HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 4 JULY 2017, THE LECTURE THEATRE, CASTLE HILL HOSPITAL AT 2:00PM
AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC
OPENING MATTERS
TRUST BOARD PAPERS ARE AVAILABLE AT:
HTTPS://WWW.HEY.NHS.UK/ABOUT-US/TRUST-BOARD-MEETINGS/

1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 6 June 2017	attached	Chair
4. Matters Arising		
4.1 Action Tracker	attached	Director of Corporate Affairs
4.2 Any other matters arising from the minutes	verbal	Chair
4.3 Board Reporting Framework 2017-18	attached	Director of Corporate Affairs
5. Chair's Opening Remarks	verbal	Chair
6. Chief Executive's Briefing	attached	Chief Executive Officer
QUALITY		
7. Patient Story	verbal	Chief Medical Officer
8. Quality Report	attached	Chief Nurse
9. Nursing and Midwifery Staffing Report	attached	Chief Nurse
10. Quality Committee minutes and summary report	attached	Quality Chair
PERFORMANCE		
11. Performance Report 11.1 – A&E Presentation	attached presentation	Executive Team A&E Team
12. Performance & Finance draft minutes and summary report	attached	Performance & Finance Chair
STRATEGY & DEVELOPMENT		
13. Revised Financial Plan including FIP2	attached	Deputy Director of Finance
14. Trust Implementation Strategy Update	attached	Director of Strategy and Planning
15. Staff Feedback – Relocation to New Offices	attached	Director of Workforce & OD

ASSURANCE & GOVERNANCE

16. Standing Orders	attached	Director of Corporate Affairs
17. Board Assurance Framework	attached	Director of Corporate Affairs
18. Board Development Programme	attached	Director of Corporate Affairs
19. Any Other Business	verbal	Chairman
20. Questions from members of the public	verbal	Chairman

21. **Date & Time of the next meeting:**
Tuesday 1st August 2017, 2 – 5pm the Boardroom,
Hull Royal Infirmary

Attendance 2017/18

	4/4	2/5	25/5 Extra	6/6	4/7	1/8	5/9	3/10	7/11	5/12	Total
T Moran	✓	✓	✓	x							3/4
C Long	✓	✓	✓	✓							4/4
L Bond	✓	✓	✓	✓							4/4
A Snowden	✓	✓	✓	✓							4/4
M Gore	✓	✓	✓	✓							4/4
S Hall	✓	✓	✓	✓							4/4
M Wright	✓	✓	✓	✓							4/4
K Phillips	✓	✓	✓	✓							4/4
T Sheldon	x	✓	✓	x							2/4
V Walker	✓	✓	✓	✓							4/4
T Christmas	✓	✓	✓	✓							4/4
E Ryabov	✓	✓	✓	✓							4/4
In Attendance											
J Myers	✓	✓	✓	✓							4/4
S Nearney	✓	✓	x	✓							4/4
C Ramsay	✓	✓	✓	✓							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 6 JUNE 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr A Snowden	Vice Chair/Non-Executive Director
	Mr C Long	Chief Executive Office
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr K Phillips	Chief Medical Officer
	Mr S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
IN ATTENDANCE	Mrs J Ledger	Deputy Chief Nurse
	Mr S Nearney	Director of Workforce & OD
	Ms J Myers	Director of Strategy & Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Assistant Trust Secretary

NO. ITEM **ACTION**

1. APOLOGIES

There were apologies received from Mr T Moran - Chairman, Mr M Wright – Chief Nurse and Prof. T Sheldon – Non-Executive Director

2. DECLARATIONS OF INTERESTS

2.1 - CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING

There were no declarations received.

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

There were no declarations received.

3. MINUTES OF THE MEETING HELD 2 MAY 2017

The minutes of the meeting held on 2 May 2017 were approved as an accurate record of the meeting.

3.1 – EXTRAORDINATORY BOARD MINUTES 25 MAY 2017

The minutes of the meeting held 25 May 2017 to approve the Trust's Annual Accounts were approved as an accurate record of the meeting.

4. MATTERS ARISING

4.1 – ACTION TRACKER

The action tracker was reviewed by the Board. All items were on track to deliver in the timescales stated.

4.2 – ANY OTHER MATTERS ARISING FROM THE MINUTES

Mr Phillips advised that the CQC Well Led inspection would be held on 19th/20th June 2017 and interview date and times had been communicated to relevant staff. Mr Bond added that the inspection now included the Use of Resources audit.

Ms Ramsay requested that a minute be added regarding the Modern

Slavery statement. This statement had been included in the Annual Report that had been approved by the Board but specific approval was required. The Board approved the Modern Slavery Statement that was included in the Annual Report 2016/17.

4.3 – BOARD REPORTING FRAMEWORK
The Board Reporting Framework was received by the Board.

5. CHAIR'S OPENING REMARKS
Mr Snowden highlighted the 'Moments of Magic' in the Chief Executive report and the members of staff willing to go over and above their responsibilities to help patients or other members of staff. The Golden Hearts award ceremony was taking place June 9th 2017 to celebrate these members/teams of staff.

6. CHIEF EXECUTIVE'S BRIEFING
Mr Long reported that the Trust was changing its name to *Hull University Teaching Hospitals NHS Trust*. He advised that this would cement links with Hull University and HYMS creating strong partnerships and synergy. A future academic strategy was being developed. It was hoped that the name change would attract potential staff to the organisation including international recruits.

Mr Long thanked the staff that had worked to rectify the IT systems following last month's cyber attack. Their efforts had meant that little disruption had been caused.

Mr Long reported that the Queens Centre now had free wifi for all patients and this was planned to be rolled out to all areas.

There was a discussion around the improvements being made in the radiology department and how this was reducing waiting times for CT/MRI scanning. The team were recognised for their commitment to reduce this further.

The Trust had enforced a smoke free hospital and Mrs Christmas asked how this was being managed. Mr Long advised the so far people had been compliant and there had been no major issues.

Mrs Walker drew the Board's attention to the charitable funds that had been approved by the Charitable Funds Committee for use on wards 8 and 80 and the dementia patients. Mrs Walker was concerned that the money approved was not being used in the way in which it was detailed in the report to the committee. This would be followed up by the Charitable Funds Committee.

Mr Snowden reported that a number of staff members were running the Jane Tomlinson 10K on behalf of the WISHH Charity and encouraged members of staff to support where possible.

Mr Gore reported that the 'Song for Hull' tickets were now on sale.

7. PATIENT STORY
Mr Phillips presented two patient stories. The first one highlighted the need for better co-ordination and communication as this had resulted in an

autistic patient becoming very distressed. The second story was regarding how the Trust had handled a resolution meeting following a complaint. This had been dealt with in a positive, compassionate and honest way and the complainant had been satisfied with the outcomes.

8. QUALITY REPORT

Mr Phillips presented the report and highlighted that the Trust had not experienced any Never Events and one serious incident, which was under review. This was the first case the Trust had reposted under the new process that has been put in place by NHS Resolution (formerly NHS Litigation Authority).

Mr Phillips also reported that patient harms were within the appropriate levels and VTE assessments continued to improve.

The complaints information now included the number of complaints compared to the episodes of care and Mr Wright was now meeting with senior staff to reinforce the importance of closing complaints within the 40 day timescales.

Resolved:
The Board received the report.

9. NURSING AND MIDWIFERY STAFFING REPORT

Mrs Ledger presented the report and highlighted that there had been a reduction in fill rates for HRI during the day due to sickness levels. Work on recruitment was continuing with 145 nurses currently being pursued from the University of Hull and a number of international nurses being interviewed.

Mrs Ledger reported that the senior team was working with wards to ensure that acuity levels were correct and working closely with the finance team when moving nurses between departments. Mrs Ledger advised that some of the registered nurse figures needed validating.

Sickness levels had increased but this was being monitored closely.

Resolved:
The Board received the report.

10. QUALITY ACCOUNTS

Mr Phillips presented the report which confirmed the current process. Mr Phillips reported that the Board would have an opportunity to review the document but requested that it delegate responsibility to the Quality Committee in June 2017 to officially sign off the Quality Accounts. External Audit would also review the Quality Accounts.

Resolved:
The Board received the update and delegated approval of the Quality Accounts to the Quality Committee in June 2017.

11. QUALITY IMPROVEMENT PLAN

Mr Phillips presented the Quality Improvement Plan which was being reviewed and the milestones developed to become more outcome focussed. The overall rating of the QIP was green.

There was a discussion around children's services as it had been flagged as amber/green in 4 areas. Mr Phillips assured the Board that a new manager was in post and work was ongoing with external partners to enhance the service.

The QIP was reviewed weekly and any issues were escalated to the Operational Quality Committee and the Quality Committee.

Resolved:
The Board received the report.

12. QUALITY COMMITTEE MINUTES 24 APRIL 2017 AND VERBAL UPDATE 24.04.17

Mr Snowden updated the committee and reported that following the major trauma peer review, substantial progress had been made by implementing the actions required. Work was ongoing regarding recruitment.

Mr Snowden also reported that the Quality Committee had received a presentation from the Head of Dietetics who had given assurance around patient nutrition.

Mr Phillips added that the Lessons Learned newsletter was being updated and would be called the Lessons Shared newsletter.

Resolved:
The Board received the update regarding the Quality Committee.

13. PERFORMANCE REPORT

Mrs Ryabov reported that the A&E performance was positive and above the national average in May and June figures were showing a sustained trend. The winter ward had now closed.

The 62 day treatment standard had suffered 369 breaches in May. Cardiac CT backlogs were a concern and there were plans in place to hire an additional van in June and July to address this. Cystoscopy had experienced an equipment failure and staff were working a Saturday in June to eliminate the backlog.

Cancer was discussed and Mrs Ryabov advised that work was ongoing with the STP programme to review the issues and their impacts on the pathways. Action plans were in place.

Mr Hall reported that diagnostic capacity was one of the key issues discussed at the Performance & Finance Committee and this would be scrutinised in more detail at the June meeting. The discussions with Yorkshire Ambulance Service regarding changeover times was recognised. Mr Gore had attended the performance meeting and had welcomed the robust discussions that had taken place.

Mr Phillips reported that the Trust was working with Business Intelligence regarding mortality and reviewing avoidable deaths. A policy would be presented to the Board in due course. Mr Phillips also reported the work ongoing to reduce the open drug systems and a clearer labelling system.

Mr Bond presented the finance section of the report. He reported that the

deficit at month 1 was £5.3m which was £1.1m above plan. Mr Bond highlighted the key issues as being a CRES shortfall of £600k, an over trade in month 1 and the control total that was yet to be signed. The Trust was also experiencing cash issues which could mean the necessity to have a working capital loan in the future. Mr Hall and Mr Gore both expressed their concern regarding the Health Group overspend.

Resolved:
The Board received the report.

14. PERFORMANCE AND FINANCE DRAFT MINUTES AND SUMMARY REPORT 24.04.17, 30.05.17

Mr Hall presented the minutes and the summary and reported that all items were covered in the performance report (item 13).

15. FINANCIAL IMPROVEMENT PROGRAMME

Mr Bond advised that the Trust had received the report prepared by the FIP2 team and this had been considered by the Executive Team. It would be presented to the Performance and Finance Committee, NHS Improvement for further scrutiny and then a proposal would be brought to the Board for approval.

Resolved:
The Board received the update.

16. PAPERLESS COMMUNICATIONS WITH PATIENTS

Mr Bond presented the report which highlighted the ways in which the Trust was communicating with patients other than traditional letters. He advised that text messaging was available in some areas but had not been rolled out across the entirety of the Trust. GP portals were being reviewed as was virtual consultancies.

Mr Snowden asked if limited capital funding was slowing down the process of implementing more technology friendly systems. Mr Bond reported that yes this was the case. Ms Myers added that work was ongoing within the STP programme to review issues with the wider health economy to enhance services.

Mr Phillips added that a number of patients would no use text messaging so other forms of paperless communications would need to be pursued. He spoke about the advantage of patients holding their own digital records and the security issues associated with this.

Resolved:
The Board received the report and noted the progress made to date.

17. ADDITIONAL PAPER A – CHANGE OF ORGANISATIONAL NAME

Mr Long presented the report and advised that the Trust would be submitting an organisational name change to the Department of Health. The Trust's would become *Hull University Teaching Hospitals NHS Trust.*

Mr Long stated that this would be a positive change for recruitment purposes. The costs would be kept low by running down the stationery stocks first and migrating to nhs.net in the future.

The Trust had written to its partners advising them of the change and welcoming comments. The change had been well received by medical staff.

Resolved:
The Board received the report and agreed that the process should proceed.

18. BOARD ASSURANCE FRAMEWORK 2017/18

Ms Ramsay presented the BAF 2017/18 as there had been further feedback received from the Performance and Finance and Audit Committees and this had been incorporated.

Ms Ramsay advised that not all gaps in assurance would be fully completed and the risks may not be closed within the year due to the nature of the risks.

There was a discussion around cyber security and whether this should be recorded as an independent risk. It was agreed that the risk was captured appropriately, but would be reviewed regularly.

Resolved:
The Board received the report and approved the changes made.

19. EXTRA ORDINARY AUDIT COMMITTEE 25.05.17

Mr Gore reported that the minutes reflected the discussions to recommend approval of the annual accounts to the Board.

20. CHARITABLE FUNDS COMMITTEE 31.05.17

Mr Snowden reported that the Committee had received updates on fundraising from the Chair of the WISHH charity at its meeting 31.05.17 and how the fundraising was being aligned to the Trust's strategic objectives. Mrs Walker asked the Board to support the fundraising events where possible.

21. STANDING ORDERS

Ms Ramsay presented the report and advised that the Trust seal had been used to sign off demolition work around the sites.

Resolved:
The Board approved the use of the seal.

22. ANY OTHER BUSINESS

There was no other business discussed.

23. QUESTIONS FROM MEMBERS OF THE PUBLIC

Support was received regarding the Trust becoming a no smoking site.

A question was received regarding the Trust changing its name.

24. DATE AND TIME OF THE NEXT MEETING:

Tuesday 4th July 2017, 2 – 5pm, the Lecture Theatre, Castle Hill Hospital

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (June 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB	Jul 2017		Not yet due
January 2017						
01.01	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Sept 2017		Not yet due
01.03	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	Jul 2017		
COMPLETED						

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

JUNE 2017

Emergency services to practise major incident response

A live exercise to test the response of emergency services to a major incident was conducted in Hull this weekend, on Saturday 24th June.

Exercise Orange Falcon was a great success and organised by a team from the Trust with support from colleagues including police, fire, ambulance, and the voluntary sector.

Staff were asked to respond as if it were a real life situation with mock 'casualties', played by students of Bishop Burton College, brought to hospital. Decontamination procedures were tested with staff coming from all areas of the hospitals including the Emergency Department.

The exercise successfully tested the ability of the various organisations taking part to work together effectively. In particular, as Hull Royal Infirmary is one of just eleven adult major trauma centres in the country, it enabled us to test our internal systems and how the various teams and departments work together.

Care has been taken to ensure the exercise will not interfere with routine services provided in the Emergency Department or elsewhere in the hospital.

HRI celebrates 50 years since its opening in City of Culture year

Last week, Hull Royal Infirmary celebrated 50 years since Her Majesty, The Queen, performed the official opening of the 14-storey hospital on Anlaby Road.

The Trust keeps a host of photographs and artefacts from the tower block's construction period and beyond in its archive. These include the original foundation stone laid by Enoch Powell on 25th September 1963 along with the ceremonial trowel and mallet, and the original programme and visitors' book signed by the Queen as part of the hospital's opening ceremony in 1967.

Many members of the public contacted us via social media to tell us their positive, moving and sometimes funny stories about experiences in the hospital and praise the work of our staff. We even heard from one individual who presented the Queen with a bouquet of flowers at the official opening.

Launch of international centre of orthopaedic excellence

East Yorkshire's reputation for healthcare innovation and research was further enhanced during June with the opening of an international centre of orthopaedic excellence at Castle Hill Hospital.

Multi-award winning healthcare company JRI Orthopaedics has worked alongside Hull and East Yorkshire Hospitals NHS Trust to establish its first UK Centre of Excellence for joint replacement.

The Hull and East Yorkshire Regional Arthroplasty Centre (HEYRAC) will have a key role in clinical research, sharing of best practice and the development of new hip replacement products and surgical techniques.

Golden Hearts Awards
Held earlier this month for the seventh consecutive year, almost 350 people came together to celebrate innovation, achievement, and care at the Mercure Grange Park Hotel in Willerby.

Fiona Dwyer from ITV Calendar News once again hosted the event for us, and there were two magical performances by classical Indian dancers, who are members of Trust staff, from the Hull and East Riding Hindu Cultural Association. A collection for Fiona's chosen charity, the SAMMI Fund which supports people with spinal injury, also raised a fantastic £750 on the night, so thank you to everyone who donated.

Congratulations to everyone who made it to the final three of each of the 15 award categories this year; once again, the standard has been so high, you really are all winners as far as the Trust, and more importantly, our patients are concerned.

Making it Better
Winner: Frailty Intervention Team
Runners up:
PARCS Home Exercise Programme
DME Elderly Continence Care Pioneer Team

Great Leader
Winner: Kay Brighton
Runners up:
Stacey Healand
Tracey Chapman

Team Spirit
Winner: Ward 11, CHH
Runners up:
Ward 8, HRI
Ward 60, HRI

Lessons Learned
Winner: Dr Tony Goldstone
Runners up:
DME Base Wards
Labour Ward Obstetric Team and Clinical Skills Team

Stronger Together
Winner: Remarkable People, Extraordinary Place campaign
Runners up:
Kay Brighton and Ward 9
Young Health Champion Traineeship Pre-employment Programme

Mentor of the Year
Winner: Hedley Wilson
Runners up:
Angela Hanstock
Matthew Handley

Apprentice of the Year
Winner: Laura Marks
Runners up:
Charlotte Robinson
Domonic Walker

Moment of Magic
Winner: Laura Marks, Heather Worrell and Mandy Maughan
Runners up:
Chris Ward
Anna Binks and Lesley Boasman

Outstanding Individual: Scientific, Technical & Therapeutic
Winner: Dearbhla Harhen
Runners up:
Lucy Aldrich
Nicola Beaumont

Outstanding Individual: Non Clinical
Winner: Peter Bugg
Runners up:
June Crosby
Carly Medlock

Outstanding Individual: Clinical
Winner: Dr Tom Cowlam
Runners up:
Miss Kathleen Merrick
Dr Anna Greenwood

Outstanding Individual: Nursing and Midwifery
Winner: Leah Dobson
Runners up:
Helen Tointon
Vonnie Hyam

Outstanding Team of the Year: Non Clinical
Winner: Endoscopy Decontamination Team
Runners up:
Portering and Helpdesk Team
HILS

Outstanding Team of the Year: Clinical
Winner: Sepsis Team
Runners up:
Ward 90, HRI
Arthroplasty Service Day case Hip and Knee Replacement Team

Lifetime Achievement Award
Winner: Dr Chris Walton
Runners up:
Mary Share
Lorraine Rowell

Health Group Trophy
For the most Golden Hearts award nominations
The Medicine Health Group

Partnership to develop nurses of the future
A new training scheme which will help to develop nurses of the future has been launched.

Hull and East Yorkshire Hospitals NHS Trust is working with the University of Hull to introduce the role of the Nursing Associate, to address current skills gaps and help individuals go on to build successful nursing careers.

Nursing Associates will work with a higher skill-set than traditional Nursing Auxiliaries to assist, support and complement the care given by registered nurses.

The Trust is a second wave pilot site for the Nursing Associate role, with study being carried out at the University and hands-on experience gained at either Castle Hill Hospital or Hull Royal Infirmary.

The University is playing a pivotal role in the region's health, by providing skilled graduates for the NHS as it leads a transformation of its health and care workforce. Seventy per cent of nursing graduates from the University go on to work in the region.

The position of Nursing Associate has been commissioned for development by Health Education England. Twenty Nursing Associates have now begun to provide high quality compassionate care to patients at Hull and East Yorkshire Hospitals NHS Trust in departments such as paediatrics and emergency care.

HRI takes the WillerBee campaign under its wing
Hull-based manufacturer Willerby has got hospital staff and patients buzzing about its new WillerBee campaign, thanks to a donation of 500 packets of special bee-friendly seeds and four handcrafted bee houses.

Hull Royal Infirmary has taken the holiday home manufacturer's campaign under its wing, with gardeners from the hospital planning to create a small patio area outside the hospital's therapies centre and plant more seeds in new flower beds across the site.

In the coming weeks the bee houses, which have been crafted specially for Willerby's campaign by prisoners at HM Prison Hull, will be situated around the therapies centre, where there are already plants and shrubs which are known to attract bees.

It's hoped that as well as supporting the conservation of the bumblebee, the flowers and boxes around the Hull Royal Hospital site will brighten up the grounds for staff, patients and visitors alike.

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 May we received 53 Moments of Magic nominations:

Two week wait referral team	I Work in the Appointments and Referrals centre, in the Wilson building, I work as part of the Appointments and Referrals team, but I actually sit in the Two Week Wait office. Every day the 4 ladies, not one in particular, but all 4, go above and beyond, to get patients to their care providers, in a world of care, they CARE! I am astounded by their dedication and constant effort to get patients seen, and onward on their journey to better heath.	**31/05/2017**
Andrew Walgate	Andrew helped a clearly distressed elderly visitor to the centre who was attending the Ophthalmology public event. The lady was a little confused in reception and Andrew offered to help the lady to her car in the main car park, She advised she felt dehydrated and he fetched her some water and sat her down to have a drink whilst he asked a manager for advice as he didn't think it was safe for the lady to drive herself home in her confused state. He the talked to the lady and convinced her to have something to eat in the restaurant before considering going home, the lady agreed and said she would get a taxi if she didn't feel any better rather than driving. Andrew arranged a wheel chair and took the lady across to the tower block so that she could get something to eat. He kept really calm and reassured the lady who said she was embarrassed. He really was a credit to our organisation and proved that we can deliver care even in a non clinical environment.	**31/05/2017**
Daphne Pashley	I would like to nominate Daphne Pashley. I have worked with her for a long time and I have seen her dedication to her work, compassionate and empathetic towards her patients, and supportive to work colleagues and a reliable member of the department. She is an asset to our department.	**31/05/2017**
DME Outpatients	From the nursing staff, auxiliaries to the clerical staff you can tell and feel the passion that they have about the care for their patients. Staff starting a sing-song in the waiting area to the nursing staff taking their time with their patients complex needs and dealing with complex patient cases to ensure that the patients' care	**31/05/2017**

	is excellent. The staff here are a pleasure to work for and are a gem to the trust. As a student nurse experiencing everything here they have certainly set the bar high for other placement areas. Thank you for having me and I hope you get the recognition you deserve for all the hard work you put in.	
Rachel Shepard	I would like to nominate Rachel from Day Surgery. Rachel has a new job and has decided to take it. Here at day surgery she is going to be missed so much by us all. She is a great member of the team and loved by all including staff and a lot of patients. She has helped so many people in many ways and will continue to help people in her new role! I would like to say we love you so much and will miss you more than ever but follow your dreams and have an amazing time!	**25/05/2017**
Jean Stowell	In the Immunology and Haemophilia Department we often have complicated requests for pharmacy, often at short notice. Jean is never phased by our requests. She always helps us to resolve queries in a friendly professional way and offers advice regarding pharmacy processes to ease with the situation. Even though she has a very busy role she is always willing to come to the phone or reception desk to deal with queries with a welcoming smile on her face.	**25/05/2017**
DME Outpatients	The staff at Westbourne DME Outpatients are a fantastic team. I have worked with them for 4 weeks as a student nurse and every member of the team is supportive and knowledgeable about their job. It is evident they have a strong passion for their job and passionate about their patients. They're all a credit to the profession.	**25/05/2017**
Hollie Deanes	Hollie was on reception for the day, the fire alarm went off in the afternoon and the building had to be evacuated. Hollie made sure that the patients were aware of what was going on and helped to ensure they made it to our assembly point, she stayed with the patients during their time outside and was talking to them to make them feel at ease. Not long after the fire alarm another patient arrived who had learning difficulties and had lost his blue badge to display in the car park, Hollie wanted to ensure that the patient was able to be seen and to not get a parking fine as the patient was quite distressed about the situation, so she obtained the contact number for the relevant department to explain the situation and the patient was successfully screened for their appointment that day. Thank you for going the extra mile and always	**24/05/2017**

	providing a helpful attitude and smile to the patients when on reception duty, it doesn't go unnoticed!	
All staff on ward 11	All ward 11 work extremely hard, when short staffed always pull through, great team!!	**23/05/2017**
Sue Thorpe	Sue Thorpe has many moments of magic she is always happy to help both staff and patients in the emergency department. Whilst coordinating the ground floor she came into the ED department and a patient needed medication through a Hickman line. No staff on duty had experience of giving medication via this route; Sue contacted a ward she had worked on previously to ensure practice had not changed and then went on to give the medication and educate staff on how to use the Hickman line. Sue is always happy, helpful and readily available for support when needed. Sue is a compassionate, caring and very professional nurse.	**23/05/2017**
Jackie Holden, Danielle Hope, Jackie Pullen	A quick note of thanks to Jackie Holden, Danielle Hope and Jackie Pullen all of whom stayed on after a very busy shift to look after the patients on ward 6 long after their shift had finished on Saturday 20th May, whilst cover was arranged to cover short notice sickness.	**22/05/2017**
Zoe, Sarah and Jodie	We would like to nominate Zoe, Sarah and Jodie from the antenatal day unit next to EPAU. One of our colleagues in the EPAU department fell ill and collapsed suddenly whilst on duty. This took us away from our clinic to care for her until the ambulance crew arrived. The midwives and midwifery assistant helped us with our colleague and offered to keep an eye on our patients and help out where they could in the hour before she was taken to the ED. Despite having their own patients to look after they were brilliantly supportive to us and our patients at the time and we are very grateful for their help. Vicky & Angela	**22/05/2017**
Simon Carter	I was looking after a little boy today and his illness was a bit unclear, besides which I was struggling to get the necessary investigations as he was tired and a bit grumpy after his long wait in ED. Simon, the paediatric registrar was very understanding of the situation, and kindly agreed to help out by reviewing the child. Besides this, Simon is always happy to come to ED and help us seeing patients when we are busy. I always get sound advice from him.	**20/05/2017**
Ross Stringer	Ross came down to the department with a very poorly	**19/05/2017**

	and confused patient who was very agitated. Due to her agitation she needed to be sedated before her procedure. Unfortunately due to one thing or another, the sedation took a long time to have a minimal effect and she was still quite agitated and needing lots of care and time. Ross stayed with the patient right through her scan, holding her hand and being so patient, never once being anything other than a hugely caring Doctor. He stayed almost an hour and a half over his leaving time with no complaints at all. He is a true credit to ward 70 and the Trust.	
Paula Russell	It was a Friday afternoon and our retinal screening clinic had finished and the screening staff had left the premises. There were a couple of colleagues left in the building and Paula was just preparing to leave for the day when she noticed two people sat in the waiting room. Enquiries revealed that the patient had originally had a screening appointment that had been cancelled but due to a breakdown in the lines of communication, the patient had never received the notification informing him of this. Paula immediately turned on the equipment and started the screening process, starting with his eye test and then having to wait 15 minutes after she had used the dilating drops before she could take the images of his retina. This whole process took quite some time. It was just so nice to see someone that put a patient first above the desire to rush out of the work environment on a Friday afternoon. Our Screening Programme is constantly witnessing such dedicated acts from a wonderful team of people and it makes me very proud to be part of it.	**19/05/2017**
Paula Russell	On Friday afternoon at 15:47 when Paula was washing her cups and getting ready to go home, she noticed a patient was waiting in the waiting room however that the screening staff had left 15-20 minutes prior and had finished their clinics for the day. After obtaining the patient information and inputting into our system it was an appointment which was previously altered however the patient still arrived, rather than having to rearrange the patients appointment and him having to come back Paula offered to see the patient even though it wasn't her duty or responsibility and meaning that she would be leaving a good 15-20 minutes after her finish time on a Friday too! Paula always offers support in situations like this, without being asked and is a credit to the team, thank you Paula! :)	**19/05/2017**
Sam Burge	Sam was Such a wonderful colleague and supported other in times of high stress and high demand on the	**19/05/2017**

	department. Your help was really appreciated thanks Sam going out of your way to help others was wonderful.	
Gurjit Chhokar	Whenever Gurjit the RMO2 is covering EAU he goes above and beyond his job role helping patients and staff. He's always happy to help and nothing is above his job role. When reviewing a patient, the patient needed to use the toilet, instead of asking one of the other members of staff to assist the patient he went and got his PPE on and took a commode to the patient himself knowing how busy we were. Which is a rare thing, nothing is too much trouble. #TEAMWORK!!!!!!!!!!!!!	**19/05/2017**
Wendy Mellors	Wendy Mellors (MITIE) is always helpful and very considerate to patients when working. Very compassionate and loyal in her role as a domestic on ward 9 CHH and always has a smile and a sweetie ;-)	**18/05/2017**
Diabetes and Endocrinology Outpatient Nurses	I had to bring my mum into the Brocklehurst Building for a blood test. This was extremely difficult as my mum is a vulnerable adult who does not like to be touched. The Outpatient nurses were absolutely wonderful. They made a real effort to reassure my mum, sing with her to distract her and generally create a nice(r) atmosphere for mum. ..and they managed to take the blood! Thank you.	**18/05/2017**
The IT Team	The Trust IT Department for their response to the recent Cyber Attack. Ian Hutty, Mike Barnett, Graham Annan and Neil Proudlove worked throughout Friday night to protect our systems and ensure that all services remained available, and on Saturday they were joined by IT colleagues Andrew Diggins, Sam Norton and Mitchell Atkinson to monitor the ongoing situation, fix issues and give help to staff where needed. Once the weekend was over, the whole IT Team worked together to respond to emerging problems and provide help and advice to users across the Trust. The work that goes on behind the scenes, day in day out, helps protects our systems and keeps us as safe as possible. That bread and butter work, together with the rapid response we saw last week from IT, allowed our business to keep running with minimal impact on our patients. Chris Long, Chief Executive	**17/05/2017**
IT Department et al	Well done to everyone involved in keeping our IT systems safe during the recent Cyber attack. It wasn't 'business as usual' and many people must have gone	**17/05/2017**

	above and beyond the call of duty and pulled out all the stops. Thank you	
Lyndon Corney	I've worked with Lyndon for some time now and I feel I need to say without him it would make our job a lot harder! He is so highly thought of by staff and patients/family, he will do anything for anybody and has skills above and beyond his job role! Constantly keeping team morale making us all smile! We all on ward 12 wanted to show our appreciation! Thank you Lyndon!!	**16/05/2017**
Lyndon Corney	Lyndon always delivers exceptional care to all patients and gets outstanding compliments from patients and family members.	**16/05/2017**
Dawn Langley	I would like to nominate Dawn Langley on A&E minors reception. She went above and beyond for me whilst I was seriously ill in hospital! I am a colleague at a different department, but she was brilliant!! Thanks Dawn :D	**12/05/2017**
Mark Croall	On Thursday morning on arrival to work I came across a lady in Argyle Street Car park on the floor in severe pain, unable to move with her partner and trying to access A&E. I left the patient safely with her partner and went to the front of Hull Royal to get help. I came across Mark who I made aware of the situation, and without any hesitation he got a wheel chair and helped me transfer the lady safely to A&E with her partner.	**12/05/2017**
Rosemary Flanagan	I cannot thank this lady enough for her support when I have come into difficulties with university studies on top of working in the Emergency Department full time. She is always so approachable, friendly and completely understanding. Rosemary worked on a letter of support for me in her own time late at night in order to request an extension on my submission date, relieving so much stress and allowing me to complete my studies. Rosemary you are wonderful and I am so grateful.	**12/05/2017**
Wendy Beale	I would like to nominate Wendy Beale our Hygienist on ward 11 who goes above and beyond. Nothing is ever any trouble, she always has a smile on her face every day no matter what work load she has on. Well done Wendy, keep up the good work, you're a legend !!!!!!	**11/05/2017**
Ward 31	My father in law has had several admissions to ward 31 CHH in the last few months. Every member of staff	**11/05/2017**

