HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 30 JANUARY 2018, THE BOARDROOM, HULL ROYAL INFIRMARY AT 9:00AM

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 Changes to be noted from Ellen Ryabov 2.2 To consider any conflicts of interest arising from this agenda **2 MINS**	verbal	Chair – Terry Moran
3. Minutes of the Meeting of the 5 December 2017 • To review, amend and approve the minutes of the last meeting	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 4.3.1 - Board Reporting Framework 2017-19 4.3.2 - Board Development Framework 2017-19 • To review the current Board Reporting Framework and Board Development Framework and determine if any updates are required **5 MINS**	attached attached	Director of Corporate Affairs – Carla Ramsay
5. Chair's Opening Remarks **2 MINS**	verbal	Chair – Terry Moran
6. Chief Executive's Briefing • To receive the Chief Executive's briefing to the Board **5 MINS**	attached	Chief Executive Officer – Chris Long

QUALITY

7. Patient Story • To focus the Trust Board on quality of patient care	verbal	Chief Medical Officer – Kevin Phillips
8. Quality Report 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	attached	Chief Nurse – Mike Wright
9. Nursing and Midwifery Staffing Report The Trust Board is requested to: • Receive and accept this report • Decide if any if any further actions and/or information are	attached	Chief Nurse – Mike Wright

required

10. Quality Committee minutes		
10.1 November 2017 final minutes (escalation sheet already received by Trust Board in December 2017)	attached	Chair – Trevor Sheldon
10.2 December 2017 draft minutes • Receive the final minutes from the November 2017 meeting and the draft minutes from the December 2017 meeting • Committee chair to highlight any areas of escalation to the Trust Board from the December 2017 minutes	attached	Chair – Trevor Sheldon

30 MINS

PERFORMANCE

11. Performance and Finance Report • To highlight the Trust's performance against the required standards	attached	Chief Operating Officer – Ellen Ryabov Chief Financial Officer – Lee Bond
11.1 Financial Position 2017/18 • To update the Board regarding the Trust's financial position 2017/18	verbal	Chief Financial Officer – Lee Bond
11.2 Borrowing Requirements 2017/18 • The Board is asked approve loan applications to a maximum of £15m for quarter 4, 2017/18 and give authority to the Chief Financial Officer, Chief Executive and Chairman to execute loan documentation and sign Board resolutions.	attached	Chief Financial Officer – Lee Bond
11.3 Financial Planning 2018/19 • To update the Board regarding the Financial Planning 2018/19	verbal	Chief Financial Officer – Lee Bond
12. Tracking Access Report • The Board to formally receive the MBI Report	attached	Chief Operating Officer - Ellen Ryabov
13. Performance & Finance Committee minutes		
13.1 November 2017 final minutes (escalation sheet already received by Trust Board in December 2017)	attached	Performance & Finance Chair – Stuart Hall
13.2 December 2017 draft minutes • Receive the final minutes from the November 2017 meeting and the draft minutes from the December 2017 meeting • Committee chair to highlight any areas of escalation to the Trust Board from the December 2017 minutes	attached	Performance & Finance Chair – Stuart Hall

30 MINS

ASSURANCE & GOVERNANCE

14. Mortality Reviews –Themes and trends • The Trust Board is recommended to receive and accept this report, and provide any feedback or points of reflection to the Board, or to be picked up at the Quality Committee.	attached	Chief Medical Officer – Kevin Phillips
15. Standing Orders • The Board to approve the use of the Trust seal	attached	Director of Corporate Affairs – Carla Ramsay
16. Board Assurance Framework • The purpose of this report is to present the updated Board Assurance Framework (BAF) for 2017-18 from the December 2017 Board Committee discussions, to determine if there are	attached	Director of Corporate Affairs – Carla Ramsay

any risk areas where this Committee can provide positive assurance and to give scrutiny to areas where there are gaps or a lack of assurance; the Trust Board is asked to review and approve the proposed Q3 BAF risk ratings

17. Draft Audit Minutes – 18 December 2017	attached	Chair Audit Committee – Tracey Christmas
18. Any Other Business	verbal	Chair – Terry Moran
19. Questions from members of the public	verbal	Chair – Terry Moran

10 MINS

20. **Date & Time of the next meeting:**
Tuesday 13 March 2018, 9.00am – 1.00pm
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	✓	✓	✓	✓	✓	✓	9/10
C Long	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
L Bond	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
M Gore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Hall	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	9/10
M Wright	✓	✓	✓	✓	✓	✓	Jo Ledger	✓	✓	✓	9/10
K Phillips	✓	✓	✓	✓	✓	Dr Purva	✓	✓	✓	C Hibbert	8/10
T Sheldon	x	✓	✓	x	✓	✓	✓	x	✓	✓	7/10
V Walker	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	9/10
E Ryabov	✓	✓	✓	✓	x	✓	Michelle Kemp	✓	✓	✓	9/10
In Attendance											
J Myers	✓	✓	✓	✓	✓	x	✓	x	✓	✓	8/10
S Nearney	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	9/10
C Ramsay	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Veysey	-	-	-	-	-	-	✓	✓	✓	✓	4/4

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 5 DECEMBER 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr T Moran CB	Chairman
	Mr A Snowden	Vice Chair/Non-Executive Director
	Mr C Long	Chief Executive Officer
	Dr C Hibbert	Medical Director – Surgery Health Group
	Mr M Wright	Chief Nurse
	Mrs E Ryabov	Chief Operating Officer
	Mrs V Walker	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Prof T Sheldon	Non-Executive Director
	Mr L Bond	Chief Financial Officer
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms C Ramsay	Director of Corporate Affairs
	Prof. M Veysey	Associate Non-Executive Director
	Ms J Myers	Director of Strategy and Planning
	Mrs R Thompson	Corporate Affairs Manager

No.	Item	Action
1	**APOLOGIES** Mr A Snowden – Vice Chair/Non-Executive Director, Mrs V Walker - Non-Executive Director, Mr K Phillips - Chief Medical Officer (Dr Hibbert acting up on his behalf).	
2	**DECLARATIONS OF INTEREST** **2.1 CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING** Mr Moran advised that he was stepping down as the Chair from 'Together for Short Lives' as at the end of this month.	
	2.2 TO CONSIDER ANY CONFLICTS OF INTEREST ARISING FROM THIS AGENDA There were no declarations made.	
3	**MINUTES OF THE MEETING OF THE 7 NOVEMBER 2017** **Item 8 Quality Report** – para 5 the word 'depravity' to be changed to 'deprivation'. **Item 13 Finance Report** – para 1 The Trust had not secured its STF income and this sentence to be removed. Para 4 – The Trust was forecasting to hit its financial targets but had a £6.6m uncovered risk. **Item 15** title to read Estates Strategy (including Backlog Maintenance and Sustainability) **Item 16 Outline Business Case** para 7 – the final sentence should read "He reported that the Trust would need to spend £7m per year over the next 10 years to ensure safety for patients and staff".	

Item 21 – Audit Committee Summary – para 2 should read "He also reported that the number of contract waiver forms for extending contracts had increased."

Following these changes the minutes were approved as an accurate record.

4 MATTERS ARISING

Mr Wright advised that Serious Incident and Never Event trends would be included in the December 2017 report.

4.1 ACTION TRACKER

All actions on the tracker were due in January 2018.

4.2 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

4.3 BOARD REPORTING FRAMEWORK AND BOARD DEVELOPMENT FRAMEWORK 2017-19

Ms Ramsay presented the frameworks and reported that due to the timings of the Board meeting in 2018 she had aligned the Board Reporting Framework to reflect this. She advised that she would work with the Chairman to ensure the agendas were appropriate following the changes.

The Board Development Framework had been aligned with the Board Assurance Framework to ensure the Board had opportunity to discuss in detail the key risks.

Resolved:

The Board received and accepted the changes to the Board Reporting and Board Development frameworks.

5 CHAIR'S OPENING REMARKS

Mr Moran stated that it was his eighth month in the Trust and as we approached the festive period he wanted to express his sincere thanks to all staff. He had witnessed many colleagues going above and beyond what might reasonably be expected so that the care delivered to our patients was high. He felt privileged and humbled to have met a large number of staff all doing great work within the Trust. He thanked all staff on behalf of the Board.

6 CHIEF EXECUTIVE'S BRIEFING

Mr Long highlighted the ongoing charity work that Ruth and Tony Knowles were doing and the amounts raised by them for the Trust. He thanked them on behalf of the Board.

Mr Long also spoke about a member of the Portering team that had won a prize for customer service and their compassionate care when looking after patients. The Board acknowledged this achievement.

Mr Long reported that Dr Allam had given the Trust a generous donation to provide a state of the art facility to replace the Brocklehurst building. This new facility would allow research into diabetes. Mr Long thanked Dr Allam on behalf of the Board.

Mr Long reported that in March 2017 a number of urology patients were flagged through the tracking access process as not having follow up appointments. This lead to a wider investigation and it highlighted that the Trust had 10,000 patients across various areas requiring follow up investigation and potentially treatment. The Trust has carried out work to validate this cohort of patients and fast-tracked any requiring additional treatment through the system. Mr Long reported that 3 patients had come to harm as a result of the tracking access issues, and the Duty of Candour process had been implemented as appropriate. MBI, an independent company specialising in this area, had been commissioned to review the Trust's systems and processes, assess the effectiveness of our action to date and provide their opinion of the work done so far.. The Trust was preparing the final plan and this would be presented to the Board in January 2018. The Trust's first priority was to ensure patient safety.

Mr Long also highlighted the Balanced Scorecard, which showed overall Trust performance in key areas. He stated that there were a number of areas that were a concern not only for the Trust but nationally such as A&E and RTT. He advised that the 62-day cancer standard had been met in October 2017, but there was still work to do to ensure good experiences for all patients and staff.

7 PATIENT STORY

Dr Hibbert reported that a letter had been received from the wife of an ex-serviceman who had been admitted to the Trust following cardiac failure and had sadly died on Remembrance weekend. The family were very grateful for the compassionate care the patient had received. The nurse who was caring for him when he died, a former member of the armed services, placed a poppy in the patient's pocket and saluted him as a mark of respect.

Dr Hibbert advised that the nurse who had carried out the gesture had been contacted and thanked for their compassion and care.

8 QUALITY REPORT

Mr Wright presented the report and updated the board regarding the 3 current investigations into declared Never Events and and informed the Board of a new Never Event, the Trust's fourth since 1 April 2017.

The fourth Never Event was due to nurses administering oral morphine intravenously. The patient had not come to harm, however the investigation into the case had begun.

Mr Wright also spoke about Serious Incidents and Healthcare Associated Infections. There had been a case of MRSA in November 2017 and the patient had died, however this was not due to the infection but other multiple health issues.

E-coli was discussed; it is unlikely that the Trust will meet its threshold at year-end based on the number of patients seen year to date; Mr Wright noted that many patients already have the infection before being admitted to the hospital.

Performance was static regarding complaints and PALs and that the 40 day response rate to formal complaints was now at 90%.

The CQC had submitted their provider request document and all information had been sent.

There was a discussion around e-Observations and how this would reduce issues around deteriorating patients. Prof. Sheldon asked how many failures would be avoided if e-Observations was fully implemented and Mr Wright advised that the number would reduce significantly. Mr Wright added that the reason why e-Observations had not been completely rolled out yet was due to limited Wi-Fi capability.

Mr Gore expressed his concern regarding the CQC information requests and inspections if they happened in the busy winter months. He stated that this would put extra pressure on an already challenging workload.

Resolved:
The Board received and accepted the report.

9 NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that fill rates were increasing due to the new nurse recruits. He stated that there were still challenges and the supply of registered nurses was still an issue.

Mr Wright reported that the nursing teams were reviewing daily how wards were staffed and this would be more challenging through winter as the Trust was not commissioning a winter ward.

There was a discussion around the apprenticeship scheme, apprenticeship levy and how the funds could be spent. Mr Nearney was discussing the issues with NHS Improvement and NHS Employers.

Resolved:
The Board received and accepted the report.

10 QUALITY MINUTES OCTOBER 2017 AND SUMMARY SHEET FROM NOVEMBER 2017

Prof. Sheldon advised that the Pharmacy team had attended the meeting to discuss medicines reconciliation, getting the right drugs to the right patient on time. The E-Prescribing system, once fully introduced, would help reduce human errors.

The Quality Committee also received the Learning from Deaths policy and the Quality Improvement Plan. There was discussion around a number of safeguarding policies being out of date and Mr Wright advised that 3 policies needed updating but the Trust was compliant with its safeguarding actions and requirements.

Resolved:
The Committee received and accepted the report.

11 PERFORMANCE AND FINANCE REPORT

Mrs Ryabov presented the report and advised that the diagnostic waiting times were improving with two main areas of concern in Cardiac CT and endoscopy. Without these two issues the Trust would have been delivering its standard. Work was ongoing to address the issues.

Referral to Treatment Times (RTT) had seen a reduction in performance and this was mainly due to the resource being used to address the Tracking Access issues. She spoke about a backlog in the typing pool to remove patients from the tracking access plans as another factor in the lower RTT performance.

There had been some cancellations on elective work due to emergencies coming into the Trust.

Mrs Ryabov advised that work was ongoing around the Trust's winter model with plans to manage the front door capacity more efficiently.

There had been 17 x 52 week waits reported and these were mainly due to the tracking access issues. Mrs Ryabov advised that this would remain a problem until the validation work was completed.

There was a discussion around cancer referrals and patients choosing not to attend their appointments within the 2 week window. There had been 17 patient choice issues and these had been fed back to the patient's GPs for further review.

Cancer 31 days subsequent surgery was behind planned trajectory but 62 day cancer performance had significantly improved. Screening and 104 days standards were also improving.

Prof. Veysey highlighted staff sickness rates in the report and asked if this was a concern as a 12-month trend. Mr Nearney advised that the HR teams were working with managers to proactively manage the issues. The Board is due to review the results from the staff survey in February 2018.

Finance

Mr Bond presented the financial section of the report and advised that the Trust deficit was £3.3m, which was £2m above plan.
CRES delivery had dropped below 80% and the run rates in the Health Groups had also deteriorated. Clinical Support had particular issues with demand for direct access tests, staffing issues and an increase in non-pay expenditure.

The uncovered financial gap had risen to £7.6m. Mr Bond advised that discussions had begun with the Commissioners to review any additional financial support.

Mr Bond reported that the Trust Capital programme was £19m and was on track for the rest of the year.

Mr Gore asked if the work from the South Bank was being reflected appropriately in the tariffs and Mr Bond assured him that it was. He

advised that the main issues relating to the financial situation were not achieving the CRES and cost pressure issues within the Health Groups.

Resolved:
The Board received and accepted the report.

11.1 FINANCIAL POSITION
Mr Bond presented the paper, which highlighted the process issue for the Board to discuss any variance in the financial forecast in Month 9.

Mr Bond asked if it was acceptable for the Performance and Finance Committee to be delegated responsibility to sign off any variation of the forecast following discussions with the regulators in December 2017.

The Board agreed to the request with the condition that Mr Moran was copied in to all correspondence regarding the matter.

Resolved:
The Board received the report and agreed:

- Delegated responsibility to the Performance and Finance Committee to agree any variations of the forecast following discussions with the regulators.
- Mr Moran to be copied into all correspondence regarding the matter.

12 PERFORMANCE AND FINANCE COMMITTEE MINUTES OCTOBER 2017 AND SUMMARY SHEET NOVEMBER 2017
Mr Hall reported that the Tracking Access Plan update would be monitored at the Performance and Finance Committee.

Mr Hall also reported that the CEO Dashboard was now a regular item on the Performance and Finance Committee agenda.

The Medical Director of the Clinical Support Health Group had attended the meeting to discuss the financial pressures and what the Health Group was doing to address the situation.

He advised that the Trust's cash flow issues were impacting on payments to suppliers and this could be detrimental to the smaller suppliers. Mr Moran asked the Board be briefed if any issues arose relating to suppliers potentially being put in financial difficulties as a result of the Trust delaying payments. Mr Bond assured the Board that weekly discussions with suppliers were being held.

Resolved:
The Board received and accepted the update.

13 UPDATE ON OPERATIONAL PLANNING
Ms Myers advised that there had been no national guidance issued to date, but the Trust had received commissioning intentions from the East Riding Clinical Commissioning Group. Ms Myers was meeting with the Directors of Hull Clinical Commissioning Group in December to receive their commissioning intentions and both CCGs are

attending the December Executive Management Committee meeting to brief Health Groups and corporate services on their commissioning plans. There was also a joint Humber wide commissioning Board that was looking to harmonise commissioning policies across the STP patch.

Internally the operational planning process was ongoing; the Health Groups are reviewing and updating their plans which are in line with the Trust strategy. Ms Myers reported that there was good engagement with the Health Groups and any good practice was being shared.

Resolved:
The Board received and accepted the update.

14 RESEARCH AND INNOVATION STRATEGY

Dr Hibbert presented the 5 year strategy which detailed the strengthening of the Trust's research capabilities with the University of Hull. There were a number of aims including every patient (where appropriate) to the Trust having the opportunity to be included in research.

Mr Moran stated that the strategy had already been received at the Quality Committee in November 2017 and a number of change requests had been made that were not yet reflected in the strategy. Therefore Mr Moran asked that the amendments be made and the strategy presented at a future Board meeting rather than seek approval at this meeting.

Mr Long suggested a Board time out to consider the strategy in more detail would be appropriate. **CR**

Resolved:
The Board received the strategy and agreed to discuss it further at a Board time out.

15 FREEDOM TO SPEAK UP GUARDIAN REPORT

Ms Ramsay presented the report and advised that she was continuing to develop the role and there had been a number of staff members contact her already. She advised that it there is no like-for-like comparison with other Trusts as each Trust is implementing the Freedom to Speak Up Guardian role differently to meet their needs, but that the organisation was in keeping with national trends on the types of issues being raised, specifically staff behaviours and patient safety.

Ms Ramsay also highlighted the other services available in this Trust to support staff such as the Staff Advice and Liaison Service (SALS) and the Whistle Blowing policy to allow staff to raise concerns.

Mr Moran asked what support Ms Ramsay needed from the Board and she asked that Board members refer any members of staff that have raised concerns.

Prof. Sheldon asked for information on the difference having the

Freedom to Speak up Guardian was having on the Trust. This would be included in future reports.

Resolved:
The Board received and accepted the report.

16 REMUNERATION TERMS OF REFERENCE

Ms Ramsay presented the updated Terms of Reference that had been endorsed at the last Remuneration Committee, and are recommended to the Trust Board for approval.

Ms Ramsay highlighted point 2.2.7 – 'vey' senior managers – should read 'very' senior managers.

Resolved:
The Board received and approved the Terms of Reference.

17 STANDING ORDERS

Ms Ramsay presented the report which highlighted any use of the Trust seal.

Resolved:
The Board received and accepted the report.

18 BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report and highlighted the Trust's cash position which had improved in Q2 but had deteriorated again in Q3 and the risk rating for Q2 had been adjusted accordingly.

Ms Ramsay also reported that the Board development sessions in 2018 would align with the Board Assurance Framework risks.

Resolved:
The Board received and accepted the the report.

19 ANY OTHER BUSINESS

There was no other business discussed.

20 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the members of the public.

21 DATE AND TIME OF THE NEXT MEETING:

Tuesday 30 January 2018, 9am – 1pm

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD ACTION TRACKING LIST (January 2018)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
November 2017						
01.11	Performance Report	VTE Assessments – Update to be received	KP	Jan 2018		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB	Jan 2018	Mar 2018	To be included in the IM&T Strategy
COMPLETED						
December 2017						
01.12	Research and Development Strategy	Trust Board to consider the R&D strategy in more detail at a future Board Development session	CR	Mar 2018		To Quality Cttee Feb 18; Board Development Scheduled March 2018
October 2017						
01.10	Performance Report	Financial Plan to be reviewed and presented to the Board following publication of month 6 figures	LB	Jan 2018		Included in November 2017 Trust Board report
		Review of other Trust's medical safe staffing reports/Development of a Trust report	SN	Dec 2017		Presented to P&F Cttee Nov 17

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
Quality Committee						
Aug 2017	Fundamental Standards	Improvement approach and how nurses are supported in the areas were more work is needed to be discussed at the committee	MW	TBC		

Trust Board Annual Cycle of Business 2017 - 2018 - 2019			2017									2018						2019		
Focus	**Item**	**Frequency**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Mar**	**May**	**May Ext.**	**July**	**Sept**	**Nov**	**Jan**	**Mar**
Strategy and Planning	Operating Framework	annual							x									x		
	Operating plan	bi annual									x								x	
	Trust Strategy Refresh	annual				x										x				
	Financial plan	annual	x	x								x	x	x				x	x	x
	Capital Plan	annual	x										x							x
	Performance against operating plan (IPR)	each meeting	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
	Winter plan	annual							x									x		
	IM&T Strategy	new strategy										x								x
	R&D Strategy	new strategy									x									
	Scan4Safety Charter	new item							x											
	Digital Exemplar	new item							x											
Strategy Assurance	Trust Strategy Implementation Update	annual		x										x						
	People Strategy inc OD	bi annual						x					x				x			x
	Estates Strategy inc. sustainabilty and backlog maintenance	annual								x								x		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	x	x	x
	Quality Report	each meeting	x	x	x	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	x	x	x
	Fundamental Standards (Nursing)	quarterly		x			x			x			x			x		x		
	Quality Accounts	bi-annual		x						x				x	x			x		
	National Patient survey	annual	x										x							x
	Other patient surveys	annual	x																	
	National Staff survey	annual	x											x						
	Quality Improvement Plan (inc. Quality Accounts and CQC actions)	quaterly			x			x				x		x			x		x	
	Safeguarding annual reports	annual							x								x			
Regulatory	Annual accounts	annual		x										x	x					
	Annual report	annual		x										x	x					
	DIPC Annual Report	annual						x									x			
	Responsible Officer Report	annual						x	x								x			
	Guardian of Safe Working Report	quarterly	x				x			x			x			x			x	
	Statement of elimination of mixed sex accommodation	annual		x										x						
	Audit letter	annual		x											x					
	Mortality (quarterly from Q2 17-18)	quarterly							x			x		x				x		x
	Workforce Race Equality Standards	annual						x									x			
	Modern Slavery	annual		x										x			x		x	
	Emergency Preparedness Statement of Assurance	annual							x								x			
	Information Governance Update (new item Jan 18)	bi-annual										x				x			x	
Corporate	H&S Annual report	annual					x									x				
	Chairman's report	each meeting	x	x	x	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	x	x	x
	Board Committee reports	each meeting	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
	Cultural Transformation	bi annual	x					x		x			x			x			x	x
	Annual Governance Self Declaration	annual		x											x					
	Standing Orders	as required		x	x	x		x	x	x	x	x	x	x		x	x	x	x	x
	Board Reporting Framework	monthly	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
	Board Development Framework	monthly			x					x	x	x	x	x				x	x	x
	Board calendar of meetings	annual						x										x		
	Board Assurance Framework	quarterly	x			x	x		x		x			x			x		x	
	Review of directors' interests	annual	x						x											
	Gender Pay Gap	annual											x							x
	Fit and Proper person	annual	x										x							x
	Freedom to Speak up Report	quarterly	x				x				x			x				x	x	x
	Going concern review	annual		x										x						
	Review of Board & Committee effectiveness	annual			x									x						

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST BOARD DEVELOPMENT PROGRAMME 2017-19

Overarching aims:

• The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does

• To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

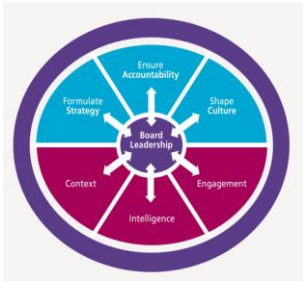
Board Development Dates 2017-19	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation		
04 July 2017			Area 1: Trust Board - updated Insights profile	Area 2 and BAF 3: Trust Strategy Refresh and appraoch to Quality Improvement				
10 October 2017			Area 1 and BAF 1: Cultural Transformation and organisational values				Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation	
28 November 2017			Area 2 and BAF 2 - Nursing staffing risks and strategic approach to solutions		Area 4 and BAF 4 - Trust position on diagnostic capacity - short-term impact and long-term issues; 62 day cancer			
				Area 1: Risk Appetitie - Trust Board to set the Trust's risk appetite against key risk areas				
05 December 2017				Area 1: High Performing Board and BAF 3 - CQC self-assessment and characteristics of 'outstanding'				
17 January 2018		Area 4 and BAF 1: Well-lead framework			Area 4 and BAF 4 - Tracking Access			
30 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - overview, process to review, key considerations	Area 2 and BAF 1: Equalities within the Trust						Area 2 and BAF 7.1 - 7.3 - Financial plan and delivery 2017-18 and financial planning 2018-19
27 March 2018	Areas 2 and BAF 4 & 5: Strategy refresh - clincial strategy	Area 1 and BAF 1: Completion of Insights exercises - what does a high-performing Board team look like?	Area 2 and BAF 2 - Staffing - short-term and long-term issues with specific focus on medical staffing. What does an adequate and sufficiently skilled workforce look like?	Area 2 and BAF 3: Research and Development strategy				

17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh - key strategic issues (partnerships, infrastructure)	Area 4 and BAF 1: General Data Protection Requirements 2018						
24 May 2018								
31 July 2018								
25 September 2018								
27 November 2018								
29 January 2019								
26 March 2019								

Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
BAF1 : 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 Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence	BAF 2: 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	BAF 3: 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	BAF 4: 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 differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a	BAF 5: 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	BAF 6: 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	BAF 7.1: 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 BAF 7.2: 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 BAF 7.3: 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

Principles for the Board Development Framework 2017 onwards

Key framework areas for development *(The Healthy NHS Board 2013, NHS Leadership Academy)* looks at both the roles and building blocks for a healthy board.
With the blue segment highlight the core roles and the crimson segments defining the building blocks of high-performing Trust Boards.



Overarching aim:

- The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
- To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?
- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?
- How can we build further resilience, trust and honesty into our relationships?
- Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect from everyone in order to have a culture that delivers outstanding patient care

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?
- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development

Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?
- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

Providing opportunity for Board development using external visits and external speakers, to provide additional knowledge, openness to challenge and support for the Board's development and trajectory

- Outcome: to provide opportunities for Board knowledge development as well as opportunities for the Board to be constructively challenged and underlying working assumptions to be challenged
- To provide an external focus to the Board not just for development but also to address the inward-facing perception reported by the Board itself as well as by the CQC

Area 4 – Deep Dive and exceptions

Internal exceptions that require Board discussion and knowledge development and ownership of issues, as they relate to the Trust's vision and delivery of the strategic goals

- Outcome: Board to challenge internal exceptions
- Board to confirm its risk appetite against achievement of the strategic goals and the over-arching aim of becoming high-performing Trust Board and 'outstanding' rated organisation by 2021-22

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

January 2018

Reducing the impact of serious infection: Sepsis/AMR

The sepsis CQUIN[1] was launched in 2015 in order to incentivise improvements in the timely identification and treatment of sepsis. Following excellent progress made by our Trust against key indicators Celia Ingham Clark, Medical Director for Clinical Effectiveness at NHS England has written to us praising the improvements we have made.

Our Trust is one of those which has seen the greatest improvements against indicators 2a) timely identification and 2b) timely treatment of sepsis from the data NHS England has received.

Many thanks and congratulations to everyone for the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place.

Hull surgeon filmed by TV documentary crew after rebuilding girls' faces

Kelvin Mizen, a maxillofacial consultant at our Trust, has travelled to Ethiopia for 10 years to help children with Noma, a bacterial infection caused by extreme poverty and chronic malnutrition which can lead to gangrene.

Now the Captive Minds documentary team, working for Channel 5's Extraordinary People series, has filmed Mr Mizen for a documentary expected to be broadcast on Channel 5 later this year.

Noma, also known as cancrum oris, can be prevented with antibiotics and immediate nutritional support if detected early enough. Left untreated, mouth ulcers lead to agonising swelling in the cheeks or lips. Within days, gangrene sets in, leaving gaping holes in children's faces. Around 90 per cent of people with Noma will die from sepsis.

It still occurs in 39 of the 46 African countries, with the World Health Organisation estimating around 140,000 new cases, commonly in children under six, every year.

Final panel unveiled for "Born Into a City of Culture" artwork

The final panel in a major piece of art to celebrate the births of babies born during Hull's year has City of Culture has been unveiled.

Families and midwives watched as the last panel in "Born Into A City of Culture" was unveiled in the foyer of Hull Women and Children's Hospital on 21 January 2018.

Handprints from midwives were used to create the tree trunks and the branches for the artwork while thousands of footprints of babies were taken during 2017 to create the leaves.

The final panel features babies born in November and December. However, another tree had to be created to fit in all the babies who came to "catch up sessions" after their footprints were not taken at the time of their births.

[1] (Commissioning for Quality and Innovation – a set of standards and measures to be implemented to improve quality of care)

More than 1,400 tickets have been sold for a celebration at the Guildhall on Wednesday 24 January 2018, where families will be able to share memories and meet other parents who took part in the artwork.

Young Health Champions award presentation
A celebration was held on Friday 20 December 2017 to recognise the achievements of our most recent Young Health Champions.

The Young Health Champions scheme began as a volunteering programme back in 2015, but quickly developed into a training programme delivered in partnership with Athena Aspire (formerly Active Humber). As a recent paper to the Trust Board detailed, the programme gives young people the chance to gain valuable work experience at the same time as gaining qualifications and undertaking department specific training. Areas which have taken trainees to date include Pathology, Estates and the Queen's Centre.

Each young person is assigned a departmental mentor to provide ongoing support and guidance throughout their traineeship. Athena Aspire also provides support with any additional needs such as confidence building and social skills.

Around 50 young people have now completed the programme, the latest of whom were recognised at this most recent awards presentation.

Patients with respiratory problems receive hospital-style treatment at home
Around 250 patients with serious lung conditions are benefiting from hospital-style treatment in their own homes as part of a project to reduce unnecessary admissions.

Our Trust has introduced non-invasive ventilation to help patients from Hull and East Yorkshire, North Yorkshire and Northern Lincolnshire stay out of hospital. This approach has been shown to benefit patients with conditions including COPD, motor neurone disease and muscular dystrophy.

Patients referred to the Trust's respiratory service by GPs are assessed by the multi-disciplinary respiratory team to see if they are suitable for home ventilation. Those rushed to hospital with respiratory failure are also assessed by a consultant to see if they might be suitable for home ventilation once they are discharged.

A team of specialists from our Trust then visit people considered suitable for the therapy home to show them how to use the equipment, enabling them to administer the treatment themselves.

Trust surgeons improve the vision of 5,000 patients in a year
A local man became the 5,000th patient to be treated by Hull eye surgeons in a year after his optician discovered a cataract had formed in his left eye, affecting his vision. Surgeons also corrected his vision at the same time, meaning he only requires glasses for reading.

Cataracts form when the lens inside the eye becomes cloudy. Symptoms can include blurred vision, inability to see colours properly, halos around light and problems with night vision. While most patients are in their 70s and 80s, staff working for our ophthalmology service see patients in their 40s all the way to those aged 100 and over. Children can also be born with congenital cataracts so attend the hospital to have them removed.

The team offers one-stop cataract clinics so patients can be assessed, tested and see the consultant in a single appointment. The streamlined appointment, lasting around two hours,

ensures patients only have to travel to hospital once for pre-assessment checks before surgery.

If the consultant decides the patient requires surgery, staff aim to book the operation for two to four weeks after the initial appointment. Surgeons can also correct short-sightedness or conditions such as astigmatism, where the eye is shaped more like a rugby ball than a football, at the same time, giving people better vision.

This is an amazing achievement by our team at the Eye Hospital, thanks and well done to everyone in the ophthalmology service.

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 December 2017 we received 40 Moments of Magic nominations:

Charlotte Croft	Charlotte is a very kind caring nurse who has a way of putting people at ease. Nothing is ever too much trouble for her and she always has time for everyone in a non-rushed way, staff or patients. A very happy cheery person.	**30/12/2017**
Emma Jones, Kirsty McDonagh, Claire Morrow, Lee Travis, Becky Trewith, Cath Chapman, Paula Grindell, Eva Scazkacs, Val Sim, Lisa Branston, Alex Elliott, Isobel Dawes, Jadwiga Nagda, Lauren Walster, Kelly Morris, Cath Hudson, Ian	Awesome team-working under unrelenting pressure on the 29th night shift, well done to each and every team member brilliant camaraderie and professionalism.	**30/12/2017**

Fletcher		
Gina Foley	This nurse is always calm and efficient, friendly and always does her job to the best of her ability. She ensures all her patients are well taken care of and is fantastic on charge, I feel she deserves this as she is excellent at her job!!	**27/12/2017**
Emily Collier, Annie Walker, Sarah Hardy, Claire Fitzgerald, Catia Cruz	Exceptional working as always but under significant pressures on boxing day night, however continued to provide exemplary cares. Deserved extra recognition - well done ladies!!	**27/12/2017**
Abdul and Dale	I would like to thank Abdul and Dale from our security team who showed great compassion and kindness towards one of our patients. They helped us in containing at times some very dangerous situations and we could not have managed without them. Thank you so much, Jacqui from Paediatrics	**27/12/2017**
Bianca Shaw	I would like to nominate Bianca Shaw (Auxiliary Nurse) for a moment of magic because of so many reasons but mainly because Bianca makes patients feel right at home on the unit. Patients, relatives as well as staff all acknowledge how hard she works. She treats everyone like family members. Her warm and loving personality and infectious laugh keeps everyone going especially on the hard days. There is no job too big or small for Bianca. She really deserves a medal.	**24/12/2017**
Nicky Day	At very short notice it became apparent that an extra member of staff would be needed for that evening's clinic. Without a moment's hesitation Sister Day cancelled her plans for the evening and stayed on. All throughout the evening she was supportive and positive despite the fact she was not expecting to be working late that day. She even took the opportunity to do some teaching with the staff on shift. As one of the staff on duty that evening I was concerned about her unexpected late finish but she was reassuring	**23/12/2017**

	that this was not necessary and kept the atmosphere cheerful. Since starting on fracture clinic I have been most impressed by the team spirit there because Sister Day leads by example which she certainly did on this occasion.	
Sue Finn	Sue is a healthcare assistant on a busy medical elderly ward and she always goes the extra mile to make sure her patients are cared for. She brings in toiletries for the patients who don't have their own. She takes home washing of patients who don't have relatives to do this for them. However busy the ward is she makes sure she spends time with each patient, brushing their hair, shaving the men and making sure they look smart as that is important to a lot of elderly people. Sue has so much patience with the dementia patients, they all love chatting to her. However hard the shift is, Sue always has a smile on her face for the patients.	**23/12/2017**
Josh	Josh from Security always has a smile on his face. He always goes above and beyond his job role. He is always there when anyone needs anything. He is good with patients, listens to them. He is will to help. Well done Josh – keep up the good work.	**22/12/2017**
Julie Griffin, Michelle Ripley, Helen Jennings	Thanks very much for holding the fort at the Eye Clinic during my recent spell of absence. You ladies are a credit to our department, thank you. Special mention also to all the staff for making my first year as your manager a truly enjoyable experience. Here's to an amazing 2018 x	**21/12/2017**
Louise Dalby	Louise Dalby has always been available and willing to assist with anything and everything she can. I as well as many others will greatly miss Louise and her amazing intuition on Infection Control. Louise will go the extra mile to ensure that the criteria for every ward and patient are met. It is going to be strange not seeing/hearing any words of advice from this lady and all of Cedar Ward staff would like to wish her all the very best for in her new job. Thank you for assisting us Louise. All the very best for the future.	**20/12/2017**

Nicola Colby	I recently worked a couple of very busy stressful nightshifts with Nicky. I just wanted to say a big thank you for making those shifts bearable. You work so hard and are so dedicated nothing is too much trouble - we are so lucky to have you.	**20/12/2017**
Charley Gallagher	Charley goes above and beyond in every shift she works, no task is ever too much for her, she is a great team player. She shows initiative and knowledge of her job role, which has been commented on by relatives and patients, how helpful and compassionate she is. Well done Charley such a credit to work with.	**18/12/2017**
Auxiliary Nurse and Staff	Ward 26 Well done your Christmas display is excellent. You have really taken time and effort, for a wonderful Christmas display to cheer everyone up	**17/12/2017**
Teresa Behag and Ruby San Juan	Two members of staff welcoming overseas nurses to join in their get-togethers and going out of their way	**15/12/2017**
Hayley Buttery	One of our staff went the extra mile and showed extreme kindness with an overseas member of staff new to the trust and England. Hayley took the nurse to her own home and shopping and to meet her family.	**15/12/2017**
Tracie Priestley	Tracie was lucky enough to win one of the staff lottery trolley dashes for Christmas and this took place at the beginning of December. After completion of the trolley dash which Tracie managed to do all her Christmas food shopping she had extra food to donate to St Charles Church in Hull city centre for the homeless and provided a bottle for the staff raffle at Sainsbury's as they had helped with the trolley dash before their shift. Truly thinking of others in the festive season. Well done Tracie!	**14/12/2017**
Martin Dickinson	For settling in well and being so helpful in the fracture clinic - it’s like he’s always been part of the team!!	**13/12/2017**

Michael Hookem and Sally Barnfather	I would like to nominate Michael Hookem and Sally Barnfather. They looked after me when I returned following post-operative complications. They reassured me, kept me calm and explained everything. I was a very nervous patient and they made everything better. Thank you.	**13/12/2017**

Mr M Fleet	I would Like to nominate Mr Fleet for a moment of magic. My son presented with an acute surgical emergency. He was very caring and kind when assessing my son. Mr Fleet was extremely reassuring to my son as well as us (parents). Despite my son requiring emergency surgery Mr Fleet put us and my son at ease, giving us every confidence in him and his team. The team on Acorn ward as well as the theatre 3 team and recovery were also amazing. Mr Fleet carried out the surgery and kept us informed of all developments and saw my son after surgery. Due to his skill and expertise my son was able to perform in his school play on the Monday having had his surgery on the Saturday. I cannot commend Mr Fleet and his team Highly enough and both me and my son are highly grateful to them for the exemplary level of care and treatment we received.	**13/12/2017**
Katie and Shelly	After coming on to a night shift Shelly and Katie soon realised they were going to be under pressure and have a very busy night due to the pressures of the ward after the previous shift. The skills and team work they have shown is commendable and resulted in patients receiving first class treatment in hard conditions, well done!!!	**13/12/2017**
Sue Fridlington & Kerry Melia	A huge well done Sue Fridlington for completing your care certificate! And thank you to Kerry Melia for supporting her ! Helen x	**12/12/2017**
Sally	After spending several hours attempting to update my smartcard using the instructions on Pattie, involving making several phone calls to IT and smartcard unlockers, I was getting concerned that my access would be stopped around the Christmas period and I require Lorenzo use every day for my	**12/12/2017**

	role. Sally in Access Management was very kind and helpful and offered to update my card right away at Suite 21. Thanks a lot Sally! You saved the day.	
Ruth Arnott	Ruth has devoted her spare time to help decorate our ward for xmas to make the place look great for patients staff and visitors. She has come to the ward on her day off the put up all her creations and the place looks great	**11/12/2017**
Jo Swanson	Our ward raises money every year for either the ward or a good cause. Staff Nurse Jo is an integral part of this fundraising. Without her it just wouldn't happen. She goes the extra mile every year ringing round companies and collecting donations in her spare time. She is an absolute gem	**11/12/2017**
Dr Wood	Due to medical staffing shortage Dr Wood had to cover the registrar shift all weekend during the day and was also on call for the sat/sun night. He worked above and beyond and I would not have coped without his help. The neonatal unit was extremely busy with very sick babies, lots of admissions and also a sick baby brought in to ED. I am very grateful for his hard work and support. The work load was intense and we didn't get any breaks etc but throughout no job was too small for him to undertake.	**11/12/2017**
Karen Kell, Helen Thompson, Helen Hotham, Ian Fletcher, Darren Bone, Sue Rea	Phenomenal team working under immense pressure in Emergency Care Area (Minors)	**11/12/2017**
Chris Horner	Chris Horner has come back after being away, hard- working and with a smile on his face. It is always good to see him when I go on the ward. I think he is a credit to himself.	**11/12/2017**

