HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 4 APRIL 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS		
1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 7 March 2017	attached	Chair
4. Action Tracker	attached	Director of Corporate Affairs
5. Matters Arising	verbal	Chair
6. Chair's Opening Remarks	verbal	Chair
7. Chief Executive's Briefing	attached	Chief Executive Officer
QUALITY		
8. Patient Story	verbal	Chief Medical Officer
9. Quality Report	attached	Chief Nurse
10. Nursing and Midwifery Staffing Report	attached	Chief Nurse
11. Statutory Supervision of Midwives	attached	Chief Nurse
PERFORMANCE		
12. Performance Report	attached	Executive Team
13. Staff Survey 2016/17	attached	Director of Workforce & OD
14. Mortality Report	attached	Chief Medical Officer
STRATEGY & DEVELOPMENT		
15. Financial Plan 2017/18	presentation	Chief Financial Officer

ASSURANCE & GOVERNANCE

16. Board Assurance Framework 2017/18 Outline	attached	Director of Corporate Affairs
17. Fit and Proper Persons test – annual assessment	attached	Director of Corporate Affairs
18. Freedom to Speak up Report	attached	Director of Corporate Affairs
19. Unadopted Minutes from Board Standing Committees		
19.1 – Performance & Finance 27.03.17	attached	Chair of Committee
19.2 – Quality 27.03.17	attached	

20. Any Other Business

21. Questions from members of the public

22. Date & Time of the next meeting:
Tuesday 2 May 2017, 2:00pm, The Boardroom, Hull Royal Infirmary

Attendance 2017/18

	4/4									
T Moran										
C Long										
L Bond										
A Snowden										
M Gore										
S Hall										
M Wright										
K Phillips										
T Sheldon										
V Walker										
T Christmas										
E Ryabov										
In Attendance										
J Myers										
S Nearney										
C Ramsay										

Attendance 2016/17

	28/4	26/5	28/6	28/7	29/9	27/10	24/11	22/12	26/1	7/03	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	x	✓	x	✓	✓	✓	✓	✓	✓	✓	8/10
L Bond	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Gore	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	9/10
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Wright	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
T Sheldon	✓	✓	x	✓	x	✓	✓	✓	x	✓	7/10
V Walker	x	✓	x	✓	✓	✓	✓	x	✓	✓	7/10
T Christmas	✓	✓	x	✓	✓	✓	✓	✓	x	✓	8/10
E Ryabov	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
In Attendance											
J Myers	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	9/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	-	-	-	7/7
S Nearney	✓	✓	x	x	✓	✓	✓	✓	✓	✓	8/10
C Ramsay	-	-	-	-	-	-	✓	✓	x	✓	3/4

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 7 MARCH 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr M Ramsden	Chairman
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr A Snowden	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms J Myers	Director of Strategy & Planning
	Ms C Ramsay	Director of Corporate Affairs
	Dr M Purva	Deputy Chief Medical Officer (Deputy for CMO)
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

NO. ITEM **ACTION**

1. APOLOGIES

Apologies were received from Mr Phillips, Chief Medical Officer

2. DECLARATIONS OF INTEREST

2.1 – CHANGES TO DIRECTORS' INTERSTS SINCE THE LAST MEETING

Ms Myers reported that she was now a Trustee for St Leonards Hospice in York.

2.2 – TO CONSIDER ANY CONFLICTS OF INTEREST ARISING FROM THIS AGENDA

There were no declarations made.

3. MINUTES OF THE MEETING OF THE 26 JANUARY 2017

Mr Snowden asked for clarity about item 11 paragraph 2 relating to nutrition issues. Mr Wright assured the Board that the issues were due to record keeping issues and not that patients were not being fed.

The minutes were approved as an accurate record of the meeting.

4. ACTION TRACKER

The action tracker was reviewed by the Board.

5. MATTERS ARISING

Mr Wright reported that work was ongoing with the Governance Team reviewing learning following incidents and how this would be disseminated to staff.

6. CHAIR'S OPENING REMARKS

Mr Ramsden paid tribute to Mrs Coggan (Hull Daily Mail) and her work

covering media issues relating to the Trust and how she presented a balanced view. He wished her well in her new role.

He reported that the CQC report had now been published and thanked all staff for their efforts whilst the inspectors were visiting the Trust. The message conveyed in the report was positive but there was more work to do.

Mr Ramsden reported that the new Chairman had been appointed for the Trust, Terry Moran who was currently working as a Non Executive Director for Mid Yorkshire Hospitals NHS Trust. Mr Moran would take up his position as Chair on 1st April 2017.

7. CHIEF EXECUTIVE'S BRIEFING

Mr Long reported that it was Mr Ramsden's last Board meeting and that he had joined the Trust 2 years ago at a difficult time with the majority of the Board members being new. He stated that the Trust had come a long way with many positive changes since then and Mr Ramsden's leadership had contributed to this. He thanked Mr Ramsden for his support both to himself and all staff.

Mr Snowden asked if Mr Long could give any details regarding the staff survey results and Mr Long advised that a report would be received at the next meeting detailing the results. He added that the key area was the increase in responses to 3700 members of staff which would give an accurate reflection of staff experiences within the Trust. Mr Nearney added that this year was the first time the Trust had not been in the bottom 20% and had moved into the middle, average section, but that there was more work to do.

8. PATIENT STORY

Mr Wright read two patient stories. The first one related to excellent care but the patient had to wait a number of hours for their medication to arrive before they could be discharged. The second one related to excellent care in neurosurgery with the patient praising all of the staff involved.

Prof. Sheldon reported that the Quality Committee was reviewing the medication link to delayed discharges and this being part of the whole pathway and patient flow.

9. QUALITY REPORT

Mr Wright reported that the Trust had no current Never Event investigations and that the investigation regarding the naso-gastric tube had concluded and the actions arising from this were progressing as planned. Serious incident reporting rates had reduced compared to the same reporting period last year, however 2 new SI's had been reported in January 2017. He advised that the Commissioners had recently given the Trust significant assurance around its handling of Serious Incidents which had changed from limited assurance last year.

Mr Wright advised that the Safety Thermometer audit results were showing that 'new harms' were at a low level. With regard to the second MRSA Bacteraemia for the year, this had been sent to Public Health England for adjudication, as there had been missed opportunities in two other hospitals and primary care to treat this patient's MRSA colonisation before he came

to this Trust. The outcome of the PHE review was awaited.
There had been a reduction in the number of complaints received and that trend was continuing. The contract for managing the Trust's Friends and Family Test data had been put out to tender with potential savings if the new provider was appointed.

Mr Wright also reported that the National Inpatient Survey Results for 2016 had been published with good improvements made overall. The new structure around reviewing hospital deaths and the structured/judgemental case note review was working well with themes being identified. The next steps were to evidence learning from the reviews.

There was a discussion around VTE and the recording of risk assessments on the Lorenzo system. Mr Wright advised that doctors are now required to sign to say that they entered the risk assessment onto the IT system to ensure assessments are recorded appropriately.

Resolved:
The Board received the report and Mr Ramsden thanked Mr Wright for the transparent and efficient reporting of the Trust's quality issues.

10. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report, which showed that nursing and midwifery staffing fill rates were reasonably high and a number of vacancies were being filled by students with a further 115 jobs offered for the next set of student that are due to qualify from the University of Hull in September/October 2017. Mr Wright advised that the recruitment campaign in the Philippines was ongoing and that the first set of nurses would be arriving in the summer.

Mr Wright expressed his concern regarding the higher than expected sickness rates in the nurse staffing area and an analysis of this would be carried out. Staff were being supported on the wards with high sickness levels and the issues were being managed through the appropriate Trust procedures.

The Trust had successfully recruited 19 Nurse Associate Trainees and their training programme for these would commence 28th April 2017.

Resolved:
The Board received the report.

11. CARE QUALITY COMMISSION REPORT

Mr Wright reported that the report had been received and the Trust had achieved a 'requires improvement' rating overall, which was in line with the Trust's self-assessment. He reported that the report was showing a much improved position with lots of positive achievements and more green 'Good' ratings but stated that there was still work to do. A Quality Summit hosted by NHS Improvement and the CQC would be held at the Trust on 17 March for formal receipt and any response from the Trust.

Resolved:
The Board received the report and noted the positive achievements of the Trust and the ongoing work that the Trust is doing to improve further.

12. PERFORMANCE REPORT

Mrs Ryabov reported that performance had not changed dramatically in the last month with demand on the MRI and CT scanners continuing to be a concern. Prof. Sheldon asked if there was an analysis being carried out to see if all tests are required and Mrs Ryabov assured him that they were.

There was work ongoing with NHS England, NHS Improvement and the Intensive Support Team to review and reduce the overall waiting list. Diagnostics and higher demand with little extra capacity was not helping the situation. Mrs Ryabov advised that NHSE and NHSI were complimentary around the ongoing work being undertaken and the understanding of the waiting list and the management of it. The Trust was working with Commissioners to reduce the level of demand coming in.

Mrs Ryabov reported that 8 patients had been waiting more than 52 weeks due to incorrect pathway pauses. Validation of the waiting list was ongoing. Mrs Ryabov advised that no harm had come to any of the patients and they had all been treated.

A&E performance had dropped in January but had increased in February to 82%. The Trust was working with partners and Mrs Ryabov thanked all staff for their continuing efforts and hard work.

Good progress was being made regarding the cancer standards with all standards being met with the exception of 62 day standard. Work was ongoing to sustain performance. Mrs Walker asked what impact would there be on cancer patients that had been waiting 104 days and Mrs Ryabov advised that these patients were usually very complex cases or late referrals from other organisations.

Mr Bond reported that at month 10 the Trust was reporting a deficit of £0.09m which was and improvement in month. The Trust's appeal against the STF performance fines had been successful. He reported that the Health Groups were £11.6m over spent and this was a £1.6m increase in month and this was the main risk of the Trust not hitting its control total at the end of the year.

The Trust had traded below its income plan by £0.6m and this was being driven by the under trade in elective activity which has been impacted by the increase in volume of non elective activity. The Trust had agreed within the contract with Commissioners a year end forecast outturn position.

The Trusts cash position was weak which was impacting on supplier relations.

The non delivery of CRES remained a significant challenge and at month 10 the Trust was reporting a £3.9m shortfall against plan. Mr Gore had expressed concern around the Health Group financial planning performance especially within the Surgery Health Group. Mr Bond advised that a finance post had been advertised for the Surgery Health Group and interviews were taking place.

Mr Bond reported that at month 10 the Trust was still forecasting achievement of the control total.

Resolved:
The committee received the report and noted the Trust's performance in month 10.

13. REVENUE SUPPORT LOAN

Mr Bond requested that the Board ratify the signed Board Resolution to enable the transfer of the Interim Revolving Working Capital Support facility to an Interim Revenue Support Loan.

Resolved:
The Board agreed to ratify the Board Resolution

14. 2017-18 CONTRACT

Mr Bond presented the report which detailed the 2017/18 Contract which had been agreed with a fixed value of £312m. This would guarantee the Trust an income of the equivalent 2016/17 outturn with an amount of growth built in.

There was a discussion around payment by results and consultants completing more work to achieve more income. This would not be the case with the new contract and Mr Bond was meeting with consultants to discuss the new ways of working. Mr Bond also reported that the Trust and the Commissioners had agreed to align their incentives and have a shared risk, shared opportunity and shared vision approach. This would ensure partnership working and a system wide approach.

Mr Bond advised that the financial plan was being revised and would be presented at the April 2017 Board meeting.

Resolved:
The Board received the update and approved the system wide approach to the 2017/18 contract.

15. BOARD CYCLE

Ms Ramsay presented the report which highlighted the expected areas of work of the Board would review in 2017/18. She advised that a Pay Gap Review had been added which would be an annual report. She asked that any new guidance or requirements be reported to the Corporate Governance Team for inclusion on the workplan. Mr Wright advised that the nursing strategy was included in the Trust wide strategy.

Resolved:
The Board received the report and noted the workplan for 2017/18.

16. UNADOPTED MINUTES FROM BOARD STANDING COMMITTEES

16.1 – PERFORMANCE & FINANCE 30.01.17, 27.02.17

The minutes were received for information. Mr Hall advised that any issues had been discussed in the performance and finance section of this meeting.

16.2 – CHARITABLE FUNDS 07.02.17

The minutes were received for information.

16.3 – QUALITY 27.02.17
Prof. Sheldon advised that the Quality Committee had discussed development of the Quality Strategy and this would be presented to a Board Development Day for scrutiny in due course.

16.4 – AUDIT 07.02.17
Mr Gore stated that the Audit Committee had questioned the Trust's solvency and assurance had been given from the Chief Financial Officer that the Trust was a viable organisation.

Mr Gore added that following the CQC report and action plan, Internal Audit could be commissioned to review any areas requiring auditing for assurance. Mr Wright added that a census day had been held with all wards being audited to ensure standard procedures were being followed.

17. ANY OTHER BUSINESS
There was no other business discussed.

18. QUESTIONS FROM MEMBERS OF THE PUBLIC
There were no questions from members of the public.

19. DATE AND TIME OF THE NEXT MEETING:
Tuesday 4th April, 2pm – 5pm, The Boardroom, Hull Royal Infirmary

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Chairman

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (April 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
January 2017						
01.01	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Jun 2017		Not yet due
01.02	Action Tracker	Guardian for Safe Working report to be presented	HC	May2017		Not yet due
01.03	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	TBC		

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

TRUST BOARD APRIL 2017

Government's mandate to NHS England

This month, the Government published its mandate to NHS England, setting out the key deliverables that NHS trusts must meet nationally for 2017-18. These are:

- Rollout seven-day services in hospitals in four priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by November 2017
- Deliver aggregate A&E performance in England above 90% in September 2017, with majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% by end of March 2018
- Meet agreed standards on A&E, ambulances, diagnostics and referral to treatment
- Achieve the 62-day cancer waiting times standard, and maintain performance against the other cancer waiting times standards
- Reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas)
- Support delivery of the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations

Where applicable, these indicators are included in the Trust's performance reports or reports to the Trust Board, as a continuation of existing requirements on NHS Trusts. Some targets, such as A&E performance, have been clarified for 2017-18.

New Chairman appointed to the Trust

Our Trust was pleased to announce the appointment of Terry Moran CB as its new Chairman. Terry is retired, having spent 36 years in the Civil Service, concluding his career as Second Permanent Secretary at the Department for Work and Pensions (DWP). Mr Moran took up post as Chairman on 1 April 2017.

He has a wealth of experience to bring to the role, and has held a number of key posts over the course of his career including time spent as Chief Operating Officer for the DWP, Chief Executive of The Pension Service, and Chief Executive of the Disability and Carers Service.

Mr Moran is currently a Non-Executive Director of Mid Yorkshire Hospitals NHS Trust; Chair of Trustees at Together for Short Lives, a leading UK charity for children with life-threatening and life-limiting conditions; and a Trustee on the Board of the Social Care Institute for Excellence.

He was appointed a Companion of the Order of the Bath (CB) in HM The Queen's Birthday Honours List 2007.

Cancer care boosted with share of £130m funding

The Radiotherapy Team at Castle Hill Hospital became one of the first in the country to benefit from a share of £130 million for new equipment. It was in October 2016, that the Chief Executive of NHS England, Simon Stevens, announced a national fund to modernise radiotherapy equipment over the next two years.

Our Trust was fortunate to be one of the first to receive funding, and now a new Varian Truebeam Linear Accelerator (Linac), valued at £1.7m, has just been installed in the

Queen's Centre for Oncology and Haematology. Using the Linac, staff will be able to treat patients with some of the very latest techniques, including SABR (Stereotactic Ablative Radiotherapy), a very short course of high dose radiotherapy treatment, which is used to target small tumours in the lung.

Staff Survey backs up hospitals' 'improving picture' message
The results of the 2016 Staff Survey for the Trust reinforced the message delivered by last month's Care Quality Commission (CQC) inspection report, which painted an improving picture in terms of quality of care and staff experience.

Staff confidence in reporting unsafe clinical practice, the percentage feeling they have equal opportunities for career progression, and the number of staff having experienced discrimination at work in the last 12 months are now amongst the best in the country, whilst local improvement has also been seen in other key areas such as bullying and the number of staff saying they would recommend the Trust as a place to work and receive care.

Over 3,500 members of staff completed the survey, representing 44% of the entire workforce and the highest response rate seen in the Trust in the past ten years. Thank you to all staff who completed the questionnaire and given us the opportunity to have much more detailed feedback about how we feel about working in the organisation.

Over 100 apprentices given their chance to shine
Our Trust has launched the healthcare careers of well over 100 apprentices in just over three years.

From those working with older people and those making sure patients get the right nutrition, right through to those working in pharmacy and caring for the bereaved, we have worked hard to develop new roles and new talent.

93% of the 108 apprentices taken on by the Trust to date have gone on to gain employment or further study.

During National Apprenticeship Week (6 to 10 March 2017) we celebrated by promoting our success and different careers through the local media. This culminated with great success at the Talent for Care Awards held at the Hull City Hall. Apprentices Charlotte Robinson (Neurophysiology), Laura Marks (Recreational Coordinator), Samantha Hewitt (GI Physiology), Samantha Tranmer (Finance) and Chrissy Charlton won in the categories of Intermediate Clinical Apprentice of the Year, Intermediate Non-Clinical Apprentice of the Year, Advanced Clinical Apprentice of the Year, Advanced Non-Clinical Apprentice of the Year and Support Staff Learner of the year. The Trust was highly commended as employee of the year, whilst Beth Walker, Michael Duke and Elaine Hua were also worthy runners up in their respective categories. Congratulations to everyone involved.

Trust takes zero tolerance approach to assaults on staff
Our security teams have been kitted out with body cams in a bid to reduce the number of assaults on NHS staff. More than 1,000 attacks on staff have taken place at the Trust in the last five years.

In a bid to deter people from violence and increase the number of successful prosecutions, the Trust has rolled out body cameras to security staff on both of its hospital sites. The footage from the cameras will also play a key role in training security staff on real-life incidents that have already taken place.

City of Culture workshops go live
Trust staff have volunteered to run workshops for colleagues based on their own talents. The first two workshops were held w/c 27th March, on Indian Dancing and theatre.

Other staff have offered to run workshops on poetry and stand-up comedy, while a group of photographers has come together to plan a large scale project which will, they hope, result in their work being displayed around our hospitals.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT MARCH 2017

Trust Board date	4TH April 2017	**Reference Number**	2017 -4 -9
Director	Mike Wright, Executive Chief Nurse	**Author**	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

Type of report	Concept paper		Strategic options		Business case	
	Performance	**Y**	Information	**Y**	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required • Approve the Annual declaration of Compliance for the Elimination of Mixed Sex Accommodation at **Appendix Two** and for publication of this on the Trust's website.

2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	**Y**	Assurance	**Y**	Delegation	

3	**STRATEGIC GOALS:**	
	Honest, caring and accountable culture	**Y**
	Valued, skilled and sufficient staff	**Y**
	High quality care	**Y**
	Great local services	**Y**
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	

4	**LINKED TO:**			
	CQC Regulation(s): All			
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N

5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board receives this report monthly on the quality aspects of its services (Patient safety, service effectiveness and patient experience).

QUALITY REPORT
MARCH 2017

EXECUTIVE SUMMARY

The purpose of this report is to inform the Trust Board of the current position in relation to:

- Patient Safety Matters
- CQC update
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates
- Eliminating Mixed Sex Accommodation Compliance

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required
- Approve the Annual declaration of Compliance for the Elimination of Mixed Sex Accommodation at **Appendix Two** and for publication of this on the Trust's website.

TRUST BOARD QUALITY REPORT
MARCH 2017

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the current position in relation to:

- Patient Safety Matters
- CQC update
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates
- Eliminating Mixed Sex Accommodation Compliance

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required
- Approve the Annual declaration of Compliance for the Elimination of Mixed Sex Accommodation at **Appendix Two** and for publication of this on the Trust's website.

2. PATIENT SAFETY

2.1 Never Events

There have been no Never Events reported since September 2016.

There are no current ongoing investigations into Never Events.

2.2 Serious Incidents

The rate of reporting of Serious Incidents in 2016/17 continues to be below the level reported in the same period last year. 58 Serious Incidents have been declared so far for 2016/17 compared with 120 for 2015/16 year.

There were two serious incidents declared in February 2017, which are summarised in the following table, are currently being reviewed:

2.2.1 Serious Incidents declared in February 2017

Ref. Number	Brief Description of SI	Health Group
3586	Treatment Delay of cauda equina within the ED department	Medicine
3731	Management of early pregnancy	Family and Women's

2.3 Serious Incident actions

At each month end, serious incident investigations are summarised and sent to all Health Groups along with all the full reports for their dissemination. The summary includes the actions to be taken, by whom and when.

The Trust completed two investigations into Serious Incidents in January 2017. These related to:

2.3.1 Failure to provide a timely follow up appointment. The patient presented with metastatic disease in September 2016 having last been seen in February 2014 and this patient has died subsequently. The learning from this investigation was that explicit instruction should have been made to continue regular follow up which did not happen. This has been shared with the speciality and administration staff.

2.3.2 Hospital acquired pressure ulcer. The recommendations from this investigation focused on the need for training of ward staff on heel elevation, bandage training, how to treat a 'diabetic' foot and to explore what additional nurse champion support could be given to the ward. This patient's sores are now healing and the patient has returned back to the care home with on-going support and treatment.

2.2 Additional updates on the Serious Incident Process

In February 2017, the Trust breached two SI investigation completion deadlines, by sending in the completed SI reports after the required 60 working day standard. One breach was due to sickness within the investigation panel team and the second breach was due to panel members wishing to make further revisions to the report. Both reports have now been completed and submitted.

These two breaches prompted the Governance Directorate to refresh its processes for the monitoring and management of SI investigations and the completion of actions. The Risk and Quality Teams now meet every Monday to go through the active SI investigations to ensure that the investigations are on track. This is also monitored through the weekly meeting with the Chief Medical Officer, Director of Corporate Affairs and Deputy Director for Quality, Governance and Assurance.

Also, this weekly meeting is an opportunity to review other elements of SI investigations, including the delivery of duty of candour responsibilities and those incidents being considered as SI's, currently.

3. CARE QUALITY COMMISSION (CQC) – COMPREHENSIVE INSPECTION – JUNE 2016

The Quality Summit in response to the CQC's comprehensive inspection of June 2016 took place on Friday 17th October 2017. The event was chaired jointly between NHS Improvement and the CQC. The event was well attended and was supported by stakeholders and partners including, Hull and ERY CCG's Hull and ERY Local Authorities, Hull and ERY Healthwatch, NHS England, Humber NHSFT, executive and non-executive directors of HEY and senior members of each Health Group. Following presentations by CQC and the Trust, there were table top discussions that considered two key questions to help inform the Trust's Quality Improvement Plan:

- What does Good/Outstanding look like? – working together, what innovative solutions are there for the Trust, e.g. flexible workforce?
- What else does the Trust need to do/what, if anything, is missing from the existing plans in place?

The Trust is due to respond with its action plan back to CQC by 31st March 2017. Regular updates on progress against this plan will be provided to the Quality Committee and the Trust Board in due course.

The QIP plans have been updated to reflect where 'must do' and 'should do' actions are being addressed and monitored. This has been shared with the CQC.

The Trust met with the CQC at its regular relationship visit on 21st March 2017. At this meeting, the Trust was informed of a change of regional inspectors. Karen Knapton, Inspection Manager has been replaced by Tracey Church and Tim Franklin, HEY's Lead Inspector, has been replaced by Alison Hudson. Karen and Tim are being moved to alterative areas, which is part of CQC's plans to rotate its staff to other work areas periodically.

The Trust was briefed on the forthcoming changes to the inspection processes by the CQC.

4. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer (ST) is a series of point prevalence audits that were established to measure the four most commonly reported harms to patients in hospital. Each month, all inpatients are assessed for the existence of any of the four harms that have occurred either before they came into hospital or whilst in hospital. Each month, all inpatients on that day are assessed for the existence of any of the four harms.

The NHS Safety Thermometer point prevalence audit results for March 2017 are attached as **Appendix One**. 896 in-patients were surveyed on Friday 13th January 2017, with the results as follows:

- **94.3%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2.57% [n=23]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **97.43%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **92.5% (n=829)** compliance. Clearly, this is more positive than is being reported (via Lorenzo) in the Integrated Performance Report and is improving steadily but these rates still need to improve further.
- VTE incidence on the day of audit was **4** patients; all of which were with pulmonary embolisms.
- New pressure ulcers remain relatively low **(n=10)**; 9 of which were at grade 2 and one at Grade 3, which has been reported as a serious incident.
- There were **16** patient falls recorded within three days of the audit day; **10** of which resulted in no harm to the patient, **5** with low harm and 1 with moderate harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain relatively low at **6/172** patients with a catheter **(3.5%)**. Of the **6** patients with infections, **3** were infections that occurred whilst the patient was in hospital **(1.7%)**. This remains a focused area for the Trust.

Overall, performance with the Safety Thermometer remains relatively positive but continues to be reviewed monthly. Each ward receives its individual feedback and results.

The original intention behind the ST was for it to be a tool for local improvement. The reporting of ST results is a contractual requirement for the Trust and, also, they are used by the Care Quality Commission and NHS Improvement in their assessments of the Trust's performance. Originally, it was never intended for the ST data to be used as a performance management tool or a benchmarking tool with other trusts. This is because not all trusts collect necessarily the same data, in the same way and to the same scale. Nonetheless, they are used in this way.

As such, it is important to put any comparators into context. Despite this, the benchmarking tables prepared by the Y&H Academic Health Sciences Network Improvement Academy are still useful reference points for comparison against the Yorkshire and Humber and England averages. These are now provided.

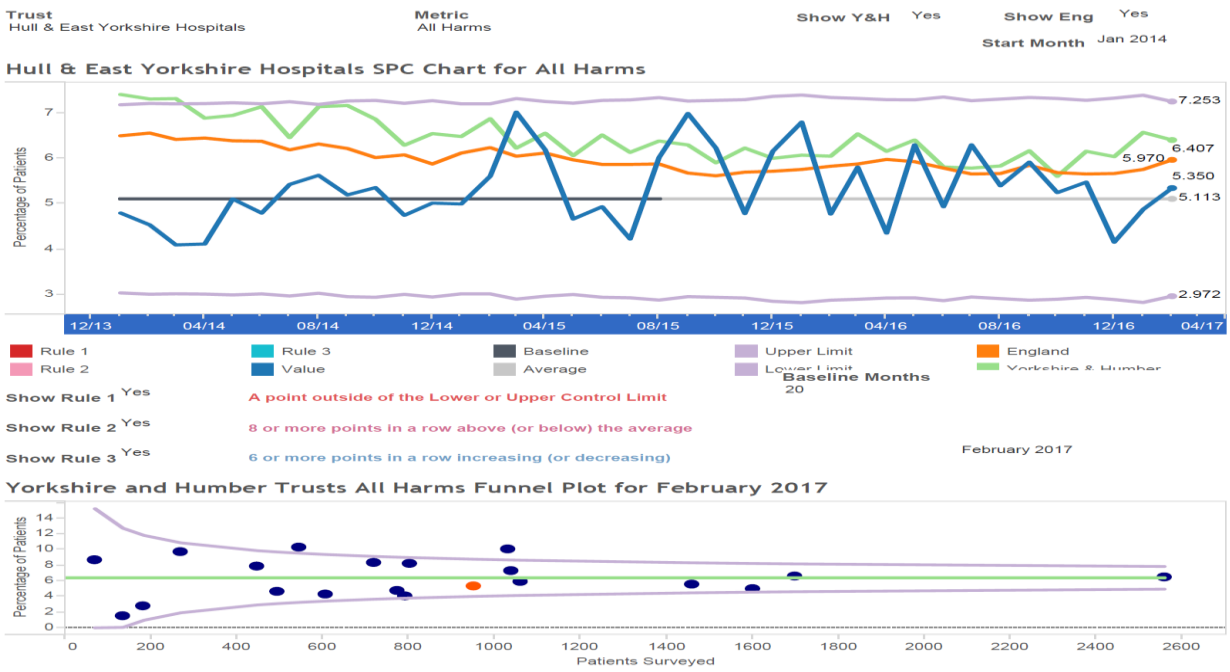
The key to these is as follows:

- **Navy Blue line** = Hull and East Yorkshire Hospitals NHS Trust
- **Orange line** = England average
- **Green line** = Yorkshire and the Humber Average

In terms of assuring the Trust Board, all appropriate inpatients at HEY are surveyed on Safety Thermometer day and this ranges between 800-900 patients on average. Only those patients that are in places such as operating theatres or radiology are not counted on the day. As such, the Trust's results/proportions are significant in this respect. The data up to February 2017 are now presented on the following pages.

4.1 All Harms

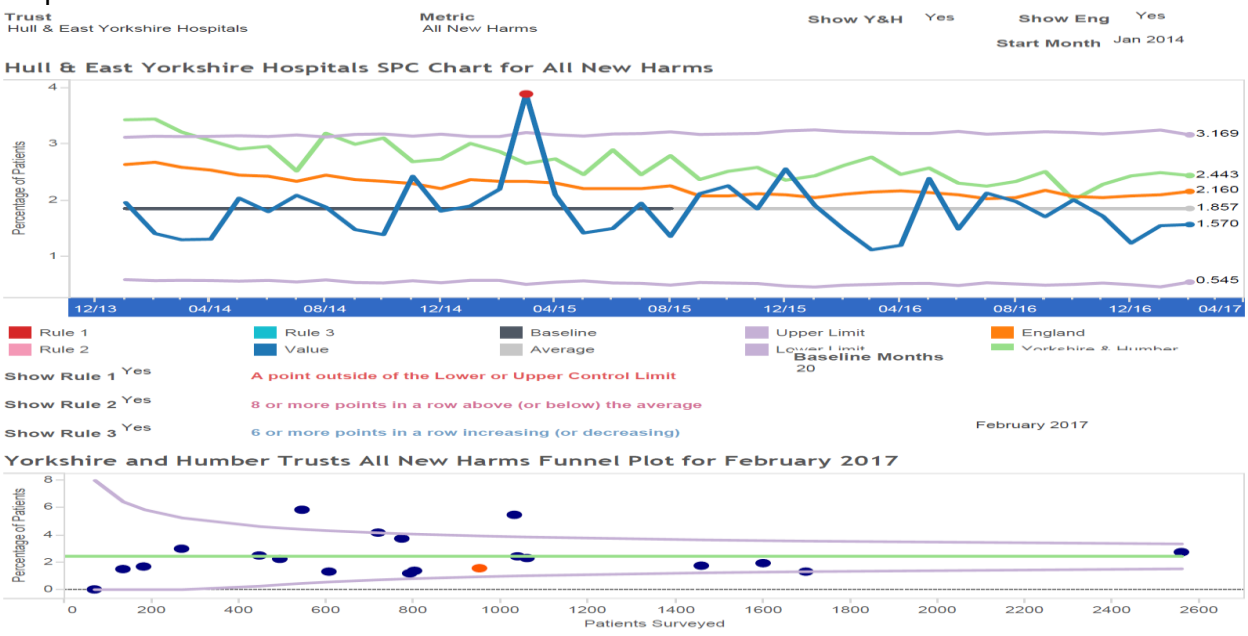
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



As can be seen, this performance sits within the control limits for this indicator and with a positive position overall when compared to the England and Yorkshire and Humber averages. In terms of the Trust's performance, it is more appropriate to consider the proportion of patients that acquire any of the four harms whilst in hospital. These are termed 'New Harms'.

3.1.1 New Harms

This measure shows the proportion of patients that sustain any of the four ST harms whilst in hospital.

