South Tees Hospitals
NHS Foundation Trust

Board of Directors

3 December 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 3 DECEMBER 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 5 November 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.	Guardian of Safe Working report	Discussion	Guardian	ENC 6
12.	Cancelled Operations	Discussion	Chief Operating Officer	ENC 7
PERFORMANCE AND FINANCE				
13.	Integrated Performance Report	Discussion	Chief Operating Officer	Presentation / ENC 8
STRATEGY AND PLANNING				
14.	Strategic Issues Affecting the Trust and	Information	Chair	Verbal

ITEM		PURPOSE	LEAD	FORMAT
	Wider Health Economy update			
15.	Friarage Hospital Northallerton	Information	Deputy Chief Executive & Medical Director UEC & FHN	Verbal
GOVERNANCE AND ASSURANCE				
16.	CQC update	Information	Director of Nursing & Quality	ENC 9
17.	Board Assurance Framework and Risk Register	Discussion	Head of Governance	ENC 10 and 11
18.	Chair's Logs from Board Committee Meetings • Workforce Committee • Audit Committee • Quality & Assurance Committee	Discussion	Chairs	ENC 12
19.	Any Other Business		Chair	Verbal
20.	Risks to be added to the Board Assurance Framework	Discussion	Chair	Verbal
21.	Reflections on Meeting	Discussion	Chair / All	Verbal
22.	**DATE OF NEXT MEETING** The next meeting of Board of Directors will take place on Tuesday 4 February 2019			
23.	**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)**			

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 December 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 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) – supplier to the Trust.
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 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria Healthcare NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808 School Governor, Ashington Academy
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	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

		March 2019 1 October 2019	ongoing	South Tees Healthcare Management Limited - Company number 10166808
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
Mark Graham	Director of Communications			No interests declared
Johanna Reilly	Chief Operating Officer	2 October 2019	Ongoing	JRR Consultants Limited – Company number 11600734

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 5 NOVEMBER 2019 AT 1:30 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
Ms S Page	Interim 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)
Mr S Mason	Director of Finance

In Attendance

Mrs J White	Head of Governance
Mr M Graham	Director of Communications
Mrs J Dobson	Director of Transformation & Strategic Partnerships
Mr K Oxley	Director of Estates, ICT and Healthcare Records
Ms J Reilly	Chief Operating Officer
Mrs R Metcalf	Director of HR

		Action
BoD/19/73	**PATIENT STORY** The Chairman welcomed Sharon Mitchinson and Lisa Tombling, Specialist Nurses Organ Donation, who presented a story on neonatal organ transplant on behalf of a family who had asked for their story to be shared. Dr Nag expressed his thanks to the nurses and the family who had shared their story and commented that South Tees Hospitals NHS Trust is a national exemplar in organ donation and transplantation, and the staff do a huge amount of work behind the scenes, working with families in very difficult situations. Mrs Hullick asked whether the story had been shared with other units around the country and Ms Mitchinson advised that they had presented the story at an NHS conference. Mrs Rutter once again thanked the nurses and family for sharing the story and drew attention to the exemplary interpersonal skills which specialist nurses demonstrate. The Chairman thanked Ms Mitchinson and Ms Tombling for	

		Action
	attending and asked that they thank the family for having the courage not only to permit donation, but also to share their very personal story.	
BoD/19/74	**WELCOME AND INTRODUCTIONS** The Chairman welcomed members to the meeting and introductions were made to Ms Page, interim CEO, Ms Reilly, interim Chief Operating Officer, and Mr Graham, interim Director of Communications. The Chairman thanked Mrs Edwards, Director of Communications, who was leaving the Trust for her support to the Trust and wished her well.	
BoD/19/75	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Professor A Owens, Medical Director.	
BoD/19/76	**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/19/77	**DECLARATION OF INTEREST** The Chairman referred members to the register of interest and asked members if there were any further declarations to be made not already included. There were no further declarations made.	
BoD/19/78	**MINUTES OF THE LAST MEETING** The minutes of the meeting held on 3 September 2019 were reviewed and agreed for accuracy subject to the following change: Page 3, BoD/19/53, Declaration of Interest, amend Northumberland to Northumbria	Head of Governance
BoD/19/79	**MATTERS ARISING** The matters arising were reviewed and the action log updated.	
BoD/19/80	**CHAIR'S REPORT** The Chairman advised that he had no further update to add which was not already covered by the agenda.	
BoD/19/81	**CHIEF EXECUTIVE'S REPORT** Ms Page said that she welcomed the opportunity to work for South Tees Hospitals NHS Foundation Trust and felt it was a great privilege to wear the Chief Executive badge. She	

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	commented that she had spent the last couple of weeks as part of her induction meeting with members of staff in all parts of the Trust and was very impressed with how they work together and look after each other in difficult times: she felt honoured to be listening to their stories. Ms Page said it was apparent from her discussions that staff have not previously been involved in key decisions and that she had taken the opportunity to bring together a new Medical Policy Group makde up of senior clinical staff, plus representatives of staff side, medical staff and other professionals, to review and take decisions on the day-to-day running of the hospital. Ms Page commented that she had also had the opportunity to visit Trust sites other than James Cook, Trust including the clinical teams working in the community hospitals and out of hospital teams: they are providing a fantastic service and need to be involved in decisions if the Trust is to 'get back to its best'. Finally, Ms Page said that she had recently had the opportunity to show Simon Stevens, Chief Executive of the NHS, around the Friarage Hospital, visiting the whole Emergency Care Pathway through the hospital and the theatres. Ms Page wished to thank staff for a very successful visit.	
BoD/19/82	**HEALTHCARE ASSOCIATED INFECTION MONTHLY REPORT** Mrs Hunt referred members to her previously circulated report, and members noted that 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. Mrs Hunt confirmed that there were 6 COHA + HOHA cases in September 2019. There have been 50 COHA + HOHA cases in the first 6 months of 2019/20. The Trust is currently over trajectory. There were no trust-assigned MRSA cases in September 2019. There have been no trust-assigned cases in the first 6 months of 2019/20. There were 4 MSSA 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. There have been 5 confirmed cases, 6 probable cases and 12 excluded cases.	

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	Mrs Rutter commented that it was disappointing to note the Serratia infection and asked for further information on the actions to address the outbreak. Mrs Hunt confirmed that the infection was unrelated to the initial Serratia outbreak and an action plan had been put in place. Mrs Hullick asked whether the Trust was seeing environmental issues causing infection outbreaks and asked what Dr Bellamy, lead for Infection Prevention and Control would advise. Mrs Hunt advised that Dr Bellamy would identify antibiotic usage and cleaning as measures to explore further. Mrs Hunt indicated that Dr Bellamy has been asked to attend the Quality Assurance Committee to discuss this further. Dr Nag commented that the Trust has changed the antibiotic guidelines, has not seen any evidence of connectivity with the infection outbreaks. However, that this should be looked at again. Mrs Hunt advised that the Trust had commissioned an external review which was due to be held on 12 and 13 November 2019. Ms Reape commented that the neonatal infection and hand hygiene assessment scores were also disappointing. She asked whether staff fully understand proper hand washing. Mrs Hunt confirmed that there is a practical hand hygiene session held annually and that it is a fundamental standard of care and staff should be challenging and escalating if this isn't done properly. Mr Heslop advised that the online training for infection control hasn't changed, and perhaps the focus needs to be on behavioural changes going forward. Mrs Hunt agreed to look into the training. **Resolution** **The Board of Directors NOTED the Healthcare Associated Infection Monthly Report**	
BoD/19/83	**<u>SAFE STAFFING MONTHLY REPORT</u>** Mrs Hunt informed members that 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% Mrs Hunt commented that she had undertaken a review of	

		Action
	staffing levels on a number of areas within the Trust including ED, Theatres, Children and Adult Inpatient areas. The reports were discussed at the Workforce Committee and it was agreed to undertake a deep dive into the methodology and results to provide further assurance to the Board. Mrs Hunt informed members that the next report will include fill rates for therapies and future reports will include medical staffing. Mr Ducker thanked Mrs Hunt for her update and asked whether in future the executive summary could include the hotspots and wards / areas which Mrs Hunt was worried about, why and what the mitigation was. Mrs Hunt confirmed that she would include this in future reports. Mr Ducker asked Mrs Hunt if she had a 3-5 year workforce plan which looked at required fill rates, skill mix and requirements, Mrs Hunt confirmed that there was a plan in place but the challenge was supply, and international recruitment was required for the next couple of years. Ms Reape asked for the next report to include information on how the Trust will support the winter period and whether there will be sufficient registered nurses. Dr Nag commented that the HCA fill rate was better than RCN, and asked whether skill mixing relieved the pressure, Mrs Hunt advised that the night fill rate is higher to compensate for RN gaps and that the Trust is looking at other support roles that could and should be included. Mrs Rutter congratulated Mrs Hunt on the 80 newly qualified nurses, but recognised that this would put pressure on the Trust and asked how the new recruits were being supported. Mrs Hunt advised that there is a yearlong preceptorship programme, and staff are supernumerary for 2 weeks with longer for specialist areas. In addition, the Educator role is really important and is getting good feedback. Ms Page asked Mrs Hunt when community nursing would be included in the report. Mrs Hunt confirmed that the Trust is piloting a tool which will give the Trust more data on community nursing and she will look to include this in future reports when available. **Resolution** **The Board of Directors NOTED the Safer Staffing Monthly report.**	

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BoD/19/84	**QUALITY, SAFETY, PERFORMANCE AND FINANCE EXCEPTION REPORT** Mr Clements introduced the Quality, Safety Performance and Finance Exception Report. Members noted that in September the Trust achieved 89.07% on the A&E target – and this was not showing an improvement into October. Members noted that there had been a 12% increase in attendances, around 25-58 patients a day, and in the last 5 weeks an extra 22 patients on average. Mrs Rutter asked Mr Clements what actions the Trust needs to take to improve performance, and Mr Clements advised that there needs to be a length of stay reduction across the site and further work on delayed transfers of care (DTOCs). Mrs Dobson said that the Trust has done some work on Model Hospital and on the SAFER initiative, but the models are not embedded across the Trust. Mrs Dobson confirmed that the Trust is embarking on a "where best" programme in December. Mrs Burns asked what was happening across the patch to ensure the flow of patients into the Trust and how effective the ICS plans are. Mr Clements confirmed that conversations have been taking place for a long time and the Trust is continuing to explore ways of ensuring that patients are treated in the most appropriate setting. Mrs Hullick asked what conversations the Trust is having with local authority colleagues about the Christmas break and Mrs Dobson confirmed that conversations are taking place. In addition, through the A& E delivery board the Trust are facilitating conversations around discharge to care homes. Further work is required to progress this. Ms Page commented that there are many routes for sick patients in to the Trust, but at the same time the Trust has patients waiting for operations and the Clinical Directors need to work together to make this flow better. Mrs Dobson confirmed that RTT performance is still deteriorating and is at 83.4%. Members noted that some areas have made an improvement, but spinal, orthopaedics and ophthalmology have had increasing demand. Discussions have been held with the CCG to look at how to manage the demand around ophthalmology and gastroenterology which may mean the Trust closes off some of the lists. Members noted that the Trust has commissioned some additional management support in orthopaedics and would hope to see some improvement going forward but there will be significant challenges over winter. With regard to Cancer, Mrs Dobson advised that there had	

		Action
	been some initial improvements between June and August but performance had dropped off in September to 77.6%. She confirmed that head and neck were struggling with sickness and to meet demand. The 6-week diagnostic for September was 94.44% with issues around endoscopy. Mrs Hunt advised that pressure ulcers in community are on a downward trajectory and static in acute inpatient areas. With regard to falls, there was a small peak in August, but the falls rate is down to 4 per 1,000 bed days, norm around 6.3. With regard to Serious Incidents, Mrs Hunt advised that there were 3 in September, 1 related to treatment delay and 2 related to safeguarding. Members noted there had been a 16% increase in the number of incidents reported and work will focus on getting feedback to staff following reporting of an incident. Finally, with regard to patient experience, Friends and Family text messaging has been introduced in A&E which had seen an increased response and the Trust was in the top performing Trusts for the A&E national patient survey. Mrs Rutter asked Mrs Hunt whether the Trust was measuring the right things with regard to patient experience and suggested there should be a focus on issues such as access, waiting times, cancellations and communication, given the themes the Trust has seen in complaints and risk. The Chairman noted that the Governors have raised similar issues on many occasions: the concerns are focused on patients' experience leading up to treatment – their interaction with the Trust's administrative and operational systems and processes. Mrs Rutter suggested that patients' comments on these issues should be added to the indicators. Mrs Metcalf introduced the People indicators and advised members that there had been an increase in sickness absence which was at 4.41%, split equally between long term and short term sickness. Mandatory training was at 86.7% against a target of 90%. Appraisal completion was at 81.62% against a target of 80%. Ms Reape asked about the support to staff in relation to sickness and asked if this was described in the Health and Wellbeing Strategy. Mrs Metcalf confirmed that the Trust is ready to launch the strategy which had been approved at the Workforce Committee the previous day. Mrs Metcalf confirmed that the strategy did cover support to staff and that resources were available.	

		Action
	Finally Mr Mason referred members to the Finance section and advised that the Trust is currently behind plan by £7.6m, largely driven by the inability to achieve the system savings target and loss of provider support funding . Members noted that the Trust is in discussion with NHSE/I regarding the year end position, which was £37m behind including £4m exceptional costs relating to the PFI life cycle costs. Mr Mason confirmed that the Trust must not see any further deterioration and that the focus should continue on reducing the shortfall. Mr Mason confirmed that the Trust had managed to secure some short term borrowing which allows the Trust to pay service suppliers and that the Trust had received approval from the regional team for capital emergency spend and was awaiting approval at national level. **Resolution** **The Board of Directors NOTED the Quality, Safety, Performance Finance Exception report**	
	QUESTIONS FROM THE PUBLIC The Chairman offered the opportunity for members of the public and those in attendance to raise a question to the Board. Mr Blood, member of the public, pointed out that non pay costs were increasing and now £7m adrift, but that there was no explanation in the finance report on what is causing this issue. Mr Mason stated the adverse variance related to the on-going work to identify and implement a programme of system related savings. This programme of work was ongoing but had become fragmented. Mr Kane, Chair of the Senior Medical Staff Forum, expressed concern about the incidences of C.diff and asked what the Trust was doing about it. Mrs Hunt confirmed that she had asked Dr Bellamy to come to the Quality Assurance Committee to provide further assurance on the measures that were being put in place. Roaqah Shaher, Staff Side Chair, asked whether the issue with fill rates related to the pay rate for nights and Mrs Hunt advised that there are fewer nurses at night and there is less interest for shifts on nights and weekends. Ms Shaher asked whether the Trust had considered increasing pay rates during the day to see if this helped with filling shifts, and Mrs Hunt advised that the Trust has periodically increased the pay rates for hot spot areas. However, we are in a bank arrangement with North Tees NHS Trust, so need to have a	

		Action
	joint discussion if the situation changes.	
BoD/19/85	**5 YEAR STP PLANNING** Mr Mason referred members to the 5 year STP planning report. Members noted that 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. Mr Mason advised that due to ICS coordination and reconciliation, the submission timetable is extremely challenging and does not always allow time for full clinical engagement and detailed bottom up analysis. Mr Mason confirmed that the plan had been developed jointly with colleagues in HR, so that the information is linked together with activity and finance. Mr Ducker commented that the plan yields something which is realistic, and is a chance for a proper dialogue for a 5 year plan. However, he was concerned about the process itself and whether it will get to the right outcome for the organisation. He recognised that this is all connected with discussions across the Tees Valley. **Resolution** **The Board of Directors NOTED the 5 year STP planning report**	
BoD/19/86	**ELECTRONIC PATIENT RECORD UPDATE** Mr Oxley introduced Mr Adair, Chief Clinical Information Officer, and Mr Ian Willis, Head of Digital, who updated members on the Electronic Patient Record (EPR) programme. Members noted that since the Board approved the business case for the Cerner EPR programme in December 2018, the Trust has worked to obtain NHS England/Improvement (NHSE/I) approval. NHSE/I have indicated that they will not approve the business case until the Integrated Care System (ICS) has given its approval and until a source of funding is identified. This paper discusses the impact and further risk of delaying or postponing the programme. Mr Oxley advised that, 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 important that investment is made in an EPR and the supporting infrastructure to prevent it from falling further behind and putting patients at risk. Whether or not it invests now in an EPR, it will still have to invest in replacing most of its core patient systems over the next 3 – 4 years. In	

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	December 2018 the Board endorsed procurement of the Cerner solution in partnership with County Durham and Darlington NHS Foundation Trust. The Trust may be exposed to risks, including risks to patient safety and the quality of services, as a result of the further delay. The Chairman thanked Mr Adair and Mr Oxley for the update. He said that the Board shared their frustration. Mrs Burns asked what was required to unblock the decision and whether the delay was the result of a view that both North and South Tees should implement the same system. Mr Adair advised that, although it would be ideal to have a single system across all three Tees valley trusts, it was more important to implement the right system, as different systems could still 'talk' to each other. Extensive and in-depth work had been undertaken, with a conclusion that Cerner was the best system for South Tees and County Durham and Darlington. Mrs Hullick commented that the provider of TrakCare, the system used by North Tees, had declined to bid for the contract. Mr Heslop drew attention to the patient safety risks which were well documented in the paper. He commented that the Trust should not underplay the cyber security risks associated with failure to replace the current antiquated systems. Mr Mason advised that the Trust has been working with the ICS and NHSE/I, and there is a further meeting in November, He said that the issue is complicated and linked to strategy in the wider region, and the Trust needs to explore further the North Tees solution. Mrs Rutter commented that she shared the frustration and concerns regarding clinical risk and asked what the Board could do to unblock the barriers. The Chairman referred members to the recommendations in the paper. He confirmed that members had take note of the increased risk to the organisation of delaying or postponing the EPR implementation and the impact this would have on patient care. He also confirmed that the Board was committed to obtaining approval. He suggested that a possible way out of the current impasse – would be to commission an independent expert to evaluate the work done so far and to make a recommendation on the implementation of a preferred EPR system for South tees.	

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	Finally, the Chairman indicated that the CEO and he would have further discussions with regional colleagues. **Resolution** **The Board of Directors NOTED the EPR update**	
BoD19/87	**EPPR CORE STANDARDS REPORT** Mr Oxley introduced the EPPR core standards report and advised members that the Trust had undertaken a self-assessment against the NHS England EPRR Core Standards and identified that 14 of the 64 standards were amber (not compliant but evidence of progress and in the EPRR work plan for the next 12 months) and therefore the Trust has declared **partial compliance** in line with the national reporting levels. An action plan is in place to address the outstanding issues and progress will be monitored through the Trust Resilience Forum (TRF). **Resolution** **The Board of Directors APPROVED the EPPR Core Standards Report**	
BoD/19/88	**CANCELLED OPERATIONS REPORT** Ms Reilly, Chief Operating Officer, presented members with a report on cancelled operations which have occurred across the Trust between April and September 2019. The report provided detailed analysis from a patient safety and quality perspective and also considered the impact on performance. Members noted that 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 critical care capacity since the ring fencing of 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. Mrs Rutter said it was good to receive the report and to acknowledge that the ITU staffing issue raised by the CQC may have brought this to the surface. This was, however, a wider issue. Mrs Rutter noted the positive impact of the opening of the Post Anaesthetic Care Unit. Mrs Rutter, however, raised concern that the report did not give consideration to those patients in beds in other trusts who are waiting for tertiary services and the number of times they get cancelled or delayed.	

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	Mr Chadwick commented that a lot of issues are administrative and that the Trust would benefit from a single point of access / central coordinated booking process. Mrs Dobson agreed that a single point of access would have significant benefits as the Trust currently has a number of different processes in place. Mr Carter-Ferris asked Mr Chadwick what the total throughput was for the Trust, and Dr Chadwick advised that the data shows a DNA (Did Not Attend) rate of 1-2% and an overall cancellation rate of 5-6 %. Ms Reilly suggested that a wider discussion and more detailed plan on the issues raised were required. The Chairman confirmed that members had noted the content of paper and acknowledged that harm might come to light in due course: clearly this is a serious issue for the Trust. The Chairman asked for regular reports on this issue and for the Quality Assurance Committee to undertake a 'deep dive' into the issue. **Resolution** **The Board of Directors NOTED the report on cancelled operations**	
BoD/19/89	**STRATEGIC ISSUES AFFECTING THE TRUST AND WIDER HEALTH ECONOMY UPDATE** The Chairman indicated that discussions continue across the Tees valley about more effective joint working, with particular focus on North Tees and South Tees working more closely together. The Chairman reiterated that the Board and Trust were signed up to whatever changes are required – including a merger of trusts – to make joined-up working a reality. **Resolution** **The Board of Directors NOTED the update on strategic issues**	
BoD/19/90	**FRIARAGE HOSPITAL NORTHALLERTON** Mr Clements confirmed that the temporary model of care continues to be successful with no significant patient safety issues. Members noted that it is week 8 of the consultation process, with 1,151 responses, 5 public meetings and staff meetings. The meeting with hard to reach groups had been successful. Mr Clements advised that the Trust is waiting for further advice regarding the impact of the general on the consultation process. There will be two additional events January 2020. **Resolution**	

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	The Board of Directors NOTED the update on the Friarage	
BoD/19/91	**CANCER STRATEGY** The Chairman welcomed Ms Taylor, who presented the Cancer Strategy. Members noted that the strategy is set within the parameters of the NHS Long Term Plan and regional and local aspirations. It provides a direction of travel for the Trust and recognises the importance of working together in partnership with partners. Ms Taylor said that 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. Mrs Burns thanked Ms Taylor for attending and for a good document. Mrs Burns commented on the significant demographic challenges and asked Ms Taylor how robust and effective she felt the current investment and programmes were. Ms Taylor advised that there had been some successes, such as cervical cancer screening with Middlesbrough Council; and we should start to see improvements in the treatment of colorectal and bowel cancer. Mrs Rutter congratulated Ms Taylor for a long awaited Strategy. She commented that the strategy could have been more aspirational, but that it was more important in the current climate that it was realistic. She suggested that more emphasis could have been placed on workforce and enabling services such as pathology, etc. Mr Heslop concurred and commented that he was delighted to have received the strategy. He added that, when the Trust has discussed failure to meet cancer targets in the past, the issues relate to GPs, other providers and the Trust. He asked what the Trust is doing to engage others in this area. Ms Taylor advised that the Trust is doing lots with CCGs to develop the pathways and build on relationships to improve targets and outcomes for patients. Mrs Dobson advised members that Ms Taylor generates significant income for the Trust and that she had been instrumental in the opening of the pet shed. Mrs Rutter asked that the Trust Board thanks be given to the Northern Cancer Alliance and Macmillan for their contribution to the Strategy. **Resolution**	

		Action
	The Trust Board APPROVED the Cancer Strategy	
BoD/19/92	**EU EXIT UPDATE** Mr Oxley presented an update to the Board on the Trust's preparedness for the EU exit. Members noted that the Trust has an assurance framework which 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. Mr Oxley advised that as the UK did not leave the EU as scheduled on 31st October 2019, the Trust will continue to assess its preparedness. **Resolution** **The Board of Directors NOTED the update on the EU preparedness arrangements**	
BoD/19/93	**FLU CAMPAIGN** Mrs Metcalf updated members regarding the national flu campaign and stressed the importance of healthcare workers getting vaccinated against 'flu. Members noted that the Trust along with all NHS organisations received information on how they should plan to ensure every staff member is offered the vaccine. Mrs Metcalf advised that there is an ambition of 100 per cent of healthcare workers with direct patient contact to be vaccinated, and there is also a Trust CQUIN target of 80%. Members were advised that the Trust has launched its flu campaign which 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 the Trust will need to vaccinate 6,122 to achieve the required minimum uptake. The Trust has 130 flu champions covering all areas. Finally members noted that at week 4 of the campaign, 51.1% of staff had been vaccinated. Mrs Hullick asked Mrs Metcalf about the redeployment of front line staff who are not vaccinated. Mrs Metcalf advised that this year there is no requirement to redeploy staff who do not have the vaccine.	

		Action
	Resolution **The Board of Directors NOTED the update on the flu campaign and gave assurance that as a Board they had all received their vaccine**	
BoD/19/94	**STAFF SURVEY RESULTS** Mrs Metcalfe referred members to her previously circulated report, and members noted that the Trust undertook an additional staff survey in August 2019 following a poor response rate to the national staff survey (413 responses). The Summer staff survey was distributed to 8,258 members of staff and the Trust received a response rate of 32% (2,666 responses). Of the 9 key lines of enquiry, there was deterioration in 7 of the key areas. Members noted that, of the 51 questions, 32 deteriorated, 19 had a slight improvement and 9 areas improved. The Chairman asked what the Trust was doing about the issues highlighted and Mrs Metcalf advised that the reason for doing the survey was to establish a baseline that the Trust had some confidence in, and now that the Trust had this information it could start to address the issues. A "you said we did" approach will start shortly. Ms Page stressed the importance of Board members reading the verbatim comments comparing these with the previous survey. Ms Reape commented that there was quite a lot of activity over the summer on staff engagement, including the formation of a focus group. She asked Mrs Metcalf where this had got to. Mrs Metcalf advised that a report of the outcome of the summer discussions and the issues which needed immediate action are going to the next staff engagement group who will develop a joint plan with Staff Side on addressing the issues. Mrs Rutter commented that it is important that the right values and behaviours are modelled by everyone, including Board members. **Resolution** **The Board of Directors NOTED the staff survey and looked forward to regular updates on progress**	

		Action
BoD/19/95	**CQC UPDATE** Mrs Hunt introduced the CQC update and members noted that the 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. Mr Heslop asked Mrs Hunt how the Trust will track progress, and Mrs Hullick commented that the Audit Committee has asked for evidence of achievement and evidence that actions remain green. Mr Clements commented that the Trust needs to look at all key lines of enquiry and do a gap analysis of the status of all services. Mrs Hunt confirmed that a list of key issues across all service areas has been pulled together and shared with members of the Oversight group. This will allow service areas to check to see if the action is relevant to them and what assurance they can provide. **Resolution** **The Board of Directors NOTED the update on the CQC action plan**	
BoD/19/96	**USE OF THE SEAL** Mrs White referred members to her previously circulated report and advised that in line with the Trust's Constitution the report provided information on the documents affixed under seal between 1 August 2018 and 30 September 2019 **Resolution** **The Board of Directors NOTED the use of the seal**	
BoD/19/97	**CHAIRS LOG FROM BOARD COMMITTEE MEETINGS** The Chair offered Chairs of Committees the opportunity to add further information from the Chairs' logs not already covered under the agenda. Mrs Rutter confirmed that the Quality Assurance Committee had received an update on harm free care which was low in comparison to other trusts and further work had been requested to understand the issues. Mr Heslop advised that the Risk Committee needed to do some further work on the Risk Strategy and the risk groups and escalation in the Trust.	

