HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 6 JUNE 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS

Item	Paper	Lead
1. Apologies	verbal	Chair
2. Declaration of interests	verbal	Chair
2.1 Changes to Directors' interests since the last meeting		
2.2 To consider any conflicts of interest arising from this agenda		
3. Minutes of the Meeting of the 2 May 2017	attached	Chair
3.1 – Extra Ordinary Board Minutes 25 May 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

Item	Paper	Lead
7. Patient Story	verbal	Chief Medical Officer
8. Quality Report	attached	Chief Medical Officer
9. Nursing and Midwifery Staffing Report	attached	Deputy Chief Nurse
10. Quality Accounts	attached	Chief Medical Officer
11. Quality Improvement Plan	attached	Chief Medical Officer
12. Quality Committee draft minutes and verbal update 24.04.17, 30.05.17	attached	Quality Chair

PERFORMANCE

Item	Paper	Lead
13. Performance Report	attached	Executive Team
14. Performance & Finance draft minutes and summary report 24.04.17, 30.05.17	attached	Performance & Finance Chair

STRATEGY & DEVELOPMENT

Item	Paper	Lead
15. Financial Improvement Programme (FIP2)	verbal	Chief Financial Officer
16. Paperless Communications with Patients	attached	Chief Financial Officer
Additional paper A – Change of Organisational name	attached	Director of Corporate Affairs

ASSURANCE & GOVERNANCE

Item	Paper	Lead
17. Board Assurance Framework 2017/18	attached	Director of Corporate Affairs

18. Extra Ordinary Audit Committee 25.05.17 attached Audit Chair

19. Charitable Funds Committee 31.05.17 verbal Charitable Funds Chair

20. Standing Orders attached Director of Corporate Affairs

21. Any Other Business

22. Questions from members of the public

23. **Date & Time of the next meeting:**
Tuesday 4th July 2017, 2 – 5pm the Boardroom, Hull Royal Infirmary

Attendance 2017/18

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

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 2 MAY 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

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

NO. ITEM **ACTION**

1. APOLOGIES
There were no apologies received.

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 OF THE 4 APRIL 2017
The following changes were made to the minutes:
Item 3 – Declarations of Interest – Mid Yorkshire Hospitals Trust is not a Foundation Trust.
Item 3 – Declarations of Interest – To amend "help children with palliative care" to read "support children with life limiting or life-threatening conditions.".
Item 3 - Minutes of the meeting – Item 16.4 – Audit 7.02.17 – Mr Bond advised that the Trust was viable from an accounts preparation perspective.
Item 8 – Quality Report – paragraph 8 – Mr Bond agreed that the service had improved and higher levels of best practice tariff was now being received.
Item 11 – Performance Report – Paragraph 4 – Mr Bond reported that due to the significant increase in demand for unplanned care all fines that had been appealed had been upheld.

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

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4. MATTERS ARISING

4.1 - ACTION TRACKER

The action tracker was reviewed by the Board.

4.2 - ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no matters arising.

4.3 - BOARD REPORTING FRAMEWORK

Ms Ramsay presented the Board cycle of business which gave a forward view of areas of work and reports to be received. She advised that the Board should review this at each meeting for a forward view of its agenda to ensure that relevant areas of business are coming to Board meetings.

Resolved:

The Board approved the Board Reporting Framework.

5. CHAIR OPENING REMARKS

Mr Moran spoke about his morning spent with ambulance handovers in the Emergency Department and had witnessed first-hand the work being done to make improvements and took confidence with the processes in place.

Mr Moran also reported that he had attended a number of Board Committees in April 2017 and thanked the chairs of the committees for their cooperation.

The agenda was taken out of order at this point.

19. GUARDIAN OF SAFE WORKING REPORT

Mr Moran asked for this item to be brought forward from later in the agenda so that Miss Cattermole could return to duties. Mr Phillips presented the report and highlighted that staffing levels, gaps and vacancies relating to the junior doctors at the Trust. The current rota gap was 15.4% which equated to 18 junior doctors. Miss Cattermole advised that the Trust had filled 51% of gaps from the deanery and locums. She reported that as the data collection improves, the information presented would develop. Mr Phillips also stated that recruitment campaigns were in place at local, national and international levels.

Resolved:

The Board received the report and:

- noted the findings of this report, which should be regarded as a baseline for future reports
- supported the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.

6. CHIEF EXECUTIVE'S BRIEFING

Mr Long presented the report and highlighted the addition of the list of staff who had been nominated for 'Moments of Magic' for going above and beyond in their jobs. Mr Snowden wanted the good practice to be recognised and shared across the Trust.

Mr Long also reported that Barrett had told the Trust that the pace of

cultural improvements made were twice as good as expected within a two-year timeframe and this was in line with recent staff survey results and the CQC report.

Mr Long advised that the CQC would be visiting all Trusts annually as part of the new inspection regime on the well led domain, and the organisation would be a pilot site for the new well led domain inspection.

7. PATIENT STORY

Mr Phillips gave four accounts, two gave examples of poor communication and two gave examples of excellent care and compassion with patients.

There was a discussion around how the Trust communicated with patients and whether more text messaging should be introduced. Ms Myers advised that as part of the Information Technology Strategy the Digital Road Map was being reviewed not only in the hospital but across the health economy.

Resolved:

The Board received the patient stories and agreed to receive an update regarding the strategy relating to digital communications. **LB**

8. QUALITY REPORT

Mr Wright presented the report and highlighted the serious incident section for the Board's attention. The number of Health Care Acquired Infections reported for 2016/17 were under the upper thresholds with the exception of MRSA with one attributed case against a zero-tolerance threshold. The Trust had been praised by Commissioners on its management of infection.

Mr Wright reported that in March 2017 the level of complaints had increased and it was thought that this was due to improvements in accessibility following the launch of the new web page enabling people to complain on line. This would be monitored going forward. The report now contained the number of complaints compared to the number of patient episodes. The 40 day response rate for completing investigations would be reviewed at the monthly Health Group performance meetings as performance was poor.

Mr Wright also reported that the friends and family test results were very positive, work was ongoing with the young volunteers and the Emergency Department Friends and Family Test was showing improved response rates after text messaging was introduced.

There was a discussion around how the Trust dealt with learning from serious incidents and the mechanisms for testing that good practice was embedded. It was agreed that this would be an agenda item on a Board Development session. **KP/MW**

The Quality Improvement Plan was discussed and Prof. Sheldon reported that although milestones had been completed the actions were not reflecting the outcomes required or being aimed for in some areas. This would be scrutinised further at the Quality Committee. **KP**

Ms Ramsay added a point of clarity regarding the MRSA figures being 2 in the performance report and 1 in the quality report. She advised that this

was due to one case being reattributed elsewhere in the health system, as noted in the quality report, but that the performance report was accurate as this notes MRSA cases at the point that they are clinically reported, rather than where the final attribution of a case might be.

Resolved:
The Board received the report and:

- Agreed to review learning lessons at a Board Development session **KP/MW**
- Agreed that the Quality Committee should review the QIP milestones and outcomes **KP**

9. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and highlighted that fill rates were still positive but that there had been a dip at the end of March which was thought to be around annual leave. E-Rostering had now gone live and this would allow real time analysis of fill rates. The twice daily safety briefs were taking place to ensure wards were safely staffed. Mr Wright advised that recruitment campaigns were ongoing.

Resolved:
The Board received the report.

10. FUNDAMENTAL STANDARDS

Mr Wright updated the Board regarding the fundamental standard reviews. He reported that good improvements had been made and all results were publically displayed and invited board colleagues to discuss and question ward staff about their results when visiting ward areas. Mr Wright reported that Mrs Ledger, Deputy Chief Nurse, met with ward sisters on a regular basis to discuss their results and ensure staff had accountability. Mrs Ledger added that the ward sisters were clear on what was expected and the areas that needed to be addressed.

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

11. DRAFT QUALITY ACCOUNTS

Mr Phillips gave a verbal update regarding the current position of the draft Quality Accounts. He reported that they had been received by the Quality Committee for comments and would be presented to the Trust stakeholders for their comments shortly and in particular, their views on the Trust's 2017-18 priorities. The Quality Accounts would be approved at the Trust Board in June 2017.

Resolved:
The Board received the update regarding the Draft Quality Accounts.

12. PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted diagnostic performance which in March 2017 had been 3.59% against a 1% standard. The main issues was around cardiac CT scans. Meetings were being held with the team to discuss a plan to reduce the backlog and achieve the trajectory 2.1% set for April 2017.

Referral to treatment times performance was 84.6% in March 2017 with the key challenges being seen in the front end of patient pathways.

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Rheumatology, Ophthalmology, Dermatology and Cardiology were being reviewed weekly.

There had been 5 x 52 week wait breaches in March: one was due to an admin error, three due to ITU capacity in cardiothoracic services and one due to lack of service capacity.

A&E performance was 94.6% in March 2017 and was being sustained. Mrs Walker congratulated all involved and asked what the key imperatives were to the sustained performance. Mrs Ryabov reported that more consistent consultants cover had made a significant difference, better discharges and the work of the frailty intervention team.

Two cancer standards had not been achieved in month, namely the 31 day target for subsequent treatment and the 62 day screening target. All patients had now been treated and breaches reallocated were necessary.

A discussion took place regarding the diagnostic issues and Ms Myers advised that the strategy team were undertaking a review to assess demand and capacity over the next 3 years and would have detailed analysis to bring back to a future meeting of the Board. Mr Gore expressed his concern regarding the costs of running old kit and the capital constraints on replacements. Mrs Ryabov added that the diagnostic capacity would be fundamental to achievement of the ED and RTT trajectories for 2017/18.

JM

Mr Moran noted the continued progress in ED and expressed thanks on behalf of the Board.

Mr Bond reported that the Trust has successfully achieved each of its statutory financial duties at the year end.

The Trust had recorded a break-even position on its SOCI which attracted just over £1m of additional STF monies from the centre that would enable the Trust to record a £1.1m surplus at 31 March 2017. Mr Bond added that although the Trust delivered its control total, the Health Groups were £14.7m overspent at the year end.

The Trust has achieved 78% of its 2016/17 CRES plan. The Trust had only delivered its SOCI plan due to receiving additional education income, reductions in PDC, savings on depreciation and releasing reserves. Agency spend had totalled £13.1m for the year which was £3.6m above plan. All of these factors will make 2017/18 a more demanding year than 2016/17.

The Trust CRES target for 2017/18 is £15m. The Financial Improvement Programme team (FIP2) were onsite to review efficiency opportunities.

Mrs Christmas expressed her concern that the implementation of the savings being potentially identified by the FIP2 team would not have a full year effect and was concerned that the Trust would struggle to meet its financial targets.

Resolved:
The Board received the performance report and agreed to receive detailed

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analysis relating to a forward look at diagnostic demand and capacity in due course. **JM**

13. FINANCIAL PLAN

Mr Bond advised that there was no further update to be provided.

14. BOARD ASSURANCE FRAMEWORK

14.1 – BOARD ASSURANCE FRAMEWORK YEAR-END 2016/17

Ms Ramsay presented the report and asked the Board to agree the year end position. The Annual Governance Statement being prepared for the Annual report reflected the residual level of risk noted in this report. Ms Ramsay recommended that 4 risks had improved ratings and four risks remain unchanged at year end 2016/17.

Resolved:

The Board approved the Board Assurance Framework 2016/17 year end position

14.2 – DRAFT BOARD ASSURANCE FRAMEWORK 2017/18

Ms Ramsay presented the new Board Assurance Framework for 2017/18. Ms Ramsay had presented the draft BAF to all of the Board Committees that met during April 2017, the Executive Management Committee and had spoken with Chiefs individually. She reported that the BAF highlighted the specific risks that would result in the Trust not achieving its strategic goals.

The Board discussed national media coverage and the impact on staff and patients, the issues around diagnostic capacity, the leadership programme, the capital programme including backlog maintenance and engagement of medical staff.

Resolved:

The Board received the draft BAF 2017/18 and approved it, pending inclusion of the additional points discussed (above).

15. RISK POLICY

Mr Phillips presented the policy and advised that it had not changed significantly but that more clarity around incident reporting had been added. Mr Snowden asked about the process after a risk had been identified. Mr Phillips reported that the Health Groups had monthly governance meetings where the risk registers were discussed and any new risks raised. Risk was also discussed at the Executive Management Board. Mr Gore asked that the policy include the overarching role of the Audit Committee.

Resolved:

The Board received the policy and subject to adding in the overarching role of the Audit Committee it was approved.

16. DRAFT ANNUAL REPORT

Ms Ramsay gave a verbal update and advised that the final version would be approved at the Extra Ordinary Board meeting 25 May 2017. The draft Annual Governance Statement and Annual Report had been presented to the Audit Committee in April 2017 for comment. The main element still to complete is the remuneration section, which is drafted and being checked

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by the Finance Team before being included. The External Auditors now had a copy of the draft report to check consistency of the content and the Board would receive a copy shortly for final comment.

Resolved:
The Board received the update.

17. MINUTES AND SUMMARY REPORTS FROM BOARD STANDING COMMITTEES

17.1 – PERFORMANCE & FINANCE 27.03.17, 24.04.17
The Board received the minutes from the meeting held 27.03.17 and summary report following the meeting held 24.04.17. Mr Hall highlighted concerns regarding the Health Group cost base, RTT and diagnostic issues and the lack of data consistency with Yorkshire Ambulance Service. All the above items would be scrutinised further at the Committee.

17.2 – QUALITY 27.03.17, 24.04.17
The Board received the Quality minutes from the meeting held 27.03.17 and summary report following the meeting held 24.04.17.

17.3 – AUDIT 27.04.17
Mr Gore reported that due to changes nationally the organisation would no longer receive a letter of assurance relating to the Trust's 'Going Concern' status. Mr Bond reassured the Board that the Trust had sufficient income streams to support the cost base and on this basis, the Audit Committee had confirmed preparing the accounts on a 'going concern' basis.

18. WELL LED SELF-ASSESMENT FRAMEWORK
Mr Wright advised that the Care Quality Commission were now inspecting all Trusts annually regarding the well led domain and one other core service. The Trust had been asked if it wanted to be a pilot site for the new well-led inspection regime in June 2017. Mr Wright reported that he would update the Board at the next meeting.

Resolved:
The Board received the update.

20. STANDING ORDERS
Ms Ramsay presented the report to the Board, which set out the use of the Trust seal.

Resolved:
The Board received the report and approved the use of the seal.

21. ANY OTHER BUSINESS
Mr Phillips raised electronic board packs and this would be reviewed alongside Board and Committee timings/frequency at a future Board Development Day. **CR**

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

23. DATE AND TIME OF THE NEXT MEETING
Tuesday 6 June 2017, 2pm – 5pm, The Boardroom, Hull Royal Infirmary

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 25 MAY 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr T Moran CB	Chairman
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr K Phillips	Chief Medical Officer
	Mr A Snowden	Vice Chair/Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Prof. T Sheldon	Non-Executive Director
IN ATTENDANCE	Ms J Myers	Director of Strategy & Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

NO. ITEM **ACTION**

1. APOLOGIES

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

2. ANNUAL GOVERNANCE REPORT

Mr Gore reported that the Auditors (KPMG) had advised that the Accounts were a fair and true view and there were no major areas of concern. He also highlighted the £2.6m additional funding that had been received unexpectedly from NHSI.

Mr Gore thanked the financial team and also the East Lancashire Financial Services for their professionalism whilst preparing the year end accounts. Mr Bond added that the recommendations made by KPMG were minor and all actions had been agreed. He highlighted the Quality Accounts and how the VTE assessments were being reviewed. There were still discrepancies between the electronic and manual records but this was being addressed with new systems in place.

Resolved:
The Board received and accepted the Annual Governance Report prepared by the Trust's external auditors KPMG.

3. AUDITED ACCOUNTS 2016/17

Mr Gore presented the accounts and advised that the Audit Committee had reviewed them and recommended approval by the Trust Board. They had achieved an 'unqualified' opinion.

He drew the Board's attention to the Trust's cash position on page 15 and the NHS payable percentage that had reduced from 87% to 23%. He highlighted this as a major risk as any disruption to supply goods and services would be a concern. Mr Moran asked for assurance that local small businesses were not placed into financial difficulties in relation to delayed payments from the Trust. Mr Bond assured the Board that appropriate processes were in place to avoid this.

Resolved:
The Board noted the Audited Accounts 2016/17 and approved them.

4. LETTER OF REPRESENTATION

The letter of representation had been prepared by KPMG highlighting the audit of the accounts and would be signed by the Audit Chair (Mr Gore) and the Chief Financial Officer (Mr Bond) on behalf of the Board.

Resolved:
The letter was received and approved by the Board.

5. ANNUAL REPORT 2016/17

The previously circulated Annual Report 2016/17 had been reviewed by the Audit Committee and the following amendments made.

- Page 2: A change in the wording regarding the surplus due to additional money that had been received
- Page 26: A change to the figure in the bottom right-hand corner of the table of figures
- Page 26: merging points 2 and 3 to read: At the end of month 12 the Trust is reporting a surplus of £2.6m. This consists of a trading deficit totalling £12.5m offset by the receipt of STF totalling £15.1m.
- Page 4: income and WTE staff figures amended.
- Page 57: Theatre consultancy should have the trading company and not a named individual. The total to be amended to 56 in the total.
- Page 57: date change from 2015/16 to 2016/17
- Page 50: a wording change regarding the Trust's liquidity risk.
- Page 8: Scale on the graphs to be consistent
- Page 11: tidy up text wrapped round a graph
- Page 17: March 2017 Friends and Family test figures to be added if available at time of publishing

Mr Gore commented that the Trust had reduced its level of landfill and wanted to express thanks for the work gone into this by the Estates Team.

Before inviting approval of the Annual Report and Governance Statement Mr Moran asked the Board if anything material had subsequently come to light since the last draft of the report that could have a bearing on our approval. Board colleagues confirmed they were not aware of anything material.

Resolved:
Following the above amendments the Board approved the Annual Report 2016/17 for publication.

6. NHS IMPROVEMENT SELF-ASSESSMENT

Mr Moran presented the report which detailed the new NHS Improvement self–assessments for the Board to review and approve.

Resolved:
The Board noted the self-assessments and approved the adoption of them.

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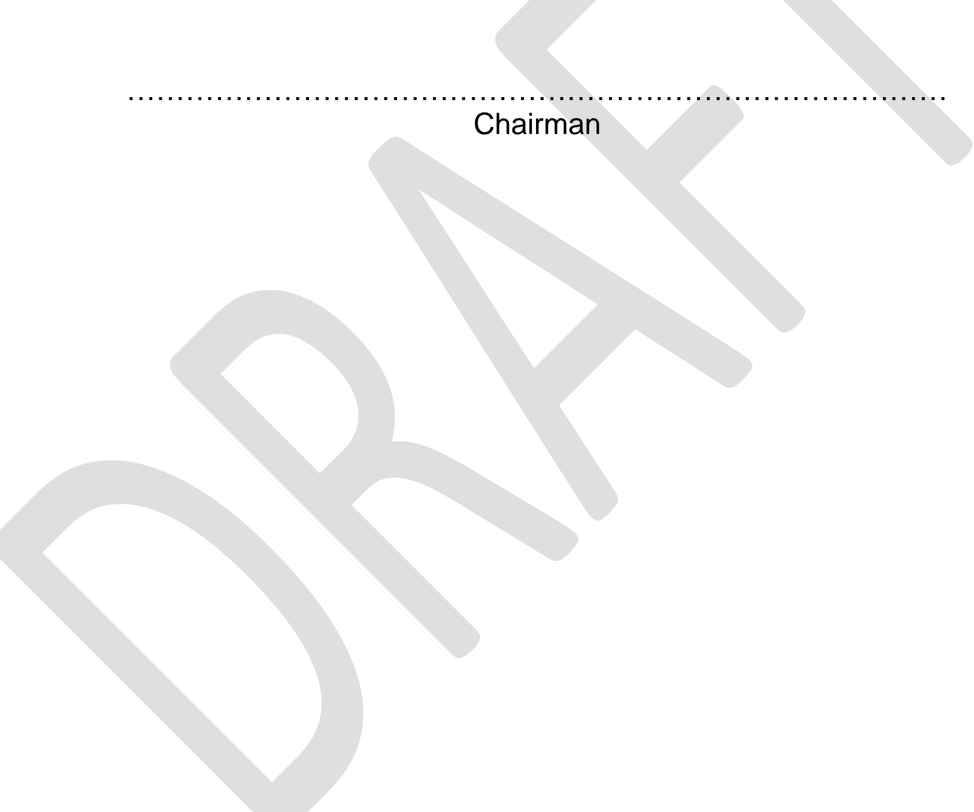
7. ANY OTHER BUSINESS

Mr Long updated the Board regarding the recent cyber attack and reported that the Trust had returned to business as usual very quickly due to the efforts of the IT team. Staff had worked through the night and the weekend to ensure that systems would not be further effected and would be fully functional as quickly as possible. Mr Long expressed his concern regarding further attacks but was assured by the overall resilience of the Trust.

Mr Moran paid tribute to the emergency teams that had helped people in the recent terror attack in Manchester.

8. DATE AND TIME OF THE NEXT MEETING:

Tuesday 6th June 2017, 2pm – 5pm, The Boardroom,
Hull Royal Infirmary



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Chairman

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (May 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

May 2017

Cyber attack – During the last month a number of NHS organisations were subjected to disruption due to computer malware. Locally, we detected malware on our system, however, it did not have a significant impact on our organisation or disrupt patient care. Our IT team responded rapidly and blocking all incoming mail, web mail and internet access while they worked through the night to keep the organisation safe. This magnificent effort deserves recognition and we would like to thank them for their hard work and professionalism.

Smoke-free sites - As part of our commitment to the health and well-being of staff, patients and visitors, from 1st June 2017 we will be reinforcing the message that our hospitals are 'smoke-free' environments. We want to ensure that no one smokes on our hospital sites, creating a more pleasant environment for all users and our workforce. A revised policy will be launched shortly offering guidance on vaping as well as smoking. We are committed to supporting staff to give up smoking. Please contact the Stop Smoking Service on 0800 3247 111 or text QUIT to 61825 for advice and support.

Radiology improvements - Rapid diagnosis for serious diseases like cancer is essential to give the highest chance of cure. Over the last year, the Radiology Department has been working hard to reduce its turnaround times for plain films and other examinations. In March 2016, only 73% of plain films were reported within two weeks. Having made a commitment to increase that figure to 95% of examinations reported within two weeks, the team has in fact exceeded its target, averaging over 99% of plain films reported within two weeks. Similar improvements are now being sought across all diagnostic radiology tests.

Improving Quality in Physiological Services - The Gastrointestinal (GI) Physiology Department based at Castle Hill Hospital has become the Trust's first 'Physiological' discipline to be granted accreditation under the Improving Quality in Physiological Services (IQIPS) programme, and only the third GI Physiology Service in the UK to be awarded accreditation status. IQIPS has been developed to improve, promote and recognise good quality practice across eight physiological disciplines including Neurophysiology, Urodynamics and Vascular Science. To gain the accreditation, the team underwent a two-day intensive on-site assessment, where documentation was also reviewed and patients, staff and carers interviewed. All staff members were found to provide a professional, patient-focused service, and the assessment team concluded that there was evidence of highly effective leadership of a motivated and proficient team. Thank you to all staff who helped in gaining this prestigious accreditation.

Frailty Intervention Team - A recent review of ED by the Emergency Care Improvement Programme (ECIP) praised the Trust for establishing an Elderly Assessment Unit in 2015, but noted elderly patients attending ED were experiencing some of the longest ED waits and a disproportionate amount of elderly patients were breaching the 4hr target.

The Frailty Intervention Team (FIT) was part of the DME response to this review. Trials involving multidisciplinary teams (consultant, physio, OT etc) being situated nearer to patients and other teams in ED Majors were deemed successful, and led to a much improved discharge rate. 61% of patients seen by the FIT team are not admitted, whereas the ED baseline for this patient group was 35%. The FIT began running on weekday afternoons and later extended its hours to 9-5. FIT works by bringing specific DME expertise into ED and significantly shortening patients' time to senior review. There are also significant

improvements in patient experience too, and there is close coordination with partners in the community/social care.

The Trust is now on track to meet the challenges set by ECIP and expects to achieve the full £1.6 m associated with the local Frailty CQUIN set by our commissioners.

Celebrating International Day of the Midwife - More than 260 hospital and community-based midwives celebrated the International Day of the Midwife on 5th May 2017. With their help, and the support of some 54 midwifery assistants, a total of 5502 babies were born across Hull and East Yorkshire in 2016.

Midwives talked about midwifery as a career and the changing role of the midwife in recent years in terms of supporting women's preferences around how and where they give birth. They also described the need to support the partner or family too, as many partners can feel quite vulnerable or unsure what to do when the focus is on the woman in labour.

It is hoped that more young people will find a career in midwifery attractive and the Trust's Remarkable People campaign will continue to support our recruitment drive.

Celebrating Nurses Day - And then on 12th May we celebrated Nurses Day. They make up almost half of the entire workforce at the Trust, providing round the clock care, compassion and a listening ear to people, often at the most vulnerable times of their lives.

International Nurses Day, Friday 12th May, coincides with the birthday of one of the world's most famous nurses, Florence Nightingale, and serves as the perfect opportunity to celebrate the huge contribution which nurses make to our lives, from beginning to end.

Once again we took the opportunity to thank all of our nursing staff for their dedication and to raise awareness of nursing careers with the Trust.

Free Wi-Fi for cancer patients
Plans to install Wi-Fi at the Queen's Centre for Oncology and Haematology in Cottingham have been brought forward thanks to the campaigning efforts of one local man.

Terry Garnett tragically lost his wife, Beverley, to pancreatic cancer in February after she was diagnosed with the disease last August. Whilst receiving treatment in the centre, which forms part of the Castle Hill Hospital site, Beverley found it difficult to stay in touch with loved ones due to a lack of mobile phone reception and data signals.

Beverley's dying wish was to enable more people in receipt of cancer treatment to keep in touch with family and friends whilst in hospital; a mantle which Terry took up with Hull and East Yorkshire Hospitals NHS Trust shortly after her death. Terry recently met with us and we have agreed to bring forward plans for free public Wi-Fi in the Queen's Centre. Originally scheduled for 2018, work to install free Wi-Fi within public and clinical areas of the building is now expected to be complete by October.

Creating patient smiles with every mile - A 50-strong hospital team hit the streets of Hull in June in support of our patients.

Staff from Castle Hill Hospital and Hull Royal Infirmary ran the Jane Tomlinson Hull 10K on Sunday 18th June to raise money for WISHH, the independent charity working to enhance facilities and equipment at both hospitals.

People with dementia will be amongst the first to benefit from the fundraising of the hospital team, which included midwives, radiographers, eye specialists, scientists and theatres staff, to name a few.

The idea to set up the hospitals team came from Chief Medical Officer, Consultant Gynaecologist and keen runner, Mr Kevin Phillips.

A Song for Hull – Tickets are now on sale for the Song For Hull musical celebration. The show, which is being supported by the Hey Let's Sing Choir will showcase local talent from Hull's primary schools alongside Jonathan Ansell, who found fame on X Factor as part of classical group, G4. As well as Jonathan and around 60 hospital staff, 240 children will also step on stage with Hull-based rapper, Nineties Boy (aka Luke Chambers) and the Garnett Family, the latter of whom also shot to stardom last year when they reached the semi-finals of Britain's Got Talent.

A Song for Hull came about as a joint venture between Hull Children's University and our choir. It has been made possible by support from the Hull UK City of Culture 2017 Creative Communities Programme and is proudly sponsored Swift Caravans, who are helping to create this amazing opportunity for local school children. Ahead of the performance, all of the children will be asked to write about what Hull means to them personally and the kind of future they want to see for our city, and these thoughts and aspirations will feature heavily on the night.

Tickets information is available at: https://www.hulltheatres.co.uk/events/song-hull

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 April we received 36 Moments of Magic nominations:

Fay Weston	I have been working with Fay on Ward 10 HRI since we started together at the end of November 2016 and she always brightens the place up with her singing, fun sense of humour and zest for life, not only for the patients but also the staff. It is always a joy to work with her.	**30/04/2017**
Ward 80 - all staff	I would like to say a big thank-you for all the excellent care given by all ward 80 staff ,to my dad he was an inpatient for 2 weeks with them, every member of staff treated him with respect, dignity and as an individual, the nursing care was excellent. My family and I were	**28/04/2017**

	kept up to date with his condition and staff communicated with us well I wish to thank all the staff on behalf of my dad , myself and my family	
Cheryl Jacklyn	I am nominating Cheryl a midwifery assistant to thank her for her hard work and commitment to her duties. Her colleague was moved areas to support another ward Cheryl had to support both the inpatient and outpatient areas. She worked with dedication and prioritised her duties to support both the women the midwives within these areas and went over and beyond to ensure everyone was supported	**28/04/2017**
Dr Hammad Rehman	Dr hammad rehman shows not just one moment of magic but a constant flow of help and support to the staff on ward 8-9. On many occasions Dr Rehman has assisted all staff on ward 8-9 when no doctor were available, he has done this by coming into work on his day off and also leaving his department to help patients in need of help and support completing discharges so patients was able to go home. Dr Rehman is an extremely caring, hardworking, friendly and supportive individual. With a wicked laugh. He goes above and beyond his duties to help deliver the best possible care that he can give. And we are truly grateful.	**27/04/2017**
Helen Bexhell	we would like to nominate Helen Bexhell for her constant hard work, she has shown great determination in improving the environment in our office. this is a department which has had many changes and has had a few issues along the way. Helen has come into the department, looked at the systems in place and has endeavoured to improve our working environment, improve moral and create a more cohesive team. This is a difficult thing to achieve with so many personalities in the department however as a team we would like Helen to know how much we appreciate her on going hard work, support and empathetic nature. She has great leadership qualities and we all very much look forward to a brighter and	**27/04/2017**

	more proactive, positive future with her as our clinical lead.	
Teams at both HLib and CLib	H Lib and C Lib. Hard working, always go the extra mile to help out wherever they can. I'd be stuck without their help and will be grateful for all their efforts.	**26/04/2017**
Jeanette Hughes	Jeanette is the eye clinic hygienist she always has a smile and kind word not only for the patients waiting to be seen but also all the staff. Jeanette is always happy to help the staff and will do things above and beyond her job role. she is valued by all the staff.	**26/04/2017**
Pippa, Jeanette, Katie, Emily	I have spent a wonderful time with the girls,I wouldn't have half the patients they show towards their patients. They are all fab with the children they look after and sometimes you can see they are stretched but they smile and get on with it.They all enjoy their job and it reflects onto their patients. Well done for a fab team!!!!!	**26/04/2017**
Claire Burnham	Each day, Claire puts in one hundred per cent effort, and truly cares for each individual patient. She is a great team member and is always at hand to help a colleague, with assistance and training when needed.	**26/04/2017**
Marta (nurse pool)	Marta was a one to one with a patient on one of the DME wards. She made not only the patient she was with but the other patients in the room feel like she really cared what they had to say.	**26/04/2017**
Sarah Rippingale	It a scary time starting a new job. On my first couple of days within the trust I had many different feel. I meet a friendly member of staff that made me feel at easy and showed me everything I needed to know about working on a ward, nothing was to much trouble for her.	**26/04/2017**
Becky Fory	Becky had a bit of a bumpy start during her apprenticeship. She had some health issues but each time she showed up to work and got on with things.	**25/04/2017**

	Even though it is early in her NHS career, she has a great attitude and I think she deserves a mention.	
Jo Holt	A patient brought a waiting list form across to the unit, Jo noticed that the patient had travelled quite a distance and would need to do so twice more, once for a pre-assessment appointment and again for surgery at some cost to the parents. Jo went out of her way to offer to do the pre-assessment whilst the patient was dropping off their form thus meaning they could be dated for surgery sooner and not have to travel the 50 plus miles to the unit additionally. Very Well done Jo :-)	**25/04/2017**
Steph Hazell	Steph hasn't been on ward 70 long, but has been a great support to staff. Especially myself regarding issues in and out of work, and am extremely grateful for this. She is working hard to slowly build the ward morale back up, and feel this needs recognising. Thankyou for your continuing support!	**23/04/2017**
Angela Robinson	being kind caring and considerate to my mother during her last days angela always made sure my mum was given regular sips of water, made sure she was comfortable at all times,	**22/04/2017**
Laura Naylor	Laura did a brilliant job of suturing a child who became apprehensive and frightened during the procedure. The young boy became upset during the LA injection and had to be calmed down in order to continue. After he was settled Laura quickly continued with the injections, and found him a nice book to look at during the suturing. After consoling him and settling him down Laura quickly applied 7 neat sutures, all the while talking to the patient and keeping him calm. He left the department happy and proud of himself.	**22/04/2017**

Jacqui Waudby	Escorting two children across to acorn from the Plastic SurgeryTrauma Unit HRI. When she got to the front	**22/04/2017**

	entrance a pregnant lady entered the main reception & her husband was going to find her a chair. The lady responded by I can not walk any further the baby's head is out. Jacqui attended to the lady & noted the baby's head was visable. There was no time to wait for help. She took incredible initiative and attended the patient although this is not her routine work. The lady within 2 minutes delivered the baby into Jacquis arms a baby girl. Jacqui was delighted & shocked at the same time that she just delivered the baby safely. Well done what an experience all in a days work. The maternity staff thanked Jacqui. We are so Proud of Jacqui from all the staff on Plastic Surgery Trauma Department. She came back to her work and carried her regular duties.	
Mandy French	Mandy is a very supportive member of staff who is always willing to lend a helping hand, especially to newly qualified staff needing extra support, in which Mandy is excellent with taking time out of her busy role to teach and support with challenging situation. She is a highly skilled nurse and works extremely hard to ensure the patients get the highest quality of care.	**21/04/2017**
Sally Cumings	Upon transferring areas within my job role I required access to my smartcard and Lorenzo which previously I had not used before in my job role. I completed the relevant training required to be able to access Lorenzo and still my card would not work. This made it difficult to fulfil part of my job role. I contacted the smartcard team and Sally was on hand to sort this problem out for me. It took numerous attempts over a short period of time but Sally was fantastic in doing so and the problem was sorted. She looked at every aspect of the problem, and identified why my card was not working. She was friendly, a fantastic communicator and went above and beyond to sort this problem for me. This may only seem like a little problem, but it has now made it possible for me to fulfil my job role. Thank you	**21/04/2017**

	Sally!	
Kayleigh Harper	Our new ward hygienist Kayleigh has made such a difference on our unit (MAX FAX OPD) We would like to say a big thankyou as Kayleigh is such a hard worker and a credit to our unit. She got a great cleaning score 100%, we never achieved that until Kayleigh started here. A big massive thank you Kayleigh. Your a star. From Diane house keeper	**21/04/2017**
Louise, Heather and Chris	WE would like to nominate Louise,Heather and Chris in the Queens Centre Phlebotemy Team. No matter how busy the girls get they are always able to smile and make the patients day, no matter how rubbish the patient is feeling. Well done girls keep up the good work!!!	**20/04/2017**
Gill Barnett	it's not one moment of magic but a continual flow. Gill goes that extra 10 miles every day to ensure the smooth running of our service ... she is a thorn in our side which we couldn't survive without!!	**18/04/2017**
Dr Hammad Rehman	On numerous occasions Dr Rehman has assisted the smooth running of ward 9 at times of need due to no Dr available. Dr Rehman left his position within another speciality in order to help patients in need allowing us to safely discharge patients from the ward. Dr Rehman is extremely hard working, friendly by nature and a pleasure to work with.	**15/04/2017**
Tammy Woollons	Tammy is new to the ward and already is a valued member of the team! she delivers exceptional care and gets outstanding compliments from patients and family members! we are lucky to have her!	**15/04/2017**
Laura Maxwell	our charge nurse laura Maxwell is a great manager keep up the good work laura	**14/04/2017**
Laura Maxwell	Our charge nurse Laura Maxwell is fantastic just want	**14/04/2017**

	to say keep up the hard work laura you are great	
Steph Hird	During one of our Diabetic Retinal Screening Slit Lamp clinics a photography patient came in with her sister to check she knew where to come for her future screening appointment. This patient speaks no English at all so we would have had to organise (and pay for) an interpreter. Steph saw them and realised that she had an opportunity to not only help the patient by saving them having to make another journey but also make the experience a more comfortable one as she had her sister with her who could explain the procedure and provide support for her. At the same time she could also save our programme and the Trust the expense of the interpreter fees and as we all know, any saving is greatly appreciated. Steph checked if the current clinic had the time available to work around the patients, and then swapped the equipment over and carried out the full procedure. This just shows that everyone can benefit from some real team spirit and patient centred focus - well done Steph!	**13/04/2017**
Dr Sheeraz Khan	Throughout my placement as a junior doctor, Sheeraz Khan was excellent in providing advice and leading by example. I remember a moment where one of our nurses called Sheeraz to cast an eye over a young baby who had some trouble breathing. He was over in an instant and provided life-saving treatment. His quick recognition and instant reaction saved a young life and was a moment of magic that will stay with me throughout my career. We need more doctors like him!	**12/04/2017**
Emma Gray	Emma was working on a busy shift on the emergency department, she was pulled from her team in majors to assist in resus as a cardiac arrest was on route. Despite Emma being recently qualified and never having worked in resus / a cardiac arrest in this environment. She was amazing. She was calm, efficient and used her initiative throughout the cardiac arrest. She never panicked, she knew her limitations	**08/04/2017**

	and she was a huge help to me, the ED staff and the patient. She then stayed to help facilitate a safe transfer of the patient and help with other patients. Emma was truly fab, is a credit to ED and will continue to become an amazing nurse.	
Victoria Shirt	Vicky was co-ordinating a very busy shift in the majors department of ED. Despite having lots of different pressures, Vicky remained calm and efficient. She was supportive and helpful, went above and beyond to support us as staff and make sure that all the patients were well cared for. Always kept her cool and would make an amazing band 7!	**08/04/2017**
Jodie McCloud	Jodie is a newly qualified staff nurse who has joined the team with dedication and compassion. Nothing is too much trouble and she works very hard with her patients. A great start to her nursing career, she is a fantastic nurse and will go far.	**07/04/2017**
Dan Bond	Generally being helpful each time.	**06/04/2017**
Alan Hostick	This gentleman always has a smile on his face and a bounce in his step. Come rain or shine he delivers and collects our post promptly with a friendly and helpful demeanour. He makes conversation with all the staff and visitors to the centre. He shows genuine care for his work and for those he comes into contact with. He always brightens our day whenever he visits the Medical Education Centre and makes us laugh with his stories, bringing a smile to all our faces; we always look forward to the post run! Thank you Alan :-) - MEC Team	**06/04/2017**
Emily Morris	Emily has worked in neurosurgery for the last 3 years. It will be sad to see Emily leave ward 40 and her hard work and dedication will be missed. Emily is a fantastic nurse and is always willing to help others. She goes above and beyond her duties and delivers the best	**05/04/2017**

	possible care that she can. We wish her the best of luck in her new role.	
Linda	Linda at Wilbers Café, CHH, is the most pleasant, friendly and helpful woman. I witness her speaking to staff, patients and visitors in such a genuine caring manner. She represents the trust and catering department in such a positive way. The café can be the hub of the building. People go there after receiving bad news, whilst waiting for their loved ones to have tests and staff too utilise it after giving their all to our patients. The friendly and warm environment that Linda creates in Wilbers is lovely.	**04/04/2017**
Dr Mo Aye	Dr Mo Aye Consultant Endocrinologist who has overseen my broken bones over a number of years. He has made decisions along with his team which have meant that my life is improving. I may be one in a million, but he makes me feel that 1 in 1,000,000. He is a natural listener, can take on board what you are saying, but more importantly what you are not saying. He not only discusses the situation with you at clinic, giving more time sometimes than is booked, and when I sit and wait a little longer for my appointment, I know that someone who is in need of a bit more attention is getting what they need. I have been given the chance of a better life and a chance to be medically better off and he has done that for me. Having broken 10 spinal bones over the years and lately a bad fracture of the humerus, he has modelled my treatment on my needs, not the needs of every patient. Thank you so much for all your kindness, opportunity and above all sincerity. Whoever has you as their Consultant is one very lucky, and fortunate Patient.	**03/04/2017**

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT MAY 2017

Trust Board date	6th June 2017	**Reference Number**	2017 – 6 - 8
Director	Kevin Phillips, Executive Chief Medical Officer	**Author**	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

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

QUALITY REPORT
MAY 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

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
MAY 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

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.

There are no current ongoing investigations into Never Events.

2.2 Serious Incidents

There was one serious incident declared in April 2017, see 2.2.1 below.

2.2.1 Serious Incident declared in April 2017

Ref Number	Type of SI	Health Group
10393	Maternity/Obstetric Incident	FWH

This incident relates to a baby that died six days after an extremely difficult birth in April 2017. This incident is under investigation currently and any matters of significance will be reported in future versions of this report.

This is the first case the Trust has reported under the new process that has been put in place by NHS Resolution (formerly the NHS Litigation Authority). This requires that, from 1 April 2017, Trusts are required to report all maternity incidents that occur on or after 1 April that are likely to result in severe brain injury or death. The CQC has also requested to see the completed SI report on this case.

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.

The Trust completed one investigation into a Serious Incidents in March 2017. This related to an in-hospital fall; a patient was within the ED, Resuscitation Area and the patient fell when outside of the bay. This patient had appeared lucid and settled and then got up off the trolley and walked out of the bay. As the consultant in the room went to help assist the patient, the patient fell. The investigation determined no new learning, and noted that all relevant documentation had been completed appropriately,

Quality Safety Bulletin No 11 was published in April 2017. The topic for this alert, entitled 'Device Related Pressure Damage', relates to the learning identified from a serious incident that occurred in 2016. This patient suffered avoidable grade 3 pressure damage, which was caused by poor plaster cast management. One action from this particular SI was to introduce a red band over

the patient's plaster cast to alert staff of patients that are at high risk of pressure related damage from having the cast in place.

