South Tees Hospitals
NHS Foundation Trust

Board of Directors meeting (to be held in Public)

Date: 4 September 2018

South Tees Hospitals NHS Foundation Trust

Board of Directors (to be held in Public) 4 September 2018 at 2pm in the Boardroom, Murray Building, James Cook University Hospital

AGENDA

	Subject	Paper/ Page No	LED By	Time
1	**Welcome and Apologies for Absence**	Verbal	Chairman	14.00
2	**Declarations of Interests** - Board Register of Interests *Any new conflict of interest and* *Any actual or potential conflict of interest in relation to any matter to be discussed*	Verbal	Chairman	
3	**Minutes of the Previous Meetings** (**approval**) Meeting held in Public on 5 June 2018		Chairman	
4	**Matters Arising** (*discussion*/**approval**)	Verbal	Chairman	
5	**Action Log** (*information*/**approval**)		Chairman	
6	**Patient Story** (*discussion/information*)	Verbal	Director of Nursing	14.15
7	**Chairman's Report** *(discussion/information)*	Verbal	Chairman	14.30
8	**Chief Executive's Report** *(discussion/information)* ***Quality, Performance and Finance Assurance Report by Exception***		Chief Executive	14.40

Strategic Update

- Sir Ian Carruthers
- Friarage Update
- Carillion Facilities Management Transition Update
- Electronic Patient Record Update

Excellence in Patient Outcome and Experience

9	**Quality and Patient Safety** (information/**approval**)			
9.1	Healthcare Associated Infection Report		Director of Nursing	15.20
9.2	Safe Staffing Monthly Report		Director of Nursing	15.25
9.3	Learning from Deaths Quarter 1 Update		Medical Director for Clinical Support Services	15.35
10	**Governance/Compliance** (*information/***approval**)			
10.1	Report of Use of Trust Seal		Chief Executive	15.45
10.2	Freedom to Speak Up Report		Director of Nursing/ Medical Director (Clinical Diagnostics and Support Services	15.50
10.3	Doctors Revalidation Report		Medical Director (Clinical Diagnostics and Support Services	16.05
11	**Items for Assurance and/or Information** *(discussion/information)*			16.15
11.1	EPRR Annual Report		Director of Estates/ICT and Health Records	
11.2	Finance and Investment Committee Chair Logs		Finance and Investment Committee Chair	
11.3	Quality Assurance Committee Chair Logs		Quality Assurance Committee Chair	
12	**Any Other Business** (*discussion/information/***approval**)	Verbal	Chairman	16.25
13	**Date and Time of Next Meeting**	Verbal	Chairman	

The next meeting of the Board of Directors will be held on Tuesday, 6 November 2018 in the Board Room, Murray Building, James Cook University Hospital, Marton Road, Middlesbrough

South Tees Hospitals NHS
NHS Foundation Trust

APPROVED Board of Directors Meeting (held in PUBLIC)
held on 5 June 2018
Boardroom, Murray Building, James Cook University Hospital

Present:

Ms A Hullick	Deputy Chair (Chair of the Meeting)
Mr R Carter-Ferris	Non-executive Director
Mrs M Rutter	Non-executive Director
Mr D Heslop	Non-executive Director
Mrs S McArdle	Chief Executive
Mr A Clements	Deputy Chief Executive/Medical Director (Urgent and Emergency & Friarage)
Mr D Chadwick	Medical Director (Planned and Specialist Care)
Dr S Nag	Medical Director (Community Care)
Mrs G Hunt	Director of Nursing and Quality

In attendance:

Ms L Hughes	Company Secretary
Mr S Kendall	Medical Director (Clinical Support Services) *item BoDC/06/13 only*
Ms C Wroe	Director of Research and Innovation (*to item BoD/06/08*)
E Harrison	Research Patient Ambassador
C Whayman	Research Patient Liaison
A Anstee	Consultant Radiologist (observing)
A Seward	Lead Governor (observing)
R Shaher	Staff Side Chair (observing)
H Rodgers-Shaw	Commercial Business Manager, Johnson and Johnson (observing)

BoD/06/01 **Apologies for Absence**

1.1 Apologies were received from Mr A Downey, Chairman; Mr J Tompkins, Non-executive Director; Mr M Ducker, Non-executive Director and Mr S Mason, Director of Finance.

BoD/06/02 **Declaration of Interests**

2.1 The Chairman requested that Directors declared any actual or potential conflict of interest relevant to their role as a member of the Board of Directors and in particular to any matter to be discussed at the meeting. There were no interests declared in relation to open items on the agenda.

BoD/06/03 **Minutes of Previous Meeting**

3.1 **Resolved:** the minutes of the previous meeting held on 1 May 2018 were accepted as a true record.

BoD/06/04 **Matters Arising**

4.1 There were no matters arising in addition to those included on the agenda.

BoD/06/05 **Action Log**

It was noted that all actions included on the Action Log had been completed.

BoD/06/06 **Patient Story**

6.1 Emily Harrison a psychologist graduate who was currently working in the

mental health sector shared her experiences that she had observed by family members who had participated in the Trust's research and clinical trial programmes. She highlighted the benefits gained by being part of such programmes and the lessons that could be learnt to benefit the patient.

6.2 The Board thanked Claire Whayman, Emily Harrison and C Wroe for attending the meeting and sharing their most interesting patient story and experience gained through research and trial programmes**.**

6.3 **Resolved:** the Patient Story was noted.

BoD/06/07 Research and Innovation Report 2017/18

7.1 C Wroe presented the Research and Innovation Report for the period covering 1 April 2017 to 31 March 2018. She drew attention to the many successes in Research and Innovation during the reporting period such as the recruitment of 3758 patients into clinical research trials which seen a 9% increase on the previous year with the Trust in the top 10% of NHS Trusts and third in the region. The Trust recruited to 2002 different clinical trials, is ranked second in the region and within the top 5% of NHS Trusts whilst also awarded innovation grants totalling £4.3m.

7.2 The Board were pleased to note the Research and Innovation plans for 2018/19 which C Wroe described in great detail and the risks identified due to financial implications.

7.3 **Resolved:** the Research and Innovation Annual Report 2017/18 was noted.

BoD/06/08 Chairman's Report

8.1 There were no items to report due to the Chairman's absence.

BoD/06/09 Chief Executive Report

9.1 The Chief Executive report was presented which included exception against plan for quality, operational and financial performance for the period ending 31 May 2018.

9.2 Accident and Emergency 4 hour performance was reported as 95.37% against the 95% target with the Trust ranked fourth in the region. The 18 week Referral to Treatment performance was reported below trajectory at 90.26% against the 92% target. The Chief Executive reported that recovery plans had been put in place with the aim of bringing back to trajectory by September 2018.

9.2.1 Performance against the Cancer 62 Day Standard was positive at 86.15% with the cancer wall now in place to continue to drive forward performance improvements.

9.2.2 Discussion took place around the Trust's elective theatre performance which the Board noted elective overnight and day case had reported 2.8% less cases in comparison to the previous period in 2017; elective day case had reported 0.6% more in comparison to the same period in 2017 and 1.4% less than plan; and elective overnight cases had shown 9.2% less cases in comparison to the same period in 2017 and 11.2% less than plan.

9.3 In terms of patient outcomes and experience it was noted that the Trust's apportioned Clostridium difficile cases were within trajectory year to date and further discussion would be provided by the Director of Nursing later in the

meeting.

9.4 With regards to people the sickness absence rate reported was reported at 4.12% and above the 3.5% target. It was noted that Human Resources were driving forward absence management processes to reduce sickness absence and to carry out a review of seasonal absences.

9.5 The financial position was noted with performance as at 30 April 2018 being £800,000 ahead of plan. The Chief Executive confirmed that work continued to drive forward productivity and efficiency plans with the aim of achieving the Trust's Control Total by 31 March 2019.

9.6 The Chief Executive was pleased to report that the Trust had taken part in the ITN NHS 70th Celebrations which featured the Trust supported by the Deputy Chief Executive/Medical Director (Urgent and Emergency & Friarage), the Medical Director (Planned and Specialist Care) and the Medical Director (Community Care). The video was planned to be shown at the NHS Confederation Annual Conference. It was agreed arrangements would be made to share the video with the Council of Governors. **ACTION (S McArdle)**

9.7 **Friarage**
The Deputy Chief Executive/Medical Director (Urgent and Emergency & Friarage) provided an update on the developments of the business case and the proposed Communications Plan which would be led by the CCG.

9.8 **Resolved:** the Chief Executive's report was noted.

BoD/06/10 Healthcare Acquired Infection Report

10.1 The Director of Nursing presented the Healthcare Acquired Infection Report for the month of April 2018. She drew reference to the Trust's objectives for 2018/19: to have no more than 54 Trust apportioned Clostridium difficile cases amongst patients aged over two years (three Trust apportioned cases were reported in April 2018). It was noted that there was no official MRSA bacteraemia target for 2018/19 and the Trust had zero cases in April 2018. There was also no official MSSA bacteraemia target for 2018/19 (three Trust apportioned cases were reported in April 2018.)

10.2 **Resolved:** the Board noted the Healthcare Acquired Infection update and the Trust's current position.

BoD/06/11 Safe Staffing Monthly Report

11.1 The Director of Nursing presented the Safe Staffing monthly report which aimed to provide assurance on the nursing and midwifery safe staffing levels for April 2018.

11.2 It was noted that the fill rate against planned roster for April 2018 was Registered Nurse/Registered Midwife day shift at 91% and night shift 96%; with HCSW day shift at 94% and night shift 110%. The Director of Nursing assured the Board that nurses are moved around to ensure the Trust maintains its safe staffing levels with update reports discussed in detail at Centre Board meetings before discussions take place with Executive Directors, the Workforce Committee then finally reported to Board.

11.3 **Resolved:** the Safe Staffing Monthly Report for April 2018 was noted which provided assurance that staffing levels are sufficient to deliver safe, high quality care with systems and processes in place should staffing fall below planned levels.

BoD/06/12 **Annual Infection Prevention Control Report**

12.1 The Annual Infection Prevention Control Report was noted which included surveillance information on Clostridium difficile, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide resistant enterococci, ESBL producing coliform infections and other health care associated infections for the period ending 31 March 2018.

12.2 **Resolved:** the Infection Prevention Control Annual Report was noted.

BoD/06/13 **Learning from Deaths Quarter 4 Report**

13.1 The Medical Director (Clinical Support Services) spoke to the Learning from Deaths Quarter 4 report. It was noted that the national Learning from Deaths policy requires all NHS providers to publish through their Board papers details of how they learn from deaths in care.

13.2 It was noted the report included count of deaths over a 10 year period to March 2018 with SHMI reported as 107 'as expected' for the period October 2016 to September 2017; and HSMR reported as 112 'higher than expected' for the period January to December 2017. It was noted that data from the Mortality Surveillance Reviews for January to March 2018 showed 113 deaths had been reviewed with 93% judged to have received good care and 9 cases (8%) showed there was room for improvement.

13.3 M Rutter, Non-executive Director (Chair of Quality Assurance Committee) confirmed that the Quality Assurance Committee had asked the Deputy Director of Clinical Effectiveness to carry out a deep dive exercise on the count and coding of deaths to gain a greater understanding and lesson learnt.

13.4 **Resolved:** i) the Learning from Deaths Quarter 4 report was noted.

BoD/06/14 **Trust's Constitution**

14.1 The Board noted that a Council of Governor Working Group had reviewed the Trust's Constitution with the Company Secretary. Recommended changes to bring the Constitution in line with the NHS Health and Social Care Act 2012 were proposed and accepted by the Council of Governors at its meeting on 8 May 2018. The Board endorsed the changes and agreed to make the necessary arrangements for a summary of changes to be presented to the Annual Members Meeting in October 2018.

14.2 **Resolved:** i) the changes to the Trust's Constitution were approved; and
ii) it was agreed that a summary of changes would be presented to the Annual Members Meeting in October 2018.

BoD/06/15 **Finance and Investment Committee Chair's Log**

15.1 The Finance and Investment Committee Chair's Log from the meetings held on 22 March 2018 and 24 April 2018 were noted.

BoD/06/16 **Quality Assurance Committee Chair's Log**

16.1 The Quality Assurance Committee Chair's Log from the meetings held on 24 April and 15 March 2018 were noted.

16.2 Discussion took place around the actions agreed following receipt of the Staff Survey some of which were planned to be taken forward via the Clinical Intelligence Unit.

BoD/06/17 **Workforce Committee Chair's Log**

17.1 The Workforce Committee Chair's log from the meeting held on 15 March 2018 was noted.

BoD/06/18 **Audit Committee Chair's Log**

18.1 The Chair's log from the Extraordinary Audit Committee meeting held on 21 May 2018 was noted.

BoDC/06/19 **Any Other Business**

19.1 There was no other business.

BoDC/06/20 **Date and Time of Next Meeting**

20.1 The next Board meeting to be held in Public is arranged to take place on Tuesday, 4 September 2018 at 2pm.

Meeting closed at 3.20pm

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date
5.06.18	BoD/06/09.6	**ITN NHS 70th Celebration Trust video**	agreed the video would be emailed to the Trust's Council of Governors	Chief Executive	12.06.18

South Tees Hospitals
NHS Foundation Trust

Chief Executive Report

4 September 2018

Board of Directors Meeting

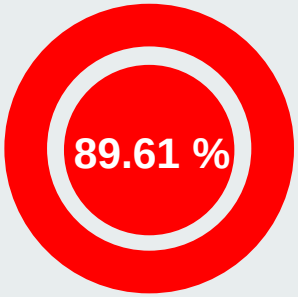
Must Do's

Must Do's 2018/19 – July 2018

Deliver Excellence in Patient Outcome and Experience….

A&E
4hr Target

RTT
18 Week Target



Cancer
62 Day Target

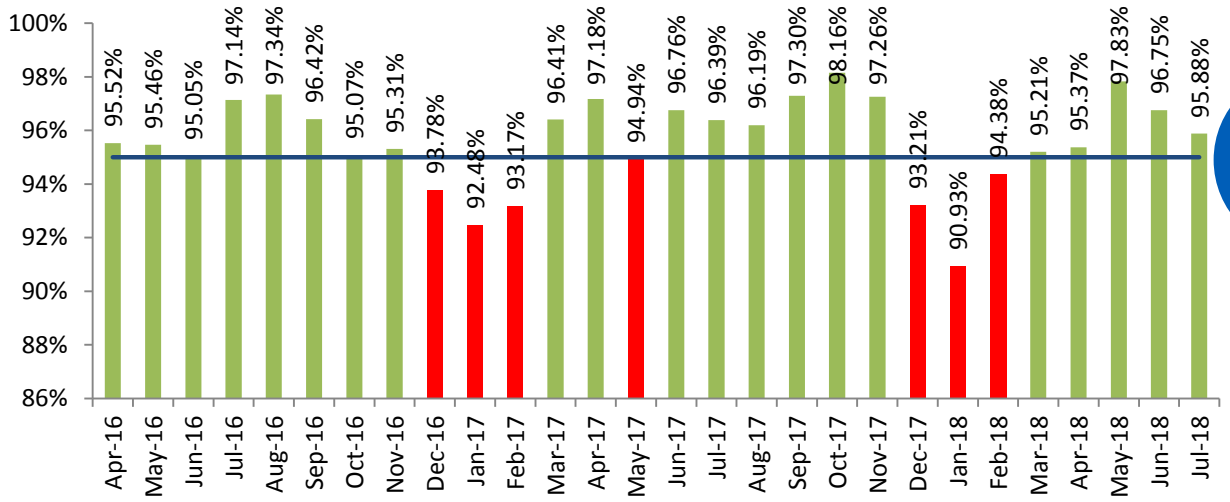
* Indicative

CDiff
HCAI Threshold

Operating Surplus

…and ensure our long term financial sustainability

Performance - A&E



95% TARGET

July 18

95.88%

Quarter 1:
96.69%

Quarter 2:
95.20%

Q2 position 22/08/2018

Regional Rank	Trust	Qtr 1
1	Northumbria Healthcare NHS Foundation Trust	98.30%
2	North Tees and Hartlepool NHS Foundation Trust	97.81%
3	**South Tees Hospitals NHS Foundation Trust**	**96.69%**
4	Gateshead Health NHS Foundation Trust	95.32%
5	South Tyneside NHS Foundation Trust	95.00%
6	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.88%
7	Harrogate and District NHS Foundation Trust	94.80%
8	County Durham and Darlington NHS Foundation Trust	91.17%
9	North Cumbria University Hospitals NHS Trust	90.31%
10	City Hospitals Sunderland NHS Foundation Trust	89.61%
11	York Teaching Hospitals NHS Foundation Trust	88.48%
	ENGLAND	**89.91%**

Quarter 1 Ranked 3rd in the region

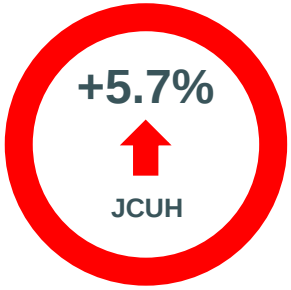
August to Date = 94.18% (Position 22/08/2018)

Performance - A&E

Increasing demand at both Acute sites

- **The last 4 weeks has seen attendances falling at both sites but still higher than last year**.
  - Weeks 17 to weeks 20 : +3.7% (+356) vs 1718
  - Weeks 17 to weeks 20 around 13 additional patients per day compared to same period last year

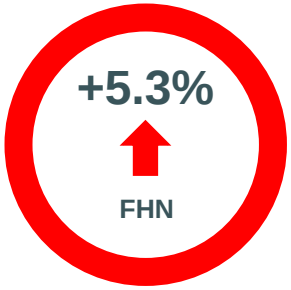
- **We are still seeing significant levels of attendances from the complex over 75s cohort.**
  - JCUH now seeing an average of 41 attendances per day for the over 75s.