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		Action
BoD/19/98	**ANY OTHER BUSINESS** There was no further business identified.	
BoD/19/99	**RISKS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK** The Chairman requested that the EPR risk on the BAF was reviewed to ensure it accurately reflected the discussion and risks identified.	
BoD/19/100	**REFLECTIONS ON MEETING** The Chairman reflected on the meeting and said that he felt that the time had been pressured at some points during the meeting and will look at agendas going forward He felt that the new room lay-out offered more interaction and engagement with members of the public. Mr Blood commented that he was encouraged and optimistic on what the new CEO had said and commended her style of leadership.	
BoD/19/101	**DATE AND TIME OF NEXT MEETING** The next meeting of the Public Board of Directors will take place on 3 December 2019.	

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		complete
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
5.11.19	BoD/19/82	HEALTHCARE ASSOCIATED INFECTION MONTHLY REPORT	Mr Heslop advised that the online training for infection control hasn't changed, and perhaps the focus needs to be on behavioural changes going forward. Mrs Hunt agreed to look into the training.	G Hunt	31.3.20		open
5.11.19	BoD/19/83	SAFE STAFFING MONTHLY REPORT	The reports were discussed at the Workforce Committee and it was agreed to undertake a deep dive into the methodology and results to provide further assurance to the Board.	G Hunt	4.2.20		open

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MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 3 December 2019			
Healthcare-associated infection (HCAI) report for October 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 October 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	The Board of Directors 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,* bacteraemia due to three Gram negative bacteria *(Escherichia coli* (*E. coli*), *Klebsiella* species. and *Pseudomonas aeruginosa)*, 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 a combined total of 81 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 12 COHA + HOHA cases in October 2019. There have been 62 COHA + HOHA cases in the first 7 months of 2019/20. We are currently over trajectory.

- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There was 1 trust-assigned case in October 2019 which is the only trust-assigned case in the first 7 months of 2019/20.

- There is no official MSSA bacteraemia target for 2019/20. There was 1 trust-apportioned case in October 2019. There have been 25 trust-apportioned cases in the first 7 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 (6th November 2019) there have been 5 confirmed cases, 8 probable cases and 16 excluded cases.

2. Recommendation

The Board of Directors is 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

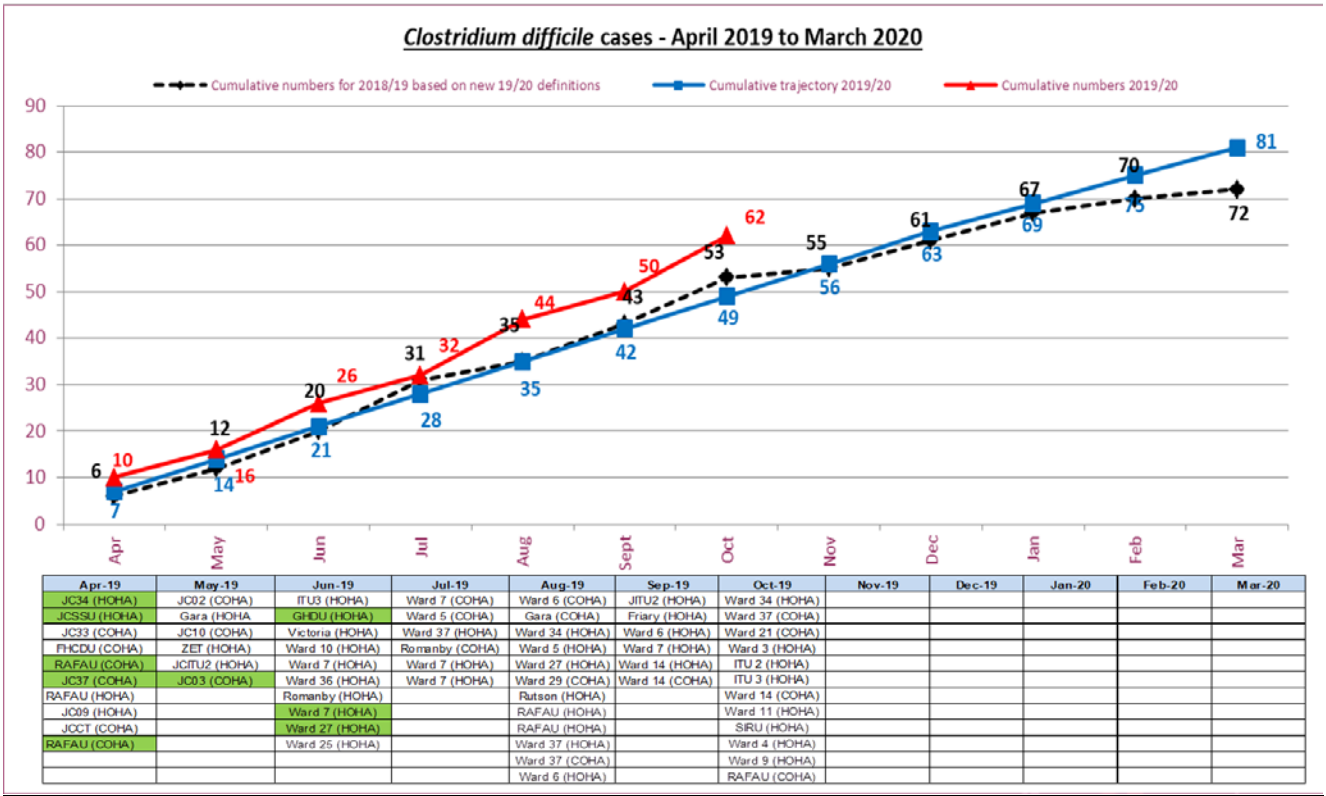
C diff	Total 2018/19	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Sep 19	Oct 19	Total 2018/19 to date	Target for 2018/19
Total cases	120	9	8	11	5	6	18	7	14	14	19	10	23	105	NA
Not trust apportioned	79	9	5	7	3	5	8	1	4	8	7	4	11	43	NA
Trust-apportioned	41	0	3	4	2	1	10(4)	6(3)	10(10)	6(3)	12(8)	6(5)	12(8)	62(41)	**81**
- JCUH	33	0	3	4	1	1	10	4	8	4	10	5	11	52	
-FHN	3	0	0	0	0	0	0	1	1	2	1	0	1	6	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	2	0	0	0	0	0	0	1	0	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	1	0	0	1	
-Friary	2	0	0	0	1	0	0	0	1	0	0	1	0	2	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Table 2 (numbers in brackets denote HOHA cases)

There were 23 cases of *C. difficile* infection in October 2019, 4 of which was classed as COHA and 8 were classed as HOHA, totalling 12 classed as trust-apportioned according to the new definition (table 2). The 2019/20 annual objective is to have no more than 81 COHA + HOHA cases. In the first 7 months of 2019/20 there have been 62 trust-apportioned cases (COHA = 21; HOHA = 41). 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 September 2019, 5 patients died during this period. Since April 2009, 309/1718 patients (18%) have died during the 30 day follow-up period.

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)	Ward 34 (HOHA)					
JCSSU (HOHA)	Gara (HOHA	GHDU (HOHA)	Ward 5 (COHA)	Gara (COHA)	Friary (HOHA)	Ward 37 (COHA)					
JC33 (COHA)	JC10 (COHA)	Victoria (HOHA)	Ward 37 (HOHA)	Ward 34 (HOHA)	Ward 6 (HOHA)	Ward 21 (COHA)					
FHCDU (COHA)	ZET (HOHA)	Ward 10 (HOHA)	Romanby (COHA)	Ward 5 (HOHA)	Ward 7 (HOHA)	Ward 3 (HOHA)					
RAFAU (COHA)	JCITU2 (HOHA)	Ward 7 (HOHA)	Ward 7 (HOHA)	Ward 27 (HOHA)	Ward 14 (HOHA)	ITU 2 (HOHA)					
JC37 (COHA)	JC03 (COHA)	Ward 36 (HOHA)	Ward 7 (HOHA)	Ward 29 (COHA)	Ward 14 (COHA)	ITU 3 (HOHA)					
RAFAU (HOHA)		Romanby (HOHA)		Rutson (HOHA)		Ward 14 (COHA)					
JC09 (HOHA)		Ward 7 (HOHA)		RAFAU (HOHA)		Ward 11 (HOHA)					
JCCT (COHA)		Ward 27 (HOHA)		RAFAU (HOHA)		SIRU (HOHA)					
RAFAU (COHA)		Ward 25 (HOHA)		Ward 37 (HOHA)		Ward 4 (HOHA)					
				Ward 37 (COHA)		Ward 9 (HOHA)					
				Ward 6 (HOHA)		RAFAU (COHA)					

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 October 2019 was 92.15% and the peer review average was 93.16%.

1.2 MRSA bacteraemia

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

Table 3

There were 2 cases of MRSA bacteraemia in October 2019 (table 3); 1 of which is classed as trust-assigned. The causes of the bacteraemias were an infected pressure ulcer (acquired out of hospital) and an infected peripheral cannula site. Lessons learnt for the trust-assigned peripheral cannula case are:

1. Our VIP charts are not consistent with HIC policy 36 with regards to when a cannula tip should be sent for culture. The chart will be revised by the IPC team to match the policy.
2. The VIP score was changed but it is not clear when. If the score was recorded correctly when the line was removed the tip should have been sent for culture according to the chart.
3. The site of insertion was not indicated on the VIP chart.
4. The patient probably acquired MRSA during the current admission, although the source of this is not clear.

In the first 7 months of 2019/20 this is the only trust-assigned case. A further key action has been a dedicated clinical assurance round assessing cannulas and VIP charts in November 2019.

1.3 MSSA bacteraemia

There were 13 cases of MSSA bacteraemia in October 2019; 2 of which were classed as trust-apportioned (table 4). In the first 7 months of 2019/20 there have been 25 trust-apportioned MSSA bacteraemia cases.

MSSA	Total 2018/19	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Total 2019/20 to date	Target for 2019/20
Total cases	134	8	12	10	8	11	12	12	17	18	17	15	13	104	NA
Not trust apportioned	92	6	8	7	5	7	9	11	12	14	11	11	11	79	NA
Trust apportioned	42	2	4	3	3	4	3	1	5	4	6	4	2	25	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 as we have 26 cases after 7 months. 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. A train the trainer approach has been adopted, with 78% of those identified trained to date with a trajectory of 90% by the end of quarter 3.

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

	Total for 18/19	**October 2019**	**Total for 19/20**
Bacteraemia due to glycopeptide-resistant enterococci	10	1	5
Bacteraemia due to E. coli	550	43	291
• Trust-apportioned	128	5	56

• Not trust-apportioned	422	38	235
ESBL producing coliform infections	953	76	462
• sample taken in community	599	48	285
• sample taken in our trust	354	28	177
• bacteraemias	28	2	15
Bacteraemia due to Klebsiella species	134	12	74
• Trust-apportioned	37	3	19
• Not trust-apportioned	97	9	55
Bacteraemia due to Pseudomonas aeruginosa	37	3	31
• Trust-apportioned	12	3	6
• Not trust-apportioned	25	0	25
Other alert organisms	1	1	1
• invasive group A streptococcus			

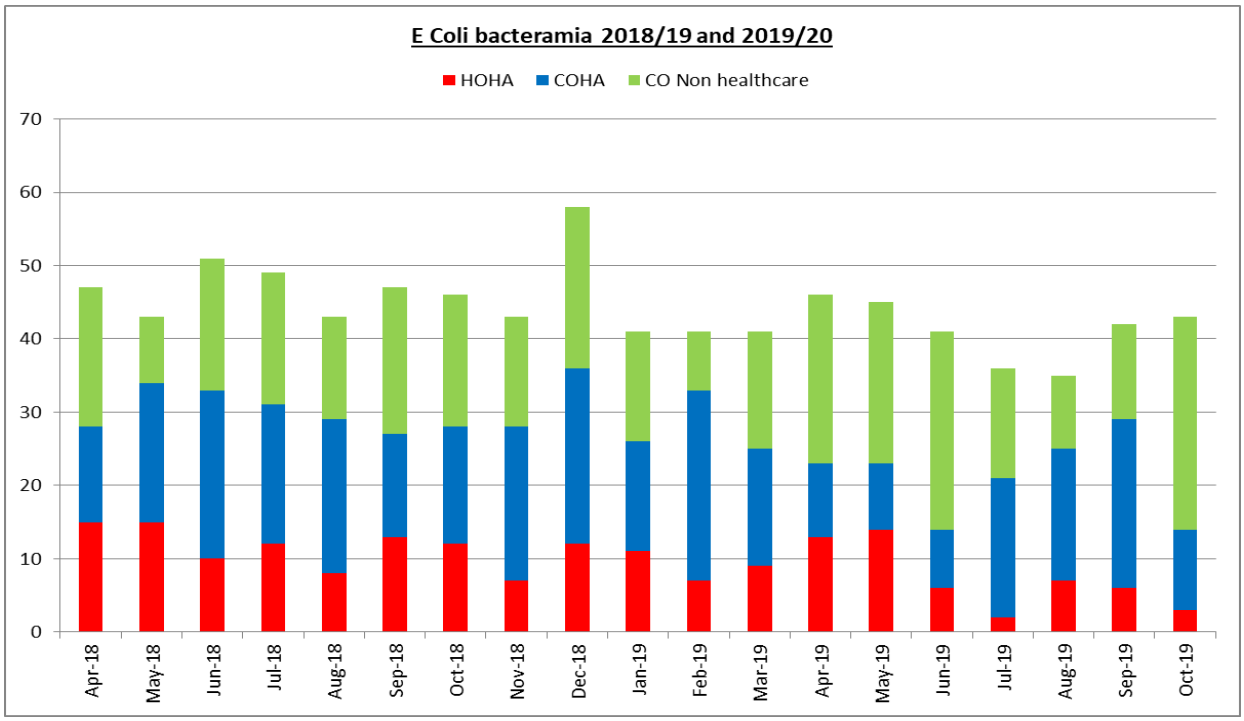
Table 5

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 October 2019, the trust reported a total of 58 cases of three GNBSI organisms which are part of national surveillance (*E. coli, 43; Klebsiella sp. 12; Pseudomonas aeruginosa* 3). Of these, 11 cases were classed as trust-apportioned as defined by the Department of Health definition. In the first 10 months of 2019/2020 there have been a total of 396 cases of the three GNBSI cases (*E.coli,* 291*; Klebsiella sp.* 74*; Pseudomonas aeruginosa* 31) and of these 81 are classed as trust-apportioned 20%). 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 month is being performed to ascertain patient-related contributory themes in the challenge to identify causes of *E. Coli* infections.

The trust's GNBSI annual plan is on track with initiatives and reduction strategies to reduce rates of GNBSIs including promotion of hydration, central venous catheter care and training and education for staff.

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, such as identifying inpatients being treated for lower urinary tract infections and working with the colorectal surgeons to amend their antibiotic prophylaxis regimen.

The Medical Director lead for antimicrobial prescribing is undertaking a review of stewardship programme with the lead antibiotic pharmacist, in view of the increase in *Clostridium difficile* infections.

Environmental Cleaning

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

The James Cook Site:

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

Table 6

Cleaning scores have been maintained on the JCUH site (table 6). No areas failed C4C inspection in October 2019 on the James Cook site. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. Concerns from clinical staff about the standard of cleaning versus the cleaning scores have been raised with Serco colleagues and escalated to IPAG and actions put in place where required. For example, the frequency of cleaning standards review meetings have been

increased from monthly to weekly and continue to be led by the Director of Estates with cleaning scores 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%**	97.91%	100%		99.8%
High Risk	**95%**			96%	95%
Significant Risk	**85%**	97.42%		96%	85%
Low Risk	**75%**	97.83%		95%	75%

Table 7

The slight deterioration of scores at the FHN was due to high dust in one area and immediate remedial action was taken.

2. OUTBREAKS OF DIARRHOEA AND VOMITING

Diarrhoea & vomiting outbreaks	Annual total 18/19	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Total 1920 to date
Total number	*1*	0	0	0	1	0	0	0	0	0	0	0	1	1
Total number of patients affected	*1*	0	0	0	1	0	0	0	0	0	0	0	6	9
Total number of staff affected	*12*	0	0	0	12	0	0	0	0	0	0	0	3	3

Table 8

There was an outbreak of Norovirus between 19th October 2019 and 28th October 2019, affecting Victoria Ward at Friary Hospital (table 8). In total this affected 6 patients and 3 staff members. The ward was closed to admissions for 7 days, an outbreak meeting was not required.

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

During October 2019, we have identified no further patients who have the *GES-carbapenemase-producing Pseudomonas aeruginosa* infection.

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

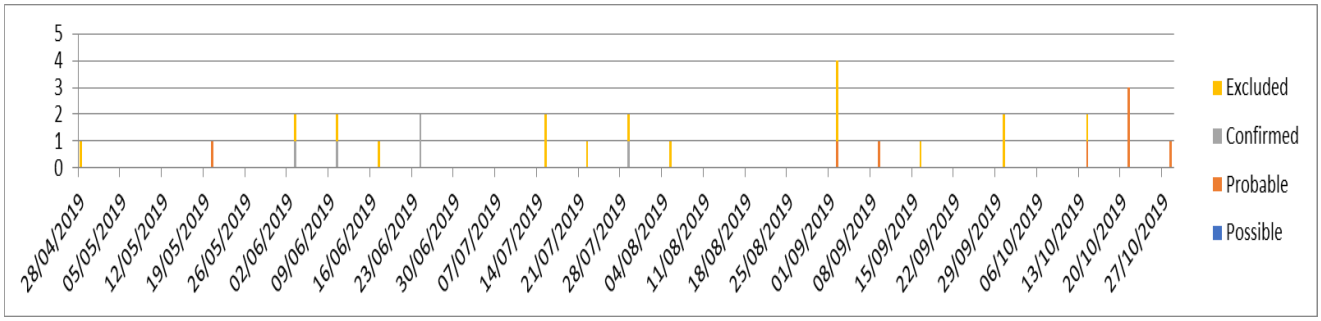
Acute trusts across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last year. In October

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 6th November 2019) we have had a total of 5 patients who are confirmed as affected by the outbreak strain, 8 cases classed as 'probable' unless proven otherwise (awaiting strain typing) and 16 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. In addition we have identified 4 patients who had been treated in Cardiothoracic ICU and/or HDU who have been infected or colonised with the same strain of *Stenotrophomonas maltophilia.* Investigations are ongoing to determine whether this cluster is also related to an environmental source.

The Cardiothoracic ICU, HDU and ward 32 have undergone a deep clean and hydrogen peroxide vapour clean and replacement of the contaminated sink. Outbreak meetings are ongoing and a detailed action plan is in place addressing potential influencing variables relating to clinical practice and the environment. The 'Dangers in Damp' awareness campaign commenced in September 2019. The outbreak status remains 'open' until assurance is provided from triangulation of clinical case data and repeat environmental swabs being taken through November 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.

When isolation becomes challenging critical care staff work with IPC staff to ensure all risk reduction strategies are put in place. This includes appropriate use of aprons, gloves, gowns and other personal protective equipment, with the visual prompt of the PPE trolley displaying a 'STOP' sign alerting staff who need to enter the bed space. Strict hand hygiene, equipment decontamination and any condition-specific devices (e.g. faecal collector) are put in place.

In October 13 patients across the critical care footprint (including specialist areas) were not isolated in a side room, all mitigating actions were implemented.

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

- In October 2019, we had 2 cases of HOHA *C. difficile* infection on Critical Care.

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

- In October 2019, we found that a third neurological HDU patient who was colonised/infected with the same strain of Serratia marcescens as the 2 patients reported in September. This indicates transmission had probably occurred between them or there was a common environmental source. This service has put in place similar actions to cardiothoracic and attend the outbreak meetings to enable shared learning.

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. Since closure of the outbreak there has been a further colonised patient, identified in November. Strain typing is awaited.

8. INVASIVE GROUP A STREPTOCOCCUS INFECTION IN MATERNTIY

Invasive group A streptococcal (iGAS) disease is a rare but serious illness. Between 2 and 11% of cases are associated with recent childbirth. We had one post-partum mother affected by this infection in October 2019. This is the seventh healthcare-associated iGAS infection we have had in the last 14 years. No significant issues with care were identified. An outbreak meeting was held, appropriate actions were taken and this 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 undertook an external review of hand hygiene compliance on the 11 wards on the JCUH site in October 2019. A compliance result of 54.09% was reported. The main area of improvement that was highlighted included excessive use of non-sterile gloves; and work to raise awareness in the appropriate use of gloves in being undertaken. A revised hand hygiene audit tool which will capture glove use has been developed; and peer hand hygiene audits conducted by IPC link workers are planned to commence at the end of November. Hand hygiene compliance varies depending on which of the five moments of hygiene HCWs undertake with compliance following contact with the patients' environment being the lowest. The compliance result reported by Ecolab is reflective of this.

- Endeavour has agreed to support the peer review of Serco cleaning processes. This is planned to take place at the beginning of December 2019.

- We have agreed to utilise measures to provide additional assurance of cleaning standards in augmented care areas using UV light to detect a UV-fluorescent marker pen. 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 with actions to reinforce hand hygiene for staff and patients, environmental and equipment cleaning and staff training.

- As part of agreed contracts; external company representatives are supporting with refresher training in relation to equipment cleaning 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 October 2019, no cases of influenza were identified in the critical care areas.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 December 2019			
Safe Staffing Report for October 2019 – Nursing and Midwifery			**AGENDA ITEM:** 10, ENC 5
Report Author and Job Title:	Eileen Aylott, Assistant Director of Nursing Education and Workforce	**Responsible Director:**	Gill Hunt, Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report details nursing and midwifery staffing levels (planned versus actual) for the month of October 2019.		
Background	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).		
Assessment	The fill rate against planned rosters for the month of October 2019 at an overall level was: • RN / RM day shift 88% night shift 91.8% • HCSW day shift 96.1% night shift 109.1%		
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.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	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		
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

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 of Directors 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 October 2019 at an overall level was:

- RN / RM day shift 88% night shift 91.8%
- HCSW day shift 94.7% night shift 110.5%

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

Gill Hunt

Signature Date 23 November 2019

Gill Hunt, Director of Nursing and Quality

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for October 2019 was submitted on 15th November 2019 with the summary of overall fill rate in the table below with the full report in Appendix 1. This month non-ward based staffing has been added to this report to include Theatres and A+E who are not reported through the UNIFY process and do not include CHPPD.

Table 1 – Overall UNIFY Return fill Rate 2019 for Ward Based Nursing and Midwifery

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%
October 2019	88.0%	94.7%	91.8%	110.5%

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 for nights was 4 RN, they have worked with 3 RN's as the RSU did not require the 4th RN due to patient acuity
2. Spinal Unit has had beds closed with an average of 16 beds occupied. Only 2 of the 4 HDU beds were open during October. Two new RN started during October with 2 weeks supernumerary.
3. PICU had average bed occupancy of 2 maintaining safe staffing in line with patient need.
4. NNU has an average of 21 patients during October and have maintained safe staffing.
5. Ainderby Ward planned staffing for days were 4 RN, they have worked with 2-3 RN for an average of 19 occupied beds (ratio 1:6) maintaining safe staffing. They also have one Registered Nursing Associate who worked 172 hours of days. A new RN started during October and was supernumerary.
6. 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. Two new RN started during October with 2 weeks supernumerary.
7. 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.
8. 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 25 beds occupied. Two new staff x1 RN and x1 AP started during October with 4 weeks supernumerary.
9. 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 27 occupied beds maintaining safe staffing.

Critical Care
Nurse staffing is monitored on a daily basis and reported on a weekly basis to ensure compliance with safe staffing.

During October:
Supervisory Coordinators were present on general critical care and cardiothoracic ITU 100% of the time.

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.

Theatres
Staffing gaps in terms of substantive staff have been highlighted through the Theatre Safe Staffing Review which was discussed at the Workforce Committee in October 2019, agency and overtime is being used to cover vacant shifts.

Joint student open days have promoted this area of work and have been successful in recruiting to vacant posts with another 5 newly qualified nurses starting work in Jan/March

2020. International recruitment was also successful with 14 experienced nurses offered posts, 3 will arrive before the end of January 2 of which will be based at FHN.

Accident and Emergency

The recent A+E Safe Staffing paper was discussed at Workforce Committee in October using both the BEST Tool and SNCT new A+E Tool. A small deficit was noted in senior cover for resus areas over the 24 hour period but they do have Military staff working across the department giving them a richer skill mix.

Planned vs actual staffing is not always a useful measure of staffing within this complex area as there are peaks and troughs in activity requiring flexible staffing during surge. There are 4 Band 4 Registered Nursing Associates and 7 Assistant Practitioners working within the team who are able to undertake complex tasks together with Emergency Care Practitioners, Advanced Nurse Practitioners and Therapeutic Care Support who support the team.