In the May 2017 Lessons Learned Bulletin, there was an article sharing the learning from an SI investigation that was completed in 2017. This related to a patient that had been accepted to come to the Trust but was subsequently sent onto another Trust after arrival at CHH by air ambulance. This was because the Trust did not have the capacity to receive this patient safely, despite a junior doctor accepting the patient earlier. There were elements of miscommunication in accepting this patient and the Trust's ability to receive the patient. The learning identified that staff needed to be clear on what happens once a patient is in an air ambulance, and how to contact the air ambulance team if required.

The article also shared the key points on contacting an air ambulance:

- Once a clinical decision has been made to accept a patient, there should be no deviation from this plan.
- Any further emergency medical communication with the helicopter whilst in flight must be undertaken through airwave radio via the East Midland Ambulance Service or Yorkshire Ambulance Service control desks only.
- Mobile telephones must not be used for these purposes as these do not link with the helicopter communication system whilst in flight.

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 May 2017 are attached as **Appendix One**.

From the 892 in-patients surveyed on Friday 12th May 2017, the results are as follows:

- **93.4%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2.24% [n=20]** 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 **97.76%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **91.2% (n=814)** compliance. VTE incidence on the day of audit was **8** patients; 4 of which were with pulmonary embolisms and 4 were deep vein thrombosis.
- New pressure ulcers remain relatively low, although higher than last month **(n=9)**; all of which were at grade 2.
- There were **9** patient falls recorded within three days of the audit day, which is a reduction on last month; **7** of which resulted in no harm to the patient and **2** with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain relatively low at **5/161** patients with a catheter **(3.1%)**. Of the **5** patients with infections, **1** was an infection that occurred whilst the patient was in hospital **(0.11%)**. This 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.

The original intention behind the ST was for it to be a tool for local improvement. The reporting of ST results is a contractual requirement for the Trust and, also, they are used by the Care Quality Commission and NHS Improvement in their assessments of the Trust's performance. Originally,

it was never intended for the ST data to be used as a performance management tool or a benchmarking tool with other trusts. This is because not all trusts collect necessarily the same data, in the same way and to the same scale. Nonetheless, they are used in this way. As such, it is important to put any comparators into context. Despite this, the benchmarking tables prepared by the Y&H Academic Health Sciences Network Improvement Academy are still useful reference points for comparison against the Yorkshire and Humber and England averages. These are now provided.

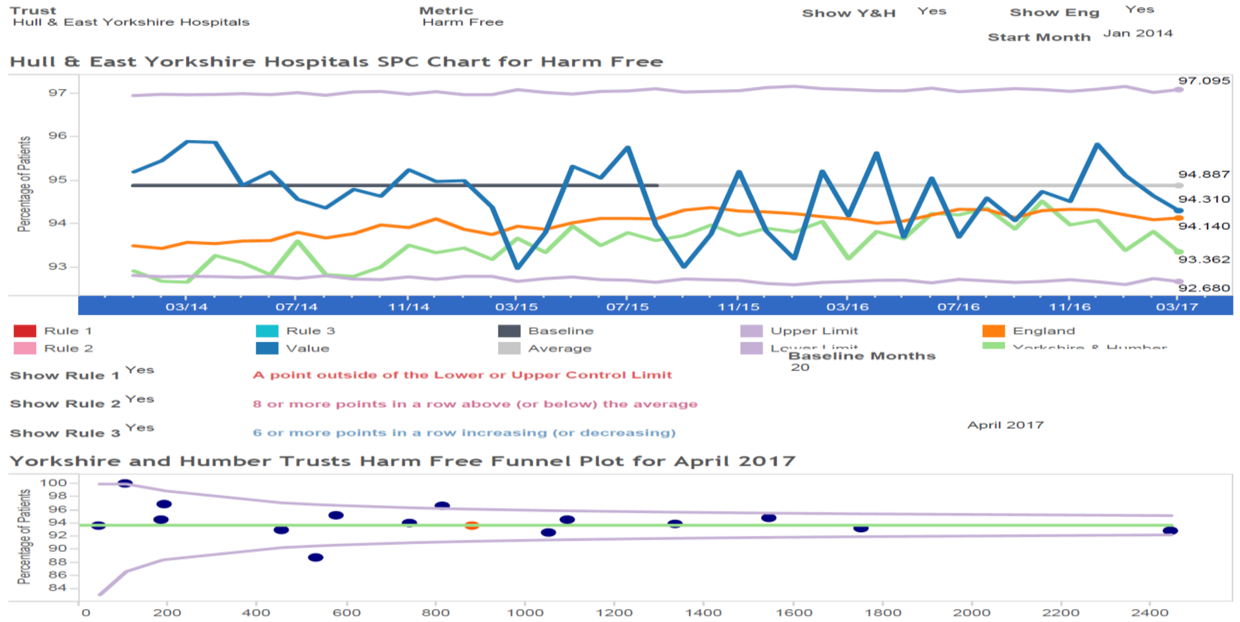
The key to these is as follows:

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

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

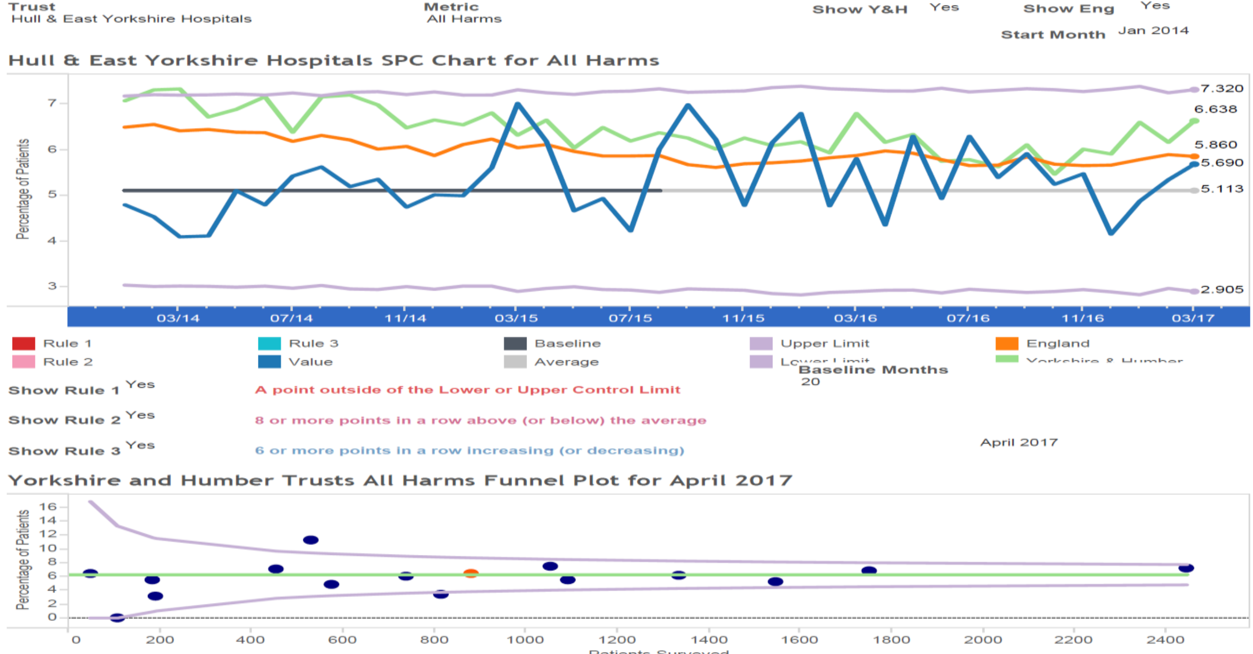
4.1 Harm Free Care

The following table and funnel plot show the percentages of patients with Harm Free Care overall (none of the four harms), either before coming into hospital or after coming into hospital. As can be seen, the Trust compares favourably with this indicator.



4.1 All Harms

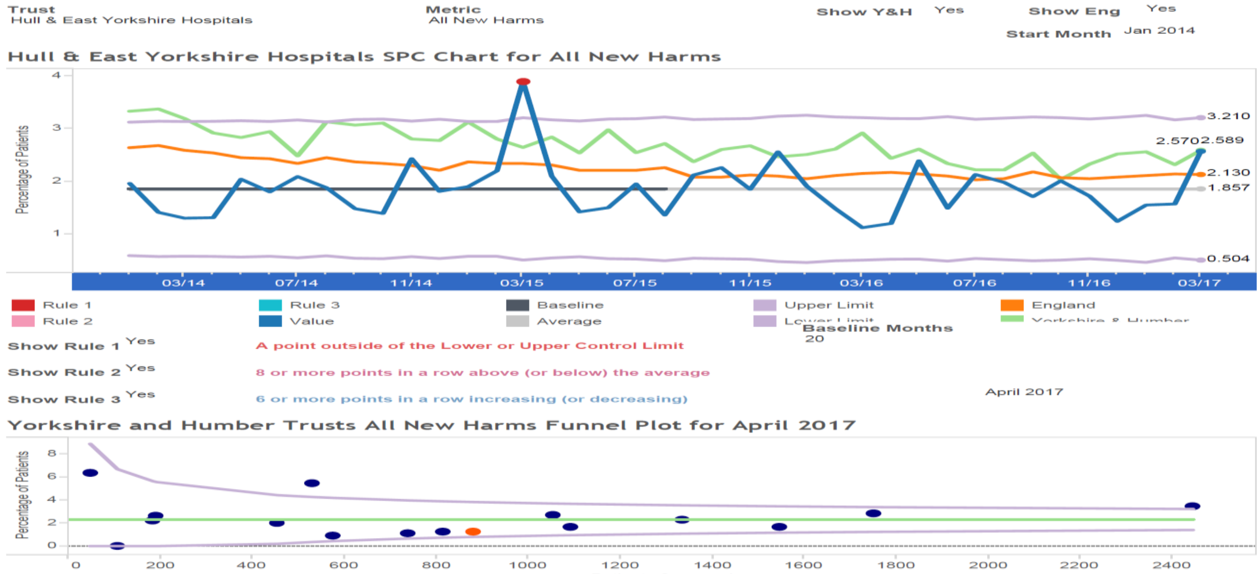
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



As can be seen, this performance sits within the control limits for this indicator and with a positive position overall when compared to the England and Yorkshire and Humber averages, particularly th elast 4 months. In terms of the Trust's performance, it is more appropriate to consider the proportion of patients that acquire any of the four harms whilst in hospital. These are termed 'New Harms'.

3.1.1 New Harms

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

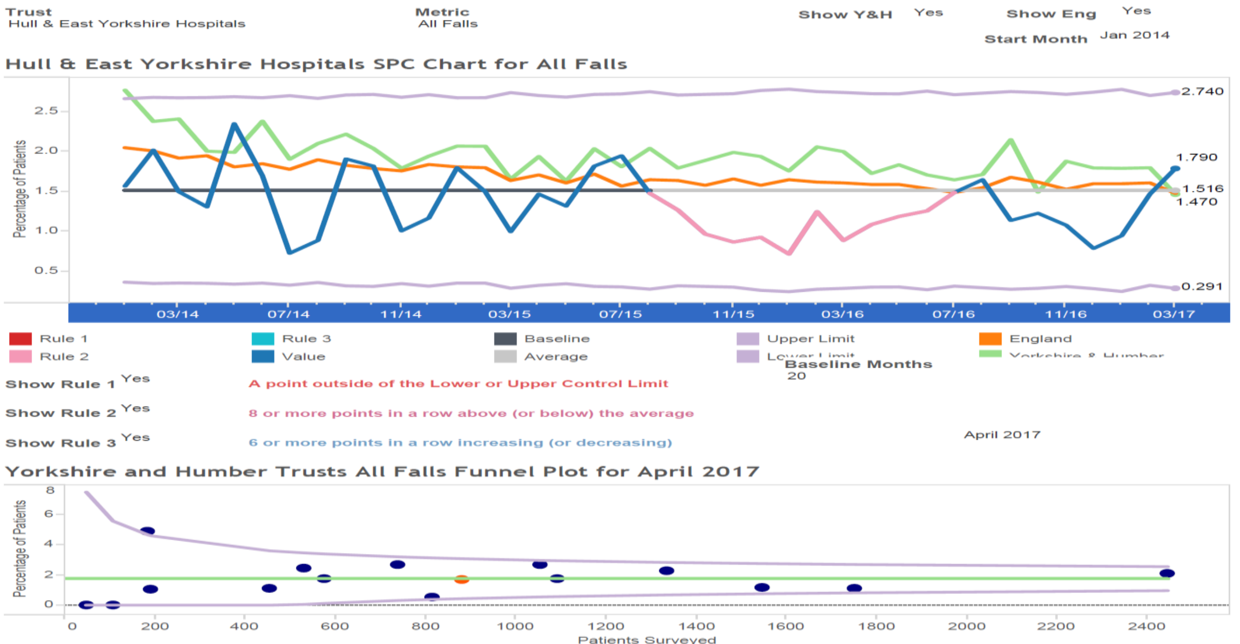


Again, and overall, the Trust performs realtively well against this indicator, with a slight peak in March 17 but there is always room for improvement, particularly where any harm is deemed avoidable. These data continue to be reviewed monthly. Each ward receives its individual feedback and results and is required to take action accordingly. To take each of the four harms in turn:

4.2 FALLS

4.2.1 Falls (all)

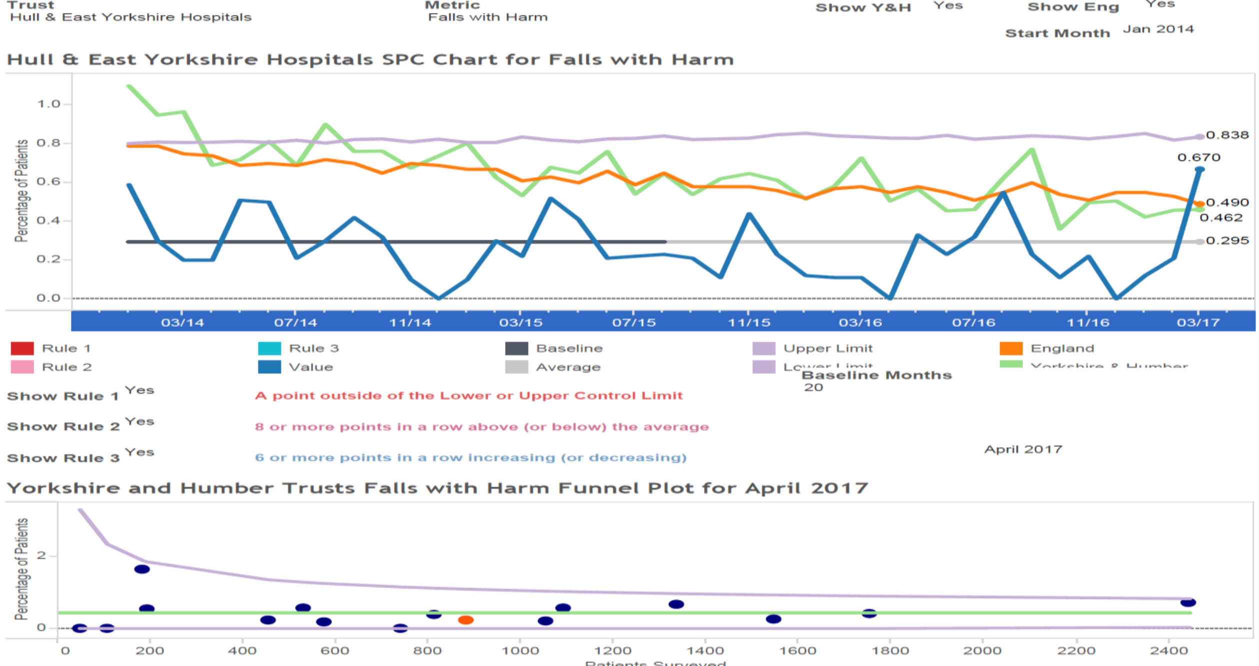
The following tables shows the percentages of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



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

4.2.2 Falls with harm

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

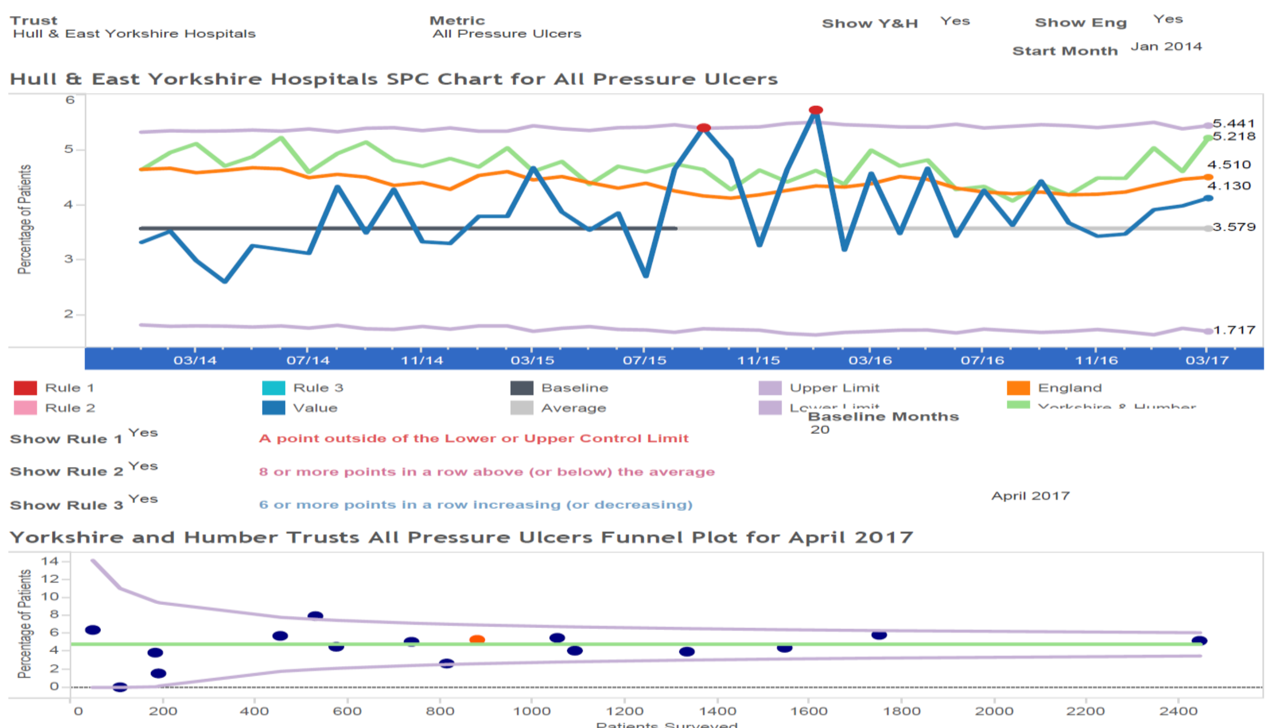


There was a spike in falls with harm in March, although these were predominatly low harm. This has come down again for April. Overall though, this remains very positivie performance when compared to peers and reflects the cotinued prevention work that is being undertaken in this area.

4.3 PRESSURE ULCERS

4.3.1 Pressure Ulcers (All)

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



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

4.3.1 Pressure Ulcers (new)

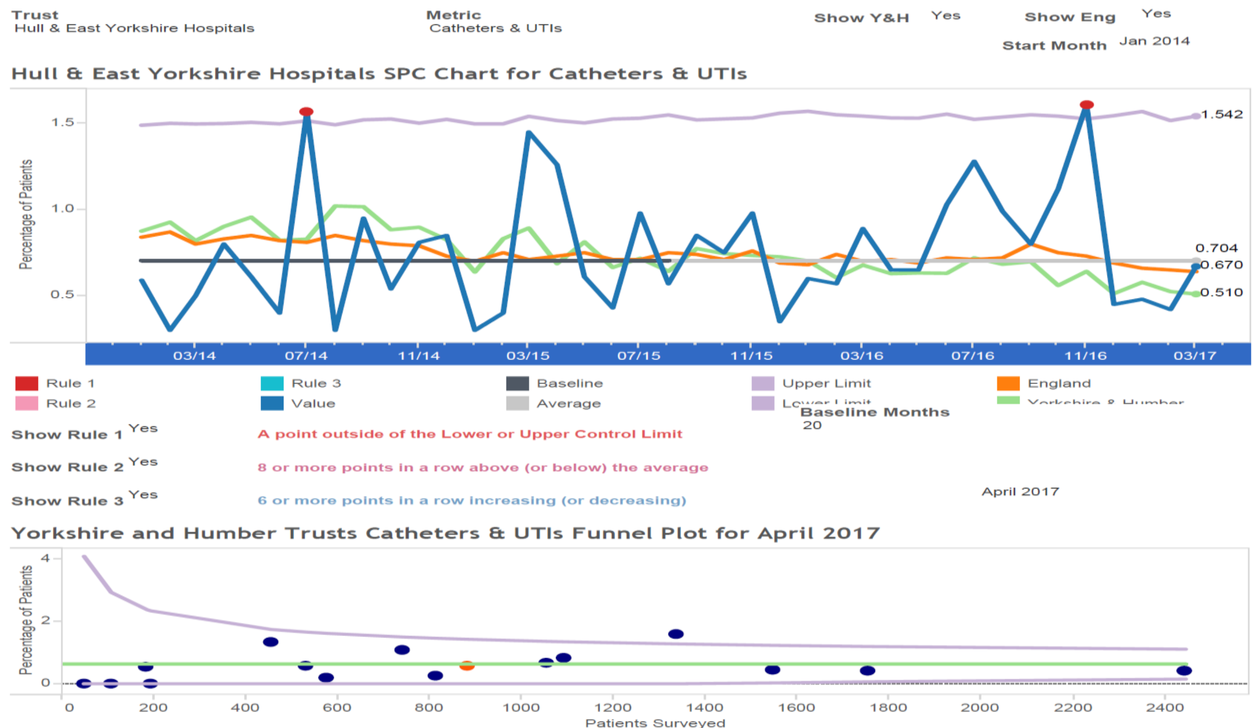
When the data for pressure ulcer harm that is acquired whilst in hospital is considered, this is an even more positive picture overall.

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

4.4 CATHETERS AND URINARY TRACT INFECTIONS (CAUTI)

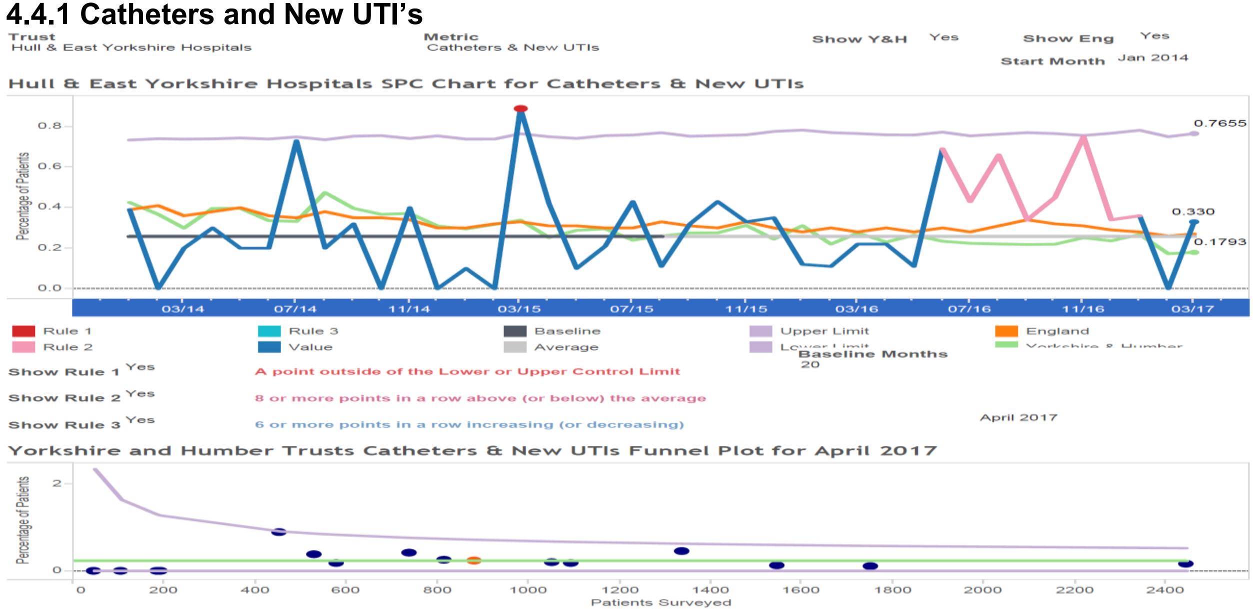
4.4.1 Catheters and UTI (All)

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



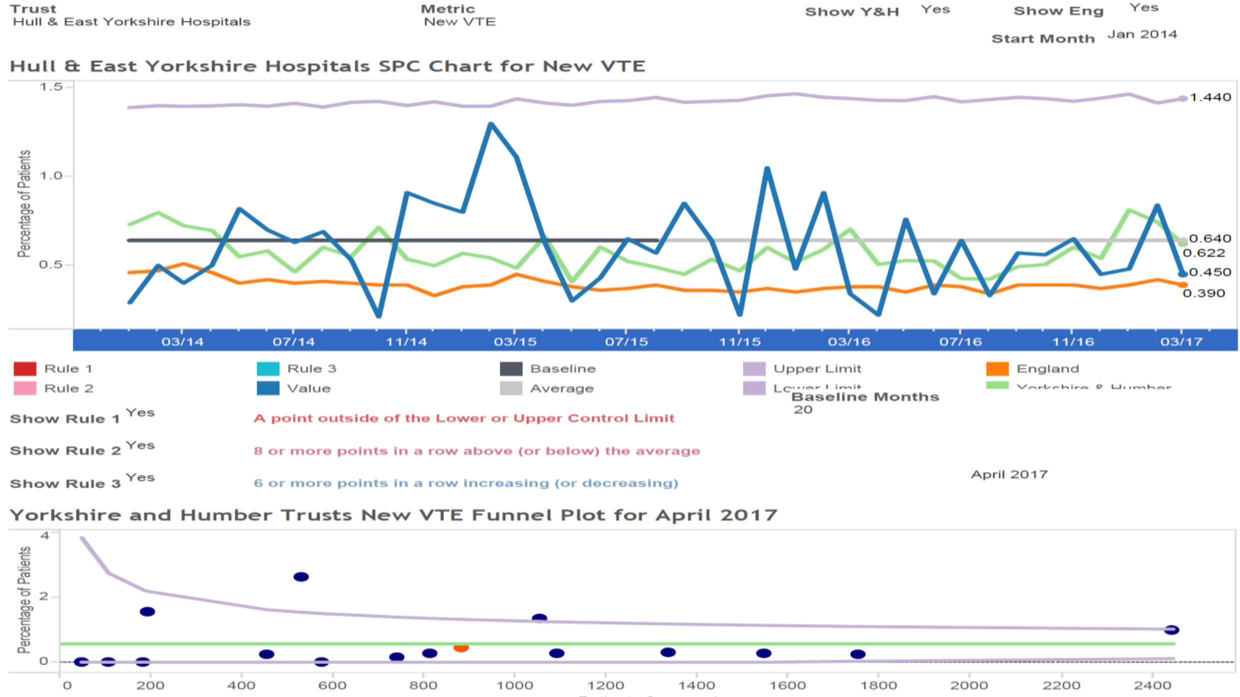
The following chart shows the rate of these infections declared new after the patient was admitted to hopsital. Performance remains variable against this indicator and work continues to improve catheter care management. This is monitored closely at the Infection Reduction Committee.

4.4.1 Catheters and New UTI's



4.5 NEW VENOUS THROMBO-EMBOLISM (VTE)

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



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

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 30th April 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**	**7** **(13% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0**
MSSA bacteraemia	**44**	**2** **(5% of threshold)**
E.coli bacteraemia	**73**	**7** **(9.5% of threshold)**

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

4.1.1. *Clostridium difficile*

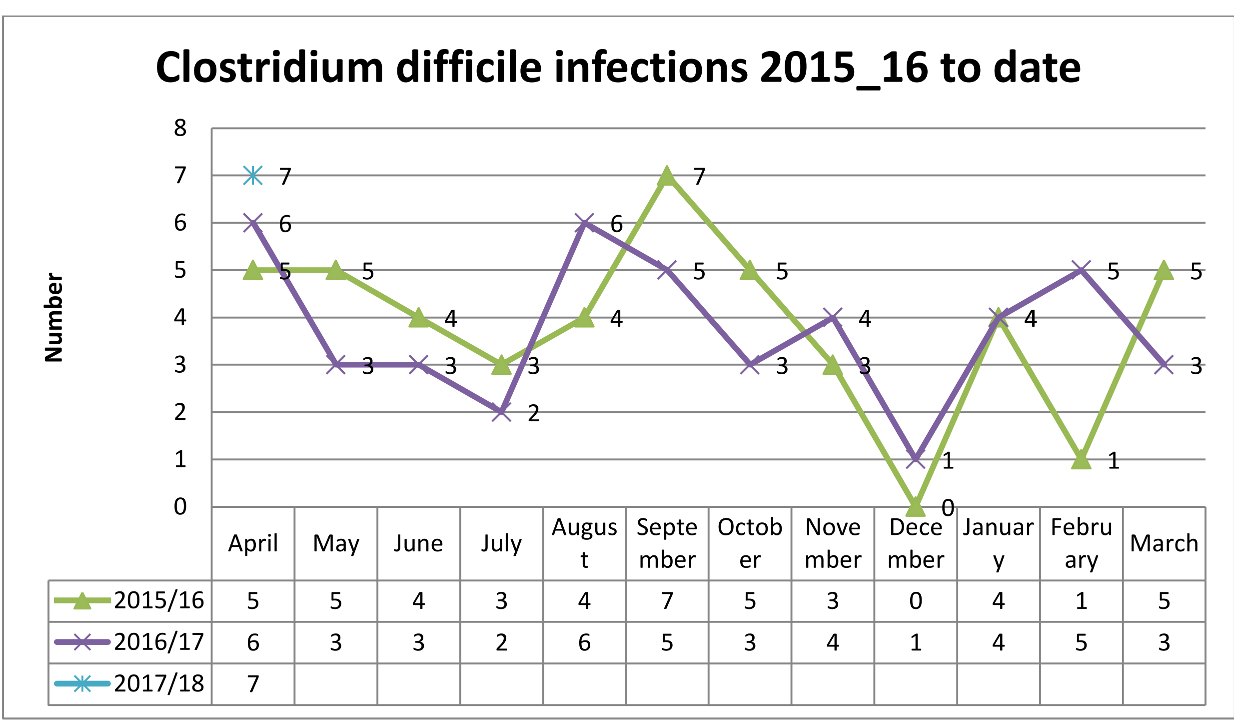
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and 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.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**7** (13% of threshold)	**2** 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 patient management	Nursing staff now aware of systems and processes related to flags on Lorenzo. Ward manager to share at team meetings – invite IPC to attend

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

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



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 (0% of threshold)**	NA

During April 2017 a MRSA bacteraemia case was detected in patient within the first 48 hours of admission and assigned to East Riding of Yorkshire CCG. Collaborative investigation highlighted

lessons learned for Primary and Community Services with the final allocation being apportioned to East Riding of Yorkshire CCG. The patient continues to be managed as an inpatient under the care of Infectious Diseases and is responding well to treatment.

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.

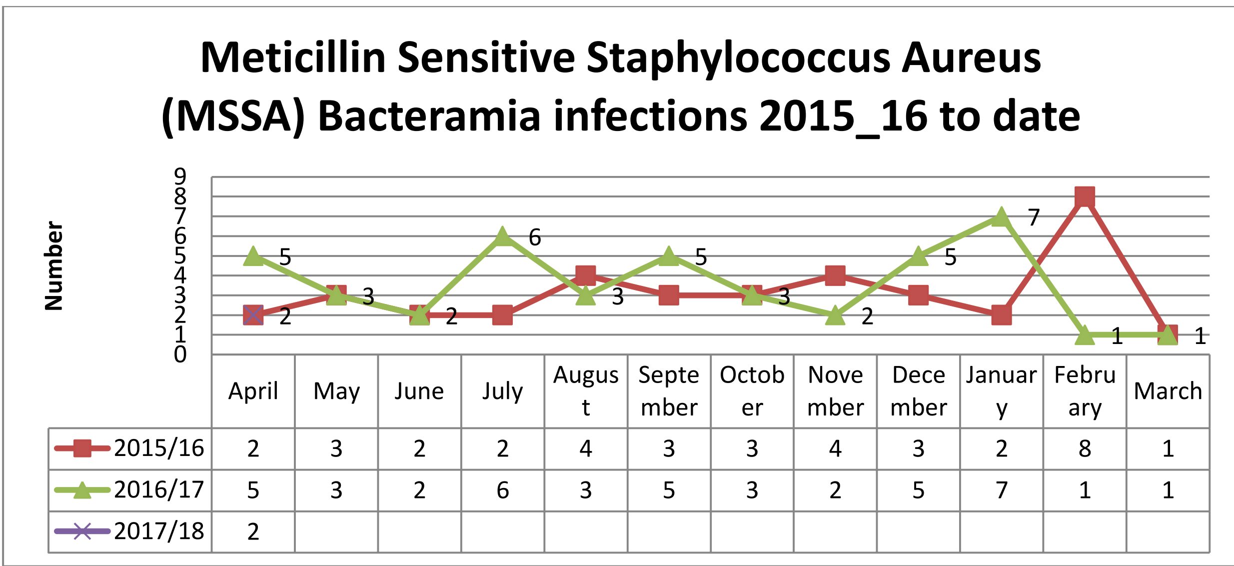
However MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused 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**	**2** (5% of threshold)	1 x contaminated sample

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 -	Pending – awaiting meeting	Pending – awaiting meeting	Pending – awaiting meeting

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 device/ 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.

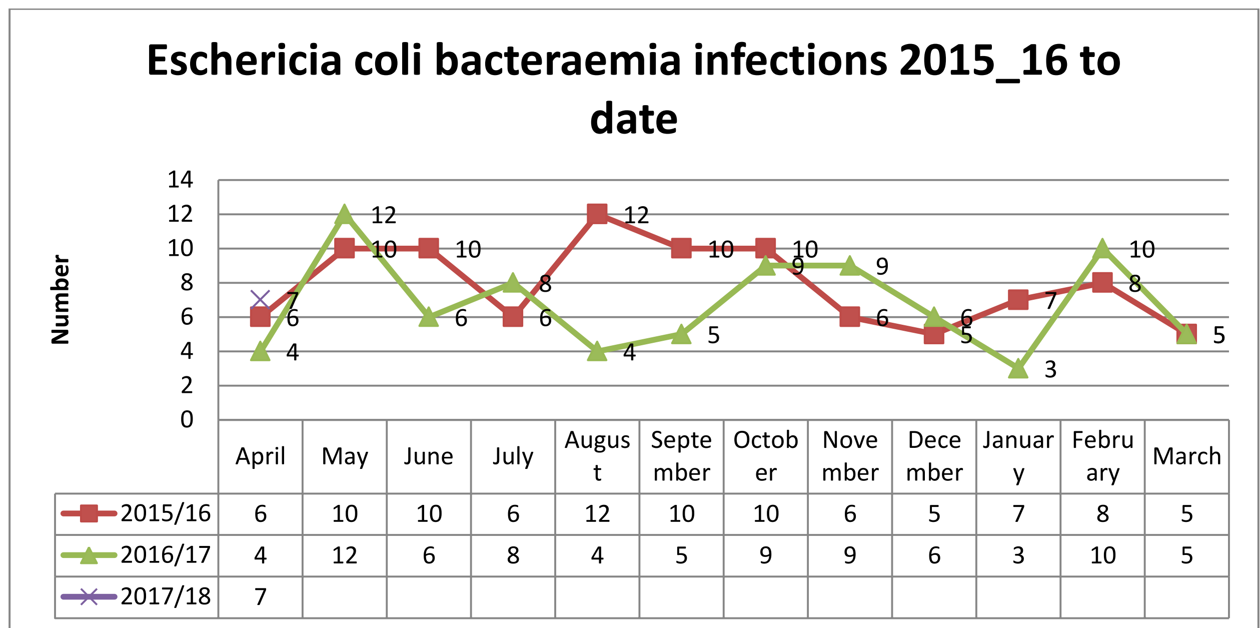
E. coli is now the commonest cause of bacteraemia reported to Public Health England. *E. coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

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)**	**7 (9.5% of threshold)**	7	1 x avoidable 1x possibly avoidable 5 unavoidable

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

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

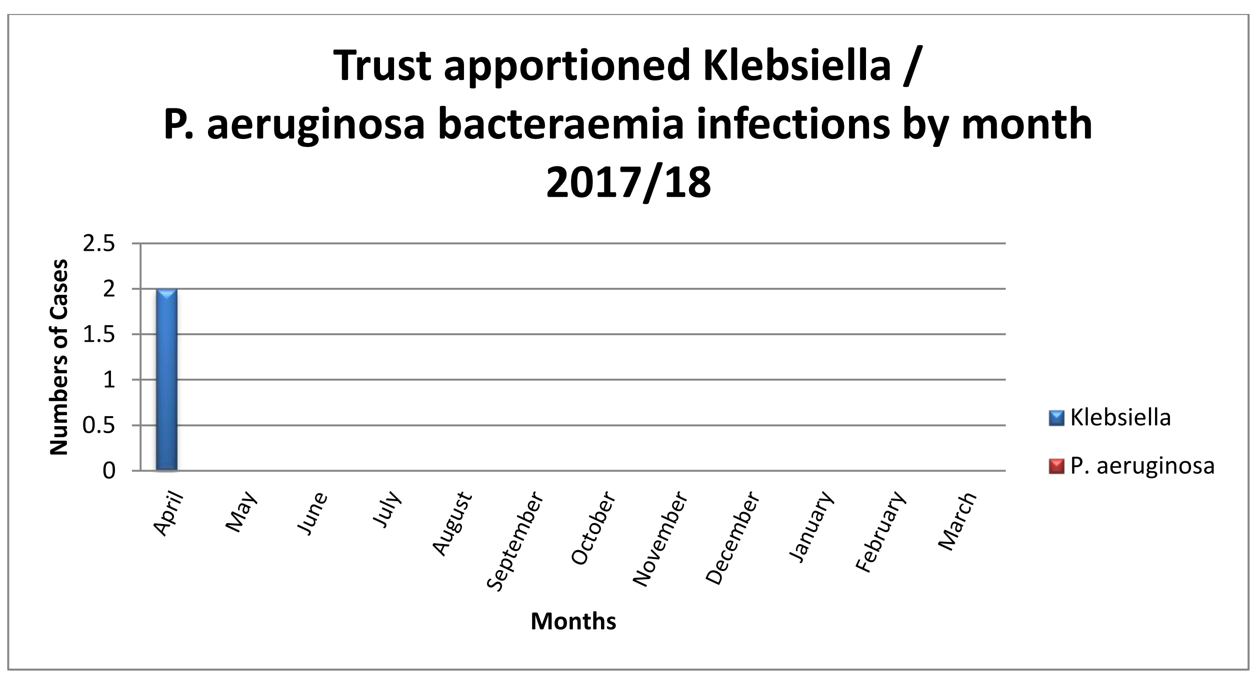


	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	6	10	10	6	12	10	10	6	5	7	8	5
2016/17	4	12	6	8	4	5	9	9	6	3	10	5
2017/18	7											

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 bacteraemias. 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. There have been no reports of outbreaks across the Trust during April 2017.

4.2.1 Influenza trends

Reports of influenza and admissions with flu-like symptoms continued to markedly reduce across the region and by the Trust during April 2017.

4.2.2 Mycobacterium chimaera (M.chimaera) infections associated with Cardiopulmonary Bypass

In 2015, Public Health England (PHE) published guidance on infections associated with Heater Cooler Units (HCU's) used in cardiopulmonary bypass systems. As a Trust, providing cardiothoracic surgery for patients across Hull, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire and North Yorkshire, the guidance required consideration and compliance.

Air sampling and monthly water sampling for M.chimaera and 3 monthly for Legionella was undertaken on these units. No adverse results were reported by PHE to the Trust during 2015/16.

In January 2017, revised guidance on this topic was published, which highlighted a number of new concerns, whereby HCU's were possibly contaminated with M.chimaera during manufacture as an environmental contaminant, so the potential to transmit this infection to humans during use was increased.

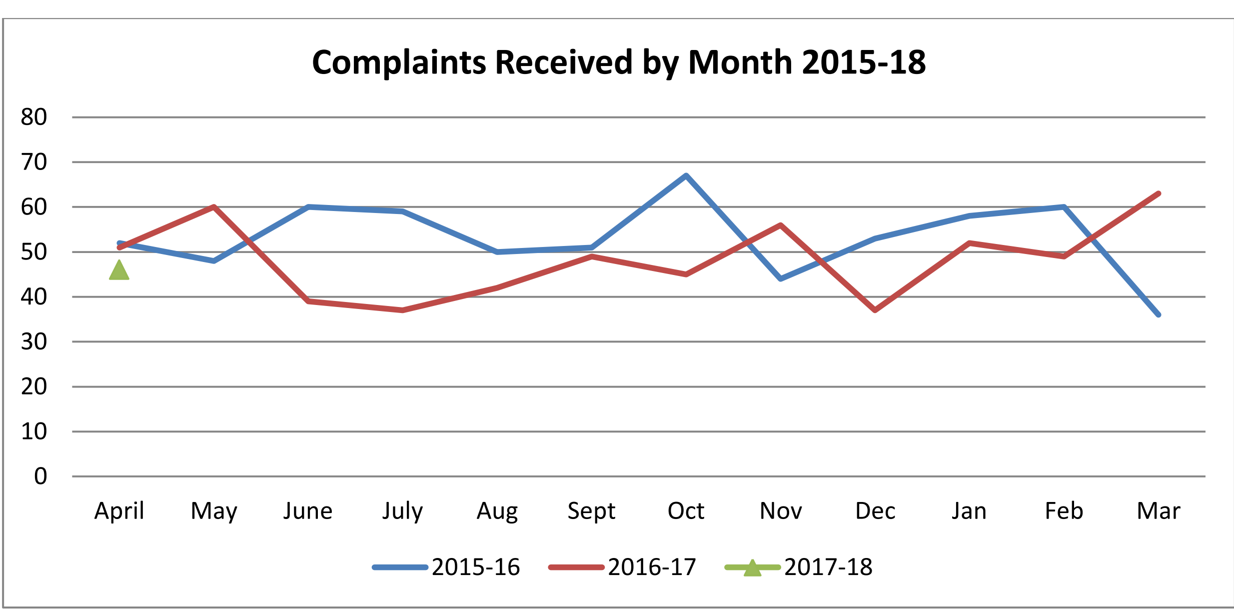
In light of the revised guidance, a review of patients that had undergone cardiopulmonary bypass surgery from 1st January 2013 until 22nd February 2017 at the Trust was undertaken. PHE has since communicated via letter to the general practitioners (GP's) of these patients. The letter provides advice and guidance on patient management should th epatient present with an infection. NHS England has also written to patients providing advice and reassurance on the very low risk from this infection following their surgery. Further information has been published on the NHS Choices website.