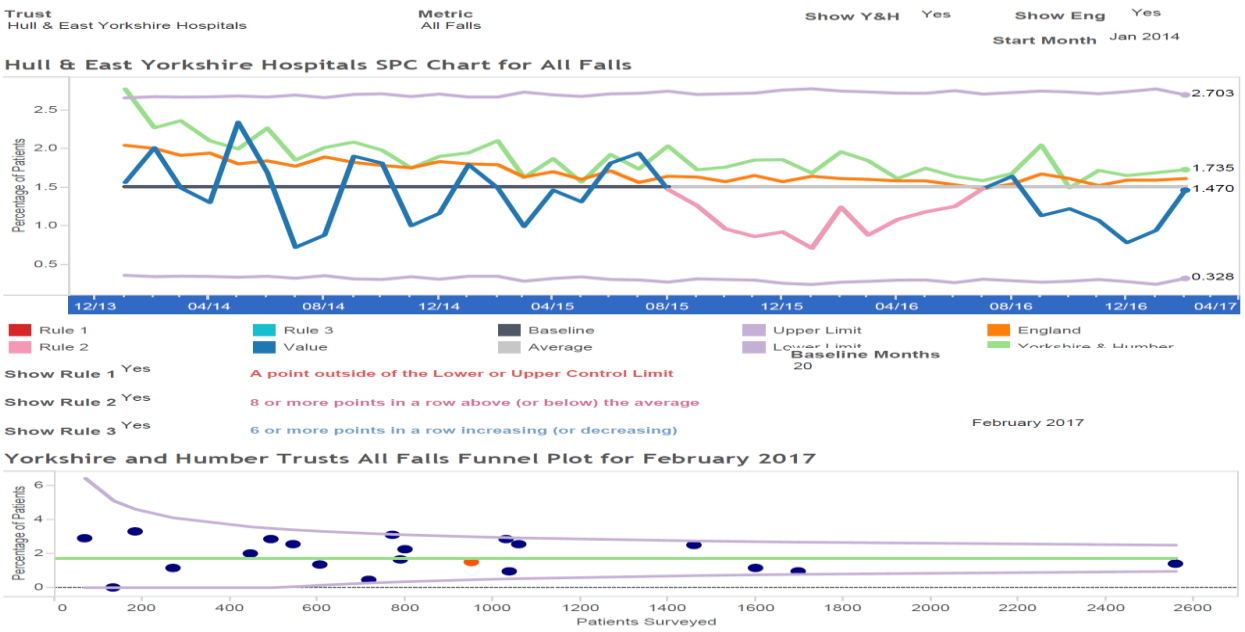


Again, and overall, the Trust performs realtively well against this indicator but there is always room for improvement, psrticularly where any harm is deemed avoidable. These data continues to be reviewed monthly. Each ward received its individual feedback and results and is required to take action accordingly. To take each of the four harms in turn:

4.2 FALLS

4.2.1 Falls (all)

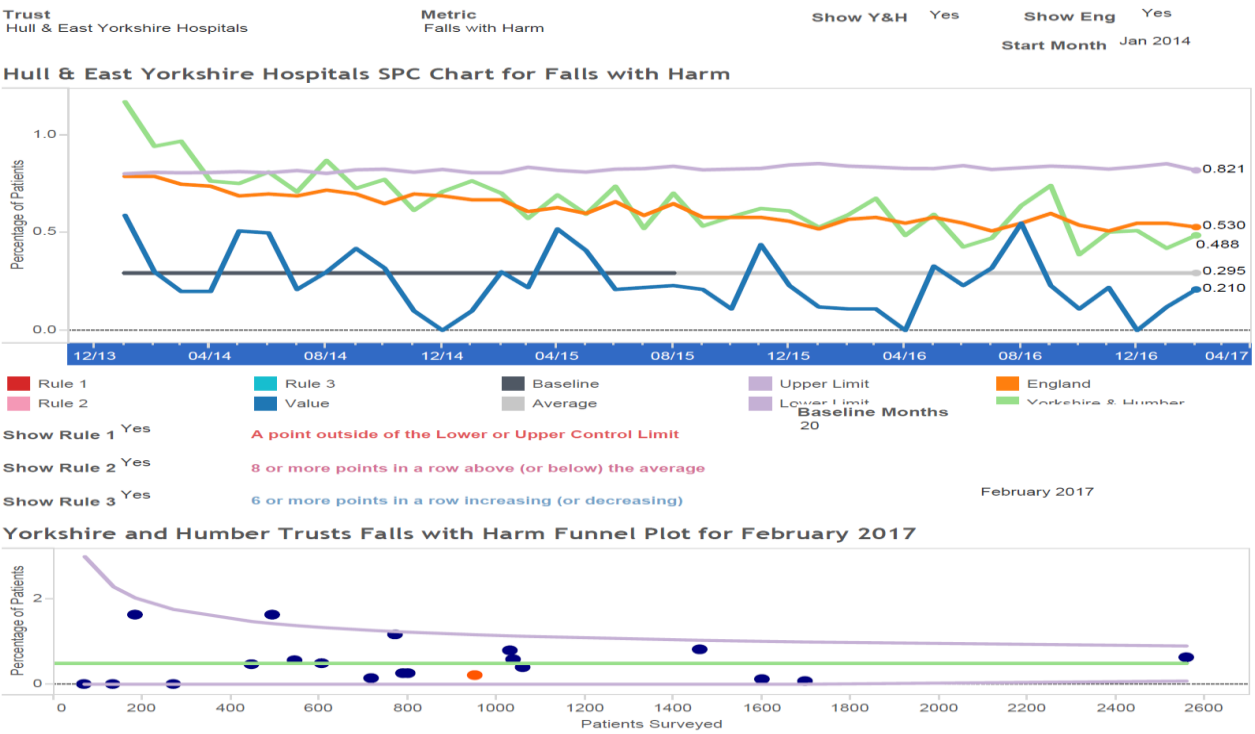
The following tables shows the percentages of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



Improvement work to help reduce patient falls continues to be rolled-out across wards as part of the Trust's transformation work to help to try and address this.

4.2.2 Falls with harm

This chart differentiates those patients that fell and sustained harm from those that fell and where there was no harm.

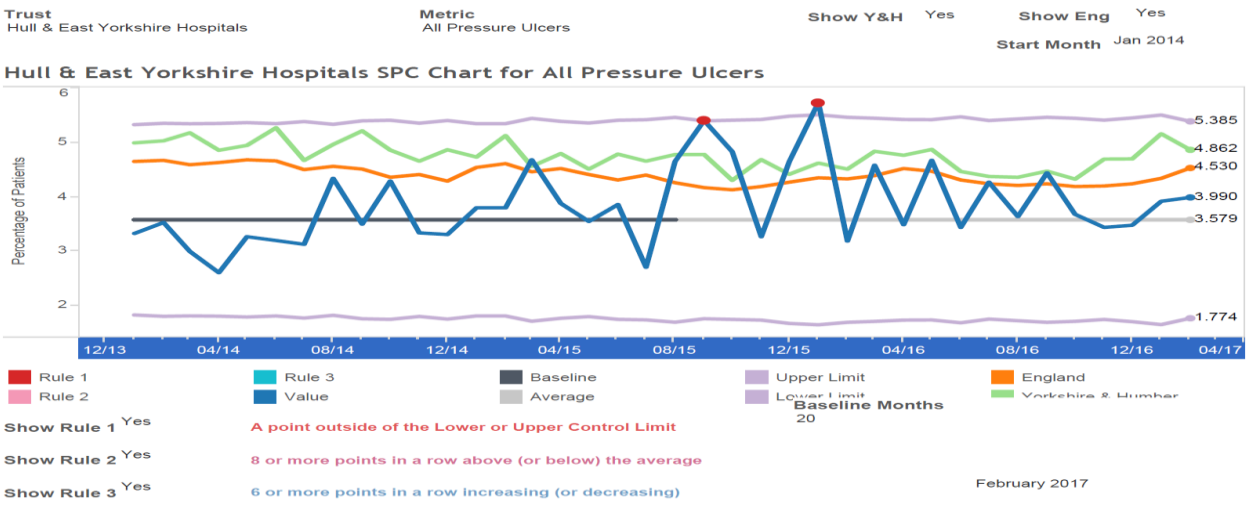


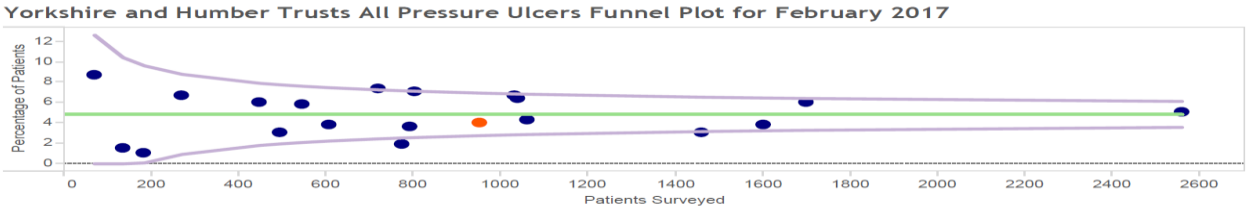
Following a recent increase in the number of patients falling resulting in harm in August 2016, this has reduced again in September 2016. Overall though, this remains very positivie performance when compared to peers and reflects the cotinued prevention work that is being undertaken in this area.

4.3 PRESSURE ULCERS

4.3.1 Pressure Ulcers (All)

The following graph and funnel plot show variable statistics on this measure. An important factor is the proportion of patients that come into the Trust with exisiting pressure ulcer damage, which is significant, particularly in patients that are admitted via the emergency department and admissions areas (AAU and EAU), altohough this has imporved in recent weeks.

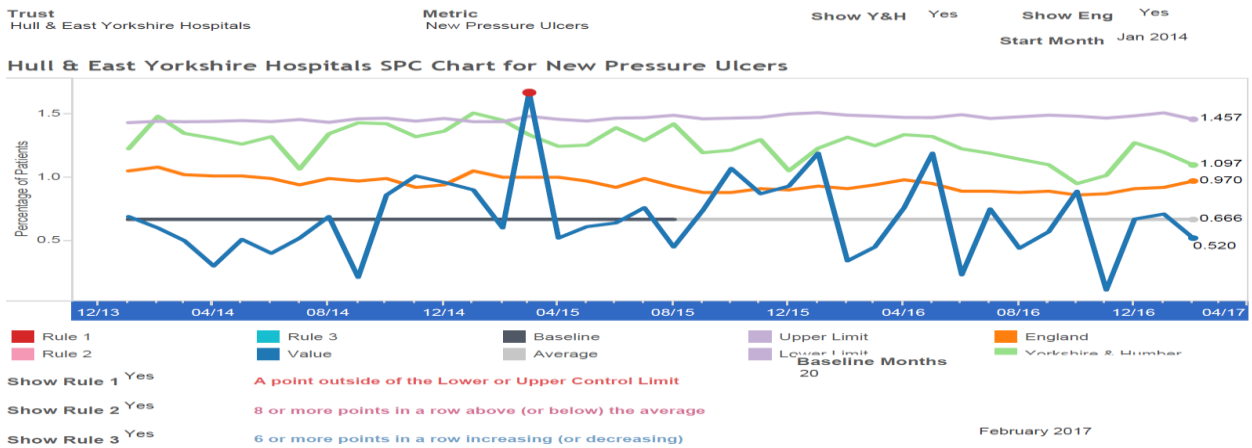


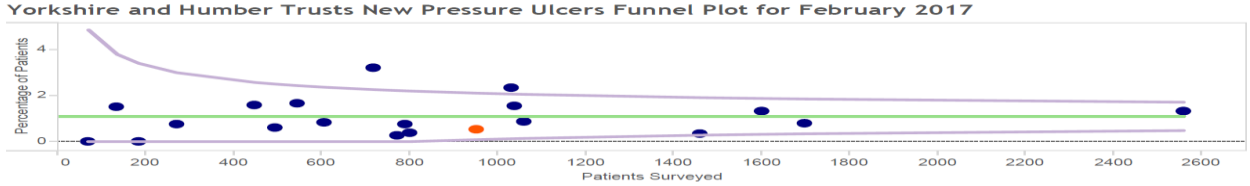


Those patients that suffer pressure damage whilst in hospital (all grades) are now described:

4.3.1 Pressure Ulcers (new)

When the data for pressure ulcer harm that is acquired whilst in hospital is considered, this is an even more positive picture overall.



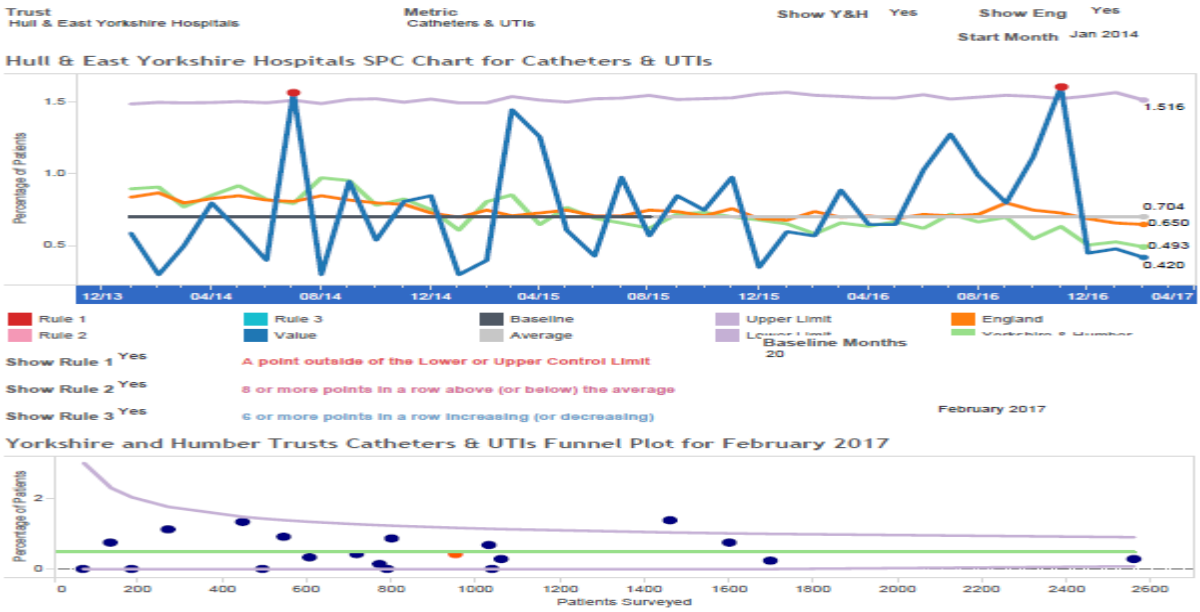


The performance for this indicator is positive overall, although the Trust is not complacent and futher work is underway to ensure further improvements in this area. Improvements in practice and care are being witnessed but the education and training programmes continue in earnest.

4.4 CATHETERS AND URINARY TRACT INFECTIONS (CAUTI)

4.4.1 Catheters and UTI (All)

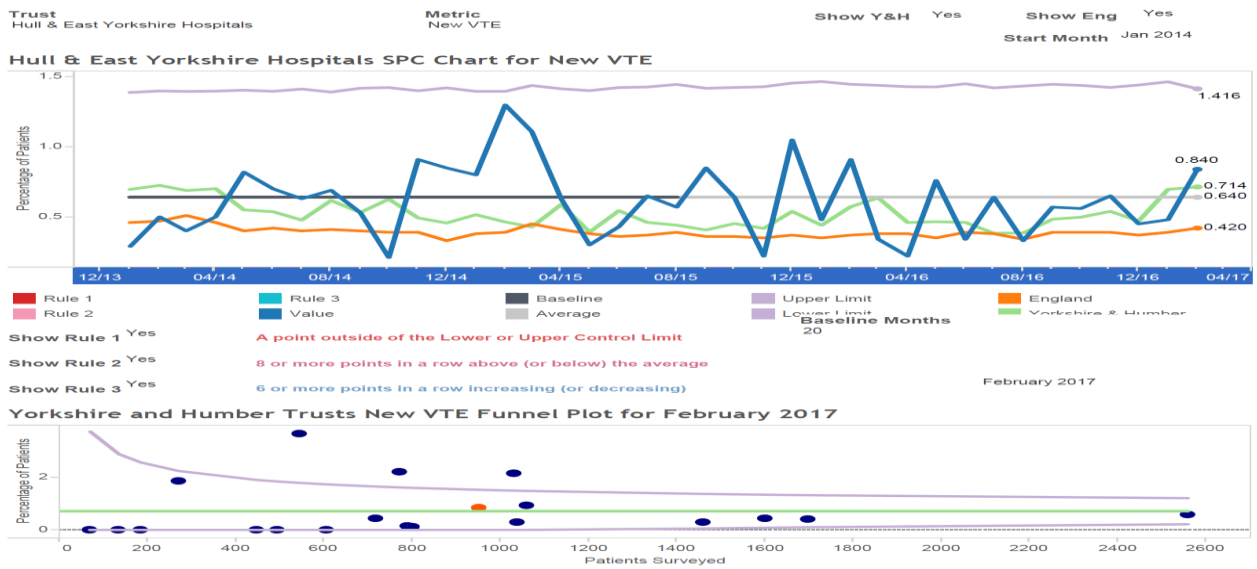
It is important to set some further context around this particular measure. Often, a patient can be admitted to hospital with signs and symptoms that may then manifest to be a CAUTI. However, if this is then diagnosed in the Trust and if treatment starts in the Trust, it is deemed to be hospital attributable; such are the limitations of this measure. The following chart details all taients with a catheter and a UTI, whether this was acquired in hospital or not.



The following chart shows the rate of these infections appears to be falling. Those patients that acwuired a 'new' infection for February were 3 in total. Th ebenchmarking chart for this indicator is not yet avaiable.

4.5 NEW VENOUS THROMBO-EMBOLISM (VTE)

The following chart shows those patients that either came into hospital with a VTE episode or acquired a venous thrombo-embolic episode whilst in hospital. Performance with this is the most erratic of the four harms, with fluctuating performance overall.



Each case of a patient identified with a VTE episode is reviewed and reported to the Thrombosis committee. Individual feedback is provided to each of the areas and teams concerned. In almost all cases, these were unavoidable and/or the patient was receiving the correct treatment.

5. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

5.1 HCAI performance 2016/17– as of 28th February 2017

The Trust is required to report monthly on performance in relation to four key HCAI's. These are summarised in the following table along with the current performance against the upper threshold for each:

Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**42 (79% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1 (100% of threshold)**
MSSA bacteraemia	**46**	**43 (93% of threshold)**
E.coli bacteraemia	**95**	**76 (80% of threshold)**

Performance against these upper thresholds is now reported in more detail, by organism.

5.1.1. Clostridium *difficile*

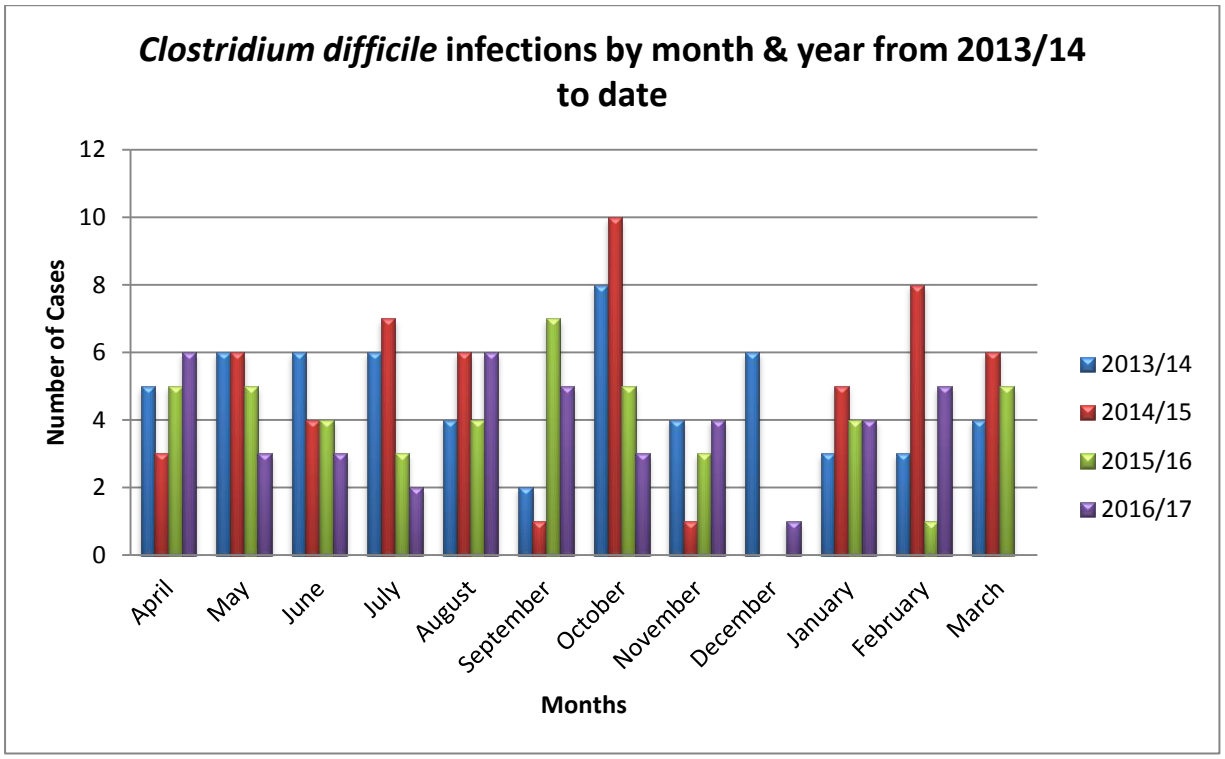
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a C.*difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and painful abdominal cramps. In extreme cases, C. *difficile* infections can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (termed toxic megacolon). In certain cases they can cause or contribute to the death of a patient.

For rates attributable to the Trust, 5 cases were reported in February 2017, bringing the total to 42 against an upper threshold of 53 for the year. Ongoing Trust efforts continue to enable a further and sustained reduction in cases. Root cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

The 5 cases reported during February 2017 were identified across Medicine, Oncology and Clinical Support and Surgery. These cases are subject to root cause analysis currently but early indications suggest no lapses in care identified in the majority of cases; the final outcome for each is to be decided at the respective case meetings.

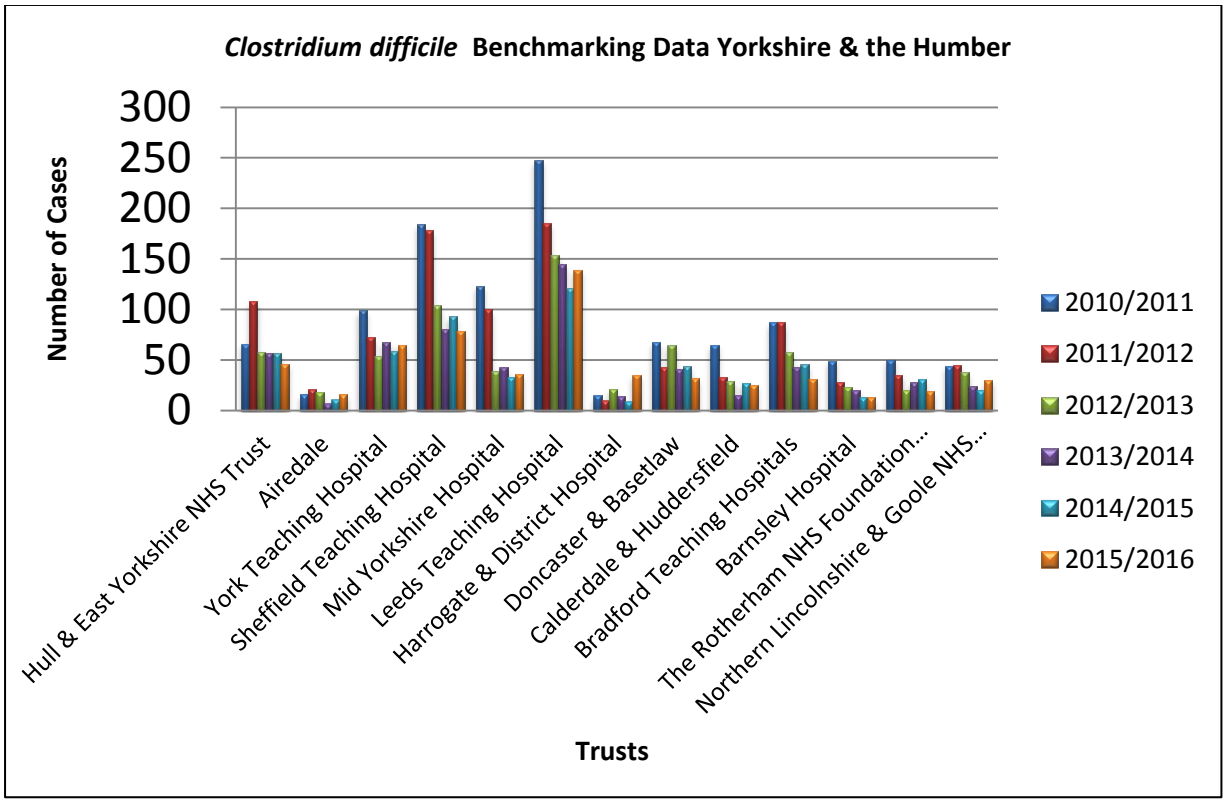
Trends following root cause analysis investigation identify the need for continued and sustained improvements in antimicrobial stewardship. Improvements on appropriate sampling and prompt isolation continue.

The following graph highlights the Trust's performance from 2013/14 to date:



following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:

Trust apportioned *Clostridium difficile* cases for Yorkshire & the Humber from 2010 onwards



As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers.

5.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia
Staphylococcus aureus (also known as staph) is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and abscesses. If the bacteria enter the body through a break in the skin, they can cause life-threatening infections, such as blood poisoning (bacteraemia).

MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

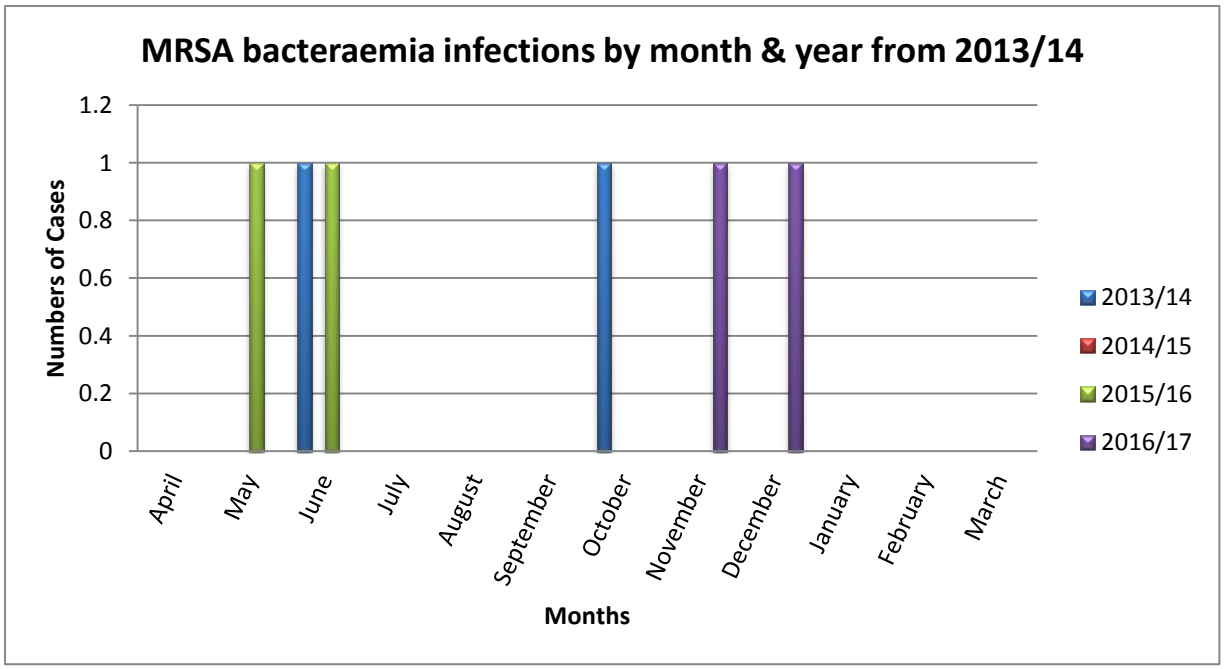
There have been no further cases of Trust apportioned MRSA bacteraemia detected during February 2017. However, since 1st April 2016 there have been 2 MRSA bacteraemia cases detected. This is against a Zero Tolerance objective for 2016/17.

One case of this infection identified during November 2016 in the Family and Women's Health Group and was deemed Trust-apportioned following Post Infection Review (PIR) investigation. This has been reported to the Trust Board previously.

A further case of this infection was identified during December 2016 in Medicine. With respect to this latter case, following Post Infection Review (PIR) investigation, a decision was made to decline apportionment and initiate MRSA bacteraemia arbitration by NHS England North. This decision was due to the complexity of the case and the patient's pathway and the involvement of two other acute Trusts (Harrogate and District NHS Foundation Trust and The James Cook University Hospital (South Tees Hospitals NHS Foundation Trust)) in the patient's care pathway.

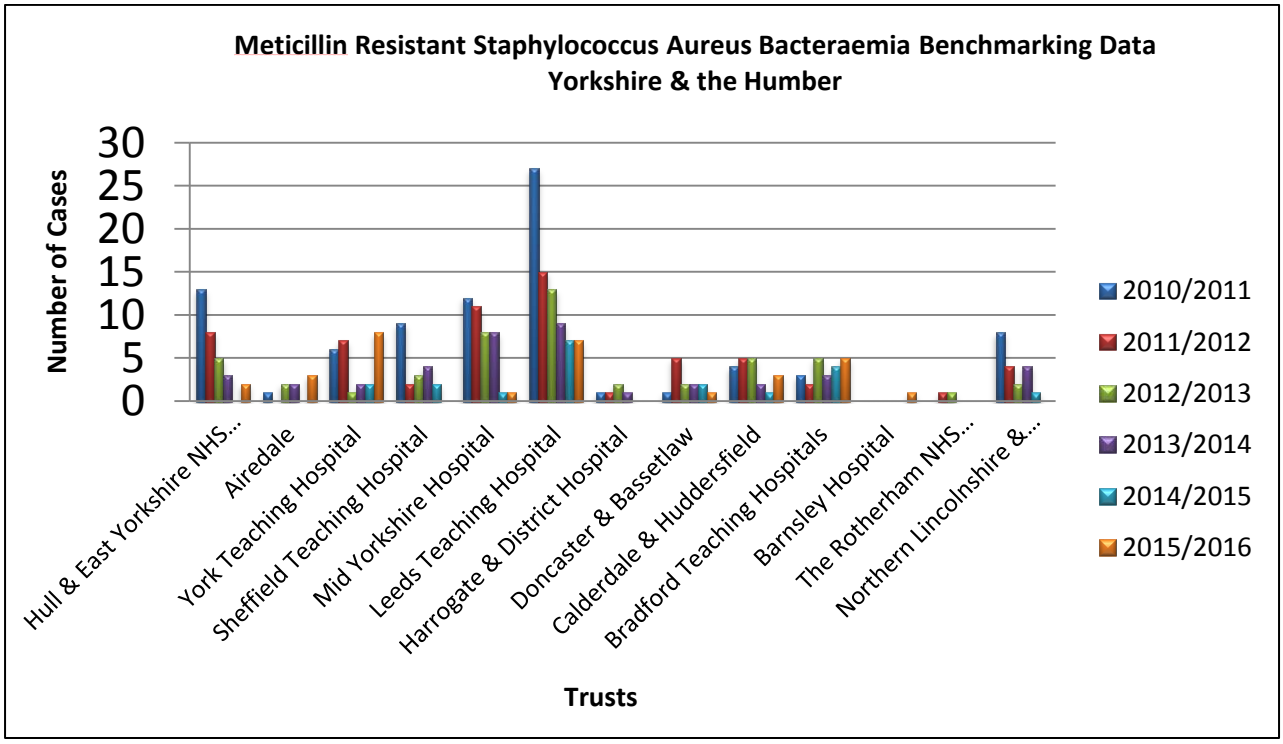
The outcome of the NHS England North MRSA arbitration panel that was convened on the 14th March 2017 decided that this infection should be assigned as 'Third Party'. As such, this will no longer be attributable to this Trust, which is positive news. As always, there are still lessons for the Trust to learn from this and these have been implemented.

The following graph highlights that cases of this infection are now extremely rare, thankfully. The performance from 2013/14 to date and demonstrates the variability in numbers year on year.



The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:

Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases for Yorkshire & the Humber from 2010 onwards

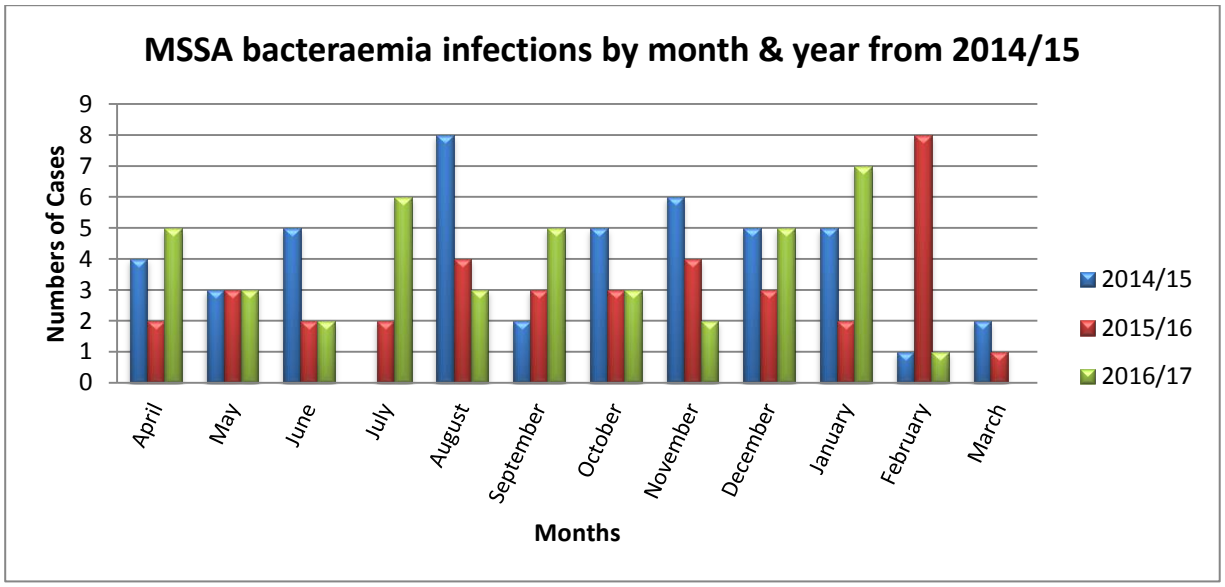


As can be seen from this, the relative improvements of this Trust over recent years are positive when compared peers in the region.