Community Nursing

The community nursing teams across H&R and Tees are undergoing some significant changes within their localities around the implementation of the Primary Care Networks;
Primary Care Networks (PCN's) signal a significant change in the way practices interact not only with each other, but the wider health and social care system. This will enable the traditional barriers to the delivery of health and care to be broken down to enable care to be delivered to a defined patient population, in a different way to meet the needs of that population, focused on prevention and personalisation of care, making best use of resources collectively.

In late 2016 the GP Five Year Forward view was launched, which strongly advocated at scale working and new models of care, but it wasn't until late 2017 that the concept of PCNs was formally launched.

The NHS Long Term Plan introduced PCNs as essential building blocks of every Integrated Care System and under the new PCN Contract Directed Enhanced Service (DES) General Practice takes the leading role in every PCN.

As such there has been some initial work completed to ensure that these PCN's are clinically focussed and driven with a Band 7 clinical lead in each one with the rest of the team following around Sisters, staff nurses and unregistered staff.

Throughout this process there have been some staff changes with internal promotion/progression which has resulted in vacancies across band 6 & 5 levels, however recruitment is on-going and we are hoping these will be appointed to by the end of November with start dates into January.

Alongside this we have also piloted the implementation of the SNCT for community nursing and this is to run across September, October and November with the 'go live' date in January, the results are currently in progress to be analysed for future implementation and reporting.

There has also been some preliminary discussions regarding the use of E-Community for our community teams, however this is in the very early stages and as such the teams are looking to visit an area that has already implemented this to map what this may look like.

Recruitment to the community area has been very successful recently with a number of newly appointed staff waiting to start.

The teams are working with e-roster to split the community nursing teams into 5 distinct teams in line with the Primary Care Networks. This work together with the SNCT community review will be used to right size the workforce for the future.

2. Temporary Staffing

The total number of hours requested for RN and HCA has remained static during October 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 538 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 133 red flags have been reported during October. 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 (47). Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Red Flags raised during October

Red flags	Early	Late	Long Day	Night	Grand Total
AMBER Beds Open	14	17		16	47
Delay in providing pain relief				1	1
Less than 2 RNs on shift	7	3		5	15
Missed 'intentional rounding'	4	4		2	10
Shortfall in RN time	19	24	2	14	59
Vital signs not assessed or recorded				1	1
Grand Total	42	48	2	35	133

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.

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 October a total of 916 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 first cohort of 5 International RN's arrived on 1st November and will be deployed to Ward 28 (Stroke), ITU, Ward 34 and OPM following a two week induction. A second cohort of 4 will arrive on 30th November and will be deployed to ITU, Ward 28 (Stroke), Anaesthetics and Recovery (JCUH).

Monthly cohorts will be deployed with two groups expected in January 2020 (total of 20+ expected). The OSCE programme to prepare these staff runs for 6 weeks with the first exams booked on 20th January for the 1st November group (first available slots as all other sessions are fully booked). In the interim they will work in the capacity of pre-registration nurses awaiting Pin Numbers which means they cannot give medications unsupervised.

A total of 95 new RN's commenced employment across the Trust between the end of September and October and undertook Corporate Trust Induction, some Preceptorship days and were within their supernumerary period. Although not all counted in the numbers they have contributed to patient care for at least 2 weeks during October.

7. Staff Retention

The Trust is part of the Cohort 5 NHSI Retention Work stream and is beginning to formulate the required action plan due for submission in December. This plan will inform the Trust Retention Strategy.

8. Workforce Safeguards

Work is underway with Community Nursing Teams to prepare for a full establishment review in January 2020. Teams are undertaking one week audits using the tool provided by NHSI to ensure staff familiarity and the reliability and validity of the scoring of patients through peer review.

Out Patient Department reviews will also begin in 2020 and initial conversations with Clinical Service Managers to prepare this work will take place in November 2019.

Eileen Aylott
Assistant Director of Nursing Workforce
November 2019

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South Tees Hospitals NHS
NHS Foundation Trust

Appendix 1 JCUH

	James Cook																																							
		Hours																	< 80	80-95	> 95																					
		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 Nights	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 Acquired Grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
UEC	Critical Care	10,030.83	9,538.67	2,603.83	2,129.83	-	-	-	-	10,044.00	9,672.00	1,152.00	1,105.67	-	-	-	-	95.3%	81.8%	-	-	96.3%	96.0%	-	-	8.20%	4.80%	4.60%	7.90%			4		817	23.54	3.96	27.50
UEC	RAFAU	2,260.17	1,892.50	1,617.92	1,866.58	144.00	144.00	-	-	1,311.67	1,129.00	1,430.33	1,950.35	-	-	-	-	83.7%	115.4%	100.0%	-	86.1%	136.4%	-	-	3.70%	6.70%	0.70%	4.40%			2		829	3.64	4.60	8.25
SP&PL	JC06 Gastro	1,069.58	1,080.17	1,415.10	1,617.77	-	-	-	-	1,069.50	1,036.33	713.00	880.25	-	-	-	-	101.9%	114.3%	-	-	96.9%	123.5%	-	-		8.40%	4.00%	5.60%	4		2		729	2.92	3.43	6.34
COM	JC09 (Ward 9)	1,835.08	1,402.00	1,404.00	1,323.00	-	-	84.00	84.00	1,488.00	1,116.00	1,110.00	1,093.33	-	-	-	-	76.4%	94.2%	-	100.0%	75.0%	98.5%	-	-	1.10%	0.70%		17.10%	6		4		815	3.09	2.96	6.05
COM	OPM (Older Persons Medicine)	1,504.80	1,215.90	2,243.87	2,427.27	-	-	-	-	1,116.00	972.67	1,112.00	1,602.10	-	-	-	-	80.8%	108.2%	-	-	87.2%	144.1%	-	-	14.50%	5.00%	6.10%	10.90%	2		2	1	842	2.60	4.79	7.38
COM	JC28 (Ward 28)	1,486.50	1,360.50	1,113.67	1,080.83	-	-	-	-	1,489.00	1,285.00	744.00	804.00	-	-	-	-	91.5%	97.1%	-	-	86.3%	108.1%	-	-	6.00%	2.90%	5.90%	9.10%	3				431	6.14	4.37	10.51
COM	Ward 3	1,428.58	1,379.33	1,784.00	2,354.67	-	-	-	-	1,077.00	954.17	722.65	1,301.78	-	-	-	-	96.6%	132.0%	-	-	88.8%	180.1%	-	-		8.30%	5.70%	8.50%	7	1	1		833	2.80	4.39	7.19
UEC	Short Stay (JC02)	1,854.17	1,765.67	1,416.00	1,413.83	-	-	72.00	72.00	1,488.00	1,227.33	1,104.00	1,175.92	-	-	12.00	12.00	95.2%	99.8%	-	100.0%	82.5%	106.5%	-	100.0%		6.10%		14.70%	5				784	3.82	3.30	7.12
SP&PL	Ward 5 Surgery	2,232.67	1,795.58	1,860.00	1,758.58	-	-	-	-	1,116.00	948.00	1,118.00	1,146.48	-	-	-	-	80.4%	94.5%	-	-	84.9%	102.5%	-	-		6.70%	5.40%	4.40%	2		1		758	3.63	3.84	7.47
SP&PL	JC35 (Ward 35)	1,164.83	1,286.00	1,533.33	1,359.08	-	-	-	-	792.00	852.00	793.00	985.00	-	-	-	-	110.4%	88.6%	-	-	107.6%	124.2%	-	-	11.60%	0.60%		9.20%	1				607	3.52	3.86	7.38
SP&PL	JC31 Vas	1,090.25	1,222.25	1,403.00	1,268.08	37.75	37.75	60.00	60.00	696.00	696.00	710.00	840.33	48.00	48.00	36.00	36.00	112.1%	90.4%	100.0%	100.0%	100.0%	118.4%	100.0%	100.0%	18.60%	4.00%		1.80%	3		4		510	3.76	4.13	7.90
SP&PL	Ward 7 Colo	1,855.25	1,476.83	1,860.00	1,689.33	-	-	-	-	1,116.00	1,007.58	745.00	1,155.00	-	-	-	-	79.6%	90.8%	-	-	90.3%	155.0%	-	-	8.00%	6.60%		8.90%	2	2	3		758	3.28	3.75	7.03
SP&PL	JC04 (Ward 4)	1,653.50	1,337.17	1,116.00	1,153.83	-	-	-	-	1,102.67	1,006.67	745.00	812.35	-	-	-	-	80.9%	103.4%	-	-	91.3%	109.0%	-	-		10.70%	18.60%	1.30%	2		2		671	3.49	2.93	6.42
SP&PL	JC14 Oncology (Ward 14)	1,857.75	1,594.92	1,008.00	1,137.17	-	-	108.00	108.00	1,111.00	1,086.83	724.33	749.00	-	-	12.00	12.00	85.9%	112.8%	-	100.0%	97.8%	103.4%	-	100.0%	4.70%	11.70%	8.00%	0.30%	6	1	2		707	3.79	2.67	6.46
SP&PL	JC33 Specialty (merger of ward 18 and ward 27)	1,486.00	1,244.00	1,408.67	1,164.17	-	-	78.00	78.00	1,117.00	1,069.17	743.83	769.52	-	-	-	-	83.7%	82.6%	-	100.0%	95.7%	103.5%	-	-		3.80%		10.40%	2				572	4.04	3.38	7.42
SP&PL	JC34 (Ward 34)	1,483.50	1,539.83	2,057.17	1,727.33	72.00	72.00	102.00	102.00	1,009.00	1,020.00	1,489.00	1,411.02	108.00	108.00	-	-	103.8%	84.0%	100.0%	100.0%	101.1%	94.8%	100.0%	-	5.60%			5.10%	1		2		821	3.12	3.82	6.94
SP&PL	JC25 Elective Ortho	1,081.98	794.98	1,076.50	999.67	-	-	-	-	720.83	713.50	357.17	374.13	-	-	-	-	73.5%	92.9%	-	-	99.0%	104.8%	-	-	15.10%	9.40%	9.20%	7.70%	4				594	2.54	2.31	4.85
SP&PL	JC36 Trauma	1,846.50	1,634.23	1,856.92	1,706.25	-	-	-	-	1,118.00	984.00	1,118.37	1,328.70	-	-	-	-	88.5%	91.9%	-	-	88.0%	118.8%	-	-	5.20%	7.60%	5.90%	9.80%		1	4		973	2.69	3.12	5.81
SP&PL	Spinal Injuries	2,143.80	1,829.95	1,569.78	1,569.48	-	-	-	-	1,488.00	1,164.00	1,116.00	1,042.00	-	-	-	-	85.4%	100.0%	-	-	78.2%	93.4%	-	-	11.80%	13.70%	6.80%	7.80%					503	5.95	5.19	11.14
SP&PL	Cardio MB	744.00	744.00	371.83	350.00	-	-	-	-	733.00	733.00	0.00	183.67	12.00	12.00	-	-	100.0%	94.1%	-	-	100.0%	-	100.0%	-		7.20%		14.30%					248	5.96	2.15	8.11
SP&PL	CCU JCUH	2,664.00	2,082.00	365.83	419.83	-	-	-	-	1,860.00	1,812.00	0.00	0.00	-	-	-	-	78.2%	114.8%	-	-	97.4%	-	-	-	3.50%	7.40%			1				293	13.29	1.43	14.72
UEC	CICU JCUH	4,059.67	3,397.33	1,245.50	726.50	-	-	-	-	3,660.00	3,204.00	744.00	456.00	-	-	-	-	83.7%	58.3%	-	-	87.5%	61.3%	-	-	4.30%	6.70%	8.70%	14.70%					247	26.73	4.79	31.51
SP&PL	JC24 (Ward 24)	1,489.42	1,351.42	1,128.50	1,346.67	-	-	48.00	48.00	1,116.00	1,082.50	732.00	1,074.00	-	-	12.00	12.00	90.7%	119.3%	-	100.0%	97.0%	146.7%	-	100.0%	1.70%	3.00%		12.80%	2	1			694	3.51	3.49	7.00
SP&PL	JC27 Neuro	1,460.00	1,488.42	1,170.25	1,405.17	-	-	-	-	744.00	745.50	973.00	1,213.98	-	-	-	-	101.9%	120.1%	-	-	100.2%	124.8%	-	-		1.30%		6.20%	2				472	4.73	5.55	10.28
SP&PL	JC26 (Ward 26)	1,134.42	1,059.83	744.83	1,031.50	-	-	-	-	744.00	745.67	370.33	726.32	-	-	-	-	93.4%	138.5%	-	-	100.2%	196.1%	-	-	7.90%	1.90%		6.70%	2				560	3.22	3.14	6.36
SP&PL	JC29 (Ward 29)	1,451.67	1,364.17	1,113.00	1,055.33	36.00	36.00	-	-	1,080.00	984.00	744.00	781.00	36.00	36.00	-	-	94.0%	94.8%	100.0%	-	91.1%	105.0%	100.0%	-		6.60%	9.70%	3.50%	5				726	3.23	2.53	5.76
SP&PL	JCCT (Ward 32)	1,624.50	1,593.00	1,253.33	1,199.33	-	-	-	-	1,116.17	828.17	754.92	958.50	-	-	-	-	98.1%	95.7%	-	-	74.2%	127.0%	-	-	12.50%	6.40%		2.10%	2				621	3.90	3.47	7.37
UEC	Cardio HDU	2,111.50	1,996.67	305.67	293.67	-	-	66.00	66.00	1,716.00	1,500.00	348.00	341.33	-	-	24.00	24.00	94.6%	96.1%	-	100.0%	87.4%	98.1%	-	100.0%	3.50%	7.10%		2.70%	1		1		240	14.57	2.65	17.22
SP&PL	Ward 8	1,860.75	1,658.50	1,855.58	1,656.42	-	-	-	-	1,118.00	1,082.00	744.00	1,094.00	-	-	-	-	89.1%	89.3%	-	-	96.8%	147.0%	-	-	4.50%	2.20%		12.50%	2		1		871	3.15	3.16	6.30
UEC	JC24 HDU	1,486.83	1,451.75	371.67	300.00	-	-	-	-	1,488.00	1,416.58	372.00	348.00	-	-	-	-	97.6%	80.7%	-	-	95.2%	93.5%	-	-	1.70%	3.00%		12.80%					162	17.71	4.00	21.71
COM	JC21 (Ward 21)	2,232.00	2,043.00	744.00	608.00	-	-	-	-	2,232.00	1,824.00	372.00	360.00	-	-	-	-	91.5%	81.7%	-	-	81.7%	96.8%	-	-	3.20%	3.70%	13.00%	1.80%					414	9.34	2.34	11.68
COM	JC22 (Ward 22)	1,113.00	1,142.50	598.50	534.00	-	-	-	-	1,020.00	996.00	96.00	96.00	-	-	-	-	102.7%	89.2%	-	-	97.6%	100.0%	-	-		5.90%							290	7.37	2.17	9.55
COM	JCDS (Central Delivery Suite)	3,712.57	3,650.58	1,180.00	706.00	-	-	-	-	4,090.17	3,720.67	740.00	677.00	-	-	-	-	98.3%	59.8%	-	-	91.0%	91.5%	-	-	2.90%	5.40%		8.50%					559	13.19	2.47	15.66
COM	Neonatal Unit	5,746.50	4,858.50	372.00	240.00	-	-	-	-	5,208.00	4,732.50	0.00	132.00	-	-	-	-	84.5%	64.5%	-	-	90.9%	-	-	-	7.70%	12.30%	20.40%	20.40%					653	14.69	0.57	15.26
COM	Paediatric Intensive Care Unit (PICU)	1,860.00	1,658.17	232.50	181.00	-	-	-	-	1,848.00	1,473.00	0.00	0.00	-	-	-	-	89.1%	77.8%	-	-	79.7%	-	-	-	3.70%	4.30%							64	48.92	2.83	51.75
COM	Ward 17 JCUH	2,210.83	2,099.83	1,111.00	943.00	-	-	-	-	1,487.05	1,509.55	1,108.50	844.50	-	-	-	-	95.0%	84.9%	-	-	101.5%	76.2%	-	-	16.70%	8.30%	6.40%	4.20%					762	4.74	2.35	7.08
COM	Ward 19 Ante Natal	1,257.83	1,000.33	310.00	315.50	-	-	-	-	743.83	707.83	0.00	0.00	-	-	-	-	79.5%	-	-	-	95.2%	-	-	-		6.00%							275	6.21	1.15	7.36
																	Site average	91.0%	95.4%	100.0%	100.0%	91.8%	115.1%	100.0%	100.0%														

	FHN	Hours																< 80	80-95	> 95																					
		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 (%)	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	Ainderby FHN	1,241.17	974.25	1,064.58	1,135.83	172.50	172.50	-	-	713.33	714.33	713.00	714.00	-	-	-	-	78.5%	106.7%	100.0%	-	100.1%	100.1%	-	-		3.30%		9.60%	4				585	2.89	3.16	6.05
UEC	Romanby FHN	1,576.00	1,142.08	1,116.48	1,173.48	-	-	-	-	713.00	713.00	708.50	835.00	-	-	-	-	72.5%	105.1%	-	-	100.0%	117.9%	-	-		3.70%		7.10%					619	3.00	3.24	6.24
COM	Rutson FHN	1,167.50	828.00	1,669.18	1,276.85	-	-	-	-	713.00	713.00	713.33	875.33	-	-	-	-	70.9%	76.5%	-	-	100.0%	122.7%	-	-	14.60%			6.00%	2				445	3.46	4.84	8.30
SP&PL	Gara Orthopaedic FHN	835.93	815.17	721.98	707.98	-	-	-	-	717.50	721.50	358.00	335.00	-	-	-	-	97.5%	98.1%	-	-	100.6%	93.6%	-	-	8.60%	6.50%		7.80%					393	3.91	2.65	6.56
COM	Maternity FHN	1,428.00	1,066.50	196.50	169.50	-	-	-	-	1,068.00	726.00	0.00	0.00	-	-	-	-	74.7%	86.3%	-	-	68.0%	-	-	-	7.40%			28.90%					8	224.06	21.19	245.25
																	Site Average	78.8%	94.5%	100.0%	-	93.7%	108.6%	-	-												

	East Cleveland	Hours								< 80	80-95	> 95																			
		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 (%)	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
COM	Tocketts Ward East Cleveland Hospital	1,825.25	967.75	2,309.73	1,714.07	1,070.08	851.58	1,644.92	1,495.92	53.0%	74.2%	79.6%	90.9%		11.00%		23.20%	9				786	2.31	4.08	6.40
									Site Average	53.0%	74.2%	79.6%	90.9%												

	Redcar	Hours																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 complains	Trust Aquired Grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
		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																				
COM	Zetland	2,221.50	1,528.25	3,095.33	2,461.15	-	-	60.00	60.00	1,116.00	1,056.00	1,117.00	1,189.00	-	-	-	-	68.8%	79.5%	-	100.0%	94.6%	106.4%	-	-		16.40%	3.50%	6.90%	1		2		844	3.06	4.32	7.39
																	Site Average	68.8%	79.5%	-	100.0%	94.6%	106.4%	-	-												

	Friary Community Hospital	Hours								< 80	80-95	> 95																	
		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 (%)	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
COM	Friary Community Hospital	1,008.00	939.92	1,347.92	1,173.92	623.00	623.00	630.75	600.75	93.2%	87.1%	100.0%	95.2%		2.40%		2.20%	3				397	3.94	4.47	8.41
									Site Average	93.2%	87.1%	100.0%	95.2%												

	James Cook									< 80	80-95	> 95														
		Hours																								
		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 (%)	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	AMU JCUH	2,232.17	2,025.67	1,488.00	1,538.43	1,861.00	1,813.00	1,489.00	1,508.67	90.7%	103.4%	97.4%	101.3%	11.20%	6.20%	4.70%	0.70%	10		1		653	5.88	4.67	10.54
UEC	AAU JCUH	2,970.00	2,828.33	1,764.00	1,781.30	1,860.00	1,764.00	1,116.00	1,200.92	95.2%	101.0%	94.8%	107.6%	7.70%	3.90%		1.30%	3				593	7.74	5.03	12.77
COM	Mat Assessment Unit	1,390.50	1,362.50	279.00	279.00	924.00	888.00	0.00	0.00	98.0%	100.0%	96.1%	-	5.60%	0.10%							31	72.60	9.00	81.60
	FHN																									
UEC	Clinical Decisions Unit FHN	1,762.00	1,345.83	1,066.33	1,203.00	1,069.83	954.83	714.00	766.50	76.4%	112.8%	89.3%	107.4%	5.00%	16.10%		6.70%	6		3		501	4.59	3.93	8.52

Inpatient Areas

	< 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	85.0%	87.1%	89.0%	109.2%
Specialist & Planned Care	91.9%	100.5%	94.0%	120.6%
Urgent and Emergency Care	87.6%	96.5%	92.4%	101.6%
Trust Average	88.1%	94.7%	91.8%	110.5%

Theatres and A+E

Name	Day Reg Planned Hrs	Day Reg Actual Hrs	Day Unreg Planned Hrs	Day Unreg Actual Hrs	Night Reg Planned Hrs	Night Reg Actual Hrs	Night Unreg Planned Hrs	Night Unreg Actual Hrs	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
MT Mixed Specialty	3,902.17	3,836.65	2,898.25	2,114.25	310.00	310.00	310.00	290.00	98.3%	72.9%	100.0%	93.5%
MT Orthopaedics	2,140.50	1,867.50	1,913.00	1,449.50	310.00	310.00	310.00	310.00	87.2%	75.8%	100.0%	100.0%
Theatres FHN	6,118.38	4,835.62	3,096.25	1,693.25	0.00	0.00	0.00	0.00	79.0%	54.7%	#DIV/0!	#DIV/0!
MT General Theatre	4,071.50	3,785.50	3,451.50	3,079.25	930.00	931.25	620.00	620.00	93.0%	89.2%	100.1%	100.0%
MT Anaes & Rec	9,967.75	7,986.50	1,015.00	1,324.00	930.00	920.00	0.00	0.00	80.1%	130.4%	98.9%	#DIV/0!
Ac&Em - J	6,835.58	7,010.33	2,283.25	1,753.75	6,227.25	6,461.58	1,896.33	1,530.50	102.6%	76.8%	103.8%	80.7%

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 December 2019			
Guardian of Safeworking – Quarter 2 report July 2019 to September 2019			**AGENDA ITEM: 11, ENC 6**
Report Author and Job Title:	Suzie Peatman, Guardian of Safeworking and Alison Wilson, HR Business Partner	**Responsible Director:**	Sath Nag, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform X		
Situation	This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1st July 2019 and 30th September 2019.		
Background	It is a requirement of the 2016 Doctors and Dentists in Training Terms and Conditions that a quarterly report is submitted to the Board of Directors. The report should include a summary of exception reporting activity and vacancies in the Doctors and Dentists in Training Workforce.		
Assessment	Please see body of report for statistics in relation to the quarter ending 30th September 2019.		
Recommendation	The Board of Directors notes and discusses the Guardian of Safe working Report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The risks associated with this report are included in section 7 of this report.		
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 ☐		

Guardian of Safeworking report 1st July 2019 to 30th September 2019

Report to The Board of Directors

Prepared by Suzie Peatman, Guardian of Safeworking and Alison Wilson, HR Business Partner

1. Purpose

This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1st July 2019 and 30th September 2019.

The report also provides information in relation to rota gaps, recruitment activity and exception reporting activity.

2. Key updates

- The overall vacancy rate is 4.1%. Gaps on rotas tend to be short term due to sickness or emergency leave. The Medical Rota Team track junior doctor sickness and any doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for foundation doctors, Lead Employer Trust for LET employed doctors).
    - Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas
    - The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 91%) being filled by internal locum cover as opposed to agency
    - The contract for the regional locum bank (Flexishift) hosted by the Lead Employer Trust has been extended following a successful pilot. The possibility of adding Trust employed doctors to the bank is currently being explored

- The Junior Doctors Forum has been established as per the contract terms and conditions. The forum has previously been slow to engage, however the first meeting held following the August 2019 intake was well attended.

- Exception reporting submissions have been consistently lower than expected but we have seen a recent increase since the August changeover particularly in one specialty. This is being monitored and measures to alleviate the problem are in hand. There has been an increase in staff numbers employed to alleviate issues and suggestions for work schedule / rota changes to address this are being put in place for the next intake.

- Dr Peatman attended the National Guardian of Safeworking conference in September 2019. A feeling from the regional GOSW group meeting was that the meeting was not designed to address GOSW issues and more time given to an NHS Employers driven agenda. There was unfortunately limited time for feedback to Allocate included in the day and therefore very little progress in software system developments to report at this stage.

3. Data summary and commentary

3.1 Numbers of doctors in training

Table 3.1.1

Number of doctors / dentists in training (total):	**363**
Number of doctors / dentists in training on 2016 TCS to date(total):	**254**

In addition to the above, the Trust is also allocated up to 37 military doctors in training who are employed on military terms and conditions and who are technically not under the protection of the Guardian of Safeworking. Following previous agreement, military colleagues have access to the exception reporting system. This allows military colleagues to highlight any issues with rotas and will provide departments and the guardian with additional information in relation to the safe working of rotas.

