HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 1 AUGUST 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS

1. Apologies	verbal	Chair – Terry Moran
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 – Terry Moran
3. Minutes of the Meeting of the 4 July 2017	attached	Chair – Terry Moran
4. Matters Arising		
4.1 Action Tracker	attached	Director of Corporate Affairs - Carla Ramsay
4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
4.3 Board Reporting Framework 2017-18	attached	Director of Corporate Affairs – Carla Ramsay
5. Chair's Opening Remarks	verbal	Chair – Terry Moran
6. Chief Executive's Briefing	attached	Chief Executive Officer – Chris Long

QUALITY

7. Patient Story	verbal	Chief Medical Officer – Kevin Phillips
8. Quality Report	attached	Chief Nurse – Mike Wright
9. Nursing and Midwifery Staffing Report	attached	Chief Nurse - Mike Wright
10. Fundamental Standards Report	attached	Chief Nurse – Mike Wright
11. Quality Committee minutes and summary report	attached	Quality Chair – Trevor Sheldon

PERFORMANCE

12. Performance and Finance Report	attached	Chief Operating Officer – Ellen Ryabov, Chief Financial Officer – Lee Bond
13. Performance & Finance minutes and summary report	attached	Performance & Finance Chair – Stuart Hall

STRATEGY & DEVELOPMENT

14. Change of Organisational Name	attached	Chief Executive Officer – Chris Long

ASSURANCE & GOVERNANCE

15. Freedom to Speak Up Report	attached	Director of Corporate Affairs – Carla Ramsay
16. Guardian of Safe Working Report	attached	Chief Medical Officer – Kevin Phillips
17. Board Assurance Framework	attached	Director of Corporate Affairs – Carla Ramsay
18. Any Other Business	verbal	Chair – Terry Moran
19. Questions from members of the public	verbal	Chair – Terry Moran

20. **Date & Time of the next meeting:**
Tuesday 5 September 2017, 2 – 5pm
The Boardroom, Hull Royal Infirmary

Attendance 2017/18

	4/4	2/5	25/5 Extra	6/6	4/7	1/8	5/9	3/10	7/11	5/12	Total
T Moran	✓	✓	✓	x	✓						4/5
C Long	✓	✓	✓	✓	x						4/5
L Bond	✓	✓	✓	✓	x						4/5
A Snowden	✓	✓	✓	✓	✓						5/5
M Gore	✓	✓	✓	✓	✓						5/5
S Hall	✓	✓	✓	✓	✓						5/5
M Wright	✓	✓	✓	✓	✓						5/5
K Phillips	✓	✓	✓	✓	✓						5/5
T Sheldon	x	✓	✓	x	✓						3/5
V Walker	✓	✓	✓	✓	✓						5/5
T Christmas	✓	✓	✓	✓	✓						5/5
E Ryabov	✓	✓	✓	✓	x						4/5
In Attendance											
J Myers	✓	✓	✓	✓	✓						5/5
S Nearney	✓	✓	x	✓	✓						4/5
C Ramsay	✓	✓	✓	✓	✓						5/5

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 4 JULY 2017
THE LECTURE THEATRE, CASTLE HILL HOSPITAL

PRESENT	Mr T Moran CB	Chairman
	Mr A Snowden	Vice Chair/Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr K Phillips	Chief Medical Officer
	Mr S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director (until end item 7)
	Mr M Wright	Chief Nurse
	Prof. T Sheldon	Non-Executive Director (until end item 13)
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms J Myers	Director of Strategy & Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance (for Mr Bond)
	Ms M Kemp	Operations Director Family and Women's Health Group (for Mrs Ryabov)
	Mr M Simpson	Clinical Director Emergency Medicine (until end of item 11.1)
	Ms H Hudson	Senior Matron Emergency Medicine (until end of item 11.1)
	Ms R Joyce	HEY Improvement Programme Director (until end of item 11.1)

NO. ITEM **ACTION**

1. APOLOGIES

There were apologies received from Mr L Bond – Chief Financial Officer, Mr C Long – Chief Executive Officer and Mrs E Ryabov – Chief Operating Officer.

2. DECLARATIONS OF INTERESTS

2.1 - CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING

There were no changes to declarations received.

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

There were no declarations received.

3. MINUTES OF THE MEETING HELD 6 JUNE 2017

Amendment to paragraph 2 of item 13 as follows (amendment in italics):
The 62-day treatment standard had *seen 34 breaches in April 2017*.

Amendment to paragraph 3 of item 16 as follows (amendment in italics):
Mr Phillips added that a number of patients would *not* use text messaging so other forms of paperless communications *were being* pursued.

The minutes of the meeting held on 6 June 2017 were approved as an accurate record of the meeting pending these amendments.

4. MATTERS ARISING

4.1 Action Tracker

The two items for July 2017 appeared on the relevant Trust Board agendas and can be closed.

4.2 Any Other Matters Arising From The Minutes

None.

4.3 Board Reporting Framework

There is one amendment previously agreed, which was confirmation that the Nursing Strategy that appears on the reporting framework is a Hull and East Yorkshire health economy Nursing Strategy and therefore will be monitored through another forum; accordingly, this item can be removed from this framework.

Ms Myers also noted that she would work with Ms Ramsay on the timings of the strategy update, pending the update on today's agenda.

Resolved:

The Board Reporting Framework was received and accepted, with the amendment from Mr Wright agreed.

5. CHAIR'S OPENING REMARKS

Mr Moran expressed on behalf of the Trust Board his sympathies for the tragic events at Grenfell Tower. He updated the Board that the Trust has been working with NHS Improvement to arrange an inspection of the Hull Royal Infirmary tower block building from the local Fire and Rescue service and for a sample of building materials to be tested. The results show that the material used on the Trust's tower block is not aluminium cladding material, therefore the Trust's tower block cladding is not the same as the cladding at Grenfell Tower. No further action is required at this stage. However, the Trust will continue to carry out fire safety checks across the Trust's buildings in line with a request from central government and reinforce fire safety messages to Trust staff. The Trust takes fire safety extremely seriously and the Trust will continue to take the necessary steps for the safety of its buildings.

Mr Moran also briefed the Trust Board on the opportunity he and other members of the Board had at lunchtime today, to attend the opening of the Trust's new Dementia Garden at Castle Hill Hospital. The Chairman commended the staff and patients involved in working with a local company to bring about a change that will be of great benefit to our patients, and the Chairman felt privileged to be present and part of the opening ceremony today.

The agenda was taken out of order at this point

11.1 A&E Presentation

Mr Simpson, Ms Hudson and Ms Joyce presented a summary of a two year journey of development in the Emergency Department. The starting position was a department that had outgrown its facilities against the number of patients using the department on a daily basis. There was crowding in the department and the number of patients waiting in corridors in old emergency department had grown over the last five years, reaching

a maximum of 22-24 patients maximum per day beyond the capacity of the old department. It was a challenging environment in which to deliver timely and safe care.

On a daily basis, the number of patients going through the system in four hours was incredibly varied – this, with the volume of patients, was a cause for concern. The Trust had had a number of teams coming in to give advice and the Trust pulled all the recommendations together in to one programme of work, which consisted of five projects with an enabling work-stream and a data sub-group. It was a whole-hospital programme with clear plans and senior leadership in all project, and measures for improvement. The programme worked towards its plans for several months but it was not seeing the required improvement; what was recognised was that staff did not have ownership to make changes and make them work.

In October 2016 the ED team put in an improvement approach to change the culture and get buy in from front-line teams, who were feeling pressured and were demoralised. By taking a quality improvement approach, the programme increased communication with staff, increased engagement with staff from different groups and grades in the department, and used three coaching questions to identify problems and be focussed on putting solutions in place. This approach enabled a new approach, rather than making assumptions about problems. The approach was to agree and implement a solution to each problem raised by the team. The team used the *Plan Do Study Act* (PDSA) methodology to try all the changes that the team thought would work. The focus was moved to what staff cared about, and to give staff a safe environment to try out changes and see what worked, with permission to an idea to 'fail'. This approach put time in to the teams; it took staff out of department in winter to give them time and space to think; 40 staff-lead improvement projects were put in place.

A key point of learning in this improvement project was to keep the team focussed on what they could do, rather than what they were not able to change. A number of ideas were tried that are still in place now, including patient allocation, real-time scanning, the transfer nurse role, improvements to the store cupboard, a training needs analysis and other ideas. The projects lead to improvements in performance and quality of care; praise for projects was shared in the staff newsletter.

Initial Assessment also needed attention, including ambulance handovers. A roaming receptionist role was trialled but did not make the anticipated difference; as an example of giving staff space to try new ideas, this idea did not lead to the required improvement, so the team were asked to try out new ideas instead. These included leadership development for the Band 6 staff, and working differently in Resuscitation, and these new ideas have made improvements.

Staff feedback was taken up through this time. A confidential Survey Monkey was sent out and staff feedback has been excellent. The Department moved its engagement score from 3.06 to 3.88 – this is above the Trust score of 3.77 and the national average of 3.81.

Following the presentation, the ED team was asked what they felt the key

achievements were from the improvement programme. The team identified that, for ED, it needed the whole health care system to respond and the better patient flows out of hospital have resulted from this. The improvement in patient care and satisfaction in ED have been quantifiable achievements, with fewer complaints compared with previous years and an improved score from patients with external surveys.

A key point of learning was the ED performance became the responsibility of the Trust, rather than just the department, which enabled Trust-wide support to solutions. The support of the health economy also improved patient flow. An ambition is to be a centre of training excellence, to train and retain the department's own staff and have more robust succession planning, and be part of sharing practice nationally. Overall, the culture change to a can-do culture has been one of the most significant achievements.

Professor Sheldon noted the whole-system approach as a point of learning, as to how this has supported improvement. He asked how the Department will be able to sustain the improvement, and also asked how sensitive performance in the Department is to the number of patients attending. Mr Snowden noted that this is an excellent improvement story; Mr Snowden also noted it as an example of using data effectively – at the recent NHS Confederation conference, Mr Simpson gave a presentation talk on how to use IT and data, which was well received and using ED as an example made it come alive. Mr Snowden asked how the Trust can harness lessons longer term from this.

Ms Joyce responded that the same improvement methodology is being used across the Trust in other teams, such as the Frailty Team. The same methodology is being used in theatres at Castle Hill Hospital and in the ward improvement programme. The HEY Improvement Team is able to train staff to use the methodology and instigate improvement in their own areas.

Ms Hudson noted a key point of learning was to give staff freedom to define what they thought the problems were, and to try out solutions. Mr Moran noted the value given to people for their ideas throughout this process, irrespective of any hierarchy. Ms Joyce noted this as a key aspect of success, together with giving people time away from their busy roles and role modelling as leaders to give support to improvement and permission to raise an idea, and to try it out.

The ED team noted that the Trust has been approached by other ED teams to learn from their approach. Mr Simpson sounded a note of caution on this point; the ED department and the Trust are still on a journey of improvement and learning how performance can be sustained. Mr Moran hoped that the Trust's staff internally looked to the ED example as a way of supporting staff to make improvement; it would be a strong message back to the Trust for colleagues to take the same approach, particularly as it has been demonstrated to work during a time of greatest operational pressure and national scrutiny on performance.

Mr Simpson, Ms Hudson and Ms Joyce were thanked for their time and attendance at the Trust Board meeting today.

Mr Simpson, Ms Hudson and Ms Joyce left the meeting at this stage

The agenda resumed its order at this point

6. CHIEF EXECUTIVE'S BRIEFING

Mr Wright presented this report on behalf of the Chief Executive. He drew attention to the Trust's Major Incident exercise event on 24 June 2017, in which a number of partner organisations took part. The Trust has taken a number of learning points from the exercise, none of which would impinge on the Trust's ability to respond to a major incident, which is positive assurance. Mr Wright also noted from the report that the Tower Block is 50 years old and has been a chance to reflect on what the hospital means for staff and to patients. Professor Sheldon gave his congratulations for the Trust's recognition as a Centre of Excellence for orthopaedics and hopes that greater research opportunities for the Trust will attract Consultants, Professor Sheldon also suggested the Trust look at its current position and contribution to national research studies as a way of increasing the Trust's profile and access to research funding, and also that the Trust may wish to speak with the University of York as one of the two national orthopaedic centres of research.

Mr Wright also highlighted the successful 'Golden Hearts' staff awards event that took place in June 2017; he also noted how many 'Moments of Magic' there are in each Chief Executive report and the details of each case, as to how caring and how willing staff are to go above and beyond their job roles on a daily basis.

Resolved:
To receive and accept the Chief Executive's briefing to the Trust Board.

7. PATIENT STORY

Mr Phillips outlined two patient stories; one where the Trust's lift provision in the tower block was a particular issue for a patient, and a letter of thanks from a patient from a residential home, who was particularly grateful to staff in the Emergency Department and on the stroke ward for the excellent care they provided.

Mr Wright responded to the patient's story with the lifts, which is a long-standing issue for the Trust with no immediate solutions. Mr Moran noted the impact that an issue, such as the lifts, will have on patients and staff. How such issues are handled as they occur is key to patients and to staff; it also brings up a question about long-term planning for a solution.

Resolved:
The Trust Board received the patient stories as a means of focusing the meeting on patient care.

Mr Gore left the meeting at this point

8. QUALITY REPORT

Mr Wright drew the Trust Board's attention to some specific issues. Firstly, the number of Serious Incidents declared in the last month was six, including three from the same area, which is Urology. This is being reviewed at present and further information will follow when the investigations are completed. The Trust is slightly high on its figure for 72-

hour *c. difficile* infections; this is being kept on a watching brief as there are high levels of *c difficile* in the community and some other organisations in the health economy exceeded their *c. difficile* thresholds last year. The Trust has a good record on antibiotic stewardship and this issue may not bear out. Mr Wright drew attention to the Trust's position on complaints, which is now expressed as a number of complaints per number of episodes of care. The Trust has received fewer complaints than last year and has seen improvement on the number of complaints not completed within 40 days, which is an issue Mr Wright is paying particular attention at present.

Mr Wright updated the Trust Board on the pilot CQC inspection on the well-lead domain. It is positive that the Trust was asked to participate in the pilot and there was useful learning for both the Trust and the CQC from the process. A particular line of enquiry during the pilot was on mortality, including weekend mortality figures, and the Trust's process to learn from patient deaths. The Trust's figures are showing an annual trend of increased deaths during winter; there is no a significant difference in the Trust in mortality figures at the weekend compared with weekdays.

Mrs Walker asked whether the three serious incidents in Urology will have any impact on cancer targets. Mr Wright was not aware of any immediate issues with this will report back on any specific impact. He confirmed that for the circumstances of these serious incidents, the Trust has applied the Duty of Candour and the patients have been involved throughout.

In relation to the issue of infection rates, Mr Hall asked if previous infection control issues are flagged on Lorenzo – Mr Wright confirmed this can be flagged where a patient has treated for an infection prevention or control issue in the past, such as decolonisation treatment. The use of this flag is being reinforced, which appears to be having a positive effect. Mr Phillips confirmed that Lorenzo is able to be used in more ways than the previous patient administration system and there is perhaps a lesson to take back around staff education on using flags as being there to help staff care better for their patients.

Professor Sheldon noted the mortality figures, which have been discussed in more detail at the recent Quality Committee; the Quality Committee will also receive a more detailed briefing on the Trust's approach to learning from patient deaths against national guidance and will bring a summary to the Trust Board in due course.

Mr Moran recognised that there are expected peaks at this time of year but noted that the Trust's mortality figures are currently higher than peer group, and would expect more detailed understanding if the Trust remains above its peer group. Mr Phillips confirmed that the Trust has a Mortality Committee that meets monthly, which considers the Trust's position against benchmarking data and 'excess' deaths. The Committee also has a focus on learning from avoidable deaths through the Trust's new mortality review process.

Resolved:
The Trust Board resolved to receive and accept the report as a source of information and assurance.

9. **NURSING AND MIDWIFERY STAFFING REPORT**

Mr Wright drew the Board's attention to the current nursing numbers. He further noted the Trust is still on track to take 145 newly-qualified nurses from the September cohort of graduating nurses. The Trust continues to have twice-daily safety briefing to ensure all wards have minimum safe staffing levels every day. The Trust is working with the University of Hull to see if the Trust can take an additional 50 students by providing training placements. Mr Wright confirmed that red flags on staffing are now able to be used now that full e-rostering is in place and each red flag is discussed at the twice-daily safety brief. The largest number of red flags so far relates to needing enhanced care – this is where a ward is running at safe staffing numbers but additional support needs are required on that particular day, such as patients needing increased observations and or to help with managing challenging behaviours. A new team to assist with enhanced care is being recruited to.

Mr Wright confirmed that his key concern at present is the number of nursing staff employed now and in the future. The nursing numbers eligible to retire at age 55 will be an issue for the Trust for next 7 years. Whilst the Trust does manage the situation as robustly as it can, it remains his largest concern. Mr Wright also looks at the reasons why staff are leaving at present, and mostly they are for personal reasons such as retirement, and career advancement. Mr Wright will include this in future reports if data become available.

Resolved

The Trust Board received and accepted this report.

10. QUALITY COMMITTEE MINUTES AND SUMMARY REPORT

Professor Sheldon presented this agenda item. He raised one point of escalation for the Board's awareness, which is a discussion at a future Quality Committee on diagnostics and the impact on patients. The Trust is struggling with diagnostic capacity and the Quality Committee are concerned about the effect diagnostics have on speed of treatment and quality of care. Mr Phillips noted that this is one of his key concerns at present; diagnostic capacity is a workstream in the local STP and there has been a meeting with neighbouring Trusts to see if diagnostics can be look at as a resource across the local health economy. Mr Moran noted that he can raise this issue at his meetings with Chairs from other Trusts.

Ms Ramsay confirmed that this issue is being looked at across the Board's Committee and is now included on the Board Development Framework for a strategic discussion on the issue.

On a separate point, Mr Snowden raised that the list of those present at the Quality Committee held 31 May 2017 will be amended in the final version of the minutes, which will come to the next Board meeting.

11. PERFORMANCE REPORT

Ms Kemp presented this report, which was taken as read. The Trust has not delivered the full suite of national targets in the last month. The Trust did not deliver against the national target or local trajectory on six-week waits for diagnostics. This is a specific area of concern for the Trust, as reflected in the earlier discussion. It is important to keep in perspective that a high percentage of patients are being tested in time but the Trust is

keeping a particular focus on this area.

The RTT trajectory for May 2017 was met, and will just be met for June 2017. There were zero 52-week breaches for May 2017 and the Trust is validating a small number of cases for June 2017 – each confirmed case will have a root cause analysis undertaken.

As noted earlier, performance in ED is strong against the required standard; the Trust was over the 90% trajectory in May and June 2017. There have been some challenging days and some days with over 100 admissions; the Trust's position was 91.54% going in to July.

In relation to cancer targets, the main area of concern is the 62-day standard: the Trust has a local trajectory of 80%, and the Trust achieved 75.7% in April 2017. The current position is a little worse at 72.7% against a trajectory of 80%. The Trust has a Cancer Operational Group in place – this is a clinically lead group to understand issues in each pathway and per tumour site, to agree actions to make improvements. At the Trust's weekly performance meetings, there is a focus on each potential 52-week breach, and this same standard at individual patient level is being applied to 62-day cancer pathways and finding where issues can be expedited. As an example of this process, 220 patient cases were run through at last Friday's meeting and the two prevalent issues are diagnostic waiting times and waiting for histology results. As a result, the Trust is not able to report an imminent improvement in cancer 62-day as result.

Mr Hall stated that the Performance and Finance Committee received a detailed presentation from Dr Tony Goldstone and Dr Oliver Byass to understand the detailed position on diagnostics. His understanding from the presentation and discussion is that the Trust is "sweating" its assets for diagnostics and the Trust does not over-order diagnostics. The Trust is seeing consequences for its equipment from this usage. Whilst a bid for national funding has been submitted, which was re-worked for revenue rather than capital, the outcome of the bid is not expected until the end of July.

Mr Moran commented that there is no easy fix to this situation; the Trust is using its resource as best it can and this remains a concern for him, not helped by responses by external colleagues. He will speak with Mr Long to see if anything can be expedited.

In relation to the performance report, Mrs Walker stated that she has raised cancer targets for the past four months and asked if there is a gap in grip that the Trust needs to fill, and asked for assurance on grip and certainty on resource.

Mr Phillips confirmed that the Trust has responsibility for the pathway to meet the 31-day standard, and has the ability to control delivery in 31 days. The 62-day target is one that is affected by pressures from the wider health economy and local Chairmen, Chief Executives and Trusts can work together better. Mr Moran stated he wished to understand how this support could be given where possible in dialogue with other organisations. In addition, Mr Wright stated that the Trust has grip on the issue – the Trust has maximised its assets to deliver as much capacity and treatment as possible but there is a shortage of capacity in the health

economy and lack of opportunity to get in short-term capacity to meet all needs, such as availability and cost of scan vans – the gap in this issue is solutions rather than grip on the situation.

Ms Myers outlined the wider strategic context of this issue – nationally there are campaigns and larger screening programmes, which will identify increasing numbers of patients for referral and treatment. The focus in the healthcare system locally and nationally has been on four-hour ED target and 62-day cancer is starting to get a focus now, in the context of a national target that has not been met for six years.

Mr Moran noted the need to have a more detailed understanding of this issue and whether we can approach the problem in the same sort of ways as ED. He asked for the Board to schedule this discussion including what the potential solutions would be, what can the Trust do and where the Board can have impact. Given the national context, the Trust should serve its patients in the best way possible, and feels that this is an important risk area that requires more focus. Ms Kemp gave assurance that Mrs Ryabov has implemented a number of measures to significantly increase focus and visibility for each patient wait, including weekly focus on each patient the weekly performance meetings as highlighted previously. **CR**

Mr Evans presented the finance section of the report. He highlighted the Trust's position of a reported deficit position at the end of month 2 of £6.3 m, which is £1.8m over the planned deficit position. The additional deficit over plan is undelivered CRES (£157m, offset in part by £0.44m release of reserves) and Health Group overspends totalling £0.65m. There was also an income shortfall of £0.25m. Mr Evans spoke to the specific areas of overspend, as detailed in the report. Mr Evans also reported that the Trust has particularly cash problems and is on hold with some suppliers. Local Clinical Commissioning Groups have agreed to pay their income to the Trust in tenths rather than twelfths – this will take off some pressure during the year.

Mr Hall highlighted the cost pressures above plan from Health Groups as a major concern. On the question of CRES, Mr Evans stated that there has been a reduction in unidentified CRES but this risk still remains. Mr Hall also noted significant concern on the cash position.

Resolved:
To receive and accept the Performance report.

12. PERFORMANCE AND FINANCE MINUTES AND SUMMARY REPORT

Mr Hall confirmed he had raised the relevant points from the Committee during the discussion on the Performance report.

13. REVISED FINANCIAL PLAN INCLUDING FIP2

Mr Evans confirmed to the Board that the Trust has now agreed a control total with NHS Improvement (NHSI). Following the month 2 figures, the Trust had additional discussions with NHSI on being able to submit an updated financial plan by the end of June, which the Trust undertook. Whilst there is a large element of risk on financial plan in relation meeting the required deficit figure, the previous lack of agreement of a control total raised additional risks to the organisation. With an agreed control total, the Trust is now eligible to receive £11.9m STF funding. The large risks are

particularly in relation to the CRES programme delivery and managing costs.

Mr Moran noted that the Trust Board did delegate the action at the April 2017 meeting to agree a control total if possible, which has now been done.

Mr Evans stated that he is starting to see some traction with CRES projects; by the end of July there will be a more detailed position on meeting CRES for the rest of the year; by this stage, the team will have put in place enhanced governance processes for CRES delivery and monitoring, and there are now CRES accountability and delivery meetings weekly.

Resolved:
To receive and accept the changes that have been made to the financial plan and support the actions being taken to deliver the financial plan, and to recognise the level of risk inherent in the financial plan.

Professor Sheldon left the meeting at this stage

14. TRUST IMPLEMENTATION STRATEGY UPDATE

Mrs Myers presented this report, which outlines one year on where each Trust strategy is up to. Mrs Myers confirmed the milestones and progress against strategies is monitored 6 monthly by EMC and subject to annual review by the Trust Board.

Mrs Myers noted in relation to cancer waiting time standards and RTT that the Trust expected to be further forward a year ago and the Trust now has new trajectories. There are some areas from the strategy that needed to be tightened up and some clarified further, such as the health prevention initiatives cited, contribution to improvements in 1- and 5-year cancer survival rates and 50% reduction in outpatient cancellation rates. Another factor is picking up on the most recent CQC feedback, to look at the visibility of strategy and connectivity of strategy and plans within the organisation.

Mrs Myers outlined in the report an approach to refresh the Trust strategy; following today's meeting, she will circulate the strategy and some questions for feedback, to be picked up at a future and pick up at Board Development session and connect this with feedback from the Health Group leadership teams.

Trust Board members discussed that elements have arisen since the strategy was agreed that should be taken in to account, such as the STP. Board members were supportive of the approach to take stock of the strategy.

Trust Board members were asked to review the current strategy document and provide their feedback to Mrs Myers, using the questions in the paper as an outline, and for portfolio leads to also provide more detailed input where appropriate. This will be taken to a Board Development session for debate once responses are received. **JM/All**

Resolved:
To note the progress in delivery of the Trust's strategy and to action the proposed process for the refresh of the strategy.

15. STAFF FEEDBACK – RELOCATION TO NEW OFFICES

Mr Nearney presented this report, which is in response to a request from Non Executives following the move of staff into redeveloped office accommodation as part of the Trust's back office restructure.

Overall feedback from staff is positive. There have been overall improvements in staff motivation, staff productivity and communication. Some negative aspects were highlighted - there were some building snagging issues when staff moved in and there are some ongoing issues on noise, smaller desk space and getting used to new work environment. As part of the solution to this, areas have implemented a work-space etiquette.

Ms Christmas asked if there was a risk of staff not working in the new office environment from becoming demotivated. Mr Nearney outlined the Trust-wide benefits that the new accommodation has brought about and that the offices represent now the benchmark of what the Trust would want to have in future.

Mr Snowden noted the transformational way of working that this office move has brought about for co-located teams and better communication, and the results reported by staff are excellent. He noted that these perhaps are better than expected given people generally do not like change. He noted the benefits of producing a cost saving to the Trust as well as improvement for staff.

Mr Moran stated that he would be interested in understanding whether staff working in the new office spaces show an uplift in staff survey results and whether this contributes to an overall improvement in the Trust's results.

Mr Nearney confirmed that the Duncan Taylor is looking at the new steps in the Trust's Estates Strategy and how more inclusive ways of working can be enabled through future estates plans. Mr Moran noted that this will need to be balanced with other estate priorities, and the good results from this development.

Resolved
To receive and accept the report

16. STANDING ORDERS

Ms Ramsay presented this report, which noted the use of the Trust seal in accordance with Standing Orders since the last meeting. Mr Moran asked if the Directors signing contracts under seal can be noted in future reports. CR

Resolved:
The Trust Board authorised the use of the Trust's seal.

17. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Ms Ramsay presented this report as read. Ms Ramsay noted that it is an early point in the new financial year therefore there will be gaps in positive

assurance at this stage. In response to queries raised by the Chairman prior to the meeting, Ms Ramsay confirmed that the way in which the BAF links with the corporate risk register is starting to develop, and the flow of information up in the organisation on corporate risks to EMC means that more challenge is going in to the risk areas themselves. For example, there is a corporate risk dating back to 2013 which has been challenged back by EMC as to whether this still captures a current risk – the Board will see in future reports that this risk has been updated.

The gaps in controls and assurance have been linked to the Board Development Framework, which is the next agenda item. Ms Ramsay also noted that the Risk team, as part of the review of risk management arrangements, have requested a session with the Trust Board on risk appetite, which is being scheduled in.

Resolved:
The Trust Board received and updated the current BAF document, including the positive assurance received by the Trust Board and its committees to date.

18. BOARD DEVELOPMENT FRAMEWORK

Ms Ramsay presented this report as read. She confirmed it has been structured on BAF and a way of focussing Board Development on the main strategic issues. This framework document is only in draft at the moment and items can change during the year to meet the needs of the Board. Ms Ramsay will add in strategy refresh and risk appetite, per the discussions earlier in today's meeting. CR

Mr Snowden asked if a column on leadership in board development could be added to the framework, to be populated with Board development leadership needs, which are broader than individual BAF issues; Mrs Walker linked this to the recent Board Development session and development of the effective team model. Mr Moran asked for the framework to give opportunities for 'time out' thinking as well as development of the Board. CR

Mrs Myers asked for the August sessions that she would lead on to be moved for annual leave and to add in a further session on quality improvement. Ms Christmas noted she would be away for the October date. CR

Ms Kemp suggested that the item on diagnostics suggested for October 2017 may want to pick up on some of the contextual issues surrounding diagnostics, as discussed earlier today.

Mr Moran asked all Board members to feed back any apologies on development dates to Ms Ramsay. All

Resolved:
The Trust Board received and accepted the draft Board Development Framework, with further actions on its development/population.

19. ANY OTHER BUSINESS

None

20. QUESTIONS FROM MEMBERS OF THE PUBLIC
None

21. DATE AND TIME OF NEXT MEETING
Tuesday 1 August 2017, 2 – 5 pm, Boardroom, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (July 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
July 2017						
01.07	Standing Orders	The Director signing the seal to be noted in future reports	RT	Aug 2017		
02.07	Board Reporting Framework	Risk Appetite and Refresh to be added	CR	Aug 2017		
03.07		A section on leadership to be added to the Board Reporting Framework	CR	Aug 2017		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB	Jul 2017		Not yet due
January 2017						
01.01	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Sept 2017		Not yet due
01.03	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	Jul 2017		
COMPLETED						

Trust Board Annual Cycle of Business 2017														2018			
Focus	**Item**	**Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Strategy and Planning	Operating Framework	annual								x							
	Operating plan	bi annual											x				
	Trust Strategy Refresh	annual						x									
	Financial plan	annual			x	x	x										
	Capital Plan	annual				x											
	Quality Improvement Plan	annual						x									
	Performance against operating plan	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Winter plan	annual									x						
	IM&T Strategy & progress	annual								x							
	Nursing strategy	annual										x					
Strategy Assurance	Trust Strategy Implementation Update	annual					x										
	People Strategy inc OD	annual									x						
	Estates Strategy	annual					x									x	
	Backlog maintenance	annual								x							
	R&D Strategy	annual					x										
	IM&T Strategy	annual					x										
Quality	Patient story	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Quality performance (CPR)	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Nurse staffing	monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Fundamental Standards (Nursing)	quarterly		x			x			x			x			x	
	Quality Accounts	bi-annual					x	x				x					
	National Patient survey	annual														x	
	Other patient surveys	annual				x											
	National Staff survey	annual			x												
	CQC progress	quaterly	x			x				x				x			
	Infection control annual report	annual								x							
	Safeguarding annual report	annual							x								
Regulatory	Annual accounts	annual					x										
	Annual report	annual					x										
	Responsible Officer Report DIPC	annual								x							
	Guardian of Safe Working Report	quarterly		x			x			x			x			x	
	Statement of elimination of mixed sex accommodation	annual				x											
	Audit letter	annual					x										
	Mortality	quarterly				x			x		x			x			
	Race Equality	bi annual						x			x						
	Modern Slavery	annual					x										
	Emergency Preparedness Statement of Assurance	annual									x						
	H&S Annual report	annual				x											
Corporate	Chairman's report	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Chief Executive's report	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Board Committee reports	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Well-Led Self Assessment	annual					x										
	Standing Orders	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Board Reporting Framework	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Board calendar of meetings	annual									x						
	Board Assurance Framework	quarterly	x			x			x		x			x			
	Review of directors' interests	annual				x											
	Gender Pay Gap	annual								x							
	Fit and Proper person	annual					x										
	Anti-Bullying	quarterly			x				x				x				
	Freedom to Speak up Guardian Report	quarterly				x				x		x			x		
	Going concern review	annual					x										
	Review of Board & Committee effectiveness	annual						x									

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

JULY 2017

National context

The NHS and international standings

The NHS was top-ranked healthcare system in a new publication from the Commonwealth Fund, which compared the healthcare systems of the United Stated, Switzerland, Sweden, France, Germany, the Netherlands, Canada, New Zealand, Norway, Australia and the UK. The Commonwealth Fund's report ranks the UK first overall and first for care process (prevention, safe care, coordination, and patient engagement) and equity (comparison of performance for higher- and lower-income individuals). The UK also scores highly in terms of getting value out of the money the tax payer puts in. The report also noted that the UK could make further improvements in health care outcomes, whilst achieving the fastest reduction in deaths amenable to health care in the past decade. The Trust's focus on quality of care and reducing avoidable harm and deaths remains paramount, recognising the increasing demand locally and nationally for the NHS's services. The Trust's latest mortality figures (HSMR) show that the Trust's mortality rate is falling again after an increase over winter; the Quality Committee is monitoring the Trust's approach to mortality closely.

NHS England performance data on the NHS

NHS England published the monthly national performance figures for the NHS (up to May 2017), showing that waiting times in A&E continue to struggle across England. The figures for May 2017 show that A&E units in England treated 84.6% of patients within four hours. The Royal College of Emergency Medicine responded to the publication with a concern of performance levels in summer, and called for long-term investment in Emergency Medicine to manage increasing demand and noted trusts may struggle to respond to winter demands in the context of these figures. This Trust's Board will note our current performance in the Emergency Department in contrast to these figures and the need to work tirelessly with our community and commissioning partners to continue to manage demand and patient pathways for emergency care and treatment.

Nationally, the NHS did not deliver the six-week waiting time standard for diagnostic tests, with 1.9% of patients waiting longer than six weeks; the Trust's performance, as discussed at last month's Board meeting, is under considerable pressure at present. Two-week wait and the cancer 31-day target were met nationally, as well as by this Trust, but the 62-day target nationally and by this Trust were not met (81% delivered nationally). The Board will be briefed in more detail at today's meeting about the Trust's performance.

New ambulance performance standards announced

Following a national review and consultation led by NHS England's Chief Medical Officer, Professor Sir Bruce Keogh, NHS England has published new ambulance performance standards. From the standards, one of the largest impacts on the Trust may be increasing the percentage of patients who receive specialised condition-specific treatment within prescribed timescales (stroke and heart attack treatment). The national standards are designed to provide ambulance service with more time to assess and triage a response to a 999 call, with a view to deploying emergency responders more appropriately and efficiently, and to better meet increasing demand.

Local context

Proud of our People, Pride in Hull

Hospital staff participated in one of Hull's biggest parties of the year as Trust staff attended the Hull Pride event on Saturday 22nd July 2017 in Hull.

Members of HEY Let's Sing, the Hull and East Yorkshire Hospitals NHS Trust staff choir, performed for the second consecutive year. This talented group of staff, which includes radiographers, midwives, consultants and therapists, were chosen to perform on the main stage. The choir was invited back for 2017 to help raise awareness of LGBT+ issues and to join in the celebrations.

As well as treating revellers to favourites from Fleetwood Mac and Katy Perry, HEY Let's Sing also joined in with the parade through the city's crowds.

Giving young men the confidence to face cancer
Young men who are receiving or have completed cancer treatment took part in a regional first this month as the Look Good, Feel Better programme came to Cottingham.

National charity, Look Good, Feel Better, has been providing advice and support to women of all ages who are living with cancer for 23 years, concentrating specifically on the visible side effects of treatment. Until now, the charity has largely focused its efforts on women, but working with staff at the Teenage and Young Adult (TYA) Unit at Castle Hill Hospital, seven young men found themselves in line for VIP treatment.

Sarah Addis from Look Good, Feel Better talked the young men through a range of different issues, from moisturising and sun protection to brow building and exfoliation.

Representatives of Skye & Craig salon, based within Total Fitness, Willerby, also gave up their time to visit the TYA Unit and offer advice on hair care, beard trimming and other aspects of male grooming. Volunteer therapists also offered massage treatments to patients to help them de-stress and relax at what is undoubtedly a very difficult time.

Chance to get hands-on with Da Vinci robot
Intuitive Surgical arranged to have its Da Vinci Xi Robotic System demonstration model available for staff to see and experience hands-on use of the system.

It was available to view in the Board Room at Castle Hill Hospital on Friday 28th July. Representatives from the company were present to explain the system and guide staff in its use.

The Trust already has its own Si Robotic System and this is currently being used by the specialties of urology, gynaecology and colorectal surgery. Opportunities to extend the application of robot assisted surgery continue to be explored and its use is expected to continue to grow in the coming years.

Golden Patient Initiative – C15
Working with the HEY Improvement Programme, Ward 15 at Castle Hill Hospital has launched the Golden Patient Initiative. This has seen average Length of Stay reduced by 12 hours. The team has also introduced a TTO cupboard with the help of Pharmacy. They are reviewing ward phlebotomy needs and embarking on another project to offer patients who come to us as a tertiary centre new options around getting their Fragmin before their procedures. Congratulations to all involved in this drive to improve services for our patients.

Summer School Success
Earlier this month scores of third year students attended a Tissue Viability Summer School workshop in a bid to improve their knowledge prior to qualifying. The event held within the new Education and Development Centre, Suite 22 at Castle Hill Hospital, was offered to all third year nursing students and trainee associate nurses.

Consolidating the knowledge and skills they have learned during their time at university, 64 students were given the opportunity to participate in range of workshops covering pressure ulcer prevention, incontinence, and skin care.

In attendance was Chief Nurse, Mike Wright and Assistant Chief Nurse, Kate Rudston who provided delegates with a warm welcome to the Trust and an inspiring overview on the importance of high quality skin care and pressure ulcer intervention.

Doctors' Conference
This will be held on 15th September at the University of Hull. Guest speakers include Roy Lilley, NHS commentator; and Chris O'Neill, director of the Strategic Transformation Programme (STP).