5.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

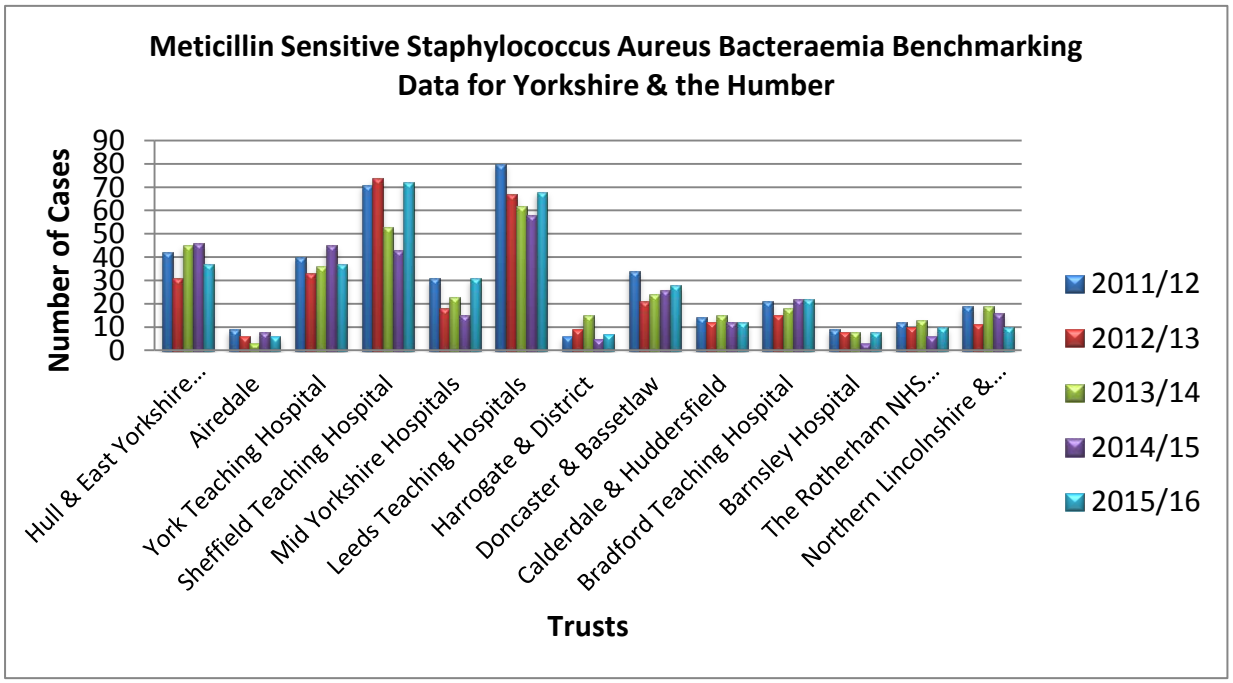
Meticillin-sensitive Staphylococcus aureus is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

However, MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds. MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream. However unlike MRSA, MSSA is more sensitive to antibiotics and therefore easier to treat MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection. Cases of patients with this infection are represented across Health Groups and provide an opportunity to investigate and further analyse any trends to improve practice. The Trust continues to see fluctuations in the number of cases reported throughout the year, although the data for February in the following graph shows a much improved position in-month.



The following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:

Trust apportioned Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases for Yorkshire & the Humber from onset of surveillance 2011 onwards



As can be seen, this is more evenly spread both across organisations and, also, recent years. The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken by the Trust.

The case of this infection identified during February 2017 was detected in the Medical Health Group and is undergoing review to determine its root cause. Cases throughout the year have been complex and associated with patients with multiple morbidities and complex risk factors.

The need for continued and sustained improvements regarding this infection remains a priority. Actions on device/ line management continue and are considered key in reducing rates of this infection.

5.1.4 Escherichia-coli Bacteraemia

There are many different types of Escherichia coli (E. *coli)* bacteria, most of which are carried harmlessly in the gut. These strains of E. *coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals.

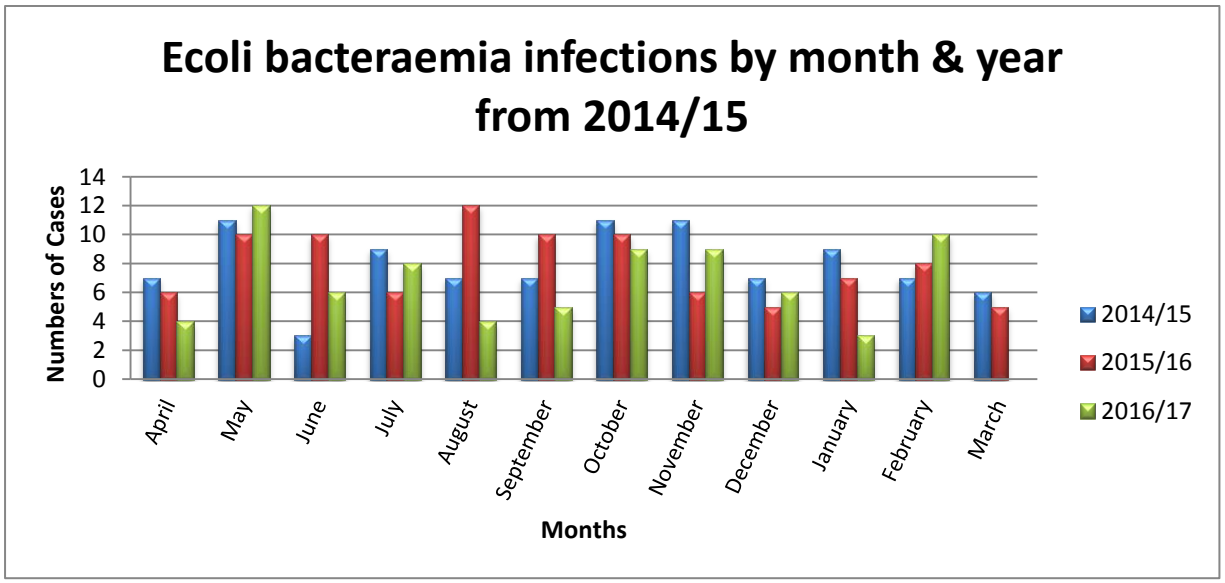
However, when strains of E. *coli* are outside their normal habitat of the gut, they can cause serious infections, several of which can be fatal. Potentially dangerous E. *coli* can exist temporarily and harmlessly on the skin, predominantly between the waist and knees (mainly around the groin and genitalia), but also on other parts of the body, i.e. a person's hands after using the toilet.

E. *coli* is now the commonest cause of bacteraemia reported to Public Health England. E. *coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example. There are no national thresholds for this infection.

E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Numbers are total numbers reported by the Trust onto the national Public Health England 'MESS' database. Most patients are admitted with this infection to hospital and have invariably acquired it whilst in the community. Sources of infection relate to urinary tract, hepatobiliary, respiratory and a previous history of E.*coli* infection.

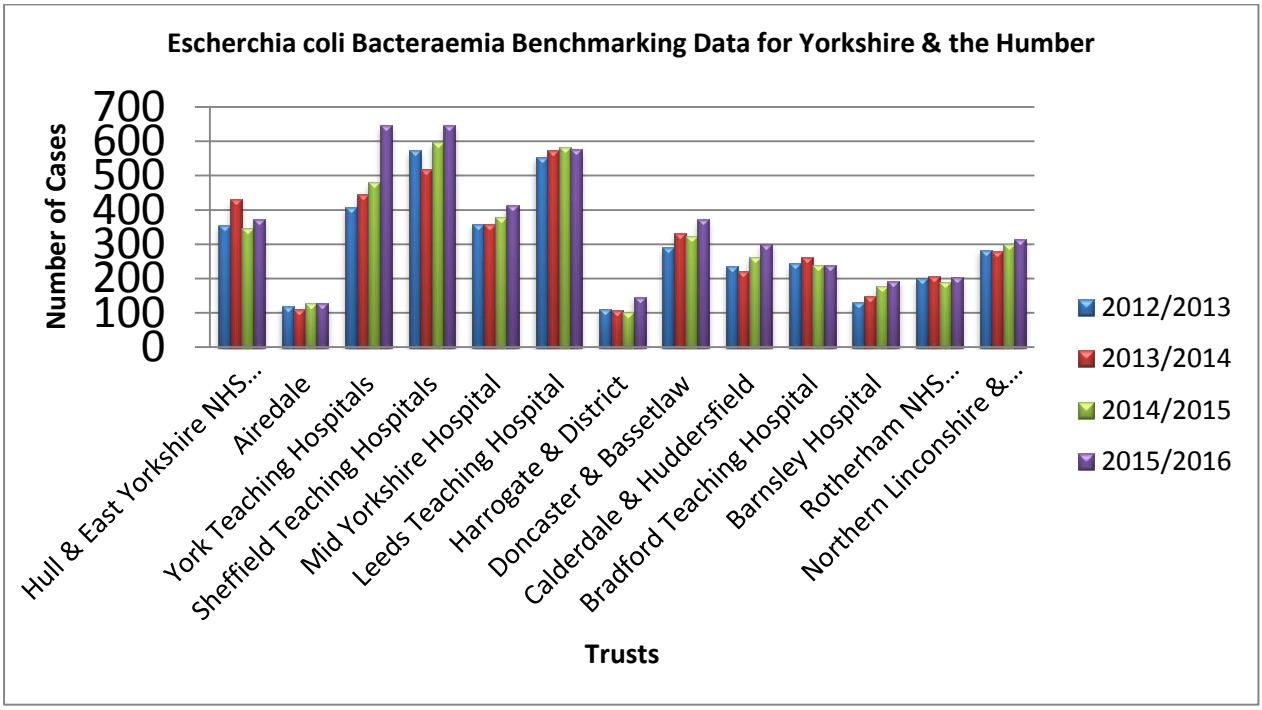
In preparation for measures being introduced by NHS England/ Public Health England from April 2017 to reduce the burden if gram negative bacteraemia, further surveillance of *E. coli,* Klebsiella and Proteus bacteraemia cases has commenced during January 2017 and to continue until March 2017.

Although a marked reduction in Trust apportioned cases was noted since November 2017, during February 2017 there were ten Trust apportioned cases of E.*coli* bacteraemia. Further surveillance of each case will determine risk factors and any possible lessons learned for the Trust.



The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:

Trust apportioned Escherichia-coli bacteraemia cases for Yorkshire & the Humber from 2012 onwards



Again, the patterns across all trusts are pretty consistent, which demonstrates the overall challenges with this infection.

5.2 Infection Outbreaks

An outbreak is defined by two or more patients with the same infection in the same ward/area.

5.2.1 Diarrhoea and vomiting episodes

During February 2017 the Trust continued to experience diarrhoea & vomiting outbreaks, restricted to just one medical elderly ward at Hull Royal Infirmary. The ward was closed and reopened following deep cleaning with a subsequent bay closure required three weeks later. In both cases, Norovirus was confirmed as the causative organism with one patient also detected with Clostridium *difficile*.

5.2.2 Influenza trends

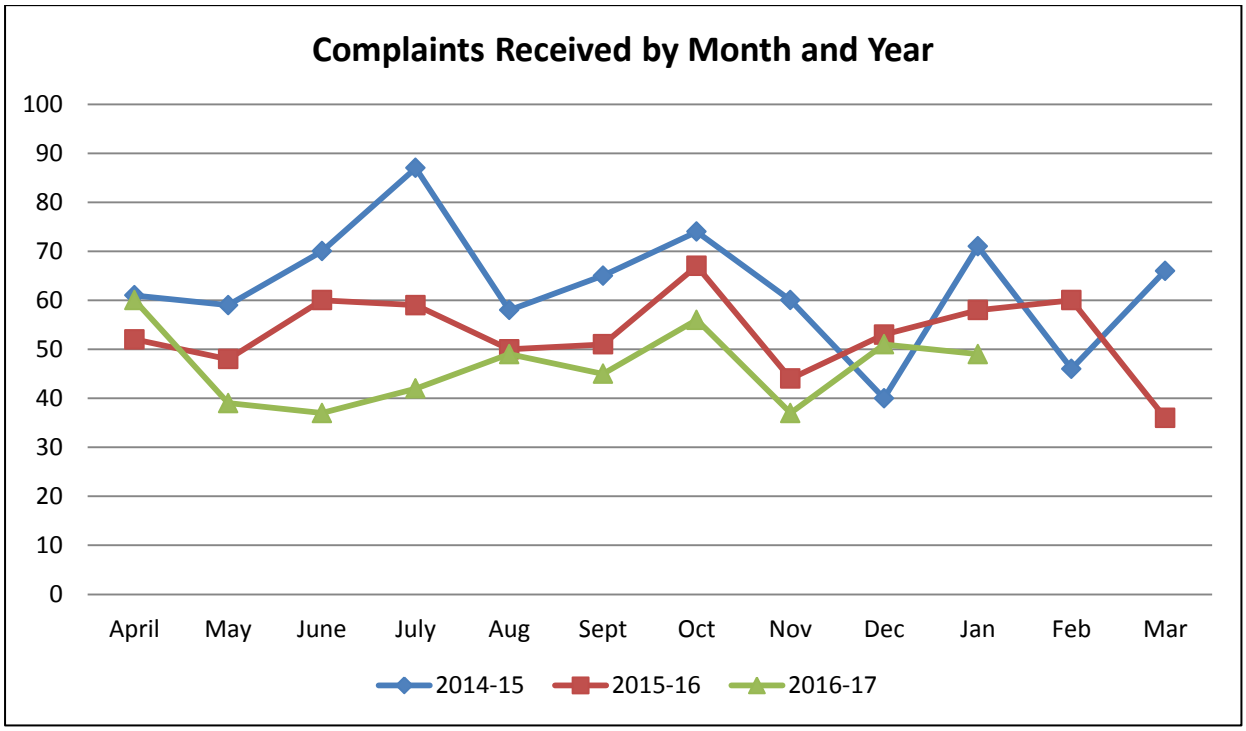
During February 2017 a cluster of Influenza A cases were diagnosed on H10, HRI. Microbiology advice was obtained and prophylaxis treatment was prescribed for those patients who had been in contact with the infected patients. Due to the number of patients affected the ward was closed to admissions in accordance with PHE advice. PHE Guidelines were followed in the use of personal protective equipment and the appropriate management of patients. The ward was reviewed daily by the Infection Prevention and Control Team and all patients monitored closely for any flu-like symptoms. In total eight patients were confirmed as Influenza A positive by laboratory testing. The ward remained closed until five days after the last new confirmed case. No staff were reportedly affected during the incident reinforcing the importance of the seasonal influenza vaccination campaign.

Reports of influenza A incidents across Yorkshire and the Humber increased during January and February 2017 with a number of acute Trusts affected by a surge in cases and the associated increased demand. This now appears to be settling.

6. PATIENT EXPERIENCE

6.1 Complaints

The graph below sets out comparative complaints data from 2014 to date.



The following table indicates the number of complaints by subject received for each Health Group during the month of February 2017.

Complaints by Health Group and Subject (primary)	ATTITUDE	CARE AND COMFORT	COMMUNICATION	DELAY, WAITING TIMES CANCELLATIONS	DISCHARGE	SAFEGUARDING	SPECIAL NEEDS	TREATMENT	Total
Clinical Support - Health Group	0	1	1	0	0	0	0	0	2
Family & Women's Health Group	0	0	0	0	1	0	0	6	7
Medicine - Health Group	1	3	2	0	2	1	0	6	15
Surgery - Health Group	3	1	2	1	4	0	1	14	26
Totals:	4	5	5	1	7	1	1	26	50

Complaints about treatment continue to be the highest in number. The two key themes relate to patients that are not being happy with the treatment plan (13) and the outcome of the surgery undertaken (4). These complaints are all looked at individually and patient/family is offered a resolution meeting. The outcome of the investigation is shared fully with the complainant. It is noted that although ED had almost 11,000 attendances during February, there were no complaints received for EMD.

6.1.2 Performance against the 40 day complaint response standard

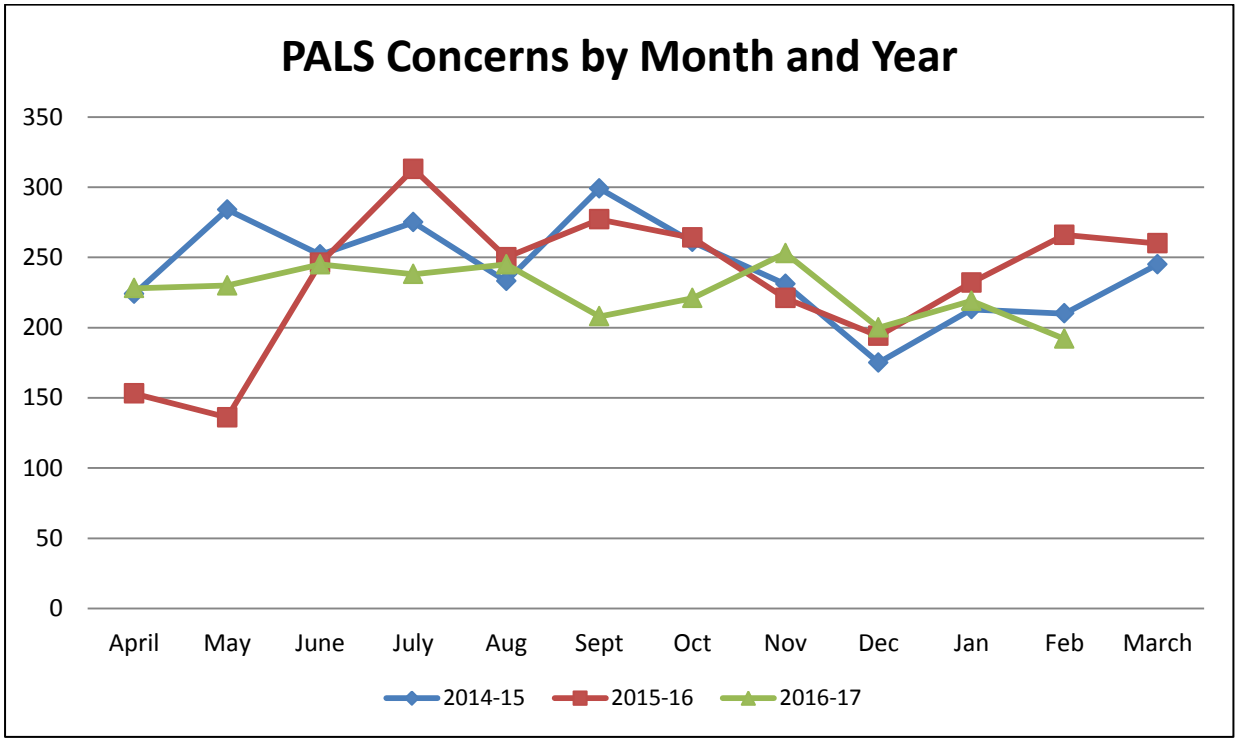
The following table sets out performance against the Trust's standard of closing 90% of complaints within 40 days:

Health Group	Closed	Closed within 40 days
Clinical Support	1	1 (100%)
Family and Women's	8	6 (75%)
Medicine	15	11 (73.3%)
Surgery	10	3 (30%)
Total	34	21 (61.8%)

The Patient Experience Team is continuing to work closely with each of the Health Groups to enable timely responses to complaints whilst maintaining the quality of responses. Of the closed complaints, 5 were not upheld, 20 were partly upheld and 6 were upheld. Two complaints were escalated for a Serious Incident investigation and one was not taken forward at this time at the request of the complainant. The Complaints Team have attended training at Hempsons and at Capstick Solicitors this month, providing reassurance that the Trust is complying with national standards.

6.2 Patient Advice and Liaison Service (PALS)

In the month of February 2017, PALS received 196 concerns as well as 16 compliments, 56 general advice issues and 4 comments/suggestions. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of waiting times for appointments.



The table below indicates the number of PALS received by Health Group and primary subject in February 2017

	ADVICE	ATTITUDE	CARE & COMFORT	COMMUNICATION	DELAY, WAITING TIMES AND CANCEL	DISCHARGE	ENVIRONMENT	HOTEL	SAFEGUARDING	SPECIAL NEEDS	TREATMENT	Total
Corporate Functions	2	1	0	3	2	0	2	2	0	0	0	12
Clinical Support	0	2	0	4	15	1	0	0	0	1	0	23
Family & Women's	4	1	0	7	21	1	0	0	0	1	7	42
Medicine	4	5	3	8	21	7	0	2	1	0	10	61
Surgery	4	6	2	9	26	2	0	0	0	0	9	58
Totals:	14	15	5	31	85	11	2	4	1	2	26	196

6.3 Compliments

The Trust has received a large number of compliments this month which include, praise for the out patients department at Castle Hill Hospital. A young adult with special needs attended an appointment; it was a very sensitive issue which caused him considerable anxiety before the appointment. The patient said that "the Consultant was very kind and understood his fears but once he had explained everything and allowed him time to ask any questions he found that he left the appointment feeling reassured".

A Compliment was received for the fracture clinic at Hull Royal Infirmary complimenting the 'amazing and efficient' care given to a patient who was anxiously awaiting a scan for what was possibly a serious diagnosis. After the patient had received the scan he rang the secretary of the consultant in his care and she kindly chased up the results and promptly called the patient back informing him that he would be able to see the consultant the next day.

6.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 6 cases under review by the PHSO currently. No new cases have been received during March. There is nothing go of exception to report from these, currently.

6.5 Friends and Family Test (February 2017 Data)

The Trust is out to tender currently to find new partners for the Friends and Family test. The Patient Experience team has been working alongside the Procurement team to award the new contract. In the interim period, the Patient Experience team has been collating FFT information 'in-house' and analysing the data until a new partner is finalised. Therefore, this information is summarised for this report.

The Trust's Friends and Family results for February for all areas excluding the Emergency Department indicate that there was a decrease in the number of responses for the month of February 2017 with 4,230 responding compared to 5,064 in January. From these, 98.61% were extremely likely/likely to recommend the Trust to friends and family, which is really positive.

6.5.2 Emergency Department (ED)

The Trust is now collecting the ED Friends and Family test results by two different methods; paper and SMS text messaging. This has resulted in a significant increase in the response rate from 7.5% of attendances to 22%.

With regard to the paper feedback, 765 patients gave feedback. Of these, 87.8% said they were extremely likely/likely to recommend ED to friends and family. 6.5% said they were extremely unlikely/unlikely to recommend.

With regards to SMS text messaging 86% of patient gave positive feedback and 9% gave negative feedback.

6.6 Voluntary Services

The Voluntary Services continue to recruit steadily with more focus on volunteers visiting patients who do not have any visitors during their hospital admission and is currently very successful within the Cardiology Unit. We are looking at extending this to the rest of the Trust.

The Patient and Public Council continue to integrate within the services and areas across the Trust. The council have been asked to become more involved with varying user groups of services within the trust.

6.7 Patient Information and Leaflets

A new feature will be added to the Trust's website in April 2017 called 'Browsealoud', which will support patients with additional needs to understand the website's content more clearly. This has been funded for the next two years via charitable funds, following a successful application by the Patient Experience Team. Browsealoud will provide audio facilities, MP3 downloads, larger font, simplified screens and translation into over 100 languages, that will also available in audio format. The information will be compatible with the browser settings on a patient's own computer to support their specific pre-set requirements.

This feature further supports the Accessible Information Standard requirements that all NHS and adult social care organisations need to comply with (section 250 of the Health and Social Care Act 2012). The standard is a legal requirement, which has been established to ensure that people who have a disability, impairment or sensory loss are issued with information that they can access and understand and, also, receive any further communication support needed.

7. OTHER QUALITY UPDATES

7.1 Venous Thromboembolism Risk Assessments (VTE)

The Trusts performance in relation to the VTE risk assessments in March 2017 is overall 90.34% (95% target). This is an improving picture and work to improve this further continues.

7.2 Major Trauma Centre Peer Review

The Major Trauma Quality Surveillance Team (QST) undertook a peer review visit in October 2016 and the Trust has recently received and responded to the report. Overall the QST were impressed with the progress that had been made since their last visit in 2015.

Assessors were particularly impressed with the designated major trauma ward and that Major Trauma Coordinators are working alongside the trauma coordinators to provide a 7-day service. The established Major Trauma MDT daily was seen as good practice. The Trust had implemented a Major Trauma Consultant on a weekly rota (the consultant undertakes a round Monday to Friday and attends Major Trauma calls).

The QST felt that there had been major improvements in recruiting to specialist posts, including a Psychologist, two Rehabilitation Coordinators, the House Keeper and a Hygienist for the Major Trauma Ward.

The QST also recognised that, by implementing a dedicated TARN data collection team, this has significantly improved the data quality and number of submissions from HEY to the national dataset.

The QST raised 4 serious concerns and these are now described along with the Trust's responses.

1. **There is not a consultant trauma leader always available within five minutes 24 hours per day**.

Trust response:
The actual availability of ED consultants out of hours is more extensive than presented originally in peer review evidence. Presently, the HEYT consultant team is covering registrar locum night shifts each Tuesday, Wednesday and Thursday, with external consultant locum cover Saturday's and Sunday's. Thus, Tuesday 00.00 - 08.00 and Saturday 00.00-08.00 are the only times with non-resident on-call consultant cover. In the absence of an on-site ED consultant, all pre alert trauma calls and all immediate trauma calls initiate the policy for the senior ED doctor in the department to notify the ED consultant on call.

2. There is an insufficient staffing resource to provide a major trauma coordinator service seven days each week. Whilst it is acknowledged that some degree of weekend cover is in place, there is no clear plan with a confirmed implementation date for this to be available each week therefore there is no assurance that all major trauma patients in the Trust have their multiple needs managed throughout the care pathway. Lack of specialist coordination could seriously compromise clinical assessment, treatment and outcomes.

Trust response:
The Trust will work with the orthopaedic trauma team to increase the robustness of the cover, the confidence and the competence to provide this service and will review further in three months with the option of exploring alternative ways to improve the service if required.

3. The TARN mortality data provided currently shows an excess number of deaths compared with similar populations. This may in part be related to the suboptimal quality of TARN data collection and analysis, however, may represent a true increase in mortality risk. Timely confirmation of data accuracy is essential so that the potential poor clinical outcomes can then be addressed. Whilst the issue of robust data collection and analysis has commenced, the reviewers were not assured that there is a clear action plan that has a confirmed end date and this could significantly compromise the quality of care for patients.

Trust response:
The Trust believes that there are now effective arrangements in place to capture timely, accurate and complete TARN data, which will be evidenced from Q3 returns onwards. In regards the excess deaths, a systematic case note review was undertaken and has reported findings and recommended actions to the December major trauma governance meeting. Monthly updates from each site including full analysis will also now be presented to the network board meetings. The Network has set up a network TARN support group to support this team with timely and accurate data collection.

4. There is a lack of provision of hyper-acute trauma rehabilitation beds and staffing resources. As a consequence patients either do not have access to the appropriate level of specialist care or have to access this a considerable distance from their home therefore impacting on patient experience and/or potentially delay the management and rehabilitation for this group of patients. This could affect the enablement of long term outcomes for patients following major trauma.

Trust response:
The Trust is working with NHS England review team to develop an action plan to address this.

The actions from this review will continue to be monitored and managed at the Trauma governance meeting.

8. ELIMINATING MIXED SEX ACCOMMODATION (EMSA) – COMPLIANCE STATEMENT 2016/17

Since 2010, there has been a requirement for all NHS provider organisations to 'virtually eliminate' mixed sex accommodation in all of their premises. National Standards are in place for this and it is a requirement of the NHS Standard Contract with commissioners.

The standards apply to sleeping areas and bathroom and toilet facilities, also.

The term 'virtually-eliminate' applies because it will not always be possible to eliminate the sharing of some clinical areas by people of both sexes, particularly when urgent clinical need or emergency access to treatment are the priority. This is in areas such as intensive care/high dependency units and haemodialysis units. In addition, the Trust has an EMSA policy in place that meets all of the national standards and this has been agreed with commissioners.

8.1 EMSA Performance 2016/17

A great deal of report is made to ensure that no person shares a sleeping area with some one of the opposite sex.

There were no breaches of these standards in 2016/17.

8.2 Annual Declaration

Trusts are required to refresh their statement of compliance annually and post these on the publically-available web site. The Annual Declaration of Compliance for the Trust is attached at **Appendix Two**, for the approval of the Trust Board. Within this, the Trust is able to declare that has virtually eliminated mixed sex accommodation in accordance with the requirements.

9. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required
- Approve the Annual declaration of Compliance for the Elimination of Mixed Sex Accommodation at **Appendix Two** and for publication of this on the Trust's website.

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

March 2017

Appendix One: Safety Thermometer Results – January 2017
Appendix Two: Eliminating Mixed Sex Accommodation Compliance Statement 2016/7

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

Pressure ulcers + Falls + Urinary infections (in patients with catheters) + VTE = Harmfreecare

SAFETY THERMOMETER NEWSLETTER March 2017

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 10th March both hospital sites. 896 patients were surveyed

94.3% of our patients received HARM FREE CARE

Harm Free Care is defined as the number/percentage of patients who have not suffered any of the four harms measured by the safety thermometer before or since admission to hospital.

2.57% (23) of our patients suffered a New Harm

New Harm is defined as the number/ percentage of patients who have suffered or have started treatment for one of the four harms measured by the safety thermometer since admission to hospital

97.43% Of our Patients received NO NEW HARM

No New Harm is defined as the number/ percentage of patients who have not suffered any of the four harms measured by the safety thermometer since admission to hospital.

HARM FREE CARE %: How is HEY performing August 16 – March 17

	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17
Harm Free Care %	94.6%	94%	94.7%	94.5%	95.8%	95%	94.6%	94.3%
Sample: Number of patients	907	879	896	930	890	843	953	896
Total Number of New Harm	18	15	18	16	11	14	15	23
NEW HARM FREE CARE %	98.0%	98.3%	98%	98.2%	98.6%	98.3%	98.5%	97.4%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	4	0.45%	4	0	0
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**			829		92.5%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**			40		4.4%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**			27		3%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	37	4.13%	31	4	2
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	27	3.01%	22	3	2
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	10	1.12%	9	1	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	16	1.79%
Severity **No Harm**: fall occurred but with no harm to the patient	10	1.12%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	5	0.56%
Severity **Moderate Harm**: longer stay in hospital	1	0.11%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number	%
Total Number/Proportion of patients recorded with a Catheter	172	19.20%
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	6	0.67%
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu **An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital**	3	0.33%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu **An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital**	3	0.33%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 7th April 2017

APPENDIX TWO

ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

DECLARATION OF COMPLIANCE 2016-17

Hull and East Yorkshire Hospitals NHS Trust is able to confirm that mixed sex accommodation has been virtually eliminated in all of its hospitals.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Hull and East Yorkshire Hospitals NHS Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. Apart from a few exceptions for clinically justifiable reasons, patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

Wards within the Trust are grouped according to their clinical specialties. This allows patients with similar conditions to be cared for in one area with staff that are experienced in this type of care. This means that men and women may be on the same ward but will not share sleeping, bathing or toilet facilities.

There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

How well are we doing in meeting these standards?
The Trust has made physical changes to many inpatient accommodation areas to provide privacy screening/partitioning and additional toilet and bathing facilities. Toilet and bathroom signage has also been improved and this work continues.

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust is required to pay a financial penalty of £250 for each of these breaches. In 2016/17, there were no breaches of these standards.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2014/15.

INFORMATION FOR PATIENTS AND SERVICE USERS

'Same gender-accommodation' means:

- The **room where your bed is** will only have patients of the same gender as you, and;
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both male and female patients on the ward but, apart from a few exceptions for clinically-justifiable reasons such as in intensive care or high dependency areas, they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through sleeping areas that are designated for people of the opposite gender to you.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to X-ray or the operating theatre).

Also, it is most likely that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting one other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed space/area.

If you need help to use the toilet or take a bath that requires special equipment to help secure your care and safety (e.g. you need a hoist or special bath), then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time as you.

The NHS and Hull and East Yorkshire Hospitals NHS Trust will not turn patients away just because a "right-gender" bed is not immediately available for them. The patient's clinical need(s) will always take precedence.

What do I do if I think I am in mixed sex accommodation?
If you think you are in mixed accommodation and shouldn't be then please speak with the nurse in charge of the ward or area. This will be taken extremely seriously by staff and action will be taken to explain the reasons behind this and assurance will be provided that you will be moved to a same gender area/bay as soon as is reasonably practicable.

The Trust also wants to know about your experiences. Please contact the Patient Advice and Liaison Service (PALS) on telephone **01482 623065** or via email at: pals.hey@hey.nhs.uk if you have any comments or concerns about single gender accommodation. Thank You.

Signed:

Terry Moran
Chairman

Chris Long
Chief Executive

04 April 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	4th April 2017		**Reference Number**	2017 – 4 - 10		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to: • Receive this report • Decide if any if any further actions and/or information are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): E4 – Staff, teams and services to deliver effective care and treatment					
	Assurance Framework Ref: Q1, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is a standing agenda item at each Board meeting.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations)[1,2] and the Care Quality Commission.