Ruth Arnott	Ruth Arnott is in the catering team. She was on ward 11 when I came onto my night shift on at 7:00pm on 9 December 2017 putting up Christmas decorations. The theme is Willy Wonka and she has hand made all of the decorations herself in her own time and they are incredible. She stayed on the ward on her night off from 7pm to 1:30am (unpaid in her own time) putting up all of the decorations. She never once complained and I think she deserves huge recognition for all her hard work for on ward 11. The ward looks very bright, colourful and fun. This will have a great positive effect on both our patients and our staff. Ruth has worked for the trust for many years. She has gone above and beyond for hey trust.	**10/12/2017**
Lisa Branston	Exceptional care compassion and support to colleagues, a fantastic nurse well done!	**10/12/2017**
Sally Hilton	Sally became aware of a shortage of ‘babies’ on the care of the elderly ward, many of the old ladies found comfort with baby dolls so she started collecting them for the ward. Her original goal was 40 dolls in 40 days as part of her bucket list relating to her 40th birthday. Sally handed over 77 dolls altogether. We are all so proud of her thoughtfulness and determination	**08/12/2017**
Norma Jarratt, Angela Chapman, Cheryl Romano, Lisa F Hartley, Donna Gotts, Robert Minter, Caroline Pyrah, Michelle Kent, Oliver Bahrami-Jenkins, Edward McGee, John Johnson, Nicola Hall, Leonie	I would just like to congratulate all staff involved in Saturdays trust pantomime 'Jack & the Towerblock Beanstalk' all the staff involved from all walks of trust life, and friends and relations who have also helped who are non-trust staff produced a magical performance & all that watched it have said how much they thoroughly enjoyed it. All these staff have given up their own free time to produce this pantomime with rehearsals covering several weeks & several hours!! Huge congratulations you are all brilliant & definitely deserve a golden heart :)	**08/12/2017**

Cholerton,Nick Stapleton, Joanne Redshaw		
Lisa Harper and Kath Ogilvie	Working on an extremely busy shift on Sunday 3rd December. Going without proper breaks and remaining cheerful and helpful to all the wards at HRI.	**08/12/2017**
Debbie Dedashty	Debbie worked on Sunday 3rd December. She came into a very difficult shift with large numbers of patients attending the ED and limited beds in the hospital. There were staffing shortfalls within the team but Debbie soldiered on without a break. Many thanks to Debbie for keeping going.	**08/12/2017**
Mike Hookem	Mike is the Charge Nurse for Max Fax Outpatients He goes above and beyond his role to ensure his patients, staff and doctors are all looked after and taken care of. As a patient I constantly see his presence whenever I've been in the department. I am a regular attender and no matter where he is working, who he is working with - he walks down the corridor and pops his head around the corner and says "are you ok is there anything I can do for you". This is said not only to his staff, but the doctors and the patients. The department is due to move in the new year and Michael prides himself on keeping everyone up to date with where the department is in the process. For us regular attendees it makes us feel part of the department and I can see how the department is going to change, and how it will look. No matter what is going on in the department, whether the roof is leaking, department has no heating - Michael always has a smile on his face. He is a star!	**07/12/2017**
Receptionist lady in ED (07/12/17 in AM)	I'm currently sat waiting in ED and I can't help but notice how cheerful, jolly and helpful the receptionist is. Many patients are coming in, checking themselves in and seem a little unhappy for obvious reasons. The receptionist keeps assisting at any possible opportunity and is a breath of fresh air in this busy and humid	**07/12/2017**

	environment. Didn't get her name but wanted to note how what a fabulous addition she is to the department.	
Heather Holland	Heather has recently supported a woman with her birth choices and acted as an advocate for her, providing information and attending clinic appointments to ensure she had the most appropriate information so that she could make the best choice for her care. This is sometimes very difficult when the choices being made are outside of guidance/usual practice. Heather is an excellent role model for the team she works in	**06/12/2017**
Mags Higson	Mags Higson, one of the Play Specialists on Acorn Ward has taken it upon herself to organise a reverse advent calendar this year, which has involved co-ordinating the staff to donate grocery and food items each day on the run up to Christmas to make a provisions hamper for a deserving family. She has been in contact with the Salvation Army and there is now a significant amount of provisions and presents to see a deserving family through the Christmas period. Apparently there is enough to also provide a hamper to an elderly couple as well. Mags is a tireless worker and never says no to any request put to her. This has all been as well as decorating the ward for the festive season, staying well beyond her normal working hours. We would be lost without her.	**06/12/2017**
Sally Hilton	The staff on Acorn Ward were left feeling quite upset and moved following a visit to the ward by an health care assistant from the 8th floor asking for help. The lady explained that there was a patient suffering with dementia on her ward who was very distressed about being discharged the following day without a doll. We managed to provide a doll in the first instance, but my HCA Sally decided she wanted to do something about it. We are quite fortunate on the Paediatric Wards with donations and Sally felt it would be nice if we could give something to the adult wards for once. She has therefore co-ordinated a mass doll collection from the staff, work colleagues and her friends on facebook. She has now managed to accumulate 77	**06/12/2017**

	dolls in total, this being in under 3 weeks! The dolls were delivered to Debbie Hamer and Stacey Healand at the beginning of this week. Sally is an extremely proactive and thoughtful member of staff and I feel her commitment should not go unmentioned.	

Dr Liz & the newly qualified staff nurse	I brought my daughter to ED due to sudden onset of pain. My daughter is very anxious and quite scared of hospital due to being born with health issues and undergoing many operations. When my daughter went into the room she was hid behind a curtain and was really scared. The staff nurse who is newly qualified let my daughter pick lots of certificates and played a game, this built up a trustful relationship with the nurse and her. The doctor Liz was amazing with my daughter and reassured her everything will be ok. The radiology team were also brilliant and within the next hour had my little girl smiling. Thank you for making my daughter feel at ease throughout her stay. You are all professional and compassionate and deserve this moment of magic for the effort you put in that day.	**05/12/2017**

HEY LONG TERM GOALS - December 2017 data

Great Staff	Great Care	Great Future

Quality

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Never Events	0	0	↓
R	Complaints (QIP - closed within 40 working days)	90%	69.40%	↓
G	Healthcare Associated Infections - MRSA	0	0	↓
G	Healthcare Associated Infections - C.Diff (YTD target)	53	32	↑
R	Safety Thermometer - Harm Free Care	95%	94.96%	↑
R	Venous Thromboembolism (VTE) Risk Assessment (Q2 v Q1 1718)	95%	89.72%	↓
G	Mortality - HSMR (September 17)	<100	74.1	↓
G	Friends & Family Test - Inpatients (November 17 - Trust v National %)	95.80%	98.10%	↓
R	Friends & Family Test - Emergency Department (November 17 - Trust v National %)	86.90%	85.40%	↓

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	1

Workforce

RAG	Indicator	Target	Performance December	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.80%	↓
G	Staff Sickness	<3.9%	3.56%	↓
R	Staff Vacancies	<5.0%	5.71%	↑
R	Staff WTE in post (<0.5% from Plan)	7327	7253	↑
G	Staff Appraisals - AFC Staff	85%	85.10%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	91.50%	↑
G	Statutory/Mandatory Training	85%	90.70%	↑
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£4.0m	£6.2m	↑
R	Staff: Friends & Family Test - Place of Work (Q1 1718 v Q2 1718)	64%	63%	↓
R	Staff: Friends & Family Test - Place of Care (Q1 1718 v Q2 1718)	81%	80%	↓

Category	No. of Risks Rated 15 and above
Corporate Staffing Risks	6
Corporate Clinical Risks	1

Performance

RAG	Indicator	Target	STF Trajectory	Performance December	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	88.40%	81.25%	↓
R	52 Week Referral To Treatment Breaches	0	0	30	↑
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	1.90%	8.97%	↑
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	82.42%	↓
R	Cancer: ADJUSTED 62 Days Referral To Treatment (November Data)	85%	85.30%	83.00%	↓
G	Length of Stay (<5.2) (October data)	<5.2	-	4.9	↑
R	Clearance Times	12 weeks	-	14.2	↑
R	Waiting List Size	50,915	-	52,814	↓
R	Clinic Utilisation	80%	-	63.50%	↓
R	Theatre Utilisation	90%	-	76.40%	↓
G	E-Referrals (Q2 target v current performance)	80%	-	90.6%	↑
R	Appointment Slot Issues	35% (TBC)	-	43.00%	↑

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	3

Finance

RAG	Indicator	Target	Performance December	Trend v Previous Month
G	Capital Expenditure	11.1	10.1	↑
R	Statement of Comprehensive Income Plan - Year to Date	-1.4	-9.4	↓
R	CRES Achievement Against Plan	10.5	7.3	↑
R	Invoices paid within target - Non NHS	95%	46%	↓
R	Invoices paid within target - NHS	95%	40%	↓
R	Risk Rating	3	4	↑

Category	No. of Risks Rated 15 and above
Corporate Non-Clinical Risks	6

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT JANUARY 2018

Trust Board date	30 January 2018	**Reference Number**	2018 – 01 – 08
Director	Mike Wright, Chief Nurse	**Authors**	Mike Wright, Chief Nurse Kevin Phillips, Chief Medical Officer Kate Southgate, Head of Compliance April Daniel, Quality Governance Lead
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		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		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					Y
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): All					
	Assurance Framework BAF 3	**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
JANUARY 2018

EXECUTIVE SUMMARY

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

- Patient Safety Matters including Never Events and Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- CQC
- Learning from Deaths

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

QUALITY REPORT
JANUARY 2018

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 including Never Events and Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- CQC
- Learning from Deaths

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

This report covers the reporting period for the months of November and December 2017. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE) – Reported Previously

The investigation into the third surgical Never Event for 2017 was completed in December 2017. The details are as follows:

2.1.1 Ref 22899 – Wrong Site Surgery

This Never Event was in relation to wrong site surgery whereby a section of incorrect rib had been resected from a patient. The arrangements and planning for the surgery were all correct. However, the surgeon was unaware at the time of resection that the marker of the area had moved. The patient was informed of the error, and had to undergo a second cardiothoracic surgical procedure to remove the correct section of rib. The patient recovered well and has since been discharged home. Nonetheless, the patient required a second complex operation, which did not form part of the original plan of care and treatment.

Following an investigation, which included an independent external cardiothoracic clinical opinion, the root cause of this incident was determined to be to a technical issue, i.e. the marker had moved without the surgeon's knowledge.

Nationally, there is no recommended marking process for this type of surgery. Therefore, the investigation report includes the recommendation that the cardiothoracic surgeons should review the feasibility of developing a specific site marking procedure. In addition, when this procedure is undertaken in the future, it is recommended that re-imaging is undertaken at the commencement of the procedure to confirm that the marker has not moved.

2.2 Serious Incidents declared in November and December 2017

The Trust declared 8 Serious Incidents in November 207 and 10 in December 2017. All of these are in the process of being investigated fully. The outcomes of all Serious Incident reports are reported to the Trust Board Quality Committee; any finding of note will also be reported to the Trust Board in due course. A summary of the incidents is contained in the following tables:

Declared in November 2017

Ref Number	Type of SI	Health Group
27953	Medication Incident – the patient was discharged with an incorrect discharge letter and medications	Medicine
27959	Treatment Delay – the patient did not receive timely follow up	Surgery
27965	Slip, Trip, Fall – the patient fell and sustained a fractured neck of femur	Medicine
27970	Obstetric Incident – the patient had a 4th degree tear which was missed following birth	Family & Women's
28011	Sub-optimal care of the deteriorating patient – the patient deteriorated following transfer from the Emergency Department	Medicine
28017	Treatment Delay – the patient did not receive sepsis screening	Medicine
28019	Slip, Trip, Fall – the patient fell whilst awaiting x-ray	Surgery
28671	Surgical Invasive Procedure – the patient had unnecessary surgery following an incorrect diagnosis	Clinical Support

Declared in December 2017

Ref Number	Type of SI	Health Group
29516	Treatment Delay – a CT scan result was not acted upon	Medicine
29521	Sub-optimal care of the deteriorating patient – the patient did not receive an appointment for iron infusions	Medicine
29552	Surgical/Invasive Procedure – lack of equipment in theatre to deal with emergency situation	Surgery
29563	Sub-optimal care of the deteriorating patient – following an issue during elective surgery, the patient deteriorated	Medicine
29631	Sub-optimal care of the deteriorating patient – a patient on telemetry was found unresponsive	Medicine
30467	Treatment Delay (lost to follow up) – the patient did not receive follow up to remove a stent	Surgery
30862	Treatment Delay – the patient did not receive timely follow up	Family & Women's
30892	Maternity/Obstetric Incident – relating to an intrauterine death	Family & Women's
31158	Treatment Delay – an ultrasound scan was not acted upon	Clinical Support
31501	Infection Control Incident – sub-optimal decontamination of surgical instruments	Surgery

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 on one day for the existence of any of the four harms that have occurred either before they came into hospital or whilst in hospital.

The NHS Safety Thermometer point prevalence audit results for December 2017 are attached as **Appendix One**.

From the 854 in-patients surveyed on the survey day in December 2017, the results are as follows:

- **94.9%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **0.7% [n=6]** patients suffered a 'New Harm' (harm whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98.73%.** This is positive overall performance against this indicator.
- In respect of VTE risk assessments reviewed on the day, of the 854 patients, 62 did not require a VTE risk assessment. Of the 792 patient, 745 had a VTE risk assessment undertaken. This is **94%** compliance on the day. VTE incidence on the day of audit was **3** patients; **1** of which was with a pulmonary embolism and **2** were deep vein thrombosis.
- There were no new pressure ulcers on the census day. However, 34 patients had pre-hospital admission pressure ulcers (30 at Grade 2, 2 at Grade 3 and 1 at Grade 4). This information is being fed back to commissioners. In addition, a health-economy wide group has now been established to look at the significant number of patients that come into hospital with pre-existing pressure damage. The Trust is a member of this group.
- There were **19** patient falls recorded within three days of the audit day. Of these, 17 resulted in no harm to the patient and 2 with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection were low in number at **5/168** patients **(3.3%)**. Of the **5** patients with infections, **1** was an infection that occurred whilst the patient was in hospital **(2%)**.

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

Each ward receives its own results and feedback and ward sisters/charge nurses develop actions to address these.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2017/18 as at 31 December 2017

The Trust is required to report monthly on performance in relation to six 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**	**32 (60% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1 (over threshold)**
MSSA bacteraemia	**44**	**30 (68% of threshold)**
Gram Negative Bacteraemia		
E.coli bacteraemia	**73**	**82 (Over threshold)**
Klebsiella (new this year)	**14**	**Baseline monitoring period**
Pseudomonas aeruginosa (new this year)	**10**	**Baseline monitoring period**

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

4.1.1. *Clostridium difficile*

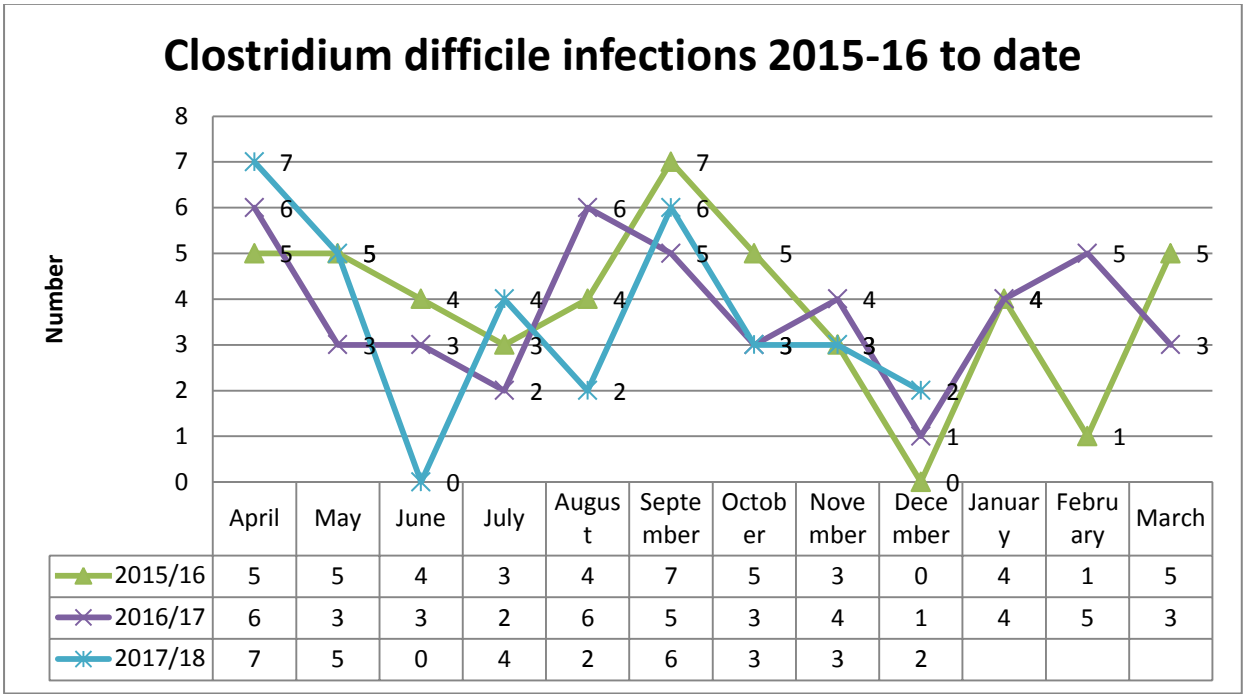
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and 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 (RCA) investigations are conducted for each infection and outcomes of RCA investigations for all Trust apportioned cases are 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 9, the Trust is reporting 32 infections against an upper annual threshold of 53 (60% of threshold). Three Trust apportioned *C. difficile* cases were reported during November 2017, all in Clinical Support Health Group (but not linked) and two in December 2017, reported in Surgery Health Group and Clinical Support Health Group.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**32** (60% of threshold)	All five cases reported during November and December 2017 were subject to RCA investigation and reviewed by Commissioners; no lapses in practice identified.

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	2	6	3	3	2			

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

Staphylococcus aureus (also known as staph) is a common type of bacteria. It is 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**	**1 case**	Ward C33 apportioned case. Post Infection Review (PIR) completed with involvement from Northern Lincolnshire and Goole NHS Foundation Trust and NHS North Lincolnshire Clinical Commissioning Group Case apportioned to Hull and East Yorkshire Hospitals NHS Trust

Trust apportioned MRSA bacteraemia – Ward C33
On the 17 November 2017 a patient nursed on C33 was detected with an MRSA bacteraemia. The case was subject to a Post Infection Review (PIR) with involvement from Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). The patient did not have a previous history of MRSA and had been screened initially by NLAG, before being transferred to C33 with newly diagnosed advanced lymphoma. On transfer into the ward, C33 did not screen further for MRSA, which is in breach of the Trust policy. However, on a subsequent admission 10 days later, the patient was screened but was found to be negative for MRSA colonisation at that stage.

The patient required a blood transfusion and chemotherapy via a Peripherally Inserted Central Catheter (PICC line), which was inserted on 15 November 2017 and became septic on 17 November 2017. At this stage, this was thought to be 'line' related. The patient responded well to antibiotics initially but due to poor prognosis associated with lymphoma died on 24 November 2017. The PIR investigation included the following findings:

- MRSA screening not undertaken on transfer to C33 but did not contribute to infection
- PICC insertion records not fully completed to provide adequate assurance of line insertion/ aseptic technique
- PICC line removed on the 17 November 2017 but tip not sent for microbiological assessment as per the Trust protocol
- The patient had a bone marrow biopsy on the 31 October 2017 at NLAG and, although there were no signs and/or symptoms of infection, the biopsy site area was swabbed because adequate healing had not being achieved (a small sinus was evident). This swab cultured MRSA. Although extremely rare, it is likely that MRSA was acquired via this site but without assurance regarding other possible sources it has been difficult to conclude. As such, the case was determined as hospital-apportioned and assigned to Hull and East Yorkshire Hospitals NHS Trust

Work is underway on C33 to review some of their fundamental practices.

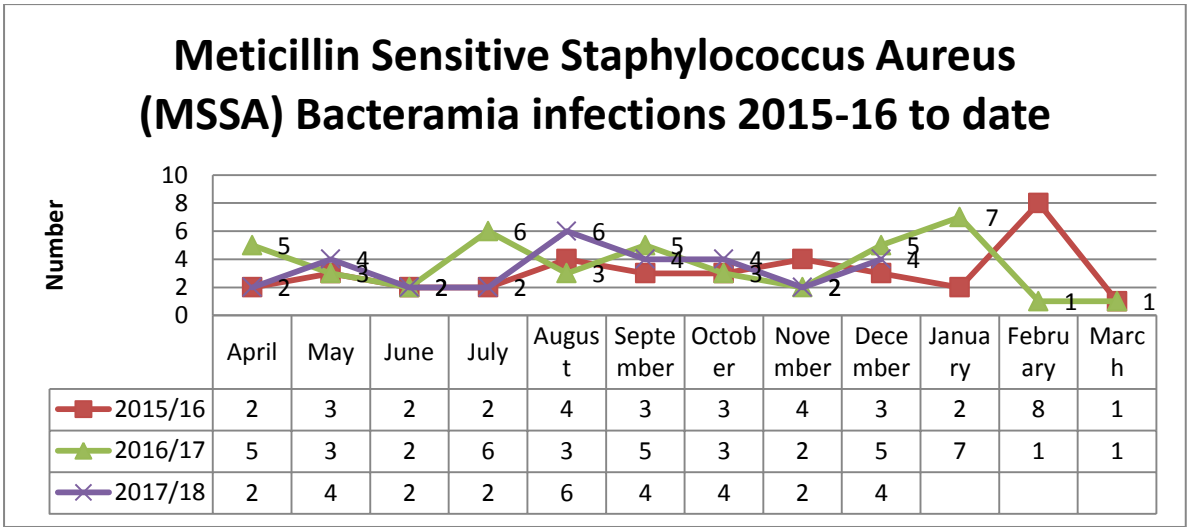
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia
Meticillin-Sensitive *Staphylococcus aureus* is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

However, MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds. MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream. However unlike MRSA, MSSA is more sensitive to antibiotics and therefore easier to treat, usually.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	**44**	**30** (68% of threshold)	14 unavoidable 8 possibly avoidable 5 avoidable 3 cases awaiting completion of RCA process

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

MSSA bacteraemia performance is provided in the following graph. 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:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	2	3	2	2	4	3	3	4	3	2	8	1
2016/17	5	3	2	6	3	5	3	2	5	7	1	1
2017/18	2	4	2	2	6	4	4	2	4			

4.1.4 *Escherichia-coli* Bacteraemia

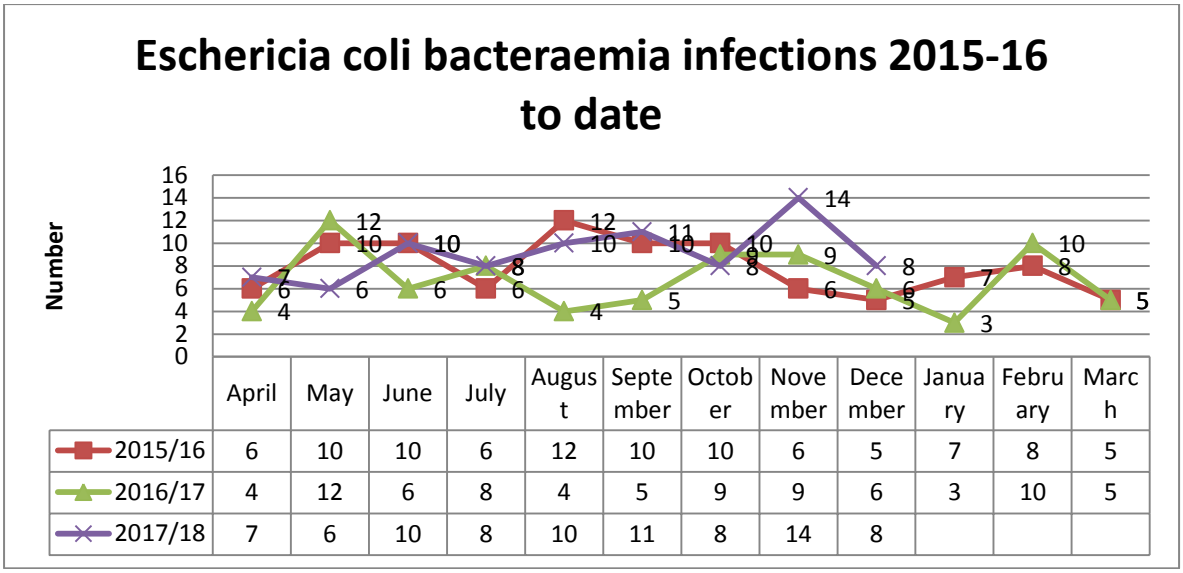
There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals. However, when strains of *E. coli* are outside 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, Trusts are required by NHS Improvement to achieve a 10% reduction in E.*coli* bacteraemia cases. Achievement of reductions will be collaborative with joint working with commissioners and with joint action plans as required by NHS Improvement. A Trust improvement plan for *E.coli* and gram negative bacteraemia for 2017/18 has been drafted and shared with commissioners. A subsequent joint improvement plan has been drafted to capture issues, trends and learning from *E.coli* and gram negative bacteraemia experienced across healthcare.

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)	**82** (above threshold)	82	4 x avoidable 7 x possibly avoidable 71 x unavoidable (the majority related to biliary sepsis)

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



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	6	10	10	6	12	10	10	6	5	7	8	5
2016/17	4	12	6	8	4	5	9	9	6	3	10	5
2017/18	7	6	10	8	10	11	8	14	8			

A significant number of apportioned cases, both Trust and community-related, account for the increase in cases detected. From the Trust's perspective, this is particularly due to improved compliance with sepsis screening, both in the Emergency Department and for inpatients. Although increases are noted and the Trust has already breached the threshold at month 8 for this infection, patients are receiving improved quality of care because of targeted identification, treatment and appropriate management.

Trust and community apportioned *E. coli* bacteraemia cases from November 2017 have also benefitted from an additional Infectious Diseases (ID) Consultant review. The review involves the collation of patient demographics, admission method, and speciality on admission. It also includes co-morbidities and pre-disposing factors along with a face to face clinical review of the affected patients, investigations to date and ID input in ongoing management. A mortality review is additionally completed in patients who die during the course of their admission.

To date, an overwhelming trend is associated with biliary sepsis, which requires hospital treatment. A detailed report is being drafted to document all *E.coli* bacteraemia cases detected at Hull and East Yorkshire Hospitals NHS Trust from November 2017 onwards and will be available with the February 2018 HCAI report.

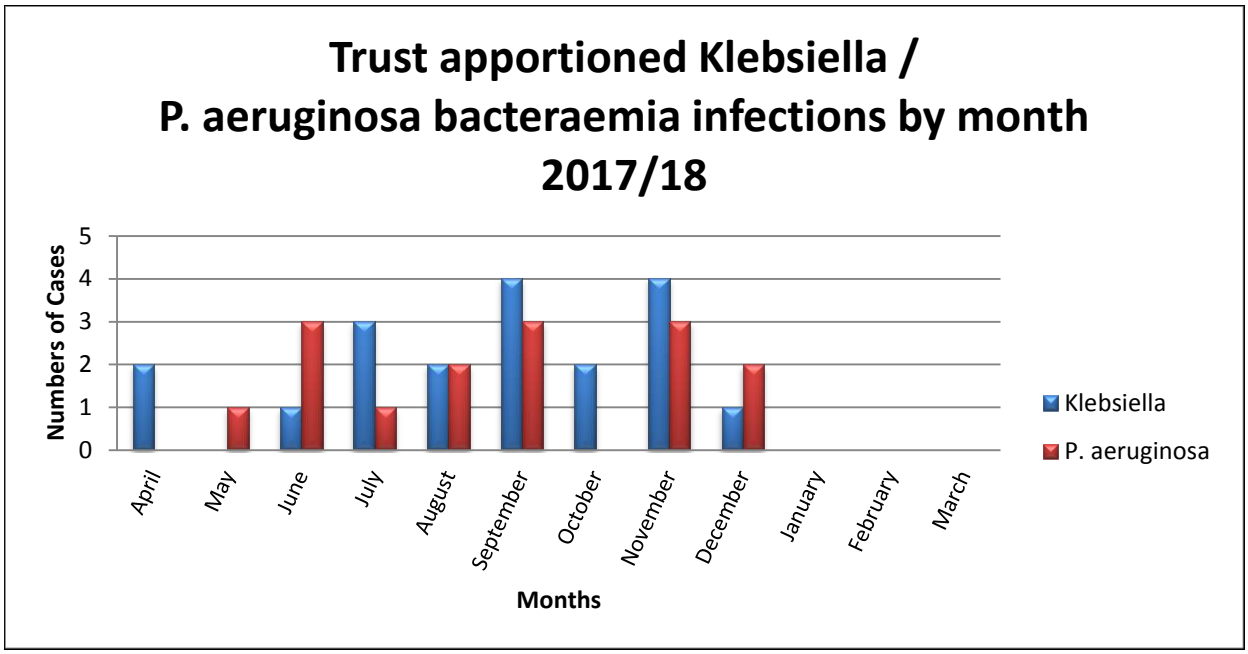
4.1.5 Gram negative bacteraemia – reporting for 2017/18

If gram-negative bacteria enter the circulatory system, they can cause a toxic reaction to the patient. This results in fever, an increased respiratory rate, and low blood pressure. This may lead to the 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.

Review of cases to date suggests similar risk factors as those found with *E.coli* bacteraemia, with Klebsiella related to respiratory infections. Subsequent trends and learning associated with these infections will be reported in future editions of this report.



4.2 Infection Outbreaks

4.2.1 Norovirus

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

During November 2017, there were 2 full ward closures affecting Ward 8 and Ward 9 at Hull Royal Infirmary, associated with diarrhoea and vomiting. Both wards were confirmed with Norovirus. Ward 9 closed on the 31 October 2017 and reopened on the 5 November 2017 following a deep clean. Ward 8 closed on the 23 November 2017 and reopened on the 1 December 2017 following a deep clean. However, due to new patients being admitted to the ward who commenced with symptoms after admission, 2 bays were closed on the 2 December 2017. These were subsequently deep cleaned and reopened on the 5 December 2017.

During December 2017, there were 3 full ward closures affecting Wards 70, 80 and 90 at Hull Royal Infirmary, associated with diarrhoea and vomiting. All affected wards were closed for at least 12 days as a result of protracted outbreaks because of Norovirus. These affected many patients with some becoming re-symptomatic after 48-72 hours. This was also compounded by the pressures on beds and the need to access beds and side rooms in clean, unaffected bays.

All 3 wards were confirmed with Norovirus affecting both patients and staff and were deep cleaned prior to reopening.

4.2 2 ICU2 HRI - Candida Auris/*Acinetobacter Baumannii*

On 4 December 2017, a patient was transferred to ICU2 from Nairobi, after sustaining a significant head and spinal injury in a road traffic accident there. The patient was infection-screened on admission and was found to be infected with both Candida Auris and highly resistant *Acinetobacter baumannii*. Both of these organisms posed a significant risk of cross-infection to other patients within ICU2 through both airborne and touch/contact contamination.

An incident meeting was held, including members of Public Health England, and the unit was closed to admissions. As patient flow permitted, the number of patients in the unit was reduced All patients nursed on the unit were screened for both organisms along with additional environmental screening. This resulted in the identification of two further patients becoming colonised with *Acinetobacter;* both of whom have subsequently died but not related to this infection.

Along with robust infection and prevention control measures, the ICU was subsequently able to be moved temporarily over a weekend to enable deep cleaning to take place with vapourised hydrogen peroxide. The unit has since re-opened with no apparent ill effects.

Follow-up of all patients admitted to ICU2 from 4 December 2017 is being undertaken, with additional support of the Microbiology laboratory. This will continue to monitor for any cases of *A.baumanni* / Candida Auris across the Trust.

All three cases were referred to Public Health England, Colindale, for further 'typing', which determined all three cases were linked and indistinguishable. i.e. they were as a result of cross-contamination.

The index (first) patient recovered sufficiently from the infection and is currently nursed in isolation on a base ward.

It is important to recognise that, thanks to robust screening of this patient on admission to ICU and the rapid actions of staff, this resulted in managing this very challenging situation extremely well in the circumstances.

4.2.3 Influenza trends

The Trust's 'flu' vaccination programme continued during November and December 2017. More than 70% of Trust staff had received a flu vaccination by the end of November 2017. A renewed call for staff to be vaccinated was disseminated on the 5 January 2018 in the light of increased cases of 'flu acorss the country. Staff can access the 'flu vaccination up to the end of February 2018.

Cases of Influenza in patients admitted to the Trust were first noted during November 2017, with 2 cases reported. This increased to 11 cases in December 2017. These cases represented normal seasonal flu activity with more cases of Influenza A noted, which was expected. Patients were screened, isolated, treated and managed appropriately.

From the 1 January 2018, however, a significant increase in cases assocaited with Influenza B has been experienced, with patients admitted to the Trust, unwell with respiratory symptoms. Affected patients have been mainly under 65 years of age but fall within 'at-risk' groups with multiple comorbidities, some of which are not vaccinated.

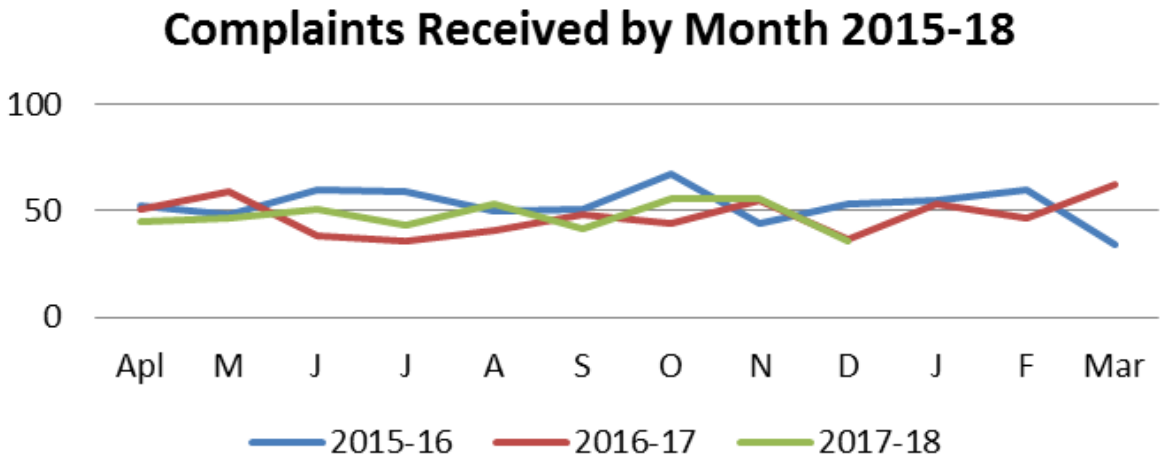
Yorkshire and the Humber have been particularly affected; despite this, the Trust has managed to isolate and/or cohort affected patients and there has been no evidence of onward patient-to-patient transmission resulting in ward closures, which has been experienced elsewhere in the region.

The Trust's Department of Infection will continue to monitor the situation closely. In addition the Trust's Seasonal and Pandemic Flu Plan has been updated and has been disseminated whilst it goes throug the Trust's ratification process.

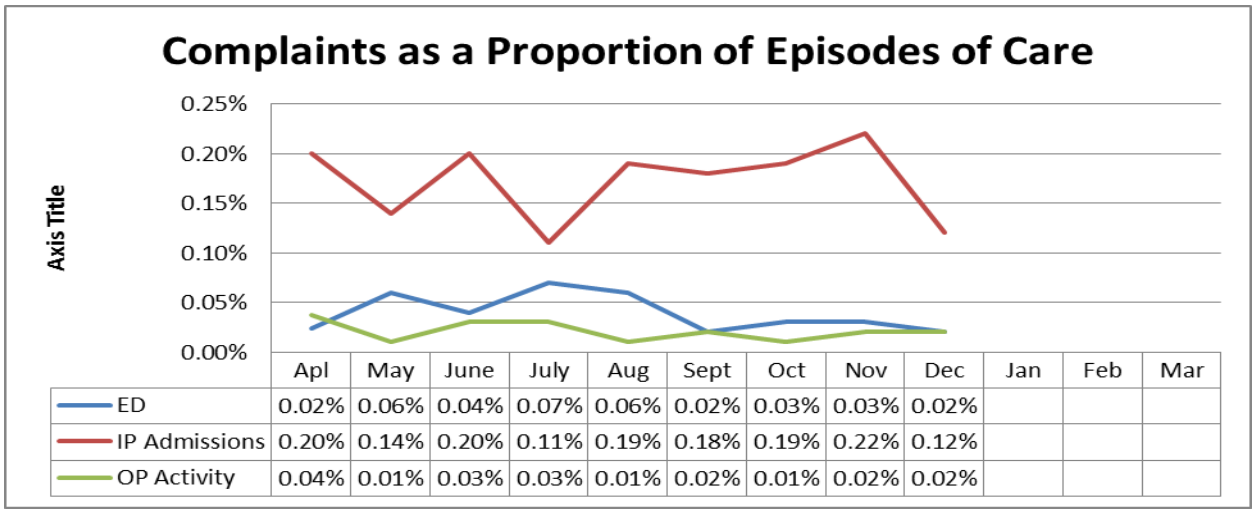
5. PATIENT EXPERIENCE

5.1 Complaints

The following graph sets out comparative complaints data from 2015 to date. There were 56 new complaints recorded in November 2017 and 35 complaints in December 2017. These figures are in line with the same period in 2016. The Patient Experience team has reviewed the complaints received to identify any themes and trends and have raised awareness with senior staff when several complaints have been received within a specific area. The average so far this financial year is 47 per month compared to an average of 47 in 2016/17 and 53 in 2015/16.