To date, 960 patients treated by the Trust have been contacted by letter and the Trust is working collaboratively with Primary Care and external partners to allay any concerns and provide reassurance. In some cases, should the patient require any additional assurance, the opportunity for them to be seen in the outpatients clinics is available. To date, this has not identified any issues of concern.

5. PATIENT EXPERIENCE

5.1 Complaints

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



There has been a decrease in complaints received during April 2017, bringing it to just under the similar number for the same period in the previous two years.

5.1.1 Complaints by Episodes of Care

The following table shows complaints as a proportion of activity for March 2017. These will be presented in trend form going forward.

April 2017	Patient Contacts	Numbers of Complaints	%
Emergency Department	12.345	3	0.024%
Inpatient Admissions	11,938	24	0.2%
Outpatient Episodes	51,864	19	0.037%
Totals	**76,147**	**46**	**0.06%**

The following table indicates the number of complaints by subject received for each Health Group during the month of April 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	1	0	0	1	0	0	4	6
Family & Women's Health Group	2	0	2	0	0	0	5	9
Medicine Health Group	0	2	0	3	0	1	8	14
Surgery Health Group	0	0	2	0	1	0	14	17
Totals:	3	2	4	4	1	1	31	46

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 (7) and the outcome of the

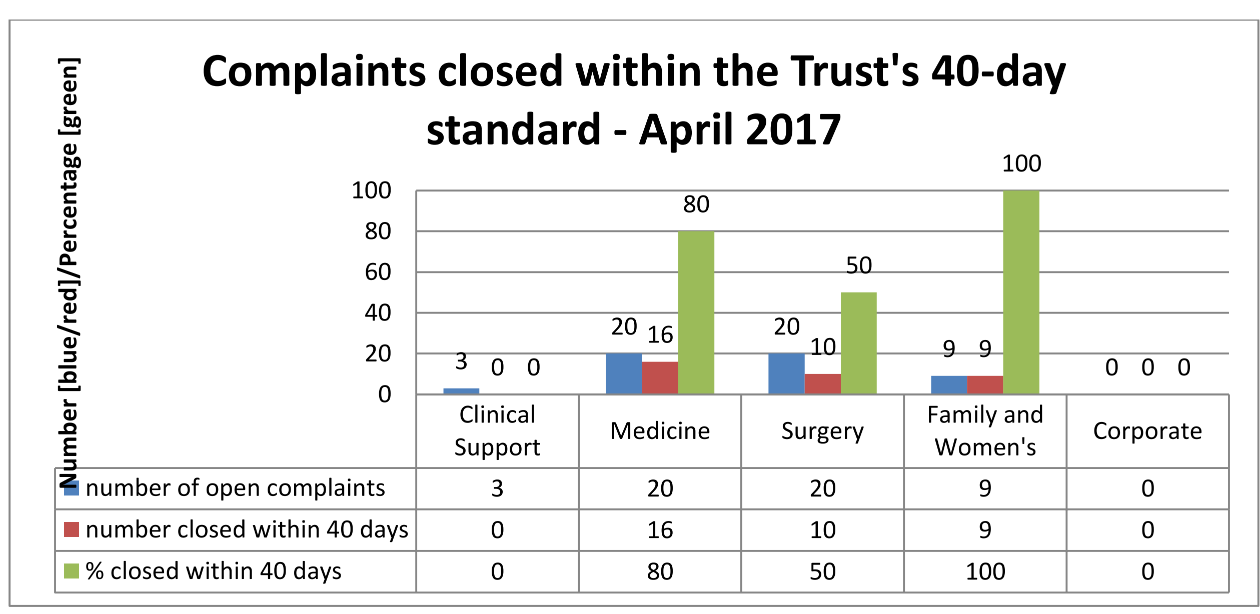
treatment undertaken (7). These complaints are all reviewed individually and the patient/family is offered a resolution meeting. The outcome of each investigation is shared fully with the complainant.

5.1.2 Examples of outcomes from complaints closed this month:

- A patient attended ED and requested morphine for her pain and felt that she was treated as a drug abuser.
  Action: The junior doctor's supervisor will work with the doctor to reflect on his actions, the manner in which he communicated with the patient and how this affected the patient.
- A patient was left in the discharge lounge in her nightwear. Family were not happy with the discharge arrangements
  Action: Issues will be discussed at the next ward meeting, including the addressing of patient dignity and effective timely communication. The Consultant will raise the importance of accurate Immediate Discharge Letter transcribing from the drug card at the next governance meeting.
- A patient was very dissatisfied with the level of care received on the ward.
  Action: The Senior Matron to discuss the importance of patient information and communication with them at the next governance meeting and during the next ward meeting.
- A complainant felt that aftercare arrangements for breast surgery patients was inadequate and made suggestions for improvement.
  Action: The Business Manager and Consultant are writing to the Commissioners to see if post-operative follow up care can be given to patients referred from Grimsby for breast surgery. The ward sister will speak to the team regarding patients accessing advice when contacting the ward following discharge.
- A complainant believes that her late husband's treatment failed to acknowledge and take into account his cancer history.
  Action: A review will be undertaken to see what could have been done differently when contacting the oncology helpline and what lessons can be learned to educate staff.
- A patient was concerned at the poor communication between different hospitals that resulted in delays in his treatment.
  Action: A review of system for referrals between different hospitals is under way, to include confirmation of this in order to ensure it has been received.

Of the closed complaints in April 2017, 13 were not upheld, 28 were partly upheld and 7 were upheld.

5.1.2 Performance against the 40 day complaint response standard – April 2017
The following table sets out performance against the Trust's standard of closing 90% of complaints within 40 days:

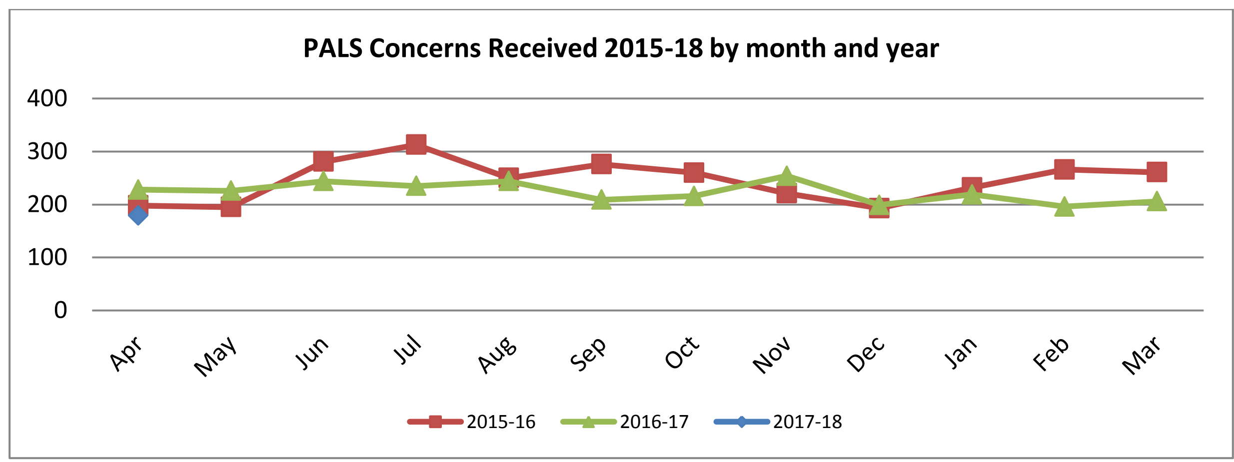


	Clinical Support	Medicine	Surgery	Family and Women's	Corporate
number of open complaints	3	20	20	9	0
number closed within 40 days	0	16	10	9	0
% closed within 40 days	0	80	50	100	0

As can be seen, this remains unacceptable performance and each Health Group's performance against this standard will now be monitored weekly by the Chief Nurse, with progress against this standard monitored at 25, 30, 35, 40 and beyond 40 days. Performance action will be taken should this prove to be necessary if the situation does not improve.

The Patient Experience Team is working closely with the Health Groups to progress complaints in a timely manner and has produced guidance to assist staff in achieving this target.

5.2 Patient Advice and Liaison Service (PALS)
In the month of April 2017, PALS received 179 concerns, 23 compliments, 84 general advice issues and 1 comment/suggestion. The majority of concerns continue to be regarding delays, waiting times and cancellations.



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

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Waiting times and Cancellation	Discharge	Environment	Hotel Services	Safeguarding	Treatment	Total
Corporate Functions	0	2	0	0	0	0	2	1	0	1	6
Clinical Support - Health Group	0	1	0	4	6	0	0	0	0	5	16
Family and Women's Health Group	0	4	3	7	16	1	0	0	0	19	50
Medicine - Health Group	4	6	1	8	20	3	1	0	1	10	54
Surgery - Health Group	1	5	1	6	28	1	1	0	0	10	53
Totals:	5	18	5	25	70	5	4	1	1	45	179

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 8 cases under review by the PHSO currently. During April there has been one new case opened, one new request for information and one case not upheld.

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

The Patient Experience Team is working closely with a new partner, Elephant Kiosk, to re-launch the Friends and Family Test at Hull and East Yorkshire Hospitals NHS Trust.

The Trust's Friends and Family results for April for all areas, excluding the Emergency Department, indicate that there was a decrease in the number of responses for the month of April 2017 with 3,276 responding, compared to March when the Trust received 4,879 responses. From these though, **97.07%** were extremely likely/likely to recommend the Trust to friends and family.

5.5.2 Emergency Department (ED)

The Trust is now collecting the ED Friends and Family test results by two different methods, paper and SMS text messaging. This has resulted in a significant increase in the response rate from 7.5% of attendances to 25**%.**

69 patients responded by the paper feedback method. Of these, **78.26%** said they were extremely likely/likely to recommend ED to friends and family. **11.59%** said they were extremely unlikely/unlikely to recommend.

When using SMS text messaging, **87.18%** of patient gave positive feedback and **7.34%** gave negative feedback.

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

5.7 Interpreters

The Patient Experience team is currently reviewing the provision of interpreters across the Trust in order to provide a more efficient and cost effective means of meeting the needs of patients who are not proficient in the English language. The use of iPads to provide voice translation has been piloted successfully with the Community Midwives for the past two years. It has identified many advantages such as being instantly available and does not involve a third party, which helps to protect patient confidentiality. This has given some patients the confidence to speak out regarding safeguarding issues that may not have been revealed with an interpreter present, as they may be known by the family/local community. The disadvantage of the iPad is that there are areas across the Trust with poor internet connection.

iPads can also be used for British Sign Language (BSL) interpretation using a Skype-type function to provide remote visual contact with a BSL interpreter within a few minutes when required. This will be particularly helpful in emergency situations and when an interpreter is required intermittently during a patient's admission. The Patient Experience team is exploring this option.

In circumstances when the iPad is not functional, the next option would be telephone interpretation, which is suitable for most consultations and ward -based requirements. It is acknowledged that some situations will require a face to face interpreter to be present such as when breaking bad news of terminal illness or when a consultation is expected to last more than 30 minutes. In these circumstances, a face to face interpreter will be approved by the Patient Experience Team.

6. CARE QUALITY COMMISSION (CQC)

6.1 Well Led Domain pilot

The Trust has been asked by the CQC to participate in a pilot of its new inspection regime, looking at the well-led domain and use of resources assessments. The pilot will involve NHS Improvement and the inspection will take place in 19 and 20 June 2017. It is understood that this will comprise 5 CQC inspectors and 3 NHSI inspectors and will involve mainly interviews with senior staff and a review of information. As this is a pilot, the Trust will receive a report for its own learning but this will not be published. Also, any rating allocated to the pilot will not impact the Trust's official CQC ratings. Nonetheless, this will be a useful learning opportunity for all involved.

7. OTHER QUALITY UPDATES

7.1 Venous Thromboembolism Risk Assessments (VTE)

The Trust's performance in relation to the VTE risk assessments in May 2017 is overall 91.87% (95% target). This is an improving picture and work to roll out the newly designed drug charts, which will assist with VTE assessment and prescribing, continues.

7.2 Claims/Coroners Report

There had been 280 potential clinical claims received in 2016/17, which is compared with 279 for the same period last year. The expenses for legal services continue to increase. The contribution assessment for the clinic risk pooling scheme has been set at £5.88m for maternity service and £14.81m for general services for 2017/18. This is an increase of £0.41m and £1.3m respectively when compared with the contribution in 2016/17. This is a similar picture in many trusts.

Health Groups are beginning to look at their claims profiles in much more detail in order to understand what preventative actions can be taken to prevent a recurrence.

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

May 2017

Appendix One: Safety Thermometer – May 2017

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

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

= Harmfreecare

SAFETY THERMOMETER NEWSLETTER May 2017

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 12th May both hospital sites. 892 patients were surveyed

93.4% 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.

2.24% (20) 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

97.76% 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 Oct 16 – May 17

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17	April 17	May 17
Harm Free Care %	94.7%	94.5%	95.8%	95%	94.6%	94.3%	93.5%	93.4%
Sample: Number of patients	896	930	890	843	953	896	882	892
Total Number of New Harm	18	16	11	14	15	23	11	20
NEW HARM FREE CARE %	98%	98.2%	98.6%	98.3%	98.5%	97.4%	98.7%	97.7%

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	8	0.90%	4	4	0

	Number	%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	814	91.2%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	55	6.1%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	23	2.5%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	44	4.93%	33	8	3
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.	35	3.92%	24	8	3
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	9	1.01%	9	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)	9	1.01%
Severity **No Harm**: fall occurred but with no harm to the patient	7	0.79%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.22%
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	**144**	**16.14%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**5**	**0.56%**	**3.4%**
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu **An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital**	**4**	**0.45%**	**2.7%**
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu **An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital**	**1**	**0.11%**	**0.6%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 9th June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	6th June 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 May 2017 (March 2017 position).

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

This report presents the 'safer staffing' position as at 30th April 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: Allocate e-roster software & HEY Safety Brief). This appendix now includes some of the new metrics that is understood will be included in Lord Carter's Model Hospital dashboard, when this is made available with up to date information. These additions are: Care Hours Per Patient Day (CHPPD), annual leave allocation, sickness rates by ward and nursing and care assistant vacancy levels by ward.

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[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*

[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing

[3] When Trust Boards meet in public

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

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

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%
Oct-16	88.51%	100.79%	90.58%	106.38%
Nov-16	91.30%	97.10%	95.70%	107.30%
Dec-16	91.23%	100.10%	97.00%	100.76%
Jan-17	93.00%	103.50%	99.10%	101.10%
Feb-17	90.10%	98.10%	94.80%	100.30%
Mar-17	86.80%	95.90%	89.60%	102.10%
Apr-17	85.20%	97.61%	89.15%	102.19%

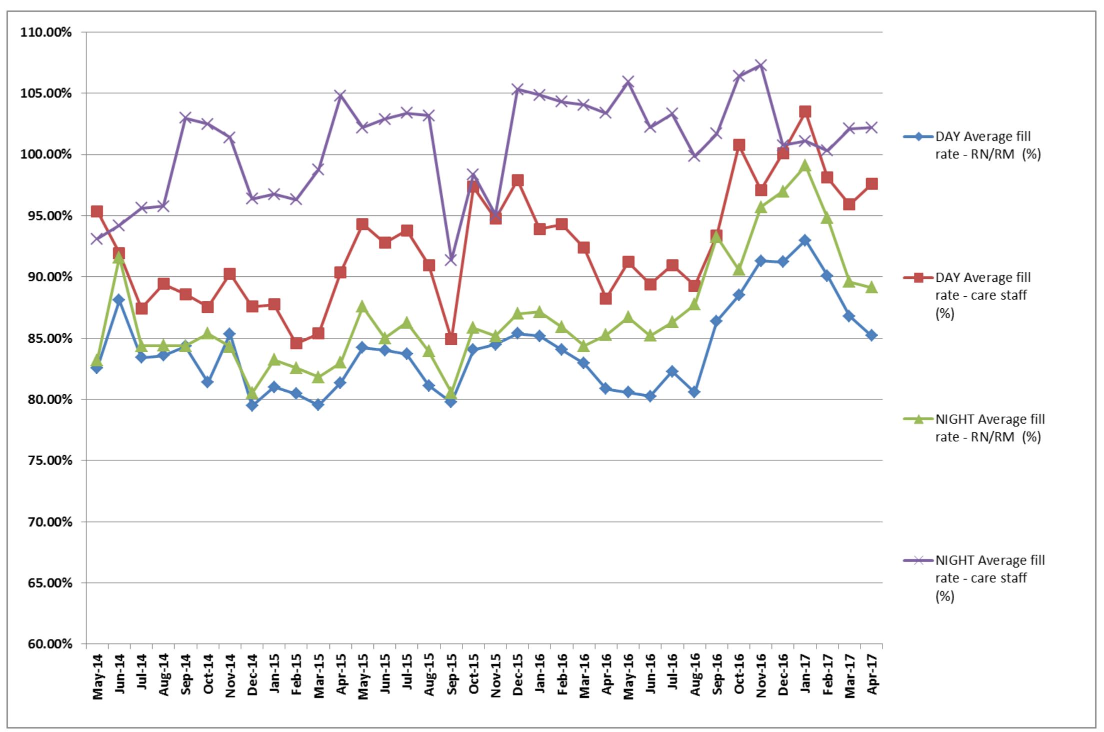
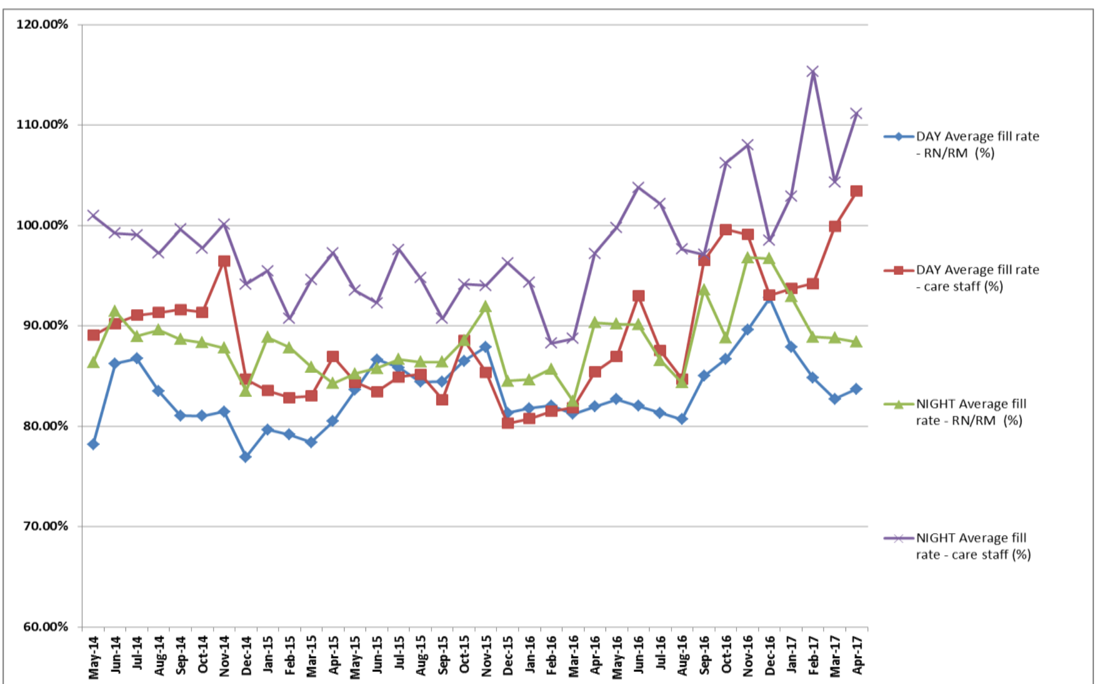


Fig 2: Castle Hill Hospital

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%



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

- Inpatient vacancy rates which are approximately circa of 120 wte Registered Nurses (RN)
- Winter Ward
- Sickness levels increased from 4.9% the previous month to 5.3% during April.
- There is also some compensation with HCA's being recruited to help fill RN vacancy gaps
- The needs for some patients to have 1:1 supervision due to their care needs

Work continues with recruitment for Registered Nurses.145 student nurses are currently being pursued by the Trust from the University of Hull. A further two recruitment exercises have been undertaken which has resulted in 12 student nurses from other Universities being pursued.

In addition, the Trust is currently exploring with the University of Hull the possibility of increasing the number of student placements in September 2017 by a further 50 places. The Trust is currently exploring its capacity to provide mentorship to support additional student placement

From the perspective of the Trusts International Recruitment campaign the Trust has successfully interviewed 61 candidates from the Philippines with further interviews scheduled. The first interviews took place in February 2017. Two of these candidates are due to join the Trust in June with further deployment scheduled for August/September subject to the candidates securing NMC authorisation, visa's and completing their notice periods. It is intended that each deployment will consist of between 10 and 20 nurses.

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

The Trust is completing its' internal preparations to ensure an effective and thorough induction takes place and that the recruits are supported in relation to completing their OSCE which will allow them to fully register with the NMC. The induction will include for example support to find accommodation, open bank accounts and register with GP's.

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, this process will be monitored closely over the next few months.

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]. Red Flags essentially portray a delay/omission in care (as illustrated

[4]Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) - *nice.org.uk/guidance/sg1*

below) or a 25% shortfall in Registered Nurse Hours or less than 2 RN`s present on a ward during any shift. There is also the opportunity to develop locally agreed Red Flags; this is illustrated below through the addition of `Security Watch` as a Red Flag. They are designed to support the Nurse in charge of the shift to systematically assess 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 currently on the ward. If a nursing red flag event occurs, it should prompt an immediate escalation response by the registered nurse in charge. An appropriate response may be to allocate additional nursing staff to the ward.

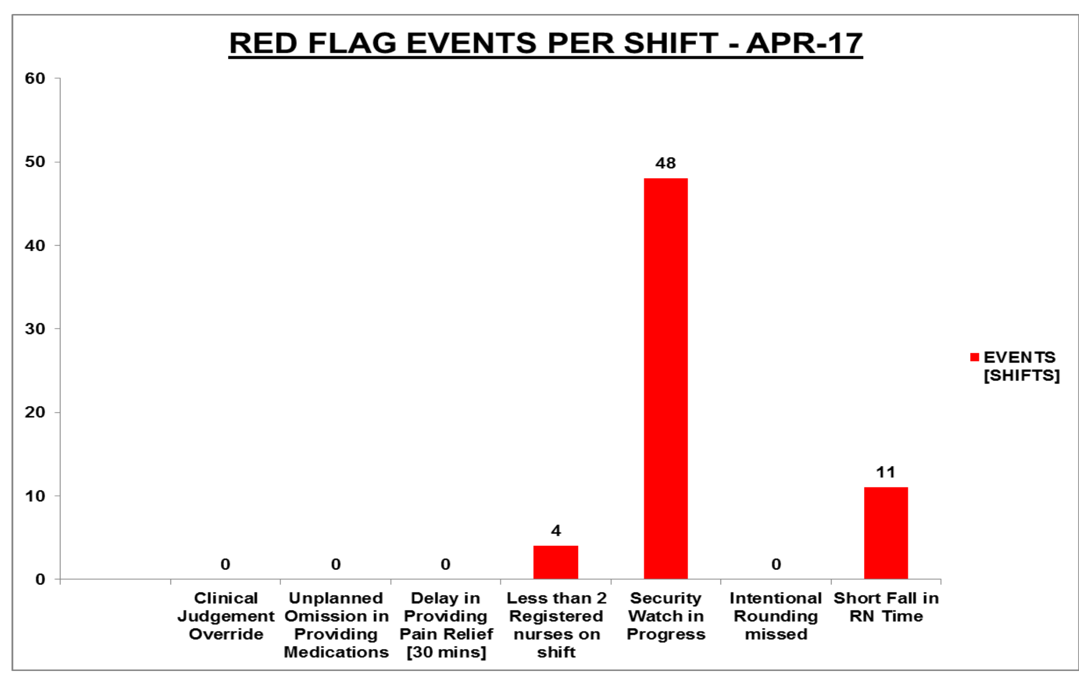
In addition it is important to keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or other appropriate action.

Red Flags as identified by National ICE (2014).

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - 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 April. Please note that the Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time.

RED FLAG TYPE	EVENTS (SHIFTS)	%
Unplanned Omission in Providing Medications	0	0
Delay in Providing Pain Relief (30 mins)	0	0
Less than 2 Registered Nurses	4	6
Security Watch in Progress	48	76
Intentional Rounding missed	0	0
Shortfall in RN time	11	18
TOTAL	**63**	**100**



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

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

- **H11** have 5.32 RN vacancies, the impact of this shortfall is supported by part time staff working extra hours, bank shifts and over filling of auxiliary shifts. There are also newly appointed RNs that will join the ward in October. The Senior Matron is reviewing the position continuously with the ward sister.

- **Emergency Department - Registered Nurse Staffing** Having only recently recruited to almost full establishment last autumn, the Department has 15.44 wte vacancies. The recruitment drive continues in ED with the Senior Matron attending national events to actively recruit students. There continues to be a steady flow of recruitment with a further 3.0 wte. being pursued who are external to the Trust. This is a slightly improved position in Registered Nurses in post, though it is recognised there is still a significant vacancy factor. In order to mitigate the challenges in this department, the Teacher/Practitioner and lead Band 7 staff are rostered into the care delivery numbers regularly. Discussions are underway with the nurse bank to try and maximise its support, also. It is likely that some shifts may need to be put out to agencies if they cannot be filled in other ways, although this will be kept to an absolute minimum. There has been a noted increase in attendance as a result of robust absence management by the Senior Nurses within the Department.

- **H70 (Diabetes and Endocrine)** has 10.49 wte RN vacancies and 1.24 wte non-registered nurse vacancies. This ward is supported in the interim by moving staff from Cardiology and Renal to assist from within the Medical Health Group. Support has also been provided from each of the other Health Groups, therefore reducing the current vacancies to 5 wte. In addition, from May 1st 2017, 2 wte pool nurses are joining the team for a six month period. Staffing across the health

group is balanced daily to help manage any risk. In addition, a Band 6 nurse will be seconded to the ward for a six month period to ensure there is continuation of senior nurse cover including weekends.

- **H11** although H 11has 5.95 wte RN vacancies, it is the view of the Senior Nursing team that the reduced fill rates seen during the month of April are predominantly due to a change in the current rota tool which has subsequently been resolved.

- **Ward C16 (ENT, Plastics and Breast Surgery)** has 4.16 wte RN vacancies and 4.22 wte non-registered vacancies at present. The RN vacancies were all successfully appointed to, with a view to reaching a fully recruited position in September 2017. However, despite some detailed work supported by HR, aimed at improving the retention figures, 2 more staff have since handed in their notice. In order to support the Ward, short term plans have been agreed to provide temporary cover. In addition to this, 2.0 wte RN Agency nurses are being used currently to bridge this gap, which is a cost pressure, but essential to maintain patient safety.

- **Neonatal Intensive Care Unit (NICU).** Recruitment in this specialty has been a concern, and there are currently 10.33 wte RN vacancies. All of these posts have been recruited to, and the staff will join us in September 2017, following completion of their training. The staffing in the interim is being managed closely by the senior matron, with staff being flexed across all paediatric inpatient and outpatient areas according to patient need. The Health Group is looking at ways in which we can improve the retention of the staff in this specialty.

- **Ward H4 -** Neurosurgery has 3.96 wte RN and 0.81 wte non-registered nurse vacancies, the ward is being supported by H40.

- **Ward H7 -** Vascular Surgery has 5.48 wte RN vacancies. This group of patients often require specialist dressings. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.

- **Ward C9 -** Elective Orthopaedic Surgery has 4.53 wte RN and 1.14 wte non-registered nurse vacancies. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 5.41 wte RN registered nurse vacancies. The nursing staff are flexed between C10 and C11.

6. TWICE YEARLY REVIEW OF NURSING AND MIDWIFERY (N&M) ESTABLISHMENTS

The National Quality Board guidance requires trusts to review N&M establishments a minimum of twice a year in order to ensure that these are appropriate and relevant to meet the current needs/acuity of patients. This was last undertaken in October 2016. The process is undertaken by senior nurses and midwives alongside sisters, charge nurses and heads of finance. The guidance requires trusts to use a validated establishment tool, where available, alongside professional judgement in determining required establishments. This process was concluded during April 2017 and is presented in Appendix 2.
As indicated in Appendix 2, information obtained using the SNCT appears to present a shortfall of 13.6 wte (cell p55). This is largely as a consequence of nurses

assessing patient`s acuity incorrectly, this is an identified problem in many Trusts and work is underway with the Senior Matrons and Sisters/Charge nurses. This is why the professional view that is undertaken is pivotal and necessary in order to validate this information. As such the information in column p should be treated with caution.

In reviewing the budgets the following issues have been resolved

- Consistency in terms of how the uplift for annual leave, sickness and study leave are allocated and treated
- Consistency with how annual leave and bank holiday entitlement are calculated and allocated

Any budget anomalies have been resolved within the agreed and available financial envelope. Even where the establishment review is indicating that additional investment is required, these anomalies will be managed from within existing budgets. As such, no additional corporate investment is required and establishments are set and financed appropriately.

7. 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. To date, this is showing the following:

7.1 Surgery Health Group

The following tables summarize the Nursing Sickness Levels across each of the four Health Groups during April 2017.

Surgery Health Group Nursing & Midwifery Apr - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	6.18%	4.92%
% Long Term	4.36%	3.24%
% Short Term	1.82%	1.68%
No. Sickness Hearings	4	1
Of which resulted in dismissal	2	1

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 review per ward and department with Senior Matron and HR advisor
- Senior Matron for Staffing & Discharge Rota
- All Nurses on Long-term sick have been reviewed in line with the Trust attendance policy
  Review complete of all Nursing staff currently on the policy
- Action to ensure all staff have a referral to Occupational Health

- Confirmation at Sister / Charge Nurse Level of assurance of managing attendance as per policy

As a result of the actions taken there are scheduled a further 4 sickness hearings planned for April – May 2017.

7.2 Medicine Health Group

Medicine Health Group Nursing & Midwifery Apr - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	4.61%	4.24%
% Long Term	1.15%	1.45%
% Short Term	3.36%	2.79%
No. Sickness Hearings	2	4
Of which resulted in dismissal	1	2

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. This is kept on an action plan and actions followed up with the Sisters accordingly each month. This action plan also contains a rolling month on month attendance level for their area so that they can assess their performance and whether this is improving or not. The HR Advisors also review individuals with the managers to ensure staff are appropriately managed 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.

7.3 Family and Women's Health Group

Family & Women's Health Group Nursing & Midwifery Apr - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	3.86%	4.97%
% Long Term	2.39%	3.36%
% Short Term	1.47%	1.61%
No. Sickness Hearings	1	6
Of which resulted in dismissal	1	6

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 will provide additional scrutiny and challenge to the current processes at departmental level. The Senior Matrons are also reviewing historical management, along with the HR Business partner for the Health Group, of staff who have been managed on the Managing Attendance Policy for some time, to ensure effective and robust management is in place. 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.

7.4 Clinical Support Health Group

Clinical Support Health Group Nursing & Midwifery Apr - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	6.15%	3.31%
% Long Term	4.03%	1.87%
% Short Term	2.12%	1.54%
No. Sickness Hearings	5	0
Of which resulted in dismissal	4	0

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

7.5 Trust Wide

The Band 7 ward sister/charge nurses are all enrolled on the corporate training programme where additional training for the management of attendance is planned. This will include in depth training and understanding of the policy and training on how to write effective referrals to the Occupational Health department and effective management cases where escalation to panel is planned.

A corporate training programme is currently under development for the Senior Matrons who will 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 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. It is hoped that this will add a level of challenge and seniority to the management of absence out of hours.

8. SUMMARY

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

balances the risks across the organisation. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses The new information that is now presented by ward will enable each of these to be scrutinised more closely to ensure that all reasonable efforts are being taken to deploy staff efficiently and, also, manage sickness/absence robustly.

9. 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
May 2017

Appendix 1: HEY Safer Staffing Report – May 2017

Appendix 2: HEY Ward Establishment Review April 2017

APPENDIX 1

HEY SAFER STAFFING REPORT APRIL-17

NURSE STAFFING | FILL RATES | CARE HOURS PER PATIENT DAY [CHPPD] [hrs] | ROTA EFFICIENCY [20-03-17 to 16-04-17] | NURSING VACANCIES [FINANCE LEDGER M1] | HIGH LEVEL QUALITY INDICATORS *[which may or may not be linked to nurse staffing]*

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	ANNUAL LEAVE [11-17%]	SICK RN & AN [3.9%]	MAT LEAVE [%]	RN [WTE]	AN [WTE]	TOTAL [WTE]	% [<10%]	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	FALLS: MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED	ACUTE MEDICINE	NA	1									14.2%	5.1%	4.5%	15.44	0.14	15.58	13.5%				3	1		1	2						0	5
	AMU	ACUTE MEDICINE	45	0	92%	83%	94%	95%	1048	5.0	2.9	7.9	13.6%	4.4%	4.7%	7.12	1.70	8.82	13.1%	100%		1	2	1			1						0	4
	H1	ACUTE MEDICINE	22	4	84%	84%	95%	99%	606	2.5	2.2	4.7	15.5%	11.5%	0.0%	4.63	-0.55	4.08	12.6%	100%		1			1		1						0	2
	EAU	ELDERLY MEDICINE	21	0	94%	97%	89%	128%	576	3.8	3.7	7.4	12.7%	3.7%	5.2%	2.04	0.13	2.17	9.6%	100%				1			1						0	1
	H5 / RHOB	RESPIRATORY	26	0	84%	93%	97%	95%	574	5.0	3.1	8.1	15.6%	11.0%	0.0%	3.33	1.24	4.57	12.1%	100%		1					0				1	1	2	3
	H50	RENAL MEDICINE	19	2	89%	101%	101%	100%	544	3.2	2.2	5.4	12.6%	7.6%	5.7%	4.16	1.93	6.09	20.9%	100%			1				0						0	1
	H500	RESPIRATORY	24	2	80%	105%	98%	100%	685	2.3	2.7	4.9	11.0%	5.3%	4.7%	-0.29	0.23	-0.06	-0.3%	100%							0						0	0
	H70	ENDOCRINOLOGY	30	0	86%	146%	79%	109%	866	2.4	2.4	4.9	8.4%	8.9%	0.0%	10.49	1.24	11.73	36.4%	100%	1	1	1		1		1						0	4
	H8	ELDERLY MEDICINE	27	33	77%	110%	98%	104%	788	2.3	2.4	4.6	10.9%	5.3%	2.0%	1.63	-2.39	-0.76	-2.6%	96%	1	1		1			1						0	3
	H80	ELDERLY MEDICINE	27	0	91%	104%	104%	102%	804	2.3	2.3	4.5	13.3%	6.2%	0.0%	0.91	0.11	1.02	3.4%	100%	2	1		2			2						0	5
	H9	ELDERLY MEDICINE	31	0	88%	102%	100%	102%	906	2.1	2.0	4.2	13.1%	2.5%	0.0%	2.22	-1.36	0.86	2.9%	100%		1		1	2		3		1				1	5
	H90	ELDERLY MEDICINE	29	0	86%	107%	100%	103%	862	2.1	2.2	4.3	12.8%	9.0%	9.1%	3.03	-2.77	0.26	0.9%	100%				1	1		2				1		1	3
	H11	STROKE / NEUROLOGY	28	11	68%	140%	91%	98%	841	2.1	2.0	4.2	16.6%	5.1%	0.0%	5.95	-0.63	5.32	16.0%	100%	2						0						0	2
	H110	STROKE / NEUROLOGY	24	1	83%	123%	100%	106%	504	4.2	3.1	7.3	13.1%	4.6%	8.4%	2.48	0.64	3.12	9.3%	95%				1			1		1				1	2
	CDU	CARDIOLOGY	9	0	87%	51%	88%		118	9.1	1.1	10.2	13.3%	1.6%	0.0%	-0.21	0.23	0.02	0.1%	100%							0						0	0
	C26	CARDIOLOGY	26	2	82%	95%	81%	110%	750	3.7	1.7	5.4	14.3%	3.0%	5.3%	0.34	2.19	2.53	7.5%	100%				3			3		1				1	4
	C28 /CMU	CARDIOLOGY	27	0	80%	104%	86%	89%	706	6.1	1.6	7.7	14.9%	6.2%	5.8%	1.91	-0.11	1.80	3.8%	100%	2	1		1			1		1				1	5
SURGERY	H4	NEURO SURGERY	30	0	85%	98%	90%	98%	715	3.2	2.0	5.2	17.7%	5.6%	5.3%	3.96	0.81	4.77	14.8%	100%		1					0						0	1
	H40	NEURO HOB / TRAUMA	15	0	90%	104%	83%	105%	335	6.3	4.3	10.6	16.0%	3.3%	3.3%	2.67	-0.59	2.08	6.7%	100%							0	1					1	1
	H6	ACUTE SURGERY	28	0	91%	92%	84%	200%	694	3.1	2.4	5.5	17.2%	3.9%	6.4%	2.07	-0.10	1.97	6.6%	100%							0		1				1	1
	H60	ACUTE SURGERY	28	0	100%	90%	95%	137%	722	3.3	2.0	5.3	10.0%	2.9%	3.3%	-0.04	-1.37	-1.41	-4.9%	94%		1	2				0						0	3
	H7	VASCULAR SURGERY	30	0	88%	78%	90%	102%	838	2.8	2.5	5.3	13.4%	6.9%	2.9%	5.48	-1.20	4.28	12.2%	100%	1	1					0						0	2
	H100	GASTROENTEROLOGY	24	2	86%	100%	88%	100%	793	2.4	2.0	4.4	15.6%	2.4%	3.3%	1.27	-0.63	0.64	2.1%	100%				1			1		1				1	2
	H12	ORTHOPAEDIC	28	1	81%	96%	85%	118%	689	3.0	2.9	5.9	16.7%	7.7%	5.7%	3.16	-0.95	2.21	6.3%	95%		1	1	1			1		2				2	5
	H120	ORTHO / MAXFAX	22	0	91%	115%	96%	112%	516	4.1	3.3	7.4	13.3%	2.3%	0.0%	1.40	-0.43	0.97	3.4%	100%		1	2				0		2		1		3	6
	HICU	CRITICAL CARE	22	0	84%	158%	82%	70%	443	26.2	1.7	27.9	17.8%	5.1%	3.1%	6.96	0.31	7.27	6.5%	100%				1			1	1					1	2
	C8	ORTHOPAEDIC	18	0	79%	89%	74%	57%	158	5.4	3.1	8.5	17.2%	10.6%	0.0%	2.19	-2.03	0.16	1.1%	100%							0		2		2		4	4
	C9	ORTHOPAEDIC	29	1	82%	98%	85%	98%	598	3.4	2.6	5.9	13.9%	2.4%	0.0%	4.53	1.14	5.67	18.4%	100%	1						0		1				1	2
	C10	COLORECTAL	21	0	81%	90%	82%	111%	404	4.5	2.6	7.1	15.3%	5.5%	0.0%	5.41	-0.41	5.00	19.2%	94%	1						0		1				1	2
	C11	COLORECTAL	22	0	85%	88%	84%	119%	506	3.9	2.2	6.1	15.0%	5.6%	0.0%	0.60	0.88	1.48	5.7%	100%		1					0						0	1
	C14	UPPER GI	27	1	88%	98%	88%	123%	650	3.4	2.0	5.4	15.6%	4.5%	0.0%	2.94	-1.75	1.19	4.0%	92%			1	1			1						0	2
	C15	UROLOGY	26	0	82%	88%	90%	85%	588	4.4	2.3	6.6	19.1%	4.8%	0.0%	0.00	0.00	0.00	0.0%	100%	1			1			1						0	2
	C27	CARDIOTHORACIC	26	0	89%	97%	94%	107%	757	3.7	1.5	5.2	11.1%	3.8%	8.8%	1.31	-1.03	0.28	0.9%	100%				1			1						0	1
	CICU	CRITICAL CARE	22	0	79%	84%	83%	73%	397	23.5	1.9	25.4	15.2%	4.5%	7.0%	3.21	-0.15	3.06	3.0%	100%		1					0						0	1
	C16	ENT / BREAST	30	0	81%	124%	122%	91%	244	8.4	5.1	13.5	16.5%	5.5%	0.0%	4.16	3.22	7.38	24.90%	100%			3				0					1	1	4
FAMILY & WOMEN'S	H130	PAEDS	20	0	89%	62%	93%	78%	374	7.1	1.0	8.1	14.7%	3.6%	8.3%	-1.55	2.02	0.47	1.80%	100%							0						0	0
	H30 CEDAR	GYNAECOLOGY	9	0	82%	74%	105%		117	11.4	3.7	15.1	16.9%	8.6%	0.0%	-1.00	0.12	-0.88	-3.90%	100%		1					0						0	1
	H31 MAPLE	MATERNITY	20	0	88%	95%	104%	100%	286	7.9	4.8	12.7	15.6%	0.9%	1.8%	5.91	2.85	8.76	12.3%	100%							0						0	0
	H33 ROWAN	MATERNITY	38	0	85%	90%	91%	102%	584	5.2	2.9	8.1	12.8%	6.6%	1.0%					100%	1						0						0	1
	H34 ACORN	PAEDS SURGERY	20	0	86%	81%	99%	107%	341	7.1	1.9	9.0	17.4%	2.7%	0.0%	-1.10	-0.50	-1.60	-6.20%	100%							0						0	0
	H35	OPHTHALMOLOGY	12	0	79%	81%	109%		237	7.8	2.0	9.8	11.0%	10.8%	5.8%	-0.54	1.53	0.99	4.80%	100%			1				0						0	1
	LABOUR	MATERNITY	16	0	88%	87%	95%	82%	314	16.4	5.8	22.2	14.0%	7.4%	4.0%	-8.68	-4.38	-13.06	-20.50%	100%		2					0						0	2
	NEONATES	CRITICAL CARE	26	0	84%	105%	76%	103%	521	12.0	1.3	13.3	13.7%	8.1%	8.6%	9.43	0.38	9.81	13.70%	100%			1				0		1				1	2
	PAU	PAEDS	10	0	100%		97%		91	15.6	0.0	15.6	16.4%	5.5%	0.0%	0.12	0.00	0.12	1.10%	100%							0				1		1	1
	PHDU	CRITICAL CARE	4	0	102%	104%	100%		64	22.7	2.1	24.8	11.5%	5.1%	0.0%	-0.14	0.00	-0.14	-1.20%	100%							0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	1	98%	92%	100%	100%	426	3.5	2.4	5.8	16.2%	6.2%	0.0%	0.47	-0.18	0.29	1.5%	100%							0						0	0
	C29	REHABILITATION	15	0	86%	141%	100%	300%	444	3.3	5.1	8.4	14.1%	4.6%	0.0%	-0.04	4.31	4.27	14.9%	100%							0						0	0
	C30	ONCOLOGY	22	0	91%	105%	96%	102%	626	2.8	1.9	4.7	17.8%	6.1%	3.2%	0.05	-0.02	0.03	0.1%	93%		1					0						0	1
	C31	ONCOLOGY	27	0	86%	116%	99%	109%	742	2.4	2.0	4.4	13.7%	3.1%	0.0%	-0.42	1.26	0.84	3.3%	100%		2	1	1			1						0	4
	C32	ONCOLOGY	22	0	93%	106%	100%	105%	565	3.0	2.0	5.0	14.7%	2.0%	3.2%	1.02	0.07	1.09	5.0%	96%							0		1		2		3	3
	C33	HAEMATOLOGY	28	1	84%	161%	87%	146%	612	4.4	2.5	6.9	17.6%	2.0%	5.2%	0.44	-2.84	-2.40	-6.8%	95%		1	1	3			3						0	5
			TOTAL:	63				AVERAGE:	551	6.1	2.5	8.6	14.5%	5.3%	2.8%	120.43	2.31	122.74	6.8%	100%			2	2										
														TOTALS:					TOTALS:	50	13	22	20	23	5	1	29	2	16	0	8	2	28	112

