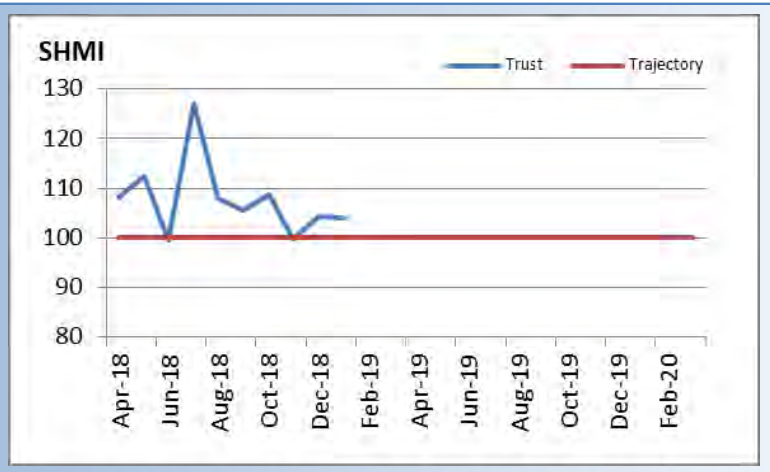
Hull University Teaching Hospitals NHS Trust

SHMI

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

January 2019 is the latest published performance

The standard for SHMI is to achieve less than 100 and January failed to achieve this at 103.9



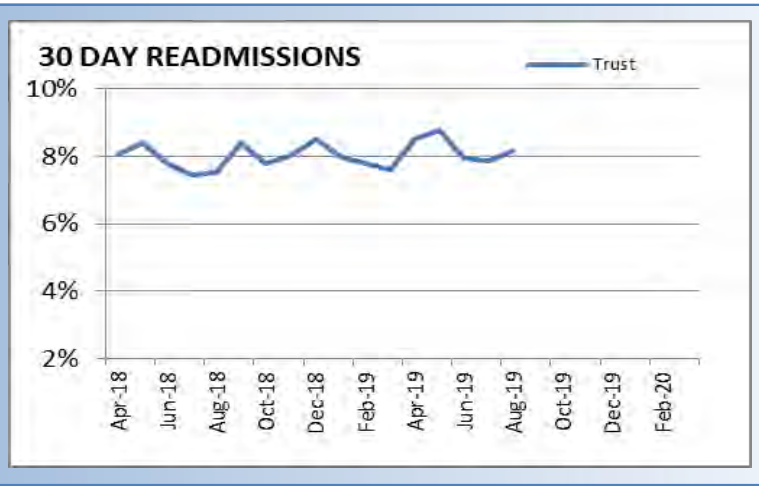
30 Day Readmissions

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

The latest available performance is August 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 8.17%.



Integrated Performance Report

EFFECTIVE

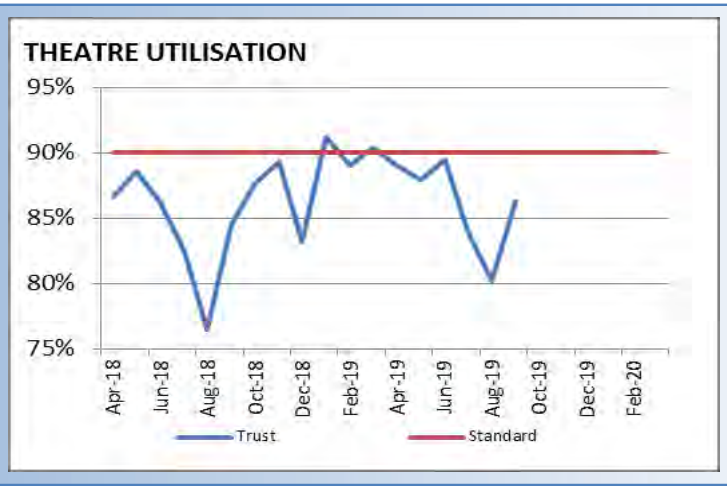
Description | Aggregate Position | Trend | Variation

Theatre Utilisation

The % of scheduled session time which has been utilised. Calculation based on anaesthetic to time out of operating room.

The Trust should aim to achieve less than or equal to 90%

September failed to meet this measure with performance of 86.25%



Integrated Performance Report

CARING

Description | Aggregate Position | Trend | Variation

NHS Hull University Teaching Hospitals NHS Trust

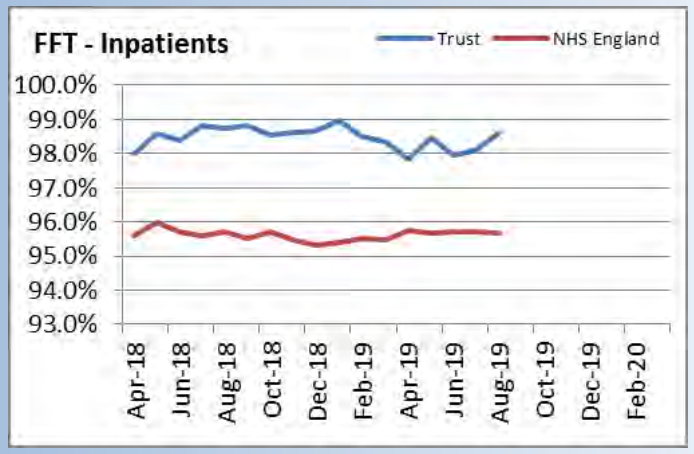
Inpatient Scores from Friends and Family Test - % positive

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

The latest published data for NHS England is August 2019.

Performance for August was 98.62%

September performance will be published in November.



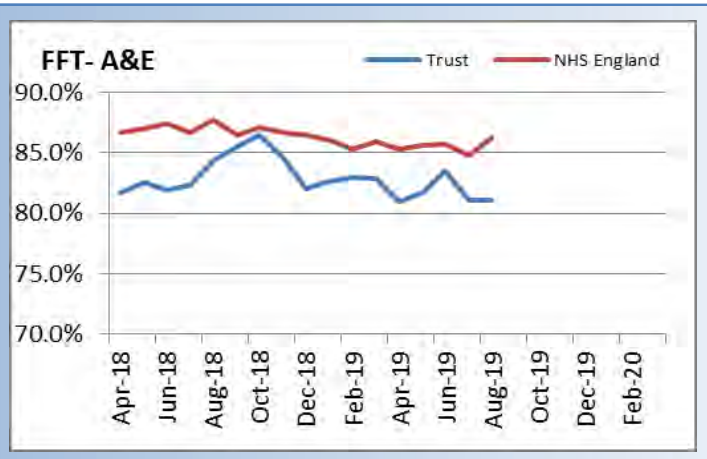
A&E Scores from Friends and Family Test - % positive

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

The latest published data for NHS England is August 2019.

Performance for August was 81.09%

September performance will be published in November.



Integrated Performance Report

CARING

Description | Aggregate Position | Trend | Variation

NHS Hull University Teaching Hospitals NHS Trust

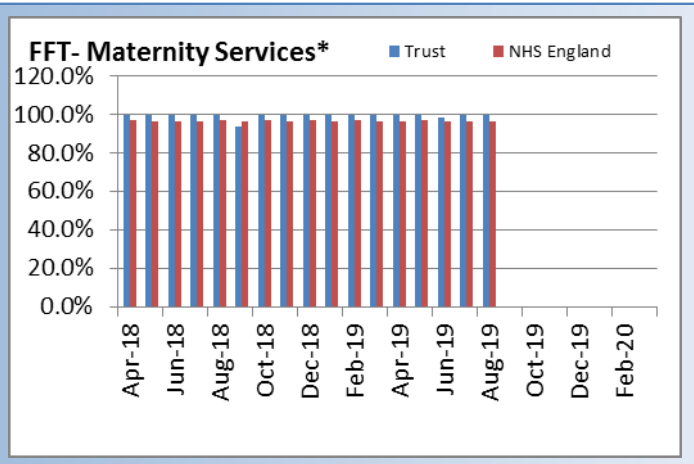
Maternity Scores from Friends and Family Test - % Positive

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

The latest published data for NHS England is August 2019.

Performance for August was 100%

September performance will be published in November.

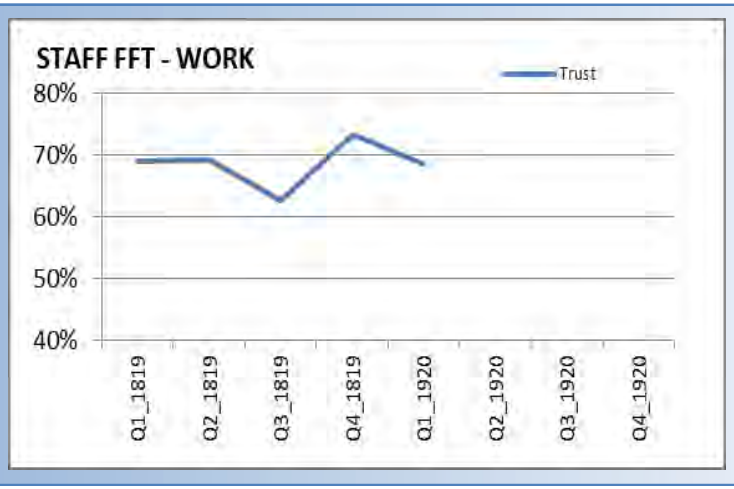


* Question relates to Birth Settings

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 Q1 shows 69% of surveyed staff would recommend the Trust as a place to work, this has decreased from the Q4 position of 73%.



Integrated Performance Report

CARING

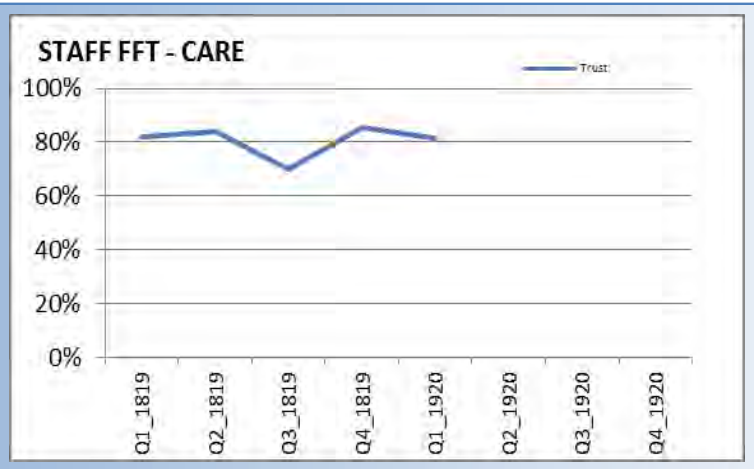
Description	Aggregate Position	Trend	Variation

Hull University Teaching Hospitals NHS Trust

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 Q1 shows 82% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has decreased from the Q4 position of 86%.

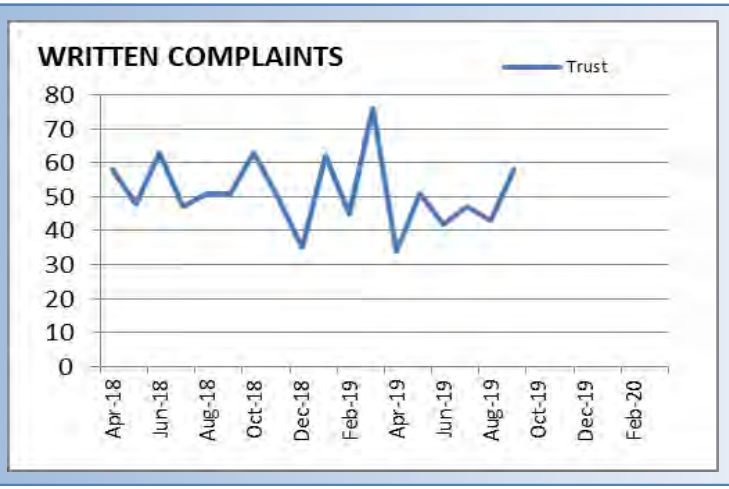


Written Complaints Rate

The number of complaints received by the Trust

The latest available position is September 2019.

The Trust received 58 complaints during September, this has increased from the August position of 43 complaints



There have been 275 complaints year to date

Integrated Performance Report

CARING

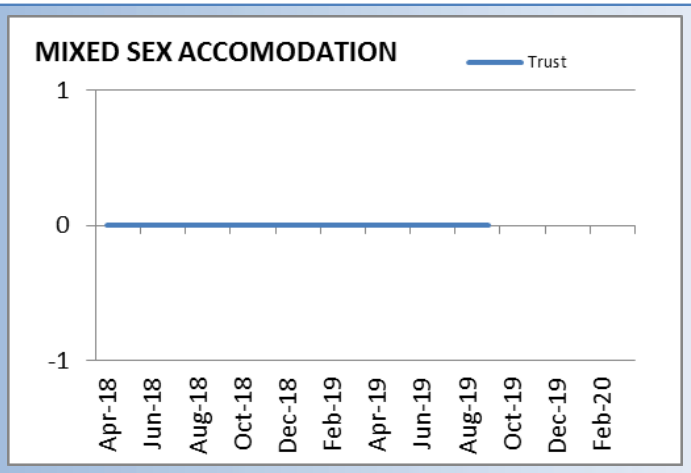
Description | Aggregate Position | Trend | Variation

NHS Hull University Teaching Hospitals NHS Trust

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 September 2019.



Integrated Performance Report

ORGANISATIONAL HEALTH

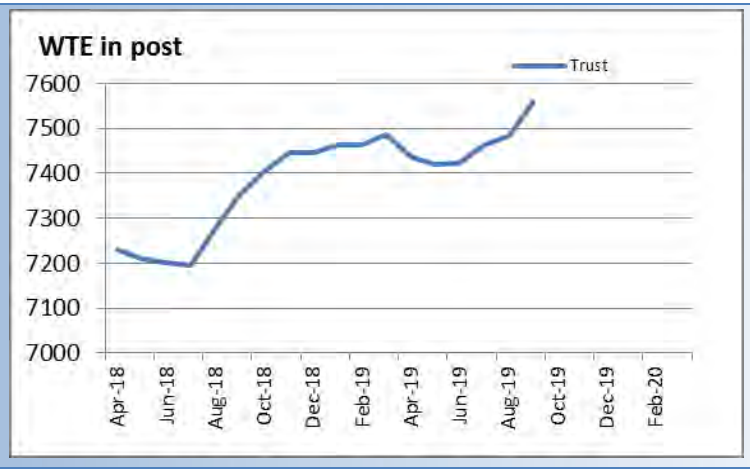
Description	Aggregate Position	Trend	Variation

Hull University Teaching Hospitals NHS Trust

WTEs in post

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

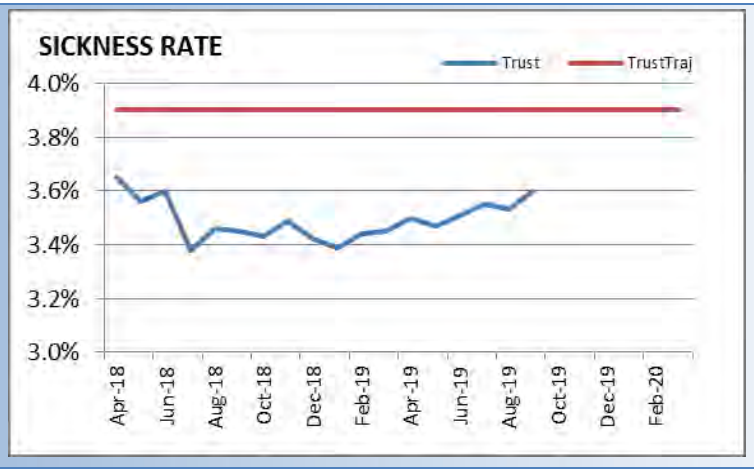
Trust level WTE position as at the end of September was 7559



Sickness Absence Rates

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

Performance for September achieved the standard of less than 3.9% with performance of 3.6%



Integrated Performance Report

ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

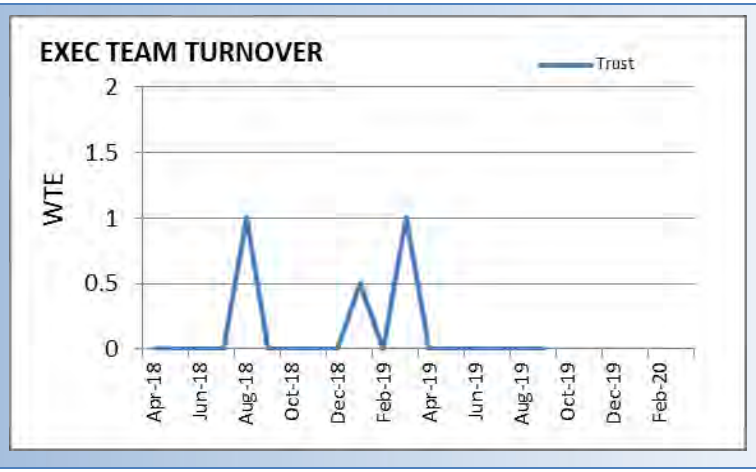
Executive Team Turnover

Trust Executive Team turnover

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

During January 2019 Ellen Ryabov Chief Operating Officer left the Trust and in March 2019 Chief Nurse Director Mike Wright retired.

Turnover has been 0% for the Executive team during September 2019.

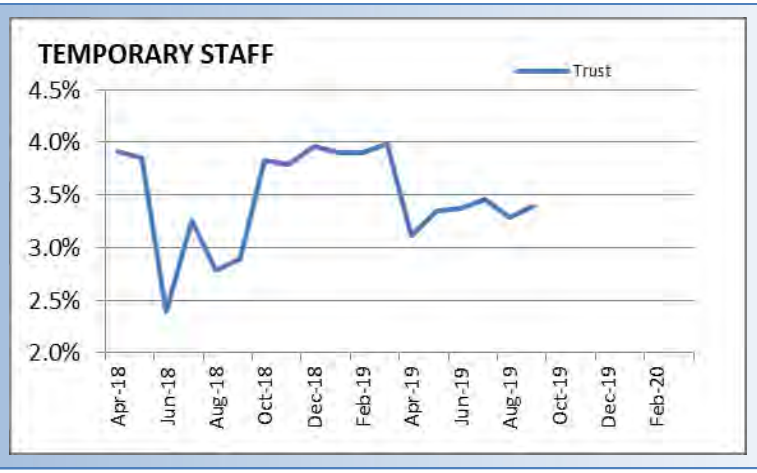


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

September performance was 3.4%



NHS
Hull University Teaching Hospitals
NHS Trust

FINANCIAL SUMMARY: 6 MONTHS TO 30th SEPTEMBER 2019

1. At the end of September the Trust is reporting a deficit of £4.7m which is in line with plan.

2. The position includes £3.1m 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 6 is £3.2m above plan after accounting for the AIC (notional £1.3m adjustment). This is £1.4m above plan in month but this was mainly in pass through income. The Trust is above contract on pass through drugs (£1.7m), Non elective (£3.7m) , outpatients (£0.7m) and devices (£1.0m) but is below plan on Wet AMD (-£0.9m). Allowances continue to be made across specialised commissioning and CCG contracts to adjust for the gains from the coding of therapy input and other notable cost (as opposed volume) variances (-£1.7m). Community Paediatrics funding has now being agreed in line with the Trusts assumptions.

4. Health groups and Corporate are reporting a gross overspend of £0.4m at month 6 which is a deterioration of £0.3m in month. The biggest pressure was within pass through drugs under the AIC which remains under analysis to identify the causes of the pressure. This is expected to be completed by end of October. Health Groups overall were £0.1m overspent with £0.2m pressure in Surgery offset by £0.1m underspend in Medicine. Other health groups were close to balance. Medical staffing remains the main pressure in Surgery. Wet AMD injection drug costs in Family & Women's Health Group continue to underspend due to activity remaining below plan. This is being partially offset by pressures from use of Pioneer in ENT and Paediatric Gastro. Corporate position improved in month due to

5. The above position includes an over delivery in CRES to date of £0.7m, with £5.8m being delivered against a target of £5.1m. This is only 31% of the annual requirement and the trajectory for delivery increases from Month 7. In month delivery was £1.0m but from month 7 £2.1m of savings will be required per month. Current forecasts predict that the Trust will be £2.3m below plan at year end (88% delivery) but this also assumes that a further £1.1m of actions will be identified above current plans in the last 6 months and remains a large risk. The Trust is reviewing all options to maximise delivery this year and is working with NHSI to set up some deep dive productivity workshops in 3 specialties (Orthopaedics, Ophthalmology & Cardiology as soon as possible).

6. The Trust has spent £4.8m on agency costs at month 6 which is £0.4m above the plan which is set to achieve the agency cap,. This was a deterioration of £0.1m in month. The additional spend has been on Nursing and Healthcare scientific and technical staff. In both these areas overall pay remains below plan.

7. The Trust is currently forecasting that it will deliver its financial plan in 19/20 but it has identified significant risks to achieving this. Health Group forecasts currently require £5.3m of actions to achieve plan and within this there are the risks on CRES delivery of £1.1m. The Trust also has additional pressures regarding key targets that may require further investment in the next few months (52 weeks, Lung Health Check, urgent treatment/AMU/SACU) which could cost £1.3m. Thus the total risk is around £8m. NHSI have asked the Trust to develop a recovery that includes the health groups improving their forecast position by £1m to £4.3m. The Trust is also in discussions with Hull CCG to receive additional non recurrent investment but no value has been agreed.

8. Despite the risk above the Trusts liquidity position continues to be relatively stable due to the additional PSF funding received in 181/9.

9. The reported capital position at month 6 shows gross capital expenditure of £4.8m compared with plan of £6.4m. The main areas of variance relate to medical equipment but this is due to slippage against the profile and does not impact on the forecast. The forecast position for capital expenditure is £28.1m. This is £1.5m above the submitted plans in July due to the inclusion of notified winter capital.

10. The underlying position remains a deficit £9.0m which is reduced from the £11.6m deficit at the end of 18/19. However 3 health groups underlying positions have deteriorated from year end by circa £0.5m (Family & Women's, Surgery and Medicine). This needs to be recovered for 20/21.

11. **Next Steps/Actions**

a) Health Groups to Identify £1.1m additional CRES actions as per forecast.
b) Health Groups/Corporate to identify additional actions worth £1m to reduce forecasts.
c) Agree funding with CCGs for Lung Health Check, 52 weeks, urgent treatment/AMU/SACU)
d) Health Groups to work on improving underlying positions for 20/21 planning..

Integrated Performance Report

ORGANISATIONAL HEALTH

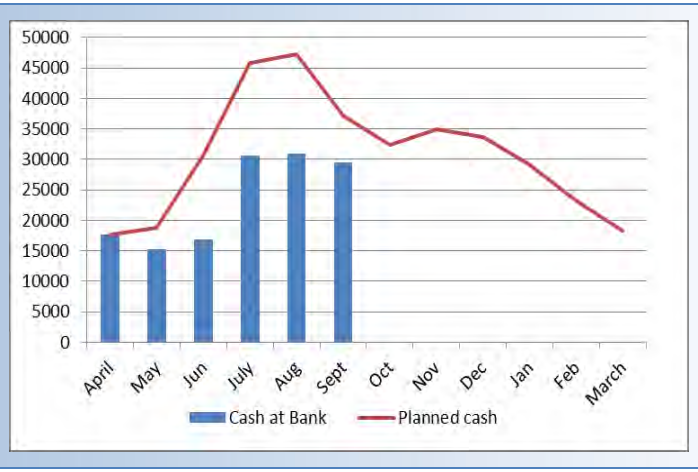
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of September we had £29.549m of cash and cash equivalents, comprising of monies in the bank of £29.532m 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 £29.549m cash was lower than planned as invoices are being processed quicker together with the PSF funding now been recevied.



CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 6 the planned level of savings is £5.05m, the actual savings are £5.77m thereby creating a £0.7m 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

ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

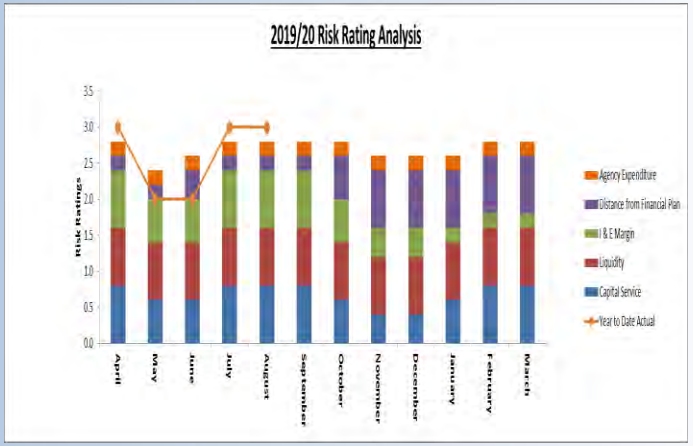
Risk Rating

Financial Sustain-ability Risk Rating

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

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

As at month 6 the Trust is reporting a YTD deficit £4.7m against a planned position of £4.7m deficit. This has resulted in liquidity being rated at a 3 , Capital and I&E margin being rated at a 4. Variance from financial plan as 1 & Agency being rated as a 2. Giving an overall risk rating of 3.

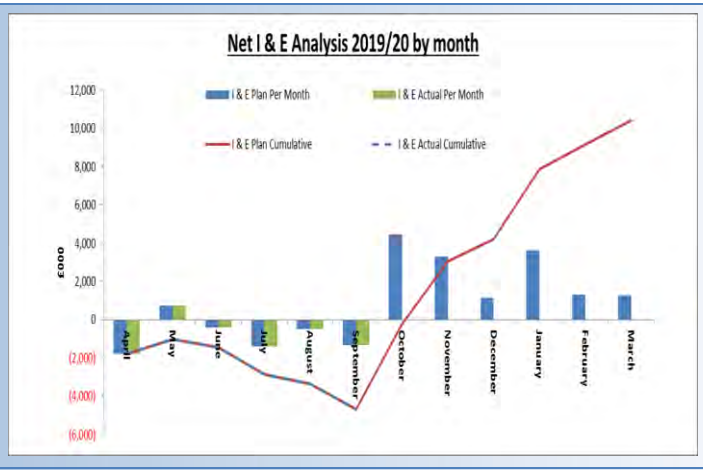


Income & Expenditure

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 6 the Trust has delivered a deficit of £4.7m against a planned deficit of £4.7m



Hull and East Riding A&E Delivery Board

System Wide High Impact Action Plan

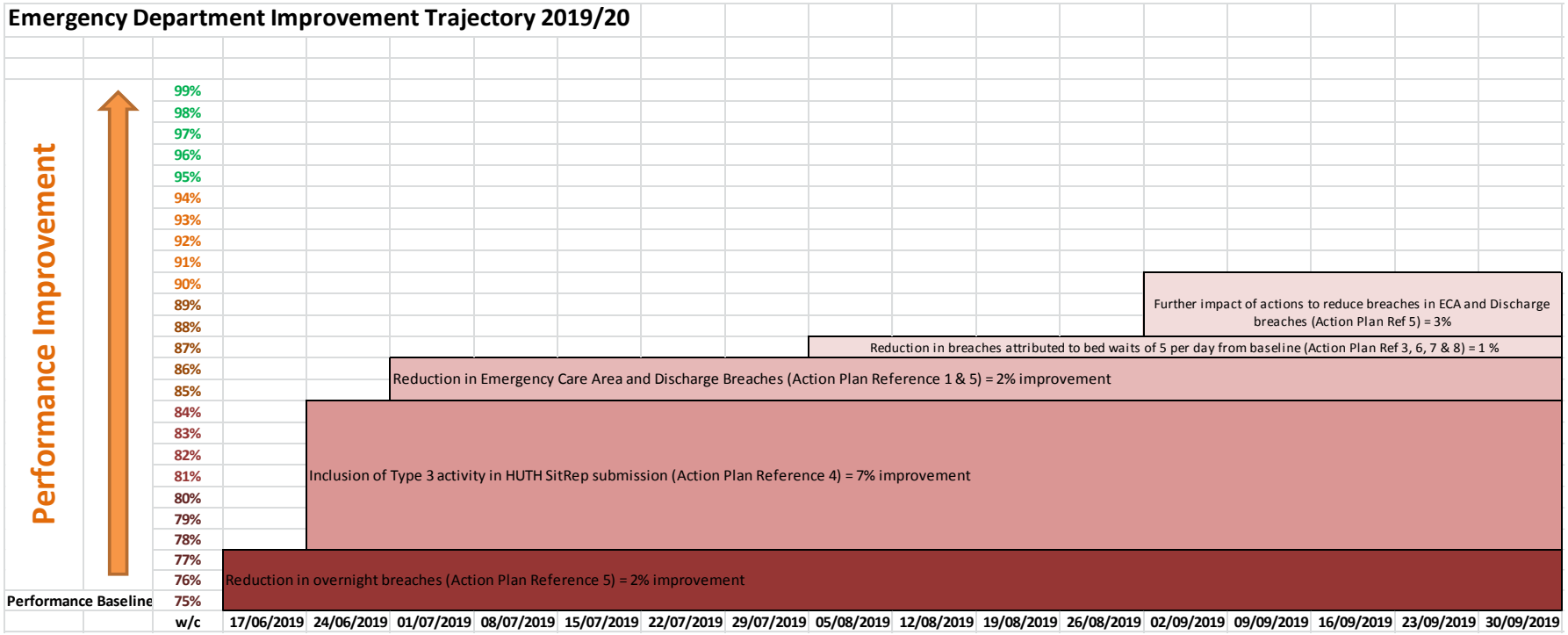
The Hull and East Riding A&E Delivery Board has signed off 8 Programmes of work which will be delivered by the Unplanned Care Delivery Group (UCDG) during 19/20 aimed to Improve the Urgent and Emergency Pathway. A PMO approach exists for each work stream with PIDS / Charters agreed for all work streams,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

This action plan will be reviewed

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

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

The Agreed Trajectory for Improvement is detailed below



	Objective	Actions	Exec Lead & Workstream Lead	Impact expected From	Expected Performance Outcomes	Risks to delivery	Update @ 13th September 2019	RAG
1	**Full Capacity Protocol and Improved Resilience**	Further updates to FCP to strengthen Medical and Nursing Leadership to flow issues within the HUTH and learning from its 'live' use.	HUTH COO HUTH – DCOO and CDN (W1)	Aug 19	Handover trajectory achieved. Shortened recovery time from time of increased pressure.	None Identified	FCP implemented from 1st July and used operationally since Implementation. FCP response section for Site Management team, Transport and Medical and Nursing leadership added. Full Implementation of updated FCP will be from w/c 25th August ***October Update*** *FCP protocol has been signed off by EPF PandA 11th October. Now for circulation and uploading to HUTH intranet system.*	Complete
		Senior Medic on call to be scoped and piloted over winter to support flow.	MHG Medical Director	1st Oct	Timely support and resolution of flow matters. Support to site team and on call management team		***September Update*** *Actions required of Senior Medical staff during escalation are incorporated within the revised FCP. Development of a separate on call rota for Medics is still being scoped.* ***October Update*** *Feedback/outcome plan awaited from MHG MD*	
		Increase HUTH staffing on Monday and Tuesday to response to demand surge (circa 450 ED attends)	HUTH COO	~~1st Aug~~ 1st Sept	Reduced number of discharge breaches in ECA. – **Achieve minimum 90% performance in ECA**.	Ability to secure additional workforce in all key areas.	Additional staff within ED, Site Team and key medicine specialties. Specialty in reach into AMU is in place. Acute cover has been strengthened at the beginning of the week. Reviewed weekly as part of Weekend Planning meeting. Risk remain about availability of workforce to meet additional staffing requirements **Action: Complete**	
		Strengthen Out of Hospital coordination of flow / response to surges in activity	Director of Commissioning ERCCG	1st October	Improved timeliness of response to surge demand and increases in the WIP / DTOC lists. **DTOC target of 22 to be achieved**		MOU of standards to be expected when partners are on higher escalation levels has been drafted and shared with partners. Awaiting sign off by A&E Delivery Board at the end of September ***September Update*** *MOU draft is on-track. EPF PandA to review when signed off by A&E Delivery Board* ***October Update*** *MOU due to the October AEDB for sign off. Workshop event held on 10 October to agree how rapid safe transfer of patients from the Trust to available community capacity can be achieved. Feedback to be provided to the AEDB*	

							at end of October	
2	**Improve AM discharges and Weekend Discharges**	Embed SAFER actions following Hospital wide audit in May 2019	HUTH CNO/CMO (W8)	1st June	LLOS Improvement in line with Operating Plan trajectory. Flow Optimised **Achieve 30% of discharges by 12 noon** **Achieve balance admission / discharge position over weekend days**		Project Plan in place with Senior Clinical Lead appointed and Project Support by HUTH Improvement Team. LLOS Improvement against reduction trajectory is monitored weekly. ***September update*** *DPTL carried out weekly. Currently behind trajectory on LLOS reduction, but Improvement demonstrated over last 2 weeks. Additional RMO staffing in place over weekend days to support patient reviews and wards are notified of EDD over weekend to ensure review of these patients take place.* *All Health Groups are undertaking post review of weekend plan each week and reviewing number of discharges against plan and any learning feeding back into weekend planning meeting.* ***October update*** *Weekend discharge levels are monitored via EPF Panda. Clinical Lead for SAFER (Tara Filby) commenced in post from beginning of October and Programme in place. SAFER Delivery Group and Governance Structure and Metrics agreed.*	
		Increase Criteria Led Discharges across HUTH	HUTH CNO/CMO	1st Sept	Increase weekend discharges. Achieve discharges earlier in the day. Reduce breaches attributable to bed delays. **Achieve balance admission / discharge position over weekend days**		Project Plan currently being developed with Senior Clinical Lead appointed and Project Support by HUTH Improvement Team. Project on CLD will commence from 1st September led by the Chief Medical Officer. *Criteria Led Discharge pilot has commenced on H36 and across 5th floor* **October update** *Pilot is in place and work is progressing. Support from SAFER programme to undertake baseline assessment ward by ward. To roll out to wards, particularly DME and 11th floor. Review metrics and how to measure improvement with support from HIP team.*	
		Change Consultant of the week rota to start midweek (not a	HUTH Health Group Medical Directors	1st October	Even out flow during the week **Achieve balance admission /**		**September Update** *Medical Director for each HG have commenced*	

		Monday or Tuesday			**discharge position over weekend days**		*this work with a deadline of September to outline planned changes and transition plan.* *F&W review has been concluded by the Medical Director. Midweek to Midweek rosters are in place for all specialities with exception of obs and and gynae which remains daily on call.* ***Complete*** *Medicine arrangements review underway led by Dr Smithson* *Clinical Support Review has been concluded by the Medical Director. No changes are required in Haematology, ID or Rehab. Additional actions are being considered to strengthen Consultant of the week cover in Oncology which is part of wider Transformation work within the Oncology Service.* ***Complete*** *Emergency Medicine remains unchanged* **October update** *Medicine review ongoing to review job plans and clinic timetables to affect the change required. DME is in place. General Medicine is the priority with timescales to be confirmed.*	
		Improve levels of Complex / Supported Discharges at the weekend	CHCP – COO (W8)	1st Sept	Increase weekend discharges. Weekend Targets for Discharge are agreed with all out of hospital partners and monitored **DTOC target of 22 to be achieved**	Care Homes willingness to asses / admit over weekend period. Ability for Package of Care to commence over weekend period	Weekend Targets for Discharge are agreed with all out of hospital partners and monitored daily as a system. System calls are scheduled when target discharges are not achieved. ***September Update*** *Workstream 8 (reducing DTOC) has been asked to review discharge targets for each partner organisation based on Q1 demand and make recommendations for change to the next Unplanned Care Delivery Group.* System have agreed an Out of Hospital coordinator role is required for the Winter period and identification of person to undertake this role is progressing led by ERCCG. Post expected to be in place from 1st November – 1st April 2020 ***September Update*** *System has agreed at AEDB on 26th September that this post will not be progressed. Therefore* ***Action Closed*** **October update** *Reduction in the DTOC position has been seen*	

							through October. Weekend Complex discharges are still not consistently meeting the targets. COO has held meeting with ERYC Director of Adult Social Care to agree further joint improvement that can be made.	
		Earlier Identification of patients suitable to transfer to CHH and Increased use of discharge lounge by Surgery	SHG Medical Director	1st Aug 1st Dec	Increased AM transfer to CHH	Clinical criteria for CHH will mean that numbers of patients able to transfer will fluctuate	Implemented and monitoring via EPF P&A meeting fortnightly. ***September Update*** *Review of criteria for transfer to CHH has commenced led by Medical Directors.* ***(New Action)*** ***October update*** *Actions in place with Surgical huddles to move patients safely to CHH.*	
3	**Increase bed capacity (**address gap identified in bed modelling review July 2019)	Additional Medicine Ward on HRI site (22 beds)	HUTH MHG	24th Sept	Improved flow from ED and reduction in ED breaches attributed to Bed Waits **Eliminate overnight lodging in ED.** **Reduce breaches attributed to bed waits**	Recruitment to all nursing and medical posts	Recruitment on going and no slippage on timescales expected. Mobilisation being monitored via HUTH internal Winter Planning meetings. Ward expected to open from week commencing 24th September 2019. ***September Update*** *Additional Medicine beds to be discussed following meeting 13th September. Staffing levels to be reviewed by Chief Nurse and approved prior to final date of opening being agreed. Medical Staffing cover is agreed and in place.* *Due to nurse staffing levels, ward unable to open until 28th October 2019. Additional 9 assessment beds have been open since 24th September to mitigate this and Cedar Ward is opening 7 days from end of September.* ***October update*** *Ward has now fully opened to 22 beds*	
		Solution to address residual bed deficit. Potential option for Additional Winter Ward 1st Dec- 31st March (22 beds)	HUTH DCOO	1st Dec	Improved flow from ED and reduction in ED breaches attributed to Bed Waits	Ability to staff ward (Nursing and Medical)	***New Action Agreed by the HUTH .xecutive Team 12th Aug*** for additional medicine ward for 4 months. Planning being undertaken by the internal winter planning group with feedback to the weekly Executive Team. ***September Update*** *When permanent ward opened and social care unit opens, the bed deficit remains at 20. Additional community capacity of 19 mitigate further the deficit. AMU extension will provide a further 12 assessment spaces.*	