The following table indicates the number of complaints compared with activity. There has been a sharp decrease in complaints regarding emergency care. Complaints regarding inpatient services have fallen, with a slight increase in outpatient concerns.



	Apl	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.02%	0.06%	0.04%	0.07%	0.06%	0.02%	0.03%	0.03%	0.02%			
IP Admissions	0.20%	0.14%	0.20%	0.11%	0.19%	0.18%	0.19%	0.22%	0.12%			
OP Activity	0.04%	0.01%	0.03%	0.03%	0.01%	0.02%	0.01%	0.02%	0.02%			

The following tables indicate the number of complaints by subject area that were received for each Health Group and Corporate department during the month of November/December 2017.

Complaints Received by Health Group and Subject - November 2017

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancel	Discharge	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0
Clinical Support	0	0	0	0	1	1	2
Family and Women's	0	0	1	1	0	15	17
Medicine	1	1	2	0	1	12	17
Surgery	0	2	0	1	0	17	20
Totals:	1	3	3	2	2	45	56

Complaints Received by Health Group and Subject - December 2017

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancellations	Treatment	Total
Corporate Functions	0	0	0	0	0	0
Clinical Support	0	0	0	0	0	0
Family and Women's	0	0	0	2	7	9
Medicine	0	2	1	1	9	13
Surgery	1	0	1	1	10	13
Totals:	1	2	2	4	26	35

As can be seen from the tables, complaints about treatment remains the highest recorded category. However, there have been a relatively low number of complaints received during the month of December, which is common for this time of year. During December, there were no formal complaints relating to patient discharge from hospital.

5.1.1 Examples of outcomes from complaints closed during November/December 2017:

- The complainant had raised concern at the delay in a diagnosis of Motor Neurone Disease from which his wife died. He felt that the delay in a diagnosis prevented him from spending more quality time with his wife.
  Outcome: Advocacy support was arranged for the complainant and a meeting with the consultant and senior matron was arranged. It was explained that a diagnosis for this devastating and complex condition requires many investigations to be undertaken over a period of time before a definitive diagnosis can be reached. This complaint will be discussed at the next staff and governance meetings for reflective learning purposes. Bereavement support has been provided to the relative.

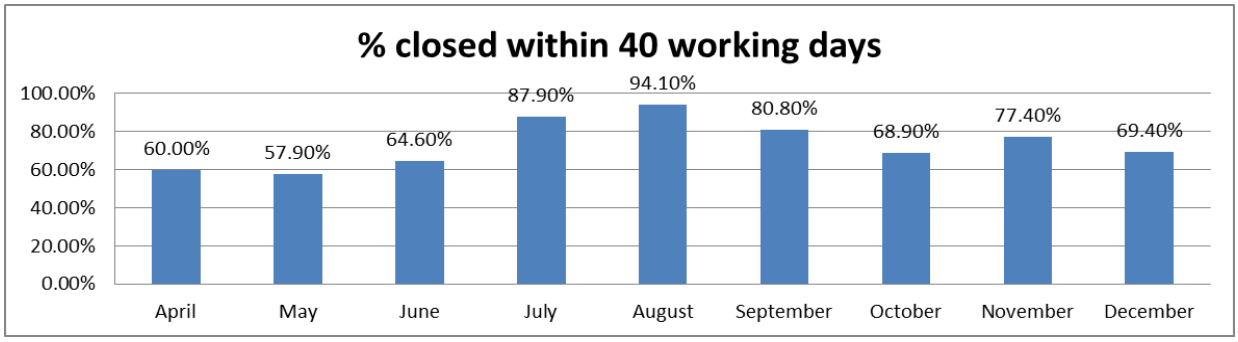
- A patient had raised concerns that his procedure had been cancelled several times.
  Outcome: Following investigation, the patient was advised that it had been necessary for the procedure to be cancelled due to a lack of ICU beds being available, which was required for his own safety due to the complex nature of the surgery he was to undergo. The patient has now had his procedure.

- A patient was admitted to hospital and was found to have pressure sores on her leg and heel. There was a delay in these being attended to by the nursing team and also for a referral to the Tissue Viability Nurse. Documentation relating to this was poor.
  Outcome: The ward sister has discussed the lack of concise documentation with staff on duty. All registered staff on the ward will repeat Tissue Viability training. This concern will also be discussed at the next ward meeting and Specialty Governance meeting for reflective learning purposes to improve patient care.

5.1.2 Performance against the 40-day complaint response standard
The following graph indicates the percentage of complaints closed within 40 working days of receipt. The Trust's target is for 90% of complaints to be closed within this timeframe.

In the last Quality Report to the Trust Board in December, the percentage of complaints closed within the 40-day timeframe for the month of October 2017 was reported as 93%. This was an error, with the actual rate being 68.9%. Apologies are offered to the Trust Board for this error and it is not yet clear why this occurred. This is being addressed personally by the Chief Nurse. Had this been known at that time, the Chief Nurse would have taken closer performance action with the Health Groups at that point. However, as performance has remained lower than the Trust's target for some time and not improved as had first been thought, this will be taken up with the Health Groups at their performance and accountability meetings on 24 January 2018. The performance for previous months has been checked and it is believed that these are correct. However, a further validation will take place to make sure and will be reported in the next version of this report.

To add some context, it is understandable that some performance may have slipped during November and December due to operational pressures and staff availability during the holiday period. Nonetheless, this level of performance is still not acceptable. The Patient Experience Team continues to work closely with the Health Groups to provide support and meets with the teams on a weekly basis to review progress with a view to improving this performance.



The Patient Experience Team has produced a training programme for ward staff to be delivered at ward staff meetings to discuss the concerns, compliments and actions from complaints specific for each ward. Several wards across both sites have already booked for the team to attend their meetings and it is anticipated that the Patient Experience Team will visit all wards during the coming year.

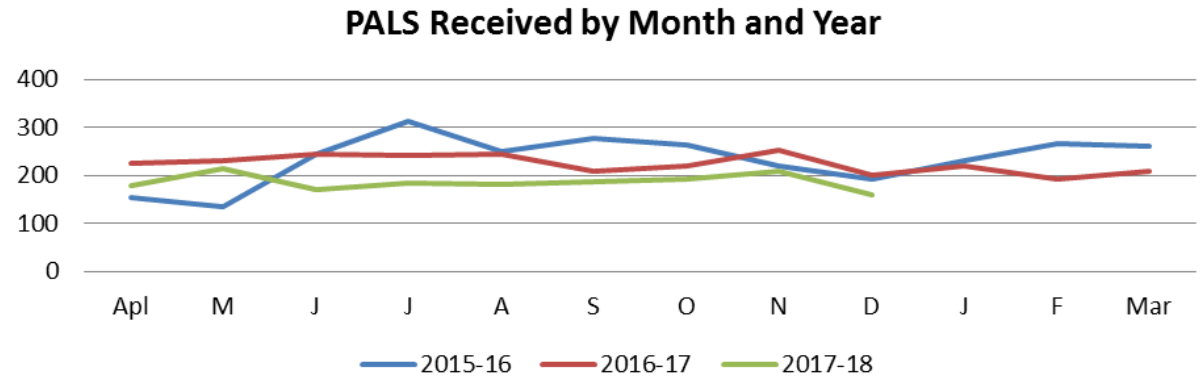
5.2 Patient Advice and Liaison Service (PALS)
In November 2017, PALS received 210 concerns, 18 compliments, 3 comments/suggestions and 34 general advice issues. The majority of concerns raised related to 'treatment', in which the patient was not satisfied with the plan for their care, to waiting times for follow-up and to outpatient appointments. Also in November, 12 complaints about staff attitude were received, which is unusual.

This information is shared with the Health Groups in order that they can review and implement any actions as necessary. The outcome of the investigation is communicated to

patients/complainants by the PALS team and also in many cases, directly by the staff involved. Staff attitude issues are shared with the Human Resources and Health Group management teams to raise awareness so that extra training can be provided as required.

In December 2017, PALS received 161 concerns, 8 compliments, 2 comments/suggestions and 21 general advice requests. As in November, the majority of concerns relate to patients not being satisfied with their treatment plan and waiting times for outpatient clinic appointments and follow-up appointments. December saw an increase in waiting list queries and concerns regarding the cancellation of clinic appointments.

The following graph shows that the number of PALS contacts in 2017-18 has been relatively consistent each month, however in December, as in previous years, there was a decrease in the number of PALS concerns received.



PALS Received by Health Group and Subject – November 2017

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times & Cancellations	Discharge	Environment	Treatment	Total
Corporate Functions	7	7	0	4	2	0	1	5	28
Clinical Support HG	2	2	0	2	1	0	0	8	15
Family and Women's HG	4	8	1	4	22	0	0	13	53
Medicine HG	4	6	1	6	17	3	0	14	51
Surgery HG	8	4	3	7	23	1	0	17	63
Totals:	25	27	5	23	65	4	1	57	210

PALS Received by Health Group and Subject – December 2017

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times & Cancellations	Discharge	Environment	Safeguarding	Treatment	Total
Corporate Functions	7	0	0	1	1	0	0	0	1	10
Clinical Support HG	2	2	0	2	2	1	0	0	3	12
Family and Women's HG	2	2	0	5	21	1	1	0	12	44
Medicine HG	5	7	2	10	16	2	0	1	13	56
Surgery HG	4	5	1	4	13	3	1	0	8	39
Totals:	20	16	3	22	53	7	2	1	37	161

5.3 Compliments

The following are excerpts from some of the compliments received during the months of November and December 2017:

- A patient with a complex medical history wanted to pass on a compliment about an auxiliary nurse without whose support the patient said he would have walked out of the hospital. The patient said it was only down to the caring attitude and patience of the auxiliary nurse that he stayed. The patient recalled: 'I get very anxious and sometimes this comes across as aggressive, but the nurse stayed with me, calmed me down and helped me through what was for me, a very challenging time. I cannot thank her enough'.

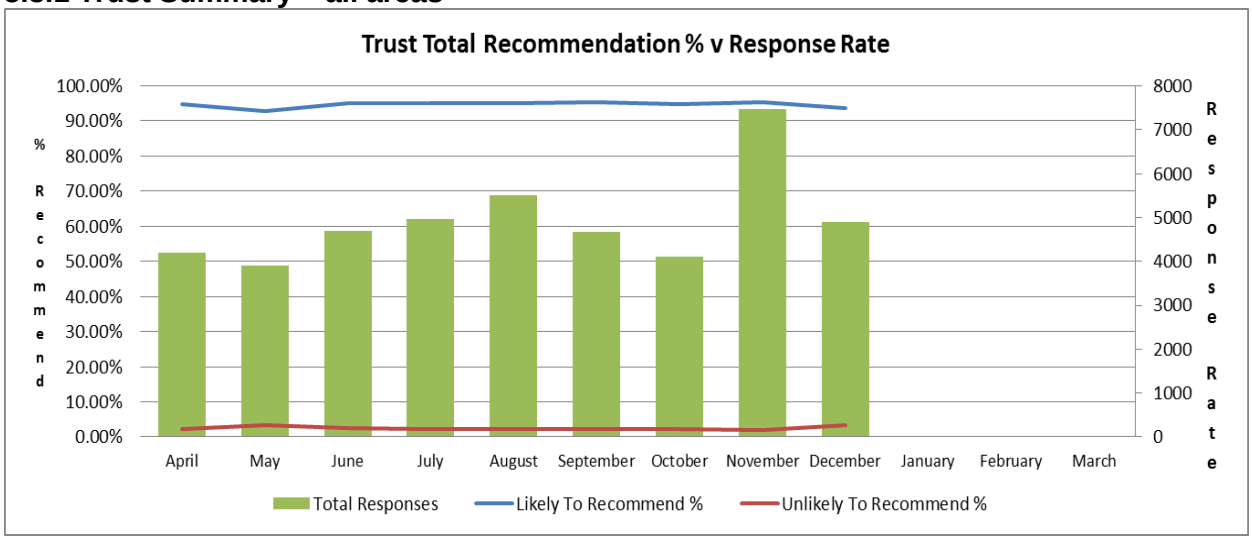
- 'My young son was taken to Hull Royal Infirmary by ambulance following an epileptic seizure. I just want to thank all the staff for their kindness and the way in which they treated my son who suffers with profound mental and physical difficulties. I was extremely pleased with the care he received and the empathy from all staff'.

- 'I would like to pass on my sincerest gratitude to everyone at Castle Hill Hospital who was involved in the treatment and wellbeing of my late husband, especially those on Ward 26. My husband was very ill when he was admitted to the hospital and I know that everything possible was done to try to assist his recovery. Nothing was ever too much trouble. He was treated with patience, dignity, professionalism and humour (when appropriate!) I know that everything possible was done for him. Having a much loved husband admitted to hospital is a very stressful experience but I was kept informed and could see that he was receiving the best of care. That is so reassuring and gave me the chance to concentrate on him. Thank you again. The NHS is much maligned and underfunded but those of us who experience the care and professionalism, which is inherent within the organisation, can only be grateful and impressed'.

5.3 Friends and Family Test (FFT)

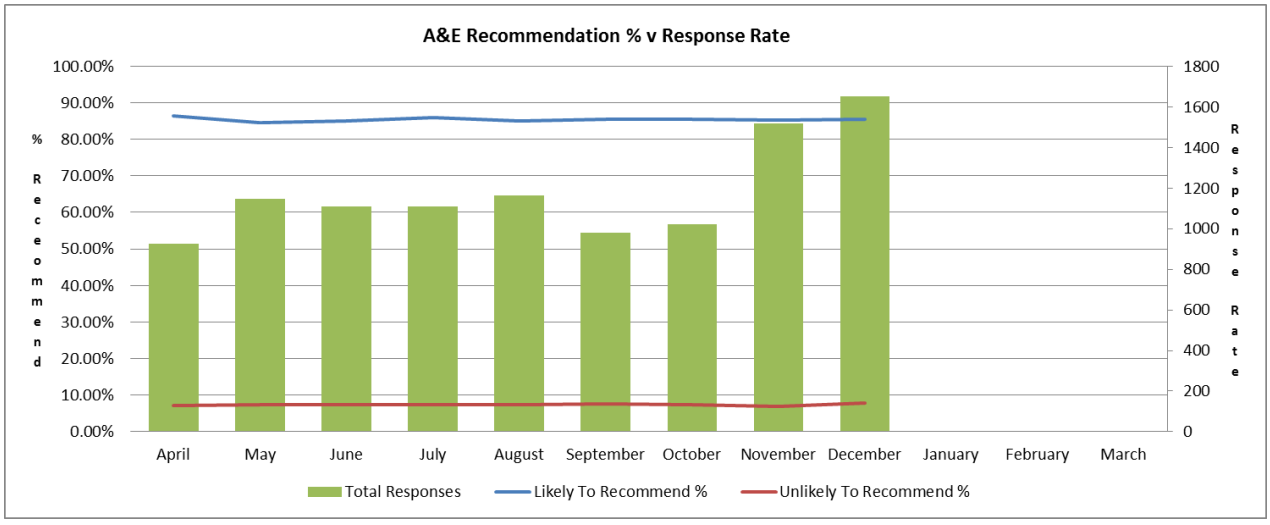
The Trust's Friends and Family results for all areas, including the Emergency Department, had a lower number of responses for December 2017 with 4,890 responses, compared to November 2017 when 7,477 responses were received, which was the highest number received this financial year. The December 2017 results indicate that **93.66%** were extremely likely/likely to recommend the Trust to friends and family, which is slightly below the nationally set-target of **95%**.

5.3.1 Trust Summary – all areas



5.3.2 Friends and Family Emergency Department (ED)

1,516 patients who attended the Emergency Department in November 2017 responded to the Friends and Family Test with **85.36%** of patients giving positive feedback and **6.86%** negative feedback. The remainder were neither positive nor negative. 1,651 patients who attended the Emergency Department in December 2017 responded to the Friends and Family Test with **85.40%** of patients giving positive feedback and **7.81%** negative feedback.



5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 12 cases currently under review by the PHSO. During the months of November/December, there was one new case opened and one case closed, which was not upheld.

5.5 Adult Volunteers

The Trust continues to recruit volunteers steadily. A Christmas party was held by the Trust to show appreciation for the work the volunteers do. The Chief Executive attended and spoke to the volunteers to thank them for the valuable support they provide to the organisation. Radio Humberside was present to capture the event and to speak to the volunteers about their roles at the Trust.

5.6 Interpreters

The Trust is in the process of changing the providers of its interpreting services. Current methods of interpreter utilisation have been extremely costly and have not always delivered a

high quality service. As such, this was put out to tender recently and a full procurement exercise has been undertaken. Three suppliers on the NHS procurement contract framework were interviewed and their bids were reviewed by a multi-disciplinary team comprising colleagues from Finance, Procurement, Information Services, Patient Experience, Outpatients and Nursing. The preferred supplier is Language Line Solutions (LLS) and the contract has been awarded to them. LLS will deliver a more professional relationship, better business intelligence information, an improved quality service to patients, seek feedback from patients, provide improved staff support and training as well as being committed to modernising the way these services are delivered. The new contract will also be more cost effective in terms of offering a range of interpreting options, which include increasing the use of telephone and web-based technologies as opposed to face to face translation, where appropriate to do so. The Patient Experience Team will work with LLS to implement the new contract, which is expected to start in April 2018.

5.7 Browsealoud

The Trust introduced Browsealoud to its website in July 2017 to assist patients requiring support for visual and language needs, in line with the national Standards for Accessible Information. This programme will adapt an internet screen to the personal needs of the viewer, such as increasing font size, changing backgrounds, de-cluttering and translating text. It also provides audio, which can make information more accessible for many people, including people with visual difficulties, for people with dyslexia and for people with learning difficulties. The audio is in English or over 100 other languages. The following table indicates the increased use of Browsealoud over the period July to November 2017.

Month (2017)	Toolbar Loads	Speech Requests
July	196	478
August	281	664
September	368	1,176
October	418	1,307
November	358	1,890

The contract for Browsealoud is for two years and the Patient Experience Team will continue to monitor its usage and effectiveness.

6. OTHER QUALITY UPDATES

6.1 Care Quality Commission (CQC)

6.1.2 CQC Well-Led and Core Services Inspections

The Trust has received written confirmation that a provider-level inspection of the “Well-Led” domain will take place between 27 February 2018 and 1 March 2018. As part of this element of the inspection, as a minimum, the following staff will be interviewed: the Chairman, Chief Executive, Chief Medical Officer, Chief Nurse, Chief Operating Officer, Chief Financial Officer, a sample of Non-Executive Directors, the Infection Prevention and Control Lead and the Freedom to Speak Up Guardian.

The Trust will be required to undertake a presentation to the CQC on Governance Arrangements on the 22 February 2018. In addition, on the first day of the inspection, the Trust will be required to present to the CQC on developments and improvements within the Trust since the last inspection.

Prior to the “Well-Led” element of the inspection, an unannounced inspection of at least one core service will take place. It is anticipated however, that at least all core services that are rated currently as “requires improvement” will be inspected, which may result in a number of unannounced inspections. The core services rated currently as “requires improvement” are: Medical Care, Surgery, Critical Care, Maternity, Outpatients and Diagnostics.

6.2 Learning from Deaths
The first themes and trends report for Structured Judgement Reviews following the deaths of patients was discussed at the Trust's Mortality Committee in January 2018 and is being received separately at today's Trust Board meeting.

The report summarises the key themes that were identified by the Structured Judgement (case-note) Reviews that have taken place within the Trust to date.

There have been a total of 302 structured judgement reviews undertaken to date, which indicate that the care delivered to patients in each phase of case is rated as very good. This is broken down as follows:

Element	**Score (out of 5) – higher is better**
Admission and Initial Care	(4.0)
Ongoing Care	(3.9)
Care during a Procedure	(4.4)
Perioperative Care (Pre-op and Post-op)	(4.0)
End of Life Care	(4.1)
Overall Assessment of Care (overall score)	**(4.0)**

The structured judgement review has highlighted good practice, including:
- Excellent management plan of patients in the correct place/location straight from admission.
- Thorough and appropriate regular communication with the patient's family.
- Early recognition of patient severity and very quick referral to the palliative care team.
- Senior advice sought quickly and appropriately during the night/weekends.
- Thorough evidence of Multidisciplinary involvement.

The main issues in care identified are:
- Lack of evidence within case-notes of patients receiving a senior review within a 24-hour period.
- A delay in undertaking sepsis screening.
- Inconsistent documentation within case-notes.
- Delay in escalating vital sign concerns.
- Delay in implementing an appropriate management plan.
- Missed opportunities to commence early End of Life care.

The process for undertaking structured judgement reviews is currently being revised to ensure that feedback to practitioners takes place to assist with learning.

7. RECOMMENDATION
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
Chief Nurse

Kevin Phillips
Chief Medical Officer

Kate Southgate
Head of Compliance

April Daniel
Quality Governance Lead

January 2018

Appendix One: Safety Thermometer – December 2017

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER December 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 8th December both hospital sites. 854 patients were surveyed

94.9% 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.

0.7% (6) 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

99.3% 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 May 17 – December 17

	May 17	June 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17
Harm Free Care %	93.4%	93.1%	95.3%	93.6%	95%	93.9%	94.6%	94.9%
Sample: Number of patients	892	904	875	859	873	886	903	854
Total Number of New Harm	20	19	12	17	16	15	14	6
NEW HARM FREE CARE %	97.7%	97.9%	98.6%	98.02%	98.1%	98.3%	98.4%	99.3%

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	3	0.35%	1	2	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	62	7.2%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	745	87.2%	94%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	47	5.5%	6%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	34	3.98%	30	3	1
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.	34	3.98%	30	3	1
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	0	0%	0	0	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)	19	2.22%
Severity **No Harm**: fall occurred but with no harm to the patient	17	1.99%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.23%
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	**151**	**17.68%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**5**	**0.59%**	**3.3%**
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	**4**	**0.47%**	**2.6%**
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	**1**	**0.12%**	**0.6%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 12th January 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	January 2018		**Reference Number**	2018 – 1 - 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: BAF 1 and BAF 2	**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

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

The last report on this topic was presented to the Trust Board in December 2017 (October 2017 position). This report presents the 'safer staffing' position as at 31st December 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 from Lord Carter's Model Hospital dashboard. 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 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%
Jul-17	84.00%	89.60%	91.30%	100.90%
Aug-17	78.40%	93.20%	88.00%	100.80%
Sep-17	77.50%	96.70%	87.60%	101.80%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	82.20%	95.90%	92.60%	103.20%
Dec-17	82.50%	93.50%	92.30%	100.30%

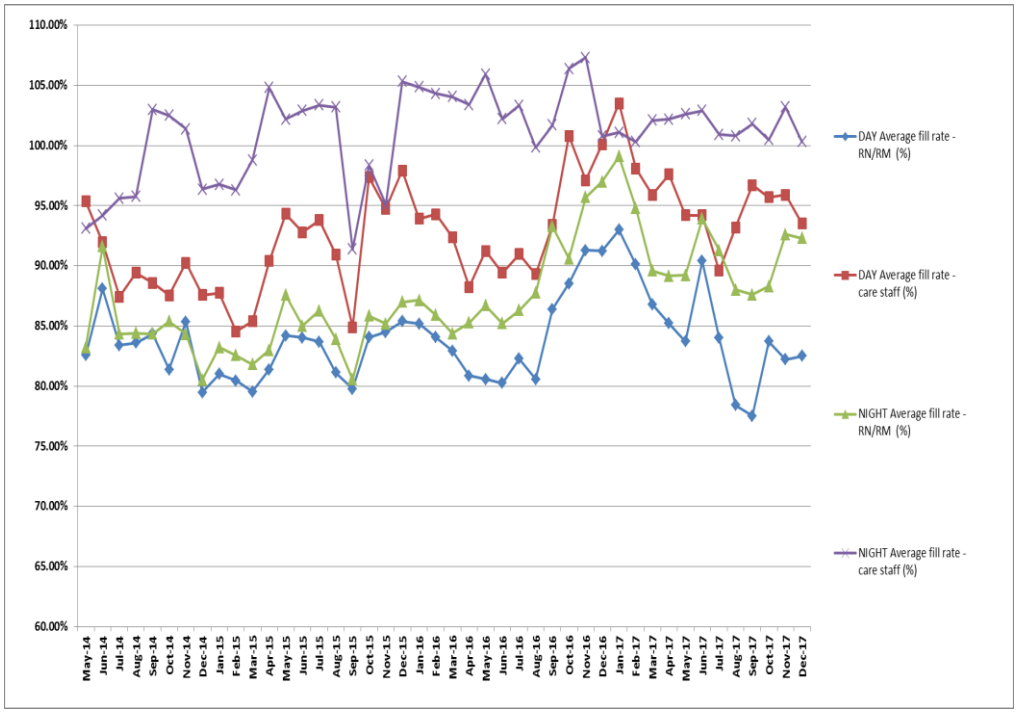
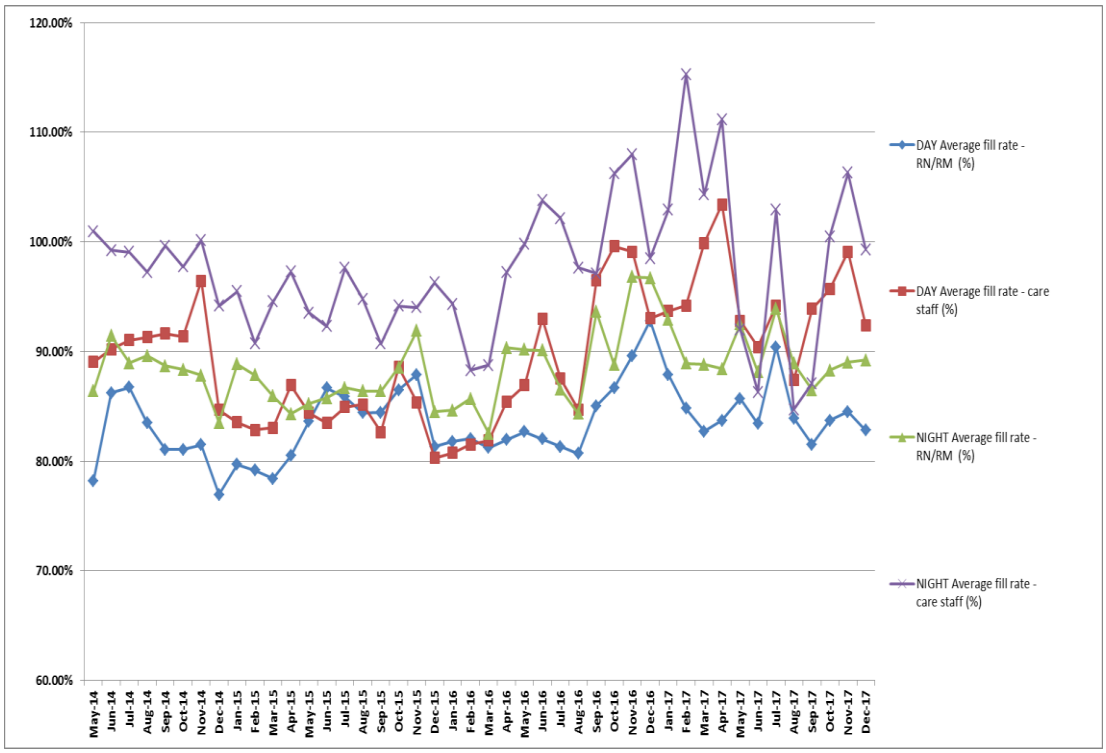


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%
Oct-16	86.70%	99.59%	88.79%	106.24%
Nov-16	89.60%	99.10%	96.80%	108.00%
Dec-16	92.79%	93.03%	96.70%	98.50%
Jan-17	87.90%	93.70%	92.90%	102.90%
Feb-17	84.80%	94.20%	88.90%	115.30%
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	83.40%	90.40%	88.10%	86.30%
Jul-17	90.40%	94.20%	93.90%	102.90%
Aug-17	83.90%	87.40%	88.90%	84.70%
Sep-17	81.50%	93.90%	86.50%	87.10%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	84.50%	99.10%	89.00%	106.30%
Dec-17	82.80%	92.40%	89.20%	99.30%



As indicated in the aformentioned tables, the fill rates for both HRI and CHH have remained at a relatively steady state, with extra non-registered staff being enlisted to help supplement registered nursing vacancies.

From an international recruitment perspective, the Trust has eleven international recruits that have arrived already, are working as healthcare assistants and who are preparing for the Objective Structured Clinical Examination [OSCE]. The OSCE is the exam that the recruits must pass in order to become fully registered with the Nursing and Midwifery Council (NMC). However, as these are experienced nurses in their own right and with intensive training and support on the wards, it is anticipated that the timescales from arrival to working as fully-registered and independent nurses will be two months.

The Trust has also had approval for 8 further certificates of sponsorship, recently. Therefore, it is therefore anticipated that, subject to visas being issued, this group of candidates should arrive in the UK by early February 2018.

The inclusive cost per recruit of each nurse from the Philippines is circa. £6k.

There are a further 110 candidates in the Philippines that have been offered posts and who are now going through the various processes that are required to enable them to travel to the UK and work towards full NMC registration. 43 of these are waiting for their NMC decision letters, which means that they should be able to travel within the next two months subject to immigration clearance.

The Trust Board has been advised already of actions that continue to be taken to balance emerging shortfalls, including:

- The closure of 20 beds within Surgery at CHH and the consolidation of beds and wards teams.
- The redeployment of staff from CHH to support HRI.
- Reduction in the number of Ward Sister/Charge Nurse supervisory shifts within all of the Health Groups 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 areas).
- The placement of Senior Matrons into clinical shifts across all Health Groups to help boost direct care-giving hours
- Support being given to wards by specialist nurses
- Utilisation of some agency shifts, albeit on a controlled basis. This has required the Trust to pay over the NHSI ‘capped rate’ on a small number of occasions in order to ensure patient safety.

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns. In addition the Chief Nurse has commissioned the development of a Nursing Workforce Committee focused on the delivery of the following:

- Improving retention by understanding why staff leave and what can be done to address that beforehand.
- Focused work with those approaching 55-year age/early retirement to see if anything can be done to persuade such staff to stay on, including part-time and flexible hours
- Considering more flexible working opportunities in general

- Looking at skill mix; as one key reason for leaving is due to the apparent lack of career progression opportunities
- Undertaking some time/motion work to understand the roles and tasks that RN's are doing compared to that of the non-registered workforce and other healthcare professionals
- Review of nursing shift patterns (underway currently)
- Undertake some staff surveys about what would make the difference to help keep nurses working here.
- Restricting annual leave allocation during peak holiday periods, especially towards the end of the summer school holidays.
- The possibility of pursuing an alternative entry point to nurse training using the apprenticeship route. However, this would require funding from the Trust to support in terms of paying the apprenticeship salary and backfill costs. Options to look at this more closely are being developed and a proposal to support this will be going to the Executive Management Committee for consideration in February 2018. Although this will not produce a short-term solution to the registered nurse supply chain, the options for training more nurses into the future through nationally-available and nationally-funded routes are just not available. Unless other national monies and entry routes are to be made available to support this in the future, trusts are going to need to supplement the development of registered nurses from their own budgets. This will only add further financial pressures to already-challenged trust budgets.

In terms of strategic context with nursing staffing, the future supply of registered adult nurses remains the primary concern for the Trust's Chief Nurse and many other chief nurses, certainly across the Yorkshire and the Humber region. All have similar ageing nursing and care assistant workforces, with many still having the option to retire at 55 yrs. of age. This continues to be a risk to the local health economy.

The Chief Nurse for the North of England held a Nursing workforce summit/think tank on 13th December 2017 to consider the solutions to the registered nursing shortfalls. This provided an opportunity to discuss and debate the structure of the future care-giving workforce, the future role of the registered nurse, possible solutions and the likely costs/funding options. The Chief Nurse has been asked by NHSE to chair the North of England Nursing Workforce Group that will take this work forward. The Deputy Chief Nurse is also part of the working group and will continue to be involved in this work proactively.

The Trust attended a careers fair in association with the University of Hull on 11 January 2018. This was attended by local/regional hospitals including: North Lincolnshire and Goole NHSFT, Mid-Yorkshire Hospitals NHST, York Teaching Hospitals NHSFT, Humber NHSFT, City Healthcare Partnership and others. This Trust has secured 150 student nurses for interview from the October 2018 cohort. This is really positive news and the challenge is on to try and retain these people and, also secure others that were not able to attend the careers fair.

In terms of midwifery staff and children's services staff, all vacant RM and RM vacancies have now been filled. In addition, or the first time in recent times, all Band 7 senior sister/charge nurse and all band 8b senior matron posts have been filled. This is really positive news.

4. ENSURING SAFE STAFFING

The safety brief reviews, which are now completed six times each day, are led by a Senior Matron with input from 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 but is not without its challenges on some days. The Trust has a 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 and this system is working well.

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, 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:

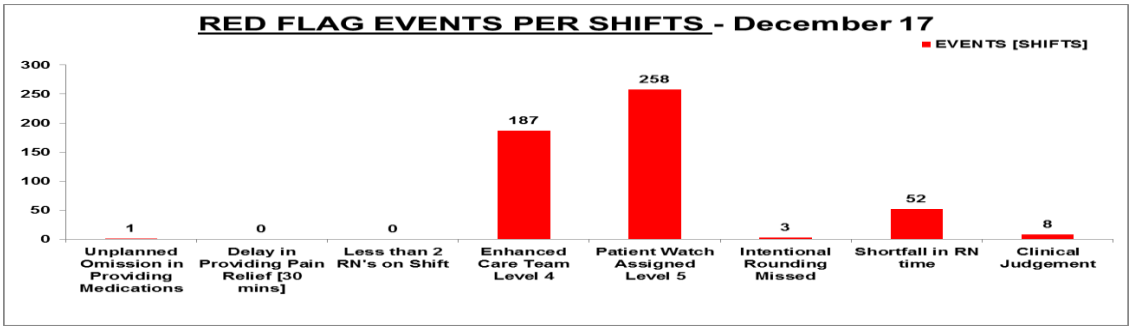
- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined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

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

- 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 December 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.

Dec-17	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	1	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	0	0%
	Enhanced Care Team Level 4	187	37%
	Patient Watch Assigned Level 5	258	51%
	Intentional Rounding Missed	3	1%
	Shortfall in RN time	52	10%
	Clinical Judgement	8	2%
	TOTAL:	509	100%



As illustrated above, the most frequently reported red flag is related to the requirement for 1:1 supervision for patients. As indicated in the previous Board Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which has almost completed its pilot and will report on its impact to the Executive Management Committee in February 2018.

There has been an increase in the recording of Patient Watch Assigned Level 5 within December. However, this needs further validation as, whilst it looks as if there has been a significant increase in the number of bookings made since October, in reality there has only been a slight increase in the number of patients requiring this level of care and supervision. This will be addressed by the health group nurse directors.

For information, an ECT level 4 is a patient requiring ward based 1:1 care with a non-registered staff member; these are often patients with dementia, those at high risk of falls and harm or those that are agitated due to their clinical condition. A Patient Watch Level 5 is a patient that is exhibiting violence/aggression that is a risk to themselves and/or others and requires a security staff member to ensure safety is maintained. These requirements for individual patients across the organisation are reviewed on a shift by shift basis and adjusted accordingly.

5. AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

Despite the recruitment of 130 new registrants, there are a number of key areas that remain particularly tight in terms of meeting their full establishments. These are:

- **H70 (Diabetes and Endocrine)** has 8.90 wte RN vacancies. This ward continues to be supported in the interim by moving staff in the Medical Health Group. Additional support has been provided from the Surgical Health Group and nurse bank, therefore reducing the current net vacancies to 2.67 wte in real terms.

- **Elderly Medicine [x5 wards]** have 15.74 wte RN vacancies. The specialty has over recruited by 10.0 wte auxiliary nurses to support the RNs in the ward areas to deliver nursing care with supervision. These are all within budget. The Senior Matrons are supporting the ward in the interim by moving staff in the Medical Health Group. There are a further 4 wte registered nurses due to start in the next 4 weeks. In addition to these new starters a further 3 RNs have been successfully recruited with an anticipated start date of February. This is an improved position when compared with the same time last year.

- **H5, RSU and H500 (Respiratory Services)** have 4.85 wte RN vacancies between them. Support is being provided from the Nurse Bank to ensure staffing levels are maintained at a safe level. Critical Care have released 2.0 wte RN's to work in the RSU. In addition there are 2.00 wte RNs on rotation from critical care working within the respiratory support unit. This has been favourably received by both clinical areas as it is offering a learning opportunity for the staff involved as well as improving the staffing numbers.

- **H11 and H110** have 10.27 wte RN vacancies. The impact of this shortfall is supported by part-time staff working extra hours, bank shifts and over filling of auxiliary shifts. Additional support is also being provided by Critical Care, who have released 2.0 wte. registered nurses to support the HASU.

- **Ward H4 -** Neurosurgery has 5.08 wte RN, **H40** has 1.19 wte RN vacancies. The band 7's work closely together to minimise the impact of the vacancies.

- **Ward H7 -** Vascular Surgery has 5.52 wte RN vacancies. This group of patients often require specialist dressings. A competency based teaching package is being developed to enable band 3 staff to undertake this role. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.

- **Ward H12 & H120 –** Trauma Orthopaedics have 5.87 wte RN vacancies across the floor. The Maxillofacial services have now moved to CHH

- **Ward C10 -** Elective Colorectal Surgery has 4.54 wte RN vacancies. There are currently 5 beds closed on C10 due to RN vacancies.

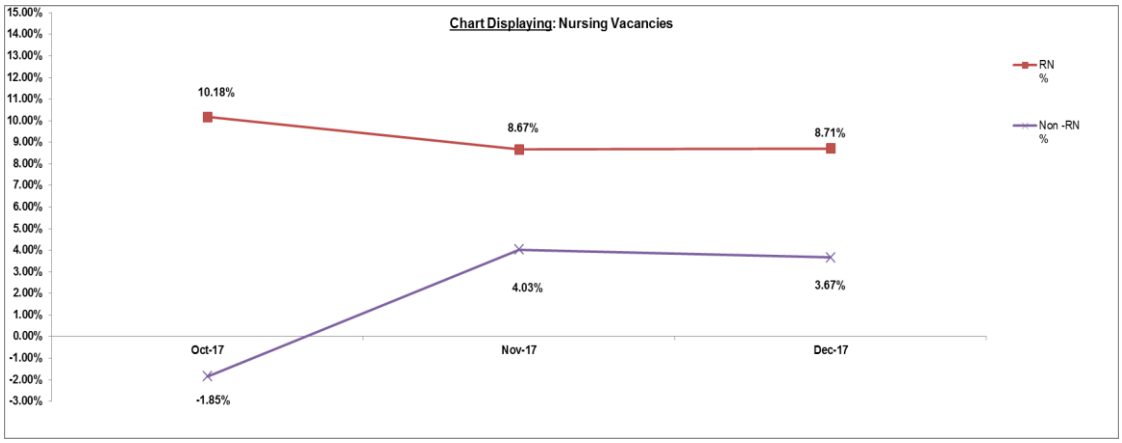
- **Wards 30-33** – Oncology and Haematology have 5.16 wte RN vacancies; staff are moved between the wards following assessment daily by the Senior Matron. An RN from the Oncology Health Centre is working to support C33 and the Sisters and Matrons are all supporting the ward areas by undertaking clinical shifts.