Apr-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	85.2%	97.6%	89.1%	102.2%	18940	4.6	2.5	7.1
CHH SITE	83.7%	103.4%	88.4%	111.2%	9291	4.8	2.3	7.1

APPENDIX 2

HEY WARD STAFFING ESTABLISHMENT REVIEW - APRIL 2017

GENERAL INFORMATION				CURRENT ESTABLISHMENT [Budgeted WTE] [1]			CURRENT IN POST [WTE]			CURRENT VACANCIES [WTE]					ESTABLISHMENT REVIEW [Mar-17] [Includes additional 0.6 WTE for supervisory] [2]	VARIANCE [1] - [2] [Headcount WTE] [Negative = shortfall]	PROFESSIONAL VIEW [WTE]			REQUIREMENT (WTE)			EXTRA BUDGET REQUIRED [£] [Inclusive of 22% uplift]			COMMENTS [Reasons for variances, decision, etc.]
HEALTH GROUP	WARD / DEPT	BEDS	SPECIALITY	RN	Non-RN	TOTAL	RN	Non-RN	TOTAL	RN	Non-RN	TOTAL	%	VALIDATED STAFFING TOOL			RN	Non-RN	TOTAL	RN	Non-RN	TOTAL	Extra RN	Extra Non-RN	TOTAL	
MHG	ED	NA	Acute Medicine	93.31	22.03	115.34	77.87	21.89	99.76	15.44	0.14	15.58	13.5%	NICE	115.59	-0.25	93.31	22.03	115.34	0.00	0.00	0.00	0	0	£0.00	
MHG	AMU	45	Acute Medicine	44.19	23.38	67.57	37.07	21.68	58.75	7.12	1.70	8.82	13.1%	SNCT	67.57	0.00	44.19	23.38	67.57	0.00	0.00	0.00	0	0	£0.00	
MHG	EAU	21	Elderly	19.11	13.16	32.27	14.48	13.71	28.19	4.63	-0.55	4.08	12.6%	SNCT	31.99	0.28	19.11	13.16	32.27	0.00	0.00	0.00	0	0	£0.00	
MHG	H1	22	Acute Medicine	14.57	7.94	22.51	12.53	7.81	20.34	2.04	0.13	2.17	9.6%	SNCT	22.77	-0.26	14.57	7.94	22.51	0.00	0.00	0.00	0	0	£0.00	
MHG	H5 + HOB	26	Respiratory	24.68	13.16	37.84	21.35	11.92	33.27	3.33	1.24	4.57	12.1%	SNCT	36.31	1.53	24.68	13.16	37.84	0.00	0.00	0.00	0	0	£0.00	
MHG	H500	24	Respiratory	16.96	12.14	29.10	12.80	10.21	23.01	4.16	1.93	6.09	20.9%	SNCT	30.81	-1.71	16.96	12.14	29.10	0.00	0.00	0.00	0	0	£0.00	
MHG	H50	19	Renal	15.11	8.43	23.54	15.40	8.20	23.60	-0.29	0.23	-0.06	-0.3%	SNCT	22.87	0.67	15.11	8.43	23.54	0.00	0.00	0.00	0	0	£0.00	
MHG	H70	30	Endocrinology	20.06	12.16	32.22	9.57	10.92	20.49	10.49	1.24	11.73	36.4%	SNCT	33.15	-0.93	19.53	13.16	32.69	-0.53	1.00	0.47	-16,324	20,300	£3,976.00	
MHG	H8	27	Elderly	16.62	13.16	29.78	14.99	15.55	30.54	1.63	-2.39	-0.76	-2.6%	SNCT	31.59	-1.81	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	H80	27	Elderly	16.62	13.16	29.78	15.71	13.05	28.76	0.91	0.11	1.02	3.4%	SNCT	30.58	-0.80	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	H11	28	Neurology / Stroke	22.52	10.64	33.16	16.57	11.27	27.84	5.95	-0.63	5.32	16.0%	SNCT	33.15	0.01	22.52	10.64	33.16	0.00	0.00	0.00	0	0	£0.00	
MHG	H110	24	Stroke	22.52	11.12	33.64	20.04	10.48	30.52	2.48	0.64	3.12	9.3%	SNCT	33.12	0.52	22.52	11.12	33.64	0.00	0.00	0.00	0	0	£0.00	
MHG	H9	31	Elderly	16.62	13.16	29.78	14.40	14.52	28.92	2.22	-1.36	0.86	2.9%	SNCT	31.65	-1.87	16.62	14.86	31.48	0.00	1.70	1.70	0	34,510	£34,510.00	need to review in relation to enhanced care team
MHG	H90	29	Elderly	16.62	13.16	29.78	13.59	15.93	29.52	3.03	-2.77	0.26	0.9%	SNCT	32.15	-2.37	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	C26	26	Cardiology	25.79	7.94	33.73	25.45	5.75	31.20	0.34	2.19	2.53	7.5%	SNCT	34.40	-0.67	25.79	7.94	33.73	0.00	0.00	0.00	0	0	£0.00	
MHG	C28 + CMU	27	Cardiology	38.18	9.60	47.78	36.27	9.71	45.98	1.91	-0.11	1.80	3.8%	SNCT	45.16	2.62	38.18	9.60	47.78	0.00	0.00	0.00	0	0	£0.00	
MHG	CDU	11	Cardiology	12.82	2.92	15.74	13.03	2.69	15.72	-0.21	0.23	0.02	0.1%	SNCT	16.32	-0.58	12.82	2.92	15.74	0.00	0.00	0.00	0	0	£0.00	
SHG	HICU	22	Critical Care	104.88	7.32	112.20	97.92	7.01	104.93	6.96	0.31	7.27	6.5%	ICS	112.17	0.03	104.88	7.32	112.20	0.00	0.00	0.00	0	0	£0.00	
SHG	H4	30	Neurosurgery	21.84	10.44	32.28	17.88	9.63	27.51	3.96	0.81	4.77	14.8%	SNCT	33.68	-1.40	21.84	10.44	32.28	0.00	0.00	0.00	0	0	£0.00	
SHG	H40	15	Neurosurgery	20.47	10.44	30.91	17.80	11.03	28.83	2.67	-0.59	2.08	6.7%	SNCT	29.72	1.19	20.47	10.44	30.91	0.00	0.00	0.00	0	0	£0.00	
SHG	H6	26	Acute Surgery	19.11	10.63	29.74	17.04	10.73	27.77	2.07	-0.10	1.97	6.6%	SNCT	31.42	-1.68	19.11	11.46	30.57	0.00	0.83	0.83	0	16,849	£16,849.00	additional shift to support night rota required as per professional view
SHG	H60	26	Acute Surgery	19.11	9.63	28.74	19.15	11.00	30.15	-0.04	-1.37	-1.41	-4.9%	SNCT	29.86	-1.12	19.11	11.46	30.57	0.00	1.83	1.83	0	37,149	£37,149.00	additional shift to support night rota required as per professional view
SHG	H7	29	Vascular	21.84	13.16	35.00	16.36	14.36	30.72	5.48	-1.20	4.28	12.2%	SNCT	33.56	1.44	21.84	13.16	35.00	0.00	0.00	0.00	0	0	£0.00	
SHG	H12	28	Orthopaedic	21.84	13.16	35.00	18.68	14.11	32.79	3.16	-0.95	2.21	6.3%	SNCT	34.47	0.53	21.84	13.16	35.00	0.00	0.00	0.00	0	0	£0.00	
SHG	H120	22	MaxFax / Ortho	16.96	11.80	28.76	15.56	12.23	27.79	1.40	-0.43	0.97	3.4%	SNCT	29.55	-0.79	16.96	11.80	28.76	0.00	0.00	0.00	0	0	£0.00	
SHG	H100	23	Gastroenterology	18.71	11.80	30.51	17.44	12.43	29.87	1.27	-0.63	0.64	2.1%	SNCT	31.44	-0.93	18.71	11.80	30.51	0.00	0.00	0.00	0	0	£0.00	
SHG	CICU	22	Critical Care	92.94	7.56	100.50	89.73	7.71	97.44	3.21	-0.15	3.06	3.0%	ICS	103.28	-2.78	92.94	7.56	100.50	0.00	0.00	0.00	0	0	£0.00	
SHG	C8	18	Orthopaedic	10.47	3.97	14.44	8.28	6.00	14.28	2.19	-2.03	0.16	1.1%	SNCT	13.35	1.09	10.47	3.97	14.44	0.00	0.00	0.00	0	0	£0.00	
SHG	C9	29	Orthopaedic	19.24	11.54	30.78	14.71	10.40	25.11	4.53	1.14	5.67	18.4%	SNCT	30.17	0.61	19.24	11.54	30.78	0.00	0.00	0.00	0	0	£0.00	
SHG	C10	21	Colorectal	18.25	7.83	26.08	12.84	8.24	21.08	5.41	-0.41	5.00	19.2%	SNCT	25.43	0.65	18.25	7.83	26.08	0.00	0.00	0.00	0	0	£0.00	
SHG	C11	22	Colorectal	18.25	7.83	26.08	17.65	6.95	24.60	0.60	0.88	1.48	5.7%	SNCT	26.51	-0.43	18.25	7.83	26.08	0.00	0.00	0.00	0	0	£0.00	
SHG	C14	27	Upper GI	20.33	9.16	29.49	17.39	10.91	28.30	2.94	-1.75	1.19	4.0%	SNCT	27.80	1.69	20.33	9.16	29.49	0.00	0.00	0.00	0	0	£0.00	
SHG	C15	26	Urology	19.91	10.44	30.35	19.91	10.44	30.35	0.00	0.00	0.00	0.0%	SNCT	39.13	-8.78	19.91	10.44	30.35	0.00	0.00	0.00	0	0	£0.00	
SHG	C27	26	Cardiothoracic	23.60	8.62	32.22	22.29	9.65	31.94	1.31	-1.03	0.28	0.9%	SNCT	31.45	0.77	23.60	8.62	32.22	0.00	0.00	0.00	0	0	£0.00	
F&W	H30	9	Gynaecology	16.70	5.64	22.34	17.70	5.52	23.22	-1.00	0.12	-0.88	-3.9%	SNCT	19.41	2.93	16.70	5.64	22.34	0.00	0.00	0.00	0	0	£0.00	Incorporates EPAU and Day Surgery
F&W	H31+H33	57	Maternity	46.26	25.08	71.34	40.56	22.65	63.21	5.91	2.85	8.76	12.3%	BRP	73.24	-1.90	46.26	25.08	71.34	0.00	0.00	0.00	0	0	£0.00	
F&W	H34	20	Paediatric	20.78	5.22	26.00	21.88	5.72	27.60	-1.10	-0.50	-1.60	-6.2%	PV	27.55	-1.55	20.78	5.22	26.00	0.00	0.00	0.00	0	0	£0.00	
F&W	H35	12	Ophthalmology	15.06	5.36	20.42	15.60	2.83	18.43	-0.54	1.53	0.99	4.8%	SNCT	19.24	1.18	15.06	5.36	20.42	0.00	0.00	0.00	0	0	£0.00	Incorporates Day Surgery
F&W	H130	20	Paediatrics	21.37	5.22	26.59	22.92	3.20	26.12	-1.55	2.02	0.47	1.8%	PV	26.67	-0.08	21.37	5.22	26.59	0.00	0.00	0.00	0	0	£0.00	
F&W	L&D	19	Maternity	50.13	13.46	63.59	58.81	17.84	76.65	0.00	0.00	0.00	0.0%	BRP	63.59	0.00	50.13	13.46	63.59	0.00	0.00	0.00	0	0	£0.00	Rotational Posts through Community
F&W	NICU	26	Critical Care	66.58	5.22	71.80	57.15	4.84	61.99	9.43	0.38	9.81	13.7%	PV	73.04	-1.24	66.58	5.22	71.80	0.00	0.00	0.00	0	0	£0.00	
F&W	PAU	10	Paediatric	10.44	0.00	10.44	10.32	0.00	10.32	0.12	0.00	0.12	1.1%	PV	10.92	-0.48	10.44	0.00	10.44	0.00	0.00	0.00	0	0	£0.00	
F&W	PHDU	4	Paediatric	11.66	0.00	11.66	11.80	0.00	11.80	-0.14	0.00	-0.14	-1.2%	PV	14.71	-3.05	11.66	0.00	11.66	0.00	0.00	0.00	0	0	£0.00	
F&W	C16	30	ENT / Breast	18.51	11.14	29.65	14.35	7.92	22.27	4.16	3.22	7.38	24.9%	SNCT	26.42	3.23	18.51	11.14	29.65	0.00	0.00	0.00	0	0	£0.00	
CS	C20	15	Infectious Disease	11.66	7.94	19.60	11.19	8.12	19.31	0.47	-0.18	0.29	1.5%	SNCT	18.41	1.19	11.66	7.94	19.60	0.00	0.00	0.00	0	0	£0.00	
CS	C29	15	Rehabilitation	13.07	15.66	28.73	13.11	11.35	24.46	-0.04	4.31	4.27	14.9%	SNCT	22.13	6.60	13.07	15.66	28.73	0.00	0.00	0.00	0	0	£0.00	
CS	C30	22	Oncology	13.89	7.94	21.83	13.84	7.96	21.80	0.05	-0.02	0.03	0.1%	SNCT	21.18	0.65	13.89	7.94	21.83	0.00	0.00	0.00	0	0	£0.00	
CS	C31	27	Oncology	13.89	11.69	25.58	14.31	10.43	24.74	-0.42	1.26	0.84	3.3%	SNCT	25.16	0.42	13.89	11.69	25.58	0.00	0.00	0.00	0	0	£0.00	
CS	C32	22	Oncology	13.89	7.94	21.83	12.87	7.87	20.74	1.02	0.07	1.09	5.0%	SNCT	22.03	-0.20	13.89	7.94	21.83	0.00	0.00	0.00	0	0	£0.00	
CS	C33	28	Haematology	27.28	7.94	35.22	26.84	10.78	37.62	0.44	-2.84	-2.40	-6.8%	SNCT	35.14	0.08	27.28	7.94	35.22	0.00	0.00	0.00	0	0	£0.00	
	TOTALS:	1165		1295.22	508.04	1803.26	1175.00	505.15	1680.15	129.11	6.69	135.80	7.5%		1811.01	-7.75	1294.69	513.40	1808.09	-0.53	5.36	4.83	-16324.00	108808.0	£92,484.00	

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY ACCOUNTS 2016/17

Trust Board date	06 June 2017		**Reference Number**	2017 – 5 - 10	
Director	Sarah Bates, Deputy Director Quality Governance and Assurance/Assistant Chief Nurse		**Author**	Leah Coneyworth, Compliance Team Manager	
Reason for the report	The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2016/17 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication.				
Type of report	Concept paper		Strategic options		Business case
	Performance		Information	✓	Review

1	**RECOMMENDATIONS** The Trust Board is requested to: • Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication. • Note the key dates detailed in section 3 of this report					
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): Regulation 17 – Good Governance					
	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
QUALITY ACCOUNTS 2016/17

1. PURPOSE OF THE PAPER

The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2016/17 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication.

2. QUALITY ACCOUNTS

The Quality Committee and the Trust Board approved the first draft of the Quality Accounts for distribution to key stakeholders on 02 May 2017. The key stakeholders are the main commissioners (NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group), Healthwatch Hull, Healthwatch East Riding of Yorkshire, Hull Overview and Scrutiny Committee (OSC) and East Riding OSC.
The stakeholders have 30 days to provide a 500 word statement each on the content of the Quality Accounts. The deadline for the stakeholders to return their statements is Friday 02 June 2017. Once all statements have been received the Trust will respond with its statement, all of which will be included in the Quality Accounts before publication.

3. NEXT STEPS

- March to June – internal audit to be undertaken an assessment to ensure the Trust has met all requirements before publishing the quality accounts
- 02 June 2017 - deadline for the stakeholder statements to be returned
- 05 June 2017 – the Compliance Team will review the statements, consider any suggested amendments and respond with the Trust statement
- 06 June 2017 – Trust Board to provide delegated responsibility to the Quality Committee for final ratification and approval before publication
- 26 June 2017– submit the final version to the Quality Committee for final sign off before for publication
- 30 June 2017 – publication of the 2016/17 Quality Accounts on NHS Choices and send to the Secretary of State and NHS England in adherence to the legal requirements

4. RECOMMENDATIONS

The Trust Board is recommended to:

- Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication.
- Note the key dates detailed in section 3 of this report

Leah Coneyworth
Compliance Team Manager
June 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY IMPROVEMENT PROGRAMME PROGRESS REPORT
APRIL 2017

Trust Board date	6 June 2017		**Reference Number**	2017 – 6 - 11	
Director	Kevin Phillips – Chief Medical Officer		**Author**	Leah Coneyworth – Compliance Manager	
Reason for the report	To update the Board regarding the Quality Improvement Programme.				
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	✓

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY IMPROVEMENT PROGRAMME PROGRESS REPORT
APRIL 2017

Programme Title: Quality Improvement	Executive Lead: Chief Medical Officer / Chief Nurse Programme Lead: Head of Compliance

Overall Programme Objectives:
The Objectives of the Quality Improvement Programme are to:
- Aid in the achievement of the Trust's overall ambition to meet its vision: Great Staff, Great Care, Great Future
- Deliver Trust wide quality improvement based on the priorities identified through programmes such as the Quality Accounts, Sign Up to Safety and CQC inspections
- Address MUST and SHOULD do actions identified by the CQC

Overall delivery of programme	Current Overall Rating	G

Overview:
The QIP Overall is currently rated as Green. The QIP was fully reviewed at the end of March 2017 and re-launched. Progress to date has been as expected and significant work has commenced with the Improvement Academy through the Measuring and Monitoring of Safety Framework.

Key activity during April 2017:
- First training sessions held by the Improvement Academy with key members of the QIP Team to develop the Measuring and Monitoring of Safety Framework.
- All projects have been reviewed and re-launched for the 2017-18 programme.

Current Position:
- 12 projects currently rated Green
- 8 projects currently rated Amber/Green
- No projects rated below Amber / Green

Areas for Escalation:
None

Project Overview	Overall – RAG	Current Month - RAG	Comments
QIP02 – Learning Lessons	G	G	This project is currently rated as Green. Significant progress was made with this project during 2016-17 with emphasis on communication methods. During 2017-18 the focus will be on embedding the learning across the Trust which will include taking part in phase 2 of the Improvement Academy Measuring and Monitoring of Safety Framework (MMSF).
QIP04 – Safeguarding, MCA and DOLs	A/G	A/G	The project is rated as amber/green due to the transferring of a number of milestones from the 2016/17 quality improvement plan to the 2017/18 plan for delivery. The project is being closely monitored by the Safeguarding Committee.
QIP05 – Medicines Management	A/G	A/G	The project is rated as amber/green because it has been carried forward onto the 2017/18 quality improvement plan for further improvement work to be undertaken and to further improve the medicine reconciliation rates within 24 hours of admission.
QIP08 – Infection Control	G	G	This project is currently rated Green. This project is

			predominantly on track to deliver to timescales with the exception of the milestone in relation to the placement of hand hygiene posters on all wards which has been slightly delayed.
QIP10 – Pressure Ulcers	G	G	This project is currently rated as Green. During 2016-17 the project did not meet all of its aims, objectives and performance targets. A review has been undertaken to ensure this project meets the needs of our patients. To assist the project with achieving the aims and objectives a project has commenced with the Improvement Academy on the Measuring and Monitoring of Safety Framework.
QIP11 – Maternity and Gynaecology	A/G	A/G	This project is rated as amber/green due to the non-compliance with the swab count audit and the delivery of the learning lessons DVD training. These requirements have been transferred onto the 2017/18 quality improvement plan for further auditing and assurance that the improvements made have been embedded.
QIP12 – Children & Young People with Mental Health needs and CAMHS	A/G	A/G	This project is rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan to continue with improving the management of children and young people are who are admitted with mental health concerns, full implementation of the mental health risk assessment and compliance with the quarterly audit and to achieve stronger relationships with external partners.
QIP14 - VTE	A/G	A/G	This project has been rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan for further improvements to be made and for continued monitoring of the VTE assessment target.
QIP15 – Sepsis	G	G	This project is currently rated Green. This project has been reopened for 2017-18 with a change to the aims and objectives in order to consolidate the work that was undertaken in 2016-17. In addition, the national CQUIN has changed and the performance indicators for this project have been altered accordingly. The team will also be involved in the quality improvement programme, Measurement and Monitoring of Safety Framework (MMSF) delivered by the Improvement Academy during the year.
QIP22 – Nutrition	G	G	This project is currently rated Green. The project has commenced well with a number of actions completed to support the delivery of the overall QIP. The trust has reviewed the food and hydration chart completion process and made a number of changes which will support the accurate completion of these charts. Further details of this process is detailed below. Performance data is not available for April as the monthly census will commence in May 2017.
QIP23 – Dementia	G	G	This project was carried forward from the Trusts quality improvement plan of 2016/2017. Although Dementia was not on the 2017/18 plan, the lead nurse wished to build upon the previous year's achievements and continue to focus on embedding the Dementia Strategy across the Trust, including growth in an understanding of the John's campaign and improved adherence to the Dementia and Delirium screening pathway. All milestones set for this period were completed and the RAG rating for the project is Green.

QIP24 – Children & Young People Services	A/G	A/G	This project is rated as amber/green due to slight delay in the delivery of a number of milestones from the 2016/17 quality improvement plan. These have been transferred onto the 2017/18 plan for delivery.
QIP28 – Patient Experience & Complaints	G	G	This project is included in the Trusts quality improvement plan for 2017/18. The Project Lead confirms that implementation of the Patient Experience Strategy continues with work undertaken towards the completion of future milestones. There were no milestones for completion during this period. Performance against target set for the period is awaited at the time of reporting. The overall rating for the project is Green.
QIP30 – Avoidable Mortality	G	G	This project is currently rated as Green. This project has been carried forward from 2016-17. Significant work was undertaken during 2016-17 including the appointment of the Clinical Outcome Manager for the Trust. This gave the project leadership and direction which instigated a strategic review of the processes in place within the Trust to undertaken comprehensive structured case note reviews.
QIP34 – Critical Care	G	G	This project is currently rated Green. The project has started well in the first month with good progress made on the recruitment campaign for vacant consultant posts and the production of a business case for 4 advanced practitioners. There has been some concern highlighted by the lead in relation to this milestone which is detailed below. There has been some slippage with the planned audit commencement, which has been reflected in the milestone forecast finish date however significant preparations have been completed this period for the audit.
QIP35 – Interventional Checklist Compliance	A/G	A/G	The project is rated amber/green due to the delay in the delivery of the milestones from 2016/17 and the transfer of them onto the 2017/18 plan for delivery. Good progress has been made against the milestones to date. All the milestones due in April 2017 have been completed and progress updates have been provided for a number of the other milestones due at a later stage.
QIP36 – Transition from Children to Adult Services	A/G	A/G	The project is rated amber/green due to the delay in the delivery of the milestones from 2016/17 and the transfer of them onto the 2017/18 plan for delivery. Good progress has been made against the milestones to date. All the milestones due in April 2017 have been completed and progress updates have been provided for a number of the other milestones due at a later stage.
QIP37 – ReSPECT	G	G	This is a new quality improvement project for 2017/18. The project is rated as green because the project is new on the 2017/18 quality improvement plan. The milestones due for delivery in April were delivered and the target is on-track to be achieved.
QIP38 – Consent	G	G	This project is rated as green because this is a new quality improvement project for 2017/18 and is on-track for delivery.
QIP39 - Outpatients	G	G	This project is currently rated Green. This project has been developed in response to actions and concerns identified from the CQC Inspections in 2015 and 2016 particularly the governance of Outpatient Services. The 2017/18 QIP will focus on the establishment of a trustwide governance committee and providing several learning resources and opportunities for staff members

			working in any outpatient areas for learning lessons and incident management.

Blue	Milestone successfully achieved
Green	Successful delivery of the project is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly.
Amber/Green	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present the project to overrun.
Amber/Red	Successful delivery is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and to determine whether resolution is feasible.
Red	Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable.

QIP02 – LEARNING LESSONS

Project title: QIP02 – Learning Lessons	**Project Lead: April Daniel**

Overall project objective(s):
The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safer Care and Treatment (12(2)(b) – doing all that is reasonably practicable to mitigate any such risks. This relates to not reviewing incidents in a timely manner and ensuring effective investigation. It also relates to ensuring learning from Never Events are disseminated and embedded.

Performance Targets:
- Baseline for cultural surveys determined.
- Improvement by year end against baseline culture survey

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated as Green. Significant progress was made with this project during 2016-17 with emphasis on communication methods. During 2017-18 the focus will be on embedding the learning across the Trust which will include taking part in phase 2 of the Improvement Academy Measuring and Monitoring of Safety Framework (MMSF).

Items for Escalation:
None

Risks to Delivery and Mitigating Actions:
None

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Baseline for cultural surveys determined	Survey Sent Out											
Improvement by year end against baseline culture survey												

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
The focus for this period has been to develop and commence implementation of the 2017-18 QIP. Progress has been made on starting a project with the Improvement Academy and the Health Foundation on the introduction of the Measuring & Monitoring of Safety Framework. A core team has been established including leads from the corporate team, mortality, sepsis, pressure ulcers and deteriorating patient. The first training session was attended on 3rd April 2017 and follow up internal meetings have subsequently been held. Wards have been identified to work with and these are C20 and H80. To start the work, a behaviour and cultural survey was undertaken with the wards.

In addition the Risk Manager as the lead for the project in 2016-17 and the Head of Compliance as the Compliance Team link met and reviewed the work undertaken during the 2016-17 project to ensure that work from the previous year had been completed and was embedded. It was determined that significant progress had been made with the project during the previous year and clear communication channels for learning were embedded across the organisation. Areas for further improvement had already been identified as part of the development of the 2017-17 project.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Behaviour and cultural surveys analysed and next steps determined	G	G	May 2017	May 2017	
2nd Improvement Academy Workshop Completed	G	G	May 2017	May 2017	16th May 2017
CIRCLE group re-launch	G	G	May 2017	May 2017	
Datix amended to include contributory factors which will be sued for themes and trends analysis	G	G	May 2017	May 2017	
Quality improvement training programme defined	G	G	June 2017	June 2017	Including Silver Level training for key team members from the IA
Quality Improvement Framework / Strategy developed	G	G	June 2017	June 2017	Draft framework has been developed.
Kitchen Table Event held (including Quality Accounts and Sign Up to Safety)	G	G	June 2017	June 2017	Packs for the kitchen table event have been ordered
3rd Improvement Academy Workshop Completed	G	G	June 2017	June 2017	26th June 2017
In-house investigation training package developed (RCA)	G	G	August 2017	August 2017	
Quality dashboard revised and launched	G	G	August 2017	August 2017	
Regional learning event with Improvement Academy held	G	G	September 2017	September 2017	9th September 2017
Re-launch of Sign Up to Safety	G	G	September 2017	September 2017	
Sharing the Learning Events held	G	G	September 2017	September 2017	
Quality Improvement Framework for 2017-18 completed	G	G	March 2018	March 2018	
Project areas (wards) behaviour and cultural survey completed	G	G	March 2018	March 2018	
1st Improvement Academy workshop completed	B	B	April 2017	April 2017	**Closed – April 2017** Training workshop attended on 3rd April 2017
Project areas (wards) determined for MMSF	B	B	April 2017	April 2017	**Closed – April 2017** Areas for improvement work identified. C20 and H8
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	B	B	April 2017	April 2017	**Closed – April 2017** Review undertaken by Risk Manager and Head of Compliance
Project areas (wards) behaviour and cultural survey completed	B	B	April 2017	April 2017	**Closed – April 2017** C20 and H80 identified

QIP04 – SAFEGUARDING, MCA AND DOLS

Project title: QIP04 - Safeguarding	**Project Lead: Kate Rudston**

Overall project objective(s):
The aim of this project is to build on the improvement work undertaken during 2016/17 and continue to further improve the safeguarding arrangements for Adults and Children.

Regulation Breaches / Requirement Notices:
Linked to a regulation breach. Regulation 13 (2) and (3) Safeguarding – systems and processes must be established and operated effectively to prevent abuse of service users and to effectively investigate, immediately upon aware of becoming aware of any allegations or evidence of such abuse. This is because there were a number of safeguarding children policies out of date, not all staff were trained to the required level 3 for safeguarding and the Trust did not have the facility to 'flag' where there were potential safeguarding concerns.

Targets:
- Achieve full implementation of the safeguarding improvement project (baseline - partially delivered in 2016/17)

Overall Delivery of the Project:

Summary of Project Delivery:
The project is rated as amber/green due to the transferring of a number of milestones from the 2016/17 quality improvement plan to the 2017/18 plan for delivery. The project is being closely monitored by the Safeguarding Committee.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
There are no risks identified.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Full implementation of the safeguarding improvement project	On-track											

Progress: April 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:
- The Chaperone Policy was reviewed and updated and the revised version has been circulated to all key staffing groups for consultation. Consultation closed 28 April 2017 and the draft is due to be approved at the May 2017 Safeguarding Committee.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Allegations against Staff for adult and children and young people policy developed and approved	A/G	A/G	August 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Adults at risk of suicide policy	A/G	A/G	October 2016	May 2017	This milestone has

developed and approved					been transferred from the 2016/17 quality improvement plan for delivery.
Absconding Children and Young People and Adults with lack of mental capacity policy developed and approved	A/G	A/G	October 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
End of Life Policy reviewed with a view to add a section on patients with Dementia and Learning Disabilities	A/G	A/G	November 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Allegations against Staff for adult and children and young people implemented	A/G	A/G	October 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Revised Chaperone Policy implemented	A/G	A/G	October 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Adults at risk of suicide policy implemented	A/G	A/G	December 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Absconding Children and Young People and Adults with lack of mental capacity policy implemented	A/G	A/G	December 2016	May 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Revised End of Life Policy implemented	A/G	A/G	January 2017	June 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Safe room in the Medical Assessment Unit created	A/G	A/G	October 2016	June 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
A protocol for transfer of care and clear process for staff to follow for delays in children receiving full medical examination following admission to Childrens wards developed and approved	A/G	A/G	October 2016	June 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
A protocol for transfer of care and clear process for staff to follow for delays in children receiving full medical examination following admission to Childrens wards implemented	A/G	A/G	November 2016	July 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	G	G	July 2017	July 2017	

Implementation of the improved recording and reporting of all patients detained under the Mental Health Act monitored and further action taken where appropriate	**A/G**	**A/G**	March 2017	August 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
ED staff to use safeguarding sheets (purple edge) for all children who have suspected NAI and safeguarding concerns	**A/G**	**A/G**	October 2016	September 2017	This milestone has been transferred from the 2016/17 quality improvement plan for delivery.
The use of safeguarding flags on the electronic patient records considered to establish if flags can be attached to the electronic patient record to identify the healthcare practitioner of key risks that would inform their approach during consultations/appointments/inpatient admissions	**G**	**G**	September 2017	September 2017	
Chaperone Policy reviewed, revised and updated	**B**	**B**	September 2016	April 2017	Closed – April 2017 Policy reviewed and updated. This milestone has been transferred from the 2016/17 quality improvement plan for delivery.

QIP05 – MEDICINES MANAGEMENT

Project title: QIP05 - Medicine Management	Project Lead: David Corral and Julie Randall

Overall project objective(s):
This project covers improvement areas identified in the Quality Accounts/Sign up to Safety, CQC inspection from February 2014, CQC re-inspection in May 2015 and comprehensive inspection in June 2016.

The overall aim of this project is to ensure a multi-disciplinary, person-centred approach to ensuring our patients receive the right medicines, at the right dose at the right time. This will be supported by an accurate record of medications on admission to the hospital by ensuring medicines are reconciled as soon as possible, ideally within 24 hours of admission. This will reduce the potential for harm and contribute to the delivery of a safe and effective medication process for our patients.

Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The HEY Medicines Reconciliation policy describes the processes that should be followed by both prescribers and pharmacy staff in order to ensure that accurate medicines reconciliation is undertaken for all patients on admission to hospital.

There are two levels of Medicines Reconciliation:

- Basic reconciliation (stage 1): obtaining an accurate drug history on admission in order to write an accurate drug chart, reflecting the patients medication requirements
- Full reconciliation (stage 2): undertaken by a pharmacist or pharmacy technician who has undergone appropriate training, resolving discrepancies and accurately recording any changes made to the patients medication regime

Basic reconciliation is done for all patients within 24 hours. However, at HEY medicines are only considered reconciled when the second stage 2 process is undertaken.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safe Care and Treatment (12.2.G – the proper and safe management of medicines). This relates to staff signing drug charts after the medication has been dispensed and not before to and the recording of medicine refrigerator temperatures daily and responding appropriately to those that fall outside of the recommended range and the records of the management of controlled drugs are accurately maintained and audited.

Targets:

- Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs (Baseline of 46%)
- Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time (Baseline of 81%)
- 10% reduction (1 hour 33 minutes) in the average waiting times for prescriptions dispensed in the hospital pharmacy (Baseline of 1 hour 43 minutes)
- Introduction of a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled (No baseline)

Overall Delivery of the Project

Summary of the Project Delivery:
The project is rated as amber/green because it has been carried forward onto the 2017/18 quality improvement plan for further improvement work to be undertaken and to further improve the medicine reconciliation rates within 24 hours of admission.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
It is important to recognise that medicines reconciliation for our patients at any time during their admission regularly reaches 80%. We have been able to recruit new staff (pharmacy traditionally has a cyclical recruitment trend) to increase staffing to the acute admissions units to improve our medicines reconciliation rate within 24 hours. We have also

commissioned enhanced reporting from Cayder which will allow us to obtain more accurate medicines reconciliation data, enabling us to easily identify patients who have not been reconciled on admission and to send a daily report highlighting these patients.

Performance Activity

Indicator	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sept 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**
Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs	Awaiting data											
Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	77.6%											
10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	1 hour and 40 minutes											
Introduction of a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled	On-track											

Progress: April 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:

- A meeting was held with the education and training lead nurse regarding the medicines management training plan for nursing staff. Currently awaiting feedback on next steps.
- Presented the discharge medication issues at Corporate Nurse PEES meeting as escalation for improvement to the nursing teams
- Appointment of project pharmacist
- Monthly medicines management meetings arranged with pharmacy and practice development matrons
- The Trust Discharge Policy has been reviewed and the first draft is available for consultation

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Embed, review and have a clear system of reporting and governance for: 1. The new monthly joint pharmacy/nursing medicines management ward checklist 2. The new weekly charge nurse monitoring checklist from the Chief Nurse	A/G	A/G	January 2017	May 2017	The milestone was carried forward from the 2016/17 quality improvement plan.
Medicine management clinical audit plan delivered	G	G	June 2017	June 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	G	G	June 2017	June 2017	
Content and monitoring systems for nurses medicines management training approved	A/G	A/G	July 2017	July 2017	The milestone was carried forward from the 2016/17 quality improvement plan.
Trust Discharge policy reviewed and updated	G	G	July 2017	July 2017	
Electronic prescribing on ward 29 at Queens Centre introduced	G	G	September 2017	September 2017	
Medication processes at discharge reviewed	A/G	A/G	March 2017	September 2017	The milestone was carried forward from the 2016/17 quality improvement plan.
'safety net' system introduced to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled	G	G	September 2017	September 2017	
Improvement project on Ward 9 at HRI undertaken with pharmacy support on the morning drug round to identify any drugs not available and facilitate ordering in a timely manner, measured by a reduction in missed doses.	G	G	October 2017	October 2017	
Reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	G	G	October 2017	October 2017	
Project to increase the use of patient's own drugs be undertaken on selected wards	G	G	March 2018	March 2018	
Reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs achieved	A/G	A/G	March 2017	March 2018	The milestone was carried forward from the 2016/17 quality improvement plan.
Dispensing errors reduced – improved environment	A/G	A/G	March 2017	March 2018	The milestone was carried forward from the 2016/17 quality improvement plan.
Trial of Pharmacists prescribing discharge medication completed	A/G	A/G	March 2017	March 2018	The milestone was carried forward from the 2016/17 quality improvement plan.

QIP08 – INFECTION CONTROL

Project title: QIP08 - Infection Prevention And Control	**Project Lead:** Director of Infection Prevention & Control (Dr Peter Moss), Infection Control Consultant (Dr Rolf Meigh) and Lead Nurse Infection Prevention & Control (Greta Johnson)

Overall project objective(s):
The aim of this project is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections.

Performance Targets:

- To have 0 Hospital acquired MRSA bacteraemia (baseline - 2)
- To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53 (baseline – 44)
- To continue to reduce the number of Hospital acquired MSSA to <=45 (baseline – 43)

  To continue to reduce the number of Hospital acquired E. Coli to <=95 (baseline – 67)

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. This project is predominantly on track to deliver to timescales with the exception of the milestone in relation to the placement of hand hygiene posters on all wards which has been slightly delayed.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
To have 0 Hospital acquired MRSA bacteraemia	Being Validated											
To reduce the number of Hospital acquired Clostridium Difficile to <=53	Being Validated											
To reduce the number of Hospital acquired MSSA to <=45	Being Validated											
To	Being Validate											

reduce the number of Hospital acquired E. Coli to <=95	d											

Progress – April 2017	RAG Status	G

Progress against Key Milestones this period:
The milestone in relation to the hand hygiene posters has been delayed slightly and as such the actual/forecast date has been changed to May 2017. Infection Prevention Control Lead Nurse has commenced preparations for the Health Economy Conference in May 2017. All other milestones are on track with no concerns highlighted in relation to delivery.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Individual 5 moments of hand hygiene posters in place on all wards	AG	AG	April 2017	May 2017	This milestone has been delayed and expected finish date has been amended to May 2017
Infection Prevention Control intranet content reviewed	G	G	May 2017	May 2017	
Continence management, catheter training and knowledge across Health Groups scoped to support reduction in catheter acquired infections	G	G	May 2017	May 2017	
Health Economy Conference on E.coli bacteraemia attended and presented by Infection Prevention Control Lead Nurse	G	G	May 2017	May 2017	
Surveillance data for July-and August 2016 and Jan- March 2017 analysed and trends/ differences in trends of Trust apportioned cases identified	G	G	May 2017	May 2017	
Infection Prevention Control risk matrix VIP chart updated	G	G	June 2017	June 2017	
Infection Prevention Control risk matrix VIP chart piloted in oncology	G	G	June 2017	June 2017	
Infection Prevention Control risk matrix VIP chart rolled out	G	G	June 2017	June 2017	
Barriers regarding compliance with sharps bin management identified e.g. physical / design / culture	G	G	June 2017	June 2017	
Action plan, based on surveillance data for July-and August 2016 and Jan- March 2017 findings, developed – e.g. CAUTI/ gram negative bacteraemia/ management of patients with biliary associated conditions	G	G	June 2017	June 2017	
The Infection Prevention & Control Practice in the Operating Department Policy developed	G	G	July 2017	July 2017	
Senior Matron / Site Coordinator resource folder published	G	G	July 2017	July 2017	
Theatre Discipline Policy developed	G	G	August 2017	August 2017	
Infection Prevention Control intranet content updated	G	G	August 2017	August 2017	
Catheter passport relaunched	G	G	August	August	

			2017	2017	
Review of recommendations from recent NICU Serious Incident complete and further milestones added in response to the recommendations	G	G	September 2017	September 2017	
The Infection Prevention & Control Practice in the Operating Department Policy ratified	G	G	October 2017	October 2017	
Options for amendment to existing sharps management with waste manager scoped	G	G	October 2017	October 2017	
Theatre Discipline Policy ratified	G	G	November 2017	November 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded -	G	G	December 2017	December 2017	
Fundamental Standard Audits completed in line with the Trust programme by IPC Team – frequency determined by audit result	G	G	March 2018	March 2018	
Annual PLACE inspections HRI/ CHH complete	G	G	March 2018	March 2018	
Infection Prevention Control ownership tool completed on a monthly basis by all wards	G	G	March 2018	March 2018	
Observational hand hygiene '5 moments' audit completed monthly	G	G	March 2018	March 2018	
Existing Infection Prevention Control education reviewed and recommendations for amendments developed	G	G	March 2018	March 2018	
Twice yearly Daniels audit completed and recommendations / actions developed	G	G	March 2018	March 2018	

QIP10 – PRESSURE ULCERS

Project title: **QIP 10 – Pressure Ulcers**	**Project Lead: Angie Oswald and Karen Harrison**

Overall project objective(s):
The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers. This project will aim to ensure that appropriate risk assessments, a plan of care highlighting required nursing interventions and meaningful evaluations are undertaken by knowledgeable staff, for every patient.