2. BACKGROUND

The last report on this topic was presented to the Trust Board in February 2017 (January 2017 position).

In July 2016, the National Quality Board updated its guidance for provider Trusts, which sets out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive staffing levels. Trust Boards are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

The guidance sets out specifications for the future format of these reports, which form part of Lord Carter's work in relation to developing a 'Model Hospital' Dashboard. However, there has been no further progression since last reported in the September Board report 2016. This format will be adopted as soon as it is released and available.

This report presents the 'safer staffing' position as at 28th February 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

3. NURSING AND MIDWIFERY STAFFING - PLANNED VERSUS ACTUAL FILL RATES

The Trust Board is advised that the Trust continues to comply with the requirement to upload and publish the aggregated monthly average nursing and care assistant (non-registered) staffing data for inpatient areas. These can be viewed via the following hyperlink address on the Trust's web-page:

http://www.hey.nhs.uk/openandhonest/saferstaffing.htm

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: Allocate e-roster software & HEY Safety Brief). This month's appendix has been modified to include some of the new metrics

[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*
[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing
[3] When Trust Boards meet in public

that is it understood will be included in Lord Carter's Model Hospital dashboard, when this is made available. These additions are:

- Care Hours Per Patient Day (CHPPD). This is the number of hours worked by registered and non-registered staff divided by the number of patients on the ward at midnight. In itself, it doesn't necessarily say much. However, the intention is to consider this metric over time alongside quality markers to help determine if staffing levels, or available hours of care per patient, have an impact on the quality of care delivered. It is also understood that, when the Lord Carter Model Hospital dashboard is made available, it will allow trusts to compare and contrast these metrics.
- Annual Leave allocation. In order to be able to meet staffs annual leave entitlements, this metric should be between 11% and 17% so as to avoid peaks and troughs in leave taken. Again, this will provide useful information over time to look at trends and behaviours in relation to annual leave management and is a marker of how well or otherwise each ward's rotas are being managed.
- Sickness rates by ward. The Trust Board will be aware of the concerns about this that were raised by the Chief Nurse in last month's staffing report. This is now presented by ward and demonstrates where further analysis and action may need to be taken. This metric includes both long (greater than 4 weeks) and short term (less than 4 weeks) sickness, although the intention is to try and separate these in future reports so that each can be scrutinised more closely.
- Nursing and Care Assistant Vacancy levels by ward. Again this will be provide better information by area going forward so that any areas of challenge can be understood and addressed more clearly.

All of this additional information will enable closer scrutiny and analysis to take place going forward and these will be developed further over time. The Chief Nurse is arranging to meet with each Health Group Nurse Director and Senior Matrons to help understand how they are addressing any areas of concern. Anything of relevance from this will be included in future versions of this report.

The fill rate trends are now provided on the following pages:

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%
Oct-16	88.51%	100.79%	90.58%	106.38%
Nov-16	91.30%	97.10%	95.70%	107.30%
Dec-16	91.23%	100.10%	97.00%	100.76%
Jan-17	93.00%	103.50%	99.10%	101.10%
Feb-17	90.10%	98.10%	94.80%	100.30%

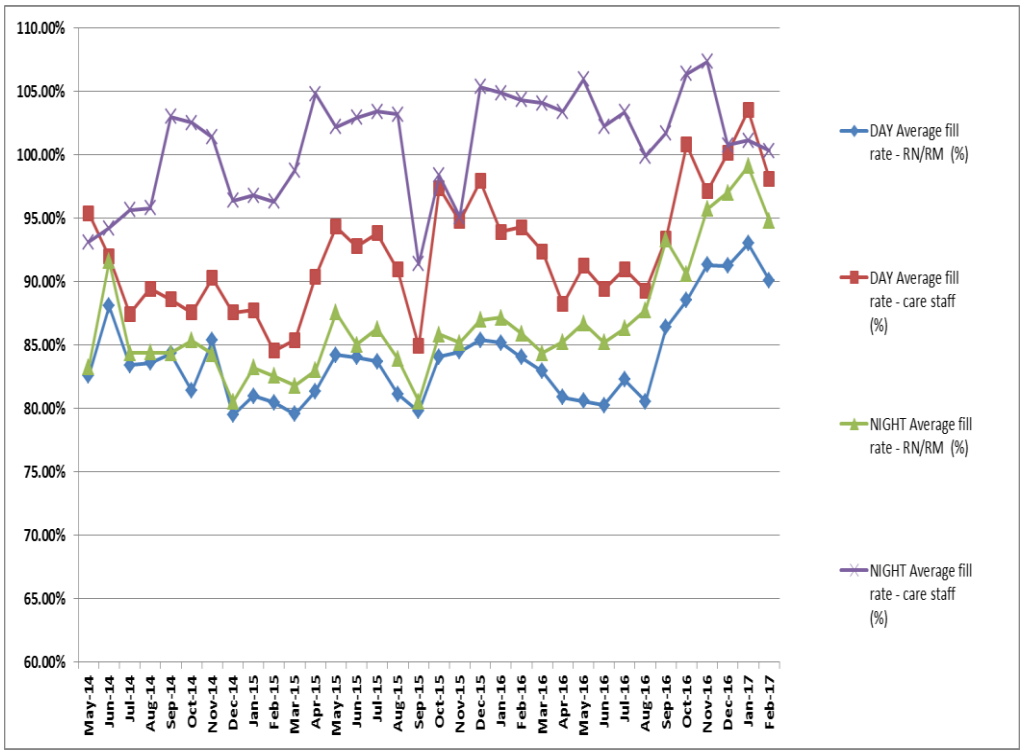
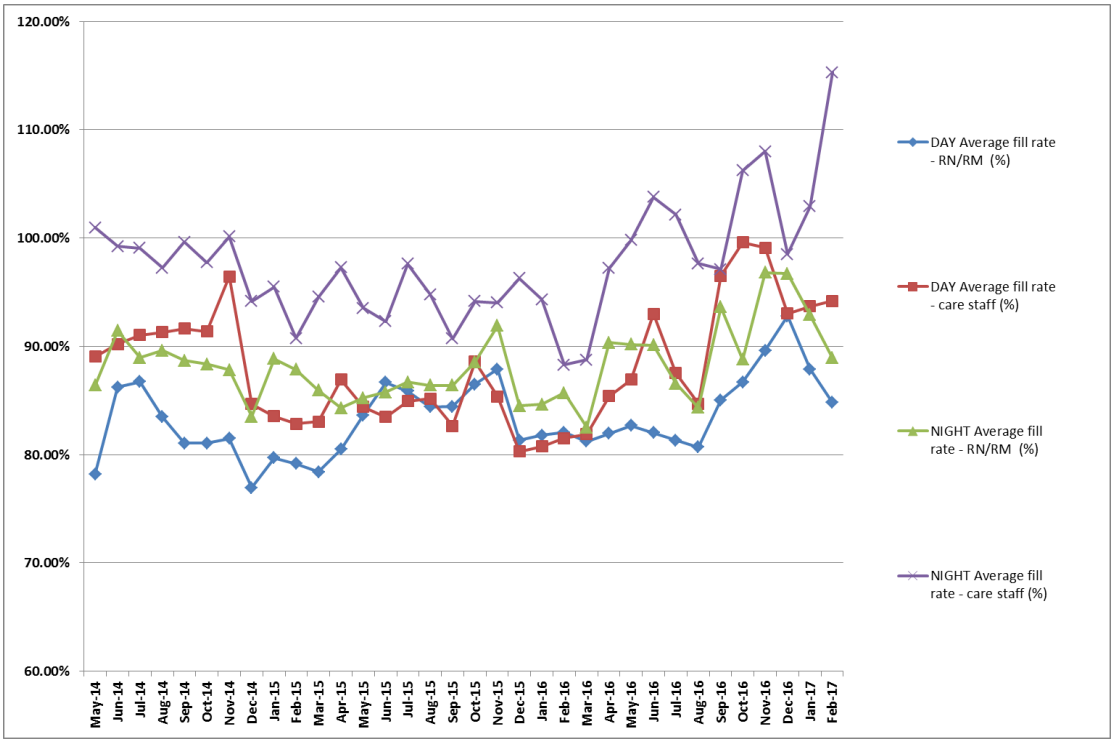


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%
Oct-16	86.70%	99.59%	88.79%	106.24%
Nov-16	89.60%	99.10%	96.80%	108.00%
Dec-16	92.79%	93.03%	96.70%	98.50%
Jan-17	87.90%	93.70%	92.90%	102.90%
Feb-17	84.80%	94.20%	88.90%	115.30%



Fill rates at HRI remain slightly higher than those for CHH. This reflects a number of issues, which include:

- The continuing need to support the winter ward H10. However, this is due to close on 29th April 2017 whereupon staff will return to their substantive wards
- Vacancy rates
- Sickness levels
- There is also some compensation with HCA's being recruited to help fill RN vacancy gaps
- The needs for some patients to have 1:1 supervision due to their care needs

Some pressures remain in recruiting to optimal staffing levels in some areas and recruitment efforts continue. The Trust is pursuing currently 138 of the adult nursing branch students and 20 of the children's nursing branch students to date, that are due to qualify from the University of Hull in September 2017. A significant amount of effort is also being made with regards to attracting additional candidates from other universities, through social marketing and media campaigns. In addition, the Trust is currently exploring with the University of Hull the possibility of increasing the number of student placements in September 2017 by a further 50 places.

With regards to international recruitment, following a successful promotion and advertising campaign within the Philippines, the Trust is currently considering 50 long-listed CV's. Interviews will be arranged and employment offers will be made following NMC clearance and employment checks. Successful applicants are expected to commence in July and August, 2017 due to UK visa waiting times. The Trust expects to have 40 overseas nurses working here before September 2017, providing this goes to plan.

4. ENSURING SAFE STAFFING

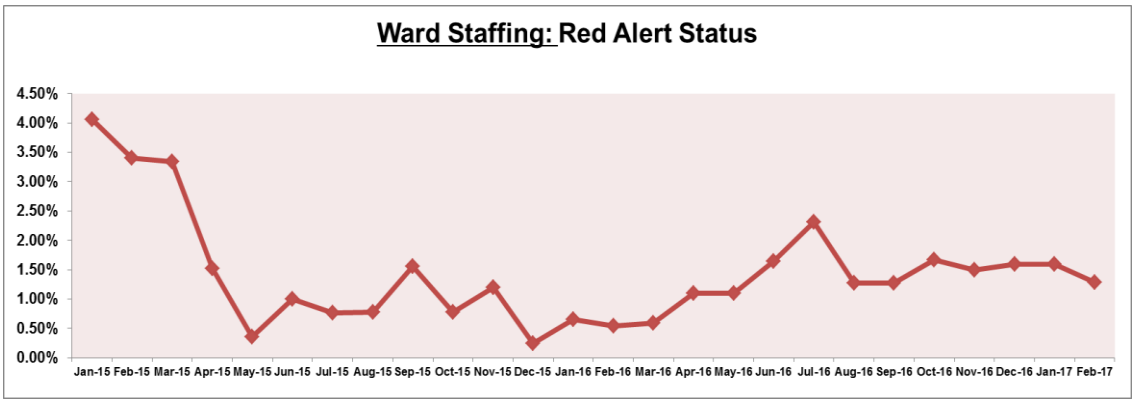
The twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. However, as has been mentioned earlier in this report, the Trust is still running a winter ward (H10) and supporting extra beds on C8 and H30, resulting in some challenges on some shifts.

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

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

The anticipated roll out of the new more automated safety brief, which will be fed directly from the e-rostering system (SafeCare), is still expected to go live during Q1 of 2017/18. Staff are being trained currently on how to use the new system.

The following table provides information on the number of occasions staff have declared their wards unsafe (Red Alert), ahead of a safety brief. These are the times over each month that this rating has been allocated represented as a percentage of the total number of assessments in that month.



The number of red alert declarations, when staff report that they feel staffing levels are not adequate, remains relatively small overall. Going forward, the Red Alert system will be replaced with a Red Flag alert system using nationally defined criteria, although this is not yet available.

The key areas that remain particularly tight in terms of meeting their full establishments currently are:

- **Emergency Department - Registered Nurse Staffing**. Having only recently recruited to almost full establishment last autumn, the Department has 16.34wte (18.25%) Registered Nurse Vacancies with a further 2.88wte leaving at the end of March/April. There is a rolling advert in NHS jobs and the team is interviewing a number of staff external to the trust. Currently, 2.8wte new recruits are being pursued. 14wte of the University of Hull newly qualified nurses will join the department in September 2017. However, this is some time away and will not help in the short to medium term. In order to mitigate the challenges in this department, the Teacher/Practitioner and lead Band 7 staff are rostered into the care delivery numbers regularly. Discussions are underway with the nurse bank to try and maximise its support, also. It is likely that some shifts may need to be put out to agencies if they cannot be filled in other ways, although this will be kept to an absolute minimum. Exit interviews are offered to all staff that have left/are leaving. The main reasons are to pursue alternative roles and, also, many are moving to work in minor injuries units as the workload is seemingly less onerous. The Chief Nurse is meeting with the Nurse Director and Senior Matron to understand this further and to agree a more robust recruitment and retention plan.
- **Acute Medical Unit** (AMU). This unit has 7.88wte (10.65%) vacancies currently with a further 4wte predicted for April 2017. These have been advertised.
- **Ward C16 (ENT, Plastics and Breast Surgery)** has 3.38wte RN vacancies and 3.35 AN (24.22%) vacancies at present with a further 2wte predicted in the near future. 4wte RN's have been recruited for September, however, like ED, this does not address the short to medium term challenges. 2 x RN Agency nurses are being used currently to bridge this gap, which is a cost pressure but is required to maintain patient safety. The Senior Matron is doing some cultural work on the ward initially with the Sister, and then the full team, with HR's support, to understand the issues with retention and how these might be addressed.
- **Neonatal Intensive Care Unit (NICU).** This is another area of concern with 12.13 wte RN vacancies (16.64%). 6 of these have been recruited to and more students are due to join in September. The staffing in the interim is being managed closely by the senior matron, with staff being flexed across all paediatric inpatient and outpatient areas according to patient need.
- **H70 (Diabetes and Endocrine)** has 10.49 (34.36%) wte RN vacancies. This ward is supported in the interim by moving staff from Cardiology, Renal and Respiratory to assist. In addition, from May 1st 2017, 2wte pool nurses are joining the team for a six month period. Staffing across the health group is balanced daily to help manage any risk. This ward had some challenges recently with its previous leadership and some associated care quality concerns. However, the new Senior Sister is having a very positive effect and it is hoped that this will help improve the ward's recruitment position.
- **Ward 110 – Stroke Unit** has some quality of care concerns recently. A new senior sister has been appointed. The senior matron is supporting this new ward sister to ensure support for staff and leadership coaching.
- **Ward H4 - Neurosurgery** has 4.53wte vacancies which equates to (14.09%). The ward is being supported by H40.

- **Ward H7 – Vascular surgery** has 4.56wte vacancies which is (13.68%). This group of patients often require specialist dressings. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.
- **C9, C10 and C11** are all elective surgical wards at CHH; there are a total of 16.64wte (20.31%) vacancies across this group of wards. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies.
- **Surgery** is currently in the process of recruiting new registrants starting in October (38wte) and a plan to recruit a total of 30 international registrants during 2017-18.

6. SUMMARY

Nursing and Midwifery staffing establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. The next establishment reviews will now be completed by the end of April 2017 and not March as planned originally. However, this is managed very carefully and in a way that balances the risks across the organisation. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses, although this position has improved in the short-term.

The new information that is now presented by ward will enable each of these to be scrutinised more closely to ensure that all reasonable efforts are being taken to deploy staff efficiently and, also, manage sickness/absence robustly.

7. RECOMMENDATION

The Trust Board is requested to:

- Receive this report
- Decide if any if any further actions and/or information are required.

Mike Wright
Executive Chief Nurse
March 2017

Appendix 1: HEY Safer Staffing Report – February 2017

HEY SAFER STAFFING REPORT FEBRUARY-17

NURSE STAFFING

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAGS [N]	FILL RATES DAY: Average fill rate - RN/RM (%)	FILL RATES DAY: Average fill rate - care staff (%)	FILL RATES NIGHT: Average fill rate - RN/RM (%)	FILL RATES NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CHPPD: RN / RM	CHPPD: CARE STAFF	CHPPD: OVERALL	ROTA EFFICIENCY [23-01-17 to 19-02-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY: SICK RN & AN [3.9%]	ROTA EFFICIENCY: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M11]: RN [WTE]	NURSING VACANCIES: AN [WTE]	NURSING VACANCIES: TOTAL [WTE]	NURSING VACANCIES: % [<10%]
MEDICINE	ED	ACUTE MEDICINE	NA	0									14.2%	7.1%	2.3%	16.34	-0.34	16	18.25%
	AMU	ACUTE MEDICINE	45	0	97%	93%	94%	83%	1134	4.7	2.6	7.3	12.9%	7.6%	3.6%	6.5	1.38	7.88	10.56%
	H1	ACUTE MEDICINE	22	0	89%	84%	100%	87%	587	2.5	2.1	4.6	21.3%	3.1%	0.3%	3.42	0.14	3.56	15.96%
	EAU	ELDERLY MEDICINE	21	0	91%	107%	91%	120%	570	3.5	3.6	7.1	16.4%	4.5%	3.2%	4.04	-0.39	3.65	13.39%
	H5 / RHOB	RESPIRATORY	26	0	87%	89%	98%	84%	525	5.3	2.9	8.2	18.7%	7.0%	1.3%	1.33	0.02	1.35	4.03%
	H50	RENAL MEDICINE	19	0	79%	100%	101%	104%	503	3.3	2.2	5.5	9.1%	2.7%	7.4%	-0.29	0.23	-0.06	-0.32%
	H500	RESPIRATORY	24	0	72%	101%	101%	98%	656	2.3	2.5	4.8	10.8%	3.2%	0.0%	4.01	0.33	4.34	15.32%
	H70	ENDOCRINOLOGY	30	0	78%	181%	73%	104%	814	2.5	2.8	5.2	14.3%	4.8%	2.0%	10.49	0.24	10.73	34.36%
	H8	ELDERLY MEDICINE	27	0	101%	100%	98%	105%	750	2.3	2.3	4.6	14.3%	4.8%	2.0%	3.65	-0.4	3.25	10.92%
	H80	ELDERLY MEDICINE	27	0	92%	101%	98%	105%	744	2.5	2.3	4.8	13.7%	7.7%	0.0%	0.93	0.57	1.5	5.03%
	H9	ELDERLY MEDICINE	31	0	74%	98%	102%	96%	856	2.0	1.9	3.9	12.5%	8.2%	2.6%	2.24	-1.34	0.9	3.02%
	H90	ELDERLY MEDICINE	29	0	91%	91%	99%	100%	787	2.2	2.2	4.4	13.0%	5.0%	5.8%	3.05	-0.85	2.2	7.40%
	H11	STROKE / NEUROLOGY	28	0	73%	154%	71%	102%	800	2.3	2.0	4.3	13.7%	5.4%	0.0%	5.36	-1.12	4.24	14.06%
	H110	STROKE / NEUROLOGY	24	0	94%	116%	98%	105%	502	3.9	2.9	6.7	15.5%	5.5%	7.4%	2.48	0.48	2.96	9.36%
	CDU	CARDIOLOGY	9	0	95%	39%	94%		118	9.3	1.0	10.2	9.2%	11.6%	0.0%	-0.21	0.48	0.27	2.05%
	C26	CARDIOLOGY	26	0	84%	68%	82%	87%	690	3.9	1.3	5.2	14.2%	3.3%	3.1%	1.26	2.19	3.45	10.25%
	C28 /CMU	CARDIOLOGY	27	0	84%	111%	84%	84%	462	8.8	2.4	11.2	13.3%	8.3%	5.2%	2.87	-0.11	2.76	6.12%
	H10	WINTER WARD	27	0	82%	101%	125%	109%	667	3.0	2.6	5.6	10.8%	12.8%	0.6%				
SURGERY	H4	NEURO SURGERY	30	0	79%	94%	80%	115%	762	2.9	1.8	4.7	20.0%	5.6%	3.4%	2.89	1.64	4.53	14.07%
	H40	NEURO HOB / TRAUMA	15	0	83%	100%	87%	102%	406	5.2	3.2	8.4	15.5%	3.0%	5.4%	0.58	1.24	1.82	7.00%
	H6	ACUTE SURGERY	28	0	104%	94%	79%	201%	664	2.9	2.4	5.3	12.1%	5.0%	3.7%	2.05	0.7	2.75	9.26%
	H60	ACUTE SURGERY	28	0	98%	90%	98%	194%	697	3.1	2.2	5.2	12.3%	2.6%	3.3%	-0.1	0.63	0.53	1.86%
	H7	VASCULAR SURGERY	30	0	78%	80%	90%	98%	800	2.9	2.4	5.3	14.2%	12.8%	2.9%	4.12	0.44	4.56	13.68%
	H100	GASTROENTEROLOGY	24	0	84%	101%	91%	98%	731	2.6	2.0	4.6	14.8%	5.8%	3.1%	1.25	0.64	1.89	6.30%
	H12	ORTHOPAEDIC	28	0	88%	96%	87%	105%	716	2.8	2.5	5.3	15.2%	5.2%	2.9%	1.31	0.01	1.32	4.00%
	H120	ORTHO / MAXFAX	22	0	102%	111%	97%	105%	565	3.7	2.7	6.4	14.4%	4.0%	0.0%	0.23	0.46	0.69	3.00%
	HICU	CRITICAL CARE	22	0	106%	95%	104%	79%	527	26.1	0.7	26.7	11.7%	10.2%	3.0%	4	2.29	6.29	5.66%
	C8	ORTHOPAEDIC	18	0	98%	71%	75%	67%	210	5.0	2.8	7.8	14.9%	5.0%	0.0%	1.23	-0.09	1.14	7.69%
	C9	ORTHOPAEDIC	29	0	74%	89%	82%	86%	585	3.3	2.4	5.7	14.9%	3.0%	0.0%	3.57	4.15	7.72	25.72%
	C10	COLORECTAL	21	0	82%	90%	90%	121%	458	4.0	2.2	6.2	11.5%	3.1%	0.0%	5.53	0.68	6.21	24.79%
	C11	COLORECTAL	22	0	88%	74%	85%	111%	522	3.9	1.7	5.6	11.5%	4.0%	0.0%	0.48	2.03	2.51	10.41%
	C14	UPPER GI	27	0	76%	86%	82%	196%	656	3.2	1.9	5.1	14.8%	7.4%	0.0%	3.87	-1.34	2.53	8.86%
	C15	UROLOGY	26	0	86%	68%	85%	93%	586	5.0	3.1	8.1	10.9%	5.9%	0.6%	1.04	-2.56	-1.52	-3.89%
	C27	CARDIOTHORACIC	26	0	83%	104%	88%	100%	659	3.8	1.6	5.4	10.8%	5.9%	9.1%	0.64	1.8	2.44	7.73%
	CICU	CRITICAL CARE	22	0	85%	93%	90%	88%	436	21.4	2.0	23.4	10.2%	8.8%	8.1%	7.77	0.07	7.84	7.90%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	91%	106%	113%	75%	239	7.7	4.3	12.0	15.5%	7.1%	0.0%	3.38	3.35	6.73	24.22%
	H130	PAEDS	20	0	85%	41%	86%	68%	357	6.6	1.1	7.6	16.5%	4.1%	13.5%	-0.74	-0.57	-1.31	-5.47%
	H30 CEDAR	GYNAECOLOGY	9	0	102%	121%	113%	34%	221	7.1	2.6	9.7	15.8%	2.5%	0.0%	-1.12	0.12	-1	-4.48%
	H31 MAPLE	MATERNITY	20	0	87%	89%	110%	100%	229	9.1	5.5	14.5	12.4%	6.6%	4.0%	7.53	2.50	10.03	13.69%
	H33 ROWAN	MATERNITY	38	0	83%	90%	82%	112%	637	4.4	2.6	6.9	15.5%	9.8%	0.0%				
	H34 ACORN	PAEDS SURGERY	20	0	94%	81%	93%	133%	257	9.0	2.4	11.3	12.7%	7.9%	0.0%	-0.75	-2.12	-2.87	-10.98%
	H35	OPHTHALMOLOGY	12	0	82%	82%	109%		286	6.6	1.2	7.9	15.5%	1.5%	4.9%	-0.12	1.84	1.72	8.50%
	LABOUR	MATERNITY	16	0	99%	90%	102%	79%	260	20.1	6.5	26.6	13.2%	8.6%	3.5%	-5.67	-2.36	-8.03	-11.90%
	NEONATES	CRITICAL CARE	26	0	94%	95%	84%	104%	675	9.3	0.9	10.3	14.4%	5.3%	8.0%	12.13	-1	11.13	16.64%
	PAU	PAEDS	10	0	92%		99%		60	21.6	0.0	21.6	12.7%	3.4%	0.0%	0.6	0	0.6	5.49%
	PHDU	CRITICAL CARE	4	0	103%	88%	109%		66	21.0	1.8	22.8	10.2%	5.7%	0.0%	3.07	0	3.07	19.54%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0	101%	97%	102%	100%	407	3.4	2.3	5.7	16.9%	6.2%	0.0%	-0.98	-0.15	-1.13	-6.07%
	C29	REHABILITATION	15	0	90%	142%	96%	386%	417	3.3	5.7	9.0	12.5%	10.3%	0.0%	0.68	3.5	4.18	16.18%
	C30	ONCOLOGY	22	0	90%	106%	101%	114%	545	3.2	2.1	5.3	14.8%	1.6%	3.2%	1.09	-0.27	0.82	4.80%
	C31	ONCOLOGY	27	0	80%	128%	96%	95%	634	2.7	2.1	4.8	18.6%	2.7%	0.0%	0.57	-0.91	-0.34	-1.80%
	C32	ONCOLOGY	22	0	92%	105%	95%	100%	517	2.9	2.0	4.9	14.4%	2.3%	3.5%	2.06	0.26	2.32	12.60%
	C33	HAEMATOLOGY	28	0	80%	128%	90%	132%	571	4.5	2.2	6.7	11.1%	7.8%	7.7%	-1.54	1.16	-0.38	-1.08%
		AVERAGE:	0				AVERAGE:		540	6.1	2.4	8.4	13.8%	5.8%	2.7%	128.12	19.65	147.77	8.3%
														TOTALS:			TOTALS:		

HIGH LEVEL QUALITY INDICATORS *[which may or may not be linked to nurse staffing]*

HEALTH GROUP	WARD	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED				3	2			2	2					2	7
	AMU	100%							0						0	0
	H1	100%							0						0	0
	EAU	100%		1					0						0	1
	H5 / RHOB	100%							0				1		1	1
	H50	100%	2	3					0						0	5
	H500	100%			1	2			2	2					2	5
	H70	100%		2		1			1	1			1		2	5
	H8	96%				3	1		4	3	1		1		5	9
	H80	96%				3		1	4	3		1			4	8
	H9	96%		2	2	3	1		4	3	1				4	12
	H90	100%		1	2				0						0	3
	H11	100%		1		1			1	1					1	3
	H110	100%	1				1		1		1				1	3
	CDU	100%							0						0	0
	C26	100%				3		1	4	3		1			4	8
	C28 /CMU	100%				2			2	2				1	3	5
	H10	100%	2	1					0						0	3
SURGERY	H4	96%		4		2			2	1					1	7
	H40	100%		1					0	3					3	4
	H6	100%	7	1					0						0	8
	H60	92%	6	1		1			1						0	8
	H7	100%	4	2	1	1			1	2			1		3	11
	H100	100%		2			1		1						0	3
	H12	100%		1	2				0						0	3
	H120	100%				1			1						0	1
	HICU	88%			3	1			1	6			1		7	11
	C8	100%	1	1					0	1					1	3
	C9	100%				1			1	1					1	2
	C10	100%	1		1				0						0	2
	C11	100%	1	1					0						0	2
	C14	100%		2					0						0	2
	C15	95%	1	1					0	1					1	3
	C27	100%		1					0				1		1	2
	CICU	100%			1				0						0	1
FAMILY & WOMEN'S	C16	100%	1						0						0	1
	H130	100%							0						0	0
	H30 CEDAR	100%	3	1					0	1					1	5
	H31 MAPLE	100%							0						0	0
	H33 ROWAN	100%							0	1					1	1
	H34 ACORN	100%							0						0	0
	H35	100%				1			1						0	1
	LABOUR	100%		1		1			1						0	2
	NEONATES	100%			1				0					1	1	2
	PAU	100%							0						0	0
	PHDU	100%							0						0	0
CLINICAL SUPPORT	C20	100%							0						0	0
	C29	100%		1					0						0	1
	C30	95%							0						0	0
	C31	95%			3				0						0	3
	C32	100%							0						0	0
	C33	100%		1		1			1	1					1	3
		99%														
			30	33	20	30	4	2	36	38	3	2	6	2	51	170
			51													

Feb-17	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT PER DAY [CHPPPD]: Cumulative Count	RN / RM	CARE STAFF	OVERALL
SAFER STAFFING OVERALL PERFORMANCE								
HRI SITE	90.1%	98.1%	94.8%	100.3%	18811	4.6	2.4	7.0
CHH SITE	84.8%	94.2%	88.9%	115.3%	8712	5.0	2.3	7.3

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHANGES TO THE STATUTORY SUPERVISION OF MIDWIVES' ARRANGEMENTS

Trust Board date	4th April 2017	**Reference Number**	2017 – 4 - 11
Director	Mike Wright Executive Chief Nurse	**Author**	Mike Wright Executive Chief Nurse
Reason for the report	To advise the Trust Board of impending changes to the Statutory Supervision of Midwives arrangements and suggest alternative arrangements until a new national model to replace it is introduced.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	**Y**	Review	**Y**

1	**RECOMMENDATIONS** The Trust Board is requested to approve the implementation of the Professional Midwifery Advocate Structure until an alternative national model is developed and implemented. There are no additional resource requirements required.					
2	**KEY PURPOSE:**					
	Decision		Approval	**Y**	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					**Y**
	Valued, skilled and sufficient staff					**Y**
	High quality care					**Y**
	Great local services					**Y**
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): All					
	Assurance Framework	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The information is being presented to the Trust Board in view of changes to the statutory arrangements and requirements for midwives and midwifery practise.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHANGES TO THE STATUTORY SUPERVISION OF MIDWIVES' ARRANGEMENTS

1. PURPOSE OF THIS REPORT

The purpose of this report is to advise the Trust Board of impending changes to the Statutory Supervision of Midwives arrangements and suggest alternative arrangements until a new national model to replace it is introduced.

2. INTRODUCTION

Supervision of Midwives (SoM) is a historic feature of midwifery practise and a statutory requirement, dating back to the Midwives Act 1902. Supervisors are experienced midwives that have had additional training and education to enable them to help midwives provide the best quality of midwifery care. Not only is this enshrined in law but it is also a requirement of the Nursing and Midwifery Council (NMC) in what is a tightly-regulated framework, currently.

Supervisors of Midwives oversee the work of midwives and meet with them regularly to ensure that high standards of care and practise are provided. They also guide and support midwives in developing their skills and expertise. Supervisors provide additional support and guidance for women in addition to the care provided by their midwife or obstetrician. They advocate for women when making choices considered outside of guidance and develop robust care plans to help facilitate safe care.

At Hull and East Yorkshire Hospitals NHS Trust, the Supervisors of Midwives' Team is well regarded both within and external to the organisation, and is supported by the Executive Chief Nurse. Supervision at HEY has developed robust systems to support the clinical governance systems within the midwifery services. As such, this is positive arrangement that works continuously to improve and modernise midwifery practise and the care of women and their babies.

The practise and standards of the Supervisors of Midwives is overseen by NHS England and the Local Supervisory Authority Midwifery Officer (LSAMO). LSAMO's are required to ensure that all midwives and supervisors practise in accordance with all statutory requirements and the requirements of the Nursing and Midwifery Council against a comprehensive portfolio of standards and functions.

Each LSAMO compiles an annual report for the NMC, in accordance with Rule 13 of the Midwives rules and standards (NMC 2012), which outlines supervisory activities over the past year, key issues, audit outcomes and emerging trends affecting maternity services. This report is signed off by the LSA and is available to a wide range of stakeholders, including all Supervisors of Midwives, to facilitate the effective commissioning and delivery of maternity services. Any areas for improvement are expected to be addressed by the respective hospital trusts.

3. DEREGULATION OF SUPERVISION OF MIDWIVES AND MIDWIVES RULES

Despite the local successes with Midwifery Supervision at this Trust, proposals to deregulate this have now been passed through Parliament and the House of Lords and will come into effect after 31st March 2017.

To explain the rationale for the proposal to change, last year the Department of Health launched a consultation on proposed changes to NMC legislation that would allow it to modernise the way it regulates midwives. The main effects of the proposed changes are to take supervision out of regulatory legislation. NMC asked for this change after a number of critical incidents and independent reports confirmed that the current arrangements are not appropriate for public protection, although this is not a universally-held view.

In January 2017, the Government published its response to this consultation. While the Government acknowledged the concerns raised by some midwives in relation to these changes, it also set out clearly why it believed they are important.

Although these changes mean that supervision will no longer be linked to regulation, this does not mean it will not exist at all. Plans for a new model of supervision are being tested in each of the four countries of the UK.

