South Tees Hospitals
NHS Foundation Trust

Board of Directors

5 November 2019
1.30 pm
Board Room, Murray Building, James Cook University Hospital

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 5 NOVEMBER 2019 AT 1.30 PM IN THE BOARD ROOM, MURRAY BUILDING, JAMES COOK UNVERSITY HOSPITAL

AGENDA

ITEM		PURPOSE	LEAD	FORMAT
1. Patient Story		Discussion	Director of Nursing	Presentation
CHAIR'S BUSINESS				
2.	Welcome and Introductions	Information	Chair	Verbal
3.	Apologies for Absence	Information	Chair	Verbal
4.	Quorum and Declarations of Interest	Information	Chair	ENC 1
5.	Minutes of the last meetings held on 3 September 2019	Approval	Chair	ENC 2
6.	Matters Arising	Review	Chair	ENC 3
7.	Chairman's report	Information	Chair	Verbal
8.	Chief Executive's report	Information	Chief Executive	Verbal
QUALITY AND SAFETY				
9.	Healthcare-associated Infection Monthly Report	Information	Director of Nursing & Quality	ENC 4
10.	Safe Staffing Monthly Report	Information	Director of Nursing & Quality	ENC 5
11.	Quality, Safety, Performance and Finance Exception Report	Discussion	Deputy Chief Executive/ Director of Nursing and Quality/ Medical Directors/ Director of Finance	Presentation / ENC 6

ITEM		PURPOSE	LEAD	FORMAT
PERFORMANCE AND FINANCE				
12.	5 Year STP Planning	Information	Director of Finance	ENC 7
13.	Electronic Patient Record update	Information	Director of Estates, ICT and Healthcare Records	ENC 8
14.	EPPR Core Standards report	Information	Director of Estates, ICT and Healthcare Records	ENC 9
15.	Cancelled Operations report	Information	Chief Operating Officer	ENC 10
STRATEGY AND PLANNING				
16.	Strategic Issues Affecting the Trust and Wider Health Economy update	Information	Chair	Verbal
17.	Friarage Hospital Northallerton	Information	Deputy Chief Executive & Medical Director UEC & FHN	Verbal
18.	Cancer Strategy	Approval	Cancer Strategic Lead	Presentation / ENC 11
19.	EU Exit update	Information	Director of Estates, ICT and Healthcare Records	ENC 12
WORKFORCE				
20.	Flu Campaign	Information	Director of HR	ENC 13
21.	Staff Survey results (summer)	Information	Director of HR	Presentation / ENC 14
GOVERNANCE AND ASSURANCE				
22.	CQC update	Information	Director of Nursing & Quality	ENC 15
23.	Use of the Seal	Information	Head of Governance	ENC 16
24.	Chair's Logs from Board Committee Meetings • Quality Assurance Committee • Finance & Investment Committee • Risk Committee	Discussion	Chairs	ENC 17

ITEM		PURPOSE	LEAD	FORMAT
25.	Any Other Business		Chair	Verbal
26.	Risks to be added to the Board Assurance Framework	Discussion	Chair	Verbal
27.	Reflections on Meeting	Discussion	Chair / All	Verbal
28.	**DATE OF NEXT MEETING** The next meeting of Board of Directors will take place on Tuesday 3 December 2019			
29.	**Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)**			

BOARD OF DIRECTORS PUBLIC MEETING – 5 November 2019			
Register of members interests			**AGENDA ITEM: 4, ENC 1**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	Members of the Board of Directors Committee are asked to note the Register of Interest in relation to the Committee.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Alan Downey	Chairman	1 March 2018 15 April 2014	ongoing 2 April 2019	Wife is Director of PricewaterhouseCoopers working mainly with local government clients in the North of England Neddown Limited (dissolved company) from 2 April 2019 and (dormant) prior to joining the Trust
Amanda Hullick	Non-executive Director (Deputy Chair)	1 June 2018	ongoing	Husband employed as Supply Chain and Operations Director at Brakes UK (Sysco Plc) – company supply to the Friarage Hospital, Northallerton
Maureen Rutter	Non-executive Director (Senior Independent Director)	1996	ongoing	Member of Macmillan Cancer Support
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance
David Heslop	Non-executive Director			No interests declared
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director	August 2019 1 October 2019	Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria Healthcare NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808
Adrian Clements	Medical Director (Urgent and Emergency Care & Friarage Hospital) and Deputy Chief Executive	23 January 2012	ongoing	Director of Clements Medico Legal Consulting Limited
David Chadwick	Medical Director (Specialist and Planned Care)	21 August 2006	ongoing	Member of Team Health LLP (dormant)
Sath Nag	Medical Director (Community Care)			No interests declared
Andrew Owens	Medical Director (Corporate Clinical and Support Services)	May 2018 March 2016	ongoing ongoing	Non-executive Director of Medicor Software Ltd – a data analytics company that provides services to the NHS Director of Niche Medical Ltd – a medical device manufacturing start-up
Gill Hunt	Director of Nursing and Quality			No interests declared
Steven Mason	Director of Finance	1 October 2017 1 September 2018 13 August 2018 March 2019	ongoing ongoing ongoing ongoing ongoing	Children employed at PricewaterhouseCoopers and Deloitte Child employed at Ernst & Young HM Property Services Ltd (family company) Client representative ELFS Management Board South Tees Healthcare Management Limited - Company number 10166808

		1 October 2019		
Jackie White	Head of Governance	March 2013 February 2017 September 2018	Ongoing Ongoing Ongoing	Director – Applied Interim Management Solutions – Company Number 08473345 Specialist Governance Advisor – CQC The Northern School of Art Director – DevCo Ltd – Company Number 11574517
Ada Burns	Non-Executive Director	2017 2017 2019	Ongoing Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University Trustee & Vice Chair – New Local Government Network (NLGN) – Public policy think tank Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Sue Page	Interim Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria
Kevin Oxley	Director of Estates, ICT and Healthcare Records			No interests declared
Rachael Metcalf	Director of Human Resource Operations			No interests declared
Joanne Dobson	Director of Transformation			No interests declared
Helen Edwards	Director of Communications	2017	Ongoing	Trust, Welfare Benefits Unit
Mark Graham	Director of Communications			No interests declared
Johanna Reilly	Chief Operating Officer			No interests declared

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 3 SEPTEMBER 2019 AT 1:00 PM IN THE BOARD ROOM, MURRY BUILDING, JAMES COOK UNIVERSITY HOSPITAL

Present

Mr A Downey	Chairman
Mr M Ducker	Non-Executive Director
Mr R Carter-Ferris	Non-Executive Director
Mr D Heslop	Non-Executive Director
Ms D Reape	Non-Executive Director
Ms M Rutter	Non-Executive Director
Mrs S McArdle	Chief Executive
Mr A Clements	Deputy Chief Executive and Medical Director (Urgent and Emergency Care and the Friarage)
Mrs G Hunt	Director of Nursing & Quality
Dr S Nag	Medical Director (Community Care)
Mr D Chadwick	Medical Director (Planned and Specialist Care)
Professor A Owens	Medical Director (Corporate Clinical Support Services)
Mr S Mason	Director of Finance

In Attendance

Mrs J White	Head of Governance
Ms H Edwards	Director of Communications
Ms H Smithies	Freedom to speak up guardian (agenda item 14)

Action

BoD/19/49 **PATIENT STORY**

Mrs Hunt introduced members to a patient story provided by a patient who had provided feedback to the Trust on her recent experience of maternity care. The lady had received antenatal care from the community maternity service. Following the birth she had received care and support from the Health Visitor and Infant Feeding Lead. On the whole the patient's experience of our services was positive however she did encounter a problem with breast feeding which Mrs Hunt shared with members. Mrs Hunt advised that the patient provided some areas that the Trust should look to improve and action has been undertaken on these are other areas identified following investigation.

Mrs Hunt also advised members that the Trust had recently received details of the Maternity survey. The Trust performed the same as others in 40 questions and was performing the same on 11 questions as the top performing trusts. Mrs Hunt discussed that there is always room for improvement and the Trust can learn from this.

Action

Mr Downey welcomed feedback from the patient.

Ms Rutter commented that she thought it was interesting when organisations have specialist roles it seems to create some disinterest in the rest of the team and was this the case at the Trust and it was disappointing that the Trust did not follow the protocol.

Mrs Hunt concurred with Ms Rutter's points and advised that Maternity services do generally have good processes in place to keep staff well informed and trained.

Ms Rutter discussed that any infant who fails to gain weight is worrying.

Mr Downey advised that this was a very good example of getting feedback from patients which is not always positive allowing the Trust to learn from these issues and it is great that people share these stories with us.

Mrs Hunt confirmed that the lady has received written and verbal feedback from the Trust and has spoken with Infant Feeding lead.

Mrs Hunt went on to provide some headline figures on the CQC inpatient survey 2018 received July 2019. For 75 questions the Trust performed about the same as comparable Trusts, achieve better on 5 questions and worse on 1 question. Themes are around communication and discharge – use of information.

Mr Carter-Ferris informed that the Trust might have scored a higher number than last year, but other Trusts might have scored high as well so the benchmark is just in relation to the peer group and Mrs Hunt confirmed this.

Ms Reape commented that it was useful to have a benchmark, and referred to the theme around communication and discharge and informed that during the discharge process there is always a risk for incidents and complaints to occur as it is a time when patients are concerned about what is happening to them and requested an update on the actions identified by the Trust to address the issues raised.

BoD/19/50 **WECOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting and introductions were made.

BoD/19/51 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Amanda Hullick, Non-Executive Director.

Action

BoD/19/52 **QUORUM**

The meeting was quorate in line with the Constitution paragraph 4.39 “Quorum - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present”.

BoD/19/53 **DECLARATION OF INTEREST**

The Chair asked members if there were any further declarations to be made not already included. In addition to those already registered Ms Reape further advised that she was undertaking work with Northumberland NHS Trust and Northumberland Council and would liaise with the Head of Governance on updating the register.

BoD/19/54 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on 2 July 2019 were reviewed and agreed for accuracy.

Head of Governance

BoD/19/55 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/19/56 **CHAIRS REPORT**

Mr Downey discussed that he feels that the Trust are under a lot of pressure from a number of challenges including the CQC report and reduced rating, serious financial challenge and shortfall in revenue funding and capital funds to replace medical equipment, rising demand across all services and growing pressure at front of house ED which are demonstrating a number of warning signs in relation to patient safety.

Mr Downey informed that the consultation process will be starting shortly on the clinical model at the Friarage which is being led by the local CCG.

With regard to the wider system, the Trust continues to participate in ongoing discussions on the potential of a greater collaborate working with neighbouring NHS acute Trusts.

Finally Mr Downey expressed his thanks to staff across the Trust in all disciplines and departments who come to work every day and receive good feedback and provide a good service.

Mr Downey reminded members that the Healthcare Professions Awards were being held on 14 October 2019 and encouraged members to attend.

Action

Resolution

The Trust Board of Directors NOTED the Chairs update

BoD/19/57 **CHIEF EXECUTIVE REPORT**

Mrs McArdle gave members an update on recent activity within the Trust and members noted that the CQC inspection report has been published and the Trust has responded to the CQC with an action plan, the legal action on the urgent temporary changes at the Friarage Hospital was dropped and the case settled, with the only action being to carry out a full public consultation, which we had committed to prior to making the changes and prior to any legal action. Mrs McArdle advised that the £1m refurbishment of ward 11 was completed with patients welcomed onto the ward from 22 July. A meeting of the staff engagement group has been held to review the Trust values and those of the NHS, and the Trust supported Health Education England's 'Values Week' with staff pledging on how they will live the values. The recent GMC survey data has seen the Trust emergency department higher specialty medical trainees rank us the best in the region (Health Education North East area) for overall satisfaction.

Mrs McArdle noted a number of media coverages which she raised including ITV Tyne Tees interviewed students and staff involved in our week-long course for aspiring doctors in partnership with the Social Mobility Forum and Tyne Tees featured James Cook patient Danika Cross as part of its Transplant Games coverage showing how having a kidney transplant transformed her life.

Mrs McArdle discussed the sad news of the death of Councillor John Blackie, who represented the Upper Dales on North Yorkshire and Richmondshire councils, and who was being cared for by staff at the Friarage. He was a great advocate for the Friarage and has been actively involved in recent discussions to help provide a sustainable future for the Friarage.

Finally Mrs McArdle informed members of the exceptional work of the community nursing team based in Leyburn in having to deal with the extreme weather conditions at the end of July, when flash flooding, road closures and broken bridges meant that they had to travel long distances to reach patients and were based out of their homes, as Leyburn Health Centre was flooded.

Resolution

The Trust Board of Directors NOTED the Chief Executive's update

Action

BoD/19/58 **QUALITY, SAFETY, PERFORMANCE AND FINANCE EXCEPTION REPORT**

Mr Clements introduced the Quality, Safety, Performance and Finance Exception report and discussed his disappointment on the delivery of the must do targets. In particular Mr Clements advised members that the A&E standard has been delivered by the Trust since introduced but this month the Trust are unlikely to meet it, particular issues on deliver relate to capacity and size of department and growth in activity which equates to 2.7% rise = 34 patients per day since 2017. Supporting services and bed base under pressure due to activity, medial admissions into hospital increased by 8% and a reduction in resource which has an effect on staff sickness and morale.

Ms Rutter asked whether there was an opportunity open more beds at the back of house to support flow through the front of house. Mr Clements advised that due to the financial constrains the Trust is under there is the opportunity to increase the bed base. Ms Rutter further informed that if there is potential for patient harm this should outweigh the finances.

Mr Downey informed that the Trust has submitted a bid for an emergency loan to fund capital equipment and are still awaiting the response from NHSI/E.

Referring to Ms Rutter's comments on increasing the bed base, Mrs McArdle commented that if the Trust did increase the bed base it would be at the front of house not back as this is where additional capacity is required and the creation of back of house beds would run the risk of inappropriate and avoidable admissions which in themselves create a risk to patient safety., Mrs McArdle also pointed out the fact that unfortunately the Trust are land locked with regard to estates capacity and despite having architects plans drawn up and clear business case for expanasion are unable to raise the capital required .

Ms Reape noted the impact on staff sickness and morale and asked Mr Clements what the Trust are doing for the staff in terms of support, Mr Clements advised that there are safe staffing levels in place at all times and the individual teams of staff support each other.

Mr Chadwick reminded members that the Board had discussed RTT and Cancer recovery plans in Private Board which set out the challengers around processes, technology and behaviours of staff and some of the potential solutions being put in place such as service redesign, preassessment

Action

etc, noting the challenges around correcting RTT are quite significant. With regard to Cancer Mr Chadwick discussed that the Trust has seen an improvement in performance on 62 day and can be optimistic to deliver this by the end of the year.

Mr Clements confirmed that the Trust is slightly below target for Diagnostic services.

Mrs Hunt highlighted the 6 CDiff cases for July and a total of 32 Trust apportioned CDiff cases for the year which equated to 4 over trajectory.

Ms Rutter commented that the significant pressure on the Trust in all areas has had an impact on delivery of the measures as it was the worst performance she had seen.

Mrs Hunt advised that there had been a reduction in pressure ulcers for 3 months and with regard to falls the nursing team are targeting areas where patients have fallen multiple times. Finally members noted that there had been 6 SI's in July and 1 which was a never event - naso gastric tube misplaced.

Mr Ducker asked Mrs Hunt what evidence she had that the Trust were delivering the action plans following an SI and Mrs Hunt advised that all SI's are tracked at the Patient Safety Group and Professor Owens concurred and confirmed that the CCG also sign off the SI's so there is additional scrutiny.

Mrs Hunt was pleased to advise members that 98% of patients would recommend the organisation as part of the patient experience indicators.

With regard to People, Mrs McArdle advised members that staff sickness was slightly up from last year, and there were plans in place to have staff compliant with mandatory training (safeguarding training and data quality issues) and SRDs at by March 2020. Mrs McArdle noted that there was better compliance with regard to supporting staff who were off sick and returning to work.

Mr Mason updated on the Financial position and advised members that the Trust delivered the control total last year but at month 4 this year the Trust is £4.4m behind plan. This includes loss of STP funding of £0.6m, £2.3 being undelivered system savings and an underlying overspend of £1.6m. The full year plan is a control total surplus of £3.2m. Mr Mason confirmed the Trust is overspent on capital and are waiting on confirmation of an emergency loan bid for funding for equipment.

Finally Mr Mason advised members that the Trust would need

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to seek further borrowing from October 2019 due to cash flow problems.

Mr Carter-Ferris noted that the Trust is between a rock and a hard place, and the Board need to recognise that the Trust are in an impossible position with no support. Staff are doing everything they can and deserve the credit.

Mrs McArdle stated that the combination of increases in both demand and also the complexity of patients presenting to the James Cook site in particular, alongside little seasonal fluctuation which traditionally has allowed the staff some respite in the summer months has resulted in a very tired workforce who are going in to winter in an organisation under continuing financial pressures and this gives cause for concern.

Resolution

The Trust Board of Directors DISCUSSED the Quality, Safety, Performance and Finance report

BoD/19/59 **HEALTHCARE ASSOCIATED INFECTION MONTHY REPORT**

Mrs Hunt referred members to her previously circulated report and highlighted the Clostridium difficile-associated diarrhoea objective for 2019/20 is to have no more than 81 community-onset healthcare-associated (COHA) plus healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 6 COHA + HOHA cases in July 2019. There have been 32 COHA + HOHA cases in the first 4 months of 2019/20. We are currently over trajectory.

There were 0 trust-assigned MRSA cases in July 2019 and 0 trust-assigned cases in the first 4 months of 2019/20.

There is no official MSSA bacteraemia target for 2019/20, however there were 4 trust-apportioned cases in July 2019. There have been 13 trust-apportioned cases in the first 4 months of 2019/20.

There has been a cluster of infections in the neonatal unit the Trust is waiting outcome of what this is. The Trust have responded swiftly from areas of surveillance when alerted to infections. Mrs Hunt confirmed that additional external observation of hand hygiene techniques and serco cleaning is being undertaken.

Finally Mrs Hunt advised that there has been an outbreak of Serratia marcescens infection affecting patients who have

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been treated in cardiothoracic ICU and/or HDU and/or Ward 32. There have been 4 confirmed cases, 8 probable cases and 2 possible cases.

Professor Owens asked what the criteria was for closing the Serratia outbreak and Mrs Hunt advised that Microbiology will confirm this at the outbreak meeting.

Ms Rutter discussed that it is a concern that outbreaks are cropping up in geographically spread out areas with different infections. Mrs Hunt acknowledged this and advised that the Trust has a good surveillance system which highlights them.

Mr Downey thanks on behalf of the Board.

Resolution

The Trust Board of Directors NOTED the Healthcare associated Infection report

BoD/19/60 **SAFER STAFFING MONTHLY REPORT**

Mrs Hunt referred members to the Safer Staffing report and highlighted the fill rate against planned rosters for the month of July 2019 at an overall level was:

- RN / RM day shift 89.2% night shift 90.9%
- HCSW day shift 94.3% night shift 107.6%

Mrs Hunt advised that due to the shortage of RNs in the next 3-5 years the Trust will need to continue to look to recruit internationally.

Ms Rutter thanked Mrs Hunt for the additional information on fill rate less than 80% contained within the report.

Resolution

The Trust Board of Directors NOTED the Safer Staffing report

BoD/19/61 **LEARNING FROM DEATHS REPORT**

Professor Owens referred members to the Learning from deaths report and highlighted that there were 159 deaths recorded in July 2019. In the same period in 2018 there were 160 deaths were recorded. The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge is 108 and is 'as expected' (ie within the variation expected statistically). With regard to the Medical Examiner service 83.1% of deaths have received a medical examiner review with 286 deaths being recommended for trust mortality surveillance review of which 205 have since been completed.

Action

Professor Owens informed that a deep dive is being undertaken into Palliative care coding and referrals which will be reported to Quality Assurance Committee.

Resolution

The Trust Board of Directors NOTED the Learning from deaths report

BoD/19/62 **ANNUAL BOARD REPORT AND STATEMENT OF COMPLIANCE**

Dr Nag presented the Annual Board Report and Statement of Compliance for the Trust. He advised that the Trust continues to ensure all Doctors engage in appraisal with the Revalidation Team aiming to fully optimise the e-Appraisal Allocate Software for the management of appraisals and revalidation recommendations. Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC.

Dr Nag asked the Board of Directors to note the report and for delegated authority to be given to the Chief Executive to sign of the report on behalf of the Board.

Ms Rutter thanked Dr Nag for the update and asked whether the Trust will secure an additional 24 people to be appraisers. Dr Nag confirmed that there are people waiting to become appraisers so there were no issues.

Mr Ducker referred Dr Nag to the outstanding action listed in the report from last year. Dr Nag confirmed that it was agreed that the piece of work be undertaken Regionally and he will need to confirm the output of this. — Dr Nag

Resolution

The Trusts Board of Directors APPROVED for the CEO to sign off the report on behalf of the Board and NOTED the Annual Report.

BoD/19/63 **FREEDOM TO SPEAK UP**

Ms Smithies, Freedom to speak up Guardian attended the meeting and referred members to her previously circulated report and advised members that there are currently 7 open cases and 8 closed cases.

Mr Carter-Ferris questioned how the number of cases within the Trust compared across the patch and whether the Trust were getting staff to report their concerns. Ms Smithies reported that the Trust numbers are quite low at the moment, there was no local benchmarking but the National Office did

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have some comparable data. Ms Smithies advised that further work needs to occur to ensure staff are aware of the guardian role and reporting arrangements.

Professor Owens discussed that the role of the investigator needs to be looked at within the Trust as a resource as sometimes with SI's and incidents the same individuals end up be being used for all the time.

Mrs McArdle asked what the communications strategy was for the Guardian role as it feels that the Trust need to step this up.

Dr Nag asked about sharing the themes and information that is shared with the Guardian and Ms Smithies advised that this isn't currently shared within the Trust.

Mr Downey thanked Ms Smithies for the update and questioned what the next steps were for the service. Mrs Hunt confirmed that the Trust now need to reflect on the future model for Freedom to Speak and that a Board development session should be held to explore this further. Ms Smithies agreed to prepare some options based on national best practice ahead of the Board Development session. — Mrs Hunt

Resolution

The Trusts Board of Directors NOTED the Freedom to Speak up report

BoD/19/64 **SOUTH TEES GROUP STRUCTURE**

Mr Mason presented the South Tees group structure report which provided an overview of the Trust Group Structure, bringing together the recent reports and decisions on the different entities within the group.

Members noted that the Trust has created different entities in connection with its functions to provide more effective value for money for certain activities.

Mr Mason advised that the Finance Investment Committee had considered the report and Ms Hullick, Non-Executive Director had raised a number of comments regarding the documentation including further clarification was required on the Corporate Trustee role, inclusion of the Finance business partner to ensure financial governance.

Mr Ducker also advised that some of the documentation referred to roles which would not be included in the group structure and these needed to be reviewed before the

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documentation was finalised.

The Trusts Board of Directors NOTED the Group Structure report

BoD/19/65 **SOUTH TEES INSTITUTE OF LEARNING RESEARCH AND INNOVATION LLT**

Mr Mason referred members to his previously circulated report and noted that the report set out the necessary information to inform the key decisions required to give effect to "go live" operations for SOUTH TEES INSTITUTE OF LEARNING, RESEARCH AND INNOVATION LIMITED LIABILITY PARTNERSHIP ("the LLP") for 2019/20 financial year.

The LLP was incorporated on 9th May 2016 following initial work and advice supported by PwC. The partners within this partnership are South Tees Hospitals NHS Trust and South Tees Healthcare Management Limited.

Mr Heslop commented that the LLP needed to have appropriate governance processes in place in line with the Trust. Mr Mason confirmed that there would be an overview of the LLP and Audit Committee would do this. In addition the LLP would report into the Board of Directors.

The Trusts Board of Directors APPROVED the LLP

BoD/19/66 **CQC ACTION PLAN**

Mrs Hunt advised members that an action plan has been developed following CQC's most recent inspection of the Trust which was carried our between the 15th January and the 23rd February 2019.

The action plan has been produced in partnership with the Trust senior leaders and covers all of the 'Must Do's and Should Do's' from the report. It has also been shared with both the CQC and the CCG.

A CQC oversight group has been established, with the first meeting being held in September. The oversight group will have trust wide representation from the centres and corporate services and will be chaired by the Director of Nursing and Quality. This group will oversee the implementation of the action plan and seek assurance through supporting evidence and the underpinning action plans, reporting on progress to both the Operational Management Board and Quality Assurance Committee on a regular basis.

Mrs Hunt informed that the action plan had been approved internal through the Operational Management Board and Senior Leadership Team and through an Extra Ordinary

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Clinical Quality Review Group meeting with Commissioners. The Trust had not yet received feedback from the CQC.

Mrs McArdle advised that she had had informal feedback on the plan and it was in line with the CQC expectations and the Trust will hear from them in due course. Mrs McArdle confirmed that the Trust are reengaging with the CQC to regain our Good rating.

Members noted that the CQC relationship manager had changed for the Trust.

Mrs McArdle advised members that she and Mrs Hunt had attended the Joint Tees Valley Overview and Scrutiny Committee to update on CQC.

Mr Carter-Ferris asked Mrs Hunt if the Trust is comfortable that all additional resources within the plan are funded. Mrs Hunt advised that there are some things that require investment which will need a business case and investment will need to be discussed.

Mr Ducker suggested that both regulators met together to discuss the issues and challenges around delivery of the plan and the financial pressures of the Trust. Mrs Hunt advised that the opportunity to do this would be at the Risk Profile Quality Summit.

Mr Downey discussed that it is clear from the action plan that the Trust have addressed the regulatory must do and should do issues but the report also set out a number of points which need to be addressed. Mrs McArdle advised that the points raised in the report relate to issues which the CQC were unable to fully quantify and do not wish these issues to be contained within the Trust CQC action plan. However the Trust will ensure these points are addressed in the South Tees CQC recovery plan.

Mr Downey felt reassured by this information and asked for a report to the Trust Board of Directors at a future meeting.

The Trusts Board of Directors NOTED the CQC action plan

BoD/19/67 **CONSTITUTION**

Mr Downey advised members that the Council of Governors Constitution Working Group had reviewed the Constitution and recommended that the same be amended to be more gender neutral. The Council of Governors approved these changes and recommend that the Board of Directors approve the amended Constitution.

Action

The Trusts Board of Directors APPROVED the Constitution

BoD/19/68 **ICS MEMORANDUM OF UNDERSTANDING**

Mr Downey referred members to the Memorandum of Understanding between the North East and North Cumbria NHS partners within the ICS which sets out the details of the commitment to work together to realise the shared ambitions to improve the health of people who live in our area, and to improve the quality of their health and care services.

Mr Downey reminded members that the draft memorandum of understanding had been previously shared with members and a number of questions and clarifications had been raised. Mr Downey confirmed that he had attended a meeting of regional Chairs with Regional Director and Alan Foster and the same issues raised had been raised by other Trusts.

Mr Downey informed members that the document is for guidance and the desire is to keep the document short as it is a statement of intent in terms of working.

The Trusts Board of Directors APPROVED the Memorandum of Understanding for the ICS

BoD/19/69 **CHAIRS LOGS FROM BOARD MEETNGS**

Members noted the updates received from the Chair logs in addition to the following information:

Quality Assurance Committee – Ms Rutter advised that the Committee met in August and escalated infection control.

Finance Investment Committee - Mr Ducker advised that the Committee met in August and escalated issues remain the same and covered by the agenda. Revenue we should strive to achieve the internal target at budget time of delivery of the control total, recognised due to the pressures already highlighted and this would be a challenge but did want to see an improvement around clinical risk and approval of SLT. Capital more serious concern and issue around no news on emergency bid. Capital position is not short term issue and we need a capital recovery plan (5 years) and it will be a lot of money but we need to have this and share with the regulators. SLT to pull together in September.

Mrs McArdle said the Senior leadership Team need to go back through the business cases driving the £7.4m variance on revenue position and further document the risk to patient safety and organisational reputation if these business cases are not progressed . She also commented that the SLT and Board need to be more explicit on the business cases we

Action

have also put on the shelf alongside those we have approved and then come back to Board with quantification of risk in terms of impact on patient safety and quality . Mrs McArdle agreed with MR Ducker that the Board now need increase visibility with regard to both the Revenue and Capital positions and the corresponding risk that presents to patient safety , quality and staff morale.

Professor Owens said with the increasing risk around capital we need to ensure the level of risk is documented at service level and look at mitigations and challenges. Professor Owens advised that that this will have further assurance within the Risk Validation Group.

Mrs McArdle reminded the Board we spent £8.4M on emergency capital in the last financial year and that the forecast emergency capital spend this year is £18.1M as advised to NHSE/I.She also asked the Board to note the personal pressure that DOF may come under by NHSI to improve on this position and said we must ensure a joined up approach which clearly includes clinical input , to manging revenue, capital and any associated patient safety risk.

Workforce – Ms Rutter confirmed that the Committee had requested a number of risks be added to the BAF and advised that following review of the BAF these had been included.

BoD/19/70 **ANY OTHER BUSINESS**

There were no further items of business.

BoD/19/71 **RISKS TO BE ADDED TO THE BAF / RISK REGISTER**

Mr Downey confirmed that there were no further risks to add to the BAF or risk register other than those which had been captured already.

BoD/19/72 **REFLECTIONS ON MEETING**

Mr Downey reflected that he would like to bring the meeting to a close with concrete clarity on the direction of travel and way forward on the issues discussed today but unfortunately he was not able to do that. He discussed that the Trust needed to continue to have dialogue with their regulators on actions to improve efficiency and save costs where we can and highlight significant hole in finance around revenue and capital and the significant patient safety and quality issues being highlighted due to the financial position

BoD/19/73 **DATE AND TIME OF NEXT MEETING**

The date of the next Board of Directors meeting to be held in public will be on Tuesday 5 November 2019.

South Tees Hospitals NHS
NHS Foundation Trust

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
3.9.19	BoD/19/62	ANNUAL BOARD REPORT AND STATEMENT OF COMPLIANCE	Delegated authority to be given to the Chief Executive to sign of the report on behalf of the Board	CEO	30.9.19		open
3.9.19	BoD/19/63	FREEDOM TO SPEAK UP	Mrs Hunt confirmed that the Trust now need to reflect on the future model for Freedom to Speak and that a Board development session should be held to explore this further. Ms Smithies agreed to prepare some options based on national best practice ahead of the Board Development session.	G Hunt	28.2.20	Option appraisal by mid January 2020 and Board development session February 2020	open

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD OF DIRECTORS – 5th November 2019			
Healthcare-associated infection (HCAI) report for September 2019			**AGENDA ITEM: 9, ENC 4**
Report Author and Job Title:	R Bellamy, Infection Control Doctor, JCUH A Ndhlovu, Lead Nurse, IPC Helen Day, Deputy Director of Nursing/Deputy DIPC Gill Hunt, Director of Nursing and Quality/ DIPC	**Responsible Director:**	Gill Hunt, Director of Nursing and Quality/ DIPC
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions being taken.		
Background	The report summarises surveillance information on healthcare-associated infections for the month of September 2019. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management. National reporting of Influenza cases started week commencing 30 September 2019 focusing on critical care areas and the report provides an update.		
Assessment	The organisation remains above trajectory for Clostridium difficile infection. The report provides an update on the recent outbreaks and assurance that robust action has been taken and policy followed.		
Recommendation	Members of the Trust Board are asked to: note the current position in respect of HCAI and for their support for the actions being taken.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 2.1 - An infection outbreak (such a influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicators		
Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to *glycopeptide-resistant Enterococci, Escherichia coli* (E. coli), Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections for the month of September 2019. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management.

- The *Clostridium difficile*-associated diarrhoea objective for 2019/20 is to have no more than 81 community-onset healthcare-associated (COHA) plus healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 6 COHA + HOHA cases in September 2019. There have been 50 COHA + HOHA cases in the first 6 months of 2019/20. We are currently over trajectory.

- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in September 2019. There have been 0 trust-assigned cases in the first 6 months of 2019/20.

- There is no official MSSA bacteraemia target for 2019/20. There were 4 trust-apportioned cases in September 2019. There have been 23 trust-apportioned cases in the first 6 months of 2019/20.

- There has been an outbreak of *Serratia marcescens* infection affecting patients who have been treated in cardiothoracic ICU and/or HDU and/or Ward 32. At the time of writing (22 October 2019) there have been 5 confirmed cases, 6 probable cases and 12 excluded cases.

2. Recommendation

The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions being taken.

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1. SURVEILLANCE DATA

The 2019/20 *C. difficile* definitions are as follows:

a) Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
b) Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
c) Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.
d) Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Table 1. 2019/20 *C.difficile* definitions

1.1 Clostridium difficile

C diff	Total 2018/19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Sep 19	Total 2018/19 to date	Target for 2018/19
Total cases	120	17	9	8	11	5	6	18	7	14	14	19	10	82	NA
Not trust apportioned	79	10	9	5	7	3	5	8	1	4	8	7	4	32	NA
Trust-apportioned	41	7	0	3	4	2	1	10(4)	6(3)	10(10)	6(3)	12(8)	6(5)	50(33)	**81**
- JCUH	33	6	0	3	4	1	1	10	4	8	4	10	5	41	
-FHN	3	0	0	0	0	0	0	0	1	1	2	1	0	5	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	2	1	0	0	0	0	0	0	1	0	0	0	0	1	
-East Cl	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	1	0	1	
-Friary	2	0	0	0	0	1	0	0	0	1	0	0	1	2	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

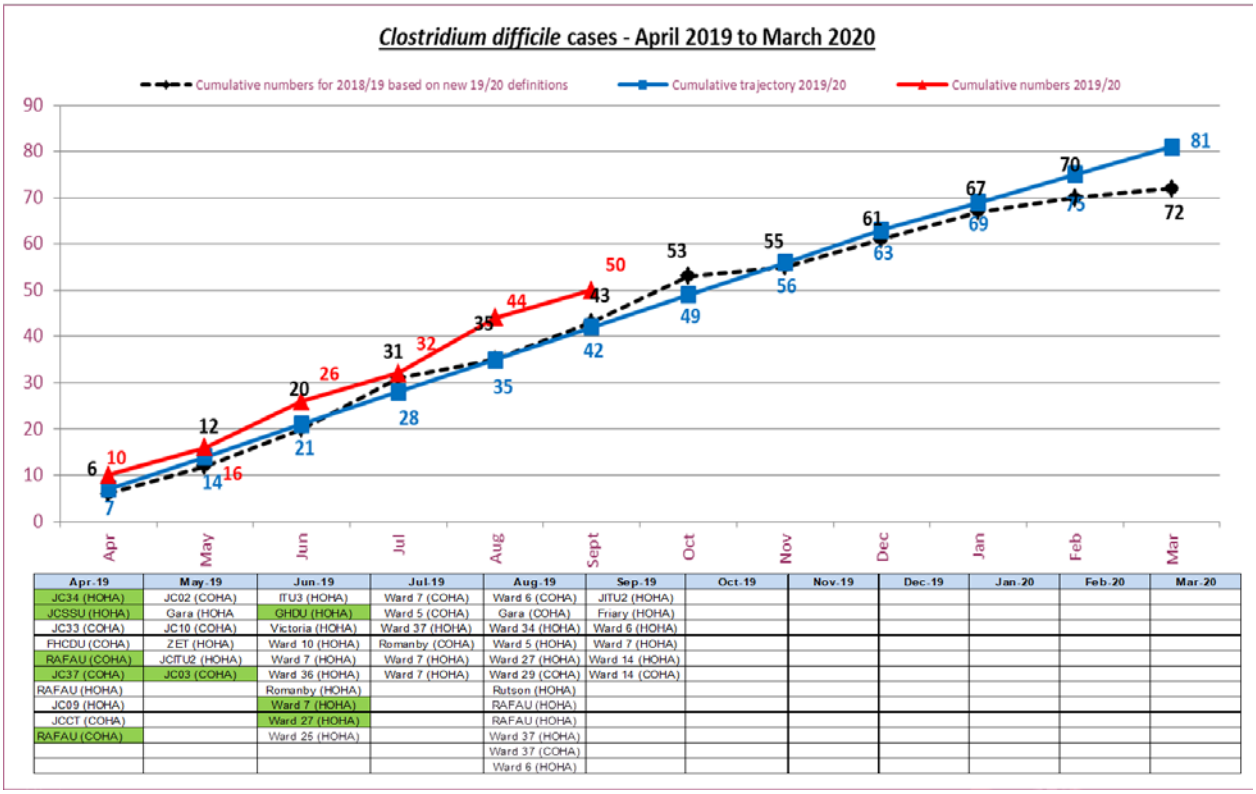
Table 2

There were 6 cases of *C. difficile* infection in September 2019, 1 of which was classed as COHA and 5 were classed as HOHA, totalling 6 classed as trust-apportioned according to the new definition (table1). The 2019/20 annual objective is to have no more than 81 COHA + HOHA cases. In the first 6 months of 2019/20 there have been 50 trust-apportioned cases (COHA = 17; HOHA = 33). All actions to ensure that robust controls are in place are monitored through IPAG and the monthly Centre Clinical Standards meetings held with Matrons.

Deaths within 30 days after *C. difficile* diagnosis: for August 2019, 1 patient died during this period. Since April 2009, 304/1708 patients (18%) have died during the 30 day follow-up period.

The outbreak meeting regarding a cluster of two patients on ward 7 with the same *C difficile* ribotype and a cluster of two patients on ward 27 with the same ribotype has been closed. An enhanced Trust wide action plan is in place addressing aspects of practice and the environment.

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2019/20 compared to trajectory:



Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
JC34 (HOHA)	JC02 (COHA)	ITU3 (HOHA)	Ward 7 (COHA)	Ward 6 (COHA)	JITU2 (HOHA)						
JCSSU (HOHA)	Gara (HOHA	GHDU (HOHA)	Ward 5 (COHA)	Gara (COHA)	Friary (HOHA)						
JC33 (COHA)	JC10 (COHA)	Victoria (HOHA)	Ward 37 (HOHA)	Ward 34 (HOHA)	Ward 6 (HOHA)						
FHCDU (COHA)	ZET (HOHA)	Ward 10 (HOHA)	Romanby (COHA)	Ward 5 (HOHA)	Ward 7 (HOHA)						
RAFAU (COHA)	JCITU2 (HOHA)	Ward 7 (HOHA)	Ward 7 (HOHA)	Ward 27 (HOHA)	Ward 14 (HOHA)						
JC37 (COHA)	JC03 (COHA)	Ward 36 (HOHA)	Ward 7 (HOHA)	Ward 29 (COHA)	Ward 14 (COHA)						
RAFAU (HOHA)		Romanby (HOHA)		Rutson (HOHA)							
JC09 (HOHA)		Ward 7 (HOHA)		RAFAU (HOHA)							
JCCT (COHA)		Ward 27 (HOHA)		RAFAU (HOHA)							
RAFAU (COHA)		Ward 25 (HOHA)		Ward 37 (HOHA)							
				Ward 37 (COHA)							
				Ward 6 (HOHA)							

Graph 1

Appeal successful	

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or her Deputy and are attended by CCG colleagues. If the panel agrees that there were no deficiencies in care then the case may be discounted from the total for performance measurement purposes.

The average hand hygiene self-assessment score in September 2019 was 91.76% and the peer review average was 92.56%.

1.2 MRSA bacteraemia

MRSA	Total 2018/19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Sep 19	Total 2019/20 to date	Target for 2019/20
Total cases	9	0	2	0	1	1	0	0	0	0	0	0	0	0	NA
Not trust assigned	8	0	2	0	1	1	0	0	0	0	0	0	0	0	NA
Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**NA**

Table 3

There were no cases of MRSA bacteraemia in September 2019 (table 3). In the first 6 months of 2019/20 there have been 0 cases.

1.3 MSSA bacteraemia

There were 15 cases of MSSA bacteraemia in September 2019; 4 of which were classed as trust-apportioned (table 3). In the first 6 months of 2019/20 there have been 23 trust-apportioned MSSA bacteraemia cases.

MSSA	Total 2018/19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun e 19	July 19	Aug 19	Sep 19	Total 2019/20 to date	Target for 2019/20
Total cases	134	9	8	12	10	8	11	12	12	17	18	17	15	91	NA
Not trust apportioned	92	5	6	8	7	5	7	9	11	12	14	11	11	68	NA
Trust apportioned	42	4	2	4	3	3	4	3	1	5	4	6	4	23	NA

Table 4

Whilst there is no external target for MSSA, the trust has set an internal target to maintain the 15% reduction of Staphylococcus aureus infections based on the 2016/17 baseline. This means no more than 35 combined MRSA and MSSA trust-apportioned cases in total. The trust is currently over trajectory for this. Enhanced training for Aseptic Non-Touch Technique (ANTT) is being implemented across the trust for all relevant staff groups to address avoidable causes of MRSA and MSSA bacteraemia related to invasive procedures.

1.4 Surveillance for other healthcare-associated infections (table 5)

	Total for 18/19	**September 2019**	**Total for 19/20**
Bacteraemia due to glycopeptide-resistant enterococci	10	0	4
Bacteraemia due to E. coli	550	42	247
• Trust-apportioned	128	7	51
• Not trust-apportioned	422	35	196
ESBL producing coliform infections	953	83	386
• sample taken in community	599	44	237
• sample taken in our trust	354	39	149
• bacteraemias	28	2	13
Bacteraemia due to Klebsiella species	134	14	62
• Trust-apportioned	37	4	16
• Not trust-apportioned	97	10	46
Bacteraemia due to Pseudomonas aeruginosa	37	5	26
• Trust-apportioned	12	0	3
• Not trust-apportioned	25	5	23
Other alert organisms	1	0	0
• invasive group A streptococcus			

Table 5

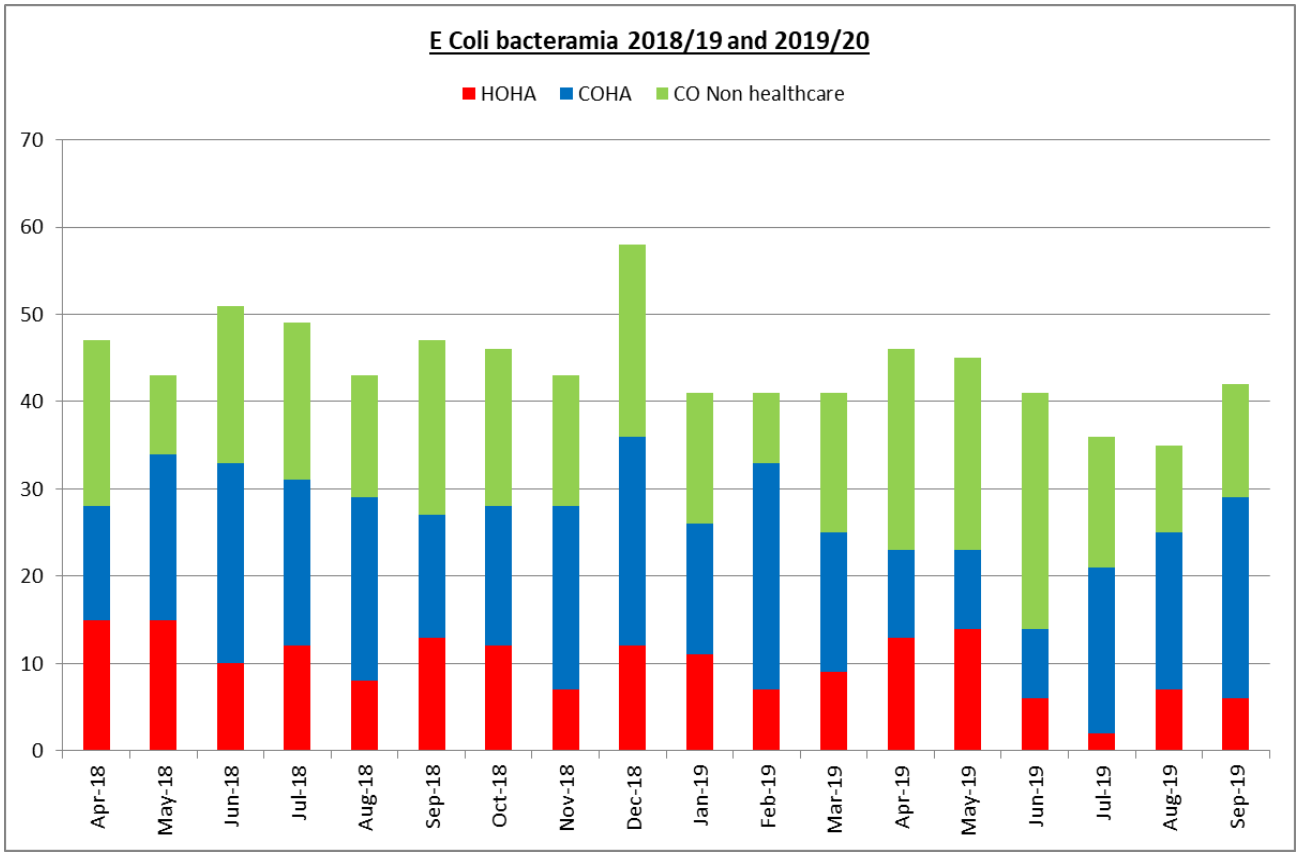
Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

In September 2019, the trust reported a total of 61 cases of three GNBSI organisms which are part of national surveillance (*E. coli, 42; Klebsiella sp. 14; Pseudomonas aeruginosa* 5). Of these, 11 cases were classed as trust-apportioned as defined by the Department of Health definition. In the first 6 months of 2019/2020 there have been a total of 335 cases of the three GNBSI cases (*E.coli, 247; Klebsiella sp. 62; Pseudomonas aeruginosa* 26) and of these 70 are classed as trust-apportioned 21%). This demonstrates the need to continue working with the wider community as

part of the Tees-wide collaborative which supports a number of initiatives within the community setting. In addition a detailed retrospective audit of 5 sets of notes per week is being performed to ascertain patient-related contributory themes in the challenge to identify causes of *E. Coli* infections.