Regulation Breaches / Requirement Notices
None

Performance Targets:
- To have no avoidable hospital acquired Stage 3 pressure ulcers
- To have no avoidable hospital acquired Stage 4 pressure ulcers
- To have no more than 8 avoidable hospital acquired unstageable pressure ulcers
- To have no more than 23 avoidable hospital acquired SDTI
- To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers
- Compliance with 14 day completion of the root cause analysis investigation
- 100% compliance with duty of candour - written
- 100% compliance with duty of candour - verbal

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated as Green. During 2016-17 the project did not meet all of its aims, objectives and performance targets. A review has been undertaken to ensure this project meets the needs of our patients. To assist the project with achieving the aims and objectives a project has commenced with the Improvement Academy on the Measuring and Monitoring of Safety Framework.

Items for Escalation:
None identified

Risks to Delivery and Mitigating Action:
None identified

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
No AHA Stage 3 pressure ulcers	Being Validated											
No AHA Stage 4 pressure ulcers	Being Validated											
No more than 8 AHA unstageable pressure ulcers	Being Validated											
No more than 23 AHA SDTI	Being Validated											
25% reduction in the number of AHA stage 2	Being Validated											

pressure ulcers													
Compliance with 14 day completion of the root cause analysis investigation	Being Validated												
100% compliance with duty of candour - written	Being Validated												
100% compliance with duty of candour - verbal	Being Validated												

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
During this period the project has been reviewed by the team to ensure that all quality priority areas are included in the 2017-18 project. In addition the leads have attended the first Improvement Academy training workshop on the Measuring and Monitoring Safety Framework (MMSF). Subsequent meetings have been held with other leads within the Trust to identify wards that the pilot will commence on. C20 and H8 have been selected for the pilot and culture and behaviour surveys have begun to initiate the work.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
2nd Improvement Academy Workshop Completed	G	G	May 2017	May 2017	16th May 2017
3rd Improvement Academy Workshop Completed	G	G	June 2017	June 2017	26th June 2017
Tissue Viability Service quarterly HEY! Skin matters bulletin / newsletter developed to improve learning	G	G	June 2017	June 2017	
Lessons Learned reviews shared at each wound management committee	G	G	June 2017	June 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	G	G	June 2017	June 2017	
Tissue Viability service eLearning modules on pressure prevention equipment, PU / Wound healing and nutritional requirements developed	G	G	August 2017	August 2017	
Each clinical area to have a TVLN who attends the mandatory TVLN twice yearly study day (qualified & unqualified)	G	G	September 2017	September 2017	
Tissue Viability Service embedded pressure ulcer prevention cares with Hull University student nurses and midwives - intensive training provided	G	G	September 2017	September 2017	
Link nurse event regarding STP held	G	G	November 2017	November 2017	
100% completion of eLearning module by all available nursing staff providing direct patient care	G	G	March 2018	March 2018	

Each clinical area to demonstrate 100% of available staff having completed the bedside assessment	G	G	March 2018	March 2018	
1st Improvement Academy workshop completed	B	B	April 2017	April 2017	**Closed – April 20167 3rd April 2017**

QIP11 – MATERNITY AND GYNAECOLOGY

Project title: QIP11 - Maternity	**Project Lead: Mel Carr and Lorraine Cooper**

Overall project objective(s):
The aim of this project is to ensure the improvement work undertaken to address the areas for improvement identified following the June 2016 CQC inspection are embedded across the service.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 11 Need for Consent – this relates to ensuring that staff are knowledgeable about Gillick competence and the process for gaining consent from children under 16 years of age. Regulation 12 Safe Care and Treatment 12(2)(b) – doing all that is reasonably practicable to mitigate such risks. This relates to staff knowledge about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 17 Good Governance (2)(a) – assess, monitor and improve the quality and safety of services provided. This relates to ensuring antenatal consultant clinics have capacity in the scanning department to implement to Growth Assessment Protocol (GAP). Regulation 18 Staffing (18)(1) – sufficient numbers of suitably qualified, competent, skilled and experienced persons. This relates to the national guidelines of 1:28 midwifery staffing ratio and collection of data to evidence one to one care in labour.

Targets:
- 100% compliance with the daily swab count audit (Baseline of 94%)

Overall Delivery of the Project:

Summary of Project Delivery:
This project is rated as amber/green due to the non-compliance with the swab count audit and the delivery of the learning lessons DVD training. These requirements have been transferred onto the 2017/18 quality improvement plan for further auditing and assurance that the improvements made have been embedded.

Items for Escalation:
There are no items to escalate

Risks to Delivery and Mitigating Actions:
Non-compliance with the swab count audit. Further action is being taken to increase the number of obstetric staff attending the learning lessons event.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
100% compliance with the daily swab count audit	100%											

Progress: April 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:
- 224 out of 244 midwives have attended the learning lessons event for far. Midwives will continue to receive this training through YMET training days
- 14 doctors have attended the learning lessons event so far.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
All midwives and obstetric staff attended learning lessons event in	A/G	A/G	January	July 2017	This is a 12 monthly rolling programme which all staff

relation to the retained vaginal swab Never Event and learning lessons DVD			2017		attends. The milestone has been carried forward from the 2016/17 quality improvement plan for further monitoring.
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded across the service	**G**	**G**	July 2017	July 2017	
Continued auditing of the swab counts to ensure 100% is achieved	**G**	**G**	July 2017	July 2017	

QIP12 – CHILDREN & YOUNG PEOPLE WITH MENTAL HEALTH NEEDS AND CAMHS

Project title: QIP12 - Children and Young People with Mental Health Needs and CAMHS	Project Lead: Vanessa Brown

Overall project objective(s):
The Trust is required to improve its mental health support for Children and Young People within the Children's Emergency Department and on the 13th floor. The aim of this project is to improve the management of children and young people who have been admitted onto the 13th floor who are at risk of self-harm and suicidal intent.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safe Care and Treatment (12.2.A&B) – assessing the risks to health and safety of service users of receiving the care or treatment and doing all that is practicable to mitigate any such risks. This relates to the completion of mental health risk assessments for children and young people and taking action to mitigate any such risks. (12.2.C) – ensuring that persons providing care and treatment to service users have the qualification, competence, skills and experience to do safely. This relates to staff having the correct skills, competence and experience to provide safe care and treatment to children with mental health needs. (12.2.I) – where responsibility for the care and treatment of service users is shared or transferred to other persons, working with such other persons to ensure that timely care planning takes place. This relates to the children and young people service working closely with others internally and externally to make sure that care and treatment remains safe for children with mental health needs.

Targets
- To achieve 80% in Q1 and then rising to 100% by Q4 compliance with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm (Baseline of 25%)

Overall Delivery of the Project

Summary of Project Delivery:
This project is rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan to continue with improving the management of children and young people are who are admitted with mental health concerns, full implementation of the mental health risk assessment and compliance with the quarterly audit and to achieve stronger relationships with external partners.

Items for Escalation:
There are no items to escalate.

Risks to Delivery and Mitigating Actions:
Risks to delivery are the completion of the mental health risk assessments and engagement with external partners. Patient safety has not been affected and the service continues to monitor closely.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
To achieve 80% in Q1 and then rising to 100% by Q4 compliance with the completion of the individual Risk Assessments for Children	Q1 – to be reported in the July 2017 progress report			Q2 – to be reported in the October 2017 progress report			Q3 – to be reported in the January 2018 progress report			Q4 – to be reported in the April 2018 progress report		

and Young People at risk of self-harm				

Progress: April 2017	RAG Status	A/G

Progress against Key Milestones this period:

- The audit of the individual self-harm risk assessments has been registered onto the 2017/18 clinical audit plan for completion on a quarterly basis. Performance will be reported as detailed above.
- CAMHS continue to provide support to inpatients where required and continue to provide training on the Paediatric in-house study days

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	G	G	May 2017	May 2017	
Service level agreement developed and signed off to formalise the external support from CAMHS to HEYHT	A/G	A/G	February 2017	December 2017	Carried forward from the 2016/17 quality improvement plan for full completion.
Quarterly audits of the individual self-harm risk assessments completed, compliance assessed and any learning identified	A/G	A/G	March 2017	March 2018	Carried forward from the 2016/17 quality improvement plan for continuous monitoring.

QIP14 – VTE

Project title: QIP14 - Venous Thromboembolism (VTE) | **Project Lead: Ahmed Saleh**

Overall project objective(s):
The aim of this project is to ensure patients are appropriately risk assessed for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements.

Regulation Breaches / Requirement Notices:
None

Targets:
- Achieve 95% compliance with the VTE Risk Assessment (Baseline of 86.15% Q3)
- Maintain 0 VTE Serious Incidents (Baseline of 2)
- To increase the number of doctors completing the VTE e-learning module (Baseline of 986)

Overall delivery of the Project

Summary of Project Delivery:
This project has been rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan for further improvements to be made and for continued monitoring of the VTE assessment target.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
The risks to delivery are the non-compliance with the VTE risk assessment target of 95%. This was not achieved in 2015/16 and 2016/17.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 95% compliance with the VTE Risk Assessment	Q1 – to be reported in the July 2017 progress report			Q2 – to be reported in the October 2017 progress report			Q1 – to be reported in the January 2018 progress report			Q1 – to be reported in the April 2018 progress report		
Maintain 0 VTE Serious Incidents	0											
To increase the number of doctors completing the VTE e-learning module	20 completed (1006 in total)											

Progress: April 2017

RAG Status | **A/G**

Progress against Key Milestones this period:
There were no milestones for delivery in April 2017. Assurance received that all milestones are on track for delivery in line with the agreed timescales.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Lorenzo VTE 'live' database activated and implemented	**G**	**G**	May 2017	May 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	June 2017	June 2017	
24 hour VTE risk assessment form developed with the associated clinical assessment attached	**G**	**G**	September 2017	September 2017	
24 hour VTE risk assessment and clinical assessments implemented	**G**	**G**	October 2017	October 2017	
Compliance with NICE CG92 achieved	**A/G**	**A/G**	March 2017	March 2018	This milestone will be transferred onto then 2017/18 quality improvement plan for further action and monitoring.

QIP15 – SEPSIS

Project title: QIP15 - Sepsis	Project Lead: Kate Adams and Donna Gotts

Overall project objective(s):
The aim of this project is to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients leading to the implementation of the sepsis pathway across the organisation. The focus of the project will be on all patients meeting the new definition of sepsis, completing the sepsis 6 bundle within an hour.

Regulation Breaches / Requirement Notices
None

Performance Targets:
CQUIN Indicators:

- 2a – The percentage of patients who met the criteria for sepsis screening and were screened for sepsis (target 90%)
- 2b – The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour (target 90%).
- 2c - Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours (target 25% for Q1, 50% for Q2, 75% for Q3 and 90% for Q4)
- 2d – There are three parts to this indicator.

1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions
2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions
3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. This project has been reopened for 2017-18 with a change to the aims and objectives in order to consolidate the work that was undertaken in 2016-17. In addition, the national CQUIN has changed and the performance indicators for this project have been altered accordingly. The team will also be involved in the quality improvement programme, Measurement and Monitoring of Safety Framework (MMSF) delivered by the Improvement Academy during the year.

Items for Escalation:
None identified.

Risks to Delivery and Mitigating Actions:
None identified

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
2a	Being Validated											
2b	Being Validated											
2c	Being Validated											
2d.1	Being Validated											
2d.2	Being Validated											
2d.3	Being Validated											

Progress – April 2017	RAG Status	G

Progress against Key Milestones this period:
During April 2017 the team commenced a project with the Improvement Academy on the Measuring and Monitoring of Safety Framework (MMSF). The first training workshop was attended on the 3rd April and subsequent meetings have taken place with the other project leads within the Trust to determine which wards will be used to pilot the framework on. Wards H8 and C20 have been selected. Behaviour and cultural surveys have commenced with the wards and analysis is being undertaken by the Improvement Academy.

In preparation for the start of the 2017-18 programme, the leads for the project, with the Head of Compliance as the corporate link undertook a review of the activity that had been undertaken during the 2016-17 programme. Significant work was undertaken during the year and performance against the key indicators proved that the work that had been undertaken was becoming embedded across the Trust. Further improvement activity has been identified and included in the programme for 2017-18. In addition, it should be noted that the Sepsis Leads were nominated for a Learning Lessons Golden Hearts award for the significant improvements that were made in year.

Further work towards future indicators has also been undertaken including interviews taking place for a second sepsis nurse.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Second Sepsis Nurse recruited	G	G	May 2017	May 2017	Interviews taken place in April 2017
2nd Improvement Academy Workshop Completed	G	G	May 2017	May 2017	16th May 2017
Second Sepsis Nurse in post	G	G	June 2017	June 2017	
3rd Improvement Academy Workshop Completed	G	G	June 2017	June 2017	26th June 2017
Sepsis Intranet site developed	G	G	September 2017	September 2017	Carried forward from 2017-18
Sepsis pathway embedded in all areas of the organisation	G	G	March 2018	March 2018	Carried forward from 2017-18
Sepsis training programme completed	G	G	March 2018	March 2018	
Awareness raised within the community with GPs, Midwives and Nurses	G	G	March 2018	March 2018	Workshops and Training to be held
Awareness raised with HEY midwives	G	G	March 2018	March 2018	Focused training to be delivered
Awareness raised with HEY medical staff	G	G	March 2018	March 2018	Focused training to be delivered
1st Improvement Academy workshop completed	B	B	April 2017	April 2017	**Closed – April 2017** Workshop attended - 3rd April 2017
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	B	B	April 2017	April 2017	**Closed – April 2017** Review undertaken

QIP22 – NUTRITION

Project title: QIP22 - Nutrition and Hydration	Project Lead: Steve Jessop (Chair of Nutrition Steering Group), Trish Prady (Senior Matron Surgery Health Group), Tina McDougal (Head of Dietetics)

Overall project objective(s):
Nutrition and hydration is an essential element of patients' care. Adequate nutrition and hydration helps to sustain life and good health and it also reduces the risk of malnutrition and dehydration while they are receiving care and treatment in hospital and provides patients with the nutrients they need to recover.

The aim of this priority is to ensure patients have an appropriate personal nutritional needs assessment completed and receive an appropriate care plan or referral to a dietician where required.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 14 Meeting Nutritional and Hydration needs. This relates to the completion of patients food diaries and fluid balance charts. Charts were not always completed and therefore it was not possible to monitor whether their needs were being met.

Performance Targets:
- 100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration (quarterly)
- 85% of wards achieve compliance with the monthly census audit for fluid balance management *(available from May 2017)*
- 85% of wards achieve compliance with the monthly census audit for flood and hydration chart *(available from May 2017)*

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. The project has commenced well with a number of actions completed to support the delivery of the overall QIP. The trust has reviewed the food and hydration chart completion process and made a number of changes which will support the accurate completion of these charts. Further details of this process is detailed below. Performance data is not available for April as the monthly census will commence in May 2017.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration												
85% of												

wards achieve compliance with the monthly census audit for fluid balance management												
85% of wards achieve compliance with the monthly census audit for flood and hydration chart												

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
Head of Dietetics and the Trust's Practice Development Matron have reviewed the current food and hydration charts and process, including the nutrition care plan, and made changes in line with feedback received from Charge Nurses. All Charge Nurses at Castle Hill have been consulted and trained on this amended process and are trialling the documentation. It is expected that all Charge Nurses at the Hull Royal Infirmary site will be trained within May 2017. Supporting documentation, such as step-by-step guides, have been produced to support this process. The QIP leads are aiming for trustwide roll-out within the following three months. Charge Nurses will support the rollout of this amended documentation by providing cascade training however this plan is yet to formally be agreed at Nursing Exec level. The review of fundamental standards questions may be brought forward as these will need to be in line with the amended process as detailed above. Several additional Nutrition Apprentices are planned to be recruited to, this is expected for June 2017. The Trust's fluid balance chart is now on e-obs at the Castle Hill site therefore bespoke training will be provided at this site for fluid balance. Three additional milestones have been included, the first relates to the QIP leads providing an update on the QIP at the Trust's Quality Committee and the review and ratification of the Nutrition and Hydration Policy which requires updating to reflect the changes to the process and documentation.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Baseline data from monthly ward census audits established	**G**	**G**	May 2017	May 2017	*Census date is 5th May 2017*
QIP leads attended Trust Board's Quality Committee to detail QIP progress and update on Nutrition and Hydration	**G**	**G**	May 2017	May 2017	***New Milestone – April 2017 (added to overall QIP)*** *Quality Committee scheduled for 31st May 2017. QIP leads to attend to provide progress against QIP*
Nutrition and Hydration Policy reviewed	**G**	**G**	June 2017	June 2017	***New Milestone – April 2017 (added to overall QIP)*** *This milestone has been added as amendments are required due to change in process*

Additional milestones which are required based on the baseline data from the monthly ward census audits identified	**G**	**G**	June 2017	June 2017	
Review of questions within the Nutrition and Hydration Fundamental standard to ensure the questions asked provide the relevant assurance that the Trust processes are being followed complete	**G**	**G**	July 2017	July 2017	*This will be required in light of the revised nutrition and hydration chart, process and care plan*
Nutrition and Hydration Policy ratified	**G**	**G**	August 2017	August 2017	***New Milestone – April 2017 (added to overall QIP)*** *This milestone has been added as amendments are required due to change in process*
Fluid balance training package delivered on all relevant wards by Trust Teacher Trainers	**G**	**G**	August 2017	August 2017	*Bespoke training for e-obs at CHH planned*
Appraisal of the role of the Nutritional Apprentice impact completed and placement of apprentices' agreed	**G**	**G**	September 2017	September 2017	*Milestone amended slightly*
Review completed on all housekeeping / ward hostess roles and standardisation of job description	**G**	**G**	October 2017	October 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	November 2017	November 2017	
All wards assessed in CQC language, based on Fundamental Standards and census audit results (good, requires improvement etc.) and disseminated	**G**	**G**	January 2018	January 2018	
Monthly ward nutrition and hydration census audits completed	**G**	**G**	March 2018	March 2018	
Quarterly Nutrition and Hydration Fundamental Standards audit completed	**G**	**G**	March 2018	March 2018	

QIP23 – DEMENTIA

Project title: QIP23 - Dementia	Project Lead: Dr Dan Harman and Suzy Bunton

Overall project objective(s):
The aim of this project is to continue to review and promote Dementia Care across the Trust through a variety of multi - disciplinary events, policy review and further dementia friendly assignments.

By continuing to work towards models of excellence and staff training and awareness, the quality of care for patients and the working environment and experience for our staff will be improved.

Regulation Breaches / Requirement Notices:
None

Performance Targets:
- Achieve 90% compliance with dementia/delirium screening assessments undertaken (baseline 65%).
- Achieve 75% compliance (H8/80, H9/90 and EAU) with the use of blue butterfly symbol over the bed and reach out to me (baseline 50%).
- Work towards 60% compliance/awareness of the John's campaign.

Overall Delivery of the Project:

Summary of Project Delivery:
This project was carried forward from the Trusts quality improvement plan of 2016/2017. Although Dementia was not on the 2017/18 plan, the lead nurse wished to build upon the previous year's achievements and continue to focus on embedding the Dementia Strategy across the Trust, including growth in an understanding of the John's campaign and improved adherence to the Dementia and Delirium screening pathway. All milestones set for this period were completed and the RAG rating for the project is Green.

Items for Escalation:
None

Risks to Delivery and Mitigating Actions:
None

Performance Activity

Indicator	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 90% compliance with dementia/delirium screening assessments undertaken. (Baseline 65%)	Being Validated											
Achieve 75% compliance with the use of blue butterfly symbol over the bed and reach out to me. (Baseline 50%)	Being Validated											
Work towards 60% compliance/awareness of the John's campaign. (no baseline)	Being Validated											

Progress – April 2017	RAG Status	G

Progress against Key Milestones this period:
Two milestones have been completed and closed during this period as anticipated.
The project lead is currently working on the development of the presentation for the nurse's day conference and planned activities for the upcoming Dementia Awareness Week sessions with catering staff.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Dementia Awareness Week completed – (involvement to drive forward organisational engagement to focus on the senses and nutritional challenges in a person living with Dementia).	G	G	May 2017	May 2017	Planned activity to include 7 Dementia Awareness sessions booked with catering staff. 17/18/19 May, activities to be held in dining rooms across the organisation.
Attended Nurses Day conference – (to show collaborative working in relation to staff education in Dementia).	G	G	May 2017	May 2017	SB working with CHCP to develop the presentation for the event on 12th May.
Participated in the Dementia Awareness Event at Princes Quay, Shopping Centre, Hull	G	G	May 2017	May 2017	Event has been booked and SB will have an information stand at the event.
The Dementia Garden at Castle Hill Hospital and Burnby Hall Gardens (Pocklington) completed.	G	G	June 2017	June 2017	Met with Allan Parry, Donna Brady- Welburn to discuss location and timelines.
EoL policy reviewed with regards to Dementia and best practice.	A/G	A/G	December 2016	July 2017	Milestone transferred over from 2016/17 QIP
Completed review of all improvement work undertaken in 2016/17 to ensure that they are being embedded	G	G	August 2017	August 2017	
Cinema area on Ward 8 and Ward 80 created	G	G	September 2017	September 2017	Meeting held and plans with Estates (LE) for taking forward.
Established links made with Dietetic team and Dementia Lead Nurse with regards to reviewing Nutritional overview of patients with Dementia and improvements.	A/G	A/G	November 2016	November 2017	Milestone transferred over from 2016/17 QIP
Audit completed to review transfers of care and quality of information (admissions, transfers and discharges).	A/G	A/G	January 2017	November 2017	Milestone transferred over from 2016/17 QIP
Audit completed of the use or adherence to the Dementia and Delirium Screening Pathway, including the Butterfly Scheme and the John's Campaign principles.	G	G	March 2018	March 2018	Quarterly reviews of a sample size of wards to confirm adherence/compliance
Dementia awareness within Hull and East Yorkshire promoted through the media.	B	B	April 2017	April 2017	1 hour radio broadcast successfully completed 12th April 2017. **Closed – April 2017**
Attended Dementia Carer's event at Hull City Hall to promote	B	B	April 2017	April 2017	Event attended on 26th April. **Closed April 2017**

QIP 24 – CHILDREN & YOUNG PEOPLE SERVICES

Project title: **QIP24 - Children and Young People Services**	**Project Lead: Vanessa Brown**

Overall project objective(s):
The Trust is required to improve its Children and Young People services and facilities. The aim of this project is to continue to improve the overall children and young people services and facilities on the 13th floor.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safer Care and Treatment (12.2.E) – ensuring that all equipment used for providing care or treatment to a service user is safe for such use and used in a safe way. This relates to the facilities for children and young people on the 13th floor at HRI.

Targets:
- Delivery of the Children and Young People Services improvement project by March 2018 (Baseline of partially delivered)

Overall Delivery of the Project

Summary of Project Delivery:
This project is rated as amber/green due to slight delay in the delivery of a number of milestones from the 2016/17 quality improvement plan. These have been transferred onto the 2017/18 plan for delivery.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
The key risk is the facilities on the 13th floor as the CQC continue to rate these as requiring improvement and until the Trust agrees/implements a relocation plan this will continue to be rated as requiring improvement.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Delivery of the Children and Young People Services improvement project	On-track											

Progress: April 2017 — RAG Status: A/G

Progress against Key Milestones this period:
- The audit against compliance with the procedural document for undertaking a pregnancy test prior to surgery for young people has been registered on the 2017/18 clinical audit plan and the audit has commenced.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Procedural document for undertaking a pregnancy test prior to surgery for young people audited and next steps agreed	A/G	A/G	December 2016	July 2017	This milestone was carried forward from the 2016/17 quality improvement plan.
Completed review of improvement work undertaken in 2016/17 to ensure they are	G	G	August 2017	August 2017	

embedded					
Children Strategy developed and approved	**A/G**	**A/G**	December 2016	December 2017	This milestone was carried forward from the 2016/17 quality improvement plan.
Children Strategy implemented	**A/G**	**A/G**	January 2017	January 2018	This milestone was carried forward from the 2016/17 quality improvement plan.

QIP28 – PATIENT EXPERIENCE AND COMPLAINTS

Project title: QIP28 - Patient Experience – Listening to our patients and acting on their feedback	Project Lead: Sarah Bates/ Louise Beedle

Overall project objective(s):
The aim of this priority is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes.

Regulation Breaches / Requirement Notices
Following the May 2015 CQC inspection, the Trust has received a number of requirement notices where the Fundamental Standards were not being met and breaches in regulations were identified. The Patient Experience quality improvement plan is linked to a regulation breach; Regulation 16 Receiving and Acting on Complaints (16.1 any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complainant or investigation). All actions identified to address the breach in regulation are included in this improvement project for improvements to be made.

Performance Targets:
- Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate – (Baseline 61.60%)

Overall Delivery of the Project:

Summary of Project Delivery:
This project is included in the Trusts quality improvement plan for 2017/18. The Project Lead confirms that implementation of the Patient Experience Strategy continues with work undertaken towards the completion of future milestones. There were no milestones for completion during this period. Performance against target set for the period is awaited at the time of reporting. The overall rating for the project is Green.

Items for Escalation:
None.

Risks to Delivery and Mitigating Actions:
None.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 85% of formal complaints closed within the 40 day target (Baseline 61.60%)	Being Validated											

Progress: April 2017 | RAG Status | **G**

Progress against Key Milestones this period:

There was no specific information to report in this period.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Patient experience dashboard used within the Health Groups to inform	A/G	A/G	March 2017	June 2017	Transferred from 2016/17 QIP

service changes/improvements					
Interpreters Policy and supporting tools implemented	**G**	**G**	June 2017	June 2017	
Patient Experience Strategy presented to the Trust board approved	**A/G**	**A/G**	Sept 2016	July 2017	Transferred from 2016/17 QIP
Patient Experience work plan developed (based on the Patient Experience Strategy objectives)	**G**	**G**	July 2017	July 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure being embedded	**G**	**G**	August 2017	August 2017	
Development of Interpreters using telephone interpreting service and 'Browse Aloud' service for the visually impaired completed	**G**	**G**	September 2017	September 2017	
Quarterly monitoring and updating against the Patient Experience Strategy work plan completed	**G**	**G**	March 2018	March 2018	
Patient Experience work plan delivered	**G**	**G**	March 2018	March 2018	

QIP30 – AVOIDABLE MORTALITY

Project title: QIP30 Avoidable Mortality	Project Lead: Chris Johnson, Clinical Outcome Manager

Overall project objective(s):
The aim of this project is to aid the organisation in the delivery of the national objective of a standardised approach to review of hospital mortality. This project will prepare the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.

Regulation Breaches / Requirement Notices
A number of mortality alerts remain open at the start of this project including Sepsis, Fracture, CABG

Performance Targets:
- To review all deaths where family, carers or staff have raised a concern about the quality of care provision.
- To review all deaths of patients who are identified to have a learning disability and/or severe mental illness
- To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.
- To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.
- **Baseline:** To review a further sample of patient deaths that do not fit into any specific category to ensure the Trust can identify where learning and improvement is needed most overall.

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated as Green. This project has been carried forward from 2016-17. Significant work was undertaken during 2016-17 including the appointment of the Clinical Outcome Manager for the Trust. This gave the project leadership and direction which instigated a strategic review of the processes in place within the Trust to undertaken comprehensive structured case note reviews.

This project will focus on embedding these processes in 2017-18 including a focus on learning. Two key documents were published in March 2017 - National Guidance on Learning from Deaths (National Quality Board) and Learning from Deaths (CQC). These documents focus on the role of key members of the Trust as well as how learning from events will be used, disseminated and impact on current practice.

Items for Escalation:
None identified

Risks to Delivery and Mitigating Actions:
There has been a significant increase in the focus of mortality and avoidable mortality nationally. The documents cited above outline the role and responsibilities all Trusts have. A review is currently being undertaken to review the resources available to achieve this.

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
100% - where family, carers or staff have raised a concern	Being Validated											
100% - patients who are identified to have a learning disability and/or severe mental illness	Being Validated											

100% - patients subject to care interventions from which a patient's death would be wholly unexpected	Being Validated											
100% - where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis	Being Validated											
Further sample of patient deaths	**Baseline to be established in 2017-18**											

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
During April 2017 the project re-open with new milestones and performance indicators. This follows a review conducted by the lead for the project, the Clinical Outcome Manager with the Head of Compliance as the corporate link to review the activity that had taken place during 2016-17. It was determined that significant work had been undertaken during the pervious year with a robust, transparent and consistent approach being implemented on Structured Case Note review across the organisation. As part of the review the lead developed the 2017-18 improvement programme and identified further milestones that would be required to embed the process fully. In order to achieve this, further activity has commenced with the Improvement Academy through the Measuring and Monitoring Safety Framework (MMSF) and the lead attended the inaugural meeting. Subsequent internal meetings with leads across the Trust have been attended and future activity identified.

In addition, it has been confirmed that the executive director responsible for mortality in the Trust is the Chief Medical Officer. This is completion of one of the key requirements of the National Guidance on Learning from Deaths (National Quality Board) and Learning from Deaths (CQC).

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Quality check process in place	G	G	May 2017	May 2017	
Reporting structure including Board Reports reviewed	G	G	May 2017	May 2017	Currently included in monthly Trust Board reports (Quality).
Review of mortality work included in Quality Accounts completed	G	G	May 2017	May 2017	
2nd Improvement Academy Workshop Completed	G	G	May 2017	May 2017	16th May 2017
Non-Executive Director Appointed to lead on Mortality	G	G	June 2017	June 2017	
Criteria for prescribed deaths via death certificates, reviews and investigations defined	G	G	June 2017	June 2017	Including clarity on the role medical examiners and coroners have in certain prescribed deaths
Process for learning from reviews and investigations developed	G	G	June 2017	June 2017	
Criteria for selecting patients to undergo case record review defined	G	G	June 2017	June 2017	Via bereaved families, learning disabilities. SIs, patients not expected to die, deaths from existing QIPs etc To include regulation 28s.

First quarterly dashboard report published	G	G	June 2017	June 2017	As stated in CQC learning from Deaths letter.
3rd Improvement Academy Workshop Completed	G	G	June 2017	June 2017	26th June 2017
Process for informing and involving next of kin confirmed	G	G	July 2017	July 2017	
Engaged with Royal College of Physicians to increase training provision	G	G	July 2017	July 2017	As stated in CQC learning from Deaths letter.
Quality check audit completed	G	G	July 2017	July 2017	
Quality check audit completed	G	G	Oct 2017	Oct 2017	
Mortality Policy developed	G	G	Oct 2017	Oct 2017	As stated in CQC learning from Deaths letter.
Quality check audit completed	G	G	Jan 2018	Jan 2018	
Executive Director Appointed to lead on Mortality	B	B	April 2017	April 2017	**Closed – April 2017** Chief Medical Officer appointed
1st Improvement Academy workshop completed	B	B	April 2017	April 2017	**Closed – April 2017** First training session attended on 3rd April 2017
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	B	B	April 2017	April 2017	**Closed – April 2017** Review completed

QIP34 – CRITICAL CARE

Project title: QIP34 – Critical Care	**Project Lead: Dr Andrew Gratrix and Becky Smith**

Overall project objective(s):
The aim of this project is to ensure that the Critical Care Service provides a high quality, fit for purpose facility by ensuring the service is adequately staffed with an appropriate skill mix in line with relevant national requirements.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 17 Good Governance (17.2A) - assess, monitor and improve the quality and safety of services provided. This relates to ensuring orthopaedic patients are regularly assessed and monitored by their consultants. (17.2.B) – assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This relates to the timely review of the critical care risk register to ensure that all risks relating to the service are included and timely action is taken in relation to controls in place and escalation to the Board. Assess. Regulation 18 (1) - sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. This relates to ensuring critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

Performance Targets:
- Number of Critical Care Consultants – target of 16 consultants

The following performance targets will be included once auditing is embedded within the service:
- *100% of patients reviewed within 12 hours by a consultant following admission*
- *100% of days when two ward rounds completed*

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. The project has started well in the first month with good progress made on the recruitment campaign for vacant consultant posts and the production of a business case for 4 advanced practitioners. There has been some concern highlighted by the lead in relation to this milestone which is detailed below. There has been some slippage with the planned audit commencement, which has been reflected in the milestone forecast finish date however significant preparations have been completed this period for the audit.

Items for Escalation:
The business case for the 4 advanced practitioners must be approved within the first two weeks of May 2017 in order to secure places on the University course.

Risks to Delivery and Mitigating Actions:
If the business case is not approved by the required deadline the milestone will not be able to be completed and the department will not be able to recruit to the additional advanced practitioner posts which will not only have an effect on the delivery of the overall QIP aim, but have a significant detrimental effect on staffing and patient care in the Critical Care Department.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Number of Critical Care Consultants – target of 16 consultants	**13**											
100% of patients reviewed	*performance targets will be included once auditing is embedded within the service:*											

within 12 hours by a consultant following admission						
100% of days when two ward rounds completed	*performance targets will be included once auditing is embedded within the service:*					

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
The audit has been approved by the Trust's Clinical Audit Team and all paperwork is collated, however the audit will not commence until May 2017 therefore the forecast finish date has been amended to reflect this. The lead has met with representatives from the Trust's HR Team and a specialist consultant recruitment firm to develop a joint package with Anaesthetics to promote recruitment to the vacant posts. Further work in the form of additional media such as pictures and videos are desired to enhance this package. Current applications to the vacant consultant posts are not of the required standard. Review has commenced of the outreach service. Business case for the 4 advanced practitioners has been completed and is waiting for approval however there are some risks to delivery in relation to this which is detailed in the section above. Whilst the milestones in relation to recruitment campaign commenced and the business case being written have been completed they will continue to be monitored on a regular basis and updates provided.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Audit of documentation for ward rounds and review of new patients within 12 hours commenced	**AG**	**AG**	April 2017	May 2017	Due to commence May 2017 however all preparations to commence are complete
4 advanced practitioner posts recruited to and applications to the University made	**G**	**AG**	June 2017	June 2017	Completion is dependent on the business case approval being complete in early May 2017
Review completed of the critical care outreach service and business case/action plan submitted to Senior Health Group Team for funding and/or reorganisation	**G**	**G**	August 2017	August 2017	Review has commenced
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	August 2017	August 2017	
Audit of documentation for ward rounds and review of new patients within 12 hours completed	**G**	**G**	October 2017	October 2017	
Inclusion of the additional performance targets (100% of patients reviewed within 12 hours by a consultant following admission and 100% of days when two ward rounds are completed) within the QIP	**G**	**G**	November 2017	November 2017	
Review of current critical care qualifications to ascertain how nursing staff can achieve a critical care qualification	**G**	**G**	January 2018	January 2018	

Review of National Guidelines to complete gap analysis. Gap analysis to provide the focus for 2018/19 QIP	**G**	**G**	February 2018	February 2018	
Implement the training of 5 advanced practitioner posts	**G**	**G**	March 2018	March 2018	
Consultant recruitment campaign commenced	**B**	**B**	April 2017	April 2017	**Closed April 2017** Campaign commenced and milestone closed however the campaign's success will be monitored within the QIP on a regular basis
Business case completed for 4 advanced practitioner posts	**B**	**B**	May 2017	May 2017	**Closed April 2017** Business case has been completed however not yet approved. Progress will continue to be monitored within the QIP on a regular basis.

QIP35 – INTERVENTIONAL CHECKLIST COMPLIANCE

Project title: QIP35 – Interventional Procedure Checklist	Project Lead: Interventional Procedure Checklists - Steve Jessop, Nurse Director and Gillian Faichney Resuscitation Checklists: Neil Jennison

Overall project objective(s):
The aim of this project is to review processes for the completion of any relevant clinical checklists used within the Trust which compliance rates require improvement. The main focus for 2017/18 will be the review current local processes for invasive procedures and ensure that they are compliant with the national standards (National Safety Standards for Invasive Procedures (NatSSIPs) and completion of the Resuscitation Checklists on all wards.

Compliance with the national standards (National Safety Standards for Invasive Procedures (NatSSIPs) will be achieved by developing a set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs). The NatSSIPs were published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. The NatSSIPs cover all invasive procedures including those performed outside of the operating department. NatSSIPs does not in any way replace the existing WHO Surgical Checklist, but enhances it by looking at additional factors such as the nee
d for education and training. Compliance with the WHO Checklist will also be monitored by this project to further support he work completed in 2016/17.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 17 Good Governance (17.2.B) – assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This relates to ensuring the effective use and auditing of best practice guidance such as the "Five steps to safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 12 Safe Care and Treatment (12.2.e– ensuring that equipment is used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way

Performance Targets:
- Achieve 95% compliance with the completion of the daily resuscitation equipment checks
- Achieve 95% compliance with the completion of the monthly resuscitation equipment checks

Overall Delivery of the Project:

Summary of Project Delivery:
The project has experienced a slight delay to one of the milestones which relates to the rollout of revised monthly and daily resuscitation checks proformas and as such the actual finish date has been amended to May 2017. One milestone in relation to the appointment of a NatSSIPs coordinator has been closed as that person is now in post.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 95% compliance with the completion of the daily resuscitation equipment checks	Being Validated											

Achieve 95% compliance with the completion of the monthly resuscitation equipment checks													

Progress – April 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
A NatSSIPs coordinator is now in post which has closed one milestone. The production of a revised form for the recording of resuscitation checks was subject to a delay which has had an effect on the roll out. The forms have now been developed and been proofed by the Resuscitation Manager. The Trust's Practice Development Matron is coordinating the print and distribution. It is expected that the roll out will now be completed in May 2017.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
New template for recording the completion of the daily and monthly resuscitation equipment checks rolled out	**AG**	**AG**	April 2017	May 2017	*Due to delay in the revision of the form this is expected to be completed in May 2017.*
Bespoke checklist compliance workshop delivered for surgeons	**G**	**G**	June 2017	June 2017	
Policy for Interventional Procedures developed which includes reference to WHO, Safer Steps to Surgery and NatSSIPs	**G**	**G**	June 2017	June 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	July 2017	July 2017	
Policy for Interventional Procedures approved which includes reference to WHO, Safer Steps to Surgery and NatSSIPs developed	**G**	**G**	August 2017	August 2017	
Policy for Interventional Procedures approved which includes reference to WHO, Safer Steps to Surgery and NatSSIPs approved	**G**	**G**	October 2017	October 2017	
All interventional procedures mapped against NatSSIPs	**G**	**G**	March 2018	March 2018	
LocSSIPs developed for all relevant interventional procedures	**G**	**G**	March 2018	March 2018	
Checklists developed for all LocSSIPs	**G**	**G**	March 2018	March 2018	
Monthly WHO Checklist compliance audit programme completed	**G**	**G**	March 2018	March 2018	
Monthly audit of the completion of the daily and monthly resuscitation equipment checklist and random sample of the contents of 5 trollies completed and results fed back to the wards for improvement and/or action	**G**	**G**	March 2018	March 2018	
NatSSIPs coordinator in post	**B**	**B**	April 2017	April 2017	**Closed – April 2017** Coordinator is now in post

QIP36 – TRANSITION FROM CHILDREN TO ADULT SERVICES

Project title: QIP36 – Transition from Children's to Adult Services	Project Lead: Michelle Kemp and Eileen Henderson

Overall project objective(s):
Following the February 2014 CQC inspections the Trust is required to improve its processes and service for the transition of children and young people to adult services.

The aim of this project is to ensure there are effective and robust processes in place for young people who transition to the adult care services.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safer Care and Treatment (**12.2.I** – where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of service users).

Targets:
- Procedural document ensuring the effective transition for young people to adult services implemented (Baseline of not implemented)

Overall Delivery of the Project

Summary of Project Delivery:
The project is rated amber/green due to the delay in the delivery of the milestones from 2016/17 and the transfer of them onto the 2017/18 plan for delivery. Good progress has been made against the milestones to date. All the milestones due in April 2017 have been completed and progress updates have been provided for a number of the other milestones due at a later stage.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
Key risks to delivery are due to delay in delivering the improvement project and addressing the required improvements identified by the CQC in May 2015. However the revised Transition to Adult Services Steering Group has been established and it meeting on a monthly basis to monitor the delivery of this project.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Procedural document ensuring the effective transition for young people to adult services implemented	On-track											

Progress: April 2017	RAG Status	A/G

Progress against Key Milestones this period:
- A further review was undertaken of the June 2016 inspection reports to ensure all areas for improvement noted and all recommendations from Paediatric Services and Outpatient Departments was undertaken and it was agreed that the project already contains all areas for improvement and that they will be addressed during 2017/18
- The Transition to Adult Services Steering Group agreed the Ready, Steady, Go toolkit as the most appropriate toolkit for

use within HEYHT. The toolkit will be written into the policy and will be piloted as detailed within this project.