These changes do not alter the status of midwifery as a distinct profession with its own standards. There will be no change to the protected title of 'midwife', and delivering a baby remains a protected function for a midwife or a medical practitioner. There are also no changes to the scope of midwifery practice, which is reflected in the Standards for competence for registered midwives and the NMC Code.

NHS England is exploring what structures, systems and actions will be required to replace these when the Local Supervising Authority (LSA) is dissolved and the statute is removed. Currently, there are pilot sites in the England undertaking the 'AEQUIP[1]' model of support for midwives. However, it is anticipated that the results from the pilots will not have been analysed or evaluated sufficiently prior to the removal of the statute. Therefore, it is likely there will not be a seamless transfer of responsibilities to a new system, whatever that ends up becoming. In addition, all Supervisors of Midwives have been written to by the LSAMO stating that their roles as supervisors will cease to exist from 31st March 2017.

In view of this and until a replacement system is determined nationally, the Chief Nurse and Head of Midwifery propose that the Trust retains its own local arrangements for supervising and supporting midwives in the interim.

4. INTERIM PROPOSAL

Following discussion between the Chief Nurse and senior midwives, it is recommended that the Trust retains something akin to the current supervisory arrangements until a new national framework for this is developed and implemented. The Trust cannot simply stop supervision without putting an alternative in its place. The team believes that this proposal is imperative for professional support and public protection during this interim/transitional period.

As the title 'Supervisor of Midwives' will no longer be able to be used after 31st March 2017, those that held the role of Supervisor of Midwives previously will become known as Professional Midwifery Advocates (PMA), which is in line with the title being proposed in the A-EQUIP model. Also at this time, the responsibility for public protection and professional development within midwifery will be transferred to the Trust via the Head of Midwifery (HoM), Janet Cairns.

In the structure, the HoM will be the midwifery expert within the organisation and will report to the Nurse Director of the health group and the Chief Nurse on all matters relating to midwifery along with the model for public protection and professional development. The Lead PMA will continue to have quarterly meetings with Chief Nurse providing a written report of activities of the team. This is what happens currently with the Contact Supervisor of Midwives and this arrangement works well.

[1] A-EQUIP (advocating for education and quality improvement) is the name for the new employer led model of midwifery supervision which is currently being tested by a number of pilot sites across England. A-EQUIP is a continuous improvement process that builds: personal and professional resilience, enhances quality of care for women and babies and supports preparedness for appraisal and professional revalidation.

The HoM will oversee the new model and assume the previous responsibilities of the LSAMO within the Trust locally, including monitoring standards required by the NMC and acting to address any shortcomings.

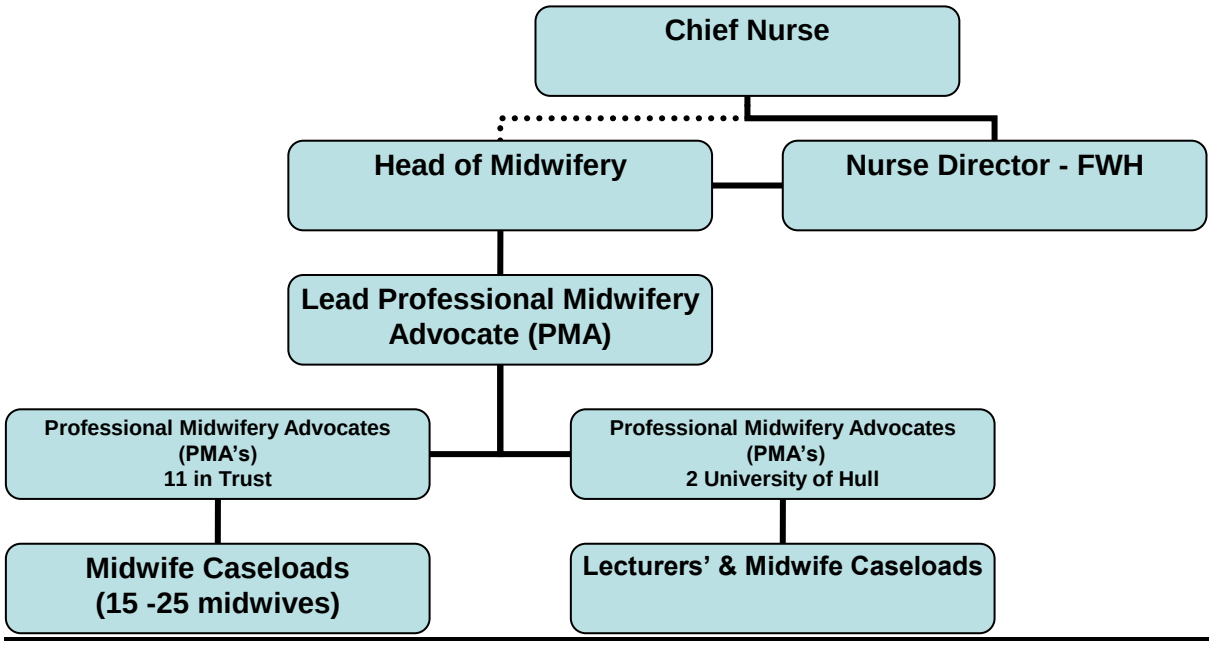
The current remaining 12 Supervisors will continue in the new role as PMA's. Currently, there is no guidance regarding the ratio of PMA's to Midwives although, presently, the NMC recommends 1:15 for supervisors of Midwives. In the new model, it is anticipated that there will be between 15-25 midwives within each PMA's caseload.

There are currently 2 Supervisors who are Midwifery Lecturers at the University of Hull; in the new model it is proposed that the Trust retains these as PMA's and continues to have close links and involvement with the university's staff.

All midwives working within the Trust will be required to have a named PMA; there will be a ballot in March 2017 to continue to facilitate choice for them.

5. PROPOSED STRUCTURE

The governance structure to support this revised framework is as detailed, as follows:



6. CONCLUSION

In view of the forthcoming deregulation of Midwifery Supervision and in the absence of an alternative national model to replace it, it is essential that the Trust takes all reasonable steps to keep women and babies safe and provides midwifery services of a high standard. In the absence of an alternative national framework to replace supervision and as this has worked well at this Trust, the most sensible way to do this is by continuing with a locally-adapted model that will ensure reasonable continuation of this support and oversee the continuing professional development of midwives.

In order to achieve implementation in the short time frame, the team will need to work with the HoM and Chief Nurse to agree and introduce the new model.

In the future, the team will work closely with the Regional Midwifery Advisor, Neil Tomlin, The Deputy Midwifery Advisor and the Support Officer, Elaine French to adopt the new model and any successor national arrangements.

7. ACTION REQUIRED OF THE TRUST BOARD

The Trust Board is requested to approve the implementation of the Professional Midwifery Advocate Structure until an alternative national model is developed and implemented. There are no additional resource requirements required.

Mike Wright
Executive Chief Nurse
March 2017

Integrated Performance Report 2016/17

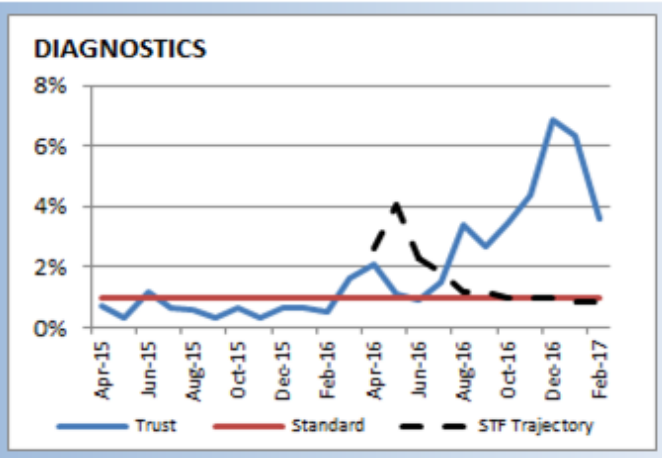
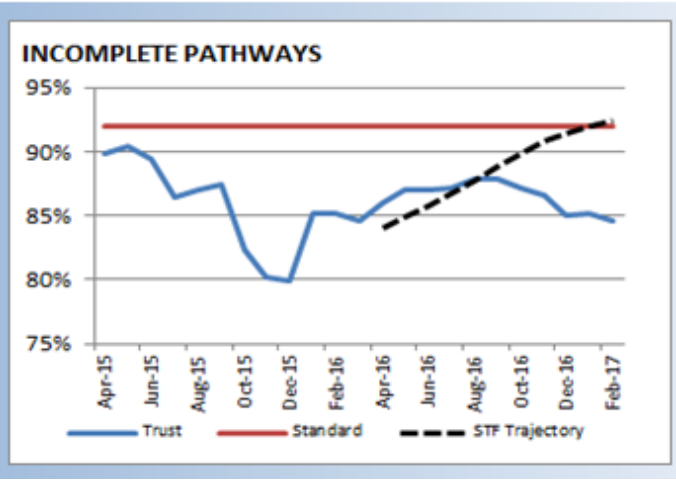
March 2017

February data

The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined in the NHS Improvement – Single Oversight Framework
https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

Integrated Performance Report - March 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times: 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made The target is less than 1% over 6 weeks	Diagnostic waiting times has failed to achieve target with performance of 3.59% in February Sustainability and Transformation trajectory is 0.8% the Trust also failed to meet this trajectory		
Referral to Treatment Incomplete pathway	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%	The Trust failed to achieve the February Sustainability and Transformation trajectory of 92.0% February performance was 84.5%		

Integrated Performance Report - March 2017

RESPONSIVE

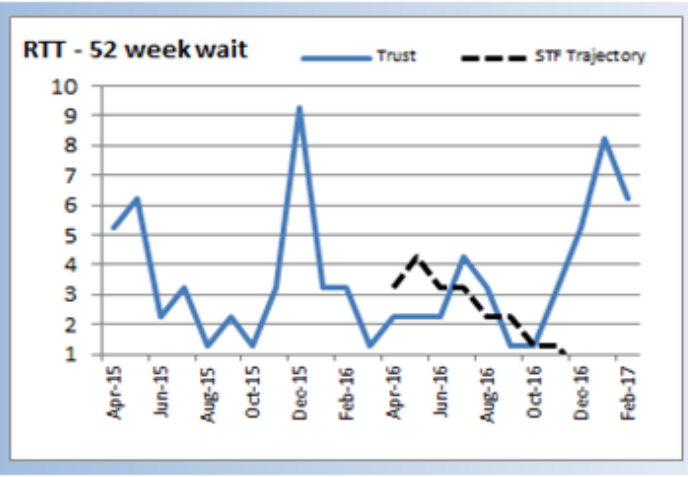
Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The Trust failed to deliver the national standard of zero breaches with 6 breaches for February

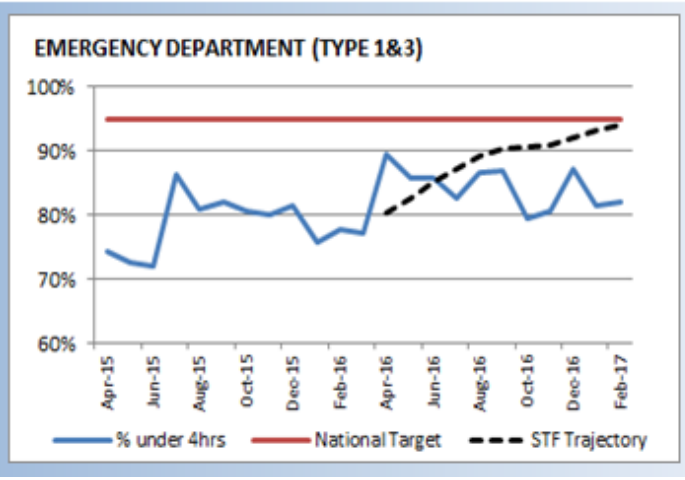
The Trust also failed to achieve the STF trajectory of zero breaches during February



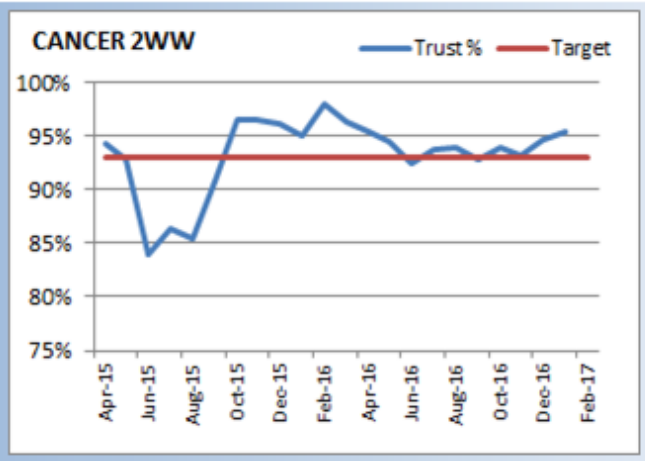
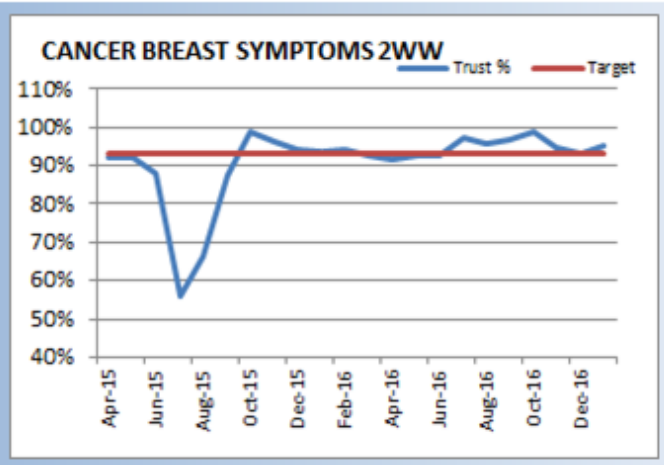
A&E Waiting Times

Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

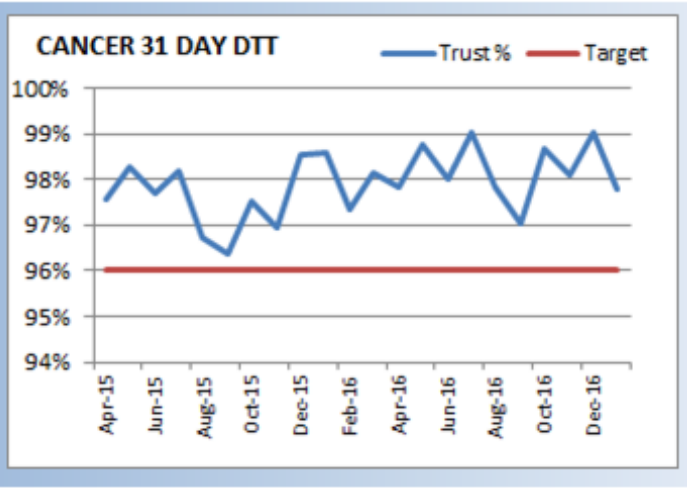
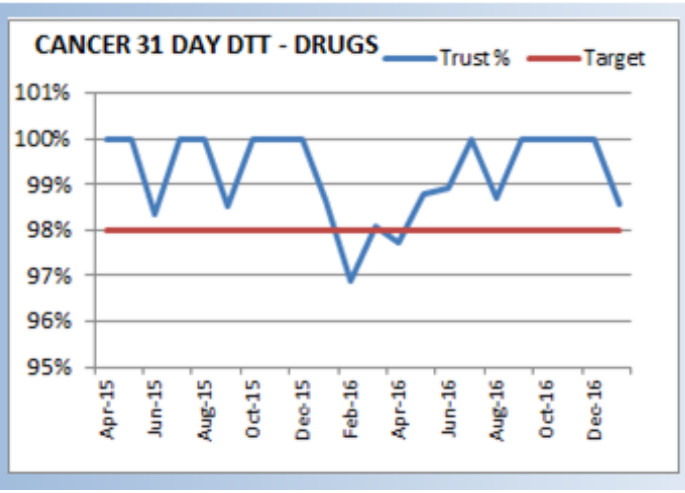
A&E performance has remained below the national 95% threshold with performance of 82.0% for February which was also below the agreed Sustainability and Transformation trajectory of 94.0%



RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: Two Week Wait Standard	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.	January performance achieved the 93% standard at 95.4%		
Cancer: Breast Symptom Two Week Wait Standard	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.	January performance achieved the 93% standard at 95.2%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	January performance achieved the 96% standard at 97.8%		
Cancer: 31 Day Subsequent Drug Standard	All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 98%.	January performance achieved standard at 98.6%		

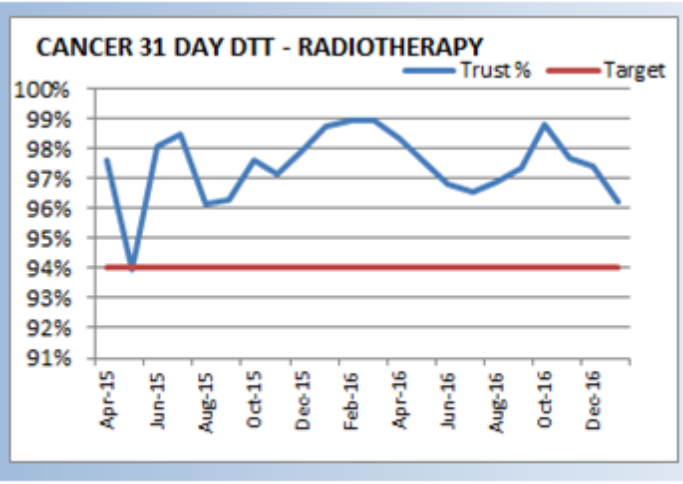
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy Standard

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

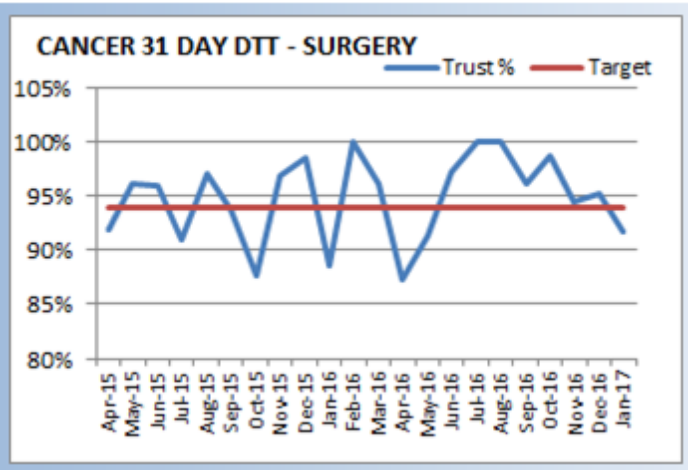
January performance achieved standard at 96.2%



Cancer: 31 Day Subsequent Surgery Standard

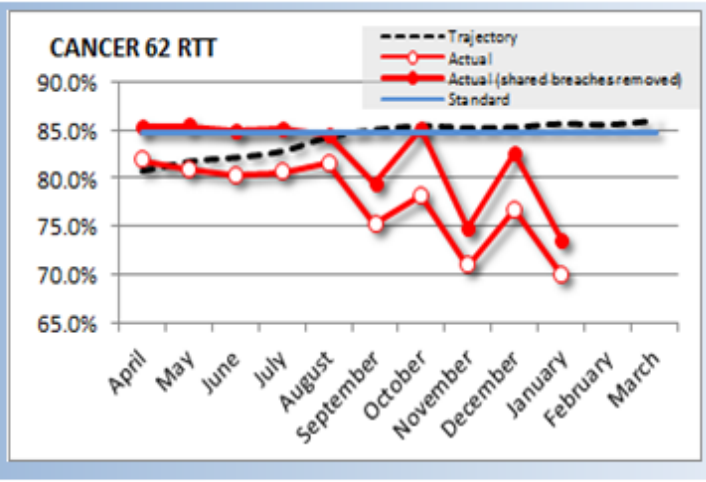
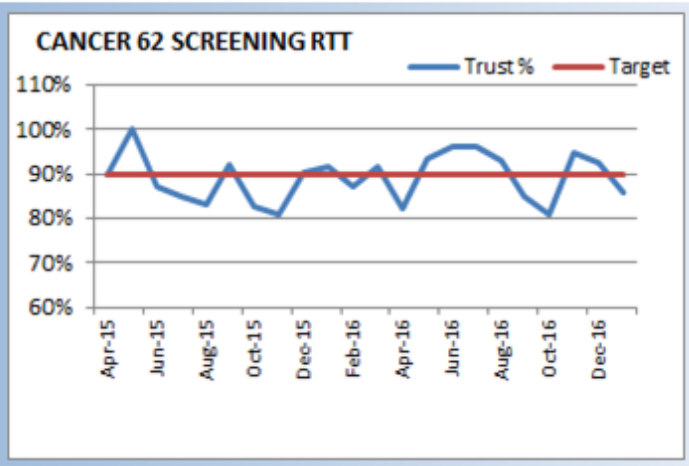
All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.

January performance failed to achieve standard at 91.8%



Integrated Performance Report - March 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: ADJUSTED - 62 Day Standard	All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85% Sustainability and Transformation trajectory is 85.8%	The adjusted position allows for reallocation of shared breaches January failed to achieve the STF trajectory of 85.8% with performance of 73.5%		
Cancer: 62 Day Screening Standard	All patients need to receive first treatment for cancer within 62 days of screening referral. Threshold of 90%	January performance failed to achieve standard at 86.0%		

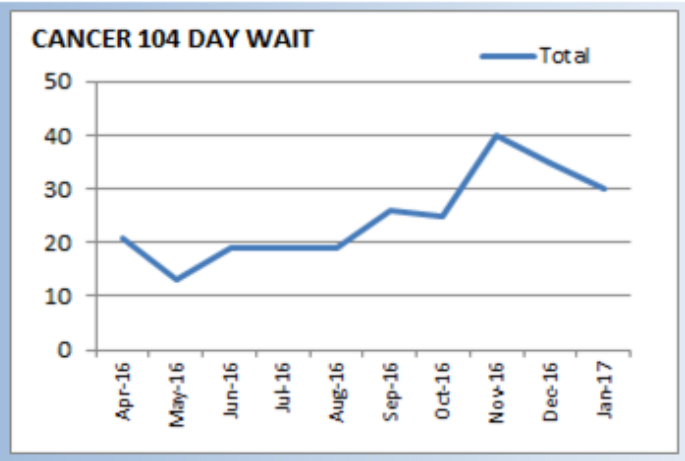
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

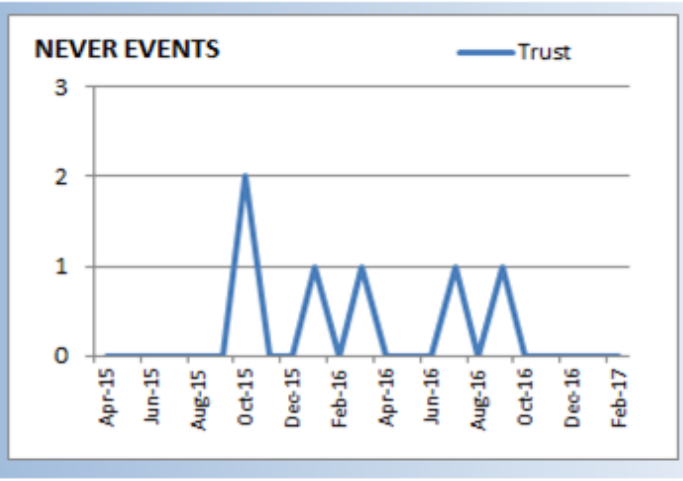
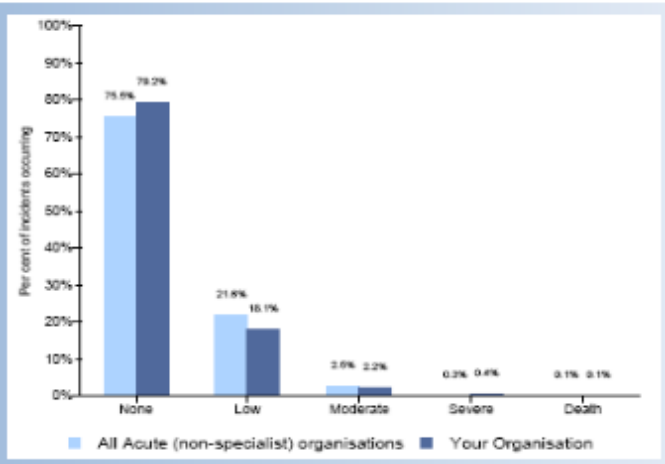
Patients on an open 62 day pathway waiting 104 days or more

There were 30 patients waiting 104 days or over during January



Integrated Performance Report - March 2017

SAFE

	Description	Aggregate Position	Trend	Variation
Occurence of any Never Event	Occurence of any Never Events	There were zero Never Events reported during February		Further information is included in the Board Quality report
Potential under-reporting of patient safety incidents	Number of incidents reported per 1000 bed days	The latest data available for this indicator is October 2015 to March 2016 as reported by the National Reporting and Learning System (NRLS). The Trust reported 5,896 incidents (rate of 34.44) during this period. The Median rate for reporting in this period was 39.91		

SAFE

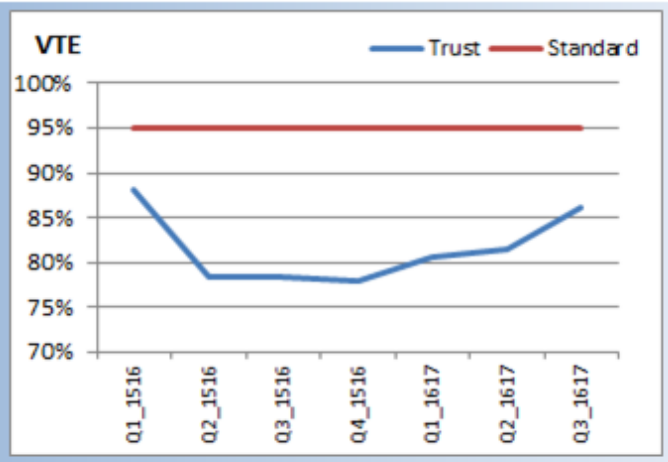
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 86.15% for Q3 2016/17.

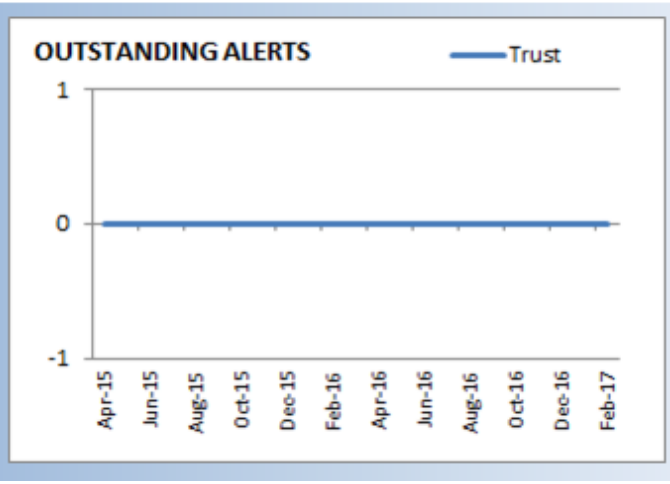


Patient Safety Alerts Outstanding

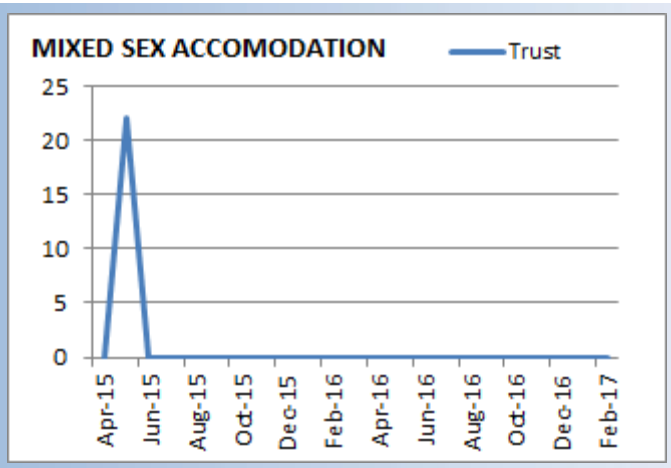
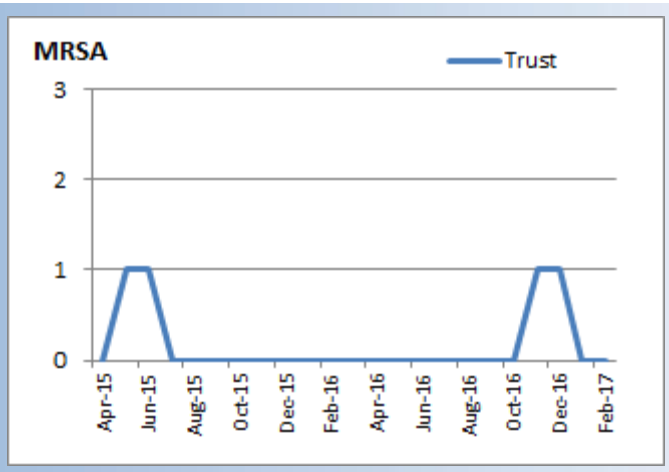
Number of alerts that are outstanding at the end of the month

There have been zero outstanding alerts reported at month end for February 2017.

There have been no outstanding alerts year to date.