Over 150 doctors have now registered their places at the conference, which will also include a Q&A session with members of the Trust Executive team, as well as a round of workshops on Checklists, Contracting Changes, Human Factors and Reporting Excellence.

Dementia Garden Opens
As noted by the Chairman at the start of last month's Board meeting, we recently opened the Southwood Dementia Friendly Garden between Wards 8 and 9 at Castle Hill Hospital. The garden offers a relaxing place for patients, visitors and staff to take time out, as well as a stimulating environment for people with dementia, using sights, sounds and smells. The garden is themed on The Wizard of Oz, complete with lion, scarecrow, tin man, and even a pair of ruby red slippers!

The garden was the brainchild of lead dementia nurse, Suzanne Bunton, and we have so many people to thank for making the garden possible, not least Cottingham-based Southwood GardenCentre and Coffee Shop who have provided us with many of the plants, shrubs and garden ornaments.

Balanced Scorecard

HEY LONG TERM GOALS - June 2017 data

Great Staff	Great Care	Great Future

Quality

RAG	Indicator	Target	Performance June	Trend v Previous Month
G	Never Events	0	0	⇨
R	Complaints (QIP - closed within 40 working days)	90%	62.60%	⇧
G	Healthcare Associated Infections - MRSA	0	0	⇨
G	Healthcare Associated Infections - C.Diff (YTD target)	53	12	⇨
R	Safety Thermometer - Harm Free Care	95%	92.81%	⇩
R	Venous Thromboembolism (VTE) Risk Assessment (Q4)	95%	90.91%	⇨
R	Mortality - HSMR (March 16)	<100	101.30%	⇨
G	Friends & Family Test - Inpatients (Trust v National %)	95.90%	97.78%	⇩
R	Friends & Family Test - Emergency Department (Trust v National %)	87.50%	74.63%	⇩

Workforce

RAG	Indicator	Target	Performance June	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.80%	⇧
G	Staff Sickness	<3.9%	3.73%	⇧
R	Staff Vacancies	<5.0%	7.92%	⇧
R	Staff WTE in post (<0.5% from Plan)	7170	7139	⇩
R	Staff Appraisals - AFC Staff	85%	81.20%	⇩
G	Staff Appraisals - Consultant and SAS Doctors	90%	90.40%	⇩
G	Statutory/Mandatory Training	85%	88.20%	⇧
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£1.5m	£1.7m	⇧
G	Staff: Friends & Family Test - Place of Work (Q4 2016 v 2017)	56%	66%	⇧
G	Staff: Friends & Family Test - Place of Care (Q4 2016 v 2017)	72%	80%	⇧

Performance

RAG	Indicator	Target	STF Trajectory	Performance June	Trend v Previous Month
G	18 Weeks Referral To Treatment (92%)	92%	85.10%	85.15%	⇧
R	52 Week Referral To Treatment Breaches (zero)	0	0	4	⇧
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	2.90%	5.56%	⇧
G	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	93.60%	⇧
R	Cancer: 62 Days Referral To Treatment (85%) (May Data)	85%	81.00%	75.70%	⇧
G	Length of Stay (<5.2)	<5.2	-	4.9	⇨
R	Clearance Times	12 weeks	-	13	⇩
R	Waiting List Size	52,449	-	54,051	⇧
R	Clinic Utilisation	80%	-	58.90%	⇩
G	Theatre Utilisation	80%	-	82.20%	⇩
G	E-Referrals (Q2 target v current performance)	80%	-	83.7%	⇧
R	Appointment Slot Issues (May)	35% (TBC)	-	35.26%	⇩

Finance

RAG	Indicator	Target	Performance June	Trend v Previous Month
G	Capital Expenditure	3.7	3.4	⇧
R	Statement of Comprehensive Income Plan - Year to Date	-2.8	-6.9	⇩
R	CRES Achievement Against Plan	3.3	2.1	⇧
R	Invoices paid within target - Non NHS	95%	31%	⇩
R	Invoices paid within target - NHS	95%	39%	⇧
R	Risk Rating	3	4	⇧

Moments of Magic

Moments of Magic nominations enable staff and patients to post examples of great care and compassion as well as the efforts of individuals and teams which go above and beyond the call of duty. They illustrate our values at work and remind us that our workforce is made up from thousands of Remarkable People.

In June we received 58 Moments of Magic nominations:

Angela Wray	Angela Wray deserves a Magic Moment. She is such a hard worker, always the optimist and is an all over super star! She brightens up the day wherever she goes. Thanks Ang!	30/06/2017
Emily Cox and Rhiannon Coupland	My daughter told me what happened the other day while out on placement. She was with her co student on their way back to CHH after a training session at HRI when they saw a man at the side of the road who appeared very unsteady. Rhiannon recognised the man as a patient from an earlier placement and they stopped and got out to see if he was ok. It turned out he was quite unwell so they called 999 for help and stayed with the man until he was taken to HRI ED for emergency care. They didn't hesitate to help this gentleman even though they were feeling nervous as both in uniform and still in their 1st year of training. Showed courage, compassion, care, communication, competence and commitment...all 6C's in a moment of kindness.	29/06/2017
IT Help Desk	I would like to say a big 'thank you' to the I.T support team. I had trouble logging on to our new system called 'Pattie'. My call was answered promptly and the guy on the other end was very helpful and polite. Unfortunately he couldn't resolve my issue and I was transferred to another helpful and polite guy who was able to resolve my issue. I am very sorry but I cannot remember the name of the two guys who helped me.	29/06/2017
Suzy	Suzy who works for the catering production/helpdesk is always willing to assist and do whatever she can to help whether it be special dietary needs for patients or if the delivery for the ward doesn't arrive, as like today. Suzy rang different people trying to prevent the driver taking the food back to CHH, so he didn't have to drive all the way back to HRI with just our order. She contacted the porters at HRI who were able to ask the driver to check the lorry and finding the food for Cedar Ward preventing a wasted trip for himself, patients meals as ordered being served and not having to do a	28/06/2017

	block order from the kitchen. Thank you Suzy, we appreciate what you do, you are always jovial/happy when we call and nothing is too much trouble.	
William Broadmeadow	Moment of Magic is every-time I speak or email this person. He is 150% helpful every-time I approach him and he needs to be recognised for this.	23/06/2017
Nicola Nuttall and Naomi Mouatt	Nicola and Naomi were the first medical people to attend at a road traffic accident whilst out on their community visits. They assisted compassionately with care and reassurance given to those injured. They stayed throughout communicating to the patients and keeping them safe. We would like to say a big thank you from one healthcare profession to another and well done to these angels	23/06/2017
Jenny Powell & Martin Sykes	A patient was referred for radiotherapy and needed a CT scan in order to design a treatment plan. Instructions were sent with the referral that stated the patient had a phobia of CT scans and would need sedation and a subsequent ward stay, so she could recover from the sedation, which is how she had managed all previous CT scans. Martin & Jenny talked the patient through the procedure, taking as much time as the patient needed, and keeping the patient calm and relaxed throughout. Through their kind and caring treatment, they carried out the whole CT procedure without the need for any sedation. This gave the patient confidence in her own abilities to have a CT in the future without sedation, and it also saved her the need for a stay on the oncology ward.	23/06/2017
Katie and Cam	I attended the MRI unit at HRI this week and would like to thank Katie and Cam for looking after me so well after I started to panic whilst being placed into the scanner. They both made me feel like I wasn't been stupid and offered lots of reassurance whilst the test was completed.	22/06/2017
Paul Hemmingway	Working on the Stroke Unit we have a number of patients who require thickened fluids due to swallowing difficulties. As these patients require extra care to ensure they do not access normal fluids, they do not have access to drinks unless they have been provided with a drink once thickened and this has been reliant on the nurses having to fit this in with all their other duties. Paul (a Generic Therapy Assistant), has experimented with thickening jugs of fluids to each consistency, to provide a formula and method to ensure that the drinks are at the right consistency and	22/06/2017

	are as palatable as possible - thus allowing patients (who are physically able) to self-access drinks and improving hydration. He has worked closely with both catering and nursing staff and the jugs are now provided for each patient. He has done this on his own initiative and will undoubtedly have a positive impact on patient care.	
Emily Clappison	Would just like to say a massive thank you to Emily Clappison/Clinical Skills for sorting out facilities enabling me to provide a training session for twelve NHS staff members at short notice. Nothing was too much trouble, all our needs accommodated. It meant the session did not have to be cancelled and re-arranged. Training went very well. Many unrecognised departments of the NHS were people are doing their utmost to help and go unnoticed. You are a little star - THANK YOU	22/06/2017
Bonnie Gray	I would like to nominate Bonnie Gray, who has been instrumental in setting up the new intranet and training, overseeing and supporting staff through this process. Bonnie goes above and beyond to help as much as she can and works tirelessly (and way-beyond her official hours) to ensure that she is available. I can only imagine the amount of stress that Bonnie could have faced in leading this project, but she has continued to be approachable, cheerful and accessible at all times. Bonnie is a credit to our organisation.	22/06/2017
Holly Deanes	We recently had a very concerning safeguarding issue with an elderly patient who was sent unaccompanied from a care home. It also appears they hadn't realised he could use the patient transport facility so they booked a taxi to bring the patient to his appointment with the patient paying for it. The screening staff were extremely caring and Holly and Debbie went out of their way to look after him. However, more concerns were raised after a conversation with the care home resulting in a datix being raised. Holly was so troubled by the events taking place, she actually arranged and paid for the taxi to take this wheelchair bound patient back to his home.	22/06/2017
Karis Cracknell	Our service has been through a challenging time recently and has also experienced long-term sickness and holidays within our management team. We would like to nominate our clerical supervisor Karis Cracknell for not only doing her own job very well as always, but stepping in and trying to plug some of the gaps created by the absence of the managers. She has worked	22/06/2017

	extremely hard and over her hours to ensure the smooth running of the service and we are all very grateful to her. Not only that, she managed to keep calm and carry on smiling!	
Mr Chris Milner and Mr Richard Pinder	I have an injury to my thumb in my dominant hand that I sustained at work some 6 months ago. It has proved resilient to healing. Today I attended the Plastics clinic to see Mr Milner. While I was there, Mr Milner called Mr Pinder in to give his opinion. The 2 of them then began bouncing ideas off each other, which was an amazing magical moment to watch/listen to. Both of them are clearly very knowledgeable, yet neither is so conceited in their knowledge that they won't seek another's opinion. I entered the clinic feeling worried for my future & that no one either believed me or cared and that maybe the injury was all I my head. I left their clinic feeling positive, that someone believed me, with an idea what the problem is and a plan for the future	21/06/2017
Emma Dean	Every time I go on to ward 30 when auxiliary nurse Emma Dean is on shift patients can’t say enough about her, how kind and caring she is and nothing is ever a trouble! Seeing her with patients is a joy she is so good with them and it never falters so I believe she deserves a golden heart because she has	21/06/2017
Kerry Osbourne and Hayley Rice	A huge well done to Kerry Osbourne for completing your care certificate and Hayley Rice for all the work she has done to help and support you through this!!!!	20/06/2017
Paula Russell	We were holding a clinic when a lady arrived who could not speak any English, My colleague Mrs Paula Russell came in and translated for me and this in turn avoided the patient been sent home without eye screening, and the patient having to come back at a later date. I believe Paula deserves a golden heart nomination as she goes far and above the call of duty.	19/06/2017
Nicky Easby, Emily Hunt, Ainsley Rooke and Christine Robinson	My niece gave birth on Friday 16 June; she was transferred to the postnatal ward (Rowan) following the birth. In the early hours of the Saturday morning her baby became unwell and deteriorated. The swift action of all the staff involved was totally commendable. They worked as team to resuscitate him and my niece said they remained calm, professional and focused at all times. The neonatal team were also pivotal in ensuring he received the correct level of care. I would like to take this opportunity to thank you all on behalf of my family, you are truly amazing and embody the profession that is the NHS. As a family we will be ever	19/06/2017

	thankful for your care, dedication and support. Lorraine	

Kathleen Merrick	Kathleen is an amazing doctor. She is very professional, caring and calms her patients wonderfully. She always works extremely hard and is a delight to have in the team.	17/06/2017
Robert Heward	Rob saved the day today! Was supportive and we are very grateful! Thank you :)	17/06/2017
Louise Elliott	I would like to nominate Louise Elliott for a moment of magic. Not only had she given great care to the patient she had brought back from theatre, but.... she had gone above and beyond in buying him the one thing he had craved all day. A bottle of coke! The patient was so grateful as he had no money or family. She certainly made his day.	16/06/2017
Daniela Dumitrescu	Daniela came to work with us from Romania and didn't know anybody here. She has fitted in amazingly and has been lovely to work with, nothing is too much trouble. I will really miss her when she returns home next month.	15/06/2017
Claire Capes specifically, and the whole nursing-team on ward 120	I recently had a tonsillectomy, so had to experience being on the `other-end` of the patient journey! Following a bilateral tonsil-bed bleed, I was admitted to ward 120, where incidentally I also cover as a Physiotherapist (so know the pressures the staff are under). The overall team were exceptional and offered wonderful, compassionate care. During the episode, I felt quite scared, as well as being exceptionally thirsty from being nil by mouth. Claire called in to see how I was getting on - she was buzzing around the wards, co-ordinating beds, but was still happy to chat with me. I told her how I was feeling, and she offered to check my throat to reassure me. I explained how thirsty I was, and Claire tried to contact the ENT consultant to ask if I could take sips of water. She couldn't get through, but assured me that she would keep trying in her office: a short time later, she returned to tell me that she had spoken to the consultant who was happy for me to take some water. I felt relieved, and also grateful that someone had cared enough to slot me into their already manic workload. It might seem a bit trivial this - but I really wanted to nominate Claire to highlight how such a small gesture can often be magnified when you are in a certain situation. It was just a little moment, but meant so much. We`re all under pressure, but it`s little	15/06/2017

	gestures like this that can often make the patient experience a much less frightening, lonely and worrying experience. Knowing that someone cares is pure magic. Thanks Claire, and to the whole team on ward 120.	
Catherine Groves	Catherine Groves has been a qualified nurse for eight months working on ward 40.She has many good qualities this is just a few, such as helping out before and after a shift starts with skin bundles, Cayder and much more. She always asks the auxiliaries if they need help throughout her shift. She helps out in different areas when she can. Catherine goes above and beyond for her patients, is a brilliant nurse, and I look forward to working with her.	15/06/2017
Mr Haeney, 3 Student Nurses and the Dermatology Team	I would just like to thank Mr Haeney, the 3 student nurses and the dermatology team at CHH for rescuing me this afternoon after I became stuck. Thank you for helping me :)	13/06/2017
Sam Toomey	My partner collapsed whilst at work in the eye clinic. Sam arrived quickly to check him over and help out any way she could. She remained calm and professional throughout, providing support to both of us. Sam stayed with us for most of the afternoon and helped with the transfer across to A&E. Thank you Sam, you're amazing!	13/06/2017
Team in Mortuary	To all the team in the Mortuary, who have consistently helped me by supporting visits of nursing staff to their department in order to better understand the Bereavement service and the care required. Over the last couple of years, they have done their best to ensure that visits were arranged in a timely and sensitive manner, accommodating as much as possible with the training day. The talks provided by staff has always been sensitive, informative and fascinating. Thank you once again. Much appreciated.	13/06/2017
Melissa Berry & Hilary Foster	Nomination for Melissa Berry and Hilary Foster, both members of staff arranged information packs regarding dementia. They also set up a cake stall for patients attending the DME outpatient department at Westbourne Avenue. This was theirown idea. They left a box for donations and have raised £100 which they are donating for the benefit of dementia patients.	13/06/2017
Leah Bulch	Leah recently demonstrated why she is not only a credit to her own Outpatients department, but to the	12/06/2017

	Trust as a whole. A very elderly gentleman from a care home recently attended one of the Outpatients clinics via hospital transport, however he did not have a carer present with him despite him needing one in this situation. Although he was not a patient on her clinic, Leah very kindly ensured that the gentleman's needs and well-being were taken care of during his visit, making brilliant use of her exceptional kindness, attentiveness and, of course, her brilliant sense of humour from the moment he entered the department to the time of his departure. Amazingly, she not only delivered first class care to this gentleman, but she also fulfilled the duties for her own clinic to her usual high standard. The gentleman expressed how grateful he was for Leah's help when he was leaving, therefore I feel it is only right that she gets the recognition that she deserves. She really is a shining example of how a nurse should be!	
Sister Mandy Price	Sister Mandy Price holds general status of LEGEND in my eyes. Having worked with and alongside her during my training in anaesthetics and critical care, and latterly as an emergency medicine registrar at HRI, I am in awe of how Mandy just makes things better. Recently we faced a huge clinical challenge in the ED requiring input from multiple specialties, imaging specialists, dealing with distressed relatives, and most importantly with a terrified patient. The treatments delivered to our patient were complex, and all staff involved were relying on our skills, knowledge and training in dealing with a hugely challenging situation, many for the first time. Every time I looked up, Mandy was supporting junior nursing colleagues on drawing up complicated infusions, teaching our two fantastic 3 stripe student nurses, supporting the intensive care doctors with drugs, and the ED team with equipment, a never ending supply of 50ml syringes and curly wurly giving sets and an uncanny sixth sense for drivers 'near end of infusion' - I swear she has 6 pairs of hands. Sister Price is well known over the whole hospital through her work as a critical care outreach sister. When she arrives, it is usually because a patient is sick and needs specialist input and one of our staff has called for help. Mandy brings with her dark blue piping and folder a sense of "the cavalry is here", yet she is never overbearing and never takes over. She is superb at empowering staff who may be dealing with a highly stressful situation and may be in need of support or guidance - very rare skills indeed. But what impresses me most about Mandy is that amongst all of the discussions about which scan to do, and what strength of this to give, at what rate and where are we going, and what other options should we consider; is	12/06/2017

	that she never forgets why we all do the jobs we do. She is supremely kind, reassuring, experienced, professional, fun, steadfast in ensuring the highest standard of care is delivered to all patients, genuine, skilled, organised and grounded. One moment she is holding a grasping hand and stroking a scared patient's face and calmly delivering just the right amount of information, and the next speaking to colleagues in the scan control room about washing machines, rugby and sharing a joke - bringing everyone down a level and regrouping. I have learned so much from Mandy over the years that I have worked here and recently (as always) was so grateful for her presence in the team at this challenging case. We all come to work to be our best - I am glad I get to work with one of the best. Mandy may have Price in her name, but to our staff and patients, she is priceless.	
Jan Gilbert	Just wanted to say a massive thank you to Jan who has been mentoring me with my care certificate, thanks for making it fun.	12/06/2017
Jackie Nevis	I nominate Jacki Nevis as she is always smiling and happy! She's a wonderful colleague to work with and does all she can to help anyone who needs it. She greets the patients and visitors with respect and has a lovely aura around her! She's a valued member of our ward 8 team.	12/06/2017
Vance Akiti	Vance Akiti came on to our ward to sit with one of our ladies, on this particular night the ward was extremely busy and we were short staffed Vance went out of his way to help with other patient making sure no one fell or got out of bed or wondered off the ward - we really appreciate everything he did. He went above and beyond his job role to help us. Thank you	12/06/2017
Sarah Fitsimmons	Sarah always brings a bit of cheer to every shift. No matter how busy she is or what pressures she has shes always happy to help and approachable for everyone.	11/06/2017
Debbie, Ward 5	Debbie is a fantastic nurse that always goes above and beyond her line of duty to help patients and staff. All staff on ward 5 would like just give her a big thank you for all her help. Never change Deb you're one in a million.	11/06/2017
Ultrasound Team	Would like to say a big thank you to all the staff in ultrasound department at HRI working on Saturday 10th June. In ambulatory care we had 8 patients attend	10/06/2017

	before 10am requiring unscheduled ultrasounds, and a few more as the day progressed. The staff in the department accommodated all the patients in a timely manner which allowed us to promptly progress their care. Thank you!	
All catering staff – Kingston /Pod/W&C/Eye	I would like to mention all the catering staff within HRI restaurant for being helpful and polite to customers throughout the changes that have been made within the catering department from the choices of food on offer to the changes in the running of the department. It has been a very stressful time these last few months with lots of changes occurring from different managers to staff levels. The staff have shown true team work under extreme pressure and I think a mention of them would keep that smile going and be a boost to them as they try their hardest to keep the departments running and provide a service to you all under extreme pressure.	10/06/2017
Darren Shakesby	There was a distressed relative on the ward. He was able to pick up on non-verbal cues and escorted us to another ward which held a quiet break-out area for family. He then came back with tissues. On arrival of transport to transfer the patient to Preferred Place of Care he came back on to the ward and sensitively interrupted my conversation with family to convey this important piece of information. Excellent patient and family centred care. Empathy displayed throughout. Thank you Darren.	09/06/2017

Vicki Riddiough	I was dealing with the paperwork and patient notes for a patient being transferred from our area to another hospital. Vicki was a great help that day, and I could not have done the job on time without her help. This wasn't part of her job, she was very busy enough herself, undertaking her own job, but dropped everything to make sure the task was completed. I think Vicki deserves a Golden Heart for helping me complete an impossible task. She is always helpful, approachable and willing to help no matter what! Please consider Vicki Riddiough for this award as she definitely deserves it!!!	09/06/2017
Tracy Eddom	On starting my new post in the Outpatients Department at Castle Hill Hospital, I was given a buddy to help me learn how the department worked and where to find resources I needed to carry out my role. Tracy helped me more then she probably realised, She helped me settle in and made me feel welcome. Without the help	09/06/2017

	from Tracy I would have been more nervous. When left to my own devices in a clinic, if I had any questions Tracy was there to point me in the right direction, for this I would like to thank her.	
Julia Lambert	I would like to nominate Julia Lambert. Julia is one of the nicest nurses I've had the chance to work with. Fantastic with her patients, fantastic with her colleagues very much a team player who will help you with anything.	09/06/2017
Eye Clinic Technical Team	Helping to support additional clinics and ensuring patients receive high standards of care throughout the process. A massive well done to pulling together as a team.	08/06/2017
Mark Edwards	Running in the rain to fix our monitor! Mark showed up no questions asked to fix our computer / system! Fixed it in minutes, who needs superheroes?!	08/06/2017
Lesley Gath	Would like to nominate Lesley because of her constant support and encouragement towards myself and other members of staff. Lesley's hard work and dedication does not go unnoticed in the department because she is always going above and beyond to help and support patients and staff every day!! Thank you Lesley	07/06/2017
Helen Thompson	Would like to thank Helen Thompson in ED minors for helping me though my Care Certificate over the last few months. It's been a big help and helping me understand it better even though she has helped other staff as well doing her own work and working though the busy times.	06/06/2017
Angie Rymer	On the 31/10/2012 I gave birth to my beautiful daughter. Mine and my husband's hearts where broken when hours after birth she was taken away critically ill to NICU. There, me and my husband remained on Maple ward for the week. Angie the ward manager was beyond unbelievable, although this all happened 4 years ago I have never forgotten her, she has often come into my mind at just how incredible she was with us. I myself was poorly during my stay and Angie treated me with so much care, and the time and support she gave me to help me cope without my daughter was just beyond anything I could ever explain. Care like that stays in your mind and heart forever. I sat with my daughter every minute I could, even through the night. When I was told that I would have to go home I was inconsolable. I couldn't be parted from my baby. Angie came to see me, she sat	05/06/2017

	by me whilst I sobbed, she held my hand, she said I'll see what I can do. Within no time she was back, she told me she'd managed to get me a room upstairs, this meant that I could be down the corridor from my daughter. Angie, I cannot thank you enough for what you did for us. Being that close to our daughter helped me so much psychologically and emotionally, and I am sure it helped our daughter in her recovery having me by her side. Those two weeks in hospital felt like eternity, but you made things so much easier. I am sorry it has taken such a long time for me to speak out, it has been a hard few years with our daughter's medical issues, but she's doing amazingly well. All my heartfelt thanks.	
Eric Whitehurst	Eric has many moments of magic! He is wonderful with patients, kind, caring, supportive. Everybody at Day Surgery thinks very highly of Eric, he's very popular. He makes what can be a very long stressful day so much easier with his kind cheery attitude. He is a valued member of the team with knowledge and skills way beyond his band 5 role. Eric is exceptional in a crisis as we have recently witnessed, he was calm, efficient, professional , and focused throughout . His care for the patient was outstanding. Eric is very deserving of this nomination.	05/06/2017
Linda Cheesman	Always works phenomenally well in ED especially when co-ordinating Emergency Care giving her all to both patients and colleagues.	05/06/2017
All the team on EAU	I would like to nominate the whole team on EAU. Since starting here 6 months ago everyone has been so welcoming and helpful, Nothing is too much for anyone. Working on the assessment unit can be extremely busy, day and night but everyone has taken time to explain things to me and teach me how things are done. Starting on the ward with not much knowledge and not knowing anyone is daunting, But everyone works together and makes you feel part of the team. A lot of our patients are quite vulnerable; an experience of coming into hospital can be a traumatic time but every staff member on this unit goes above and beyond the job role to make the patients and their families feel at ease. The staff work so hard and deserve something to show for it #proudtobeDME	05/06/2017
Rebecca Evans	Becky has recently joined the Stroke Team at HRI as the new Senior Sister. Becky is always cheerful and positive. She is determined to ensure the patients on her ward receive the best possible care and has	05/06/2017

	already made many improvements on the ward. The staff love working for her as she is motivational and inspiring and they all feel cared for and supported. You are a star Becky - all the staff and patients love having you on the ward! Thank you for joining the team - it certainly was a magic moment for the stroke service!!	
Hanan Harb	Hanan is the clinical lead Occupational Therapist on neuro-rehab, ward 29. She always goes out of her way to provide the best therapy and support for her patients, and recently has been working in and out of work hours to provide a new constraint induced therapy plan for one of our young patients with a brain injury. Compiling the methods, exercises and the training for all staff on the ward has taken a lot of hard work, but Hanan has remained positive and focused on achieving a great outcome for the patient - to regain use of his right arm, which at the tender age of 16 is so important. Hanan is a credit to the OT department and the trust, and she deserves to be recognised for all her hard work, passion and dedication. She is awesome!	03/06/2017
Gary Usher	Due to a manufacturing issue the supplier of walking aids to HEY was unable to deliver any walking frames this week. Despite frequent and urgent discussions with the distributor the situation was becoming desperate and Physiotherapy needed to move stock urgently from CHH to HRI. Without these frames patients could not be safely discharged and would be delayed in getting home. Gary Usher the Transport Officer could not have been more helpful. He quickly reacted to the urgency of the situation and arranged transport the next morning. Gary took a can do approach from the start and focused on finding a way to help. Gary made a huge contribution to making sure patient discharges were not held up and his actions show the true meaning of teamwork and how everyone, clinical and non-clinical have a role to play in patient care. Thanks Gary from everyone in Physiotherapy	02/06/2017
Inga Jorgensen	Inga always makes sure that patients are not nervous and goes above and beyond to make them laugh in recovery. She cheers patients and staff members up all the time with her sense of humour.	01/06/2017
Wendy, Mandy and staff in the café in the Queens Centre	I would like to nominate all the girls who work behind the counter in the café at the Queen's Centre; they are so busy, work tirelessly and always have a cheery word.. or a little bit of cheek to make you smile. I have witnessed their ongoing professionalism as they take	01/06/2017

	on board the criticism that customers are giving due to the enforced changes on the menu. They have dealt with many complaints calmly, politely and consistently whilst trying to still deliver a service in an already busy working environment. I would just like to say keep up the good work girls and thank you.	
Lee-Ann Broadley	I want to nominate Lee-Ann for a night shift a month or so ago. She helped care for a lady who was end of life care. The support she gave both myself and the patient was outstanding. She cared for the patient until her last moments. Thank you for all you did. I am certain the patient would have thanked you for all you did.	01/06/2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT JULY 2017

Trust Board date	1st August 2017	**Reference Number**	2017 – 8 - 8
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					
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
July 2017

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission

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

TRUST BOARD QUALITY REPORT
July 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
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission

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

2. PATIENT SAFETY

2.1 Never Events

The Trust's last Never Event occurred in September 2016.

2.2 Serious Incidents

The Trust declared six Serious Incidents in June 2017; one of which has been de-escalated subsequently, and these are summarised, as follows:

2.2.1 Serious Incidents declared in June 2017

Ref Number	Type of SI	Health Group
14058	Grade 3 Pressure Ulcer H110	Medicine
14199	Grade 3 Pressure Ulcer C14	Surgery
14517	Sub-optimal care (unexpected death), relating to a patient who died after being transferred from ED to AMU. Issues raised appear to around the lack of ceiling of care for this patient and a clear plan.	Medicine
15177	Sub-optimal care (unexpected death) relates to a patient that had a cardiac arrest in the CT department.	Medicine
15934 (de-escalated)	Surgical/Invasive procedure related to a possible foreign object left in a paediatric patient. Following an initial review of the patient's notes was undertaken, it has been determined that the incident was not an SI (or a Never Event) as no foreign object was retained in the patient. *The Commissioners have accepted the de-escalation of this as an SI.*	FWH
16180	Treatment delay relates to a patient who was seen by the Neurology service and should have had further investigations as a result of abnormal blood results taken in January 2016. The results were not acted upon until the patient presented in June 2017 when further treatment was needed.	Medicine

In view of a recent number of severe pressure ulcers, the Chief Nurse has convened a meeting with Nurse Directors on Friday 27th July 2017 to discuss what additional actions need to be taken. A verbal update on the outcome of this will be provided at the Trust Board meeting.

2.3 New Investigation Training launched
Two of the Trust's key quality improvement areas for 2017/18 relate to improving investigations and embedding learning.

One of the ways the Trust can achieve these priorities is to improve how it investigates when things go wrong. To help staff in their investigations, the Governance Team has launched some new training around Learning, Candour and Accountability. This training is being delivered to Governance staff firstly, and will be available for all other staff to book via the Trust's online learning web page from September 2017.

The training will:

- Provide an understanding of duty of candour
- Provide direction on the immediate action(s) to be taken when an incident occurs with regards to capturing and securing key information and evidence
- Provide understanding on statement writing and interviewing staff when an incident occurs
- Train on Root Cause Analysis and Action Planning as part of conducting an investigation
- Provide guidance on report writing skills

3 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 July 2017 are attached as **Appendix One**. The benchmarking data for the Safety Thermometer by the Yorkshire and Humber Academic Health Sciences Network - Improvement Academy had not been updated by the time this report was compiled. This information will be included when it has been updated.

From the 882 in-patients surveyed on Friday 14th July 2017, the results are as follows:

- **95.3%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.37% [n=12]** 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 **98.63%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **95% (n=788)** 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 and be sustained.
- VTE incidence on the day of audit was **4** patients; three of which were with pulmonary embolisms and one with a Deep Vein Thrombosis.
- New pressure ulcers remain relatively low **(n=6)**; one of which was a category 3 (declared as an SI) and five at grade 2.
- There were **10** patient falls recorded within three days of the audit day; all of which resulted in no harm to the patient. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain relatively low at **5/163** patients with a catheter **(3%)**. Of the **5** patients with infections, **2** were infections that occurred whilst the patient was in hospital **(1.2%)**. 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 and is required to take corrective action, where necessary.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 30th June 2017

The Trust is required to report monthly on performance in relation to four key HCAI's. These are summarised in the following table.

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**12 (23% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0**
MSSA bacteraemia	**44**	**8 (18% of threshold)**
E.coli bacteraemia	**73**	**23 (31% of threshold)**

The current performance against the upper threshold for each and reported in more detail, by organism:

4.1.1. *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. Root cause analysis investigations are conducted for each infection and outcomes of RCA investigations for all Trust apportioned cases shared collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

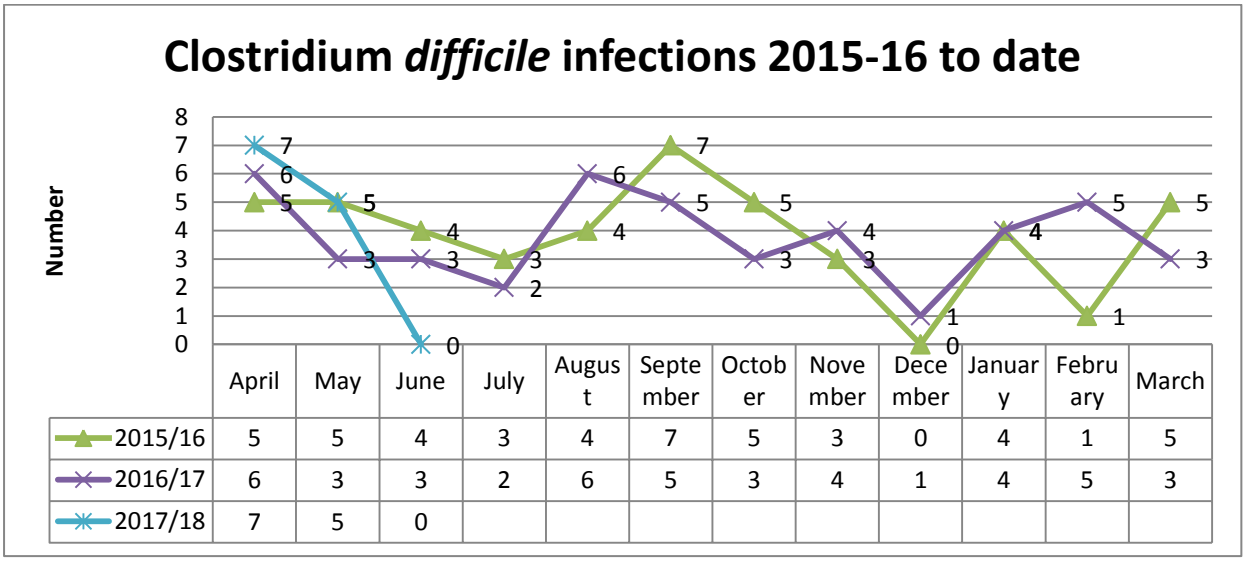
To date this financial year, at Month 3, the Trust has reported 12 infections against an upper threshold of 53 (23% of threshold). There were no Trust-apportioned *C. difficile* cases in June 2017, a significant improvement on trends reported previously and which evens out performance for this time of year.

During June 2017, 11 of the 12 cases reported during April and May 2017 were shared with commissioners, with the twelfth case carried over for review into July 2017. In spite of some lapses in practice being reported by the Trust, e.g. delay in sampling, isolation and poor compliance with bowel chart completion, commissioners concurred that these were not contributory to the acquisition of *C.difficile* and, therefore, did not meet the criteria as a lapse in practice. This is very positive; however, there remains an opportunity for the Trust to continue to make improvements on managing patients with diarrhoea.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**12** (23% of threshold)	Nil to report

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Nil to report	Nil to report	Nil to report	Nil to report

The following graph highlights the Trust's performance from 2015/16 to date with this infection:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	5	5	4	3	4	7	5	3	0	4	1	5
2016/17	6	3	3	2	6	5	3	4	1	4	5	3
2017/18	7	5	0									

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

Staphylococcus aureus (also known as staph. aureus) 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.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of PIR Investigation / Final assignment
MRSA bacteraemia	**Zero tolerance**	**0**	N/A

No MRSA bacteraemia cases have been detected so far this financial year.

4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

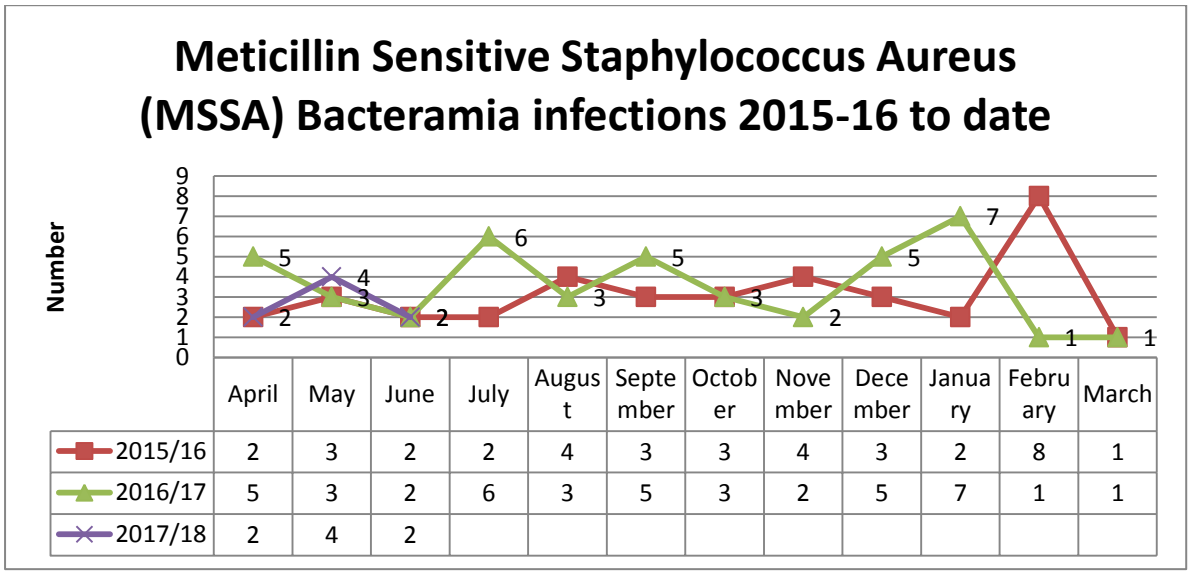
Meticillin-Sensitive *Staphylococcus aureus* is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

However, MSSA colonisation usually causes them no problems, but it can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people that are unwell already. 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, usually.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	**44**	**8** (18% of threshold)	7 x RCA completed 1 x pending investigation - 3 cases to date deemed lapses in practice/ evidence of suboptimal practice
Lapses in practice/ Evidence of suboptimal practice (not reported previously)	**Reason for lapses in practice/ suboptimal**	**Lessons learned/ Identified learning**	**Actions**
Case 1	Complex case – oncology patient with sepsis. Possible sources identified – duodenal stent, Peripherally Inserted Central Catheter (PICC) and/or cannula	Ensure VIP charts are completed at all times and ensure we look to implement a care plan for PICC/Skin Tunnelled Catheter (STC) lines to ensure the reviews are documented.	To discuss the case at next ward meeting with all staff. Staff to be booked onto Central Venous Access Device (CVAD) training. Education to be given at ward level. Roll out of updated VIP chart.
Case 2	Complex case – bariatric patient with sepsis post bariatric surgery. Possible intra-abdominal leak, possible infective haematoma. Central line removed as a precaution but tip did not culture MSSA so not deemed line related	Risks of bariatric surgery discussed – management in line with sepsis bundle so prudent management of patient	To discuss the case at next ward meeting with all staff involved.

MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection. The need for continued and sustained improvements regarding this infection remains a priority. Actions on vascular access devices/line management continue and are considered key in reducing rates of this infection both locally and nationally.

The following graph highlights the Trust's performance from 2015-16 to date:



4.1.4 *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.

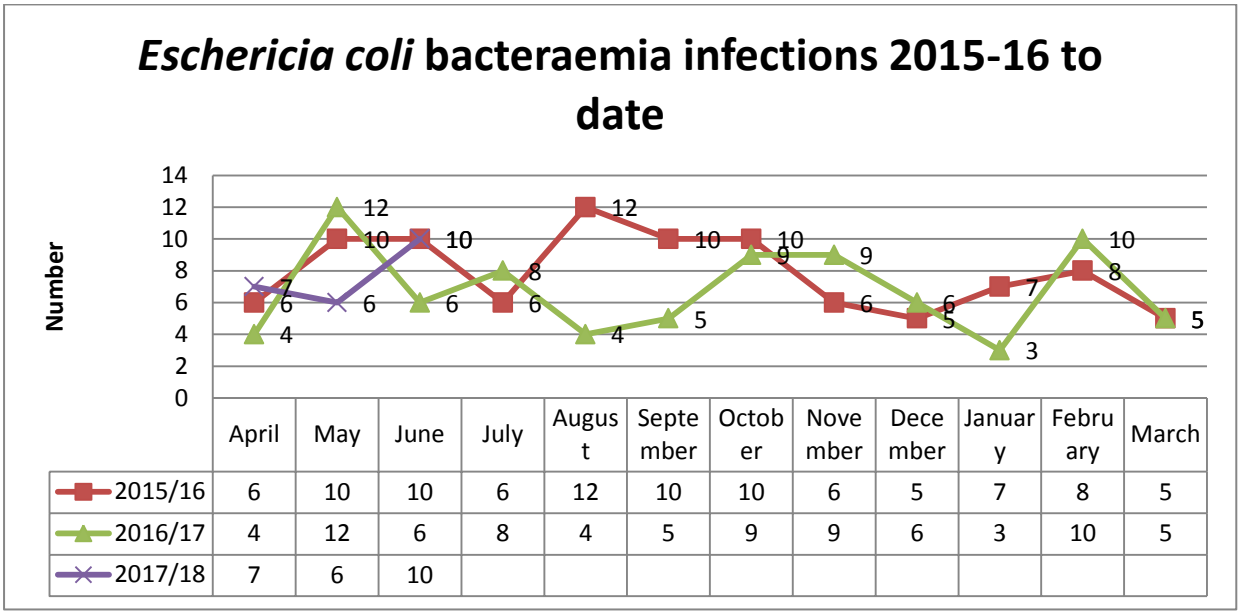
E. coli is now the commonest cause of bacteraemia reported to Public Health England. *E. coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

During 2017/18, health systems and Trusts are required by NHS Improvement (in a letter of 28th June 2017), to achieve a 10% reduction in *E. coli* bacteraemia cases overall. Achievement of reductions will require collaborative working with commissioners and jointly-owned action plans. However, this will be a challenging target for the Trust as most patients come into hospital for the treatment of this infection. The Trust is commencing this work with commissioners shortly.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	No. of cases investigated clinically	Outcome of Clinical Investigation (avoidable/ unavoidable)
E. coli bacteraemia	**73 (after 10% reduction from 81 previously)**	**23 (31% of threshold)**	23	1 x avoidable 2 x possibly avoidable 20 x unavoidable (complex, multi morbidities including bowel and biliary sepsis majority requiring ITU management)

Avoidable / Possibly avoidable *E. coli* bacteraemia cases		
Source of Infection (not reported previously)	**Trends/ Risk Factors**	**Actions**
Possibly avoidable Possible hospital acquired pneumonia Catheter associated urinary tract infection (CAUTI)	Long stay ICU patient with complex needs - E.coli found in urinary catheter sample and also sputum sample	Disseminate learning of case and associated risk factors to medical and nursing team Prevalence audit of urinary catheters Update of catheter policy and associated care bundle

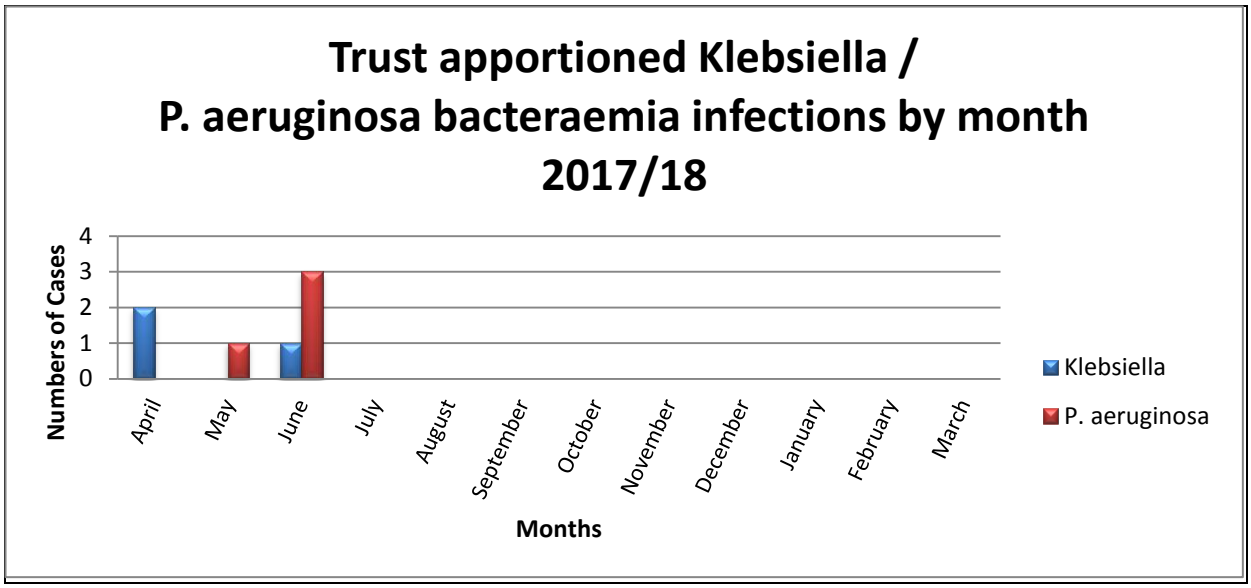
The following graph highlights the Trust's performance from 2014/15 to date:



4.1.5 Gram negative bacteraemia – reporting for 2017/18
If gram-negative bacteria enter the circulatory system, this can cause a toxic reaction to the patient. This results in fever, an increased respiratory rate, and low blood pressure. This may lead to life-threatening condition of septic shock.

NHS England and Public Health England (PHE) introduced a new set of measures from April 2017 to reduce the burden of gram negative bacteraemia. There is a requirement across the health economy to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021. This includes two additional organisms that have not been required to be reported on previously. Surveillance of *E. coli* bacteraemia continues. However, alongside this, Klebsiella and Pseudomonas aeruginosa bacteraemia cases are now reported to PHE.

Any learning associated with these infections will be reported in future editions of this report.



4.2 Infection Outbreaks

An outbreak is defined by two or more patients with the same infection in the same ward/area. During June 2017, two wards had short-lived incidents involving patients with diarrhoea and vomiting resulting in bay closures only. No causative organisms were identified from these with bed bays being deep cleaned and reopened within 3 days. All patients have recovered satisfactorily.

4.2.1 Incident regarding a confirmed case of laryngeal Miliary Tuberculosis (TB)

An incident control group meeting was held on the 19th June 2017 to discuss a case of a patient with confirmed laryngeal Miliary Tuberculosis who was admitted via the Emergency Department HRI and transferred to C16 under the care of ENT on the 12/6/2017. The patient was transferred promptly to C20 on diagnosis. The multi-agency incident control group discussed case management and contact tracing requirements. A further meeting is being planned week commencing 24th July 2017 once initial screening and results of the patient's household contacts is known. The patient has responded well to treatment, has been discharged from C20 and is now being managed in the community by the community TB team and with Infectious Diseases follow-up appointments.

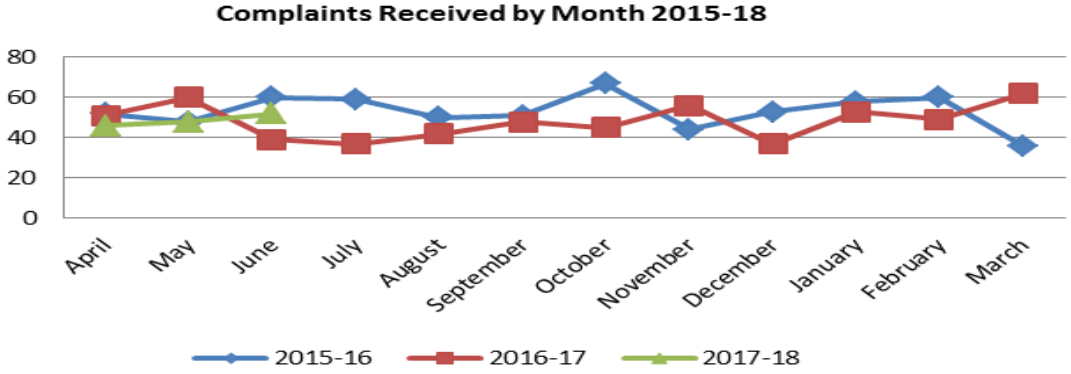
4.2.2 Influenza trends

There were no cases of Influenza to report during June 2017.

5. PATIENT EXPERIENCE

5.1 Complaints

The following graph sets out comparative complaints data from 2014 to date. There was an increase in the number of complaints received in June 2017 compared to the same period the previous year. There is no obvious reason for this trend but it will continue to be monitored closely.

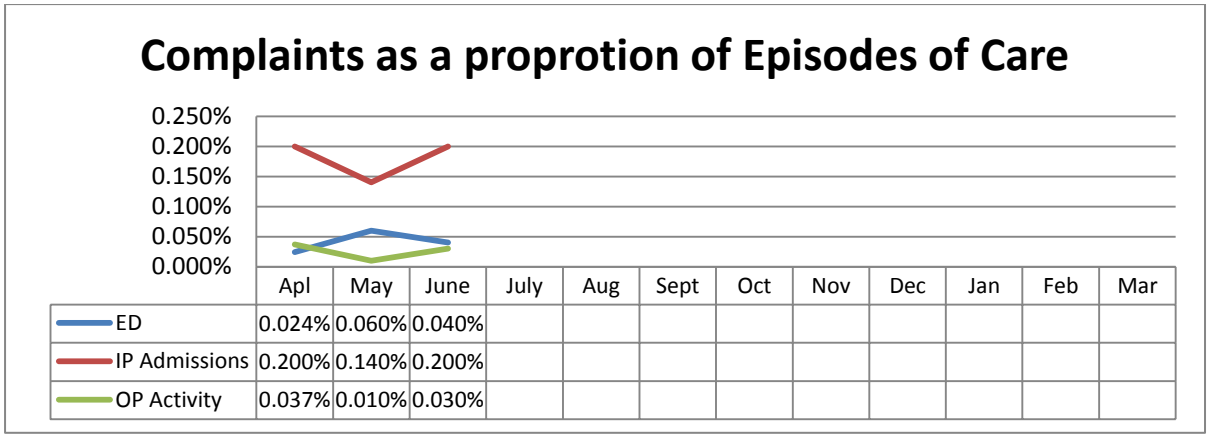


5.1.1 Complaints as a proportion of Episodes of Care

The following table shows complaints as a proportion of activity for June 2017.

May 2017	Patient Contacts	Numbers of Complaints	% (complaints as a proportion)
Emergency Department	12,782	6	0.04%
Inpatient Admissions	13,118	27	0.20%
Outpatient Episodes	61,784	20	0.03%
Totals	**87,684**	**53**	**0.06%**

The following below shows the monthly trend of complaints against activity:



Complaints about 'treatment' continue to be the highest in number. The two key themes relate to patients that are not happy with the treatment plan (9) and those that are not satisfied with the outcome of the surgery undertaken (7). These complaints are all reviewed individually and the patient/family is offered a resolution meeting. The outcome of the investigation is shared fully with the complainant.

The following table indicates the number of complaints by subject area that were received for each Health Group during the month of June 2017.

Complaints by Health Group and Subject (primary)	Attitude	Care And Comfort	Communication	Delay, Waiting Times Cancellations	Discharge	Safeguarding	Treatment	Total
Clinical Support Health Group	0	1	0	0	0	0	2	3
Family & Women's Health Group	0	0	2	1	0	0	6	9
Medicine Health Group	0	2	2	1	4	0	9	18
Surgery Health Group	2	0	0	3	1	1	16	23
Totals:	2	3	4	5	5	1	33	53

5.1.2 Examples of outcomes from complaints closed this month:

- A patient had a CT scan in August 2016 and the results were not conveyed until she attended the clinic recently.
  Action: The Harvard traffic light system has been put in place and results are now flagged to the referrer to prevent similar incidents recurring in the future. This produces information

about who is and who isn't accessing results and where management action needs to be taken to address any shortcomings. This can then be audited to check compliance.

- A patient was unhappy with the care and follow on consultations post-surgery.
  Action: Post-operative discharge follow up arrangements to be monitored to ensure patients are not missed. Voicemail/pre-recorded message facility in the department to be removed from all secretarial telephone numbers and cross cover arrangements put in place so that patients are able to speak with secretarial staff.
- A patient's family was unhappy with the lack of communication and the length of time it took to assess X-ray results, which meant a delay is commencing Nasogastric (NG) feeding with the patient.
  Action: Concerns regarding any aspects of the NG feeding pathway issues are to be discussed at the Nutritional Steering Group, identifying any trends and themes, so that appropriate action can be taken.
- A patient was discharged from the ED without sufficient tests or treatment and his condition deteriorated at a later stage.
  Action: An ED Consultant is to review the departmental guidelines for abdominal pain and information will be made available to all ED staff via a link to the National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary for treating patients with Ulcerative Colitis.

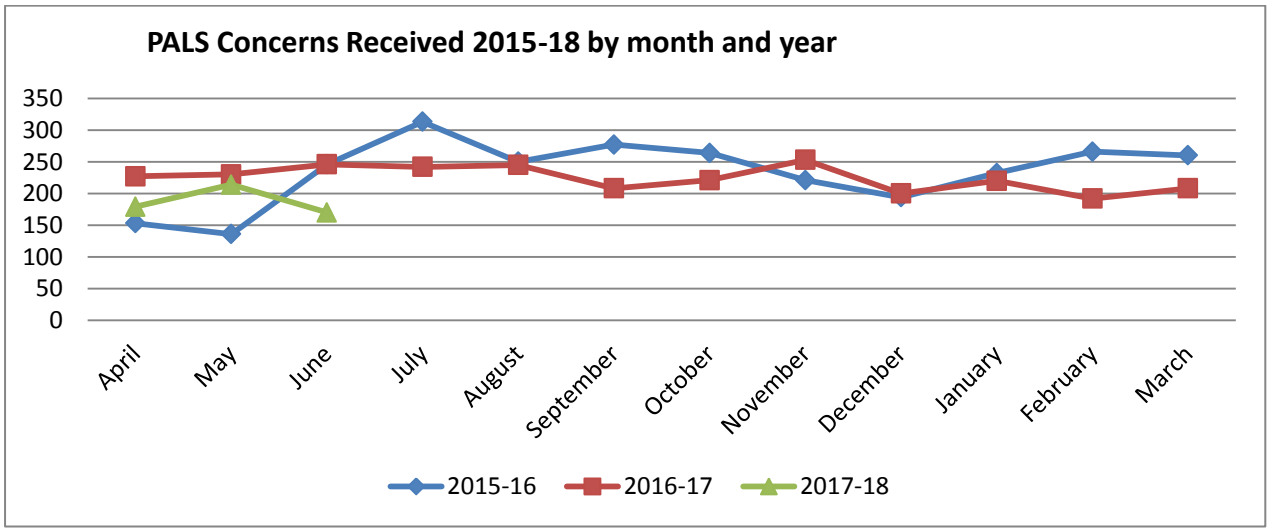
Of the 94 closed complaints in June 2017, 33 were not upheld, 44 were partly upheld and 16 were upheld. One complaint was not investigated as the complainant was not in a position to take it forward at this time.

5.1.2 Performance against the 40 day complaint response standard

The Patient Experience Team has been working closely with the Health Groups to progress complaints in a timely manner and has produced guidance to assist staff in achieving the Trust's target of 90% or formal complaints to be responded to fully within 40 days of receipt. At the time of this report there are 49 complaints open with four open over 40 days (92%).

5.2 Patient Advice and Liaison Service (PALS)

In the month of June 2017, PALS received 170 concerns, 39 compliments and 104 general advice issues, with an overall reduction when compared to June over the last two years. The majority of concerns were regarding waiting times/cancellations, delay in notification of results and not being satisfied with treatment plans. These are all passed back to Health Groups for investigation and action where required.



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

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Treatment	Total
Corporate Functions	0	4	0	4	2	0	1	6	0	2	19
Clinical Support - Health Group	0	1	0	5	3	2	0	0	0	1	12
Family and Women's Health Group	0	2	0	7	26	0	0	0	0	5	40
Medicine - Health Group	1	5	1	8	20	1	1	0	1	12	50
Surgery - Health Group	0	4	1	9	25	2	0	0	0	8	49
Totals:	1	16	2	33	76	5	2	6	1	28	170

5.3 Compliments
The Trust received a large number of compliments in July 20117. One of these praised Ward 4 at Hull Royal Infirmary for the outstanding nursing and medical care which the patient received. The patient expressed how dedicated all the staff were on the ward and that they couldn't do enough for them and nothing was too much trouble.

Compliments also were passed onto to the Cardiology Hospital for their outstanding care from outpatients to the wards areas. They have contributed to improving the patient's quality of life and left them with an outstanding impression of the service.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 8 cases under review by the PHSO currently. During the month of June 2017 there have been no new cases opened; one case was upheld and one case was not upheld.

5.5 Friends and Family Test (FFT) - June 2017 Data
The Trust's Friends and Family results for June 2017 for all areas, excluding the Emergency Department, indicate that there was an increase in the number of responses for the month with 3,576 patients responding compared to May when the Trust received 2,751 responses.
From these, **97%** were extremely likely/likely to recommend the Trust to friends and family.

5.5.2 Friends and Family Test - Emergency Department (ED)
With regards to the Emergency Department, 35 patients responded by the paper feedback method. Of these, **74.29%** said they were extremely likely/likely to recommend ED to friends and family. **17.14%** said they were extremely unlikely / unlikely to recommend.

When using SMS text messaging, **85.38%** of patient gave positive feedback and **8.66%** gave negative feedback.

Although paper responses were low for the month of June in the ED, the SMS (text messaging) method of providing this feedback had a high percentage of respondents and is proving to be more popular in this area.

The Patient Experience team is working with all departments to embed the new system. For the month of June we are now starting to see an increase in the responses from all areas due to staff being engaged in the new Friends and Family system. More staff have now taken ownership of

their own department and are looking at ways in which they can improve their response rates in the future. They are also very much involved in looking at their themes and trends, outcomes and lessons learned.

5.6 Volunteers

5.6.1 The Young Volunteers/ Young Health Champions

The Trust's Young Health Champions traineeship programme is working with the Boulevard Centre in Hull with young mothers who would like a career in healthcare in the future. The Trust has also been asked by Mrs Kath Evan, Experience of Care Lead for Maternity, Infants, Children and Young People at NHS England to speak at the Youth Board in September at the 'Health Expo' event in 2017. Mrs Evan is very interested in the Young Health Champions programme and Young Voluntary services.

5.6.2 Adult Voluntary Services

The Adult Voluntary Service continues to steadily recruit, and Voluntary Services continue to support areas in the Trust offering support and reassurance to the patients and public.

5.7 Interpreters

The Patient Experience Team has introduced iPads into several outpatient clinics to assist with the interpretation requirements for patients. This will be particularly useful should a patient arrive at the clinic with no planned interpreter present. The iPad has an application that will translate over 80 different languages into English and provide a response from English into the chosen language back to the patient. This is supported by text on the screen to confirm the conversation accuracy. The iPads are available in multiple clinics and the ED at HRI. The idea has received a good reception from staff and feedback and will be reviewed formally over the next few months.

6. CARE QUALITY COMMISSION (CQC)

6.1 Well Led Domain pilot

The Trust Board is aware already that the Trust took part in a joint CQC well-led and NHS Improvement (NHSI) Use of Resources pilot on the 19th and 20th June 2017. The Trust has received a letter from the CQC, which summarises the high level feedback given to the Trust at the end of the pilot visit. In its letter, the CQC provided positive feedback on how cohesive the board was, the improvements achieved in the delivery of safe and high quality care and significant improvements in the culture of the organisation. The CQC found clear governance systems and a culture of learning and the Trust had established strong relationships with local partners for learning from patient deaths. The CQC noted areas where the Trust would benefit from further work being undertaken relating to a clear improvement strategy, improving medical engagement, improving links with patient and public engagement and the clearer articulation and alignment of Health Group and Trust strategies.

The Trust has provided a response to this and, also, provided feedback to NHSI and CQC in terms of what the inspection was like from its perspective. The draft fuller report from the CQC is awaited and will be shared with the Trust Board in due course.

8. 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

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

Appendix One: Safety Thermometer

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER July 2017

Absence of harm from

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

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 14th July both hospital sites. 875 patients were surveyed

95.3% 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.

1.37% (12) 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

98.63% 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 Dec 16 – July 17

	Dec 16	Jan 17	Feb 17	March 17	April 17	May 17	June 17	Jul 17
Harm Free Care %	95.8%	95%	94.6%	94.3%	93.5%	93.4%	93.1%	95.3%
Sample: Number of patients	890	843	953	896	882	892	904	875
Total Number of New Harm	11	14	15	23	11	20	19	12
NEW HARM FREE CARE %	98.6%	98.3%	98.5%	97.4%	98.7%	97.7%	97.9%	98.6%

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	0.46%	3	1	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	49	5.6%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	788	90.6%	95%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	38	4.3%	5%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	33	3.77%	24	3	6
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	3.09%	19	2	6
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	6	0.69%	5	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)	10	0.66%
Severity **No Harm**: fall occurred but with no harm to the patient	10	0.55%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	0	0%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	**163**	**18.63%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**5**	**1.32%**	**3%**
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**	**0.34%**	**1.8%**
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	**2**	**0.23%**	**1.2%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 11th August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	1st August 2017		**Reference Number**	2017 – 5 – 9		
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 July 2017 (May 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.

This report presents the 'safer staffing' position as at 30th June 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 appendix now includes some of the new metrics that is understood will be included in Lord Carter's Model Hospital dashboard, when this is made available with up to date information. These additions are: Care Hours Per Patient Day (CHPPD), annual leave allocation, sickness rates by ward and nursing and care assistant vacancy levels by ward.

[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

The inclusion of all of these additional sets of data is in its early stages. Over time, it is anticipated that this will help determine more comprehensively what impact nursing and midwifery staffing levels have on patient care and outcomes.

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%
Mar-17	86.80%	95.90%	89.60%	102.10%
Apr-17	85.20%	97.61%	89.15%	102.19%
May-17	83.70%	94.20%	89.20%	102.60%
Jun-17	90.40%	94.20%	93.90%	102.90%

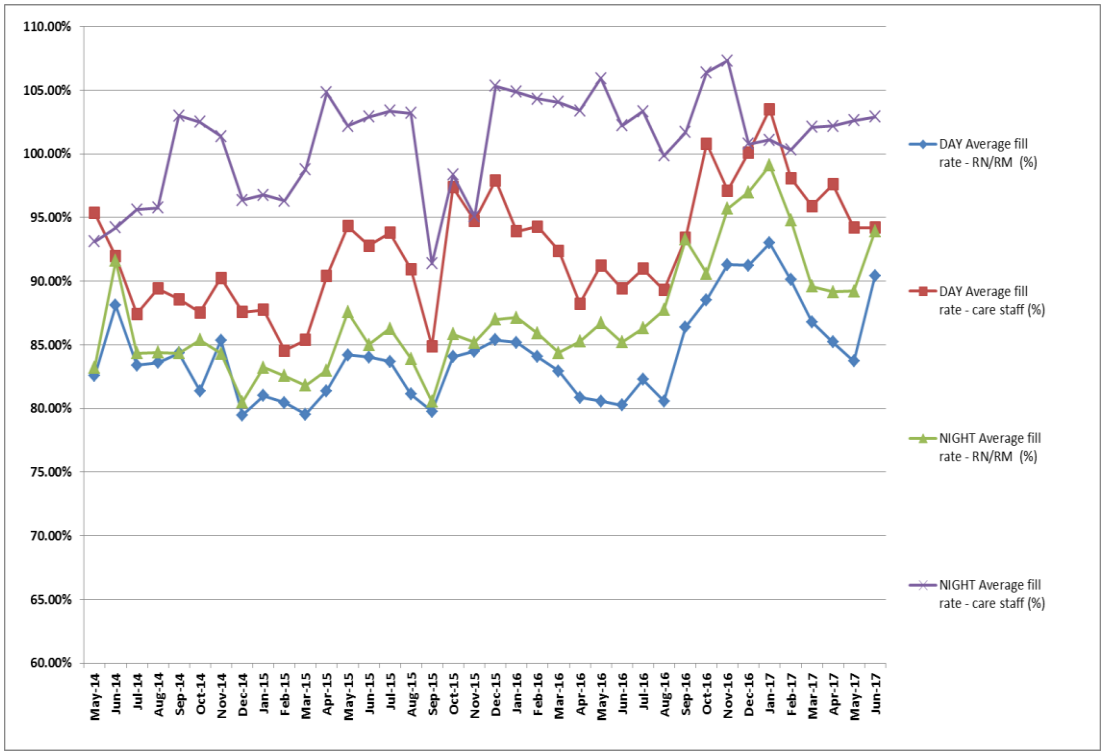
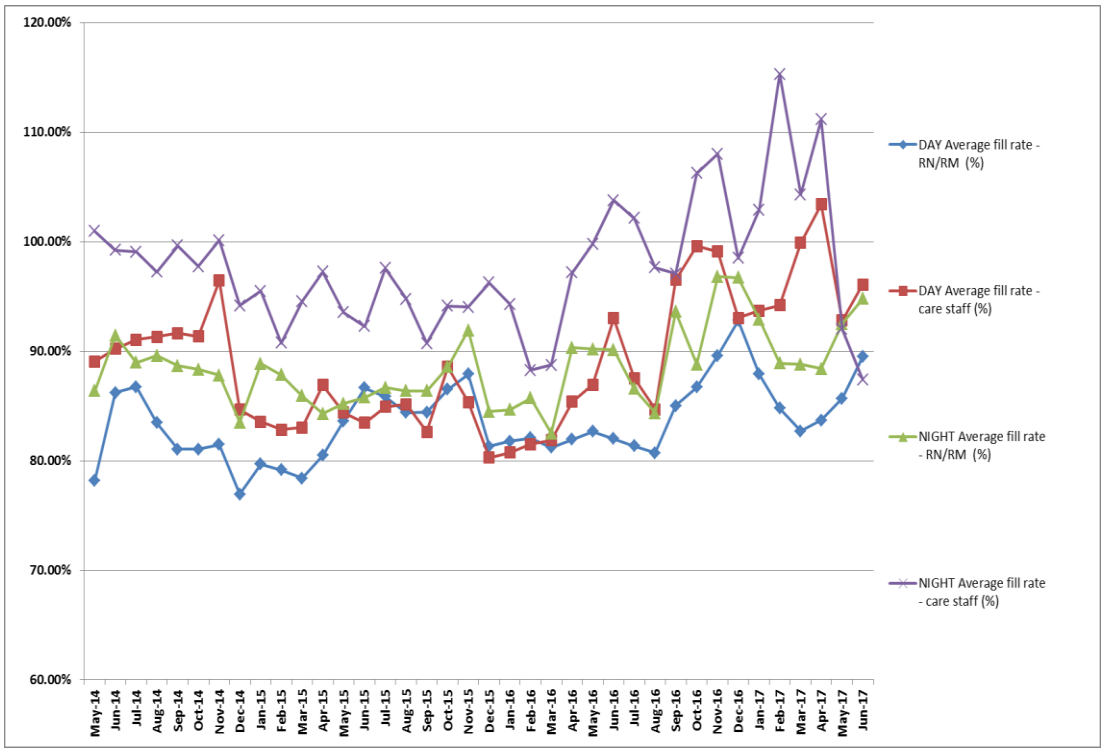


Fig 2: Castle Hill Hospital

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%
Mar-17	82.70%	99.90%	88.80%	104.30%
Apr-17	83.71%	103.40%	88.41%	111.16%
May-17	85.70%	92.80%	92.50%	92.00%
Jun-17	89.50%	96.10%	94.80%	87.40%



As indicated in the tables above the fill rates for both HRI and CHH have improved during the month of June compared to previous months. This reflects a number of factors, which include:

- The closure of 14 beds within Surgery at CHH.
- The redeployment of staff from CHH to support HRI.
- Reduction in the number of Ward Sister/ Charge Nurse supervisory shifts within Medicine on a temporary basis, to support the areas where there are significant vacancies. (Additional managerial support is being provided by the Senior Matron for the clinical area).
- The Rostering of Senior Matrons into clinical shifts within Surgery to help boost direct care-giving hours.
- Inpatient vacancy rates, which are approximately circa 153 wte Registered Nurses (RN) - an increase of only 3 wte from the previous month
- Sickness levels reduced from 4.8% the previous month to 1.3% during June (*please note this requires further validation*).
- The majority of clinical areas were within the 11-17% annual leave allocation, with only three areas over slightly, which means that annual leave is being managed within the requirements of the Trust's Policy.

Work continues with recruitment for Registered Nurses. 145 student nurses are currently being pursued by the Trust from the University of Hull. A further two recruitment exercises have been undertaken, which has resulted in a further 20 student nurses from other Universities being pursued.

In addition, the Trust is exploring currently with the University of Hull the possibility of increasing the number of student placements in September 2017 by a further 50 places. The Trust has identified sufficient capacity to provide the required mentorship to support the additional student placements and is currently waiting for confirmation from the University to support this initiative.

From the perspective of the Trusts International Recruitment campaign, the Trust has successfully interviewed 80 candidates from the Philippines, with a view to recruiting 40 candidates throughout the year (usual to have a 50% attrition rate). The plan is for staff to commence in September/October 2017 and begin in three cohorts, subject to NMC authorisation and visas being issued. Candidates have applied for their visas, however, they are experiencing delays with the Immigration department within the Home Office. The Trust's recruitment partner is supporting candidates to work through the issues. These delays may impact upon current timescales.

Many of the candidates that have been successful have considerable experience, which will help the Trust in filling posts which are difficult to recruit into.

The Trust is completing its internal preparations to ensure an effective and thorough induction takes place and that the recruits are supported in relation to completing their Objective Structured Clinical Examination (OSCE), which will allow them to register fully with the NMC. The induction will include support to find accommodation, open bank accounts and register with GP's as well as being welcomed by the team, service and organisation.

From the perspective of the Apprenticeship Levy, the Chief Nurse has commissioned a focused piece of work to review the potential financial options to support the possible implementation of the Pre-Registered Apprenticeship scheme, which is

expected to go live towards the end of February 2018, subject to an accepted business case.

4. ENSURING SAFE STAFFING

The safety brief reviews, which are now completed four times each day, are 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. Staffing levels are assessed directly from the live e-roster and SafeCare software.

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 professional view on the safety and staffing levels that day
- The physical layout of the ward
- The availability of other staff – e.g. bank/pool, matron, specialist nurses, speciality co-ordinators and allied health professionals.
- The balance of risk across the organisation

5. RED FLAGS AS IDENTIFIED BY NICE (2014).

Incorporated into the census data collected through SafeCare are a number of `Nursing Red Flags` as determined by the National Institute of Health and Clinical Excellence (NICE) (2014).[4]

Essentially, 'Red Flags' are intended to record a delay/omission in care, a 25% shortfall in Registered Nurse Hours or less than 2 x RN`s present on a ward during any shift. They are designed to support the nurse in charge of the shift to assess systematically that the available nursing staff for each shift or at least each 24-hour period is adequate to meet the actual nursing needs of patients on that ward.

When a 'Red Flag' event occurs, it requires an immediate escalation response by the Registered Nurse in charge of the ward. The event is recorded in SafeCare and all appropriate actions to address them are recorded in SafeCare, also, which provides an audit trail. Actions may include the allocation or redeployment of additional nursing staff to the ward. These issues are addressed at each safety brief.

In addition, it is important to keep records of the on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

The 'red flags' suggested by NICE, are:

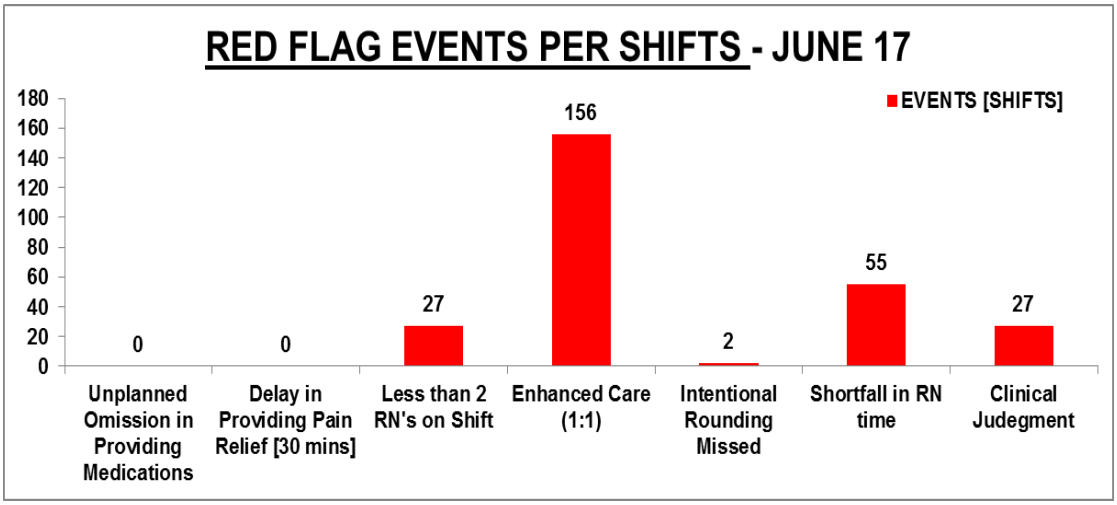
- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:

[4] NICE 2014 - Safe staffing for nursing in adult inpatient wards in acute hospitals

- Pain: asking patients to describe their level of pain level using the local pain assessment tool.
- Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
- Placement: making sure that the items a patient needs are within easy reach.
- Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

The following table illustrates the number of Red Flags identified during June 2017. Please note that the Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time.

Jun-17	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	0	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	27	10%
	Enhanced Care (1:1)	156	63%
	Intentional Rounding Missed	2	0%
	Shortfall in RN time	55	19%
	Clinical Judegment	27	8%
	TOTAL:	267	100%



As illustrated above a number of the Red Flags identified throughout June relate predominantly to `Enhanced Care`; this issue is being addressed currently through the development of an Enhanced Care Team.

The Enhanced Care Team Pilot will commence week beginning the 18th September 2017 and is planned for three months. The agreed pilot areas are H1, H4 and H40, H70, H8 and H9. The aim is to test the concept of using a trained team of clinical non-registered staff to undertake 1 to 1 supervision on patients when this element of care is identified either at initial assessment or during their inpatient stay. This will

also help to reduce the reliance on security guards. A significant amount work has been undertaken to ensure that this project has the management and governance processes in place with engagement with key stakeholders, with a robust project plan. The pilot will be evaluated formally at regular intervals and following the three month test period; a full report of the pilot will be presented to the Executive Management Board for review and consideration.

Following an induction week, the team will provide 1 to 1 supervision, including fundamental nursing care for the patient in the pilot areas. The service will cover 7 days a week and will operate under the management of the Project Lead and supervision of the Site Matron Team.

With regards to the Red Flags relating to less than 2 Registered Nurses on a shift, the data provided reflects the information inputted into the system by the ward areas prior to the Safety Briefs. Any shortfalls are always addressed at the Safety Briefs and plans are formulated to ensure no clinical area is ever left with fewer than two registered nurses. In order to ensure that this is completed in a timelier manner, the Safety Briefs are now completed four times a day, as opposed to the previous three.

6. AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

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

- **H11** have 9.59 RN vacancies, the impact of this shortfall is supported by part time staff working extra hours, bank shifts and over filling of auxiliary shifts. There are also newly appointed RNs that will join the ward in October. The Senior Matron is reviewing the position continuously with the ward sister.