3.2 Amount of time available in job plan for guardian to carry out duties of the role

1 PA / 4 hours per week.

4. Exception reports

The tables below give a breakdown and analysis of the 43 exception reports raised between 1st July 2019 and 30th September 2019

Table 4.1

Exception reports raised July to September 19			
Specialty	**No. Exceptions Raised**	**No. Exceptions Closed**	**No. Exceptions Outstanding**
General Medicine	3	0	3
General Surgery	38	20	18
Obstetrics & Gynaecology	1	1	0
Trauma & Orthopaedics	1	0	1
Total	**43**	**21**	**22**

Table 4.2

Exception report category			
Specialty	**Education**	**Hours & Rest**	**Service Support**
General Medicine	0	2	1
General Surgery	0	33	5
Obstetrics & Gynaecology	0	1	0
Trauma & Orthopaedics	0	1	0
Total	**0**	**37**	**6**

Table 4.3

Exception report type							
Specialty	**Early Start**	**Early Start & Late Finish**	**Late Finish**	**Unable To Achieve Breaks**	**Working pattern does not match work schedule**	**Unable To Attend Scheduled Teaching / Training**	**Other**
General Medicine	0	0	2	0	0	0	0
General Surgery	0	0	33	0	0	0	5
Obstetrics & Gynaecology	0	0	1	0	0	0	0
Trauma & Orthopaedics	0	0	0	1	0	0	0
Total	**0**	**0**	**36**	**1**	**0**	**0**	**5**

Table 4.4

Exception report action taken					
Specialty	**No Action Required**	**Payment For Additional Hours**	**Time Off In Lieu**	**Work Schedule Review and payment**	**Other**
General Medicine	0	0	0	0	0
General Surgery	0	19	1	0	0
Obstetrics & Gynaecology	0	0	1	0	0
Trauma & Orthopaedics	0	0	0	0	0
Total	**0**	**19**	**2**	**0**	**0**

Exception reports continue to be predominantly for the reason of additional hours being worked which is being compensated with payment or time in lieu.

The recent increase in exception reports from general surgery (FY1&2 mainly) is due to change in the working practice on the unit and the creation of the surgical assessment unit. The situation has been acknowledged by the Clinical Director for surgery and recruitment has taken place to back fill gaps but this has taken time. Working practices on the unit are changing as a result of feedback and these will be implemented for next rotation.

5. Vacancy data

Outstanding vacancies by month July 19 to September 19					
Specialty	**Grade**	**July 19**	**Aug 19**	**Sept 19**	**Comments**
Diabetes	ST3+	1	1	1	Rota adjusted to accommodate
Dermatology	Innovative Gpr	0	1		Appointed – date of commencement tbc
Obs and Gynae	ST1/2/3	1	0	0	
Obs and Gynae	ST3+	1	1.8	0.8	Department do not wish to fill currently
Neonatology	ST3+	0.8	1.8	1.8	1 x WTE Appointed – pending visa
Colorectal	FY1	1	1	1	Rota adjusted to accommodate
Plastics	ST3+	1	0	0	
Urology	Research Fellow	1	1	1	Department did not wish to recruit previously, awaiting update from department
Urology	FY1	0	0	1	Out to advert
Orthopaedics	FY2	0	0	1	Appointed to position - ESD end of Sep 19
Orthopaedics	CT1/2	0	1	1	Department agreed to leave the position vacant until the end of the rotation (Dec 2019)
Orthopaedics	Trust Doctor	0	1	1	Appointed – expected start date Nov 19
Ophthalmology	ST3+	1	1	1	Rota adjusted to accommodate, out of hours covered by locum
Spinal Surgery	ST3+	0	1	0	
Neurosurgery	ST3+	1	0	0	
Neurology	GP Trainee	0	0.4	0.4	Department do not wish to fill currently
A&E	FY2	3	3	3	Rota adjusted /covered by supernumery MOD doctors
A&E	CT1/2	2	1	1	Rota adjusted to accommodate
A&E FHN	Trust Doctors	2	2	2	Covered by locums
Totals		**15.8**	**15**	**16**	

6. Guardian of safeworking fines

There were no Guardian of Safeworking fines issued during the quarter.

7. Risks/issues and next steps

There are a number of risks and issues to bring to the attention of the Board of Directors.

- Not all junior doctors across the region have transferred to the new contract as many are employed on existing run through training contracts which do not expire for some time (in some cases as late as 2023). This has resulted in doctors being employed on differing terms and conditions which leads to rotas being composed of a hybrid workforce.

  For example, doctors on the new contract are under the protection of the Guardian of Safeworking for rota and training breaches where as those on the old contract are not. Also, doctors on the new contract will be entitled to claim for additional hours where rota hours are exceeded whereas those on the old contracts are not.

  To date this does not appear to have impacted on morale; however this will continue to be monitored via the junior doctor forum.

- Further guidance regarding non-resident on call rotas has been issued from NHS Employers and the BMA. The non resident on call rotas affected are being monitored for rest and hours and may need revision after monitoring.

- In July 2019, an agreement was reached between NHS Employers, the British Medical Association (BMA) and Department of Health and Social Care (DHSC) on the amendments to the 2016 terms and conditions for junior doctors. This ended the dispute between the BMA and the DHSC over the implementation of the contract.

- As part of this agreement, there are a number of changes to the 2016 terms and conditions which will be phased in by August 2020. This may result in the need for redesign of some rotas. An implementation plan has been formulated with the first changes due in December. This is posing challenges with some rotas. The change to a maximum 1 in 3 weekends from December 2019 (currently 1 in 2) is a particular challenge in some areas. Discussions are on-going and a final published version of the amended terms and conditions by NHS Employers has been delayed until mid November.

8. Conclusion

The Guardian of Safeworking in submitting this report to the Board of Directors acknowledges the work which has been undertaken by the medial workforce and postgraduate teams and clinicians within departments to manage the additional work involved in the implementation of the 2016 contract.

The contract remains work in progress, currently our issues are centred on the implementation of the changes to the contract from December 2019 and the challenges of ensuring rotas remain compliant with the contractual rules.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 DECEMBER 2019			
Cancelled Operations Update			**AGENDA ITEM: 12, ENC 7**
Report Author and Job Title:	Ian Bennett, Head of Patient Safety & Governance Joanne Dobson, Director of Transformation & Strategic Partnerships	**Responsible Director:**	Johanna Reilly, Chief Operating Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This paper provides details of cancelled operations which have occurred across the Trust between April and October 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. An area of concern is the number of on the day patient cancellations. 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. As of November the unit is fully operational.		
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 Board of Directors are asked to: • Note the content of the paper, including the current monitoring arrangements which are in place • 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 risk 3.4 - Risk that patients deteriorate or actual harm materialises due to patients being moved from list to accommodate 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 ☐	

South Tees Hospitals NHS
NHS Foundation Trust

Cancelled Operations Update

November 2019

1. Purpose of the Report

This paper provides details of cancelled operations which have occurred across the Trust between April and October 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 implications for patients and the Trust 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. 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.

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.

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. 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, see table below.

Reason	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Total
Patient DNA	90	101	130	119	106	130	128	804
Patient self-cancelled	45	70	46	54	48	41	53	357
Insufficient time remaining	51	30	37	36	45	34	30	263
Bed Unavailable Ward	22	31	12	28	15	53	54	215
Administrative	25	32	25	22	34	24	32	194
Bed Unavailable HDU/ITU	29	27	20	42	18	29	18	183
Surgical - procedure not required	30	18	18	22	17	24	47	176
Surgical - patient not prepared	21	22	23	27	25	25	25	168
Anaesthetic - condition changed since pre-assessment	27	18	21	26	25	15	26	158
Displaced by Emergency	22	29	4	15	7	11	11	99
Session Cancelled	7	8	21	5	8	9	8	66
Patient(s) Unavailable clinical	8	3	8	6	9	6	14	54
Service unavailable	11	7	16	2	1	5	7	49
Equipment unavailable	10	7	4	13	6	3	2	45
Anaesthetic - inadequate pre-assessment	11	7	5	8	5	4	4	44
Case already done	2	3	4	3	8	2	7	29
Patient(s) Unavailable non-clinical	1	4	2	4	1			12
Patient Unfit	1	1	2	3			3	10
Anaesthetic - No pre-assessment		1		3	2	1	1	8

Surgical - inappropriate grade of surgeon	2		1		1		2	6
Anaesthetic - inappropriate grade of Anaesthetist		1	2					3
Patient Not Confirmed > 48 Hrs	1	1						2
Total on the day cancellations	**416**	**421**	**401**	**438**	**381**	**416**	**472**	**2945**
Total cases completed	3586	3636	3585	3966	3616	3609	4067	26065
Total cases booked	4002	4057	3986	4404	3997	4025	4539	29010
% cases cancelled on the day	**10.4%**	**10.4%**	**10.1%**	**9.9%**	**9.5%**	**10.3%**	**10.4%**	**10.2%**

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 illustrates the number of operations not carried out between April and October 2019 has remained static. Of the 2495 that did not take place during the period, 40% (1161) can be attributed to either the patient not attending or cancelling the operation themselves, with 7% (183) 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 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.

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. As from 4th November the unit is fully operational with 5.5 beds open. Since the PACU opened the number of cancelled operations has reduced for general patients requiring a HDU/critical care bed but has remained static for patients requiring cardiac surgery.

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.

3.1 Quality and Patient Safety Perspective

Between 1st April and the 31st October there were 174 Datix forms completed where a patient had an operation cancelled due to a lack of HDU/ITU beds. This is less than the 183 which were reported operationally during the same period, although does demonstrate staff are reporting many of these incidents when they occur via Datix.

Table 2 below illustrates these broken down by month and speciality. July had the highest number of cancelled operations (44), this was also the highest number reported operationally. In October, 15 incidents were reported via Datix. General Surgery contributing to 35% of the cancelled operations reported on Datix during this period.

Table 2

	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	2019 10	Total
Cardiac Surgery	12	3	0	6	1	13	14	49
Ear Nose & Throat	0	0	1	0	0	0	0	1
General Surgery	7	21	11	17	0	5	0	61
Gynaecology	2	0	0	0	0	1	0	3
Critical Care Services	3	1	1	13	10	6	1	35
Neurosurgery	3	2	5	5	0	0	0	15
Orthopaedics	0	2	1	0	0	0	0	3
Urology	1	0	0	3	2	0	0	6
Vascular Surgery	0	0	1	0	0	0	0	1
Totals:	28	29	20	44	13	25	15	174

Table 3 below illustrates the level of harm associated with each cancelled operation at the time it is reported via Datix. The majority result in no or minor harm, with 1 incident reported resulting in major harm. It should be noted that grading may be subject to change as the incidents are investigated as some of those included in this data have not yet been finally approved. Those previously reported as moderate harm have been regarded following investigation as the initial grading may not reflect the actual harm to the patient. Duty of Candour would apply to any incident where moderate harm or above has occurred.

Table 3

	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Cardiac Surgery	18	31	0	0	0	49
Ear Nose & Throat	1	0	0	0	0	1
General Surgery	2	59	0	0	0	61
Gynaecology	3	0	0	0	0	3
Critical Care Services	1	34	0	0	0	35

Neurosurgery	4	11	0	0	0	15
Orthopaedics	3	0	0	0	0	3
Urology	0	5	0	1*(SI)	0	6
Vascular Surgery	0	1	0	0	0	1
Totals:	32	141	0	1	0	174

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

It is important to note that the level of harm may change in some instances in future months and years as further details and information comes to light about other potential quality and safety related consequences of these and other patients who have had their operations cancelled previously, which we did not know about at the time they occurred.

Table 4 below illustrates the majority of patients have their operation cancelled once (83%), with only 6 patients having their operation cancelled 3 or more times.

Table 4

	1 cancellation	2 cancellations	3 cancellations	4 cancellations	Total
Cardiac Surgery	**42**	7	0	0	49
Ear Nose & Throat	**1**	0	0	0	1
General Surgery	**52**	5	3	1	61
Gynaecology	**2**	1	0	0	3
Critical Care Services	**29**	6	0	0	35
Neurosurgery	**11**	3	1	0	15
Orthopaedics	**3**	0	0	0	3
Urology	**3**	2	0	1	6
Vascular Surgery	**1**	0	0	0	1
Totals:	**144**	24	4	2	174

Table 5 below illustrates that patients are more likely to have their operations cancelled on a Tuesday, which accounts for 33% within this category.

Table 5

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**
Cardiac Surgery	6	12	5	11	15	0	0	49
Ear Nose & Throat	0	0	1	0	0	0	0	1
General Surgery	15	17	5	18	6	0	0	61
Gynaecology	1	2	0	0	0	0	0	3
Critical Care Services	4	13	11	4	2	1	0	35
Neurosurgery	1	12	1	1	0	0	0	15
Orthopaedics	0	0	2	1	0	0	0	3
Urology	3	1	1	0	1	0	0	6

Vascular Surgery	0	1	0	0	0	0	0	1
Totals:	30	58	26	35	24	1	0	174

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
- Standard responses are being generated as part of the investigation, including that a clinical review has taken place, however it is not clear on the level or professional background of the person completing these reviews

4. Summary

This paper provides an operational, quality and safety perspective on the number of operations which have been cancelled between April - October 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. In addition, work is taking place to ensure South Tees NHS Hospitals Foundation Trust's community services can be fully utilised to enable appropriate step-down care.

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 is 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 with this needs a standard approach and early escalation, or at the earliest opportunity that the harm is identified, in an open and transparent way.

5. Recommendations

The Board of Directors are asked to:

- Note the content of the paper, including the current monitoring arrangements which are in place

- Note work underway with North Tees & Hartlepool NHS Foundation Trust to ensure critical care capacity across the Network is fully utilised.
- 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 & Strategic Partnerships
Update 25th November 2019

South Tees Hospitals
NHS Foundation Trust

Quality, Operational & Finance Performance Report

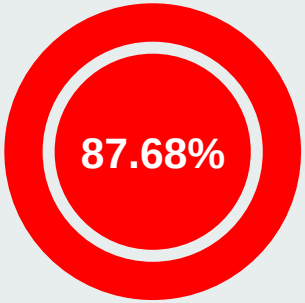
26th November 2019

Must Do’s

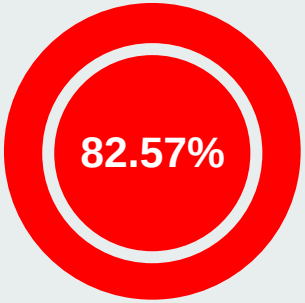
Must Do's 2019/20 – October 2019

Deliver Excellence in Patient Outcome and Experience….

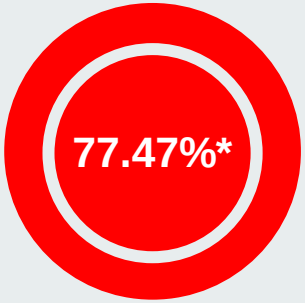
A&E
4hr Target



RTT
18 Week Target



Cancer
62 Day Target



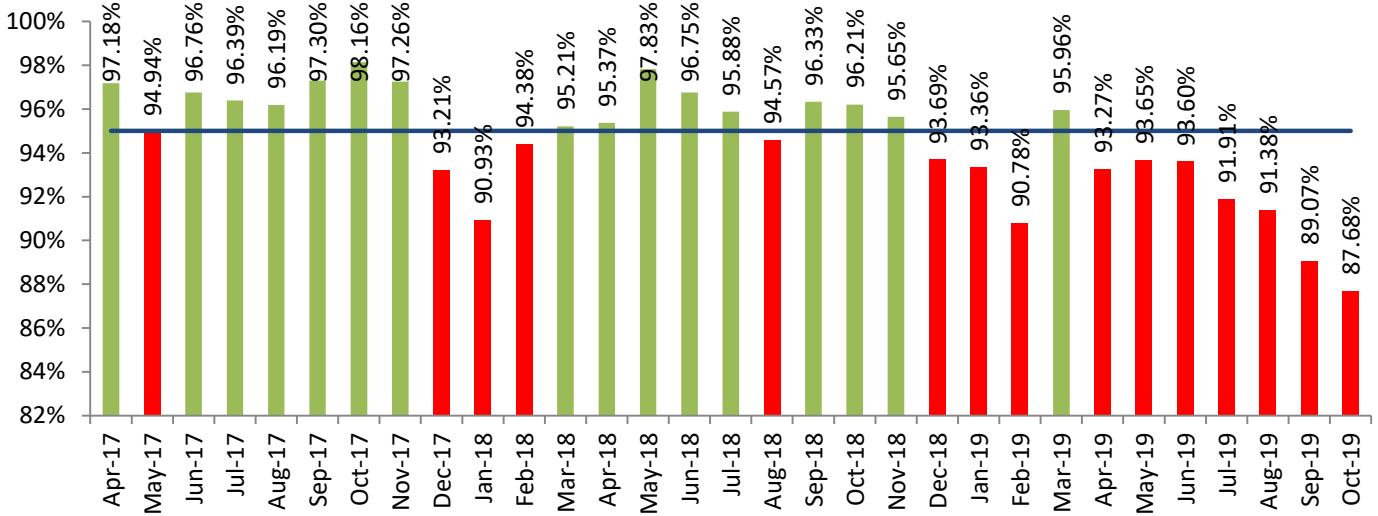
* Indicative

CDiff
HCAI Threshold

Operating Surplus

…and ensure our long term financial sustainability

Performance - A&E



95%
TARGET

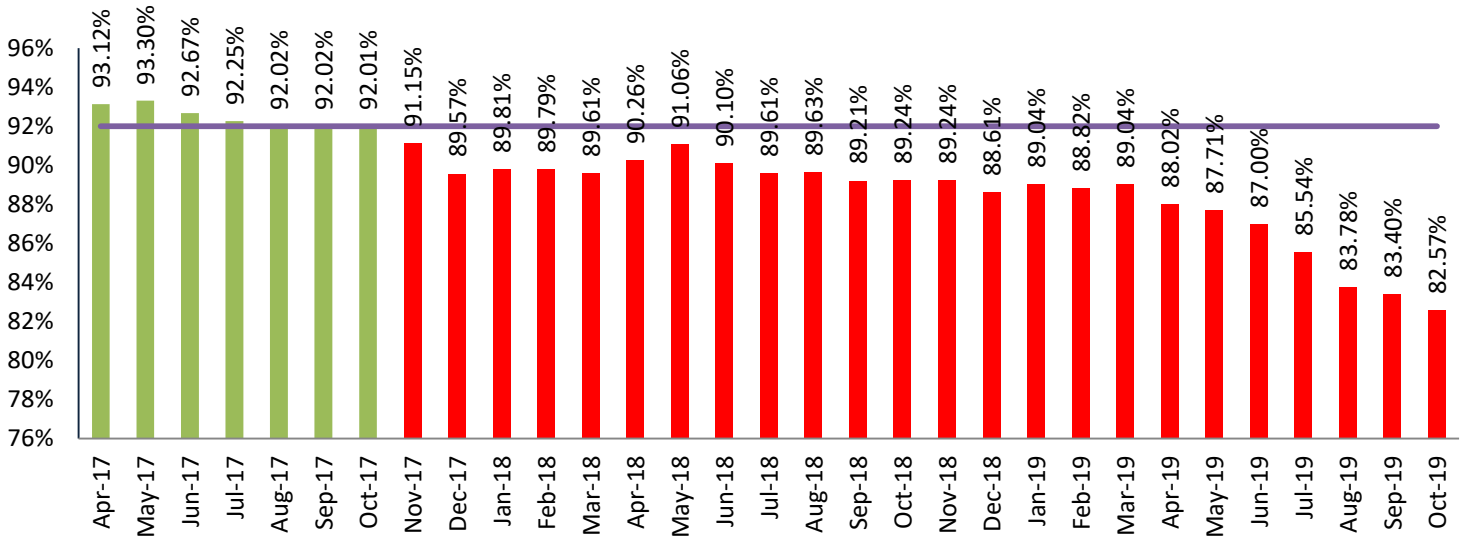
Oct 19
87.68%

Nov to date (as at 25/11/19)
86.08%

Regional Rank	Trust	Oct-19
1	Northumbria Healthcare NHS Foundation Trust	95.65%
2	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93.57%
3	Harrogate and District NHS Foundation Trust	90.39%
4	Gateshead Health NHS Foundation Trust	89.76%
5	**South Tees Hospitals NHS Foundation Trust**	**87.68%**
6	York Teaching Hospitals NHS Foundation Trust	80.38%
7	North Cumbria University Hospitals NHS Trust	79.86%
8	South Tyneside And Sunderland NHS Foundation Trust	78.33%
9	County Durham and Darlington NHS Foundation Trust	74.98%
-	North Tees and Hartlepool NHS Foundation Trust	-
	ENGLAND	**86.63%**

Oct 19
Ranked 5th in the region

Referral to Treat



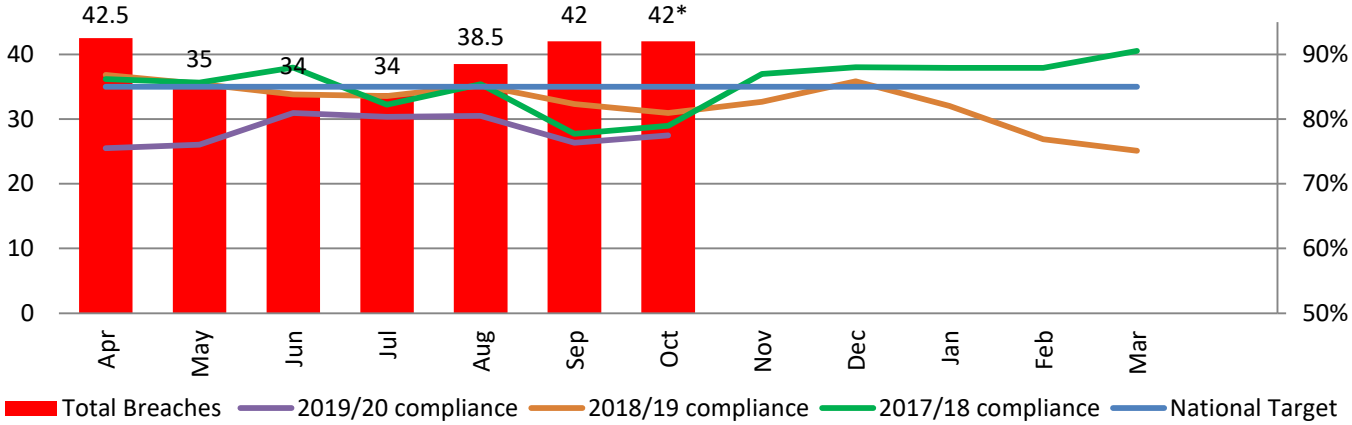
92%
TARGET

Oct 19
82.57%

Regional Rank	Trust	Sep-19
1	North Tees and Hartlepool NHS Foundation Trust	92.37%
2	Gateshead Health NHS Foundation Trust	92.23%
3	Northumbria Healthcare NHS Foundation Trust	92.16%
4	South Tyneside And Sunderland NHS Foundation Trust	92.14%
5	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	90.31%
6	County Durham and Darlington NHS Foundation Trust	89.93%
7	**South Tees Hospitals NHS Foundation Trust**	**83.42%**
8	York Teaching Hospital	76.03%
9	North Cumbria University Hospitals NHS Trust	71.95%
10	Harrogate and District NHS Foundation Trust	-
	ENGLAND	**84.78%**

Sep 19
Ranked 7th in the region

Performance – 62 Day Cancer Standard



% compliance and number of breaches

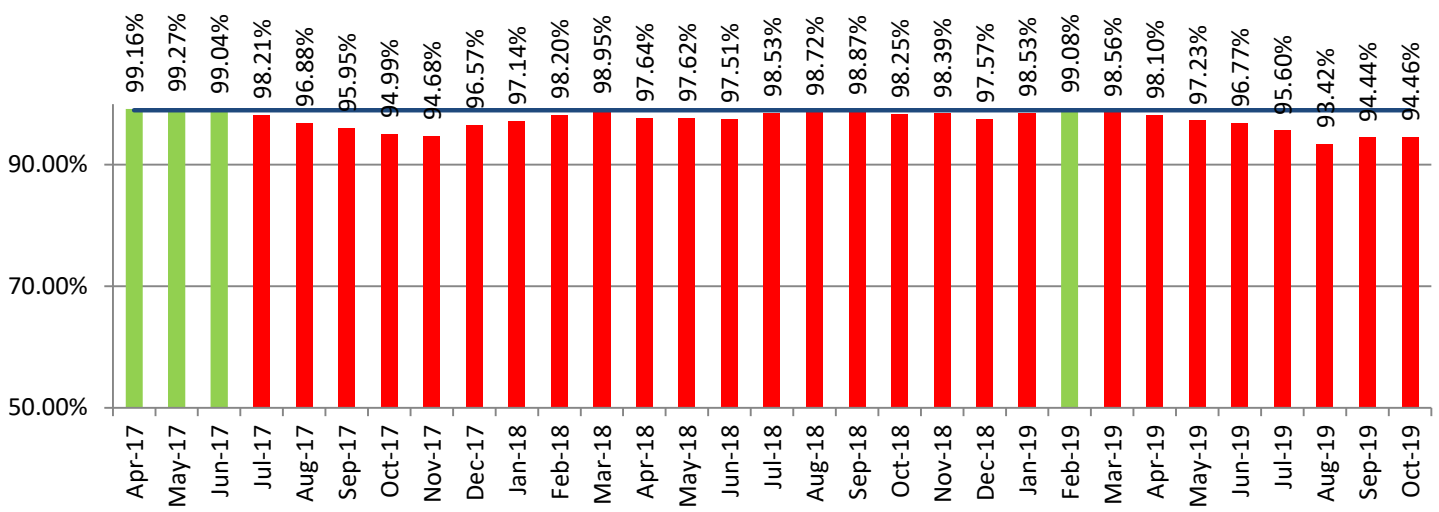
* Indicative

Apr 19	May 19	Jun 19	Jul 19	Aug 9	Sep 19	Oct 19*
75.50%	76.30%	80.95%	80.35%	80.41%	76.34%	77.47%

Regional Rank	Trust	Sep-19
1	Northumbria Healthcare NHS Foundation Trust	90.91%
2	Harrogate and District NHS Foundation Trust	90.91%
3	County Durham and Darlington NHS Foundation Trust	84.49%
4	South Tyneside and Sunderland NHS Foundation Trust	82.09%
5	North Tees and Hartlepool NHS Foundation Trust	80.67%
6	York Teaching Hospitals NHS Foundation Trust	79.44%
7	North Cumbria University Hospitals NHS Trust	77.27%
8	**South Tees Hospitals NHS Foundation Trust**	**76.34%**
9	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	75.13%
11	Gateshead Health NHS Foundation Trust	69.67%
	ENGLAND	**76.89%**