							October update *Position remains the same. EPF/WPG has some confidence that the planned changes and bed capacity increases will address the overall deficit.*	
		Additional Assessment Space (12 spaces) co-located with AMU	HUTH Director of Estates HUTH MHG Medical Director	1st Jan	Opportunity to expand assessment / SDEC opportunity. Role and function of the additional space to be defined.		***September Update*** *Capital allocation has been agreed for this scheme and project underway to determine use and function of this space. Expected to be finalised and signed off by end of September with space available by mid-December.* **October update** *On track. Winter Planning Group to track delivery starting with the definition of the clinical model for the new area to be decided by MHG in the next week (by 18.10.19). Clinical Model now agreed and funding signed off by Exec Team.*	
		Cedar Ward to move from 5 day ward to 7 days ward over the winter period	HUTH FWHG	1st Nov	Increased flow.	Recruitment to nursing staff	Planning being undertaken by the internal winter planning group to open Cedar Ward 7 days over winter period. ***September Update*** *Business case for 7 day ward has been developed and will be considered by Exec Team at the end of September. Cedar Ward will open 7 days to mitigate any delay in opening additional medicine ward.* **October update** *Agreed up until 31st March 2020, funding in place. Business case to follow if further 7 day extension required.*	
		Social Care Discharge Facility (14 beds)	Director of Adult Social Care - ERYC	2nd Dec	Reduce DTOC for ERYC **DTOC target of 22 to be achieved**	CQC registration GP Cover	Contract has been awarded with standstill period ending on 23rd August 2019. Mobilisation plan in place and CQC registration for the facility being progressed. Due to open on 2nd December 2019. ***September Update:*** *Remain on track for opening on 2.12.19. GP cover has been secured for the facility.* **October update** *East Riding Social Services Suite remains on track. Planned to open 2nd December*	
		Additional capacity	CHCP - COO	1st Oct	Reduce DTOC rates by	Fragility of care home	***New Action; Agreed at AEDB July***	

		commissioned by community equivalent to 19 beds			increasing access to intermediate healthcare beds Capacity will assist in addressing overall bed deficit and support they system in achieving an overall daily WIP target of a maximum of 22. **DTOC target of 22 to be achieved**	market. Recruitment of therapists to care for people within the additional beds	CHCP have produced a proposal for Hull CCG to support the procurement of an additional 19 beds across Hull. The beds will be additional level 3 and 4 ICT but can also be used flexibly to support the wider system, 10 of the proposed beds are in a nursing care home. ***September Update*** *Additional level 3 and Level 4 beds have been commissioned at Rossmore and Holyname which will come on line from end of September with all additional capacity open from w/c 4th November* **October update** *All new community bed capacity to be available by end of October via a phased implementation plan.*	
		Implement a pilot across Driffield area, to support delivery of short term care packages as part of an enhanced CHCP ICT offer to prevent delayed discharges from HUTH and ICT community beds	CHCP COO EROYCCG AD	31st Oct	Improved patient flow through both HUTH and community beds will reduce DTOCs awaiting ERIC packages.	Recruitment to staff mitigated via existing CHCP bank.	Pilot agreed in July 2019 as part of the ICT transformation programme.	
4a	**ED Improvement (HUTH Internal)** Reduce Discharge Breaches ECA Improve Time to first seen Majors .	Increase Medical staffing, ANPs Progresses Chasers during evening and overnight period.	HUTH COO	1st June	Reduce evening and overnight breaches **Achieve no more than 10 overnight breaches**	Ability to secure additional workforce	Additional 170 hours of medical cover above funded base levels in July. August 383 hours (month to date – 16/8) due to additional senior medical cover in place over Junior Dr handover week. ***September Update*** *Trialling various agencies for ECP roles covering GP slots to enhance workforce.* *Progress chasers 24/7 covering all areas now in place* *Additional hours offered to NPs to cover Monday and Tuesday demand.* **October update** *Progress chasers 24/7 in place. Continuing to fill work force gaps throughout October with 1 agency ECP already in post.*	
		Review Paediatric ED operating hours.	HUTH COO	1st Oct	Reduce overnight breaches by streamlining services, and		***September Update***	

					enhancing rota at peak demands		*Rota tool designed – will require staff consultation and some further additional funding. Risk to be noted regarding requirements for 24/7 provision of service* **October update** *Out of scope*	
		Increase GP and ANP staffing to Primary Care Steaming Area.	HUTH COO & CCG Lead	1st Aug	**Achieve minimum 90% performance in ECA**.	National and local shortage of GPs and potential to adversely impact other systems e.g. GP OOH/Extended and Enhanced Access which could result in increased demand for ED	***September Update*** *Exploring ANP role specific for PCS using current NP monies will require places x2 at university / HEE* *Utilising PC funding use agency ENP x1 sought* **October update** *Advert placed for 2 x ACPs for PCS*	
		Implement Front Door Streaming ECA	HUTH EMHG	1st Aug	Reduce discharge breaches ECA **Achieve minimum 90% performance in ECA**.		***September Update*** *PDSA tested model x 4 weeks requires from August. Confirms additional workforce required to deliver – rota designed and costs presented to CFO. Cost discussed with CCGs and awaiting funding decision. Design for new capital development has been agreed between estates and operational team.* **October update** *Clinical Model and Workforce Model agreed at A&E Delivery Board on 26th October. Will be implemented from mid December once estates works have been completed*	
		All internal referral to ED from specialties to to be referred to EPIC	HUTH Medical Directors	1st Aug			Has been implemented from w/c 12th August and will be monitored via EPF P&A meeting. ***Action Complete***	
		Ambulance Direct to ACU Pathway	MHG Medical Director	1st October	Improve Ambulance Handover		***September Update*** *Clinical pathway being reviewed by Ed Middleton and Jacqui Smithson. Ambulance direct to ACU will not be available from 1st October. Revised timeline with be agreed with the MHG* **October update** *MHG to look at models in other Hospitals on how this is being delivered. To include a member of the ACU and ED teams for a site visit to Bradford. Concerns regarding safety issues to be reviewed. Review clinical pathways and ambulance handovers.UCDG on 10.10.19 requested urgent set up of a new T&F project group to deliver an Amb to ACU pilot before the*	

							end of Q3. YAS and HUTH to jointly lead this.	
4b	**Reduce Proportion Type 1 Minors activity**	Extend the Hours of Storey Street to create a Hull UTC and co-located OOH	Hull CCG Director of Integrated Commissioning. CHCP COO	1st November	Reduce ECA attends	Estates provision – though ground floor would support development Access to X Ray Agreement to increase opening hours to 24/7 of the Wilberforce HC	***New Action - Agreed as part of system meeting w/c 5 Aug.*** ***September Update*** *To be discussed further at system meeting on 7th October.* **October update** *Extension to Storey Street presented to A&E Delivery Board in October and endorsed extension. CCG are considering Business Case.*	
		Increase Radiography Provision at Bransholme and Beverley	HUTH COO	1st October	Reduced ECA attends	National and local shortage of radiographers	***New Action; Agreed as part of system meeting w/c 5 Aug.*** HUTH Radiology are attempting to source additional radiographers. ***September Update*** *HUTH Radiology Dept have been unable to identify additional staffing currently but will continue to try to secure additional locum staff .* **October update** *Extended Radiography Pilot has been agreed commencing early November to run for 6 weeks on a Monday and Tuesday at Bransholme Health Centre*	
		Progress co-located UTC with HRI ED	Hull CCG Director of Integrated Commissioning	TBC			***New Action; Agreed as part of system meeting w/c 5 Aug***. ***September Update*** *Capital bid approved to remodel front entrance of the hospital to create full Primary Care Streaming Services. Will be completed by mid December. Meeting with commissioners to discuss UTC model scheduled for 7th October* **October update** *Primary Care Streaming model agreed by the A&E Delivery Board in October. Checklist against UTC specification is being undertaken by CCGs*	
		Offer patients not requiring emergency care direct access to community based UTC GP OOH, walk in and extended access	HUTH COO CHCP COO	Aug 19	Diversion from A&E will free up staff within A&E to focus on genuine emergency care including life threatening cases	Local people may be reluctant to take up choice offer, once within ED	Onward referral information refreshed by CHCP in Aug 19 and shared with HUTH team. ***September Update*** *In Place for HUTH clinicians to contact alternative service and direct patients to that service.*	

							October Update *A number of alternative Out of Hospital pathways have been agreed for the Primary Care Streaming Area which will commence from late December*	
		Review of Paediatric and 0-20 year ED Activity	CHCP COO HFT COO	Dec 19	Reduce paediatric and 0-20 year attends ED attends by offering diversionary pathways including rapid access to health visiting, Urgent Care Paediatric ANPs and explore the provision of on line GP consultations e.g. for the 16-20 age group.	Funding to procure E Health Solutions may pose a risk Retention of ANP paediatrics due to GP pressures in primary care.	***New Action agreed at A&E Delivery Board July 2019*** E Consultation forms part of the CHCP transformation plan and additional funding could result in widening the offer to NON CHCP registered patients e.g. frequent flyers. CHCP and Humber each provide 0-19 services and so can look to offer alternative pathways for 0-20 year olds HUTH have provided detailed/anonymised activity data relating to 0-20 year olds to support this work	
5	**Reduce Mental Health Breaches and TID for Mental Health patients**	Open Additional S136 Suite at Miranda House	HFT COO	March 2020	Reduce TID and Mental Health breaches Work is currently on track to complete on time and HTFT will consider ways to bring this date forward of possible.		***September Update*** *Still on track. HUTH HFT meeting to be schedule before end of September to look at option of HUTH internal crisis pad / safe space for Winter.* **October update** *Recent successful recruitment campaign at Humber FT. On track for completion March 2020*	
		Restore staffing levels to Core 24 compliant levels	HFT COO	September 2019	Reduce TID and Mental Health breaches Some recruitment completed, more underway and action plan to address shortfall is in place		***September Update;*** *Staffing levels are improving within the Hospital Mental Health Team. Review of data collection and metrics to be undertaken by the HUTH HFT liaison meeting.*	
		Limited Street Triage Pilot to commence	HFT COO	TBC 2019	Reduce ED attends Work in place to work in place between HTFT and Humberside police commencement date to be finalised by September 2019		***September Update*** *Humberside Police are proposed to implement Right Care: Right Person from January 2020. Significant concerns have been raised from all Health and Care partners on the impact of this decision. Therefore full system response is required in response to proposed new model proposed by Humberside Police. The Crisis Care Concordat is expected to take forward*	

							system work to consider the revised models of delivery that Health and Care will need to implement.	
6	**Maximise Same Day Emergency Care Opportunities**	Incorporate Surgical Ambulatory Care Service into Medical Ambulatory Care Unit (via modular extension)	HFT SHG & MHG Medical Director	1st Dec	Increased SDEC provision. Reduced breaches in ED for speciality waits.		Unable to use Westbourne Suite (planned space) as this is agreed location for additional CT scanner which has been brought forward to 19/20. Agreement to combine Medical and Surgical Ambulatory Care Unit and add modular unit to this to create sufficient space. Will be all surgical specialities. 6th Floor Surgery Assessment Facility will continue to be used. ***September Update:*** *Capital secured for the scheme and option designs prepared. Final decision on layout and configuration by 25.09.2019. Expected commencement mid December* **October update** *Initial proposed model agreed with a T&F group in place between MHG and SHG. Conditions, diagnosis and model agreed. Number of patients per day has been forecasted for SACU. Workforce agenda meeting in place. Facilities meeting in place. On target for 14th December for surgical patients.*	On track
		Daily Ultrasound provision to the 6th floor Surgical Ambulatory Assessment Area	SHG Medical Director	1st Sept	Increased SDEC provision.		***September Update*** *Confirmed as commenced from 1st September. Monitoring of Impact will be via EPF PandA.* *Initial feedback of the initiative is very positive.*	Complete
		Review AMU conversion rate and opportunity for increased SDEC on AMU / ACU	~~HFT~~ HUTH MHG Medical Director	1st October	Reduce conversion rate to base wards. Increased SDEC for Medicine specialties .		**October update** *MHG process in place at the 8am handover on AMU consistently.*	Completee
		Review space utilised by Frailty Intervention Team in ED	~~HFT~~ HUTH MHG Medical Director	1st Sept			Extended FIT pilot has been undertaken and further pilot will commence on 21st August to undertake FIT in cubicles 1-3 in ED. ***September Update*** *No alternative space could be secure for FIT on ground floor and therefore this programme of work is being incorporated into wider ground plans for Q3.*	

							Decision has been made at the Urgent and Emergency Care Board on the 25th September that Elderly Assessment Unit will move to H36 during Q3 and this will create space for FIT to be incorporated in the Facility. **October update** *Plan in place and on track for 14th December for FIT to relocate to H36*	
7	Diversionary Pathway (including Care Home Programme)	Increase Direct to speciality pathways within HUTH	ICP Programme Director	31st October	Increase direct access for ambulance crews to key specialties – Urology and Gynaecology		Current pathways have been reviewed.	
		Increase alternative to ED pathways in the community (focus on Care Homes and Respiratory)	ICP Programme Director	1st September	Increase ambulance use of community pathways including district nursing and to UTCs Reduce ED attends and NEL admissions from Care Homes Reduce the number of Care Home respiratory admissions		Top 20 referring Care Homes have been identified across Hull and East Riding. Full MDT Outreach Implemented from Hull ICC. Integrated Care Planning for each resident with direct access to OOH services for the top 20 care homes. Model now being rolled out to other homes. NP support model in place for Hessle Care Homes as part of phase 1 of roll out across ER. Respiratory Physios have been recruited and are now in post. They will manage respiratory exacerbation of respiratory conditions in Care Home resident and provide care homes **October update** *System level Respiratory Group is being set up. Hospital at home, lung health check programme, RDC and community service review work streams to be run through this Group.*	

Hull University Teaching Hospitals NHS Trust

Meeting: Trust Board

Date: 12th November 2019

Title:	**2019-20 Winter Plan**
Responsible Directors:	**Teresa Cope** Chief Operating Officer **Beverley Geary** Chief Nursing Officer
Author:	**Jackie Railton** Deputy Director Strategy and Planning

Purpose:	To update the Trust Board on the Trust's Winter Plan for 2019-20	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	Implementation of the Winter Plan will ensure that the Trust: • has appropriate resources and processes in place to cope with increased workload; • has appropriate escalation arrangements in place to cope with significant peaks in demand; • works effectively and efficiently with partner organisations; • improves against Emergency Department (ED) performance indicators; • minimises the extent to which increases in emergency and acute activity adversely affects cancer services and performance against other waiting time targets; • has appropriate arrangements in place for dealing with severe weather events, such as snow and flooding; and • has appropriate arrangements in place for dealing with a severe seasonal influenza outbreak.	

Recommendation:	The Trust Board is asked to receive the Winter Plan paper and identify any areas where further information or assurances are needed.

Hull University Teaching Hospitals NHS Trust

Winter Plan 2019/20

1. Purpose

This plan sets out the actions the Trust will take to manage increased emergency activity safely and efficiently during the winter months. The plan has been developed with Health Groups and Corporate Directorates and in consultation with local health partners.

As in previous years, the Trust's Winter Plan includes work undertaken within the Urgent and Emergency Care (UEC) Programme.

2. Plan Objectives

Implementation of the Winter Plan will ensure that the Trust:

- has appropriate resources and processes in place to cope with increased workload;
- has appropriate escalation arrangements in place to cope with significant peaks in demand;
- works effectively and efficiently with partner organisations;
- continues to improve against Emergency Department (ED) performance indicators;
- minimises the extent to which increases in emergency and acute activity adversely affects cancer services and performance against other waiting time targets;
- has appropriate arrangements in place for dealing with severe weather events, such as snow and flooding; and
- has appropriate arrangements in place for dealing with a severe seasonal influenza outbreak.

3. System Learning from Winter 2018/19

A workshop was held for the Hull and East Riding health and care system in March 2019 to review winter 2018/19 and to plan for winter 2019/20. The review identified what had gone well and what could have been done better.

Successes included:

- Partners having a much better daily understanding and control of the system (including improved communication and management of escalation).
- Improved information and information flow overall (not just discharge hub activity).
- Partners had supported each other (for example through using beds flexibly across Hull and East Riding system.
- System support in collectively securing care calls via the Intermediate Tier services had also helped.
- Hull University Teaching Hospitals (HUTH) maintained an effective elective plan throughout Winter, enabling the 52 week position and Waiting List Volume (WLV) target to be achieved at the end of March 2019.
- There were strong partnerships and system working when in crisis
- Spot purchase of community based beds at times of pressure and additional monies for therapy had provided valuable system support.
- Workforce skills development supported widening of roles.
- Partnership relationships across hospital teams, community teams and the voluntary sector were good.
- An increased number of patients were dealt with in the community, avoiding hospital admissions.

Despite the things that went well, the system continued to experience high pressure and reported high OPEL levels during Winter 2018/19.

Areas for improvement included:

- Provision of additional medical beds at Hull Royal Infirmary
- Staffing of winter ward – need to ensure continuity of staff, particularly where seconded from other areas. Communications and recruitment campaign to be more specific.
- Improved communications and clarity in relation to winter ward, when it would be opened and for how long it would remain open.
- Primary Care Streaming area – phased approach to deliver the agreed interim and longer term model
- Introduction of the High Intensity User Model in Hull and the East Riding
- Review of the community bed model as part of the Intermediate Tier Hull and East Riding transformation plans
- In-reach by community providers (eg: to increase MDT input for complex patients)
- Creation of a Social Care Discharge Ward at Castle Hill Hospital
- Trusted Assessor and Discharge to Assess to move forward at pace
- Review and development of diversionary pathways with all partners including direct admit to hospital specialties.

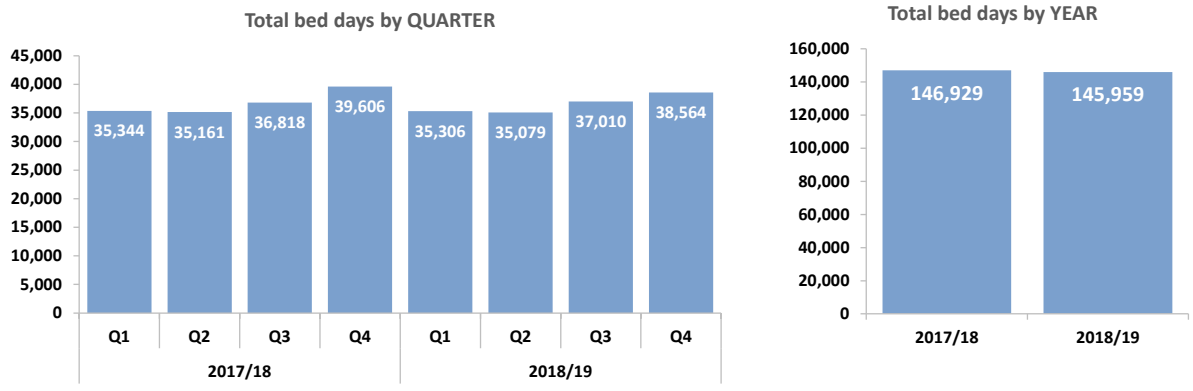
4. Bed Requirements for Winter 2019/20

During the winters of 2017/18 and 2018/19 there was insufficient capacity within the medical bed base to meet demand. This affected patient experience and care standards, operational delivery and the achievement of NHS Constitutional thresholds.

4.1 Midnight bed occupancy analysis 2017/18-2018/19

The following tables show the total number of medical patient bed days by quarter based on midnight bed occupancy.

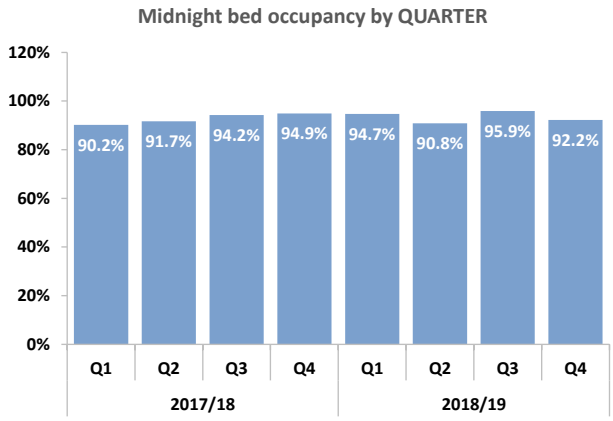
In 2017/18 a total of 146,929 bed days were utilised compared to 145,959 in 2018/19, a decrease of 970 bed days (-0.7%).

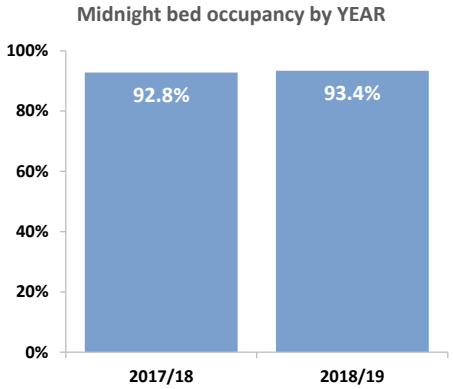


Total Medical bed days (midnight bed occupancy) 2017/18-2018/19

4.2 Medical Wards Bed Occupancy Rates (including AMU)

Based on midnight bed occupancy, the table below shows the bed occupancy rate for the medical wards at Hull Royal Infirmary.

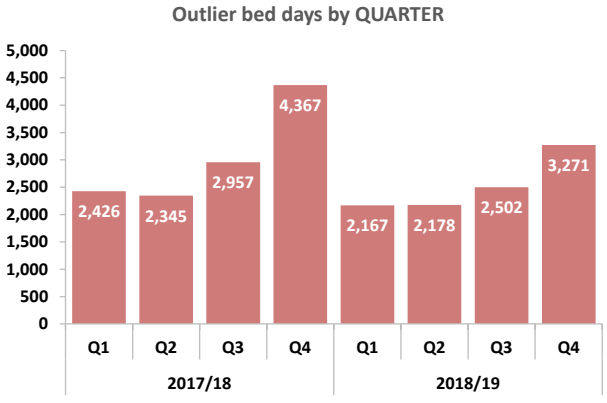


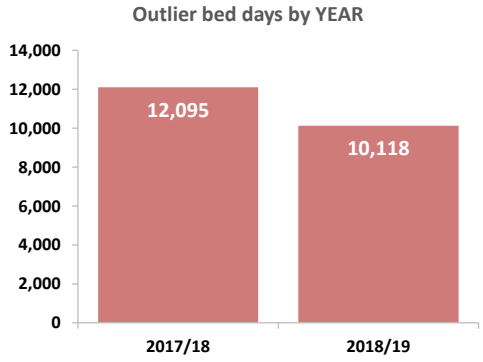


Medical Wards at HRI bed occupancy rates (midnight bed occupancy), 2017/18-2018/19

4.3 Medical Outlier Bed Days (midnight, as a subset of overall activity)

An assessment was undertaken of the number of bed days per quarter in 2017/18 and 2018/19 that medical patients occupied a bed in an outlying ward instead of on the specialty base ward (midnight bed occupancy). This often results in poor patient experience and exposes the patient to possible clinical risk as a consequence of disrupting their plan of care. The total number of medical outlier bed days was 12,095 in 2017/18 and 10,118 in 2018/19. This represented a decrease of 1,977 bed days in 2018/19 compared to 2017/18 (-16.3%).





4.4 Review of Winter 2018/19

The Trust's average bed occupancy rate for 2018/19 (excluding critical care bed days) was 90% which is in excess of recommended rates. Consequently the Trust experienced significant bed capacity pressures which impacted adversely on the quality of care and service delivered to patients and the Trust's performance against key constitutional targets.

During the 2018/19 winter the Trust saw:

- A decrease in Emergency Department attendances, but an increase in the percentage of attendances that converted to an admission.
- A decline in ED performance against the 4 hour waiting time threshold.
- An increase in average length of stay.
- A decrease in the readmission rate (30 days) for Medicine Health Group patients.

At its meeting in August 2019, the Trust's Winter Planning Group considered the lessons learned from winter 2018/19:

- The closure of 10 beds on Ward C16 had had an adverse impact on the delivery of RTT in ENT, Plastic Surgery and Breast Surgery.
- The use of Cedar Ward (although it opened at weekends during the winter period) to support Medicine Health Group patients had a negative impact on elective activity in gynaecology.
- Where ad hoc weekend working on Cedar Ward was put in place, staffing difficulties were experienced, particularly where the ward opened at short notice.
- Acute Surgical weekend capacity at HRI had been adversely affected by gynaecology patients when Cedar Ward was closed.
- Staffing of the 2018/19 winter ward had been problematic. It had proved difficult to get sufficient volunteers for the 5-6 month period, resulting in the need to rotate staff in order to cover this.
- Uncertainty around the closure date for the 2018/19 winter ward had made it difficult to staff to the appropriate level.
- There was a view that the 2018/19 winter ward should have opened earlier in the year.

4.5 Bed Modelling for 2019/20

Modelling of bed requirements for Hull Royal Infirmary based on 2018/19 activity and bed days consumed, demonstrated a shortfall of 71 beds (based on 90% bed occupancy) if zero LOS patients were taken into account, or 47 beds when all zero LOS inpatients were omitted (critical care, paediatrics, obstetrics and day units were excluded from the calculation and adjustments were made for 5 day wards and wards with bed reductions at weekends).

It was concluded that an increase in medical beds was required in order for the Trust to manage the flow of emergency patients through the Trust and meet surges in demand, particularly during winter. As a consequence, funding has been identified to provide an additional 22 bedded medical ward on a permanent basis from the end of October 2019.

It is intended that changes to urgent and emergency care pathways, the delivery of Same Day Emergency Care (SDEC), reductions in length of stay and delayed transfers of care, will make a collective contribution to freeing up bed capacity and reduce the number of medical outliers impacting on surgical services.

4.6 Impact of Infection

The incidence of infections that require patients to be isolated increases in the winter months: this includes Norovirus, Respiratory Syncytial Virus (RSV), influenza and other respiratory tract infections. This has caused a particular problem in paediatrics in past years due to the shortage of isolation facilities but will be monitored closely.

Forecasting the impact on the bed base is impossible to do accurately. It is not yet clear whether the incidence of influenza will be higher or lower than average, nor whether the vaccine will have significant protective effect. There is a plan for managing adult influenza cases.

5. Proposed Winter Plan Actions for 2019/20

Work across the Hull and East Riding health and care system and within the Trust has identified the following actions to date:

- **East Riding Adult Social Care Suite (Ward C20, Castle Hill Hospital**
  - 14 bedded facility, with the potential to extend up to 19 beds
  - Operational for a period of 12 months from 2 December 2019 to 1 December 2020.
  - Purpose: to accommodate people occupying an acute bed, who are medically optimised and are waiting for arranged post-discharge social care provision to commence.
  - Aim: to provide seamless transfer out of an acute bed to an on-site step down bed to minimise individual (and cumulative) length of stay in acute beds, freeing up acute bed capacity and contributing towards relieving overall system pressures.

- **SAFER Patient Flow**
  - Utilisation of the SAFER tool to reduce delays for patients on adult inpatient wards (excluding maternity).

- **Same Day Emergency Care (SDEC)**
  - Development and redesign of SDEC patient pathways
  - Expansion of the medical ambulatory care unit to create a multi-specialty facility for delivery of SDEC.

- **Increased use of progress chasers during the Winter period.**

- **Increased streaming in the Emergency Care Area (ECA) through care navigation and enhanced primary care provision in the ED**

- **Infection Control Team**
  - Recruitment to B5/B6 posts
  - Roster modelling for 7 day service provision
  - Recruitment to Microbiologist posts

- **Community bed capacity to be reviewed**

- **Winter Ward 2019/20**
  - Potential for winter ward to be provided – Health Groups working on resource requirements.

In preparing for winter, further actions will be taken as follows:

5.1 Emergency Medicine HG

The Trust is contracted for a flat increase in attendances of 1.7% averaged across the year, with the peaks in attendances anticipated in the winter months. Reviewing previous winters, quarter 4 is the most pressured in respect of numbers of patients per day and the acuity of these patients, which is a mixture of seasonal influenza patients, increased trauma and major trauma relating to adverse travel conditions and increased severe illness, particularly amongst the elderly population and paediatric patients.

The above schemes will significantly contribute to mitigating the impact of increased numbers of patients, and increased acuity of patients, attending the Emergency Department in winter. The ability of the Emergency Department to triage and move patients into acute

services and increase flow out of the Emergency Department mitigates the increased risk of crowding seen in the Emergency Department in the winter months, which impacts on achievement of the four-hour standard, increases ambulance hand-over times and impacts on paramedics being able to attend calls in the community.

The Emergency Department is supporting with the identification of pathways and putting in place Standard Operating Procedures with other clinical specialties to gain best benefit of the increased acute and Same Day Emergency Care capacity being put in place at Hull Royal Infirmary, to create more timely flow out of ED and be able to manage the ED clinical workload to best effect.

The Health Group has submitted the financial calculations for the staffing required to support a full Primary Care Streaming service, which is being enabled by capital funding, by December 2019. This will be key in maintaining and improving ED performance against the four-hour target in the Emergency Care Area (ECA). Currently, between 40-50% of patients attending ECA per day require a primary care practitioner to meet their clinical need; there is an increase in patients during winter presenting at ECA. A full streaming model would enable patients to be triaged at the front door, including redirection to other available primary care services. In preparation for winter the Emergency Department is working with partner organisations to agree pathways and the ability to book into, or use, primary care capacity when a patient triaged to primary care has arrived at the ED. In addition to the staffing for primary care streaming, the ED is putting in place a new staffing model to provide a more robust daily workforce to ECA and primary care area, including Emergency Nurse Practitioners and Advanced Care Practitioner posts, to work alongside the current complement of ED Nurse Practitioners and those GPs who are available to work in primary care.

5.2 Medicine HG

As outlined previously a bed modelling exercise has been undertaken and this demonstrates that the Medicine Health Group does not have the established bed base which it requires to maintain patients within its core bed base and, as a consequence, there are times when patients are moved outside of the Medicine Health Group specialty bed base. This demonstrates that there is available capacity elsewhere. However it is recognized that managing differing specialties together can be difficult, particularly when many of the medical patients fall into the complex category. Not only that, the geography and lack of appropriately located medical cover, where any extra beds are available, can lead to these beds not being utilized to the optimum; for example Ward 35 at HRI and Ward 16 at CHH. This has led to the Medicine Health Group being at OPEL level 3-4 for a significant period of time and, as result, this has meant the Health Group has been invoking the Full Capacity Protocol (FCP), which encompasses two hourly ‘huddles’ for the Senior Management, Matron and Triumvirate team, along with cancelling non-essential work/meetings. This has provided increased escalation and extra leadership on the wards and departments.

The Medicine Health Group has undertaken a number of initiatives in order to manage within the bed base and maintain a low length of stay for patients, these being:

- Specialty in-reach provides AMU/ED a daily in-reach service from all specialties: DME, Diabetes & Endocrinology, Gastroenterology, Respiratory, Renal, Cardiology and Neurology. This level of specialty in-reach demonstrates senior medical leadership and support to patient flow.
- The Frailty Intervention Team (FIT) provides in-reach into AMU & ED on a daily basis enabling discharges of frail elderly complex patients who would otherwise be admitted to a base ward. This has proved extremely successful and the FIT team is reviewing if they can extend their working hours, as a recent trial showed that working until 10pm increased their discharge numbers further.

- Progress to Discharge Unit provides support ensuring complex medical patients are dealt with by specialist nurses, therapies and social workers. Such initiatives have led to lower lengths of stay for patients and a reduction in DME patients being cared for outside the Medicine bed base.

These initiatives will continue through 2019/20 to support non-elective flow.

In order to support the four hour Emergency Department (ED) standard and improve patient flow, further initiatives have been identified for the seasonal winter period, these being:

- Ambulatory Care Unit (ACU) is reviewing medical pathways in order to create increased Same Day Emergency Care (SDEC) capacity; the Medicine Health Group will also be working closely with Surgical Health Group and Family & Women's Health Group in order to form a multi-specialty ACU. This will allow capacity to move patients out from ED and provide support to the four hour ED standard. This will require four extra clinical examination rooms in order to provide extra capacity. Following building work sign off it is anticipated to be operational mid December 2019.

- Opening of 22 extra beds on a permanent basis - this will start from week commencing 28th October 2019. This has been a significant challenge due to a number of nursing vacancies within the Medicine Health Group. This ward will be managed by the Rheumatology medical team.

- The Social Service suite of 14-19 beds will come on line in December 2019. It is envisaged that approximately two thirds of these beds will be utilized for Medicine specialty patients, other Health Groups will also be able to utilize this facility.

- Ward 70 and the Medical Day Case Unit's functionality will be improved providing clinic rooms to support extra OPD capacity along with further SDEC capacity, again to support patient flow.

- Reconfiguration of the Ground floor:
    - Ward 36 will return to Ward 1 mid October 2019 - this is the short stay ward.
    - Following this, the Elderly Assessment Unit will relocate to Ward 36. This will require some minor estates work.
    - Ground floor plans are being worked through with the Estates team as there is a potential for twelve further assessment beds co-located with AMU, along with OPD clinic space for DME/FIT. However the capital monies which will address the 12 assessment beds does not have a revenue stream, therefore business plans are being worked up should further winter monies become available to support this, along with extra portering, medical staff and PDA's for every ward.

The Triumvirate has engaged with the clinical teams and Clinical Leads/Directors throughout the year and this will continue in order to ensure staff are engaged and are able to raise any concerns or issues regarding winter or other seasonal escalation.

5.3 Surgery Health Group

As the winter 2018/19 analysis above demonstrates, the Surgery Health Group did accommodate medical outliers in its HRI bed base. This was at a much reduced volume compared to winter 2017/18. This was largely due to the Surgery Health Group experiencing

significant growth in its own non-elective patients flows (specifically from non-ED referral sources such as Neurosurgery and Major Trauma). Unfortunately this growth has continued throughout 2019/20 and therefore much of the Surgery Health Group's winter preparedness work has been largely focussed on ensuring that it has robust capacity plans in place to not only manage this current level of growth, but accommodate any further growth over the winter period.

The Surgery Health Group introduced twice daily huddles towards the end of 2018/19 and has continued to refine the format and content over the last 6 months. During this winter, these huddles will continue to be the vehicles for managing and monitoring acute surgical non-elective flow, critical care capacity and elective flow at CHH, which is essential for delivering the challenging elective care standards. Surgery's FCP has been live tested on numerous occasions throughout the year and there is a high degree of confidence that this does help to restore Business As Usual (BAU) capacity provision at pace.

The Surgery Health Group also introduced a Senior Manager Late Rota earlier this year. This will be reviewed and refreshed ahead of November 2019. It is expected that this initiative will help to provide a greater degree of resilience over the winter period by ensuring the huddle plans are executed prior to handover to the on call teams. The Surgery ward and department teams will also benefit from the additional senior support provided.

The Triumvirate have recently signed off plans to introduce twice weekly ward and departmental walk rounds both at HRI and CHH starting from November 2019. The theme of these walk rounds will be winter preparedness and are aimed at providing staff with an opportunity to voice any concerns they may have about winter, or even better, suggest options and solutions for navigating through this challenging time. The Medical Directors also intend to discuss winter preparedness with the clinical leads over the coming weeks and agree a communication and engagement strategy which works for them.

The Health Group continues to work through some potential reconfiguration options for Major Trauma and Trauma activity. If able to implement, it is envisaged that these plans will help create additional capacity and better patient flow, not only for these specific patient groups, but other groups of patients such as Neurosurgery. Following successful approval of the Health Group's Expansion of Trauma business case last year, two of the additional trauma theatre lists are due to become operational from 25th November 2019. This will greatly assist with flow and will help to achieve and maintain VTOMS Level 2/3.

In relation to supporting the wider organisation through the winter period, the Health Group is on plan to help deliver a multi-speciality ambulatory care unit. The final model for this facility will be confirmed by the end of October 2019, and will be operational from the 14th December 2019. It is envisaged that this initiative will help to pull patients out of ED and increase bed base provision but reducing the number of patients admitted with a zero LOS.

The Surgery Health Group has also committed to providing 4 volunteers to help support the additional medical ward for the winter period.

5.4 Family and Women's Health Group

The Family and Women's Health Group (F&WHG) provides support year-round predominantly to the Medicine Health Group by flexibly using the bed base on Ward H35 and H30. Health Group "huddles" implemented earlier this year ensure that bed capacity for "outliers" is identified early each week day to improve flow through the hospital.

The paediatric medical and surgical ward, Coral (H130) and Acorn respectively, will flex their total capacity to support the elective and non-elective demand. NICU and the Paediatric

High Dependency Unit (PHDU will be flexing their capacity in line with the respective network protocols and requirements.

The F&WHG has further considered the specialities, wards and actions which are critical to supporting the wider organisation through the winter period; this is in the context of continued challenges to delivering the elective care standards. The options proposed are as follows:

- A business case has been developed for Cedar to be a 7-day ward from December 2019 to March 2020 in order to provide an average of 4 beds for use by the Medicine Health Group and to enable gynaecological activity to be sustained over the winter period (gynaecology performance has been adversely affected during the previous two winters)
- Consider maintaining C16 at 30 beds over weekends (usually reduces to 18 beds from Saturday morning until Monday morning each week) to support the transfer of any Family and Women's Health Group surgery division patients (where that is clinically appropriate) to support the Surgery Health Group bed base within HRI
- Reviewing options and staffing requirements in order to step up the PHDU from 4 beds to 6 beds through an additional locum paediatric consultant and non-registered nursing staff
- Request to specialty medical teams to review their on-call arrangements – looking to split weekends and/or commence on-call weeks on a Friday (rather than a Monday)

5.5 Clinical Support Services HG

The Clinical Support Health Group will continue to support all Health Groups in terms of Diagnostic and Therapy provision. The Physiotherapy and Occupational Therapy Department will support the opening on H70 but will have to pull resources from other areas. These resources will be prioritised on a clinical basis. A senior Therapist will be rostered into weekend services to provide leadership to the weekend team and will work closely with the site management and discharge team.

There are no immediate plans to expand Radiology services as all scanners are working 6 & 7 days already. At the end of 2019 the service will begin installing an additional CT and MRI scanner into the ground floor at HRI. These scanners will go clinical in February 2020. At the same time it is planned to take down the 2nd Floor CT scanner at HRI and replace with a new scanner.

The Pathology service will continue with their business as usual 24/7 service and will continue to offer rapid diagnosis on suspected flu cases.

Pharmacy provision will remain at a business as usual level providing a 7 day service.

In reach services from Infectious Diseases, Complex Rehabilitation and Acute Oncology will continue.