	on ward 31 showed outstanding kindness, compassion and professionalism. He would always tell everyone he met how fabulous everyone on ward 31 was which is a great testament to the team and the organisation!. He felt safe and comfortable there and everyone always greeted him with a big smile which made a huge difference. Well done to a fab team x	
Dr Kirsten Saharia and Debra Marsh	Dr Kirsten Saharia and Debbie Marsh (Macmillan CNS palliative care) were involved in the care of my father in law during a recent stay at the Queens Centre CHH. Kirsten and Debbie went above and beyond in their role in demonstrating outstanding professionalism, compassion and kindness. They organised transfer to Dove House Hospice in line with his wishes where he died the following day. They both made such a huge difference to my father in law and the whole family at a very difficult time.	**11/05/2017**
Carol Griffin	We had a sick patient on the ward who did not live locally. The patient's partner was staying nearby and was spending long periods of time away from home- approx. 2hrs drive away. It was brought to my attention that the partner had ran out of their supply of crucial cardiac medications and I was asked if I could do anything to help. I was unsure what could be done in this situation and spoke with Carol our ward's nominated medications management technician and she liaised with the relative and their GP surgery and arranged for an emergency prescription to be faxed to the Queens Centre pharmacy and the relative was issued with an emergency 5 day supply of the drugs they required. Other staff from pharmacy were involved in making this happen but it was Carol that made it happen. When the supply of drugs were given to the relative, both the patient and relative were in tears and were so shocked and grateful that we had helped.	**11/05/2017**
Lindsay Smith and Donna Caldo	I would like to thank Lindsay and Donna on behalf of the whole Neurophysiology team for their extremely hard work over the last 3 months whilst our manager has been on sick leave. Not many people could carry an extra person's work load and there have been some tough challenges but you've have been absolutely amazing and we wouldn't of survived without your commitment and dedication. Just want you both to know how much we appreciate the extra work you've put in. Thank you.	**10/05/2017**
Sue Stevenson	Sue has been complimented many times by patients	**10/05/2017**

	who come for their screening. She is always helping patients in and out of the rooms, holding doors open and always ensuring patient transport is booked when required. Patients have said how nice it is to have someone so friendly and helpful screening them. During the days when she is not on the clinic Sue always ensures the receptionist is ok for a cuppa and always makes time for her colleagues to ask how they are. She shows genuine care and compassion to patients and makes them feel welcome. They always express how they look forward to coming back next year which just goes to show she is great at what she does. Thank you for making the patients feel well looked after, this creates a nice, chatty waiting room.	
Louise Beedle	I would like to nominate Louise Beedle for a Moment of Magic. Louise oversees the Patient Experience Team which are based across at 2 sites. Lou is a fantastic leader. Every day she makes an effort to make all team members feel included and up to date within the team and in what is going on throughout the Trust. With a team that is involved in so much, this is essential. Louise is a really positive and bubbly person with a can do attitude. When a problem presents, Lou will find a way to solve it, sometimes with the help of asking the universe for support (she says if you ask the universe for something, it will give it to you)! She is a people person and has a sixth sense in detecting anyone's upset which is why she has gained the name of Voodoo Lou throughout her years in the Trust. There are a number of amazing managers and people within the Patient Experience Team with Louise being one of them.	**10/05/2017**
Andrew McKay	Andy always makes time to say thank you to reception after his screening has finished. This may not seem like much to some, but to be thankful and appreciate your part in team work can make a big difference to someone's day. He is also very considerate and helpful to the patients, holding the doors open for them, helping them to get in / out the screening rooms, and also making sure that the patients transport has been booked. Patients have complimented Andy for being helpful as they have been waiting for their transport and have expressed how So this is just to say a thank you back from me and the patients who have complimented you.	**10/05/2017**
Ann Brown and Mary Leanne	I am a GP trainee, currently in hospital posting. I would like to take this opportunity to appreciate Ann Brown and Mary Leanne who are coordinating GP training and teachings. They are always available to help you	**10/05/2017**

	and they have all the information you need, if they are not sure they make sure they find about it and update you. Always have a smile on their face, never seen them being upset or grumpy! Always ready to help.	
Sally Littlewood	I arrived on ward 9 as a new student nurse and worked with Sally on several night shifts never doing nights before she really looked after me and by the time I had left felt as though I had learnt a lot of basic skills nothing was too much trouble I just want to say Thank You and will take those skills with me through my training.	**10/05/2017**
Steph Flanagan	Steph Flanagan one of our hospital at night practitioners went above and beyond in organising a 'song for Sepsis' to help raise awareness of this within our trust. The filming of the song went ahead this week and her organisational skills, witty song writing, directorship and professionalism was amazing. The song would never have happened without her, I can't wait for this to be shared with the Trust and raise awareness in a innovative way to help reduce avoidable deaths due to Sepsis. a massive well done to Steph and all involved.	**09/05/2017**
Helen Russell	Helen was telephoned from the critical unit for some advice on her weekend off. She assessed the situation and selflessly gave up her plans with her family, to support her colleagues by going into work to set up a time critical therapy.	**08/05/2017**
Sam Good / Marcus Moore	I would like to nominate two of my colleagues for the care and support towards patients and their auxiliaries. It was a hard shift on AAU and Sam and Marcus chipped in with us; no matter what the auxiliaries asked, they were there to help - nothing was too much for them. Thank you to you both. We made a good team .	**08/05/2017**
Janice Brentano	Janice's professionalism makes her a joy to work with. Whenever I have needed assistance in an audit, she is prompt in her response. She makes sure I get the help I need and puts me in touch with the right people who can assist me if she cannot. She is an asset to the clinical audit team; I wish everyone was as professional and efficient as she is!	**07/05/2017**
Christine Lison	Christine has only been on the ward 6 months but fitted in straight away, nothing is ever too much trouble for her and she always has a smile for the patients and makes them feel relaxed and cared for. She will help	**07/05/2017**

	any member of the team and nothing is too much trouble. Even when the ward is extremely busy she keeps calm and works twice as hard. She is a pleasure to work with and loved by all the patients.	
Rebecca Healey	Beccy is an extremely compassionate and caring Foundation Year One Doctor who puts her patients and their care at the centre of everything she does, whether that be comforting distressed patients or taking the time to listen to relatives worries. Foundation doctors have many hoops to jump through whilst at the same time finding their feet in a new department every 4 months. No matter what stress she is under one thing that has never changed is her kindness and generosity. Recently she learnt that it was one of her patient's birthdays and she went out of her way to liaise with catering to get a birthday cake to the patient on the ward with staff singing happy birthday. This is one of many selfless gestures, she has undertaken in her early career. She really is one of a kind and a credit to the profession.	**05/05/2017**
Winter Ward (ward 10 HRI) now closed and all gone to existing/new posts within the Trust	We have worked on the Winter Ward (Ward 10 HRI) from the end of November 2016 to it closing on the 5th May 2017 and would like to so our appreciation to all staff members, from the Ward Sister Kay Brighton down to the Caterers and Cleaners for all of the hard work, compassion and care provided on the ward on each and every day. It made a huge difference to all the patients that came through the ward, there relatives and us as new Auxiliary Nurses. Thank you all. Barry Hawkes and Lynda Smirk.	**05/05/2017**
MRI Department	I started in the MRI department in January 2017. It was my first job within the NHS and I wasn't sure what to expect. The job role was completely different to anything I had previously done but the people in the department are amazing to work for and with. They have been there for me if I needed any help with anything. They are always going out their way to help the patients. They do far more than what is required. I'd just like to thank all of the staff in the department for accepting me, helping and been patient when I was asking 101 questions. You really are a great bunch of people and a credit to the NHS, if any of my family members were to need an MRI scan I would know they were in safe hands and would be taken good care of. Sad to be leaving but my career pathway is taking a different road. Will miss you all.	**05/05/2017**
Janet Boddy	Our department works very hard during sickness and	**05/05/2017**

	breaking down of machines we are always trying to get as many outpatients and inpatients through the door no matter what. On one occasion the scanner broke down. This means a full list of patients have to be cancelled because the other scanners are fully booked up. MRI are open 7 days a week and have full lists on all scanners. Everyone is dedicated to their role and are always going that extra mile the cleaner, clerical, support workers, radiographers and management. Janet our manager does all her work plus is always helping others and if we have a problem she is always trying to fix it for us and point us in the right direction.	
Dr Elizabeth Herrieven	Liz has been a huge support to the Paediatric ED team, she always finds ways to boost staff morale and the little things she does really do go a long way! She is amazing at her job and goes above and beyond for patients and their families. She is a driving force within the department and is an absolute pleasure to work with! We all really appreciate her on-going help and support, she is a genuinely kind and caring person who we all love! :) x	**04/05/2017**
Tracey Morfitt	Tracy (who is an auxiliary nurse) showed care and compassion towards the family of a patient who was coming towards the end of her life. She was witnessed to take control of the situation, and gave personalised support to each of the family members. This gave the family comfort at a very difficult time. She was a shoulder to cry on, provided drinks and snacks and all this whilst caring for the rest of the patients on the ward. As the junior sister, I felt that Tracey was confident and competent in this situation and was a role model for the rest of the team! Well done Tracy and thank you for all your hard work.	**04/05/2017**
All staff in Paediatric ED	All the paediatric A&E staff who regularly work late when department is busy or when there are critically ill children in resus. They are dedicated, hard working, genuinely care about the patients and families and provide high standard of care. They are wonderful colleagues and support each other in times of high stress and high demand on the department	**03/05/2017**
Michaela Ward	Michaela has helped and supported me to get through the care certificate, along with several other auxiliary nurses. She is always ready to explain things and always makes time for us even though she is extremely busy. We were presented with our certificates last week and can credit her with	**03/05/2017**

	supporting most of us from our department.	
Lucy Boult	I was having a really bad day, and was very busy Lucy helped and supported me throughout the shift!!! Thank you LUCY!!! for being so caring and supportive!!!!	**01/05/2017**
Christina Tambaros	Recently a patient on the ICU was to be transferred to York hospital. Transport was ordered and gave a 4 hour window, by 6:30pm the ambulance had still not arrived. So the nurse escort would now be leaving within an hour before the end of the shift, meaning they would not return until well after the finish of their shift. The nurse set to accompany this patient had her partner returning to active duty with the military the next morning so really didn't need to be finishing work 2 hours late. Christina volunteered to take hand over of the patient and swap and escort the patient back to York. Meaning she would be getting off work 2 hours late but the other nurse would get home to see her partner off!! Excellent example of team work!	**01/05/2017**

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT JUNE 2017

Trust Board date	4 July 2017	**Reference Number**	2017 – 7 - 8
Director	Kevin Phillips, Executive Chief Medical Officer	**Author s**	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	**Y**	Assurance	**Y**	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					**Y**
	Valued, skilled and sufficient staff					**Y**
	High quality care					**Y**
	Great local services					**Y**
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): All					
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board receives this report monthly on the quality aspects of its services (Patient safety, service effectiveness and patient experience).					

QUALITY REPORT
JUNE 2017

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission
- Other Quality Updates
    - VTE risk assessments
    - Quality Improvement Programme
    - Mortality
    - Emergency Preparedness and Resilience – Major Incident Test

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

TRUST BOARD QUALITY REPORT
JUNE 2017

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission
- Other Quality Updates
    - o VTE risk assessments
    - o Quality Improvement Programme
    - o Mortality
    - o Emergency Preparedness and Resilience – Major Incident Test

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

2. PATIENT SAFETY

2.1 Never Events

There have been no Never Events reported since September 2016.

2.2 Serious Incidents

There were six serious incidents declared in May 2017, see 2.2.1 below.

2.2.1 Serious Incident declared in May 2017

Ref Number	Type of Serious Incident	Health Group
*2017/12643 *2017/12646 *2017/12669	Treatment delays with three patients - The patients were lost to follow-up in Urology	SHG
2017/11424	Treatment Delay	CSHG
2017/14199	Hospital Acquired Pressure Ulcer	Surgery
2017/14058	Hospital Acquired Pressure Ulcer	Medicine

The three serious incidents of 'lost to follow up' in Surgery relate to three patients within the Urology service. One of the incidents was identified through a complaint, which led to a review of patients within the urology service. This review identified a further two patients that did not receive a follow up and presented with symptoms, subsequently.

The treatment delay within Clinical Support relates to a patient where there were concerns around complications that arose leading up to the patient's death.

Two pressure ulcer serious incidents were declared within the month; one Grade 3 occurring on Ward 14, Castle Hill Hospital, and the other Grade 3 occurring on Ward 110, Hull Royal Infirmary.

Each of these incidents is now under investigation and their findings will be summarised in this report in the future.

2.3 Learning from Serious Incidents
At each month end, serious incident investigations are summarised and are sent to all Health Groups along with all the full reports for their dissemination, as appropriate. The summary includes the investigation findings, lessons shared and recommendations.

In May 2017, the Trust's Lessons Learned Bulletin was re-launched as 'Lessons Shared'. This new format focused on one key learning issue(s), and linked the issue and learning to the Trust's improvement priorities for 2017/18. The latest issue focused on was about identifying and treating sepsis, and gave information on the work undertaken to date on sepsis management, and how learning from previous incidents have identified some key actions, which can help to prevent sepsis. (**Appendix One**)

3. SAFETY THERMOMETER – HARM FREE CARE

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

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

From the 904 in-patients surveyed on Friday 9th June 2017, the results are as follows:

- **93.1%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2.10% [n=19]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **97.90%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 904 patients, 57 did not require a VTE risk assessment. Of the remainder, 822/847 had a VTE risk assessment undertaken. This is **97%** compliance on the day. VTE incidence on the day of audit was **10** patients; **6** of which were with pulmonary embolisms and **4** were deep vein thrombosis.
- New pressure ulcers were low on audit day at 2, both of which were grade 2. However, 38 patients has pre-hospital admission pressure ulcers. These are now being fed back to commissioners to manage.
- There were **6** patient falls recorded within three days of the audit day, which is a reduction on last month; **5** of which resulted in no harm to the patient and **1** with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection were moderate at **12/161** patients with a catheter **(7.2%)**. Of the **12** patients with infections, **6** were infections that occurred whilst the patient was in hospital **(3.6%)**. This continues to be a focused area seems to be an area of improvement in the Trust.

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

Due to the timing of this report, the latest benchmarking data from the Yorkshire and The Humber Academic Health Sciences Network Improvement Academy is not available. This will be presented next month.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 31st May 2017

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

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**12 (23% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0**
MSSA bacteraemia	**44**	**6 (14% of threshold)**
E.coli bacteraemia	**73**	**13 (18% of threshold)**

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

4.1.1. *Clostridium difficile*

Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and painful abdominal cramps. In extreme cases, *C. difficile* infections can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (termed toxic megacolon). In certain cases they can cause or contribute to the death of a patient. Root cause analysis investigations are conducted for each infection and outcomes of RCA investigations for all Trust apportioned cases shared collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

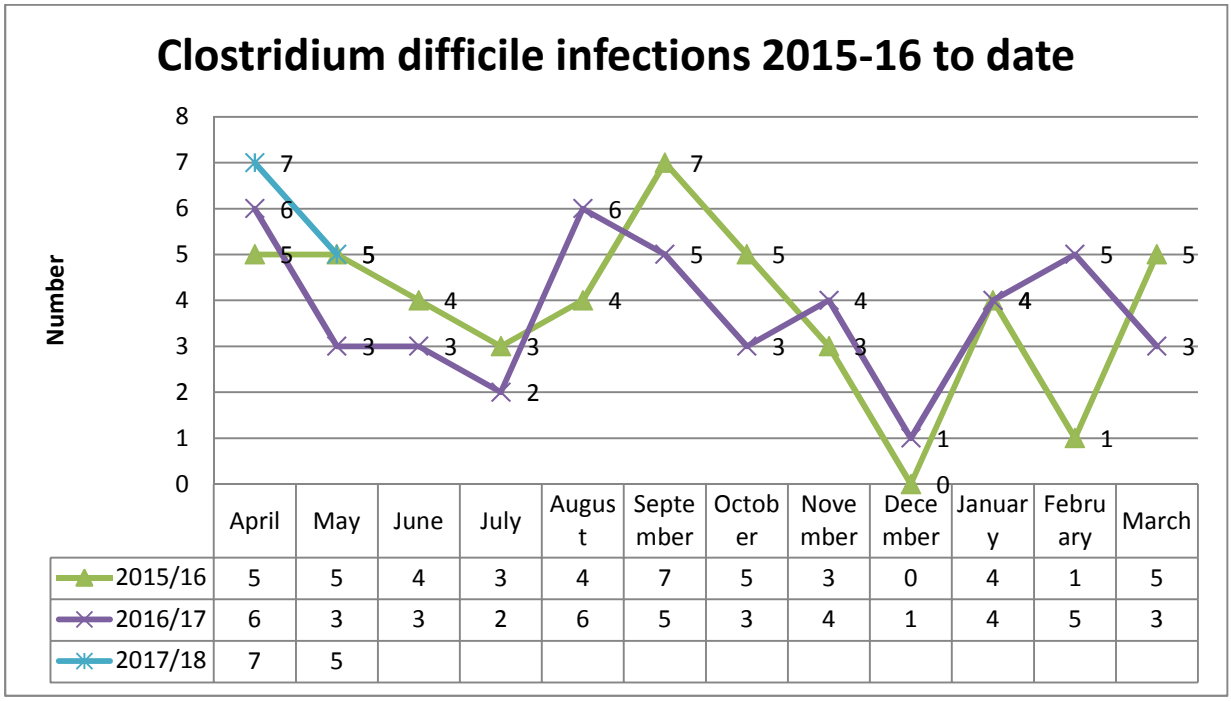
To date this financial year, at Month 2, the Trust is reporting 12 infections against an upper threshold of 53 (23% of threshold). This is relatively high but this is one of the peak times of the year for this infection. As such, there is nothing to deduce other than to keep a watching brief on the trends. There have been some lapses in practice but nothing of exception to report at this stage.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**12** (23% of threshold)	3 to date (see following table)

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Lack of awareness of previous positive *C.difficile* status	Nursing staff not aware of IPC flag on Lorenzo re. *C.difficile* positive status	Nursing staff now aware of systems and processes. Ward manager to share at team meetings Suboptimal practice identified but did not impact on mgt. of pt.	Nursing staff now aware of systems and processes related to flags on Lorenzo. Ward manager to share at team meetings with IPC present.

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Sample not obtained in timely manner by ward prior to transfer. Lack of cognisance that diarrhoea could be related to *C.difficile* by surgical team. Stool chart not completed appropriately	Nursing and medical team did not sample as other causative factors suspected. Patient transferred from surgery to medicine – intentional rounding completed in both areas but lack of understanding regarding need to maintain bowel chart	Clinical teams to suspect and rule out *C.difficile* if diarrhoea commences and continues	Board rounds – teams to challenge Reminder re. key points of *C.difficile* policy Reminder during ward meetings for the need to maintain bowel charts. New bowel chart await final draft and roll out
Lapses in practice/ Evidence of suboptimal practice	**Reason for lapses in practice/ suboptimal practice**	**Lessons learned/ Identified learning**	**Actions**
A delay in obtaining a sample when requested by the medical team A delay in isolating the patient. Stool chart no completed appropriately	Nursing and medical team did not sample initially as patient treated for constipation, but symptoms did not improve.		Reminder re. key points of *C.difficile* policy Reminder during ward meetings for the need to maintain bowel charts. New bowel chart await final draft and roll out

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										

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

Staphylococcus aureus (also known as staph) is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and abscesses. If the bacteria enter the body through a break in the skin, they can cause life-threatening infections, such as blood poisoning (bacteraemia). MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

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

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

4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

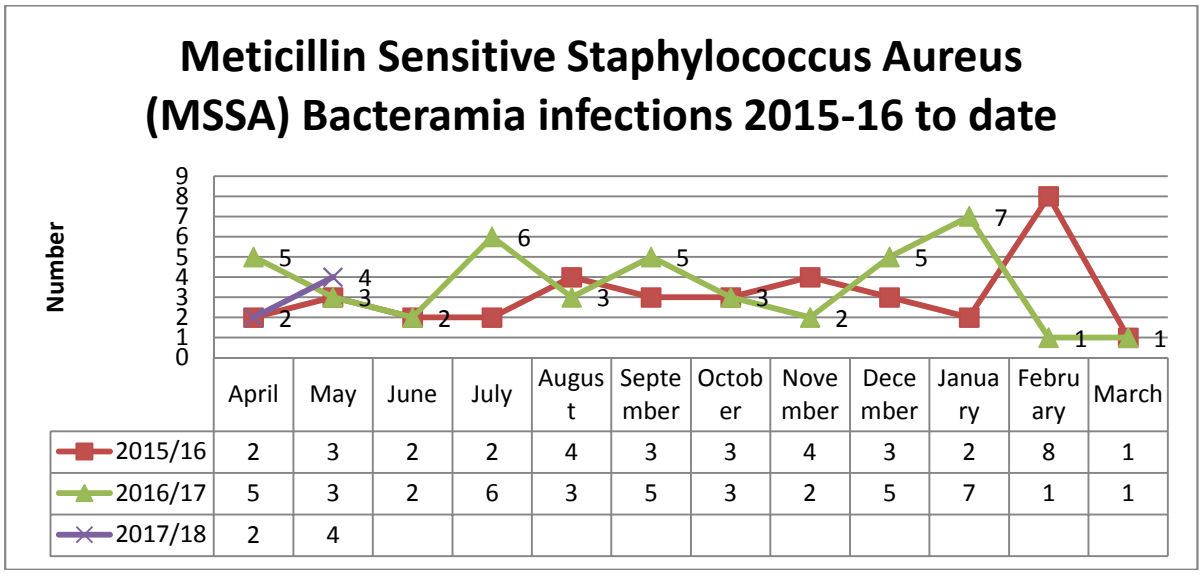
Meticillin-Sensitive *Staphylococcus aureus* is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

However, MSSA colonisation usually causes them no problems, but 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**	**6** (14% of threshold)	4 x RCA completed 2 x pending investigation
Lapses in practice/ Evidence of suboptimal practice	**Reason for lapses in practice/ suboptimal**	**Lessons learned/ Identified learning**	**Actions**
Case 1	Possible sub-optimal blood culture taking technique	Need for review of blood culture taking technique amongst medical staff including juniors on unit	Teaching on unit for blood culture taking. Consider audit review of practice should incidence occur again.
Case 2	Complex case – oncology patient with sepsis. Possible sources identified – duodenal stent, Peripherally Inserted Central Catheter (PICC) and/or cannula	Ensure VIP charts are completed at all times and ensure we look to implement a care plan for PICC/Skin Tunnelled Catheter (STC) lines to ensure the reviews are documented.	To discuss the case at next ward meeting with all staff. Staff to be are booked onto Central Venous Access Device (CVAD) training. Education to be given at ward level. Roll out of updated VIP chart.

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

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



4.1.4 *Escherichia-coli* Bacteraemia

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

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

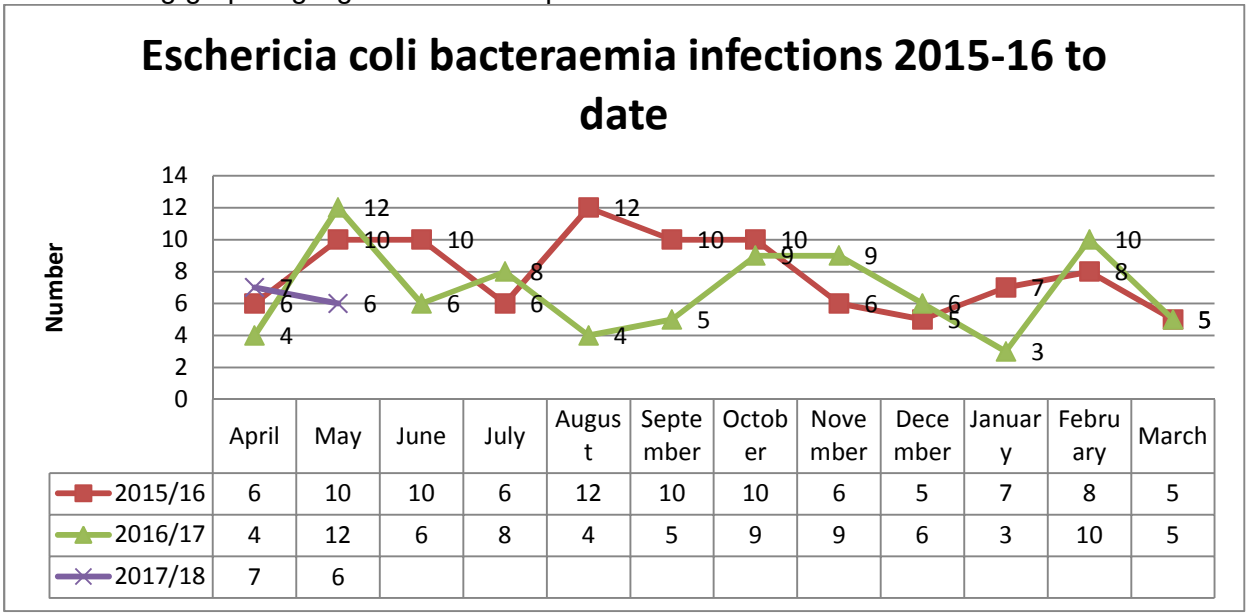
E. coli is now the commonest cause of bacteraemia reported to Public Health England. *E. coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

During 2017/18, Trusts will be required by NHS Improvement to achieve a 10% reduction in E. coli bacteraemia cases.

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)**	**13 (18% of threshold)**	13	1 x avoidable 2 x possibly avoidable 9 x unavoidable 1 x pending outcome discussion

Avoidable / Possibly avoidable *E. coli* bacteraemia cases		
Source of Infection	**Trends/ Risk Factors**	**Actions**
Avoidable Hospital acquired pneumonia	E.coli cultured from sputum Previous surgery for a sigmoid malignancy (with liver metastases) 5 days prior to positive sample	Disseminate learning of case and associated risk factors to medical and nursing team
Possibly avoidable Percutaneous insertion of biliary drain/biliary biopsy 6 days prior to positive blood culture	Recent surgical intervention Liver malignancy and multiple metastases Intra-abdominal sepsis	Disseminate learning of case and associated risk factors to medical and nursing team Review procedure of percutaneous insertion of biliary drain / biliary biopsy to reduce risk (if possible) of E.coli bacteraemia
Possibly avoidable Possible hospital acquired pneumonia Catheter associated urinary tract infection (CAUTI)	Long stay ICU patient with complex needs - E.coli found in urinary catheter sample and also sputum sample	Disseminate learning of case and associated risk factors to medical and nursing team Prevalence audit of urinary catheters Update of catheter policy and associated care bundle

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

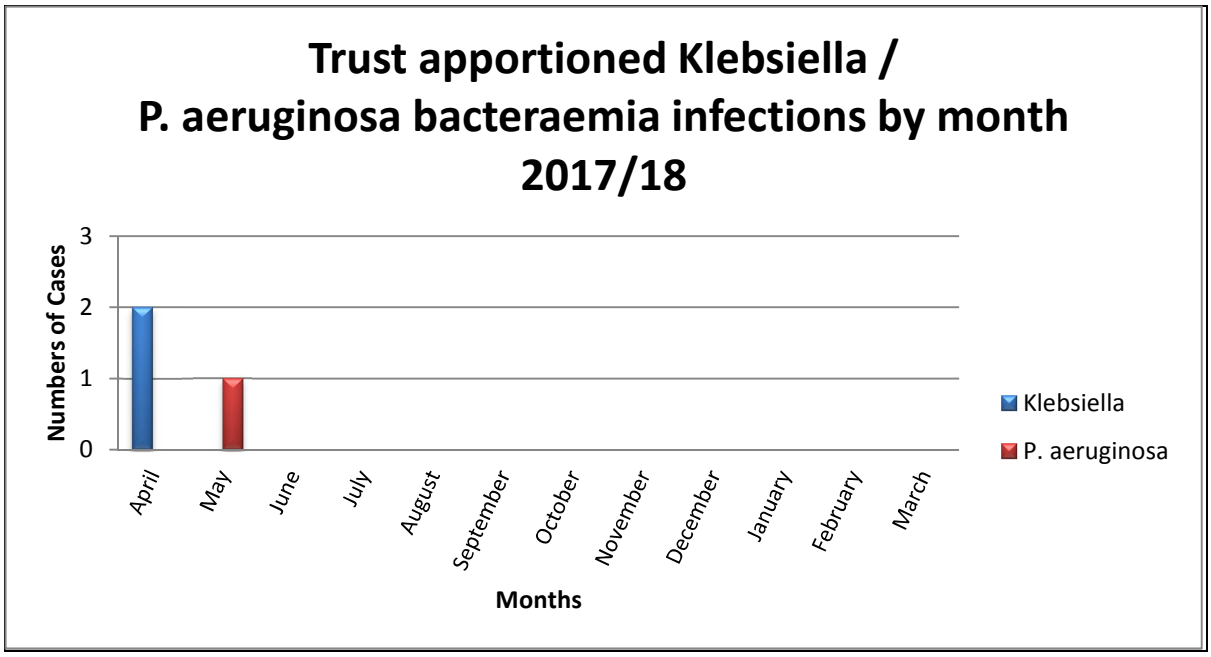


4.1.5 Gram negative bacteraemia – reporting for 2017/18

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

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

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



4.2 Infection Outbreaks

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

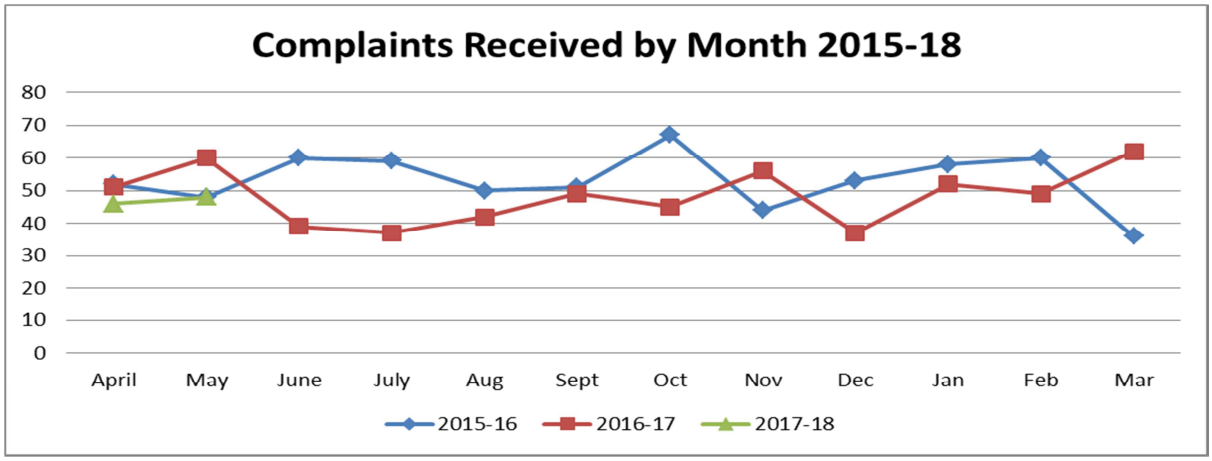
4.2.1 Influenza trends

During May 2017 on the winter pressure ward, a patient was detected with Influenza A, following admission with respiratory symptoms unusually late in the season. The patient was treated and 3 contact patients were treated prophylactically as a precaution. No further concerns were identified. All patients receovered satisfactorily.