Sep 19 Ranked 8th in the region

6 Week Diagnostic



99% TARGET

Oct 19

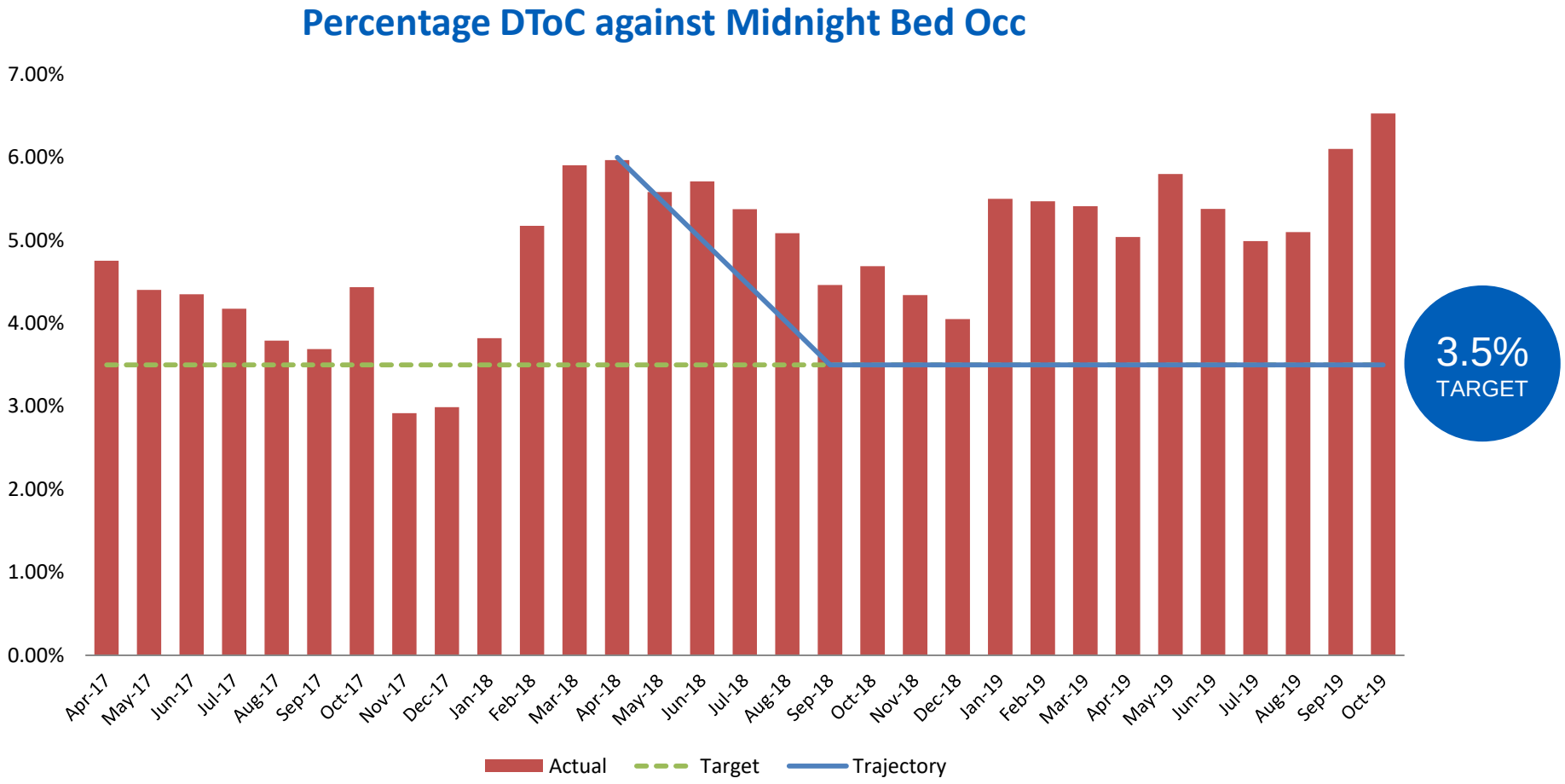
94.46%

6 Week Diagnostic Performance (Target 99%)	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Magnetic Resonance Imaging	99.29%	99.19%	98.65%	99.69%	99.75%	99.83%	99.64%	98.81%	99.78%	99.96%	99.73%	99.89%
Computed Tomography	100.00%	100.00%	100.00%	99.79%	99.92%	99.85%	99.94%	99.93%	99.93%	99.80%	99.93%	99.30%
Non-obstetric ultrasound	97.21%	95.71%	100.00%	100.00%	100.00%	100.00%	99.90%	99.97%	99.90%	99.92%	99.97%	99.93%
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	99.77%	99.74%	99.77%	98.55%	98.83%	96.22%	98.11%	97.99%	94.86%	88.51%	87.10%	86.57%
Cardiology - echocardiography	87.50%	76.00%	100.00%	92.50%	93.62%	92.31%	88.24%	69.70%	83.78%	97.62%	96.88%	100.00%
Cardiology - electrophysiology												
Neurophysiology	99.35%	97.29%	83.07%	95.21%	91.30%	84.09%	70.74%	72.06%	70.64%	66.53%	73.38%	79.23%
Sleep studies	70.59%	54.55%	65.38%	67.31%	50.00%	44.44%	14.29%	22.64%	34.92%	40.00%	49.06%	62.75%
Urodynamics - pressures & flows	61.54%	66.67%	65.63%	47.37%	18.52%	48.00%	52.08%	73.91%	79.07%	85.29%	70.45%	76.47%
Gastro - Colonoscopy	100.00%	100.00%	100.00%	98.41%	94.30%	93.75%	94.86%	89.72%	71.53%	62.66%	64.38%	62.86%
Gastro - Flexi sigmoidoscopy	100.00%	100.00%	100.00%	96.77%	94.12%	92.75%	89.47%	91.49%	74.38%	60.63%	69.51%	65.00%
Urology - Cystoscopy	94.44%	96.77%	96.17%	95.95%	97.18%	100.00%	94.62%	96.07%	96.83%	92.68%	91.84%	95.60%
Gastroscopy	100.00%	100.00%	100.00%	98.32%	95.95%	96.48%	98.11%	90.87%	88.85%	77.52%	83.81%	87.66%
Trust Total	98.39%	97.57%	98.53%	99.08%	98.56%	98.10%	97.23%	96.77%	95.60%	93.42%	94.44%	94.46%

Operational Management

2

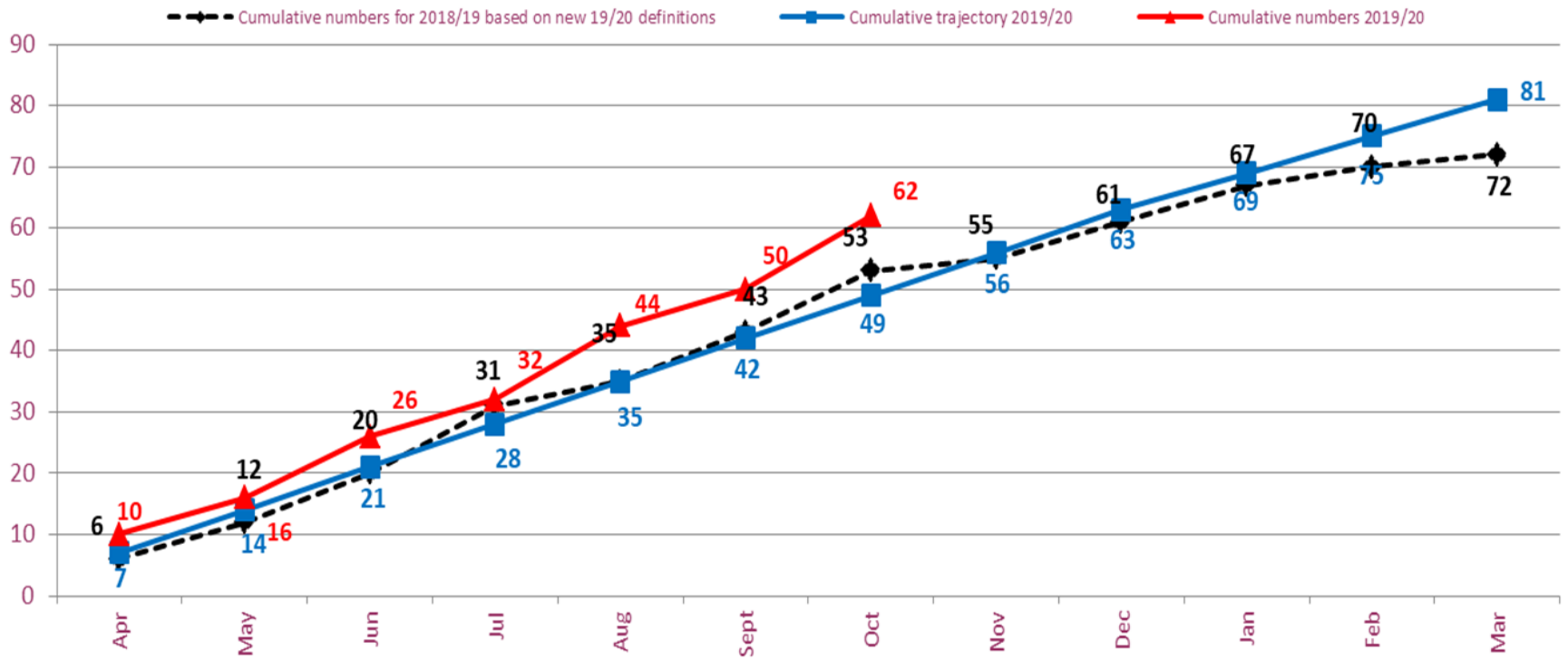
Delayed Transfer of Care (DToC)



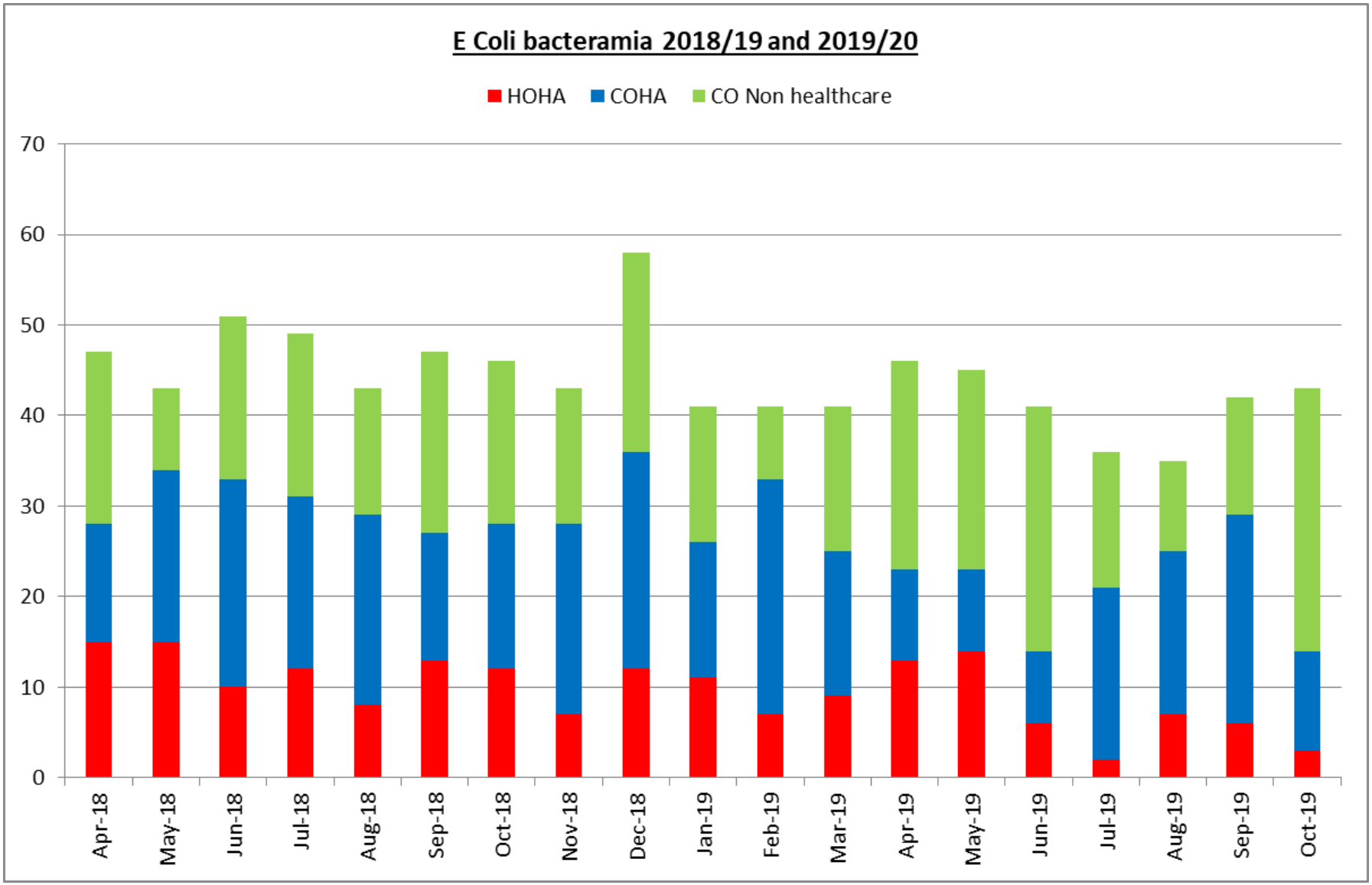
Patient Safety, Outcome and Experience

3

Clostridium difficile cases - April 2019 to March 2020

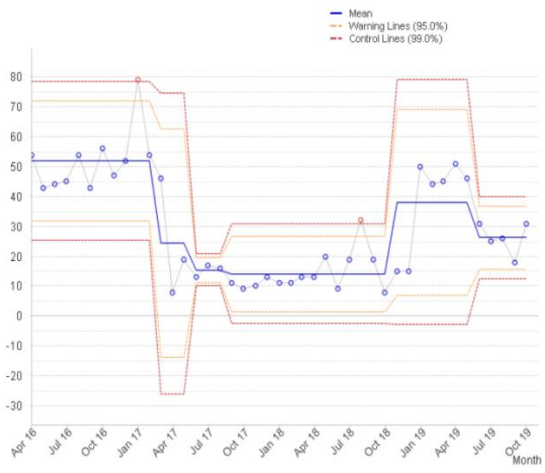


Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
JC34 (HOHA)	JC02 (COHA)	ITU3 (HOHA)	Ward 7 (COHA)	Ward 6 (COHA)	JITU2 (HOHA)	Ward 34 (HOHA)					
JCSSU (HOHA)	Gara (HOHA	GHDU (HOHA)	Ward 5 (COHA)	Gara (COHA)	Friary (HOHA)	Ward 37 (COHA)					
JC33 (COHA)	JC10 (COHA)	Victoria (HOHA)	Ward 37 (HOHA)	Ward 34 (HOHA)	Ward 6 (HOHA)	Ward 21 (COHA)					
FHCDU (COHA)	ZET (HOHA)	Ward 10 (HOHA)	Romanby (COHA)	Ward 5 (HOHA)	Ward 7 (HOHA)	Ward 3 (HOHA)					
RAFAU (COHA)	JCITU2 (HOHA)	Ward 7 (HOHA)	Ward 7 (HOHA)	Ward 27 (HOHA)	Ward 14 (HOHA)	ITU 2 (HOHA)					
JC37 (COHA)	JC03 (COHA)	Ward 36 (HOHA)	Ward 7 (HOHA)	Ward 29 (COHA)	Ward 14 (COHA)	ITU 3 (HOHA)					
RAFAU (HOHA)		Romanby (HOHA)		Rutson (HOHA)		Ward 14 (COHA)					
JC09 (HOHA)		Ward 7 (HOHA)		RAFAU (HOHA)		Ward 11 (HOHA)					
JCCT (COHA)		Ward 27 (HOHA)		RAFAU (HOHA)		SIRU (HOHA)					
RAFAU (COHA)		Ward 25 (HOHA)		Ward 37 (HOHA)		Ward 4 (HOHA)					
				Ward 37 (COHA)		Ward 9 (HOHA)					
				Ward 6 (HOHA)		RAFAU (COHA)					


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
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

Delivering Safe Care 19/20

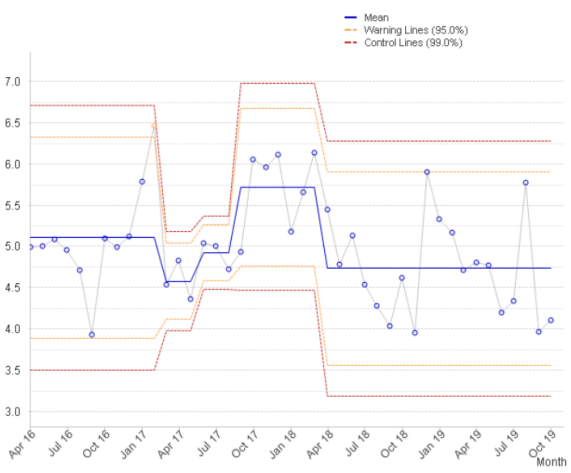
New or deteriorating category 2 pressure ulcers October 2019



Inpatient rate is 1.8 per 1000 bed days.

31 community category 2 pressure ulcers

Falls October 2019



Rate 4.1 per 1000 bed days.

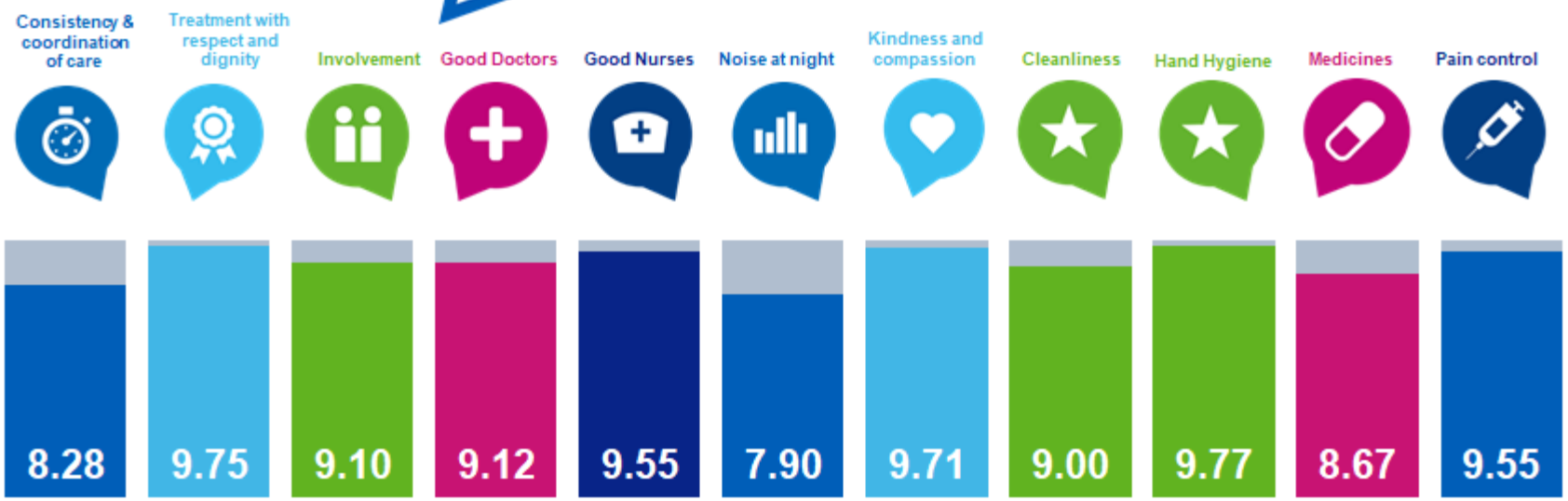
Continued Focus on Refreshed Pressure Ulcer Prevention Strategies

Patient Experience

Trust

How do patients rate us out of 10…?

NHS
South Tees Hospitals
NHS Foundation Trust



In October 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	347	No of respondents	661

People

4

HR Workforce Data

Sickness

0.07% increase on September. Short Term was 1.82% up 0.20%, Long Term 2.65%, down by -0.14%. Sickness rate at 4.48% is -0.44% lower than October 2018. Long Term is at lowest rate since May 2018 and 0.88% lower than October 2018. Stress/Anxiety accounts for the most fte days lost, 3,461.97 and accounts for over a third of all sickness. In October 237 staff were absent with Stress/Anxiety with an average of 14.5 days per employee. Other musculoskeletal is next highest with 1,194.99 fte days lost. General Surgery & Gynae Theatres have the highest overall sickness followed by Spinal Injuries Unit JCUH.

Training

3.02% increase on September. Highest compliance since March 2019. Areas of concern are ENT Medical Secs Admin – 54.76% followed by Ophthalmology Secs Admin – 55.71%. Portfolio of concern is Trauma & Orthopaedics – 80.58% followed by Plastics, Dermatology & Ophthalmology – 81.55%. CS Centre Management is the best performing Portfolio – 100% followed by Paediatrics & Neonatology – 96.53% Of the Core 7, Information Governance has the lowest compliance – 80.58% followed by Safeguarding Adults – 87.63%.

Appraisals

Met target for 4th month running. Compliance has increased by 9.60% in last 12 months. Areas of concern are OT care at Home – 9.09% followed by Middlesbrough Intermediate Care and Pulmonary Rehab with 16.67%. CC Centre Management is a concern with 50% followed by Community & Palliative Care with 64.52%. UEC Centre Management is the best performing Portfolio – 96.23%

Reminders continue to be sent by HR to all staff and managers that are overdue. Of the 1453 overdue, 713 are from 2018, 538 from 2017 and 202 from previous years.

Turnover

Increase in fte of 181.05 in last 12 months. 64% of all leavers are due to Voluntary Resignation with the next highest being Retirement – 15.47% although of these 37.24% are Flexi Retirements. Turnover at 10.96% is 1.43% lower than 12 months ago.

Employee Relations

113 cases received in the last 12 months of these 65 being Disciplinary. 15 of these were due to Inappropriate Behaviour followed by 8 due to Negligence. Of the 65 Disciplinary cases 21 or 32.31% were within Nursing & Midwifery registered which also the largest staff group with 32.17% of all staff. Additional Clinical Services had the next highest cases with 17 or 26.15% whereas they only account for 22.23% of all staff.

General Update

New staff side Partnership Agreement has been adopted.

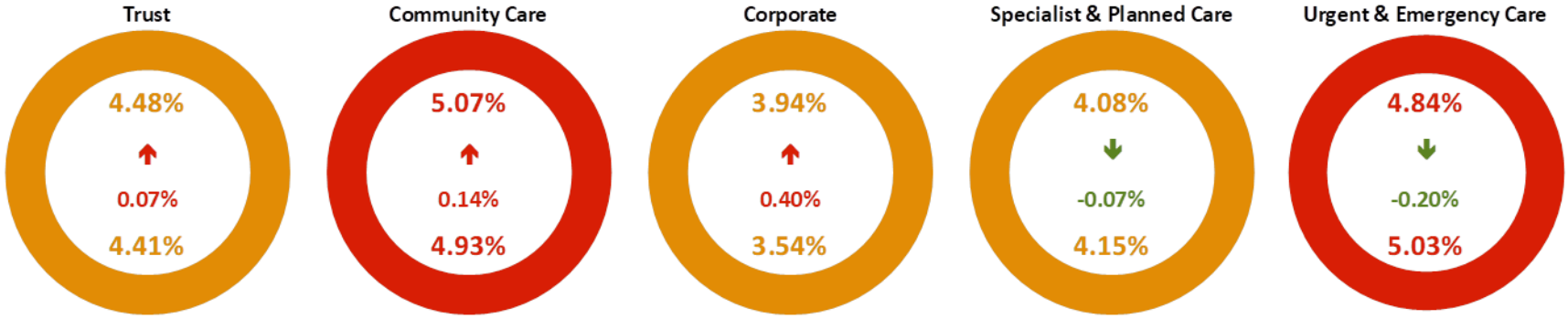
Weekly meeting with CEO and staff side colleagues continues.

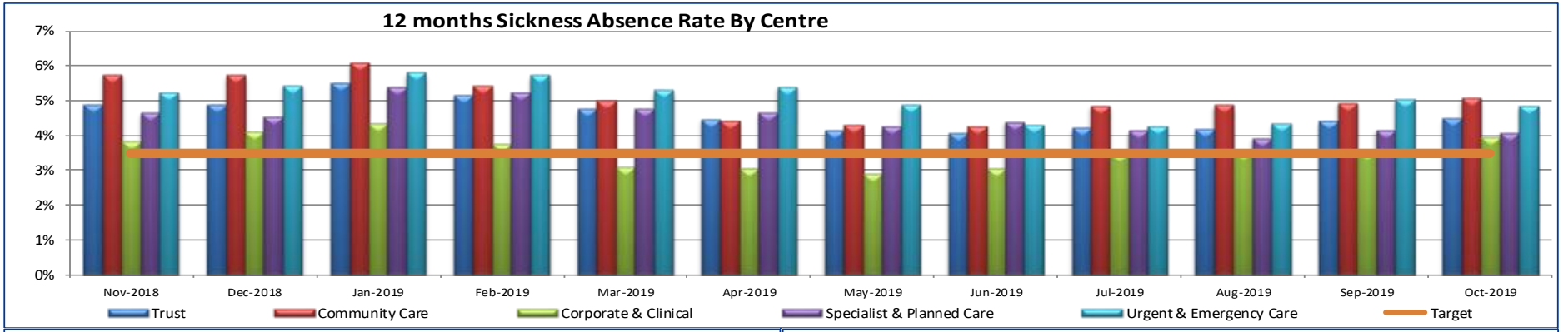
Staff Engagement Session took place with 15 participants, and the recommendation that we adopt the NHS Values rather than the current South Tees Values.