The Cancer Assessment Unit based in the Queens Centre will continue to take direct referrals from GPs and from within the Trust to enable patients to directly access Oncology and Clinical Haematology services and therefore bypass the Emergency Department

5.6 Patient Transport

During previous winters, additional funding was secured for the provision of extra ambulance crews, but during the winter of 2018/19 this was not the case. The cost of providing these extra ambulance crews along with overtime payments to Crews 1 & 2 was absorbed by the Trust and recharged to the various Health Groups: Surgery, Medicine, Clinical Support and Family & Women's.

	Dec'18	Jan-19	Feb-19	Mar-19	Total

	£	£	£	£	£
Cost	19,285	26,886	19,329	25,952	91,452

The Trust is currently operating with extra ambulance crews from 14:00 - 22:00 as per the table below.

	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Cost Per Month (£) over Contract if reserved before 1st Nov'19	Cost Per Month (£) over Contract if reserved before 1st Nov'19
Overtime for Contracted Crews	2	2	2	2	2	2	2	3,000	3,000
Extra Crews	2	2	1	1	1	1	1	15,000	18,000
Total Crews	4	4	3	3	3	3	3	18,000	21,000
Total Cost Dec19–Mar20								72,000	84,000

The current monthly cost over and above the main contract, including overtime for crews 1 & 2 is approx. £21k. If it was agreed to keep at the current levels for the period 1st Dec 2019 – 31st Mar 2020 the cost would be approx. £72k, but that is based on the Trust committing to Amvale before 1st Nov'19. After this date Amvale could not guarantee providing any extra crews which would result in the Trust having to go to another supplier and the price could increase to £84k.

In the past few weeks when the Trust has been on OPEL 3 or 4, there have been times when we have had 2 extra crews each day. With the trend of patients attending ED only increasing over winter the likelihood of the Trust operating at 3 or 4 could be more common. With this potential increase the table below shows what the cost would be if 2 x extra crews were supplied Mon-Fri. The costs are based on the Trust committing to Amvale before 1st Nov 2019, otherwise we would have to source elsewhere and the cost could increase as illustrated in the table below:

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Cost Per Month (£) over contract if reserved before 1st Nov'19	Cost Per Month (£) over Contract if reserved before 1st Nov'19
Overtime for Contracted Crews	2	2	2	2	2	2	2	3,000.00	3,000.00
Extra Crews	2	2	2	2	2	1	1	20,000.00	25,000.00
Total Crews	**4**	**4**	**4**	**4**	**4**	**3**	**3**	23,000.00	28,000.00
Total Cost Dec'19 - Mar'20								92,000.00	112,000.00

When the Trust has implemented Full Bed Capacity a third crew has been sourced. If necessary this is something that could continue to happen as and when the need occurs but due to the demand on providers this could not be guaranteed.

5.7 Portering and security services

5.7.1 Portering

- Cross site working to provide additional porter support
- Weekly roster reviews to ensure porter provision in place
- Recruitment/pursuing ongoing to vacant positions
- Porter provision at OPEL 3 & OPEL 4 reviewed and provided to meet patient activity

5.7.2 Security

- Security establishment would not be uplifted, however ad-hoc, planned additional staff will be considered and an assessment based on risk for high-risk occurrences.
- Routine, customer-service type activities will be reduced to meet most urgent needs.
- Business hours for access card and parking permit applications would be compressed to release staff to urgent activity demands.
- Traffic management shall be dynamically assessed and parking enforcement may be reduced in main parking areas to allow for traffic management to ensure flow continues for blue light ambulances for admissions and PTS for discharges.
- Plans rehearsed for partial closure of sites and diversions to be set up and maintained due to extreme weather, or weather related issues (such as flood, high wind damage etc.).
- Patient 1:1 security may be reduced to meet increased core security functions.

6. Bank Holiday, Key Events and Weekend service resilience planning

6.1 Possible EU Exit weekend 1st to 4th November 2019

A briefing document has been drafted outlining the Trust's response arrangements and 'No Deal' EU Exit-specific considerations. The actions outlined in the document build on existing Business Continuity Plans and the Trust's Major Incident Plan. In the event of delays at the Humber ports leading to traffic congestion on the local road network, the Trust has identified risks and mitigating actions in relation to:

- Staff delays/shortages
- Patient travel delays
- Clinical supply delays and shortage of chronic and life preserving medicines and equipment
- Delays to the delivery of radio-isotopes
- Non-clinical supply delays
- Potential fuel delays
- Waste collection delays.

All Health Groups and Corporate Directorates have been tasked with reviewing their business continuity plans, conducting EU Exit-specific risk assessments and putting mitigating actions in place where necessary. Any issues are raised at the weekly EU Exit/Winter Planning meetings.

In the event of disruption/shortages occurring immediately following the UK's exit from the EU, the Trust's existing bed management and control room procedures would be invoked to ensure an effective organisational response.

6.2 Christmas and New Year Period 2019/20

The Trust will collate operational resilience plans for the Christmas and New Year period and will also contribute to the system level resilience planning by providing details of the on call teams within HUTH and specific information about the following key services:

Service Number	Service Name
1	Acute Medical Unit
2	Ambulatory Care Unit
3	Elderly Assessment Unit
4	Emergency Department
5	Medical Wards
6	Acute Surgery
7	Neurosurgery refer-a-patient electronic system
8	Emergency Gynaecology and Early Pregnancy Assessment Unit
9	Ophthalmology – Urgent Eye Clinic
10	Paediatrics Assessment Unit
11	Plastics Trauma service

7. Escalation Response Framework and Full Capacity Protocol

Actions taken to deal with significant peaks in demand are set out in the Trust's Escalation Plan. In accordance with national guidance, the plan is based around 4 levels of escalation:

- OPEL 1 – Steady state/low levels of pressure
- OPEL 2 – Moderate pressure
- OPEL 3 – Severe pressure
- OPEL 4 – Extreme pressure.

Examples of the actions to be taken in periods of extreme pressure (OPEL 4) include:

- Establish Control Team, (consisting of Health Group Operations Director, Nurse Director, Medical Director and Operations Support within hours, and On-Call Director/ Manager and Duty Matron out-of-hours) to command, control and coordinate tactical response to crisis through to de-escalation;
- All clinical on call teams to attend the hospital for instructions from the Control Team;
- All inpatients to be reviewed with a view to early discharge, which includes the possibility of reducing the threshold for discharge, where it is safe to do so; and
- Initiate system leaders' conference with directors from key partners to activate a community health and social care response.

One of the measures used during escalation is the activation of the Trust's Full Capacity Protocol (FCP). This protocol has been revised under the oversight of the Emergency Pathways and Flow Performance and Activity meeting (EPF PandA).

The Full Capacity Protocol (FCP) is designed to provide a set of structured responses across the organisation in the event of severe capacity pressure in any or all of the following 5 Health Groups:

- Emergency Medicine
- Medicine
- Surgery
- Family & Women's
- Clinical Support.

The objective of the FCP, full or targeted, is to create sufficient inpatient capacity to support and restore patient flow. The use of the FCP response plans will naturally be tightly coupled with the use of the OPEL escalation framework, and it is acknowledged that many of the response actions will be common to both processes.

There is a strong culture of HGs, specialties and support services working together to provide support and capacity assistance during periods of escalation, and this should continue to be a feature of the day to day approach, regardless of the escalation status we are operating under.

The Hull and East Riding System Partners will undertake a daily assessment of the system pressure level utilising the same four level system. At levels 3 and 4 system leaders will be convened via conference call to agree the system response.

8. Emergency Preparedness

8.1 Cold Weather Plan

The Trust has in place a Cold Weather Plan that sets out actions taken at the four Cold Weather Alert levels up to a major emergency. The approach is based on the established Heatwave Plan and is linked to the Met Office weather warning system, which has been in place for ten years. This plan includes the support of Yorkshire 4x4 Response, managed by the Trust Transport Manager (HRI x15565), to transport key staff and patients when appropriate.

8.2 Trust Seasonal and Pandemic Influenza Plans

The Trust has developed plans to address Seasonal and Pandemic Influenza outbreaks.

The Trust has an Influenza Vaccination Plan and has a proven record in terms of achieving and exceeding national targets for the vaccination of staff.

Whilst the NHS England CQUIN target for 2019/20 is to vaccinate 80% of staff by the end of December 2019, NHS England has stated the ambition should be to achieve 100% flu vaccine uptake by staff. The Trust has a robust plan in place to vaccinate staff. 'Drop in' clinics are open on both hospital sites, additional vaccinators within services are providing the jab and staff can book into Occupational Health clinics as well. The Trust has identified its high risk areas and Occupational Health is working with those managers to achieve 100% take up. Should there be a number of staff in high risk areas declining the vaccine, this leaves the service vulnerable. This will be escalated to the Chief Medical Officer, Chief Nurse and Director of Workforce and OD to decide whether those unvaccinated staff will be redeployed to other services, as per NHS England guidance.

8.3 Norovirus

The Trust has a well-established outbreak response, including the management of outbreaks of Norovirus (Winter Vomiting Bug), which has been shown to be effective in limiting the spread and timespan of outbreaks and therefore their impact on bed availability.

A protocol for health and social care assessments and discharges to care homes from wards closed for infection outbreaks, has been in place previously and will continue during 2019/20.

8.4 Business Continuity

The Trust takes a structured approach to business continuity based on ISO 22301 standards, best practice and in line with the statutory requirements contained within the Civil Contingencies Act (2004). Business Impact Assessments (BIAs) and Business Continuity Plans (BCPs) have been produced and are regularly reviewed. These are published on the Trust's intranet.

8.5 Major Incident Response

The Trust's Major Incident Plan is reviewed and revised on a regular basis to ensure that the information contained within the plan and action cards is up-to-date. The content is informed by national, regional and local live and desktop exercises, as well as changes in best practice and legislation.

The Trust holds regular desktop and practical exercises to ensure key members of staff are familiar with the required actions in the event of a major incident.

A multi-agency live major incident exercise was held in June 2017 to test the Trust's major incident response. A further live exercise is being planned for 2020.

Strategic Leadership in Crisis training has been provided for members of the Trust's Executive team, Directors, and first on call managers.

9. Financial Implications

Funding was identified in 2019/20 to support:

- Development of the Social Care Suite (C20)
- Provision of an additional medical Ward (H70)
- Primary care streaming
- Frailty Intervention Team.

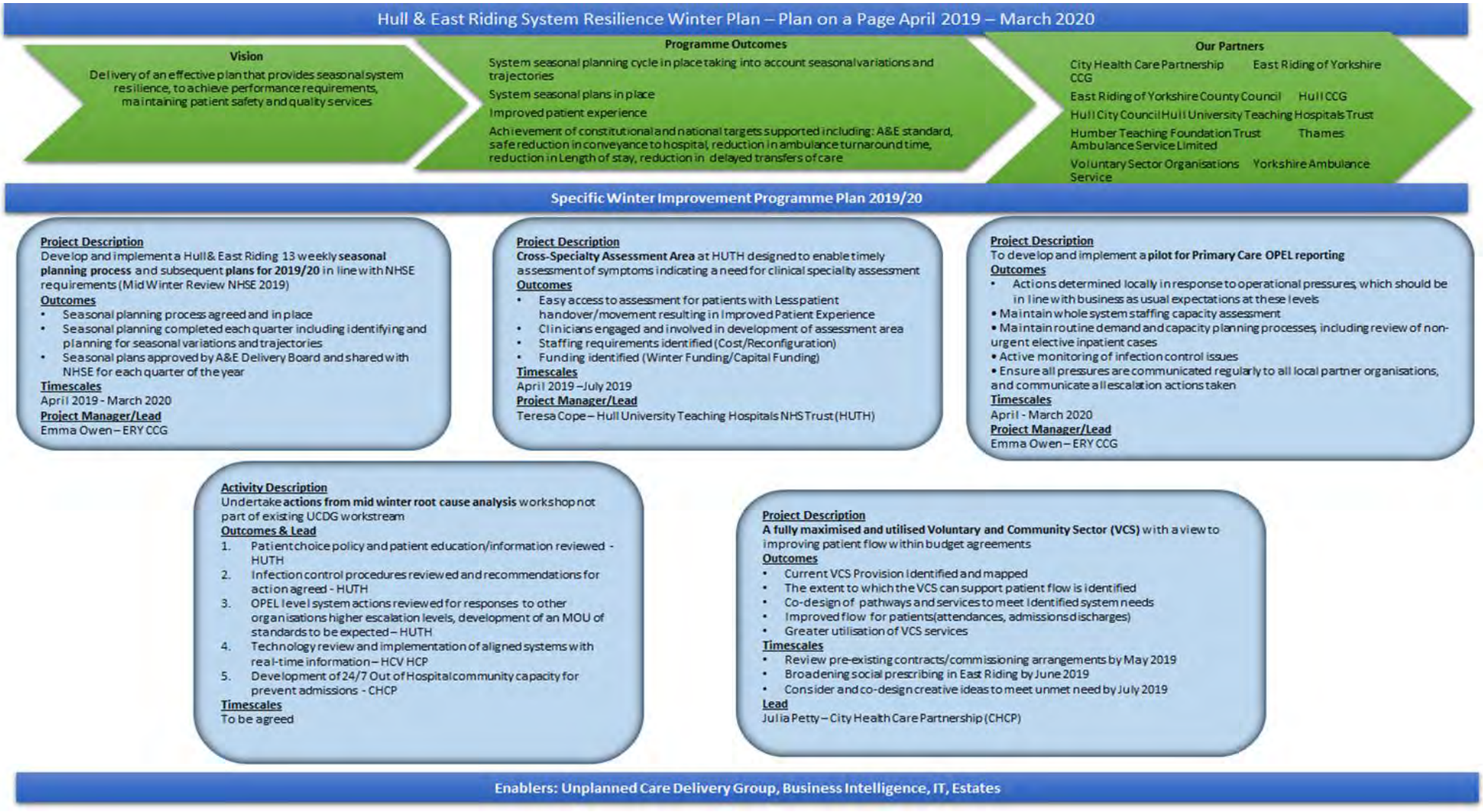
No additional winter funding has been made available to date to support developments during 2019/20.

10. Hull and East Riding System Seasonal Resilience Plan

The Hull and East Riding (H&ER) System Seasonal Resilience Plan 2019/20 has been developed by, and is owned by, the H&ER system to provide assurance to the local system organisations, the A&E Delivery Board and NHS England/Improvement (NHSE) that the system has the resilience and support to maintain safe and effective patient flows across H&ER.

The System's Seasonal Resilience Plan-on-a-Page for April 2019 to March 2020 is shown overleaf and includes:

- the creation of a cross-specialty assessment area at HUTH designed to enable timely assessment of symptoms indicating a need for clinical specialty assessment;
- a fully maximised and utilised Voluntary and Community Sector (VCS) with a view to improving patient flow within budget agreements;
- development and implementation of a Hull and East Riding 13 weekly seasonal planning process;
- development and implementation of a pilot for Primary Care OPEL reporting;
- improving ambulance handover times
- reducing Delayed Transfers of Care (DToCs)
- improving discharge processes.


Hull & East Riding System Resilience Winter Plan – Plan on a Page April 2019 – March 2020
Vision
Delivery of an effective plan that provides seasonal system resilience, to achieve performance requirements, maintaining patient safety and quality services
Programme Outcomes
System seasonal planning cycle in place taking into account seasonal variations and trajectories
System seasonal plans in place
Improved patient experience
Achievement of constitutional and national targets supported including: A&E standard, safe reduction in conveyance to hospital, reduction in ambulance turnaround time, reduction in Length of stay, reduction in delayed transfers of care
Our Partners
City Health Care Partnership
East Riding of Yorkshire CCG
East Riding of Yorkshire County Council
Hull CCG
Hull City Council
Hull University Teaching Hospitals Trust
Humber Teaching Foundation Trust
Thames Ambulance Service Limited
Voluntary Sector Organisations
Yorkshire Ambulance Service
Specific Winter Improvement Programme Plan 2019/20
Project Description
Develop and implement a Hull & East Riding 13 weekly seasonal planning process and subsequent plans for 2019/20 in line with NHSE requirements (Mid Winter Review NHSE 2019)
Outcomes
• Seasonal planning process agreed and in place
• Seasonal planning completed each quarter including identifying and planning for seasonal variations and trajectories
• Seasonal plans approved by A&E Delivery Board and shared with NHSE for each quarter of the year
Timescales
April 2019 - March 2020
Project Manager/Lead
Emma Owen – ERY CCG
Project Description
Cross-Specialty Assessment Area at HUTH designed to enable timely assessment of symptoms indicating a need for clinical speciality assessment
Outcomes
• Easy access to assessment for patients with Less patient handover/movement resulting in Improved Patient Experience
• Clinicians engaged and involved in development of assessment area
• Staffing requirements identified (Cost/Reconfiguration)
• Funding identified (Winter Funding/Capital Funding)
Timescales
April 2019 – July 2019
Project Manager/Lead
Teresa Cope – Hull University Teaching Hospitals NHS Trust (HUTH)
Project Description
To develop and implement a pilot for Primary Care OPEL reporting
Outcomes
• Actions determined locally in response to operational pressures, which should be in line with business as usual expectations at these levels
• Maintain whole system staffing capacity assessment
• Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases
• Active monitoring of infection control issues
• Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken
Timescales
April - March 2020
Project Manager/Lead
Emma Owen – ERY CCG
Activity Description
Undertake actions from mid winter root cause analysis workshop not part of existing UCDG workstream
Outcomes & Lead
1. Patient choice policy and patient education/information reviewed - HUTH
2. Infection control procedures reviewed and recommendations for action agreed - HUTH
3. OPEL level system actions reviewed for responses to other organisations higher escalation levels, development of an MOU of standards to be expected – HUTH
4. Technology review and implementation of aligned systems with real-time information – HCV HCP
5. Development of 24/7 Out of Hospital community capacity for prevent admissions - CHCP
Timescales
To be agreed
Project Description
A fully maximised and utilised Voluntary and Community Sector (VCS) with a view to improving patient flow within budget agreements
Outcomes
• Current VCS Provision Identified and mapped
• The extent to which the VCS can support patient flow is identified
• Co-design of pathways and services to meet Identified system needs
• Improved flow for patients (attendances, admissions discharges)
• Greater utilisation of VCS services
Timescales
• Review pre-existing contracts/commissioning arrangements by May 2019
• Broadening social prescribing in East Riding by June 2019
• Consider and co-design creative ideas to meet unmet need by July 2019
Lead
Julia Petty – City Health Care Partnership (CHCP)
Enablers: Unplanned Care Delivery Group, Business Intelligence, IT, Estates

11. Communication

Hull and East Riding Health and Social Care Community communication leads are working in close partnership to increase community awareness regarding alternatives to hospital-based emergency care, with the aim of changing behaviour in the long term. This year's Winter Communication Plan will include a creative targeted marketing/PR campaign and will involve proactive engagement with schools and the media.

As in previous years, a communication plan will be implemented to ensure all relevant members of staff are properly briefed regarding the service arrangements set out in the Winter Plan.

12. Risks

A risk assessment has been undertaken to identify risks associated with the Winter Plan and is attached as an Appendix.

Jo Ledger
Deputy Chief Nurse

Michelle Kemp
Deputy Chief Operating Officer

HUTH 2019-20 Winter Planning Group

31 October 2019

Winter Plan Risk Assessment

Risk	Pre-Mitigation			Mitigating action	Lead	Post-Mitigation		
	Impact	Likelihood	Total			Impact	Likelihood	Total
There will be insufficient acute medical beds for the numbers of patients requiring admission	4	3	12	Additional medical ward from 28.10.19 Increase in delivery of Same Day Emergency Care Provision of social care beds and additional community bed provision Enhanced site management arrangements will deploy escalation plan responses and help from system partners as required	Medicine HG Surgery HG			
Service capacity in the community and support to discharge/transfer of care processes adversely affected by planned changes to service models	4	4	16	Plans for the provision of adequate levels of health and social care services through the winter period will be reviewed and endorsed by the A&E Delivery Board	CEO/COO	3	4	12
Emergency service capacity will be adversely affected by severe weather or by an outbreak of flu	3	4	12	Remedial actions will be taken in accordance with the Trust's agreed severe weather and flu outbreak plans	Medicine HG Surgery HG	3	3	9
Additional pressure during winter may compromise already challenged nurse staffing levels	4	4	16	Managed through daily nursing safety briefing by Nurse Directors	Chief Nurse	2	4	8

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 30 September 2019

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	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
In Attendance:	Mrs R Thompson	Corporate Affairs Manager

No	Item	Action
1	**Apologies** Mr L Bond, Chief Financial Officer	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held on 27 August 2019** The minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** The Outpatient Transformation Programme update to be received at the December 2019 meeting. ENT quality performance to be reviewed at the Quality Committee in relation to any harms being raised.	**TC** **SH**
5	**Action Tracking List** All the items on the Tracking list had been addressed.	
6	**Workplan** Mr Nearney explained that the Job Vacancy report had been received at the Board meeting in September 2019 and was now a Board requirement.	

The Agenda was taken out of order at this point

10.3 Impact of Pension Issue on Consultant Activity
Mr Nearney presented the spreadsheet and advised that the Trust had received the first application from a consultant and this was being worked through.

Mr Nearney advised that Mr Goldstone one of the Consultants was discussing the issues with the Consultant body and was the liaison with the Executive Team. He added that the Health Group Medical Directors were also being proactive and having regular job planning discussions with their medical staff.

Mrs Christmas asked how many consultants were impacted and Mr Nearney advised that the numbers were being monitored and would be reported at the Remuneration Committee.

Resolved:
The Committee received and accepted the information.

11.1 Variable Pay Report
Mr Nearney presented the report and advised that the Trust was reporting £12.7m pay position end of month 5.

Mr Nearney advised that there were a number of things being done to address the pay position such as launching the Medical Bank. There was now 15 doctors on the Bank. There was also a focus on overtime and further discussions with the Health Groups regarding medical staffing costs.

Mrs Christmas asked how the Trust compared to peers and Mr Nearney advised that the Trust was better than average. Mr Gore suggested benchmarking with Newcastle or Salford Trusts as these were seen as high performing Trusts.

Resolved:
The Committee received and accepted the report.

11.2 Workforce Transformation Progress Report
Mr Nearney presented the report and advised that 150 new nurses had started in the Trust, 60 of which were from the Philippines. There had also been 17 Associate nurses start and the 1st apprentice physiologist had qualified.

There was good feedback from the Leadership Programme and the coaching and mentoring programme and the Trust was hosting a BME summit in October 2019.

Mrs Cope stated that more work was necessary regarding Allied Health Professionals and the joint work ongoing with CHCP. She added that the diagnostic expansion programme would need the new scanners staffing and this would tie in with Allied Health Professionals. Mr Nearney agreed to add this detail into his next report. Mr Nearney to report on how AHP's are being recruited/upskilled to take into account the provision of the diagnostic expansion programme. **SN**

There was a discussion around working closely with NLAG and increasing the profile of medical training in the Deanery and beyond. Mr Nearney reported that work was ongoing with NLAG and York.

Resolved:
The Committee received and accepted the report.

11.3 Recruitment Manager Update
Mr Nearney presented the report and advised that there was positive feedback regarding the Recruitment Manager role and the general and consultant vacancy rates had shown a reduction since the manager had been in post.

The Recruitment Manager was liaising with the BMJ and reviewing joint advertising. There had been good connections made and links strengthened with the schools and Hull College. There were also a number of external

events taking place to enhance the reputation of the Trust and promote services.

There was a discussion around performance management within this role.

Resolved:
The Committee received the report.

Board Assurance Framework
Ms Ramsay presented the BAF and advised that the capital risks should be reviewed due to the risks around the critical infrastructure. She advised that the risks were not out of control but the risk scores may need reviewing.

Mrs Cope reviewed the performance risks and stated that the Trust was not in a worse position in Q2, but was frustratingly similar to Q1.

Mrs Christmas spoke of Brexit and the concerns around 1st November 2019 and Mrs Cope assured her that there were local and national plans in place.

Mr Evans advised that at this point the Trust was still forecasting that it would deliver the financial plan although the risk was greater. Mrs Drury added that the underlying Health Group position was improving.

Resolved:
The Committee received and accepted the report.

8.1 Performance Report
Mrs Cope presented the report and advised that there had been a small improvement in the Emergency Department performance during August although performance was still off track. Mrs Cope advised that there were a number of factors in the ED impacting on performance such as inexperienced Junior Doctors and new Registrars. Sickness in medical staff was also an issue and August is the worst month for ward staffing due to annual leave.

There was a number of positive improvements such as an increase in weekend discharges and progress made on length of stay. Mrs Cope advised that Community action around complex discharges was key.

Mrs Cope reported that the medical ward that was due to open last week had been deferred by 4 weeks due to nurse staffing issues.

Mental health communication was showing improvement and Same Day Emergency Care was going well.

Mrs Christmas stated that the August staffing difficulties happened every year and asked what was being done to mitigate the risks. Mrs Cope advised that the Trust had the numbers in place but had lost some experienced registrars. Extra consultants had been recruited but had left on rotation. She added that the Community provision was also lacking.

There was a discussion around frequent attenders in the ED and Mrs Cope advised that the Trust was working with Humber FT as part of the GIRFT review to address the issues.

There was work ongoing with the top 10 Care Homes to ensure that the FIT

team could turn around patients quickly with minimum impact on the hospital.

Mrs Cope advised that 52 week waits were being maintained but RTT had an error rate of 30% requiring validation and additional training for the admin teams. Internal Audit was reviewing the processes.

Diagnostic performance was improving with the exception of endoscopy due to an increase in demand. MRI and CT had stabilised.

Mrs Cope reported that the Trust had spent the month working through the national guidance changes relating to cancer. She added that 104 waits were due to very late referrals from other Trusts. The cancer lead was working to ensure appropriate escalation took place.

Mr Hall stated that the 62 day screening performance was the worst he had seen it, but recognised the complexities in the patient pathways.

Resolved:
The Committee received and accepted the report.

9.1 Demand and Activity
Mrs Drury presented the report and advised that there had been a 2.2% growth in demand overall and GP referrals were down by 1%.

The reason for the increase in non-GP referrals was due to an increase in ED referrals, optometrists and dentists and consultant to consultant referrals.

The growth in referrals from ED was due to the increase in ACU attendances along with growth in trauma and orthopaedics, ENT and Max Fax. The consultant to consultant referral growth is in cardiology, cancer, breast surgery, paediatric surgery, pain and gynaecology and 13% of the growth is from the South Bank.

South Bank overall referrals had increased along with GP referrals. There is growth in breast surgery, cardiology, pain, T&O and ophthalmology and this has been highlighted to the Commissioners.

East Riding CCG have specifically requested that routine referrals for dermatology are rejected and given the referral route to their community provider. Mrs Cope to meet with the GPs to discuss the governance arrangements around referrals. Making the service electronic by introducing Tele-Dermatology was being reviewed.

Advice and guidance was showing growth.

Overall elective activity was 613 cases below plan at the end of August with 87 less day cases and 526 less inpatients. Outpatient activity was above plan.

ED performance was showing an improvement in Type 1 attendances and non-elective admissions was above plan. The main increase was in Clinical Support and in cancer specialties. Medicine was overall in line with planned levels.

The income position reported at month 5 was an overtrade of £1.8m. The main areas of variance was in the pass through drugs and devices and non-

elective activity. In addition Wet AMD injections were significantly lower than plan due to sickness and delays in recruitment.

There was a discussion around cardiology which was had low contract performance in specific areas and Mrs Drury agreed to bring more details at the next meeting. **AD**

Resolved:
The Committee received and accepted the report.

10.1 Finance Report
Mr Evans presented the report and advised that the Trust was reporting a deficit of £3.3m which is in line with plan. The position included £2.5m of Provider Sustainability Funding on the basis that it is in line with plan.

Income was £0.2m below plan in month and the Trust was above plan on pass through drugs, non-elective, outpatients and devices.

Health Groups were holding their financial positions although spend was high regarding agency costs. Mr Evans spoke of the financial risks around the new Lung Health Check initiative and the funding from the Commissioners.

Mr Evans reported that the Trust was still on plan at month 6 and the control total had not changed. He recommended that the Committee did not need to change the BAF risk rating at this stage.

Resolved:
The Committee received and accepted the report.

10.2 CRES Report
Mr Evans presented the report and advised that at month 5 schemes worth £16.9m had been identified. The in month improvement of £0.9m had been risk adjusted within the plan.

Mr Evans advised that energy savings were being reviewed which would help close the CRES gap.

Resolved:
The Committee received and accepted the report.

10.5 PLICs Q1 Report
Mr Evans presented the Q1 Report relating to the SLR position. The report was still work in progress and along with other Trusts working towards national cost collection to allow consultant comparisons.

Mr Evans informed the Committee that Coventry NHS Trust had shared their data with the Trust and it showed a loss although their ED was making a small profit. Mr Gore explained that Coventry's ED was outside of the city and less easy to get to. Mr Evans was still waiting for benchmark data from Nottingham.

Mr Evans advised that the Physiotherapy Service was making a loss and was working with the services to understand why. The Service only charged £24 as an average follow up cost but other Trusts were charging £48.

Mr Evans stated that the next steps was for the Costing Team to work through NHSE/I's costing assessment tool to rate the costs overall and work with Health Groups who used the costing information.

Mr Hall was keen to see the outcome of the review of Ophthalmology at Consultant to Consultant level. Mr Evans agreed to bring this back to the Committee. **SE**

Resolved:
The Committee received and accepted the report.

15.1 Contract Extension with ELFS
Mr Evans presented the report which was to confirm the contract extension to the contracted out financial services.

Resolved:
The Committee received and approved the extension to the financial services.

10.4 Financial Planning/Recovery
Mr Evans presented the report which was for information as there was still work ongoing to review the Trust's financial issues but the whole system as well. A procurement update was being presented at the Productivity Efficiency Board which included IM&T expenditure which was lower than average for the Trust's size.

Mr Gore commented that the report drew on the Model Hospital, Right Care and GIRFT initiatives and how this would be integrated into the Trust's recovery plan. Mr Evans advised that the finance teams were working with the Health Groups to understand the issues and benchmark with other Trusts.

Mr Gore stated that he had seen very little cost releasing due to GIRFT and Mr Hall advised that Dr Purva would be attending the meeting in October 2019 to discuss this further.

Resolved:
The Committee received and accepted the report.

15 Any Other Business
Mr Hall reported that Mr Curry would be taking over as Chair of the meeting from October 2019.

Mr Gore thanked Mr Hall on behalf of the Committee for his time as Chair. He stated that it was a difficult meeting to chair and that Mr Hall had handled all agenda items very well and his level of commitment was second to none. Mr Hall thanked the Committee.

16 Date and time of the next meeting:
Monday 28 October 2019, 1.30pm – 4.30pm, The Boardroom, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 28 October 2019

Present:	Mr T Curry	Non-Executive Director (Chair)
	Mr S Hall	Vice Chair/Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce and OD
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mrs M Kemp	Deputy Chief Operating Officer (Items 8.2/8.3)
	Dr R Owen-Smith	Consultant (Item 13.1 only)
	Dr M Purva	Chief Medical Officer (Item 10.5)
	Mrs A Rajendran	Senior Project Manager (Item 10.5)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
	The agenda was taken out of order at this point	
	10.5 Getting It Right First Time (GIRFT) Presentation Dr Purva gave the presentation which gave an overview of the GIRFT projects and the progress that had been made. Dr Purva advised that GIRFT was clinically led and aimed to reduce unwarrented variation, reduce costs and improve quality. Clinicians were benchmarked against their peers and quality improvement and best practice were shared. Information was shared nationally for each Trust and highlighted outcomes. Dr Purva spoke of improved patient experience, improved coding, efficiency savings and standardisation. Dr Purva highlighted future opportunities around day case procedures and looking at new innovative ways of working as well as reducing length of stay. Mrs Cope suggested that a piece of work could be carried out to review patients that are brought in the day before their procedure and whether this was actually required.	**MP**
	Mr Bond advised that the savings being made from the GIRFT projects should be identified to the financial teams to ensure they were demonstrated to the Board and not lost.	**MP**
	Mr Hall asked about the governance around GIRFT and Dr Purva advised that the Steering Group meets to pull together the actions and reports into the Operational Governance Committee. Mr Curry asked what the plan looked like and Dr Purva agreed to share it with him. She also invited Mr Curry to attend one of the working groups.	**MP**

Resolved:
The Committee received and accepted the report.

1 Apologies:
Apologies were received from Mr M Gore, Non-Executive Director

2 Declarations of Interest
There were no declarations made.

3 Minutes of the meeting held 30 September 2019
Item 12 – Workforce Transformation Progress Report - Mr Nearney stated that the 60 nurses from the Philippines were in addition to the 150 new nurses.

An update on the AHPs to be presented in the next Workforce report. **SN**

11.3 Recruitment Manager Update – Mr Nearney asked that the update read:
"Mr Nearney presented the report and advised that there was positive feedback regarding the Recruitment Manager role and the general and consultant vacancy rates had shown a reduction since the manager had been in post.

The Recruitment Manager had improved our recruitment adverts, marketing and promotional material and the Trusts social media presence. There had been good connections made and links strengthened with schools, Hull College and University. There were also a number of external events taking place to enhance the reputation of the Trust and to promote services. The Trust had also been nominated for a national award, in partnership with the BMJ for our innovative advertising campaigns.

The work of the recruitment manager has also had a positive impact upon staff retention as the Trust is better at celebrating and promoting the Trust as a good employer and the benefits offered to staff.

8.1 Performance Report – 5th paragraph: Mrs Cope stated that locum consultants were not available and had not left on rotation.

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

5 Action Tracker
All items on the Tracker were covered by the agenda with the exception of the Outpatient Transformation plan – Mrs Henderson to be invited to the December 2019 meeting and the Ophthalmology review. **RT**

6 Workplan
Ms Ramsay advised that the Operational Planning dates required updating. There were no other amendments to the Workplan.

7 Board Assurance Framework
Mrs Thompson presented the BAF and advised that the only changes made were to BAF 7.1 to add in further assurance required relating to pensions, Health Group run rates and the 5 year financial plan.
Ms Ramsay added that Q2 performance was not improving but had not

deteriorated significantly to change any of the ratings. The BAF had been approved by the Board in September 2019.

Mr Bond suggested that the risk ratings should remain until the NHS I plan had been implemented and streaming in ED was in place. Work was ongoing to address the Health Groups deficits. Mr Hall asked about the step down wards and Mr Bond advised that staffing was the key issue.

Mr Curry asked that with only limited progress with risk mitigation to date how long are the risks reported. Ms Ramsay advised that the report came every month to the meeting so any major changes would be captured. She added that most of the risks spanned longer than a year so meeting with the risk owners to discuss mitigation strategies was important.

Mr Hall added that the extra ordinary Performance and Finance meeting being held in November 2019 may highlight other risks or provide mitigating actions.

Resolved:
The Committee received and accepted the report.

8.1 Performance Report
Mrs Cope presented the report and advised that ED performance had been static for the last 4 months and was not meeting the agreed trajectory. Additional capacity had been opened and additional community beds would be coming on line. Work had started at the front of the hospital and the Frailty Team had moved to H36.

Ambulance handovers were being reviewed and the Trust was working with YAS to ensure both sets of data matched and appropriate challenge of data was given.

The 52 week wait performance was being maintained but the pressure was increasing as winter approached.

Mrs Cope reported that the waiting list volume position would hit the trajectory by the end of October 2019 but expressed her concern regarding the RTT admin error rate. Work was ongoing to flush out any compliance issues. Mr Hall asked if the HIP Team could be utilised. Mrs Cope advised that the team were involved with the improvement work.

Diagnostics had seen a small improvement and there had been work commissioned by the Spire. Mrs Cope advised that £90k had been funded for CT colonoscopy.

Mrs Cope advised that the cancer position for September was much more positive at 77% and largely driven by the improvements in diagnostics. A review was underway to encourage patients to attend their appointments.

Mr Hall mentioned the new workforce model and Mrs Cope advised that ED was now fully staffed from a nursing point of view and work was ongoing with CHCP and Humber.

Mr Hall asked about the 104 day standard and how easy it was for patients to cancel their appointments and could Trust volunteers be used to call patients.

Mrs Cope advised that trained call handlers deal with the calls but it was down to patients honouring their appointments. Mrs Christmas asked if there was anything else that could be done and Mrs Cope advised that invasive testing was always difficult for patients, especially elderly ones. The answer was to have more CT scans but demand was too high at the moment.

Mr Bond queried the stranded and super stranded patients and how the Trust is managing the bed base. Mrs Cope advised that discussions were ongoing with Surgery and Medicine Health Groups regarding any opportunities.

TC

Resolved:
The Committee received and accepted the report.

13.1 ED Workforce Presentation
Dr Owen-Smith attended the Committee and advised that all Junior Doctors were on the e-Roster system but it was taking time to get them to use it. He advised that Job Plans had been base-lined and work was ongoing to improve them.

There was a discussion around the difficulties with the junior workforce and how difficult decisions were made. Dr Owen-Smith stated that ACPs were more experienced in this area. Mr Hall asked about ring fencing clinicians to ensure the workload was being managed and Dr Owen-Smith advised that a lot of it came down to the leadership on the day.

There was a discussion around e-Roster and how it was not a live system. There were issues around the culture and how clinical leads were made more accountable. Mr Nearney added that the bed issues and surges of patients have begun to become normal in the department which was adding to the pressure. Dr Owen-Smith advised that consultants needed to be engaged before they would discuss new ways of working.

Resolved:
The Committee received and accepted the report.

8.2 Same Day Emergency Care
Mrs Kemp presented the update and advised that the National initiative that was being driven by the Centre to reduce bed occupancy and move from 1/5 admissions to 1/3 admissions discharged in the same day.

The 3 areas that the Acute Provider was being measured on was Acute Medicine, Acute Surgery and Acute Frailty.

Mrs Kemp advised that recording Same Day Emergency Care would mean a change in software that could be uploaded to the Centre.

In addition to the hospital level there was a CQUIN scheme running relating to Pulmonary embolism, Atrial Fibrillation and Pneumonia and evidence was required on a regular basis to ensure the Trust was meeting its objectives.

A dashboard was being developed to ensure the SDEC opportunities were reported along with SPC charts.
Mr Hall asked if there were limitations with the Lorenzo system and if so should it be on the risk register. Ms Ramsay agreed to check this.

Mrs Kemp also reported that work was ongoing with ambulatory care and ED to review service configurations and manage the patients outside of the ED. **CR**

Resolved:
The Committee received and accepted the report.