YTD – JCUH A&E Type 1 Attendances

1718	1819
41,195	**43,562**

- +5.7% (+2367) attendances.
- Avg additional 17 patients per day.
- Ambulance +4.9% (+500).
- Over 75s +10% (+515)



YTD – FHN A&E Type 1 Attendances

1718	1819
7,369	**7,759**

- +5.3% (+390) attendances.
- Avg additional 3 patients per day.
- Over 75s +2.6% (+29)

Referral to Treat

92% TARGET

July 18

89.61%

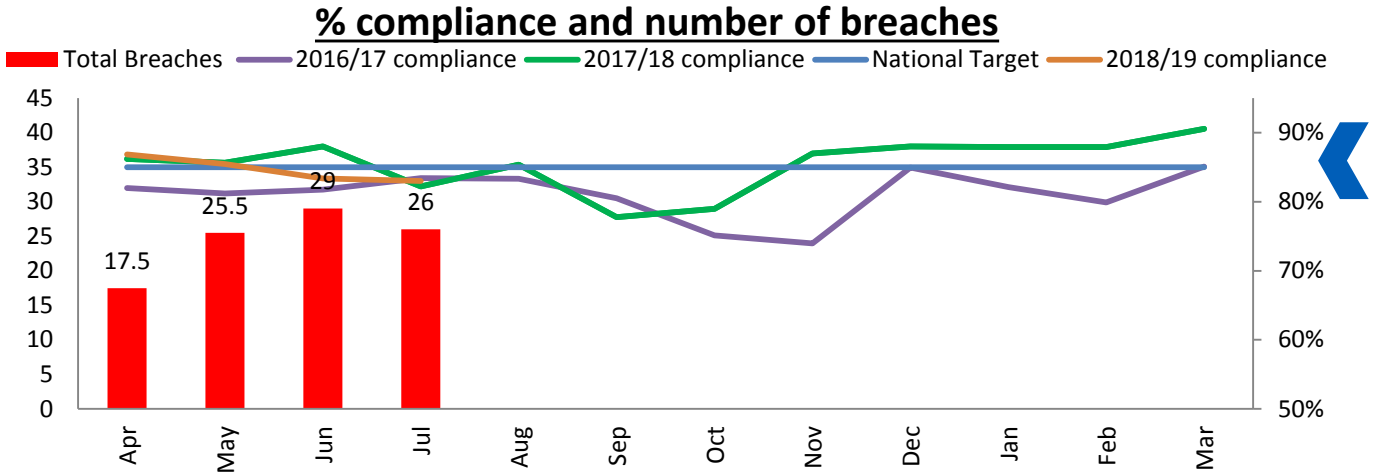
Quarter 1:
90.47%

Regional Rank	Trust	June
1	South Tyneside NHS Foundation Trust	96.2%
2	North Tees and Hartlepool NHS Foundation Trust	94.7%
3	City Hospitals Sunderland NHS Foundation Trust	94.3%
4	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.2%
5	Northumbria Healthcare NHS Foundation Trust	93.6%
6	Gateshead Health NHS Foundation Trust	92.8%
7	County Durham and Darlington NHS Foundation Trust	92.5%
8	Harrogate and District NHS Foundation Trust	91.0%
9	**South Tees Hospitals NHS Foundation Trust**	**90.1%**
10	North Cumbria University Hospitals NHS Trust	85.9%
11	York Teaching Hospital	84.1%
	ENGLAND	**87.8%**

June 18 Ranked 9th in the region

Recovery programs to be produced by 2nd of September 2018 for all failing specialties

Performance – 62 Day Cancer Standard



% compliance and number of breaches

*** Indicative Darlington Urology also to be added**

Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	July 18
87.92%	87.90%	89.56%	86.84%	85.43%	83.81%	83.00%*

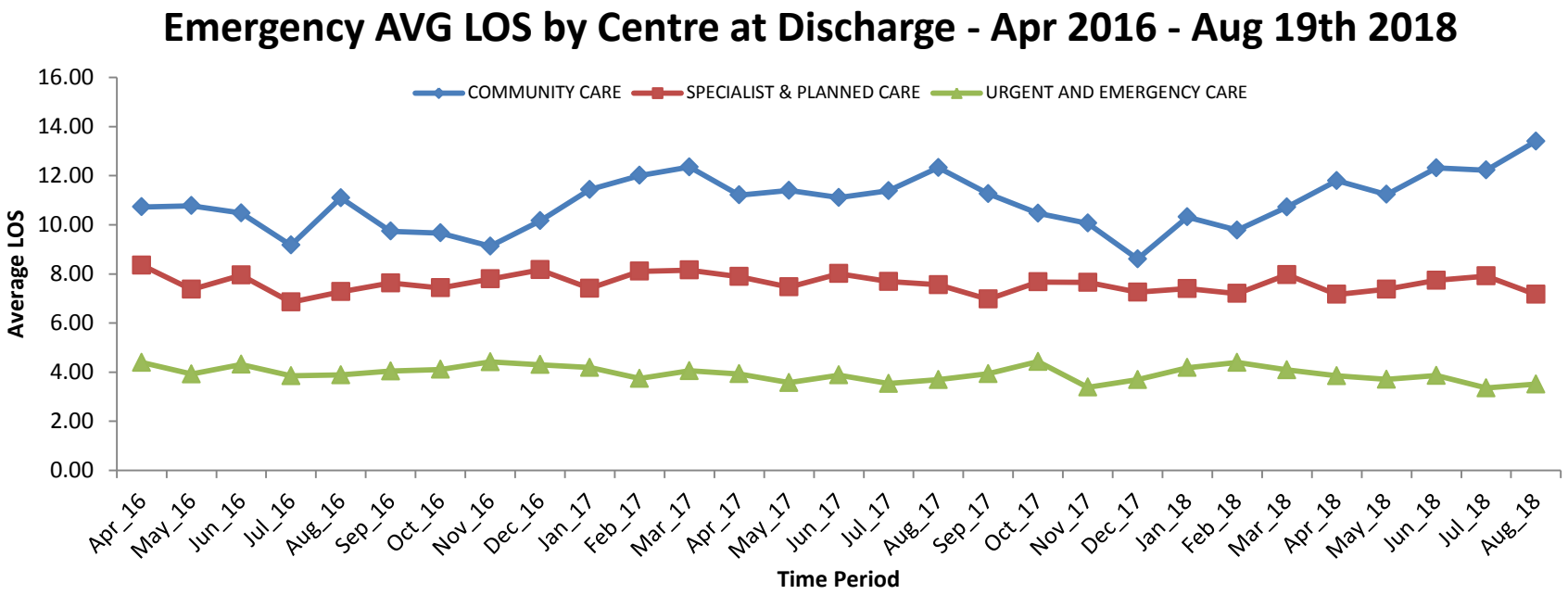
Regional Rank	Trust	June
1	County Durham and Darlington NHS Foundation Trust	91.48%
2	South Tyneside NHS Foundation Trust	86.21%
3	Harrogate and District NHS Foundation Trust	88.10%
4	North Cumbria University Hospitals NHS Trust	85.12%
5	City Hospitals Sunderland NHS Foundation Trust	84.70%
6	**South Tees Hospitals NHS Foundation Trust**	**83.81%**
7	York Teaching Hospitals NHS Foundation Trust	82.04%
8	Gateshead Health NHS Foundation Trust	81.12%
9	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	78.84%
10	North Tees and Hartlepool NHS Foundation Trust	76.67%
11	Northumbria Healthcare NHS Foundation Trust	75.26%
	ENGLAND	**79.24%**

June 18 Ranked 6th in the region

Best performing cancer centre in the Region

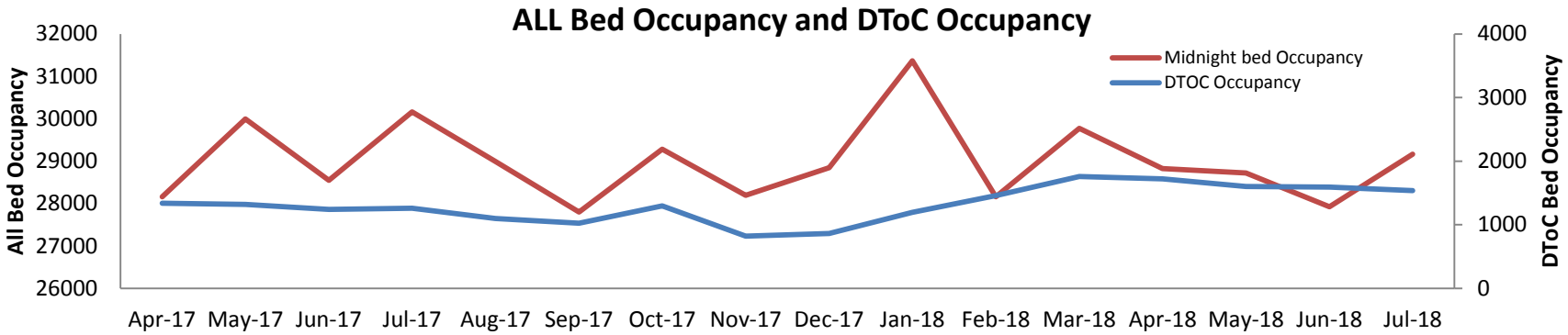
Operational Management

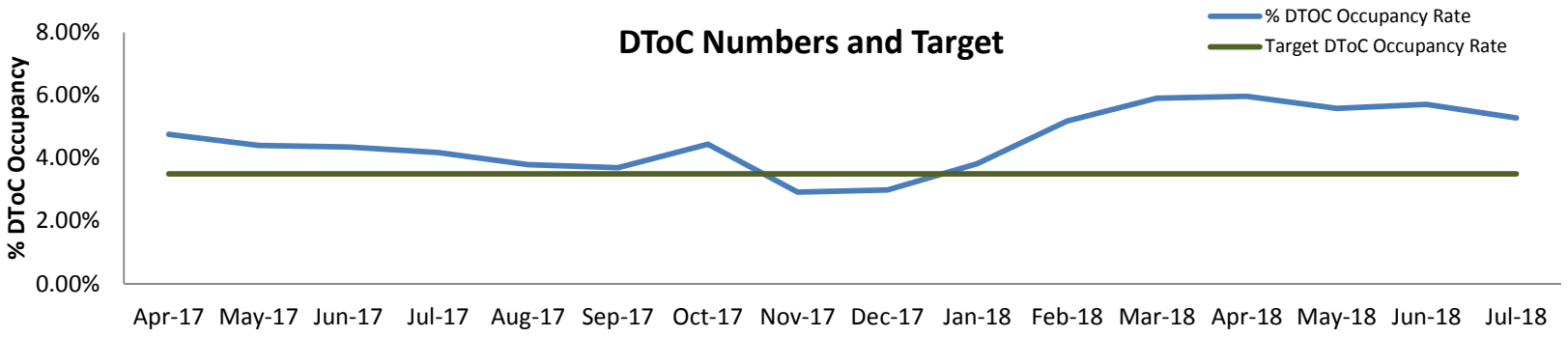
Emergency Length of Stay by Centre

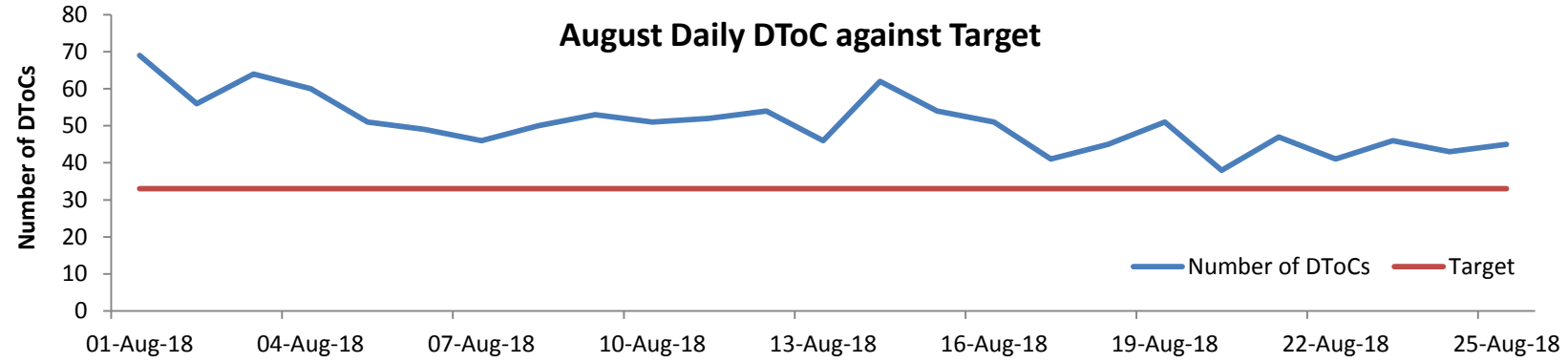


AVG LOS				
Centre	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1617	10.5	7.7	4.1	7.3
1718	10.7	7.6	3.9	7.2
1819	12.1	7.5	3.7	7.1

Delayed Transfer of Care (DToC)



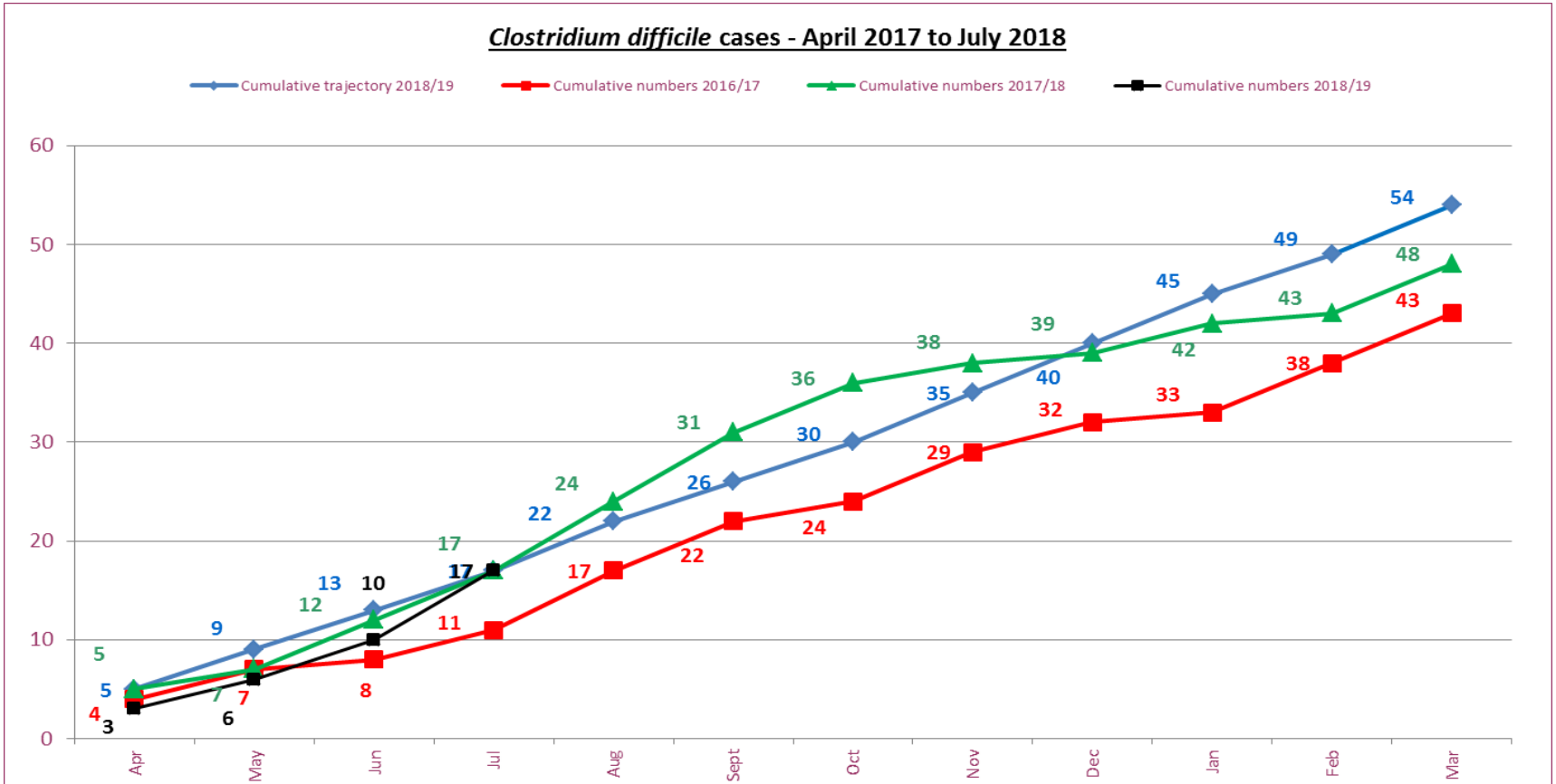




NHS
South Tees Hospitals
NHS Foundation Trust

Patient Outcome and Experience

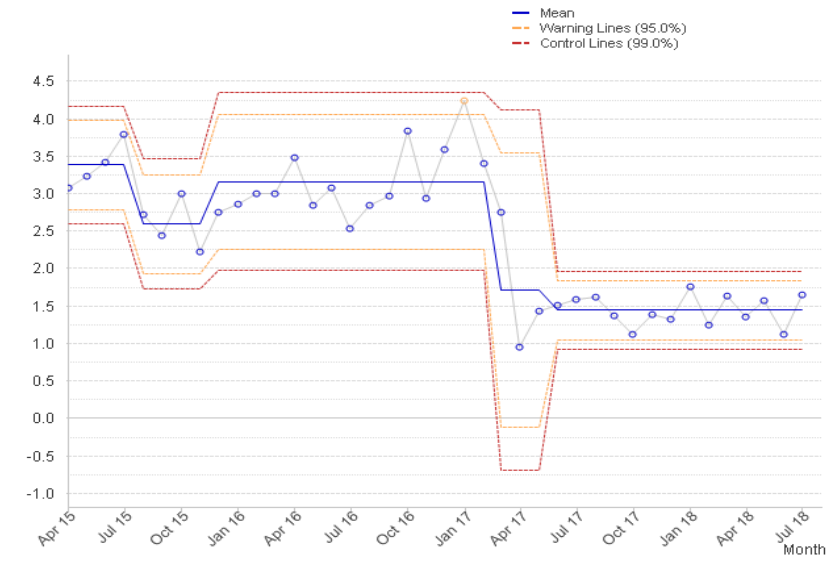
Trust apportioned Clostridium difficile



Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
JC33	JCITU2	JC07	FHAIND	JC33	JC34	JC08	JC24	JC34	JC24	JC31	ECTO	JC06
JC34	JC11	JC03	JC05	JC36		FHAIND		JC10	JC14	JC14	FHGara	FHGara
JCGHDU	JC12	JC07	FHAIND			JC07		JC03	JSIRU	JC08	JC33	Zetland
JC33	JC02	JCITU	JCITU2					JC03			JC34	ITU FHN
AAU1	JC07	JC07	JCITU2					JC06				JC12
	JC09	JC11										JC11
	JCGHDU	JCGHDU										JC27

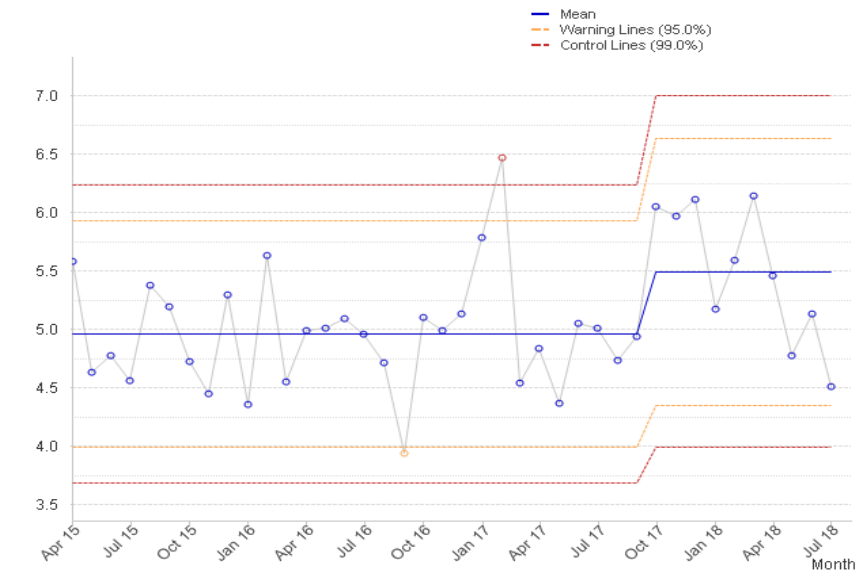
Delivering Safe Care 18/19

Trust attributed category 2 pressure ulcers July 2018



Rate 1.6 per 1000 bed days. Rate within normal variation

Falls July 2018



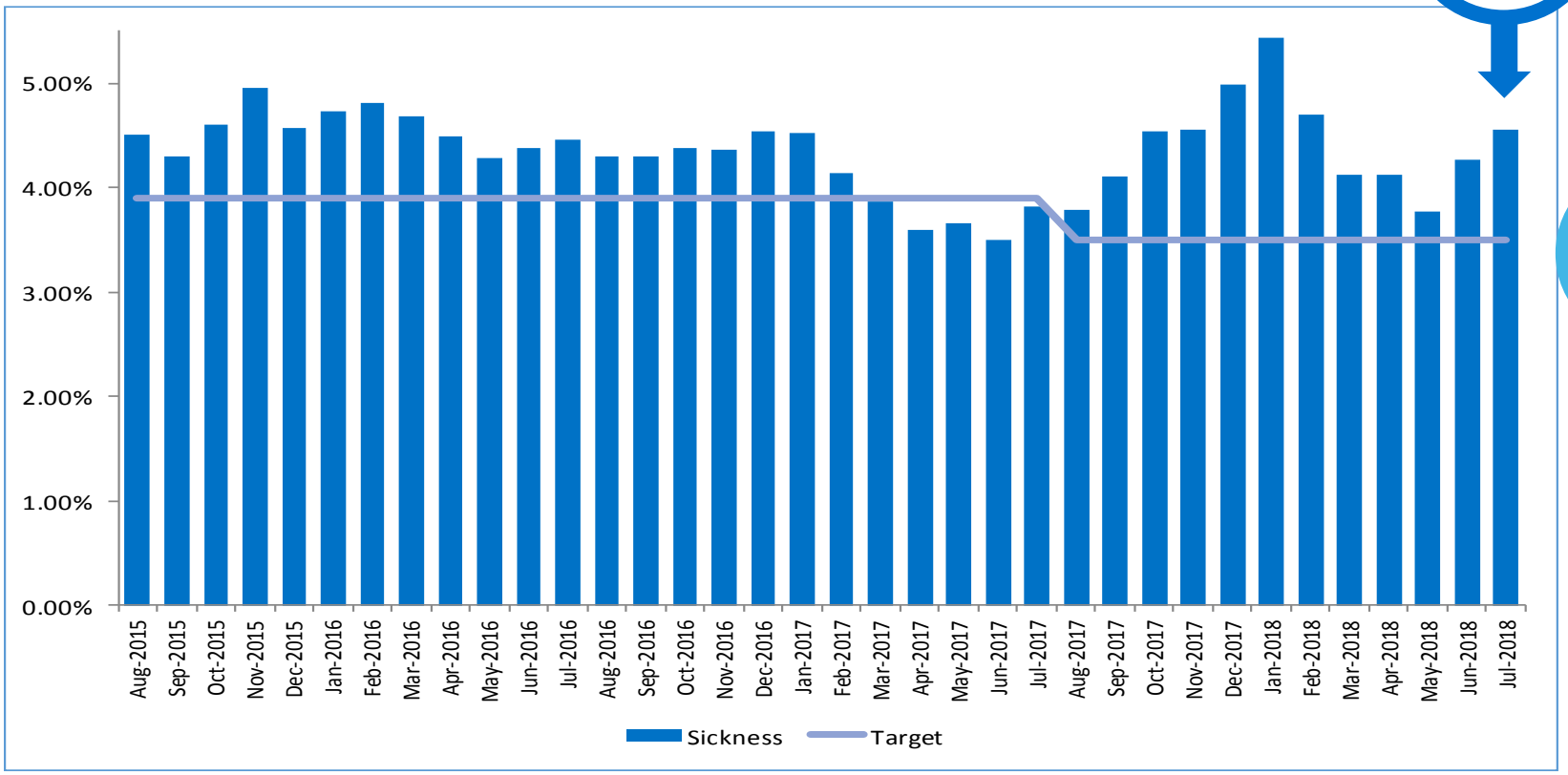
4.5 per 1000 bed days. Rate within normal variation and lowest rate in the last 12 months