The trust continues to take part in the national GNBSI urinary tract infection collaborative hosted by NHS Improvement/ NHS England. The focus of this improvement programme is hydration in both the community setting in the older population and care home setting with a number of resources being made available as well as specific hydration campaigns. This work is being led by a post holder working with the IPC team, currently hosted by the trust and funded through health and social care funding the 'Better Care Fund'. Initiatives in the community will be emulated and implemented within the acute trust in order to reduce these infections.

Graph 2 – E Coli bacteraemia cases 2018/19 and 2019/20



Graph 2: note that the definition of cases above is based upon information available to the infection control team. Information around community healthcare interventions may be incomplete overestimating the proportion of CO non-healthcare-associated cases as defined by the PHE definition.

Antimicrobial Stewardship

The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK project.

The antibiotic guidelines app was launched at the end of September 2019. This complements the "Antibiotic Sepsis/ Infection (not sepsis)" poster which was released in January 2019. The change in guidance carries a potential risk of increased cases of *C. difficile* as it could lead to an increase in appropriate prescribing of broad-spectrum antibiotics.

The antimicrobial CQUIN for 2019/20 focuses on 3 areas:

1. Diagnosis and antibiotic prescribing for lower urinary tract infections.

2. Antibiotic prophylaxis for colorectal surgery.

3. Diagnosis and antifungal prescribing for systemic fungal infections.

The antimicrobial pharmacy team are currently performing audits for these CQUINs, but there are significant challenges in achieving them.

Environmental Cleaning

The average cleaning scores by month are as follows (table 6):

The James Cook Site:

Risk Category	NSC Target	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19
High Risk	**95%**	98%	98%	98%	98%	98%	99%	99%	99%	99%	98%	98%	99%
Significant Risk	**85%**	97%	97%	97%	96%	97%	98%	97%	97%	98%	97%	97%	98%
Low Risk	**75%**	95%	95%	95%	94%	95%	96%	96%	95%	96%	96%	95%	97%

Table 6

Cleaning scores have been maintained on the JCUH site (table 5). No areas failed C4C inspection in September 2019 on the James Cook site. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO.

As The frequency of cleaning standards review meetings have been increased from monthly to weekly continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital (table 7):

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	**98%**	99%	98%		98%
High Risk	**95%**			96%	95%
Significant Risk	**85%**	96%		96%	85%
Low Risk	**75%**	99%		95%	75%

Table 7

2. OUTBREAKS OF DIARRHOEA AND VOMITING

Diarrhoea & vomiting outbreaks	Annual total 18/19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Total 1920 to date
Total number	*1*	0	0	0	0	1	0	0	0	0	0	0	0	0
Total number of patients affected	*1*	0	0	0	0	1	0	0	0	0	0	0	0	0
Total number of staff affected	*12*	0	0	0	0	12	0	0	0	0	0	0	0	0

Table 8

There were no outbreaks of diarrhoea and vomiting in September 2019 (table 7).

3. OUTBREAK OF GES – CARBAPENEMASE-PRODUCING MULTI-DRUG-RESISTANT PSEUDOMONAS AERUGINOSA INFECTION IN ICU2/3, GHDU, WARDS 4 AND 24HDU AND OTHER AREAS

During September 2019, we have identified no further patients who have the *GES-carbapenemase-producing Pseudomonas aeruginosa* infection. We believe that this long-standing renal dialysis patient may have acquired colonisation with this organism several years ago, probably during the outbreak in 2014/2015.

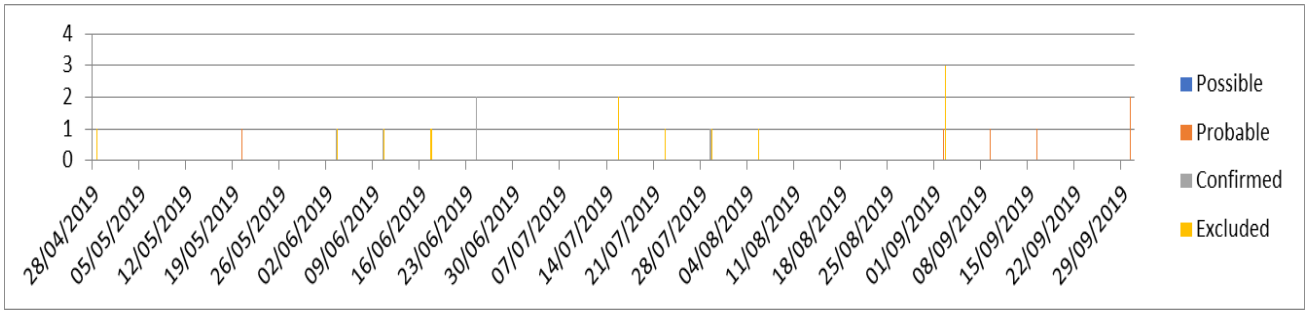
In total there have been 25 confirmed patients identified who are colonised or infected with a GES carbapenemase-producing strain of *Pseudomonas aeruginosa* in our trust since November 2014.

4. OXA-48-CARBAPENEMASE-PRODUCING KLEBSIELLA PNEUMONIAE

Acute trusts across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last year. In September 2019 we did not identify any further cases that carried the strain which has been linked to this cluster. We do not believe transmission has occurred unknowingly in our trust. An extensive contact screening programme has only identified one case.

5. OUTBREAK OF SERRATIA MARCESCENS WITHIN THE CARDIOTHORACIC SURGICAL SERVICE

In July we found that our surveillance system for potential clusters of gram negative bacteria had identified that 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*. Further investigations have determined (as of 22 October 2019) we have had a total of 5 patients who are confirmed as affected by the outbreak strain, 6 cases classed as 'probable' unless proven otherwise (awaiting strain typing) and 12 cases which have subsequently been found to be unlinked. The timeline of outbreak cases is shown in graph 3. Environmental sampling has identified *Serratia marcescens* from a sink area where there was damage to the wall behind the sink. The Cardiothoracic ICU, HDU and ward 32 have undergone a deep clean and hydrogen peroxide vapour clean and replacement of the contaminated sink. Several outbreak meetings have been held and a detailed action plan has been developed addressing potential influencing variables relating to clinical practice and the environment. The 'Dangers in Damp' awareness campaign commenced in September 2019.



Graph 3

6. OTHER CRITICAL CARE SURVEILLANCE

Isolation capacity for patients with infection continues to pose a challenge particularly on ICU2, ICU3 and Cardiothoracic ICU. Processes to mitigate risk of transmission of infection continue to be put in place including increased presence of the IPC team to support staff.

During September there were 29 datix reports submitted indicating occasions when we were unable to isolate patients due to the unavailability of side rooms (across the critical care footprint, including

specialist critical care units). When this occurs the critical care staff work with IPC staff ensure all risk reduction strategies are put in place. Effective use of aprons, gloves, gowns and other personal protective equipment, with the visual prompt of the PPE trolley displaying a 'STOP' sign alerting staff not to enter the bed space. Strict hand hygiene, equipment decontamination and any condition specific devices (e.g. faecal collector) are put in place.

An external architecture and healthcare planning specialist team have instigated a review of critical care facilities and will provide an options appraisal for increasing isolation facilities.

- In September 2019, we have not identified any cases of MRSA transmission of colonisation or infection on Critical Care.

- In September 2019, we had one case of HOHA *C. difficile* infection on Critical Care.

- In September 2019, 0 healthcare-onset cases of the three GNBSI organisms which are part of national surveillance have been identified in Critical Care.

- In September 2019, we found that two neurological HDU patients were colonised/infected with the same strain of Serratia marcescens, indicating transmission had probably occurred between them.

7. ENTEROBACTER CLOACAE ON NEONATAL UNIT

In July and August 2019 we identified 5 patients on the neonatal unit who were colonised or infected with *Enterobacter cloacae*. Strain typing has found that 3 patients (two of whom were twins) had the same strain and this same strain was also isolated from environmental samples. This suggests environmental transmission occurred. This outbreak has now been closed.

8. BACTERAEMIA DUE TO GLYCOPEPTIDE-RESISTANT ENTEROCOCCI ON WARD 33

In July 2019 we identified 3 patients on ward 33 (haematology) who had developed bacteraemia due to Glycopeptide-resistant *Enterococcus*. The most likely cause of the bacteraemias is infection of tunnelled central lines. Strain typing found that the cases are not linked. An outbreak meeting was held as a precautionary measure and a number of actions to minimise potential future risk to patients have been carried out. This outbreak has now been closed.

9. ENHANCED ACTIONS

In response to the recent outbreaks and incidence of *Clostridium difficile* a number of further actions have been implemented and/or agreed:

- Ecolab have undertaking an external review of hand hygiene compliance on the JCUH site, we are awaiting their report. Peer review assessment of cleaning has not yet been agreed.

- We have agreed to utilise measures to provide additional assurance of cleaning standards in augmented care areas using UV light and this commenced in September 2019.

- Develop a more collaborative approach with Serco in terms of education delivery and audits including hand hygiene and IPC and Serco joint monitoring in augmented care areas (this is a recent development and we will review effectiveness).

- Decant and deep clean of Ward 7 occurred in September and a review of the deep clean programme for 2019/20 is being performed.

- Weekly DIPC / Dep. DIPC Matron IPC huddles.

- As part of agreed contracts external suppliers are supporting with refresher training in relation to equipment cleaning and ANTT for clinical staff.

10. INFLUENZA REPORTING

National reporting of Influenza cases started week commencing 30 September 2019 focusing on critical care areas. All patients admitted to ICU/HDU with a laboratory-confirmed influenza result (A, H1, H3 or Novel) or B will be reported. If two influenza types are detected in the same patient, this will be reported as influenza A. In the month of September 2019, no cases of influenza were identified in the critical care areas.

<table>
<tr><td colspan="4">MEETING OF THE TRUST BOARD OF DIRECTORS – 5 November 2019</td></tr>
<tr><td colspan="3">Safe Staffing Report for September 2019 – Nursing and Midwifery</td><td>AGENDA ITEM:
10, ENC 5</td></tr>
<tr><td>Report Author and Job Title:</td><td>Eileen Aylott, Assistant Director of Nursing Education and Workforce</td><td>Responsible Director:</td><td>Gill Hunt, Director of Nursing and Quality</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☒ Inform ☒</td></tr>
<tr><td>Situation</td><td colspan="3">This report details nursing and midwifery staffing levels (planned versus actual) for the month of September 2019.</td></tr>
<tr><td>Background</td><td colspan="3">The requirement to publish nursing and midwifery staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).</td></tr>
<tr><td>Assessment</td><td colspan="3">The fill rate against planned rosters for the month of September 2019 at an overall level was:
RN / RM day shift 88.1% night shift 91.8%
HCSW day shift 96.1% night shift 109.1%</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board of Directors are asked to note the content of this report and to be assured that there are systems and process in place to ensure nursing and midwifery staffing levels are sufficient to deliver safe, high quality care.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3">BAF 5.1 Demographic changes and shifting cultural attitudes to careers, combined with employment market factors resulting in critical workforce gaps (such as Registered Nurses) in some clinical services</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="3">Care Quality Commission
NHS Improvement
NHS England</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td>Excellence in patient outcomes and experience ☒</td><td colspan="2">Excellence in employee experience ☒</td></tr>
<tr><td>Drive operational performance ☐</td><td colspan="2">Long term financial sustainability ☐</td></tr>
<tr><td>Develop clinical and commercial strategies ☐</td><td colspan="2"></td></tr>
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1. Executive Summary

South Tees Hospitals NHS Foundation Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses (RN), Midwives (RM) and Health Care Support Workers (HCSW), matches the acuity and dependency needs of patients within the organisation. To ensure there is an appropriate level and skill mix of staff to provide safe and effective high quality care.

The requirement to publish nursing and midwifery staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).

From April 2019 all staffing reports presented to the Board must comply with NHSI Workforce Safeguards and require a signed declaration by the Director of Nursing or appropriate Director for the staff group (s).

The fill rate against planned rosters for the month of September 2019 at an overall level was:

- RN / RM day shift 88.1% night shift 91.8%
- HCSW day shift 96.1% night shift 109.1%

2. Recommendation

The Board of Directors are asked to note the content of this report and to be assured that there are systems and process in place to ensure nursing and midwifery staffing levels are sufficient to deliver safe, high quality care.

Workforce Safeguard Compliance and Governance

Signature Gill Hunt Date 22 October 2019

Gill Hunt, Director of Nursing and Quality

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for September 2019 was submitted on 15th October 2019 with the summary of overall fill rate in the table below with the full report in Appendix 1.

Table 1 – Overall UNIFY Return fill Rate 2019

2019	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
January 2019	96.8%	94.0%	96.0%	106.4%
February 2019	93.7%	94.7%	94.3%	108.4%
March 2019	92.8%	91.2%	94.2%	106.6%
April 2019	94.2%	94.7%	95.8%	105.8%
May 2019	92.7%	92.3%	95.4%	110.3%
June 2019	92.1%	96.5%	95.6%	111.6%
July 2019	89.2%	90.9%	94.3%	107.6%
August 2019	89.3%	95.5%	93.8%	109.2%
September 2019	88.1%	96.1%	91.8%	109.1%

Centre Associate Directors of Nursing lead the twice daily SafeCare meetings Monday to Friday with Clinical Matrons providing weekend leadership in this area. Temporary staffing requirements are reviewed daily together with acuity, dependency and clinical judgement to ensure safe and efficient staffing.

Specialist Nurses, Critical Care Outreach and Corporate Nurses have all supported wards with complex patients and those with higher acuity and dependency but do not appear in the fill rate. Matrons provide oversight and assurance across their areas addressing red flags and supporting decision making.

Paediatric and Midwifery teams meet daily to review staffing across the floor and move staff accordingly. Unavailability is adjusted to meet the needs of the service with managers working clinically as required to maintain safe staffing. The Pediatric wards and NNU have been added to SafeCare to improve visibility.

Appendix 1. Details staffing fill rate by ward (i.e. planned versus actual), parenting and sickness percentage and a range of quality metrics by ward.

Further information in relation to wards with an RN fill rate of less than 80% is below:

1. Ward 9 Planned staffing was 4 RN, they have worked with 3 RN's as the RSU did not require the 4th RN due to patient acuity

2. OPM planned staffing for days were 5 RN; they have worked with 3 RN's taking into account bed occupancy an RN: patient ratio on average of 1:9 was maintained with 5 HCA.

3. Ward 34 planned staffing for days were 4 RN; they have worked with 3 with RNA support. Nights was planned to have 4 RN, they have worked with 2 RN's (nurse patient ratio 1: 13) A registered Nursing Associate also worked one 12 hour night shift

4. CICU had an average of 7 patients on the ward during the month.

5. Ward 26 planned staffing for days were 3 RN, they have worked with 2-3RN's for an average of 18 occupied beds (ratio 1-9)

6. PICU had average bed occupancy of 2 maintaining safe staffing in line with patient need.

7. Ainderby Ward planned staffing for days were 4 RN, they have worked with 3 RN for an average of 19 occupied beds (ratio 1:6) maintaining safe staffing. They also have one Registered Nursing Associate who worked 91 hours of days

8. Romanby ward planned staffing was 4RN, they have worked with 3 RN for an average of 20 occupied beds (ratio 1:7) maintaining safe staffing

9. Rutson Ward planned staffing for days were 3RN, they have worked with 3 RN in the am and 2RN in the pm for an average of 14 occupied beds maintaining safe staffing.

10. Tocketts Ward planned staffing for days was 5 RN and working with 3RN (1:8) nights was 3RN and working with 2 RN (ratio 1:12) for an average of 24 beds occupied.

11. Zetland Ward planned staffing for days was 6 RN's, they have worked with 4 or 5 RN's (ratio 1:6) for an average of 26 occupied beds maintaining safe staffing.

Maintaining the RN fill rate has been challenging during September with senior daily focus required. RN's have been deployed from other centres to ward 34 on a short/medium term basis.

Around 80 newly qualified RN's have joined the organisation in September and have begun their preceptorship period. During September there were 3237 supernumerary RN hours not captured in the fill rate.

Critical Care

Nurse staffing is monitored on a daily basis and reported on a weekly basis to ensure compliance with safe staffing. The rare occasion of non-compliance has been due to late sickness or late cancellation of temporary staff, all efforts are made to cover.

During September:

- General critical care: 7 shifts with 2 coordinators rather than 3 and 5 shifts with 1 Coordinator
- CICU: 2 shifts missing a coordinator
- CHDU: 1 shift missing a coordinator
- Neuro HDU: No gaps in staffing requirements

Stroke Ward (W28)

If safe staffing cannot be maintained and all other options have been exhausted the escalation policy includes an option to temporarily reduce capacity. Due to RN workforce shortages 6 beds were reduced on ward 28 in July and remained closed during August and September.

2. Temporary Staffing

The total number of hours requested for RN and HCA has increased during September by 4,000 hours with a 67% fill rate overall. Agency Nurses and dedicated NHSP staff have contributed to Critical care to give the trust flexibility and resilience with 267 hours of nursing agency worked across Critical Care (ITU/GHDU) and theatres.

Daily review of all shifts continues to take place during the morning SafeCare meeting with ADoN's to ensure both safe and efficient allocation of staff.

3. Red Flag Reporting

A total of 118 red flags have been reported during September. These are investigated by Clinical Matrons prior to the morning SafeCare meeting on a daily basis and action to address taken in real time. The predominant themes are Shortfall in RN time (59) and opening of 'amber' beds (40). Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Red flags September 2019	Column Labels				
Row Labels	Early	Late	Long Day	Night	Grand Total
AMBER Beds Open	14	12	4	10	40
Delay in providing pain relief	1			2	3
Less than 2 RNs on shift	3	1		2	6
Missed 'intentional rounding'	2	1			3
RED Beds Open	1	1	2	1	5
Shortfall in RN time	27	14	7	11	59
Unplanned omission in providing medications			1		1
Vital Signs not assessed or recorded	1				1
Grand Total	**49**	**29**	**14**	**26**	**118**

Amber beds are used as part of routine escalation during surge and are managed within planned staffing levels. The system alerts the matron to the opening of amber beds which

ensures the matron can support patient flow as required. No area would be left with less than 2 RN's and these red flags are immediately mitigated.

The system records 3 counts per day so an escalation bed may only be open for part of a day and then reclosed.

4. Redeployed staff

SafeCare gives the Trust the ability to redeploy staff from an area with excess hours to one which is short using the acuity and dependency calculation to support patient care and ensure effective use of resource. During the month of September a total of 1262 hours were redeployed across adult inpatient areas via SafeCare.

5. Care Hours Per Patient Day (CHPPD)

CHPPD is a national measurement recorded monthly through the UNIFY safe staffing report and is a Model Hospital metric. Triangulation between hours planned vs hours worked in this report should be considered with CHPPD and professional judgement to ensure areas have safe and efficient levels of staffing. The Model Hospital metric also provides the Trust with a peer review option to enable us to compare with hospitals of a similar size and complexity as well as the National trend.

The latest Trust results published on the Model Hospital website are from July 2019 and were 9.1 against a peer group median of 8.3 and a national median of 8.2.

6. Band 5 Vacancy Rate and Recruitment Activity

The Trust continues to actively recruit to all Band 5 RN/RM's posts and have interviewed Adult Student Nurses Qualifying in January /March 2020 on 7 October with a total of 53 offers made. International recruitment has successfully begun with NHSP to recruit a total of 50 Adult Registered Nurses from the Philippines and India, targeting nurses with skills and experience in both hard to recruit to areas and those areas with increased demand. A team travelled to the Philippines on 11 October to continue this campaign.

The first cohort of 5 RN's will arrive on 1 November and will be deployed to Ward 28 (Stroke), ITU, Ward 34 and OPM. A second cohort of 5/6 will arrive on 30 November and will be deployed to ITU, Ward 28 (Stroke), Anaesthetics and Recovery (JCUH) and possibly Ward 9.

Further cohorts are expected from 3 January 2020

7. Staff Retention

The retention work has begun with the Student nurses attending for interview and the October Preceptorship programme. They were asked why they chose South Tees as their first destination employer. HRBP's are telephoning the last 3 months RN/RM leavers to undertake qualitative exit interviews and focus groups will be held with staff who have been in post for 2 years plus asking them why they stay working for the Trust.

This data will formulate the N+M Retention plan focusing on 3-4 key areas for improvement and will inform a wider staff retention strategy.

8. Workforce Safeguards

Establishment reviews undertaken during June 2019 across adult inpatients, A+E, theatres and Paediatrics will be presented to the Workforce Committee in November 2019.

Eileen Aylott
Assistant Director of Nursing Workforce
October 2019

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Safe, sustainable and productive staffing in urgent and emergency care https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_urgent_and_emergency_care.pdf

South Tees Hospitals NHS
NHS Foundation Trust

Appendix 1 JCUH

James Cook		Hours																< 80	80-95	> 95						RN		HCA											
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Days	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Inpatient Falls	Formal complaints	Trust Aquired Grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
UEC	Critical Care	9,705.92	9,172.93	2,519.17	2,021.17	-	-	-	-	10,800.00	8,990.17	1,116.00	924.00	-	-	-	-	94.5%	80.2%	-	-	83.2%	82.8%	-	-	7.60%	6.40%	5.30%	9.90%			7		827	22.0	3.6	25.5
UEC	RAFAU	2,028.00	1,924.50	1,588.67	1,891.00	120.00	120.00	-	-	1,152.00	1,080.00	1,289.33	1,726.00	-	-	-	-	94.9%	119.0%	100.0%	-	93.8%	133.9%	-	-	3.50%	13.50%	5.10%	3.60%	10		1		815	3.7	4.4	8.1
SP&PL	JC06 Gastro	1,046.75	1,129.50	1,385.92	1,274.57	-	-	-	-	1,035.00	990.25	690.00	776.75	-	-	-	-	107.9%	92.0%	-	-	95.7%	112.6%	-	-		7.00%	4.00%	9.40%	4	1	3		723	2.9	2.8	5.8
COM	JC09 (Ward 9)	1,783.98	1,374.65	1,374.00	1,283.67	-	-	60.00	60.00	1,440.00	1,068.00	1,080.00	1,033.00	-	-	-	-	77.1%	93.4%	-	100.0%	74.2%	95.6%	-	-		3.20%		22.80%	4				766	3.2	3.0	6.2
COM	OPM (Older Persons Medicine)	1,810.65	1,183.57	2,155.30	1,944.97	-	-	-	-	1,080.00	984.00	1,080.67	1,374.00	-	-	-	-	65.4%	90.2%	-	-	91.1%	127.1%	-	-	14.70%	6.70%	5.60%	7.40%	5	1			814	2.7	4.1	6.7
COM	JC28 (Ward 28)	1,441.83	1,282.83	1,078.05	1,083.72	-	-	-	-	1,440.00	1,260.00	720.00	756.00	-	-	-	-	89.0%	100.5%	-	-	87.5%	105.0%	-	-	8.50%	1.30%	6.10%	6.40%	4	1			419	6.1	4.4	10.5
COM	Ward 3	1,383.17	1,303.17	1,730.42	2,258.33	-	-	-	-	1,037.92	1,009.33	683.00	1,352.77	-	-	-	-	94.2%	130.5%	-	-	97.2%	198.1%	-	-		6.30%	5.40%	11.50%	7		3		810	2.9	4.5	7.3
UEC	Short Stay (JC02)	1,800.00	1,806.00	1,434.00	1,393.33	-	-	-	-	1,440.00	1,140.00	1,080.00	1,119.98	-	-	-	-	100.3%	97.2%	-	-	79.2%	103.7%	-	-		1.10%		8.70%	6		1		763	3.9	3.3	7.2
3	Ward 5 Surgery	2,160.00	1,890.00	1,800.00	1,640.17	-	-	-	-	1,080.00	1,043.83	1,071.25	1,059.65	-	-	-	-	87.5%	91.1%	-	-	96.7%	98.9%	-	-		6.90%	6.20%	5.10%					769	3.8	3.5	7.3
SP&PL	JC35 (Ward 35)	1,078.25	1,263.17	1,438.50	1,195.25	-	-	-	-	713.25	821.25	727.27	757.50	-	-	-	-	117.1%	83.1%	-	-	115.1%	104.2%	-	-	11.10%	2.90%		24.70%	2				586	3.6	3.3	6.9
SP&PL	JC31 Vas	1,080.67	1,332.75	1,312.75	1,230.42	84.00	84.00	48.00	48.00	720.00	720.00	600.00	595.33	72.00	72.00	48.00	48.00	123.3%	93.7%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	19.60%			8.90%	4				516	4.0	3.5	7.5
SP&PL	Ward 7 Colo	1,804.83	1,496.33	1,800.00	1,725.25	-	-	-	-	1,080.67	1,044.50	720.00	1,082.18	-	-	-	-	82.9%	95.8%	-	-	96.7%	150.3%	-	-	6.30%	5.30%		3.70%	7	1	1		702	3.6	4.0	7.6
SP&PL	JC04 (Ward 4)	1,581.00	1,325.17	1,056.25	1,100.92	-	-	-	-	1,072.33	852.00	720.00	904.17	-	-	-	-	83.8%	104.2%	-	-	79.5%	125.6%	-	-		17.70%	17.80%	11.80%	1		1		648	3.4	3.1	6.5
SP&PL	JC14 Oncology (Ward 14)	1,799.83	1,541.00	951.83	1,098.00	-	-	120.00	120.00	1,080.00	1,031.83	720.00	808.00	-	-	-	-	85.6%	115.4%	-	100.0%	95.5%	112.2%	-	-	4.80%	7.00%	7.70%	1.10%	2		2		669	3.8	2.8	6.7
SP&PL	JC33 Specialty (merger of ward 18 and ward 27)	1,438.00	1,254.83	1,329.83	1,175.33	-	-	96.00	96.00	1,079.50	1,007.67	709.33	871.17	-	-	-	-	87.3%	88.4%	-	100.0%	93.3%	122.8%	-	-		4.60%	3.20%	4.30%	1				550	4.1	3.7	7.8
SP&PL	JC34 (Ward 34)	1,348.98	1,031.90	2,144.67	1,801.50	96.00	96.00	-	-	1,080.00	804.00	1,428.00	1,624.67	12.00	12.00	-	-	76.5%	84.0%	100.0%	-	74.4%	113.8%	100.0%	-	6.20%	9.10%		11.40%	6		2		796	2.3	4.3	6.6
SP&PL	JC25 Elective Ortho	1,040.68	825.52	1,038.00	1,091.42	-	-	-	-	692.00	680.50	345.00	368.67	-	-	-	-	79.3%	105.1%	-	-	98.3%	106.9%	-	-	12.80%	2.60%	8.80%			1			585	2.6	2.5	5.1
SP&PL	JC36 Trauma	1,799.33	1,486.67	1,791.67	1,618.17	-	-	-	-	1,082.00	1,009.00	1,084.33	1,271.67	-	-	-	-	82.6%	90.3%	-	-	93.3%	117.3%	-	-	5.60%	2.70%	5.30%	4.90%	3		3		950	2.6	3.0	5.7
SP&PL	Spinal Injuries	2,055.03	1,865.72	1,873.77	1,770.23	-	-	-	-	1,440.00	1,295.58	1,080.00	1,041.33	-	-	-	-	90.8%	94.5%	-	-	90.0%	96.4%	-	-	13.30%	10.10%	4.90%	3.70%					488	6.5	5.8	12.2
SP&PL	Cardio MB	720.00	720.00	359.67	323.67	-	-	-	-	720.00	720.00	0.00	0.00	-	-	-	-	100.0%	90.0%	-	-	100.0%	-	-	-		7.50%		7.40%					240	6.0	1.3	7.3
SP&PL	CCU JCUH	2,568.00	1,992.33	360.00	477.33	-	-	-	-	1,800.00	1,776.00	0.00	16.98	-	-	-	-	77.6%	132.6%	-	-	98.7%	-	-	-	3.20%	5.20%			2				263	14.3	1.9	16.2
UEC	CICU JCUH	3,834.17	2,886.33	1,201.50	718.50	-	-	-	-	3,468.00	2,915.92	720.00	408.00	-	-	-	-	75.3%	59.8%	-	-	84.1%	56.7%	-	-	3.40%	9.80%	8.20%	1.80%			2		208	27.9	5.4	33.3
SP&PL	JC24 (Ward 24)	1,438.75	1,337.25	1,027.50	1,356.50	-	-	120.00	120.00	1,080.00	1,044.00	720.00	1,066.67	-	-	-	-	92.9%	132.0%	-	100.0%	96.7%	148.1%	-	-	3.20%	4.30%		9.00%	8	1			654	3.6	3.7	7.3
SP&PL	JC27 Neuro	1,392.42	1,424.25	1,106.67	1,176.38	-	-	-	-	720.00	721.00	924.00	1,017.92	-	-	-	-	102.3%	106.3%	-	-	100.1%	110.2%	-	-		1.40%		4.10%	2				424	5.1	5.2	10.2
SP&PL	JC26 (Ward 26)	1,096.92	863.25	720.00	1,164.00	-	-	-	-	720.00	720.00	360.00	703.65	-	-	-	-	78.7%	161.7%	-	-	100.0%	195.5%	-	-	8.20%	8.80%		4.30%					529	3.0	3.5	6.5
SP&PL	JC29 (Ward 29)	1,344.00	1,236.00	1,079.33	1,049.50	96.00	96.00	-	-	1,080.00	996.00	720.00	732.00	-	-	-	-	92.0%	97.2%	100.0%	-	92.2%	101.7%	-	-		5.00%	9.10%	1.00%	1				714	3.1	2.5	5.6
2	JCCT (Ward 32)	1,569.75	1,512.50	1,205.67	1,163.67	-	-	-	-	1,079.83	755.83	719.33	886.33	-	-	-	-	96.4%	96.5%	-	-	70.0%	123.2%	-	-	12.10%	11.60%		5.40%					621	3.7	3.3	7.0
UEC	Cardio HDU	2,015.92	1,833.08	294.00	282.00	-	-	66.00	66.00	1,632.00	1,404.00	336.00	348.00	-	-	24.00	24.00	90.9%	95.9%	-	100.0%	86.0%	103.6%	-	100.0%	3.40%	1.80%							219	14.8	2.9	17.7
SP&PL	Ward 8	1,802.92	1,600.58	1,799.83	1,618.33	-	-	-	-	1,080.00	1,068.00	720.00	1,027.42	-	-	-	-	88.8%	89.9%	-	-	98.9%	142.7%	-	-	4.40%	1.40%		5.90%	2		2		886	3.0	3.0	6.0
UEC	JC24 HDU	1,441.98	1,393.32	359.83	401.67	-	-	-	-	1,440.00	1,431.50	360.00	420.00	-	-	-	-	96.6%	111.6%	-	-	99.4%	116.7%	-	-	2.00%	6.30%							175	16.1	4.7	20.8
COM	JC21 (Ward 21)	2,160.00	1,768.50	562.50	540.00	-	-	-	-	2,160.00	1,740.00	360.00	348.00	-	-	-	-	81.9%	96.0%	-	-	80.6%	96.7%	-	-	3.30%	1.50%	12.10%						459	7.6	1.9	9.6
COM	JC22 (Ward 22)	1,077.50	1,088.00	553.50	535.50	-	-	-	-	972.00	972.00	108.00	105.50	-	-	-	-	101.9%	96.7%	-	-	100.0%	97.7%	-	-		7.10%		1.50%					288	7.2	2.2	9.4
COM	JCDS (Central Delivery Suite)	3,597.33	3,521.08	1,086.00	764.50	-	-	-	-	3,953.02	3,622.02	732.03	664.53	-	-	-	-	97.9%	70.4%	-	-	91.6%	90.8%	-	-	3.00%	5.20%		11.50%					602	11.9	2.4	14.2
COM	Neonatal Unit	5,557.50	4,593.50	360.00	204.00	-	-	-	-	5,040.00	4,417.00	0.00	108.00	-	-	-	-	82.7%	56.7%	-	-	87.6%	-	-	-	7.70%	11.20%	20.10%	19.20%					649	13.9	0.5	14.4
COM	Paediatric Intensive Care Unit (PICU)	1,800.00	1,331.50	225.00	188.50	-	-	-	-	1,800.00	1,344.00	0.00	0.00	-	-	-	-	74.0%	83.8%	-	-	74.7%	-	-	-	3.40%	8.40%							59	45.3	3.2	48.5
COM	Ward 17 JCUH	2,159.33	1,964.33	1,067.00	911.00	-	-	-	-	1,440.00	1,452.50	1,064.50	873.00	-	-	-	-	91.0%	85.4%	-	-	100.9%	82.0%	-	-	16.10%	4.10%	6.40%	6.40%					699	4.9	2.6	7.4
COM	Ward 19 Ante Natal	1,204.50	940.30	300.00	246.00	-	-	-	-	719.83	671.83	0.00	0.00	-	-	-	-	78.1%	-	-	-	93.3%	-	-	-		6.70%							247	6.5	1.0	7.5
																	Site average	89.7%	97.5%	100.0%	100.0%	91.6%	114.7%	100.0%	100.0%												

	FHN	Hours																< 80	80-95	> 95					Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
UEC	Ainderby FHN	1,229.00	988.00	1,010.08	1,154.08	132.00	132.00	-	-	690.00	690.00	690.33	724.83	-	-	-	-	80.4%	114.3%	100.0%	-	100.0%	105.0%	-	-	16.3%	0.5%		3.0%	1.6%		1.1%	22.6%	13.3%	1.8%		11.8%	0.5%	0.3%		27.7%	591	2.84	3.18	6.02
UEC	Romanby FHN	1,550.48	1,135.82	1,099.23	1,200.25	-	-	-	-	690.00	690.00	690.00	828.00	-	-	-	-	73.3%	109.2%	-	-	100.0%	120.0%	-	-	16.3%		1.7%	6.0%	0.3%		5.1%	29.4%	14.1%	0.3%		8.6%			3.5%	26.5%	590	3.09	3.44	6.53
COM	Rulson FHN	1,112.48	834.98	1,562.33	1,170.88	-	-	-	-	690.00	690.00	690.00	747.50	-	-	-	-	75.1%	74.9%	-	-	100.0%	108.3%	-	-	15.2%		8.9%	0.5%	1.5%		6.1%	32.1%	16.8%			2.0%	0.5%		6.2%	25.5%	418	3.65	4.59	8.24
SP&PL	Gara Orthopaedic FHN	806.73	753.83	710.00	641.98	-	-	-	-	684.83	652.33	345.00	346.00	-	-	-	-	93.4%	90.4%	-	-	95.3%	100.3%	-	-	20.1%	1.0%	0.4%	5.0%	1.4%		6.8%	34.5%	17.8%	0.6%		6.2%	0.7%			25.3%	331	4.25	2.98	7.23
COM	Maternity FHN	1,069.33	973.50	289.50	289.50	-	-	-	-	732.00	675.50	0.00	37.50	-	-	-	-	91.0%	100.0%	-	-	92.3%	-	-	-	10.6%	0.1%	7.1%	1.1%	4.8%			23.6%	6.6%							6.6%	20	82.45	16.35	98.80
																	Site Average	82.6%	97.8%	100.0%	-	97.5%	108.4%	-	-																				

	East Cleveland	Hours								< 80	80-95	> 95		Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
COM	Tocketts Ward East Cleveland Hospital	1,764.00	972.00	2,391.50	1,826.98	1,040.73	817.50	1,710.42	1,462.17	55.1%	76.4%	78.6%	85.5%	17.3%			8.5%	2.0%		10.8%	38.6%	14.0%	1.3%		9.2%	1.2%		3.5%	29.1%	735	2.43	4.48	6.91
									Site Average	55.1%	76.4%	78.6%	85.5%																			

	Redcar	Hours																< 80	80-95	> 95						Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives /Nurses	Care Staff	Overall
COM	Zetland	2,175.75	1,398.25	3,067.50	2,485.83	-	-	24.00	24.00	1,080.00	1,020.00	1,080.00	1,068.00	-	-	-	-	64.3%	81.0%	-	100.0%	94.4%	98.9%	-	-	14.7%	0.3%		10.7%	0.1%		7.6%	33.4%	15.7%	0.7%	3.4%	9.0%	0.9%		1.2%	30.8%	781	3.10	4.55	7.65
																	Site Average	64.3%	81.0%	-	100.0%	94.4%	98.9%	-	-																				

	Friary Community Hospital	Hours																< 80	80-95	> 95						Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
COM	Friary Community Hospital	958.75	920.75	1,301.63	1,136.08	-	-	32.50	32.50	600.75	601.75	606.00	566.00	-	-	-	-	96.0%	87.3%	-	100.0%	100.2%	93.4%	-	-	14.8%			0.8%	0.6%		5.6%	21.8%	13.1%	0.2%		4.1%	1.1%		6.6%	25.1%	379	4.02	4.49	8.51
																	Site Average	96.0%	87.3%	-	100.0%	100.2%	93.4%	-	-																				

	James Cook	Hours								< 80	80-95	> 95		Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
UEC	AMU JCUH	2,160.00	2,126.67	1,427.83	1,453.33	1,800.00	1,692.00	1,620.00	1,578.02	98.5%	101.8%	94.0%	97.4%	12.1%	1.0%	8.5%	7.6%	0.7%	0.2%	5.8%	36.1%	12.2%		4.7%	7.9%	0.5%		4.8%	30.2%	678	5.63	4.47	10.10
UEC	AAU JCUH	2,874.00	2,759.33	1,692.00	1,569.83	1,800.00	1,752.00	1,080.00	1,147.33	96.0%	92.8%	97.3%	106.2%	13.5%		7.5%	3.9%	1.0%		0.7%	26.7%	16.8%			5.7%	1.6%		0.7%	24.8%	574	7.86	4.73	12.59
COM	Mat Assessment Unit	1,332.00	1,299.00	270.00	238.00	864.00	768.00	0.00	0.00	97.5%	88.1%	88.9%	-	14.6%	3.0%	7.7%	2.0%	4.3%		3.8%	35.4%	32.1%			2.9%				35.0%	35	59.06	6.80	65.86
	FHN																															
UEC	Clinical Decisions Unit FHN	1,722.08	1,568.58	1,024.50	1,029.75	1,035.00	946.50	690.67	667.50	91.1%	100.5%	91.4%	96.6%	12.7%		4.7%	1.6%	1.1%	0.6%	1.6%	22.2%	14.7%			8.5%	2.5%	0.2%	5.0%	30.8%	451	5.58	3.76	9.34

	< 80	80-95	> 95	
	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
Trust Average				
Community Care	83.1%	88.2%	90.2%	106.6%
Specialist & Planned Care	91.8%	101.6%	93.6%	120.1%
Urgent and Emergency Care	90.2%	98.4%	91.7%	100.7%
Trust Average	88.3%	96.1%	91.8%	109.1%

South Tees Hospitals
NHS Foundation Trust

Quality, Operational & Finance Performance Report

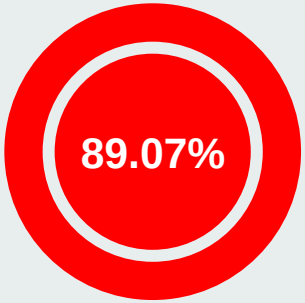
October 2019

Must Do’s

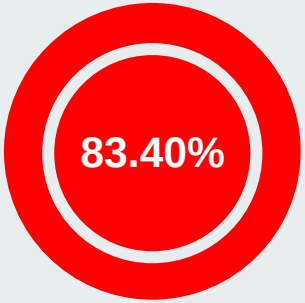
Must Do's 2019/20 – September 2019

Deliver Excellence in Patient Outcome and Experience….