8.3 Operational/Winter Planning
Mrs Kemp gave a presentation that related to EU Exit and winter planning.

She advised that a winter planning group had been launched in the summer with clear purpose and a number of actions on the centralised workplan.

The meeting was led by Mrs Kemp and Mrs Ledger who had a list of priorities should any extra winter funding became available.

There were a number of issues to address such as bed capacity, escalation, ambulatory care, flu, discharge protocol and ward clerk coverage to support the nurses.

Mrs Kemp advised that EU Exit planning was ongoing and the Trust was responding as it could to the political situation. The main areas were being risk assessed to ensure staff could get to work and medicines were in stock at the appropriate places.

Mrs Kemp advised that new developments included additional community beds, a 7 day model on H30, new medical ward expanding to 22 beds by December and the relocation of FIT.

Mr Hall stated that the presentation was robust and asked to see the workplan, which Mrs Kemp agreed to circulate.

MK

Resolved:
The Committee received and accepted the report.

9.1 Demand and Activity Report
Mrs Drury presented the Demand and Activity report and advised that overall referrals were down on the same period last year.

Consultant referrals were up 1.6% and advice and guidance had seen a 90% increase compared to last year.

There had been a reduction in day cases compared with last year potentially due to less capacity.

A&E was 2% below plan with Hull CCG but ERCCG were 3% above plan. Non-Elective had seen a 1.9% increase and GP referrals were 2.4% lower than last year.

The increase in referrals is mainly from consultants, ED and growth from other health professionals.

Resolved:

The Committee received and accepted the report.

10.1 Finance Report September 2019
Mr Evans presented the report and advised that the Trust was reporting a deficit of £4.7m which was in line with plan. The position included £3.1m of PSF.

The Health Groups were reporting a £400k overspend and the majority of this was in pass through drugs.

Mr Evans reported that the Trust was still forecasting delivery of the financial plan although this was subject to a number of risks and confirmation of additional funding from local commissioners.

Resolved:
The Committee received and accepted the report.

10.2 CRES 2019/20
The Trust was reporting an over delivery in CRES to date of £0.7m with £5.8m being delivered against a target of £5.1m. This was only 31% of the annual requirement and the trajectory for delivery would increase from month 7.

Mr Curry enquired whether a high proportion of the savings related to vacancies and therefore may not be sustainable. This was acknowledged as a factor.

Mrs Christmas asked how confident Mr Bond was that the Health Groups would identify enough CRES to meet the year end target and Mr Bond advised that he was not confident. He reported that work was ongoing with the Health Groups to not only review 2019/20 but 2020/21 as well. He reported that NHS Improvement were now looking at the Health economy as a whole rather than individually and costs were being managed as a system.

Resolved:
The Committee received the report.

10.3 Productivity and Efficiency Report
Mr Evans presented the report and advised that NHS Improvement were working through the benchmarking data for legal and procurement and IM&T.

A meeting was being set up with NHS I, the finance team and IT team to review the outputs and identify which areas the Trust should focus on.

Resolved:
The Committee received and accepted the report.

10.4 Impact of Pension Issue on Consultant Activity
Mr Nearney updated the Committee and advised that there had been little change since last month with 1 consultant reducing their hours due to the pension issue.

Mr Nearney advised that pension letters would be received in October 2019 which could impact.

Resolved:
The Committee received and accepted the report.

10.6 Financial 5 Year Plan Update
Mr Bond updated the Committee with the latest 5 year financial plan. He advised that it would be submitted on 1st November 2019.

Mr Bond reported that performance trajectories had been put into place to improve RTT by 2024 and achieve Cancer and diagnostics by 2024.

The Trust had received its control total for the next 4 years and the ask for HUTH is to deliver £1.49m surplus next year (20/21) and a slight increase each year to £1.66m surplus in 23/24.

The CRES requirement for 20/21 is £6.2m, tariff plus £9m underlying, plus the control total surplus at £1.49m equalling £16.7m.

He advised that the operational delivery strategy was being discussed with Health partners to build on primary care streaming and redirecting activity away from the organisation.

The Capital Funding priorities highlighted in the STP for HUTH were the IT Network, a Rehabilitation Ward and the theatre upgrade programme alongside an intention to commence the detailed planning work around the replacement of the HRI Tower Block.

The Committee discussed what was being asked over the next five years and how it was important to understand the risks. Mr Bond advised that the process had started for next year and he was currently discussing this with the Health Groups.

Mrs Christmas asked Mr Bond whether he thought that delivery of a £17m CRES programme next year was likely. Mr Bond replied stating that it was beyond the organisations capability acting alone, however, it was not impossible to deliver across the Humber economy if all partners worked together. The Committee agreed that this represented a significant risk for the Trust.

Resolved:
The Committee received and accepted the presentation.

11.1 Variable Pay Report
Mr Nearney presented the report and advised the Trust position was better than it was at this time last year although was still above plan. Overall the Trust was underspent on workforce pay.

There was a discussion around the new pay rates for medical agency staffing and Mr Nearney agreed to bring back more information in his December 2019 report. **SN**

Mrs Christmas highlighted a report that had been received at the Audit Committee on 24 October 2019 regarding agency staffing and how theatres were not using the current framework. Mr Nearney asked to review the report to enable him to respond. **SN**

Resolved:
The Committee received and accepted the report.

12.1 Carter Minutes
The minutes were received and accepted by the Committee.

13.2 Capital Resource Allocation Committee
Mr Bond presented the minutes and advised that the Capital Plan was at £26m and the money would have to be spent by the end of March 2020.

Mr Bond reported that the Trust has been successful with a recent bid to NHS I for replacement CT and MRI Scanning equipment. The details of the award have not yet been received. He added that the money was only for the purchase of the scanners and not the installation costs which often equalled to capital cost.

Resolved:
The Committee received and accepted the report.

14 Items delegated by the Board
There were no items delegated by the Board.

15 Any Other Business
There was no other business discussed.

16 Date and Time of the Next Meeting:
Monday 25 November 2019, 1.30pm – 4.30pm

Hull University Teaching Hospitals NHS Trust

Trust Board

Date 12 November 2019

Title:	Trust Strategy Implementation Midyear Update	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this report is to apprise the Board of progress towards the achievement of the goals set in our Trust Strategy 2019 - 2024	
BAF Risk:	The Strategy is relevant to all of our BAF risks	
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	X
Key Summary of Issues:	• Good progress in being made against the commitments in the new Trust Strategy	
Recommendation:	1. That Trust Board notes the contents of the paper and indicates any areas where further action or assurance is sought.	

Trust Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Great Staff	Staff survey overall result top 20% of Trusts	Staff report able to make improvements top 20% of Trusts
	Staff engagement score top 20% of Trusts	More BME staff in leadership roles
	80% of staff recommend us as a place to work	95% of posts are filled with permanent staff
	At least a 92% retention rate	Improve the health and wellbeing of our staff
Great Care	Achieve 'Outstanding' overall CQC rating	Increase harm free care year on year
	Increase the length of time between SIs and NEs	Deliver the 4 priority 7 day working standards
	Fewer complaints and PALS relating to outpatient services	Patient Friends and Family Test score : in top 20% of Trusts
	Improve transition from children's to adult services	Provide patient electronic access to medical records
	Extend access to latest surgical and drug treatments	Achieve and sustain 28 day and 6 week diagnostic targets
	Deliver 10,000 health prevention interventions	Reduce hospital stays for patients in the last year of life
	Reduce admissions for patients with long term conditions	Deliver year on year reductions in our length of stay
	Ensure our integrated teams have access to shared care records	Meet the standard for fractured neck of femur
	Deliver standards for urgent and emergency care	Reduce face to face outpatient appointments
	Expand and update our diagnostic capacity	Deliver the 'Better Birth' ambitions
	Centralise inpatient paediatrics and improve the NICU	Deliver the clinical access standards for cancer and electives
	Secure sustainable specialist paediatric service	Continue to improve our major trauma survival rates
	Improve timely access to acute and elective cardiac care	Improve the cancer stage of presentation and survival rates
	Establish a mechanical thrombectomy service	Working with partners, support the progression of the HCAV HCP into an ICS
	Establish an ICP that can show measurable improvement to the health of its population	Working with partners across the Humber region, secure safe and sustainable acute hospital services
	Support the work to create a sustainable clinical model for hospitals services in Scarborough	Establish mature programmes of workforce development and research with our international partners
Great future	Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit	Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio
	Achieve all Department of Health and NIHR research performance metrics	Secure three new long-term commercial research partnerships
	Secure 'top 5' national status with our Academic Oncology Research Unit	Working with partners, achieve financial balance across our ICP
	Improve the quality of our estate and increase the productivity per square metre	Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy
	Become greener by reducing our energy consumption and waste	Become a digital first organisation; removing paper

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Staff survey overall result top 20% of Trusts		
Exec Owner S Nearney		
Milestone	By When	Progress
4 of the key findings in the top 20% and 6 equal too or better than the national average	March 2020	Progress in 2018 survey, 2019 survey currently underway
6 of the key findings in the top 20% and 4 equal too or better than the national average	March 2021	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Staff report able to make improvements top 20% of Trusts

Exec Owner: S Nearney

Milestone	By When	Progress
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2020	2019 survey underway. Improvements delivered in 2018
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2021	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.4%	March 2022	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2023	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2024	
Achieve top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Staff engagement score top 20% of Trusts		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey result for staff engagement – 7.1	March 2020	2019 survey underway.
National Staff Survey result for staff engagement – 7.2	March 2021	
National Staff Survey result for staff engagement – 7.3	March 2022	
Achieve top 20% ranking	March 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

More BME staff in leadership roles		
Exec Owner: S Nearney		
Milestone	By When	Progress
Number of BME staff in leadership roles will increase by 0.5% to 6.25%	March 2020	Action plan being implemented
Number of BME staff in leadership roles will increase by 0.75% to 7%	March 2022	
Number of BME staff in leadership roles will increase by 1% to 8%	March 2024	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

At least 80% of staff recommend us as a place to work		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey question . Staff response will be 67%	March 2020	2019 survey underway
National Staff Survey question . Staff response will be 70%	March 2021	
National Staff Survey question . Staff response will be 74%	March 2022	
National Staff Survey question . Staff response will be 77%	March 2023	
National Staff Survey question . Staff response will be 80%	March 2024	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

95% of posts are filled with permanent staff		
Exec Owner: S Nearney		
Milestone	By When	Progress
94.2% of posts filled with permanent staff	March 2020	94.07% As at end of Sept 2019
94.6% of posts filled with permanent staff	March 2021	
95% of posts filled with permanent staff	March 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

At least a 92% retention rate		
Exec Owner: S Nearney		
Milestone	By When	Progress
91% staff retention rate	March 2020	91.1% as at end of Sept 2019
91.5% staff retention rate	March 2021	
92% staff retention rate	March 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Improve the health and wellbeing of our staff		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2020	2019 survey underway. Improvement achieved in 2018
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2021	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2022	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2023	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2024	
Achieve 6.4 point score which will deliver a top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Achieve 'Outstanding' overall CQC rating		
Exec Owner: C Long		
Milestone	By When	Progress
Achieve overall 'Good' rating	Mar 2020	CQC visit now planned for January 2020. Trust has joined the NHSE&I 'Moving to Good' Programme
Sustain overall 'Good rating' and achieve 'Outstanding' rating in 2 core services	Mar 2022	
Sustain overall 'Outstanding' rating	Mar 2024	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Increase harm free care year on year		
Exec Owner: Makani P		
Milestone	By When	Progress
Establish mechanisms to measure harm and establish a baseline	September 2019	Morbidity form in development – launch November 2019
Identify areas of improvement to achieve harm free care	November 2019	
Focus on one area of improvement	January 2020	
Roll out to wider areas and Embark on further areas of improvement	January 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Increase the length of time between SIs and NEs		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Refresh mechanisms to capture and manage SIs	November 2019	Refresh underway
Full launch of Stop the Line Campaign	March 2020	Campaign in development
Develop and deliver projects to address key themes	March 2020	
Continually capture real time data	March 2020	
Embed proactive safety culture	December 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Achieve compliance with the 4 clinical priority standards for 7 day services by March 2020		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Develop a series of metrics to support reporting of progress against the 7DS standards	July 2019	Complete (actual performance to date 2 of 4 achieved)
Identify those specialties who continue to under-perform against the standards and agree specific actions to address the shortfalls in delivery	August 2019	Complete
Provide six monthly updates on progress to the Trust Board in accordance with the 7DS Board Assurance Framework	Ongoing	Om track

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Fewer complaints and PALS relating to Outpatient Services		
Exec Owner: B Geary		
Milestone	By When	Progress
Baseline report based on 2018/19 to be completed	June 2019	Baseline of reported complaints/PALS for 2018/19 36 compliments 957 concerns (PALS) 191 Complaints (Formal) (However not all linked to outpatient activity due to categorisation – this is being addressed)
Focussed patient engagement to be undertaken	July 2019	Family and Friend continues to be used in OPD's. 2018/19 97.83%.Questionairre to be amended to ask "Did you need to attend today?" NHS Choices reported monthly. All areas act on comments/concern/compliments on a daily basis
Action plan to be developed and approved by the OP Governance Group	July 2019	Patient stories shared monthly at OPG and datix and discussed. Monthly break down of PALS at Committee since October again future work as not all concerns
Quarterly monitoring to commence against baseline	Oct 2019	Commenced first report received at October committee
Development and deployment of Trust annual outpatient survey	2020/2021	Not yet commenced

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Patient Friends and Family Test score : in top 20% of Trusts		
Exec Owner: B Geary		
Milestone	By When	Progress
Identify themes in F&FT and agree action plan to address	Sept 2019	Wider review of patient and public feedback well underway
Delivery improvement on 2018/19 baseline	March 2020	
Following launch of successor scheme to F&FT, develop and deploy plan to achieve top 20% rank	TBC	

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2019/20 half year update

Improve transition from children's to adult services		
Exec Owner: T Cope		
Milestone	By When	Progress
Baseline audit against NICE standards	March 2019	Complete
Broader transition partnerships developed and activated	March 2020	In development
Patient and carer levels of knowledge regarding condition and adult services enhanced	March 2020	
Robust patient experience measurement tool developed	March 2021	
Delivery model for transition clinics reviewed and changes implemented as indicated	March 2022	
Tool deployed and shows improved experience	2022 - 2024	

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2019/20 half year update

Provide patient electronic access to medical records		
Exec Owner: L Bond		
Milestone	By When	Progress
Go Live with 'Patient Knows Best' system	Jul 2019	Slightly delayed by flow of national funding but will be delivered by March 2020
Rollout, linked to the Yorkshire and Humber Care Record programme	Sept 2020	
Deliver plan to maximise patient take up, with focus on long term conditions	Sept 2021	

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Extend access to latest surgical and drug treatments

Exec Owner: Makani P

Milestone	By When	Progress
Increased commercial research activity year on year from 2018/19 baseline.	March 2020 (Yr 1)	Engagement with Y&H CRN 2019/20 Annual Plan. As at 07.10.19 HUTH (119) has third highest commercial recruitment behind Sheffield (146) and Leeds (455) .
Increased research workforce capability to deliver increased activity.	On-going from 2019/20	4 PhD Scholarships awarded (1 AHP). 6 Research Support Funding awards (with HYMS) to support protected time and provide methodological support. 6 Clinical Research Fellows appointed (Renal, cardiothoracic, Orthopaedics and Gastro). 5 NIHR ACF Posts awarded to start in 2020. 7 new Principal Investigators engaged (Renal, ID, ED, Imaging). 2 posts supported in Pharmacy Trials Team (from September). Lead Research Nurse appointed (October) Radiotherapy research nurse appointed.
Increased research awareness from Trust visitors, carers and patients.	On-going from 2019/20	Website development on-going with facility for researchers to upload and share stories and promote activities/articles and presentations.

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Achieve and sustain 28 day and 6 week diagnostic targets

Exec Owner: T Cope

Milestone	By When	Progress
Determine the Capacity requirements in each modality and target	August 2019	Demand on each modality is monitored and discussed vi a Performance and Activity meeting fortnightly
Understand the impact of referrals from outside HUTH	August 2019	This is reported fortnightly via Performance and Activity Meeting and report on Inter Hospital Transfer are provided to referring Trusts on a monthly basis
Project growth in demand over the next 5 years	August 2019	This work has been completed as part of the Long Term Plan
Factor in changing technologies or therapies over the next five years	August 2019	This work has been completed as part of the Long Term Plan
Develop staged milestones required to achieve the targets	Sept 2019	In place
Breach percentage against the 6 week standard reduced to 2%	March 2020	Trajectory in place. Recovery plan in place to reduce the number of Endoscopy breaches
6 week standard achieved	March 2021	
28 day standard achieved	September 2021	

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

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Reduce hospital stays for patients in the last year of life		
Exec Owner: T Cope		
Milestone	By When	Progress
Embed SAFER principles across the organisation, with Home First as a priority.	1st July 2019	SAFER has been re-launched across the organisation with agreed metrics in place which are monitored by the Emergency Performance and Flow Performance and Activity Meeting.
Use Red2Green days to reduce any unnecessary waiting.	1st July 2019	see above
Work with the Discharge Hub to support advanced care planning.	1st June 2019	A review of the Discharge Hub has been undertaken in Q1 and a work programme for the Hub has been agreed to improve interface with the wards and Out of Hospital partners. This is monitored via the Unplanned Care Delivery Group
Ensure all RESPECT forms are appropriate and up to date.	1st July 2019	
Develop and implement an improvement plan, for the above.	1st June 2019	See above
Develop and implement an improvement plan for diagnostics, equipment and treatments/medications to allow patients to leave hospital sooner.	1st July 2019	See above

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Reduce admissions for patients with long term conditions

Exec Owner: T Cope

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

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Deliver year on year reductions in our length of stay		
Exec Owner: T Cope		
Milestone	By When	Progress
Deliver 40% reduction in number of occupied bed days of patient with a length of stay of 21 days or greater. Baseline 126 patients Target 77 patients	March 2020	SAFER has been relaunched across the organisation and an Improvement action plan is in place which is monitored via the Emergency Performance and Flow Performance and Activity meeting fortnightly. Reduction targets for 2020/21 and 2021/2022 have been submitted as part of the Long Term Plan submission
Make year on year reductions in length of stay of patients who are in hospital 7 days or longer.	March 2022 - 24	Reduction targets for 2020/21 and 2021/2022 have been submitted
Work collaboratively with out of hospital partners to reduce delays in the transfer of care for patients with a length of stay of 7 days or greater. Baseline – 15%	March 2020	Daily discharge targets are agreed with all partners and LLOS data shared daily. Performance against this milestone is monitored by the Unplanned Care Delivery Group and the A&E Delivery Board.
Improve pre-operative length of stay in Surgery	March 2020	

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2019/20 half year update

Ensure our integrated teams have access to shared care records		
Exec Owner: L Bond		
Milestone	By When	Progress
Agree benefits case for the Yorkshire and Humber Care Record Programme (YHCR), ensuring it achieves functional shared care records for Humber, Coast and Vale (HCAV)	March 2020	On track – draft benefits case currently under review by Y&H Directors of Finance
Develop and agree investment plan for the YHCR	March 2020	
Complete YHCR rollout in HCAV	March 2021	

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

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Deliver standards for urgent and emergency care

Exec Owner: T Cope

Milestone	By When	Progress
Develop ED recovery and improvement plan linked to agreed performance standards trajectory	10th May 19	Complete. System Wide ED Recovery Plan in place and monitored via the Unplanned Care Delivery Group and the A&E Delivery Board
Sign off of ED recovery and improvement plan via UCDG	1st June 19	Complete
Primary Care Streaming (PCS) service specification developed and signed off by CCGs and HUTH	1st June	Complete. Primary Care Streaming Service commences from mid December following capital investment and estates reconfiguration works
PCS Implementation plan developed and signed off by UCDG	1st June	Complete
Develop and implement ACU improvement plan	1st July	Complete. ACU will be expanded to provide a Multi-specialty ACU with effect from mid December.
Develop and implement AMU improvement plan	1st August	In progress. AMU will be expanded to provide an Initial Assessment and Triage Zone from mid December to support effective flow.
Develop and implement Discharge Lounge improvement plan	1st September	Complete

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Reduce face to face outpatient appointments		
Exec Owner: T Cope		
Milestone	By When	Progress
Programme for reducing the number of face to face outpatient follow-ups agreed by the Out-Patient Improvement Board.	April 2019	Approach agreed via the OPD Improvement Board.
Phase 1 specialties for the reduction programme, support by the Trust Improvement Team, identified.	April 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 2 specialties for the reduction programme, supported by the Trust Improvement Team, identified	September 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 3 specialties for the reduction programme, supported by the Trust Improvement Team, identified	April 2020	
Out-patient follow-up volume reduced by 50% from baseline at 31/3/19.	June 2020	Progress at M6 2019/20 has been assessed and reported to PAF.
Phase 4 specialities for the reduction programme, supported by the Trust Improvement Team, identified	September 2020	

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2019/20 half year update

Expand and update our diagnostic capacity		
Exec Owner: L Bond		
Milestone	By When	Progress
Replace oldest CT and Gamma Camera	March 2020	Orders placed
Explore options for accelerating access to Wave 4 capital	March 2020	Plan agreed
Agree business case for expanded endoscopy capacity	March 2020	Case in development
Install additional MRI and CT and commission additional endoscopy capacity	No later than March 2022	On track
Agree demand requirements across the STP for key modalities through to 2024	March 2020	
Agree and deliver further diagnostic capacity that meets forecast demand	March 2023	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Deliver the 'Better Birth' ambitions

Exec Owner: B Geary

Milestone	By when	Progress
Continuity of Carer	35% of women to be on a pathway for CoC by March 2020. 51% by March 2021	Transformational funding £216k received to this KPI. 12 fixed term secondments have been recruited to CoC implementation Lead Diabetes Specialist Midwife, Midwifery Assistants x 4 for each CoC team. Primrose the 2nd Caseloading team launched June2019, linked to area of high depravation. Ivy team in place 1 year , 190 births and achieving 85% births attended by team member FABC model commenced July 2019. Currently 15.1% CoC, demonstrating the full pathway
All women to have access to digital personalised care plan	March 2021	Work on-going with IS to develop personalised care plan
Maternity Voices Partnership to be in place	MVP to be in place by March 2019	MVP's in place for Hull and the East Riding of Yorkshire. Meetings set up and Hull MVP will be 'walking the patch' in the next couple of months
Prevention of Cerebral Palsy in pre-term infants Avoiding Term Admissions to neonatal units Reducing smoking (to 6% nationally)	Reducing stillbirths and morbidity by 2025	All midwives have undertaken ATAIN training, recent submission of ATAIN audit indicates decrease of term admissions. Smoking in pregnancy (SIP) LMS Prevention Lead recruitment in progress. HUTH have declared compliance with CNST SafetyAction6 including SIP elements. Mat Neo Collaborative project; 'Increasing the Proportion of Smoke-Free Homes' with the Primrose team.
Improved safety systems and culture, working with the Local Maternity System	March 2021	HUTH actively contributes to the Y&H safety learning network.
Workforce development – agree STP wide recruitment strategy and training standards	March 2021	Scoping Maternity Support Worker roles B3 with Hull College Engagement with Hull University addressing increase midwifery placements Culture survey feedback on-going Potential for LMS wide recruitment

Strategy Implementation Scorecard 2019-2024
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Centralise inpatient paediatrics and improve the NICU		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree plan for future configuration of paediatrics	Mar 2020	Plan agreed for paediatrics and included in wave 4 capital bid
Agree funding stream for plan	Mar 2021	Wave 4 capital bid approved
Agree plan for improvement of NICU	Mar 2020	
Complete implementation of plans	Mar 2022	

Strategy Implementation Scorecard 2019-2024
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Deliver the clinical access standards for cancer and electives		
Exec Owner: T Cope		
Milestone	By When	Progress
Deliver Improvement in the 62 day Cancer performance to 85% (adjusted)	March 2020	Stock take review at month 6 2019/20 has been conducted. September performance 78% and in line with Improvement trajectory.
Deliver 62 day cancer performance standard (unadjusted)	September 2021	
Reduce ASI / Holding by 50% from baseline position (31/3/19)	March 2020	Stock take review at month 6 2019/20 has been conducted and reported to PAF on 7th November. A number of specialties will achieve this target.
Eliminate ASI / Holding	March 2021	
Improve RTT performance to 84.5%	March 2020	Stock take review at month 6 2019/20 has been conducted and reported to PAF 7th November
Reduce total waiting list volume by 3,000 from baseline 31/3/19)	March 2020	Stock take review at month 6 2019/20 has been conducted and reported to PAF 7th November. The Trust anticipates reducing its WLV in 19/20 but not by the stretch target of 3,000.
Improve RTT performance to 92%	December 2021	

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Secure sustainable specialist paediatric service		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree an approach to the service review with NHSE Specialist Commissioners	Mar 2020	Discussions in progress with both the specialised commissioners and as part of the Humber Acute Services Review
Undertake review and agree recommendations	Mar 2021	
Fully implement agreed revised service model	Mar 2022	

Strategy Implementation Scorecard 2019-2024
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Continue to improve our major trauma survival rates

Exec Owner: T Cope

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

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

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

Strategy Implementation Scorecard 2019-2024
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Improve the cancer stage of presentation and survival rates

Exec Owner: Makani P

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

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2019/20 half year update

Establish a mechanical thrombectomy service

Exec Owner: T Cope

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

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Working with partners, support the progression of the HCAV HCP into an ICS		
Exec Owner: J Myers		
Milestone	By When	Progress
Support STP team to complete the system 5 year plan	Dec 2019	On track
ICS established in shadow form	Mar 2021	HCAV gained a place on the NHSE&I ICS Accelerator Programme
ICS fully established	Mar 2022	

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Establish an ICP that can show measurable improvement to the health of its population		
Exec Owner: J Myers		
Milestone	By When	Progress
Working with partners, establish a governance structure to develop the ICP	Oct 2019	In progress but not complete. Programme Director in post and overarching board established
Support creation of ICP infrastructure and work programme	Mar 2020	Initial work programme in place but needs review
Support the development of ICP population health capability and agree improvement targets	Mar 2021	
Demonstrate improved population health in target areas	Mar 2024	

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Working with partners across the Humber region, secure safe and sustainable acute hospital services		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree with all partners the approach and method for the review of acute services	Jun 2019	Complete
Ensure effective participation and leadership from HUTH teams and reps	Mar 2020	In progress
Ensure effective scrutiny, and review of all service proposals for alignment to both Trust and review goals	Mar 2020	In progress
Working with colleagues and partners, oversee timely and effective implementation of service changes.	Mar 2022	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Support the work to create a sustainable clinical model for hospitals services in Scarborough		
Exec Owner: J Myers		
Milestone	By When	Progress
Ensure effective participation in the review by all relevant Trust teams	Mar 2020	Trust has a seat on the Steering Group for the Board
Represent HUTH on the review steering group and ensure active support for solutions and alignment to HUTH strategy	Mar 2020	Plan for sustainable oncology services agreed

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Establish mature programmes of workforce development and research with our international partners		
Exec Owner: Makani P		
Milestone	By When	Progress
Exchange programme for doctors in key specialities.	August 2019 - sustained on-going programme over the next few years	
Development of educational resources facilitated by an exchange programme of staff and resources.	May 2019 and on-going	Overseas simulation fellowship opportunities- to commence the first fellowship by May 2019 and follow up with others by May 2020
Development of joint research opportunities and projects and Joint Research Conference.	December 2019	Sri Ramachandra Research Institute (Microfluidics, Infectious Disease, Geriatrics, Rehabilitation, Renal, Orthopaedics, Simulation research) – collaborative research conference in Chennai (India)February 2020.

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2019/20 half year update

Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit		
Exec Owner: Makani P		
Milestone	By When	Progress
Be an active and influential voice as part of the HHTU Advisory Board.	June 2019	R&D Manager invited to review HHTU provisional accreditation application that was submitted in August 2019.
Provide access to Trust expertise and staffing (i.e. Quality Assurance Team) as a formal contribution to the HHTU core staffing infrastructure.	On-going	R&D QA support provided as part of development activities of HHTU including complex drug study setup. Trial Manager invited to spend some time in the Trust R&D QA Team.
Provide a clear pathway allowing efficient and easy access to the HHTU and UoH research methods support.	March 2019 and on-going.	Supported the HHTU and UoH ICAHR launch in March 2019: ICAHR R&D Manager supporting seminar events for researchers .
Maximise the exploitation of Hull Health Trials Unit facilities (i.e. outsourcing skills and expertise to external partners).	On-going	HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU.

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2019/20 half year update

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

Exec Owner: Makani P

Milestone	By When	Progress
Ensuring equity of access to research for our patients - increasing the number of patients recruited into NIHR Portfolio studies.	March 2020	Target for 2019/20 is 6,000 participants. Delivery monitored monthly. Forecast to come under this target in 19-20 due to a switch towards lower recruiting but highly complex studies. Future national focus is on research to meet the disease prevalence of our population.
Embracing Y&H CRN systematic early review processes to encourage all clinicians to regularly look for opportunities to participate in research.	On-going from April 2019	Expression of interest monitored by Y&H CRN monthly. HUTH R&D to assess barriers and capacity issues. Pharmacy SLA signed to help unblock issues.
Proactive and realistic feasibility and assessment of capability and capacity (C&C).	On-going from April 2019	70% of studies open to recruitment within 30 days (as at 14.10.19).
Maximising resource utilisation - improved flexibility and responsiveness in our agreed priority areas.	December 2019	Lead Research Nurse appointed. To formalise robust line management structure by December.

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Achieve all Department of Health and NIHR research performance metrics		
Exec Owner: Makani P		
Milestone	By When	Progress
Provide enhanced performance management data to research teams and Health Groups on all local and national metrics (NIHR High Level Objectives (HLOs)).	April 2019	Power BI research performance dashboards developed and available on Pattie.
Provide quarterly performance report for Trust Board.	July 2019 and quarterly thereafter	Executive summary info graphic available on Power BI (Pattie) by end of Oct.
Focus on Recruitment to Time and Target (RTT) metrics (80% compliance for commercial and non-commercial studies).	Achieve 12 month rolling target for closed studies by March 2020.	Commercial RTT = 100% (all 7 closed studies) Non-commercial RTT = 40% (3 of 8 studies closed).

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Secure three new long-term commercial research partnerships		
Exec Owner: C Long		
Milestone	By When	Progress
Working with our university colleagues, identify potential partners that align to Trust Research and Innovation Strategy goals and undertake initial discussions	Mar 2020	On track
Set goals for shortlisted partnerships and broker arrangements	Mar 2021	
Agreements in place with 3 new commercial research partners	Mar 2022	

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2019/20 half year update

Secure 'top 5' national status with our Academic Oncology Research Unit		
Exec Owner: Makani P		
Milestone	By When	Progress
Consider Y&H CRN/ NIHR 'peer-review' of the Oncology/Haematology research unit infrastructure and delivery models.	December 2019	Senior research Nurse is influential member of Y&H CRN Oncology research nursing group. Discussion has commenced on formalised programme.
Establish baseline position on NIHR KPIs for Oncology.	Q2 2019/20	Power BI dashboards currently being developed. Some data already available on Pattie HUTH is currently 2nd in Y&H for recruitment after month 1.
Define objectives to achieve KPIs for Oncology.	Q3 2019/20	Based on baseline position. National data to be collated at end of Q1. Focus is TYA and SABRE trials.
Establish commercial 'preferred site' status for Oncology/Haematology.	2020/21	Development of an industry engagement document by Q2 2019-20.

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2019/20 half year update

Working with partners, achieve financial balance across ICP		
Exec Owner: L Bond		
Milestone	By When	Progress
Deliver HUTH contribution to Hull and East Riding system financial plan for 2019/20	March 2020	HUTH 2019/20 plan has risks to delivery
Agree Hull and East Riding system plan for 2020/21 that eliminates recurrent deficits	April 2020	In progress but pressures in ER CCG
Deliver HUTH contribution to Hull and East Riding system financial plan for 2020/21	March 2021	
Working with NLAG, development and delivery of the financial plan to support the output of the Humber Acute Services Review	March 2021	
Working with York Trust, development and delivery of the financial impact of the Pathology collaboration	March 2021	

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

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

Strategy Implementation Scorecard 2019-2024
2019/20 half year update

Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy		
Exec Owner: L Bond		
Milestone	By When	Progress
Complete and sign off the refresh of the Development Control Plan for HRI	Oct 2020	On track
Complete and sign off the refresh of the Development Control Plan for CHH	March 2021	
Agree approach to business case(s) for capital funding	Oct 2021	
Achieve business case(s) approval and secure capital funding stream(s)	March 2023	

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Improve the quality of our estate and increase the productivity per square metre		
Exec Owner: D Taylor		
Milestone	By When	Progress
Delivery of Estates Rationalisation Programme Phase 2	Late 2019 TBC	Wilson building demolition Due to start November2019. Phase 2 programme under review pending capital investment
Carter Metric - Non-clinical space <35% (under utilised space at 0%, Carter Metric 2.5%)	Late 2019 onwards	Currently 33.8%, further opportunities identified in Phase 2 Estates Rationalisation Programme
Implement office accommodation strategy including flexible and agile working.	Summer 2019	Suite 36 complete and Wilson building emptied of all staff and provided in Alderson House , craven building and Suite 36 Refresh of office accommodation strategy progressing
Upgrade vacant old cardiac theatres to robotic theatres	Mar 2020 Completion	Scheme out to tender

Strategy Implementation Scorecard 2019-2024
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Become a digital first organisation; removing paper		
Exec Owner: L Bond		
Milestone	By When	Progress
Agree capital financing for the Trust Digital Strategy	Sept 2019	Delayed due to capital constraints – awaiting news on national pots of capital for digital renewal
Agree plan for e-casenotes	March 2021	
Complete network upgrade	March 2021	
Complete rollout of e-prescribing	March 2021 (CHH) March 2021 (HRI)	
Complete rollout of e-observations	March 2022	
Deploy e-casenotes solution	March 2023	

Strategy Implementation Scorecard 2019-24 progress report colour rating key

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

Hull University Teaching Hospital NHS Trust

Trust Board

June 2019

Title:	Review of Information Technology
Responsible Director:	Tony Curry
Author:	Tony Curry

Purpose of the report:	This report presents a high-level assessment of the Trust's information technology resources and its ability to meet the Trust's current needs and ambitions of becoming a digital organisation.	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and enough staff	✓
	High quality care	
	Great clinical services	✓
	Partnership and integrated services	
	Research and Innovation	✓
	Financial sustainability	✓
Summary Key of Issues:	The Trust makes extensive use of information technology and in 2018 launched a 5-year digital strategy. The digital strategy sets out the overall direction for information technology with the ambition of increasing digitisation. Implementation of the strategy according to current timetable depends on securing around £18m of funding over the next 3 years and this will be very challenging in the current climate. A large part of the strategy is about replacing IT assets which have reached end-of-life i.e. both systems and hardware. This modernisation will support but not in itself deliver strategic change. The flagship initiative in the strategy is the Lorenzo Digital Exemplar (LDE). Successful implementation will be transformative and yield significant improvements in patient care and with a reduction in costs. However, its full implementation depends on the modernisation programme. Delivery is likely to protract, and it will be important to maintain commitment and focus to make sure it is delivered. As the modernisation of systems and hardware will take several years to complete and because many items are also important to day-to-day service, setting priorities is crucial to achieving the best balance of outcomes both operationally and strategically. The Digital Strategy Board originally proposed at the start of the strategy should be instigated to improve oversight of the change agenda, to define priorities, budget and timescales. The Trust's spend on information technology is low compared to the sector average for healthcare organisations. IT will continue to require significant and ongoing investment to 'catch-up' and then transform. Delivering the modernisation required in reasonable timescales will mean committing additional investment or accepting longer lead times for meaningful change. Given the constraints on capital now and in the	

	future, alternative and more sustainable approaches to funding should be considered. Whilst existing computer disaster recovery arrangements should support the recovery of some systems it is likely that recovery procedures would take time to deploy. There is a need to review arrangements to make sure they support the timely recovery of critical systems. There are also gaps in existing IT security measures some of which should be addressed with the planned upgrade to Windows 10 later this year. Both areas require further work and investment to improve current arrangements. The importance of these requirements needs to be considered alongside other priorities to make sure they are not overlooked. Recent turnover has led to gaps in the leadership and management of the IM&T function. Resolving leadership, management and governance will be vital to establish proper accountability, authority and to oversee the change agenda. A number of IT functions currently operate autonomously in other departments (i.e Oncology, Radiology, Pharmacy and Pathology). However many of the core housekeeping and support are the same and the current approach misses the opportunity to consolidate and rationalise the services to free-up much needed effort to support the Trust's IT agenda. The management team should further consider whether current staffing levels are appropriate for current and future workloads and to provide out-of-hours cover.

Recommendation:	The Board is asked to note the contents of this report and the recommendations made.

Hull University Teaching Hospitals NHS Trust

Trust Board

Review of Information Technology

1. Purpose of the report

This report presents a high-level assessment of the Trust's information technology and its ability to meet the Trust's current needs and its ambitions of becoming a digital organisation.

2. Introduction

The Trust has a significant dependency on information technology, it is important to understand its current evolution, the role it plays and the opportunities to further exploit IT to support the Trust's vision and strategic goals. The report comments on the current state of information technology, the digital strategy and the capacity and capability to operate services and manage change. It does not examine the detailed management of the IM&T function or comment on specific systems.

The specific objectives of the review were to:

- Undertake a high-level assessment of the Trust's current adoption of IT/digital resources including effectiveness and security;
- Undertake a high-level assessment of the IT strategy and plans for development and deployment of IT/digital resources; and
- Undertake a high-level assessment of our capability and capacity in terms of people and skills.

The review was based on a review of key documentation and discussions with key managers within IM & T.

The term Information Technology is used to refer to a wide range of resources including:

- the computer infrastructure i.e. severs, data networks, desktop computers

- the clinical and administrative and information systems e.g. pathology system, finance system, management information systems.

3. Background

IM&T Department

Most information technology is managed by the Trust's IM&T function.

The IM & T department has three core teams:

(1) **IT Services** manages the computer infrastructure,
(2) **Digital Services** (CRS) manages and deploys the clinical and administrative systems and,
(3) **Information Services** includes commissioning and data quality, clinical coding, patient administration, performance and reporting functions.

This report references the IT Services and Digitisation Services teams because they have a key role delivering information technology solutions. The Information Services team delivers specialist functions but in the context of this report is user of information technology solutions.