Continued Focus on Falls Prevention Strategies

People

People

Sickness % Rate



SDR % Rate - 80.17% (Target 80%)

2015/16	2016/17	2017/18	2018/19
68.58%	71.27%	84.70%	82.81%

Training % Rate 90.63% (Target 90%)

2015/16	2016/17	2017/18	2018/19
79.75%	89.35%	92.38%	91.40%

Finance

Summary Financials by Centre - July 2018

Summary Financials	Year to Date		
	Plan £'000	Actual £'000	Variance £'000
Community Care			
Income	30,623.9	31,313.3	689.4
Pay expenditure	(18,400.5)	(17,794.0)	606.5
Non-Pay expenditure	(6,253.4)	(6,180.3)	73.1
EBITDA	**5,969.9**	**7,338.9**	**1,369.0**
Clinical Support			
Income	14,104.7	13,862.0	(242.7)
Pay expenditure	(23,086.3)	(22,276.7)	809.6
Non-Pay expenditure	(8,301.1)	(8,206.6)	94.5
EBITDA	**(17,282.7)**	**(16,621.3)**	**661.4**
Urgent and Emergency Care			
Income	25,763.2	27,988.8	2,225.6
Pay expenditure	(19,986.8)	(20,781.9)	(795.1)
Non-Pay expenditure	(1,941.1)	(1,838.5)	102.6
EBITDA	**3,835.3**	**5,368.4**	**1,533.1**
Specialist and Planned Care			
Income	103,007.4	102,501.6	(505.8)
Pay expenditure	(40,081.8)	(40,283.4)	(201.6)
Non-Pay expenditure	(30,000.3)	(30,512.5)	(512.2)
EBITDA	**32,925.3**	**31,705.7**	**(1,219.6)**

Trust Headlines

Month 4 Trust performance

Control Total

£0.4m ahead of plan
£0.9m ahead plan Pay
£0.5m behind plan Non-Pay

Productivity and Efficiency savings

£15.2m YTD Plan
£13.6m YTD Actual

£35.6m Plan for year

South Tees Hospitals
NHS Foundation Trust

Strategic update

Board of Directors	
Agenda item	9.1
Title of Report	Healthcare-associated infection report for July 2018
Date of Meeting	4 September 2018
Presented by	Gill Hunt, Director of Nursing and Quality / DIPC
Authors	Richard Bellamy, Infection Control Doctor, JCUH Judith Connor, Assistant Director of Nursing / Deputy DIPC Gill Hunt, Director of Nursing and Quality/ DIPC
Approved by	Gill Hunt, Director of Nursing
Previous Committee/Group Review	Operational Management Board – 30 August 2018
Purpose	Approval ☑ Decision ☐ Discussion ☐ Information ☑
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to note the current position in respect of HCAI and for their support for the actions being taken.

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, E.coli, ESBL-producing coliform infections and other important healthcare-associated infections for the month of July 2018.

- The *Clostridium difficile*-associated diarrhoea objective for 2018/19 is to have no more than 54 trust-apportioned cases among patients aged over 2 years. There were 7 trust-apportioned cases in July 2018. In the first 4 months of 2018/19 there have been 17 trust-apportioned cases, which is 1 over trajectory.

- There is no official MRSA bacteraemia target for 2018/19. There were 0 trust-assigned cases in July 2018. In the first 4 months of 2018/19 there have been 0 trust-assigned cases.

- There is no official MSSA bacteraemia target for 2018/19. There were 2 trust-apportioned cases in July 2018. In the first 4 months of 2018/19 there have been 14 trust-apportioned cases.

2. Recommendation

The Board 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

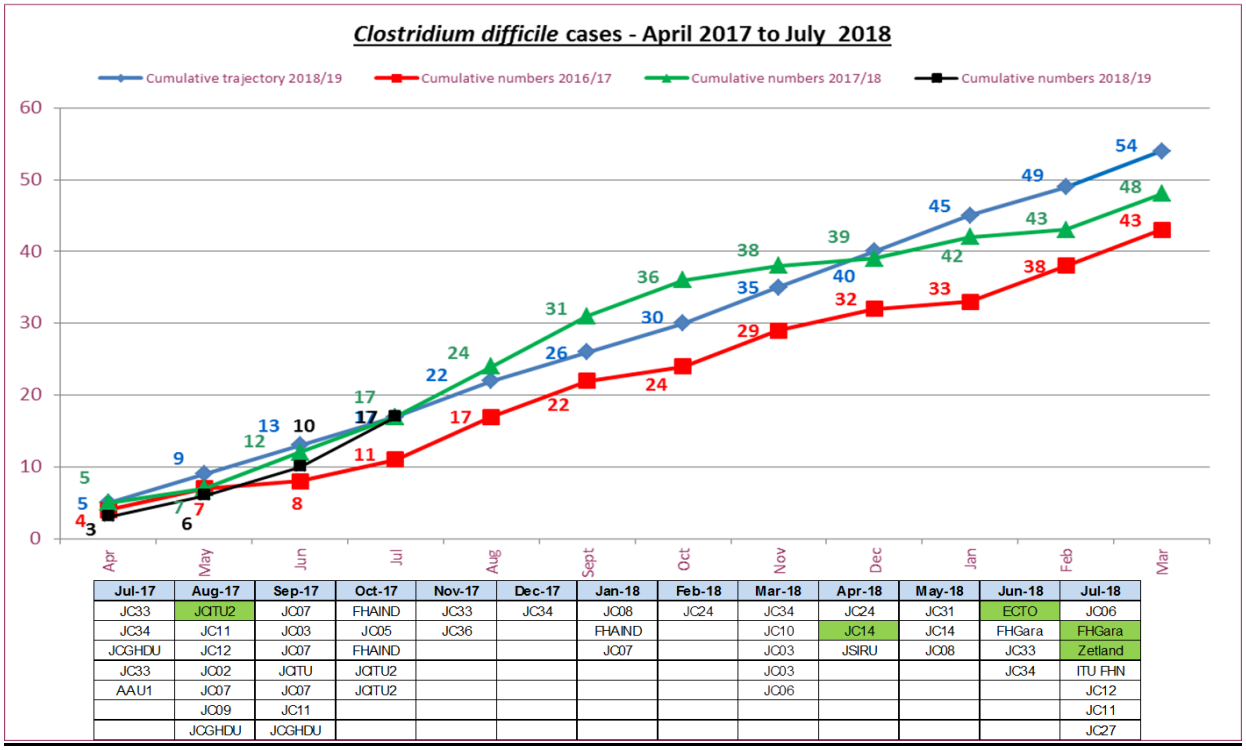
1.1 Clostridium difficile

C diff	Total 2017/18	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Total 2018/19 to date	Target for 2018/19
Total cases	125	10	18	11	8	4	10	6	8	8	11	12	14	45	NA
Not trust apportioned	77	3	11	6	6	3	7	5	3	5	8	8	7	28	NA
Trust apportioned	48	7	7	5	2	1	3	1	5	3	3	4	7	17	54
- JCUH	45	7	7	3	2	1	2	1	5	3	3	2	4	12	
-FHN	3	0	0	2	0	0	1	0	0	0	0	1	2	3	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
-East Cl	0	0	0	0	0	0	0	0	0	0	0	1	0	1	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

There were 14 cases of *C. difficile* infection in July 2018, 7 of which were classed as trust-apportioned. The annual objective is to have no more than 54 trust-apportioned cases. There have been 17 trust-apportioned cases in the first 4 months of 2018/19 which is 1 over trajectory. We have in previous years seen an increase in the number of cases during the summer months. All actions to ensure robust controls are in place are monitored through both IPAG and the 'Performance Wall' held with Matrons to ensure continued focus.

Deaths within 30 days after *C. difficile* diagnosis: for July 2018, 2 patients died during this period. Since April 2009, 282/1562 patients (18%) have died during the 30 day follow-up period.

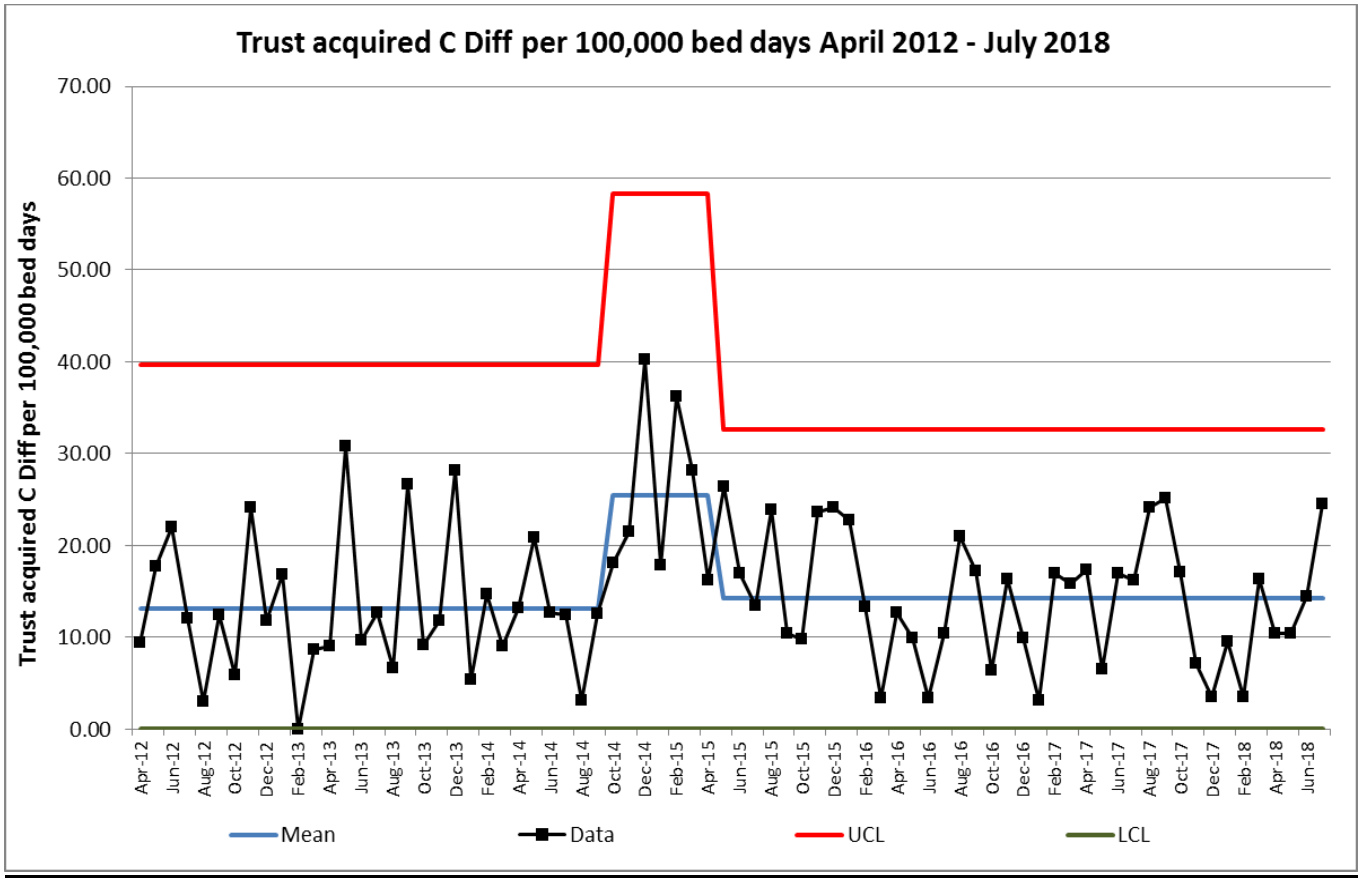
Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2018/19 compared to 2017/18 & 2016/17 trajectory:

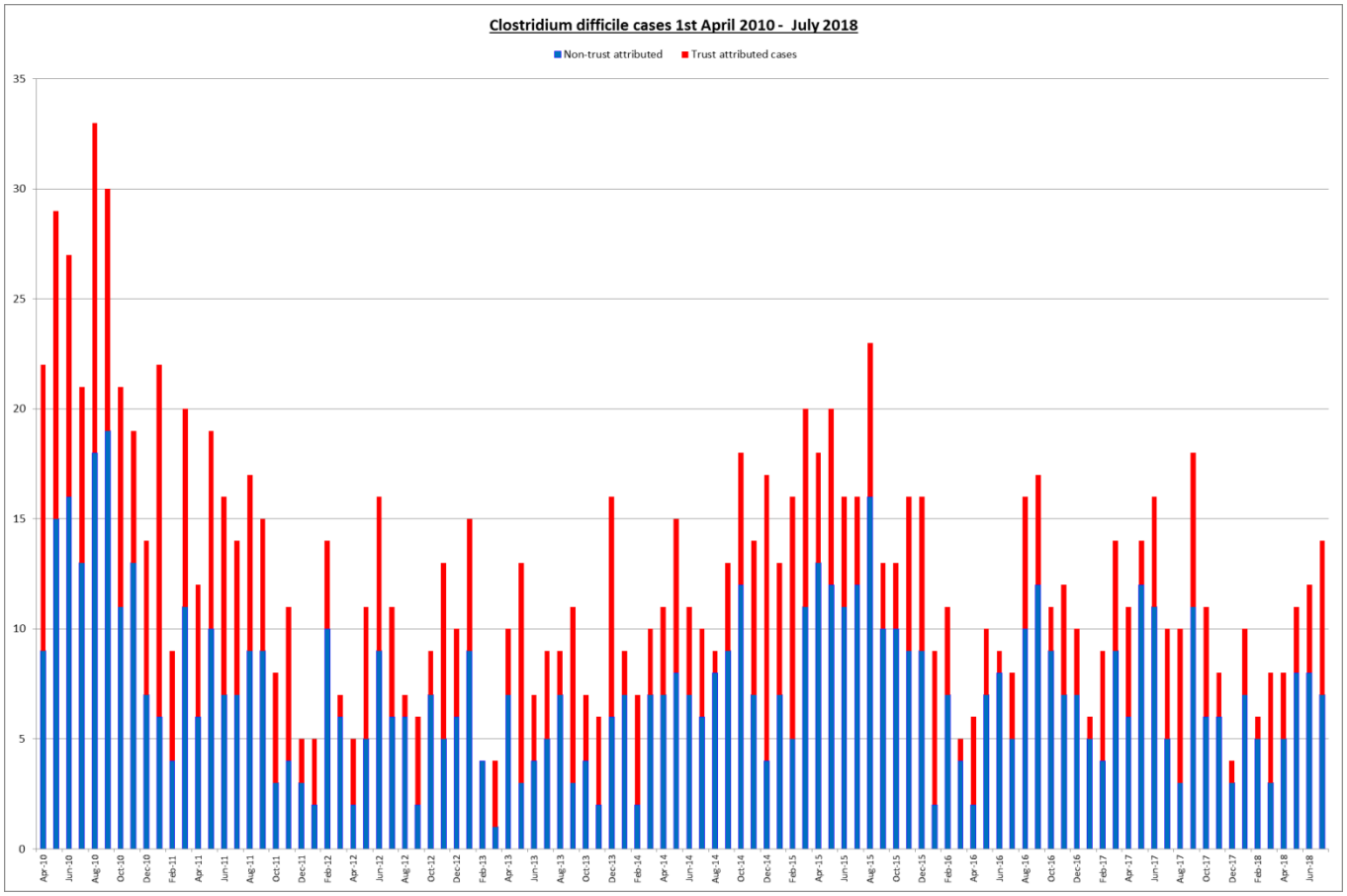


Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
JC33	JCITU2	JC07	FHAIND	JC33	JC34	JC08	JC24	JC34	JC24	JC31	ECTO	JC06
JC34	JC11	JC03	JC05	JC36		FHAIND		JC10	JC14	JC14	FHGara	FHGara
JCGHDU	JC12	JC07	FHAIND			JC07		JC03	JSIRU	JC08	JC33	Zetland
JC33	JC02	JCITU	JCITU2					JC03			JC34	ITU FHN
AAU1	JC07	JC07	JCITU2					JC06				JC12
	JC09	JC11										JC11
	JCGHDU	JCGHDU										JC27

Successfully appealed

Graph 2: Rate of Clostridium *difficile* infection per 100,000 bed days.





Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Whilst the total number of cases is 17, this only relates to 16 patients as 1 patient had 2 positive samples, but as the second sample was taken after the 28 day time frame this had to be classed as another case as per national guidance.

Panel reviews are chaired by the DIPC or Deputy DIPC and attended by CCG colleagues. Due to the robustness of review and challenge the CCG will now accept the decision of the panel as to whether the case is classed as appealable (i.e. no lapses in care / preventability identified).

There have been no episodes of linked cases by ribotype since June/July 2017.

The average hand hygiene self-assessment score in July 2018 was 93.82% and the peer review average was 92.5%. Installation of the refreshed hand hygiene product and associated campaign continued in July 2018.

A pilot of a new diarrhoea management algorythm is curerntly underway and it is planned that this will replace the current diarrhoea assessment tool.

Antimicrobial Stewardship

The antimicrobial stewardship CQUIN data for the last 2 years needed revision as there had been some double-counting of prescribing over this period. This correction has reduced our official antibiotic consumption but has also reduced the baseline we were comparing against for 2017/2018.