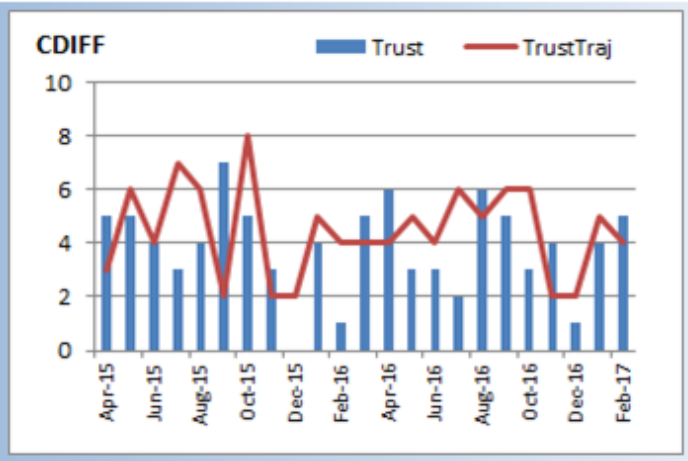
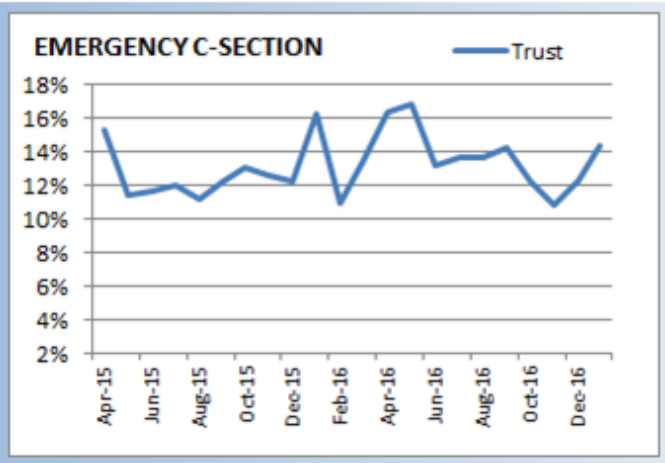


SAFE

	Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches	Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.	There were no occurrences of mixed sex accommodation breaches throughout February 2017.		
MRSA Bacteraemias	National objective is zero tolerance of avoidable MRSA bacteraemias	The Trust has reported 2 cases of acute aquired MRSA bacteremia year to date There were no cases reported during February		Further information is included in the Board Quality report

Integrated Performance Report - March 2017

SAFE

Description	Aggregate Position	Trend	Variation
Clostridium Difficile: The Clostridium difficile target for 2016/17 is no more than 53 cases	There have been 42 cases year to date There were 5 incident reported during February which failed to achieve the monthly trajectory of no more than 4 cases		
Emergency C-section rate: Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for January failed to achieve this standard at 14.40%		

EFFECTIVE

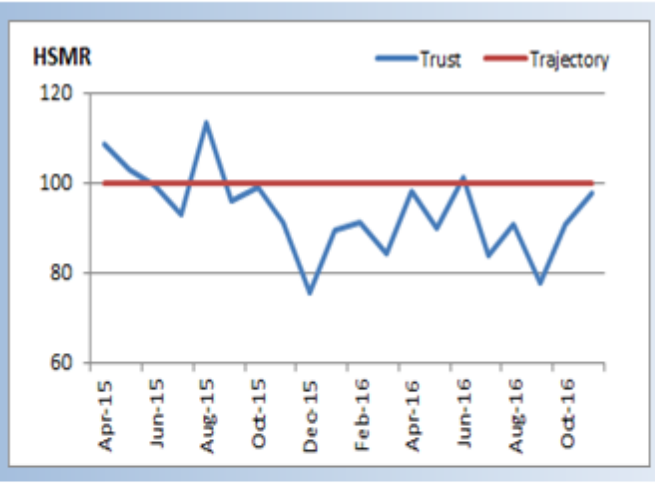
Description	Aggregate Position	Trend	Variation

HSMR

HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups

November 2016 is the latest available performance

The standard for HSMR is to achieve less than 100 and November 2016 achieved this at 97.8

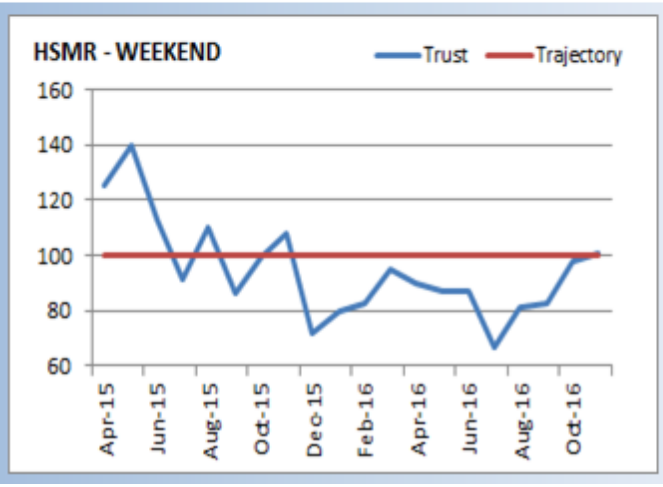


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

November 2016 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and November 2016 failed to achieve this at 101



EFFECTIVE

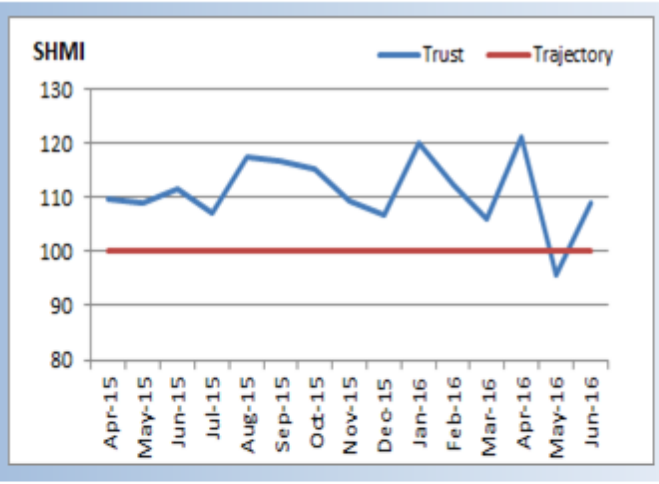
Description	Aggregate Position	Trend	Variation

SHMI

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

June 2016 is the latest published performance

The standard for SHMI is to achieve less than 100 and June 2016 failed to achieve this at 108.9

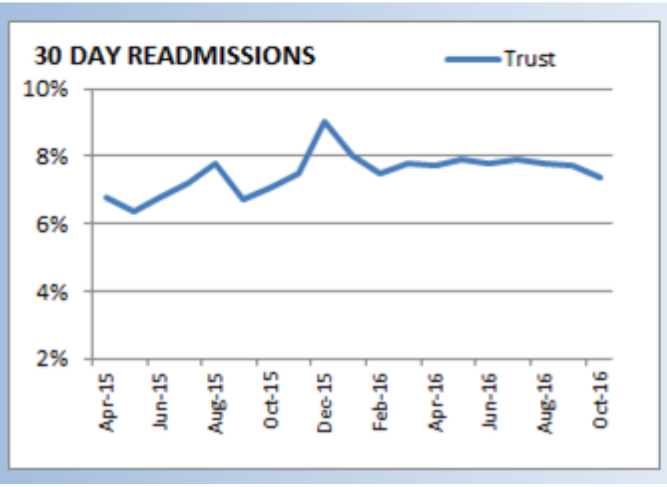


30 DAY READMISSIONS

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

The latest available performance is November 2016

The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than 7.8%. The Trust achieved this measure with performance of 7.6%



CARING

Description	Aggregate Position	Trend	Variation

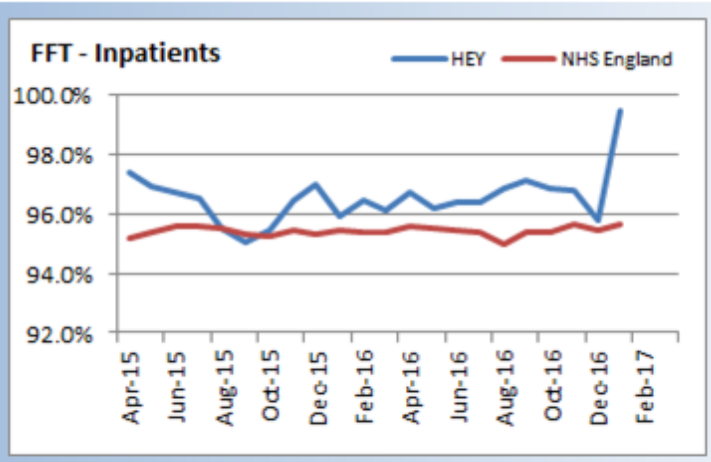
Inpatient Scores from Friends and Family Test - % positive

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

Performance for January was 99.49%

The latest published data for NHS England is January 2017.

February 2017 will be published 6th April 2017.



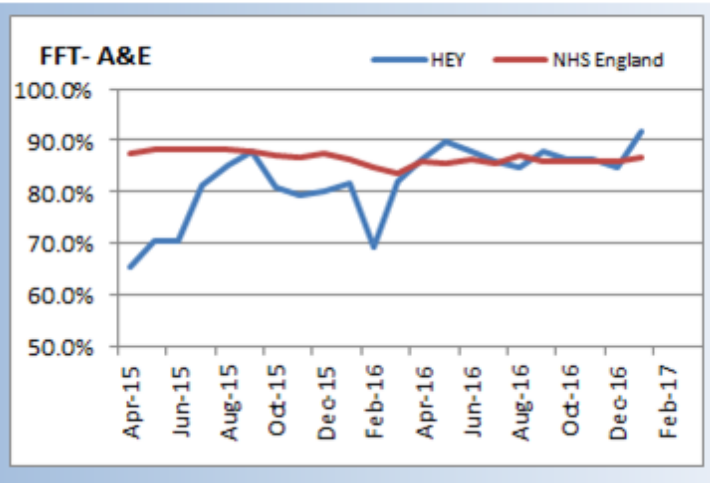
A&E Scores from Friends and Family Test - % positive

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

Performance for January was 91.68%

The latest published data for NHS England is January 2017.

February 2017 will be published 6th April 2017.



Integrated Performance Report - March 2017

CARING

	Description	Aggregate Position	Trend	Variation

Maternity Scores from Friends and Family Test - % Positive

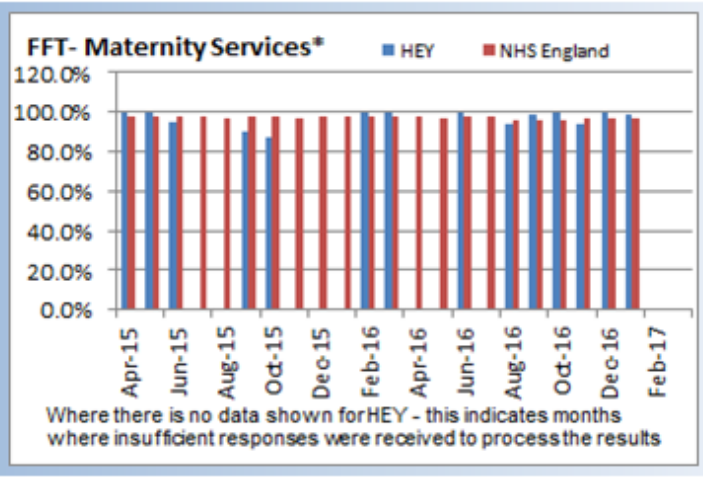
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for January was 98.75%

The latest published data for NHS England is January 2017.

February 2017 will be published 6th April 2017.

Months with no data for HEY is due to insufficient responses



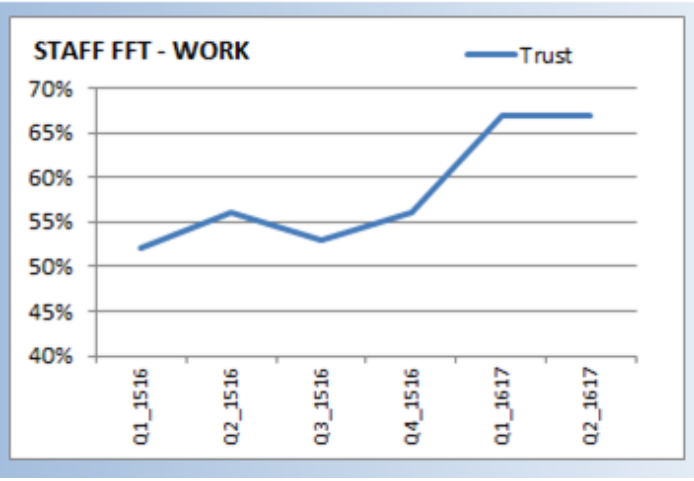
* Question relates to Birth Settings

Relative Position in Staff Surveys

Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?

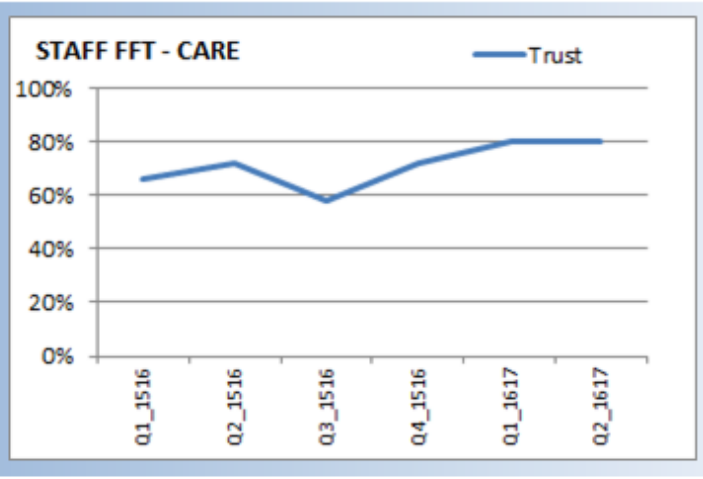
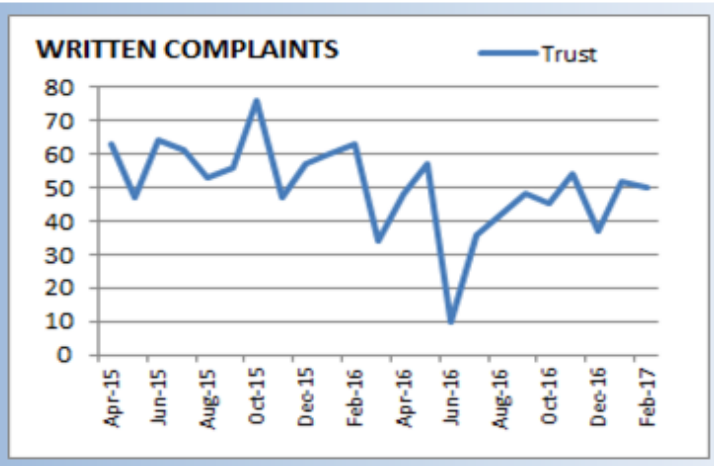
The latest Friends and Family Test position is Quarter 2 2016/2017 shows that 67% of surveyed staff would recommend the Trust as a place to work, this remains consistent with 67% for Quarter 1.

Quarter 3 performance is part of the annual staff survey and will be reported when published.



The overall response rate for Quarter 2 was 20.3%

CARING

	Description	Aggregate Position	Trend	Variation
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?	The latest Friends and Family Test position is Quarter 2 2016/2017 shows that 80% of surveyed staff would recommend the Trust as a place to receive care/treatment, this remains consistent with 80% for Quarter 1. Quarter 3 performance is part of the annual staff survey and will be reported when published.		The overall response rate for Quarter 2 was 20.3%
Written Complaints Rate	The number of complaints received by the Trust	The Trust received 50 complaints during February, this is a slight decrease on the January position of 52 complaints		There have been 479 complaints year to date

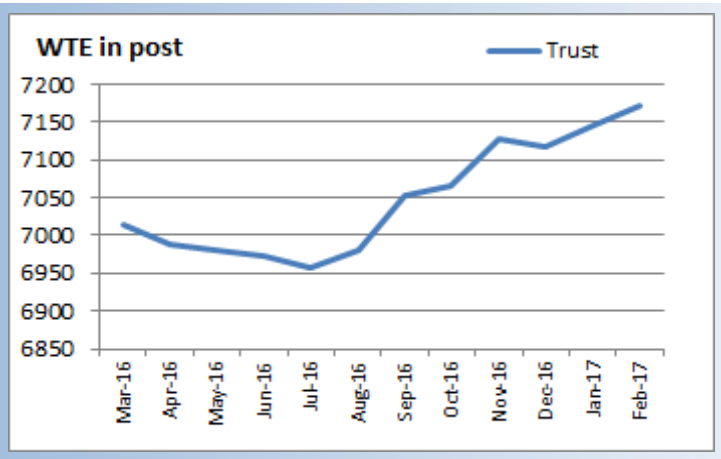
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

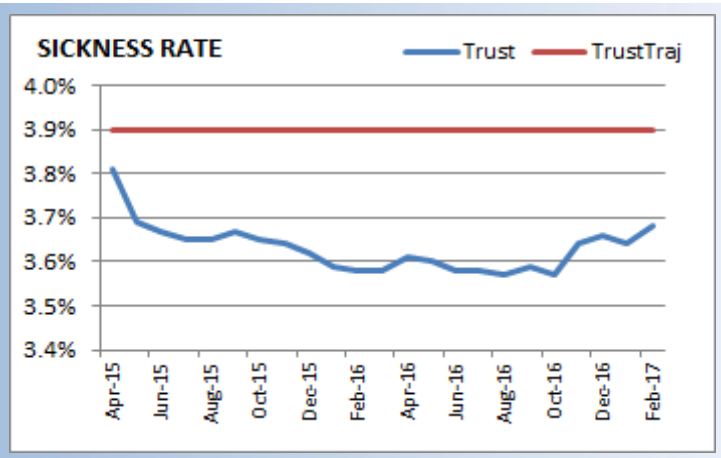
Trust level WTE position as at the end of February was 7172



Sickness Absence Rates

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

Performance for February achieved the standard of less than 3.9% with performance of 3.68%



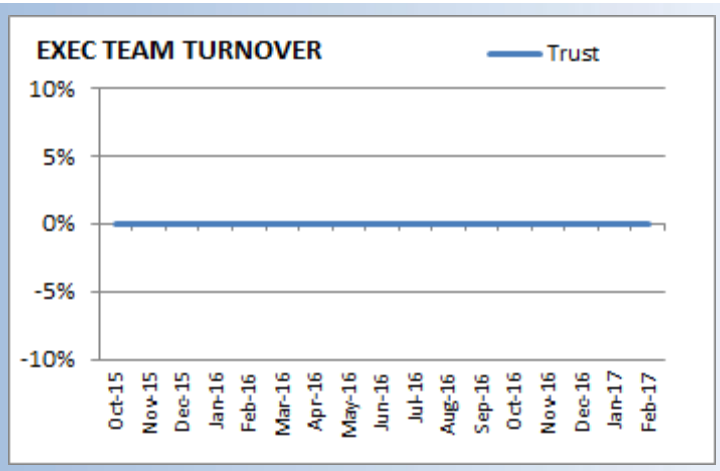
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

Turnover has been 0% for the Executive team within the last 12 month period.

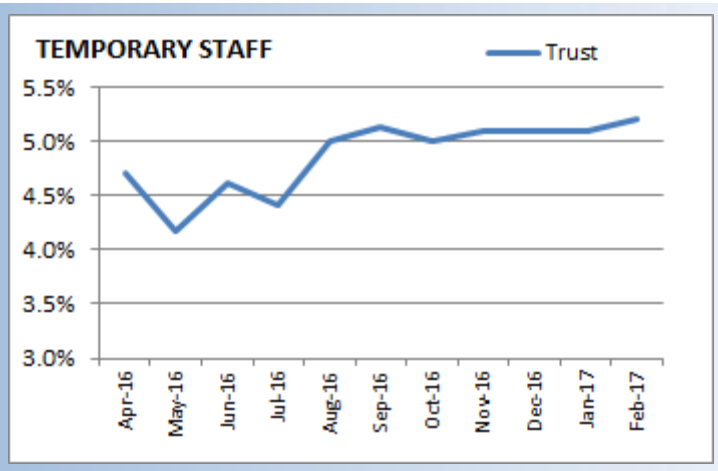


Proportion of Temporary Staff

% of the Trusts pay spend on temporary

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

February performance was 5.2%



FINANCIAL SUMMARY: 11 MONTHS TO 28th FEBRUARY 2017

1. At the end of month 11 the Trust is reporting a deficit of £2.0m which is in line with plan. This is consistent with the previous months reported position and assumes that the Trust will be successful in its appeal against quarter 3 and 4 STF fines.

2. Excluding STF Health Group positions are £13.2m overspent. This is £1.6m increase in month and £0.6m above Health Group forecasts. All health groups deteriorated in month. The deterioration was partially offset by an improvement in the corporate position..

3. The Trust has only being able to report that it is still on plan due to the release of reserves above the monthly rate. The Trust has now released 94% of its available reserves and has only £0.97m of reserves remaining to cover any overspend in month 12.

4. The Trust is forecasting that it will deliver its control total at year end. This assumes that the Trust is successful in its appeal against the STF fines and is able to contain its costs within the final month such that the estimated £1.3m risk is managed down to zero and no additional cost pressures materialise in the month. **Health Groups need to contain costs within their monthly budget** and the Trust will also undertake a full review of its Balance Sheet to ensure that all appropriate actions have been taken.

5. Failure to achieve the plan would lead to the Trust losing the £3.5m quarter 4 STF funding and a further £1.6m of CQUIN funding in 2017/18. **This would require the Trust to deliver an increased CRES target in 2017/18 on top of its current £15m plan.**

5. In Month the Trust has traded above its income plan by £0.8m driven largely by expenditure on PBR excluded drugs and devices to that level. An over trade in non elective activity was offset by under trade in elective activity. The Trust has agreed a year end forecast outturn position with its 2 main local commissioners and NHS England Specialist Services, in line with the Trust's forecasts.

6. The Trust's cash position remains weak. This is impacting on supplier relationships and has impacted on the Trust's performance against the Better Payment Practice Code. The 2 main local Commissioners paid £6m of the agreed £8m additional payments in early February which has eased the pressure. The remaining £2m cash and around £4m from NHS England will be received in March 17.

7. As per previous months the non delivery of CRES is a significant concern with the month 11 position showing a £4.3m shortfall against a £17.3m plan with an anticipated outturn of £4.4m (23%) below plan. Offsetting this, the Trust's financial plan included a risk provision (reserve) totalling almost £5m recognising the risk inherent within the CRES program. In addition, the plan made a further £5m allowance against the risk of non delivery of the RTT recovery plans. In total the Trust is forecasting a deficit of approximately £5.8m against the planned activity targets. **The bigger issue is the growth in the Health Group cost base above budgeted levels without delivering the funded levels of activity. This is particularly an issue in Surgery but to a smaller extent also FWH.**

8. **The Trust's underlying financial position is now a £26.1m deficit. This is a deterioration of £6.5m in year and is one which urgently need to be reversed.**

ORGANISATIONAL HEALTH

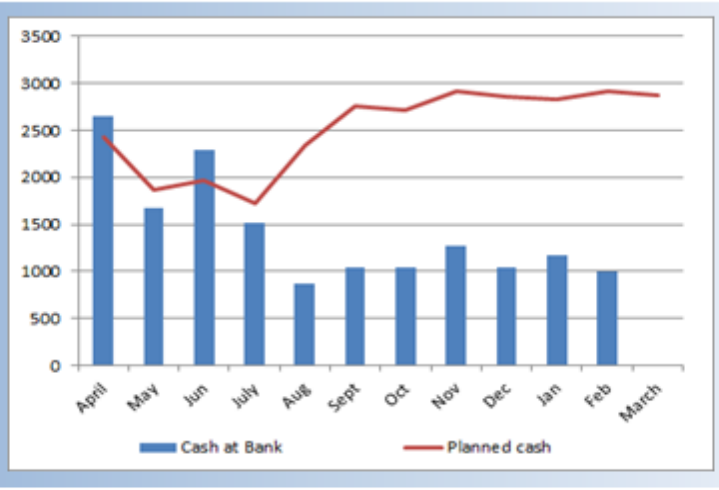
Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of February was £0.996m.

The Trust has converted its temporary borrowings into a short term loan which means that the £1m minimum bank balance limit has now been removed. There is still intense pressure on cash and the Trust is still unable to meet obligations to suppliers as they fall due. The Trust expects to meet its statutory External Financing Target (EFL).

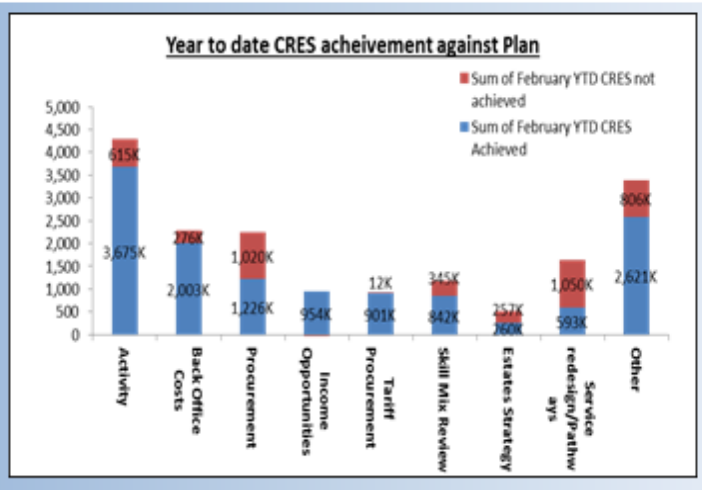


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 11 the Trust has achieved £13.1m of CRES savings against a plan of £17.3m, an adverse variance of £4.2m.

The breakdown of the CRES programme by major work streams is shown on the chart with the red and blue combined reflecting the overall plan as at October, the blue section being that which has been achieved and the red being that which has not.



The Health groups have been tasked with finding additional schemes to cover their CRES shortfall.

ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

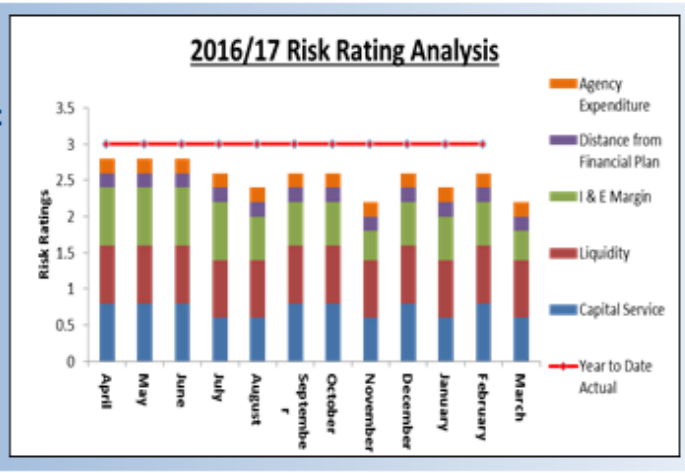
Risk Rating

Financial Sustain-ability Risk Rating

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

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

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst (this is a change from previous rating metrics which had 4 as the best score and 1 the worst). The Trust's risk rating is currently 3.



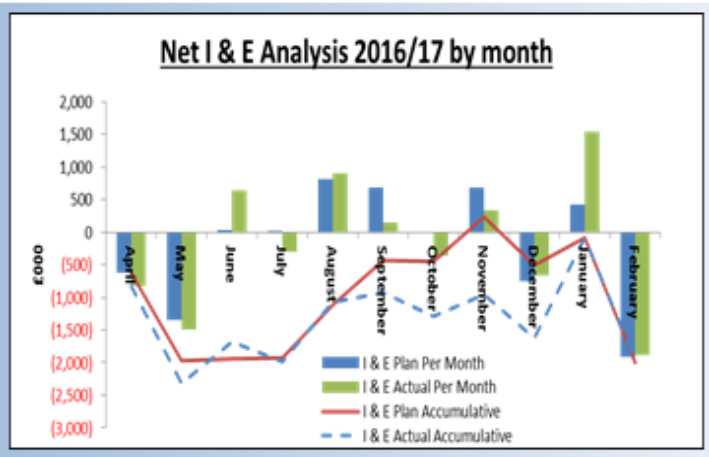
The Trust is currently reporting a risk rating of 3 with poor liquidity one of the main contributing factors.

Income & Expenditure

Net income and Expenditure

The Net I & E analysis shows how the trust has performed in each month in terms of the overall performance surplus plan. The bars showing each months performance and plan in isolation and the lines showing the accumulative position of plan and actual.

At month 11 the Trust is in line with plan with a £2m deficit reported, the forecast (and plan) for month 12 is to achieve a break even position



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FINAL REPORT - NATIONAL STAFF SURVEY 2016

Trust Board date	4 April 2017		**Reference Number**	2017 – 4 - 13		
Director	Simon Nearney – Director of Workforce & OD		**Author**	Myles Howell – Director of Communications		
Reason for the report	The purpose of this report is to provide the Trust Board with the findings and results of the National Staff Survey 2016					
Type of report	Concept paper		Strategic options		Business case	
	Performance	✓	Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive and note the contents of this report, acknowledge the progress being made, as well as the areas identified for improvement. The Board is also requested to approve version 1 of the Staff Survey Action Plan as well as work underway to address issues within the medical and dental workforce.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information	✓	Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W3 – Leadership and culture**					
	Assurance Framework Ref: H2	**Raises Equalities Issues?** Y	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Action plan overseen by the Staff Survey Working Group					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FINAL REPORT - NATIONAL STAFF SURVEY 2016

TUESDAY 20th MARCH 2017

PURPOSE

The purpose of this report is to provide the Trust Board with the findings and results of the National Staff Survey 2016

The report also includes the latest scores from the quarterly FFT staff survey conducted in February 2017.

The Board is requested to discuss and comment upon the key issues and approve the proposed objectives and action plan (Appendix 1).

INTRODUCTION

Hull and East Yorkshire Hospitals NHS Trust undertook the NHS National Staff Survey 2016 between October and December for a full census of its staff.

The response rate for the Trust was 44% (3,508 staff), against a national average of 43%. Of these completed survey questionnaires, 0.23% were paper questionnaires and 99.77% were online. This is the largest number of staff to respond to the staff survey in the past ten years, with staff groups represented proportionately.

In the 2016 report there are 32 key findings and a measure of staff engagement. Each key finding is comprised of a cluster of questions, which can be found in the full version of the Trust's report, which was published on 7th March 2017.

A Staff Survey Working Group has been established to oversee the ongoing development and delivery of the action plan which is intended to be dynamic and respond to emerging issues from the workforce. Terms of reference for this group can be found in Appendix 3.

A separate group, focusing on medical engagement and accountability has also been established and five themes for improvement have been identified (Appendix 4).

KEY FINDINGS

The staff survey's 32 key findings are grouped into nine categories:

1. Job satisfaction
2. Managers
3. Patient care & experience
4. Violence, harassment and bullying
5. Appraisals and support for development
6. Equality and diversity
7. Errors and incidents
8. Health and wellbeing
9. Working patterns

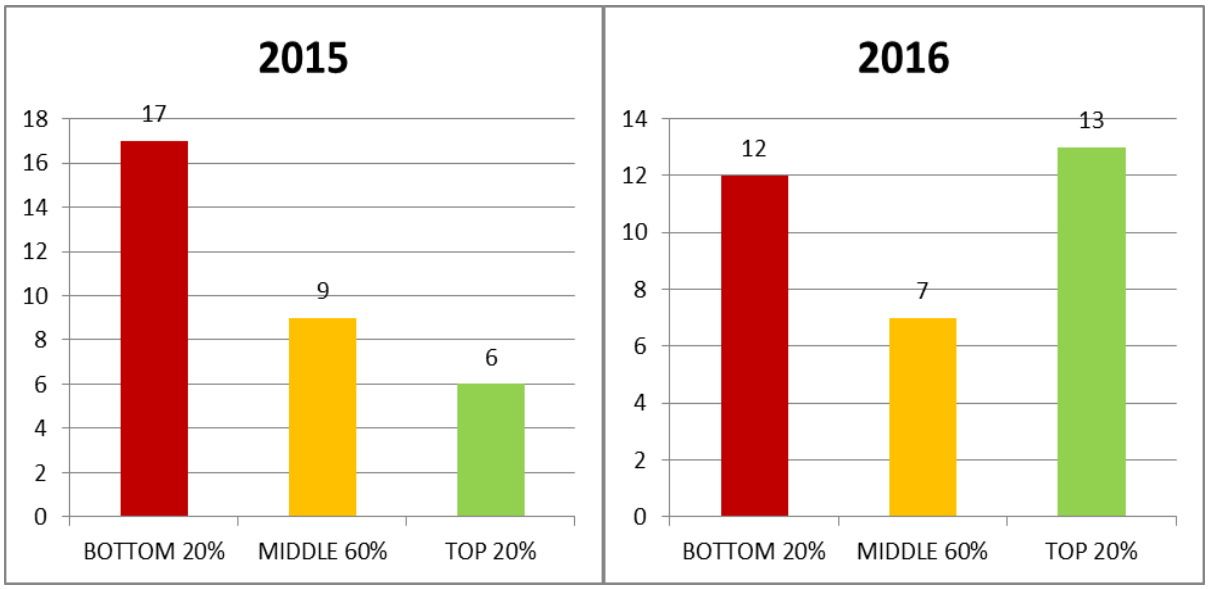
The staff survey report shows benchmarking performance for other similar Trusts as well as performance against these nine categories by occupational group.

KEY FINDINGS BENCHMARK PERFORMANCE
When compared with similar type organisations for all 32 key findings the Trust's benchmarked performance has improved, with the number of scores in the top 20% increasing by over 100%:

2016
In the top 20% for 13 key findings
In the middle 60% for 7 key findings
In the bottom 20% for 12 key findings

2015
In the top 20% for six key findings
In the middle 60% for nine key findings
In the bottom 20% for 17 key findings

Performance is deemed to have improved significantly against five key findings:



Five scores are deemed to have improved significantly since 2015.

1. % staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
2. % staff feeling unwell due to work related stress in the last 12 months
3. % staff witnessing potentially harmful errors, near misses or incidents in the last month
4. % staff experiencing harassment, bullying or abuse from staff in the last 12 months
5. % staff appraised in the last 12 months

Of these, however, the following remain in the bottom 20% of trusts:

KF17. % staff feeling unwell due to work-related stress in the last 12 months
KF26. % staff experiencing harassment, bullying or abuse from staff in the last 12

months

The Staff Survey provides information about our top five and bottom five ranking scores when compared with other similar Trusts. These are as follows:

Top five ranking scores:

1. % staff experiencing discrimination in the last 12 months
2. % staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
3. % staff witnessing potentially harmful errors, near misses or incidents in the last month
4. % staff experiencing harassment, bullying or abuse from patients or the public in the last 12 months
5. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Bottom five ranking scores

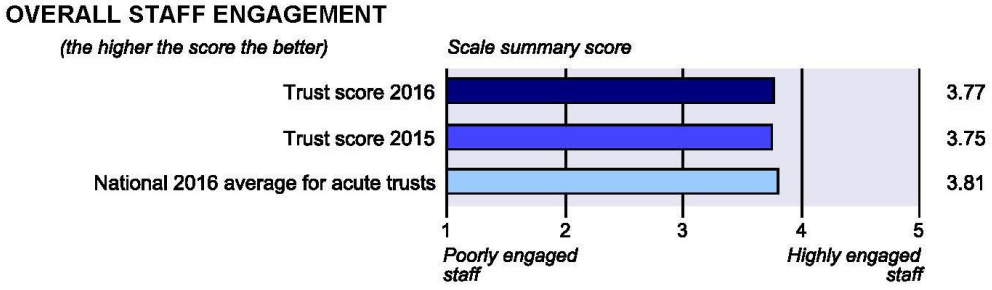
1. % staff experiencing harassment, bullying or abuse from staff in the last 12 months
2. Organisation and management interest in and action on health and wellbeing
3. % staff feeling unwell due to work related stress in the last 12 months
4. % staff reporting potentially harmful errors, near misses or incidents in the last month
5. Staff recommendation of the Trust as a place to work or receive care or treatment

Despite being one of the worst ranking scores KF26 (% staff experiencing harassment, bullying or abuse from staff in last 12 months), is one of the Trust's most improved scores, a statistically significant shift from 38% in 2015 to 31% in 2016.

KF29 (% staff reporting errors in the last month) has also improved by two percentage points since the last survey from 87% to 89%, and is now only one percentage point behind the national average. To put this into context the Trust is in the middle 60% of Trusts in terms of volumes of incidents reported and harm caused to patients.

OVERALL STAFF ENGAGEMENT

The Trust's engagement score improved from 3.75 in 2015 to 3.77 in 2016. Despite this, the Trust remains lower than the national average of 3.81. In 2014 the Trust's engagement score was 3.54.



KEY FINDINGS BY OCCUPATIONAL GROUPS

Six staff groups scored 20 or more of the key findings as better than the Trust or national average. Of these Physiotherapy scored 29 and also had 17 of the best scores for the organisation.