3.1 Effectiveness and security of current IT/digital resources

This section considers the general scope and use of information technology and makes specific comments about the adequacy of business continuity and disaster recovery arrangements.

3.1.1 Systems

Computer systems at the Trust have been introduced over a long period of time and cover a wide range of hospital departments and functions such as cardiology, pathology, bed management.

These systems deliver a very valuable but largely utility service. Systems are mainly organised around hospital departments e.g. cardiology department operates the cardiology system. There is limited integration of systems which means data can be duplicated and inconsistent. Whilst these systems continue to provide good support many are now obsolete and need to be replaced.

It worth noting that the next generation of systems has improved greatly compared to the last generation. Modern systems typically offer better integration, mobile working and self-service as standard.

3.1.2 Hardware

Clinical and administrative systems are supported by a lot of computer hardware; computer servers, data networks, printers and personal computers etc. Much of the hardware in use is old and due for replacement.

As well as impending hardware obsolescence, the advent of new clinical systems such as electronic observation (eOBS) and electronic prescribing (ePMA) is also driving the need for better technology in this case to support mobile computing at the bedside.

Technical diversity has become an issue. The IT systems introduced by some hospital departments in the past have not conformed with the de facto standard and this has resulted in multiple computer operating systems and unnecessary complexity. The failure to achieve a common standard also underlies some security, resilience and support issues. It is important that the Trust defines and adheres to technical standards going forward to reduce complexity and risk. A technology architecture and road map which describes the desired state should be developed and used to govern future procurement of technology. Decisions about systems must have strong governance and oversight to make sure that long-term interests as well as short-term interests are served.

The Trust has now reached a cyclical point where many of its technology assets both systems and hardware are due for replacement. Whilst assets will continue to support the hospital services, the urgency to systematically replace assets is building with the risk of continuity problems if hardware or software support fails. New systems are planned or underway for cardiology, electronic prescriptions, electronic observations, scan4safety, bed management, imaging, pathology, maternity records and management information. Replacement of worn-out hardware has also started with work on the data network and computer servers.

3.1.3 Current IT Spend

Based on industry benchmarking data the average spend on IT in the healthcare sector is around 3.49% (1) of income which would equate to annual spend of £18.5m for the Trust. Recent spend data indicates operating costs at around £5.5m/annum (2). Capital spend in 2018/19 was around £3.6m plus around £2.4m of external funding. These costs exclude the salaries of 18 IT staff in other departments. However, if these salaries are included at average rates (say £1m), the total spend appears to be in the region of £12.5m which is less than the benchmark average.

1.Deloitte 2016-2017 Global CIO Survey
2.Excluding the cost of the Information Services team

Obviously, benchmarks don't reflect local circumstances or affordability and averages will mask some wide variability, however, they provide a useful comparator for understanding typical spend.

Whilst the Trust has continued to invest in IT during tough financial conditions, a long period of low investment combined with a break-fix policy (for some IT assets) has contributed to the high levels of obsolescence now faced.

The cost of refreshing some IT assets (systems and hardware) may in part be met from other sources e.g. NHSI, STP, however, the burden of cost will be borne by the Trust and at a time when there are many competing demands for capital. The pace of the current modernisation programme and the Trust's digital ambitions will be mainly driven by the availability of capital. Much of the investment needed reflects the cost of maintaining the Trusts operational IT as distinct from delivering transformational change.

The Trust also faces a significant increase in IT operating costs in 2021 as it starts to pay commercial rates for the Lorenzo system as NHSI funding comes to an end. This cost is expected to be around £1m per annum. This will add to the current cost pressures.

A growing response to the challenges of funding large capital IT programmes can be met in part by increasing the use of the Cloud (see further below). It is also worth considering whether leasing IT assets offers a more reliable way of managing key assets over the longer term as the availability of capital becomes more problematic. Downward pressure on operating budgets is acknowledged. Management should consider the options for future funding of IT which avoids the current swings in capital requirements which can be difficult to respond too and manage.

Spend at current levels delivers a low cost but essential service. Without extraordinary budget it will be difficult to deliver significant service improvements in the short to medium i.e. 1 to 3 years. There is an increased risk of inertia if investment is slower than the rate of obsolescence. External funding is and will continue to help but is unlikely to address the investment deficit.

3.1.4 Priorities

With many projects underway there is a risk that critical items may stall for the lack of funding. It is also possible that some initiatives may be more beneficial if delivered quickly. For example, implementing a new bed management solution to support the improvement needed in ED performance might be considered a worthy priority. Another influence is priorities, which are set externally either as conditions of funding such as the Pathology System funded by the STP or the need to comply with national directives such as the Windows 10 upgrade.

In summary, there is a heavy tension between maintaining existing services through the modernisation programme and the expectation of delivering strategic transformation. In

these circumstances understanding and choosing priorities is crucial to achieving the best balance of outcomes. There is no obvious mechanism for deciding these priorities. Instigating the Digital Strategy Board as originally proposed would provide a forum for deciding priorities.

3.1.5 Collaboration

A valid question is why hospitals don't collaborate more on IT services to manage costs and deliver more innovation? One significant barrier is the wide variety of technologies and systems currently used by Trusts as well as different ways of working. Switching to common technologies will usually mean unifying working practices too and this is a significant task.

Reaching a decision to collaborate is difficult as each Trust generally has different priorities as well as limited capital. In these circumstances, aligning desire with need is difficult. Without a common cause and adequate funding progress is difficult. The collaborations emerging from the STP initiative should deliver some common systems such as the pathology system currently being discussed. The availability of external funding eliminates one key barrier to a common approach.

Use of the Cloud perhaps offers the greatest opportunity in the medium long term for reducing the complexity and cost of delivering IT services. Cloud systems will play an increasing role commoditising what most would agree should be the availability of standard off-the-shelf solution for hospitals.

Moving to the Cloud will take time and it is likely that the Trust will need to operate a hybrid model in the short to medium term using a combination on premise systems, shared services and Cloud-based services. However, in the medium-long term the bias is likely to shift to Cloud provision.

A Cloud approach is likely to succeed where national systems have struggled in the past because each Trust will be able to manage the transition according to its own priorities, timescales and affordability.

3.1.6 Cloud Computing

The historical bias for large capital programmes to deliver IT is fast eroding. Increasingly, software suppliers are switching delivery of their systems to the cloud.

As well as turnkey systems, some organisations are also using the cloud for general computing requirements such as backup, disaster recovery and data storage to reduce investment in on premise IT facilities.

Initial concerns in the sector about data security have largely been overcome.

Cloud computing offers many key benefits:

- It reduces upfront capital investment and switches more of the cost to ongoing revenue charges
- It eliminates or significantly reduces asset refresh costs because these are absorbed in the ongoing running costs
- It transfers responsibility for day to day aspects of the operation to the supplier
- It delivers highly resilient services
- It reduces the complexity of on premise IT
- It commoditises making the true cost more transparent.

The Trust makes only limited use of the Cloud and the most significant Cloud system is the Lorenzo system which is delivered as a managed service. It has been suggested that the

reason for the limited uptake is the lack of a clear policy as well as the challenges of switching costs away from capital budgets to revenue budgets (which are also under pressure).

Cloud solutions must become a key consideration. There is a need for clear direction to make sure that its use is not overlooked especially given the constraints on capital.

3.1.7 Business Continuity

Maintaining the operation of clinical systems is vital to the delivery of care. The availability of systems depends on having resilient IT which can be recovered quickly following any incident. This is often achieved by having a separate backup system at a different location. Such arrangements are designed to overcome disaster scenarios relating to loss of power, fire, water damage, denial of access etc.

The Trust has two separate computer facilities split across its two hospital sites. However, neither of these can support the processing of all the Trust's central IT systems. Whilst current arrangements would support the recovery of some systems it is likely that recovery procedures would take time and the Trust may need to revert to manual procedures until systems were restored. This could lead to service degradation and interruptions if timescales protracted. A further factor is the recent changes and introduction of systems which increase the criticality and dependency on some systems e.g. eOBS, ePMA, Scan4Safety etc. It is not clear whether specific priorities have been decided with clear plans to support their rapid recovery.

Actions are underway to improve disaster recovery with the provision of new computer facilities at both hospitals. The upgrade at Castle Hill Hospital was completed in 2018/19. Investment plans for 2019/2020 include budget proposals to upgrade Hull Royal Infirmary. Once completed, the IT facilities at either hospital should be capable of supporting all central systems. However, completing these arrangements depends on making capital available in the 2019/20 budget. The Trust also has the option of using a Cloud based service for disaster recovery. This would reduce the need for some of the upfront capital investment and replace this with an ongoing revenue charge.

Business continuity arrangements are important given the current dependency on IT which is also set to increase. Any major sustained loss of IT which affected patient care would be very serious and likely to attract adverse publicity which would be difficult to defend.

Management needs to carefully assess the priority of completing business continuity arrangements against other investment priorities.

3.1.8 Security

Cyber security is a requirement in terms of data privacy and for business continuity. The latter was heightened by the disruption caused to the NHS by the WannaCry computer virus in 2017. Recent independent reviews of the Trust's cyber security have highlighted issues, most of which management have since confirmed have been addressed. A recommendation remains to improve the traceability and accounting of all software licences given the importance of this to security protection. The upgrade to Windows 10 later this year is expected to include software that will do this. There is also an issue relating to the software versions of certain clinical systems which makes security improvements problematic.

Cyber defences have evolved gradually over time in response to the emergence of threats. The Trust has implemented a range of security defences which offer protection. However, security is not a static issue and new threats emerge frequently and this means constant scrutiny of security threats and countermeasures. Similar to other organisations, the Trust's

security controls have evolved ‘bottom up’ over time and it is not clear whether there is a complete understanding of risk which has been approved by senior management alongside a mitigation strategy.

Like many other organisations cyber security is currently managed at a technical level within the IT function. However, this focuses the responsibility for cyber security too narrowly making it a technical issue rather than the corporate issue it has become. Achieving strong security sometimes means inconvenience and additional cost, with the true cost of achieving strong security often overlooked.

In response to national policy, the Trust now faces the significant task of upgrading to the Windows 10 operating system. This upgrade is partly in response to the security concerns posed if the Trust were to remain on Windows 7 which becomes unsupported in January 2020. However, completing this upgrade will require significant effort as well as some extra-ordinary budget because many of the Trust’s PCs need to be upgraded at the same time to be able to use Windows 10.

Public sensitivity to data breaches is heightened because of the constant flow of adverse publicity. A further consideration is the recent Data Protection legislation due to GDPR, which poses greater sanctions for organisations who fail to protect personal data.

The IM&T management team should raise the profile of cyber security to make sure it attracts the commitment and resources to be fully effective. Specifically, there is a need to develop a clear strategy for cyber security aligned to risk.

3.1.9 Lorenzo Initiative

As already noted, the Trust has a wide range of systems involved in patient care. The Lorenzo system is noteworthy given its strategic importance.

The decision to implement Lorenzo represents a very significant improvement to the information management related to the delivery of clinical care. Introducing the Lorenzo electronic patient record is fundamental to the Trust’s digital ambitions.

As an early adopter of Lorenzo, the Trust has benefited from high levels of external funding from the NHSI. This funding continues with the Lorenzo Digital Exemplar (LDE) Programme and the Trust continues as a key player in a small but influential group who are now exploiting the wider development and deployment of Lorenzo.

It is pleasing to note that the Trust’s foresight and commitment to the Lorenzo initiative has equipped it with a key system that it needs to transform care with the bulk of its cost covered externally. Given cost pressures it is unlikely that the Trust would have achieved the same progress outside of this initiative.

The Trust is also set to benefit from funding made available under the STP initiative with the current focus on a new Pathology system. Other systems are envisaged as funds are agreed and allocated.

3.1.10 Summary

The Trust has a basic IT service which has reached a cyclical point where significant investment is needed to modernise. A lot of work is underway and planned, much of this will preserve current service and some will pave the way for transformation. With such a big change agenda and only limited investment it is important to maintain a focus on critical items and priorities to make sure the right things get done. Basic ‘housekeeping’ requirements such as security and business continuity should not be overlooked.

Importantly, more consideration should be given to the use of the Cloud as an alternative to investing in on premise assets.

3.2 IT strategy and plans for development and deployment of IT/digital resources

This section deals with the Trust's Digital Strategy, it repeats several points already made but within the context of the current strategy.

The Trust has developed a digital strategy which sets out the vison for improving digital services over the period 2108 – 2023. This includes the ambition for a joined-up care record, better patient information, patient self-service and using technology to drive greater efficiency. The strategy also reflects NHS national policy requirements and the STP technology objectives.

Whilst the ambition for greater digitisation emerges, the strategy document is difficult to read because there is a conflation of tactical ambitions such as replacing clinical systems and strategic ambitions such as 'paper-free at the point of care'. This arises in part because of the overwhelming need for modernisation. Many of the initiatives in the strategy will replace existing solutions with more up to date solutions. New solutions such as Scan4Safety will address gaps in the current portfolio.

The real digital transformation will come from exploiting the Trust's portfolio of technology solutions once these are updated to create better ways of working. The principal agent for this in the Digital Strategy is the LDE programme. The successful implementation of LDE will be transformational because it will align the use of technology along patient pathways rather than within the current boundaries of clinical departments. This should deliver a joined-up patient record and patient care plan supported by high levels of automation which in turn reduce the administrative burden placed on clinical and other staff. Positive results would signal the opportunity to accelerate investment to deliver transformation faster

The digital strategy of necessity has a range of inwardly focussed initiatives reflecting the modernisation programme. There are several initiatives which are aimed at increasing the integration with other providers (e.g. GP Portal) and the ability of patient to self-serve some aspects of their care management – the Patient Knows Best (PKB) initiative.

3.2.1 Strategy Core Themes

The Digital Strategy as currently documented embodies 3 core themes:

(1) Upgrading the hospitals technology infrastructure

The work needed to modernise the hospitals core technology infrastructure to replace worn out assets and deliver better technology. This work is essential to current operational service as well as a precursor for transformation.

(2) Replacing and introducing new clinical systems

Replacing some of the Trust's older clinical systems with new systems because of obsolescence and to deliver improved functionality.

(3) Re-engineering working practices for key patient pathways

Changing working practices for several patient pathways to deliver more joined-up ways of working. This work will exploit the new technology and systems outlined above.

Many of the initiatives are interdependent. For example, improving patient pathways requires the appropriate clinical systems to be in place which in turn requires a modern infrastructure.

3.2.2 Implementation Plans

Current plans for the strategy encompass 52 initiatives in the period 2019 – 2022. This represents a complex portfolio of change which delivers the new hardware infrastructure, new clinical systems and the first phases of new patient pathways (LDE).

There was a clear demonstration of dependencies and sequencing of projects. The current plans are in part driven by several macro-level factors including national mandates (to upgrade to Windows 10 and move to NHS Mail etc.), the availability of external funding (LDE, pathology etc.) and the availability of internal funding. As already stated, the plans do not convey any specific priorities or benefits (albeit some items appear to be more important than others) but demonstrate phasing of initiatives over time with the assumption that adequate funding is made available.

A good level of planning information was evident especially the LDE programme, which serves as the umbrella project for many of the current strategic initiatives.

3.2.3 Investment

Delivering the strategy as currently planned will require investment of around £18m. Budget proposals call for around £7.5m capital in 2019/20 (including approximately £3m of external funding), £6.5m in 2020/21 (including approximately £2.2m of external funding) and £3.5m in 2021/22. More investment will be needed beyond this to complete the work on other patient pathways (extending the scope of LDE) and for further modernisation.

If this level of funding is not available, the timescales for implementing the strategy will protract. This has implications for initiatives which are more critical to day to day services. Conversely, there is an opportunity to accelerate plans if more investment can be made available. In both cases there is a need to set the priorities to achieve the best outcomes for the investment available.

3.2.4 Governance & Oversight

The strategy document proposes a governance structure with two main oversight groups:

- A Digital Strategy Board
- A Digital Programme Board

Whilst the Digital Programme Board is extant, the Digital Strategy Board remains to be constituted. Both Boards require broad membership which is reflective of the users they serve.

The current challenges which are likely to emerge in relation to investment and priorities make board oversight an imperative. The Digital Strategy Board should be constituted and oversee the digital agenda with an initial focus of reviewing scope, budget, timescales and priorities.

3.2.5 Summary

Whilst the current digital strategy sets out the overall direction for digitisation the supporting documentation is less clear about how systems fit together so it is difficult to establish an overall view of the target state. There is a need to develop systems and technical architectures to increase awareness of the desired state to allow for greater debate challenge and certainty. Much of the strategy is concerned with modernising IT as opposed to real strategic transformation. The singular strategic initiative is the LDE programme. LDE should transform ways of working once modernisation is complete. Affordability is likely to constrain progress in which case priorities and benefits need to be clear to make sure critical items receive attention. With so many competing initiatives there is a danger of change overload especially given the small size of the teams involved in delivery.

Much of the strategy is inwardly focussed, partly of necessity. More consideration needs to be given to the integration with other providers, the community and patients if a joined-up care system is to be realised in the future.

In many respects the current strategy is foundational rather than transformational.

3.3 Capability and Capacity

This section deals with skills and capacity of the IM&T function to manage existing systems and deliver strategic change.

The department delivers a vital service to the Trust not only supporting day to day operations but increasingly supporting many change initiatives. The volume of change now is very significant. IT Services has a small number of staff and is trying to absorb this extra work. The Digital Services team is similarly challenged but has addressed some of the work demand with temporary workers funded by capital projects.

The loss of senior management in the department has created some uncertainty.

The successful delivery of key initiatives such as ePMA and network upgrades indicate a good level of capability.

Alongside funding, people capacity is an issue which if unaddressed will have an impact on the rate of modernisation and transformation.

3.3.1 Leadership

Following several leadership changes and the loss of the most recent Digital Services Director (IM & T Director) the director role is currently vacant. The affairs of the IM & T are being managed by the Deputy Director of Digital Services and Administration reporting to the Chief Financial Officer.

In response to the turnover is a proposal to create a new digital services structure with triumvirate reporting lines, which includes roles for both a clinical and nursing lead (pro tem). This approach appears reasonable because it should lead to greater ownership and engagement with new solutions as these emerge. The benefits of strong clinical leadership in IT projects have been cited in the successful deployment of ePMA at the Queen's Centre.

Resolving the leadership of the IM&T function with the appointment of a senior officer is key to galvanising the department after a period of uncertainty as well as to re-establish proper accountability and authority. Alongside this management should reassess the subordinate departments to make sure the structure and staffing levels are appropriate.

3.3.2 IT Services Team

Whilst there is evidence of a good management control within the IM & T department generally, management of the IT department appears more problematic. The current lack of a senior manager means there is a gap in key skills and critically the technical leadership of the department. This is evident given the lack key planning tools such as a technology architecture, applications architecture and security architecture. Whilst IT are involved in decisions about technology initiated elsewhere in the hospital, their degree of influence has been questioned. This has been voiced as the departments failure to plan and lead and conversely their view that they can be too easily overruled.

The IT department has a very low number of staff (16 WTE) when considering the scale of the Trust's IT operation. This places the Trust at a ratio of 1:600 users which is very high compared to known benchmarks which for some organisations can be as low as 1:75. Whilst this delivers a very low-cost operation it carries with it the risk of a de minimis service. Whilst there was no evidence of serious service issues, concerns were raised about the capacity of the IT department to support current and emerging change initiatives. IT staff also raised concerns about the current workload and their inability to cope with the current demand and to become more pro-active.

With only a small team there is a major focus on day-to-day service. Where the team are involved in change initiatives there is evidence that modern technologies are being deployed. The department's response to new initiatives appears to be largely reactive and transactional. It is not clear how much long-term planning is carried out.

3.3.3 Devolved IT Functions

As already noted, the Trust has several autonomous IT functions embedded in other hospital departments i.e. Oncology, Radiology, Pharmacy and Pathology. There are 18 staff carrying out IT related roles who do not sit within the central IT department. This exceeds the number of staff within the central function who operate the Trust's other systems. The reasons for this diversity are not entirely clear. Although the devolution of IT functions may have proven useful in the past, it is now associated with difficulties maintaining technical standards, software management and providing adequate cover when staff are absent. Whilst an element of specialisation is recognised much of the core management and support activity is similar across all systems and could therefore be consolidated whilst maintaining strong links and specialism to clinical teams.

Centralising the management of all IT activities and staff would potentially support greater alignment of technical solutions, standards and working practices as well as being a larger multi-skilled team that would support greater opportunities for career development and progression.

3.3.4 Digitisation Services (Care Records Service (CRS)) Team

The Trust has established a change management function which supports new change initiatives as well as maintaining and enhancing existing systems. This group are primarily responsible for the delivery the initiatives set out in the Digital Strategy. With a significant volume of work which exceeds capacity temporary work contractors are often used to address the deficit. The Trust also benefits from a high level of support from DXC as part of the LDE initiative. However, this has led to an ongoing and high dependency on temporary workers to support key initiatives. This presents issues in terms of continuity of knowledge and delivery aligning budget to employment contracts and project timescales is often difficult and imprecise. Local market conditions in Hull make it difficult to recruit key IT skills, the use of temporary contracts further reduces appeal. Given the value and importance of this work, the management team should consider the benefits of creating substantive posts where the volume of work and or skill requirements make this more appropriate in the medium and long term.

A further factor is an apparent grading disparity that can arise when similar roles are available within the Trust with higher salary grades. Key project staff have been lost to other hospital roles. The impact of grade disparity on staff turnover and retention should be reviewed and addressed.

3.3.5 Summary

The skills needed to achieve transformative change are evident. There has/continues to be a dependency on external advisors (DXC) for some strategic elements but skills transfer is evident. Resources in IT Services and Digitisation Services are modest considering the amount of change underway and proposed. It is not clear whether the resource requirements of the Digital Strategy have been defined or fully budgeted. The use of fixed contractors and external consultants (for LDE) is to a large extent propping up the current change agenda. Gaps in funding increase the risk of discontinuity and rework. Operational staffing appears de minimis and could be improved by merging all IT functions within the central department.

4. Recommendations

The Board is asked to consider the report and following recommendations

- Update the current digital strategy and plans to be clear about the target state priorities, costs and benefits. Confirm the ambitions, timescales and affordability.
- Instigate the Digital Strategy Board to improve oversight and management of the digital agenda.
- Consider the options for funding of IT which avoids the current swings in capital requirements.
- Develop a system and a technical architecture and road maps which describe the target state of Information Technology.
- Set clear direction to make sure that Cloud solutions are not overlooked.
- Develop a clear strategy for cyber security aligned to the Trust's appetite for risk and allocate the budget needed to address critical items on the basis of managing risk across the Trust.
- Confirm the full suite of business continuity arrangements.
- Appoint a leader for the IM&T function
- Review the IM & T department to make sure the structure remains relevant and staffing levels are appropriate and consider the consolidation of all IT staff within the central IT services department to create a stronger central function.
- Review the impact of grade disparity on staff turnover and retention in CRS.

Tony Curry
Associate Non-Executive Director
May 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

12 November 2019

Title:	Staff Survey FFT Quarter 2 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 survey results for Q2 2019/2020	
BAF Risk:	BAF risks 1 and 2 Recruitment and retention of staff and organisational culture	
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 is above national average	

Recommendation:	The Trust Board is requested to note the performance and action plan and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Staff Survey FFT Results Q2 2019/2020

1 Purpose of the Report

To inform the Trust board of the staff survey FFT results for Q2 2019/2020 and outline actions currently underway to sustain and further improve this performance.

2 Background

From 1st April 2014 all organisations providing acute, community, ambulance and mental health services are required to implement the Staff Friends and Family Test (Staff FFT); giving staff the opportunity at least once a quarter to answer two standard questions:

- how likely are you to recommend your trust as a place to work?
- how likely are you to recommend your trust to friends and family if they needed care or treatment?

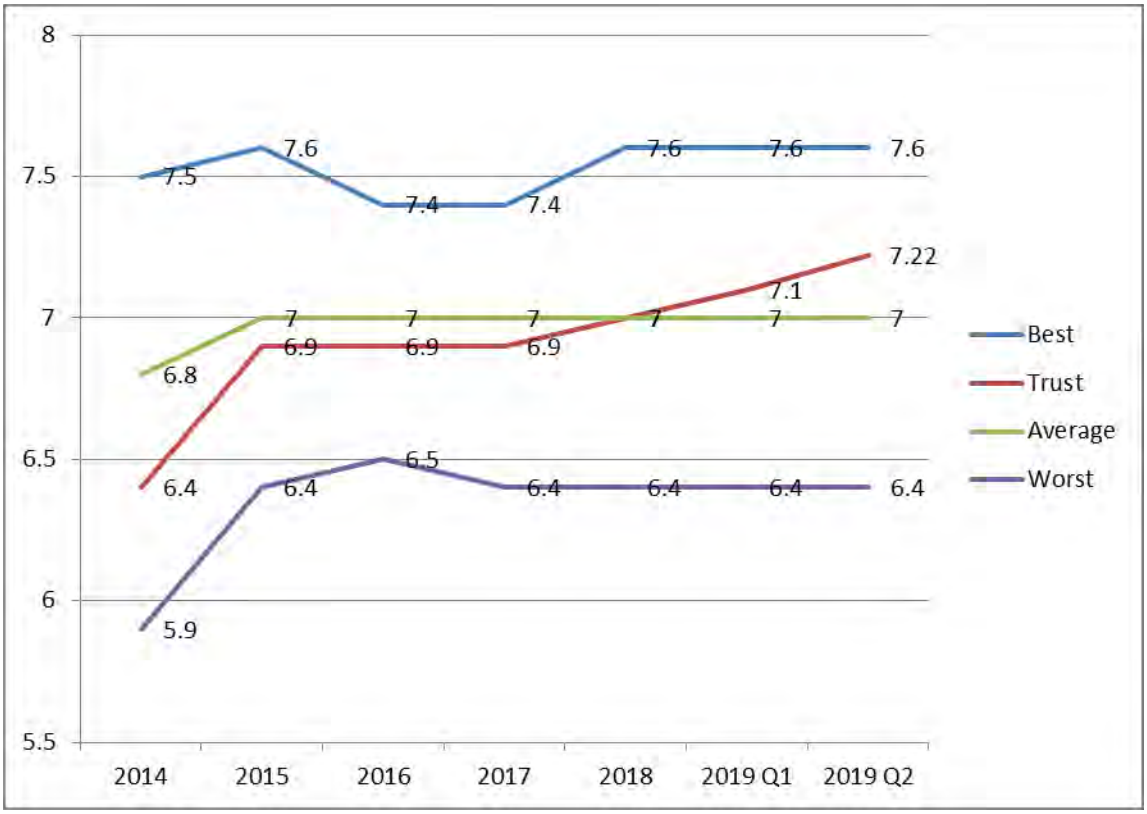
The third quarter test is not undertaken because it coincides with the NHS National Staff Survey.

Hull University Teaching Hospitals NHS Trust Staff FFT for quarter two 2019/20 operated from 27th August until 30th September 2019. 8547 staff were invited to participate, with 662 responding equivalent to a 7.7% response rate.

3 Overall score for engagement

	Question	Positive %	Score (max of 5)	Score (max of 10)
Q1	How likely are you to recommend Hull University Teaching Hospitals NHS Trust to friends and family if they needed care or treatment?	83%	4.13	7.82
Q2	How likely are you to recommend Hull University Teaching Hospitals NHS Trust to friends and family as a place to work?	69%	3.71	6.78
Q3	There are frequent opportunities to show initiative in my role	74%	3.95	7.38
Q4	I am able to make suggestions to improve the work of my team / department	76%	3.99	7.47
Q5	I am able to make improvements happen in my place of work	64%	3.74	6.84
Q6	Care of patients / service users is my organisation's top priority	76%	4.01	7.52
Q7	I look forward to going to work	59%	3.60	6.49
Q8	I am enthusiastic about my job	73%	3.89	7.24
Q9	Time passes quickly when I am at work	73%	3.99	7.47
	Average:	**72%**	**3.89**	**7.22**

The trend scores since 2014 are as follows, where this graph shows our trust average score compared with the national average, best trust in the country and worst trust in the country:



4 Engagement scores ranked by department/staff group

For all areas where 10 or more staff complete a survey the trust receives an overall score for engagement. In Q2 this is ranked as follows, where green is above the trust target score of 7.36 (top 20% of trusts), amber is between national average (7.0) and the target score and red is below the national average. Staff groups are highlighted in light blue.

AREA	RESPONDENTS	ENGAGEMENT SCORE
Chief Nurse	17	8.65
General Management	40	8.53
Family and Women's Management	14	8.44
Nursing Services and Chaplains	12	8.43
MRI Department	16	8.41
HR, OD, Communications, Workforce Planning	19	8.39
Family and Women's Health Management Admin	11	8.36
Family and Women's Health Management Admin - Other	11	8.36
Ward Catering CHH	15	8.34
Finance & Business and Planning	14	8.28
Imaging	23	8.19

Orthopaedics	10	8.17
Workforce and OD	33	8.15
Obstetrics	16	8.09
Trauma	14	7.92
Corporate	140	7.89
Information & Coding	26	7.77
Finance and Business	46	7.68
Clinical Support Management	20	7.65
Emergency Department inc. Paediatrics	25	7.62
Registered Nurses and Midwives	94	7.57
Emergency and Acute Medicine	29	7.55
Womens and Childrens	33	7.54
Elderly Medicine	22	7.51
Allied Health Professionals/ Healthcare Scientists/ Scientific and Technical	125	7.38
IT	19	7.37
Therapies	19	7.34
Family & Women's Health	75	7.34
Hull Royal Infirmary	340	7.29
Medicine	88	7.29
Specialist Services	28	7.28
Nursing or Healthcare Assistants	79	7.25
Castle Hill Hospital	311	7.20
All Respondents	662	7.19
Clinical Support Services	137	7.18
Facilities	66	7.16
Estates, Facilities & Development	88	7.16
Wider Healthcare Team	71	7.03
Care Records Service	13	6.98
Estates Management	14	6.96
Pharmacy	11	6.94
Administrative Staff	220	6.94
Catering Retail HRI	20	6.86
Patient Meal Production	14	6.75
Surgical Specialties	25	6.66
Digestive Diseases	16	6.60
Pathology	24	6.44
Ophthalmology	15	6.38
Theatres	22	6.34
Surgery	88	6.25
Cardiology	16	6.23
Medical and Dental	14	5.88

Blood Sciences	12	5.65
Specialties Division	24	5.25

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.

Organisational culture and creating the right environment for staff to work is a key priority for the Trust and Health Groups / Directorates. Culture is a key performance measure that is discussed at Executive and Health Group and service performance and accountability meetings. The results and rank order of services are also published on Pattie for our people to note and discuss within team meetings.

6 Work programme

The current staff survey work programme falls under eight key areas indicated as follows:

Action	Required Outcome	Lead	Deadline
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	Complete
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	Five completed. Three ongoing. More to commence in 2020/2021.
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	Completed. More to commence in 2020/2021.
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	Completed. WDES action plan in 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	Reviewed and re-launched.
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	Completed.
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	Patient Safety Board established with HIP workstream.
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	Workstreams identified and actions being delivered.

8 Recommendations

The Trust board is requested to note the performance and action being taken and to provide any feedback.

Simon Nearney
Director of Workforce and OD
November 2019

Hull University Teaching Hospitals NHS Trust
Minutes of the Audit Committee
Held on 24 October 2019

Present:	Mrs T Christmas	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Prof M Veysey	Non-Executive Director
In Attendance:	Mr L Bond	Chief Financial Officer
	Mr S Evans	Deputy Director of Finance
	Mr A Hussain	RSM
	Mr R Barnett	RSM
	Mrs A Deagan	RSM
	Mr M Gill	RSM
	Mrs A Baron-Medlam	Compliance Manager (Item 14)
	Mrs V Shaw	Clinical Audit Manager (Item 13)
	Mrs R Thompson	Corporate Affairs Manager

1 Apologies
Apologies were received from Mr P Sethi, Grant Thornton, Mr G Kelly, Grant Thornton, Ms C Ramsay, Director of Corporate Affairs and Mrs K Southgate, Acting Deputy Director of Quality Governance and Assurance

2 Declarations of Interest
There were no declarations made.

3 Minutes of the meeting held 25th July 2019
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
RSM had shared their Audit plan with Mrs Christmas, Mr Gore and Mr Bond. This item to be removed from the Tracker. **RT**

Mr Evans agreed to find out when the Credit Control Policy was due for review. **SE**

Two items were added to the tracker: consultant job planning risk clarity and honorarium payments. These would be reviewed by Ms Ramsay. **CR**

4.2 Workplan
The Workplan was reviewed by the Committee. There were no issues raised.

5 Internal Auditors - RSM
5.1 Internal Audit Report
Mr Hussain presented the report and advised that 3 reports had been completed since the last meeting. The recruitment review was underway and there had been a proposed timing change for the payroll review.

Mr Hussain reported that the temporary staffing review had received a split opinion due to the different processes carried out by different areas

of the Trust, such as ED and Theatres. There were agreed actions in place.

Mr Gill presented the financial management review which had been given negative assurance and advised that a large number of actions had been agreed with Mr Bond. Mr Gill reported that the financial systems and processes had been audited along with the management structure and framework.

The 3 main areas of concern were the Trust's deficit, the CRES position and the underlying financial position. There had been 31 recommendations out of the review and realistic timescales had been set. Mr Bond advised that the cultural and behavioural recommendations would be the most difficult to achieve.

There was a discussion around how discussions at the Performance and Finance Committee are escalated to the Board and that this was timely with the changes to the Board agenda and how reports are received and Committees escalate issues. Mr Gill stated that the executive summaries should highlight major concerns to ensure the difficult issues were discussed.

The Committee discussed circulation of the report and it was agreed that it would be circulated to the Non Executive Directors that had not seen it and that Mr Bond would discuss it further with the Executive Directors.

Mr Hussain presented the Follow Up Report which was still showing 50% of actions not able to be completed and the report had received negative assurance.

Mr Gore stated that the Trust was poor in this area and Mr Barnett suggested calling heads of service to the Audit Committee in the areas of concern. Ms Ramsay had sent an update to the Committee stating that she had made progress with the Pathology actions and would be bringing a paper to the meeting in January 2020 highlighting what had been achieved.

Mr Barnett suggested the Trust working with project management software to ensure the responsible manager completed their actions.

Mrs Christmas agreed to discuss how follow up actions could be managed differently in the future with Mr Bond and Ms Ramsay. **TC/LB/CR**

It was agreed that the finance management review would be formally received by the Board and that it would be received at the Performance and Finance meeting in November 2019.

Mrs Christmas thanked RSM for the comprehensive reports received.

Resolved:
The Committee received and accepted the report.

5.2 Counter Fraud Report
Mrs Deagan presented the report and advised that she was finalising the strategic fraud assessment.

Mrs Deagan advised that November was Fraud Awareness month and that there would be a number of initiatives happening in the Trust. She reported that there had been 10 fraud referrals so far and 2 formal investigations.

Mrs Deagan had been liaising with Ms Lumb regarding the National work around procurement and best practice guides and self-assessment tools were being shared.

There was a discussion around overtime claims and overtime payments were being reviewed to highlight any fraudulent activity.

Mr Gore asked about Cyber Security and expressed his concerns around how email accounts were being hacked and what the Trust was doing to prevent this. Mr Bond advised that there was an IT Audit in place for the New Year.

Mrs Christmas asked about November being the Fraud Awareness month and what would be taking place. Mrs Deagan advised that there would be stands in the hospital restaurants, presentations and screen savers. Mr Gore asked that the specific dates could be sent to him and Mrs Christmas so that if available they could attend. **AD**

Resolved:
The Committee received and accepted the report.

Mrs Shaw and Mrs Baron-Medlam joined the meeting

13 Clinical Audit Report

Mrs Shaw attended the Committee and presented the report that had been written in April 2019. The report highlighted the monitoring of the Audit plan and Mrs Shaw advised that 260 Audits had been completed since the report had been written.

Mrs Shaw spoke of the National Audits and the amount of work involved in them. She advised that she was reviewing previous results to determine themes and trends coming out of the audits.

The NICE guidance audits were now compliant. Mr Gore complimented the team on the amount of work the audits created and the processes in place to ensure compliance.

Mrs Shaw advised that the follow up actions in the report had been chased and the majority of them were now rated green.

There was a discussion around what was driving the audits and Mrs Shaw advised that some were mandatory and others were Junior Doctors carrying out projects as part of their training. Prof Veysey stated that it would be useful to understand which audits mandatory or otherwise and this information to be included in the report.

Mr Gore added that the top 4 risks to the organisation could also be highlighted in the report as part of the executive summary.

Mr Bond asked if the financial implications of introducing new drugs could be flagged earlier to the financial teams and Mrs Shaw suggested liaison with the Chief Pharmacist would be the correct route. **LB**

Resolved:
The Committee received and accepted the report.

14 Update on Quality Accounts Delivery

Mrs Baron-Medlam presented the Quality Improvement Programme ad advised that the Quality Accounts priorities now formed part of the QIP.

She advised that the QIP was monitored through the Operational Quality Committee and the Board Quality Committee.

Mrs Baron-Medlam advised that the priorities were nutrition, medicines optimisation, deteriorating patient, pressure ulcers, acute kidney injury, VTE, mental health, dementia and patient experience.

There were improvements in the milestones for each project compared with last year's figures. Nutrition and VTE were due to records not being updated rather than failing performance targets. She added that the Matron's handbook was being completed well by some teams and poorly by others and this had been escalated to the Deputy Chief Nurse. Prof Veysey advised that the VTE figures were good considering the Trust did not have electronic prescribing.

The Committee discussed the mental health agenda and working more closely with NHS Humber FT. Mrs Christmas reported that she was now the NED Safeguarding lead following Mrs Walker's departure.

Resolved:
The Committee received and accepted the report.

Mrs Shaw and Mrs Baron-Medlam left the meeting

6 External Auditor Report

There was no report to review from the External Auditors.

7 Committee Matters

The Performance and Finance Committee minutes were reviewed and there were no issues raised.

Prof Veysey advised that the Quality Committee was discussing Mental Health support from Humber FT and also the possibility of having a Board to Board to establish a closer working relationship.

Mr Gore stated that the main aim of the Charitable Funds Committee was to ensure the smooth transition of the Trust charitable funds into the WISHH Charity, which would be completed by the end of March.

Resolved:
The Committee received and accepted the minutes.

8 Changes to Accounting Policies, Standing Orders and SFIs

Mrs Thompson presented the report and advised that the paper had been received by the Trust Board in September 2019 and no concerns had been raised.