- **Emergency Department - Registered Nurse Staffing** - The Department has 15.93 wte RN vacancies. The recruitment drive continues in ED, with the Senior Matron attending national events to actively recruit students. Senior nurses are helping to backfill, 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. There has been a noted increase in attendance as a result of robust absence management by the Senior Nurses within the Department.

- **H70 (Diabetes and Endocrine)** has 11.49 wte RN vacancies. This ward is supported in the interim by moving staff from Cardiology and Renal to assist from within the Medical Health Group. Support has also been provided from each of the other Health Groups, therefore reducing the current vacancies to 5 wte. In addition, from May 1st 2017, 2 wte pool nurses have joined the team for a six month period. Staffing across the health group is balanced daily to help manage any risk. In addition, a Band 6 nurse will be seconded to the ward for a six month period to ensure there is continuation of senior nurse cover including weekends.

- **Ward C16 (ENT, Plastics and Breast Surgery)** has 3.12 wte RN vacancies and over-established for non-registered vacancies at present. The RN vacancies have all been appointed to, with the aim of reaching a fully-recruited position in September 2017. However, despite some detailed work supported by HR, aimed at improving the retention figures, 2 more staff have since handed in their notice. In order to support the Ward, short term plans have been agreed to provide temporary cover. In addition to this, 2.0 wte RN Agency nurses are being used currently to bridge this gap, which is a cost pressure, but essential to maintain patient safety.

- **Neonatal Intensive Care Unit (NICU).** Recruitment in this specialty has been a concern, and there are currently 9.48 wte RN vacancies. All of these posts have been recruited to, and the staff will join the Trust in September 2017, following completion of their training. 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. The Health Group is looking at ways in which it can improve the retention of the staff in this specialty.

- **Ward H4 -** Neurosurgery has 4.60 wte RN and 1.71 wte non-registered nurse vacancies, the ward is being supported by H40.

- **Ward H7 -** Vascular Surgery has 4.52 wte RN vacancies. 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.

- **Ward C9 -** Elective Orthopaedic Surgery has 4.65 wte RN and 1.06 wte non-registered nurse vacancies. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 5.08 wte RN registered nurse vacancies. The nursing staff are flexed between C10 and C11.

7. SUMMARY

The latest review of nursing and midwifery establishment reviews have identified that these are set and financed at good levels in the Trust and these are managed very closely on a daily basis. This is all 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. 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.

8. 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
July 2017

Appendix 1: HEY Safer Staffing Report – June 2017

HEY SAFER STAFFING REPORT JUNE-17

NURSE STAFFING

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

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [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 [15-05-17 to 11-06-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY: SICK RN & AN [3.9%]	ROTA EFFICIENCY: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M3]: RN [WTE]	NURSING VACANCIES: AN [WTE]	NURSING VACANCIES: TOTAL [WTE]	NURSING VACANCIES: % [<10%]	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	ACUTE MEDICINE	NA	0									12.1%	1.6%	4.6%	15.93	1.03	16.96	13.6%				3				0								0	3
	AMU	ACUTE MEDICINE	45	2	104%	90%	101%	102%	1000	5.3	3.0	8.4	14.0%	0.0%	4.1%	8.74	-1.60	7.14	8.9%	100%		2	3	1			1						0	6
	H1	ACUTE MEDICINE	22	8	103%	101%	107%	102%	599	2.6	1.8	4.4	13.6%	2.9%	0.0%	2.69	2.14	4.83	19.2%	100%			1	1			1		1				1	3
	EAU	ELDERLY MEDICINE	21	26	101%	119%	98%	129%	526	3.8	4.1	7.9	13.0%	0.8%	6.4%	5.84	-1.53	4.31	13.2%	100%				1			1				1		1	2
	H5 / RHOB	RESPIRATORY	26	11	97%	87%	103%	98%	566	3.7	2.4	6.1	13.1%	1.3%	0.0%	1.69	-0.66	1.03	2.7%	100%								0		1				1	1
	H50	RENAL MEDICINE	19	0	73%	104%	101%	100%	543	3.1	2.2	5.3	12.0%	1.4%	1.8%	1.71	1.39	3.10	16.4%	100%			2	1				1						0	3
	H500	RESPIRATORY	24	3	81%	99%	100%	98%	687	2.2	2.5	4.7	12.7%	1.8%	3.8%	5.13	0.47	5.60	18.7%	100%								0						0	0
	H70	ENDOCRINOLOGY	30	12	104%	135%	101%	110%	880	2.4	2.2	4.5	9.5%	0.0%	0.0%	11.49	-0.24	11.25	33.9%	100%				2				2		1				1	3
	H8	ELDERLY MEDICINE	27	25	105%	124%	102%	110%	785	2.4	2.6	4.9	12.7%	1.2%	2.0%	2.88	-0.58	2.30	7.5%	92%		1		2	1			3						0	4
	H80	ELDERLY MEDICINE	27	14	80%	101%	113%	122%	793	2.2	2.5	4.7	10.3%	0.9%	0.0%	4.93	0.91	5.84	18.9%	100%		1		3				3						0	4
	H9	ELDERLY MEDICINE	31	21	97%	99%	100%	110%	888	2.2	2.1	4.3	15.6%	0.0%	0.0%	0.60	-0.34	0.26	0.8%	100%						1	1			1			1	2
	H90	ELDERLY MEDICINE	29	32	75%	110%	100%	101%	833	2.0	2.3	4.3	12.5%	5.4%	4.2%	5.31	-2.41	2.90	9.4%	96%		4	1	4	1			5						0	10
	H11	STROKE / NEUROLOGY	28	11	71%	167%	98%	102%	821	2.1	2.2	4.4	15.0%	0.0%	0.0%	9.59	-0.47	9.12	26.7%	96%		1						0		2				2	3
	H110	STROKE / NEUROLOGY	24	2	95%	129%	100%	93%	520	4.2	2.9	7.1	12.0%	0.7%	9.7%	3.48	0.01	3.49	10.1%	95%	1		1	1	1		2	1	1				2	6
	CDU	CARDIOLOGY	9	0	92%	65%	100%		102	11.9	1.0	13.0	18.7%	0.0%	0.0%	0.89	0.48	1.37	8.7%	100%								0						0	0
	C26	CARDIOLOGY	26	5	81%	88%	81%	97%	714	3.8	1.6	5.4	13.6%	0.0%	7.2%	1.43	-0.23	1.20	3.5%	100%			1	2				2		1				2	5
	C28 /CMU	CARDIOLOGY	27	5	77%	79%	82%	51%	684	5.9	1.4	7.3	11.2%	3.7%	3.7%	1.34	-0.11	1.23	2.5%	95%	4	1				1		1				0	6
SURGERY	H4	NEURO SURGERY	30	7	95%	93%	88%	108%	766	3.0	1.9	4.9	11.8%	4.4%	3.7%	4.60	1.71	6.31	19.5%	100%		2		1				1		1				1	4
	H40	NEURO HOB / TRAUMA	15	13	95%	102%	102%	92%	388	5.7	3.3	9.0	13.3%	0.9%	3.4%	3.35	0.61	3.96	12.8%	100%				1				1	1					1	2
	H6	ACUTE SURGERY	28	2	106%	70%	99%	177%	675	3.1	1.8	4.9	9.2%	0.5%	6.6%	3.07	1.47	4.54	15.3%	100%	2		1					0					0	3
	H60	ACUTE SURGERY	28	2	104%	88%	81%	167%	648	3.3	2.3	5.6	16.5%	0.0%	3.3%	1.36	1.38	2.74	9.0%	100%	1	1		1				1						0	3
	H7	VASCULAR SURGERY	30	5	100%	76%	93%	101%	867	2.8	2.3	5.1	14.1%	0.0%	0.7%	4.52	-0.79	3.73	10.7%	100%	1	1		1	1			2		1		1		2	6
	H100	GASTROENTEROLOGY	24	4	104%	100%	98%	97%	728	2.5	2.1	4.7	13.8%	2.7%	3.3%	3.95	0.34	4.29	14.1%	100%		1	2	1				1						0	4
	H12	ORTHOPAEDIC	28	2	95%	88%	101%	120%	759	2.7	2.6	5.3	14.5%	0.5%	3.6%	5.39	-1.19	4.20	12.0%	100%	1		1					0					0	2
	H120	ORTHO / MAXFAX	22	2	100%	108%	103%	119%	577	3.5	2.9	6.5	13.0%	0.0%	0.0%	1.52	1.39	2.91	10.1%	83%				1				1				1		1	2
	HICU	CRITICAL CARE	22	0	100%	110%	95%	53%	433	27.2	1.4	28.6	13.8%	1.5%	3.8%	7.42	0.01	7.43	6.6%	83%			1					0		1		4	2	7	8
	C8	ORTHOPAEDIC	18	0	99%	91%	99%	81%	259	4.3	2.4	6.7	17.5%	2.8%	0.0%	2.99	-1.03	1.96	13.6%	100%		1						0						0	1
	C9	ORTHOPAEDIC	29	0	96%	100%	103%	100%	675	3.2	2.3	5.5	12.5%	0.7%	0.0%	4.65	1.06	5.71	18.6%	100%								0						0	0
	C10	COLORECTAL	21	0	99%	59%	98%	90%	448	4.6	1.7	6.3	8.9%	8.2%	0.0%	5.08	0.59	5.67	21.7%	100%								0						0	0
	C11	COLORECTAL	22	0	97%	86%	94%	123%	424	4.7	2.4	7.1	14.8%	2.1%	0.0%	0.84	1.79	2.63	10.1%	100%								0						0	0
	C14	UPPER GI	27	0	96%	88%	100%	103%	653	3.4	1.8	5.1	12.6%	1.9%	0.0%	2.93	-0.56	2.37	8.0%	100%								0						0	0
	C15	UROLOGY	26	0	93%	79%	96%	94%	594	4.3	2.3	6.6	17.0%	1.3%	1.8%	-0.30	0.75	0.45	1.1%	100%			1	1				1		1		1		2	4
	C27	CARDIOTHORACIC	26	5	97%	91%	100%	103%	668	4.1	1.6	5.7	15.2%	0.0%	5.8%	1.15	-0.67	0.48	1.5%	100%		1						0						0	1
	CICU	CRITICAL CARE	22	0	93%	57%	92%	33%	386	22.3	1.3	23.7	15.0%	0.4%	5.3%	5.39	0.34	5.73	5.7%	100%								0				1		1	1
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	102%	168%	129%	84%	195	10.2	6.2	16.3	9.5%	0.0%	0.0%	3.12	-0.42	2.70	9.1%	100%	1	1						0						0	2
	H130	PAEDS	20	0	84%	29%	78%	63%	343	6.9	1.0	7.9	12.0%	0.0%	8.8%	-0.55	2.02	1.47	5.2%	100%								0						0	0
	H30 CEDAR	GYNAECOLOGY	9	0	86%	70%	109%		149	9.9	3.2	13.2	14.0%	2.8%	0.0%	-1.00	0.12	-0.88	-3.9%	100%								0						0	0
	H31 MAPLE	MATERNITY	20	0	87%	94%	113%	98%	419	5.4	3.2	8.6	15.0%	1.1%	1.9%	4.54	2.85	7.39	10.4%	100%	1							0						0	1
	H33 ROWAN	MATERNITY	38	0	84%	88%	90%	100%	1164	2.6	1.4	4.0	15.5%	2.0%	2.0%				-2.2%	100%	1		1					0						0	2
	H34 ACORN	PAEDS SURGERY	20	0	93%	59%	100%	100%	258	10.1	2.0	12.1	14.5%	0.0%	0.0%	-0.14	-0.50	-0.64	-2.2%	100%								0						0	0
	H35	OPHTHALMOLOGY	12	0	79%	63%	107%		232	8.8	1.8	10.6	14.8%	0.0%	4.6%	-0.54	1.53	0.99	4.8%	100%		1	1	1				1		2				2	5
	LABOUR	MATERNITY	16	0	84%	63%	81%	62%	295	15.9	4.5	20.4	12.8%	4.4%	4.5%	-5.47	-4.37	-9.84	-15.5%	100%	2		1					0	1					1	4
	NEONATES	CRITICAL CARE	26	0	80%	88%	82%	103%	666	10.5	1.0	11.6	13.5%	0.5%	7.7%	9.48	-0.66	8.82	12.3%	100%			1					0						0	1
	PAU	PAEDS	10		83%		98%		61	21.8	0.0	21.8	10.9%	2.1%	0.0%	-0.20	0.00	-0.20	-1.9%	100%								0						0	0
	PHDU	CRITICAL CARE	4	0	94%	56%	100%		55	25.6	2.3	27.9	17.6%	0.0%	0.0%	-3.15	0.00	-3.15	-30.0%	100%								0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	6	93%	94%	101%	97%	443	3.2	2.3	5.5	9.5%	0.2%	4.8%	1.48	0.96	2.44	12.1%	100%			1	3				3						0	4
	C29	REHABILITATION	15	29	77%	105%	102%	66%	446	3.1	4.1	7.3	14.8%	0.0%	0.0%	1.37	2.22	3.59	12.4%	100%		1						0						0	1
	C30	ONCOLOGY	22	1	87%	103%	100%	97%	606	2.9	2.0	4.9	12.7%	0.0%	2.7%	1.14	0.03	1.17	5.3%	100%		2						0						0	2
	C31	ONCOLOGY	27	4	77%	127%	100%	101%	707	2.6	2.1	4.7	13.0%	0.6%	0.0%	-0.33	1.33	1.00	3.9%	100%				2				2				1		1	3
	C32	ONCOLOGY	22	0	94%	99%	102%	100%	605	3.0	1.8	4.7	14.4%	1.3%	3.1%	-0.53	1.72	1.19	5.0%	100%		1		1				1		1				1	3
	C33	HAEMATOLOGY	28	0	84%	151%	86%	125%	695	4.3	2.0	6.4	11.8%	0.0%	5.1%	2.97	-1.99	0.98	2.8%	100%	1							0					1	1	2
		TOTAL:	259		AVERAGE:				565	6.2	2.3	8.5	13.4%	1.3%	2.6%	153.77	10.30	164.07	8.5%	98.8%															
													TOTALS:					TOTALS:		49	16	23	23	32	4	2	38	3	14	0	12	3	32	132

Jun-17	DAY		NIGHT		CARE HOURS PER PATIENT PER DAY [CHPPPD]			
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Cumulative Count	RN / RM	CARE STAFF	OVERALL
HRI SITE	90.4%	94.2%	93.9%	102.9%	19136	4.5	2.3	6.9
CHH SITE	89.5%	96.1%	94.8%	87.4%	9304	4.8	2.1	6.9

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

GREAT STAFF, GREAT CARE, GREAT WARD:
NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS

Trust Board date	1st August 2017	**Reference Number**	
Director	Mike Wright - Chief Nurse	**Author**	Mike Wright, Chief Nurse Jo Ledger, Deputy Chief Nurse Caroline Grantham, Practice Development Matron
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Determine if this report provides sufficient information and assurance • Determine if any further actions 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): All Safe domains; E1 (evidence-based); E2 (outcomes); E3 (staff skills); E4 (team working); C1 (care, respect and dignity)			
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** The Board receives this report on a quarterly basis, to provide an overview of fundamental standards of care, positive assurance on progress and any risk issues arising.			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
GREAT STAFF, GREAT CARE, GREAT WARD:
NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in May 2017. Good progress is being made and this report presents the position as of June 2017.

Areas of achievement are summarised alongside the next areas for focused attention. Good progress is being made overall.

Audit results are publicised in wards and departments as part of ongoing transparency and accountability to patients and the public for the care provided.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
GREAT STAFF, GREAT CARE, GREAT WARD:
NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. The Trust must account for the quality of care it delivers to patients and ensure that care is both evidence-based, where possible, and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by the Trust's nursing and midwifery teams. The last report on this topic was presented to the Trust Board in May 2017. This provides a progress report up to the end of June 2017.

As indicated in **Table 1** below, the review process is set around nine fundamental standards, with the emphasis on delivering safe, effective and high quality care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care. This ensures consistency of what is looked at and creates a credible, comparable rating. The aim is to celebrate areas of excellent practice, identify areas where further improvements/support are required and with a clear time frame for the improvement to be delivered.

TABLE 1 - The Nine Fundamental Standards

1. STAFF EXPERIENCE
2. PATIENT ENVIRONMENT
3. INFECTION CONTROL
4. SAFEGUARDING
5. MEDICINES MANAGEMENT
6. TISSUE VIABILITY
7. PATIENT CENTRED CARE
8. NUTRITION & HYDRATION
9. PATIENT EXPERIENCE

2. ASSESSMENT PROCESS

A fundamental part of the process is that it is objective; therefore a number of the standards audits are conducted by speciality teams. For example, assessment of the Nutrition core standard is completed by the Dietetic Team and the Infection Control core standard, the Infection Prevention and Control Team. In addition, the methodology used during the assessment process is varied and includes:

- Observation of care given and patients' documentation
- Discussion with patients and staff members
- Discussion with the Department Senior Sister/Charge Nurse

Following the assessment process a rating is given (as illustrated below) for each fundamental standard depending on the percentage scored from the visit. Each of these carries a specific re-audit time period and this is incentive based; the higher the score, the less frequent the requirement to re-audit.

Score	less than 80%	80% to 89.9%	90 to 94.9%	95% or above
Frequency of Review	3 month review	6 month review	9 month review	12 month review

In order to ensure the process is both robust and reflects clearly the standard of care being delivered within a clinical setting, performance and outcome data is also used alongside these audits and is triangulated with the information obtained during the assessment process.

This is of particular relevance when reviewed in relation to both the Infection Control and Tissue Viability Core Standards. The final ratings for these two standards are capped at 80% if the clinical area:

- Scores Amber or above on the ward inspection (above 80%) but has had a hospital acquired harm in the previous six months, i.e. Hospital Acquired Clostridium difficile infection, MRSA Bacteraemia or an avoidable Hospital Acquired Pressure Ulcer
- Scores Red on the ward inspection but has not had hospital acquired harm in the previous six months.

Following the review, the Ward Sister/Charge Nurse is required to formulate an action plan, within a two-week time period. A copy of each review and action plan is then sent to the Senior Matron and Nurse Director responsible for that area to approve and endorse. Performance against each action plan is monitored through the Health Groups' Governance Structures. In addition, it is a requirement that each action plan is discussed and progress reported and documented at monthly ward/unit meetings.

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard, then the Ward Sister/Charge Nurse will have an appraisal completed by the Senior Matron, with clear objectives set. If the ward gets a second consecutive Red, then the Senior Sister/Charge Nurse will have an appraisal completed by the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse in order to determine what additional help/support and/or performance action may be required.

In an endeavour to strengthen further the `Ward to Board` concept, the Chief Nurse has introduced an additional panel, chaired by the Deputy Chief Nurse that reviews the performance of each ward against all of the Fundamental Standards in conjunction with the

ward/department Charge Nurse/Sister every six months. This purpose of this is essentially threefold:

1. To ensure that good practice is disseminated and areas of concern are reviewed and addressed from a corporate perspective.
2. Identification of themes across the clinical services, which require an organisational approach to resolve, for example issues relating to the nursing documentation.
3. Provide the Chief Nurse with independent assurance in relation to the level of delivery, understanding, consistency and ownership of each of the fundamental standards at ward/department level.

Transparency is deemed fundamental to improving standards of care. In an endeavour to embrace this concept, each of the ward/department now displays its individual results on a "How are we doing?" board (as illustrated below in Figure 1). These are for patients, relatives and visitors to view and as part of our drive to be more transparent and accountable to them for the standards on that ward. Each fundamental standard result is colour-coded according to the rating achieved and states "What we are doing well" and "Areas for improvement".

Ward 40's "How are we doing?" board

Figure 1

3. CURRENT POSITION

Fifty Four Clinical areas have been reviewed consisting of Ward Areas, Critical Care Units & the Emergency Department. Table 2 below illustrates the overall Trust position in relation to all of the fundamental standards. **Appendix One** provides an overview of individual ratings by clinical area, where applicable. Please note that a number of the fundamental standards are not applicable within all clinical areas, for example the nutritional fundamental standard is not completed on the Labour ward, this relates to the duration of time the patients spend within this clinical setting.

Current Trust Position for all Fundamental Standards: June 2017								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
23 wards	18 Wards	3 wards	40 wards	19 Wards	10 wards	12 wards	9 wards	22 wards
24 wards	30 Wards	9 wards	11 wards	23 Wards	7 wards	16 wards	17 wards	26 wards
7 wards	4 Wards	42 wards	3 wards	12 Wards	29 wards	22 wards	15 wards	6 wards
0 wards	0 Wards	0 wards	0 wards	0 Wards	5 wards	3 wards	7 wards	0 wards

Table 2

The following tables illustrate the progress made in relation to each fundamental standard from April 2017 to June 2017, across the four Health Groups. Please note that in some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of each fundamental standard's assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken to address any shortcomings.

4. STAFF EXPERIENCE

This standard focuses predominantly on the leadership capability within the area. It requires the Charge Nurse/Sister to demonstrate that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of the patients being cared for in that clinical area. It requires the Leader to demonstrate that they are promoting a `Learning Environment`, where staff improve continually the care they provide by learning from patient and carer feedback, incidents, adverse events, errors, and near misses.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	April 17	**June 17**
5	5	4	**4 wards**	5	5	6	**6 wards**	14	15	10	**9 wards**	12	12	7	**5 wards**
1	1	2	**2 wards**	4	4	3	**3 wards**	5	4	9	**10 wards**	7	6	7	**8 wards**
0	0	0	**0 wards**	1	1	1	**1 wards**	0	0	0	**0 wards**	0	1	5	**6 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**

Progress since April: 7 reviews have been completed during this period. There is one outstanding review within Family & Women's; this will be completed in July 2017. There are no areas rated as Red for this standard. The number of clinical areas rated as Blue has decreased within Surgery and Medicine, which relates to the changes made to the assessment process for this standard. The number of staff questions has increased in order to capture areas of concern raised following the recent CQC inspection, focusing specifically

on safe staffing levels and escalation processes. In order to address a number of the concerns raised by staff out of hours, particularly on a weekend, the site team has been enhanced by the addition of a band 7 sister/charge nurse. The purpose of which is as follows:

- Support the site team in ensuring the safe redeployment of nursing staff across the organisation.
- A point of contact for clinical issues escalated by ward/departmental staff.
- Support junior staff in prioritising clinical workloads.

5. PATIENT ENVIRONMENT – this standard assesses whether clinical environments are clean and safe for patients and that they are cared for with dignity & respect.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**
0	0	0	**0 wards**	3	2	3	**4 wards**	3	4	5	**6 wards**	1	2	7	**8 wards**
5	5	6	**6 wards**	4	5	5	**5 wards**	11	13	11	**10 wards**	8	9	7	**9 wards**
1	1	0	**0 wards**	2	2	1	**0 wards**	3	1	2	**2 wards**	9	8	5	**2 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**	1	0	0	**0 wards**

Progress since April: 25 reviews have been completed during this period. The number of clinical areas rated Blue has continued to increase in number; in Family & Women's, Medicine and Surgery. There are no areas rated Red. These improvements are related predominantly to enhancements made to patient areas such as ward day rooms and storage areas, where staff have implemented the core elements of Productive Ward lean methodology to eliminate unnecessary stock levels and ensure effective stock rotation.

6. INFECTION CONTROL – this standard assesses the adherence of the clinical area to the Trust's Infection and Control policies.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	April 17	**June 17**
0	0	0	**0 wards**	0	0	0	**0 wards**	1	1	1	**1 wards**	1	1	1	**2 wards**
1	1	2	**3 wards**	0	1	1	**1 ward**	3	5	3	**3 wards**	2	3	2	**2 wards**
5	5	4	**3 wards**	10	9	9	**9 wards**	14	12	15	**15 wards**	15	14	16	**15 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	1	1	0	**0 wards**	1	1	0	**0 wards**

Progress since April: There are 8 outstanding reviews for this standard this quarter. 21 reviews were completed during this period. There are no areas rated Red. The number of Green-rated clinical areas has increased within Clinical Support for the second quarter in a row. The Medicine Health Group has seen an increase in their Blue-rated areas this quarter. The Practice Development Matrons are working closely with the facilities department to ascertain if the domestic staff can take on any cleaning of equipment, which should support improved compliance in this area. A focused piece of work has been commissioned to look at the feasibility of supporting the wards with hygienist cover 7 days a week. In addition, the Infection Control Team is reviewing currently the cleaning requirements across all clinical areas in an endeavour to standardise practice.

7. **SAFEGUARDING –** this standard assesses compliance of the clinical area with the local safeguarding policy to ensure that patients are protected from abuse or the risk of abuse and that their human rights are respected and upheld.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**
4	5	5	**5 wards**	5	9	7	**7 wards**	14	15	16	**16 wards**	12	11	12	**12 wards**
2	1	1	**1 wards**	5	1	2	**2 wards**	4	2	2	**2 wards**	7	7	6	**6 wards**
0	0	0	**0 wards**	0	0	1	**1 wards**	1	2	1	**1 wards**	0	1	1	**1 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**

Progress since April: 8 reviews have been completed during this review. There has been no change in the overall ratings per ward across all Health Groups, although this standard scores relatively highly overall.

8. **MEDICINES MANAGEMENT –** this standard assesses whether staff within the clinical area handle medicines safely, securely and appropriately in accordance with the Trust's Policy and Procedures and that medicines are prescribed and administered to patients safely.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**
1	1	0	**0 wards**	3	5	7	**7 wards**	5	6	6	**7 wards**	0	2	5	**5 wards**
3	3	3	**2 wards**	6	5	2	**2 wards**	3	8	9	**11 wards**	9	8	7	**8 wards**
2	2	3	**4 wards**	1	0	1	**1 wards**	11	5	4	**1 wards**	9	9	7	**6 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**	1	0	0	**0 wards**

Progress since April: 14 have been completed during this period. There has been an increase in the number of Blue and Green-rated clinical areas within Medicine and Surgery. There are no clinical areas rated Red for this standard. The improvements are related to a step-changed sustained compliance in 24 hour monitoring of medication fridges and controlled drugs checks.

9. **TISSUE VIABILITY –** this standard assesses clinical staffs, knowledge and delivery of safe and effective pressure ulcer prevention.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**
0	0	0	**0 wards**	6	6	5	**6 Wards**	1	1	1	**1 wards**	2	3	3	**3 wards**
2	2	2	**2 wards**	0	0	0	**2 Wards**	2	3	1	**4 wards**	0	1	1	**1 wards**
4	4	4	**5 wards**	4	4	5	**3 wards**	9	10	12	**11 wards**	9	8	8	**10 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	7	5	5	**3 wards**	5	4	4	**2 wards**

Progress since April: 34 reviews have been completed during this period, with no outstanding reviews for this standard. There has been an increase in the number of Blue and

Green-rated clinical areas within Family & Women's and Surgery. We have also seen a decrease in Red-rated areas overall this quarter within Surgery and Medicine health groups. As a result of the areas of concern highlighted through the completion of the Tissue Viability Fundamental Standard, relating specifically to documentation, a task and finish group has been set up to review the current Nursing Record. The Working Group has reformatted the current Nursing Care Bundle with a plan to pilot within a number of Clinical Areas throughout August 2017.

10. PATIENT CENTRED CARE – this standard assesses whether patients' clinical records are accurate, fit for purpose, held securely and remain confidential in accordance with the Trust`s policies and procedures.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	April 17	**June 17**
0	0	0	**0 wards**	5	5	5	**5 wards**	3	3	5	**5 wards**	1	1	2	**2 wards**
2	2	2	**2 wards**	2	1	1	**3 wards**	3	2	4	**6 wards**	7	7	5	**5 wards**
4	4	4	**4 wards**	2	3	2	**1 wards**	11	12	7	**8 wards**	6	5	8	**9 wards**
0	0	0	**0 wards**	0	0	1	**0 wards**	2	2	3	**0 wards**	4	5	4	**3 wards**

Progress since April: 11 reviews have been completed during this period. There has been a decrease in Red-rated Scores within Family & Women's, Surgery & Medicine. There has been an increase in Green and Amber-rated scores within Family & Women's & Surgery.

11. NUTRITION – this standard assesses compliance with the Trust`s Nutrition and Hydration policy. It requires staff to demonstrate how they reduce the risk of poor patient nutrition and dehydration through comprehensive assessments, individualised care planning and implementation of care to ensure that patients are receiving adequate nutrition and hydration.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	April 17	**June 17**
0	0	0	**1 wards**	3	4	2	**2 Wards**	3	4	4	**5 wards**	3	1	2	**1 wards**
1	1	1	**2 wards**	1	1	2	**2 Wards**	4	2	4	**7 wards**	2	4	5	**5 wards**
3	3	4	**3 wards**	3	2	2	**1 Wards**	4	5	7	**5 wards**	8	3	8	**6 wards**
2	2	1	**0 wards**	0	0	1	**2 wards**	8	8	4	**2 wards**	4	9	2	**3 wards**

Progress since April: 32 reviews completed during this period. Clinical Support and Surgery have both seen a decrease in Red-rated areas for this standard and an increase in Blue-rated areas. The Family & Women's and Medicine Health Groups have seen an increase in the number of Red-rated areas. There are two predominant reasons for the Red-rated scores within this standard. Firstly, poor compliance in relation to the completion of the Food and Hydration charts. Although staff members are entering what the patients are eating on a daily basis, the current food chart requires the staff to calculate a score, which is not always completed consistently. Secondly, although the nursing staff are activating an appropriate plan of care based on a comprehensive risk assessment, they are not always documenting specific patient needs consistently/reliably. There is no evidence to suggest that this is resulting in patient harm or that patients are not receiving appropriate nutrition and hydration.

In response to the issues highlighted through the completion of the Nutrition Fundamental Standard, the Nursing Care Bundle and Food Chart have been reformatted with a plan to pilot within a number of Clinical areas throughout August and September 2017.

12. PATIENT EXPERIENCE – this standard assesses whether the clinical area has an active process of obtaining feedback from patients. That there is demonstrable evidence that practice is reviewed and changed where appropriate on the basis of patient feedback.

Clinical Support				Family & Women's				Surgery				Medicine			
Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**	Oct 16	Jan 17	Apr 17	**June 17**
4	4	2	**3 wards**	8	8	5	**5 wards**	13	14	10	**8 wards**	12	13	8	**6 wards**
2	2	4	**3 wards**	1	1	4	**4 wards**	6	5	9	**11 wards**	3	3	5	**8 wards**
0	0	0	**0 wards**	0	0	1	**1 wards**	0	0	0	**0 wards**	3	2	6	**5 wards**
0	0	0	**0 wards**	0	0	0	**0 wards**	0	0	0	**0 wards**	1	1	0	**0 wards**

Progress since April: 7 reviews completed during this period. There are no Red-rated areas for this standard. There has been a decrease in Blue-rated clinical areas for this standard within Medicine and Surgery and an increase in Green-rated areas. This is due to the changes that have been made to the audit tool for this standard. An environment check is now also completed as part of this standard, incorporating areas of concern raised following the recent CQC inspection.

13. OVERALL POSITION:
Good progress is being made against all of the fundamental standards, 41 of the 54 clinical areas reviewed now have no Red Standards; figure 2 illustrates the progress that has been made from a Trust perspective over the last quarter in relation to the number of Fundamental Standards rated Red. Figure 3 illustrates progress since October 2016 in the reduction of clinical areas with one or more fundamental standards rated as Red.

13 clinical areas have one or more fundamental standard rated as Red. Of these:

- 11 clinical areas have one red standard
- 2 clinical areas have two red standards.

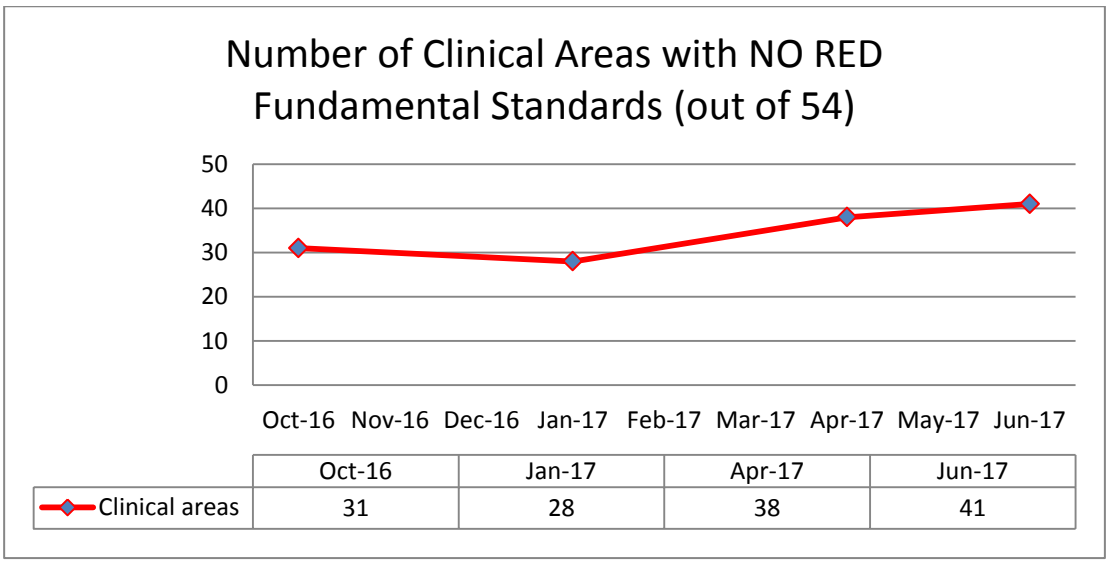


Figure 2

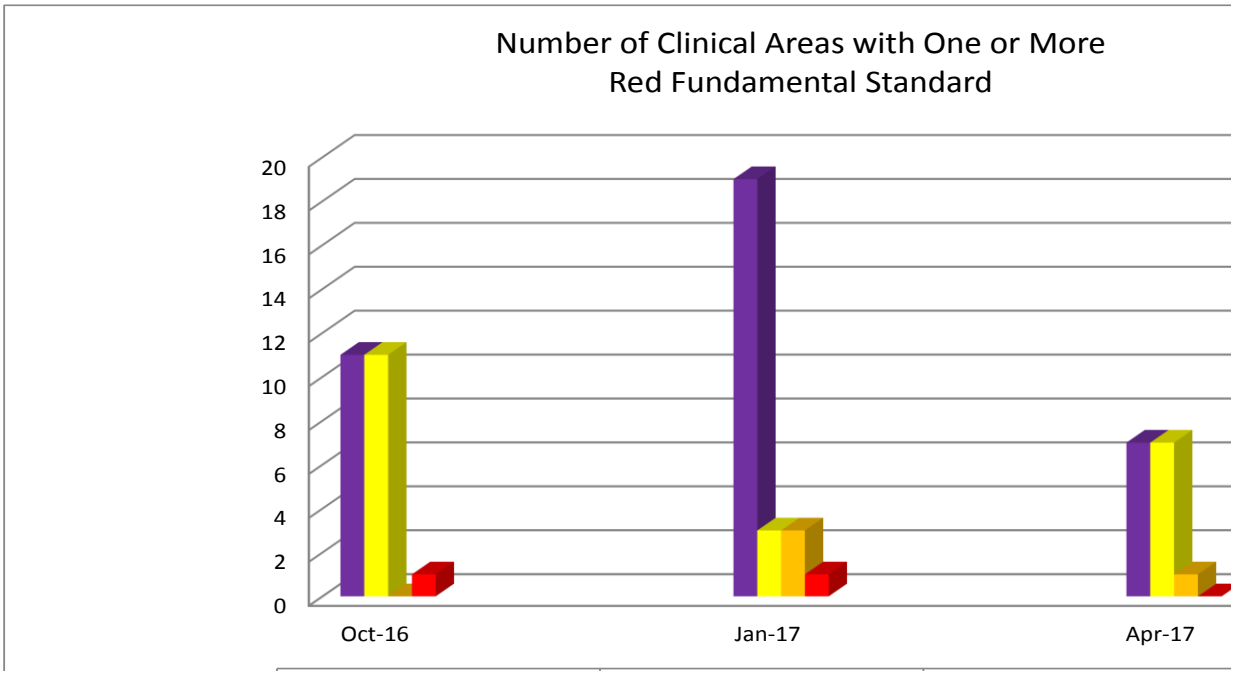


Figure 3

14. AREAS FOR IMPROVEMENT

To ensure continual improvement, the following trajectories have been endorsed by the Chief Nurse indicating that by September 2017:

- No clinical areas will have any fundamental standards rated as Red
- Blue standards will be maintained
- Standards currently at Amber or Green will improve to the next rating.

Focused work has commenced on addressing each of the standards that are rated Red and Amber to ensure the above trajectory is met. Progress in relation to each of the standards will be presented to the Trust Board on a quarterly basis.

15. SUMMARY

Although there are still a number of fundamental standards that are currently rated as red, significant progress has been made over the last three months to improve this position. A concentrated effort on improving the core standards that review Nutrition and Tissue Viability will remain a key priority of the Senior Nursing Teams. The Deputy Chief Nurse continues to meet with each of the Ward Sisters/Charge Nurses to ensure progress is been made against each of the above trajectories.

16. ACTION REQUESTED OF THE TRUST BOARD

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
July 2017

Appendix One – Nursing and Midwifery Fundamental Standards Audits Scores as at June 2017.