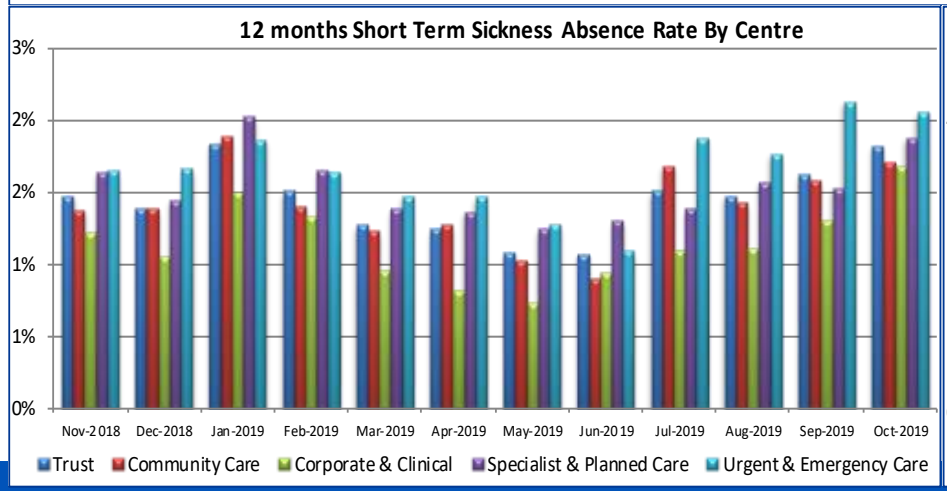
800 Rainbow badges have been distributed and our rainbow flag has arrived.

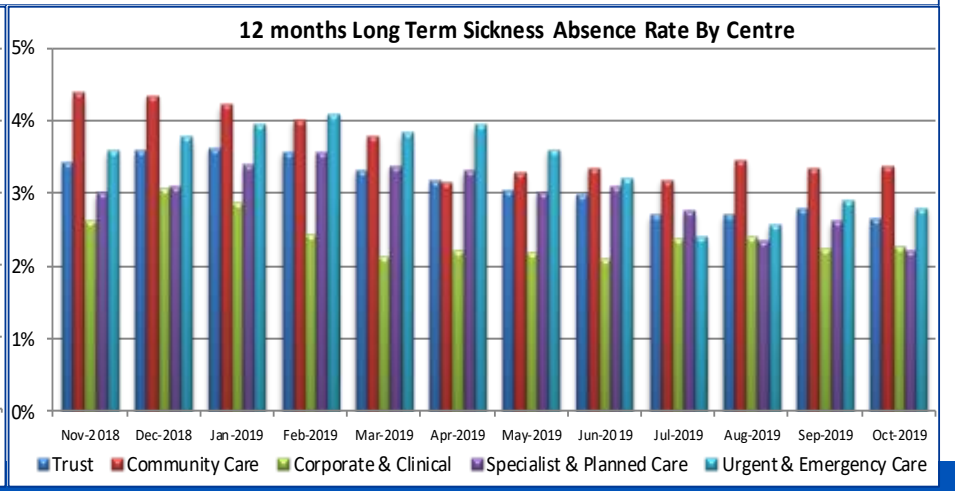
Our flu vaccination rate is currently 58% and we are 2nd across the region.

Sickness


Trust
4.48%
0.07%
4.41%
Community Care
5.07%
0.14%
4.93%
Corporate
3.94%
0.40%
3.54%
Specialist & Planned Care
4.08%
-0.07%
4.15%
Urgent & Emergency Care
4.84%
-0.20%
5.03%


12 months Sickness Absence Rate By Centre
7%
6%
5%
4%
3%
2%
1%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Community Care
Corporate & Clinical
Specialist & Planned Care
Urgent & Emergency Care
Target


12 months Short Term Sickness Absence Rate By Centre
3%
2%
2%
1%
1%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Community Care
Corporate & Clinical
Specialist & Planned Care
Urgent & Emergency Care


12 months Long Term Sickness Absence Rate By Centre
5%
4%
3%
2%
1%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Community Care
Corporate & Clinical
Specialist & Planned Care
Urgent & Emergency Care

Top 10 Sickness by Ward/Department

All Sickness

Rank	Ward/Department	FTE	% Rate
1	General Surgery & Gynae Theat	61.45	6.57%
2	Spinal Injuries Unit JCUH	44.85	9.27%
3	Central Delivery Suite	65.87	5.94%
4	Ward 7 Colorectal	40.23	9.47%
5	Ward 2 Acute Medicine	42.15	8.47%
6	Orthopaedic Theatres	36.16	10.69%
7	Surgical Day Unit JCUH	52.11	6.75%
8	Catheter Lab	36.20	9.41%
9	Haematology	48.84	6.88%
10	CSSD FHN	15.76	20.33%

Short Term

Rank	Ward/Department	FTE	% Rate
1	Anaesthetics And Recovery JCUH	85.67	7.11%
2	A & E Department JCUH	169.80	4.60%
3	Pharmacy Department	126.21	4.54%
4	District Nursing Redcar & Cleveland	85.09	6.14%
5	Tocketts Ward ECH	47.39	12.99%
6	ICU JCUH	117.40	6.37%
7	District Nursing Middlesbrough	84.10	6.02%
8	Improve Community	18.80	10.98%
9	Ward 2 Acute Medicine	42.15	8.47%
10	Medical Records JCUH	69.33	6.71%

Long Term

Rank	Ward/Department	FTE	% Rate
1	Neonatal Unit	95.57	9.78%
2	ICU JCUH	117.40	6.37%
3	A & E Department JCUH	169.80	4.60%
4	Tocketts Ward ECH	47.39	12.99%
5	Cardiothoracic ITU	71.60	6.80%
6	Anaesthetics And Recovery JCUH	85.67	7.11%
7	Clinical Decisions Unit FHN	50.70	9.99%
8	Pharmacy Department	126.21	4.54%
9	CSSD FHN	15.76	20.33%
10	District Nursing Middlesbrough	84.10	6.02%

Includes only Wards/Departments with greater than 5.0 WT Scoring is calculated by taking the FTE and multiplying by the % Absence Rate

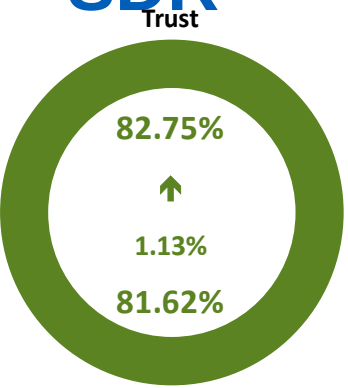
Top 10 Sickness Reasons By FTE Days Lost

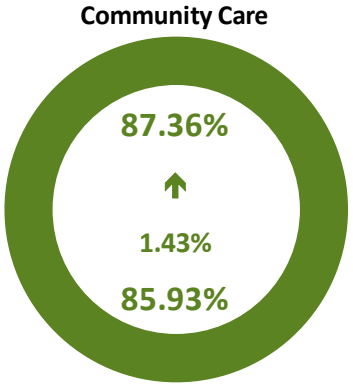
Absence Reason	Headcount	FTE Days Lost	Abs Estimated Cost	% of All Sickness
Stress/Anxiety	237	3,461.97	£300,024.05	33.1
Other musculoskeletal	96	1,194.99	£94,187.10	11.4
Gastrointestinal	316	975.13	£83,400.43	9.3
Injury, fracture	55	682.86	£55,787.71	6.5
Cold, Flu	230	675.27	£61,342.62	6.5
Back Problems	53	551.45	£48,220.34	5.3
Genitourinary & gynae	44	427.34	£35,193.63	4.1
Pregnancy related	35	309.32	£28,644.70	3.0
Chest & respiratory	50	286.84	£26,057.20	2.7
Tumours, Cancer	15	266.01	£23,213.98	2.5

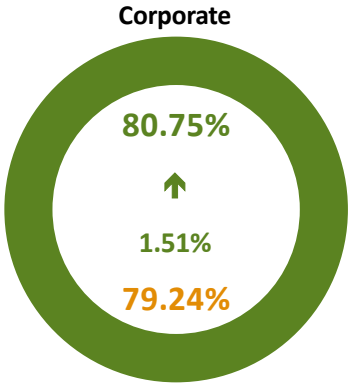
Total estimated cost = Salary Based Absence Cost OSP OMP Adjusted + Employers Cost OSP OMP Adjusted.

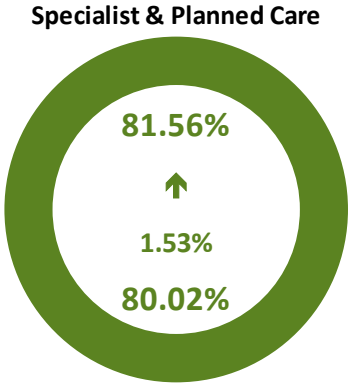
Please note, because ESR does not record shift patterns, this is only an estimate using the assignment FTE and calendar days.

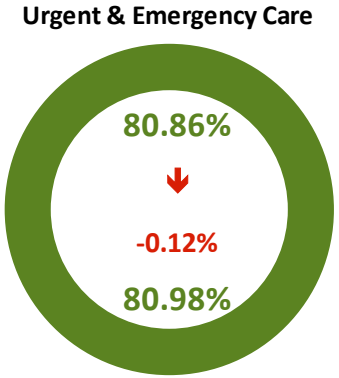
SDR

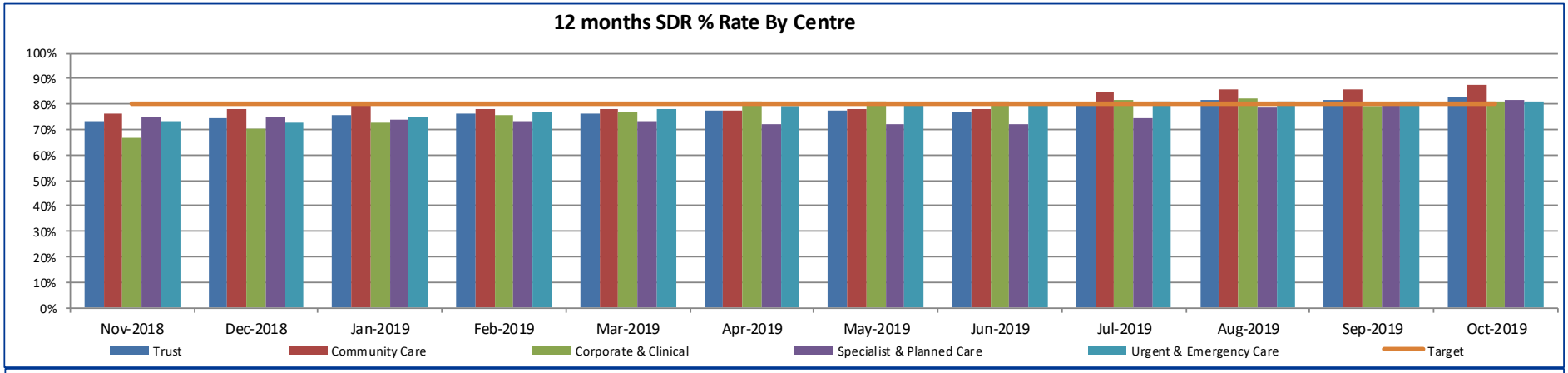

Trust
82.75%
1.13%
81.62%

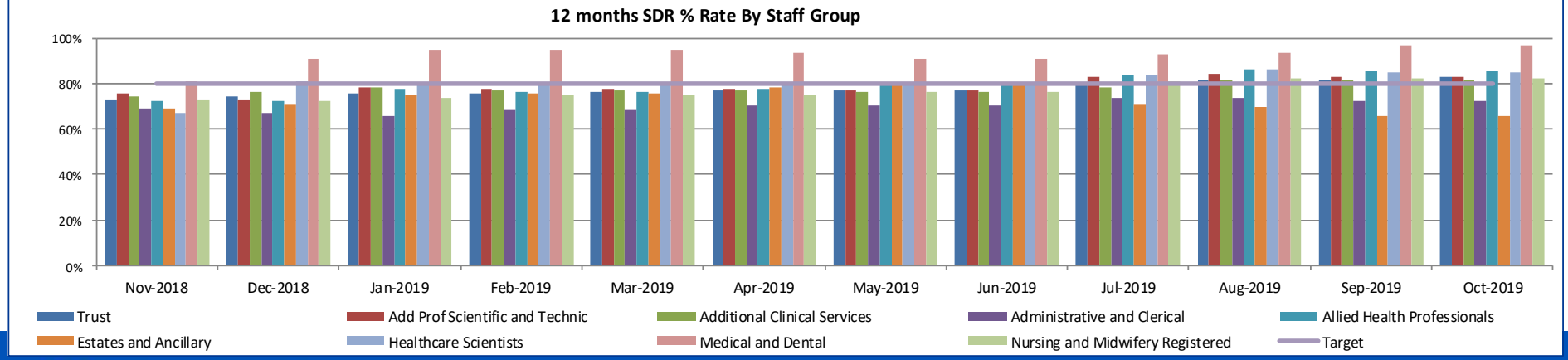

Community Care
87.36%
1.43%
85.93%


Corporate
80.75%
1.51%
79.24%

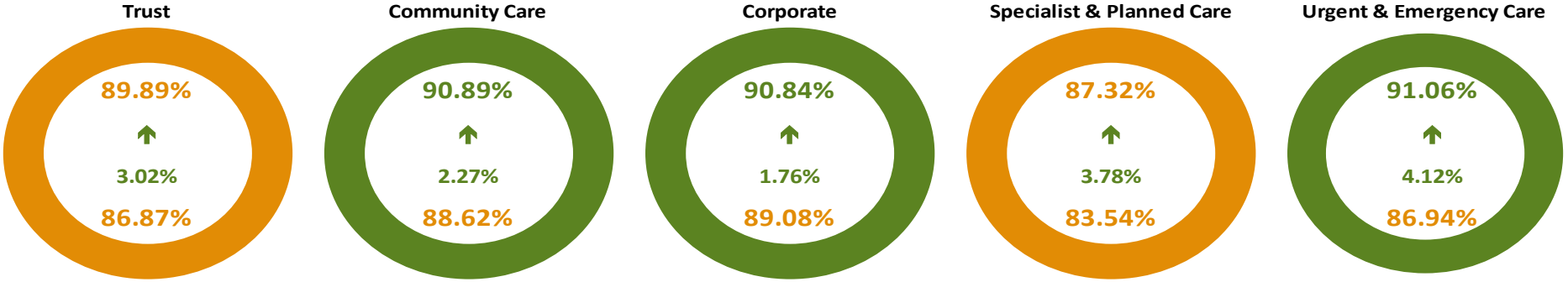

Specialist & Planned Care
81.56%
1.53%
80.02%

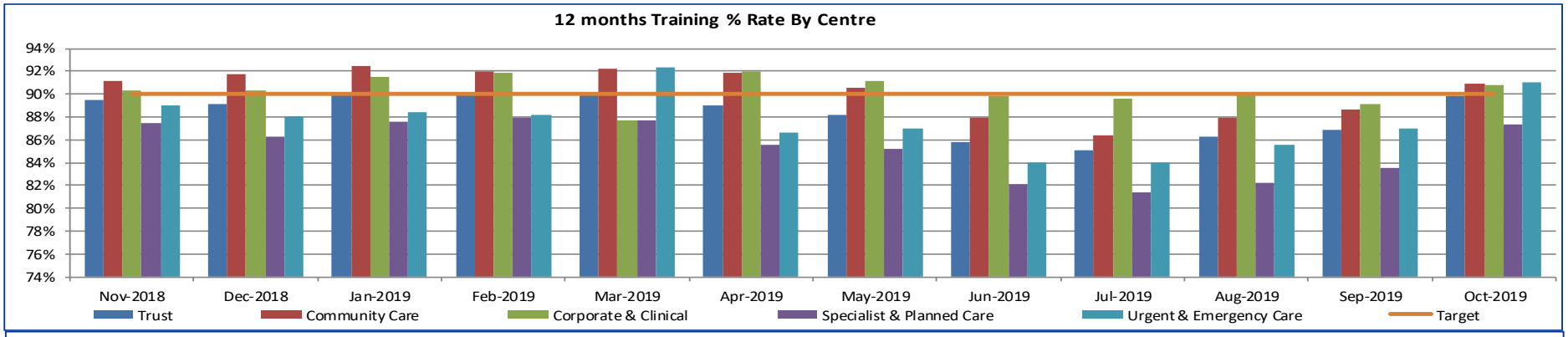

Urgent & Emergency Care
80.86%
-0.12%
80.98%

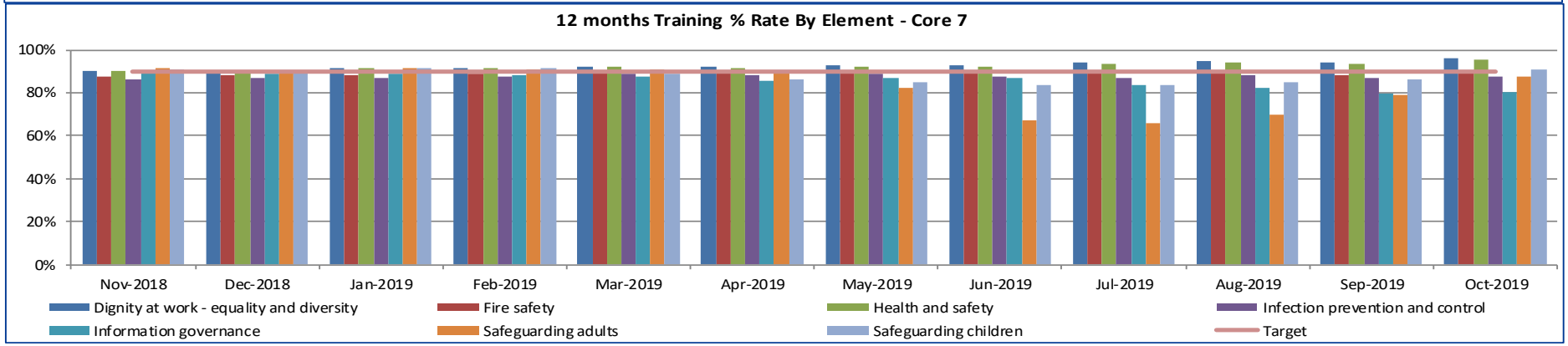

12 months SDR % Rate By Centre
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Community Care
Corporate & Clinical
Specialist & Planned Care
Urgent & Emergency Care
Target


12 months SDR % Rate By Staff Group
100%
80%
60%
40%
20%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Add Prof Scientific and Technic
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered
Target

Training


Trust
89.89%
3.02%
86.87%
Community Care
90.89%
2.27%
88.62%
Corporate
90.84%
1.76%
89.08%
Specialist & Planned Care
87.32%
3.78%
83.54%
Urgent & Emergency Care
91.06%
4.12%
86.94%


12 months Training % Rate By Centre
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
74%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Trust
Community Care
Corporate & Clinical
Specialist & Planned Care
Urgent & Emergency Care
Target


12 months Training % Rate By Element - Core 7
100%
80%
60%
40%
20%
0%
Nov-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Dignity at work - equality and diversity
Fire safety
Health and safety
Infection prevention and control
Information governance
Safeguarding adults
Safeguarding children
Target

Employee Relations

Employee Relations Cases received

Month	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019
Grievance	7	4	5	5	1	1	2	1	0	0	2	2
Disciplinary	6	0	13	10	6	4	4	4	5	4	4	5
Capability	0	1	2	0	1	1	0	0	2	0	1	0
Dignity at Work	0	0	2	2	0	0	1	2	1	1	0	1
Total	13	5	22	17	8	6	7	7	8	5	7	8

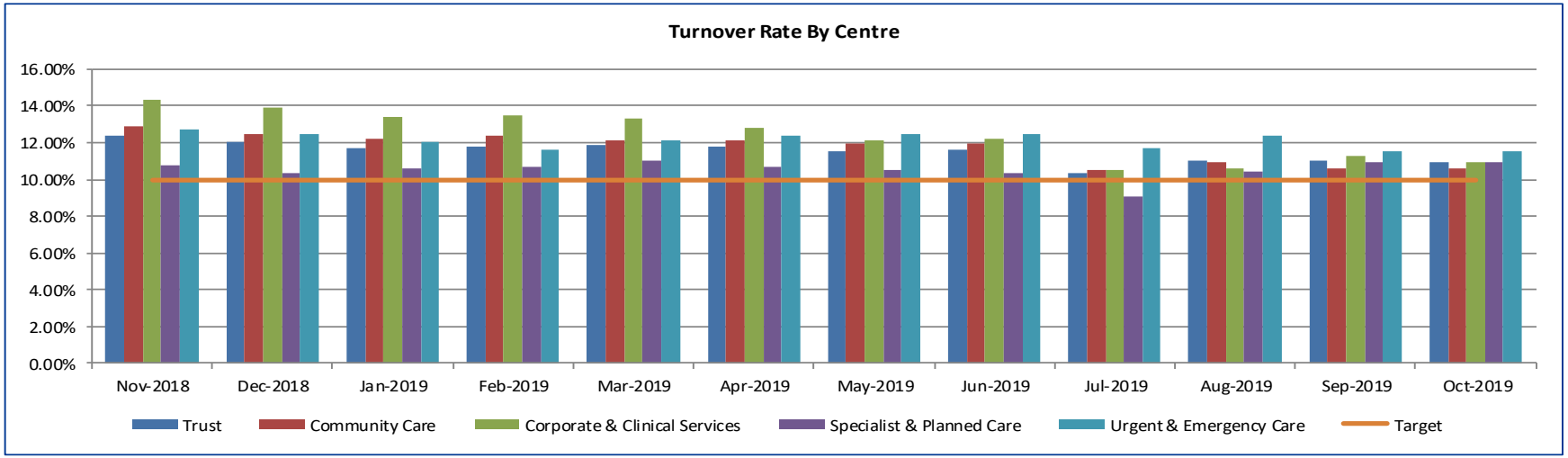
Reasons for Disciplinary Cases

Nature of Allegation	Community Care	Corporate & Clinical Services	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
Breach of confidentiality	1	1		3	5
Breach of Health and Safety Requirements		2			2
Disregard of instructions		2		2	4
Failure to Renew Prof Reg	2		3	1	6
Falsification of records	1				1
Fraud	2				2
Inappropriate Behaviour	5	3	4	3	15
Inappropriate use of NHS resources			1	1	2
Maltreatment of other Worker				1	1
Maltreatment of Patient / Client	6		1		7
Misconduct	4	1	1	1	7
Negligence	4		3	1	8
Other Allegation	1		1		2
Theft of Money or materials	1	1	1		3
Total	27	10	15	13	65

Staff in Post & Turnover

Staff in Post by FTE

Centre	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019
Community Care	2082.38	2082.52	2094.391	2097.484	2101.994	2091.718	2000.51262	1919.106	1929.45	1896.123	1915.062	1931.976
Corporate & Clinical Services	1595.303	1592.263	1591.749	1598.209	1596.729	1590.189	1595.53596	1611.906	1634.873	1645.453	1650.902	1676.77
Specialist & Planned Care	2113.272	2102.892	2094.258	2093.291	2079.771	2081.957	2133.90692	2163.39	2175.83	2187.016	2200.399	2226.834
Urgent & Emergency Care	1586.35	1586.185	1607.915	1612.835	1619.224	1616.664	1645.87417	1667.481	1671.026	1664.8	1717.848	1722.771
Trust	**7377.304**	**7363.859**	**7388.313**	**7401.819**	**7397.719**	**7380.528**	**7375.82967**	**7361.883**	**7411.178**	**7393.392**	**7484.212**	**7558.35**



Leavers By Reason

Reasons	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Total
Dismissal	4	1	2	3	4	2	4	1	2	2	4	2	31
End of Fixed Term	4	3	3	8	2	1	4	1	5	50	8	4	91
Flexi Retirement		3	1	3	6	4	8	9	4	2	10	4	54
Redundancy	1	2	1	4	1	1	1				1		12
Retirement	11	12	6	7	20	19	15	11	12	9	10	13	145
Voluntary Resignation	54	52	55	38	60	42	37	51	48	65	69	31	600
Grand Total	**74**	**73**	**68**	**63**	**93**	**69**	**69**	**73**	**71**	**128**	**102**	**54**	**937**

Finance

5

Summary Financials - YTD October 2019

Community Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	2,533	2,844	311
Pay	(54,225)	(54,632)	(407)
Non Pay	(22,690)	(23,174)	(483)
Total	(74,382)	(74,962)	(579)

Corporate Clinical Services	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	13,162	14,139	977
Pay	(21,790)	(21,843)	(53)
Non Pay	(10,286)	(11,244)	(958)
Total	(18,913)	(18,948)	(35)

Specialist & Planned Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	2,065	2,084	19
Pay	(69,255)	(69,442)	(187)
Non Pay	(49,693)	(48,825)	868
Total	(116,883)	(116,183)	700

Urgent & Emergency Care	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	621	608	(13)
Pay	(50,745)	(51,563)	(818)
Non Pay	(7,558)	(7,697)	(139)
Total	(57,682)	(58,652)	(970)

Corporate	YTD Budget £	YTD Actual £	YTD Variance £
Nhs Clinical Income	334,759	334,234	(525)
Other Income	8,829	6,262	(2,567)
Pay	(21,722)	(19,872)	1,850
Non Pay	(42,914)	(52,445)	(9,531)
Depreciation And Interest	(13,928)	(13,504)	423
Other Non Operating	(3,634)	(3,575)	58
Restructuring Costs	(292)	(365)	(73)
Total	261,099	250,735	(10,364)