The appendix highlighted the updated financial scheme of delegation and the changes made to reflect the new OJEU thresholds for EU tenders. The Trust Board had approved these changes and the document had been updated and uploaded to PATTIE and the Trust's website.

Resolved:
The Committee received and accepted the report.

9 Update from Quality and Remuneration Committees on governance and control issues discussed

Mrs Thompson presented the report and advised that both committees had been reviewed and there were no gaps in governance reported. Remuneration had considered a number of issues but there had been no significant control issues.

The Quality Committee had seen improvements to the QIP in that the milestones were more realistic and relevant and there were now senior leads linked to each project. Work was ongoing to embed the WHO checklist and all Never Events were reviewed by the Committee.

Mr Gore asked why the other Committees were not included in the review. Mrs Thompson agreed to clarify at the next meeting. **RT**

Resolved:
The Committee received and accepted the report.

10 Review of Credit Card Expenditure

Mr Evans presented the report which highlighted the credit card usage in the Trust. He advised that there were 6 credit card holders and the majority of the expenditure was in bulk IT purchases. Mr Evans stated that he had no concerns with any of the expenditure.

Resolved:
The Committee received and accepted the report.

11 Review of Losses, Special Payments and Write Offs

Mr Evans presented the report and advised that it covered the first 6 months of the year and that the value was £2200. The majority of the items were patient's lost property including teeth and glasses. The most expensive item was a hearing aide.

Mr Hussain advised that the value was low compared to other Trust's and that he had no concerns with the report. He added the alignment with ensuring patient records were completed appropriately would ensure any false claims were picked up.

Resolved:
The Committee received and accepted the report.

12 Single Source Waivers

Mr Bond presented the report which highlighted single source waivers. Mr Bond stated that the contracts on the report where there was only one supplier who could supply the goods was not an issue, but that it was the contract extensions due to poor planning by the teams that concerned him. Work was ongoing to discuss the management processes with the Health Groups.

Resolved:

The Committee received and accepted the report.

15 Audit Committee Effectiveness Review

Mrs Thompson presented the paper which highlighted a questionnaire sent to Committee members asking them to rate the effectiveness of the Committee. The responses were analysed and it was agreed that the Audit Committee was effective in all areas.

Mr Bond stated that the nature of the Committee was very prescriptive and Governance led so the effectiveness score should be expected.

It was agreed that future reviews would be sent to a representative from RSM and Grant Thornton rather than sending it to each committee attendee.

Resolved:

The Committee received and accepted the report.

16 Any Other Business

There was no other business discussed.

17 Date and time of the next meeting:

Thursday 23 January 2019, 9am – 12pm, The Committee Room, Hull Royal Infirmary

Hull University Teaching Hospitals NHS Trust
Quality Improvement Programme
Prepared for the Trust Board

November 2019

Title:	QIP
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Kate Southgate, Acting Deputy Director of Quality Governance and Assurance

Purpose:	To provide assurance to the Trust Board on the progress being made on the Trustwide QIP.	
BAF Risk:	BAF 3 – Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	• The majority of project indicators continue to display positive performance against their targets however the three projects which rely on Matron's Handbook data, deteriorating Patient, Nutrition and Dementia, are unable to demonstrate accurate achievement due to the low numbers of returns for these audits and deficiencies identified with many of the wards submission, such as blank sections and questions, using an old version of the form and not using e-obs to complete the paper audits and leaving these sections incomplete. • Two projects have shown an overall decrease in performance data this month, Deteriorating Patient and Dementia. As mentioned previously, these projects rely on data from the Matron's Handbook Audits which include very small returns and do not provide optimum compliance data. • QIP28 Patient Experience and QIP10 Pressure Ulcers are both performing well with most milestones on track.	

Recommendation:	It is recommended that the Trust Board receive this report for assurance and determine if further information is required.

2019-20 Quality Improvement Project (QIP) – September 2019 Update	
PROJECT SPONSOR: Beverley Geary, Chief Nurse	**PROJECT LEADERS: Kate Southgate, Acting Deputy Director of Quality Governance**
AIM	
The QIP has been developed to incorporate Care Quality Commission (CQC) "must" and "should" do actions as well as the delivery of the Quality Account priorities. The QIP aims to ensure regulatory compliance as well as improve aspects of key care deliverables within the organisation.	
REGULATORY INFLUENCES	
The CQC requires the organisation to act on all regulatory breaches and corresponding actions to ensure future compliance. The organisation has received some form of inspection from the CQC each year, for the past 5 years. This Quality Improvement Plan (QIP) forms the CQC action plan to deliver regulatory compliance. Each project details where CQC actions are required, as well as other regulatory influences, such as NHS Improvement.	
UPDATES FROM OPERATIONAL QUALITY COMMITTEE	
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month	
DIAGNOSTICS / PERFORMANCE	
• The majority of project indicators continue to display positive performance against their targets however the three projects which rely on Matron's Handbook data, deteriorating Patient, Nutrition and Dementia, are unable to demonstrate accurate achievement due to the low numbers of returns for these audits and deficiencies identified with many of the wards submission, such as blank sections and questions, using an old version of the form and not using e-obs to complete the paper audits and leaving these sections incomplete. • Two projects have shown an overall decrease in performance data this month, Deteriorating Patient and Dementia. As mentioned previously, these projects rely on data from the Matron's Handbook Audits which include very small returns and do not provide optimum compliance data. • QIP28 Patient Experience and QIP10 Pressure Ulcers are both performing well with most milestones on track.	
KEY UPDATES – September 2019:	**KEY ACTIONS – October 2019:**
• QIP47 – Acute Kidney Injury (AKI) has now been closed and will be continued as business as usual • Clinic start times audit report was presented and found that over 70% of clinics started on time or early. This will continue to be re-audited and monitored through QIP39 • Three milestones have been included in QIP28 • There has been a significant number of actions that have taken place by the DME Nutrition Task and Finish group led by the Assistant Chief Nurse (Special Projects) which are detailed in the Nutrition project update • The Recognise and Respond Fundamental Standard has now been launched and Compliance Team will discuss with the project lead to review whether any additional performance targets can be included using this audit	• A number of projects require a robust review of milestones to ensure they are up to date, including Medicines Optimisation, Pressure Ulcers and Mental Health • The Trust must make a commitment to increase participation in the Matron's Handbook Audits and ensure that all areas are completing them fully and accurately as per agreed process • Commence the next clinic waiting times audit • Review all reports sent to the Patient Engagement and Experience Committee to ensure they meet the requirements set out by the project milestones • Dementia bundle to be finalised • Work towards new dementia training launch • review actions associated with dietician risks and fasting audit results and agree next steps
RISKS	
The Quality Improvement Plan (QIP) is linked to the Board Assurance Framework (BAF) risk 3: BAF 3: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years. Lack of progress against the Quality Improvement Plan (QIP) could prevent the Trust from achieving this goal.	

The following projects pose a potential risk to the overall achievement of the plan:

- Deteriorating Patient: NEWS data has not shown a significant increase in compliance since the beginning of the project and not enough trustwide data returned to demonstrate progress – also linked to CQC actions
- Nutrition: not enough trustwide data returned to demonstrate progress – also linked to CQC actions
- Dementia: some delays identified to the milestones linked to CQC actions including re-launch of updated dementia bundle and launch of new dementia training
- Mental Health: Significant delays to the completion of a number of milestones and the development of performance indicators to provide data to support achievement of aim. Some milestones are linked to CQC actions

Report author: Annabelle Baron-Medlam, Compliance Manager

QIP05 Medicine Optimisation

PROJECT SPONSOR: David Corral, Chief Pharmacist	PROJECT LEADERS: Simon Gaines, Clinical Governance Pharmacist
PROBLEM	**AIM**
Medication provision at the point of discharge is not optimal.	The aim of this project is to improve key aspects of the medicine management discharge process. Three focused projects will be completed to achieve this – increased referrals to the Transfer of Care Around Medicines Scheme will improve the process Trust wide. Two focused pilot projects will be completed to improve turnaround times of dispensing discharge prescriptions for the patient lounge and improved timeliness of IDS from Boots to Queens Centre. The intention would be to use the pilot to then launch trust wide in the 2020-21 programme

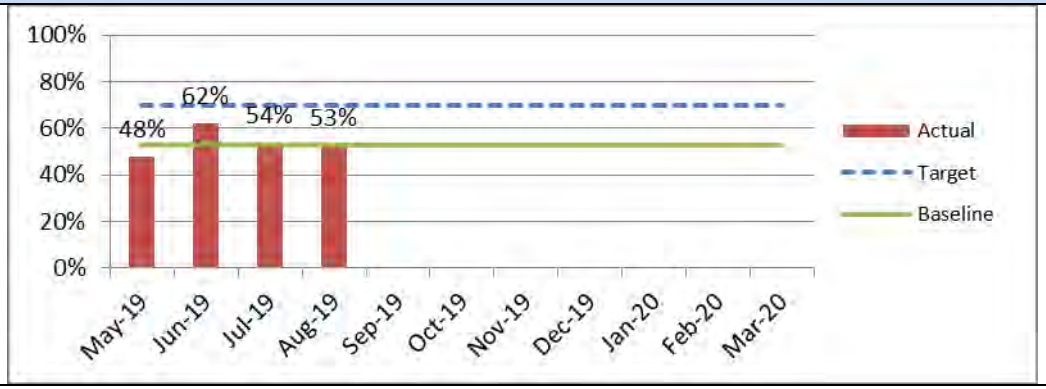
REGULATORY INFLUENCES

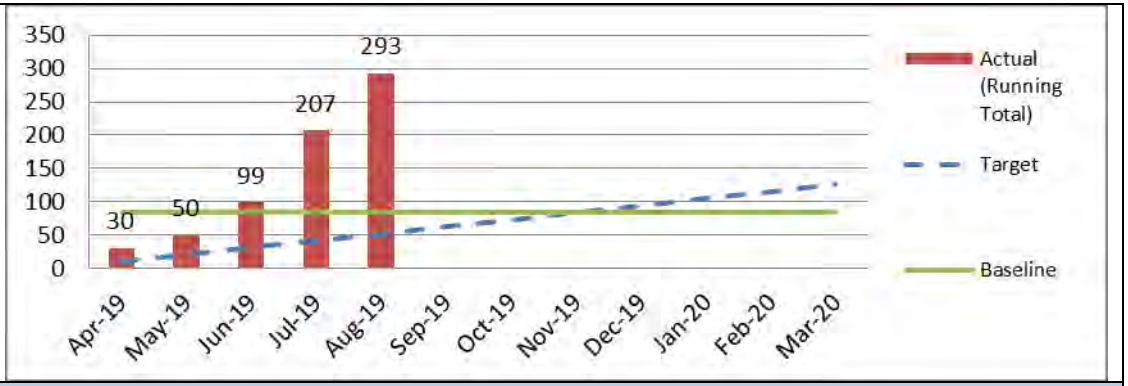
CQC Inspection 2018 – *The trust must ensure that registered nurses follow the correct steps when administering medicines in line with their nurse policy and NMC regulations and sign medication charts after it has been given to patients.*
CQC Inspection 2016 – *The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.*
CQC Inspection 2016 – *The trust must ensure that records of the management of controlled drugs are accurately maintained and audited within A & E.*
CQC Inspection 2015 – *The Trust should record and monitor daily temperatures of fridges used for storage of medicines within A & E*
CQC Inspection 2015 – *Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.*
Linked to regulation breach – Regulation 12 Safe Care and Treatment. **These have been addressed and closed by the Trust as sufficient actions have been put in place however the Trust has not yet been re-assessed as compliant by the CQC.**

UPDATES FROM OPERATIONAL QUALITY COMMITTEE

October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month

DIAGNOSTICS / PERFORMANCE

Indicator	Baseline	Target	Performance
% of discharge prescriptions dispensed within an hour for patient lounge by March 2020	53%	70%	

50% increase in referrals to “Transfer of Care Around Medicines Scheme” by March 2020	84	>126	

KEY UPDATES – September 2019:	KEY ACTIONS – October 2019:
• Indicator data continues to be positive, with data for August meeting the baseline for % of discharge prescriptions dispensed within the hour however not yet meeting the target. An action plan based on 6 months of data is planned for October which will highlight any areas of action • The indicator for 50% increase in referrals to “Transfer of Care Around Medicines Scheme” has been far exceeded with a total of 293 made since April 2019	• Update all milestones

RISKS

Linked risk on the Risk Register: 3028 Risk to patient safety involving discharge medicines:
“There is a risk to patient safety and experience from issues with discharge medicines. This is caused by a number of different issues involving medical, nursing & pharmacy staff and discharge processes. The consequences include incorrect prescribing and supply of medication, delays, and patients not understanding how to use their medicines or what they are for. This has led to complaints.” Currently rated moderate 12

QIP06 Deteriorating Patient

PROJECT SPONSOR: Beverley Geary, Chief Nurse	PROJECT LEADER(S): Jo Ledger, Deputy Chief Nurse
PROBLEM	**AIM**
Patients are not always escalated in line with Trust Policy	To ensure all patients with an elevated NEWs to be escalated in line with Trust Policy (which incorporates NEWS2)

REGULATORY INFLUENCES

CQC Inspection 2018 – *The Trust must ensure that patients are escalated for medical reviews in line with the trust policy when the trigger is altered when using the National Early Warning Scores (NEWS).*

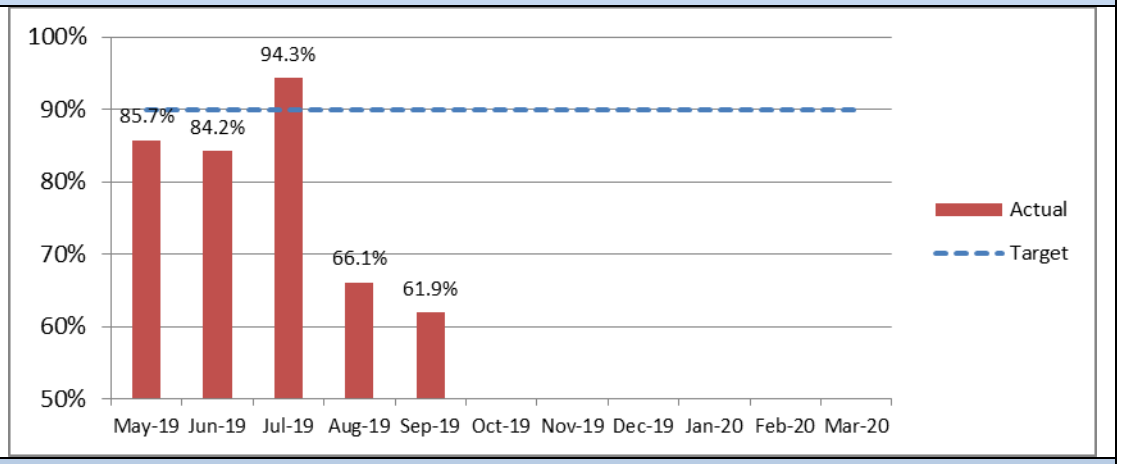
CQC Inspection 2016 – *The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Maternity and obstetrics early warning score (MOEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.*

Linked to regulation breach – Regulation 12 Safe Care and Treatment

UPDATES FROM OPERATIONAL QUALITY COMMITTEE

October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month

DIAGNOSTICS / PERFORMANCE

Indicator	Baseline	Target	Performance
Percentage of patients that have a NEWS Score above 1 have evaluation, states actions taken or escalation documented (Health Groups Deteriorating Patient Dashboards data collected via Matrons Handbook monthly)	Baseline to be established for 2019-20	90%	

KEY UPDATES – September 2019:	KEY ACTIONS – October 2019:
• A new Fundamental Standard Inspection audit has been developed and implemented. 21 wards have so far been audited. Agreement from lead to be obtained to include relevant audit data into this QIP. • Performance requires improvement, both August and September have not met the agreed target of 90%, however it should be noted that the numbers these percentages are taken from are small, due to the poor returns of	• Ensure all wards are completing the Matron's Handbooks as required • As reported in previous reports, a number of wards use e-obs which has prevented data being inputted into the monthly matron's handbook. All matrons have been advised to review how they can still complete the handbooks using the data stored on Nerve centre.

handbooks. September percentage is based on 13 out of 21 patient's evaluation having the appropriate escalation and 41 out of 62 in August.

- Returns for the Matrons Handbook audits continue to be poor, which have a significant impact on the quality and accuracy of the data used for the indicator for this project. At the date of writing this report (2/10/19) 20 wards submitted returns for August 2019, four of these used the old form which does not include the relevant data for QIP performance and six of these could not be included in the number due to using e-obs. Lead has confirmed that all areas should now be using the correct form and the audits should still be completed using e-obs and transferring the documentation onto the paper audit form. At the date of writing this report only 5 wards had submitted returns for September, one of which could not be counted as the old form had been used

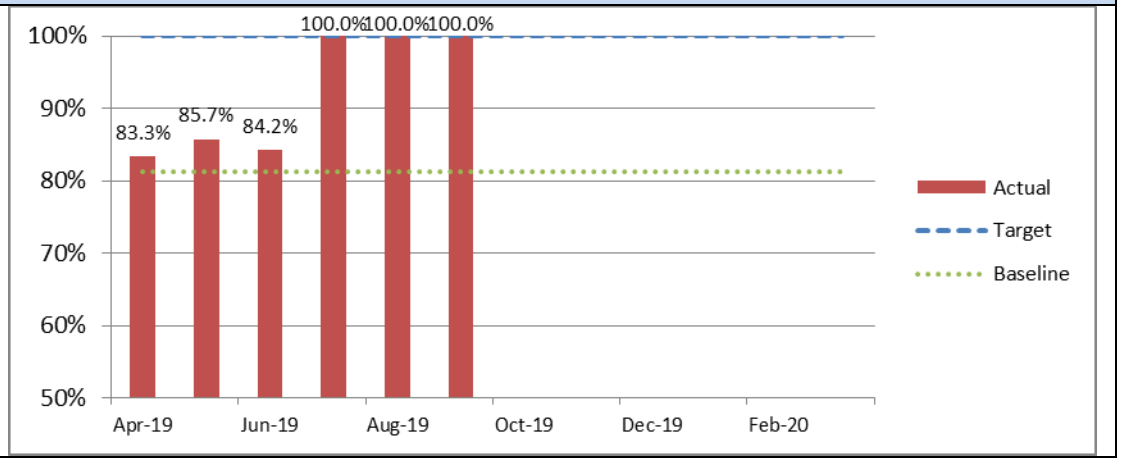
Matron's Handbook Performance

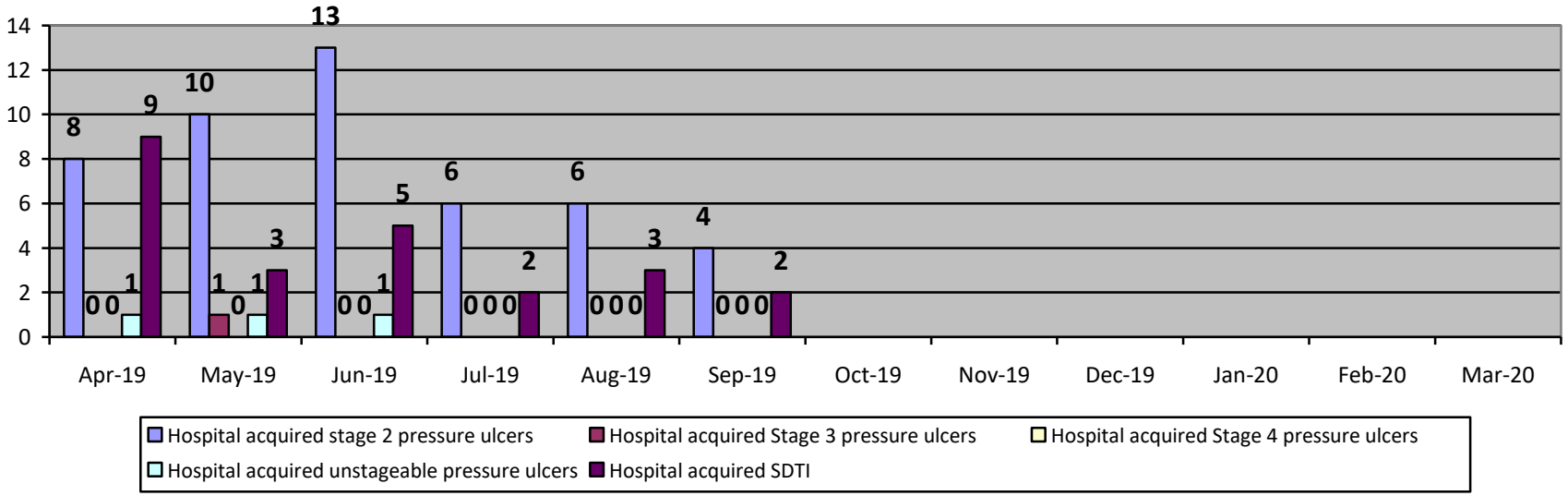
Health Group	*Total wards*	**July 2019**			**August 2019**			**September 2019**		
		Number Submitted	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*
Clinical Support	6	6	***1 – e-obs***	**83%**	6	***6 – e-obs***	**0%**	1	0	**17%**
Family and Women's	10	2	***2 – old form***	**0%**	0	0	**0%**	0	0	**0%**
Medicine	14	7	***1 – old form***	**43%**	6	***2 – old form***	**29%**	3	***1 – old form***	**14%**
Surgery	16	10	***2 –1x e-obs and 1x old form***	**50%**	8	***2 – old form***	**38%**	1	0	**6%**
Emergency Medicine *(NB Majors, Paeds and Initial Care areas use a different proforma)*	2	1	***1 – incomplete form***	**50%**	0	0	**0%**	0	0	**0%**

RISKS

There are no risks on the Corporate Risk register in relation to this project however there are risks that should be noted. The project is now over one quarter into the project term with a minimal number of milestones in place to assist in the completion of the aim. Completion of the Matrons Handbook continues to be a potential risk due to the low numbers of returns, including a number of wards using e-obs with no agreed process for obtaining the data. Accurate reporting of data is essential as the overall Trust wide picture of compliance cannot be reviewed for potential areas of improvement

QIP10 Pressure Ulcers	
PROJECT SPONSOR: Karen Harrison, Tissue Viability Nurse	**PROJECT LEADERS: Jo Ledger, Deputy Chief Nurse**
PROBLEM	**AIM**
Patients at risk of developing hospital acquired pressure ulcers and moisture associated skin damage	To be open and transparent skin damage reporters, improving safety and patient experience through robust assessment, care planning and evaluation by sharing best practice from areas with low reported incidents and to improve understanding of key themes and trends from all reported incidents.
REGULATORY INFLUENCES	
Implementation of the NHS Improvement - Pressure Ulcers Revised Definition and Measurement.	
UPDATES FROM OPERATIONAL QUALITY COMMITTEE	
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month	
DIAGNOSTICS / PERFORMANCE	

Indicator	Baseline	Target	Performance
Completion of RCA in 14 days	81.3%	100%	



KEY UPDATES – September 2019:	KEY ACTIONS – October 2019:
Lead has continued to progress all open milestones. Performance data continues to be positive without any remedial actions required to address the indicators performance.	Update all milestones and review against aim

RISKS

There are no risks on the Corporate Risk register in relation to this project and no potential risks with the delivery of this project at this point

QIP22 Nutrition and Hydration	
PROJECT SPONSOR: Beverley Geary, Chief Nurse	**PROJECT LEADERS: Jo Ledger, Deputy Chief Nurse**
PROBLEM	**AIM**
Patients are at risk of not being assessed correctly in relation to nutrition and hydration.	To ensure patient's nutrition and hydration needs are risk assessed in accordance with Trust Policy (CP335) To ensure patients are weighed in accordance with Trust Policy (CP335) To ensure that patients are fasted pre-operatively in accordance with policy

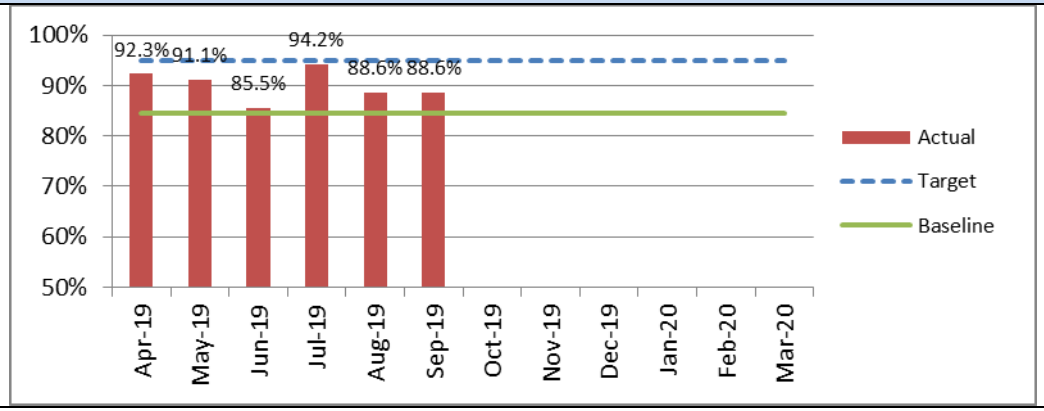
REGULATORY INFLUENCES

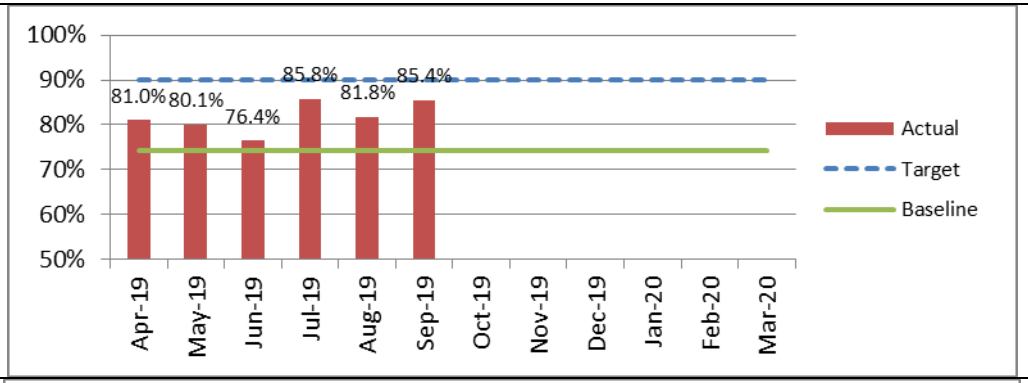
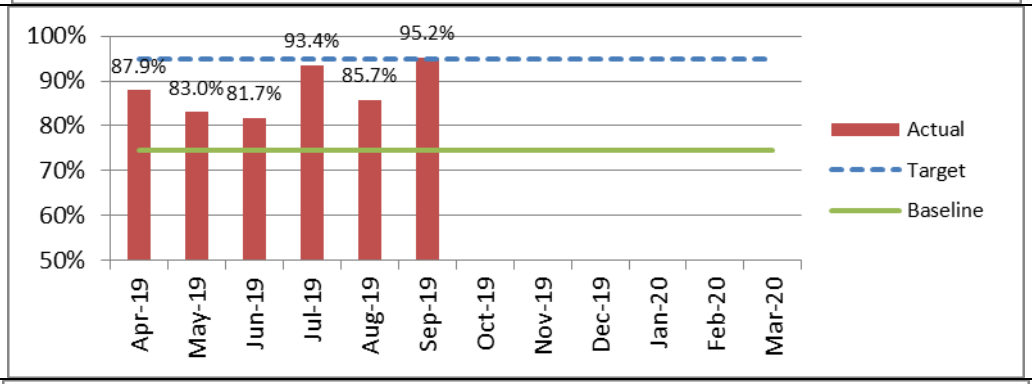
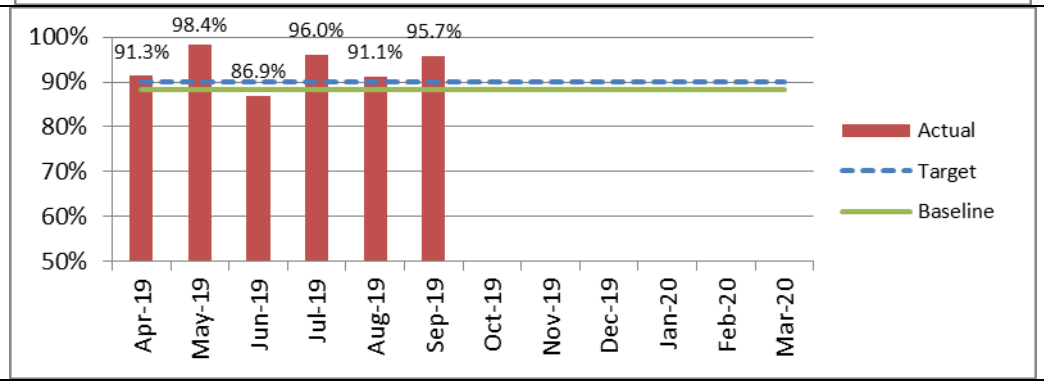
CQC Inspection 2018 – *The Trust must ensure that patients are fasted pre-operatively in line with best practice recommendations*
The Trust must ensure that patient risk assessments are completed to determine if patients are at risk of malnutrition
The Trust should ensure that all patients have weights record in their record
Linked to regulation breach – Regulation 12 Safe Care and Treatment
CQC Inspection 2016 – *The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.*
CQC Inspection 2015 – *Ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients (***This has been addressed and closed by the Trust as sufficient actions have been put in place however the Trust has not yet been re-assessed as compliant by the CQC)**
Linked to regulation breach – 14 Meeting nutritional and hydration needs.

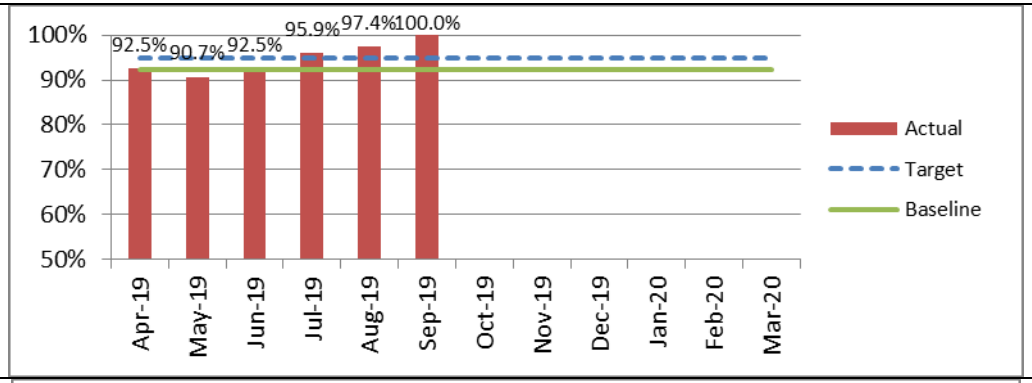
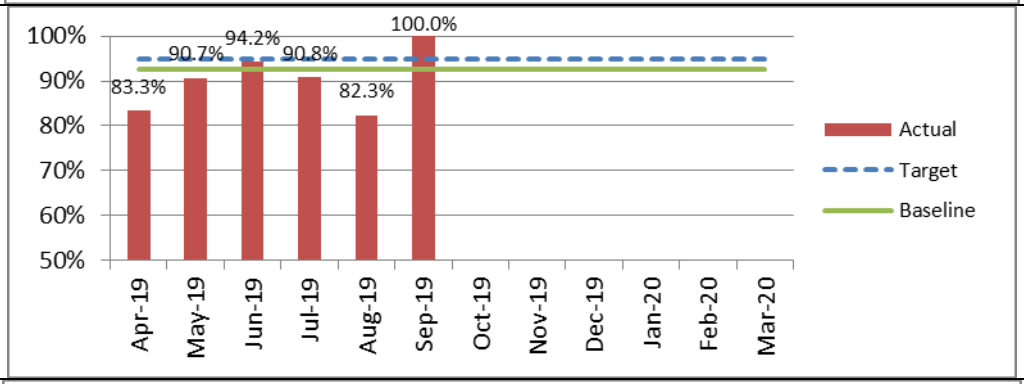
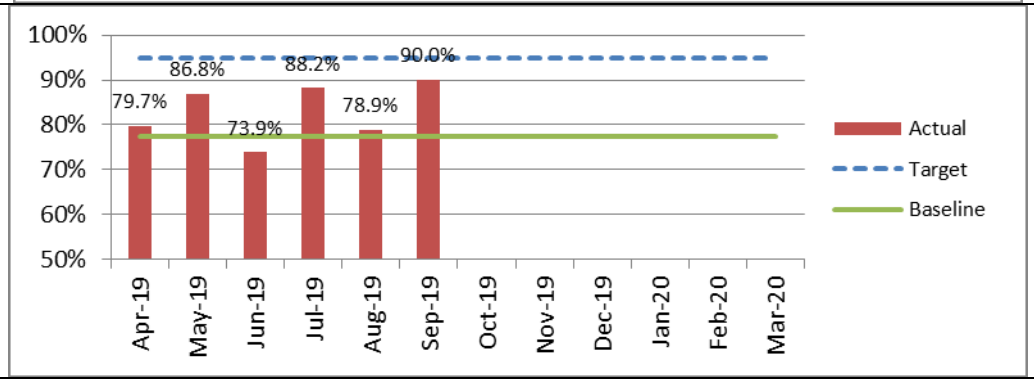
UPDATES FROM OPERATIONAL QUALITY COMMITTEE

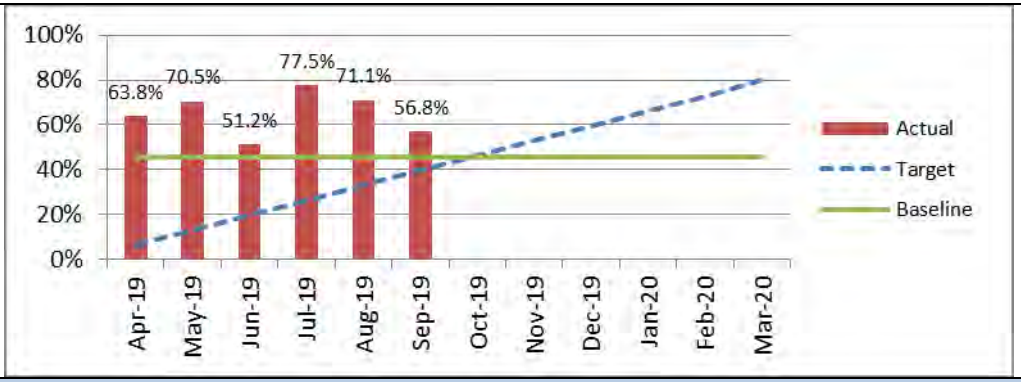
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month

DIAGNOSTICS / PERFORMANCE

Indicator	Baseline	Target	Performance
Percentage of patients weighed within 24hrs of admission	84.5%	95%	

Percentage of patients weighed every 72hrs	74.3%	90%	
Percentage of weighs plotted on weight graph	74.4%	95%	
Percentage of weight recorded on Drug Chart	88.3%	90%	

Percentage of daily Nutrition Risk Assessments	92.4%	95%	
Percentage of appropriate referral to Dietician	92.6%	95%	
Percentage of care plan states “low, Medium or High Risk”	77.4%	95%	

Percentage of hydration charts completed	45.8%	80% by year end	

KEY UPDATES – September 2019:	KEY ACTIONS – October 2019:
A number of actions have been taken over the last year to improve the nutritional care of patients on the elderly care wards, as part of the Task and Finish Group which is a milestone of this QIP. These include; Introduction of a cooked breakfast, Implementation of a 'cake & shake' round, Moved the main meal to the lunch-time service, Offered soup in addition to the buffet tea service, Made finger foods available where appropriate, for patients with dementia and Improved working relationships between nursing, dietetics and catering staff. The task and finish group, chaired by the Assistant Chief Nurse (Special Projects), is overseeing additional actions to drive further improvements in care. This group involves dieticians, nursing staff and catering teams working in collaboration on a number of initiatives, including; Ensuring all wards have access to relevant equipment including freezers and microwaves, Ordering redesigned white boards for the kitchen to improve communication around high risk patients, Raising awareness of the needs of dementia patients, Pilot of coloured plates and Exploring suitable alternative snacks. The nursing teams across the elderly care wards continue to work towards improving standards and this has been reflected in improved scores on 2 wards as assessed by the Fundamental Standards audit process. **Performance:** • In general, performance against the indicators using data from the Matron's Handbook is positive; however returns for the Matrons Handbook audits continue to be poor, which have a significant impact on the quality and accuracy of the data used for the indicator for this project. • Of the 20 audits returned in August, six had blank section for the hydration chart performance and two used the old form which cannot be counted in	• Lead to review actions associated with dietician risks and fasting audit results and agree next steps • Continue work against the incidents and complaints review • Ensure all wards are completing the Matron's Handbooks as required • As reported in previous reports, a number of wards use e-obs which has prevented data being inputted into the monthly matron's handbook. All matrons have been advised to review how they can still complete the handbooks using the data stored on Nerve centre.

the audit results as this section is not included. Again, a high number of blanks were submitted in July for this performance which cannot provide an accurate % of compliance	

Matron's Handbook Performance

Health Group	Total wards	July 2019			August 2019			September 2019		
		Number Submitted	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*
Clinical Support	6	6	0	**100%**	6	0 *However significant number of blank sections*	**100%**	1	0	**17%**
Family and Women's	10	2	0 *However significant number of blank sections*	**20%**	0	0	**0%**	0	0	**0%**
Medicine	14	7	0	**50%**	5	0 *However significant number of blank sections*	**36%**	3	**0** *However one ward not counted against the hydration indicator*	**21%**
Surgery	16	11	0 *However some questions not completed due to e-obs*	**69%**	8	**0** **High number of wards not counted against the hydration indicator**	**50%**	1	0	**6%**
Emergency Medicine *(NB Majors, Paeds and Initial Care areas use a different proforma)*	2	1	0	**50%**	1	0	**50%**	0	0	**0%**

RISKS

The project is now one quarter into the project term with delays in the achievement of a number of key milestones, detailed in the key actions section, which may impact on the achievement of the aim. Completion of the Matrons Handbook continues to be a potential risk due to the low numbers of returns