The corrected data is shown in the following tables:

CQUIN 2016/17	2013/14 Baseline	Required Reduction	New 2016/17 Result	Reduction Achieved	CQUIN met?
Total	4006	1%	3886.66	2.98%	Yes
Piperacillin/Tazobactam	126	1%	121.8932	3.26%	Yes
Carbapenems	110	1%	102	7.27%	Yes

CQUIN 2017/18	2016 Baseline	Required Reduction	2017/18 Result	Reduction Achieved	CQUIN met?
Total	3964.72	1%	3938.347	0.67%	No
Piperacillin/Tazobactam	125.3065	1%	100.1702	20.06%	Yes
Carbapenems	109.5913	1% (or 2%)*	83.83816	23.50%	Yes

For July 98.51% of antibiotic prescriptions reviewed were deemed appropriate and prescribed in line with the trusts antibiotic formulary.

Environmental Cleaning

The average cleaning scores by month are as follows:

The James Cook Site:

Risk Category	NSC Target	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
High Risk	**95%**	98%	98%	98%	98%	98%	98%	99%	98%	99%	99%	99%	98%
Significant Risk	**85%**	97%	96%	98%	98%	97%	98%	98%	98%	97%	98%	97%	97%
Low Risk	**75%**	93%	91%	95%	95%	95%	95%	96%	96%	95%	95%	96%	95%

Cleaning scores have been maintained on both acute hospital sites. No areas failed the C4C inspection in July 2018 on the James Cook site with all areas having returned to monthly monitoring. Maintaining cleaning standards remains an area of continued focus and we continue the previous work with Carillion with the new service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG.

The trust has trialled a new product that provides the opportunity to decontaminate small rooms such as toilets and bathrooms where we are unable to use the current machinery. Further discussion is required with Serco following the trial.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital:

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	**98%**	98.47%	100%		100%
High Risk	**95%**			96%	100%
Significant Risk	**85%**	97.19%		95%	100%
Low Risk	**75%**	100%		93%	100%

Cleaning scores for The Friary and East Cleveland have not been regularly received from NHS Property Services. The trust has formally requested that this information is provided monthly in line with contractual agreements.

1.2 MSSA bacteraemia

MSSA	Total 2017/18	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Total 2018/19 to date	Target for 2018/19
Total cases	130	10	5	17	13	10	10	9	21	9	23	8	13	53	NA
Not trust apportioned	96	7	4	11	11	7	5	6	17	6	16	6	11	39	NA
Trust apportioned	34	3	1	6	2	3	5	3	4	3	7	2	2	14	NA

There were 13 cases of MSSA bacteraemia cases in July 2018; 2 of which were classed as trust-apportioned. There have been 14 trust-apportioned cases in the first 4 months of 2018/19.

Whilst there is no external target for MSSA or MRSA bacteraemia, the trust has set an internal target to maintain the 15% reduction of Staphylococcus aureus infections based on the 16/17 baseline, meaning no more than 35 combined MRSA and MSSA trust-apportioned cases in total.

1.3 MRSA bacteraemia

There were 2 cases of MRSA bacteraemia cases in July 2018. Provisionally these cases are both classed as not trust-assigned. There have been 0 trust-assigned cases in the first 4 months of 2018/19.

MRSA	Total 2017/18	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Total 2018/19 to date	Target for 2018/19
Total cases	4	0	0	0	0	0	2	0	0	0	2	0	2	4	NA
Not trust assigned	3	0	0	0	0	0	2	0	0	0	2	0	2	4	NA
Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	0	NA

1.4 Surveillance for other healthcare-associated infections

	Total for 17/18	**July 2018**	**Total 18/19**
Bacteraemia due to glycopeptide-resistant enterococci	7	2	5
Bacteraemia due to E. coli	500	49	189
• Trust-apportioned	106	12	49
• Not trust-apportioned	394	37	140
ESBL producing coliform infections	798	83	302
• sample taken in community	490	50	183
• sample taken in our trust	304	33	119
• bacteraemias	25	3	9
Bacteraemia due to Klebsiella species	131	16	42
• Trust-apportioned	41	5	11
• Not trust-apportioned	90	11	31
Bacteraemia due to Pseudomonas aeruginosa	41	2	7
• Trust-apportioned	19	0	3
• Not trust-apportioned	22	2	4
Other alert organisms	1	0	0
• invasive group A streptococcus			

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction by 2021.

In July 2018 the trust reported a total of 67 cases of the 3 GNBSI organisms which are part of national surveillance (Ecoli, 49; Klebsiella sp. 16; Pseudomonas aeruginosa 2). Of these, 17 cases were classed as trust-apportioned (25%) as defined by the Department of Health definition. This demonstrates the need to provide further support to the wider community in order to reduce these infections.

The trust has confirmed the members of a system wide team to participate in the second cohort of trusts to take part in a national urinary tract infection collaborative. This national work which is supported by NHS Improvement is also aligned to the focus and priorities identified within our system wide GNBSI collaborative action plan. The first meeting is due to take place in September 2018.

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 17/18	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Total 18/19 to date
Total number	*3*	0	0	1	0	0	0	0	2	0	0	0	0	0
Total number of patients affected	*42*	0	0	11	0	0	0	0	31	0	0	0	0	0
Total number of staff affected	*15*	0	0	2	0	0	0	0	13	0	0	0	0	0

There were no significant outbreaks of diarrhoea and vomiting in the trust in July 2018.

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

There have been no new patients identified with GES carbapenemase-producing Pseudomonas aeruginosa since October 2017. There were no further cases detected in July 2018, however, we will continue with our surveillance for this organism.

In total there have been 21 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

The region has seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. We had no new cases in July 2018.

5. DECONTAMINATION

A monthly report is prepared by the Lead for Decontamination and presented to IPAG. Key points from the most recent report are as follows:

- The deep clean for the General High Dependency Unit was completed over two days on 28 and 29 July 2018.

- Life cycle works are planned for ITU 2 and 3 and has been confirmed as commencing on the 13 August 2018 which will include a deep clean of both clinical areas.

Board of Directors	
Agenda item	9.2
Title of Report	Safe Staffing Report – Nursing and Midwifery
Date of Meeting	4 September 2018
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing, Workforce
Approved by	Gill Hunt, Director of Nursing and Quality
Previous Committee/Group Review	
Purpose	Approval ☐ Decision ☐ Discussion √ Information √
Alignment to Trust's Strategic Objectives	√ 1. We will deliver excellence in patient outcomes and experience √ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future √ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to receive and note the content of this report.

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).

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

- RN / RM day shift – 91.4%, night shift 94.3%
- HCSW day shift 92.3%, night shift 107.3%

2. Recommendation

The Board is asked to note the content of the report and to be assured that staffing levels are sufficient to deliver safe, high quality care with systems and processes in place should staffing levels fall short of those planned.

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for July 2018 was submitted on 15th August 2018 with the summary of overall fill rate in the table below with the full report in Appendix 1.

Table 1 – Overall UNIFY Return fill Rate 2017/2018

2017/2018	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
April 2017	92.7%	99.0%	95.3%	111.9%
May 2017	91.0%	97.4%	95.0%	109.5%
June 2017	91.5%	98.3%	93.5%	109.1%
July 2017	88.7%	97.4%	93.9%	111.0%
August 2017	87.2%	96.9%	92.1%	113.1%
September 2017	88.3%	100.3%	91.7%	113.9%
October 2017	88.7%	96.6%	93.1%	116.0%
November 2017	88.5%	95.1%	93.6%	109.6%
December 2017	87.1%	92.8%	92.6%	107.9%
January 2018	90.7%	91.2%	93.0%	109.1%
February 2018	89.4%	89.2%	93.1%	107.4%
March 2018	91.1%	92.6%	94.2%	109.2%
April 2018	91.0%	94.7%	96.4%	110.9%
May 2018	92.1%	91.4%	96.2%	112.1%
June 2018	92.7%	93.1%	94.6%	109.5%
July 2018	91.4%	92.3%	94.3%	107.3%

Average fill rates for RN and HCA days and nights has decreased slightly overall during July.

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 with both full and part shifts. 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. These areas are not currently on SafeCare and changes may not always be captured on the roster.

Ward 9 (RN days and nights), CCU, Ainderby, Allerton and Zetland (RN days) had a fill rate of less than 80% during July.

Ward 9 staffing is being closely monitored by the Clinical Matron. The ward plans to have 5 RN's for both day and night shifts to accommodate the requirement of 1:2 staffing of patients within the

Respiratory Support Unit (RSU) for the first 24hrs of acute care. The Assistant Director of Nursing Workforce has undertaken a review of acuity and dependency with the Clinical Matron and a system to report RSU occupancy was introduced on 9th July. Since this system was introduced SafeCare has reported 4 occasions where CHPPD fell below the required level (reported x3 daily). Night fill has been supported by an Assistant Practitioner. Recruitment efforts have been successful with a number of new RN's due to start on ward in in September which will improve the substantive RN fill rate.

The Friarage Matron has monitored staffing levels on Ainderby and Allerton and redeployed staff according to bed occupancy.

Zetland ward is experiencing high levels of RN sickness (24%). Planned staffing is for 5 RN's but filled hours are providing 4/3 for early and late shifts. Bed occupancy was at 80% (27 beds) with RN's supported by 6 HCA/AP's, Nurse Practitioners and Therapy staff to maintain safety.

2. Temporary Staffing

The number of temporary staffing hours during July decreased with a combined RN/HCA fill rate of 70%. This is in line with the annual trend for holiday periods. 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 70 red flags have been reported during June. 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 a shortfall in RN hours (33) and opening of 'amber' beds (21) Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

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.

Row Labels	Count of Red Flag Type
AMBER Beds Open	21
Delay in providing pain relief	4
Less than 2 RNs on shift	5
Missed 'intentional rounding'	5
RED Beds Open	1
Shortfall in RN time	33
Vital signs not assessed or recorded	1
Grand Total	**70**

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 July 774 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. At a macro level our CHPPD is relatively consistent with peers, the latest published data was in April 2018 during which time we were in line with our peer group of with an overall CHPPD at South Tees Hospitals NHS Foundation Trust of 8.6 CHPPD.

6. Staff Retention

The retention of nurses and midwives is as important as the recruitment activity undertaken to fill vacant posts. The Trust is working with NHS Employers and NHSI on a retention work stream focused on our flexible working and retirement strategies.

7. Band 5 Vacancy Rate and Recruitment Activity

A total of 5 nurses arrived from the Philippines in July and were deployed on wards 11, 14, 24, A+E and ITU with a further 5 expected at the end of August to be deployed on wards 1, 9, 11, Spinal Unit and Theatres.

The nursing open day planned for July has been rearranged for 1st September and will give applicants wishing to apply for the current band 5 advert, for which will interview in October, to visit the Trust and speak to staff.

8. Annual Safe Staffing reviews

The Paediatric staffing review was completed in June for wards 21 and 22 using the new Children and Young Peoples Staffing Nursing Care Tool (CYP SNCT).

Permissions have been obtained to share data required to complete the District Nursing safe staffing pilot.

References

Department of Health (2016) **Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles** *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf*

National Quality Board (2016) **How to ensure the right people, with the right skills are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.** London

Safe, sustainable and productive staffing in maternity services
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Maternity_final_2.pdf

Safe, sustainable and productive staffing for neonatal care and children and young people's services
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Neonatal_mYLJCHm.pdf

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

South Tees Hospitals NHS
NHS Foundation Trust

Appendix 1 JCUH

		Hours								DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Registered								Unregistered										
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights					Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
UEC	Critical Care	10,047.67	9,212.00	2,604.00	1,958.67	10,044.00	9,132.00	1,114.02	792.00	91.7%	75.2%	90.9%	71.1%	15.50%	0.10%	2.90%	7.90%	0.00%	0.00%	2.10%	28.5%	9.10%	1.00%	4.80%	4.80%			1.60%	21.4%	859	21.4	3.2	24.6
UEC	AMU JCUH	2,226.17	2,178.17	1,488.00	1,518.33	1,860.00	1,812.00	1,326.00	1,374.00	97.8%	102.0%	97.4%	103.6%	14.70%	1.30%		1.60%			3.20%	20.9%	12.20%	0.20%	4.80%	3.70%	0.70%		6.00%	27.7%	623	6.4	4.6	11.0
UEC	RAFAU	2,496.00	2,105.00	1,478.25	1,599.83	1,116.00	1,008.00	1,164.25	1,359.75	84.3%	108.2%	90.3%	116.8%	14.60%		4.40%	2.70%	1.60%		2.50%	25.8%	15.60%	0.40%		7.00%				22.9%	759	4.1	3.9	8.0
PL	JC06 Gastro	1,426.25	1,244.75	1,609.92	1,314.00	713.08	714.08	713.00	898.00	87.3%	81.6%	100.1%	125.9%	16.40%		11.80%	4.70%	0.40%		0.40%	33.7%	18.70%		6.70%	6.70%	0.20%	0.40%		32.8%	711	2.8	3.1	5.9
COM	JC09 (Ward 9)	1,846.67	1,430.17	1,479.75	1,428.75	1,488.00	1,092.00	1,116.00	1,140.00	77.4%	96.6%	73.4%	102.2%	17.70%			2.10%	0.20%		2.60%	22.6%	17.50%		5.50%	1.60%	1.60%		2.40%	28.5%	763	3.3	3.4	6.7
COM	Ward 12 General Medicine	1,550.50	1,302.50	1,487.83	1,938.93	1,116.00	852.00	744.00	1,680.00	84.0%	130.3%	76.3%	225.8%	13.90%	6.80%		4.40%	1.10%		2.80%	29.0%	12.50%		5.60%	3.50%			0.40%	22.0%	667	3.2	5.4	8.7
COM	JC28 (Ward 28)	1,855.00	1,779.00	1,116.00	1,030.67	1,488.00	1,371.00	744.00	876.00	95.9%	92.4%	92.1%	117.7%	15.60%		4.30%	5.10%	0.00%		2.40%	27.4%	14.70%	0.50%	7.70%	4.80%				27.7%	562	5.6	3.4	9.0
UEC	AAU JCUH	2,976.00	2,858.33	1,752.00	1,417.67	1,860.00	1,836.00	1,116.00	1,146.17	96.0%	80.9%	98.7%	102.7%	15.90%	3.10%	7.90%	2.80%	0.80%		1.80%	32.3%	14.80%	0.60%		6.40%	1.10%		2.20%	25.1%	547	8.6	4.7	13.3
COM	Ward 3	1,433.83	1,403.83	1,778.42	1,848.42	1,074.17	944.33	714.33	1,024.67	97.9%	103.9%	87.9%	143.4%	16.50%		7.30%	3.60%	0.40%		2.80%	30.6%	16.50%			12.10%				28.6%	841	2.8	3.4	6.2
UEC	Short Stay (JC02)	1,488.00	1,414.00	1,116.00	1,129.17	744.00	744.00	739.17	763.17	95.0%	101.2%	100.0%	103.2%	11.70%	2.80%		4.00%	0.90%		2.50%	21.9%	13.20%	0.70%			0.70%			14.6%	530	4.1	3.6	7.6
COM	Ward 11 Elderly Care	1,590.13	1,294.65	1,125.50	1,486.25	1,116.00	948.00	744.00	1,253.83	81.4%	132.1%	84.9%	168.5%	16.00%	1.70%	7.10%	13.60%	1.70%		2.40%	42.6%	13.10%	5.10%	3.50%	16.50%	1.70%		0.70%	40.6%	745	3.0	3.7	6.7
PL	PCAU	738.25	855.50	744.00	853.33	744.00	708.00	372.00	372.00	115.9%	114.7%	95.2%	100.0%	10.90%			2.80%	2.50%		1.00%	17.3%	15.70%		11.00%	3.10%	0.20%			30.0%	231	6.8	5.3	12.1
PL	JC35 (Ward 35)	1,860.00	1,740.00	1,488.00	1,302.00	840.00	840.00	743.67	768.00	93.5%	87.5%	100.0%	103.3%	16.20%		5.70%		0.40%		3.00%	25.3%	14.70%		4.80%	7.10%				26.6%	731	3.5	2.8	6.4
PL	JC05 Vas	1,119.75	1,177.25	1,483.00	1,248.25	744.00	744.00	744.00	732.00	105.1%	84.2%	100.0%	98.4%	17.60%			4.90%			7.70%	30.2%	13.40%	1.60%	23.00%	3.20%	2.40%		0.50%	44.2%	476	4.0	4.2	8.2
PL	Ward 7 Colo	1,860.00	1,797.00	1,856.58	1,585.08	1,116.00	1,104.00	744.00	768.00	96.6%	85.4%	98.9%	103.2%	15.70%			1.10%	0.20%		3.30%	20.3%	14.60%		14.90%	8.20%				37.7%	908	3.2	2.6	5.8
SP	JC04 (Ward 4)	1,642.25	1,488.83	1,116.00	1,105.67	1,100.00	1,028.00	744.00	744.00	90.7%	99.1%	93.5%	100.0%	15.80%	0.40%	5.50%	4.90%	2.60%		2.90%	32.0%	16.40%		9.20%	6.40%	0.60%			32.6%	682	3.7	2.7	6.4
SP	JC14 Oncology (Ward 14)	1,846.67	1,679.50	1,116.00	1,101.33	1,116.00	1,116.00	744.00	768.00	90.9%	98.7%	100.0%	103.2%	15.70%	0.30%	4.60%	1.10%	1.70%		8.30%	31.8%	16.00%	1.60%		17.90%	1.00%			36.5%	652	4.3	2.9	7.2
SP	JC33 Specialty (merger of ward 18 and ward 27)	1,486.83	1,240.83	1,486.17	1,412.50	1,116.00	1,056.17	744.00	828.50	83.5%	95.0%	94.6%	111.4%	16.90%	0.50%		7.40%	1.10%		4.70%	30.5%	13.30%	6.70%		5.50%	1.10%		0.90%	27.5%	521	4.4	4.3	8.7
PL	JC34 (Ward 34)	1,582.83	1,447.33	1,854.50	1,717.50	792.00	792.67	1,350.00	1,464.00	91.4%	92.6%	100.1%	108.4%	13.90%		6.00%	13.80%	0.20%		0.60%	34.5%	16.60%		6.90%	9.00%	0.50%			33.0%	758	3.0	4.2	7.2
PL	Ward 25 Ortho Plan	1,075.50	969.32	1,071.98	1,011.98	713.33	713.33	356.50	356.50	90.1%	94.4%	100.0%	100.0%	13.40%	1.90%	4.90%	7.40%	2.20%		0.80%	30.6%	17.90%			7.80%		0.20%	1.30%	27.2%	558	3.0	2.5	5.5
PL	JC36 Trauma	1,927.75	1,965.25	1,485.30	1,550.63	1,114.25	1,090.25	1,118.00	1,142.33	101.9%	104.4%	97.8%	102.2%	15.10%	0.40%		3.50%	0.20%		3.30%	22.4%	14.40%	1.10%		9.70%	0.20%		0.40%	25.8%	902	3.4	3.0	6.4
SP	Spinal Injuries	2,475.08	2,479.08	1,912.27	1,486.45	1,488.00	1,452.00	1,116.00	1,152.00	100.2%	77.7%	97.6%	103.2%	15.90%	0.20%	0.40%	11.90%	1.80%		3.00%	33.2%	10.60%	0.70%		14.70%	0.20%		3.40%	29.7%	710	5.5	3.7	9.3
SP	Cardio MB	742.33	741.83	372.00	389.67	744.00	720.00	0.00	48.00	99.9%	104.7%	96.8%	-	13.40%		7.70%		1.40%		1.90%	24.4%	2.30%							2.3%	248	5.9	1.8	7.7
SP	CCU JCUH	2,664.00	1,992.00	372.00	354.00	1,860.00	1,800.00	0.00	0.00	74.8%	95.2%	96.8%	-	14.70%	1.30%	9.70%	2.00%	0.60%		2.70%	31.1%	24.40%						2.60%	27.0%	261	14.5	1.4	15.9
SP	CICU JCUH	3,978.00	3,349.50	1,190.50	807.20	3,600.00	3,168.00	600.00	444.00	84.2%	67.8%	88.0%	74.0%	14.90%	0.10%	1.20%	10.00%	1.20%		8.30%	35.7%	12.00%			2.70%				14.8%	265	24.6	4.7	29.3
SP	JC24 (Ward 24)	1,671.33	1,505.33	1,116.50	1,590.00	1,116.67	1,058.67	744.00	1,104.00	90.1%	142.4%	94.8%	148.4%	10.70%		10.90%	9.80%	0.60%		2.30%	34.3%	12.60%	1.10%	12.70%	0.60%	0.10%			27.1%	918	2.8	2.9	5.7
SP	JC27 Neuro	1,448.08	1,510.50	1,125.83	1,220.17	744.00	758.33	960.00	1,056.17	104.3%	108.4%	101.9%	110.0%	13.00%			10.10%	1.10%		5.20%	29.3%	11.80%			1.50%	2.00%	0.10%	0.30%	15.5%	441	5.1	5.2	10.3
SP	JC26 (Ward 26)	1,130.50	1,103.42	767.83	810.33	744.00	744.00	372.00	480.00	97.6%	105.5%	100.0%	129.0%	14.00%			0.80%	0.40%		4.40%	19.6%	15.50%			16.60%			11.10%	43.2%	519	3.6	2.5	6.0
SP	JC29 (Ward 29)	1,246.17	1,209.17	1,107.83	1,040.17	744.00	744.00	744.00	770.00	97.0%	93.9%	100.0%	103.5%	13.70%	1.20%	10.00%	7.50%	1.60%		5.30%	39.2%	18.10%			11.30%	2.30%		0.40%	32.0%	539	3.6	3.4	7.0
SP	JC31 (Ward 31)	1,939.35	1,774.47	1,201.32	1,081.82	1,116.00	1,080.00	744.00	780.00	91.5%	90.1%	96.8%	104.8%	19.10%		1.90%	3.50%	1.30%		4.20%	30.1%	14.90%			8.90%	2.70%		2.80%	29.4%	784	3.6	2.4	6.0
SP	Cardio HDU	2,088.00	1,976.02	372.00	367.50	1,692.00	1,500.00	372.00	360.00	94.6%	98.8%	88.7%	96.8%	14.60%	0.30%	0.50%	4.10%	2.10%		2.40%	24.0%	14.60%				8.50%		3.70%	26.9%	222	15.7	3.3	18.9
PL	Ward 8	1,828.00	1,595.00	1,909.75	1,665.17	1,117.33	1,021.17	1,117.33	889.33	87.3%	87.2%	91.4%	79.6%	15.60%	2.80%	4.80%	5.30%	2.00%		4.30%	34.8%	16.20%	0.60%	3.60%	6.80%	0.20%	3.00%		30.3%	854	3.1	3.0	6.1
COM	JC21 (Ward 21)	2,232.00	2,068.00	744.00	469.00	2,232.00	1,812.00	372.00	360.00	92.7%	63.0%	81.2%	96.8%	17.60%	0.40%	1.90%	0.70%	5.90%		1.40%	27.9%	24.50%	1.00%		3.10%	0.30%			28.9%	509	7.6	1.6	9.3
COM	JC22 (Ward 22)	1,116.00	984.00	582.00	504.00	1,008.00	882.00	108.00	156.00	88.2%	86.6%	87.5%	144.4%	16.60%			11.70%	0.70%		0.70%	29.7%	21.20%				1.90%	1.40%	0.70%	25.3%	270	6.9	2.4	9.4
COM	JCDS (Central Delivery Suite)	3,876.83	3,732.00	952.83	682.00	4,091.83	3,707.83	744.00	714.00	96.3%	71.6%	90.6%	96.0%	16.50%	0.40%	2.70%	2.10%	1.00%		6.00%	28.7%	9.10%			15.60%	1.50%			26.2%	580	12.8	2.4	15.2
COM	Neonatal Unit	5,367.00	4,383.25	372.00	427.25	4,464.00	3,687.50	0.00	216.00	81.7%	114.9%	82.6%	-	15.80%	0.90%	7.30%	7.50%	1.00%	0.20%	1.90%	34.6%	11.30%	1.30%		16.20%	0.20%			29.0%	558	14.5	1.2	15.6
COM	Maternity Assessment Unit	1,375.75	1,375.75	290.00	290.00	744.00	744.00	0.00	0.00	100.0%	100.0%	100.0%	-	13.20%	0.40%	10.20%	3.30%	1.50%		5.70%	34.2%	10.40%							10.4%	33	64.2	8.8	73.0
COM	Paediatric Intensive Care Unit (PICU)	1,860.00	1,483.00	232.50	199.50	1,860.00	1,472.50	0.00	0.00	79.7%	85.8%	79.2%	-	16.20%	0.40%	10.80%	3.70%	2.90%	0.80%	6.40%	41.1%	14.30%							14.3%	86	34.4	2.3	36.7
COM	Ward 17 JCUH	2,225.75	2,121.75	1,173.75	1,065.75	1,761.33	1,660.00	204.00	167.00	95.3%	90.8%	94.2%	-	13.90%	0.50%		7.90%	2.20%		8.10%	32.5%	17.30%	0.60%	16.50%	10.40%	3.10%		1.90%	49.8%	825	4.6	1.5	6.1
COM	Ward 19 Ante Natal	1,253.50	1,025.00	232.50	131.00	744.00	744.00	0.00	0.00	81.8%	-	100.0%	-	15.90%		3.10%		11.00%		1.70%	31.7%	34.20%							34.2%	322	5.5	0.4	5.9
									Site average	92.1%	96.0%	93.5%	112.1%																			