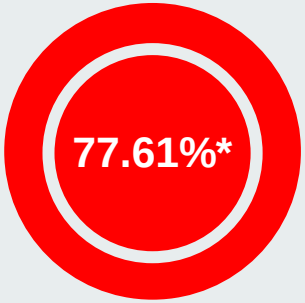
A&E
4hr Target



RTT
18 Week Target



Cancer
62 Day Target



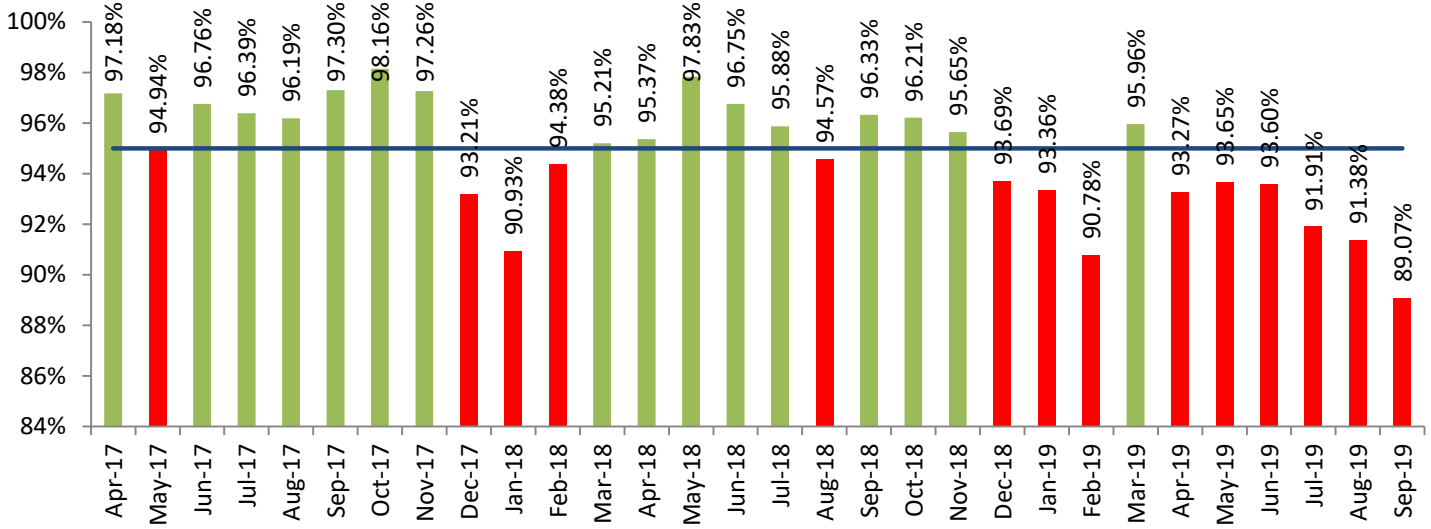
* Indicative

CDiff
HCAI Threshold

Operating Surplus

…and ensure our long term financial sustainability

Performance - A&E



95% TARGET

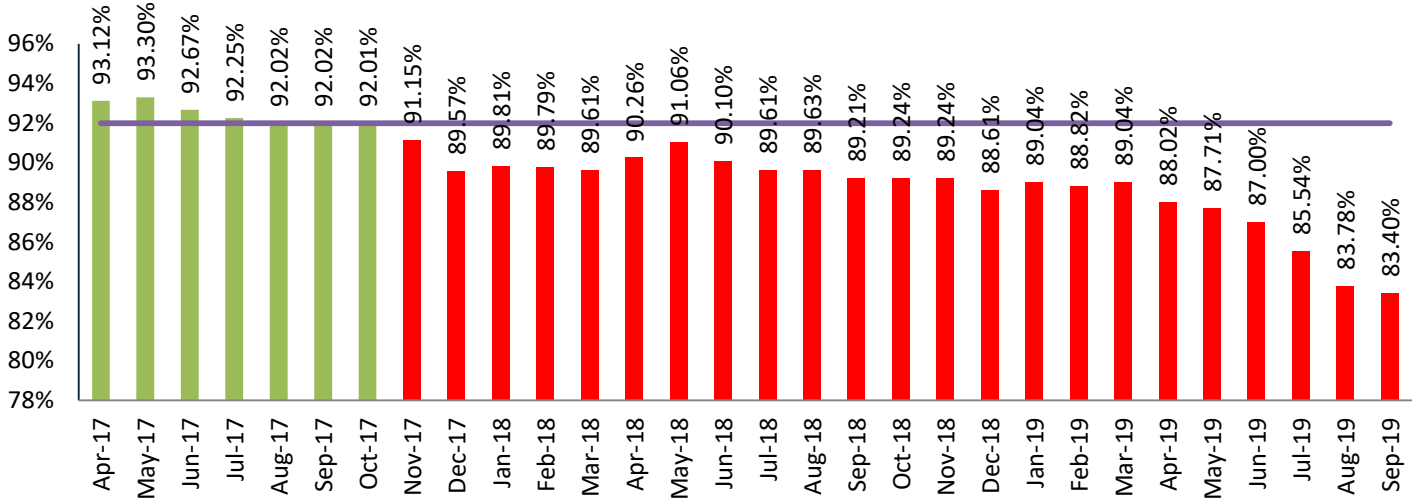
Sept 19
89.07%

Oct to date (at 21/10/19)
86.33%

Regional Rank	Trust	Sep-19
1	Northumbria Healthcare NHS Foundation Trust	95.39%
2	Harrogate and District NHS Foundation Trust	93.99%
3	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93.11%
4	Gateshead Health NHS Foundation Trust	91.02%
5	**South Tees Hospitals NHS Foundation Trust**	**89.07%**
6	South Tyneside And Sunderland NHS Foundation Trust	85.01%
7	North Cumbria University Hospitals NHS Trust	82.07%
8	County Durham and Darlington NHS Foundation Trust	79.35%
9	York Teaching Hospitals NHS Foundation Trust	78.13%
-	North Tees and Hartlepool NHS Foundation Trust	-
	ENGLAND	**85.39%**

Sept 19
Ranked 5th in the region

Referral to Treat



92%
TARGET

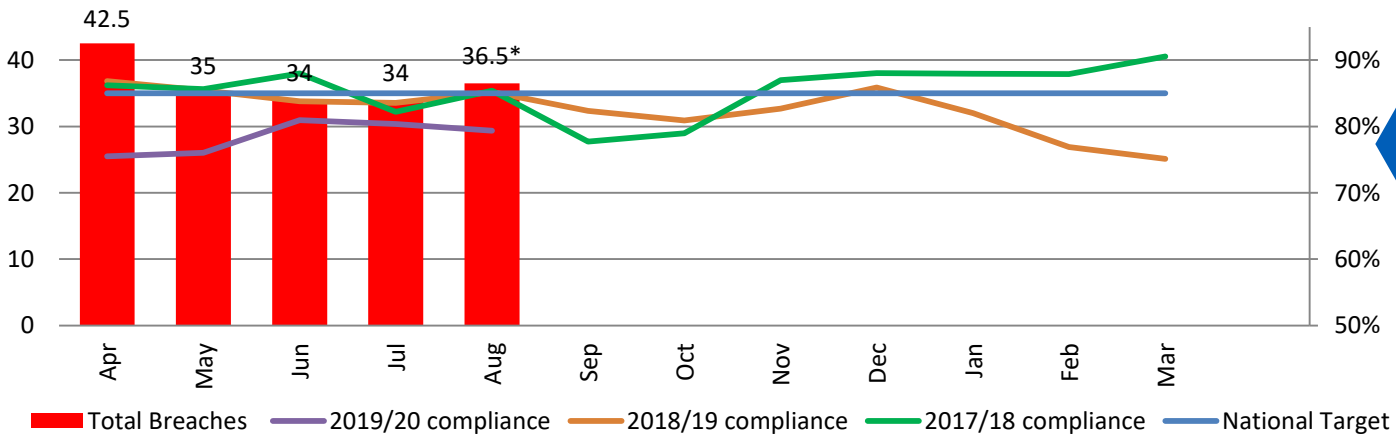
Sept 19

83.40%

Regional Rank	Trust	Aug-19
1	North Tees and Hartlepool NHS Foundation Trust	92.82%
2	Gateshead Health NHS Foundation Trust	92.26%
3	South Tyneside And Sunderland NHS Foundation Trust	92.15%
4	Northumbria Healthcare NHS Foundation Trust	91.71%
5	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	90.60%
6	County Durham and Darlington NHS Foundation Trust	89.73%
7	**South Tees Hospitals NHS Foundation Trust**	**83.78%**
8	York Teaching Hospital	76.66%
9	North Cumbria University Hospitals NHS Trust	70.80%
10	Harrogate and District NHS Foundation Trust	-
	ENGLAND	**84.98%**

Aug 19
Ranked 7th in the region

Performance – 62 Day Cancer Standard



% compliance and number of breaches

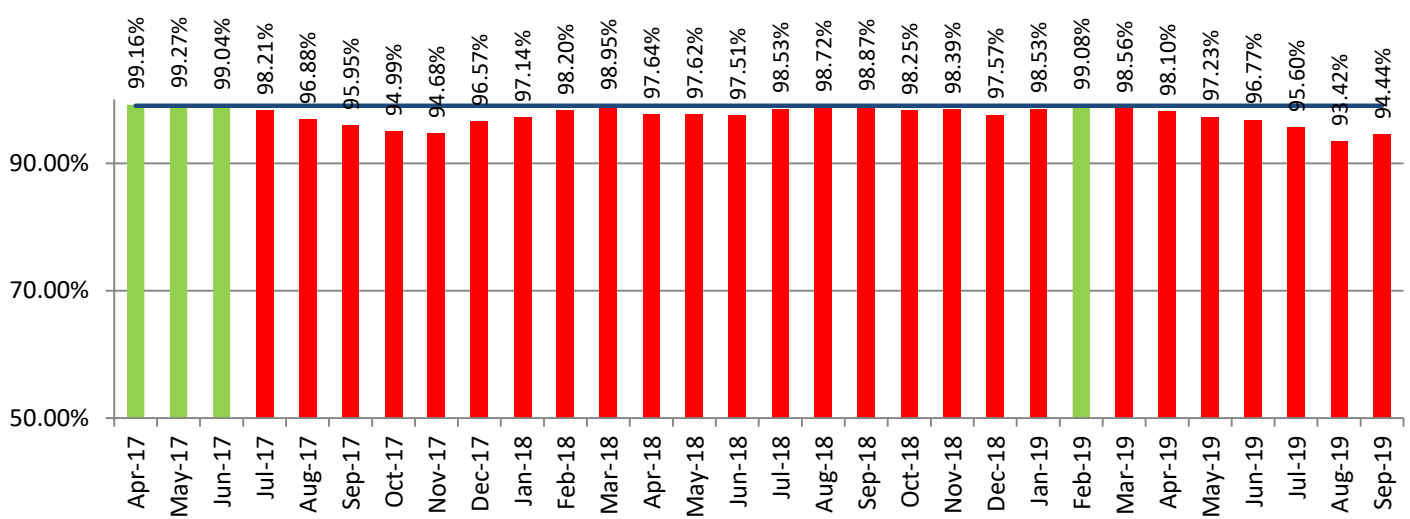
*** Indicative**

Mar 19	Apr 19	May 19	Jun 19	Jul19	Aug 19	Sep 19*
75.57%	75.50%	76.30%	80.95%	80.35%	80.41%	77.61%

Regional Rank	Trust	Aug-19
1	Northumbria Healthcare NHS Foundation Trust	87.43%
2	County Durham and Darlington NHS Foundation Trust	86.07%
3	South Tyneside and Sunderland NHS Foundation Trust	85.57%
4	North Tees and Hartlepool NHS Foundation Trust	82.35%
5	North Cumbria University Hospitals NHS Trust	81.21%
6	York Teaching Hospitals NHS Foundation Trust	80.66%
7	**South Tees Hospitals NHS Foundation Trust**	**80.41%**
8	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	80.24%
9	Harrogate and District NHS Foundation Trust	77.19%
11	Gateshead Health NHS Foundation Trust	74.60%
	ENGLAND	**78.51%**

Aug 19 Ranked 7th in the region

6 Week Diagnostic



99% TARGET

Sept 19

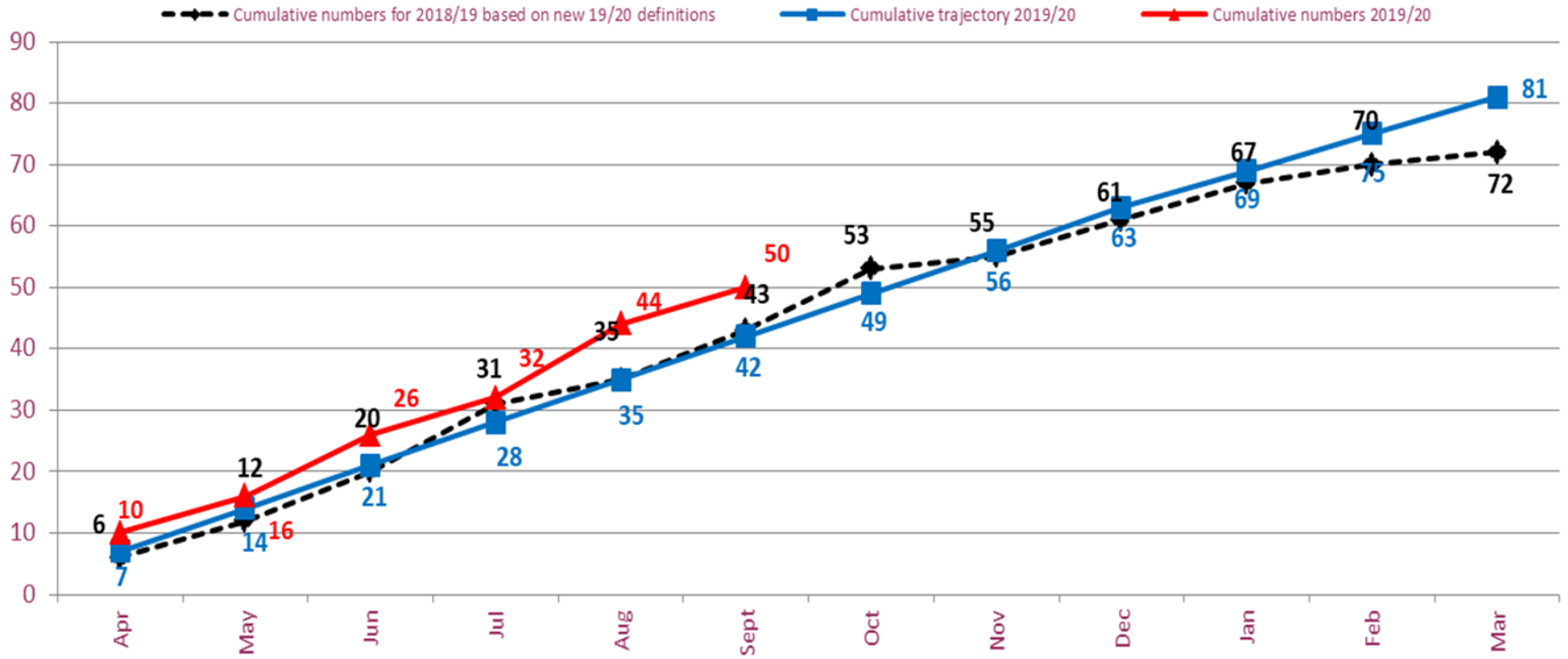
94.44%

6 Week Diagnostic Performance (Target 99%)	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Magnetic Resonance Imaging	99.73%	99.29%	99.19%	98.65%	99.69%	99.75%	99.83%	99.64%	98.81%	99.78%	99.96%	99.73%
Computed Tomography	99.93%	100.00%	100.00%	100.00%	99.79%	99.92%	99.85%	99.94%	99.93%	99.93%	99.80%	99.93%
Non-obstetric ultrasound	96.57%	97.21%	95.71%	100.00%	100.00%	100.00%	100.00%	99.90%	99.97%	99.90%	99.92%	99.97%
Barium Enema												
DEXA Scan	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology Assessments	99.55%	99.77%	99.74%	99.77%	98.55%	98.83%	96.22%	98.11%	97.99%	94.86%	88.51%	87.10%
Cardiology - echocardiography	94.59%	87.50%	76.00%	100.00%	92.50%	93.62%	92.31%	88.24%	69.70%	83.78%	97.62%	96.88%
Cardiology - electrophysiology												
Neurophysiology	100.00%	99.35%	97.29%	83.07%	95.21%	91.30%	84.09%	70.74%	72.06%	70.64%	66.53%	73.38%
Sleep studies	56.25%	70.59%	54.55%	65.38%	67.31%	50.00%	44.44%	14.29%	22.64%	34.92%	40.00%	49.06%
Urodynamics - pressures & flows	95.45%	61.54%	66.67%	65.63%	47.37%	18.52%	48.00%	52.08%	73.91%	79.07%	85.29%	70.45%
Gastro - Colonoscopy	100.00%	100.00%	100.00%	100.00%	98.41%	94.30%	93.75%	94.86%	89.72%	71.53%	62.66%	64.38%
Gastro - Flexi sigmoidoscopy	100.00%	100.00%	100.00%	100.00%	96.77%	94.12%	92.75%	89.47%	91.49%	74.38%	60.63%	69.51%
Urology - Cystoscopy	95.93%	94.44%	96.77%	96.17%	95.95%	97.18%	100.00%	94.62%	96.07%	96.83%	92.68%	91.84%
Gastroscopy	99.46%	100.00%	100.00%	100.00%	98.32%	95.95%	96.48%	98.11%	90.87%	88.85%	77.52%	83.81%
Trust Total	98.25%	98.39%	97.57%	98.53%	99.08%	98.56%	98.10%	97.23%	96.77%	95.60%	93.42%	94.44%

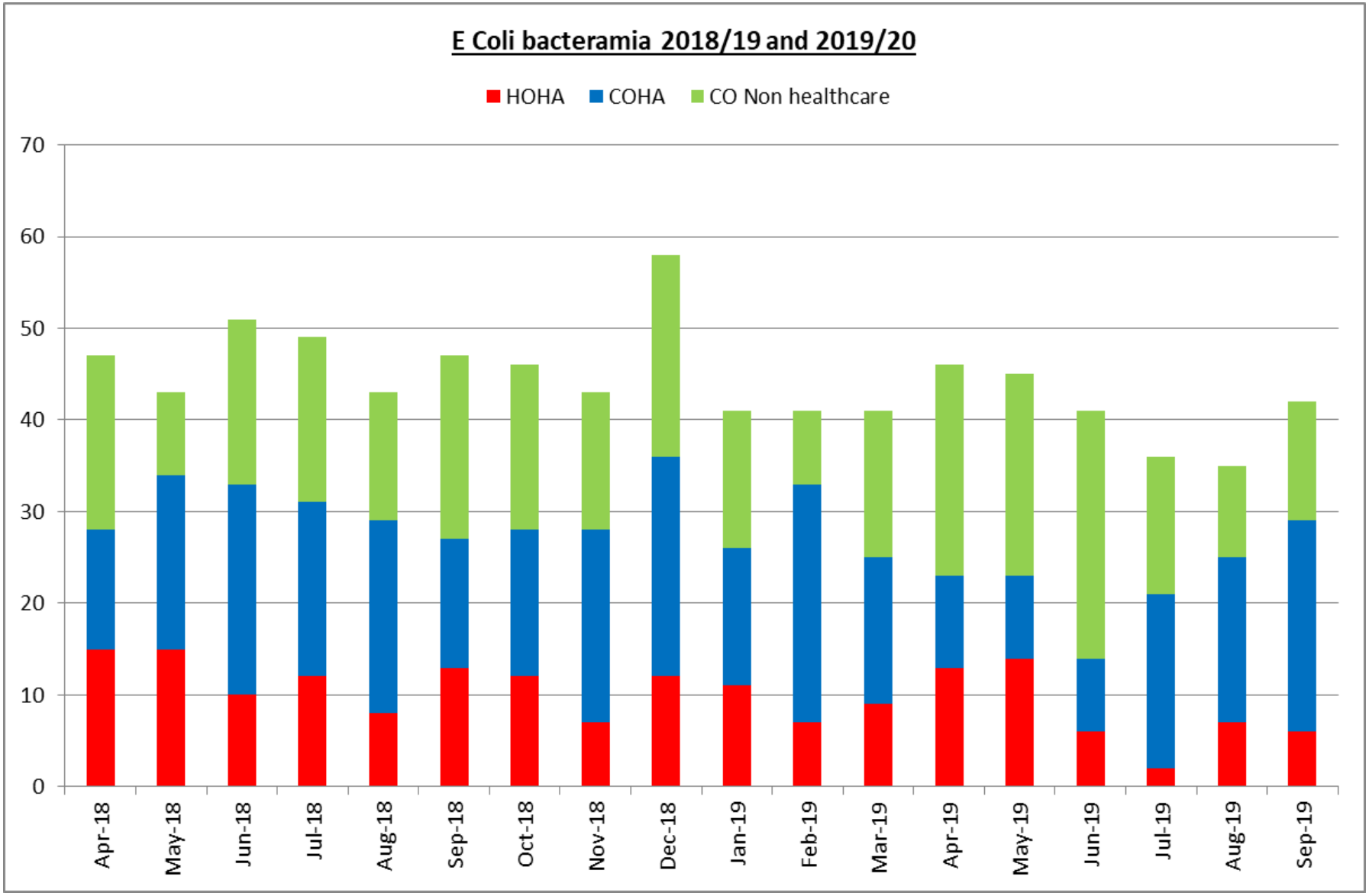
Operational Management

2

Clostridium difficile cases - April 2019 to March 2020



Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
JC34 (HOHA)	JC02 (COHA)	ITU3 (HOHA)	Ward 7 (COHA)	Ward 6 (COHA)	JITU2 (HOHA)						
JCSSU (HOHA)	Gara (HOHA	GHDU (HOHA)	Ward 5 (COHA)	Gara (COHA)	Friary (HOHA)						
JC33 (COHA)	JC10 (COHA)	Victoria (HOHA)	Ward 37 (HOHA)	Ward 34 (HOHA)	Ward 6 (HOHA)						
FHCDU (COHA)	ZET (HOHA)	Ward 10 (HOHA)	Romanby (COHA)	Ward 5 (HOHA)	Ward 7 (HOHA)						
RAFAU (COHA)	JCITU2 (HOHA)	Ward 7 (HOHA)	Ward 7 (HOHA)	Ward 27 (HOHA)	Ward 14 (HOHA)						
JC37 (COHA)	JC03 (COHA)	Ward 36 (HOHA)	Ward 7 (HOHA)	Ward 29 (COHA)	Ward 14 (COHA)						
RAFAU (HOHA)		Romanby (HOHA)		Rutson (HOHA)							
JC09 (HOHA)		Ward 7 (HOHA)		RAFAU (HOHA)							
JCCT (COHA)		Ward 27 (HOHA)		RAFAU (HOHA)							
RAFAU (COHA)		Ward 25 (HOHA)		Ward 37 (HOHA)							
				Ward 37 (COHA)							
				Ward 6 (HOHA)							


E Coli bacteramia 2018/19 and 2019/20
HOHA
COHA
CO Non healthcare
70
60
50
40
30
20
10
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
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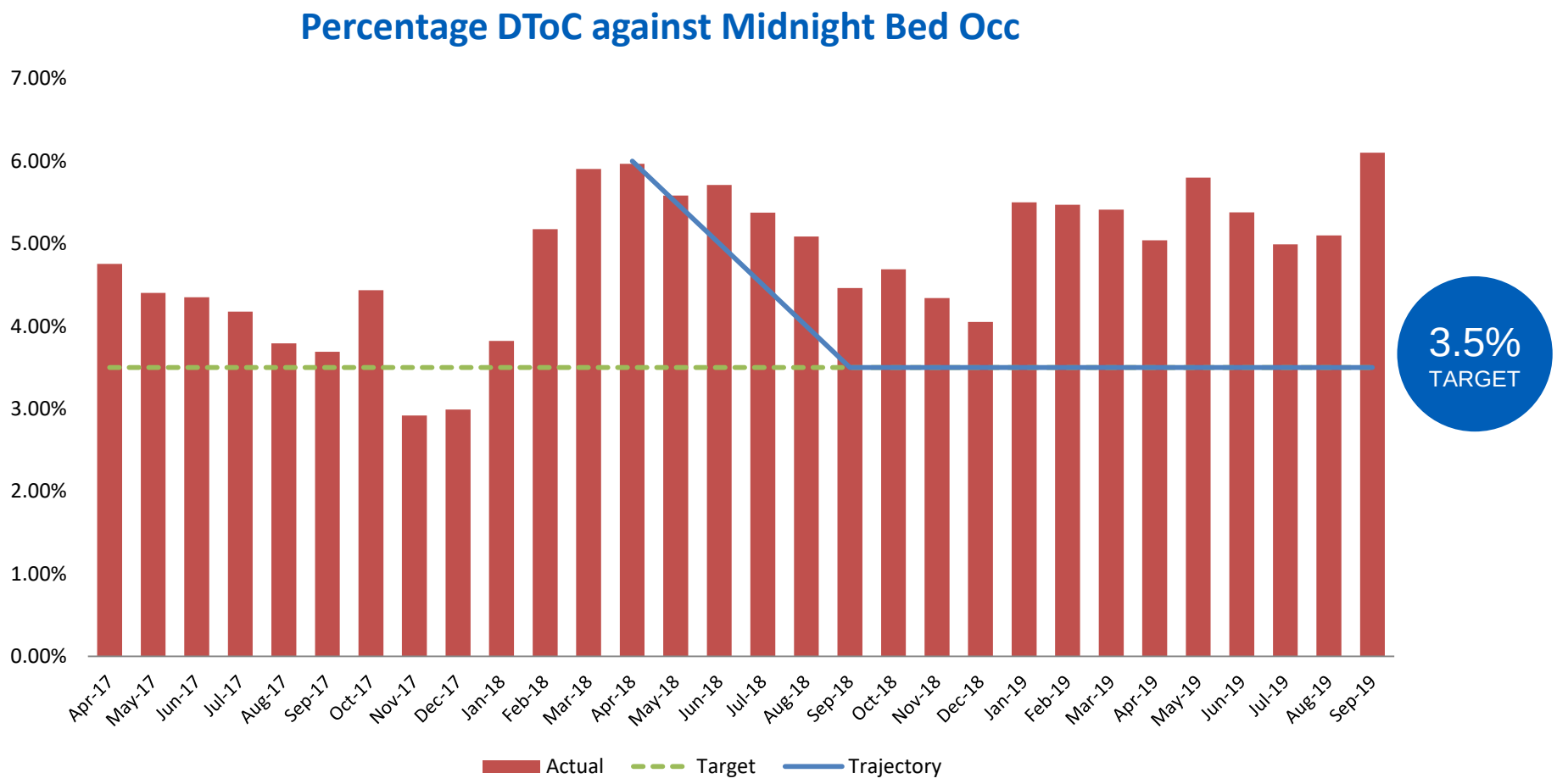
Jun-19
Jul-19
Aug-19
Sep-19

Delayed Transfer of Care (DToC)



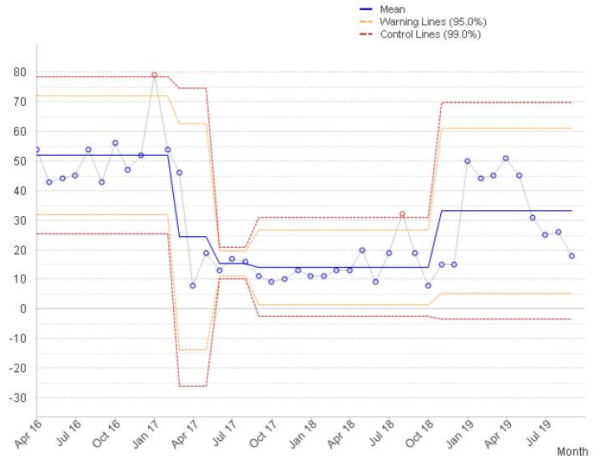
September 2019 – 6.10% Bed Occupancy

Patient Outcome and Experience

3

Delivering Safe Care 19/20

New or deteriorating category 2 pressure ulcers September 2019



Inpatient rate is 2.0 per 1000 bed days.

26 community category 2 pressure ulcers

Falls September 2019

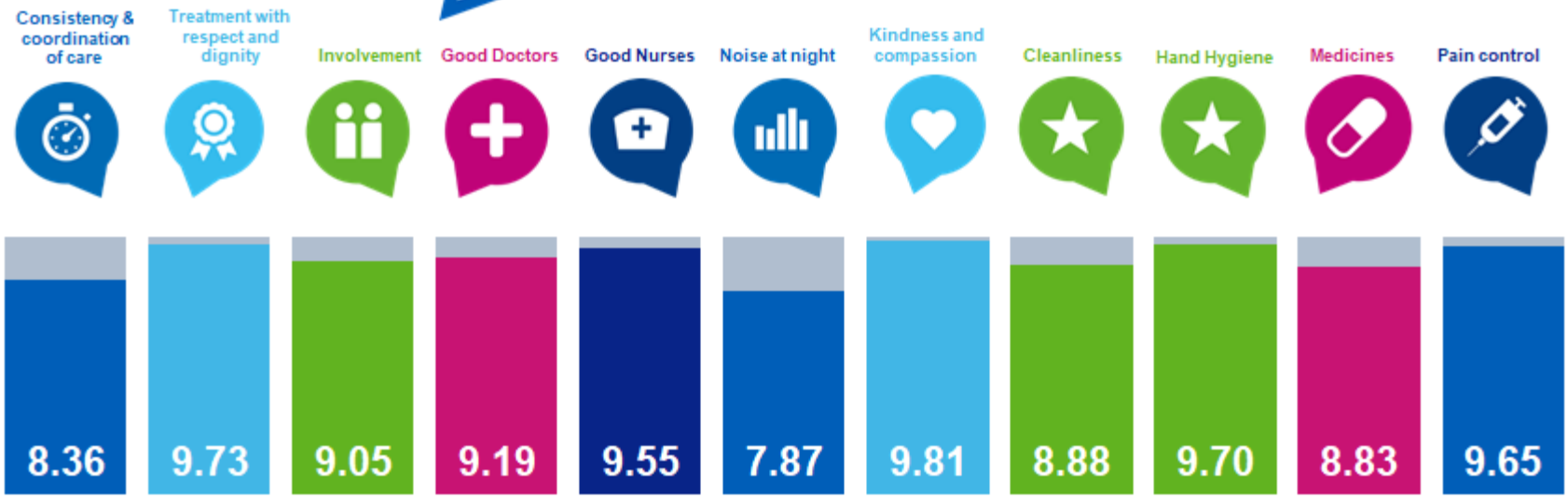
Rate 5.9 per 1000 bed days.

Continued Focus on Refreshed Pressure Ulcer Prevention Strategies

Patient Experience

NHS
South Tees Hospitals
NHS Foundation Trust

How do patients rate us out of 10…?



In September 2019 patients gave us an overall rating of... **9.04 out of 10**

% of patients surveyed would highly likely or likely recommend this ward to their families and friends	99%	No of patients on new medication	350	No of respondents	684

Incidents Reported as Serious Incidents in September 19

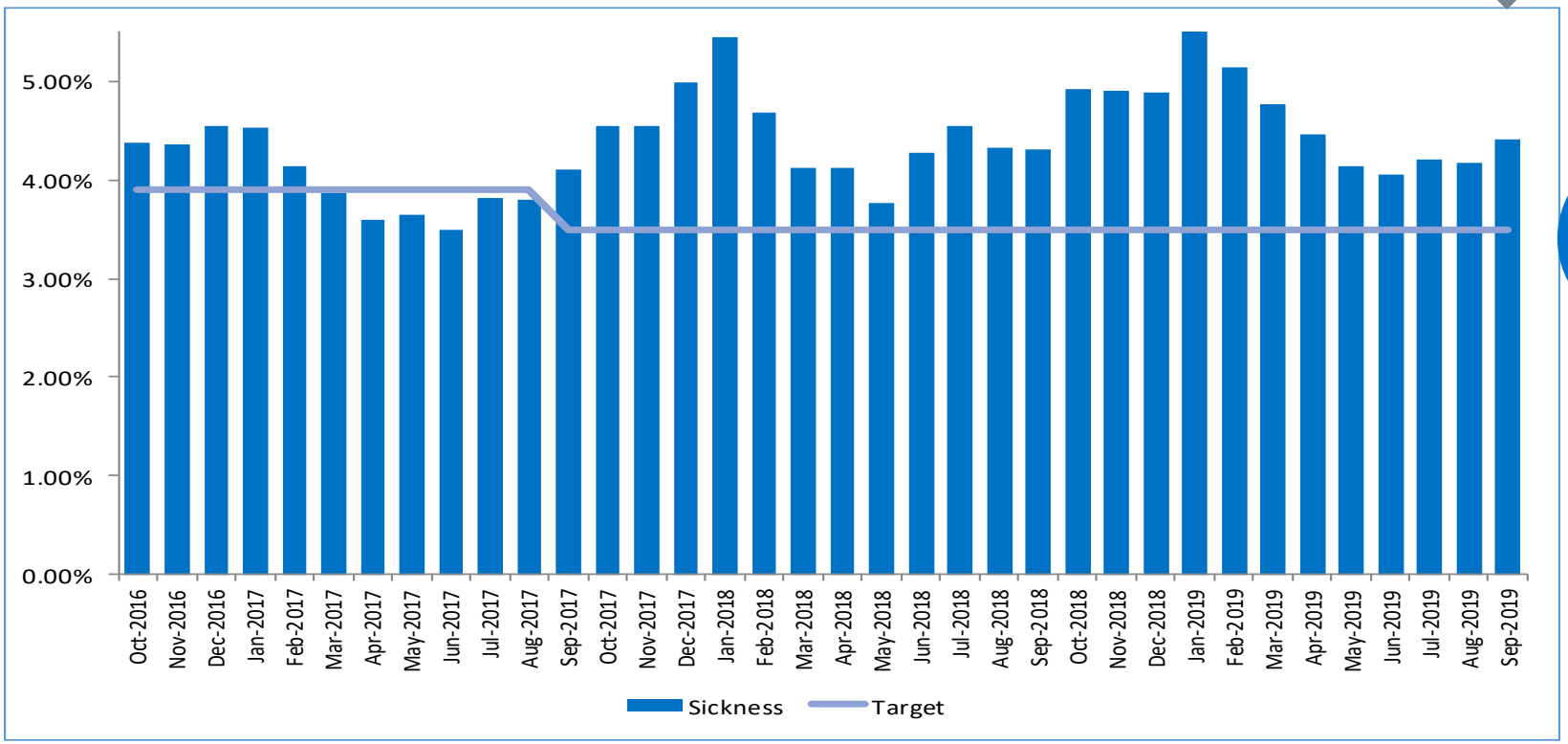
	2018 10	2018 11	2018 12	2019 01	2019 02	2019 03	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	Total
Anaesthetics / Theatre / Surgery	0	0	1	1	0	0	0	0	2	0	0	0	4
Breach /Cancellation of Treatment	0	0	0	0	0	0	1	0	0	0	0	1	2
COSHH (Contact with a harmful substance)	0	0	0	0	0	0	0	0	0	0	1	0	1
Death of Person	0	0	1	1	0	0	2	0	0	0	0	0	4
Nutrition Related	0	0	0	0	0	0	0	0	0	1	0	0	1
Fall/slip/trip	1	2	2	2	0	3	2	2	2	1	2	0	19
Controlled lowering to floor* likely to be changed to Fall following RCA review	0	0	0	0	0	0	0	0	0	0	1	0	1
Infection Control	0	0	0	0	0	0	0	0	0	1	0	0	1
Obstetrics related	0	0	0	0	3	1	0	0	1	0	0	0	5
Medication	0	0	0	0	0	0	0	0	0	1	0	0	1
Treatment, procedure	1	0	1	0	0	2	0	1	1	2	2	0	10
Pressure Ulcer	6	1	2	2	0	3	1	2	0	0	1	0	18
Infrastructure e.g. buildings, utilities	0	0	0	0	0	0	0	1	0	0	0	0	1
Safeguarding Adults (18 yrs and over)	0	0	0	0	0	0	0	0	0	0	0	2	2
Totals:	8	3	7	6	3	9	6	6	6	6	7	3	70

- 3 SI's reported in September with a total of 34 Ytd
- One related to a delay in cancer treatment and two relates to safeguarding concerns – one of which is a joint investigation with TEWV
- All SI's have been reported to the CCG and the CQC and are investigated thoroughly to determine the cause of the incident and areas for learning and improvement across the organisation

People

4

People
Sickness % Rate



SDR % Rate - 81.62% (Target 80%)

2016/17	2017/18	2018/19	2019/20
71.27%	84.70%	77.83%	79.18%

Training % Rate 86.87% (Target 90%)

2016/17	2017/18	2018/19	2019/20
89.35%	92.38%	90.31%	86.89%

People Sickness % Rate by Staff Group

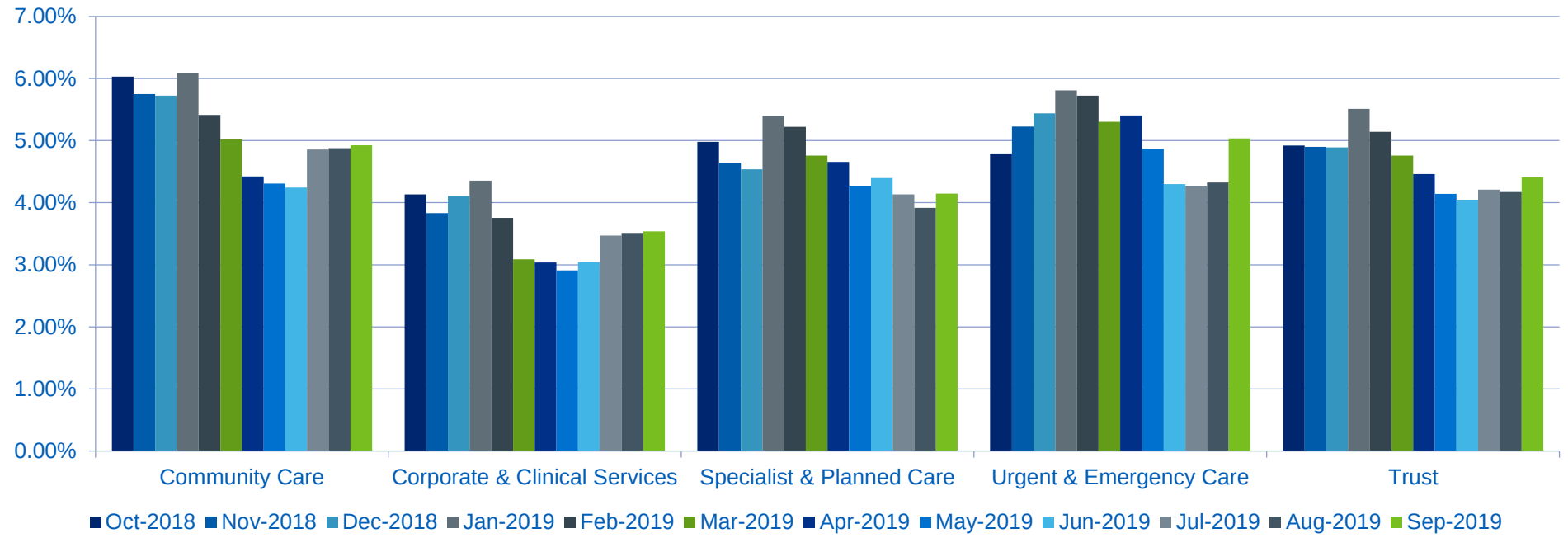
Sickness % Rate by Staff Group

Staff Group	Sep-19	Aug-19	% Change
Add Prof Scientific and Technic	4.09%	3.63%	0.47%
Additional Clinical Services	5.87%	6.02%	-0.15%
Administrative and Clerical	3.84%	3.46%	0.38%
Allied Health Professionals	3.13%	2.54%	0.59%
Estates and Ancillary	5.02%	4.91%	0.11%
Healthcare Scientists	2.93%	2.83%	0.10%
Medical and Dental	0.71%	0.92%	-0.22%
Nursing and Midwifery Registered	5.04%	4.77%	0.27%
Students	0.00%	0.00%	0.00%

- Realigned HR operations into Centres
- Standardised absence data across the Trust and ensured it is regularly available to managers
- Updated HR information on ward notice boards
- Fortnightly meeting with Head of HR Ops to discuss every long term absence case and progress
- Absence 30, 60, 90 day action plan in place for each Centre
- Absence KPI meetings arranged between HR Team and Service Managers to ensure robust management process in place
- Trajectories being developed to ensure target of 3.5% is met within 6 months

People
12 months Sickness % Rate by Centre

Centre	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Community Care	6.03%	5.75%	5.72%	6.09%	5.41%	5.02%	4.42%	4.31%	4.24%	4.86%	4.88%	4.93%
Corporate & Clinical Services	4.13%	3.83%	4.11%	4.35%	3.75%	3.09%	3.04%	2.91%	3.04%	3.47%	3.51%	3.54%
Specialist & Planned Care	4.98%	4.64%	4.54%	5.40%	5.22%	4.76%	4.66%	4.26%	4.40%	4.13%	3.92%	4.15%
Urgent & Emergency Care	4.78%	5.23%	5.44%	5.81%	5.72%	5.30%	5.40%	4.87%	4.30%	4.27%	4.33%	5.03%
Trust	4.92%	4.90%	4.89%	5.51%	5.14%	4.76%	4.46%	4.14%	4.05%	4.21%	4.17%	4.41%



Sickness Process Summary

Total Triggered

337 ⬇

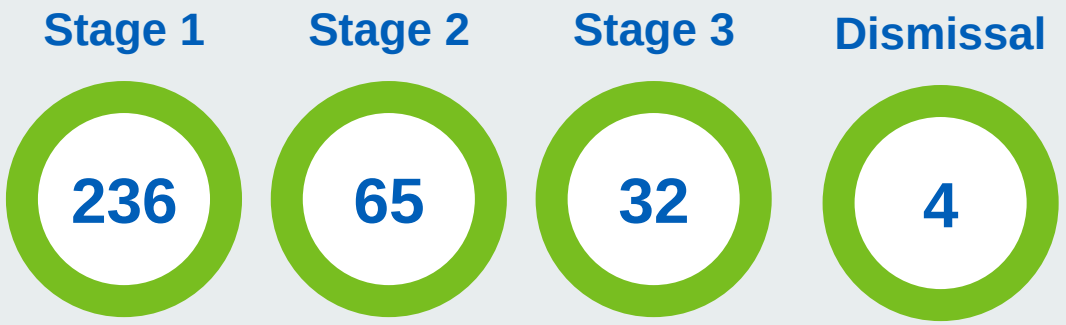
346 Previous Month

- Forensic review of all cases to agree action plans
- Cascade data to Board, centers and management teams to provide visibility of the detail
- Analyse data to develop a sickness forecast
- Measure results against predictions within the forecast

Total in Process

98.81% ⬇

98.84%
Previous Month



Total not in Process

1.19% ⬆

1.16%
Previous Month

Finance

5

Summary Financials - YTD September 2019

Community Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	2,180	2,441	**261**
Pay	(46,461)	(46,850)	**(389)**
Non Pay	(19,419)	(19,704)	**(285)**
Total	**(63,700)**	**(64,113)**	**(413)**

Corporate Clinical Services	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	11,303	12,160	**857**
Pay	(18,665)	(18,626)	**39**
Non Pay	(8,791)	(9,520)	**(730)**
Total	**(16,153)**	**(15,986)**	**167**

Specialist & Planned Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	1,769	1,795	**26**
Pay	(59,405)	(59,675)	**(270)**
Non Pay	(42,269)	(41,284)	**984**
Total	**(99,905)**	**(99,165)**	**740**

Urgent & Emergency Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	533	504	**(28)**
Pay	(43,421)	(44,081)	**(660)**
Non Pay	(6,453)	(6,618)	**(165)**
Total	**(49,342)**	**(50,195)**	**(853)**

Corporate	YTD Budget £	YTD Actual £	YTD Variance £
Nhs Clinical Income	286,655	286,148	**(507)**
Other Income	6,924	4,832	**(2,092)**
Pay	(19,074)	(17,106)	**1,968**
Non Pay	(38,943)	(45,900)	**(6,958)**
Restructuring Costs	(250)	(365)	**(115)**
Depreciation And Interest	(11,938)	(11,572)	**366**
Other Non Operating	(3,115)	(3,065)	**50**
Total	**220,260**	**212,972**	**(7,288)**

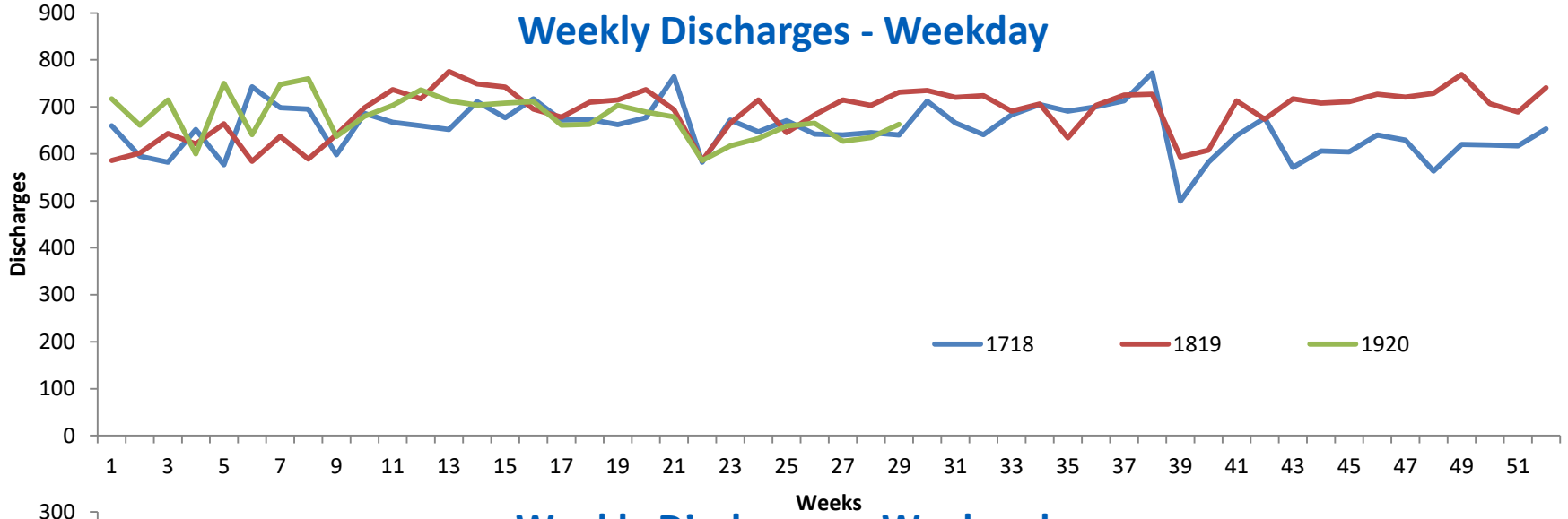
Total	**(8,839)**	**(16,486)**	**(7,647)**

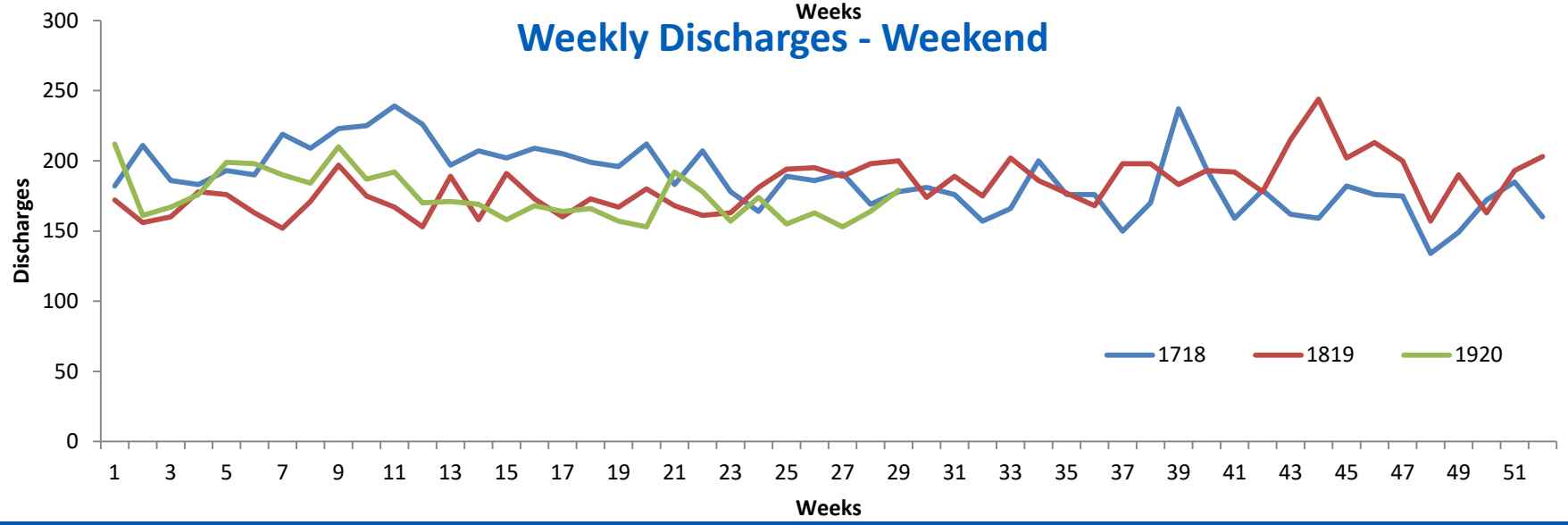
- **Trust headlines YTD M6**
- **Control total**
- Behind plan by £7.6m
- Loss of PSF funding £1.9m, £6.5m being undelivered system savings, underlying underspend of £0.8m
- Full year plan is a control total surplus of £3.2m
- **Productivity and Efficiency savings**
- YTD savings of £5.0m

Appendices

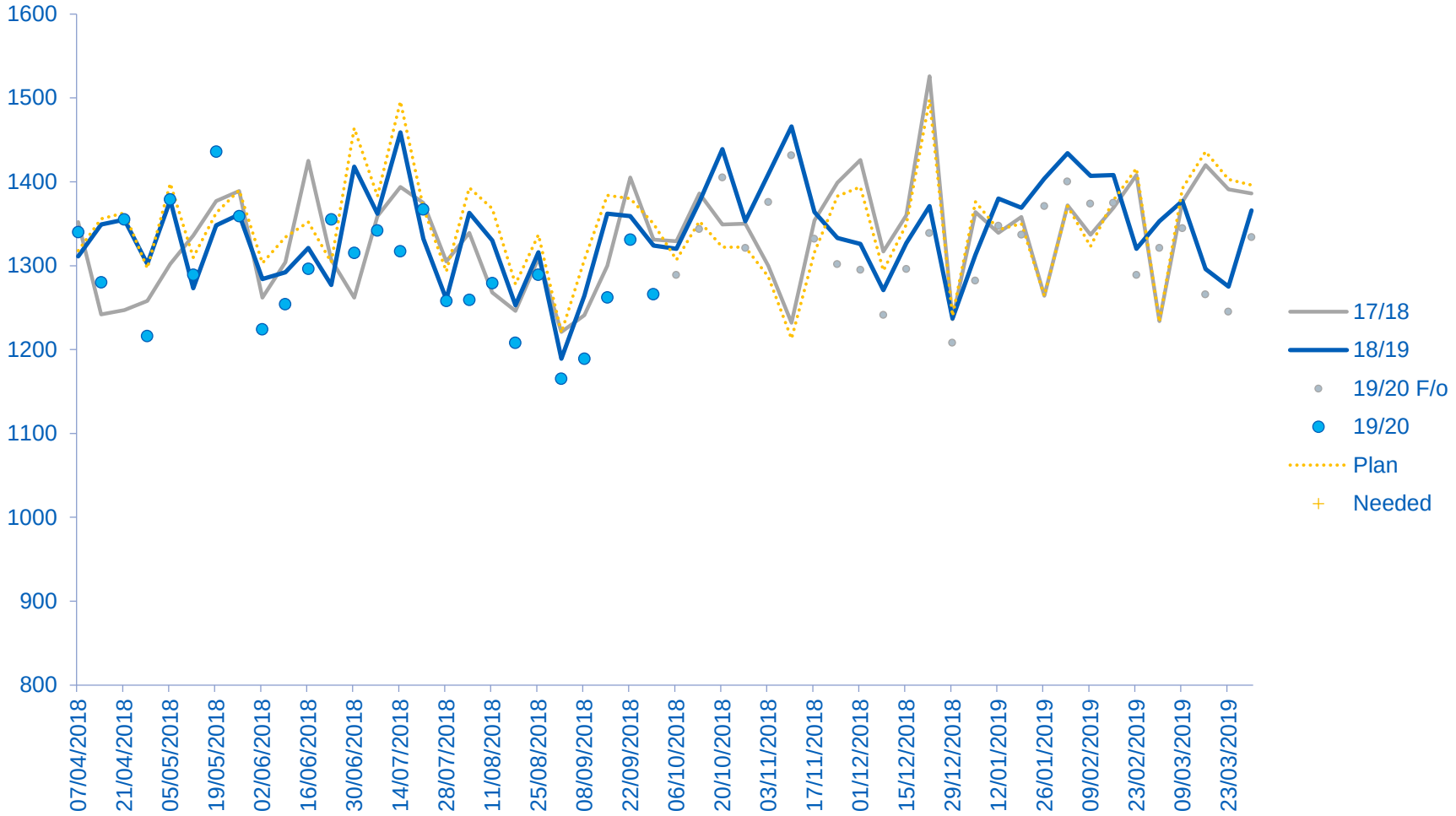
6

JCUH Adult Ward Discharge Rates



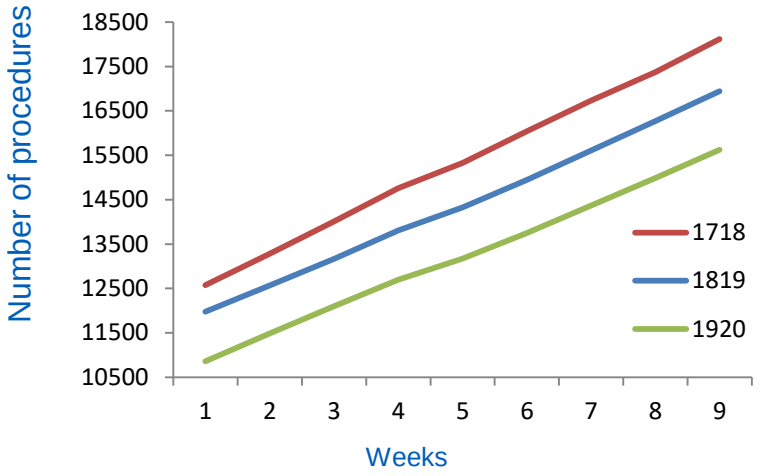


Non-Elective Delivery - All



Elective – Theatre Throughput

Elective overnight and day case - 9 week delivery period from 19/08/2019 FY19/20 compared with FY17/18 & FY18/19

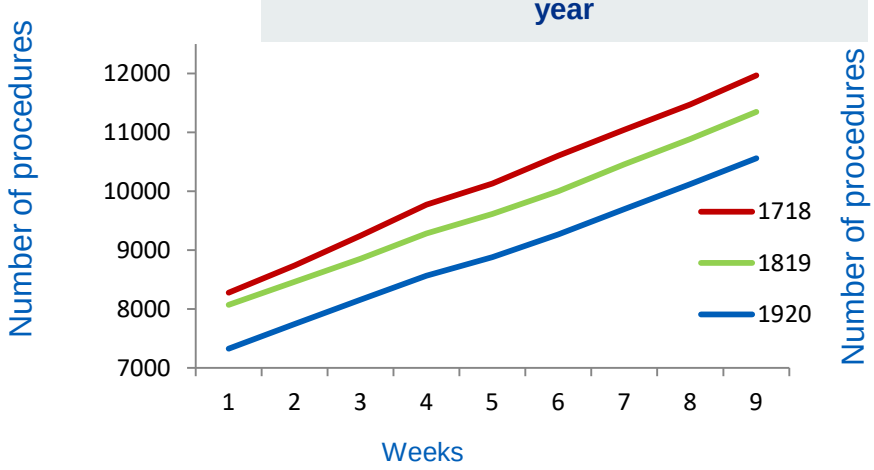


5.3% *less* cases undertaken in last 9 week period this year when compared to last.