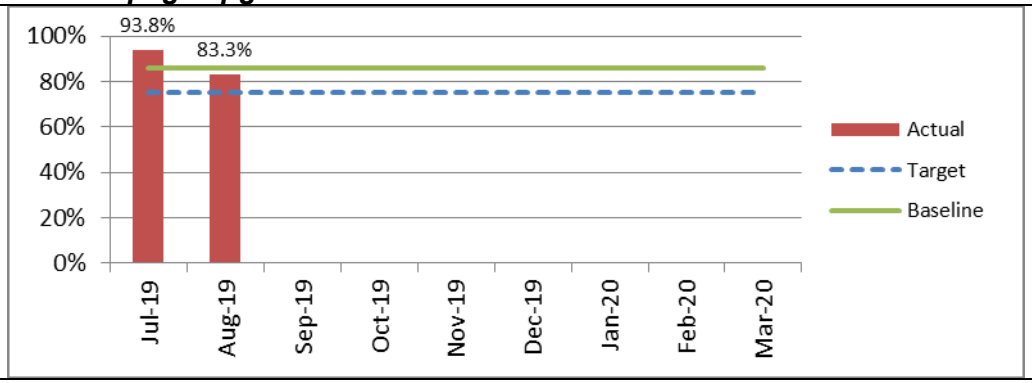
Linked risk on the Risk Register: 2817 - Inability To Access Dietetic Reviews For Paediatric Patients:

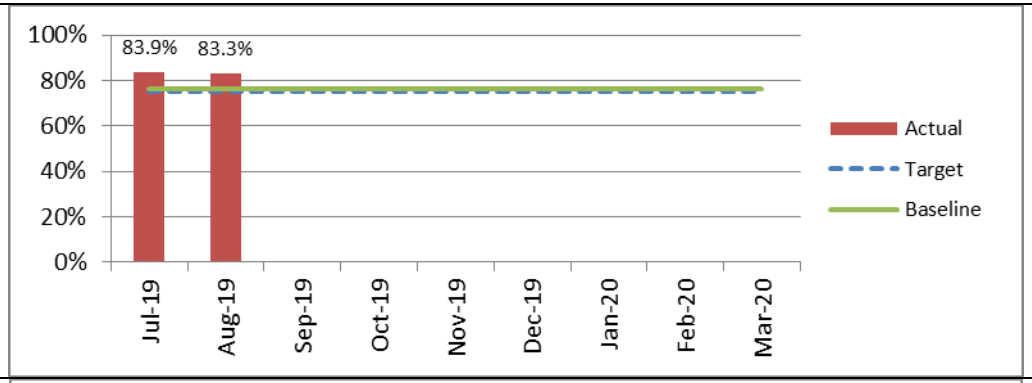
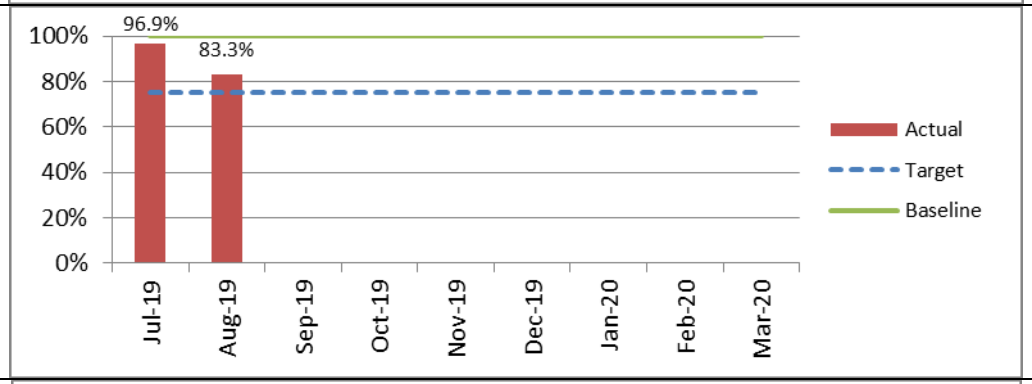
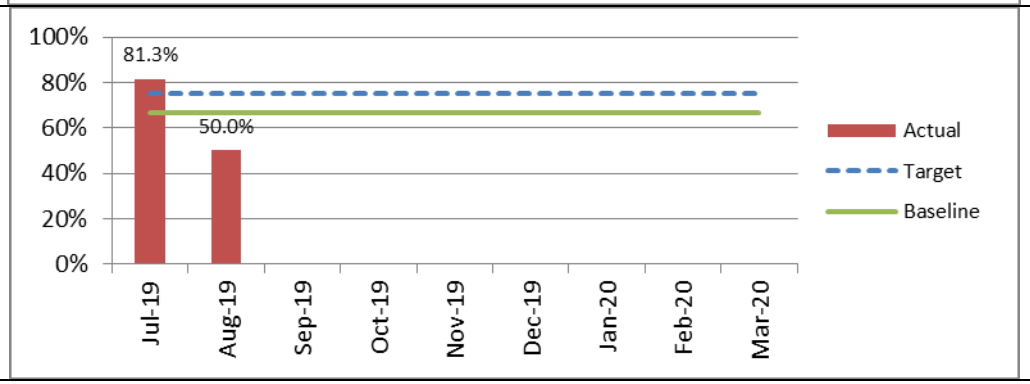
"Paediatrics do not have the appropriate dietetic capacity, reduced due to Maternity leave and vacancies, therefore children do not receive a timely dietetic review. The consequence is lack of ability to review inpatients for nutritional support. Potential to not meet service standards for specialist outpatient services; paediatric diabetes, paediatric gastroenterology, paediatric neuro disability"

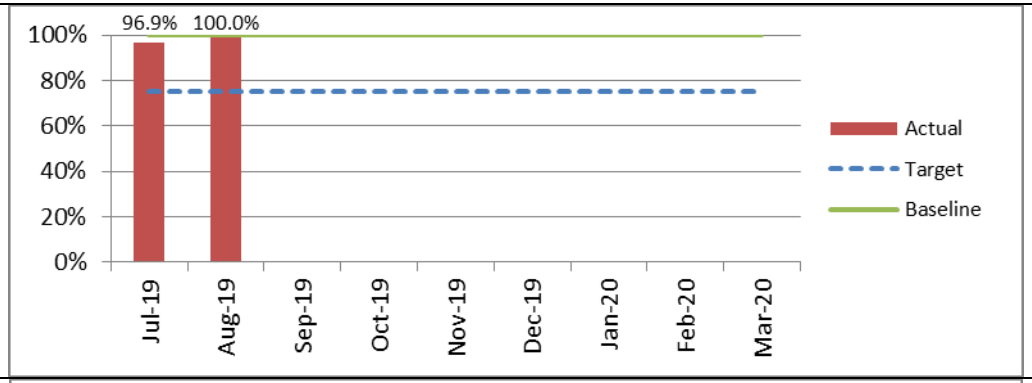
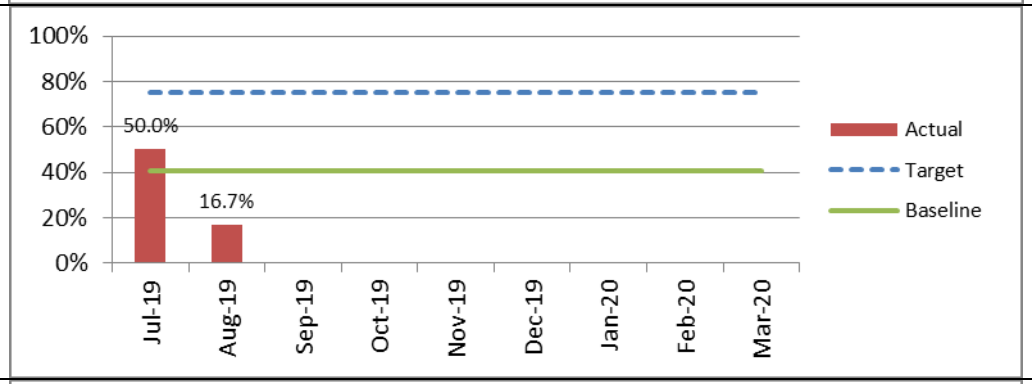
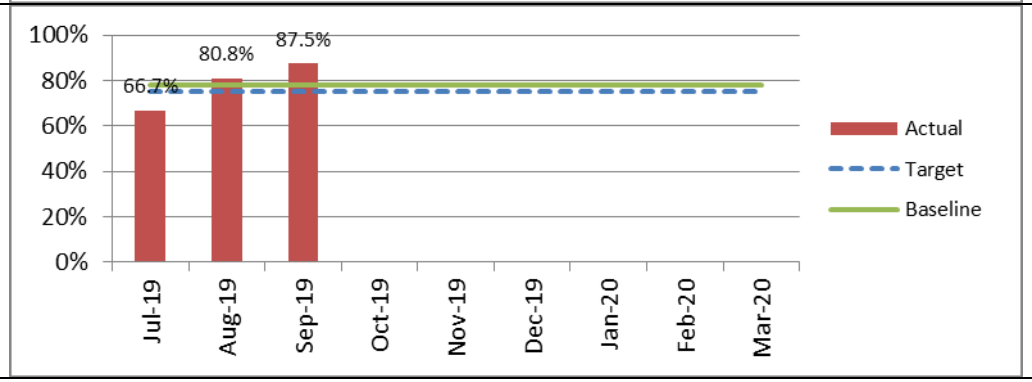
Linked risk on the Risk Register: 3101 - Inability to deliver dietetic care to all high risk inpatients referred to the dietetic service:

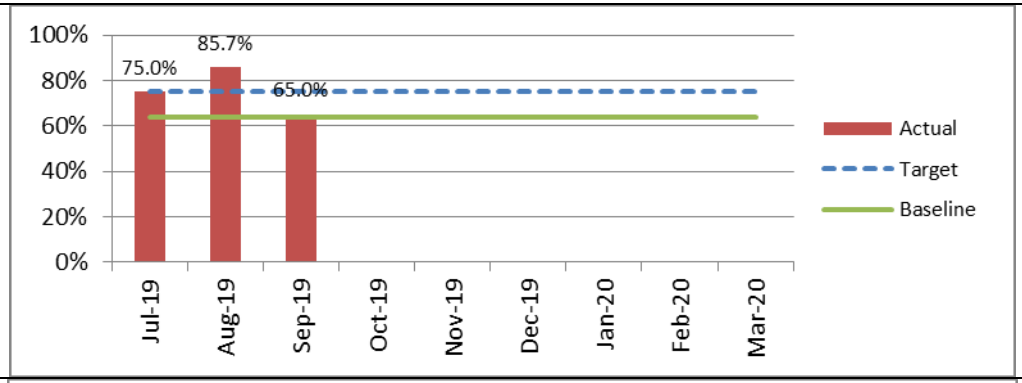
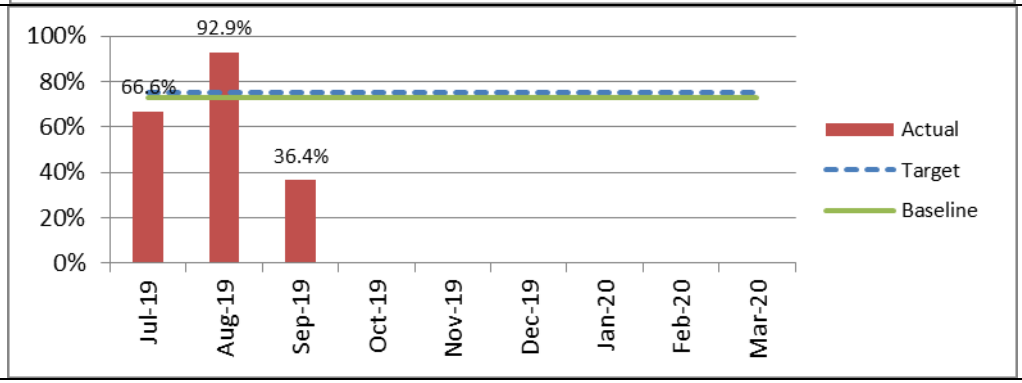
"There is currently an inability to deliver dietetic care to all high risk inpatients referred to the dietetic service caused by an increased demand and inadequate staffing levels. The consequences of the risk are a reduction in 24 hour response to accepted referrals and a possible increased length of stay, re-admission and cancelled clinics. In addition, increased pressure on staff and potential increased errors."

QIP23 – Dementia	
PROJECT SPONSOR: Dr Purva, Chief Medical Officer	**PROJECT LEADERS: Dr Yoghini Nagandran, DME Consultant and Kay Brighton, Dementia Nurse**
PROBLEM	**AIM**
Staff in relevant wards may not be fully trained in dementia and the associated documentation which means that compliance with dementia documentation is inadequate and could result in the wrong care being delivered.	The aim of this project is to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and dementia documentation is consistently completed to the appropriate level.
REGULATORY INFLUENCES	
CQC Inspection 2018 - *The trust should continue to develop and embed the documentation in relation to dementia care.*	
UPDATES FROM OPERATIONAL QUALITY COMMITTEE	
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month	

DIAGNOSTICS / PERFORMANCE			
Indicator	**Baseline**	**Target**	**Performance**
The Committee is asked to note that the indicators for this QIP have been amended slightly this month. This is because the Dementia section within the Matrons Handbooks audits is now being completed monthly and will therefore provide a Trust wide compliance figure for the previously reported indicators that were based on elderly wards. These indicators have now been greyed out however compliance data for these is still included on the indicator pages pg. 25			
Dementia / delirium screening pathway completed in the medical document	85.7% (June 2019 data)	75%	

Online dementia/delirium screening tool completed	76.2% (June 2019 data)	75%	
Diagnosis documented in the medical notes	100% (June 2019 data)	75%	
Butterfly displayed at the bedside	66.7% (June 2019 data)	75%	

Butterfly icon in place on cayder	100% (June 2019 data)	75%	
Reach Out To Me document at the bedside	40.9% (June 2019 data)	75%	
Two members of staff able to articulate the meaning of “Johns Campaign & Butterfly Scheme	77.8% (June 2019 data)	75%	

Clinical area displaying poster re: Johns Campaign	75% (June 2019 data)	75%	
Clinical area displaying poster re: Butterfly Scheme	66.7% (June 2019 data)	75%	
30% of Trust Tier 1 staff have completed the relevant dementia training	No baseline	30%	Data collected from November 2019
30% of Trust Tier 2 staff have completed the relevant dementia training	No baseline	30%	
30% of Trust Tier 3 staff have completed the relevant dementia training	No baseline	30%	
% compliance with dementia/delirium screening assessments undertaken	90.4%	90%	Superseded by 1st and 2nd indicators
% compliance on H8, H9, H90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol and the Reach Form	73%	75%	Superseded by 3rd to 6th indicators
% staff awareness of John's campaign	100%	75%	Superseded by 7th and 8th indicators
% relative/carer awareness of Johns campaign	88%	75%	No longer measured

KEY UPDATES – September 2019:	**KEY ACTIONS – October 2019:**
• Lead has confirmed that further work is required before the dementia care bundle can be re-launched, lead is working with the Practise Development Matron to ensure the bundle can be used electronically • Pilot of the non-verbal pain score has commenced H90	• Ensure all wards are completing the Matron's Handbooks as required • As reported in previous reports, a number of wards use e-obs which has prevented data being inputted into the monthly matron's handbook. All matrons have been advised to review how they can still complete the handbooks using the data stored

- Finger food is available for dementia patients, and a Dementia PILs has been made available on Pattie which was an action from the Dementia Action Plan
- In general, performance against the indicators using data from the Matron's Handbook is positive, however returns are poor. A number of wards have continued to use the old form which does not contain a dementia section. As reported last month, a number of wards are also continuing to complete the forms incorrectly, and failing to answer all questions within the dementia form such as the staff knowledge and display questions when there are no dementia or delirium patients on the ward at that time.

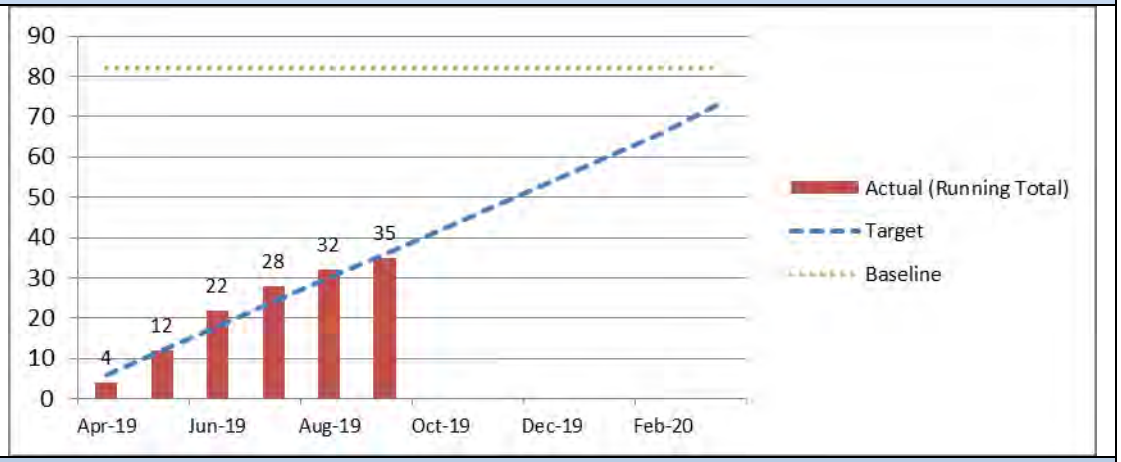
on Nerve centre.
- Finalise dementia bundle
- Work towards final approval of training launch

Matron's Handbook Performance

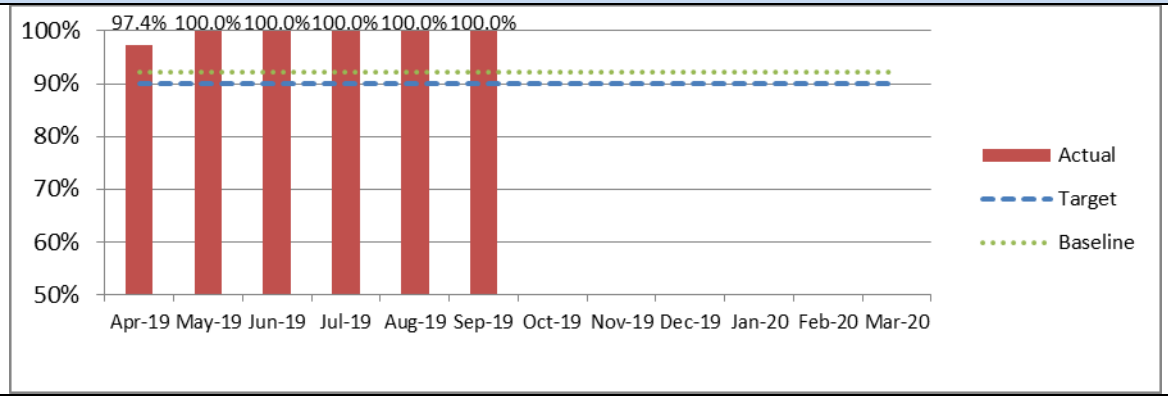
Health Group	Total wards	July 2019			August 2019			September 2019		
		Number Submitted	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*	*Number Submitted*	*Number that could not be counted*	*% counted in the audit data*
Clinical Support	6	6	0 *Some gaps*	**100%**	6	**0**	**100%**	1	0 *Some gaps*	**17%**
Family and Women's	2	0	*0*	**0%**	0	0	**0%**	0	0	**0%**
Medicine	14	7	**1 – old form** *Some gaps*	**43%**	5	**2 – old forms** *Some gaps*	**21%**	3	**1 – old form**	**14%**
Surgery	16	11	**2 – 1x old forms and 1x blank section** *High number of gaps*	**56%**	8	**3 – 2x old forms and 1x blank section** *Some gaps*	**31%**	1	0	**6%**
Emergency Medicine *(NB Majors, Paeds and Initial Care areas use a different proforma)*	2	1	0	**50%**	1	0	**50%**	0	0	**0%**

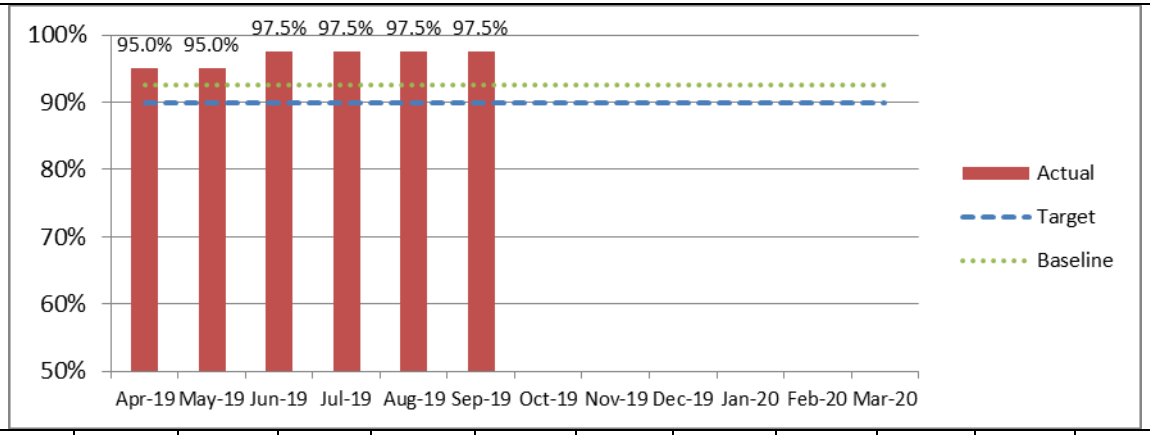
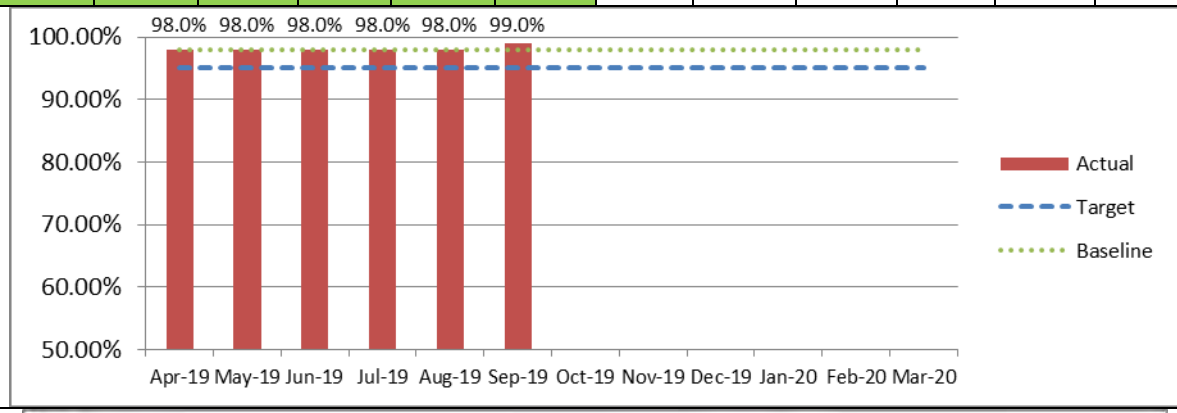
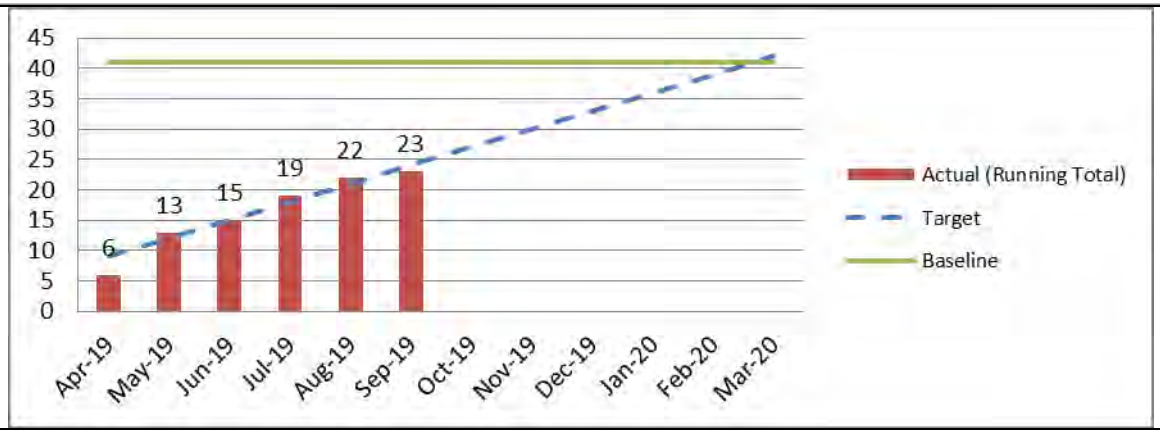
RISKS

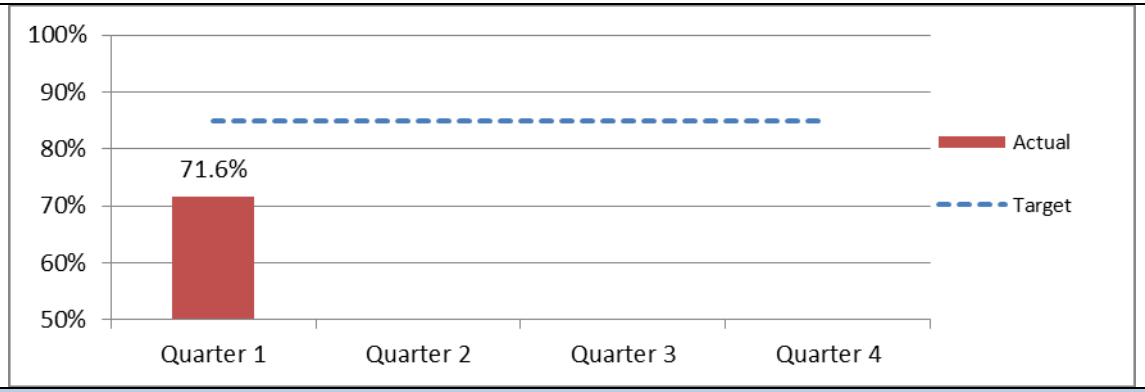
There are no risks on the Corporate Risk register in relation to this project and no potential risks with the delivery of this project at this point, however completion of the Matron's Handbook is a concern as without accurate reporting on dementia documentation the trust will not be able to demonstrate achievement of the aim and could impact on the completion of the CQC actions related to this QIP. A number of milestones are linked to CQC compliance actions and will continue to be closely monitored.

QIP28 – Patient Experience			
PROJECT SPONSOR: Beverley Geary, Chief Nurse			**PROJECT LEADERS: Louise Beedle, Head of Patient Experience**
PROBLEM			**AIM**
Improvements are required on the number of re-opened complaints due to dissatisfaction			Reduce the number of re-opened complaints due to dissatisfaction and facilitate a process to address all recommendations from the NHS Patient Survey 2018 and Mersey Internal Audit Agency Complaints Management Review
REGULATORY INFLUENCES			
CQC Inspection 2015 – *Ensure that there is an effective and timely system in place, which operates to respond to, and act on, complaints.* Linked to regulation breach – Regulation 16 Receiving and acting on complaints. **This has been addressed and closed by the Trust as sufficient actions have been put in place and assurance was received from the February 2018 CQC inspection "People using services felt they could raise concerns and complaints and they would be listened to."**			
UPDATES FROM OPERATIONAL QUALITY COMMITTEE			
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month			
DIAGNOSTICS / PERFORMANCE			
Indicator	**Baseline**	**Target**	**Performance**
Reduce the number of reopened complaints due to dissatisfaction	82	Reduce by 10% of baseline by year end – 73.8	
KEY UPDATES – September 2019:			**KEY ACTIONS – October 2019:**
• Performance data remains positive, it is likely that followed the current trajectory a 10% decrease on last year's baseline of 82 will be achieved. • An action plan has been developed in response to the NHS Inpatient Survey from 2018 as part of the established working group and is being taken forward by the representatives from each health group • Three new milestones have been added this month, the first relates to the updating of the Complaint policy which is on-going. The second relates to			• Lead to provide update against NHS Patient Survey action plan at PEEC • Lead to revise reporting requirements to include those as part of the recommendations from the internal audit action plan • SOP for the SALs process to be in draft and/or completed • Completion of look back exercise against improvement activity in 2018/19 between lead and Compliance Team

the full review of the SALs process. A SOP will be produced to support the implementation of a new module on datix. The third milestone relates to the establishment of a patient experience and engagement committee from the previously established Patient Experience Forum. This is now a formal committee with the Assistant Chief Nurse as Chair and a revised ToR.	
RISKS	
There are no risks on the Corporate Risk register in relation to this project and no potential risks with the delivery of this project at this point	

QIP39 – Outpatient Services			
PROJECT SPONSOR: Beverley Geary, Chief Nurse and Dr Purva, Chief Medical Officer			**PROJECT LEADERS: Eileen Henderson, Head of Outpatient Services**
PROBLEM			**AIM**
Learning tools are not always fully utilised. Data is not always available consistently on wait times in clinics.			To use learning tools such as complaint and survey data to improve the outpatient service. To improve the availability of data on wait times in clinics
REGULATORY INFLUENCES			
CQC Inspection 2018 - *The trust should ensure they develop processes to formally monitor patient waiting times*			
UPDATES FROM OPERATIONAL QUALITY COMMITTEE			
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month			
DIAGNOSTICS / PERFORMANCE			
Indicator	**Baseline**	**Target**	**Performance**
% of OP areas rated green or blue Patient Experience Fundamental Standard	92.3% (March 2019)	90%	

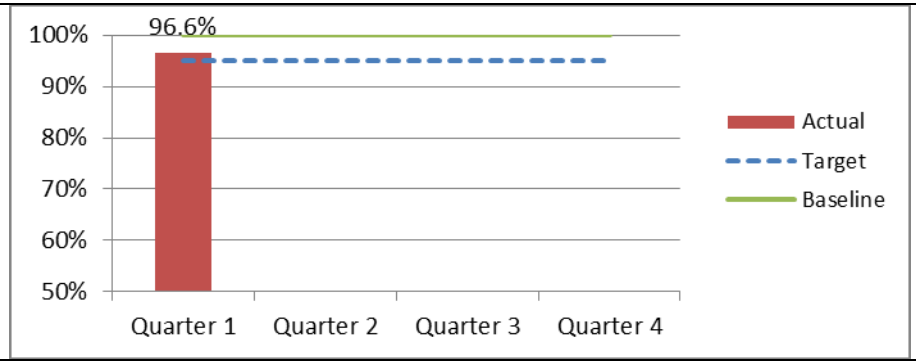
% of OP areas rated green or blue Staff Experience Fundamental Standard	92.5% (March 2019)	90%	
Outpatient Governance Committee held	Achieved	Achieved	Apr19 May19 Jun19 Jul19 Aug19 Sep19 Oct19 Nov19 Dec19 Jan19 Feb19 Mar19
% Friends and Family Test Scores for Outpatients (April 2019 data)	98% (2396 responses)	95%	
Increase in positive compliments or comments on NHS Choices	41	>41	

Improved waiting times at clinics	No baseline	85% - TO BE CONFIRMED	

KEY UPDATES – September 2019:	**KEY ACTIONS – October 2019:**
• Baseline patient waiting times audit has been completed and a robust report submitted to the September Outpatient Governance Committee. A number of recommendations were made and next steps will be agreed at the October committee. Results show that 71.6% of clinics started on time or early. • All performance data remains positive • A number of milestones that relate to the sharing and interrogation of outpatient complaints data have been closed as sufficient evidence from the 2019/20 OGC papers	• Approve and circulate staff surveys • Agree actions from the waiting time audit • Continue work towards Pattie workspace or page developed for Outpatient Staff • Next waiting time audit date has been agreed for October 2019

RISKS
There are no risks on the Corporate Risk register in relation to this project although there are a number of risks in relation to capacity and backlog within Outpatients. There is a potential risk with the delivery of this project as a number of milestones have been significantly delayed which could mean that the project is unable to provide any evidence of meeting the aim within the project timescale.

QIP47 – Acute Kidney Injury (AKI) CLOSE DOWN REPORT	
PROJECT SPONSOR: Prof Sunil Bhandari, Dr Martin Chanayireh, Consultant Nephrologists	**PROJECT LEADERS: Dr Sofia Sofroniado, Consultant Nephrologist**
PROBLEM	**AIM**
The Trust's care of patients at risk of acute kidney injury does not fully comply with NICE Quality Standard 76	The project aims to increase compliance specifically with the following Quality Statements from NICE Quality Standard 76: • Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition • Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored • Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected This will be a short-term project to support the completion of the outstanding work from the 2018/19 QIP.
REGULATORY INFLUENCES	
None	
UPDATES FROM OPERATIONAL QUALITY COMMITTEE	
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month	
OVERVIEW OF PROJECT ACHIEVEMENTS:	
The project was designed to be a short-term project to support the completion of an audit against compliance with the Quality Statements 2, 3 and 4 from NICE Quality Standard 76. A number of milestones were completed within the 2018/19 project to increase compliance with the three quality statements. The audit that was completed at the end of the 2018/19 project and into the 2019/20 project evidenced some improvements, with quality statement 2 and three increasing from not compliant to partially compliant. QS3 remained partially compliant. The lead identified two key areas that the Trust must consider in order to improve compliance by the completion of the audit. These relate to the introduction of online and face to face mandatory training for the diagnosis and management of AKI for both juniors and seniors. Excellent on line training is already in place but is not mandatory. The results of the audit have shown that not only juniors but also seniors still do not have a clear picture about what is AKI and the impact in morbidity and mortality. Secondly, the introduction of an AKI care bundle in the initial patient clerking sheet would increase compliance with the three quality statements. This is an action that the lead had included early in the 2018/19 QIP however was not taken forward due to the challenges involved in redesigning the patient documentation. Along with this, it has been identified that the whole AKI toolkit in the patient's initial clerking sheet would be beneficial as this will prompt staff to follow the checklist.	
REASON FOR CLOSURE:	
It has been agreed that these fall under the remit of business as usual and do not require a specific project in place to support the completion of these. These are long-term improvements that will require significant agreement and engagement on a trustwide level and are unlikely to be in place within the project term of this QIP.	
RISKS AND NEXT STEPS:	
There are no risks on the Corporate Risk register in relation to this project and no potential risks with the closure of this project. The project will be monitored quarterly and reported to Operational Quality Committee on the further success or risks related to this project.	

QIP48 Mental Health			
PROJECT SPONSOR: Beverley Geary, Chief Nurse			**PROJECT LEADERS: Kate Rudston, Assistant Chief Nurse**
PROBLEM			**AIM**
Information and governance arrangements are not as robust as the Trust requires.			• To improve the sharing of patient information between the Acute Trust and Mental Health services both internally and externally • To ensure that all children with Mental Health needs have an individual care plan appropriate to their needs and risk assessments undertaken to eliminate potential self-harm • To ensure that all mental health training is recorded centrally • To ensure the SLA (Adults) with Humber is monitored and delivered via the specific Mental Health Committee
REGULATORY INFLUENCES			
CQC Inspection 2016 - Regulation 12 – Safe Care and Treatment - *The trust must ensure it works actively with others internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.*			
UPDATES FROM OPERATIONAL QUALITY COMMITTEE			
October 2019 Committee: The Committee reviewed progress against the project and were sufficiently assured with the progress made within month			
DIAGNOSTICS / PERFORMANCE			
Indicator	**Baseline**	**Target**	**Performance**
Quarterly operational working group with CAMHs leads and HUTH Children's Service held	No baseline	Held	In development
% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm	100%	95%	
% compliance with paediatric relevant staff trained in CAMHS	No baseline	95%	In development
Established bi-monthly Mental Health Committee	No baseline	Held	In development
KEY UPDATES – September 2019:			**KEY ACTIONS – October 2019:**
Work is on-going with a number of key milestones, matching all CAMHs			• Agree ToR for MH Committee, including attendees and dates of meetings

training already provided with the HEY24/7 system and the development of a MH committee within the Trust with external support from key agencies. Quarter 2 performance data is being collated.	• Continue to align training
RISKS	
There are no risks on the Corporate Risk register in relation to this project and no potential risks with the delivery of this project at this point, however non-delivery of milestones or outcomes that can provide assurance that the CQC action from 2016 has been met will result in a significant risk for the Trust	

Hull University Teaching Hospitals NHS Trust

Trust Board

November 2019

Title:	**Mortality – Learning from Deaths** **Quarter 2 2019/20**	
Responsible Director:	**Executive Chief Medical Officer**	
Author:	**Chris Johnson, Clinical Outcomes Manager**	
Purpose:	The purpose of this report is to provide an update to 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	Information is provided in the report on the following topics:	

of Issues:	• 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
QUARTER 1 2019/20

EXECUTIVE SUMMARY

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 2, 2019/20 (July 1st 2019 to September 30th 2019).

The 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 2 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 2, 2019/20 (July 1st 2019 to September 30th 2019).

Information relating to themes and actions taken are obtained from the Trust Datix reporting system, for cases that were completed within Quarter 2, 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 Q2 2019/20, drawing comparison to last year:

	Total number of In-hospital deaths in Q2	Of which were elective admissions / Day case deaths	Of which were Non-elective admissions
2018/19	532	22	510
2019/20	517	25	492

2.1 Most Common Causes of Death

The following illustrates the 3 most common causes of death during Q2 2019/20:

1. Pneumonia – 60 deaths
2. Septicaemia – 53 deaths
3. Acute Cerebrovascular Disease – 35 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 Q2 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	1/1
LeDeR Reviews (internal HEY patients)	1/1
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 Q2, where it is likely that problems in care contributed to patient death.	2 (2 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 Q2 2019/20, a total of 23 Structured Judgement Reviews were undertaken. This is 4.5% of all in-hospital deaths for this quarter. The following table provides a breakdown of review types:

Total Number of SJR undertaken in Q2	Cases escalated to Tier 2	Cases requiring Triumvirate decision	SJR cases escalated and declared as a Serious Incident
23	3	1	0

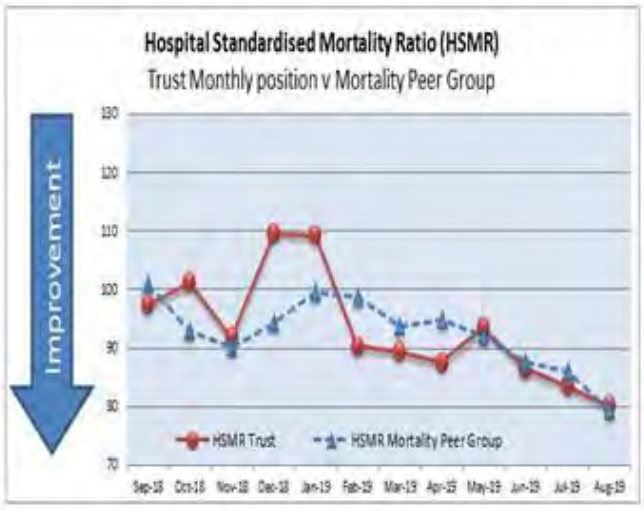
2.4 Deaths Investigated and Finalised as Serious Incidents

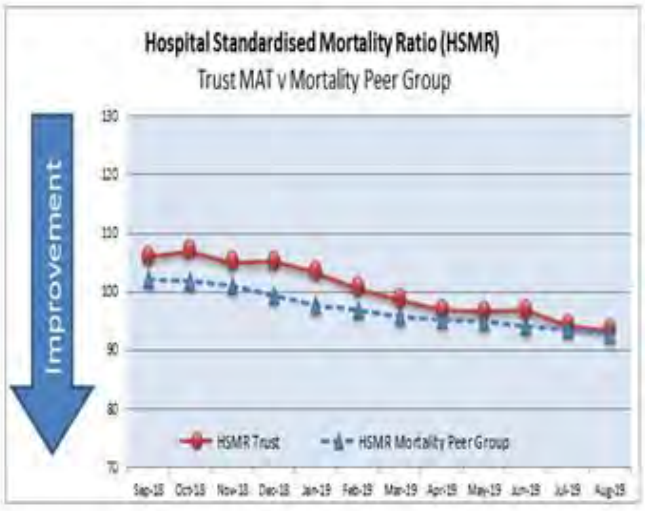
There were 2 Serious Incident Investigations that completed within Quarter 2, where the patient deaths were more likely than not to have been due to problems in care.