- A baseline assessment of all transitional arrangements in place for the transition from children's services to adult services was undertaken. All relevant specialities that are required to be involved were identified and will be included in the delivery of this project during 2017/18.
- A baseline assessment of compliance against the NICE quality standards was undertaken. The results and next steps are to be discussed at the May 2017 Transition to Adult Services Steering Group meeting
- The review all improvement work undertaken in 2016/17 to ensure they are embedded was completed. It identified that although the project wasn't fully delivered and the aims and targets weren't achieved some progress was made to improving the processes for the transition from children's to adult's services. The milestones that were delivered during 2016/17 remain in place and are supported by evidence of completion. The 2017/18 project will further improve on those changes made and will aim to deliver effective and robust processes for transition.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Virtual network of all adult and paediatric clinicians both nursing medical and AHP's working in the transition from children to adults developed	G	G	May 2017	May 2017	Received encouraging response and volunteers for all those specialties involved in transition. Network established
Baseline assessment completed to demonstrate Trust compliance against the Transition NICE quality standards and areas of improvement	A/G	A/G	March-17	May 2017	This milestone was carried forward from the 2016/17 quality improvement plan. Fresh review of NICE Guideline (Feb 2016) and Quality Standards (Dec 2016) agreed at April 2017 meeting to be presented to May 2017 meeting.
Procedural document ensuring there is effective transition for young people to adult services developed	A/G	A/G	May 2015	July 2017	This milestone was carried forward from the 2016/17 quality improvement plan. This document will be developed taking into account findings from baseline assessments completed as part of this project.
Procedural document ensuring there is effective transition for young people to adult services approved	A/G	A/G	April 2016	August 2017	This milestone was carried forward from the 2016/17 quality improvement plan.
Communication campaign promoting the procedural document ensuring there is effective transition for young people to adult services launched	A/G	A/G	February 2016	September 2017	This milestone was carried forward from the 2016/17 quality improvement plan. This work will commence in due course dependant on delivery of above but within timescale.
Procedural document ensuring there is effective transition for young people to adult services implemented	A/G	A/G	October 2016	September 2017	This milestone was carried forward from the 2016/17 quality

					improvement plan. It was confirmed at the April 2017 meeting that the project is working towards this timescale.
Ready, Steady, Go toolkit implemented in Diabetes, Epilepsy and Cystic Fibrosis and audited in order to learn any lessons prior to implementing across the other speciality services	**A/G**	**A/G**	August 2016	September 2017	This milestone was carried forward from the 2016/17 quality improvement plan. Initial review to be undertaken of progress of using toolkit in these specialties within timescale.
Review of the relevant recommendations from paediatric services and OP's detailed in the CQC reports from the 2015 and 2016 inspections completed to ensure all areas for improvement are captured and addressed	**B**	**B**	April 2017	April 2017	**Closed – April 2017** Review complete and relevant recommendations captured in the project
Baseline assessment of all transitional arrangements from children to adults within the Trust and from specialist centres completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017** Baseline assessment completed with initial findings of all specialties involved in transition. To be developed further over the forthcoming year through the delivery of this project.
Ready, Steady, Go toolkit approved	**B**	**B**	June 2016	April 2017	This milestone was carried forward from the 2016/17 quality improvement plan. **Closed – April 2017** The Ready Steady Go toolkit was agreed at the meeting on the 10th April 2017
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	April 2017	April 2017	**Closed – April 2017** Lookback exercise completed. All milestones and improvements made during 2016/17 remain in place.

QIP37 – RESPECT

Project title: QIP37 – ReSPECT	Project Lead: Neil Jennison

Overall project objective(s):
The aim of this project is to implement the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) with a supporting education package to ensure the ReSPECT process is fully embedded across the organisation.

The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

Regulation Breaches / Requirement Notices
None

Targets
- Delivery of the ReSPECT quality improvement project implementation plan (No baseline)

Overall Delivery of the Project:

Summary of the Project Delivery:
This is a new quality improvement project for 2017/18. The project is rated as green because the project is new on the 2017/18 quality improvement plan. The milestones due for delivery in April were delivered and the target is on-track to be achieved.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
No risks identified at this stage.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Delivery of the ReSPECT quality improvement project implementation plan	On-track											

Progress: April 2017	RAG Status	G

Progress against Key Milestones this period:
- A formal ReSPECT adoption paper was presented to the March 2017 Operational Quality Committee and it was agreed that the Trust adopt the new ReSPECT process. Formally signed up to the ReSPECT terms of use.
- A ReSPECT implementation task and finish group was establish following the agreement to sign up to the ReSPECT terms of use. This group is to be chaired by the Resuscitation Manager and the Deputy Director of Governance and Assurance / Assistant Chief Nurse. The first meeting is scheduled to take place 05 May 2017 to discuss the delivery of the ReSPECT quality improvement plan, to agree the terms of reference and to agree future meeting arrangements.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Formal links established with key health and social care providers in the Humber Region	G	G	June 2017	June 2017	
Training needs identified	G	G	June 2017	June 2017	
Staff and patient awareness and communication plans developed	G	G	September 2017	September 2017	
ReSPECT process, staff and patient awareness, communication and disseminated	G	G	September 2017	September 2017	
Training package and plan developed	G	G	September 2017	September 2017	
Review electronic development opportunities for an IT solution	G	G	September 2017	September 2017	
Training package rolled out	G	G	October 2017	October 2017	
Local launch date agreed	G	G	October 2017	October 2017	
Review of current Trust policy completed and revised to embed ReSPECT processes into Trust policy	G	G	November 2017	November 2017	
Implementation progress, audited and baseline compliance identified	G	G	March 2018	March 2018	
Future monitoring arrangements agreed	G	G	March 2018	March 2018	
Formal adoption agreed by the Trust and sign up to ReSPECT terms of use completed	B	B	April 2017	April 2017	**Closed – April 2017** The Trust signed up to the ReSPECT terms of use.
ReSPECT implementation task and finish group established	B	B	April 2017	April 2017	**Closed – April 2017** The task and finish group has been established and membership agreed.

QIP38 – CONSENT

Project title: **QIP38 – Consent**	**Project Lead: Sarah Bates**

Overall project objective(s):
The aim of this project is to review and strengthen the governance arrangements regarding the development, approval and the central monitoring of the Trust consent forms. The project will also commence the development work of the transfer of the Trust consent forms onto Lorenzo.

Regulation Breaches / Requirement Notices
None

Targets
- To have all consent forms managed and monitored through a central process by March 2018

Overall Delivery of the Project:

Summary of the Project Delivery:
This project is rated as green because this is a new quality improvement project for 2017/18 and is on-track for delivery.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
No risks identified at this stage.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
To have all consent forms managed and monitored through a central process	On-track											

Progress: April 2017 | **RAG Status** | **G**

Progress against Key Milestones this period:
- Consent task and finish group established and held its first meeting 28 April 2017. Terms of reference agreed and identified further representatives for inclusion in the group.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Ward rounds undertaken and all old consent forms removed from circulation	G	G	June 2017	June 2017	
Consent Policy reviewed and revised to incorporate the new CJD wording	G	G	July 2017	July 2017	
Pilot areas identified for the Lorenzo	G	G	September	September	

consent forms			2017	2017	
Pilot of the Lorenzo consent forms completed	**G**	**G**	December 2017	December 2017	
Pilot of the Lorenzo consent forms analysed and next steps agreed	**G**	**G**	January 2018	January 2018	
New CJD wording added to all consent forms	**G**	**G**	March 2018	March 2018	
Lorenzo consent forms fully developed	**G**	**G**	March 2018	March 2018	
To have new printed consent forms available for patients	**G**	**G**	March 2018	March 2018	
Consent forms linked to up to date patient information leaflets and leaflets available at the time of consent	**G**	**G**	March 2018	March 2018	
Development, approval and monitoring process for the Trust consent forms developed and implemented	**G**	**G**	March 2018	March 2018	
Consent task and finish group task terms of reference and work plan agreed	**B**	**B**	April 2017	April 2017	**Closed – April 2017** First meeting held 28/04. CS and FWH HG representatives attended. Need to establish rep from Medicine and Surgery, and also additional Anaesthetic Rep.

QIP39 - OUTPATIENTS

Project title: QIP39 – Outpatient Services	Project Lead: Eileen Henderson (Head of Outpatient Services)

Overall project objective(s):
To ensure the Trust has a robust leadership and governance structure for all Outpatient Services to deliver consistent, high quality care and address all concerns relating to Outpatients from the 2015 and 2016 CQC Comprehensive Inspections.

Regulation Breaches / Requirement Notices
Regulation 17 HSCA (RA) Regulations 2014 Good governance: Systems and processes were not always operated effectively to ensure improvement and good governance of services

Performance Targets:

- Outpatients governance committee held

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. This project has been developed in response to actions and concerns identified from the CQC Inspections in 2015 and 2016 particularly the governance of Outpatient Services. The 2017/18 QIP will focus on the establishment of a trustwide governance committee and providing several learning resources and opportunities for staff members working in any outpatient areas for learning lessons and incident management.

Items for Escalation:
None at this time.

Risks to Delivery and Mitigating Actions:
The programme of work required to bring all outpatient areas up to the required standard will require monetary investment and as such will be subject to agreement from senior trust management.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Outpatients governance committee held	Target to be monitored from June 2017											

Progress – April 2017	RAG Status	G

Progress against Key Milestones this period:
Development and commencement of the QIP for 2017/18 has been the main focus for this period and however several milestones have been closed this period. The board level lead for Outpatient Services has been identified and a Head of Outpatient Services has been appointed and identified as the lead for this project. The lead has already begun work on an action plan to address all areas of concern highlighted by the CQC in the 2015/2016 inspections that are not included within the 2017/18 QIP which may have been completed. This will provide assurance to the trustwide governance committee that all areas identified for improvement or highlighted as a concern by the CQC have been addressed.

The lead has commenced preparations for a trustwide governance committee and invitations to attend will be sent out in May 2017. A TOR will be drafted in May 2017 and tabled at the first committee in June 2017.

A programme of development has been developed which identifies all outpatient areas that require investment or action to achieve the required standard and be fit for purpose. Several areas have already been addressed, such as the Surgical Outpatients preparation room. This also includes the Audiology Outpatients clinical area which has received a deep clean and replacement furnishings to those that posed an infection control or safety risk. A regular programme of cleaning in line with trust requirements is in place by Trust contractors MITIE.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Terms of reference developed for a trustwide governance committee	G	G	May 2017	May 2017	Draft commenced
A trustwide governance committee for Outpatient Services established with required regular health group attendance	G	G	June 2017	June 2017	
Clear governance map for outpatients produced which demonstrates a ward to board process	G	G	June 2017	June 2017	
Targeted information developed for outpatient staff on all outpatient SIs to provide learning	G	G	June 2017	June 2017	
Terms of reference approved for a trustwide governance committee	G	G	July 2017	July 2017	
Action plan developed to address all areas of concern highlighted by the CQC in the 2015/2016 inspections that are not included within the 2017/18 QIP	G	G	July 2017	July 2017	
Targeted information developed for outpatient staff on all outpatient complaints/PALs to provide learning	G	G	July 2017	July 2017	
Targeted information developed for outpatient staff on all outpatient incidents to provide learning	G	G	July 2017	July 2017	
Risk register developed specific to Outpatient Services	G	G	August 2017	August 2017	
Existing asset management process for outpatient areas assessed for efficiency and assurance	G	G	September 2017	September 2017	
Create Learning Space for outpatient staff members on the intranet to include resource on risks, incidents and learning lessons	G	G	November 2017	November 2017	
Communications strategy for internal and external Outpatient Services with a focus on public and patient engagement	G	G	December 2017	December 2017	Initial meeting was held in April 2017
Head of Outpatient Services appointed	B	B	April 2017	April 2017	**Closed April 2017** Eileen Henderson has commenced the post of Head of Outpatient Services
Board level lead for Outpatient Services identified	B	B	April 2017	April 2017	**Closed April 2017** Ellen Ryabov, Chief Operating Officer, has been identified as the board level lead for Outpatient Services
Audiology Outpatients clinical area deep cleaned	B	B	April 2017	April 2017	**Closed April 2017** Deep clean completed and cleaning rota in place
Audiology Outpatients clinical area unsuitable furnishings replaced	B	B	April 2017	April 2017	**Closed April 2017** All unsuitable furnishing have been replaced.
Programme of development in place to address all outpatient areas where the environment is not fit for purpose	B	B	April 2017	April 2017	**Closed April 2017** Programme developed which highlights all outpatient areas which

					require some form of investment to address environmental issues
Surgical Outpatients preparation room assessed and made fit for purpose	**B**	**B**	April 2017	April 2017	**Closed April 2017** Deficiencies to the Surgical Outpatients preparation room have been addressed
Plastics outpatients consultants rooms desks replaced	**B**	**B**	April 2017	April 2017	**Closed April 2017** Old and unfit for purpose desks replaced

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	24 April 2017	**Chair:**	T Sheldon	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Lead dietician to attend the Committee in May to discuss patient nutrition and record keeping
- Draft Quality Accounts received and reviewed by the Committee
- Presentations received regarding medicines management (missed doses and factors affecting speed of discharge and accurate prescription at discharge)
- Serious incidents – March 2017 were received by the Committee and need for greater clarity over root causes discussed
- Quality Improvement Programme – discussion around how performance is measured, the extent to which progress on milestones reflects improvement in processes and outcomes and the need to become more outcome focussed.
- Operational Quality Committee – Report received. RESPECT form discussed
- Major Trauma Peer Review was discussed. Mr Snowden and Mr Phillips to discuss the outcomes
- The Board Assurance Framework for 2017/18 was presented to the Committee for review
- The effectiveness Review of the Committee was presented.

Decisions made by the Committee:

- General – greater clarity is needed over which reports are presented, when (try to see before they go to Trust Board) and why so that the committee can focus key issues and add value
- Serious Incident Report – The RCA results to be added
- Medicines Management to give a 6 month update regarding progress in reducing missed doses and improving discharge
- Board Assurance framework
  - More work to make it less general (especially in areas such as avoidable mortality)
  - The risk mitigation and obstacles to achieving this need to be more clearly defined
  - More focus on the an effective model of improvement and building capacity to implement this through the organisation
- Quality Accounts
  - Easy read version to be prepared;
  - more focus on the development of an overall integrated and effective Trust framework and models for improvement
  - include the deteriorating patient in future priorities

Key Information Points to the Board:

- Quality Accounts

Matters escalated to the Board for action:

Matters deferred to other Board Committees:

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON MONDAY 24 APRIL 2017
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	Chair – Non Executive Director
	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
	Ms C Ramsay	Director of Corporate Affairs
	Mr D Corral	Chief Pharmacist
IN ATTENDANCE:	Mrs S Bates	Interim Deputy Director of Quality, Governance and Assurance
	Ms G Gough	Deputy Chief Pharmacist
	Ms N Gilchrist	Physiotherapy Manager
	Dr M Purva	Deputy Chief Medical Officer
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES — **ACTION**

Apologies were received from Mrs A Green – Lead Clinical Research Therapist

2. MINUTES OF THE MEETING 27 MARCH 2017

The minutes of the meeting held 27 March 2017 were approved as an accurate record of the meeting

3. ACTION TRACKING LIST/WORKPLAN

Documentation Review – The report to be presented to the June 2017 committee meeting. **CR**

Chaperone Policy – Mr Wright advised that this would be presented to the next Nursing and Midwifery Board and then the Quality Committee in May 2017. **MW/SB**

4. MATTERS ARISING

Mrs McDougal (Lead Dietician) would attend the May 2017 meeting to discuss patient nutrition and record keeping. Mr Snowden requested the discussion also include the quality of food. It was agreed that this would be a separate discussion.

It was agreed that the Non Executive Director members of the Committee could visit Harrow Street to view the Medical Records store.

There was a discussion around quality champions raised by Mrs Walker and whether a group should be established within the Trust. Mrs Bates wanted to bring all quality work streams together to review improvement methodology and use resources effectively.

5. REDUCING AVOIDABLE HARM

5.1 – QUALITY ACCOUNTS

Mrs Bates presented the draft Quality Accounts to the Committee, she advised that the document was prescribed by the Department of Health.

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Prof. Sheldon commented that the turnaround for the Committee to review and sign off was within tight timescales but also added that there were no surprises in the document. Mrs Bates reported that the document included forward thinking and how the Trust was working differently to achieve the actions in the Quality Improvement Plan. Mrs Bates advised that the Health Group quality leads had been included in the development of the document and Mr Snowden asked if the Trust partners had been given the chance to comment. Mr Wright assured him that the Trust stakeholders were included in the consultation process.

Mrs Walker offered to discuss a more outcome focussed language with Mrs Bates to reassure members of the public. It was also agreed that an easy read version of the accounts should be prepared. **VW/SB**

Prof. Sheldon added that the accounts should include the deteriorating patient in future priorities. This was agreed by the Committee.

Resolved:
The Committee received the draft Quality Accounts and agreed to pass any comments to Mrs Bates. **ALL**

5.2 – LESSONS LEARNED NEWSLETTER
The Lessons Learned Newsletter was received by the Committee. There was a discussion around the presentation of the document and it was agreed that work with the Communications Team to make it more impactful would take place. Prof. Sheldon stated that the document name should be reviewed as it was not clear as to whether staff had learned lessons.

Mrs Walker added that lessons should be shared following investigations into incidents but also successes within the Trust should equally be shared.

Resolved:
The Committee received the newsletter and agreed that it should be updated via the Communications Team. **SB**

5.3 – MEDICINES MANAGEMENT - MISSED DOSES
Mrs Gough gave a presentation regarding avoidable missed doses and why they happen. The main issues related to missing drug charts or the drugs being unavailable. A number of objectives had been set to address these issues such as increasing stock, better prescribing, patients using their own drugs and supplying medication more promptly.

There was a discussion around e-Prescribing and how this will show efficiencies around the current labour intensive paper based system. Mrs Gough reported that work had already started and was having an impact, and would be rolled out to other wards. Mr Moran added that improvements needed to be sustainable and behaviours embedded to improve practices.

DISCHARGE ISSUES
Mr Corral reported that there were a number of issues relating to discharge including complex elderly patients, Immediate Discharge Letters not being collected in a timely manner and patients leaving without their medication.

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Mrs Walker expressed her concern that patients and carers could not pick up their hospital medication from a community pharmacy.

Mr Corral advised that a number of initiatives were being developed to address the issues. These were: sharing problems and working closely with the Clinical Commissioning Groups, working with GPs, reviewing the discharge policy, e-Prescribing and having discharge coordinators. He also reported that the Trust was using summary care records as baseline information and this meant that the coding was much more accurate.

Resolved:
The Committee received the presentations relating to medicines management and requested a 6 month update report to review progress. **DC/GG**

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

6.1 – SERIOUS INCIDENTS - MARCH 2017

Mrs Bates presented the serious incidents relating to March 2017. She advised that nationally the Trust was a good reporter of incidents but the comparison was difficult to judge due to all Trusts reporting differently.

Mrs Bates added that improvements in the quality of investigations had been seen in 2016/17 when reviewing themes and identifying lessons and that this had been confirmed by the Trust's commissioners.
There was a discussion around including patient experience and the root causes into the serious incident reports and Mrs Bates advised that the investigation reports included both but a snapshot was provided to the Committee.

Resolved:
The Committee received the information relating to serious incidents and agreed to have the root causes included in the next report. **SB**

7. RECEIVED FOR ASSURANCE

7.1 – QUALITY IMPROVEMENT PROGRAMME

The Quality Improvement Programme was received as assurance that work was ongoing to address emerging quality concerns. Mr Wright advised that this was a ward to board process and the Health Groups were involved in the production of the document. There was a discussion around the measures used in the report and whether the projects were outcome focussed and sustainable. It was agreed that some of the narrative in the report should be more explicit to ensure that performance was improving and the Trust's learning was being embedded.

7.2 – INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report was received for information. There was a discussion around triangulating complaints, claims, serious incidents and reviewing the emerging themes. Mr Wright added that the Board Quality Report would now include the number of attends/FCEs in relation to the number of complaints received in the given time period.

7.3 – OPERATIONAL QUALITY COMMITTEE REPORT

The Committee received the Operational Quality Committee summary report and Mr Wright highlighted the discussion on the new national programme ReSPECT (recommended summary plan for emergency care

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and treatment). This is a process which creates personalised recommendations when patients are not able to make or express choices regarding their care.

7.4 – HEALTHCARE DELIVERY IMPROVEMENT GROUP
This item was deferred to the next meeting in May 2017. **MP**

7.5 – QUALITY REPORT
The Quality Report was received by the Committee. It was agreed that since they are reviewed at the Board meetings any emerging issues would be delegated to the Committee from the Board.

7.6 – BOARD ASSURANCE FRAMEWORK 2017/18 DRAFT
Ms Ramsay presented the draft 2017/18 Board Assurance Framework. She advised that the document had been to the Executive Management Board and the principle risks linked to the Trust's goals. Ms Ramsay asked the Committee for any feedback prior to presentation at the May 2017 Trust Board.

Mrs Walker stated that the key risks should highlight specific areas, such as the cancer targets to focus thinking when developing action plans. The risk mitigation and obstacles to achieving this need to be more clearly defined with focus on an effective overall improvement model.

Resolved:
The Committee received the Board Assurance Framework and agreed to forward any comments to Ms Ramsay.

7.7 – ANNUAL COMMITTEE REPORT AND EFFECTIVENESS REVIEW
Ms Ramsay reported that the effectiveness review had been mapped to the Committee's terms of reference

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

9. CHAIRMAN'S SUMMARY TO THE BOARD
A summary of the meeting would be presented at the May 2017 Board meeting.

10. DATE AND TIME OF NEXT MEETING:
Wednesday 31 May 2017, 10.15am – 12.15am, The Committee Room, Hull Royal Infirmary

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Integrated Performance Report 2017/18

May 2017

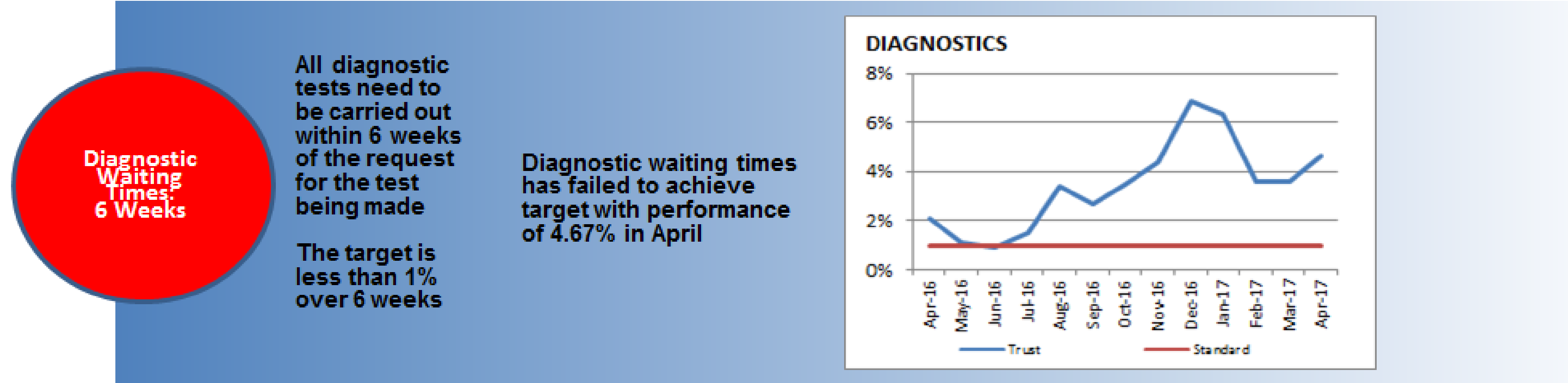
April data

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 - May 2017

RESPONSIVE

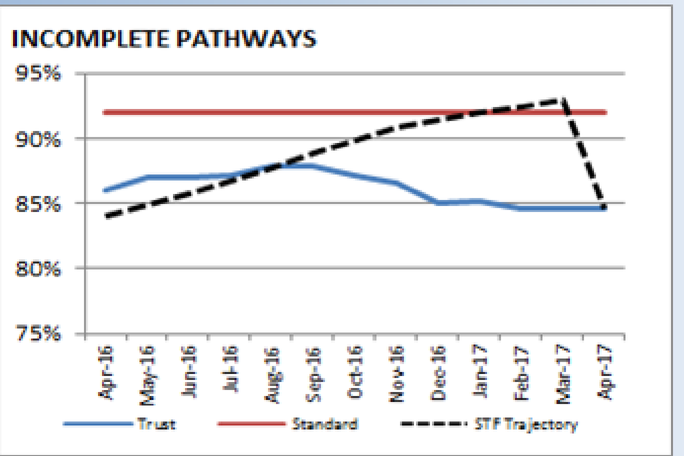
Description	Aggregate Position	Trend	Variation



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

The Trust achieved the April Improvement trajectory of 84.5%

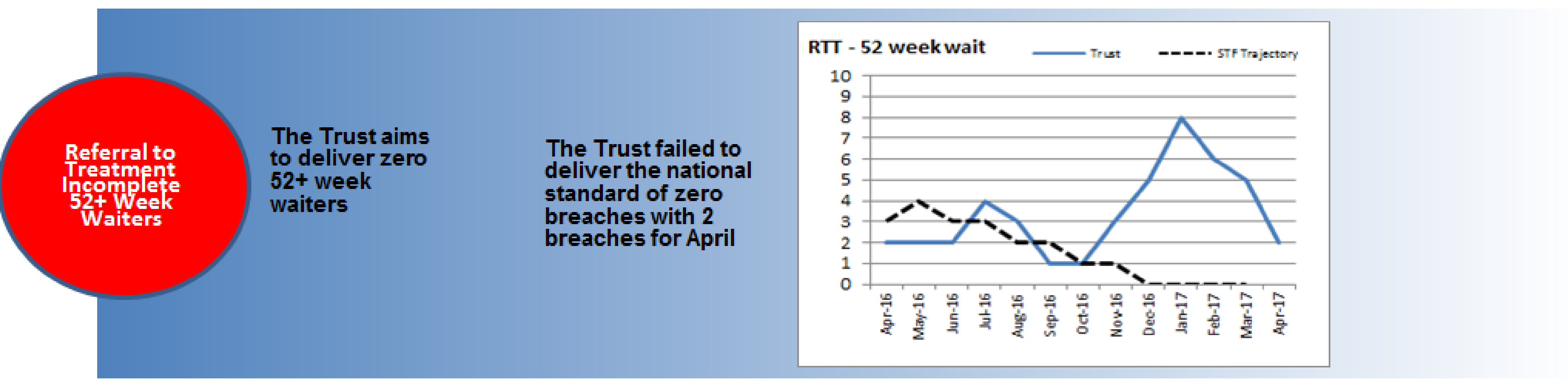
April performance was 84.5%



Great Staff - Great Care - Great Future

RESPONSIVE

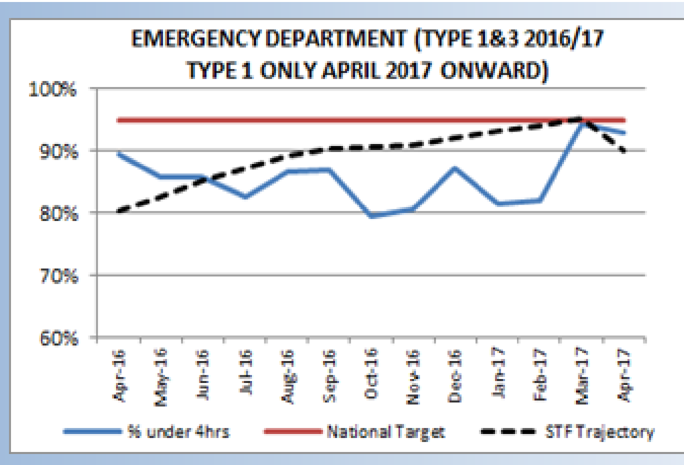
Description	Aggregate Position	Trend	Variation



A&E Waiting Times

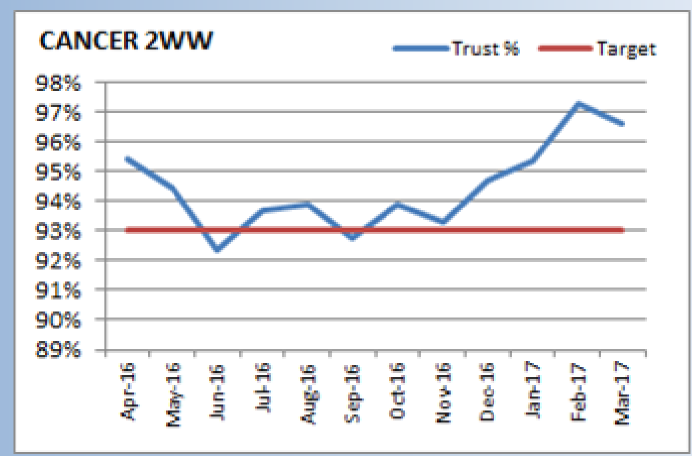
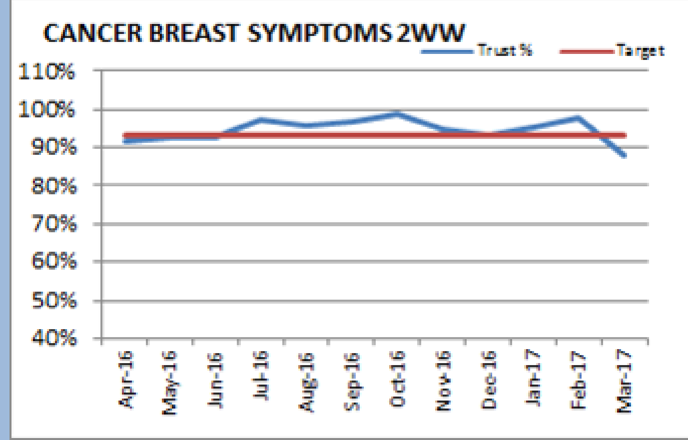
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance achieved the Improvement trajectory of 90.0% with performance of 93.8% for April. This has failed to achieve the national 95% threshold.



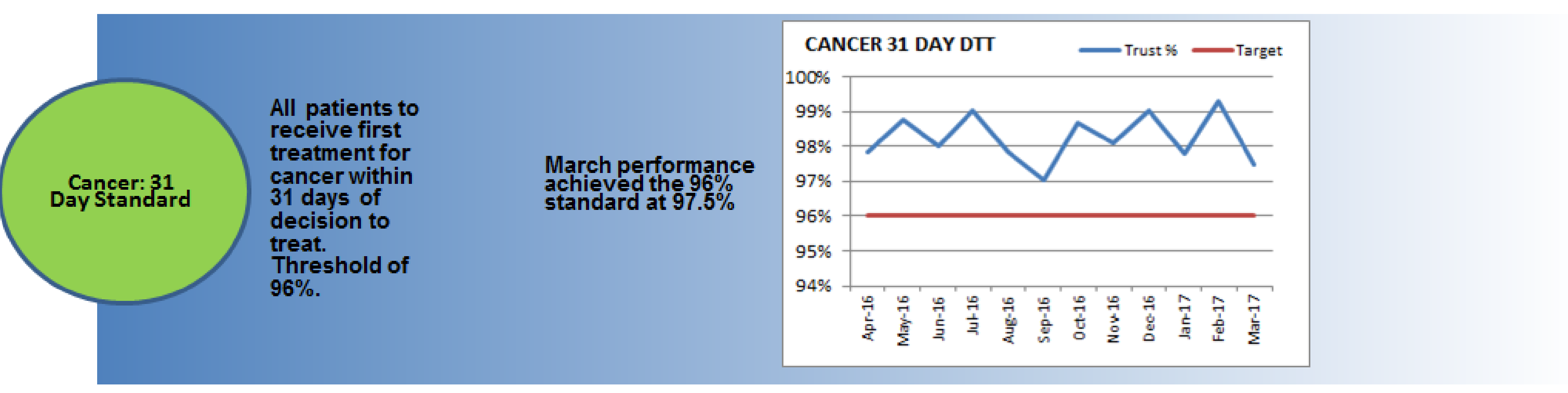
Performance has decreased by 0.6% during April compared to March performance of 94.4%.

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%.	March performance achieved the 93% standard at 96.6%		
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.	March performance failed to achieve the 93% standard at 88.2%		

RESPONSIVE

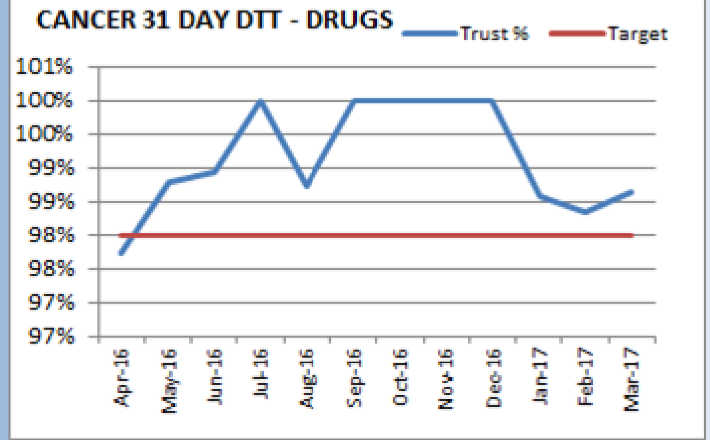
Description	Aggregate Position	Trend	Variation



Cancer: 31 Day Subsequent Drug Standard

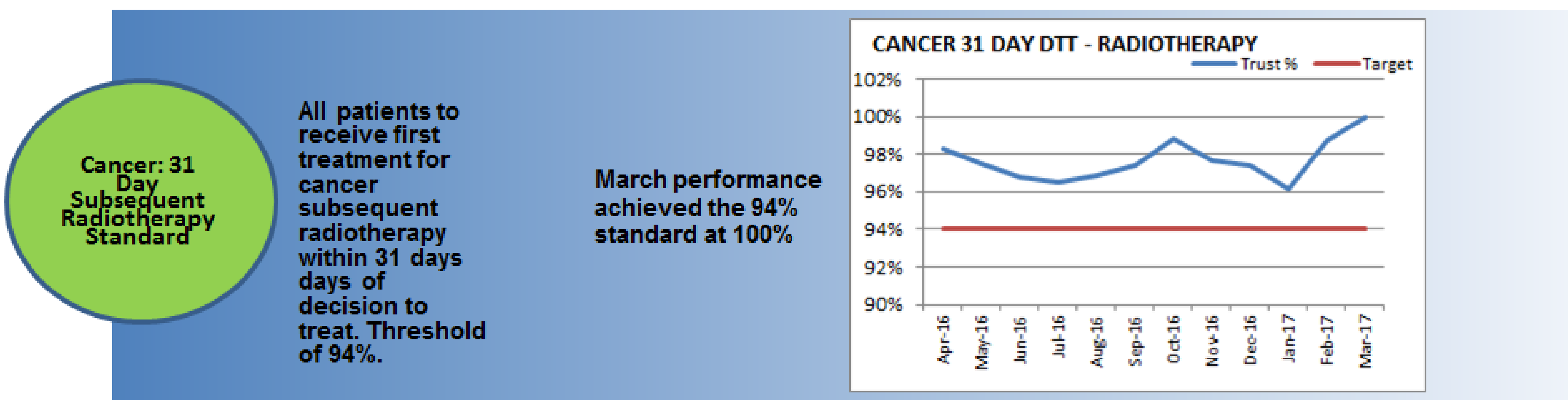
All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 98%.

March performance achieved the 98% standard at 98.6%



RESPONSIVE

Description	Aggregate Position	Trend	Variation



Cancer: 31 Day Subsequent Radiotherapy Standard

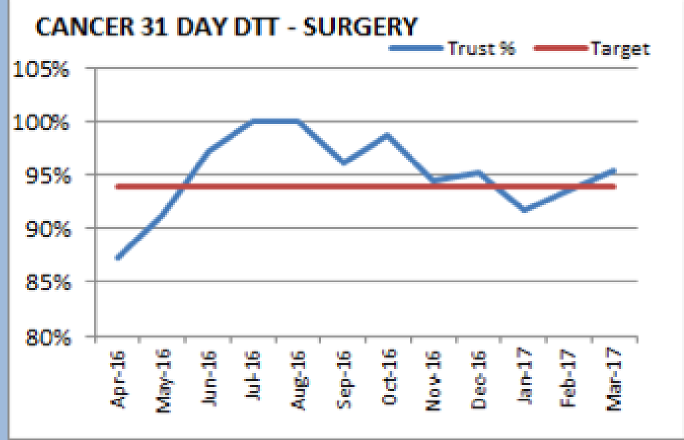
All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.

March performance achieved the 94% standard at 100%

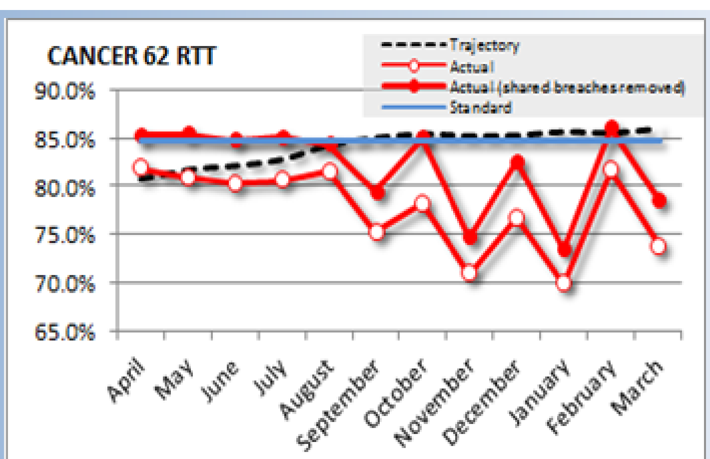
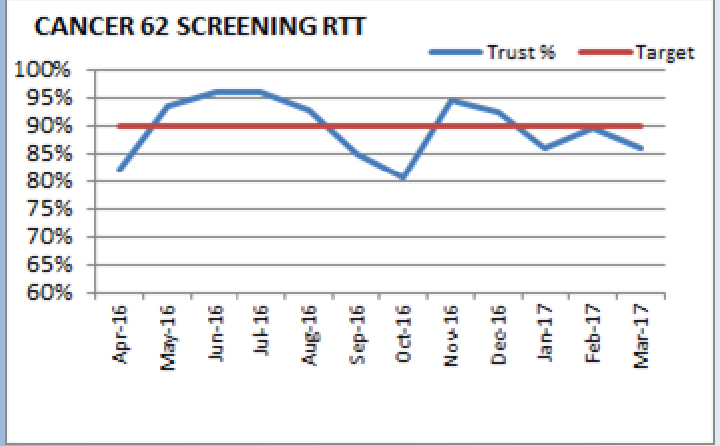
Cancer: 31 Day Subsequent Surgery Standard

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

March performance achieved the 94% standard at 95.4%

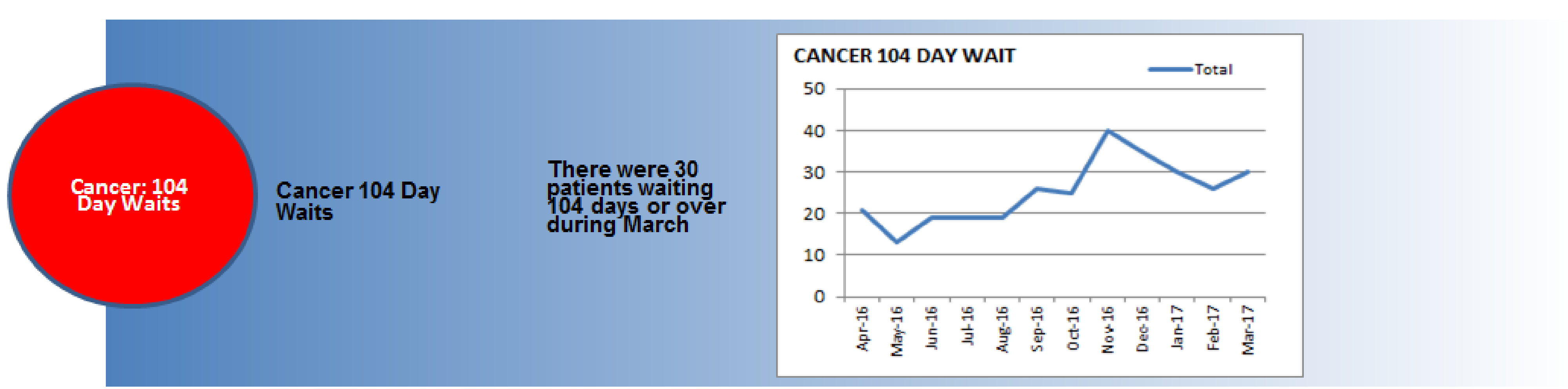


RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: ADJUSTED - 62 Day Standard	All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85% Sustainability and Transformation trajectory is 85.7%	The adjusted position allows for reallocation of shared breaches March failed to achieve the STF trajectory of 85.7% with performance of 78.3%		
Cancer: 62 Day Screening Standard	All patients need to receive first treatment for cancer within 62 days of urgent screening referral. Threshold of 90%	March performance failed to achieve the 90% standard at 86.0%		

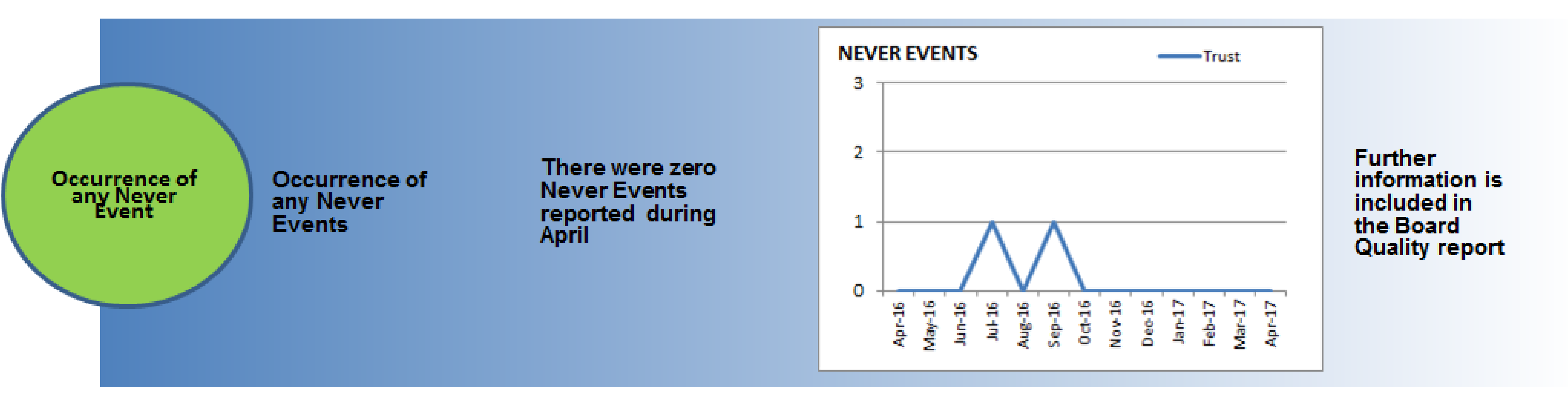
RESPONSIVE

Description	Aggregate Position	Trend	Variation



SAFE

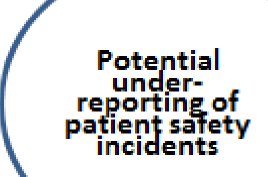
Description	Aggregate Position	Trend	Variation



Occurrence of any Never Events

There were zero Never Events reported during April

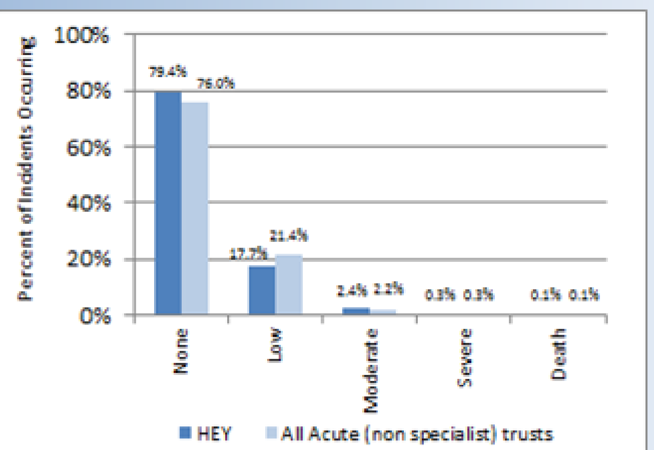
Further information is included in the Board Quality report



Number of incidents reported per 1000 bed days

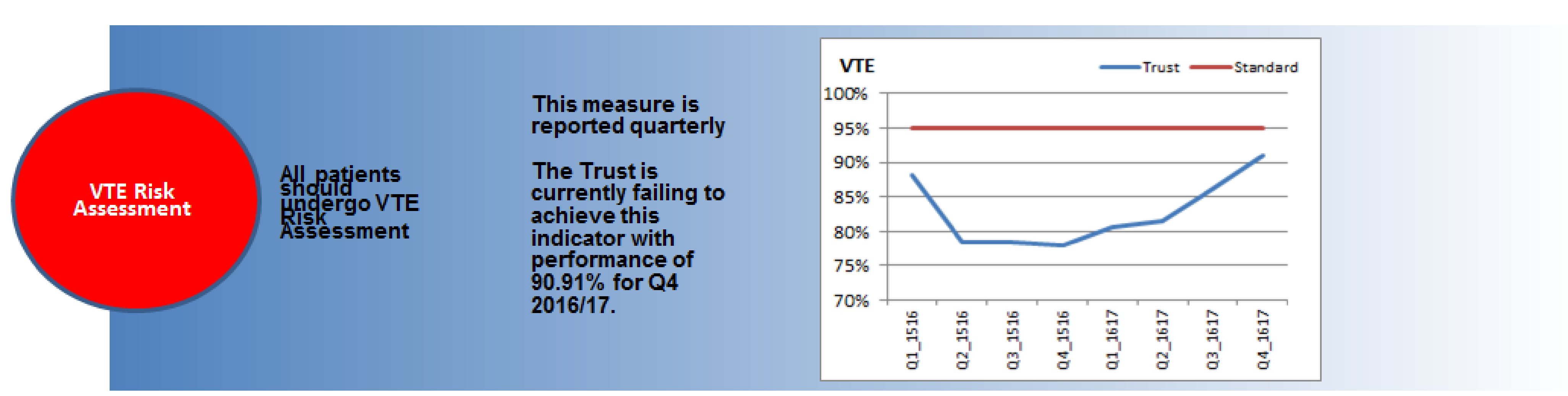
The latest data available for this indicator is April 2016 to September 2016 as reported by the National Reporting and Learning System (NRLS).