Four of the Trust's main occupational groups scored 20 or more of the key findings as worse than the national or Trust average: Medical and Dental (20), Scientific and Technical (22), Admin and Clerical (22) and Maintenance/Ancillary (24). Furthermore Admin and Clerical (7) and Maintenance/Ancillary (6) had over 5 of the worst Trust scores for the 32 key findings.

The full table of scores by 13 of our largest occupational groups is as follows ((the best and worst Trust score columns do not total 32):

KEY FINDINGS BY OCCUPATIONAL GROUP	Better than average	Worse than average	Best Trust score	Worst Trust score
Adult / General nurses	17	15	1	3
Other registered nurses	16	16	0	4
Nursing / healthcare assistants	16	16	2	4
Medical and dental	12	20	1	4
Occupational Therapy	25	7	2	0
Physiotherapy	29	3	17	0
Radiography	21	11	1	1
Other Allied Health Professionals	26	6	1	0
General Management	25	7	2	1
Scientific and Technical	10	22	0	4
Admin and Clerical	10	22	2	7
Corporate services	25	7	7	1
Maintenance / Ancillary	8	24	0	6

A separate survey of medical and dental staff (Medical Engagement Scale) has indicated that there are particular issues affecting this part of our workforce. The survey results showed low levels of engagement for all grades of medical and dental staff but a disconnect between those with management responsibility, who did feel engaged and those without, who did not. Those working at Castle Hill were less engaged than those at Hull Royal Infirmary, and there is a clear issue in the surgical workforce. Please see sections below on Objectives and Progress to Date, as well as Appendix 4 for more details.

OTHER DEMOGRAPHIC GROUPS

Work has been undertaken in 2015/2016 to address issues with our Black, Minority and Ethnic (BME) workforce. Over 300 BME staff completed the 2016 survey and while issues of discrimination persist (18% say they continue to experience discrimination at work) this is the demographic which, overall, scores the Trust most positively in the 2016 survey. Work is continuing with the BME network to understand how discrimination manifests in our organisation and this will form part of the Staff Survey action plan. However, BME staff scored better than average for 25 of the 32 key findings and had the best score of any demographic for 19 of the 32 key findings.

The Trust's disabled workforce scored worse than both Trust and national averages for 30 of the 32 key findings and had the lowest score of any demographic for 25 of the 32 key findings.

KEY FINDINGS BY DEMOGRAPHIC GROUP	Better than average	Worse than average	Best Trust score	Worst Trust score
Men	10	22	1	3
Women	23	9	4	1
Disabled	2	30	0	25
Not disabled	28	4	9	0
White	22	10	1	0
BME	25	6	19	2

FOURTH QUARTER FFT FOR STAFF

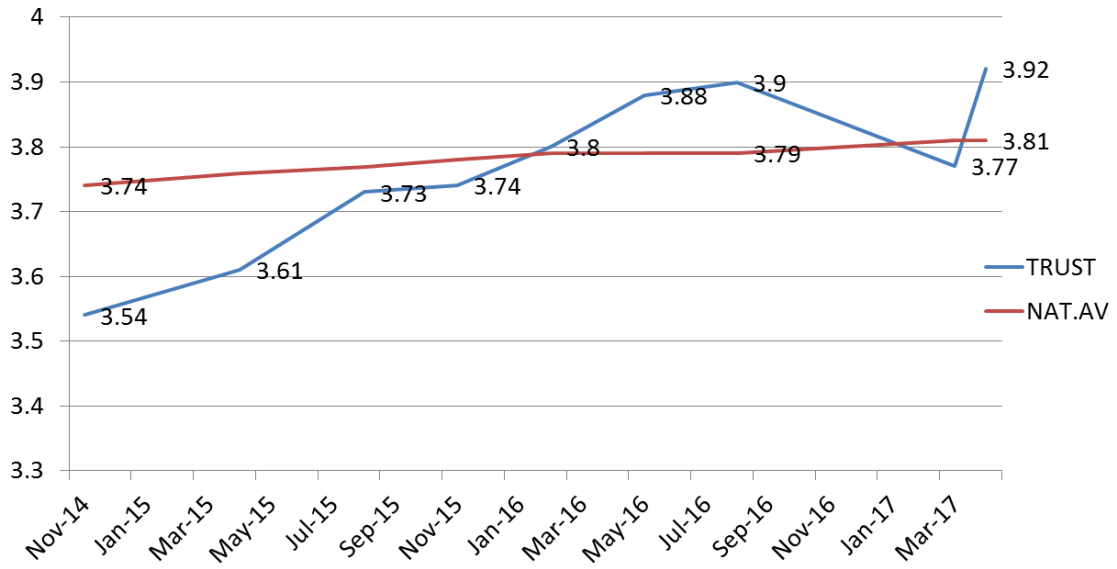
In addition to the annual National Staff Survey the Trust is required to ask the FFT questions for staff three times a year:

- Would you recommend this organisation as a place to work?
- Would you recommend the Trust to family or friends if they needed care or treatment?

The Trust uses this opportunity to also ask the other seven questions which make up the overall score for engagement for the organisation.

- Care of patients / service users is my organisation's top priority
- There are frequent opportunities for me to show initiative in my role
- I am able to make suggestions to improve the work of my team / department
- I am able to make improvements happen in my area of work
- I look forward to going to work
- I am enthusiastic about my job
- Time passes quickly when I am working

In the quarter four survey, which ran for two weeks in February, 1279 (16%) staff completed the questionnaire, approximately one third of the return for the National Staff Survey.



The engagement score shows a very positive upwards trajectory at 3.92, above the national average for acute trusts of 3.81 and the score in the National Staff Survey, at 3.77. All Health Groups and Directorates scored above 3.88.

These results need to be set in the context of the breakdown of staff who completed the survey, which included: nursing (20%), medical and dental staff (6%) wider healthcare team (4%), and a very high representation of allied health professionals, scientists and technical staff (25%).

The survey also showed a skew in terms of Health Group responses. Only 8% of staff from the Surgery Health Group completed the FFT, equating to 99 staff. In the National Staff Survey, 20% of staff from the Surgery Health Group completed a survey, equating to over 700 people.

While a useful indicator of performance in some areas, overall these results are not so proportionately representative of the organisation's workforce. Where we have received larger samples, however, the results will enable us to identify areas of good practice and concern and will play a useful role in the ongoing development of our action plan.

OBJECTIVES AND THE TRUST'S LONG-TERM GOALS

While progress has clearly been made, and the FFT results are strongly suggesting that overall engagement is much improved, the Trust is not satisfied to be in the middle 60% of trusts for performance against the National Staff Survey. In his recent CQC State of Care Report into the NHS, Professor Sir Mike Richards, Chief Inspector of Hospitals, commented "We have found that the NHS Staff Survey is one of the most reliable predictors of the effectiveness of NHS trusts' leadership and of the quality of care they provide for patients".

Evidence that links good staff engagement with good performance, care and financial performance can be found in the Michael West King's Fund report: Employee Engagement and NHS Performance, 2012. https://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

Three objectives are proposed for Trust Board approval and support:

Objective 1 Trust performance in the National Staff Survey will be in the top 20% of Trusts in the UK by February 2019, on publication of the 2018

survey results. The overall score for engagement will be the key performance indicator in this respect.

Objective 2 Medical and dental engagement will be in the top 20% of Trusts by February 2020 on publication of the 2019 results.

Objective 3 Scores for non-clinical staff (including Corporate and Estates, Facilities and Development will be comparable to those of the best performing Health Group by publication of the 2018 results.

Delivery of these objectives is connected directly to the organisational vision of Great Staff, Great Care, Great Future. Through better staff engagement and communication, and with well supported staff who have clear roles, responsibilities and career pathways, this work will have a direct impact on the ability of the Trust to achieve its long-term goals:

1. Honest, accountable and caring culture
2. Valued, skilled and sufficient staff
3. High quality care
4. Great local services
5. Great specialist services
6. Partnership and integrated services
7. Financial sustainability

PROGRESS TO DATE

In order to achieve the objective set out above, a Staff Survey Working Group has been established. This includes membership from all Health Groups and Directorates, and has been extended to include medical and nursing members. The Head of Therapies has also been invited to join the group in an effort to learn from areas of excellent practice and shift at some focus on to best practice. A standing agenda item for the group will be 'learning from excellence'. The group will meet monthly and report to the Workforce Transformation Committee. The action plan in Appendix 1 is the first version of the group's actions agreed to date and will be updated following further discussions with specific areas of the workforce. These discussions will include "all staff" focus groups, workshops with our disabled workforce, a focus on good practice in therapies and specific interventions for both the medical and dental workforce as well as the Estates, Facilities and Development directorate.

Senior manager briefing sessions will be held during May to August for all 800 managers within the Trust. These will set out and reinforce the expectations of a HEY manager to create and maintain the right environment for their people and assist them in achieving this.

A separate group focusing specifically on medical engagement and accountability has been established with medical membership from all Health Groups. The first meeting of this group was held in March. The discussion built upon feedback from a workshop with Health Group Triumvirates and clinical directors held in December, with five clear themes emerging:

1: Basic needs: Car parking, office accommodation, admin/secretarial support, training and development, organisational respect and SPA time
2: Clarity of roles: Job descriptions, appraisals and job planning/team planning
3: Structures: Sharing the workload, clinical hierarchy and clear expectations
4: Relationships: Secretaries, Patient Admin service, business/service managers, networking, consultants' forum and team working with the wider clinical team
5: Accountability: Empowerment and authority to act,, delegated decision-making, hand back control over waiting lists and strong performance management

The group, led by the Chief Medical Officer, will continue to meet monthly to develop a robust plan of action, based on the five themes. The action plan will be discussed by and approved at both the LNC and Trust Board.

ACCOUNTABILITY

The monthly Performance Reviews for Health Groups will focus on those areas where Health Groups currently fall below the Trust or national average in the National Staff Survey (see Appendix 2); as well as the Health Group score for overall engagement. Updated scores will continue to be provided by the quarterly Friends and Family Tests surveys for staff.

Corporate and Estates, Facilities and Development directorates will be required to present their progress against the National Staff Survey scores at the Workforce Transformation Committee.

In addition, it is proposed that quarterly progress reports are received by the Trust Board with the next such report being presented in July 2016.

SUMMARY AND NEXT STEPS

The Trust has continued to progress and improve against most measures and key findings in the 2016 National Staff Survey. The number of key targets in the top 20% of trusts nationally has more than doubled with the number in the bottom 20% reducing significantly.

Despite this there are some key areas across the organisation for improvement and further investigation, including a focus on staff with a disability, and continuing with the ongoing reduction of incidences of violence, bullying and harassment.

Some staff groups, including Medical and Dental, Admin and Clerical and Estates, Facilities and Development are priority areas for improvement.

An action plan, linked to the key aims of the People Strategy, is to be found in Appendix 1 for the Trust Board to comment upon and approve. This will be presented to JNCC. A separate medical engagement action plan will be presented to LNC.

RECOMMENDATIONS

The Trust Board is requested to receive and note the contents of this report, acknowledge the progress being made, as well as the areas identified for improvement. The Board is also requested to approve version 1 of the Staff Survey Action Plan as well as work underway to address issues within the medical and dental workforce.

Simon Nearney,
Director of Workforce and OD
March 2017

APPENDIX 1.

2016 STAFF SURVEY ACTION PLAN V.1

Ref	Actions	Required Outcome	Lead	RAG	Due
Appraisals and support for development					
1	Design and implement a KPI for the QPRs on Quality of Appraisals	Achieve score of 3.22 in 2017 NSS (current score 3.05)	Dave Withers		7.4.17
2	Review current Totara system for appraisal and compare with ESR proposal	Online system is receiving positive feedback and number of appraisals increases	Dave Withers		26.5.17
3	Discuss quality and provision of non-mandatory training, learning or development with EF&D	Assurances provided from frontline staff that training and personal development is being offered	Myles Howell		7.4.17
4	Promote non-mandatory training courses (inc Bitesize) to all staff, particularly line managers	Increased attendance on key courses – Corporate and EF&D	Myles Howell		23.6.17
Equality and diversity					
4	Hold a series of workshops for disabled staff on issues affecting their employment	Obtain feedback and update the action plan	Lucy Vere		23.6.17
5	Promote regional Disability conference to all staff	WTC receives a report from the conference	Jackie Railton		24.3.17
7	BME staff – discrimination. Attend BME network to discuss reporting arrangements in the Trust	SALS and FTSU Guardian promoted to the network	Myles Howell		5.4.17
Errors and incidents					
8	Launch 'report it' campaign to encourage staff to report all forms of discrimination, errors and incidents. Includes SALS, FTSU Guardian, Datix, line management, HR, Occupational Health etc.	Increase % of staff reporting incidents and identify areas where discrimination is prevalent.	Rachel Johnson		26.5.17
Health and wellbeing					
9	Deliver the Health &Wellbeing strategy 2016-18 and supporting action plan	Programme of actions delivered according to agreed timescales in People Strategy. Affect a reduction in % staff reporting work-related stress.	Sue Richards		30.3.18
10	Promote Health and Wellbeing activities to all staff and create a strong intranet presence	Staff are accessing H&WB activities	Myles Howell		23.6.17
Job satisfaction					

	Conduct eight on-site focus groups with invitations to all staff to discuss how we move into top 20%	Identify clear actions to be delivered corporately	Myles Howell		23.6.17
	Staff-led improvement – roll-out of Improvement Academy Silver Training & bitesize programme	Trust staff in all areas accessing improvement training	Rachel Joyce		23.6.17
	Greatix – launch of excellence reporting	System for logging and promoting/sharing excellence launched to all staff online	Myles Howell		23.6.17
	Meet with physiotherapists and management team to understand what works well	Include key aspects in the action plan	Myles Howell		7.4.17
Managers					
	Eight Chief Exec-led briefing sessions for Trust managers	All managers are clear on expectations for improvements	Simon Nearney		25.8.17
	800 line managers attend Leadership programme modules	All managers undertake Leadership Academy Model training (400 after 12 months)	Lucy Vere		21.6.18
	20 staff to commence the New Leaders Leadership programme Course	FFT scores and workforce indicators set for all participants	Lucy Vere		21.6.18
	20 staff to commence the Talent Development programme	Increase the number of internal applicants for triumverate and Executive roles	Lucy Vere		21.6.18
	Corporate communication reviewed and adapted to reflect the need for improved ward-based communications	Non-office based staff can access corporate communications, including patient feedback	Rachel Johnson		23.6.17
	Staff not knowing who the senior managers are – intranet structure charts available, exec and triumverate to be displayed	Available at intranet launch	Myles Howell		23.6.17
Patient care and experience					
	Induction reviewed and adapted to make clear connections for all staff and patient care	Non-clinical staff not understanding the contribution they make to patient care	Myles Howell		5.6.17
	Effective use of patient/service user feedback – staff receive feedback about the care they provide	Connects to improved corporate communication	Carla Ramsay		23.6.17
Violence, harassment and bullying					
	Targeted programme of actions to reduce violent attacks on staff implemented	Reduction in assaults and communications activities undertaken with public and local media	Eddie McGee		27.10.17
	Re-launch PaCT refresher training and establish PaCT Academy	Separate working group to be established	Lucy Vere		23.6.17
	Trust Board to have PaCT refresher training	Role modelling communicated across the Trust	Lucy Vere		26.5.17
Medical engagement and accountability					

	Engagement and accountability group established and sessions booked for 2017	Meetings take place monthly	Myles Howell		7.4.17
	Separate action plan for medical and dental workforce approved at LNC	Signed off by LNC in May	Simon Nearney		5.6.17
	Medical leadership development programme launched	Full attendance for 20 places by June	Lucy Vere		5.6.17
Admin and clerical					
	Focus groups held to enable admin and clerical to voice their concerns and ideas for improvement	Clarity on actions to help staff feel valued	Myles Howell		8.5.17
Estates, facilities and development					
	Focus groups held in estates, portering, catering and development to enable staff to voice their concerns and ideas	Feedback built into management action plan	Myles Howell		8.5.17
	Separate action plan approved at JNCC	Signed off at JNCC and reports presented to WTC	Jason Clemmey		23.6.17
Health Groups and Directorates					
	Each HG and Directorate to present improvement plans at the WTC and monthly PM's, based on areas which fall below the national average	Action plans and progress presented at QPRs each quarter	Simon Nearney		14.4.17

RAG rating
Red – off track and overdue
Amber – off track but recoverable
Green – in process, on track, within timescales
Blue – completed
No colour – not yet commenced

APPENDIX 2.

TERMS OF REFERENCE
Staff Survey Working Group 2016-2018

PURPOSE
To design and deliver a programme of activity that aims to shift the Trust from bottom 20% Trusts nationally to Top 20% of Trust nationally in terms of National Staff Survey performance in two years.

ACCOUNTABILITY
The working group will be accountable to the Director of Workforce and OD and will report to the Workforce Transformation Committee on a monthly basis.

MEMBERSHIP
- Myles Howell, Director of Communications - Chair
- Simon Nearney, Director of Workforce and OD
- Penny McManus, Breast Care Consultant
- Joanne O'Connor, Sister
- Nicky Gilchrist, Head of Therapies
- Sarah Bates, Director of Clinical Governance
- Dave Withers, Head of Education and Development
- Jackie Railton, Head of Strategic Planning
- Lucy Vere, Head of OD
- Rachel Johnson, Head of Communications
- Rachel Joyce, Programme Director, HEY Improvement Team
- Sue Richards, Head of Workforce Transformation
- Jason Clemmey, HR Business Partner, F&WH, EF&D
- Tina Smallwood, HR Business Partner, Surgery
- Sarah Addleshaw, HR Business Partner, Medicine
- Sam Kettlewell, HR Business Partner, Clinical Support Services
- Jenny Jethwa, Senior HR Advisor, Corporate Directorates

The programme group may also seek to invite other attendees, as appropriate.

MEETINGS
Meetings of the Group shall be held monthly until February 2019.

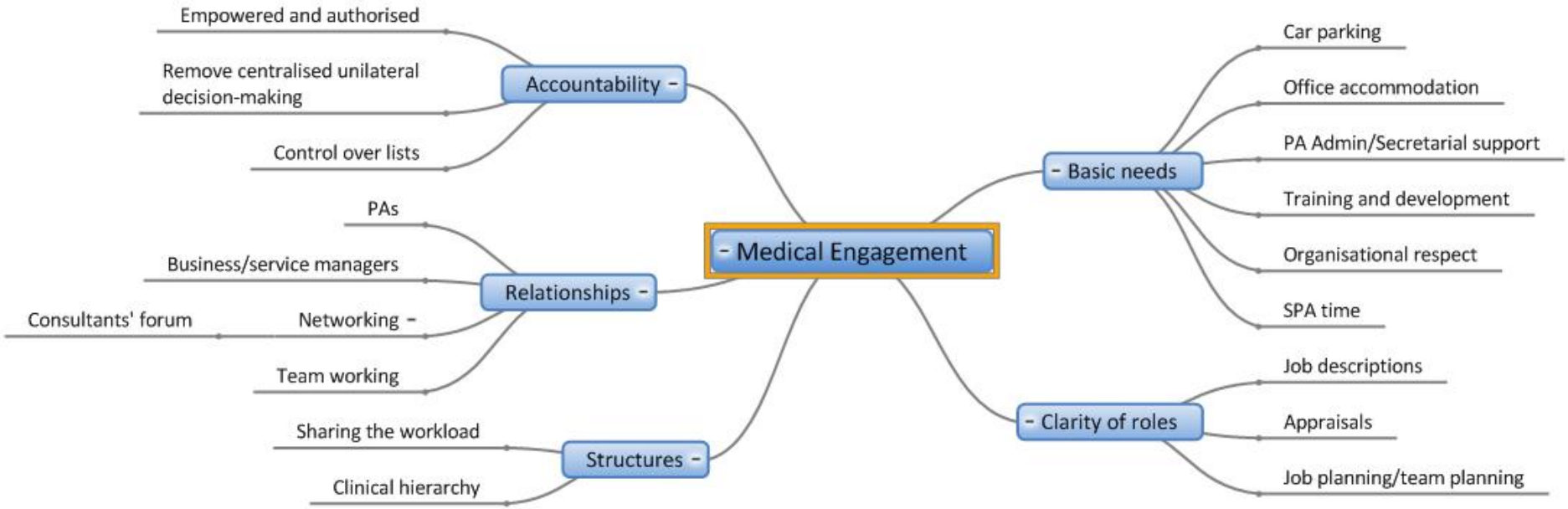
REMIT AND EXPECTATIONS OF GROUP MEMBERS
- To review the key issues in the 2016 Staff Survey
- To design an action plan which will deliver a significant improvement in the National Staff Survey prior to November 2017 and move the Trust to the top 20% of organisations within two years
- To be accountable for the delivery of actions in their respective areas
- To provide monthly updates to the Workforce Transformation Committee on their areas of responsibility
- To promote the key actions to their Health Groups and Directorates
- To attend every meeting and where this is not possible ensure a deputy attends on their behalf

REVIEW OF TERMS OF REFERENCE

The Terms of Reference will be reviewed after 6 months.

APPENDIX 3.

MEDICAL ENGAGEMENT AND ACCOUNTABILITY – MIND MAP OF THEMES



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

MORTALITY REPORT

Trust Board date	4 April 2017		**Reference Number**	2017 – 4 - 14		
Director	Mr K Phillips, Chief Medical Officer		**Author**	Mrs S Bates, Interim Deputy Director of Governance		
Reason for the report	The purpose of this report is to inform the Trust Board of the progress in relation to Structured Mortality Judgement Review					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to: • Receive the report • Decide if any further actions and/or information are required.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	✓	Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W3 – Leadership and culture openness and transparency to promote good quality care**					
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Reviewed by the Mortality Committee and the Quality Committee.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
STRUCTURED MORTALITY JUDGEMENT REVIEW
MARCH 2017

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the progress in relation to:

- **Structured Mortality Judgement Review Progress Report**

2. Background and context

Two key documents were published in March 2017 - National Guidance on Learning from Deaths (National Quality Board) and Learning from Deaths (CQC). These documents focus on the role of key members of the Trust as well as how learning from events will be used, disseminated and impact on current practice. The document also suggests that Trusts are going to be supported further via training sessions to be delivered by the Royal College of Physicians, although further clarification on this is needed.

The new methodology is now being implemented into the Medicine Health Group, Clinical Support Health Group and Family and Women's Health Group and has been presented to the Quality Committee.

Further in-house training sessions are planned to be delivered to Clinicians, Specialist Nurses and Matrons.

As of 28th March 2017, there has been a total of 70 patient case note reviews completed.

3. Results

The mortality review scores the care between 1-5 (5.0 being the best score), more that 95% of the reviews undertaken so far have scored good to excellent care. Any care scores that were 2 or less triggered a Tier 2 review**.**

4. Themed Analysis

The Trust has started to be able to examine any themes and trends from the reviews. The issues highlighted to date are surrounding documentation are still the main trending theme (continuing from the last board paper). These issues are related to one or more of the following:

- Lack of Consultant time/date, printing of name and designation within case notes after a patient review.
- Poor condition of case notes/pages out of order
- Sporadic entries made at varying locations within case note (e.g. entries written on "inpatient" page, and then continued within a separate booklet).

5. Mortality Proforma Changes

The themed analysis only allowed the reviewer to highlight negative care, or "issues surrounding" a specific elements of care.

However, as of 27th March 2017, a new amendment to the digital Lorenzo based proforma now allows users to rate elements of care, thus allowing great care to be highlighted and shared among the Trust. For example, a reviewer may now highlight the "Communication with family" element and rate this as "Excellent."

The Lorenzo form will also ask a reviewer to briefly summarise what they believe the main issues were that could have contributed to a patient's death. If they don't believe there were any issues, this section can be left blank. This amendment will allow closer monitoring of any specific actions that are born from the mortality review, as the Lorenzo form will ask the reviewer to state who will be responsible for any such action/recommendation.
It is appreciated that many actions are a lengthy process, perhaps involving an audit or even a culture change, taking many months to embed, but it is important to have a standardised method of capturing these actions throughout the Trust.

6. Involving the Next of Kin

A letter has been sent to the Bereavement service manager to be included within bereavement packs given to next of kin, which informs them about the structured case note review process.

7. Seeking General Practitioner Input into Mortality Review

Further work is being undertaken to devise a working plan to involve GP's in specific mortality reviews.

8. Quality Improvement Work

The Avoidable Mortality Quality Improvement Plan (QIP) for 2017/18 has been written to aid the organisation in the delivery of the national objective of a standardised approach to review of hospital mortality. This project will prepare the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.

9. Recommendation

The Trust Board is requested to:

- Receive the report
- Decide if any further actions and/or information are required.

Kevin Phillips
Chief Medical Officer
March 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18 OUTLINE

Trust Board date	Tuesday 4 April 2017	**Reference Number**	2017 – 4 – 16
Director	Terry Moran – Chairman	**Author**	Carla Ramsay - Director of Corporate Affairs
Reason for the report	The purpose of this report is to outline the process for compiling the Board Assurance Framework for 2017-18 for the Board to review and approve.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Board is asked to review and approve the proposed process for compiling the Board Assurance Framework for 2017-18					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board Assurance Framework details the key risks to achieving the organisation's goals. It is reviewed quarterly by the Board to determine if there is sufficient or a lack of assurance against each goal, with delegated discussions to each of the Board's Committee for specific risks relevant to their Terms of Reference for more detailed assurance.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18 OUTLINE

1. PURPOSE OF THIS REPORT

The purpose of this report is to outline the process for compiling the Board Assurance Framework for 2017-18 for the Board to review and approve.

2. BACKGROUND

The Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's goals, and detail the level (or lack) of assurance during the year as to what extent the level of risk is being managed. The Board Assurance Framework (BAF) also determines what an acceptable level of risk would be. The BAF is a key governance mechanism to measure and monitor the level of strategic risk in the organisation.

3. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

The Trust Board approved the Trust's strategy in April 2016. This set out six long-term goals for the organisation; the BAF in 2016-17 was ordered against the key strategic areas of the Trust's business and included the Trust's strategic goals once agreed by the Trust Board.

It is proposed that the BAF in 2017-18 will be constructed as follows:

- Each of the six strategic goals will be the six BAF risk areas for 2017-18
- BAF risks that were not managed down to the required level of risk in 2016-17 will be carried over (and updated, if required) to the 2017-18 BAF. As the Trust goals are long-term, it is appropriate that risk management in some of these areas spans more than one year
- Include a ward-to-board escalation of corporate risks on to the 2017-18 BAF, where these describe organisational risks that are linked to the delivery of the organisation's long-term goals. This was detailed in the flow-chart appendix to the BAF16-17 Q3 review and agreed by the Trust Board, to strengthen the link between operational and corporate risks and the Board Assurance Framework and delivery of the Trust's long-term goals. This flow-chart is appended to this report as an aide-memoire

Should the Trust Board approve this outline, the next steps will be to:
In order to po

4. RECOMMENDATIONS

The Board is asked to review the BAF and satisfy itself that the risks are being appropriately managed, and to confirm the proposed ratings for Q3, specifically the changed risk ratings for risks F1 and F3.

The Board is also asked to review and approve the process mapped out at Appendix 4, to strengthen the 'ward to board' escalation of corporate risks linked to Board Assurance Framework issues.

Carla Ramsay
Director of Corporate Affairs
January 2017

Appendix 1

BOARD ASSURANCE FRAMEWORK Q3 – 2016/17

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Mitigating Actions Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q1	Chief Medical Officer, Chief Nurse Quality Committee	5 risks • Crowding and physical space issues (2) • Safeguard-ing training compliance (1) • Reduction in trained staff in blood transfusion labs (compliance risk) (1) • Paediatric access to dietary assessment (1)	**The Trust is non-compliant with CQC regulatory requirements** There is a risk that the Trust does not achieve the fundamental standards and that regulators and service users may have concerns about the quality and safety of our patient services.	**20** **L-4** **X** **S-5**	• QIP established • Fortnightly QIP meetings chaired by CMO to monitor achievement of milestones • QIP programme reviewed at Operational Quality Committee and deviations from plan escalated • Internal inspection programme in place during Q1 • NHSI involved in 'health check' • Governance toolkit developed to support staff to prepare for inspection • Fortnightly Charge Nurse meetings with ward sisters	Informal feedback from the CQC identified areas where further work needs to be undertaken. This includes embedding checking procedures, adherence to escalation procedures, documentation and staffing. A review has been undertaken of the QIP following informal CQC feedback and the QIP has been updated. This will be reviewed on receipt of the formal CQC report **Leads**: CN, CMO and Director of Governance **Completion**: Anticipated March 2017	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**		**4** **L1** **X** **S4**	**Positive assurance** • Informal feedback received from the CQC following the comprehensive inspection at the end of June 2016 identified a number of areas where positive improvements had been made • Review by Internal Audit that the QIP was complete and accurate – reported to the Audit Committee at May 2016 meeting • Internal reports giving significant assurance during 2015/16 – Fit and Proper persons, discharge planning, safe staffing levels, performance management arrangements and lessons learnt • Internal Audit provided positive feedback on the Duty of Candour arrangements (May 2016) • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days • QIP programme reviewed – areas with progress made that are now business as usual now removed; deteriorating patient programme provisionally closed ; overall programme rating amber/green **Further assurance required** • Internal audit reports giving limited assurance in 2015/16 – infection control, incident reporting, planned medical staff absence and responding to Francis • Recently established Heath Care Delivery Improvement Group. This group will be responsible for ensuring learning is shared and embedded throughout the Trust • 2 Never Events declared in 2016/17 • Two areas escalated from the QIP in November/December 2016 – VTE compliance and Resuscitation equipment checks audit compliance

Q – High Quality Care													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q2	Chief Medical Officer Quality Committee	0 risks	**Lessons learned** There is a risk that the Trust does not learn from adverse events and that errors continue to occur which could affect patient care and safety	**20** **L4** **X** **S5**	• Learning lessons QIP project group established • Monthly Lessons learned newsletter • Quality Bulletin • Lessons Learned Intranet site • Monthly SI summary report distributed to Health Groups • Analysis of incidents and trends • Use of videos to replicate incidents in order to improve learning • Application of Root cause analysis techniques and training • Operational Quality Committee • Health Group Governance meetings • Health Group performance reviews • Clinical Incident Review Creating a Learning Environment **(**CIRCLE) • Table top RCA's being piloted for some SI's • Trialling PDSA cycles for learning	• At the end of Q2 there was a reduction in the number of SIs reported when compared to 2015/16 .The themes and trends in incidents and Serious Incidents (SIs) are continuing from 2015/16 into 2016/17. Further review and analysis required • Revised incident reporting system launched April 2016. The national coding structure implemented at the same time is causing some concerns when analysing themes and trends and is being reviewed **Lead:** Director of Governance **Completed:** December 2016	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**		**4** **L2** **X** **S2**	**Positive assurance** • Significant Assurance – internal audit, lessons learned review, March 2016 • Positive feedback received from staff who attended the learning lessons workshops (May 2016) which included the training video of the Never Event retained vaginal swab • Positive feedback received from CQC that staff were aware of the Lessons Learned Bulletin and the safety brief and that work had been undertaken to improve learning from incidents including human factors training • Information about changes in practice now being included in the Board's Quality report related to complaints and Never Events/Serious Incidents • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days. • Training videos produced and PDSA cycle being introduced • Fewer Serious Incidents declared year-to-date • Improvements to structured case review for lessons learned with mortality and patient deaths • QIP for Lessons Learned still on track to deliver against milestones for March 2017 **Further assurance required** • New processes for dissemination of information strengthened during 2015/16. However, there is evidence that changes in practice are not always occurring across the Trust and further work needs to be put in place so that learning occurring in one part of the Trust is transferred to other areas. • 2 Never Events declared in 2016/17 • Recurrent themes in Serious Incidents – amber/green rating Lessons Learned QIP as a result

Q – High Quality Care												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q3	Director of Workforce and OD Workforce Transformation Committee	6 risks • Recruitment and retention of skilled/ sufficient nursing staff (2) • Recruitment are retention of skilled medical staff (4)	**Workforce** There is a risk that the Trust is unable to recruit to the numbers of staff required to deliver high quality and safe services	**20** **L5** **X** **S4**	• Overseas recruitment programme for nursing staff • 'Values' based recruitment now implemented in Trust recruitment process • Recruitment and retention premia for designated posts • Apprentice scheme • New roles in place – 27 Advanced Practitioner posts in a number of services to off-set shortages in junior doctors • Development of non-registered nursing staff • Innovative recruitment strategies, utilising social media and active advertising campaigns to attract skilled and experienced staff in place • Ward establishments review twice a year • New roles e.g. ward based A&C Personal Assistants, Ward Hygienists and Discharge Facilitators	• Working with Universities and Health Education England to develop new 2 year programmes for Advanced Practitioners and Physicians Associates **Lead:** S Nearney **Completion**:31.9.17	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**		**6** **L3** **X** **S2**	**Positive assurance** • Monthly nursing and midwifery staffing report to Board • Significant assurance – internal audit, Recruitment • Significant assurance – internal audit, Safe staffing levels, 2015/16 • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • Staff sickness levels below Trust target of 3.57% (October 2016), 0.33% below the target, and continues decrease in staff sickness rate • Mandatory training levels above Trust target of 88.1% (September 2016) 3.1% above the target • Staff turnover below Trust target of 9.2% (September 2016) 0.1% below the target • Staff FFT results showing continuous improvement over each quarter; quarterly analysis received November 2016 • People Strategy approved at May 2016 Trust Board • Senior Responsible Officer report and assurance received by the Trust Board November 2016 **Further assurance required** • Recruitment to high-rated risk areas