FUNDAMENTAL STANDARDS June 2017

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C20	99%	April 18	90%	July 17	90%	Sept 17	100%	Mar 18	94%	Nov 17	80%*	Dec 17	82%	July 17	90%	Mar 18	97%	Mar 18
C29	91%	Jan 18	91%	Jan 18	86%	Oct 17	97%	Feb 18	92%	Nov 17	**84%**	Oct 17	**80%**	Aug 17	100%	June 18	96%	Feb 18
C30	96%	April 18	93%	Feb 18	**90%**	Jan 18	97%	Dec 17	84%	Aug 17	89%	Oct 17	82%	Aug 17	**94%**	Mar 18	94%	Dec 17
C31	96%	Mar 18	89%	Feb 18	84%	Sept 17	100%	Mar 18	84%	Jan 18	80%*	July 17	85%	Sept 17	81%	Dec 17	95%	Mar 18
C32	96%	Mar 18	89%	Jan 18	91%	Dec 17	100%	Mar 18	87%	July 17	88%	July 17	**89%**	Dec 17	81%	Dec 17	94%	Dec 17
C33	89%	Jan 18	91%	Jan 18	**87%**	May 17	92%	Sept 17	85%	Jan 18	80%*	Oct 17	89%	Mar 18	83%	Dec 17	92%	Dec 17

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	90%	Mar 18	95%	April 18	86%	July 17	90%	Nov 17	92%	Aug 17	80%*	Sept 17	98%	Jan 18	78%	Sept 17	94%	Dec 17
Cedar H30	88%	Sept 17	91%	April 18	80%	Oct 17	97%	Dec 17	95%	Feb 18	80%*	July 17	91%	Mar 18	87%	Sept 17	96%	June 18
H31	96%	April 18	93%	Dec 17	**80%***	May 17	88%	Sept 17	86%	Oct 17	89%	Jan 18	99%	Jan 18	NA		93%	Nov 17
H33	94%	Jan 18	89%	April 18	80%*	May 17	98%	Nov 17	95%	Jan 18	100%	April 18	99%	Jan 18	NA		96	Jan 18
ACORN	95%	April 18	91%	Oct 17	80%*	Sept 17	100%	Feb 18	100%	Mar 18	100%	June 18	93%	Feb 18	**89%**	Dec 17	96%	Mar 18
H35	89%	Dec 17	97%	June 18	89%	Sept 17	100%	Oct 17	94%	Mar 18	81%	Oct 17	96%	Feb 18	92%	Sept 17	92%	Dec 18
H130	95%	Jan 18	95%	Mar 18	**80%***	Sept 17	100%	Feb 18	97%	Mar 18	100%	April 18	90%	Nov 17	**72%**	Sept 17	88%	Aug 17
Labour	95%	Jan 18	NA		**80%***	April 17	100%	Nov 17	96%	Dec 17	100%	Sept 17	99%	Jan 18	NA		98%	Jan 18
NICU	**90%**	Jan 18	95%	June 18	**88%**	Dec 17	97%	Mar 18	100%	Mar 18	100%	Mar 18			100%	June 18	98%	Mar 18
PHDU	97%	Mar 18	93%	Oct 17	**86%**	Jan 18	94%	Nov 17	100%	Oct 17	100%	June 18	86%	Aug 17	**96%**	Mar 18	93%	Dec 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C8	92%	Mar 18	91%	Feb 18	**80%***	June 17	100%	Jun 18	95%	Nov 17	**80%***	Sept 17	85%	July 17	**100%**	June 18	97%	June 18
C9	90%	Dec 17	85%	Oct 17	**80%***	April 17	96%	Jan 18	94%	April 18	**71%**	Aug 17	92%	Feb 18	**82%**	Dec 17	89%	Jan 18
C10	94%	Jan 18	95%	June 18	88%	Sept 17	94%	Oct 17	91%	Nov 17	**80%***	Sept 17	83%	Aug 17	92%	Mar 18	96%	Mar 18
C11	96%	Oct 17	91%	Jan 18	81%	July 17	95%	Dec 17	97%	June 18	**80%***	Aug 17	82%	July 17	93%	Mar 18	89%	Dec 17
C14	91%	Jan 18	93%	Jan 18	83%	Jan 18	100%	Aug 17	89%	Aug 17	**67%**	Sept 17	81%	July 17	82%	Sept 17	95%	Mar 18
C15	100%	April 17	93%	Mar 18	82%	Jan 18	87%	May 17	94%	April 18	**80%***	Sept 17	82%	Aug 17	93%	Mar 18	94%	Dec 17
C27	99%	Mar 18	93%	Mar 18	89%	Sept 17	100%	Mar 18	94%	Aug 17	**89%**	Jan 18	93%	Nov 17	**87%**	Sept 17	91%	Dec 17
CICU1	98%	April 18	100%	April 18	97%	April 18	100%	May 18	99%	Oct 17	93%	Mar 18	96%	June 18	96%	May 18	97%	Mar 18
CICU2	90%	April 18	95%	Sept 17	85%	Sept 17	100%	May 18	100%	Oct 17	**96%**	April 18	95%	April 18	100%	May 18	92%	Dec 17

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	95%	Mar 18	95%	Mar 18	**81%**	Oct 17	100%	Dec 17	92%	Aug 17	**80%***	Aug 17	80%	Jan 18	**76%**	**Oct 17**	92%	Dec 17
H40	92%	Sept 17	93%	Oct 17	86%	Oct 17	100%	Dec 17	89%	Aug 17	**80%***	July 17	93%	Apr 18	**65%**	Oct 17	94%	Dec 17

H6	95%	Mar 18	93%	Dec 17	**80%***	Nov 17	97%	June 18	90%	Nov 17	**55%**	July 17	94%	Dec 17	**84%**	Jan 18	90%	Dec 17
H60	95%	Mar 18	97%	June 18	**86%**	July 17	97%	Jan 18	96%	Oct 17	**81%**	Sept 17	96%	Mar 18	**91%**	Mar 18	95%	Mar 18
H7	89%	Dec 17	97%	Mar 18	**80%***	Sept 17	97%	Mar 18	91%	Aug 17	**90%**	Oct 17	**96%**	Mar 18	**95%**	June 18	92%	Dec 17
H12	92%	July 17	93%	Mar 18	80%*	Oct 17	97%	Dec 17	91%	Aug 17	90%	July 17	90%	Oct 17	**89%**	Mar 18	96%	Mar 18
H120	95%	Mar 18	93%	Mar 18	**86%**	Sept 17	96%	Dec 17	91%	Aug 17	**80%**	Dec 17	80%	Oct 17	**98%**	Mar 18	95%	Mar 18
H100	89%	Jan 18	88%	Jan 18	**80%***	July 17	100%	Dec 17	83%	Dec 17	**80%***	July 17	82%	Jan 18	85%	Dec 17	90%	Dec 17
HICU1	89%	Jan 18	94%	July 17	92%	Sept 17	100%	April 18	95%	Nov 17	80%*	Aug 17	92%	Jan 18	**92%**	Mar 18	95%	Mar 18
HICU2	89%	Jan 18	NA		92%	Sept 17	97%	June 18	97%	June 18	80%*	Oct 17	91%	Jan 18	**90%**	Mar 18	93%	Dec 17

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	93%	Jan 18	**95%**	April 18	97%	May 18	100%	May 17	89%	July 17	94%	Aug 17	**92%**	Dec 17	92%	Mar 18	94%	Dec 17
C26	94%	Mar 18	93%	Mar 18	86%	Sept 17	100%	Mar 18	91%	Aug 17	81%	Nov 17	81%	July 17	86%	Sept 17	95%	Mar 18
C5DU	93%	Dec 17	91%	Jan 18	97%	Oct 17	96%	June 18	98%	Feb 18	100%	April 18	98%	Mar 18	100%	Mar 18	96%	Mar 18

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
MAU	85%	July 17	89%	April 18	80%*	Sept 17	100%	Oct 17	89%	Mar 18	**80%**	Oct 17	**82%**	Sept 17	**61%**	Sept 17	94%	Mar 18
H1	93%	Oct 17	91%	April 18	**82%**	Aug 17	91%	Aug 17	87%	July 17	80%*	July 17	**86%**	July 17	**89%**	Jan 18	93%	Mar 18
H200/EAU	96%	Mar 18	95%	Mar 18	**80%***	July 17	100%	Jan 18	80%	Jan 18	**80%***	Dec 17	86%	Oct 17	**81%**	Sept 17	89%	Dec 17
H5	84%	Jan 18	89%	April 18	**84%**	July 17	100%	Feb 18	89%	July 17	84%	Jan 18	**87%**	Sept 17	**89%**	Dec 17	92%	Dec 17
H50	95%	May 18	90%	Dec 17	**80%***	July 17	100%	Mar 18	96%	Mar 18	**96%**	Jan 18	**86%**	Oct 17	**87%**	Sept 17	96%	Mar 18
H500	94%	Jan 18	95%	June 18	**91%**	Mar 18	92%	Dec 17	90%	Mar 18	**80%***	July 17	89%	Jan 18	**93%**	Mar 18	93%	Dec 17
H70	95%	Mar 18	95%	June 18	**80%**	Sept 17	100%	Oct 17	87%	Jan 18	**69%**	July 17	**82%**	Nov 17	**65%**	Sept 17	**85%**	Sept 17
H8	93%	Dec 17	97%	Mar 18	80%*	Oct 17	**96%**	May 17	94%	Dec 17	80%*	July 17	95%	Mar 18	83%	Sept 17	85%	Sept 17
H80	95%	Mar 18	94%	Sept 17	80%	July 17	95%	May 18	90%	Dec 17	83%	July 17	49%	July 17	**84%**	Dec 17	81%	Sept 17
H9	85%	Oct 17	91%	Dec 17	80%*	Aug 17	100%	Mar 18	94%	Aug 17	97%	Sept 17	93%	Jan 18	81%	Sept 17	83%	Sept 17
H90	85%	Oct 17	91%	Oct 17	80%*	Aug 17	90%	Dec 17	89%	Nov 17	**88%**	Oct 17	87%	Oct 17	73%	Sept 17	84%	Sept 17
H11	88%	Sept 17	**86%**	Jan 18	80%*	Aug 17	97%	Mar 18	84%	Dec 17	**74%**	July 17	**77%**	Sept 17	93%	Mar 18	90%	Dec 17
H110	94%	Dec 17	**88%**	Jan 18	80%*	Oct 17	100%	Oct 17	86%	Dec 17	**80%***	Sept 17	58%	Sept 17	86%	Jan 18	93%	Nov 17

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management				Patient Centred Care (inc TV)		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
Majors ED	93%	Jan 18	**96%**	Dec 17	88%	June 17	95%	Dec 17	98%	Oct 17			80%	Aug 17	92%	Oct 17	96%	Jan 18
Paeds ED	95%	April 18	**96%**	Dec 17	94%	Sept 17	88%	July 17	95%	Feb 18			94%	Oct 17			95%	Jan 18
Emergency Care	80%	Oct 17	**96%**	Dec 17	80%	June 17	93%	Sept 17	100%	Oct 17			94%	Nov 17			96%	Jan 18

Scoring System	Above 95% 12 Month Review	89%- 94.9% 9 Month Review	80% - 88% 6 Month Review	Below 80% 3 Month Review	*Denotes capped

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE MINUTES
HELD ON MONDAY 26 JUNE 2017, 9.15AM – 12.15PM
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	Chair
	Mr A Snowden	Non Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Dr A Green	Lead Clinical Research Therapist
	Mrs S Bates	Interim Deputy Director of Quality, Governance and Assurance
	Mrs G Gough	Deputy Chief Pharmacist
	Dr M Purva	Deputy Chief Medical Officer
IN ATTENDANCE:	Mrs R Thompson	Assistant Trust Secretary (Minutes)

No. Item **Action**

1. APOLOGIES

Apologies were received from Mrs V Walker – Non Executive Director and Mr D Corral – Chief Pharmacist

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE MEETING OF 31 MAY 2017

- Prof. Sheldon to be removed from the apologies list.
- Item 5.3, paragraph 2 – The paragraph to start "In addition to the Trust's audits nutrition is one of the fundamental standards."
- Item 5.3, paragraph 6 – to read "As a result of better screening this has led to an increase in dietetic referrals by 40%; of those referred to the dietetic team 50-70% had hospital acquired malnutrition.

Subject to the above changes the minutes were approved as an accurate record of the meeting.

3.1 – MATTERS ARISING

There were no matters arising.

3.2 – ACTION TRACKING LIST

Mr Wright requested that Fresenius (CQC inspection) be added to the tracker for the committee to receive and update

3.3 – ANY OTHER MATTERS ARISING

Mr Snowden reported that in his CQC interview with Mrs Walker, the increase in mortality rates was discussed both on weekdays and weekends and how this was monitored. Mr Snowden had informed the CQC that a full case note reviews were now carried out and mortality rates were monitored at the Quality Committee and the Board.

3.4 – WORKPLAN

Safeguarding Report to be deferred to a future meeting. **MW**
Quality Impact of CRES was deferred to the August 2017 meeting. **MW**

4. REDUCE AVOIDABLE DEATHS

4.1 – MORTALITY – CASE NOTE REVIEWS

Mr Phillips presented the item and reported that case note reviews were being carried out but that more staff were required to undertake the training. He advised that the Trust currently had around 30 trained staff but work was ongoing to increase this number. The compliance team were delivering the training and time had been built into consultant job plans were necessary. There was a discussion around the feasibility of every consultant carrying out a case note review against experienced external staff being bought in. Mr Phillips added that the process allowed the teams to triangulate serious incidents, complaints and claims information to determine any emerging trends.

Mr Snowden asked how engaged the clinical teams were with the process and Mr Phillips advised that some teams were more engaged than others. Mrs Bates agreed to bring a report to the Committee detailing the milestones for training, any emerging themes following the reviews and highlighting the findings. **SB**

Resolved:
The Committee received the report. Mrs Bates to provide a more detailed report highlighting any themes and trends following the reviews.

5. REDUCE AVOIDABLE HARM

5.1 – APPROVAL OF THE QUALITY ACCOUNTS

The Committee reviewed the Quality Accounts. The Board had delegated responsibility to the Quality Committee to approve them on its behalf. All Board members had been circulated the final version prior to the meeting. Prof. Sheldon pointed out that the deteriorating patient section was not included in the summary list and it was agreed that this would be added into the document.

There was a discussion around Duty of Candour and when this was instigated and Prof. Sheldon asked Mrs Bates if she could include this in a report and triangulate and claims or complaints in this area. **SB**

Patient related outcome measures (PROMs) were also discussed and this would be an agenda item at a future meeting. **SB**

Resolved:
Following the amendment noted above the Quality Committee approved the Quality Accounts on behalf of the Board.

5.2 – SERIOUS INCIDENTS – APRIL 2017

Mrs Bates presented the incident and it was agreed that future incident reports would include “what happened”, “what should have happened” and what was learned” to ensure the key issues were discussed.

Dr Purva added that sequential simulation was a good way to review a serious incident, allowing teams to act out what happened and discuss what could have been done differently. Mrs Green stated that it was useful to have best practice feedback from these sessions and Mrs Bates agreed that good and bad feedback would feature in the lesson shared newsletter.

Resolved:
The Committee received the report.

5.3 – QUALITY IMPROVEMENT PROGRAMME
Mrs Bates presented the report which had been revised in line with 2017/18 timescales. The committee agreed that any items with a red rating should be highlighted to the committee by exception. Mr Snowden stated that he felt the report reflected more realistic timescales.

Mr Wright reported two areas of concern, one was the loss of two tissue viability nurses who had been seconded to the team and the other was crash trolley checks. Mr Wright assured the Committee that he was closely monitoring the situation and challenging nursing staff.

Resolved:
The Committee received the update and agreed to receive further updates relating to crash trolley checks. **MW**

6. INCREASE INCIDENT REPORTING TO THE HIGHEST 25% COMPARED TO PEERS

7. RECEIVED FOR ASSURANCE
7.1 – INTEGRATED PERFORMANCE REPORT
The report was reviewed by the Committee. A discussion took place around the diagnostic capacity issues and the implications on patient safety. The Performance & Finance Committee were reviewing this issue and the financial implications and it was agreed that the Committee would escalate it to the Board. There was a discussion around 104 day wait patients in relation to the diagnostic issues and Mr Phillips reassured the committee that these would usually be patients with complex issues and co-morbidities and receive appropriate care.

Ms Ramsay highlighted that VTE assessment compliance was increasing and continued to improve due to the work being undertaken.

Resolved:
The Committee received the report.

7.2 – OPERATIONAL QUALITY COMMITTEE MINUTES
The minutes were received for assurance. It was noted that the Chaperone Policy had been approved by the Committee.

7.3 – HEALTHCARE DELIVERY IMPROVEMENT GROUP
Dr Purva advised that work was ongoing regarding the WHO checklist and the committee would receive and updated position in 3 months time.

7.4 – LESSONS SHARED NEWSLETTER
The newsletter had been updated and the new format was presented to the committee.

7.5 – RADIOLOGY RESULTS ACKNOWLEDGEMENT SYSTEM
The Committee reviewed the report and acknowledged the work that had been undertaken by Mr Goldstone and his team. The data relating to surgeons acknowledging radiology results and compliance levels was now published. The KPIs were now set as mandatory requirements in the

surgeons objectives. Mr Snowden asked that the Trust promoted the work undertaken and the improvement in results.

Resolved:
The Committee received the report and noted the improvement of results.

7.6 – CQC CASE STUDIES
Mr Wright reported that members of the executive team would be visiting Morecombe Bay Hospital to find out how the Trust went from 'special measures' to 'good'. Dr Green advised that another helpful report to be presented at the committee was 'State of Care' also published by the CQC.

Resolved:
The Committee received the report.

8. BOARD ASSURANCE FRAMEWORK
Ms Ramsay reported that the BAF would be presented monthly to the Committee for scrutiny and to give assurance. The Committee discussed mapping any gaps in assurance to a Board development session so that the Board could be presented with more details regarding the issues.

Resolved:
The Committee received the report and agreed to discuss mortality and diagnostic capacity at a future Board development session.

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

10. CHAIRMAN'S SUMMARY TO THE BOARD
Prof. Sheldon agreed to summarise the meeting to the Board.

11. DATE AND TIME OF THE NEXT MEETING:
Monday 31 July 2017, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2017/18

July 2017

June 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 - July 2017

RESPONSIVE

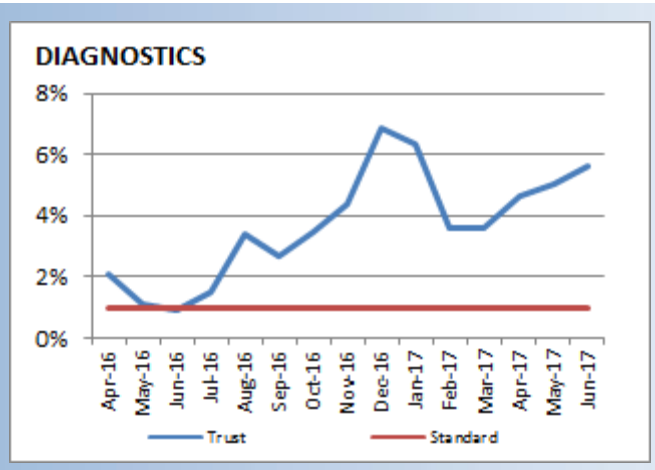
Description	Aggregate Position	Trend	Variation

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 5.56% in June

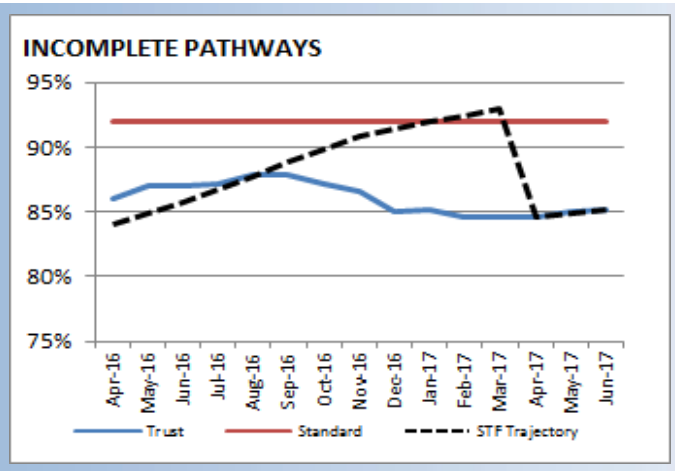


Referral to Treatment Incomplete pathway

Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%

The Trust achieved the June Improvement trajectory of 85.1%

June performance was 85.15%. This failed to meet the national standard of 92%.



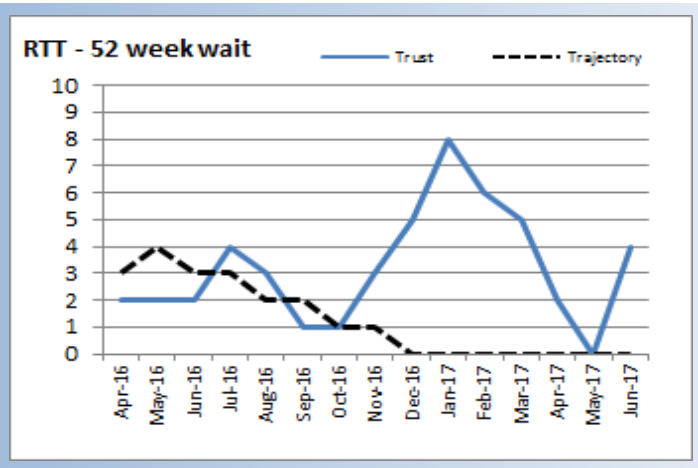
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

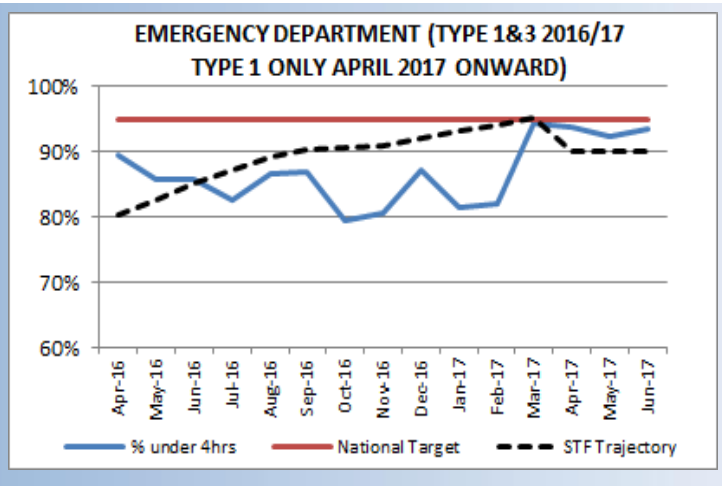
The Trust failed to achieve the national standard of zero breaches with 4 breaches reported during June



A&E Waiting Times

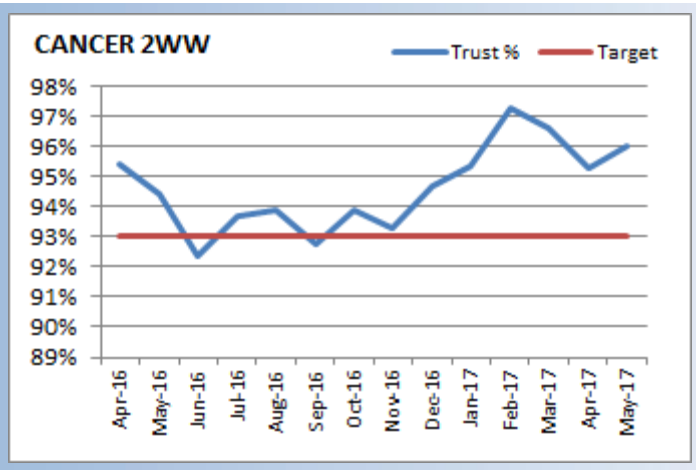
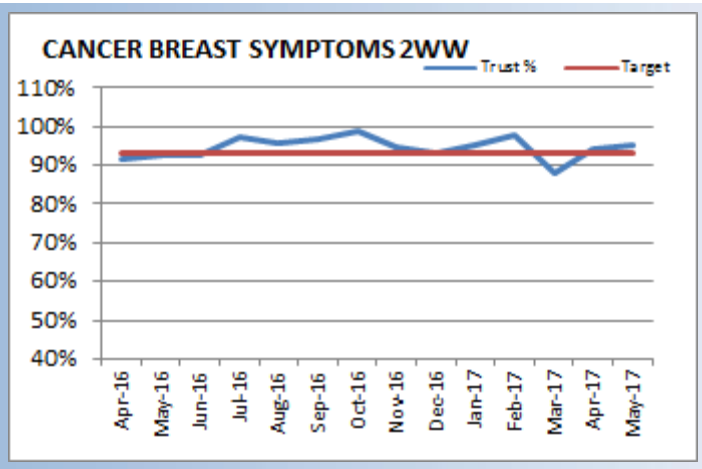
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance achieved the Improvement trajectory of 90.0% with performance of 93.6% for June. This has failed to achieve the national 95% threshold.

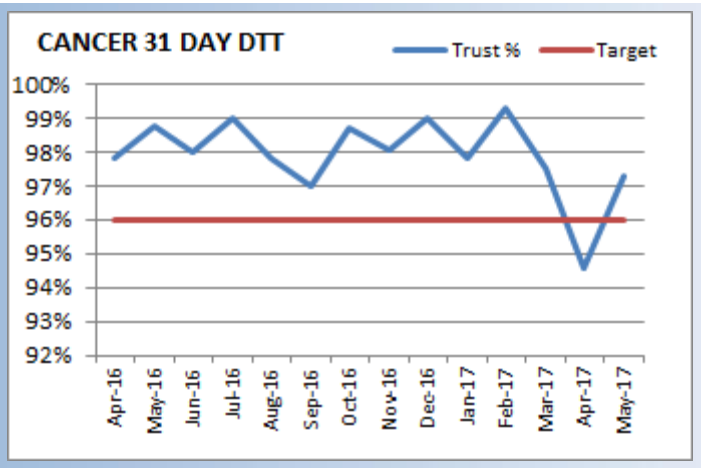
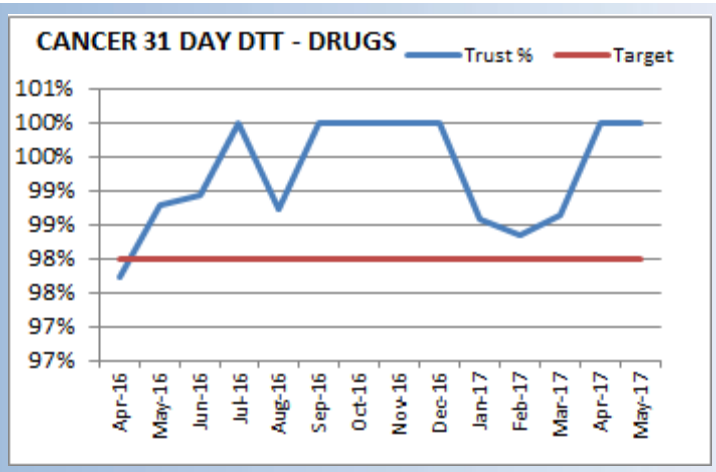


Performance has increased by 1.1% during June compared to May performance of 92.5%.

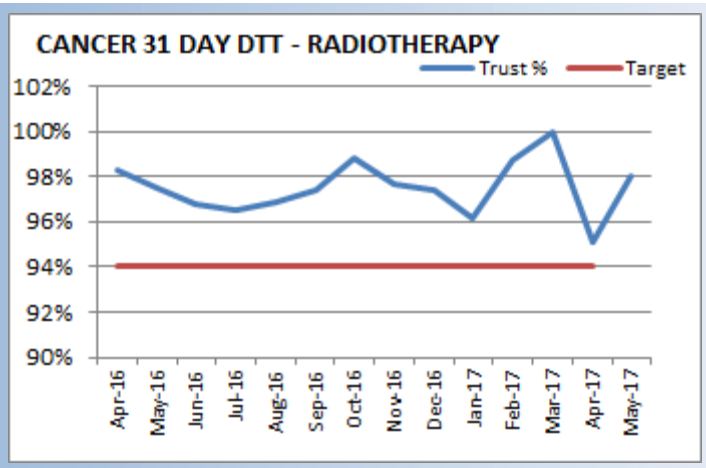
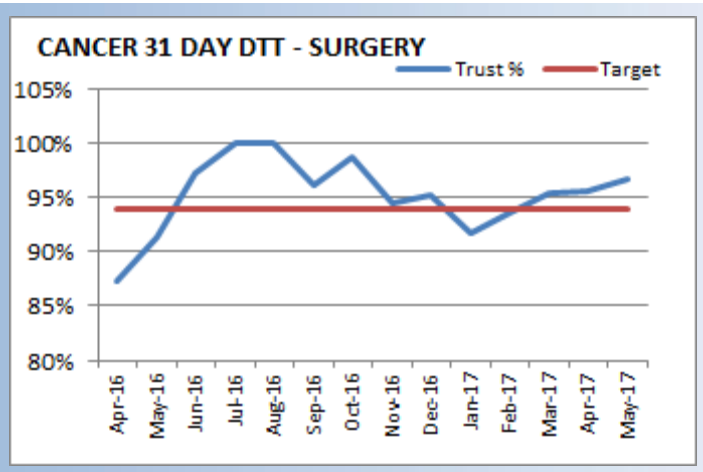
RESPONSIVE

	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%.	May performance achieved the 93% standard at 96.0%		
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.	May performance achieved the 93% standard at 95.4%		

RESPONSIVE

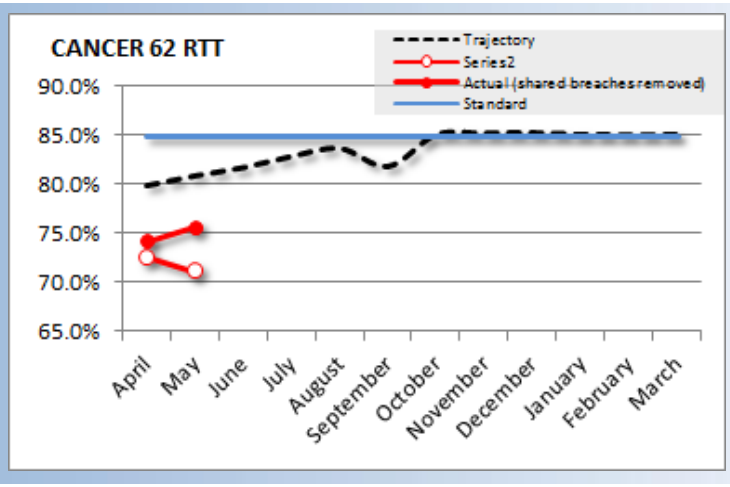
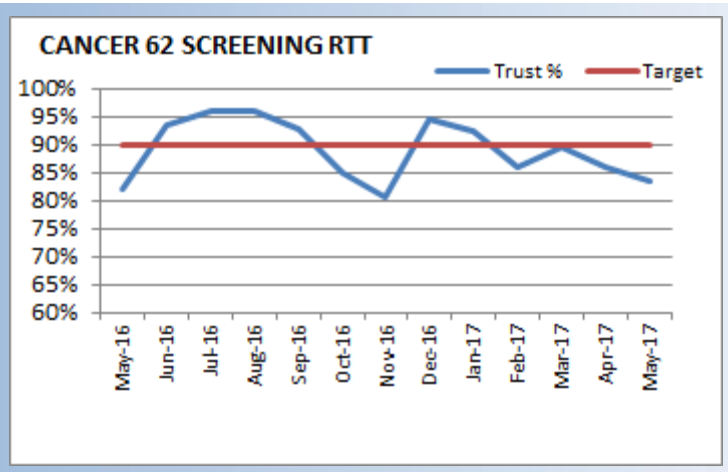
	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	May performance achieved the 96% standard at 97.3%		
Cancer: 31 Day Subsequent Drug Standard	All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 98%.	May performance achieved the 98% standard at 100%		

RESPONSIVE

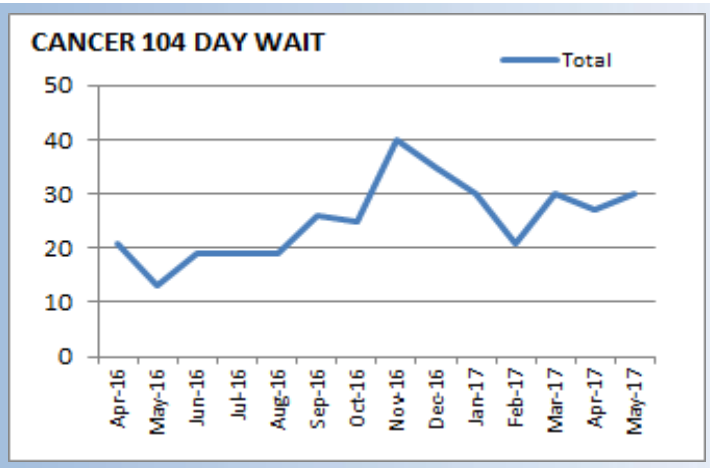
	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	May performance achieved the 94% standard at 98.0%		
Cancer: 31 Day Subsequent Surgery Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	May performance achieved the 94% standard at 96.7%		

Integrated Performance Report - July 2017

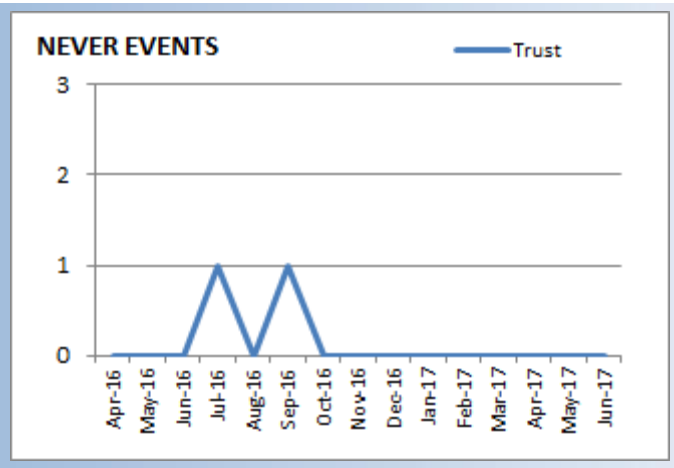
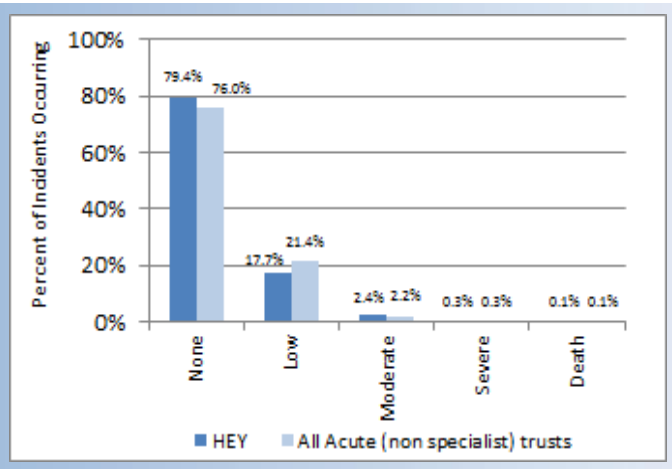
RESPONSIVE

	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 80.0%	The adjusted position allows for reallocation of shared breaches May failed to achieve the STF trajectory of 80.0% with performance of 75.7%		
Cancer: 62 Day Screening Standard	All patients need to receive first treatment for cancer within 62 days of urgent screening referral. Threshold of 90%	May performance failed to achieve the 90% standard at 78.0%		

RESPONSIVE

Description	Aggregate Position	Trend	Variation
Cancer 104 Day Waits	There were 30 patients waiting 104 days or over during May		

SAFE

	Description	Aggregate Position	Trend	Variation
Occurrence of any Never Event	Occurrence of any Never Events	There were zero Never Events reported during June		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 April 2016 to September 2016 as reported by the National Reporting and Learning System (NRLS). The Trust reported 5,546 incidents (rate of 32.71) during this period.		

Integrated Performance Report - July 2017

SAFE

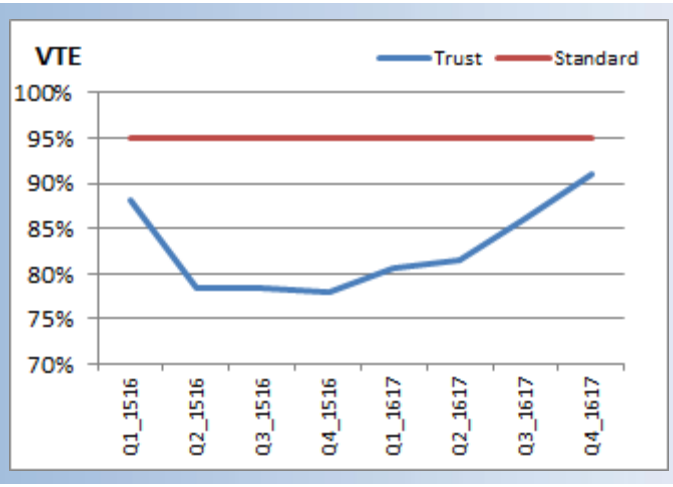
Description	Aggregate Position	Trend	Variation

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 90.91% for Q4 2016/17.