YTD 7.7% *less* than last year

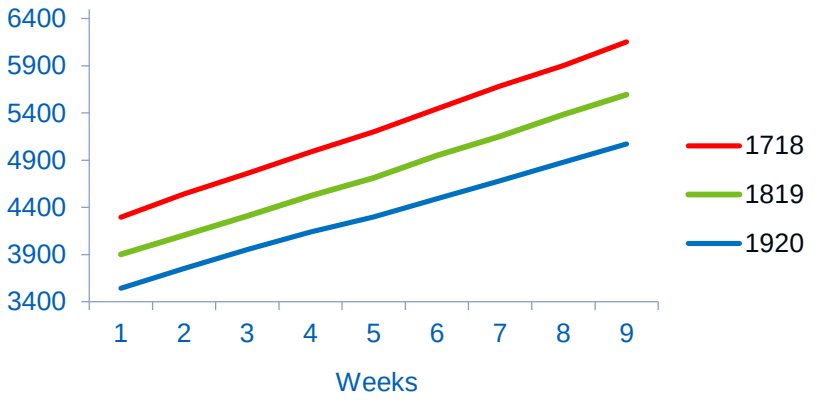
Elective day case

YTD 6.9% *less* when compared with last year



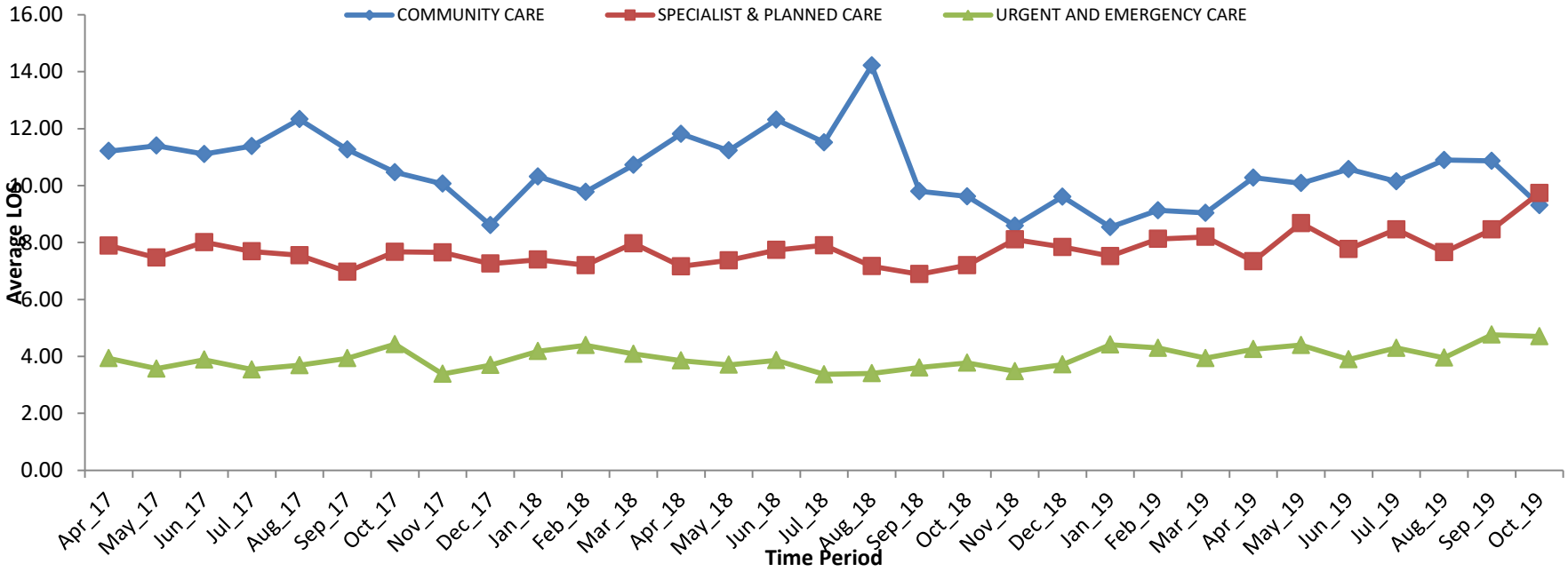
Elective overnight

YTD 9.3% *less* when compared with last year



Emergency Length of Stay by Centre

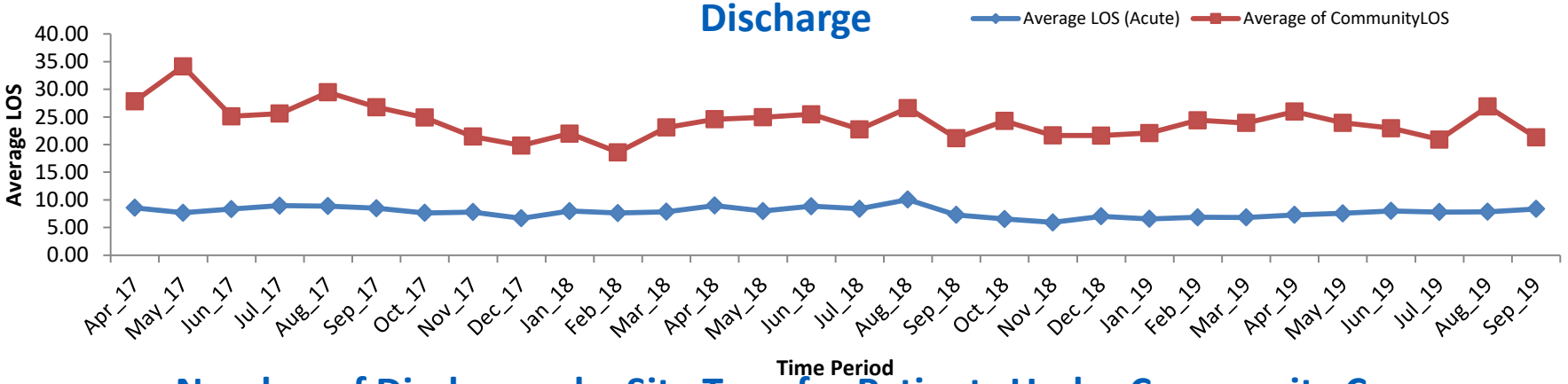
Emergency LOS by Centre at Discharge - 1st April 17 - 20th October 19



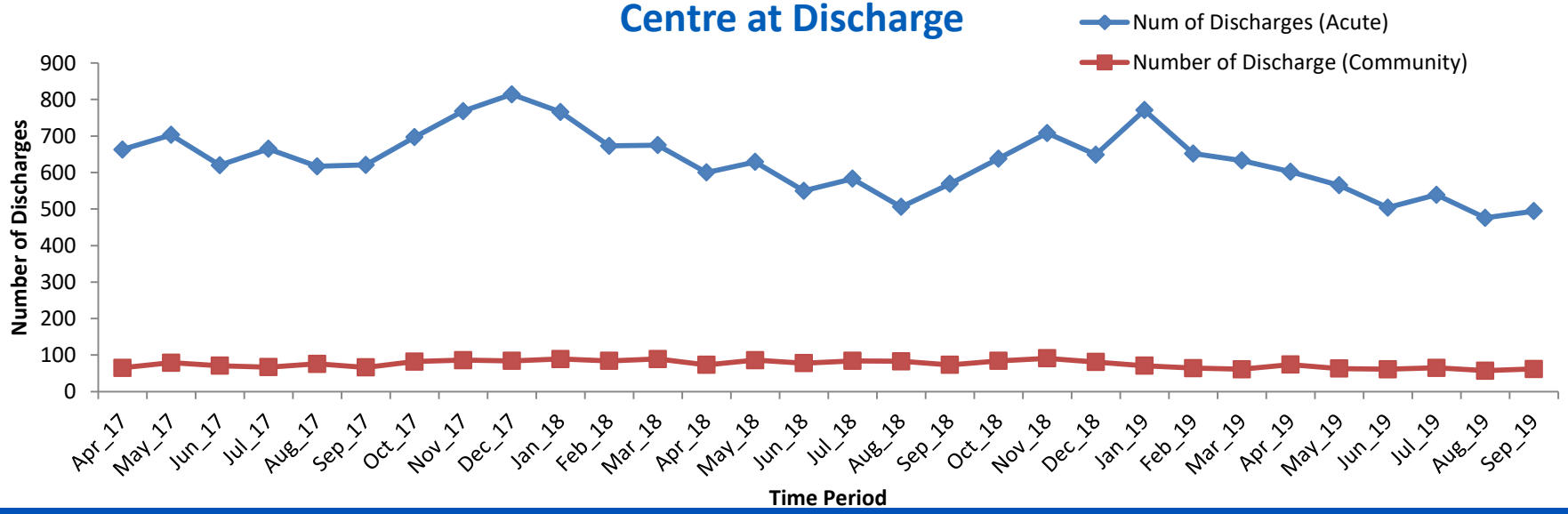
AVG LOS				
Centre	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1718	10.7	7.6	3.9	7.2
1819	10.4	7.6	3.8	6.9
1920	10.3	8.2	4.3	7.3

Emergency LOS for Community Centre by Site Type

Average LOS by Site Type for Patients Under Community Care Centre at Discharge



Number of Discharges by Site Type for Patients Under Community Care Centre at Discharge



MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5Th November 2019			
Five Year STP Planning			**AGENDA ITEM: 12, ENC 7**
Report Author and Job Title:	Chris Dargue – Senior Finance Business Partner	**Responsible Director:**	Steven Mason – Director of Finance
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	To update on the reporting timetable for the strategic system 5 year plan and to ensure the submission is completed on time following adequate clinical engagement.		
Background	The Trust has to submit a 5 year plan, including Finance, activity and workforce as part of the NHS Long Term Plan (LTP). The Trust plan forms part of the Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) plans.		
Assessment	Due to ICS coordination and reconciliation the submission timetable is extremely challenging and does not allow sufficient time for full clinical engagement and detailed bottom up analysis.		
Recommendation	The report is presented for information and the members are asked to note • the process the Trust has undertaken in producing the 5 year plan including • the clinical engagement and the link to the 2020/21 budget setting process.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 4.3 Lack of robust financial management information and grip and control may result in poor financial governance and decision making leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☐		

Strategic System 5 Year Plan

1. PURPOSE OF REPORT

The purpose of this report is to update on the reporting timetable for the strategic system 5 year plan and to ensure the submission is completed on time following adequate clinical engagement.

2. BACKGROUND

The NHS Long Term Plan (LTP) published in January 2019, calls on local health systems - Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) - to create strategic system plans. These are expected to clearly set out the practical actions that each system will take to deliver the LTP commitments. It is an opportunity for each ICS/STP to describe the system's strategy over the 5 year period, 2019/20 to 2023/24, forming the basis for continued engagement with local partners and stakeholders throughout the period of the plan.

System plans should clearly describe the population needs and case for change and set out the practical actions they will take to deliver the LTP commitments. The ICS is required to submit data requirements for each health system's strategic system plan, within which the ICS providers and commissioners will input into individual organisation returns. This will then be collated to inform the overall finance, activity and workforce articulation of the commitments for each system, including how this will be delivered as well as setting out the major milestones and risks to achieving the plan.

3. DETAILS

Key Assumption

In compiling the 5 year plan the follow assumptions have been made.

Revenue: All financial inputs are to be entered including inflation and all organisational and system efficiencies.

Capital: Systems are asked to draw up capital investment plans and associated capital cash management plans in line with local investment priorities, agreed strategic plans and affordability.

Workforce: The template collects high-level information on the total planned number of staff needed to deliver STP/ICS service plans, with a breakdown for 12 staff groups.

Activity: The activity section of the tool covers referrals, outpatient attendances, elective spells, non-elective spells and A&E attendances, as well as primary care GP appointments.

The plan must have triangulation between the following data points
• Income against Activity
• Staff expenditure against Workforce
• Patient Care Activity against Workforce
• CCG expenditure versus provider income (alignment)

The timetable is extremely challenging and does not allow sufficient time for full clinical engagement and limited executive team oversight. The first submission was on the 27th September and draft information has been submitted for Finance, Activity and workforce. Executive team approval will be needed for the 15th November submission. The summary timetable is below.

LTP External Timetable

	Milestone	Date
	Interim People Plan published	3 June 2019
	Publication of the Implementation Framework	27 June 2019
	Main technical and supporting guidance issued	July 2019
	Initial system planning submission	By 27 September 2019
	System plans agreed with system leaders and regional teams are submitted	By 15 November 2019
	Further operational and technical guidance issued	December 2019
	Publication of the national implementation programme for the LTP	December 2019
	First submission of draft operational plans	Early February 2020
	Final submission of operational plans	By end March 2020

A more detailed draft timetable is below which incorporates more internal deadlines, including clinical engagement, financial budget setting and commissioner interaction.

Triangulation of Finance, Activity and Workforce returns
The Human Resources department are leading the workforce return and have liaised with the Nursing Directorate, Head of Professions, Service Managers and Clinical Directors. The workforce return indicates a cumulative investment of £29.12M and on average an annual increase of 75.0 wte, costing over £3.0M each year. This has not been included in the financial return at this stage as this increase has not been approved by the Trust.

	31st Mar 21	31st Mar 22	31st Mar 23	31st Mar 24
Annual Investment	£3.65M	£3.15M	£2.83M	£3.04M
Cumulative Investment	£3.65M	£6.81M	£16.44M	£29.12M
WTE	84.38	74.38	69.81	71.88
Average cost per WTE	£43,278	£42,404	£40,569	£42,292

The Business Intelligence and finance team have meet and discussed the activity assumptions for the 5 year period with the clinical services on the 16th September. The key assumptions are

- Base data used is the most recent available 9+3 month (July 2018 to June 2019)
- The baseline takes actual activity plus change in waiting list
- Then looks at demographic changes by CCG and 5 year age bands and applies the assumed impact of those changes assuming the two criteria below.

1. We maintain the Trusts overall Waiting List size
2. RTT neither improves nor deteriorates

Detail feedback from the centres has been received and of the 138 responses the majority will not impact on the demand estimates, the rest can be categories into 3 main areas.

1. Service changes x 46
2. Demand is expected to change at a different rate than projected by population changes alone. x 6
3. The demand plan methodology will not have taken the issue into account x 6

The detail of the feedback from the clinical services is attached below. (Appendix 1)

Most of these will need further information from or work with the services and this refinement will be done alongside their assessment of capacity. Major changes such as the Vascular transfer from CDDFT and the activity change due to the FHN A&E reconfiguration have been reported consistently with other organisations in the ICS.

Briefings have on the LTP have gone to FIB and FIC to keep everyone informed of the process and to facilitate engagement and coordination of the returns.

Latest LTP Update

It has been confirmed that the LTP plan submissions are due to be submitted on 23rd October to allow consolidation by 25th October, which is unfortunately ahead of what we had anticipated in the internal plan but we have

accommodated this new date in the timetable below. The latest LTP request requires that the finance plan will need to be updated to reflect the following:

- The month 5 Forecast outturn position as submitted to NHSE/I (This will include any non-recurrent allocations and expenditure/income, removed to arrive at the 2020/21 opening position)
- Any known changes in recurrent/FYE contract positions that need to form the CCG expenditure/FT income assumptions i.e. vascular, or non-recurrent in year expenditure that needs to be removed from both income and expenditure on both sides i.e. Maternity transformation funding
- Any known adjustment to the LTP additional funding that has been previously notified to the Trust i.e. FTs adjusted for additional income and matched with expenditure in the plans
- Plans balanced to notified "Control Totals"
- Now confirmed merging CCGs to select one CCG to use for combined CCG, therefore Tees Valley CCG (Darlington/HAST/STEES) will be using Darlington CCG, therefore providers will also need to combine income assumptions under Darlington.
- The sections on "Regulatory Context and Support in place" "Governance arrangements" and "Financial Improvement" must be reviewed and completed in full.
- The section "Efficiency Opportunities" to be reviewed and completed in full.

LTP Internal plan

To ensure the LTP is submitted as per the ICS timetable the internal plan is attached. (Appendix 2)

Budget Setting and Annual Plan

Information gathered for the centres with regard to service, activity and workforce changes will be incorporated into the production of the annual plan and the Trust annual budget setting process. The introduction of the LTP process has enabled an earlier start of annual plan and budget setting process within the organisation. The LTP will provide the basis for the more detailed Annual plan and budget for 2020/21, this will involve Clinical Director and Service Manger sign off.

4. RECOMMENDATIONS

The report is presented for information

Members of the Trust Board are asked to note the process the Trust has undertaken in producing the 5 year plan.

Members of the Trust Board are asked to note that the LTP plan will form the basis of the 2020/21 budget and the continuing clinical involvement in this process.

APPENDICES

Appendix 1 – Centre Activity feedback
Appendix 2 - Internal STP submission Plan

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
CDSS	H&R community	None	0	All services appear to be listed and on comparing the CBIS data and the data from the last management meeting there is a difference of about 500 with CBIS being higher. This is likely to be due to all contacts being counted irrespective of face to face/admin/phone calls whereas the data received in the monthly reports only counts contacts.	Currencies are different
CDSS	Tees community-Diabetes	None	0	Not listed as separate services in the weekly activity. Total contacts for in 2018/19 = 9,999	Included in specialist nurses
CDSS	Tees community-CHD	None	0	Not listed as separate services in the weekly activity. Total contacts for in 2018/19 = 5,565	Included in specialist nurses
CDSS	Tees community-Continence	None	0	Not listed as separate services in the weekly activity. Total contacts for in 2018/19 = 1,612	Included in specialist nurses
CDSS	Tees community-Stoma	None	0	Not listed as separate services in the weekly activity. Total contacts for in 2018/19 = 3,089	Included in specialist nurses
CDSS	Tees community-nursing	None	0	South Tees Community Nursing – total activity is circa 19,500 higher in the CBIS report, however the difference is likely to be due to all contacts (including non-face to face) being included. There is also a review currently taking place of community nursing activity in Redcar & Cleveland to validate the activity data	Currencies are different
CDSS	Therapies	None	0	Falls and osteo service are not listed on the weekly activity. Therefore, these services cannot be checked to see if this is accurate data for them. It is assumed that pulmonary rehab is included in the community therapy figures as they share a systmone unit but this is not clear.	Need to check what service these are grouped to
CDSS	Therapies	Incease	?	The previous trends look the same as the reported trends even though the actual numbers are different, but due to a lot of increased waiting lists it would appear that the projected contacts is using the baseline information might be slightly less than they should be, this has been added to the narrative document attached	Growth in waiting list means demand estimate will be too low
CDSS	Therapies	Increase	?	For ST Com Therapy and HR Int Care Therapy on the PoDDet this includes Community Therapy localities as well as PCH Therapy data. The referrals for Community Therapy have increased slightly year on year e.g. for South Tees Community Therapy increase of 16 referrals so far in 19/20 but the contacts are showing a reduction of nearly -900 for the projected year based on our data which is due to issues with staff recruitment ,not reduced demand- waiting list to be taken into account.	Growth in waiting list means demand estimate will be too low
CDSS	Therapies	None	0	Also on the weekly data sheet week 39 looks significantly less than other weeks is there an overall reason for this as it's the last week of the financial year. e.g. in community it looks like a reduction of about 500 contacts in that week compared to others?	Week 39 is Christmass week
CDSS	All	None	0	With all the caveats itemised we expect to deliver the contract as is with the same levels of activity	Capacity statement ?
CDSS	All	None	0	Assuming a population growth in the elderly we should expect to see a corresponding increase across all community services as they are our main component	Built in to demand model
CDSS	All	Possible	?	PCNs – this is currently about wrapping the service around the patients and addition of social prescribing. However each PCN may ask for a change in who sees and when we see patients at a local level and we have no assessment at this time if this will mean contacts will decrease, stay the same, increase or change in complexity. We therefore have to be clear that if they ask for extended visiting this isn't in the demand. **See attached narrative**	Potential service change
CDSS	All	Possible	?	Care homes – there is to be a national directive for extended care home provision to nursing care homes for community services. This will increase our demand in the community and this is not ion contract currently but we have no assessment yet of impact and will not be in the demand plan	Potential service change
CDSS	All	Possible	?	**See attached narrative**. Several material changes	Service changes

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
Comm	Plastic	Increase		Anticipate managing 18/19 activity levels in 1920. Reduction in activity of baseline period due to maternity leave and down 1 consultant. Mis Barnard returns in January 2020	Check waiting list impact ?
Comm	Dermatology	Increase		Anticipate growth of approc 500 patient in 2WW / skin cancer. Most be be seen and treated on day, approx. 1/4 will come back for review. Have seen year-on -year increase and volume has nearly doubled in last 7 years approx.	Demand increase beyond demographics
Comm	Ophthalmology	Increase		Approx. 70% of RTT recovery activity (470) will convert to IP, therefore need to add 350 onto elective same day and theatres as additional activity.	Knock-on not in model
Comm	Ophthalmology	Increase		Approx 1600 Glaucoma surveillance review patients not logged onto system and waiting for appointments. Approx 600 review appointments p.a. for photography reviews - not previously recorded on CAMIS.	Hidden list
Comm	Ophthalmology	Possible		Looking at pathways for Glaucoma reviews and Cataract reviews. Numbers not yet available	Potential service change
Comm	SCBU/NITU	Increase		Took over North Tees ITU on 2nd September 2018. Increased capacity by 3 ITU beds. Need to use baseline period from September 2018 rather than July 2018.	FYE
Comm	Community hospital beds	Possible		Winter Planning for 2020 ? follow same plan as this year to reduce GP beds (Note from Review of Demand Projections, September 16 2019 • Bed utilisation – Zetland & Tocketts – draft proposal to change this for winter 2019: increase Stroke beds by 4, OPM Consultant beds to remain as they are , reduce GP beds , change D2A to ECPCH OR combine GP, SUSD , EOL & D2A flexibly.	Potential service change
Comm	Maternity	Possible		Various guidelines are being introduced to Obstetrics including Better Births, Savings Babies Lives, Continuity of Carer etc. These changes will inevitably result in a change in demand but as yet the extent of this is not known, therefore no adjustments have been made to the demand predictions modelled.	Potential service change
Comm	Maternity	None		Although the birthrate has not grown as expected based on previous demand prediction there is clear evidence, included in an external review, of an increase in acuity which needs to be considered when assessing capacity.	Capacity
Comm	Maternity	Increase		Birthrate used as a sense check to the demand prediction modelled. Various data sources used including 18/19 birthrate, 19/20 YTD birthrate and bookings for future months in 19/20 and 20/21. Taking all of these factors into consideration, the sensible expectation of birthrate is in line with 18/19 which represents a 3.6% increase from the final modelled demand. Therefore 3.6% applied to all demand predictions.	Demand change not in line with ONS projections
Comm	Gynaecology	Possible		There are currently no new expected screening campaigns although there could be in the future which could effect demand. There are changes to guidance for HPV screening which will have an impact on Colposcopy demand, however at this stage the impact on demand is unknown, however the pilot sites have evidenced a significant increase in demand. In addition changes to the Uro-gynae service and guidance may also have an impact on demand.	Potential service change
Comm	All other services	None	0	Ok	

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
SPAP	Orthopaedics	None	0	LLP planning approx 8 procedures per weekend.	Capacity
SPAP	Cardiology	Increase		Increased 'surveillance' waiting list not captured in data.	Hidden list
SPAP	Cardiology	Increase		Potential increase in TAVI cases from an average of 111 to circa 200 per year. Increase depends upon specialist commissioning decision and agreement between Cardiac surgery and Cardiology.	Potential service change
SPAP	Cardothoracic surgery	Reduction		Potential reduction in aortic valve replacement surgery if commissioning of TAVI procedures increases. Increase depends upon specialist commissioning decision and agreement between Cardiac surgery and Cardiology.	Potential service change
SPAP	Cardothoracic surgery	Reduction		NHS England has decommissioned Pectus surgery as of September 2019 – this will result in approximately 30 less patients per annum.	Service change
SPAP	Cardothoracic surgery	Increase		Year-on-year increases in lung cancer cases due to advances in ability to identify cancers earlier.	Demand increase beyond demographics
SPAP	Vascular surgery	Increase		Inherited work from Darlington Vascular service in May 2019. This has so far been an average of 61 outpatients per month which has not yet been factored into the demand plan. The approximate conversion rate of new outpatients to elective procedures is 20%., which will also need to be factored into our figures.	FYE
SPAP	Vascular surgery	Increase		Year-on-year increase in the incidence of diabetes in the population will have an impact on the number of referrals that Vascular receive.	Demand increase beyond demographics
SPAP	ENT & audiology	None		Whilst demand for ENT services remains steady the complexity of treatments given has grown significantly	Capacity
SPAP	ENT & audiology	Increase		Previous lack of workforce within audiology having significant impact on waiting times/ activity levels within the team. Vacancies are in the process of being recruited to with a further 1 wte due to leaver.	Hidden list
SPAP	ENT & audiology	None		Consultant commenced in September 2019, with specialty doctor commencing Jan 20.	Capacity
SPAP	ENT & audiology	None		Issues within Audiology linked to equipment and IT systems- which has impacted upon patient wait times.	Included in hidden list issue
SPAP	ENT & audiology	Increase		Expansion of the CI NICE criteria has now commenced and an expected increase in the number of patients that will now be suitable for CI will start to come through (see attached).	Potential service change
SPAP	ENT & audiology			Theatre demand for CI will increase, it is predicted that there will be a requirement for an additional 107 hours theatre time to accommodate the increase in unilateral and bilateral implants	Capacity
SPAP	ENT & audiology	Increase		AQP Adult Hearing service – procurement process expected to commence late 19 with contract commencing April 2020. Increase demand expected – to be fully understood via procurement process	Potential service change
SPAP	ENT & audiology	None		Head and Neck Cancer pathways are under review, increase in demand not anticipated but new ways of working to be explored to streamline patient pathways and increase efficiencies .	Capacity
SPAP	Gastroenterology	None		Current lack of workforce having significant impact on activity levels within the team. Currently 4 consultants short with 1 consultant recruited to replace a leaver. 1.5 Nurse Endoscopists down with 1 further leaver expected. Capacity can be increased significantly through withdrawal of the Gastroenterologists from the General Medical intake	Capacity
SPAP	Gastroenterology	IP > AEC		Expected development of an ambulatory care unit for Medical patients requiring input which will enable reduced LoS for emergency admissions and development of more ambulant pathways	Capacity
SPAP	Gastroenterology	?		Lack of any capacity to service EUS activity. Expecting activity to	
SPAP	Gastroenterology	Increase		Expected development of a Liver Nurse Specialist service improving pathways for patients with Parasanthantisis. Will release Consultant DCC time	Potential service change
SPAP	Gastroenterology	?		Introduction of FIT testing in July 2019 will impact on the volume of 2ww referrals for the service. Current impact not fully understood.	Potential service change
SPAP	General Surgery	None		Insufficient access to in patient bed base is impacting on delivery of elective over-night stay activity particularly routine case and cases requiring HDU beds.	Capacity
SPAP	General Surgery	None		Proposed development of emergency laparotomy pathway in line with agreed BPT guidance which will require Elderly medicine input in to patient care.	Capacity
SPAP	General Surgery	PoD shift		Surgical ambulatory care opened in March 2019, the change between over-night stay and ambulatory care attendances to mirror current demand.	Potential service change

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
SPAP	General Surgery	Site		Due to Friarage changes centralisation of non-elective and elective over-night stays - Change of site	
SPAP	General Surgery	Complex PoD shift		Plan to implement hot gallbladder service by the end of 2019/20 financial year (approximately 200 patient per year – patients to have surgery on index admission)	Potential service change
SPAP	General Surgery	None		Breast Services in phase 1, however changes are not expected to have any impact on activity levels due to current working arrangements with South Tees.	Service delivery not site
SPAP	General Surgery	None		Bariatrics in phase 2 , the impact of this is unknown at this time.	ICP not to be included
SPAP	General Surgery	Site		Following Friarage changes from March 2019 onwards, changes to non-elective and overnight admissions pathways to be amended in annual plan in line with consultation process	Mainly site but potential shift to CDD
SPAP	Haematology	Increase		Increased demand on Iron Infusions	Demand increase beyond demographics
SPAP	Haematology	Increase		Increased incidence of genetic blood conditions for eg. Haemochromatosis and Polycythaemialeading to increased incidence of myelofibrosis	Demand increase beyond demographics
SPAP	Haematology	None		Increased lenalidomide use up front	
SPAP	Haematology	Increase		Increased daratumumab use in 2nd line treatment which we hope to implement once the day unit capacity planning is finalised. This will be 50 patients/year – 2 infusions/week for 2 weeks, then once weekly for 2 months, then 2 weekly so a significant workload & budgetary impact currently not in use.	Potential service change
SPAP	Haematology	Increase		By 2021 it is anticipated that there will be a move to use daratumumab first line which will impact significantly	Potential service change
SPAP	Nephrology	Increase		Hep B vaccines to be given in Secondary Care instead of Primary care (as above)	Potential service change
SPAP	Nephrology	None ?		Tolvaptan Drugs (drug already in use however numbers will increase over time)	Potential service change
SPAP	Nephrology	None ?		Etelcalcetide (drug already in use relatively low numbers although will increase in next 2-3 years)	Potential service change
SPAP	Nephrology	??		WebICE consultant referrals - Service receives referrals via WebICE. Want to flag that these are captured in regards to demand for the service.	Hidden list ?
SPAP	Nephrology			Transplant Patients – As of April 2019 we have a total of 570 PTs. Numbers are slowly increasing year on year. The service provides all the clinical work up, prescribing immunosuppressant drugs and then facilitates on-going review 10 days post-transplant. Patients are prescribed life-long anti-rejection drugs . All of which carry a cost to the service.	Demand increase beyond demographics
SPAP	Neurology	None		Request further detail of TFC_Sub_DP mapping, as possibility that activity for Neurophysiology (TFC 401) is being mapped incorrectly to Neurology (TFC 400)	DQ issue. Included but may be in wrong place
SPAP	Neurology	None		Concern that the demand does not acknowledge a background if increasing referrals.	It should
SPAP	Neurophysiology	Site shift		Possible commencement of activity at UHH however not confirmed and would not generate additional demand but reallocate existing activity from JCUH.	Service change
SPAP	Neurophysiology	None		Request further detail of TFC_Sub_DP mapping, as possibility that activity for Neurophysiology (TFC 401) is being mapped incorrectly to Neurology (TFC 400)	DQ issue. Included but may be in wrong place
SPAP	Neurophysiology	None		Noted that service does not see review patients	
SPAP	Sleep	Site shift		Commencing Outpatient activity at Redcar Primary Care Hospital e/f 1st December 2019. c. 30% (FYE) outpatient capacity will be transferred away from JCUH.	Service change
SPAP	Stroke	None		Impact of potential HASU unknown – further detail to follow	ICP not to be included
SPAP	Stroke	None		Increase in APC_Non-EL spells possibly linked to opening of black beds on W28 due to winter pressures.	Allocation
SPAP	Stroke	None		6 beds closed on W28 due to staffing e/f Jul-19	Capacity
SPAP	Neurosurgery	Increase		Increased use of 5ALA, c 10-20 cases per year. Minimal impact on demand	Service change
SPAP	Neurosurgery	Increase		Increasing need to introduce spinal cord monitoring for spinal cord tumours – very limited cases per annum however (estimated 5 pa)	Service change
SPAP	Neurosurgery			F Nath sickness Jan-19 to May-19	Capacity
SPAP	Neurosurgery			Impact of cancellation due to lack of critical care / insufficient beds has supressed demand.	Capacity
SPAP	Pain	Increase		New cancer service commenced May-19. Approx 150 additional new OPA with majority converting IP.	Service change

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
SPAP	Pain	Increase		Change pathway for cervical injections commenced Mar-19. New require new OPA prior to admission (previous straight to admission)	Service change
SPAP	Pain	None		Recruiting substantive Consultant to replace Dr Milligan. Dr Hughes reducing job plan e/f Feb-20	Capacity
SPAP	Pain	None		Dr Milligan / Dr Kansal had sick leave during base period	Capacity
SPAP	Pain	None		Data Quality query -OPA attend figures look low – could TFC_Sub_DP detail be supplied to allow further investigation?	DQ issue. Included but may be in wrong place
SPAP	Pain	Increase		Theatre cases – Issues with sessions in Neuroradiology not always being captured, therefore Thv_EL-SD possible understated	DQ. Not captured at all ?
SPAP	Pain	None		Background of increasing referrals.	
SPAP	Spinal	Increase		North Tees ceased complex spine & spinal malignancy work c. Mar-19	Service change (ICP ?)
SPAP	Spinal	Increase		Move towards use of Spinal Navigation as normal practice. Limited impact on demand (c100 cases per annum)	Service change
SPAP	Spinal	None		Recruiting additional substantive Consultant	Capacity
SPAP	Spinal			Ceased FHN operating May-19 as part of new theatre schedule, with net reduction in operating sessions (1 session per week). Outpatient activity continues	Capacity
SPAP	Spinal	Increase		Impact of cancellation due to lack of critical care / insufficient beds has supressed demand.	Hidden list effect ?
SPAP	Spinal	None		Data Quality - Request further detail of TFC_Sub_DP mapping, as possibility that activity for Spinal Surgery (TFC 108) is being mapped incorrectly to Spinal Cord Injuries (TFC 323)	DQ issue. Included but may be in wrong place
SPAP	Spinal	None		Data Quality – Unsure were Back Pain Pathway activity, captured on System 1, is being reported?	Included in community activity
SPAP	Neurorehab	Increase		Reduction in review outpatient activity in Spasticity clinics due to physio staffing – waiting list pressures for spasticity service pts now waiting over 30 weeks between injections (should be 12-16 weeks)	Hidden list
SPAP	Neurorehab	Increase		Waiting list pressures for traumatic brain injury clinics – requires psychology & headway nurse	Hidden list
SPAP	Neurorehab	None		Potential hidden 'waiting list' for Inpatients from all areas within the trust that cannot be accommodated on W26 due to bed pressures. On average 4 – 5 patients awaiting a bed.	Capacity
SPAP	SCIU	None		Request further detail of TFC_Sub_DP mapping, as possibility that activity for Spinal Surgery (TFC 108) is being mapped incorrectly to Spinal Cord Injuries (TFC 323) – note significant increase in 18/19 v 17/18?	DQ issue. Included but may be in wrong place
SPAP	SCIU	None		APC_Non-El figures appear low – c 55 new injuries per year	DQ issue. Included but may be in wrong place
SPAP	SCIU	None		Query where Simon Fulford activity is being captured (Urology) c 200-250 elective procedures per year also does a number of OPA	Included in Urology
SPAP	SCIU	None		Haroon Siddiqui does OPA clinics for pressure sores – where captured	DQ issue. Included but may be in wrong place
SPAP	SCIU	None		OPA_Review – c1300 pts "on the books" all receive annual review	DQ issue. Included but may be in wrong place
SPAP	OMFS & orthodontics	None		Whilst demand for OMFS services have increased slightly the complexity of treatments given has grown significantly	Capacity
SPAP	OMFS & orthodontics	None		Significant pressures within OMFS re medical workforce - 1 vacancy and 1 LTS at present. Business case approved to advertise	Capacity
SPAP	OMFS & orthodontics	None		Consultant Orthodontist pressures BC approved to proceed to recruit to 4PA's,with consultant also started August. (will start to see increase also linked to income) – ongoing work linked to predicted demand/income.	Capacity
SPAP	OMFS & orthodontics	Increase		Potential to expand within 3D printing, both internally and externally to the trust, cranial plates for Neuro, ability to accommodate 24 per annum to support team. Opportunities for further growth depending upon business case approval.	Service change
SPAP	OMFS & orthodontics	Increase		Potential to expand on the private orthodontics work within the lab. This would generate an additional 30-40k per annum. Growth to be further understood.	Service change

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
SPAP	OMFS & orthodontics	Increase		Retirement and Long Term Sick within the department has impacted upon the flexibility to run clinics. Department is now having to cancel clinics for major cases, this has had a detrimental effect on patients being seen in clinics in appropriate time scales.	Hidden list
SPAP	OMFS & orthodontics	Increase		A sedation service has been developed at JCUH which will see an increase in demand.	Service change
SPAP	OMFS & orthodontics	Reduction		Ongoing discussions within Oral surgery regarding tier 1 and 2 patients who are referred by dentists. It is understood that commissioners are keen for service to see tier 3+ (small number of tier 1-2 required for training purposes), but need to understand any financial implications.	Service change
SPAP	OMFS & orthodontics	PoD shift		Initial conversations with POSDU re training requirements which will see a decrease in patients requiring an overnight bed as POSDU will be sufficient.	
SPAP	Oncology	None		Whilst demand for oncology services remains steady the complexity of treatments given has grown significantly	Capacity
SPAP	Oncology	?		Newly approved systemic anti-cancer drugs & immunotherapy drugs	Service change
SPAP	Oncology	?		NHSE National guidance on commissioning of SABR for oligometastatic disease	Service change
SPAP	Oncology	?		Hypofractionation for prostate radiotherapy	Service change
SPAP	Oncology	?		Attached below is approval tracker for drugs we have approved to deliver following NICE guidance *(Please note there are additional drugs that are NICE approved that we at present do not have capacity to deliver)*	Service change
SPAP	Oncology	?		Introduction of SpaceOAR for Radiotherapy planning of prostate patients	Service change
SPAP	Oncology	?		MR radiotherapy planning	Service change
SPAP	Oncology	?		DIBH for breast patients as we increase use of Catalyst service	Service change
SPAP	Oncology	?		Introduction of Clarity for Prostate Radiotherapy	Service change
SPAP	Oncology	?		Radiotherapy Operational Delivery Network may increase or decrease some flows of demand for some tumour specific sites (For eg. Brachytherapy	Service change
SPAP	Oncology	?		Cardiac SABR	Service change
SPAP	Oncology	?		Regional review taking place by the Northern cancer Alliance which may	Service change
SPAP	Oncology	None		Ageing population across our ICP. Especially across our local population of over 75s. Cancer is a disease of ageing so incidence is likely to increase by same increase in elderly population	
SPAP	Oncology	?		Early detection could increase or decrease use of neo/adjuvant chemotherapy which would increase/decrease future demand	Service change
SPAP	Oncology	?		https://www.nice.org.uk/guidance/indevelopment/gid-ta10187 Due May 2019.	Service change
SPAP	Oncology	?		https://www.nice.org.uk/guidance/indevelopment/gid-ta10184 Due March 2019. Something will get approved but its probably a higher risk sub group. BUT that could still be a big group. Without knowing the subgroup size makes predicting numbers hard. The other thing that is hard is NHS E may make us change the other part of treatment we give (currently SC to IV). So I think its likely 36 doses per patient, About 0.02 chairs per patient and probably 0.01 nurses. There will be at least 50 patients in the region. I suspect 100. If we predict on 50 for now, 1800 doses, 1 chair, 0.5nurses.	Service change
SPAP	Oncology	?		https://www.nice.org.uk/guidance/indevelopment/gid-ta10245 Due July 2019. Approx 80 patients. They don't all respond, but potentially 1400 doses.	Service change
SPAP	Urology	Increase		Service changes at DMH with regards Sunderland withdrawal from Bishop Auckland has seen a drift of patients to services at DMH and James Cook. Growth in demand not yet fully understood, further work required.	FYE
SPAP	Urology	PoD shift		Further change to day case TURBT pathway with expectation of reaching 60% of all TURBTs as day case by end of 20/21	
SPAP	Urology	Reduction		Bladder outflow surgery developments expected potential for move of HOLEP (high ASA grade) to North Tees as a result of Friarage changes. Numbers to be understood.	Service change
SPAP	Urology	None		35 nephrectomies per year to transfer from North Tees on to James Cook site. Theatre capacity to be released by transfer of high ASA grade HOLEPS and Hot stones to North Tees. (35x 2.6 patients per list = 91)	ICP not to be included

STHFT: 2020/25 annual plan: Service responses to [2021_plan_v03a.xlsx] demand estimates					
Centre	**Service**	**Demand effect**	**Quantity**	**Comment**	**DP_comment**
SPAP	Urology	None		Expected transfer of Non-elective urology work to James Cook expected, based on worse case the addition of 698 overnight admissions, equating to 10 beds, 338 ambulatory care attendances per year and 1 non-elective theatre usage per day. Renal colic pathway particularly urgent due to high clinical risk.	ICP not to be included
SPAP	Urology	Site shift		Following Friarage changes from March 2019 onwards, changes to non-elective and overnight admissions pathways to be amended in annual plan in line with consultation process	

Task	Responsible Officer	Milestone Date
Added in 2019/20 Establishment	Luke Armstrong	02/10/2019
Verify 5 year workforce establishment with Centres	HRBP	03/10/2019 - 07/10/2019
Update Return with Centre/service information	HRBP	08/10/2019
Finance and HR	Jane Herdman/Luke Armstrong/Chris Dargue	09/10/2019
Update FIB on Timetable	Chris Dargue	10/10/2019
Cost additional workforce and Triangulate to Activity	Luke Armstrong/Chris Dargue	10/10/2019 - 11/10/2019
Collate demand feedback from services	John Cundy	07/10/2019 - 11/10/2019
Establish Demand & Capacity GAP and solutions to close the Gap	OD's /SM's	14/10/2019 - 18/10/2019
Cost impact of Demand & Capacity Gap	Luke Armstrong/Chris Dargue	21/10/2019 - 23/10/2019
initial ICP sumbission	Luke Armstrong	23/10/2019
Draft 2 presented to FIB - (Further Triangulation and Impact of Demand & Capacity Gap, cost of HR)	Chris Dargue	24/10/2019
Implement FIB recommendations/actions	Jane Herdman/Luke Armstrong/Chris Dargue	21/10/2019 - 23/10/2019
Final plan agreed by FIB	Chris Dargue	31/10/2019
Re submit LTP to ICP	Luke Armstrong	01/11/2019
Final Paper to Board	Luke Armstrong/Chris Dargue	05/11/2019
System plans agreed with system leaders and regional teams are submitted	Luke Armstrong/Chris Dargue	15/11/2019
Update FIC	Steven Mason	26/11/2019

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5th November 2019			
Electronic Patient Record (EPR) Programme – Risks of delaying implementation of EPR			**AGENDA ITEM:** Agenda 13, ENC 8
Report Author and Job Title:	Ian Willis – Head of Digital Programmes	**Responsible Director:**	Kevin Oxley – Director of Estates, IT and Health Care Records
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	There is significant financial, clinical and reputation risk to the organisation if it further delays or postpones the EPR programme.		
Background	Since the Board approved the business case for the EPR programme in December 2018, the Trust has worked to obtain NHS Improvement (NHSI) approval. NHSI have indicated that they will not approve the business case until the Integrated Care System (ICS) have given their approval and until a source of funding is identified. The Trust has engaged with ICS, however, official approval has not yet been given. A source of funding has still not been identified. This paper discusses the impact and further risk of delaying of postponing the programme.		
Assessment	Due to a lack of investment in IT over a number of years, the Trust is not as digitally mature as its peers. It is now critical that investment is made in an EPR and the supporting infrastructure to prevent it from falling further behind and putting patients at risk. Without investing now in an EPR it will still have to invest in replacing most of its core patient systems over the next 3 – 4 years.		
Recommendation	Members of the Trust Board are asked to: • Note the increased risk to the organisation of delaying or postponing the EPR programme and the impact this could have on patient care • To support the Director of Estates, IT and Health Care records as the Senior Responsible Officer and Executive Lead of the EPR programme in gaining NHSI business case approval and ICS support for the programme • Note the impact of the delay in identifying a funding source for the programme and the supporting infrastructure		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 4.4 Risk of successful delivery of Electronic Patient Records		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance	Long term financial sustainability ☒	

	☒	
	Develop clinical and commercial strategies ☒	

South Tees Hospitals
NHS Foundation Trust

ELECTRONIC PATIENT RECORD (EPR) PROGRAMME DELAY RISKS

1 PURPOSE OF REPORT

1.1 This paper has been prepared for the Board to highlight the risks to the Trust of not proceeding with the Electronic Patient Records (EPR) programme. It has been written at the request of the Programme Senior Responsible Officer (SRO) and Chief Clinical Information Officer (CCIO). The paper uses the Trust's standard risk framework domains to categorise the risks.