5. PATIENT EXPERIENCE

5.1 Complaints

The graph below sets out comparative complaints data from 2015 to date.



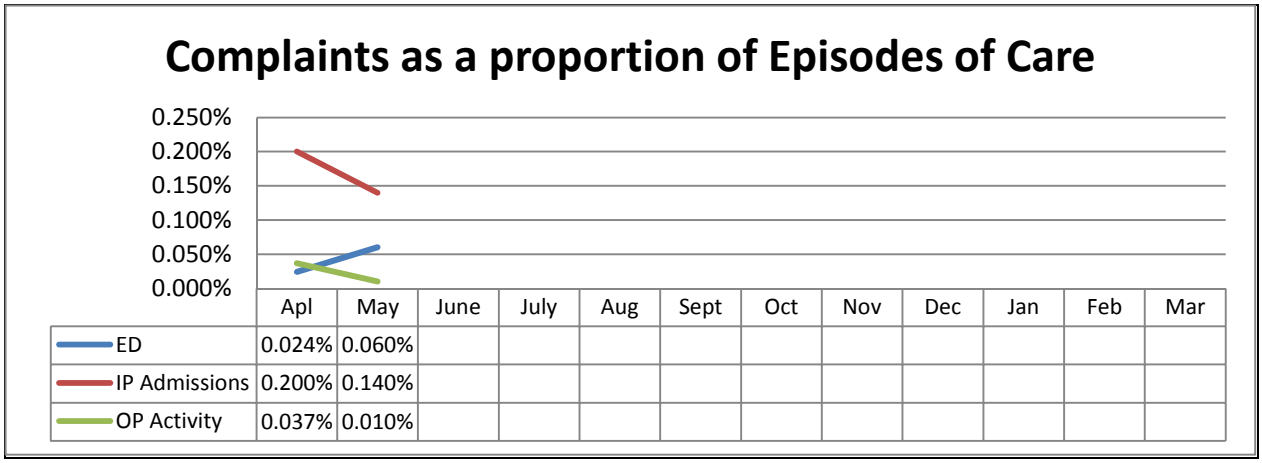
There has been a slight increase in complaints received during May 2017 when 48 complaints were received, although this is still below the number received in 2016/17.

5.1.1 Complaints by Episodes of Care

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

May 2017	Patient Contacts	Numbers of Complaints	%
Emergency Department	13,289	8	0.06%
Inpatient Admissions	13,521	19	0.14%
Outpatient Episodes	62,167	7	0.01%
Totals	**76,147**	**48**	**0.06%**

The table below shows the monthly trend of complaints as a proportion of activity:



Complaints about treatment continue to be the highest in number. The two key themes relate to patients that are not being happy with the treatment plan (13) and incorrect diagnosis (6). These complaints are all reviewed individually and the patient/family is offered a resolution meeting. The outcome of the investigation is shared fully with the complainant. The following table indicates the number of complaints by subject received for each Health Group in May 2017.

Complaints by Health Group and Subject (primary)	Attitude	Care And Comfort	Communication	Delay, Waiting Times Cancellations	Discharge	Safeguarding	Treatment	Total
Clinical Support Health Group	0	0	0	0	0	1	2	3
Family & Women's Health Group	0	0	0	0	0	0	10	10
Medicine Health Group	0	4	2	0	0	1	12	19
Surgery Health Group	1	0	2	2	1	0	10	16
Totals:	1	4	4	2	1	2	34	48

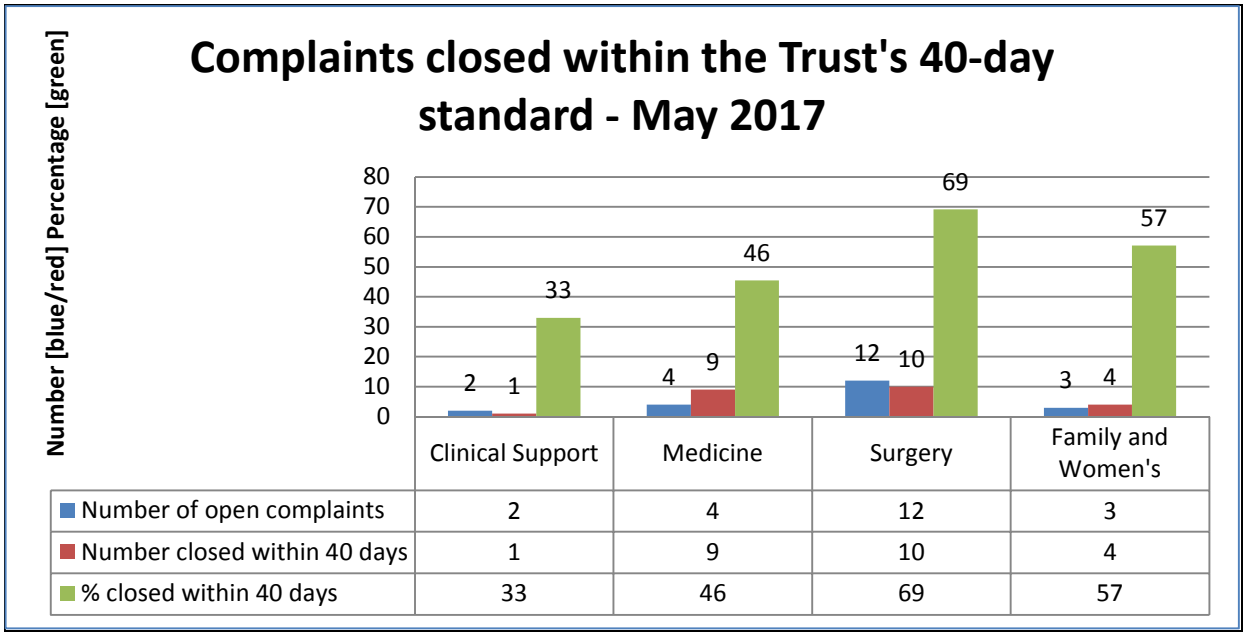
5.1.2 Examples of outcomes from complaints closed this month:

- A family was unhappy with the discharge arrangements and delays in assessing for palliative care.
  Action: The Consultant is to lead a quality improvement project with regards to a discreet visual reminder of patients' palliative care needs (e.g. purple ribbon scheme) as suggested by the family. The consultant to contact all medical and medical elderly team to reiterate that referral to the Palliative Care Team can be made from all clinical areas, including EAU and ED.

- A patient was not satisfied with the way her Hickman line was inserted.
  Action: A discussion with the trainee surgeon involved has been undertaken at supervision. A training competence package to include increased skills required in line insertions will be developed.
- A family was not satisfied with the treatment and care provided.
  Action: The Consultant has re-looked at the referral pathway internally and with Leeds Hospital and will revise where failings in the referral process are identified. Highlighted issues and learning actions are to be discussed at the Cardiology Clinical Governance Meeting. The complaint is to be used as a case study for agreed learning actions at a future educational event, subject to obtaining consent from the family.
- A staff member was described as being rude, which caused the patient distress.
  Action: The ward sister has discussed the need for professionalism in work areas (i.e. no chatting around the nurse station) at the ward meeting with all staff.

Of the closed complaints in May 2017, 19 were not upheld, 16 were partly upheld and 8 were upheld.

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

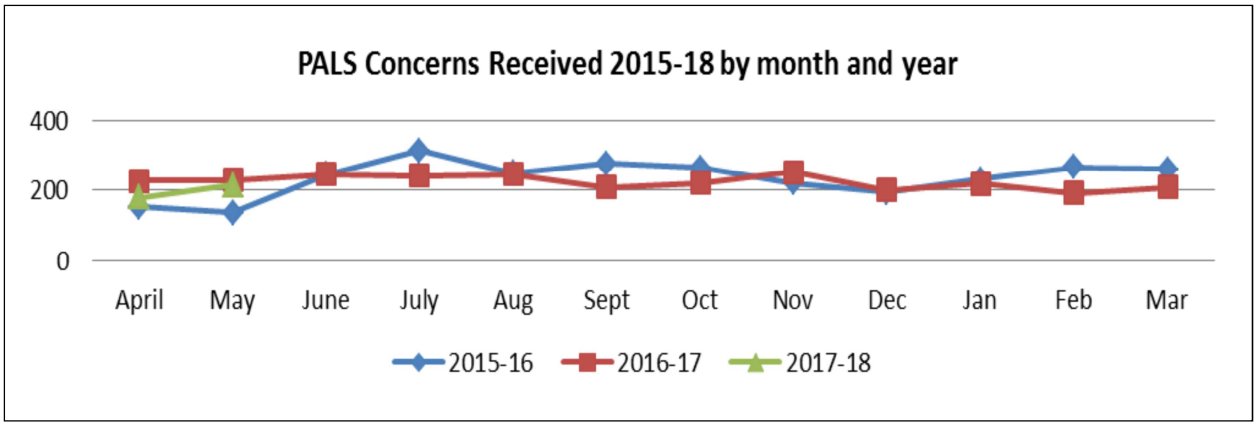


	Clinical Support	Medicine	Surgery	Family and Women's
Number of open complaints	2	4	12	3
Number closed within 40 days	1	9	10	4
% closed within 40 days	33	46	69	57

There has been a targeted focus led by the Chief Nurse to ensure all complaints are closed in a timely manner and the importance of this has been cascaded through the Health Groups. Weekly performance monitoring has been put in pace for all Health Groups by the Chief Nurse. During June, all Health Groups have closed outstanding complaints and it is expected that from July 2017 the minimum 90% target will be achieved.

5.2 Patient Advice and Liaison Service (PALS)

In May 2017, PALS received 212 concerns, 52 compliments, 79 general advice issues and 4 comment/suggestions. The majority of concerns were regarding waiting times/cancellations, delay in notification of results and not being satisfied with treatment plans.



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

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Treatment	Total
Corporate Functions	8	3	0	6	1	0	1	3	0	0	22
Clinical Support - Health Group	0	2	0	3	8	0	0	0	0	1	14
Family and Women's Health Group	1	4	0	6	23	1	0	0	0	9	44
Medicine - Health Group	7	7	4	10	25	4	1	0	1	11	70
Surgery - Health Group	5	2	2	5	37	1	0	0	0	10	62
Totals:	21	18	6	30	94	6	2	3	1	31	212

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 8 cases under review by the PHSO, currently. During May 2017, there have been no new cases opened, two new requests for information and one case provisionally not upheld.

5.5 Friends and Family Test (FFT) - May 2017 Data

The Trust's Friends and Family results for May for all areas, excluding the Emergency Department, indicate that there was a decrease in the number of responses with 2,571 responding, compared to April when the Trust received 3,276 responses. From these, 96% were extremely likely/likely to recommend the Trust to friends and family.

5.5.2 Emergency Department (ED)

67 patients responded by the paper feedback method. Of these, 73.13% said they were extremely likely/likely to recommend ED to friends and family. 17.91% said they were extremely unlikely/unlikely to recommend.

When using SMS text messaging, 85.29% of patient gave positive feedback and 8.51% gave negative feedback.

Although paper responses were low for the month of April in ED, the SMS text method had a high percentage of respondents again.

At the moment, the Trust's Friends and Family responses are lower than the Trust would have hoped, but the patient experience team is working with all departments and the new F&F Test Provider, Elephant Kiosk, to improve the uptake by patients and service users.

All staff that have seen the new system so far are all looking forward to taking ownership of their own departments and look at ways in which they can improve on their response rates in the future. The trusts patient feedback is a rich source of improvement throughout the organisation.

5.6 Volunteers

5.6.1 The Young Volunteers/ Young Health Champions

The Trust's Young Health Champions programme has now recruited another ten people onto its traineeship; all youngsters recruited are looking for a career in health care. The Trust offers opportunities for the youngsters to train in a wide variety of areas.

The patient experience department has just attended the Trust's Golden Hearts awards where it was a finalist in the partnership working category.

5.6.2 Adult Voluntary Services

The Adult Voluntary Service continues to recruit people and the new volunteers in the Emergency Department are providing reassurance and greater communication between the relatives in the new waiting area and the patients in the 'Majors' department. The Voluntary Services Team has also opened the Welcome Hub on the 8th Floor of the Tower block. This is run solely by volunteers providing a warm welcome and reassurance to the visitors as they arrive.

6. CARE QUALITY COMMISSION (CQC)

6.1 Well Led Domain pilot

The Trust took part in a joint CQC and NHS Improvement pilot on 19th and 20th June 2017 to test the new 'Well-Led' inspection methodology, which included the 'Use of Resources' inspection, also. During the inspection, there were three work streams: Well-led framework, Use of Resources and Financial Governance. As part of the inspections, key leaders were interviewed including Chiefs, Directors, Health Groups and Non-Executive Directors. Key areas of enquiry included:

- Trust wide governance arrangements
- Trust strategy and connectivity across health groups and services
- Mortality and learning from deaths
- Mental health resources and initiatives
- Patient and public involvement
- Trust vision and values
- Innovations
- Areas that individuals were proud of
- Key risks
- Financial planning
- Cost Improvement Plans and Quality Impact Assessments
- Agency spend/staffing deployment
- 'Lord Carter' work-streams
- Did not attend (DNA) rates
- Elective and non-elective admissions
- Staff rotas
- Sickness absence and turnover
- Backlog maintenance
- Partnership working
- Procurement costs

Initial feedback has been positive and the Trust has been invited to provide written feedback to CQC and NHSI on its views of the process. Further discussions are planned with both CQC and NHSI to feedback on how the Trust found the pilot process.

7. OTHER QUALITY UPDATES

7.1 Venous Thromboembolism Risk Assessments (VTE)

The first quarter of 2017/18 has shown an increase in VTE risk assessments to just under 92%. Although not meeting the 95% required, the Trust has shown month on month sustained improvement and it is anticipated that this will continue.

7.2 Quality Improvement Programme (QIP)

The Quality Improvement Programme continues to progress well overall. A revised review and escalation process has been implemented for monitoring the QIP. All leads will be required to attend a QIP meeting at least once a quarter. Monthly meetings will continue to be held and where projects are off track leads will be required to attend to discuss mitigating actions.

7.3 Mortality

7.3.1 Learning from Patient Deaths

Initial gap analysis has been undertaken against the National Quality Board (2017) document entitled: National Guidance on Learning from Deaths[1] This report provides recommendations for Trusts to consider in order to get a picture of where the Trust is in terms of meeting the national minimum requirement for reviewing in-hospital deaths. The minimum requirement is that the Trust reviews:

- All deaths where family, carers or staff have raised a concern about the quality of care provision
- All deaths of those who are identified to be significantly disadvantaged, particularly all deaths of those with Learning Disabilities and all deaths of those identified with severe mental illness
- All deaths in a service specialty, particular diagnosis or treatment group, where an 'alarm' has been raised with the Trust
- All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures
- Deaths where learning will inform the organisation's existing or planned improvement work learning lessons

To enable the identification of this cohort of patients, substantive work has been undertaken on the Business Intelligence analyser. This includes the ability to now identify any patients who had Coronary Artery Bypass Graft (CABG), Pressure Ulcer (stage 3, 4 and unstageable), in addition to fractured neck of femur and sepsis.

In addition to this, quality improvement work has begun to help resolve some of the issues relating to documentation. A baseline audit of patient case note documentation is underway currently, focusing on patients with a fractured neck of femur. The audit is designed to gather information on how often clinicians are writing in patient notes during a review, and how often they are signing, printing and timing entries.

The Clinical Outcomes Manager has also begun working with GP advisors from Hull and the East Riding of Yorkshire, with the aim of primary care colleagues being involved more closely with mortality reviews, thus engendering wider and 'cross-speciality' input. The CCG's task and finish group is attended by the Clinical Outcomes Manager to help facilitate this.

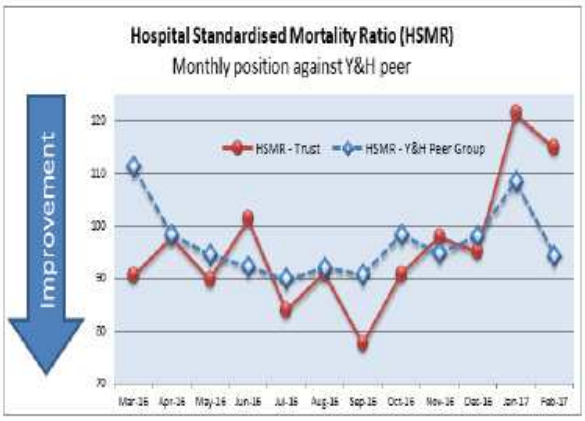
7.3.2 Hospital Standard Mortality Ratio (HMSR)

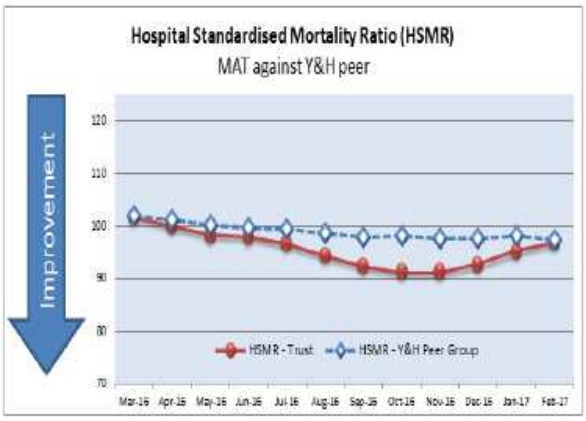
The HSMR is a method of comparing hospital mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus, if

[1] National Guidance on learning from Deaths – A Framework for NHS Trusts and NHDS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths In Care (March 2017)

mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

There have been some concerns expressed with regard to this ratio in our organisation. The data presented in the Corporate Performance Report is from the official returns and, as such, only includes deaths up to February 2017. The following below show how the Trust compares to its Yorkshire and Humber Peer groups.





There was a spike in the ratio during January and February 2017. The weekday and weekend data has been compared and the spike occurred in both indicators and at a similar rate in both. There was an increase in the number of crude deaths in January and February 2017 as expected during the winter time. However, using the structured case note review process, as recommended nationally, a set of these deaths will be reviewed and any avoidability themes will be explored and acted upon as necessary. This method of review was commended at the Trust's CQC well-led pilot inspection recently. The report into these deaths will be reviewed at the mortality committee and then the quality committee, with any ongoing matters of concern or of exception being escalated to the Trust Board, if required.

7.5 Emergency Preparedness And Resilience – Major Incident Test

On Saturday 24 June2017, the Trust undertook a live test of its Major Incident Plan. The Trust has a statutory duty to undertake a live exercise at least every three years. The plan had been updated substantially in 2016 to take account of the latest national guidance, consultation with other local teaching hospitals and to ensure it reflected current configuration and management arrangements.

The test incident related to a possible chemical incident and a situation where a truck ran into a large number of people, resulting in many casualties.

The test involved the Yorkshire Ambulance Service, St John's Ambulance, Humberside Fire and Rescue, Humberside Police and the Trust and was also supported by the Army who kindly made Londesborough Barracks available as the incident site. Bishop Burton College students took part and acted as the incident victims. Within the Trust, all aspects of the required response were simulated, whilst ensuring that normal Trust business was not disrupted. The site was 'locked down' and the Emergency Department simulated its response fully, including decontaminating the incident victims, assessing them clinically and sending mock blood samples to the laboratories. The Hospital Control Team simulated command of the response of the hospital, with the acute medical, surgical and critical care teams identifying the assessment, bed and operating capacity they could muster based on the actual patients in their care at that time.

The test was both observed and filmed. A 'hot debrief' took place at the time and a much more detailed debrief is planned. Overall, the test showed that the Trust is able to provide an effective response in the face of a multiple casualty event (36 patients). The test was, however, invaluable in revealing a number of areas where the Trust can strengthen its plan and, also, many ideas within the clinical teams, which they will now follow up to enhance the detail of their scenario planning for the future.

Many staff involved gave of their own time to participate in the exercise and all of those involved are to be commended for their efforts.

8. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

June 2017

Appendix One: Lesson Shared bulletin – June 2017
Appendix Two: Safety Thermometer – June 2017

LESSONSSHARED
June 2017
NHS
Hull and East Yorkshire Hospitals
NHS Trust

Identifying and treating Sepsis

One of our key priorities for 2017 is to identify and treat patients with blood poisoning (sepsis). This includes:

- **Rapidly identifying and treating blood poisoning in patients on our wards or presenting in ED**
- **Reducing the use of antibiotics for patients admitted to hospital**

WORK TO DATE:

A clear pathway for sepsis within the Emergency Department has been introduced. As part of this process the team has spent a significant amount of time training individuals (internally and externally), listening to their feedback, and implementing revised training to ensure the department can deliver the best possible outcomes for these patients. The Emergency Department has shown consistent improvement during the year, going from 0% compliance in August 2015 to above 90% compliance since July 2016. We have also developed a virtual sepsis ward in our electronic Cayder board system that identifies patients within the Emergency Department and the wider Trust. This work is being reviewed at a regional level in order for other Trusts to learn from the Trust's experience.

Our learning from previous incidents has identified some key actions which can help to prevent sepsis:

- Ensure patients are reviewed by the multidisciplinary team on the ward, taking into account management plans and reviewing input and advice from other professionals
- Registered nurses to provide supervision to all non-registered staff, and monitor care plans, as they are accountable for the care delivered
- Verbal handover to be completed prior to transfer of a patient from one ward to another (Clinical Handover of Care and Transfer of Patients Policy 313)

Please ensure this is discussed within your team. This is why it is important:

CASE STUDY FROM 2013

Patient was admitted to the Emergency Department – The patient had suffered a fall at home and sustained a haematoma to the left side of their head. This patient was elderly, frail, suffered with dementia and was incontinent; lived at home with their son with a complex care package.

A scan showed a fracture at C1 which was discussed with the neurosurgeon and was treated conservatively with a neck collar. The patient also had a large area of unstageable pressure damage to both buttocks on admission.

The patient was admitted to the Acute Assessment Unit (AAU) and then transferred to the Elderly Short Stay Unit (ESSU) on ward 8. On ward 8 the patient underwent various investigations to rule out other injuries sustained from their fall and was treated by the physiotherapist. Nutrition was monitored but this was difficult for the patient as they were wearing a hard neck collar to stabilise the C1 fracture; the patient was also referred to the speech and language team to assess their swallowing ability.

Two weeks after admission - The patient was transferred to ward 70 and developed a spontaneous haematoma on their right leg, which burst, leaving a large wound. During the investigation it was determined that spontaneous haematomas are very common in this group of elderly patients and can develop in a short space of time. The patient was reviewed by the plastic surgeon who identified a management plan in terms of daily dressings to the leg and advised tissue viability should be contacted if there were any further concerns. During the following 2 weeks the dressing to the patient's leg wound was only renewed on 2 occasions despite the plan requiring daily leg dressings.

One month after admission - The patient was transferred late at night to ward 16 at Castle Hill Hospital, to create further medical capacity at Hull Royal Infirmary.

No verbal handover or communication regarding the patient's needs occurred between ward 70, HRI and ward 16, CHH.

Three days later - The wound was noted to be 'fist sized' and black. The tissue viability nurse was contacted at this point for advice and the patient was subsequently reviewed again by the plastic surgeons. The wound was necrotic, infected, and antibiotics were prescribed intravenously. Care continued on ward 16 although the patient's general health continued to deteriorate.

Five days later - The medical staff and ward sister explained to the family that the patient was deteriorating despite treatment. At this stage the medical team agreed that the patient required end of life care; antibiotics and intravenous fluids were discontinued.

The patient passed away within a week and the cause of death was recorded as:

a) Sepsis
b) Right leg necrotic ulcer, right calf
c) Old age, frailty

LESSONSSHARED

OUR IMPROVEMENT PRIORITIES FOR 2017/2018

1. Reduce and eliminate avoidable infections
2. Prevent all patients developing pressure ulcers
3. Assess all patients' nutrition and hydration requirements
4. Assess all patients for blood clots (Venous Thromboembolism – VTE)
5. Reduce patient falls
6. Ensure our patients receive the right medicines, at the right dose, at the right time
7. Identify and treat patients with blood poisoning (sepsis)
8. Complete equipment and safety checklists
9. Reduce all avoidable deaths
10. Ensure we have a culture of learning lessons
11. Act quickly on patient complaints
12. Improve the safeguarding arrangements for adults and children
13. Improve facilities and pathways for children and young people
14. Improve the care of dementia patients
15. Ensure critical care is fully staffed with correct skill mix
16. Provide better care for patients who are unable to make or express choices
17. Standardise consent forms and have robust governance in place
18. Deliver more consistent and better outpatient services

If you have an idea for a future bulletin, please contact April Daniel within the Risk Team – **april.daniel@hey.nhs.uk**

Remarkable people.
Extraordinary place.

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER June 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 9th June both hospital sites. 904 patients were surveyed

93.1% of our patients received HARM FREE CARE

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

2.10% (19) of our patients suffered a New Harm

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

97.90% 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 Nov 16 – June 17

	Nov 16	Dec 16	Jan 17	Feb 17	March 17	April 17	May 17	June 17
Harm Free Care %	94.5%	95.8%	95%	94.6%	94.3%	93.5%	93.4%	93.1%
Sample: Number of patients	930	890	843	953	896	882	892	904
Total Number of New Harm	16	11	14	15	23	11	20	19
NEW HARM FREE CARE %	98.2%	98.6%	98.3%	98.5%	97.4%	98.7%	97.7%	97.9%

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	10	1.11%	6	4	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	57	6.3%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	822	90.9%	97%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	25	2.7%	3%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	40	4.42%	31	8	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.	38	3.21%	29	8	1
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	2	0.22%	2	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)	6	0.66%
Severity **No Harm**: fall occurred but with no harm to the patient	5	0.55%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	1	0.11%
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	**166**	**18.36%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**12**	**1.32%**	**7.2%**
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	**6**	**0.66%**	**3.6%**
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	**6**	**0.66%**	**3.6%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 14th July 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	4th July 2017		**Reference Number**	2017 – 5 – 9		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	✓

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

The last report on this topic was presented to the Trust Board in June 2017 (April 2017 position), which included the latest revision to nursing and midwifery establishments.

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

This report presents the 'safer staffing' position as at 31st May 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.

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

[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

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%

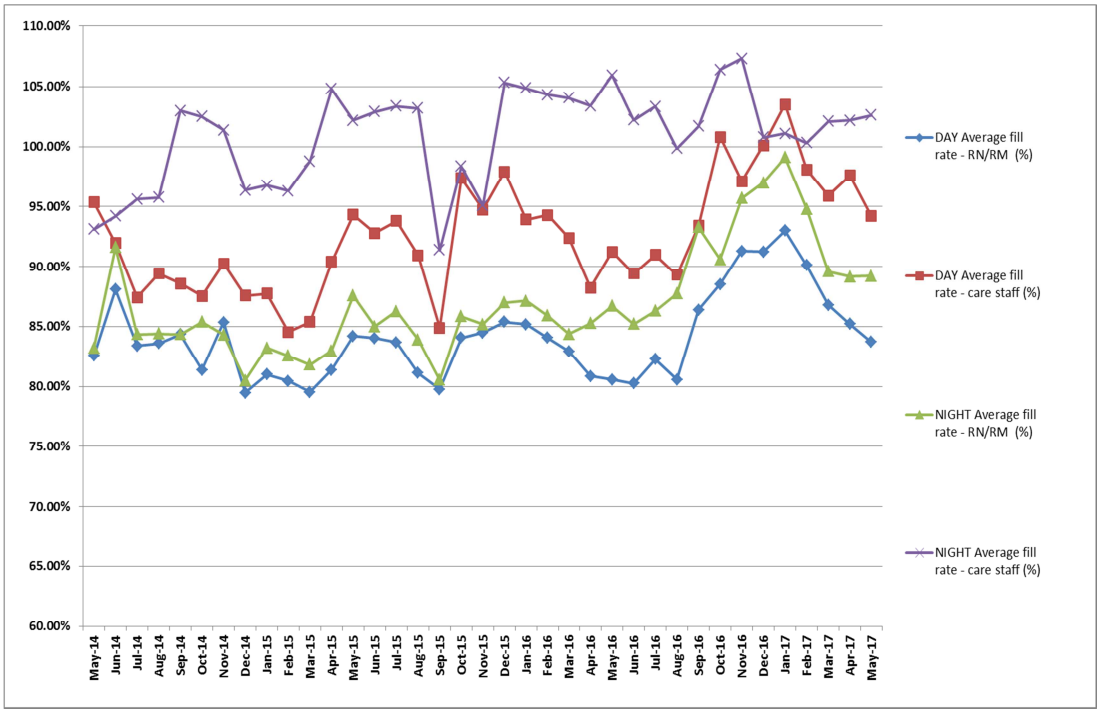
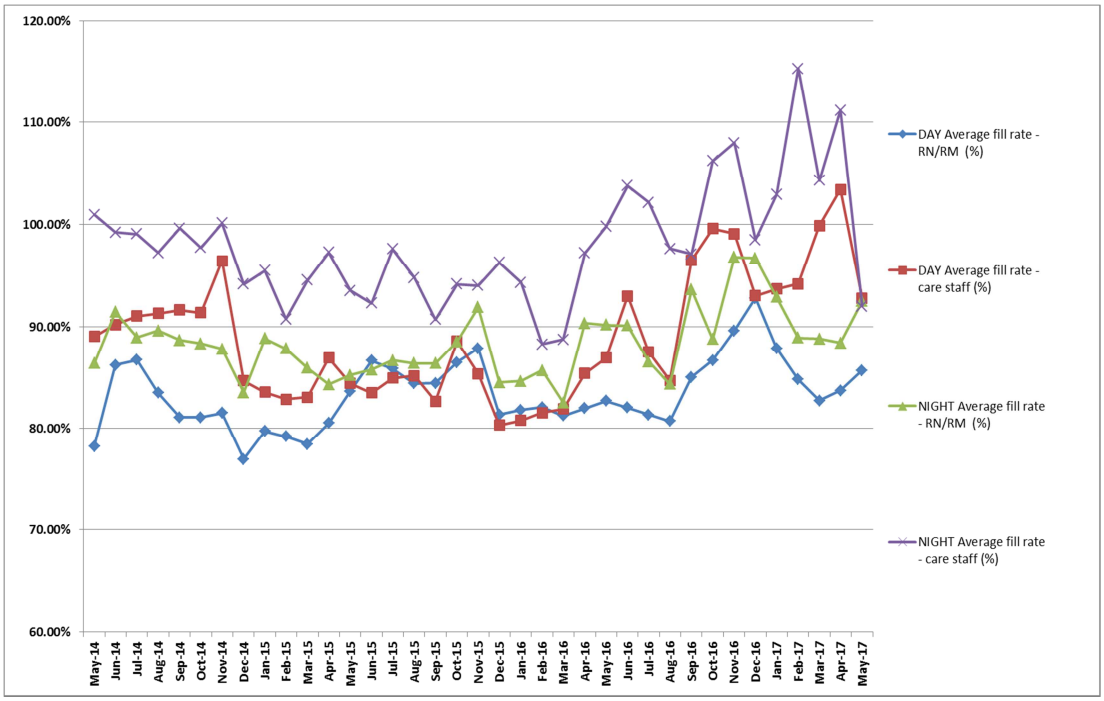


Fig 2: Castle Hill Hospital

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%



Fill rates at HRI are slightly lower than those for CHH. There has been a reduction in the fill rates at HRI compared to previous months. This reflects a number of issues, which include:

- In-patient nursing vacancy rates, which have increased by crica. 30 vacancies from the previous month. The reasons for these are being looked into, although there does not appear to be anything obvious or of exception to note.
- There is also some compensation with non-registered staff being recruited to help fill RN vacancy gaps.