H – Honest, Caring and Accountable Culture												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H1	Chief Nurse Quality Committee	0 risks	**Patient Experience** There is a risk that patients receive and report a poor experience through complaints, PALS, Family and Friends Test and the National Patient Survey. The impact of this poor experience is loss of confidence and trust in the care provided for new and existing patients along with reputational damage for the Trust	**16** **L4** **X** **S4**	• Ward audit programme • FFT being used as improvement tool 'You said we did'. • Patient Council established • Complaint Policy • Inpatient survey top quartile for improvements in patient experience • Intentional Rounding in ED every 2 hours • Two hourly Board Rounds in ED, led by Emergency Physician in Charge • Monthly Health Group Performance reviews	• Response times to complaints. Further work needs to be undertaken to improve response times to complaints within 40 days **Lead** :HG Medical Directors Completed:30.11.16	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**		**8** **L2** **X** **S4**	**Positive assurance** • Quality Report to every Trust Board including lessons learned • Patient Stories presented at every Trust Board • The FFT report for September 2016 identifies • Average score of 4.75 • Trust information indicates 94.9% patients likely to recommend the Trust (2.1% unlikely to recommend) • ED information indicates 87.9% likely to return and 6.6% would not return • PHSO – Complaints about acute trusts 2014-15 identified Trust has a low conversion rate of 1.61 per 10,000 clinical episodes • 17% decrease in the number of complaints received when comparing 2015/16 to 2014/15 • No. of complaints responded to over 40 days improved in Q3 **Further assurance required** Health Groups are not meeting the Trust's standard of responding to complaints within 40 days – improvement seen in November 2016 of 78% of complaints closed within 40 days against target of 90% - need to continue improvement

H – Honest, Caring and Accountable Culture

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
H2	Chief Executive Cultural and Transformation Committee	0 risks	**Cultural Transformation** Staff do not continue to report an improvement in the Trust's culture (via the cultural survey and the national staff survey)	**25** **L5** **X** **S5**	• Professionalism and Cultural Transformation Committee • The Trust has implemented a Staff Advisory Liaison Service (SALS) where staff can report bullying incidents in a safe environment • FFT (staff) survey • Line Manager cultural briefing sessions • People Strategy which identifies 7 goals which will connect to individuals and service objectives • Health and Wellbeing Strategy 2016-18 launched	• Leadership programme to be launched **Lead** :L Vere **Completion**: 1.3.17 • PaCT Training V2 commenced **Lead** :M Purva **Completion**: 31.3.18 • Medical engagement programme in development – first session arranged 16 December 2016 **Lead** : K Philips **Completion:** to be updated following first engagement session • Values survey to be repeated in Jan 2017 **Lead** :L Vere **Completion**: 31.1.17	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**		8 L2 X S4	**Positive assurance** • Barrett Values survey (To be repeated in Jan 2017) • New values approved (April 2015 Board) • New Trust goals in place (April 2016) • Positive feedback from GMC and Deanery following Junior Doctors review • PaCT training undertaken by 6,500 staff • Remarkable People campaign has doubled nurse recruitment numbers on last year • Equality and Diversity Steering group established • BME staff network commenced in Sept 2016 • FFT survey completed by 1600 staff (Q2 2016/17). Overall engagement score improved to 3.9 (out of 5). This would place the Trust in the top 20% of Trusts nationally. • Q2 staff FFT results received by the Trust Board November 2016 – increase in engagement and staff recommending treatment at the Trust **Further assurance required** • Staff charges for catering and car parking are potential barriers to the identified risk. • Update on Medical engagement programme

G – Great Performance and Reliability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
G1	Chief Operating Officer Performance and Finance Committee	6 risks • Capacity in Radiology (2) • Ophthalmo -logy delays (3) • Medical outliers (1)	**NHS Constitution standards** There is a risk that the Trust will not improve on its current TDA Oversight Category – Single Oversight Framework rating of 3 (requires support)	**16** **L4** **X** **S4**	• Increased management support • Emergency Care Improvement Programme (ECIP) support • IST support from NHSI for RTT • Action plans for emergency care recovery including ED • Action plan for RTT recovery • Action plan for Cancer recovery • Agreed trajectories with NHSI • SAFER bundles agreed and implemented. • Urgent and Emergency Care Programme established	• RTT is not expected to deliver fully against trajectories • Trajectories are being updated with commissioners for 18 weeks - year-end position with commissioners will impact on this area • **Lead:** Chief Operating Officer **Completion**:31.03.17 It is possible that the risk rating will increase in Q4 as trajectories will not be met – need to understand if this impacts on SOF rating	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**		4 L2 X S2	**Positive assurance** • Operating plan approved at April 2016 Trust Board • Some improvement seen in Q3 ED performance due to changes in pathways and resources **Further assurance required** • Internal audit - Performance reporting/Management - April 2015 Significant assurance – corporate. Limited assurance – Health Group • Understanding impact of year-end financial agreement on trajectories • Internal Audit report identified limited assurance for medical staffing planned absence management (June 2015)

P – Partnership and integrated services												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
P1	Director of Strategy and Planning Trust Board	0 risks	**Sustainability Transformation Plan (STP)** There is a risk that the emerging plan will not be developed with sufficient Trust input and will herald changes to the provider sector that are either unrealistic or pose risks to the achievement of the Trust's long term goals	16	Ensuring meaningful engagement by Trust leaders in all STP development activities. Developing a close working relationship with the STP leadership team and providing support in the drafting of key STP documents and shaping the Acute Trust Provider Alliance CE0 now Chair and senior responsible officer for Hull and East Riding System Board	• Full understanding of activity and financial flows to support to support creation of new models of primary and community care • Impact of reconfiguration of urgent care services in North and North East Lincs. and sustainability of acute services at NLaG.	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**		**12** **L3** **X** **S4**	**Positive assurance** • Humber Coast and Vale STP document received by the Trust Board, as with all partner organisations, in December 2016 • Financial model for activity and income flows 2016 – 2021 built • Governance structure includes Trust in relevant membership . **Further assurance required** • Input and sign off of further iterations of the plan as they emerge. • Full impact of activity of the financial model across 5 years and between organisations.

F – Financial Sustainability													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F1	Chief Finance Officer Performance and Finance Committee	4 risks •Surgery, Medicine and Clinical Support Health Groups all have high-rated risks relating to CRES identification and delivery (3) •Surgery HG risk of CQUIN delivery and income (critical care discharges) (1)	**Financial Deficit** There is a risk that the Trust will not resolve the financial deficit	**25** **L5** **X** **S5**	• Financial plan agreed with NHSI • Robust performance management arrangements with Health Groups • Contingency reserve • Close monitoring of CQUIN schemes	• The Trust is not delivering the planned level of elective activity at the end of Q1 **Lead:** Operations Director Surgery **Completion**: Q2 • Agency spend on medical staff **Lead:** Medical Directors **Completion**: Q2 CRES programme and identification of further schemes **Lead**: Health Group triumvirates **Completion**: Ongoing	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**20** **L4** **X** **S5**		**10** **L2** **X** **S5**	**Positive assurance** • Forecast break even position (at month 5) • Delivery of the financial plan at the end of quarter 1, 2016/17 and securing the first quarter payment from the Sustainability and Transformation fund. **Further assurance required** • Closing the gap on the unidentified CRES • Health Group overspends • Agency spend by HGs • Winter costs • Under-trade against income plan • Delivery of STF targets

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F3	Chief Finance Officer Performance and Finance Committee	4 risks • Imaging equipment (2) • Ageing telephone system (1) • Decontamination equipment (1)	**Capital Programme** There is a risk that the capital programme is insufficient to meet all of the identified priorities and therefore has the potential to impact on the delivery of clinical services (both volume and quality of services).	**16** **L4** **X** **S4**	• Medical Equipment group meets regularly to prioritise programme for replacement • CRAC committee meets monthly and manages in-year emerging pressures • on the committee • Where clinical risk is deemed to be so significant arrangements are put in place by CRAC/EMC to provide service using alternative methods (e.g. IRT3 taken out of use)	Expenditure being managed within capital budget	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**			**8** **L2** **X** **S4**	**Positive assurance** • Monthly Performance and Finance Committee and updates to the Board • No incidents reported resulting in Serious Incident/RCA investigations. • Agreed plan in place for 2016/17 with Health group support. Risk assessment process built into our reporting structure. Capital committee to oversee this issue on monthly basis **Further assurance required**

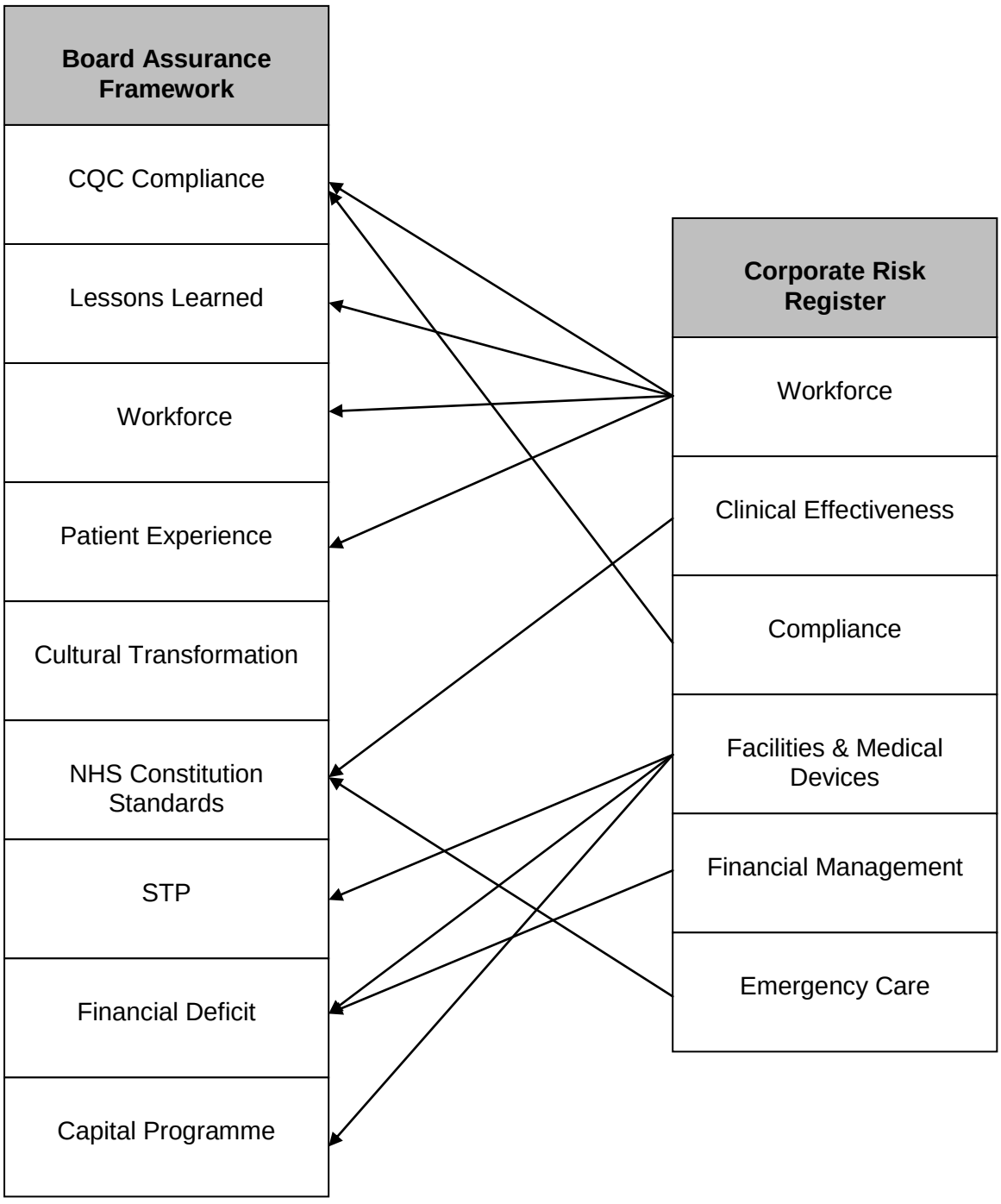
Appendix 2

Board Assurance Framework risks and Trust Board agendas

No	BAF Risk	Trust Board
Q1	CQC	Quality Report (April, May, July & September, October, November 2016) Integrated Performance Report (April, May, July & September, October, November 2016) Board Assurance Framework (April, July and October 2016) Chair Opening Remarks (April, November 2016) Portfolio Board Report (May 2016) Infection Prevention and Control Annual Report (September 2016)
Q2	Lessons Learned	Portfolio Board Report (May 2016) Quality Accounts (June 2016) Quality Report (April, May, July, September, October and November 2016)
Q3	Workforce	Nursing & Midwifery Report (April, May, July, September, October and November 2016) Equality Objectives 2016 – 20 (April 2016) Transforming HEY's Culture – Progress Report (May and November 2016) People Strategy Report (April 2016) Chief Executive's opening Remarks - Success at the Apprenticeship Awards, (April 2016) Chairman's opening remarks - Junior Doctors Strike (July 2016) Workforce Race Equality Standard 2016 Return (July 2016) Guardian of Safe Working Hours – Junior Doctors in Training (September 2016) Modern Slavery Statement (September 2016) Responsible Officer Report (October 2016) Agency spend (November 2016)
H1	Patient Experience	Patient Story (April 2016) Corporate performance report (April, May, July, September, October and November 2016) Quality Report (April, May, July, September, October and November 2016)
H2	Cultural Transformation	Cultural Transformation – Progress Report (September and November 2016)
G1	NHS Constitution	Integrated Performance Report (April, May, July, September, October and November2016) Emergency Department Report and Action Plan (April 2016) Operational and Financial Plan 2017/18, 2018/19 (December 2016) Winter Plan (November 2016)
P1	STP	Trust Strategy (April, May, July, September and November 2016) Sustainability and Transformation Plans (April, October and December 2016)
F1	Financial Deficit	Corporate Finance Report (April, May, July, September, October and November 2016) Annual Accounts 2015/16 (May 2016) Standing Orders/SFIs (September 2016) Capital Developments Update (September 2016) Charitable Funds Annual Accounts (November 2016)
F3	Capital Programme	

Appendix 3

Relationship between Board Assurance Framework and the Corporate Risk Register



Appendix B - Operational, Corporate Risk Registers and the Board Assurance Framework

Ward to Board Escalation

1. Operational Risk Register (ORR)
Formed of: ward, speciality, divisional, health group (HG) and corporate functions (CF) risks
Managed by Health Groups/Corporate Functions via DATIX

At the point an operational risk reaches a score of 15 or above (high-rated risk), or a HG/CF believes it is beyond their management and/or is a trustwide* risk, it is escalated* to Operational Quality Committee (OQC) OR Non Clinical Quality Committee (NCQC) for consideration for adding to the Corporate Risk Register.
*e.g non-compliance with a national patient safety alert
*either via HG escalation report or through Risk Team

2. Corporate Risk Register (CRR)
Managed by OQC and NCQC, who decide what is recommended for acceptance on to the CRR and severity ratings etc.
Risk Team will send CRR to OQC/NCQC in form of monthly report.
Updates from committee to Risk Team who will update corporate risk register onto DATIX

Corporate Risk Register recommendations from OQC and NCQC sent to EMC for read-across of risks. EMC to: accept a risk on the Corporate Risk Register, or refer risk back for local management, or refer risk back for further detail,

EMC to also consider each accepted Corporate Risk against the Board Assurance Framework (BAF) and determine whether any new Corporate Risk provides positive assurance or poses a risk to the achievement of the Trust's strategic goals. If so, the specific area of the BAF to be escalated to the Trust Board Quality Committee (for clinical goals) or to the Trust Board Performance and Finance Committee (for resource or performance goals) for review

Linked to BAF risks on DATIX

3. Board Assurance Framework (BAF)
Managed by Trust Board. The BAF describes the key risks to achieving the Trust's strategic goals, and the positive assurance received by the Trust Board as to how these goals are being achieved
BAF to show the ORR and CRR risks linked to each BAF as part of report. Trust Board receives regular updates on progress with BAF, which will include issues escalated by the Trust Board's Quality or Performance and Finance Committees
Deputy Director of Governance and Director of Corporate Affairs to meet regularly to review the ORR, CRR and BAF and report on significant shifts on

Notes on implementation
Need to add to DATIX for ORR and CRR – approval and escalation process, action plans, control measures, assurance on controls
Ward to Board escalation is shown. Board to Ward communication achieved through HG and Corporate Function representation at OQC (clinical risks), Non-clinical Quality Committee (non-clinical risks) and EMC
HG and Corporate Functions need to share any updates back through governance structures.
Existing Corporate Risk Register of 6 themes can still be used to 'group' together the types of risks within DATIX or can group these under the Trust's 7 strategic goals

HULL AND EAST YORKSHIRE HOSPTIALS NHS TRUST
FIT AND PROPER PERSONS

Trust Board date	Tuesday 4 April 2017	**Reference Number**	2017 – 4 - 17
Director	Carla Ramsay – Director of Corporate Affairs	**Author**	Rebecca Thompson – Assistant Trust Secretary
Reason for the report	To provide assurance that all Board members have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5: Fit and Proper Persons.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board to review and confirm there is assurance that: • that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons • that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W3 – Leadership and culture –** reflect vision and values and encourage openness					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Presented annually to the Trust Board for confirmation and assurance					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
FIT AND PROPER PERSONS

1. PURPOSE

To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.

2. BACKGROUND

In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non Executive Directors.

The Trust Board confirm compliance annually for all Board members and Trust Directors. In addition, arrangements are in place through the Disclosure and Barring Service to ensure that the Trust is informed of any subsequent issues that may be a cause of concern in relation to Board members.

3. PROCEDURE

At the end of every financial year all Board members and Trust Directors are asked to complete a declaration of interest form which includes the Fit and Proper Person declaration. The forms for 2016/17 were completed by Board members in March 2017. The Trust had appointed a new Chairman in April 2017 (Terry Moran), who had also completed a declaration. Any material issues included on the declarations are reviewed by the Chairman and/or Director of Corporate Affairs to determine if it is relevant to the individual remaining a Fit and Proper Person.

Any changes in, or conflicts of, declared interests are entered onto the declaration register held by the Director of Corporate Affairs and reported in the Trust's Annual Report as well as to the Trust Board in-year.

Appendix A details the March 2017 completed declarations by Board members and Trust Directors, for review by the Trust Board for assurance. Appendix B contains the Fit and Proper Person Assessment criteria, for reference.

4. RECOMMENDATION

The Trust Board to review and confirm there is assurance that:

- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Rebecca Thompson
Assistant Trust Secretary
March 2017

APPENDIX A

FIT AND PROPER PERSON DECLARATIONS FOR BOARD MEMBERS AND TRUST DIRECTORS COMPLETED MARCH 2017

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Mr Terry Moran	Chairman (from 1 April 2017)	✓	No	No
Mr Mike Ramsden	Chairman (to 31 March 2017)	✓	No	No
Mr Andy Snowden	Non Executive Director/Vice Chair	✓	No	No
Mrs Vanessa Walker	Non Executive Director	✓	No	No
Mrs Tracey Christmas	Non Executive Director	✓	No	No
Mr Martin Gore	Non Executive Director	✓	No	No
Mr Stuart Hall	Non Executive Director	✓	No	No
Prof. T Sheldon	Non Executive Director	✓	No	No
Mr Chris Long	Chief Executive Officer	✓	No	No
Mr Mike Wright	Chief Nurse	✓	No	No
Mr Kevin Phillips	Chief Medical Officer	✓	No	No
Mr Lee Bond	Chief Financial Officer	✓	No	No
Mrs Ellen Ryabov	Chief Operating Officer	✓	No	No
Ms Jacqueline Myers	Director of Strategy and Planning	✓	No	No
Mr Simon Nearney	Director of Workforce	✓	No	No
Mr Duncan Taylor	Director of Infrastructure and Development	✓	No	No
Ms Carla Ramsay	Director of Corporate Affairs	✓	No	No

There are no outstanding declarations due – all Board members and Trust Directors have completed the relevant disclosures

APPENDIX B

FIT AND PROPER PERSON DECLARATIONS

DETAIL OF WHAT DECLARATIONS MUST BE MADE

Disclosure	Y/N
Have you been convicted of a criminal offence in the UK or elsewhere?	
Do you consent to the Trust obtaining an automatic annual notification under the DBS?	
Are you on the Safeguarding (children and adults) barred list?	
Have you been prohibited from holding office under the Companies Act or the Charities Act?	
Do you have undischarged creditors?	
Do you have a debt relief order?	
Are you an undischarged bankrupt?	
Do you have a bankruptcy restriction order?	
Are there any reasons related to health that mean that you are unable to fulfil your role?	
Have you ever been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals?	
Do you have an outstanding referral to your professional body for an issue relating to a CQC regulated activity?	
Are there any other factors that you consider your employer should be aware of that could impact on the Fit and proper persons Test?	

HULL AND EAST YORKSHIRE HOSPTIALS NHS TRUST
FREEDOM TO SPEAK UP GUARDIAN – QUARTERLY REPORT

Trust Board date	Tuesday 4 April 2017	**Reference Number**	2017 – 4 – 18
Director	Carla Ramsay – Director of Corporate Affairs	**Author**	Carla Ramsay – Director of Corporate Affairs
Reason for the report	To provide the first quarterly update report on the Trust's Freedom to Speak Up Guardian role		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to: • receive and accept this report as a first report from the Freedom to Speak Up Guardian to outline the approach to the Freedom to Speak Up Guardian role • feed back on any specific issues contained in the report and for any future developments of this report and the Freedom to Speak Up Guardian role					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W3 – Leadership and culture –** reflect vision and values and encourage openness					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Freedom to Speak Up Guardian is required to report quarterly to the Trust Board. It is important that the Freedom to Speak Up Guardian reports directly to the Trust Board in order to reflect the requirements of the role.					

HULL AND EAST YORKSHIRE HOSPTIALS NHS TRUST
FREEDOM TO SPEAK UP GUARDIAN – QUARTERLY REPORT

1. PURPOSE

To provide the first quarterly report from the Trust's Freedom to Speak Guardian and to take feedback on the report and the issues raised.

2. BACKGROUND

One of the recommendations from Sir Robert Francis' *Freedom to Speak Up* review of the NHS, published in February 2015, was that each NHS Trust should appoint a Freedom to Speak Up Guardian (FTSUG). The role of the FTSUG is to work with Trust leadership teams to be part of creating a culture where staff are able to speak up, in order to protect patient safety and empower employees.

A National Guardian has also been appointed: Dr Henrietta Hughes was appointed as the National Guardian for the NHS in October 2016. As taken from the National Guardian's website: *Dr Hughes is a practising GP with over 20 years of experience across primary, secondary and community healthcare. She was previously the Medical Director for NHS England's North Central and East London region, providing system leadership across 12 clinical commissioning groups and 12 NHS trusts.*

The National Guardian's Office provides advice on the Freedom to Speak Up Guardian role and supports a Freedom to Speak Up Guardian network.

The key points for the Freedom to Speak Up Guardian role in each NHS Trust is to:

- Work with the Board to help create an open culture which is based on listening and learning and not blaming.
- Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely
- Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.
- Be able to act independently of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.
- Providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.
- Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.
- Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time

3. UPDATE TO THE TRUST BOARD

For Hull and East Yorkshire Hospitals NHS Trust, the Freedom to Speak Up Guardian role is part of the Director of Corporate Affairs job role. This reflects the more independent nature of the Director of Corporate Affairs role to be able to address issues directly to the Board.

Each Trust is advised to implement the FTSUG role in a way that best fits their organisation. As a result of the bullying culture that has been raised previously in this organisation and work to address this still continues, this organisation has already put in place a number of additional mechanisms and support to staff to raise concerns, informally and formally.

The Trust has a strong values statements of *Care, Honesty and Accountability* linked to the Trust's vision of *Great Staff, Great Care, Great Future*. The role and feedback from the FTSUG should therefore link to the Trust's vision and values.

The Director of Corporate Affairs therefore proposes that the FTSUG is a 'value-added' role in this organisation, with a particular emphasis on helping to understand and feed back to the Board more about the 'noise' in the system, and the feel of staff culture, as a number of quantitative measures on staff culture and staff reporting already exist. Another element of this role is to be able to 'read across' these quantitative data against informal feedback to understand if there are any emerging messages on issues relating to staff behaviour and being able to raise concerns that are not being addressed within the organisation. The role is also to signpost staff to be able to raise concerns within the organisation and feed back if it does not appear a concern is being addressed seriously or the individual being dealt with fairly. The approach is not to act on anecdote but be part a reflective process at the Trust Board to understand what staff are saying, or feel they are not able to say, in the organisation.

Against the bullet point requirements of the role above, since being appointed the Director of Corporate Affairs has:

- Attended the national Freedom to Speak Up Guardians Conference and network meeting
- Attended a briefing and practice-sharing session facilitated by NHS Audit (Yorkshire)
- Prepared briefing materials on the ways in which staff can raise concerns and information on the FTSUG , as part of a Trust-wide campaign on Speaking Up, which is being put together following the most recent results from the staff survey
- Set up and started quarterly discussions with key members of Trust staff to understand the 'noise' in the organisation
- Linked in with the working group on the national Staff Survey, to include the FTSUG role in the action plan implementation as appropriate, and also as a source of intelligence about current issues in the organisation about feeling able to speak up and raise concerns
- Become a member of the Trust's Diversity and Inclusion Steering Group, which seeks to bring about fair and equal treatment for all members of staff, particularly those sharing a protected characteristic (who are often more reluctant to raise concerns and are often detrimentally a result of doing so)
- Linked in with the Patient Experience and Quality teams for quantitative data on staff concerns (raised through the Staff Advice and Liaison Service), patient complaints and incident reporting, to undertake a 'read across' of issues in future quarter reports to the Trust Board
- Worked with the Human Resources team to become the keeper of the Trust's file of completed whistleblowing investigations. This is to ensure the files are kept securely and independently of the areas in which they are raised to protect the sensitivity of the issues and the protections afforded to whistleblowers under legislation, and also to be part of the 'read across' of issues in the organisation

The National FTSUG office recommends that the Trust Board is also updated on any particular cases that the Trust's FTSUG has advised on/signposted. To date, the

FTSUG has received contact from one individual (a Consultant) on concerns they have in respect of a system being implemented by the Trust and the way in which their concerns have been addressed to date. The FTSUG has worked with the Chief Medical Officer to understand if these are new or existing issues and taken advice as to how this individual's concerns can be addressed, which is being fed back.

From a practical point of view, as an example of the communications that the FTSUG has been working on, and as an aide memoire to the Trust Board members, a key issue is reminders to staff of the routes through which they can raise concerns. This also links with the FTSUG role on developing an organisational culture that positively encourages and supports speaking up, part of which is supported by making speaking up as accessible as possible.

These routes to speak up have been put together on one page. This is attached at Appendix A. This will be put in to a more eye-catching format and be part of a communications campaign on Speaking Up across the organisation.

Future FTSUG reports will link in with other strands of work in the organisation on cultural and workforce development, as part of a deeper approach to organisational change around behaviours.

4. RECOMMENDATION

The Trust Board is asked to:

- receive and accept this report as a first report from the Freedom to Speak Up Guardian to outline the approach to the Freedom to Speak Up Guardian role
- feed back on any specific issues contained in the report and for any future developments of this report and the Freedom to Speak Up Guardian role

Carla Ramsay
Director of Corporate Affairs
March 2017

HOW TO RAISE CONCERNS

If you are concerned about patient safety or staff welfare at the Trust, there are a number of places you can turn to

Speak up at any time
At any time, if you are concerned about patient safety or staff welfare in the Trust, you can contact any of the following:

- Your line manager or member of your management team
- Your staff side/union representatives
- The Human Resources team
- Occupational Health
- The Trust's Freedom to Speak Up Guardian
- Your PaCT Ambassador
- The Staff Advice Liaison Service (SALS)
- The Chaplains' team

SALS – Staff Advice and Liaison Service
SALS is a confidential advice line for staff experiencing bullying in the workplace.

If you have any queries about poor behaviours and bullying this should be your first port of call. Whether you want to get things off your chest or you need advice on what actions you can take to make work life better, please contact the Staff Advice Liaison Service on CHH ext. 4317 or email SALS.Team@hey.nhs.uk

Occupational Health
The Occupational Health service can help you if you are feeling anxious or stressed about work-related issues. It is a confidential service, and you can self-refer at any time. If a situation in your team is having a detrimental effect on you, please consider speaking to a member of the Occupational Health team about it. Contact details are available on the intranet.

Human Resources Team
The Trust's Human Resources team is there to advise you when you are feeling concerned. You can contact your Human Resources Business Partner or member of your HR team for advice at any time.

Contact details are available on the intranet.

Chaplains' Team
The Trust's Chaplaincy team is available to staff and patients to support their welfare. A list of local chaplains and contact details can be found on the intranet.

Union Representatives
The Trust has good working relationships with trades unions; if you are a member of a union and have a concern about your workplace, you can contact your local Union representative for advice.

A full list of local union representatives can be found on the staff intranet, under Trade Union Contacts

Through the Raising Concerns at Work (Whistleblowing) Policy
The policy is available from the staff intranet. The first page is a useful flowchart for how to raise concerns under this policy.

It is a way of raising concerns about dangerous or illegal activity in the Trust. There are legal protections built in to whistleblowing to encourage staff to speak up without repercussions on their employment.

Your PaCT Ambassador
The Professionalism and Cultural Transformation (PaCT) Ambassadors act as first responders for any team member who has concerns about the behaviour of colleagues. They are able to signpost colleagues to the relevant reporting and support services, including SALS, Occupational Health, HR etc.

A list of PaCT Ambassadors is available on the intranet under Professional and Cultural Transformation. Dr Purva is Cultural Ambassador for the Trust, and can help individuals look at team behaviours and dynamics.

Freedom to Speak Up Guardian
All Trusts have a Freedom to Speak Up Guardian. For our organisation, it is Carla Ramsay, Director of Corporate Affairs on HRI ext. 4920 or carla.ramsay@hey.nhs.uk

The Freedom to Speak Up Guardian is a senior manager who staff can turn to and discuss issues in the workplace if they are concerned about patient safety or staff welfare. The Freedom to Speak Up Guardian has a key role in helping to raise the profile of raising concerns in the Trust and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. The Freedom to Speak Up Guardian does not get involved in investigations or complaints, but helps give advice where needed, and has a role to ensure organisational policies are followed correctly.

Incident report – you should always report on Datix any incident concerning patient or staff safety in the normal way, via the intranet

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE

Meeting Date:	27 March 2017	**Chair:**	S Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Workplan – The Committee discussed how assurance would be received regarding Health Group Cash Releasing Efficiency Schemes
- Mr Bond updated the Committee regarding the Trust's Financial Plan
- Performance – ED performance was improving. Extra triage staffing was in place and working well
- RTT – performance 85.55% against a target of 92%. List size had increased.
- 52 week waits – 6 patients with incorrect clock stops
- Cancer performance – remains challenging – ICU capacity and diagnostic waiting times being the main concerns
- Finance – At month 11 the Trust was reporting a deficit of £2m which was in line with the plan.
- CRES – Month 11 showed a £4.3m shortfall against the plan of £17.3m
- Agency Report – Agency spend at month 11 was £12m
- Financial Improvement Planning – Executive Directors meeting with external company for the initial presentation of the programme
- Mr Bond updated the Committee regarding the Trust's capital planning

Decisions made by the Committee:

- Review of 52 week waiters – Analysis of the type of patients and any themes or trends emerging.
- Formal CRES escalation process to be developed

Key Information Points to the Board:

- The Trust is working through issues relating to IR35 and Personal Service Contracts, the legislation for which changes on 6th April 2017.

Matters escalated to the Board for action:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	27 March 2017	**Chair:**	A Snowden	**Quorate (Y/N)**	

Key issues discussed:

- Workplan - themed in line with Trust Strategy quality elements
- The vision for Quality Governance presentation – To bring together quality initiatives and patient experience
- Quality Improvement Programme
  - How incidents are reported to NRLS
  - Nutrition - Record keeping
  - VTE – Trust compliant – sustaining the 95% score
- Operational Quality Committee – Naso gastric tubes Never Event and subsequent roll out of training programme was discussed
- Integrated Performance Report – Assurance given around C-Section rates
- Update from Healthcare Delivery Improvement Group – Dr Purva updated the committee regarding the WHO Checklist roll out and clinical engagement
- Major Trauma Report – Good practice and areas to improve were discussed

Decisions made by the Committee:

- Member of the dietetics team to attend a committee meeting to discuss nutrition
- Lessons learned newsletter to be added as a monthly agenda item
- WHO Checklist – New checklists and feedback report to be received

Key Information Points to the Board:

- Major Trauma Report – Trust response and follow up actions to be discussed at the Quality Committee – The Board to be aware of how the Trust had improved and the further work required.

Matters escalated to the Board for action: