Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held in Public

28 January 2020

1	**Apologies**	verbal	Terry Moran - Chair
2	**Declarations of Interest** 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Terry Moran - Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 12 November 2019	attached	Terry Moran - Chair
4	**Matters Arising**		
	4.1 Action Tracker	attached	Carla Ramsay – Director of Corporate Affairs
	4.2 Board Reporting Framework 2017/20	attached	
	4.3 Board Development Framework 2017/19	attached	
5	**Chair's Opening Remarks**	verbal	Terry Moran - Chair
6	**Chief Executive's Briefing**		
	6.1 Chief Executive's Report	attached	Chris Long – Chief Executive Officer
	6.2 Balanced Scorecard (Summary of 12.2)	attached	Chris Long – Chief Executive Officer/ Teresa Cope – Chief Operating Officer/Lee Bond – Chief Financial Officer
	6.3 Standing Orders	attached	Carla Ramsay – Director of Corporate Affairs
	6.4 Trust Board Constitutional Matters	attached	Carla Ramsay – Director of Corporate Affairs
7	**Governance**		
	7.1 Reports and Escalation from the Performance and Finance Committee	attached	Tony Curry – Chair of Performance and Finance Committee
	7.1.1 Performance and Finance Committee Extraordinary meeting 7 November 2019	attached	Tony Curry – Chair of Performance and Finance Committee
	7.1.2 Performance and Finance Committee 25 November 2019	attached	Tony Curry – Chair of Performance and Finance Committee
	7.1.3 Performance and Finance Committee 16 December 2019	attached	Tony Curry – Chair of Performance and Finance Committee
	7.2 Escalation Report and Minutes from Quality Committee	attached	Martin Veysey – Chair of Quality Committee
	7.2.1 Quality Committee 25 November 2019	attached	Martin Veysey – Chair of Quality Committee
	7.2.1 Quality Committee 16 December 2019	attached	Martin Veysey – Chair of Quality

*Items marked * are for information only and will not be discussed unless agreed with the Chairman at the start of the meeting*

	7.2.3 Quality – Summary Report (summary of 12.3)	attached	Committee Beverley Geary – Chief Nurse
	7.3 Escalation Report from Audit Committee Chair – 23 January 2020	attached	Tracey Christmas – Chair of Audit Committee
8	**Great Staff**		
	8.1 Frontline staff	discussion	Community Paediatrics
	8.2 Nursing and Midwifery Escalation Report	attached	Beverley Geary – Chief Nurse
9	**Great Care**		
	9.1 Patient Story	verbal	Marie Stern – Chair of Patient Council
10	**Great Future**		
	10.1 Board Assurance Framework Q3	attached	Carla Ramsay – Director of Corporate Affairs
	10.2 BAF 2 – Valued, Skilled and Sufficient Staff	attached	Simon Nearney – Director of Workforce and Organisational Development
11	**Items for approval by the Board**		
	11.1 Capital Support Loan	attached	Lee Bond – Chief Financial Officer
	11.2 EPRR Arrangements	attached	Jacqueline Myers – Director of Strategy and Planning
	11.3 Contract Extension for the continued use of the Healthtrust Europe Total Workforce Solutions Framework Agreement	attached	Simon Nearney – Director of Workforce and Organisational Development
	11.4 CNST – Maternity Incentive Scheme	attached	Jan Cairns – Head of Midwifery
	11.5 Guardian of Safe Working Report	attached	Androniks Mumdzjans – Guardian of Safe Working
12	**Reports to the Board**		
	12.1 Partnership with the Sri Ramachandra Institute in Chennai update*	attached	Makani Purva – Chief Medical Officer
	12.2 Integrated Performance Report*	attached	Teresa Cope – Chief Operating Officer/Lee Bond – Chief Financial Officer
	12.3 Quality Report*	attached	Beverley Geary – Chief Nurse
	12.4 Nursing and Midwifery Report*	attached	Beverley Geary – Chief Nurse
13	**Chairman's Summary of the Meeting**	verbal	Terry Moran – Chair
14	**Any Other Business**	verbal	Terry Moran – Chair

*Items marked * are for information only and will not be discussed unless agreed with the Chairman at the start of the meeting*

15 Any Questions from Members of the Public verbal Terry Moran - Chair

16 Date and time of the next meeting:
Tuesday 10 March 2020 – 9am – 1pm,
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	✓	✓	✓	✓	✓						5/5
A Snowden	✓	✓	-	-	-						2/2
S Hall	✓	x	✓	✓	✓						4/5
V Walker	✓	✓	x	✓	-						3/4
T Christmas	✓	✓	✓	✓	✓						5/5
M Gore	✓	x	✓	✓	✓						4/5
C Long	x	✓	✓	✓	✓						4/5
L Bond	✓	✓	✓	✓	✓						5/5
T Cope	xMK	✓	xMK	✓	✓						3/5
M Purva	✓	x	✓	✓	✓						4/5
M Veysey	✓	x	✓	✓	✓						4/5
B Geary	✓	✓	✓	✓	✓						5/5
J Jomeen	✓	✓	✓	x	✓						4/5
In Attendance											
T Curry	✓	✓	✓	x	✓						4/5
J Myers	✓	✓	x	✓	✓						4/5
S Nearney	✓	x	✓	✓	✓						4/5
C Ramsay	✓	✓	✓	x	✓						4/5
R Thompson	✓	x	✓	✓	✓						4/5

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Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 12th November 2019

Present:	Mr T Moran CB	Chairman
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Prof M Veysey	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs B Geary	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Dr M Purva	Chief Medical Officer
In Attendance:	Mr S Nearney	Director of Workforce and OD
	Ms J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mr J Illingworth	Research and Development Manager
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies:
There were no apologies received.

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting
Mrs Christmas advised that she was now a trustee of SLP Performing Arts College in Leeds.

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

3 Minutes of the meeting 10 September 2019
The minutes were accepted as an accurate record of the meeting.

4 Matters Arising
Mrs Thompson advised that the Board to Board with Humber FT NHS Trust progressing and a provisional date had been discussed.

4.1 Action Tracker
Ms Myers advised that the stakeholder session would take place on 28th January 2020 at the Board Development Session.

4.2 Board Reporting Framework
The Board received the framework.

4.3 Board Development Framework
Ms Ramsay agreed to update the Board Development to incorporate any changes.

4.4 Any other matters arising from the minutes
There were no other matters raised.

5 Chair's Opening Remarks

Mr Moran advised that all public services were now in Purdah until the end of the General Election process. This meant that any decisions that could influence in a political context should be checked before taken.

Mr Moran also stated that the Quality paper had changed format and he had found it refreshing and relevant.

6 Chief Executive's Briefing

Mr Long highlighted the Pathology modernisation update and how it was progressing at pace. He advised that the governance model was being changed and complex issues were emerging. The new arrangements would be presented to the Board following the Business Case being presented to the Performance and Finance Committee.

Mr Long also advised that the Trust's Radiotherapy Team had launched their Varian Halcyon linear accelerator on Friday 11 October. Mr Long thanked Mr Bond for the financial input that was required to make this happen.

Mr Long also reported that a Chief Registrar had been appointed, Dr Alexander McNeil.

Mr Gore wanted to thank the Estates Teams for the work being undertaken on the ground floor of the Tower Block and the pace at which it was happening.

There was a discussion around the HSJ awards and how the impact of winning was linked to staff morale, recognition and Trust reputation.

7 Patient Story

Dr Purva presented a number of patient stories, the first related to a patient that did not receive information due to pressures in the system and not enough time was taken to discuss the next steps with the patient. Since this the patient has been reassured and the right steps had been taken.

There were also 3 positive stories, one was regarding an 11 month old child who's parents had been given advice and information in a professional and compassionate way which had resulted in them thanking the hospital team and making it a good patient and family experience.

Dr Purva gave another example of care and compassion when a patient had asked if her partner could be present during a sensitive procedure and the clinical team had gone out of their way to make this happen.

Dr Purva also reported on a patient who had undergone a cataract operation and wanted to thank the anaesthetist for looking after them and calming their nerves. He also thanked the recovery staff.

Mr Moran added a story about a young patient who had passed away abroad which meant the family faced charges to bring the patient home. The family wanted to donate organs and had arranged for the patient to be returned at their own personal cost to ensure the organs were. Mr Moran stated that this was a remarkable set of circumstances to ensure another

patients quality of life could continue.

8 Board Assurance Framework

Ms Ramsay presented the Board Assurance Framework and advised that the Quality, Performance and Finance and Audit Committees had reviewed the document and at the end of quarter 2 were not recommending any changes to the risk ratings. This was despite work ongoing on mitigations and assurance.

Mr Gore expressed his concern regarding the risk to patient safety regarding the Patient Tracking List and Mrs Cope advised that and extended waits were subjected to a clinical harm review.

Mr Hall added that the Health Groups had all presented a stock take of their performance to the Performance and Finance Committee and Ms Ramsay advised that any relevant issues would be captured in the BAF update.

Resolved:

The Board received and approved the BAF.

8.1 BAF 6 – Research and Innovation

Mr Illingworth joined the meeting and gave a presentation around the performance data relating to Research and Innovation. The Board agreed to include Research and Innovation as one of their development sessions to allow more time for questions.

Work was ongoing and recently a Lead Research Nurse had been appointed. Volunteers were also in post to sign-post patients should they want to be involved in trials. There was also a visual presence on ward areas and an opportunity to check post codes to see what research is happening.

There had been positive news regarding the link with the University of Hull and the clinical trials additional funding. He reported that since the Trust had changed its name there was an aligned focus on strategies and there was protected time for researchers and admin support had been put into place. The risk identified was a potential lack of available funding.

Mr Illingworth spoke of major partnerships in particular with the York and Humber Clinical Research and the key objectives set and the number of patients required. There had been a reduction in funding but Mr Illingworth stated that sometimes this drove clinical teams to find funds which lead to more grants. The forecasted trails for this year was 4000 compared to 6000 in the previous year, however the mix of work had shifted to more interventional work.

Mr Illingworth advised that the Trust was looking to get income for Research and Innovation and work was ongoing with the Communications Department to ensure the Trust had the capacity to do so.

The next steps were focussing on needs such as mental health, international collaborations to generate funding and using a mix of clinical and allied health professionals to initiate trials. The aim for the Trust was to be in the top 5 nationally working in close partnership with the University of Hull.

The Trust Board discussed generic leaders and leaders in their field of interest and how this could impact on the trials. Prof Jomeen added that she welcomed more involvement with the non-medical leaders working in this area. She also added that a big piece of culture work was required and would take many years.

Dr Purva stated that research was sometimes sacrificed in meeting performance targets and it was important to balance Trust ambition. Research sacrificed at meeting other targets. Where do we balance our ambitions.

Mr Moran thanked Mr Illingworth and it was agreed that the Performance and Finance Committee would review the potential income generations and how it would be used. Mr Gore added that it was important to celebrate the success stories. **LB**

Resolved:
The Board received and accepted the presentation.

9 Director Reports

9.1 Quality Report

Mrs Geary presented the report and advised that the Trust had received its Provider Information Request from the CQC and work was ongoing to gather the evidence required.

Mrs Geary spoke of the NHS I programme relating to the Well Led and moving to good improvements and that she was attending a culture workshop in Manchester.

The Never Event 10 point plan was being presented to the November Quality Committee.

Mr Gore asked about incident reporting rates and how they were increasing. Mrs Geary added that as part of the Safety campaign safety champions had been put into place to increase the level of reporting, but added that the level of harm was to be taken into account, which was low.

There was a discussion around the Matron's handbook and the work ongoing to ensure these were completed and data uploaded. Mr Bond stated that completion of records would be key to the CQC inspection.

Resolved:
The Board received and accepted the report.

9.2 Health Care Associated Infections

Mrs Geary presented the report and advised that there had been a further case of Pseudomonas detected in the Neonatal Intensive Care Unit. A new sink cleaning agent had been piloted with positive results.

A case of Legionnaires disease had been identified but this had been acquired in the community and had no links to the previously reported cases.

There were a number of bays closes due to Norovirus but this was being

managed appropriately.

Resolved:
The Board received and accepted the report.

9.3 Patient Experience
Mrs Geary presented the report and advised that work was ongoing to improve the performance against the 40 working day standard. The Family and Friends Test was showing that 97.3% of patients were likely to recommend the hospital and the volunteer recruitment was ongoing with dining companions being appointed to help elderly patients at mealtimes.

Mrs Geary was impressed with the Young Health Champions and their positive impact on the Trust.

Work was ongoing with the Patient and Public Council and a recruitment campaign was underway to appoint 2 new members.

Mr Moran asked about the high numbers of complaints and whether it was a one off. Mrs Geary advised that the team was working to break down the categories further to focus improvement work.

Resolved:
The Board received and accepted the report.

10 Nurse and Midwifery Report
Mrs Geary presented the report and advised that the Care Hours Per Patient Day methodology and calculation was detailed in Appendix 4. She advised the calculation was based on 100% bed occupancy and should be worked out on the number of patients in beds at midnight and midday. The updated figures would be included in the next report to the Board.

Nurse recruitment was ongoing with a 129 new nurses commencing with the Trust and work was ongoing to develop retention strategies to ensure nurses remained within the Trust. Prof Jomeen commended the recruitment figures and the new training programmes in place.

The report also included the twice yearly review of the nursing and midwifery establishments and she advised that the figures were all within budget.

There was a discussion around the RAG ratings and it was agreed that this would be discussed further at the Quality Committee. **BG/RT**

Mr Moran asked Mrs Geary about her high and low points whilst in her Chief Nurse Clinic which was open to all staff. Mrs Geary advised that having quality time, face to face with staff members was her high point and an emotional patient story was her low point.

Mr Moran advised that he had been given some feedback regarding the new Chief Nurse complimenting her approach to the role and the real conversations being had.

The Board discussed the Red Flags and Mrs Geary agreed to add trend analysis to the report. Mrs Christmas (the new Safeguarding Non-Executive **BG**

lead) agreed to speak to Ms Rudston regarding the Safeguarding Red Flags. **TC**

Resolved:
The Board received and accepted the report.

11 Quality Committee Minutes 30 September 2019/28 October 2019

Prof Veysey presented the minutes and highlighted discussions that had taken place regarding the Matrons handbook and establishing better links with Humber FT NHS Trust. He added that the Learning Report was changing its name to the Themes Understood and Actions Taken report.

Mr Bond raised the item around the WHO Checklist and how it could be seen as a tick box exercise. Dr Purva advised that work was ongoing to ensure that the procedures were robust and training was up to date and relevant. Mr Hall advised that the meetings he had attended relating to the Never Events investigations had shown that clinical staff took the checklist seriously and that compliance was close to 90%. Ms Myers added that the Trust was addressing the culture of the organisation and highlighted the Stop the Line campaign.

Resolved:
The Board received and accepted the minutes.

12 Performance and Finance Report

Mrs Cope updated the Board regarding unplanned care and advised that ward H70 was now open with an extra 22 beds available. She thanked the Estates Teams for their work around this.

Mrs Cope spoke of the Health Group stock take that had been received at the Performance and Finance Committee in November 2019. A number of targets had been set including a 50% reduction in the ASI and follow ups and maintaining the 52 week wait position.

Mrs Cope advised that the Intensive Support Team had been invited back to the Trust to work with the Cancer teams, specifically in Upper GI and Gynaecology Departments.

Mr Gore asked about the waiting list and how it had increased over the last 5 months and whether this was a tracking access problem. Mrs Cope clarified that it was not a tracking access issue but that there were some data quality errors and the Teams were working collectively to improve the quality of the data. Every patient was tracked and the delays were around the clock stops not being at the earliest opportunity and not a tracking access error.

There was a discussion around diagnostic performance improvements and Prof Veysey advised that there had been a change in screening guidelines that would help performance further.

Resolved:
The Board received and accepted the report.

Finance

Mr Bond presented the financial section of the report and advised that the Trust was on track at month 7 and was still forecasting to meet the plan. He

added that the level of risk stood at £5.3m.

Income and Health Group deterioration were both on plan for month 7.

Mr Bond advised that work was ongoing with the Commissioners and NHS I/E to review the North Humber regions financial issues to ensure meeting the plan at the end of the year.

Mr Bond advised that there was some slippage in the Capital expenditure at month 7 and the Health Group underlying positions had deteriorated further.

Mr Hall asked if the capital expenditure could be ring-fenced for next year and Mr Bond advised that it could. Mr Bond agreed to discuss the Health Group underlying position at the next Performance and Finance Committee. **LB**

Resolved:
The Board received and accepted the report.

The agenda was taken out of order at this point

14 Performance and Finance Minutes – 30 September 2019/28 October 2019
The Board received and accepted the minutes.

12.1 Winter Plan
Mrs Cope presented the report and advised that the Performance and Finance Committee had scrutinised the report at the October 2019 meeting.

She reported that the Trust was looking to maximise the opportunities around Same Day Emergency Care protocols and that the work ongoing on the Ground Floor of the Tower Block was key to this.

Mrs Cope highlighted the additional beds that the SDEC protocols would free up as well as the additional community beds and in total this would create 65 beds. Mr Gore asked if there were issues around SDEC and Lorenzo and Mrs Cope advised that it would not stop the Trust following the requirements.

Mrs Cope advised that a perfect fortnight initiative would take place in January 2020 which would help with the winter pressures at this time. Mr Hall added that morning discharges were key as well as front entrance triaging ensuring patients were re-routed appropriately. Mrs Cope added that there were developments around Primary Care streaming that the Trust had not had before and a number of alternative care pathways had been identified for re-directing patients.

There was a discussion around length of stay and understanding patients that have had over a 7 day stay. Prof Veysey stated that freeing up a senior
Resolved:
The Board received and accepted the report.

13 Five Year Submission
Ms Myers presented the item and advised that the Board had already seen the STP partnership plan and it would be submitted on Friday 15th November 2019. Mr Bond added that each STP would have to be control

total compliant and if the Humber Coast and Vale STP achieved their £72m deficit then £73m of central funding would be made available. He added that there was a degree of risk to the level of ambition and improvements required.

Early developments in the STP partnership were the emergency care business cases to revamp the front doors of the hospitals and the development of primary care networks.

The Trust had received initial positive feedback from the centre. Mr Moran asked about the future capital funding and Mr Bond advised that the Trust had flagged the network replacement scheme, operating theatre refurbishment and the Tower Block replacement scheme but nothing was confirmed yet.

Resolved:
The Board received and accepted the update.

The agenda returned to order at this point

15 Trust Strategy Implementation

Ms Myers presented the first progress report relating to the renewed Trust Strategy. She advised that it was showing good progress but that it was still early and the milestones would get harder to achieve as time went on.

Each area had been appointed a lead director to drive the progress and highlight the rag rating to be indicated.

Mr Moran asked for a summary arrow to be added to each area to show whether progress was improving or not as the case may be. **JM**

Resolved:
The Board received and accepted the report.

16 IM&T Paper

Mr Curry presented the paper and advised that he had been tasked reviewing the Trust's IM&T Strategy and had summarised that significant capital investment was required but the Trust was clear on its priorities.

Mr Curry advised that there were good initiatives in place and the strategy was adequately resourced and invested in relative to the risks.

Mr Bond had shared Mr Curry's report with the IT Management Team who had supported the conclusions.

There was a discussion on the Trust's expenditure regarding IT and if there were any opportunities to reduce costs to the organisation.

Resolved:
The Board received and accepted the report.

17 Staff Survey Results Q2

Mr Nearney presented the report and advised that the 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.

Engagement scores were highlighted in the report and were above average with an upward trend. An action plan was in place to address any issues.

Mr Moran stated that the results were encouraging and that the small numbers could mean that only staff that were not satisfied answered the survey, which could be seen as a positive.

Prof Veysey asked about the admin staff and Mr Nearney clarified that the clinical admin review had taken place and this was causing the issues, although actions were in place to address it.

It was agreed that arrow indicators would be added to the report to monitor positive and negative trends.

Resolved:
The Board received and accepted the report.

18 Audit Minutes October 2019

Mrs Christmas presented the minutes and highlighted the Financial Management Review report that had been received from the Internal Auditors. This would be discussed at the November 2019 Board Development session.

Mrs Christmas also reported that the External Auditors had not attended the meeting but that she would write to them to clarify that they were expected to attend each quarterly meeting.

The follow up action report was discussed and Ms Ramsay advised that further progress had been made but that there was more work to do.

Resolved:
The Board received and accepted the minutes.

19 Quality Accounts Update/Quality Improvement Plan

Mrs Geary presented the report and advised that she was introducing a new assurance meeting to review data before reports were written. She advised that the Quality Improvement Plan included the Quality Account indicators and were being measured as part of the plan.

Mr Gore asked if the Safeguarding Policies were now in place and Mrs Geary advised that they were.

Prof Veysey added that each QIP had an executive lead.

Resolved:
The Board received and accepted the report.

20 Learning from Deaths Guidance

Dr Purva presented the report which gave assurance that the Structured Judgement Reviews were being carried out appropriately. She added that a new initiative was being introduced reviewing morbidity and near misses by using the Datix system.

Prof Veysey added that the new Medical Examiner role would impact on the

mortality data once implemented in 2020.

Mrs Christmas asked what process was used if a patient died due to lack of care and Dr Purva advised that the Duty of Candour process would be triggered.

Resolved:
The Board received and accepted the report.

20.1 Perinatal Mortality Review Tool
Dr Purva presented the report which gave assurance to the 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).

Resolved:
The Board received and accepted the report.

21 7 Day Services Report
Dr Purva presented the report and advised that the framework had changed to bi-annual reporting. The Trust was still not compliant with 2 standards, first consultant review and ongoing review.

Dr Purva advised that the reviews were taking place but the documentation was not being completed on a number of occasions. Mr Bond expressed his concern regarding clinical teams not recording information on the systems and focus should be on this area. Mr Hall added that the performance figures showed that 69% of reviews were being captured against a target of 90%. Dr Purva advised that a new process had been put into place to allow Registrars to lead the reviews and a further audit would be undertaken in December 2019 to check progress.

Mr Moran was keen to learn where the Trust rated when benchmarked against other Trusts. **MP**

Resolved:
The Board supported and approved the report.

22 Guardian of Safe Working Report
This item was deferred until the January 2020 meeting.

23 Freedom to Speak Up Report
Ms Ramsay presented the report and advised that work was ongoing to ensure the guidance from the National Guidance Office was being followed and implemented appropriately.
She reported that the National Office was focussed on Patient Safety issues and the Trust was above average on this issue. The biggest area in the Trust was still culture and bullying.

Ms Ramsay advised that there were no Whistleblowing links to Freedom to Speak up issues and that they were all individual cases.

Resolved:
The Board received and accepted the report.

24 Standing Orders

Ms Ramsay presented the report and advised that the Trust Seal had been used and the details were in the report of when and why. She advised that one of the documents had only required one signature and this had been highlighted in the report.

Mr Hall asked about the premises being used in Witty Street and Ms Ramsay advised that it was a storage facility.

Ms Ramsay also advised that she had updated the Roles and Responsibilities of lead Directors which included the Non-Executive roles and the Caldicott Guardian changes.

Resolved:
The Board received and accepted the report.

25 Any Other Business

There was no other business discussed.

26 Any questions from members of the public

There were no questions received from the 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

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (January 2020)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
November 2019						
Nov 2019	Nursing and Midwifery Report	Red Flag trend analysis to be added to the next report	BG	January 2020		
		Mrs Christmas to discuss the safeguarding Red Flags with Ms Rudston	TC	TBC		
	Trust Strategy Implementation	Summary arrow to be added to show whether standards were improving or not	JM	May 2020		
	7 Day Services Report	Trust benchmarking information to be presented to the Board	MP	March 2020		
COMPLETED						

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
November 2019						
Nov 2019	Research and Innovation	Income generation and how it is used to be discussed at PAF	LB			
	Nursing and Midwifery Report	Rag ratings to be discussed at the Quality Committee	BG			
	Finance	Health Group underlying positions to be discussed at PAF	LB			

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		
	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									

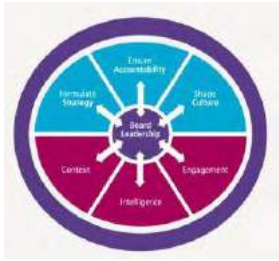
Other topics to consider:
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

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 co mon purpose?
- Is there an understanding the impact the Trust Board has on the succ ss 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 ve continually improve them?
- How can we build further resilience, trust and honesty into our relatior ships?
- 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 'outstar ding'-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 a consistent role-models for these values and behaviours?
- What else is needed at Trust Board level in respect of behaviours? 1owards 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 ne ded

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

28 January 2020

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:	Allam donation, ICS update, Climate Emergency, ED works, Outpatients transformation, Queen's Honours	

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 28 January 2020

1. Key messages from November and December 2019

Allam family's multi-million pound health care legacy for future generations

Businessman and philanthropist Dr Assem Allam is to donate almost £8m to our Trust for the provision of world-class treatment and research facilities at Hull Royal Infirmary and Castle Hill Hospital.

The multi-million pound donation will create a centre of excellence in the care and treatment of patients with diabetes and metabolic bone diseases such as osteoporosis, a new facility to treat digestive diseases and a major expansion of robotic surgery. It will also provide additional funding for the Molecular Imaging Research Centre developed by the Daisy Appeal to help patients with cancer, heart disease and dementia at Castle Hill Hospital.

Work will begin on the new projects early in 2020, with the centres up and running by the end of 2021.

As ever the Trust is extremely grateful to Dr Allam for this generous gesture and we would like to thank him and his family formally on behalf of the Trust Board.

ICS update

The development of region-wide Integrated Care System (ICS) is one step closer with the announcement that the Humber Coast and Vale ICS has been accredited by NHS England.

The ICS aims to ensure that all 28 organisations which make up the Humber Coast and Vale partnership work together to provide joined up services based around the needs of the individual patient and not the needs of organisations. It enables a more collaborative approach to managing resources between hospital services, community providers, local authorities and CCGs.

From our perspective we are continuing to work with our acute partners in ensuring that all patients receive the best care inside hospital and that they can be discharged back into the most appropriate services outside of hospital as appropriate.

Climate Emergency

Our Trust is keen to support both Hull City Council and the East Riding of Yorkshire Council in their goal to be carbon neutral by 2030. Hull City Council is one of a number of organisations to have declared a formal climate emergency. As the region's largest employer and provider of healthcare services to over 1,000,000 patients we have a moral and corporate obligation to reduce carbon emissions to preserve and improve the health of all hospital users.

It is our intention to follow other public organisations in declaring a climate emergency and in doing so state the measures we intend to take in order to realise this ambition.

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 together more closely after Hull University Teaching Hospitals NHS 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.

Senior clinicians will work with NHS Improvement to review clinician feedback and formalise a plan to drive forward real and lasting change which will benefit patients.

First unit of its kind in the country opens at Castle Hill Hospital
Our new social care unit, the first of its kind in the country to help patients regain independence after stays in hospital, has been set up at Castle Hill Hospital

The 14-bed facility, set up by East Riding of Yorkshire Council, will help people who are well enough to 'step down' from the intensive support provided by Hull University Teaching Hospitals NHS Trust but can't go home until out-of-hospital support is in place.

The East Riding Social Care Suite aims to reduce pressure on both Hull Royal infirmary and Castle Hill Hospital by providing additional capacity for people who need a little more support.

People invited to spend time in the suite will have short-term care and support, able to take part in a range of activities to show them what is available close to their homes. They are being given advice on how to live healthily and independently for longer.

MBE for David Haire
David Haire, Project Director (Fundraising) for Hull University Teaching Hospitals NHS Trust has been awarded an MBE for services to patients and staff in East Yorkshire.

David, from Hull, has enjoyed a long and varied career since starting out as an administrative trainee at Hull's Hull Princess Royal Hospital in 1967.

Within 15 years he had become the Planning Manager for the District Health Authority responsible for community, mental health and hospitals. But it was as Director of Operations for Hull and East Yorkshire Hospitals NHS Trust in 1999 where David's influence really began to be felt. He was the driving force behind many key developments, including the Women and Children's Hospital, the Eye Hospital, the Queen's Centre for Oncology and Haematology and the Cardiac Centre.

Furthermore, he drove the construction of a world class research facility at Castle Hill with the construction of the Daisy Centre.

More recently he has helped to establish the WISHH (Working Independently to support Hull Hospitals) charity for the Trust.

'Streaming' introduced at Hull's Emergency Department to prioritise sickest patients
People who turn up at our Emergency Department with minor conditions are to be redirected to other services this winter to ease the pressure on emergency services.

Our Trust has introduced "patient streaming" at the front door of the Emergency Department to ensure people in need of emergency care are prioritised.

Every person attending the department in the future will be met by a senior nurse known as a “nurse navigator” within 15 minutes who will determine the most appropriate place for them to be treated. That could include services away from the Emergency Department, such as another service based at the hospital or in the community.

Anyone using the Emergency Department for minor illnesses and injuries because they cannot get an appointment with their GP will be re-directed to an appropriate alternative service in the community.

Major transformation of Hull Royal’s ground floor almost complete
A £1.5m transformation of Hull Royal Infirmary’s ground floor to ensure patients are seen by the right health professional in the shortest possible time is almost complete..

Our Trust has undertaken a major project to expand our assessment and diagnostic area and introduce a new patient streaming area to ensure people are directed to the correct service as soon as they arrive at Hull Royal Infirmary.

Construction work of the ground floor projects was completed in December, to enable patients to access the new facilities.

The work has been possible after the trust was successful in securing funding from the Department of Health and Social Care as part of its winter planning.

A new Surgical Ambulatory Care Unit has been built on the side of the existing Ambulatory Care Unit with two consulting rooms and two treatment rooms where minor surgical procedures, formerly carried out in the Fracture Clinic or A&E, can be carried out.

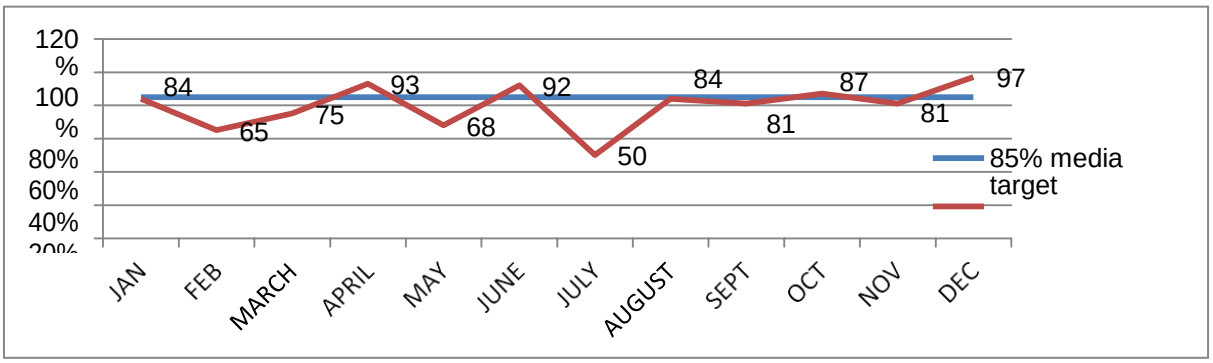
The Acute Medical Unit has also been extended to include two additional six-bay units to give additional assessment capacity.

A new front entrance allowing people to come straight to the Emergency Care area with minor illnesses and injuries will open in February. In addition, a new MRI centre, built on the site of the former chapel, will be opened on the ground floor to reduce the number of in-patients being taken outside to the existing MRI building at Hull Royal. Another CT scan room will also be created on the ground floor to extend the current Emergency Department CT facility and that will be opened by March.

2. Media Coverage

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

In November 81% of our media coverage was positive and in December 97% 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.



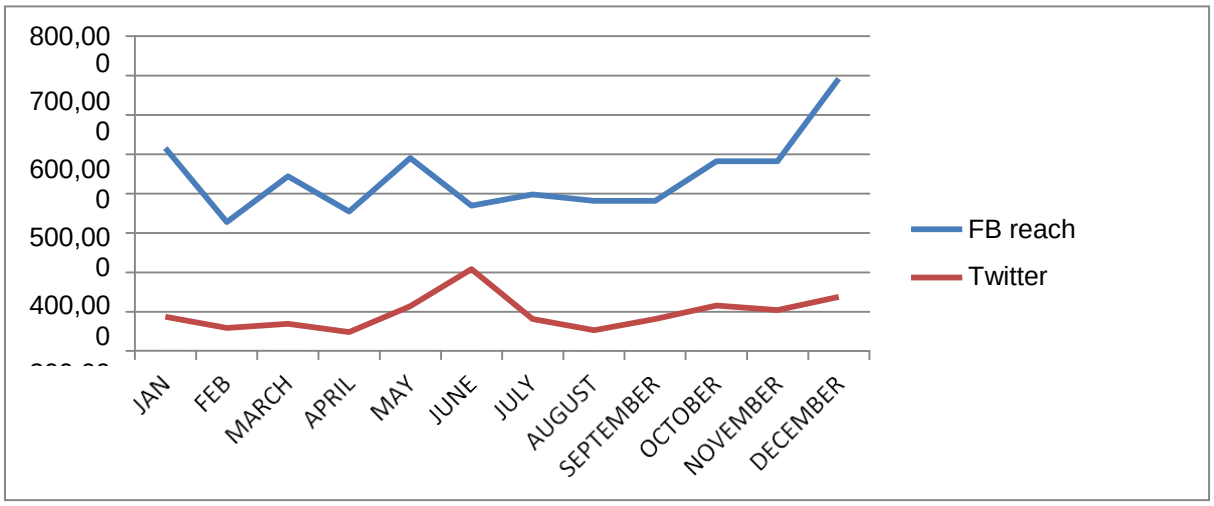
Facebook reach is the number of people that have seen content within a certain period, it can also be called unique impressions.

- In November total "reach" for all posts on trust Facebook pages was 481,491
- In December total "reach" for all posts on trust Facebook pages was 691,176

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 103,500 (November)
- @HEYNHS Twitter account impressions 136,600 (December)

Social media reach and impressions November 2019 - December 2019



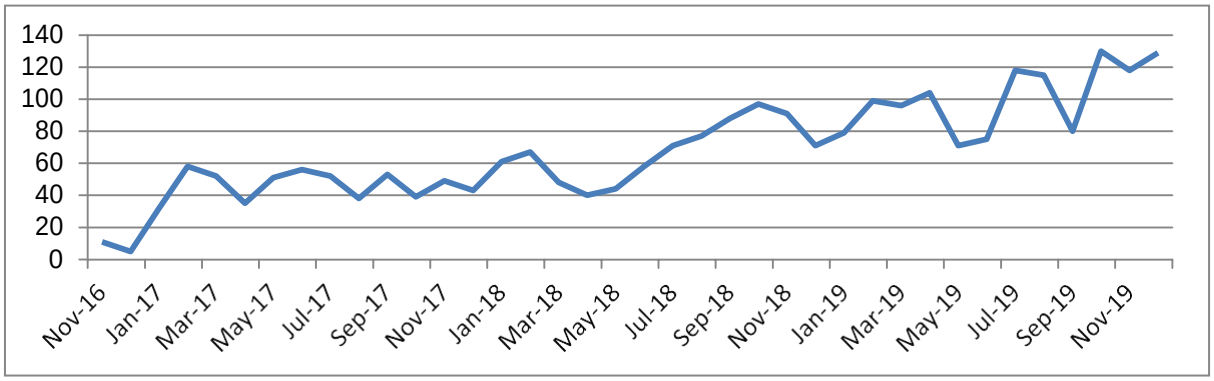
3. Moments of Magic

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 November and December 2019 we received 118 and 129 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



LONG TERM GOALS - December 2019 data

Hull University Teaching Hospitals NHS Trust

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance December	Trend v Previous Month
R	Never Events	0	2	↑
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	80	28	-
R	Safety Thermometer - Harm Free Care	95%	93.76%	↓
R	Venous Thromboembolism (VTE) Risk Assessment (Q2 1920)	95%	92.29%	↓
G	Mortality - HSMR (October 2019)	<100	86.5	↓
G	Friends & Family Test - Inpatients (November 19 - Trust v National %)	95.80%	98.00%	↑
R	Friends & Family Test - Emergency Department (November 19 - Trust v National %)	84.02%	78.89%	↓

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

Workforce

RAG	Indicator	Target	Performance December	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.50%	↑
G	Staff Sickness	<3.9%	3.58%	↓
G	Staff Vacancies	<5.0%	4.94%	↑
R	Staff WTE in post (<0.5% from Plan)	7535	7663	↓
R	Staff Appraisals - AFC Staff	85%	80.80%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	92.20%	↓
G	Statutory/Mandatory Training	85%	92.10%	↑
G	Temporary Staff/Bank/Overtime costs (Medical YTD)	11.142m	10.591m	-
G	Staff: Friends & Family Test - Place of Work (Q1 1920 v National)	66%	68%	↓
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 December	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	82.97%	69.66%	↓
G	52 Week Referral To Treatment Breaches	0	0	0	↓
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	10.71%	↑
R	Emergency Department: 4 Hour Wait Standard	95%	85.0%	59.58%	↓
R	Cancer: 62 Days Referral To Treatment (November Data)	85%	79.41%	68.00%	↓
G	Length of Stay (August Data)	<5.2	-	4.9	↓
R	Clearance Times	12 weeks	-	17.2	↓
G	Waiting List Size	52,800	52,850	52,757	↓
G	Available Clinic Slot Utilisation	80%	-	90.50%	↓
R	Theatre Utilisation	90%	-	81.10%	↓
R	Appointment Slot Issues	35% (TBC)	-	46.75%	↓

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

Finance

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Capital Expenditure	12m	9.9m	↑
G	Statement of Comprehensive Income Plan - Year to Date	4.208m	4.208m	-
R	CRES Achievement Against Plan	11.838m	11.237m	-
R	Invoices paid within target - Non NHS	95%	92.9%	↑
R	Invoices paid within target - NHS	95%	84.7%	↑
A	Risk Rating	1	2	→

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

Hull University Teaching Hospitals NHS Trust

Trust Board

28 January 2020

Title:	Standing Orders
Responsible Director:	Director of Corporate Affairs – Carla Ramsay
Author:	Director of Corporate Affairs – Carla Ramsay

Purpose:	To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary of Key Issues:	The Trust's seal has been used, for review by the Trust Board. The (EU) thresholds for tenders have been revised. The Trust Board is asked to approve amendments to these new thresholds, as detailed in the paper, to bring Trust Standing Orders in line with new procurement requirements.	

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal • Approve amendments to Standing Financial Instructions in Standing Orders for new procurement threshold values and the simplification of the OJEU tender table

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
2019/24	Settlement and variation agreement in respect of replacement water mains works arising under a project agreement entered into between Healthcare Solutions Hull Ltd and HUTH	8/11/19	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2019/25	Hull University Teaching Hospitals NHS Trust and the East Riding of Yorkshire Council – Lease of Suite 20, Castle Hill Hospital, Castle Road, Cottingham	13/12/19	Teresa Cope, Acting CEO and Carla Ramsay, Director of Corporate Affairs

3 Amendments to Standing Orders

The (EU) Public Contract Regulations review tender threshold values every two years. A new set of values are applicable from 1 January 2020. There is also a simplified version of where OJEU tender thresholds are applicable.

The Board is asked to approve the following amendments to Trust Standing Orders, including Standing Financial Instructions and the Financial Scheme of Delegation, where these values are referenced.

The value at which tendering is required has changed from £118,133 to £122,976

The value of a programme of "works" has changed from £4,551,413 to £4,733,252

The table of 6 OJEU limits has been simplified to 2 limits

Old table of OJEU tender limits:

Goods and Services – central procurement including NHS Trusts	£118,133
Goods and service sub central government (including NHS foundation Trusts)	£164,176
Goods and services – utilities and defence	£328,352
Light touch regime services – public sector rules	£589,148
Light touch regime services – utilities	£785,530
Works	£4,551,413

To be replaced with (incorporating the new values, detailed above):

Goods and Services – central procurement including NHS Trusts	£122,976
Works	£4,733,252

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve amendments to Standing Financial Instructions in Standing Orders for new procurement threshold values and the simplification of the OJEU tender table

Carla Ramsay
Director of Corporate Affairs
January 2020

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 28 January 2020

Title:	Trust Board agenda and constitutional matters
Responsible Director:	Terry Moran CB - Chairman Chris Long – Chief Executive
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	To provide a written briefing note on key actions to be taken following a Board Development session regarding the Board agenda structure, proposal for a Trust Board Workforce Committee and increased staff and patient involvement at Trust Board. This briefing note also makes a proposal regarding the Trust Board structure to best support the prioritised focus on workforce, which will require application for an amendment to the Trust's Establishment Order.	
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:	Following the Board Development session on 26 November 2019, a number of principles were agreed regarding the Board agenda structure, proposal for a Trust Board Workforce Committee and increased staff and patient involvement at Trust Board. This briefing note summarises how these are being enacted. This briefing note also makes a proposal regarding the Trust Board structure to best support the prioritised focus on workforce, which will require application for an amendment to the Trust's Establishment Order.	

Recommendation:	The Trust Board supports the implementation of these actions, and specific recommendations at Section 4 of this paper, including required changes to Trust Standing Orders, to establish a new Trust Board Committee.

Hull University Teaching Hospitals NHS Trust

Trust Board Structure, Agenda, Board Committees and Patient Involvement

1. Purpose of the paper

The purpose of this paper is to make a number of proposals regarding the Trust Board, following recent discussions amongst Board members, and a formal discussion at the Board Development session 26 November 2019.

2. Background

The biggest enabler to the Trust's ability to deliver its strategy and strategic objectives centres is its workforce, reflected in the Trust's refreshed Strategy 2019-2022, where the Trust's work on organisational culture, values and staff engagement continue. The Trust's refreshed strategy also included a new strategic objective on Research and Innovation.

Separately to this, the Chief Executive prepared a briefing note, circulated to Board members three months' ago, on some potential changes to the Trust Board agenda structure, to provide more time for strategic discussion by the Trust Board, and to make best use of the Trust Board Committee structure to provide oversight and assurance up to the Trust Board on their areas of specialism.

This was discussed at the Trust Board development session on 26 November 2019 and the main principles of the proposal were agreed.

3. Changes to be enacted

3.1 Trust Board Agenda Structure

Following a proposal circulated by the Chief Executive in October 2019, the Board considered the structure and effectiveness of the Trust Board agenda at its Board Development session on 26 November 2019. The following changes were agreed, to trial for at least a six month period (therefore covering 3 Trust Board meetings), and review further:

- To change the main agenda sections per the model attached at Appendix 1
- To include an agenda item at each public Trust Board from a team within the Trust, to showcase the work of the team, to share staff experience of working in that area, as well as to include patient experience and patient voice where possible
- To spend more time on strategy delivery and understanding of board assurance

The Board is not to lose sight of issues that require Board-level oversight or sign-off, but to keep the balance of board time on collective discussion and decision-making against the Trust's strategy and delivery, and risks to delivery of its strategic objectives. The Board Secretary will work with the Chairman to ensure all necessary Board business is conducted, but in a way that is in keeping with these principles and agenda format.

As discussed at the Board Development session, this may also require a change in the way Executive members present papers and the way in which issues are discussed, so as to focus the discussion on strategic elements, assurance and risk, rather than information-giving or briefing. There will be the need for more effective summaries as front-sheet to Board Committee minutes, and for the Non-Executive Chairs of the Committees to talk to these and raise points of exception. The Board Secretary will facilitate the latter part, and can help advise on the way in which Board items are presented as discussed as a work in progress during the trial period, to see that the above principles are achieved.

3.2 Workforce

At present, the Trust Board has oversight of workforce and culture issues, and key issues and metrics are reviewed in more detail between the Trust Board's Performance and Finance Committee and Quality Committee.

The Performance and Finance Committee review workforce recruitment and retention, costs associated with the workforce and oversight of key workforce metrics. This focuses on tracking performance over time and understanding actions being taken to address any exceptions. Through its work, the Quality Committee has identified a specific need for Board-level review of organisational learning culture and capability, the quality of education and training across the Trust, which is outside of the core purpose of the Quality Committee but an identified need.

There is no Board-level Committee that has oversight of workforce, culture and organisational development in the round and what this means in respect of delivering the Trust's overall strategy and the Trust's People Strategy. Considering the importance of our workforce and the work on-going to create a values-based, high performing organisation, the proposal to create a Board specific committee seems logical and necessary to focus on all workforce related matters.

A draft set of Terms of Reference for a new Trust Board Workforce, Education and Culture Committee is attached. This takes some elements currently taken from the Scheme of Delegation from the Performance and Finance and Quality Committees' Terms of Reference, therefore if adopted, the Board is agreeing to a) set up a new Trust Board Committee b) agree the set of Terms of Reference and c) amend the Terms of Reference for the Performance and Finance and Quality Committees, as marked in the draft Terms of Reference attached at Appendix 2.

3.3 Director of Workforce and Organisational Development role
Currently, the HUTH Trust Board consists:

- One Non-Executive Chairman
- 6 additional Non-Executive Directors, one of whom is appointed from the University of Hull
- 5 Executive Directors (Chief Executive, Chief Medical Officer, Chief Nurse, Chief Operating Officer, Chief Financial Officer)

HUTH continues on a journey of improvement on staff culture; staff recruitment, engagement, inclusion, development and wellbeing are core to the Trust's current vision, mission and strategy. As outlined above, a new Trust Board Workforce Education and Culture Committee is being established to take delegated responsibly for staff culture, engagement, the quality of education and teaching, and recruitment and retention. This new Trust Board Committee will streamline governance associated with workforce and culture (currently discharged by the Trust Board, the Performance and Finance Committee and the Quality Committee collectively) as well as workforce and organisational development specifically as Board business and a key strategic enabler.

At present, the role of the Director of Workforce and Organisational Development is a non-voting Board member role. As a result of this increased profile and recognition of workforce and culture at Board level, and the establishment of a new Board Committee with delegated responsibility for this area, it would be prudent to change the Director of Workforce and Organisational Development role to be a voting executive role at the Trust Board, and be the executive-side lead associated with this Board Committee. This change will require a request to amend the Trust's Establishment Order to increase the number of Executive posts by one.

This increase of executive voting roles will still retain the Non-Executive majority membership required of all NHS Trusts. However, an additional Board Committee will require an additional time commitment of Non-Executive Directors to support this; alongside this, the current time commitment of Non-Executive Directors to the various requirements within the Trust, above and beyond attendance at Trust Board and Committee meetings, may necessitate the request for an amendment to the Establishment Order to also include an additional Non-Executive Director, to ensure that the workload can be managed across the Non-Executive Director cohort, make best use of all Non-Executives' skills-sets, as well as spread the workload as equally as possible. This is under review at the present time.

3.4 Patient and Staff Voice

There was a discussion at the Board Development session on how to increase patient and staff voice at Board meetings.

In respect of staff voice, it was agreed at the Board Development session that there should be attendance and discussion with a team from the Trust at each Trust Board meeting, with a view to bringing the Board closer to the views of staff, the quality of care being delivered in the Trust and how the Board can support staff in delivering patient care. Through meeting with a staff team at each meeting, this would by extension bring in some elements of patient experience, and patient reps would be welcome to attend with the team if it was felt this would be appropriate to the discussion.

In relation to patient voice, an invitation to the Chair of the Patient Council to come to Board meetings as a co-opted member was also discussed and was agreed to be trialled also. Concerns were raised that this could concentrate patient voice down to one individual and the contacts points of the Patient Council, and not wishing to put further time pressures on the Patient Council Chair, so this will be reviewed alongside the other changes being made, after 6 months.

4. Recommendations

It is recommended that the following actions take place:

- The principles of the new format Board agenda, including staff and patient voice, are adopted for the January 2020 Trust Board and used for the following two Trust Board meetings, then reviewed
- TheWorkforce, Education and Culture Committee established per the draft set of Terms of Reference, for a start in February 2020, and to meet every two months thereafter
- If the Workforce, Education and Culture Committee is approved, for the appended draft Terms of Reference to be approved, and for relevant changes to Trust Standing Orders to be made
- That an application is made for an amendment to the Trust's Establishment Order for the Director of Workforce and Organisational Development post to become an Executive Director (voting) post, and consideration given to increase the number of Non-Executive Directors by one through the same or future application
- That the Chair of the Patient Council invited to attend the next 3 Trust Board meetings

Carla Ramsay
January 2020

Appendix 1

Trust Board agenda – format from January 2020 (Chief Executive's Briefing note)

1. Apologies
2. Declarations of Interest
3. Minutes of Previous Meeting
4. Matters arising
5. Chair's opening remarks
6. Chief Executive's Briefing. This will start with a verbal update on what is happening at national level, regional level and the ICS and a general update on how the Trust is and the feel of the place. The written report will also incorporate any governance issues such as use of the seal, changes to standing orders etc. The balanced scorecard in this report becomes the de facto finance and performance report seen by the Board *[Trust Secretary's note: current work in progress]*.
7. Governance
    a. Escalation report from Audit Chair
    b. Escalation report from PAF Chair
8. GREAT STAFF
    a. A briefing from one of the front line teams on how it feels to work for us. This could be the sister, a staff nurse and a HCA from one of the wards, three people from one of our theatres, etc. The Board's role is to listen to them; the team can make one (reasonable) "ask" of the Board to make things easier for them - the Board enacts that.
    b. All other workforce reports have already been through the Workforce Committee and therefore they do not need to come to the Board for full discussion. This includes WRES, WDES, staff survey etc. The chair of the Workforce Committee brings a one-page summary of "issues for escalation" to the full Board, including a recommendation of statutory requirements that have been through the Workforce Committee that require specific Board approval, which will be attached to this escalation report.
9. GREAT CARE
    a. The Chair of the Patient Council tells us what they are seeing and hearing. They presents the "patient story(ies)".
    b. Similar to 7b above. All nurse staffing, quality patient experience reports have been through the Quality Committee and the Committee chair brings an escalation report to the full Board.
10. GREAT FUTURE
    a. Review of chosen BAF item

b. Review of chosen BAF item

11. By exception, any other report the Board really needs to see. Examples include EU Exit report, annual operating plan, with the Audit Committee providing a supporting role if an item can be delegated in advance

12. Chairman's summing up of business discussed

13. Any other business

14. Questions from the public

Appendix 2

Hull University Teaching Hospitals NHS Trust

Trust Board Workforce, Education and Culture Committee

Draft Terms of Reference

1. Formation of this Committee

The Workforce, Education and Culture Committee is a Committee of the Trust Board and has been established in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee has formal terms of reference and powers as delegated by the Trust Board.

2. Role

The Committee is responsible for seeking assurance on the delivery of the Trust's People Strategy, the quality of teaching and education within the Trust and the ongoing work to improve staff engagement and the culture of the organisation.

3. Responsibilities

3.1 To gain regular assurance on the People Strategy, including key workforce metrics as well as the key objectives and strands within the Strategy

3.2 To gain regular assurance on the Trust's current workforce position as it relates to the People Strategy and plans for delivery, as well as the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce

3.3 To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey and Staff Engagement, and to link this to the delivery and outputs required of the People Strategy, particularly with regard to inclusion and wellbeing

3.4 To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes

3.5 To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including staff satisfaction, including the delivery of action plans to address any gaps identified through feedback

3.6 To review items of workforce planning and statutory workforce compliance on behalf of the Board, including lessons learned and action plans, for recommendation to be approved at the Trust Board

3.7 To ensure that the Board is informed of significant issues, underperformance, and deviation from plans that would constitute a particular risk to the delivery of the Trust's People Strategy, and to provide assurance on action being taken

3.8 To seek assurance that agreed delivery plans are being implemented in a timely fashion and delivering the required outcomes

3.9 To provide oversight of progress against the Trust's Research and Innovation strategy, including key enablers and risks

3.10 Review the risks on the Board Assurance Framework relevant to the remit of the Committee ensure that controls are in place and mitigating action is effective, and that positive assurance is received where appropriate

4. Membership of the Committee

The Committee shall comprise:

- Non-Executive Director (Chair)
- 2 Non-Executive Directors (one of whom will be designated as vice chair)
- Director of Workforce & Organisational Development
- Chief Medical Officer
- Chief Nurse Officer

Other officers will be invited to attend the Committee to speak to specific agenda items, which can include, amongst others:

- Director of Post Graduate Medical Education
- Director of Undergraduate Medical Education
- Guardian of Safe Working

It is expected that all members will attend at least 4 out of 6 committee meetings per financial year. If Executive Directors are unable to attend a meeting they will be represented by a deputy who has the authority to make decisions on their behalf.

An attendance record will be submitted to the Committee for information and action at each meeting.

The Trust Board will ensure that the Committee membership is refreshed and that undue reliance is not placed on particular individuals when undertaking the responsibilities of the Committee.

5. Chairman of the Committee

The Chairman and Vice Chairman of the committee shall be Non-Executive Directors.

6. Quorum

The quorum shall be a minimum of 3 out of 6 members. Of these, two must be Non-Executive Directors as well as one Executive Director. In the event of a vote being taken where an equal number of Non-Executive and Executive Directors are in attendance, the Non-Executive Chairman will have a casting vote.

7. Meetings

The Committee shall meet 6 times a year. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

8. Attendance at meetings

Other senior employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that post-holder.

9. Notice of meetings

Meetings of the Committee shall be set in advance of the calendar year by the Corporate Affairs team. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

10. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced in the standard agreed format of the Trust and kept by the Corporate Affairs team.

11. Reporting Arrangements

The proceedings of each meeting of the Committee shall be reported to next meeting of the Board following production of the minutes. The Chair of the meeting shall draw the attention of the Board to any issues that require disclosure or require Board action. The Chair is required to inform the Board on any exceptions to the annual work plan or strategy.

12. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

12.1 Produce an annual work plan in the agreed Trust format, in line with the objectives set, for approval by the Trust Board.

12.2 Produce an annual report setting out the achievements of the committee and any gaps in control or effectiveness of reporting arrangements

12.3 Communicate and consult with the Health Groups and Directorates in achieving the objectives of the annual work plan, policy or strategy.

12.4 Monitor, review and recommend any changes to the terms of reference annually to the Trust Board

13. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek the information it requires from any employee, and all employees are directed to co-operate with any request made by the committee, including representation where appropriate at Committee Meetings.

The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust.

14. Relationship with Other Committees

The Committee will work closely with the Trust's Quality Committee, for the link between workforce and high quality care. The Committee should work with the Performance and Finance Committee where any significant or growing risk exists around performance, service delivery and the People Strategy.

The Committee may refer issues to the Audit Committee or be requested to consider issues raised by the Audit Committee.

15. Administration

The Committee is supported administratively by the Corporate Affairs team, who will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the Committee.

Date last approved by Trust Board:	TBC
Date updates received by Trust Board:	
Review date:	January 2021

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Extra Ordinary Performance and Finance

Meeting Date:	7 November 2019	**Chair:**	Stuart Hall - NED	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:
The Committee met to take stock of Health Group performance after 6 months of delivery and the forward view for the rest of the year.

Each Health Group presented their progress against the six standards listed below as well as a projected year end position.

Referral to Treatment

1. 50% reduction in Holding / ASI list size
2. Incomplete list size to be no greater than March 2019 baseline by March 2020
3. 50% reduction in Outpatient follow up backlog >3 months
4. Maintain zero 52 week waits

Cancer Waiting Times

5. Delivery of the 62 day performance trajectory to meet the 85% standard by March 2020
6. Reduction in >104 day waiters to a maximum of 5 by March 2020 (excluding late transfers from other organisations)

Key decisions made:
The Committee decided that the stock-take needs to be followed up in the exception reports at subsequent Performance and Finance Committees each month including how the issues raised are being addressed.

Risk and assurance matters to be received by the Board:
The Trust anticipates meeting the no increase in RTT list size requirement, will maintain zero 52 week breaches and the 104 day cancer targets. The Trust will make overall reductions in ASI/holding and the follow-up backlog but not the overall 50%; likewise the Trust will make progress against 62-day cancer standard but not the full progress requirement. The position against baseline shows achievement of 3/6 targets but progress against all 6.

Matters to be escalated to the Board:
None

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Extraordinary meeting held on 7 November 2019

Present:	Mr S Hall	Vice Chair/Non-Executive Director (meeting chair)
	Mr T Curry	Non-Executive Director (committee chair)
	Mrs T Christmas	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
In Attendance:	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Ms L Topliss	Head of Performance
	Ms C Ramsay	Director of Corporate Affairs (action notes)
	Ms D Dyble	Divisional General Manager – General Medicine (during Medicine Health Group presentation only)
	Mr S Smyth	Divisional General Manager – Specialist Medicine (during Medicine Health Group presentation only)
	Mr J Wood	Director of Operations - Cancer and Clinical Support Health Group (during Health Group presentation only)
	Ms M Veitch	Director of Operations Surgery Health Group (during Health Group presentation only)
	Dr C Hibbert	Joint Medical Director Surgery Health Group (during Health Group presentation only)
	Mr B Willingham	Management Trainee, Surgery Health Group (during Health Group presentation only)
	Ms J Mizon-Harrison	Director of Operations, Family and Women's Health Group (during Health Group presentation only)
	Mr C Vize	Medical Director, Family and Women's Health Group (during Health Group presentation only)

Action

Mr Hall set the scene for the purpose of the extraordinary meeting, which was as a stock take after 6 months of delivery, and the forward view for the rest of the year.

Ms Cope set an overview of the Trust's elective care priorities for 2019-20; the overview from each Health Group at today's meeting will report progress and a projected year-end position against the following six standards:

Referral to Treatment

1. 50% reduction in Holding / ASI list size
2. Incomplete list size to be no greater than March 2019 baseline by March 2020
3. 50% reduction in Outpatient follow up backlog >3 months
4. Maintain zero 52 week waits

Cancer Waiting Times

5. Delivery of the 62 day performance trajectory to meet the 85% standard by March 2020
6. Reduction in >104 day waiters to a maximum of 5 by March 2020 (excluding late transfers from other organisations)

Ms Cope confirmed that the Trust's PTL (waiting list) does include all patients on the ASI/holding list.

In respect of an overview, the month 6 position is that the Trust is not yet meeting the ASI and holding and RTT ambition; there are improvements in cancer 62-day and the Trust has had zero 52-week breaches this year. The position in each Health Group is varied. The increase in two week-wait cancer referrals is above the growth built in to the contract. Across services, very good progress has been made in Advice and Guidance. Ms Drury confirmed that there are two tariff rates for advice and guidance and is built in to all contracts now: the higher tariff is for advice and guidance received within 2 days, with the lower tariff for advice and guidance responses within 7 days.

The national requirements are increasingly focused on waiting list size rather than 18-weeks percentage. The Trust's position on 92% 18-weeks has deteriorated. The Trust will get back on track on waiting list volume. Whilst the total waiting list size has not grown significantly, performance has deteriorated. This is due to longer waiting times for diagnostics and treatment due in part by accommodating increasing amounts of urgent work and cancer work.

In respect of the outpatient follow up backlog, there was an engagement event two weeks ago between Consultants and GPs to talk about different ways of managing outpatient requirements. The Trust has a backlog of circa 38,000 appointments at present.

The Trust has maintained its position in 52-weeks but the number of patients waiting over 36 weeks is increasing, which increases the risk of breaches.

The Health Groups were to give a breakdown of targets and a projected year-end position in each of their presentations.

Medicine Health Group

The team from Medicine Health Groups worked through the key points in their presentation (held on file).

Medicine Health Group carries most risk in cardiology; Mr Smyth reported the work with the Trust's Improvement Team and on validation is having a positive effect, however, the service has the fifth longest waiting times out of 137 cardiology providers. The service needs to achieve 67 more clock stops per week to manage the current position and 125 clock more stops per week to the end of the year to achieve the baseline requirement. There is a plan to deliver as much of this as possible through validation and extra sessions.

There was an initial spike in referrals to the Trust following a change in community service provision, but this is now resolved. However, as with two week- waits (2WW) in cancer services, the Rapid Access Chest Pain Clinic (RACPC) referrals are growing. The service is putting on additional capacity almost weekly to meet this demand. Mr Smyth has not noted a particular decrease in diagnosis rate from this increase in referrals. Following a deep dive

into cardiology, there is a need for review of clinical models and investment/reconfiguration of service. Cardiology has just started with Advice and Guidance and has talked about triage prior to appointment but resources in job plans do not yet allow for this. There is a risk from the anticipated closure of the academic cardiology service but a plan in place to mitigate against this in respect of delivering a heart failure service.

In respect of respiratory medicine, the service is aiming to maintain zero 52-week, cancer 2WW and 104 day cancer targets, and is holding a time out in two-weeks' time to look at other models and delivery of outpatient appointments, including the need for outpatient follow-up; specialist nurses are having an impact on being able to offer telephone follow-up, which is proving very popular with patients.

Overall, Medicine Health Group:

- Anticipates meeting the 52-week target to year-end
- Rheumatology will meet all requirements
- The 50% reduction in follow-up backlog will be achieved in medical elderly, neurology, respiratory, rheumatology, stroke and TIA
- As a Health Group, cardiology has the largest impact across as the volumes of patients are significant
- Reduction in RTT should be met in all areas except cardiology and neurology
- As a Health Group the reduction in ASI/holding will be achieved despite cardiology numbers

In respect of finance, the Medicine Health Group has identified 74% of CRES target as at Month 6 (risk adjusted). CRES is maintained by short-term vacancies or temporary gains, which will need recurrent CRES schemes. Cardiology is still benefiting from bulk deals and there is further potential with this; Scan4Safety has produced 6 months of data and helped give granularity to help change practice and these will be captured as recurrent CRES.

Following a question from Mr Curry, Mr Hall confirmed that the detail and monitoring of this stock-take will be referred to the exception reporting at P&F Committee, including a question on assurance as to whether the positions being outlined today are being achieved.

Mr Gore asked about the impact of referrals from Northern Lincolnshire and Goole NHS Foundation Trust (NLAG); Ms Dyble confirmed that these were not material for general medicine services; Mr Smyth confirmed that there are some issues in cardiology but these are managed on a case-by-case basis.

Cancer and Clinical Support Health Group
Mr Wood noted the key points from the Health Group presentation (held on file).

In summary, the anticipated year-end position for the Health Group will be that all standards will be met.

Within the Health Group, imaging and cellular pathology have a responsibility to support the other Health Groups to meet their cancer targets; the Health Group has particular pressures in cellular pathology and particular types of imaging, which is impacting on the ability of the other Health Groups to meet their targets.

In chemical pathology, there was a recovery plan in place for the follow up

backlog and RTT list size; the HG will look to get ahead in chemical pathology so as to have more resilience with peaks in referrals, when these occur.

There are service pressures caused by the transfer of work from NLAG in immunology, oncology and haematology as well as staffing pressures within the Trust in haematology and oncology, reflecting a significant shortfall nationally of Consultant staff. Mr Hall asked for confirmation that it is the Trust's decision to change models of delivery in order to maximise Consultant and medical staffing resources; Mr Wood confirmed that it was. The Health Group is also working closer with referring specialities internally to understand what the best diagnostic test would be to meet the clinical need.

The GIRFT meeting in Radiology noted that the Trust was an outlier for Head CT and abdominal x-rays; work is being undertaken to prioritise diagnostic scans, including outsourcing capacity if/where possible and appropriate.

Overall, the Health Group is offering assurance that all improvement trajectories will be met at Month 12.

In respect of CRES, the Health Group has identified 71% of its CRES target (risk-adjusted). Mr Wood explained the situation with pass-through savings and currently the Health Group maintains vacancies as non-recurrent, even though the vacancies might be long-standing.

Mr Hall reiterated that the purpose of the meeting today is to understand that the Health Group has grip of the situation, has strategies to manage the position and this appears to be the case with CCSHG. Mr Hall asked if the Health Group can or is planning for the unknown elements; Mr Wood outlined that the Health Group has faced a number of operational challenges this year and the Health Group has responded to these; Mr Wood stated that the Health Group is maximising its resources and is thinking ahead to future demands, recruitment challenges and different models of delivery.

Surgery Health Group
Ms Vietch provided the overview of the HG position to M6 (presentation held on file).

In respect of outpatient follow-up backlog (OPFU), the Health Group has made more progress since month 6, which is per the Health Group's plans. The position in the first half of the year worsened, was gripped and has been improved, with plans to further improve past the baseline position. The Health Group outlined the actions being taken on validation. The Health Group monitors the 36 week position closely; around one-third of the long-waiting patients in Surgery Health Group are in urology; upper GI and colorectal have been impacted also by an increase in cancer referrals.

The Health Group has improved the governance structure and put in place relevant meetings and a project management structure to provide assurance and understanding in the Health Group. The ability to do more however is more limited as a result of the pension issue; the solutions to address shortfalls now take longer to implement. The Health Group has both lost some sessions but the ability to do more.

Ms Vietch outlined the main risks to delivery, which include late referrals from NLAG and diagnostic capacity. There are some specific risks in orthopaedic

paediatrics, the impact of lung health check on cardiac and thoracic surgery if this is greater than anticipated, and continued growth of 2WW referrals in colorectal surgery.

Ms Cope raised that there is a significant concern on the inter-hospital referrals and there is a compliance issue with this process with NLAG. HUTH is the only Trust in the STP that has maintained the zero 52-week position and is working hard to maintain this.

Ms Vietch confirmed that the impact on the SHG from NLAG referrals was not material in terms of volumes but is material in respect of the resource in the Trust to resolve each late referral. Of the three specialties that are projected a year-end position where all standards are not met, Ms Vietch confirmed there are plans in train to make improvements but may not resolve the issues fully.

Ms Vietch and Dr Hibbert confirmed that the greatest concern access to diagnostics to help with cancer waiting times. Ms Vietch confirmed that there is a plan in place for the endoscopy capacity issues; vascular and interventional radiology are also a concern – the Trust has the worst amputation rate in the country; in terms of patient impact, this is one of the largest concerns.

The ageing Trust infrastructure also cause increasing issues, such as the leaks in theatres, problem with steam and specific aging equipment. The Health Group has the highest theatre utilisation rate in the Trust so this leaves the Health Group much less capacity to mitigate against the impact of infrastructure failures.

In respect of CRES, 72% of the Health Group target is identified (risk-adjusted), with 85% of this being re-current. SHG has not included non-recurrent vacancies in CRES. Mr Bond raised that the Health Group underlying position has deteriorated in-year. Dr Hibbert confirmed that all specialities have had GIRFT reviews; anaesthetics is scheduled for December 2019. Ms Vietch also outlined that there are income opportunities for the rest of the year. Dr Hibbert outlined that a hybrid theatre for vascular would be a spend to save: the opportunity to do an investigation and procedure at the same time would be more efficient but this is a considerable investment. Dr Hibbert also flagged up that trauma capacity continues to affect elective capacity but cannot afford to be compromised further.

Mr Gore asked if there is an opportunity through GIRFT on day surgery and length of stay. Ms Vietch stated that there is but there is currently no more capacity in day case theatres, which is something the Health Group is looking at. In respect of pre-operative length of stay, this is something that the HG is sometimes challenged about; there are some clinical reasons to do this but is an element being reviewed by the Health Group; however on the day cancellations are the lowest in the region and part of this is bringing in more complex patients the night before.

In respect of Scan4Safety, there have been some benefits generated in CTS and potential for more, and has gone live this week in upper GI. There is more work to be done on the system as a tool.

Family and Women's Health Group
Ms Mizon-Harrison presented the Health Group position (held on file).

Many of the pressures in the Health Group are around workforce pressures, which were detailed in the presentation. From a service perspective, a particular

concern is the number of gynaecology patients waiting over 36 weeks; there is a historic aspect to the size of waiting list in this area and there is a plan to open Cedar ward 7-days per week, as well as use of Pioneer, to manage this position.

There is a plan regarding Dermatology for photography to accompany each referral to be able to triage referrals when received.

Another key area of pressure is in ophthalmology services. Whilst there is a private provider who could take some patient groups, it would not release the right sort of capacity back to the ophthalmology service. There is a risk to patients who have had cataract operations and need follow-up laser surgery, where there is a lack of capacity to treat in HUTH; there has been a move to put in place optometrists for follow up appointments, which took place last month, and should have a positive impact.

There are some opportunities with the workforce but there has been an impact across specialities from the pensions issue. There are some pressures from other areas, to work more closely with NLAG and internal HUTH services to achieve together. It was noted that the partnership work with NLAG in ENT has been positive but this is in spite of the Humber Acute Services Review. The additional time and resource needed from clinicians for HASR, on top of the clinical networking teams are already doing, was noted.

Failing equipment is now a red-rated risk in the Health Group and specific examples were given. The Trust support for the reconfiguration of paediatrics services was requested to be maintained. Ms Cope noted that the winter plan looks to protect gynaecology capacity; it has been helpful to look at long-term planning already and this has demonstrated a need to review again theatre allocations to achieve the five-year plan.

In relation to CRES, the Health Group has identified 91% CRES (risk-adjusted) however the schemes are largely non-recurrent. The process for 2020-21 and recurrent schemes has already started. The Health Group was successful in receiving the CNST reimbursement.

Ms Drury asked in respect of optometry whether it was a financial issue or an expertise issue in the community; Mr Vize confirmed that this is a financial issue that would require CCG investment and there is also an opportunity for the Local Ophthalmic Council or CCGs to help with electronic referrals/technology for optometriss to be able to access advice and guidance.

Summary
Ms Cope summarised the overall Trust position; the Trust anticipates meeting the no increase in RTT list size requirement, will maintain zero 52 week breaches and the 104 day cancer targets. The Trust will make overall reductions in ASI/holding and the follow-up backlog but not the overall 50%; likewise the Trust will make progress against 62-day cancer standard but not the full progress requirement. The position against baseline shows achievement of 3/6 targets but progress against all 6.

Mr Hall asked how the Executive team would progress this and to understand the assurance that the Executive can provide. Ms Cope responded that the Cancer and Clinical Support Health Group has a lower risk position relative to the other Health Groups. Surgery Health Group has a good grip of their issues and plans in place, putting the relative risk level around medium overall, with some areas of

lower risk. Family and Women's Health Group carries the largest volume of risk but there is good assurance on their understanding of the issues and how they will progress these issues over the next 12 months. There is good progress in Medicine Health Group but there is concern that the position in Cardiology affects the overall Health Group and Trust position to such an extent. There is a need to grip the issues and there are forthcoming changes that will help address some long-standing issues.

Mr Hall confirmed that this stock-take needs to be followed up in the exception reports at subsequent Performance and Finance Committees each month including how the issues raised today are being addressed.

Mr Hall expressed the thanks of the Committee to the Executive team and the Health Groups for this detailed piece of work and the lead this has given the Performance and Finance Committee to follow this up, and gain assurance that plans are mitigating risk and producing the anticipated outcomes coming up to year-end.

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Performance and Finance

Meeting Date:	25 November 2019	**Chair:**	Tony Curry - NED	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:
[Please summarise key points which resulted in actions being directed by the Committee.]

- Emergency Preparedness Annual Assurance Statement – A number of areas required strengthening to ensure the Trust was compliant.
- BAF – Review had taken place and CR had met with the Executives for their input
- Performance Report – good progress with 52 week waits. Still issues with ED performance, diagnostics and cancer
- Demand and Activity Report – overall referrals demand is 0.8% above the same period last year.
- Finance Report – Deficit of £0.2m which is in line with plan.
- CRES – over delivery of £0.7m
- Pension impact on consultant activity – 36 consultants had reduced their hours between June and October 2019.
- Procurement strategy – a review of shared procurement services with York, NLAG and Humber was underway.
- STP 5 year plan – outline 4 priority areas for HCV as well as control totals to achieve financial balance in 2023/24.
- Variable pay - £17.7m at month 7 (less compared to last year at the same time)
- Job Vacancy Report – consultant vacancy rate 12.2%, nursing midwifery vacancy rate 4.5%.
- Capital Resource Allocation Committee - £26m to spend

Key decisions made:
[Please record all decisions approved.]

- Emergency Preparedness Annual Assurance Statement – a review of all standards to be undertaken and the statement would be presented to the Board in January 2020 for approval
- 3 Contracts were approved by the Committee and 1 was not approved until clarity was sought around approving an already expired contract.

Risk and assurance matters to be received by the Board:
[Please record anything not captured above.]

- Finance - Surgery and F&W HG underlying positions had deteriorated in month. The finance teams are working with all the Health Groups to improve their financial positions.
- Capital risk that the Trust can deliver everything by 31 March 2020.

Matters to be escalated to the Board:
[Please itemise matters that require the Board to: be aware/take action/make a decision and specify urgency, e.g. can it wait until the Board meeting or does it need attention sooner?]

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 25 November 2019

Present:	Mr T Curry	Non-Executive Director (Chair)
	Mr S Hall	Vice Chair/Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	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 K Hadfield	Personal Assistant (Minutes)

No	Item	Action
1	**Apologies:** There were no apologies received.	
2	**Declarations of Interest** There were no declarations made.	

12.2 Emergency Preparedness Annual Assurance Statement
Ms Myers briefed the Committee on the EPRR annual assurance statement. Ms Myers noted that standards have changed since last year's submission. As a result of this as the Trust's new EPRR Manager has gone through the standards to determine what level of compliance the Trust has achieved in each area. The Trust has more standards as partially compliant compared to last year; therefore, the overall recommended level of compliance is partially compliant. The summary position is that of the 64 standards 50 were fully compliant, 13 partially compliant and 1 non- compliant.

Ms Myers noted that this year's standards have identified a number of areas to be strengthened, for example a new requirement for non-sequential numbering in mass casualty situations. Ms Myers stated that it has been a useful exercise to go through this year's standards. One of the changes already implemented is to have an overarching EPRR policy which has pulled together a number of existing practices. This policy was taken to EMC and approved pending a couple of amendments.

Mr Bond asked whose judgment is used to determine what is fully compliant. Ms Myers confirmed that it was a joint view of Ms Myers, Jackie Railton and Taryn Milton. In response to a question from Mr Bond, Ms Myers confirmed that this needs to be presented at Resilience Committee as well.

Mrs Cope noted that this assessment has a lower compliance level than last year and asked whether there was any consequence for the Trust. Ms Myers confirmed that there is no direct consequence; the Trust is required for any areas of partial compliance to give 3 monthly updates to NHSI.

Mr Bond noted that with 50 fully compliant statements and the remaining partial and non-compliant areas, that it would only take a slight drop to make

the Trust non-compliant. Ms Myers confirmed this is the case.

Ms Ramsay asked what the NHS England Confirm and Challenge process consisted. Ms Myers advised she had met with NHSE/I who had reviewed the draft submission including the levels of compliance and raised no further questions.

Mrs Cope noted that the Trust is very close to being non-compliant and that her concern would be that there is a significant amount of work to be done to keep the Trust compliant. Ms Christmas asked whether Ms Myers was completely sure that the assessment on each standard is correct. Ms Myers confirmed she is satisfied with the assessment and confirmed she is more than happy to declare any non-compliance if need be. It was confirmed that these standards are reviewed by the CQC.

Ms Myers noted that whilst there are a number of partially complaint statements that these are easily addressed to become fully compliant.

Mr Nearney noted that the Emergency Planning Lead is leaving the organisation and asked how these standards will be progressed. Ms Myers confirmed that the post is going out advert and that her team can get the immediate plan in place. Ms Myers is also meeting with NLAG to look at working jointly.

Mr Curry raised that he could not gained sufficient assurance from the document. He required further information particularly on policy items for example when was the last policy version, when was policy written, when was it tested and when was it signed off.

Mr Bond asked for a confirmation on timescales for submission to NHSE. Mr Curry would not be comfortable signing this off on behalf of PAF. Ms Myers agreed to go through each of the standards and include the relevant detail to demonstrate why each standard has the corresponding level of compliance.

There was detailed discussion as to how the relevant assurance would be given to the Chair of PAF in order that he can recommend a level of compliance to be signed off on behalf of the organisation. Ms Myers picked up the action to do this including submission of full details to Mr Curry and a review of the statements at the Resilience Committee this Thursday. The Committee emphasised that the Trust must submit an accurate assessment which Ms Myers confirmed has always been the intention of the exercise.

Resolved:
The Committee agreed the above assurance process

3 Minutes of the meeting held 28 October 2019

Item 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 bed 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 will move to H36 from the beginning of December.

3.1 Extra Ordinary Minutes held on 7 November 2019

Mr M Gore to be added as being present at the Extra Ordinary PAF

Committee.

4 Matters Arising from the Minutes
There were no matters arising discussed from the minutes

5 Action Tracker
All items on the Tracker were covered by the agenda.

6 Work Plan
Ms Ramsay presented the work plan. The Committee has received all relevant papers to date. Mrs Ramsay confirmed that no business case, investment or di-investment items have been received which is why these are not shaded on the work plan.

7 Board Assurance Framework
M Ramsay presented the updates to the Board Assurance Framework, she noted that BAF 6 research and innovation had been updated in respect of positive assurance and gaps in assurance following the detailed presentation given at the Sept Trust Board. She also noted the updates to BAAF 4following the extra ordinary PAF meeting. The Committee has the opportunity to review all risks ratings this quarter, but in respect of BAF in particular, the Committee may consider reducing the risk as a result of the forward view given at the extra ordinary meeting.

Ms Ramsay confirmed that she is in the process of meeting with Exec's to update the mitigating actions in particular the mitigating actions on the BAF and will bring these updates to the December Committee meeting.

Mr Hall noted that the Board Development session tomorrow will consider the recent internal audit report on Financial Management and is keen to see whether this would be reflected in the BAF. Mr Curry noted that he was not able to attend Board Development tomorrow, but shared some detailed reflections on the way in which information is presented at PAF. Mr Curry will share these thoughts further via e-mail.

Mr Gore asked for an update in respect of the Windows 10 upgrade which is referenced in BAF 7.3. Mr Bond confirmed that a full project plan is in place to deliver this. Ms Ramsay also confirmed that an update had been received at the IG Committee this week and that the national timescales for the upgrade have been adjusted to allow more time. Ms Ramsay confirmed that the IM&T Team recognise the risk of a gap between Windows 7 no longer being supported and the implementation of Windows 10 and are managing this risk with the national team accordingly.

Resolved:
The Committee received and accepted the report.

8.1 Performance Report
Mrs Cope presented the report and advised that RTT Incomplete 52+ Week Waiters achieved the national standard of zero breaches and are back on trajectory at the end of October for WLV.

Diagnostic Waiting Times: 6 Weeks failed to achieve October target with performance of 9.23%, 108 breaches in total.

There continues to be no improvement with ED waiting times. The Trust has failed to achieve October planned trajectory with performance of 70.6% – 71% type 1 and 70% combined.

Mr Hall asked if the FIT process was in place. Mrs Cope replied that it was and operates in ED between the hours of 8am and 8pm. The FIT Team will relocate to H36 at the beginning of December and will run as a 7 day service. This will then be SDEC CQUINS compliant.

Mr Hall also asked about the GP streaming area. Mrs Cope replied that the estates work is on track and that the pathway has been clearly defined. Area due to open on the 16 December.

Mr Bond asked when we will see an impact on the things that have been planned for. Mrs Cope replied that the test will be on ECA performance and that the work being undertaken in ECA should work irrespective.

Mr Bond also asked if any modelling had been done to see could potentially happen to our type 1 and type 3. Mrs Cope replied that counting scenarios are being undertaken by Tracy Sowersby and her team and that recording of the new area is really important.

Mr Gore queried the cashing up of clinics. Mrs Cope replied that we are receiving a higher level of assurance on the cashing up of clinics as this is reported through PandA at a Hub level.

Mr Hall queried cancer standards and how we manage cancellations. Mrs Cope replied that there is a process in place to fill cancelled slots.

Mr Hall asked how the issues in Cardiology are to be resolved. Mrs Cope replied that she is hoping that a new ops Director presence with fresh eyes will be able to help resolve the issues.

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 demand is 0.8% above the same period last year.

An audit on Consultant to Consultant referrals is to be undertaken due to referrals increasing by 3% since the switch off of paper referrals.

There has been a reduction in GP referrals, 2.9% lower than last year. Non-elective ED attendances is 0.4% lower than plan, non-elective inpatients are 2.3% above plan and elective demand activity 2% lower than plan.

£4.5m above contract
£1.3m growth since last month, this is due to pass through drugs
Mr Gore queried the loss of £900k over the last month. Mr Bond advised that he would look into this. **LB**

Mr Hall asked that as a one off is there anything we can do to show who is more ~~responsive and who is least responsive~~. It was noted that Eileen Henderson was to attend the December meeting and would be able to

provide this information.

Resolved:
The Committee received and accepted the report.

10.1 Finance Report October 2019
Mr Evans presented the report and advised that the Trust was reporting a deficit of £0.2m which was in line with plan. The position included £4.0m of PSF.

The Health Groups were reporting a £400k overspend, this was unchanged from the previous month. The biggest pressure area is in pass through drugs, but there is an increasing pressure due to pension changes.

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.

A meeting is scheduled to take place with NHSE/I in December to look at undertaking deep dive reviews early in the New Year. The 3 areas identified for this exercise are Cardiology, Ophthalmology and Orthopaedics.

Mr Gore queried the contract income in month gain of £877k. Mrs Drury replied

Mr Hall queried the £300k worsening of underlying deficit in Surgery health Group. Mr Evans replied that they have to recruit and use a lot more expensive agency costs. Surgery Health Group have deteriorated by 0.9% and Family and Women's by 0.7%, there level of recurrent spend is minimal. All Health Groups need to identify how they will bring their underlying run-rates under control.

Mr Hall queried the receivables balance past 90 days. Mrs Evans replied that NLAG's over 90 day balance has increased to £1.5m. This is seen as a cash issue only rather than disputing invoices. We expect NLAG to make a payment of £650k on the 3 December 2019; they also have approval for a further £200k to be paid, waiting payment confirmation date.

Mr Bond informed the Committee that an agreement of balances exercise is to take place at month 09, this is a national exercise.

Mr Bond also informed the Committee that East Riding CCG have formally declared a £2m risk to NHSE/I on prescribing and that Hull CCG also have problems around prescribing. If the Hull CCG position worsens, they may need to use some of the £3m contingency that they allocate to the Trust..

Resolved:
The Committee received and accepted the report.

10.2 CRES 2019/20
Mr Evans reports that 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. In month target has increased to £2.3m per month with £6.8m being delivered, this over delivery to date reduced to £0.2m and expected to show below plan next

month.

Resolved:
The Committee received and accepted the report.

10.3 Productivity and Efficiency Report
Discussed under agenda item 10.1.

10.4 Impact of Pension Issue on Consultant Activity
Mr Nearney presented this report and updated the Committee on the current position. 36 Consultants have reduced their hours between Jun and October this year, 2 in November and a further 29 have indicated they may reduce their hours.

In respect of the Supplement in Lieu of Pension Scheme, which is a local Trust scheme, 16 applications have been received of which 9 require further information, 6 have been approved and 1 has been rejected.

Mr Nearney also noted that a letter had been received in the last few days from NHSE/I which has been circulated to PAF members. This letter states that the costs of any tax bill to a Consultant this financial year will be supported by the Department if the individual uses Scheme Pays.

Mr Nearney stated that he will keep the Committee updated on this position. He confirmed that the Trust will continue ~~to~~ the Supplement in Lieu of Pension Scheme alongside NHSE/I's letter and that there is no conflict in offering both.

Resolved:
The Committee received and accepted the report.

10.5 Procurement Strategy Update
Mr Bond presented the strategy. Julie Lumb is currently working through the areas that we have agreed to deliver.

Mr Bond informed the Committee that the Trust is struggling with price efficiency at a national level and the Trust is still one if not the biggest user of NHS Supply Chain.

Mr Bond reported that he had met approximately 12 months ago with York and NLAG with a view to procurement shared services. At the time neither Trust wanted to participate. Recently NLAG have been in touch and subsequently met with Mr Bond with a view to revisiting this. Mr Bond advised that Humber NHS Foundation Trust have been asked to consider this joint service and that the MOU is currently being drafted. Once the MOU is complete, a copy will be sent to York.

Resolved:
The Committee received and accepted the presentation.

10.6 STP 5 Year Plan/Trust 2020/21
Mr Bond presented 2 papers, the first of which detailed the assumptions from this Trust that have been built into the HCV STP 5 year plan. The 5 year plan is based on delivering the NHS Long Term Plan at STP level. The paper details the principles that have been built in which have the greatest impact

on HUTH including the 4 priority areas for Humber Coast and Vale. The paper also included the control totals that HUTH will need to achieve to move to financial balance by 2023/24 and also includes the financial trajectory requirement for each NHS organisation in the STP.
Mr Bond noted that this plan includes Hambleton, Richmondshire and Whitby CCG (HRW CCG) which has moved back into this STP, which has a financial impact of a £4m deficit.

Due to the required level of CRES, the plan as submitted presents a particular financial challenge for next year, particularly as large proportion of this year's CRES in non-recurrent.

The second document is the final draft STP document which is due to be circulated formally following the general election.

Resolved
The Committee received and accepted the report

11.1 Variable Pay Report
Mr Nearney presented this report. At the end of month 07 the Trust has spent £17.7m on variable pay. The Trust has spent £1.4m less on variable pay compared to this time last year.

Resolved:
The Committee received and accepted the report.

11.2 Job Vacancy Report
Mr Nearney presented this report. This report is due to move to the Trust Board agenda from January 2020. The Trust has a consultant vacancy rate of 12.2% which represents 56.07 vacancies. Of these vacancies 54.6 posts are covered by locum or agency.

Mr Nearney also noted that the Trust's current sickness absence rate is 3.64% which is lower than the national average of 4.29%.

Mr Nearney stated that the Trust's registered nursing/midwifery vacancy rate will be 4.5% once the new students receive their pin numbers.

The paper included a detailed set of actions being taken on Therapy recruitment.

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 Trust has £26m capital to spend and has currently spent £6-7m. There may be further additional funding to spend on imaging (4 x CT's, 3 x MRI's and 2 x breast trailers).

The biggest risk is ensuring we can deliver everything by the 31 March 2020.

There is a national concern around the total capital spend this financial year.

Mr Bond advised that he has spoken to NHSE/I and informed them that we could potentially spend some additional monies new boilers/CHP's on all sites.

Mrs Cope informed the Committee that the Trust had been approached by NHSE/I to submit a bid to equip and staff additional beds, H200 has been identified for this. The bid was submitted totalling £2.2m, awaiting outcome. The main concern is the staffing of these additional beds.

Mr Hall queried the ED GP area submitted costs which far exceed the project allocation. Mr Bond informed him that the costs are being managed.

Mr Hall raised the problem relating to the Cardiology clinic rooms and was there any scope to use any of the capital monies to solve the problem. Further conversation to be had with Eileen Henderson at the next meeting.

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
15.1 Papers for Approval
The scheme of delegation requires these contracts to be presented at PAF. Three contracts were included and Mr Bond tabled a fourth. The Committee queried that one of the contracts was already passed its completion date and asked why it was being presented at the Committee so late. Mr Bond to find out the impact if the Committee will not approve a contract that has already expired.

The Committee approved the two other contracts included in the papers and on presentation of the fourth contract approved this also.

15.2 Committee Effectiveness
Ms Ramsay informed the Committee that the committee effectiveness survey had initially been sent out in May 2019. All responses between May and July have been collated and identified that members think that this Committee is effective overall. The Committee reviewed the verbatim comments included in the report. There were no specific improvements identified.

16 Date and Time of the Next Meeting:
Monday 16 December 2019, 1.30pm – 4.30pm, Board Room, Alderson House

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Performance and Finance Committee

Meeting Date:	16 December 2019	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

The Committee considered 3 items of urgent business only at its December 2019 meeting, which were three contracts:

Contract 1 – Provision of blood borne virus testing systems
Ms Ramsay presented this paper. The procurement process and recommendation is compliant with Trust Standing Orders, Standing Financial Instructions and EU regulations. It represents a cost saving to the organisation. The provision has been discussed with York Teaching Hospitals NHS Trust and the details of this included in the paper.

Contract 2 – Clinical Waste Disposal contract extension
Ms Ramsay presented this paper. The Trust has a new contract in place for clinical waste disposal, which was for an initial 10 month period with a 12-month extension option. The paper noted rationale for the extension, including stability of provision, the volatility in the clinical waste sector and the advice of NHS Improvement.

Contract 3 – Purchase of Magnatom Sola MRI scanner
Ms Ramsay presented this paper. The Trust has capital funds available for the purchase of this MRI scanner, which will replace one of the oldest scanners in the Trust's fleet. The scanner will bring clinical and efficiency benefits. The purchase is available from NHS Supply Chain through a National Framework Agreement for Capital Equipment.

Key decisions made:
All three contract recommendations were received and approved by the Committee. The decisions requested of the Committee were in line with Trust Standing Orders.

Risk and assurance matters to be received by the Board:
The decisions requested of the Committee were in line with Trust Standing Orders.

Matters to be escalated to the Board:
None

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 16 December 2019

Present:	Mr S Hall	Vice Chair/Non-Executive Director (meeting chair)
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Ms C Ramsay	Director of Corporate Affairs
In Attendance:	N/A	

No Item **Action**

1. Apologies for absence
Apologies were received from Mr T Curry, Mr L Bond, Mr S Evans and Ms A Drury. The meeting had a quorum.

2. Declarations of interest
None

3. Urgent business
The Chair confirmed that the purpose of today's meeting was to discuss one item of urgent business. Due to the changing in timing of the meeting to earlier in the month, the full set of data is not available for consideration as normal and the organisation is under significant operational pressures. As a result of these, the Chair stepped down the full meeting and is taking one agenda item that is time sensitive, which is the approval of contracts.

Contract 1 – Provision of blood borne virus testing systems
Ms Ramsay presented this paper. The procurement process and recommendation is compliant with Trust Standing Orders, Standing Financial Instructions and EU regulations. It represents a cost saving to the organisation. The provision has been discussed with York Teaching Hospitals NHS Trust and the details of this included in the paper.

The Committee approved the recommendation and the award of the contract.

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Ms Ramsay presented this paper. The Trust has a new contract in place for clinical waste disposal, which was for an initial 10 month period with a 12-month extension option. The paper noted rationale for the extension, including stability of provision, the volatility in the clinical waste sector and the advice of NHS Improvement.

The Committee approved the recommendation and the award of the contract.

Contract 3 – Purchase of Magnatom Sola MRI scanner
Ms Ramsay presented this paper. The Trust has capital funds available for the purchase of this MRI scanner, which will replace one of the oldest scanners in the Trust's fleet. The scanner will bring clinical and efficiency benefits. The purchase is available from NHS Supply Chain through a National Framework Agreement for Capital Equipment.

The Committee approved the recommendation and the award of the contract.

4. Date and Time of the Next Meeting:
Monday 27 January 2020, 2.00 – 5.00 pm, Committee Room, HRI

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	25 November 2019	**Chair:**	Prof. M Veysey	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Presentation on drug shortages (national and international), how these are managed, examples of mitigation actions in last 12 months; the Committee to be updated if this situation changes significantly in the next 12 months, and to receive an update on the e-prescribing roll-out in the Trust
- A new monthly Quality Improvement Programme meeting has been established, to provide detailed review of the QIP, pick up on issues/actions not on track, and detail assurance (where relevant) where the QIP projects are on track; QIP reporting to move to bi-monthly to the Quality Committee as a result
- The Trust is participating in the NHSE/I 'Moving to Good' programme, to learn from other Trusts recently rated 'Good' by CQC – the Committee will be kept appraised of the learning from this

Key decisions made:

- As a result of the new monthly QIP meeting, it was requested that reporting on the QIP becomes bi-monthly to the Quality Committee – this was agreed

Risk and assurance matters to be received by the Board:

- Assurance given that the Trust has processes in place to manage drug shortages, including communication to prescribing staff
- Changes are being made to the Integrated Performance Report (received by the Trust Board and the Quality Committee), reflecting a newly published Single Operating Framework by NHSE/I; the updated version will include SPC in its graphs, to determine if each target/performance metric is inside/outside of normal variation for the Trust
- The status of actions from the last CQC report have been reviewed, to ensure progress/closure. On the specific action around an SLA to be in place between the Trust and Humber NHS Foundation Trust, the Trust has the required clinical risk management processes and relationships with the Humber teams in place
- Due to a total of four recent Never Events being reported by the Trust a Task and Finish group was implemented and a Safety Improvement Plan was developed. This plan was shared with the Committee. The Safety Improvement plan has been replaced by a Patient Safety Programme which will also continue work from the Safety Improvement Plan
- Mrs Geary advised the Committee that a Serious Incidents Committee has been implemented and the intention is to involve Health Groups. The plan is to not just look at incidents but where the Trust is in the chain of events. It will be a robust committee, challenging the Trust and the recommendations raised by the action plans. Lessons learned will be reviewed to ensure practice is embedded.
- The Committee effectiveness review was received; overall the Committee was rated by its members as effective, with a steer towards discussing some agenda items more in respect of the patient safety issues that are core of the issue at hand, rather than performance

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 25th November 2019

Present:	Prof M Veysey	Non-Executive Director (Chair)
	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 M Stern	Patient Council Chair
	Mrs T Cope	Chief Operating Officer
In Attendance:	Mr P O'Brien	Chief Registrar
	Mrs T Proctor	Personal Assistant (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs K Southgate, Acting Deputy Director of Quality Governance.	
2	**Declarations of Interest** A declaration was made from Dr M Purva whose niece has joined the Trust but the Committee agreed this would not cause any conflict.	
3	**Minutes of the meeting held 30th September 2019** Minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Dr Purva wanted to clarify that the tick box exercise, suggested as the process used by the Trust at the surgical pause before incision in theatre, was more a feeling that not everyone in the theatre at that time were paying attention to the questions being asked. (Item 4.5 paragraph 3)	
	3.2 Action Tracking List The Committee reviewed the tracking list. Due to Ms Rudston and Mrs Southgate being unable to attend this meeting their Actions were rolled over to the next meeting	
	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 at this point.	
	4.5 Drug Shortages – Item taken out of order so that Mr O'Brien could leave the meeting. Mr O'Brien gave a presentation, the contents of which gave assurance to the Committee that the Trust will be able to manage any issues with drug shortages. There are plans in place which have been tested in the past when shortages have occurred.	

Provision for the control of drugs through E-prescribing is included in a five year plan which was requested to be presented to this Committee. **DC**

Resolved:
The Committee received and accepted the update.

4.1 Quality Improvement Programme
Mrs Geary advised the Committee that she had established regular Quality Improvement Monitoring meetings which produce a bi-monthly report. It will form as an assurance meeting to sit below this Committee. This Committee accepted that the assurance reports would be received bi-monthly and that at the meetings in between people will be invited to present their progress against the report. The monitoring meeting will ensure that information reported is accurate and actions are in put in place. The first report will be presented to this Committee in December when the Committee will agree who to invite to the following meeting based on the highest risks presented.

The work plan will be amended to reflect the change in the reporting cycle **RT**

Resolved:
The Committee received and accepted verbal update.

4.2 Integrated Performance Report
Ms Ramsay clarified that the report produced is based on all measures set nationally to bring all Trusts to account, this framework has just changed, new measures are to be included and emergency care targets may change. Going forward SPC charts will be used for every measure, to enable exceptions for long term trends to be picked up. Mr Hall commented that the current report was predictive and it would be a shame to lose this predictive element. The report has previously focused on targets but the focus needs to turn to patient outcomes and patient harm. There is nothing to suggest that the Trust is not safe but the reports show a lot of red areas. The quality of the patient experience suffers when targets are not met and bringing in 4 hour targets has had the effect of raising patient expectations. Consideration will be given to include other types of data in the report, e.g. Friends and Family results, to give assurance that the patient experience is of a high quality.

It was noted that the Maternity Friends & Family scores have suddenly dropped to 80% from a longstanding figure of 100%. Ms Ramsay will investigate to see if she can identify why. **CR**

Resolved:
The Committee received and accepted the report.

4.3 Quality Report
Mrs Geary presented the Quality Report to the Committee. She highlighted the key updates from the report which included a list of the information that has been requested by the Care Quality Commission which indicates an imminent inspection. It was also of note that the Trust has received an invitation to participate in the Moving to Good Programme. After attending the initial event from this programme, Mrs Geary said, in her opinion, the Trust compared favourably with the peer group of 11 other Trusts; this positive reinforcement needs to be communicated to our staff. There are a

small number of actions outstanding from the previous CQC inspection, which are being continuously monitored. Mrs Geary emphasised that although the Service Level Agreement with Humber has not been completed joint working to mitigate risks is taking place.

Mr Hall asked if examining the CQC report from NLAG would be helpful although noting they do have different challenges. It was agreed that all plans put in place for the next inspection could be at risk if a staff member wanted to give negative feedback to the inspectors. The Trust cannot mitigate this risk, it is important to ensure communication to staff is positive and we celebrate what we do well. In addition we should ensure strong positive narrative is given on the things that are changing because of new leadership. The last inspection did highlight from the CQC a need for changes and these have taken place, including a change in the Executive Team, the journey. The impact of these changes should be communicated. There has not been a relationship meeting with our appointed CQC lead since summer, this is required to build good relationship between them and the Trust and arrangements are currently being organised.

Resolved:
The Committee received and accepted the report.

4.4 Seven Day Services
Dr Purva resented the report that had previously been delivered to the Trust Board. A greater sample of patients will be audited next year. After discussion it was agreed that linking in with SAFER would be a way of building a better quality audit and ways to address the 7 days standard. This will also provide assurance escalation processes are being followed.

Resolved:
The Committee received and accepted the report.

4.6 Never Event Plan
Due to a total of four Never Events being reported by the Trust a Task and Finish group was implemented and a Safety Improvement Plan was developed. This plan was shared with the Committee. The Safety Improvement plan has been replaced by a Patient Safety Programme which will also continue work as noted in the key milestones from the plan

Resolved: The Committee were assured that plans are in place to take actions forward.

5.1 Serious Incidents – Lessons Learned – Themes and Trends
Mrs Geary advised the Committee that a Serious Incidents Committee has been implemented and the intention is to involve Health Groups. The plan is to not just look at incidents but where the Trust is in the chain of events. It will be a robust committee, challenging the Trust and the recommendations raised by the action plans. Lessons learned will be reviewed to ensure practice is embedded.
Mrs Geary was asked to clarify why an action was raised for training to take place when this training was mandatory for staff. Mrs Geary responded by saying this was a recommendation to refresh training and practice in one area.
On Page 3 of the report the Medical device incident highlighted a failure to follow manufacturer's instructions, it was noted that Mr Hall found it difficult

to believe no one would read the manufacturers instructions on a piece of equipment.
There didn't seem to be any continuity between the boxes reading across the item on Treatment delay on page 4. This will be checked.

Resolved:
The Committee received and accepted the report mindful of the point that there are two actions that will not have a completion date

6.1 Operational Quality Committee Report
Dr Purva presented escalation report
Mr Hall voiced concerns after he had visited the Emergency Department around the impact on the department when a patient needs a Mental Health Assessment.

Resolved:
The Committee received and accepted the report.

6.2 Board Assurance Framework
Ms Ramsay advised that the BAF report has had some significant updates. An extraordinary Performance and Finance meeting was useful as a stock take of the Trust position which has been included in BAF 4. The members of the Performance and Finance Committee tasked Ms Ramsay to link with the Executive team to confirm the framework and put some challenge into the risks and movement of risks. Ms Ramsay will include this in the next version of the Framework.
Mrs Geary advised that the risk around staffing had reduced.

Resolved:
The Committee received and accepted the report.

6.3 Committee Effectiveness Review
Following a review of the effectiveness of this Committee from members Ms Ramsay produced a paper which summarised the average scores and comments. The overall picture shows that the Committee was generally effective.
As a Committee all agreed that they have to be careful they were considering patient safety more than performance.

Resolved:
The Committee received and accepted the report.

7 Any Other Business
No extra items were raised

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 16 December 2019, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary
(apologies have been accepted from David Corral)

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	16 December 2019	**Chair:**	Prof. M Veysey	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- The QIP was discussed by the Committee. It was agreed that any areas of concern or any areas needing more assurance would be highlighted and if significant, the team in question given an opportunity to attend the Quality Committee to discuss further. On this basis, it was agreed that the Committee would receive presentations on dementia and nutrition QIPs at the next meeting.
- Safeguarding – Mrs Geary advised that a written report clarifying the Trust's referral position would be received at the January 2020 meeting; this is following the submission of data externally and a query raised by Mrs Geary that all relevant referrals/reports are being completed and recorded
- In the Q3 Claims report, the Committee will receive a summary of the response being sent to the West Yorkshire coroner following a Regulation 28 letter received jointly by HUTH and Leeds Trusts
-

Key decisions made:

- No specific requests made of the Committee; all reports were accepted

Risk and assurance matters to be received by the Board:

- The Exec team are holding an additional meeting with Family and Women's Health Group, to discuss current issues and any clinical risks that the Health Group needs to raise; this will be updated to the Board through the next Performance and Finance Committee exception report
- Ms Ramsay advised that she had met with the Executive Leads for each of the Board Assurance Framework risks and made updates to the mitigating actions and assurance. Ms Ramsay asked the Committee if they could review the BAF with the Quarter 3 ratings in mind. Any deteriorating risks or improving risks would be discussed at the Board meeting in January 2020.
- There was a discussion around pressure ulcers and the issues around patients coming into the Hospital with skin damage. Mrs Geary advised that the Wound Management Committee was reviewing each case and there was an action plan to address the issues

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 16 December 2019

Present:	Prof M Veysey	(Chair) Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs B Geary	Chief Nurse
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Green	Lead Clinical Research Therapist
	Mrs K Southgate	Acting Deputy Director of Quality Governance and Assurance
In Attendance:	Mrs R Thompson	Corporate Affairs Manager

No **Item** **Action**

1 Apologies:
Apologies were received from Dr M Purva, Chief Medical Officer, Mrs T Cope, Chief Operating Officer, Prof J Jomeen, Non-Executive Director and Mr D Corral, Chief Pharmacist

2 Declarations of Interest
There were no declarations made.

3 Minutes of the meeting of 25 November 2019
Item 4.3 – 1st paragraph, sentence 4 should read: "After attending the initial event from this programme, Mrs Geary said, that in her opinion, the Trust compared favourably with the peer group of 11 other Trusts…"
The minutes were approved as an accurate record of the meeting.

3.1 Matters Arising
The QIP was discussed by the Committee. It was agreed that any areas of concern or any areas needing more assurance would be highlighted and the team in question given an opportunity to attend the Quality Committee to discuss further.

3.2 Action Tracker
Safeguarding – Mrs Geary advised that a written report clarifying the Trust's referral position would be received at the January 2020 meeting. **BG**

Quality Improvement Plan – AKI actions were included in December 2019 report, clinic start times to be included in the January 2020 report.

Ms Ramsay advised that the Maternity Friends and Family scores reducing appeared to be a monthly downturn in performance but not an ongoing issue. Performance to be monitored but the item removed from the tracker.

The provision for the control of drugs through e-Prescribing which is included in the five year plan, would be presented to the Committee in January 2020. **DC**

3.3 Any Other Matters Arising
There were no other matters arising.

3.4 Workplan 2019/20
The Workplan had been changed to reflect the Quality Improvement

Programme bi-monthly reporting schedule.

4.1 Quality Improvement Programme
Mrs Southgate presented the QIP and advised that the report had not yet been reviewed by the Operational Quality Committee as this meeting had been cancelled due to operational pressures.

The Committee discussed the Matron's handbook relating to a number of areas and how the performance reflected how well data was being collected. There was a difference between the electronic data collected and paper collection. There were no issues around quality of care.

There was a discussion around pressure ulcers and the issues around patients coming into the Hospital with skin damage. Mrs Geary advised that the Wound Management Committee was reviewing each case and there was an action plan to address the issues. Mr Hall asked for clarity around the key updates and Mrs Southgate agreed to include a clear general statement in the next report to the Committee.

The Committee agreed that nutrition would be the first QIP presentation to the Quality Committee in January 2020.

The Committee discussed the Dementia QIP and what was being done to ensure the programme was on track. Mrs Geary advised that there was a new matron in the Elderly wards and the Dementia bundle was being finalised. An update on this QIP will also come to the January 2020 Committee meeting.

There was a discussion around Outpatient Services and the clinical waiting time audits. Mrs Southgate advised that the data were being analysed by the Business Information teams and would be presented to the Committee in due course. Prof Veysey advised that he had started contacting follow up patients by telephone (where this was clinically appropriate) and determining whether or not he needed to see patients in his clinic or not. It was confirmed that several specialities in the Trust were also doing this.

The Acute Kidney Injury report had been closed down as this now complied with the NICE quality standard.

Mrs Southgate agreed to present an updated QIP at the January 2020 meeting, incorporating the specific items discussed.

Resolved:
The Committee received and accepted the report.

4.2 Integrated Performance Report
The Committee reviewed the Integrated Performance Report and discussed the national and Trust issues around Emergency Department performance.

Ms Ramsay advised that the national measures for ED would likely be changing and this would be reflected in any updated version of the report. The Committee discussed the issues around ED in particular flow and how this could be improved in the future.

Mrs Geary reported that 46% of people attending the ED did not need an

ED consultation and could be cared for in more appropriate ways and pathways. A harm review was being carried out on all patients waiting longer than 12 hours in ED and the results would be received at the Serious Incident Committee.

Prof Veysey asked what was being done about the 46% of people who did not need to be in the Emergency Department and 22 other pathways through patient streaming had been identified.

Resolved:
The Committee received and accepted the report.

4.3 Quality Report
Mrs Geary advised that the Trust had reported another Never Event relating to a neonatal error and the investigation was under way with processes already in place to avoid the incident happening again.

Mrs Geary also mentioned the Diabetes service and how patients were being managed. A retrospective look back was being undertaken and monitored through the Diabetes Safety Group.

Mrs Geary advised that the CQC had completed their first site visit linked to their imminent inspection of the Trust. The Provider Information Request evidence had been submitted to the inspection team.

Resolved:
The Committee received and accepted the report.

4.4 Quality Impact of CRES
Mrs Geary advised that Quality Impact Assessments were carried out on CRES initiative that either exceeded £100k or would impact on quality of care. She reported that there were no current schemes to report within these criteria.

Resolved:
The Committee received and accepted the update.

4.5 Claims Report
Mrs Southgate presented the Q2 report which highlighted how many claims the Trust had received and closed. There were also details regarding one regulation 28 notice which had been jointly received by Hull and Leeds Trusts. Mrs Southgate agreed to summarise the response to the Coroner in the Q3 Claims Report. **KS**

Mrs Geary advised that an extra ordinary assurance meeting was being held with the Family and Women's Health Group to review quality and safety risks. The outcomes would be included in the Performance Exception report received by the Performance and Finance Committee.

Resolved:
The Committee received and accepted the report.

5.1 Serious Incidents
Mrs Southgate reported that there had been 39 serious incidents to date compared to the last full year of 72.

Mrs Geary advised that the Trust was reviewing harm and was encouraging increased reporting, learning and an increase in near miss reporting. She added that the Trust was already a good reporter but there was more work to be done.

There was a detailed discussion around the Surgery Never Event and how empowerment of the whole clinical team was key to stop the line when necessary. The Committee also discussed very difficult Serious Incidents and how they were being managed.

Resolved:
The Committee received and accepted the report.

6.1 Board Assurance Framework
Following the Quality Improvement Programme discussion it was agreed that following any assurance received (after presentations to the Committee) the BAF would be updated to reflect the discussions.

Ms Ramsay advised that she had met with the Executive Leads for each of the risks and updates to the mitigating actions and assurance had been completed. Ms Ramsay asked the Committee if they could review the BAF with the Quarter 3 ratings in mind. Any deteriorating risks or improving risks would be discussed at the Board meeting in January 2020.

BAF goal 6 had been updated following the presentation to the Board regarding Research and Innovation. The key enablers and the key risks had been highlighted alongside the Trust's Research and Innovation Strategy.

Mr Hall asked if the outcome of the General Election would impact the Trust and the high level risks. Ms Ramsay advised that the main area that would be affected would be staffing due to Brexit. She advised that it would be prudent to wait until the Brexit plan had been announced before reviewing against the BAF.

Resolved:
The Committee received and accepted the report.

8 Any Other Business
There was no other business discussed.

9 Date and time of the next meeting:
Monday 28th January 2020, 9am – 11am, The Committee Room, HRI

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Audit Committee

Meeting Date:	23 January 2020	**Chair:**	Tracey Christmas	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Receipt of nursing documentation audit – this was a pro-active advisory internal audit requested by the Chief Nurse. The report highlighted some inconsistencies in practice and some duplication of practice. This report has highlighted areas on which the Trust can make further progress; an action plan will be drawn up.
- Internal audit on payroll currently underway – included in the methodology is review of individuals receiving additional/overtime payments amounting to more than 10% additional payments; this might helpfully flag up excessive overtime issues for further management action
- Anti-fraud report received including 12 areas to review where fraud might be committed; these will feed into next year's reports and work on anti-fraud awareness and identification in the Trust
- Receipt of the external audit plan for the 2019-20 accounts; this includes some new areas for review. The Trust's key management risks for review within the external audit are Revenue and expenditure recognition, management override of controls and valuation of land and buildings; there will be significant additional work undertaken by the external auditors on valuation of land and buildings that will need close working with the Trust's valuation team. An progress report will come to the next Audit Committee in advance of the extra-ordinary Audit and Board meetings at the end of May 2020
- There was a detailed discussion regarding the external audit fee for 2019-20, which is proposed to increase. The external auditors outlined the rationale for the increase and the factors within the sector as a response to regulator expectations that are driving this. The Chief Financial Officer and the Head of External Audit will discuss this following the Committee meeting and bring a proposal back to the Audit Committee chair
- A briefing paper was received on IFRS16, which is the accounting treatment of leases. There will be an impact on the Trust's accounts in respect of the leases recognised within the accounts and an impact on revenue; an initial review and return has been undertaken and returned to NHS Improvement; the Chief Financial Officer will continue to review this for any risk to the Trust's ability to spend capital – the way in which this will be recognised in the accounts next year remains under discussion therefore as yet a risk cannot be quantified; the Audit Committee will be regularly briefed on this issue and will be escalated to the Board if a material risk is quantified
- The Audit Committee received an update on the current declarations of business interests, gifts, hospitality and sponsorship. There will be some follow-up actions to individual declarations. The Anti-fraud service is scoping a piece of best practice work around triangulation of declarations of sponsorship and business interests, which will reported to the Audit Committee in due course
- A paper was received regarding the proposed financial principles of the Hull York Pathology Network currently in the process of being set up. The financial modelling based on these principles is the next piece of work to be completed and will be reported back to the relevant Board Committee

Key decisions made:

- Request to be made to the Chief Nurse for a six-month update on progress towards the actions arising from the internal audit advisory report on nursing documentation

Risk and assurance matters to be received by the Board:

- Risk management internal audit received – 'reasonable assurance' opinion from the internal auditors
- Recruitment and retention internal audit received – 'reasonable assurance' opinion from the internal auditors

- Deep dive internal audit into incident management - ‘reasonable assurance’ opinion from the internal auditors
- Update on Anti-fraud reporting within the Trust and an update on national changes with NHS Counter Fraud Authority – no exceptional issues to escalate
- A paper was received on the effectiveness of speaking up arrangements in the Trust, which is brought every 6 months to the Audit Committee. There was positive assurance that the Trust’s arrangements remain in line with NHS England requirements and that staff are using mechanisms to speak up about concerns within the Trust accordingly
- The Trust’s rate of reporting information governance breaches to the regulator (the Information Commissioner’s Office) has decreased in the last two quarters; completed investigations by the ICO of previously reported incidents have not levied fines or formal action by the ICO to the Trust

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust
Quality Report

Trust Board

28 January 2020

Title:	Quality Report Summary (to accompany agenda item 7.2 Quality Committee Escalation Report)
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Kate Southgate, Acting Deputy Director of Quality Governance and Assurance

Purpose:	The attached summary is taken from the detailed Quality Report scrutinised on behalf of the Trust Board by the Quality Committee. Key actions and points of escalation arising from the Quality Committee as discussion will have already been brought to the Trust Board's attention on today's agenda at agenda item 7.2. The attached summary is brought to the Trust Board to accompany this Quality Committee escalation report. The full report is received by the Trust Board at agenda item 12.4 for briefing purposes and to have the detail of the full data set. The Trust Board is asked to consider the escalation report at agenda item 7.2 as its substantive item of business.	
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 report contains all key Quality metrics for the month alongside a focus update on SI themes.	

Recommendation:	The Trust Board is asked to receive this summary report alongside the Quality Committee Escalation report.

QUALITY REPORT – EXECUTIVE SUMMARY TO TRUST BOARD

LEAD: Beverley Geary, Chief Nurse

PURPOSE OF THE REPORT

The purpose of this report is to provide an executive summary of items for escalation from the latest Quality Report

ITEMS FOR ESCALATION IN MONTH (December 2019)

Safe:

- A new Never Event in relation to Wrong Site Surgery was declared in December 2019, a patient's fallopian tube was removed instead of the planned appendix
- This was the 7th Never Event to be declared during 2019/20. Following this, a NHS Improvement WHO Checklist Peer Review visit was held on the 3rd January 2020. Initial feedback and actions were given after the event. The Trust is now awaiting the report from this visit.
- A Never Event Learning Event was held on Tuesday 7th January, led by the Chief Medical Officer, with senior consultant staff involved in some of this year's Never Events sharing their experiences, this event was an opportunity for staff to share thoughts and ideas on the Trust's patient safety culture
- During December 2019 five serious incidents were declared, including the two never events declared in December 2019

Effective:

- No areas of escalation within month.

Caring:

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

Responsive:

- It should be noted that a focus will place in Quarter 4 on new processes for learning from claims and links to the GIRFT programme.

Well-led:

- The CQC has commenced the inspection preparation with the Trust. The Trust has received and submitted the Provider Information Request
- The Trust has instigated a review of patient's with long waits within the emergency department. Further detail is provided in the well-led section
- The "focus on" section this month is a focus on the themes from SIs

RISKS TO DELIVERY

- The declaration of a 7th Never Event in the financial year has been noted as a risk within month.

Hull University Teaching Hospitals NHS Trust
Nursing and Midwifery (Safe) Staffing Summary Report

Trust Board

28 January 2020

Title:	Nursing and Midwifery Staffing Summary report (to accompany agenda item 12.4 Nursing and Midwifery (Safe) Staffing Report)
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Joanne Ledger, Deputy Chief Nurse

Purpose:	The attached summary is taken from the detailed Nursing and Midwifery (Safe) Staffing report. The attached summary is brought to the Trust Board to be the substantive discussion item for this report. The full report is received by the Trust Board at agenda item 12.4 for briefing purposes and to have the detail of the full data set. The Trust Board is asked to consider the summary report under the Quality section of the agenda alongside the Quality Committee Escalation reports.	
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:	This report summarises the key points from the Nursing and Midwifery (Safe) staffing report. There are no items of escalation or unmitigated risks to draw to the Board's attention. Work on monitoring safe staffing and on nurse recruitment continues and there have been continued successes with the intake of newly qualified nurses and international recruitment.	

Recommendation:	The Trust Board is asked to receive this summary report alongside the Nursing and Midwifery (Safe) Staffing report.

Nursing and Midwifery (Safe) Summary Report

LEAD: Beverley Geary, Chief Nurse

Purpose of this report

The purpose of this report is to provide a summary of the Nursing and Midwifery (Safe) Staffing Report

Items for escalation to the Trust Board

None

Summary of key issues from the report

Care Hours Per Patient Day (CHPPD):

- CHPPD improved from the August position of 6.70 to 6.78 in November 2019. However the CHPPD has remained relatively static over the last three months.
- The number of Registered Nursing vacancies has risen in October 2019 to 169.75 (9.2%) but subsequently dropped in November 2019 to 150.68 (8.2%). However, given the number of new registrants employed by the Trust in September 2019 it appears that these numbers still reflect a high number of newly qualified nurses in their transition period whilst awaiting their NMC PIN.
- The Trust still remains in the lower 25th Quartile as indicated through the Model Hospital Metrics, with a peer median of 8.7 CHPPD and national median of 8.0 CHPPD (October 2019 data).With regards to the Quality and Safety metrics, the Trust continues to perform well against both peers and national performance.
- The Deputy Chief Nurse and Chief Information Officer in conjunction with the Finance team and the E – roster lead, have undertaken a comprehensive review of the CHPPD submission, to determine additional factors which may be influencing the Trusts current static position.

Professional Nursing Staffing Risk Assessment:

- All inpatient areas have undertaken risk assessments; these are to identify any areas where patient care may be compromised as a consequence of staffing levels.
- Each of the inpatient areas are reviewed in relation to all of the Nurse Sensitive Metrics; particular attention is given to those areas rated as a `Medium` or higher risk, to determine any potential or actual deterioration.
- There are no areas rated as a ‘high’ risk at present
- The total number of areas is 51. Of these, 17 are rated ‘medium’ and 34 rated ‘low’
- 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.

Recruitment and Retention:

- At present the Trust has 116 Adult Branch Student Nurses scheduled for interview for late January and early February 2020. The vast majority (105) of students are from the University of Hull.
- 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 Recruitment process has commenced for the next cohort of Trainee Nurse Associates planned to commence their academic course March 2020; work is ongoing to develop a financial model to support a further cohort of student nurse apprentices and health care support apprentices.
- From an international perspective the Trust has successfully recruited 78 nurses in total; 70 of whom have passed their OSCE/received their PIN. A further 8 international nurses joined the Trust in November and are scheduled to sit their OSCE on 29 January 2020.
- In addition the Medicine Health Group is currently pursuing an additional 13 international nurses

Red flags:

- '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. NICE has identified a list of 'red flag' issues to report.
- There were 669 red flags recorded in November 2019, of which 251 concerned supervision being provided by a bank or agency nurse and 193 were categorised as safeguarding.
- There have been no red flags raised for maternity services in the last reporting period

Overall Risk Position

- 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

Hull University Teaching Hospitals NHS Trust
Trust Board
Tuesday 28th January 2020

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

Purpose:	The purpose of this report is to present the 2019-20 Board Assurance Framework, to highlight the specific risk areas and for continued review during this financial year.	
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. These were reviewed at the end of Q2 by the Committee and the Trust Board and Q2 ratings were confirmed by the Trust Board in November 2019. At the request of the Performance and Finance Committee a round of meetings with Executive leads have been held and these updates are included in the attached report. This paper provides recommendations to the Board for the Q3 risk ratings.	

Recommendation:	The Trust Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas in the Committees for this financial year. The Board is also asked to consider the proposed Q3 risk ratings and approve them if the Board agree with the proposals set out in the attached BAF.

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 Board to review the BAF risk areas for this financial year. It is also an opportunity to highlight any positive assurance or areas requiring further assurance and agree the Q3 risk 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 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 November 2019.

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 Focus on Committee Input

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

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.

At the request of the Performance and Finance Committee a round of meetings with Executive leads have been held and these updates are included in the attached report.

The attached BAF also includes Q3 ratings for each BAF risk, to be reviewed by the Trust Board.

In respect of BAF 1, although there is positive assurance in the Staff Survey Results and work is underway regarding the Medical Leadership programme and there is a gradual improvement generally around staff engagement, it is recommended that the Risk of 15 (5 impact x 3 likelihood) remains the same for Q3. The Committee is asked to review the year end position with a view to reducing the risk should improvements continue, which will specifically be seen in the Staff Survey results due to be received in Q4.

BAF 2 has been updated with positive assurance around sickness levels with the Trust being below the national average. The recommendation is that the risk remains the same for Q3 as the specific BAF

wording on the risk is around the gaps in the workforce, some of which have been filled during the year (positive assurance), however, further assurance is required around the overall unavailability of Registered and Un-registered Nurses and whether this increases the level of risk.

BAF 3 – Another Never Event was declared in December 2019 and a number of areas further assurance were required in relation to the Quality Improvement Plan. Positive assurance has also been detailed in the attached BAF. The recommendation is that the risk remains the same for Q3.

BAF 4 – In November 2019 there was an extra-ordinary Performance and Finance Committee to review Health Group performance relating to key performance requirements. The risks and positive assurance have been included in the attached BAF. Through this extra-ordinary meeting, PAF received a detailed breakdown of 6 performance measures including a forward view to year end in order to provide assurance as to which measures will most likely be met at year-end. A clinical harm review process is in place for any patient who is a confirmed 52 week breach, cancer 104 day wait, 28 day cancelled operation breaches and urgent outpatient appointments cancelled for the second time. PAF was also briefed on actions being taken to year end per Health Group. The recommendation is that the risk remains the same for Q3 but with a view in Q4 as to what remains on track for delivery at year-end, at which point, the risk rating may be able to be decreased due to the amount of mitigation work undertaken this year.

BAF 5 – work is ongoing with the Humber Coast and Vale Health and Care Partnership; there have been no specific updates to report that impact on the BAF during Q3. It is recommended that the Risk Rating remains the same for Q3.

BAF 6 – The Research and Innovation Strategy was presented to the November 2019 Board meeting and the BAF was updated following the presentation. It is recommended that the risk remains the same for Q3 based on the balance of positive assurance and current risks provided in the November 2019 update.

BAF 7.1 - The Committee has noted throughout this financial year that that the Trust's financial plan however 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.

BAF 7.1 has been updated with the following points: The Trust has delivered its financial plan to month 8 and as updated in BAF 7.1 through recent PAF and Board discussions, Health Groups have been set a stretch target to improve the forecast outturn position. Discussions are ongoing with Commissioner colleagues regarding any further financial availability.

As noted at the extra-ordinary PAF the key risk to mitigate this year is the gap in the CRES programme to avoid as far as possible carry over into next financial year. A further point to note is that financial positions and recovery are increasingly being looked at as a system issue.

It is recommended that the risk rating for 7.1 should remain the same for Q3, with a view that the risk will be reduced if the Trust achieves its financial plan in Q4.

In respect of BAF 7.2, the mitigating actions have been updated to reflect feedback received from NHSI/E relating to the Five Year Forward Plan and meetings are in place to develop this further; it is recommended that the BAF risk rating remain at 20 for Q3; whilst the Trust delivered the five-year plan submission requirements, the delivery of this plan, at system and at local level, and what this means for this particular BAF on the Trust's underlying financial position, still require further discussion.

In respect of BAF 7.3, positive assurance has been received in relation to the notification of funding for the replacement of imaging kit and the bring-forward of capital funding from the £19.3m STP submission. It is recommended that the risk rating remains the same in Q3 as the risk relates to capital funding availability for critical infrastructure - whilst funding has improved this year, this has been on more of an

ad hoc basis rather than the ability to have included new capital availability at the beginning of the financial year; the new capital funding in-year is very welcome but has not addressed all critical infrastructure requirements, therefore on balance, it is recommended that the risk rating remains 20.

3.2 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 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.

The Trust Board also received an update regarding BAF Risk 7.3 and changes in the Capital Programme. This was being managed and relevant funding could be ring-fenced for 2020/21.

4. Recommendations

The Trust Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas in the Committees for this financial year.

The Board is also asked to consider the proposed Q3 risk ratings and approve them if the Board agree with the proposals set out in the attached BAF.

Carla Ramsay
Director of Corporate Affairs

Rebecca Thompson
Corporate Affairs Manager

January 2020

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 DECEMBER 2019

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement	None	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy focusses on staff culture and engagement – wide consultation on the refresh Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff – continues in 2019 with additional cohorts Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas Continuous examples and feed back to staff as to how speaking up makes a difference Medical engagement needs to be a journey of improvement – this could be more planned	**15**	**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 Trust launched a BME and LGBT Network over 12 months ago Work is underway regarding the Medical Leadership Programme **<u>Further assurance required</u>** Engagement of medical workforce in Trust strategy and objectives; feeling empowered in to lead teams to make improvement

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

Risk Appetite

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse, OPD vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists CCSHG: lack of compliance with blood transfusion competency assessments	**5 (impact)** **3 (likelihood)** **= 15**	Refreshed People Strategy articulates changing workforce requirements New Workforce Monitoring requirements at Trust Board level Workforce Transformation Committee – staying ahead of the game with meeting changing workforce requirements, international recruitment and new roles Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 19-20; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place and held to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend	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**	15		5 x 2 = 10	**Positive assurance** Nursing training and investment in new roles – over 150 graduate adult branch nurses recruited to start in September 2019; first take of qualified nursing associates in June 2019 and new take of trainees; projection on filling vacancies on track for next 3 years The November 2019 Nursing and Midwifery report to the Board highlighted that the Trust has successfully appointed 129 adult branch nurses, 20 midwives, 5 child branch and 10 ODPs. 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. 8 junior doctors on two-year MTI started from July 2019 from partnership with Pakistan The Trust's current sickness absence rate is 3.64% which is lower than the national average of 4.29%. Trust Board November 2019 **Further assurance required** Understanding of local impact through pension taxation changes as well as national action to mitigate risk Overall unavailability of Registered and Un-registered Nurses had risen in September 2019 – Does this increase the level of risk?

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

Risk Appetite

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

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient	CCSHG: Risk to patient safety involving discharge medicines Corporate: Embedding ReSPECT process	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) was updated in light of latest CQC report and has been further updated from the new CQC report published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being adapted for Outpatients. Will be monitored at the Trust Board and Quality Committee Opportunities to move to good and outstanding care identified Participation in the "Moving to Good" Programme	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**	**12**		4 x 2 = 8	**<u>Positive assurance</u>** Stop the Line campaign was launched in September 2019 to coincide with the first World Safety Day on 17th September 2019; safety champions and a new safety governance structure being put in place New Datix form being used for Mortality and Morbidity review methodology. Medics finding it easier to use. Number of incidents reported remains in the control limits (SPC) Outpatient QIP performance remains positive and all other QIPs seeing progress – exceptions noted below **<u>Further assurance required</u>** Further development of organisational learning from SIs including Never Events Quality concerns raised by NHSI team visiting ED in July 2019 – quick timescale on actions required A new Never Event relating to wrong site surgery declared in December 2019 The following projects may pose a potential risk to the overall achievement of the plan (Quality Report to the Quality Committee in December 2019); • QIP06 Deteriorating Patient • QIP22 Nutrition and Hydration • QIP23 – Dementia • QIP39 – Outpatient Services • QIP48 Mental Health

		and stakeholder engagement, detailed in a strategy								

Risk Appetite

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

GOAL 4 – GREAT CLINICAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2019/20 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog *What could prevent the Trust from achieving this goal?* ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG Capacity of intra-vitreal injection service ECHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target CCSHG: Pathology results reviewed by requesting clinicians Cancer – Clinical Support – oncology work through the issues Delivery of regional	**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 Weekly Performance monitoring of all operational standards Oncology – additional resourcing with forward plan and revised Trust clinical model agreed across network	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**	**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 Additional endoscopy capacity in place from September 2019 with improvement trajectory Clinical harm reviews in place for patients over 52 weeks, cancer 104 days and 28 day breaches and urgent ops cancelled for 2nd time. Weekly reviews of all standards via Performance and Activity Weekly system wide oncology meeting – cancer IST linked for support Ground floor transformation added to additional CT/MRI in Q4 November 2019 – Extra Ordinary PAF Positive assurance around the HG plans particularly in 52 Week Waits and ongoing work to clear waiting time backlogs, and make reductions in RTT waiting times **<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 Improved Cancer performance Q3 compared to Q2 Coding challenge with Specialist Commissioners requires further feedback November 2019 – Extra Ordinary PAF- Risk overview

		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	services								• Impact on support to NLAG in a number of specialties • Late IHTs (cancer) and IPTs (52 weeks) impacting on delivery • Improvement required in 6 week diagnostic waits • Stabilisation of Clinical Admin hubs • Increase in 2ww Cancer referrals • Impact of Lung Health Check programme – January 2020 • Winter

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 5	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	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**	**12**		4 x 1 = 4	**Positive assurance** 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. Good progress in being made against the commitments in the new Trust Strategy (Report to the Board November 2019) **Further assurance required** 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;

					address the 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 6	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**	**12**		3 x 2 = 6	**<u>Positive assurance</u>** Detailed update to Trust Board Nov 19 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)

											Further assurance required Detailed update to Trust Board Nov 19 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.

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**	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 Extra PAF Nov 19 to review RTT, cancer and CRES Five-year STP plan required for Nov 19 Working with commissioning colleagues and NHSI/E to agree a recovery plan for 19/20. Monthly meetings taking place to review progress. Ongoing management of Trust cash balances to ensure no liquidity issues.	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**	**20**		5 x 3 = 15	**Positive assurance** Financial Plan delivered to M8 **Further assurance required** HG Forecasts at month 8 were on plan. Trying to get to £4.3. Stretch targets set, now trying to see what HGs are doing to achieve Secured £1m (circa) to support LHC and Acute capacity investments Potentially £3m available from commissioner colleagues, dependant on commissioner positions. Increasingly a system perspective. Gap still to find – high risk CRES – Health groups to identify £0.5m additional CRES (November 2019 Finance Report to PAF)

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 Feedback received from NHSI/E on the 5 year operating plan submission, meeting in the diary to work up with CCG colleagues in November 2019 HGs asked for recovery plans against deterioration in run rates reported in year (FWHG and Surgery)	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**	**20**		5 x 1 = 5	**Positive assurance** Trust has met new five-year STP financial plan submission requirements, which include projections for Trust financial balance **Further assurance required** Five year financial plan completed which demonstrates continued improvement in underlying financial health of Trust. Now need to focus on delivery.

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**	**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 There has been notification of funding for replacing imaging kit which Is being worked through. **Further assurance required** The reported capital expenditure at month 6 shows £4.8m against a plan of £6.4m. The main areas of variance relate to medical equipment and this is due to slippage against the profile and does not impact the forecast. The reported capital position at month 7 shows gross capital expenditure of £5.5m compared with plan of £7.8m. The main areas of variance relate to slippage on IT, buildings maintenance and the radio-pharmacy development. 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.

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

Hull University Teaching Hospitals NHS Trust

Trust Board

28 January 2020

Title:	Achieving the Trust's Goal of: Valued, Skilled and Sufficient Staff
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Simon Nearney Director of Workforce and OD

Purpose:	The purpose of the report is to apprise the Board of the key issues in relation to BAF risk 2; actions that have been taken to date to mitigate the risk and further work planned.	
BAF Risk:	Goal 2 – Valued, Skilled and Sufficient Staff	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Key Summary of Issues:	There are national shortages in most of the clinical professions within the NHS, including Consultant, Junior Doctor, Nursing and Radiographers. This is no different in HUTH, however positive progress is being made. The Trust has a Consultant vacancy rate of 12.2% (excluding locum and agency staff) a Junior Doctor vacancy rate of 5.95%, current Nurse and Midwifery vacancy rate of 5.18% together with vacancies in Radiology, Pharmacy, Speech Therapy and Dietetics. Recruitment plans continue to be progressed and the shortage of key staff does present a risk to the Trust.	

Recommendation:	1. That the risk score for Goal 2, valued, skilled and sufficient staff remains 15 (likelihood 3 x impact 5 = 15) 2. That a further review of the management of this risk be reviewed during 2020/21. 3. That the actions that have been taken to manage this risk are added to the BAF. 4. That Trust Board notes the content of the paper and indicates any areas where further action or assurance is sought.

Hull University Teaching Hospitals NHS Trust

Trust Board

28 January 2020
Goal 2 – Valued, Skilled and Sufficient Staff

1. Purpose

The purpose of the report is to apprise the Board of the key issues in relation to BAF risk 2 - to develop and deliver a valued, skilled and sufficient workforce that can deliver Great Care to our patients and their families.

2. Background to the risk

The Board is fully aware of the national staff shortages in most clinical professions within the NHS, including Consultant, Junior Doctor, Nurse, Physiotherapist, OT and Radiographers. The position within HUTH is better than the national picture as the organisation through Remarkable People, Extraordinary Place campaign has managed to attract and recruit certain staff and therefore reduce gaps.

As the national supply is not there, NHS Trusts are competing against one another for staff and therefore through delivery of the Trust's Strategy 2019-24 and People Strategy 2019-22, HUTH has to 'stand out from the crowd'. Given the current competition for talent, recruitment and retention of staff remains a key priority.

It is well known that a shortage of professionally qualified and competent staff is the key underlying reason for high agency spend and variable pay costs, reduction in the quality of care patients receive and staff feeling less motivated and engaged, which may lead to higher sickness levels.

3. Current Position

Consultant vacancies

The Trust has 56.07 Consultant vacancies within the Trust. This represents a 12.2% vacancy rate, however 54.6 posts are covered by locum or agency. In addition services are dealing with additional patients from North and North East Lincolnshire, particularly Haematology, Oncology, Radiology, ENT, Ophthalmology and Cardiology. The Trusts key risks in terms of Consultant shortages remain in Critical Care and Anaesthetics, Radiology, Haematology, Oncology, Cellular Pathology, ED, Acute Medicine, Ophthalmology and Elderly.

The Trust seeks to recruits Consultants nationally and internationally through innovative recruitment campaigns, word of mouth, through the development and retention of Junior Doctors and development of Specialist Doctors via the Consultant CESR qualification route. The Trust is also working with the BMJ to source Drs from overseas and has a partnership with the College of Physicians and Surgeons Pakistan (CPSP) and with teaching universities in India. The Trust has also launched its medical bank to enable doctors to work on a temporary basis with the Trust.

Speciality Doctor vacancies

The Trust has 11.52 Specialty Doctor vacancies from an establishment of 56.02 wte.

Junior Doctor vacancies

The Trust has a current fill rate of 94.05% of Junior Doctors. This includes Doctors from HEE/Deanery, Trust employed Doctors recruited to fill gaps and overseas Doctors on MTI training programmes.

Registered Nurse and Midwifery

The vacancy rate for Registered Nursing and Midwifery is currently 5.18%. The Trust continues with its overseas recruitment programme and in addition to the 70 nurses that are already employed and working in the numbers, a further 8 will be taking their OSCE exam on 29th January, 2020. A further 25 international nurses will be joining the Trust in February, to strengthen Medicine Health Group. Whilst the overall vacancy position is reasonably healthy compared to other Trusts, we have 'hot spots' were staffing is low. These wards are being supported and with the daily safety briefings happening 5 times a day, nurse staffing is adjusted to ensure risk is managed and patients are safe. The Trust has also opened additional beds for winter pressures requiring a further c11wte registered nurses.

The Trust has been very successful in recruiting registered nurses and midwives through our Remarkable People campaigns, recruiting students from the University of Hull, as well as Leeds, Lincoln and Nottingham and through our nurse associate and apprentice programmes.

Other Key Staff vacancies

Physiotherapists – 0%
Occupational Therapy – 0%
Speech Therapy – 21.48% (3.6 wte)
Dietetics – 14.01% (4.9 wte)
Radiology (Radiographers) – 8.51% (18.9 wte)
Pharmacy – 7.85% (6.13 wte)

Staff vacancies and action being taken to address shortages is reported to the Performance and Finance Committee on a quarterly basis. Commencing February, subject to Board approval the data and information will be reported to the new Workforce, Education and Culture Committee.

Physiotherapy

Action taken:

- External rotations for band 5 and 6 with Humber Foundation Trust and CHCP.
- Career pathway progression programme band 5-6.
- Increased recruitment at band 5 level to aid succession planning.
- Remarkable People recruitment campaign and international recruitment ongoing.
- Relocation package in place for new recruits.
- New posts e.g. Exercise Professional posts (band 5) have been developed and we currently have 6 in post.
- 2 Physiotherapy assistants are currently undertaking the Foundation Apprenticeship Degree at North Lindsey College, once completed they are eligible to commence in year 2 at Sheffield University.
- The use of apprenticeships continues and is actively encouraged, particularly for those with aspirations of becoming a physiotherapist. The department also works closely with St Mary's college and Wkye 6th formers to encourage them to take up a career in physiotherapy.
- The department has close links with Universities to encourage student placements. Students also work as assistants on the bank and this often leads to them wanting to work with the Trust once qualified in substantive posts.
- The Undergraduate degree commences in 2020 at the University of Hull.
- A range of flexible working options are available for staff to develop a better work-life balance.
- There is effective staff engagement within the physiotherapy department and staff survey responses and results are consistently good.
- Structured training is in place across lunch times and the department is actively seeking to host more courses on both sites.
- The 'Refer a Friend Scheme' for physiotherapists at band 6 level is in operation and has resulted in the recruitment of 1 wte band 6.

Occupational Therapy

Action taken:

- 1 OT Assistant is currently undertaking the degree apprenticeship at Sheffield Hallam University.
- The department has invested in recruitment at band 4 level grade to support with band 5 shortages.
- Exploring new roles e.g. band 4 Nursing Therapy Assistant.
- Exploring OT degree course to be provided at the University of Hull.
- Remarkable People recruitment campaign and international recruitment ongoing.
- Attendance at recruitment fairs.
- A range of flexible working options are available for staff to develop a better work-life balance.

Speech and Language Therapy

There are national shortages at qualified levels. Turnover at band 6 level occurs when staff are ready to progress into band 7 posts but find there are no vacancies. This is due to the current band 7's being a fairly static group and with the department establishment overall being small. The service has just recruited to a new Head of Speech and Language Therapy.

Action taken:

- Remarkable People recruitment campaign.
- Work continues to promote the department nationally and put HUTH Speech and Language on the map. We are exploring using social media to further promote the service.
- Career pathway progression programme for band 3-4 and 5-6. Progression programmed for band 6-7 is in development.

Dietetics

The department is struggling to recruit to newly qualified Dietitians and band 6 roles; this shortage is replicated across the Yorkshire and Humber region. A significant and sustained increase in inpatient referrals is currently contributing to capacity issues within the Dietetic Service. The department has seen an increase in staff leaving the profession due to increased work pressures.

Action taken:

- A business case for the development of the Dietetic Service is being produced to address current challenges.
- Target recruitment campaigns for newly qualified recruits prior to them qualifying.
- Recruitment incentives have been approved.
- Increased links with educational establishments.
- Pre-graduation employment opportunities for existing students.
- 'Growing our own' through work with apprenticeship schemes and dietetic assistant pathways.
- The University of Hull is seeking to become a dietetic provider.
- The service is looking at opportunities to explore patch wide appointments in collaboration with other local providers.
- Development and career planning is in place for all staff, career pathways are clearly mapped out with opportunities for career advancement.
- A range of flexible working options are available for staff to develop a better work-life balance.
- The department has received funding from the Cancer Alliance for an Upper GI Dietician post.

Radiology

The vacancy factor in Radiology is reflected across the country with a national shortage of qualified Radiographers, resulting in increased competition to recruit newly qualified staff. The Trust is involved in actively training Radiographers but due to the high demand regionally and nationally, Hull has to appoint

from the small pool of Radiographers who qualify on an annual basis or from the limited number of more specialised Radiographers who are actively searching for alternate posts.

Action taken:

- A relocation package is in place and is proving to be a successful recruitment tool.
- Overseas recruitment is ongoing and the department has recently appointed 2 qualified Radiographers through this route.
- Career pathway progression programme band 5-6.
- Extended and new roles such as Consultant Sonographers and Radiographers and reporting Radiographers have been recruited too.
- The department encourages and supports post graduate education and research.
- The department 'grows their own' by encouraging learning and development for non-registered staff, promoting opportunities for career advancement.
- Newly qualified staff commence in MRI and CT rather than General to develop their skills and this approach is attractive to new graduates.
- 'Refer a Friend Scheme' for Therapy Radiographers at bands 5 and 6 level
- A range of flexible working options are available for staff to develop a better work-life balance.
- Recruitment days are undertaken with Universities.

Pharmacy

Vacancies are showing at band 6 level although these posts are currently being held open for career progression for our band 5 staff following the next intake of newly qualified Pharmacists. Challenges are currently faced as more Pharmacy posts are being funded and recruited to in Primary Care. Nationally the Government are funding 7,500 new pharmacist posts.

Action taken:

- Excellent internal career progression offered within the service.
- The service works in partnership with other local providers to recruit to patch wide joint appointments e.g. CHCP, NECS, GP Practices. Development and expansion of this model of recruitment is being explored.
- A seconded post in HEE allows the service to link in with funding opportunities.
- Extended and new roles e.g. Trainee Advanced Pharmacists have been recruited to.
- Pre-graduation employment opportunities for existing University students.
- Remarkable People recruitment campaign.
- The department 'grows their own' by encouraging learning and development for non-registered staff, promoting opportunities for career development.
- Development and career planning is in place for all staff, career pathways are clearly mapped out with opportunities for career advancement.
- A range of flexible working options are available for staff to develop a better work-life balance.

4. Conclusion

Given the current vacancy position across the Trust, recruitment and retention remains a key priority. Progress is being made through short, medium and longer term workforce plans, however not having sufficient staff is a significant risk for the Trust.

5. Recommendations

1. That the risk score for Goal 2, valued, skilled and sufficient staff remains 15 (likelihood 3 x impact 5 = 15)
2. That a further review of the management of this risk be reviewed during 2020/21.
3. That the actions that have been taken to manage this risk are added to the BAF.
4. That Trust Board notes the content of the paper and indicates any areas where further action or assurance is sought.

Officer to contact:
Simon Nearney
Director of Workforce and OD
Tel: 01482 67643

Hull University Teaching Hospitals NHS Trust

Trust Board

28 January 2019

Title:	Capital Support Loan – Urgent and Emergency Care
Responsible Director:	Lee Bond – Chief Financial Officer
Author:	Samantha Graves – Head of Finance Capital

Purpose:	The purpose of this report is to request Trust Board approval for the drawdown of a Capital Support Loan in advance of PDC for the Urgent & Emergency Care STP Wave 4 Bid.	
BAF Risk:	BAF 7.1/7.3	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary Key of Issues:		

Recommendation:	The Board is asked to support the application process for the Capital Loan and to sign the Board Resolution agreement.

Hull University Teaching Hospitals NHS Trust
Capital Support Loan

1. Purpose

The purpose of this report is to request Trust Board approval for the drawdown of a capital support loan.

2. Introduction

The Trust Board has previously received a report relating to the business case for the Wave 4 STP transformation of Urgent & Emergency care at HRI.

In order to progress the work associated with the scheme to Full Business Case (FBC) and submit to NHS Improvement for approval, the Trust needs to incur costs and fees in advance of the capital funds being released. A total of £727k over two financial years is required.

The Trust does not have enough internal capital resources in order to fund the necessary works and so requested capital support from NHS Improvement. This support has been approved in the form of a capital loan in advance of the capital funds being released once the FBC has been approved.

3. Capital Loan

The Trust has been notified that the Department of Health has approved a capital loan for the Trust for £727k in relation to the Wave 4 STP transformation of Urgent & Emergency care at HRI.

This loan will support the Trusts capital programme and it is anticipated the loan will be drawn down in two parts: 2019/20 £375k and 2020/21 £352k. This is in line with the planned programme of works.

The capital loan will be repayable as per the schedule shown below and once the Trust has an approved FBC and the PDC funding associated with this is released, the full balance of the loan will be repaid.

Repayment Schedule of Capital Loan	
18 November 2020	5.26%
18 May 2021	5.26%
18 November 2021	5.26%
18 May 2022	5.26%
18 November 2022	5.26%
18 May 2023	5.26%
18 November 2023	5.26%
18 May 2024	5.26%
18 November 2024	5.26%
18 May 2025	5.26%
18 November 2025	5.26%
18 May 2026	5.26%
18 November 2026	5.26%
18 May 2027	5.26%
18 November 2027	5.26%
18 May 2028	5.26%
18 November 2028	5.26%
18 May 2029	5.26%
18 November 2029	5.32%

Interest on the capital loan will be determined by the National Loan Fund rate on the date of signing the loan agreement, the Trust has estimated this to be around 2%.

In order for the loan transfer to occur the Trust must complete:

- A signed and dated Facility Agreement supported by a Board Resolution. The required Board Resolution is attached at Appendix 1.

The Performance & Finance Committee understand the Trust's forecast cash position and recommend the approval for the drawdown of the capital loan

4. Recommendation

The Board is asked to support the application process for a capital loan and sign the Board Resolution minute.

Lee Bond
Chief Financial Officer, January 2020

Hull University Teaching Hospitals NHS Trust

Board Resolution

Statement from the Chair and Chief Executive of Hull University Teaching Hospitals NHS Trust regarding the Trust Board approval of an Uncommitted Loan Agreement.

A paper has been presented to the T r u s t B o a r d in January 2020 for scrutiny regarding the proposed loan.

This recommends that a Capital Support Loan totaling £727 thousand is taken; repayable upon final approval of the business case associated with The Humber, Coast & Vale Partnerships Wave 4 STP Capital allocation for the Transformation of Urgent & Emergency Care Services when PDC will be released to cover the loan repayment.

We confirm the Board have accepted this recommendation and therefore approve the Capital Loan on behalf of the Trust.

We also:

a) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

b) A uthorise the Chief Finance Officer to execute the Finance Documents to which it is a party on its behalf; and

c) Authorise the Chief Finance Officer to sign and/ or dispatch all documents and notices (including the Utilisation Request) in connection with the Finance documents to which it is a party on its behalf.

d) Confirm our undertaking to comply with the Additional Terms and Conditions

We certify that a paper has been presented to the Trust Board for scrutiny regarding the proposed Finance Documents and that this has been circulated to all Trust Board members.

Terry Moran -Chair, Hull University Teaching Hospitals NHS Trust

Signature:

Chris Long - Chief Executive, Hull University Teaching Hospitals NHS Trust

Signature:

Dated:

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

28 January 2020

Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2019-20	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	To seek Trust Board approval for the 2019/20 EPRR Annual Assurance Assessment	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Partnership and integrated services	X
	Research and Innovation	X
	Financial sustainability	X
Key Summary of Issues:	As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. This is undertaken through the annual EPRR assurance process. A total of 64 EPRR standards are applicable to the Trust as an acute provider. Of the 64 standards, the Trust is fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard, resulting in an overall assessment of 'partially compliant'. The draft assessment has been reviewed in a workshop with peers from Yorkshire and Humber Trusts and the Regional NHSE&I EPRR Team. They are content with our assessment and action plan to address the 14 standards with which the Trust does not fully comply. The assessment has been subject to a review by the Director of Corporate Affairs. This did not recommend that any of the compliance ratings be altered. Since the completion of the assessment, progress has been made against the delivery of the action plan. This is being tracked via the Trust Resilience Committee, with quarterly updates provided to the Non-Clinical Safety Committee.	
Recommendation	That the Trust Board approves the assessment.	

Hull University Teaching Hospitals NHS Trust

Trust Board

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2019-20

1. Purpose

The purpose of this document is to present to the Trust Board the outcome of the 2019/20 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2019-20.

2. Background

2.1 NHS Core Standards for EPRR

As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this NHS England (NHSE) and NHS Improvement (NHSI) ask commissioners and providers of NHS funded care to complete an annual EPRR assurance process. This process incorporates four stages:

- Organisational self-assessment against NHS Core Standards for EPRR
- Local Health Resilience Partnership (LHRP) confirm and challenge
- NHSE and NHSI regional EPRR confirm and challenge
- NHSE and NHSI national EPRR confirm and challenge.

The NHS Core Standards for EPRR are the minimum requirements commissioners and providers must meet. They cover ten core domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical, Biological, Radiological, Nuclear (CBRN).

The applicability of each core standard is dependent on the organisation's function and statutory requirements. Each organisation type (eg acute provider, commissioner), has a different number of core standards to assure itself against.

Participating organisations are asked to rate their compliance as follows:

- Non-compliant — Not compliant with the core standard
  The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.

- Partially compliant — Not compliant with the core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
- Fully compliant — Fully compliant with core standard.

An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with. The thresholds for each assurance rating are indicated below:

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve
Non-compliant	The organisation is compliant with 76% or less of the core standards they are required to achieve.

2.2 Deep Dive Review

In addition to the self-assessment against the NHS Core Standards for EPRR, each year NHS organisations are asked to undertake a deep dive review to gain additional assurance in a specific area. Previous years have covered such topics as business continuity, governance, pandemic flu or command and control arrangements. For 2019/20, NHS organisations have been asked to assure themselves on their responsiveness to severe weather and climate adaptation.

The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating.

2.3 Timescales for Submission

Assurance returns are to be submitted by 31 October 2019 and will be subject to confirm and challenge by the Local Health Resilience Partnership (LHRP) and NHSE/I. This year the Trust agreed an extension to this deadline and has to submit its assessment by 30 November 2019. This was to facilitate a review of a number of issues raised by the new Head of Emergency Planning, following the retirement of the former post holder in June 2019.

3. Trust EPRR Assurance Self-Assessment

A total of 64 EPRR standards are applicable to the Trust as an acute provider. In 2018/19 the Trust's self-assessment found that it was not fully compliant with 5 of the standards, resulting in an overall assessment of 'substantially compliant'. This was endorsed by the subsequent LHRP and NHSE/I confirm and challenge process.

In 2019/20, the Trust's self-assessment is that overall we are 'partially compliant'. Of the 64 standards, the Trust is fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	8	6	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	2	1	1
Business Continuity	9	6	3	0
CBRN	14	14	0	0
Total	64	50	13	1

The areas of partial compliance are in relation to:

Standard	Issue
17 - Mass Countermeasures	This related to the distribution of mass prophylaxis or vaccination. We have not previously had a written policy as this is led by the community providers, we have an arrangement in place, however we will liaise with our partners and put a written procedure in place.
19 – Mass Casualty – Patient ID	There is a new requirement for the patient ID system to be none sequential. Process in ED to be updated (we are also awaiting an e-solution)
20 – Whole site evacuation plan	The Trust does not have this in place for HRI or CHH. Support has been sought from NHSE and peer Trusts.
21 - Lockdown procedure	We have this covered in the Major Incident Plan and an annotated site map but it needs to be strengthened with traffic flow plans and tested.
22 – VIP policy	The policy is overdue review
23 – Excess deaths arrangements	The Trust has some arrangements in place but needs to review the capacity and agree mutual aid arrangements
27 – exercise and training programme	The Trust has some training and a programme of testing in place. Needs to be strengthened with an annual training plan and a single action tracker for learning from tests
30 – Incident Co-ordination Centre (ICC)	The Trust needs to test its fall back ICC
32 - Business Continuity Plans(BCPs)	Overarching Plan to be set out that includes Trust level response to Trust wide incidents.
42 – Mutual aid arrangements	This is covered in the Major Incident plan, including a process for requesting military aid and arrangements for mass casualties. It needs to be strengthened to include a range of other types of mutual aids
49 - Business Impact Assessment	This is contained within the Trust process for development of business continuity plans, however, the approach needs to be articulated in the overarching Business Continuity Plan
50 – Data Protection and Security Toolkit	This is a new standard – the toolkit was published in March 2019 and we are on track to comply by the March 2020 deadline

51 – Business Continuity Plans	Same issue as standard 32, need overarching Trust level BCP

The area of non-compliance is in relation to:

Standard	Issue
40 – Attendance of the Accountable Emergency Officer at the Local Resilience Forum (75%) meetings	Diary has not allowed this. HUTH has been represented at all meetings.

An EPRR action plan has been developed to address areas where attention is required and to strengthen areas where the Trust is already compliant.

Progress against the actions identified will be monitored through the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.

4. Approval Process

The Trust's draft self-assessment has been subject to a 'confirm and challenge' process by the Local Health Resilience Partnership, which involves peers and data from Yorkshire and Humber Trusts and the NHSE/I Regional EPRR Team. This took place on 19 November 2019. Subject to Trust sign off the HUTH assessment and action plan were accepted. A progress report against the action plan is required within six months.

Following discussion, further evidence submission and then endorsement by the Performance and Finance Committee, the EPRR assessment report and template was presented to the Trust Deputy Chairman for Chairman's action, in order to meet the submission deadline of 30 November 2019. This enabled it to form part of the NHSE&I overall Regional and National EPRR assurance exercise.

The report will then be submitted to the Public Board in January 2020 in order to form part of the public record.

5. Recommendation

The Trust Board is asked to:

- Endorse the findings of the 2019/20 EPRR assurance process and the assurance rating of 'Partially Compliant'
- Endorse the Trust's EPRR action plan and monitoring arrangements.

Jacqueline Myers
Director of Strategy and Planning
Accountable Emergency Officer

Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	8	6	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	2	1	1
Business Continuity	9	6	3	0
CBRN	14	14	0	0
Total	64	50	13	1

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	12	3	0
Long Term adaptation planning	5	0	4	1
Total	20	12	7	1

Overall assessment:	Partially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Jacqueline Myers, Director of Strategy and Planning as the AEO (Corporate director) Terry Moran, NED, Chairman	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust has an EPRR Policy covering Emergency Planning and Business Continuity	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Results of the 2018/19 EPRR Assurance exercise were presented to the Trust Board in September 2018 and an Annual Report is regularly submitted to the Non-clinical Quality Committee.	Fully compliant	The Director of Strategy and Planning will present the assurance process findings to the Trust Board for approval prior to submission to NHSE/I on 30 November 2019.	Director of Strategy and Planning	30/11/2019	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	The Head of Emergency Planning has a comprehensive workplan covering 2019/20. The workplan is a live document and will be continuously refreshed. Progress against the workplan will be monitored via the Trust Resilience Committee and Non Clinical Quality Committee.	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	The Trust has allocated pay and non pay funding to support the EPRR function. Key roles supporting EPRR include: Jacqueline Myers - Director of Strategy & Planning - AEO Jackie Railton - Assistant Director of Strategy & Planning - Oversight Taryn Milton - Head of Emergency Planning Lucy Ellyard - Assistant Planning Manager - part time assistance EP Nicky Evans - Assistant Planning Manager - part time assistance BC	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Process included in draft EPRR document and lessons learned action tracker has been developed. The EPRR Action Tracker is monitored through the Trust Resilience Committee through out the year.	Fully compliant				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	The EPRR risk process is outlined within the draft EPRR Policy. The EPRR Risks are captured on the EPRR Risk Register which is monitored through the Trust Resilience Committee.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust has an EPRR Risk Register which feeds into the Corporate Risk Register as per the Trust Risk Policy. The EPRR Risk Register is monitored through the Trust Resilience Committee. The Trust Risk Policy also refers to EPRR Risks.	Fully compliant				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Partners are consulted routinely as part of the planning process eg Major Incident, seasonal resilience, surge and escalation. Trust representatives liaising with national, regional and local partners in relation to planning for EU Exit and no deal scenario. EPRR Policy outlines the requirement for all EPRR plans to document the consultation process with partner organisations.	Fully compliant				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The definition of a critical incident is incorporated into the Trust Major Incident Plan (1.02: Major Incident Plan - Definitions). The Major Incident Plan would cover the response to a critical incident.	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a Major Incident Plan in place approved by the Executive Committee	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Adverse Weather Plan contains Heatwave response	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Adverse Weather Plan contains the Cold Weather Response	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Tust has a Pandemic Flu plan in place	Fully compliant				

16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Infection Control and Outbreak Policy has been updated and is going to IRC for ratification on 13/11/19	Fully compliant	Due for ratification at IRC on 13th November 2019	Director for Infection Control	13/11/2019	
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust does not have a Mass Countermeasures Plan. This will be addressed through the workplan.	Partially compliant	Develop Mass Countermeasures Plan	Head of Emergency Planning in conjuction with Pharmacy and Infection Control Leads	Oct-20	
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has outlined its response to a Mass Casualties incident as an appendix to the Trust Major Incident Plan	Fully compliant				
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust's mass casualty patient identification system was signed off by Trust Patient Administration / CRS teams and tested during the June 2017 Live Exercise. However, the system is a manual one and based on sequential numbering.	Partially compliant	Review Major Incident patient numbering and Lorenzo system with Patient Admin Leads.	Head of Emergency Planning liaising with Patient Admin	Jun-20	
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Fire Safety Policy states that clinical areas should carry out an evacuation drill, exercise or simulation on an 18-month basis. Non-clinical areas are on a 2-yearly frequency. Logistics, practicalities and sheer work load in departments have proven to be contributing factors to why some departments have not been able to carry out these exercises. The Fire Safety Team are picking these up when carrying out routine Fire Safety Audits and addressing them with the co-operation and assistance of Ward/Department Management. These informal sessions are being well-received by staff. A Trust Site Evactuation Plan is to be developed.	Partially compliant	Hospital full site evacuation plan to be developed	Head of Emergency Planning in conjunction with Head of Security and Fire Team	01/09/2020	
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The lockdown reference on the Major Incident pages on the Trust intranet contain a basic map of the site with no traffic flows or lockdown identified on the map. The Trust Security Lead is currently developing a Trust lock down plan. The Trust have locked down parts of the site in exercises and localised incidents so are able to secure the site if necessary however we dont have a formalised, documented process in place	Partially compliant	Head of Security to develop lock down plan	Head of Security	TBC	
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage "protected individuals"; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust VIP Visitor Access & VIP Patient Policy is due for review	Partially compliant	Communications team are currently making some amendments to the Trust VIP Visitor Access & VIP Patient Poilcy and this is not yet completed	Communications Team	29/11/2019	
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust works in partnership with the Local Resilience Forum in relation to mass fatalities; plans are currently being reviewed. The Trust currently has temporary measures in place to manage rising tide events that are under review, due to current capacity issues.	Partially compliant	Liaison with local councils and Local Resilience Forum to formulate both regional and Trust excess death plans.	Head of Emergency Planning and Head of Mortuary Services	May 2020	This is reliant on potential for Nutwells to be reserved as back ups to our current mortuary capacity as well as the LRF process being formalised and Documented
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	The Trust has a 24/7 oncall process with a 1st on call (senior manager) and a 2nd on call (director) on call at all times. This process is captured in the EPRR Policy and refered to in Section 1.04 of the MIP	Fully compliant				
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	The Training requirements for on call are captured in the Draft EPRR Policy. A large number of 1st & 2nd On Call have been on the Strategic Leadership in a Crisis Training and this can be seen on the EPRR training record.	Fully compliant	This can be marked as fully compliant if the EPRR Policy is approved prior to submission. The Head of Emergency Planning has begun the process of organising a training date for Strategic Leadership in a Crisis to be held in March/April 2020. This will capture any remaining untrained on call staff.	Head of Emergency Planning	March/April 2020	
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Current training includes: - CBRN training - mandatory MIP training (online) - Loggist Training EPRR Prospectus to be developed as per worklpan & training records being collated into one place Draft EPRR Policy captures training requirements The EPRR Training records capture future training to be completed and training that been has completed to date.	Fully compliant	TNA to be completed Head of Emergency Planning to develop EPRR Training prospectus for the coming year	Head of Emergency Planning	End of November Training Prospectus to be developed by January 2020	
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	EPRR Prospectus to be developed & EPRR action tracker identifies actions captured at exercises	Partially compliant	Head of Emergency Planning to develop EPRR Training Prospectus for 2020.	Head of Emergency Planning	Jan-20	

28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	EPRR Training & Exercising prospectus to be developed and a TNA to be completed. Training & Exercising portfolio requirements are included in the EPRR Policy and a central training record is kept by the Head of Emergency Planning Strategic Leadership in a Crisis training has been undertaken by a large number of our Strategic & Tactical on call staff. A future training session for SLiC is due to be held in March/April 2020	Fully compliant	EPRR training requirements captured in the EPRR Policy TNA to be completed SLiC dates to be confirmed	Head of Emergency Planning	TNA 22/11/2019 SLiC December 2019	
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	The Trust has a Hospital Control Centre and a Fall back site. Action cards are part of the MIP & i Review. Training & Testing of these is to be included in the EPRR Training Prospectus	Partially compliant	Testing of the ICC and Fall Back site to take place in 2020	Head of emergency planning	30/06/2019	
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	The Major Incident Plan is held on the trust intranet with hardcopies available in the control centre	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	The Trust has departmental Business continuity plans in place that are reviewed regularly. The Trust Overarching Business Continuity Plan is on the EPRR Workplan fordevelopment	Partially compliant	Trust overarching BCP to be developed	Head of Emergency Planning	Jul-20	
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	The Trust has a current list of all trained loggists within the organisation and regular training sessions are provided. An out of hours contact list for all trained loggists is held in Switchboard who will call in the required number of loggists dependant on the incident	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	The trust has 5 members of the sitrep team who are able to complete and upload sitreps. This process has been formalised within the MIP. This has been tested during EU Exit prep & response	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard co	On the intranet & hard copies in ED	Fully compliant				
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard co	Hard Copies are available in ED	Fully compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Communication strategy outlined within EPRR plans including Major Incident Plan (Communications & Media Mangement Section) and Media Liaison Officer Action Card - reviewed / revised following incidents / Live Exercise.	Fully compliant				
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Communication strategy outlined within the Major Incident Plan (Communications & Media Management Section) and Media Liaison Officer Action Card. All lessons are captured on the EPRR Action Tracker.	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Communication strategy outlined within the Major Incident Plan (Communications & Media Management Section) and Media Liaison Officer Action Card. All lessons are captured on the EPRR Action Tracker.	Fully compliant				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	Attendance has been and will continue to be by the Assistant Director of Strategy & Planning with the Head of Emergency Planning deputising when necessary	Non compliant				
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Attendance has been by Assistant Director of Strategy & Planning and the Head of Emergency Planning	Fully compliant				
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	The process for MACA is refered to within the MIP. Other Mutual aid to be included in the MIP comprehensive review Review	Partially compliant	Comprehensive MIP review to be undertaken	Head of Emergency Planning	31/05/2020	
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	This is outlined in the MIP which is due for review. There is a Humber LRF Multi-agency Information Sharing Protocol available.	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity is included in theEPRR policy	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	Business Continuity is included in the EPRR policy	Fully compliant				
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Documented BIA process for departments in place and annually reveiwed and the Trust over-arching BIA to be completed	Partially compliant	Trust overarching BIA to be developed	Head of Emergency Planning	Jul-20	
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Data SECURITY and PROTECTION Toolkit Information Governance not IT The DSPT for 2018/2019 was published 28/03/2019 Standards not fully met with plan agreed and we are on course to complete the DSPT for 2019/2020	Partially compliant	DSPT to be completed by 2020	Information Team	2020	

51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Departmental BCPs in place and reveiwewd annually. Over-arching trust BCP is to be developed	Partially compliant	Trust overarching BCP to be developed	Head of Emergency Planning	Jul-20	
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	EPRR Policy Document in place Action Tracker in place to capture all learning from Exercises and incidents	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Internal Audit undertaken in 2018/19 via internal auditing. Report available. EPRR Policy to be approved by board	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	EPRR Policyin place Actions from events/exercises are captured on the EPRR Action Tracker. Current Departmental Plans are tested through desk top exercises and events and the dates of these are captured on the BCP spreadsheet	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	It is requirement that all suppliers to the Trust must have documented and audited procedures in place for the continuity of goods and/or services in the event of a major incident alert within the Trust that may necessitate a very quick response and also in the event of a serious national or international incident which may affect the supply chain. The suppliers are requested to have plans incorporated in the tender to deal with emergency request. The information provided by the supplier is held centrally for easy access, and is scored as part of the tender to ensure contingency planning is fit for purpose.	Fully compliant				
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Documented in CBRN Plan	Fully compliant				
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Documented in CBRN Plan	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	This is captured in the EPRR Risk Register	Fully compliant				
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	A&E ensure that CBRN training is part of their localised induction training which ensures all A&E staff are appropriately trained and there is 24/7 capability to respond. The Trust Rota system also captures this information	Fully compliant				
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material:	Y	Completed equipment inventories; including completion date	The CBRN Lead ensures that a log of equipment checks is kept up to date. This can be found in the MI Cupboard in A&E	Fully compliant				
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Recently checked by YAS CBRN Inspector	Fully compliant				
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	The CBRN Lead ensures that a log of equipment checks is kept up to date. This can be found in the MI Cupboard in A&E. The estates team also regularly erect the decontamination tent to ensure it is in working order and use this opportunity to train/refresh estates and portering staff on how to erect he tent. The RAMGene is calibrated at least annually by our radiology team within the trust. This is compliant with national standards. The PRPS suits are serviced annually to ensure they are in good working order in the event of an incident where they need ot be used.	Fully compliant				
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	The CBRN Lead ensures that a log of equipment checks is kept up to date. This can be found in the MI Cupboard in A&E. The estates team also regularly erect the decontamination tent to ensure it is in working order and use this opportunity to train/refresh estates and portering staff on how to erect he tent. The RAMGene is calibrated at least annually by our radiology team within the trust. This is compliant with national standards. The PRPS suits are serviced annually to ensure they are in good working order in the event of an incident where they need ot be used.	Fully compliant	Contact Decontamination Unit manufacturer (Hughes) with a view to arranging for a service contract to be established and provide for an annual service check	Head of Emergency Planning in liaison with CBRN lead	Mar-20	
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Disposal of PPE is captured within the plan along with disposal of contaminated waste	Fully compliant	Include contact details for the disposal of the PRPS suits	Head of Emergency Planning in liaison with CBRN lead	Mar-20	
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	The Trust currently has 3 certified trainers for CBRN of which the CBRN lead is one	Fully compliant				
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	The Trust CBRN Lead ensures training is provided in line with current guidance and the Trust CBRN Policy.	Fully compliant				
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	The Trust currently has 3 certified trainers for CBRN	Fully compliant				

68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf	Decontamination training takes place throughout the year in line with current guidance.	Fully compliant				
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Staff have access to FFP3 masks.	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	See the Adverse Weather Plan	Fully compliant				
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	This is captured within the Adverse Weather Plan. Estates provide air conditioning units to areas identified as overheating and have a contract in place to hire in further units as needed.	Partially compliant	Add known areas of overheating and their mitigating arrangements - Discuss with Estates & Facilities	Head of Emergency Planning in liaison with the Deputy Director of Estates & Facilities	Mar-20	
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	The Adverse weather plan captures details of ensuring essential staff can get into work as well as the process staff should follow if they are unable to get into work. The Facilities team have accomodation available and the trust have a system in place where staff who live close to site can offer accommodation to those who need it in order to attend work. Departmental Business COntinuity Plans outline the the arrangements to maitain services during a disruption.	Fully compliant				
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	The Adverse Weather Plan has actions for in-hospital services as well as community based services in the event of Heatwave, Cold Weather, Flooding etc	Fully compliant				
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	The Adverse Weather Plan has actions for in-hospital services as well as community based services in the event of Heatwave, Cold Weather, Flooding etc this includes what is needed to ensure safe discharge of patients	Fully compliant				
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	The Trust Adverse weather plan refers to the gritting of sites. Estates have gritting procedural documents in place to ensure that access to the site is maintained.	Fully compliant				
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	The Adverse weather plan has clearly identified roles and responsibilities which include dissemination and assessment of severe weather warning as well as the levels of warnings and the actions needed at each level	Fully compliant				
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	Estates have a gully & guttering maintenance and clearing programme in place. In terms of third party owned drainage, there is currently no documneted process although the estates team would contact the relevant council to alert them of the issues	Partially compliant	Estates to add contact details for local councils and any other third party drainage contacts to their flood prevention planning	Deputy Director of Estates & Facilities	01/02/2020	
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	The Trust Adverse Weather plan references the linkage between the Trust and the Multi-agency LRF Flood Plan. The Trust sits on the Humber LRF and has been able to comment on and have input into the LRF Flood Plan - see LRF minutes	Fully compliant				

10	**Severe Weather response**	**Warning and informi**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	The Trust Adverse Waether Plan covers linkage with partners for consistent messages The plan also accounts for in hours and out of hours responsibilities	Fully compliant				
11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	As both sites of the Trust are in flood risk areas they have not been specified in the plan but will be included in the flood plan review 2020 The estates teams on both sites have plans in place for managing flooding on each site The Flood Risk is captured by the EPRR Risk Register	Partially compliant	Include site specific flooding details in the 2020 Adverse Weather Plan Review	Head of Emergency Planning	Sep-20	
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Risk identified on EPRR Risk Register	Fully compliant				
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	The organisation seeks assurance, as per the core standards, that suppliers provide comprehensive BCPs as part of their tendering process. Departments have individual BCPs to deal with alternative supplier arrangements	Fully compliant				
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	The organisation responded to a heatwave in 2019 and a post-incident report was completed and lessons identified (JR). These actions have been captured on the EPRR Action Tracker	Fully compliant				
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services, We have 500 remote users with a further 4000 that access email remote. As both trust sites are in flood zones and the server rooms are on the ground floor the entrance ot this area has been raised slightly by a few inches. A lot of the Trust's information is stored on cloud servers off site as a secure retrieval option Cooling systems are in place	Fully compliant				
Domain: long term adaptation planning											
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	We currently have a known temp area (North Block Theatres) on our EF&D risk register	Partially compliant	The organisation should consider mitigating actions for future planning. The water cooled chilling systems are currently on the workplan dependant on funding	Director of EF&D	2021	
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	The Building Management System has limited ability to record temperatures. During peak periodsof high temperatures (crica 2/3 weeks per annum) instantaneous temperatures are noted. There is no associated risk entry on the Trust risk register. As part of adverse Weather planning a recommendation has been given tothe board to suggest all inpatient areas install a wall thermometer and capture the temperature regularly (a few times a day in extreme temperatures) and capture it on the temperature recording sheet in the Adverse Weather Plan.	Partially compliant	All inpatient areas to install wall thermometers	All inpatient areas	May-20	
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	There is no adaptation plan in place. In the event of extreme weather event EF&D would implement business continuity plans alongside the Trust Adverse Weather Plan. When planning new builds or building modifications raising the level of the building from the ground is always discussed as a flood prevention method where possible	Non compliant	Consider the need for a Trust Adaptation plan	Director of EF&D	2021	

19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	There is no adaptation plan in place. Historically, the Trust has implemented a number of flood alleviation schemes especially at CHH. When planning new builds or building modifications raising the level of the building from the ground is always discussed as a flood prevention method where possible	Partially compliant	Consider the need for a Trust Adaptation plan	Director of EF&D	2021	
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	New build projects have to satisfy Planning and Building Regulations which includes SUDS. The Capital Project Team follow Capital Investment Manual process and procedures.	Partially compliant	Consider severe weather conditions when planning all future new build projects	EF&D	ongoing	

Overall assessment:										
Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Results of the 2018/19 EPRR Assurance exercise were presented to the Trust Board in September 2018 and an Annual Report is regularly submitted to the Non clinical Quality Committee.	Fully compliant	The Director of Strategy and Planning will present the assurance process findings to the Trust Board for approval prior to submission to NHSE/I on 30 November 2019.	Director of Strategy and Planning	30/11/2019	

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 28th January 2020

Title:	Contract Extension Recommendation Paper for the Continued use of the Healthtrust Europe Total Workforce Solutions Framework Agreement
Responsible Director:	Simon Nearney Director of Workforce and O.D
Author:	Sue Richards - Head of Workforce Transformation & Service Delivery Chris Harker - Head of Finance Corporate Diane Mitchell - Contracts Support Officer

Purpose:	The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement for a period of 12 months from 1st November 2019 to 31st October 2020.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	
	Great local services	✓
	Partnership and integrated services	✓
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	This is an official contract extension for the provision of Total Workforce Solutions Non - Medical & Non - Clinical (Inc. Executive) Services. Under framework NMNC HTE-TWS-4 with Healthtrust Europe.	

Recommendation:	The Chief Executive / Chief Finance Officer and Trust Board are requested to approve the extension of access to the HealthTrust Europe's Total Workforce Solutions Framework Agreement for a further 12 months from 1st November 2019 to 31st October 2020.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

CONTRACT EXTENSION RECOMMENDATION PAPER FOR THE CONTINUED USE OF THE HEALTHTRUST EUROPE TOTAL WORKFORCE SOLUTIONS FRAMEWORK AGREEMENT

COMPLIANT CONTRACT RECOMMENDATION

Status:	**Official Contract Extension**
Trust Reference:	**HEY/16/255/A – LOT 3A Medical Locums (Temporary)** **HEY/16/255/B – LOT 3B Nursing (Temporary)** **HEY/16/255/C – LOT 3C Allied Health (Temporary)** **HEY/16/255/D – LOT 4 Non-clinical (Temporary)**
Type:	**Contract Extension**
Original Contract Term:	**36 months with an option to extend for up to 24 months**
Original Period of Contract:	**(01/12/2016 – 31/10/2018)**
Period of official extension taken:	**12 Months (01/11/2018 – 31/10/2019)**
Periods of official extension period remaining:	**12 Months**
Period and date(s) of this official compliant extension period being recommended:	**12 Months (01/11/2019 – 31/10/2020)**
Health Group:	**Corporate**
Division:	**Workforce and O.D.**
Department:	**Human Resources**
Original Procurement Process Used:	**HealthTrust Europe Total Workforce Solutions Framework (Direct Award)**
Total Contract Extension Value (Ex. VAT):	**£9,719,399.65 Variable**
Cost Centre:	**All Trust clinical departments can use this framework.**
Terms and Conditions which apply:	**NHS Framework Agreement for the Provision of Services.**
G.D.P.R. Applicable:	**Yes**
Procedure Compliant with Trust SFI's:	**Yes**

1. PURPOSE

1.1 The purpose of this paper is to seek approval of the Chief Executive / Chief Finance Officer and the Trust Board to extend the access to the HealthTrust Europe Total Workforce Solutions Framework Agreement for a period of 12 months from 1st November 2019 to 31st October 2020.

2. BACKGROUND

2.1 In December 2016 the Trust signed up to three NHS mandated framework agreements established to provide NHS Trusts with access to temporary staffing providers:

- The North of England Commercial Procurement Collaborative's (NOECPC) National Clinical Staffing Framework Agreement: For nursing temporary staffing.

- HealthTrust Europe's Total Workforce Solutions Framework Agreement: For allied health, scientific, and medical temporary staffing.

- Crown Commercial Service's Non Clinical Non-Medical Framework Agreement: For non-clinical and non-medical temporary staffing.

These frameworks provide a compliant route to engage temporary staff at nationally agreed pay rates. The terms of the sign-up enables the Trust to access the framework for the entirety of the framework period.

3. EXTENSION RECOMMENDATION

3.1 This extension recommendation concerns the HealthTrust Europe framework agreement – which is being utilised to engage temporary allied health, scientific and medical staffing.

3.2 In October 2019 the HealthTrust Europe advised that the framework term had been extended until 31/10/20.

3.3 This recommendation is being made to request continued use of this framework in line with this extension.

4. FINANCIAL IMPLICATIONS

4.1 CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum:	**£9,719,399.65**
Current cost inclusive of VAT per annum:	**£11,663,279.58**
Current contract end date:	**31/10/2019**
Comments The costs listed above referred to the spend on allied health, scientific, and medical agency staffing only.	

4.2 PROPOSED EXTENSION COSTS

Proposed cost exclusive of VAT per annum:	**£9,719,399.65**
Proposed cost inclusive of VAT per annum:	**£11,663,279.58**
Proposed contract extension start date:	**01/11/2019**

Duration of extension:	**12 months**
Value of total contract extension including VAT:	**£11,663,279.58**
Comments: The costs listed above refer to spend on allied health, scientific, and medical agency staffing only	

4.3 FUNDING DETAILS

Source of Funding:	**Revenue**
Cost Centre:	**All Trust clinical departments can use this framework.**
Expense Code:	**All Trust clinical departments can use this framework.**
Financial Implications approved by:	**Chris Harker**

5. HEALTH GROUP EXTENSION RECOMMENDATION

5.1 The following colleagues from the Corporate Health Group were directly involved in the recommendation of this extension:

- Sue Richards - Head of Workforce Transformation & Service Delivery
- Chris Harker - Head of Finance Corporate

6 RECOMMENDATION

6.1 The Chief Executive / Chief Finance Officer and Trust Board are requested to approve the extension of access to the HealthTrust Europe's Total Workforce Solutions Framework Agreement for a further 12 months from 1st November 2019 to 31st October 2020.

Simon Nearney
Director of Workforce and O.D

Procurement Department comments

This recommendation is compliant with Trust Standing Orders, Standing Financial instructions and EU Regulations.

Procurement Department additional comments: None

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Please indicate approval or rejection of this paper by signing in the appropriate box below.

Scheme of Delegation as per Section D Point 9.12 of Corporate Policy 105 – Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions (February 2017)

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Total Workforce Solutions Framework Agreement.

Contract ref: HEY/16/255.

The above recommendation **is** accepted.

Signed: …… Date: ……

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed: …… Date: ……

Trust Board

Total estimated contract value above £3,000,000.00 (Inc. of VAT) - Trust Board Approval Required

Contract title: Total Workforce Solutions Framework Agreement

Contract ref: HEY/16/255

The above recommendation **is not** accepted.

Signed: …… Date: ……

Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Signed: …… Date: ……

Trust Board

Reasons for rejection of recommendation:

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Contracts Ref:	HEY/16/255	**Supplier Ref:**	Medical Locums HTE-TWS-3A Nursing & Care HTE-TWS-3B AHPS/HSS HTE-TWS-3C
Contracts Contact:	DM	**Date submitted for approved:**	19/12/2019

Hull University Teaching Hospitals NHS Trust
Trust Board
28 January 2020

Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme – Year Three
Responsible Director:	Beverley Geary - Chief Nurse
Author:	Beverley Geary, Chief Nurse Janet Cairns, Head of Midwifery Lisa Pearce, Divisional General Manager

Purpose	The purpose of this report is to provide information and assurance in relation to the self-assessment against the ten safety actions requiring Trust Board approval, and sign off for submission to NHS Resolution.	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great clinical services	Y
	Partnership and integrated services	Y
	Research and Innovation	Y
	Financial sustainability	Y
Key Summary of Issues	The service has undertaken a benchmarking exercise against the ten maternity safety actions to inform the Board of the key issues and requirements to be able to successfully submit evidence to NHSR by 17 September 2020. There is a specific requirement on a Quarter 3 data submission, which is included in this report to the Trust Board. At the present time, the Trust is declaring partial compliance with the standards, which is detailed in this report, and the actions being taken to improve compliance prior to submission.	

Recommendation	The Trust Board is requested to: • Receive the team's assessment of the Trust's current level of compliance • Receive assurance by the team that the action plan will address the identified requirements and move the Trust to full compliance by September 2020

Hull University Teaching Hospitals NHS Trust
Trust Board

Clinical Negligence Scheme for Trusts Maternity Incentive Scheme – Year Three

1. Purpose of the report

The purpose of this report is to provide information with regards to the requirements to achieve the maternity incentive scheme requirements. The report contains an initial benchmarking of safety actions and is prepared in readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2020/21.

This report presents the following:

- Benchmarking of the year three CNST safety actions
- Required evidence to be received by the Board as part of this submission
  - Review of perinatal mortality in the Trust
  - Action plan to achieve the 10 Safety Actions
- Formal recording in Board minutes for:
  - Review of perinatal mortality for Q3 September 2019 – December 2019

2. Background

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

Due to the higher risk nature of maternity services in insurance terms, by definition, specific premia are calculated for these services; compliance against the 10 safety actions provides for an incentive of a 10% premium reduction. The Maternity CNST rebate in 2019 was £471k with a further £20k allocation from Trusts who were not compliant with all ten safety actions. The maternity premium for the Trust for 2020/21 is £6,173,276. The maternity incentive contribution is £561,207 which, if allocated, would reduce the overall contribution to £5,612,070.

The standards have once again been augmented with further evidence required to be submitted to achieve compliance. As previously, the Trust Board is required by NHS Resolution to be sighted on the details of Safety Action 1, 4, 5, 6 and 10 with formal noting in the Board minutes. The Trust Board is required also to permit the Chief Executive to sign the submission declaration on its behalf for submission in September 2020. There are some specific Quarter 3 data requirements that are included in this paper to the Board.

The evidence will be subject to external verification by the Care Quality Commission, NHS Digital, the National Neonatal Research Database and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths). Trusts will then be notified of results at the end of October 2020. The payments made under the maternity incentive scheme will be communicated to trusts by the end of December 2020.

The full details of the scheme are publically available:
https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf

3. The Maternity Incentive Scheme

The 10 maternity safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions Into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)?
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification (NHSEN) scheme?

The initial benchmark indicates the Trust can demonstrate partial compliance with all ten maternity safety actions, with an expectation by September 2020 there will be full compliance. Meetings are being held weekly to update on progress for each standard and issues for escalation will be included in the quarterly updates for the Trust Board. The self-assessment has been validated by the Head of Midwifery, the Clinical Lead for Maternity Services and the Divisional General Manager.

The following table provides an overview of the current position against the year-three standards. This is a position statement at this point in time: the table identifies what the Board needs to do in respect of the standards and when the Trust Board will receive this for sign off, in order to achieve full compliance by the 17 September 2020 submission deadline.

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool** **PARTIAL COMPLIANCE**	The Trust Board will receive quarterly reports between 20 December 2019 and 17 September 2020. The report will evidence compliance with the required standards.
2	**Maternity Services Data Set** **PARTIAL COMPLIANCE**	MSDS submissions will be made in each of the last 6 months November 2019 – May 2020 data, submitted to deadlines between January 2020 and June 2020. The Board will be provided with evidence of compliance with 14 standards in order to submit the Board Declaration of assurance following evidence review in September 2020. NHS Resolution will cross reference self-certification against NHS Digital data but will receive the confirmation for criterion 13 directly from the Trust.
3	**Transitional Care Services** **PARTIAL COMPLIANCE**	Pathways of care for transitional care are in place, with a data collection process for capturing transitional care activity. An action plan to address local findings of the ATAIN reviews will be agreed with the Board level safety champion in order to submit the Board Declaration of assurance following evidence review in September 2020
4	**Clinical Workforce Planning** **PARTIAL COMPLIANCE**	**Obstetric medical workforce** All boards should formally record in their minutes the proportion of obstetrics and gynaecology trainees in their trust who responded 'disagreed or /strongly disagreed to the 2019 General Medical Council National Trainees Survey question: In my current post, educational/training opportunities are rarely lost due to gaps in the rota. An action plan should be signed off by the trust Board and a copy with evidence of Board approval submitted to the RCOG. There is no change to this element from the information submitted in 2019. **Anaesthetic medical workforce** An action plan is in place and agreed at trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. There is no change to this element from the information submitted in 2019. **Neonatal medical workforce** This is a new element to this safety action where there is a requirement for formal recording in trust Board minutes that the neonatal unit meets the British Association of Perinatal Medicine BAPM national standards of junior medical staffing **Neonatal nursing workforce** This is a new element to this safety action where there is a requirement for an action plan in place agreed at trust Board level to meet the recommendations of the service specifications for neonatal nursing standards. The required updates will be reported to the Trust Board in June 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020
5	**Midwifery workforce Planning** **PARTIAL COMPLIANCE**	A Bi Annual Chief Nurse midwifery staffing oversight report that covers staffing and safety issues will be reported to the Trust Board in June 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020
6	**Saving Babies Lives Care Bundle Version 2** **PARTIAL COMPLIANCE**	There is a requirement for Trust Board level consideration of how the maternity services is complying with Saving Babies Lives Care Bundle Version 2 published in April 2019. Full implementation of the SBLCBv2 is included in the 2019/20 standard contract with each element of the care bundle implemented. The care bundle can be accessed via the link below. https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
7	**Working with the Maternity Voices Partnership** **PARTIAL COMPLIANCE**	The required updates will be reported to the Trust Board in June 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020
8	**Multi Professional Training** **PARTIAL COMPLIANCE**	The required updates will be reported to the Trust Board in September 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020
9	**Trust Safety Champions** **PARTIAL COMPLIANCE**	The required updates will be reported to the Trust Board in September 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020

10	**NHS Resolution Early Notification scheme PARTIAL COMPLIANCE**	Trust Board should have sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and number reported to NHS Resolution. The required updates will be reported to the Trust Board in June 2020 in order to submit the Board Declaration of assurance following evidence review in September 2020

5. Financial Implications

If the Trust is successful in its application, this will result in a circa £561k saving against its CNST contributions for 2020/21 which is identified as part of the Family and Women's Health Group cost reducing efficiency savings (CRES) for 2020/21. A Quality Impact Assessment (QIA) will be undertaken as part of the Health Group Governance process for the CRES programme.

6. Safety Actions

All ten maternity safety actions require Trust Board assurance of compliance against the minimal evidential requirements. Safety Actions: 1, 4, 5, 6 and 10 require a formal declaration of approval recorded in the minutes of actions plans and evidence submitted. The action plan has been submitted to the Board Secretary and the detail of this can be reviewed by Board members as required. The Maternity Team are recommending this action plan as being sufficient and will lead the Trust to full compliance for the September 2020 submission deadline.

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

The Trust Board is requested to have sight of a quarterly report, which includes details of perinatal death reviews and the consequent action plans. A multidisciplinary review group was established in 2018 to undertake perinatal reviews using the PMRT. The Q3 report is attached as an appendix to this report.

6.2. Safety Action 2 Maternity Services Data Set

The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway. The quality and completeness of the data submission, relating to 14 mandatory criteria will be cross referenced by NHS Resolution and the deadline for submission is 30 June 20. There are issues with how data for the MSDS can be collected from Maternity Lorenzo with regards to compliance with Saving Babies Lives Version 2, as there are elements currently which are not recorded in the data system.

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

The action plan for ATAIN from 2019 will be agreed as complete and a re-audit will be undertaken and shared with the Board Safety Champion and the neonatal safety champion

6.4. Safety Action 4 Clinical Workforce Staffing

6.4.1. GMC National Training Survey

The Trust Board is requested to formally record in the minutes the results of GMC National Training Survey *Question: To what extent do you agree or disagree with the following statement? 'In my current post, educational/training opportunities are RARELY lost due to gaps in the rota'.* These data will follow in a future update to the Board once the survey data are available.

6.4.2 Anaesthesia Clinical Services Accreditation (ACSA) standards.

The Trust is required to formally record in Trust Board minutes the proportion of ACSA standards met. Audits to be undertaken to evidence minimal delays to elective procedures and rapidness of emergencies to support local arrangements, the results of which will be reported in a future Board report.

6.4.3 The Trust is required to formally record in trust Board minutes whether it meets

the recommendations of the neonatal medical workforce training action. A position statement will be provided in a future Board report.

6.4.4 The Trust is required to formally record to the trust Board minutes the compliance to the Service specification standards, for neonatal nursing, annually. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust Board. The action plan has been submitted to the Board Secretary and the detail of this can be reviewed by Board members as required. The Maternity Team are recommending this action plan as being sufficient and will lead the Trust to full compliance for the September 2020 submission deadline.

6.5. Safety Action 5 Midwifery Workforce
The Trust Board receives bi-annual reports from the Chief Nurse which outline the systematic process to calculate midwifery and nurse staffing. These reports will include evidence to assure that the labour ward coordinator has supernumerary status and that women receive one to one care in labour.

6.6 Safety Action 6 Saving Babies Lives Care Bundle Version 2 (SBLCB V2)
Maternity Services reported full compliance with SBLCB Version 1 in 2016, reported to the Trust Board in 2019. Maternity services submit quarterly surveys to the Clinical Network regarding compliance. SBLCB V2 was published in March 2018 and has a 5th element in respect of Pre-term Birth, Prediction, Prevention and Preparation. An action plan has been submitted to the Board Secretary and the detail of this can be reviewed by Board members as required. The Maternity Team are recommending this action plan as being sufficient and will lead the Trust to full compliance for the September 2020 submission deadline

6.7 Safety Action 7 Patient Feedback mechanism for maternity services
Maternity Voices Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. An MVP creates and maintains a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners. The Trust feeds into two MVPs for Hull and the East Riding of Yorkshire respectively. The MVPs have supported patient surveys and workshops to improve the maternity care services.

6.8 Safety Action 8 Multidisciplinary Training
90% of all staff groups have undertaken an in-house multi-professional emergencies training session Trusts will be evidencing the position as at end of Thursday 17 September 2020

6.9 Safety Action 9 Maternity Safety Champions
The Board level safety champions are undertaking monthly feedback sessions for maternity and neonatal staff and can demonstrate progress with auctioning named concerns visible to staff. With evidence that discussions and concerns, progress and actions are reflected in the minutes of the Board, Local Maternity System and Local Learning Systems. Action plan to achieve 51% of women being placed on a Continuity of Carer pathway has been developed and shared with the Board safety champion.

6.10 Safety Action 10 NHS Early Resolution Scheme
The Trust Board is required to have sight of records of qualifying Early Notification Incidents and numbers reported to NHS Resolution Early Notification Team in the financial year 2019/20. These figures will follow in a future report to the Trust Board.

7. Summary
In summary, following a rigorous self-assessment process the service is declaring partial compliance with all of the required CNST Incentive safety actions. The new standards require Board oversight, assurance and endorsement on all of the evidence required before

being able to submit the Trust's application. An update will be provided quarterly, and the final evidence to be signed off by the Chief Executive will be submitted for the Trust Board on 8 September 2020.

8. Recommendations

The Trust Board is requested to:

- Receive the team's assessment of the Trust's current level of compliance
- Receive assurance by the team that the action plan will address the identified requirements and move the Trust to full compliance by September 2020
  Decide if any further information and/or assurance are required

Janet Cairns
Head of Midwifery

Beverley Geary
Chief Nurse

January 2019

Hull University Teaching Hospitals NHS Trust
Family & Women's Health Group
Women's Services

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) INCENTIVE SCHEME – STANDARD 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

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST). This is administered by NHS Resolution (formerly the NHS Litigation Authority). A national standardised Perinatal Mortality Review Tool (PMRT) The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews.

3. SAFER MATERNITY CARE

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

4. THE MATERNITY INCENTIVE SCHEME

Trusts that are able to demonstrate compliance with ten safety actions will be entitled to at least a 10% reduction in their CNST maternity contributions. To encourage this additional focus, the Department of Health re-set the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth to 2025, bringing this forward by five years. By meeting the ten standards, Trusts are likely to deliver safer maternity services and are likely to be expected to have fewer cases of brain injuries or other harm, which can lead to negligence claims.

The requirements for Safety Action 1; Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

a) A review of 95% all deaths of babies suitable for review using the PMRT have been started within four months of each death.
b) At least 50% of all deaths of babies will have been reviewed, by a multidisciplinary review team, within four months of each death.
c) In 95% of all deaths of babies 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 MBRRACE-UK

The aim of the PMRT is to support standardised perinatal mortality reviews by:

- Systematic, multidisciplinary reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death

- Active communication with parents to ensure they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;

At the conclusion of the multidisciplinary review the team agree the grading of care, the categories are as follows;

6. CONCLUSION

To demonstrate compliance with the safety actions it is reported that the PMRT multidisciplinary team have commenced reviews within 4 months of the death occurring in **100%** of neonatal deaths and **96%** of stillbirths. The reason that the Stillbirth was below 100% was due to the requirement to notify two historical.

A review has been completed for **70%** of cases in the first 4 months of the reporting period. The parents were told in **100%** of all cases that a review of their baby's death would be undertaken. The parents are given a leaflet provided by MBRRACE-UK and their perspective is sought and encouraged. This process is supported by the midwifery bereavement team.

Sarah Green – Bereavement Midwife
Sue Cooper – Bereavement Midwife
Janet Cairns – Head of Midwifery

3 January 2020

OVERVIEW OF DEATHS REVIEWED (From 12th December 2018)

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review Quarter 3 September 2019 - December 2019							
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1		Neonatal Death 36+0	Q1 2019			**D/B/A**	SI investigation also completed. Bereavement midwife support through the process **Actions** 1. Review IOL guideline 2. Reminder to staff re smoking cessation referral for family members 3. Consideration of redesigning emergency boxes
2		Twins 1 neonatal death	Q2 2019			**B/B/A**	Review completed awaiting agreed action plan from neonates
3		Neonatal death 23+1 day	Q2 2019			**B/B/A**	Actions 1. Review DNA guideline 2. Discuss care in labour on Mandatory training for midwives 3. Individual feedback to staff involves 4. Reminder to staff re process for placenta for histology
4		Neonatal death 39+2	Q2 2019			**A/A/A**	Completed – no issues identified following the review
5		Neonatal Death 32+0	Q2 2019				Review on-going
New Neonatal cases Q3 (October 2019 - December 2019)							
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1		Neonatal death 23+6	Q3 2019				Review on-going
2		Neonatal death 25weeks	Q3 2019				Review on-going

Perinatal Mortality Reviews reporting From 12th December 2018 completed maternity cases Q3 (Sept - Dec 2019)							
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	[redacted]	Stillbirth of 1 Twin	Q1 2019			**A/A**	Completed – no issues identified following the review
2		Stillbirth 36+0	Q1 2019			**B/B**	Completed – no issues identified following the review
3		Stillbirth and neonatal Death 31+0	Q1 2019			**B/A**	Baby 1 Stillbirth review completed, writing report. Baby 2 NND review in progress
New Maternity cases Q3 (October 2019 - December 2019)							
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	[redacted]	Stillbirth 32+2	Q3 2019				Review on-going
2		Stillbirth 24+2	Q3 2019				Review on-going
3		Stillbirth 36+6	Q3 2019				Review on-going
4		Stillbirth 30+2	Q3 2019			**C/B**	**Actions** 1. Individual reflection and review of decision making 2. Bereavement training with midwifery teams.
5		Stillbirth 37+1	Q3 2019			**A/A**	Completed – no issues identified following the review
6		Stillbirth 24+3	Q3 2019				Review on-going

Grading Key
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.

Hull University Teaching Hospitals NHS Trust

Trust Board

28 January 2020

Title:	Quarterly Report on Safe Working Hours: Junior Doctors in Training – for quarter 1 July 2019 to 30 September 2019
Responsible Director:	Mr Androniks Mumdzjans, Guardian of Safe Working
Author:	Mr Androniks Mumdzjans, Guardian of Safe Working

Purpose:	The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate	
BAF Risk:	BAF 2 – Staffing	
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:	In this quarter the following were the number of episodes of exceptions reported trainees by Health Group Clinical Support - 37 Family and Women – 5 Medicine – 29 Surgery - 39 GP placement – 0 Exception Report trends: Oncology: This was the area with the most exception reports (33 episodes) in this quarter. The main reason for reporting was the volume of work and staff shortages which leads to overstay.	

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

Hull University Teaching Hospitals NHS Trust
Quarterly Report on Safe Working Hours
Doctors and Dentists in Training 1 July – 30 September 2019

Executive Summary

The Guardian Report for this Trust Board Meeting covers the quarter from July 2019 to September 2019

Exception Reporting patterns and responses

There were a total of 110 exception reports with a total of 110 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to volume of work which lead to trainees staying beyond the contracted hours. Other reasons include missed educational and training opportunities as well as staying beyond contracted hours in the interest of patient care and staff shortage.

In this quarter the following were the number of episodes of exceptions reported trainees by Health Group

Clinical Support - 37
Family and Women – 5
Medicine – 29
Surgery - 39
GP placement – 0

Exception Report trends:
Oncology: This was the area with the most exception reports (33 episodes) in this quarter. The main reason for reporting was the volume of work and staff shortages which leads to overstay.

Summary

Mr Androniks Mumdzjans has been appointed as Guardian of Safe Working, replacing Mr N Muthukumar since 2 September. At the current time there still is no system in place to robustly capture all instances were trainees have breached the safe working hours as required by the Junior Doctor Contract 2016, However, Rachel Fitzmaurice has been appointed as Guardian of Safe Working Medical Staffing Analyst and is due to start in this role from mid-November.

Mr Androniks Mumdzjans aims to achieve a maximum eroster compliance across all departments.

Questions for consideration

The Trust Board is requested to receive this report and:

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

Mr Androniks Mumdzjans
Consultant Obstetrics & Gynaecology
Guardian of Safe Working Hours
Hull and East Yorkshire Hospitals NHS Trust

Encl:
Appendix 1: Board Report GSW 1 July 2019 – 30 September 2019

Hull University Teaching Hospitals NHS Trust
Quarterly Report on Safe Working Hours
Doctors and Dentists in Training 1 July 2019 – 30 September 2019

1. Purpose of the Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from October to December 2018 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	558 (establishment) 535.5 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	535.5
Amount of time available in job plan for guardian to do the role:	1 PA / 4 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors: (max; varies between HGs)	0.25 PAs per trainee

All trainees in the Trust are now on the 2016 terms and conditions of service (TCS) and have received their work schedules. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hour's adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.
Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.

The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

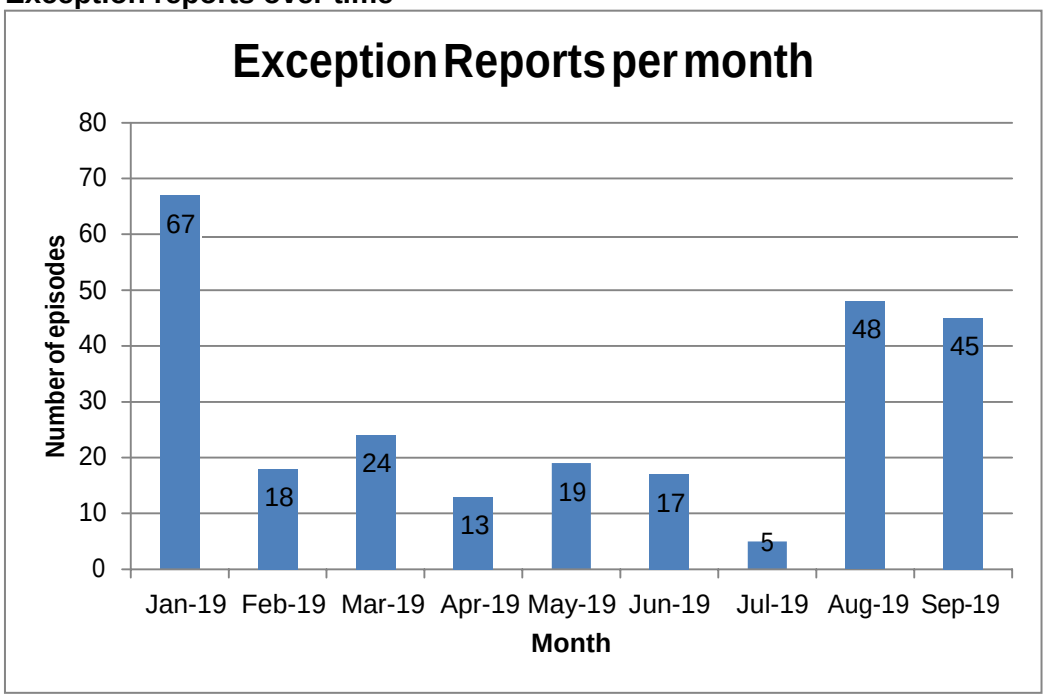
The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

3. Junior Doctor Working Hours

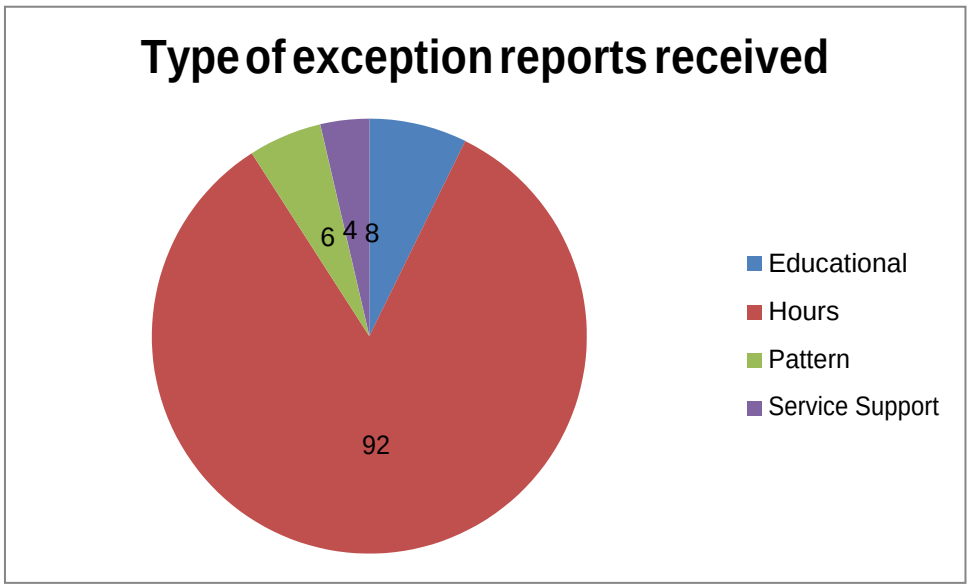
The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region. In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern.

There were 98 exception report episodes submitted between 1 July and 30 September 2019 and 12 carried forwards from the previous quarter.

Exception reports over time



Types of exception reports received 1 July – 30 September 2019



Exception reports (episodes) by specialty 1 July – 30 September 2019

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
A&E		1		1
Acute Internal Medicine		1	1	
Cardiothoracic Surgery		3		3
Colorectal Surgery		10	8	2
Critical Care		1	1	
Elderly Medicine	3	4	4	3
Endocrinology		18	18	
ENT	4	2	5	1
Neurosurgery		1	1	
Oncology		37	34	3
Opthalmology		3	3	
Orthopaedic Surgery	1			1
Paediatrics		1	1	
Renal	1			1
Respiratory		1	1	
Upper GI		3	2	1
Urology	9		4	5
Vascular	1		1	
Vascular Surgery	4		4	

Exception reports (episodes) by grade 1 July – 30 September 2019

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1		2	1	1
CT2		3	2	1
F1	57	1	49	9
F2	4	25	18	11
GPS T1	3		3	
GPS T2		2	2	
ST2		10	9	1
ST3	2		2	
ST5	1		1	

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are

learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades, as time goes on and as they get used to the contract and the exception reporting mechanism. Numbers are small, however, and it is not possible to draw conclusions from these reports yet.

Exception reports (episodes) by rota 1 July – 30 September 2019

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 8 - Onocology/Haematology SHO		21	21	
23 - Vascular Surgery F1 (inc. ENT/Uro)	4		4	
Rota 1 - A&E F2		1	1	
Rota 12 - Medical Oncology SpR		3	2	1
Rota 121 - Cardiology / Ct Surgery SHO		3	3	
Rota 124a - General Surgery (acute)		13	11	2
Rota 124b General Surgery (Uro/ENT) SHO		15	9	6
Rota 133 - Neurosurgery (ENT) F2 & CT		1		1
Rota 134 - Orthopaedics F2		1	1	
Rota 14 - Medicine SHO blp 431	3	2	3	2
Rota 18 - Medicine F1		17	14	3
Rota 25 - Acute/Elective F1		1		1
Rota 29 - Vascular Surgery	1		1	
Rota 4 - Medicine F1		3	2	1
Rota 58 - Paediatrics SHO		1	1	
Rota 59 - Paediatrics SpR		1	1	
Rota 6 - RMO		1	1	
Rota 18B - Crit Care F1 (Aug 18)		1	1	
Rota 18B - Medicine F1		17	17	

Exception reports (episodes) - response time 1 July – 30 September 2019

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open
CT1	1			
CT2	2			2
FY1	23	7	19	9
FY2	1	7	10	11
GPST1			3	
GPST2			2	
ST2	8	1		1
ST3	1			1
ST5				1

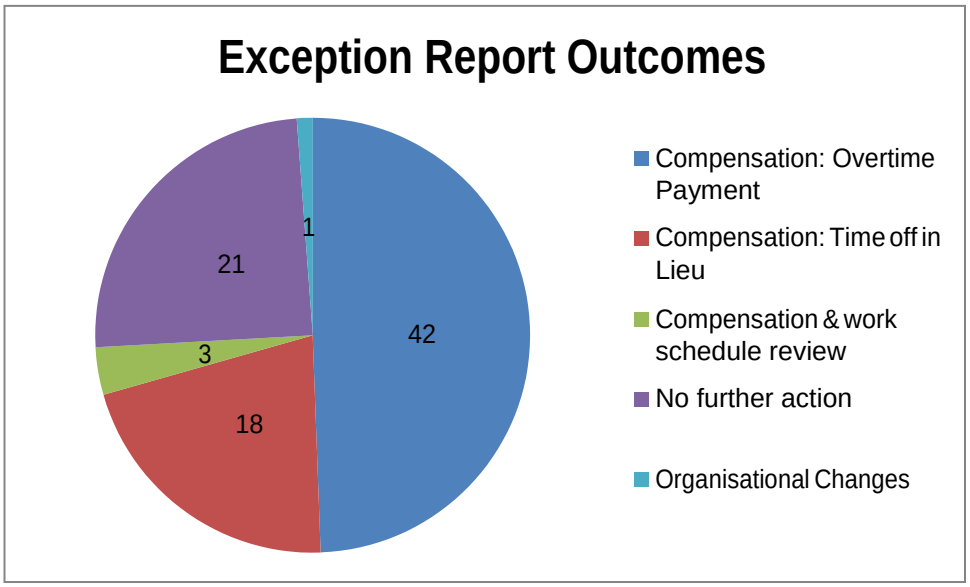
The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.`

This is shown in the table below:

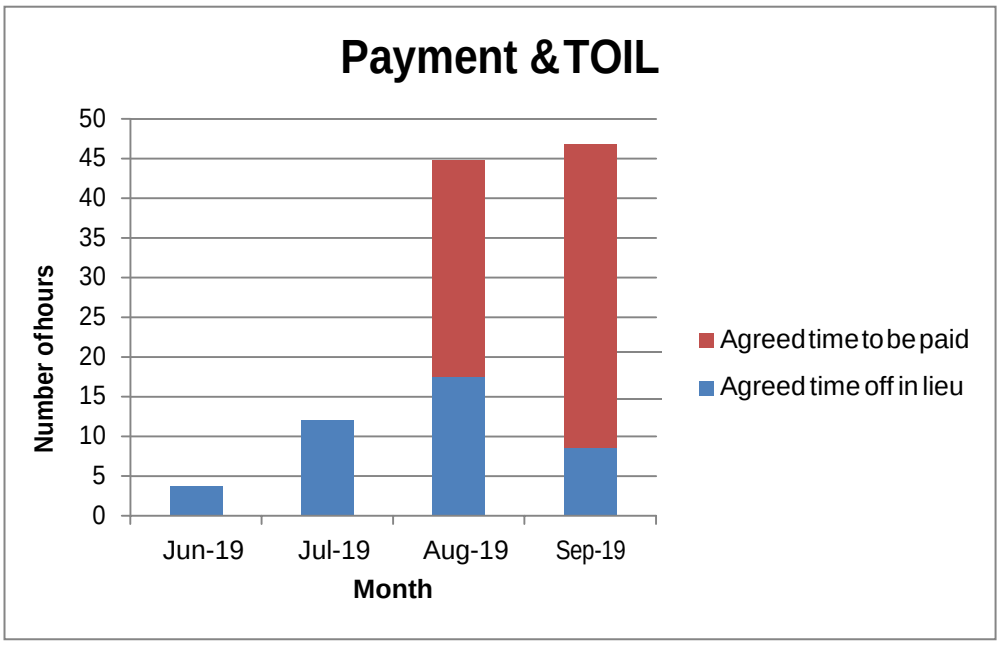
Department (base dept)	No of reports (episodes)	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
Acute Surgery/ Colorectal	10	4	3	1		2	
Acute Surgery / Upper GI	3	3					
Cardiothoracic Surgery	3					3	
Elderly Medicine	7		1	3		3	
Emergency Medicine	1					1	
Endocrine & Diabetes	18	14	4				
ENT	6			5		1	
General Paediatrics	1					1	
General Surgery / Vascular	5			4		1	
ICU / Anaesthetics	1	1					
Oncology	37	12	6	16		3	
Ophthalmology	3			3			
Orthopaedic Surgery	1			1			
Paediatrics	1					1	
Renal	1					1	
Respiratory Medicine	1					1	
Upper GI	1					1	
Urology	9	1	2	1	5		
Neurosurgery	1					1	

Outcomes of completed exception reports 1 July – 30 September 2019



The above chart shows the outcomes of completed exception reports within this quarter. Compensation: overtime payment has been the agreed outcome for 49% of all completed exception reports. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Work schedule reviews

There are currently no ongoing work schedule reviews as a result of exception reports by trainees. However, as part of the agreement of NHS Employers and the BMA on changes to the 2016 Terms and Conditions of Service, Medical Staffing will be reviewing all rotas within the Trust in line with the agreed working hours limits and working with the Health Groups and Doctors in Training to change rota patterns to be compliant with the updated T&Cs as required. So far, Medical Staffing have reviewed and updated (where required) 22 of the 67 rotas across the Trust as per the timeline agreed between NHS Employers and the BMA.

a) Locum bookings 1 July to 30 September 2019

i) Bank 1 July to 30 September 2019

The Trust currently had an informal medical bank in place which strives to fill as many shifts internally as it can. This data does not include additional shift worked by rotational doctors.

From 21st October 2019, the Trust has launched its 'Remarkable Bank' in a view to expanding it's use of internal Locums. We currently have 31 Medical Staff singed up to the 'Remarkable Bank' and we have also published an advert on the Trust's Website, NHS Jobs and the BMJ to attract external candidates onto the Bank. With the 'Remarkable Bank' going live, we are hoping to see an increase in Bank Locum Bookings and a decrease in the reliance of Locum Agency Staff.

The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade				
Grade	**Number of shifts requested**	**Number of shifts Worked**	**Number of hours requested**	**Number of hours worked**
F1*	71	0	486.00	0.00
F2	532	19	4,333.60	143.00
CT/ST-2/GPSTR	673	40	6,428.08	334.50
ST3+	925	0	9,904.89	0.00
TOTAL	**2,201**	**59**	**21,152.57**	**477.5**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

Locum Bookings (bank) by department				
Speciality	**Number of shifts requested**	**Number of shifts Worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	217	2	1746.73	16.00
Anaesthetics	1	0	9.00	0.00
Breast Surgery	81	0	1012.00	0.00
Cardiology	32	0	261.00	0.00
Chest Medicine	27	0	267.15	0.00
Colorectal	201	0	1,983.00	0.00
CT Surgery	159	0	1494.04	0.00
Dermatology	6	0	57.50	0.00
Elderly Medicine	101	0	903.75	0.00
Endocrinology	8	0	57.25	0.00
ENT	51	6	568.50	26.00
Gastroenterology	23	0	200.75	0.00
Haematology	7	0	168.00	0.00
Infectious Diseases	2	0	8.50	0.00
Neonates	5	0	75.50	0.00
Neurology	82	0	745.25	0.00
Neurosurgery	313	12	3548.35	130.00
Obstetrics & Gynaecology	2	0	25.00	0.00
OMFS	23	0	165.50	0.00
Oncology	132	0	1454.80	0.00
Ophthalmology	3	0	14.00	0.00
Orthopaedics	436	19	3925.50	153.00
Paediatric Surgery	35	0	362.50	0.00
Plastic Surgery	8	0	129.00	0.00
Renal	9	0	62.00	0.00

Rheumatology	15	0	172.00	0.00
Stoke Medicine	80	0	640.00	0.00
Upper GI	19	2	119.00	9.00
Urology	96	18	721.00	143.50
Vascular	27	0	256.00	0.00
TOTAL	**2,201**	**59**	**21,152.57**	**477.5**

Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	27	0	344.50	0.00
Compassionate/Special Leave	10	0	118.00	0.00
Extra Cover	167	6	1568.25	34.00
Maternity/Paternity Leave	3	0	32.00	0.00
Sickness	149	0	1336.00	0.00
Study Leave	9	2	77.50	8.00
Vacancy	1836	51	17,676.32	435.50
TOTAL	**2,201**	**59**	**21,152.57**	**477.5**

ii) Agency 1 July to 30 September 2019

Locum bookings (agency) by grade				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	71	0	486.00	0.00
F2	532	91	4,333.60	992.75
CT/ GPSTR/ST-2	673	223	6,428.08	2,414.50
ST3+	925	415	9,904.89	4,061.50
Total	**2,201**	**729**	**21,152.57**	**7,468.75**

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	217	26	1746.73	218.00
Anaesthetics	1	0	9	0.00
Breast Surgery	81	77	1012	962.50
Cardiology	32	3	261	34.50
Chest Medicine	27	2	267.15	25.00
Colorectal	201	84	1,983.00	745.50
CT Surgery	159	92	1494.04	853.00
Dermatology	6	0	57.5	0.00
Elderly Medicine	101	1	903.75	12.25
Endocrinology	8	0	57.25	0.00
ENT	51	0	568.5	0.00
Gastroenterology	23	0	200.75	0.00
Haematology	7	0	168	0.00
Infectious Diseases	2	0	8.5	0.00
Neonates	5	5	75.5	75.50
Neurology	82	7	745.25	121.00
Neurosurgery	313	102	3548.35	1,269.50
Obstetrics & Gynaecology	2	0	25	0.00
OMFS	23	0	165.5	0.00
Oncology	132	35	1454.8	411.50
Ophthalmology	3	0	14	0.00
Orthopaedics	436	199	3925.5	1,889.00
Paediatric Surgery	35	0	362.5	0.00
Plastic Surgery	8	4	129	96.00
Renal	9	0	62	0.00
Rheumatology	15	2	172	24.50
Stoke Medicine	80	80	640	640.00

Upper GI	19	0	119	0.00
Urology	96	10	721	91.00
Vascular	27	0	256	0.00
TOTAL	**2,201**	**729**	**21,152.57**	**7,468.75**

Locum bookings (agency) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	27	7	344.5	121.00
Compassionate/Special Leave	10	6	118	77.00
Extra Cover	167	28	1568.25	240.00
Maternity/Paternity Leave	3	2	32	25.00
Sickness	149	17	1336	212.50
Study Leave	9	1	77.5	12.50
Vacancy	1836	668	17676.32	6,780.75
Total	**2,201**	**729**	**21,152.57**	**7,468.75**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they have to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover; for example sickness is not mentioned as a reason for seeking cover. This has probably been included in the catch-all term 'vacancy' but will need to be teased out in future.

iii) Emergency Department

The Emergency Department books its own doctors directly; these figures are currently reported slightly differently.

Locum Bookings (bank) by 01.07.2019 to 30.09.2019 AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	463	292	463	4,344.30	2,670.30

Locum Bookings (bank) by 01.07.2019 to 30.09.2019 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	1,204	668	741	5,826.00	4,426.50

b) Locum work carried out by trainees 1 July to 30 September 2019

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Base Speciality	**Grade**	**Number of hours worked**	**Number of hours rostered per week**	**Opted out of EWTD**
Neurology	ST3+	160.25	45:45	Yes
Neurosurgery	F2	153.25	47:45	No
Palliative Medicine	GPSTR	141.5	41:30	Yes
GP	GPSTR	86.25	40:00	Yes
GP	F2	141.25	40:00	Yes
Neurosurgery	ST3+	72.5	47:00	No
Endocrinology	ST3+	63.5	45:00	Yes
ENT	F2	56	46:30	Yes
Pediatrics	ST3+	52	27:53	Yes
Acute Medicine	ST3+	48	45:15	Yes

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Especially at F2 level, doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis. The appointment of rota co-ordinators is in progress across the Trust as part of the roll-out of e-roster for medical staff, and entry of this data will be a key part of their role.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has EWTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of these rules however Medical Staffing are not responsible for overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required.

Vacancies – table showing vacancies among medical training grades and by rota on 8th November 2019. Detailed below is a table indicating the rota establishment and WTE in post as of 8th November 2019 and Doctor in Training establishment as of 8th November 2019.

Hull University Teaching Hospitals NHS Trust - Junior Doctor Rota Establishment Effective 08/11/2019

	Trainee Establishment						Rota Establishment						In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Posts Filled 10/07/2019**	**% Posts Filled 08/11/2019**
Academic	0	5	0	0	0	5	0	5	0	0	0	5	0	5	0	0	0	5	100.00%	100.00%
Acute Medicine	3	6	9	0	6	24	3	6	9	0	6	24	3	6	9	0	6	24	87.50%	100.00%
Anaesthetics	4	4	15	0	28	51	4	4	16	0	32	56	4	4	13.7	0	32	53.7	91.07%	95.89%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	2	0	1	0	1	4	80.00%	80.00%
Cardiology	2	1	4	1	9	17	2	1	4	1	12	20	2	1	5	1	12	21	100.00%	105.00%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	3	0	0	6	9	91.67%	75.00%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	0	0	50.00%	0.00%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	0	1	0	2	100.00%	100.00%
Elderly Medicine	5	3	6	6	6	26	5	3	6	7	6	27	4	3	9	5	5.6	26.6	96.30%	98.52%
Emergency Medicine	0	12	6	6	8	32	0	12	6	6	8	32	0	12	6	6	13.6	37.6	100.00%	117.50%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	3	0	2	0	3.5	8.5	88.89%	94.44%
ENT	1	1	2	1	4	9	1	1	3	1	6	12	1	1	3	1	6	12	75.00%	100.00%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	2	0	5	10	90.00%	100.00%
General Practice	0	18	0	45	0	63	0	18	0	45	0	63	0	17	0	43	0	60	71.58%	95.24%
General Surgery	0	1	0	0	0	1	0	1	2	0	0	3	0	1	0	0	0	1	33.33%	33.33%
Haematology	1	0	2	0	4	7	1	0	2	0	7	10	1	0	1	0	5.6	7.6	76.00%	76.00%
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	3	3	0.00%	75.00%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	5	9	2	0	2	0	4	8	66.67%	88.89%
Lower GI Surgery	7	0	1	0	3	11	7	0	2	0	7	16	7	0	2	0	7	16	93.33%	100.00%
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	2	4	0	6	14	96.43%	100.00%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1	1	3	0	11	16	83.16%	84.21%
Obstetrics & Gynaecology	0	2	6	4	12	24	0	2	6	4	12	24	0	2	6	4	12	24	100.00%	100.00%
Oncology	3	1	3	4	5	16	3	1	8	4	12	28	3	1	7	3	11	25	96.43%	89.29%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	7	9	1	1	0	0	6	8	90.00%	88.89%
Oral & Maxillofacial Surgery	0	4	10	0	2	16	0	4	10	0	6	20	0	4	10	0	6	20	77.78%	100.00%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	1	7	0	0	6	0	1	7	100.00%	100.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	7	0	7	14	0	0	5	0	7	12	79.29%	85.71%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	4	6	0	0	2	0	3	5	83.33%	83.33%
Paediatrics	3	4	3	2	8	20	4	4	3	2	8	21	2.6	4	2.6	1	7	17.2	85.71%	81.90%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	0	2	0	2	100.00%	100.00%
Plastic Surgery	0	0	3	0	5	8	0	0	4	0	7	11	0	0	4	0	6	10	80.00%	90.91%
Psychiatry	5	5	0	5	0	15	5	5	0	5	0	15	4.6	5	0	4	0	13.6	85.71%	90.67%
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	100.00%
Radiology	0	0	0	0	24	24	0	0	0	0	24	24	0	0	0	0	20.8	20.8	86.67%	86.67%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	2	1	2	0	5	10	100.00%	100.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	2	2	2	8	20	97.50%	100.00%
Rheumatology	0	0	1	2	3	6	0	0	1	2	3	6	0	0	1	1.5	2	4.5	91.67%	75.00%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0.00%
Trauma & Orthopaedics	0	4	3	1	9	17	0	11	4	1	14	30	0	10	4	1	12	27	74.19%	90.00%
Upper GI Surgery	7	0	3	0	4	14	7	0	4	0	7	18	7	0	3	0	7	17	83.33%	94.44%
Urology	1	3	2	0	3	9	1	3	2	0	5	11	1	2	2	0	4	9	81.82%	81.82%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	6	12	5	0	1	0	5.8	11.8	90.00%	98.33%
TOTAL	70	86	112	82	208	558	**71**	**93**	**129**	**83**	**268**	**644**	**68.2**	**90**	**120.3**	**75.5**	**250.9**	**604.9**	**86.65%**	**93.93%**

Increased vacancies since last report	
Decreased vacancies since last report	
No change in vacancies since last report	

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment effective 08/11/2019

	Trainee Establishment						Trainee In Post						
Department	F1	F2	CT/ST1-	GPSTR	ST	Total	F1	F2	CT/ST1-	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	100.0%
Acute Medicine	3	6	9	0	6	24	3	6	9	0	2	20	83.3%
Anaesthetics	4	4	15	0	28	51	4	4	15	0	28	51	100.0%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	80.0%
Cardiology	2	1	4	1	9	17	2	1	5	1	8	17	100.0%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	3	6	100.0%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	100.0%
Elderly Medicine	5	3	6	6	6	26	4	3	8	5	5.6	25.6	98.5%
Emergency Medicine	0	12	6	6	8	32	0	12	5	6	13.6	36.6	114.4%
Endocrinology	3	0	2	0	4	9	3	0	2	0	3.5	8.5	94.4%
ENT	1	1	2	1	4	9	1	1	2	1	4	9	100.0%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	100.0%
General Practice	0	18	0	45	0	63	0	17	0	43	0	60	95.2%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Haematology	1	0	2	0	4	7	1	0	2	0	4	7	100.0%
Histopathology	0	0	0	0	4	4	0	0	0	0	3	3	75.0%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	4	8	88.9%
Lower GI Surgery	7	0	1	0	3	11	7	0	1	0	3	11	100.0%
Neurology	2	2	4	0	5	13	2	2	4	0	5	13	100.0%
Neurosurgery	1	1	2	0	4	8	1	1	1	0	4	7	87.5%
Obstetrics & Gynaecology	0	2	6	4	12	24	0	2	6	4	12	24	100.0%
Oncology	3	1	3	4	5	16	3	1	3	4	4	15	93.8%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	5	7	87.5%
Oral & Maxillofacial Surgery	0	4	10	0	2	16	0	4	10	0	1	15	93.8%
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	6	0	0	6	85.7%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	6	0	7	13	92.9%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	0	2	100.0%
Paediatrics	3	4	3	2	8	20	2.6	4	2.5	1	7	17.1	85.5%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	100.0%
Plastic Surgery	0	0	3	0	5	8	0	0	3	0	5	8	100.0%
Psychiatry	5	5	0	5	0	15	4.6	5	0	4	0	13.6	90.7%
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Radiology	0	0	0	0	24	24	0	0	0	0	20.8	20.8	86.7%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	100.0%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	100.0%
Rheumatology	0	0	1	2	3	6	0	0	1	1.5	3	5.5	91.7%
Stroke Medicine	0	0	0	0	1	1	0	0	2	0	0	2	200.0%
Trauma & Orthopaedics	0	4	3	1	9	17	0	4	3	1	8	16	94.1%
Upper GI Surgery	7	0	3	0	4	14	7	0	3	0	4	14	100.0%
Urology	1	3	2	0	3	9	1	2	2	0	3	8	88.9%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	2.8	8.8	97.8%
TOTAL	**70**	**86**	**112**	**82**	**208**	**558**	**68.2**	**84**	**113.5**	**76.5**	**193.3**	**535.5**	**96.0%**

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

The gaps in rota that was an area of concern particularly in some specialties have improved since last August. This is probably due in part to the continued relaxation in visa rules.

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 28th January 2020

Title:	Research & innovation Strategy Update: International Partnerships
Responsible Director:	Dr Makani Purva
Author:	James Illingworth, R&D Manager

Purpose:	The purpose of this paper is to provide the Trust Board with an update on progress with the development of international partnerships as part of the Trust Research and Innovation Strategy 2018-23.	
BAF Risk:	BAF 6 – Research and Innovation	
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	X
	Financial sustainability	
Summary Key of Issues:	An 'Agreement for Academic Exchange and Co-operation' was signed with Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India in May 2019. This agreement has already yielded a number of returns including a Joint Research Conference in Chennai in February 2020 and the foundation for research collaborations in several mutually beneficial clinical and academic areas. The wider academic and research exchange with SRIHER will support the Trust's long term goal of establishing mature programmes of workforce development and research with our international partners by showcasing the facilities to support and nurture these staff, working in areas of development that will impact positively on key performance and quality indicators and contributing to the generation of a research active and aware workforce.	

Recommendation:	The Trust Board is asked to acknowledge the progress made to date by the Trust in the development of an international partnership with SRI Ramachandra Institute of Higher Education and Research (SRIHER).

Hull University Teaching Hospitals NHS Trust

Research and Innovation Strategy Update
International Partnerships

1. Purpose of Paper

The purpose of this paper is to provide the Trust Board with an update on progress with the development of international partnerships as part of the Trust Research and Innovation Strategy 2018-23.

2. Background

The Research and Innovation Strategy 2018-23 was approved by the Trust Board in July 2018. A core pillar of this strategy is the need to establish positive and proactive research partnerships. Since late 2018 the Trust has nurtured a collaborative relationship with SRI Ramachandra Institute of Higher Education and Research (SRIHER) in Chennai, India in support of academic exchange and research.

3. Progress to Date

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

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

- *Joint Research Conference in Chennai in February 2020. A delegation representing HUTH and UoH (Faculty of Health Sciences) and HYMS will attend. Monthly planning meetings are currently on-going with an agenda and outline published* https://hull.sriher.com/ to include*:*

    - *Endocrinology – Polycystic Ovarian Syndrome & Recent Developments in Diabetic Care (Prof Sathyapalan)*
    - *Infectious Diseases – Antimicrobial Resistance (Dr Barlow)*
    - *Simulation – Transforming Healthcare through Simulation (Dr Purva)*
    - *Nephrology – Dialysis (Prof Bhandari)*
    - *Geriatrics – Early detection of Cancer in the Elderly (Prof Macleod)*
    - *Microfluidics – Utilising Microfluidics for Individualised Cancer Therapy (Prof Greenman)*
    - *Rehabilitation/Sports Science and Wound Healing – Cardiac rehabilitation in the UK (Prof Ingle) and Understanding Wound Repair (Prof Hardman)*
    - *Research Methodology – Understanding the role of Geographical Data in Health Research (Dr Lee) and Principles of Publishing Success, (Prof Hayter)*

- *Overseas Simulation Fellow programme commenced with one SRIHER consultant undertaking a fellowship at the Hull Institute of Learning and Simulation from May to June 2019 with further visiting fellowships planned for 2020.The programme has already resulted in completed research projects and publications in peer reviewed journals.*

- *A working group of HUTH elderly medicine consultants and SRIHER internal medicine consultants is developing elderly medicine as a speciality for the first time in SRIHER with the support of the Royal College of Medicine (Edinburgh). Progress has been made towards establishing a curriculum for an overseas geriatric medicine fellowship programme between Chennai and HUTH.*

- *Formal visit of Prof of Rehabilitation from SRIHER to understand and explore our facilities for Oncology rehabilitation including a visit to Sports, Health and Exercise Unit at UoH to strengthen partnership working for further research in pre-habilitation and rehabilitation more widely.*

- *Recruitment of doctors from SRIHER in hard pressed specialities-Two Anaesthetic Registrars (commencing January 2020), 2 Emergency Medicine middle grades (commencing later this year) and one Haematology middle grade (commenced 2019) and one Glaucoma Fellow (commencing later this year).*

- *The Dean of HYMS has established connections with SRIHER Medical School and as part of the Joint Research Conference will hold face to face discussions on establishment and finalisation of exchange and elective programmes in February 2020.*

4. Impact

It is envisaged that the conference will cement foundations for research collaborations in several mutually beneficial clinical and academic areas. This will be assessed in terms of future grant developments and funding secured. In turn, it is hoped that this will attract further academic exchange with the ability to exploit recruitment opportunities across clinical, nursing and other allied health professional groups.

Specifically, the wider academic and research exchange with SRIHER will support the Trust's long term goal of establishing mature programmes of workforce development and research with our international partners by:

- Facilitating the integration of research and innovation activities into clinical services, generating a research-aware workforce.
- Increasing capacity (both clinically and academically) with the potential to increase research participation opportunities for our patients alongside the potential to increase the number of successful research grant awards and associated income.
- Establishing research programmes with the potential to positively impact our key performance and quality indicators (i.e. ED and cancer waiting times).
- Working to establish priority areas for research with a particular focus on health inequalities, ageing and 'bench to bedside' clinical and lab priorities.
- Developing strong and purposeful international research partnerships in collaboration with local healthcare providers and academic partners in Dementia and Mental Health, Social Care and Elderly Medicine, Rehabilitation and Population Health.
- Showcasing the facilities we have available in support of individuals embarking on exchange programmes (i.e. Hull Health Trials Unit, Institute for Clinical and Applied Health Research and University of Hull's Faculty of Health Sciences Research Methods Hub, Simulation Training, Virtual Reality, PET-CT and Cyclotron).
- Working to establish potential joint areas of unique strength to be pursued for mutual benefit (i.e. Business and Enterprise development to strengthen opportunities for commercial partnerships that enhance patient opportunities, experiences and outcomes).
- Providing academic and exchange staff opportunities to benefit from our membership of established national networks to pursue funding and academic support (i.e. Y&H Clinical Research Network, NIHR Applied Research Collaboration (ARC), Northern Health Science Alliance (NHSA), Yorkshire & Humber Academic Health Science Alliance (Y&H AHSN).

Further updates will be provided to the Trust Board following the visit to Chennai in February.

5. Recommendation

The Trust Board is asked to acknowledge the progress made to date by the Trust in the development of an international partnership with SRI Ramachandra Institute of Higher Education and Research (SRIHER).

James Illingworth
R&D Manager
Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospitals NHS Trust

Integrated Performance Report 2019/20

January 2020

December 2019 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

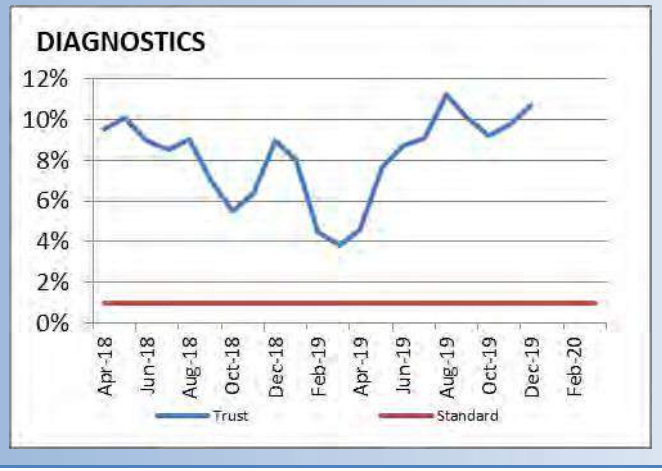
Description	Aggregate Position	Trend	Variation

Diagnostic Waiting Times: 6 Weeks

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

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve the target during December with performance of 10.71%



Breaches in month were:

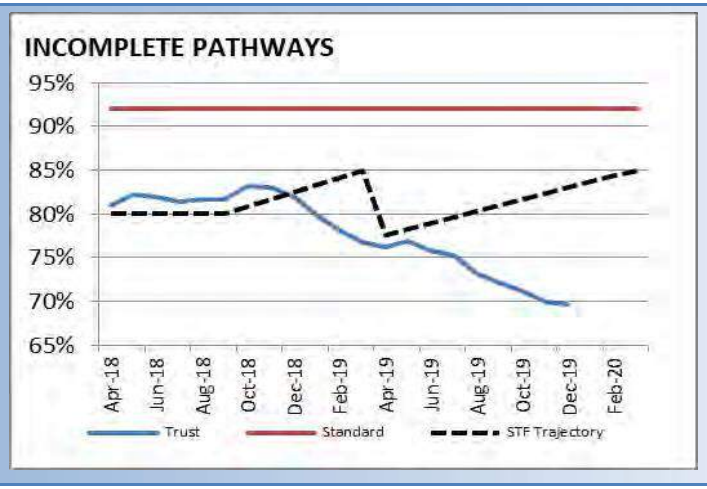
Magnetic Resonance Imaging	45
Computed Tomography	243
Cardiology - echocardiography	7
Neurophysiology	1
Respiratory physiology	2
Urodynamics - pressures & flows	5
Colonoscopy	354
Flexi sigmoidoscopy	2
Gastroscopy (x8 Paed)	240
Cystoscopy (x1 Paed)	56
TOTAL	955

Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the November improvement trajectory of 83.0%

December performance was 69.66%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 14 specialties that failed to meet the improvement trajectory

Integrated Performance Report

RESPONSIVE

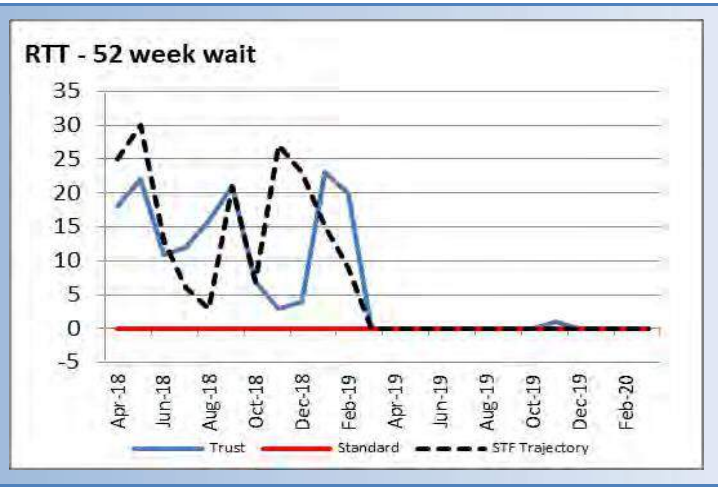
Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

There were no breaches reported during Decemember this achieved the improvement trajectory of zero breaches

The Trust achieved the national standard of zero breaches.

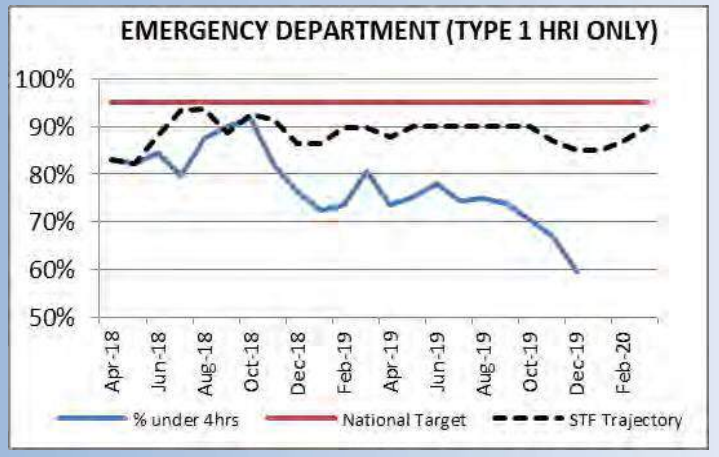


ED Waiting Times (HRI only)

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 59.6% for December

This has failed to achieve the national 95% threshold.



Performance has decreased 7.3% during December

Integrated Performance Report

RESPONSIVE

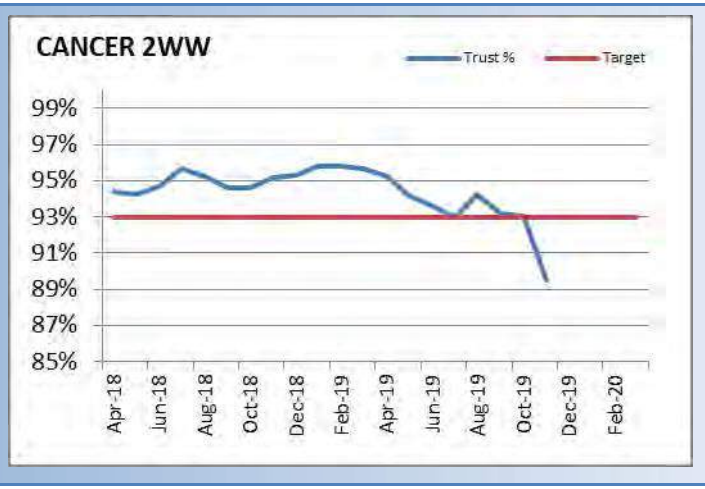
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cancer: Two Week Wait Standard

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

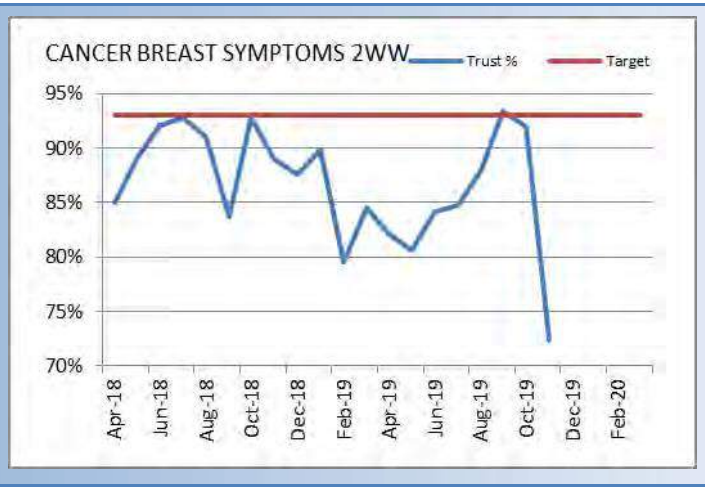
November performance failed to achieve the 93% standard at 89.5%



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.

November performance failed to achieve the 93% standard at 72.3%



Integrated Performance Report

RESPONSIVE

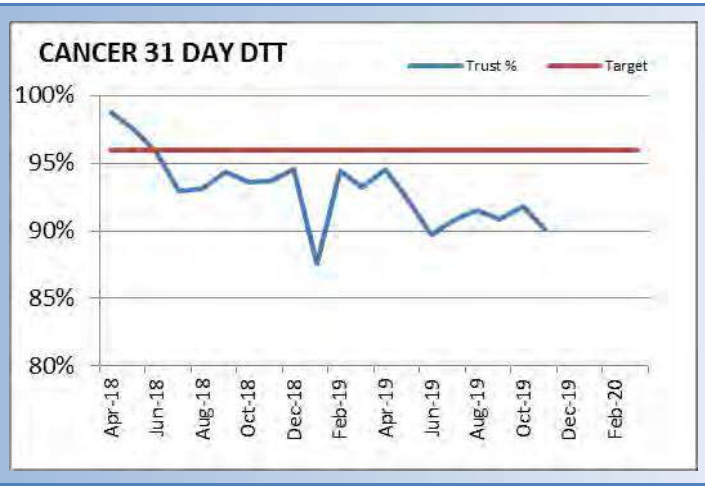
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Standard

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

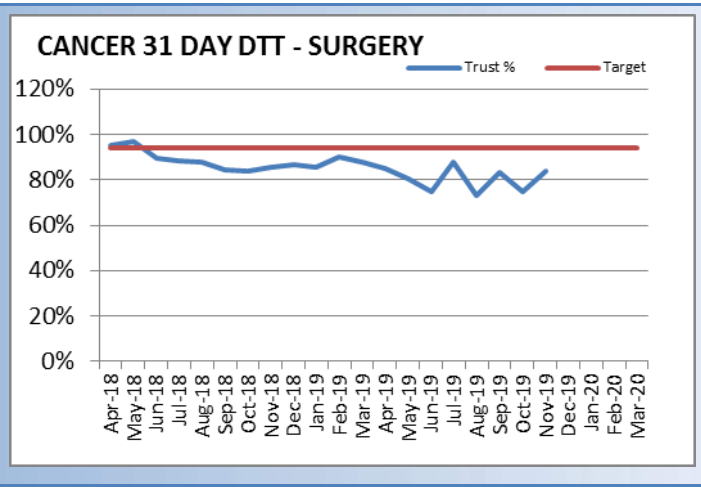
November performance failed to achieve the 96% standard at 90.1%



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%.

November performance failed to achieve the 94% standard at 83.8%



Integrated Performance Report

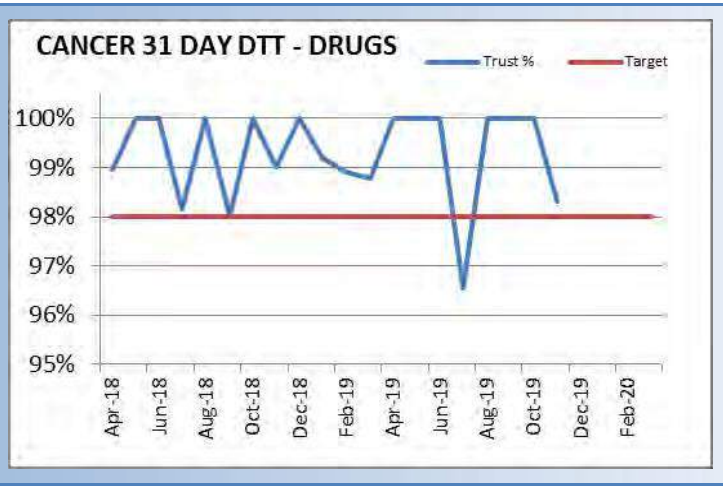
RESPONSIVE

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%.

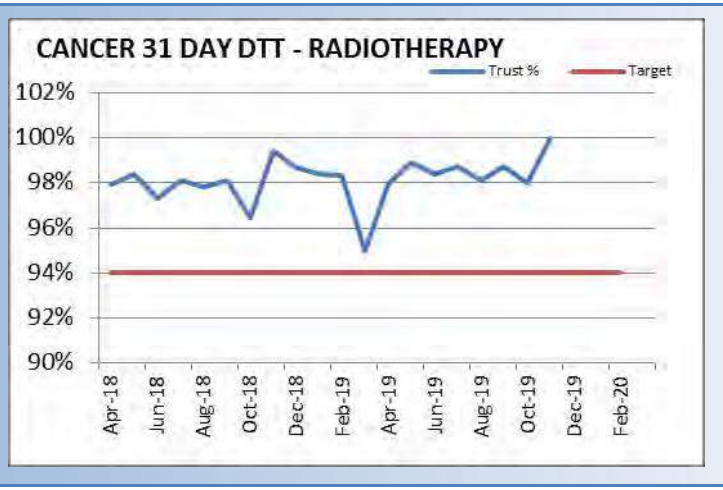
November performance achieved the 98% standard at 98.3%



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%.

November performance achieved the 94% standard at 100%



Integrated Performance Report

RESPONSIVE

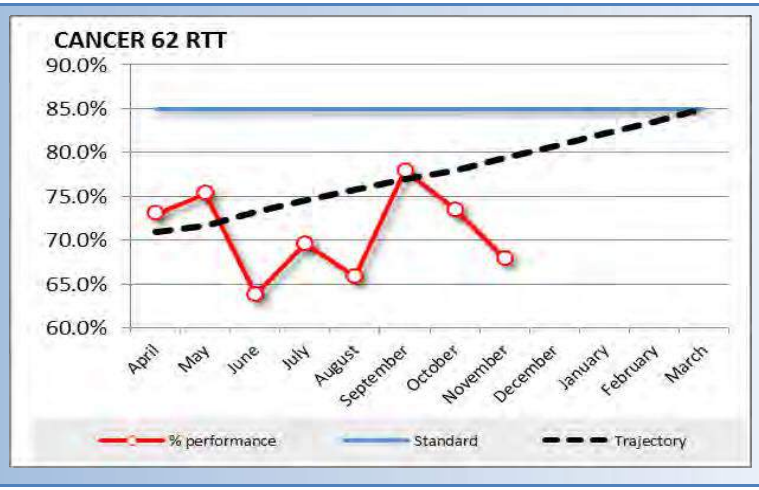
Description	Aggregate Position	Trend	Variation

Cancer: 62 Day Standard

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

November performance failed to achieve the 79.4% improvement trajectory with performance of 68.0%.

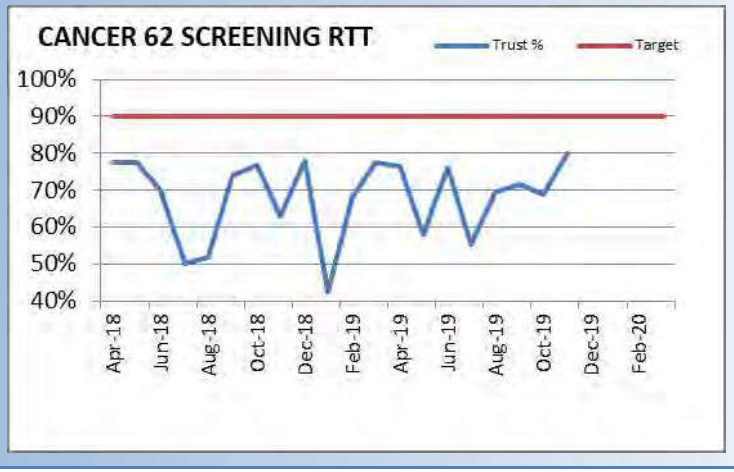
Performance failed to achieve the national standard



Cancer: 62 Day Screening Standard

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

November performance failed to achieve the 90% standard at 80.0%



Integrated Performance Report

RESPONSIVE

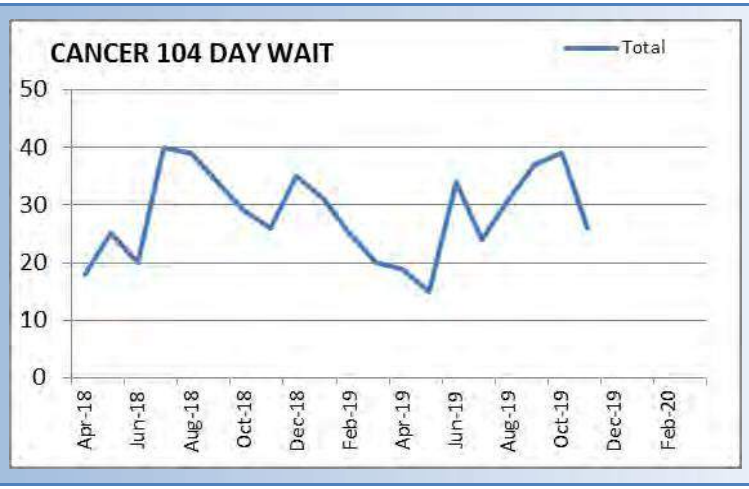
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 26 patients waiting 104 days or over at the end of November



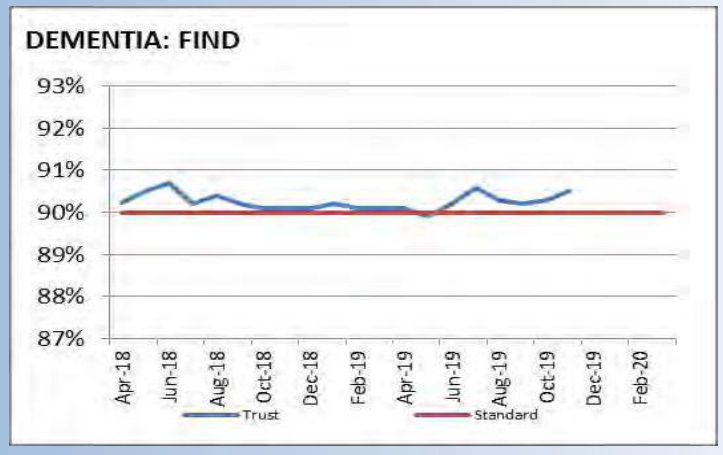
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 November 2019.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 90.5%



Integrated Performance Report

RESPONSIVE

Description	Aggregate Position	Trend	Variation

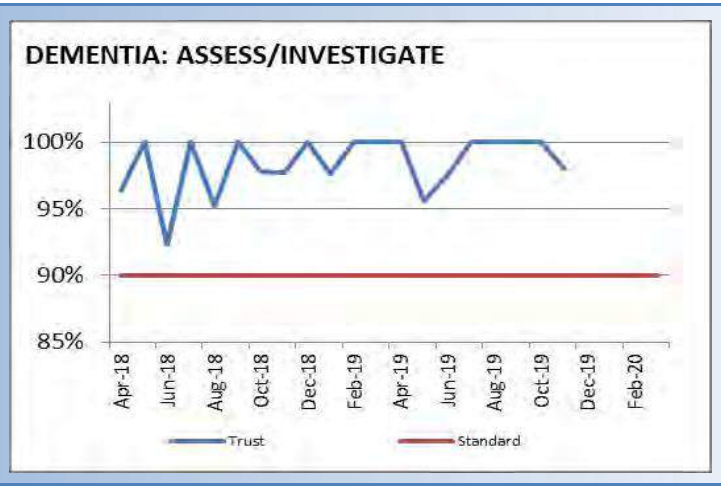
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is November 2019

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 98.0%



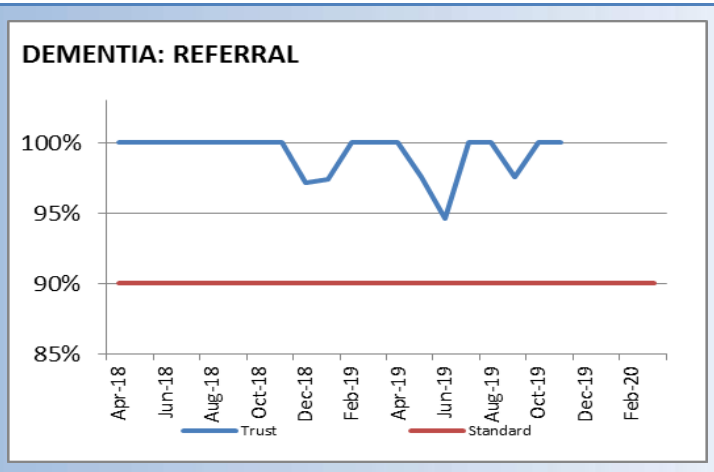
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 November 2019.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 100%



Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

Occurrence of any Never Event

Occurrence of any Never Events

There have been 7 cases reported year to date.

There were 2 cases reported during December 2019.

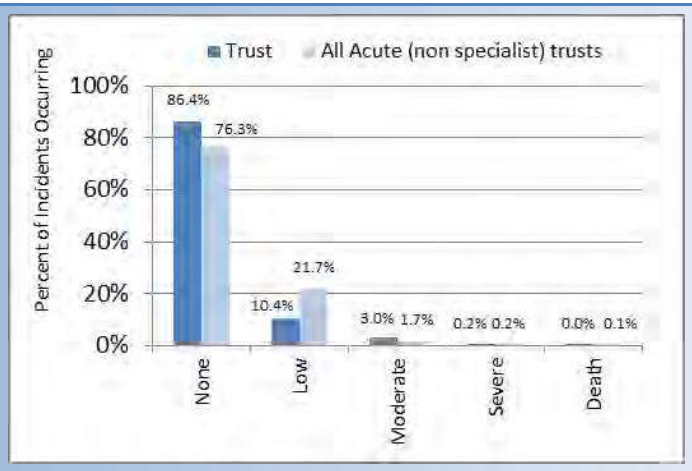
Further information is included in the Board Quality report

Potential under-reporting of patient safety incidents

Number of incidents reported per 1000 bed days

The latest data available for this indicator is October 2018 to March 2019 as reported by the National Reporting and Learning System (NRLS).

The Trust reported 8,585 incidents (rate of 50.75) during this period. This rates the Trust in the highest 25% of reporters



Degree of Harm:

None 7,417
Low 889
Moderate 259
Severe 18
Death 2

Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

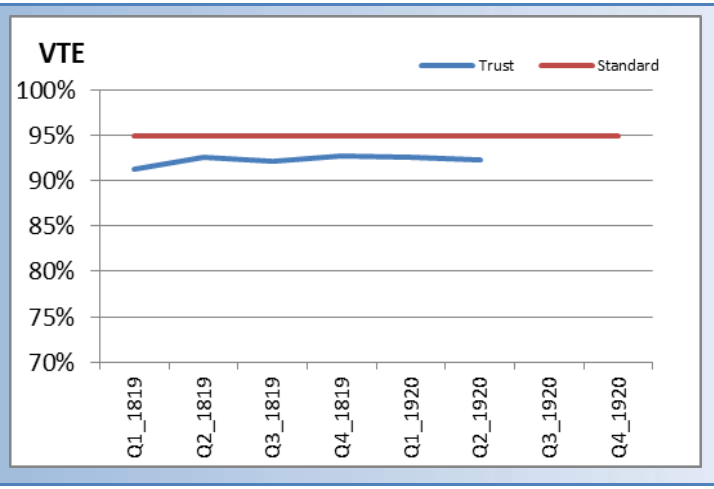
Hull University Teaching Hospitals NHS Trust

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 92.29% for Q2 2019/20.

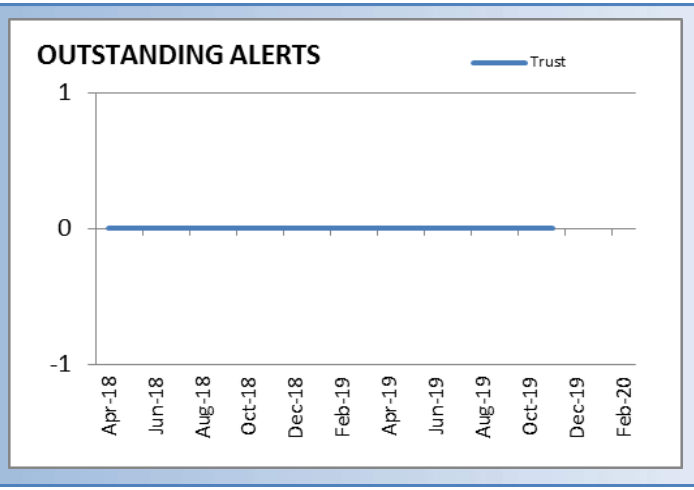


Patient Safety Alerts Outstanding

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

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

There have been no outstanding alerts year to date.



Integrated Performance Report

SAFE

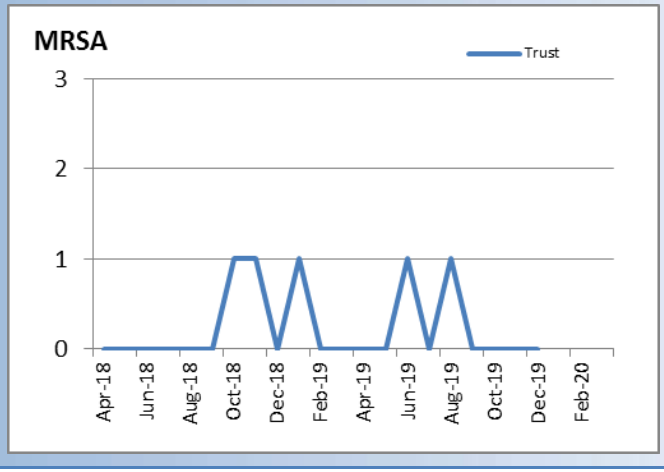
Description	Aggregate Position	Trend	Variation

MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

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

There were no cases reported during December 2019.
There have been 2 cases reported year to date.



Further information is included in the Board Quality report

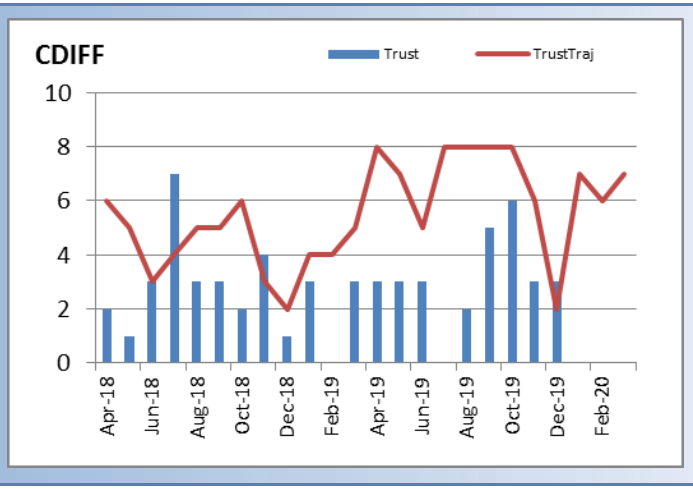
Clostridium Difficile

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

There were 32 cases during 2018/19

There were 3 cases reported during December which failed to achieve the monthly trajectory of no more than 2 cases

Year to date position is 28 cases against the trajectory of no more than 58 cases.



Further information is included in the Board Quality report

Integrated Performance Report

SAFE

Description	Aggregate Position	Trend	Variation

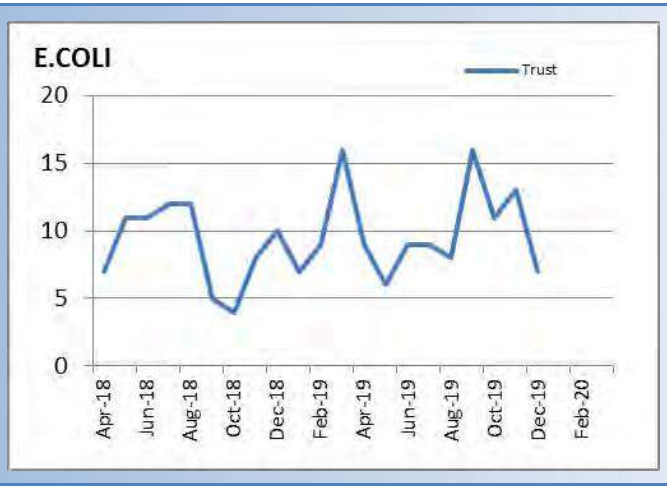
Hull University Teaching Hospitals NHS Trust

Escherichia Coli

Number of incidence of E.coli bloodstream infections

There were 112 cases during 2018/19

There were 7 incidences reported during December 2019.
There have been 88 incidences reported year to date.

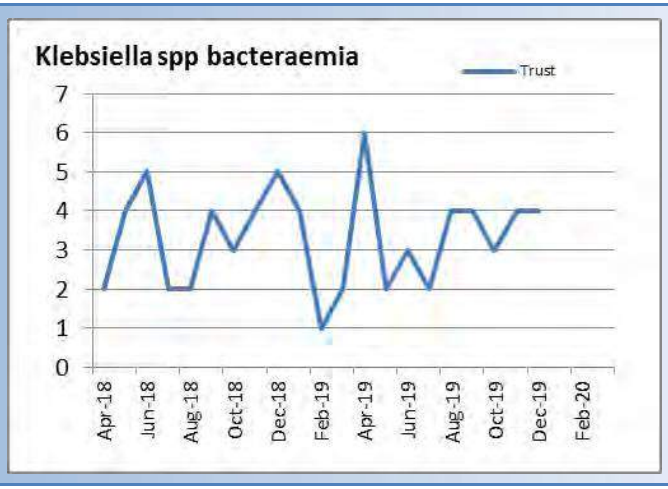


Klebsiella spp bacteraemia

Number of incidence of Klebsiella spp bacteraemia

There were 4 cases reported during December 2019.

There have been 32 incidences reported year to date.



Integrated Performance Report

SAFE

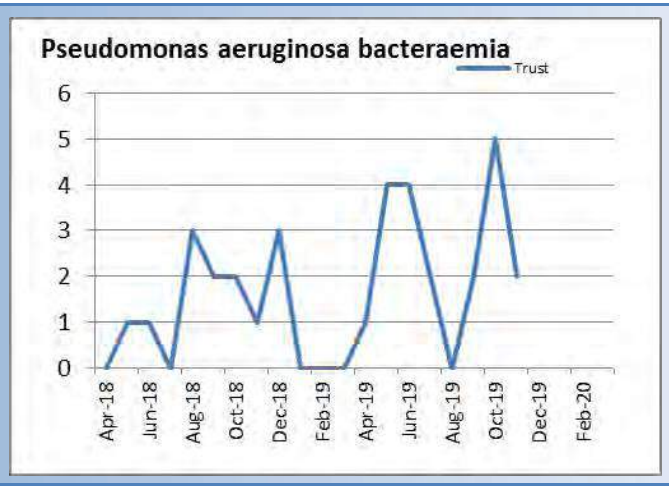
Description	Aggregate Position	Trend	Variation

Pseudomonas aeruginosa bacteraemia

Number of incidence of Pseudomonas aeruginosa bacteraemia

There has been 2 incidences reported during December 2019.

There have been 22 incidences reported year to date.

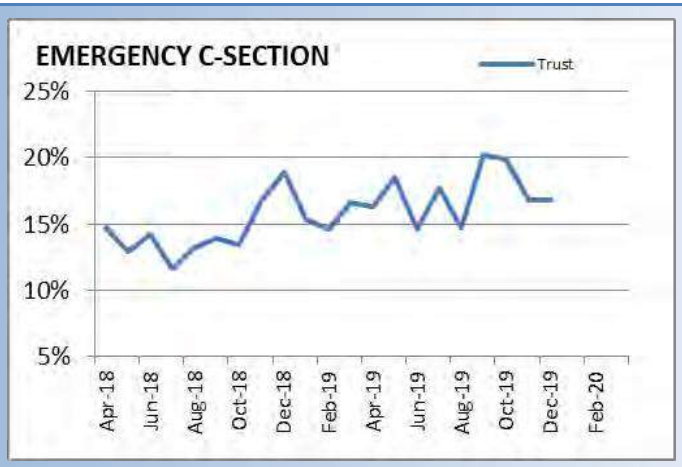


Emergency C-section rate

Maternity: Emergency C-section rate per month

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

Performance for December failed to achieve this standard at 16.8%



Further information is included in the Board Quality report

Integrated Performance Report

EFFECTIVE

Hull University Teaching Hospitals NHS Trust

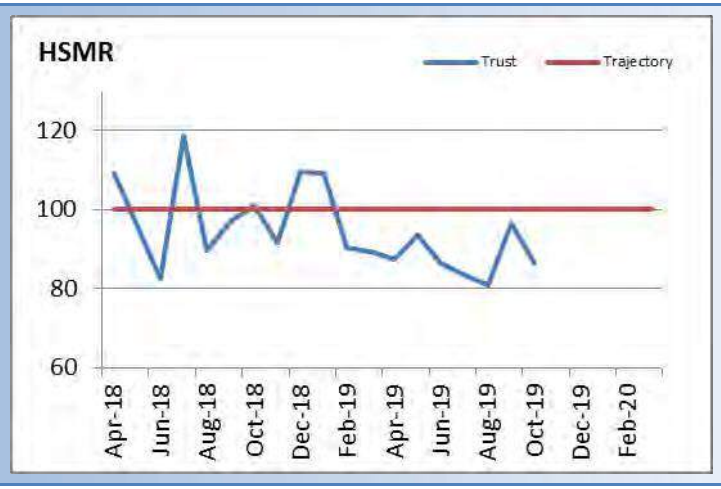
Description	Aggregate Position	Trend	Variation

HSMR

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

October 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and October achieved this at 86.5

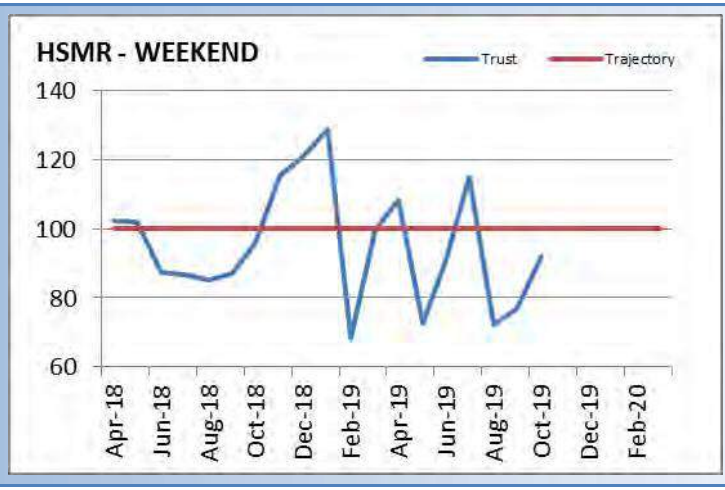


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

October 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and October achieved this at 91.8



Integrated Performance Report

EFFECTIVE

Hull University Teaching Hospitals NHS Trust

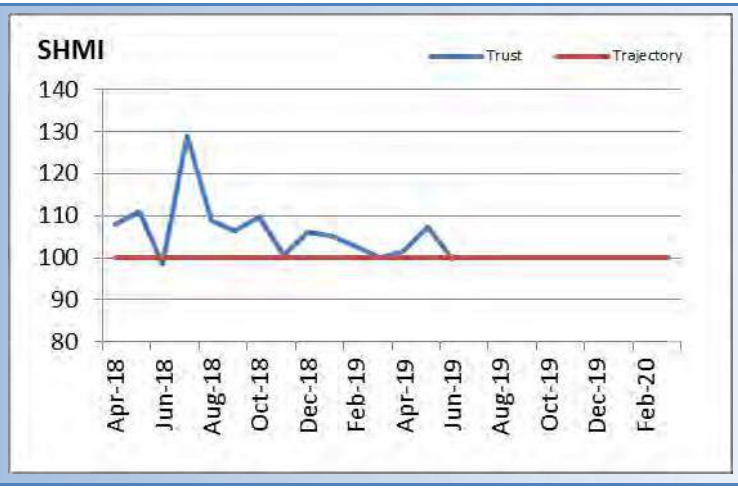
Description	Aggregate Position	Trend	Variation

SHMI

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

July 2019 is the latest published performance

The standard for SHMI is to achieve less than 100 and July failed to achieve this at 106.3



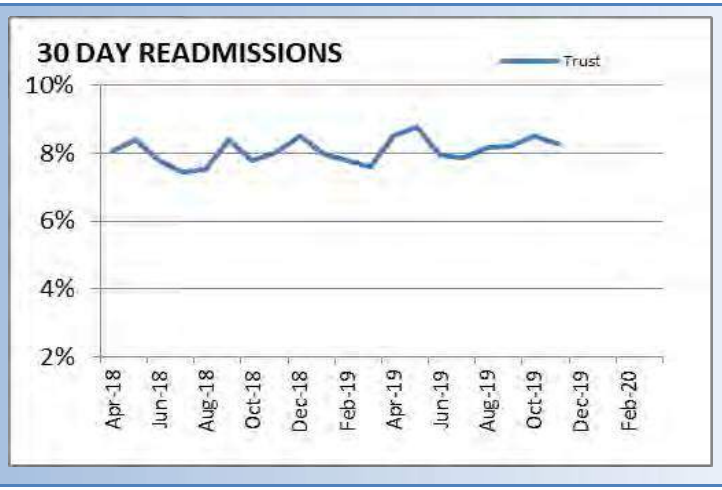
30 Day Readmissions

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

The latest available performance is November 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 8.27%.



Integrated Performance Report

EFFECTIVE

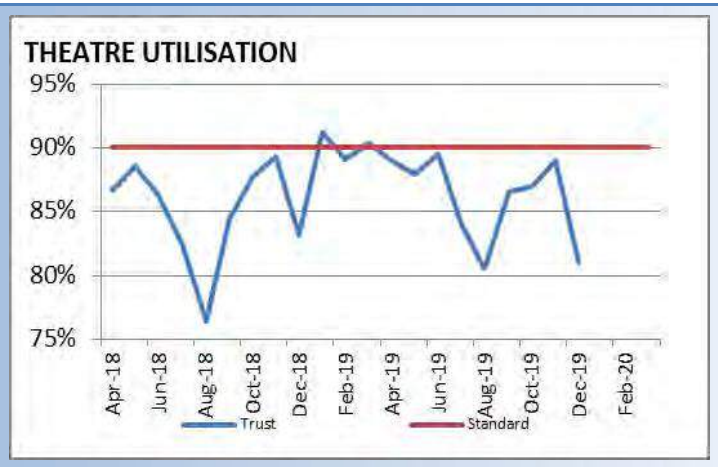
Description	Aggregate Position	Trend	Variation

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%

December failed to meet this measure with performance of 81.10%



Integrated Performance Report

CARING

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

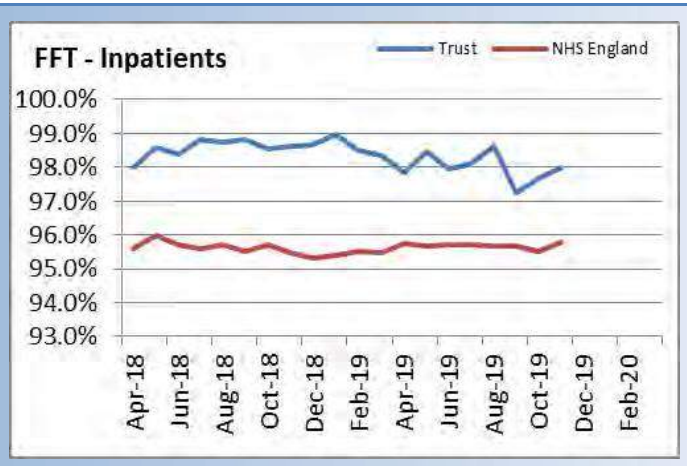
Inpatient Scores from Friends and Family Test - % positive

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

The latest published data for NHS England is November 2019.

Performance for November was 98.00%

December performance will be published in February.



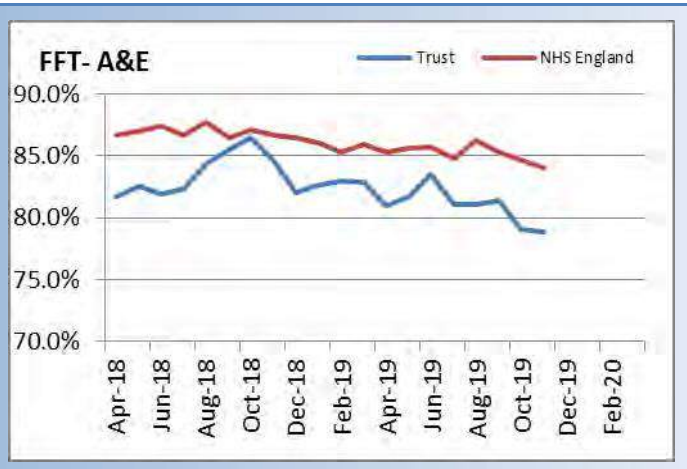
A&E Scores from Friends and Family Test - % positive

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

The latest published data for NHS England is November 2019.

Performance for November was 78.85%

December performance will be published in February.



Integrated Performance Report

CARING

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

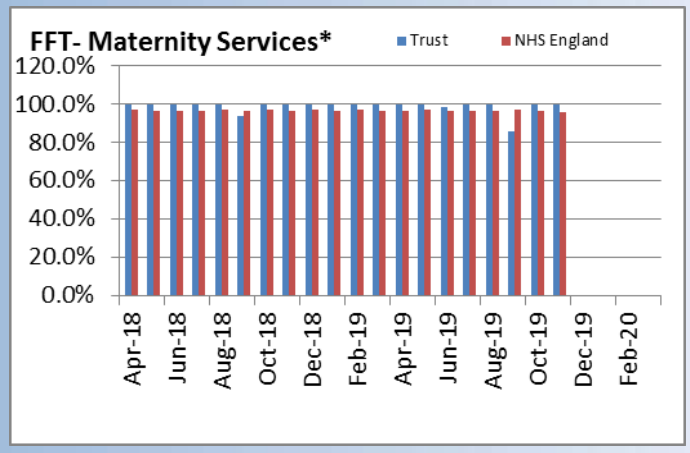
Maternity Scores from Friends and Family Test - % Positive

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

The latest published data for NHS England is November 2019.

Performance for November was 100%

December performance will be published in February.

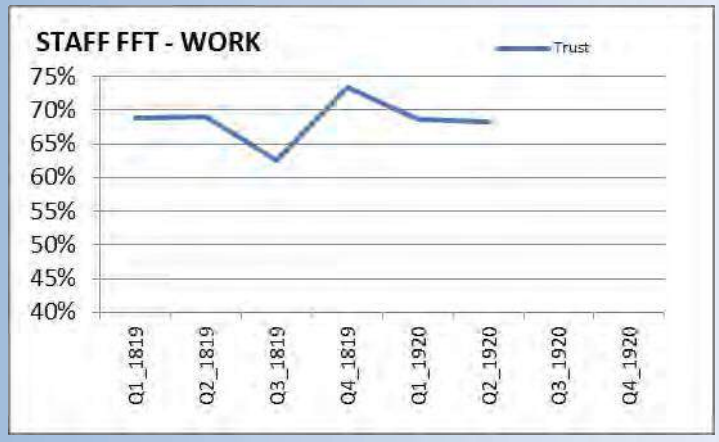


* Question relates to Birth Settings

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 Q2 shows 68% of surveyed staff would recommend the Trust as a place to work, this has decreased slightly from the Q1 position of 69%.



Integrated Performance Report

CARING

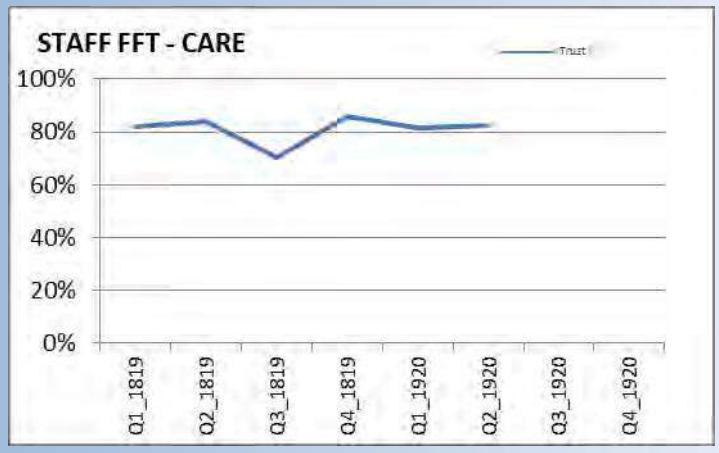
Description	Aggregate Position	Trend	Variation

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?

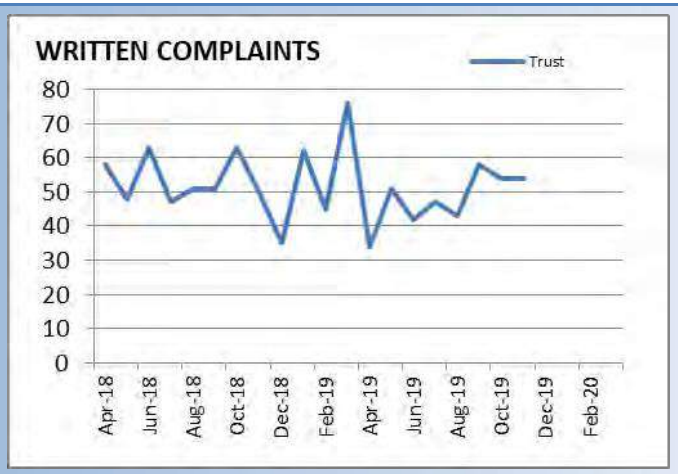
Performance for Q2 shows 82% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has remained consistent with Q1 position



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 45 complaints during December



There have been 428 complaints year to date

Integrated Performance Report

CARING

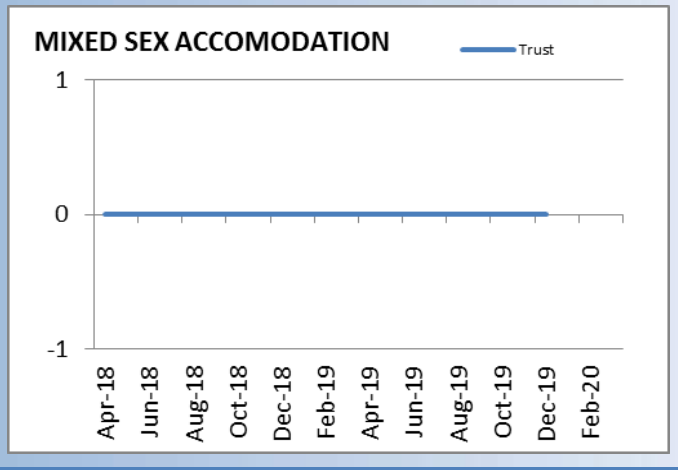
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Mixed Sex Accommodation Breaches

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

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



Integrated Performance Report

ORGANISATIONAL HEALTH

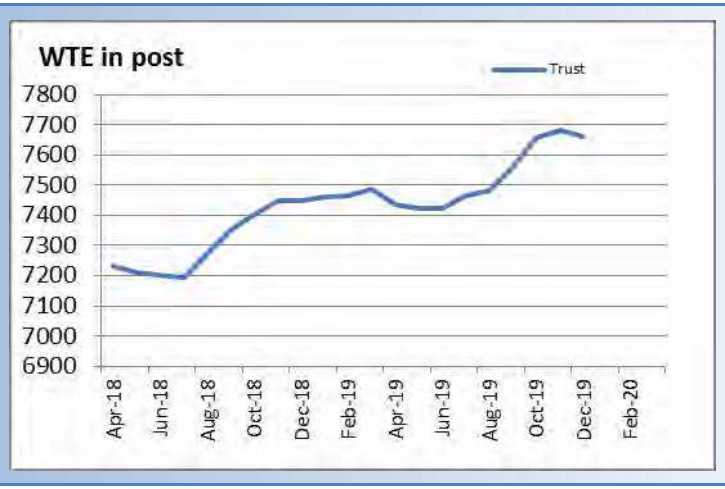
Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

WTEs in post

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

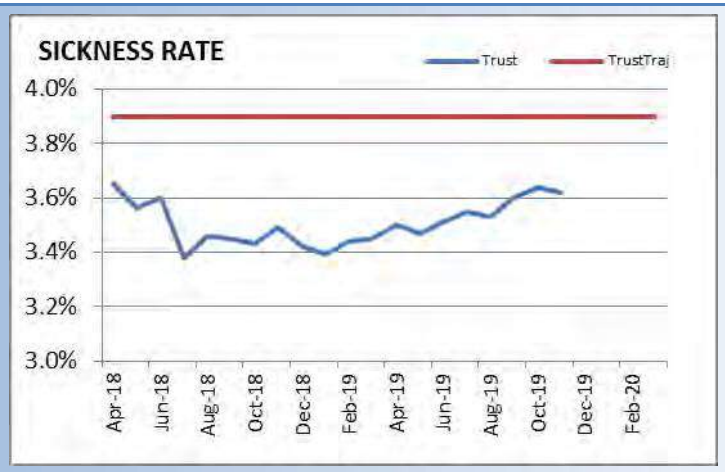
Trust level WTE position as at the end of December was 7663



Sickness Absence Rates

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

Performance for December achieved the standard of less than 3.9% with performance of 3.58%



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.

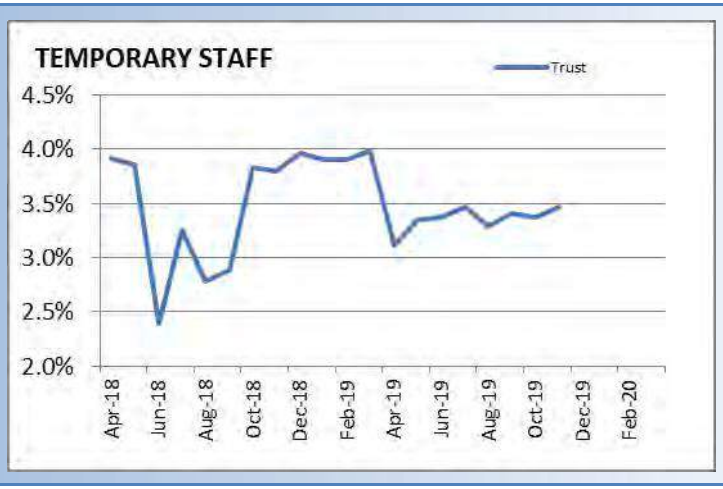
Turnover has been 0% for the Executive team during December 2019.

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

December performance was 3.57%



NHS
Hull University Teaching Hospitals
NHS Trust

FINANCIAL SUMMARY: 9 MONTHS TO 31st DECEMBER 2019

1. At Month 9 the Trust is reporting a surplus of £4.2m (£1.6m deficit excluding PSF) in line with plan. This position is reliant on additional income from local commissioners totalling £1.8m. This in line with a year end agreement of the Trust receiving an additional £4.5m from system partners.

2. The Trust has estimated that the level of income delivered at month 9 is £6.5m above plan after accounting for the AIC (£0.5m adjustment). This is £0.86m above plan in month but this was mainly due the to specific allocations from Hull CCG for agreed investments such as lung health check, winter pressures, diagnostics and RTT risk. In addition there was an in month allocation of £0.15m for Community Paediatrics. 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 price variances (-£2.4m).

3. Health groups/Corporate are reporting a gross overspend of £2.4m at month 9 which is a deterioration of £1m in month. The biggest variance was in the Surgery HG with an increased deficit of £0.6m and was £0.5m more than expected. This related to reduced income, increased non pay costs and increased agency spend on medical staff. Medicine HG deteriorated by £0.1m mainly due to a large back payment to a Consultant and Emergency HG also went out by £0.1m due to increased medical staffing costs. Family & Women's HG and Clinical Support HG also deteriorated by £0.1m in month but these were both in line with expectations relating to unidentified CRES.

4. The above position includes an under delivery in CRES to date of £0.6m, with £11.4m being delivered against a target of 12.0m. This is a reduction of £0.5m from month 8. Expected delivery in last 3 months is £5.2m and current year end forecast is for delivery of £16.6m (88%) leaving a gap of £2.2m. There remains an element of risk (£0.2m) in the forecast as health groups look to identify further schemes to achieve the total.

5. The Trust has spent £7.5m on agency costs at month 9 which is £0.9m above the plan. This is a £0.2m increase in month. The forecast is currently to be £1.4m above the cap of £9.1m

6. The Trust is forecasting that it will deliver its financial plan in 19/20 following the agreement of another £4.5m of income from commissioners. However there still remains a risk to delivery of this target. Prior to receiving the income the Trusts forecasts indicated that actions of £5.4m were required to achieve the plan. Health Group forecasts increased by £0.9m in month and it is imperative that these positions are brought back in line with month 8 forecasts as soon as possible.

7. The reported capital position at month 9 shows gross capital expenditure of £9.9m compared with plan of £12.0m. The main areas of variance relate to slippage on IT, buildings maintenance and the radio-pharmacy development. The forecast position for capital expenditure is now £33.7m. This is above the submitted plans in July due to the inclusion of notified PDC for winter capital £1.5m , £0.5m HSLI, £4.7m for imaging equipment and £0.4m for cybersecurity. In addition the Trust has received confirmation of a temporary capital loan relating to the urgent and emergency care STP business case for £0.4m . This is in lieu of receiving the PDC once the full business case is approved.

8. The underlying position has deteriorated to a deficit of £10.0m. Surgery HG run rate deficit has increased by £0.7m and is now £1.7m above last year. Family & Women's HG is £0.5m above but other health groups have improved. Surgery and Family and Women's HG need to take actions to show how these will be recovered for 20/21.

9. Next Steps/Actions

a) Health Groups need to return forecast positions to the Month 8 forecasts and improve the overall position by £0.9m

b) 2 Health Groups to identify solutions to move run rates back to 19/20 opening levels.

Integrated Performance Report

ORGANISATIONAL HEALTH

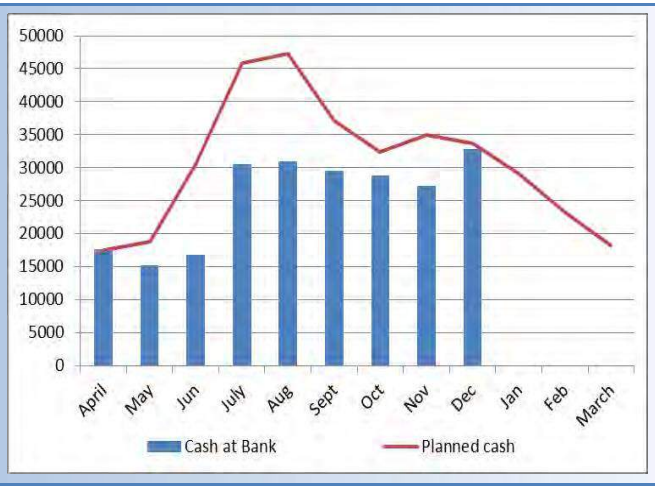
NHS Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of December we had £32.831m of cash and cash equivalents, comprising of monies in the bank of £32.817m and £0.014m in petty cash floats. The cash position remains stable and the availability of cash is reflected in our BPPC performance, which although lower than the required standard is good and constant. At £32.831m cash was slightly lower than planned as invoices are being processed more quickly but we have a number of invoices in query, preventing payments to be made.

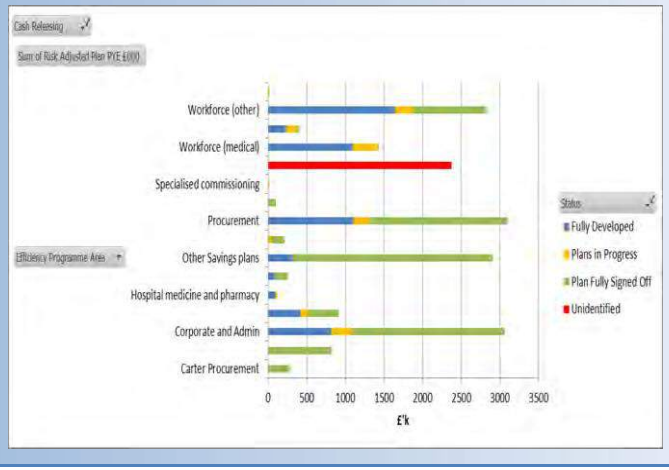


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 9 the planned level of savings is £12m, the actual savings are £11.4m thereby creating a £0.6m adverse variance from the plan.

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



The target for the year is to save £19.9m, the Trust is expecting to deliver this target

Integrated Performance Report

ORGANISATIONAL HEALTH

Hull University Teaching Hospitals NHS Trust

Description	Aggregate Position	Trend	Variation

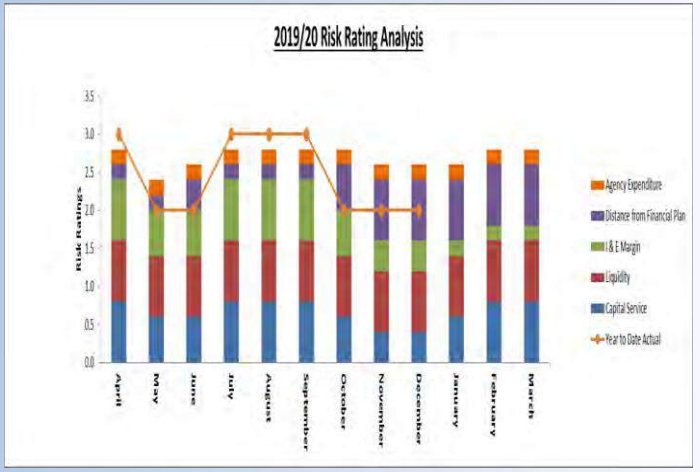
Risk Rating

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 now assess risk. Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst

As at month 9 the Trust is reporting a YTD surplus £4.2m against a planned position of £4.2m surplus. This has resulted in liquidity being rated at a 3, Capital and I&E margin , variance from financial plan & Agency rated as a 2. Giving an overall risk rating of 2.

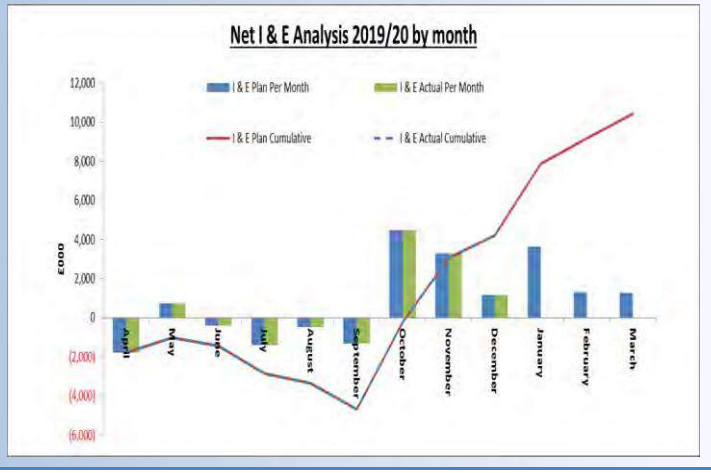


Income & Expenditure

Net income and Expenditure

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

As at month 9 the Trust has delivered a surplus of £4.2m against a planned surplus of £4.2m.



Hull University Teaching Hospitals NHS Trust
Quality Report

Trust Board

28 January 2020

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

Purpose:	The attached report is reviewed in detail by the Quality Committee. It is circulated to the Trust Board for briefing purposes and unless agreed with the Chair prior to the meeting, is not scheduled for discussion today. Board members are expected to brief themselves on the report. Key actions and points of escalation arising from the Quality Committee discussion will have already been brought to the Trust Board's attention on today's agenda at agenda item 7.2 and a summary of this report is received by the Board at 7.2.1. The overall purpose of this report is to provide assurance to the Quality Committee 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; Claims, CQC and the Quality Improvement Programme. The Quality Committee is tasked with reviewing this report on behalf of the Broad, escalating issues as necessary (per agenda item 7.2).	
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 report contains all key Quality metrics for the month alongside a focus update on SI themes.	

Recommendation:	The Trust Board is asked to receive this report for briefing purposes.

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 (December 2019)

Safe:

- A new Never Event in relation to Wrong Site Surgery was declared in December 2019, this is currently under investigation.
- This was the 7th Never Event to be declared during 2019/20. Following this, a NHS Improvement WHO Checklist Peer Review visit was held on the 3rd January 2020. Initial feedback and actions were given after the event. The Trust is now awaiting the report from this visit.
- A Never Event Learning Event was held on Tuesday 7th January, led by the Chief Medical Officer, with senior consultant staff involved in some of this year's Never Events sharing their experiences, this event was an opportunity for staff to share thoughts and ideas on the Trust's patient safety culture
- During December 2019 five serious incidents were declared, including the two never events declared in December 2019

Effective:

- No areas of escalation within month.

Caring:

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

Responsive:

- It should be noted that a focus will place in Quarter 4 on new processes for learning from claims and links to the GIRFT programme.

Well-led:

- The CQC has commenced the inspection preparation with the Trust. The Trust has received and submitted the Provider Information Request
- The Trust has instigated a review of patient's with long waits within the emergency department. Further detail is provided in the well-led section

RISKS TO DELIVERY

- The declaration of a 7th Never Event in the financial year has been noted as a risk within month.

Included in this month's report:

	SAFE	• **Never Events and Serious Incidents** • **Incident Reporting Rates and NRLS** • **Duty of Candour**
	EFFECTIVE	• **Clinical Audit**
	CARING	• **None**
	RESPONSIVE	• **Claims**
	WELL-LED	• **CQC**

SAFE

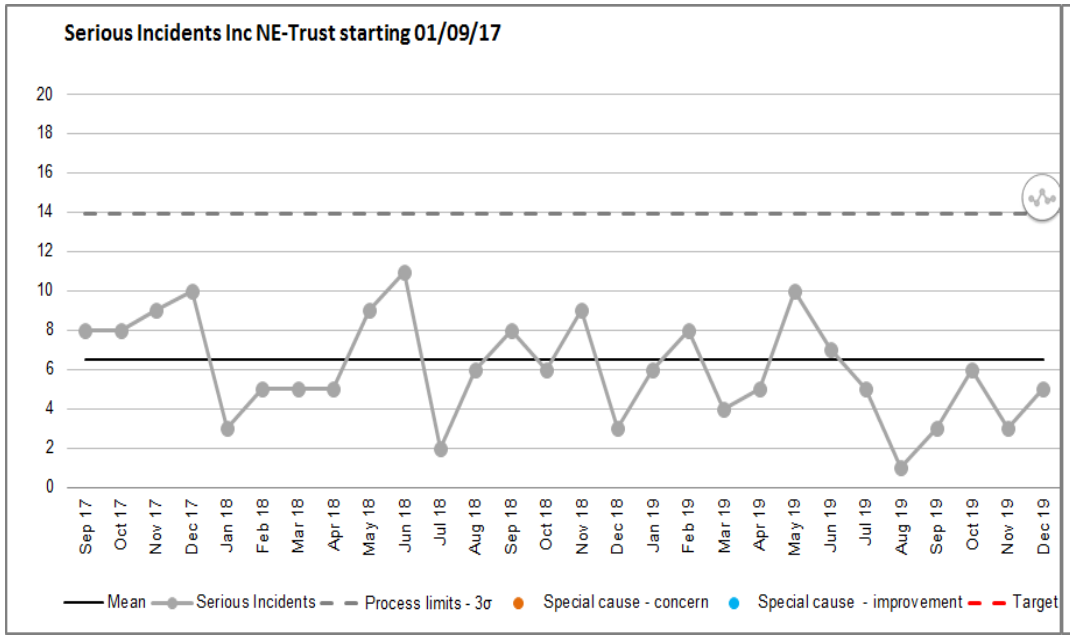
NEVER EVENTS AND SERIOUS INCIDENTS

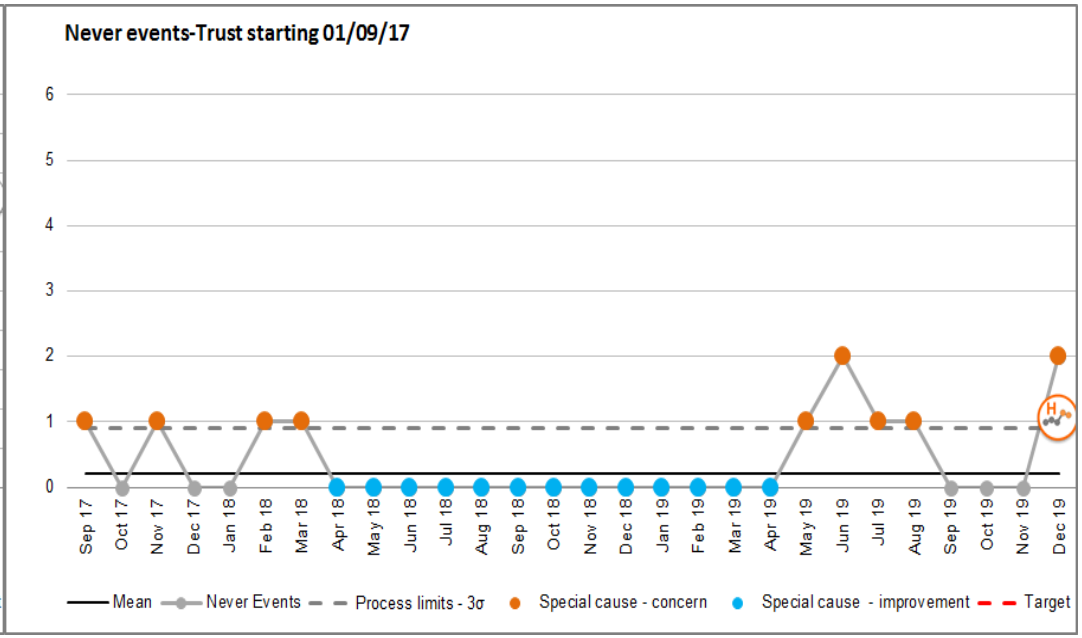
AREAS FOR ESCALATION

Declaration of 7 Never Events within 2019-20 to date. The 7th was declared in December 2019
During December 2019 5 serious incidents were declared, relating to two wrong site surgery never events, an in-hospital fall resulting in injury, a sub-optimal care of the deteriorating patient and a treatment delay.

KEY UPDATES IN MONTH

The chart below indicates the trend in Never Events and Serious Incidents. 7 Never Events have been declared in 2019-20.





RISKS TO DELIVERY

Any serious incident is, by its nature, a significantly serious event where an investigation is required to establish if serious harm occurred, or if there is significant opportunities for learning to be identified. Each of the serious incidents declared in December will receive a robust investigation, and the findings of these will be shared throughout the organisation, after discussion and completion of the investigation report within the Trust Serious Incident Committee.

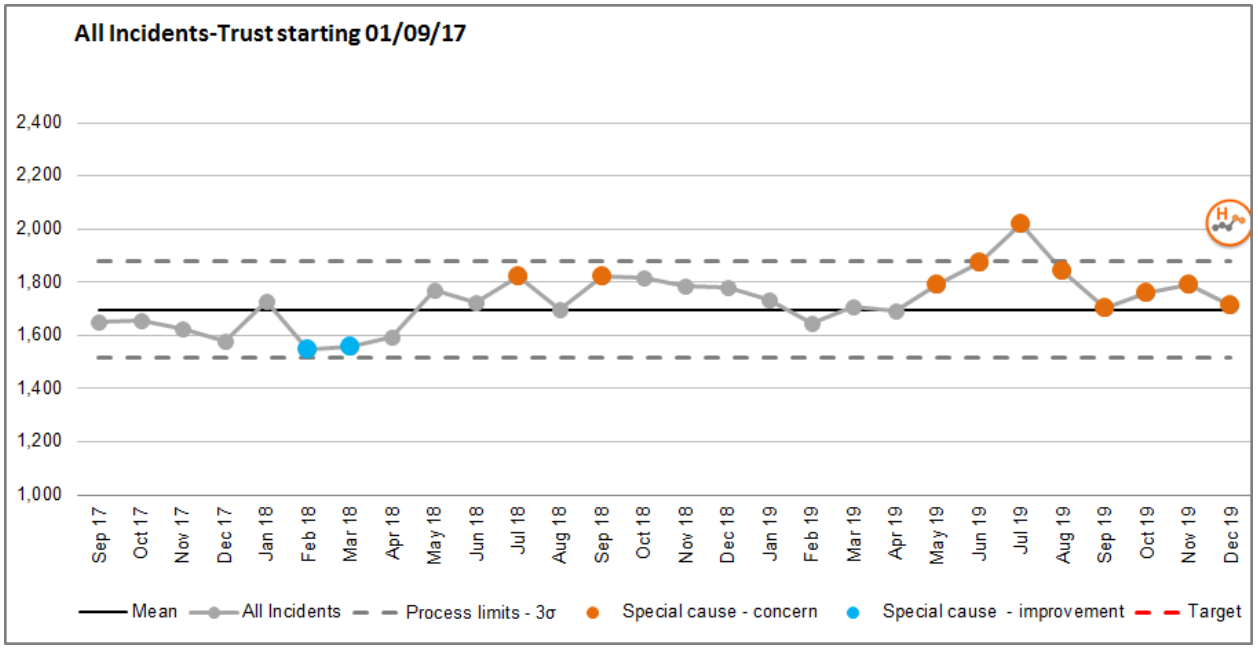
INCIDENT REPORTING RATES

AREAS FOR ESCALATION

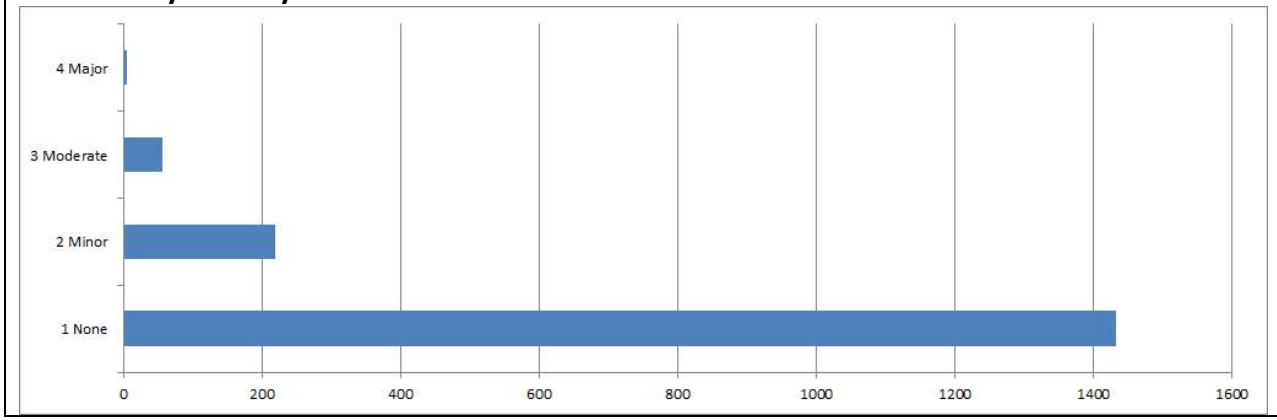
None to escalate this month.

KEY UPDATES IN MONTH

Incident Reporting Rates by Health Group: The number of incidents reported remains within expected control limits.

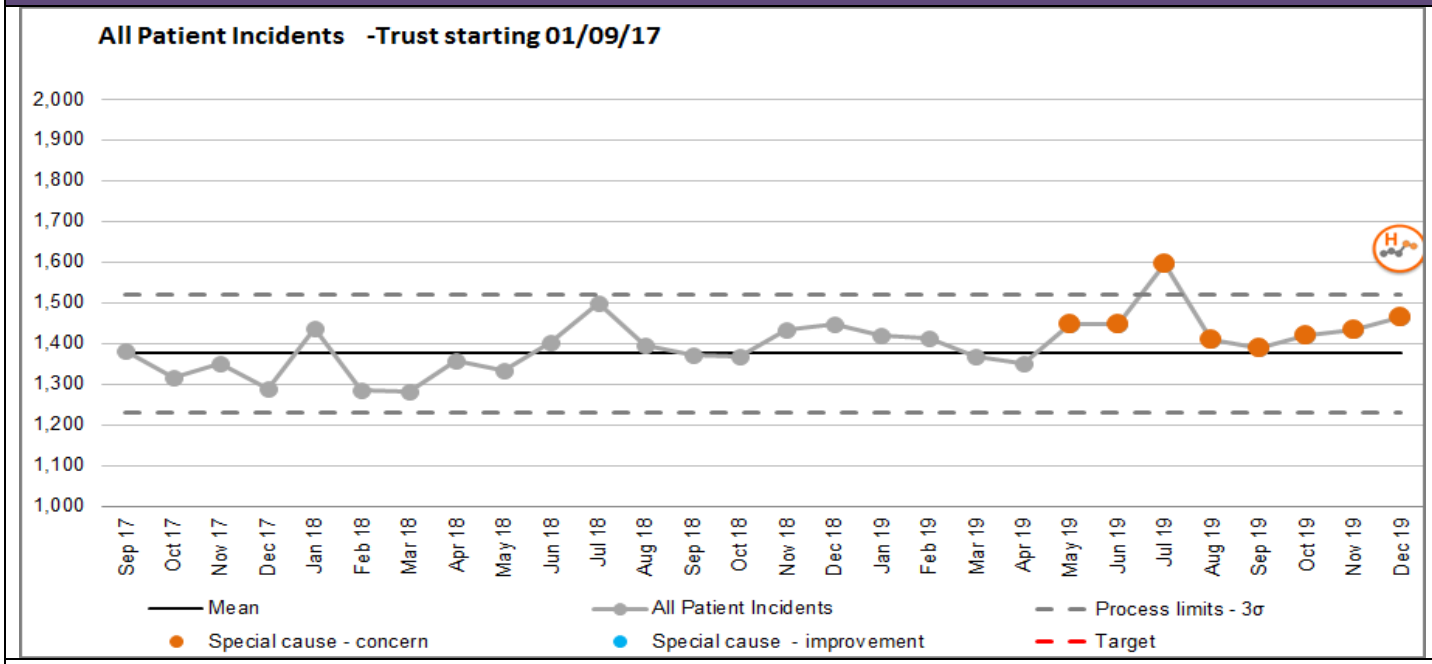


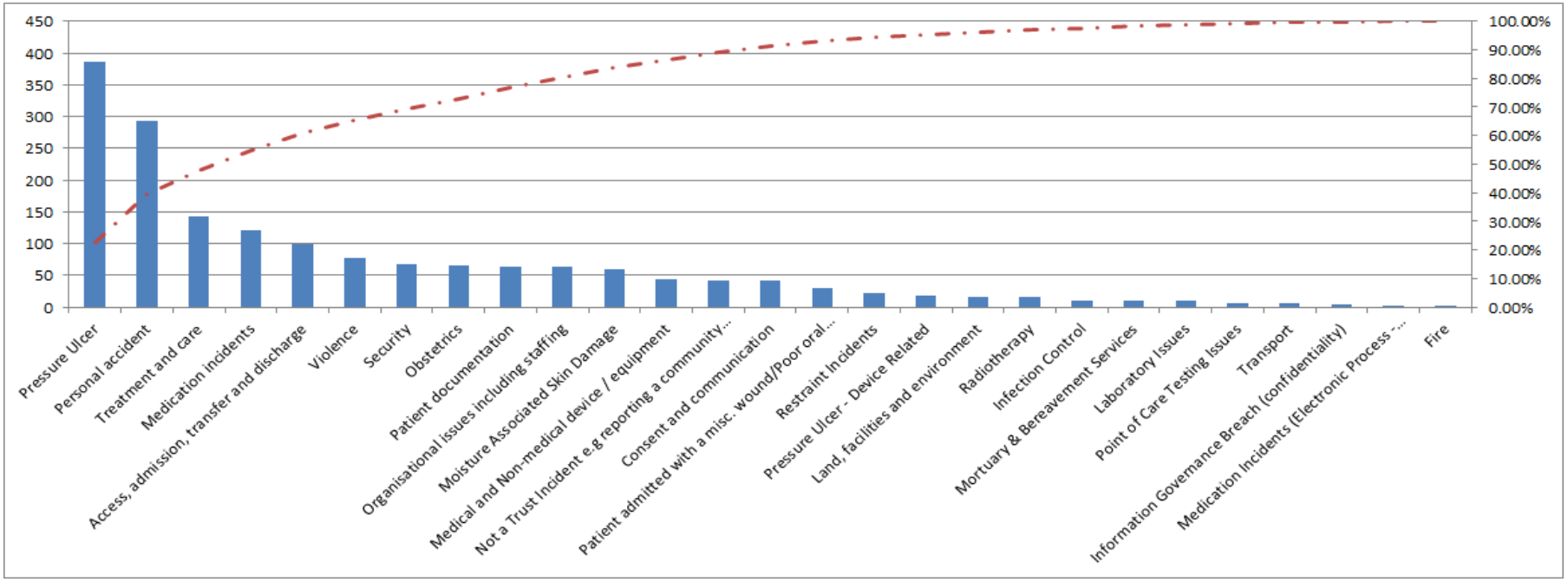
Incidents by severity



The severity of reporting rates remain consistent.

INCIDENT REPORTING RATES





The Graph shows that the top five 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

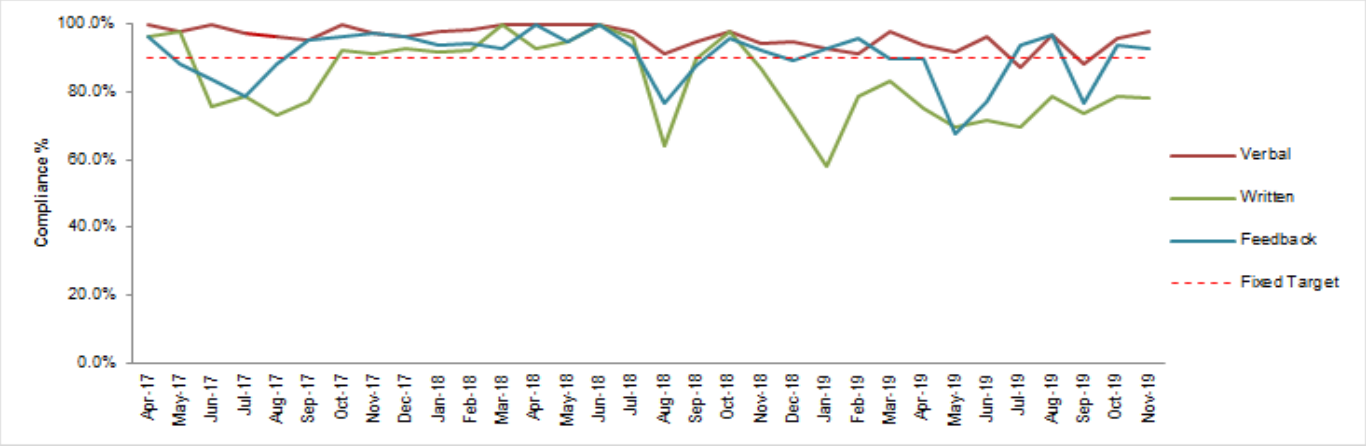
No risks to delivery have been identified within month.

DUTY OF CANDOUR

AREAS FOR ESCALATION

No items to escalate this month.

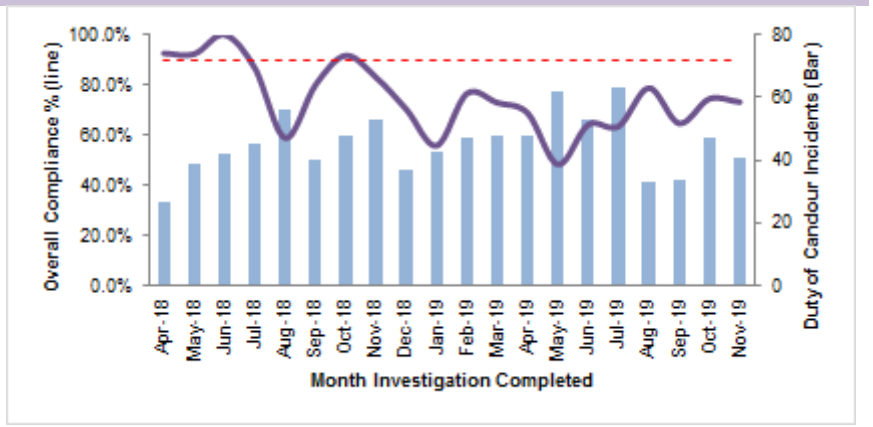
KEY UPDATES IN MONTH



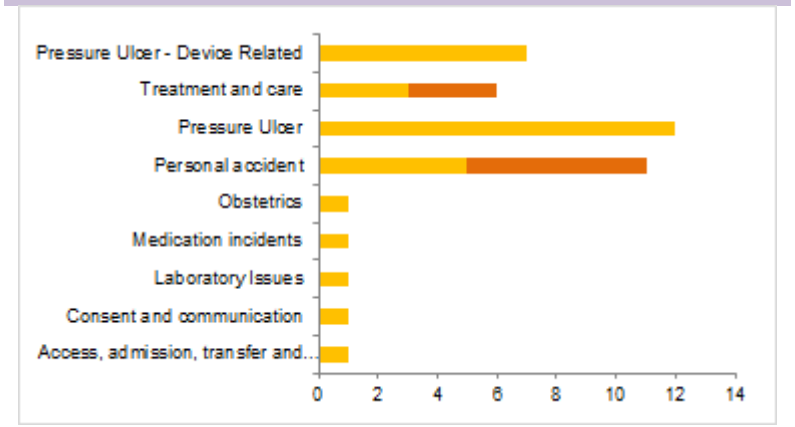
The Quality Governance Team continues to monitor the duty of candour process. Following changes made to the process in Quarter 3, improved compliance is starting be evidenced.

Incidents investigated in the last 12 month period with the compliance circles and types of incidents investigated– date remains one month behind to the time lag 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 continue to monitor the duty of candour process.

CLINICAL AUDIT

AREAS FOR ESCALATION

There are no areas for 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.

Number of audits commenced	Current stage of audits		Number of audits completed
310	Data collection	127	97
	Data analysis	5	
	Report	7	
	Complete	97	
	Ongoing	74	
	Abandoned	0	
Number of audits due to have commenced			**Number of audits due to have been completed**
130			56

RISKS TO DELIVERY

No identified risks to delivery.

RESPONSIVE

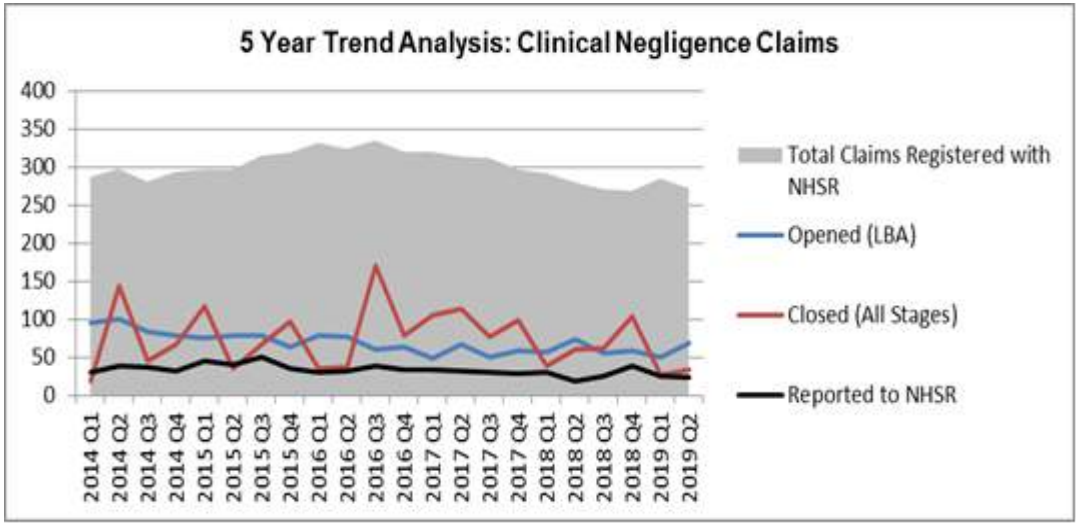
CLAIMS

AREAS FOR ESCALATION

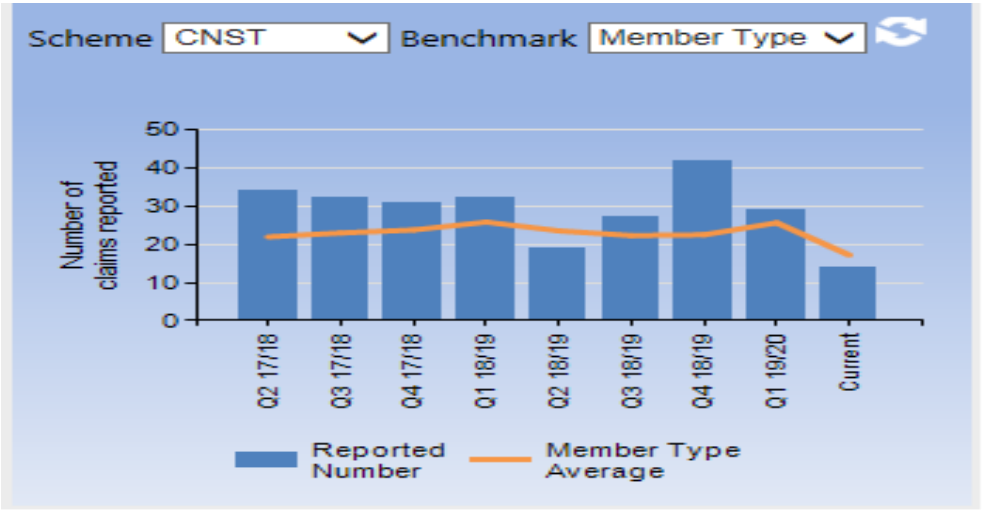
It should be noted that a focus will place in Quarter 4 on new processes for learning from claims and links to the GIRFT programme.

KEY UPDATES IN MONTH

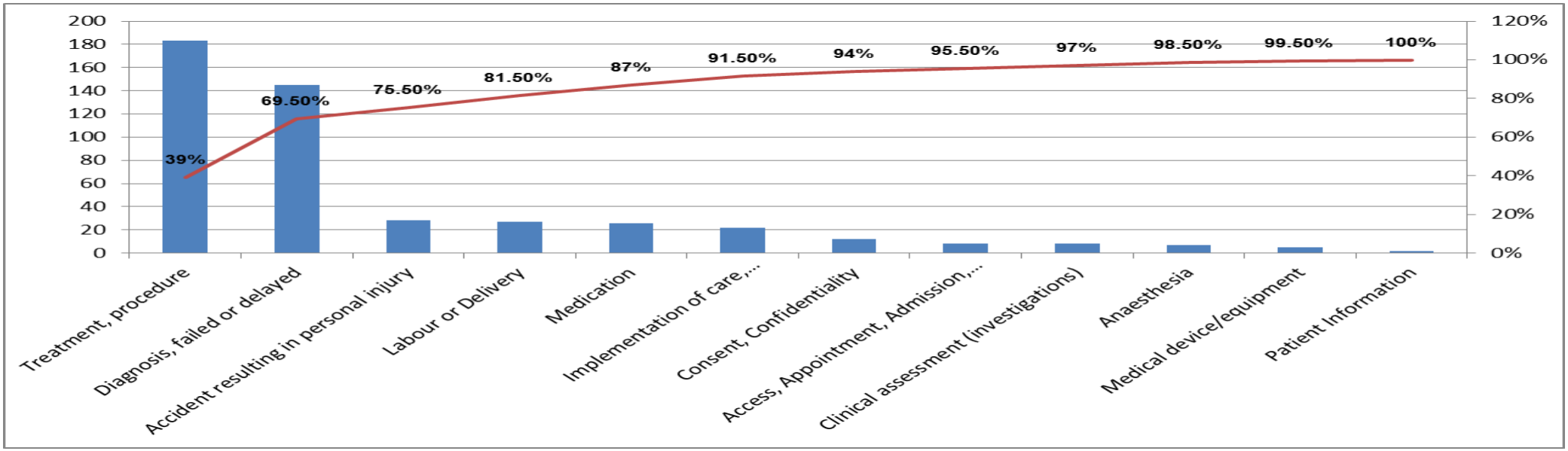
5-Year Trend Clinical Negligence Claims



Number of Claims reported to NHSR (Data not available– Extranet currently being upgraded and back on line February 2020)



5-Year rolling trend settled claims at Q2 2019/20 – Incident type



RISKS TO DELIVERY

No identified risks to delivery.

WELL-LED

KEY UPDATES

Care Quality Commission:

- The Trust continues to interact with the CQC on a regular basis. General information requests continue to be received on; for example, completed Serious Incidents, Coroners Cases and Complaints.
- The quarterly engagement meeting took place on 13th January 2020 and was attended by the CQC Relationship Managers, along with the Chief Nurse, Chief Medical Officer and Deputy Director of Quality Governance from the Trust.
- As reported previously, the Trust received the Provider Information Request (PIR) in October 2019. This commences a three month timetable cumulating in both an announced Well-led inspection and an unannounced Core Service Inspection.
- The Compliance Team have undertaken a check and challenge initiative on the 2018 CQC Actions with no key areas of concern highlighted.
- The Trust continues to play an active part in the NHSI/E Moving to Good Programme. On the 30th January 2020 a Patient Safety course / workshop is being held and will be attended by the Governance, Communication, OD and Improvement Teams from the Trust. A Governance course / workshop is being held on the 20th February 2020 which will be attended by Chief Nurse, Deputy Director of Quality Governance and a clinical leads from across the Trust.

Emergency Department Patient Review work stream:

Following the increase in activity in the Emergency Department at the end of 2019, the organisation has instigated a review. The review will take place in a number of work streams:

1. A Serious Incident was declared in relation to Ambulance Turnaround times. This SI has now commenced and will focus on patient safety and review any potential harms
2. OPEL4 was declared on two dates in December with long waits in the ED. A multi-disciplinary harm review group led by Dr Adams with input from the Medical Director of Yorkshire Ambulance Service will this cohort of patients.

RISKS TO DELIVERY

All projects within the QIP are progressing well, however some delays have been noted and the projects highlighted above could pose a risk to the achievement of the overall plan and the Board Assurance Framework (BAF) Risk 3 which is linked to the Trust receiving an overall rating of good.

A FOCUS ON THEMES WITHIN SERIOUS INCIDENTS
KEY UPDATES
See the detailed report at appendix 1
RISKS TO DELIVERY
The lack of progress on the above actions could pose a risk to core service ratings and the overall rating of the Trust at the next inspection.

Appendix 1

Serious Incidents Themes Report January 2020

1. CURRENT POSITION

As at 1 January 2020 the Trust has reported 43 Serious Incidents, which includes 7 Never Events.

Information on reported Serious Incidents, including Never Events is reported within the Trust Quality Report, and within reports to Operational Quality Committee and Quality Committee.

During 2019 a new Trust Committee was established in relation to Serious Incidents. Meeting on a monthly basis and chaired by Chief Nurse and Chief Medical Officer this new committee oversees all the Serious Incidents investigations and SI processes.

During 2020 it is expected that this committee will widen its membership and start to look more in-depth to the themes and trends within SIs.

This report gives an overview of the themes which have arisen through Serious Incidents declared 2019/20 to date.

2. Themes within Serious Incidents from April 2019 to date

The following are the current identified themes and trends within Serious Incidents.

2.1 Surgical Checklists

Following the declaration of the 7th Never Event* within 2019/20, NHS Improvement offered a WHO checklist peer review. This review was undertaken on the 3rd January 2020. The Trust is now awaiting a response report, however, initial findings included

- It was noted that there is a lot of ego in this Trust that is getting in the way of safety
- Whilst staff do feel empowered to stop the line - it depends on the surgeon and/or anaesthetist present at the time as to whether they actually will do it
- There was reported a lack of professional inquisitiveness amongst medical staff, but that enthusiasm was noted amongst non-medics (and occasional medical staff)
- New staff are embracing the culture, old staff take time to embrace new cultural change

A Never Event learning session was held on Tuesday 7 January 2020, to attempt to understand the factors and issues which are contributing to, and causing these incidents.

The Acting Deputy Director of Quality Governance undertook a review of the 5 never events reported at the time of the review to the December 2019 Serious Incident Committee (these were 12800, 15108, 18796, 12801, 10523).

The following themes were identified;

Checklists, Checks and Balances

Undertaking the correct checks and balances were a key contributor to a number of the Never Events including:

- 2019-12800 – a chest x-ray was reviewed to confirm placement of the NG tube. However, the wrong x-ray was viewed
- 2019-12801 – a wrong tooth was extracted. One of the contributing factors was that a number of staff members, at different points in the process, did not undertake the necessary checks eg the dentist did not count the teeth (aloud or in their head), the scrub nurse did not visualise the tooth
- 2019-10523 – the correct checks were not made to ensure all swabs were accounted for.
- 2019-18796 – the safety checklist that was on the wall was partially obscured by equipment although the paper record in the patient's notes was completed and available. In addition, there were inconsistencies between the procedure documented on the consent form and that recorded in ORMIS

Assumptions

- 2019-12800 – assumptions were made that the x-ray identifying the correct placement of the NG tube was the most recent x-ray taken as well as assumptions that the ACCP had displayed the most recent image for the consultant to view
- 2019-15108 – a patient was connected to air rather than oxygen. Due to the design of the equipment, the individual assumed they had connected the patient to oxygen
- 2019-12801 – an x-ray was available of the patient's tooth, however, the staff member assumed that the procedure would be straight-forward and therefore did not review the image
- 2019-10523 – during the swab count a member of staff noted another member of staff placing a further swab into the count. The assumption was that this was the "final" swab. It was not, it was an additional swab that had been used to clean the patient's mouth.
- 2019-18796 – the operating surgeon had in their mind which digit to operate on and did not personally read the consent form

System faults

- 2019-12800 – the x-ray images do not automatically display in chronological order
- 2019-15108 – a piece of equipment was being used which was nearly identical to another piece of equipment. Both intended for two different jobs. Ie the flow meters are not an intuitive design.
- 2019-10523 – a swab was used rather than a throat pack which would normally be used by the team. If the throat pack had been used, a sticker would have been placed on the forehead to indicate that a throat pack was in situ. Due to a swab being used, this did not happen.
- 2019-18796 – areas marked to aid in the correct identification of the digit were obscured.

Ownership

- 2019-15108 – a specialist was not in the room at the time of the procedure, this was a contributing factor
- 2019-10523 – the consultant surgeon left the theatre whilst each team member focused on their own tasks. Staff present were no confident to call the surgeon back into the theatre. There was also no "leader" to lead the sign out.
- 2019-18796 – the operating surgeon was not present at the team brief where crucial information is discussed. In addition, senior operating department practitioners were not present in the theatre when the procedure commenced

Other analysis
Following the declaration of the 6th and 7th Never Events, the Chief Medical Officer requested Dr Adam Dalby, Clinical Fellow, has undertook a review of the last 5 years of Never Events occurring within this Trust.

Next Steps
The feedback from the NHS Improvement visit and from the NE Learning Event has been considered, and actions are being developed. These actions include reviewing policies in relation to WHO checklist, and enhancement of the Human Factors training delivered within the organisation. This may include joint working with Airedale NHS Foundation Trust Hospital to develop some regional human factors training.

***2019/20 Never Events**

- 2019-12800 – misplaced Naso Gastric Tube
- 2019-15108 – unintentional connection of patient requiring oxygen to an air flow meter
- 2019-18796 – wrong site surgery – surgery performed on the wrong digit
- 2019-12801 – wrong site surgery – incorrect tooth removal during extraction of wisdom tooth
- 2019-10523 – retained foreign object –following dental surgery a swab was left in the patient
- 2019 -26456 – wrong site surgery – lumbar puncture undertaken on wrong baby
- 2019-27512 – wrong site surgery – fallopian tube removed rather than intended appendix

2.2 Maternity
Serious Incidents have continued to be reported within the maternity services.

The Trust Acting Deputy Director of Quality Governance undertook a review of maternity serious incidents themes and trends for SI investigations completed March 2019 to September 2019. This was following a review which was undertaken of maternity SIs March 2018 to March 2019. The outcome of the review was reported to the November 2019 Serious Incidents committee and the findings were

Seven Maternity SIs concluded in the time period. These were:

- **2019-10001 –** baby born by Neville Barnes forceps in poor condition due to possible placental abruption in second stage of labour
- **2018-27728 –** baby born with HIE
- **2018-29224 –** baby born in poor condition and died – original SI declared by Leeds Teaching Hospitals NHS trust
- **2019-4420 –** Mother diagnosed with severe sepsis and IDU
- **2019-2070 –** Mother diagnosed with AKI and transferred to ICU, baby unexpected admission to NICU
- **2019-9995 –** Delay in delivery with unplanned admission to NICU
- **2019-11123 –** Cord prolapse leading to emergency C-section, baby to NICU

Fundal Height
Fundal height measurement was noted as an issue in 4 of the 7 Sis. This including not plotting height on growth charts, not undertaken growth measurements and / or scans as per plan and not acting upon reduction or increase in growth identified (2019-10001, 2018-29224, 2019-2070 and 2019-9995).

Deviations from Guidelines
All 7 SIs had deviation from guidelines as a contributing factor.

Language Barriers
An issue with language was noted in 2 of the 7 SIs, with inappropriate interpreters being used in both cases. It was noted that this contributed to the mother and clinicians understanding of events (2018-27728 and 2019-4420).

Poor Communication with the Mother
Poor communication with the mother in terms of what was happening to their baby on transferred to NICU was identified in 2 of the 7 SIs (2019-9995 and 2019-11123).

Delay in Reporting Incidents
In the majority of the SIs for this time period there is a delay of approximately one month between the incident date and the date it is reported.

It was agreed that following this review there would be a further 'deep dive' into the serious incidents undertaken by the Nurse Director, Family and Women's Health Group and the Acting Deputy Director of Quality Governance.

2.3 Diabetes

There were three Serious Incidents declared in 2018/19 and there has been one serious incident declared 2019/20 in relation to diabetes and insulin management. The issues within the events related to failure to follow guidelines, omitted insulin doses due to inexperience and limited knowledge of staff in caring for patients with diabetes and poorly written insulin prescription and documentation within notes

The Trust has established a Diabetes Safety Group which first met in November 2019. This group will review diabetes and insulin management across the Trust, including any issues arising from incidents/serious incidents.

The Governance Directorate have begun to organise patient safety walk rounds, where bi-monthly governance staff with other staff groups will walk to ward areas delivering patient safety messages. The message for December was around diabetes and insulin. Demonstrations were given, and some of these have been added as videos to Pattie for people to view. This was included as a news item in the Lessons Learned Bulletin for January 2020.

2.4 Diagnostic Incidents

Following on from SIs also reported in previous years, 2019/20 has seen SIs continue to be reported in relation to failure to follow up on diagnostic results which were available. A report was presented at the November 2019 Serious Incident committee on the 8 serious incidents declared from April 2019 to date which had elements which could be attributed to the theme of failure to follow up abnormal results (including diagnostics).

The Quarter 2 2019/20 Commissioners Serious Incident Report refers to this theme as ''*There are several variances of delay / failure to follow up and can be from failure to book a patient for a scan, repeat scans or failure to act on abnormal results. These are also not isolated to specific areas / services and also vary in nature.''*

The Chief Medical Office reported at the December 2019 Commissioners Quality Delivery Group that for the new Trust Clinical Digital Lead, Dr Alastair Pickering, has received information on the Serious Incidents which this theme relates to (following a review undertaken of this theme by the Medical Directors office) and has agreed to take forward with the Trust CRS team developments to the Lorenzo system functionality to enable available results to be flagged up so that the appropriate clinical teams are highlighted to the available results. This will be a significant programme of work so will not be a short term solution to the issue.

Individual SIs will still be declared if there are failings relating to this theme which cause significant patient harm

2.5 Ovarian torsions

There have been four serious incidents declared 2019/20 to date which relate to patients experiencing ovarian torsions, and failings in our care of these patients which led to harm.

A meeting was held in December 2019 to discuss the 4 serious incidents over 18 months. The meeting was attended by senior gynaecology consultant and ED team and led by the FW HG Operations Director. A follow up to the meeting will be held in January 2020.

Actions were agreed in relation to

- Improving the education and awareness of ovarian torsion in the Emergency Department, Gynaecology and Surgery – to include likely symptoms, clinical presentation, requirement for a gynaecological history taking and case presentation
- Pathway to be developed which identifies the clinical presentation likely for ovarian cyst/torsion – this is to be used to assist with the efficient and effective recognition, diagnosis and treatment in hours using ultrasound and out of hours through CT. Agreed that there would be no requirement for the Radiology registrar to approve a CT request out of hours (numbers likely to be minimal and patients already being scanned at some point in their presentation so no increase in activity overall).
- Clinical Audit and Further Meeting – on-going review of identification and management of torsions to be considered and further meeting to review impact of agreed actions; acknowledging that increased awareness and education will impact on the suspected diagnosis and request for diagnostics initially

2.6 Pressure Ulcers

There have been four serious incidents declared 2019/20 to date in relation to hospital acquired pressure ulcers.

- 2019/8872 – Category 4 – Ward 11, HRI
- 2019/12484 – Unstageable pressure ulcer – Ward 90, HRI
- 2019/13130 – Unstageable pressure ulcer – Ward 14, CHH
- 2019/14406 – Category 4 – Ward 11, HRI

The investigation method for all four pressure ulcer SI's was to engage staff from the individual wards and to apply the Yorkshire Contributory Factors Frame Work (YCCF) method.

The YCFF meetings identified the following themes across all four investigations:

- Poor recognition by staff of the associated risks to skin in patients with reduced mobility
- Poor recognition by staff in relation to a patient's nutritional status and the impact on skin integrity
- Inconsistent SSKIN care bundle delivery
- Poor nursing and medical documentation

The commissioners have identified as themes from completed investigations into pressure ulcers SIs as; **'***lack of knowledge regarding wound type/identification, failures in basic nursing care, delay to report on Datix / notify TVNs, poor documentation and not identifying patients at risk.'*

Improvement work around pressure ulcers is included in the Trust Quality Improvement Plan for 2019/20.

3. Sharing the themes and trends information

The information included in this report will be shared across the Trust within the new Be Remarkable e-bulletin in February 2020.

4. Serious Incident Actions

Each serous incident investigation results in an action plan. This action plan is monitored to delivery by the responsible Health Group/Department.

In December 2019 the Quality Governance Lead reviewed all overdue Serious Incident actions and addressed any issues preventing completion of actions.

Serious Incident actions now receive strategic oversight through the monthly serious incident committee.

Healthcare Associated Infections Report
Quarter 3 2019

Lead: Greta Johnson, Director of Infection Prevention & Control

Purpose of the Report

The purpose of this report is to provide information and assurance to the Trust Board on matters relating to the prevention and control of healthcare associated infections (HCAIs) and opportunistic infections

Items for Escalation at close of Quarter 3 (December 2019)

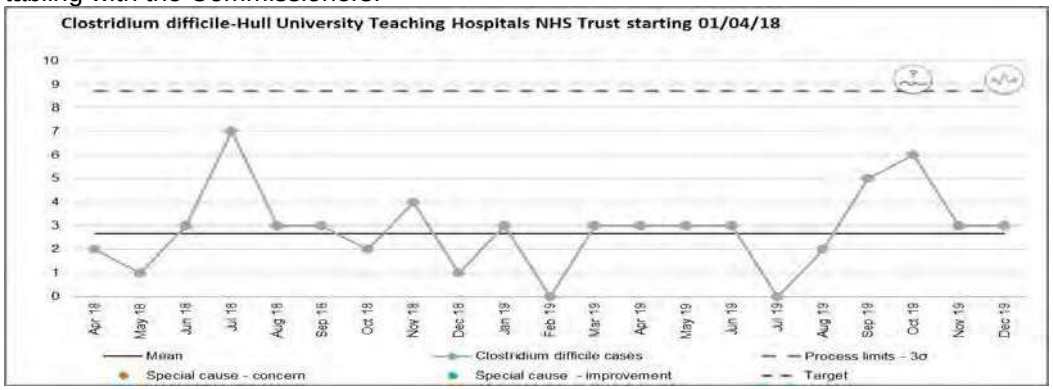
- Three Trust apportioned MRSA bacteraemia cases, one deemed avoidable, one unavoidable and the third awaiting outcome of discussions following Post Infection Review meeting due to complexity of the case.
- Forty four Trust apportioned MSSA bacteraemia cases – a slight reduction in number of cases reported for the same time period 2018/19. All Trust apportioned cases are investigated using a root cause analysis (RCA) process.
- Twenty eight hospital onset healthcare associated Clostridium difficile cases and fourteen 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 forty two cases are investigated using a root cause analysis (RCA) process and tabled at a commissioner led HCAI review group. To date, of the cases tabled four 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, eighty eight E.coli bacteraemia have been reported (109 in 2018/19), thirty one Klebsiella (27 in 2018/19) and twenty one Pseudomonas aeruginosa (13 in 2018/19). Any differences should be treated with caution due to small numbers and natural variation.
- During Quarter 3, one colonised case of Pseudomonas aeruginosa was detected on the Neonatal Intensive Care Unit (NICU), this occurred in October 2019 – this case had a unique profile and is distinguishable from all other cases identified on the unit.
- Influenza activity was noted as early as October 2019 in the Trust with a peak in cases noted during December 2019, this peak was experienced a month earlier than the 2018/19, but in line with activity across the UK and in keeping with the previous activity noted in the Southern Hemisphere. To date there has been no incidences of Trust apportioned outbreaks of influenza.
- Norovirus activity has continued during October – December 2019 affecting mainly medical and medical elderly wards but an outbreak on Ward H12 impacted on trauma activity during October 2019. Of note, outbreaks have been protracted, the reasons being multifactorial, including patients being symptomatic for longer, no floor to ceiling partitions in affected wards and effectiveness of cohort nursing.

Clostridium difficile (CDI)

2019/20 threshold – 80 cases, HOHA and COHA.

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

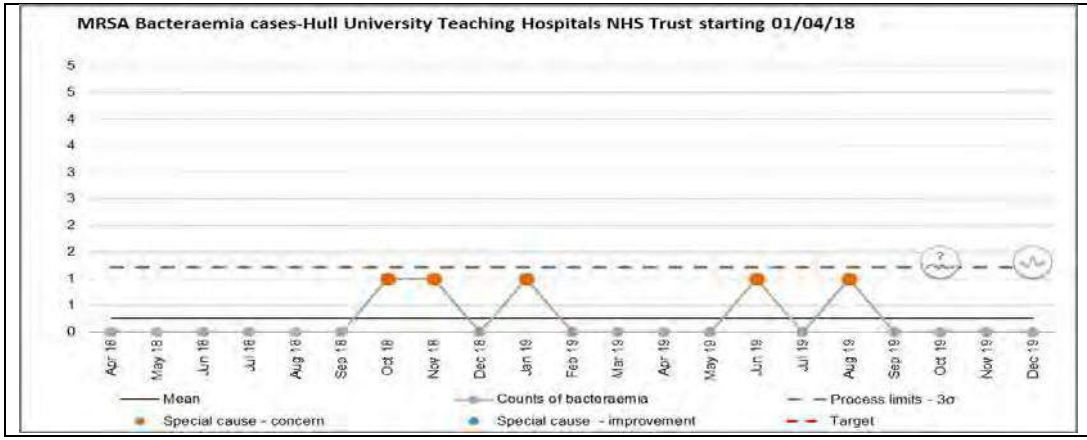
diarrhoea.
By December 2019, the Trust reported 28 HOHA and 14 COHA infections against an upper threshold of 80 (53% of threshold). Of the HOHA cases, from the 1st April 2019, a total of sixteen cases are apportioned to the Medical Health Group, nine to Surgical Health Group three to Clinical Support but no cases identified in the Families & Women's Health Group. By December 2019, two Trust reported cases relate to the same patient with a relapse in symptoms. Twenty two cases have been tabled at the HCAI Commissioner Led Review Group and four cases deemed as lapses in practice linked to prescribed antibiotics not in line with Trust guidelines with feedback provided to those clinical areas. A further twenty cases are either awaiting investigation and/or tabling with the Commissioners.



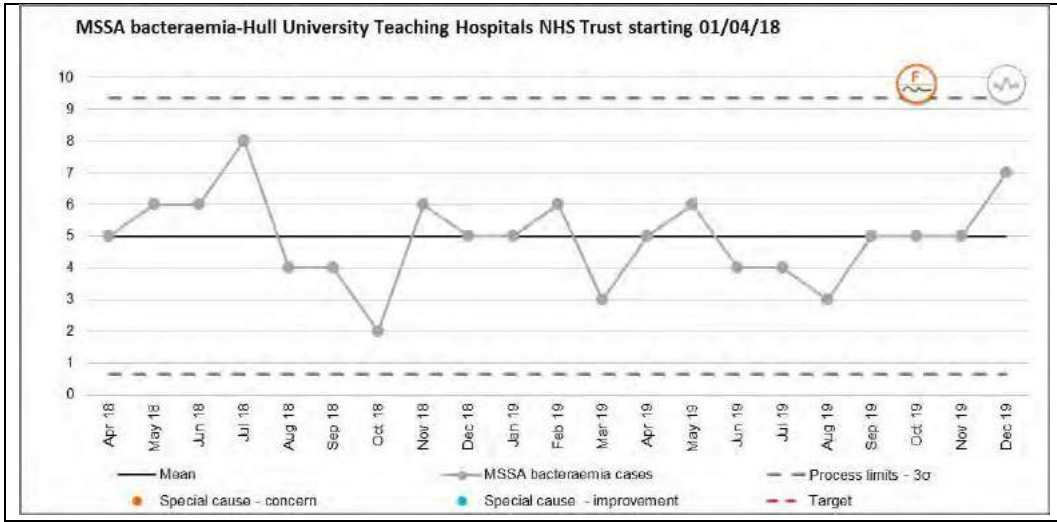
Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia

2019/20 threshold - Zero tolerance

By December 2019 the Trust reported 2 Trust apportioned cases.
First case reported in June 2019 in the Medicine Health Group and the second case reported in the Surgical Health Group during August 2019. A community case was reported in the Medicine Health Group in November 2019 but was investigated as a Trust apportioned case due to timing of previous hospital discharge
Outcome of PIR investigation and final assignment:
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.
November 2019 - Post Infection Review investigation completed and outcome meeting held. Further follow up required as a consequence of meeting outcome to determine whether case was avoidable or not. Patient is likely to have a deep seated infection secondary to a long standing pacemaker.



Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia
2019/20 threshold - there are no national thresholds for this infection but for 2019/20 there is a locally agreed CCG stretch target of 50 cases By December 2019 the Trust reported 43 Trust apportioned cases. Of the 43 reported cases investigated it has identified that 43% are linked to CVCs & PVCs with the remainder mixed trends including pneumonia (HAP/VAP), surgical site infections (SSIs), skin and soft tissue infections (pressure sores/ leg ulcers), urinary tract infections (UTIs), possible contaminant and some cases unknown source. Ongoing work around CVC usage continues with some cases being managed by other teams outside of the Trust. Updated bundles, competency training and education All cases are reviewed by the IPCT and RCAs are being completed by the respective HGs. The Surgical Health Group are reporting 22 cases, Medicine Health Group 13 cases, 8 in Clinical Support and none reported in Families & Women's Health Group.



Ecoli Bacteraemia

For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England require a year on year 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.

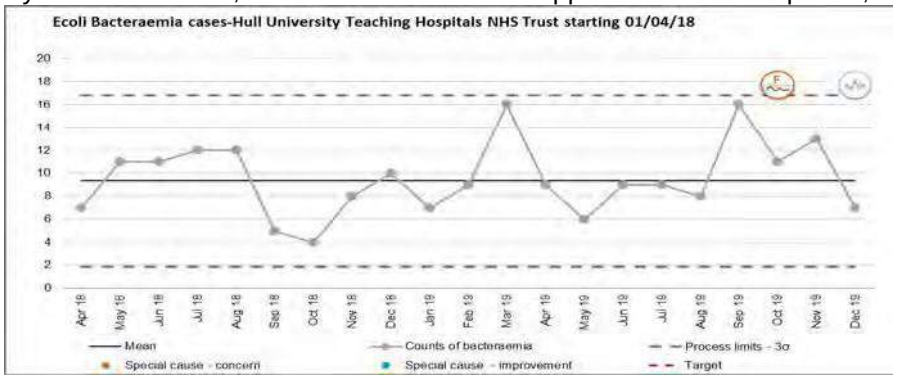
The focus of attention is on the reduction of urinary tract infections, which are responsible for the largest burden of E.coli infections. The Trust, along with system partners, across Hull and East Riding are involved in a number of projects to try and reduce the burden of these infections including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

The main points 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 below, 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.

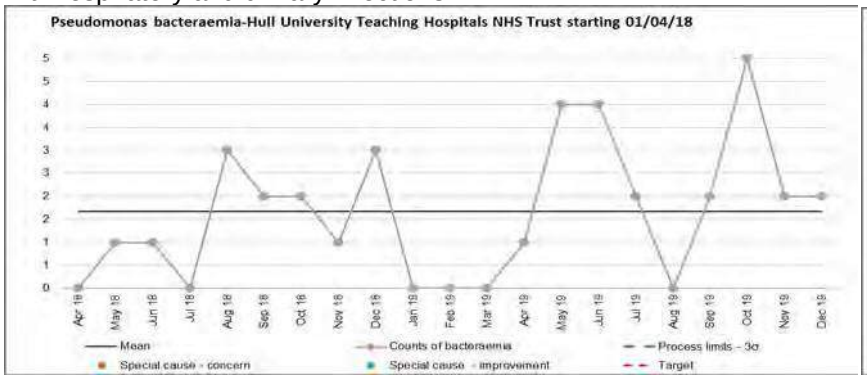
Review of cases suggests ongoing causes related to complex abdominal and urological surgery, biliary and urinary sepsis. Ongoing review of cases continues by the IPCT with those deemed possibly preventable or preventable requiring an RCA by the HG. The cases requiring an RCA relate to urinary tract infections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

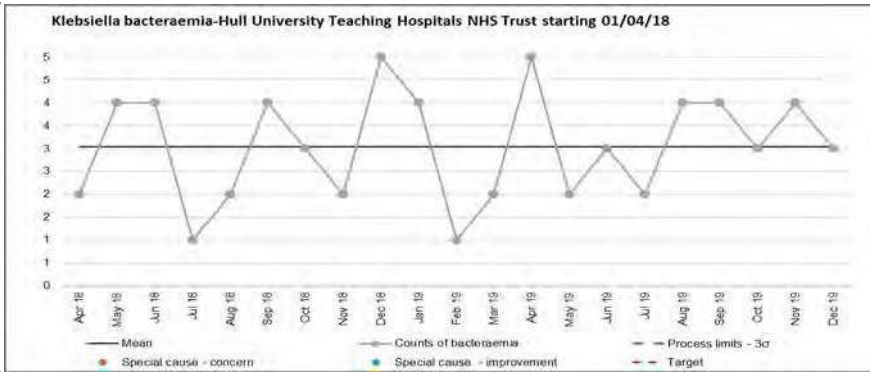
By December 2019, there has been 88 Trust apportioned cases reported, in comparison to 80 cases for the same time period last year.



Klebsiella & Pseudomonas Aeruginosa Bacteraemia (Gram-negative bloodstream infections)

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.





Incidents

Pseudomonas aeruginosa in NICU

During Quarter 3, the screening of babies for Pseudomonas aeruginosa has continued on the Neonatal Intensive Care Unit (NICU). These take place on admission and on a weekly basis thereafter. A colonised case was detected during October 2019 but no further clinical infections detected since July 2019 and no bacteraemia cases 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. 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, results pending. A pilot of a novel cleaning agent used to clean and decontaminate hand wash basins commenced on the 2nd August 2019 on the unit and lasted 2 weeks, pre and post pilot swabs were taken, yielding a 50% reduction in pseudomonas contamination. A longer pilot of the product is planned on the unit but has been delayed due to commercial issues but it is hoped that this will commence as soon as possible. Further updates will be provided in future reports.

MSSA incident on NICU

A neonate with underlying ichthyosis nursed in SCBU was found to be colonised with Staphylococcus aureus. The baby was well throughout, and was subsequently discharged. Concerns were raised by staff caring for the baby that they had developed skin lesions. Following review by occupational health, screening of affected staff for S. aureus was undertaken. Of 6 staff screened, 2 had lesions which grew S. aureus, 2 were nasal screen positive and 2 were negative. All affected staff were risk assessed, and offered topical decolonisation. No further reports of new lesions were made subsequent to this. Baby contacts of the index baby were also screened, 5 of 6 were positive and all 6 babies were subsequently decolonised. The affected bay was restricted until decolonisation treatment had been completed. No baby contacts had clinical infection concerns at this time. All isolates were sent for toxin detection and typing for both identified staff and contacts - all results were distinguishable, none of which linked to the index case. Incidentally, a staff member was found to be colonised with a toxin producing strain of MSSA, which was distinguishable to the index case but prompted management from Occupational Health. This demonstrates that in spite of a staff member harbouring a toxin producing strain of MSSA this was not passed onto the neonates on the unit, supporting the premise that hand hygiene and use of PPE id being adhered to.

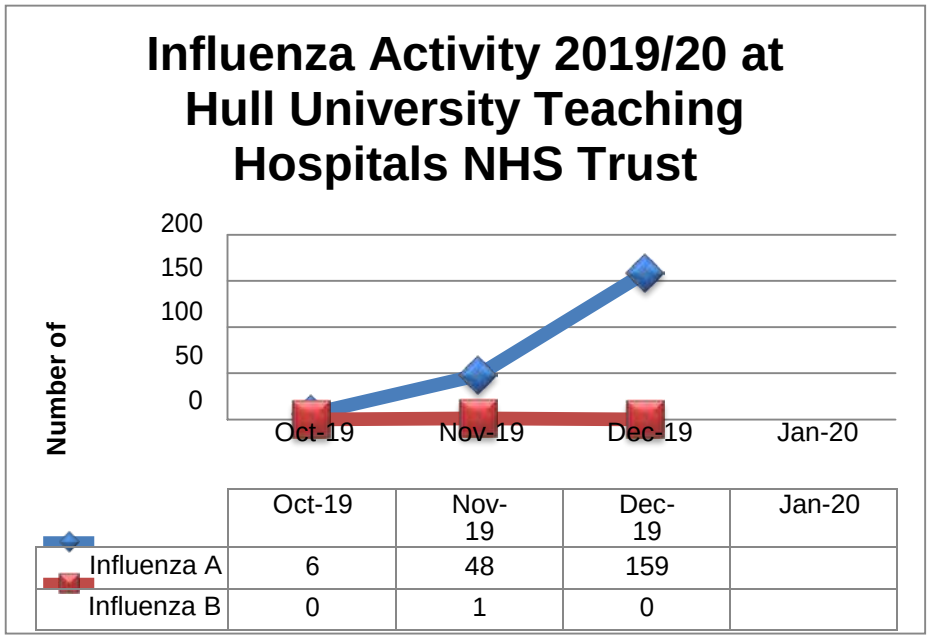
Norovirus outbreaks

Norovirus activity has continued during October – December 2019 affecting mainly medical and medical elderly wards but an outbreak on Ward H12 impacted on trauma activity during October 2019. Of note, outbreaks have been protracted, the reasons being multifactorial, including patients being symptomatic for longer, no floor to ceiling partitions in affected wards and effectiveness of cohort nursing. Less staff have been affected during this outbreak season to date but flow and capacity have been affected by bay and ward closures. From the 1st October 2019 to the 31st December 2019, 1044 bed days were lost with 106 of those been unoccupied bed days.

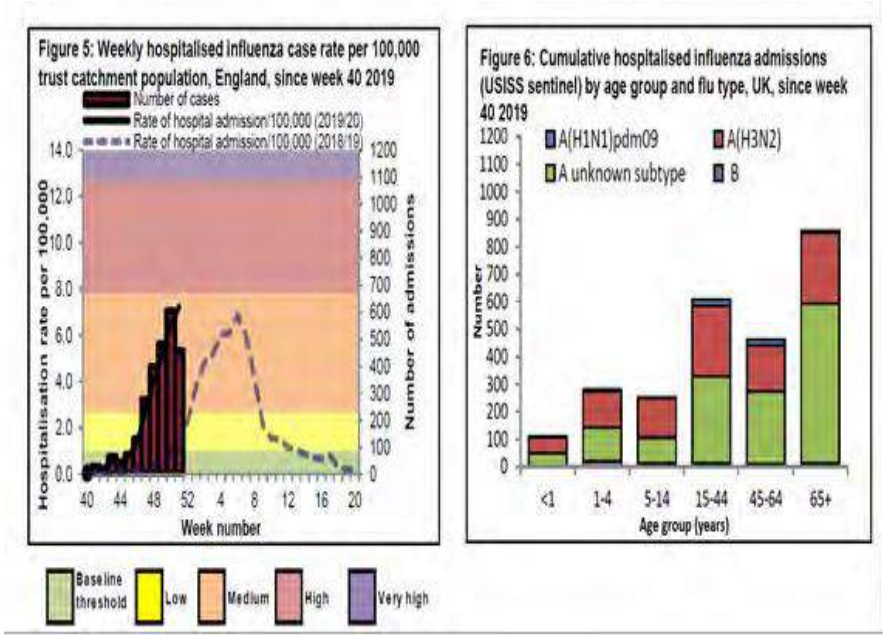
Influenza

Cases of Influenza in patients admitted to the Trust were first noted during October 2019, a month earlier than normal but in keeping with experiences reported in the Southern Hemisphere with an early onset of influenza. In October 2019, 6 cases were reported, this increased to 48 cases in November 2019, with a marked increase noted during December 2019, with 159 reported cases. In spite of the earlier onset and the significant increase, these cases represented normal seasonal flu activity; all cases detected with Influenza A (with one paediatric exception who was also Influenza B positive). Patients were screened, isolated, treated and managed appropriately.

The increase in influenza cases during December 2019 requiring admission impacted on the organisation and the need for isolation facilities – in some cases influenza A cases were cohorted and treated in bays. No reported ward outbreaks caused by influenza have occurred to date.
Patients have also been proactively screened for influenza during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety.



	Oct-19	Nov-19	Dec-19	Jan-20
Influenza A	6	48	159	
Influenza B	0	1	0	



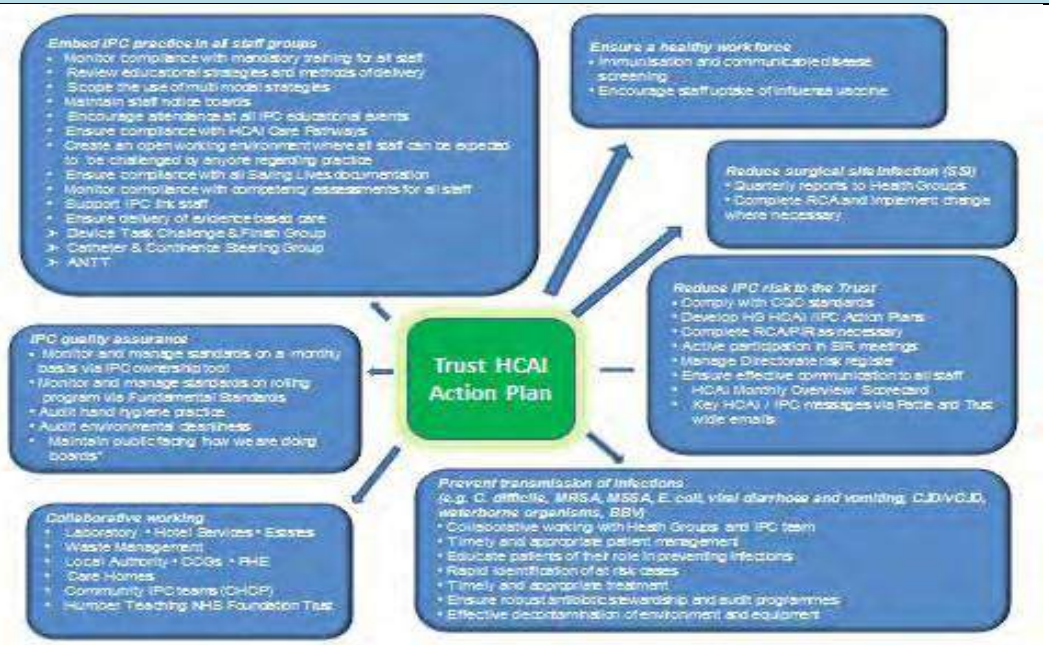
England Flu Activity PHE Weekly National Influenza Report

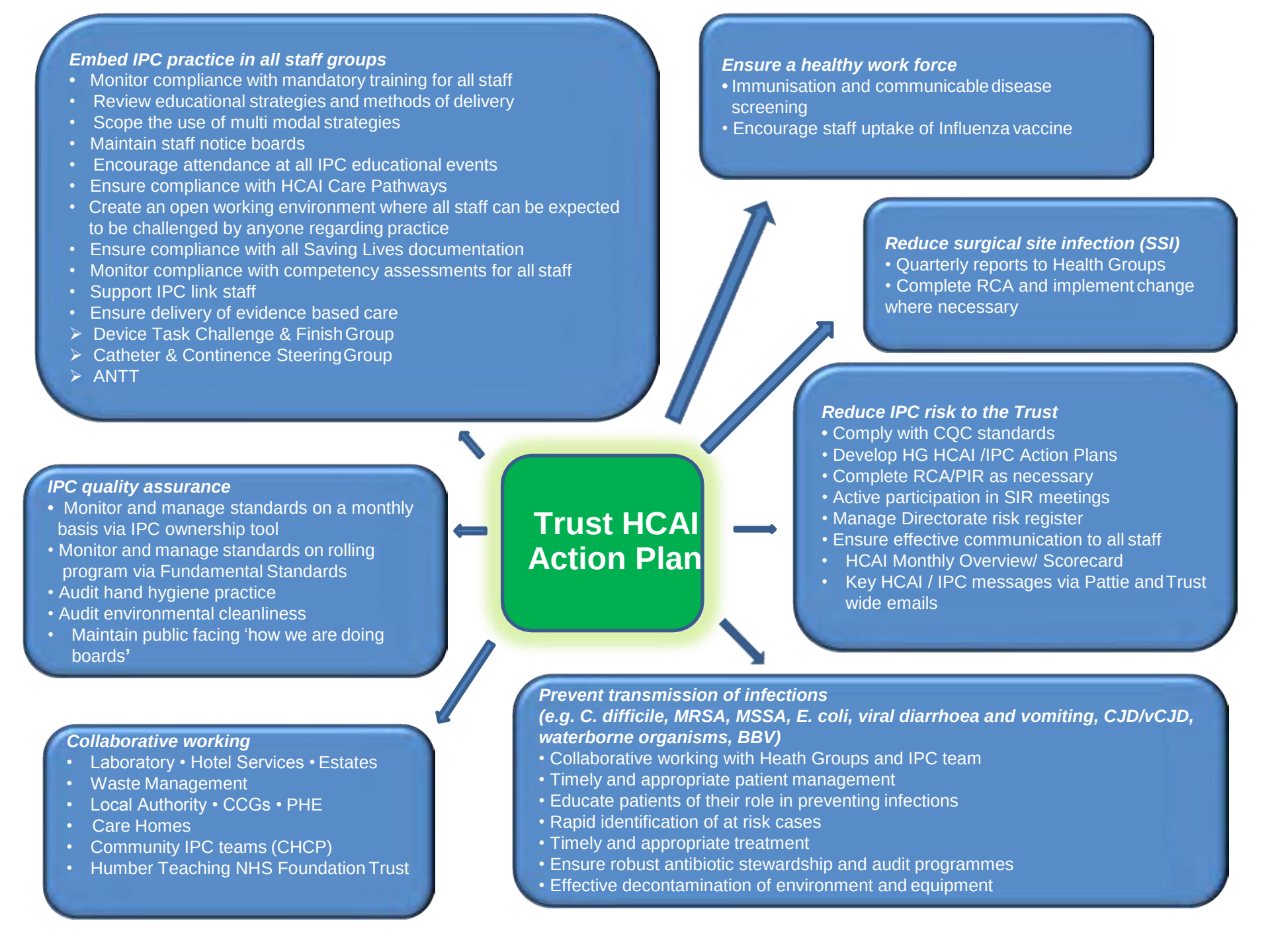
To date flu vaccination rates, reported by Occupational Health stands at 81% of staff involved in providing direct patient care.

Gram-negative Bloodstream Infection (GNBSI) ambition and Antimicrobial Resistance (AMR)

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 regional meeting on the 5th February 2020 organised by NHS England and NHS Improvement, bringing together healthcare leaders in the North East. A report following this meeting and Trust plans to reduce the burden of GNBSI and tackle antimicrobial resistance will be discussed at subsequent Trust Board meetings.

HCAI Action Plan




Trust HCAI Action Plan
Embed IPC practice in all staff groups
• Monitor compliance with mandatory training for all staff
• Review educational strategies and methods of delivery
• Scope the use of multi modal strategies
• Maintain staff notice boards
• Encourage attendance at all IPC educational events
• Ensure compliance with HCAI Care Pathways
• Create an open working environment where all staff can be expected to be challenged by anyone regarding practice
• Ensure compliance with all Saving Lives documentation
• Monitor compliance with competency assessments for all staff
• Support IPC link staff
• Ensure delivery of evidence based care
➢ Device Task Challenge & Finish Group
➢ Catheter & Continence Steering Group
➢ ANTT
Ensure a healthy work force
• Immunisation and communicable disease screening
• Encourage staff uptake of Influenza vaccine
Reduce surgical site infection (SSI)
• Quarterly reports to Health Groups
• Complete RCA and implement change where necessary
Reduce IPC risk to the Trust
• Comply with CQC standards
• Develop HG HCAI /IPC Action Plans
• Complete RCA/PIR as necessary
• Active participation in SIR meetings
• Manage Directorate risk register
• Ensure effective communication to all staff
• HCAI Monthly Overview/ Scorecard
• Key HCAI / IPC messages via Pattie and Trust wide emails
Prevent transmission of infections
(e.g. C. difficile, MRSA, MSSA, E. coli, viral diarrhoea and vomiting, CJD/vCJD, waterborne organisms, BBV)
• Collaborative working with Heath Groups and IPC team
• Timely and appropriate patient management
• Educate patients of their role in preventing infections
• Rapid identification of at risk cases
• Timely and appropriate treatment
• Ensure robust antibiotic stewardship and audit programmes
• Effective decontamination of environment and equipment
Collaborative working
• Laboratory • Hotel Services • Estates
• Waste Management
• Local Authority • CCGs • PHE
• Care Homes
• Community IPC teams (CHCP)
• Humber Teaching NHS Foundation Trust
IPC quality assurance
• Monitor and manage standards on a monthly basis via IPC ownership tool
• Monitor and manage standards on rolling program via Fundamental Standards
• Audit hand hygiene practice
• Audit environmental cleanliness
• Maintain public facing 'how we are doing boards'

Hull University Teaching Hospitals NHS Trust

Trust Board
January 2020

Title:	Nursing and Midwifery (Safe) Staffing Report – January 2020
Responsible Director:	Beverley Geary – 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
January 2020

1. Purpose of the 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 November 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.

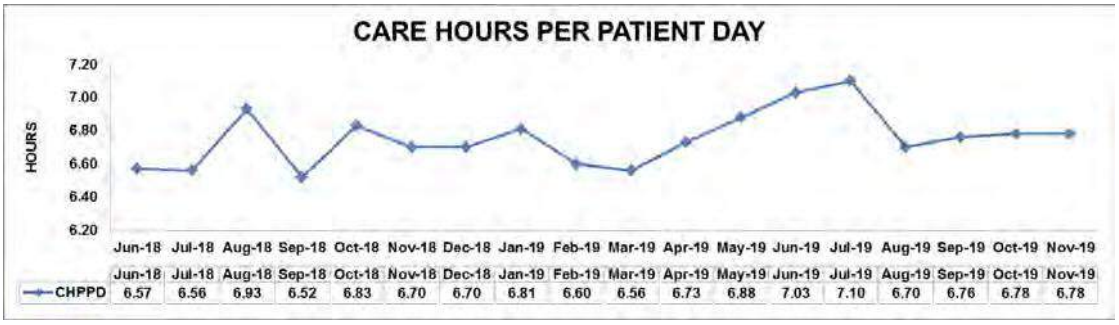
This report presents the 'safer staffing' positions for October and November 2019 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staffing.

[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	Oct-19	Nov-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	6.78	6.78

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 from the August position of 6.70, the CHPPD has remained relatively static over the last three months. The number of RN vacancies has risen in October 2019 169.75 (9.2%) but subsequently dropped in November 2019 to 150.68 (8.2%). However, given the number of new registrants employed by the Trust in September 2019 it appears that these numbers still reflect a high number of newly qualified nurses in their transition period whilst awaiting their NMC PIN.

The Trust still remains in the lower 25th Quartile as indicated through the Model Hospital Metrics, with a peer median of 8.7 CHPPD and national median of 8.0 CHPPD (October 2019 data).With regards to the Quality and Safety metrics the Trust continues to perform well against both peers and national performance.

The Deputy Chief Nurse and Chief Information Officer in conjunction with the Finance team and the E – roster lead, have undertaken a comprehensive review of the CHPPD submission, to determine additional factors which may be influencing the Trusts current static position. This has included:

- Further review of all clinical roles to ensure they are captured in the CHPPD calculation in accordance with the NQB guidance.
- Review of the calculated CHPPD for each ward/department provided through the twice yearly establishment reviews.

Further work required:

- Manual data collection of the number of patients reported on the electronic system at 23:59 compared to actual numbers over a four week period for each ward /unit which contribute to the overall CHPPD submission.

The conclusions drawn from the above actions will be collated and presented to the Trust Board in the March 2020 Safer Staffing Report.

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 October 2019.
Appendix Two provides the Nursing Staffing Key metrics for November 2019.
Appendix Three provides the Nurse Staffing Quality Indicators for November 2019.
Appendix Four provides the definitions of CHPPD.

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

The Risk Ratings have been agreed as follows:

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

4.1 Nursing and Midwifery Staffing Risk Assessments – 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.

4.1.1 Clinical Support Health Group

Ward	Professional Risk Assessment	Rationale for risk rating	Actions
C7	**LOW**	Not triggering any quality indicators and no staffing issues so deemed to be safely staffed	
C29	**LOW**	Not triggering any quality indicators and deemed to be safely staffed	New B7 Sister in post and the B6 1.0wte post vacant currently being recruited to.
C30	**LOW**	Not triggering any quality indicators and deemed to be safely staffed	In-patient beds are increasing by 4 once the enabling works are completed in the next few weeks. The ward establishment has been increased to support the extra capacity and all vacancies have been recruited to. From 1st April a co-ordinator post has been included into the ward establishment
C31	**MEDIUM**	This ward has 1.34 wte RN vacancies with the new registrants having started. Some quality indicators are triggering, complaints, SI and staff morale. Even with the reduced capacity there are still concerns and further support for the ward team and leaders being implemented.	In-patient beds are decreasing by 4 once the enabling works are completed to support the ward team. The ward establishment has been amended to reflect the bed base. Skill mix has been identified as a potential issue as the ward has 5 new starters. Support is being provided by the head and neck CNS nurses who are working clinical shifts on the ward. From 1st April a co-ordinator post has been included into the establishment
C32	**LOW**	Not triggering any quality indicators and deemed to be safely staffed	B5 0.64 post vacant currently been recruited From 1st April a co-ordinator post has been included into the establishment
C33	**LOW**	This ward has no RN vacancies &	Ward is supporting additional bed

		RN ML at 1.6 wte; and no quality indicators are triggering; this continues to be closely monitored	capacity (H200) with 1 RN

4.1.2 Medicine Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk assessment	Comments/Mitigation
AMU	**MEDIUM**	No staffing related quality concerns, 6.27 wte RN vacancies	There has been an increase by 10 beds in this area and the model of use is still being worked through by the AMU management team. Staffing is a challenge due to this increase in bed numbers, the current establishment will be reviewed on completion of the agreed clinical model, at present the unit is being supported day to day through the movement of staff from other clinical areas, bank and agency.
EAU	**LOW**	No staffing related quality concerns	EAU has now moved to ward 36 and combines DME clinic facility, FIT team area and the discharge lounge. The rotas and staffing are all currently being combined into one roster/budget
H1	**LOW**	No staffing related quality concerns	
H5/ RHoB	**MEDIUM**	No staffing related quality concerns. 5.31 wte RN vacancies	Due to the departure of a number of RNs to the Lung Health Check programme, the respiratory wards are being supported by agency nurses where required.
H50	**LOW**	No staffing related quality concerns. 3.73 wte RN vacancies	
H500	**LOW**	No staffing related quality concerns.	
H10	**MEDIUM**	There are 9.06 wte RN vacancies.	Utilising agency and bank. RN pool nurses allocated for continuation and stability.
H70	**MEDIUM**	No staffing related quality concerns but ward being closely monitored by Senior Matron due to newly established ward with staffing challenges. 5.8 wte RN vacancies	Utilising agency and bank. RN agency nurses allocated for continuation and stability. This is a new medical ward and being supported with staff from other HGs but active recruitment continues.
H8	**LOW**	No staffing related quality concerns.	
H9	**LOW**	There are 4.4wte RN vacancies. No quality concerns.	Additional non registered nurses in post to support
PDU H80	**LOW**	No staffing related quality concerns. 2.34 wte RN vacancies	
H90	**LOW**	No staffing related quality concerns however 5.9 wte RN vacancies.	Additional non registered nurses in post to support
H11	**MEDIUM**	There are 8.09 wte RN vacancies.	Bank and agency utilised. Flexing staff across the floor to maintain safety. Additional non-registered nurses in place to support, international nurses allocated to ward and support of a teacher/trainer.
H110	**MEDIUM**	No staffing related quality concerns. 6.83 wte RN vacancies	Rosters being reviewed, stroke coordinator roles also being reviewed in light of them supporting the ward at times of shortfalls and the risk this has on the patient and thrombolysis pathways
CDU	**LOW**	No staffing related quality concerns	
C26	**LOW**	No staffing related quality concerns	
C28/C MU	**LOW**	No staffing related quality concerns. 2.4 wte RN	

		vacancies.	
H200	**MEDIUM**	This is the additional winter ward, currently has no established team.	Plan being worked on by all HGs to release RNs to support and establish a core team.

4.1.3 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
H4	**LOW**	No staffing related quality concerns.	
H40	**MEDIUM**	No staffing related quality concerns, however increasing demand for major trauma capacity. Ward has 3.0 wte RN vacancies.	Using Bank, Agency and support from H4 & ICU to ensure appropriate skill mix as patient acuity very high. Ward requires high level of support from Senior Matron
H6	**LOW**	No staffing related quality concerns. 2.66 wte RN vacancies.	
H60	**LOW**	No staffing related quality concerns. 1.0 wte RN vacancy.	
H7	**LOW**	No staffing related quality concerns. 2.45 RN vacancies.	
H100	**LOW**	No staffing related quality concerns. 2.0 wte RN vacancies and 1.0 wte supporting H70	
H12	**MEDIUM**	No staffing related quality concerns. 7.0 wte RN vacancies.	Using bank, agency and staff from other surgical wards to support. Regular meetings held with Senior Nursing Staff and requiring high level of support from Senior Matron.
H120	**LOW**	No staffing related quality concerns. 1.0 wte RN vacancy.	Matron continuing to support area due to maternity leave but ward staffing continuing to improve.
HICU	**LOW**	No staffing related quality concerns. 7.0 wte RN vacancies.	ICU staff work across sites to provide appropriate cover. Support from agencies required occasionally when unit has high number of level 3 beds above designated level 3 capacity.
C9	**LOW**	No staffing related quality concerns. 2.0 wte RN vacancies. 3 wte RN to H200 7 1 wte RN to H70.	Ward is being closely monitored by Senior Matron and Nurse Director to ensure safe staffing levels whilst supporting other wards.
C10	**LOW**	No staffing related quality concerns. 1.0 wte RN to H70.	
C11	**MEDIUM**	6.24 RN vacancies.	Ward requires high level of support from Senior Matron. RN support from C10 and bank and agency.
C14	**MEDIUM**	No staffing related quality concerns. 1.2 wte RN vacancies.	Support provided by bank/agency and matron provides a high level of support. Work progressing to identify if further HOB capacity is required on, to support patient acuity levels.
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. Nurse sensitive metrics are continuing to improve.
C27	**LOW**	No staffing related quality concerns.	1.0wte RN vacancy. 1.0 wte RN to H200
CICU	**LOW**	Not triggering any quality concerns. 5.8 wte RN vacancies. 1.0 wte RN to H70.	ICU staff work across sites to provide appropriate cover. Support from agencies required occasionally when unit has high number of level 3 beds open above designated level 3 capacity.

4.1.4 Family and Women's Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
C16	**MEDIUM**	Vacant Band 7 Senior Sister post at present with 5.34 wte RN vacancies. 4 Hospital acquired pressure ulcers declared this month, and whilst there is no apparent link to staffing in any of these cases, the vacancies are a cause for concern.	Increased Matron presence and monitoring of all quality measures. Lesson shared from RCA process. Senior Sister commencing in post 6th January 2020. Use of bank and overtime to cover shortfalls, and review of activity maintained.
H130	**LOW**	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. New recruits have improved staffing numbers and this includes recruitment to 50% of maternity leave, however new staff require support whilst developing skills.
Cedar H30	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime.
Maple H31	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime.
Rowan H33	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime.
Acorn H34	**LOW**	No staffing related quality concerns	Staff in the children's wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours or bank to cover shortfalls.
H35	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis, utilising bank and overtime when necessary..
NICU	**MEDIUM**	Although not triggering on quality issues, there are 11 staff on maternity leave and 2.98 wte vacancies	6.6 wte new starters recruited but currently in their supernumerary period whilst developing skills. Bank and overtime are being utilised and flexing staffing resources. Additional short-term actions in place to minimise staffing shortfalls. Approach made to agencies for short term contracts which have been agreed and approval from the CFO to pay double overtime pay until 15 December 2019.
PAU	**MEDIUM**	Although not triggering on quality issues, there is a 1.96wte 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 or bank to cover shortfalls. 1.8wte had been recruited to with 0.64 to commence in January; the 1.0wte post has had to be withdrawn and is back out to advert. The sister and junior sister are supporting shifts frequently
PHDU	**MEDIUM**	Although not triggering on quality issues, there is a 0.62 wte 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 or bank to cover shortfalls. The recruitment of a number of junior staff over recent months has required the sister and junior sister to supporting shifts frequently whilst new staff develop skills.
Labour	**LOW**	No staffing related quality concerns	Staffing is managed by the senior team on a daily basis with bank and overtime.

5. Recruitment and Retention

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns and rotational programmes.

The Trust has commenced its recruitment campaign focused on September 2020 student nurse graduates. At present the Trust has 116 Adult Branch Student Nurses scheduled for interview for late January and early February 2020. The vast majority (105) of students are from the University of Hull, 8 students are from the University of Lincoln, 2 from the University of Sheffield and 1 from the University of Salford.

HUTH will be attending a recruitment fair at the University of Leeds on Friday 24th of January and are in negotiation with the University of Hull to arrange a HUTH only recruitment fair in the near future when it is hoped HUTH can attract even more students and keep in touch with the students we will have recently interviewed and offered posts to.

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.

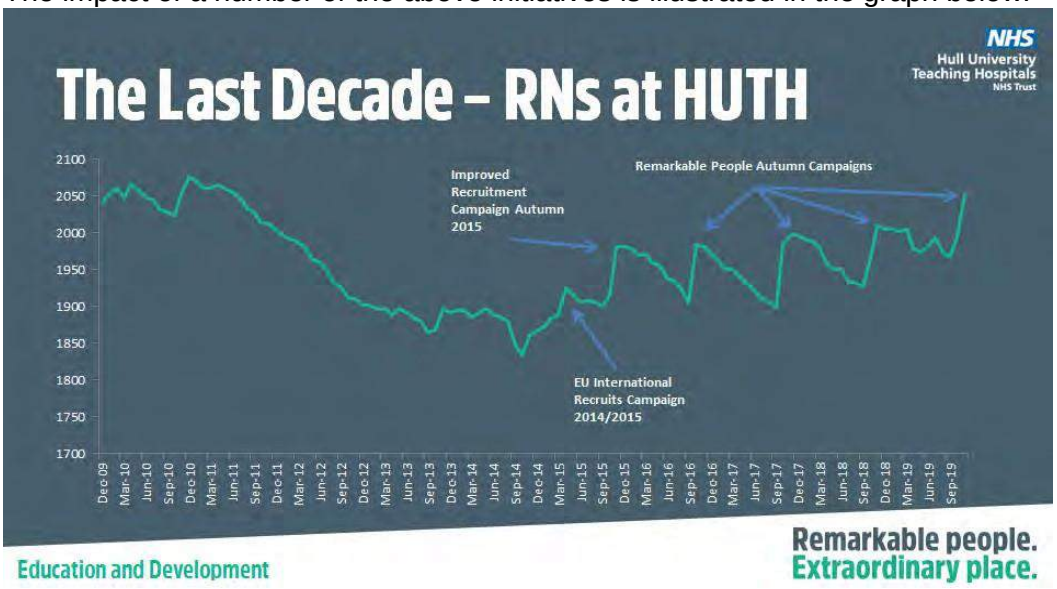
The Recruitment process has commenced for the next cohort of Trainee Nurse Associates planned to commence their academic course March 2020; work is ongoing to develop a financial model to support a further cohort of student nurse apprentices and health care support apprentices.

From an international perspective the Trust has successfully recruited 78 nurses in total; 70 of whom have passed their OSCE/received their PIN. A further 8 international nurses joined the Trust in November and are scheduled to sit their OSCE on 29 January 2020.

In addition the Medicine Health Group is currently pursuing an additional 13 international nurses to support the opening of the new medical ward and the DME and Stroke specialties. The Chief Nurse and Deputy Chief Nurse are currently working with Medicine Health Group to develop a financial model to support an additional 12 international nurses.

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

The impact of a number of the above initiatives is illustrated in the graph below:



6. Ensuring Safe Staffing

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

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

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

7. Red Flags as Identified by NICE (2014)

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

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

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

allocation or redeployment of additional nursing staff to the ward. These issues are addressed at each safety brief.

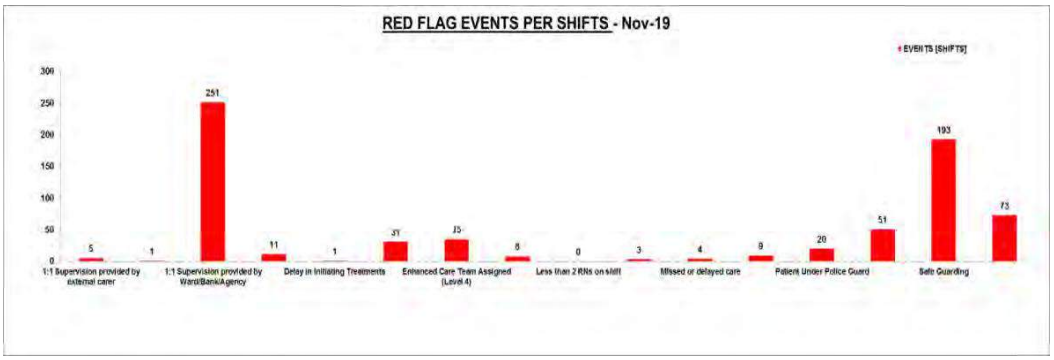
In addition, it is important to keep records of on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

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 graphs illustrates the number of 'Red Flags' as suggested by NICE [2014] and additional flags recorded each shift through the staffing safety brief during November 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.

Nov-19	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	**5**	1%
	1:1 Supervision provided by family member	**1**	0%
	1:1 Supervision provided by Ward/Bank/Agency	**251**	36%
	Clinical Judgement Override	**11**	2%
	Delay in Initiating Treatments	**1**	0%
	Deprivation of Liberty	**31**	4%
	Enhanced Care Team Assigned (Level 4)	**35**	5%
	Fall with Harm	**8**	1%
	Less than 2 RNs on shift	**0**	0%
	Missed 'intentional rounding'	**3**	0%
	Missed or delayed care	**4**	1%
	No of Learning Difficulties	**9**	1%
	Patient Under Police Guard	**20**	3%
	Patient Watch Assigned (Level 5)	**51**	7%
	Safe Guarding	**193**	28%
	Shortfall in RN time	**73**	10%
	TOTAL:	**696**	100%



As illustrated above, 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 has commenced in post and has successfully interviewed and recruited 13wte members of the ECT due to commence employment with the Trust in March 2020.

As identified above the second most frequently reported red flag relates to Safeguarding. The Chief Nurse has commissioned a formal review of the current systems and processes in place, which relate to the identification and escalation of Safeguarding concerns. The outcome of which will be reported formally to the Quality Committee in due course.