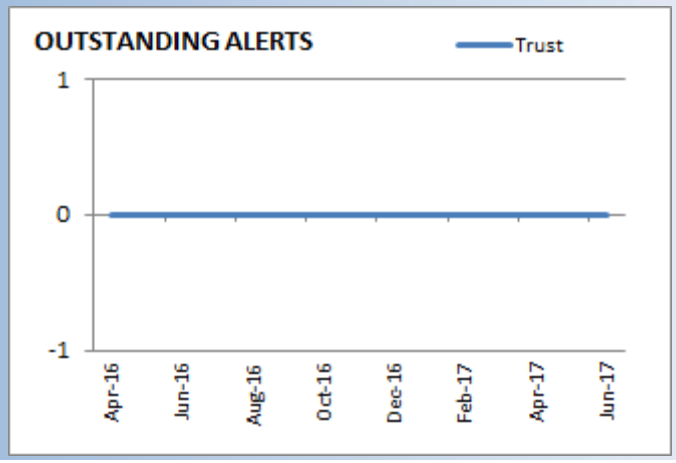


Patient Safety Alerts Outstanding

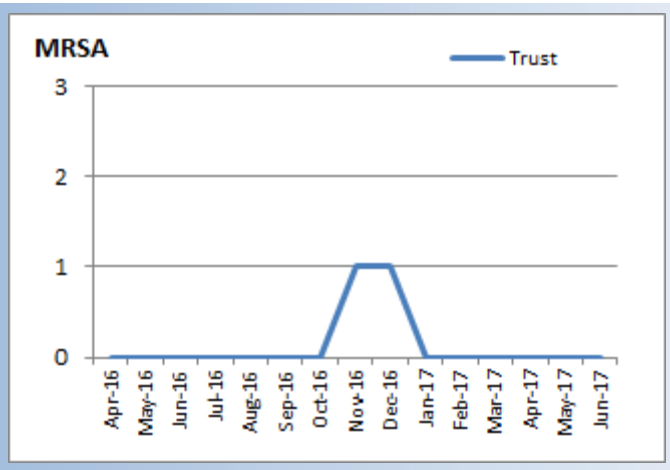
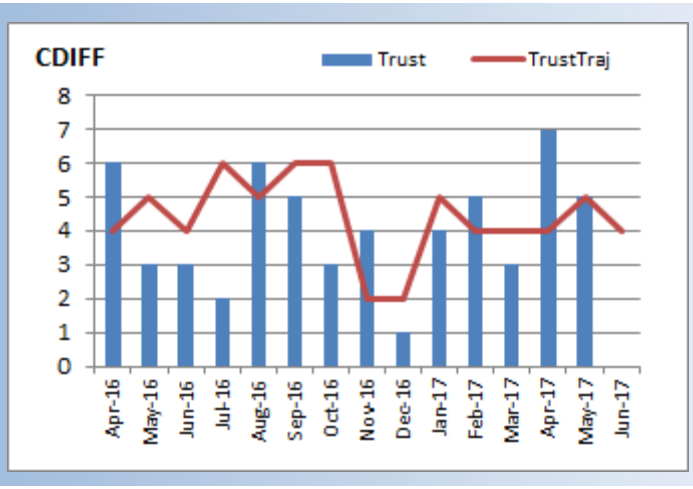
Number of alerts that are outstanding at the end of the month

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

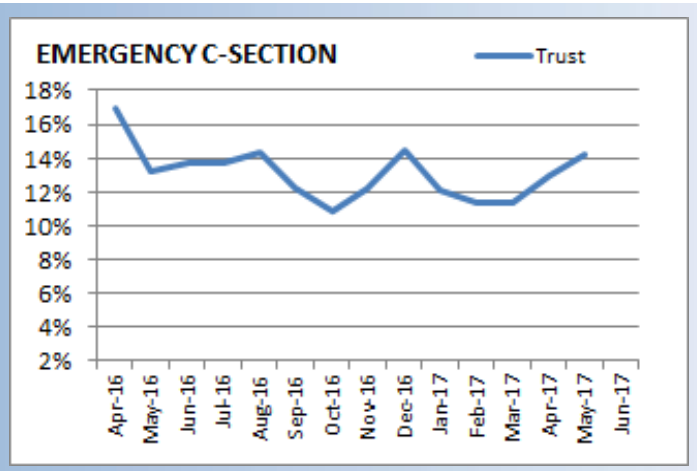
There have been no outstanding alerts year to date.



SAFE

	Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 2 cases of acute acquired MRSA bacteraemia during 2016/17. There were no cases reported during June 2017.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2017/18 is no more than 53 cases	There have been 12 cases year to date There were zero incidents reported during June which achieved the monthly trajectory of no more than 4 cases		Further information is included in the Board Quality report

SAFE

Description	Aggregate Position	Trend	Variation
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 June failed to achieve this standard at 14.2%		Further information is included in the Board Quality report

EFFECTIVE

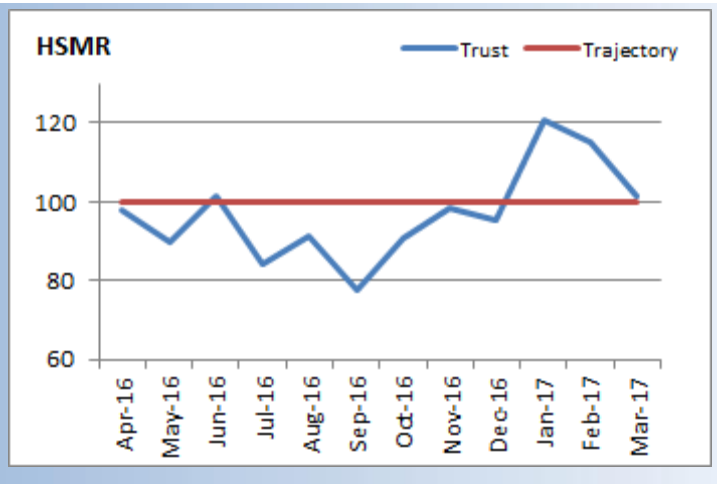
Description	Aggregate Position	Trend	Variation

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

March 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and March 2017 failed to achieve this at 101.3

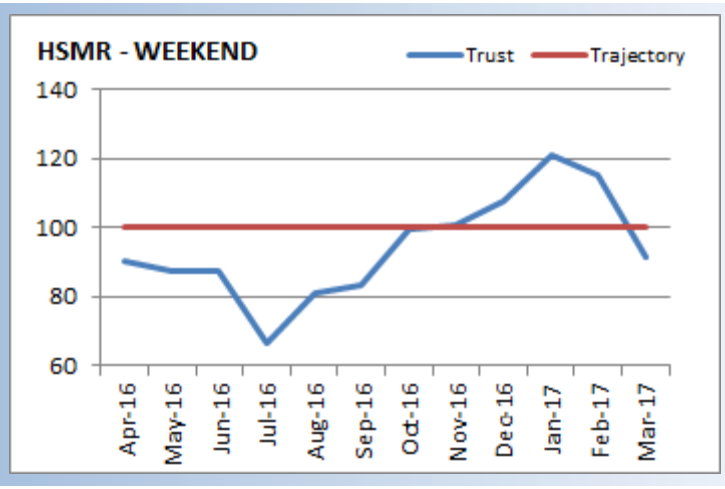


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

March 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and March 2017 achieved this at 92



EFFECTIVE

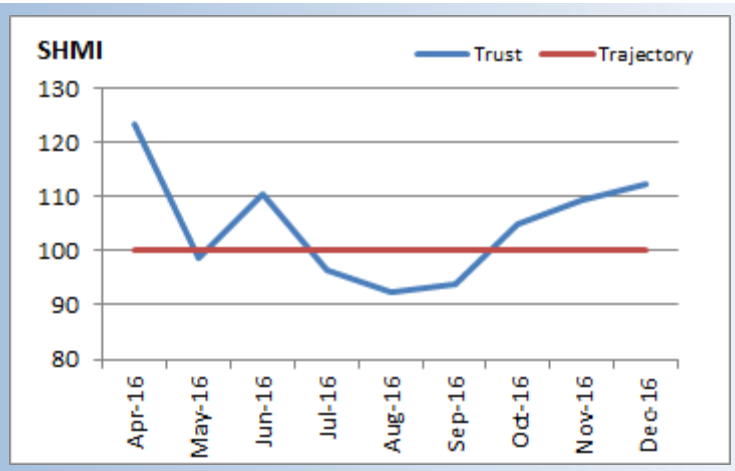
Description	Aggregate Position	Trend	Variation

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.

December 2016 is the latest published performance

The standard for SHMI is to achieve less than 100 and December 2016 failed to achieve this at 112

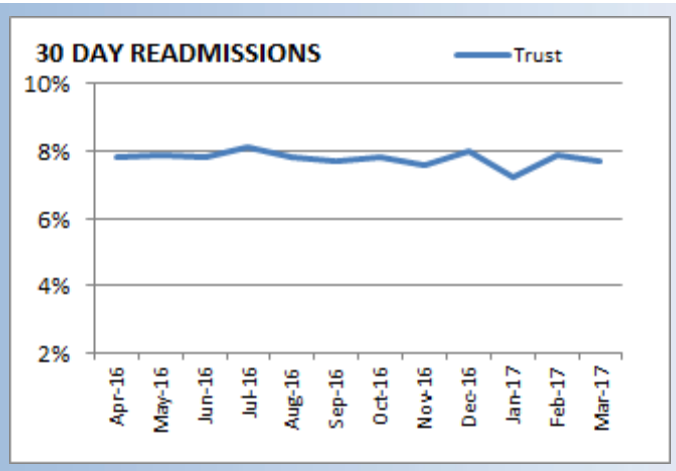


30 DAY READMISSIONS

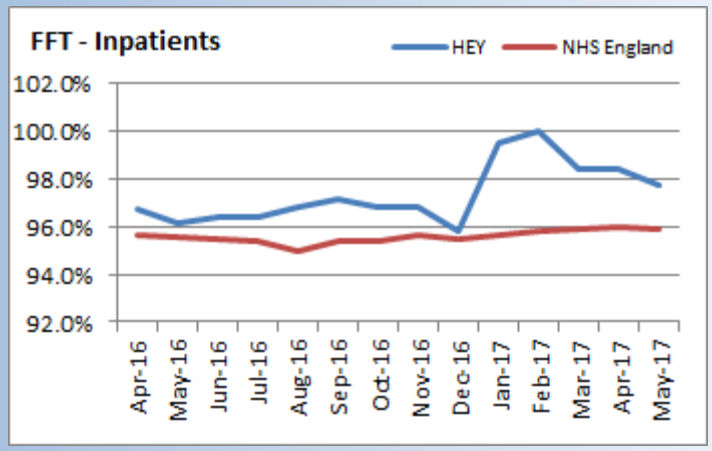
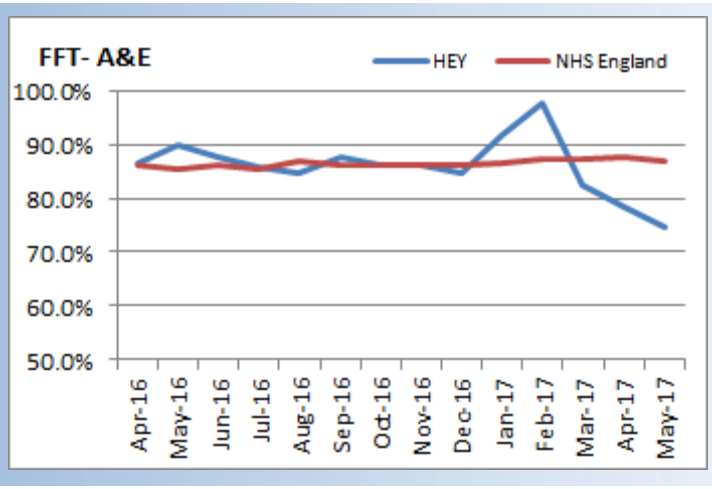
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is March 2017

The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than or equal to 7.8%. The Trust achieved this measure with performance of 7.7%.



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 May was 97.78% The latest published data for NHS England is May 2017. June 2017 will be published 10th August 2017.	
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for May was 74.63% The latest published data for NHS England is May 2017. June 2017 will be published 10th August 2017.	

CARING

Description	Aggregate Position	Trend	Variation

Maternity Scores from Friends and Family Test - % Positive

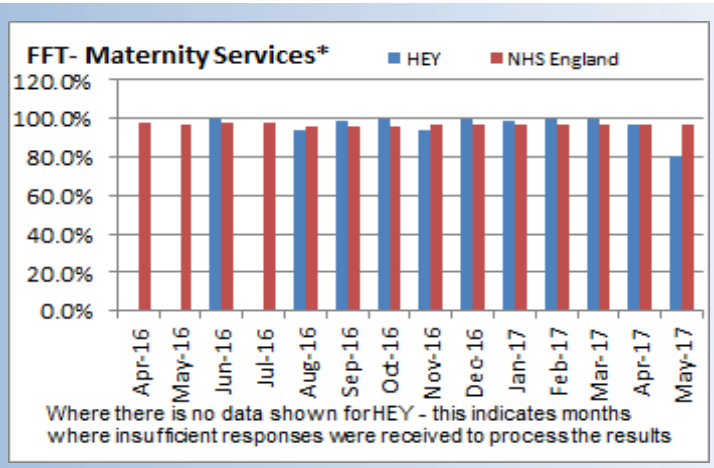
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for May was 80.0%

The latest published data for NHS England is May 2017.

June 2017 will be published 10th August 2017.

Months with no data for HEY is due to insufficient responses



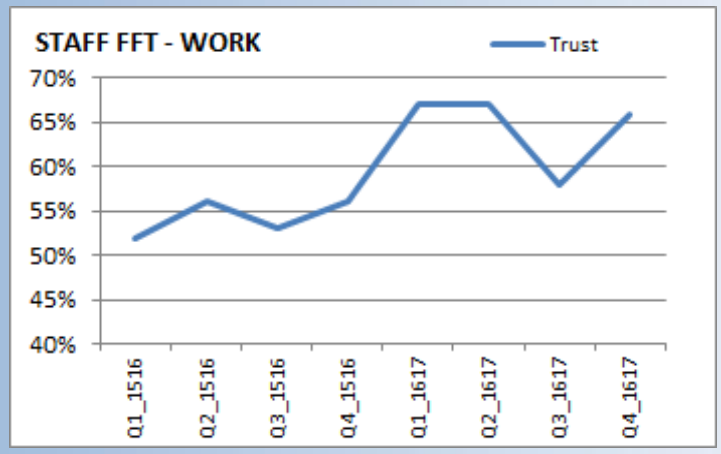
* Question relates to Birth Settings

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 4 2016/2017 shows that 66% of surveyed staff would recommend the Trust as a place to work, this has improved from the quarter 3 position.

Quarter 1 performance will be published 24th August 2017.



Integrated Performance Report - July 2017

CARING

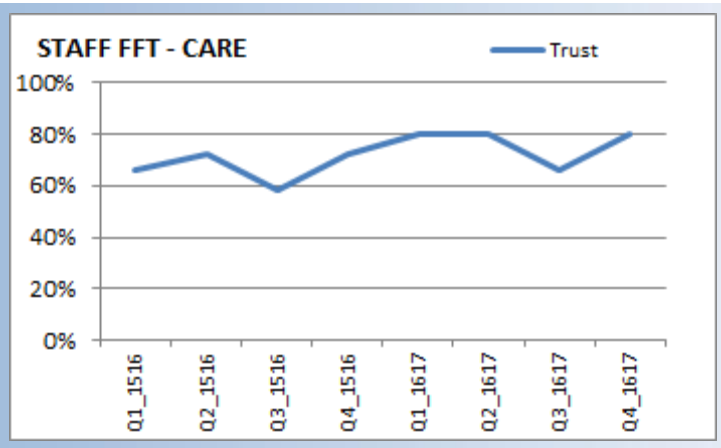
Description	Aggregate Position	Trend	Variation

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 4 2016/2017 shows that 80% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has improved from the quarter 3 position.

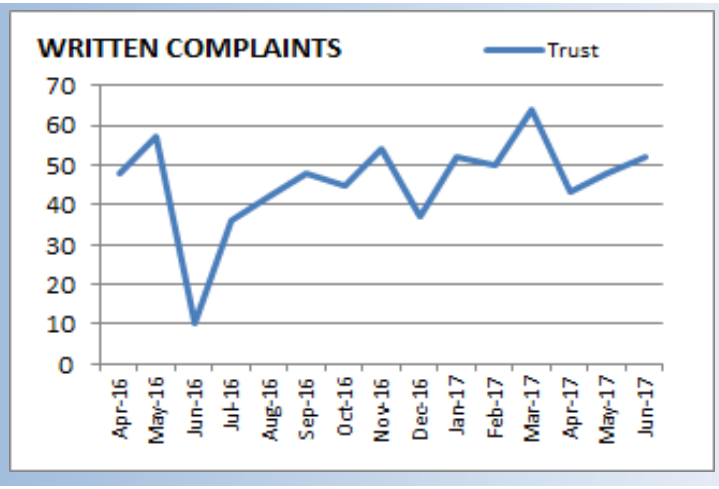
Quarter 1 performance will be published 24th August 2017



Written Complaints Rate

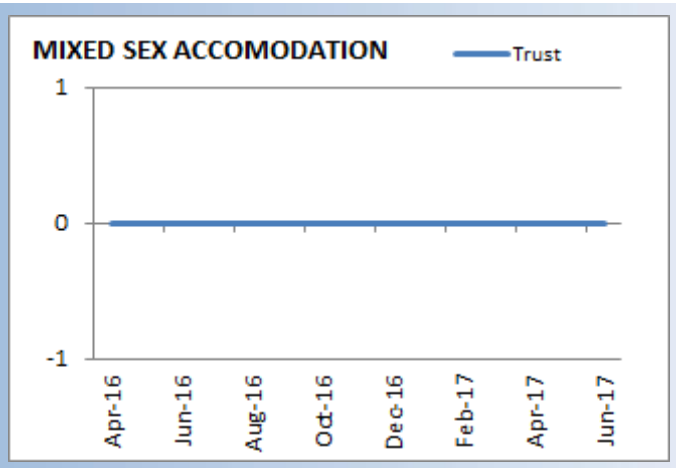
The number of complaints received by the Trust

The Trust received 52 complaints during June, this is a increase on the May position of 48 complaints



There have been 143 complaints year to date

CARING

	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 June 2017.		

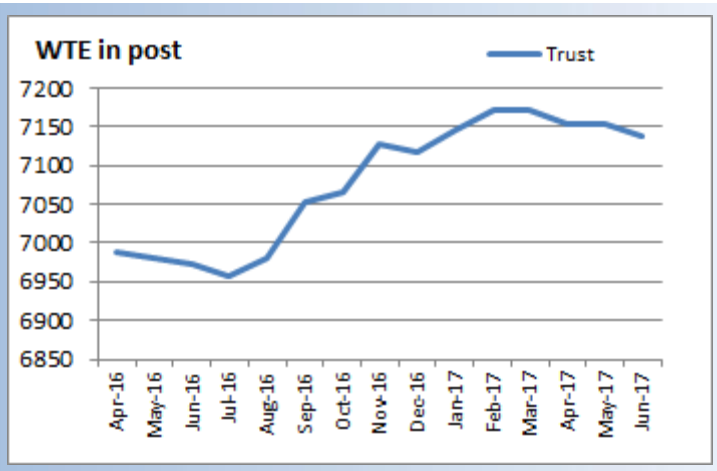
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

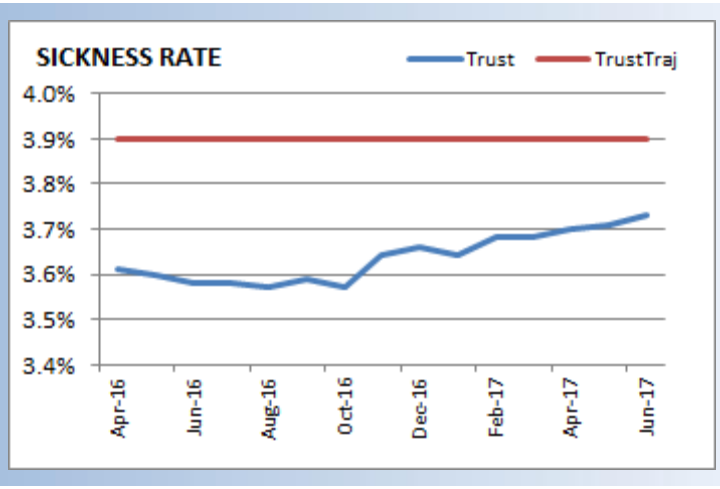
Trust level WTE position as at the end of June was 7139



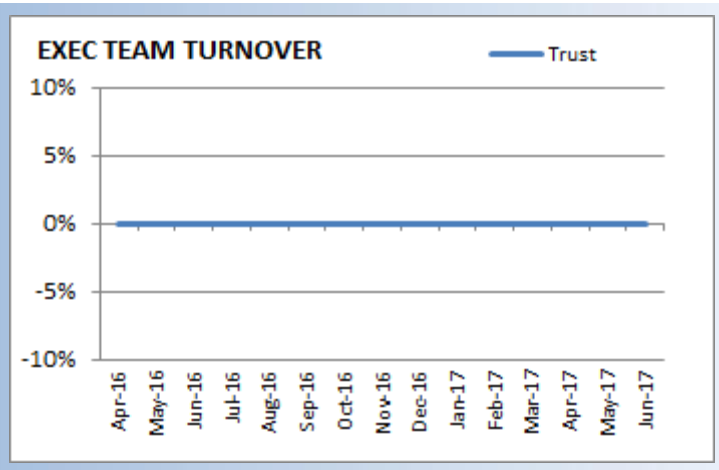
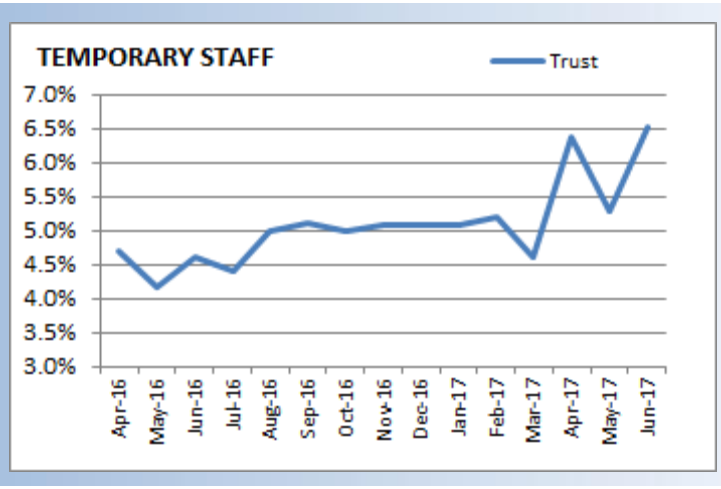
Sickness Absence Rates

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

Performance for June achieved the standard of less than 3.9% with performance of 3.73%



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 June performance was 6.5%	

FINANCIAL SUMMARY: 3 MONTHS TO 30TH JUNE 2017

1. The Trust has agreed its control total of an £11.5m deficit. If this position is delivered the Trust will receive support funding of £11.9m enabling it to report a £0.4m surplus for the year.

2. At the end of month 3 the Trust is reporting a deficit of £6.9m. This is £4.1m above the planned deficit of £2.8m.

3. The deficit includes non receipt of £1.8m of STF income for non delivery of the financial plan in Q1. The Trust can regain this funding if it moves back to its financial plan in later months.

4. The Trust has an income shortfall of £0.7m after pass through drugs and devices are covered.

5. The Trust has a CRES shortfall at month 3 of £1.2m. The Trust has released 3/12ths of its CRES reserve (£0.375m) to reduce this to a deficit of £0.9m.

6. Health Groups have further run rate issues of £2.0m of which £0.2m are non recurrent. Medicines main pressures are on the staffing of the 3 zone Acute model (£0.3m), the Fit model (£0.1m) and ED medical staffing (£0.2m) although these are partly offset by nursing vacancies (-£0.3m). Surgery have problems on non delivery of income excluding Cardiothoracic and Neurosurgery (£0.6m) and in non pay consumables, the majority of which is unrelated to levels of activity being undertaken.(£0.6m). Clinical Support HG has pressures on Radiology outsourcing (£0.2m) and medical agency staffing to cover vacancies and sickness. Family and Women's HG has pressures on Medical staffing (£0.2m) related to vacancies and sickness.

7. Agency spend to the end of June is £2.8m which is in line with plan.

8. General reserves of £1.0m have been released to partially offset the run rate and income pressures.

9. The Health Groups have made initial assessments of year end forecasts based on current financial information. These indicate that the Trust could have a problem of £10m by year end if current trends continue. This is based on Health Groups being £11.9m overspent and £4.0m short on income, offset by the release of £5.9m of reserves. Immediate actions need to be identified by Health Groups to offset this potential £10m risk.

10. In line with published NHSI guidance the Trust is still reporting that it will achieve its year end financial plan. As indicated above this will be very challenging

11. The Trusts cash position has now improved due to the receipt of additional cash from the 2 local CCGs to reflect the movement to paying in 10ths rather than 12ths. By mid July the Trust is up to date with paying all outstanding suppliers where payments have been authorised. If the deficit continues then the cash position will again start to deteriorate and will be increased by non receipt of STF funding. This will place additional pressure on the Trust and may require loans to be taken out in Q3 or Q4.

12. The Trust has spent £3.4m of capital at month 3 and is forecasting to spend £18.96m during the financial year in line with plan.

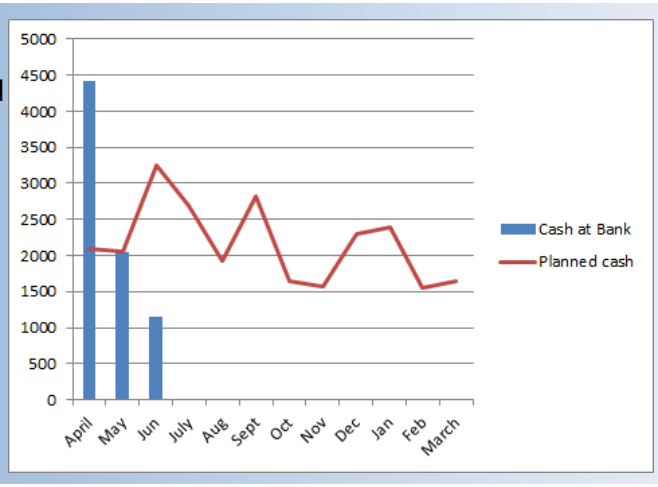
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of June was £1.157m, of which £1.140m was held in bank accounts and the rest in petty cash. There continues to be intense pressure on cash and the Trust is still unable to meet obligations to suppliers as they fall due. June has been a particularly difficult month with more than an average number of suppliers refusing to supply goods unless invoices are settled. At times cash has fallen to well below £1m.



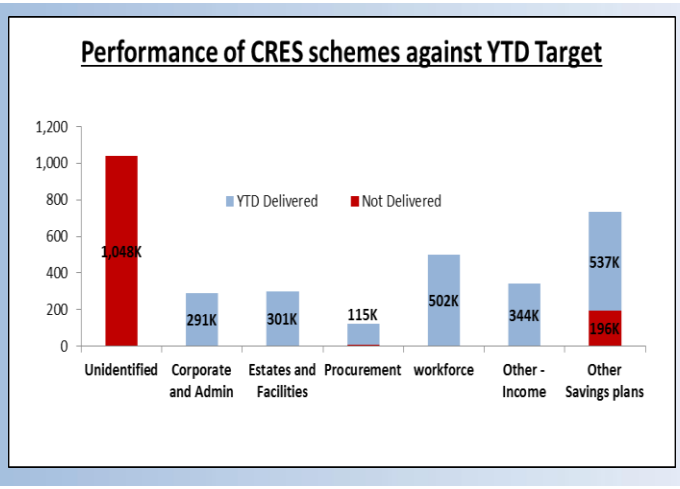
The receipt of £20m from our Commissioners as a result of changing payment profiles will ease the immediate pressure on cash and improve relationships with suppliers.

CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 3 the Trust has delivered £2.1m of CRES savings against a CRES ytd plan of £3.3m (£1.2m adverse variance)

The Trust is forecasting delivery of £11.1m of savings against a plan of £15.0 (£3.9m adverse). Through working closely with Deloittes the Trust expects to identify new schemes and revise its forecast to a more favourable one in coming months.



The target for the year is to save £15m, the Trust is expecting to deliver this target

Description	Aggregate Position	Trend	Variation

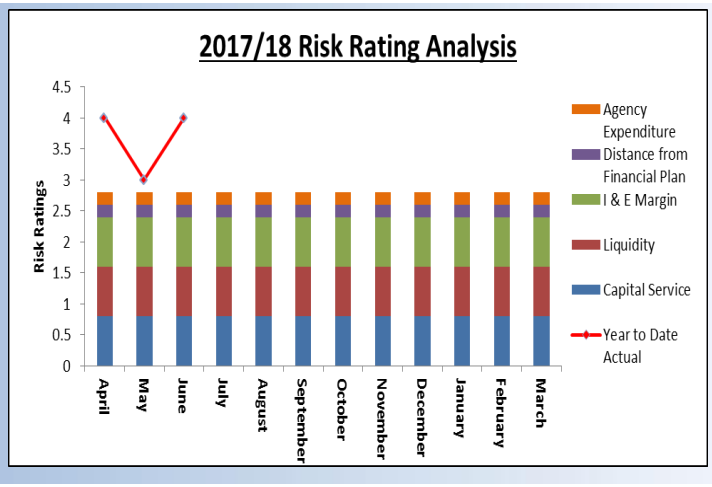
Risk Rating

Financial Sustainability 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.

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst

As at month 3 the Trust is reporting a deficit of £6.9m against a planned deficit £2.8m (£4.1m adverse) this has resulted in liquidity, Capital servicing, I&E Margin and distance from plan all being rated as a 4, resulting in an overall risk rating of 4. Last month agency was rated a 1 but has become a 2 in month 3, this has caused a change in the overall rating from last month.

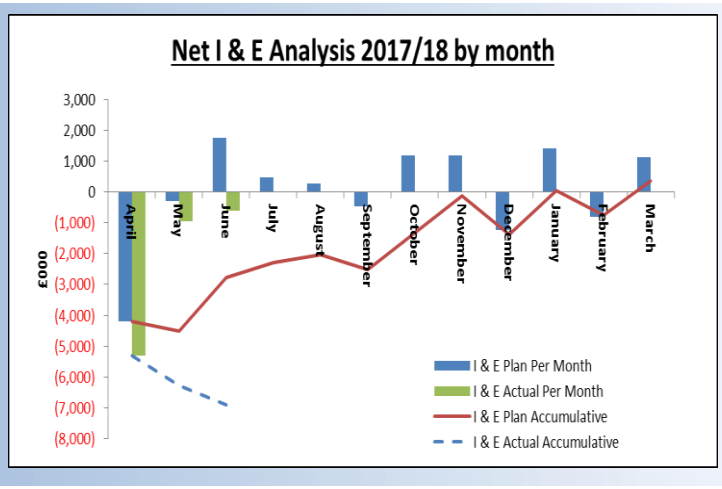


Income & Expenditure

Net income and Expenditure

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

At month 3 the Trust has delivered a deficit of £6.9m against a plan of £2.8m deficit (£4.1m adverse). The plan for 17/18 is to deliver a surplus of £0.3m, this includes STP funding.



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON 26 JUNE 2017

PRESENT:	Mr S Hall	Chair, Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs E Ryabov	Chief Operating Officer
IN ATTENDANCE:	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
	Dr T Goldstone	Consultant in Radiology and Nuclear Medicine (Item 4.1 only)
	Dr O Byass	Consultant Radiologist (Item 4.1 only)
	Mrs R Thompson	Assistant Trust Secretary

1. APOLOGIES **ACTION**

Apologies were received from Mr L Bond – Chief Financial Officer.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE MEETING HELD ON 30 MAY 2017

Item 6, first sentence should read, "the Trust was in the top 5 nationally.."

Following this change the minutes were accepted as an accurate record of the meeting.

4. MATTERS ARISING FORM THE MINUTES

There were no matters arising from the minutes.

4.1 – DIAGNOSTIC PERFORMANCE

Dr Goldstone and Dr Byass attended the meeting to discuss diagnostic capacity and the issues being created due to increased demand. Dr Goldstone advised that the problem with diagnostic demand was a national issue, but the Trust had 9 scanners that were all beyond their shelf lives. CT demand had grown by 33% and MRI by 16%, this meant that typically 300 breaches were occurring each month.

Mr Goldstone reported that actions were in place to address these issues such as recruiting more staff, skill sharing, looking at new ways of working and working with surrounding organisations. The Trust was offering overtime as an incentive for staff to ensure the machines were working to their full potential. Vans were being hired by the Trust to help with the increased demand.

Mr Goldstone advised that a £4m bid for STP funding had been submitted to enable the Trust to buy an additional CT and MRI scanner. Mr Goldstone agreed to email the Committee members regarding the outcome of the submission. Dr Goldstone and Dr Byass expressed their concern around the impact on services if the STP funding was not

awarded to the Trust.

There was a discussion around the shortage of radiology staff and how this was now a national problem. Dr Byass advised that staff had been working weekend shifts to help reduce the capacity issues.

Resolved:
The Committee received the presentation and noted the issues regarding MRI/CT capacity. The outcome of the STP bid to be communicated to the Committee. **TG**

4.2 – PERFORMANCE & FINANCE COMMITTEE DEVELOPMENT
Mr Hall presented the report which had reviewed the Committee and its workstreams. It was agreed that Mr Evans would attend future meetings due to his lead role in managing the Health Group cash releasing efficiency schemes.

Mr Hall suggested that a number of key indicators highlighted in the Use of Resources audit by NHS Improvement be reviewed by the Committee. It had also been agreed that Mr Hall, Mr Bond and Mrs Ryabov would meet before each meeting to discuss any emerging issues and form the agenda. The BAF would be reviewed at each meeting to ensure key risks were being monitored appropriately and it was agreed that a workforce planning section would be added as a quarterly report. **SN**

The Executive team were working on a performance and finance dashboard which would highlight key areas for review by the Committee and the Board. The Committee asked that actual activity levels be tracked on the new dashboard. **AD**

Resolved:
The Committee received the report.

5. ACTION TRACKER
The tracker was reviewed by the Committee.

6. WORKPLAN 2017/18
It was agreed that the workplan 2017/18 would be updated for the July 2017 meeting. **RT**

7. DEMAND REPORT – MONTH 2
Mrs Drury presented the report which showed the actual activity against the plan and the overall GP referrals (which had reduced against last year's figures). There had been a growth in ENT referrals. Work was ongoing with the Commissioners to review the referrals from the North and South bank.

There was a discussion around A&E attendances which were above contract levels causing operational pressures. There had been improvements made in surgical admission due to the FIT model and ambulatory care which had allowed space to be created in the AMU for more patients. Mrs Drury advised that demand was increasing in the Minor Injury Units also.

Mr Gore asked if the report could highlight services where demand was lower than plan and Mrs Drury agreed that this could be added to the next report. **AD**

Mrs Ryabov reported that elderly care was working well even with the large numbers of patients. Work was ongoing with the CCGs to find what was driving the increased activity levels.

Resolved:
The Committee received the report and agreed to receive the demand report at each meeting.

8. REVISED FINANCIAL PLAN

Mr Evans reported that the control total had been signed and the Trust had accepted £11.5m deficit. Now that the Trust had signed up to its control total it would have access to STP funding. He advised that the Trust was working with Deloitte to maximise CRES where possible. The CRES target for 2017/18 was £14m. Not all of this was developed plans some of the target highlighted opportunities to be explored.

Resolved:
The Committee received the update.

8.1 – CORPORATE FINANCE REPORT

Mr Evans reported that the Trust was showing £6.3m deficit at month 2 which was £1.8m above plan. This was mainly due to non identification of CRES schemes.

The Health Groups were still a concern with run rate issues of £0.65m of which £0.15m were non recurrent. The Trust had also experience an income shortfall of £0.25m. Mr Gore expressed his concern regarding the underlying overspend and Mr Evans agreed to bring a report to the next Committee giving more details. **SE**

As the control total had been agreed at £11.5m deficit the Trust was eligible to receive STP funding. It had been agreed to receive the money in 10 payments rather than 12 within the financial year.

Agency spend was slightly below plan but there was still work to do to reduce this further.

The Committee discussed the cash flow and if suppliers were not being paid on time, the consequences of this. Mr Hall agreed to escalate this issue to the Board. **SH**

Resolved:
The Committee received the report and agreed to escalate the cash flow position to the Board. **SH**

8.2 – CRES REPORT

CRES was discussed by the Committee. The Trust plan highlighted £1m shortfall and this would need to found as part of the CRES. Work was ongoing by the Health Groups to identify schemes which was alongside the FIP2 team who were working with the Trust. Mr Evans advised that plans were being developed and would be in place by the

end of August 2017. Mr Evans also reported that the 2017/18 plans were being worked up and would be in place by March 2018.

Resolved:
The Committee received the report and noted the CRES position and the development plans in place.

8.3 – CAPITAL RESOURCE ALLOCATION COMMITTEE MINUTES 07.06.17
Mr Evans presented the report and advised that a business case had been presented to the committee regarding a bar code scanning system for medical records. The system would result in staff reduction savings. Mr Hall asked if a report giving more details could be received at the next meeting. **SE**

Mr Gore asked about the relocation of Maxillo Facial services and Infectious Diseases and whether these had been prioritised appropriately. Ms Ramsay reported that both of the services were in premises that were not clinically appropriate and needed to move.

Resolved:
The Committee received the report.

9. PERFORMANCE REPORT
Mrs Ryabov reported that A&E figures had met the trajectory in May and the June figure was at 93.3% so far. The Trust was 5% above the England average. Ambulance turnaround and RTT was improving although there was more work to be done.

Diagnostic performance was highlighted as a major concern and would be escalated to the Board for further discussion.

31 day cancer standard had failed the target and teams were reviewing the avoidable breaches. There was now access to the robot for some procedures and other specialities had also started to use it. 62 Day RTT had failed mainly due to diagnostic delays as had 62 day screening. 28 Day cancellations had also failed and this was due to equipment breakdowns. Ms Ramsay reported that the Quality Committee were reviewing diagnostic performance and any quality issues relating to patient care. A tumour lead meeting was being held to manage the breaches and highlight themes and trends. This would be fed back to the Quality Committee in due course.