In summary, when all of the current new recruits are accounted for, this leaves an outstanding RN vacancy rate on the Trust's wards, ED and ICU of 111.23 wte

against an establishment of 1276.47 wte (8.71%). The non-registered workforce vacancies are 18.72 wte (3.67%) although a number of wards have over recruited to support the RN vacancies, as mentioned earlier in this report.

The following below illustrates a summary of the Vacancy position for both Registered and Non-Registered nurse over the previous quarter. Where the line is a negative figure, this means that over-recruitment has taken place of non-registered staff to compensate for RN vacancies. This will now start to balance out as new RN's get their PIN.

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.5917807	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.2866765	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.0371387	1276.47	509.93	1786.4	7.28%



As indicated in the narrative, support is being provided to wards that have staffing shortfalls through the redeployment of registered nurses from elsewhere within the Trust. This has been completed in a planned and coordinated manner, in order to try and minimise the continual movement of staff on a daily basis, although staff are still moved daily in response to further short notice shortfalls and assessment of the clinical areas. Despite the work undertaken, there remain some significant shortfalls in the some wards thereafter and these are risk assessed and managed each day.

The Trust Board will also be aware of the concerns mentioned previously regarding the Trust's ability to staff a 'winter ward'. This has been managed very carefully through a mix and match of securing nurses from all health groups and corporate services. Ward H10, a 27-bedded inpatient ward opened on 2nd January 2018 and has been facilitated through the following steps being taken:

- Release of 2 wte RN's from Clinical Support Health Group
- Release of 10 wte RN's from surgery and critical care to support medical wards
- Release of 3.33 wte RN's from the Family and Women's Health Group from C16 (which has reduced bed numbers from 30 to 21 beds to accommodate this)
- Use of 11 beds on Cedar Ward (gynaecology) for medical patients. Also, this ward has been extended from a 5-day ward to a 7-day ward. Temporary staffing has been used to facilitate this
- Allocation of bank and pool staff to the winter ward

It is essential that the nursing workforce is not diluted to such an extent as to become inefficient and present a risk to both patients and staff and this is the whole point of the safer staffing work, the NQB requirements and reporting requirements. In order

to ensure safety, the Nurse Directors and Senior Matrons are responsible for assessing and monitoring their areas on a daily basis. There is no doubt that the opening of a winter ward has added to an already pressured system. However, this continues to be managed and monitored very carefully each day.

The inability to recruit sufficient numbers of registered nurses in order to meet safer staffing requirements remains a recorded risk at 16 (Likely 4 x Severity 4) until staffing levels stabilise more.

6. SUMMARY

Nursing and midwifery establishments 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 and will continue to be so. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses.

Nonetheless, it is important that the Trust Board recognises the significant effort that is being made by many registered and non-registered nursing staff, which includes many working outside their normal area of speciality, to help care for medical patients in what are often very challenging circumstances. They are to be thanked an congratulated for doing this.

7. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
January 2018

Appendix 1: HEY Safer Staffing Report – December 2017

HEY SAFER STAFFING REPORT DECEMBER-17

NURSE STAFFING

FILL RATES

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)
MEDICINE	ED	ACUTE MEDICINE	NA	0				
	AMU	ACUTE MEDICINE	45	2	104%	72%	104%	102%
	H1	ACUTE MEDICINE	22	5	92%	98%	104%	103%
	EAU	ELDERLY MEDICINE	21	17	88%	95%	67%	80%
	H5 / RHOB	RESPIRATORY	26	0	71%	96%	106%	103%
	H50	RENAL MEDICINE	19	4	76%	109%	102%	116%
	H500	RESPIRATORY	24	0	75%	99%	101%	102%
	H70	ENDOCRINOLOGY	30	15	65%	128%	67%	101%
	H8	ELDERLY MEDICINE	27	10	71%	99%	106%	104%
	H80	ELDERLY MEDICINE	27	18	63%	102%	101%	105%
	H9	ELDERLY MEDICINE	31	31	66%	133%	97%	127%
	H90	ELDERLY MEDICINE	29	1	62%	124%	100%	108%
	H11	STROKE / NEUROLOGY	28	94	65%	167%	68%	123%
	H110	STROKE / NEUROLOGY	24	3	63%	142%	104%	97%
	CDU	CARDIOLOGY	9	0	99%	50%	100%	
	C26	CARDIOLOGY	26	3	79%	79%	78%	103%
	C28 /CMU	CARDIOLOGY	27	15	74%	91%	83%	51%
SURGERY	H4	NEURO SURGERY	30	2	68%	117%	80%	116%
	H40	NEURO HOB / TRAUMA	15	17	90%	98%	112%	108%
	H6	ACUTE SURGERY	28	3	93%	83%	83%	152%
	H60	ACUTE SURGERY	28	4	96%	87%	91%	164%
	H7	VASCULAR SURGERY	30	0	80%	80%	84%	99%
	H100	GASTROENTEROLOGY	24	17	83%	97%	94%	98%
	H12	ORTHOPAEDIC	28	13	72%	93%	81%	123%
	H120	ORTHO / MAXFAX	22	23	89%	103%	83%	113%
	HICU	CRITICAL CARE	22	0	88%	150%	85%	45%
	C9	ORTHOPAEDIC	35	4	74%	87%	92%	86%
	C10	COLORECTAL	21	1	82%	56%	100%	85%
	C11	COLORECTAL	22	4	84%	84%	81%	121%
	C14	UPPER GI	27	1	79%	73%	87%	155%
	C15	UROLOGY	26	2	80%	63%	89%	94%
	C27	CARDIOTHORACIC	26	9	85%	78%	97%	100%
	CICU	CRITICAL CARE	22	0	83%	112%	84%	61%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	62%	98%	109%	40%
	H130	PAEDS	20	1	95%	54%	88%	68%
	H30 CEDAR	GYNAECOLOGY	9	3	86%	52%	109%	
	H31 MAPLE	MATERNITY	20	0	95%	77%	108%	99%
	H33 ROWAN	MATERNITY	38	0	89%	81%	84%	96%
	H34 ACORN	PAEDS SURGERY	20	0	88%	69%	97%	114%
	H35	OPHTHALMOLOGY	12	0	90%	19%	114%	
	LABOUR	MATERNITY	16	0	102%	81%	101%	91%
	NEONATES	CRITICAL CARE	26	0	76%	89%	90%	77%
	PAU	PAEDS	10	0	107%		98%	
	PHDU	CRITICAL CARE	4	0	120%	54%	107%	
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	1	111%	82%	101%	94%
	C29	REHABILITATION	15	149	105%	103%	100%	95%
	C30	ONCOLOGY	22	35	93%	101%	99%	101%
	C31	ONCOLOGY	27	0	87%	93%	100%	96%
	C32	ONCOLOGY	22	0	88%	100%	101%	112%
	C33	HAEMATOLOGY	28	2	80%	148%	89%	129%
	TOTAL:		509		AVERAGE or TOTAL:			

CARE HOURS PER PATIENT DAY [CHPPD] [hrs]

	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL
AMU	1151	4.7	2.3	7.1
H1	658	2.9	1.7	4.6
EAU	624	3.5	2.9	6.4
H5 / RHOB	598	2.6	1.9	4.6
H50	571	3.1	2.3	5.3
H500	723	2.4	2.4	4.9
H70	807	2.4	2.5	4.9
H8	815	2.3	2.3	4.6
H80	808	2.2	2.4	4.6
H9	953	1.9	2.6	4.4
H90	842	2.1	2.6	4.6
H11	367	5.2	5.7	10.9
H110	564	3.6	3.0	6.6
CDU	94	10.2	1.0	11.1
C26	681	4.0	1.6	5.6
C28 /CMU	687	6.0	1.6	7.6
H4	748	2.9	2.3	5.2
H40	372	6.7	3.9	10.6
H6	651	3.4	2.2	5.6
H60	729	3.2	2.1	5.3
H7	847	3.0	2.2	5.2
H100	769	2.8	2.1	4.9
H12	639	3.4	3.1	6.5
H120	600	3.4	2.8	6.2
HICU	476	26.1	1.5	27.6
C9	638	3.9	2.3	6.2
C10	326	5.4	2.3	7.7
C11	520	4.0	2.1	6.2
C14	653	3.5	1.9	5.4
C15	609	4.2	2.2	6.3
C27	588	4.7	1.7	6.4
CICU	451	21.6	2.2	23.8
C16	194	9.2	4.5	13.8
H130	509	5.4	0.9	6.4
H30 CEDAR	187	7.8	2.2	10.0
H31 MAPLE	375	6.1	3.5	9.5
H33 ROWAN	1160	2.8	1.4	4.2
H34 ACORN	260	9.4	2.4	11.8
H35	256	5.8	0.6	6.4
LABOUR	321	18.6	5.9	24.4
NEONATES	719	10.8	0.9	11.7
PAU	131	11.6	0.0	11.6
PHDU	96	17.3	1.3	18.6
C20	426	3.4	2.2	5.6
C29	463	3.5	4.1	7.6
C30	571	3.1	2.0	5.2
C31	662	2.6	2.3	4.9
C32	580	3.1	2.0	5.1
C33	622	4.4	2.4	6.9
AVERAGE or TOTAL:	573	5.8	2.3	8.2

ROTA EFFICIENCY [27-11-17 to 24-12-17]

	ANNUAL LEAVE [11-17%]	SICK RN & AN [3.9%]	MAT LEAVE [%]
	12.4%	5.1%	3.2%
AMU	15.6%	5.0%	2.8%
H1	13.4%	5.0%	0.0%
EAU	18.5%	1.5%	7.2%
H5 / RHOB	14.6%	4.7%	6.9%
H50	16.0%	9.3%	0.0%
H500	10.5%	15.7%	0.0%
H70	11.8%	14.7%	0.0%
H8	14.5%	6.0%	3.1%
H80	12.9%	8.1%	6.3%
H9	15.3%	2.1%	4.8%
H90	8.5%	7.7%	3.6%
H11	12.9%	4.1%	0.1%
H110	17.8%	9.7%	6.0%
CDU	13.6%	10.2%	0.0%
C26	13.1%	8.4%	11.4%
C28 /CMU	21.2%	6.3%	0.0%
H4	14.4%	6.8%	3.5%
H40	14.2%	3.4%	0.0%
H6	17.4%	3.0%	0.0%
H60	16.0%	1.3%	2.2%
H7	15.8%	0.6%	0.3%
H100	14.2%	4.5%	6.3%
H12	13.6%	4.4%	6.3%
H120	14.0%	3.9%	0.0%
HICU	15.2%	7.3%	2.9%
C9	14.3%	8.7%	2.0%
C10	17.8%	5.4%	2.4%
C11	17.2%	7.2%	4.3%
C14	16.0%	9.0%	8.2%
C15	15.9%	4.0%	3.1%
C27	13.4%	7.2%	7.7%
CICU	15.7%	6.2%	3.4%
C16	17.1%	6.9%	7.6%
H130	15.5%	5.5%	5.3%
H30 CEDAR	14.6%	17.9%	0.0%
H31 MAPLE	13.0%	5.7%	0.0%
H33 ROWAN	14.9%	1.2%	2.6%
H34 ACORN	17.4%	2.4%	0.0%
H35	14.2%	11.7%	16.6%
LABOUR	16.1%	4.2%	2.4%
NEONATES	13.3%	5.5%	8.5%
PAU	13.8%	9.0%	6.8%
PHDU	13.1%	0.0%	0.0%
C20	26.3%	0.9%	1.2%
C29	14.7%	7.7%	0.0%
C30	17.6%	7.3%	5.0%
C31	15.1%	2.3%	5.2%
C32	16.7%	1.6%	0.0%
C33	15.3%	4.2%	4.5%
TOTAL:	15.1%	6.0%	3.5%

NURSING VACANCIES [FINANCE LEDGER M9]

	RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]
	3.31	3.6%	1.26	5.7%	4.57	115.34
AMU	8.94	20.2%	-0.10	-0.4%	8.84	67.57
H1	1.84	12.6%	0.33	4.2%	2.17	22.51
EAU	3.42	17.9%	-3.17	-24.1%	0.25	32.27
H5 / RHOB	1.49	6.0%	1.20	9.1%	2.69	37.84
H50	-0.49	-3.2%	0.43	5.1%	-0.06	23.54
H500	3.36	19.8%	1.65	13.6%	5.01	29.10
H70	8.90	44.4%	-0.08	-0.7%	8.82	32.22
H8	0.86	5.2%	-1.18	-9.0%	-0.32	29.78
H80	1.99	12.0%	-2.80	-21.3%	-0.81	29.78
H9	2.82	17.0%	-1.84	-14.0%	0.98	29.78
H90	6.65	40.0%	-1.99	-15.1%	4.66	29.78
H11	6.89	30.6%	0.76	7.1%	7.65	33.16
H110	3.38	15.0%	0.48	4.3%	3.86	33.64
CDU	0.00	0.0%	0.48	16.4%	0.48	15.74
C26	0.87	3.4%	0.61	7.7%	1.48	33.73
C28 /CMU	4.43	11.6%	0.69	7.2%	5.12	47.78
H4	5.08	23.3%	0.44	4.2%	5.52	32.28
H40	1.19	5.7%	0.48	4.3%	1.67	31.95
H6	2.91	15.2%	2.47	23.2%	5.38	29.74
H60	0.56	2.9%	1.38	13.0%	1.94	29.74
H7	5.52	25.4%	-0.23	-1.8%	5.29	34.89
H100	2.95	15.4%	-0.18	-1.5%	2.77	31.23
H12	5.35	24.5%	-0.03	-0.2%	5.32	35.00
H120	0.52	3.1%	1.35	11.4%	1.87	28.42
HICU	4.78	4.6%	-1.40	-19.1%	3.38	112.20
C9	2.91	13.3%	0.06	0.5%	2.97	33.39
C10	4.54	24.9%	1.91	24.4%	6.45	26.08
C11	1.16	6.4%	1.79	22.9%	2.95	26.08
C14	1.88	9.3%	-1.16	-12.8%	0.72	29.38
C15	-0.01	-0.1%	0.44	3.6%	0.43	32.71
C27	0.81	3.4%	0.34	3.9%	1.15	32.22
CICU	7.51	8.1%	0.62	8.2%	8.13	100.50
C16	1.72	9.3%	2.47	22.2%	4.19	29.65
H130	-1.79	-8.4%	2.02	38.7%	0.23	26.59
H30 CEDAR	0.27	3.6%	0.12	3.1%	0.39	11.33
H31 MAPLE	-0.42	-0.9%	1.73	6.4%	1.31	73.34
H33 ROWAN						
H34 ACORN	-0.82	-4.0%	0.54	10.3%	-0.28	26.00
H35	1.38	12.4%	3.76	138.8%	5.14	13.84
LABOUR	0.21	0.4%	0.79	5.8%	1.00	63.84
NEONATES	0.66	1.0%	-1.00	-13.3%	-0.34	74.51
PAU	-1.24	-11.9%	0.00	0.0%	-1.24	10.44
PHDU	-1.80	-15.4%	0.00	0.0%	-1.80	11.66
C20	1.58	13.1%	2.48	30.2%	4.06	20.22
C29	-0.47	-3.6%	2.31	14.7%	1.84	28.89
C30	1.11	7.9%	0.03	0.4%	1.14	21.97
C31	-0.74	-5.3%	1.33	11.3%	0.59	25.74
C32	0.25	1.8%	0.12	1.3%	0.37	23.57
C33	5.01	18.3%	-2.99	-37.4%	2.02	35.44
TOTALS:	111.23	8.7%	18.72	3.7%	129.95	1786.40

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

HIGH LEVEL

	SAFETY THERMOMETER HARM FREE CARE [%]	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]
				3
AMU	100%	1		2
H1	100%			
EAU	100%		1	
H5 / RHOB	100%	1		
H50	100%			
H500	100%		1	
H70	100%	1		
H8	100%		2	1
H80	100%	1	3	
H9	96%	1		
H90	100%		1	
H11	96%		1	
H110	100%	1		1
CDU	100%			
C26	100%			1
C28 /CMU	100%			1
H4	100%			
H40	100%			
H6	100%	5		
H60	100%	2		
H7	100%	3		
H100	96%	1	2	2
H12	100%			
H120	100%			
HICU	100%			
C9	100%			
C10	100%		1	
C11	100%	1		
C14	100%			
C15	100%			1
C27	100%			
CICU	100%			1
C16	100%			
H130	100%		2	
H30 CEDAR	100%			
H31 MAPLE	100%		2	
H33 ROWAN	100%	2	1	
H34 ACORN	100%			1
H35	100%			
LABOUR	100%	9		
NEONATES	100%	1		5
PAU	100%			
PHDU	100%			
C20	100%			
C29	100%			
C30	100%			
C31	100%			
C32	100%			
C33	100%			1
TOTALS:	99.8%	49	30	17

FALLS

	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL
	2			2
AMU		1		1
H1				0
EAU	6			6
H5 / RHOB				0
H50				0
H500	1	1		2
H70	1			1
H8	2			2
H80	3			3
H9	3	1		4
H90	3			3
H11				0
H110	1			1
CDU				0
C26				0
C28 /CMU	2			2
H4				0
H40	1			1
H6	2			2
H60				0
H7				0
H100	2			2
H12				0
H120				0
HICU				0
C9				0
C10				0
C11				0
C14	2			2
C15	2			2
C27				0
CICU				0
C16	4			4
H130				0
H30 CEDAR	2			2
H31 MAPLE				0
H33 ROWAN				0
H34 ACORN				0
H35				0
LABOUR				0
NEONATES				0
PAU				0
PHDU				0
C20				0
C29				0
C30	1			1
C31	1			1
C32	3			3
C33	1			1
TOTALS:	45	3	0	48

HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]

	1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL
						0
AMU	1	1				2
H1		1				1
EAU						0
H5 / RHOB					1	1
H50						0
H500					1	1
H70						0
H8						0
H80						0
H9				3		3
H90				1		1
H11						0
H110		1				1
CDU						0
C26						0
C28 /CMU						0
H4						0
H40						0
H6						0
H60						0
H7		1				1
H100		3				3
H12						0
H120		1				1
HICU				2	1	3
C9						0
C10						0
C11						0
C14	1					1
C15						0
C27						0
CICU				1		1
C16						0
H130						0
H30 CEDAR						0
H31 MAPLE						0
H33 ROWAN						0
H34 ACORN						0
H35						0
LABOUR						0
NEONATES						0
PAU						0
PHDU						0
C20						0
C29				1		1
C30		1				1
C31		2				2
C32						0
C33		1				1
TOTALS:	12	0	8	3	25	

QUALITY INDICATOR TOTAL

5
6
1
7
2
0
4
2
5
7
8
5
1
4
0
1
3
0
7
1
2
4
1
10
0
1
3
3
0
1
2
2
3
0
0
9
6
0
0
0
1
2
3
140

Dec-17	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT PER DAY [CHPPPD]: Cumulative Count	RN / RM	CARE STAFF	OVERALL
SAFER STAFFING OVERALL PERFORMANCE								
HRI SITE	82.5%	93.5%	92.3%	100.3%	19377	4.8	2.4	7.2
CHH SITE	82.8%	92.4%	89.2%	99.3%	8894	4.8	2.2	6.9

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.5917807	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.2866765	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.0371387	1276.47	509.93	1786.4	7.28%

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE MINUTES
27 NOVEMBER 2017, THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Prof. M Veysey	Non-Executive Director
	Mr K Phillips	Chief Medical Officer
	Mrs A Green	Lead Clinical research Therapist
	Mrs G Gough	Deputy Chief Pharmacist
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Mrs Y Holloway	Principal Pharmacist Medicines Optimisation
IN ATTENDANCE:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

NO ITEM **ACTION**

1 APOLOGIES

Mike Wright, Chief Nurse and Dr M Purva, Deputy Medical Director

2 DECLARATIONS OF INTEREST

There were no declaration of interests received.

The meeting was taken out of order at this point

5.5 MEDICINES MANAGEMENT

Mrs Gough gave a presentation which highlighted missed doses during inpatient stays. She reported that avoidable missed doses was a national issue as well as a Trust issue.

Ms Gough advised that a lot of work had been carried out linked to serious incidents, PDSA cycle work and reviewing which interventions make a difference. Prof Veysey asked when the Trust would move to electronic drug charts so that data could be run daily and in real time. Mrs Gough advised that e-Prescribing would go live in the Queens Centre in March 2018 and would be rolled out to the rest of the Trust once the Wifi capability was adequate.

Mrs Gough also reported that a band 3 Medicines Management facilitator would be employed to assist with the ordering of drugs, monitoring, reconciling and liaising with the pharmacy team.

The Pharmacy team had also evaluated patients that are transferred with their own medication. A review of how the non stock requisitions are completed had been carried out with the pharmacy technicians to assist the nursing staff.

Immediate discharge letters had also been reviewed and made clearer for the GPs to understand. The team had updated the discharge policy and care bundle, working with the nurses to give better experience and safety for patients. IDLs are now sent electronically within 24 hours. The Trust is looking to recruit discharge assistants to help with the paperwork and

planning to discharge patients quickly and safely.

Mrs Walker stated that staff should be adequately trained when using the electronic systems, not just accept the figures if something looked wrong.

Mrs Holloway gave a presentation which reviewed the medicines reconciliation work ongoing in the surgical assessment lounge. She reported that NICE guidelines state that 70% of medicines should be reconciled within 24 hours. She was working with the teams to facilitate the discharge process for patients who had been to theatre ensuring their medication was ready in a timely manner. She reported that the trial would be carried out from Monday – Friday from 9am – 12pm for 8 weeks. The results and learning would be reported back to the Committee.

There was also work ongoing with the Community services to join the gap between primary and secondary care. Prof Sheldon urged the team to speak with Alison Blenkinsop who had research funding to review medicines management.

Resolved:
The Committee received and accepted the presentations and requested outcomes and any learning from the initiatives when available. **GG/YH**

3 MINUTES OF THE MEETING HELD 30 OCTOBER 2017

Apologies section – Mr Veysey should read Prof. Veysey.
Minute 3.1 – paragraph 3 – "…Mr Snowden asked if the trust was discussing front end community care with Primary Care and the Commissioners."
Minute 5.1 Serious Incidents – Mr Snowden clarified the minute. He advised that although the Committee did state that the report had improved there was still more work to do. More detail around outcomes and lessons shared would be received in the February 2018 report. He asked that the resolved section stated "the Committee received and acknowledged the report."

Following the above changes the minutes were accepted as an accurate record of the meeting.

3.1 MATTERS ARISING

Maternity Outlier – CQC Response – Mr Phillips advised that there had been no official response from the CQC, but the Trust's letter had been acknowledged in the recent relationship meeting.

Integrated Performance Report – Feedback was requested regarding the 300 referrals in endoscopy. **KP**

3.2 ACTION TRACKING LIST

Emergency readmissions – Mr Phillips agreed to circulate updated information for discussion at the next meeting December 2018. **KP**

3.3 ANY OTHER MATTERS ARISING

There were no other matters arising.

3.4 WORKPLAN

Mr Snowden asked that appropriate and valuable invitations to Health

Groups be incorporated into the workplan. Ms Ramsay agreed to review the workplan. **CR**

5 REDUCE AVOIDABLE HARM

5.1 SERIOUS INCIDENTS

Mrs Bates presented the report and advised that the 4th never event in 2017/18 had been declared. She advised that the patient had not suffered any harm but had been given oral medication intravenously. The event had happened in ED and the patient had been apologised to. A panel had been set up and the investigation started. Mrs Bates agreed to share the investigation results and any lessons learned with the Committee once completed.

There was a discussion around pressure ulcers and the de-escalation of a Serious Incident relating to this area. Prof Sheldon stated that it would encourage staff to report more incidents if de-escalation took place where appropriate to do so. Mrs Bates added that only the Commissioners could approve de-escalation of Serious Incidents.

Resolved:
The Committee received and accepted the report.

5.2 DUTY OF CANDOUR

Mrs Bates presented the report to the Committee. Mr Snowden asked about the quality of the letters and if they were in plain English and easy to understand. Mrs Bates assured him that all the letters had been standardised to ensure that they were patient friendly and had been signed off at all Health Group governance boards. Mrs Walker stressed that Duty of Candour should be a genuine apology and not just a process to be followed. Mrs Bates added that verbal apologies were given 100% of the time within 45 hours of the patient complaint or incident.

Mr Phillips added that there had been a fundamental positive change in behaviours and attitudes towards Duty of Candour in the last 2 years. Mr Snowden asked what timings were adopted once the Duty of Candour standard was triggered. Mrs Bates advised that it was within 48 hours for a verbal apology and 10 days for a written response. These standards were set by the Trust.

Resolved:
The Committee received and accepted the report.

5.3 NRLS REPORTING

Mrs Bates presented the report which highlighted that the Trust was in the top 25% of reporters. There was a discussion around falls and pressure ulcers and Mr Phillips advised that the vast majority of pressure ulcers occur outside of the Trust. Work was ongoing with the Commissioners to address this issue.

Resolved:
The Committee received and accepted the report.

5.4 QUALITY IMPROVEMENT PLAN

The Quality Improvement Plan was presented by Mrs Bates. There was a discussion around which QIPs had been completed, which were off track

and which had been moved to 'business as usual'. For example the resuscitation trolleys had been closed and were being treated as 'business as usual'. Mrs Bates agreed to clarify the report.

There was a discussion around outstanding Safeguarding policies and how the QIP relating to these could be closed down once the policies had been reviewed.

Mrs Walker asked if there were any issues to escalate regarding nutrition and Mrs Bates advised that all issues were around documentation and not patients not being fed.

Resolved:
The report was received and more clarification requested regarding outcomes and 'business as usual'. **SB**

6 RECEIVED FOR ASSURANCE

6.1 INTEGRATED PERFORMANCE REPORT

The Committee noted that the Standardised Hospital Mortality Index was moving in correlation with the Hospital Standardised Mortality Rates.

A discussion regarding the recording of VTE assessments took place and the varying results shown even across the same department. Mrs Walker suggested that any poorly performing areas should be invited to the Committee to discuss any issues they may have.

Resolved:
The Committee received the report. Mr Phillips to highlight any poorly performing areas regarding VTE assessment recording to the Committee. **KP**

6.2 OPERATIONAL QUALITY COMMITTEE

Prof Sheldon stated that the discussion regarding the Operational Quality Committee Terms of Reference should be sited by the Committee. **SB/KP**

Mrs Bates reported that the CQC request for information would be submitted 28th November 2017 and this would be in preparation for them visiting the Trust in the New Year.

Resolved:
The Committee received and accepted the report.

6.3 LEARNING FROM DEATHS POLICY

The Learning from Deaths Policy was presented to the Committee. Mr Phillips advised that it was developed using the Government guidance. Mrs Bates agreed to circulate the guidance to the Committee members.

A detailed discussion took place regarding which procedures would be reviewed, who would carry out the reviews and ensuring that staff had sufficient skills to carry out the reviews. How to investigate patients with learning difficulties and other mental health issues were also included in the policy. Work was also ongoing with GPs and the Commissioners to review patients and collect data that have left hospital but died within 7 days of leaving.

Mrs Bates advised that the guidance stated that Trust's must ensure

sharing of information and learning is evidenced following an investigation, however, Trust's no longer had to state whether or not the death was avoidable. She also advised that the Mortality Steering Group would monitor progress against the policy.

Prof Sheldon stated that he would be attending a national NED meeting were the national guidance would be discussed. He suggested that if any Committee members had any questions to let him know and he would raise them.

Resolved:
The Committee received and accepted the policy.

7 BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report and highlighted that the key risks would be incorporated into Board Development sessions to ensure proper scrutiny and discussion.

Risk appetite would be discussed at the November 2017 Board Development session to review the ceiling of tolerance the Board would accept with key risks.

Prof. Sheldon commented that the Committee was yet to see any significant savings proposals that might have an effect on quality or any associated risks. Mr Phillips advised that alongside the Chief Nurse and the Chief Operating Officer CRES schemes were reviewed with any quality impacts highlighted.

Mr Snowden reported that he was working with key staff to discuss the Trust scorecard and how this would accurately reflect quality issues as well as performance issues and how these would be reported to the Board.

Resolved:
The Committee received and accepted the report.

8 ANY OTHER BUSINESS

There was no other business discussed.

9 DATE AND TIME OF THE NEXT MEETING:

Monday 18 December 2017, 9.15am – 11.15am

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE MINUTES
18 DECEMBER 2017

PRESENT:	Prof. T Sheldon	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mr K Phillips	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Dr M Purva	Deputy Chief Medical Officer
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Ms C Ramsay	Director of Corporate Affairs
IN ATTENDANCE:	Mr M Simms	Consultant Urological Surgeon (Item 4.5)
	Mr D Haire	Project Director (Fundraising) (Item 4.5)
	Mrs V Shaw	Clinical Audit Manager (Item 4.4)
	Mr T Moran CB	Chairman
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

NO. ITEM **ACTION**

1. APOLOGIES

Apologies were received from Prof. Veysey – Associate Non-Executive Director, Mr Wright – Chief Nurse and Dr Green – Lead Clinical Research Therapist

2. DECLARATIONS OF INTEREST

There were no declarations of interest received.

The agenda was taken out of order at this point.

4.5 ROBOTICS UPDATE

Mr Simms gave a presentation which highlighted the advantages of using robotics to carry out advanced keyhole surgery including prostatectomies, colorectal and gynaecological procedures.

Benefits included greater ability to perform more complex cases, and reductions in length of stay. The robot had also enhanced the reputation of the Trust.

There were also disadvantages such as only doing two procedures a day, not all staff being trained in robotic techniques, the cost of the robot, specialties competing for robot time and increased patient demand. Mr Simms also reported that a robotic co-ordinator was required to ensure the scheduling of the procedures was maximised and efficient.

Mr Snowden asked where the discussions were taking place regarding the recruitment of a co-ordinator and Mr Haire advised that there was a working group for each speciality looking at using the robot as efficiently as possible. Mrs Walker asked if local research was being carried out to gain definitive outcomes to support the case for a second robot and Mr Simms advised that no formal research had been conducted, but that benchmarking was being carried out with other Trusts. Prof. Sheldon commented that it was unfortunate that use of robots was being rolled out internationally without convincing supportive research evidence. Mr

Simmns noted the improvements in outcomes and the ability to operate on and provide treatment to patients who had previously had inoperable condition or more risky procedures.

There was a discussion around the amount of time saved by the robot. Ms Ramsay added that there were a number of improvement projects linked to the robot.

Mr Simms reported that a second machine was required, which would be challenging from a cost point of view but would ensure more patients could receive their procedures robotically.

Resolved:
The Committee received and thanked Mr Simms for the presentation.

Mr Simms and Mr Haire left the meeting.

4.4 NICE GUIDANCE

Mrs Shaw attended the meeting and updated the Committee regarding mandatory NICE Guidance and the Trust's compliance. She advised that a non-compliance report was presented at the Operational Quality Committee regularly for review.

Prof. Sheldon asked how the level of compliance was known and Mrs Shaw advised that clinical staff arrange their own audits and the results and any outstanding audits are kept on a Trust database. When new guidance is received, it is reviewed by the clinical teams and any areas of non-compliance documented. There are low levels of non-compliance in the Trust - Mrs Shaw agreed to share her compliance report with the Committee showing Trust compliance and any reasons for non-compliance. Ms Ramsay noted that this is already in the Committee workplan.

Mrs Walker asked about the general feeling amongst the clinicians when new NICE guidance was published and Mrs Bates assured her that generally the responses were positive, but any concerns were raised at Health Group meetings.

Resolved:
The Committee thanked Mrs Shaw for the information regarding NICE compliance and agreed to supply the compliance report to the next meeting. **VS**

Mrs Shaw left the meeting

The meeting returned to order at this point.

3. MINUTES OF THE MEETING HELD 27 NOVEMBER 2017

Mrs Holloway to be added to the 'In Attendance' list and her title be amended to Princip**al** Pharmacist Medicines Optimisation.

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

3.1 MATTERS ARISING

Item 5.5 – Medicines Management – Outcomes and learning report, following the initiatives presented to be received at the Committee to be received in July 2018. **DC**

3.2 ACTION TRACKING LIST

The Committee reviewed the Tracker and one item was outstanding. Ms Ramsay to review governance assurances with other external providers for the next meeting.

3.3 OTHER MATTERS ARISING

Mrs Bates reported that the incident categorisation report from the NRLS had not yet been received. This would be reported to the Committee once received. **SB**

Mr Phillips agreed to discuss the Safeguarding policies outstanding with the Safeguarding lead. **KP**

Mr Phillips advised that further discussions with the clinical leads regarding VTE assessments were ongoing. Ms Ramsay to discuss any problem areas with Mr Phillips and invite the clinical leads to the January 2018 meeting. **KP**

Mr Phillips reported that the Learning from Deaths Policy had been published and Prof. Sheldon added that the Trust would be required to have a Medical Examiner in 2019.

Mrs Bates advised that a Harms Committee had been set up to review the tracking access issues but would also review all harms in the future. Prof. Sheldon asked that the Terms of Reference and an understanding of where this Committee fits in to the Trust Committee structure be included on the next agenda. **KP**

3.4 WORKPLAN

The Committee reviewed the workplan and a claims report is to be received at the next meeting.

4.1 SERIOUS INCIDENTS

Mrs Bates highlighted that there was an error on the first page of the report and that there had been 46 Serious Incidents to date and 4 Never Events.

There was a discussion around one of the Never Events (wrong site surgery) and the changes that had been put into place. Mr Phillips advised that a 'loud pause' was being implemented to allow surgeons and other clinical staff to have a moment of concentration.

Prof. Sheldon asked about the well-being of the surgeon in question and Mr Phillips reported that support had been given. Mr Snowden asked how confident more junior staff were to approach a surgeon if they thought something was wrong; Dr Purva advised that major cultural changes such as the 'loud pause' and challenge between colleagues would take time to be embedded.

The Committee discussed the increase in Serious Incidents and what the

underlying issues were. Mrs Bates agreed to review any reasons in the February 2018 report to the Committee. She also advised that more Serious Incidents were de-escalated which made staff more confident to report them.

Resolved:
The Committee received and accepted the report.

4.2 QUALITY IMPROVEMENT PROGRAMME
The Committee reviewed the Quality Improvement Programme.

There was a discussion around the front summary sheet and having clearer indication on the areas the Committee were being asked to review.

Prof. Sheldon highlighted the Wound Management Committee and the quoracy issues, expressing his concern especially relating to pressure ulcer management. Mrs Bates advised that the Chief Nurse was meeting with the Nurse Directors to rectify this issue.

Resolved:
The Committee received and accepted the report.

4.3 MEDICINES MANAGEMENT FRAMEWORK
Mr Corral reported that the framework would be received at the January 2018 meeting as he wanted it to be received by the Safe Medication Committee first.

Resolved:
The Committee agreed to receive the framework in January 2018. **DC**

5.1 INTEGRATED PERFORMANCE REPORT
Due to the timing of the Committee the report was not ready for circulation and was not received.

6. OPERATIONAL QUALITY COMMITTEE
Mr Phillips presented the item and advised that the Terms of Reference of the Committee had been discussed and the final version would be presented to the Quality Committee.

There were two policies approved:
Safer Standards for Invasive Procedures
Eliminating Mix Sex Accommodation

He also reported, as mentioned earlier in the meeting, that a new Clinical Harms group is being established to review any patients that had suffered harm, initially due to the tracking access issues but then reviewing all harms. This group would be chaired by Mr Shaw, Medical Director in the Surgery Health Group.

Resolved:
The Committee received and accepted the report.

7. BOARD ASSURANCE FRAMEWORK
Ms Ramsay presented the report and advised that a detailed discussion

had taken place at the November 2017 Board time out relating to risk appetite and the level of risk the Trust was happy to tolerate.

Prof. Sheldon stated that the mitigating actions around medical engagement could be more robust and Mr Phillips advised that a meeting had been held with the clinical leads and medical directors to discuss roles and accountability. Ms Ramsay added that it would be useful for the Committee to receive Mr Nearney's quarterly update of the People Strategy implementation. **CR**

Mrs Walker had witnessed clinical leads attending a Board meeting at another Trust and felt this would be a good way for clinical leads to have a broader view of the Trust's issues. Dr Purva also suggested Non-Executives attending clinical lead meetings.

Resolved:
The Committee received and accepted the report.

8. ANY OTHER BUSINESS

Mrs Walker asked about Non-Executives visiting ward areas with the Executive Team and whether enough was being done. Mr Moran suggested that this item be discussed at the next Non-Executive meeting.

Prof. Sheldon asked that he be invited to attend some Mortality Reviews. **SB/KP**

There was a discussion around inviting different clinicians and specialities to the Committee in the new year. Prof. Sheldon wanted to ensure that the Committee's objectives for inviting representation were clear.

9. DATE AND TIME OF THE NEXT MEETING:

Monday 29th January 2018, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2017/18

January 2018

December 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. This has been updated in August 2017. The draft proposal location is https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/

RESPONSIVE

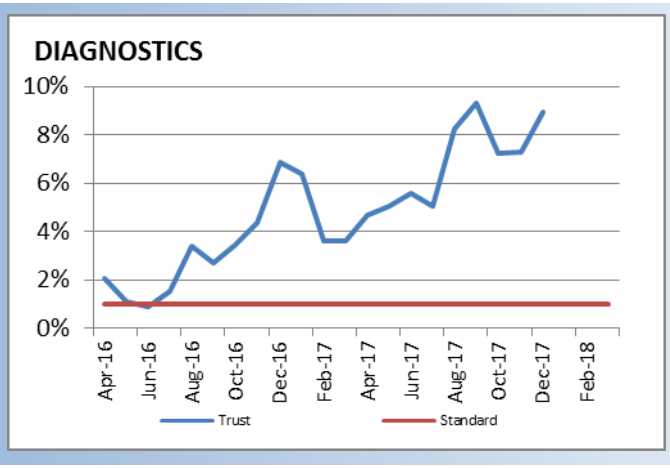
Description	Aggregate Position	Trend	Variation

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 8.97% in December

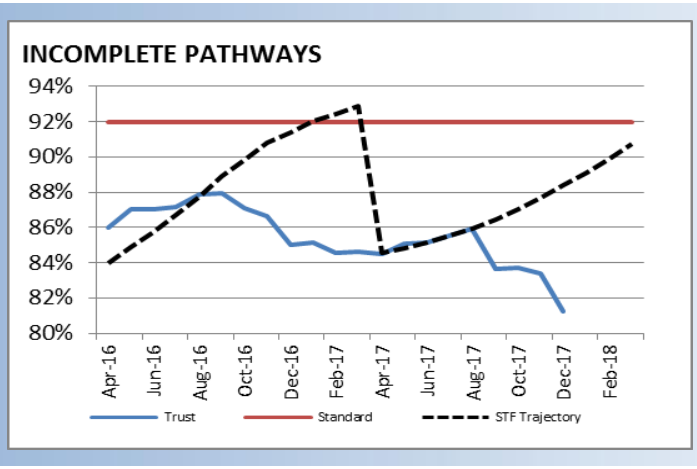


Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the December Improvement trajectory of 88.4%

December performance was 81.3%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 17 specialties that failed to meet the STF trajectory

Integrated Performance Report - January 2018

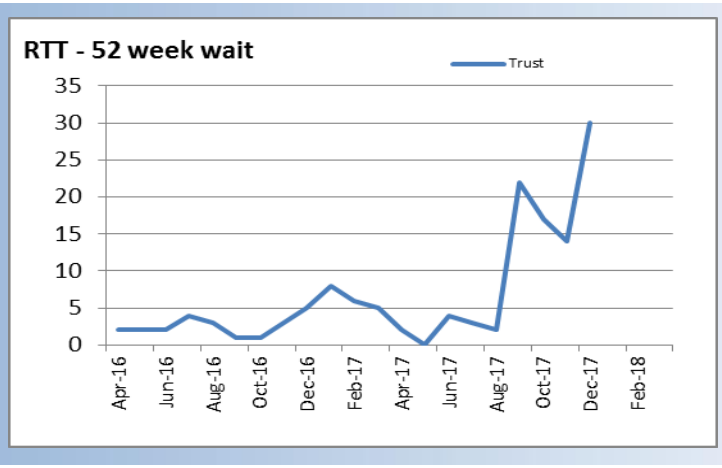
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

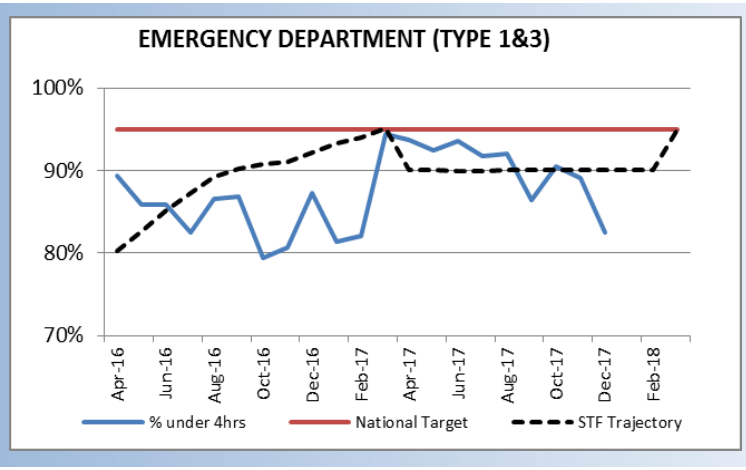
The Trust failed to achieve the national standard of zero breaches with 30 breaches during December.



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 failed to achieve the Improvement trajectory of 90.0% with performance of 82.4% for December. This has failed to achieve the national 95% threshold.



Performance has decreased by 6.7% during December compared to November performance of 89.1%.

Integrated Performance Report - January 2018

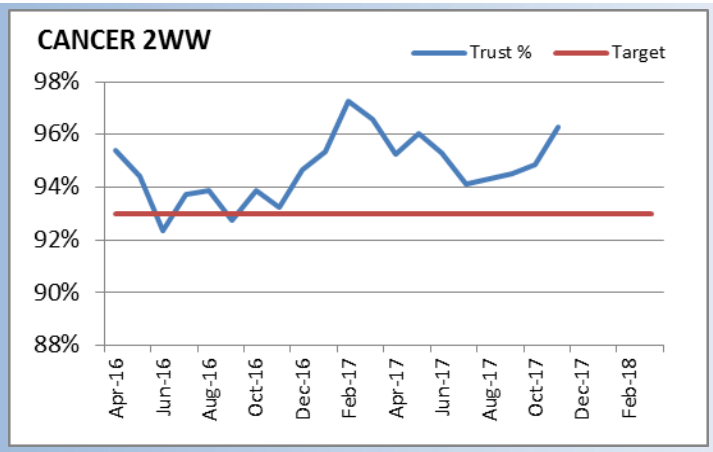
RESPONSIVE

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%.

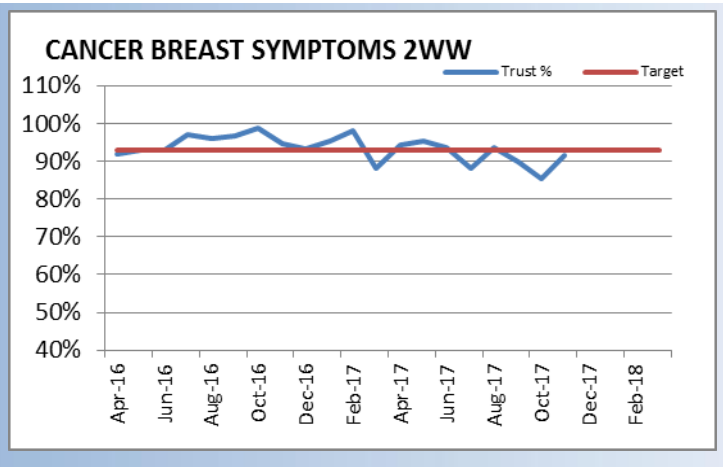
November performance achieved the 93% standard at 96.3%



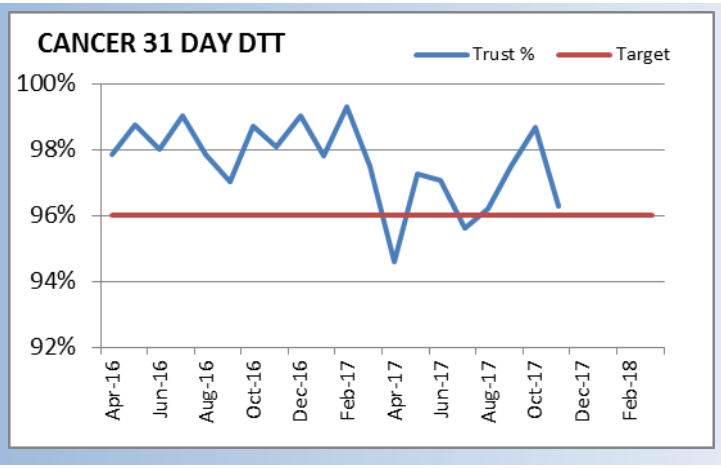
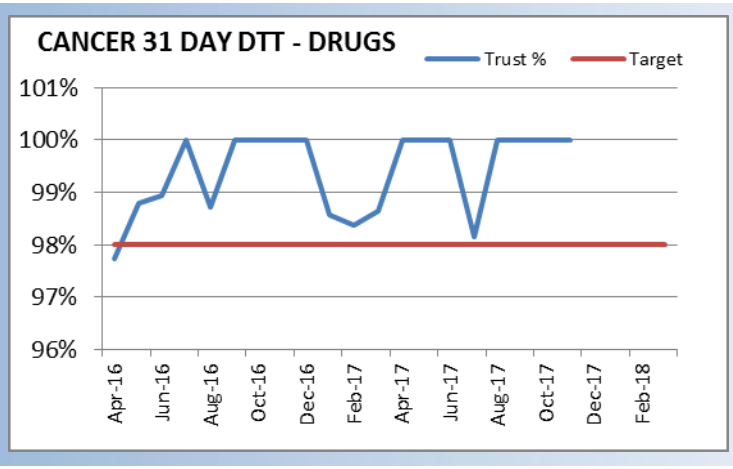
Cancer: Breast Symptom Two Week Wait Standard

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

November performance failed to achieve the 93% standard at 91.5%



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%.	November performance achieved the 96% standard at 96.3%		
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%.	November performance achieved the 98% standard at 100%		

Integrated Performance Report - January 2018

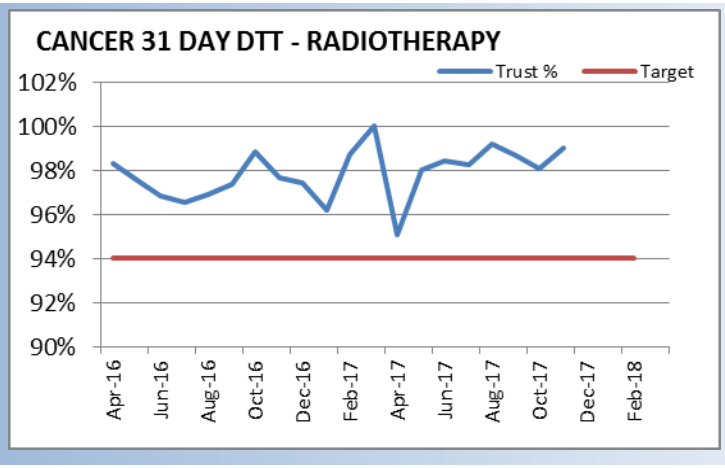
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy

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

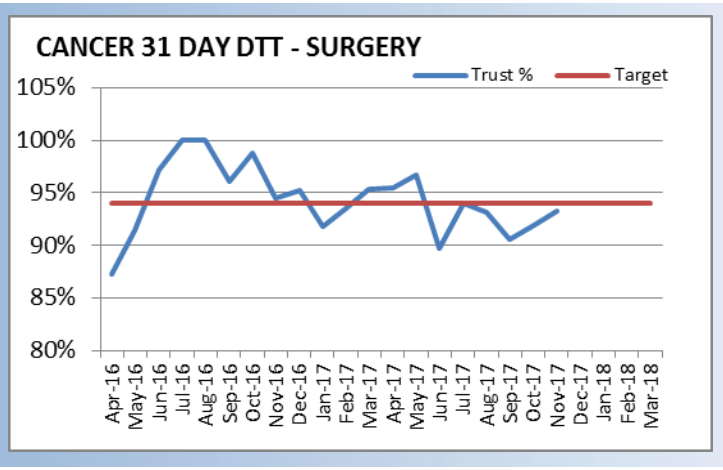
November performance achieved the 94% standard at 99.0%



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%.

November performance failed to achieve the 94% standard at 93.2%



RESPONSIVE

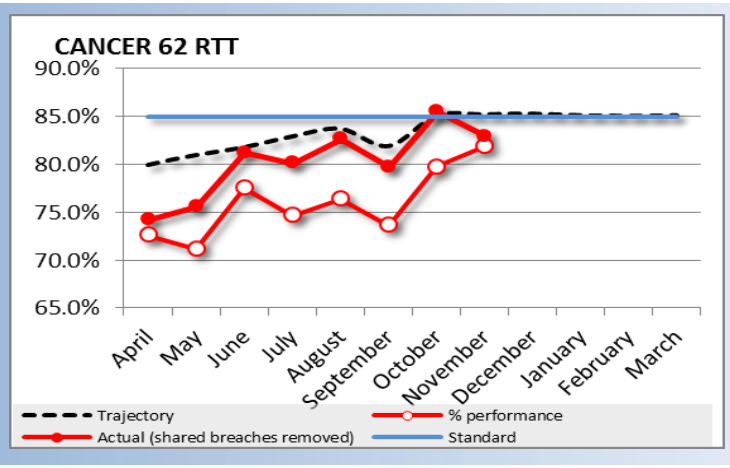
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%

The adjusted position allows for reallocation of shared breaches

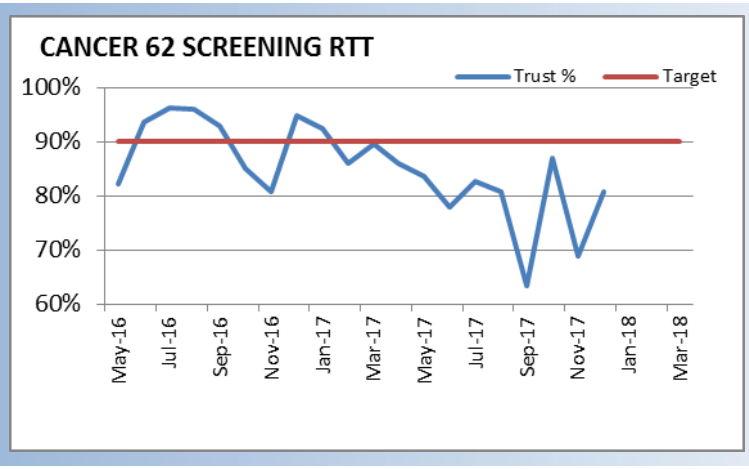
November performance failed to achieve the STF trajectory of 85.3% with performance of 83.0%



Cancer: 62 Day Screening Standard

All patients need to receive first treatment for cancer within 62 days of urgent screening referral. Threshold of 90%

November performance failed to achieve the 90% standard at 80.6%



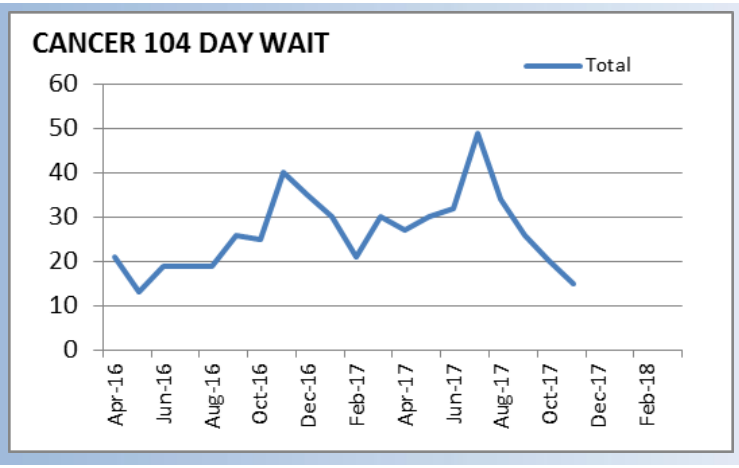
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 15 patients waiting 104 days or over at the end of November



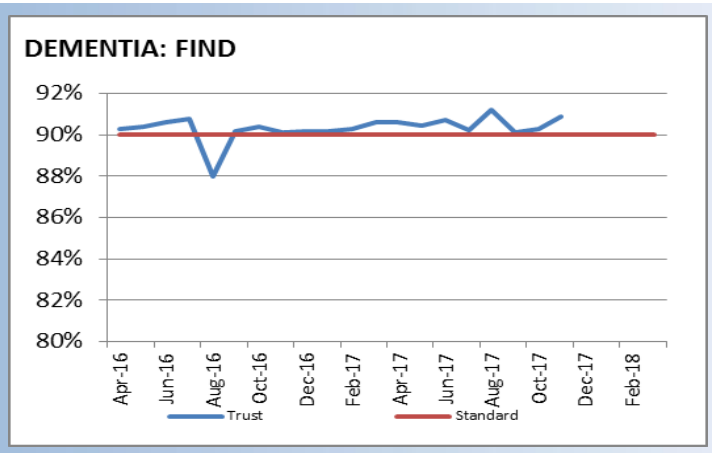
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of all patients asked the dementia case finding question within 72 hours of admission, or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question cannot be completed for clinical reasons.

The latest performance available is November 2017.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 90.9%



RESPONSIVE

Description	Aggregate Position	Trend	Variation

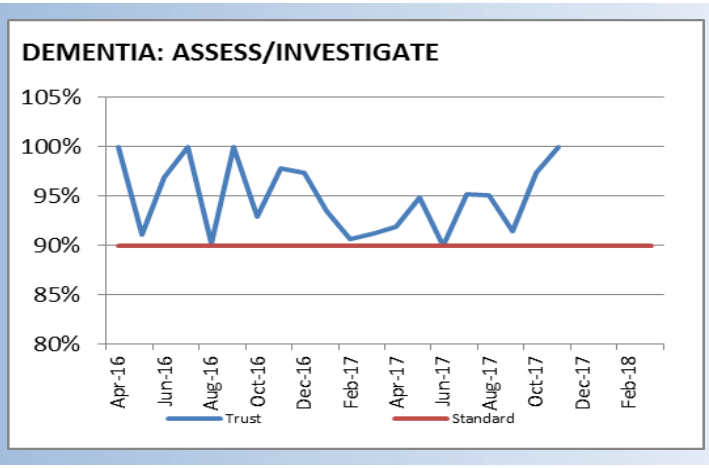
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of patients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations.

The latest performance available is November 2017.

The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 100%



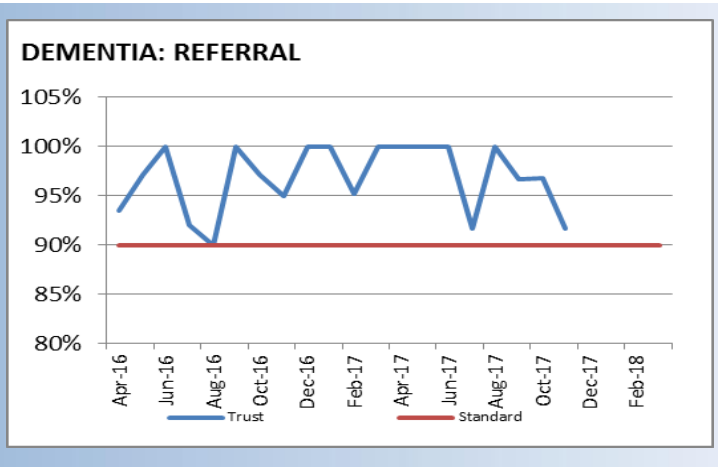
Dementia: Aged 75 and over emergency admission greater than 72 hours

% of patients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.

The latest performance available is November 2017.

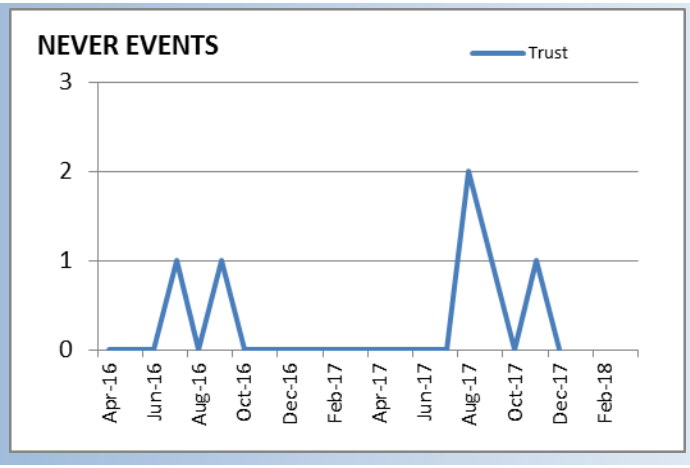
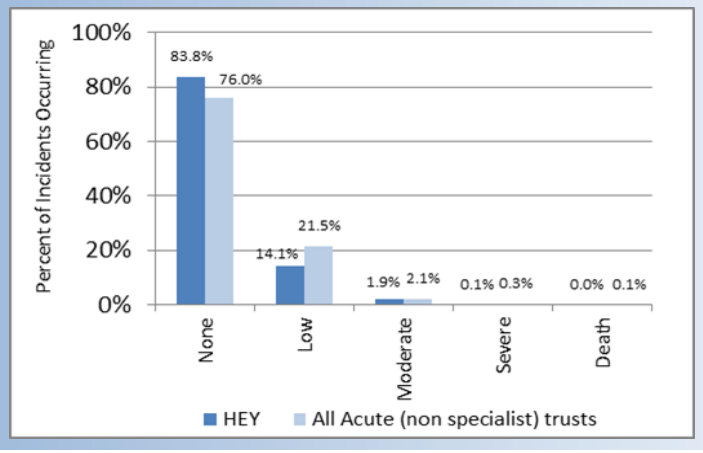
The standard for this indicator is to achieve 90%.

Performance for November achieved this standard at 91.7%



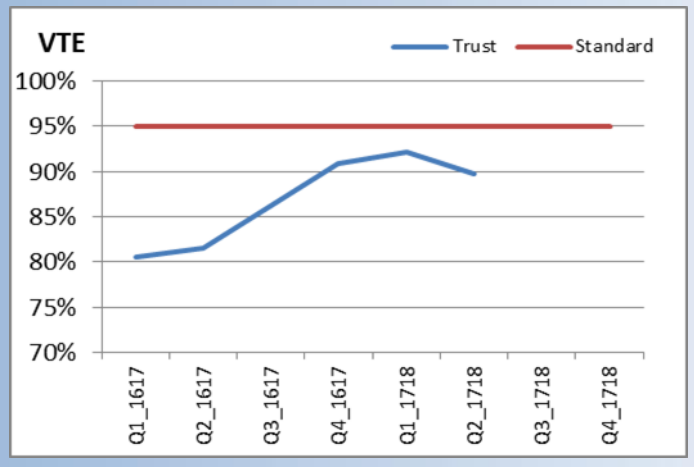
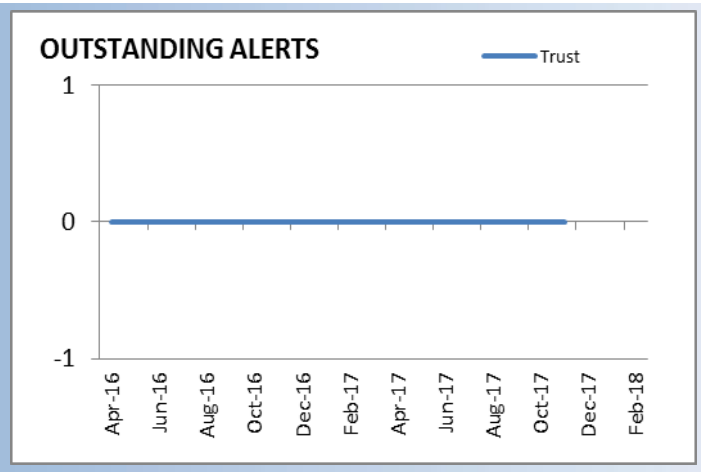
Integrated Performance Report - January 2018

SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Event	Occurrence of any Never Events	The latest available performance is December 2017 There were no Never Events reported during December		Further information is included in the Board Quality report
Potential under-reporting of patient safety	Number of incidents reported per 1000 bed days	The latest data available for this indicator is October 2016 to March 2017 as reported by the National Reporting and Learning System (NRLS). The Trust reported 9,468 incidents (rate of 55.67) during this period.		

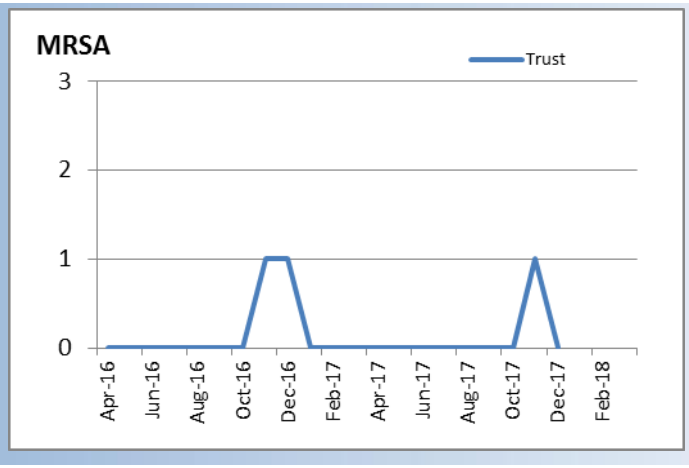
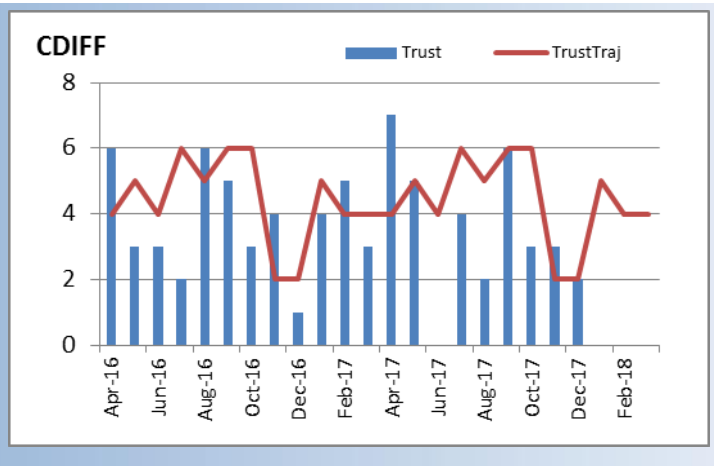
Integrated Performance Report - January 2018

SAFE

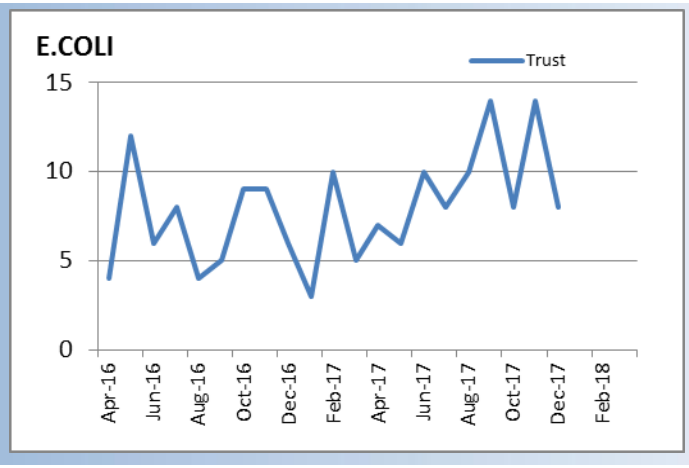
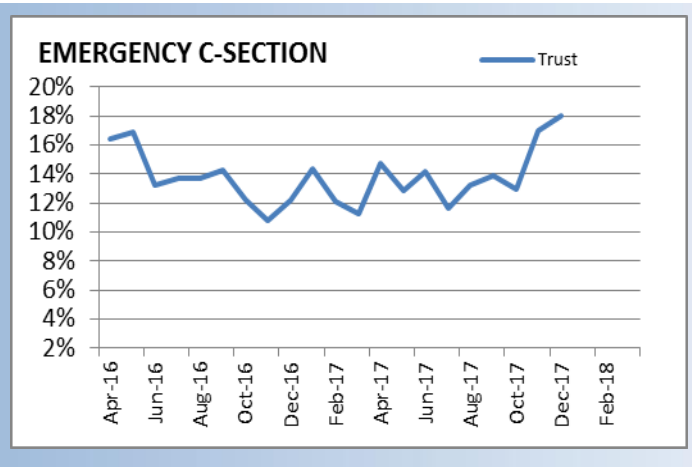
Description	Aggregate Position	Trend	Variation
VTE Risk Assessment	All patients should undergo VTE Risk Assessment	This measure is reported quarterly The Trust is currently failing to achieve this indicator with performance of 89.72% for Q2 2017/18. Q3 performance will be available for February 18 report.		Further information is included in the Board Quality report
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 December 2017. There have been no outstanding alerts year to date.		

Integrated Performance Report - January 2018

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 have been no cases reported during December 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 32 cases year to date There were 2 incidents reported during December which achieved the monthly trajectory of no more than 2 cases		

SAFE

Description	Aggregate Position	Trend	Variation
Escherichia Coli	Number of incidence of E.coli bloodstream infections	There have been 85 cases year to date There were 8 incidents reported during December.	
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 December failed to achieved this standard at 18%	

Further information is included in the Board Quality report

Integrated Performance Report - January 2018

EFFECTIVE

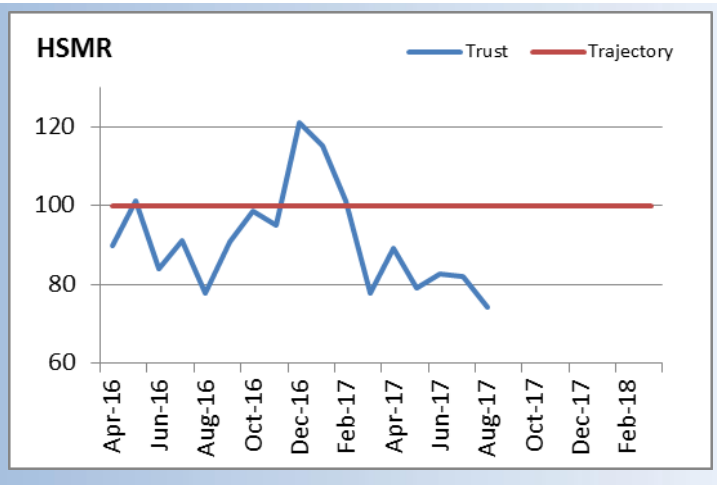
Description	Aggregate Position	Trend	Variation

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

September 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and September 2017 achieved this at 74.1

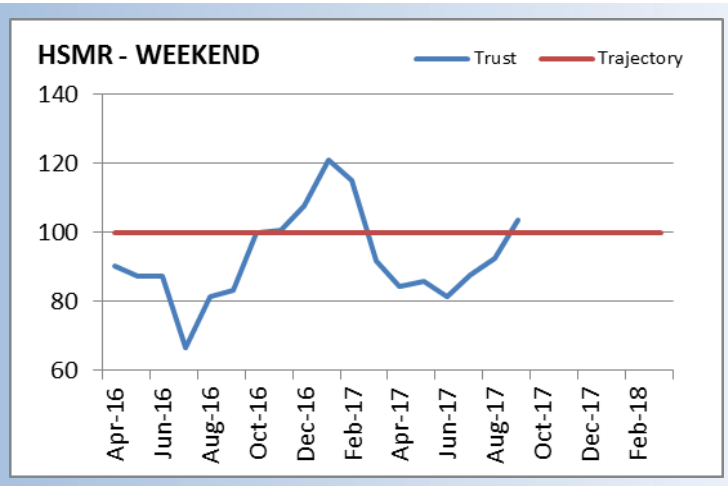


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

September 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and September 2017 failed to achieve this at 103.6



EFFECTIVE

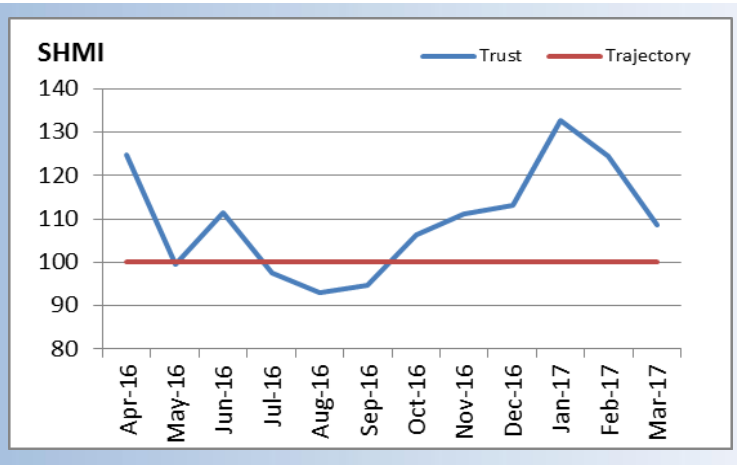
Description	Aggregate Position	Trend	Variation

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.

March 2017 is the latest published performance

The standard for SHMI is to achieve less than 100 and March 2017 failed to achieve this at 109

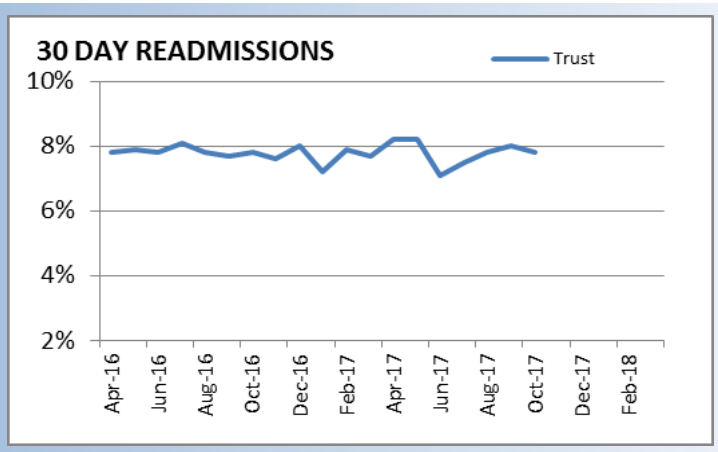


30 DAY READMISSIONS

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

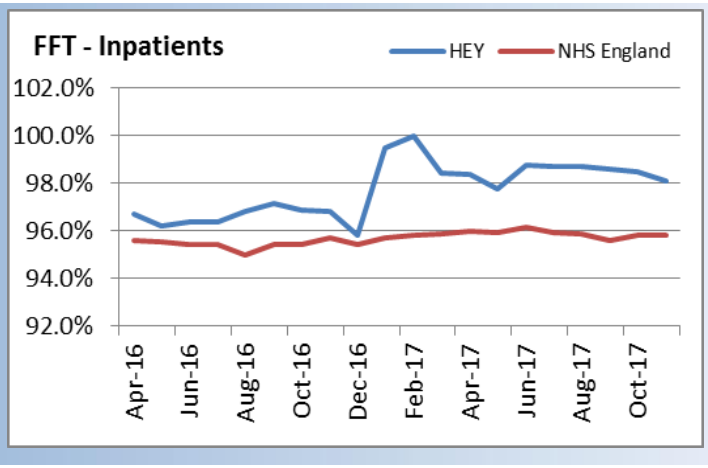
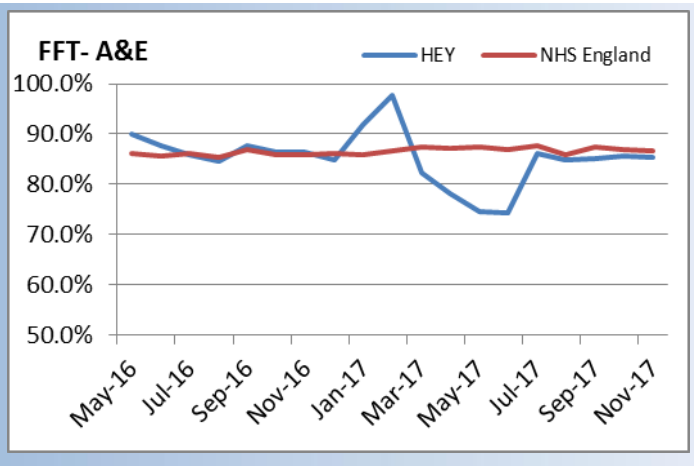
The latest available performance is October 2017

The readmissions performance is measured against the peer benchmark position for 2016/17 to achieve less than or equal to 7.4%. The Trust failed to achieve this measure with performance of 7.8%.



Integrated Performance Report - January 2018

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 November was 98.10% The latest published data for NHS England is November 2017. December performance will be published on 8th February 2017.		
A&E Scores from Friends and Family Test - %	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for November was 85.40% The latest published data for NHS England is November 2017. December performance will be published on 8th February 2017.		

CARING

Description	Aggregate Position	Trend	Variation

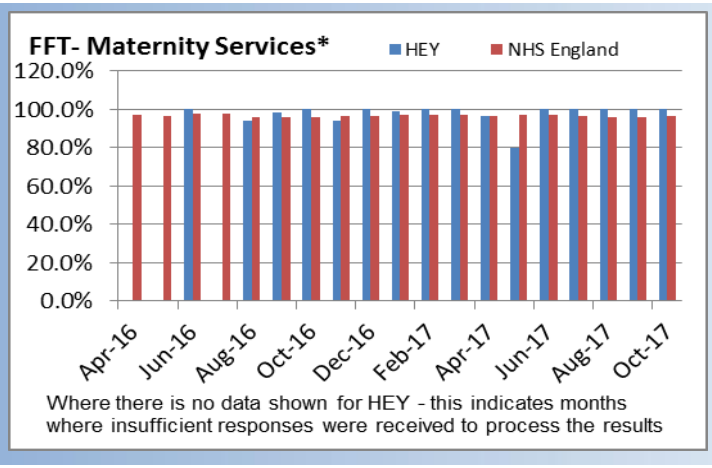
Maternity Scores from Friends and Family Test - % Positive

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

Performance for October was 100%

The latest published data for NHS England is October 2017.

Months with no data for HEY is due to insufficient responses

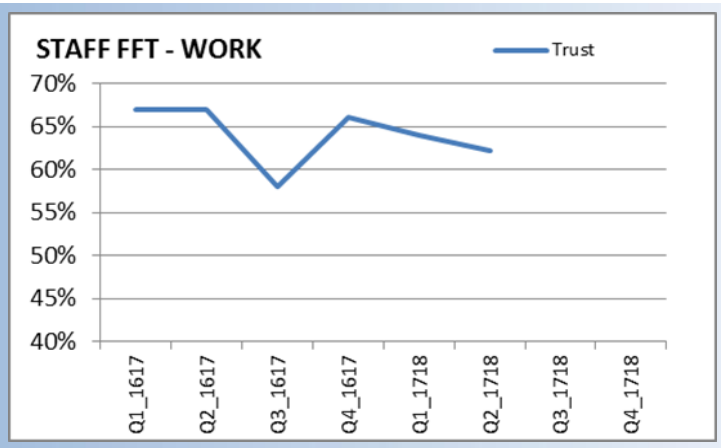


NHS England extended the closing dates of the affected collections to increase the possibility of producing accurate outputs. Unfortunately, it has not been possible to validate the Maternity returns in time for the November publication. Every effort is being made to produce this as soon as possible, subject to data quality considerations.

Relative Position in Staff Surveys

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

The latest Friends and Family Test position is quarter 2 2017/2018 shows that 62% of surveyed staff would recommend the Trust as a place to work, this has decreased from the quarter 1 position of 64%.



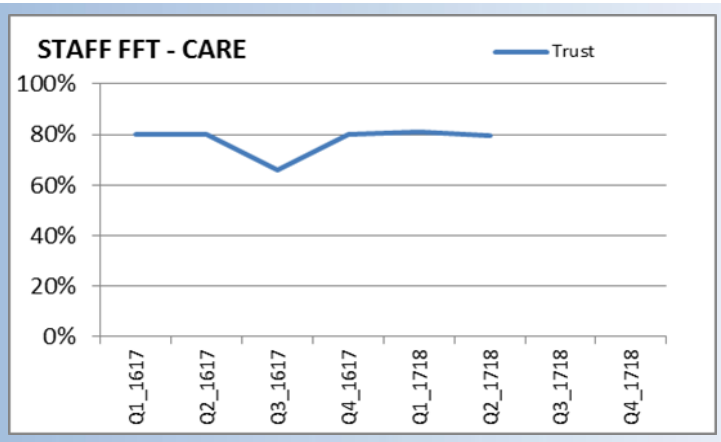
CARING

Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

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

The latest Friends and Family Test position is quarter 2 2017/2018 shows that 79% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has decreased from the quarter 1 position of 81%.

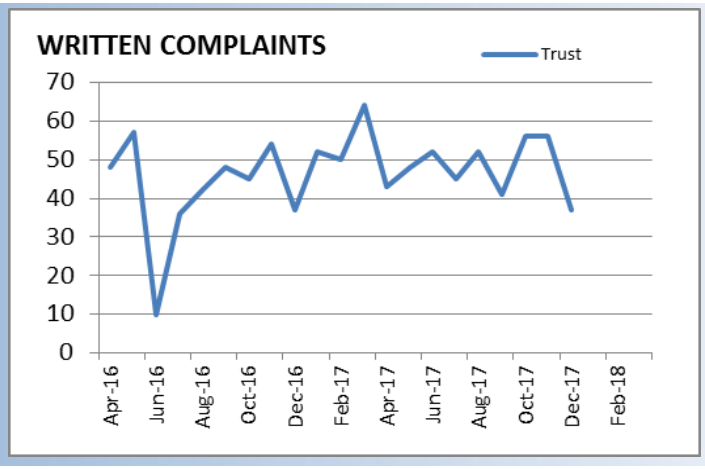


Written Complaints Rate

The number of complaints received by the Trust

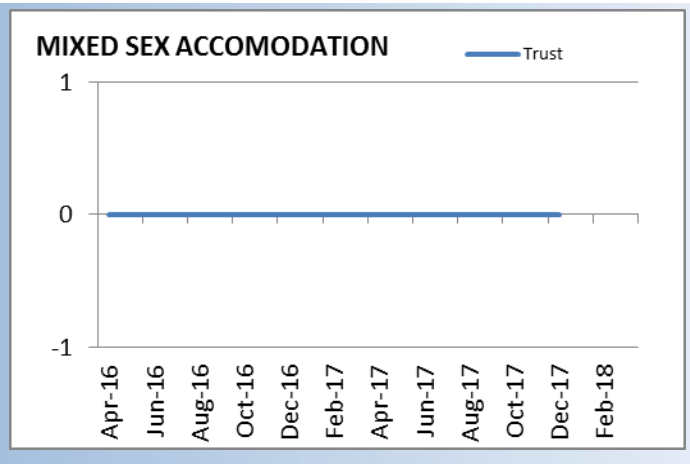
The latest available performance is December 2017

The Trust received 37 complaints during December, this has decreased from the November position of 56 complaints

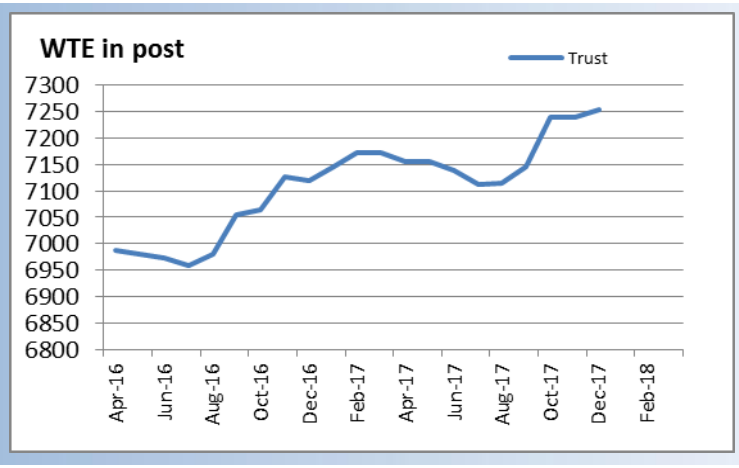
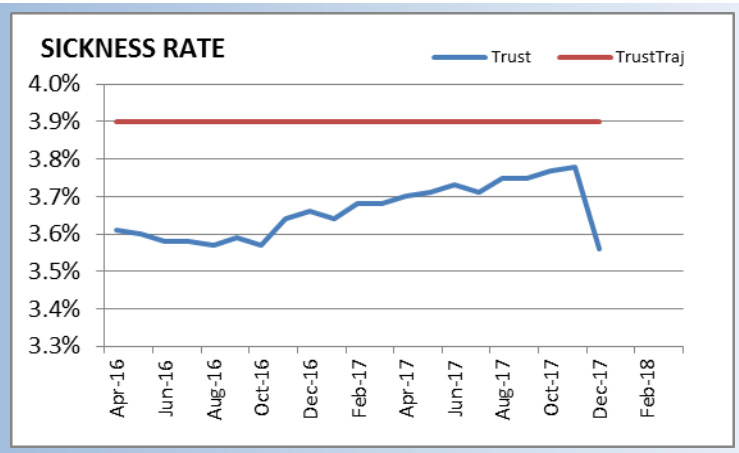


There have been 430 complaints year to date

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 December 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 December was 7253	
Sickness Absence Rates	Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.	Performance for December achieved the standard of less than 3.9% with performance of 3.56%	

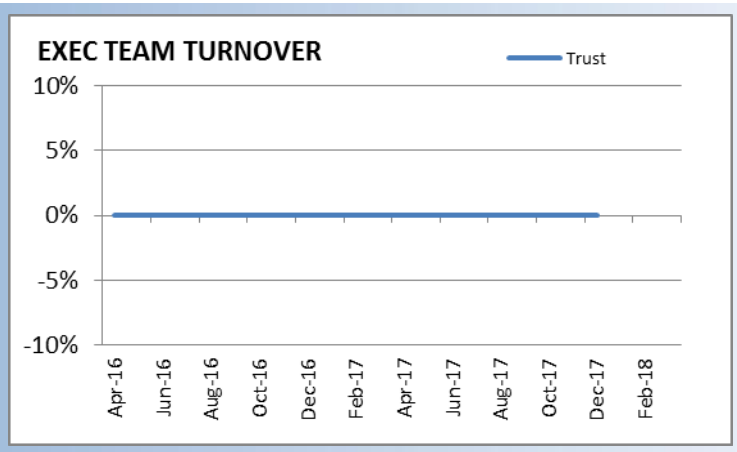
ORGANISATIONAL HEALTH

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.

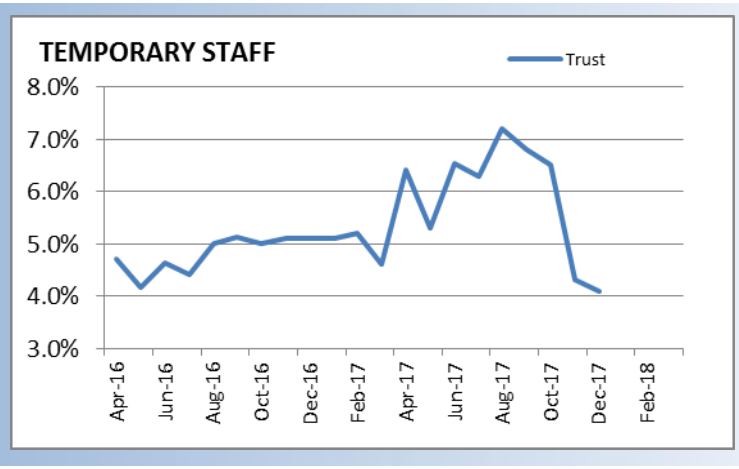


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

December performance was 4.10%



EXECUTIVE SUMMARY: 9 MONTHS TO 31st DECEMBER 2017

Key Points

1. As at the end of December, the Trust is reporting a year to date adjusted deficit of £9.4m which is £8.0m away from the plan.

2. This position includes £3.6m due to non-receipt of STF funding for quarter 3. Excluding STF the Trust is £4.4m away from plan. This is a deterioration of £2.1m in month.

3. The Trust has a gross contract income gain of £6.3m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs, there is a net shortfall of £2.5m which is a £0.5m adverse movement in the month. Although the AIC contract is broadly in balance there is an impact on expenditure as we are above plan on areas with high variable costs eg Wet AMD, Drugs, ED but are below plan on areas where it is difficult to release costs eg outpatients, excess bed days. This is estimated to be costing around £2.25m at this point.

4. The Trust has a CRES shortfall at month 9 of £2.9m. The in month shortfall on CRES delivery is £0.1m. The year end forecast has improved by £0.3m to £11.6m (77%). Each HG has been tasked with increasing year end delivery to a minimum of 80%. £0.4m additional is required to reach 80% at Trust level but if each health group achieved that level the improvement would be £1.2m.

5. Health Group run rate positions have deteriorated in month by £2.1m. CSS HG position deteriorated by £1.1m which was £0.7m more than forecast. The in month position was driven by increased non pay expenditure. Surgery position deteriorated by £0.7m with additional pressures on medical staffing pay and non pay overspends. Medicine's reported in month position shows a small deterioration (-£0.1m) in line with forecast. Family and Women's run rate deteriorated by £0.1m mainly related to non pay issues.

6. Agency spend to the end of December is £7.6m which is below planned levels (£8.0m). The actual December position was £0.3m below plan. However, there has been increased expenditure within overtime, locum sessions and bank and the overall variable pay position is overall similar to the same period last year.

7. Overall forecasts have worsened by £0.9m driven by 2 of the health groups. CSS HG forecast deteriorated by £0.7m and Surgery HG by £0.2m. Medicine and Family & Women's HG forecasts did not change. Both of the deteriorating health group positions were driven by non pay issues and both health groups will need to undertake deep dive analysis of the problems to ensure that they can be managed going forwards, with no further deterioration.

8 Further to the report last month and the recent meeting between the Trust and NHSI representatives on 11/1/18, the Trust is now formally revising its forecast outturn for month 9 and is reporting an outturn deficit of £15m excluding STF (3.5m worse than plan). Including STF, the reported Trust deficit forecast is £11.3m worse than plan.

9 Achievement of the forecast outturn is dependent on a range of actions which the Trust Executive are looking to deliver during the final quarter. More stringent measures to control the rate of non-pay and variable pay are being introduced with immediate effect, whilst other actions, some of which involve external parties, will take longer to crystalise. This work is being supported by a trust wide communications programme which is being designed to promote financial awareness at all levels of the Trust. Weekly updates on the actions being taken have been introduced in order to provide greater assurance to the Chairman and the Non-Executive Directors.

EXECUTIVE SUMMARY: 9 MONTHS TO 31st DECEMBER 2017

Key Points (continued)

10. The reported capital position at month 9 shows gross capital expenditure of £10.1m. The forecast position for capital expenditure is £20.3m. This contains £3m in relation to the proceeds from a land sale. This receipt has not yet been received but the Trust has agreed Capital cover for this transaction with the central Capital team. The forecast position also includes £0.3m relating to PDC recently approved for Cybersecurity.

11. The cash position is extremely challenging as a result of the deficit position. The cash shortfall is expected to be between £15-20m be the end of the financial year and in response to this we have requested deficit support loan funding of £11m during February and March. In addition to the deficit support loan we may have the option to apply for an "exceptional working capital" loan of around £4m. The amount we will apply for will depend on the timing of payments from our Commissioners and whether our financial position improves in line with our revised plans. The exceptional working capital loan is not guaranteed.

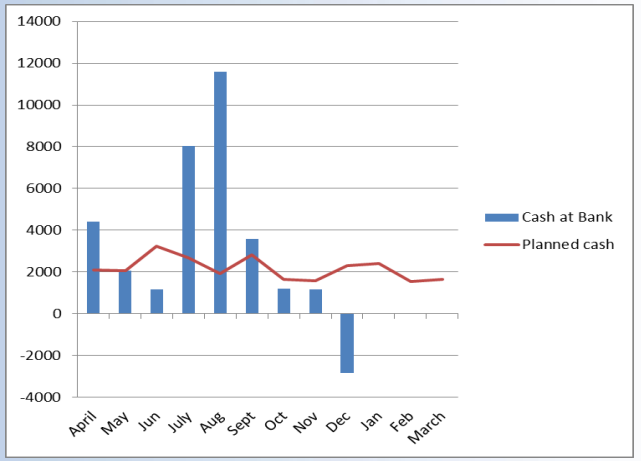
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of December we had negative £2.846m of cash on our balance sheet, comprising of a "book overdraft " of £2.860m and £0.014m of petty cash floats. Although the Trust disclosed an overdraft, it did not overdraw on its Government banking account. We have only managed to pay around half of our Non NHS and NHS suppliers on time during December. Despite this we have managed to maintain good relationships with suppliers and there has been a minimal impact on operations. The outlook to March is one of challenge which we expect will place significant pressure on cash and relationships with suppliers . To manage and restrict the impact on operations we will apply for revenue support loans during February and March, £4m is planned for February followed £7m - £11m in March.

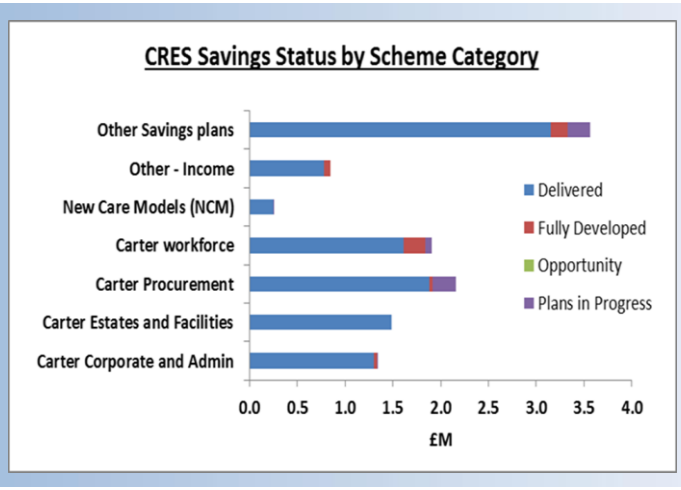


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 9 the Trust has delivered £7.3m of CRES savings against a CRES ytd plan of £10.5m (£3.2m adverse variance)

The Trust is currently forecasting delivery of £11.6m of savings against the plan but is still working 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

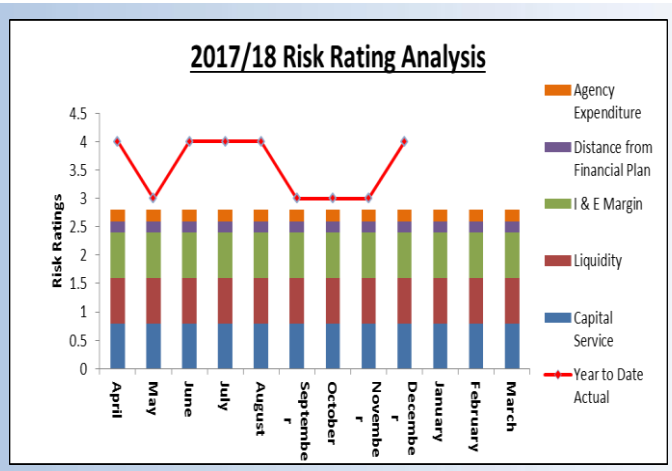
Risk Rating

Financial Sustain-ability Risk Rating

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

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess risk. Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst

As at month 9 the Trust is reporting a deficit of £9.4m against a planned deficit of £1.4m. This has resulted in liquidity , Capital servicing and I&E margin being rated as a 4, with distance from plan rating as 3. This culminates in an overall risk rating of 4.



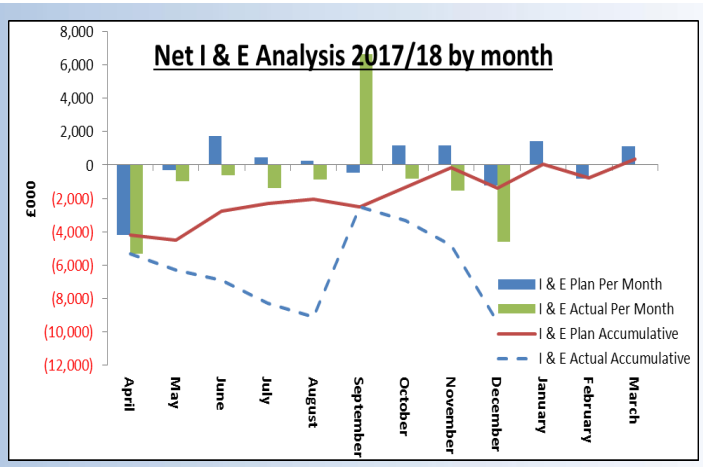
Income & Expenditure

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 a cumulative position of plan and actual.

At month 9 the Trust has delivered a deficit of £9.4m against a planned deficit of £1.4m (£8.0m adverse)

The plan for the full year 17/18 is to deliver a surplus of £0.4m, this includes STP funding.



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
BORROWING REQUIREMENTS

Trust Board date	30 January 2018	**Reference Number**	2018 – 1 – 11.2
Director	Lee Bond – Chief Financial Officer	**Author**	Lee Bond – Chief Financial Officer
Reason for the report	To brief the Board on the Trusts cash position and seek approval to draw further revenue support loans to a maximum value of £15m for the remainder of 2017/18.		

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

1	**RECOMMENDATIONS** The Board is asked approve loan applications to a maximum of £15m for quarter 4, 2017/18 and give authority to the Chief Financial Officer, Chief Executive and Chairman to execute loan documentation and sign Board resolutions.					
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):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
BORROWING REQUIREMENTS

1. PURPOSE

The purpose of this paper is to seek approval from the Trust Board to draw a further £11- 15m of loans during February and March 2018.

2. BACKGROUND

The Trust previously had an Interim Revolving Working Capital Support Facility (IRWCSF) in place. This enabled the Trust to drawdown funds and provided cash flow financing on a monthly basis. That facility was withdrawn in February 2017 and the Department of Health have introduced an alternative process of issuing Uncommitted Loans. Uncommitted loans are term loans wholly repayable on the redemption date.

At their meeting in October the Trust Board approved an application for an uncommitted loan of £4.177m repayable in full in November 2020.

3. BORROWING REQUIREMENTS

The Trust has received its quarter one and two Strategic Transformation Funding (STF) but has not qualified for any STF subsequently. As a result the Trust is now forecasting a revised SOCI deficit incl STF of approximately £11m. Such a significant deficit will translate directly into an equivalent cash shortfall given that the Trusts full depreciation charge is committed on capital expenditure and the level of liquid resources held within the Balance Sheet is considered to be extremely limited.

The Trust is able to access uncommitted revenue support loans to cover its forecast adjusted financial position as at the end of March. If required, additional borrowing is available in the form of an exceptional working capital loan. Access to exceptional working capital is not guaranteed. Based on recent payment history the Trust may need up to a further £4-6m of exceptional working capital funding during March in order to maintain its payment performance with creditors.

It is proposed to take out a loan of £4m during February followed by a further £7m during March. During February there will be a further assessment to determine whether an application for exceptional working capital is required. Each loan will be wholly repayable in 3 years and is expected to carry an interest rate of 1.5%. As part of the loan application process a daily cash flow forecast for the period 17 January to 19 May will need to be sent to NHS Improvement to support the loan applications.

Details of all revenue support loans taken or proposed for 2017/18 are shown in the table below. Accessing loans of £15m during February/ March will bring the total revenue borrowing for the year to £19.177m. NHSI have agreed that the £4.177m taken in November 2017 can be temporarily used to fund the cash shortfall in the capital program that has arisen from the delay in the sale of the land at Castle Hill.

	£
Nov-17	4.177
Feb-18	4.000
Mar-18	7.000
Total revenue support loans	15.177
Potential exceptional working capital loan - Mar	4.000
	19.177

The draw date of the first loan is 12 February and as at the date of writing this paper the detail of the loan agreement and the prescribed Board resolution for all three loans is not available; however they are expected to be very similar to the agreement and resolution required for the £4.177m loan taken in October. The resolution from the October loan is shown in appendix A.

4. RECOMMENDATION

The Trust Board is asked to:

- **a.** Approve further loan applications to a maximum of £15m for the remainder of 2017/18.
- **b.** Authorise the Chief Financial officer to execute the Finance Documents on behalf of the Trust.
- **c.** Authorise the Chief Executive and Chair to sign the Board Resolution on behalf of the Trust Board.

Lee Bond
Chief Financial Officer
21 January 2018

Appendix one – Sample Board Resolution

Statement from the Chair and Chief Executive of Hull and East Yorkshire Hospitals NHS Trust regarding the Trust Board approval of an Uncommitted Loan Agreement.

A paper has been presented to the Trust Board on 3 October 2017 for scrutiny regarding the proposed loan.

This recommends that an Uncommitted Loan totaling £4.177million is taken, repayable by 2020.

We confirm the Board have accepted this recommendation and therefore approve the Uncommitted Loan on behalf of the Trust.

We also:

a) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

b) Authorise the Chief Finance Officer to execute the Finance Documents to which it is a party on its behalf; and

c) Authorise the Chief Finance Officer to sign and/ or dispatch all documents and notices (including the Utilisation Request) in connection with the Finance documents to which it is a party on its behalf.

d) Confirm our undertaking to comply with the Additional Terms and Conditions

We certify that a paper has been presented to the Trust Board for scrutiny regarding the proposed Finance Documents and that this has been circulated to all Trust Board members.

Terry Moran -Chair, Hull and East Yorkshire Hospitals NHS Trust

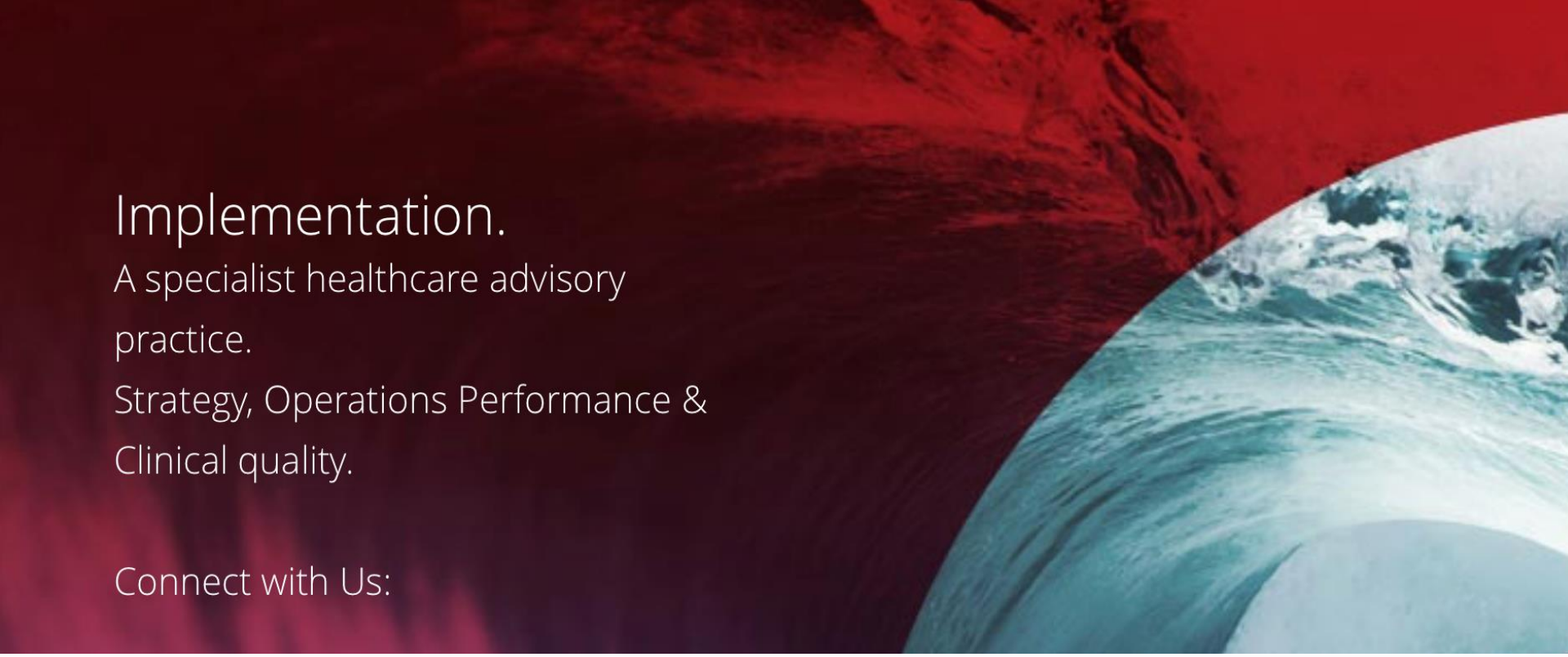
Chris Long - Chief Executive, Hull and East Yorkshire Hospitals NHS Trust

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRACKING ACCESS

Meeting date	Tuesday 30 January 2018	**Reference Number**	2018 – 01 – 12
Director	Ellen Ryabov – Chief Operating Officer	**Author**	MBI Health Group
Reason for the report	To present the summary report from the externally commissioned review from MBI Health Group, to receive their findings of the Trust's Tracking Access issues. This review was commissioned following the identification of some Tracking Access issues, which has been declared as a Serious Incident.		

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

1	**RECOMMENDATION** The Trust Board is recommended to receive and accept this summary report of the externally commissioned review in to the Trust's tracking access issues.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		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): S2 – lessons learned R3 – timely access to care W2 – Governance					
	Assurance Framework BAF 4	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Tracking Access issues were reported verbally by the Chief Executive at the December 2017 Trust Board. The Performance and Finance Committee is receiving monthly updates on the work towards validating cases and addressing the tracking access issues identified by the Trust.					



Hull and East Yorkshire NHS Trust - RTT Rapid Improvement: Diagnostic Report

December 2017

MBI Health Group

MBI Health Group
Delivering Together

Background and Overview

MBI Health Group have been engaged by HEY to provide an external expert opinion on the strength and completeness of the current assurance efforts underway. The main focus to the work being a review of the process and actions currently being delivered to assure the Trust Board, CCGs and NHSI that all patient tracking and associated risk issues identified are being addressed. This work has been extended to include an RTT Recovery diagnostic evaluation:

1. **Data review and further analysis**
2. **The MBI 8 box model**

This review will outline any further areas of concern from both a data quality and operational process perspective.

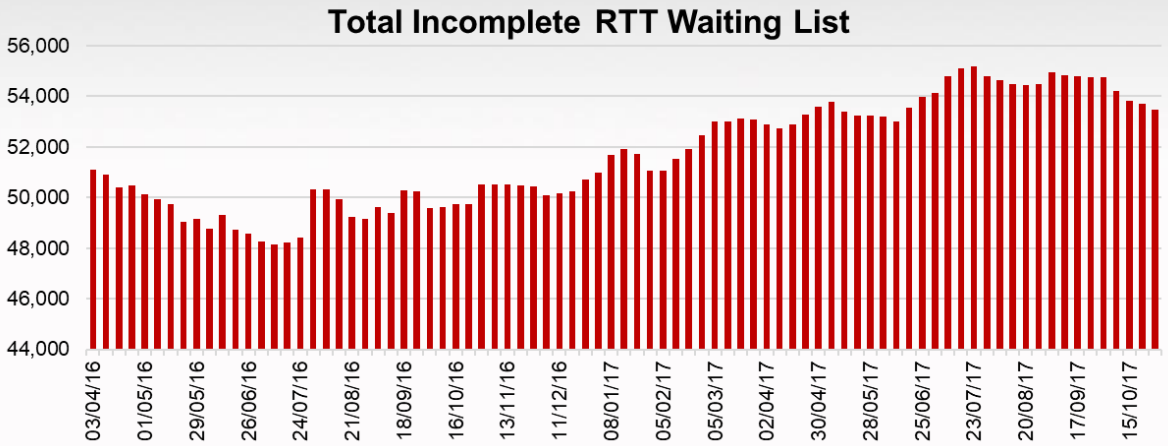
The Lorenzo Go Live in June 2015 saw incompletes rise to 70,000 and then slowly stabilise at 50,000 by early 2016.

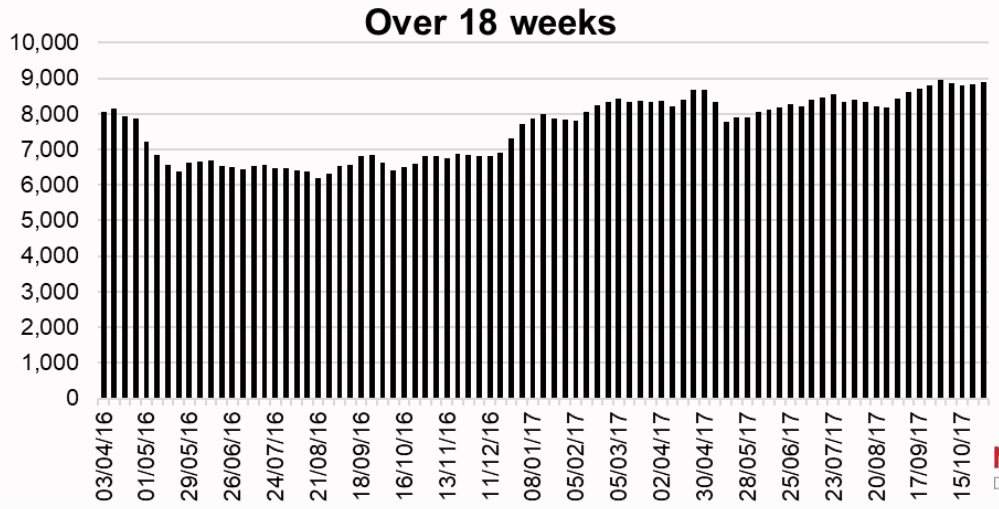
Further reductions were made until the summer 2016 but since then overall numbers have grown.

A fall in numbers in Oct /Nov 2017 has reduced the total list size to 53,500, the lowest in 5 months.

The number of over 18 week waits had mirrored the trends in overall list size but has not seen the recent reductions in Oct/Nov 2017.

The Trust are seeking further assurance following the uncovering of Tracking issues with a number of patient cohorts.





MBI Health Group
Delivering Together

HEY Assurance process

HEY have taken positive steps in addressing the issues discovered with patient tracking. In MBIs experience the approach being taken is the right one. The process that needs to be followed is:

- **Identify** the cohorts of patients at risk.
- **Prioritise** the specialties/disease groups where there is a higher risk of harm
- **Validate** and review each record
- Take **action**
  - Take immediate action following findings of individual reviews
  - Build necessary monitoring and tracking processes and reporting

Proactive Communication
- Patients
- Commissioners
- Staff
- Regulators

The Trust have identified the requirement of 14 wte staff from within the organisation to validate the 54,000 records. Our experience would not recommend the outsourcing of this work as the staff need to be 100% cognisant of the requirement of them and supervised by Trust management. In similar situations where outsourcing of validation work has taken place the supervision has not always been sufficient and therefore subsequent re-validation can result in a lower assurance level and the expenditure associated with this quickly becomes an issue.

These staff would have dedicated space on both the HRI and CHH sites and be supported by an equally dedicated management team who would provide daily progress reports. Using 14wte would support the aim of ensuring that all 54,00 records are validated both administratively and then clinically by the end of March 2018. The delay in identifying the validation staff is the biggest risk to this timeline, the resource requirement for clinical review is also of some concern and will need to be managed appropriately with the relevant clinical teams.

The immediate issues around assurance need to be prioritised. The Trust has set up a Task and Finish Group consisting of Chief Operating Officer, Trust Performance Lead, Head of Patient Administration, Head of Information, CRS Training Lead, and the 4 Health Group Operations Directors. This group needs to ensure that there is adequate capacity beneath them in order to deliver the required changes quickly enough.

Our Report

RTT @ HEY– The Current Scenario

Context

- Trust found issues following Lorenzo go live and thought it had addressed them all
- Subsequently additional patient cohorts have been discovered where decisions have not be actioned due to tracking and non-action issues
- Actions have been taken to address the issues improve tracking, ensure planned outcomes & improve overall visibility.
- The Trust requires further assurance that there are no additional tracking or other issues and to ensure effective management of their waiting lists.

Prioritisation

- Currently Divisions see everything as a priority although there is a clearly a focus on:
  - Financial Stability
  - Delivering the 4 hour Emergency Department target
  - Delivering the 62 day Cancer Target
- The delivery of the RTT target is pressurised by all of the above
- Huge emphasis currently placed on addressing the long term follow up backlog.

System Balance

- Neighbouring Acute Trust experiencing delivery issues particularly NLAG which represents a significant risk to the future performance and viability of some of the Trusts services
- In addition, NLAG activity "leaking" North and their current high payment to Consultants for WLIs creating some issues at HEY as the rate is lower and therefore some staff will not do WLIs at HEY
- New demand management initiatives in place from the Local CCG restricting access for patient who smoke and / or >35BMI

Patient Safety

- Following the identification of Tracking Access Issues, the Trust have identified a further 54,000 patients that need to be reviewed to rule out whether they have come to any potential harm and if a further appointment/treatment is needed
- Requirement for the Trust to be sure that the tracking issues have not resulted in any actual or potential harm to patients
- Approach taken needs to be robust and in some case triggers need to be reviewed

Operational Focus

- RTT "business rhythm" in place and working on a weekly cycle
- The tracking and co-ordination of RTT is delivered by Junior staff. Tracking relies heavily on Band 3 Medical Secretaries
- RTT is seen as a high priority but delivery is not being planned for the longer term and there are still patients waiting in excess of 52wks. No evidence of robust capacity and demand planning to deliver RTT
- Lots of performance challenges elsewhere in the Trust and multiple improvement programmes already underway

Data Quality

- Trust have been proactive in adding the necessary data quality and management reporting into the performance process
- The Trust PTL is exceptionally clean
- Suite of reports aimed at different management levels in place
- Work on-going to fully understand and address all of the current blind spots such as Ward Discharges
- Major worries amongst operational staff who need the further assurance

Scope of Evaluation-Analytics

Field work is reinforced through detailed analysis of RTT performance using the following lines of enquiry.

1. Outpatients
- Current (new outpatient) PTL sorted by specialty and weeks waiting (1st appointment) including urgency and appointment dates;
- Current follow-up outpatient / diagnostic) PTL sorted by specialty and weeks waiting including urgency appointment dates;
- Post treatment outpatient waiting list (non-RTT) sorted by due date to be seen;

2. Inpatients
- Current (RTT admitted) PTL sorted by weeks waiting (including Urgency and TCI date);
- Current Inpatient Waiting list (RTT and Non-RTT);

3. Planned
- All patients on a planned (including diagnostic surveillance) waiting list sorted by specialty and due date to be seen;

4. Data Quality Checks
- Previous Outcome “DNA” with no future appointment booked (current PTL);
- Previous outcome “Discharge” with no future appointment booked (current PTL);
- Duplicate registrations in the same specialty (current PTL);
- On a planned WL with an open RTT clock (current PTL);
- TCI dates in the past;
- Unknown clock starts;
- Code 98’s & 99’s;
- Patients on “active monitoring” who have not had an appointment in the last 6 months or an appointment booked in the next 6 months;
- Un-outcomed clinic appointments > 24 hours.

5. Review of Key PTL scripts
- Review of scripts used to produce the Trust wide PTL

RTT Evaluation Framework

MBI have reviewed the following 8 RTT competency areas as part of its evaluation of the current position. The following highlights the key outcomes of each area in priority order of sequence in which they should be addressed by the Trust.

The main focus of the RTT evaluation was concentrated on the specialty areas viewed by the trust to be the most challenged. These being Urology, Neurosurgery, T&O, Cardiology, Colorectal, Ophthalmology and Cancer. However parts of the review crossed over into other specialties where conversations included their management staff or with staff with generic functions.

Competency

Leadership

- Reprioritisation of RTT
- Tracking Leadership and accountability
- RTT Business Performance Rhythm

Data Quality

- Clean up-to-date waiting list reports
- Validation Lists
- Unoutcomed appointments
- Advanced dashboards

Booking & Scheduling

- Chronological Booking
- Standardised practice
- Corporate Benchmarks

Governance

- Policy Documents
- Compliance Audits
- Standard Operating Procedures

Competency

Training

- Training Modules
- Self-Service On-Line Resources
- Scenario-led training

Patient Safety & Clinical Governance

- Building ownership of access targets as a primary quality indicator
- Planned patients
- Non-RTT Follow Ups

Clinical Admin

- Turnover rates
- Use of Temporary Staff
- Policy Handbooks
- Front Office Configuration

Capacity & Demand

- Balanced demand and capacity plans and schedules
- Clinical variation reports
- Conversion Ratios and ROTT

At a Glance

The Trust has worked hard on both improving RTT performance and assuring the appropriate management of tracking of patients. It has made progress on many specific areas such data quality reporting and the introduction of a standardised approach to the management of RTT. However the Trust holds both a clinical and performance risk on RTT, therefore further assurance and improvement work is required to ensure that all patients have been appropriately managed.
There is awareness across the organisation on behalf of senior management staff that RTT sustainability is possibly affecting clinical outcomes, increasing clinical variation and increasing costs of treatment. Clinical administration processes and structures are variable and RTT policy compliance is either not measured or consistently achieved. Currently, many staff within the HGs see everything as a priority which is not manageable. The Trust must re-set RTT as a key priority for everyone in order to improve.

Within the recommendations, there are three component phases that require focused implementation.

Of critical importance is the stabilisation of the organisation's position relating to:

- Data quality and validation, particularly of the 54,000 records found to be at risk;
- Satisfy the Board that no harm has come to patients within these backlog cohorts;
- Agree priorities to bring forward current improvement work to impact RTT;
- Ensure competency of staff delivering key RTT tracking processes.

As the remedial actions take effect, the Trust can use clean data to:

- Agree trajectories that are accurate and clinically owned;
- Particularly, agree processes for the removal of the legacy backlogs;
- Accelerate demand management schemes such as Advice and Guidance;
- Develop clinically led and commissioner agreed capacity and demand schedules.

Finally, the Trust must address its key strategic challenges relating to income, workforce resilience, clinical utilisation and patient experience.

Immediate Recommendations

- Validation of the identified "at risk" cohorts (Clinical risks around the management of long term follow ups as well as those identified from clinic and ward discharges)
- Ensure the RTT grip from an information perspective translates into appropriate management action
- Continue to progress with the programme of improvements
- Escalate the importance of RTT. No more 52wk waits
- Look to establish a strategic approach to Demand & Capacity planning. There is a high risk to the current trajectory due to capacity not meeting job planned activity .
- Refresher training and competency test for all staff with regards to the use of all RTT access plans
- Need to have one source of the Truth. Staff using different lists to book from with no one source of the Truth. Some use the Trackers other use the PTL.
- Increased process scrutiny required to ensure process adherence i.e. are staff doing everything that the are meant to be doing, how is this measured and reported?

Moving Forward

Improvement & Prioritisation - Trust Summary of Requirements

The recovery programme must focus on 3 distinct phases:

1. **Stabilisation – These are some immediate actions HEY needs to take without delay;**
2. **Sustainability – There are a number of activities that are more complex to implement and needs to have strong clinical and organisational engagement across the Trust;**
3. **Strategic Challenge – Wider organisational issues set in the context of the overall local and national health and social care system driven by the Trust Board.**

Stabilisation - Impact and Immediate Action
0-3 months

Sustainability- Short Term Actions
2-8 months

Key Strategic Challenges
6-12 months

Improvement & Prioritisation

MBI have identified that immediate and remedial action is required pending further conversations with Trust Leadership

1. Leadership

System-wide reset of RTT as a priority

Develop plan and strategy for the management of long waiters

2. Validation & Data Quality

Validatie and take action on the 54,000 at risk patients and ensure progress is tracked daily.

Develop a Discharged no appt report

3. Booking

Review patient communication processes to ensure all in coming requests are captured

Address the referral triage turnaround time

4. Governance & Harm

Board Awareness

Access Policy Correction

Access Policy Compliance Audits

Agree strategy for harm review approach within all backlog cohorts

5. Training

Training Refresh to existing staff & competency assurance

Focus on staff involved in tracking

Develop a competency test

Stabilisation - Impact and Immediate Action 0-3 months

Begin to plan for good RTT performance – stop the fire fighting

Undertake the validation of the "54,000", develop a plan to ensure robust tracking

Produce a plan specifically for long waiting specialties

Improvement & Prioritisation: Continued

MBI have identified where subsequent actions will be needed

Operational resilience

Maintain the weekly rhythm and grip

Assuring staff competency

Remove the backlog

Expedite the clinical admin role redesign

Demand Management planning

Planning to meet the demand particularly in OP but for all referrals not just GP

Utilisation review of clinical space and redistribute where needed

RTT Strategy

Implementation of long waiter recovery strategy

Patient Safety

Focus on all patients

Process adherence audits

Education

Sustainability - Short Term Actions
2-8 months

Complete competency assurance on all staff tracking patients

Bring forward the Clinical Admin Redesign to bring new clarity of roles

Re-distribute and make effective unused/poorly utilised clinical capacity

Begin to develop system wide approaches to demand & capacity issues

Improvement & Prioritisation – Continued

MBI have identified where strategic challenges are emerging

Strategy

Workforce & training

Deliver the demand and capcity strategy

Clinical Utilisation Management

Alignment of Job Plans to the challenges ahead

New/FU appt introduce new ways of working

Capacity & Demand

System wide RTT and Demand Management strategy

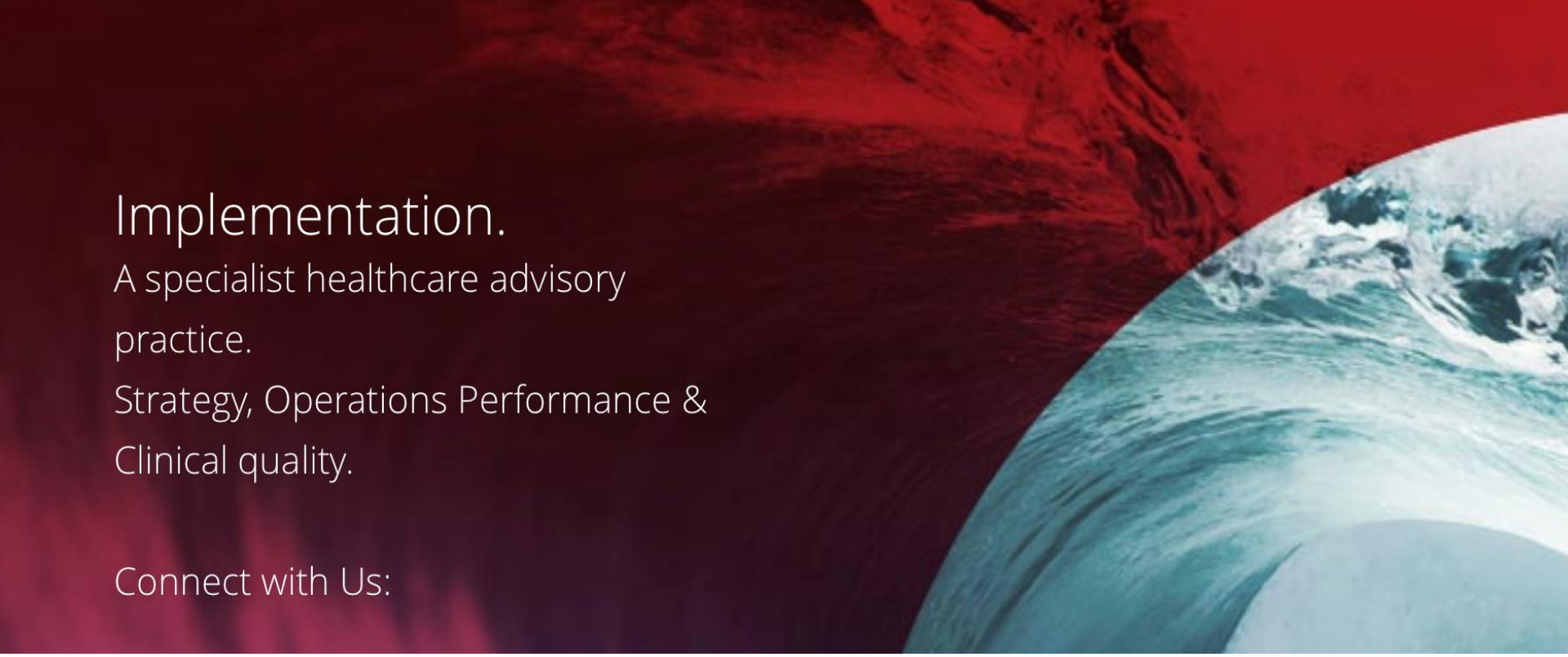
Patient Engagement

Quality Improvement Programme

Patient Literacy

Strategic Challenges
0-12 months

- **Match Job plans to the recovery trajectory**
- **Ensure system wide accountability for the delivery of RTT**
- **Engage with patients and the public**
- **Recruit and retrain sufficient staff to deliver the plan**



Hull and East Yorkshire NHS Trust - RTT Rapid Improvement: Diagnostic Report

December 2017

MBI Health Group

MBI Health Group
Delivering Together

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

27 NOVEMBER 2017, THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Drury	Deputy Director of Finance
	Mr S Nearney	Director of Workforce and OD
	Mr S Evans	Deputy Director of Finance
IN ATTENDANCE:	Dr R Patmore	Medical Director –Clinical Support (Item 8.3)
	Mrs R Wrightson	Head of Finance – Clinical Support (Item 8.3)
	Mrs R Thompson	Corporate Affairs Manager

NO. ITEM **ACTION**

1 APOLOGIES

Mrs T Christmas, Non-Executive Director

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 MINUTES OF THE MEETING HELD 30 OCTOBER 2017

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

4 MATTERS ARISING FROM THE MINUTES

Item 4 Hull CCG winter plan – Mrs Ryabov informed the committee that work was ongoing with CHCP to finalise the plan. She also advised that the Trust was not opening a winter ward and that more work would be carried out at the front end of the system.

Mr Nearney to bring the business case to the meeting once approved at Executive Management Board – January 2018 **SN**

Mr Evans to circulate the FIP2 schemes as discussed in the PEB meeting. Mr Gore to be invited to the next PEB meeting. **SE**

Item 8.2 Lord Carter of Coles – update regarding IDL task and finish group to be received. **ER**

4.1 LOAN KITS

Mr Bond presented the report which highlighted non pay spend in orthopaedics that fell outside of the standard procurement practices. HRGR were reviewing purchasing processes nationally as well as with the Trust with a view to tightening up control to reduce wastage.

Mr Gore asked about the impact and Mrs Ryabov informed the Committee that the overspend is greater than expected, more complex than first thought, the Trust had spent more money but was not getting the income back. The budget setting process had not been robust enough so the impact had been greater than expected.

Mr Bond said that improvements were being seen, control was much better and costs were coming down.

Resolved:
The Committee received and accepted the report.

5 ACTION TRACKING LIST

The action tracing list was reviewed and the following items were removed:
Orthopaedic case mix
FIP2 schemes **RT**

Benchmarking report relating to non-pay costs had not yet been received as Mr Bond was still waiting for further information from other Trusts **LB**
E-roster business case – would be received in January 2017 **SN**

6 WORKPLAN 2017/18

Mr Hall asked that financial planning be added into the workplan for 2017/18 **CR**

7 DEMAND REPORT

Mrs Drury reported that at week 31 there had been a 4.2% reduction of referrals overall, with 5.4% reduction in Hull CCG GP referrals and 3% reduction in the East Riding GP referrals. Similar patterns had been experienced on the South Bank. There had been an increase in electronic referrals.

Overall elective activity was 5% below plan and was mainly in colorectal surgery, plastic surgery, interventional radiology and clinical haematology.

The Trust is no longer contracted by the CCGs for the provision of the Minor Injury Unit in Beverley so they would no longer be included in the figures. The average attendances for October 2017 totalled 21 compared to the YTD average of 384.

At the end of October 2017 elective activity was 5% below plan and was mainly in colorectal surgery, plastic surgery, interventional radiology and clinical haematology. All of these specialties were showing much lower rates of activity compared with last year.

Outpatients below plan at 2.8% for follow-ups and 6% below plan for new outpatients. Ophthalmology follow-ups were below plan but the plan did not include the additional activity to reflect the backlog.

Non electives were overall 1% above plan.

At month 7 the overall contract trading position as if all commissioners were on a PbR basis is an overtrade of £6.8m prior to adjustments. The main areas of overtrade relate to drugs, non-electives and outpatients.

Resolved:
The Committee received and accepted the report.

7.1 REVIEW OF ACTIVITY LEVELS 2014-15 TO 2017-18

Mrs Drury presented the paper which highlighted the level of admitted activity undertaken over the last 4 years.

The information highlighted that overall elective activity was below last year's levels by just over 3%, non-elective activity up by 1.8% and an overall reduction of 1.1%. Clinical Support elective activity was 7% lower than last year, with Clinical haematology particularly being under review as this was 13% lower than last year.

Family and Women's elective activity was 4% lower than last year, mainly in plastics following staffing changes. Plastic surgery non elective activity was above plan by 16%.

Non elective activity is overall 5.4% above plan which included obstetric and midwifery with changes in activity recording in maternity services.

There was a discussion around having a clear understanding of the Trust's Use of Resources, broken down by Health Group. Follow up appointments were also discussed and how these could be done in different ways such as telephone, rather than face to face. Mr Bond clarified that follow ups cost the Trust less and less time was allocated for the sessions.

Resolved:
The Committee received and accepted the report.

8 CORPORATE FINANCE REPORT

Mr Bond reported that at month 7 the Trust was reporting a deficit of £3.3m, which was £2m behind plan. This includes a £1.2m deficit due to non-receipt of STF funding. Reserves had not changed in month, income had also remained the same, however, there had been a deterioration in CRES and Health Group run rates.

The main issues were in the Clinical Support Health Group who's position had deteriorated by £600k in month.

Mr Bond assured the Committee that the Commissioners were willing to help with the Trust's financial situation and the contract with them specified a shared risk.

The Trust's cash position was under severe pressure which was causing problems with servicing creditors in a timely way.

There had been a delay in the land sale at Castle Hill Hospital and Mr Bond advised that this would hopefully be covered by the Centre until the sale went ahead.

Resolved:
The Committee received the report and agreed to escalate the Trust's cash flow position to the Board in December 2017. **SH**

8.1 CRES REPORT

Mr Bond presented the report and advised that the Trust was reporting actual delivery of £5m against a plan of £7.9m at month 7. This was 62% delivery. Current year end forecast was at 76%.

Resolved:
The Committee received and accepted the report.

8.2 HEALTH GROUP RUN RATE REPORT
Mr Bond presented the report which summarised the key drivers in the Health Group overspend. The overall position showed a deficit of circa £12m with a slightly improved position at the start of 2018/19.

A main issues were CRES shortfalls, hard to recruit staff and clinical activity levels being below plan.

Resolved:
The Committee received the report and expressed their concern regarding the Health Group underlying run rates.

Dr Patmore and Mrs Wrightson joined the meeting at 3.25pm

8.3 CLINICAL SUPPORT SERVICES – FINANCIAL POSITION
Dr Patmore reported that the variance in the Clinical Support Health Group's financial position was mainly due to unidentified CRES, issues in Pathology (namely recruiting pathologists which is a national problem) and other medical staffing.

There were issues around delivering activity to maintain services with staffing issues and having to source expensive agency replacement staff and in some cases outsource the whole service.

There were significant financial pressures in radiology, due to sickness and maternity leave, as well as an increase in complex cases.

Dr Patmore also reported that the Trust had lost staff in oncology and due to staffing issues the Health Group had to bring locums in on premium rates as the specialist roles were extremely difficult to recruit. Compounding the issues were additional patients from the South Bank. There was a discussion around working more widely with the health community and reviewing system-wide issues together.

Mr Bond added that he was meeting with the Clinical Support Health Group to pick up the issues and review the cost pressures it faces.

Resolved:
The Committee thanked Dr Patmore and Mrs Wrightson for their attendance at the meeting.

Dr Patmore and Mrs Wrightson left the meeting

8.4 FINANCIAL PLAN 2018/19
Mr Bond presented the Trust's outline financial plan for 2018/19.
He reported that there were significant in-year 2017/18 financial pressures, £10.1m latest assessment, activity levels were increasing and the Trust was likely to overtrade against all contracts, there could be some winter funding and discussions had begun with the Commissioners.

Mr Bond outlined the planning process and CRES targets to achieve in

2018/19, as there was an expectation that we have to improve 2017/18 planned position by £5m.

There was a discussion around how the Trust could deliver this and at what cost to the system, taking into account the underlying run rates to be recovered by the Health Groups.

Mr Bond advised that the next steps were to progress internal planning process using intelligence from STP/External planning discussions, finalise CRES targets, progress discussions with the Centre as well as keeping a grip on the remaining 4 months of 2017/18.

Resolved:
The Committee received the presentation.

9 PERFORMANCE REPORT

Mrs Ryabov presented the report and advised that the Emergency Department had delivered above 90% in month and was still above the national position. Mrs Ryabov also reported that ambulance arrivals were variable and work was ongoing.

Referral to treatment times was problematic at 83.7% which was below trajectory. The Trust had been working with MBI to review the tracking access planning to prioritise patients and put plans in place to reduce the backlog.

There had been 17x 52 week waits and these were mainly due to tracking access issues.

There were 22 patients who breached the Breast Symptomatic cancer standard, however, 17 of these were due to patient choice. 31 day subsequent cancer had breached but this was due to the small numbers involved. The 62 day standard performance was improving and the 62 day screening had 2 breaches due to the complexity of the cases.

There were still issues with diagnostics performance and the implementation of the new scanner could cause further disruption. The Trust was discussing more complex cases with York.

An external agency MBI had been working with the Trust to review the Tracking Access issues and give external assurance that the action plans were being implemented. They were due to present their report to the December 2017 Board meeting and a task and finish group had been set up to carry out the further validation taking place.

Mr Gore asked about the 20 RIP patients and Mrs Ryabov assured him that the validation work had begun. Mr Gore stated that the Lorenzo system should fail safe and this should be considered in the plans.

Resolved:
The Committee received and accepted the report.

9.1 ENDOSCOPY DIAGNOSTIC UPDATE

Mrs Ryabov presented the update and advised that the demand for endoscopy services had increased by 9% which was 1,738 patients.

Work was ongoing to reduce the backlog. There had been staffing issues with a member of staff retiring, but a new colorectal surgeon had been appointed. Mr Bond asked about the case mix and Mrs Ryabov stated that more complex cases were being carried out which was also impacting on the service.

Resolved:
The Committee received and accepted the update.

10 AGENCY SPEND PROGRESS REPORT

Mr Nearney presented the report which highlighted that there had been little change in month and that the Trust was still below its trajectory.

There was a discussion around agency staffing expenditure and bank staffing costs. Mr Nearney agreed to add this into the report for the next meeting in December 2018. **SN**

Mr Gore expressed his concern regarding the level of Junior Doctors allocated by Health Education and Mr Nearney advised that he was meeting with them with the Chief Executive and Chief Medical Officer to discuss further.

Resolved:
The Committee received and accepted the report.

10.1 JOB VACANCIES WITHIN THE TRUST

Mr Nearney presented the report which highlighted the staffing gaps for key personnel within the Trust such as nurses, doctors and junior doctors. He reported that Mr Wright would present the nursing issues at the next Board Development session to outline the problem.

There was discussion around attracting new staff and remuneration packages and negotiations with potential new doctors starting to work at the Trust.

Resolved:
The Committee received the report and agreed:

- The report would be received quarterly **SN**
- Midwifery would be split out of the nursing element **SN**
- ODPs to be highlighted **SN**

11 CAPITAL RESOURCE ALLOCATION COMMITTEE

Mr Bond presented the report. Mr Gore asked if there were any Fire issues and Mr Bond advised that fire safety was a priority and a fire based engineer would be appointed at the Trust.

There was discussion around car parking for staff following demolition of the Haughton building and receiving an end of support notice from Phillips for the Trust wide patient monitoring equipment.

Mr Bond agreed to clarify the Telemetry costs for replacing the units. **LB**

Resolved:
The Committee received and accepted the report.

12 BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the Board Assurance Framework to the Committee. She advised that the BAF would be informing the Board Development discussions with the Board strategically reviewing areas of assurance and any gaps.

Ms Ramsay highlighted BAF 7.3 relating to the Trust's cash flow position. This risk had been reduced but it was agreed to increase it due to the cash position deteriorating in month.

The Board would also be discussing risk appetite and which risks are acceptable and at what level.

Resolved:
The Committee received and accepted the report.

13 ITEMS DELEGATED BY THE BOARD

There were no specific items delegated by the Board.

14 ANY OTHER BUSINESS

Mr Bond reported that the Trust had been given £3m in capital funding to build a new diabetes research centre. This would be on the site of the Wilson Building next to the Women and Children's hospital.

Ms Ramsay informed the Committee that the Trust had declared a Never Event involving oral medication being given intravenously. She reported that the patient had not been harmed and that the CCG and the CQC had been informed.

15 DATE AND TIME OF THE NEXT MEETING:

Monday 18 December 2017, 2pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE MINUTES
18 DECEMBER 2017, 2.00 PM – 5.00 PM

PRESENT:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director (from 2.45 pm)
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD (from 3.05 pm)
IN ATTENDANCE:	Mrs R Thompson	Corporate Affairs Manager (Minutes)
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance

NO.	ITEM	ACTION
1.	**APOLOGIES** Apologies were received from Mrs A Drury, Deputy Director of Finance	
2.	**DECLARATIONS OF INTEREST** There were no declarations of interest.	
3.	**MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2017** **Item 4 - Matters arising –** update regarding IDL task and finish group to be received. **Item 7 - Demand report** – there had been 4.2% reduction in referrals and not 42%. **Item 8 – Corporate Finance Report** – the deficit was £2m behind plan. **Item 11 – Capital Resource Allocation Committee** – para 2 – 2 spelling mistakes: notice and Phillips. Following the above amendments the minutes were approved as an accurate record of the meeting.	**ER**
4.	**MATTERS ARISING FROM THE MINUTES** Mr Gore and Mr Bond to meet regarding the Trust's balanced scorecard and to check with Mr Snowden to ensure work was not being duplicated. Mr Nearney reported that the meeting with Health Education England to discuss the Trust's allocation of Junior Doctors had gone ahead. Mr Nearney advised that Hull was not the first choice of some doctors and that other ways of recruiting staff were being reviewed.	**MG/LB**
5.	**ACTION TRACKING LIST** Mr Bond had clarified the Telemetry position to Mrs Ryabov. This item to be removed from the tracker. Mr Gore requested the outcome reports from the Getting It Right First Time initiative to date. The reports would be forwarded by Mrs Bates' Team.	**RT/CR**

6. WORKPLAN 2017/18

The Workplan was received by the Committee. Ms Ramsay advised that the draft 2018/19 Workplan would be circulated at the next meeting for review. **RT**

The agenda was taken out of order at this point

8.1 AGENCY REPORT

Mr Nearney presented the report and advised that there had not been much change since last month with the Trust coming in slightly under the £7m budget. The key areas of expenditure were in Surgery Health Group due to ODPs, theatre staff and junior doctors and Medicine Health Group due to medical consultants and junior doctors in elderly and acute services.

Mr Nearney reported that one new Consultant Interventional Radiologist would be joining the Trust on a locum contract and there was another potential trainee who will qualify next year as a Consultant to join the Trust.

There was a query raised around the 25% reduction in agency costs and Mr Evans agreed to clarify this position. It was also agreed to compare agency staffing costs with bank costs for the next meeting in January 2018 to see if the reduction in agency costs is due to a move to using bank and overtime. **SE/SN**

Resolved:

The Committee received and accepted the report.

- Mr Evans to clarify whether the 25% reduction in agency pay had been achieved **SE**
- Agency costs to be compared with bank and overtime in the next report January 2018 **SE/SN**

9.1 DEMAND REPORT

Mr Evans presented the report which showed that elective referrals were still below plan and less than last year. This was both across the North and South Bank. Elective activity was 4.5% below plan and ED was above plan by 2%.

ED Performance had achieved 94.4% in Q1, 92.8% in Q2 and 94% in October.

Mr Evans reported that some areas of non-elective activity were below plan. The Service Level Agreement Management (SLAM) results were showing an overtrade (against Payment by Results) of £6.4m. He advised that discussions had started with the Commissioners regarding 2018/19.

Resolved:

The Committee received and accepted the report.

10.1 CORPORATE FINANCE REPORT

Mr Bond reported that at Month 8 the Trust was in deficit by £4.8m, which was £4.7m worse than plan. This includes non-receipt of STF funding for October and November due to non-delivery of the plan.

The Trust had a gross contract income gain of £5.9m. After adjustments to

Health Group income allocations and reflecting pass through drugs and devices there was a net shortfall of £2m.

Health Group run rate positions had deteriorated by £0.9m, principally in Cancer and Clinical Support Health Group and Surgery Health Group.

Mr Bond advised that NHS Improvement had emailed the Trust regarding its financial situation asking the Trust to develop a recovery plan. Mr Bond reported that the Trust would have to limit its elective activity to maintain performance in ED. Winter pressures were a concern to the worsening position.

Resolved:
The Committee received and accepted the report.

10.2 CRES REPORT

The Trust needs to deliver a CRES program of £15m to support delivery of its control total for 2017/18. The report confirmed the position that around £13.8m of schemes have been identified with £1.2m remaining unidentified. This is a small improvement of £0.2m in month reflecting the difficulty to identify new schemes. When the schemes are risk adjusted, the total plan identified is £12.1m with £2.9m unidentified, an improvement of £0.1m in month

The report included a detailed break-down of issues within each Health Group, which are specific to each Health Group.

The report confirmed the position of corporate services as well as Estates, Facilities and Development, which are meeting their CRES targets.

Each Health Group had been tasked with increasing year end delivery to a minimum of 80%.

Resolved:
The Committee received and accepted the report and requested specific focus by the Health Groups on CRES delivery to year-end.

10.3 FINANCIAL PLAN 2018/19

Mr Bond expressed his concern regarding the 2018/19 plan and suggested that the Board discuss it as part of the next Board Development session.

Resolved:
The Committee agreed to discuss the Financial Plan 2018/19 at the next Board Development session in January 2018.

7.1 PERFORMANCE REPORT

Mrs Ryabov reported that the Emergency Department had achieved 88.25% in November 2017. She advised that daytime performance was better than at night. The acuity of patients was higher. Trust performance was still above other major trauma centres nationally.

There was a discussion around the problems faced combined with the peaks in demand. The 4 month changeover of Junior Doctors was not helping the situation.

Mrs Ryabov reported that the ambulance attendances peaked after 4pm and work was ongoing to match this with the consultant rotas. The flow during the day determines the work load for staffing levels. This balance was being addressed.

The Committee discussed the idea of a GP surgery in A&E, but Mr Bond advised that GPs were also short in supply and was not currently possible.

Referral to treatment times (RTT) were still challenging and performance had been 83.7% in month. This had been impacted by the tracking access issues. There had been 14 x 52 week breaches for November 2017 and these patients were due to tracking access issues, clinical capacity, patient health on the day of appointment, and patient choice.

Cancer 31 days subsequent had seen 7 breaches due to capacity constraints, but there was good news regarding the 62 day standard as it had achieved 85% for the first time in 2 years. The Committee agreed to highlight this achievement to the Board.

The 62 day cancer screening had 7 breaches and the reasons for the breaches contained in the report.
Diagnostic performance was similar to last month and a plan had been put into place to incorporate more weekend working. Mrs Ryabov advised that the new CT scanner was being installed in the New Year and performance would dip before it improved.

Resolved:
The Committee received and accepted the report.

7.2 TRACKING ACCESS REPORT

Mrs Ryabov informed the Committee that the Tracking Access plan was progressing with just over 10,000 patients receiving validation.

Mrs Ryabov presented the reports received from MBI which gave assurance about the procedures put into place to clear the queue. Management of the process had been complimented and it had highlighted the need for an admin review regarding how the Trust booked and managed referral to treatment times.

Mrs Ryabov reported that 1250 patients had been clinically reviewed with 3 harms and 3 potential harms. A Clinical Harm Group had been established to review these harms as well as any other clinical issues reported. The Group will also be confirming the Structured Case Note reviews undertaken of the 27 patients who have died, the details of which were contained in the report. The 26 Structured Case Note reviews completed to date state that none of these deaths are relating to the appointment awaited by the patient. One review is underway.

In relation to progress being made with validation, the Committee noted that some of the validation work is behind schedule, with issues highlighted with the Surgery Health Group falling behind the trajectory for clinical review. There are also some capacity issues in clinical correspondence that would enable tracking access plans to be closed. The actions in progress were detailed in the report. ER to continue to provide monthly updates to this Committee. **ER**

Resolved:
The Committee received and accepted the report.

7.3 DISCHARGE BREACHES

Further to an action from a previous meeting, Mrs Ryabov presented the report which showed data relating to discharge breaches in the Emergency Department from 4 December – 10 December 2017 inclusive.

Resolved:
The Committee received and accepted the report.

10.4 PATIENT LEVEL COSTING

Mr Evans presented the report and provided an overview of Quarter 2. Quarterly reports were now being produced showing Health Group and other (corporate services) positions. Mr Evans pointed out that the reporting was still new and was being developed and refined each quarter.

The key areas were Medicine contributing a £3.9m surplus to the Trust's position and Surgery making a £7.9m loss. Family and Women's and Clinical Support Services both made small losses.

Mr Bond explained that it was important to focus on contribution; the Trust's overall contribution level is 11.5% Surgery Health Group were making a 3% contribution to overheads with all other Health Groups making contributions above 10%.

Mr Evans advised that the Trust would be focussing on the eight services currently reporting the largest losses at contribution level. Three of these services are also below their income plan, which would have significantly improved their position.

Mr Gore praised the Profit and Loss format in the report and asked if it could be incorporated into the monthly report to the Committee. **SE**

Resolved:
The Committee received and accepted the report. It was agreed that the report would be received on a quarterly basis. **SE**

11.1 CAPITAL RESOURCE ALLOCATION COMMITTEE MINUTES 6 DECEMBER 2017

Mr Bond had previously reported that there was a £3m risk to the 2017/18 capital programme as a result of delays to the finalisation of the land sale at Castle Hill Hospital. He updated the Committee that this risk has now been avoided. He added that the Castle Hill Hospital land sale should be finalised in February 2018

Mr Bond also reported that the fire stopping implications would be factored into the capital plan 2018/19. The Trust would be managing the position with the Fire Service.

Resolved:
The Committee received and accepted the minutes.

11.2 LORD CARTER OF COLES MINUTES NOVEMBER 2017

The minutes of the meeting were received for information. Mr Bond advised that the Care Quality Commission relationship manager had been in attendance.

Resolved:
The Committee received and accepted the minutes.

11.3 SCAN4SAFETY

Mr Bond presented the report, which highlighted the project board established and its objectives. He reported that the Trust needed to have the foundations in place to be able to meet the growing demand for the barcoding technology. The project would also add to the Trust's costing capabilities.

Six demonstrator sites had already been trialling the Scan4Safety technology and it was hoped that the Trust would be in the second wave of pilot sites.

Resolved:
The Committee received the report and asked for a presentation in April 2018 to review progress. **RE**

11.4 BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report and highlighted the previous discussions at the Quality and Audit Committees relating to staffing and culture and further assurance requirement relating to the STP.

Risk appetite had been discussed at a previous development session and the level of risks the Trust was prepared to tolerate. This has been added to the Board Assurance Framework.

There was a discussion around the financial risks, both from the month 8 position and CRES schemes. Both of these risks to be reviewed and ratings adjusted accordingly. Mr Bond and Ms Ramsay to meet to approve the narrative required. **LB/CR**

Mr Gore asked where the Tracking Access risk was shown and Ms Ramsay advised that it was being put on to the Corporate Risk register.

Resolved:
The Committee received and accepted the report.

12. ITEMS DELEGATED BY THE BOARD

There were no items delegated by the Board.

13. ANY OTHER BUSINESS

There was no other business discussed.

14. DATE AND TIME OF THE NEXT MEETING:

Monday 29th January 2018, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
MORTALITY – STRUCTURED JUDGEMENT REVIEWS
SUMMARY OF FINDINGS TO DATE

Meeting date	Tuesday 30 January 2018	**Reference Number**	2018 – 1 – 14
Director	Kevin Phillips – Chief Medical Officer	**Author**	Chris Johnson, Clinical Outcomes Manager
Reason for the report	The purpose of the report is to present a summary of the Trust's themes, trends and learning from Structured Judgement Reviews of casenotes, in accordance with National Quality Board guidelines. Part of the national guidelines is to present findings from the Structured Judgement reviews quarterly to the Trust Board.		

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

1	**RECOMMENDATION** The Trust Board is recommended to receive and accept this report, and provide any feedback or points of reflection to the Board, or to be picked up at the Quality Committee.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		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): S2 – lessons learned E1 – use of evidence-based guidance E2 – monitoring outcomes					
	Assurance Framework N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board was updated on the mortality guidance requirements in October 2017 and briefing papers have been received by the Quality Committee to monitor compliance with national guidance and the work in progress. The Quality Committee will continue to give more detailed scrutiny to the findings from the mortality reviews; the Trust Board will receive a quarterly update on themes and trends in line with national guidance.					

Mortality – Structured Judgement Reviews
Summary of findings to date

1. Introduction

The purpose of this report is to highlight the main themes identified from structured case note reviews undertaken on 302 case notes to date.

The data are taken from Business Intelligence (BI) analyser – HEY Mortality Case Note review Analysis and Mortality Patient Review Reports, covering the period 1st November 2016 to the time of writing (3rd January 2018).

2. Results

The following results are split into the 4 core phases of care, to reflect the framework of the Structured Judgement Review (SJR) methodology. The phases of care receive a score between 1-5 (1 being very poor, 5 being excellent).

At each phase of care, the Trust's scores show good overall care to patients. The SJRs have as well highlighted some learning points.

2.1. Main Themes Identified from Admission and Initial Care (first 24 hours)

The average score for the admission and initial care phase is 4.0 out of 5.0. This reflects good overall care.

1. Phase of care	Average Score	Very poor 1	2	3	4	Excellent 5
Admission & initial care (1st 24hrs)	4.0	1.4%	5.7%	12.8%	50.0%	30.1%
		4	16	36	141	85

In relation to learning, 20 cases had identified potentially poor care during the admission and initial care phase.

The main themes and trends identified from the admission and initial care phase score are:

- **No Senior Patient Review delivered in first 24 hours/delay in Senior Review**

Commentary taken from SJR
"No senior review evident in case notes until 3rd day of admission"
"Delay in senior review"
"Patient seen by FY Dr but no senior review evident"

The case-note review relies on documented evidence within the patient record, so where there is no legible print of a seniors name and time of review, this is accepted as a non-review.

This theme also appears throughout the "ongoing care" phase.

- **Sepsis pathway delayed/not screened**

Commentary taken from SJR
"No Sepsis screening performed in ED despite clear red flags"
"ED failed to respond to high NEWS and lactate of 17 and no sepsis considered"

Some of the judgement commentaries state that the triage team were unable to take blood samples due to patient agitation.

The failure to screen for Sepsis theme also appears within the "ongoing care" phase.

2.2. Main Themes Identified from Ongoing Care

The average score for the admission and initial care phase is 3.9 out of 5.0. This reflects good overall care.

1. Phase of care	Average Score	Very poor 1	2	3	4	Excellent 5
Ongoing care	3.9	2.2% 4	7.4% 16	17.8% 36	44.8% 141	27.8% 85

The main themes and trends identified from ongoing care phase of care score are:

- **Inconsistent and patchy documentation**

Commentary taken from SJR:
"Patchy documentation makes it very difficult to assess the appropriateness of care delivered"
"No clear documentation of blood glucose level from admission"

- **Delay/Failure to escalate observations**

Commentary taken from SJR:
"Zero evidence that high NEWS score was escalated"
"There was no clear consideration or documentation of the need for escalation when GCS was deteriorating"

- **Delay/Missing appropriate management plan**

Commentary taken from SJR:
"A lack of leadership in decision making, especially regarding escalation plan"
"Poor escalation management"
"No management plan once patient was transferred from ICU to Ward"

2.3. Main Themes Identified from Care During a Procedure / Perioperative Care

The average score for the admission and initial care phase is 4.4 out of 5.0. This reflects good overall care.

1. Phase of care	Average Score	Very poor 1	2	3	4	Excellent 5
Care during a procedure	4.4	0.0% 0	4.2% 4	8.3% 8	33.3% 32	54.2% 52

No real themes have emerged within this phase; however there were a very small number of cases with the following issues:

- **Time/Date on drug chart missing (Documentation)**

- **No documentation in anaesthetic pre-assessment of discussion/consideration of regional anaesthesia.**

2.4. Main Themes Identified from End of Life Care

The average score for the admission and initial care phase is 4.1 out of 5.0. This reflects good overall care.

1. Phase of care	Average Score	Very poor 1	2	3	4	Excellent 5
End of life care	4.1	0.7% 2	4.3% 12	17.6% 49	42.8% 119	34.5% 96

The main themes and trends identified from this phase of care score are:

- **Delay in commencing End of Life pathway**

Commentary taken from SJR:
"Delay in diagnosing dying"
"Missed opportunity to commence EOL [End of Life] pathway earlier"

- **Lack of/patchy documentation of End of Life plan**

Commentary taken from SJR:
"No documented evidence of active management plan for the dying patient"

2.5. Other Themes Identified

The following themes did not fit specifically into one phase of care section but are of importance:

- Delay in DNACPR [Do Not Attempt Cardiopulmonary Resuscitation]
- DNACPR not reviewed/updated
- Poor condition case-notes
- No evidence of communication with patients family/Next of kin.
- Failure to act on adverse observations

3. CONCLUSION

Overall, the quality of care reflected is very good. The main themes identified will require further work to improve outcomes. It must be noted that for every negative theme occurring there are also positive themes. This further reiterates the fact that the Structured Judgement Review is a tool for analysing gaps and improving quality, rather than creating performance statistics to be measured against peers.

New thematic analysis techniques are currently being developed to allow a higher level of detail to be obtained. Currently, analysing a large amount of free text is proving to be very difficult

This report will be received on a quarterly basis by the Quality Committee for more detailed review on assurance and process against the relevant national guidance, and will be shared at the Trust Board for assurance and sharing lessons.

4. RECOMMENDATION

The Trust Board is recommended to receive and accept this report, and provide any feedback or points of reflection to the Board, or to be picked up at the Quality Committee.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	30 January 2018	**Reference Number**	2018 – 1 - 15
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson Director of Corporate Affairs – Carla Ramsay
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to authorise the use of the Trust's seal. The Trust Board is also requested to approve minor amendments for the inclusion of a new sign-off process should the Trust bid for new areas of work. Furthermore, the Audit Committee recently reviewed and updated its Terms of Reference; approval of these changes is reserved to the Trust Board as a change to Standing Orders.					
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** Approval of the Trust's seal and amendments to standing orders are reserved to the Trust Board.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

The Trust Board is requested to authorise the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2017/20	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Windmill Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/21	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Priory Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/22	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Parks Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/23	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Macmillan Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/24	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Marfleet Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/25	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Longhill Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/26	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Lemon Tree Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/27	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Bude Park Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
			– Director of Corporate Affairs
2017/28	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Ainthorpe Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/29	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council, Licence agreement relating to Acorns Children's Centre	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/30	Hull and East Yorkshire Hospitals NHS Trust and Community Health Partnerships Ltd, Hull Citycare Limited Lift underlease for part of Bransholme Health Centre, Goodhart Road, Hull, HU7 4DW	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2017/31	Hull and East Yorkshire Hospitals NHS Trust and DKP Consulting, contract documents relating to infectious diseases unit. 2x Form of agreement 2x Work/site information incorporating the contract drawings 2x Pricing documents	22.12.17	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/01	Hull and East Yorkshire Hospitals NHS Trust and Daisy Medical Research Limited and Alliance Medical Limited – Deed of variation of equipment hire agreement dated 12 May 2014. 3 x copies of Deed of Variation, executed as a deed by the above named parties	23.01.18	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs

3 AMENDMENTS TO STANDING ORDERS

3.1 Submission of bids for new work

The Trust has recently drawn up a new procedure should it be considering submitting a bid for new areas of work, for example, submitting a bid against an Invitation to Tender (ITT) that has gone out to the market for bids. Part of the new procedure is to give adequate scrutiny of the work being bid for and Executive-level sign off that this is work for which the Trust should bid.

The following amendment is therefore requested to Trust Standing Orders. This will form a new section (9.20) to Standing Financial Instructions.

9.20 Trust submission of bids for new areas of work
It is part of the Chief Executive's executive powers to approve tender submissions. The Chief Executive discharges this responsibility through the Chief Operating Officer who will sign off the final tender response and the Chief Financial Officer who will sign off the final financial model.

Within the procurement timeline sufficient time will be allowed for a final review of the Invitation to Tender (ITT) response or bid submission by the appropriate Trust Committee and, where required, for any necessary alterations to be made to the final submission. The Chief Operating Officer and Chief Financial Officer are required to sign off this final version prior to submission.

The Committees providing relevant sign-off based on the total value of the contract bid for are:

- Health Group Triumvirate/Directorate sign off – value up to £100K
- Executive Management Committee for £100k - £2m
- Performance and Finance Committee (value £2m - £5m)
- Trust Board (value over £5m)

In the event that there is insufficient time within the tendering process to enable sign off at the appropriate committee, authority will be given to the Chief Operating Officer and Chief Financial Officer (or in their absence another member of the Executive Team) to sign off the final ITT for submission. If it is a bid of a value of more than £2m, this will also require the signature of the Chairman (or in their absence another Non-Executive Director).

3.2 Audit Committee Terms of Reference

The mains areas of work of the Audit Committee form part of Trust Standing Orders, within the scheme of delegation. Furthermore, as a Board Committee, changes to the Audit Committee's terms of reference require Board approval.

The Audit Committee reviewed some amendments to the Audit Committee's Terms of Reference at its meeting in December 2017, and recommends approval by the Trust Board. Most amendments are house-keeping only, rather than substantive changes to the Terms of Reference, to reflect changes in job and organisational titles in the last year. One amendment at 3.1 (e) is made in anticipation of changes to the Information Governance toolkit in 2018-19 and a new requirement at 3.1 (f) is made for new requirements under General Data Protection Regulations from May 2018. These will require amendments to Trust Standing Orders.

The Trust's Anti-Fraud adviser has also reviewed and made amendments to 1.4(a), 3.1(d), 3.2, 3.6.3 and 3.8 to bring the Terms of Reference fully up-to-date with requirements (3.1(d) and 3.8) and the most current anti-fraud language (all other amendments).

The proposed changes are made within the attached Terms of Reference as tracked changes, for review and approval by the Trust Board. By approving these amendments, the Trust Board is also asked to approve the required changes to Trust Standing Orders.

4. RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal
- approve the addition of a new section in the Standing Financial Instructions within Standing Orders, for the approval of bids for new areas of work

- to approve the proposed changes to the Audit Committee Terms of Reference and subsequent updates to Trust Standing Orders as a result of these amendments

Carla Ramsay
Director of Corporate Affairs
January 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 Establishment

The Trust Board has established an Audit Committee (The Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. This committee reports directly to the Board.

1.2 Membership

The Committee shall be appointed by the Board from amongst the Non Executive Directors of Hull and East Yorkshire Hospitals NHS Trust ("the Trust") and shall consist of not less than three members. The Chairman of the Trust shall not be a member of the Audit Committee. Appointments to this Committee shall be made by the Board in consultation with the Audit Committee Chairman. Appointments to be for an initial period of up to 3 years, extendable by no more than one additional 3 year period.

1.3 Quoracy

A quorum shall be two members.

1.4 Attendance

(a) The Chief Financial Officer, Director of ~~Governance~~Corporate Affairs, Head of Internal Audit, the Trust's nominated Local ~~Counter~~ Anti-Fraud Specialist and representatives of the External Auditors shall normally attend meetings advising the Committee on pertinent issues / areas. The Committee will meet in private with External and Internal Auditors without any Executive – Directors or members of the Trust staff present at least once a year.

(b) The Chief Executive, other Directors or lead officers may be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that individual.

(c) The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

(d) The Trust Secretary, or assistant, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair of Committee and its members.

1.5 Meetings

Meetings shall be held not less than five times a year. The Chair of the Committee can call additional meetings as required to discuss urgent business.

2 AUTHORITY

2.1 Authority to investigate and seek information

(a) The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

(b) The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant expertise if it considers this necessary.

3 ROLE AND PURPOSE OF THE AUDIT COMMITTEE

The duties of the Committee are:

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:-

(a) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board.

(b) The structures, processes and responsibilities for identifying and managing key risks facing the organisation in particular the Board Assurance Framework ~~–~~including the link with the corporate risk register.

(c) The underlying control and assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements.

(d) The policies and procedures for all work related to fraud, ~~and~~ corruption and bribery as set out in Secretary of State Directions, the standard commissioning contract and as required by the NHS Counter Fraud ~~and Security Management Service~~ Authority.

(e) Consider and review the Annual Information Governance Toolkit (or replacement requirements) and the Data Quality Reports.

(f) Trust arrangements to meet the requirements of the General Data Protection Regulations that apply from 25 May 2018

3.2 Power to seek reports and assurances

In carrying out this work the Committee will primarily utilise the work of Internal Audit, ~~Counter~~ Anti-ffraud**,** External Audit and other assurance functions, but will not be limited to these audit functions. It may also seek reports and assurances from Directors and managers as appropriate, concentrating on the over arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The Committee will receive the minutes of the Board's Performance and Finance Committee, Quality Committee and Charitable Funds Committee to inform its assurance work.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.3 **Internal Audit**

The Committee shall ensure that there is an effective internal audit function established by management; that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee.

It will:-

(a) Recommend the appointment of the Internal Auditors to the Board, approve the annual fee and consider any questions of resignation and dismissal.

(b) Review and approve the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework and Strategic Plans.

(c) Consider the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

(d) To review progress on implementing internal audit recommendations.

(e) Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

(f) Monitor the effectiveness of internal audit through their annual review

3.4 **External Audit**

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

This will be achieved by:-

(a) Recommending to the Trust Board the appointment of the External Auditor.

(b) Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.

(c) Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

(d) Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken alongside the annual audit plan together with the appropriateness of management responses.

(e) Review and monitor the external auditor's independence and objectivity, taking into account relevant UK professional and regulatory requirements.

(f) To develop and implement a policy on the engagement of the external auditor to supply non audit services.

3.5 **Financial Reporting**

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focussing particularly on:-

(a) The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

(b) Changes in, and compliance with, accounting policies, practices and estimation techniques.

(c) Unadjusted mis-statements in the financial statements.

(d) Letter of Representation.

(e) Significant judgements in preparation of the financial statements.

(f) Significant adjustments resulting from the audit.

3.6 **Other Assurance Functions**

3.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Improvement, ~~Monitor~~, NHS Litigation Authority etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

3.6.2 In addition, the Committee will consider the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This Committee also needs to be review the assurances gained from clinical audit activities in the organisation.

3.6.3 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of ~~counter~~ anti-fraud work.

3.6.4 The Committee will seek annual assurance that a current, clear and effective Whistleblowing or Protected Disclosures Policy is in place and that all Trust staff have access to this policy. One Non Executive Director under the current policy (reference CP169) will be one of a number of internal contacts available to consult and be the "Whistleblowing Champion" of the Trust.

3.7 **Reporting**

3.7.1 The minutes of the Audit Committee meetings shall be approved by the Chairman of the Audit Committee and submitted to the Board. The Chairman of

the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.7.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and effectiveness of risk management in the organisation, the integration of governance arrangements and produce an annual work plan.

3.8 **Other Matters**

The Committee shall undertake reviews of:

- Risk register
- Write offs and compensations
- Outstanding debtors over £50,000 and 90 days or more outstanding.
- ~~Fraud register~~
- Decision to waive tender procedures
- Offers of hospitality/gifts and sponsorship
- Review of Standing Orders and Standing Financial Instructions and approval of proposed changes
- Waiver of Standing Orders
- Going Concern Reviews
- Corporate credit card expenditure
- Legal expenditure

3.9 **Administration**

The Committee shall be supported administratively by the Trust Secretary, or assistant and the Deputy Director of Accounting and Treasury. ~~,~~ ~~t~~Their duties in this respect will include:

- Agreement of each agenda with the Chairman and collation of papers
- Taking the ~~M~~minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues
- Enabling the development and training of Committee members

4 MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

The Trust Secretary and the Chairman of the Committee have a joint responsibility for ensuring compliance with these Terms of Reference. Any member or person in attendance who considers compliance with these Terms of Reference is at risk should bring their concerns to the attention of the Trust Secretary.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Meeting date	Monday 29 January 2018	**Reference Number**	2018 – 01 –16
Director	Carla Ramsay - Director of Corporate Affairs	**Author**	Carla Ramsay - Director of Corporate Affairs
Reason for the report	The purpose of this report is to present the updated Board Assurance Framework (BAF) for 2017-18 from the December 2017 Trust Board and Committee meetings, for review and assurance on process.		

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

1	**RECOMMENDATIONS** The Board is asked to review the current risk areas on the Board Assurance Framework and determine whether: • The Board would support the proposed Q3 ratings of the BAF risks • There is positive assurance or any new gaps in assurance from the Board's discussions to add to the BAF • Provide input on risk appetite for any particular BAF risk area					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Briefing		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 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 (BAF) for 2017-18 from the December Trust Board and Board Committee meetings, to determine if there are any risk areas where the Board can provide positive assurance and to give scrutiny to areas where there are gaps or a lack of assurance.

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 – December 2017 Trust Board meetings and Board Committee, there are some areas of positive assurance that have been received and are captured in the updated BAF at Appendix A.

Suggested Q3 ratings have been added to the BAF, for the Board to review and agree.

The change from Q2 to Q3 ratings is proposed as:

- BAF 7.1 risk to achievement of financial plan 2017/18
  It is proposed that this is increased in rating from 20 to 25. This is based on the financial information and discussion at the December 2017 Trust Board, in that the Trust will most likely not achieve its original financial plan for this financial year. As reported separately to the Trust Board this month, the Trust has a revised target now agreed with NHS Improvement; it is hoped that this would pose a lower risk in Q4 of non-achievement.

All other risks have been reviewed and it is not proposed to change the risk ratings at this point.

Specifically:

- In relation to BAF 4, whilst performance against NHS Constitutional waiting times and local trajectories has changed during quarter 3, the overall level of risk faced by the organisation has not changed, but may do in quarter 4.
- In relation to BAF 7.2, there a three new corporate risks detailed below that relate to this area; the highest-rated risk is being mitigated by the application of a loan or for PDC to support the Trust's infrastructure; the overall level of risk relating to this area has remained around the same
- In relation to BAF 7.3, the Trust is managing its liquidity position closely and is applying for working capital loans to protect the Trust's liquidity position; the level of risk remains the around the same

Following the Board's review of the proposed risk ratings, if accepted, this would maintain the highest-rated BAF risk areas as:

- BAF 2 – valued, skilled and sufficient staff (rated 20 all year)
- BAF 7.1 – risk to achieving the financial plan for 2017-18 (rated 20 to date, proposed to move to 25)

There are other three high-rated risks, proposed to maintain ratings of 16:

- BAF 4 – achievement of waiting time requirements
- BAF 5 – tertiary patient flows
- BAF 6 – changes via STP

3.2 Corporate Risk Register – January 2018

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 Executive Management Committee reviewed the Corporate Risk Register in December 2017 and January 2018; a new corporate risk around tracking access issues is in development and will be added to the Corporate Risk Register in due course.

The latest Corporate Risk Register is attached at Appendix B is largely populated with risks relating to specific specialities, with some Trust-wide corporate risks also included.

Since the last version of the Corporate Risk Register was received by the Trust Board linked to the BAF, the following changes have been made:

<u>New corporate risks linked with the Board Assurance Framework risks</u>

- New corporate risk (rated 20 – risk 3153): Switchboard resilience – this has been linked to BAF risk 7.2 on infrastructure
- New Medicine Health Group risk (rated 16 – risk 3125): Junior doctor vacancies – this has been linked to BAF risk 2 on staffing
- New corporate risk (rated 16 – risk 3127): Risk of Fire Safety Prohibition Notice – this has been linked to BAF risk 7.2 on infrastructure
- New corporate risk (rated 10 – risk 3146): cybersecurity – this has been linked to BAF risk 7.2 on infrastructure
- New corporate risk (rated 10 – risk 3152): move to new ReSPECT process in 2018 – this has been linked to BAF3 on quality of care

<u>Risks mitigated and moved back to operational risk registers</u>

- Family and Women's Health Group risk on breast screening equipment has been removed from the Corporate Risk Register – removed from BAF 4
- Corporate risk on non-compliance with IR35 removed from the corporate risk register as this risk has been mitigated – removed from BAF 2
- Family and Women's Health Group risk on neo-natal staffing has reduced – removed from BAF 2
- Surgery Health Group risk to CQUIN income has reduced – removed from BAF 7.1

The Balanced Scorecard received at each Trust Board meeting shows the number of corporate risks related to each quadrant of the scorecard, to provide a visual prompt as to where the risk burden of clinical and non-clinical corporate risk sits in the organisation

Corporate risks are linked to the relevant areas of the BAF to show the links between these risks and the long-term goals of the organisation.

The current Corporate Risk Register is retained as a source of information for the current BAF at Appendix B.

3.3 Further Risk Management Developments linked with the Trust Board

A section on the BAF has been added for each area on risk appetite, with a view to determine the Board's appetite for risk in each of these areas; each BAF risk has a target risk score – the risk appetite would be what would be the strategy and actions to mitigate this risk and what level of risk, including the current level of risk, the Board is prepared to live with. Each area of the BAF will be discussed as topics through Board Development sessions to detail this risk appetite. The Board is also asked to give any initial views on risk appetite on any of the BAF risk areas at this stage.

4. RECOMMENDATIONS

The Board is asked to review the current risk areas on the Board Assurance Framework and determine whether:

- The Board would support the proposed Q3 ratings of the BAF risks
- There is positive assurance or any new gaps in assurance from the Board's discussions to add to the BAF
- Provide input on risk appetite for any particular BAF risk area

Carla Ramsay
Director of Corporate Affairs

January 2018

APPENDIX A

BOARD ASSURANCE FRAMEWORK 2017-18 UPDATED FOLLOWING TRUST BOARD DECEMBER 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		
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	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	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**	**12**	**12**		**4 x 1 = 4**	**<u>Positive assurance</u>** 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; quarterly reports received at Trust Board on FTSUG role – no new Trust-wide concerns raised to date 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 Progress continues towards the People Strategy and areas for improvement identified from latest staff surveys and WRES data – use of latest data to support current actions and identifying new areas of work Quarterly updates on People Strategy now received at Performance and Finance Committee Detailed staff engagement session at Trust Board Development session October 2017

		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 Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence			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 engage, develop and inspire staff Integrated approach to Quality Improvement						**Further assurance required** Use of positive messages from most recent results to engender further confidence in staff engagement and staff feelings of job satisfaction Progress made towards narrowing the gap of experiences between BME and white staff, per WRES data and report to Trust Board November 2017 Trust Board – some engagement scores have decreased in most recent quarterly survey

Risk Appetite

Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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 is a risk that staff shortages in specific areas will continue and increase 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: anaesthetic cover for under-two's out of hours SHG: registered nurse and theatre vacancies 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 dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologist	**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 and nursing roles, in addition to new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff 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	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**	**20**	**20**		5 x 2 = 10	**Positive assurance** 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 Nov 17: further progress made on data collection and exception reporting on safe working; junior doctors successfully moved to new contract. Trust has worked to fill rota gaps since Aug 17 Positive assurance received in Nov 2017 on the intake of graduate nurses and international recruitment – anticipate improvements in fill rates Twice-yearly review of nursing and midwifery establishments presented June 17 Monthly 'Moments of Magic' reported by Chief Executive Service Resilience report requested from Dec 2017 to understand impact of staff and resources on maintaining core services – includes medical and other staffing Increased fill rates in December 2017 as new cohort of staff start to receive PIN numbers **Further assurance required** 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' Nursing and midwifery (qualified and unqualified staff) sickness levels are an area of focus (July 17) – currently above Trust target; nursing fill rates at lowest point in financial year (October 2017) Guardian of Safe Working Nov 17: new gaps on rotas due to fill rates through the Deanery – need to be filled by Trust actions and additional costs Assurance on implementation of e-rostering and electronic job plans from a benefits realisation/service capacity optimisation point of view

					agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training					Audit Cttee Oct 17 – focus in quarterly updates to P&F on People Strategy re: work on staff retention Longer-term strategy for nursing and midwifery discussed at Trust Board Development November 2017 – solutions will come at a cost to the Trust

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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 That the Trust does not further develop its learning culture That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy	Corporate risk: management of consent policy and patient records Corporate risk: Restricted use of open systems for injectable medication MHG: Hyper Acute Stroke Unit capacity Corporate risk: Move to ReSPECT process CCSHG: lack of compliance with blood transfusion competency assessments	**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)	**12**	**12**	**12**		4 x 1 = 4	**<u>Positive assurance</u>** 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 Participation in the CQC well-led pilot – identified positive areas of progress made Updated QIP presented to the Trust Board in Sept 17 – reworked to provide more stretch and new milestones identified to make further progress; monitored in more detail and regularly by the Quality Committee Positive assurance on progress made towards new Mortality Review national requirements and understanding of progress still to make QIP reviewed monthly by Quality Committee – regular scrutiny on progress **<u>Further assurance required</u>** Some QIP areas have a greater impact on organisational development and are the ones needing more progress such as Lessons Learned QIP Four Never Events year-to-date (December 2017); impact on patients, services and potential regulatory attention Trust will be receiving its first inspection under the new CQC regime – PIR received November 2017 Nov 17 - Tracking access issues and current performance pressures in RTT, diagnostics and cancer have a potential impact on quality of care - scale of risk being quantified at present and will be subject to Board Development sessions for more detailed understanding Dec 17 – more information on tracking access issues; potential for patient harm being assessed at present. Detailed action plan being put in place to address

											underlying issues.

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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: Delays in Ophthalmology service due to capacity F&WHG Capacity of intra-vitreal injection service	**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**	**16**	**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 being available 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; to understand any risks relating to patient care or patient hard Nov 17 – impact due to current pressures in diagnostics, cancer and RTT, with additional tracking access issues – discussed at Board Development sessions; recovery in some areas being seen but not yet improved to trajectory

		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										

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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**	**16**	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 Trust Board time out October 2017 – time spent on strategy regarding partner organisations Meetings with the new STP chair have held with Chief Executives of the local acute Trusts and with the Chairman **Further assurance required** Role of STP and impact on Trust strategy/forward planning

Risk Appetite

Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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**	**16**	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

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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 and achieve financial balance 17-18 MHG risk: risk to achieving CRES 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; HGs hold own performance meetings 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	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**	**20**	**25**		5 x 1 = 5	**<u>Positive assurance</u>** June 17 - contract with Deloitte to identify and set up more detailed PMO arrangements for CRES identification and tracking July 17 - control total and financial plan now agreed with NHSI, per delegated action at April 2017 Trust Board Sept 17 – progress made by Deloitte, reported to P&F Committee, on additional CRES identification and pace; Deloitte provided recommendations to strengthen CRES process; noted that the Trust has identified relevant opportunities for CRES Oct 17 – detailed discussion on FIP2 at Performance and Finance Committee, including attendance of Health Groups, impact and outstanding position for 17-18; underlying run-rate issues slowing but not addressed Dec 17 – some reductions in non-elective pathways seen to date ?commissioner management of referral demands **<u>Further assurance required</u>** August 17 - gap in CRES identification in 17-18 Oct 17 - gaps in CRES delivery to date and increased corporate risks on CRES Introduction of service line reporting planned during 17-18 – assurance would be to see positive impact of SLR on understanding and reducing cost base Dec 17 – underlying deficit increased in-year as reported to the Trust Board; CRES delivery currently below 80% for the financial year. Question on any Trust's ability to remove costs when delivering same level, or increased level, of service. Q3 submission to be returned to the centre to show updated position against control total

					to manage demand					

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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 infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**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		**10**	**10**	**10**		5 x 1 = 5	**Positive assurance** 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 June 17 - successful practice Major Incident including key stakeholder organisations and lessons learned Oct 17 – Audit Committee received positive assurance regarding external resilience against cyber attack Oct 17 – updated Estates Strategy approved by Trust Board, with review of backlog maintenance and capital requirements at P&F Cttee – scale of capital issue detailed **Further assurance required** Gap in completion and upload of all service-level business continuity plans Longer-term view of capital requirements and access to sufficient capital funding to address this +/- STP requirements/support/plans Enforcement Notice served by Humberside Fire and Rescue service on fire safety audits Availability of funds if significant failure requires significant investment Oct 17 – Audit Committee noted actions being taken to further improve internal IT security

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

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 Relief funding application signed off by Trust Board in October 2017-18		**20**	**12**	**12**		4 x 1 = 4	**Positive assurance** Cash flow improved in Q2 due to receipt of STF funding Cash loan application in October 2017 to assist cashflow position Cash loan application In January 2018 to assist liquidity position **Further assurance required** Need to sell land and/or explore issue with the Department of Health as to how the Trust can inject cash Two local CCGs no longer able to pay Trust across tenths in 2017-18 – need to update cashflow projections

Risk Appetite

Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

APPENDIX B – CORPORATE RISK REGISTER (AS PRESENTED TO EXECUTIVE MANAGEMENT COMMITTEE ON 16 JANUARY 2018)

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
2675	Clinical Support - Health Group	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 - Valued, skilled and sufficient workforce, Goal 4 - Great local services, Goal 7 - Financial sustainability	20
3153	Corporate Functions	The Switchboard may not be able to respond to urgent calls e.g. Crash Calls and fire alerts.	15/11/2017	Switchboard will not be able to manage the increased number of calls due to the removal of the e-telephone directory (phone list) held on Trust Intranet. This has the potential to impact on urgent calls, fire response and crash calls. Condition: The Web Committee has made a unilateral decision to remove the current e-telephone directory (phone list) from the intranet without the provision of a robust alternative. Cause: It is understood that the system is no longer supported by IT but the Switchboard continue to update its content. Consequence: - Internal calls are likely to increase as staff will ring the Switchboard to obtain internal telephone numbers. This has the potential to 'overload' the Switchboard	None Postpone removal currently planned for 30 November 2017, until such a time that a robust solution is identified and implemented		20

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
				and also there is the potential that an important call could be missed, such as crash calls, fire team response requests. - Increase in internal calls will delay response time to external (including public/GP surgeries/ NHS organisations) call handling - The reputation of the Switchboard could be negatively affected - Potential to impact on staff turnover as the work load increases leading to staff suffering from stress.			
3110	Medicine - Health Group	Failure to deliver the CRES programme for 2017/18	16/06/2017	The risk is that the Health Group will not deliver the CRES target for 2017/18 due to the fact that only 50% of the target was fully identified at plan stage. CRES delivery for 2017/18 is currently forecast at 74% for MHG leaving £0.65 million CRES currently unidentified for 2017/18	1. Regular individual financial performance meetings at budget holder level 2. Performance reviews at Divisional and Health Group level 3. Dedicated focus at Health Group Business meeting 4. Finance committee and Transformation committee focuses on CRES delivery 5. Productivity and Efficiency Board meetings at Trust level		16
3096	Medicine - Health Group	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	Patients are reviewed by a consultant in order to prioritise them for use of available HASU beds.		16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
				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.			
3109	Surgery - Health Group	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. SHG total overspend is due to the non-achievement of CRES. Currently £800k of CRES is forecasted not be achieved. Failure to deliver key financial targets could result in withdrawal of non-recurrent support funding. The 2017/18 CRES value is £4,232k.	1.Devolved CRES targets/accountability to Divisional Managers 2.Monthly Divisional Performance Meetings to challenge progress 3.Weekly PEB meetings to discuss with Execs the HG progress. 4.Regular Business and Finance Committee meetings where CRES is an Agenda item. 5.Business meetings for each Speciality - Finance and CRES is an Agenda item.	Goal 7 - Financial sustainability	16
3038	Clinical Support - Health Group	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 - Valued, skilled and sufficient workforce	16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
2982	Family and Women's Health - Health Group	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 - Great local services	16
3125	Medicine - Health Group	Multiple junior doctor vacancies - risk to patient safety and care	19/07/2017	New risk of multiple junior doctor vacancies. There is a national shortage of junior medical staff across all levels. This shortage is expected to be an increasing problem over the next year with the implementation of the new junior doctor contract. Vacancies in the rota lead to problems delivering safe and effective care on the wards and gaps in the on call rotas are often impossible to fill with locum staff putting patient's safety at risk out of hours. Carrying multiple rota gaps also puts added stress on our existing doctors and increases sickness levels plus negatively affects future recruitment.	Creation of specialist high level nursing roles. a. Increase number of MTI trainees. b. Consider alternative posts that may be more attractive to prospective applicants eg clinical fellow posts c. Consider recruitment of HEY Chief registrar to do further work on recruitment/junior staff engagement and rotas.	Goal 2 - Valued, skilled and sufficient workforce	16
2665	Family and Women's Health - Health Group	Patients may be delayed resulting in loss of eyesight due to lack of capacity for follow up(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, MEDICAL RETINA and PAEDIATRIC pathways. 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. Newly introduced glaucoma virtual review sessions.	Goal 4 - Great local services	16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
2789	Family and Women's Health - Health Group	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. The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely affect their vision.	On a weekly basis the service meet to discuss capacity and plans are made to create additional capacity where needed. The service is 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 - Great local services	16
2949	Surgery - Health Group	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: 80.3 WTE. 24 ODP [HRI 18] CHH 6]	1) Daily safety brief (5 times) 2) Block booking of agency staff. 3) Current staff working overtime. 4) Band 7s, Matron and Senior Matron all working clinical shifts to support. 5) ODP apprentice programme is under development 6) Reduction in elective bed base to support acute bed base 7) Focused nurse / ODP	Goal 2 - Valued, skilled and sufficient workforce	16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
				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.	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 [x3 applied] 11) Option to recruit to RN and support with anaesthetic nurse module 13.04.17 First recruits, with PIN numbers, will arrive by March 2018.		
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 - Financial sustainability	16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
3044	Family and Women's Health - Health Group	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 - Great local services	16
3127	Corporate Functions	There is a risk that the Trust could be served with a Fire Safety Prohibition Notice	19/07/2017	Condition: As a consequence of a fire risk incident in a high rise building the local Regulating Authority (Humberside Fire & Rescue Service) and subsequent inspections the Trust was served with a Fire Safety Improvement Notice (expires 22 November 2017) for the HRI Tower Block. Cause: Concerns regarding the lack of roof void protection and a lack of risk assessments to support this arrangement. Operational failures such as the propping open of fire doors and the blocking of Fire evacuation routes by staff. The HF&RS still harbour concerns relating to the Tower Block cladding despite the feedback from the BRE (testing laboratory). Concerns regarding sufficient fire dampers installed in the ventilation systems. Concerns that damaged fire door are not repaired in a timely manner.	Staff mandatory training levels has improved. Additional resources have been secured to undertake fire stopping audits and remedial actions An additional Fire Saety Advisor has been secured to support the undertaking of Fire Risk Assessments. High profile staff safety poster campaign undertaken. Recruitment is underway to secure an Authorising Engineer (Fire Safety) who will advise on various professional matters, including the frequency of Fire Risk Assessments. Currently the Trust adopts the HTM approach of risk based frequency whilst the		16

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
				Consequence: The local Regulating Authority can insist that the building is closed with immediate effect.	Regulating Authority is keen to see annual assessments implemented. Comprehensive risk assessment has been commissioned to review the cladding and its method of installation. A review of fire door planned maintenance is being conducted with a view to move from annual inspections to more frequent inspections (6 monthly) for fire doors in high use areas. An audit has been completed of all existing fire dampers with a separately commissioned review of additional fire damper requirements has just been completed. Most of the improvement works above will have a dependency on the availability of finance, the extent of which is unknown at present. A bi-weekly operational Fire Safety committee has been established which is chaired by a director and is attended by a Director from each Health Group to resolve operational matters.		

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
2817	Family and Women's Health - Health Group	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
2799	Medicine - Health Group	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 November 2017. 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	1. Safety briefing 3 times a day chaired by senior nurse to address any short notice concerns re: safety and staffing 2. Senior Matron to sign off all off duty to ensure efficient use of available resources 3. Regular discussions with nurse bank/agency Senior Nurse to improve fill rates 4. International recruitment is being promoted/pursued 5. Maternity leave is now being managed through vacancy control 6. Clinical nurse specialists and teacher trainers are working clinical shifts 7. Recruitment / communications with universities to promote appointments of student nurses into HEY posts. 8. Skill mix review to attract and retain staff in areas difficult to recruit to.	Goal 2 - Valued, skilled and sufficient workforce	15

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
					9. Teacher trainers working planned clinical shifts 10. Ward Manager management shifts worked as clinical shifts when required to maintain safe staffing levels. 11.Band 2 recruitment commenced, RN support from other HG's for Winter Ward 12. Working with recruitment agency to promote DME, ED and Stroke to improve adverts and showcase these specialities 13. HR asked to support in gaining feedback on exit interviews. 14. Dedicated induction programme delivered by teacher trainers for newly qualified new starters		

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to 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.	Support for the existing system continues to be provided by a 3rd party. A new Internet Protocol Telephony (IPT) system is being rolled out as part of the network upgrade programme. The CHH Campus is planned to be fully transferred by 31/3/18. The existing IPT system at HRI (covering ED) will be upgraded by 31/3/18. For the remainder of the Trust 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.	Goal 7 - Financial sustainability	15

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
3146	Corporate Functions	Cyber Security	23/10/2017	NHS Digital require that all NHS organisations operate an effective cyber security assurance framework, based upon the National Cyber Security Centre Cyber Essentials Scheme. An independent assessment of compliance was undertaken as part of the national CareCert Assure programme. Failure to address the findings and recommendations set out in the August 2017 CareCert Assure review will significantly compromise the Trusts ability to adequately protect itself from the risk of a successful Cyber Attack. Depending on the nature of the attack, this may result in critical systems being affected. A catastrophic Trust wide attack would carry a serious risk of potential for patients to not receive safe, effective and timely care. Also, the potential for patients to be harmed or receive the wrong care. Furthermore total loss of clinical and operational systems, resulting in an inability to carry on business.	There are a variety of technical controls in place including : Boundary Firewalls, Anti-Virus, Web-Filtering, Device encryption and a security patching regime for desktops and servers. Remediation Action Plan agreed with CareCert Assure auditors and shared with NHS Digital. Action Plan reviewed by Executive Management Committee	Goal 3 - High quality care, Goal 7 - Financial sustainability	10

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to 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. December 2017 update - the T& F group has been on hold and the project is going to have a review and re-launch in early 2018.	Goal 3 - High quality care	10

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
3089	Corporate Functions	Risk of incidents occurring 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.	Pharmacy Department and Health Groups have worked together on audits to establish what areas are using open systems, and to offer alternative working practices where available. HGs have provided statements of assurance to say compliant. One exception is Ophthalmology. A working group has been set up, first meeting was held in April 2017, to respond to this alert. As at December the group is now closed. 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	10

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
3152	Corporate Functions	Transfer over to ReSPECT process in January 2018	13/11/2017	The Trust has agreed to launch the ReSPECT process on the 8 January 2018. This will add more value to the documentation, as other factors in relation to patient wishes can be added to this new documentation. ReSPECT will replace our regional DNACPR form for adults, and some local Paediatric decision making tools. There is a risk that if the launch is not completed correctly and staff are not fully aware there could be confusion over the documentation and a patient could have the wrong care delivered to them.	ReSPECT training is being rolled out, including an e-learning training package which is also being delivered to primary care. There is a Task and Finish group in place, chaired by the Resuscitation Manager. There are locality meetings being held as GPs are launching at same time. DNACpr still in place until the launch in January 2018. During December 2017 the Resus Team will be visiting every clinical area with a launch pack which will contain all the information required and ReSPECT forms to use. All other agencies also have been informed, i.e. YAS. In January 2018 there will be a visit to every area from the Resus Team to remove all DNACPR pro formas		10

ID	Health Group/ Corporate Services	Title	Opened	Description	Controls in place	Linked to Strategic Goals	Rating (current)
2131	Clinical Support - Health Group	Non-compliance with blood transfusion competency assessments	17/06/2011	The risk is that the Trust may not achieve compliance with the NPSA Safer Practice Notice (Right Blood Right Patient - SPN14 - amended April 2008) The risk is due to difficulties in achieving and maintaining 100% compliance with blood transfusion competency assessments of all relevant staff at all times - although this has been recognised within the NPSA alert notification update of 2008. In addition, the CQC standard (Outcome 9) requires the Trust to be compliant with all NPSA alerts.	1. Transfusion Policy which reflects current competency assessments 2. The policy and competency assessments are regularly reviewed (every 3 years) 3. Cascade training programme in place for healthcare professionals involved in blood transfusion 4. Staff competency assessments recorded on ESR for monitoring purposes 5. Competency assessment is supported by mandatory transfusion training every 3 years 6. Trust wide report to all Nurse Directors with their HG compliance status broken down to individual areas (11/10/17)	Capable, effective, valued and committed workforce (W)	9

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE
HELD 18 DECEMBER 2017

PRESENT:	Mr M Gore	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
IN ATTENDANCE:	Mr L Bond	Chief Financial Officer
	Mrs D Roberts	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Mr G Baines	MIAA
	Mr G Kelly	Grant Thornton

NO. ITEM **ACTION**

1. APOLOGIES
There were no apologies received.

2. DECLARATIONS OF INTEREST
There were no declarations of interest received.

3. MINUTES OF THE MEETING 26 OCTOBER 2017
The minutes of the meeting held 26 October 2017 were approved as an accurate record of the meeting.

4. MATTERS ARISING
Mr Bond reported that the preliminary information that had received from the vendor for patient wi-fi at Castle Hill Hospital was that it was using large amounts of data. This had been raised as a risk to slowing down clinical systems when patient wi-fi is rolled out to more areas. This was being reviewed.

4.1 ACTION TRACKER
Cyber security checklist had been shared with Mr Smith – action closed

Single source waivers had been included in the workplan.

Mr Phillips was discussing the out of date Safeguarding policies with the Safeguarding lead. **KP**

There was a discussion around an expensive watch claim and Mr Bond advised that the guidance around patient belongings would be re-launched in December 2017. **LB**

Mr Kelly advised that the review of the Annual Report would be undertaken and reported to the February 2018 committee. **GK**

4.2 WORKPLAN
Ms Ramsay advised that the workplan had been updated to reflect timing changes. The Committee agreed with the slight changes to the document and this was circulated at the meeting.

5. BOARD COMMITTEE MINUTES:

5.1 PERFORMANC E AND FINANCE 27.11.17

Mr Gore asked if the meeting with Health Education England had gone ahead regarding the Trust's allocation of Junior Doctors. Ms Ramsay agreed to confirm this at the next meeting in February 2018. **CR**

5.2 QUALITY COMMITTEE

Ms Ramsay reported that the Learning from Deaths policy had been published in line with National guidance. The Audit Committee would receive assurance via the Board that a quarterly report detailing the Trust's progress would be received.

Mr Phillips had agreed to discuss the outstanding Safeguarding policies with the Safeguarding lead.

6.1 PROGRESS UPDATE REPORT

Mr Kelly presented the report which set out the audit responsibilities of Grant Thornton. He reported that a handover meeting had taken place with KPMG (the previous external auditor) and the initial audit plan was being finalised and would be brought to the next committee.

Mr Kelly highlighted a number of workshops and publications including one relating to income generation. Mr Bond asked for further details regarding this. The STP and governance arrangements were discussed and Mr Gore expressed his concern regarding losing out on capital funding due to the lack of an estates strategy at STP level. This would be escalated to the Board. **MG**

The General Data Protection Regulation was discussed and Mr Bond asked the Auditors whether there was any concern in the system due to the introduction of it. Mr Kelly advised that Grant Thornton had produced a checklist for Trusts to ensure everything required by them was in place. Mr Baines added that he had a benchmark report reviewing other Trust's readiness and agreed to share it with Mr Bond. **GB**

Mr Kelly reported that the audit planning process was going well and according to plan with help from the Financial teams.

Resolved:

The Committee received and accepted the report.

7.1 INTERNAL AUDIT PROGRESS REPORT

Mr Baines presented the report which highlighted 7 audits, 5 of which had received limited assurance and 2 significant assurance.

The limited assurance reports related to ward locality reviews with fundamental standards not always being compliant, such as a drug cupboard being unlocked and resuscitation trolleys not being checked daily. There was a discussion around these audits; Mrs Bates advised that the Chief Nurse was discussing the outcomes with the Nurse Directors, and at Health Group and ward level.

There were two reports showing significant assurance and these related to incident reporting and quality metrics.

OUTSTANDING AUDIT ACTIONS

Mr Baines reported that out of the 150 outstanding, 50old actions had been signed off, 40 were due for completion and 55 were not due yet. All outstanding actions had been RAG rated and Ms Ramsay advised that she was reviewing the high risk areas as a priority.

Mr Gore asked for a report showing all outstanding audit actions and their status at the next meeting in February 2018. Mr Baines and Ms Ramsay to liaise with the relevant managers and provide commentary on the status of the actions. **GB**

Resolved:

The Committee received and accepted the update.

8. TERMS OF REFERENCE

Ms Ramsay presented the Terms of Reference to the Committee which had minor job title changes and regulator name changes. Ms Ramsay reported that the new General Data Protection Regulations would be included and this would mean a change to Standing Orders, which would need to have Board approval.

Resolved:

The Committee received and accepted the Terms of Reference changes, to be recommended to the Trust Board for approval. **CR**

9. BOARD ASSURANCE FRAMEWORK (BAF)

Ms Ramsay presented the report and highlighted the process relating to the BAF.

She reported that the report went to the monthly board committees and was also presented at Board meetings for review. The Board development sessions now incorporated the BAF risks to the organisation and a new section of the BAF has been added to incorporate risk appetite and the level of risk the Trust was prepared to tolerate against achievement of its strategic objectives.

Ms Ramsay advised that the corporate risk registers were discussed at Health Group and Executive Management Board levels and were linked to the Board Assurance Framework areas as appropraite.

BAF 3 and 4 were discussed and the failure of receiving STF funding for capital requirements. This would be reflected in the next report. The financial element of the BAF would be discussed at the Performance and Finance Committee in December 2017.

Resolved:

The Committee received and accepted the report. STF capital funds to be escalated to the Board. **MG**

10. EFFECTIVENESS OF SPEAKING UP ARRANGEMENTS

Ms Ramsay presented the report which highlighted the processes through which staff could speak up, including whistleblowing. She reported that the Board receives a quarterly Freedom to Speak Up Guardian update and new requirements regarding the Whistleblowing policy had been incorporated last year in to the Trust's policy.

Ms Ramsay stated that the key themes coming out from staff concerns across different data sources in the Trust were mainly linked to staff behaviours.

Ms Ramsay also confirmed that the CQC and Anti-Fraud both had dedicated lines to report staff raising issues formally.

Ms Ramsay believes the Trust has in place the mandated requirements to support staff to speak up with concerns, as well as additional support such as the Staff Advice and Liaison service (SALS).

Resolved:
The Committee received and accepted the report.

11. CREDIT CARD EXPENDITURE

Ms Ramsay presented the report which showed most recent expenditure was in line with previous quarters' expenditure.

Mr Bond advised that IT were reviewing an online marketplace through Business Services Authority and that the Estates Department had requested a credit card for out of hours expenditure. Mrs Roberts to review the Estates request to check that it was appropriate.

Resolved:
The Committee received and accepted the report.

12. BOARD EXPENSES

Ms Ramsay presented the item and reported that expenditure was consistent with previous quarters and there were no issues to raise with the Committee.

Resolved:
The Committee received and accepted the report.

13. LEGAL FEES

Ms Ramsay presented the report which detailed the Trust expenditure relating to legal fees. Ms Ramsay reported that there was nothing unusual about the expenditure.

She advised that work was ongoing with 2 legal firms to discuss a fixed fee to reduce costs. The new contract would be on a volume basis with a 10% either way risk share to ensure costs were more static. Ms Ramsay advised that once the process was completed, the recommendation would be made to the to the Executive Team as to whether to move to this sort of contract arrangement.

Resolved:
The Committee received and accepted the report.

14. ANY OTHER BUSINESS

Mr Gore raised the latest Tracking Access Report from MBI and expressed his concern regarding the wider management issues.

Mr Bond explained the issues to the Auditors and asked for their opinion.

A meeting would be set up to discuss this further. **LB**

Mr Kelly asked about the impact on the mandatory indicators such as referral to treatment times and how this would be managed. Mr Bond added that the Clinical Commissioning Groups, local MPs and NHS Improvement were aware of the issues.

15. DATE AND TIME OF THE NEXT MEETING:

Tuesday 27th February 2018, 9am – 12pm, The Committee Room, Hull Royal Infirmary