2 BACKGROUND

2.1 The Trust has been working on the Electronic Patient Record (EPR) programme with County Durham and Darlington Foundation Trust (CDDFT) for nearly two years. The Full Business Case (FBC) was approved at Trust Board in December 2018, subject to an agreed source of funding being identified and NHS Improvement (NHSI) approval being granted due to the total investment being over £35m. A paper was presented to Senior Leadership Team (SLT) in March 2019 recommending that work continues in the "Mobilisation Phase" in order that the Trust would be prepared to "hit the ground running" once approval was granted and funding identified.

2.2 Since the Trust approached NHSI for approval, they have indicated that the FBC and supporting documentation will not be reviewed until Integrated Care System (ICS) support is given and funding is identified. The Trust, along with CDDFT, has continued to engage with the ICS to gain their support.

2.3 The key timelines in the mobilisation phase are:

Task	Date
Funding Approval	End Sept 2019
NHSI approval	End Oct 2019
Final Contract Schedules Approved	November 2019
Trust Board Approval of refreshed business case	December 2019
Contract Award	January 2020
Programme begins	April 2020

2.4 Clearly the timeline is reliant on the identification of funding and this is the key milestone for the programme which remains outstanding. This paper identifies the risk to the organisation if it does not now complete the EPR programme or if there are further delays.

3 OVERVIEW OF EPR PROGRAMME

3.1 The EPR is planned to be live following a 2 year implementation and organisational readiness programme. The FBC includes the entire programme resource needed to implement a solution of this scale at this pace. This includes all of the programme and project team resource, such as project and business change managers, all additional technical resources such as interface and data archiving experts, along with additional training resource for example go live "floor walkers" to support staff when the system goes live.

3.2 The programme resource also includes backfill for clinical and non-clinical "subject matter experts" to be seconded onto the programme to design and configure the solution.

3.3 The main systems that the EPR would replace are:

- PAS (including the bed-management)
- Clinical documentation/workflow (Evolve)
- Theatres (TheatreMan)
- Emergency Department (ED) (Symphony)
- Maternity (E3)
- Bedside observations (VitalPAC)
- Spinal Injuries (IMS Maxims)
- Orthopaedic trauma audit system (Bluespier)
- Clinical Utilisation Review (Medworxx)
- Cancer Information System (Infoflex)
-

3.4 Other departmental clinical systems would also be considered to be replaced with the EPR as their contracts come to an end. The stance of an "EPR first" approach was recommended such that, over time, as much of the patient record as possible is available in a single solution. Examples of this are Endoscopy, Renal and Ophthalmology, all of which currently have their own specialist systems. Additional specialist modules from the EPR may be required in some instances and it would be a matter of business casing and evaluating the benefits and risks of taking an integrated EPR module against a separate specialist standalone solution.

3.5 Moreover, the plan is to introduce additional functionality with the EPR which would further support the ambition of a single integrated record and improve patient care. These are:

- E-prescribing/Electronic Prescribing and Medicine Administration (EPMA) functionality which is currently not available within the Trust. This has been highlighted as a major patient safety risk for several years
- Critical care functionality to enable the removal of the current paper charts and something that was highlighted during the due diligence process as being a key part of the EPR functionality

- Fetal Monitoring to enable Cardiotocographic (CTG) traces to be recorded electronically allowing remote and centralised monitoring of CTGs. This has been explored previously by the department and has major patient benefits around reducing the risk of perinatal death
- ECG management to enable ECGs to be recorded electronically and stored against the patient record again removing the current paper traces and the requirement to scan them into the patient record.

3.6 Detailed in Appendix C are all the major systems and the current risk associated with continuing with them, along with the expected replacement timescales.

3.7 Finally, the EPR FBC included the costs for replacement kit (both IT and medical) along with new equipment such as workstations on wheels, which would be required to ensure access to the system was available wherever and whenever it was needed.

4 DETAILS

4.1 CLINICAL SAFETY RISKS

4.1.1 A separate clinical risk document has been prepared by the CCIO and Chief Nurse Information Officer (CNIO). This is attached in appendix B. In summary the main clinical risks of not proceeding are:

- The Trust is the only Major Trauma unit in England without an EPMA solution which increases the risk of prescribing and drug administration errors
- We do not have a clinical decision support solution with workflow to guide good practice and improve patient safety
- Clinicians do not have timely access to clinical information, and no single "source of the truth" with the majority of patient records still held on paper that is not always readily available. Other specialist notes are held separately, e.g. radiotherapy, physio and maternity
- Aging infrastructure and systems including IT and clinical equipment limits the flow of clinical information, reduces clinician's confidence and impacts patient care
- We cannot share information sub-regionally and regionally via electronic means i.e. Great North Care Record, which will impact patient care when patients present across the region
- Staff (in particular trainees) are choosing not to come to South Tees due to the lack of electronic records.

4.1.2 It concludes by saying:

"In conclusion, not investing in an electronic patient record equates to ongoing unnecessary clinical risk within the organisation. These risks can only perpetuate as the rest of the NHS continues to move forward digitally; we

will be putting our patients at risk of harm, harm which could be mitigated or prevented."

4.1.3 Please refer to appendix B for more details.

4.2 FINANCIAL

4.2.1 Based on current market costs, the estimated capital investment required to replace the core systems and the current annual revenue costs for these systems is as follows (figures are ex VAT):

System	Contract Expiry Date	Capital (estimated)	Current Revenue Costs p.a.	5 year Revenue Costs	10 year Revenue Costs
PAS	31/03/2022	£1,000,000	£590,076	£2,950,380	£5,900,760
A&E Symphony	31/03/2022	£325,000	£70,891	£354,455	£708,910
Theatres	31/03/2020	£150,000	£19,300	£96,500	£193,000
Bluespier	29/11/2021		£11,845	£59,225	£118,450
Maternity	31/05/2019	£100,000	£37,567	£187,835	£375,670
VitalPac	13/03/2021	£700,000	£248,942	£1,244,710	£2,489,420
Infoflex*	31/03/2020		£82,630	£413,150	£826,300
Spinal Injuries	Out of Contract		£16,132	£80,660	£161,320
Evolve	31/03/2020	£1,000,000	£292,536	£1,462,680	£2,925,360
Web-ICE	01/04/2021	£250,000	£71,228	£356,140	£712,280
EPMA**	-	£1,600,000	£200,000	£1,000,000	£2,000,000
Total		**£5,125,000**	**£1,641,147**	**£8,205,735**	**£16,411,470**

Note:

* The current costs for Infoflex are £82,630 p.a. however the Trust has recently received notice from Chameleon Information Systems (CIMS) that these costs are due to increase to £377k for a 1 year extension. For a 5 year contract costs are £179k p.a. rising to £203k p.a. at year 5.

** These costs include EPMA which is currently not in the Trust but are shown here as a comparison to the costs for the EPR.

4.2.2 The business case for the EPR indicates that the annual costs are £1.9m p.a. with initial capital expenditure of £5.3m. This means that the EPR would cost an additional £175k in capital compared to replacing the equivalent standalone systems. Based on current revenue costs, an EPR would be an additional £259k p.a. in revenue, equivalent to £1,295,000 over 5 years or £2,590,000 over 10 years. Please note the preferred supplier of the EPR has indicated that their prices, quoted in October 2018 for the business case, cannot be held indefinitely and prices will go up in line with annual uplifts including Retail Price Index (RPI).

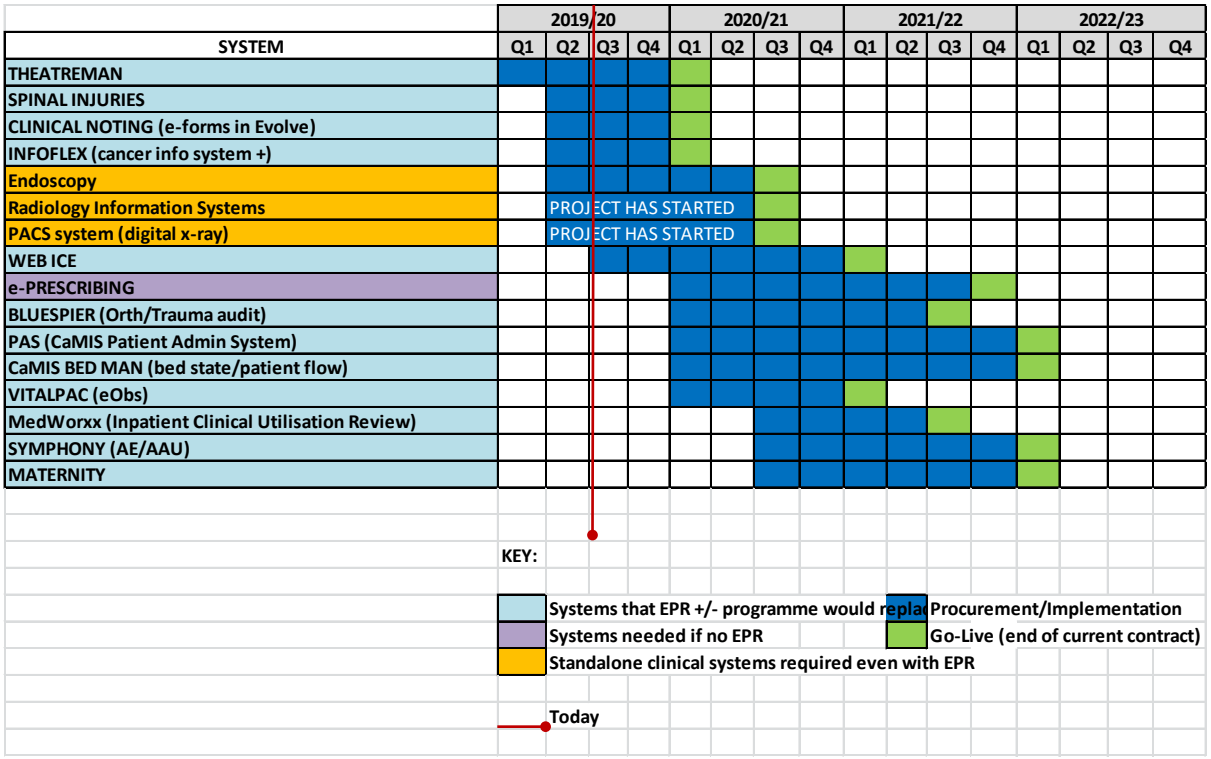
4.2.3 However, the integrated EPR enables both clinical and non-clinical benefits to be realised which are detailed in the FBC. This includes benefits such as reductions in storage and transport costs of clinical notes and reductions from repeated tests. This equates to £11m over 10 years, a net benefit of £8.4m (over 10 years).

4.2.4 This indicates that if the Trust does not now pursue an EPR, it will still have to invest a similar amount of capital and revenue in keeping separate systems running which assumes none will go end of life or be unsupported by the supplier. Crucially though, it will not realise any of the cash releasing and qualitative benefits identified in the FBC. There is also a risk that the costs of procuring best of breed solutions will now be higher than when contracts were first and subsequently negotiated.

4.2.5 The cost of replacing each system on a like for like basis is also much higher if separate systems are kept, requiring separate procurement programmes to be managed with separate procurement and implementation teams. This in turns raises the risk of data inconsistency and data quality across these systems. Each system requires its own hardware and software platform which has to be managed and maintained independently.

4.2.6 The EPR on the other hand is an offsite managed solution and this significantly negates this requirement.

4.2.7 The Trust has delayed replacing systems in favour of implementing the EPR. The following table below indicates the timeline for replacing systems over the next 3 – 4 years, if this current programme is abandoned.



4.2.8 This table includes the systems identified as being replaced with the EPR, but also shows additional critical clinical systems that need to be replaced, such as Radiology, PACS and Endoscopy. These are included to highlight the separate procurements that would be required over the next 3 – 4 years. As

shown, a number of these systems, such as TheatreMan and Spinal Injuries, are now at the end of their contract and if they are to be replaced, procurements should have already started.

4.2.9 Therefore, against the advice of procurement due to Standing Financial Instructions (SFI) rules, these contracts now have to be rolled on. This also means that there is no opportunity to test the market and ensure value for money with these systems.

4.2.10 The majority of systems will require procurement programmes to begin in Q1 of 2020/21 and will all be running in parallel. This has a significant impact on procurement, IT and clinical teams who are required to provide expert advice and guidance during the tendering and implementation phases.

4.2.11 The Trust's aging infrastructure is also highlighted in the approved FBC. The plan includes the replacement and enhancement of the IT equipment (laptops, mobile devices, carts etc.) and medical devices; infusion pumps, observation machines, ECG machines etc. with EPR compatible devices.

4.2.12 Without further investment in IT and medical equipment, there is a serious risk that equipment could, and is beginning to, fail. The Trust is now in the position of having devices that cannot be upgraded any further to keep step with software/cyber security requirements being released such as Windows 10.

4.2.13 The EPR business case has these costs identified as below:

Device	**Total over 5 years**
Replacement for old/obsolete kit	£2,736,071
Basic cart with laptop	£294,925
Carts with arms/draws	£2,434,232
Handover screens	£321,225
Medication carts	£516,125
Specimen cart	£1,723,772
Visiting teams	£132,354
Total	**£8,158,704**

4.2.14 Failure now to continue with the EPR programme will still leave a gap in the Trust infrastructure. Even without the EPR, the Trust will have to start a rolling replacement programme for the old kit which is end of life. Within the next 12 – 24 months this will directly impact a clinician's ability to deliver safe and efficient care. Therefore even without the EPR significant investment is still needed to replace aging and obsolete equipment.

4.3 BUSINESS PLANS

4.3.1 The “mobilisation phase” has been planned with CDDFT to ensure both organisations are ready to “hit the ground running” once the go ahead for the programme is given. On the whole, this work requires no additional funding, needing only the resources of the team currently working on the EPR programme. However, there is some pre-work identified within the mobilisation phase which requires a small amount of funding. A paper was originally taken to Senior Leadership Team (SLT) to secure this funding; however this was not supported at the time.

4.3.2 The work identified was:

- **Data Migration “discovery”** – This was early prep work on the PAS to identify the data to be migrated and the potential data quality issues that may be encountered. Feedback from other sites suggested that poor planning for data migration was the main cause of go live delays. As South Tees and CDDFT have the same PAS (CaMIS) the plan was to do this work together and share costs which attracted a small cost saving from the company (Stalis). Given our delays in funding this, CDDFT has now contracted separately with Stalis to complete this work. The Trust now is not aligned to CDDFT and once approval for funding is given we will need to engage with Stalis separately to complete the work.

- **Third party review of contracts** – South Tees and CDDFT have continued to work with the preferred supplier in completing the schedules and finalising the contracts. A number of schedules will be common between South Tees and CDDFT, however each organisation will have completely separate contracts. Once the schedules have been finalised, the plan was to use a third party company to review them and perform further due diligence. Again, the proposal was to do this jointly and share costs given there will be such similarities in the schedules. However, with the Trust delaying funding this, CDDFT have started supplier engagement with the intention of doing a direct award off a framework as soon as their contract is ready. Without completing an independent external review of our contract the Trust could expose itself to risk. Contract signature is planned for January 2020.

4.3.3 Additionally, the Trust received funding from the Health System Lead Investment (HSLI) to replace its integration engine but further match funding from the Trust is required. As the plan is to share the same EPR database solution with CDDFT, there will only be one set of interface messages from the EPR. Therefore it would be strategically beneficial to have the same integration engine as CDDFT and to share interface development and management. Ideally, The new integration engine will need procuring and implementation to begin within the next 6 – 12 months to prevent it having a detrimental effect on the EPR timescales.

4.4 REPUTATIONAL

4.4.1 As highlighted in the FBC and the Trust's IT Strategy (2018-2023), on the latest clinical digital maturity index score, the trust is ranked 105 out of 150. In addition we are currently the lowest ranked major trauma centre nationally.

Rank	Trust	Score
1	Newcastle Upon Tyne	95
1	North Tees and Hartlepool	95
1	County Durham & Darlington	95
23	City Hospital Sunderland	90
32	Gateshead Health	87
42	York Teaching Hospital	85
45	Northumbria Healthcare	84
85	South Tyneside	73
105	South Tees	69

4.4.2 This position would be improved with the implementation of an EPMA solution, however there would still be a number of gaps including clinical decision support tools; enterprise scheduling and full electronic clinical noting that would prevent the Trust from moving further up the ranking table.

4.4.3 Implementation of a regional Health Information Exchange (HIE) – Great North Care Record (GNCR) – is underway. The trust has committed to be a part of this programme, the objective of which is for all Health and Social Care organisations in the region to be connected to the HIE. This then provides the organisations with the capability to send and receive information to and from other providers in the region. Without an EPR this Trust will not be able to connect for either sharing or consuming information. This will put us as an outlier in the region, being the only acute service unable to share and view patient records. Also as the Trust is a Tertiary Referral centre, this places our patients at a significant disadvantage clinically in the provision of their integrated care, e.g. unable to access GP records and records from other Trusts.

4.4.4 South Tees has worked very closely with CDDFT for the last two years on the EPR programme. The programme has been developed based on an assumption there will be a shared database instance across the two organisations which not only gives benefits in terms of shared data, shared processes and standardised pathways, but means the costs for hosting can be shared. This represents a significant saving to both organisations of around £5m.

4.4.5 If South Tees were to pull out of the programme now this would have an impact on the costs for CDDFT. CDDFT are aware of the risk and have built into their business case the cost of proceeding without South Tees. However, their preferred option is to continue with a joint procurement. The wider concern is the impact on the relationships that has been built with County Durham over the last 2 years which could be significantly damaged if the Trust now pulls out of the programme.

5 RECOMMENDATIONS

5.1 The risks of the Trust not proceeding with the Electronic Patient Record has been raised with the board previously, and is on the Board Assurance Framework. The Board is asked to note the increased risk to the organisation of delaying or postponing the Electronic Patient Record (EPR) programme and the impact this could have on patient care.

5.2 The Board is asked to support the Director of Estates, IT & Health Care records as the SRO / Executive lead for the EPR programme in gaining business case approval by NHSI and note that the two principle delays are ICS support of the business case and identification of a funding source for the programme and the supporting infrastructure.

6 APPENDICES

- Appendix A – The Risk Log
- Appendix B – The Clinical Risk paper prepared by the CCIO and the Chief Nurse Information Officer (CNIO)
- Appendix C – List of major clinical systems to be replaced by the EPR and the risks associated with not replacing them.

Appendix A – Risk Log

South Tees Hospitals NHS Foundation Trust

					Original risk rating (where applicable)							Current Review Data						
Risk No.	Domain	Service	Description	Impact	Severity	Likelihood	Score	Risk Response Category	Mitigation Actions and Progress	Owner	Actionee	Date Logged	Current Review Date	Severity	Likelihood	Score	Status	Notes
				Consequence	1 = Low 5 = Critical	1 = Low 5 = Critical	Impact x Probability	(Avoid, Reduce, Transfer, Accept)	What is being done now and how is it progressing? What are the timescales for current actions? What would be done if the risk occurred?					1 = Low 5 = Critical	1 = Low 5 = Critical	Impact x Probability		
NER001 (EPR risk R008)	Quality Safety Reputational Staffing retention & recruitment	All	EPR Solution is ultimately unaffordable	Programme can't be delivered and STees pull out of procurement. This also has impact on CDDFT costs. Replacement of legacy systems still required due to contract expiry dates. Patient Safety benefits not realised.	5	3	15	Reduce	Share overall costs in cost model with DoF as soon as possible to discuss affordability. If solution does become unaffordable explore where costs can be reduced without jeopardising programme timescales and quality. If risk is accepted, submission of several business cases for replacement of	AA	IW	06/09/2018	26/07/2019	5	4	20	Open	Business Case costs were reduced in Mar 2019 by taking out £8m capital for the replacement of aged IT and Medical Devices that would either not be at minimum spec or capable of interfacing with EPR. The intention was to place these into a rolling replacement programme to be developed and maintained for the life of the EPR contract. All other costs have been similarly reviewed several times in attempt to reduce costs. Escalation of this risk within the trust is recommended
NER002 (EPR risk R015)	Quality Safety	All	Capital funding to support necessary replacement of aging IT server hardware, user devices is not available	Ongoing BAU and corporate projects at risk due to low specification PCs/devices e.g. Voice recognition project. Audit of 95 PCs has demonstrated that 94% are below specification for the solution to be rolled out. Future systems procured as detailed in this log may require higher specification PCs	4	4	16	Reduce	Memory upgrades are currently funded as and when required. However is potentially a false economy when the total number is known	AA	IW	05/11/2018	26/07/2019	4	5	20	Open	As above. Regardless of EPR business case proceeding as planned, audit of IT & medical devices within the trust demonstrated: Aging equipment, the risk of which rises expotentially whilst no replacement programme exists Poor use of medical device procurement policy within the trust
NER003 (EPR risk R015)	Quality Safety	All	Capital funding to support necessary replacement of aging medical devices is not available	Ongoing BAU and corporate projects at risk due to low specification PCs/devices e.g. Voice recognition project. Audit of 95 PCs has demonstrated that 94% are below specification for the solution to be rolled out. Future systems procured as detailed in this log may require higher specification PCs	4	4	16	Reduce	Memory upgrades are currently funded as and when required. However is potentially a false economy when the total number is known	KO/AA	IW	05/11/2018	26/07/2019	4	5	20	Open	As above. Regardless of EPR business case proceeding as planned, audit of IT & medical devices within the trust demonstrated: Aging equipment, the risk of which rises expotentially whilst no replacement programme exists Poor use of medical device procurement policy within the trust
NER003	Quality Safety Staffing retention & recruitment Human Resources	All	Several key clinical service systems will require replacement between 19/20 and 22/23	Multiple procurement projects will be required. Potential for an increased capital and revenue spend on multiple systems. Procurement, ICT, implementation resources; backfill; multiple data migration projects; training; procurement; spec writing; mulitple points of failure; limited computer rooom capacity and environment					Detailed assessment of the residual costs of maintaining these systems and timeline for replacement required	AA	IW		26/07/2019	4	4	16	Open	Most of the business critical clinical systems have been on a rolling contract for longer than legally feasible. This in itself carries a risk of financial penalty i.e. 5% of the annual income of the trust per system contract rolled over beyond legal limits
NER004	Quality Safety Staffing retention & recruitment	All	No ePMA provision	18 - 24 months procurement and implementation cycle. Stand alone ePMA will not provide full mitigation for trust identified safety issues of not having an ePMA. Will not be part of an integrated patient record.	4	3	12	Reduce	Write up to date specification and business case. ICT Business Analyst & Pharmacy resource required for this task	AA	IW	26/07/2019		4	4	16	Open	As of September 2019 - NHS England have announced that a further round of ePMA funding will be available for trusts to bid for (cost matched by trust bid) in April 2020. Head of Digital Programmes is working with Dep Chief Pharmacist on preparing for this bid
NER004	Quality Safety Reputational Financial	All	Data sharing to the regional Health Information Exchange will not be possible	View only access to HIE. South Tees will not be able to provide its patient records digitally within the ICS. Tertiary clinical pathways will be compromised - loss of reputation within the region. South Tees would potentially only be able to share AE and WebICE results data to	4	3	12	Reduce	Explore possible solutions to view HIE data and sharing possibilities.	AA	IW	26/07/2019		4	4	16	Open	
NER005	Quality Safety Reputational	All	Integration with regional Patient Portal initative will be limited	Ability to provide full dataset and information to patients dependent upon interfaces and systems required.	4	3	12	Reduce	Explore if there are any possible solutions.	AA	IW	26/07/2019		4	4	16	Open	

ELECTRONIC PATIENT RECORD

Current clinical risks and the risks of doing nothing

This supporting document considers the clinical (and digital) position of South Tees NHS Foundation Trust as it currently stands and the impact on clinical practice and clinical safety by not having an electronic patient record (EPR).

1. E-prescribing

Currently we are the only major trust in the region without an electronic prescribing solution. The absence of such a system puts the organisation at risk in several different ways.

> *"Unsafe medication practices and medication errors are a leading cause of injury and avoidable harm in health care systems across the world. Globally, the cost associated with medication errors has been estimated at £31 billion annually."* World Health Organisation

a. *Prescribing and drug administration errors.*

Last year alone there were 566 drug administration errors in the organisation, of which 59 resulted in direct harm to patients. In the same time period there were 218 prescribing errors, 13 of which resulted in direct patient harm.

It has been well documented that prescribing errors and adverse drug reactions, secondary to both prescribing and drug administration errors can be reduced by having an e-prescribing solution integrated within an EPR.

- *West Suffolk NHS Foundation Trust: 57% reduction in pharmacist interventions*
- *Wirral Hospitals NHS Foundation Trust: 45.1% increase in number of prescriptions not requiring pharmacist intervention*
- *Children's Hospital Pittsburgh, US (same configuration as Newcastle): Reduced Adverse Drug Events by 50%*

Inform Health, following benchmarking, evidence from other trusts and a benefits analysis; predict a 50% improvement and reduction in prescribing related errors and therefore patient harm by 50%. The planned automated medication dispensing solution (Omnicell automated drug cabinets) will further contribute to this. Recent papers have quoted up to a 67% reduction in drug preparation and administration errors.

b. *Risks to junior doctors and non-medical prescribers (and patients).*

Being the only major trust without an electronic prescribing solution, we are putting future junior doctors and non-medical prescribers (as well as the patients) at risk. A true, fully integrated e-prescribing system comes with intelligent decision making tools and alerting. This not only prompts and mandates certain actions, but also alerts against potential drug interactions and errors.

As junior doctors rotate into our trust, we are effectively removing their prior safety net of alerting and decision making which they have had in other digitally mature trusts, dramatically increasing the risk to both clinician and patient.

We currently often prescribe without immediate access to the clinical record, increasing clinical risk as the prescribing is therefore done without the full clinical picture. This situation would not occur with an integrated electronic record which not only gives immediate clinical information, but also provides access to the primary care record, improving medicines reconciliation.

c. *Standardisation of antimicrobial prescribing.*
Antimicrobial resistance is a significant threat to global health. NICE guidance (NG15) recommends all NHS Trusts have a broad-ranging approach to antibiotic stewardship to help slow the spread of resistance.
Electronic prescribing will support the safe and judicious use of antibiotics using a variety of approaches:

i. Standardised, evidence-based, decision support protocols to prevent prescribing errors caused by antibiotic drug interactions, hypersensitivity reactions and contra-indications.
ii. Promotion of formulary compliance with the recommended duration of anti-microbial therapy (e.g. using review dates/ prompts); reducing the risk of antimicrobial resistance and *C. difficile* infection. 17% of antibiotic overuse was related to unnecessarily prolonged courses in a recent study (ESPAUR 2018).
iii. NICE guidance (NG15) suggests that lack of review, reflection and critical evaluation of antimicrobial prescribing is a barrier to improving antimicrobial use. E-prescribing can provide summary data to evaluate errors, antimicrobial choices and course length. This data can be fed back with supporting information to individual prescribers, clinical areas, clinical teams and directorates for review. This is not currently feasible with hand-written prescriptions.
iv. The UK government has set a target to reduce inappropriate antibiotic prescribing by 50% by 2020. Electronic records can be used to identify areas of poor prescribing trust-wide. This information can be used to support an improvement plan.
v. A rapid review of ‘restricted access’ antibiotic is not possible using current prescribing methods. E-prescribing can be used by antimicrobial stewardship teams to ensure safe prescribing (e.g. for agents requiring therapeutic drug monitoring such as Colistin) and to check adherence to national antimicrobial strategies (e.g. CQUIN targets such as reducing Carbapenems use) in real-time.
vi. Targeted antibiotic ward rounds are challenging using handwritten prescriptions. E-prescribing can be used to highlight specific cases of irregular prescribing for antimicrobial stewardship team review.
vii. The electronic patient record has in-built “harm-free” care bundles which can prompt and guide the clinician, as well as automatically place clinical treatments and ‘orders’.

d. *Future recruitment to the trust.*
For the first time, we are starting to see the digital immaturity of the trust being cited as one of the reasons for doctors not wanting to work at South Tees NHS Trust. Last year, the lack of electronic prescribing was specifically identified as a reason that a trainee did not want to work within the trust. This obviously potentially impacts on both future recruitment and retention of staff.

2. Clinical workflows and decision tools

An EPR has the ability to drive effective and safe medical practice and standards by using clinical decision tools and built in 'condition specific' workflows. We have been able to evidence this as we have seen some discrete areas within the trust became digital and/or paperless in recent years:

- *In the emergency department, the implementation of the Symphony system and use of its decision tools and mandated scoring, has improved sepsis screening from 42% (baseline in 2014) to 100% (current)*
- *Symphony is also able to evidence paediatric safeguarding screening from 14% to 100%*
- *The implementation of Vitalpac improved sepsis screening from 32% to 100% (adult wards only)*
- *Vitalpac screening and alerting improved trust mortality by 1% (10% to 9%)*

Whilst Vitalpac has already realised benefits in relation to mortality and sepsis screening, the trust still has a significant number of clinical areas which remain on paper e.g paediatrics and maternity currently screen sepsis on paper and have a current compliance rate of 67%.

Sepsis is one of the main reasons that a pregnant woman may require admission to critical care (Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman, 2011). Therefore these services would clearly see the above benefits from a trust wide electronic solution.

Inform Health have benchmarked and reviewed our current systems, workflows, practices and believe that an EPR will bring about the following benefits (these are specific to South Tees NHS Trust):

- *Reduction in adverse drug reactions by 50% (see above)*
- *Surgical/in-house DVT reduction: reduction in clinical morbidity and a 1 day length of stay*

- *Emergency elderly patients readmissions within 30 days: proposed 1% reduction due to access to patient records*
- *Sepsis Screening (see above): improved screening translates to improved care/mortality and reduced length of stay*
    - *There is potential for even further benefit than predicted as screening within an EPR can be proactive as well as reactive, potentially increasing detection*
    - *The earlier identification of sepsis not only translates to improved mortality, but also fewer intensive care admissions*
- *Detection and treatment of acute kidney injury (AKI): 10% improvement*

- *Management of frail patients: reduced length of stay and clinical incidents*
- *Falls with harm: 25% reduction*
- *Trust mortality: benefits already from Vitalpac as described above however a further estimated reduction of 1.4% to 1.3% (143 per year)*
- *Fractured neck of femur: 2 day reduction in length of stay with mortality reduction from 7% to 6%*

These clinical benefits are well documented in major sites which have an electronic clinical decision support systems/EPR. The benefits are achievable through better identification of patients with a risk; better alerting; electronic decision support tools and mandated evidence based care protocols and bundles.

The above clinical benefits are based on benchmarking of our baselines and known current practices. There are many more predicted and potential clinical benefits which we are more than likely to realise, based on future benchmarking work as the EPR becomes live and matures, such as:

- *Reduction in duplicate tests, reducing potential harm to the patient as well as cost*
- *Efficiencies in handover and transfer of care which is known to be point when there is a huge potential for error. An electronic record could bring about efficiencies as well as reducing risk*
- *Reduction in pressure ulcer detection and therefore treatment*
- *Improvement in operating theatre efficiencies and slot utilisation improving turnover, reducing waiting time, fewer cancellations (Royal Free London: 7% improvement*

3. Access to information

The majority of the organisation remains paper-based and therefore, as described in the prescribing section, inability to access/find clinical records put our patients at significant risk of harm. This applies to both acute admission information and historical records. Examples of issues from panel reviews have been inappropriate clinical decision making, lack of evidenced escalation plans in place as there is no access to historic information on admission culminating in patients being inappropriately resuscitated.

Conversely, even when records are available clinicians are often provided with superfluous and disorganised information marking timely and efficient decision making significantly adversely affected. Clinicians currently lack an indexed, searchable single source of the truth. Recent consultant interviews stated that, when reviewing clinical records, they could not quickly separate the “signal from the noise” to support sound clinical decision making. In addition, availability, chronology and legibility have been highlighted as issues during external audits and visits.

The trust has both ageing infrastructure and ageing systems with very limited connectivity which results in extremely limited flow of clinical information, impacting on clinical care.

a. *Multiple logins are required, no flow of information*

   A single point of access and a single source of the truth is the key to efficient, effective and safe care. The lack of flow of linked information and the absence of a single patient record means that multiple systems need to be accessed. This requires multiple logins and repeated transcription of information between the systems. Each point of access and each episode of transcription is a potential point of significant error.

- *A recent workflow audit highlighted that in investigating and treating the average oncology patient, the clinician was required to access 15 separate systems during the patient journey.*

b. Ageing devices

i. IT equipment

Ageing technology and equipment directly impacts on the clinicians' ability to deliver safe efficient care. This lack of reliability and subsequent lack of clinical confidence is introducing significant risk to patient care.

- *At the point of potentially going live with an electronic patient record in 2020:*
  91% of our 3321 machines will be 5 years and over
  61% will be aged 10 years and over

ii. Medical devices

The Cerner EPR has the ability to interface with medical devices such as observation machines, ECG's and ventilators. This functionality would allow the direct transfer of critical data into the patient record. A lack of prior investment in medical devices has resulted in an aged and non-standardised equipment estate. Currently 1500 out of the 4500 devices in the trust are not able to connect to any potential EPR system (the oldest being from 1993). Not addressing this issue will result in inefficiencies and potential clinical error as multiple points of transcription will be required

4. Sharing of information

Regionally, the plans for the Great North Care Record (GNCR) are moving forward at pace. South Tees' current position means that if we do not progress with an EPR, the lack of information sharing capabilities will put our clinicians, and therefore patients, at risk. Without a fully integrated electronic record, we will have little information to share with both regional organisations and the primary care domain.

Without seamless integration of the GNCR with an electronic patient record, another separate system and access login would be required. This moves us even further away from a single source of the truth.

Considering our local population, we have little or no ability to track or flag relevant groups of patients, for example the vulnerable (patients with a learning disability, autism or mental health problems). These patients are at a greater risk of death as soon as they enter an acute organisation, often can't communicate and we can't access information systems externally that would support us to care for patients better. This patient cohort is an estimated 2.5% of the population and probably higher within our locality due to comorbidities and deprivation. Yet we have only got 0.05% patients accessing our service that are currently flagged with a learning disability. This clearly demonstrates a deficiency in the ability of our current systems to flag these patients.

5. Staff retention and recruitment

Our lack of digital maturity and regional/national standing with regards to the national Clinical Digital Maturity Index rankings means that most staff rotating through the trust have come from an organisation which is more digitally enabled, thus empowering these clinicians to work more efficiently and effectively. This inevitably will translate to patient risk as the trust lacks that standardisation and built in decision support and alerting which informs good, evidence based practice.
It is unlikely that staff would want to work under these circumstances in an already pressured environment; any impact on staff retention and recruitment potentially directly impacts on clinical care. During a recent interview and selection process, an external candidate was asked what would they see as the greatest challenge in the role; their answer…?

> *"Having to go back to paper, having worked with electronic patient records for over a decade"*

6. Conclusion

In conclusion, not investing in an electronic patient record equates to ongoing unnecessary clinical risk within the organisation. These risks can only perpetuate as the rest of the NHS continues to move forward digitally; we will be putting our patients at risk of harm, harm which could be mitigated or prevented.

System	Description	Risks of not replacing/implementing	Timeline	Costs
PAS / Bed Management	The PAS is used mainly by administrative staff and is the system that manages patient flow in the organisation, all outpatient appointments, waiting lists, coding, referral to treatment (RTT) etc. It is vital for producing all funding and reporting extracts such as commissioning data sets (CDS) and secondary uses services (SUS). The patient master index contained within the PAS is the central record of patient demographics which feeds all other clinical systems.	Potentially there is an option to extend the contract for the PAS but this breaks current Trust SFIs and puts the Trust at risk of being challenged by other suppliers. This could lead to a fine of up to 5% of the Trust's turnover. Although there have been hardware updates, the technology that the current PAS sits on is 25 years old and recent cyber audits have indicated that it poses a security risk. Uncertainty over the future of CaMIS PAS. EMIS will cease support of OpenCaMIS in 2020 (our current version). Trust is being forced to take additional E-CaMIS modules from April 2020.	The contract has been extended on a number of occasions and will currently now expire on 1st April 2022. Replacing a PAS would take 18 months to 2 years to complete. Procurement will need to start Q1 in 2020/21 (April 2020) to enable an implementation by quarter 1 2022.	It is estimated that a standalone PAS would cost in the region of £1m capital.
E-Prescribing/ EPMA	E-prescribing / Electronic Prescribing and Medicines Administration (EPMA). Electronically prescribe and administer medications including all inpatient medication and outpatient prescriptions (To Take Out medication). Includes decision support to help guide clinicians and alert to	See separate clinical risk paper (Appendix A). We are the only Trust in the region without an EPMA solution. Recent Coroner's report recommended Trust implements EPMA.	An EPMA impacts the whole organisation and is a 2 year project from start to finish (1 year procurement, 1 year implementation). As the Trust does not have an EPMA	Approximately £2m for software/hardware. Approximately £1.8m in project resources, including subject matter experts (SMEs), training resource, floor walkers etc.

	potentially incorrect dosages or patient safety concerns such as allergies.		there is no current contract that is due to expire, but the Trust has made a commitment to implement an EPMA solution as soon as possible.	
Clinical Documentation with workflow and decision support	The Trust currently doesn't have a full clinical documentation and workflow solution. It does have the Evolve solution for clinical documentation with limited workflow. It is currently only used in paediatrics and therapies. Potentially this could be expanded and used as an enterprise wide clinical documentation solution.	The current solution does not include any clinical decision support elements and is fundamentally an electronic document management solution (EDM). Many of the clinical and non-clinical benefits expected from the EPR would therefore not be achievable. The contract for Evolve comes to an end at the end of March 2020 so will have to be re-negotiated and a new contract signed. An alternative option would be to purchase a new solution with appropriate clinical decision support.	18 months – 2 year project requiring a team of subject matter experts seconded in from across the organisation along with a project team to manage the process mapping, business change, roll out and training.	Unknown cost. Likely to be in the region of £1m capital.
Theatres (and anaesthetics)	TheatreMan used to manage theatre scheduling for inpatient and day cases. System has been in the Trust for over 20 years.	The current system is running on an unsupported Windows version with an unsupported SQL database. Contract could be rolled on but this would be subject to SFIs and may not be possible.	The contract has been extended a number of times and is now due to expire on 1st April 2020. A replacement programme would	The estimated cost for a new system is £150,000 capital.

		Current system has limited use outside of Theatres, and is not for example used to record anaesthetic charts,	take about a year to complete. Therefore at this stage the current system would have to be extended again for a least another year to allow time to re-procure a new system.	
ED – Symphony	The current ED/urgent care system is Symphony provided by EMIS. It has enabled the department to go paperless. It manages and tracks patient flow through the department. It is used at James Cook and Friarage A&E and is also used in the urgent treatment centre at Redcar.	Symphony is written in Visual Basic 6 which went out of mainstream support from Microsoft in 2005 and extended support in 2008. This indicates that the Symphony solution is written using out of date technologies and is at risk of cyber-attacks. This also raises a question over EMIS's long term plans for the current version of Symphony. Maintaining a separate solution means many of the expected benefits from an integrated EPR will not be realised, such as improved patient safety and patient flow with full access to the record across the organisation. Contract could be rolled on but this would be subject to SFIs and may not	This is due to be replaced in quarter 1 of 2022. A replacement programme would take approximately 2 years from procurement design & build and implementation. It would require a project team consisting of subject matter experts such as clinicians, nurses, bed managers etc., and non-clinical support staff including project managers, data analysts and	The estimated costs are £325,000 capital

		be possible.	trainers.	
Maternity	Maternity solution has been in the organisation since the late 1980s, however it has recently been upgraded to the latest version, E3. It provides a complete electronic pregnancy record and is accessed in the community via laptops with 3G cards.	Solution is currently not capable of meeting the Women's Digital Care Report project aims (https://digital.nhs.uk/services/digital-maternity-programme/womens-digital-care-record). Further investment will be required to meet this. If contract is extended again, this could break SFIs and result in the Trust being fined. CTG monitoring was planned to be implemented as part of the EPR. Without this, additional benefits including early detection and warning of fetal distress will not be achievable.	The contract is now due to expire in quarter 1 of 2022. A replacement programme would require a 12 – 18 month project from procurement through to implementation.	Capital in the region of £100,000 capital
Order Comms / Results reporting	Current solution is Web-ICE and has been in the Trust since 2003. The last update to the system was performed in 2011. It is used to record requests for orders, and to report on results. It is used across GPs to request tests etc.	Current solution is running on old hardware and the version is now out of date. An update is planned this year which has enhanced functionality and fixes a number of issues currently with the system where workarounds have been put into place. If this is not funded then the solution will very soon no longer be supported by the supplier (Sunquest).	Contract due to expire quarter 1 2021. It would be an 18 month to 2 year project to replace it.	Approximately £250,000 capital

		If contract is extended again, this could break SFIs and result in the Trust being fined.		
VitalPAC	VitalPAC is used to collect patient observations (vitals) at the bedside (adult wards only). It calculates NEWS2, has alerting for sepsis and AKI with an interface to pathology.	System is over 5 years old. Kit used to collect and view obs (IPads and IPods) are now beginning to fail. Wards have to go back to paper due to failures which introduces patient safety risks. System is not integrated to any other system and cannot be shared as part of the patient record.	Contract has recently been renewed for another 3 years. Contract is due to expire April 2022. A replacement programme would take about 12 – 18 months	Approximately £700,000 capital
Spinal Injuries	System has been in the Trust since 2004. It is an EPR for Spinal Injuries and has enabled the department to go paperless. Hardware and software has recently been upgraded.	System is not integrated to any other system requiring electronic forms to be printed out when patients move to departments outside of spinal injuries. There is currently no formal contract with the supplier with the contract rolled on annually. This potentially breaks current SFIs. – Department is looking to put a new contract in place	Contract is currently rolled on annually. A replacement system would take between 18 months – 2 years.	Costs to replace are unknown
Bluespier	A clinical audit and coding system used by Trauma. It went live in November 2016 and was designed to manage patients in Trauma. As the clinicians	System is a standalone solution used only in Trauma. The department is looking to use it for post-operative management of trauma cases by implementing an enhanced interface to PAS.	Replacing the system would take about 9 – 12 months.	Costs to replace are unknown

	enter their operation notes the system automatically maps the diagnostic, procedure and co-morbidity codes, which improves accuracy and completeness.	The EPR programme included replacing Bluespier so that the full patient pathway for trauma patients, including inpatients, outpatients and waiting lists could be managed		
Infoflex	Used in the Trust since 1998, initially for Radiotherapy to record data from case notes then developed to performance manage cancer treatment provision, including tracking of patients' progress and treatments for the cancer waiting time agenda, and provision of clinical audit and national datasets.	System is standalone and does not integrate into any other systems. The current costs are £82.6k p.a. However, CIMS have provided updated costs for a new contract which range from £377k p.a. for a one year contract or £179k rising to £203k p.a. for a five year contract. The intention was to provide many aspects of the Infoflex system within the EPR e.g. access to a full clinical record and provision of clinic letters and look at an alternative solution, such as Somerset for collecting the cancer registry data.	The current contract was awarded in 2014 and is due to expire in March 2020. Process to re-procure this system has now started.	Costs to replace are unknown – cost currently looking at alternative solutions.