Resolved:
The Committee received the report and agreed to escalate the issues around diagnostic performance.

10. AGENCY SPEND PROGRESS REPORT
Mr Nearney presented the report and reported that the Trust had been set a target to reduce agency spend by 25%. He advised that medical spend was the key issue but the HR teams were working with the Health Groups to review and manage the staff shortages. One solution would be to expand the Trust's internal bank but this would take some investment. A number of controls were in place to keep all expenditure to a minimum but some specialities still needed to bring in agency staff

to ensure the service continued to run safely.

Resolved:
The Committee received the report.

10.1 – AGENCY SPEND EXCEPTION REPORT
Mr Nearney presented the report and advised that the Trust was compliant with the new mandated frameworks. The area of concern was the roll out of Allocate the roster system which would reduce the reliance of third party companies due to better coordination of bank and agency bookings. Mr Nearney advised that a business case was being developed to ensure the Trust had appropriate resource to roll out the roster system and what the return on investment would be.

Resolved:
The Committee received the report and requested an update regarding the business case at the next meeting in July 2017. **SN**

11. WORKFORCE TRANSFORMATION COMMITTEE MINUTES
Mr Nearney presented the minutes to the Committee and reported that staff turnover, retention and sickness absence was discussed at every meeting.

The Committee discussed the need for more Workforce statistics to be included in a report to the Committee. Mr Gore asked for more information around what the Trust was doing to retain staff and any exit interview themes and trends. Mrs Christmas asked if long term attrition rate planning could be added to the report.

Resolved:
The Committee received the minutes and requested a quarterly Workforce Planning report to be received. The first report would be received at the August 2017 meeting. **SN**

12. ITEMS DELEGATED BY THE BOARD
12.1 – FIP 2 (Item 8)

13. BOARD ASSURANCE FRAMEWORK
Ms Ramsay presented the report and highlighted BAF 2, workforce planning, BAF 4, waiting times and diagnostic issues and BAF 7.1 – 7.3 financial planning (control total sign off, CRES, FIP2) as discussion points for the Committee.

The Committee noted that the Director of Estates was ensuring that the cladding on the tower block was being inspected for fire safety reasons.

There was a discussion around the escalation process relating to the non delivery of CRES. Mr Evans advised that Health Groups would escalate any issues to the Chief Operating and Chief Financial officers in the first instance and then the Committee if the issues cannot be resolved.

Resolved:
The Committee received the report and agreed that it should be a standing agenda item at each meeting. **CR**

14. LAND DISPOSAL UPDATE

Mr Evans presented the report which highlighted the land sale at Castle Hill Hospital. The value had reduced in price but the financial impact of the sale had been covered in the 2017/18 financial plan.

Resolved:

The Committee approved the land sale at Castle Hill Hospital.

15. ANY OTHER BUSINESS

There was no other business discussed.

16. DATE AND TIME OF NEXT MEETING:

Monday 31 July 2017, 2pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHANGE OF ORGANISATION NAME

Trust Board date	Tuesday 1 August 2017	**Reference Number**	2017 - 8 - 14
Director	Chris Long – Chief Executive	**Author**	Carla Ramsay - Director of Corporate Affairs
Reason for the report	The purpose of this report is to brief the Trust Board and gain approval to proceed with the process to change the name of the Trust		

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

1	**RECOMMENDATIONS** The Board is asked to review and approve continuing to undertake the required process to change the organisation's name, following consideration of stakeholder feedback, as detailed in this paper.					
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** Matters linked with the organisation's name are reserved to the Trust Board					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHANGE OF ORGANISATION NAME

1. PURPOSE OF THIS REPORT

The purpose of this report is to brief the Trust Board and gain approval to proceed with the process to change the name of the Trust.

2. BACKGROUND

Since its formation through merger in 1999, and in the predecessor organisations, the Trust has had the status as a training and teaching centre for medical and nursing staff, staff from the professions allied to healthcare, and administrative and managerial staff. This has not been reflected in the name of the Trust.

3. CHANGING ORGANISATIONAL NAME

The Trust Board gave approval in June 2017 to proceed with the process to change the Trust's name in accordance with Department of Health mandatory guidance.

The guidance requires that a change of name is supported by key stakeholders, that the name is clear and unambiguous, that it includes a key geographical reference and the type of NHS trust, and that a use of a protected title, such as 'Royal' or 'University' has the required permissions.

3.1 Stakeholder Engagement

Following the June 2017 Trust Board, stakeholder views were sought on the proposal to change the Trust's name to: *Hull University Teaching Hospitals NHS Trust.* Stakeholder views were sought from:

- Senior leaders of local NHS Trusts, commissioners and local authorities
- Trust staff
- The Trust's membership base (members of the public and patients)

From the stakeholder engagement, senior leaders were happy to support, or did not object to, the propose name change. The University of Hull is happy to indicate its support to this proposal, and can proceed down any required formal route following the Trust Board's consideration today.

In respect of staff, 59 staff submitted written responses to the stakeholder engagement. Of those 59 responses, 14 members of staff supported the proposal outright, 38 supported the principle but submitted questions or comments for consideration and 7 did not support the name change.

With regard to members of the public and patients from the Trust's membership, 30 responses were received. Of these, 21 supported the proposal outright, 5 supported the principle but submitted questions or comments for consideration and 4 did not support the name change.

3.2 Comments and Questions Raised

The comments received fell in to six frequently asked topics. A number of alternative suggestions for the new organisational name were also received, which also reflect some of these comments and questions.

The key issues raised by stakeholders were (in order of frequency raised, from most to least frequent):

- Wanting to retain the 'HEY' branding
- Requesting clarification as to what the reference to 'University' specifically means for the Trust

- Wanting to retain a reference to East Yorkshire
- Checking the rationale and benefit for the Trust are robust
- Asking whether the correct title of 'Kingston Upon Hull' should be used
- A technical question about HEY numbers (the Trust's internal patient numbering system)

Feedback from stakeholders is much appreciated and helps to build up the Trust's plan to progress the name change, given the overall positive and supportive response to the name change.

To respond to this feedback, the following is proposed and offered as clarification:

- In respect of the HEY branding and retaining a reference to East Yorkshire, the Trust will add a branding strapline to its publications, such as 'serving the communities of Hull, East Yorkshire and the wider region'.
- The rationale is as outlined to the Trust Board in the June 2017 proposal – the proposed name provides a stronger projection of the Trust and its core business, and will be an incentive for staff recruitment and retention. Such positive gains in recruitment and reduction in agency costs have been reported by a Trust that has recently changed its name, and a number of staff who provided positive support to the proposal also commented that the proposed name is a better reflection of the Trust's purpose and work.
- The inclusion of 'University' does not entail ownership by the University of the Trust or that the Trust is a part of the University, nor is it to reflect the title of the University of Hull within the Trust's name, which were the points of clarity raised by some responders. It describes the formal links between the Trust and the University and denotes a status as a type of NHS organisation i.e. a University NHS Trust. The formal links between the University and the Trust are around research and the financial and academic support between the two organisations for formal academic clinical faculties. These are already in existence and are long established: the proposed name change reflects what already exists rather than any particular change in arrangements.
- The full title of the city is Kingston Upon Hull; however, the Trust has been using 'Hull' as per the commonly accepted title since its establishment and did in its preceding title ("Royal Hull Hospitals"). The local authority is entitled Hull City Council to the public (whereas its formal title to central government is Kingston Upon Hull City Council) so the continued use of "Hull' is in keeping with the long established national common title for the city.

A more detailed set of responses as Frequently Asked Questions has been drawn up and will be circulated to stakeholders following this Trust Board meeting, should the Board endorse the proposal to proceed with the organisational name change.

A number of different organisational names were proposed by stakeholders. Some of these were not consistent with NHS naming requirements, so should not be considered by the Board. The remaining proposals were either to retain 'Hull and East Yorkshire' within the title, or to have either 'Teaching' or 'University', and not both. With the Trust responding to feedback to retain the HEY branding and reference to East Yorkshire and the wider region in its publication as a strapline, and the strength that 'Teaching' and 'University' will both offer as an accurate reflection of the Trust's core business, the Trust Board is asked to endorse the title as proposed: *Hull University Teaching Hospitals NHS Trust.*

The minority of staff and members who did not support the proposal gave the following reasons:

- Do not agree it is necessary
- Do not agree with any financial outlay associated with a name change

3.3 Summary

The majority of feedback from stakeholders is positive support to the proposal and provides constructive points for consideration as to how the Trust would proceed with the name change.

The negative feedback does not give a strong case against the proposed change; costs will be minimised and the Trust Board accepted the rationale as outlined previously as providing a positive case for change. Therefore, following the rationale previously provided, and in accordance with positive overall support for the proposal, the Trust Board is asked to endorse progressing with the name change.

4. RECOMMENDATION

The Board is asked to review and approve continuing to undertake the required process to change the organisation's name, following consideration of stakeholder feedback, as detailed in this paper.

Chris Long
Chief Executive
July 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT

Meeting date	Tuesday 1 August 2017		**Reference Number**	2017 – 8 - 15		
Director	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian		**Author**	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian		
Reason for the report	The purpose of the report is to provide a quarterly update from the Freedom to Speak Up Guardian					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and comment on the first quarter's report and 'read across' from the Freedom to Speak Up Guardian as part of the initial stages of developing the 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): **W2 –** Governance					
	Assurance Framework Ref: BAF 1	**Raises Equalities Issues?** Y	**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; this is to ensure the Guardian can report issues directly to the Board as well as to keep the Board appraised of speaking up in the organisation					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT

1. PURPOSE OF THE PAPER

To provide a quarterly report from the Freedom to Speak Up Guardian as part of the Trust's processes to enable staff to raise concerns.

2. INTRODUCTION

All Trusts from 1 April 2017 were required to have a Freedom to Speak Up Guardian in place. The Trust Board agreed an outline position as to how the Guardian role would be used within the Trust; the main purpose of the Guardian role is to be part of continuing to develop a positive culture that supports staff to raise concerns and to make continuous improvement to a culture that supports the highest standards of care and openness.

3. FREEDOM TO SPEAK UP GUARDIAN

The Freedom to Speak Up Guardian's main activities during Quarter 1 of 2017-18 have been around establishing the role in the organisation against the approach agreed by the Trust Board.

To this end, the Guardian has:

- Met informally twice with senior leaders in the organisation to introduce the role and start a dialogue to be able to raise and listen to concerns in the organisation from those closer to operational delivery; these meetings are set up quarterly with the aim of being a FTSUG informal network and support
- Attended the Trust's two staff side bodies (LNC for medical staff and JNCC for staff on agenda for change terms and conditions) to introduce the role
- Attended the HR Advisors' team meeting to explain the role and test out some early FTSUG concerns as case studies and establish ways of working with the HR team, as there is a risk that the FTSUG role could over-lap or interfere with active HR casework
- Worked with the Staff Advice and Liaison Service to pick up individual cases and concerns, as well as signpost staff contacting the Guardian to SALS support
- Worked with the Trust's anti-bullying Tsar to establish the Guardian role alongside the work undertaken by the Tsar
- Been referred to individual members of staff wishing support, advice and guidance on raising concerns
- Provided whistleblowing evidence and was interviewed as part of the CQC Well-Led inspection pilot in June 2017 – the Guardian will always be part of the interview schedule for the new well-led inspections
- Had an article in the monthly Team Brief with an explanation of the role and reminder of all sources of support to staff to raise concerns (not just the Guardian role) – the diagram of support available to staff is attached at Appendix A

The National Guardian's Office sets out a requirement for Guardian's to be able to access the Chief Executive and the Trust Board directly if they have significant concerns about an area. As this is part of the Director of Corporate Affairs role, this link already exists.

The National Guardian's Office also sets out a requirement to report to the Trust Board the number of contacts that the Freedom to Speak Up Guardian has received.

Since starting in post, these contacts are as follows:

Date	Referral route	Issue
May 2017	Anti-bullying Tsar	Concerns about HR process affecting the individual and concern about fair treatment
June 2017	Anti-bullying Tsar	Member of staff under investigation following incident citing patient safety
June 2017	Anti-bullying Tsar	Member of staff wanting independent advice as to taking forward their concerns on bullying behaviour
June 2017	Anti-bullying Tsar	Member of staff not able to approach line manager about difficult behaviours and attitude being shown towards them
June 2017	Chief Executive	Referred as source of support and guidance following completion of investigation in to staff member's concerns about patient safety and staffing
June 2017	SALS	Member of staff concerned about unfair treatment and citation of patient safety concerns
July 2017	Human Resources	Independent review of a complex HR case where whistleblowing is now being cited

The Chief Executive, Chief Nurse and the Director of Workforce and OD have also cited the Guardian role in responses to staff as a source of further guidance and support, should they wish to make contact, which is positive promotion of the role.

Dr Makani Purva became the Trust's anti bullying Tsar following the publication of the CQC comprehensive inspection of the Trust in 2014. Staff who felt that they were being bullied were able to make a referral to Dr Purva, who investigated their concerns and met with the line manager of the individual raising concerns in the presence of their line manager.

Dr Purva continues to undertake this role in the Trust but has been focussing her time and attention more recently on medical staff cases. Dr Purva and the Freedom to Speak Up Guardian have confirmed ways of working between them so that the Guardian picks up appropriate contacts to Dr Purva that concern staff other than medical staff, and makes the first response back to the member of staff seeking advice and support. Staff continue to be able to contact Dr Purva via the intranet and in person to raise a concern and between Dr Purva, SALS and the Guardian, the member of staff will receive contact and support.

In terms of next steps for the Guardian role, quarter 2 will consist:

- Further promotion of the Guardian role to staff as part of the Stop the Line campaign being championed by the Chief Nurse and the Executive team
- Updated communications about the Guardian role on the new intranet, including if possible, a short video to introduce the Guardian and the role
- Continued promotion of the role through team brief and other Trust-wide communications

4. 'READ ACROSS'

The Trust has several data sources that already capture where staff are speaking up about issues of concern.

When presenting the first Freedom to Speak Up Guardian's report to the Trust Board, the Board agreed the following principles:

- That the Guardian's role can help 'sense-check' organisational culture, to see if staff feel increasingly enabled to raise concerns about patient safety and staff welfare, and also report if staff are being treated detrimentally as a result of raising concerns
- That the Trust Board did not want the Guardian to start producing lengthy reports to try to cross-refer numerous data sources
- That the Guardian should not work on rumour or conjecture, or read correlation or causation into issues falsely

4.1 Staff Advice and Liaison Service

One such source is the Staff Advice and Liaison Service (SALS). SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. SALS received 22 contacts in the remaining quarter of 2014/15, 57 contacts in 2015/16 and 51 contacts in 2016/17. In quarter 1 of 2017/18, 16 concerns were raised.

Date	Number	Highest reporting	Health Group
Jan- March 2015	22	Radiology (6) A&E (5) Ophthalmology (4) Portering (4) Cardiology (3) ICU (3) Obstetrics (3) Therapies (4) Others not specified or only raised up to 2 times across all concerns	28 - Medicine 29 - Clinical Support 24 – Surgery 24 – Corporate 26 – F&W All others not specified
April 2015-March 2016	57		
April – June 2016	9		
July – Sept 2016	11		
Oct – Dec 2016	22		
Jan – Mar 2017	7		
Apr – June 2017	16		

The majority of issues raised have been queries about attitude, staff behaviours and being managed through HR processes. Actions taken have been providing advice and guidance to staff, gaining further support from HR and Occupational Health and being a conduit for supported conversations with line managers, as well as referring issues with permission from the member of staff to a senior manager for review.

4.3 National Staff Survey

The National Staff survey contains questions that provide insight as to how confident staff feel about raising concerns and their overall feelings about working for the Trust.

As reported to the Board earlier this year, results for the Trust showed overall improvement compared with previous results. Specifically relating to speaking up:

- KF5. Recognition and value of staff by managers and the organisation remains above average compared with other Trusts in the 2016 survey, but showed a slight deterioration in scoring

The following are in the top 20% of Trusts:

- KF22. % experiencing physical violence from patients, relatives or the public in last 12 months
- KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF20. % experiencing discrimination at work in the last 12 months
- KF21. % believing they have equal opportunities for career progression/promotion
- KF28. % witnessing potentially harmful errors, near misses or incidents
- KF31. Staff confidence and security in reporting unsafe clinical practice

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 results demonstrate improvement into the top 20% of Trusts for staff feeling more confident in reporting unsafe clinical practice and being witness to patient safety issues. There are fewer staff reporting issues of discrimination, however the Trust remains worse than average in relation to staff experience bullying, harassment or abuse by other staff.

Staff report they feel able to, and have less cause to report patient safety concerns. However, this is an area in which the Trust cannot be complacent or dilute the message that reporting is important. Specifically, there are cultural issues about staff treatment and staff values that are still high on the Trust's agenda to address.

On this basis of providing a 'read-across' of data, between these data sources and the individual concerns that the Guardian has reviewed to date, the Guardian has also reviewed the following:

- Each Quality report to the Trust Board from January 2017, including the ward dashboard as an appendix to the report
- Each nursing Safer Staffing report to the Trust Board from January 2017
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The detail of all SALS cases 2017-18 year to date – role and grade of staff member and department working in
- The headline National Staff Survey data, as above, and the Quarter 4 staff Friends and Family test data
- The Trust's whistleblowing case data

In relation to the 'read across' as Freedom to Speak Up Guardian, the Guardian offers the following observations:

- Those members of staff making direct contact with the Freedom to Speak Up Guardian have been individual cases – in that they have each come from a different part of the Trust and the details of each case are specific to that individual
- Those cases are not coming from any of the same areas or concerns as any whistleblowing case
- Those cases are not coming from any of the same wards flagged up in the Quality report to the Trust Board as areas of concern, with the exception of one case which demonstrates the focus on leadership that the Board has been briefed on in a particular area

All Freedom to Speak Up Guardian cases concern staff who are all going through a formal HR process and are seeking support, advice and guidance on their welfare and well-being – none have raised direct concerns about patient care. This seems consistent with the picture emerging nationally from Freedom to Speak Up Guardians, where one-third of cases nationally relate to patient safety concerns and the other two-thirds concern staff culture and supporting speaking up.

There is a consistency between the staff survey result and the issues coming through the SALS service, and with the individual Guardian cases – they all concern staff behaviours, communication between teams and individuals and the way in which staff and managers are supported to improve team relations or work through difficult issues, such as performance management. There are no new issues emerging from the Guardian's work or read-across that the organisation is not already aware of but there are some initial observations that the Guardian will feed back to specific leads for consideration. The staff culture report due to the September 2017 Trust Board will provide more detail as to the work underway to examine and address some of the underpinning issues being reported by staff in the most recent staff survey, particularly in relation to staff engagement scores that are lower in particular areas and the number of staff experiencing bullying, harassment or abuse.

4 RECOMMENDATION

The Trust Board is requested to receive this report and comment on the first quarter's report and 'read across' from the Freedom to Speak Up Guardian as part of the initial stages of developing the Guardian role

Carla Ramsay
Director of Corporate Affairs
July 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.

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.

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.

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

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING APRIL 2017

Meeting date	1 August 2017	**Reference**	2017 – 8 - 17
Director	Kevin Phillips – Chief Medical Officer	**Author**	Helen Cattermole – Guardian of Safe Working
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to: • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Acknowledge that the Trust has had to develop new systems and processes to capture the required data, and that, although significant progress has been made both within the organisation and in comparison to other Trusts, further refinement is required • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions 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): Well Led					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y/N	**Legal advice taken?** Y/N	**Raises sustainability issues?** Y/N		
5	**BOARD/BOARD COMMITTEE REVIEW**					

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING APRIL 2017

1.PURPOSE OF THIS REPORT

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

- Junior doctor working hours
- Exception reports, where appropriate
- Rota gaps
- Locum usage
- System-wide junior doctor issues, where appropriate

The Trust Board is requested to receive this report and:

- Acknowledge that the Trust has had to develop new systems and processes to capture the required data, and that, although significant progress has been made both within the organisation and in comparison to other Trusts, further refinement is required
- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from April - June 2017 with reference to:

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

2. HIGH LEVEL DATA

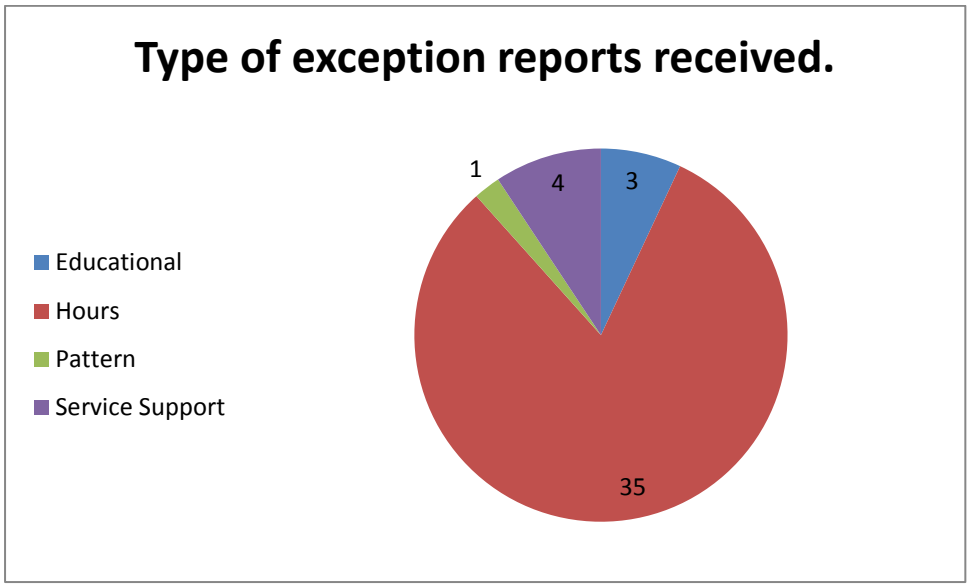
Number of doctors / dentists in training (total):	441
Number of doctors / dentists in training on 2016 TCS (total):	127
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max. varies between HGs)

All doctors currently on the 2016 terms and conditions of service (TCS) have received their work schedules in good time and in accordance with the timetable set out in the contract. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system. The next cohort of trainees (approx. 241) start on the 2016 TCS in August 2017.

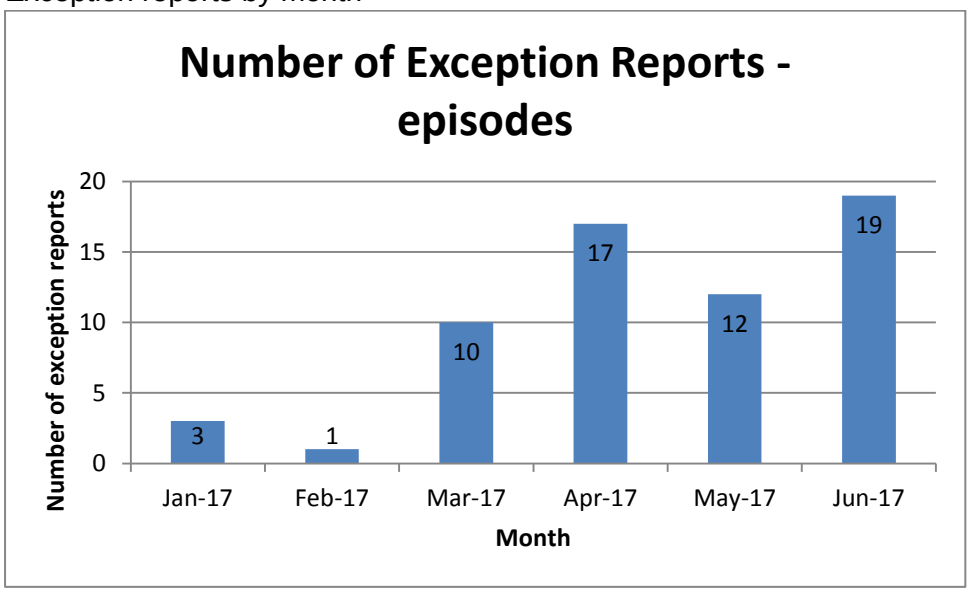
3. JUNIOR DOCTOR WORKING HOURS

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region. There were 43 exception reports submitted between 28 March and 30 June 2017. However, a number of these reports contained more than one episode of concern; the data presented below will often relate to the number of **episodes** reported.

Types of exception reports received 28 Mar 2017- 30 June 2017



Exception reports by month



a) Exception reports (with regard to working hours)

Exception reports (episodes) by specialty 28 Mar 2017-30 June 2017

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
AAU	1	0	1	0
Acute Surgery HRI	2	3	4	1
Cardiology	4	0	4	0
Colorectal Surgery	0	6	6	0
DME	0	2	2	0

ENT	0	2	0	0
Gastro	0	1	1	0
General Surgery (CHH)	1	4	3	2
Haematology	2	2	4	0
Oncology	0	3	0	3
Respiratory	3	9	12	0
Rheumatology	0	10	10	0
Stroke Medicine	1	0	1	0

Exception reports (episodes) by grade 28 Mar 2017-30 June 2017

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	8	44	44	8
CT2	0	1	1	0
ST1	0	2	2	0

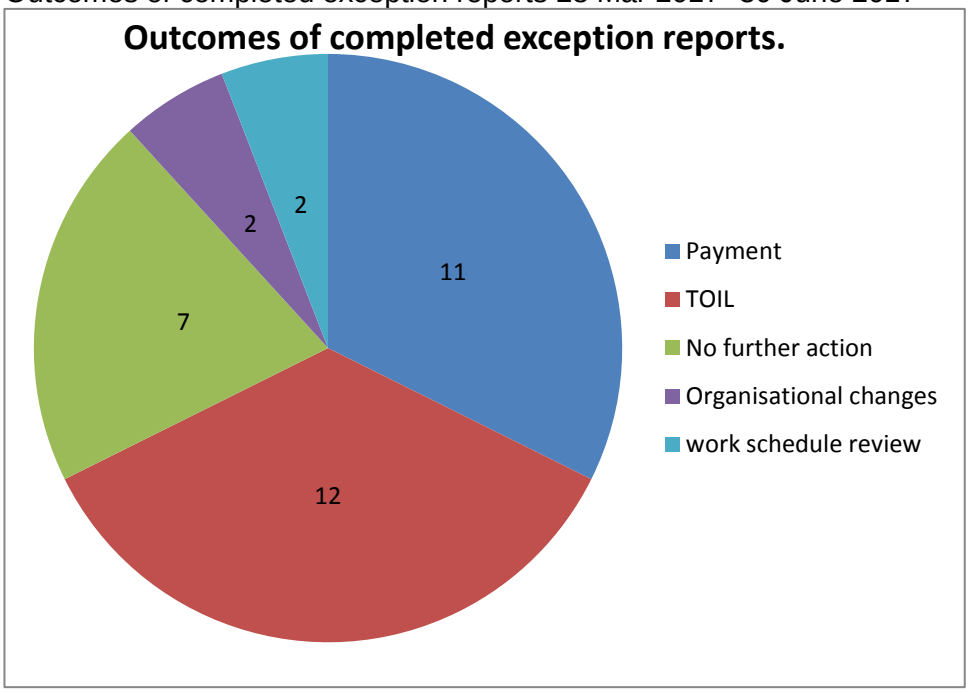
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 124a - General Surgery (acute) SHO	0	1	0	1
(2016) Rota 18 - Medicine F1	0	1	0	1
(2016) Rota 4 - Medicine F1	0	6	5	1
18B - Medicine	0	9	9	
25 - Acute/Elective Surgery F1	3	11	11	3
Rota 124a - General Surgery (acute) SHO	0	1	1	0
Rota 124b General Surgery (Uro/ENT) SHO	0	2	2	0
Rota 18 (General Medicine)	1	7	6	2
Rota 4 (General Medicine)	1	0	1	0
Rota 4B (General Medicine)	3	0	3	0

Exception reports (episodes) - response time 28 Mar 2017- 30 June 2017

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
F1	12	31	13	Trainee rotated – new supervisor	8	Trainee leave (3)

				involved (3) Consultant leave (2) Slow response, no reason (5) Refusal or no response from supervisor (3)		Refusal or no response from supervisor (1)
CT 2	0	0	1	Slow response, no reason	0	
ST1	0	0	2	Slow response, no reason	0	

Outcomes of completed exception reports 28 Mar 2017- 30 June 2017



Extra hours paid resulting from exception reporting 28 Mar 2017- 30 June 2017:

Specialty	Grade	Overtime worked	Cost
Cardiology	F1	03:00	£42.26
Acute Surgery HRI	F1	04:15	£86.89
Rheumatology	F1	06:00	£140.00
General Surgery CHH	F1	00:50	£19.40
Stroke Medicine	F1	01:30	£34.69
Acute Medicine	F1	06:30	£150.34

Agreed time off in lieu resulting from exception reporting 28 Mar 2017 – 30 June 2017:

Specialty	Grade	TOIL
Colorectal	F1	01:30
Haematology	F1	01:00
Respiratory	F1	03:45
Rheumatology	F1	01:30

Patterns and responses
Patterns of exception reports have been seen and dealt with as follows:

General Surgery CHH
Rota review (see Work Schedule Reviews, section b below)

Respiratory
Routine heavy ward work was being reported by trainees early in this period, causing them to work over time. This is not related to any particular trainee. This appears to have reduced since April, but was reported to the Medical Director, Medicine HG at the time. No common factors have been identified.

Rheumatology
This department is experiencing a recent increase in reports of heavy workload from a single trainee. No common factors have been identified and the rotas in this department are fully staffed. The educational and clinical supervisors are offering extra support to the junior doctors.

Gastroenterology
Although only one exception report has been raised, this identified a number of issues over a long period of time. Discussions are underway with the department to try and address these issues.

Hours Monitoring Exercises
Routine bi-annual hours monitoring ceased in July 2017 as trainees migrated on to the new 2016 TCS where hours monitoring is replaced by exception reporting. Monitoring exercises currently in progress will be completed.

Monitoring of trainees in GP placements
Historically, and nationwide, hours monitoring of Junior Doctors working out of the Trust on placement at local GP practices has never taken place. The posts were unbanded, and there was an expectation that trainees worked 40 hours Mon-Fri. During this quarter we were asked, for the first time, to monitor a rota that foundation doctors were working in a local GP practice. This exercise has highlighted some issues in the monitoring outcome that the Trust is currently reviewing with colleagues from the practice, the Foundation School and the Director of Medical Education. The discussions are still ongoing and will be reported back to the Guardian once complete.

Hours Monitoring exercises (for doctors on 2002 TCS only) April-June 2017						
Speciality	Grade	Rostered Hours	Monitored Hours	Monitored Band	WTR compliant (Y/N)	Comments
Oncology/ Haematology	F2/CT1-2	46:58	N/A	N/A	Yes	2 rounds of monitoring with insufficient returns
Anaes CHH	ST1-7	49:36	N/A	N/A	No	2 rounds of monitoring with insufficient returns
Radiology	ST2+	46:04	46:39	1A	Yes	Valid 2nd round
Urology	ST3+	65:48	N/A	N/A	No	2 rounds of

		(on call)				monitoring with insufficient returns
Gen Surgery HRI	ST3+	48:08	N/A	N/A	No	2 rounds of monitoring with insufficient returns
Orthopaedics	ST3+	47:10	N/A	N/A	Yes	2 rounds of monitoring with insufficient returns
Cardiothoracic/Cardiology	F2/CT1-2	47:02	N/A	N/A	Yes	2 rounds of monitoring with insufficient returns
Orthopaedics & Surgery	F2	47:35	N/A	N/A	Yes	2 rounds of monitoring with insufficient returns
AAU	F2/CT1-2	45:17	43:13	1A	Yes	2 rounds of monitoring with insufficient returns
A&E F2	F2	44:45	N/A	N/A	Yes	Insufficient return so currently remonitoring
A&E SpR	ST3+	45:38	45:02	1A	Yes	
A&E StR	ST1-2	41:31	42:18	1A	Yes	
Medicine rota 215	F2/CT1-2		N/A	N/A	N/A	Insufficient return so currently remonitoring
Medicine rota 575	F2/CT1-2		N/A	N/A	N/A	Insufficient return so currently remonitoring
Medicine rota 431	F2/CT1-2		N/A	N/A	N/A	Insufficient return so currently remonitoring
Medicine rota 450	F2/CT1-2		N/A	N/A	N/A	Insufficient return so currently remonitoring
RMO	ST3+		N/A	N/A	N/A	Insufficient return so currently remonitoring

a) Work schedule reviews

Work schedules have been reviewed in the following departments:

F1 acute surgery HRI: The work pattern has been adjusted across the entire rota, and the changes will be introduced in August. This has involved moving shifts to improve cover in the early evening and hopefully reduce the need for doctors to stay late.

F1 elective surgery CHH: The rota has been adjusted from August to prevent ‘bunching ‘of trainees on one ward with corresponding depletion on another ward.

F1 Vascular Surgery: possible adjustments are still under discussion with relevant parties to make the conditions on this rota more pleasant (no exception reports have been received from this rota).

b) Locum bookings April – June 2017

i) Bank April – June 2017

The Trust currently has an informal medical bank in place which strives to fill as many shifts internally as it can. With the successful creation of a Nurse and Clerical Bank the Trust is looking at creation of a formal Medical Bank in line with the 2016 TCS. The work to start bringing this together is to start in the summer with the aim of getting a formal process in place later in 2017. The work on this project will be fed through to the Guardian by the Medical Staffing Operations Group.

Since the previous report, it is now possible to provide a cost summary of bank use across the Trust, in areas where the e-rostering system is in use. This represents an improvement in data capture; further refinements are expected in time.

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

Locum Bookings (bank) by grade					
Grade	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
F1	52	0		571.00	0
F2/CT/ST-2/GPSTR	525	213		5115.50	1783.75
ST3+	124	27		2314.00	668
Total	701	240		7795	2451.75

Locum Bookings (bank) by department					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Acute Medicine	82	29		625.82	182.07
Acute Surgery	9	2		112.50	112.50
Colorectal Surgery	53	5		1002.00	324.00
Elderly Medicine	332	104		2078.00	773.50
Extra Medicine	102	59		1083.68	582.18
Neurology	21	10		176.25	82.75

Neurosurgery	11	4		182.00	59.50
OMFS	5	3		76.00	40.00
Orthopaedics	23	4		356.50	41.50
Respiratory Medicine	19	4		172.00	34.25
Rheumatology	23	4		233.50	49.00
Upper GI Surgery	21	12		328.00	170.50
Total	701	240		6426.25	2451.75

Locum Bookings (bank) by reason					
Grade	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Additional Staff	119	30		875	232.00
Vacancy	582	210		6907.50	2219.75
Total	701	240		7782.5	2451.75

Locum Bookings (bank) by 3rd April 2017 to 30th June 2017 AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	579	460	579	3974.04	2659.04
Total					

Locum Bookings (bank) by 3rd April 2017 to 30th June 2017 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	610	610	610	3881.00	3881.00

Data in these tables is still work in progress and should be interpreted with caution until the internal bank is fully operational and all shifts are logged routinely on e-roster using consistent processes.

ii) Agency April – June 2017

Since the last report, the data in these tables is now able to be collected and presented in the standard fashion requested by NHS Employers, and this provides more information about locum requirements for junior doctor vacant posts.

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Acute Medicine	10	1	111.50	11.75
Cardiology	52	0	399	0
Cardiothoracic Surgery	1	0	12	0
Elderly Medicine	116	100	925.25	750
Respiratory Medicine	36	0	295.50	0
ENT	27	6	254	72
Gastroenterology	3	0	35.25	0
General Medicine	808	147	7146.75	1337.5
General Surgery	80	45	850	460.5
Neonatal Medicine	6	0	70.50	0
Neurology	82	0	621.75	0
Neurosurgery	38	30	344.50	259
Obstetrics and Gynaecology	13	4	155.50	46
Oncology	161	88	1216.50	660
Orthopaedic and Trauma Surgery	132	74	1287	690
Paediatric Surgery	38	14	396.50	151
Paediatrics	1	0	12	0
Plastic Surgery	5	3	60.50	34.5
Total	1609	512	14194	4472.25

The Emergency Department books its own agency locums through the same agency.

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	21	0	205.50	0
F2/CT/ST-2/GPSTR	1832	410	15118.67	3455.75
ST3+	348	102	3402.37	1016.50
Total	2201	512	18726.54	4472.25

Locum bookings (agency) by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Extra Cover	103	2	760.67	24
Other	24	5	280	60
Paternity Leave	6	4	69	46
Vacancy	1267	501	16765.37	4342.25
Total	1400	512	17875.04	4472.25

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

c) Locum work carried out by trainees April – June 2017

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

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents an improvement in the amount of information available since the last report but is not sufficient, in its current form, to allow the individual at risk of breaching to be identified.