The Trust reported 5,546 incidents (rate of 32.71) during this period.



SAFE

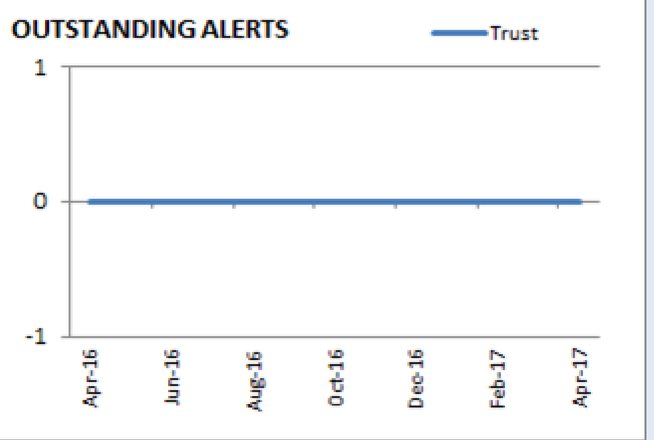
Description	Aggregate Position	Trend	Variation



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

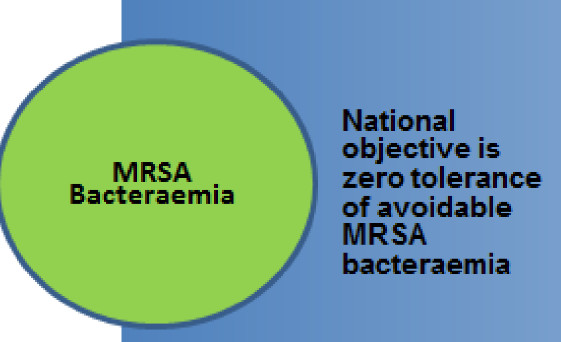
There have been zero outstanding alerts reported at month end for April2017.

There have been no outstanding alerts year to date.



SAFE

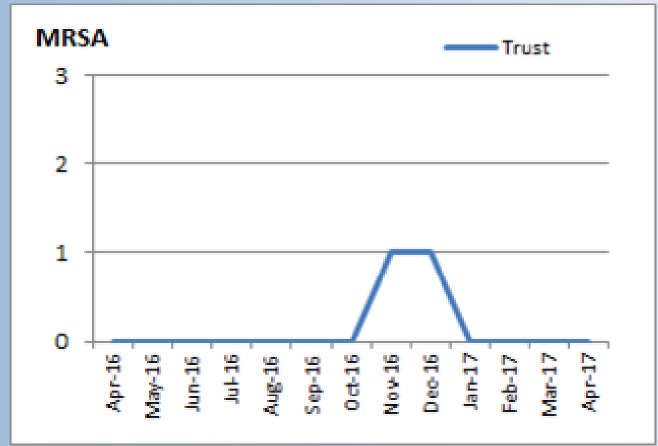
Description	Aggregate Position	Trend	Variation



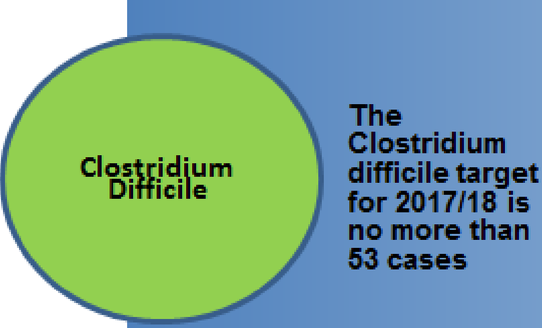
National objective is zero tolerance of avoidable MRSA bacteraemia

The Trust has reported 2 cases of acute acquired MRSA bacteraemia during 2016/17.

There were no cases reported during April 2017.



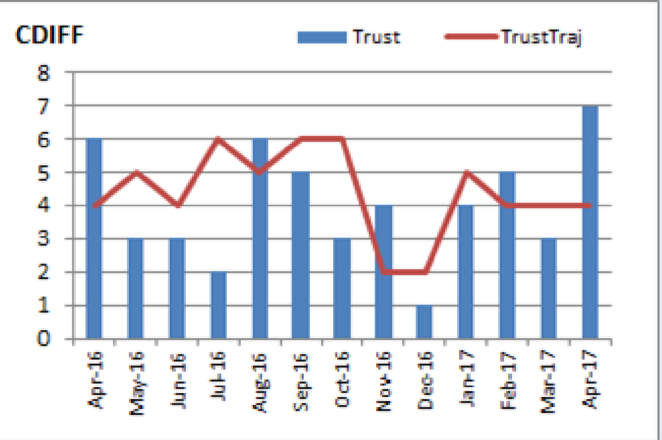
Further information is included in the Board Quality report



The Clostridium difficile target for 2017/18 is no more than 53 cases

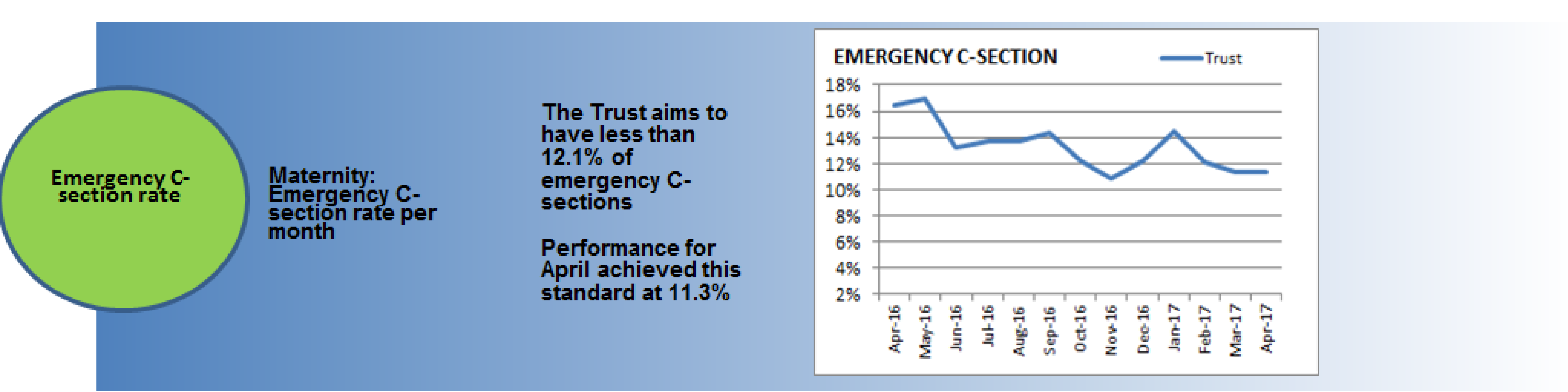
There have been 7 cases year to date

There were 7 incident reported during April which failed to achieve the monthly trajectory of no more than 4 cases

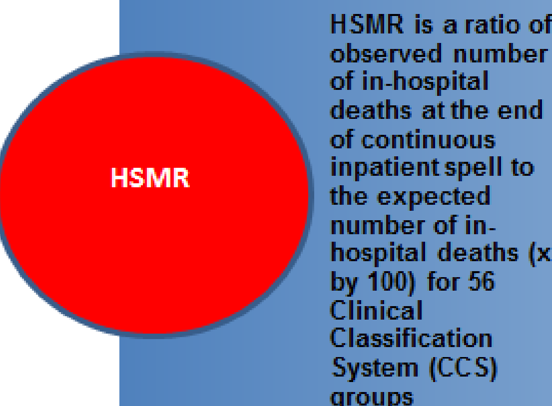
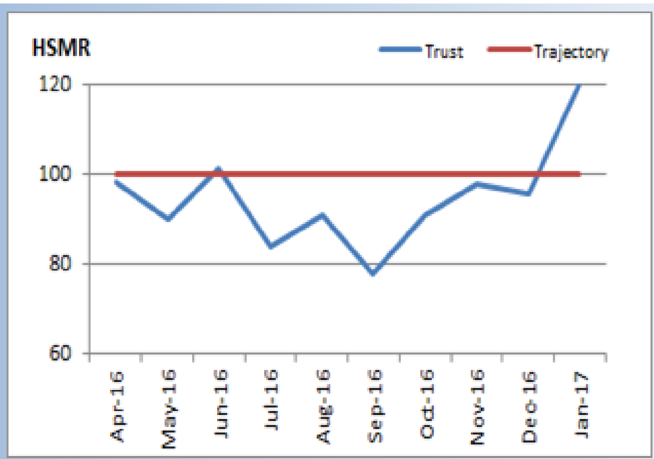
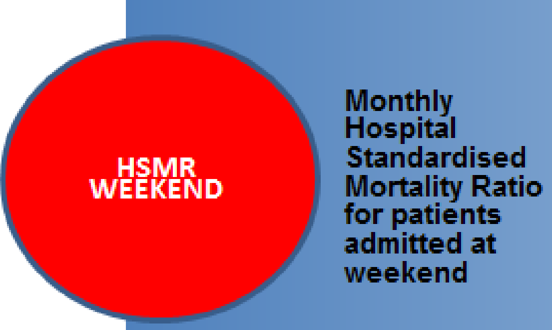
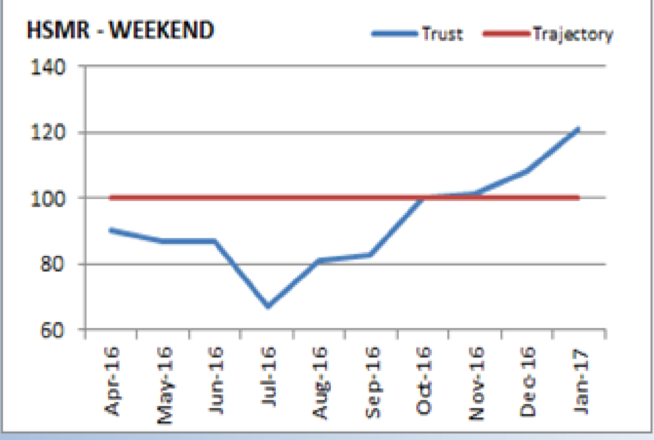


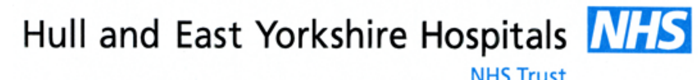
SAFE

Description	Aggregate Position	Trend	Variation

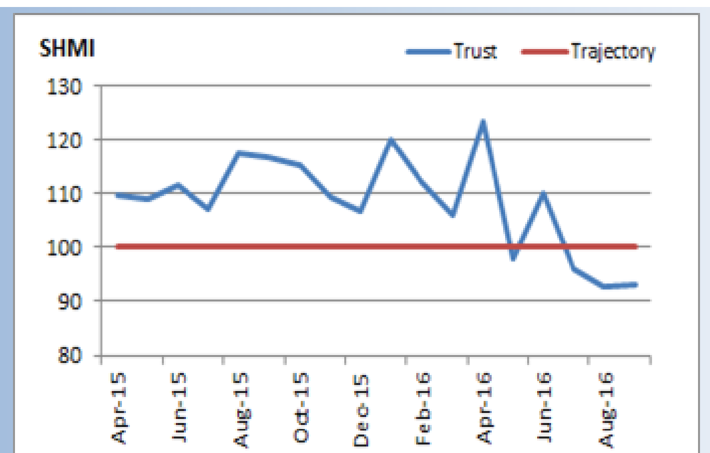
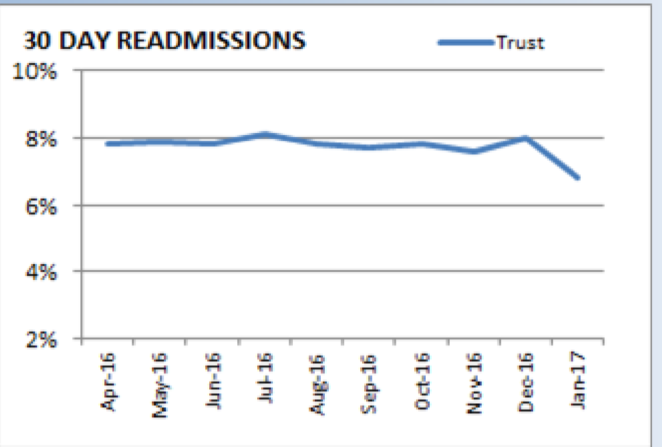


EFFECTIVE

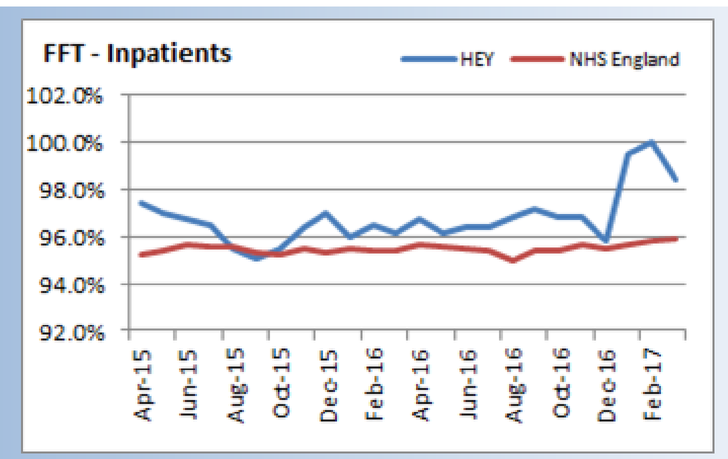
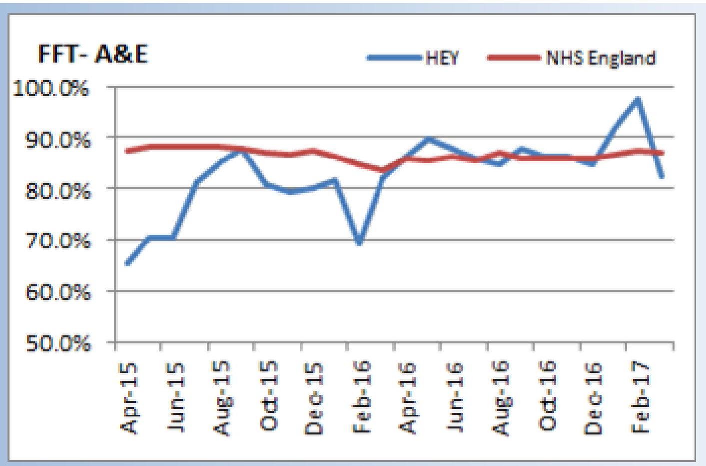
	Description	Aggregate Position	Trend	Variation
	HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups	January 2017 is the latest available performance The standard for HSMR is to achieve less than 100 and January 2017 failed to achieve this at 119.7		
	Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend	January 2017 is the latest available performance The standard for HSMR at weekends is to achieve less than 100 and January 2017 failed to achieve this at 121		



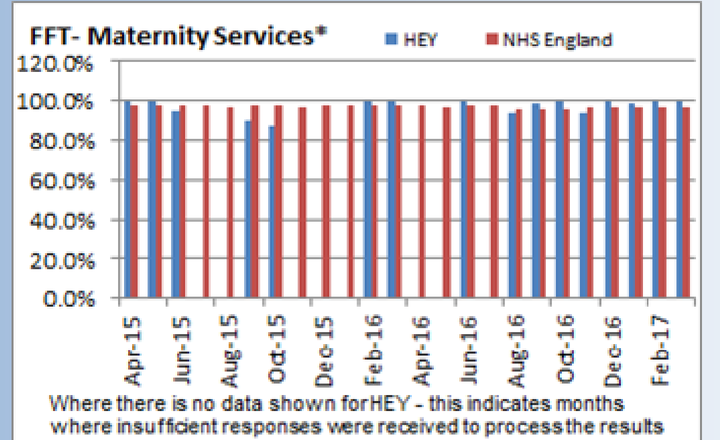
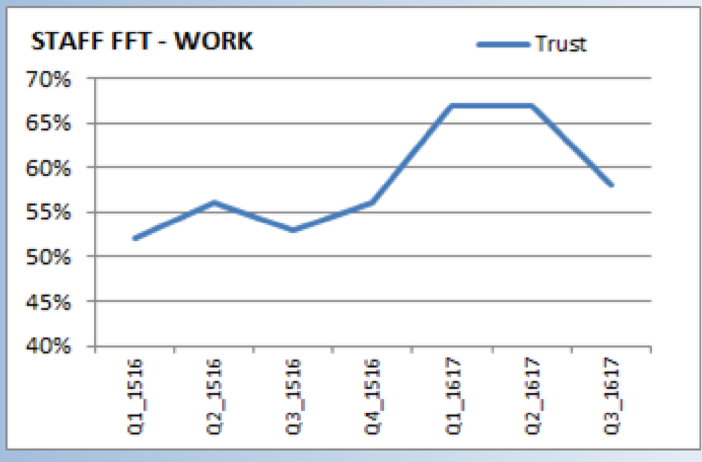
EFFECTIVE

	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 January 2017 The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than or equal to 7.8%. The Trust achieved this measure with performance of 6.8%.		

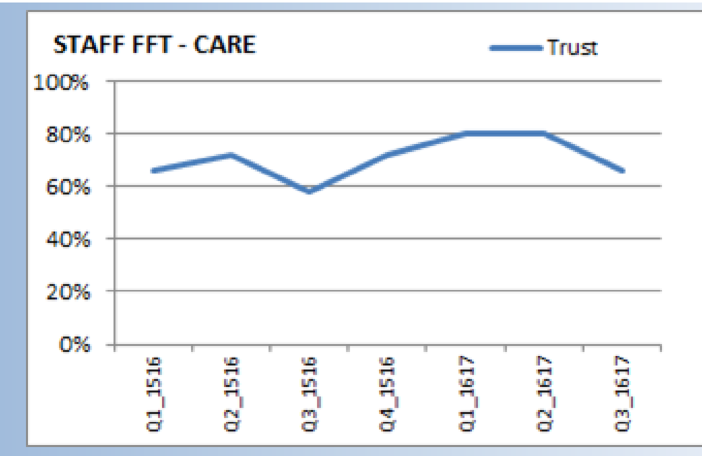
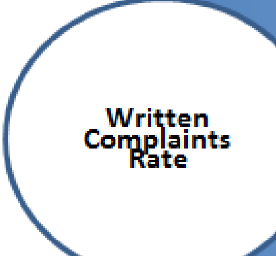
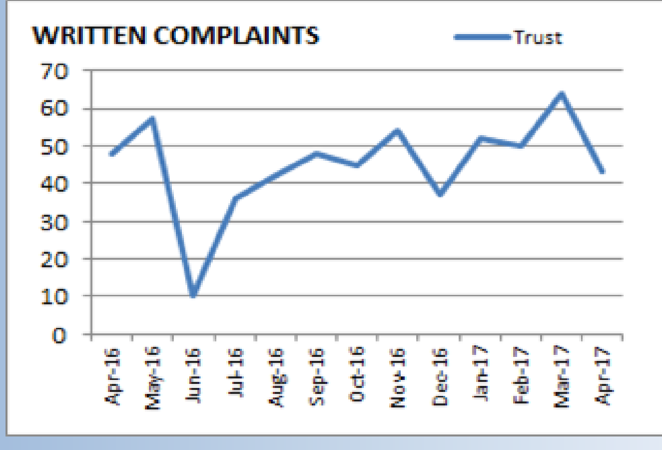
CARING

	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 March was 98.4% The latest published data for NHS England is March 2017. April 2017 will be published 8th June 2017.		The overall response rate for March was 21.0%
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for March was 82.4% The latest published data for NHS England is March 2017. April 2017 will be published 8th June 2017.		The overall response rate for March was 2.9%

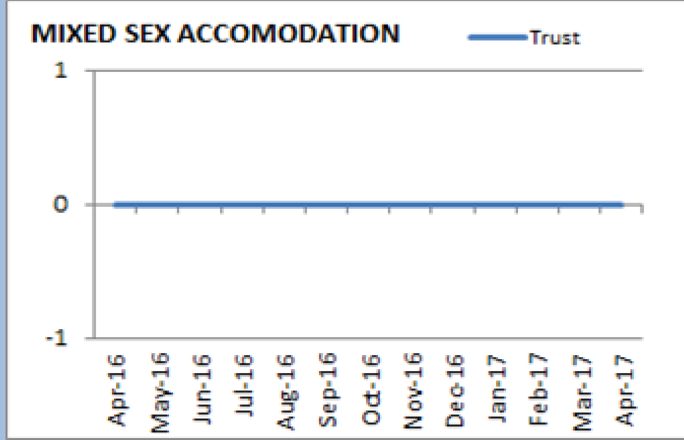
CARING

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 March was 100% The latest published data for NHS England is March 2017. April 2017 will be published 08th June 2017. Months with no data for HEY is due to insufficient responses		* Question relates to Birth Settings The overall response rate for March was 14.2%
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 3 2016/2017 shows that 58% of surveyed staff would recommend the Trust as a place to work, this has deteriorated from the quarter 2 position. Quarter 4 performance will be published 1st June 2017.		The overall response rate for quarter 3 was 44%

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 3 2016/2017 shows that 66% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has deteriorated from the quarter 2 position. Quarter 4 performance will be published 1st June 2017.		The overall response rate for quarter 3 was 44%
 Written Complaints Rate	The number of complaints received by the Trust	The Trust received 43 complaints during April, this is a decrease on the March position of 64 complaints		There have been 43 complaints year to date

CARING

Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches — Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.	There were no occurrences of mixed sex accommodation breaches throughout April 2017.		

ORGANISATIONAL HEALTH

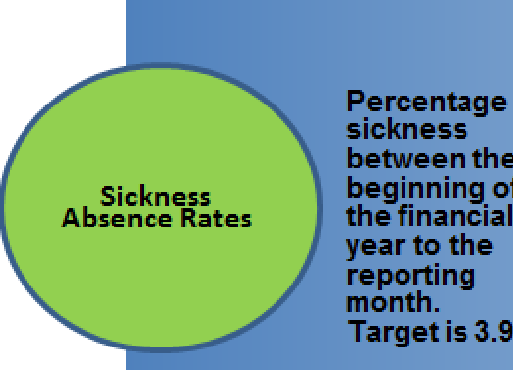
Description	Aggregate Position	Trend	Variation
WTEs in post – Contracted WTE directly employed staff as at the last day of the month	Trust level WTE position as at the end of April was 7155 .1	WTE in post (chart)	
Sickness Absence Rates – Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.	Performance for April achieved the standard of less than 3.9% with performance of 3.70%	SICKNESS RATE (chart)	

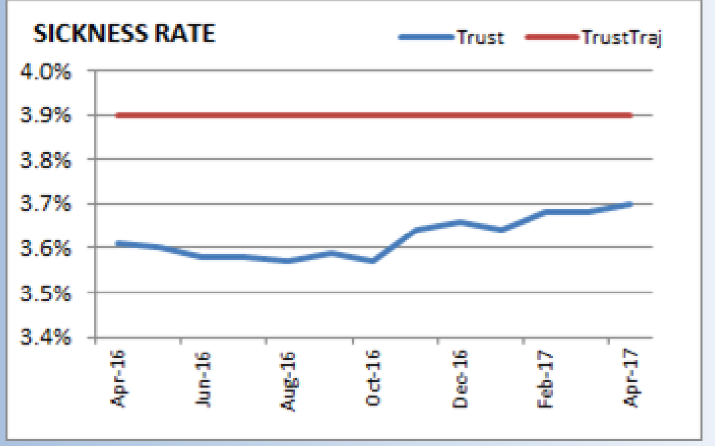
WTE in post

Trust

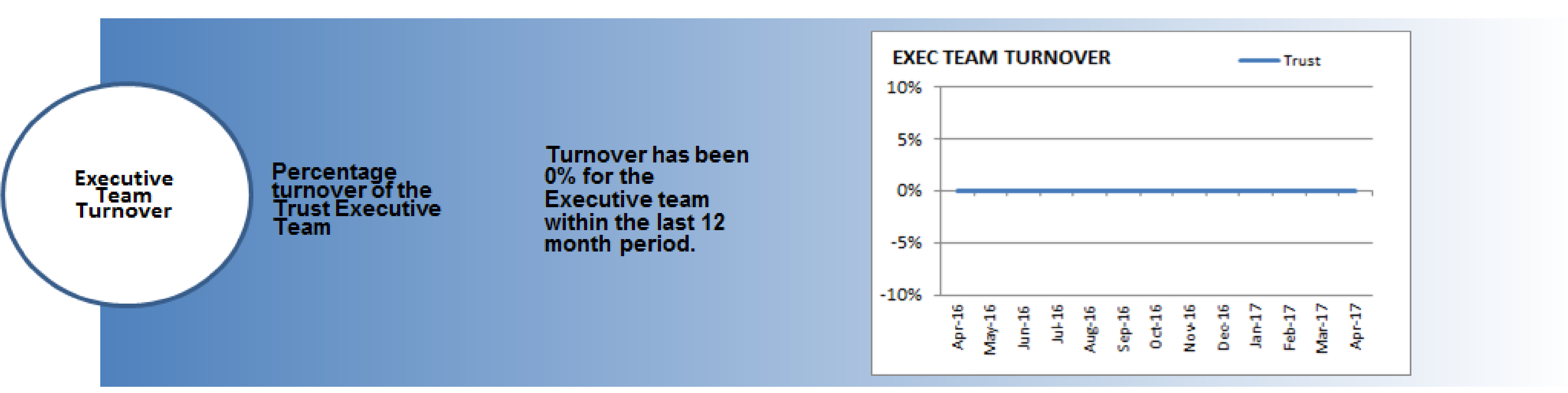
7200
7150
7100
7050
7000
6950
6900
6850

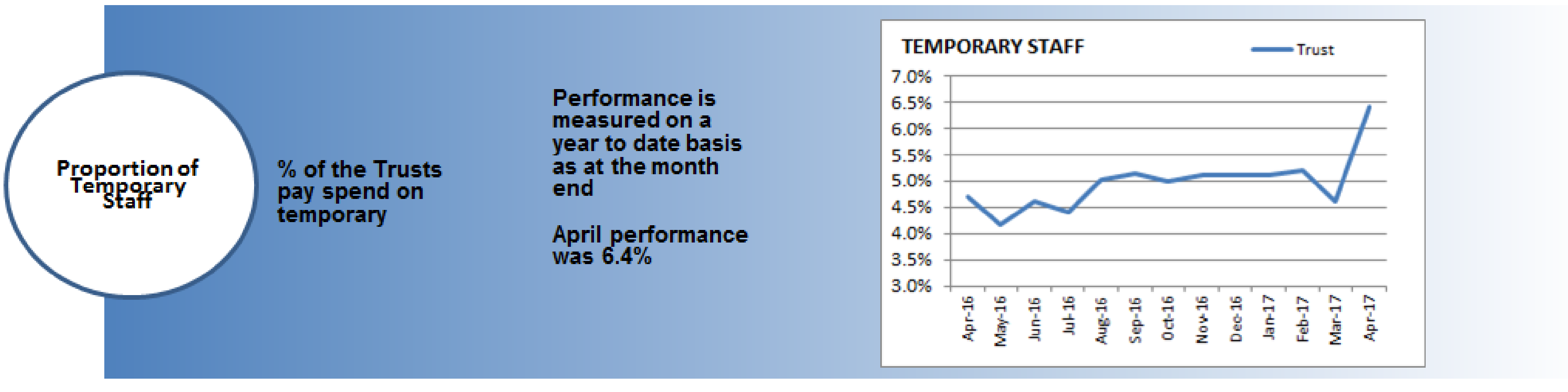
Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17

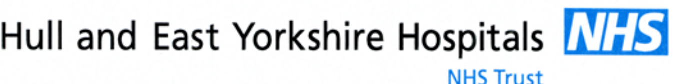




Description	Aggregate Position	Trend	Variation







FINANCIAL SUMMARY: 1 MONTH TO 30TH APRIL 2017

1. At the end of month 1 the Trust is reporting a deficit of £5.3m. This is £1.1m above the planned deficit of £4.2m.

2. The planned level of deficit in month 1 reflects the low level of 'working days' in April 17 (only 18 working days).

3. Health Group positions are £1.1m overspent. The main issues driving the overspend are £0.6m CRES shortfall (after release of £0.2m contingency reserve), £0.2m for Junior Doctors rota issue in acute medicine, and £0.3m non pay pressures, predominantly in the Surgery HG, that need resolving immediately.

4. The Trust is trading at £1.0m above contract at month 1. This over trade includes additional activity that may be included within the Aligned Incentives Contract. The Trust is therefore reporting that it is £0.5m above its income plan at month 1, mainly related to PBR excluded drugs and devices that come under the remit of NHS England. At month 2 a more robust assessment of the split of any contract variance between Commissioners will be available.

5. To the end of April the Trust has delivered £0.4m of CRES savings against a target of £1.2m for the month. The plan for the year is £15m but to date only £3.9m of plans have been fully developed, with another £5.5m of plans in progress. The FIP2 process is being utilised to identify additional savings.

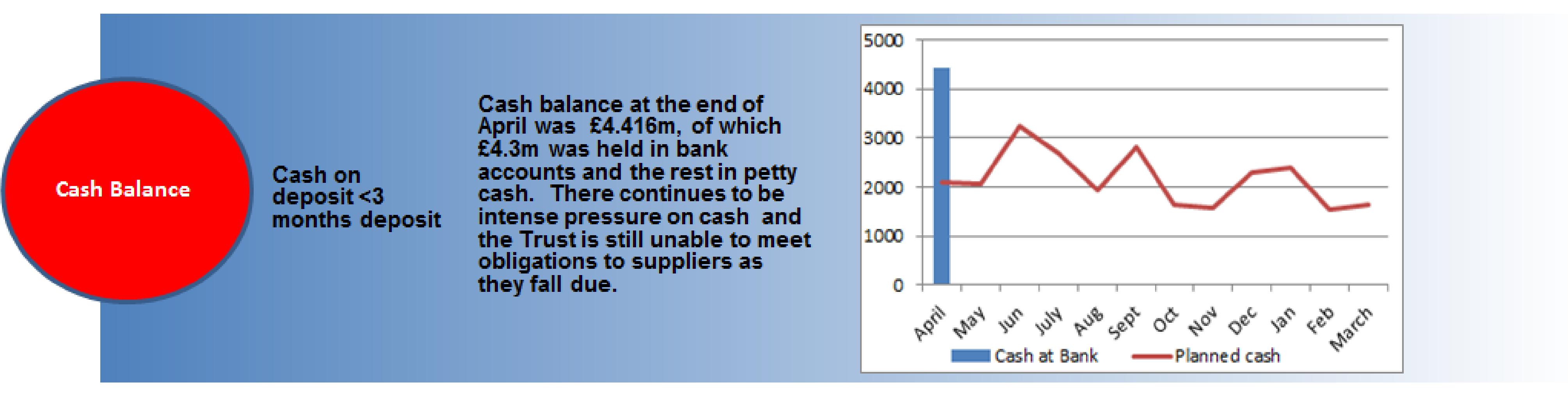
6. Agency spend for the month was £0.9m which is in line with the plan.

7. The Trust has not agreed the control total for 2017/18 and is forecasting a £14m deficit at he year end. Based on the initial assessment from Deloittes as part of the FIP2 process there is an additional risk of around £3.5m that the underlying position of the Trust is worse than reported.

8. A combination of the planned SOCI deficit at £14m and the deteriorating financial position due to non delivery of CRES and other financial pressures could lead to the Trust reaching a deficit of approximately £30m by the year end. This is equivalent to £2.5m per month and is not sustainable in terms of cash availability. To mitigate this risk, the Trust has agreed with its 2 main commissioners that its contract income will be paid in instalments based on 1/10ths, not 1/12ths. This will provide the Trust with £5m additional cash per month for the first 10 months of the year but will leave a significant cash shortfall in the final two months of the year. There is therefore significant pressure for the Trust to agree a control total and gain access to STF support ,as well as capitalising as fully as possible on any savings opportunities arising from the FIP2 process as quickly as possible. Failure to do this will require the Trust to take out emergency cash support loans in the final quarter of the year.

ORGANISATIONAL HEALTH

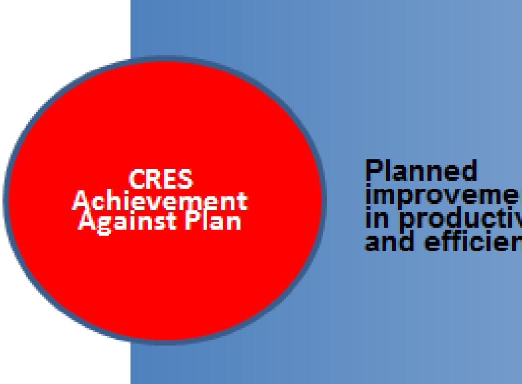
Description	Aggregate Position	Trend	Variation



Cash Balance

Cash on deposit <3 months deposit

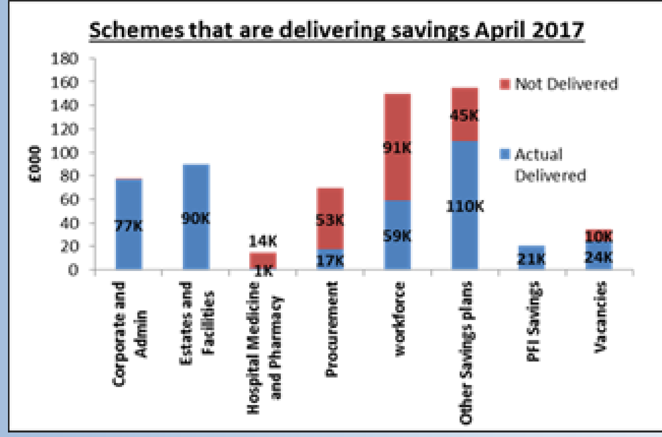
Cash balance at the end of April was £4.416m, of which £4.3m was held in bank accounts and the rest in petty cash. There continues to be intense pressure on cash and the Trust is still unable to meet obligations to suppliers as they fall due.



Planned improvements in productivity and efficiency

As at month 1 the Trust has delivered £0.4m of CRES savings against a CRES ytd plan of £1.2m (£0.8m adverse variance)

The chart shows an analysis of schemes that are delivering some level of savings against those identified in the initial plan (£0.4m against planned schemes of £0.6m), it should be noted that there is a further £0.6m in the CRES savings plan that are still considered unidentified.



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

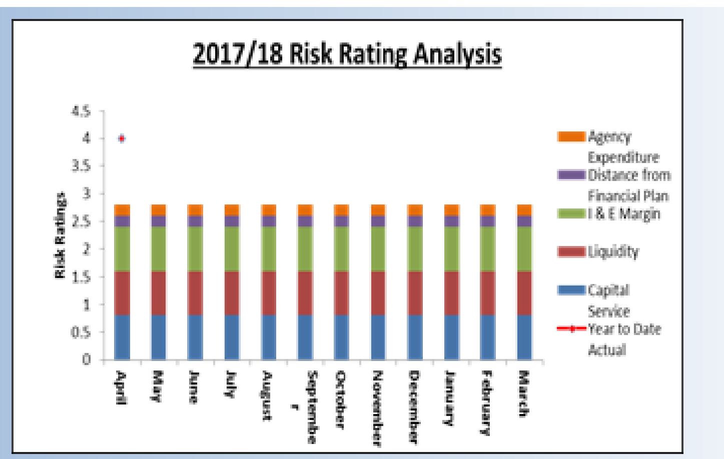
Description	Aggregate Position	Trend	Variation

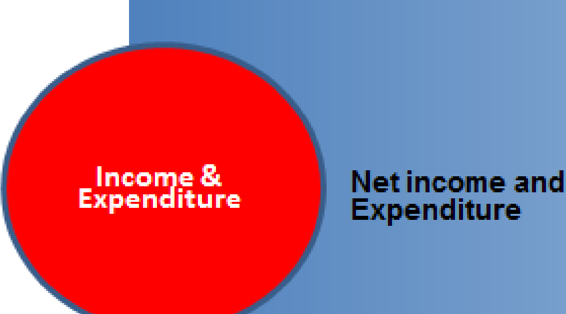
Financial Sustainability Risk Rating

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 Trusts risk rating is currently 4.

The Trust has started the year with a deficit of £5.3m against a plan of deficit £4.2m (£1.1m adverse) this has resulted in liquidity, Capital servicing, I&E Margin and distance from plan all being rated as a 4, resulting in an overall risk rating of 4.