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5TH NOVEMBER 2019			
2018/19 Emergency Preparedness, Resilience and Response (EPRR) Core Standards			**AGENDA ITEM: 14, ENC 9**
Report Author and Job Title:	Diane Hurley, Head of EPRR	**Responsible Director:**	Kevin Oxley Director of Estates, ICT and Healthcare Records
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	NHS Trusts are required to undertake an annual self-assessment against the NHS England EPRR Core Standards and provide a statement of compliance to the Board.		
Background	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect services or patient care. These could be anything from loss of power or extreme weather conditions to an infectious disease outbreak, major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended), which requires NHS organisations to demonstrate that they can effectively respond to such incidents while maintaining services to patients.		
Assessment	The self-assessment was undertaken by the Director of Estates, ICT and Healthcare Records and the Head of EPRR in liaison with relevant personnel across the Trust. Following this, 58 of the standards have been assessed as green (fully compliant) with the remaining 6 standards assessed as amber (partially compliant), plus full compliance with the deep dive. Overall, this means that the Trust can report **substantial compliance** for 2018/19.		
Recommendation	The Trust Board are asked to receive this report for information and note the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards. A detailed action plan will be developed to further address the areas of partial and shared with SLT.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.4 - A major incident (cyber attack, critical infrastructure failure, supply chain failure etc) resulting in temporary hospital closure or a prolonged disruption to the continuity of care services across the Trust, which also impacts significantly on the local health service community		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐	
	Drive operational performance ☒	Long term financial sustainability ☐	

	Develop clinical and commercial strategies ☐	

Emergency Preparedness, Resilience and Response (EPRR) Core Standards 2018/19

Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect services or patient care. These could be anything from loss of power or extreme weather conditions to an infectious disease outbreak, major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended), which requires NHS organisations to demonstrate that they can effectively respond to such incidents while maintaining services to patients.

Under the CCA the Trust is designated as a category 1 responder which means that it must be able to provide an effective response in emergencies whilst maintaining services. It is subject to the full range of civil protection duties as follows:

- Assessing the risk of emergencies occurring and using this to inform planning
- Putting in place emergency and business continuity plans
- Putting in place and maintaining arrangements to warn, inform and advise the public
- Sharing information and co-operating with other local responders

This work is referred to as 'emergency preparedness, resilience and response' (EPRR) and requires NHS organisations to develop plans, policies and procedures, provide training for staff on their role in an incident, exercise these plans to ensure they are fit for purpose and support any response and recovery efforts when an incident occurs.

National core standards for EPRR

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations must meet. The Trust is required to undertake an annual self-assessment against the core standards and produce a statement of compliance for presentation to the Board of Directors. In the event that the Trust is not compliant with any of the standards, an action plan will be developed and monitored through the EPRR governance arrangements.

In 2017/18 the Trust reported non-compliance with the standards, as there were a number of areas rated as amber (*not compliant but evidence of progress and in the EPRR work plan for the next 12 months*). An action plan was developed to address these and substantial progress has been made over the past 12 months.

2018/19 assessment

This year there are 64 standards that the Trust is required to report against, split into 10 domains. In addition, there is a separate 'deep dive' into command and control.

The self-assessment was undertaken by the Director of Estates, ICT and Healthcare Records and the Head of EPRR in liaison with relevant personnel across the Trust. Following this, 58 of the standards have been assessed as green (fully compliant) with the remaining 6 standards assessed as amber (partially compliant), plus full compliance with the deep dive.

Overall, this means that the Trust can report **substantial compliance** for 2018/19.

The table below gives an overview of the areas identified as partially compliant; an action plan has been developed to address these and can be found in the self-assessment spreadsheet (appendix A).

The Trust was required to submit their completed submission and statement of compliance to NHS England, Cumbria and the North East by 24th September 2018. This was reviewed and externally validated at a moderation session held on 2nd October 2018 during which it was compared with other Trusts across the North Cumbria and North East area (appendix B). No changes were required following this session.

Domain	No of standards	Compliance
Governance	6	All fully compliant
Duty to assess risk	2	All fully compliant
Duty to maintain plans	14	13 fully compliant; 1 partially compliant • Mass countermeasures plan
Command and control	2	All fully compliant
Training and exercising	3	All fully compliant
Response	7	All fully compliant
Warning and informing	3	2 fully compliant; 1 partially compliant • EPRR media strategy
Co-operation	4	3 fully compliant; 1 partially compliant • Mutual aid arrangements
Business continuity	9	6 fully compliant; 3 partially compliant • Business continuity management system scope and objectives • Business impact analysis • Assurance of suppliers BCPs
CBRN	14	Full compliance
Total	**64**	**58 fully compliant; 6 partially compliant**
Deep Dive – command and control	8	Full compliance

A regional assurance visit is being undertaken in October to review progress since 2017/18. This will be led by the Regional Head of EPRR for NHS England, supported by NHS Improvement and the lead Clinical Commissioner. A report will be produced following the visit and will form part of the overall regional assurance at the end of the year.

Conclusion

Board of Directors is asked to receive this report and note the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards. A detailed action plan will be developed to further address the areas of partial and shared with SLT.

Diane Hurley, Head of EPRR
Kevin Oxley, Director of Estates, ICT and Healthcare Records / Lead Director for EPRR

Appendix A – Action Plan (see separate document)

Appendix B – Submission and Statement of Compliance (see separate document)

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
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	Andrew Owens, Medical Director appointed as AEO Debbie Reape appointed as NED	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.	EPRR strategy developed; signed off by Trust Resilience Forum; updated version being presented for approval by Operational Management Board in September 2019	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 England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	2018/19 assurance report presented to Board on 6/11/18 2019/20 assurance report to be presented to Operational Management Board on 24/10/19 and Public Board on 6/11/19; to include annual report and work plan	Fully compliant			
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	Annual EPRR work programme in place; reviewed during 1-2-1 sessions with lead Director and shared with TRF Currently being refreshed for 2019-20 to take account of EPRR core standards submission; will be included in annual report submitted to OMB and Board	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	Additional support available via Head of Facilities and Estates team; 6 month secondment in place re business continuity assurance and testing. Clinical lead for EPRR to be appointed August / September 2019 EPRR strategy currently being rolled out and EPRR liaison personnel being identified to take forward planning and testing within services	Partially 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	Structured debriefs held after each exercise and critical / major incidents. Post event report prepared and shared with all Operations Directors, Service Managers, TRF members and others involved with the exercise / incident Lessons identified monitored through an action tracker with progress reported through the TRF	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	EPRR risk register in place; currently being reviewed in line with national risk and security arrangements (NRSA) published in August 2019	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	Risks recorded via the Datix system; any with a score of 12 or more are included on the Corporate risk register Any urgent risks would be escalated via the lead Director for EPRR (or deputy) to ensure that the Trust is aware of any issues / concerns	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	All plans are developed in conjunction with the relevant services, departments or external organisations. There is also extensive consultation through the TRF and with other partners prior to arrangements being signed off	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	Incorporated within the EPRR strategy and Trust incident response plan	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	Trust incident response plan; interim review in December 2018 Full review currently underway; to be tested at Trust exercise in November 2019 and regional exercise in May 2020	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	Heatwave plan (reviewed June 2019)	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	Cold weather plan (reviewed November 2018; currently under review for winter 19/20)	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	Pandemic influenza plan; last reviewed in 2015; interim review in 2018 but not finalised; pandemic influenza group to be re-established to update and test plan	Partially compliant	Pandemic influenza and high consequence outbreaks steering group to be established to review plans and supporting arrangements	Head of EPRR	Jan-20
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	Trust infectious disease arrangements in place but need to review to include high consequence diseases; working group to be establised to take forward	Partially compliant	Pandemic influenza and high consequence outbreaks steering group to be established to review plans and supporting arrangements	Head of EPRR	Jan-20
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	Included within current CBRN SOPs and referenced within incident response plan. More detailed SOP to be developed regarding distribution of mass countermeasures particularly mass prophylaxis following recent attendance at North Yorkshire exercise	Partially compliant	Pandemic influenza and high consequence outbreaks steering group to be established to review plans and supporting arrangements	Head of EPRR	Jan-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	Regional framework response in place; Trust arrangements included as appendix in IRP; tested during recent exercises (Pelican 2, Pelican 3 and Archer); further work underway with strategic trauma lead to improve arrangements; walkthrough exercise to be carried out in November 2019	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	Tried and tested arrangements in place for BAU which will be used for critical or major incidents; recently reviewed with blood transfusion leads and tested in Pelican 3; further test of system to be held in May 2020	Fully compliant			
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	Evacuation plans are in place however work is currently underway in respect of training staff and testing arrangements	Partially compliant	Training programme developed and being rolled out over the next few months	Head of Facilities	Mar-20
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	Recently updated lockdown SOP in place; training currently underway and will be completed by end of March 2020; arrangements being exercised (ED and Ward 29 recently tested)	Partially compliant	Training programme developed and being rolled out over the next few months	Head of Facilities	Mar-20
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	SOP in place and shared with TRF; developed in conjunction with Cleveland Police and other stakeholders; has been implemented a number of times in the last 12 months in respect of high profile offenders and some public interest personnel	Fully compliant			
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	Trust engaged with Cleveland LRF arrangements; mortuary staff involved in recent exercises	Fully compliant			
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.	24/7 tactical and strategic on call rota in place; callout arrangements via switchboard and Confirmer automated messaging system; tested separately and during recent Pelican exercises All on call personnel notified via Confirmer (not just the duty manager); team and departmental cascades in place as part of BCM arrangements	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	All on call staff receive initial training re the response to critical and major incidents including definitions, use of JDM and defensible decision making; delivered in line with NOS and EPRR competencies; refresher training being developed and will be rolled out during 2020 All on call personnel required to complete HMIMMS	Fully compliant			
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	Training needs analysis currently being updated; training provided in line with identified needs; presentations made available to all on call staff; training records held	Fully compliant			

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 part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Comms tests held during Ex Pelican 2 and 3; regular Confirmer tests scheduled Trust tabletop exercises held in December 2019and May 2019; next one scheduled for November 2019 Live / CPX - Ex Pelican 2 and 3 Involvement in local multi-agency exercises as required All recommendations monitored by TRF via action tracker	Fully compliant			
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	Training records held centrally; individual portfolios being rolled out; strategic leadership training being developed and will be delivered in first half of 2020	Fully compliant			
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	Main ICC will be established in theatres resource room; alternative locations available at JCUH (Ops office or Murray Building) or at FHN (Radiology meeting room)	Fully compliant			
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	Hard copies of response arrangements held in JCUH and FHN ICCs; copies also available in EPRR office Electronic documents available on shared drive, intranet and RD	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	Service continuity plans in place; currently being audited and updated	Fully compliant			
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	20+ loggists trained; contact details held by Head of EPRR and in ICC; no formal rota but trained personnel have indicated whether they can be contacted out of hours	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	Sitreps included within IRP and ICC SOP; copy of national sitrep held in incident management folder; completion of sitreps undertaken for waste management incident and EU Exit as well as during the Pelican exercises	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 cc	Issued electronically to ED staff and other key personnel; link shared with on call staff and included within mass casualty arrangements; copy held in incident management folder; hard copy held in ED and in EPRR office	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 cc	Issued electronically to ED staff and other key personnel; link shared with on call staff and included within CBRN SOP; copy held in incident management folder; hard copy held in ED and in EPRR office	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	BAU media strategy agreed but still developing arrangements for additional response during a critical or major incident; currently in draft format but not signed off / published yet; will be complete by early 2020	Partially compliant	Major incident communications strategy being developed	Director of Communications	Mar-20
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	BAU media strategy agreed but still developing arrangements for additional response during a critical or major incident; currently in draft format but not signed off / published yet; will be complete by early 2020	Partially compliant	Major incident communications strategy being developed	Director of Communications	Mar-20
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'	Media strategy agreed and signed off; tested on a daily basis; media spokespersons identified; refresher training being looked at Specific major incident strategy currently being finalised	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 delegated to Head of EPRR due to large portfolios held by AEO and lead director for EPRR; all meetings attended - lead director attends 1 per year (assurance meeting in October)	Fully 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	Head of EPRR and / or Head of Facilities attend LRF meetings including Strategic Board, Tactical Business Group and relevant sub groups	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	Included within IRP but separate SOP to be developed; awaiting health system SOP to be reviewed and updated by NHSE North East and Yorkshire	Partially compliant	Trust mutual aid arrangements to be updated as part of IRP review. Still waiting for regional health system MoU to be updated	Head of EPRR	Mar-20
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'.	Trust information sharing agreement (ISA) in place LRF ISA in place; shared with IG and signed off by Trust; currently being updated	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 Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	BCM policy in place; currently under review	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 • Stakeholders	Included within BCM policy and EPRR strategy	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.	BIA process currently being reviewed and updated; number of services still need to complete	Partially compliant	New business continuity guidance and business impact analysis template being developed.	Head of EPRR	Dec-19
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	Non compliance reported for 2018/19 but action plan in place to be fully compliant by March 2020	Partially compliant	Action plan being implemented by IG	Head of Information Governance	Mar-20
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 following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	BCPs are in place for each service however BC arrangements are currently being audited and the plans need to be reviewed, updated and tested	Partially compliant	Service BCPs to be reviewed, updated and tested in line with timescales agreed in audit	Ops Directors / Service Managers	Dec-19
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	Updated KPIs have just been implemented and all plans are now being reviewed against these BCM will be included in the annual report to Board being delivered in Nov 2019	Partially compliant	KPIs being implemented and BCPs being audited against these	Head of EPRR	Dec-19
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	BC audit is currently underway; outcomes are reported through the TRF and will be included in the annual report to 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	Process outlined in BC policy and EPRR strategy Lessons identified from incidents and exercises shared with TRF members to support review of BCPs where appropriate	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	BCPs requested from external suppliers but not currently assessed; further work required with Procurement to provide assurance	Partially compliant	Review of BCM processes within Procurement to be carried out to consider how external plans can be appropriately assessed	Head of Procurement	Dec-19
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	Numbers included within CBRN SOPs and incident contact directory; hard copies held within ED and the ICC; electronic copies available on the shared drive; to be added to intranet and RD	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	Hazmat / CBRN overview in incident response plan; Hazmat / CBRN specific SOPs developed	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	Hazmat / CBRN specific SOPs and supporting documents	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	Staff trained across all rotas; decontamination room available 24/7	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: http://www.iesip.org.uk/what-will-iesip-do/training/	Y	Completed equipment inventories; including completion date	Equipment held in ED major incident cupboards	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	20 suits currently held in ED; delivered in 2018; awaiting further 4 to be delivered to bring up to full total of 24 Suits to be transferred to Trust ownership; waiting for documentation to be sent out	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.	Regular checks carried out by ED staff; named CBRN ED lead identified to manage this (Sarah Mackenzie)	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	Regular checks carried out by ED staff and records maintained	Fully compliant			
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	Arrangements in place for disposal of PPE no longer required	Fully compliant			

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	ED training lead identified	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		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		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.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	ED staff provided with hazmat / CBRN training; regular tests carried out of processes	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		Standard IPC procedures in place	Fully compliant			

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

STATEMENT OF COMPLIANCE

South Tees Hospitals NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards (v2.3).

Following the self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2019-20 standards as: **Partially compliant**

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 compliant with 76% or less of the core standards they are required to achieve.

Where areas require further action, this is detailed in the organisations *EPRR Work Plan* and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

05/11/2019 — *Date of board / governing body meeting*

11/09/2019 — *Date signed*

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 November 2019			
Cancelled Operations Update			**AGENDA ITEM: 15, ENC 10**
Report Author and Job Title:	Ian Bennett, Head of Patient Safety & Governance Joanne Dobson, Director of Transformation & Strategic Partnerships	**Responsible Director:**	Jo Dobson, Director of Transformation & Strategic Partnerships / Johanna Reilly, COO
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This paper provides details of cancelled operations which have occurred across the Trust between April and September 2019. It provides a detailed analysis from a patient safety and quality perspective and also considers the impact on performance.		
Background	The Trust has a high number of patient cancellations that are multifactorial in nature and these have increased over recent months. An area of significant concern is the increasing number of on the day patient cancellations due to a lack of critical care capacity since the introduction of ring fencing three critical care beds on a daily basis for non-elective patients. This practice was instigated in April by the Trust following feedback from the CQC. The Post Anaesthetic Care Unit (PACU) was scheduled to open March 2019 but due to difficulties with recruitment this was delayed until 24th September 2019. It is currently open for 3.5 days per week and it is anticipated that the unit will be operational 4.5 days per week from 4th November, in line with projected elective demand.		
Assessment	In addition to the above, further work is ongoing with North Tees & Hartlepool Foundation Trust to ensure critical care capacity across the Network is fully utilised, which will further reduce the number of on the day cancellations within the organisation.		
Recommendation	Members of the Trust Board are asked to: • Note the content of the paper, including the current monitoring arrangements which are in place • Acknowledge and prepare for the fact that harm may come to light in future months and years where patients have had their operations cancelled as a result of no HDU/ITU beds being available		

	• Note work underway with North Tees & Hartlepool NHS Foundation Trust to review critical care capacity across the Network • Support a whole system approach to reviewing the multi-factorial reasons for patient cancellations and the development of a programme of work to improve quality and efficiency across elective pathways • Suggest any other action the Trust should take to address the issues identified	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 3.4 - Risk that patients deteriorate or actual harm materialises due to patients being moved from list to accomodate cancelled surgical procedures due to inadequate capacity in critical care	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐
	Drive operational performance ☒	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

Cancelled Operations Update

1. Purpose of the Report

This paper provides details of cancelled operations which have occurred across the Trust between April and September 2019. It provides a detailed analysis not only from a patient safety and quality perspective, but also from an operational and performance perspective.

The report highlights some of the changes that have already been made and also considers some of the wider issues which have been raised, including the impact of multiple cancelled operations and the wider impact for the Trust and the patients when operations are rescheduled.

2. Background

Since 2003 all NHS trusts have been required to report on elective operations which are cancelled for non-clinical reasons in line with NHSE/I guidance.

When a patient's operation is cancelled by the hospital at the last minute for non-clinical reasons, the hospital will have to offer another binding date within a maximum of the next 28 days or fund the patient's treatment at the time and hospital of the patient's choice.

Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.

A breach should be counted at the point it occurs i.e. if after 28 days of a last minute cancellation the patient has not been treated then the breach should be recorded.

The following should be noted:

- All planned or elective operations should be counted including day cases.
- Invasive X-ray procedures carried out on inpatients or day cases should be counted, as an operation and any cancelled procedures should be included for the purpose of monitoring this standard.
- Telephone cancellations made to patients on or after the day of admission should be included for the purpose of monitoring this standard.

An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. For postponements, the following apply:

- the 24 hour period is strictly 24 hours and not 24 working hours, i.e. it includes weekend/other non-working days
- the patient should not be discharged from hospital during the 24 hour period
- a patient postponed more than once is counted as a cancellation

3. Details

3.1 Local Operational Reporting

From an operational perspective, every time an operation does not take place this is captured and reported within the centre and through the business intelligence unit. The reasons for these are varied as set out in table 1 below

Table 1

Reason	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Grand Total
Patient DNA	90	101	130	119	106	130	676
Patient self-cancelled	45	70	46	54	48	41	304
Insufficient time remaining	51	30	37	36	45	34	233
Bed Unavailable HDU/ITU	29	27	20	42	18	29	165
Administrative	25	32	25	22	34	24	162
Bed Unavailable Ward	22	31	12	28	13	53	159
Surgical - patient not prepared	21	22	23	27	25	23	141
Anaesthetic - condition changed since pre assessment	27	18	21	26	25	15	132
Surgical - procedure not required	29	18	18	21	16	23	125
Displaced by Emergency	22	29	4	15	7	11	88
Session Cancelled	7	8	21	5	8	9	58
Equipment unavailable	10	7	4	12	6	3	42
Service unavailable	11	7	16	2	1	4	41
Patient(s) Unavailable clinical	8	3	8	6	9	6	40
Anaesthetic - inadequate pre assessment	11	7	5	8	5	4	40
Case already done	2	3	4	3	8	2	22
Patient(s) Unavailable non-clinical	1	4	2	4	1		12
Anaesthetic - No pre assessment		1		3	2	1	7
Patient Unfit	1	1	2	3			7
Surgical - inappropriate grade of surgeon	2		1		1		4
Operation not required	1			1	1	1	4
Anaesthetic - inappropriate grade of Anaesthetist		1	2				3
Patient Not Confirmed > 48 Hrs	1	1					2
Closed Beds					2		2
Not NBM						2	2
Images unavailable						1	1
Equipment				1			1
Grand Total	416	421	401	438	381	416	2473

If there is potential for a patient to be cancelled on the day of surgery the centre management team explore all alternatives in an attempt to avoid a cancellation from occurring.

Significant work has been carried out within the Specialist and Planned Care Centre to minimise the number of cancelled operations on the day. A datix incident form is completed for any patient cancelled on the day of surgery and an investigation completed, details of which are explored further in the paper.

Planned surgery has been smoothed across the week ensuring the demand on critical care capacity is balanced. This approach has had some impact, but too many patients continue to experience cancellations on the day of surgery.

Table 1 above shows that the number of operations not taking place between April and September 2019 has remained static. Of the 2473 that did not take place during the period, 40% (970) can be attributed to either the patient not attending or cancelling the operation themselves, with 7% (165) of operations being cancelled because a HDU/ITU bed was not available.

The Trust has experienced an increasing number of on the day patient cancellations due to a lack of critical care capacity following the introduction of ring fencing three critical care beds on a daily basis for non-elective patients. This practice was instigated in April by the Trust in response to the CQC inspection findings.

A post anaesthetic care unit (PACU) was planned to open in March 2019, however this was delayed as a result of recruitment issues and partially opened five beds, 3.5 days a week on the 24th September 2019. It is anticipated that the unit will be operational 4.5 days per week from 4th November, in line with projected elective demand. Since opening the number of cancelled operations has reduced.

Further work is required across the organisation to improve efficiency and reduce the number of cancellations regardless of the reason. Specific work includes improving patient flow to ensure the elective programme and non-elective demand can be managed effectively. Standardising pre-assessment services to ensure patients are only listed when they are fit for surgery. Patient DNA rates are high and require further investigation to understand the cause.

3.2 Quality and Patient Safety Perspective

Between 1st April and the 19th September 2019 there were 119 datix forms completed where a patient had an operation cancelled due to a lack of HDU/ITU beds. This is less than the 165 which were reported operationally during the same period and is being followed up to ensure full completion.

Table 2 below illustrates these broken down by month and speciality. July had the highest number of cancelled operations, with 39 reported via Datix in this month. This was also the

highest number reported operationally. General Surgery contributing to 45% of the cancelled operations reported on Datix during this period.

Table 2

	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	Total
Cardiac Surgery	12	3	0	2	0	0	17
Ear Nose & Throat	0	0	1	0	0	0	1
General Surgery	7	20	11	16	0	0	54
Gynaecology	2	0	0	1	0	1	4
Critical Care Services	2	0	0	12	1	6	21
Neurosurgery	3	2	5	5	0	0	15
Urology	1	0	0	3	2	0	6
Vascular Surgery	0	0	1	0	0	0	1
Totals:	27	25	18	39	3	7	119

Table 3 below illustrates the level of harm associated with each cancelled operation at the time it is reported via Datix. A process is in place to review all cases, co-ordinated by the Clinical Director to establish the level of harm.

Whilst acknowledging every cancelled operation is clearly unsatisfactory and has a detrimental psychological impact the majority result in no or minor actual harm at the time of the incident being reported.

During the period, 1 incident was categorised as major and is being investigated through the Trusts Serious Incident (SI) process. The full investigation report will be shared at the Centre Board, PPSG and QAC once concluded.

Duty of Candour would apply to any incident where moderate harm or above has occurred. It is important to note that the level of harm may become apparent in some instances in future months.

Table 3

	Insignificant Incident - No Actual Harm	Minor Incident	Moderate Incident	Major Incident	Catastrophic Incident	Total
Cardiac Surgery	15	2	0	0	0	17
Ear Nose & Throat	1	0	0	0	0	1
General Surgery	3	51	0	0	0	54
Gynaecology	4	0	0	0	0	4
Critical Care Services	2	19	0	0	0	21
Neurosurgery	4	11	0	0	0	15
Urology	0	5	0	1*(SI)	0	6
Vascular Surgery	0	1	0	0	0	1
Totals:	29	89	0	1	0	119

Table 4 below illustrates the majority of patients have their operation cancelled once (87.5%), with only 6 patients having their operation cancelled more than 3 times

Table 4

	1 cancellation	2 cancellations	3 cancellations	4 cancellations	Total
Cardiac Surgery	15	2	0	0	17
Ear Nose & Throat	1	0	0	0	1
General Surgery	45	6	2	1	54
Gynaecology	3	1	0	0	4
Critical Care Services	19	2	0	0	21
Neurosurgery	13	1	1	0	15
Urology	4	1	1	0	6
Vascular Surgery	0	0	1	0	1
Totals:	100	13	5	1	119

Table 5 below illustrates that patients are more likely to have their operations cancelled on a Tuesday, which accounts for 36% within this category.

Table 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
Cardiac Surgery	2	5	2	3	5	0	0	17
Ear Nose & Throat	0	0	1	0	0	0	0	1
General Surgery	14	12	4	18	6	0	0	54
Gynaecology	1	2	0	1	0	0	0	4
Critical Care Services	3	10	3	1	4	0	0	21
Neurosurgery	1	12	1	1	0	0	0	15
Urology	3	1	1	0	1	0	0	6
Vascular Surgery	0	1	0	0	0	0	0	1
Totals:	24	43	12	24	16	0	0	119

The themes emerging from the Datix investigations include:

- Emergency patients being admitted and taking priority
- Patient awaiting repatriation to other hospital Trusts and occupying a bed at South Tees
- Other non-elective patients being prioritised, causing further bottle necks and potential quality and safety issues in the coming weeks, months and years
- No empty beds available within the Trust at 8am and no step down patients identified in order to create capacity

4. Summary

This paper provides both an operational, quality and safety perspective on the number of operations which have been cancelled between April - September 2019, specifically focusing on when a HDU/ITU bed has not been available.

Robust monitoring arrangements are in place and provide assurance that the tracking of these groups of patients is effective and that at the time the operation is cancelled, a datix is completed and that most of the patients received a subsequent clinical review to determine the level of harm that may have occurred as a result.

Work is also underway with North Tees & Hartlepool NHS Foundation Trust to ensure critical care capacity is fully utilised across the Network,

Further work is required across the organisation to address all causes of cancelled operations. In particular a review of patient flow and the standardisation of pre-assessment processes are required to ensure the elective programme and non-elective demand can be managed effectively.

In addition, the process for clinically reviewing patients who have had their operations cancelled and the degree of harm associated needs close monitoring, prompt escalation and reporting at the earliest opportunity that the harm is identified, in an open and transparent way.

5. Recommendations

The Board is asked to:

- Note the content of the paper, including the current monitoring arrangements which are in place
- Acknowledge and be aware that harm may become apparent in future month where patients have had their operations cancelled as a result of no HDU/ITU beds being available
- Note work underway with North Tees & Hartlepool NHS Foundation Trust to review critical care capacity across the Network
- Support a whole system approach to reviewing the multi-factorial reasons for patient cancellations and agree a programme of work to improve quality and efficiency across elective pathways
- Suggest any other action the Trust should take to address the issues identified

Authors
Ian Bennett - Head of Patient Safety & Quality
Joanne Dobson – Director of Transformation
Update 29th October 2019

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5th November 2019			
South Tees Cancer Strategy 2019-2024			**AGENDA ITEM: 18, ENC 11**
Report Author and Job Title:	Carol Taylor: Macmillan Transformation Lead - Cancer	**Responsible Director:**	Joanne Dobson: Dir. Transformation
Action Required	Approve ☒ Discuss ☐ Inform ☐		
Situation	As a Cancer Centre South Tees is expected to have strategy for Cancer providing direction of travel for cancer services over the short to medium term.		
Background	The strategy is set within the parameters of the NHS Long Term Plan, regional and local aspirations to provide a direction of travel for the Trust in recognition of working together in partnership with our key strategic partners and others.		
Assessment	It is good seen as good practice for a cancer centre to have an up to date and credible strategy for cancer. Currently in South Tees this is not the case. Whilst the challenges in achievement of the strategy are clear and laid out within the document these are not insurmountable if collaborative working arrangements continue in the current vein.		
Recommendation	Members of the Trust Board are asked to: I. Consider the content of the report and associated appendices II. Approve the South Tees Cancer Strategy 2019-2024.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☒	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☒		

SOUTH TEES CANCER STRATEGY 2019 -2024

1. PURPOSE OF REPORT

The purpose of the reports is to present the South Tees Cancer Strategy to the Trust Board and seek approval for implementation and action planning against each strategic objective set out within.

2. BACKGROUND

South Tees NHS FT is a specialist cancer centre meaning that the Trust works in partnership with surrounding and neighbouring Trusts to try to ensure the best treatment and care for all patients across the sub-region.

It is considered good practice for a Cancer Centre to have a clearly defined set of strategic objectives contained within a short to medium term overarching strategy to provide the direction of travel for cancer during a defined period of time. Unfortunately South Tees NHS FT has not had a Cancer Strategy in place since 2015.

In an attempt to correct this and to set a clear direction of travel the attached document has been developed in partnership with internal and external colleagues and partners and our patients. See appendices 1 and 2 attached.

3. DETAILS

The strategy has been developed under the headings of 5 key themes (strategic objectives) see appendix 1 and 2. These themes were developed in conjunction with colleagues, partners and patients and are underpinned by the foundation of 'Workforce' placing the patient at the heart of everything that we do. The themes agreed are as follows:

1. **Leading Cancer Centre** – We will aspire to be the provider of choice for cancer care delivery and the centre of excellence for specialist cancer services
2. **Personalised Care and patient experience** - We will ensure that wherever our services are delivered patients receive the best experience throughout their illness.
3. **Research & Development** – We will increase the recruitment and numbers of clinical trials alongside supporting the development of internationally competitive research making our data on outcomes readily available to the public
4. **Outcomes** - We will aspire to offer the latest in diagnostic and treatment capability to continually improve patient outcomes now and in the future.
5. **Partnership & Engagement** – We will continue to work with our partners and patients to deliver the best outcomes and experience for people affected by cancer across the health economy.

4. RECOMMENDATIONS

The Board are asked to:

I. consider the content of this report and associated appendices.
II. Approve the South Tees Cancer Strategy 2019-2024

APPENDICES
(List any appendices)

- Cancer Strategy 2019-2024 - Presentation to Board
- Draft Cancer Strategy 2019-2024 v6

South Tees Hospitals
NHS Foundation Trust

November 2019

South Tees NHS FT Cancer Strategy 2019-2024

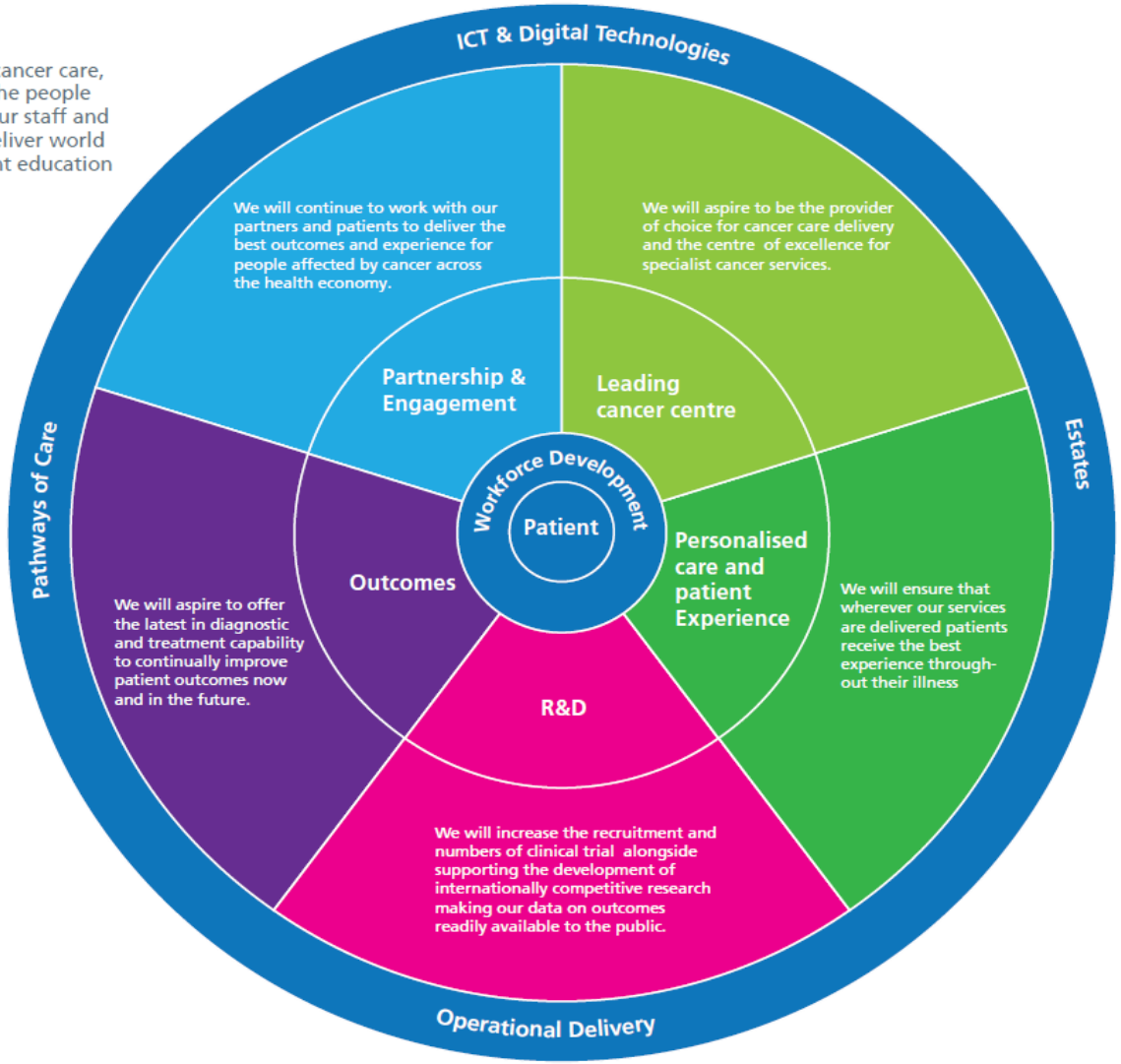
Trust Board – 05.11.19

Excellence in Patient Outcome and Experience

South Tees NHS FT

Vision

To provide excellence in cancer care, improving outcomes for the people we serve by investing in our staff and working with others to deliver world class patient care, excellent education and world-class research.



Local Context

- Overall incidence of cancer is higher than national levels and survival for some cancers is amongst the worst in the country.
- The North East experiences the highest incidence of lung cancer in England for males and females 117 per 100,000 males compared to 88.5% per 100,000 in London
- Middlesbrough LA ranked 147/148 for colorectal cancer premature deaths 140/150 LA's for all premature cancer deaths. Middlesbrough is ranked 81/32,844 on the IMD and encounters higher than average rates of illiteracy, smoking and obesity.
- Mbro and R&C Life ave. life expectancy is below the national average and 4-7 years lower for males and females than in HR&W.
- HR&W have a mixed urban and rural population making equity of access a challenge.
- All areas have an industrial history of environmental exposure to known carcinogens now resulting in a higher than average incidence of some cancers i.e. lung and myeloma

Themes

- Leading Cancer Centre – We will be the provider of choice for cancer care delivery and the centre of excellence for specialist cancer services - Leadership, Multi–disciplinary Teams, Governance

- Personalised Care and patient experience - We will be the provider of choice for cancer care delivery and the centre of excellence for specialist cancer services - Early Diagnosis, Treatment, Stratified Pathways of Care

- Research & Development – We will increase the recruitment and numbers of clinical trials alongside supporting the development of internationally competitive research making our data on outcomes readily available to the public - Increasing patient participation in research studies, commercial research and research experience studies and provide equity of research across the South Tees footprint.

- Outcomes - We will aspire to offer the latest in diagnostic and treatment capability to continually improve patient outcomes now and in the future - shorter and better patient pathways (28 day FDS), view national cwt as a minimum standard, improving and surpassing targets year on year, use data to drive decision making and prioritisation around pathways, support implementation of Fast Track 150 processes

- Partnership & Engagement - Work with partners to support them in the delivery of a comprehensive prevention agenda, deliver improved screening, particularly breast and bowel and to increase 1, 5 and 10 year survival rates

Underpinned by:

- **Workforce**
  - *Ensure that cancer awareness is built into the Induction programme for all employees in South Tees Hospitals NHS FT.*
  - *Ensure that all apprentice allied health professionals therapies complete a cancer care module as part of their training.*
  - *Ensure that Advanced Practitioners in therapies complete a cancer care module as part of their training.*
  - *Continue to work with centres to ensure that teams have the correct skills mix and a range of expertise to provide the appropriate level of care for people affected by cancer whatever stage of their journey.*
  - *Work with South Tees Research and Innovation (STRIVe) team to develop a suite of learning programmes for staff and partners. This will include learning programmes and events specifically in relation to personalisation and care.*

Next Steps

- *Sign off at Trust Board 5th November 2019*
- *Complete action plans for cancer with centre management and partners aligned against strategic objectives.*
- *Present strategy to Health & Well being boards December 2019 for information.*
- *Accountability for achievement against action plans to be undertaken by Cancer Delivery Group and Cancer Strategy Board Dec 2019 onwards.*

Governance & Performance monitoring

MEETING	FREQUENCY	PURPOSE	ATTENDEES
Cancer services team	Daily	Review of patient lists for specific tumour sites with a focus on pathways requiring action, escalation and expediting appointments.	Cancer trackers, MDT Co-ordinators, waiting list managers, service managers, Cancer Care Co-ordinators
Cancer Performance Wall	Weekly	Performance monitoring of CWT against Patient Tracking Lists (PTL). This is patient level discussion of patients whose pathways are at risk of breaching key milestone targets (either approaching the deadline without a date, or with a date beyond the deadline).	Executive Lead (Cancer), Macmillan Clinical Lead (Cancer), Dir Transformation, Macmillan Transformation Lead (Cancer), Macmillan Cancer Performance and Access Manager, Service Managers.
Cancer Wall: Process, preparation and planning	Weekly	Following the Cancer Performance wall to review process, data quality assurance for next wall, review action relating to service improvement requirements.	Cancer Services management team.
Cancer Delivery group	Monthly	The purpose of this Cancer Delivery Group is to maintain a coordinated overview which includes operationally delivering commitments made in the South Tees Cancer Strategy. The CDG will report back to the South Tees Cancer Strategy Board formally on a quarterly basis and informally as and when required by the Chair. The Board will ensure that Centre based cancer action plans are developed, delivered and monitored through this group.	Cancer Services Senior Management Team, Dir Transformation, Macmillan Cancer Performance and Access Manager, Service Manager representative, Macmillan Business Analyst (Cancer), representatives from Rad-Onc, Radiology, pathology, R&D, medical physics and Professions
Macmillan Integration of Cancer Care Programme Board	Quarterly	To better support those affected by cancer residing in the first instance within the South Tees NHS Foundation Trust improving experience and outcomes for patients by promoting patient choice and integrated working practice improving patient outcomes across the health economy (currently under review).	Partnership Board.
Cancer Strategy Board	Quarterly	The purpose of this Strategy Board is to maintain a coordinated overview of strategy for the Trust. The South Tees Cancer Strategy Board will ensure that the cancer strategy for the Trust is implemented, reviewed quarterly and updated annually.	The Board comprises of senior representatives from across the health economy partnership.
Senior Leadership team	Weekly	Drive results and service improvement, to make decisions and to ensure organisational alignment and collective action.	Chief Executive, Operational Directors.
Operational Management Board	Monthly	The role of OMB is to oversee the effective operational and strategic management including the achievement of statutory duties, the delivery of the Service Strategy clinical standards and targets, the delivery of high quality patient centred care and financial targets.	Chief Executive (Chair), Deputy Chief Executive, Medical Directors, Director of Nursing and Quality, Director of Finance, Director of Estates, ICT and Health Records, Director of Human Resources, Director of Strategy & Business Development, Director of Communications, Company Secretary, Operations Directors, Associate Directors of Nursing
Trust Board		The Trust Board of Directors is responsible for setting the strategic direction of the organisation and making sure the organisation is performing as it should be.	The board is made up of the Chairman, Chief Executive, Executive Directors and Non-Executive Directors.

THANK YOU

NHS
South Tees Hospitals
NHS Foundation Trust

Cancer Strategy

2019 - 2024

Excellence in Patient Outcome and Experience

www.southtees.nhs.uk

Our Vision

To provide the best cancer care, improving outcomes for the people we serve by investing in our staff and working with others to deliver top quality patient care, excellent education and world-class research.

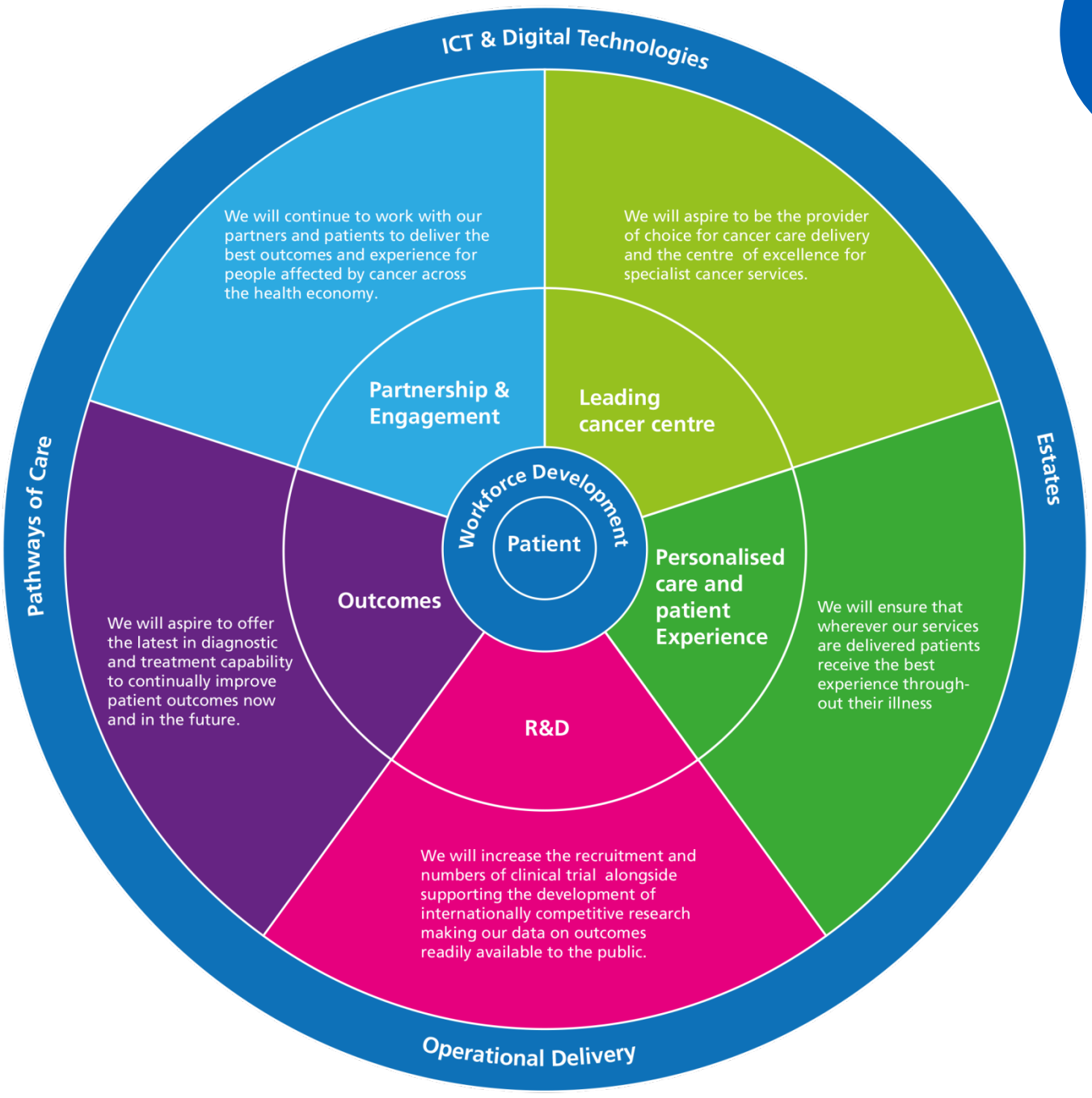


Fig.1

Introduction

Wider determinants of health – Kings Fund:

What does improving population health mean[1]?

The Kings Funds have determined four pillars of population health as follows:

1. The wider determinants of health
2. Our health, behaviours and lifestyles
3. An integrated health care system
4. The places and communities we live in and with.

Over the last 100 years we have grown used to people living for longer and longer, but in recent years life expectancy has stopped increasing in England and in some areas has been reducing.

Area	Male 2017	Female 2017	Male 2014	Female 2014
Middlesbrough	76.2 (YRS)	79.8	76.7	79.8
Redcar & Cleveland	77.8	80.9	78.6	82.1
Hambleton	81.4	84.4	81.3	85.2
Richmond	81.4	84.4	81.4	83.5
Darlington	78.1	82.1	78.2	82.2
Stockton	77.7	81.5	78.4	82.3
England	79.5	83.1	79.4	83.1

Fig. 2[2]

Health inequalities are widening and England lags behind comparable nations of many key measures of health outcomes. For example cancer survivorship rates in Sweden are 64.7% and Germany 59.1% as compared to 50.2% in England[3]. Demand on NHS services has been increasing, but much of that extra demand is for treatment of conditions which are preventable. At heart, the NHS remains a treatment service for people when they become ill.

Action needs to be taken at three levels:

- **national** – e.g. government, arm's length bodies, membership organisations
- **regional** – e.g. devolution areas, sustainability and transformation partnerships, integrated care systems
- **local** – e.g. individual cities, towns and neighbourhoods.

Improving population health is an urgent priority. NHS England has been increasingly vocal in its aim of reducing health inequalities, and has identified prevention as one of the key themes in the NHS Long Term Plan. The plan places emphasis on population health as a key focus for integrated care systems (ICS) as they are rolled out across the country. The four pillars of population health provide a framework that can be used for reviewing achievements and gaps, to inform the development of local plans and approaches.

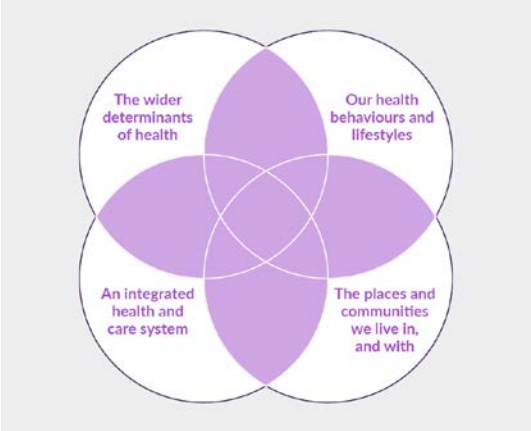


Fig 3. A population Health system

National context

More people in the UK today are living with Cancer than ever before. Half of all people born since 1960 will be diagnosed with cancer in their lifetime[4]. The other half will undoubtedly be affected by the cancer diagnosis of family or loved ones, close friends or someone they know.

Over 250,000 people in England are diagnosed with cancer every year and around 130,000 die from the disease.

Cancer is the leading cause of premature death (people under 75) nationally and the second highest cause of death across all age groups. One in two people will develop cancer at some stage and one in four will die from it. Evidence suggests that later diagnosis of cancer has been a major factor in the poorer survival rates in the UK compared with some other countries in Europe. However, the earlier a cancer can be diagnosed the greater the prospect of survival. Cancer survival rates are at an all-time high. Cancer survival is the highest it's ever been and thousands more people now survive cancer every year. For patients diagnosed in 2015, one year survival was 72% – over 11 percentage points higher than in 2000.

There are now an estimated 2.5 million people living with cancer in the UK, rising to 4 million by 2030. The number of people living with cancer has increased by almost half a million people in the last five years

The number of older people (aged 65 and over) living with cancer has grown by 300,000 (or 23%) in the five years to 2015. The number of people who have survived five or more

years since diagnosis has increased by over 260,000 (or 21%) in the five years to 2015 and that the number of people living with cancer in the UK is increasing by 3% every year (CRUK[4])

National Agenda

In October 2014, the NHS in England set out changes required to improve cancer care in its Five Year Forward View[5]. The forward view made clear the NHS's intention to support and stimulate the creation of a number of major new care models, including cancer services. It also began to set out a series of five-year ambitions for better prevention, faster diagnosis and better treatment and care for all.

In July 2015, Achieving World-class Cancer Outcomes[6], the report of the Independent Cancer Taskforce, applied a cancer lens to the themes of the Five Year Forward View. It made 96 recommendations, including that 'cancer alliances' should be created and that a new way of providing cancer care under a single lead organisation for a region should be tested. In May 2016 NHS England committed to delivering the Independent Taskforce's report by 2020. In taking the strategy forward it set out the first steps towards this, focussing on the major building blocks for change.

NHS Long Term Plan

In January 2019 the NHS published its Long Term Plan[7]. The plan intends to build on the success of The Five Year Forward View by keeping all that's good about our health service and its place in our national life.

The NHS Long Term Plan commits to continuing to transform cancer care so that from 2028:

- an extra 55,000 people each year will survive for five years or more following their cancer diagnosis; and
- three in four cancers (75%) will be diagnosed at an early stage.

The NHS have committed to achieving this by:

- Reduction or elimination of preventable cancers before they appear
- Finding more cancers before symptoms appear through the most comprehensive screening programmes in the world
- Diagnosing cancers earlier and faster
- Ensuring universal access to optimal treatment and adopting faster, safer and more precise treatments
- Offering personalised care and effective follow up for all patients; and
- Enabling research and innovations so that new, smarter and kinder diagnosis and treatment methods are developed and quickly adopted
- Harness the collaboration of academia, the NHS and industry to develop and rapidly translate into practice the screening, early detection and targeted treatment models of the future.

Regional context

Regionally and sub-regionally, cancer poses particular challenges to the health of the population, in particular here on Teesside and in some of our rural populations. Overall, incidence of cancer is higher than experienced nationally and survival rates for some cancers are amongst the worst in the country. For example; Lung cancer in the North East region as a whole experiences by far the highest incidence in England for both males and females – e.g. 117 per 100,000 males compared to 88.5 per 100,000 in London and for example, Public Health England ranked Middlesbrough Local Authority as 147th out of 148 LA's for colorectal cancer premature deaths and 140 out of 150 LA's for all premature cancer deaths.

Integrated Care Systems

Integrated Care Systems (ICS) are central to the delivery of the NHS Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering primary and specialist care, physical and mental health services, and health with social care, consistent with what GPs report is needed. By April 2021 ICS will cover the whole country and agree system-wide objectives, including those which relate to cancer, with the relevant NHS England/NHS Improvement regional teams.

The strategic direction for cancer across the region is supported by the Northern Cancer Alliance (NCA)[8]. The NCA, will be coterminous with one or more ICS across the North East and Cumbria. It is a collaborative through which health, including South Tees NHS FT, social care and third sector stake-holders, work together to develop and deliver new models of care and to achieve the collective goal of delivering the ambitions identified by the National Cancer Taskforce in 2015 as well as those highlighted in the NHS Long Term Plan.

The NCA work-plan for 19/20 focusses on improvements in the following areas:

- Sustainable operational performance
- Prevention
- Screening and early diagnosis
- Personalise care

Local Context – South Tees

The Trust covers a mixed area in terms of demographics, each of which poses its own challenge and requires potentially different solutions to improve care. Middlesbrough and Redcar and Cleveland have an average life expectancy below national average and 4-7 years lower for both male and females than in Hambleton and Richmondshire (H&R). Middlesbrough in particular has a higher BME population of at least 12%, a higher multiple deprivation index, higher illiteracy, obesity and smoking rates with Redcar being somewhere in between this and H&R. H&R have a mixed urban and rural population which makes equality of access a real challenge. All areas have an industrial history of environmental exposure to known carcinogens or cancer-causing agents. This now results in a higher than average incidence of some cancers for example lung cancer and myeloma.

Key issues:

- High levels of mortality from cancer can be attributed in part, to the excessively high levels of risk factors in both socioeconomic and lifestyle terms.
- High numbers of diagnoses made at late stage disease resulting in poor outcomes as evidenced by 1 year and 5 year survival figures.
- Public awareness of early cancer symptoms is poor. This may be contributing to late presentation and poorer survival. Education and provision of information in a way that is accessible are key challenges across the whole locality.
- Participation in national screening programmes can significantly reduce a person's risk of developing specific cancers. Uptake in certain screening programmes is particularly poor for varying reasons. South Tees Clinical Commissioning Group (CCG) performs lower for screening invitation uptake than the national average for example, bowel cancer 56.5% of 60-74 year olds in South Tees CCG area attend a screening appointment within 6 months of invitation vs national average of 59.0% (Public Health England, 2018).

In addition to the national and regional commitments, South Tees NHS FT firmly puts the patient at the centre of everything we do. We believe our strategic objectives should reflect that. We also believe that our strategic objectives and priorities should be in line with what people living with and beyond cancer say that they want to see, taking into account local population needs and demographics with specific consideration of those who are most vulnerable.

Resources:

The NHS has to achieve value for money and the best quality for patients. Shifting to new patterns of care is a recognised requirement for the NHS and for us here in South Tees, particularly if we are to balance growth and quality within a static funding status. There are a number of factors to consider as part of this strategy i.e. increasing cost of providing care – from both a growing and ageing population, productivity gains, payment systems and incentives. A clear understanding of the potential impact and how we can best manage these to minimise the effect on our strategic objectives is required. In order to do this we will model future service demands, ensuring optimisation of resources and assets across

the whole of South Tees and in partnership with others. This will allow us to identify where increasing or decrease in capacity is likely to occur and to adjust spending plans accordingly.

Whilst no specific budget has been allocated to the delivery of this strategy, cancer services within South Tees will continue to work in partnership with centers across the Trust and our partner organisations to support prioritisation and funding of delivery of cancer services in order to maximize both impact and outcome for our patients and our communities. We will continue to work with key strategic partners such as the Northern Cancer Alliance, Clinical Commissioning Groups and Health and Social Care networks to ensure that funding made available to the Trust in respect of cancer services is fully utilised to the benefit of our patients.

Funding allocations from our partner organisations is allocated on a year on year basis and is non recurrent. This means that it is not guaranteed. However, this funding is usually substantial and targeted at specific projects. For example projects targeted towards the early diagnosis were given were supported during 18/19 and 19.20 e.g. Direct to CT (COPD) pilot received £200k in 18/19 and £110k in 19/20. In addition the Serious Non-specific (vague) Symptoms pilot in Hambleton and Richmondshire also received approx. £152k in 18/19 and we are hopeful that we will secure additional funding in 20/21 to expand this pilot and implement a Rapid Diagnostic Centre approach across the whole of the South Tees NHS FT footprint.

Together with people affected by cancer, Macmillan Cancer Support (MCS) have created five experience principles. We will continue to work with Macmillan to adhere to these principles so that all of our patients affected by cancer feel supported throughout their whole cancer journey

INTRODUCTION

We take the time to understand you and all your needs

We're close at hand and easy to reach whenever you need us

We see things through to a clear and right conclusion

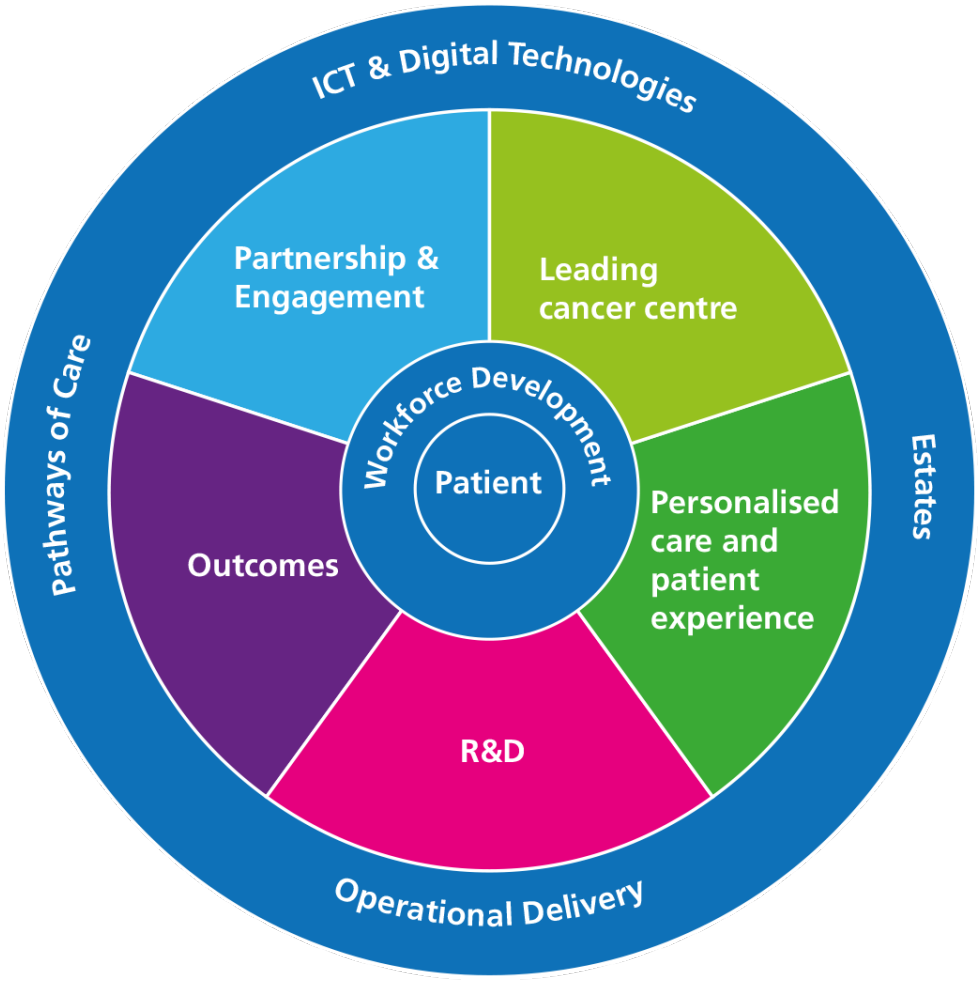
Fig 4: Five Macmillan Experience Principles

Our Strategy for Cancer

In developing this strategy we identified five key themes from which we have developed our objectives for the forthcoming years. These themes are:

- Leading Cancer Centre
- Personalised Care and Patient Experience
- Research and Development
- Outcomes
- Partnership and Engagement

None of these objectives can be achieved without the support for and ongoing investment in our staff and from our colleagues in other organisations working with people affected by cancer and of course the patients that we serve. Therefore the five themes listed above are underpinned by our **WORKFORCE** placing the **PATIENT** at the centre of everything we do.



Theme 1

Leading Cancer Centre

We will be the provider of choice for cancer care delivery and the centre of excellence for specialist cancer services.

South Tees NHS FT is the largest hospital in the Tees Valley. We provide services via two acute hospitals – The James Cook University Hospital (JCUH) and Friarage Hospitals Northallerton (FHN) as well as from a number of community hospitals throughout the geography. We employ almost 9,000 members of staff providing a range of regional specialist services, including cancer care to over 1.5 million people. We welcome more than 1 million patients and visitors to our hospitals every year.

In 2018/19 we received 18,978 two week wait referral, and diagnosed 1724 people with cancer (approx. 9.1% conversion rate). We are a tertiary cancer centre which means we also see patients already diagnosed and referred to us by other hospitals and have a particularly close working relationship with County Durham and Darlington FT and the University Hospital of North Tees and Hartlepool FT.

We provide a comprehensive range of surgical and non-surgical treatments, inpatient care, advanced radiotherapy, chemotherapy and other systemic anti-cancer therapies (medicines) and immunotherapies. We bring together expert staff, high-quality care facilities and provide outstanding specialist care for patients.

In in 2017/18 we delivered intensity modulated radiotherapy to 63% of patients receiving radical radiotherapy. This exceeded the national target (24%) and was the highest rate of all radiotherapy centers in the country. In 2018/19 we increased this by a further 3% to delivering IMRT to 66% of our radically treated patients. We remain the first in the country and we continue to develop new radiotherapy techniques[10].

Our plans for the future

We have expanded and improved cancer services offered with the development of the new £10 million Sir Robert Ogden Macmillan Centre at FHN. This reconfirms the Trust's commitment to the continued delivery of excellent cancer care and services from FHN. The new centre will significantly improve care for people affected by cancer across the geography.

There is still much that can be done to ensure that our estate is fit for future purpose, can cope with increased demand and to ensure that patient access to services is not hindered.

However, our ability to offer improved access to services must not be confined to those that can only be offered in physical 'bricks and mortar' settings. ICT and digital technologies are now part of everyone's daily lives. ICT and digital technologies will not only further enhance the way in which we communicate with our partners, colleagues and patients but also how we treat, support and review people affected by cancer.

We will therefore:

- Continually review the estate and provision to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future
- Continue to work with our partners on all four wider determinants of health to develop an integrated population health system, narrowing the gap in health inequalities locally, across the Tees Valley and the sub region.
- Ensure we are at the forefront of using new technologies in the delivery of cancer treatments.
- Ensure that clinicians can access and interact with cancer patient records and care plans wherever they are.
- Develop the case for enhanced diagnostic infrastructure.

Multi-Disciplinary Teams

Fundamental to the successful delivery of cancer services are multidisciplinary teams (MDTs). An MDT is made up of a variety of health professionals involved in treating and caring for patients, such as surgeons, clinicians, nurses and diagnosticians. MDTs are a crucial component in ensuring that patients are diagnosed early and that they receive the treatment and care which are best for their cancer and their life. A culture of teamwork, with strong leadership and a focus on personal development and training should prevail throughout.

The number of patients discussed in MDT meetings has grown significantly as has the complexity of patients. This in part can be attributed to an ageing population and the growing number of treatment options available.

Year	Overall numbers discussed at MDT: First discussion
2016	15023
2017	15751
2018	15848
Grand total	46622

Fig. 5 Sourced Infoflex July data 2019[11]

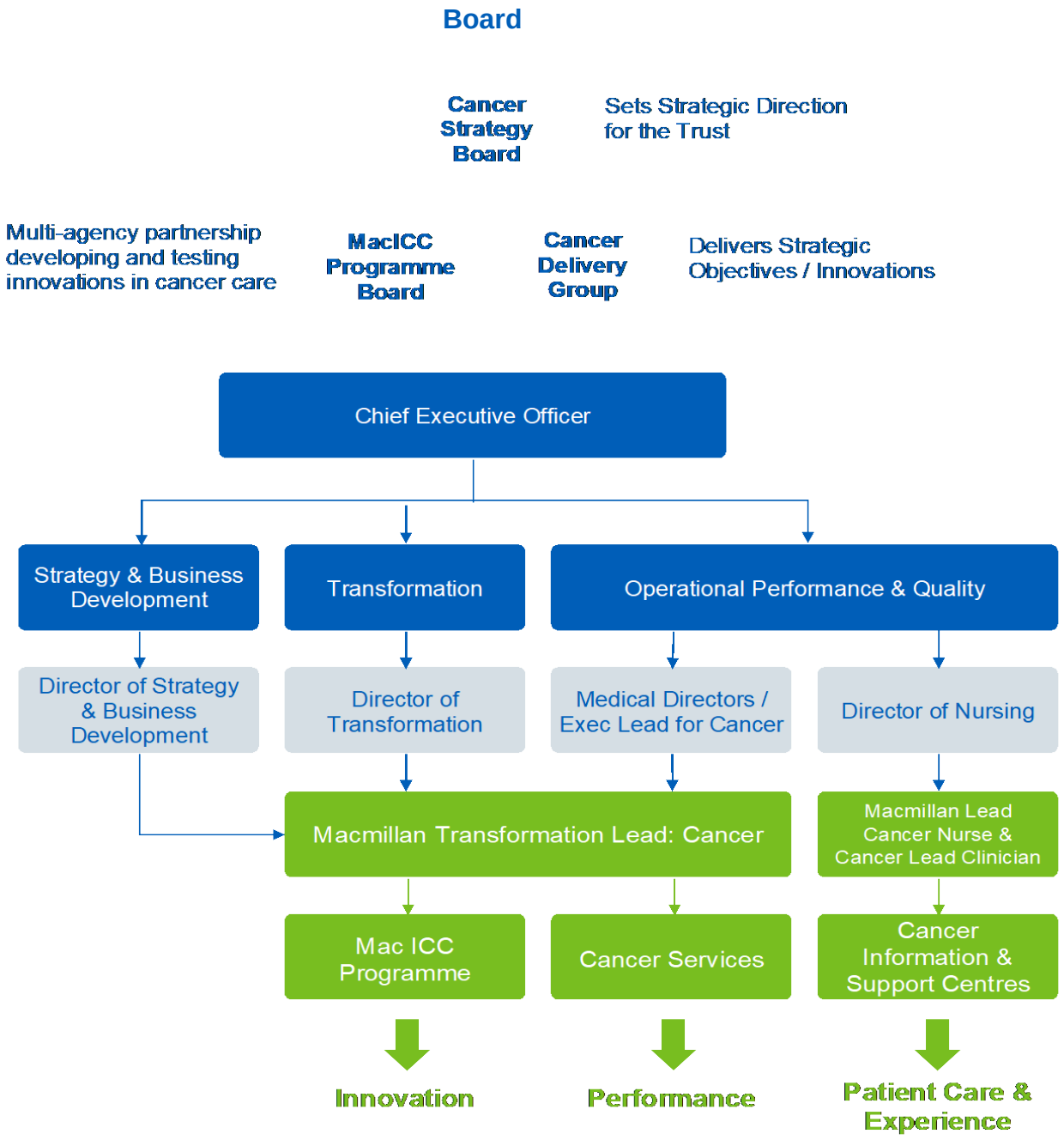
To reflect the changing nature of cancer care and the increased demand for cancer and palliative care services, there is a need to refresh the format of MDT meetings to make them work more effectively and efficiently. We are committed to developing healthy Multi-Disciplinary Teams (MDTs) where clinicians are empowered to make informed decisions about patient treatment and care.

We will therefore:

- Review and develop ‘Healthy MDTs’ which support:
- Achievement of the 28day Faster Diagnosis Standard
- Focussed discussion on those patients who need it
- Improved patient experience including for those patients who require best supportive care or end of life care.

Governance

Internally we have developed a governance structure to support both leadership of and accountability for cancer services see Fig 6. Overseen by the Chief Executive this model ensures that strategy, operational delivery and innovation combine to ensure leadership, continuous improvement and achievement are maintained throughout the services we deliver.



We will therefore:

Ensure the best and targeted use of available monies to develop, test and deliver the best possible pathways of care for our patients.

Theme 2

Personalised Care and Patient Experience

We will ensure that wherever our services are delivered patients receive the best experience throughout their illness.

THEME 2

Our patients are at the heart of everything we do. We want our patients to be partners in their treatment and care planning, to empower our staff to be responsive to the changing need of the patient, to deliver high quality sustainable care and to achieve better outcomes. We want to promote a 'shared responsibility for health' recognising the importance of 'what matters to someone' is not just 'what's the matter with someone'. We want our patients to be informed about the choices they have around treatment and care and to feel supported in the decisions they make.

Stratified pathways of care

We understand the implementation of stratified pathways of care following treatment benefits patients and carers. Patients have needs met in a timely manner, are better informed about their disease, treatment and any longer term effects. With a firm focus on both physical and mental health and wellbeing, patients are supported to takeback control of their lives as soon as they are able. We believe that a supported self-management pathway with appropriate follow up and guaranteed re-access should now be offered as standard practice across all tumour groups following treatment for cancer.

We will therefore:

- Improve sharing of quality of information with patients and primary care via electronic Holistic Needs Assessments (eHNA) and Treatment Summaries.
- Embed holistic therapies, supportive care and improve access to psychological therapies providing advice for patients and carer's within every tumour pathway fully utilising services available through the Trinity Holistic Centre and the Macmillan Information Centres.
- Implement stratified pathways of care – supported self-management, shared care or complex case management - across all cancer pathways and ensure that review and aftercare is tailored to individual needs.
- Continue to work with referring Trusts to ensure seamless pathways between organisations.
- Implement the quality of life metric to demonstrate how well people are living beyond treatment (metric published September 2019).

Early diagnosis

Patients diagnosed with cancer early, stages 1 and 2, have the best chance of curative treatment and long-term survival. We remain committed to providing earlier diagnosis for people affected by cancer. This means we will continue to work closely with our partners, colleagues, stakeholders and patients to develop and implement new models for diagnosing cancer earlier. We will continue to work with our partners and colleagues locally and across the region to ensure that our patients, regardless of postcode, are diagnosed early and receive rapid and excellent treatment.

We will therefore:

- Engage with partners to deliver new models to improve patient access to cancer diagnostics.
- Develop the case for enhanced diagnostic infrastructure.
- Continue to develop and expand the South Tees Optical Referral Project (STORP) across the whole of the South Tees NHS FT footprint, the Tees Valley and the sub-region.
- Consider direct referrals for other potential cancers direct from other health care sectors.
- Continue to work with our partners in the NCA and primary care to expand the successful uptake of the low dose Direct to CT (COPD) programme to increase early stage 1 and 2 diagnosis of lung cancers.
- Expand on achievements already made at FHN to continue to develop, test and implement a Rapid Diagnostic Centre (RDC) within the Tees Valley and the sub-region.

Treatment

The NHS has reinvigorated action to provide better, more focussed and targeted treatments for people affected by cancer. This includes access to optimal treatment pathways and adopting faster, safer and more precise treatments. Locally that means improving access to new technologies that improve patient outcomes such as cutting edge radiotherapy that targets cancer more effectively and reduces side effects and appointment times along with greater access to promising new treatments such as immunotherapy.

Our radiotherapy department delivers around 40,000 fractions of radiotherapy annually. Our specialist chemotherapy services provide around 24,000 treatments annually. We also run a growing oral chemotherapy service delivered on an outpatient basis, along with a further day case service from Darlington Memorial Hospital which is run in conjunction with our colleagues at County Durham and Darlington NHS Foundation Trust (CDDFT).

We will therefore:

- Implement optimal cancer pathways with clear timelines for appointments, diagnostics, decisions and treatments, including direct patient navigation for the most complex patient pathways.
- Identify and embed best clinical practice into patient pathways, such as application of one stop models and stratified follow up.

- Ensure sufficient capacity exists to support timely patient care.
- Seek to develop a pathway for Malignancy of Unknown Origin (MUO) to further complement work done in the Cancer of Unknown Primary (CUP) pathway and Acute Oncology Service (AOS).
- We will routinely offer genomics medicine in line with national targets and in the following tumour sites: leukaemia and sarcoma. We will increase the number of pathways within which genomic medicine is offered in line with national expectation.
- Support the business case to replace 4 Linear Accelerator units by 2021.
- In partnership with primary care consider fully the benefits of delivering chemotherapy closer to home within primary care setting for those patients who are best suited to receive it.
- Implementation of SpaceOAR procedure to help reduce the effects of radiation associated rectal Proctitis, leading the region in providing the best of care to our patients.

Allied Health Professionals and Psychological therapies

AHPs and psychological professions are central to meeting the changing demand the NHS faces from our growing and ageing population. They are instrumental in delivering person-centred, evidence-based care as clinical practitioners. AHPs make a crucial contribution as first-point-of-contact practitioners to faster diagnostics, living well with and beyond cancer, supporting earlier interventions in primary care, and embedding a greater sense of ‘shared responsibility’ for care between patients, primary and community health services. Psychological professionals deliver highly effective psychological therapies to people affected by cancer. This ranges supporting patients who are suffering with immediate trauma through to long term survivorship and the impact that ‘living’ with a cancer diagnosis may have on individuals.

In partnership with others we will therefore:

- Ensure that both prehabilitation and rehabilitation are clearly embedded into stratified pathways of care.
- Consider how new technologies in telehealth may support patients access to psychological therapies and better promote self-help where appropriate.
- Work more collaboratively with other statutory and third sector agencies to promote and support better mental health for people affected by cancer.

Accident and Emergency (A&E)

Around a fifth (21%) of cancer cases in England are diagnosed after presenting as an emergency. More than three quarters (77%) of these cases with known stage are diagnosed late (stages III or IV). Around two thirds (65%) of emergency presentation cases are via Accident and Emergency (A&E).[12] We will continue to work with colleagues in A&E to ensure that people affected by cancer continue to get the best care and treatment whilst in their care, with appropriate follow-up following attendance at either the urgent treatment centre or emergency department.

We will therefore:

Develop and test – and if successful implement - a Rapid Diagnostic Centre pathway within A&E for those patients with serious non-specific (vague) symptoms.

End of Life Care

The Trust and everyone who works within it, places great emphasis upon preventing avoidable deaths however, when preventing death is no longer an option we will continue to treat and support our patients including those affected by cancer, throughout their last months and weeks of life. End of life care is distinct from palliative care and here in South Tees Hospitals NHS FT we align with the Leadership Alliance in defining end of life care as 'care given in the last 12 months of life'. This includes patients whose death is imminent (expected within a few hours or days).

In the End of Life Care Strategy for Adults 2019 – 2022[13] the South Tees End of life Strategy Group have committed to ensure that the vision is fulfilled and have developed six ambitions to support this.

We fully support the six ambitions outlined as follows:

- Each person is seen as an individual
- Each person has fair access to care
- Patient comfort and well-being are maximised
- Care is coordinated
- All staff members are prepared to care
- Each community is prepared to help

We will also:

- Seek to ensure that carers receive the best support and advice, including during the last days of life of their loved ones.
- Ensure all patients at end of life are given the opportunity to discuss their preferred place of death

THEME 3

Theme 3

Research and Development

We will increase the recruitment and numbers of clinical trials alongside supporting the development of internationally competitive research making our data on outcomes readily available to the public.

Patients benefit enormously from research and development with breakthroughs in research enabling more effective treatments, better outcomes and faster recovery. We will continue to support and expand in areas of research, development and innovation to drive future patient outcome improvements.

Our focus and size enables us to uniquely deliver effective and efficient specialist care offering patients the best possible outcomes from our research programmes. We aspire to provide a level of scale which enables us to attract new research opportunities from commercial and grant awarding organisations. This will help drive improvements in cancer patient experience and outcomes.

We will therefore:

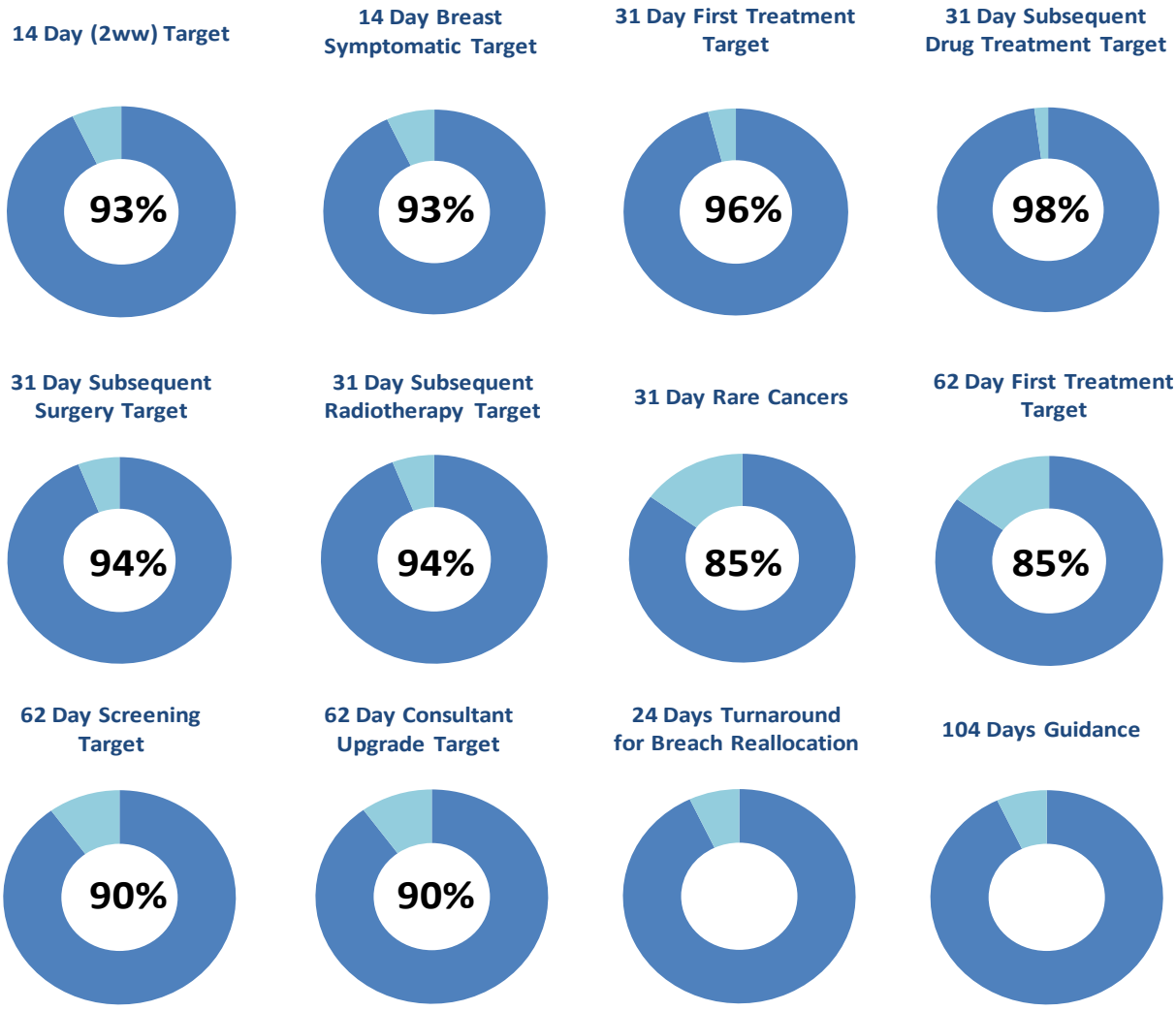
- Increase engagement with commercial research aiming to increase the number of studies, number of participants and number of investigators year on year.
- Ensure any studies undertaken recruit to time and target
- Engage patients in research experience studies
- Create a balanced research portfolio reducing the burden on pharmacy, chemotherapy and radiotherapy.
- Work with the R&D department to strategically grow the research capacity and capability within the cancer research team.
- Provide equity of research studies across the South Tees footprint.

Theme 4

Outcomes

We will aspire to offer the latest in diagnostic and treatment capability to continually improve patient outcomes now and in the future.

Time to diagnosis and time to treatment are key indicators for patients about the services they receive and both can contribute to longer-term patient outcomes. We will continue to focus on diagnosis and treatment and to ensure that as a minimum we meet each of the national cancer waiting times (CWT) standards – see Fig 7.



National Cancer Waiting Time Targets

Fig 7. National Cancer Waiting Time Targets

South Tees NHS FT will continue to work closely with the Northern Cancer Alliance, NHS England and NHS Improvement to ensure that national Cancer Waiting Time targets are continually reviewed, developed, tested and implemented to the benefit of those people affected by cancer.

We need also ensure that the targets we work towards support actions to drive earlier diagnosis, improved survival, better quality of life and patient experience.

Building on commitments made above we will therefore:

- Develop shorter and better patient pathways in line with the 28day Faster Diagnosis standard.
- Continue to view national cancer waiting time targets as a minimum standard, improving and surpassing targets year on year.
- Use data to drive decision making and prioritisation around pathways.
- Use predictive techniques to support implementation of Fast Track 150 processes to better identify patients diagnosed with cancer already in the system ensuring capacity meets demand.
- Use intuitive tools to capture data as a by-product of care in ways that reduce the administrative burden.
- Support development of a cancer clinical information system at MDT level which is fit for purpose.
- Publish outcomes information and make it available to patients, the public and commissioners in a way that can be understood.
- Support the development of decision support and artificial intelligence (AI) to help clinicians in applying best practice.

Theme 5

Partnership and engagement

We will continue to work with our partners and patients to deliver the best outcomes and experience for people affected by cancer across the health economy.

We recognised that the whole journey for people affected by cancer does not begin and end when they visit a hospital, nor do they live their lives in isolation as a result of their condition. The journey for most begins with awareness of the disease, prompting a visit to a GP in primary care followed by a referral for diagnostics and possible treatment in a secondary care setting or hospital. Throughout this and often following treatment too, patients may also interact with social care, community and voluntary sector organisations, hospices, mental health teams, charities and a whole host of other organisations.

South Tees NHS FT has a long history and a strong foundation of highly valued partnership working across the whole of the health and social care economy. We are committed to continuing this work in cancer services to the benefit of our patients, their families and their carer's.

Integrated Cancer Care

By continuing to work in partnership with local government, public health, social care, hospices, Macmillan Cancer Support and other third sector organisations alongside our primary and secondary care partners, we are committed to integration of cancer care at both system and operational levels. We will achieve this by continuing to support our Public Health and primary care colleagues in meeting their prevention targets as dictated in the NHS Long Term Plan. The Global Burden of Disease (GBD) study quantifies and ranks the contribution of various risk factors that cause premature deaths in England. Key challenges faced by our partners in South Tees in relation to the top five are:

Smoking

Smoking remains the biggest cause of cancer in the world. It causes at least 15 different types of cancer and around 7 in 10 lung cancer cases in the UK, which is also the most common cause of cancer death. It causes other cancers including mouth, pharynx (upper throat), nose and sinuses, larynx (voice box), oesophagus (food pipe), liver, pancreas, stomach, kidney, bowel, ovary, bladder, cervix, and some types of leukaemia.

Obesity

According to Cancer Research UK, obesity is the UKs biggest cause of cancer after smoking. Poor diet in particular accounts for nearly two thirds of adults in England being overweight or obese. In 2016/17 617,000 admissions to NHS hospitals recorded obesity as a primary or secondary diagnosis. In South Tees during the same period this equated to 426 patients. Whilst childhood obesity rates in Hambleton, Richmondshire and Whitby

CCG have improved the situation continues to decline in the South Tees CCG area. (CRUK Sept 2018)

Alcohol consumption

Drinking alcohol causes 11,900 cases of cancer a year in the UK. Alcohol causes 7 types of cancer, including breast, mouth and bowel cancers and the risk increases at small amounts. Prevention of avoidable illness and its complications can be improved by smoking cessation, obesity reduction and a reduction in alcohol misuse.

We will continue to work in partnership with Public Health teams and community and voluntary sector organisations to tackle inequalities locally and to fully utilise interactions in health care professionals to make every contact count regarding prevention and screening.

In parallel to this we will increase collaborative working with colleagues across the sub-region and the region to improve achievement in cancer waiting times, survival outcomes and reduce variation through greater networking of specialised expertise to maximise local delivery of care.

We will therefore:

- Work with local government public health teams to support partner organisations in delivery of a comprehensive prevention agenda promoting public health awareness campaigns across all of our hospital sites making every contact count.
- Work with partner organisations to deliver improved screening in line with national requirements with particular reference to breast cancer and bowel cancer.
- Increase 1, 5 and 10 year survival rates
- Support partner organisations in delivery of a comprehensive prevention agenda.

Workforce

The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. Nationally and locally our staff are feeling the strain. That's partly because over the past decade workforce growth has not kept up with the increasing demands on the NHS.

The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. But staff are feeling the strain and many of those leaving the NHS would remain if employers can reduce workload pressures, offer improved flexibility and professional development. The interim NHS People Plan 2019[14] committed to 5 key themes and outcomes as follows:

1. Making the NHS the best place to work
2. Improving our leadership culture
3. Addressing urgent workforce shortages in nursing
4. Delivering 21st century care
5. A new operating model for workforce

In support of the outcomes above South Tees NHS FT has recently published its health and well-being strategy containing an additional four key strategic Human Resource (HR) objectives. These are:

- Identifying and attracting the right workforce
- Engaging and retaining people
- Rewarding and recognising high performance
- Developing and delivering our work force for the future.

We fully support the Trust's strategic approach to recruitment, retention and development of a cancer workforce that is fit for the future.

However, staffing gaps already present challenges, in particular in diagnostic capacity for many providers locally, regionally and nationally. Some specialties such as radiology, are suffering significant shortages of suitably qualified and trained staff. We will continue to work collaboratively with our colleagues and partners including the NCA, to provide cross-organisational and cross boundary solutions to these issues, maximising expertise and resource to the fullest extent and to the benefit of our patients.

There are also concerns around the ageing workforce. For example our Cancer Nurse Specialist (CNS) workforce demographics show xxxx. If this trend continues without specific intervention, by xxx we will have significantly reduced numbers of suitably qualified and trained CNS to replace the current resource. These challenges do however, present us with opportunities to look at how we might resource the cancer workforce differently, considering further a more balanced skills mix within teams providing a cancer workforce that is both resilient and fit for the future. In areas where there are national skills shortages such are oncology, radiology and other specialist consultant posts, we need to look at how best we can free up their time with a greater skills mix in teams whilst also considering the

potential for sub-regional or regional working promoting better cross cover, so that specialist staff can focus more of their time on acute patient care.

The 2019 evaluation of the Macmillan Cancer Care Coordinators in South Tees showed that the new roles are widely regarded as valuable both in terms of health service efficiency and patient experience. The University of Sheffield School of Health and Related Research (SCHARR)[15] also found good quality evidence to support the claim that the new roles helped to provide the right care, at the right time, with the right person. The findings support the further adoption and spread of the CCC roles to other cancer specialties across the Trust.

We acknowledge that the workforce for cancer extends far beyond the acute sector. In developing this strategy our colleagues, patients and partners told us that professional participation in continuous learning and development was vital to inspire confidence in a highly skilled cancer workforce across the health economy. They also stressed to us that the offer of learning and development to raise awareness of cancer; the risks, signs and symptoms and support, should not be limited to professionals but should be extended to volunteers, carers and support workers where appropriate and at the appropriate level.

We will therefore:

- Ensure that cancer awareness is built into the Induction programme for all employees in South Tees Hospitals NHS FT.
- Ensure that all apprentice allied health professionals therapies complete a cancer care module as part of their training.
- Ensure that Advanced Practitioners in therapies complete a cancer care module as part of their training.
- Continue to work with centers to ensure that teams have the correct skills mix and a range of expertise to provide the appropriate level of care for people affected by cancer whatever stage of their journey.
- Work with South Tees Research and Innovation (STRIVe) team to develop a suite of learning programmes for staff and partners. This will include learning programmes and events specifically in relation to personalisation and care.

Performance monitoring

In order to establish accountability for monitoring progress and achievement against targets outlined in this strategy, Cancer Services will utilise current mechanisms as detailed below:

Meeting	Frequency	Purpose	Attendees
Cancer services team	Daily	Review of patient lists for specific tumour sites with a focus on pathways requiring action, escalation and expediting appointments.	Cancer trackers, MDT Co-ordinators, waiting list managers, service managers, Cancer Care Co-ordinators
Cancer Performance Wall	Weekly	Performance monitoring of CWT against Patient Tracking Lists (PTL). This is patient level discussion of patients whose pathways are at risk of breaching key milestone targets (either approaching the deadline without a date, or with a date beyond the deadline).	Executive Lead (Cancer), Macmillan Clinical Lead (Cancer), Dir Transformation, Macmillan Transformation Lead (Cancer), Macmillan Cancer Performance and Access Manager, Service Managers.
Cancer Wall: Process, preparation and planning	Weekly	Following the Cancer Performance wall to review process, data quality assurance for next wall, review action relating to service improvement requirements.	Cancer Services management team.
Cancer Delivery group	Monthly	The purpose of this Cancer Delivery Group is to maintain a coordinated overview which includes operationally delivering commitments made in the South Tees Cancer Strategy. The CDG will report back to the South Tees Cancer Strategy Board formally on a quarterly basis and informally as and when required by the Chair. The Board will ensure that Centre based cancer action plans are developed, delivered and monitored through this group.	Cancer Services Senior Management Team, Dir Transformation, Macmillan Cancer Performance and Access Manager, Service Manager representative, Macmillan Business Analyst (Cancer), representatives from Rad-Onc, Radiology, pathology, R&D, medical physics and Professions
Macmillan Integration of Cancer	Quarterly	To better support those affected by cancer residing in the first instance within the South Tees NHS	Partnership Board.

Care Programme Board		Foundation Trust improving experience and outcomes for patients by promoting patient choice and integrated working practice improving patient outcomes across the health economy (currently under review).	
Cancer Strategy Board	Quarterly	The purpose of this Strategy Board is to maintain a coordinated overview of strategy for the Trust. The South Tees Cancer Strategy Board will ensure that the cancer strategy for the Trust is implemented, reviewed quarterly and updated annually.	The Board comprises of senior representatives from across the health economy partnership.
Senior Leadership team	Weekly	Drive results and service improvement, to make decisions and to ensure organisational alignment and collective action.	Chief Executive, Operational Directors.
Operational Management Board	Monthly	The role of OMB is to oversee the effective operational and strategic management including the achievement of statutory duties, the delivery of the Service Strategy clinical standards and targets, the delivery of high quality patient centred care and financial targets.	Chief Executive (Chair), Deputy Chief Executive, Medical Directors, Director of Nursing and Quality, Director of Finance, Director of Estates, ICT and Health Records, Director of Human Resources, Director of Strategy & Business Development, Director of Communications, Company Secretary, Operations Directors, Associate Directors of Nursing
Trust Board		The Trust Board of Directors is responsible for setting the strategic direction of the organisation and making sure the organisation is performing as it should be.	The board is made up of the Chairman, Chief Executive, Executive Directors and Non-Executive Directors.

Acknowledgements

We would like to thank all of our colleagues, partners and patients who have given their time and support in the development of this strategy.

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South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5th November 2019			
Trust Response Framework for EU exit			**AGENDA ITEM:**19, ENC 12
Report Author and Job Title:	Diane Hurley Head of EPRR and Laura Mills Head of Facilities	**Responsible Director:**	Kevin Oxley
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	To assure the Board of Directors that the Trust has an assurance framework and it is designed to provide a flexible and timely response to any impact on the Trust as a result of the UK's withdrawal from the EU.		
Background	Article 50 of the Lisbon Treaty was invoked on 29th March 2017 giving the UK two years to agree to terms for withdrawal from the European Union. The UK is scheduled to leave the EU at 2300 on Thursday 31st October 2019. However, to date terms for our withdrawal have not been agreed which may result in us leaving the EU on a 'no deal' basis which could cause serious disruption to individuals and businesses in the short term.		
Assessment	In particular, it is anticipated that there could be some delays in receiving some medicines and supplies, due to additional border checks having to be carried out. The Trust has put in place a number of contingency arrangements to try and reduce any disruption to services should there be any issues with deliveries. This has been supported by work undertaken at national level to ensure continued supply of medicines and consumables.		
Recommendation	For members of the Board of Directors to be assured of the Trusts preparedness arrangements		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1.4 - A major incident (cyber attack, critical infrastructure failure, supply chain failure etc) resulting in temporary hospital closure or a prolonged disruption to the continuity of care services across the Trust, which also impacts significantly on the local health service community		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☒	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Purpose

To provide the Board of Directors with assurance that the Trust has a framework for responding to the UKs exit from the EU and key strategic objectives can be met which are;

Ensure that access to services for patients and the public is maintained at all times
Ensure that there is minimal impact on patients, staff and visitors
Establish and maintain effective liaison and communication with health partners and other stakeholders
Consider the potential impact of any EU Exit related issues on the Trust
Ensure effective Trust command, co-ordination and communication in the event of a critical or major incident occurring
Ensure that the Trust response is co-ordinated and integrated with that of partner organisations

At the point of writing this report there remains uncertainty on the outcome and timing of EU exit;

1. Leave with a deal on 31st October
2. Leave without a deal on 31st October
3. Delay

If the legislation is passed by the end of the month and the UK leaves with a deal on 31st October, the UK will enter a transition period until at least 31st December 2020 (with an option to extend by a further 1-2 years to agree a free trade agreement with the EU), during which time the UK's trading relationship with the EU would not change.