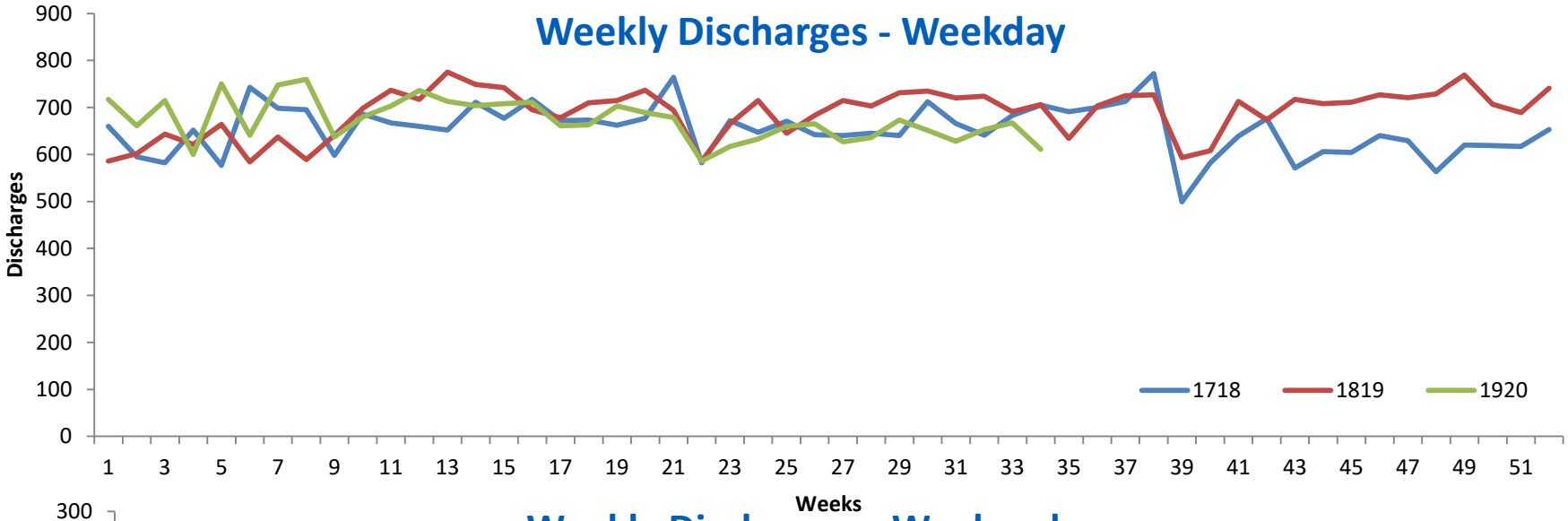
Shm Pharmacy	YTD Budget £	YTD Actual £	YTD Variance £
Other Income	07	08	0
Pay	(39)	(23)	16
Non Pay	(15)	(14)	01
Total	(47)	(29)	17
Total	(6,808)	(18,039)	(11,231)

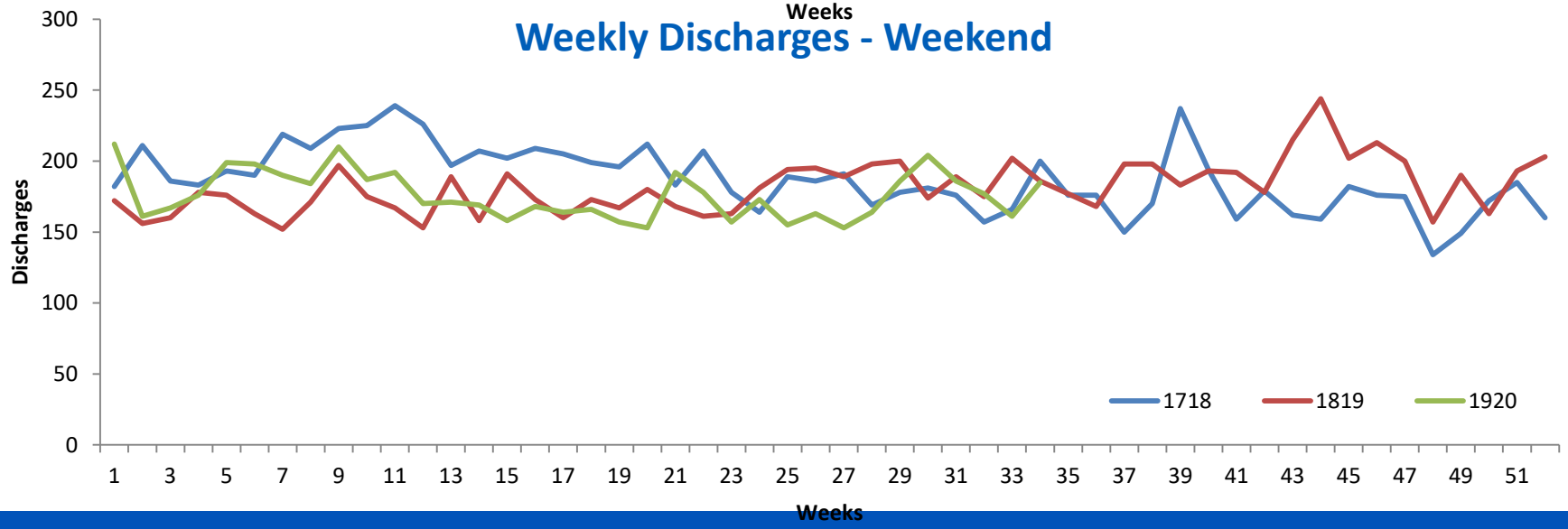
- **Trust headlines YTD M7**
- **Control total**
- Behind plan by £11.2m
- Loss of PSF funding £2.9m, £9.1m being undelivered system savings, underlying underspend of £0.8m
- Full year plan is a control total surplus of £3.2m
- **Productivity and Efficiency savings**
- YTD savings of £5.6m

Appendices

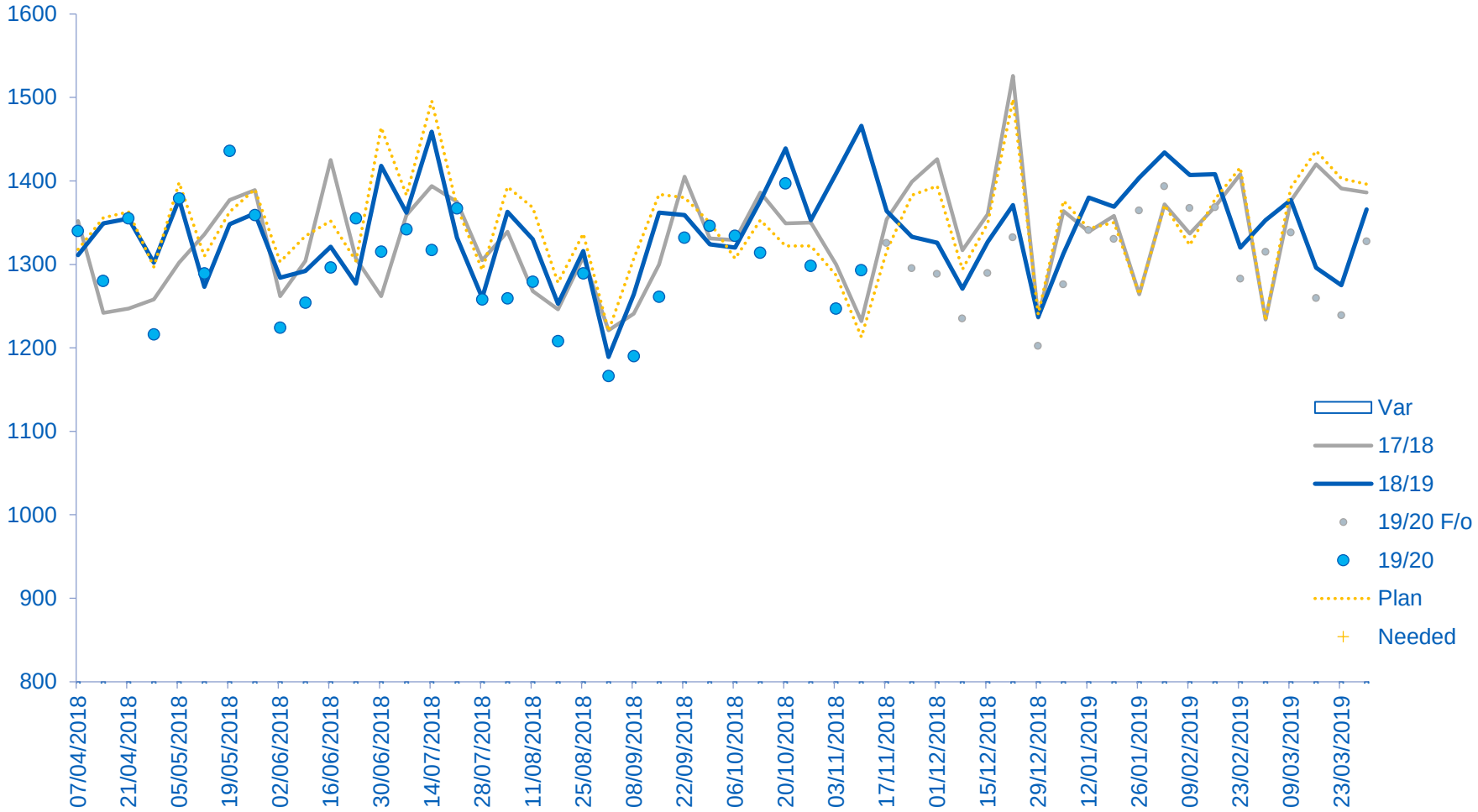
6

JCUH Adult Ward Discharge Rates



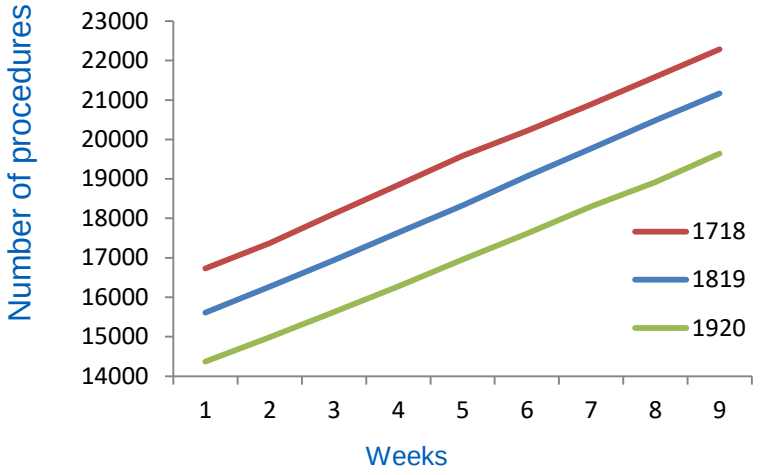


Non-Elective Delivery - All



Elective – Theatre Throughput

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

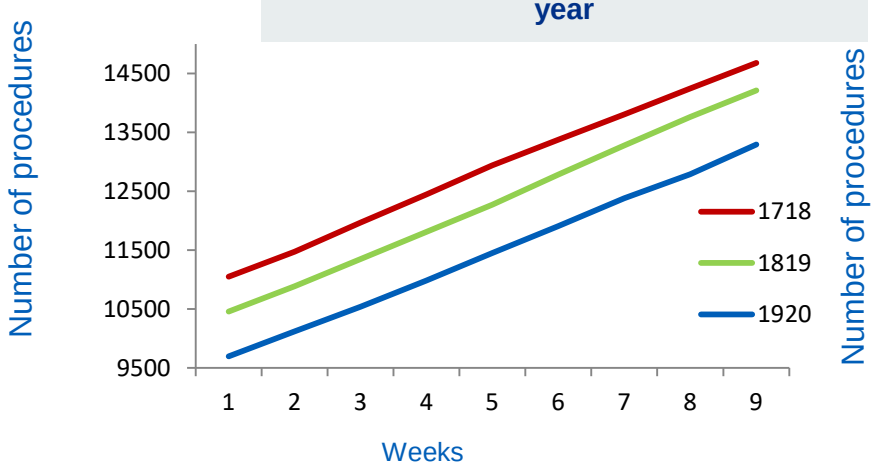


5.1% *less* cases undertaken in last 9 week period this year when compared to last.

YTD 7.2% *less* than last year

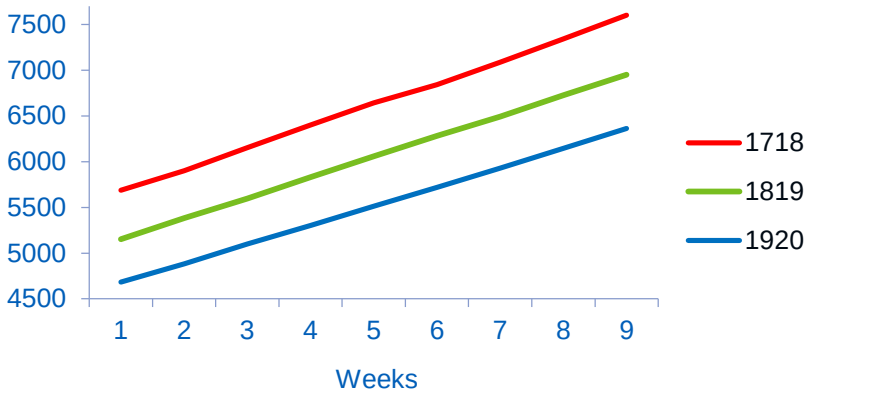
Elective day case

YTD 6.5% *less* when compared with last year



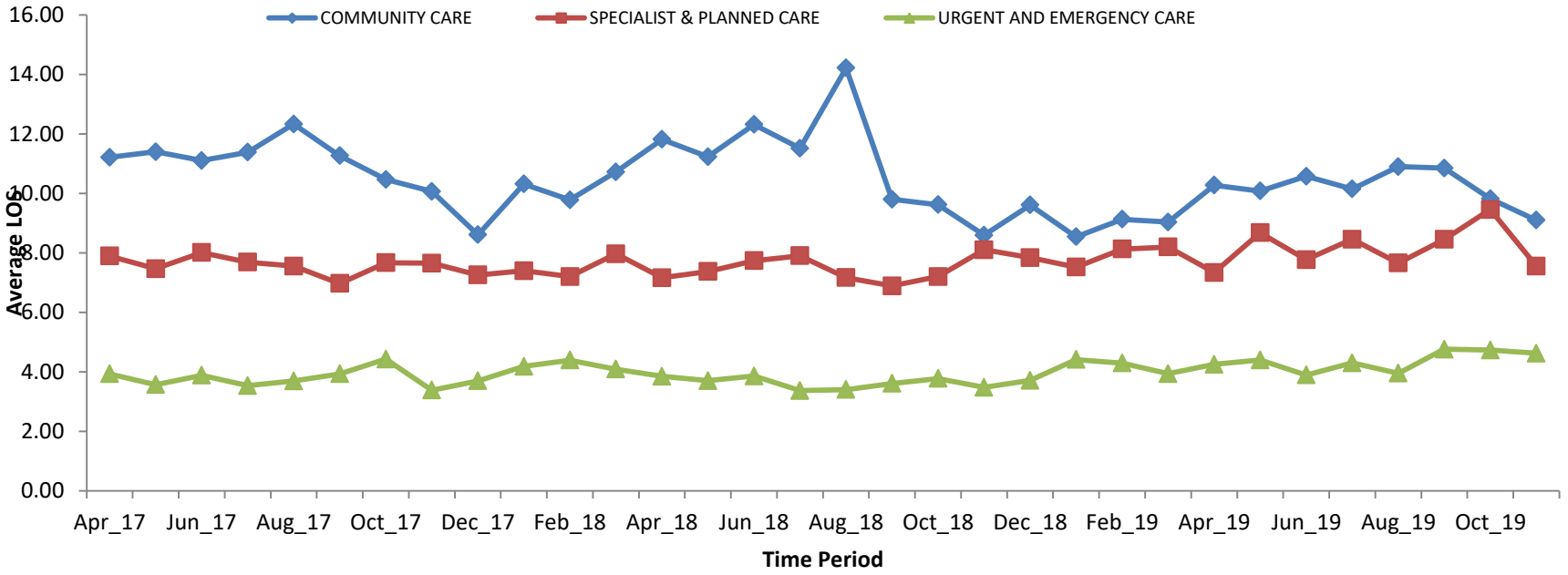
Elective overnight

YTD 8.5% *less* when compared with last year



Emergency Length of Stay by Centre

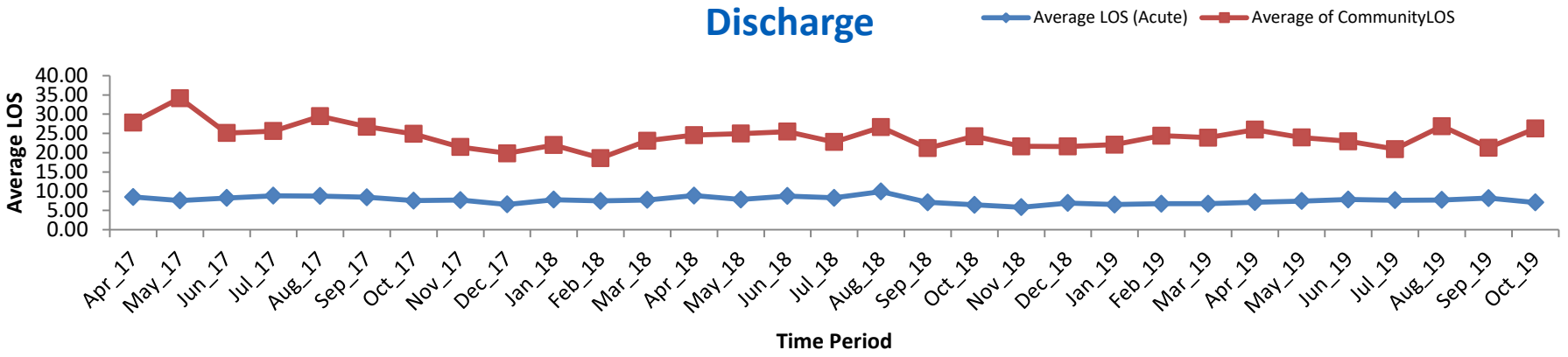
Emergency LOS by Centre at Discharge - 1st April 17 - 24th Nov 19



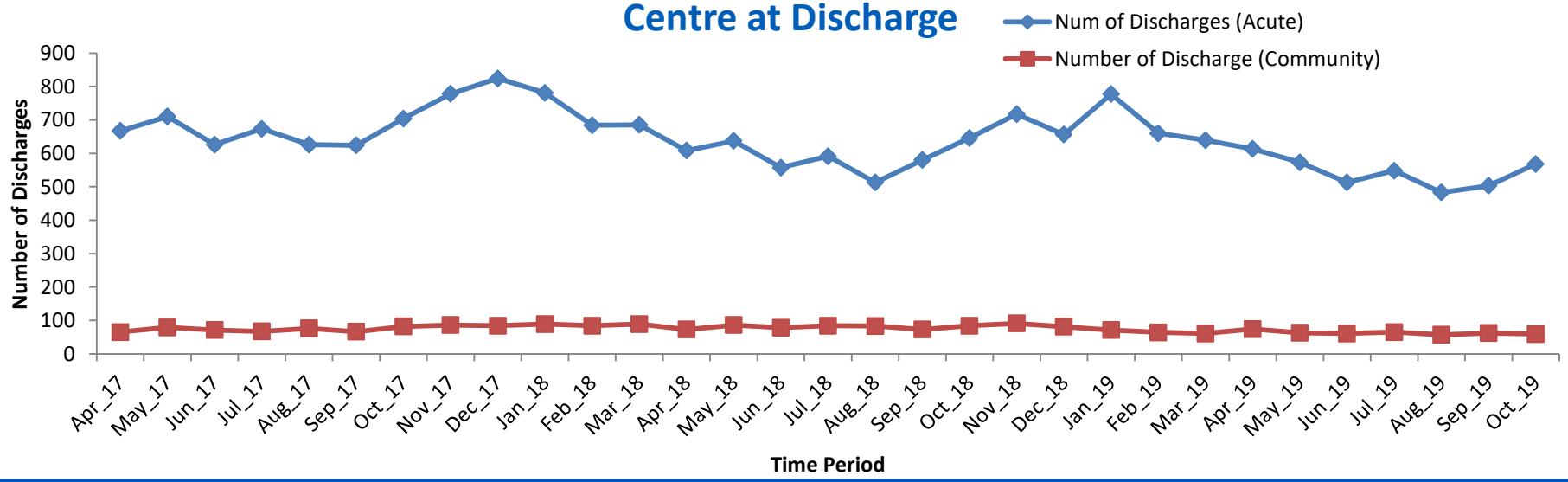
AVG LOS				
Centre	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1718	10.7	7.6	3.9	7.2
1819	10.4	7.6	3.8	6.9
1920	10.4	8.3	4.3	7.3

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 – 3 December 2019			
CQC Action Plan Progress Report			**AGENDA ITEM: 16, ENC 9**
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 the regulatory breaches ('must do' actions) and also 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 and those with financial implications.		
Recommendation	For Board of Directors to be made aware and to discuss progress with all actions on the action plan tracker and to be made aware of the actions that have not been delivered within agreed timescales and what the mitigating actions are to bring these back on track. For Board of Directors to be made aware of the actions that have financial implications. For Board of Directors to receive an update on the NHSI 'Moving to Good' programme which the Trust has joined.		
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 the 26 regulatory notices, the 'Must Do's and the 23 'Should Do's' from the inspection report. It has also been shared with both the CQC and the CCG's.

The CQC Oversight Group meets 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 are 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.

A detailed action plan is in place and monitored and updated daily on progress and now includes the financial resources are required and when actions are relevant Trust wide.

2. BACKGROUND

Following the CQC inspection of the Trust which was carried out between the 15th January and the 23rd February where the Trust was rated overall as 'requires improvement'. The Trust was rated good for the caring and responsive domains.

A detailed action plan has been developed to address all the 'must do' actions and also the 'should do' actions and this has been submitted to the CQC.

A dedicated CQC mailbox has been set up – stees.cqc@nhs.net and all evidence relating to CQC actions and responses to CQC information requests will be sent and received via this mailbox.

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

3. DETAILS

The attached action plan provides details of the current state of all the actions. There are now 164 actions (one action has been removed and is detailed in this report). The tables below show the number of actions that have been completed and the number of actions rated red due to either action not being completed by the required time or lack of evidence to demonstrate that the action has been completed.

The actions have also been separated into the 'must do' actions and the 'should do' actions and the actions that have a financial implication.

A breakdown is provided below.

All actions

Completed	86
In progress – and on track	32
In progress – significant risks to delivery or outcomes identified	46
Total	**164**

Of the 46 actions which are currently rated red, there are only 25 of these actions deemed to be 'true red' actions, with the remaining 21 being turned to green and marked as complete, once the relevant evidence had been received from the leads. It should be noted that there a number of actions which relate to the same issue (i.e. 4 relating to SI reporting and 2 relating to procurement of the Datix upgrade)

The 25 'true red' actions consist of 18 'must do' actions and 7 'should do' actions. The table overleaf shows the actions which are currently classed as 'true red'

CQC Required actions	Proposed Resolution	Mitigation	Should do or must do	Responsible Director
2. Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the Organisation (as per 19/20 Quality Priority Action Plan - link to plan in evidence column)"	2.4 Ensure all Serious Incidents are reported within 48 hours from May 2019	This is reported in the monthly quality report however the action has been left as red as the Trust is not reporting all SI's within 48 hours of the incident being identified.	Must do	Gill Hunt, Director of Nursing and Quality
"18. Review the policy for the storage of patient records and ensure they are stored securely when unattended"	18.1 Ensure all notes trolleys can be locked when unattended	This has been left red as the notes trolleys / locks have been ordered but not delivered /fitted. All ward managers are aware of the need to ensure notes are not unsecure when not attended. This has been added to the daily nurse in charge checklist and overseen by the matrons.	Must do	Gill Hunt, Director of Nursing and Quality
"19. Ensure that the compelling case for an electronic patient record as an essential component of delivering contemporary healthcare to support patient safety is made at regional and national level"	19.1 Secure funding for an EPR	Remains red as funding for an EPR has not been secured	Must do	Steven Mason, Director of Finance

"20. Review compliance with the risk management process from Ward to Board"	20.1 Review all Directorate and Centre Risk Registers to ensure they accurately reflect risks	Work is ongoing to review risk registers	Must do	Kevin Oxley, Director of Estates
	20.2 Review the risk escalation process from Directorate Risk Register to Board Assurance Framework	The process has been reviewed but further assurance that escalation is embedded in practice is required	Must do	Kevin Oxley, Director of Estates
	20.3 Identify barriers to risk escalation, devise and implement a comms and engagement strategy to raise awareness of risk management and address barriers	Draft strategy to be ratified and implemented	Must do	Kevin Oxley, Director of Estates
Must Do	24.1 To ensure clear and appropriate training requirements for each specific staff group	Awaiting evidence	Must do	Rachael Metcalfe, Director of HR
"28. Ensure that the environment is suitable for the purpose and is compliant with paediatric standards"	28.2 Strategic overview of Trust position and plans for the future management of children in the Emergency Care setting in line with RCPYP is made explicit	Remains a red as there is still a need for a dedicated paediatric ED	Must do	Adrian Clements, Medical Director

	and documented, including the need for capital investment for a dedicated Paediatric ED			
	28.3 Evidence of risk and mitigation documented on the risk register and escalated	Awaiting evidence	Must do	Adrian Clements, Medical Director
The Trust must take action to ensure that the environment is suitable for the purpose being used and is secure and compliant with current standards especially for paediatric patients and patients with mental health needs (Reg 12)	29.3 Commission and completion of minor works to ensure that the disabled toilet is ligature free	Funding agreed and parts ordered.	Must do	Adrian Clements, Medical Director
"43. Specialist Pharmacy posts available in line with GPICS standards"	43.1 Staffing in post in line with GPICS standards	RAG rating changed to red as the staff will not be in post by January although recruitment has commenced. It is suggested the date for this action to be completed should be amended.	Must do	Gill Hunt, Director of Nursing and Quality
"49. Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the Organisation	49.2 Re-launch the upgraded Datix system with associated communication and engagement plan	Procurement and business planning process requires clarification by the DoF and DoE&IT. A plan is in place to discuss this.	Must do	Gill Hunt, Director of Nursing and Quality

(as per 19/20 Quality Priority (see embedded action plan in word doc)"	49.4 Ensure all serious incidents are reported within 48 hours	This remains red as per 2.4 until the Trust is assured that all SI's are being reported within 48 hours of being made aware of the incident	Must do	Gill Hunt, Director of Nursing and Quality
Must Do	55.1 Evidence that the action plan has been fully implemented and changes made where necessary to ensure appropriate action is taken.	Clinical leadership in place overseeing the audit, confidence of improved compliance stated, timeline to turn to green to be confirmed.	Must do	David Chadwick, Medical Director
The Trust must ensure there is a robust system to ensure that incidents are reported, managed and used for on-going improvements according to Trust Policy (Reg 17)	"66.1 Re-launch the upgraded Datix system with associated communication and engagement plan"	Procurement and business planning process requires clarification by the DoF and DoE&IT. A plan is in place to discuss this.	Must do	Gill Hunt, Director of Nursing and Quality
	"66.3 Ensure all serious incidents are reported within 48 hours"	This remains red until the Trust is assured that all SI's are being reported within 48 hours of being made aware of the incident	Must do	Gill Hunt, Director of Nursing and Quality
	"67.1 Evidence of communication regarding lessons learnt"	Remains red until more robust evidence is available to provide assurance of this	Must do	Gill Hunt, Director of Nursing and Quality
The Trust should continue to ensure performance in national audits improves and that related action plans address all concerns	"76.1 Completion of a review within the Centres and agreed governance processes in place in order to track local compliance"	Remains red until evidence from centre is received to show that processes are in place and are being discussed and monitored at Directorate and Centre Boards	Should do	Sath Nag (Medical Director)

highlighted.	"76.2 Evidence of regular monitoring by the Centre to highlight slippage and non-compliance"	Remains red until evidence from centre is received to show that processes are in place and are being discussed and monitored at Directorate and Centre Boards	Should do	Sath Nag (Medical Director)
	"76.3 Audit reports included in monthly directorate meetings and escalated through to Clinical Standards Sub Group and Quality Assurance Committee"	Remains red until evidence from centre is received to show that processes are in place and are being discussed and monitored at Directorate and Centre Boards	Should do	Sath Nag (Medical Director)
	"76.4 Robust action plans in place and implemented when performance requires improvement"	Remains red until evidence from centre is received to show that processes are in place and are being discussed and monitored at Directorate and Centre Boards	Should do	Sath Nag (Medical Director)
"79. Roll out an updated system for reporting incidents to facilitate incident reporting"	"79.3 Ensure all serious incidents are reported within 48 hours"	This remains red until the Trust is assured that all SI's are being reported within 48 hours of being made aware of the incident	Must do	Gill Hunt, Director of Nursing and Quality
"88. Ensure that capacity forms are completed appropriately by staff and in accordance with best interest decision"	"88.2 Evidence from audit and safeguarding assurance round that staff are aware of the processes for best interest decisions and	Red until evidence has been submitted to show that this has been completed	Should do	Gill Hunt, Director of Nursing and Quality

	are appropriately skilled"			
"93. Undertake an audit of patient consent to determine a baseline and develop an action plan to address issues identified"	"93.1 Audit conducted and an action plan developed and implemented to address shortfalls"	No evidence that this has been conducted	Should do	David Chadwick (Medical Director)
	"93.2 Month on month audit to demonstrate improved compliance with consent processes"		Should do	David Chadwick (Medical Director)

Must Do Actions

Completed	62
In progress – and on track	16
In progress – significant risks to delivery or outcomes identified	30
Total	**108**

It should be noted that this figure has been amended as 79.3 is a 'must do' action although the overarching action that it sits within is a 'should do' action.

Should Do Actions

Completed	24
In progress – and on track	16
In progress – significant risks to delivery or outcomes identified	16
Total	**56**

A review of the evidence for actions graded green is being undertaken to provide assurance that the action has been completed and there is sufficient supporting evidence to demonstrate that the action is complete. If there is insufficient evidence that the action has been completed then the action will be changed to red.

The reds were discussed at the CQC Oversight Group meeting on 18 November 2019 and where the action had been completed, evidence was requested so that the action could be changed to green.

Actions Graded Red

There are currently 46 actions rated as red as per discussion at the CQC Oversight Group on 18th November and following a data cleanse up until 22nd November.

At the CQC Oversight Group meeting it was requested that all evidence relating to actions graded red must be sent to the CQC mailbox by 12 noon on 21st November. A further follow up of the outstanding reds took place on the 22nd November and this paper reports on the current position as of 22nd November.

Actions removed from the action plan

5.1 CEO to attend 2 directorate meetings in all specialties annually

This action has now been removed as it is no longer appropriate. 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.

Actions with Financial Implications

An additional column has been added to the action plan tracker to capture this information: Where the financial cost is currently not known this information has been requested from the relevant action Lead(s) and will be included in future reports. A review of all actions where there is a 'possible' financial implication will be undertaken to establish definitively if there is a financial implication.

All CQC actions and financial implications

Yes	**38**
Possible	**18**
No	108
Total	**164**

A total of 56 actions have been identified as either having a definite financial implication or a possible implication. A review of the possible implications is taking place and an update will be provided in the next report.

3.1 Issues for Escalation

It was agreed at the CQC Oversight Group that the following actions required escalation to QAC.

1. Paediatric resuscitation capacity issues within ED – although there is a separate area for children it was reported that there are occasions when rooms may be used for adults due to demand and capacity challenges. A request has been made for every episode to be reported on Datix to quantify the frequency.
2. Radiology workforce issues – Local and national shortage of radiologists is impacting on our reporting and the fact that we have to outsource reporting to a private company. This is also a national issue. A full workforce review is on-going and the scheduled diary exercise has been pushed back to January due to issues outside of our control, this means that the December deadline date cannot be met.
3. Identify actions within the action plan which have a resource implication

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 were 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 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

3.2 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.

The Board have agreed to carry 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. This has already commenced within Urgent and Emergency Care.

3.3 Moving to good

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

The Trust has signed up to the Moving to Good Programme which is offered and facilitate by NHSi/E. The Director of Nursing, the Head of Patient Safety and Quality and the Head of Corporate Governance attended the first workshop on the 30th October in Leeds. Participating in this programme, along with 10 other Trusts, will see us receiving bespoke support from NHSI/E, whilst also being partnered with a similar organisation which has been rated as either good or outstanding.

A summary of the programme and the key elements is included below:

- Expert-led, practically focussed workshops on specific topics including:

• Culture – Thursday 5th December 2019 in Manchester – it has now been confirmed that Gill Hunt, Director of Nursing and Quality, Ian Bennett, Head of Patient Safety and Quality, Jackie White, Head of Governance and Rachael Metcalfe, Director of HR and Jenny Winnard, Operations Director for STRIVE will be attending this workshop to share the learning from this workshop across the Trust.

• Governance – Thursday 20th February 2019 in Leeds. This will focus on Board and Corporate governance and the 5 members from the Trust who will attend this still needs to be confirmed.

• Quality improvement – date tbc, estimated this will take place mid-March 2020

• Staff engagement – date tbc, estimated to go ahead towards the end of April 2020

We are in the process of identifying up to 5 people from the Trust to attend each of the above workshops once the agendas have been finalised

- On-site support for boards and senior leaders, including access to supporting Documentation
- An opportunity to pair with other trusts in the region
- Focussed project on safety, with training on QI and action learning sets
- Interactive learning and talks
- Dedicated regional programme team and access to on-going support

On Site Visit
An Individual first site visit (diagnostic) to the Trust on 11th December between 10 – 12 noon, to review areas within our CQC action plan

Safety Project
Every trust has been asked to identify 3 priority areas, including an area of concern relating to 'Safety' within their current CQC action plan to work on during the project with a specific aim, goal or outcome which is achievable by the end of the programme (September 2020) if not before.

It is proposed that the Trusts 3 areas focus on:

- To increase incident reporting and learning
- To Develop a Quality strategy and identify and implement the Trusts approach to Quality Improvement
- Safety Project Objective – To eliminate Never Events by focusing on Safer Surgery

3.4 Quality Risk Profile, Single Item Quality Surveillance Group

It was agreed at a meeting on the 27th October 2019 between the Trust, NHSE/I and Commissioners that a number of quality issues had been identified as part of the QRP and which were reflected in the latest CQC Report. In light of the agreed quality concerns the group agreed the following next steps:

1. To establish a Single Item Quality Surveillance Group (QSG). The purpose of the Single Item QSG is for key stakeholders to come together to share and review information where serious concern about the quality of care has been raised. Moving to a Single Item QSG will give specific, focused consideration to the concerns raised and enable the system to act supportively to agree the actions needed and support improvements in the quality of services provided by South Tees Foundation Trust, working with NHS England and Improvement, Clinical Commissioning Groups and Regulatory Bodies. The QSG will meet every 4 – 6 weeks to monitor progress and met again on the 25/11/2019.

2. To develop an Overarching Improvement Plan. The Trust would formulate an overarching improvement plan to address the agreed 7 areas of risk as identified below, as well as those areas for improvement highlighted in their most recent CQC inspection.

1. Low rate of incident reporting
2. Never events
3. Key access and performance targets
4. Health Care Associated Infections
5. Nurse staffing in Critical Care
6. Staff engagement and organisational development
7. Leadership and governance

The improvement plan will form the basis for on-going monitoring of the quality improvements and cross reference other organisational improvement areas where relevant, ensuring any system support requirements are identified early.

4. RECOMMENDATIONS

For Board of Directors to be made aware and to discuss progress with each action on the action plan tracker.

For Board of Directors to be aware of the actions that have not been delivered within agreed timescales and what the mitigating actions are to bring these back on track.

For Board of Directors to be aware of the Moving to Good programme which the Trust has joined and the 3 priority areas outlined above.

To note that in addition to the CQC action plan, the Trust needs to develop an Overarching Improvement Plan to address the 7 areas of risk as identified above. ,

To build on currently support and levels of assurance, by identifying additional support in order to gain further assurance and move at pace with the delivery of the CQC action plan by establishing a small team of people to oversee the progress of the CQC action plan on a daily basis. This should include members of the finance and performance teams.

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 December 2019			
Board Assurance Framework			**AGENDA ITEM: 17, ENC 10**
Report Author and Job Title:	Jackie White Head of Governance	Responsible Director:	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☒ Inform ☐		
Situation	The Board of Directors are provided with an update report on the Board Assurance Framework (BAF) which contains the principle risks facing the Trust.		
Background	The Board of Directors review the Board Assurance Framework on a quarterly basis. They have responsibility for ensuring that there is assurance identified against the risks and ensure that the controls are appropriate and up to date.		
Assessment	The BAF risks have been reviewed by lead Executive Directors and Board Sub Committees and updates made. No additional risks have been added to the BAF during the last quarter; however four risks have increased their risk rating to high. Updates have been made to gaps in control and assurance and assurances.		
Recommendation	Members of the Board of Directors are asked to receive the updated BAF risks		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The risk implications associated with this report are included in the 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 ☐		

1. PURPOSE OF REPORT

The purpose of the report is to update members on the Board Assurance Framework principal risks affecting the Trust and the control measures which have been introduced.

2. BACKGROUND

The BAF must meet the requirements of the DoH Guidance on Building an Assurance Framework and is reviewed annually by Internal Audit. The Trust Board reviews the Board Assurance Framework (BAF) on a quarterly basis.

The BAF is the means by which the Trust holds itself to account and assures the safety of patients, visitors and staff. It does this by clarifying the risks to not achieving the Strategic Objectives. The Board has the responsibility for ensuring that there is assurance identified against the risks and ensures that the controls are appropriate and up to date.

The Board must also assess the assurance, which could be internally generated, external, evidence based, or potential assurance. It is important that actual examples of assurance in the BAF are drawn from a broad spectrum of evidence, noting that some evidence is stronger than other, eg external audit report will be stronger evidence than an internally generated review. By including a wide range of assurance, the BAF will be a more robust and effective tool.

3. DETAILS

There are 25 risks on the Board Assurance Framework which is consistent with the previous quarter report. There are 18 high risks, which is an increase of four (4) from the last report and seven (7) moderate risks.

Four (4) BAF risks have increased their risk ratings to high and these are detailed as follows:

BAF risk 2.1 (1) – risk of an infection outbreak (4 x 4 = 16)
BAF risk 3.2 – ability to deliver national access target for 18 week RTT (4 x 4 = 16)
BAF risk 3.3 – ability to deliver national access target for 62 day cancer (4 x 4 = 16)
BAF risk 4.5 – underdeveloped informatics infrastructure resulting in potential cyber-attack (5 x 4 = 20)

Updates of key controls, assurances, gaps and target dates have been made to 16 BAF risks. Five (5) risks have remained unchanged and one (1) risk has been closed which related to the BAF risk 4.6 – risk that contractual targets for CQUIN are not achieved.

4. RECOMMENDATIONS

It is recommended that members note the changes to the BAF since the last report. It is recommended that the Board explore one BAF risk on a quarterly basis in more detail.

APPENDICES

BAF – previously circulated separately

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 December 2019			
Corporate Risk Register			**AGENDA ITEM:** **17, ENC 11**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Kevin Oxley Director of Estates, ICT and Healthcare Records
Action Required	Approve ☐ Discuss ☒ Inform ☐ (select the relevant action required)		
Situation	The Trust has a number of risk registers which provide a comprehensive picture of all risks that affect the Trust. The mechanism for escalating risks to the Board of Directors is through the Risk Validation Group, Senior Leadership Team a Board Committee or the Risk Management Group.		
Background	In line with the Risk Management Policy the attached report sets out the risks which have been brought together into the Corporate Risk Register which are risks facing the Trust and scored 16 and above and are brought to the attention of the Board of Directors		
Assessment	This is the first report on the risk register received by the Board of Directors. Future risks will include trend analysis information in terms of changes to the risk register. There are two risks which have been escalated for consideration by the Board of Directors detailed in the report.		
Recommendation	Members of the Board of Directors are asked to note the risk report and full risk register which has been previously circulated to members.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk implications associated with this report are contained within the 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 ☒		

Risk Register Report

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Board with an update on the risks monitored at Board level. These are risks which are graded as 16 and above which are high or extreme risk and contained on the Trust corporate risk register.

2. BACKGROUND

The corporate risk register is an active tool through which the Trust manages its risks. Its purpose is to log all risks identified in the high or extreme categories and the controls in place or planned to manage the risk to its lowest possible level (residual risk). The corporate risk register is built up from the Centre registers and the organisation-wide and strategic risks identified by corporate committees and the Senior Leadership Team. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

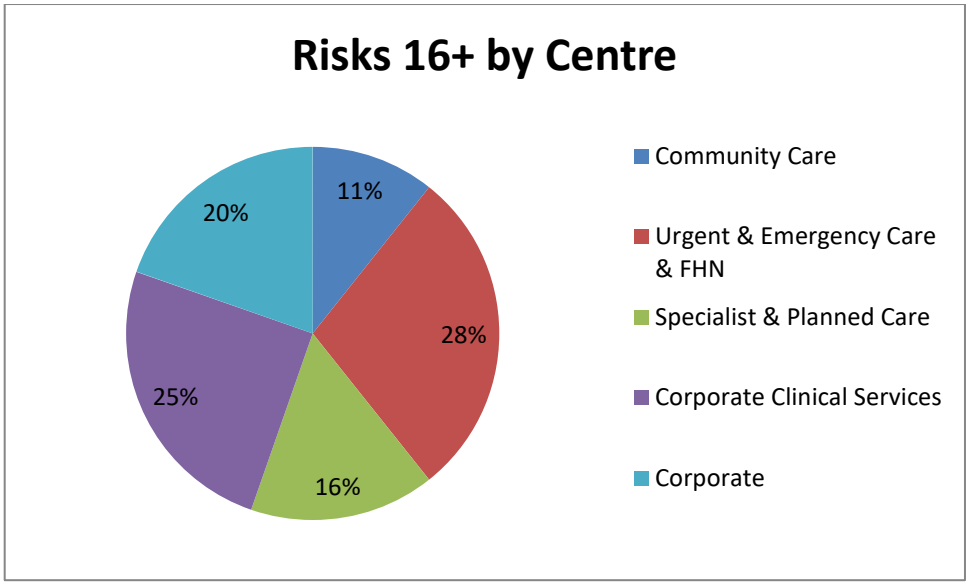
The Risk Validation Group is responsible for reviewing locally approved new and existing risks scored as 16 and above (the Corporate Risk Register), to validate the risk score and grade; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan; and to consider any cross-cutting issues and the implications for risk aggregation.

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Directorate risk register to a Centre register, or from the Centre risk register to the Corporate risk register reviewed by the Senior Management Team, Finance and Investment, Audit, Workforce and Quality Assurance Committees, and finally the Board.

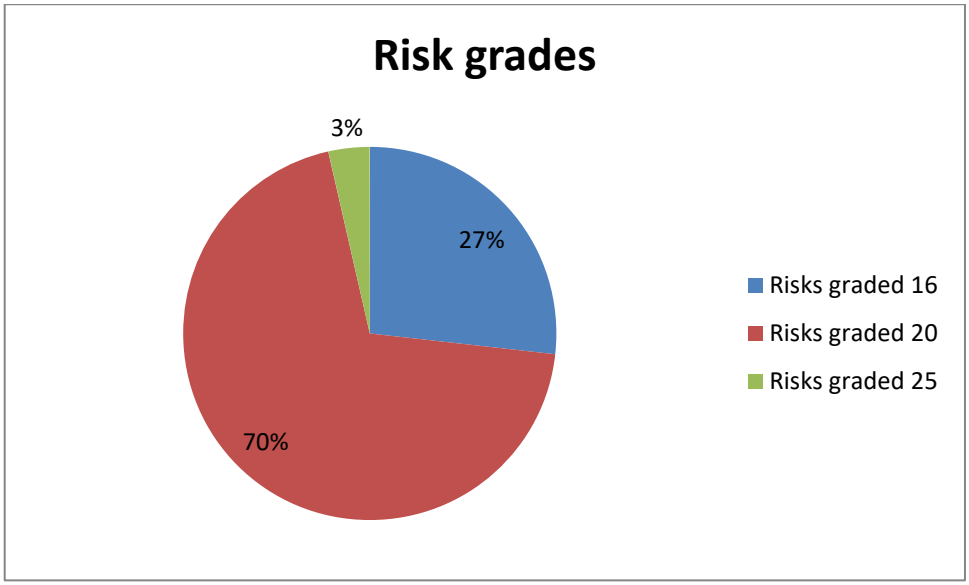
3. DETAILS

This is the first report to the Trust Board on the corporate risk register. This initial report will provide some factual information on the register and will highlight a number of risks which the Board should note. Future reports will provide trend analysis information on changes to the risk register.

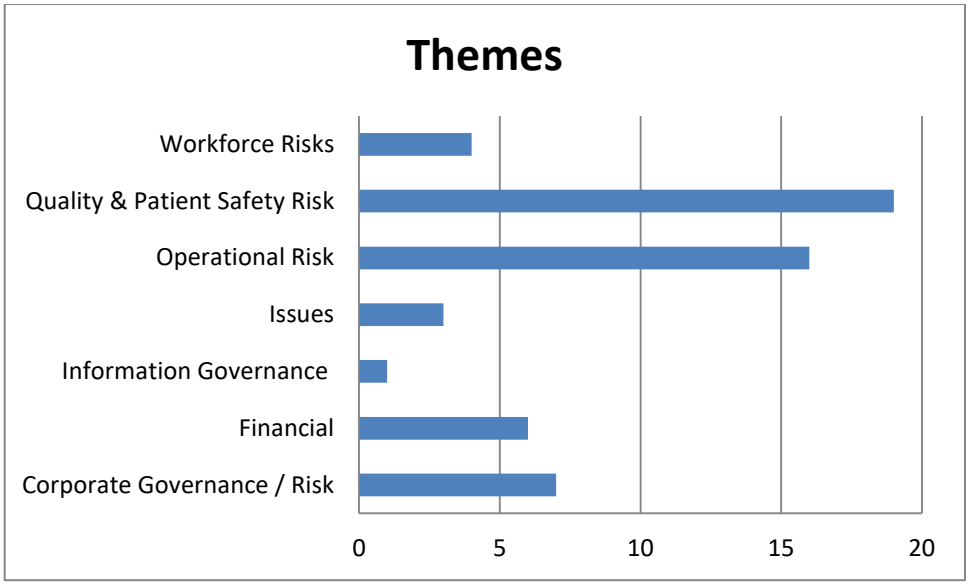
As of 22 November 2019 there are 56 risks on the corporate risk register of 16 and above which are broken down by centre below.



In terms of risk grades the highest proportion of risk are graded 20 and below with only 2 risks graded as 25.



The main themes of the risks are within the quality & patient safety risk and operational risk categories. Further work to explore these themes will be undertaken and be discussed in the next report.



Of the 56 risks on the risk register all risks have an action plan to mitigate the risk and only 5 of the 56 risks have an overdue review date.

The two risks which scored 25 are both in the Community Care Centre and relate to Ophthalmology. The details are as follows:

- Risk 2140 - Risk of overall safety and sustainability of the Ophthalmology service due to capacity

- Risk 2170 – Risk of significant financial overspend due to increasing activity in Ophthalmology not matching aligned incentive

4. RECOMMENDATIONS

The Board are asked to note the corporate risk register and discuss the two risks which are brought to the attention of the Board in further detail.

APPENDICES
Corporate Risk Register

Audit Committee
Chair's Log

Meeting: Audit Committee	**Date of Meeting**: November 19th, 2019
Highlights for: Board Meeting	**Date of Meeting**: December 3rd, 2019

Overview of key areas of work

Matters Arising from previous meeting – DoF agreed to follow up on outstanding Audit points relating to Pre-Employment Checks, Mobile Technology Ordering /Disposal and Sickness Management.

Counter- Fraud

1. Meeting agreed to approve updated Anti-Fraud and Anti-Corruption Policy.
2. CF gave update of work to meeting – DoF to review issues raised in Private Patient review.

Internal Audit

3. Update provided to meeting
4. Points raised in relation to Waste and H&S were discussed with Director of Estates. He will take back to SLT for action plans to be put in place

External Audit

5. KPMG requested to provide written notice to leave audit but they noted that until Charity Audit is complete they cannot formally resign.
6. Charity accounts presented – some changes identified and KPMG have some final audit work to complete. Subject to no further matters arising and the changes implemented AC recommend that the Corporate Trustee approve the annual accounts.
7. LLP accounts – AC reviewed and found accounts to be in order. AC recommended to LLP members that they be formally approved and signed.

Actions to be taken	Responsibility / timescale
• Matters identified above	DoF / Dir of Estates
Board action	**Responsibility / timescale**
• As Corporate Trustee to formally approve Charity accounts once finalizsed	DoF and Board

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 26/11/2019
Connecting to: Board of Directors	**Date of Meeting**: 03/12/2019

Key topics discussed in the meeting	
• Gap Analysis and action plan for the new national standards for saving babies lives • Ophthalmology update on SI • Update on JAG Accreditation • Monthly Quality report • Mortality / Learning from Death quarterly report • HCAI monthly report • Monthly SI report • FHN update • QEIA Update • Committee effectiveness review • CQC action plan update • Review of Board Assurance Framework • Chairs logs from reporting sub groups	
Actions agreed in the meeting	**Responsibility / timescale**
• Maternity – Saving Babies Lives to be monitored quarterly by QAC & notified to Board	• Gill Hunt / QAC Chair – Ms Reape / Jan 2020
• Endoscopy – staffing issues, including Nurse Endoscopists. Needs a future plan and booking / admin support	• Mrs Hunt & Mrs Metcalf
Escalation of issues for action by connecting group	**Responsibility / timescale**
• Ophthalmology – capacity / demand & process issues – High risk	
• Infection – possibly due to cleaning standards	• Mr Oxley & Mrs Hunt
• Paediatric resuscitation area (CQC action plan)	
• Medicines reconciliation (CQC action plan)	• Mrs Hunt & Mrs Jones
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Add risk 2140 (ophthalmology to BAF. Recommended by QAC.	• Mrs White / Board of Directors
• EPR – Lack of EPR leading to patient safety issues.	

Workforce Committee
Chair's Log

Meeting: Workforce Committee	**Date of Meeting**: 4th November 2019
Connecting to: Board	**Date of Meeting**: 3rd December 2019

Key topics discussed in the meeting	
• Current resources for FTSU • New process for safe staffing across all nursing, medical and professional staff • Safer Staffing Report – Nursing and Midwifery • Nursing Staffing Reviews in Theatres, ED, Adult Inpatient, Paediatric Inpatient. • Professions Workforce Strategy • Regional Passport Scheme • Local Clinical Excellence Awards • People KPIs • Summer Staff Survey • Equality and Diversity Strategy • STFT approach to working with HEE and changes ot the Learning and Development Agreement • Review of BAF risks	
Actions agreed in the meeting	**Responsibility / timescale**
• Mrs Hunt agreed for Mrs Smithies to pull together an options paper with some recommendations on resourcing FTSU and suggested that resourcing would need to be discussed a Board level. • Professor Owens to bring back a template to the next meeting on key indicators for ensuring safe medical staffing • Undertake a deep dive into nurse staffing reviews • The Workforce Committee approved the Professions Workforce strategy • The Workforce Committee approved the paper on Regional Passport Scheme subject to stress testing regarding responsibility held by each Trust • The Workforce Committee approved the Health & Wellbeing Strategy	GH/28th November 2019 AO/10th December 2019 Chair/28th November 2019 RM/10th December 2019
Escalation of issues for action by connecting group	**Responsibility / timescale**
None	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**

No new risks identified.	