FHN	Hours								< 80	80-95	> 95		Registered								Unregistered											
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
Ainderby FHN	1,473.83	1,134.50	1,211.50	995.50	713.00	690.00	713.00	782.00	77.0%	82.2%	96.8%	109.7%	15.00%	1.00%	6.70%	4.80%	1.00%		5.90%	34.4%	13.40%		8.40%	0.50%	4.90%		1.20%	28.3%	579	3.151123	3.069948	6.221071
Clinical Decisions Unit FHN	1,773.33	1,644.50	1,069.50	1,127.00	1,069.50	966.00	713.00	704.00	92.7%	105.4%	90.3%	98.7%	13.70%		8.30%	5.70%	3.10%	0.60%	3.10%	34.5%	17.10%	2.40%			2.90%		1.50%	23.8%	550	4.746364	3.329091	8.075455
FHICU (ICU FHN)	1,112.50	970.83	327.00	147.00	1,116.00	972.00	0.00	0.00	87.3%	45.0%	87.1%	-	18.40%	0.30%		12.20%	0.00%		2.80%	33.7%				48.00%				48.0%	83	23.40763	1.771084	25.17871
Romanby FHN	1,320.50	1,174.00	1,099.98	1,135.98	707.00	707.00	713.67	678.83	88.9%	103.3%	100.0%	95.1%	14.70%			9.40%	1.00%		2.10%	27.2%	15.90%			17.70%	1.20%			34.8%	583	3.226415	3.112893	6.339308
Rutson FHN	1,157.48	938.98	1,511.92	1,078.42	713.33	713.33	713.67	713.67	81.1%	71.3%	100.0%	100.0%	16.70%			4.20%	1.00%		3.30%	25.3%	12.00%			16.70%	1.00%		8.10%	37.7%	428	3.860553	4.187111	8.047664
Allerton Ward FHN	1,486.92	1,099.33	1,115.50	1,056.00	744.00	732.00	744.00	684.00	73.9%	94.7%	98.4%	91.9%	14.00%		7.00%	8.40%			3.80%	33.2%	12.80%			3.70%			1.80%	18.3%	608	3.012061	2.861842	5.873904
Gara Orthopaedic FHN	824.75	807.75	735.50	678.50	713.00	678.50	356.67	333.67	97.9%	92.3%	95.2%	93.6%	15.00%	0.90%	1.20%	2.30%	1.30%		5.20%	25.8%	17.70%			2.80%	0.90%			21.4%	346	4.29552	2.925337	7.220857
Maternity FHN	1,070.50	930.00	285.00	275.50	741.75	741.75	12.00	12.00	86.9%	96.7%	100.0%	-	13.50%		18.50%		2.90%		2.70%	37.7%	22.60%				9.60%			32.2%	22	75.98864	13.06818	89.05682
								Site Average	85.7%	86.3%	96.0%	98.2%																				

East Cleveland	Hours								< 80	80-95	> 95		Registered								Unregistered											
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A	Parenti	Sicknes	Study D	Unknov	Workin g Day	Total	Leave	Other A	Parenti	Sicknes	Study D	Unknov	Workin g Day	Total	CHPPD	Regist ered Midwiv es/Nur	Care Staff	Overall
Tocketts Ward East Cleveland Hospital	1,369.17	1,152.67	1,989.00	1,694.42	1,077.83	891.50	1,069.25	1,222.08	84.2%	85.2%	82.7%	114.3%	17.10%		6.60%	14.10%	1.00%		4.10%	42.9%	14.90%	3.80%		8.60%	1.00%	3.50%	2.00%	33.7%	810	2.523663	3.600617	6.12428
								Site Average	84.2%	85.2%	82.7%	114.3%																				

Redcar	Hours								< 80	80-95	> 95		Registered								Unregistered											
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Da	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Da	Unknown	Working Day	Total	CHPPD	Register ed Midwives /Nurses	Care Staff	Overall
Zetland	1,828.00	1,350.50	2,237.08	2,193.33	1,081.67	967.00	1,069.83	1,300.33	73.9%	98.0%	89.4%	121.5%	13.20%	1.30%		26.40%	0.80%		5.90%	47.7%	18.10%	4.10%		2.70%	1.10%		3.00%	29.0%	835	2.77545	4.18403	6.95948
								Site Average	73.9%	98.0%	89.4%	121.5%																				

Friary Community Hospital	Hours								< 80	80-95	> 95		Registered								Unregistered											
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/I	Parenting	Sickness	Study Da	Unknown	Working Day	Total	Leave	Other A/I	Parenting	Sickness	Study Da	Unknown	Working Day	Total	CHPPD	Register ed Midwive s/Nurse	Care Staff	Overall
Friary Community Hospital	1,050.75	955.75	1,304.00	1,121.50	620.00	620.00	390.75	370.75	91.0%	86.0%	100.0%	94.9%	17.10%	3.30%		1.50%	1.00%		0.90%	23.7%	13.50%			5.10%	2.00%			20.6%	370	4.258784	4.033108	8.291892
								Site Average	91.0%	86.0%	100.0%	94.9%																				

	< 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	87.2%	94.6%	90.4%	122.2%
Planned Care	94.6%	90.4%	98.2%	100.7%
Specialist	92.3%	98.3%	96.1%	107.7%
Urgent and Emergency Care	91.7%	86.1%	92.5%	98.6%
Trust Average	91.4%	92.3%	94.3%	107.3%

Board of Directors	
Agenda item	9.3
Title of Report	Quarter 1 Mortality Learning from Deaths Report
Date of Meeting	4 September 2018
Presented by	Simon Kendall, Medical Director CDS & Responsible Officer
Author	Tony Roberts Deputy Director (Clinical Effective) Jo Raine, Data Analyst Clinical Effectiveness / Mortality Surveillance Coordinator
Approved by	Simon Kendall, Medical Director CDS & Responsible Officer
Previous Committee/Group Review	Quality Assurance Committee Operational Management Board
Purpose	Approval ☐ Decision ☐ Discussion ☐ Information ☑
Alignment to Trust's Strategic Objectives	☐* 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to note the Learning from Deaths Report

1. Executive Summary

The national Learning from Deaths policy requires all Trust to publish through public facing Board papers, details of how they learn from deaths in care, as detailed in their Trust's Responding to Deaths policy (South Tees published on our website in September 2017)

This report updates the format of the existing monthly and quarterly Board reporting of mortality. Data included is: count of deaths over a 10 year period to June 2018; SHMI January 2017 – December 2017 (111 'as expected'); HSMR April 2017 – March 2018 (114'higher than expected'); and rates of palliative care and comorbidity coding.

The Learning from Deaths Dashboard includes the number of deaths, the number of deaths reviewed or investigated and the number of those judged to be potentially preventable. Data is provided separately for patients with learning disabilities.

Data from the Mortality Surveillance Reviews for June 2018 shows that of the 20 deaths reviewed in the period 75% were judged to have received good care with no preventability.

The Medical Examiner Service is now operational, allowing all deaths to receive stage one review. The new service will also impact on the number of second stage reviews completed and this will be monitored through the Learning From Deaths dashboard.

2. Recommendation

The Board is asked to receive and note the Quarter 1 Learning from Deaths update report.

Learning From Deaths Quarterly Dashboard

1 Responding to Deaths

1.1 In March 2017 the National Quality Board published *Guidance on Learning from Deaths* (LFD)[1] and a national work programme has been established for LFD. NHS Improvement hosted a conference on 14 December 2017 LFD: One Year On and have published case studies[2].

1.2 The Trust published it's *Responding to Deaths* Policy (in line with the national LFD requirements) in September 2018. It sets out the Trust's approach to learning from deaths in care: https://www.southtees.nhs.uk/about/trust/responding-deaths-policy/ There are broadly three opportunities to learn:

- at the time of certification of death. The Trust has established a Medical Examiner Service which commenced work in April 2018. When the service is fully established, all deaths will receive scrutiny, including a 'stage one' case record review, discussion with the attending team and a discussion with the bereaved family

- at a 'stage two' case record review, usually conducted within weeks of a death, any death identified by a 'stage one' case record review plus all deaths of patients with learning disabilities, serious mental illness, where an incident or complaint has been reported, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred.

- at the time of investigation when a death has occurred where an incident has been reported through the Trust's incident reporting system (Datix).

1.3 The Learning From Deaths dashboard has been redesigned to make it more easily interpreted and reports the number of deaths, the number deaths with 1st stage reviews (by Medical Examiners), number of deaths with 2nd stage reviews or investigations and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities. For the year to end of June 2018, there were 2,070 deaths, of which 506 received a review or investigation (134 1st stage only) and 3 deaths were considered to be potentially avoidable. In the same period there were 17 deaths in patients with learning disabilities, of which 8 received a review or investigation and 0 deaths were considered to be potentially avoidable. Potential learning from both good care and from problems in care are outlined. Changes that are being implemented relate to better coordination and documentation of care and these will be easier to address as enhancement to the use of electronic patient records occur and the impact of these changes will also become easier to assess from digital records.

2 Mortality indicators

2.1 The dashboard includes the number deaths from April 2008 to June 2018. Since the winter peak the number of deaths per month has averaged 150 – about what would be expected for the Trust at this time of year.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
[2] https://improvement.nhs.uk/uploads/documents/Learning_from_deaths_case_studies_Web_version.pdf

2.2 Two risk-adjusted mortality indicators are included in the dashboard. The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (including 12 months of data in each release) by NHS Digital and is an official government statistic. Current reporting is January 2017 - December 2017. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 111 and is 'as expected' (ie within the variation expected statistically). The Hospital Standardised Mortality Ratio (HSMR) includes approximately 80% of in-hospital deaths and uses different risk adjustment methods. Current reporting is April 2017 – March 2018. The HSMR is 114 and is 'higher than expected'.

2.3 SHMI and HSMR risk-adjust deaths in diagnostic groups based on the primary diagnosis coded in the first Finished Consultant Episode (FCE), risk-adjusted for age, sex, method of admission and comorbidities (ie other clinical conditions coded in secondary positions). The Comorbidity score per FCE for South Tees and England is shown in quarters from October 2014 to December 2017. This shows the broadly static coding level for South Tees and the higher and rising rate for England. The relative difference is adversely affecting the HSMR and accounts for part of the difference in value between the SHMI and HSMR (as HSMR is more sensitive to this issue than SHMI). HSMR (but not SHMI) also adjusts for specialist palliative care coding and the chart for Palliative Care Coding for January 2016 to June 2018 shows that the number of cases with the relevant codes is static or falling slightly. This is adversely affecting the HSMR by about 1.6 points.

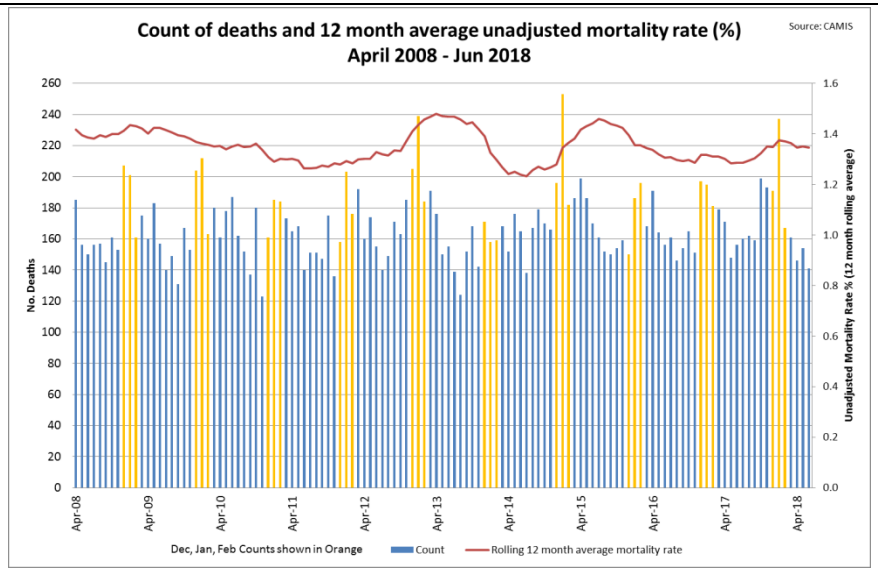
3 Next steps

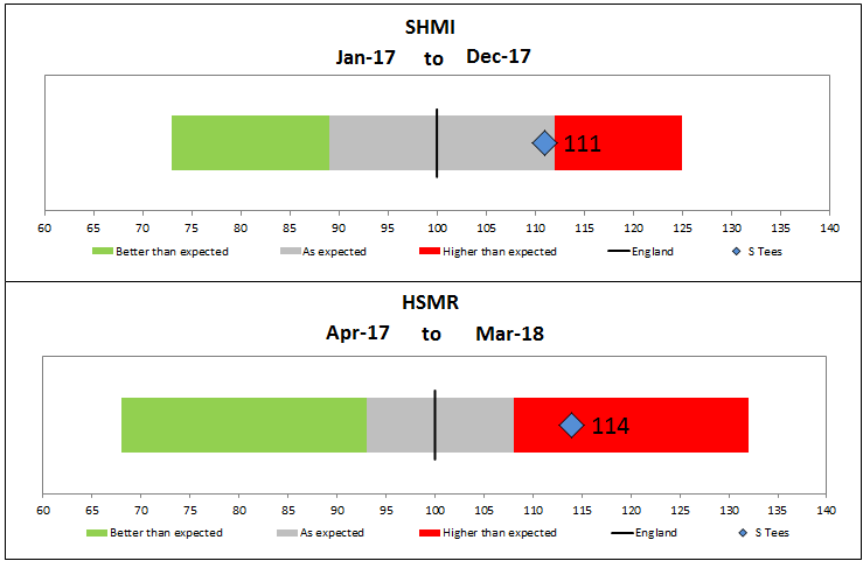
3.1 The Learning From Death work was reported in the annual Quality Account which was published in June 2018.