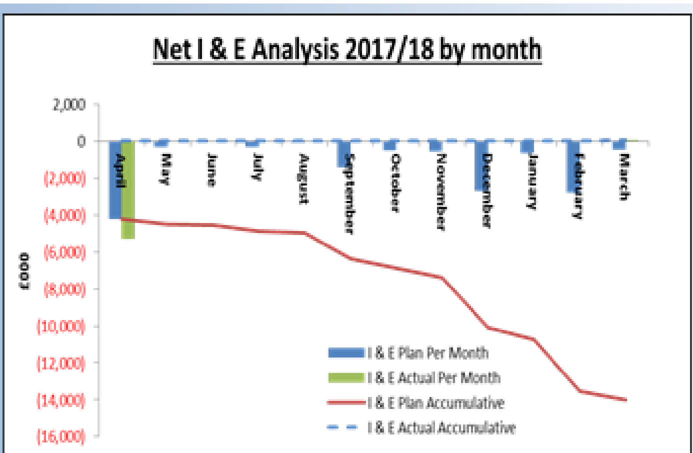




Net income and Expenditure

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

At month 1 the Trust has delivered a deficit of £5.3m against a plan of £4.2m deficit (£1.1m adverse). The plan for 17/18 is to deliver a deficit of £14m



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

Meeting Date:	24 April 2017	**Chair:**	Stuart Hall	**Quorate (Y/N)**	Y

Key issues discussed:

- Surgery Health Group gave a presentation regarding theatre performance, RTT, staffing, CRES and finance issues. New Finance Director appointed, new nurses appointed.
- 'Getting it right first time' report was circulated to the Committee – ER to circulate action plan and process
- Workplan was reviewed by the Committee
- Governance and accountability of the Health Groups and Executives was discussed
- Interaction with key stakeholders discussed with a focus on Yorkshire Ambulance Service
- Financial Plan – Control total to be confirmed
- Financial Improvement Programme – Phase 1 in progress to be reported to the Committee
- Performance – A&E much improved position, RTT - work ongoing, cancer standards struggling due to diagnostic issues.
- End of year Financial position - £78k surplus
- Agency Report – year end position £13.1m against £9.5m budget.
- Capital Resource Allocation Committee – Archiving strategy standardisation, ground floor refurbishment to include MRI/CT capacity upgrades
- Effectiveness Review – mapped against the Terms of Reference
- The Board Assurance Framework was presented for the Committee to review

Decisions made by the Committee:

- The Chair and Director of Governance to review the workplan ahead of the next meeting to ensure it reflects the key responsibilities of the Committee throughout 2017/18
- Exception report to be received relating to Agency Spend

Key Information Points to the Board:

- Trust's Control Total to be confirmed
- Diagnostic issues – GP direct referrals to be reviewed

Matters escalated to the Board for action:

Matters deferred to other Board Committees:

- Hyper Acute Bed issues to be referred to the Quality Committee

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE
HELD ON 24 APRIL 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:	Mr T Moran	Chairman
	Mr S Nearney	Director of Workforce & OD
	Ms C Ramsay	Director of Corporate Affairs
	Mr P Watson	Operations Director – Surgery Health Group
	Ms D Sweeney	Deloittes
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES **ACTION**

There were no apologies received.

2. MINUTES OF THE MEETING HELD 27 MARCH 2017

The Chair proposed the following amendments:

- Mrs M Veitch's title should read: Deputy Chief Operating Officer.
- Item 7 – Performance Report – 5th paragraph – should read "Cancer targets still remained challenging with a number of breaches mainly due to increased demand on diagnostics".

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

3. ACTION TRACKING LIST

Hyper Acute Beds – Issues referred to the Quality Committee. **SH**

Clinical Research Outpatient Review – Mrs Ryabov to provide at the next meeting. **ER**

Surgery Health Group Presentation

Mr Watson from the Surgery Health Group gave a presentation which highlighted theatre productivity trends and performance and finance issues. The main issues raised were theatre performance, CRES shortfall and agency spend.

Theatre work was ongoing to improve theatre scheduling and eliminate as many staff vacancies as possible. Two new back specialists had been recruited but further work to recruit nurses and ODPs was required. Mr Watson reported that electronic job plans would be in place by September 2017 which would encourage more efficient working.

There had been an issue in the ICU and a number of nurses had now been recruited. The Health Group had seen an overspend of £500k due to nursing vacancies but this would now reduce due to the 95 new nurses that had been recruited.

Mr Watson advised that a review of beds was taking place at Castle Hill

Hospital.

Mr Gore expressed his concern regarding accurate forecasting and asked how this would be addressed going forward. Mr Watson advised that a new head of finance had been appointed to monitor the plans and drive the CRES programme.

Resolved:
The Committee received the presentation.

4. MATTERS ARISING

Hospital Improvement Programme – Mr Hall to discuss requirements with Mrs Joyce prior to the next meeting in May 2017. **SH**

Referrals Dashboard – Mrs Ryabov to present the dashboard to the next committee in May 2017. **ER**

Nominated clinical leads – Mr Bond to confirm the leads from each of the HGS to help with the development of our costing systems. **LB**

4.1 – 'Getting It Right First Time' OUTCOMES – ORTHOPAEDICS REVIEW

Mr Bond had circulated the Orthopaedics review prior to the meeting to show the Committee where improvements had been made through GIRFT projects and what work was still to be done. One of the key recommendations was to establish local clinical networks to standardise small volume procedures.

Mr Hall asked if a report could be produced showing other specialities, how the Trust was learning from good practices and what effect the GIRFT was having. Mrs Ryabov agreed to summarise the process and provide the overall action plans to the Committee. **ER**

Resolved:
The Committee received the update and agreed to receive further updates when available.

5. DRAFT WORKPLAN 2017/18

Ms Ramsay presented the draft workplan to the Committee. She advised that the plan would be a standard agenda item. The new Financial Improvement Programme was to be added (FIP2) and Health Group attendance would have a themed approach. Ms Ramsay added that the issues should link to the Board Assurance Framework to inform any lack of control or gaps in assurance.

There was a detailed discussion around Health Group and Executive accountability and it was agreed that the Executives were accountable overall but the Health Groups could be invited to reinforce and assure the committee further.

There was a discussion around the Lord Carter programme and Mr Bond advised that the model hospital dashboard was available on line for Committee members to view. **LB**

Resolved:
The Committee received the workplan for 2017/18 and agreed to receive it as a standing agenda item at each meeting.

6. **FINANCIAL PLAN 2017/18 UPDATE INCLUDING FIP2**

Mr Bond reported that the Trust had not yet signed off its control total and that year end accounts were being prepared which was delaying actions regarding this.

Mr Bond updated the Committee regarding the Financial Improvement Programme (FIP2) and reported that the first phase was in progress. Within 4 weeks the Trust would have a report detailing the works required to gain the most savings and would have to decide whether to go ahead with the final phase of the programme.

Resolved:

The Committee received the update and Mr Bond agreed to update the Committee regarding the control total and the FIP2 programme when further information was available.

7. **PERFORMANCE REPORT**

Mrs Ryabov reported that the A&E performance for March was 94.5% which was a much improved position. She advised that the Unplanned and Emergency Care programme had been completed and a number of actions were being implemented. Trust performance had reached 95.2% in April 2017 making the organisation 2nd in the region and 18th in the Country. Mr Hall asked that this achievement be recognised and staff thanked for their hard work.

Ambulance turnaround times were discussed and Mr Moran advised that the previous Trust he worked for worked closely with Yorkshire Ambulance Service to accurately record timings and reduce long waits. Mrs Ryabov advised that the Trust did have a good relationship with YAS but more could be done.

The Referral to Treatment Times performance was at 91.6% just under the improvement trajectory of 92.9%. The high levels of activity were still an issue and the front end of the pathway was being reviewed in an attempt to reduce the backlog. Diagnostic and theatre pressures were compounding the increases in activity. Mr Hall asked for further information relating to this topic and Mrs Ryabov agreed to bring the performance reviews presented quarterly to the PandA meetings.

ER

There had been 5 x 52 week waits in March due to admin error, patient not attending and ICU capacity. All patients had now been treated.

Mrs Ryabov reported that the 31 day subsequent treatment cancer standard had not been achieved but that the numbers were very small with no clinical complications. 62 day RTT was 81.7% and this was due to late referrals. The cancer lead to review this with referring cancer managers.

There were still major concerns relating to diagnostics and this is having implications across the board. The cardiac CT scanning service had seen an increased level of referrals and issues with consultant capacity. A number of radiologist posts had been recruited to and a review of GP direct access referrals was under way. More diagnostic capacity was required but funding was an issue. Mr Bond advised that he had put in a

capital bid for STP additional funding to enable the Trust to purchase more MRI/CT capacity. Mrs Ryabov added that she would circulate the capacity and demand papers to the committee members for information. **ER**

Resolved:
The Committee received the information and:

- receive performance information relating to diagnostics **ER**

8. CORPORATE FINANCE REPORT

Mr Bond reported that the Trust had achieved a surplus of £78k at month 12 and had delivered its statutory financial targets. The position was based on the Trust receiving the full £14m STF funding as per NHSI guidelines.

He reported that the Health Groups were overspent by £14.7m. The Trust had delivered its plan due to receiving additional educational income, reductions in PDC and releasing reserves. The Health Groups had seen an increase in their cost bases but had failed to deliver the funded levels of activity.

The control total for 2017/18 had not been agreed and the Trust would be developing a Financial Improvement Programme (FIP2) with external support.

Resolved:
The Committee received the updated financial position at month 12.

8.1 – CRES 2017/18

Mr Bond reported that the Trust had delivered £15m of efficiency savings in 2016/17 which was £4.2m short of plan. There was a discussion around how the Health Groups would manage the process and achieve their targets in 2017/18.

8.2 – AGENCY REPORT (FINANCE)

Mr Nearney reported that the Trust had spent £13.1m on agency staff against a budget of £9.5m. He advised that the Trust didn't meet its NHS Improvement target but would not incur any penalties due to this. The Intensive Care Unit had incurred high costs throughout the year but this should now reduce due to the current successful recruitment campaign.

Mr Nearney stated that he would bring a report detailing regional and national comparators. He also advised that Health Groups had been tasked with reducing their agency spend by 25% in 2017/18 and reviewing different ways of working.

Mr Gore asked if a report showing what we have spent, by specialty, on Waiting List Initiatives over the past 2-3 years and what we have outsourced to Spire in that period also could be prepared. **LB**

Mr Hall asked if an exception report, similar to the performance report presented by Mrs Ryabov could be developed for the Agency expenditure. **SN**

Resolved:
The Committee received the report and requested an exception report to be developed.

9. CAPITAL RESOURCE ALLOCATION COMMITTEE

Mr Bond presented the report and highlighted work ongoing to review the cardiology archiving system to ensure the most efficient service was provided. He also reported that the front main entrance of the Tower Block at Hull Royal Infirmary was being reviewed with a view to incorporating more MRI/CT and theatre capacity.

Resolved:
The Committee received the update.

10. ANNUAL REPORT AND EFFECTIVENESS REVIEW

Ms Ramsay presented the report which reviewed the previous year's agenda items and mapped them against the committee's terms of reference. This gave assurance regarding the performance of the committee and highlighted any areas for development. Ms Ramsay advised that a further review document would be circulated to members to allow them to comment on the 'look and feel' of the committee.

Resolved:
The Committee received the annual report and effectiveness review.

11. ITEMS DELEGATED BY THE BOARD

11.1 – BOARD ASSURANCE FRAMEWORK 2017/18

Ms Ramsay presented the BAF to the Committee. She advised that the document contained the Trust's 7 strategic goals and principal risks and had been reviewed alongside the corporate risk register. This had been sense checked at the Executive Management Committee. She advised that the document was being presented to all Board committees and the Board for comments.

Resolved:
The Committee received the Board Assurance Framework.

12. ANY OTHER BUSINESS

There was no other business discussed.

13. DATE AND TIME OF THE NEXT MEETING:

Tuesday 30th May, 2pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE SUMMARY REPORT

30 MAY 2017

The Performance & Finance Committee met on 30 May 2017. The following points were discussed/agreed at the meeting:

1. The Director of Strategy and Planning presented the HEY Improvement model and outcomes in 2016/17. There had been improvements in theatre efficiencies and work was ongoing to develop further cost saving plans within the hospitals.

2. Mrs Ryabov presented the weekly RTT monitoring dashboard to the Committee which showed clock starts, the number of GP referrals and the waiting list profiles.

3. The workplan was reviewed and it was agreed that Mr Hall, Mr Bond and Mrs Ryabov would meet prior to the next meeting to review any topical issues to be added to the agenda. It was also agreed to review demand for elective and non-elective activity at each meeting. This would be added to the workplan.

4. A&E performance was consistent at 93.8% and the Trust was in the Top 5 trusts in the Yorkshire area. The frailty model would be implemented in June 2017 which would assist flow further. RTT was improving and work was ongoing at the front end of the waiting list. The STP had established 4 projects relating to cancer work to help improve pathways.

5. Diagnostic capacity was still an issue with discussions being had with York and NLAG to review their capacity.

6. Mr Bond reported that the current deficit was £5.3m which was £1.1m above plan. The control total had not yet been agreed and was a risk, but would not be resolved until after the election. The Committee agreed to escalate concerns regarding overspend by the Health Groups and CRES issues to the Board meeting in June 2017.

7. Agency Spend Report was presented and it was agreed to discuss workforce planning at the next meeting in June 2017.

8. Mr Bond updated the Committee regarding the FIP2 programme. He advised that the Executive Team had reviewed each of the potential pieces of work. He reported that the Board would be presented with a proposal to consider in June 2017.

9. Mr Bond presented a paper relating 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) is not agreed.

10. Capital programme - Mr Bond reported that the Trust was still waiting to hear whether it had been successful following a £4.4m bid for STP monies.

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 significant deterioration in the Trust's financial performance as reported at month 1. Specifically the gap in the CRES programme and the emerging overspends at Health Group level.
- The Committee was concerned regarding the Trust's diagnostic capacity and a representative from the area would be invited to the next meeting.

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

Stuart Hall
May 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PAPERLESS COMMUNICATIONS WITH PATIENTS

Trust Board date	6 June 2017			**Reference Number**	2017 – 6 - 16	
Director	Lee Bond – Chief Financial Officer			**Author**	Martyn Smith – Director of IM&T	
Reason for the report	To update the Trust Board on the evolution of electronic communications with patients.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to note the contents of the report. IM&T Strategy to be refreshed Q2 2017/18. No specific recommendations are made at this time.					
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): Responsive: services are organised so that they meet your needs					
	Assurance Framework Ref:		**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N	
5	**BOARD/BOARD COMMITTEE REVIEW**					

BRIEFING PAPER: PAPERLESS COMMUNICATIONS WITH PATIENTS

1. Introduction

Over the last 3 years National Policy has set out a number of expectations and challenges regarding how better use of information technology will drive innovation and efficiency and will contribute to transforming health and social care. In summary, these expectations are that:

- Care professionals and organisations will use Data and Technology to Transform Outcomes
- There will be greater interoperability, with more joined up systems and greater sharing of information with care partners and service users
- Systems will support 'paper free at the point of care' wherever that may be
- Access to information will enable care to be more integrated across sectors, and be provided closer to home.

The Trust Information Management & Technology Strategy is currently under review and is being refreshed to take account of evolving national requirements, patch wide IM&T intentions in support of the Sustainable Transformation Plans (STP's) and progress with internal Trust technological priorities.

In advance of the refreshed strategy, this paper summarises the current status and emerging thinking around electronic communications with patients.

National Policy references are given at the end of this paper (Appendix 1).

2. Sharing Information Digitally with GP's and Patients

National Policy, including the recently refreshed Five Year Forward View, sets out a number of mandates relating to eradicating paper and driving up the electronic exchange of information between GP's and Providers. Core targets are:

- 100% of referrals to be made electronically by October 2018
- 100% of Immediate Discharge Summaries to be transmitted electronically to GPs by October 2015
- All outpatient clinic letters to be transmitted electronically as structured messages to GPs by October 2018 and not via e-mail
- GPs able electronically to seek advice and guidance from a hospital specialist without the patient needing an outpatient appointment

With specific regards to patients, there is a mandate to provide all patients with access to their care record electronically by 2020 and that all patients will be offered the option of receiving correspondence electronically. Not mandated, but expected, is that Trust's will adopt a variety of approaches and will take advantage of technology to communicate more effectively with patients, including:

- use of available technology such as SMS messaging to remind patients of their upcoming appointments
- use of video conferencing / social media to provide virtual consultations, support home based care and avoid hospital visits
- e-mail, web and 'app' technology to share information and support new care models

All of these approaches are active components of the ICT Strategy, which will be refreshed to take account of emerging information / products. Section 3 sets out the Trusts approach to the specific challenge of electronic communications with patients and giving them access to their care record.

3. Sharing Information Digitally with Patients: The Trust Approach

3.1 SMS Appointments Reminder Service

The SMS service was initially rolled out to all clinics managed via the Appointments and Referrals Centre (ARC) under the purview of Patient Administration. The SMS service is not a simple '*Yes I am attending / No I am not attending*'. It is interactive and offers the patient a range of options, including the ability to change the appointment. If a patient wished to cancel or rebook an appointment, the call centre staff will have to deal with the outcome of that request.

Some specialties have clinics that are not managed by ARC:

- *Breast Surgery*
- *Cardiology*
- *Orthopaedics*
- *Neurosurgery*
- *CTS*
- *Therapies*
- *Most Diagnostic areas (excluding ECG & Metabolic Bone Scans)*

The strategy is to add the clinics that are managed by the specialties themselves into the SMS texting service. Preliminary work has commenced with the Surgical Health Group and in order to put these remaining clinics on the system we will need to identify who from the services will manage the outcomes (ie non-attenders and requests for changed appointments) and train those individuals to access to the system. A similar exercise will be required with the other Health Groups. The aim is to achieve this by 31st March 2018, though as yet the timescale remains undefined due to the disparate nature of the management arrangements. There is a potential to centralise this workload, dependent upon the outcome of the Clinical Administration Review.

There is currently a technical problem linked to the way in which data is extracted from Lorenzo in relation to Allied Health Professionals and their clinics. Work is ongoing to resolve this; once completed we will be able to add Dietetics to the system The plan would be to then progress to other AHP clinics.

Orthoptics and Physiotherapy are currently using the SMS system. Physiotherapy have been using the system to text patients when they receive a referral asking them to contact the department for an appointment. This has eradicated the need to send a letter (saving on cost of admin and postage) for those patients with a live mobile phone number. This development could be used by other services to realise similar savings.

The key issue for the Trust to address *before* extending the SMS service across all outpatient clinics is the need to provision resources to respond to those patients who request an appointment change. When the national Electronic Referrals Service (ERS) is fully rolled out, the staff currently involved on the management of paper referrals could potentially be redeployed to support the text messaging service.

The contract with Healthcare Communications, supplier of the SMS system, is due for renewal in 2018. Discussions will commence soon to identify what other service

elements are available, such as texting or emailing patients to advise them that they have a letter waiting in the patient portal (see below). The continued use of SMS is an important component of the digital roadmap for patient e-comms. Our strategy is to align, optimise and, where possible, consolidate the various current, planned and emerging technologies.

3.2 E-Mailing Patient Letters

Lorenzo is the core system from which electronic correspondence to both GP's and patients is generated. All Lorenzo generated Immediate Discharge Summaries are now transmitted into 107 GP Practice systems following clinical sign-off. This method, using structured letter templates and structured electronic messaging, will be adopted to meet the Trust's obligations in terms of the electronic transmission of clinic letters to GP's as per the target described in Section 2 above. This is in pilot phase with a large local practice (Brough and South Cave). Lessons learnt will be incorporated into a roll-out plan by 31st July 2017.

With specific regards to patients, Lorenzo is also able to e-mail Trust correspondence to patients on request. HEY is currently awaiting approval from NHS Digital to be the Lorenzo national first-of-type adopter of this facility, expected to be later this summer. Patients will be offered the chance to sign-up to the secure e-mailing service as a preference and, once signed up and tested, all future correspondence with that patient, including appointments, will be via e-mail.

It should be noted that correspondence can be sent only via the secure mail service, which requires patients to respond to an e-mail, set up an account and validate a test transmission. This has a personal overhead for the patient and a resource overhead for Patient administration. At this stage it is not known what proportion of patients will sign up to the mailing preference.

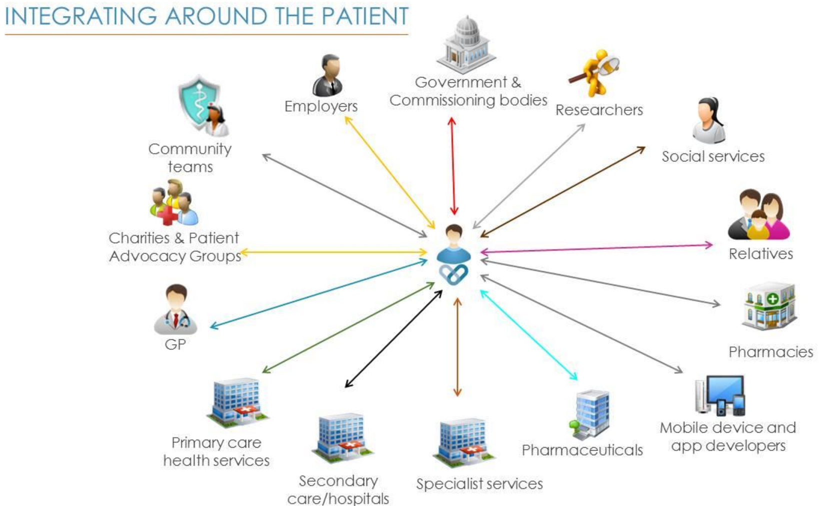
Our priorities are aligned to national mandates and contractual requirements, which is mainly around in-patient and outpatient correspondence. However, it is acknowledged that there is a multitude of other documentation in 'the system' (eg MDT outcomes / referrals to community teams / care plans / advice & guidance leaflets). These do not fall under mandated IM&T priorities. They all form part of the digital roadmap and will need to be addressed.

3.3 Patient Portal – access to records, correspondence & results

Throughout 2016 the ICT Team have developed the GP Lorenzo Portal Viewer, which allows all GP Practices to track the status of their patients and view correspondence and test results. This complements the electronic transfer of IDS's and Pathology results into their Practice systems.

The GP Viewer is currently being enhanced to include the alerting of abnormal Radiology scans to GP's and an electronic acknowledgment facility back to HEY. Additionally, there are expressions of interest to extend access to Social Care, Community and NLAG Trust.

The ICT Strategy envisages that a Patient Portal Viewer will be procured or developed as part of the Lorenzo optimisation programme. The ICT Team are currently reviewing options and have identified a system: Patient Knows Best which enables the patient to see all relevant information about their care and puts the patient at the centre of their care:



Patient Knows Best (PKB) is based upon a granular, dynamic, consent to share information model which is owned and driven by the patient, with legally auditable 'break glass'. The system is secure, web based and able to be viewed on any device by the patient. It includes:

- Patient clinical details, correspondence & results
- Appointments
- Care plans that can be viewed and contributed by everyone involved in the care process
- Symptom tracking and remote-monitoring via connection to 100+ telehealth solutions, apps and devices
  PROMs, PREMs, and surveys delivered digitally
- Videos or other media content
- Communication with remote messaging & video consultations
- Self-management "Red, Amber, Green" traffic light system

The system has been demonstrated to clinicians in HEY and York and discussions are ongoing to get agreement on using PKB for the shared Cystic Fibrosis service. A demonstration to HEY Executives and Clinical Directors is also planned. PKB is emerging as the most flexible solution to enable HEY to meet its record sharing obligations. If adopted, it will become the core hub via which patents can see key information about their care, and can interact with their care givers.

There are also ongoing discussions at the patch Digital Roadmap Programme Board to assess the potential for PKB to be the strategic sharing solution across multiple care partners in our STP.

3.4 E-Consultations

As part of the new data network and unified communications programme, the Trust will be able to offer virtual consultations using the CISCO Virtual Waiting Room product. This is a secure process, controlled by the Trust and which supports planned and structured virtual clinics and also ad-hoc consultations. It is device agnostic and does not require patients to remember complex passwords.

The Virtual Waiting Room will be available this summer and proof-of-concept trials have been agreed within Queen's. The system can be deployed into any clinical area where

the new network is installed, and ultimately across all clinical specialties as the network is rolled out. The following link provides a short demonstration of the system:

https://www.youtube.com/embed/KIFrnqFZ76g

4 Key Messages

- There is no single, mandated method of electronic communications with patients.
- Current use of SMS texting is being reviewed and will be extended to all specialties subject to resource availability.
- The secure e-mailing of patient correspondence is now possible and will be launched this summer. Adoption by patients is not yet known but will not be 100% of all correspondence.
- There is a need to extend the electronic sharing of information with patients and the procurement or development of a Patient web 'Portal' is part of next phase in the development of the HEY Care Record.
- Alongside of the sharing of e-documents, HEY will launch a trial of the 'Virtual Waiting Room' this summer within Queens. The upgraded data network is able to support structured video consultations for all specialties.
- All of the aforementioned technologies have a role to play, however, further work is required to align, optimise and, where possible, consolidate the various current, planned and emerging technologies. This will feed into the refresh of the ICT Strategy, which will take account of STP strategies and emerging technologies such as Patient Knows Best.

5 Recommendations

The Trust Board are asked to:

- Note the national expectations and obligations regarding the use of technology to communicate more effectively with service users
- Consider the plans set out above to expand and enhance the current position
- Advise whether anything further is required to support and promote the use of virtual consultations throughout the Trust

Martyn Smith
Director of IT & Innovation
30/05/17

Appendix 1

NATIONAL IM&T POLICY & EXPECTATIONS

Lord Carter Review: Productivity in NHS Hospitals
https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

NHS Five Year Forward View (2014) & Next Steps (2017)
https://www.england.nhs.uk/ourwork/futurenhs

NHS Information Policy (May 2012): The Power of Information: Putting all of us in control of the health and care information we need
https://www.gov.uk/government/publications/giving-people-control-of-the-health-and-care-information-they-need

NHS Information Board: Personalised Health and Care (November 2014)
https://www.gov.uk/government/publications/personalised-health-and-care-2020

Paper Free at the Point of Care: Digital Roadmaps (September 2015)
https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/09/digi-roadmaps-guid.pdf

Paper Free at the Point of Care: Digital Maturity Self Assessments (November 2015)
https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/11/dig-maturity-guid-11-15.pdf

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHANGE OF ORGANISATION NAME

Trust Board date	Tuesday 6 June 2017		**Reference Number**	2017 – 6 – Additional Paper A	
Director	Chris Long – Chief Executive		**Author**	Carla Ramsay - Director of Corporate Affairs	
Reason for the report	The purpose of this report is to brief the Trust Board and gain approval to proceed with the process to change the name of the Trust				
Type of report	Concept paper	✓	Strategic options		Business case
	Performance		Information		Review

1	**RECOMMENDATIONS** The Board is asked to review and approve the proposal to undertake the required process to change the organisation's name					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: N/A		**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N	
5	**BOARD/BOARD COMMITTEE REVIEW** Matters linked with the organisation's name are reserved to the Trust Board					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHANGE OF ORGANISATION NAME

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

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

3. CHANGING ORGANISATIONAL NAME

The Department of Health has issued mandatory guidance on changing NHS organisational names. The following proposal is in keeping with this guidance.

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

The proposal is to change the Trust’s name to: *Hull University Teaching Hospitals NHS Trust*

3.1 Rationale

The Trust is at a pivotal moment in its journey of improvement and development. The proposed name better reflects the Trust’s existing status as one of the largest university teaching hospitals in the country, which has not been celebrated in the Trust’s name. Moreover, the proposed name is more attractive to future and potential staff, better reflecting the clinical opportunities and career offer available at the Trust for all types of staff, and will better position the Trust nationally and internationally for recruitment. The proposed name is a point of pride for current staff, to be able to reflect that they work at a university teaching trust in a major geographical centre. It also consolidates the existing relationship with the University, including the medical school, with ‘teaching’ demonstrating the wider reach and role of the Trust in supporting the training of multiple professions. Additionally, there are no proposals to change the name of the hospital sites, thereby retaining staff and community identity and connections with Hull Royal Infirmary and Castle Hill Hospital.

In terms of process, the Trust would need to engage key stakeholders for their support prior to making a formal submission to the Department of Health for approval, for a Minister to grant an Amendment Order to the Trust’s Establishment Order. The Communications team with support of the Corporate Affairs team will lead an exercise for staff and patient feedback, and the Chief Executive will write to key stakeholders for their support. The Trust will also need formal permission from the University of Hull to use ‘university’. The Trust previously engaged the University in this issue in 2009 when it was starting its NHS Foundation Trust application. The University gave permission to use ‘university’ in the title at the point of authorisation as a NHS Foundation Trust. It is therefore hoped that the University will give the same permission in these circumstances.

3.2 Cost

The Trust would be able to undertake a name change at a low cost. Gaining insight from another Trust that recently changed its name, costs can be minimised such as changing signage using adhesive covers rather than purchasing new signs. Stationery stocks can be run

down and the organisation name changed when next batches of paperwork are ordered, which would incur minimal additional costs. An estimate of the costs of changing organisational name on this basis is circa £10,000 - £15,000.

In addition, all NHS organisations have been contacted by the NHS branding team in the Department of Health, which has undertaken a process of change and standardisation of layout of all organisational names. The Trust is required to change its logo this year in any case in line with this requirement. Therefore, to change the organisation's name now would be opportune as the Trust needs to change its logo on its website and stationery to display the new logo layout in any case.

Thirdly, the Trust has an on-going issue of recruitment of staff in key areas. The Trust's spend on Consultant medical staff agency costs were £3,384 million, and £3,332 million for below-Consultant grade medical agency in 2016/17. A large amount of the spend was specifically on hard-to-recruit Consultants in ED, acute medicine and Medical Elderly (£2,274 million). The Trust has budgeted for the substantive posts and covering the posts through agency costs significantly in excess of the budgeted salary and on-costs for these posts; agency spend exceed budget by over £3 million in 2016/17. The Trust must reduce its agency spend. To recruit to one hard-to-recruit post as a result of the name change and reduce the associated agency spend will also cover the costs of signage, stationery, etc for the name change. There prospect of the name change also gives opportunities to retain talented staff and be a more attractive destination staff who have finished their training at through Trust rather than moving on to other teaching university trusts.

4. RECOMMENDATIONS

The Board is asked to review and approve the proposal to undertake the required process to change the organisation's name.

Chris Long
Chief Executive
May 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Meeting date	Tuesday 6 June 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: • Review and agree the amended Board Assurance Framework for 2017/18 • Raise any queries or concerns about the current status of any BAF risk area • Receive the positive assurance detailed from the April – May 2017 Trust Board and Committee meetings (where the Board as received these Committees' minutes) • Raise if any collection of risks from the corporate risk register should become a new BAF issue, or added as a collection of risks as a risk area of its own to an existing BAF area					
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 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 Additional BAF risk areas

The 2017-18 BAF was reviewed and approved by the Trust Board at its May 2017 meeting. Following this meeting, feedback has been received on BAF risk area 7, relating to financial risks.

The BAF 17/18 has been amended in line with this feedback, to detail three risk areas relating to finance (BAF 7.1 – 7.3). This is to split out the over-arching Risk (BAF 7) in to its component areas, so there is better visibility of the specific risks and issues in each area of financial risk, and detail the different areas of assurance required The Trust Board is asked to review and approve these changes. The full BAF 2017/18 is attached at Appendix A.

3.2 Assurance

From the April – May 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. As part of this, the Trust Board is asked to note that the Chairman and Chief Executive will be building in elements of the BAF and assurance requirements needed in to upcoming Board Development sessions in 2017/18.

3.3 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 Executive Management Committee reviewed an updated Corporate Risk Register in May 2017, onto which 3 high-rated risks from the Medicine Health Group were agreed for inclusion. These are included at the end of the Corporate Risk Register (attached at Appendix b). Two of these areas directly link with BAF 2, so are included in the updated BAF attached.

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

asked at its last meeting to provide feedback as to whether any single risk or collection of similar risks raises a new organisation-wide risk that risks delivery of a strategic objective, and therefore should be placed on the BAF. The Trust Board is asked to do so again, in light of the three additional risks from the Medicine Health Group that are now on the Corporate Risk Register.

4. RECOMMENDATIONS

The Trust Board is asked to:

- Review and agree the amended Board Assurance Framework for 2017/18
- Raise any queries or concerns about the current status of any BAF risk area
- Receive the positive assurance detailed from the April – May 2017 Trust Board and Committee meetings (where the Board as received these Committees' minutes)
- Raise if any collection of risks from the corporate risk register should become a new BAF issue, or added as a collection of risks as a risk area of its own to an existing BAF area

Carla Ramsay
Director of Corporate Affairs

May 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: What is being done to manage the risk? (controls)	Mitigating Actions: What controls are still needed or not working effectively?	2017/18 risk ratings: Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
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: What is being done to manage the risk? (controls)	Mitigating Actions: What controls are still needed or not working effectively?	2017/18 risk ratings: Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
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	**Positive assurance** Discussion with HYMS and stakeholders with a view to increasing medical student training posts locally by circa 50%, including recruitment of local students Guardian of Safe Working 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. **Further assurance required** Delivery of medical staff revalidation – to give a measure of competent and skilled staff Use of appraisals across the Trust as a means of valuing staff – staff survey reports that appraisals are not fully valued across the Trust Measures to understand whether staffing body is 'skilled' and 'sufficient' Further level of assurance on junior doctor gaps and potential issues leading to fines cannot yet be given via the Guardian of Safe Working

			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	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 Updated QIP developed going in to 17-18 – monitored at Quality Committee **Further assurance required**

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)** **= 20**	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 **<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

		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	The role of the public, NEDs and more widely, Trust Boards in understanding, developing or driving change through the STP Issue of clarity of strategy between STP, STP workstreams and place-based plans and Trust positioning within these					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

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 May 2017 Trust Board) – brings potential additional risks					5 x 1 = 5	**Positive assurance** **Further assurance required** Gap in CRES identification of £10m at start of 17-18 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	**Positive assurance** **Further assurance required** Gap in completion and upload of all service-level business continuity plans Business Continuity Plan refresh for significant event (flood, fire, etc)

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

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

AUDIT COMMITTEE

Meeting Date:	25 May 2017	**Chair:**	Mr M Gore	**Quorate (Y/N)**	Y

Key issues discussed:

- Annual Governance Report (Presented by KPMG)
- Audited Accounts 2016-17
- Letter of Representation
- Annual Report 2016/17

Decisions made by the Committee:

- The Audited Accounts 2016/17 were recommended for approval by the Trust Board
- The Annual Report (following amendments made in the meeting) were recommended for approval by the Trust Board

Key Information Points to the Board:

Matters escalated to the Board for action:

- The Audited Accounts 2016/17 were recommended for approval by the Trust Board
- The Annual Report (following amendments made in the meeting) were recommended for approval by the Trust Board

Matters referred to other Committees:

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE MINUTES
HELD ON THURSDAY 25 MAY 2017
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr M Gore (Chair)	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
IN ATTENDANCE:	Mrs D Roberts	Deputy Director of Finance
	Mr J Prentice	KPMG
	Ms C Ramsay	Director of Corporate Affairs
	Mr C Long	Chief Executive Officer
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

Action

1. APOLOGIES

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

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. ANNUAL GOVERNANCE REPORT (KPMG)

Mr Prentice presented the report and advised that the audit was substantially complete and was not aware of any reason why the Audit Committee could not recommend approval of the accounts to the Trust Board.

Mr Prentice highlighted risks going forward which were the gap in the 2017/18 financial plan and how this would be closed, the STP funding and the Health Group overspend.

Mr Prentice reported that the Trust's Quality Accounts had been reviewed and the VTE indicator was still an issue. The electronic and manual recording of assessments were showing discrepancies and this was being addressed. The results were currently at 85% with a target of 95% to be achieved. Mr Bond added that the results were improving steadily and VTE would now be included on the performance meeting agendas as a standing item.

Mr Prentice praised East Lancashire Financial Services (ELFS) for their cooperation whilst preparing the accounts and was impressed with the processes in place between the Trust and ELFS. He did add that the Trust was still responsible for any outcomes and should have a robust control matrix in place. Mr Hall asked how the committee would be assured that the governance arrangements were in place and Mrs Roberts agreed to bring a paper to the July 2017 Audit committee showing this information. **DR**

Mr Bond asked the Committee to recognise the hard work of the financial team and ELFS for their input at year end and throughout the difficult year the Trust had faced.

The Committee also thanked Mr Prentice for his help and professionalism over the years as this was to be his last meeting with the Audit Committee. Mr Bond thanked Mr Prentice personally for his help and advice.

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Resolved:
The Committee received the report and agreed with the comments made.

4. AUDITED ACCOUNTS 2016/17

Mr Bond presented the accounts 2016/17 and reported that the Trust had reported a turnover of £540m and a surplus of £2.7m. The Trust had received a revenue support loan from the Department of Health which had helped the cash position in 2016/17.

Mr Bond drew the Committee's attention to the increase in debtors which was creating liquidity issues and the need to reduce stocks and inventory which was at £12m. Mr Gore asked how the Trust was managing supplier relationships. Mr Bond advised that relationships were fragile but the Trust was supporting small, local businesses where possible. £3k had been paid out in interest due to late payments being made.

Mr Bond praised Mr Taylor (Director of Estates) and his team for their work to improve the catering for staff and patients and trading at a surplus.

Mr Bond also reported that the NHSLA negligence figure had been increased to £139m.

Resolved:
The Audit Committee agreed to recommend approval of the accounts 2016/17 to the Trust Board at its meeting 25 May 2017.

5. LETTER OF REPRESENTATION

Mr Prentice presented the letter and advised that this was standard procedure and would be signed by the Chief Financial Officer and the Chair of the Audit Committee.

Resolved:
The letter was received by the Committee.

6. ANNUAL REPORT

Ms Ramsay presented the Trust's annual report and highlighted a number of amendments that had been highlighted by the Board. These included the change in wording regarding the surplus due to additional STP funding, a change to the income and WTE figures and a date change. The Committee went through the report and made further changes which would be amended before the Board meeting to approve the report 25 May 2017.

Resolved:
The Committee recommended approval of the report following the changes made in the meeting.

7. DATE AND TIME OF THE NEXT MEETING:

Thursday 27 July 2017, 9am – 10am, The Committee Room, Hull Royal Infirmary

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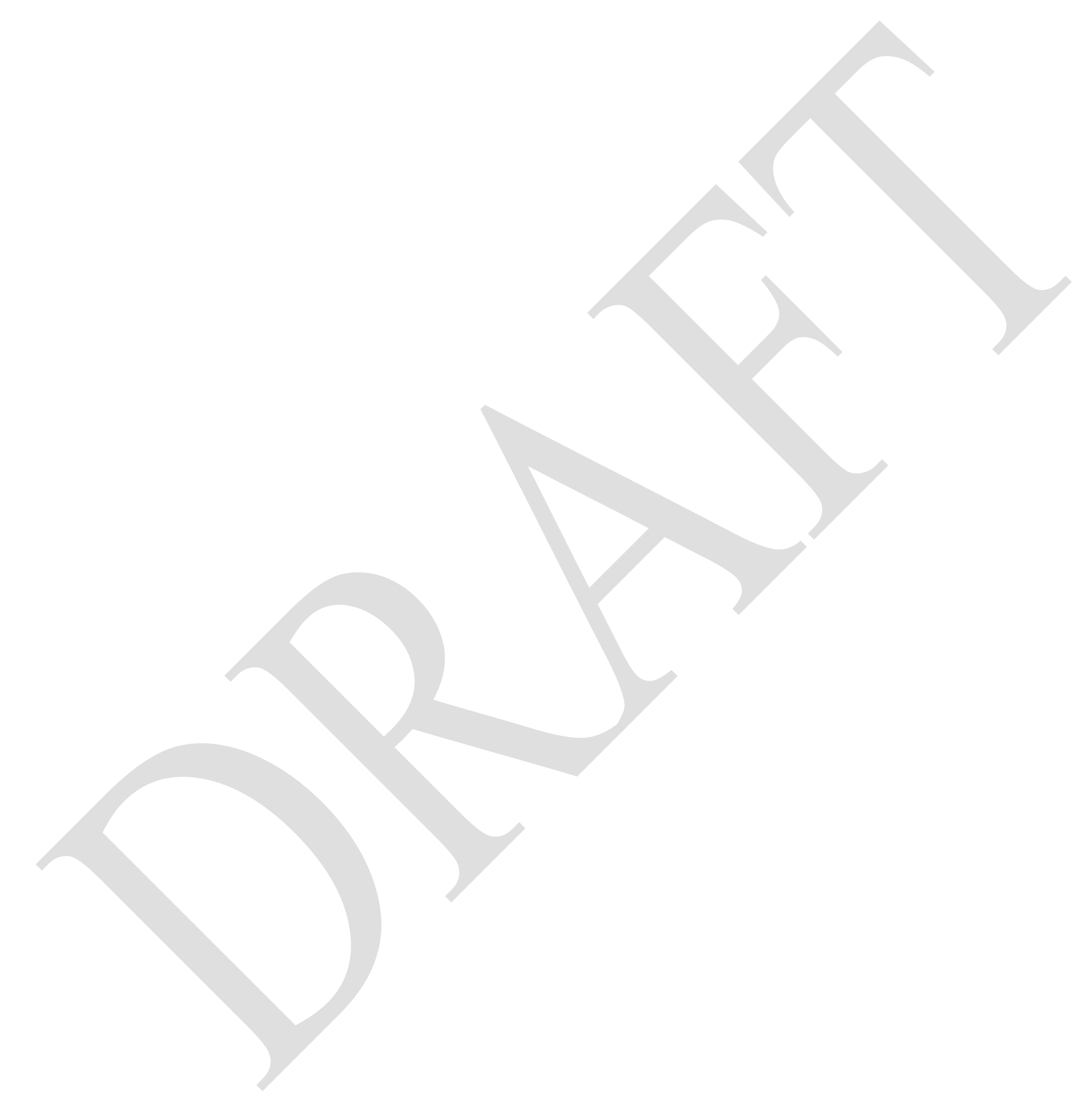

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	6 June 2017	**Reference Number**	2017 – 6 – 20		
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
2017/03	Hull and East Yorkshire Hospitals NHS Trust and DKP Consulting – Demolition of blocks 7 (Haughton Building West), 20 (Simpson Building), 21 (Occupational Therapy), 80 (Capital Development Cabin) and 81 (Security) all at Hull Royal Infirmary. Demolition of blocks 3 (ward 2), 48 (finance building) and 50 (Infrastructure and Development) at Castle Hill Hospital	26.05.17

5 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Assistant Trust Secretary
May 2017