4. ENSURING SAFE STAFFING

The twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift.

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

The SafeCare fully-automated e-rostering system went live for the wards on the 24th April. Work continues to ensure that all staff are competent in using the new system and this process monitored closely by the nurse directors and matrons.

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

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

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

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

The 'red flags' suggested by NICE, are:

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

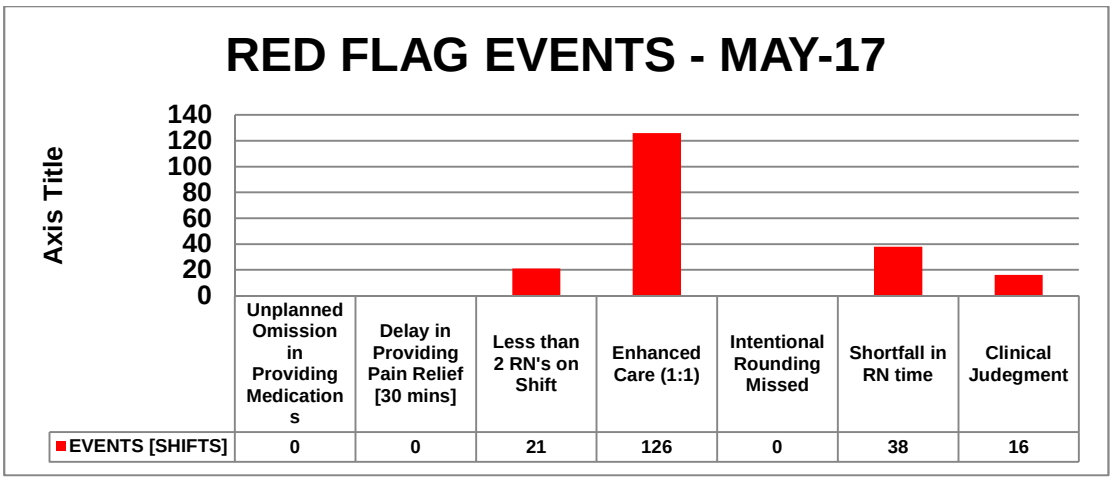
[4] NICE 2014 - Safe staffing for nursing in adult inpatient wards in acute hospitals

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

The following table illustrates the number of Red Flags identified during May 2017. 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 is required in order to be able to collect the information relating to medication administration delays and omissions. 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.

In addition to the NICE categories, this Trust also records the numbers of occasions when extra staff are required over and above normal establishment levels. This is for occasions when patients require 1:1 close supervision or another type of enhanced care. This includes patients that may be confused, agitated, prone to wandering or falling, etc. This is the 'Enhanced Care' category.

May-17	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	0	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	21	10%
	Enhanced Care (1:1)	126	63%
	Intentional Rounding Missed	0	0%
	Shortfall in RN time	38	19%
	Clinical Judegment	16	8%
	TOTAL:	201	100%



From the perspective of the Red Flag relating to fewer than 2 RN's on a particular shift, these were concerns that were raised and recorded prior to the shift commencing (usually due to short term staff sickness). However, all of these were

resolved by the re-deployment of staff from other areas to ensure a minimum of 2 Registered Nurses at all times.

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

- **Emergency Department - Registered Nurse Staffing**
  The department continues with the recruitment drive. Attendance at the recent Nursing Times recruitment event was successful in recruiting external candidates. ED has 15.30wte vacancies, currently. There continues to be a steady flow of recruitment with a further 4.0wte being pursued who are external to the Trust. This is a slightly improved position in Registered Nurses in post, although it is recognised there is still a significant vacancy factor. There is additional concern as the summer holiday period commences. However, work will continue with the nurse bank to support with unregistered nurses. In order to mitigate the challenges in this department, the Teacher/Practitioner and lead Band 7 staff are rostered into the care delivery numbers regularly. As such, the department is safe.

- **Acute Medical Unit**
  Currently, the unit has 9.62wte vacancies with a further 5.0wte on maternity leave. The unit has successfully recruited 3.0wte and has 7 newly qualified nurses are allocated to commence in September 2017.

- **Medical Elderly Wards**
  There are currently 19.29wte vacancies with an expected 8wte newly qualified nurses commencing in September. A focused recruitment strategy is being developed to help address the remaining shortfall.

- **H11 - Stroke/Neurology**
  Currently, this ward has 9.59wte vacancies with a further recruitment drive in place. These vacancies are being covered, in the main, by staff working additional hours. Nutritional apprentices will be recruited in July to support the qualified nurses in providing direct patient care. Two newly qualified nurses have been allocated to commence employment in September 2017.

- **H110 - Stroke Ward**
  The Stroke ward has 1.48wte vacancies with a further 2 nurses leaving in July. This will leave a significant shortfall within the service. The recruitment team has been asked to provide support with a further recruitment drive and the nurse bank has been notified of additional support needed, if possible. All senior nurses within the team are providing additional support on the ward and are rostered into the care delivery numbers. All staff are receiving exit interviews. Two newly qualified nurses are expected to start employment on H110 in September.

- **H70 - Diabetes and Endocrine**
  There are 10.49wte registered nurse vacancies on H70. Ward 70 is currently being supported by cardiology, surgery, family and women's health and clinical support. The nurse bank supports, also. The recruitment team has been asked to provide support with a further recruitment drive for tis area.

- **H500 - Respiratory**
  This ward has 4.13wte RN vacancies and there are 4 newly registered nurses allocated to commence in September.

- **Ward C16 - ENT, Plastics and Breast Surgery**
  This ward has 4.12wte RN vacancies and 1.22wte non-registered vacancies at present. The RN vacancies are out to advert and it is encouraging to see that there are external candidates amongst the applicants. It is anticipated that this will allow full recruitment by September 2017. In order to support the Ward, short term plans have been agreed to provide temporary cover to support the Registered Nurse establishment, with a view to limiting the Agency costs to the service.

- **Neonatal Intensive Care Unit (NICU).**
  Recruitment in this specialty has been a concern previously, and there are currently 6.5wte RN vacancies. However, all of these posts have been recruited to, and the staff will join the Trust in September 2017, following completion of their training. In the short term, the Senior Matron is working closely with the teams to flex staff across all paediatric inpatient and outpatient areas according to patient need. The Health Group is looking at ways in which the Trust can improve the retention of the staff in this specialty.

- **Ward H4 - Neurosurgery**
  This ward has 4.76wte RN and 2.71wte non-registered nurse vacancies. The ward is being supported by H40 staff.

- **Ward H7 - Vascular Surgery**
  This ward has 4.52wte RN vacancies. This group of patients often requires specialist dressings, which increases the acuity and care needs of the patients there. Staff are supporting from other wards within the Health group.

- **Ward C9 - Elective Orthopaedic Surgery**
  This ward has 4.65wte RN and 2.06wte non-registered nurse vacancies. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 - Elective Colorectal Surgery**
  This ward has 4.41wte registered nurse vacancies and 2.06wte non-registered nurse vacancies. There are currently 4 beds closed on C10 and 4 beds closed on C11 to support staffing across the organisation. This has not resulted in the cancellation of any elective procedures in relation to lack of ward capacity.

5. FOCUS ON NURSING AND MIDWIFERY SICKNESS LEVELS

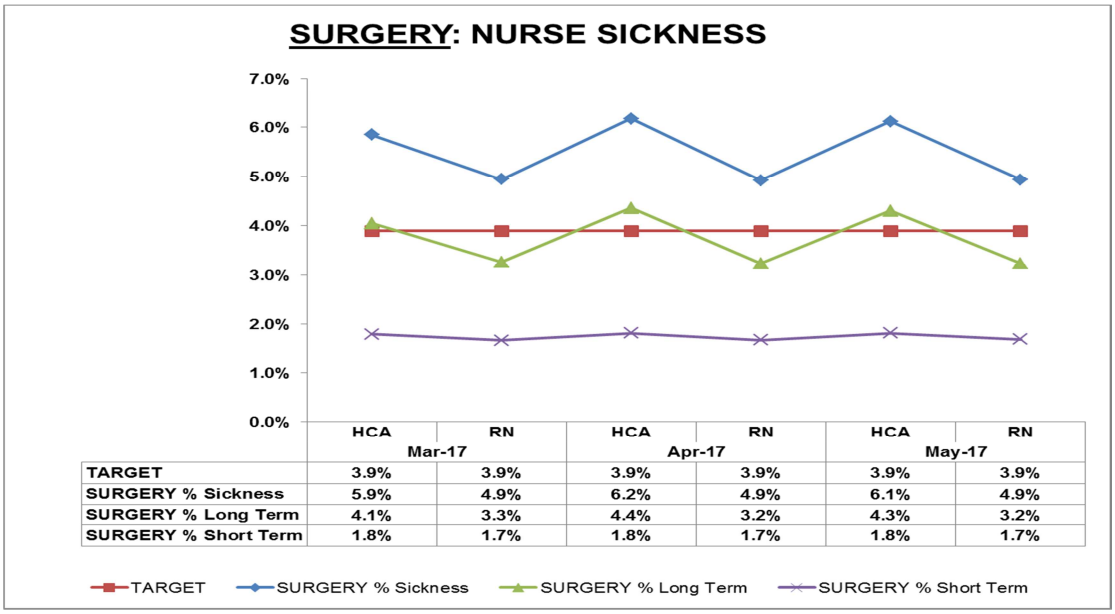
The Trust Board is aware of the of the focused work the Chief Nurse is undertaking with the health group Nurse Directors in relation to N&M sickness levels. After this month, it is proposed to provide an update on the sickness review work on a quarterly basis thereafter.

5.1 Surgery Health Group

The main issue for the Health Group relates to Long-term [>4 weeks] certificated sickness. The Health Group has taken a number of actions to address the management of attendance including:

- Weekly Sickness reviews, by ward and department, with a Senior Matron and HR advisor.
- Senior Matron for Staffing & Discharge – a daily Matron rota is in place to oversee all staffing and complex patient discharge matters

- All Nurses on Long-term sick leave have been reviewed in line with the Trust's attendance policy
- Action has been taken to ensure that all staff have a referral to Occupational Health, where necessary.
- Assurance has been sought that Sisters and Charge Nurses are managing attendance as per the Trust's policy
- As a result of the actions taken there are scheduled a further 3 sickness hearings planned for June and July 2017.

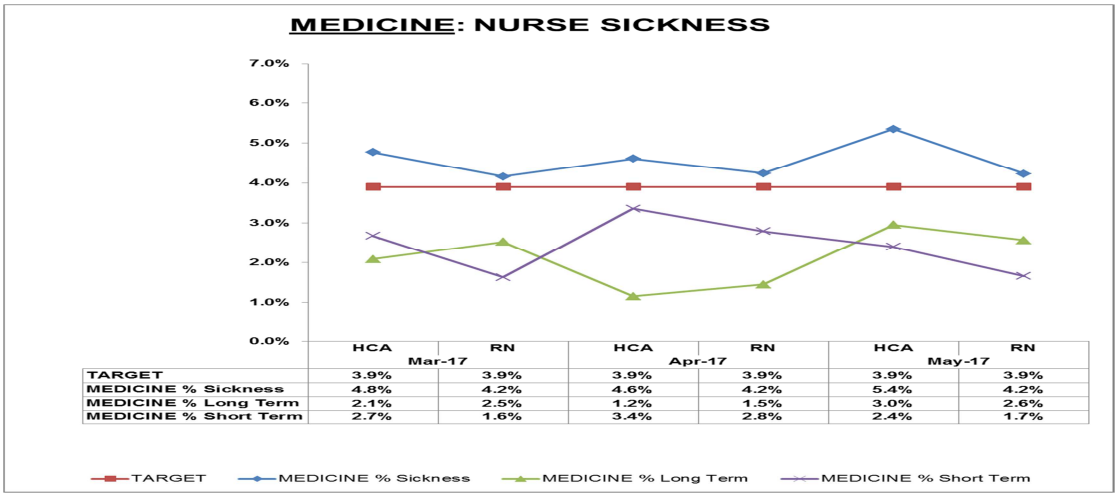


	HCA	RN	HCA	RN	HCA	RN
	Mar-17		Apr-17		May-17	
TARGET	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
SURGERY % Sickness	5.9%	4.9%	6.2%	4.9%	6.1%	4.9%
SURGERY % Long Term	4.1%	3.3%	4.4%	3.2%	4.3%	3.2%
SURGERY % Short Term	1.8%	1.7%	1.8%	1.7%	1.8%	1.7%

5.2 Medicine Health Group

Within the Medicine Health Group, there is a discussion on a monthly basis with a Senior Sister and HR Advisor to go through all HR KPI's, including attendance rates for each of their members of staff. Any actions are followed up with the respective Ward Sisters each month. This action plan also contains a rolling month on month attendance level for each area so that the respective teams can assess their performance and whether this is improving or not. The HR Advisors also review individuals with the managers to ensure staff are managed appropriately on the Managing Attendance Policy.

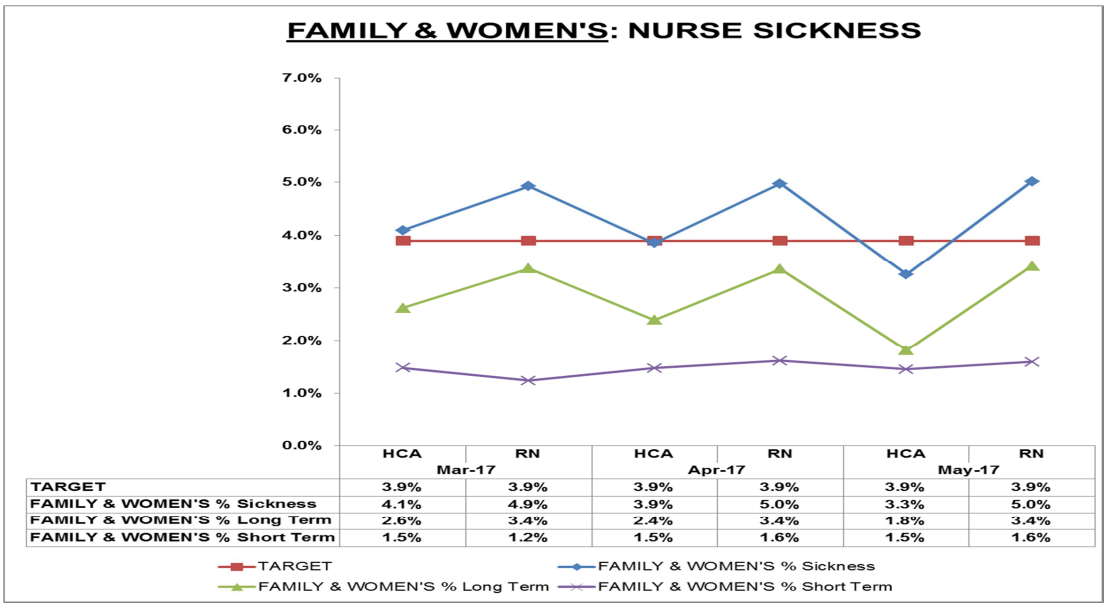
The Health Group is working with Occupational Health to ensure joint meetings take place, which include Senior Matrons, to advise on the best way of managing an individual from both a HR and Occupational Health perspective to ensure joined up working and consistent application of the Managing Attendance Policy. These will take place monthly.



	HCA	RN	HCA	RN	HCA	RN
	Mar-17		Apr-17		May-17	
TARGET	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
MEDICINE % Sickness	4.8%	4.2%	4.6%	4.2%	5.4%	4.2%
MEDICINE % Long Term	2.1%	2.5%	1.2%	1.5%	3.0%	2.6%
MEDICINE % Short Term	2.7%	1.6%	3.4%	2.8%	2.4%	1.7%

5.3 Family and Women's Health Group

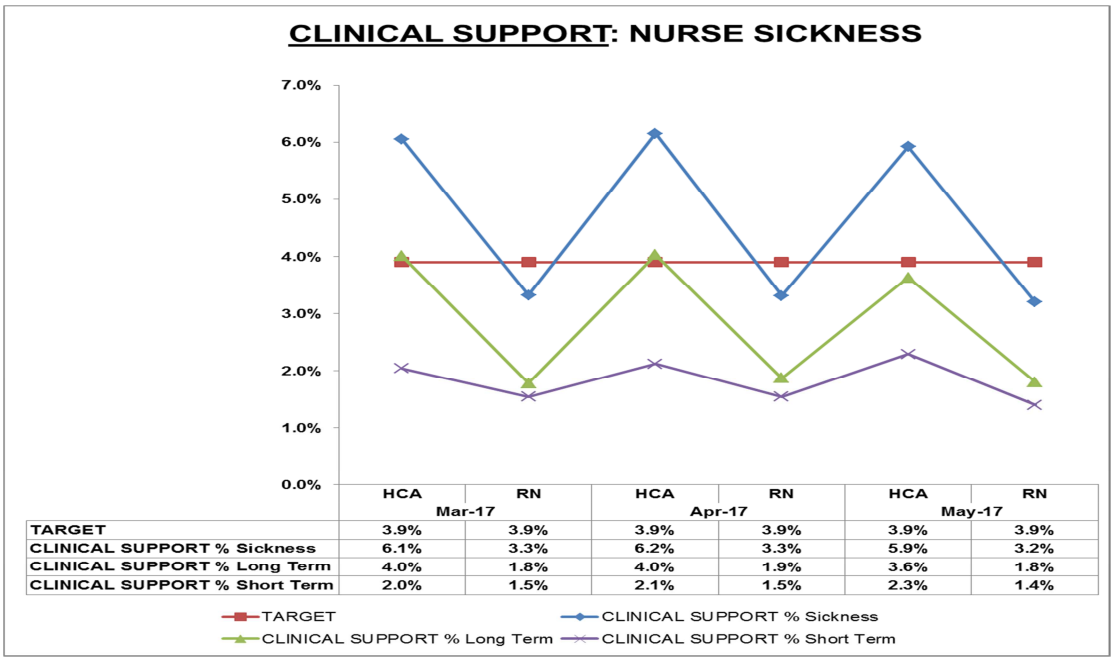
In order to improve the robustness of sickness absence management, the Senior Matrons are attending the monthly departmental reviews with HR and Occupational Health. This provides additional scrutiny and challenge to the current processes at departmental level. The Senior Matrons are also reviewing the historical management of staff that have been managed on the Managing Attendance Policy for some time to ensure that this is being managed properly. The Nurse Director and HR Business Partner are looking at ways to improve attendance in individual areas, where attendance is poor, with a view to extending the cultural work in each of these departments.



	HCA Mar-17	RN Mar-17	HCA Apr-17	RN Apr-17	HCA May-17	RN May-17
TARGET	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
FAMILY & WOMEN'S % Sickness	4.1%	4.9%	3.9%	5.0%	3.3%	5.0%
FAMILY & WOMEN'S % Long Term	2.6%	3.4%	2.4%	3.4%	1.8%	3.4%
FAMILY & WOMEN'S % Short Term	1.5%	1.2%	1.5%	1.6%	1.5%	1.6%

5.4 Clinical Support Health Group

All staff members, registered and non-registered are being monitored closely and managed appropriately using the Trust's sickness and absence policy. Staff sickness is taken seriously and Sisters are supported to manage staff members efficiently and effectively.



	HCA Mar-17	RN Mar-17	HCA Apr-17	RN Apr-17	HCA May-17	RN May-17
TARGET	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
CLINICAL SUPPORT % Sickness	6.1%	3.3%	6.2%	3.3%	5.9%	3.2%
CLINICAL SUPPORT % Long Term	4.0%	1.8%	4.0%	1.9%	3.6%	1.8%
CLINICAL SUPPORT % Short Term	2.0%	1.5%	2.1%	1.5%	2.3%	1.4%

5.5 Trust Wide

The Band 7 ward sister/charge nurses are all enrolled on the corporate leadership development programme, where additional training for the management of attendance is being provided. This includes in-depth training and understanding of the policy and training on how to write effective referrals to the Occupational Health department and, also, the effective management of cases where escalation to a decision panel is required.

A corporate training programme is under development for the Senior Matrons to learn skills in the preparation and hearing of disciplinary cases for the Management of Sickness Absence.

The departmental managers are to be monitored on the completion of 'return to work' interviews and the options to add this into the e-roster to record that it has taken place are being explored.

The reporting of sickness absence out of hours has been agreed at a senior level and will now be reported through the Site Matron for a trial period, which is due to commence on the 1st July 2017. It is hoped that this will add a level of challenge and seniority to the management of absence out of hours.

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 and in a way that balances the risks across the organisation via the safety brief. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses. However, recruitment efforts continue wherever possible.

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
July 2017

Appendix 1: HEY Safer Staffing Report – May 2017

HEY SAFER STAFFING REPORT MAY-17

NURSE STAFFING

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES DAY: Average fill rate - RN/RM (%)	FILL RATES DAY: Average fill rate - care staff (%)	FILL RATES NIGHT: Average fill rate - RN/RM (%)	FILL RATES NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: RN / RM	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: CARE STAFF	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: OVERALL	ROTA EFFICIENCY [17-04-17 to 14-05-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY [17-04-17 to 14-05-17]: SICK RN & AN [3.9%]	ROTA EFFICIENCY [17-04-17 to 14-05-17]: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M2]: RN [WTE]	NURSING VACANCIES [FINANCE LEDGER M2]: AN [WTE]	NURSING VACANCIES [FINANCE LEDGER M2]: TOTAL [WTE]	NURSING VACANCIES [FINANCE LEDGER M2]: % [<10%]
MEDICINE	ED	ACUTE MEDICINE	NA	0									10.8%	4.9%	4.5%	15.30	-0.34	14.96	13.7%
	AMU	ACUTE MEDICINE	45	3	93%	72%	91%	96%	1114	4.8	2.9	7.7	11.5%	3.0%	4.0%	9.62	-0.94	8.68	11.6%
	H1	ACUTE MEDICINE	22	16	72%	85%	99%	104%	638	2.5	2.0	4.6	11.9%	10.9%	0.0%	2.69	0.14	2.83	13.1%
	EAU	ELDERLY MEDICINE	21	13	91%	97%	67%	136%	557	3.9	4.0	8.0	12.0%	3.6%	6.3%	5.84	0.61	6.45	23.6%
	H5 / RHOB	RESPIRATORY	26	0	78%	96%	93%	96%	609	4.8	3.0	7.8	13.8%	9.5%	0.0%	1.69	-0.66	1.03	3.0%
	H50	RENAL MEDICINE	19	1	92%	105%	101%	101%	559	3.2	2.2	5.4	15.5%	7.8%	3.9%	1.71	1.39	3.10	16.3%
	H500	RESPIRATORY	24	0	81%	99%	100%	96%	719	2.3	2.5	4.7	9.7%	3.8%	7.4%	4.13	0.87	5.00	17.6%
	H70	ENDOCRINOLOGY	30	3	79%	125%	68%	93%	914	2.5	2.2	4.7	6.5%	4.9%	0.0%	10.49	0.76	11.25	36.0%
	H8	ELDERLY MEDICINE	27	50	91%	121%	100%	132%	818	2.3	2.7	4.9	14.3%	6.4%	2.0%	3.52	0.42	3.94	13.2%
	H80	ELDERLY MEDICINE	27	3	77%	110%	115%	105%	807	2.2	2.5	4.6	9.4%	8.9%	0.0%	5.93	1.71	7.64	25.6%
	H9	ELDERLY MEDICINE	31	7	90%	99%	100%	105%	941	2.2	2.0	4.2	14.7%	1.5%	0.0%	0.60	-2.34	-1.74	-5.8%
	H90	ELDERLY MEDICINE	29	18	84%	111%	102%	105%	882	2.0	2.3	4.3	10.9%	11.0%	8.4%	3.61	-0.61	3.00	10.0%
	H11	STROKE / NEUROLOGY	28	24	73%	162%	92%	102%	845	2.1	2.3	4.4	12.8%	1.8%	0.0%	9.59	-1.04	8.55	28.1%
	H110	STROKE / NEUROLOGY	24	6	74%	122%	100%	95%	547	4.1	2.8	6.9	10.4%	4.1%	9.8%	1.48	-0.15	1.33	4.2%
	CDU	CARDIOLOGY	9	0	75%	35%	90%		110	10.8	0.8	11.6	16.2%	1.1%	0.0%	0.89	0.48	1.37	10.3%
	C26	CARDIOLOGY	26	0	81%	76%	82%	100%	768	3.8	1.4	5.2	13.2%	1.1%	5.9%	1.27	0.25	1.52	4.5%
	C28 /CMU	CARDIOLOGY	27	1	94%	92%	99%	49%	731	6.0	1.4	7.4	12.0%	7.8%	3.7%	1.34	-0.11	1.23	2.7%
SURGERY	H4	NEURO SURGERY	30	1	93%	95%	89%	102%	790	3.0	1.8	4.8	11.5%	4.2%	4.6%	4.76	2.71	7.47	23.1%
	H40	NEURO HOB / TRAUMA	15	9	97%	94%	97%	98%	381	5.9	3.7	9.5	10.7%	6.8%	3.3%	4.94	0.77	5.71	18.8%
	H6	ACUTE SURGERY	28	1	91%	72%	88%	149%	707	3.2	1.9	5.0	11.2%	4.7%	6.6%	3.07	2.47	5.54	18.6%
	H60	ACUTE SURGERY	28	0	97%	88%	87%	174%	744	3.1	2.1	5.2	13.3%	0.8%	3.2%	1.76	1.38	3.14	10.3%
	H7	VASCULAR SURGERY	30	3	78%	76%	84%	110%	864	2.9	2.5	5.4	11.8%	2.2%	3.0%	4.52	-0.15	4.37	13.2%
	H100	GASTROENTEROLOGY	24	10	91%	102%	99%	102%	824	2.4	2.0	4.3	13.9%	7.0%	3.3%	2.95	0.34	3.29	11.1%
	H12	ORTHOPAEDIC	28	16	89%	92%	87%	113%	777	2.7	2.6	5.3	14.5%	5.9%	4.3%	4.39	-1.19	3.20	9.4%
	H120	ORTHO / MAXFAX	22	2	89%	103%	90%	137%	625	3.5	3.0	6.4	8.5%	0.7%	0.0%	1.00	1.39	2.39	8.7%
	HICU	CRITICAL CARE	22	0	84%	125%	85%	65%	465	26.7	1.5	28.2	13.9%	5.0%	3.1%	8.54	0.44	8.98	8.0%
	C8	ORTHOPAEDIC	18	1	76%	64%	69%	66%	202	4.8	2.8	7.6	15.9%	8.3%	0.0%	3.19	-0.43	2.76	19.1%
	C9	ORTHOPAEDIC	29	1	96%	97%	102%	100%	689	3.4	2.3	5.7	13.0%	2.3%	0.0%	4.65	2.06	6.71	22.5%
	C10	COLORECTAL	21	1	83%	68%	89%	106%	512	4.2	1.8	6.0	12.6%	9.3%	0.0%	4.41	2.59	7.00	27.9%
	C11	COLORECTAL	22	0	85%	86%	79%	98%	471	4.5	2.2	6.7	13.9%	4.8%	0.0%	-0.04	1.94	1.90	7.9%
	C14	UPPER GI	27	3	92%	87%	92%	117%	641	3.7	1.9	5.6	13.7%	3.0%	0.0%	2.93	-0.39	2.54	8.9%
	C15	UROLOGY	26	1	85%	78%	85%	98%	649	4.1	2.3	6.5	15.2%	4.4%	0.5%	-0.30	-0.85	-1.15	-2.9%
	C27	CARDIOTHORACIC	26	1	83%	86%	94%	100%	738	3.8	1.5	5.3	14.1%	4.5%	8.7%	0.35	0.33	0.68	2.2%
	CICU	CRITICAL CARE	22	0	83%	56%	88%	45%	409	23.2	1.4	24.6	13.0%	2.2%	7.6%	5.31	0.34	5.65	5.8%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	78%	132%	128%	73%	280	7.4	4.8	12.1	6.5%	2.5%	2.0%	4.12	1.22	5.34	18.5%
	H130	PAEDS	20	0	83%	34%	86%	45%	318	8.1	1.0	9.1	10.2%	4.4%	8.8%	0.38	0.14	0.52	2.1%
	H30 CEDAR	GYNAECOLOGY	9	0	92%	73%	105%		153	9.9	3.5	13.4	10.7%	6.7%	0.0%	-1.00	0.12	-0.88	-3.9%
	H31 MAPLE	MATERNITY	20	0	97%	96%	117%	100%	103	23.6	13.7	37.4	10.1%	2.3%	1.8%	4.67	2.85	7.52	10.5%
	H33 ROWAN	MATERNITY	38	1	87%	95%	92%	99%	946	3.3	1.9	5.2	11.6%	5.8%	2.0%				
	H34 ACORN	PAEDS SURGERY	20	0	89%	84%	99%	108%	283	9.1	2.4	11.5	14.0%	3.2%	0.0%	1.17	0.74	1.91	6.8%
	H35	OPHTHALMOLOGY	12	0	79%	83%	112%		243	8.6	2.1	10.7	12.9%	2.3%	4.6%	-0.04	0.85	0.81	4.0%
	LABOUR	MATERNITY	16	0	81%	75%	83%	79%	283	17.0	6.0	23.0	9.1%	6.4%	4.0%	-7.07	-4.37	-11.44	-18.0%
	NEONATES	CRITICAL CARE	26	1	77%	104%	79%	97%	679	10.2	1.1	11.2	13.8%	4.2%	6.8%	6.50	-1.00	5.50	8.4%
	PAU	PAEDS	10	0	99%		100%		86	17.4	0.0	17.4	11.2%	9.6%	0.0%	0.60	0.00	0.60	5.5%
	PHDU	CRITICAL CARE	4	0	102%	106%	102%		70	21.6	1.3	22.9	12.1%	3.7%	0.0%	0.07	0.00	0.07	0.5%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	1	102%	89%	100%	97%	476	3.3	2.1	5.4	14.0%	6.0%	2.4%	-0.04	0.96	0.92	4.8%
	C29	REHABILITATION	15	0	93%	100%	100%	92%	449	3.5	4.2	7.7	15.7%	5.0%	0.0%	1.37	3.42	4.79	18.4%
	C30	ONCOLOGY	22	2	93%	108%	103%	105%	634	3.0	1.9	4.9	11.6%	2.0%	2.9%	1.14	0.03	1.17	6.7%
	C31	ONCOLOGY	27	0	84%	126%	99%	105%	780	2.5	2.0	4.5	11.0%	5.8%	0.0%	0.67	1.33	2.00	9.9%
	C32	ONCOLOGY	22	0	101%	98%	100%	98%	639	3.0	1.7	4.7	12.4%	2.1%	3.1%	-0.53	0.12	-0.41	-2.2%
	C33	HAEMATOLOGY	28	1	91%	164%	100%	156%	688	4.2	2.4	6.6	14.4%	5.9%	5.0%	2.61	-1.99	0.62	1.9%
		TOTAL:	201		AVERAGE:				583	6.4	2.5	8.9	12.3%	4.8%	2.9%	150.75	18.61	169.36	6.8%
														TOTALS:			TOTALS:		

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

HEALTH GROUP	WARD	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED								0						0	0
	AMU	90%		1	4	3		1	4		2		2		4	13
	H1	100%							0						0	0
	EAU	100%	1	1					0						0	2
	H5 / RHOB	100%							0						0	0
	H50	100%			2				0						0	2
	H500	100%							0		1		1		2	2
	H70	100%			3				0		1				1	4
	H8	100%				2			2				1		1	3
	H80	100%				1			1						0	1
	H9	100%	2			2			2						0	4
	H90	92%		1	1	3	1		4						0	6
	H11	100%		1	1	3	1		4		1				1	7
	H110	88%	3	1	2	1			1		4			1	5	12
	CDU	100%							0						0	0
	C26	100%		1					0						0	1
	C28 /CMU	100%							0		1		1		2	2
SURGERY	H4	95%	1	1					0						0	2
	H40	100%							0						0	0
	H6	100%	2	1	2				0						0	5
	H60	100%	1		2				0						0	3
	H7	100%		1		1			1						0	2
	H100	92%	1			1			1						0	2
	H12	95%		1					0		1				1	2
	H120	96%				2			2				1		1	3
	HICU	83%			3	1			1		2				2	6
	C8	100%		1					0						0	1
	C9	100%			1				0		2				2	3
	C10	100%							0						0	0
	C11	100%	4	1	1				0						0	6
	C14	100%							0		1				1	1
	C15	100%		1					0		1				1	2
	C27	100%							0						0	0
	CICU	100%							0						0	0
FAMILY & WOMEN'S	C16	100%	3						0						0	3
	H130	100%		1					0						0	1
	H30 CEDAR	100%		1					0						0	1
	H31 MAPLE	100%							0						0	0
	H33 ROWAN	100%			2				0						0	2
	H34 ACORN	100%							0						0	0
	H35	100%							0						0	0
	LABOUR	100%	2	1	1				0						0	4
	NEONATES	100%							0						0	0
	PAU	100%							0						0	0
	PHDU	100%							0						0	0
CLINICAL SUPPORT	C20	93%							0		2				2	2
	C29	100%				1			1		3				3	4
	C30	100%		1	1	3			3						0	5
	C31	100%			1				0						0	1
	C32	95%			1				0						0	1
	C33	100%				1	1		2						0	2
		TOTALS:	49	20	17	28	25	3	1	29	0	22	0	6	1	29	123

May-17	DAY		NIGHT		CARE HOURS PER PATIENT PER DAY [CHPPPD]			
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Cumulative Count	RN / RM	CARE STAFF	OVERALL
HRI SITE	83.7%	94.2%	89.2%	102.6%	19320	4.7	2.4	7.1
CHH SITE	85.7%	92.8%	92.5%	92.0%	9866	4.8	2.1	6.9

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	31 May 2017	**Chair:**	T Sheldon	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Detailed presentation on nutrition
- WHO surgical checklist – update from Operational Quality Committee discussions
- CQC inspections of local renal dialysis units
- Quality aspects of Integrated Performance Report, specifically mortality indicators
- Updates being made to the Quality Improvement Plan (QIP)

Decisions made by the Committee:

- WHO Surgical checklist – update on progress to come in three months' time
- View to be requested from Ellen Ryabov on longer cancer waiting times and potential impact on quality

Key Information Points to the Board:

- As above

Matters escalated to the Board for action:

- None

Matters deferred to other Board Committees:

- None

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON WEDNESDAY 31 MAY 2017, 10.15 AM– 12.15 PM
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr A Snowden	Vice Chair/Non Executive Director
	Mrs V Walker	Non Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer (arrived 10.25 am)
	Ms C Ramsay	Director of Corporate Affairs
	Mr D Corral	Chief Pharmacist
	Dr A Green	Lead Clinical Research Therapist
	Mrs S Bates	Interim Deputy Director of Quality, Governance and Assurance
IN ATTENDANCE:	Dr M Purva	Deputy Chief Medical Officer
	Ms T McDougall	Head of Dietetics (until 11.15 am)

1. APOLOGIES **ACTION**

Apologies were received from Professor T Sheldon, Non-Executive Director. Mr Snowden took the chair for this meeting.