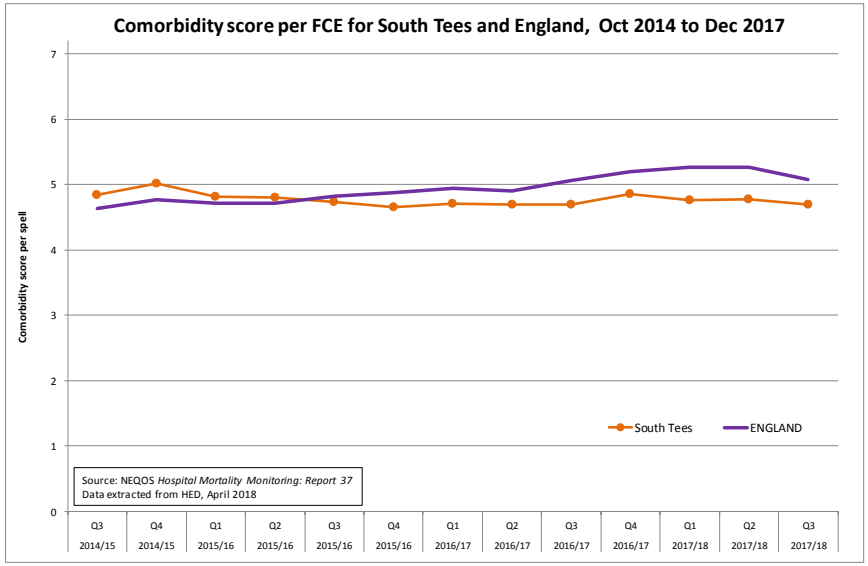
3.2 The Medical Examiner Service is now operational, allowing all deaths to receive stage one review. The new service will also impact on the number of second stage reviews completed and this will be monitored through the Learning From Deaths dashboard.

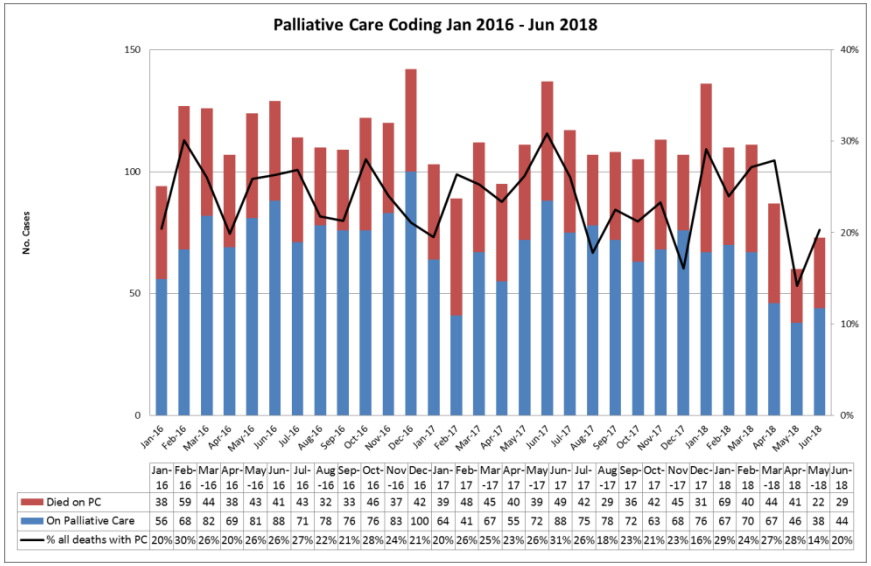
3.3 Mortality indicators will continue to be monitored. Issues around the recording of comorbidities and specialist palliative care coding are being addressed through relevant departments of the Trust.

3.4 This Learning From Deaths Quarterly Dashboard is a development of previous Board reporting and will continue to evolve. A longer report is considered by the Mortality Surveillance Group (MSGG) who report to the Quality Assurance Committee (QAC) who report to the Board of Directors.









	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Died on PC	38	59	44	38	43	41	43	32	33	46	37	42	39	48	45	40	39	49	42	29	36	42	45	31	69	40	44	41	22	29
On Palliative Care	56	68	82	69	81	88	71	78	76	76	83	100	64	41	67	55	72	88	75	78	72	63	68	76	67	70	67	46	38	44
% all deaths with PC	20%	30%	26%	20%	26%	26%	27%	22%	21%	28%	24%	21%	20%	26%	25%	23%	26%	31%	26%	18%	23%	21%	23%	16%	29%	24%	27%	28%	14%	20%

Learning from Deaths Monthly Dashboard - Jun 2018

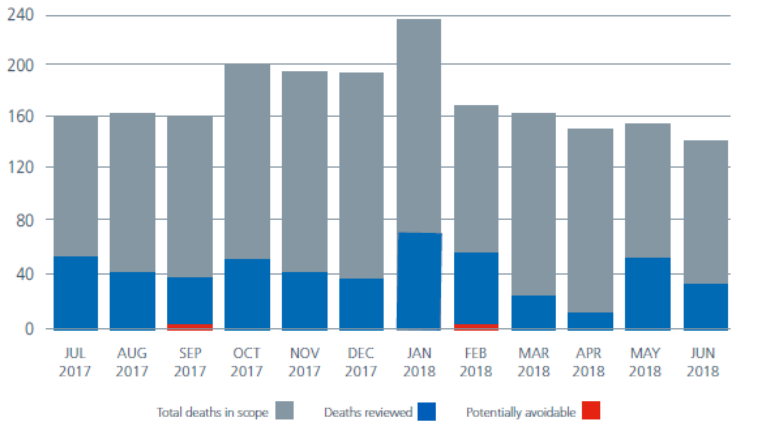
NHS
South Tees Hospitals
NHS Foundation Trust

Total number of deaths reviewed and deaths deemed preventable
(includes patients with identified learning disabilities)

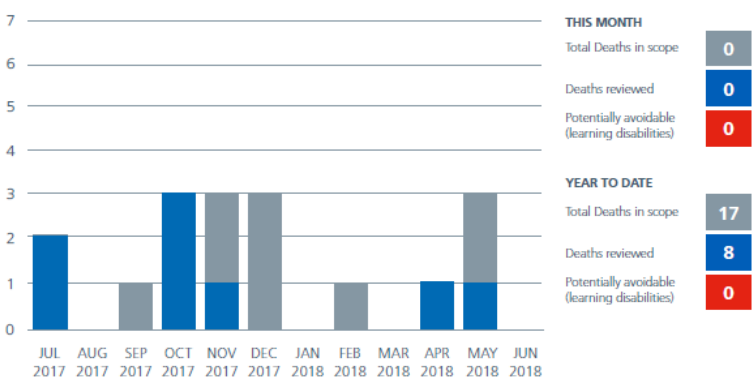
	Total deaths in scope	Total deaths reviewed	1st stage review only	Definitely not preventable	Slight evidence of preventability	Possibly preventable (<50:50 but close call)	Possibly preventable (>50:50 but close call)	Strong evidence for preventability	Definitely preventable	Total potentiallly avoidable deaths
This month	141	32	31	1	0	0	0	0	0	0
Previous 12 months	2070	506	134	344	18	7	2	1	0	3

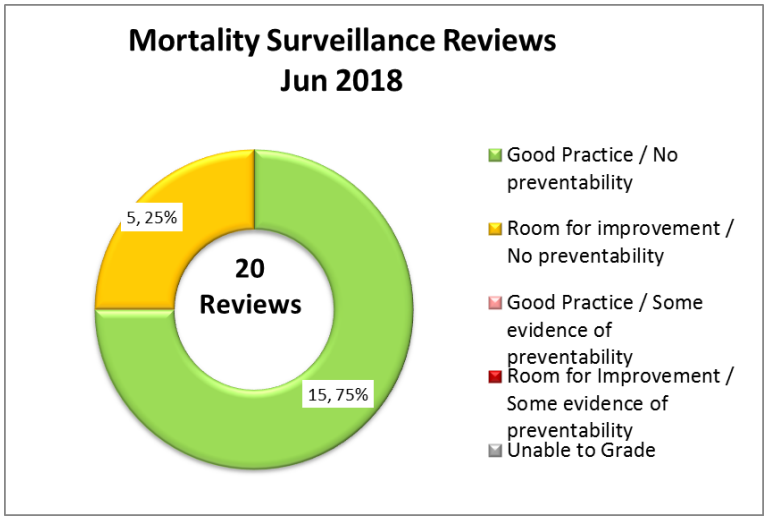
2nd stage review

All patients:
Mortality over time, total deaths and deaths considered potentially preventable



Patients with learning disabilities:
Mortality over time, total deaths and deaths considered potentially avoidable





Of the 20 deaths reviewed in June 2018, 75% of patients were judged to have received good care with no preventability. 5 cases (25%) were judged to have had care which showed room for improvement without evidence of preventability and no cases showed room for improvement with some evidence of preventability.

4 cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 5 cases were highlighted as identifying learning from problems in care.

Positive lessons were around good coordination of clinical care with multi-team involvement and decision making. Negatives reflected poorly coordinated care and lack of senior input into cases.

REVIEWS IDENTIFYING LEARNING FROM GOOD CARE	4
Good coordination of clinical care / senior input / advanced decision making	3
Good communication with family	1
Good documentation	1
Good quality clerking	1

REVIEWS IDENTIFYING LEARNING FROM PROBLEMS IN CARE	5
Poor coordination of clinical care / lack of senior input / advanced decision making	3
Availability of appropriate bed (nonICU) compromising care	1
Delay in test results / tests being undertaken	1
Delay in treatment/surgery due to staff shortages/equipment failure	1
Delayed discharge into community/lack of appropriate supportive care package	1
Incomplete physiological observations / deterioration not escalated	1
Lack of ICU Bed	1
Medication Error	1
Poor communication with family	1

Board of Directors	
Agenda item	10.1
Title of Report	Use of Trust Seal
Date of Meeting	4 September 2018
Presented by	S McArdle, Chief Executive
Author	L Hughes, Company Secretary
Previous Committee/Group Review	-
Purpose	Approval ☐ Decision ☐ Discussion ☐ Information √
Alignment to Trust's Strategic Objectives	√ 1. We will deliver excellence in patient outcomes and experience √ 2. We will drive operational performance to deliver responsive, cost effective care √ 3. We will deliver long term financial sustainability to invest in our future √ 4. We will deliver excellence in employee experience to be seen as an employer of choice √ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	• NHS Act 2006
Recommendation(s)	The Board is asked to note the documents affixed under seal during 1 June 2018 and 31 July 2018.

Use of Trust Seal

1.0 Introduction

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

In line with the Trust's Standing Orders this report provides information on the documents affixed under seal between 1 June 2018 and 31 July 2018:

Table 1. Sealed Documents

Date of Sealing	Seal No	Document	Signed and Sealed by
26 June 2018	2018/1	Deed of Variation of the Concession Agreement at James Cook University Hospital	S McArdle, Chief Executive S Mason, Director of Finance
26 June 2018	2018/2	Lease relating to the Premises between: BNY Melon Trust and Depositary (UK) Limited and South Tees University Hospital NHS Foundation Trust	S McArdle, Chief Executive S Mason, Director of Finance
26 June 2018	2018/3	TP1 between: South Tees NHS Foundation Trust and BNY Mellon Trust and Depositary (UK) Limited	S McArdle, Chief Executive S Mason, Director of Finance
26 June 2018	2018/4 and 2018/5	Deed of Surrender and Deed of Variation relating to the Headlease and Underlease for the James Cook University Hospital between: South Tees Hospitals NHS Foundation Trust and Endeavour SCH Plc	S McArdle, Chief Executive S Mason, Director of Finance
27 June 2018	2018/6 and 2018/7	Deed of Covenant and Deed of Variation relating to the Transfer of Land at James Cook University Hospital between: Tees Esk and Wear Valley NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust	S McArdle, Chief Executive S Mason, Director of Finance

9 July 2018	2018/8	Deed of Indemnity between: South Tees Hospitals NHS Foundation Trust; Endeavour SCH Plc; and Serco Limited	S McArdle, Chief Executive A Downey, Chairman
9 July 2018	2018/9	1. Deed of Novation of Hotel Services Direct Agreement, and 2. Deed of Novation of the Maintenance Services Direct agreement between: Sovereign Hospital Services Limited (in liquidation); Serco Limited; South Tees Hospitals NHS Foundation Trust; Prudential Trustee Company Limited; and Endeavour	S McArdle, Chief Executive A Downey, Chairman
9 July 2018	2018/10	Parent Company Guarantee for Hotel Services and Maintenance Services Agreements between: Serco; Endeavour; and South Tees Hospital NHS Foundation Trust	S McArdle, Chief Executive A Downey, Chairman
9 July 2018	2018/11	Deed of Release relating to a HAS and MSA Parent Company Guarantee between: Carillion JM Limited; Endeavour; and South Tees Hospitals NHS Foundation Trust	S McArdle, Chief Executive A Downey, Chairman

2.0 Recommendation

The Board is asked to note the documents included within the report that were affixed under seal during 1 June 2018 and 31 July 2018.

South Tees Hospitals NHS
NHS Foundation Trust

Board of Directors	
Agenda item	10.2
Title of Report	Freedom to Speak Up Report
Date of Meeting	4 September 2018
Presented by	Gill Hunt, Director of Nursing and Quality
Authors	Helen Smithies, Assistant Director of Nursing, Safeguarding Laura Mills, Head of Facilities
Approved by	Gill Hunt, Director of Nursing and Quality
Previous Committee/Group Review	Operational Management Board – 30 August 2018
Purpose	Approval [√] Decision [ ] Discussion [ ] Information [√]
Alignment to Trust's Strategic Objectives	[√] 1. We will deliver excellence in patient outcomes and experience [ ] 2. We will drive operational performance to deliver responsive, cost effective care [ ] 3. We will deliver long term financial sustainability to invest in our future [√] 4. We will deliver excellence in employee experience to be seen as an employer of choice [ ] 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to note the content of this report, to ensure that they are cognisant of their individual and collective responsibilities in this area and to support the work of the newly established Freedom to Speak up Guardians as the role evolves over the coming months. It is asked to approve the proposed action plan in Appendix 1.

1. Executive Summary

In May 2018 Guidance for Boards of NHS Trusts on Freedom to Speak Up was published by NHSI. It sets out the expectations placed on Boards and was accompanied by a self-review tool. The document outlines eight expectations of Boards in general and individual responsibilities for Board members. In addition it provides details of their expectations of regular FTSU Guardian reports to the Board. Finally it makes clear that the Care Quality Commission will assess an organisations speaking up culture under key line of enquiry as part of the well-led question. In July 2018 the office of the National Guardian published recording and reporting requirements.

This paper outlines the current arrangements in place and the proposed action plan to strengthen the trusts response to these requirements.

2. Recommendations

The Board is asked to note the content of this report, to ensure that they are cognisant of their individual and collective responsibilities in this area and to support the work of the newly established Freedom to Speak up Guardians as the role evolves over the coming months. It is asked to approve the proposed action plan in appendix 1.

1. Introduction

Following the Mid Staffordshire NHS Foundation Trust Public Inquiry the Inquiry Chair Sir Robert Francis made a number of recommendations designed to make the culture of the NHS more patient focused, open and transparent – one in which patients are always put first and their safety and the quality of their treatment are the priority.

Significant progress has been made towards the implementation of those recommendations. As a result the NHS has improved its ability to provide better and safer care. Part of that progress was an increased recognition of the contribution staff can make to patient care through speaking up and raising concern. However it was recognised that there were significant shortcomings with regard to the treatment of staff that raise genuine concerns about safety and other matters of public interest, and the handling of those concerns. The Secretary of State asked Francis to undertake an independent review into creating an open and honest reporting culture in the NHS, thereafter known as 'Freedom to Speak Up' (FTSU), the report was published in February 2015. The report recommended that organisations which provide NHS health care should implement the principles and actions stated in the report and that the Secretary of State for Health should review the progress made towards that implementation and the performance of the NHS in handling concerns and the treatment of those who raise concerns at least annually and report to Parliament.

In May 2018 Guidance for Boards of NHS Trusts on Freedom to Speak Up was published by NHSI. It sets out the expectations placed on Boards and was accompanied by a self-review tool. The document outlines eight expectations of Boards:

1. Leaders are knowledgeable about FTSU
2. Leaders have a structured approach to FTSU
3. Leaders actively shape the speaking up culture
4. Leaders are clear about their role and responsibilities
5. Leaders are confident that wider concerns are identified and managed
6. Leaders receive assurance in a variety of forms
7. Leaders engage with all relevant stakeholders
8. Leaders are focused on learning and continual improvement

It also makes clear individual responsibilities for the Chief Executive and Chair, Executive Lead, Non-executive Lead, Human Resources and Organisational Development Directors, Medical Director and Director of Nursing. In addition it provides details of their expectations of FTSU Guardian reports to the Board. Finally it makes clear that the Care Quality Commission will assess an organisations speaking up culture under key line of enquiry as part of the well-led question. In July 2018 the office of the National Guardian published recording and reporting requirements.

This paper outlines the current arrangements in place and the proposed action plan to strengthen the trusts response to these requirements and to have robust recording arrangements in place to enable appropriate and accurate reporting as required.

2. Trust position

Trust policy P39 (Freedom to Speak Up: Raising Concerns (Whistleblowing) was issued in December 2016. At this time the trust Freedom to Speak Up Guardian was the Company Secretary, this was later transferred to the Director of Human Resources. Where staff felt unable to raise their concerns with their line manager/supervisor they were advised to contact an external independent company, 'SeeHearSpeakUp'. This service was provided at a cost of £8750 +VAT per annum.

Since its inception in December 2016 the company has dealt with four incidents of staff raising concerns:

Reported cases

Q4 16/17	3
Q1 17/18	0
Q2 17/18	0
Q3 17/18	0
Q4 17/18	0
Q1 18/19	1

The Trust has a range of informal and formal processes for dealing with issues which arise and acknowledge that this will be the case in the majority of situations. Freedom to Speak Up should augment and support usual management practices to promote an open and transparent culture.

The lack of utilisation of the independent service coupled with five staff concerns raised directly with the CQC since April 2017 does support the need for a review, refresh and relaunch of organisational approach.

3. Actions from May 2018 and proposed future plans

Following the Guidance for Boards published in May 2018 the self-assessment tool was completed and has informed the action plan. The Executive Leads are the Director of Nursing and Quality and Medical Director, CDS Centre and Non-Executive Lead Mrs Maureen Rutter. Two individuals have been identified as suitable Freedom to Speak Up Guardians, Helen Smithies, Assistant Director of Nursing, Safeguarding and Laura Mills, Head of Facilities. Their new responsibilities have been discussed with them. The Guardians have begun to implement the findings from the self-assessment and develop a forward work plan (appendix 1.), including six monthly updates to the Board. The Guardians will undertake the required national training in November 2018.

The Guardians primary responsibilities are to develop a culture where staff feel able to safely raise concern in the knowledge that they will be listened to and treated fairly, reporting on concerns raised directly to the Board.

4. Conclusion

The Board of Directors are asked to note the content of this report, to ensure that they are cognisant of their individual and collective responsibilities in this area and to support the work of the newly established Freedom to Speak up Guardians as the role evolves over the coming months. It is asked to approve the proposed action plan in appendix 1.