However, there are currently 2 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. Hospital Standardised Mortality Ratio (HSMR) compared to the Mortality Peer Group

The Trust's HSMR for August 2019 when measured as a Moving Annual Total (MAT) is 93.5. The monthly HSMR value for the Trust for August is 80.1.





4. OTHER UPDATES – DIGITALISED MORTALITY AND MORBIDITY MEETINGS

The various Specialities within the Trust regularly undertake mortality and morbidity reviews to allow for learning to take place, in order to continuously improve the service that the trust delivers to its patients.

However, there are no nationally set standards to determine how the mortality and morbidity meetings should be ran, including what data is captured and where this data is reported to.

In September 2019, the Chief Medical officer, assisted by the Associate Chief Medical Officer for Mortality and the Clinical Outcomes Manager visited NHS Grampian, Aberdeen Royal Infirmary, to learn about their new approach of undertaking standardised Mortality and Morbidity meetings.

Aberdeen Royal Infirmary uses the same incident reporting system as HUTH, the Datix system. This has allowed them to develop a bespoke electronic form that is used to input mortality and morbidity information that can be utilised within the regular meetings that are undertaken (M&M meetings).

Hull University Teaching Hospitals are now developing an electronic, Datix based Mortality and Morbidity forms to allow for a standardised methodology for collecting M&M data, and to allow for a more efficient and accurate way of collecting and analysing themes and trends.

A staged rollout is planned, with the Vascular Speciality being used to pilot the new system.

5. CONCLUSION

The ongoing development of the electronic Mortality and Morbidity (Datix) form should allow for the Trust to accurately record key elements of M&M discussion, highlighting important aspects of care in a standardised way. The electronic system approach will allow for the creation of data dashboards, making the identification and reporting of themes and trends more efficient and accurate.

Hull University Teaching Hospitals NHS Trust
Family & Women's Health Group
Maternity Services

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme – Safety Action ONE- MBRRACE UK Perinatal Mortality Review Tool

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that the national Perinatal Review Tool is being completed by a multidisciplinary team, to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

2. Introduction

'Safer Maternity Care' published in 2016 set out a vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030.

3. SAFER Maternity Care

There are a number of initiatives supporting the delivery of safer maternity care. These include work by:

- MBRRACE (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).
- NHS Resolution has contributed significantly by reviewing maternity mortality and morbidity cases, recommending where and how services and the wider system can focus efforts for improvement and raising national awareness about these.

4. The CNST Incentive Scheme

The aim of the CNST scheme is to incentivise the implementation of good practice across all maternity units.

The requirements for standard 1; Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

a) A review of 95% all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) have been started within four months of each death.
b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.
c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died), the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of the baby have been sought.
d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

5. Perinatal Mortality Review Tool MBRACE-UK

The aim of the PMRT is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports: Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. At the conclusion of the multidisciplinary review the team agree the grading of care, the

categories are as follows;

Prior to the confirmation of the baby's death;
A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.

Following the conformation of the baby's death;
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother.

6. Overview of Deaths Reviewed

Perinatal Mortality Reviews December 2018- August 2019 Neonatal cases							
	MBRRACE ID	**Neonatal Death (NND)**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	[redacted]	NND 24 weeks	[redacted]	[redacted]	YES	**C/B/B**	Completed
2	[redacted]	NND 24 weeks	[redacted]	[redacted]	YES	**A/B/A**	Completed
3	[redacted]	NND 39 weeks	[redacted]	[redacted]	YES	**D/B/A**	Review completed **Declared as an SI**
4	[redacted]	NND 25 weeks	[redacted]	[redacted]	04/07/19	**A/B/A**	Completed ready for report writing
5	[redacted]	NND (Twin) 31weeks	[redacted]	[redacted]	05/08/19	**B/A**	Completed ready for report writing
6	[redacted]	NND 36 weeks	[redacted]	[redacted]			Reviewed commenced **Declared as an SI**
7	[redacted]	NND 23 weeks	[redacted]	[redacted]	28/08/19	**A/B/A**	Completed ready for report writing
8	[redacted]	v 32 weeks	[redacted]	[redacted]			Review commenced
9	[redacted]	Twin one NND	[redacted]				Awaiting review
10	[redacted]	NND 23+1 day	[redacted]				Awaiting notes
11	[redacted]	NND 39+2	[redacted]				Review started

Perinatal Mortality Reviews December 2018- August 2019 - Maternity cases							
	MBRACE ID	**Stillbirth/ Late miscarriage**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	[redacted]	Late miscarriage 22 weeks	[redacted]	[redacted]	YES	**A/B**	Identified issues with care – observations in labour No impact on out come
2	[redacted]	Stillbirth 27 weeks	[redacted]	[redacted]	YES	**A/A**	No issues with care identified
3	[redacted]	Stillbirth 29 weeks	[redacted]	[redacted]	YES	**B/A**	Referral for family members to smoking cessation team
4	[redacted]	Stillbirth 24 weeks	[redacted]	[redacted]	YES	**A/A**	No issues with care identified
5	[redacted]	Late miscarriage 23 weeks	[redacted]	[redacted]	YES	**A/A**	Unbooked pregnancy Baby born at home no signs of life
6	[redacted]	Stillbirth 38 weeks	[redacted]	[redacted]	YES	**B/A**	Complete Writing report
7	[redacted]	Stillbirth 24 weeks	[redacted]	[redacted]	YES	**A/A**	No issues with care identified
8	[redacted]	Stillbirth 24 weeks	[redacted]	[redacted]	YES	**A/B**	Completed
9	[redacted]	Stillbirth Twins	[redacted]	[redacted]	IN PROGRESS		Waiting for PM report to complete
10	[redacted]	Stillbirth 41 weeks	[redacted]	[redacted]	YES	**A/A**	completed
11	[redacted]	Late miscarriage 23 weeks	[redacted]	[redacted]	IN PROGRESS		Booked in Hull delivered in The Wirral. Joint review to be organised
11	[redacted]	Stillbirth 36 weeks	[redacted]	[redacted]	IN PROGRESS		Waiting for PM report to complete and to grade care
12	[redacted]	Stillbirth Twins 31 weeks	[redacted]	[redacted]	IN PROGRESS		Waiting for PM report to complete. Further information required from Dr Coady regarding scans
13	[redacted]	Stillbirth 33 weeks	[redacted]	[redacted]	YES	**A/A**	Completed no issues
14	[redacted]	Stillbirth 36 weeks	[redacted]	[redacted]	YES	**B/A**	Completed email sent to all staff reminding to follow up on GTT request
15	[redacted]	Late miscarriage 22+1 weeks	[redacted]	[redacted]	YES	**A/A**	Report completed/ writing report. Has been escalated as formal complaint. Robust plan for subsequent pregnancy

7. Conclusion

A PMRT review for all Neonatal deaths, Stillbirths has been commenced in a **100%** of the required cases within 4 months of the baby's death and the parents perspective was sought and encouraged. This is supported by the Bereavement Midwifery Team.

A review has been completed for **88.5%** of all deaths of babies, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated,

Sarah Green
Bereavement Midwife
September 2019

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

12 November 2019

Title:	Board Assurance Framework for Seven Day Hospital Services – November 2019 Update
Responsible Director:	Dr Makani Purva, Interim Chief Medical Officer
Author:	Jackie Railton, Assistant Director, Strategy and Planning

Purpose:	The purpose of this paper is to present to the Trust Board the bi-annual assessment of the Trust's progress towards compliance with the ten clinical standards outlined in the Board Assurance Framework for Seven Day Hospitals Services (NHSE, 2018).	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Trust is required to submit its bi-annual return on compliance with the 7 Day Services Clinical Standards, together with a copy of this Board Report, to the regional and national 7DS teams by 30 November 2019. The August 2019 Seven Day Services audit of medical records showed that the Trust is non-compliant with priority clinical standards 2 and 8. This report provides on update on the actions endorsed by the Board in January 2019 and the progress made to date.	

Recommendation:	The Board is asked to: • Note the contents of this paper and the Trust's performance against the 7DS clinical standards. • Approve the actions outlined • Approve the submission of the bi-annual return to NHSE/I.

Hull University Teaching Hospitals NHS Trust

Board Assurance Framework for Seven Day Hospital Services

November 2019

1. Purpose of Paper

The purpose of this paper is to present to the Trust Board the bi-annual assessment of the Trust's progress towards compliance with the ten clinical standards outlined in the Board Assurance Framework for Seven Day Hospitals Services (NHSE, 2018)[1].

2. Background

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013, with a particular emphasis on four priority standards identified in 2015, ie:

- **Standard 2 – First consultant review** (all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within **14 hours** from the time of admission to hospital).

- **Standard 5 – Timely access to diagnostics** (hospital inpatients must have scheduled **7 day** access to diagnostic services, typically ultrasound, CT, MRI, echocardiography, endoscopy and microbiology with consultant-directed diagnostic tests and completed reporting within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients).

- **Standard 6 – Access to consultant-directed interventions** (24 hours a day, 7 days a week)

- **Standard 8 – Ongoing Review** (All patients with high dependency needs should be seen and reviewed by a consultant **twice daily**. Once a clear pathway has been established, patients should be reviewed by a consultant at least **once every 24 hours, 7 days a week**, unless it has been determined that this would not affect the patient's care pathway).

To achieve each clinical priority standard a provider must be able to evidence it has met this level of care for at least 90% of its patients.

In addition to compliance with the four clinical priority standards, Trusts must demonstrate continuous improvement towards achievement of the remaining six standards.

All providers are required to implement fully the 7DS Board Assurance Framework. This includes completion of a standard measurement template uploaded to NHS Improvement on a six monthly basis which is completed following a self-assessment process based on local data, including consultant job plans, clinical audits and wider performance and experience measures (eg: weekday and weekend ratio data in mortality, length of stay and readmissions). The self-assessments are published to demonstrate progress.

[1] https://improvement.nhs.uk/documents/3494/7DS_Board_assurance_guidance_v2a.pdf

The Care Quality Commission's inspection regime assesses 7DS performance as part of its judgement on a Trust's effectiveness and will use a provider's self-assessment of 7DS delivery as supporting evidence.

In May 2019, the Board received the first bi-annual assessment of the Trust's progress towards compliance with the 7DS standards. This paper provides the latest position following the most recent 7DS audit in August 2019.

4. Findings of the August 2019 Self-Assessment Process
Detailed below are the findings from the August 2019 self-assessment process.

4.1 Audit of Casenotes - Clinical Priority Standards 2 and 8
In order to establish whether the Trust had improved in its performance against Standards 2 and 8, an audit was undertaken of 245 patients (adults and children) who were admitted as an emergency during the 7 days commencing 12 August 2019. The initial findings from the audit are outlined below:

- **Standard 2 (Time to first consultant review)**
  Of the 245 casenotes reviewed, 175 patients were admitted on a weekday, whilst 70 patients were admitted on a weekend.

  Of the patients admitted Monday - Friday, 79% (139 out of 175) were seen by a Consultant within 14 hours, while 59% (41 out of 70) of patients admitted during the weekend received a Consultant review within 14 hours. Overall the Trust performance across the 7 days was 73%, a deterioration of 6% on the Trust's performance in the March 2019 audit.

  Appendix 1 provides a breakdown of performance against Standard 2 by day of admission (Table 1), and admitting specialty (Table 2).

  The Trust's performance against Standard 2 was impacted by the lack of documentary evidence in 25 sets of casenotes, ie no signature, designation or date/time had been recorded. Mr Kotwal, Associate CMO, undertook a further review of these notes to determine the outcome for the patient in order to give assurance that they came to no harm as a result of not having had a consultant review. It was Mr Kotwal's view that none of the patients in the audit had come to harm as a result of not receiving a consultant review within 14 hours of admission to hospital.

- **Standard 8 (Ongoing Review)**
  During the week of the audit, only 1 patient required twice daily reviews and this was achieved.

  Given the low sample of patients in respect of a twice daily review, a separate audit was undertaken by critical care staff to provide assurance that patients are being reviewed in a timely manner. The results of the independent critical care audit are outlined later in this paper.

  For those patients requiring one review per day, a total of 619 reviews were required, 437 on a weekday and 182 on the weekend. Only 69% of the reviews were conducted by a consultant on a weekday and 66% on the weekend. The percentages increased to 83% and 84% respectively when reviews by an ST3 were taken into consideration.

  Of the 619 possible reviews during the audit period, no documentary evidence of compliance with Standard 8 could be found in 40 instances. As reported earlier, Mr Kotwal reviewed these casenotes to see if, in his clinical opinion, any of these

patients had been fit for discharge and therefore had not required a daily review, or if a review had been required and the patient came to harm by not having had a review. Assurance was given that no patient in the sample audit had come to harm.

Appendix 2 provides a breakdown of the daily and twice daily review performance by day of the week.

- **Independent Critical Care Audit on Standard 8**
  The audit was based on 16 patients admitted during the week commencing 12 August 2019. It was noted that 4 of the patients (25%) were reviewed by a Consultant twice per day.

  There were 35 eligible days in total for the 16 patients. Of these, patients were seen by a Consultant twice a day on 13 (37%) days.

  Of the 22 'failed' days
  - 15 failed because they were reviewed twice but were reviewed by a mixture of Consultants and delegated staff
  - 7 failed because they only had one Consultant review.

  As there were 35 eligible days, there were potentially 70 Consultant reviews within the audit period. Of the 70 potential reviews, 44 (63%) were Consultant reviews, 10 (14%) were Advanced ICM trainee reviews, 5 (7%) were ST3 and above reviews, 4 (6%) were below ST3 (but not FY) reviews and 7 had no review recorded.

  Of the 7 reviews which were not recorded, 6 of the patients had been reviewed once by a Consultant that day and the other patient had been reviewed by an Advanced ICM trainee.

In order to improve performance against Standards 2 and 8, a series of actions had previously been identified:

- Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. *It is noted that this action is on the roadmap for future upgrades to Lorenzo, but is not likely to take place within the next 1-2 years.*

- Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. *This action was undertaken following the March 2019 audit and report and was reiterated prior to the most recent audit.*

- Undertake specific work with each specialty to address shortfalls in delivery. *It is proposed to target the Acute Medical Unit and General Surgery (H6/H60) during December with a service specific audit focusing on the patient pathway and documentation over a weekend (Friday to Sunday).*

- Adoption of standardised model for the identification of those patients requiring/not requiring a consultant review. *The model was circulated to the Health Groups for adoption. The August 2019 audit has demonstrated a need for the delegation of daily reviews to be formally recorded in the patient record to enable the auditors to take the delegated review into account.*

4.2 Standard 5 (Timely access to diagnostics)

Under this priority standard, hospital inpatients must have scheduled 7 day access to diagnostic services. During the audit week in August 2019 a review was undertaken of the urgent and routine CT, MRI and Ultrasound diagnostic requests for the patients within the audit sample. The results are shown below.

Standard	Modality	Weekday	Weekend	Total
Urgent – Performed within 12 hours	CT MRI Ultrasound	100% 100% 100%	100% 100% 100%	100% 100% 100%
Urgent – Reported within 12 hours	CT MRI Ultrasound	95% 100% 100%	100% 100% 100%	97% 100% 100%
Routine – Performed within 24 hours	CT MRI Ultrasound	100% 100% ***	100% 100% ***	100% 100% ***
Routine – Reported within 24 hours	CT MRI Ultrasound	100% 100% ***	100% 100% ***	100% 100% ***

*** No requests received for patients within audit sample

The above results represent a significant improvement on the previous position and reflect the work that has been done to increase CT and MRI capacity and reporting turnaround times.

4.3 Standard 6 (Access to consultant-directed interventions)

The Trust is currently compliant with this standard.

5. Triangulation of Evidence

The 7DS Board Assurance Framework recommends that Trusts utilise a range of evidence sources to demonstrate compliance with the clinical standards. In response to this, the 7DS Working Group has developed a report providing summary analysis of a number of metrics including the Hospital Standardised Mortality Ratio (HSMR), Crude Mortality rate, length of stay and emergency readmission rate. Data has been sourced from Lorenzo, CHKS and benchmarking peer comparators utilising emergency admission data by quarter.

The report is used to assess whether there is any disparity between weekday and weekend performance which may warrant further investigation.

A summary of the information is provided at Appendix 3.

6. Next Steps

In addition to the actions identified Section 4.1, it is also proposed to:

- Collect ST3+ data in future audits to provide a fuller picture of who saw the patient and whether this was appropriate and part of the delegated arrangements.
- Undertake a quality improvement project in key areas led by the Leadership Fellow.
- Review mortality over the audit period to see if 7 day service performance has had an adverse impact on mortality rates.

- Link with the SAFER project in relation to senior clinical review and criteria-led discharge.

The Trust is required to submit its bi-annual return (Appendix 4), together with a copy of its Board Report, to the regional and national 7DS teams by 30 November 2019.

6. Recommendation

The Board is asked to:

- Note the contents of this paper and the Trust's performance against the 7DS clinical standards.
- Approve the actions outlined
- Approve the submission of the bi-annual return to NHSE/I.

Dr Makani Purva
Chief Medical Officer

01 November 2019

7DS Audit Results – Standard 2

Table 1: Time from admission to 1st consultant review by day of the week (based on day of admission)

	Day of admission									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	31	29	26	27	26	20	21	129	41	180
Number of patients reviewed by a consultant outside of 14 hours	4	6	9	8	9	15	14	36	29	65
Total	35	35	35	35	35	35	35	175	70	245
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	88.57%	82.86%	74.29%	77.14%	74.29%	57.14%	60.00%	73.71%	58.57%	73.47%
Number of patient notes with documentation issues (these are counted as 'review outside of 14 hours') - e.g. no time recorded, no review documented, no staff designation recorded.	2	2	4	3	3	5	6	14	11	25

Table 2: Time to 1st consultant review within 14 hours of admission by admitted specialty

	Weekday				Weekend			
Admitting specialty	**Within 14 hours**	**Outside of 14 hours**	**Total**	**Proportion reviewed within 14 hours**	**Within 14 hours**	**Outside of 14 hours***	**Total**	**Proportion reviewed within 14 hours**
Acute Internal Medicine	77	18	**95**	**81%**	29	12	**41**	**71%**
Cardiology	3	1	**4**	**75%**	0	1	**1**	**0%**
Cardio-thoracic Surgery	0	1	**1**	**0%**	0	0	**0**	**0%**
Diabetes and Endocrinology	0	0	**0**	**0%**	1	0	**0**	**0%**
Emergency Medicine								
Gastroenterology	0	1	**1**	**0%**	0	0	**0**	**0%**
General Surgery	15	7	**22**	**68%**	2	4	**6**	**33%**
Geriatric Medicine	8	0	**8**	**100%**	1	1	**2**	**50%**
Haematology	0	0	**0**	**0%**	0	0	**0**	**0%**
Infectious Diseases	0	0	**0**	**0%**	0	0	**0**	**0%**
Intensive Care Unit	0	0	**0**	**0%**	1	0	**1**	**0%**
Neurology	0	0	**0**	**0%**	0	0	**0**	**0%**
Neurosurgery	4	0	**4**	**100%**	0	1	**1**	**0%**
Obstetrics and Gynaecology	0	0	**0**	**0%**	0	0	**0**	**0%**
Oncology	0	1	**1**	**0%**	0	2	**2**	**0%**
Ophthalmology	1	0	**1**	**100%**	0	0	**0**	**0%**
Paediatric intensive care unit								
Paediatric Medicine	8	4	**12**	**67%**	1	1	**2**	**50%**
Paediatric Surgical Wards	4	0	**4**	**100%**	2	2	**0**	**0%**
Palliative Care	0	0	**0**	**0%**	0	0	**0**	**0%**
Renal Medicine (Nephrology)	1	0	**1**	**100%**	0	0	**0**	**0%**
Respiratory Medicine (Thoracic	6	1	**7**	**86%**	1	0	**0**	**0%**
Rheumatology	1	0	**0**	**0%**	0	0	**0**	**0%**
Stroke Medicine	4	1	**5**	**80%**	0	0	**0**	**0%**
Trauma and Orthopaedic	4	0	**4**	**100%**	2	1	**3**	**67%**
Urology	0	0	**0**	**0%**	1	0	**1**	**100%**
Vascular Surgery	0	0	**0**	**0%**	0	0	**0**	**0%**
Other	3	1	**4**	**75%**	0	4	**4**	**0%**
Total	**139**	**36**	**175**	**79%**	**41**	**29**	**70**	**59%**

* some cases received no Consultant review

7DS Audit Results – Standard 8

Table 3: Twice daily reviews

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Twice daily reviews required & received from Consultant	0	0	0	0	0	2	2	0	4	4
Twice daily reviews required & received from ST3+	0	0	0	0	0	2	2	0	4	4
Twice daily reviews required & not received	0	0	0	0	0	0	0	0	0	0
Total number of daily reviews	0	0	0	0	0	2	2	0	4	4
Percentage - Receiving twice daily reviews by Consultant	0%	0%	0%	0%	0%	100%	100%	0%	100%	100%
Percentage - Receiving twice daily reviews by ST3+ or Consultant	0%	0%	0%	0%	0%	100%	100%	0%	100%	100%

Table 4: Once daily Consultant reviews

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Once daily reviews required & received	62	69	65	55	50	56	65	301	121	422
Once daily reviews required & not received from Consultant	27	31	25	32	32	31	30	147	61	208
Total number of daily reviews	89	90	90	86	82	87	95	437	182	619
Percentage - Receiving required once daily reviews	70%	77%	72%	64%	61%	64%	68%	69%	66%	68%

Table 5: Once daily Consultant or ST3+ reviews

	Day of review									
	Mon	Tue	Wed	Thu	Fri	71	Sun	Weekday	Weekend	Total
Once daily reviews required & received	77	78	77	66	63	16	81	361	152	513
Once daily reviews required & not received from Consultant or ST3+	12	12	13	21	19	87	14	77	30	107
Total number of daily reviews	89	90	90	86	82	90	95	437	182	619
Percentage - Receiving required once daily reviews	87%	87%	86%	77%	77%	82%	85%	83%	84%	83%
Documentation issues (No review documented	2	3	3	6	12	9	5	26	14	40

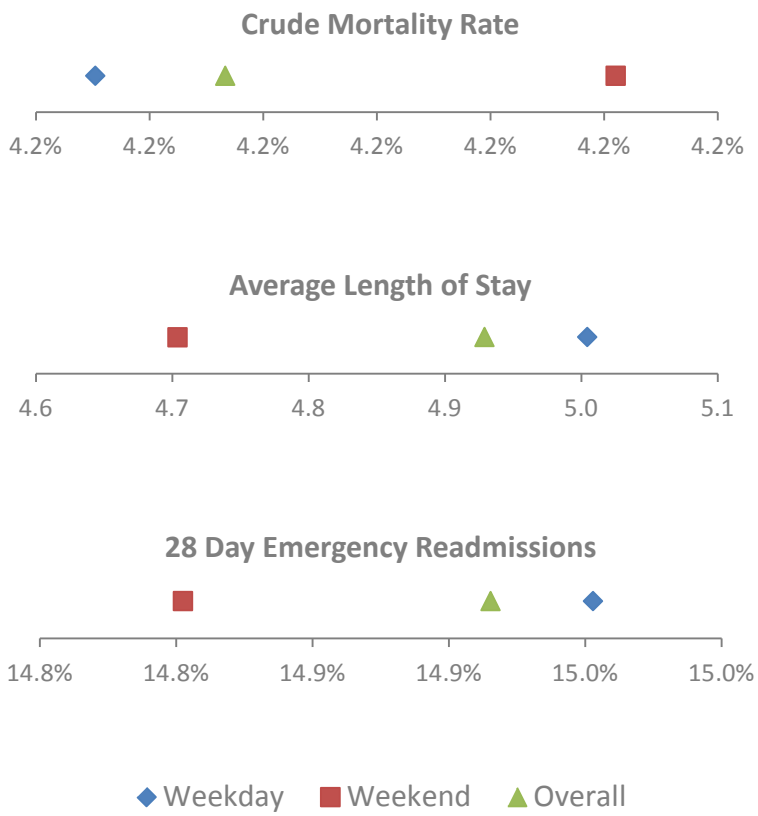
7 Day Hospital Services Review

Emergency admissions performance

The below summarises Crude Mortality, Average Length of Stay and 28 Day Emergency Readmissions for all Emergency admissions split between Weekday and Weekend admissions

SPECIALTY	(All)

		YEAR	QTR					
		2017/18	2018/19				2019/20	Grand Total
WEEKDAY_TYPE	Data	Q4	Q1	Q2	Q3	Q4	Q1	
WEEKDAY	Spells	9,913	10,053	9,596	10,399	10,331	10,438	60,730
	Crude Mortality Rate	5.3%	3.7%	4.1%	4.1%	4.3%	3.6%	4.2%
	Average Length of Stay	5.2	4.9	5.2	4.9	5.0	4.9	5.0
	28 Day Emergency Readmission Rate	14.3%	14.9%	14.8%	15.1%	14.9%	15.5%	15.0%
WEEKEND	Spells	3,352	3,455	3,279	3,343	3,409	3,422	20,260
	Crude Mortality Rate	5.2%	3.5%	3.3%	4.5%	4.7%	4.0%	4.2%
	Average Length of Stay	4.9	4.6	4.6	4.8	4.6	4.7	4.7
	28 Day Emergency Readmission Rate	15.1%	15.6%	14.1%	14.3%	13.9%	15.8%	14.8%
Total Spells		13,265	13,508	12,875	13,742	13,740	13,860	80,990
Total Crude Mortality Rate		5.2%	3.7%	3.9%	4.2%	4.4%	3.7%	4.2%
Total Average Length of Stay		5.1	4.8	5.0	4.9	4.9	4.8	4.9
Total 28 Day Emergency Readmission Rate		14.5%	15.1%	14.7%	14.9%	14.7%	15.6%	14.9%


Crude Mortality Rate
4.2%
4.2%
4.2%
4.2%
4.2%
4.2%
4.2%
Average Length of Stay
4.6
4.7
4.8
4.9
5.0
5.1
28 Day Emergency Readmissions
14.8%
14.8%
14.9%
14.9%
15.0%
15.0%
Weekday
Weekend
Overall

Hull University Teaching Hospitals NHS Trust: 7 Day Hospital Services Self-Assessment - August 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance Of the 245 casenotes reviewed from the audit period, 175 patients were admitted on a weekday and 70 patients were admitted on a weekend. 79% of patients were seen by a Consultant within 14 hours during the week, however this dropped to 59% of patients at the weekend. Overall the Trust performance across the 7 days was 73%, a deterioration of 6% on the Trust's performance in the March 2019 audit. Areas for improvement include: • Exploring opportunities to strengthen the electronic recording of consultant reviews through further development of the Trust's electronic patient record (will require upgrade to system. Current roadmap suggests 1-2 years away) • Communicating to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. • Undertaking a quality improvement project with General Surgery and Acute Medicine led by a Leadership Fellow. • Adoption of standardised model for the idetification of those patients requiring/not requiring a consultant review. • Linking the work on 7 day services with the SAFER project in relation to senior clinical review and criteria-led discharge.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site
		Computerised Tomography (CT)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement
		Ultrasound	Yes available on site	Yes available on site
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Echocardiography	Yes available on site	Yes available on site
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement
		Upper GI endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Emergency Renal Replacement Therapy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance During the week of the audit (12/08/2019-18/08/2019), there were a total of 619 reviews required for patients that required one review per day . Of these reviews 437 were required on a weekday, however only 69% received the required review. Of the 182 patient reviews that were required on a weekend, only 66% received the required review. The percentages increased to 83% and 84% respectively when reviews by an ST3 were taken into consideration. Only 1 patient in the sample required twice daily reviews and this was achieved.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards, highlighting areas where progress has been made since 2015 Standard 1: Patient Experience - Compliant - Information given to patients does not differ at weekends or weekdays. Standard 3: MDT Review - Partially Compliant - Pharmacy support to majority of ward or board rounds not available at weekends, but is available on call or for dispensing. 7 day MDT assessment will be undertaken by appropriate staff and in accordance with clinical need, but not all modalities will be present. Speech and Language Therapy, Occupational Therapy and Dietetic Services are mainly 5 day services (though some Saturday services in dietetics). Standard 4: Shift Handovers - Partially Compliant - Within Medicine Health Group there are twice daily shift handovers at designated times. Clinical data recorded electronically on CAYDER. Oncology, Haematology and Rehabilitation Medicine are fully compliant. Standard 7: Mental Health - Partially Compliant - There is a Mental Health Hospital Liaison Team available 24/7. Response times vary according to clinical need and capacity and are not recorded on Trust systems. Standard 9: Transfer to Community, Primary and Social Care - Partially Compliant - There is no integrated care record shared between primary and secondary services. Advice may be sought from specialties via the on call rota 24/7. System wide work is ongoing to share care plans between providers. OOH access to external services (eg Social services) only available in emergency situations. Transport is available 7 days. Oncology/Haematology Services have employed 2 discharge co-ordinators to ensure, where possible, all unnecessary prolonged stays are avoided over a weekend. Standard 10: Quality Improvement - Compliant - Nurse staffing ratios do not differ for weekday or weekend provision, but may be flexed according to capacity, demand and exceptional circumstances (eg large local events). Services participate in Peer Reviews, mortality reviews, grand rounds, national audit (SSNAP), GIRFT, benchmarking exercises, governance meetings, business meetings, DATIX and SI reviews and investigations. The Trust is accredited via the Deanery as a training provider, which is also subject to quality assurance processes.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met. Hyperacute Stroke - Reviewed daily by ward based consultant. On call cons may review patients OOH but not embedded. Patients will be reviewed further at any time if required

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 12 November 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
In October 2019, the National Guardian's Office released a report providing a 'Freedom to Speak Up' index measurement for all NHS Trusts. This is calculated on scores from specific National Staff Survey questions, as follows:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

The report provides an index score for each organisation, as well as a national average for same kind of NHS Trust.

Hull University Teaching Hospitals NHS Trust's Freedom to Speak Up index score is 78%, using the 2018 Staff Survey results, against a national average score for acute trusts of 77%. The national average has risen from 75% in 2015 to 78% in last year's survey results.

The highest score of any acute trust is 84% (The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust). The highest score nationally is 87% (Cambridgeshire Community Services NHS Trust).

Whilst the Trust is above the national average, staff culture and the Trust's values remain key drivers for organisational development and staff engagement. The specific questions link closely to patient safety and the Freedom to Speak Up Guardian is linking in closely with the Patient Safety campaign launched in the Trust on World Safety Day in September 2019, specifically on the role to support and train the new Safety Champions on the link between safety and speaking up.

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 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	4 - Medicine (inc.

July - Sept 2018	3	except one	Emergency) 1 - Clinical Support 1 – Surgery 11 – Corporate 5 – F&W 0 – Not specified 1 – external
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 September 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	6
Requesting advice for a colleague	-
Contacted via SALS	-
Signposted by manager	-
Signposted by Occupational Health	-
Signposted by a FTSGU in another Trust	-
Total	**6**

The contacts with the 1 April 2019 – 30 September 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) 2 - Clinical Support 2 – Surgery 1 – Corporate 1 – F&W 0 – Not specified 0 – external
July - Sept 2019	3		
Oct – Dec 2019			
Jan – Mar 2020			
Total			

The following types of concern were raised 1 April 2019 – 30 September 2019:

Type of concern	Number of contacts
Concerns about bullying behaviour	2
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	2
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). The SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. 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.

4.3 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 April 2019, no gaps in assurance or control were identified. The next review is due to go to the Audit Committee in January 2020.

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
- The link between speaking up and patient safety is one that will form the focus of the FTSUG for the remainder of the year, linking this with the Patient Safety work underway in the Trust

6. Recommendation
The Trust Board is asked to receive and accept this report, and feed back any observations on how further to develop the Freedom to Speak Up Guardian role in the Trust

Carla Ramsay
Director of Corporate Affairs
October 2019

Hull University Teaching Hospitals NHS Trust

Trust Board

12 November 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. To additionally receive a list of current roles required in the organisation, to confirm current arrangements in the Trust – this is for briefing purposes only.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary of Key Issues:	The Trust's seal has been used, for review by the Trust Board. There are a number of roles required to be held within the Trust, which are Board-required roles or roles that need to be able to feed directly in to the Trust Board if necessary: for good governance, an appendix to this paper outlines these roles and by whom these are currently held.	

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal • Receive for information the current list of required roles in the organisation

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders November 2019

1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2019/22	Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust – Car parking lease relating to Miranda House	18.09.19	Teresa Cope – Acting CEO (only one signature included in document)
2019/23	Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust- Deed of surrender and variation relating to rooms at Beverley Community Hospital	25.09.19	Teresa Cope – Acting CEO/ Carla Ramsay - Director of Corporate Affairs
2019/24	Hull University Teaching Hospitals NHS Trust and IPM Personal Pension Trustees Ltd – Counterpart lease relating to Unit D, Venture Business Park, Witty Street, Hull, HU3 4TT	27.09.19	Teresa Cope – Acting CEO/ Carla Ramsay – Director of Corporate Affairs
2019/25	Hull University Teaching Hospitals NHS Trust and RPP Ltd and Hull and East Yorkshire Medical Research Centre – Consultants deed of warranty in favour of a landlord of a development at Castle Hill Hospital, Castle Road, Cottingham	15.10.19	Chris Long – CEO/Carla Ramsay – Director of Corporate Affairs

3 Roles required in the organisation

There are a number of roles that each NHS Trust is required to staff, such as Director of Infection Prevention and Control, Guardian of Safe Working, Freedom to Speak Up Guardian, as well as lead roles that Executive Directors and Champion roles that Non-Executive Directors are expected to hold.

The attached appendix is for information purposes only, to detail by whom these roles are currently held.

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Carla Ramsay
Director of Corporate Affairs
November 2019

Appendix 1

Roles required in Hull University Teaching Hospitals NHS Trust involving the Trust Board as of 1 November 2019

Role	Requirement	Post holder
Accountable Emergency Officer	To present the Trust's Emergency Preparedness annual statement to the Trust Board for Board agreement	Jacqueline Myers, Director of Strategy and Planning
Accountable Officer	To be the statutory Accountable Officer for the organisation	Chris Long, Chief Executive
Caldicott Guardian	To be able to report directly to the Trust Board any issues of significance affecting the Trust regarding the safe management of patients' medical records	Dr Alastair Pickering, Chief Clinical Information Officer
Champion for End of Life Care (Non-Executive)	To champion high quality end of life care at Trust Board level	Julie Jomeen, Non-Executive Director
Data Protection Officer	To be responsible, under the Data Protection Act 2018, for raising any significant breaches of confidentiality or data protection to the Trust Board and ensure the Board is briefed on data protection arrangements	Carla Ramsay, Director of Corporate Affairs
Director of Infection Prevention and Control	To report at least annually directly to the Trust Board the Trust's arrangements for infection prevention and control	Greta Johnson, Lead Infection Prevention and Control Nurse and Infection Prevention and Control Team Leader
Equality and Diversity (Workforce Race Equality Standards and Workforce Disability Equality Standards	To champion equality and diversity in the workforce (and ensure compliance with statutory returns and publication requirements)	Teresa Cope, Chief Operating Officer (and Simon Nearney, Director of Workforce and Organisational Development)
Emergency Preparedness (Non-Executive)	To champion robust emergency planning arrangements at Board level	Terry Moran, Chairman
Freedom to Speak Up Guardian	To report periodically to the Trust Board on the arrangement to support staff to speak up about issues of concern or patient safety in the organisation	Carla Ramsay, Director of Corporate Affairs
Guardian of Safe Working	To report periodically to the Trust Board the Trust's arrangements to comply with	Mr Androniks Mumdzjans, Consultant in Obstetrics

	the requirements for supporting doctors in training	
Lead for maternity and mid-wifery (Non-Executive)	To champion high quality maternity and midwifery at Trust Board level	Julie Jomeen, Non-Executive Director
Learning from Deaths (Non-Executive)	To champion meeting the NHS Quality Board Learning From Deaths requirements at Trust Board level	Martin Veysey, Non-Executive Director
Responsible Officer	To report to the Board at least annually about the robustness of the organisation's arrangements for doctors' revalidation, conduct and fitness to practice	Dr Makani Purva, Chief Medical Officer
Safeguarding Champion (Non-Executive)	To champion robust safeguarding arrangements at Trust Board level	Tracey Christmas, Non-Executive Director
Safeguarding Lead (Executive Director level)	To have a Board member responsible for safeguarding arrangements in the organisation and report these directly to the Board	Beverley Geary, Chief Nurse
Senior Information Risk Owner	To have an Executive Director with responsibly for information security and risk management in the organisation	Lee Bond, Chief Financial Officer
University of Hull Non-Executive Director appointment	As a Trust with a significant teaching commitment, the Trust's Establishment Order requires that the University of Hull appoints one of the Non-Executive Directors	Julie Jomeen, Non-Executive Director