The agenda was taken out of order at this stage

5.3 Nutrition Update

The committee welcomed Tina McDougall, Head of Dietetics. Ms McDougall gave a presentation on the state of nutrition of patients. The Trust undertook an audit of the state of patient nutrition on admission two years ago, which has just been repeated. The level of malnourishment on admission amongst the Trust's patients is slightly higher than the national average. Ms McDougall presented the health and treatment risks associated with malnourishment on admission and during hospital stay. The Trust has processes in place to recognise patients who are at risk of malnourishment during their inpatient stay and the steps taken to treat and improve the health of patients, working jointly between dietetics, nursing and catering staff.

The Trust audits nutrition as one of the fundamental nursing standards. The Trust's Dieticians undertake quarterly ward audits, from which the ward receives a written report, with training and support from the Dieticians available as required. The current average is circa 85% compliance for nutritional care from the fundamental standards audit.

Where patients are at high risk, they should be referred to the Dietician team at an early stage. This was reviewed following feedback by the CQC, which picked up on some referrals not being made in a timely basis. The team had been receiving circa 500 referrals per month at the time of the CQC inspection; as a result of the work with wards, this is now 800 referrals per month. This is as a result of meeting unmet need, as well as the increase in frail, elderly patients with increased nutritional needs that has been seen over the last few years. The referrals received are generally appropriate referrals to the team.

Kevin Phillips joined the meeting at this stage

The audits have shown some differences in practice and compliance between wards at HRI and CHH, which the team is now focussing on.

It was recognised that nutrition assessments largely fall to nursing staff to complete. The question was asked as to the role of medical staff in factoring in nutrition to treatment plans, surgical plans etc. There are some specialties that will focus on nutrition more, such as Gastroenterology and the Department of Medical Elderly, but it will be more variable in other areas. It was recognised as something in which doctors receive less training and the way in which nutrition links with patient care, treatment and recovery. From a pharmacy point of view, in critical areas where nutrition and patient weights are particularly are important factors, such as chemotherapy, these are well managed processes. From a nursing perspective, the nursing and dietetics teams have been reducing the paperwork burden and looking at engaging nursing staff, who have a number of assessments to complete per patient. There is a concerted effort to raise awareness of the link between nutrition, recovery and care.

The challenges are a 40% increase in dietetic referrals; of those referred to the dietetic team 50-70% had hospital acquired malnutrition. The aim is to prevent hospital acquired malnutrition by targeting treatment for moderate risk patients thereby reducing conversion to high risk, which triggers a dietetic referral. The Trust has a Nutrition Steering Group is in place, chaired by Steve Jessop, Nurse Director, with medical input from Dr Fiona Thompson, DME Consultant. Ms McDougall also shared other steps being taken, such as nutrition champions, pre-operative information and treatment, standardisation of ward processes, communication of the malnutrition pathway (including to community services, GP and community pharmacists), additional nutrition apprenticeships and nutrition education packages. Some follow up questions were asked regarding the work with the community and how to inform GPs on patients' nutritional risks.

Tina is attending the Area Prescribing Committee to talk to GPs about how to communicate these needs. Mr Phillips would like IDLs to be more dynamic and completed by different members of the team during a patient's admission.

The Chair observed that there are elements of the work of the Dietetic team that are around an improvement approach and consistent with the improvement methodology of the Trust. The Chair also forwarded a Cochrane review to Ms McDougall that is newly published and raises some questions that would be helpful to review, on the link between nutrition and adverse events.

Ms Walker asked about assistance to patients who are less mobile or less able to feed themselves. Ms Bates replied that there are more roles and volunteers on the wards at HRI, which is different to CHH. There is a higher turnaround of patients on the surgical wards CHH, where patients also have shorter lengths of stay.

Ms McDougall was thanked for her detailed presentation and attendance.

Ms McDougall left the meeting at this stage (11.15 am)

The agenda was taken back in order

2. MINUTES OF THE MEETING 24 APRIL 2017

The minutes of the meeting held 24 April 2017 were approved as an accurate record of the meeting

3. ACTION TRACKING LIST/WORKPLAN

Action 01.03 – the approach to Quality Improvement will go to the Trust Board development session in July 2017 **CR**

Action 02.02 – update the description of this action to be received in September 2017 to match the due date **RT**

Action 02.10 – this was updated that assurance should be presented to the Quality Committee that the Chaperone Policy has been updated to reflect all requirements and has been approved through the Trust's governance structure **RT**

The actions noted as complete were agreed to be removed from the action tracker

There were no changes or comments for the Committee Work Plan

4. MATTERS ARISING

The Trust has mapped its processes against the new national Mortality requirements; Mrs Bates to bring to the next meeting assurance that the Trust has mapped against requirements and has actions in place to meet future requirements. **SB**

5. REDUCING AVOIDABLE HARM

5.1 Quality Safety Bulletin

The Lessons Learning newsletter format will change to be more user-friendly format and be Lessons Shared – previous comments have been taken on board by the team.

Mr Wright raised whether there is evidence that the newsletter only goes down to a certain level in the organisation, i.e. do all Trust staff read and take on board key messages? Mrs Bates' team has audited this recently and it shows a mixed position across the Trust; the Compliance team is working on an engagement strategy with the Communications Team as a result.

5.2 Renal contract

Mr Wright updated the Committee on the renal contract. Renal dialysis services are provided by Fresenius, a private sub-contracted renal provider, which was commissioned via NHS England Specialised Commissioners, with the management of the contract being handed to the Trust on 1 April 2017. The CQC were inspecting all of Fresenius's renal dialysis units in this area during April – May 2017. The provider was given a warning notice by the CQC for one of units in East Yorkshire. Mr Phillips, Mrs Bates and Mr Wright met with Fresenius on 1 May 2017 to seek assurance as to how the provider is addressing the concerns raised and whether these would have an impact on the inspection for the Hull unit. There is a further meeting scheduled today to review the agreed actions. All these CQC inspections for renal dialysis services in the patch, including Hull, are now complete and there has been no further feed back to date on any further warning notices. There will be a report for each unit.

The Trust has learned lessons from this; the Trust already had contract management arrangements in place between the Medicine Health Group and Fresenius but these need to be strengthened as the provider did not recognise the issues that it had at Bridlington, and needs to provide more assurance at Hull as a result. Follow-up meetings will be put in place monthly for the CQC elements. The Trust will review the reports from all 5 local renal dialysis units; the Trust will write to follow up the Hull report formally and then meet regularly thereafter. The Trust can take action under the contract with Fresenius if needed, depending on the results and assurance received. The Trust has put strengthened oversight, specifically nursing oversight, in to the unit. This Committee will be kept updated. The CQC will likely review the way the Trust is managing this issue as part of the Trust's upcoming pilot well-led assessment.

5.4 – Serious Incidents – April 2017

There is one closed SI in this month's report. A more detailed briefing on this SI is in the Quality report to the Trust Board this month. Mr Wright confirmed that in this particular case, the patient was conscious and had been stabilised and was with a doctor. The doctor had turned around, the patient moved quickly and fell. The report stated that there was no new learning identified from this incident, which was queried by Mrs Walker. It was confirmed this is the case in this instance.

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

It was noted that all Trusts cannot be in the highest 25% of Trusts. The Trust's approach is to put more effort and review in the levels of harm and wanting to have the highest proportion of incidents causing no harm or as near misses, rather than focussing on a volume of incidents reported.

7. RECEIVED FOR ASSURANCE

7.1 – Quality Improvement Programme (QIP)

Mrs Bates presented this item. This is the second year of the QIP approach, to put all the Trust's compliance requirements in to one over-arching plan. There will be a refresh between the QIP will be reviewed with the HEY Improvement team as to how some of QIP projects will monitor and be measured.

Using the example of the Nutrition presentation at today's committee, the QIP is around certain projects and meeting certain milestones. There is still work to do in order to capture the Trust's needs and improvement requirements – the Nutrition team has highlighted some areas for further work and compliance as an improvement approach that are not yet captured in the QIP, for example.

There are other QIP programmes that have the same sort of elements, such as checklists and the work going on with wards – that does not yet reflect fully the level of work and risk going on.

The QIP report is accurate against what it is measuring; there are some QIP projects where the measures or project aims need to be changed to reflect current practice vs. the aims for quality improvement, and how this is captured on the QIP updates, including measures of outcomes.

Mr Snowden asked whether this was the correct report for this committee and whether this committee should focus on the progress towards achievement of

an outcome. Mr Phillips will be looking at the work of the Healthcare Delivery Improvement Group and how this is reflected. Mr Snowden asked whether there were trajectories set for outcomes and improvement and whether these could be detailed in the report to give this oversight. Mr Wright noted that this QIP approach has brought structure where this did not exist previously and there was agreement that this repot can evolve.

7.2 Integrated Performance Report
This is the first time this report has been received prior to the Board, to enable the Committee to review and seek assurance on the Quality indictors in the report prior to the Board. It was noted that there are few red indicators for Quality

Mr Snowden noted the latest SHMI and HSMR data and noted these are national reporting requirements. Mr Snowden asked how the Committee and the Board could have a more accurate measure of mortality. Professor Sheldon raised that a focus on avoidable deaths would be more valuable, which is where the new mortality review and approach the Trust is taking is heading towards. Mr Phillips confirmed that this Committee will receive formal reports quarterly on the mortality reviews, which will provide better insight and data on the Trust's position on mortality, including avoidable deaths and what follow up has happened.

The Trust's HSMR rose to 119.7 in the January 2017 data and at 121 at weekends. Mr Phillips gave assurance that these data are reported to the Trust's Mortality Committee; the Mortality Committee also looks at CHKS data against specific conditions, particularly areas triggered nationally that Trusts' should review (i.e. deaths relating to pneumonia, cardiac surgery). The Trust previously waited for alerts whereas the Trust is taking a more pro-active approach to using data, anticipating these alerts and reviewing the Trust's position in these areas.

The Committee should receive assurance from the Mortality Committee as a result of these reviews as to whether the Trust understands increases in mortality rates, including avoidable factors. This is to be included routinely in the quarterly Mortality updates to this Committee.

Mrs Walker asked whether there is a focus on the cancer standards; Ms Ramsay fed back from the Performance and Finance Committee that this is a key area of focus; Mr Phillips noted that this is intrinsically linked to the Trust's diagnostic capacity. Mr Snowden asked about the patients breaching 104 days for cancer treatment; Mr Phillips responded that such patients are often too unwell to have commenced treatment sooner; each patient over 104 days is reviewed at the weekly performance meetings to understand if the breach is due to the patient's health and/or due to other factors, such as Trust diagnostic and treatment capacity. Mr Snowden asked for this to be followed-up, as there are quality impacts on patient waiting times that this Committee should consider.
Action: CR to request view from Ellen Ryabov on the 104 day cancers and whether there are any quality impacts or recurrent themes that affect patient care that this Committee should review **CR**

7.3 Operational Quality Committee Report
The Committee noted that the Trust has agreed to be a pilot for the CQC's new well-lead domain. The Trust's inspection will be on 19-20 June 2017.

Mr Phillips noted the work currently ongoing on unlicensed chlorhexidine and open systems – there are no concerns to escalate to the Quality Committee at this time.

Professor Sheldon noted the escalation report from Surgery, in that issues regarding payment to suppliers that had affected patient care and asked if these have been resolved at present. The most urgent issues are at present.

Professor Sheldon requested an update on claims and impact on quality. CR noted that the report states that the Trust's legal spend has increased; CR confirmed that it is the Trust's insurance premium cost that has increased and not legal spend; the Trust's legal spend has actually decreased in the last 12 months. **SB**

7.4.1 WHO Checklist report

Dr Purva presented this report; she reminded the Committee of the concerns raised by the CQC previously and the approach taken to change the checklist and behaviours to increase compliance. There is a solution noted in the Operational Quality Committee report regarding a particular issue on signatures and what these mean. The next steps are to embed the change and to continue to gather data to identify if this is making a difference. The new process has gone to all theatres in CHH and there results will be reviewed to see if any further changes and PDSA cycles are needed.

Mr Wright raised concerns that the new checklist does not note who is present at the safety briefs and what to do if any of the questions are answered 'no'. Mr Wright met with the Chairman this morning, who visited theatres and observed two checklist processes. Mr Wright said that there is still a need to set a corporate standard as to what is required, the requirement for all staff to participate in the five steps for safer surgery and how to implement a process to pause if something is not right. Mrs Bates noted that the checklist is part of the theatre booklet, which does list who is in the theatre and requires signatures from all present. Dr Purva noted that the previous version in place for the last 10 years required the signature of one person only, which was normally the circulating nurse.

Professor Sheldon concluded that this is still a work in progress and that the Quality Committee needs to understand the current position. The Chair also noted that a national review noted some of the common issues that the Trust has also found (Gillespe, 2015) and also asked if the approach by other Trusts had been reviewed.

Mr Wright asked how user feedback is being taken up; he is aware of a level of unrest being expressed by colleagues and whether there is sufficient accountability and participation. Mrs Bates noted that the HEY Improvement Team will be supporting work this in future. Mr Phillip also confirmed that the reason that the pilot remains at CHH only at present is to take up feedback from all colleagues involved.

Further assurance to be received at this Committee in due course (3 months' time). **MP**

7.5 Lessons learned Newsletter
SB confirmed that the format of this report will change, and will be lessons shared.

8. ANY OTHER BUSINESS
There were no items of other business discussed.

9. CHAIRMAN'S SUMMARY TO THE BOARD
A verbal summary of the meeting would be presented at the June 2017 Board meeting; a written summary will accompany the minutes to the July 2017 Board.

10. DATE AND TIME OF NEXT MEETING:
Monday 26 June 2017, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	26 June 2017	**Chair:**	Prof T Sheldon	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Mortality – The Committee discussed HSMR and SHMI data and trends and how this related to the developing case note reviews of deaths to identify which deaths might be avoidable and how these could be prevented in future.
- The Quality Accounts were approved by the Committee following the addition of the deteriorating patient information.
- A serious incident was discussed and the desirability for a simplified focused report detailing what should have happened, what actually happened and what lessons there were to be learned to be presented at the next Committee.
- Quality Improvement Plan – any projects rated red or amber would be highlighted to the Committee and what was being done to get the improvements on track..
- Integrated Performance Report – The Committee discussed the issues around diagnostic performance and the impact on patient care.
- The Operational Quality Committee minutes were received – The Chaperone Policy had been approved at the Committee in May 2017.
- A report regarding the acknowledgement rate of radiology results was received.
- CQC Case Study report was received to review what 'good' looks like.
- The Board Assurance Framework was received. The Committee agreed to 'deep dive' major quality risks at a Board development session.

Decisions made by the Committee:

Key Information Points to the Board:

Matters escalated to the Board for action:

- Diagnostic capacity

Integrated Performance Report 2017/18

June 2017

May data

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

Integrated Performance Report - June 2017

RESPONSIVE

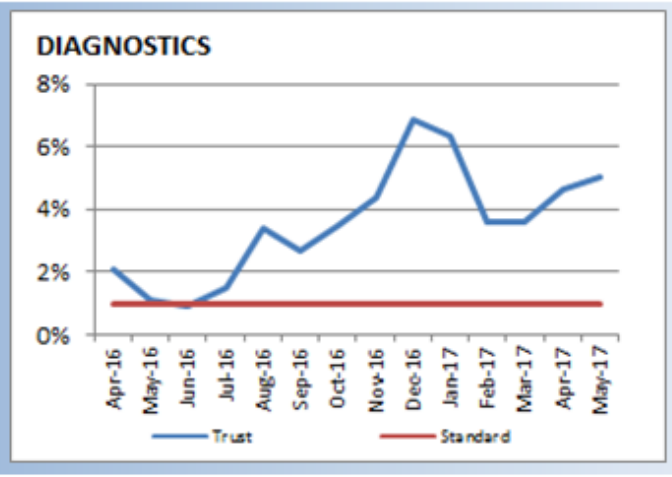
Description	Aggregate Position	Trend	Variation

Diagnostic Waiting Times: 6 Weeks

All diagnostic tests need to be carried out within 6 weeks of the request for the test being made

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target with performance of 5.04% in May

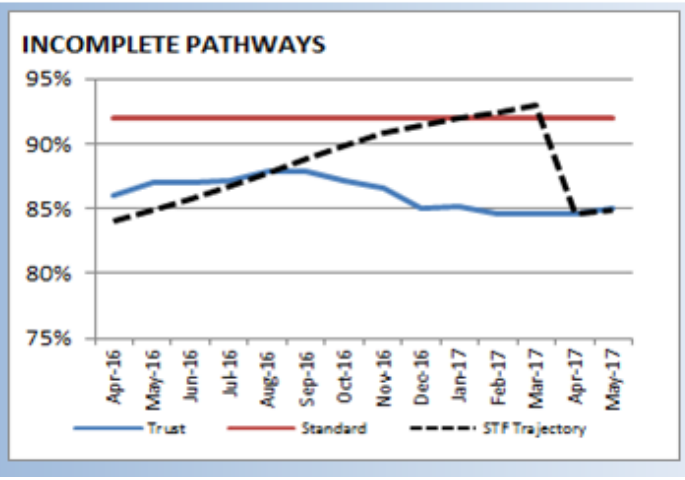


Referral to Treatment Incomplete pathway

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

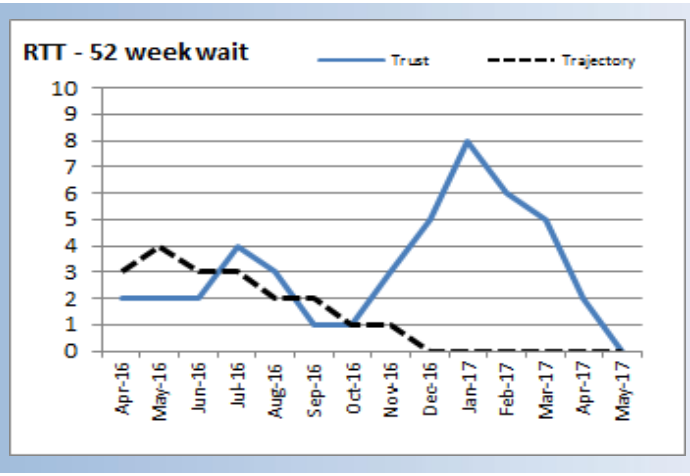
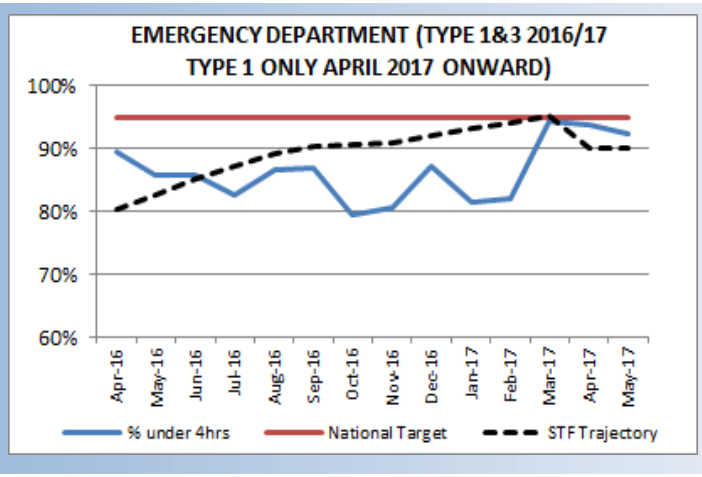
The Trust achieved the May Improvement trajectory of 84.8%

May performance was 85.06%. This failed to meet the national standard of 92%.

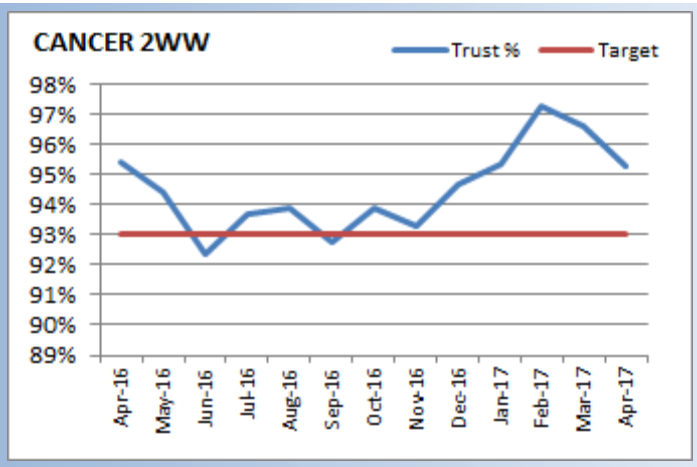
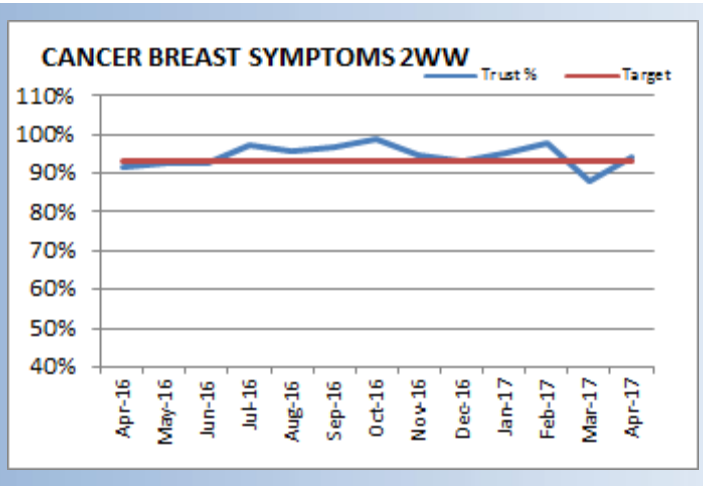


Integrated Performance Report - June 2017

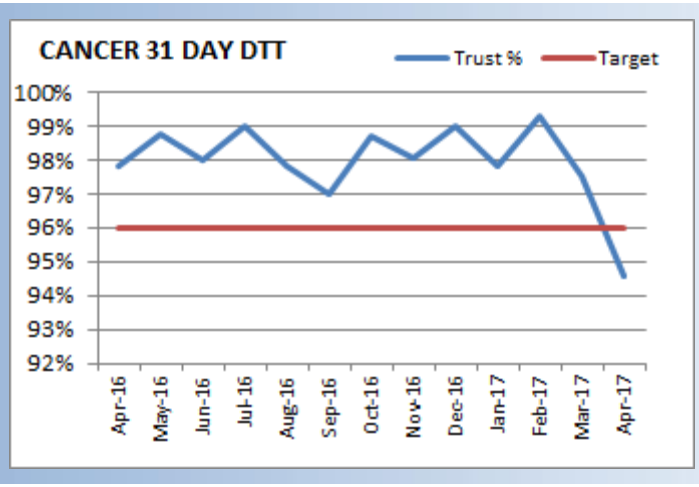
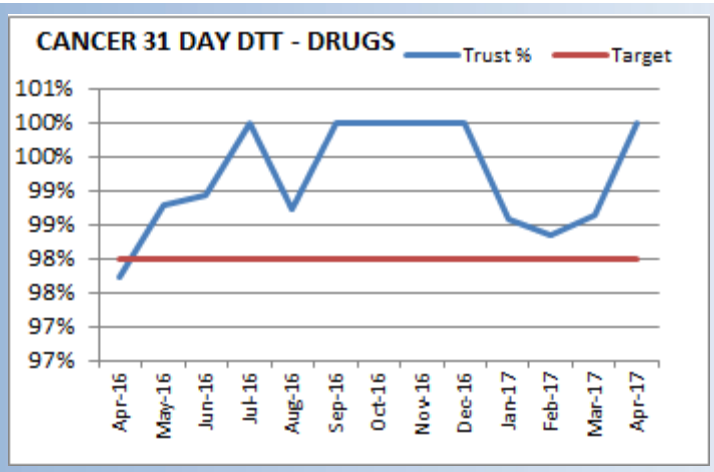
RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Referral to Treatment Incomplete 52+ Week Waiters	The Trust aims to deliver zero 52+ week waiters	The Trust achieved the national standard of zero breaches for May		
A&E Waiting Times	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	A&E performance achieved the Improvement trajectory of 90.0% with performance of 92.5% for May. This has failed to achieve the national 95% threshold.		Performance has decreased by 1.3% during May compared to April performance of 93.8%.

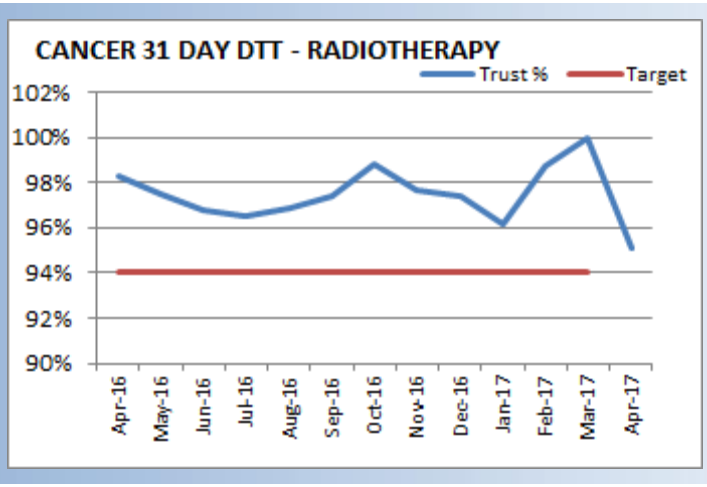
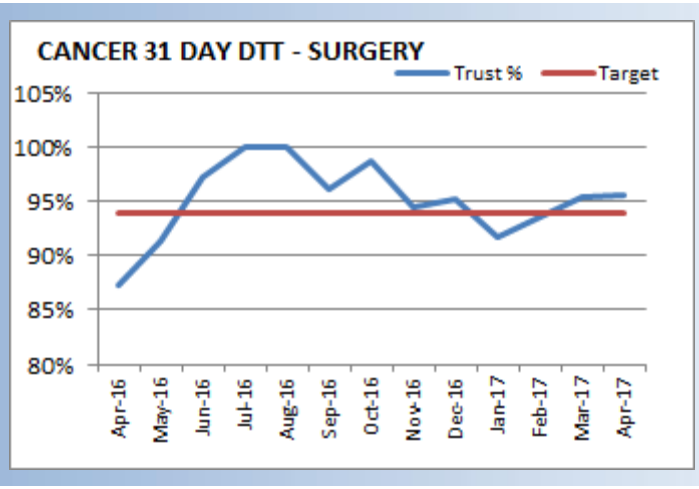
RESPONSIVE

	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%.	April performance achieved the 93% standard at 95.3%		
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.	April performance achieved the 93% standard at 94.4%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	April performance failed to achieve the 96% standard at 94.6%		
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%.	April performance achieved the 98% standard at 100%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	April performance achieved the 94% standard at 95.1%		
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%.	April performance achieved the 94% standard at 95.5%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation

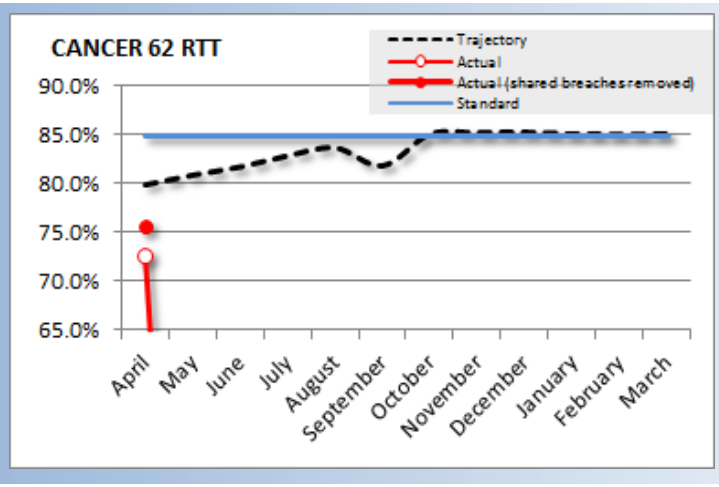
Cancer: ADJUSTED - 62 Day Standard

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

Sustainability and Transformation trajectory is 80.0%

The adjusted position allows for reallocation of shared breaches

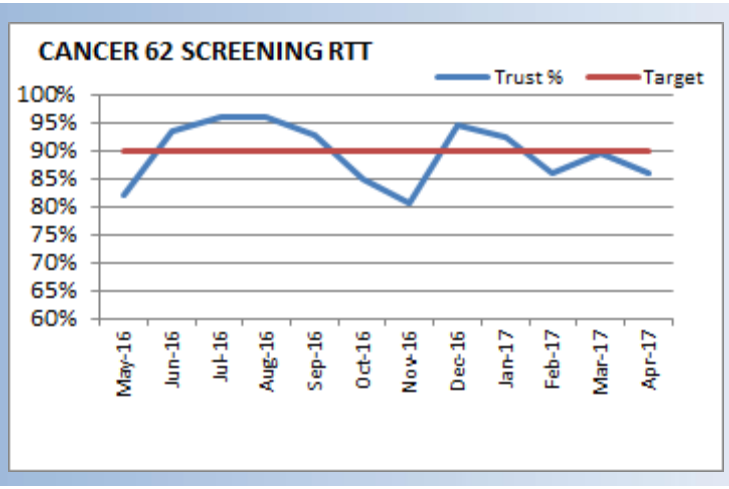
April failed to achieve the STF trajectory of 80.0% with performance of 75.7%



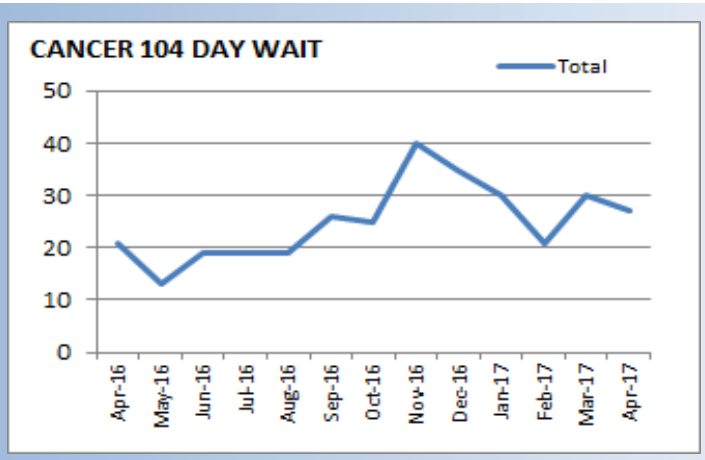
Cancer: 62 Day Screening Standard

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

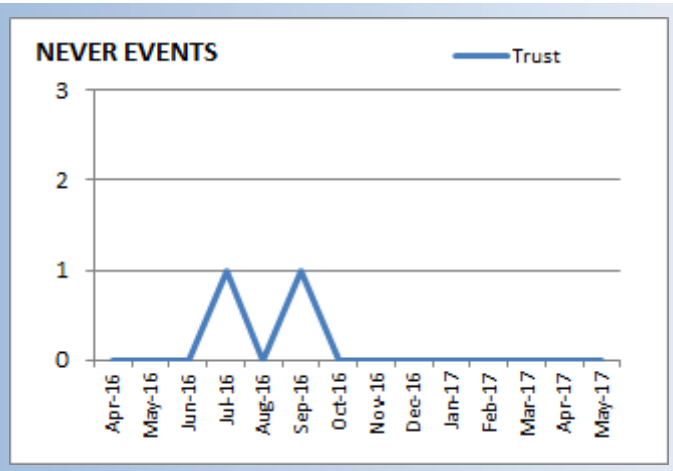
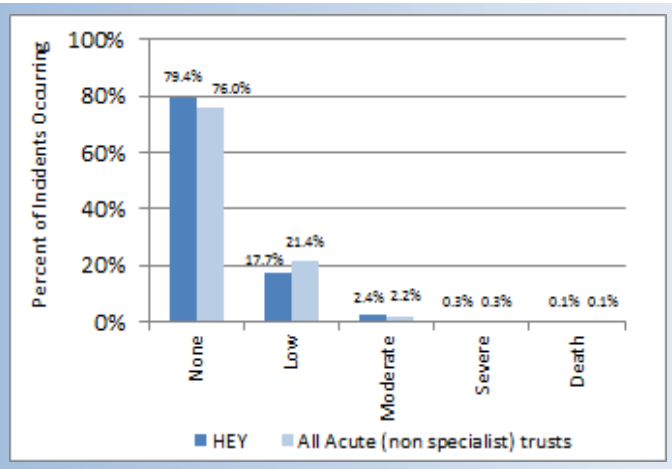
April performance failed to achieve the 90% standard at 83.7%



RESPONSIVE

Description	Aggregate Position	Trend	Variation
Cancer 104 Day Waits	There were 27 patients waiting 104 days or over during April		

SAFE

	Description	Aggregate Position	Trend	Variation
Occurrence of any Never Event	Occurrence of any Never Events	There were zero Never Events reported during May		Further information is included in the Board Quality report
Potential under-reporting of patient safety incidents	Number of incidents reported per 1000 bed days	The latest data available for this indicator is April 2016 to September 2016 as reported by the National Reporting and Learning System (NRLS). The Trust reported 5,546 incidents (rate of 32.71) during this period.		

Integrated Performance Report - June 2017

SAFE

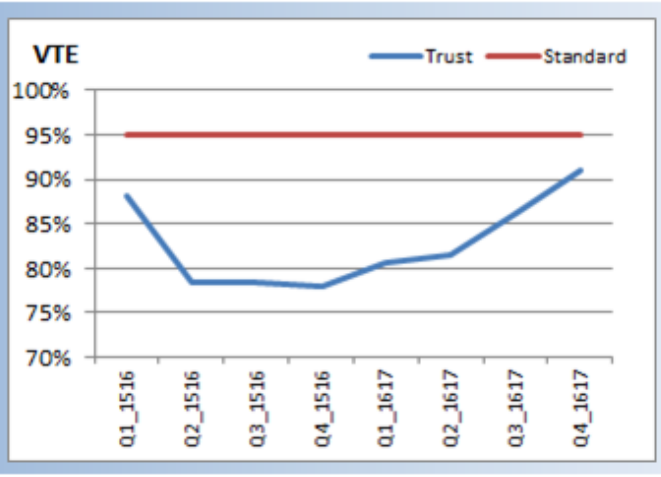
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 90.91% for Q4 2016/17.

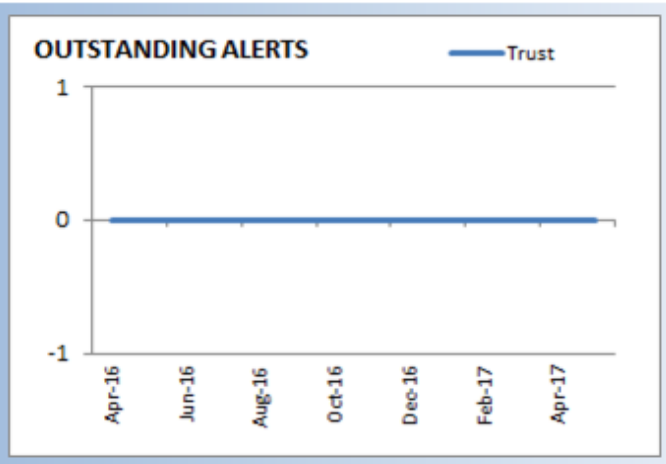


Patient Safety Alerts Outstanding

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

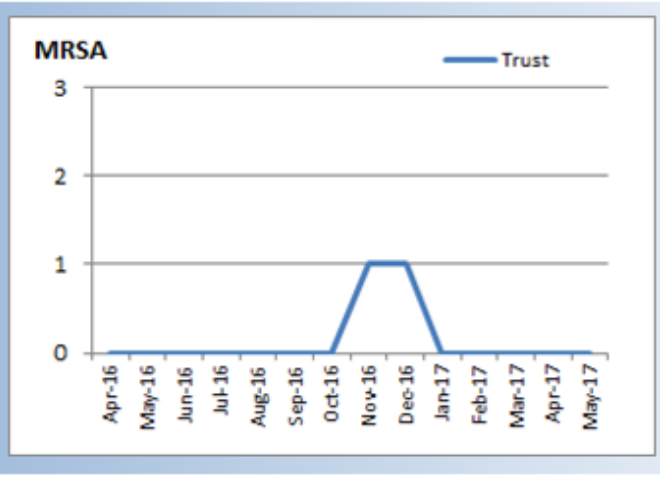
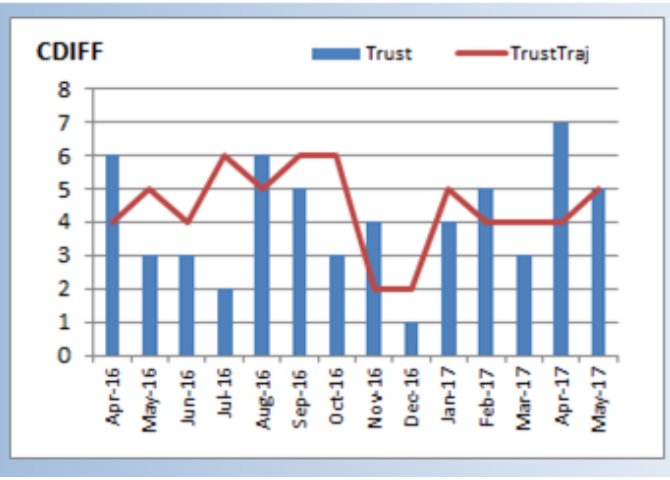
There have been zero outstanding alerts reported at month end for May 2017.

There have been no outstanding alerts year to date.



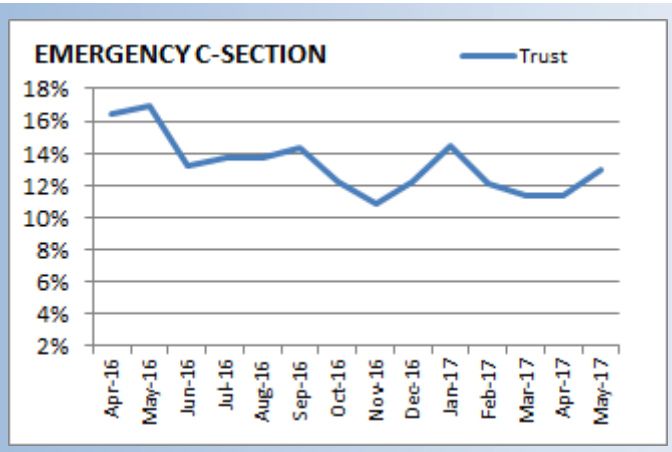
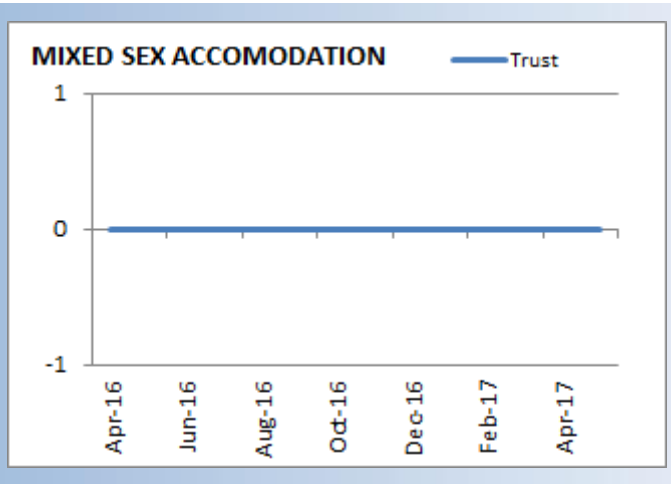
Integrated Performance Report - June 2017

SAFE

	Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 2 cases of acute acquired MRSA bacteraemia during 2016/17. There were no cases reported during May 2017.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2017/18 is no more than 53 cases	There have been 12 cases year to date There were 5 incident reported during May which achieved the monthly trajectory of no more than 5 cases		

Integrated Performance Report - June 2017

SAFE

Description	Aggregate Position	Trend	Variation
Emergency C-section rate Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for May failed to achieve this standard at 12.9%		Further information is included in the Board Quality report
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 May 2017.		

EFFECTIVE

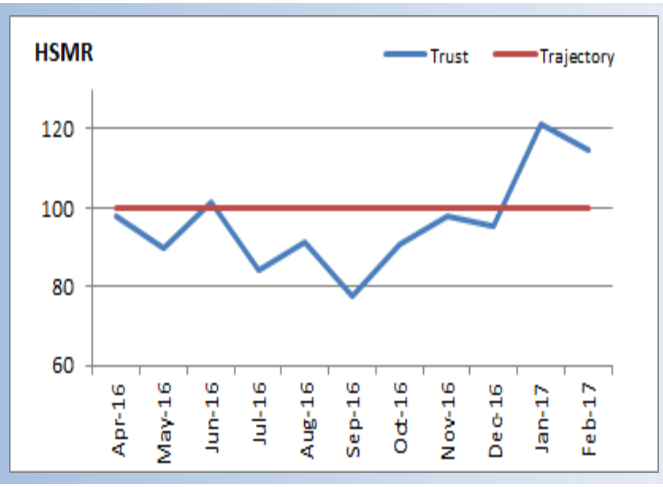
Description	Aggregate Position	Trend	Variation

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

February 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and February 2017 failed to achieve this at 114.8

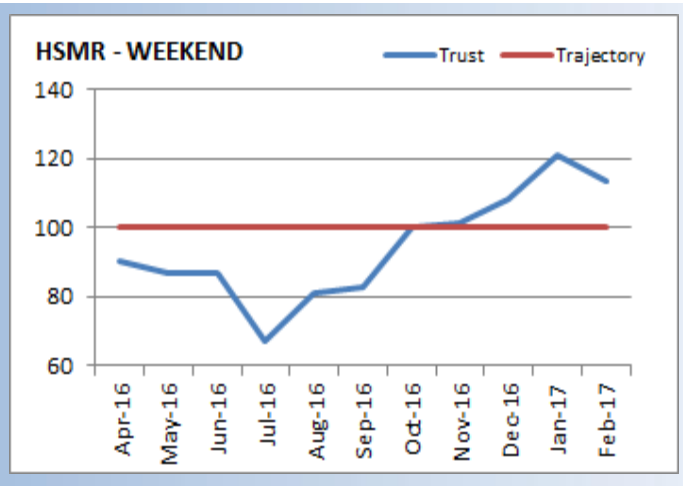


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

February 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and February 2017 failed to achieve this at 114



EFFECTIVE

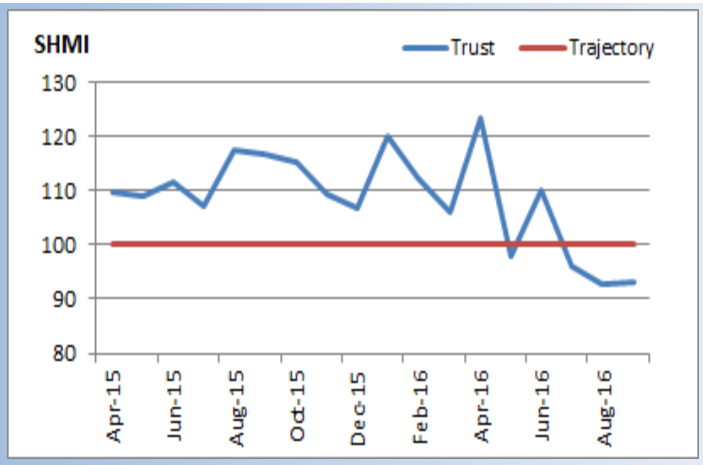
Description	Aggregate Position	Trend	Variation

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.

September 2016 is the latest published performance

The standard for SHMI is to achieve less than 100 and September 2016 achieved this at 93

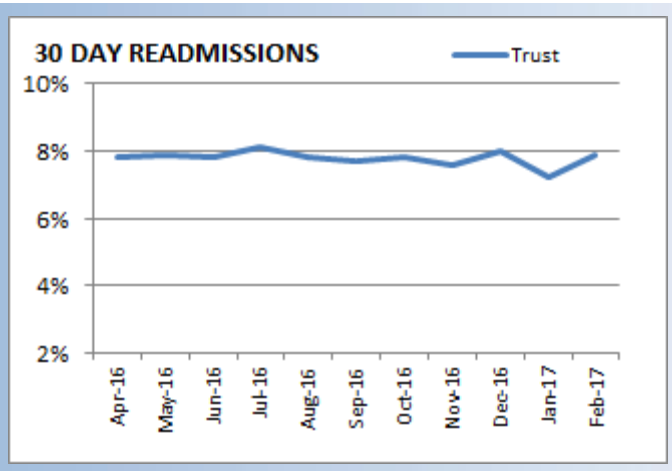


30 DAY READMISSIONS

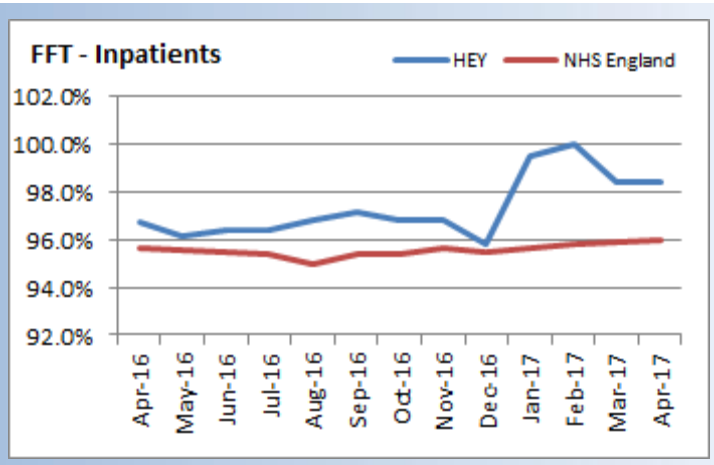
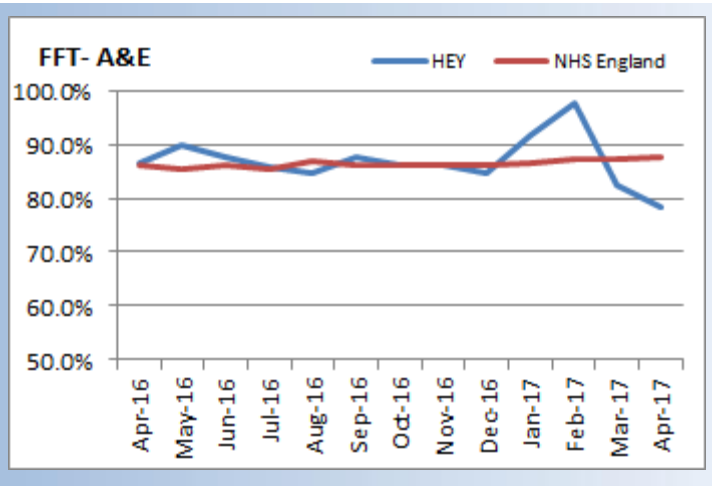
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is February 2017

The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than or equal to 7.8%. The Trust failed to achieve this measure with performance of 7.9%.



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 April was 98.4% The latest published data for NHS England is April 2017. May 2017 will be published 6th July 2017.	
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for April was 78.3% The latest published data for NHS England is April 2017. May 2017 will be published 6th July 2017.	

CARING

Description	Aggregate Position	Trend	Variation

Maternity Scores from Friends and Family Test - % Positive

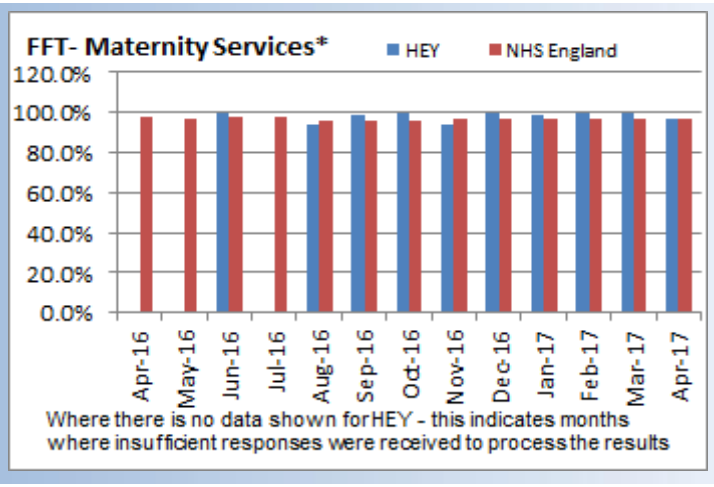
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for April was 96.5%

The latest published data for NHS England is April 2017.

May 2017 will be published 6th July 2017.

Months with no data for HEY is due to insufficient responses



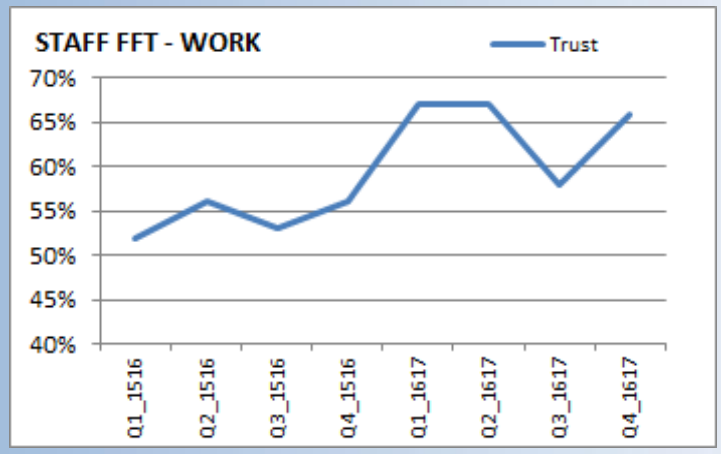
* Question relates to Birth Settings

Relative Position in Staff Surveys

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

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

Quarter 1 performance will be published 24th August 2017.



CARING

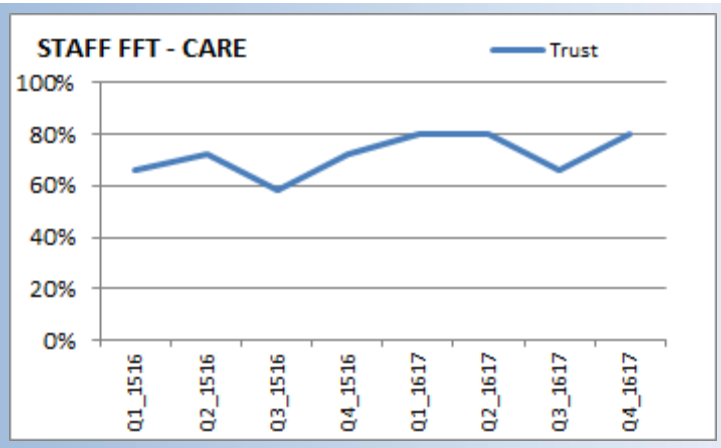
Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

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

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

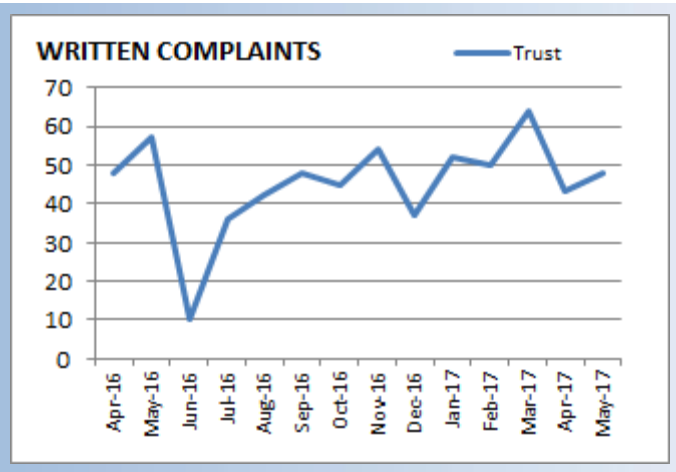
Quarter 1 performance will be published 24th August 2017



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 48 complaints during May, this is a increase on the April position of 43 complaints



There have been 91 complaints year to date

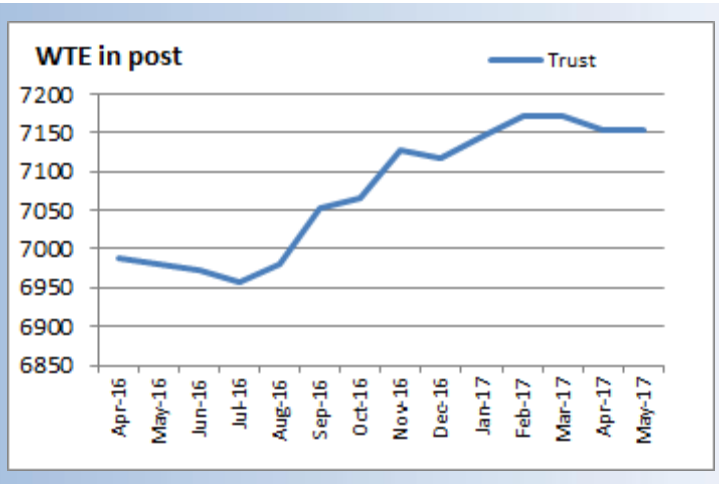
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

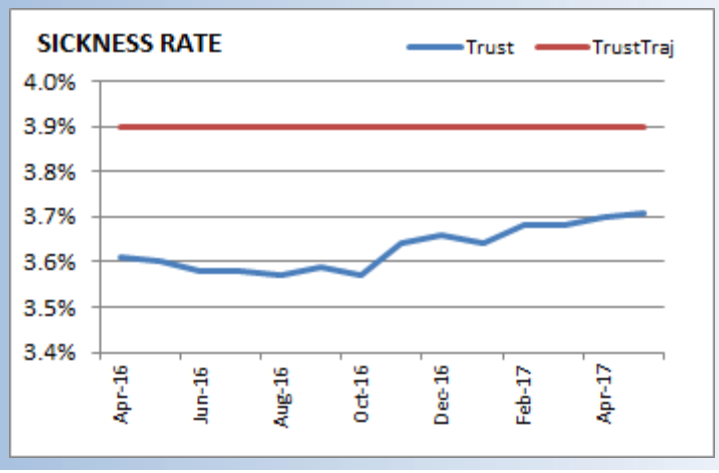
Trust level WTE position as at the end of May was 7154 .9



Sickness Absence Rates

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

Performance for May achieved the standard of less than 3.9% with performance of 3.71%



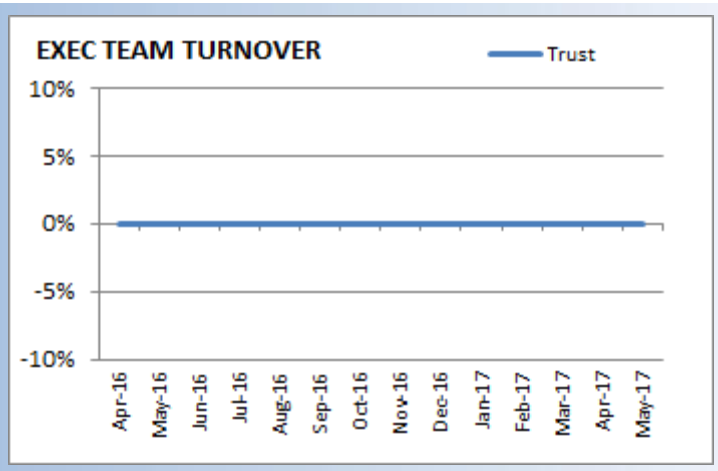
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

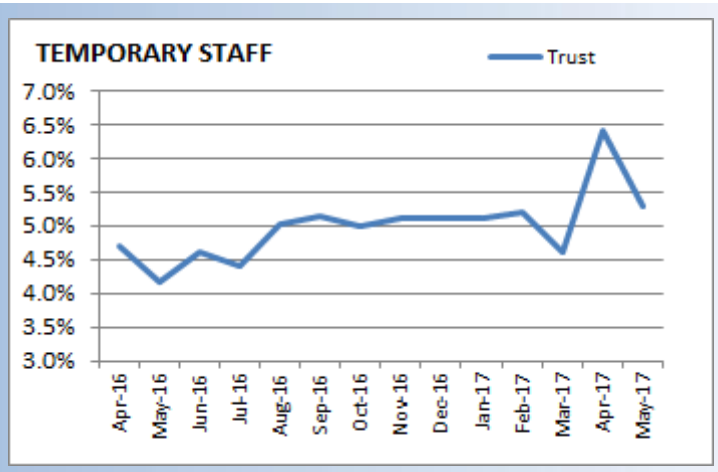


Proportion of Temporary Staff

% of the Trusts pay spend on temporary

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

May performance was 5.3%



FINANCIAL SUMMARY: 2 MONTHS TO 31ST MAY 2017

1. At the end of month 2 the Trust is reporting a deficit of £6.3m. This is £1.8m above the planned deficit of £4.5m.

2. The Trust has a CRES shortfall at month 2 of £1.57m and has released 2/12ths of its CRES reserve (£0.44m) to reduce this to a deficit of £1.1m.

3. Health Groups have further run rate issues of £0.65m of which £0.15m are non recurrent. There are a range of issues in each of the health groups. Medicine HG have pressure on the cost of implementing the 3 zone acute model (£0.2m), Family and Women's HG have pressures on medical pay relating to sickness and maternity leave (£0.2m) and Clinical Support HG have pressures on Radiology reporting (£0.1m).

4. The Trust has an income shortfall of £0.25m after pass through drugs and devices are covered.

5. General reserves of £0.25m have been released to offset the run rate and income pressures.

6. The current cash position is extremely tight and the Trust continues to manage its cash position by limiting payments to NHS suppliers and diverting cash to pay non NHS suppliers. The cash position in the plan assumed a revenue support loan would be required in Q1 to support the deficit position given that the Trust has not agreed the control total and is therefore not expecting any STF funding. Since the plan was submitted the Trust has secured agreement with its main CCG commissioners to amend the profile of the contract income payments from monthly to tenths. This action was agreed in order to improve cash management and delay the application for revenue support. The impact is an extra £5m per month which is offsetting the deficit position.

5. Agency spend to the end of May is £1.8m and is slightly below planned levels (£0.05m).

6. At month 2 the Trust is still forecasting a £14m deficit.

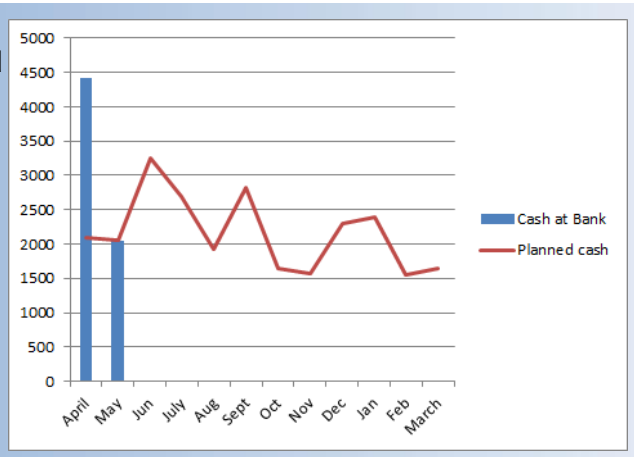
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of April was £2.047m, of which £2.030m was held in bank accounts and the rest in petty cash. There continues to be intense pressure on cash and the Trust is still unable to meet obligations to suppliers as they fall due. Our main Commissioners have agreed to pay contracts in 10ths rather than 12ths resulting in additional cash of £20m coming into the Trust during July. This will ease the immediate pressure and improve relationships with suppliers.

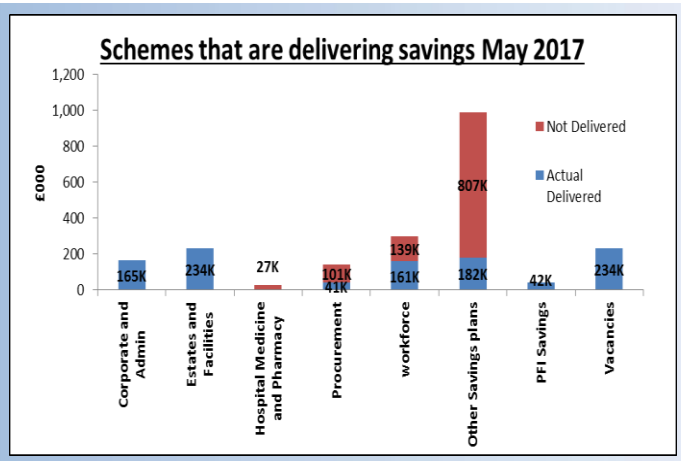


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 2 the Trust has delivered £1.1m of CRES savings against a CRES ytd plan of £2.1m (£1.0m adverse variance)

The Trust has so far identified £12.6m of savings against a plan of £15.0 (£2.4m adverse). Through working closely with Deloittes the Trust expects to identify new schemes and revise its forecast to a more favourable one in coming months.



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

Description	Aggregate Position	Trend	Variation

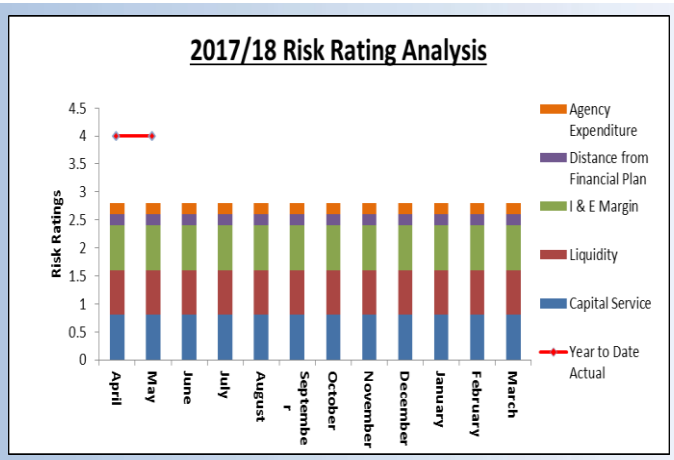
Risk Rating

Financial Sustainability Risk Rating

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

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

As at month 2 the Trust is reporting a deficit of £6.3m against a planned deficit £4.5m (£1.8m adverse) this has resulted in liquidity, Capital servicing, I&E Margin and distance from plan all being rated as a 4, resulting in an overall risk rating of 4.

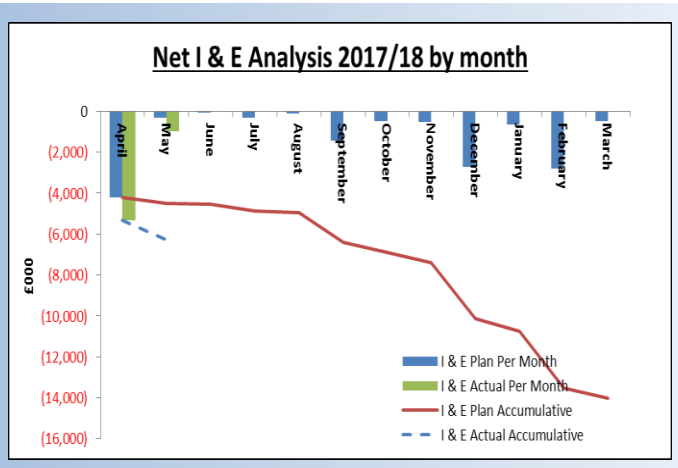


Income & Expenditure

Net income and Expenditure

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

At month 2 the Trust has delivered a deficit of £6.3m against a plan of £4.5m deficit (£1.8m adverse). The plan for 17/18 is to deliver a deficit of £14m



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON 30 MAY 2017

PRESENT:	Mr S Hall	Chair, Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs E Ryabov	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
IN ATTENDANCE:	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Assistant Trust Secretary

ACTION

1. APOLOGIES

Apologies were received from Mr S Nearney, Director of Workforce and OD.

2. MINUTES OF THE MEETING HELD ON 24 APRIL 2017

Item 7, paragraph 3 – RTT performance was at 84.6% and not 91.6% and the performance reviews were weekly and not quarterly.

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

3. ACTION TRACKING LIST

The Clinical Research outpatient review – the numbers were not material and this item would be removed from the tracker. **RT**

Performance dashboard – Mrs Ryabov presented the dashboard to the Committee

GIRFT – Mr Phillips to be invited to the Committee to discuss the Carter meetings and the outcomes. **RT**

4. MATTERS ARISING

Diagnostic capacity and demand was discussed and it was agreed to invite Mr Wood and Dr Patmore (Clinical Support Services) to a future meeting to discuss further. **RT**

Mr Hall requested an exception report for the Agency report similar to the performance exception report. Mr Hall to discuss further with Mr Nearney. **SH/SN**

4.1 – HIP TEAM UPDATE

Ms Myers presented the update and highlighted the work that had been carried out by the team in 2016/17. There would be a number of tools on the new intranet site which would include change management techniques, PDSA cycles, improvement models and capability analysis. Ms Myers advised that the project managers held gold level training standards which enabled them to train other members of staff in the quality improvement methodology.

Ms Myers advised that lessons learnt had included being clear on outcomes and measures, ownership of projects and clinical engagement. Strong leadership is key as well as aligning projects with operational issues.

Mrs Christmas asked about clinical buy in and Mrs Myers advised that this was mixed but this was mainly due to the nature of the projects as many of them were difficult hard to reach issues.

Resolved:
The Committee received the Hospital Improvement Programme annual report.

5. WORKPLAN 2017/18

The workplan was presented and a discussion took place regarding inviting health group representatives to the Committee and how this could be used in a meaningful way. Mrs Ryabov added that inviting Health Group representatives was a good idea but should be for specific reasons/items as the executive team was ultimately accountable. Mr Hall agreed and agreed that only seemingly unsolvable issues (by exception) would result in a Health Group representative attending the meeting.

Resolved:
The Committee received the workplan and agreed that Mr Hall, Mr Bond and Mrs Ryabov would discuss any emerging issues at the beginning of the month that would inform the agendas. At that point any Health Group representation would be agreed. **SH/LB/ER**

6. WINTER PLAN ASSURANCE

Mrs Ryabov updated the Committee and reported that the winter ward had now closed. Capacity had settled down and beds were being managed well. Mrs Ryabov agreed to circulate the 'what went well' paper to the committee members. The winter plan for 2017/18 would be finalised in August 2017 and presented to the Committee. **ER**

Resolved:
The Committee received the update and agreed to receive the winter plan for 2017/18 in due course. **ER**

7. PERFORMANCE REPORT

Mrs Ryabov reported that performance in A&E was consistent at 93.8% and the Trust was in the top 5 Yorkshire trusts in April 2017. She advised that work was ongoing to manage frequent attenders to the hospital and ensure appropriate care was received and in the correct setting. RTT had hit its trajectory in April 2017 and work was ongoing on front end of the waiting list.

There were 4 STP projects under the cancer brief with a number of key tasks to help improve the pathways, again concentrating on the front end.

Cancer targets were not being met and work was ongoing with the multidisciplinary teams and general managers to review management of patients. Any breaches from other Trusts/GPs were now being reallocated.
There were still issues around diagnostic capacity and prioritisation of key areas was difficult. Another MRI/CT van would be hired to carry out routine work to help clear the backlog.

Mrs Ryabov presented the performance dashboard reviewed at the weekly performance meetings which held key pieces of information

around clock starts and GP referrals. Work to reduce the patients waiting to tip into the 18 weeks was being reviewed on a weekly basis and Mrs Ryabov reported that managers had a much better understanding of the issues.

Resolved:
The Committee received the report and the RTT weekly monitoring dashboard.

8. CORPORATE FINANCE REPORT

Mr Bond reported that the Trust had a deficit of £5.3m at month 1, which was £1.1m above plan. This was due to 3 issues, £600k CRES shortfall, £200k was attributable to a junior doctor rota issue and £300k non pay pressures.

Mr Bond advised that the control total had not yet been agreed and this would not be resolved until after the election.

There was a discussion around the Health Group overspend (over and above the CRES shortfall) and the Committee members expressed concern that if this was ongoing the Trust's financial position would deteriorate further. It was agreed that Mr Hall should escalate this to the Board meeting in June 2017.

Resolved:
The Committee received the report and agreed that Mr Hall should escalate the Health Group overspend to the Board in June 2017. **SH**

8.1 – CRES REPORT

Mr Bond presented the report which showed a £0.6m shortfall at month 1. He reported that work was ongoing with the HIP and the FIP2 teams to ensure double counting did not occur.

Resolved:
The Committee received the report.

8.2 – AGENCY REPORT (FINANCE)

Mr Bond presented the report and advised that the Trust had spent £919k in month 1 against a budget of £915k. The biggest challenged was the doctor agency spend.

Mrs Christmas expressed her concern regarding workforce planning and it was agreed to discuss this further at the next meeting when Mr Nearney would be in attendance.

Resolved:
The Committee received the report and noted the key issues around controlling agency expenditure.

8.3 – WAITING LIST INITIATIVE REPORT

Mr Bond presented the report which updated the Committee regarding waiting list initiative and Spire expenditure over the last 3 years and the expected levels in 2017/18.

Mr Bond reported that the budgets had been set in line with expectation of required expenditure or would be covered by vacant post funding. A small budget had been set for usage at Spire in 2017/18.

Resolved:
The Committee received the report.

8.4 – FIP 2 UPDATE
Mr Bond presented the update and reported that the FIP 2 team had presented their report to cover the shortfall between the forcasted £14m deficit and the control total. He advised that the Executive team had worked through the numbers presented by the FIP 2 team and had identified specific areas of work.

Mr Hall asked what the next steps would be and Mr Bond advised that the recommended areas of work would be reported to the Trust Board in June 2017. A shopping list of areas would be drawn up and presented to Deloittes and then NHS Improvement would approve the projects identified.

Resolved:
The Committee received the update and noted that a Board discussion would take place in June 2017.

8.5 – LOAN REPORT
Mr Bond presented the paper which related to the Trusts deteriorating cash position and outlined the measures being put in place to manage the day-to-day activities of the Trust. Mr Bond drew attention to the potential requirement for a significant loan application in quarter 3 of this year if the SOCI deficit continued to increase and a control total (and therefore access to STF cash) was not agreed.

Resolved:
The Committee approved the approach being taken and agreed to escalate the issue to the Board in June 2017.

9. CAPITAL RESOURCE ALLOCATION COMMITTEE
Mr Bond presented the report and highlighted that the Capital Programme for 2017/18 had been signed off, the new maternity information system was in place and a bid for £4.4m of capital funds had been made to the STP.

Resolved:
The Committee received the update.

10. ITEMS DELEGATED BY THE BOARD
There were no specific items delegated by the Board.

11. ANY OTHER BUSINESS
Mr Bond had circulated a paper which detailed demand for elective and non-elective activity. He asked the Committee to consider whether the report was useful and should be a standing agenda item.

There was a discussion around ED attendances, GP referrals and commissioners helping with the capacity issues and it was agreed

that the paper should be a standing item and it should be co-written by Mr Bond and Mrs Ryabov. **LB/ER**

12. DATE AND TIME OF THE NEXT MEETING:
Monday 26 June 2017, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE SUMMARY REPORT

26 JUNE 2017

The Performance & Finance Committee met on 26 June 2017. The following points were discussed/agreed at the meeting:

1. Mr Goldstone and Dr Byass gave a presentation which highlighted the diagnostic pressures in MRI and CT. Issues raised were growing demand, recruitment issues and ageing equipment requiring replacement with no funds available. A £4m bid had been placed with NHS Improvement for a new MRI and CT scanner plus enabling works, but a contingency plan was not in place should the funding be rejected. The committee agreed to revisit the situation once the decision from NHS I is know.

2. The Committee development was discussed and Mr Evans would attend the meetings due to him driving the CRES agenda with the Health Groups. Mr Hall circulated NHS Improvement's KLOEs and asked for comments back from the Committee as this would inform the focus of the next agenda. Mrs Drury is also to attend the meeting to support the finance function.

3. Mrs Drury presented a paper which reviewed activity against the plan and the increase in demand. Work was ongoing with the Commissioners to review the drivers and management of the issues.

4. Mr Evans presented the financial plan and reported that the Trust had now signed up to a control total of £11.5m deficit. Work was ongoing with Deloitte and the Financial Improvement Plan to ensure CRES schemes were implemented and maximised. There was concern regarding the underlying run rate and overspend issues in the Health Groups. STP funding was now available and it had been agreed that this would be received in 10 monthly payments instead of 12.

5. In month 2 the Trust was reporting a deficit of £6.3m which was £1.8m above plan. This was mainly due to non identification of CRES schemes. Revised plans to take into consideration the FIP programme. To be presented at the next meeting.

6. The Trust's cash flow and the payment of suppliers was discussed. The Committee agreed to escalate the risk of non supply of goods and services due to late payments and how this could impact on patient care.

7. A&E performance was consistent at 93.9% and the Trust 5% above average in England. RTT was still improving with good results in rheumatology and dermatology.

8. Mrs Ryabov reported that a tumour leads group had been established to review cancer demand and capacity and the impact of the diagnostic delays.

9. Mr Nearney presented the Workforce element of the agenda and it was agreed that a quarterly report detailing turnover, sickness levels, recruitment and retention would be received. Agency spend was slightly below planned levels.

10. Mr Evans presented the report which highlighted the land sale at Castle Hill Hospital. The financial impact of the sale had been covered in the financial plan. The Committee approved the approach being taken.

Recommendations:
The Board is asked to note the discussion held at the Performance and Finance and to consider the following items specifically.

- Sustained improvement in ED performance
- The gap in the CRES programme and the emerging overspends at Health Group level.
- The issues relating to late payments to suppliers which could impact on patient care.

Actions:
The Board is asked to consider what further actions if any, are required to support the Trust's financial position.

Stuart Hall
June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

REVISED 2017/18 FINANCIAL PLAN

Meeting date	4 July 2017		**Reference Number**	2017 – 7 - 13		
Director	Lee Bond – Chief Financial Officer		**Author**	Steve Evans – Deputy Director of Finance		
Reason for the report	To inform the Board of the revised 2017/18 Financial Plan.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** • Board members are asked to note the changes that have been made and to support the actions being taken with regards the delivery of the plan. • Board members are also asked to recognise the level of risk inherent in the plan and to consider what additional measures, if any, they would want to see with regards the delivery of the financial plan.					
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 Ref: 7.1,7.2, 7.3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Performance & Finance Committee had received the revised Financial Plan report at its June 2017 meeting.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

REVISED 2017/18 FINANCIAL PLAN

TRUST BOARD
JUNE 2017

1. INTRODUCTION

Board members are aware that the Trust agreed a financial plan in March 2017 which shows the Trust making a deficit totalling £14m in 2017/18. As a result of this deficit, the paucity of available cash resources in the Trust Balance Sheet and the absence of STF funding, allowance was made in the plan to apply for £14m of cash support (distress funding) from the Department of Health.

Achievement of the £14m deficit requires the delivery of a £15m efficiency programme (CRES). Excluding CRES, the underlying deficit of the Trust is in the region of £29m. This figure has been validated by an external provider (Deloitte) as part of the FIP2 diagnostic programme.

The £14m deficit is £2.5m short of the control total required by NHSI. To date, the Trust has maintained that it could not safely deliver a deficit of £11.5m. The consequence of this action being that the Trust is not able to access sustainability and transformation funding on offer of £11.9m.

Over the past two months, the Trust has been working with Deloittes as part of the FIP2 programme to identify measures which may be used to bridge the gap and to develop the Trust's CRES programme such that it can be delivered with greater confidence.

2. CURRENT POSITION

As at the end of March, the Trust's CRES programme was reported as follows:

	Fully Developed	In Progress	Opportunities	Subtotal	Unidentified	Total
	£m	£m	£m	£m	£m	£m
31 March	2.5	3.3	2.6	8.4	6.6	15.0
22 June	4.4	5.9	0.7	11.0	5.0	16.0
Movement	1.9	2.6	(1.9)	2.6	-1.6	1.0

The work done with Deloittes has helped extend the CRES programme and has helped accelerate its development. The value of unidentified schemes now totals £5.0m and whilst this is clearly still a significant risk, it is much improved.

In addition, the Trust has revisited its financial governance arrangements, and it is hoped that by working further with Deloitte (Phase III) this rate of progress can be sustained and delivery of the plans maximised.

As at the end of month 02, a shortfall in CRES totalling £1.1m was reported. In addition, other cost pressures totalling £0.5m and an income shortfall of £0.2m combined to leave the Trust some £1.8m away from plan.

3. EXTERNAL REGULATION

The Trust was informed that a further revision of its financial plan could be made by close of play on 21 June 2017. Refusal to accept the control total at that point would mean that the Trust would permanently forego the opportunity to realise the 1st quarters STF funding. The value of this funding is estimated at £1.79m.

The caveat to this being that unless the Trust is able to improve its financial position in month 03 to bring it back in line with plan then it will not qualify for the STF in any event.

4. ACTIONS TAKEN

As a result of the FIP2 work and the deadlines imposed by NHSI, the following actions have been taken which enabled the Trust to submit a revised financial plan on 21 June. This plan looks to reduce the 2017/18 SOCI deficit to £11.5m (ie in line with the control total offered by NHSI).

1. Added a £1m income target to the financial plan relating to the specialist services contract (notably Cardiothoracic, Neurosurgery and Vascular Services).

2. Released a £1.5m CQUIN reserve which is no longer required.

The services included within the Specialised Services contract each have sizable waiting lists which could be addressed in order to achieve the additional income target. Detailed implementation plans have been requested from the services involved.

The release of the CQUIN reserve is low risk, however, the consequence of this action is that these monies are no longer available to support any other general cost pressures that may materialise in year.

5. ASSURANCE AND FIP2

In terms of assurance, Deloitte have revisited their forecast financial projection (as included in their Phase II report) and have concluded that a range of outcomes from £11.5m to £21.2m could reasonably be assumed in this financial year (see attached).

Delivery of the revised plan is reliant on significant delivery of CRES and tight budget management throughout the remainder of the year. Based on current intelligence and the month 02 results, this is extremely challenging but achievable.

6. CONCLUSIONS AND RECOMMENDATIONS

By increasing the Trust's overall income expectations by £1m and releasing a reserve (£1.5m) that is no longer required, the Trust is able to bridge the planning gap between the financial plan submitted in March 2017 and that required by NHSI in terms of its control total system.

Working with Deloitte as part of FIP2, the Trust has improved its grip on the CRES programme. There is still a significant gap to close and lots of work required to deliver all of the schemes within the programme, however, the Trust is better placed to deliver at this point.

As a result of timing deadlines laid out by NHSI, a revised financial plan has been submitted which meets the £11.5m control total. This action was taken following discussions between the Executive Team with the Trust Chairman and the Chair of the Audit Committee.

Board members are asked to note the changes that have been made and to support the actions being taken with regards the delivery of the plan.

Board members are also asked to recognise the level of risk inherent in the plan and to consider what additional measures, if any, they would want to see with regards the delivery of the financial plan.

Lee Bond
Chief Financial Officer

21 June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

REPORT ON PROGRESS IN DELIVERING THE TRUST'S STRATEGY 2016-2021

Meeting date	4 July 2017		**Reference Number**	2017 – 7 - 14		
Director	Jacqueline Myers – Director of Strategy and Planning		**Author**	Jacqueline Myers – Director of Strategy and Planning		
Reason for the report	The purpose of this paper is to provide an update to the Board on progress on the delivery of the long term goals set out in the Trust Strategy 2016-2021and make proposals for the refresh of the strategy and for enhancing implementation arrangements.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board is asked to: • Note the progress made in the delivery of the Strategy • Agree the proposed process for the refresh of the Strategy					
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 Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

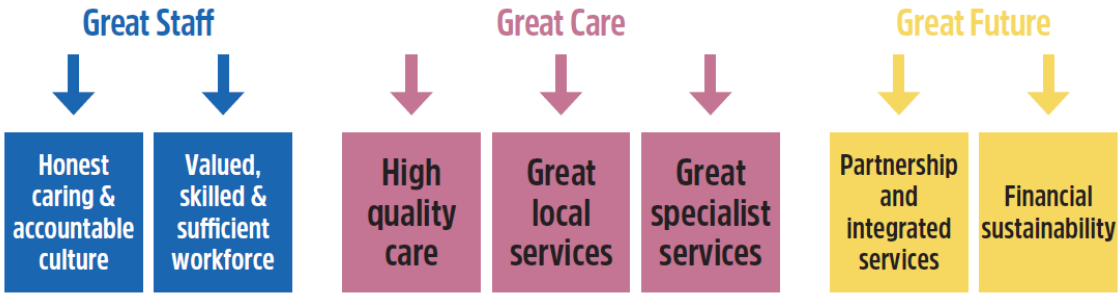
REPORT ON PROGRESS IN
DELIVERING THE TRUST'S STRATEGY 2016-2021

1. PURPOSE OF PAPER

The purpose of this paper is to provide an update to the Board on progress on the delivery of the long term goals set out in the Trust Strategy 2016-2021and make proposals for the refresh of the strategy and for enhancing implementation arrangements.

2. BACKGROUND

The Trust Strategy 2016-2021 was approved by the Board in April 2016. The Strategy sets out the Trust's approach to the achievement of our vision and does so by defining a number of long term goals, setting the scope and level of ambition for each goal over the next five years, and providing guidance on the approach or 'strategy' we plan to take in achieving those goals.



The Trust Strategy incorporates our clinical service and quality improvement strategies.

3. IMPLEMENTATION PLAN

In order to assist with the monitoring of progress in achieving the Trust's goals an Implementation Plan was developed which identified the following:

- Domain
- Five year goal
- Actions to deliver the goal
- Key performance indicators
- Timescale for delivery
- Lead responsibility
- Progress to date
- Monitoring committee
- Supporting comments.

The approach to implementation is to ensure each goal has an owner and a home within the Trust's committee structure, and then to draw together overall progress from these sources, rather than to create another bureaucracy. Updates from the leads are sought by the Head of Strategic Planning every six months. Highlights from the end of year one progress update are:

Domain	Progress to date
Honest, caring and accountable culture	• Improvement in the overall score for Staff Engagement in the national Staff Survey 2016 • 68% of media stories about the Trust were positive; this is good progress towards our goal of 75%
Valued, skilled and sufficient workforce	• Improvement in the percentage of staff recommending the Trust as a place to work (as reported in the National Staff Survey 2016) • Implementation of the Trust's People Strategy including recognition of our innovative 'Remarkable People, Extraordinary Place' recruitment campaign
High quality care	• 2016 CQC visit showed improvements in domain ratings, although not sufficiently to move to an improvement in the overall CQC rating for the organisation. • Approach to identifying avoidable and potentially avoidable deaths agreed and implemented. • Improved performance in our 'fundamentals of care' audits • Progress towards compliance with 7 Day services priority standards • Reduced numbers of patient complaints. • Agreed to progress a Trust name change to strengthen our links with the University and help attract the best staff
Great local services	• Improvement in the ED 4 hour waiting time • Delivery of the Frailty Intervention Team (FIT) model has delivered progress against our goal of reducing unnecessary admissions • Working with partners to implement the Digital Roadmap, including development of a portal for access to shared care records.
Great specialist services	• Agreement of the 5 year strategy for specialised services in our STP footprint with NHS England. • Agreement of the specialist vascular services • Development of the Major Trauma Centre and improved peer review.
Partnership and integrated services	• Closer working with Community Health Care Partners and establishment of a Collaboration Steering Group • Agreement of an Aligned Incentives Contract with Hull and East Riding CCGs • Trust took on leadership of the STP In Hospital Workstream
Financial sustainability	• Programme of Estate modernisation and rationalisation underway • Development of GS1 'Scan for Safety' Programme including inventory management in theatres and intelligent scanning of medical records in progress. • Implementation of Ricoh print management solution nearing completion and work on enhanced use of Lorenzo progressing us towards our goal to be paper free.

Overall progress is good with some aims being achieved early, there are however two areas where progress is not in line with the milestone set by the relevant lead for the end of 2016/17. These are:

- Achievement of the national cancer waiting times standards
- Achievement of the 92% referral to treatment target (although the Trust is on trajectory for its planned performance in 2017/18)

There are also a number of areas where further clarity is needed in regard to the arrangements for the achievement of the goals. These are:

- Delivery of 10,000 health prevention initiatives
- Improvements of 1 and 5 year cancer survival rates
- 50% reduction in outpatient cancellation rates.

These issues will be taken to the Executive Management Committee for resolution. This was scheduled prior to this Trust Board update but the meeting was deferred due to the CQC Inspection.

Following feedback from the recent CQC visit, the Director of Strategy and Planning will review the implementation arrangements with a view to both strengthening them and making them more visible within the organisation. The operational planning process will be augmented to require the divisions to set out their response to relevant commitments within the strategy and the communication of implementation progress will be stepped up.

4. STRATEGY REFRESH

The Trust Board should review the strategy annually with a view to either recommitting to it or refreshing it. This process has been slightly delayed to allow the new Chairman to settle in. Some discussion of the Trust's approach to its role in the wider health economy recently took place at a Board Development Workshop. There have been some developments internally and externally which are likely to influence to tone and emphasis of the Strategy. It is also understood that the Quality Committee would like to revisit elements of the quality goals and the strategies to achieve them.

The following refresh process is therefore proposed:

- All Trust Board members are asked to revisit the strategy and provide comments to the Director of Strategy and Planning by the end of July, covering the following points:
    - Are you happy to recommit to the Vision and Long Term Goals?
    - Is there anything within the Strategy you feel is no longer relevant?
    - Is there anything missing?
    - Do we need to strengthen our strategies to achieve any of the long term goals?
- This feedback will then be collated to form the basis of a further Board development session discussion.
- Engagement will take place with the Health Groups and their teams to gain their input into the strategy refresh
- A refreshed strategy will be presented to the Trust Board for approval at the early November meeting.

5. RECOMMENDATION

The Board is asked to:

- Note the progress made in the delivery of the Strategy
- Agree the proposed process for the refresh of the Strategy

Jacqueline Myers
Director of Strategy and Planning

26 June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STAFF FEEDBACK ON NEW OFFICE ACCOMMODATION

Meeting date	4 July 2017	**Reference Number**	2017 – 7 - 15
Director	Simon Nearney – Director of Workforce & OD	**Author**	Simon Nearney – Director of Workforce & OD
Reason for the report	To inform the Board of the staff feedback following relocation into the new office accommodation at Castle Hill Hospital		

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

1	**RECOMMENDATIONS** The Trust Board is requested to: • Receive and accept the report • Decide if any further actions and/or information are required.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	✓	Assurance		Delegation	

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

4	**LINKED TO:**			
	CQC Regulation(s): **N/A**			
	Assurance Framework Ref: BAF 1	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board requested an update on staff views on the new accommodation following the capital investment in the former ramp wards			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STAFF FEEDBACK ON NEW OFFICE ACCOMMODATION

1. INTRODUCTION

Following the refurbishment of the ramp wards at Castle Hill Hospital (Wards 18, 19, 21 and 22[1]) and the transfer of back office staff to these newly refurbished suites the Board requested a report to establish whether the initiative had been a positive step for staff and the Trust.

2. BACKGROUND

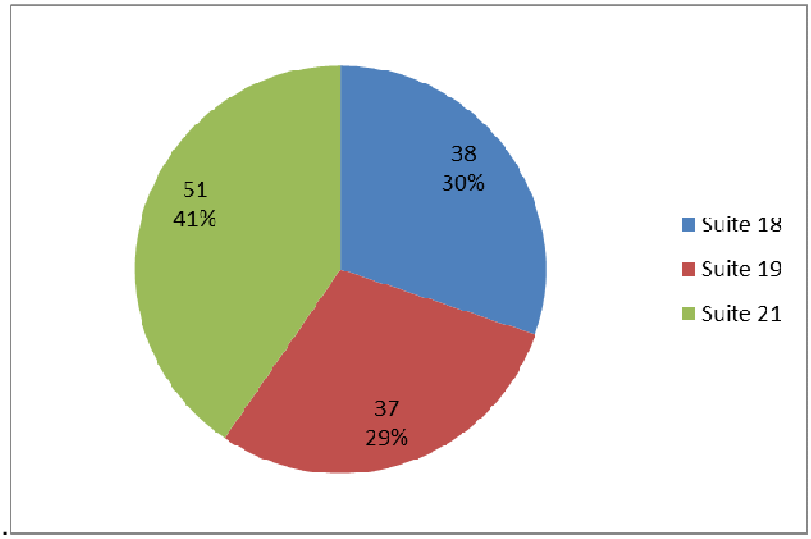
The Trust agreed in 2016 to begin work on transforming back office functions by centralising these services and converting the closed ramp wards to appropriate office accommodation. This would then allow the demolition of buildings which were no longer fit for purpose. The demolition of the Haughton Building at Hull Royal Infirmary would also facilitate the relocation of the helipad and create additional car parking for staff at HRI. Additional car parking will also be created at CHH.

3. METHODOLOGY

Survey questions were created and staff in Suites 18,19 and 21 were asked to complete the survey electronically through SurveyMonkey. The survey was open from 12th May to 2nd June 2017 (inclusive). The results were then analysed.

4. RESULTS

126 members of staff completed the survey and the table below shows the percentage of responses from each Suite. 270 staff are located in the three suites, which represents a 46.6% response rate.

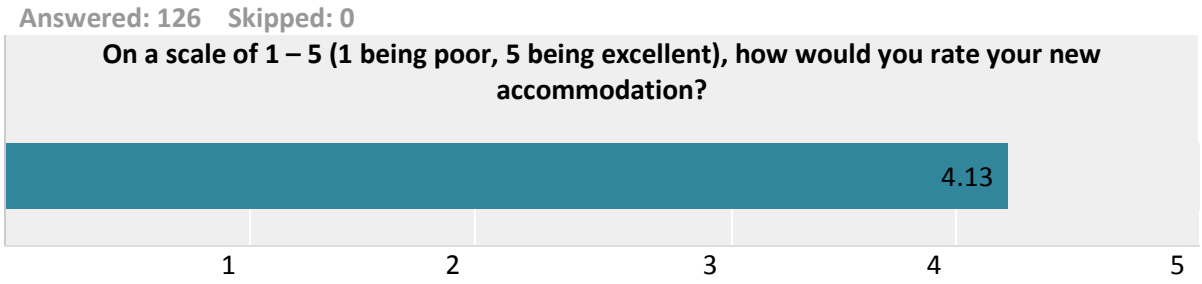


Departments occupying each suite:

Suite 18 – Finance and Estates and Development
Suite 19 – Governance, Quality and Performance
Suite 20 – HR, Payroll, Recruitment and E-Rostering

[1] The refurbishment work to create a new Education and Development facility for staff training will be completed early July, 2017. This area has not been included in the survey.

Staff were asked:



Staff were then asked:

A further breakdown of the responses, both by number of staff and percentage of responses for each question, for the above table are as follows:

Has this new environment had a

Answer Options	Poor		Fairly Poor		Good		Very Good		Excellent		Rating Average
	%	No.	%	No.	%	No.	%	No.	%	No.	
Positive impact on Communication?	2.44	3	4.88	6	26.02	32	37.4	46	29.27	36	3.86
Positive impact on Efficiency?	1.65	2	6.61	8	46.28	56	27.27	33	18.18	22	3.54
Positive impact on Productivity?	1.64	2	11.48	14	45.08	55	26.23	32	15.57	19	3.43
Positive impact on Team Working?	3.28	4	9.84	12	27.87	34	34.43	42	24.59	30	3.67
Positive impact on Staff Motivation?	0.83	1	9.92	12	44.63	54	29.75	36	14.88	18	3.48
Positive impact on your ability to contribute to improvements?	5.83	7	12.5	15	36.67	44	31.67	38	13.33	16	3.34

Staff were given the opportunity to add any further comments on the impact the new environment has had.

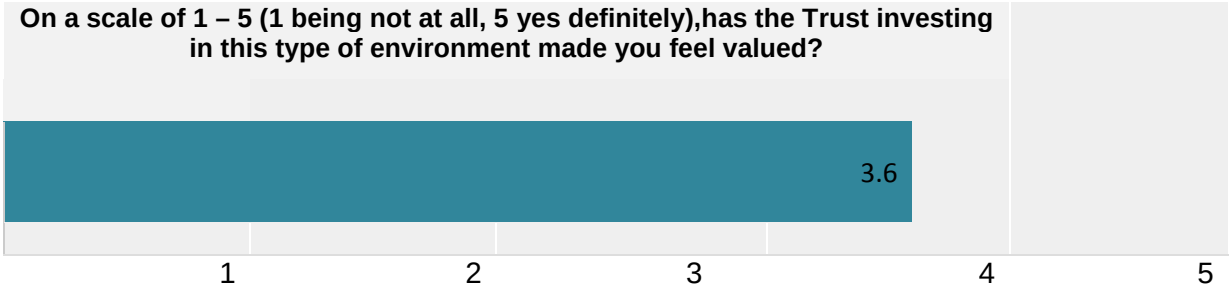
There was a mixture of comments, both positive and negative. It should also be noted that the move meant a relocation for some staff from Hull Royal Infirmary to Castle Hill and whilst the move was welcomed by some, it was not welcomed by all.

In terms of results, communication was mentioned frequently as a real positive especially amongst teams required to work together, but previously accommodated separately. Teams are more integrated both with work and socially as there are communal areas to meet and have lunch together which helps staff morale. Greater access to meeting rooms was raised as a positive, as were the new facilities generally. The culture of the department was also noted to have improved.

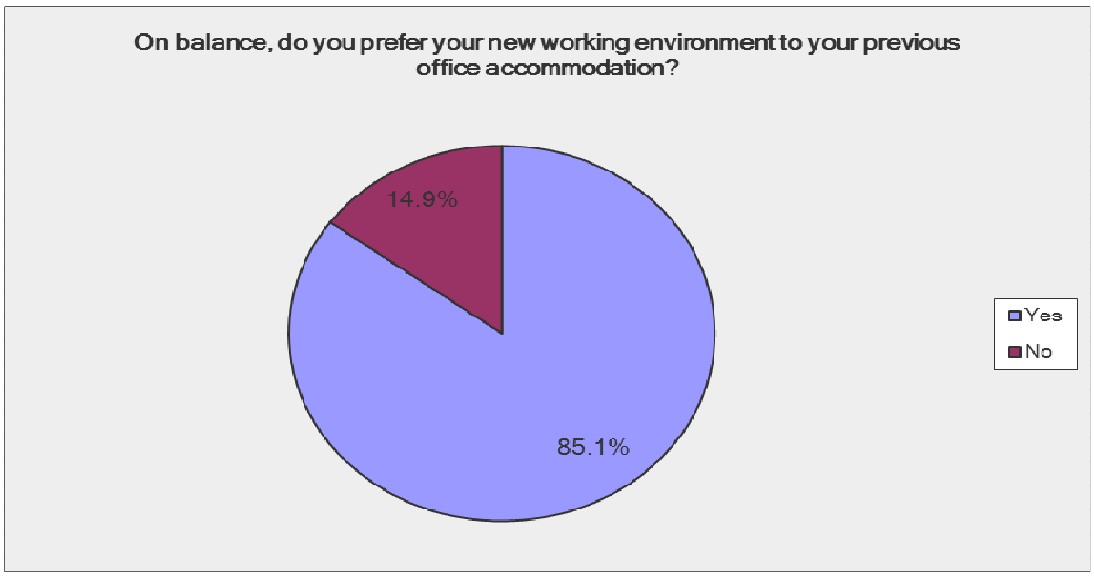
It was commented by several respondants that noise levels can be an issue in the open plan office with both telephone conversations and 'ad hoc' meetings around desks, in walkways and while leaving meeting rooms. This is being addressed with staff and a 'working etiquette' is to be agreed.

Staff were asked:

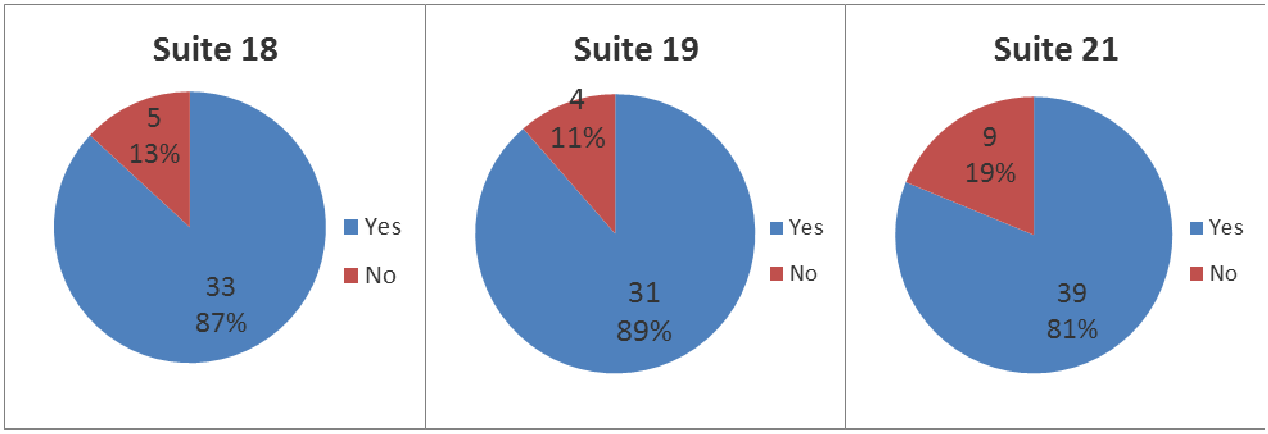
Answered: 120 Skipped: 6



Staff were asked:

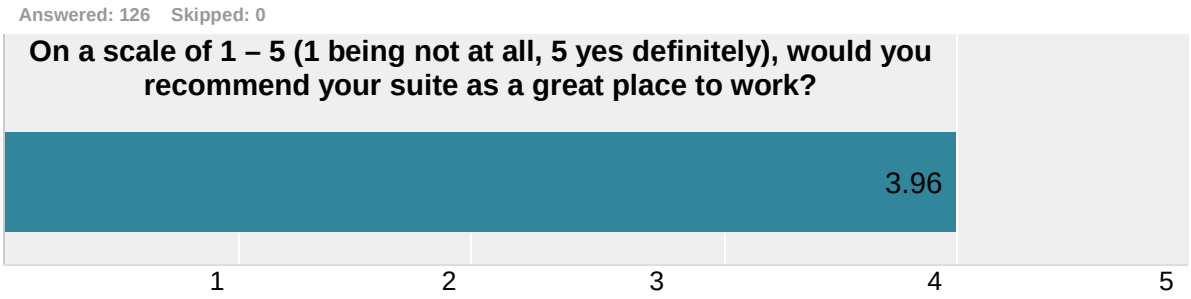


The above responses were broken down by suite as follows:

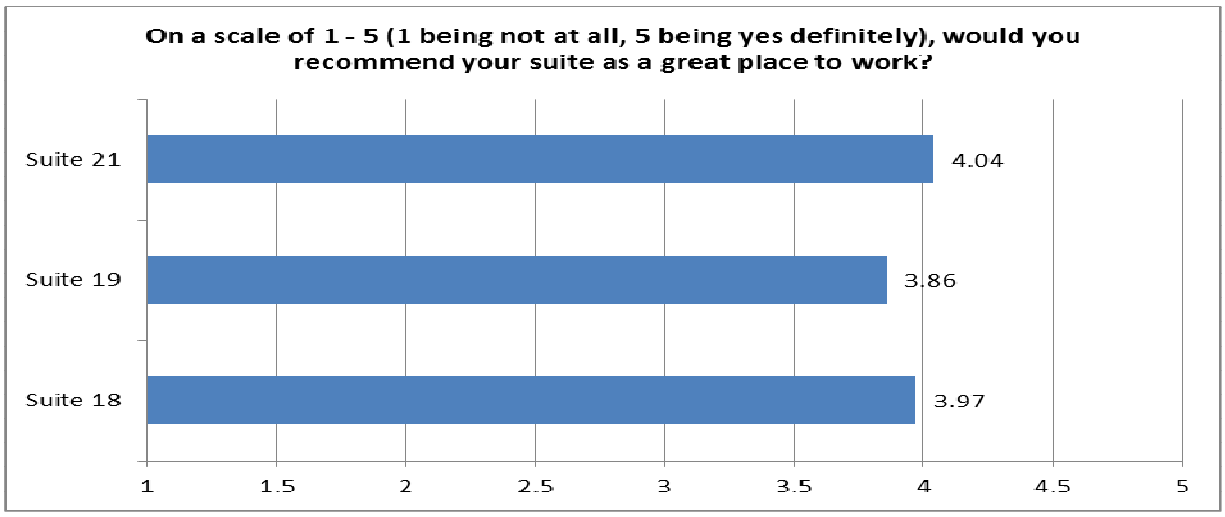


Staff who answered 'no' to this question were given the opportunity to say why. The main reason for a negative answer to this question appeared to be noise levels within an open plan environment and the inability to have confidential conversations either in person or on the telephone. Some responders did balance this by stating they liked to be able to work together better as a team.

Staff were asked:



The above question was broken down by suite as follows:



Staff were asked if there was anything else they would like to comment upon about their new environment.

There were positive comments across all suites regarding the new accommodation including that overall it was a great improvement on their previous office space. There was appreciation for the equipment and the 'fit for purpose' space provided. In general people felt that the new environment helped with communication within and between teams.

There were however some issues common across all the suites with regards to the heating and air conditioning not functioning well (along with in inability to open windows to allow fresh air to circulate). The concern regarding the noise levels in an open plan environment was mentioned again.

Finally, staff were asked:

If we built another one, what should we change? These are some of the comments:

- More consultation with staff during design stage to ensure layout and storage facilities are as required
- Blinds/anti-glare on the windows to be considered and fitted where appropriate before the move
- Bigger desk drawers (N.B these comments were made by responders from Suite 18 and 19 - Suite 21 has a different design and different larger drawer pedestals were installed)
- More work on noise reduction – sound proof meeting rooms and higher dividers between desks
- Break/dining area to be more separate due to noise and smells from food (N.B. This appears to be more of an issue in Suites 18 and 19 where the kitchen is open plan in the centre of the Suite. Suite 21's kitchen is enclosed)
- Better heating/air circulation
- Ensure snagging is completed prior to moving in
- Phone extension outside the main doors to allow visitors to contact staff member directly to admit them (N.B. applicable to Suite 18 and 19)
- Adequate car parking availability

5. CONCLUSION

The results of the survey overall show that staff believe the new suites are a good place to work and are an improvement on their previous accommodation encouraging better communication, both work related and personal.

Many of the more negative comments arise from staff now working in an open environment necessitating different practices in terms of confidential conversations and managing noise levels, and the environmental factors that impact upon heat and light. The most frequent comment regarding the new way of working was the challenge of working in an open plan environment due to noise levels, smaller working space and lack of privacy. This has been a big change for many staff and it may be helpful for them to be able to work through these issues with working groups or time outs to consider how these issues can be managed better.

In the event that the Trust plans further development projects of this size and complexity, comments from staff should be considered, particularly more consultation at the beginning of the project, better soundproofing (especially meeting rooms) and ensuring work is finished before staff move in.

Overall, the new accommodation is more beneficial for staff and the organisation. Staff say that communication, team working, and staff morale has improved due to the new office accommodation and 85% of staff say that the change has had a good/excellent impact upon productivity.

6. RECOMMENDATIONS

The Trust Board is requested to:

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

Simon Nearney
Director of Workforce and OD
June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	4 July 2017	**Reference Number**	2017 – 7 - 16
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Assistant Trust Secretary – Rebecca Thompson
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		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is requested to authorise the use of the Trust's Seal.					
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:	**Raises Equalities Issues?** N		**Legal advice taken?** N		**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** Approval of the Trust's seal is 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
2017/04	Hull and East Yorkshire Hospitals NHS Trust and East Riding of Yorkshire Council – Deed of variation for the sale of De La Pole land	16.6.17
2017/05	Hull and East Yorkshire Hospitals NHS Trust and Kingston upon Hull City Council – Contract for the sale of freehold land with vacant possession – Anlaby Road	16.6.17
2017/06	Hull and East Yorkshire Hospitals NHS Trust and Land Registry – TP1 Transfer of property – Land at Anlaby Road	16.6.17
2017/07	Hull and East Yorkshire Hospitals NHS Trust and DKP Consulting – Contract for the refurbishment and reconfiguration of the existing X-Ray rooms 1 and 2 and associated control room	16.6.17
2017/08	Hull and East Yorkshire Hospitals NHS Trust and DKP Consulting – Contract for the resurfacing of the existing fracture clinic roof to provide a new watertight finish.	16.6.17

3 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Assistant Trust Secretary
June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Meeting date	Tuesday 4 July 2017		**Reference Number**	2017 – 6 – 17		
Director	Terry Moran - Chairman		**Author**	Carla Ramsay - Director of Corporate Affairs		
Reason for the report	The purpose of this report is to present the updated Board Assurance Framework for 2017-18 for discussion					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to: • Raise any queries or concerns about the current status of any BAF risk area • Receive the positive assurance detailed from the April – June 2017 Trust Board and Committee meetings (where the Board has received these Committees' minutes) • Feed any views on gaps in controls or assurance requiring broader Board discussion in to the Board Development Programme discussion later in today's meeting					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: All	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board Assurance Framework details the key risks to achieving the organisation's goals. It is set annually Trust Board and is monitored regularly at Trust Board and Committee level for positive assurance received, as well as maintaining and oversight and requesting action on gaps on control or assurance					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

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

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

3. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

3.1 Assurance

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

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

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

3.2 Corporate Risk Register – May 2017

The BAF has been populated with corporate risks and updated in line with the Corporate Risk Register, for the flow of corporate risks up to the BAF as part of the agreed 'ward to board' risk escalation process. The most recent version of the Corporate Risk Register is that from May 2017, which was presented at the last Trust Board meeting – there are no changes to corporate risks to draw the Board's attention to at this stage.

4. RECOMMENDATIONS

The Trust Board is asked to:

- Raise any queries or concerns about the current status of any BAF risk area
- Receive the positive assurance detailed from the April – June 2017 Trust Board and Committee meetings (where the Board has received these Committees' minutes)
- Feed any views on gaps in controls or assurance requiring broader Board discussion in to the Board Development Programme discussion later in today's meeting

Carla Ramsay
Director of Corporate Affairs

June 2017

APPENDIX A

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

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement		**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan to focus on a forward-looking Board, with a defined set of accountabilities at Health Group and corporate service level, which supports achievement and positive enforcement of behaviours and organisational culture Leadership Development Programme commenced April 2017 to develop managers to become leaders able to	Clarity as to full set of accountabilities, deliverables and acceptable standards given the progress made in the last two years is still required and an understanding of cascade/ communication and acceptance of the same; this needs to be at Health Group leads and cascaded down, as well as support service leads					**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 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 **<u>Further assurance required</u>** Use of positive messages from most recent results to engender further confidence in staff engagement and staff feelings of job satisfaction

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

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

			posts		choice during and following completion of training							

GOAL 3 – HIGH, QUALITY CARE

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

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small	Clinical support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: management of medical and medical outliers on Cedar Ward F&WHG: availability of paediatric surgeons inc. emergency care F&WHG: ophthalmology service issues F&WHG: breast screening equipment and breast pathology issues	**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					4 x 2 = 8	**<u>Positive assurance</u>** Trust meeting ED 4-hour target from the start of 2017/18 and meeting RTT trajectory at start of 2017/18 **<u>Further assurance required</u>** Effectiveness of accountability framework and improved consistency of delivery Role of external agencies in supporting ED in particular (links to BAF6) – these may change during 17-18 as new service developments come on line external to the Trust and as the STP and placed-based plans look at service configurations Sufficient diagnostic capacity available now to meet demand and to receive onward investment to meet future demand alongside equipment replacement requirements and staffing issues, as well as manage in-year impact of diagnostic capacity on cancer pathways and waiting times

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

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk*: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships *What could prevent the Trust from achieving this goal?* Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP		**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					4 x 2 = 8	**<u>Positive assurance</u>** 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 **<u>Further assurance required</u>**

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		**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					4 x 2 = 8	**<u>Positive assurance</u>** **<u>Further assurance required</u>** STP NED event held – start of engagement process but few tangible outcomes at present Issue of clarity of strategy between STP, STP workstreams and place-based plans and Trust positioning within these

GOAL7 – FINANCIAL SUSTAINABILITY

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

GOAL7 – FINANCIAL SUSTAINABILITY

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

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	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						4 x 1 = 4	**Positive assurance** **Further assurance required** Need to sell land and/or explore issue with the Department of Health as to how the Trust can inject cash

APPENDIX B – CORPORATE RISK REGISTER (AS PRESENTED TO EMC ON 17 MAY 2017)

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
11/04/2016 Surgery Health Group	Registered Nurse and ODP vacancies	Condition: Surgery Health Group has significant registered nurse and ODP vacancies across wards, theatres and critical care. Cause: Difficulties in recruitment, limited availability of bank and agency staff. University course now completed annually and ODP course now 3 year duration. 6 New Registrant ODP appointed from Oct 17 cohort Current Registered Vacancies: 92.7 WTE. 24 ODP [HRI 18] CHH 4] New Agency Restrictions: 1st April 2017 may reduce the availability of Agency Staff under new contract. Consequence: This has an impact on the level of care that can be provided to deliver safe patient care. Reduced bed capacity (closed beds)limited ability to provide theatre access for elective surgery.	1) Twice daily safety brief 2) Block booking of agency staff. 3) Current staff working overtime. 4) Band 7s, Matron and Divisional Nurse Manager all working clinical shifts to support. 5) Senior Nurse to complete a workforce review by August 2016 6) Reduction in elective bed base to support acute bed base 7) Focused nurse / ODP recruitment, European recruitment 8) 30 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
31/05/2016 Surgery Health Group	Inability to deliver appropriate efficiency schemes	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2016-17. Failure to deliver key financial targets could result in withdrawal of non-recurrent support funding. Delays in authorising expenditure due to additional controls presents clinical risk.	Devolved CRES targets/accountability. Challenge through monthly divisional performance meetings. Created CRES efficiency matrix tool to enable divisions to focus on key areas of opportunity. Introduction of regular operational and efficiency meeting in 2016-17. Commencing specialty level reviews and benchmarking process. Re-aligning financial/business support in the Health Group to support delivery.
05/10/2016 Surgery Health Group	CQUIN delayed discharges risk financial risk of not achieving 250k of income	To reduce delayed discharges from Adult Critical Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow and to remove delayed discharges of 4 hours or more within daytime hours. There is a national standard that all discharges should be made within 4 hours of a clinical decision to discharge being taken within daytime hours. The service have been unable to achieve the standard in Q1 and Q2 and is not on track to deliver the planned reduction of 30% delayed discharges by Q4. This will mean that there is a high risk of reduced patient experience and high risk to income (CQUIN payment) The Hull and East Yorkshire Hospitals NHS Trust have been categorised as a Tier 2 organisation and will on average gain £240,000. This is reliant on achieving the CQUIN in Q4.	An action plan has been devised to tackle any issues throughout Q3 and to ensure full compliance in Q4. Please see attached document. Quarterly reports are provided to health group board regarding the position.

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
24/08/2016 Pharmacy	Risk to the continuity of drug supplies	There is a risk that pharmacy will be unable to continue supply some medicines to patients. This is due to some manufacturers not fulfilling our orders due to non payment of invoices. The consequence is we may run out of certain medicines causing concerns for our patients' safety and their effective treatment	We are currently negotiating with manufacturers to try and resolve the issues. We are trying to obtain supplies from alternative manufacturers.
11/01/2017 Oncology	Inability to fill junior doctors rota in the oncology wards at Queen's Centre, CHH	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 post 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
22/01/2014 Radiology	Patients may experience delays in treatment due to insufficient capacity to accommodate the increase in demand	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)
10/12/2016 Blood Transfusion	Reduction in trained staff in the Blood Transfusion Laboratories (Compliance Risk).	There have been a number of vacancies in the Blood Transfusion Laboratories which are being currently addressed. Though this is required to maintain future service delivery there is the short to medium term problem that the one to one training which is required to meet compliance with the Blood Safety and Quality Regulations means that both trainee and trainer are not available for service delivery. This is having a knock on effect on the maintenance of the quality system as more senior staff resources are being diverted to service delivery and training.	1. Service delivery is being maintained by distribution of trained senior staff into key areas. The situation is improving as staff training continues and new staff become competent at more tasks.
20-Nov-2013 Ophthalmology	Patients treatment may be delayed resulting in potential loss of eyesight due to lack of capacity (chronic eye disease service)	The risk is Ophthalmology is currently experiencing a significant delay in meeting outpatient appointments, particularly in relation to the management of chronic disease pathways including glaucoma and medical retina disease. The cause is insufficient capacity. The consequence is patients are not been reviewed in a timely fashion which may have adverse implications for their vision.	Review the position on a weekly basis with the consultant team and re-deploy capacity were possible. Urgent self referrals/GP referrals seen as a priority. Newly introduced glaucoma virtual review sessions.
08-Sep-2016 Breast Screening	Equipment Issues Within Breast Screening Service	The risk is that the equipment is unreliable and breakdowns causing excessive down time and has resulted in 1500 ladies needing to be rebooked. This, if left, will directly impact on the 36 month round length, causing breaches.	Maintenance contracts, staff awareness, extra clinics being booked.

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
18-Jan-2017 Breast Surgery	Shortage of Breast Pathologist	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
16-Nov-2016 Gynaecology	Cedar Ward - Patients out with their own Specialty	The risk is the inability to provide safe and effective care to patients on Cedar Ward (Ward 30) within the Women's and Children's Hospital. The cause of the risk is the use of extra capacity for medical and surgical patients out with their own Specialty. The consequence of the risk is staffing levels are unable to provide quality care to Gynaecology inpatients and day cases. Loss of privacy and dignity for women utilising the day case area with bedded inpatients in there. The use of triage nurse from Friday night to Monday morning limiting the availability of this nurse for the Gynaecology inpatients.	Monitor on a daily basis and report to patient placement meetings to ensure patient safety is not compromised and that patient's are in the right place at the right time.
01-Apr-2015 Acute Paediatric Medicine	Inability to access dietetic reviews for Paediatric patients	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
29-Apr-2016 Neonatal Services	Shortfall in Neonatal staffing	Condition - acute staffing shortfall and increased proportion of inexperienced staff over the summer period of 2016 Cause - Combination of retirement of experienced staff, maternity leave and the national shortage of suitably qualified nurses Consequence - potential inability to staff the full 26 cots on the neonatal unit leading to increase in in-utero transfers	The children's service have looked to mitigate by: - a) Rolling recruitment program b) Secondment of nurses from paediatric wards to NICU over summer period c) Suspension of all non-essential training d) ANPs, Neonatal Outreach and other staff undertaking additional shifts.
16-Dec-2014 Ophthalmology	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. This capacity risk has increased recently as a result of the time to treatment for patients requiring injections increasing to 10 weeks, rather than the recommended 48 hours. Additional causes to this risk are: 1. The significant expansion in the numbers of retinal diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service	On a weekly basis the service meet to discuss capacity and plans are made to create additional capacity where needed. The service are currently trying to recruit to a number of medical staffing posts. The posts are currently out to advert. A nurse practitioner was recently appointed to provide support to the nurse injection service.

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
		The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely effect their vision.	Injection service has begun at CHH (November 2015).
19-Aug-2016 Paediatric Surgery	Lack of Anaesthetic cover for Under 2's out of hours	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.
05/08/2015 Corporate Functions Information Technology	There is a risk that the Trust phone system cannot be repaired resulting in a loss of communications and fire & CPR alerts	Condition: Potential total loss of telephone system Cause: The Trust has an old telephone system which has been progressively upgraded over the years, but which is fundamentally based on traditional analogue technology. All such systems will no longer be supported by suppliers from April 2017. Moreover, spare parts are increasingly difficult to source. The Trust has embarked on a re-procurement of the telephone system alongside the data network replacement. This will see the transition to a fully digital data and voice service in due course. Work has commenced to replace the telecommunications network. Consequences: There is a risk that, if there was a total failure of major component in the telephone system, the phone service would be disrupted for a long time. This would potentially affect both internal and externally facing services. There is a risk that, if there was a total failure of major component post April 2017 there will be no technical support available and/or no spare parts. A catastrophic event of this nature would carry a serious risk of a total and permanent failure of telephone service across HEY.	Internet Protocol Telephony (IPT) systems will be upgraded as a priority. A single IPT telephone will be deployed to all key departments in order to improve resilience. The Trust fall back telephone system (red phones) is available in key locations. Exploring means of obtaining parts for the old system.
29/03/2017 Corporate Functions Information Technology	Resilience of critical IT infrastructure	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
29/03/2017 Corporate Functions Estates, Facilities and Development	Lack of assurance on Enhanced DBS checks	significant risk was identified as the lack of assurance available from our outsourced business partner who provides security services concerning the security clearance status (enhanced DBS) of their operatives. This is a significant issue as these operatives are routinely in proximity to vulnerable and potentially “at risk” patients. As such it is important for the Trust to be assured that the appropriate clearances have been	This issue is being pursued by Director of Estates, Facilities and Development in conjunction with the Chief Nurse. Assurance being sought from third-party provider on an urgent basis. EMC also supportive of new model of support to vulnerable patients where additional security staff are currently deployed – new approach and team

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
		made for these staff.	being implemented in Spring 2017
18/04/2017 Corporate risk Quality Governance and Assurance	Consent	There is a lack of robust systems for the updating, management and monitoring of consent forms within the Trust.	A Task and Finish Group has been set up to review consent, and to also work towards a Trust-wide solution of managing consent through Lorenzo
18/04/2017 Corporate risk Quality Governance and Assurance	Patient Safety Alert – Restricted use of open systems for injectable medication	The Trust cannot be assured it is compliant with this PSA, which needs to have actions completed by June 2017.	Meetings are being arranged with Governance, Pharmacy and HG staff to work on solutions towards compliance. Monitored at Operational Quality Committee
18/04/2017 Corporate Functions Planning	Emergency Preparedness	Whilst HEY NHST has undertaken Table Top exercises during 2016 (June, September and October) and participated in other Live exercises (Leeds Teaching Hospitals, July 2016 and Humberside Airport, December 2016), a Trust focused exercise last took place in 2007. This was highlighted to NHS E during the 2016/17 Core Standards annual assurance exercise	Amulti-agency Live Exercise is now planned for June 2017. A Project Group has been established which includes key Trust staff plus all emergency service partners and is co-ordinating the planning of the exercise. The exercise will test the Trusts response to a major contamination exercise and will involve 60 casualty volunteers. This is a medium risk for the organisation as participation in other live exercises and table top exercises minimises the risk. The risk can be removed once the June exercise has taken place.
Medicine Health Group	ED – potential situation for crowding (linked to volume of people in department)	Crowding will occur in ED due to peaks in demand, insufficient staff and delays in other services, increasing risk of mortality	Action plan has been achieved at speciality level. Controls are in place and risk being currently managed at Health Group level
Medicine Health Group	Insufficient nursing staff	Patient care/experience may be compromised due to the inability to recruit and retain sufficient nursing staff across the Medicine Health Group	Recruitment plan in place, awaiting start dates for newly qualified staff.
Medicine Health Group	DME Consultant vacancies	There is a risk that patients do not receive a timely senior review due to vacancies in DME Consultants posts	Recruitment procedures being followed. Long term locums are filling vacancies

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD DEVELOPMENT PROGRAMME 2017-18

Meeting date	Tuesday 4 July 2017	**Reference Number**	2017 – 6 – 18
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 a draft Board Development Programme for 2017-18 for discussion and agreement		

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

1	**RECOMMENDATIONS** The Trust Board is asked to discuss the draft Board Development Programme as attached, and to amend (as required) and agree the Programme					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: BAF 1	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board Development Programme sets out the key areas for strategic discussion, further assurance and the development of the Board as a team. It is set annually and regularly reviewed to ensure it meets the Board's needs.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD DEVELOPMENT PROGRAMME 2017-18

1. PURPOSE OF THIS REPORT

The purpose of this report is to present a draft Board Development Programme for 2017-18 for review and agreement.

2. BACKGROUND

It is good practice for the Board to have a development plan in place. This provides the opportunity for the Board to:

- Have more detailed strategic discussions that would benefit from set-aside time for the ability to interrogate issues in more detail
- Have set-aside time to debate key gaps in assurance and how these feed in to the Trust's future plans
- Further develop its team working as a unitary board

.

Any decision-making required as a follow-up from Board Development discussions would flow through to Trust Board meetings through the Board Reporting Framework.

3. BOARD DEVELOPMENT PROGRAMME (BAF) 2017-18

3.1 Framework

As noted in Trust Board meetings this financial year, the Chairman and the Chief Executive have requested that the Board Development Programme in 2017/18 is an opportunity to hold strategic discussions on key issues on the Board Assurance Framework (BAF) for this year, as the BAF captures the key risks to the Trust achieving its strategic objectives during this year.

3.2 Draft Programme

The Board Development Programme has been based on the 7 BAF areas (9 BAF issues in total) and is attached to the paper.

Page 1 is the draft Programme with suggested topics for each scheduled Board Development session. This is a draft programme at present – Board members are invited to comment on the draft and asked to agree the programme, or any amendments to it, should the Board feel that other/different issues should take priority in the programme. The Board is also asked if it wishes to consider any additional Board Development Programme dates for the year.

Page 2 is for ease of reference – these are the BAF issues for 2017/18.

Page 3 notes where BAF-related issues are routinely discussed at the Board and Board Committees – this is to provide guidance as to what issues are subject to regular discussion, to help the Board to determine which topics would benefit from more detailed discussion at the Board Development sessions.

4. RECOMMENDATIONS

The Trust Board is asked to discuss the draft Board Development Programme as attached, and to amend (as required) and agree the Programme.

Carla Ramsay
Director of Corporate Affairs

June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST BOARD DEVELOPMENT PROGRAMME 2017-18

Board Development Dates 2017-18	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					Strategic discussion - role of Trust in local health economy		
04 July 2017		Trust Board - updated Insights profile	Trust approach to Quality Improvement				
08 August 2017					Discussion on tertiary patient flows and specialised service strategy	Discussion on STP and Trust role/positioning	
10 October 2017				Trust position on diagnostic capacity - short-term impact and long-term issues			Financial plan and delivery 2017-18 AND financial planning 2018-19
December 2017 (date TBC)			Trust approach to Mortality and detailed understanding of new mortality reviews, linked with CQC requirements				
February 2018 (date TBC)		Staffing - short-term and long-term issues with specific focus on medical staffing					

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	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

Regular reporting and developments at Board and Committee level

P&F Committee - Workforce section from June 2017 - to start quarterly report on People Strategy delivery from July 2017	Monthly Board report on nursing and midwifery staffing P&F Committee - Workforce section from June 2017 - review of monthly Integrated Performance Report workforce KPIs and use of agency	Quality Committee - Need to develop QIP discussions on accountability and assurance, and moving closer to 'good'	P&F Committee - monthly exception reporting on waiting times, diagnostic capacity and demand; new monthly report on Demand introduced from May 17			Detailed monthly P&F Committee discussion on financial position, including detailed CRES position and position against budget; financial position reported monthly to Trust Board P&F - monthly Finance report includes cash, cash position and cash management