Work Programme **Appendix 1**

No.	Overall aim	Detailed Action	Responsible	Target Date	Progress
1.	Develop the role of Freedom to Speak up Guardian (FTSUG)	National training for Guardians	Guardians	November 2018	Training Booked
		Inclusion of role into job descriptions	DoN & Director of Estates	October 2018	
		Arrange quarterly updates with CEO	CEO's office	December 2018	
		Arrange quarterly role review with FTSU Executive leads.	FTSU Executives	December 2018	
		Join Regional Group	Guardians	October 2018	
2.	Appoint and Develop the role of Freedom to Speak up Champions (FTSUC)	Identify FTSU Champions across Centres to work with and support the FTSUGs	Operations Directors	End of September 2018	
3.	Raise awareness of Freedom to Speak up with staff, the role and identity of FTSU Guardians, Executive and Non-Executive leads	Work with Director of Communications to raise staff awareness through: • Launch new guardians into role • Web page internal/external • Posters • Trust Briefings • Promote FTSU month (October 2018)	FTSU guardians	Following initial training of Guardians (Q3 18/19)	
4.	Policy	Review current policy to ensure that new arrangements are reflected	Guardians	December 2018	1st draft prepared
5.	Training	• Include in mandatory training managers/practitioners in line with requirements from National Guardians office • Workshops for managers in handling disclosures	Guardians/ Corporate training team	December 2018	Reviewed e-learning available via ELfH. Working with Kate Harrison, Corporate Trainer, to plan potential mandatory training package

No.	Overall aim	Detailed Action	Responsible	Date	Progress
6.	Raising concerns and recording process	Discuss IG implications of recording concerns raised with information governance team	Guardians / Information Governance Manager	December 2018	
		Explore web based reporting of FTSU concerns	Guardians/ Systems Development team		
		Devise ways of recording and tracking FTSU concerns	Guardians/ Systems Development team		
		Review contract with 'SeeHearSpeakUp' and make recommendation to Executive Directors	Guardians / Human Resources		
7.	Reporting	FTSU concerns to be reported to the relevant Board Committees and a Six monthly report of collective FTSU concerns reported to OMB, Audit Committee and Board of Directors	Guardians/ Exec Guardians	September 2018	

Board of Directors	
Agenda item	10.3
Title of Report	Doctors Revalidation Report
Date of Meeting	4 September 2018
Presented by	S Kendall, Medical Director (Clinical Diagnostics and Support Services/Responsible Officer)
Author	Mr. James Auty - Revalidation & Job Planning Manager and Mrs. Alison Wilson - HR Business Partner Medical Workforce
Approved by	S Kendall, Medical Director (Clinical Diagnostics and Support Services/Responsible Officer) Dr. Mithilesh Lal - Medical Lead for Appraisal & Revalidation
Previous Committee/Group Review	Operational Management Board
Purpose	Approval √ Decision ☐ Discussion ☐ Information ☐
Alignment to Trust's Strategic Objectives	√ 1. We will deliver excellence in patient outcomes and experience √ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future √ 4. We will deliver excellence in employee experience to be seen as an employer of choice √ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	• NHS England • General Medical Council
Recommendation(s)	The Board is asked to grant approval for the Chief Executive to countersign the Statement of Compliance on behalf of the designated body.

1. Executive Summary

The purpose of this paper is provide the Board of Directors with assurance that recommendations for the revalidation of Doctors are being made, in accordance with GMC guidance, for Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust and Teesside Hospice Care Foundation.

The main body of the report provides:

- An update on governance arrangements, reporting mechanisms, trust policy/escalation process and quality assurance of information provided in relation to the RO making revalidation recommendations
- An update on revalidation recommendations made in the last appraisal year, those submitted in the current appraisal year and revalidation recommendations for the remainder of the 2018-19 appraisal year
- The end of year report for 1st April 2017 – 31st March 2018, Annual Organisational Audit (AOA), which was submitted to NHS England (North) for monitoring purposes on 5th June 2018 (Appendix A)
- A Framework of Quality Assurance for Responsible Officers and Revalidation - Statement of Compliance - confirming that the organisation, as a designated body, is in compliance with regulations, to be submitted to NHS England (North) by 28th September 2018 (Appendix B)

The Board of Directors can be assured that:

- Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC
- All appraisals and supporting information are undergoing robust quality checks
- Doctors are continually supported by the Revalidation Team with their appraisals and revalidation
- Outstanding appraisals are routinely addressed
- Appraisers have access to dedicated support and training to aid their roles as appraisers

Next steps will include the Revalidation Team will continue to:

- Ensure appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines
- Check that appraisals and supporting information are sufficient for the RO to make a positive recommendation for revalidation to the GMC
- Optimise the reporting mechanisms within the Allocate Software
- Explore new ways of working to further enhance the Trust's revalidation and appraisal processes
- Build and maintain working relationships with Doctors, Managers and Directors across the organisation
- Seek feedback from service users to improve upon current working practices

1.1 Recommendation

The Chief Executive is asked to countersign the Statement of Compliance (Appendix B) on behalf of the Board.

Doctors Revalidation

1. Background

Medical revalidation was launched in 2012 to strengthen the way that Doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that the Board of Directors will oversee compliance by:-

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their Doctors
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their Doctors
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

2. Governance Arrangements

Mr Simon Kendall, Medical Director for Clinical Support Services, was appointed as the Trust's Responsible Officer (RO) in July 2016. The RO has a statutory and professional responsibility for all Doctors in the organisation holding a prescribed connection to South Tees Hospitals NHS Foundation Trust. The RO's statutory responsibility is to ensure Doctors are fit to practice and maintain their licence to practice.

For revalidation purposes, the RO is supported by:-

- Dr Mithilesh Lal – Medical Lead for Appraisal & Revalidation (Consultant Neonatologist)
- Mr James Auty – Revalidation & Job Planning Manager
- Miss Lisa Silk – Revalidation Assistant
- Dr Mike Ingram – Lead Appraiser (Consultant Anaesthetist)
- Mr Sanjay Rao – Lead Appraiser (Consultant Obstetrician)
- Mr Anil Reddy – Lead Appraiser (Consultant General Surgeon)
- Dr Nicola Barham – Clinical Lead for Locally Employed Doctors (LEDs) (Consultant Anaesthetist)

Members of the team also represent the Trust at the Revalidation North quarterly meetings where Trusts across the region share best practice and developments.

2.1 Teesside Hospice Care Foundation

The Trust holds a service level agreement with Teesside Hospice Care Foundation; the RO for South Tees takes on the role of its RO. Although Teesside Hospice employs a small number of Doctors (3 currently connected), the same quality and governance checks are made in compliance with South Tees' policies.

The RO and Revalidation Manager visited Teesside Hospice on 28th August 2018 to meet with the Acting Chief Executive and Lead Consultant to discuss appraisals and revalidation,

provide assurance that processes remain in place and that the service level agreement continues to be satisfactory to both organisations. South Tees continues to offer support to all Doctors at the Hospice and access to any local appraisal workshops.

3. Reporting Mechanisms

3.1 Doctors with a Prescribed Connection

The team ensures its records are kept up to date with Doctors who have a prescribed connection to South Tees and Teesside Hospice via GMC Connect - the online tool whereby Doctors' recommendations for revalidation are made. It is therefore essential the team are kept updated with new appointments and Doctors who leave the Trust via the HR Workforce Information team. The team makes a conscious effort to build and maintain close working relationships with the Medical Directors, Clinical Directors and other staff across the Trust to help to ensure records are kept up to date.

3.2 Electronic Appraisal

Allocate Software's e-Appraisal system has been used by the Trust since September 2015 with full implementation of the system completed at the end of 2016. Following minor issues at initial implementation, positive feedback is now regularly received from Doctors who find the system simple to use and easy to access.

The enhanced dashboard overview added at the end of 2017 has aided the Revalidation Team's management of the escalation process for non-participation in appraisal and appraisal sign off compliance. Allocate Software continue to update e-Appraisal with a detailed four stage development plan for the system in place for the coming years. Future system developments should help to further improve the overall usability of the system from both an administrative and clinician perspective with plans to enhance the system's reporting capability, user interface and a number of trust configurable elements being added.

4. Policy and Escalation Process

The Medical Appraisal for Revalidation Policy P57 was revised during the first quarter of 2018. A comprehensive re-write of the policy was undertaken to reflect the move from a paper based system to electronic software along with updates to the Trust's reporting structure and national guidance.

The escalation process for non-participation in the appraisal process has also been updated with the process now included as an Appendix within the policy rather than sitting as a separate document. The policy is currently awaiting OMB approval before being published to staff.

4.1 Choice of Appraiser

The Revalidation Team have been promoting a major change in how Doctors choose their appraiser. Historically, it has been the Doctor's Clinical Director tasked with conducting each appraisal but we have found that appraisals conducted by colleagues out-with the Doctor's own specialty are very positive experiences. The Trust have 145 colleagues fully trained in appraisal with some currently being under-utilised. Furthermore, it is hoped that Doctors choosing a different appraiser will reduce the appraisal workload for our Clinical Directors, although they will still have the responsibility of signing off the appraisal.

5. Quality Assurance

Based on the embedded systems and processes in place within the Trust, the Revalidation Team continues to work from a position of strength. The electronic appraisal system is now well established with robust support available to all users.

To ensure a high quality of appraisal and quality assurance of appraisers, all new appraisers are provided with a full day training from an approved external agency as well as having access to appraiser update sessions held throughout the year.

The Lead Appraiser Team quality assure 100% of appraisals and feedback to appraisers and appraisees alike where there are any areas which fall short of expectations. Appraisal documents are re-opened by the Revalidation Team in order for appraisees to address any identified shortfalls prior to their appraisal being signed off once more. Appraisals are usually re-opened where evidence of mandatory training hasn't been uploaded, if individuals haven't reflected on their whole scope of practice or if patient identifiable information has been included in their appraisal documentation. It is hoped that the Lead Appraiser Team will be able to switch from quality checking 100% of appraisals to a smaller sample size once the identified recurring themes begin to decrease.

Comprehensive support is provided to all Doctors in helping them to compile the required documentation for their appraisal. Four of the six essential areas of supporting information stated by the GMC are fully automated:-

- Colleague feedback (completed once in every 5 year revalidation cycle) organised via CFEP
- Patient feedback (completed once in every 5 year revalidation cycle) organised via CFEP
- Information on significant events – reports produced by the Trust's Patient Safety Team
- Information on complaints – reports produced by the Trust's Patient Safety Team

Further supporting information is also readily available to Doctors in the form of Mandatory Training reports produced by the Revalidation Team and Healthcare Evaluation Data reports compiled by the Trust's Quality Assurance Team. The facilitation of significant event reports and complaints reports has been improved based on feedback received from Doctors; reports sent to Doctors are now fully anonymised, removing the task for Doctors having to anonymise the reports prior to uploading the documents to their e-Appraisal.

The Revalidation Team now also produce a quarterly Revalidation Newsletter circulated to all Consultants, SAS Doctors and LEDs. The newsletter communicates updates to appraisal and revalidation policies, procedures and guidance at both a local and national level, provides useful hints and tips to appraisers and appraisees to aid them in the completion of appraisal documentation whilst also circulating other key messages in relation to appraisal and revalidation.

The Medical Lead for Appraisal & Revalidation, in conjunction with the Revalidation & Job Planning Manager, continue to work to ensure that the appraisal process for Doctors is easy, thorough and time efficient.

6. Locally Employed Doctors (LEDs)

This group of Doctors (constituting Staff Grades, Associate Specialists and temporary / short term contract holders) presents particular challenges due to the transient nature of the workforce (i.e. short term contracts, overseas Doctors).

Dr Nicola Barham (Consultant Anaesthetist) is the Clinical Lead to support LEDs. Dr Barham runs appraisal training sessions every quarter which are open to all Doctors but specifically targeted towards LEDs. These sessions communicate the importance of appraisal and revalidation and provide Doctors with the necessary guidance to help them in presenting the required evidence and supporting information. LEDs are contacted by the Revalidation Team on commencement and encouraged to attend induction and additional training sessions.

Once again this year, the organisation has seen a number of Doctors who are in their first post in the UK and we will continue to educate and support this group as they adjust to meeting UK appraisal requirements.

7. Revalidation Recommendations

Revalidation recommendation dates are set by the GMC with Doctors coming 'under notice' four months prior to their revalidation date. The number of revalidation recommendations made in the 2017-18 appraisal year was:-

- 32 Positive Recommendations
- 6 Deferrals

Doctors can be deferred for a number of reasons but it is usually because they have provided insufficient evidence to allow the RO to make a positive recommendation for revalidation. This is not seen to be detrimental to the Doctor or their practice however, when a Doctor is deferred twice the GMC automatically contacts the RO for further information as to the reasons why a second deferral has been made; these cases are always discussed with the Trust's appointed GMC Employer Liaison Adviser.

The number of revalidation recommendations made so far in the current appraisal year is:-

- 57 Positive Recommendations
- 9 Deferrals

A further 83 recommendations are due to be made this appraisal year. With revalidation having launched in 2012 and the requirement to revalidate once every five years, individuals are now entering their second cycle of revalidation, hence the increase in the number of recommendations. The Revalidation Team keep a record on the amount of recommendations due to be made each month in order to plan accordingly and to ensure all supporting information is in place for the RO to hopefully make a positive recommendation for each individual.

8. Annual Organisational Audit – Appraisal Year 1st April 2017 – 31st March 2018

NHS Healthcare organisations are monitored by NHS England and are required to submit quarterly appraisal rates for the first three quarters of the year. The Annual Organisational Audit is then submitted to NHS England at the end of the final quarter with reports for both South Tees and Teesside Hospice completed in early June 2018. The Hospice have provided their Board of Directors with their AOA whilst South Tees' AOA is included in this report which is summarised below.

As at 31st March 2018, the Trust's AOA reported to NHS England stated:-

Type of Doctor	Totals	Completed Appraisal		Approved Incomplete or Missed Appraisal		Unapproved Incomplete or Missed Appraisal	
Consultants	458	438	96%	12	3%	8	1%
Staff Grades, Associate Specialists, Specialty Doctors	41	39	95%	0	0%	2	5%
Temporary or Short Term Contract Holders	112	84	75%	22	20%	6	5%
Totals	**611**	**561**	**92%**	**34**	**5%**	**16**	**3%**

Taking into account completed appraisals and approved incomplete or missed appraisals combined, the Trust's overall percentage compliance rate was 97%, a 7% increase on the last appraisal year.

One of the outstanding actions from last year's AOA concerned the Trust having arrangements in place to access sufficient trained case investigators and case managers; this has now been addressed with two of the three Lead Appraisers having completed the necessary training.

The one remaining outstanding action concerns the Trust undertaking an independent review of its processes relating to appraisal and revalidation. This action plan is on hold for now following on the discussions and advice at the Revalidation North RO Forum.

9. A Framework of Quality Assurance for Responsible Officers and Revalidation - Statement of Compliance - Appendix A

Responsible Officers are required to submit the Statement of Compliance to NHS England by 28th September 2018. This document asks a series of questions regarding appraisals and revalidation for which the designated body must answer yes or no and provide additional comments.

The Hospice have presented their own Statement of Compliance to their Board of Directors and their Acting Chief Executive has countersigned this prior to submission. The Statement of Compliance for South Tees is included in this report in Appendix A. The Chief Executive is asked to countersign the document prior to submission.

10. Conclusions and Next Steps

The Trust continues to ensure all Doctors engage in appraisal with the Revalidation Team aiming to fully optimise the e-Appraisal Allocate Software for the management of appraisals and revalidation recommendations. The Board of Directors can be assured that:-

- Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC
- All appraisals and supporting information are undergoing robust quality checks
- Doctors are continually supported by the Revalidation Team with their appraisals and revalidation
- Outstanding appraisals are routinely addressed

- Appraisers have access to dedicated support and training to aid their roles as appraisers

11. Recommendations

The Board of Directors is asked to:

1. note the contents of this report;
2. accept the Statement of Compliance confirming the Trust as a designated body which is in compliance with the regulations; and
3. grant delegated authority to the Chief Executive to sign the Statement of Compliance (Appendix A) on behalf of the Board for submission to NHS England.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board of South Tees Hospitals NHS Foundation Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes; **Mr Simon Kendall** **GMC No. 2960386** **Medical Director - Clinical Support Services**

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes; **Allocate Software's e-Appraisal system is utilised to maintain a database of all Doctors holding a prescribed connection to South Tees. The system is continually maintained and cross-checked with GMC Connect by a dedicated Revalidation Manager and Revalidation Assistant.**

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes; **There are currently 145 appraisers in the Trust to undertake appraisals for over 600 Doctors. All 145 appraisers have undergone full revalidation and appraisal training.**

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

Yes; **There is ongoing training and support from the Responsible Officer, Medical Lead for Appraisal & Revalidation, Lead Appraiser Team, Revalidation Manager and Revalidation Assistant. Several workshops led by the Medical Lead for Appraisal & Revalidation and Lead Appraisers have taken place in the last 12 months to allow all appraisers to meet, discuss any issues and share best practice.**

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes; **The Trust ensures its Doctors undertake annual appraisal in accordance with local policies and procedures and GMC requirements. A record of missed or incomplete appraisals is kept with the Revalidation Manager working closely with the Medical Lead for Appraisal & Revalidation to establish the reasons why and enforcing the Trust's escalation policy for non-participation in appraisal where necessary.**

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

Yes; **Processes are in place to provide Doctors with the appropriate supporting information in readiness for their appraisal. Mandatory Training reports are compiled by the Revalidation Assistant whilst Healthcare Evaluation Data reports, Significant Events reports and Complaints reports are produced by the Trust's Patient Safety and Quality Assurance teams. All reports are made available to Doctors prior to their appraisal meeting. The Trust maintains a relationship with CFEP (Client Focused Evaluation Programmes) who help to conduct patient and colleague feedback for Doctors.**

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes; **The Trust follows appropriate processes, policies and national guidance regarding medical practitioner's fitness to practice.**

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes; **The Trust has a process in place for receiving and providing information to and from other organisations in respect of medical**

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

practitioner's fitness to practice; this is usually obtained via a Medical Practice Information Transfer (MPIT) form.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes;

Appropriate pre-employment background checks are carried out by the Trust's recruitment team. Healthcare Locums (HCL) are used as the master vendor for providing Medical Locums across all specialties for all medical roles.

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes;

The Trust's policies are treated as live documents whilst the publication of a quarterly Revalidation & Appraisal newsletter helps to communicate any audit findings, NHS England policy changes or GMC guidance changes to Doctors.

Signed on behalf of the designated body

Official name of designated body: **South Tees Hospitals NHS Foundation Trust**

Name: **Mrs Siobhan McArdle** Signed:

Role: **Chief Executive**

Date: **04.09.2018**

5

Board of Directors	
Agenda item	11.1
Title of Report	2017/18 Emergency Preparedness Resilience & Response (EPRR) annual report
Date of Meeting	4 September 2018
Presented by	Kevin Oxley, Director of Estates, ICT and Healthcare Records / Lead Director for EPRR
Author	Diane Hurley, Head of EPRR
Approved by	Kevin Oxley, Director of Estates, ICT and Healthcare Records / Lead Director for EPRR
Previous Committee/Group Review	Operational Management Board (OMB)
Purpose	Approval [√] Decision [ ] Discussion [ ] Information [ ]
Alignment to Trust's Strategic Objectives	[ ] 1. We will deliver excellence in patient outcomes and experience [√] 2. We will drive operational performance to deliver responsive, cost effective care [ ] 3. We will deliver long term financial sustainability to invest in our future [ ] 4. We will deliver excellence in employee experience to be seen as an employer of choice [ ] 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and Section 46 of the H&SC Act 2012 which requires NHS organisations to demonstrate that they can effectively respond to such incidents while maintaining services to patients.
Recommendation(s)	The Board is asked to receive and note the contents of this report and ratify the 2018/19 work plan which was approved at OMB.

Emergency Preparedness, Resilience and Response
(EPRR) Annual Report
May 2017 – April 2018

1.0 Introduction

1.1 The past few months have been an eventful period for South Tees Hospitals NHS Foundation Trust, not just in terms of additional demands on NHS services but also for a variety of unexpected incidents (including power outages, severe weather and the liquidation of Carillion) which required the implementation of contingency arrangements to keep patients safe and maintain essential services.

1.2 The EPRR Team have worked closely with Trust management and clinical colleagues, the wider NHS and other stakeholders to move towards achieving compliance with the EPRR core standards and begin to develop and update the South Tees EPRR arrangements in line with local risks, National policy and lessons identified from recent events. This work will continue through 2018/19 and will be supported by a number of training events and exercises to raise awareness of EPRR, to test our arrangements and highlight any issues to be addressed.