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. Risk Assessment

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

9. Summary

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

10. Recommendation

The Trust Board is requested to:

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

Author Jo Ledger
Deputy Chief Nurse
September 2019

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

APPENDIX FOUR - CHPPD Description, Methodology, Benefits and Limitations

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

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

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

CHPPD is calculated, as follows:

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

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

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

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

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

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

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

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

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

APPENDIX 1

HUTH NURSE STAFFING KEY METRICS DASHBOARD

Oct-19

KEY METRICS ROTA: 30th Sep 2019 - 27th Oct 2019

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	Cumulative Count Over The Month of Patients at 23:59 Each Day				MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M7] RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]	TEMPORARY STAFFING [30th Sep - 27th Oct] 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]
						RN / RM	CARE STAFF	OVERALL																															
MEDICINE	ED	GENERAL MEDICINE	NA	MEDIUM	NA	NA	NA	NA	NA	NA	NA	NA	8.22	7.8%	3.11	14.3%	11.41	126.79	2.5%	2.3%	0.2%	75.0%	20.3%	5.1%	9.5%	0.9%	3.2%	0.6%	1.0%	54.0	33.0	0.5	0.0	0.5	13.4%	1.0%	166.5	166.5	0.0
MEDICINE	AMU	GENERAL MEDICINE	45	LOW	1262	5247.5	2566.8	6.2	7.55	-1.36	7.31	-1.12	12.84	24.9%	2.31	8.2%	15.40	79.63	6.9%	6.8%	0.1%	74.7%	26.8%	3.7%	10.7%	0.9%	7.2%	0.0%	4.3%	47.0	47.0	0.2	0.0	0.2	10.1%	0.7%	181.5	216.5	35.0
MEDICINE	H1	GENERAL MEDICINE	22	LOW	NO CHPPD DATA AVAILABLE DUE TO WARD MOVE								0.85	6.2%	-1.04	-13.1%	-0.13	21.59	23.4%	20.5%	2.9%	75.9%	30.0%	5.3%	11.3%	0.0%	4.3%	0.6%	8.5%	40.0	26.0	0.2	0.0	0.2	13.1%	0.2%	97.0	224.0	127.0
MEDICINE	EAU	GERIATRIC MEDICINE	17	LOW	618	2055.0	2051.0	6.6	6.94	-0.30	7.74	-1.10	6.25	32.7%	-1.59	-12.1%	4.99	32.27	2.9%	2.4%	0.5%	31.6%	23.3%	3.4%	9.8%	0.0%	3.1%	4.7%	2.3%	49.0	49.0	0.3	0.1	0.2	8.5%	4.6%	18.5	40.0	21.5
MEDICINE	H5 / RHOB	RESPIRATORY MEDICINE	26	MEDIUM	752	3061.8	2092.0	6.9	6.74	0.11	6.38	0.47	4.16	17.3%	1.50	11.4%	5.83	37.25	14.2%	12.4%	1.8%	51.7%	25.2%	3.9%	12.8%	0.0%	7.1%	0.4%	1.0%	38.0	4.0	0.2	0.0	0.2	16.1%	-1.0%	32.8	87.8	55.0
MEDICINE	H50	NEPHROLOGY	19	LOW	576	1623.8	1147.3	4.8	7.23	-2.42	7.00	-2.19	2.08	14.0%	-0.26	-11.1%	1.96	17.20	7.0%	7.0%	0.0%	75.0%	26.8%	10.9%	11.8%	0.0%	0.9%	0.1%	3.1%	77.0	77.0	0.0	0.0	0.0	15.0%	-0.8%	67.5	77.0	9.5
MEDICINE	H500	RESPIRATORY MEDICINE	24	LOW	730	1796.4	1751.0	4.9	6.74	-1.88	6.38	-1.52	3.63	22.2%	1.37	10.4%	5.22	29.53	5.5%	4.3%	1.2%	47.6%	26.8%	7.9%	9.2%	0.8%	5.5%	0.0%	3.4%	20.0	11.0	0.0	0.0	0.0	19.6%	1.7%	41.0	69.0	28.0
MEDICINE	H10	GENERAL MEDICINE	30	MEDIUM	822	2209.5	2358.5	5.6	7.55	-1.99	7.31	-1.75	8.63	40.6%	-4.16	-22.8%	4.88	39.55	14.5%	8.6%	5.9%	48.9%	33.1%	11.2%	10.9%	3.1%	7.9%	0.0%	0.0%	19.0	18.0	0.5	0.2	0.3	21.0%	20.8%	-128.5	153.5	282.0
MEDICINE	H70	GENERAL MEDICINE	22	MEDIUM	NO CHPPD DATA AVAILABLE DUE TO WARD MOVE								2.84	17.4%	5.19	34.4%	8.20	31.44	14.5%	8.6%	5.9%	48.9%	33.1%	11.2%	10.9%	3.1%	7.9%	0.0%	0.0%	19.0	18.0	0.5	0.2	0.3	21.0%	20.8%	464.1	477.6	13.5
MEDICINE	H8	GERIATRIC MEDICINE	27	LOW	820	1837.5	1971.3	4.6	6.94	-2.30	6.74	-2.10	2.28	13.9%	-0.64	-4.9%	1.78	29.53	4.7%	4.7%	0.0%	84.7%	22.5%	3.6%	10.0%	0.6%	3.9%	1.1%	3.3%	49.0	48.0	0.1	0.0	0.1	11.7%	-1.9%	109.0	139.0	30.0
MEDICINE	PDU H80	GERIATRIC MEDICINE	27	LOW	560	1583.3	3032.0	8.2	6.94	1.30	6.74	1.50	2.28	20.9%	-5.28	-33.2%	-2.79	26.82	10.3%	7.1%	3.2%	85.5%	24.6%	8.1%	10.4%	0.5%	1.1%	1.5%	3.0%	23.0	19.0	0.4	0.4	0.0	13.1%	2.1%	70.5	88.5	18.0
MEDICINE	H9	GERIATRIC MEDICINE	30	MEDIUM	918	1874.5	2279.5	4.5	6.94	-2.41	6.74	-2.21	3.31	20.2%	-1.97	-12.6%	1.54	32.03	2.4%	2.4%	0.0%	98.4%	17.5%	3.0%	12.8%	0.0%	1.1%	0.6%	0.0%	68.0	55.0	0.2	0.0	0.2	7.5%	2.8%	3.5	60.5	57.0
MEDICINE	H90	GERIATRIC MEDICINE	29	LOW	885	1695.5	1858.5	4.0	6.94	-2.92	6.74	-2.72	3.41	20.8%	-1.72	-13.1%	1.90	29.53	8.7%	8.1%	0.6%	92.9%	35.2%	5.4%	17.5%	1.8%	2.8%	7.4%	0.3%	105.0	95.0	0.1	0.1	0.0	15.1%	0.4%	174.5	188.0	13.5
MEDICINE	H11	STROKE / NEUROLOGY	28	MEDIUM	852	1705.0	2171.5	4.5	7.55	-3.00	7.41	-2.86	7.10	32.9%	-3.74	-35.8%	3.69	32.03	7.1%	3.8%	3.3%	29.1%	28.1%	4.2%	10.2%	3.3%	3.8%	0.0%	6.6%	39.0	13.0	0.2	0.1	0.1	16.8%	1.6%	62.0	73.0	11.0
MEDICINE	H110	STROKE / NEUROLOGY	24	MEDIUM	617	2497.4	2346.3	7.9	7.55	0.30	7.41	0.44	8.76	32.1%	-3.03	-29.0%	6.05	37.72	12.7%	12.5%	0.2%	54.7%	29.1%	8.6%	9.6%	0.1%	5.7%	0.1%	5.0%	14.0	13.0	0.2	0.1	0.1	17.7%	3.2%	44.5	198.0	153.5
MEDICINE	CDU	CARDIOLOGY	9	LOW	65	1113.8	144.5	19.4	7.93	11.43	7.73	11.63	1.02	8.0%	0.48	19.7%	1.58	15.25	4.3%	4.3%	0.0%	54.7%	31.4%	15.0%	7.3%	0.0%	1.0%	0.6%	7.5%	56.0	41.0	0.0	0.0	0.0	33.4%	0.2%	0.0	0.0	0.0
MEDICINE	C26	CARDIOLOGY / CTS	26	LOW	866	2757.5	1044.0	4.4	8.46	-4.07	9.93	-5.54	1.12	4.7%	-1.29	-16.3%	-0.12	32.03	2.3%	2.3%	0.0%	67.5%	24.9%	3.9%	11.3%	0.0%	6.9%	0.5%	2.3%	59.0	24.0	0.1	0.0	0.1	13.5%	0.6%	20.0	31.0	11.0
MEDICINE	C28 /CMU	CARDIOLOGY	27	LOW	681	3959.0	1257.5	7.7	7.44	0.22	7.87	-0.21	9.04	23.8%	-1.27	-15.8%	8.01	46.04	1.6%	1.6%	0.0%	42.9%	29.4%	6.4%	10.3%	0.1%	2.9%	7.1%	2.6%	61.0	13.0	0.3	0.3	0.0	26.6%	-1.5%	123.8	204.5	80.8
SURGERY	H4	NEUROSURGERY	28	MEDIUM	839	2428.6	1692.8	4.9	8.39	-3.48	8.71	-3.80	6.86	31.8%	0.07	0.7%	7.25	32.03	11.7%	11.7%	0.0%	70.8%	30.4%	6.8%	9.1%	1.2%	12.8%	0.5%	0.0%	30.0	30.0	0.3	0.1	0.2	12.6%	-4.1%	30.3	41.3	11.0
SURGERY	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	406	2554.7	1468.8	9.9	8.39	1.52	8.71	1.20	2.99	14.0%	-1.47	-15.8%	1.66	30.68	8.6%	8.3%	0.3%	42.2%	19.1%	1.8%	9.2%	0.3%	7.0%	0.8%	0.0%	37.0	31.0	0.0	0.0	0.0	16.1%	4.8%	46.3	96.3	50.0
SURGERY	H6	GENERAL SURGERY	28	LOW	740	2253.2	1656.5	5.3	6.99	-1.71	7.26	-1.98	5.19	27.0%	-1.29	-10.9%	4.17	31.01	15.4%	15.4%	0.0%	75.0%	28.5%	3.0%	10.0%	1.4%	4.7%	5.8%	3.6%	55.0	51.0	0.1	0.1	0.0	9.0%	0.8%	54.8	65.8	11.0
SURGERY	H60	GENERAL SURGERY	28	LOW	771	2370.5	1795.5	5.4	6.99	-1.59	7.26	-1.86	1.49	7.8%	2.40	20.3%	3.97	31.01	8.2%	8.2%	0.0%	67.0%	18.0%	1.9%	11.4%	0.2%	3.7%	0.8%	0.0%	52.0	51.0	0.1	0.0	0.1	7.8%	-0.8%	-118.5	31.5	150.0
SURGERY	H7	VASCULAR SURGERY	30	MEDIUM	860	2772.3	1899.5	5.4	6.99	-1.56	7.26	-1.83	5.29	22.0%	-2.13	-20.0%	3.38	34.76	16.0%	13.7%	2.3%	37.8%	28.6%	2.9%	11.4%	0.0%	8.1%	0.2%	6.0%	48.0	48.0	0.3	0.0	0.3	12.3%	-0.8%	-20.0	68.0	88.0
SURGERY	H100	GASTROENTEROLOGY	27	LOW	822	2150.0	2051.8	5.1	6.63	-1.52	6.29	-1.18	2.54	12.9%	1.05	8.1%	3.72	32.68	15.8%	15.2%	0.6%	78.2%	22.5%	5.3%	11.2%	0.0%	2.4%	0.3%	3.3%	67.0	67.0	0.2	0.1	0.1	7.7%	3.1%	46.0	142.5	96.5
SURGERY	H12	ORTHOPAEDIC	28	LOW	601	2385.0	2063.0	7.4	7.13	0.27	7.25	0.15	3.70	17.1%	-1.33	-10.1%	2.54	34.75	7.3%	6.8%	0.5%	40.1%	21.1%	4.5%	10.9%	0.0%	2.3%	2.0%	1.4%	24.0	18.0	0.5	0.3	0.2	12.6%	0.7%	3.5	34.0	30.5
SURGERY	H120	ORTHO /MAXFAX	22	LOW	634	1997.3	1899.3	6.1	7.13	-0.98	7.25	-1.10	0.81	5.0%	0.22	1.9%	1.08	28.17	16.4%	14.4%	2.0%	85.7%	36.1%	7.2%	10.4%	0.0%	2.5%	3.7%	12.3%	24.0	18.0	0.2	0.1	0.1	5.1%	2.4%	62.5	78.5	16.0
SURGERY	HICU	CRITICAL CARE	22	LOW	419	11792.5	944.5	30.4	27.13	3.27	26.60	3.80	8.54	8.1%	-1.28	-17.5%	7.34	112.20	0.1%	0.0%	0.1%	12.2%	27.7%	8.8%	11.7%	1.4%	1.9%	0.7%	3.2%	62.0	56.0	0.0	0.0	0.0	11.3%	2.0%	55.8	238.0	182.3
SURGERY	C9	ORTHOPAEDIC	35	LOW	647	2533.2	1503.0	6.2	7.13	-0.89	7.25	-1.01	2.39	10.9%	1.71	13.3%	4.21	34.79	9.2%	9.2%	0.0%	41.5%	33.1%	5.2%	14.5%	0.3%	5.6%	4.7%	2.8%	58.0	48.0	0.0	0.0	0.0	14.9%	0.6%	-60.0	75.0	135.0
SURGERY	C10	GENERAL SURGERY	21	LOW	465	2353.3	1163.8	7.6	6.99	0.57	7.26	0.30	4.19	23.2%	-0.88	-10.9%	3.54	26.15	7.7%	7.7%	0.0%	50.4%	24.8%	4.1%	11.7%	0.5%	3.9%	4.6%	0.0%	53.0	51.0	0.2	0.1	0.1	12.0%	2.3%	-183.6	98.4	282.0
SURGERY	C11	GENERAL SURGERY	22	LOW	535	2247.1	1147.7	6.3	6.99	-0.64	7.26	-0.91	3.92	19.1%	1.49	18.5%	5.60	28.61	12.4%	12.4%	0.0%	55.8%	26.2%	5.3%	9.8%	0.4%	4.0%	6.7%	0.0%	53.0	51.0	0.4	0.2	0.2	18.1%	1.3%	90.3	206.8	116.5
SURGERY	C14	GENERAL SURGERY	27	LOW	794	2446.8	1285.0	4.7	6.99	-2.29	7.26	-2.56	2.58	12.9%	-2.21	-22.6%	0.50	29.84	5.0%	5.0%	0.0%	49.9%	24.7%	3.0%	14.2%	0.0%	2.3%	1.7%	3.5%	51.0	48.0	0.1	0.1	0.0	10.5%	-1.8%	56.3	68.8	12.5
SURGERY	C15	UROLOGY	26	MEDIUM	600	2516.3	1749.8	7.1	6.47	0.64	6.67	0.44	2.81	13.7%	-0.47	-4.5%	2.48	31.01	9.8%	9.3%	0.5%	64.3%	29.5%	5.7%	11.0%	0.0%	6.6%	0.2%	6.0%	34.0	32.0	0.0	0.0	0.0	11.7%	0.9%	110.3	125.8	15.5
SURGERY	C27	CARDIOTHORACIC	26	LOW	758	2749.3	1152.0	5.1	8.46	-3.31	9.93	-4.78	2.45	10.4%	-0.15	-1.7%	2.40	32.24	2.3%	2.3%	0.0%	80.9%	23.6%	6.4%	11.2%	0.0%	3.1%	0.0%	2.9%	54.0	52.0	0.1	0.1	0.0	11.3%	3.3%	-15.3	38.8	54.0
SURGERY	CICU	CRITICAL CARE	22	LOW	453	8169.8	981.0	20.2	27.13	-6.93	26.60	-6.40	1.25	1.4%	0.47	6.4%	1.73	98.08	1.3%	1.3%	0.0%	87.1%	30.3%	6.7%	14.6%	0.1%	2.4%	0.9%	5.6%	62.0	56.0	0.0	0.0	0.0	12.1%	5.0%	-216.3	109.5	325.8
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	MEDIUM	428	1865.0	1260.9	7.3	6.58	0.72	9.03	-1.73	4.13	22.6%	3.20	28.7%	7.56	29.46	18.1%	16.9%	1.2%	63.2%	33.2%	5.0%	9.4%	0.7%	8.5%	9.6%	0.0%	59.0	51.0	0.3	0.3	0.0	20.7%	0.7%	-61.3	28.5	89.8
FAMILY & WOMEN'S	H130	PAEDIATRICS	20	LOW	372	2320.8	943.8	8.8	11.44	-2.66	12.20	-3.42	1.57	7.5%	-0.61	-9.2%	1.04	27.50	2.2%	2.2%	0.0%	108.9%	34.5%	4.7%	10.3%	0.0%	5.5%	1.9%	12.1%	44.0	44.0	0.0	0.0	0.0	18.7%	0.3%	28.8	40.8	12.0
FAMILY & WOMEN'S	H30 CEDAR	GYNAECOLOGY	9	LOW	163	1667.2	690.5	14.5	8.02	6.44	7.70	6.76	0.17	1.6%	0.03	0.8%	0.22	14.62	8.1%	6.0%	2.1%	86.4%	20.3%	0.5%	12.7%	0.1%	7.0%	0.0%	0.0%	42.0	39.0	0.3	0.2	0.1	5.7%	-2.6%	-59.3	25.5	84.8
FAMILY & WOMEN'S	H31 MAPLE	OBSTETRICS	20	LOW	380	2068.3	1343.0	9.0	10.11	-1.13	15.48	-6.50	0.37	0.88%	-0.19	-0.84%	0.18	64.53	0.5%	0.5%	0.0%	100.0%	32.0%	7.0%	14.0%	0.9%	2.5%	7.6%	0.0%	69.0	62.0	0.0	0.0	0.0	17.9%	-2.0%	0.0	0.0	0.0
FAMILY & WOMEN'S	H33 ROWAN	OBSTETRICS	38	LOW	1138	2878.9	1503.0	3.9	10.11	-6.26	15.48	-11.63							2.1%	2.1%	0.0%	81.2%	30.0%	7.4%	13.7%	0.5%	1.8%	4.0%	2.6%	68.0	62.0	0.0	0.0	0.0	13.8%	-2.5%	0.0	0.0	0.0
FAMILY & WOMEN'S	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	263	2294.8	530.0	10.7	9.11	1.63	11.01	-0.27	0.28	1.4%	-1.46	-23.0%	-1.17	26.64	0.6%	0.6%	0.0%	100.0%	29.3%	10.0%	11.4%	0.0%	1.5%	1.8%	4.6%	39.0	-30.0	0.0	0.0	0.0	22.6%	-0.4%	-19.0	12.0	31.0
FAMILY & WOMEN'S	H35	OPHTHALMOLOGY	12	LOW	324	1533.5	375.0	5.9	11.20	-5.31	10.70	-4.81	0.85	5.7%	-0.33	-7.1%	0.58	19.48	0.6%	0.6%	0.0%	100.0%	18.5%	6.1%	11.9%	0.0%	0.5%	0.0%	0.0%	60.0	52.0	0.0	0.0	0.0	11.8%	-0.5%	-115.5	17.0	132.5
FAMILY & WOMEN'S	LABOUR	MATERNITY	16	LOW	317	5662.9	1331.0	22.1	10.11	11.95	15.48	6.58	-7.21	-16.1%	-4.43	-42.4%	-11.80	55.36	1.8%	1.8%	0.0%	97.1%	28.4%	3.3%	12.6%	0.3%	1.8%	9.7%	0.7%	69.0	62.0	0.0	0.0	0.0	6.9%	-3.9%	22.0	22.0	0.0
FAMILY & WOMEN'S	NEONATES	NEONATOLOGY	26	MEDIUM	611	7655.8	652.0	13.6	13.26	0.34	12.98	0.62	5.77	8.0%	0.83	15.9%	6.68	77.01	2.7%	2.7%	0.0%	72.0%	32.8%	3.3%	8.4%	0.2%	7.6%	0.7%	12.6%	51.0	51.0	0.1	0.0	0.1	21.0%	-0.9%	0.0	0.0	0.0
FAMILY & WOMEN'S	PAU	PAEDIATRICS	10	LOW	81	1275.3	0.0	15.7	11.44	4.30	12.20	3.54	1.37	13.1%	0	0.0%	1.37	10.44	7.5%	7.5%	0.0%	99.7%	23.2%	9.7%	11.3%	0.0%	1.9%	0.3%	0.0%	45.0	44.0	0.2	0.2	0.0	28.4%	-1.3%	0.0	0.0	0.0
FAMILY & WOMEN'S	PHDU	PAEDIATRICS	4	LOW	78	1414.5	150.0	20.1	11.44	8.62	12.20	7.86	0.91	7.8%	0	0.0%	0.91	12.66	3.0%	3.0%	0.0%	101.1%	14.5%	0.7%	8.1%	0.0%	5.7%	0.0%	0.0%	45.0	44.0	0.1	0.1	0.0	10.7% 11.00%	-4.7%	0.0	0.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	312	1434.0	755.5	7.0	7.76	-0.74	7.91	-0.89	0.76	6.6%	-0.64	-8.1%	0.19	19.40	4.7%	4.2%	0.5%	61.4%	26.2%	7.8%	14.6%	1.4%	2.0%	0.4%	0.0%	44.0	26.0	0.0	0.0	0.0	12.3%	8.0%	-36.5	34.0	70.5
CLINICAL SUPPORT	C29	REHABILITATION	15	LOW	457	1607.5	1744.5	7.3	7.69	-0.36	6.66	0.67	1.1	8.7%	1.46	9.3%	2.65	28.28	0.0%	0.0%	0.0%	-	23.4%	4.6%	9.0%	0.9%	4.8%	0.7%	3.4%	53.0	51.0	0.0	0.0	0.0	14.3%	2.6%	-19.0	36.5	55.5
CLINICAL SUPPORT	C30	CLINICAL ONCOLOGY	22	LOW	663	1508.3	1331.8	4.3	7.92	-3.64	7.14	-2.86	1.9	13.9%	-0.32	-4.0%	1.72	21.68	7.5%	6.7%	0.8%	67.0%	33.7%	5.7%	9.6%	0.5%	11.5%	3.5%	2.9%	59.0	59.0	0.3	0.1	0.2	3.7%	-1.4%	42.5	48.5	6.0
CLINICAL SUPPORT	C31	CLINICAL ONCOLOGY	27	MEDIUM	731	1753.3	1790.8	4.8	7.92	-3.07	7.14	-2.29	7.36	42.0%	0.27	2.6%	8.05	27.95	14.1%	8.7%	5.4%	59.6%	31.2%	8.5%	9.2%	0.0%	12.9%	0.6%	0.0%	45.0	31.0	0.0	0.0	0.0	13.3%	1.8%	51.5	70.0	18.5
CLINICAL SUPPORT	C32	CLINICAL ONCOLOGY	22	LOW	661	1803.6	1421.3	4.9	7.92	-3.04	7.14	-2.26	2.47	18.1%	-0.11	-1.4%	2.54	21.59	9.0%	7.1%	1.9%	64.7%	26.7%	4.0%	13.7%	0.9%	4.8%	0.5%	2.8%	55.0	54.0	0.2	0.1	0.1	7.7%	-5.3%	7.8	24.3	16.5
CLINICAL SUPPORT	C33	CLINICAL HAEMATOLOGY	28	LOW	640	2664.7	1481.5	6.5	8.21	-1.73	7.23	-0.75	3.13	11.5%	-1.21	-15.2%	2.03	35.22	10.6%	10.6%	0.0%	54.4%	33.9%	6.2%	10.2%	0.0%	7.9%	1.7%	7.9%	55.0	54.0	0.3	0.2	0.1	17.9%	-0.2%	29.0	50.5	21.5
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR				29472	4.45	2.33	6.78	8.87	-21.85	9.29	-42.17	169.75		-19.34		150.41	1836.06	7.6%	6.7%	0.9%	67.9%	27.1%	5.8%		4.7%	2.0%	3.0%	49.1	40.5	8.3	3.9		14.2%	1.2%		4422.6	3061.3

APPENDIX 1

HUTH NURSE STAFFING KEY METRICS DASHBOARD

Nov-19

KEY METRICS ROTA: 28th Oct 2019 - 24th Nov 2019

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	ADDITIONAL SUPPORT ASSESSMENT	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 M8] RN [WTE]	RN % [<10%]	NON-RN- [WTE]	NON-RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN- Est. [WTE]
MEDICINE	ED	GENERAL MEDICINE	NA	MEDIUM	NA	NA	NA	NA	NA	NA	NA	NA	9.06	8.6%	3.65	16.2%	12.80	128.50
	AMU	GENERAL MEDICINE	45	LOW	1262	5163.2	2280.3	5.9	7.55	-1.65	7.31	-1.41	11.07	21.9%	3.56	12.3%	14.85	79.63
	H1	GENERAL MEDICINE	22	LOW	NO CHPPD DATA AVAILABLE DUE TO WA D MOVE								0.84	6.2%	-0.85	-10.7%	0.05	21.59
	EAU	GERIATRIC MEDICINE	17	LOW	610	2410.0	1711.0	6.8	6.94	-0.18	7.74	-0.98	5.87	30.7%	-1.54	-11.7%	4.64	32.27
	H5 / RHOB	RESPIRATORY MEDICINE	26	MEDIUM	747	3003.8	1622.3	6.2	6.74	-0.55	6.38	-0.19	4.70	19.5%	3.28	24.9%	8.18	37.25
	H50	NEPHROLOGY	19	LOW	573	1545.3	1063.0	4.6	7.23	-2.68	7.00	-2.45	2.38	16.0%	-0.26	-11.1%	2.28	17.20
	H500	RESPIRATORY MEDICINE	24	LOW	727	2080.5	1501.3	4.9	6.74	-1.81	6.38	-1.45	2.52	15.4%	-0.21	-1.6%	2.46	29.53
	H10	GENERAL MEDICINE	27	MEDIUM	820	1974.3	2074.0	4.9	7.55	-2.61	7.31	-2.37	8.63	40.6%	-4.16	-22.8%	4.88	39.55
	H70	GENERAL MEDICINE	22	MEDIUM	NO CHPPD DATA AVAILABLE DUE TO WA D MOVE								2.84	17.4%	5.19	34.4%	8.20	31.44
	H8	GERIATRIC MEDICINE	27	LOW	820	1690.6	1765.2	4.2	6.94	-2.73	6.74	-2.53	1.95	11.9%	-0.73	-5.6%	1.34	29.53
	PDU H80	GERIATRIC MEDICINE	27	LOW	560	1525.1	2900.0	7.9	6.94	0.96	6.74	1.16	2.90	26.5%	-4.74	-29.8%	-1.57	26.82
	H9	GERIATRIC MEDICINE	30	MEDIUM	913	1779.5	2146.0	4.3	6.94	-2.64	6.74	-2.44	2.35	14.4%	-0.99	-6.3%	1.50	32.03
	H90	GERIATRIC MEDICINE	29	LOW	881	1820.5	1724.5	4.0	6.94	-2.92	6.74	-2.72	3.60	22.0%	-1.77	-13.5%	2.05	29.53
	H11	STROKE / NEUROLOGY	28	MEDIUM	851	1709.0	2403.0	4.8	7.55	-2.72	7.41	-2.58	7.22	33.4%	-3.74	-35.8%	3.81	32.03
	H110	STROKE / NEUROLOGY	24	MEDIUM	616	3276.1	2129.5	8.8	7.55	1.23	7.41	1.37	8.54	31.3%	-2.06	-19.7%	6.79	37.72
	CDU	CARDIOLOGY	9	LOW	65	977.5	97.5	16.5	7.93	8.61	7.73	8.81	1.15	9.0%	0.48	19.7%	1.72	15.25
	C26	CARDIOLOGY / CTS	26	LOW	861	2682.3	1080.5	4.4	8.46	-4.09	9.93	-5.56	0.17	0.7%	-0.30	-3.8%	-0.12	32.03
	C28 /CMU	CARDIOLOGY	27	LOW	681	4453.0	1082.5	8.1	7.44	0.69	7.87	0.26	7.57	19.9%	-0.34	-4.2%	7.43	46.04
SURGERY	H4	NEUROSURGERY	28	MEDIUM	829	2613.6	1452.0	4.9	8.39	-3.49	8.71	-3.81	5.00	23.2%	1.36	13.0%	6.59	32.03
	H40	NEUROSURGERY / TRAUMA	15	MEDIUM	405	2772.8	1083.5	9.5	8.39	1.13	8.71	0.81	2.80	13.1%	-1.18	-12.7%	1.75	30.68
	H6	GENERAL SURGERY	28	LOW	735	2703.8	1621.5	5.9	6.99	-1.11	7.26	-1.38	1.13	5.9%	2.90	24.6%	4.09	31.01
	H60	GENERAL SURGERY	28	LOW	765	2359.3	1729.6	5.3	6.99	-1.65	7.26	-1.92	1.63	8.5%	2.39	20.3%	4.10	31.01
	H7	VASCULAR SURGERY	30	MEDIUM	860	3071.5	1481.7	5.3	6.99	-1.70	7.26	-1.97	4.81	20.0%	-1.83	-17.2%	3.18	34.76
	H100	GASTROENTEROLOGY	27	LOW	816	2039.9	1859.6	4.8	6.63	-1.85	6.29	-1.51	2.62	13.3%	1.10	8.5%	3.85	32.68
	H12	ORTHOPAEDIC	28	LOW	599	3077.3	1935.8	8.4	7.13	1.24	7.25	1.12	1.77	8.2%	0.64	4.9%	2.49	34.75
	H120	ORTHO / MAXFAX	22	LOW	625	2002.8	2119.7	6.6	7.13	-0.53	7.25	-0.65	0.73	4.5%	0.22	1.9%	0.99	28.17
	HICU	CRITICAL CARE	22	LOW	419	10558.0	736.3	27.0	27.13	-0.17	26.60	0.36	8.88	8.5%	-1.12	-15.3%	7.84	112.20
	C9	ORTHOPAEDIC	35	LOW	647	2666.3	1591.8	6.6	7.13	-0.55	7.25	-0.67	2.36	10.8%	1.57	12.2%	4.04	34.79
	C10	GENERAL SURGERY	21	LOW	465	2372.5	988.8	7.2	6.99	0.24	7.26	-0.03	1.90	10.5%	0.89	11.0%	2.90	26.15
	C11	GENERAL SURGERY	22	LOW	532	2197.4	987.8	6.0	6.99	-1.00	7.26	-1.27	4.17	20.3%	1.49	18.5%	5.86	28.61
	C14	GENERAL SURGERY	27	LOW	790	2352.0	1316.5	4.6	6.99	-2.35	7.26	-2.62	0.85	4.2%	-0.24	-2.5%	0.65	29.84
	C15	UROLOGY	26	MEDIUM	600	2639.4	1430.9	6.8	6.47	0.31	6.67	0.11	2.12	10.3%	-0.49	-4.7%	1.73	31.01
	C27	CARDIOTHORACIC	26	LOW	754	2730.5	1025.0	5.0	8.46	-3.48	9.93	-4.95	2.45	10.4%	-0.17	-2.0%	2.38	32.24
	CICU	CRITICAL CARE	22	LOW	453	8613.3	707.2	20.6	27.13	-6.55	26.60	-6.02	1.03	1.1%	0.53	7.2%	1.57	98.08
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	MEDIUM	471	1872.2	1110.5	6.3	6.58	-0.25	9.03	-2.70	4.41	24.1%	3.06	27.4%	7.71	29.46
	H130	PAEDIATRICS	20	LOW	372	2446.0	715.0	8.5	11.44	-2.94	12.20	-3.70	1.3	6.2%	-0.51	-7.7%	0.85	27.50
	H30 CEDAR	GYNAECOLOGY	9	LOW	144	1763.3	457.0	15.4	8.02	7.40	7.70	7.72	-0.06	-0.6%	0.12	3.1%	0.05	14.62
	H31 MAPLE	OBSTETRICS	20	LOW	380	2235.6	1322.5	9.4	10.11	-0.75	15.48	-6.12	0.21	0.74%	-0.10	-0.44%	0.21	64.53
	H33 ROWAN	OBSTETRICS	38	LOW	1138	2823.3	1535.5	3.8	10.11	-6.28	15.48	-11.65						
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	263	2347.3	422.0	10.5	9.11	1.42	11.01	-0.48	0.31	1.5%	-1.43	-22.5%	-1.10	26.64
	H35	OPHTHALMOLOGY	12	LOW	324	1488.5	345.0	5.7	11.20	-5.54	10.70	-5.04	0.83	5.6%	-0.33	-7.1%	0.56	19.48
	LABOUR	MATERNITY	16	LOW	317	5871.3	1349.5	22.8	10.11	12.67	15.48	7.30	-7.97	-17.7%	-4.16	-39.9%	-12.31	55.36
	NEONATES	NEONATOLOGY	26	MEDIUM	611	8188.1	512.0	14.2	13.26	0.98	12.98	1.26	5.55	7.7%	0.9	17.2%	6.53	77.01
	PAU	PAEDIATRICS	10	LOW	81	1201.5	0.0	14.8	11.44	3.39	12.20	2.63	1.36	13.0%	0	0.0%	1.36	10.44
	PHDU	PAEDIATRICS	4	LOW	76	1336.0	105.0	19.0	11.44	7.52	12.20	6.76	0.97	8.3%	0	0.0%	0.97	12.66
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	312	1404.5	631.5	6.5	7.76	-1.23	7.91	-1.38	0.83	7.2%	-0.66	-8.3%	0.24	19.40
	C29	REHABILITATION	15	LOW	457	1492.0	1903.0	7.4	7.69	-0.26	6.66	0.77	1.16	9.2%	1.48	9.5%	2.73	28.28
	C30	CLINICAL ONCOLOGY	22	LOW	662	1781.3	1077.0	4.3	7.92	-3.60	7.14	-2.82	1.56	11.4%	-0.35	-4.4%	1.32	21.68
	C31	CLINICAL ONCOLOGY	27	MEDIUM	675	2171.9	1370.3	5.2	7.92	-2.67	7.14	-1.89	6.89	39.4%	0.27	2.6%	7.55	27.95
	C32	CLINICAL ONCOLOGY	22	LOW	659	1826.4	1392.5	4.9	7.92	-3.04	7.14	-2.26	2.5	18.3%	-0.09	-1.1%	2.59	21.59
	C33	CLINICAL HAEMATOLOGY	28	LOW	636	2693.3	1267.5	6.2	8.21	-1.98	7.23	-1.00	3.22	11.8%	-1.18	-14.9%	2.16	35.22
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR				29286	4.63	2.15	6.78	8.87	-29.76	9.29	-50.08	150.68		-0.45		150.23	1837.77

WARD	TEMPORARY STAFFING [28th Oct - 24th Nov] 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]
ED	4.2%	3.7%	0.5%	81.2%	27.4%	5.9%	14.4%	1.1%	3.8%	0.8%	1.4%	54.0	33.0	0.0	0.0	0.0	14.6%	0.5%	91.9	98.4	6.5
AMU	7.8%	7.4%	0.4%	57.9%	30.3%	3.4%	12.9%	0.8%	8.2%	0.0%	5.0%	27.0	24.0	0.0	0.0	0.0	10.0%	-0.2%	121.1	219.1	98.0
H1	17.9%	15.1%	2.8%	56.6%	36.4%	10.9%	8.4%	0.0%	1.4%	1.0%	14.7%	38.0	32.0	0.0	0.0	0.0	15.8%	0.5%	83.3	177.8	94.4
EAU	3.4%	2.3%	1.1%	33.2%	26.7%	3.8%	15.5%	0.0%	2.9%	2.2%	2.3%	61.0	60.0	0.0	0.0	0.0	23.1%	2.0%	-64.0	11.0	75.0
H5 / RHOB	13.0%	11.1%	1.9%	44.2%	30.2%	5.4%	17.5%	0.0%	3.2%	0.0%	4.1%	25.0	21.0	0.0	0.0	0.0	21.0%	0.0%	80.3	154.8	74.5
H50	6.8%	6.8%	0.0%	75.0%	27.7%	5.5%	12.3%	3.8%	1.0%	1.8%	3.3%	61.0	54.0	0.0	0.0	0.0	17.2%	-1.1%	26.8	26.8	0.0
H500	6.6%	5.1%	1.5%	49.0%	22.0%	5.4%	8.7%	1.1%	3.3%	0.0%	3.5%	-8.0	-11.0	0.0	0.0	0.0	20.2%	1.8%	47.5	64.5	17.0
H10	11.8%	5.1%	6.7%	57.2%	24.2%	4.4%	10.2%	3.8%	5.6%	0.2%	0.0%	13.0	6.0	0.0	0.0	0.0	17.0%	20.6%	-6.0	80.8	86.8
H70	11.8%	5.1%	6.7%	57.2%	24.2%	4.4%	10.2%	3.8%	5.6%	0.2%	0.0%	13.0	6.0	0.0	0.0	0.0	17.0%	20.6%	202.2	263.8	61.6
H8	6.6%	6.6%	0.0%	83.4%	28.3%	5.7%	10.8%	0.0%	4.0%	4.4%	3.4%	45.0	45.0	0.0	0.0	0.0	17.3%	-2.5%	95.8	128.0	32.3
PDU H80	10.8%	6.7%	4.1%	88.2%	27.2%	7.6%	11.8%	0.0%	1.2%	3.5%	3.1%	49.0	47.0	0.0	0.0	0.0	14.6%	5.2%	95.0	95.0	0.0
H9	3.7%	3.4%	0.3%	75.7%	23.2%	6.2%	14.0%	0.3%	1.4%	1.3%	0.0%	61.0	60.0	0.0	0.0	0.0	10.1%	3.0%	47.3	78.8	31.5
H90	3.9%	3.6%	0.3%	103.0%	27.9%	5.7%	13.4%	0.4%	2.7%	3.4%	2.3%	123.0	110.0	0.0	0.0	0.0	12.3%	0.6%	89.9	114.9	25.0
H11	19.1%	14.5%	4.6%	71.0%	29.2%	5.6%	8.8%	3.4%	2.8%	1.7%	6.9%	24.0	23.0	0.0		0.0	10.8%	0.6%	53.0	82.0	29.0
H110	13.3%	12.9%	0.4%	78.4%	27.2%	6.9%	11.3%	0.0%	2.2%	0.9%	5.9%	33.0	31.0	0.0	0.0	0.0	18.2%	4.0%	91.8	412.8	321.0
CDU	3.1%	3.1%	0.0%	35.3%	34.8%	8.3%	12.3%	6.0%	0.3%	0.4%	7.5%	61.0	38.0	0.1	0.0	0.1	29.0%	-0.4%	0.0	0.0	0.0
C26	3.9%	3.7%	0.2%	66.0%	19.0%	1.6%	10.7%	0.0%	4.2%	0.1%	2.4%	54.0	37.0	0.0	0.0	0.0	10.6%	0.7%	43.3	61.3	18.0
C28 /CMU	1.9%	1.6%	0.3%	43.8%	23.1%	5.6%	10.7%	0.2%	2.8%	1.5%	2.3%	52.0	17.0	0.0		0.0	26.5%	-0.7%	74.8	131.8	57.0
H4	11.9%	11.9%	0.0%	80.7%	28.7%	8.0%	13.2%	0.3%	5.9%	1.3%	0.0%	39.0	39.0	0.0	0.0	0.0	18.7%	-3.6%	59.8	71.8	12.0
H40	4.0%	4.0%	0.0%	19.6%	18.2%	1.5%	14.5%	0.5%	1.3%	0.4%	0.0%	44.0	39.0	0.0	0.0	0.0	20.2%	5.5%	3.3	63.8	60.5
H6	19.1%	19.1%	0.0%	65.4%	27.0%	3.9%	9.0%	0.9%	3.2%	6.4%	3.6%	55.0	55.0	0.0	0.0	0.0	12.6%	9.1%	67.3	83.3	16.0
H60	8.5%	8.5%	0.0%	66.6%	17.0%	2.7%	12.8%	0.0%	0.9%	0.6%	0.0%	55.0	55.0	0.0	0.0	0.0	8.6%	7.0%	20.8	63.0	42.3
H7	14.6%	12.0%	2.6%	36.1%	27.5%	3.5%	16.8%	0.0%	4.1%	0.1%	3.0%	54.0	54.0	0.0	0.0	0.0	27.0%	-3.7%	-56.8	75.5	132.3
H100	13.5%	13.5%	0.0%	55.9%	26.9%	7.6%	12.9%	0.0%	2.6%	0.4%	3.4%	56.0	55.0	0.0	0.0	0.0	18.5%	1.5%	116.9	164.3	47.4
H12	11.0%	9.9%	1.1%	47.2%	29.2%	5.0%	15.7%	0.2%	3.4%	3.5%	1.4%	23.0	20.0	0.0	0.0	0.0	15.7%	0.4%	43.8	120.8	77.0
H120	22.9%	22.6%	0.3%	85.5%	40.3%	3.9%	14.7%	1.0%	1.3%	7.8%	11.6%	19.0	9.0	0.0	0.0	0.0	10.2%	1.6%	162.8	196.8	34.0
HICU	0.0%	0.0%	0.0%	-	25.0%	5.0%	13.3%	0.4%	2.4%	0.9%	3.0%	61.0	55.0	0.0	0.0	0.0	20.8%	3.3%	-308.8	96.0	404.8
C9	9.5%	9.2%	0.3%	38.3%	25.9%	7.5%	12.8%	0.0%	2.2%	2.5%	0.9%	55.0	54.0	0.0	0.0	0.0	17.6%	1.2%	-5.0	58.5	63.5
C10	8.9%	8.9%	0.0%	42.9%	24.7%	4.9%	14.8%	0.3%	2.5%	2.2%	0.0%	37.0	37.0	0.0	0.0	0.0	15.3%	4.0%	-55.1	91.0	146.1
C11	11.1%	11.1%	0.0%	37.0%	25.5%	4.6%	12.7%	0.0%	3.2%	1.8%	3.2%	69.0	69.0	0.0	0.0	0.0	20.8%	3.9%	72.6	155.6	83.0
C14	5.0%	5.0%	0.0%	37.4%	26.6%	11.2%	10.0%	0.7%	0.4%	0.8%	3.5%	35.0	34.0	0.0	0.0	0.0	13.1%	-0.9%	117.8	128.8	11.0
C15	6.0%	6.0%	0.0%	37.9%	30.5%	4.6%	13.0%	0.0%	3.7%	3.4%	5.8%	38.0	38.0	0.0	0.0	0.0	14.0%	1.0%	-64.8	24.3	89.0
C27	1.0%	1.0%	0.0%	76.0%	22.8%	3.0%	12.8%	0.5%	2.6%	1.0%	2.9%	52.0	49.0	0.0	0.0	0.0	12.5%	2.8%	-23.0	8.5	31.5
CICU	1.5%	1.5%	0.0%	89.9%	29.4%	5.2%	14.4%	0.2%	3.4%	1.1%	5.1%	61.0	55.0	0.0	0.0	0.0	18.3%	3.5%	131.3	294.8	163.5
C16	19.2%	18.1%	1.1%	64.8%	29.3%	10.9%	8.7%	0.0%	2.8%	6.9%	0.0%	61.0	59.0	0.0	0.0	0.0	20.9%	1.4%	-33.0	17.0	50.0
H130	0.4%	0.4%	0.0%	100.0%	34.9%	7.0%	12.5%	0.0%	1.1%	2.5%	11.8%	52.0	52.0	0.0	0.0	0.0	14.9%	1.1%	11.0	23.0	12.0
H30 CEDAR	2.5%	1.4%	1.1%	18.2%	15.0%	0.3%	12.1%	0.0%	1.4%	1.2%	0.0%	61.0	51.0	0.0	0.0	0.0	21.6%	0.1%	-37.5	35.5	73.0
H31 MAPLE	2.2%	2.2%	0.0%	96.8%	29.8%	8.4%	13.8%	0.2%	4.0%	3.4%	0.0%	32.0	0.0	0.0	0.0	0.0	19.5%	3.0%	-12.0	0.0	12.0
H33 ROWAN	1.4%	1.4%	0.0%	78.0%	26.7%	6.1%	13.2%	0.2%	3.0%	1.5%	2.7%	65.0	58.0	0.0	0.0	0.0	12.8%	-3.1%	12.0	12.0	0.0
H34 ACORN	0.0%	0.0%	0.0%	0.0%	25.2%	4.9%	10.7%	1.5%	1.4%	0.7%	6.0%	32.0	0.0	0.0	0.0	0.0	20.5%	-0.3%	0.0	0.0	0.0
H35	0.0%	0.0%	0.0%	-	27.0%	6.6%	18.9%	0.0%	1.5%	0.0%	0.0%	62.0	59.0	0.0	0.0	0.0	11.0%	-1.0%	-13.0	0.0	13.0
LABOUR	0.9%	0.9%	0.0%	107.7%	27.6%	3.2%	15.5%	0.2%	3.4%	4.3%	1.0%	59.0	58.0	0.0	0.0	0.0	6.9%	-5.9%	0.0	0.0	0.0
NEONATES	4.1%	2.0%	2.1%	74.5%	31.7%	3.2%	10.1%	0.1%	5.4%	0.4%	12.5%	37.0	34.0	0.0	0.0	0.0	22.5%	-1.1%	0.0	0.0	0.0
PAU	3.7%	3.7%	0.0%	118.6%	28.8%	16.9%	10.2%	0.0%	1.7%	0.0%	0.0%	52.0	52.0	0.0	0.0	0.0	13.0%	-4.9%	0.0	12.0	12.0
PHDU	3.3%	3.3%	0.0%	100.0%	22.1%	3.2%	17.8%	0.0%	1.1%	0.0%	0.0%	52.0	52.0	0.0	0.0	0.0	16.7%	-4.5%	-11.0	0.0	11.0
C7	1.1%	1.1%	0.0%	36.4%	26.9%	7.2%	16.9%	0.0%	2.7%	0.1%	0.0%	33.0	20.0	0.0	0.0	0.0	17.5%	6.3%	-29.0	18.0	47.0
C29	3.9%	3.9%	0.0%	85.3%	26.6%	6.1%	10.4%	0.9%	4.3%	1.4%	3.5%	35.0	35.0	0.0	0.0	0.0	14.7%	2.4%	16.5	45.5	29.0
C30	3.4%	3.4%	0.0%	55.1%	28.6%	4.1%	11.9%	1.4%	4.7%	3.6%	2.9%	46.0	46.0	0.0	0.0		8.5%	-1.3%	13.0	35.0	22.0
C31	11.2%	7.4%	3.8%	46.0%	23.3%	7.0%	8.4%	1.7%	3.6%	0.8%	1.8%	44.0	41.0	0.0	0.0	0.0	19.6%	0.5%	43.1	77.1	34.0
C32	8.0%	6.5%	1.5%	55.0%	21.7%	2.5%	13.7%	0.0%	2.4%	0.2%	2.9%	48.0	48.0	0.0	0.0	0.0	9.4%	-4.7%	-51.8	15.5	67.3
C33	7.3%	6.1%	1.2%	46.1%	32.1%	3.3%	19.0%	0.0%	2.5%	0.6%	6.7%	54.0	53.0	0.0	0.0	0.0	24.8%	0.0%	61.8	61.8	
WARD	7.3%	6.3%	0.9%	62.4%	26.9%	5.6%			2.9%	1.7%	3.3%	46.4	40.5	0.1	0.0		16.5%	1.6%		4250.1	2823.7

	ED	ACUTE MEDICINE	NA	86.2%	89.8%	95.0%	95.6%	99.0%	89.2%	88.5%	89.3%		1	1	2	1	3	13	82	1	1	95	864		1	6	115			2	13	32	181			19	18				1	167	144	0	1	
	AMU	ACUTE MEDICINE	45	70.0%	90.8%	91.8%	90.3%	93.1%	91.7%	70.8%	90.3%					0	0	4	24			16	116		1		12			1	4	6	47			4	27	1	2			31	230	1	3	
	H36	ACUTE MEDICINE	22	84.0%	96.0%	88.0%	84.0%	84.0%	80.0%	60.0%	87.5%					0	0		4				7				1		1				1		1		3				1	0	16	0	2	
	EAU	ELDERLY MEDICINE	21	96.9%	94.2%	91.1%	87.9%	87.9%	87.9%	90.9%	90.9%		1			0	1	1	40	1	2	6	77		1		5				2	5	32	1	1	1	17					13	173	1	2	
	H5 / RHOB	RESPIRATORY	26	67.7%	88.4%	81.5%	82.1%	84.6%	74.4%	74.4%	92.3%			1	1	1	1		3		3	1	7		2		1						2		1				1		1	1	13	0	4	
	H50	RENAL MEDICINE	19	82.6%	94.9%	94.9%	93.3%	93.3%	93.3%	93.3%	100.0%		1			0	1		3			1	14				1						1		1		1					1	20	0	1	
	H500	RESPIRATORY	24	70.4%	100.0%	85.2%	82.1%	89.3%	78.6%	75.0%	75.0%					0	0				3	2	5			1	1			1	1						1					4	8	0	0	
	H10	ENDOCRINOLOGY	27	68.1%	100.0%	88.4%	83.3%	100.0%	83.3%	83.3%	66.7%		1		1				4	1	4	1	6	4	9		2							1	4		3		1		2					
	H70	GENERAL MEDICINE	22	40.0%	88.1%	89.9%	96.2%	76.9%	88.5%	69.2%	92.3%		7			0	7		2		2	3	6	2	4									2	3					1	2	3	8	4	7	
MEDICINE	H8	ELDERLY MEDICINE	27	96.6%	92.2%	87.3%	82.9%	77.1%	82.9%	82.9%	94.3%	1	4		2	1	6	1	9	2	15	3	10	3	9							1	4	1	3		5		1	2	6	5	28		13	
	H80	PDU	27	86.2%	82.9%	88.9%	87.5%	71.0%	81.3%	78.1%	80.6%		2		3	0	5				1				1																	0	0	0	1	
	H9	ELDERLY MEDICAL	30	92.1%	89.0%	89.8%	88.5%	91.4%	85.8%	79.0%	85.7%	1	3		1	1	4		2		8		5										1		1						1	0	8	0	1	
	H90	ELDERLY MEDICINE	29	100.0%	81.8%	89.7%	88.5%	93.1%	85.4%	79.0%	96.6%	1	2		3	1	5		1			1	3										1	1	2							1	5	1	2	SUI/2019/124
	H11	STROKE / NEURO	28	66.7%	90.9%	78.1%	78.1%	93.8%	75.0%	59.4%	71.9%		1			0	1						2		1		1									1	2			1	1	1	5	0	1	SUI/2019/144
	H110	STROKE / NEURO	24	67.6%	92.5%	77.9%	72.7%	69.7%	60.6%	75.8%	72.7%					0	0		3	3	9	2	8	2	13								3		1					1	5	2	14	2	14	
	CDU	CARDIOLOGY	9	92.9%	73.8%	93.3%	87.5%	93.8%	100.0%	87.5%	100.0%					0	0		1				1																			0	2	0	0	
	C26	CARDIOLOGY	26	79.0%	94.5%	86.5%	78.1%	93.8%	62.5%	62.5%	71.9%		2			0	2		1		2		3		5																2	0	4	0	5	
	C28 /CMU	CARDIOLOGY	27	73.8%	81.0%	89.0%	83.3%	92.9%	78.6%	71.4%	90.5%					0	0		6	1	11		4	1	9		3		1								3		1	1	5	0	16	1	11	
	H4	NEURO SURGERY	28	54.6%	94.5%	87.0%	86.2%	86.2%	69.0%	62.1%	96.6%					0	0	1	5	1	4		5	1	4		1								2				1			1	11	1	7	
	H40	NEURO / TRAUMA	15	56.7%	75.0%	84.1%	74.2%	71.0%	87.1%	64.5%	80.6%					0	0				3		2		2										1				2	1	7	0	2	0	5	
	H6	ACUTE SURGERY	28	89.7%	84.6%	85.4%	89.3%	85.7%	85.7%	78.6%	85.7%					0	0		1		3	2	6		2								2				1					2	10	0	2	
	H60	ACUTE SURGERY	28	90.6%	85.5%	92.6%	80.8%	96.2%	100.0%	80.8%	100.0%		1		1	0	2		3		2	1	5										3		1		1					1	12	0	1	
	H7	VASCULAR SURGERY	30	81.1%	95.2%	78.6%	75.7%	81.1%	73.0%	54.1%	81.1%		1		1	0	2		5	1	7	1	19	2	5	1	2		1			1	7	2	9	2	28		3		2	5	61	4	18	
	H100	GASTRO	24	84.9%	92.1%	90.1%	89.3%	100.0%	82.1%	67.9%	89.3%		2			0	2		5		2	2	4	1	5								1		3						1	2	10	1	8	
	H12	ORTHOPAEDIC	28	56.4%	93.3%	87.0%	84.6%	97.4%	87.2%	84.6%	89.7%					0	0	1	5	1	8		5		8							1	4		1	1	2		1		2	3	16	0	10	
	H120	ORTHO / MAXFAX	22	65.6%	91.9%	96.8%	93.1%	96.6%	93.1%	93.1%	93.1%	1	1			1	1		4	1	10	1	9		10										4	1	2		1		7	2	15	0	15	
SURGERY	HICU	CRITICAL CARE	22	81.1%	92.1%	91.0%	92.0%	91.2%	77.9%	86.7%	84.1%					0	0	1	4		11		3	2	8								3		5		2	1	1	2	13	1	12	3	14	
	C9	ORTHOPAEDIC	35	94.6%	87.5%	89.8%	88.4%	89.2%	85.7%	79.2%	91.9%		2		1	0	3	1	1		2		3	2	6										1		1		2		2	1	5	2	9	
	C10	COLORECTAL	21	65.2%	84.5%	88.5%	96.2%	88.5%	88.5%	80.8%	76.9%					0	0				4		4																			0	4	0	0	
	C11	COLORECTAL	22	82.6%	75.6%	85.2%	88.9%	88.9%	81.5%	70.4%	96.3%					0	0		1		3		2		1			1	1		1				1		1					0	5	1	3	
	C14	UPPER GI	27	81.8%	87.6%	87.6%	100.0%	90.9%	87.9%	93.9%	84.8%					0	0						3		11								1						1		2	0	4	0	12	SUI/2019/131
	C15	UROLOGY	26	71.4%	90.8%	85.3%	85.7%	77.1%	85.7%	65.7%	85.7%					0	0	3	10	2	13	4	20		11						2		2	1	3		2			1	5	7	0	1	14	
	C27	CARDIOTHORACIC	26	91.4%	89.3%	91.8%	87.5%	90.6%	96.9%	59.4%	90.6%					0	0		1		3		3		2																	0	4	0	2	
	CICU	CRITICAL CARE	22	88.8%	92.1%	94.2%	93.0%	94.0%	90.0%	88.0%	97.0%					0	0	1	1	5	8				2										6						5	1	1	0	8	
	C16	ENT / BREAST	30	92.0%	94.1%	96.8%	91.7%	87.5%	95.8%	87.5%	95.8%					0	0		1		1		5		3									1	1							0	6	1	4	
	H130	PAEDS	20	66.7%	84.4%	89.7%	88.6%	71.0%	85.5%	79.1%	71.0%					0	0								1																1	0	0	0	1	
	H30 CEDAR	GYNAECOLOGY	9	87.5%	100.0%	96.2%	93.8%	87.5%	93.8%	87.5%	93.8%					0	0				1												1			1	1					1	2	0	0	
	H31 MAPLE	MATERNITY	20	89.9%	94.1%	93.0%	88.7%	90.1%	93.0%	85.9%	87.3%																															0	0	0	0	
	H33 ROWAN	MATERNITY	38																																										0	
FAMILY & WOMEN'S	H34 ACORN	PAEDS SURGERY	20	78.8%	97.5%	93.9%	93.1%	96.3%	93.1%	86.2%	77.8%																																		0	
	H35	OPHTHALMOLOGY	12	95.2%	95.2%	97.9%	100.0%	94.4%	94.4%	94.4%	100.0%					0	0						1																			0	1	0	0	
	LABOUR	MATERNITY	16	84.9%	95.6%	89.7%	88.6%	94.6%	85.5%	78.9%	82.4%					0	0																		1							0	0	0	1	
	NEONATES	CRITICAL CARE	26	80.8%	90.2%	89.5%	88.4%	97.4%	85.4%	78.6%	92.2%					0	0				1																					0	0	0	0	
	PAU	PAEDS	10	75.0%	90.1%	87.8%	91.7%	91.7%	83.3%	66.7%	75.0%					0	0																									0	0	0	0	
	PHDU	CRITICAL CARE	4	75.0%	75.9%	93.6%	83.3%	90.9%	75.0%	83.3%	81.8%					0	0		1				1		2														1		3	0	2	0	3	
	C7	INFECTIOUS DISEASE	19	100.0%	100.0%	91.5%	90.0%	90.0%	85.0%	90.0%	90.0%					0	0							1	3																	0	0	1	3	
	C29	REHABILITATION	15	83.3%	96.7%	92.3%	89.3%	78.6%	89.3%	85.7%	100.0%		3		2	0	5				4		2		4				1			1	2									1	4	0	5	
CLINICAL SUPPORT	C30	ONCOLOGY	22	73.1%	95.6%	89.3%	91.3%	87.0%	87.0%	73.9%	100.0%					0	0	1	4				9										2		1	1	13				1	2	28	0	1	
	C31	ONCOLOGY	27	50.0%	84.6%	70.5%	75.0%	70.8%	75.0%	70.8%	62.5%					0	0		11		3	2	29				1					2	15		3	1	9				1	5	65	0	3	
	C32	ONCOLOGY	22	76.9%	100.0%	94.9%	90.5%	95.2%	95.2%	85.7%	81.0%		2			0	2		1		1	1	20				1					1	5			1	7		1			3	34	0	1	
	C33	HAEMATOLOGY	28	64.9%	88.7%	86.2%	84.8%	100.0%	72.7%	69.7%	84.8%			1	1	1	1	1	2		5		5		4		1						2				1				1	1	11	0	4	
	TOTALS :			78.6%	90.3%	89.1%	87.5%	88.6%	84.8%	77.9%	86.9%	4	37 0 3		19 0 7	54		29	251	20	160 0	145	1303	21	150	8	148	1	5	4	23 0 0	50	323	10	61	33	321	2	20	10	81	268	2318	25	222	