Locums Worked By Trainees						
Speciality/Rota	Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual Hours Worked per week	Opted out of EWTD
Acute Medicine	F2/CT/GPSTR	30	236.25	46:15		
Anaesthetics	CT	2	25.00	46:30		
Anaesthetics	ST3+	21	156.75	46:30		
Cardiology/CT Surgery	F2/CT/GPSTR	28	344.50	47:15		
Cardiothoracic Surgery	ST3+	7	184.75	47:30		
Elderly Medicine	F2/CT/GPSTR	182	1016.00	46:00		
ENT/Urology	F2/CT/GPSTR	3	51.00	46:45		
Gastroenterology/Rheumatology	F2/CT/GPSTR	17	147.75	46:45		
General Surgery	CT	37	498.00	44:45		
GIM	ST3+	56	647.50	45:45		
Medicine	F1	43	219.50	45:45		
Neurology	F2/CT/GPSTR	11	93.50	46:45		

Neurosurgery	F2/CT	7	112.50	47:00		
OMFS	CT	2	36.00	47:00		
Orthopaedics/Plastics	F2/CT	29	624.00	46:45		
Paediatrics	F1	3	39.00	46:45		
Respiratory Medicine	F2/CT/GPSTR	12	108.75	46:45		
Surgery	F1	15	107.00	47:15		

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

Trainee opt-out from the Working Time Regulations will be collected systematically from new starters beginning in August 2017 and will be recorded on e-roster so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. As the systems for capturing this data improve, monitoring compliance with the WTR should improve, but this may be at the expense of service cover, if trainees currently doing large numbers of extra shifts are prevented from so doing.

d) Vacancies – table showing vacancies among medical training grades on 30 June 2017

	Establishment						Vacanices						
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	0	0	0	0	0	100.0
Acute Medicine	0	6	9	0	6	21	0	0	1	0	3	4	81.0
Anaesthetics	4	4	19	0	29	56	0	0	4	0	3	7	87.5
Breast Surgery	2	0	0	0	2	4	0	0	0	0	1	1	75.0
Cardiology	2	1	4	1	9	17	0	0	1	0	3	4	76.5
Cardiothroacic Surgery	0	3	0	0	3	6	0	0	0	0	1	1	83.3
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0
Dermatology	1	0	0	1	0	2	0	0	0	0	0	0	100.0
Elderly Medicine	5	4	6	7	6	28	1	0	0	1	1.5	3.5	87.5
Emergency Medicine	0	12	8	5	13	38	0	0	0	0	4	4	89.5
Endocrinology	3	0	2	0	4	9	0	0	0	0	2	2	77.8
ENT	1	1	2	1	5	10	0	0	0	0	0	0	100.0
Gastroenterology	3	0	2	0	5	10	0	0	1	0	1	2	80.0
General Practice	0	18	0	0	0	18	0	0	0	0	0	0	100.0
General Surgery	0	1	1	0	0	2	0	0	1	0	0	1	50.0
Haematology	1	0	2	0	3	6	0	0	2	0	1	3	50.0
Histopathology	0	0	0	0	4	4	0	0	0	0	1	1	75.0
HIV/GUM	0	1	0	0	0	1	0	0	0	0	0	0	100.0
Infectious Diseases	2	0	2	0	4	8	0	0	1	0	1	2	75.0
Lower GI Surgery	7	0	2	0	3	12	1	0	0	0	0	1	91.7
Neurology	2	2	4	0	5	13	0	0	1	0	0	1	92.3
Neurosurgery	1	1	2	0	4	8	0	0	0	0	0	0	100.0
Obstetrics & Gynaecology	0	2	7	4	11	24	0	0	4	0	1	5	79.2
Oncology	3	1	3	4	6	17	0	0	2	1	2	5	70.6
Ophthalmology	1	1	2	0	4	8	0	0	0	0	0	0	100.0
Oral & Maxillofacial Surgery	0	0	10	0	3	13	0	0	3	0	0	3	76.9
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	0	0	0	0	100.0
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	0	0	1	1	92.9
Paediatric Surgery	0	0	2	0	0	2	0	0	1	0	0	1	50.0
Paediatrics	3	4	3	4	9	23	0	0	0	0	0.4	0.4	98.3
Palliative Care	0	0	0	2	0	2	0	0	0	0	0	0	100.0
Plastic Surgery	0	0	3	0	6	9	0	0	0	0	1	1	88.9
Psychiatry	5	5	0	4	0	14	0	0	0	3	0	3	78.6
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0.0
Radiology	0	0	8	0	14	22	0	0	0	0	2	2	90.9
Renal Medicine	2	1	2	0	5	10	0	0	0	0	2	2	80.0
Respiratory Medicine	6	2	2	2	8	20	0	0	1	1	3	5	75.0
Rheumatology	3	0	1	3	3	10	0	0	0	0	0.4	0.4	96.0
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	100.0
Trauma & Orthopaedics	0	5	3	1	9	18	0	0	0	0	0	0	100.0
Upper GI Surgery	7	0	2	0	3	12	0	0	0	0	0	0	100.0
Urology	1	3	3	0	3	10	0	0	0	0	0	0	100.0
Vascular Surgery	5	0	1	0	3	9	1	0	0	0	0	1	88.9
TOTAL	70	84	130	39	203	526	3	1	23	6	36.3	69.3	86.8

fine lies with this department. Measures have been put into place to try and prevent this type of breach happening again.

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at the end of this quarter
£00.00	£39.26	£00.00	£39.26

Qualitative information

E-roster roll out

E-roster continues to be rolled out across the organisation and the pace of change has increased due to all new starters going on to the new contract, the exception reporting system and e-roster at the August 2017 rotation.

Implementation of the new contract

This has been a challenge to the Medical Staffing team, Medical Education team and the Health Groups because of the tight timescales involved and the large number of doctors transitioning to the new contract at the same time (approx. 250). The Medical Staffing team has worked extremely hard in producing work schedules for the trainees starting in August. All but a few trainees received their work schedules on time, and where this was not possible (e.g. due to addressing complex pay protection issues) they received an interim letter with as much information as possible to allow them to plan while the issues were addressed.

Junior Doctor Forum

The Junior Doctor Forum is well-established but will face a challenge to ensure suitable representation as so many doctors rotate away from the Trust in August. It is hoped that as the contract becomes more widely established that trainees will step forwards and recognise the management training opportunities this represents.

Consultant engagement

There is an ongoing programme of training aimed at consultant supervisors, run by the Director of Medical Education and the Guardian of Safe Working. This has uncovered a number of misconceptions about the time and skills required for supervisors to deal with the issues raised by the contract, and about the culture of exception reporting. It is hoped that with more uptake of the contract among all grades of trainees that some of these anxieties can be allayed. The Health Group management have all been active in assisting consultants to address the exception reports in a timely manner.

Rota administrative support

It is clear that data about junior doctors needs to be captured in real time at department level and entered on to the e-rostering system as it happens. This is to allow service planning, to place trainees in the correct environment for their training and service, to capture where vacancies exist and where these have been filled. There is already an investment into rota administrative support at this level, but, particularly where rotas are large and/or complex, health groups need to be sure that the administrative support is adequate for the multiple tasks required.

Issues arising

This report gives much more information than has ever been previously available about the working hours of trainees. Many of the systems and processes required to produce a comprehensive report are still under development or refinement, and therefore, although there is a substantial amount of new information, it is still not possible to triangulate the information to identify departments, grades or rotas that are at particular risk of breaching safe working hours.

It is clear that rota gaps, for whatever reason, are putting a significant strain on the system, particularly when shifts are put out for cover and this cannot be found. More information about the effect this has on individual departments or rotas is needed to produce a complete picture of the risk.

Actions taken to resolve issues

There is a significant investment across all Health Groups into administrative support for e-rostering. This will allow real-time input of the hours that trainees actually work, rather than just their rostered hours. All new starters will be using e-roster from August, and this, together with the huge efforts of the Medical Staffing team to streamline work schedules, recruitment, rota approval and other processes, will mean that more information will be available for analysis by the Guardian in the coming months.

In the interim, exception reports and work schedule reviews are mechanisms to identify departments and rotas that are at risk of unsafe working and this system seems to be working well.

Summary

The Trust continues to make good progress in developing systems and processes that will allow the Guardian to monitor safe working hours. Exception reporting seems to be a good early-warning system to indicate where there may be issues. However this information needs triangulating with other sources to gain a complete understanding of system problems and to develop appropriate and robust solutions.

Questions for consideration

The Trust Board is requested to receive this report and:

- Acknowledge that the Trust has had to develop new systems and processes to capture the required data, and that, although significant progress has been made both within the organisation and in comparison to other Trusts, further refinement is required
- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Dr Helen Cattermole
Consultant Trauma & Orthopaedic Surgeon
Training Programme Director, Core Surgery Yorkshire & the Humber
Guardian of Safe Working, Hull and East Yorkshire Hospitals NHS Trust
NCEPOD Ambassador, Hull and East Yorkshire Hospitals NHS Trust

July 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Meeting date	Tuesday 1 August 2017		**Reference Number**	2017 – 8 - 18		
Director	Terry Moran - Chairman		**Author**	Carla Ramsay - Director of Corporate Affairs		
Reason for the report	The purpose of this report is to present the updated Board Assurance Framework for 2017-18 for discussion					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to: • Raise any queries or concerns about the current status of any BAF risk area • Receive the positive assurance detailed from the April – July 2017 Trust Board and Committee meetings (where the Board has received these Committees' minutes) • Review and confirm the Quarter 1 ratings for each BAF area • Identify any BAF areas with gaps in controls or assurance requiring broader Board discussion					
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: All	**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 set annually Trust Board and is monitored regularly at Trust Board and Committee level for positive assurance received, as well as maintaining and oversight and requesting action on gaps on control or assurance					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

1. PURPOSE OF THIS REPORT

The purpose of this report is to present the updated Board Assurance Framework for 2017-18 for review and agreement, as well as to provide an overview on gaps in control, assurance and where positive assurance has been received to date.

2. BACKGROUND

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

The Trust has put in place a 'ward to board' process for risk management, for the BAF to include reference to relevant risks form the Corporate Risk Register, which is reviewed and agreed by the Executive Management Committee. This provides the opportunity to link corporate-level risks where they impact on the strategy and achievement of the Trust's over-arching goals.

3. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

3.1 Assurance

From the April – July 2017 Trust Board meetings and Board Committee meetings, there are some areas of positive assurance that have been received, as detailed in the attached BAF.

As this is an early stage in the year, there are some areas showing gaps in control and gaps in assurance. The Trust Board is asked to review these and raise any queries or concerns in specific areas that need quick remedial action.

In addition, as a separate agenda item, a draft Board Development programme for 2017/18 is on today's agenda for discussion – this has been constructed to build in elements of the BAF and assurance requirements for more detailed Board discussion and assurance.

Quarter 1 ratings have been added to each BAF area for the Board's consideration. No risks are recommended for escalation (higher risk rating) and are recommended to decreased their ratings towards target risk score at this stage.

3.2 Corporate Risk Register – July 2017

The BAF has been populated with corporate risks and updated in line with the Corporate Risk Register, for the flow of corporate risks up to the BAF as part of the agreed 'ward to board' risk escalation process. The most recent version of the Corporate Risk Register is that from July 2017, which is presented to the Trust Board at this meeting for the first time. There is one new corporate risk from the Medicine Health Group (ID 3096 – Hyper Acute Stroke Unit capacity) – this is now linked to BAF 4.

Since the last iteration of the Corporate Risk Register in May 2017, the following risks have been removed from the corporate risk register. These are still risks within their health groups/corporate service but are no longer sufficiently significant to require entry on to the Corporate Risk Register:

- Family and Women's Health Group - Risk 3027 Cedar Ward - Patients out with their own Specialty
- Medicine Health Group - Risk 2701 Crowding will occur in ED due to peaks in demand, insufficient staff and delays in other services, increasing risk of mortality

- Medicine Health Group - Risk 2552 There is a risk that patients do not receive a timely senior review due to vacancies in DME Consultants posts

These have been removed as associated corporate risks from the BAF.

The Board's attention is drawn to the number of corporate risks that are linked (directly or indirectly) to BAF 2 (shortfalls in staffing). This is also the area where the Nursing and Midwifery report to the July 2017 Trust Board highlighted that the number of nursing and midwifery staff in post at this time of year is at its lowest point.

4. RECOMMENDATIONS

The Trust Board is asked to:

- Raise any queries or concerns about the current status of any BAF risk area
- Receive the positive assurance detailed from the April – July 2017 Trust Board and Committee meetings (where the Board has received these Committees' minutes)
- Review and confirm the Quarter 1 ratings for each BAF area
- Identify any BAF areas with gaps in controls or assurance requiring broader Board discussion

Carla Ramsay
Director of Corporate Affairs

July 2017

APPENDIX A

BOARD ASSURANCE FRAMEWORK 2017-18 UPDATED FOLLOWING TRUST BOARD MAY 2017

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement	None	**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan to focus on a forward-looking Board, with a defined set of accountabilities at Health Group and corporate service level, which supports achievement and positive enforcement of behaviours and organisational culture Leadership Development Programme commenced April 2017 to develop managers to become leaders able to	Clarity as to full set of accountabilities, deliverables and acceptable standards given the progress made in the last two years is still required and an understanding of cascade/ communication and acceptance of the same; this needs to be at Health Group leads and cascaded down, as well as support service leads	**12**				**4 x 1 = 4**	**Positive assurance** Receipt of detailed staff survey report and action plan – analysis of where work is needed to make further impact on staff engagement; positive messages from most recent results; best results for the Trust in a long time for the number of questions in the top 20 percent of Trusts Approach agreed in April 2017 regarding the Freedom to Speak Up Guardian role, and how this will feed back issues on staff culture and behaviour to the Trust Board Verbal update May 2017 that Barratt (cultural work) had told the Trust that the pace of cultural improvements made were twice that as would normally be seen in a two-year timeframe July 2017: positive engagement and feedback from office moves to CHH **Further assurance required** Use of positive messages from most recent results to engender further confidence in staff engagement and staff feelings of job satisfaction

		Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence			engage, develop and inspire staff							

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There are recurring risks of under-recruitment and under-availability of staff to key staffing groups There is a risk that the Trust continues to have shortfalls in medical staffing *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence	F&WHG: neonatal staffing F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse and theatre vacancies Cancer and Clinical Support HG: blood transfusion trained staff Cancer and Clinical Support HG: junior doctor levels Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access diabetic review of paediatric patients –	**5 (impact)** **4 (likelihood)** **= 20**	People Strategy 2016-18 in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices, Advanced Clinical Practitioners being deployed to cover Junior Doctor roles Remarkable People, Extraordinary Place campaign – targeted recruitment to staffing groups/roles Overseas recruitment and University recruitment plans in 17-18 Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of	Need clarity as to what 'sufficient' and 'skilled' staffing looks like and how this is measured: 1) measured for daily delivery of a safe service (nursing measures already in place), particularly medical staff 2) measured in terms of having capacity to deliver a safe service per contracted levels 3) measured in terms of skills across a safe and high quality service	**20**				5 x 2 = 10	**<u>Positive assurance</u>** Discussion with HYMS and stakeholders with a view to increasing medical student training posts locally by circa 50%, including recruitment of local students Guardian of Safe Working report May 17: 18 junior doctor rota gaps exist; 51% gaps in junior doctor rotas now filled through Trust actions Positive assurance received in April 2017 on the approach to international recruitment being taken and the support being given to new international staff. In addition, the Trust has offered post to 138 nurses due to graduate this summer, with support and opportunities to work as an auxiliary nurse in their clinical area while awaiting their PIN. Twice-yearly review of nursing and midwifery establishments presented June 17 **<u>Further assurance required</u>** Delivery of medical staff revalidation – to give a measure of competent and skilled staff Use of appraisals across the Trust as a means of valuing staff – staff survey reports that appraisals are not fully valued across the Trust Measures to understand whether staffing body is 'skilled' and 'sufficient' Further level of assurance on junior doctor gaps and potential issues leading to fines cannot yet be given via the Guardian of Safe Working Nursing and midwifery (qualified and unqualified staff) sickness levels are an area of focus – currently above Trust target Nursing and midwifery staffing report July 2017: nursing shortfalls at this time of year

			staffing Corporate Risk: The Trust may not be fully compliant with IR35		choice during and following completion of training							

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years *What could prevent the Trust from achieving this goal?* Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like	Corporate risk: management of consent policy and patient records Corporate risk: Restricted use of open systems for injectable medication	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) being updated in light of latest CQC report QIP being reviewed ton ensure actions are correct and include sufficient stretch to reach good and outstanding Trust taking part in CQC well-lead pilot – will give an opportunity for the Trust to test out part of new inspection methodology and also have further insight in to part of what 'good' and 'outstanding' look like	Needs organisational engagement – CQC commented that Trust has the right systems and processes in place but does not consistently comply or record compliance Need to build in feedback from CQC around greater involvement of patients in pathway review/development Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1) New CQC regime being introduced – impact of this and how quickly the Trust will be able to move up the ratings is unknown at present	**12**				4 x 1 = 4	**Positive assurance** CQC report and Quality Summit going in to 16-17 – steer on how to move to 'good' and support of stakeholders to do so Strategy refresh programme will include consideration of strategic goals and supporting strategies, to ensure these reflect the ambition to move to 'good' and 'outstanding' as part of the Trust's strategic and supporting plans Open and transparent reporting on current quality measures, including 12 month data. Good progress overall, and highlights to specific areas of work **Further assurance required** Updated QIP presented to Trust Board June 17 – has been updated in light of 'must do' and 'should do' areas and governance for delivery tightened – further assurance needed that the QIP projects will stretch the Trust to 'good' and 'outstanding'

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small	Cancer and Clinical Support HG:: risk of diagnostic capacity vs. continued increases in demand F&WHG: ophthalmology service issues x 2 F&WHG: breast screening equipment and breast pathology issues MHG: Hyper Acute Stroke Unit capacity	**4 (impact)** **4 (likelihood)** **= 16**	Trajectories set against sustainable waiting lists for each service, which are more affordable to commissioners, and move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Work to resource and implement improvements that have demonstrated they work, such as the FIT model Capacity and demand work in cancer pathways	Consistency of operational performance (links to BAF1) Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	**16**				4 x 2 = 8	**Positive assurance** Trust meeting ED 4-hour target from the start of 2017/18 and meeting RTT trajectory at start of 2017/18 Detailed understanding of Radiology capacity and underlying/contributing factors at July 2017 Performance and Finance Committee Detailed presentation by Emergency Department team July 2017 on sustainable changes made within ED to sustain, and continue to improve, ED waiting times **Further assurance required** Effectiveness of accountability framework and improved consistency of delivery Role of external agencies in supporting ED in particular (links to BAF6) – these may change during 17-18 as new service developments come on line external to the Trust and as the STP and placed-based plans look at service configurations Sufficient diagnostic capacity available now to meet demand and to receive onward investment to meet future demand alongside equipment replacement requirements and staffing issues, as well as manage in-year impact of diagnostic capacity on cancer pathways and waiting times

		differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes										

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk*: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships *What could prevent the Trust from achieving this goal?* Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP	None	**4 (impact)** **4 (likelihood)** **= 16**	Trust CEO chair of Acute Trust STP workstream Trust has membership of relevant STP Committees and STP Board Trust has relationship with NHS England as specialised commissioner	Build in STP/ use of Board Development sessions to Trust Board agendas and work plan Need to understand role of Trust and regulators in this work, which may be additional to formal STP structures Understanding of specialised commissioning workplan to confirm Trust strategy on specialised services, including sufficient population base, financial standing of each service and whether Trust outcomes are of high enough quality	**16**				4 x 2 = 8	**Positive assurance** Trust Board time out held 25 May 2017 – examined issues regarding patient flows and position with tertiary patient flows for the stability of Trust clinical services **Further assurance required**

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**4 (impact)** **4 (likelihood)** **= 16**	The Trust has the leadership of the local in-hospital work stream in the STP The Trust is part of local placed-base plan developments The Trust is talking with partner organisations on opportunities in the local health economy The Trust has a seat on the two local Place-Based STP groups	Mapping out internal governance and contribution to all STP workstreams and how this feeds in to Trust decision-making	**16**				4 x 2 = 8	**Positive assurance** **Further assurance required** STP NED event held – start of engagement process but few tangible outcomes at present Issue of clarity of strategy between STP, STP workstreams and place-based plans and Trust positioning within these

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2017-18 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	SHG risk: risk to delivering sufficient CRES SHG risk: risk to income from critical care CQUIN, which continues in 17-18	**5 (impact)** **4 (likelihood)** **= 20**	Detailed briefings to senior managers and Trust-wide to explain the level of challenge and responsibly throughout the organisation Budgets re-based with Health Groups for 2017-18, requiring accountable officer sign off, to take account of increase spend and cost pressures with a view to eliminating over-spends in 17-18 Strengthen governance around CRES planning and delivery, including a new escalation process up to the Trust Board Committee level (linked with BAF1) HG held to account on financial and performance delivery at monthly Performance reviews FIP2 diagnostic to understand Trust-wide potential for additional savings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities – may link to FIP2 diagnostic New governance structure with local system partners to try to manage demand	Embedding CRES delivery and financial management requirements in Health Groups, rather than await escalation of issues Assurance from local health economy on demand management Assurance over grip and control of cost base	**20**				5 x 1 = 5	**<u>Positive assurance</u>** Contract with Deloitte to identify and set up more detailed PMO arrangements for CRES identification and tracking Control total and financial plan now agreed with NHSI, per delegated action at April 2017 Trust Board **<u>Further assurance required</u>** Gap in CRES identification of £10m at start of 17-18, leading to gaps in CRES delivery in M1 Introduction of service line reporting planned during 17-18 – assurance would be to see positive impact of SLR on understanding and reducing cost base

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: telephony resilience Corporate risk: IM&T resilience	**5 (impact)** **2 (likelihood)** **= 10**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Recourse Allocation Committee to manage equipment replacement and equipment failure requirements	Availability of funds if significant failure requires significant investment	**10**				5 x 1 = 5	**<u>Positive assurance</u>** Signed-off capital plan for 2017/18 – Trust addressing what it can afford to in infrastructure Capital Resource and Allocation Committee meeting summary to Performance and Finance Committee – assurance on delivery of capital plan and prioritisation to date **<u>Further assurance required</u>** Gap in completion and upload of all service-level business continuity plans Business Continuity Plan refresh for significant event (flood, fire, etc) Longer-term view of capital requirements and access to sufficient capital funding to address this +/- STP requirements/support/plans Recovery of overspend position as at Month 2

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a reputational risk as a result of the Trust's ability to service creditors on time, with the onward risk that businesses refuse to supply *What could prevent the Trust from achieving this goal?* Lack of sufficient cashflow	Cancer and Clinical Support HG – continuity of supplies during cashflow issues	**4 (impact)** **5 (likelihood)** **= 20**	Judicious management of cash balances to ensure suppliers are paid on as timely a basis as possible Cash management actions being taken to maximise cash availability Detailed monitoring of cash position, Better Payment Practice and any impact on patient care, at the Performance and Finance Committee Review of cash position and loan opportunities reviewed and approved at the Performance and Finance Committee		**20**				4 x 1 = 4	**Positive assurance** Local CCGs agreed to pay Trust in tenths rather than twelfths over the course of 2017/18 – ease cashflow position in first half of year **Further assurance required** Need to sell land and/or explore issue with the Department of Health as to how the Trust can inject cash

APPENDIX B – CORPORATE RISK REGISTER (AS PRESENTED TO EXECUTIVE MANAGEMENT COMMITTEE ON 18 JULY 2017)

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2675	CCSHG	Patients may experience delays in treatment due to insufficient capacity to accommodate the increase in demand	22/01/2014	Condition - Demand continues to increase (to greater than current capacity / faster than capacity growth) Cause - Increasing numbers of referrals to all speciality areas within Radiology (highest demand growth is in MRI) Consequence - Waiting times increased, breaches experienced, additional sessions & expenditure incurred	Waiting lists / times monitored (Capacity & demand) & managed on a day by day basis Additional capacity requirements identified and created (additional scanning sessions arranged, temporary extension of working hours, additional reporting sessions, reporting outsourcing, alternative providers utilised)	Goal 2 Goal 4 Goal 7	20
2984	FWHG	Equipment Issues Within Breast Screening Service	08/09/2016	The risk is that the equipment is unreliable and breakdowns causing excessive down time and has resulted in 1500 ladies needing to be rebooked. This, if left, will directly impact on the 36 month round length, causing breaches.	Maintenance contracts, staff awareness, extra clinics being booked.	Goal 4	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3096	MHG	Hyper Acute Stroke Unit (HASU) capacity no longer meets needs of the service	08/05/2017	The risk identified during the Stroke Peer Review was that an increase in HASU capacity of up to 12 beds was recommended to safeguard current and future demand. The cause of this is that the HASU currently operates with 4 beds, the Peer Review recommends that there should be between 8 and 12 HASU beds to meet current and future demand. The consequence of not increasing HASU capacity is that patients are moved out of HASU onto the Stroke ward before the HASU phase of care is completed, leading to patient's care and recovery being potentially delayed.	Patients are reviewed by a consultant in order to prioritise them for use of available HASU beds.		16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3109	SHG	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2017-18.	15/06/2017	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2017-18. Failure to deliver key financial targets could result in withdrawal of non-recurrent support funding. Delays in authorising expenditure due to additional controls presents clinical risk. The 2017/18 CRES value is £4,232k.	Devolved CRES targets/accountability. Challenge through monthly divisional performance meetings. Created CRES efficiency matrix tool to enable divisions to focus on key areas of opportunity. Introduction of regular operational and efficiency meetings. Commencing specialty level reviews and benchmarking process. Re-aligning financial/business support in the Health Group to support delivery.	Goal 7	16
3038	CCSHG	Inability to fill junior doctors rota in the oncology wards at Queen's Centre, CHH	11/01/2017	Condition: Inability to fill the junior doctor rota; this is especially in haematology service. Cause: There is a national shortage of junior doctors to recruit into the posts Consequence: Inability to safely cover the rotas within the Queen's Centre ward base. This will impact on patient care.	1. Attempting to cover via specialty doctors and / or locums	Goal 2	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2982	FWHG	Lack of Anaesthetic cover for Under 2's out of hours	19/08/2016	The risk is delay in treating a child for their surgery. The consequence is children and neonates may have to be transferred to another hospital for treatment. The cause is the lack of paediatric anaesthetist emergency cover for children under the age of 2. (This is due to vacancy and sickness)	Children are managed conservatively until it is safe to operate and transfer to an alternative hospital will be arranged.	Goal 4	16
2789	FWHG	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	16/12/2014	Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. This capacity risk has increased recently as a result of the time to treatment for patients requiring injections increasing to 10 weeks, rather than the recommended 48 hours. Additional causes to this risk are: 1. The significant expansion in the numbers of retinal diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely effect their vision.	On a weekly basis the service meet to discuss capacity and plans are made to create additional capacity where needed. The service are currently trying to recruit to a number of medical staffing posts. The posts are currently out to advert. A nurse practitioner was recently appointed to provide support to the nurse injection service. Injection service has begun at CHH (November 2015).	Goal 4	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2665	FWHG	Patients treatment may be delayed resulting in potential loss of eyesight due to lack of capacity (chronic eye disease service)	20/11/2013	The risk is Ophthalmology is currently experiencing a significant delay in meeting outpatient appointments, particularly in relation to the management of chronic disease pathways including glaucoma and medical retina disease. The cause is insufficient capacity. The consequence is patients are not been reviewed in a timely fashion which may have adverse implications for their vision.	Review the position on a weekly basis with the consultant team and re-deploy capacity were possible. Urgent self referrals/GP referrals seen as a priority. Newly introduced glaucoma virtual review sessions.	Goal 4	16
2916	CCSHG	Reduction in trained staff in the Blood Transfusion Laboratories (Compliance Risk).	10/12/2015	There have been a number of vacancies in the Blood Transfusion Laboratories which are being currently addressed. Though this is required to maintain future service delivery there is the short to medium term problem that the one to one training which is required to meet compliance with the Blood Safety and Quality Regulations means that both trainee and trainer are not available for service delivery. This is having a knock on effect on the maintenance of the quality system as more senior staff resources are being diverted to service delivery and training.	1. Service delivery is being maintained by distribution of trained senior staff into key areas. The situation is improving as staff training continues and new staff become competent at more tasks.	Goal 2	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3092	Corporate Functions	Resilience of Critical Infrastructure	25/04/2017	The resilience of critical IT infrastructure is being routinely affected, particularly by mandatory generator testing.	IM&T and Estates functions are working together to minimise the future impact of these operations and to consider systems resilience in general Audit being undertaken on critical systems and systems checks following power changes	Goal 7	16
3044	FWHG	Shortage of Breast Pathologist	18/01/2017	The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also. There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.	Negotiations are to be had with Nottingham to outsource some of the Pathology work. Trust grade doctors to support solitary Consultant Pathology to explore recruiting more Advanced Practitioners Pathology to explore recruiting more Consultants	Goal 4 -	16
2817	FWHG	Inability to access dietetic reviews for Paediatric patients	01/04/2015	condition - Lack of dietetic input to children as both inpatients and within MDTs cause - Substantive dietetic team reduced by 2/3 due to Maternity leave consequence - children do not receive a timely dietetic review	Service working with dietetic lead to look at robust future arrangements F&WHG paying for locum dieticians as available Dietetic team prioritising work		15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3090	Corporate Functions	Lack of governance around consent forms	13/04/2017	There is a risk that the consent processes within the Trust are not managed through a central governance system. The lack of one process to manage consent processes means that consent forms are inconsistent in terms of format, content and update. The cause is the lack of a central process. The consequence may be that forms are not updated appropriately, miss key content and do have version control.	Consent forms are currently managed within Health Groups and clinical teams. The Clinical Effectiveness, Policies and Practice Development committee is the Trust committee for the management of consent forms. A Task and Finish Group has been set up to put in place a central governance system for the management of forms, to co-ordinate the collation of all forms in use and to pursue a long term goal of management of consent through Lorenzo.	Goal 3	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2799	MHG	Patient care/experience may be compromised due to the inability to recruit and retain sufficient nursing staff across the MHG	31/12/2014	Increasing vacancies within the funded MHCG nursing establishments and the opening of the Winter Ward in December 2016. The cause of the risk is the inability to recruit due to a shortage of suitably qualified registered nurses. An increase in the supervision required for the newly recruited overseas nurses. Registered nurses leaving the trust has been higher than anticipated increasing the pressure on the current establishment. The consequence is that there is an increased risk of the ability of the nursing workforce capacity to deliver timely, holistic safe care		Goal 2	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2949	SHG	Registered Nurse and ODP vacancies	11/04/2016	Condition: Surgery Health Group has significant registered nurse and ODP vacancies across wards, theatres and critical care. Cause: Difficulties in recruitment, limited availability of bank and agency staff. University course now completed annually and ODP course now 3 year duration. 6 New Registrant ODP appointed from Oct 17 cohort. Current Registered Vacancies: 92.7 WTE. 24 ODP [HRI 18] CHH 4] New Agency Restrictions: 1st April 2017 may reduce the availability of Agency Staff under new contract. Consequence: This has an impact on the level of care that can be provided to deliver safe patient care. Reduced bed capacity (closed beds)limited ability to provide theatre access for elective surgery.	1) Twice daily safety brief 2) Block booking of agency staff. 3) Current staff working overtime. 4) Band 7s, Matron and Divisional Nurse Manager working clinical shifts 5) ODP apprentice programme is under development 6) Reduction in elective bed base 7) Focused nurse / ODP recruitment, European recruitment 8) 20 nurses from the Philippines commencing May 2017 9) Associate nurse role out registered and NMC phase 2 rollout will assist with theatres and critical care. 10) Secondment of theatre staff onto the ODP course 11) Option to recruit to RN and support with anaesthetic nurse module	Goal 2	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3089	Corporate Functions	Risk of incidents occuring from the use of open systems for injectable medication	13/04/2017	PSA 2016/008 was published September 2016. The risk is that the Trust has identified within Operational Quality Committee that it is not fully compliant with the alert as some areas still use open systems. The cause is that it is accepted working practice within the organisation to use open systems, and in some areas safe alternative systems cannot be adopted due to restrictions in available equipment. The consequence is that the trust may be at risk of incidents relating to this alert happening, as well as being non-compliant with this alert be the deadline of 7 June 2017.	Pharmacy Department and Health Groups have been working together on audits to establish what areas are using open systems, and to offer alternative working practices where available. A working group has been set up, first meeting was held in April 2017, to respond to this alert. The alert has been disseminated widely so people are aware of the risk. Gina's Story has been shown in learning events and is on the Trust intranet site.	Goal 3 - High quality care	15
2956	FWHG	Shortfall in Neonatal staffing	29/04/2016	Condition - acute staffing shortfall and increased proportion of inexperienced staff over the summer period of 2016 Cause - Combination of retirement of experienced staff, maternity leave and the national shortage of suitably qualified nurses Consequence - potential inability to staff the full 26 cots on the neonatal unit leading to increase in in-utero transfers	The children's service have looked to mitigate by: - a) Rolling recruitment program b) Secondment of nurses from paediatric wards to NICU over summer period c) Suspension of all non-essential training d) ANPs, Neonatal Outreach and other staff undertaking additional shifts.	Goal 2	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2888	Corporate Functions	There is a risk that the Trust phone system cannot be repaired resulting in a loss of communications and fire & CPR alerts	05/08/2015	Condition: Potential total loss of telephone system Cause: The Trust has an old telephone system which has been progressively upgraded over the years, but which is fundamentally based on traditional analogue technology. All such systems will no longer be supported by suppliers from April 2017. Moreover, spare parts are increasingly difficult to source. The Trust has embarked on a re-procurement of the telephone system alongside the data network replacement. This will see the transition to a fully digital data and voice service in due course. Work has commenced to replace the telecommunications network. Consequences: There is a risk that, if there was a total failure of major component in the telephone system, the phone service would be disrupted for a long time. This would potentially affect both internal and externally facing services. There is a risk that, if there was a total failure of major component post April 2017 there will be no technical support available and/or no spare parts. A catastrophic event of this nature would carry a serious risk of a total and permanent failure of telephone service across HEY.	Internet Protocol Telephony (IPT) systems will be upgraded as a priority. A single IPT telephone will be deployed to all key departments in order to improve resilience. The Trust fall back telephone system (red phones) is available in key locations. Exploring means of obtaining parts for the old system.	Goal 7	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2979	CCSHG	Risk to the continuity of drug supplies	24/08/2016	There is a risk that pharmacy will be unable to continue supply some medicines to patients. This is due to some manufacturers not fulfilling our orders due to non payment of invoices. The consequence is we may run out of certain medicines causing concerns for our patients' safety and their effective treatment	We are currently negotiating with manufacturers to try and resolve the issues. We are trying to obtain supplies from alternative manufacturers.	Goal 7	12

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3085	Corporate Functions	The Trust may not be fully compliant with IR35	05/04/2017	IR have strengthened the IR35 legislation and NHSI have implemented new policy from 6th April, 2017 which states NHS organisations must not use PSC arrangements either directly or indirectly through agencies. HEY is assessing each PSC arrangement and will be ending the majority of these assignments with immediate effect. However some PSC arrangements will continue as the IR self-assessment tool confirms the arrangement is outside IR35. Having passed this test, the IR may still be of the view that some of our PSC arrangements are not IR35 compliant and therefore the IR may fine the Trust, seek the Trust to pay any outstanding tax and NI for the person(s). There is also a reputational risk. In respect of 2 medical Consultants in Acute Medicine, they have passed the IR35 test and we must continue with then for patient safety reasons, so we are continuing with their PSC arrangements, although its not through an agency, its directly with us, so reducing our spend on agency. Both Consultants have signed a declaration as well committing to paying any additional tax and NI should the IR deem the arrangement is an employee / employer one.	HR are undertaking an audit to identify all PSC arrangements and will be making an assessment whether to continue with services on an individual basis. Clear instructions have been issued re-enforcing the new IR35 rules, that in exceptional circumstances would IR35 exemptions be accepted.	Goal 2	12

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3091	Corporate Functions	Live Major Incident Exercise - Resilience	13/04/2017	The NHS England Emergency Preparedness, Resilience and Response Framework (2015) states NHS funded organisations are required to have a “Live play exercise” every three years. This requirement is contained within the NHS Contract / Core Standards, Civil Contingencies Act and the NHS Act. Whilst HEY NHST has undertaken Table Top exercises during 2016 (June, September and October) and participated in other Live exercises (Leeds Teaching Hospitals, July 2016 and Humberside Airport, December 2016), a Trust focused exercise last took place in 2007. This was highlighted to NHS E during the 2016/17 Core Standards annual assurance exercise.	In terms of action; a multi-agency Live Exercise is now planned for 24 June 2017. A Project Group has been established which includes key Trust staff plus all emergency service partners and is co-ordinating the planning of the exercise. The exercise will test the Trusts response to a major contamination exercise and will involve 60 casualty volunteers.		9

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3080	Corporate Functions	The level of DBS check for Security guards is insufficient and has the potential to put vulnerable patients and guards at risk	03/03/2017	Currently security guards only have a standard DBS check before commencing work on the Trust sites. A further review of the service has identified that they could be in a situation involving a vulnerable adult or vulnerable child which would then require an enhanced DBS check. Additionally the contract requires security guards to have an enhanced DBS check prior to commencing work.	All Security staff have been instructed not to attend a patient incident alone, dependant on the urgency and nature of the incident, they must be accompanied by another Security Guard. As per current policy nursing staff must retain line of sight of all Security Guards undertaking 'bed-watches'.		8

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2986	SHG	CQUIN delayed discharges risk financial risk of not achieving 250k of income	05/10/2016	To reduce delayed discharges from Adult Critical Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow and to remove delayed discharges of 4 hours or more within daytime hours. There is a national standard that all discharges should be made within 4 hours of a clinical decision to discharge being taken within daytime hours. The service have been unable to achieve the standard in Q1 and Q2 and is not on track to deliver the planned reduction of 30% delayed discharges by Q4. This will mean that there is a high risk of reduced patient experience and high risk to income (CQUIN payment) The Hull and East Yorkshire Hospitals NHS Trust have been categorised as a Tier 2 organisation and will on average gain £240,000. This is reliant on achieving the CQUIN in Q4. The contract has been amended with the Commissioners and the financial consequences reduced.	An action plan has been devised to tackle any issues throughout Q3 and to ensure full compliance in Q4. Please see attached document. Quarterly reports are provided to health group board regarding the position. The position is reported 4 hourly at the Site Control meeting and action taken to place patients.	Goal 7	6

CCSHG – Cancer and Clinical Support Health Group
FWHG – Family and Women's Health Group
MHG – Medicine Health Group
SHG – Surgery Health Group