2.0 Context

2.1 The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect services or patient care. These could be anything from loss of power or extreme weather conditions to an infectious disease outbreak, major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and Section 46 of the H&SC Act 2012 which requires NHS organisations to demonstrate that they can effectively respond to such incidents while maintaining services to patients.

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

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

2.3 The Trust is also required to comply with the requirements set out in the following:

- NHS standard contract (service condition 30)
- NHS England EPRR Framework (2015)
- NHS England Business Continuity Framework (2016)
- NHS England EPRR core standards

2.4 This work is referred to as ‘Emergency Preparedness, Resilience and Response’ (EPRR) and requires NHS organisations to develop plans, policies and procedures, provide training for staff on their role in an incident, exercise these plans to ensure they are fit for purpose and support any response and recovery efforts when an incident occurs.

2.5 Responsibility for compliance with these requirements ultimately rests with the Chief Executive. However, in order to discharge these duties day to day executive oversight of the EPRR remit has been delegated to Kevin Oxley, Director of Estates, ICT and Healthcare Records who has been appointed as lead director for EPRR, working with the Head of EPRR

to ensure that the relevant EPRR arrangements are put in place and regularly reviewed / tested.

2.6 This is also supported by Simon Kendall, Medical Director who has been appointed as the Accountable Emergency Officer (AEO) responsible for ensuring that the Trust complies with legal and policy requirements in respect of EPRR and ensuring that the Board is regularly updated regarding EPRR issues.

3.0 EPRR Governance

3.1 The Trust Resilience Forum (TRF) (previously the EPRR Business Group) meets on a bi-monthly basis to oversee the development and maintenance of Trust EPRR arrangements and ensure compliance with the Trust's EPRR strategy.

3.2 The group is chaired by the lead director for EPRR and membership includes service managers from each centre plus representation from key corporate departments. Emergency Preparedness leads from external NHS organisations are invited to attend twice a year (April and October) in order to share best practice and ensure engagement across the wider health system.

3.3 The TRF is accountable to OMB and the Terms of Reference for the group are available on request. It met a total of seven times during 2017/18; representation at these meetings is shown in appendix A.

3.4 In addition, a number of EPRR sub groups have been established to take forward specific pieces of work including business continuity, CBRN, mass casualties and training / exercises.

4.0 STHFT EPRR Strategy

4.1 An EPRR strategy has been developed which sets out the strategic framework for management of EPRR (including business continuity) to ensure that the Trust can provide an effective, robust and co-ordinated response to any incident.

4.2 Following consultation with TRF members, the strategy is due to be signed off at the next TRF meeting in June 2018 and then, subject to approval by OMB will then be available on the intranet. This will also replace the current Business Continuity Policy.

5.0 EPRR Core Standards

5.1 The NHS England Core Standards for EPRR identify the minimum standards which NHS organisations must meet and are split into nine domains comprising of 66 core standards. The Trust is required to undertake an annual self-assessment against the standards and provide assurance to NHS England that robust and resilience EPRR arrangements are established and maintained within the Trust.

5.2 The 2017/18 self-assessment was undertaken in August 2017 following which the Trust reported **51** of the standards as **green** (fully compliant with core standard) and **15** as **amber** (not compliant but evidence of progress and in the EPRR work plan for the next 12 months).

5.3 Overall, this meant that the Trust were **non-compliant** for 2017/18 (arrangements in place do not fully address 11 or more core standards) although it was considered that this did not significantly impact on the Trust's immediate preparedness and resilience.

5.4 An action plan was developed to address the amber issues and major progress has been made in closing the gaps. The current status is shown in the table below.

Domain	Compliance (Sept 2017)	Compliance (April 2018)
1 – Governance	**Full compliance**	**Full compliance**
2 – Duty to assess risk	**Full compliance**	**Full compliance**
3 – Duty to maintain plans	**Not compliant** • Business continuity plans • Severe weather plans • Mass countermeasures plan • Mass casualties plan • Fuel disruption plan • Evacuation plan • Utilities, IT and telecoms failure plan • Business continuity arrangements	**Not compliant** • Mass countermeasures plan – 2019/20 EPRR workplan • Mass casualties plan – in progress • Fuel disruption plan – 2019/20 EPRR workplan • Evacuation plan – awaiting regional framework; 2019/20 EPRR workplan • Utilities, IT and telecoms failure plan – in progress
4 – Command and control	**Full compliance**	**Full compliance**
5 – Duty to communicate with the public	**Full compliance**	**Full compliance**
6 – Information sharing	**Full compliance**	**Full compliance**
7 – Co-operation	**Substantial compliance** • Mutual aid arrangements	**Substantial compliance** • Mutual aid arrangements - awaiting regional framework; 2019/20 EPRR workplan
8 – Training and exercising	**Substantial compliance** • Continuous personal development portfolio	**Full compliance**
9 – CBRN	**Not compliant** • HAZMAT / CBRN plan • Risk assessments • Training lead appropriately trained • Internal training • Sufficient trained staff	**Substantial compliance** • HAZMAT / CBRN plan – draft prepared; being amended to incorporate latest guidance issued in May 2018

5.5 It is now anticipated that we will be able to demonstrate at least partial compliance (6-10 amber standards) if not substantial compliance (1-5 amber standards) in the 2018/19 self-assessment later this year. However, there are some areas (including hospital evacuation and mutual aid) where further local guidance is awaited from the Local Health Resilience Partnership (LHRP). Therefore these have been deferred to the 2019/20 EPRR workplan and will be incorporated into the Trust's arrangements as soon as guidance is available.

6.0 Emergency Preparedness

6.1 In the event of a critical or major incident, the Trust is required to respond at all levels to manage the incident whilst continuing to provide / maintain core services at an appropriate level. In order to do this, the Trust is responsible for developing and maintaining contingency arrangements, taking account of local risks and National policy / guidance to ensure resilience during a prolonged incident.

6.2 The Trust incident response plan (IRP) outlines the response to be taken by STHFT in the event of a critical or major incident. It is supported by a series of Standard Operating Procedures (SOPs) and tactical briefs including initial notification arrangements, establishment of the incident co-ordination centre and decision logging handbook.

6.3 The IRP is currently being reviewed and updated to reflect current Trust structure and processes as well as incorporating the learning from recent incidents. Once compete, the plan will be validated through a number of table top exercises.

6.4 To support the activation of the IRP it is vital that there is a robust and timely mechanism in place to notify key personnel / services of any critical or major incidents. The Head of EPRR, in liaison with the Head of Facilities and ICT department, is currently in the process of implementing an automated communications system (Confirmer) which can send out a number of messages at the same time, thereby reducing the impact on switchboard staff.

7.0 Mass Casualty Arrangements

7.1 Following the publication of the National Mass Casualty Concept of Operations (ConOps) and the Cumbria and North East (CNE) mass casualty framework, work is underway to develop Trust mass casualty arrangements in consultation with key clinical leads. This will take account of the learning from the attacks in London and Manchester last year.

7.2 Mass casualty clinical modelling has been carried out to assess the capacity of the Trust to receive priority 1 and 2 casualties within the first two hours of a declared mass casualty incident. This has been incorporated into the CNE Framework and will be used as the basis for internal planning.

8.0 Business Continuity

8.1 Business continuity management is a key component of the CCA and the Trust is required to have plans to ensure that they can continue to maintain services to patients in the event of a disruptive incident.

8.2 A workshop was held in December 2017 to assist staff in preparing individual service continuity plans and a peer review is planned in the next few weeks. Once this is complete, an overarching corporate business continuity plan will be developed which will identify the critical services across the Trust.

9.0 Partnership Working

9.1 The Trust recognises the importance of partnership working and liaises closely with the North East Health Economy and non NHS partners to address EPRR issues.

9.2 The Head of EPRR is an active participant in a variety of EPRR related groups including the Local Health Resilience Partnership (LHRP), Health and Social Care Resilience Group (H&SCRG) and the Cleveland Local Resilience Forum (LRF). In addition, as the Friarage Hospital is located within the North Yorkshire area, the Head of EPRR maintains liaison with the North Yorkshire LHRP, LRF and relevant sub groups attending meetings as appropriate.

10.0 Training

10.1 Training is an essential element of EPRR and a training plan for on call and supporting staff has been developed in order to ensure that they are as prepared as they can be and are competent to undertake their designated roles.

10.2 On call training sessions were delivered in December 2017 and January 2018 and further refresher sessions are planned later this year. Training has also been provided to 627 bleep holders at Friarage Hospital.

10.3 Two Loggist training sessions were held in February and March 2018 and were attended by a total of 11 staff. Further sessions are to be delivered over the next few months to increase the number of trained Loggists available within the Trust. This will also include an event at the Friarage.

10.4 The Trust also hosted a two day Hospital Major Incident Medical Management and Support (HMIMMS) course in February 2018 which was attended by 31 members of staff including 7 of the 8 identified surgeon commanders plus representatives from Carillion (security). This brings the number of HMIMMS trained staff within the Trust to over 60 and a further course is planned for later this year.

10.5 All training delivered is in line with the National Occupational Standards (NOS) for civil contingencies and a continuous personal development portfolio has been developed to be maintained by all on call personnel and submitted annually to the Head of EPRR for assurance and audit purposes.

11.0 Exercises

11.1 In order to ensure that the Trust's EPRR arrangements are robust and effective they are regularly validated and tested through table top or live play exercises which allow staff the opportunity to practice their skills in a safe environment, whilst increasing their confidence and knowledge in preparation for responding to a real incident. These are carried out either internally, involving a single function or a number of services, or externally in liaison with multi-agency partners.

11.2 The NHS EPRR Framework requires that the Trust carries out the following:

- A communications test every six months
- A table top exercise every year
- A live play exercise every three years
- A command post exercise every three years

Note: if the Trust activates its plan in response to a live incident this replaces the need to run an exercise, providing a debrief is held and any lessons identified are addressed

11.3 Tests of the communications cascade were held on 22nd January 2018 and 11th April 2018. These highlighted a small number of issues, most of which were quickly addressed. Callout lists are currently being updated as part of the review of the IRP and the implementation of the Confirmer automated messaging system.

11.4 The ward mobiles were also tested at the same time and work is underway with ward managers to ensure that these are available at all times to provide resilience in the event of disruption to communications.

11.5 A business continuity table top exercise was held on 14th December 2017, to look at the response to a severe weather situation and was attended by 44 personnel from all five centres plus key corporate departments including ICT, Estates and HR.

11.6 A mass casualty's command post exercise (Pelican) was held on 11th April 2018 which involved representatives from A&E, ITU and the establishment of the Incident Co-Ordination Centre (ICC). This was a no-notice, out of hours exercise focusing on the capacity and capability of the Trust to receive large numbers of casualties in a very short space of time. It also provided an opportunity to work with social care colleagues to consider options for discharge support out of hours in order to rapidly increase bed capacity. A number of lessons were identified from the exercise and where relevant these will be incorporated into the regional mass casualty framework and / or the Trust's mass casualty arrangements.

11.7 A list of the training events, workshops and exercises held during 2017/18 together with details of those planned for 2018/19 can be found at appendix B. Where appropriate, the Head of EPRR will co-ordinate Trust attendance at these events.

12.0 Incidents

12.1 Whilst there were no events that resulted in a critical or major incident being declared by the Trust between March 2017 and April 2018, there were a number of incidents which impacted on the Trust during this time. These included:

- Loss of power to A&E, ITU and radiology on 23rd November 2017
- Loss of telephony to a large part of the James Cook site on 2nd March 2018
- Severe weather across the North East between 27th February 2018 and 2nd March 2018 which affected staff and patients getting into the hospitals.

12.2 Debriefs were held for each of these incidents and post incident reports produced. Recommendations have been captured and are tracked through the TRF.

12.3 In addition, the Trust implemented a command support function in respect of the liquidation of Carillion on 15th January 2018 including the establishment of the Incident Co-Ordination Centre (ICC) and the co-ordination of the response by the Incident Management Team (IMT). This proved to be a useful test and identified a number of minor issues which have since been addressed.

13.0 2018/19 workplan

13.1 An EPRR workplan has been developed and is currently being implemented by the Head of EPRR, supported by the Head of Facilities. Key priorities over the next 12 months include:

- Continuing to develop the Trust's capacity and capability to respond in the event of a business continuity, critical or major incident
- Co-ordination and delivery of EPRR arrangements across the Trust
- Achieving a minimum of partial compliance with the 2018/19 EPRR core standards
- Review of the IRP to take account of changes within the Trust and lessons identified during incidents and exercises as well as ensure that they reflect current guidance
- Implementation of the Confirmer electronic notification software to support the incident callout cascade
- Further development of incident specific SOP's and tactical briefs to underpin the incident response plan including CBRN and adverse weather
- Development of a Trust mass casualty framework / standard operating procedures (SOP)
- Facilitating the development of local response arrangements at a ward / department level in conjunction with nominated leads / EPRR champions

- Continued development of business continuity plans and arrangements to enhance the current level of preparedness within services
- Development of on call pack to support those undertaking this role
- Co-ordination and delivery of the 2018/19 training plan and exercise programme for on call personnel, supporting staff and Loggists
- Delivery of a further HMIMMS course within Trust
- Development and delivery of a table top exercise to test the updated incident response plan
- Maintaining information sharing and co-operation with other local responders including continued attendance at the LHRP, LRF and sub groups

14.0 Conclusion

14.1 The past few months have seen good development in the move towards achieving compliance with the EPRR core standards. However, more work is required in order to achieve a high level of resilience within the Trust which will require the support of all centres and departments.

15.0 Recommendation

15.1 The Board is asked to receive and note the contents of this report and ratify the 2018/19 work plan which was approved at OMB.

Appendix A

Trust Resilience Forum (TRF) attendance 2017/18

Centre / Department	2017						2018	
	27th March	24th April	22nd May	21st Aug	2nd Oct	11th Dec	5th Feb	5th March
Clinical Diagnostic and Support Services	✓	✓	✓	✓	X	✓	N/A	*Cancelled due to changes in EPRR structure / number of apologies*
Clinical and Corporate Support Services	N/A	N/A	N/A	N/A	N/A	N/A	✓	
Community Care	✓	✓	✓	X	X	✓	X	
Planned Care	X	X	X	X	X	X	N/A	
Specialist Care	✓	✓	✓	✓	✓	✓	N/A	
Specialist and Planned Care	N/A	N/A	N/A	N/A	N/A	N/A	✓	
Urgent and Emergency Care / Friarage	✓	✓	✓	✓	✓	✓	✓	
Communications	X	X	X	X	X	X	X	
EPRR	✓	✓	✓	✓	✓	✓	✓	
Estates	✓	✓	✓	✓	✓	✓	N/A	
HR	✓	✓	✓	X	X	X	X	
ICT	X	X	✓	✓	✓	✓	N/A	
Estates, ICT and Healthcare Records	N/A	N/A	N/A	N/A	N/A	N/A	✓	
Info Governance	*Not on group*				✓	✓	✓	
Nursing	✓	X	✓	✓	X	✓	✓	
Patient Flow	X	✓	✓	✓	X	X	X	
Endeavour	✓	X	X	X	X	X	X	
Carillion	✓	X	✓	✓	✓	✓	✓	

Appendix B

Exercises, training events and workshops
November 2017 to May 2018

Date	Event	Additional information
2017 events		
30th May 2017	Exercise Michelle Multi-agency table top exercise	Managing the consequences of a major RTC
15th/16th May 2017	HMIMMS course	31 Trust attendees
13th July 2017	Business continuity workshop	
1st August 2017	On call training	
23rd August 2017	Mass casualty workshop	Strategic launch of CNE framework
24th August 2017	Exercise Warmhart Internal table top exercise	Initial response to mass casualty incident
29th August 2017	On call training	
14th September 2017	Exercise Stonehart Regional health table top exercise	Longer term response to mass casualty incident
19th September 2017	On call training	
29th September 2017	NE hospital evacuation workshop	Sharing learning from Cumbria
4th October 2017	Exercise Border Reiver Cross border live exercise	Co-ordination of response to terrorist incident in Scotland
6th October 2017	Exercise Armadillo Mental health table top exercise	
9th October 2017	Communications test	Regional test co-ordinated via NEAS
1st November 2017	Clinical mass casualty workshop	Sharing learning from Manchester and other recent events
14th December	Business continuity workshop	
14th December 2017	Exercise Robin Business continuity table top exercise	
2018 events		
10th January 2018	Exercise Athens Internal table top exercise	Business continuity response re potential collapse of Carillion
12th January 2018	On call training	
22nd January 2018	Communications test	Regional test co-ordinated via NEAS
5th February 2018	Loggist training	
8th / 9th February 2018	HMIMMS course	29 Trust attendees
14th March 2018	End of life care and support workshop	
19th / 20th March	Project Griffin awareness sessions	

2018		
20th March 2018	Critical threat workshop	
23rd March 2018	LHRP risk workshop	
26th March 2018	Loggist training	
11th April 2018	Exercise Pelican No notice, out of hours command post exercise	Regional response to mass casualty incident

Finance & Investment Committee
Chair's Log
Date: 20 July 2018

Meeting: Finance & Investment Committee	**Date of Meeting**: 19 July 2018
Connecting to: Board of Directors meeting	**Date of Meeting**: 4 September 2018
Key topics discussed in the meeting	
• Q1 financial position • Aligned incentive contracts • Productivity and efficiency programme • Energy Centre proposal • Future of Financial Improvement Board (FIB)	
Actions agreed in the meeting	Responsibility / timescale
• Q1 financial position: FIC congratulated the executive team on delivering ahead of budget, while noting the various risks and challenges. • Aligned incentive contracts: FIC endorsed the stance taken by the Chief Executive and Director of Finance in the CCG negotiations and agreed that contracts should be signed on the basis outlined, subject to satisfactory resolution of the dispute with South Tees CCG over £1.8m of prior year income. • Productivity and efficiency programme: FIC noted the current position and the challenging targets for Q2-4 • Energy Centre: FIC endorsed the proposal for the Trust to invest in, and take energy from, an SPV with Tees Valley Combined Authority. • Future of FIB: FIC agreed that FIB could be decommissioned, subject to checking with NHSI, as it had met all the conditions for decommissioning defined when it was set up.	Executive team Chief Executive and Director of Finance (ongoing) Executive team (ongoing) Director of Finance and Director of Estates (ongoing) Committee Chair (immediate)
Issues for Board escalation/action	Responsibility / timescale
• Board to note the points listed above.	For discussion at the Board meeting on 4 September 2018

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 24 July 2018
Connecting to: Board of Directors	**Date of Meeting**: 4 September 2018

Key topics discussed in the meeting	
• Medication Error SI Audit Report (SI-2018/19818) • Quality Priorities quarterly update (Deferred) • CQC Inpatient Survey results • Review of Sis post priority gold star (Deferred) • Complaints Annual Report • Q1 Learning from Deaths report • LDF Guidance for Trusts working with bereaved families and carers • Update on national implementation of ME's • Life Cycle Planning report • Monthly SI report • RCA – SI-2018/9320 (Deferred) • RCA – SI-2018/9212 – Simon Milburn • RCA – SI-2018/9049 – David Chadwick • RCA – SI-2018/11653 (Deferred) • Monthly Quality Report • Review of Quality Risks • Chairs logs from reporting sub groups	
Actions agreed in the meeting	**Responsibility / timescale**
• SI Medication Error: Audit shows poor results. Stronger actions required re Prescribing – update Action Plan	• J Swaddle / D Chadwick / August 2018
• LeDeR reviews – more people to be trained	• G Hunt / September 2018
• Implement new process for incident reporting	• G Hunt / August 2018
Escalation of issues for action by connecting group	**Responsibility / timescale**
• Q1 Learning from Deaths report – HSMR "higher than expected" – issues around reduced Palliative Care activity but also effect of Sepsis reporting is not understood. External examination by HED of our data to be requested	• T Roberts / August 2018
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Incident reporting remains biggest risk	• G Hunt / August 2018