The Trusts planning assumptions are based on a no deal exit on 31st October, however if the UK leaves with a deal or the process is delayed the Senior Responsible Officer (SRO) will amend the plans as appropriate with approval from the Trusts Senior Leadership Team.

Background

In December 2018, as part of their contingency planning for a 'no deal' exit from the EU, the Department of Health and Social Care (DHSC) issued operational guidance for health and social care.

Within the guidance the DHSC identified 7 areas of activity that it was focusing on as part of 'no deal' contingency planning:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

National contingency arrangements for these include:

- Development of a UK-wide contingency plan to ensure continued supply of medicines and vaccines
- Pharmaceutical suppliers to have a minimum of 6 weeks additional supplies held in the UK
- Provision of additional funding and warehouse capacity to support the storage of these additional supplies
- Increase in stock levels of medical devices and clinical consumables at a national level
- Review of supply chain for non-clinical consumables, goods and services to identify areas of concern which may need additional support
- Development of a workforce settlement scheme and support for EU workers within the NHS
- Guarantee of continued funding for certain EU funded research projects

Details

In recent months, the Trust has been reviewing its preparedness for a 'no deal' exit from the EU in line with the DHSC December 2018 guidelines and developing appropriate contingency arrangements.

Kevin Oxley, Director of Estates, ICT and Healthcare Records has been appointed the SRO for EU Exit, supported by Diane Hurley, Head of EPRR and Laura Mills, Head of Facilities.

A summary of preparedness is below;

EU Exit task and finish group chaired by SRO
EU Exit task and finish group has been established to develop and maintain contingency arrangements for the potential impacts of EU Exit. The group has met weekly for 6 weeks and will move to daily meetings from the 28th October.

The group covers the 7 areas identified by the DHSC December 2018 guidelines and key South Tees identified areas.

The group is attended by pharmacy, HR, finance, winter planning lead, estates, centre leads, research and development, medical engineering, communications, procurement, Estates, LRI and PFI partners.

The group has prepared an EU Exit risk register with mitigations and reviews the key areas of activity at each meeting to identify any additional action required. A copy of the risk register can be found in appendix A.

Testing and exercising
The Trust has participated in a number of exercises and workshops in the lead up to EU Exit, Including a North East NHS exercise on 20th May 2019, regional workshop on 5th September and a joint LRF event on 27th September 2019.

In addition, the Trust preparedness for EU Exit was tested at an internal table top exercise on 3rd October 2019. This was facilitated by NHS England and NHS Improvement and attended by all directorates, PFI colleagues, the SRO and supporting officers.

Engagement with key stakeholders
Over the last 12 months there has been full engagement with local and regional health and social care partners and other external organisations including the Local Resilience Forum (LRF) to ensure that there is a common understanding of the potential impact of EU Exit

Response arrangements
The SRO has complied a rota for tactical and strategic cover for EU exit related matters this covers Monday to Friday 7am – 10pm, from 21st October to the 29th November 2019. This rota is supplementary to the Trusts normal tactical and strategical arrangements.

Assurance Framework

The SRO and supporting officers will be working towards a Trust response framework (appendix B). This framework is designed to provide a flexible and timely response to any impact on the Trust as a result of the UK's withdrawal from the EU. This document will be amended if necessary to support Parliamentary timelines should there be a delay.

Recommendation

The Board of Directors are asked to receive this report and note the continuing work to ensure that the Trust is as prepared as possible for EU Exit.

Appendices (available but not circulated)

A – EU Exit Risk Register
B – Trust Response Framework

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 November 2019			
FLU CAMPAIGN UPDATE			**AGENDA ITEM: 20, ENC 13**
Report Author and Job Title:	Jude Cooper Occupational Health and Wellbeing Service Manager	**Responsible Director:**	Rachael Metcalf HR Director
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	To achieve >80% uptake of flu vaccinations for frontline Healthcare Workers		
Background	NHS England and NHS Improvement wrote to chief executives of NHS trusts on 17th September 2019 to highlight the importance of healthcare workers getting vaccinated against 'flu. The letter advises how organisations should plan to ensure every staff member is offered the vaccine which will enable NHS organisations to achieve the highest possible level of vaccine coverage this winter. There is an ambition of 100 per cent of healthcare workers with direct patient contact to be vaccinated. There is also a CQUIN target of 80%		
Assessment	The South Tees Hospitals NHS Foundation Trust staff flu campaign covers a catchment area reaching from East Cleveland Primary Care Hospital in Brotton to The Friary Hospital in Richmond, North Yorkshire. There are 7,652 frontline healthcare workers, therefore will need to vaccinate 6,122 to achieve the required minimum uptake. We have 130 flu champions covering all areas. Our flu campaign is well established and we have constantly achieved the required target in the last five years.		
Recommendation	Members of the Trust Board are asked to acknowledge the requirements from NHS England and note the self-assessment of the best practice checklist devised by NHS England. Board assurance is to be provided to NHS England by December 2019		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risks associated with this paper.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒
	Drive operational performance ☒	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

1. PURPOSE OF REPORT

The purpose of this report is to give assurance to the board that we will achieve an 80% uptake of flu vaccines in frontline Healthcare workers.

2. BACKGROUND

Last year the trust celebrated a record year with champions vaccinating 80.4% of frontline healthcare staff, 5.4% higher than the required 75% national target. The previous record was 76.9% in 2016/17.

We had support from all levels of the organisation including our senior leadership team, used a range of strategies for communication and staff engagement and increased our accessibility for hard to reach staff groups.

The successful campaign also gained nation recognition with the trust shortlisted for the NHS Flu Fighter Awards in two categories.

3. DETAILS

This year we want to repeat this success and to encourage staff to have the vaccine much earlier, ideally by the end of November. The national target is to vaccinate 80% of staff by February 2020.

The flu flyers campaign is built around an airline theme. Staff will be invited to join the flu crew by having their vaccination. They will then receive a flu crew pen or retractable pull, a sticker and a voucher for a free drink and cake. The campaign will highlight that we are providing “first class” care by protecting patients and that we want to be “flying high” this year with more staff vaccinated in record time. Flu consent forms will take the form of a boarding pass and staff will be able to complete these in advance by downloading a PDF to help speed up the vaccination process.

This still reflects the key national messages about protecting patients but in a way that is fun, eye-catching and unique to the trust. The campaign officially launch on 7 October

Last year, 6,749 of our 8,421 staff were vaccinated (see breakdown by staff below) - 4,332 had been vaccinated by 31 October.

This year, to hit our Trust target we need to vaccinate 6,122 people with the aim of achieving this figure eight weeks from launch, although this depends on delivery dates of vaccines.

By Staff Group	Vaccinated	Total Staff	% Vaccinated
Doctors (1)	828	882	93.9%
Nurses, Midwives and Health Visitors (3)	2223	2700	82.3%
Other Professionally Qualified (4)	762	987	77.2%
Support to Clinical Staff (5)	2407	3167	76.0%
Healthcare Workers (Reported)	**6220**	**7736**	**80.4%**
Non-Clinical Staff (5U)	529	685	77.2%

We have an established Flu Steering Group for campaign planning, made up of representatives from pharmacy, communications, senior nurse managers, IPC, staff side union (RCN), Carillion/Serco, and HR, led by the Occupational Health Service Manager with a dedicated campaign co-ordinator.

An evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt:

- Revision of the previous years' spread of Flu Champions compared to the previous years' uptake figures. Our main site, The James Cook University Hospital, had achieved continually high results but still needed revising.
- Analysis of the Flu Champion ratios at the 'satellite' hospitals and community areas in the Trust that had previously shown up in the records as low responders, establishing the weaker links.
- Accessibility of vaccination trust-wide to see if any existing Flu Champions could be better utilised or if staff with more mobility could be recruited thereby decentralising and taking the vaccines to more outlying areas more often.

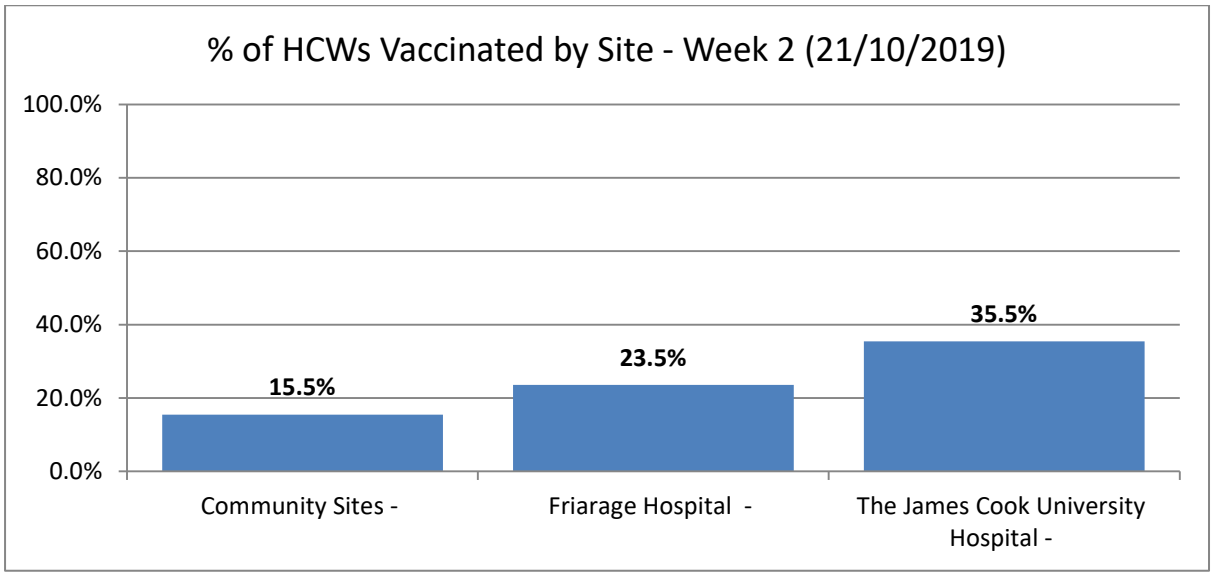
There are also a wide range of incentives to be won, including an iPad, fitbit and free car parking for a year. The prize draw will be done on 1st December 2019. This is also to celebrate and thank our staff for their hard work and dedication for providing first class care for patients.

The Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers who are <65 years of age before 31st March 2020. This year we have also ordered the Trivalent vaccine for staff who are aged >65 as recommended.

4. Current Position

Our current uptake for flu vaccination at the end of week 2 for Healthcare Workers is 31.9%.

Weekly trajectories are in place to ensure we achieve 80% and these targets will be shared across the organisation on a weekly basis.



5. RECOMMENDATIONS

The Board are asked to acknowledge the requirements from NHS England and note the self-assessment of the best practice checklist devised by NHS England.

Board members are also asked to confirm they intend to receive flu vaccination so that this can be publicised.

Board assurance is to be provided the NHS England by December 2019.

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APPENDICES

Flu letter
Self Assessment

NHS England and NHS Improvement

Pauline.Philip@nhs.net

17 September 2019

Ms Siobhan McArdle

Chief Executive,
South Tees Hospitals NHS Foundation Trust

CC: Mr Alan Downey

Chair,
South Tees Hospitals NHS Foundation Trust

Dear Siobhan,

Healthcare worker flu vaccination

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. Provider flu plans for 2018/19 saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff. Our ambition is to improve on this through the actions outlined in this letter.

In March 2019, the Department of Health and Social Care (DHSC), NHS England and Improvement and Public Health England (PHE) wrote to all trusts setting out the appropriate vaccines for adults up to 64, the egg and cell-base Quadrivalent influenza vaccines (QIVe and QIVc) and for over 65s, the adjuvanted trivalent influence vaccine (aTIV) as well as QIVc.

Today, we are writing to ask you to tell us how you plan to ensure that all of your frontline staff are offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Background

Healthcare workers with direct patient contact need to be vaccinated because:

a) Flu contributes to unnecessary morbidity and mortality in vulnerable patients

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated

Whilst overall uptake levels have increased every year since 2015/16, there is significant variation in the uptake rates achieved as some trusts have developed excellent flu programmes that deliver very high level of vaccination coverage, however others have not made the same progress.

An evaluation of last year's flu season showed that trusts that have developed a multicomponent approach have achieved higher uptake levels. Innovative methods to reach staff, going ward-to-ward, holding static and remote drop-in clinics and encouraging staff to contact vaccinators directly have been established. Trusts also used incentives to encourage staff, and even small incentives, such as badge stickers, worked to reinforce positive messages. Above all, board and ward leadership are critically important to promote vaccination to staff, providing visibility and transparency.

In order to ensure your organisation is doing everything possible as an employer to protect staff and patients from flu, we would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce. You can also access resources including National Institute for Health and Care Excellence (NICE) guidelines: https://www.nice.org.uk/guidance/ng103 and Public Health England's Campaign Resource Centre: https://campaignresources.phe.gov.uk/resources/campaigns/92-healthcare-workers-flu-immunisation-

We are now asking that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of December 2019. Your regional lead will also work with you to share best practice approaches to help support an improvement in your uptake rates.

It is important that we can track trusts' overall progress towards the 100% ambition and all trusts will be expected to report uptake monthly during the vaccination season via 'ImmForm'.

As discussed, there is variation of uptake rates between trusts. Many trusts have made successful progress and have achieved near full participation, whilst other trusts are not increasing uptake rates quickly enough to protect staff and patients. It is important that improvements are made in those trusts. To support this, the healthcare worker flu vaccination CQUIN is in place again this year. New thresholds for payment have been set at 60% (minimum) and 80% (maximum).

We are also increasing requirements for trusts who have had low uptake rates. Each trust that was in the bottom quartile for vaccination uptake (at 61.7% or below) in the published data (Immform in 2018/19) will be required to buddy with a higher uptake trust. Working with them will provide an opportunity to learn how to prepare, implement and deliver a successful vaccination programme.

For trusts in this quartile progress will be reviewed weekly during the flu season by regional teams in addition to the monthly reporting that is provided to PHE via Immform.

In 2018/19, your trust achieved a frontline healthcare worker flu vaccination uptake rate of 80.2%. This does not put your trust in the lower quartile of trusts.

Organisations should use the Written Instruction for the administration of seasonal 'flu vaccination developed by The Specialist Pharmacy Service. NHS trusts vaccinating their own staff may consider that a PGD is more appropriate if it offers a benefit to service delivery e.g. provision by healthcare practitioners other than nurses, who may legally operate under a PGD. Health and social care workers should be offered either the egg or cell-based quadrivalent influenza vaccine. For the small number of healthcare workers aged 65 and over, if you are unable to offer the cell-based flu vaccine, these staff should ask their GP or pharmacy for an adjuvanted trivalent influenza vaccine (aTIV) which is preferable to the non-adjuvanted egg-based flu vaccine particularly if they are in an at risk group.

Finally, we are pleased to confirm that NHS England and Improvement this year is offering the vaccine to social care and hospice workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely,

Pauline Philip
National Director of Emergency and Elective Care
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer
NHS England and NHS Improvement

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Flu team to meet regularly from September 2019	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Flu vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop in clinics agreed	
C3	Schedule for 24 hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

Appendix 2

Healthcare worker flu vaccination best practice management checklist

A	**Committed leadership**	**Trust Self-Assessment (RAG rated)**
A1	Board record commitment to achieving the ambition of 100% of frontline health care workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	
A3	Board receive an evaluation of the flu programme 2018-19, including data, successes and lessons learnt.	
A4	Agree on board champion for flu campaign	
A5	Agree on how data on uptake and opt-out will be collected and reported.	
A6	All board members receive flu vaccination and publicise this.	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	
A8	Flu team meet regularly from September 2019.	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	
B3	Board and senior managers having their vaccination to be publicised	
B4	Flu vaccination programme and access to vaccination on induction.	
B5	Programme to be publicised on screensavers, posters and social media.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	
C2	Schedule for easy access drop in clinics agreed.	
C3	Schedule for 24 hour mobile vaccinations to be agreed.	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this.	
D2	Success to be celebrated weekly.	

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 November 2019			
SUMMER STAFF SURVERY 2019			**AGENDA ITEM: 21, ENC 14**
Report Author and Job Title:	Rachael Metcalf Director of HR	**Responsible Director:**	Rachael Metcalf Director of HR
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The Trust undertook an additional staff survey in August 2019 to develop an accurate base line for staff opinions.		
Background	Following a poor response rate to our national staff survey in 2018 (413 response) a decision was taken to undertake an additional staff survey for all staff rather than a sample as was previously undertaken.		
Assessment	The Summer staff survey was distributed to 8258 members of staff and we received a response rate of 32% (2666 responses). The staff Survey can be categorized into 9 areas: Quality of Appraisals Equality, Diversity & Inclusion Safety Culture Health and Wellbeing Morale Staff Engagement Immediate Manager Support Quality of Care Violence, harassment and Bullying The Trust position has deteriorated in 7 of the key areas.		
Recommendation	Members of the Trust Board note the content of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 5.2 - Ineffective engagement with the workforce may result in low staff morale, leading to poor outcomes & experience for patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover. BAF 5.3 - Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care		
Legal and Equality and Diversity implications	The Summer staff survey raises concern that 54% of respondents do not feel the Trusts acts fairly with regard to career progression regardless of ethnic background, gender, religion, sexual orientation, disability or age.		
Strategic Objectives	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☒	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Summer Staff Survey 2019

1. PURPOSE OF REPORT

The purpose of the reports is to provide the Board with full analysis of the summer staff survey results.

The results show that the Trust position has seen a deterioration in 19/51 questions and an improvement in 32/51 questions in comparison to our 2018 National staff survey results.

2. BACKGROUND

The national staff survey carried out in Autumn 2018 was sent to a sample of 1,247 members of staff and we received a response rate of 33% with 413 staff completing the survey.

It was decided to conduct an additional Summer Survey in 2019 and provide the opportunity for all staff to conduct the survey to gain a more accurate baseline of staff opinion.

The summer staff survey was sent to 8,258 members of staff via email and we had a response rate of 32% with 2,666 members of staff completing the survey. The Summer Staff Survey was open from 12 July – 26 August 2019.

3. DETAILS

Staff participation with the NHS staff survey is not compulsory, although staff are strongly encouraged to use the opportunity to give their opinions and views about the organisation in which they work. It is important therefore that as many employees as possible complete the questionnaire. The higher the survey response rate, the more confident the Trust can be that the survey findings are representative of the organisation as a whole.

Response rates by Centre

Centre	Percentage
Overall	32%
Clinical Support Services	41%
Community Care	30%
Corporate Services	49%
Specialist and Planned Care	32%
Urgent and Emergency Care	21%

The following key areas are included in the staff survey questionnaire:

- Quality of Appraisals
- Equality, Diversity & Inclusion
- Safety Culture
- Health and Wellbeing
- Morale
- Staff Engagement
- Immediate Manager Support
- Quality of Care
- Violence, harassment and Bullying

The results show deterioration in 7 areas, with Support from Immediate Managers and Violence, harassment and bullying showing a slight improvement.

Full analysis is included in the presentation.

4. RECOMMENDATIONS

Members of the Trust Board note the content of this report

APPENDICES

Presentation of full staff survey results

NHS
South Tees Hospitals
NHS Foundation Trust

Summer Staff Survey 2019

October 2019

Excellence in Patient Outcome and Experience

Executive Summary – Summer Staff Survey 2019

Survey Carried Out

12th July- 23rd August 2019

Method

Electronic census survey

Response Rate

32%

2666/ 8258 (2018 survey 33%, 413 staff)

Survey Results

19/51 **Questions improved**

from previous year

32/51 **Questions Deteriorated**

The summer staff survey was carried out at the Trust in July 2019/ August 2019. This Trust survey was sent to 8,258 staff and was completed by 2666 people (32%).

Results Summary – Summer Staff Survey 2019

Quality of appraisals

1/4 questions improved;
3/4 questions deteriorated

Equality & diversity and inclusion

1/3 questions improved; 2/3 deteriorated

Safety culture

1/6 questions improved; 5/6 questions deteriorated

Health & wellbeing

5/5 questions deteriorated

Morale

5/9 questions improved; 4/9 questions deteriorated

Staff engagement

3/9 questions improved;
6/9 questions deteriorated

Immediate Managers

5/6 questions improved; 1/6 questions deteriorated

Quality of Care

3/3 questions deteriorated

Violence, harassment & bullying

3/6 questions improved
3/6 questions deteriorated

Quality of Appraisal – Comparison Results

Quality of Appraisals

1/4 questions improved;
3/4 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	2019	2018 national average
It helped me to improve how I do my job	Improvement	19.5%	14.2%	16%	21.5%
It helped me agree clear objectives for my work	Deterioration	32.6%	27.2%	27%	33.3%
It left me feeling that my work is valued by my organisation	Deterioration	26.3%	24.8%	24%	31.1%
The values of my organisation were discussed as part of the appraisal process	Deterioration	22.5%	19.4%	17%	35.2%

Equality, Diversity & Inclusion - Comparison Results

Equality, diversity and inclusion

1 / 3 questions improved; 2/3 deteriorated

Question	Improvement/ deterioration	2017	2018	2019	2018 National average
Does your organisation act fairly with regard to career progression /promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	Deterioration	85.7%	87.7%	54%	85.5%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	Improvement	5.2%	4.9%	3%	5.2%
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	Deterioration	6.1%	4.5%	6%	7%

Safety Culture - Comparison Results

Safety Culture

1/6 questions improved;
5/6 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	2019	2018 National average
My organisation treats staff who are involved in an error, near miss or incident fairly	Deterioration	49.2%	50.0%	36%	59%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	Deterioration	67.1%	62.9%	55%	70%
We are given feedback about changes made in response to reported errors, near misses and incidents	Deterioration	55.2%	51.7%	43%	58.9%
I would feel secure raising concerns about unsafe clinical practice	Improvement	65.6%	65.8%	67%	70.3%
I am confident that my organisation would address my concern	Deterioration	54.0%	49.9%	48%	58%
My organisation acts on concerns raised by patients / service users	Deterioration	68.2%	59.6%	59%	73.1%

Health & Wellbeing – Comparison Results

Health & wellbeing

5/5 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	2019	2018 National average
The opportunities for flexible working patterns	Deterioration	47.7%	47.8%	42%	52.8%
Does your organisation take positive action on health and well-being?	Deterioration	25.8%	15.9%	14%	27.8%
In the last 12 months have you experienced musculoskeletal problems(MSK) as a result of work activities?	Deterioration	25.4%	30.0%	33%	27.4%
During the last 12 months have you felt unwell as a result of work related stress?	Deterioration	36.9%	40.1%	47%	38.8%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	Deterioration	56.0%	53.6%	60%	56.3%

Morale – Comparison Results

Morale

5/ 9 questions improved deteriorated; 4/9 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	Summer 2019	2018 National average
I am involved in deciding on changes introduced that affect my work area / team / department	Improvement	51.5%	44.3%	47%	53.1%
I receive the respect I deserve from my colleagues at work	Deterioration		74.1%	69%	72.1%
I have unrealistic time pressures	Deterioration	_	21.6%	40%	22.5%
I have a choice in deciding how to do my work	Improvement	_	49.6%	52%	56.3%
Relationships at work are strained	Improvement	_	41.5%	21%	45.8%
My immediate manager encourages me at work	Improvement	_	61.4%	65%	68.8%
I often think about leaving this organisation	Deterioration	_	37.3%	38%	28.8%
I will probably look for a job at a new organisation in the next 12 months	Deterioration	_	21.3%	24%	20.7%
As soon as I can find another job, I will leave this organisation	Improvement	_	18.4%	18%	14.7%

Staff Engagement – Comparison Results

Staff engagement

3/9 questions improved; 6/9 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	Summer 2019	2018 National Average
Motivation					
I look forward to going to work	Deterioration	53.6%	50.8%	47%	59.3%
I am enthusiastic about my job	Improvement	73.6%	67.7%	68%	74.8%
Time passes quickly when I am working	Improvement	76.2%	75.6%	76%	77.6%
There are frequent opportunities for me to show initiative in my role	Improvement	69.9%	68.5%	69%	73.4 %
I am able to make suggestions to improve the work of my team / department	Deterioration	74.6%	73.8%	70%	75.2%
I am able to make improvements happen in my area of work	Deterioration	53.8%	50.2%	49%	56.5%
Recommendation of the organisation as a place to work/ receive treatment					
Care of patients / service users is my organisation's top priority	Deterioration	66.3%	59.9%	58%	76.5%
I would recommend my organisation as a place to work	Deterioration	54.2%	47.2%	43%	61.6%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Deterioration	69.9%	70.2%	66%	69.9%

Immediate Managers – Comparison Results

Immediate Managers

5/6 questions improved/ 1/6 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	Summer 2019	2018 Average
The support I get from my immediate manager	Improvement	69.1%	63.3%	66%	70%
My immediate manager gives me clear feedback on my work	Improvement	60.6%	55.4%	57%	61.1%
My immediate manager asks for my opinion before making decisions that affect my work	Improvement	52.8%	50.8%	52%	54.6%
My immediate manager takes a positive interest in my health and well-being	Improvement	67.7%	62.1%	65%	67.8%
My immediate manager values my work	Improvement	71.5%	67.7%	69%	71.9%
My manager supported me to receive this training, learning or development	Deterioration	47%	51.6%	44%	54.3%

Quality of Care – Comparison Results

Quality of care

3/3 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	Summer 2019	2018 National average
I am satisfied with the quality of care I give to patients / service users	Deterioration	83.4%	79.0%	75%	80.5%
I feel that my role makes a difference to patients / service users	Deterioration	91.0%	89.8%	89%	89.4%
I am able to deliver the care I aspire to	Deterioration	71.0%	64.7%	58%	67.3%

Violence, harassment & Bullying – Comparison Results

Violence, harassment & bullying

3/6 questions improved
3/6 questions deteriorated

Question	Improvement/ deterioration 18/19	2017	2018	2019	2018 average
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	Improvement	17.6%	13.2%	12%	12.6%
In the last 12 months how many times have you personally experienced physical violence at work from managers?	Improvement	0.9%	0.4%	0%	0.5%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	Improvement	2.1%	1.6%	1%	1.5%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	Deterioration	27.5%	27.8%	28%	25.8%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	Deterioration	8.3%	9.9%	12%	12.1%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	Deterioration	21.8%	18.2%	19%	18.4%

Staff Survey - Key Areas of Focus for 2020

Quality of Appraisals

Review and re-launch behavioural competencies as part of the SDR process
Introduce the Talent Management Appraisal Form

EDI

Continue to develop and establish staff networks to support staff with protected characteristics
Following launch in October 2019 continue to promote NHS Rainbow badge campaign across the Trust
One initiative/ campaign per month

Safety Culture

Review the procedures for reporting incidents and providing feedback and include findings as part of informed discussions and lessons learnt at identified forums

Bullying and Harassment

Putting people back into Trust Policies
Implement the Civility Saves Lives initiative
Anti-bullying Campaign
Participate and embed the NHSI Pilot

Health and Wellbeing

Embed Health & Wellbeing Strategy
Publicise Health and Wellbeing event agenda . Explore initiatives e.g. related to supporting mental health
Review flexible working arrangements
Identify top 3 reasons for absence and develop an action plan to mitigate circumstances that may contribute and implement preventative actions

Morale

Develop and deliver the Ward to Board programme – increase visibility of Senior Leaders.
Implement the 'itchy feet' initiative as part of the retention review
Be actively engaged in the Retention Direct Support Programme

Staff Engagement

Continue and expand staff engagement forums ensuring that actions are monitored, implemented and communicated across the Trust
Ensure that the results of the 2019 National Staff Survey is communicated and development of action plans include representation of staff

Immediate Managers

In conjunction with line managers, identify the tools they require to successfully manage and lead their staff and teams and develop a programme of support to assist them

Quality of Care

Promote a renewed focus on 'back to basics' that enables the delivery of high quality care. Develop a culture of effective team working and communication across all staff groups.

MEETING OF THE TRUST BOARD OF DIRECTORS – 5 November 2019			
CQC Action Plan Update			**AGENDA ITEM: 22, ENC 15**
Report Author and Job Title:	Ian Bennett, Head of Patient Safety and Quality Jackie White Head of Governance	**Responsible Director:**	Gill Hunt, Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This paper provides an update on progress with the CQC action plan		
Background	Following the CQC inspection of the Trust which was carried out between the 15th January and the 23rd February, a detailed action plan was developed to address all the 'must do' actions and the 'should do' actions		
Assessment	This report outlines the actions that are on track to be delivered on time, the actions that have been completed and also the actions that are rated red and behind schedule and actions taken to mitigate the risks		
Recommendation	The Board of Directors are asked to note the content of the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF reference 2.2 - Risk that failure to comply with the CQC Health and Social Care Act could lead to restrictions on service provision leading to reputational damage and/or financial penalties		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐	
	Drive operational performance ☒	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

CQC Action Plan Update

1. PURPOSE OF REPORT

This paper provides an update on the action plan which has been developed following the CQC's most recent inspection of the Trust which was carried out between the 15th January and the 23rd February 2019.

The action plan has been produced in partnership with senior leaders from across the organisation and covers all of the 'Must Do's and Should Do's' from the inspection report. It has also been shared with both the CQC and the CCG's.

The CQC Oversight Group has been established and the meeting frequency has been increased to fortnightly, in order to ensure timely oversight and intervention.

This Group is responsible for overseeing the implementation of the action plan and seeking assurance through supporting evidence and reporting on progress to Quality Assurance Committee on a regular basis. Fortnightly updates will also be provided to the Senior Leadership Team, via the Director of Nursing and Quality. The group is focussed on ensuring there are effective ongoing assurance mechanisms in order to translate the action plan into business as usual. A priority is to ensure effective trust wide monitoring is in place for all actions, to be assured that where a concern has been identified in one core service it would not be the case elsewhere in the trust.

The latest version of the CQC action plan has been transferred over into an excel spread sheet, in order to make it easier to manipulate the information contained within it, including clearer oversight on the RAG rating and the collation of underpinning evidence to support the level of assurance for each action. A detailed review of assurance of the evidence is currently taking place to ensure where actions are marked complete there is sufficient evidence available to demonstrate this.

2. BACKGROUND

Following the CQC inspection of the Trust which was carried out between the 15th January and the 23rd February, a detailed action plan was developed to address all the 'must do' actions and also the 'should do' actions.

3. DETAILS

The attached action plan provides details of the;

Of the 165 actions in the improvement plan 12 are at risk of not delivering the required outcomes based on current results and progress. A breakdown is provided below.

Completed	100
In progress – and on track	53
In progress – significant risks to delivery or outcomes identified	12

A review of the actions graded green is being undertaken to provide assurance that the action has been completed and there is supporting evidence to demonstrate that the action is complete.

The following actions are graded red following discussion at the CQC Oversight Group meeting on 10/10/19.

2.4 All SI's should be reported within 48 hours

It was agreed that this should be rated red as in September only one of the 3 SI's reported was reported within 48 hours from being made aware of the incident. Further work is taking place to address this and ensure staff are aware of the importance of reporting an SI or potential SI's as soon as they are made aware of the incident, in accordance with the SI Policy and procedures.

4.1 Utilise the Warwick Medical Engagement Scale

This is behind schedule as this action was due to be completed in September. The aim of this is to understand how engaged doctors feel in the work of the organisation.

5.1 CEO to attend 2 directorate meetings in all specialties annually

It is recommended that this action be removed as is no longer appropriate. With regard to the regulatory action the Trust is now promoting visible, accessible and responsive leadership to help us get back to our best. Clinical leaders from across the Trust are now being empowered to come together on a regular basis to make more of the decisions about how we manage and develop our services in the best interests of patients. An invitation to attend the Clinical Leaders Group has been extended to SLT, Senior Medical Forum (SMF) and Staff Side and a revised purpose and terms of reference have been agreed. The CEO is meeting both informally, formally and as part of her induction programme with Clinical Directors across the Trust.

It is recommended that this action be removed from the action plan.

7.1 Ensure effective communication between the senior medical forum (SMF) and SLT – amend TOR

The Clinical Directors Group has extended an invitation to attend the meeting to SLT, Senior Medical Forum (SMF) and Staff Side and a revised purpose and terms of reference have been agreed. The CEO meets weekly with SLT, SMF and the CD group.

7.2 Agree SLT frequency of attendance and standing agenda items

SLT meetings take place every week for 2 hours on a Thursday. A standard set of agenda items has been agreed. SLT includes all staff responsible to the CEO.

13.1 Review and implement a programme of Board Development Sessions

A board development programme has been developed and agreed with the Chair and CEO which will commence in November.

20.3 Review compliance with the risk management process from ward to board

Identify barriers to risk escalation, devise and implement a communication and engagement strategy to raise awareness of risk management and address barriers. Kevin Oxley, Director of Estates advised that a meeting has been arranged for the end of October 2019 to discuss how best to engage with staff and how risk is escalated, the quality business partners (QBP's) will feed into this meeting as they have been out in their Centres talking to staff and gaining feedback about risk escalation. This action was due to be completed in September and is therefore behind schedule.

28.2 Ensure that the ED environment is suitable for the purpose and is compliant with paediatric standards

The CQC Oversight Group was updated that the business case is being reviewed.

38.1 Ensure that MDT sessions have been completed following traumatic debriefs if required

There was a discussion at the last CQC Oversight Group on how best to record that debriefs happen. The ED leadership team are arranging meetings with HR to discuss supporting staff, how best to evidence this, testing that it works and ensuring it happens. We need to raise awareness around debriefs and supporting staff. It was agreed at the CQC Oversight Group that there is still work to be done around assurance and evidence so this action will continue to be rated red for the time being.

49.4 As per 2.4 all SI's should be reported within 48 hours (this action was specific to Critical Care)

This action has been rated red as per action 2.4 and 66.3 as currently the Trust is not reporting all SI's or potential SI's within 48 hours of being made aware of the incident.

55.1 Develop and implement an action plan to address issues highlighted from the national laparotomy report

Evidence that the action plan has been fully implemented and changes made where necessary to ensure appropriate action is taken. An update was provided at the CQC Oversight Group on this action and it was advised that whilst there has been

progress in terms of the audit process the issue of critical care capacity is still a constraint and needs to be addressed. The RAG rating has therefore been turned to Red.

66.3 As per 2.4 and 49.4 - Ensure all SI's are reported within 58 hours (NB this relates specifically to diagnostic imaging)

This action has been rated red as per action 2.4 and 49.4 as currently the Trust is not reporting all SI's or potential SI's within 48 hours of being made aware of the incident.

The action plan presented at the meeting showed 10 actions as being rated red. One of the actions, 29.3 was discussed and it was agreed this should be rated amber due to the business case being submitted relating to the disabled toilet in ED being made ligature free and a quote being received for the work to be completed.

3.1 Escalation

It was agreed that the following actions will be escalated to QAC.

- Action point 25 – Achieving 90% Mandatory training compliance by the end October (Jane Herdman)
- Action point 16.1 - Documentation audit needs wider scoping to include medical and AHP staff (Helen Day)
- Ownership of the CQC action plan – Corporate and Centre Ownership – All

3.2 Well Led

In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. It is strongly encouraged that all providers carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances *(ref: Monitor - Developmental reviews of leadership and governance using the well-led framework)*

There are three elements to the well led framework: self-review, developmental review and detailed review – undertaken by the CQC.

Self-review - The board should reflect on its performance with an initial investigation that involves self-review against the framework. This should identify any areas in the framework or extra areas outside the framework (e.g. arising from internal and external audit review findings, annual or corporate governance statements) that require particular focus as part of the review.

The Trust last carried out a self-review in November 2016 which was subsequently followed up with a developmental review in 2017.

Developmental review - External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not available within the provider. Providers should also ensure reviewers are suitably independent of the board. This includes avoiding using reviewers who have done audit or governance-related work for the provider in the previous three years, unless there are suitable safeguards against conflict of interest.

A developmental review was carried out in 2015 and a follow up in 2017 by Deloitte. An action plan was developed in 2015 to address the issues highlighted which was overseen by the Trust Board and updates provided to NHSI.

Detailed review – CQC inspection - From the 5 to 7 February 2019 the CQC undertook a planned unannounced inspection of the Trust which looked at the quality of leadership at the trust and how well the trust managed the governance of its services.

The CQC rated the Trust for the well-led (leadership) taking into account Trust and centre level information as requires improvement which was a deterioration from the last inspection of good.

The findings of the well led inspection are detailed in appendix 1 which identified a number of key themes :

- Leadership capacity and capability
- Staff engagement
- Equality and diversity
- Risk and incident culture, reporting and learning
- Financial governance and links with quality

3.3 Way forward

Following discussion at SLT it is suggested that a self-review is undertaken of the well led standards in conjunction with identifying actions to address the issues identified in the well led inspection report.

It is recommended that the Board carried out the self-review in 2 phases to ensure it is robust. These are summarised as:

• Board workshop in December 2019, led by the Director of Nursing & Quality and Head of Corporate Governance. The aim of the workshop is to consider each of the standards within the well-led framework, identify any evidence to support implementation of that standard and then to review the CQC Ratings Characteristics to ascertain what rating to give each of the standards. Attendees will be divided into 2 groups: executives & non-executive directors (NEDs) and asked to consider each of the 8 standards. As well as undertaking a self-assessment, attendees will be asked to identify 3 actions which needed to be taken to improve compliance

(referring to the CQC inspection report as necessary) – these actions will then be considered by the Board as a whole and the top 3 agreed for each of the standards.

• Following the board workshops, the executives will meet with the Director of Nursing & Quality and Head of Governance to clarify the evidence available to support that self-assessment.

It is also recommended that each of the Centre boards undertake a similar exercise within each of their areas to look at their own well led rating.

Key issues identified in the CQC inspection report will be cross checked with actions identified in the self-review process. These actions will be pulled into an action plan which when finalised will be monitored by the SLT and the Board on a quarterly basis with the aim of moving the Trusts overall rating to 'Good'.

3.4 'Moving to Good'

The Director of Nursing, the Head of Patient Safety and Quality and the Head of Governance are attending the launch day of the 'Moving to Good' programme on the 30 October. Participating in this programme led by NHSI will also see out Trust partnered up with a similar organisation which has been rated as either good or outstanding.

4. RECOMMENDATIONS

For the Board of Directors to note the progress with actions on the action tracker and also to be made aware of the actions that are off track, the reasons for this and the agreed mitigation to address these.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 November 2019			
Use of Seal			**AGENDA ITEM: 23, ENC 16**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Sue Page Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	In line with the Trust's Constitution this report provides information on the documents affixed under seal between 1 August 2018 and 30 September 2019		
Background	In line with the Constitution para 14.5 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).		
Assessment	There are no underlying issues for discussion regarding this report.		
Recommendation	Members of the Trust Board are asked to note the sealed documents report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	Legal requirement of 2006 Act incorporated in Trust board standing orders		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

1.0 Introduction

The Common Seal of the Trust is affixed to documents under the authority of the Board of Directors in accordance the Trust's Standing Orders.

In line with the Trust's Standing Orders this report provides information on the documents affixed under seal between 1 August 2018 and 30 September 2019:

Table 1. Sealed Documents

Date of Sealing	Seal No	Document	Signed and Sealed by
26 June 2018	2018/1	Deed of variation of the Concession Agreement at James Cook University Hospital	S McArdle, Chief Executive S Mason, Director of Finance
19 February 2019	2019/01	Settlement deed in relation to a concession agreement dated 16 August 1999	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/02	Deed of surrender of part of deed of variation relating to the head lease of James Cook University Hospital	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/03	Deed of variation of concession agreement relating to James Cook University Hospital	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/04	Deed of surrender of part and deed of variation relating to an under lease of part of the James Cook University Hospital	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/05	Lease relating to car parking spaces at Prissick car parking Middlesbrough	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/06	Lease relating to premises know as Learning, Research and Innovation Institute Building James Cook University Hospital	S McArdle, Chief Executive A Downey, Chairman
28 March 2019	2019/07	TP1 South Tees Hospitals NHS Foundation Trust And	S McArdle, Chief Executive A Downey, Chairman

		(1) WGIF (Jersey) TrusteeI limited (2) WFIF (Jersey) TrusteeII Limited	
4 July 2019	2019/08	Deed of Variation South Tees Hospitals NHS Foundation Trust And James Cook University Hospital Voluntary Services Council	S McArdle, Chief Executive A Downey, Chairman

2.0 Recommendation

The Board is asked to note the documents included within the report that were affixed under seal during 1 August 2018 to 30 September 2019.

Finance and Investment Committee
Chair's Log

Meeting: Finance and Investment Committee	**Date of Meeting** 26th September 2019
Key topics discussed in the meeting	
• Month 5 and YTD financial performance • Forecast outturn for 2019/20 • 5 Year STP planning • Liquidity issues • Guisborough Hospital lease	
Actions agreed in the meeting	**Responsibility / timescale**
• The Committee noted M5 YTD performance was £5.7m behind plan, driven principally by the loss of PSF and the inability to access planned system savings • The full-year forecast indicates a £36.9m deficit with £6.7m of this being due to internal performance, £22m due to failure to deliver system savings and £8.3m from the resulting loss of PSF. A robust recovery plan is required to close as much of the gap as possible which must be balanced against patient care standards • The 5-year plan under development by the ICS was welcomed, but it is important to ensure that our submission is fully socialised within the Trust and signed off by the Senior Leadership Team before final submission • The Guisborough Hospital lease proposal was supported from a financial viewpoint, but it was noted that a clinical review of the proposed service provision was required before a firm recommendation to Board together with clarity on break clauses	Senior Leadership Team October 2019 Director of Finance/Senior Leadership Team October 2019 Director of Estates October 2019
Issues for Board escalation/action	**Responsibility / timescale**
• The urgent need for a credible financial recovery plan which is supported by the full Senior Leadership Team was noted once again • The Guisborough Hospital lease proposal is recognized as time sensitive issue with CCG pressure, but which requires updated clinical review before Board approval	Senior Leadership Team October 2019 Medical Directors October 2019

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 24/09/2019
Connecting to: Board of Directors	**Date of Meeting**: 01/10/2019

Key topics discussed in the meeting	
• Monthly Quality Report • "Deep Dive" Quality Surveillance • Maternity risk mitigation plan • Intentional rounding in the Emergency Department – improving situation • LocSSIPs Update – complete end of September 2019 • Monthly SI Report • Specialist palliative care coding • Annual inpatient survey report – some deterioration • Friarage Hospital Northallerton 'Urgent Temporary Change' Chairs report • Board Assurance Framework – QAC aligned 15+ Risks • Chairs logs from supporting sub-groups • ToR from CQC and CIU oversight groups	
Actions agreed in the meeting	**Responsibility / timescale**
• Assurance received regarding Maternity risk mitigation	• Monitor quarterly at QAC – S.Nag / F. Toller
• "Deep Dive" into Harm Free Care issues (inc. Pressure ulcers)	• G.Hunt / October 2019
• Internal audit of S.I processes	• I. Bennett / October 2019
• Critical care quality "Deep Dive"	• QAC / October 2019
Escalation of issues for action by connecting group	**Responsibility / timescale**
• QAC assured regarding Specialist Palliative care coding – provision and coding	• A.Owens / S.Nag
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Risk Committee
Chair's Log
Date: 10 October 2019

Meeting: Risk Committee	**Date of Meeting**: 10/10/19
Connecting to: Board of Directors	**Date of Meeting**: 5/11/19
Key topics discussed in the meeting	

The meeting received an excellent presentation on the risk management processes and risks from the Urgent and Emergency Care Centre. The Committee took assurance from this that the processes in the centre to manage, report and treat risks was robust.

The quality business partner (QBP) structure has a good focus on risk management and aggregation of risk is being considered by joint working across the QBP group.

This demonstrated the connectivity to Risk Validation Group and the efficacy of the risk management structure from ward to board. The committee decided to have a presentation at each committee meeting from all the centres on a rolling basis.

The committee reviewed and discussed the structure and broad content of the Board Assurance Framework (BAF). The committee noted that the BAF had been significantly strengthened prior to presentation at the recent board meeting. It was noted that the various risk owners and board committees had not yet had chance to review the revised document.

The BAF was reviewed and several observations made about (in particular) risks 4.2, 4.4, 5.1 and the workforce risks to assist further review.

We continue to make good progress and the document continues to evolve. There is still some tidying up to do with completion of some dates and filling the gaps in the control framework for some risks where we are not yet at the required level. It is important that the wording for all risks complies with best practice:

The committee discussed the increase in the volume of risks on the BAF and challenged whether they are indeed all "board level" or whether they should be on risk logs elsewhere in the organisation. Suggestions were made to relegate, remove or consolidate some of the risks to give the BAF more focus.

Given the committee focus on ward to board process and the BAF, the 15+ register was not considered. It was decided that this should be the domain of the Executive Risk Group and the Risk Validation Group and that in future they would be the primary scrutiny of that document with summaries provided to Risk Committee on an exception basis.

The committee considered the organisational risk appetite and discussed a straw man structure. Further work was to be commissioned before a way forward was agreed. The aim is to present a document to Board in due course for discussion.

The committee considered the Emergency Preparedness Resilience and Response (EPPR) report. The current position of "partial compliance" requires further work to improve the position and this work has been planned. The committee approved the document.

A review of the committee performance was undertaken outside the meeting and areas for improvement have been noted.	
Actions agreed in the meeting	**Responsibility / timescale**
Regular presentations by the centre QBPs to be scheduled. BAF- articulate suggestions to relevant Exec/ Committee Chair for review of BAF content. Set up working group to look at risk appetite statement	• Jackie White –next meeting • Jackie White/Gill Hunt/Kevin Oxley – immediate • Jackie White – in advance of next meeting.
Escalation of issues for action by connecting group	**Responsibility / timescale**
None	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	